



West Midlands Pension Fund

# A GUIDANCE MANUAL FOR APPROVED DOCTORS

WEST MIDLANDS



PENSION FUND

# Contents

Introduction	1
Establishment of Doctors' Panel	2
Flow Chart of Process	4
Certification of Fund Forms	5
Standards of Evidence for Permanent Incapacity Opinions	6
Permanent Incapacity Evidence Checklist	7
Ill-Health Retirement Guidance (an extract)	8
LGPS Ill-Health Statutory Guidance 24 Nov 2009	20
CLG FAQs May 2009	47
LGPS Supplementary Guidance 28 July 2009	61
Fund Medical Forms	67
LGPS Regulations - Regulation 20 , 31 and 56	72
HM Treasury July 2000 Report	76

# Introduction

The West Midlands Pension Fund (the Fund) frequently publishes guides or publications to assist employers in discharging their responsibilities under the LGPS regulations.

This, the latest version of '*A Guidance Manual for Doctors*' published in April 2010, sets out the Fund's interpretation of the current procedures required to safeguard not only the assets of the Fund, but also the integrity of the ill-health procedure.

Much has been written about the guidance published by CLG and the intent behind the changes to the procedure itself but, overall, it is aimed that those members who have the need to call upon the Scheme's generous ill-health benefits will still be able to do so under tier 1, while others with less critical, but nonetheless limiting conditions, will still benefit as appropriate by virtue of the regulations under tiers 2 and 3.

Those employers participating in the Fund include the seven West Midlands district councils, several joint authorities and smaller statutory bodies, large numbers of schools and colleges and a great variety of other public service bodies, will be aware of the wealth of information available on the subject of ill-health. It is hoped that this guide will be a central depository for all such information, as well as detailing the Fund's procedure.

Fund employers are reminded that a decision under the Scheme regulations on ill-health matters is a decision that must be communicated to employees, and as such must also contain details of the relevant appeal procedure as required by the internal dispute resolution procedure (IDRP).

It should be noted that nothing contained within this guide can override the prevailing regulations, and that the prevailing regulations will be used, along with the Fund's interpretations of the regulations at all times, to settle any disputes that may arise.

Decisions on entitlement to pension benefits under the LGPS are the responsibility of a person's employer or former employer. However, where a person's ill-health may be relevant to pension benefits, employers are required, before making their decision on pension benefits, to obtain an opinion from an approved independent registered medical practitioner (referred to from now on in this guide as an approved doctor) on whether a person is permanently incapacitated because of ill-health. It is the responsibility of the Fund in the case of employers to approve doctors for this purpose.

The main aim of this guide is to help employers and doctors understand the important role they have to play within the LGPS regulatory framework; it may also prove to be beneficial for Scheme members, employee representatives and local referees.

The Fund wishes to acknowledge the contribution of the various authors and contributors, without whom the guide would not be possible. Credits are provided within the text to the various sources and reference materials.

Please refer any comments or questions about this guide to the Fund in the normal way.

# Establishment of Doctors' Panel

**The Fund has sought to increase the number of approved independent registered medical practitioners, in accordance with Regulation 56(2) of the LGPS (Administration) Regulations 2008.**

**A panel of approved IRMPs has been established.**

## 1) Purpose of Panel

- ▶ To assist West Midlands Pension Fund in discharging its responsibilities for approving and processing ill-health retirements.
- ▶ To act as Fund doctors under regulation 56 (2) of the LGPS (Administration) Regulations.
- ▶ To set and maintain high professional standards in applying medical expertise to the application of the LGPS ill-health regulations.
- ▶ To act as a reference point to colleagues for individual cases and matters relating to the interpretation of regulations.

## 2) Activities

- ▶ To evaluate and, where appropriate, to approve ill-health retirements in accordance with the LGPS regulations as an approved Fund doctor.
- ▶ To assist fellow panel members in determining cases and setting operating practices.
- ▶ To give an opinion and report on appeal and other cases referred for a further independent opinion as required under the LGPS appeals process or third party interventions, such as the ombudsman.
- ▶ To attend panel meetings as required by the Chairman, Dr Archer, when practical.

## 3) Member Standards

- ▶ To be accredited specialist in occupational medicine in terms of qualifications, experience of considering ill-health retirement and knowledge of the LGPS regulations.

## 4) Other Matters

When a panel member is acting for an employing body as an occupational health doctor, this role is expected to take precedence. The panel doctor will only go on to act as the Fund's approved doctor for that case, if the case is a straightforward strong case in medical terms. The Chair of the panel will provide guidance on specific cases if necessary.

It is recognised by all parties that the interests of the individual are the major issue, and ill-health retirements should be approved if it is clear the circumstances of the case meet the LGPS ill-health provisions. In complex cases, the panel will be a professional confidential reference point if required, or referral of a case.

## 5) Operational Practices

- i) All panel doctors should agree to work to the standards recommended in the ALAMA guidelines and to have their recommendations on behalf of the West Midlands Pension Fund audited.

While acting as a panel doctor, he or she should be in good standing with the Faculty of Occupational Medicine for Continuing Professional Development and with the General Medical Council for revalidation, conduct and competency purposes and with no restriction to practise. Panel doctors operate to the best practice guidelines which includes:

- ▶ Chair's checklist
- ▶ ALMA guidelines
- ▶ LGPS Regulations Statutory Guidance
- ▶ HM Treasury July 2000 Report – *Review of Ill-Health in the Public Sector*

- ii) The LGPS Regulations require an independent registered medical practitioner (IRMP) qualified in occupational health medicine to determine eligibility and state the necessary qualifications of such a person [Regulation 20(14)], but do not state what is meant by independent.

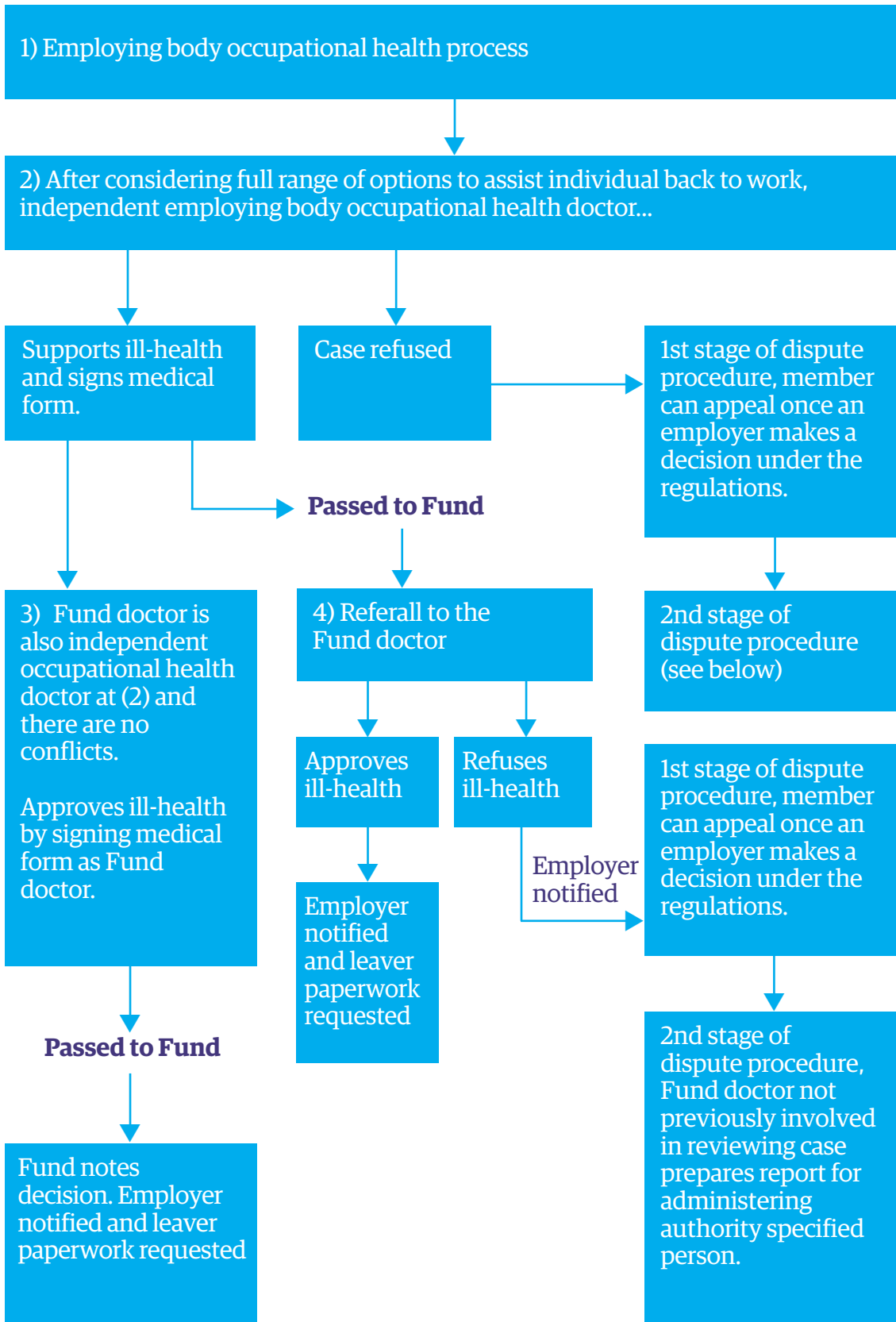
However, the Fund assumes that for an IRMP to be seen as independent, he or she must be able to give the declarations referred to in Regulation 56(1) of the Administration Regulations:

- a) he has not previously advised, or given an opinion on, or otherwise been involved in the particular case for which the certificate has been requested; and
- b) he is not acting, and has not at any time acted, as the representative of the member, the employing authority or any other party in relation to the same case.

The Fund also interprets 'independent' to mean independent of any previous involvement in advising the employing body of the options for the employee concerned, and is capable of acting in the Fund's interests without any conflicts with the employing body or individual.

- iii) In situations where there could be a real or perceived conflict in acting as the Fund's doctor, the panel doctor will discuss with the Chair or declare no availability to act as the Fund's doctor.

# Flow Chart of Process



## Certification of Fund Forms

The appropriate medical form should be completed by the employer and the independent employing body occupational health doctor. Where the doctor is an independent registered medical practitioner approved by the Fund under regulation 56(2) of the Administration Regulations (a panel doctor), then he or she will also be eligible to sign the form at Part C, if there is no perceived conflict or need for a further opinion.

In all cases the medical form should be sent to the Fund. Where the form has been signed by an approved panel doctor, it will not be forwarded to a further panel doctor. The case notes at Part D will not be required. The member's record will be updated with the decision, and the leaver paperwork will be requested from the employing body.

Where the occupational health doctor is not an approved panel doctor, the medical form will continue to be referred to an approved Fund doctor.

Where ill-health retirement is approved, the Fund will advise the employing body and request the leaver paperwork.

# Standards of Evidence for Permanent Incapacity Opinions

An occupational physician, or doctor with a qualification in occupational medicine, who acts as an independent doctor advising the Local Government Pension Scheme or other pension scheme on applications for ill-health retirement benefits, should be able to justify and audit their occupational health opinions using best practice standards. Permanent incapacity is the outcome of an occupational health and workability assessment rather than the outcome a clinical opinion.

It is important at the outset to establish that independent doctors should confine themselves to an opinion on whether or not there is sufficient evidence of permanent incapacity due to ill-health. He or she does not make decisions concerning eligibility for ill-health retirement. That is a matter for the employer not the doctor.

The paper by Poole et al '*Ill-health retirement: national rates and updated guidance for occupational physicians in Occupational Medicine 2005: 55: 345-8*' gives an evidence and consensus basis for doctors who give professional opinions about health or disability-related incapacity which underpin eligibility for ill-health retirement pension benefits.

When evidence is obtained from a treating doctor, it should preferably be in the form of answers to specific questions concerning investigations, diagnosis, treatment plans and outcomes. Correspondence between the treating specialist and GP will often be helpful.

Unfortunately, some doctors, including specialists, are inclined to give uninvited opinions on matters such as ill-health retirement without necessarily being familiar with the duties of the job, the criteria of the pension scheme or being qualified in occupational health. The independent OHP retained by the pension scheme should be in a position to

justify their own opinion to the pension scheme. He or she should not rely on an opinion from a clinical specialist or other doctor about matters outwith their competence, such as the nature of the job and eligibility to ill-health retirement benefits. The occupational physician or other OH advisor acting for the employer should supply an objective assessment of the applicant's disability and functional capacity to do their job, and potentially any other job outside of local government employment. The applicant should be given the opportunity to submit their own description of how they feel that their medical condition causes incapacity. Relevant and significant motivational or psychosocial factors ('yellow flags') should also be included in the medical report. Any history of significant or long-term disaffection between the employer and employee is also likely to be relevant.

The employer should provide the independent occupational physician with details of the current job description and include information about adjustments to the job or workplace, redeployment and other rehabilitation measures that have been offered or tried. (Unexplained failure of rehabilitation is often an indicator of illness behaviour or deception.)

The opinion of the independent doctor should be expressed in the form of an occupational health report with sufficient detail to show why a particular opinion was formed. This should accompany the statutory certificate.

The checklist that follows may act as a useful aide-mémoire both for the employer's OHP submitting an application and the independent doctor considering an application. It may also serve as the basis for justification of a particular opinion or for audit cycle purposes.

**Dr Dale Archer**

# Permanent Incapacity Evidence Checklist

Applicant name: ..... Date of birth: .....

Job title: ..... Years in current post: .....

Years of local government service: .....

		Yes	No
1	Is it clear which pension regulation applies to this application?		
2	Has the employer dismissed or is in the process of dismissing the applicant, on what grounds and on what date?		
3	Has the employer Included details of current absence?		
4	Has the employer submitted a clear detailed job description?		
5	Does the applicant and his/her employer understand the medical criteria for permanent incapacity?		
6	Has a relevant diagnosis or diagnoses been established?		
7	Is there sufficient medical information documenting investigations, diagnosis, treatment plan clinical and workability prognosis from any of the following?: <ul style="list-style-type: none"> <li>• employer's occupational physician</li> <li>• treating or other specialist</li> <li>• GP</li> <li>• other health professional, eg, clinical psychologist</li> </ul>		
8	Have all investigations been completed and the outcomes known?		
9	Have all reasonable and evidence-based treatments been tried and given for a therapeutic period of time and has there been adequate time to allow for recovery?		
10	Is there a clear clinical and workability prognosis in relation to the job and alternative employment?		
11	Has an assessment of functional capabilities and disabilities in relation to the current job and alternative work been included?		
12	If applicable, has the employer explored reasonable adjustments under the DDA?		
13	Is there a credible explanation as to why adjustments or rehabilitation attempts were not successful?		
14	If alternative work was offered, is there an explanation as to why it was not taken up?		
15	Has the employer included details of significant workplace disaffection, job satisfaction, work stress or motivational factors?		
16	Has the applicant included a statement of his or her own medical condition and functional limitations?		

## Ill-Health Retirement Guidance

**Extract from appendix to *Ill-health retirement: national rates and updated guidance for occupational physicians*. CJM Poole, CM Bass (co-opted), JE Sorrell, ME Thompson, JR Harrison and AD Archer on behalf of the Association of Local Authority Medical Advisers. *Occupational Medicine* 2005; 55: 345-348.**

### General Guidance

Before advising on the merits of an application for early retirement, the following steps should be followed by the occupational physician:

#### **Obtain the Relevant Medical Information**

A professional opinion should not be offered until all the relevant facts are known: (a) From what disease, illness or injury is the applicant suffering? This may be ascertained during the consultation or subsequently with additional information. (b) Is it a recognised medical condition contained for example in the International Classification of Diseases?<sup>1</sup> (c) What treatments have been tried, and are there others with a good evidence base that have not been tried and would be reasonable for the patient to try? (d) What is the normal prognosis of the condition? (e) Did the employee have the condition when they were appointed? If so, why has their incapacity become so great that they are incapable of working now and in the future?

If clinical information about the patient is required from their general practitioner or a treating specialist, then the Access to Medical Reports Act 1988 will apply. Such a request has the potential of putting these doctors in a position of conflict of interests and may damage the doctor-patient relationship. To minimise the likelihood of this happening, a letter from the occupational physician to either of these doctors should ask specific questions about the patient or medical condition, rather than asking for a non-specific report or an opinion on fitness to work. Direct access to the hospital or GP records, with the patient's informed written consent in accordance with the Data Protection Act, may be helpful in some circumstances. Examples of specific questions are: what treatments have been tried and what treatments are planned? Could I have a copy of the x-ray and MRI scan reports please?

#### **Assess the Workplace and the Job**

When formulating an opinion it is helpful, not only to examine the patient, but also to obtain information from the patient's line manager that addresses the specific problems at work, and details of any steps that have been taken to remedy the situation. The information should be factual rather than hearsay or inferential. It may be helpful for the occupational physician to visit the workplace, to obtain a job description and to clarify the duties of the patient, especially if he or she is unfamiliar with the job. Answers to explicit questions about working relationships, workload, work rate and the physical or emotional demands of the job may also be necessary from the patient and line manager. Because the content of jobs change with time, fitness for the job is usually taken as the current job and not one that appears on an out of date job description. Where possible, disability should be reduced by aids or adaptations to the workplace or by adjustments to the method of working to accommodate the patient's impairments.

#### **Do Not Be Pressurised into Making Hasty Decisions**

The decision about eligibility for a pension should be distinguished from the decision about employment. The occupational physician should resist any pressure from the patient or the employer to make a hasty decision when, for example, the relevant medical information is not known, a diagnosis has not been made, treatment has not been completed, it is likely that the patient's condition will improve or solely to avoid disciplinary action. Refusal by the patient to undergo reasonable treatment for the purposes of gaining benefits should not be condoned. Adjustments to the workplace, with or without the help of the Access to Work Team, will take time to organise and a period of assessment following such changes will need to take place. Similarly a trial of 'permitted' (previously called therapeutic) work while off sick in agreement with the Department of Work and Pensions, or 'supported' employment with the help of a job 'coach' from a JobCentre Plus provider organisation will take time to organise.

Problems due to unsatisfactory working relationships will also take time to address. The role undertaken by an employee is nowadays unlikely to remain unchanged, and neither is an employee likely to remain in the same job or with the same manager for years at a time. So unless there has been serious misconduct on the part of the employer, or the employee's personality is especially vulnerable, the occupational physician should not use an employee's refusal to return to a particular workplace because of interpersonal difficulties as a reason for supporting early retirement due to ill-health.

### **Base Advice on Objective Medical Evidence**

The decision whether or not to support an early retirement on the grounds of permanent ill-health should be based on objective medical evidence and assessment of true functional ability. Psychosocial factors that may be contributing to disability should be identified. The occupational physician should be alert to the possibility of wilful illness deception (malingering). Requests to leave out materially relevant information for the purpose of creating a biased report should be resisted. A lack of motivation or other non-medical factor, such as anger, embitterment or disaffection with the employer, when it is the primary cause for the employee refraining from work, should not be accepted as a reason for supporting early retirement due to ill-health. On the other hand, the employee should not be required to make heroic efforts to keep working and rarely, for reasons of safety and efficiency, a particularly disabled patient may need to be encouraged or even required to take early retirement.

The applicant's general practitioner should be informed about any materially relevant findings or recommendations. When the occupational physician's opinion regarding fitness to work or eligibility for a pension differs from that of another doctor, the patient should, if he or she wishes, be given the opportunity of including the other doctor's report in representations to the relevant decision makers. Wherever possible, the occupational physician should state in the report why he or she does not agree with the other doctor's opinion.

### **Employment Law**

An employee's contract may be terminated under the Employment Rights Act 1996 by the employer on the grounds of capability (as assessed by reference to skill, aptitude or health), misconduct, redundancy of the job, a statutory reason or for some other substantial reason.<sup>2</sup> Eligibility to an early pension due to ill-health is not a reason for terminating a contract. In law, eligibility to a pension may be contractual or discretionary and the wording of the criteria should reflect this fact. Advice from a lawyer is recommended when wording the eligibility criteria.

The Disability Discrimination Act 1995 applies equally at the end of employment as it does at recruitment or during employment. It gives the employee certain rights provided he or she has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities. Although physical and mental impairment is not defined in the act, tribunals have stated that mental symptoms must constitute a clinically well-recognised illness, whereas for physical symptoms there need only be impairment of function. Substantial is not defined, but is interpreted to mean more than trivial and applies to the functional ability of the patient off medication or without special aids. Long-term means that the disability has lasted or is likely to last more than 12 months. Normal day-to-day activities encompass mobility, manual dexterity, physical co-ordination, continence, the ability to lift, carry or move everyday objects, speech, hearing or eyesight, memory, ability to concentrate, learn or understand and the perception of risk of physical danger.

The act and the requirement for reasonable adjustments to the job or workplace apply throughout employment from recruitment to dismissal and includes retirement. Disabled patients should be allowed an increased amount of time off work for treatment but not just by virtue of being disabled. Patients who are ill but do not fulfil the criteria for a pension and who are unable to return to work after a reasonable period of absence, may be dismissed by management on the grounds that they are incapable of fulfilling the terms of their contract due to ill-health.<sup>2</sup>

### **Injury Award**

This is payable when an employee suffers permanent incapacity as a result of an injury or disease caused by their work [The Local Government (Discretionary Payments) Regulations 1996]. It is designed to compensate for loss of earning capacity rather than any percentage loss of function, which for local government and NHS employees provides for up to 85% of average earnings. No guidance is currently available on how to calculate an award.

For the purposes of police or firemen's pensions, the qualifying injury, disease or illness must have caused or substantially contributed to the claimant's disability. An award is calculated as a percentage of salary from the difference between the claimant's pre-injury salary and their current or projected earnings. It is not necessary for the claimant to have found work for an assessment to be made. A personnel officer normally makes the assessment of earning capacity. A copy of the general practitioner's records or access to hospital records is often helpful to confirm the accuracy of information provided, or to help establish causality and apportionment when incapacity may be due to other medical conditions in addition to the injury itself. Ill-health which arises directly from normally conducted disciplinary proceedings should not warrant the payment of an injury award.<sup>3</sup> An injury award is not intended to compensate for loss of function, pain or suffering for which an industrial injury benefit or personal injury claim may be appropriate.

In some pension schemes, retirement benefits are significantly enhanced as a consequence of a work-related injury. In certain patients this may encourage wilful illness deception that may be difficult for the doctor to identify. This is because in normal medical practice, the patient makes an honest disclosure of their symptoms and there is no incentive to deceive. Illness deception should be distinguished from normal illness behaviour, a functional or somatoform disorder, or hysterical conversion. Diagnoses that rely on self-reported symptoms that cannot be verified independently or by testing, such as pain, psychiatric symptoms or functional disability, are vulnerable to errors of diagnosis. Helpful markers of deception include: a delay between the alleged injury and onset of symptoms; inconsistent or inappropriate symptoms for the diagnosis; excessively severe symptoms for the diagnosis; inconsistencies on examination such as overreaction or positive Waddell's signs<sup>4</sup>, an unusually poor functional ability for the diagnosis or a lack of response to appropriate treatment.<sup>5</sup> In a systematic review of 32 controlled trials of patients with physical dysfunction and pain, seeking financial compensation was associated with greater complaints of pain and a reduced response to treatment.<sup>6</sup>

## Specific Guidance

Some applications for early retirement are difficult to assess, and examples of such conditions are given below. In general, those employees who fail to respond to specialist treatment and whose illnesses have features of the worst prognosis may warrant early retirement on the grounds of permanent ill-health, if reasonable aids or adaptations to the workplace or job have been unsuccessful. Mental ill-health and musculoskeletal disorders are the most common diagnostic reasons for early retirement and so will be considered first.

### Anxiety and Somatoform Disorders

These include adjustment disorders, generalised anxiety, anxiety coexisting with depression, phobias, social disorders, panic attacks, agoraphobia, dissociative (conversion) disorders, depersonalisation, somatoform (hysterical) disorders and hypochondriasis. The majority (especially acute reactions to stress and adjustment disorders) have a very good prognosis and are helped by supportive counselling or other forms of psychological therapy. Short courses of anxiolytics or high dose antidepressant medication may be required. It should not be necessary for all symptoms to disappear for successful vocational rehabilitation to take place.

A phobic anxiety about a person(s) or aspect of the job may be difficult to treat, but relocation to a different team or to comparable work that does not involve the anxiety-provoking stimulus should be sought. An employee who has been treated particularly unreasonably by their employer will need greater support from the occupational physician, which may include the recommendation that an application is made for an injury award.

### Functional Illness (Medically Unexplained Symptoms)

The terms functional illness, non-organic or medically unexplained symptoms are used when the patient's symptoms cannot be explained by disease or physiological disturbance particularly if the illness is unduly severe or persistent. If the symptoms last for more than six months, then the term 'somatoform disorder' should be used. Examples of this illness may be found in patients with multiple symptoms but no significant findings on examination or from investigations; non-specific back pain or arm pain; generalised fatigue or weakness of a limb; dysphonia.

In a six-year longitudinal study of 64 patients with unexplained function (eg, hemiparesis and tremor) only three developed new organic neurological disorders, but subsequent psychiatric illnesses (depression, anxiety and personality disorder) were common.<sup>7</sup>

In attempting to understand the patient, the occupational physician should try to gain insight into the underlying initiating and maintaining psychosocial factors, which may not be identical. Identifying links between psychosocial factors and somatic aspects of their illness (eg, "You told me that you were unhappy with your new manager. I wonder if this has contributed to your headaches and fatigue?"), may be helpful to the patient. Those patients who are dissociated from their emotions or who have fixed beliefs about an organic aetiology may be resentful of such an explanation. One of the psychological therapies such as cognitive behavioural therapy may be helpful for these patients.<sup>8</sup> For those with functional dysphonia, voice therapy and voice amplification are usually successful. Patients with co-morbid psychiatric illness should be referred to a psychiatrist. Early retirement should not be supported when a functional (non-organic) illness is the main cause of incapacity.

### Stress

Feelings of an inability to cope with the pressures of work or emotional fatigue ('burnout') are not recognised illnesses in either ICD10 or DSM-IV and should not warrant early retirement on the grounds of ill-health, unless associated with mental ill-health which has been unresponsive to appropriate psychiatric treatment and workplace adjustments. Modern UK health and safety legislation requires managers to identify hazards to health, both physical and psychological, to undertake risk assessments and to control risks by reasonably practicable means. During the course of a consultation, relevant job specific aetiological factors may be identified which may have contributed to the employee's ill-health. These are usually of an organisational nature such as an excessive workload, or work rate, high physical or emotional demands, poor interpersonal working relationships, poor communication, excessive control by others of the way in which a job is done, conflicting roles at work or conflicting demands between the home and work, or job insecurity.

Relevant factors should be identified by the occupational physician and communicated to management as part of the medical report. Non work-related factors such as divorce, bereavement or family illness should also be taken into consideration and the patient managed accordingly. Feelings of stress, with or without anxiety or depression, are unlikely to be a justifiable reason for early retirement.

### **Post-Traumatic Stress Disorder**

This may occur after exposure to or witnessing of a traumatic event of exceptional severity which is likely to cause pervasive distress in almost anyone.<sup>1</sup> Examples of such traumatic events are aspects of military combat, torture, violent personal assault to include rape and severe road traffic accidents. The definition of post-traumatic stress disorder (PTSD) is wider in the American classification DSM-IV than in ICD-10 and includes the learning of life-threatening harm to relatives or close friends. Disciplinary hearings or the witnessing of unpleasant events that may occur as part of one's job should not fall within the definition.

Treatment consists of giving the patient opportunities to recall the stressful experience and to express their associated emotions ('working through') with a sympathetic person who need not be a health care worker ('peer debriefing'). Treatment with anxiolytics, antidepressants, cognitive behavioural therapy or eye movement desensitisation and reprocessing may be necessary and are usually successful.<sup>9</sup> A systematic review of eight randomised controlled trials, comparing debriefing with no interventions, found no evidence that debriefing prevents PTSD and one trial found that it was harmful.<sup>10,13</sup> Patients should be encouraged to resume normal activities, and reassured that it is not necessary for all symptoms to disappear before returning to work.

Adverse prognostic factors are an acute stress reaction at the time of the trauma, a vulnerable pre-morbid personality such as neuroticism, bereavement as a result of the trauma, coexisting depression or somatization, an absence of supportive relationships and ongoing litigation.<sup>11</sup> The diagnosis of PTSD largely depends on self-reported symptoms and so an opportunity arises for some patients to deceive the occupational physician about their illness. Over-reporting of symptoms or very high PTSD

scores on clinical scales have been found in this situation.<sup>12</sup> Only in the severest cases, with several adverse prognostic features and a failure to respond to appropriate treatment, should early retirement be necessary.

### **Depressive Disorders**

Depression can occur in isolation or more commonly in association with anxiety. There is good evidence that most patients with depression, or depression coexisting with anxiety, respond to psychological treatments such as cognitive, interpersonal or problem solving therapy, as well as to antidepressant medication but not to non-directive counselling.<sup>13</sup> Antidepressant medication should be continued for up to six months after the acute episode and as maintenance therapy for at least a year for recurrent episodes.<sup>14</sup> Any contributory workplace factors should be identified by the occupational physician and included in the report to management.

Early retirement due to permanent incapacity should not be indicated in a mild to moderate depression, particularly if the patient is several years from their normal retirement age. In a patient with recurrent or refractory depression who, for medical reasons, has failed to respond to any significant degree, or for any significant length of time, to therapeutic doses or two or more pharmacological treatments and one evidence-based psychological treatment, and adjustments to the job have been unsuccessful, then an application for early retirement should be supported.

### **Bipolar Affective Disorder (Manic Depressive Psychosis)**

Treatment of this condition has been revolutionised by prophylactic lithium therapy and many people with manic depression manage to work satisfactorily.<sup>15</sup> Tremor is a common side effect of lithium which may be relevant for some jobs.

The worst prognosis is associated with patients who have a rapidly cycling form, psychotic symptoms with their mania, or a personality disorder.<sup>16,17</sup> For group 2 drivers, the licence must be revoked until the patient is well and stable for a minimum of three years. Group 1 drivers will have their licence revoked for a shorter period, and provided driving is not an integral part of their job or comparable non-driving work is unavailable, then this illness should not lead to early retirement.

### **Obsessive-Compulsive Disorder**

A longitudinal study for 40 years of 122 patients in Sweden has shown that 83% improved and 48% recovered (some with sub-clinical symptoms).<sup>18</sup>

With modern treatments of cognitive-behavioural therapy and high-dose selective serotonin reuptake inhibitors prognosis should be even better. Prognosis is worse for those patients with severe obsessional symptoms and compulsive behaviours, coexistent other mental illnesses, a personality disorder or continuing stressful events in their life.<sup>17,18</sup> Early retirement would be appropriate if the above treatment is unsuccessful and there are features of the illness associated with a poor prognosis.

### **Eating Disorders**

Eating disorders are relatively common in young women and only rarely progress to anorexia or bulimia nervosa. Longitudinal studies have shown that most patients recover or improve with treatment, but a significant minority (20%) remain chronically ill or die from the illness. The best form of treatment is unknown although psychoanalytic, cognitive-analytic and family therapy have been found to be effective.<sup>19</sup> Poor prognostic features are a personality disorder, a late onset of illness, other self-harming behaviour and a long duration of illness.<sup>20</sup> Employment as a clinical health care worker, nursery nurse or with children is not recommended while suffering from a severe eating disorder or other recurrent self-harming behaviour.<sup>21,22</sup> Because most people with this illness are relatively young and respond to treatment or can be relocated to work which does not involve patient or client contact, early retirement should be unusual.

### **Schizophrenia**

About one third of patients will recover from their first episode and have no further symptoms of schizophrenia in the next five years.<sup>23,24</sup> Of the remaining two thirds, some will have a chronically relapsing illness with no symptoms in between, some will have a chronically relapsing illness with stepwise deterioration and some will have an illness from which they never recover. Factors associated with a poor prognosis are an insidious onset, a long episode of illness, a previous psychiatric history, negative symptoms, a young age of onset, single status, poor psychosexual adjustment, an abnormal pre-morbid personality, social isolation and poor

compliance with treatment.<sup>13,17</sup> Someone with a relapsing schizophrenic illness who complies with treatment may be able to cope with an undemanding job, but early retirement is likely in severe cases.

Any decision about retirement in a newly diagnosed patient with schizophrenia should be deferred for two years from the time of diagnosis, by which time those patients who are likely to have a natural and prolonged remission should be known.

### **Alcohol Misuse**

An applicant for early retirement should have had at least one trial of detoxification and treatment.

Outcome appears to be independent of the type of programme, and the majority of patients manage to reduce their consumption or abstain from alcohol altogether. Treatment by cognitive behavioural therapy, 12-step facilitation or motivational-enhancement therapy have all been shown to be effective treatments.<sup>25</sup> There is always a risk, however, of relapse in this chronic condition. Early retirement would be appropriate if there is evidence of serious end-organ damage such as hepatic failure or encephalopathy, ascites, oesophageal varices, peripheral neuropathy, organic brain damage (confirmed by psychometric testing), or if there is coexisting major mental illness which is unresponsive to treatment.

### **Chronic Fatigue Syndrome**

This is the term currently given to fatigue lasting for more than six months sufficient to interfere with the patient's normal physical and mental functioning, and for which there is no conventional medical cause. In practice, the diagnosis is frequently given to a heterogeneous group of patients with conditions that include chronic depression, chronic anxiety, psychological distress, poor motivation to return to work, as well as to conscientious perfectionists who find it difficult to set limits for work, and possibly to others with an, as yet, unidentified disorder of the central fatigue mechanism. Fatigue is a symptom commonly encountered in primary care settings and is recognised to last for weeks or months after infectious mononucleosis or polio but not after other infections.<sup>26</sup> Examination should include exploring psychosocial factors such as life events, home and workplace stresses, as well as symptoms of anxiety and depression. Investigations should exclude anaemia, diabetes, hypothyroidism, occult carcinoma,

a collagen disease and infectious mononucleosis. Other conditions that might need to be excluded are sleep apnoea, the acquired immune deficiency syndrome and coeliac disease.

Most longitudinal studies of prognosis have been in secondary care and show that the majority of patients make a progressive functional recovery, although a significant minority remain symptomatic but at no increased risk of mortality. A community based study of 65 patients with a three-year follow-up found that the majority (57%) of subjects experienced a partial or total remission, with 23% receiving alternative diagnoses of which a sleep disorder was the most common. At the three-year follow-up point only five patients still fulfilled the criteria for CFS.<sup>27</sup>

Treatment with graded activities and cognitive behavioural therapy to address unhelpful thoughts, such as fixed physical illness beliefs or unhelpful behaviours, such as avoiding activity or sleeping during the day, have been shown to be effective and in those few studies that have included return to work as an outcome, to improve the likelihood of a successful return to work.<sup>28</sup> Prolonged rest, antidepressants in the absence of depression, corticosteroids or immunotherapy are unlikely to be beneficial.<sup>13,29</sup> Factors associated with a poor prognosis are a belief by the patient that an undiagnosed physical illness is responsible for their symptoms, a concurrent or previous psychiatric diagnosis, avoidance of physical activity, a perceived lack of control over symptoms (ie, an external locus of control), concurrent somatoform symptoms, dissatisfaction with work, concurrent litigation against employer or severe symptoms lasting for more than four years.<sup>30-32</sup>

The identification and remedying of any workplace factors which may be contributing to the fatigue, part-time working and restricted duties may be helpful in the occupational rehabilitation of these patients. A decision about early retirement should not be made until appropriate investigations and treatment have been undertaken. Because most patients are relatively young at diagnosis and, therefore, many years from their normal age of retirement, permanency of incapacity for early retirement is unlikely to be met in the majority of cases.

### **Fibromyalgia**

This common condition was previously known as fibrositis or muscular rheumatism and in the USA as psychogenic rheumatism.<sup>33</sup> Various forms were recognised which included lumbago, stiff neck and generalised rheumatism. Treatment was in the form of rest initially, with aspirin, massage with or without a rubifacient containing methyl salicylate, heat and if prolonged, regular exercises and encouragement to return to work. More recently, the term fibromyalgia has been used to describe a triad of pain, usually in an axial distribution, nodules or tender trigger spots and sleep disturbance.<sup>34</sup> The term 'chronic widespread pain' is preferred by some doctors because of the difficulty in identifying nodules, and an association between the number of tender spots and the degree of distress of the patient.<sup>33,34</sup> Some authors doubt whether fibromyalgia is a distinct disease.<sup>35</sup>

Treatment involves identifying relevant psychosocial factors, addressing unhelpful beliefs or avoidance behaviour, graded exercise, hydrotherapy and antidepressants.<sup>36-40</sup> The occupational physician should reinforce these treatments, address any perpetuating workplace factors and encourage the patient to return to normal functioning by way of temporary part-time work or reasonable workplace adjustments. Although symptoms may persist, the prognosis in most cases is good and in the longest reported longitudinal study of 14 years, 73% (16/22) of patients said that their symptoms interfered little, if at all, with work.<sup>41</sup> For all of these reasons, the occupational physician should not normally support early retirement due to fibromyalgia.

### **Back Pain**

Considerable guidance has recently been written on the diagnosis, aetiology, prognosis and management of back pain.<sup>13,42-47</sup> There is general agreement that back pain should be divided into three main diagnostic categories: (1) non-specific (mechanical); (2) spinal cord or radicular to include spinal stenosis or cauda equina lesions and (3) serious spinal pathology in patients with a general medical condition such as cancer, an infective or inflammatory condition, or a structural deformity such as may occur with a severe scoliosis or spondylolisthesis.

There is also agreement and good quality evidence to show that patients with non-specific (mechanical) back pain should be advised to maintain normal activities and only rest in bed for one or two days, or for longer if the back pain is associated with severe sciatica (pain radiating below the knee). Disability from non-specific back pain is more dependent on psychosocial factors than on the physical demands of the job. Treatment with analgesics or non-steroidal anti-inflammatory drugs, conditioning low-stress aerobic exercises, manipulative therapy (physiotherapy, chiropractic or osteopathy), and therapies which address negative beliefs about back pain such as a need to be pain-free before undertaking normal activities, or which promotes self responsibility towards controlling the pain, have all been shown to be effective. Epidural or facet joint injections, however, have been shown in systematic reviews to be ineffective.<sup>13</sup> There is also good evidence that multidisciplinary rehabilitation in an occupational setting and the provision of temporary modified duties are also effective in returning patients to work.

A graduated return to work with initial avoidance of heavy manual handling or prolonged sitting may be helpful. Potentially adverse psychosocial factors such as anxiety, depression, job dissatisfaction or litigation should be identified and addressed as appropriate. Patients with a persistent or recurring radiculopathy (pain, with or without numbness or paraesthesia, radiating below the knee) due to a prolapsed disc or spinal stenosis will need to be managed more cautiously. If symptoms of a prolapsed disc do not resolve spontaneously, or with the help of physiotherapy, then referral to a spinal surgeon will be necessary. Most patients with a spinal stenosis will need to be referred to a spinal surgeon. A microdiscectomy for a single level prolapsed disc should not prevent a return to manual work and most (85%) of patients can return to work within a month of this operation.<sup>48</sup> Patients who have had more extensive back surgery (eg, discectomy with laminectomy or surgery at multiple levels or a spinal fusion) will need to be managed more cautiously. Early degenerative changes on an x-ray in keeping with the patient's age or early degeneration of discs as shown on a MRI scan by desiccation, disc bulge or protrusion (as opposed to a prolapse) are found in normally ageing patients without back pain and

should not lead to prolonged disability or work restrictions. Pain from an annular tear should resolve over a few months.

Non-specific (mechanical) back pain should not normally justify retirement due to ill-health or permanent restriction of a particular type of work. This may be necessary however for multiple disc prolapses, spinal stenosis, serious spinal pathology, or if degenerative disease is more advanced than would normally be expected for the age of the patient, and if the response to treatment has been unsatisfactory, and reasonable adjustments to the workplace or job have been unsuccessful. The principles that apply to back pain also apply to neck pain.

### **Whiplash**

This is the commonly used term for rapid hyperextension-flexion injuries to the neck. Other than the most severe cases, prognosis varies according to the population studied with insurance/compensation cases faring worst.<sup>13,49</sup> It has been shown how the management of this condition (ie, what is said to the patient and the various treatments they may receive, eg, rest, collar, physiotherapy, etc) can cause it to evolve into a chronic and disabling disorder maintained by psychosocial factors.<sup>50</sup> A prospective study has shown that eliminating compensation for pain and suffering significantly improves recovery from a whiplash injury.<sup>51</sup> A systematic review of randomised trials for the treatment of whiplash has shown that active interventions such as advice to maintain usual activities is more effective than rest and immobilization with a collar.<sup>52</sup> Early retirement on account of a whiplash injury without a cervical fracture or spinal cord damage should be unjustified in most cases.

### **Diabetes**

Diabetes mellitus should not be a bar to most jobs. Shift work is acceptable for those requiring treatment with insulin, without compromise to glycaemic control, provided the timing of therapy is flexible and the shift changes are not too rapid.<sup>53</sup> Patients who started treatment with insulin after 1 April 1999 are legally barred from holding a group 2 driving licence.<sup>54</sup> Early retirement would be appropriate if the applicant has end organ damage such as severe visual

impairment, peripheral neuropathy, nephropathy or arteriopathy for which treatment and job modifications or adaptive technology have been unsuccessful.

### **Cardiovascular Disease**

For patients with angina or who have had a myocardial infarction, an exercise stress test will give a guide to exercise tolerance and may be good for morale by helping patient to regain confidence for physical activity. It may also help to distinguish physical from psychological disability. It will also give an estimate of metabolic equivalents (METs) which can be used with tables of energy requirements to assess fitness for various activities or occupations for patients with ischaemic heart disease.<sup>55</sup> An exercise stress test off cardiac medication is essential after myocardial infarction if group 2 driving is being considered.<sup>54</sup> Furthermore, cardiac rehabilitation with exercise has been shown in a systematic review to improve coronary risk factors and reduces the risk of major cardiac events after myocardial infarction.<sup>13</sup>

A link between perceived psychological stress and heart disease has been debated for some time. In a recent observational study, stressed patients were found to be more likely to report symptoms such as angina, but less likely to have evidence of ischaemic heart disease.<sup>56</sup>

A number of observational studies have reported an association between stress and myocardial infarction<sup>57</sup>, but controlling for recall bias is a methodological problem. Significantly the joint British Cardiac, Hypertension, Diabetic and Hyperlipidaemic Societies do not recognise psychosocial stress as a risk factor for the prevention of coronary heart disease.<sup>58</sup> On balance, and as a consequence of this weight of opinion, early retirement after myocardial infarction on the grounds of stress at work, or elsewhere, should be inappropriate.

To facilitate an early return to work after myocardial infarction, it might be helpful for the occupational physician to advise job modification on a temporary basis for those employees with highly-pressurised jobs. In the light of the wide range of therapeutic options now available to treat hypertension, early retirement due to hypertension is unlikely to be

justified unless the hypertension is associated with significant end organ damage or is truly resistant to therapy.

A successful heart or lung transplant should not prevent a patient from returning to work. The holding of a group 1 driving licence and even heavy manual work is permissible after transplantation. Published studies have shown that the majority of patients who were in work six months prior to their transplant, do return to work although the ten-year survival rate after cardiac transplantation is about 50%. Some centres have succeeded in getting more patients back to work by adopting a policy of not supporting a patient's claim for disability benefits in the absence of a medical indication.<sup>59</sup> Early retirement is only appropriate, therefore, if the transplant has been unsuccessful or the applicant's job necessitates the holding of a group 2 licence.

### **Limited Life Expectancy**

For employees with a life expectancy of less than a year, the Local Government Pension Scheme allows for commutation of pension equal to five times the annual pension, in excess of the guaranteed minimum pension, for both active and deferred members. Unfortunately, the regulations require that the member apply for commutation, which may create difficulties if the patient is unaware of their prognosis. For those still in service at the time of their death, the death grant of twice annual salary may be greater than the lump-sum benefit for ill-health retirement. Therefore, to prevent the patient or their dependants from being materially disadvantaged, each case should be judged on its merits with the help of a pensions officer.

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24 November 2008

All LGPS Pension Managers  
in England and Wales

Our Ref:  
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Dear Pension Manager

### **Local Government Pension Scheme - Ill Health Statutory Guidance**

I attach a copy of the Local Government Pension Scheme Ill Health Statutory Guidance. **Please pass a copy of this guidance to every employer participating in your Fund, your appointed independent registered medical practitioners, and other interested parties who need to use the guidance.**

This guidance is issued, under Regulation 56(3) of the Local Government Pension Scheme (Administration) Regulations 2008, to all administering authorities, employing authorities, other employers who are admitted to the Local Government Pension Scheme (LGPS), Independent Registered Medical Practitioners (IRMP) and other relevant interested parties in England and Wales with statutory responsibilities under the new LGPS that came into effect on 1 April 2008.

Employers, administering authorities and IRMPs must have regard to this guidance when carrying out their functions under Regulation 20 of the LGPS (Benefits, Membership and Contributions) Regulations 2007 (SI 2007/1166) as amended by the LGPS (Amendment) Regulations 2008 (SI 2008/1083), and Regulation 56 of the LGPS (Administration) Regulations 2008.

In this guidance, the term 'employer' relates to local authority employing authorities and other employers participating in the Scheme.

This guidance includes details of the relevant statutory provisions and an explanation of the operation of the new ill-health retirement benefit provisions as they apply from 1 April 2008. The background and policy development for the new ill-health framework is at Annex A. Two model ill-health certificates are provided at Annex B and C to assist employers participating in the scheme, and independent doctors will need to complete a certificate for each ill-health retirement case.

Department for Communities and Local Government  
5/F5 Eland House  
Bressenden Place  
London  
SW1E5DU

Tel 020 7944 6002  
Email [lynda.jones@communities.gov.uk](mailto:lynda.jones@communities.gov.uk)

The Ill Health Monitoring Group (IHMG) has been set up to evaluate the effectiveness of the new LGPS ill health framework, and the Group will ask for relevant data about the application of the new regulations to inform their work. The IHMG is able to make recommendations for changes to the regulatory framework in the light of experience of implementing the new ill health provisions.

The Secretary of State will keep the content of the guidance under review and will update it as necessary, in the light of recommendations from the IHMG, or experience of administering authorities, employers, IRMPs and others, in the application of this guidance.

The guidance will shortly be available on the website at  
<http://www.xoq83.dial.pipex.com/index.htm>

Yours faithfully

Lynda Jones

**Lynda Jones**

**LOCAL GOVERNMENT PENSION SCHEME (LGPS)**  
**GUIDANCE ON THE APPLICATION OF THE LGPS ILL HEALTH REGULATIONS WHICH**  
**TOOK EFFECT FROM 1 APRIL 2008**

Introduction.....	2
Section 1 – The Legal Framework.....	3
Entitlement on ceasing employment.....	3
Entitlement after ceasing employment.....	5
First instance determinations – ill health.....	5
Section 2– General Guidance.....	6
Part I: Role of the employer.....	6
Part II: Questions for the employer to determine.....	6
Entitlement to payment of deferred benefits on the grounds of ill health.....	7
Part III: The role and status of the independent registered medical practitioner (IRMP).....	8
Part IV: Questions for the IRMP.....	8
Part V: Definitions .....	9
“permanently incapable”.....	10
“gainful employment”.....	10
significance of three years.....	10
“obtaining”.....	10
“reduced likelihood”.....	11
Section 3 – The Regulations in Practice.....	11
Part VI: The first tier.....	11
Part VII: The second tier.....	11
Part VIII: The third tier.....	12
Part IX: Special considerations.....	14
Transitional protections.....	14
Gainful employment and short contracts.....	15
Resolving disagreements and IDRP.....	16
Section 4 – Documentation.....	17
Annex A – Background.....	18
The rationale for a multi tier pension provision.....	18
Policy development.....	19
Annex B - Pro-forma certificates (current employee) (example A).....	
Annex C - Pro-forma certificate ( review) (example B) .....	

THIS ILL HEALTH GUIDANCE REFLECTS THE REGULATORY PROVISIONS OF THE LOCAL  
GOVERNMENT PENSION SCHEME (BENEFITS, MEMBERSHIP AND CONTRIBUTIONS)  
REGULATIONS 2007 (SI 2007/1166), AS AMENDED BY THE LOCAL GOVERNMENT PENSION  
SCHEME (AMENDMENT) REGULATIONS 2008 (SI 2008/1083)



## GUIDANCE ON THE LGPS ILL HEALTH RETIREMENT PENSION PROVISIONS

1. This guidance is issued, under Regulation 56(3) of the Local Government Pension Scheme (Administration) Regulations 2008, to all administering authorities, employing authorities, other employers who are admitted to the Local Government Pension Scheme (LGPS), Independent Registered Medical Practitioners (IRMP) and other relevant interested parties in England and Wales with regulatory responsibilities under the new LGPS that came into effect on 1 April 2008.
2. Employers and IRMPs must have regard to this guidance when carrying out their functions under Regulation 20 of the LGPS (Benefits, Membership and Contributions) Regulations 2007 (SI 2007/1166) as amended by the LGPS (Amendment) Regulations 2008 (SI 2008/1083), and Regulation 56 of the LGPS (Administration) Regulations 2008.
3. In this guidance, the term 'employer' relates to local authority employing authorities and other employers participating in the Scheme.
4. This guidance includes details of the relevant regulatory provisions and an explanation of the operation of the new ill-health retirement benefit provisions as they apply from 1 April 2008. The background and policy development for the new ill health framework is at Annex A. Two model ill health certificates are provided at Annex B and C to assist employers participating in the scheme, and independent doctors will need to complete a certificate for each ill health retirement case.
5. The Ill Health Monitoring Group (IHMG) has been set up to evaluate the effectiveness of the new LGPS ill health framework, and the Group will ask for relevant data about the application of the new regulations to inform their work. The IHMG is able to make recommendations for changes to the regulatory framework in the light of experience of implementing the new ill health provisions.
6. The Secretary of State will keep the content of the guidance under review and will update it as necessary, in the light of recommendations from the IHMG, or experience of administering authorities, employers, IRMPs and others, in the application of this guidance.
7. Unless a specific reference is made to regulations by their full title, the reference is to a regulation of the LGPS (Benefits, Membership and Contributions) Regulations 2007 (SI 2007/1166), as amended by the LGPS (Amendment) Regulations 2008 (SI 2008/1083) ("the Benefits Regulations").

## **Section 1 - The Legal Framework**

8. The regulatory provisions governing ill health retirements under the LGPS with effect from 1 April 2008 are set out in regulations 20 and 31 of The Local Government Pension Scheme (Benefits, Membership and Contributions) Regulations 2007 (SI 2007/1166), as amended by The Local Government Pension Scheme (Amendment) Regulations 2008 (SI 2008/1083), and in regulation 56 of the Local Government Pension Scheme (Administration) Regulations 2008 (SI 2008/239) as amended by The Local Government Pension Scheme (Amendment) Regulations 2008 (SI 2008/1083) :-

### **A : Entitlement on ceasing employment early owing to ill health:-**

“20.—(1) If an employing authority determine, in the case of a member who satisfies one of the qualifying conditions in regulation 5—

- (a) to terminate his employment on the grounds that his ill-health or infirmity of mind or body renders him permanently incapable of discharging efficiently the duties of his current employment; and
- (b) that he has a reduced likelihood of obtaining any gainful employment before his normal retirement age,

they shall agree to his retirement pension coming into payment before his normal retirement age in accordance with this regulation in the circumstances set out in paragraph (2), (3) or (4), as the case may be.

(2) If the authority determine that there is no reasonable prospect of his obtaining any gainful employment before his normal retirement age, his benefits are increased—

- (a) as if the date on which he leaves his employment were his normal retirement age; and
- (b) by adding to his total membership at that date the whole of the period between that date and the date on which he would have retired at normal retirement age.

(3) If the authority determine that, although he cannot obtain gainful employment within three years of leaving his employment, it is likely that he will be able to obtain any gainful employment before his normal retirement age, his benefits are increased—

- (a) as if the date on which he leaves his employment were his normal retirement age; and
- (b) by adding to his total membership at that date 25% of the period between that date and the date on which he would have retired at normal retirement age.

(4) If the authority determine that it is likely that he will be able to obtain any gainful employment within three years of leaving his employment, his benefits—

- (a) are those that he would have received if the date on which he left his employment were the date on which he would have retired at normal retirement age; and
- (b) unless discontinued under paragraph (8), are payable for so long as he is not in gainful employment.

(5) Before making a determination under this regulation, an authority must obtain a certificate from an independent registered medical practitioner qualified in occupational health medicine as to whether in his opinion the member is suffering from a condition that renders him permanently incapable of discharging efficiently the duties of the relevant employment because of ill-health or infirmity of mind or body and, if so, whether as a result of that condition he has a reduced likelihood of obtaining any gainful employment before reaching his normal retirement age.

(6) A person who receives benefits under paragraph (4) shall—

- (a) inform the authority if he obtains employment; and
- (b) answer any inquiries made by the authority as to his current employment status, including as to his pay and working hours.

(7) (a) Once benefits have been in payment to a person for 18 months, the authority shall make inquiries as to his current employment.

- (b) If he is not in gainful employment, the authority shall obtain a further certificate from an independent registered medical practitioner as to the matters set out in paragraph (5).
- (8) (a) The authority shall discontinue the payment of benefits under paragraph (4) if they consider—
- (i) that the person is in gainful employment; or
  - (ii) in reliance on the certificate obtained under paragraph (7)(b), that he is capable of obtaining such employment
- and may recover any payment made in respect of any period before discontinuance during which they considers him to have been in gainful employment.
- (b) The authority shall in any event discontinue the payment of benefits under paragraph (4) after they have been in payment to a person for three years.
- (c) The authority shall forthwith notify the appropriate administering authority of any action they have taken under this paragraph.
- (9) A person in respect of whom the payment of benefits is discontinued under paragraph (8) shall be treated as a pensioner member with deferred benefits from the date the suspension takes effect, and shall not be eligible to receive benefits under paragraph (4) in respect of any future period.
- (10) If a person in respect of whom the payment of benefits is discontinued under paragraph (8) subsequently becomes an active member of the Scheme, his earlier period of active membership in respect of which benefits were paid under paragraph (4) shall not be aggregated with his later active membership.
- (11) (a) An authority which has made a determination under paragraph (4) in respect of a member may make a subsequent determination under paragraph (3) in respect of him.
- (b) Any increase in benefits payable as a result of any such subsequent determination is payable from the date of that determination.
- (12) (a) Subject to sub-paragraph (b) and to paragraph (13), in the case of a member in part-time service, the period to be added under paragraph (2)(b) or (3)(b), as the case may be, is calculated in accordance with regulation 7(3) as if he had remained in such part-time service until his normal retirement age.
- (b) If the certificate obtained under paragraph (5) states that, in the medical practitioner's opinion, the member is wholly or partly in part-time service as a result of the condition that has caused him to be incapable of discharging efficiently the duties of the relevant local government employment, no account shall be taken of such reduction in his service as is attributable to that condition.
- (13) But if, in the case of a person who is a member before 1st April 2008, and who has attained the age of 45 before that date, the period to be added under paragraph (2)(b) or (3)(b) is less than the period that would have been added had regulation 28 of the 1997 Regulations applied, then his benefits are increased by adding the latter period.
- (14) In this regulation –
- “gainful employment” means paid employment for not less than 30 hours in each week for a period of not less than 12 months;
- “permanently incapable” means that the member will, more likely than not, be incapable until, at the earliest, his 65th birthday; and
- “qualified in occupational health medicine” means—
- (a) holding a diploma in occupational medicine (D Occ Med) or an equivalent qualification issued by a competent authority in an EEA State; and for the purposes of this definition, “competent authority” has the meaning given by the General and Specialist Medical Practice (Education, Training and Qualification) Order 2003(1); or
  - (b) being an Associate, a Member or a Fellow of the Faculty of Occupational Medicine or an equivalent institution of an EEA State.
- (15) Where, apart from this paragraph, the benefits payable to a member in respect of whom his employing authority makes a determination under paragraph (1) before 1st October 2008 would place him in a worse position than he would otherwise be had the 1997 Regulations continued to apply, then those Regulations shall have effect in relation to him as if they were still in force instead of the preceding paragraphs of this regulation.”

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(1) S.I. 2003/1250.

**B : Entitlement after ceasing employment early owing to ill health:-  
(Regulation 31 of the benefits regulations)**

“31.—(1) Subject to paragraph (2), if a member who has left his employment before he is entitled to the immediate payment of retirement benefits (apart from this regulation) becomes permanently incapable of discharging efficiently the duties of that employment because of ill-health or infirmity of mind or body he may ask to receive payment of his retirement benefits immediately, whatever his age.

(2) Before determining whether to agree to a request under paragraph (1), an authority must obtain a certificate from an independent registered medical practitioner qualified in occupational health medicine as to whether in his opinion the member is permanently incapable of discharging efficiently the duties of the relevant employment because of ill-health or infirmity of mind or body and, if so, whether that condition is likely to prevent the member from obtaining gainful employment (whether in local government or otherwise) before reaching his normal retirement age, or for at least three years, whichever is the sooner .

(3) In this regulation, “gainful employment”, “permanently incapable” and “qualified in occupational health medicine” have the same meaning as in regulation 20.”

**C : First instance determinations: ill-health :-**

**(Regulation 56 of the Local Government Pension Scheme (Administration) Regulations 2008 (SI 2008/239) (“the Administration Regulations”) as amended by regulation 24 of the Local Government Pension Scheme (Amendment) Regulations 2008)(SI 2008/1083).**

“56.—(1) An independent registered medical practitioner from whom a certificate is obtained under regulation 20(5) of the Benefits Regulations in respect of a determination under paragraph (2), (3) or (4) of that regulation (early leavers: ill-health) must be in a position to declare that—

(a) he has not previously advised, or given an opinion on, or otherwise been involved in the particular case for which the certificate has been requested; and

(b) he is not acting, and has not at any time acted, as the representative of the member, the employing authority or any other party in relation to the same case,

and he must include a statement to that effect in his certificate.

(2) If the employing authority is not the member’s appropriate administering authority, it must first obtain that authority’s approval to its choice of registered medical practitioner for the purposes of regulation 20 and 31 of the Benefits Regulations.

(3) The employing authority and the independent registered medical practitioner must have regard to guidance given by the Secretary of State when carrying out their functions under this regulation or, in the case of the employing authority, when making a determination under regulation 20 of the Benefits Regulations.”

## **Section 2 - General Guidance**

### **Part I - Role of the employer**

9. In the context of ill health retirements, the role of the employer begins a long time before employment has been terminated and the question of entitlement to an ill health retirement benefit arises. The management of ill health in the work force and, in particular, during the period leading up to termination of employment, is outside the scope of this guidance. The “prevention and management of sick absence” replaced the “management of ill health handbook” and was published by the Local Government Employers in 2007. The handbook does not, however, contain details of the changes to the ill-health retirement benefits from 1 April 2008.

### **Change in process for the employer in the 2008 ill health provisions**

10. Under the 1997 Scheme regulations, any question concerning entitlement to an ill-health retirement benefit could only be decided when a member had left local government employment on the grounds of permanent ill health. Whilst this did not prevent an employer and medical advisers from looking onto the question of entitlement to an ill health pension and grant beforehand, in regulatory terms, the actual decision about entitlement and any appeal arising from the determination of that question could only have been made on or after the member left employment. Concerns have been raised in the past about the effect that certain decisions made by the courts and the Pensions Ombudsman might have on this separation between the “leaving employment” and the “entitlement to pension benefit” question that has been part of the scheme’s regulations for a considerable time. The ill health provisions in Regulation 20 now require the employer to commence medical processes prior to any termination of employment on ill health grounds.

11. Responsibility for deciding the grounds on which the employment of a scheme member has been terminated rests solely with the employer (Reg 20 (1)). But an employer cannot make a determination under Regulation 20 unless they have obtained a certificate from an independent registered medical practitioner (“IRMP”) qualified in occupational health medicine (Regulation 20 (5) and (14 (a) and (b))).

12. It is also important to note that all the regulations referred to in this guidance are subject to the civil law burden of proof. As such, the determination of questions is based on the “balance of probabilities” test and not on the stricter criminal law test of “beyond reasonable doubt”.

### **Part II - Questions for the employer to determine**

13. Under Regulation 20, the appropriate employer is required to consider and decide a number of questions before entitlement to an ill health retirement benefit under that regulation can be awarded. These include :-

- a) is the length of total membership at least three months or a transfer value is credited to the member? (but see the Benefits Regulations 5 (1)(a) and 20(1)); and
- b) does the member's ill health or infirmity of mind or body render him permanently incapable of discharging efficiently the duties of his current employment? (Regulation 20(1)(a)); and
- c) does the member have a reduced likelihood of obtaining gainful employment (whether in local government or elsewhere) before his normal retirement age? (Regulation 20(1)(b)).

(Note: see explanations concerning 'gainful employment' and 'reduced likelihood' at paras 24 and 28 below)

14. If the answers to all three questions are in the affirmative, there is a prima facie entitlement to payment of an ill-health benefit under Regulation 20. To decide the level of benefit, the employer must further decide which of the following three situations applies:-

- a) is there no reasonable prospect of the member obtaining any gainful employment before reaching his Normal Retirement Age (NRA) (i.e. age 65)? In these circumstances, the member receives benefits based on his accrued rights up to the date of termination and enhancement equal to all his prospective service from that date to his NRA. (Regulation 20(2)); or
- b) is the member is judged to be incapable of obtaining gainful employment within three years of leaving local government employment, but is thought likely to be able to do so before reaching his NRA? In these circumstances benefits equal to his accrued rights and an enhancement of 25% of his prospective service to NRA will be awarded. (Regulation 20(3)), or
- c) Is the member likely to recover sufficiently from his incapacity to enable him to be capable of obtaining gainful employment within three years of leaving local government employment? In these circumstances, benefits equal to his accrued rights, with no enhancement, will be awarded. (Regulation 20(4)).

15. Additional questions concerning part time employment and the protection rights of certain members fall to be considered by virtue of Regulations 20(12), (13) and (15) respectively.

#### **Entitlement to payment of deferred benefits on the grounds of ill health**

16. Under Regulation 31 of the Benefits Regulations, an ill health benefit can also be paid to a member, who has left a local government employment with an entitlement to a deferred benefit, and becomes permanently incapable of discharging efficiently the duties of their former employment before becoming entitled to payment of that deferred benefit. The member has to apply for the early release of the deferred benefit and payment would be from the date of the application. The By virtue of regulation 31(2), the early payment of deferred benefits can only be made in circumstances where the IRMP has certified that the member's condition is likely to prevent him from obtaining gainful employment, whether in local government employment or elsewhere, before reaching his normal retirement age or for at least three years, whichever is the sooner. In other words, the deferred pensioner member would have to satisfy the criteria set out in regulation 20(2) or (3).

**Payments**

17. Ill health retirement benefit payments are made by the relevant LGPS administering authority following notification of the determination by the employer (regulation 64 of the administration regulations).

**Part III - The role and status of the independent registered medical practitioner**

18. The introduction of the certification of ill health retirements by an independent registered medical practitioner qualified in occupational health was one of the 35 recommendations made in the HM Treasury review. It has been a feature of the 1997 scheme regulations for a number of years and is carried forward into the new scheme arrangements in Regulation 20(5). This regulation sets out the questions that the IRMP must address in his certificate but provisions relating to the doctor's certification are also set out in the Local Government Pension Scheme (Administration) Regulations 2008. In particular, regulation 56(1) of those regulations requires the IRMP to include a statement confirming his independent status in his certificate under regulation 20 (5). The IRMP may be asked to sign the certificate required under regulation 20 (5) and it is recommended that the IRMP complies with this request.

19. Regulation 20(14) of the Benefits Regulations defines what is meant by "qualified in occupational health medicine".

**Part IV - Questions for the independent registered medical practitioner**

20. In many respects, these reflect the questions that the employer is ultimately responsible for deciding but it is important to bear in mind that the independent doctor is not being asked to confirm the termination or otherwise of the member's employment. Under Regulation 20(5), the role of the IRMP is to certify whether or not, in his opinion, on the balance of probabilities, the criteria for entitlement to an ill health benefit are satisfied in any individual case. On this basis, the questions to be considered by the IRMP doctor are:-

- a) is the member permanently incapable of discharging efficiently the duties of the relevant local government employment because of ill health or infirmity of mind or body (Regulation 20(5)) and, if so –
- b) whether this has resulted in a reduced likelihood of obtaining any gainful employment and, if so :-
  - whether there is no reasonable prospect of his obtaining any gainful employment before his normal retirement age (Regulation 20(5) when read in conjunction with Regulation 20(2), or
  - Whether, although there is no prospect of obtaining gainful employment within three years, there is a reasonable prospect of his obtaining gainful employment before reaching his normal retirement age. (Regulation 20(5) when read in conjunction with Regulation 20(3);or
  - whether there is a reasonable prospect of his obtaining gainful employment within three years of leaving local government employment (Regulation 20(5) when read in conjunction with Regulation 20(4)).

- c) in the case of a member who is wholly or partly in part-time service, was this as a result of the condition that had caused him to be permanently incapable of discharging efficiently his current employment? (Regulation 20(12)(b)).
- d) under regulation 20(5), the IRMP is also asked to consider whether or not there is a reduced likelihood of obtaining gainful employment. But, in the context of regulation 20(8)(a)(ii) (action at the review) and the definition of “reduced likelihood” below, it is clear that if the IRMP says there is no reduced likelihood of obtaining gainful employment, then this means that regulation 20(8)(a)(ii) is satisfied. This means that a 3rd tier benefit should be discontinued following the 18 month review, if the employer, based on the opinion of the certifying doctor, determines that the member is now capable of obtaining gainful employment.
- e) regulation 20(15) provides that for determinations made by the employer up to and including 30th September 2008, the employer will need to consider a member’s entitlement under both the current provisions of regulation 20 and the former ill-health provisions of the 1997 Scheme regulations (see para. 48 below). This does mean that, for this limited period, IRMPs will need to consider the permanency question both in relation to a member’s actual local authority employment and any comparable employment for the purposes of regulation 27 of the 1997 Scheme regulations. Under those regulations, the term “comparable employment” was defined as any other comparable employment with his employing authority as follows:

"comparable employment" means employment in which, when compared with the member's employment

(a) the contractual provisions as to capacity either are the same or differ only to an extent that is reasonable given the nature of the member's ill-health or infirmity of mind or body; and

(b) the contractual provisions as to place, remuneration, hours of work, holiday entitlement, sickness or injury entitlement and other material terms do not differ substantially from those of the member's employment.

21. It is important at this stage to highlight the fact that both regulations 20(1) and (5) restrict entitlement considerations to medical factors. Although regulation 20(1) enables the authority to make an award where a member, amongst other things, "...has a reduced likelihood of obtaining any gainful employment", it is important to note that by virtue of the conjunctive "and" at the end of regulation 20(1)(a), any "reduced likelihood" for the purposes of regulation 20(1)(b) must be as a direct result of the permanent incapacity referred to in regulation 20(1)(a). On this basis, non-medical factors such as the availability of gainful employment in a particular area, are not relevant factors for the purposes of regulation 20(1). The same rule applies to regulation 20(5), except here, the relevant conjunctive is "and, if so, whether as a result of that condition".

### **Part V - Definitions**

22. It is important that all parties are clear about the meanings behind the terms used in either the regulations or this guidance. The examples given below expand on the definitions given in regulation 20(14), but others refer to words or phrases that are not defined but which merit explanation.

23. The term “**permanently incapable**” is defined in regulation 20(14) as meaning “that the member will, more likely than not, be incapable until, at the earliest, his 65th birthday.” In addressing questions about permanent incapacity, whether in terms of the local government employment or gainful employment elsewhere, consideration must therefore be given not to the immediate or foreseeable future, but to the date when the member attains their NRA.

24. The term “**gainful employment**” is defined by Regulation 20(14) as “paid employment for not less than 30 hours in each week for a period of not less than 12 months”. This term is not to be confused with the concept of “comparable employment” which was a feature of the 1997 Scheme from 1999. From 1 April 2008, the IRMP will be required to judge the member’s capability of obtaining any gainful employment - rather than one based on the type of local government formerly held by the member. This reflects government policy whereby public service ill health pensions are to be paid not only on the basis of ability to undertake the member’s current employment, but also other employment in the general workforce.

25. **Significance of ‘3 years’**. The level of benefits payable under regulation 20 are dependant upon the duration of the “reduced likelihood” of obtaining gainful employment, having taken into account the medical condition at the time when the employer determines to terminate a member’s employment. Originally, the view was taken that the regulations should rely on the concept of a “reasonable period” to distinguish 2nd tier from 3rd tier cases. In the light of representations made by interested parties, the decision was taken that any reference to a reasonable period should be replaced with a fixed period of time, applied consistently across all cases. Three years represents a “reasonable period” distinction for the purposes of considering either a 2nd or 3rd tier award (Regulation 20 (3) and (4)). The regulations also provide for a limit of 3 years for payment of 3rd tier benefits (Regulation 20 (8(b))).

26. “**Obtaining**”. It is important to highlight the fact that both regulations 20(1) and (5) restrict entitlement considerations to medical factors. The IRMP will wish to consider, in the context of regulations 20 and 31, that the word “obtaining” may be taken to include the capacity of the individual in question to carry out gainful employment, taking into account the full medical effects of the condition which gave rise to the retirement on the grounds of permanent ill health. In some cases, the condition may comprise certain medical or physical impediments which have a bearing on the individual’s capacity to obtain gainful employment. For example, a person who is house-bound or unable to travel because of the medical condition, but is otherwise capable of carrying out gainful employment, is likely to have a reduced likelihood of obtaining gainful employment for the purposes of regulations 20 and 31. The regulations therefore allow for the possibility that certain individuals with a permanent incapacity, although theoretically having the capacity to carry out gainful employment, may not in practice be able to obtain it because of the full medical effects of their condition.

27. Non-medical factors, such as the general availability of gainful employment in a particular area or the attitude of employers to certain conditions, **would not be material factors and should not be part of the IRMP’s consideration**, while the effect a medical condition would have on their practical ability to obtain gainful employment would. The same would apply to the individual’s own attitude towards their condition, which could be a limiting factor to obtaining gainful employment, although it is recognised that in some cases, the member’s attitude may constitute a medical condition in itself and the IRMP could be asked to make a judgement about this.

28. **“Reduced likelihood”**. From the outset, the policy objective has always been to encourage a return to work for those people who have left their local government employment because of ill health but who are otherwise capable of carrying out a wide range of employment elsewhere. Regulation 20 does not, therefore, provide an ill health retirement benefit to any member whose employment was terminated on the grounds of ill health or infirmity of mind or body which renders him permanently incapable of discharging efficiently the duties of his current employment, but he does not have a reduced likelihood of obtaining gainful employment (20(1)). In such circumstances, the member would be regarded as immediately capable of obtaining gainful employment as defined in regulation 20(14). “Immediately” means at the point the member’s employment is terminated. It follows that a 1st, 2nd or 3rd tier pension can only be awarded to a member whose likelihood of obtaining gainful employment is reduced because of that permanent incapacity.

### **Section 3 – The Regulations in practice**

#### **Part VI – The first tier**

29. Regulation 20(2) provides for payment of a first tier ill-health retirement pension where :-

- a) the member has a qualifying period of at least 3 months or a transfer value is credited to the member (but see the Benefits Regulations, regulation 5 (1));
- b) a certificate has been obtained under regulation 20(5);
- c) based on that certificate, the employer has decided to terminate the member’s employment on the grounds that his ill health or infirmity of mind or body renders him permanently incapable of discharging efficiently the duties of his current employment and, because of that condition, he has a reduced likelihood of obtaining any gainful employment before normal retirement age (regulation 20(1) (a) and (b), and
- d) the authority determines that there is no reasonable prospect of him obtaining any gainful employment before normal retirement age (regulation 20(2).

30. Where a first tier pension is awarded under regulation 20(2), the member’s normal benefits are increased as if the date on which he left local government employment was his normal retirement age and by adding to the total membership at that date the whole of the prospective service up to normal retirement age. Regulation 20(12) makes provision for a different calculation in the case of a member in part-time service. A first tier pension is not subject to any review mechanism.

#### **Part VII – The second tier**

31. Regulation 20(3) provides for payment of a second tier ill health retirement pension where the circumstances are the same as those described in the first three bullet points in paragraph 29 above, but the employing authority determines it is likely that the member will become capable of obtaining gainful employment before their normal retirement age but cannot obtain gainful employment within three years of their leaving local government employment.

32. Where a second tier pension is awarded under regulation 20(3), the member’s normal benefits are increased by adding to the member’s total membership at the time of leaving, 25% of their prospective service to normal retirement - subject to the provisions of regulation 20(12) if

the service in question was part-time. A second tier pension is not subject to any review mechanism.

### **Part VIII – The third tier**

33. The 3rd tier provides retirement benefits for a member who is judged by an IRMP to be permanently incapable of their local authority employment and has a reduced likelihood of obtaining gainful employment before his normal retirement age, but is also medically considered capable of obtaining gainful employment within three years of leaving employment. The member would be entitled to their accrued LGPS pension benefits, with no enhancement, and payments are made until such time as the member obtains gainful employment. Payments would be discontinued if, following a review, under regulations 20 (7) (a) and (b), the IRMP certificate is to the effect that the member is now capable of gainful employment. 3rd tier payments cannot, in any event, continue beyond three years (regulation 20 (8) (b)).

34. All ill health payments are made by the relevant LGPS administering authority following notification of the determination by the employer (regulation 64 of the administration regulations).

### **Requirement to obtain a certificate from an Independent Registered Medical Practitioner qualified in occupational health medicine (IRMP)**

35. Regulation 20(5) requires an employer to obtain a certificate from an IRMP qualified in occupational health medicine.

### **Return to gainful employment**

36. The member with 3rd tier benefits is required to notify the previous employer when employment is obtained and provide details, including the pay and working hours, of that employment. The employer considers the details regarding that employment and, if they decide this is gainful employment as defined in paragraph 20 (14) of the Benefits Regulations, payments are discontinued. The employer should notify the relevant administering authority without delay when payments are to be stopped, and payments should be stopped from the date when gainful employment commenced (see para 38 concerning the treatment of overpayments).

### **The Review mechanism**

37. 1st and 2nd tier ill health benefits are not reviewable but 3rd tier benefits are subject to a review. Under regulation 20(7)(a), the previous employer needs to undertake a review when 3rd tier payments have been made for 18 months. The employer should write to the 3rd tier member asking for details of their employment status. If, from the information provided, the employer decides that gainful employment had been obtained, the 3rd tier payments are discontinued.

### **Repayment of overpaid payments**

38. The date of return to gainful employment will determine the date payments should be stopped and the employing authority is required to notify the relevant administering authority without delay when 3rd tier payments should be discontinued and from what date (regulation (20 (8) (c)). If payments have continued when gainful employment has been found, the employer has powers to recover any overpayment from the 3rd tier member under regulation 20(8)(a). Employers are recommended to pass the amount of the recovered 3rd tier payments, without delay, to the relevant pension fund.

### **3rd tier member returns to local government employment**

39. Regulation 20(10), requires that when benefits are stopped and the 3rd tier member subsequently becomes an active member of the LGPS, the earlier period of membership which resulted in 3rd tier benefits is not aggregated with the later active membership.

### **Status of member when payments cease**

40. The status of a 3rd tier member whose benefits are stopped is 'a pensioner member with deferred benefits', and he is not eligible to receive 3rd tier payments in respect of any future period, regulation 20(9) refers.

### **Seeking a further opinion from an IRMP**

41. If, as a result of the employer's enquiry at the review, it is found that a 3rd tier member has not found gainful employment, the employer is required by regulation 20(7)(b) to seek a further opinion from an IRMP concerning the condition which resulted in the 3rd tier membership.

42. The same IRMP can sign the certificate that resulted in the first determination and the certificate at the 3rd tier review. This is because the provision to obtain a further certificate from the IRMP is under regulation 20(7) (b) which means that 56(1) of the LGPS Administration Regulations does not apply. There is, effectively, no requirement that the IRMP has to be able to certify at a 3rd tier review that they have not previously advised, given an opinion on, or otherwise been involved in the case.

### **Employers' ability to uplift the member from 3rd tier to a 2nd tier following the review (Regulation 20 (11))**

43. The employer can determine that a member with 3rd tier benefits can receive the enhanced 2nd tier benefits upon the certification by the IRMP following the review or at any time, even if the payment of the 3rd tier benefit has been discontinued. The employer must take the same steps when determining the 2nd tier concerning certification by an IRMP. The date of the second determination will decide the date from which the uplift to 2nd tier will be put into payment. There is no provision to make a determination for a 1st tier payment at the review or a subsequent occasion. If at the 3rd tier review or subsequently, the IRMP judges that the member is, because of the condition resulting in 3rd tier benefits, now permanently incapable of their local authority employment and has no prospect of obtaining gainful employment before normal retirement age, the employer only has powers to award a 2nd tier enhanced pension from the date of the later determination and can do this where the medical certification justifies it. The 2nd tier determination may be considered when 3rd tier payments are ongoing or have been discontinued. Also, the employer is not prevented from seeking a medical reassessment during the three year period should this be requested by the member.

### **Part IX – Special considerations**

#### **Member reduces their hours because of the ill health condition which subsequently results in ill health retirement**

44. Where a member is awarded ill health retirement benefits but, prior to their leaving employment, they have had to reduce their hours as a result of the condition that lead to the ill health retirement award, no account is taken of the reduction in hours. The member's reduction in service which is accrued between the date of the reduction in hours and the date they leave employment is ignored for the purposes of calculating his ill health benefits. The IRMP has to certify that the reduction in hours is as a result of the condition that causes him to be permanently incapable of the relevant local government employment and have a reduced likelihood of obtaining gainful employment, in accordance with regulation 20 (12) (b). If this is certified, the employer can make a determination, and the ill health pension will be calculated based on accrued service with no reduction in service because of the reduction in hours; this applies to past service and, where appropriate, any future service enhancement for a 2nd or 1st tier award.

45. If a member who is employed at the outset on a part time basis because of an ill health condition, further reduces their hours as a result of that ill health condition, and this is certified to be the case by an IRPM, no account is taken of that further reduction when calculating an ill health retirement award. This applies for both past service and, where appropriate, any future service enhancement for a 2nd or 1st tier award. The calculation is based on the pre reduction part time service.

46. If, after starting part-time employment, there is no subsequent reduction in the member's part time hours as a result of the ill health condition that is being assessed for ill health retirement, regulation 20 (12) (b) will not apply as there has been no reduction in the current service as a result of the condition resulting in ill health retirement.

#### **Treatment of those aged 45 before 1 April 2008 - 1st and 2nd tier determination**

47. Under regulation 20(13), protection is given for a person who was both a member and aged 45 before 1 April 2008, and where there is entitlement to enhanced ill health retirement benefits (i.e. a 1st or 2nd tier award). This protection means that the member should be in no worse a position than they would have been had Regulation 28 of the 1997 Regulations applied and the conditions of that regulation were met. The employer will be required to establish entitlement under the 1997 regulations and the 2007 Benefit Regulations as amended, and award the greater of the benefits.

#### **Transitional protections**

48. Under regulation 20 (15), transitional protections apply for determinations made before 1 October 2008 to provide that if the benefits payable to a member under the amended regulation 20 would place him in a worse position than he would otherwise be had the 1997 Regulations continued to apply, then those Regulations shall apply as if they were still in force. For all practical purposes, Regulation 27 of the 1997 Regulations remains in force in the transitional period.

49. This means that the employer needs to consider whether the employee would be entitled to ill health benefits under Regulation 20 of the benefit regulations as amended by the LGPS (Amendment) Regulations 2008. The employer also needs to consider whether the member is entitled to ill health benefits under the 1997 Regulations. A calculation of any benefits payable, under the two sets of regulations, is made and any enhancement of prospective service for both calculations is at the 1/60th accrual rate. A comparison should then be made and the member is awarded the greater amount.

50. Until the end of September 2008, the ill health certificate to be completed by the independent registered medical practitioner will need to include questions about whether the member would meet the ill health definition in the LGPS Regulations 1997 as well as ill health questions relating to the Benefits Regulations 2007 (as amended).

51. For example, in the transitional period, a member who qualifies for a 3rd tier pension and would also qualify for an enhancement of 6 2/3 under the 1997 Regulations, would receive a 1997 Regulation non reviewable, permanent pension with the enhancement calculated at 1/60th accrual.

**How to assess 'gainful employment' if a member in receipt of a 3rd tier pension informs the employer that they have a short term contract.**

52. It would be unreasonable for an employer to assume that a person is in gainful employment having notified them that they have just entered a short term contract of employment for, say, six months. Whether that contract will be renewed or not, would be pure conjecture and should not, therefore, fall to be considered. Even if a 3rd tier member had served two months of the six month contract, it follows that the definition of gainful employment has not been satisfied. Neither would it be reasonable to make any assumption that four months on, the contract might be reviewed for a further six months which could arguably bring it within the gainful employment definition.

53. Where the employer is notified of a member's employment showing contract details of 30 hours or more in each week, for a period less than 12 months, the 3rd tier payments should not be stopped but the employer should check the current employment status with the member at the point the contract is due to end. If it is found that a further contract has been obtained, and this was again for 30 hours or more in each week, for a period less than 12 months, it will be reasonable to stop payments when a continuous 12 month period has been undertaken, as the gainful employment test will have been satisfied.

54. Under some contracts, the hours may be variable and this may cause some difficulty in deciding whether, over the future, the 30 hour test is satisfied over a 12 month period. If employment was obtained some time ago, it should be possible to ascertain a pattern of working from the variable hours worked up to that point and to base a decision on that evidence. A better way forward would be to defer any decision until later in the employment when evidence about working hours has been established.

55. In other words, taking short term contracts may avoid the 3rd tier pension being suspended in the short time, but once the employment in individual contracts for 30 hours or more in each week have been undertaken over a continuous 12 month period, the definition of gainful employment would be satisfied.

56. In any event, if it is clear from the outset that the member has obtained employment with a specified period of less than 12 months, the employer will wish to ask the member in receipt of a

3rd tier pension, to let them know their employment status at the end of the period of the first short term contract, and subsequent contracts until the gainful employment test has been met.

57. The view is also taken that the words “in each week” where they appear in the definition of “gainful employment” in regulation 20(14) means in each week throughout the 12 month period, rather than in each week where there is a contract of employment. Otherwise, the definition would be satisfied by a person taking just a one month contract of employment for 35 hours a week.

58. Where a member notifies the previous employer that they have obtained employment, for example, 37 hours a week on an open contract ie one that has no specified end date, it would be reasonable for the employer to take the view that the gainful employment test was met and to discontinue payment of the 3rd tier benefits.

### **Regulation 31 – Early payment of pension by reason of ill health**

59. A pensioner member whose 3rd tier benefits have ceased and who has deferred benefits is not precluded from applying under Regulation 31 as a result of a medical condition unrelated to the condition that resulted in 3rd tier payments. A member whose 3rd tier payments have ceased, is precluded from resumed 3rd tier payments under regulation 20 (9). If a pensioner member whose 3rd tier benefits have ceased, seeks release of benefits as a result of the condition that resulted in the 3rd tier payment, an employer should consider whether there is eligibility for a 2nd tier pension under Regulation 20 (11) (a).

### **Resolution of disagreements and Internal Dispute Resolution Procedure (IDRP)**

60. Regulation 58 of the Administration Regulations enables a scheme member to make an application for any disagreement, between themselves and an employer or an administering authority, to be resolved about a matter in relation to the scheme. This includes any decision taken by an employer or administering authority under the LGPS ill health regulations regarding entitlement to an ill health retirement benefit at the date employment ends (regulations 55 (6) and (7), or the early payment of deferred retirement benefits on ill health grounds having already ceased that employment (regulation 31 of the Benefits Regulations). The IDRP arrangements also apply in cases where an employer or administering authority has failed to make a decision within any period prescribed by the scheme’s regulations.

61. Other decisions which fall within the scheme’s IDRP provisions include:-

- a) any disagreement with the entitlement level of 1st, 2nd or 3rd tier pension (regulations 20(2), (3) and (4) of the Benefits Regulations;
- b) whether a certificate has been obtained from an IRMP in compliance with the scheme’s regulations (regulation 20(5) of the Benefits Regulations and regulation 56 of the Administration Regulations);
- c) whether the employing authority has had regard to guidance in carrying out their functions under regulation 56 of the administration regulations or regulation 20 of the Benefits Regulations; and
- d) whether a 3rd tier pension should be suspended because the member has obtained gainful employment or, if not, is judged to be capable of obtaining such employment (regulation 20(8)) of the Benefits Regulations.

62. This list is by no means exhaustive and is only given as an illustration of some of the main decisions on ill health retirement pensions that fall within the scheme's IDRPs arrangements. It is also important to note that these arrangements do not apply directly to the opinions given by the IRMP because their role is to give an opinion on whether or not the medical criteria for entitlement to an ill health pension is satisfied. It is the scheme employer that has the regulatory responsibility to decide the entitlement question based on the certificate and/or report submitted by the IRMP and against whom any IDRPs dispute regarding entitlement to benefit rests.

63. Detailed guidance for both scheme employers and scheme members on the scheme's IDRPs arrangements can be found at <http://www.xoq83.dial.pipex.com/empgb.htm> (scheme members) and <http://www.xoq83.dial.pipex.com/idrpguide.pdf> (scheme employers). The guides also refer to the role of the Pensions Ombudsman.

#### **Exchange of information by authorities**

64. Regulation 64 of the administration regulations requires employers to provide the relevant administering authority with such information as it needs to discharge its Scheme functions.

#### **Section 4 – Documentation**

65. The regulations themselves do not prescribe the precise format of the certificate that the IRMP is required to provide under Regulation 20(5), although the overall content is set out in the regulation itself. To assist practitioners in this process, examples of pro-forma certificates are included at **Annex B and C**. Individual employers, in consultation with their medical advisers, and IRMP, may wish to adapt the example to reflect local circumstances and procedures provided that the content complies fully with the scheme's regulatory requirements. In addition, a complete suite of forms including action at the review, reapplication by 3rd tier member whose benefits are discontinued etc, can be provided for employers from their administering authority.

## **Annex A**

### **Background and policy formulation for the current ill health framework**

66. In July 2000, HM Treasury published its review of ill-health retirement in the public sector. The 35 recommendations of the report were accepted in full by the Government and government departments responsible for public service pension schemes were tasked to come forward with individual action plans to implement the report's recommendations. The then DETR's action plan was agreed and published in October 2001.

67. The Department's action plan to implement the inter-Departmental report into ill health retirements in the public sector 2000, included an undertaking to prepare a discussion paper outlining the scope for introducing four changes to the arrangements for the payment of illhealth retirement benefits under the Local Government Pension Scheme Regulations 1997.

68. The four recommendations included in the Action Plan relevant to this guidance were :-

- **Recommendation 27** - To examine the scope for introducing a two-tier ill-health retirement provision into the LGPS;
- **Recommendation 28** – To introduce the facility to review the levels of ill-health retirement benefit during retirement;
- **Recommendation 29** – To consider the role of abatement in the context of ill-health retirement, and
- **Recommendation 34** – To consider the scope for introducing a more efficient system for awarding enhanced membership on ill-health retirement with less incentive for members to seek ill-health retirement at specific ages.

### **The rationale for a multi tier ill-health pension provision**

69. In common with most other occupational pension schemes in the public sector, the LGPS has historically assessed entitlement to ill-health retirement benefits on the individual employee's capacity to perform efficiently the duties of their former employment. However, the LGPS is different to the extent that since April 1999, it has also required employers to consider the capacity to undertake other local government employments that are comparable on the basis of pay, location, training/skill levels, etc. But that apart, there remained the problem envisaged by the July 2000 report that the LGPS, in common with most other occupational pension schemes in the public sector, failed to address the issue of a person's ability to perform a wide range of jobs in the employment sector as a whole.

70. The proposal to introduce a two-stage level of ill-health retirement benefit entailed the introduction of a new upper level of benefit LGPS members whose condition rendered them permanently incapable of any work, whether in local government or elsewhere. For the remainder whose incapacity meant that they were still capable of performing work elsewhere, the second level of benefit would be assessed on a case by case basis according to a number of factors, including the degree of incapacity and the extent to which this might affect future earning potential. But given the Government's aim of reducing the levels of ill-health retirement and of retaining people in the workforce up to their normal retirement age and possibly beyond, the scope for introducing a series of measures designed to ease the transition between work

and retirement and to retain staff in employment despite their inability to perform their current duties because of ill-health would have to be explored.

71. Although the HM Treasury review focussed its attention on a two tier ill-health pension arrangement, the working group set up by the then DETR to take forward implementation of the action plan considered that the range of incapacities covered by the second tier - from those just short of meeting the top tier criteria and those who would be capable of obtaining gainful employment within a reasonable period after ceasing their local government employment on permanent ill-health grounds - was such that a three tier provision might be more appropriate.

72. It was also suggested that there could be a role for some form of income-protection arrangement as a way of managing long term sickness absence and ensuring that other alternatives to ill-health retirement, eg, re-training, rehabilitation, re-deployment and flexible retirement, were fully explored before employment is finally terminated on grounds of incapacity.

### **Policy development**

73. After consideration of the views expressed by interested parties, Ministers came forward, in April 2007, with a two tier arrangement as set out in the Local Government Pension Scheme (Benefits, Membership and Contributions) Regulations 2007 (benefit regulations). A 1st tier member will receive their accrued pension entitlements plus a service enhancement of all (100%) of their prospective membership to their normal retirement date. A 2nd tier member with a lower level of incapacity will receive 25% of that prospective membership along with their accrued pension entitlements.

74. The final element of ill health remained to be decided. CLG explored with key stakeholders the scope for a form of income replacement allowance, outside the pension scheme and to be paid by employers from their revenue. However, agreement was not reached. As new tax rules, introduced in the 2007 Finance Act, did not preclude the cessation of a pension, consideration of a 3rd tier within the LGPS was then an option.

75. In November 2007, interested parties were consulted on a reviewable third tier of ill health retirement benefit for a Scheme member who leaves employment because they are assessed by an independent occupational health practitioner as being permanently incapable of their current job but medical evidence indicates that they are capable of obtaining alternative employment within three years of their leaving.

Annex B

**Example III Health Retirement Certificate for a Current Employee – England and Wales – for determinations made after 30 September 2008.**

**Medical certificate to be provided by an independent, approved, duly qualified registered medical practitioner in accordance with regulation 20 of the Local Government Pension Scheme (Benefits, Membership and Contributions) Regulations 2007 (as amended) in respect of a current employee.**

**Part A: To be completed by the employer**

Surname of employee:

Forenames:

Mr / Mrs / Miss / Ms\*

Date of birth:

NI Number:

Home address:

Employer:

Place of work:

Nature of employment (job description attached):

Have the employee's contractual hours been reduced as a result of their ill health or infirmity or mind or body? Yes / No \* (If 'Yes', please attach a statement providing background details e.g. factors that led to the reduction in hours, date(s) reduction(s) in hours occurred. This is to assist the registered medical practitioner when answering questions B8/B9).

(\*delete as appropriate)

**Part B: To be completed by the approved (1) registered medical practitioner. Please tick appropriate boxes. Please tick either B1 or B2**

I certify that, in my opinion, the employee named in Part A

B1: IS       B2: IS NOT

on the balance of probabilities, permanently incapable (2) of discharging efficiently the duties of his / her employment with his / her employer because of ill health or infirmity of mind or body.

**If B1 has been ticked, please tick B3 or B4**

I certify that, in my opinion, as a result of that ill health or infirmity the employee named in Part A

B3: DOES       B4: DOES NOT

have a reduced likelihood of being capable of obtaining (3) other gainful employment (4), whether in local government or elsewhere, before age 65.

**If B3 has been ticked I further certify that, in my opinion:**

B5: As a result of their ill health or infirmity, there is no reasonable prospect of the employee named in Part A being capable of obtaining (3) gainful employment (4) before age 65.

OR

B6: Although, as a result of their ill health or infirmity, the employee named in Part A cannot obtain (3) gainful employment (4) within the next three years he / she is likely to be capable of gainful employment (4) at some time thereafter and before age 65.

OR

B7: Having considered their ill health or infirmity, the employee named in Part A is likely to be capable of obtaining (3) gainful employment (4) within the next three years.

**If B3 has been ticked and the contractual hours of the person named in Part A have been reduced by the employer (as indicated in Part A) please tick B8 or B9**

I certify that, in my opinion, the employee named in Part A

B8: IS       B9: IS NOT

in part-time service wholly or partly as a result of the condition that has caused him / her to be permanently incapable of discharging efficiently the duties of his / her employment (5).

<p><b>General statement</b></p> <p>I do / do not* attach a copy of my full report / assessment and I certify that:</p> <p>I have not previously advised, or given an opinion on, or otherwise been involved in this case</p> <p>AND</p> <p>I am not acting, and have not at any time acted, as the representative of the employee named in Part A, the employer or any other party in relation to this case</p> <p>AND</p> <p>I hold a diploma in occupational health medicine (D Occ Med) or an equivalent qualification issued by a competent authority in an EEA State, which has the meaning given by the General and Specialist Medical Practice (Education, Training and Qualification) Order 2003, or I am an Associate, a Member or a Fellow of the Faculty of Occupational Medicine or of an equivalent institution in an EEA State</p> <p>AND</p> <p>I have given due regard to the guidance issued by the Secretary of State when completing this certificate.</p> <p>..... Date: .....</p> <p>Signature of independent registered medical practitioner</p> <p>.....</p> <p>Printed name of independent registered medical practitioner</p> <p>(* delete as appropriate)</p>
<p><b>Important notes:</b></p> <ul style="list-style-type: none"><li>(1) The independent registered medical practitioner signing the certificate must have been approved for this purpose by the Pension Fund administering authority.</li><li>(2) 'Permanently incapable' means that the person will, more likely than not, be incapable until, at the earliest, their 65th birthday.</li><li>(3) The independent registered medical practitioner is providing an opinion on the person's capability of obtaining gainful employment based solely on the effect the medical condition has on the ability to undertake gainful employment.</li><li>(4) 'Gainful employment' means paid employment (whether in local government or elsewhere) for not less than 30 hours in each week for a period of not less than 12 months. It does not have to be employment that is commensurate in terms of pay and conditions with that of the person's current employment.</li><li>(5) If the reason that the contractual hours have been reduced is wholly or partly as a result of the condition that has caused him / her to be permanently incapable of discharging efficiently the duties of his / her employment, then the Pension Fund administering authority will ignore the reduction in hours when calculating the pension benefits due to the scheme member.</li></ul>

Annex C

***Example 3rd Tier III Health Retirement Review Certificate for a Current 3rd Tier Pensioner – England and Wales – Review taking place within 3 years of date of cessation of employment.***

**Medical certificate to be provided by an independent, approved, duly qualified registered medical practitioner in accordance with regulation 20 of the Local Government Pension Scheme (Benefits, Membership and Contributions) Regulations 2007 (as amended) in respect of a 3rd tier pensioner whose pension is currently in payment.**

**Part A: To be completed by the employer**

Surname of former employee:

Forenames:

Mr / Mrs / Miss / Ms\*

Date of birth:

NI Number:

Home address:

Former Employer:

Former position (post title):

Nature of former employment (job description attached):

Date of cessation of former position:

The former employee named above was, at the date of cessation of their former position, certified as being, on the balance of probabilities, permanently incapable (1) of discharging efficiently the duties of his / her employment with his / her employer because of ill health or infirmity of mind or body, and that, although having a reduced likelihood of being capable of obtaining other gainful employment (2), whether in local government or elsewhere, before age 65, it was nevertheless likely that he / she would be capable of obtaining gainful employment (2) within 3 years of the date of cessation of employment. He / she was awarded a short-term, reviewable, 3rd tier pension. It is now necessary to review, in accordance with regulation 20 of the Local Government Pension Scheme (Benefits, Membership and Contributions) Regulations 2007, whether he / she is still capable of obtaining (7) gainful employment (2) within 3 years of the date of cessation of employment.

(\*delete as appropriate)

**Part B: To be completed by the approved (3) registered medical practitioner. Please tick appropriate boxes. Please tick either B1 or B2**

I certify that, in my opinion, having considered their ill health or infirmity, the former employee named in Part A

B1: IS STILL       B2: IS NOT (4)

likely to be capable of obtaining (7) gainful employment (2) within three years of the date of leaving shown in Part A.

**If B1 has been ticked, please tick B3 or B4**

I certify that, in my opinion, the former employee named in Part A

B3: IS CURRENTLY CAPABLE OF OBTAINING (7) GAINFUL EMPLOYMENT (2)(5)

B4: IS NOT CURRENTLY CAPABLE OF OBTAINING (7) GAINFUL EMPLOYMENT (2) BUT IS LIKELY TO BE CAPABLE OF DOING SO WITHIN THREE YEARS OF THE DATE OF LEAVING SHOWN IN PART A. I WOULD LIKE TO REVIEW THIS CASE  
*[ENTER DATE, BEING A DATE GREATER THAN 18 MONTHS BUT LESS THAN THREE YEARS AFTER THE DATE OF LEAVING SHOWN IN PART A] (6)*

**General statement**

I do / do not\* attach a copy of my full report / assessment and I certify that:

I hold a diploma in occupational health medicine (D Occ Med) or an equivalent qualification issued by a competent authority in an EEA State, which has the meaning given by the General and Specialist Medical Practice (Education, Training and Qualification) Order 2003, or I am an Associate, a Member or a Fellow of the Faculty of Occupational Medicine or of an equivalent institution in an EEA State

AND

I have given due regard to the guidance issued by the Secretary of State when completing this certificate.

..... Date: .....  
Signature of independent registered medical practitioner

.....  
Printed name of independent registered medical practitioner

(\*delete as appropriate)

**Important notes:**

- (1) 'Permanently incapable' means that the former employee was, more likely than not, incapable until, at the earliest, their 65th birthday.
- (2) 'Gainful employment' means paid employment (whether in local government or elsewhere) for not less than 30 hours in each week for a period of not less than 12 months. It does not have to be employment that is commensurate in terms of pay and conditions with that of the employee's former employment.
- (3) The independent registered medical practitioner signing the certificate must have been approved for this purpose by the Pension Fund administering authority.
- (4) 'If Box B2 is ticked, the former employer can determine to award an enhanced (2nd tier) ill health pension, payable from the date of their determination.
- (5) If Box B3 is ticked, the 3rd tier ill health pension will cease to be payable immediately (or, if later, from the date 18 months after the date of leaving shown in Part A).
- (6) If Box B4 is ticked, the 3rd tier ill health pension will continue in payment but the case is to be referred back to the independent medical practitioner at the time indicated by the independent medical practitioner for a further review (unless the pension is stopped before then upon the former employee obtaining gainful employment).
- (7) The independent registered medical practitioner is providing an opinion on the former employee's capability of obtaining gainful employment based solely on the effect the medical condition has on the ability to undertake gainful employment.



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**THE LOCAL GOVERNMENT PENSION SCHEME (BENEFITS, MEMBERSHIP AND CONTRIBUTIONS) (AMENDMENT) REGULATIONS 2008 (benefits regulations) as amended by the LGPS (AMENDMENT) REGULATIONS 2008**

**FAQs – Edition 2 – May 2009 – this replaces Edition 1 which should no longer be used**

**Ill Health benefits for LGPS Scheme members**

**Main questions answered**

This CLG aide-memoir is intended to help practitioners apply the new ill health LGPS regulations and supports the LGPS Ill Health Guidance. The Ill Health Guidance can be seen at:

<http://www.xoq83.dial.pipex.com/Final%20draft%20statutory%20ill%20health%20guidance%2019%20November%202008.doc>

This note does not replace the regulations and practitioners will want to seek their own legal advice as necessary.

**Q1. Can ill health benefits be awarded if the member resigns?**

No. Ill health retirement benefits are only awarded when the employer terminates the member's employment on the grounds that the member's ill health or infirmity of mind or body, renders him permanently incapable of discharging efficiently the duties of his current employment and the member has a reduced likelihood of obtaining gainful employment (whether in local government or elsewhere) before his normal retirement age (Regulation 20(1) (b)).

**Q2. Who makes the decision to award ill health retirement benefits?**

It is the employer who makes the decision to terminate a member's employment on the grounds of ill health but they cannot make this decision without having first obtained a certificate from an independent registered medical practitioner qualified in occupational health medicine (IRMP).

If the employer decides to terminate a member's employment on the grounds of ill health, it is also for them to decide whether to award 1st, 2nd or 3rd tier ill health retirement benefits.

### **3rd tier framework**

#### **Q3. Why is a 3rd tier needed?**

All employees who are members of the LGPS and whose employment is terminated because they are permanently incapable of their current job and cannot work immediately after they leave their current job, are entitled to an ill health provision.

The ill health regulations provide a pension for those employees whose employer terminates their employment because they are permanently incapable of it but either cannot work again before normal retirement age or are unlikely to work again within 3 years of leaving (1st and 2nd tiers).

The 3rd tier provides a reviewable pension for a member whose employer terminates their employment because they are permanently incapable of their current job but are judged capable of obtaining gainful employment within 3 years.

#### **Q4. How is the 3rd tier benefit paid?**

It is a pension made up of the member's accrued benefits to the point that their employment was terminated on the grounds of ill health. There will also be a lump sum if the member has pre 1 April 2008 membership and/or opts to commute some pension to a lump sum.

### **The 3rd tier Review**

#### **Q5. Why is there a review for the 3rd tier?**

A 3rd tier benefit is an interim pension until the member returns to other work and is not payable if gainful employment is found. The 3rd tier member is required to inform their former employer if work is found and payments will stop if the employer considers that this is gainful employment as defined in the regulations. The employer needs to check the 3rd tier member's employment status where payments have continued for 18 months. Payments will stop if gainful employment has been obtained. If it is found that the member is not in gainful employment at the review, there is a requirement for the employer to check the latest medical position.

#### **Q6. How many times does the employer undertake a 3rd tier review?**

The employer is only required to undertake a review once when payments have continued for 18 months. The employer is not required to undertake a further review but they are not prevented from looking at the case again in the light of the medical assessment at the review.

#### **Q7. Is there a review for the 1st and 2nd tiers?**

No.

**Q8. Who does the review?**

The previous employer, or successor body, has to check the 3rd tier member's employment status if payments have continued for 18 months.

**Q9. Why does an employer need to ask about the terms of a member's contract at the review?**

A member in receipt of a 3rd tier pension, who notifies their former employer that they have started paid employment, is not expected to work out whether they have 'obtained gainful employment', as this is a matter for the employer. To help this assessment process, the employer needs to know if the work obtained is actually paid employment and will need details of pay to check this. They also need to be advised about how many hours the member is working each week and the terms of the contract ie is this for a fixed period or an open contract with no end date, so that the employer can establish whether gainful employment has been obtained. In Regulation 20 (14) of the benefits regulations "gainful employment" means paid employment for not less than 30 hours in each week for a period of not less than 12 months.

**Q10. What happens if the person had obtained work when the employer conducts the review at 18 months?**

The employer is required to stop payments if the work obtained is 'gainful employment' as defined in the regulations ("gainful employment" means paid employment for not less than 30 hours in each week for a period of not less than 12 months). The employer should notify the administering authority without delay that payments should be discontinued.

**Q11. What happens if the member fails to respond to the former employer's enquiry?**

If an employer has written to a member at the review with no response, they may wish to check whether a change of address notification has been received by the administering authority. If despite reminders, there is still no response from the member, it would be considered reasonable to cease payments until the employment position has been clarified.

**Q12. What happens if work was found some time before the 18 month review and the 3rd tier member failed to inform their previous employer?**

Any payment made beyond the date of return to gainful employment can be regarded as an overpayment and the former employer has powers to recover that overpayment.

However, if the employer has had to ask for further information to be able to assess whether the employment is 'gainful employment' as described in the regulations, the employer may wish to consider ceasing payments at the point when the information received confirms gainful employment.

Recovered payments will be the gross amount paid to the member and should be returned without delay to the relevant pension fund. The member will be able to reclaim any tax paid on these payments from HMRC.

If the employer considers that an overpayment has been made but then chooses not to seek recovery, or is unsuccessful in seeking to recover the overpayment, this would result in the payment being an unauthorised payment unless the payment was made in error and was for less than £250 gross. If it is an unauthorised payment the relevant administering authority has to provide the member with various information by the following 7 July (amount of overpayment, dates, nature of overpayment), and has to report the overpayment to HMRC as an unauthorised payment which will lead to a 40% unauthorised payment tax charge on the member and a scheme sanction charge of 40% or 15% on the Fund (unless a case can be made for HMRC to waive the scheme sanction charge).

**Q13. Should the employer tell the member when their 3rd tier payments are stopped?**

Yes, if 3rd tier benefits are stopped the employer should tell the member why and from what date. For example, if payments are stopped because of a return to paid employment, the employer should inform the member that they have decided that the paid employment they have is 'gainful employment' as described in the regulations. The employer also needs to promptly inform the relevant administering authority to discontinue the 3rd tier payments and the reason why.

**Q14. If a 3rd tier member continues to be incapable of work at the point of the review, can retirement benefits continue?**

Yes, in certain circumstances. A further medical judgement would be needed and where the medical assessment justifies this, an employer would be able to decide to award the enhanced 2nd tier benefit from the date of the decision to award the 2nd tier.

Alternatively, 3rd tier payments could also continue based on the initial medical assessment up to the maximum three years after the date of termination of employment, as prescribed in the regulations. 3rd tier benefit payments would, of course, cease if gainful employment was obtained.

**Q15. Can a 3rd tier member be considered for an enhanced retirement pension at the review?**

Yes. The regulations provide that an employer can consider an uplift from a 3rd tier to a 2nd tier pension either at the review or at some other stage but this must relate to the condition that resulted in the 3rd tier award.

An employer will need to be aware that there could be tax implications for the award of the enhanced 2nd tier pension and have regard to HMRC normal rules for the increases of pensions, see <http://www.hmrc.gov.uk/manuals/rpsmmanual/RPSM11104310.htm>.

### **Stopping 3rd tier payments**

#### **Q16. Why are payments stopped after 3 years?**

The duration of three years is consistent with the eligibility criteria where a member is judged capable of obtaining gainful employment within three years or not capable of obtaining gainful employment within three years, for the 3rd and 2nd tiers respectively. A 3rd tier pension is a short term benefit to provide financial assistance until such time as gainful employment can be, or is, found. It is not the intention that a member, whose medical condition requires payments beyond three years, should remain a 3rd tier member and the employer has powers to consider an enhanced 2nd tier pension at the 3rd tier review. Even after 3rd tier payments have been stopped, a further determination can be made under Regulation 20 (11) (a) where the original medical condition justifies this.

#### **Q17. Can 3rd tier payments be stopped regardless of whether a review has been undertaken or not?**

If payments are continuing until the review, payments cannot be stopped until a review is undertaken by the employer at 18 months as the regulations require this when payments have been made for that long. It follows, therefore, that while 3rd tier payments will stop at three years if they are continuing at that point, they cannot be stopped at any point up to the three year threshold without an earlier review. The exception is where the member has obtained gainful employment.

#### **Q18. Does the employing authority have to notify the administering authority when payments stop?**

Yes and promptly. The employing authority should notify the administering authority without delay when 3rd tier payments need to be stopped giving the reason i.e. that gainful employment has been found, or after the review when the member is judged immediately capable of gainful employment, or when the payments need to stop because they have been paid for three years.

### **Certain protections for members**

#### **Q19. What if the member's employment was terminated on ill health grounds and they were a member aged 45 or over before 1 April 2008?**

In these circumstances, for a member judged eligible for a 1st or 2nd tier enhancement, an employer will consider the benefits under both the 1997, and the 2007 ill health regulations as amended. They will make a comparison of the calculations, with the enhancement of prospective service for both calculations at the 1/60th accrual rate, and award benefits that are the greater of the two.

**Q20. What about cases that were being considered when the new regulations were introduced in May 2008 and there may have been uncertainty about which regulations would apply?**

Under regulation 20 (15), transitional protections applied for determinations made before 1 October 2008 (even if the actual termination date was after 1 October) to provide that if the benefits payable to a member under the amended Reg 20 would have placed him in a worse position than he would otherwise have been had the 1997 Regulations continued to apply, then those Regulations should have applied as if they were still in force. For all practical purposes, Regulation 27 of the 1997 Regulations and Regulation 20 of the Benefits Regulations 2007, as amended, both remained in force in the transitional period.

This means that the employer needed to consider whether the employee would be entitled to ill health benefits under Regulation 20 of the Benefit Regulations as amended by the LGPS (Amendment) Regulations 2008. The employer also needed to consider whether the member was entitled to ill health benefits under the 1997 Regulations. A calculation of any benefits payable, under the two sets of regulations, had to be made and any enhancement of prospective service for both calculations was to be at the 1/60th accrual rate. A comparison should then have been made and the member awarded the greater amount.

Until the end of September 2008, the ill health certificate to be completed by the independent registered medical practitioner had to include questions about whether the member would meet the ill health definition in the LGPS Regulations 1997 as well as ill health questions relating to the Benefits Regulations 2007 (as amended).

For example, in the transitional period, a member who qualified for a 3rd tier pension and would also qualify for an enhancement of 6 2/3 under the 1997 Regulations, would receive a 1997 Regulation non reviewable, permanent pension with the enhancement calculated at 1/60th accrual.

**Q21. If a member receives an ill health retirement pension based on the 1997 regulations in the transitional period to 30 September 2008, but would otherwise have been entitled to a 3rd tier pension under the 2007 amended regulations, would their payments be reviewed?**

No. The 1997 ill health regulations apply in all respects and there is no review.

**Q22. Could a member joining post 1 April 2008 who had an ill health determination before 1 October 2008, be eligible for an ill health award under the 1997 regulations?**

Yes, if the qualifying period for entitlement to a pension was satisfied. The 1997 regulations apply as if they were in force during the transitional period.

**Q23. What if the person has to reduce their hours just before their employment is terminated on ill health grounds?**

Where a member is awarded ill health retirement benefits but, prior to termination of their employment, they have had to reduce their hours as a result of the condition that lead to the ill health retirement award, no account is taken of the reduction in hours. The member's reduction in service which is accrued between the date of the reduction in hours and the date they leave employment is ignored for the purposes of calculating his ill health benefits. For this provision to apply, the IRMP will need to certify that the reduction in hours is as a result of the condition that causes him to be permanently incapable of the relevant local government employment and that the member has a reduced likelihood of obtaining gainful employment; this is set out in regulation 20 (12) (b). If this is certified, the employer can make a determination, and the ill health pension will be calculated based on accrued service with no reduction in service because of the reduction in hours; this applies to past service and, where appropriate, any future membership enhancement for a 2nd or 1st tier award.

**Q24. What happens to a member who has always been employed part-time because of an existing ill health condition and is being considered for ill health retirement because of that ill health condition?**

If a member's part time hours are not further reduced as a result of the ill health condition that is being assessed for ill health retirement, regulation 20 (12) (b) will not apply as there has been no reduction in their current service as a result of the condition resulting in ill health retirement.

If a member employed at outset on a part time basis because of an ill health condition, further reduces their hours as a result of that ill health condition, and this is certified to be the case by an IRMP, and the employer determines to make an health retirement award, no account is taken of that further reduction in part time hours when calculating the ill health retirement award. This applies for both past service and, where appropriate, any future service with the enhancement for a 2nd or 1st tier award. The calculation is based on the pre reduction part time pay.

**Need for Certification by Independent Registered Medical Practitioner qualified in occupation health medicine****Q25. Do all decisions regarding an ill health pension need a certification by an independent registered medical practitioner qualified in occupational health?**

Yes, this includes decisions for those who have already left local government and are asking for early release of their pension. Regulations 20 and 31 of the Benefits Regulations require this. Regulation 56 of the Administration Regulations stipulate certain conditions that must be met.

**Q26. Can the independent doctor who made the medical assessment that resulted in a 3rd tier award, undertake the second medical assessment at the 18 month review if asked to do so by the employing authority?**

Yes. The same doctor can sign the certificate that resulted in the first determination as well as at the 3rd tier review. This is because the provision to obtain a further certificate from the IRMP is under regulation 20(7) (b) which means that 56(1) of the LGPS administration regulations does not apply. There is, effectively, no requirement that the IRMP has to be able to certify at a 3rd tier review that they have not previously advised, given an opinion on, or otherwise been involved in the case.

**Q27. Can a 3rd tier member whose payments have stopped ask for pension payments to resume if it relates to the condition that resulted in a 3rd tier award?**

Only in certain circumstances but there is no future entitlement to 3rd tier payments. Regulation 20 (11) (a) permits a determination for a 2nd tier pension relating to the condition that resulted in 3rd tier payments, if that condition subsequently merits such an award, and this is not time limited. A former 3rd tier member can apply for reconsideration of ill health payments and the employer will be required to seek a further independent medical assessment. Where the medical condition justifies it, the employer can agree to an enhanced 2nd tier retirement pension from the date of the 2nd tier determination.

**Other relevant issues**

**Q28. Would a lump sum be payable again if a further determination to a 2nd tier pension is made?**

No. The termination of employment on ill health grounds and award of 3rd tier benefits triggered a benefit crystallisation event with early release of retirement benefits and a lump sum payment. A member whose 3rd tier benefits have stopped is a pensioner member and, therefore, any future entitlement to ill health retirement benefits in respect of the ill health condition that resulted in 3rd tier ill health benefits, is likely to be a 2nd tier award which has an enhancement of 25% of their prospective membership to normal retirement age, based on 1/60th accrual with no option to commute for an additional lump sum.

**Q29. Can a 3rd tier member whose benefits have ceased ask for release of retirement benefits under Regulation 31 of the Benefits Regulations for an unrelated condition?**

Yes. A pensioner member whose 3rd tier benefits have ceased and who has 'deferred'<sup>1</sup> benefits is not precluded from applying under Regulation 31 as a result of a medical condition unrelated to the condition that resulted in 3rd tier payments.

A member whose 3rd tier payments have ceased, is precluded from resumed 3rd tier payments under regulation 20 (9).

If a pensioner member whose 3rd tier benefits have ceased, applies again for release of retirement benefits as a result of the condition that resulted in the 3rd tier payment, an employer should consider whether there is eligibility for at least a 2nd tier pension under Regulation 20 (11) (a).

**Q30. From what date does the administering authority make any payments payable under Regulation 31?**

The member should notify the relevant employing authority that they want benefits to be released under regulation 31. The employing authority is required to obtain a certificate from an IRMP regarding the member's condition and whether it renders the member permanently incapable of their former local authority employment and whether they have a reduced likelihood of gainful employment (ie would now meet the qualifying test for tier 1 or 2 of Regulation 20). The employer should notify the administering authority to release unenhanced benefits from the day the member asked or elected for these payments to be made if the medical condition justifies this.

**Q31. Can a 3rd tier member be uplifted to the enhanced 2nd tier with a condition other than that which resulted in the ill health retirement?**

No. The regulations are quite clear that it is the initial condition resulting in an ill health 3rd tier payment that should be considered when assessing a possible uplift to a 2nd tier pension.

**Q32. Can the employee return to local authority or another LGPS employer?**

They are not expected to return to their employment that resulted in the 3rd tier retirement benefits but they could obtain other employment with a local authority or LGPS employer.

<sup>1</sup> In effect these are benefits that have been suspended

**Q33. If a 3rd tier member obtains employment with a local authority or LGPS employer can the earlier membership resulting in a 3rd tier pension be aggregated with the new period of membership?**

No. Regulation 20 (10) requires that when benefits are stopped and the 3rd tier member subsequently becomes an active member of the LGPS, the earlier period of membership which resulted in 3rd tier benefits is not aggregated with the later active membership.

**Q34. The 3rd tier member has written to the former employer saying that they have a short term contract. How does the employer decide if the member has satisfied the gainful employment test?**

It would be unreasonable for an employer to assume that a person is in gainful employment having been notified that the member had entered a short term contract of employment for, say, six months. Whether that contract will be renewed or not, would be pure conjecture and should not, therefore, fall to be considered. Even if a 3rd tier member had served two months of the six month contract, it follows that the definition of gainful employment has not been satisfied. Neither would it be reasonable to make any assumption that four months on, the contract might be reviewed for a further six months which could arguably bring it within the gainful employment definition.

Where the employer is notified of a member's employment showing contract details of 30 hours or more in each week, for a period less than 12 months, the 3rd tier payments should not be stopped but the employer should check the current employment status with the member at the point the contract was due to end. If it is found that a further contract has been obtained, and this was again for 30 hours or more in each week, for a period less than 12 months, it will be reasonable to stop payments when a continuous 12 month period has been undertaken, as the gainful employment test will have been satisfied.

Under some contracts, the hours may be variable and this may cause some difficulty in deciding whether, over the future, the 30 hour test is satisfied over a 12 month period. If employment was obtained some time ago, it should be possible to ascertain a pattern of working from the variable hours worked up to that point and to base a decision on that evidence. A better way forward would be to defer any decision until later in the employment when evidence about working hours has been established.

In other words, taking short term contracts may avoid the 3rd tier pension being suspended in the short time, but once the employment in individual contracts for 30 hours or more in each week have been undertaken over a continuous 12 month period, the definition of gainful employment would be satisfied.

In any event, if it is clear from the outset that the member has obtained employment with a specified period of less than 12 months, the employer will wish to ask the member in receipt of a 3rd tier pension, to let them know their employment status at the end of the period of the first short term contract, and subsequent contracts until the gainful employment test has been met.

The view is also taken that the words “in each week” where they appear in the definition of “gainful employment” in regulation 20(14) means in each week throughout the 12 month period, rather than in each week where there is a contract of employment. Otherwise, the definition would be satisfied by a person taking just a one month contract of employment for 35 hours a week.

**Q35. Does an employer need to wait until 12 months of an open contract have been served before stopping payments, where it is clear that the contract was for 12 months or more and for not less than 30 hours in each week?**

Where a member notifies the previous employer that they have obtained employment, for example, 37 hours a week on an open contract ie one that has no specified end date, it would be reasonable for the employer to take the view that the gainful employment test was met and to discontinue payment of the 3rd tier benefits.

**Q36. Would a member who obtains employment only during term time, be regarded as obtaining gainful employment?**

In the LGPS (Benefits, Membership and Contributions Regulations 2007 (Regulation 3 (7) ), a “term-time worker” means a person whose contract of employment provides for a regular pattern of periods of work and periods of no work so as to result in a recognisable cycle of work consisting of one year (but is not limited to persons working in educational establishments). It follows that if a member notifies the previous employer that they have obtained employment as a ‘term time worker’ on a standard hours contract that is not less than 30 hours each week with an unspecified end date, it would be reasonable for the employer to take the view that the gainful employment test was met and to discontinue payment of the 3rd tier benefits. If, however, the member notifies that term time working had been obtained with a specified end date within 12 months, the employer should check the position at the end of the contract. If the member entered into a further term time contract of not less than 30 hours per week, it would be reasonable for the employer to cease payments when the aggregated contract period is not less than 12 months.

A member may choose to obtain employment on a term time only basis for other reasons, such as child care arrangements, and a member in this position would be treated as a part time worker.

The gainful employment test for a member on a term time working contract with no specified end date but with hours of less than 30 hours a week would not be satisfied. 3rd tier retirement benefits would be payable in these circumstances.

**Q37. What happens if a member has an 'added years' contract?**

Regulation 83 of the 1997 Regulations has been retained by the LGPS (Transitional Provisions) Regulations 2008. This means that a person with an added years contract will be deemed to have completed the purchase of the added years if they meet the definition of ill health retirement under regulation 27 of the 1997 Regulations. Therefore,

a) a member who meets the 1997 Regulations ill health definition but not the 2008 Benefits Regulation 20 definition, will get the added years contract bought out even though they will not be entitled to an ill health pension under the Benefits Regulations; or

b) a member who meets the 1997 Regulations ill health definition and meets the 2008 Benefits Regulation 20 definition, will get the added years contract bought out and receive a tier 1, 2 or 3 pension under the Benefits Regulations; or

c) a member who does not meet the 1997 Regulations ill health definition but does meet the new definition in the Benefits Regulations will not get the added years contract bought out. The member will only be entitled to the proportion of the added years contract purchased to the date of termination of employment but will be entitled to an ill health pension under tier 1, 2 or 3 of the Benefits Regulations.

**Q38. What happens if a member is paying Additional Regular Contributions (ARCs)?**

A member paying ARCs who is entitled to a 1st or 2nd tier ill health pension will be deemed to have completed all their ARC payments and will be credited with the whole of the extra pension they had contracted to buy.

A member who is entitled to a 3rd tier ill health pension will only be credited with that proportion of the extra pension which they have paid for by the date of leaving i.e. they will not be deemed to have completed payments. There are no plans to change this.

**Q39. Can a member receive his retirement benefits without retiring on ill health grounds if he is over 60 but would have been a 3rd tier member?**

It is the employer who has to determine the reason for terminating employment. An employer may wish to consider not terminating the member's employment on ill health grounds and, for instance, where existing protections permit the early release of unreduced retirement benefits, retire the employee as a regular retiree.

**Q40. What death grant is payable in respect of a 3rd tier pension?**

If a 3rd tier member dies (either while in receipt of the 3rd tier pension or where the 3rd tier pension has ceased and future retirement benefits are deferred), a death grant is payable under Regulation 35 of the benefits regulations. This would be 10 times the pension in payment (or the pension that would have been in payment but for the suspension) less the amount that has already been paid.

**Q40. What death grant is payable in respect of a 3rd tier pension?**

If a 3rd tier member dies (either while in receipt of the 3rd tier pension or where the 3rd tier pension has ceased and future retirement benefits are deferred), a death grant is payable under Regulation 35 of the benefits regulations. This would be 10 times the pension in payment (or the pension that would have been in payment but for the suspension) less the amount that has already been paid.

**Q41. Is a member's reduction in hours ignored if it relates to the condition that resulted in the death of an active member?**

No. The protection for a reduction in hours only relates to the early release of retirement benefits on the grounds of ill health.

**Q42. What survivor benefits are payable in respect of a 3rd tier pension?**

If a 3rd tier member dies (either while in receipt of the 3rd tier pension or the 3rd tier pension is suspended), survivor benefits can be considered in accordance with regulations 36 and 37 of the Benefits regulations respectively.

**Q43. Is a member's reduction in hours ignored when calculating survivor benefits if the reduction relates to the condition that resulted in the death of an active member?**

No. The protection for a reduction in hours only relates to the early release of retirement benefits on the grounds of ill health.

**Q44. Can a member commute any pension accrued after 1 April 2008 before a 3rd tier pension is awarded?**

Yes but this is subject to the limit that the commuted sum must not exceed 25% of the capital value of the member's accrued rights.

**Q45. Does a member with a 3rd tier pension qualify under the pension increase legislation?**

Yes, a member with a 1st, 2nd or 3rd tier retirement pension would qualify under the Pensions (Increase) Act 1971 as the member has retired on account of physical or mental infirmity from the employment in respect of which the pension is payable. Pensions (Increase) Act 1971 section 3 (2) (b) refers.

**Q46. What do the terms mean in the regulations?**

Unless defined in the scheme's regulations, words, terms and phrases are to be given their normal and everyday meaning, except where clarification or an explanation is given in the ill health statutory guidance.

**Q47. What happens if the member is unhappy with the employer's decision about an ill health retirement application?**

A member does have recourse to query decisions made by an employer regarding ill health retirements under IDRPs. This would include any disagreement with the level of ill health retirement benefit that was awarded ie 1st, 2nd or 3rd tier. Also, a member, who has left local government employment and who was awarded deferred retirement benefits can appeal against this decision by writing to the employer that made the decision, setting out the reasons for their disagreement with the decision, in accordance with Regulation 58 of the LGPS (Administration) Regulations 2008. Any appeal against the decision of the employing authority is required within 6 months of the date of the original decision. The 6 months period within which an appeal should be lodged can be extended at the discretion of the official who is to give the decision on the appeal. Currently, the regulations do not provide for appeals before a member's employment is terminated where an ill health retirement pension is not awarded.

Detailed guidance for both scheme employers and scheme members on the scheme's IDRPs arrangements can be found at [www.xoq83.dial.pipex.com/idrpguide.pdf](http://www.xoq83.dial.pipex.com/idrpguide.pdf) and [www.xoq83.dial.pipex.com/empgb.htm](http://www.xoq83.dial.pipex.com/empgb.htm) respectively. The guides also refer to the role of the Pensions Ombudsman.

**Communities and Local Government  
Workforce, Pay and Pensions  
May 2009**



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28 July 2009

**Supplementary Guidance for Independent Registered Medical Practitioners qualified in occupational medicine (IRMPs)**

Attached is guidance issued jointly by Communities and Local Government and the Faculty of Occupational Medicine, to help Independent Registered Medical Practitioners (IRMPs) who are asked to make an assessment under the ill-health provisions in the Local Government Pension Scheme (LGPS) Regulations.

Under revised LGPS Regulations, a completely new ill-health retirement benefits scheme came into effect from April 2008, and this supplementary guidance has been developed to address various concerns that have been brought to our attention by occupational physicians who advise local government employers.

The supplementary guidance does not replace the regulations or CLG's earlier guidance on them that was published in November 2008. Rather, it aims to clarify further the role of the IRMP and the medical advice that is being sought when a referral is made under the LGPS ill-health regulations. Importantly, it aims to ensure that IRMPs do not give advice that extends beyond their professional competence (e.g. relating to an employee's aptitude for different types of work rather than just the effects of illness or injury on his/her capacity to obtain and carry out paid work).

Any queries on the LGPS ill-health regulatory framework should be sent, in the first instance, to Nicola Rochester ([Nicola.rochester@communities.gsi.gov.uk](mailto:Nicola.rochester@communities.gsi.gov.uk) or 020 7944 6016)

A handwritten signature in black ink that reads "Lynda Jones".

Lynda Jones  
CLG

A handwritten signature in black ink that reads "David Coggon".

Professor David Coggon  
President  
Faculty of Occupational Medicine



28 July 2009

## **Local Government Pension Scheme (LGPS)**

### **Supplementary Guidance for Independent Registered Medical Practitioners qualified in occupational health medicine (IRMPs)**

**This guidance is issued jointly by CLG and the Faculty of Occupational Medicine to help IRMPs who have been asked to make an assessment under the LGPS ill health retirement regulations<sup>1</sup>. This guidance does not replace the regulations, or CLG's supporting guidance, but aims to clarify further several areas that have been drawn to the attention of the Faculty of Occupational Medicine, Association of Local Authority Medical Advisers, the British Medical Association Occupational Medicine Committee, and CLG.**

#### ***Background***

1. Within the Local Government Pension Scheme, a new regulatory framework for ill-health retirement came into effect in April 2008, introducing three tiers of ill health retirement benefits. Subsequently, in November 2008, the Department of Communities and Local Government (CLG) issued guidance on their implementation. Amongst other things, this addressed the advice that should be sought from an independent registered medical practitioner (IRMP) to

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<sup>1</sup> Regulation 20 of the Local Government Pension Scheme (Benefits, Membership and Contributions) Regulations 2007 (S.I. 2007/1166), as amended by regulation 13 of the Local Government Pension Scheme (Amendment) Regulations 2008 (S.I. 2008/1083).

enable decisions to be made on eligibility for pensions under the new-look scheme.

2. This supplementary guidance is intended to assist doctors further when they are providing reports for LGPS Scheme employers in relation to a Scheme member who may be eligible for a pension to be paid before normal retirement age on the grounds of ill-health. It should be read in conjunction with the CLG Guidance issued in November 2008, which includes the text of the relevant legislation, and also an example of an ill-health retirement certificate, Part B of which is to be completed by the doctor.
3. The IRMP must consider whether, on the balance of probabilities, an illness renders the employee permanently incapable of discharging efficiently the duties of his/her relevant employment, and, if so, whether as a result of that condition he/she has a reduced likelihood of obtaining any gainful employment before reaching normal retirement age<sup>2</sup>. (If, in your opinion, the employee is suffering from a condition that renders him or her permanently incapable of discharging efficiently the duties of his/her employment, you should ask yourself whether the employee will, as a result of that illness, more likely than not, be incapable in this way until, at the earliest, his/her 65th birthday<sup>3</sup>).

### **Guidance**

4. The ill health certificate asks if the IRMP is attaching a full report or assessment. We are aware that some IRMPs prefer to include a narrative report with the certificate and we support this, particularly where it would help to clarify the severity of a condition. A narrative report can also assist the employer by providing more detail where the IRMP considers that advice from a disability advisor would be beneficial.
5. When completing Part B of an Ill-Health Retirement Certificate, as an IRMP, you are not making a decision as to whether the employee is eligible for a category of ill health retirement pension at tier 1, 2 or 3. Rather, you are providing an opinion and advice to the employer about the individual's likely

<sup>2</sup> See Regulation 20(5)

<sup>3</sup> See regulation 20(14) and the definition of "permanently incapable"

future health and what employment task-related ability the individual has in relation to the medical condition that is being assessed. It is the employer who will, based on that opinion, decide whether to terminate the member's employment on grounds of ill health, and if so, which tier of ill-health retirement benefit is to be awarded.

6. As made clear in footnote (3) of the example Ill-Health Retirement Certificate, the doctor is asked to provide his/her opinion on the person's capability of obtaining gainful employment based **solely on the effect of the medical condition**.
7. Boxes B1-B2 of the certificate require the doctor to indicate whether the employee, on the balance of probabilities, is permanently incapable of discharging efficiently the duties of his/her employment with his/her employer because of ill-health or infirmity of mind or body. In answering this and subsequent questions, "ill-health or infirmity of mind or body" should be taken to include illnesses such as non-specific arm pain, non-specific low back pain, chronic fatigue syndrome and fibromyalgia, despite the fact that there may be no demonstrable underlying pathology. However, the fact that an employee is diagnosed with such an illness, should not automatically mean that the employee is deemed to be permanently incapable. Similarly, an employee who becomes mentally ill through work or as a consequence of a breakdown in working relationships should not automatically be deemed to be permanently incapable of their employment. The IRMP may wish to recommend to the employer that the member tries alternative working arrangements and, if this can be achieved, that the employer consider whether an injury allowance would be more appropriate.
8. Boxes B3 -B4 ask whether, as a result of the ill-health or infirmity, the employee does or does not have a reduced likelihood of being capable of obtaining other gainful employment, whether in local Government or elsewhere, before age 65.

9. Here, “reduced likelihood” means in comparison with the position of the same individual if he/she did not have the illness. In other words, are there jobs, which the employee could reasonably be expected to be capable of obtaining in the absence of his/her illness, but not in its presence?
10. Boxes B5-B7 refer to the prospect/likelihood of the employee being capable of obtaining gainful employment in different time windows. Here, “gainful employment” means paid employment for 30 or more hours per week in an unsubsidised job (i.e. excluding sheltered employment).
11. Non-medical factors, such as the general availability of gainful employment in a particular area or the attitude of employers to certain conditions, **are not material factors here, and should not be part of the IRMP’s consideration.** It is the effect that the medical condition would be expected to have on the employee’s practical ability to obtain gainful employment that should be considered. This should include any effect that the condition has on the individual’s attitude towards obtaining gainful employment, which could be a limiting factor in their search for employment. In considering the capability of obtaining employment, you should assume that the individual has average motivation, except in so far as his/her motivation may have been reduced as a clinical feature of the illness.
12. Medical incapacity could arise, not only because of disability resulting from the employee’s illness, but also if there were a serious risk that a job could exacerbate the employee’s illness. For example, an employee with allergic occupational asthma might need to avoid exposure to the sensitising agent.
13. The salary that would be paid for jobs that the employee could undertake in the future is not an issue here for the IRMP. For example, if a Chief Executive had suffered a head injury in a road traffic accident leading to mental impairment, but would be capable in the future of working for 30 or more hours per week at other work such as a car park attendant, then he/she should be reported by the IRMP as having a reasonable prospect of being medically capable of obtaining

gainful employment. However, in such circumstances, it might help the employer if you indicated the type of work for which the employee would be capable.

14. You are not expected to take into account the competencies or aptitude of the employee in the absence of his/her illness. For example, if a manual labourer were rendered permanently incapable of performing his normal duties because of a chronic back disorder, but someone with such a disorder could be capable of working in a clerical job, you should classify the employee as capable of obtaining gainful employment, even if you think his aptitude would not enable him to work as a clerk. In these circumstances, you should add a report indicating the types of work for which someone with an illness or disability such as that affecting the employee, would be medically fit. This information can then be taken into account by the employer, when deciding the overall likelihood of the employee obtaining gainful employment.
15. Nor should you take account of factors other than the illness or disability that might influence the employee's competitiveness when applying for jobs (e.g. potential to perform well at interview, poor sickness absence record). You should assume the employee has average competitiveness.

# Medical Forms

**M1** – ill-health retirement certificate for a current employee for determinations made after 30 September 2008.

**PRIVATE AND CONFIDENTIAL**

**No.**



## form M1

Ill-health retirement certificate for a current employee – for determinations made after 30 September 2008.

Certificate of permanent incapacity by an independent, approved, duly qualified registered medical practitioner in accordance with Regulation 20 of the Local Government Pension Scheme (Benefits, Membership and Contributions) Regulations 2007 (as amended) in respect of a current employee.

**NOTES AS TO COMPLETION OF FORM**

1. The white copy should be sent to the named officer at the authority or body in a sealed envelope marked 'Private and Confidential', once completed by the registered medical practitioner appointed by the employing authority or body.
2. The yellow copy is to be sent in a sealed envelope marked 'Private and Confidential', Medical Adviser to the Fund, West Midlands Pension Fund, PO Box 3948, Wolverhampton WV1 1XP.
3. The green copy is to be retained by the registered medical practitioner who is providing the report at the request of the employing authority or body.

**PART A: TO BE COMPLETED BY THE EMPLOYER**

Name and address of officer who is to receive the completed certificate:

Employer name:

Surname:

Forenames:

Title:  Mr  Mrs  Miss  Ms  Other (please state)

Pension ref. no:  Payroll number:

Date of birth:  National insurance no:

Place of work:

Nature of employment:

Job description attached:  Yes  No

Have the employee's contractual hours been reduced as a result of their ill-health or infirmity of mind or body?  Yes  No

**M1 (D)** – ill-health retirement certificate for a deferred member who ceased membership of the Scheme on or after 1 April 2008.

**PRIVATE AND CONFIDENTIAL**

**No.**



## form M1(D)

Ill-health retirement certificate for a deferred member who ceased membership of the Scheme on or after 1 April 2008.

Certificate of permanent incapacity by an independent, approved, duly qualified registered medical practitioner in accordance with Regulation 31 of the Local Government Pension Scheme (Benefits, Membership and Contributions) Regulations 2007 (as amended) in respect of a deferred member.

**NOTES AS TO COMPLETION OF FORM**

1. The white copy should be sent to the named officer at the authority or body in a sealed envelope marked 'Private and Confidential', once completed by the registered medical practitioner appointed by the employing authority or body.
2. The yellow copy is to be sent in a sealed envelope marked 'Private and Confidential', Medical Adviser to the Fund, West Midlands Pension Fund, PO Box 3948, Wolverhampton WV1 1XP.
3. The green copy is to be retained by the registered medical practitioner who is providing the report at the request of the employing authority or body.

**PART A: TO BE COMPLETED BY THE FORMER SCHEME EMPLOYER**

Name and address of officer who is to receive the completed certificate:

Former Employer name:

Surname:

Forenames:

Title:  Mr  Mrs  Miss  Ms  Other (please state)

Pension ref. no:  Payroll number:

Date of birth:  National insurance no:

Former position (post title):

Nature of former employment:

Date of cessation of former position:

Date of application for early payment of deferred benefits:

PAS 183 10/10

**M1 (D)** – ill-health retirement certificate for a deferred member who ceased membership of the Scheme on or before 1 April 2008.

**PRIVATE AND CONFIDENTIAL**

**No.**



## form M1(D) – Pre-1 April 2008 Leaver

Ill-health retirement certificate for a deferred member who ceased membership of the Scheme on or before 1 April 2008.

Certificate of permanent incapacity by an independent, approved, duly qualified registered medical practitioner in accordance with Regulation 97 of the Local Government Pension Scheme Regulations 1997 (as amended) or Regulation D11 of the Local Government Pension Scheme Regulations 1995 (as amended) in respect of a deferred member.

**NOTES AS TO COMPLETION OF FORM**

1. The white copy should be sent to the named officer at the authority or body in a sealed envelope marked 'Private and Confidential', once completed by the registered medical practitioner appointed by the employing authority or body.
2. The yellow copy is to be sent in a sealed envelope marked 'Private and Confidential', **Medical Adviser to the Fund, West Midlands Pension Fund, PO Box 3948, Wolverhampton WV1 1XP.**
3. The green copy is to be retained by the registered medical practitioner who is providing the report at the request of the employing authority or body.

**PART A: TO BE COMPLETED BY THE FORMER SCHEME EMPLOYER**

Name and address of officer who is to receive the completed certificate:

Former Employer name:

Surname:

Forenames:

Title:  Mr  Mrs  Miss  Ms  Other (please state)

Pension ref. no:  Payroll number:

Date of birth:  National insurance no:

Former position (post title):

Nature of former employment:

Date of cessation of former position:

Date of application for early payment of deferred benefits:

PAS 183a 1/11

M2 – medical declaration to be completed by the employee or former employee



**form M2**

**West Midlands Pension Fund  
Medical Declaration**  
(for pension purposes only)

This declaration is for the early release of pension benefits (or deferred pension benefits) on the grounds of permanent incapacity due to ill-health or infirmity of mind or body.

An application for ill-health retirement or early payment of deferred benefits on ill-health grounds under the Local Government Pension Scheme Regulations requires a medical certificate. The medical certificate must be signed by a independent registered medical practitioner approved by the Fund in accordance with regulation 56(2) of the LGPS (Administration) Regulations 2008 and be supported by the employing body's independent registered medical practitioner.

I understand that:

- 1) The decision regarding this application will be made by my employer (or former employer) and will be based, amongst other things, on the medical advice from an independent registered medical practitioner (IRMP) used by my employer (or former employer) named on this certificate and the Fund's approved medical practitioner (in some circumstances the same doctor) for this purpose.
- 2) The recommendation will normally be based on medical and other information provided by the employer as part of the application for release of benefits on the grounds of permanent incapacity.
- 3) I, the applicant, may be examined where it is not possible to obtain information by other means.
- 4) Where I disagree with the medical opinion because I think it is based on factual inaccuracies, I have the right to correct that inaccuracy and ask for the opinion to be reconsidered.
- 5) If I disagree with the medical opinion because I have other medical evidence to the contrary, I have the right to make an appeal through the appeal procedure.

I CONSENT to:

- 1) My employer's (or former employer's) independent registered medical practitioner supplying a copy of my full occupational health record, (including reports from my GP and/or other doctors) to the Fund's approved medical practitioner for the purpose of processing my application.
- 2) The employing body's independent registered medical practitioner and the Fund's approved medical practitioner providing a certificate to my employer (or former employer) containing the medical opinion regarding my incapacity.
- 3) The Fund's approved medical practitioner providing a report to my employer/former employer/pension scheme manager/occupational health service explaining the medical opinion in terms of my likely potential for recovery and work abilities. In appropriate cases, this report will advise on what kinds of work might be suitable or unsuitable now or before normal retirement at age of 65 (  please tick if you consent to this).
- 4) I wish to receive a copy of the certificate and report to be provided to me when it is sent to my employer (  please tick).

M3 – 3rd-tier ill-health review certificate for a current 3rd-tier pensioner

**PRIVATE AND CONFIDENTIAL**

**No.**



**form M3**

3rd tier ill-health retirement review certificate for a current 3rd tier pensioner – review taking place within three years of date of cessation of employment.

Medical certificate to be provided by an independent, approved, duly qualified registered medical practitioner in accordance with regulation 20 of the Local Government Pension Scheme (Benefits, Membership and Contributions) Regulations 2007 (as amended) in respect of a 3rd tier pensioner whose pension is currently in payment.

**NOTES AS TO COMPLETION OF FORM**

1. The white copy should be sent to the named officer at the authority or body in a sealed envelope marked 'Private and Confidential', once completed by the registered medical practitioner appointed by the employing authority or body.
2. The yellow copy is to be sent in a sealed envelope marked 'Private and Confidential', Medical Adviser to the Fund, West Midlands Pension Fund, PO Box 3948, Wolverhampton WV1 1XP.
3. The green copy is to be retained by the registered medical practitioner who is providing the report at the request of the employing authority or body.

**PART A: TO BE COMPLETED BY THE EMPLOYER**

Name and address of officer who is to receive the completed certificate:

Surname of employee:

Forenames:

Title:  Mr  Mrs  Miss  Ms  Other (please state)

Pension ref. no:  National insurance no:

Date of birth:

Former employer:

Former position (post title):  Date of cessation of former position:

Nature of former employment:  Job description attached:  Yes  No

The person named above was, at the date of cessation of their former position, certified as being, on the balance of probabilities, permanently incapable (1) of discharging efficiently the duties of his/her employment with his/her employer because of ill-health or infirmity of mind or body, and that, although having a reduced likelihood of being capable of obtaining other gainful employment (2), whether in local government or elsewhere, before age 65, it was nevertheless likely that he/she would be capable of obtaining gainful employment (2) within three years of the date of cessation of employment. He/she was awarded a short-term, reviewable, 3rd tier pension. It is now necessary to review, in accordance with regulation 20 of the Local Government Pension Scheme (Benefits, Membership and Contributions) Regulations 2007, whether he/she is still capable of obtaining (7) gainful employment (2) within three years of the date of cessation of employment.

## Regulations

### Regulation 20: Early Leavers: Ill-Health

#### The Local Government Pension Scheme (Benefits, Membership and Contributions)

##### Regulations 2007 (as amended)

1) If an employing authority determine, in the case of a member who satisfies one of the qualifying conditions in [regulation 5](#) —

- a) to terminate his employment on the grounds that his ill-health or infirmity of mind or body renders him permanently incapable of discharging efficiently the duties of his current employment; and
- b) that he has a reduced likelihood of being capable of undertaking ([SI 2010/2090](#)) any gainful employment before his normal retirement age,

they shall agree to his retirement pension coming into payment before his normal retirement age in accordance with this regulation in the circumstances set out in paragraph (2), (3) or (4), as the case may be.

2) If the authority determine that there is no reasonable prospect of his being capable of undertaking ([SI 2010/2090](#)) any gainful employment before his normal retirement age, his benefits are increased —

- a) as if the date on which he leaves his employment were his normal retirement age; and
- b) by adding to his total membership at that date the whole of the period between that date and the date on which he would have retired at normal retirement age.

3) If the authority determine that, although he is not capable of undertaking gainful employment ([SI 2010/2090](#)) within three years of leaving his employment, it is likely that he will be able to obtain capable of undertaking ([SI 2010/2090](#)) any gainful employment before his normal retirement age, his benefits are increased —

- a) as if the date on which he leaves his employment were his normal retirement age; and
- b) by adding to his total membership at that date 25% of the period between that date and the date on which he would have retired at normal retirement age.

4) If the authority determine that it is likely that he will be capable of undertaking gainful employment within three years of leaving his employment, or normal retirement age if earlier, his benefits —

- a) are those that he would have received if the date on which he left his employment were the date on which he would have retired at normal retirement age; and
- b) unless discontinued under paragraph (8), are payable for so long as he is not in gainful employment.

([SI 2011/561](#))

5) Before making a determination under this regulation, an authority must obtain a certificate from an independent registered medical practitioner qualified in occupational health medicine ("IRMP") ([SI 2010/2090](#)) as to whether in his opinion the member is suffering from a condition that renders him permanently incapable of discharging efficiently the duties of the relevant employment because of ill-health or infirmity of mind or body and, if so, whether as a result of that condition he has a reduced likelihood of being capable of undertaking ([SI 2010/2090](#)) any gainful employment before reaching his normal retirement age.

6) A person who receives benefits under paragraph (4) shall —

- a) inform the authority if he obtains employment; and
- b) answer any inquiries made by the authority as to his current employment status, including as to his pay and working hours.

7) a) Subject to sub-paragraph (c), once benefits under paragraph (4) have been in payment to a person for 18 months, the authority shall make inquiries as to his current employment. ([SI 2010/2090](#))

- b) If he is not in gainful employment, the authority shall obtain a further certificate from an independent registered medical practitioner as to the matters set out in paragraph (5).

c) Sub-paragraph (a) does not apply where a person reaches normal retirement age. ([SI 2010/2090](#))

- 8) a) The authority shall discontinue the payment of benefits under paragraph (4) if they consider—
- i) that the person is in gainful employment; or
  - ii) in reliance on the certificate obtained under paragraph (7)(b), that he is capable of obtaining undertaking (SI 2010/2090) such employment
- and may recover any payment made in respect of any period before discontinuance during which they consider him to have been in gainful employment.
- b) Subject to sub-paragraph (bb), the authority (SI 2010/2090) shall in any event discontinue the payment of benefits under paragraph (4) after they have been in payment to a person for three years.
- bb) Paragraph (b) does not apply where a person reaches the age of 65. (SI 2010/2090)
- c) The authority shall forthwith notify the appropriate administering authority of any action they have taken under this paragraph.
- 9) A person in respect of whom the payment of benefits is discontinued under paragraph (8) shall be treated as a pensioner member with deferred benefits from the date the suspension takes effect, and shall not be eligible to receive benefits under paragraph (4) in respect of any future period.
- 10) If a person in respect of whom the payment of benefits is discontinued under paragraph (8) subsequently becomes an active member of the Scheme, his earlier period of active membership in respect of which benefits were paid under paragraph (4) shall not be aggregated with his later active membership.
- 11) a) An authority which has made a determination under paragraph (4) in respect of a member may make a subsequent determination under paragraph (3) in respect of him.
- aa) A subsequent determination under paragraph (3) must be made within three years of the date that payment of benefits is discontinued under paragraph (8)(b) paragraph (8) (SI 2011/561), or before the member reaches the age of 65 if earlier. (SI 2010/2090)
  - b) Any increase in benefits payable as a result of any such subsequent determination is payable from the date of that determination.
- 11A) Where an authority makes a determination of benefits under paragraph (2) or (3) ("the subsequent determination") in the case of a person-
- a) for whom a retirement pension had already been determined under paragraph (2) or (3) ("the initial determination"), and
  - b) who subsequently became an active member of the Scheme, his earlier period of active membership (calculated under the initial determination) shall not when aggregated with his later period of active membership (calculated under the subsequent determination), exceed the total membership he would have had, were the initial determination to have been made under paragraph (2). (SI 2010/2090)
- 12) a) Subject to sub-paragraph (b) and to paragraph (13), in the case of a member in part-time service, the period to be added under paragraph (2)(b) or (3)(b), as the case may be, is calculated in accordance with regulation 7(3) as if he had remained in such part-time service until his normal retirement age.
- b) If the certificate obtained under paragraph (5) states that, in the medical practitioner's opinion, the member is in part-time service wholly or partly as a result of the condition (SI 2010/2090) that has caused him to be incapable of discharging efficiently the duties of the relevant local government employment, no account shall be taken of such reduction in his service as is attributable to that condition.
- 13) But in the case of a person who is an active member before 1st April 2008 and who-
- a) has reached the age of 45 before that date;
  - b) has had continuous membership; and
  - c) has not received any benefits in respect of that membership,
- his benefits are increased by adding the period that would have been added had regulation 28 of the 1997 Regulations applied if such period is greater than the period to be added under paragraph (2)(b) or (3)(b).  
(SI 2010/2090)

14) In this regulation-  
"gainful employment" means paid employment for not less than 30 hours in each week for a period of not less than 12 months;

"permanently incapable" means that the member will, more likely than not, be incapable until, at the earliest, his 65th birthday; and

"an independent registered medical practitioner ("IRMP") qualified in occupational health medicine" means a practitioner who is registered with the General Medical Council and -

- a) holds a diploma in occupational health medicine (D Occ Med) or an equivalent qualification issued by a competent authority in an EEA state; and for the purposes of this definition, "competent authority" has the meaning given by section 55(1) of the Medical Act 1983; or
- b) is an Associate, a Member or a Fellow of the Faculty of Occupational Medicine or an equivalent institution of an EEA state."

(SI 2011/561)

15) Where, apart from this paragraph, the benefits payable to a member in respect of whom his employing authority makes a determination under paragraph (1) before 1st October 2008 would place him in a worse position than he would otherwise be had the 1997 Regulations continued to apply, then those Regulations shall have effect in relation to him as if they were still in force instead of the preceding paragraphs of this regulation.

(SI 2008/1083)

## Regulation 31: Early Payment of Pension: Ill-Health

### The Local Government Pension Scheme (Benefits, Membership and Contributions) Regulations 2007 (as amended)

1) Subject to paragraph (2), if a member who has left his employment before he is entitled to the immediate payment of retirement benefits (apart from this regulation) becomes permanently incapable of discharging efficiently the duties of that employment because of ill-health or infirmity of mind or body he may ask to receive payment of his retirement benefits immediately (SI 2010/2090), whatever his age.

2) Before determining whether to agree to a request under paragraph (1), an authority must obtain a certificate from an independent registered medical practitioner qualified in occupational health medicine as to whether in his opinion the member is permanently incapable of discharging efficiently the duties of the relevant employment because of ill-health or infirmity of mind or body and, if so, whether that condition is likely to prevent the member from obtaining gainful employment (whether in local government or otherwise) before reaching his normal retirement age, or for at least three years, whichever is the sooner. (SI 2010/2090)

2) Before determining whether to agree to a request under paragraph (1), an employing authority must obtain a certificate from an IRMP as to whether in the IRMP's opinion the member is suffering from a condition that renders the member permanently incapable of discharging efficiently the duties of the relevant employment because of ill-health or infirmity of mind or body and, if so, whether as a result of that condition the member has a reduced likelihood of being capable of undertaking any gainful employment before reaching normal retirement age, or for at least three years, whichever is the sooner. (SI 2010/2090)

3) In this regulation, "gainful employment", "permanently incapable" and "qualified in occupational health medicine" have the same meaning as in regulation 20. (SI 2011/561)

3) In this regulation, "gainful employment", "IRMP" and "permanently incapable" have the meaning as given to those expressions by regulation 20(14). (SI 2011/561)

(SI 2008/1083)

## Regulation 56: First Instance Determinations: Ill-Health

### The Local Government Pension Scheme (Administration) Regulations 2008 (as amended)

1) An independent registered medical practitioner subject to paragraph (1A), an independent registered medical practitioner ("IRMP") (SI 2010/2090) from whom a certificate is obtained under regulation 20(6) of the Benefits Regulations under regulation 20(5) of the Benefits Regulations in respect of a determination under paragraph (2), (3) or (4) of that regulation (SI 2008/1083) (early leavers: ill-health) must be in a position to declare that—

- a) he has not previously advised, or given an opinion on, or otherwise been involved in the particular case for which the certificate has been requested; and
- b) he is not acting, and has not at any time acted, as the representative of the member, the employing authority or any other party in relation to the same case,

and he must include a statement to that effect in his certificate.

(1A) Paragraph (1)(a) does not apply where a further certificate is requested for the purposes of regulation 20(7) of the Benefits Regulations. (SI 2010/2090)

(2) If the employing authority is not the member's appropriate administering authority, it must first obtain that authority's approval to its choice of registered medical practitioner for the purposes of regulation 20 and 31 of the Benefits Regulations.

(3) The employing authority and the independent registered medical practitioner must have regard to guidance given by the Secretary of State when carrying out their functions under this regulation or, in the case of the employing authority, when making a determination under regulation 20 of the Benefits Regulations. (SI 2010(2090)

(3) The employing authority and the IRMP must have regard to guidance given by the Secretary of State when carrying out their functions under this regulation, and-

- a) in the case of the employing authority, when making a determination under regulation 20 of the Benefits Regulations; or
- b) in the case of the IRMP, when expressing an opinion as to the matters set out in regulation 20(5) and regulation 31(2) (early payment of pension : ill health) of those Regulations. (SI 2010/2090)

# Review of Ill-Health Retirement in the Public Sector

**HM Treasury July 2000**

# Executive Summary

## Introduction

Pension schemes typically provide some form of cover or compensation for employees who suffer permanent incapacity or ill-health before normal retirement age. For the majority of public and private sector schemes, this takes the form of an immediate payment of a pension and a lump-sum. A contingent ill-health retirement pension is in effect part of an employee's remuneration package.

Ill-health retirement was a rarity in the 1970s. But during the 1980s and 1990s the incidence of ill-health retirement grew, particularly in the public sector. By the mid-1990s about 40,000 public servants were retiring early each year on medical or injury grounds. The incidence has now fallen from this peak to about 22,000 per year but this is still high by historical standards, and considerably higher in many parts of the public sector than in the private sector. Within these numbers, there are very wide variations both between the rates of ill-health retirement in different sectors, and between employers in the same sector. For example, on current performance, ill-health typically accounts for 39% of all retirements in the police service, 39% in local government and 22% in the Civil Service. And within the fire service, rates of early retirement on ill-health grounds vary between 11% for some fire authorities and 93% for others.

Some of these differences can be explained. A relatively high level of ill-health retirement is only to be expected in areas of work such as the fire service where the physical demands are much greater than in other careers. But the large variations in performance, in particular between employers in the same sector inevitably raises questions, as does the continuing high incidence overall of ill-health retirement in the public sector.

It is important to address these questions. Ill-health retirement has a heavy cost: financially for the taxpayer (the estimated capitalised additional pension costs of new cases is around one billion pounds annually), but also for employers who may be losing skilled staff, and employees whose lifetime earnings are curtailed by early retirement.

## Tackling Ill-Health Retirement

Recent studies by the Audit Commission, Her Majesty's Fire Services Inspectorate and Her Majesty's Inspector of Constabulary have highlighted the case for action to address ill-health retirement levels in local government, the fire service and police. And some important steps have been taken already in particular in the NHS and Teachers' pension scheme. In the course of this review, many excellent examples of good practice have been identified.

But it is clear that much more could be done to reduce the incidence of ill-health retirement. There is a need for concerted action across the public sector. This report sets out a range of recommendations to achieve this. These recommendations place the onus in particular on employers to protect the health of their employees, and to ensure that ill-health provisions are applied fairly and rigorously.

That is not to say that employees who are genuinely suffering from poor health should not be granted ill-health retirement. This is an important right and a necessary protection for employees who fall ill, whether as a result of work or otherwise. But ill-health retirement should only be granted in appropriate cases and where no other means can be found of accommodating the employee in work.

The report's recommendations fall under four main headings:

### 1) Good Management Practice

A key part of any strategy for reducing ill-health retirement should be to ensure that employees do not fall ill in the first place and that when they do, all reasonable steps are taken to help them recover. Employers, therefore, have an important part to play in ensuring that employees enjoy a healthy workplace, and that employees' health does not deteriorate to the point where there is no alternative to ill-health retirement. The best employers have active procedures and measures for managing sickness absence and providing access to occupational health services. And there are opportunities for staff to be moved to alternative or less demanding duties where they are in poor health.

The report therefore recommends that:

- ▶ best practice on the management of sickness absence should be adopted by all employers. This requires employers to record the incidence and causes of sickness absence, analyse these data and design appropriate interventions where an employee’s health record is a matter of concern.
- ▶ this needs to be supplemented by effective workplace health policies which ensure that preventative measures are put in place, occupational health information and training is available, and staff have reasonable access to occupational health services. It is important that stress management is addressed as part of these policies.
- ▶ in cases where an employee’s state of health makes it difficult for him to remain in his existing duties, employers should look actively at the scope for adapting their work or moving the employee to suitable, alternative duties. Forthcoming tax concessions for flexible retirement should assist in such cases.

**2) Assessment of Ill-Health Retirement**

Each public sector scheme has its own criteria. These determine the ‘gateway’ to ill-health retirement.

In essence two questions are considered in each case:

- ▶ is the employee’s health preventing him working permanently?
- ▶ what type of work can he carry out?

But there is no consistency in the terms in which these criteria are expressed. ‘Permanence’ has a variety of definitions. And the work which the employee is assessed against can be simply his own job or a wider range of duties. Also, there are differences in the ways in which medical advice is obtained and used to apply the criteria.

There needs to be more consistency and rigour in these arrangements so that the ‘gateway’ is designed and policed effectively. The report recommends therefore that:

- ▶ ‘permanence’ should be defined as being ‘until normal pensionable age’;
- ▶ the test should consider whether the employee is capable of carrying out a wider range of duties than his present job, especially if appropriate adjustments are made to the work; and
- ▶ the medical evidence should be assessed against the criteria by an independent occupational health physician assisted by appropriate guidelines.

**3) Choices Made at the Point of Exit and Afterwards**

Ill-health retirement should not be abused as an exit route. The appropriate exit route should be used in each case. For example, redundancy or dismissal on grounds of capability or conduct. The report recommends that the full range of exit routes should be available to managers and that procedures are put in place to ensure their appropriate use.

Inappropriate use may have been considered where financially it offered the most advantageous terms for the employee. To prevent this, it is recommended that, wherever possible, the decision to award an ill health pension should be taken by the pension scheme.

Some employees who take ill-health retirement will never be able to work again because of the state of their health. But others may satisfy the scheme’s criteria, yet be fit enough to take up employment elsewhere, for example where their original employer demands a high minimum fitness standard. To provide for these cases, the report recommends that schemes should consider paying a reduced pension, or a medical severance payment, to those who are capable of employment elsewhere.

If the gateway to ill-health retirement is policed effectively, there should be no need in most cases to check whether the employee’s state of health justifies the continued payment of an ill health pension. But it will be cost effective in some cases to monitor specific categories of employees and have the powers to abate their pensions if they have taken up employment elsewhere.

#### 4) Incentive Structure

The costs of ill-health retirement need to be transparent and publicly available. The cost of making inappropriate use of ill-health retirement, or failing to look for alternative duties for the employee, must be transparent at the point when the decision is taken.

The report recommends:

- ▶ managers are made aware of the costs in individual cases
- ▶ financial reports disclose the costs incurred in each financial year
- ▶ these data are used to publicly compare the performance of individual employers
- ▶ the service delivery agreements agreed in the 2000 spending review should set targets for reductions in ill-health retirement
- ▶ Departments should consider in 2002, whether in light of the impact of the other recommendations, a proportion of the additional costs of ill-health retirement should be charged out to employers

### Making the Changes

If a significant improvement is to be made in the management of ill-health retirement, action will be needed on a number of fronts. In total, the report sets out thirty six recommendations to take this forward.

The recommendations have different implications for individual employers and schemes, as some are closer to the recommended practices and procedures than others. By raising standards in all areas of employment to that of the best, a marked improvement in the way ill-health retirement is managed should be possible.

Departments will now draw up action plans for taking forward the recommendations. These will be finalised by October 2000.

# 1) Introduction

**1.1** Provisions for ill-health retirement exist in all major public sector pension schemes to ensure that employees are adequately provided for in the event of their becoming too ill to continue in work before their normal retirement age. It is right that such provisions should exist. Inevitably some employees will find themselves in the position where their state of health prevents them from working.

**1.2** However, ill-health retirement can have a heavy cost, both human and financial. Human because few people want to give up work prematurely because their health is poor and suffer a loss in earnings. Financial because it imposes additional costs on the taxpayer. The annual cost of each year's new ill-health retirements is estimated to be around one billion pounds.

**1.3** It is important, therefore, that ill-health provisions are reserved for those who are genuinely too unwell to continue working. They should not be used to provide a means of departure for employees who are leaving for other reasons. For example, ill-health retirement should not be used to ease out employees whose performance is deemed unsatisfactory for reasons other than health, as a means of reducing staffing levels, or simply as a convenient way of retiring staff before normal pensionable age. Similarly the existence of an ill-health safety net should not encourage employers to neglect their responsibility to take reasonable steps to prevent ill-health in the workplace.

**1.4** The level of ill-health retirement in public services is now substantially higher than it was in the 1970s, both at the aggregate level and at individual scheme level. The increase peaked in the mid-1990s at about 40,000 retirements a year and has now fallen to about 22,000 per year. But historically this is still a very high level. And it is above the levels experienced in the private sector (where levels of ill-health retirement are typically around a third lower than in the public sector). There are also wide variations in the rates of ill-health retirement between different parts of the public sector and between different employers within the same public service.

**1.5** This begs a number of obvious questions. Firstly, why have the levels of ill-health retirement grown as society in general has got healthier? And secondly, why are the levels so much higher for some employers than for others? There are a number of possible answers, some of which raise wide social and economic issues: the demands of the workplace may have led to poorer health among some employees, people may be less prepared now than in the past to soldier on in work despite poor health, employers may be keener to retire older workers to make way for new skills. But at least part of the answer to these questions seems to rest on the way in which sickness and ill-health retirement is managed in different organisations.

**1.6** Against this background, the Government has conducted a review of ill-health retirement in the public sector to consider why the levels of ill-health retirement are so high, why they vary so much and how to ensure that ill-health retirement is only granted in appropriate cases. The terms of reference for the review are attached at **Annex A**.

**1.7** From the outset, it has been clear that both the way in which pension schemes are managed and operated and wider human resource policies have an important part to play in the management of ill-health retirement. For this reason the review, and this report, has considered both:

- ▶ human resource policy issues, including health and safety at work, management of sickness absence and redeployment to alternative duties; and
- ▶ how the 'gateway' to ill-health retirement can be designed in a way which avoids inappropriate use.

**1.8** Section 2 sets out the context for the review and considers how ill-health retirement is managed across the public sector. Section 3 analyses the strengths and weaknesses of the present arrangements. Section 4 sets out recommendations which are aimed at improving the management of ill-health and reducing its incidence further over time.

**1.9** In producing this report there has been conscious recognition of the need to strike the right balance between ensuring that essential rights for employees are preserved on the one hand, and the need for effective policies for the proper management of ill-health retirement on the other. In formulating its recommendations therefore, the review has been guided by four principles:

- ▶ employees should have access to ill-health benefits where their state of health justifies it
- ▶ employers should take all reasonable steps to prevent staffs' health deteriorating to the point where ill-health retirement becomes an issue
- ▶ no employee should be retired on health grounds when suitable alternative employment can be found for them or where there are more appropriate exit routes
- ▶ the procedures for awarding ill-health benefits must be founded on good quality, impartial and objective medical evidence

**1.10** Section 5 explains how the recommendations will be pursued across the public sector.

## 2) The Management of Ill-Health Retirement in the Public Sector

### Review Coverage

2.1 The review has examined the provision for ill-health retirement available to the majority of employees in the public sector.<sup>1</sup> The range of occupations and duties covered in the process varies enormously, as the following chart illustrates:

**Chart 1: Range of Occupations Within the Public Sector Workforce**



- NHS trusts
- NHS non-trusts
- Civil Service
- Local government: education
- Local government: social services
- Local government: police (incl. civilians)
- Local government: other (incl. fire service)
- Central government: (excl. Civil Service)
- HM forces
- Nationalised industries
- Other public corporations

2.2 These jobs naturally place different sorts of demands on employees, both physical and mental. And some of them require employees to meet a very high fitness standard in order to perform the job.

2.3 These factors mean that the steps which individual employers take to promote good health in the workplace will vary according to circumstances. And that there will be some differences in the rates of ill-health retirement between different areas of employment. Nevertheless, it is reasonable to suppose that there should be some common principles and forms of best practice which could be applied across the public sector, while allowing for some flexibility in how these are applied in particular areas.

### Ill-Health Retirement Pension Provisions

2.4 Most public sector employees belong to occupational pension schemes. The schemes covered in this report are as follows:

	<b>Approximate numbers of active Scheme members (to nearest thousand)</b>
Local government	1,260,000
Teachers	620,000
Fire	34,000
Police	124,000
Armed Forces	208,000
Civil Service	490,000
NHS	1,100,000

2.5 All of these schemes provide for retirement on grounds of ill-health at an age before the scheme's normal retirement age, with immediate payment of a pension. A contingent ill-health retirement pension is in effect part of the remuneration package for employees. It is available to scheme members, subject to satisfying the relevant medical tests, whether or not the incapacity is attributable to injury on duty. However, in most cases employees have to serve for a minimum of two years to qualify for such a pension.

<sup>1</sup>The review has covered central and local government employment, but not public operations such as the Post Office, BBC and London Transport

**2.6** Ill-health retirement pensions are determined in broadly the same way in different public service schemes. In general, the practice is to pay a lump-sum and an immediate pension, which is enhanced by adding up to around ten years of reckonable service, depending on the employee's length of service. So, for example, an employee with twenty-five years' service would typically receive a pension based on a notional service of thirty-two years. Furthermore, no actuarial reduction is made to the pension to take account of it being paid at an earlier age than the scheme normally allows. Table 1 shows the level of enhancements paid.

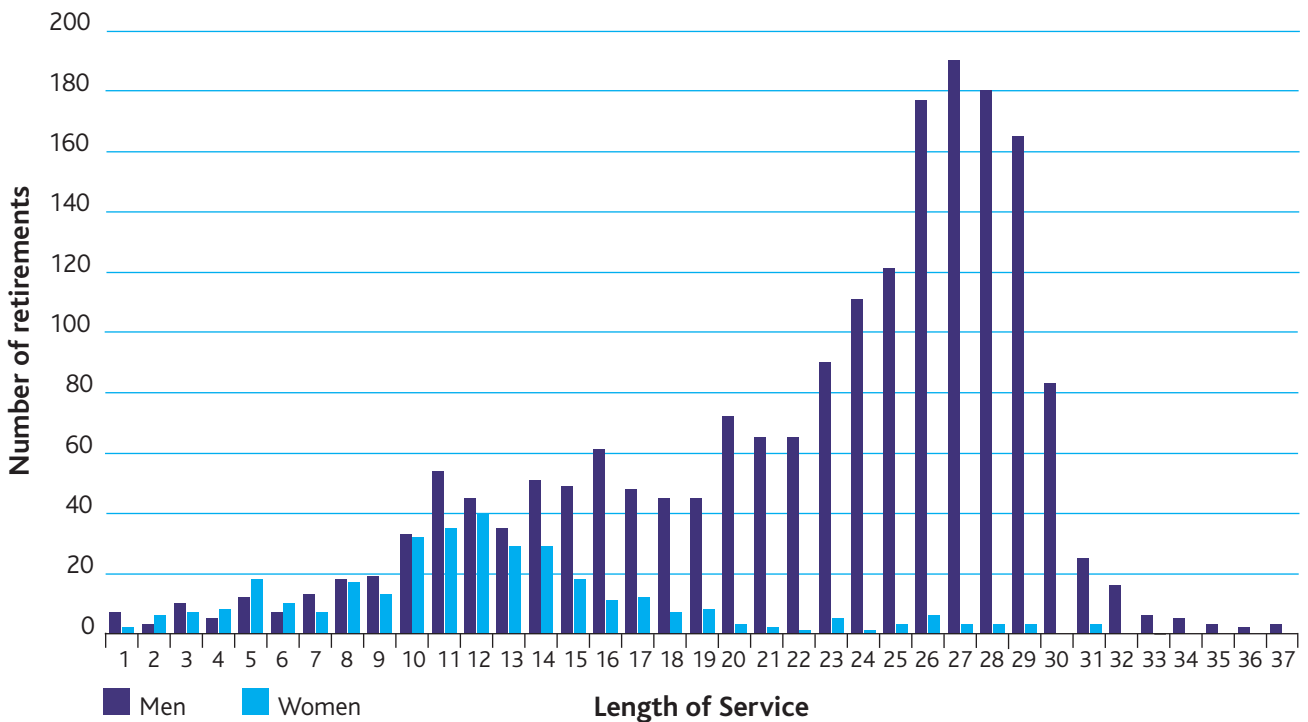
**Table 1: Enhancement Provisions**

	<b>Years of service</b>	<b>Enhancement</b>
<b>Police</b>	2-10 10-13 more than 13	doubling of service service enhanced to 20 years extra 7 years' service
<b>Fire</b>	less than 5 5-10 10-13 more than 13	no enhancement doubling of service service enhanced to 20 years extra 7 years' service 1 x 60ths for each year up to 20 2 x 60ths for each year over 20, with a maximum of 40/60ths
<b>NHS</b>	2-5 5-10 10-13 <sup>1</sup> / <sub>2</sub> 13 <sup>1</sup> / <sub>3</sub> plus	no enhancement doubled service enhanced to 20 years extra 6 <sup>2</sup> / <sub>3</sub> years
<b>Local government</b>	2-5 5-10 10-13 <sup>1</sup> / <sub>3</sub> 13 <sup>1</sup> / <sub>3</sub> plus	no enhancement doubling of service enhanced to 20 years extra 6 <sup>2</sup> / <sub>3</sub> years
<b>Teachers</b>	2-10 10-13 <sup>1</sup> / <sub>3</sub> 13 <sup>1</sup> / <sub>3</sub> plus	doubling of service enhanced to 20 years extra 6 <sup>2</sup> / <sub>3</sub> years
<b>Civil service</b>	2-5 5-10 10-13 <sup>1</sup> / <sub>3</sub> 13 <sup>1</sup> / <sub>3</sub> plus	no enhancement doubling of service enhanced to 20 years extra 6 <sup>2</sup> / <sub>3</sub> years
<b>Armed forces</b>	2-5 5 plus	no enhancement generally worth about 2-3 years, if unattributable to service

**2.7** In some schemes, there is a close correlation between the length of service of employees who retire on grounds of ill-health and the step points when the calculation of the added years is enhanced. An example of this phenomenon is shown in Chart 2, which shows that for the police service there is a clear correlation between peaks in the levels of ill-health retirement and the points at which additional enhancements accrue. In this case, service of ten years and over is enhanced to a fixed twenty years, and service over twenty six and a half years is enhanced to the maximum thirty years. There are peaks in the numbers of ill-health retirements, on and around the time when these enhancements take effect.

**2.8** Some employees leaving on ill-health grounds receive both an ill-health pension and an injury benefit. Injury benefits are paid if an injury or disease is regarded as attributable to duty. In some cases, the injury or disease may have contributed to, or be wholly responsible for, the employee’s incapacity to carry out existing and alternative forms of employment. Annex B provides further details of injury benefits.

**Chart 2: Correlation Between Length of Service of Police Medical Retirements and Points Where Calculation of Added Years are Enhanced**



## Scheme Rules and Procedures

**2.9** The 'gateway' to ill-health retirement is determined by the criteria which each pension scheme sets for awarding ill-health benefits, and the procedures followed in the application of the criteria.

### Criteria

**2.10** Each scheme has its own specific criteria. But in essence two key questions lie at the heart of each test:

- ▶ is the employee's state of health going to prevent him working permanently?
- ▶ what type of work is he capable of carrying out?

**2.11** However, these questions are framed in different ways by individual schemes.

**2.12** All schemes seek to establish that the relevant medical condition is 'permanent' in nature. But the description of the medical condition and definition of 'permanence' differs between schemes:

- ▶ the medical condition is variously referred to as 'disability', 'incapacity', 'infirmity' or 'ill-health'; and
- ▶ the definitions of permanence cover a wide time spectrum, ranging from twelve months to the normal pensionable age.

**2.13** Similarly, there is no common approach to the nature of the work which the employee is being tested as being capable of doing. In some cases, the question is whether the employee is capable of carrying out his present job. For example, the Scottish NHS scheme requires employees to be tested only against their current job. For the fire service pension scheme, all members are tested against the requirements to engage in firefighting. In practice this has been interpreted to mean that a firefighter must be tested against the fitness criteria for basic firefighting duties rather than the role of their rank or current post. The result is that where an employee fails to meet the standard he cannot be retained for other duties either. In others such as the Principal Civil Service Pension Scheme (PCSPS), interpretation

is slightly more flexible and relates to the duties of the grade or rank of the individual. In the case of local authorities, regulations have recently been amended to allow for a still more flexible approach in this area. Here employees are tested against existing duties or 'comparable employment'.

**2.14** Annex C summarizes the criteria used in each schemes' regulations.

### Processing Applications for Ill-Health Retirement

**2.15** Applications for ill-health retirement can be initiated by the employer or employee (or both), depending on the scheme rules.

**2.16** All schemes use medical advice to judge whether an applicant meets the criteria for ill-health retirement. But the source of this advice varies between schemes. It can come from:

- ▶ the applicant's GP and/or consultant. This source is rarely used in isolation.
- ▶ an in-house medical practitioner. Examples of schemes employing this approach are police, armed forces and fire (although some brigades do now contract the work out and so fall into the next category).
- ▶ an external medical practitioner. Examples of schemes employing this approach are local authority schemes and the PCSPS.

Only the local authority and PCSPS schemes make it a mandatory requirement for the physician providing the advice to have a qualification from the Faculty of Occupational Medicine.

**2.17** The final decision on the application is taken either by the managers of the pension scheme, (eg, teachers' scheme for England & Wales), an external medical adviser acting on behalf of the pension scheme (eg, PCSPS) or the employer (eg, police and fire). The local government scheme requires the final decision to be taken by elected members of the council.

**2.18** In all of the schemes covered in this report, the employee has the right to appeal against the refusal of an ill-health retirement application. The procedures for appealing vary between schemes, but, in line with the Pensions Act 1995, they usually distinguish between medical and procedural aspects.

An independent medical referee or an appeal panel is used in some cases. For example, on behalf of the fire service, the Home Office have recently set up an appeal panel process which is chaired by an independent occupational health practitioner supported by a second occupational health practitioner and a specialist in the medical condition which is the subject of the appeal. In others, a different physician within the body taking the first decision is used. For example, the medical firm contracted to PCSPS will direct appeals to different occupational health physicians within their service. Procedural and medical rights of appeal operated by schemes are in addition to the statutory right of appeal to the Pensions Ombudsman.

**2.19** Once an employee is in receipt of an ill-health pension, it is rare for any checks to be carried out by the pension scheme or employer on his health to determine whether he continues to meet the scheme criteria. Although most scheme regulations do provide for the suspension or abatement of pensions on such grounds, the costs of such checks are generally considered to outweigh the benefits in terms of reduced pension payments.

### Private Sector Practice

**2.20** It is relevant to compare the provision made for ill-health retirement in the public sector with that in the private sector.

**2.21** Annex D contains an analysis derived from surveys by the National Association of Pension Funds (NAPF) between 1994 and 1999. The charts show:

- › what conditions have to be satisfied to be eligible for an ill-health pension; and

- › the minimum service required to qualify for an ill-health retirement pension.

**2.22** The key points that this analysis brings out are:

- › an ill-health award is the most common form of benefit available for final salary schemes but less so for money purchase schemes. However, the use of permanent health insurance (PHI) has increased particularly in money purchase schemes.

PHI provides an agreed level of income replacement during periods of incapacity to work. It starts after an agreed period (eg, six months), and ends on return to work, death, or the achievement of retirement age;

- › for final-salary schemes, the most common form of award payable is an accrued pension plus all of potential pension, although the incidence of this benefit has declined slightly. This contrasts with public sector schemes which pay more than the accrued pension, but less than its full potential;

- › money purchase schemes differ in that they pay the proceeds of the individual account (63% of schemes) and, in a minority of cases, augment it by some amount;

- › for both final-salary and money purchase schemes, the most common criteria for ill-health retirement is that the member is no longer able to do his normal job; and

- › 60% of private sector and 81% of money purchase schemes have no qualifying period for payment of an ill-health pension.

- › what benefits are payable on ill-health retirement (including whether permanent health insurance is provided);

- › how the pension provided for ill-health retirement is calculated, ie, including the calculation of any enhancements;

**2.23** A number of private sector schemes have been taking steps in recent years to improve the management of ill-health retirement. An example is the Sainsbury Pension Scheme.

**Sainsbury's final-salary scheme is consciously managing a reduction in level of ill-health retirements by:**

- › raising the consistency and quality of medical evidence; two medical opinions are required for each case
- › increasing the use of redeployment
- › ensuring that all rehabilitation options are fully explored
- › providing enhanced training to local personnel officers and occupational health advisors to ensure that all understand the criteria that need to be fulfilled and the correct procedures to be followed in order to qualify for an ill-health retirement.

**2.24** Private sector pension schemes, especially those which offer more than one level of ill-health retirement benefits, tend to use the review facility more frequently. An example is Sainsbury's final-salary pension scheme which already has a relatively low rate of ill-health retirement. It will undertake to give an ill-health retirement pension with an accompanying conditional two-year review process attached. Unilever review all their ill health retirement pension cases; scheme administrators write to all recipients of ill-health pension benefits asking them about their current health status. GP confirmation is also required and where appropriate, benefit payments are reduced. Railpen require their scheme members in receipt of ill-health pension benefits to confirm that they are in receipt of state incapacity benefit and use this as a guide for maintaining or reducing payments.

### The Incidence of Ill-Health Retirement

**2.25** Ill-health retirement was less common 20 to 25 years ago in most parts of the public services. But most schemes have experienced a marked upward trend in ill-health retirements over the intervening

period, although with some variation between schemes. By the mid-1990s about 40,000 public servants a year were retiring early on medical or injury grounds. As Table 2 illustrates, the share of all retirements accounted for by ill-health retirements varied between schemes, over the years from 1994 to 1999.

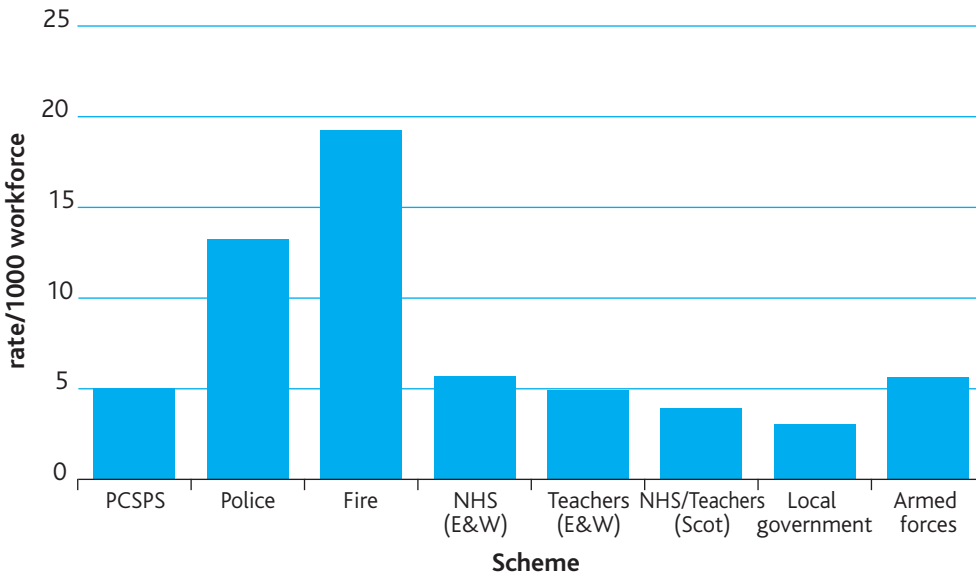
**Table 2: Medical Retirements as a % of All Retirements for Public Sector Schemes (Average of Five Most Recent Years)**

Scheme	%
Fire	68
Police	49
Local government	39
NHS	23
Teachers	25
Civil service	22
Armed forces	6

**2.26** The overall growth for this period is illustrated by the teachers and NHS schemes. Annex E illustrates how the position has changed in the case of teachers, comparing the numbers of ill-health retirements over the period from 1983 to 1999. There is a marked upward trend up to 1996-97 which contrasts with the subsequent years over which the Teachers' Scheme (England & Wales) has seen a considerable reduction in the incidence of ill-health retirement. This coincides with changes made to the scheme regulations in 1997.<sup>2</sup> Annex F presents a similar picture of growth in incidence to the mid-nineties for the NHS scheme based on the assumptions made by the Government's Actuary Department for the 1969 and 1994 valuations.

**2.27** The overall figures for the mid-1990s represent a peak as rates have since fallen for all schemes. The overall incidence is now about 22,000 per annum. But in historical terms this figure is still very high.

**Chart 3: Rate of Medical & Injury Retirements per 1000 Public Servants by Employer Group 1998-1999**



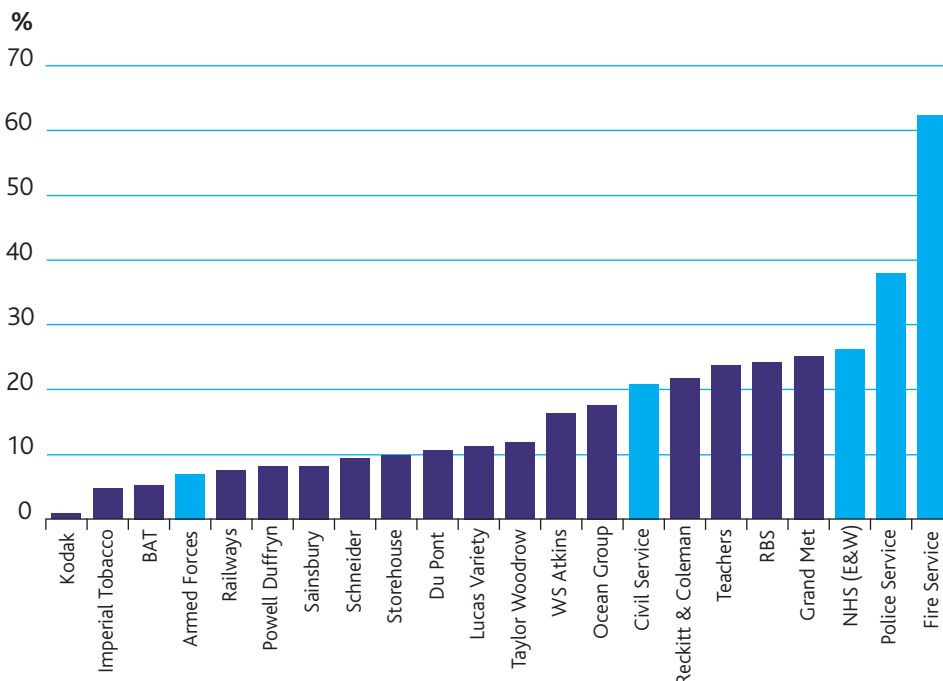
**2.28** Chart 3 shows the rate of ill-health retirement per thousand of the workforce grouped by employer and scheme for the latest year available (1998–99).

**2.29** And within employer groups, there are wide variations in the incidence of ill-health retirement. Annex G illustrates the variation between police

authorities, between fire brigades and between local authorities.

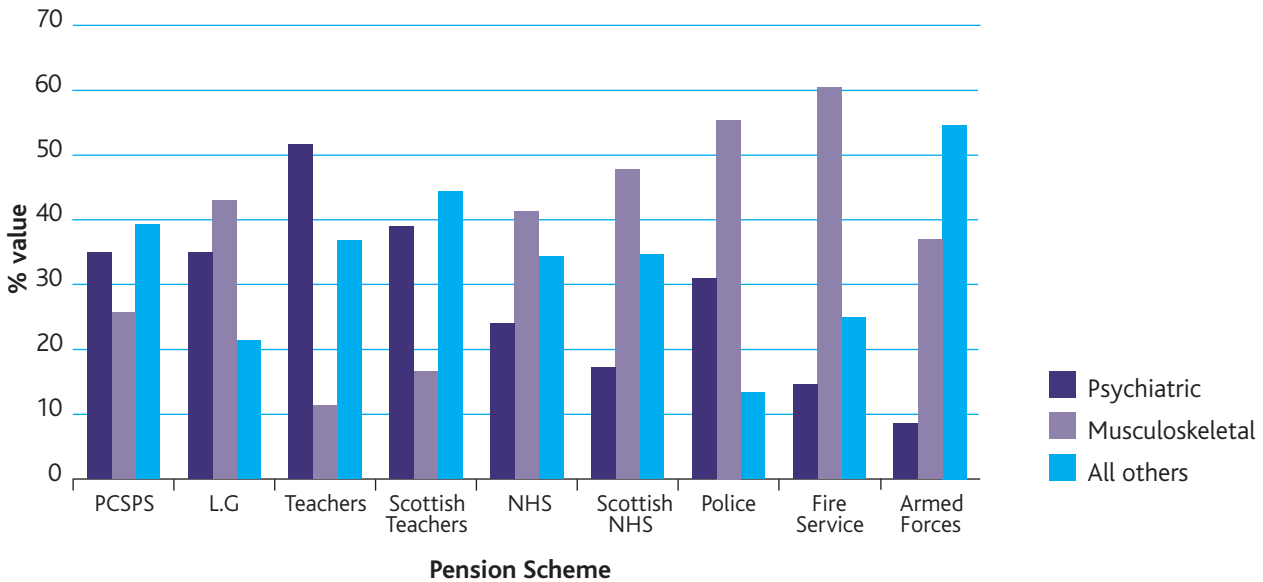
**2.30** Despite the recent fall in incidence in the public sector, rates are generally higher than in the private sector. Chart 4 compares the rates in selected public and private schemes in the financial year 97–98.

**Chart 4: Private Sector/Public Sector Comparison % Ill-Health Retirements 97-98**



Source: IDS Pension Bulletin Issue No 115: May 1998 & Schemes

**Chart 5: Medical Causes of Ill-Health Retirement: All Schemes**



Source: All Schemes

**Recorded Grounds of Ill-Health Retirement**

**2.31** The main causes of ill-health retirement in the public and private sector are musculoskeletal illness and psychiatric illnesses. In recent years the public sector and much of the private sector has seen an increase in incidence of stress related illnesses. These include anxiety, depression and fatigue. Most schemes report increasing difficulties in managing applications for ill-health retirement on the grounds of stress. This echoes the growing concerns of employers in managing the incidence of stress in the workplace. Chart 5 provides a break down of the current major causes of ill-health retirement by public sector scheme.

**Costs of Ill-Health Retirement**

**2.32** The ill-health retirement provisions in schemes are a form of ‘insurance’ benefit. Most schemes, notably local government, NHS, teachers and the PCSPS, operate an employer contribution regime under which the employee pays a fixed contribution and the remainder of the accruing costs of providing the scheme’s benefits are charged out to employers, with typically the level of charge being reviewed and adjusted every three years. A common employer contribution is usually charged. But in the case of local government, rates are differentiated between individual employers. The police and fire services are the main exception to this general practice. In their

case, ill-health retirement costs fall directly on authorities’ budgets, supplemented by employee contributions (‘pay as you go’).

**2.33** The employer contribution is therefore the means for most schemes by which the costs of historical higher rates of ill-health retirement are spread in to the future. Members see their fixed contribution as a form of mutual insurance against early retirement on health or other grounds.

**2.34** The pension costs of medical retirements usually substantially exceed the costs of a retirement at normal pension age. This is because:

- ▶ a pension is paid immediately and is usually, therefore, in payment for more years; and
- ▶ this pension is generally enhanced by the addition of extra years of reckonable service.

**2.35** The capitalised additional cost (the present day value of the extra cost of paying a higher and earlier pension and lump sum) of a typical ill-health retirement of a teacher, NHS employee, civil servant or local government official is estimated to be in the order of £50-60,000 when compared with the preserved benefits if the individual had simply resigned.

**2.36** On this basis, and with around 22,000 cases of ill-health retirement a year, the capitalised additional pension cost resulting from such retirements is around £1 billion a year. This is equivalent to a contribution of the order of 1.5 to 2% of salaries. A proportion of this cost covers the provision of benefits for those whose state of health clearly justifies them. However, it is far from clear that all of this expenditure is justified.

**2.37** It is also important to remember that pension costs are only part of the picture. Other additional costs are incurred to replace the retiring employee, as the following example illustrates:

#### **THE TRUE COST OF RETIRING A NURSE ON ILL-HEALTH GROUNDS**

**The loss of a female grade E nurse retiring at 50 results in:**

- › a net loss to the nursing pool;
- › loss of around 20 years of NHS experience;
- › duplication of earnings during her sickness while her post is being covered;
- › the need for a permanent replacement after her termination. In shortage areas, this might have to be covered by more expensive agency staff;
- › early access to an enhanced pension.

**Taking these elements in to account, the true cost of retiring a nurse on ill-health grounds is over £100,000.**

#### **European Practices**

**2.38** The findings of a 1999 survey of ill-health retirements in the public sector in Europe is reproduced at Annex H. The results told a similar story to the experience in this country.

#### **Human Resource Policies**

**2.39** The pension scheme arrangements for ill-health retirement are only one part of the overall picture. Equally important are the steps taken at earlier stages to prevent employees' health deteriorating to the point where ill-health retirement becomes an issue. This points to looking at employers' policies on occupational health and the management of sickness absence, as well as broader human resource issues around how best to avoid wastage of trained staff and to manage the 'stepping down' of staff to less demanding tasks where individuals' performance has deteriorated for health reasons.

#### **Promoting Good Health**

**2.40** All public sector employers, other than the Civil Service, operate a policy of 'fit for employment, fit for pension' scheme. An offer of appointment is made in most areas of employment subject to a satisfactory medical report on the potential employee. This is usually achieved through the employee completing a medical questionnaire at the time the offer is made.

**2.41** Although the Civil Service also operates a broadly 'fit for employment, fit for pension' rule, the medical procedure associated with appointment is more rigorous. In addition to normal job-related medical requirements at recruitment, the PCSPS require applicants to complete a further medical questionnaire. Where a combination of medical and actuarial evidence indicates the likelihood of a substantial additional cost, access to ill-health retirement benefits of the scheme is denied. The scheme effectively operates a system of underwriting on joining to protect the scheme against the individual who, for example, was unlikely to work for more than a few years and applied for a job simply because the ill-health provisions of the pension scheme were advantageous.

**2.42** Practices relating to the monitoring of the health of employees during employment varies from employer to employer, depending on the standards of fitness required and quality of occupational health (OH) available. Some employees have regular health check ups, while others have periodic access to medical services. Practice here varies not only across

schemes but within schemes depending on the occupational health policies of the employer. For example, occupational health services across fire brigades vary from full access on a self-referral basis to access agreed by managers on a case by case basis, triggered by a long-term sickness event or inexplicable drops in performance.

**2.43** OH services will allow access to some or all professionals including, for example, doctors, nurses, physiotherapists, psychologists, counsellors and physical instructors. Typically, they will cover:

- › advice on individual health problems;
- › advice on general issues where the working environment may be causing problems to individuals;
- › assessing individuals fitness for employment;
- › ensuring compliance with legal requirements for health and safety;
- › promotion of safe and healthy working practices;
- › monitoring of injury and ill-health.

The best services will also incorporate preventative arrangements utilising the skills of health and safety professionals, ergonomists etc.

**A WEST MIDLANDS NHS TRUST - OCCUPATIONAL HEALTH SERVICE**

The Trust Occupational Health department provides services to some six thousand staff spread over several sites, including six private sector companies who purchase its services. It employs three nurses, a part-time occupational health physician and two clerical staff. Its key tasks include:

- 1) Pre-employment health screening consisting of full assessment of past and present medical and employment history in order to:
  - › assess potential risks of work on health and health on work of the potential employee;
  - › advise management on any required adjustments to working practice or workplace in order to facilitate employment in accordance with the DDA;

- › advise the potential employee on measures necessary to maintain or improve health status, ie, infection control, and correct use of personal equipment;
- 2) Advice on compliance with legislation, risk assessments and accident prevention.
- 3) Undertake health surveillance of workers who are exposed to substances hazardous to health.
- 4) Regular screening of staff such as night worker assessments.
- 5) Assessment of fitness for work.
- 6) Liaison with GP and or specialist as required to facilitate rehabilitation and redeployment following sickness absence.
- 7) Immunisation against work-related illnesses.

**2.44** Some employers have introduced imaginative new arrangements for promoting health in the workplace. One example is the teaching profession.

DfEE runs in conjunction with the Department of Health a website 'Wired for Health', which aims:

- › to provide accurate and engaging information on health for teachers and learners;
- › to provide information on the 'Healthy Schools' programme, a joint initiative between the two departments; and
- › to provide information about national health policies and initiatives.

Part of this encompasses the 'Healthy Schools, Healthy Teachers' programme, the purpose of which is to help educate staff at local level to develop strategies for promoting positive health in teachers.

**The DfEE also:**

- › helps to fund ‘Teacher Line’, which is a free confidential 24-hour counselling, support and advice service explicitly for teachers.
- › has issued guidance for consultation on occupational health for employers of teachers emphasising the importance of referral to occupational health services, in conjunction with sickness absence procedures, at an early stage, and the benefits this can accord both to the employer and the teacher.

**2.45** External checks are used in some cases. For example, HM Inspector of Constabulary examine health and safety and sickness management policy when each police force is inspected.

**2.46** If an employee falls ill, the general practice is that, subject to a minimum period of service having been served, he is entitled to draw sick pay equivalent to full pay for up to a specified maximum period. If this entitlement is exhausted, sick pay equivalent to a lesser amount and up to a further maximum period can be paid. For example, in local government, the facility exists for employees to receive sick pay up to the equivalent of six months’ full pay followed up by up to six months’ half pay, once they have been in service for five years. What happens to an employee if they are allowed to exhaust their full entitlement varies between cases; for example, if recovery is in prospect, the employee may be kept on the employers’ workforce. If there is no foreseeable prospect of recovery, ill-health retirement may be considered. But there are cases where the employee is dismissed on the grounds of incapacity and yet does not satisfy the permanency criterion for ill-health retirement.

**Sickness Management**

**2.47** The Government has already identified sickness and absence management as a key issue for public sector managers. Sickness absence imposes major costs on the public sector (an estimated £6 billion per annum) and is consistently higher than in the private sector.

**2.48** This issue was therefore addressed in 1998 in the Cabinet Office report ‘Working Well Together: Managing Attendance in the Public Sector’. The report

looked at existing examples of best practice in the public and private sectors and set out a package of policies and techniques for monitoring and managing sickness absence, and set demanding targets for improvement.

**2.49** This package was later incorporated into a resource pack drawn up to help public sector bodies to manage attendance in a fair, consistent and supportive way. This has resulted in many public sector employers putting in place new procedures and measures to improve the management of sickness absence. For example, The Employers’ Organisation for Local Government has recently distributed guidance encouraging local education authorities and schools to devise and implement policies and procedures for sickness absence levels among teaching staff with a view to reducing absence levels. This covers the importance of controlling such absence, prevention, policy statements and the role of occupational health services. However, it is not clear that all employers have taken the full range of steps recommended in ‘Working Well Together’ to reduce levels of sickness absence.

**‘Fit for Work’ is the Inland Revenue’s response to ‘Working Well Together’.** Its key aims are to:

- › improve the health and well-being of people in the department; and
- › to contribute to the Civil Service targets to reduce sickness absence.

**A key element of the initiative is the Fit for Work driver based on the European Foundation for Quality Management Excellence model. This enables employees and managers to conduct a structured self assessment of achievement against the key aims and to take action for improvement. Statistics and guidance on sickness management are readily available to all staff via the intranet. Staff are able to monitor their own achievement against action taken.**

**Initiated in 1998, evidence of its success is already clear. In February 2000, sickness absence was down by over 12% compared with February 1998 and down 5% over the previous twelve months compared with the 1998 baseline year.**

**WEST MIDLANDS POLICE FORCE** have a proactive approach to sickness management and a 95% (or better) attendance rate. Key to their success are:

- › the operation of attendance management targets and trigger points (including early intervention);
- › basic 'MOTs' - health & fitness checks for all staff on a needs basis;
- › full use of outplacement support and redeployment for both uniformed and non-uniformed staff where appropriate;
- › maintenance of contact with those on sick leave;
- › rehabilitation programmes which include the option of retaining individuals after their sick pay entitlement has run out, where there remains a possibility of the individual's health improving;
- › rewarding good attendance with extra annual leave, study leave or personal development via their 'Always There' scheme.

### Opportunities for Redeployment and Rehabilitation

**2.50** Some employees suffering from ill-health may be unable to carry out their existing duties but remain capable of performing alternative duties at the same level; or be able to continue in employment but either in a lower, less demanding capacity or by reducing their working hours.

**2.51** Policy and practices on redeployment vary between employers, though they are all obliged to meet their obligations under the Disability Discrimination Act<sup>3</sup> to help disabled staff remain in employment. In principle, larger employers have more scope to find alternative posts for employees, though this is dependent on suitable vacancies being available. In some areas, redeployment within the organisation is difficult. For example, with the move towards local management of schools and Fair Funding, the scope for redeployment of teachers has been significantly reduced.

**2.52** The extent to which rehabilitation takes place of staff who would otherwise remain on long term sickness absence also varies between employers. For example, West Midlands Police Force have an active rehabilitation programme while other forces make much less use of this practice. The NHS is increasingly developing local rehabilitation programmes as the following example illustrates.

#### A NORTH EAST AMBULANCE TRUST

Ambulance trusts have identified a problem with rehabilitation and redeployment. The nature of the jobs involved makes it difficult for some staff who have been ill to return to the post in which they are normally employed. For example, returning two or three days a week in to a front-line service is not a practical or a realistic option for an individual who has suffered from a back injury. This trust has successfully introduced rehabilitation for its front line staff by introducing them back to work in a staged manner through clerical work, secondary services such as hospital car runs and then back in to front-line work.

### Stepping Down

**2.53** Where stepping down to lighter duties is an option, a natural concern for many employees will be the impact on their pension entitlement, given that public sector pensions are generally based on final salary.

**2.54** Some schemes offer arrangements which help to protect the employee's pension in such circumstances, although these are not in practice widely used. The PCSPS and teachers' pension schemes are two examples.

**2.55** Teachers aged fifty or over who have served for five years and who have stepped down to a lower paid post of lesser responsibility may, with the consent of their employer, elect to protect their pension by choosing to continue to pay contributions on their former higher salary. The notional salary on which the contributions are paid is index-linked so that the value of the teacher's eventual pension benefits is maintained.

**2.56** Alternatively, the teachers' scheme offers a two-part pension arrangement which provides for a person's pension benefits, earned up to the point of stepping down to a post of lesser responsibility, to be protected. At retirement a two-part pension is calculated comprising (a) benefits calculated as if the person had retired at the date he stepped down, which are index-linked, and added to (b) benefits based purely on service undertaken since stepping down and average salary at retirement. The two-part pension is paid if it is more beneficial than benefits calculated in the normal way at retirement.

**2.57** The PCSPS contains downgrading provisions for an individual to move to a lower grade either at their own or the department's request. Accrued benefits from service at the higher level are preserved, and the service in the lower grade is counted separately, if this gives an overall better result at retirement.

**2.58** In practice there are a number of potential obstacles to redeployment and stepping down, some of which are as much cultural as practical or linked to particular pension scheme rules. The tax regime has also acted as a barrier because it has required a clear line to be drawn between those who are retired and those who are still in work. Under current rules, people in an occupational pension scheme can take a pension at any time between fifty and seventy five so long as they retire at the same time.

**2.59** However, important changes are now planned which will remove some of these barriers. For both private and public employees, the Government will be consulting later this year on tax changes which will allow pension schemes to adopt arrangements, whereby employees will be able to draw their retirement benefits any time between ages fifty<sup>4</sup> and seventy five irrespective of whether they have actually retired and without incurring any tax penalties. When introduced, this approach to flexible retirement will provide a new opportunity for employees to change their working pattern where their health is coming under strain from their existing duties.

<sup>4</sup>Conclusion 32 in the recent Performance Innovation Unit (PIU) report, '*Winning the Generation Game*' states that, "The minimum age an immediate pension is payable should be increased from 50 to 55 between 2010 and 2020". The government will be consulting widely on the practical implications of this recommendation.

## 3) Tackling the Increase in Ill-Health Retirement

### Introduction

**3.1** The significant increase in the incidence of ill-health retirement over the last twenty five to thirty years has coincided with a general improvement in the health of the country. But equally it has coincided with other developments in the context of the wider economy. For example:

- ▶ similar proportionate increases in the numbers on state incapacity benefit;
- ▶ a big fall in economic activity rates of older men in particular (the subject of a report by the PIU);
- ▶ a greater emphasis on improving efficiency and productivity; and
- ▶ the emergence of stress and mental illness as major causes of medical incapacity.

**3.2** In the wider economy, the Government have been pursuing measures to raise economic activity in those who suffer ill-health or have a disability but who are capable of working. For example:

- ▶ reforms to incapacity benefit (IB) payments made in the Welfare Reform and Pensions Act and measures designed to help IB claimants back into work;
- ▶ the introduction of the Disability Discrimination Act 1995 has given new rights in the workplace to people who have a disability which makes it difficult for them to carry out normal day to day activities. In broad terms, it prevents any discriminatory treatment on the grounds of an individual's disability at the point of recruitment and during subsequent career, including promotion, training, career breaks and retirement.

**3.3** However, changes in society at large are only part of the picture. There are a number of ways in which the incidence and costs of ill-health retirement in the public sector could be reduced. In producing the recommendations in this report, it has reflected and built on a number of earlier initiatives which have looked at ill-health retirement in specific parts of the public sector.

### Previous Initiatives on Ill-Health Retirement

#### Local Government

**3.4** In 1997, the Audit Commission published a report on the operation of the Local Government Pension Scheme '*Retiring Nature: Early Retirement in Local Government*'. Its focus was on local authorities' use of their discretionary powers in relation to early retirement and practices that relate to ill-health retirement. The report highlighted that in 1995-96:

- ▶ three quarters of the 42,000 retirements by scheme members were earlier than the normal retirement age; and
- ▶ 40 per cent of all retirements were on the grounds of ill-health.

**3.5** '*Retiring Nature*' also drew attention to the wide variations among different authorities in the scale of early and ill-health retirements within local government. Although ill-health retirements were not strictly a matter for management discretion, the report argued, the disparities in the figures suggested that levels of ill-health retirement were 'often a matter of management policy rather than unavoidable incapacity'.

**3.6** The report set out a range of recommendations aimed at improving the quality and the amount of information available to those making decisions in local authorities.

**3.7** Following the publication of '*Retiring Nature*', a number of changes were made to the local government pension scheme regulations in respect of ill-health. These included:

- ▶ the term 'permanent' being defined as at least up until the age of 65; and
- ▶ to qualify for ill-health retirement, the employee must be permanently unfit for any 'available broadly comparable job'. DETR later issued guidance on the interpretation of that term.

**3.8** In March 2000 the Audit Commission published a follow-up report on early retirement in local government. It found that:

- ▶ early retirement as a proportion of all retirements in local government had fallen from 75 per cent in 1995-96 to 67 per cent in 1999; but
- ▶ ill-health retirement had fallen less rapidly than early retirements on grounds of efficiency or redundancy. **Annex I** illustrates this point.

So while there is some evidence that local government is turning the corner on managing early retirement generally, there are still concerns about the management of ill-health retirement.

**3.9** The Commission also found that there was still considerable variation in performance between local authorities:

- ▶ the top 25 per cent of local authorities had 40 per cent less ill-health retirement as a proportion of overall retirements than the average for local government as a whole; and
- ▶ the top 25 per cent of local authorities had over 20 per cent less early and ill-health retirement as a proportion of overall retirements than in local government as a whole.

**3.10** The Commission concluded that a number of local authorities will have to make significant improvements over the next five years if they are to match the performance of the top 25 per cent of authorities.

### Fire Service

**3.11** In March 2000 Her Majesty's Fire Service Inspectorate published a thematic review of sickness absence and ill-health retirements in the Fire Service in England, Wales and Northern Ireland ('Fit for Duty').

**3.12** The review identified a number of major issues of concern, including:

- ▶ although there had been an overall reduction in both sickness absence and ill-health retirements in recent years, there was an urgent need for all fire-brigades to collate, analyse and use detailed information to inform decisions about the actions to be taken to improve health and attendance;
- ▶ occupational health provision varies significantly; and
- ▶ medical standards and guidance were limited, dealing in the main with recruitment and making little provision for personnel in-service, and they are not applied with consistency across the country. Also, not all were related to the tasks expected to be undertaken and, therefore, led to some staff retiring on ill-health grounds in circumstances that appeared to be inappropriate.

**3.13** The report made thirty two recommendations to improve management practice among fire brigades, including:

- ▶ the Home Office should develop an independent and objective procedure for making medical decisions in relation to ill-health retirements;
- ▶ all fire authorities should have an effective policy to employ staff on 'modified duties' whenever appropriate, to enable rehabilitation of staff after illness and injury;
- ▶ fire brigades should capture, collate and analyse information about sickness absence and ill-health retirements for all employees using common methodology. The Home Office should provide guidance on the protocols to be adopted;
- ▶ fire brigades should ensure that all Brigade Medical Advisors hold at least a Diploma in Occupational Medicine; and
- ▶ the Home Office should secure changes in the Fire Service Pension Scheme to remove the global requirement for 'operational fitness' and substitute a 'role-related' medical requirement.

**Police**

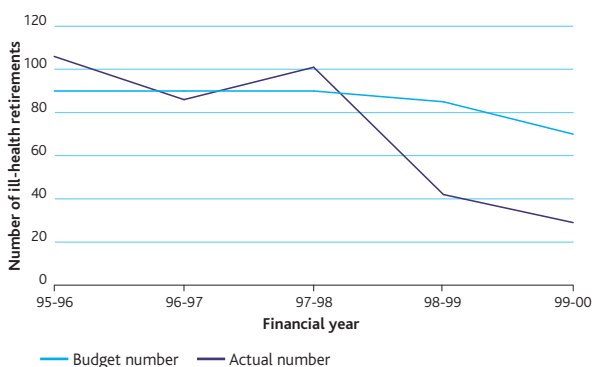
**3.14** In 1997, Her Majesty’s Inspectorate of Constabulary (HMIC), published a thematic inspection report examining sickness management and medical retirement in a number of police forces (‘lost time’).

**3.15** The report found that:

- › medical retirement as a proportion of all retirements had been dropping as a direct result of management action within the existing framework of the regulations;
- › but there was a wide variation in the incidence of medical retirement reflecting the differences in management and culture in police forces and, unlike almost every other organisation, there was no formalised way to assist departures by officers from the service other than by medical retirement;
- › the costs of medical retirements were likely to be unsustainable in the longer term; and
- › the retirements were susceptible to management action and individual reduction targets based on force performance should be agreed.

**West Midlands Police Force have implemented the recommendations of the Audit Commission’s ‘Retiring Nature’ and the HMIC thematic report on sickness absence with positive results. They have adopted a cross functional, integrated approach to the management of ill-health retirement applications, and from a rate of 34.75% in 98/99, currently have one of the lowest rates of ill-health retirement among all police forces at 16%. The following graph shows the downward trend since recommendations were actioned in 1998.**

**Chart 6: West Midlands Police Force: Number of ill-health retirements**



Source: West Midlands Police Force Headquarters

**3.16** The report set out twenty recommendations for securing improvements. It also provided a check list of good practice and management of sickness absence and medical retirement.

**Teachers**

**3.17** In 1997 changes in the regulations of the Teachers’ Pension Scheme resulted in a considerable narrowing of the gateway to ill-health retirement. To qualify for ill-health retirement a teacher must now be found to be permanently incapable of teaching where ‘permanence’ is strictly interpreted to mean ‘until normal retirement age’. This can mean that an individual can be deemed unfit to teach on the grounds of ill-health by the governors of a school but still be refused ill-health retirement. Therefore, the more stringent requirement of being ‘permanently unfit to teach’ could result in an increase in the numbers dismissed on incapability grounds where once they may have retired early with a pension. Another change to the regulations prevents those receiving ill-health benefits from taking on relevant employment as a supply teacher in a school or in a further education college. There is nothing in the regulations to stop these individuals from taking on work outside education. But their ability to do so is also a factor in forming a judgement on the extent to which they are incapacitated. The impact of these changes on incidence of ill-health retirement is illustrated at Annex E (see also paragraph 2.26).

**Analysis From the Present Review**

**3.18** There is no doubt that these initiatives have contributed to improvements in the management of ill-health retirement and sickness absence in the public sector, and have played an important part in achieving the reduction in ill-health retirement levels from the peak of 40,000 cases per year in the mid-90s to around 22,000 new cases last year. However, the most recent reviews including those by the Audit Commission and HM Fire Services Inspectorate have emphasised the need for further action. This section considers what action is needed to build up and sustain the momentum across the public sector in improving the management of ill-health retirement.

## Healthy Workplace

**3.19** One way of helping to keep rates of ill-health retirement low is to help employees to stay in good health. This is not, of course, wholly within the control of the employer. But there are a number of steps which employers can take to contribute to this outcome, beyond simply meeting their legal obligations under health and safety legislation.

**3.20** All public sector employers should adopt a pro-active approach to reducing ill-health caused or made worse by work. Those who are made ill by work should be encouraged to have timely and appropriate treatments to help restore health, and the opportunity to undergo rehabilitation.

**3.21** Ideally policies should be focussed on prevention and not be designed simply to provide a 'safety net' to deal with problems which may not have arisen in the first place. To achieve this, employers need to have sufficient knowledge of the health trends within their workforce in order to tailor their policies and interventions, and understand the problems that need to be tackled.

**3.22** Once problems related to work arise, it is important that staff should have reasonable access to multi-disciplinary occupational health services. Employers should understand the potential risks to employees, and either have the capacity to address these risks or have access to a point of enquiry that can either suggest solutions or signpost employers and managers to appropriate advice. In the latter case, the assistance required will not necessarily be a doctor or nurse but, for example, an occupational psychologist, safety officer or manual handling trainer. Employees views should also be sought on health strategies, both to draw on their day-to-day experience but also to emphasise the common interest in raising health standards in the workplace.

**3.23** The issue of stress needs particular attention. Earlier in this report it was noted that the increasing incidence of stress is a factor in the rate of ill-health retirement. The 1998 Workplace Employee Relations Survey reflected the growing incidence of work related (induced) illness in the economy as a whole. In almost half (45 per cent) of workplaces, managers

said that one or more of their employees had experienced illness of this type. The physical and behavioural effects of stress are often short-lived and cause no lasting harm. When the pressure recedes, there is a return to normal. But in some cases, particularly where the pressures are intense and continue for some time, the effects can be more sustained and far more damaging, leading to psychological problems and physical ill-health. Stress should be specifically addressed therefore as part of any workplace health strategy, particularly as the number of ill-health retirements attributable to stress has substantially increased. The emphasis should be on auditing stress levels and stress management, rather than reacting to the problem when it manifests itself. The evidence indicates that stress in the workplace is less of an issue in well managed organisations which focus on the best use of their human resources, open problem solving and recognition of pressure points and their causes.

### NEW EMPLOYER INITIATIVES TO COMBAT STRESS

- › **West Midlands Police Force have recently appointed the first force psychiatrist. This is in response to the growing incidence of depression and post-traumatic stress disorder. It is aimed at providing the right treatment at the right time as well as building up expertise on the specific types of mental health issues that cause these conditions in serving police officers.**
- › **Bradford Metropolitan District Council have carried out a stress audit and as a direct result have created two new posts:**
  - **a Counselling Co-ordinator to ensure that counselling services are available to all employees, and;**
  - **a Health Promotion Advisor to lead on health promotion initiatives; these include freely available individual health advice from the occupational health team and discounted access to all council sports facilities.**

**3.24** None of the above ideas are groundbreaking. They reflect the type of practices that the best employers already use and those recommended in 'Working Well Together'. They are consistent with the work of the Health and Safety Commission in raising the profile of occupational health in all sectors of the economy. But not all employers follow them. If they did, more employees would enjoy better health. The productivity of the workforce would then increase and fewer employees would suffer the downward spiral in their health which can lead to ill-health retirement. Two new and important documents by the Health and Safety Executive: '*Revitalising Health and Safety*' and '*A Long-term Occupational Health Strategy for England, Scotland and Wales*' will give added impetus to these ideas.

### **Redeployment and Rehabilitation**

**3.25** Moving an employee to alternative duties or changing their working pattern (for example, a temporary or permanent move to part time work) may help to alleviate health problems connected with an employee's present duties and/or to facilitate a return to work after illness. This may be particularly true where a problem is stress related; redeployment may offer the prospect of alleviating the symptoms, and rehabilitation may ease the individual back in to the work regime. This does not remove the need for the employer to tackle the source of stress so that other members of staff do not develop similar health problems.

**3.26** However, the evidence suggests that redeployment and rehabilitation are not always investigated as actively as they might and this may have added to the incidence of ill-health retirement in later years as employees have continued working in the same post. In some cases there are barriers to redeployment. For example, following a High Court judgment in 1999, wholetime uniformed personnel who are found to be unfit for operational duties can no longer remain within the Fire Service Pension Scheme, and fire authorities presently have no alternative but to retire them on medical grounds. And often cultural factors such as stigma attached to redeployment, discourage its use. Rehabilitation is also underused. By some employers, it is perceived as resource intensive with little return and therefore not

worth the effort. Inconvenience and logistical problems are also cited as reasons against rehabilitation and redeployment. However, if these processes result in the retention of an individual with valuable skills then none of these barriers are defensible.

**3.27** Redeployment and rehabilitation should be addressed long before ill-health retirement becomes an issue. Both should be management actions considered when an employee's cumulative sick absence exceeds a preset threshold, or where there are other signs of an inability to cope. Employers should consider carefully what other positions such employees could fill, taking account of their experience, abilities and salary level. Where rehabilitation is key, a flexible approach to working patterns and hours should be adopted to facilitate the process of returning to work. As such, rehabilitation should be an intrinsic element of employers' policy on sickness absence management.

**3.28** In large organisations, internal redeployment will often be an option where suitable vacancies are available. But in cases where internal suitable vacancies are not available, employers could investigate alternatives with all other local public sector employers, not just those within the same scheme. This will be especially true for small autonomous units which have little scope to offer alternative work or vary work patterns.

### **Scheme Rules and Procedures**

**3.29** It is not evident that the variations in the definition of the medical condition ('incapacity', 'ill-health' etc) lead to material differences in the decisions taken by individual schemes. In practice, the terms appear to be interpreted in a similar way.

**3.30** However, the varying definitions of 'permanence' and the duration to which this relates self evidently do impact on the decision making process. Someone who is diagnosed as being incapable of working for the next twelve to eighteen months would qualify under some schemes for ill-health retirement but not under those which define 'permanence' as being 'until normal retirement age'.

**3.31** The rationale for paying ill-health retirement benefits is to compensate employees for a loss in earning power before reaching pensionable age. It follows that the test in each case should be whether the employee is capable of working until that age. In practice, it may not always be possible for physicians to provide a prognosis in some individual cases until that age. But the principle still remains valid.

**3.32** The lack of a common approach to the nature of the work which the employee is being assessed against is another serious weakness in the present arrangements. In some cases, the question is simply whether the employee is capable of carrying out his present job. In others, it encompasses a wider range of duties.

**3.33** This is an unsatisfactory position. An employee's health may prevent him from continuing to perform his present duties but he may be perfectly capable of carrying out alternative tasks. This is particularly true where the individual concerned is presently carrying out a physically demanding job which demands a high standard of fitness. If there is no requirement to consider alternative duties, redeployment may not be actively considered. The employee's skills and experience can thus be unnecessarily lost to the service.

**3.34** Unless these two pillars of the gateway to ill-health retirement (permanence and duties) are soundly constructed, there will continue to be an inherent weakness in the way in which applications for ill-health retirement are dealt with.

### Medical Assessment

**3.35** If the scheme criteria are robust, it is important that they are interpreted and applied objectively by suitably qualified doctors.

**3.36** To secure objectivity, it is important that in each case an independent medical view is provided on the employee's prospects of being permanently incapable of carrying out the range of duties which the scheme criteria specifies he must be incapable of doing to qualify for ill-health retirement. Non-medical factors should not be allowed to influence that medical

judgement. However, if the physician and applicant are both employed by the same organisation, as is sometimes the case, the physician may face a conflict of interests and come under pressure to make a biased judgement. Similarly, the employee's GP or his hospital specialist are ethically bound to be sympathetic to their patient.

**3.37** The final assessment should be conducted, therefore, at arm's length from the employer to ensure that this is based on objective and impartial medical evidence. This will require the physician to carry out his own assessment and prognosis of the applicant's condition, if necessary carrying out an examination and tests, and to make judgements about ill-health retirement in keeping with professional guidelines.

**3.38** To reach a prognosis on an employee's capability to carry out the range of relevant duties, the physician needs to have sufficient knowledge of the nature of the medical condition and the prospects of recovery, and the physical and mental demands placed on employees by their present and possible alternative jobs. The physician will only be able to form a view on the second of these issues if he has an occupational health qualification. Physicians can acquire a diploma in occupational health following a short training course. Some, but not all, schemes require physicians to hold this level of qualification. However, there is a case for bringing more expertise and experience to the assessment process by using physicians who possess a recognised qualification as indicated by entry on to the Specialist Register of the General Medical Council. There are currently about 1,100 physicians in the UK with these qualifications.

**3.39** The physician's judgement can be assisted if schemes have produced medical guidelines. These can provide greater transparency, encourage consistent application in difficult cases and can lead to fewer appeals. The Association of Local Authority Medical Advisers has produced guidelines for the Local Government Pension Scheme suitable for any pension scheme where 'permanent' ill-health is interpreted to mean 'until normal retirement age'. The NHS has published similar guidelines for their own scheme.

### THE IMPACT OF BETTER MANAGEMENT OF THE PENSIONS GATEWAY

In the first full year following its launch, the NHS Pensions Agency found that the acceptance rate for ill-health retirements was very high at 99%. Over the following two years, action to clarify the terms of approval, in particular the consistency and rigour with which applications were assessed, resulted in the acceptance rate falling to 75%. Building on this experience, from 1997, the agency contracted out both its handling of applications and its medical advisory services to a commercial firm with access to a pool of qualified OH physicians. As a result of the agency formalising the criteria for dealing with ill-health retirements, and through the use of independent OH advisors, there is now effective and transparent management of the ill-health retirement gateway to the pension scheme. In the last three years ill-health retirements in the NHS were some 60% lower than in the first three years of the decade.

#### Exit Routes

**3.40** The evidence suggests that ill-health retirement has been used in a significant number of cases where an alternative exit route might have been appropriate (redundancy, early retirement, dismissal on grounds of capability or conduct). High rates of ill-health retirement have coincided with a number of restructuring exercises in the public sector which have led to substantial numbers of staff leaving. Also, the variations in the rates of ill-health retirement between similar employers are so wide in some cases that they cannot be explained by medical phenomena alone. They must be the product of management actions.

**3.41** Tightening the criteria for ill-health retirement and the medical assessment procedure should make inappropriate use of ill-health retirement less common. But it will take time to narrow the gateway in some cases. For example, some regulations may need to be amended and employers may need to take steps in parallel to ensure that alternative exit routes are used when appropriate.

**3.42** However, in some parts of the public sector, the full range of exit routes do not presently exist. This increases the risk of managers and employees seeking to use ill-health retirement when other grounds of

departure would be appropriate. This weakness needs to be addressed. Employers should in any event be in a position to have the full range available to them.

#### Deciding on Ill-Health Applications

**3.43** The medical prognosis should be the key input to the final decision as to whether to grant ill-health retirement. But the decision to grant ill-health retirement, or refuse it, should not be taken by the physician. That is a decision that can only be taken by the employer or the pension scheme.

**3.44** In effect, three decisions have to be taken. First, the decision whether to bring an employee's contract to an end. This can only be taken by the employer. Second, the medical decision on whether or not the case meets the criteria for ill-health retirement. Third, the decision on the terms under which the employee should leave. Where there are pension considerations, the final decision could fall either to the employer or the pension scheme (the latter is only an option in cases where there is a funded or notional scheme). Pension scheme managers have no reason to grant ill-health benefits without good supporting medical evidence. However, employers may have management reasons for wanting an individual to leave on ill-health retirement, for example, it may provide the best financial terms for the employee. Leaving the decision to the pension scheme would remove the risk of that happening.

#### Level of Benefits

**3.45** Ill-health benefits are paid to compensate employees for a shortening of their working life. However, some employees may satisfy the test of 'permanence' but still be capable of taking up alternative employment elsewhere, particularly where the minimum fitness standards are high and there is limited scope to redeploy staff to other duties. Indeed, some employees in this category will have an expectation of moving to other paid employment as they are unlikely to satisfy the fitness standard up until the normal pensionable age.

**3.46** There is a case for paying a reduced set of benefits to those falling into this category. For example, a lower rate of ill-health pension or a lump-sum but no immediate pension. This would reserve the existing, full level of benefits for those who are unlikely to be capable of carrying out any alternative work.

**3.47** Another argument in principle for moving to two rates of benefit arises with stress-related cases. Where the cause of these cases can be directly related to the employee's present duties and there is no scope to alter these, he may satisfy the 'permanence' test and legitimately qualify for ill-health retirement. But he may enjoy a full recovery once he has left and so take up paid employment elsewhere. In such circumstances, a lower tier of benefit or a lump sum may be appropriate.

**3.48** If a two-tier system was introduced, the implications would have to be carefully considered to ensure that it worked in a practical and fair way. In particular, the dividing line between the two tiers would have to be drawn in a way which helped medical assessors to offer an opinion on an employee's capability to work elsewhere, particularly in those schemes where there is no fitness standard.

#### **ILL-HEALTH REFORM IN THE POST OFFICE**

**The Post Office has recently completed a review of its ill-health provisions. This found that approximately 50% of those retiring on ill-health grounds find new employment within 12 months of retiring. A number of reforms are being introduced to improve the management of ill-health:**

- › **introducing a more stringent definition of ill-health requiring members to be in 'serious and permanent ill-health' and be unable to work in any reasonable alternative role;**
- › **improving the level of ill-health retirement provision to 75% of projected service for those who meet this definition;**
- › **paying to members who are in serious but not permanent ill-health a medical severance payment of 6-9 months' salary; and**
- › **encouraging a wider use of redeployment for those unable to continue in their current post.**

#### **Exposing the Costs**

**3.49** When considering an application for ill-health retirement, employers are not usually aware of the additional costs involved. For funded or notional schemes, the costs are not picked up until the next actuarial review and are then reflected in the new contribution rate. So employers have little financial incentive to investigate an alternative to ill-health

retirement. Furthermore, in most cases, contribution rates are uniform across employers, so the costs are dispersed. In addition, where efforts are made by individual employers (or delegated levels of management) to improve health more generally, they are not rewarded by any savings achieved overall.

**3.50** In contrast, for 'pay as you go' schemes, some of the costs have to be paid upfront out of the budget of the employing authority, notably the early payment of the lump-sum.

**3.51** The disclosure of the estimated additional costs would provide two potential benefits:

- › managers would consider more carefully the benefits of promoting better health and whether ill-health retirement was the most appropriate option for an employee; and
- › public accountability would be increased. In those cases where the employing and pension authorities are effectively the same, it would expose the extent to which resources are going into ill-health retirement rather than service delivery.

**3.52** The availability of annual information on additional costs would enable comparative data to be regularly published on the performance of employers within the same groups, for example, all police authorities.

**3.53** This raises the further question of whether the additional costs should be charged out upfront to individual employers (or appropriately defined units) in notional and funded schemes. Given that the additional costs do not directly impact on most individual employers and rates are only reviewed every three years, there is a weak link between the decision to grant ill-health retirement and the impact of the costs. If an employee's performance deteriorates or some shedding of staff is needed, early retirement on medical grounds can be less costly to the employer than more appropriate solutions such as compensation payments for early severance or a prolonged period of sick pay which would fall on the employer's own budget. This distortion of incentive is worst if the employer takes the final decision, but even where he does not, the incentive remains to support an application for ill-health retirement.

**3.54** However, if some of the additional costs were charged out upfront, those price signals would encourage the promotion of good health and the appropriate use of ill-health retirement.

**3.55** This argument would still apply even if the decision on the award of ill-health benefits was taken by the pension scheme. Charging out the costs in this way would incentivise employers to maintain workplace health policies which helped to reduce the level of ill-health retirement in their organisation over time.

**3.56** Schemes differ in their processes for ill-health retirement decisions, the funding arrangement, the way contributions are set and the employment structure. The principle of charging therefore would need to be tailored to meet the specific characteristics and needs of each pension scheme. But there is potential for improvement in the incentive structure for all of them.

### Costs and Added Years

**3.57** It was noted in Section 2 that all schemes provide enhancements to ill-health pensions in the form of added years. But such enhancements do not accrue uniformly. For example, in many schemes the level of an ill-health pension is the same for those retiring with service of between 10 and 13 years. The most obvious example is the point at which further service ceases to attract further enhancement or indeed ceases to attract further years of pension at all.

**3.58** This can be an incentive for:

- ▶ employees to initiate ill-health retirement applications at the most financially advantageous point in time for them; or
- ▶ employees suffering ill-health to remain in post until the point when further service has reduced value or has no value in pension terms. In such cases, it may be more appropriate for the employee to retire at an earlier date if they satisfy the scheme criteria.

Chart 2 provides evidence for both of these points.

**3.59** If the rate at which enhancements accrue was even throughout the period of service, these incentives would no longer be there. Ill-health applications would be made at the time when an employee's health justified it. And the costs would be reduced at the margin.

### Alternatives to Ill-Health Pensions

**3.60** It might be argued that the most effective means of ensuring that ill-health retirement is only available in appropriate cases would be for provision to be decoupled from pension schemes and for employers to purchase permanent health insurance cover for their employees. The insurer would provide an income replacement for employees who satisfied the medical criteria in the policy, and would have the right incentives to ensure that this was applied rigorously. And the insurer would be entitled – depending on the precise terms of the policy – to terminate payment if and when the employee made a later recovery.

**3.61** However, as Section 2 shows, permanent health insurance is not widely used in this way in the private sector, although usage is increasing. Most employees who belong to final-salary pension schemes remain entitled to a contingent ill-health pension, the payment of which is guaranteed in later years. It would be premature at present for public sector employers to consider the permanent health insurance option. But if its application in the private sector continues to grow in the future, the costs and benefits of using it in the public sector should be considered.

## 4) Recommendations

### Introduction

**4.1** The levels of ill-health retirement in the public sector are high compared to the private sector and high in historical terms. There are also significant variations in the incidence between schemes and within some schemes, between employers. The analysis in Section 3 indicates that there is scope for improving the management of ill-health retirement and reducing its incidence. This will offer some employees the opportunity to remain in employment longer than they otherwise might. And it will reduce costs to the taxpayer.

**4.2** In considering the costs, it is important to remember that these are not all additional in the sense that they could be avoided if appropriate steps were taken. A proportion of them represent the inescapable extra costs of funding ill-health retirement in cases where there is a genuine medical need. So the issue is about reducing costs at the margin. By way of illustration, if ill-health retirement was reduced by ten per cent a year, the present value of the gross saving in public expenditure would be of the order of £100 million.

**4.3** This section sets out a wide range of recommendations for securing improvements in the present arrangements.

### Principles

**4.4** It is important that the ill-health retirement arrangements in each scheme are conducted with both fairness (to safeguard employees) and rigour (to protect the taxpayer's interests). So the recommendations have been guided by the following four principles:

- ▶ employees should have access to ill-health benefits where their state of health justifies it;
- ▶ employers should take all reasonable steps to prevent staffs' health deteriorating to a point where ill-health retirement becomes an issue;
- ▶ no employee should be retired on health grounds when suitable alternative employment can be found for them or where there are more appropriate exit routes; and

- ▶ the procedures for awarding ill-health benefits must be founded on good quality, objective and impartial medical advice.

**4.5** In framing these recommendations, account has also been taken of the range of schemes across the public sector and their varying circumstances. It was recognised from the outset of the review that it would not be feasible or desirable to produce a set of recommendations which could be applied automatically by every scheme and/or employer. The key is that they are applied in a way which meets the underlying purpose of the recommendation in a way which best suits the circumstances of each scheme.

**4.6** The recommendations set out below are grouped under four broad headings:

- ▶ good management practice
- ▶ the processing of ill-health retirement applications
- ▶ choices made at the point of exit and afterwards
- ▶ incentives

### 1) Good Management Practice

#### Sickness Management

**4.7** There is already an existing body of good practice and guidance on the management of sickness absence. If this was applied more widely it would help to reduce the number of employees who end up in the position where ill-health retirement becomes a possibility. The key elements of an effective strategy which link to ill-health retirement can be summed up by the following recommendations.

**Recommendation 1: Public sector employers should have robust management systems in place for recording the incidence and causes of sickness absence.**

**Recommendation 2: Public sector employers should systematically analyse the causes of short and long term sickness absence in their workforce to inform the design of workplace health policies.**

**Recommendation 3:** The recommendations in *Working Well Together* provide a model of best practice for all public sector employers to follow. A number of these recommendations can help to reduce the incidence of ill-health retirement through early intervention and should be universally adopted. In particular, the recommendations that employers should:

- › define review points to trigger management action including ones based on an individual's cumulative absences from work;
- › provide clear guidance on the range of line management actions available at these points; and
- › consider introducing progressively earlier or wider referrals to occupational health services to address cases of workplace injury or ill-health.

### Workplace Health

**4.8** Strong sickness management needs to be bolstered by effective policies which promote health in the workplace and which make appropriate use of occupational health services. The next set of recommendations are aimed at achieving this.

**Recommendation 4:** All employers should ensure that appropriate mechanisms, including preventative measures, are in place for accessing information, advice, and other support on occupational health. In some cases, economies of scale may make it appropriate for groups of employers to combine resources to create common enquiry points.

**Recommendation 5:** All managers should improve their understanding of the skills and competencies needed to improve health in the workplace, not all of which require formal qualifications. For example, offering training on how to prevent occupational accidents or on how to cope with stress.

**Recommendation 6:** As a matter of good practice, employees should be given reasonable access to occupational health services and be clear about the conditions under which such help will be provided.

**4.9** It is important that such policies are not 'imposed' on the workforce but take account of their views and experience. This will also help them to address their own responsibilities in terms of making the workplace a safer place for all.

**Recommendation 7:** Wherever possible, partnership arrangements between employers and employees should be established which involve employees or their representatives in the decision-making processes and implementation of workplace health policies.

**4.10** Given the increasing number of ill-health retirements which are attributed to stress, it is important that stress is addressed as a discrete issue in any health strategy.

**Recommendation 8:** Employers should take steps to promote positive health by identifying and reducing sources of stress through stress management programmes.

### Redeployment and Rehabilitation

**4.11** Moving staff to alternative duties, enabling 'stepping down', and active programmes of rehabilitation, when health problems manifest themselves which are serious or are likely to become so, will help reduce the burden on the employee and in some cases avoid an ill-health retirement.

**Recommendation 9:** Employers should put in place procedures which ensure that:

- › redeployment is always considered when existing duties are contributing to an employee's ill-health; and
- › rehabilitation is actively addressed as part of sickness absence management.

**4.12** If redeployment is not feasible within the employing body, other local public sector employers may sometimes be able to offer posts. This would be particularly helpful for small autonomous units with little scope for moving staff to other duties.

**Recommendation 10:** Wherever possible, employers should put in place, at local level, arrangements which facilitate the redeployment of staff between employers.

**4.13** Unnecessary barriers to redeployment should be removed where they exist. For example by amending pension schemes to allow continued membership for staff moved to alternative duties by their employer.

**Recommendation 11: Pension schemes should urgently review any restrictions on membership of the scheme, linked to the performance of specific duties, with a view to removing these restrictions.**

**4.14** The proposals for flexible retirement, will, when introduced, enable staff to move to lighter duties or part time working when their health is a problem, which in some cases would help to protect earnings. Used imaginatively, this will provide a valuable opportunity for employers to keep experienced staff on the payroll and will help to reduce costs in the process.

**Recommendation 12: When flexible retirement becomes available, employers should actively consider offering employees with health problems the opportunity to draw their pension and step down to alternative duties or part-time working.**

### Rehabilitation Payments

**4.15** It is possible for an employee to be absent on long term sick leave and exhaust their sick pay entitlement, but not satisfy the scheme criteria for ill-health retirement because there is some prospect of recovery. Even if the employee is retained on an unpaid basis, there may be a risk of him losing touch with his employer and his health deteriorating to a point where the ill-health criteria are satisfied.

**4.16** A more active role by the employer will pay a dividend if a later ill-health retirement is avoided. It would also provide an extra incentive for the employee who may be pessimistic about the probability of returning to work.

**4.17** In such circumstances, there may be a case for the employer making a form of payment for a limited period of time, if and when normal sick pay options have been exhausted. This should be conditional upon the employee undergoing regular medical assessments and an active programme of rehabilitation. It will obviously impose an extra cost on the employer.

However, from the Exchequer's point of view, the costs of such a payment would be more than offset by the savings from the benefits otherwise paid if a successful application for ill-health retirement was later made. But a judgement would have to be made in each case, based on medical advice and cost-effectiveness, as to the likelihood of medical recovery and so the case for making such a payment.

**Recommendation 13: Employers should consider whether it would be cost-effective, and beneficial to employees, to pay time-limited rehabilitation allowances, conditional on appropriate medical treatment being taken, if and when normal sick pay options have been exhausted.**

## 2) Assessment for Ill-Health Retirement

### Criteria for Ill-Health Retirement

**4.18** The adoption of a common definition of the term 'permanence' in the criteria set out in scheme regulations is central to establishing any coherent framework for ill-health retirement across the public sector. And that definition must reflect the fact that a payment is being brought forward from the age at which an employee would normally retire.

**Recommendation 14: The definition of 'permanence' in scheme regulations should be amended, where necessary, to mean 'until normal retirement age'.**

**4.19** Equally, there must be a presumption that an ill-health pension will only be awarded in any scheme where the employee cannot perform any duties within the organisation which would be reasonable for someone of their position and experience. Inability to carry out existing duties is, on its own, too narrow a test.

**Recommendation 15: The test which is applied for ill-health retirement applications should relate to existing duties and 'comparable employment', or an equivalent term which embraces a wider range of duties than those which the employee currently carries out.**

**4.20** The tightening of the 'gateway' to ill-health retirement could lead in some cases to an increase in the number of employees dismissed on grounds of incapability due to ill-health, but without pension benefits. For example, their health may be poor but not so poor as to meet the 'permanence' test. Some of the employees falling into this category may be able to carry out other forms of work but no suitable opportunities may be available within the organisation. However, alternative duties might be found with another local public sector employer in the area.

**Recommendation 16:** The local pooling arrangements discussed in Recommendation 10, should be used wherever possible, to facilitate the redeployment of employees who may otherwise be dismissed on the grounds of incapacity but fail to qualify for ill-health retirement benefits.

### Medical Assessment

**4.21** The need to ensure that the medical assessment carried out at the applications stage is objective and impartial will require a clear separation in the role and responsibilities of the doctor who first sees the applicant and the doctor who advises whether the scheme criteria are met. But it is important that the introduction of this procedure is not used to delay the processing of applications.

**Recommendation 17:** Two doctors should be involved in the medical assessment:

- › first, the employee's GP/hospital specialist or employer's doctor should compile the medical evidence supporting the application; and
- › second, an independent occupational physician should consider the evidence and if necessary, examine the applicant, and advise the party taking the final decision whether the scheme criteria are satisfied.

**4.22** In those cases where this practice is not followed at present, steps will have to be taken to put the 'second doctor' in place. Funded pension schemes should meet the cost of employing these doctors. In the case of pay as you go schemes, the doctor's independence will be protected, if a number of employers share these costs and he is not under an obligation to any one of them.

**Recommendation 18:** Arrangements should be made for an independent occupational physician to be available to carry out stage two medical assessments, for example by consulting an independent and suitably qualified physician or by entering in to a service contract with one or more suitably qualified physicians.

### Medical Qualifications

**4.23** Expertise in occupational health is critical in reaching a judgement as to whether the scheme criteria are met or not. It may not be possible in the short term to employ doctors in every case who have more than a diploma given current supply constraints. But over time the aim should be to raise the minimum requirement and use doctors with a higher level of qualification.

**Recommendation 19:** The physicians used at the first and second stages should be accredited specialists in occupational health medicine and on the Specialist Register of the General Medical Council. Ideally, the physician should be a Member or Fellow of the Faculty of Occupational Medicine (MFOM or FFOM), or EEA (European Economic Area) equivalent. The minimum requirement should be that the physician holds a diploma in occupational medicine (D Occ Med) or is an Associate of the Faculty of Occupational Medicine (AFOM), or EEA equivalent.

**4.24** The need for expertise is even more critical at the appeal stage where an employee may be challenging a refusal of ill-health retirement on the grounds that the medical opinion supporting it was flawed. In this situation, a second opinion should only be given by an accredited specialist in occupational medicine.

**Recommendation 20:** The physicians used at the appeal stage should be accredited specialists in occupational health medicine, and a Member or Fellow of the Faculty of Occupational Medicine (MFOM or FFOM) or EEA equivalent.

### Medical Guidance

**4.25** Inevitably, there will be some variation in the conclusions reached by medical assessors on the employment capacity of individuals suffering from similar complaints. It is right that there is scope to reach different conclusions depending on the evidence in each case. However, in order to achieve a degree of consistency, each recommendation should be guided by a common set of guidelines. These can provide greater transparency, encourage consistent application in difficult cases and can lead to fewer appeals. The guidelines drawn up by the Association of Local Authority Medical Advisers provide an example of how this can be done.

**Recommendation 21:** All schemes should put in place appropriate medical guidelines to assist medical assessors. It should be a contractual requirement that assessors have regard to them when advising on applications for ill-health retirement.

### Injury Benefits

**4.26** A significant number of employees leaving some public services on ill-health grounds receive both an ill-health retirement benefit and an injury benefit. The latter is paid where an employee has demonstrated that he has suffered an injury (physical or mental) or disease which can be attributed to his employment. Such payments are tax free. The number of injury awards to employees has increased in recent years.

**4.27** Injury benefits are subject to a separate process and criteria from ill-health benefits and fall outside the scope of the present review. But they account for a significant part of the overall cost to the Exchequer arising from ill-health retirements. It is important that the regimes for these benefits are consistent with the detail and spirit of the changes recommended for ill-health retirement in this report.

**Recommendation 22:** The rules and procedures for the payment of injury benefits should be subject to separate review to ensure that they are administered with the same fairness and rigour as proposed for ill-health benefits.

## 3) Choices Made at the Point of Exit and Afterwards

### Alternative Exit Routes

**4.28** Widening the scope of the test applied under the scheme regulations to relate to 'comparable employment' or equivalent, will only have effect if employers take active steps to identify other available posts which the employee could move to. The key to this is employers recognising that they have a responsibility to look for ways of keeping staff with health problems in employment. And requiring employers to consider other posts which will become available in the medium term will keep open the option of an employee remaining on sick leave until such a vacancy becomes available.

**Recommendation 23:** Employers should always consider whether an employee is capable of performing suitable alternative work when an application for ill-health retirement is made; and if so, whether such work is available or will be available in the foreseeable future.

**4.29** When an ill-health retirement application is put forward, employers should as a matter of course consider whether the employee's health is the reason why his possible departure is an issue, and that an alternative exit route would not be more appropriate. This will require all forms of exit routes to be available for use in the first place.

**Recommendation 24:** All employers should ensure that the full range of exit routes are available (ill-health retirement, voluntary/compulsory redundancy, early retirement, dismissal on grounds of capability or conduct), and ensure that the most appropriate exit route is used in every case.

### Who Decides on the Award of Ill-Health Benefits?

**4.30** The second doctor's task is to provide a medical judgement on whether the criteria for ill-health retirement have been met but not to take a decision on an application. The impartiality secured by the use of the second doctor will be maintained if the decision on award of benefits is taken by a party who faces no conflict of interest.

**Recommendation 25:** In the case of funded or notional pension schemes, the decision on the award of ill-health benefits should be taken by pension scheme managers on the basis of objective and impartial medical advice. In cases where this is not legally possible, those taking the decision should be provided with full and accurate information encompassing the merits and estimated costs of the application.

**4.31** In the case of pay as you go schemes and the Armed Forces Scheme, this division of responsibility cannot be made as there is no separation between the employer and pension scheme. And in these cases, a high fitness standard is a requirement of the job. There is a need to balance the risk of employers being unduly influenced by non-medical factors against the employer's responsibility to enforce fitness standards. This would be addressed in the police and fire cases if the employer was involved in the decision-making process but did not have the sole say in the final decision. (The nature of the Armed Forces makes this separation difficult in their case.)

**Recommendation 26:** The decision on the award of ill-health benefits in employments where there are specific fitness standards for the generality of employees should be taken by a panel made up of a representative of the employer and two other independent parties who have no connection with either the employer or employee.

### Two-Tier Benefits

**4.32** There is a strong case for distinguishing between those leavers who are unlikely to ever work again and those who have a reasonable prospect of finding alternative work. The career pattern of those who work in services with high fitness standards indicates that many leavers fall into the latter category.

But the same issue arises for other employment groups, particularly but not exclusively, in cases of stress-related illness.

**Recommendation 27:** Pension schemes should actively consider the desirability and feasibility of paying a reduced pension, or only a medical severance payment, for those who meet the criteria for ill-health retirement but who are judged to be capable of employment elsewhere.

### Abatement of Pension

**4.33** If the 'gateway' to ill-health retirement is policed more effectively, there should be little reason in general for tracking the employment pattern of those who leave. But there are cases where it would be sensible, for example where people leave early in their working life and later recovery cannot be wholly ruled out.

**Recommendation 28:** Schemes or their employers should introduce review procedures for targeted groups which schemes judge would be cost effective to monitor by, for example, monitoring the tax codes of a selection of retirees.

**4.34** If such monitoring is introduced, schemes will need to consider at what point pensions should be abated and by how much.

**4.35** Schemes which introduce two tier benefits would need to distinguish between those who had left with full benefits, and had no expectation of working again, and those in receipt of reduced benefits, with an expectation of finding paid employment. In the former case, where an individual has left with full benefits but does in fact find paid employment, the logical step would be to reduce the ex-employee's pension to the lower rate while providing a right of appeal. In the latter case, there would be no grounds for any further abatement.

**4.36** Schemes which continue to pay a common set of benefits to all staff leaving on ill-health grounds would need to consider an alternative approach. One option would be to abate an ex-employee's pension on a sliding scale once their total income (pension and earned income) exceeds their salary (uprated in line with the RPI) at the point of retirement.

**Recommendation 29:** Schemes which monitor earnings of those in receipt of an ill-health pension should draw up appropriate rules for abating these pensions.

**Recommendation 32:** Departments or schemes should use the data disclosed by individual employers to construct and publish details annually of comparative performance for each employer group.

## 4) Incentive Structure

### Disclosure

**4.37** Greater transparency about the costs of ill-health retirement is needed to influence decision-making and increase accountability for this expenditure. Managers would then have added incentives to handle health issues effectively in the workplace and consider alternative duties for staff suffering from ill-health.

**Recommendation 30:** Arrangements should be put in place which ensure that managers are aware of the estimated additional costs of ill-health retirement in individual cases.

**Recommendation 31:** All financial reports by employers should publicly disclose the estimated extra costs of ill-health retirements agreed in the financial year covered.

**4.38** The availability of annual information on additional costs would enable comparative data to be regularly published on the performance of employers within the same groups, for example, all police authorities or local authorities. This in turn would provide a mechanism for encouraging the worst performers to improve their performance through better management.

**4.39** The object of such an approach would not be to expect the incidence of ill-health retirement for all employers to be identical. Some differences will be inevitable reflecting variations between the health of the population as a whole, for example, within and between regions and age profile and medical history of each employer's workforce. But the extent of the current variations in performance cannot be explained by these factors alone. The management practices of those with the lowest rates offer a model for the poorer performers to raise their performance and over time narrow the performance gap.

**4.40** A further discipline may be needed to improve the management of ill-health retirement by those employers with the highest incidence, whether or not the decision to agree retirement on these grounds lies with them. Requiring such employers to face the additional costs upfront, should encourage them to address the efficacy of their health and human resource policies.

**4.41** However, if applied, any charging mechanism would need to be modified in the way it applies to small employers where the chance element in the incidence of ill-health is less likely to be spread evenly.

**Recommendation 33:** Departments should consider, in 2002, whether, taking account of the impact of other recommendations in the report, employers with rates of ill-health retirement consistently in the highest quartile for their employer group should be charged 50% or more of the additional costs of each ill-health retirement.

### Ill-Health Pension Enhancements

**4.42** The incentives which present scheme rules create for employees to initiate ill-health retirement applications at the most financially advantageous point in time, or to delay applications until that time, need to be removed. The calculation of added years does not have to accrue through a series of step changes after specified lengths of service.

**Recommendation 34:** The rate at which enhancements for ill-health benefits accrue should be adjusted so that these accrue at a more even rate over time.

## Targets

**4.43** Targets are being used widely to raise public sector performance. The local government section in the existing DETR public service agreement already requires authorities 'to set measurable targets for reducing ill-health retirements, early retirements and sickness absence over a five year period to levels consistent with or better than those at present achieved by the best quartile of authorities.'

**4.44** Similar targets for other employers would provide an overarching performance framework for the improvements in the management of ill-health retirement recommended elsewhere in this report.

**Recommendation 35:** Service delivery agreements agreed in the 2000 spending review should set high level targets challenging employers to reduce ill-health retirement by 2005 to a level consistent with or better than those at present achieved by the best quartile of employees.

## 5) Next Steps

**5.1** Given the number of employers across the public sector and the wide range of duties carried out by employees, it is not possible to devise a single template for improving the management of ill-health retirement across the public sector.

The recommendations in Section 4 provide, therefore, a common framework for pursuing such improvements which can be tailored, as appropriate, to fit individual circumstances.

**5.2** The recommendations also have different implications for individual employers and schemes. For example, some employers will have more to do than others to implement the recommendations on workplace health, redeployment and rehabilitation. Some pension schemes will have to make changes to their scheme regulations to bring them in line with the recommendations and time will be needed to consult the relevant stakeholders. In the case of recommendations which alter employees' pension rights, employers will need to take legal advice on the position of existing employees. So the speed at which reform will take place will vary between different groups.

**5.3** Several of the recommendations, for example in the area of workplace health, will have some cost implications for some employers. But the analysis in this report demonstrates that if this expenditure is incurred wisely, and reflects best practice elsewhere, it should be more than recouped by better use of staff resources and a reduction in the costs arising from ill-health retirement.

**5.4** It is important that the report is followed up energetically right across the public sector so that improvements are secured as early as possible. A further recommendation therefore is:

**Recommendation 36:** Each of the Government Departments (Ministry of Defence, Department of Environment, Transport and the Regions, Department for Education and Employment, Cabinet Office, Department of Health and the Home Office) which have been engaged in the review will draw up action plans by October 2000 specifying the steps which will be taken by employers and schemes to implement the report and the timescale for implementing these.

**5.5** In the case of local government and the fire service, the action plans will be drawn up, as appropriate, taking account of the specific conclusions and recommendations reached by the Audit Commission and Fire Services Inspectorate in their recent reports.

**5.6** A further review will be carried out in 2002 to assess the progress which has been made against individual action plans and the benefits which have been secured as a result.

## a) Terms of Reference for the Review

### Review of Ill-Health Retirement in the Public Sector

#### **Terms of Reference**

“To review the factors leading to ill-health retirement, including why its incidence is much higher in some parts of the public sector and in some employing authorities than others;

To identify best practise both in the management of pension scheme provisions and the operation of relevant human resource policies; and

To make recommendations to ministers on the implementation of measures to spread best practise and to ensure the appropriate use of ill-health retirement benefits.”

## b) Injury Benefits

Injury benefits are part of the financial 'package' received by some employees leaving on health grounds. Their cost is met by the employer and not by the pension scheme.

They are generally more generous for individuals than ill-health pensions alone and can, therefore, greatly increase the cost of individual early retirements. In recent years the numbers of injury claims have been increasing.

### Private Sector Practice on Injury Benefits

Private sector employees who are injured or killed in the course of their work may be entitled to injury or disability benefits. However, very few private employers have specific provisions to cater for attributable injuries and death, largely because such events happen relatively rarely in most private sector employments covered by occupational pension schemes. Where the employee or his or her dependant believes that a claim for negligence can be sustained, this would normally be covered by the employer's liability insurance. There may be ill-health retirement or death-in-service benefits provided as of right to employees through an occupational pension scheme and, in some cases, pension scheme trustees may exercise their discretion in order to pay additional benefits (within Inland Revenue limits).

Therefore, most employers will have arrangements in place to compensate employees and their families for work-related death or disablement and associated loss of income or earnings, often through the employer's liability insurance. These arrangements are generally designed to protect or indemnify the employer against the minimum statutory requirements and any higher damages awarded by the courts. The level of benefits applicable in such circumstances would usually be determined on a case-by-case basis, either to be settled by the courts or by negotiation between the employer's insurance company and the lawyers acting on behalf of the applicant. Employees and their dependants may also qualify for DSS injury or disability benefits.

### Public Service Practice on Injury Benefits

A number of public sector pension schemes make specific provision for injury benefits. Examples are the PCSPS, the schemes for local government, NHS, police and fire, (the Armed Forces is more complex with Armed Forces Pension Scheme (AFPS), injury benefits and DSS 'non-occupational' war pensions).

All the above mentioned public service occupational pension schemes generally follow the same pattern, the benefits being designed to bring the member's or former spouse's income from specified sources (including any occupational pension) up to a guaranteed level. The specified sources generally include any income paid wholly or partly from public funds, including sick pay and social security benefits. Arrangements for calculating awards vary across the public services, but usually there is provision for a lump sum related to pensionable pay and, for other than very minor injuries, a guaranteed income payment (or 'pension') which depends on length of service and percentage impairment and provides up to a maximum of 85% of pensionable pay.

The injury benefit payments to the former employee are tax free (like comparable private sector lump-sum or, more rarely, periodic payments) which makes them more valuable than ordinary ill-health benefits. They are also generally aimed at maintaining in-work income and do not appear to allow for the lifetime earnings pattern. Therefore, they do not take account of periods when pension rather than work earnings would have been paid.

The widow(er)'s guaranteed level is generally 45% of pensionable pay if death is treated as attributable. Other levels apply to children and dependants. An additional lump-sum injury payment of up to six months' pensionable pay is payable on death or leaving service. Public service injury benefits are payable primarily in respect of loss of earnings capacity (including loss of such support in the event of death) rather than as compensation for any loss of mental or physical faculties or for any degree of pain and suffering. Some public service schemes have freestanding injury arrangements, but for most their rules are still part of the main pension scheme. It is, however, an Inland Revenue requirement that specific provision for injury benefits should not form part of an approved occupational pension scheme.

Qualification for injury benefits may be dependent upon for example:

- ▶ suffering an injury or being killed while on duty; or
- ▶ suffering an injury or being killed (whether on duty or not) as a result of a terrorist attack or similar act, if the incident is directly attributable to the employment; or
- ▶ contracting a disease to which an individual has been exposed by the nature of their duties.

Travel to and from work is not normally eligible, nor are sporting injuries in recreational time periods. However, there are certain variations in this practice, particularly within the uniformed services, for example, the police and fire services, where the concept of being on duty is more broadly defined.

### Contrast With Ill-Health Award Criteria

The criteria for the two awards, ill-health retirement benefits and injury benefits, are different. Ill-health pensions are related to the *inability to perform existing duties* (and in some cases alternative duties) *for a period of time*. Payment is made by reference to reckonable service and usually enhanced. Such benefits are paid for by employers and employees through pension contributions and pay offsets.

Injury pensions are concerned more specifically with *loss of earnings capacity*. This could arise where an individual was re-employed in ways involving a loss of earnings, eg, because of having to work part-time or in a lower level job. The tariff takes some account of reckonable service rewarding those with longer service, and also takes account of the level of impairment. Employee contributions do not cover injury benefits (indeed employees who are not pension scheme members are eligible), so this is a pure employer cost.

### Procedures for Assessment and Review

The procedures for assessing injury awards are similar to those for ill-health retirements. Medical advice is sought to establish whether a qualifying injury has occurred or whether a valid causal link between an

injury and the work performed has been established. However, there will be differences in procedures and responsibilities. For example, an award can be reviewed to take account of improvement or worsening of the injury or disease and the degree of earnings impairment.

### Damages and Criminal Injuries

Public service injury benefit arrangements are 'no fault' schemes, ie, the benefits are payable regardless of whether the employer was at fault or the injury was caused by a third party. Benefits would normally only be withheld if the injury was wholly or mainly due to serious or culpable negligence or misconduct on the part of the individual.

However, public servants have separate rights to sue for damages or make claims under the Criminal Injuries Compensation Scheme (CICS), run by the Home Office (or equivalent arrangements run by MoD for Armed Forces personnel serving overseas). However, if a claim for damages is successful the money received will generally be taken into account in assessing the award under the main occupational injury provisions. This is to prevent the payment from public funds of benefits when compensation is coming from another source for the same purpose. The provisions may, however, vary between schemes.

### Relationship to Ill-Health Awards

Public service injury 'pensions' are payments which top up any occupational pension scheme provision. As these injury benefits guarantee a minimum income, a calculation must always be done to see if any ill-health pension awarded is greater than the injury benefit, in which case only the ill-health amount is put into payment. If the ill-health award is less, the income is generally topped up by the injury benefit payment (although in the case of the Armed Forces, the AFPS injury award subsumes the AFPS ill-health award).

Therefore, there is a direct relationship between ill-health awards and injury benefits; changes in ill-health retirement payments could lead to changes in the size of injury benefit awards.

## Financing/Charging

The normal financing arrangement is for the employing body to meet the cost of benefits provided in respect of injuries (eg, under the NHS and PCSPS arrangements). This helps to ensure that employers recognise this employment cost and should help to encourage them to take remedial measures to avoid or reduce the risk of disease or injury and to ensure that injury benefit provisions are applied correctly. It also accords with the appropriate treatment under public expenditure classification and Resource Accounting and Budgeting principles.

## c) Summary of Key Terminology Used in Criteria for Ill-Health Retirement Contained in Regulations Used by Individual Schemes

### The Medical Condition

Schemes use a variety of terms to define the nature of the medical condition which justifies ill-health retirement.

#### *'Permanently disabled'*

Schemes using this terminology: fire service, police service.

#### **Fire Service**

- ▶ 'Disabled' means 'incapacity through physical or mental infirmity for the performance of duty'.
- ▶ 'Permanently disabled' means 'Disabled at the time when the question arises for decision and to his disablement being at that time likely to be permanent'.

This, in its turn, depends on the medical evidence available at that time. No guidance on 'likely to be permanent' is given except that if an individual is receiving in-patient care at the time the decision is taken then they are automatically deemed as permanently disabled. In such cases 'in patient care' is linked to 'qualifying injury'. A 'qualifying injury' is defined as 'an injury received by a person without his own default in the execution of his duties as a regular firefighter'. Here, a connection is intended between someone who is seriously injured on duty and who is hospitalised as a result and who is not expected to return to work; these individuals do not have to submit to the usual procedures.

#### **Police**

- ▶ 'Disabled' means 'unable to carry out the ordinary duties of your rank because of physical or mental infirmity'.
- ▶ 'Permanently disabled' means 'Disabled at the time when the question arises for decision and to his disablement being at that time likely to be permanent'.

The in-patient rule as described for the fire service also applies to the police scheme. In addition, and in contrast to the fire service, the definition of 'permanent' is further defined via the phrase 'Likely to be permanent'. This means no reasonable prospect of recovery in the foreseeable future – the foreseeable future has recently been revised from 'about 12 months hence' to 'three years hence'.

#### *'Permanently incapable' or 'permanent incapacity'*

Schemes using this terminology: Scottish Teachers & NHS Pensions, NHS & Teachers (E & W) and, DETR - Local Government Pensions, PCSPS

- ▶ For all these schemes, the definition of 'permanent' is 'until member's normal retirement age'.

The **Teacher's Pension Scheme** uses the term, 'permanent incapacity', where 'permanent' means up to age 60 (no different to the above), and 'incapacity' means 'unfit by reason of illness or injury and despite appropriate medical treatment to serve as such and is likely to permanently be so'. 'Likely to permanently be so' means 'more likely than not'.

Interpretation of 'more likely than not' is strict; it has to be more likely than not that a member will not be able to work again before normal retirement age. The eligibility for ill-health retirement is then further narrowed because work means all relevant work. So a member must show balance of proof against being able to work in all relevant work areas.

**Local government pensions** and **Scottish local government pensions** define 'incapable' to mean 'unable to discharge efficiently the duties of that employment because of ill-health or infirmity of mind or body'. This contrasts with the police and fire service who define disability in terms of infirmity and make no reference to ill-health.

The **NHS Pension Scheme** defines 'permanent incapacity' similarly to local government pensions except that 'incapable' is defined in terms of mental or physical infirmity and 'ill-health' is not mentioned. Likewise for **Scottish NHS pensions** and **Scottish local government pensions**.

The only scheme which uses the term 'ill-health' alone is the **PCSPS**. In this scheme, the medical advisor must sign a statement saying 'In my opinion, the officer is incapable, because of ill-health, of giving regular and efficient service in the duties described and the incapacity is likely to be permanent'.

## The Test of What an Employee Can Do

Schemes apply varying approaches to define and assess the nature of the duties which the employee is capable of performing, although the terminology used to guide the process is typified by the following:

"A member who **retires from pensionable employment** because of physical or mental infirmity that makes him permanently incapable of **efficiently** discharging the duties of **that employment** shall be entitled to receive an immediate pension under this regulation if he has at least two years' qualifying service or qualifies under regulation E1 (normal retirement pension)." (Regulation E2(1), NHS Pension Scheme)

The phrase '**retires from pensionable employment**' means the contract must cease because of ill-health. **Schemes are unanimous on this point.**

The term '**efficiently**' means producing the required result competently. **Scottish NHS pensions, NHS pensions (E & W).**

Variations on this include '**regular and efficient**', **PCSPS**.

There may be internal inconsistencies in respect of toleration levels of efficiency within and across schemes, but these are the words most commonly used.

The phrase '**that employment**' has various definitions:

- ▶ just that – ie not extending to a job of similar nature or standard elsewhere **Scottish NHS pensions**
- ▶ the post or posts to which their contract of employment relates. **NHS Pensions E&W**

▶ duties of the grade; the medical advisor will consider whether the person could do other jobs in the grade and also whether a change of work location would help. **PCSPS**

▶ comparable employments; employment in which when compared with the member's employment contractual provisions as to capacity are the same or differ only to the extent that is reasonable given the nature of the member's ill-health and contractual provisions as to place, remuneration, hours of work, holiday etc do not differ substantially from those of the member's employment. **DETR – Local Government Pension Scheme.**

▶ **The fire service** uses 'duties of your rank'. This has been interpreted by the courts to mean that fire authorities cannot continue to employ firefighters who are no longer fit for firefighting duties – so they cannot be retained for other duties either. The HM Fire Services Inspectorate report '*Fit for Duty*', February 2000, recommends that the Home Office secure changes in the scheme to remove the global requirement for 'operational fitness' and substitute a 'role-related' medical requirement.

▶ **The police service** use 'inability to perform the ordinary duties of a male or female member of the force' currently relates to the rank of the officer. The HMIC Thematic Inspection Report 96-97 recommends that forces have a flexible approach to this, and consider whether the officer is able to carry out sufficient duties for the rank concerned to justify retention.

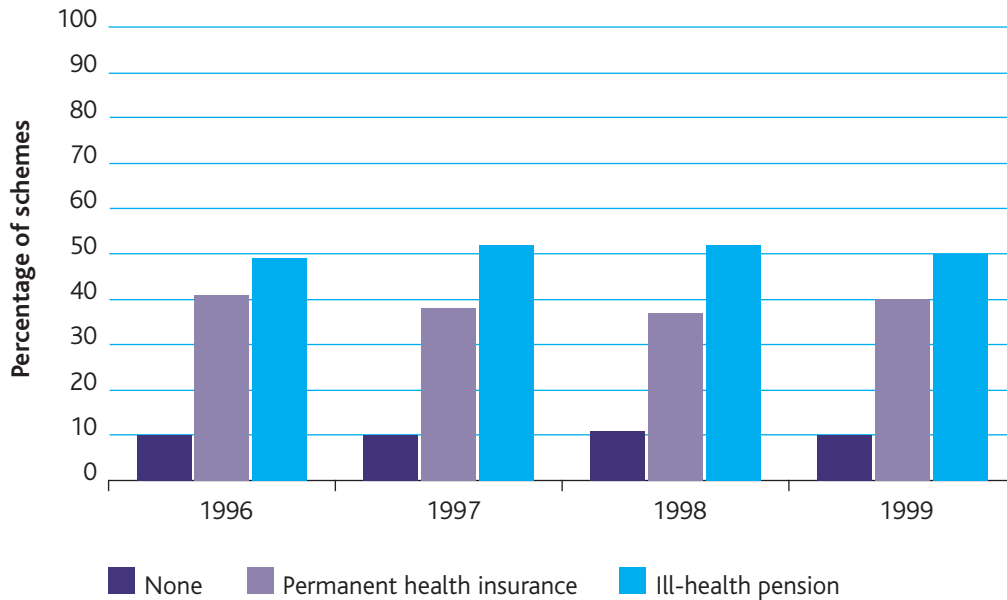
▶ The interpretation of '**permanent incapacity**' as contained in **Education (Teachers) Regulations** prevents the re-employment of teachers in receipt of an ill-health retirement pension awarded in any **relevant employment**. This includes part-time teaching.

**The Armed Forces**

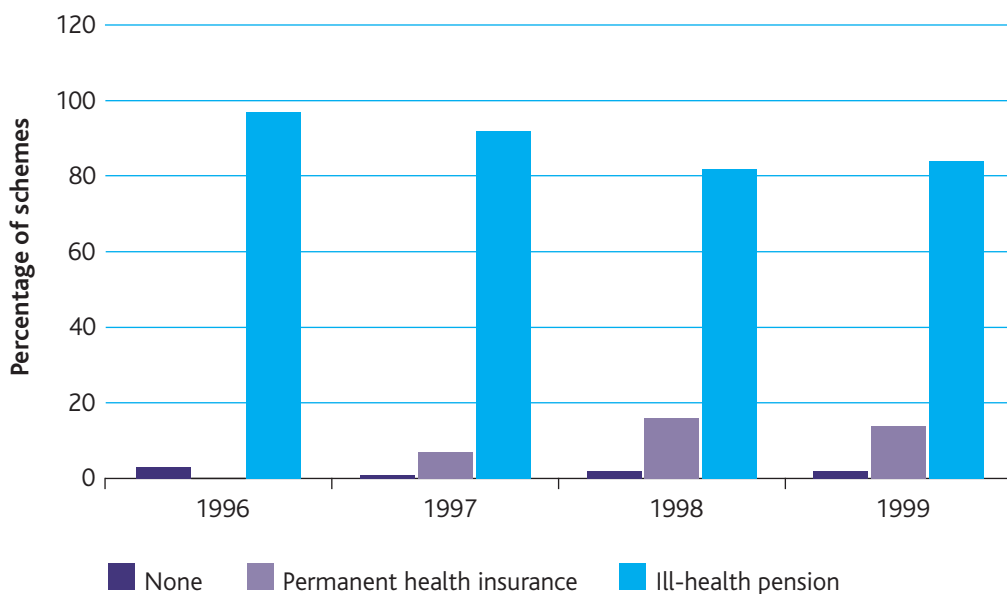
Regulations vary between forces, but typically on joining the services an individual will sign on for an engagement of a limited period. Therefore, the term 'normal retirement age' is not applicable and a full career normally means service to complete a pensionable commission or engagement. Key to decisions made on medical discharges is the high standard of fitness required for service. Therefore, regulations focus on the ability or otherwise of the individual to ever attain full fitness again. Those deemed unable to do this are given medical discharge. Those deemed to be in a temporarily reduced medical employability category are subject to further review and, in some cases, retained in the service in this reduced medical category – taking in to account the needs of the service and the preferences of the individual.

## d) National Association of Pension Funds Survey Extracts 1994 - 1999

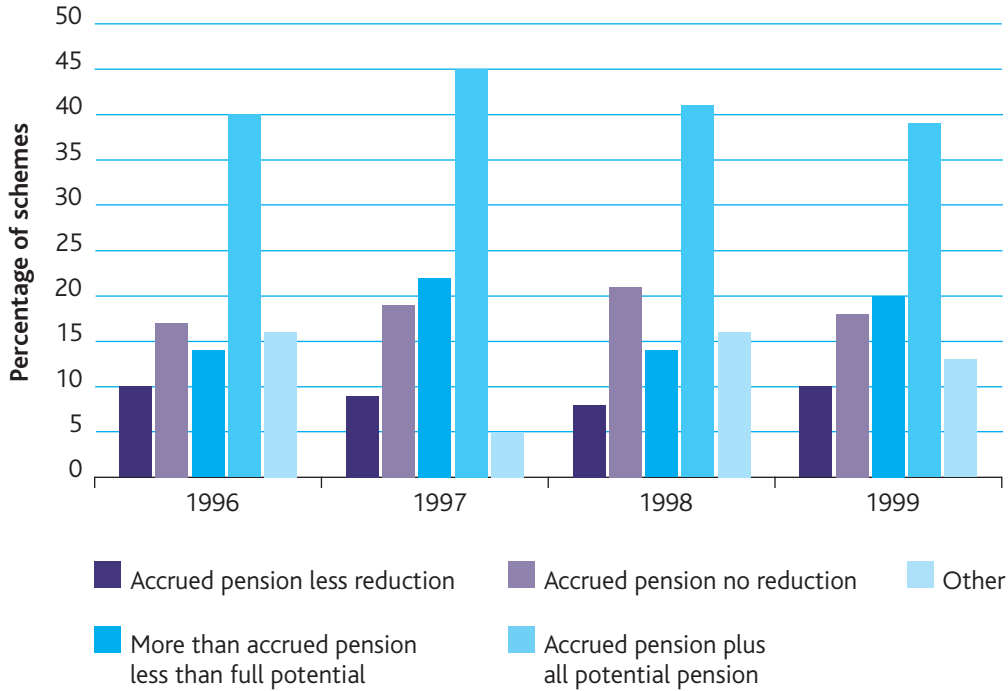
### Benefits Payable on Ill-Health Retirement in Money Purchase Schemes 1996-1999



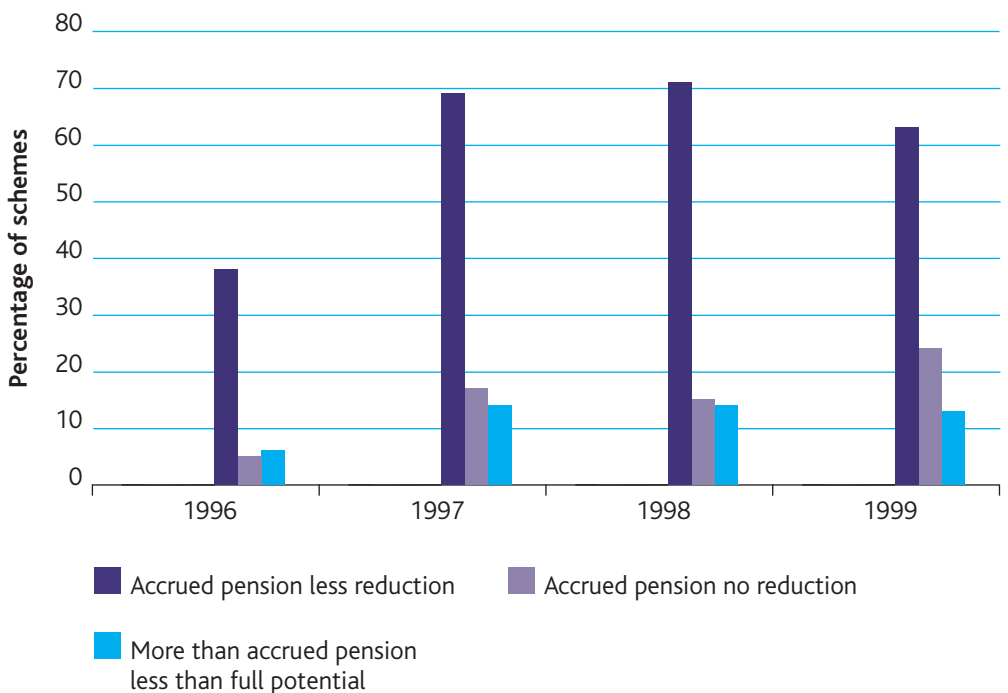
### Benefits Payable on Ill-Health Retirement in Private Sector Final Salary Schemes 1996-1999



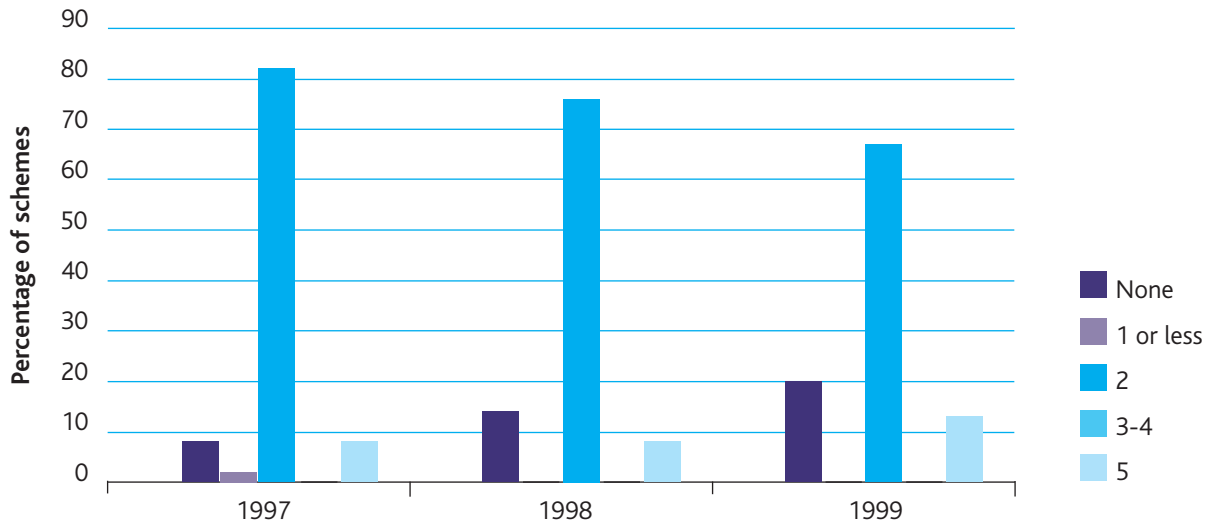
**Forms of Provision in Private Sector Final Salary Schemes Where Ill-Health Retirement is Available 1996-1999**



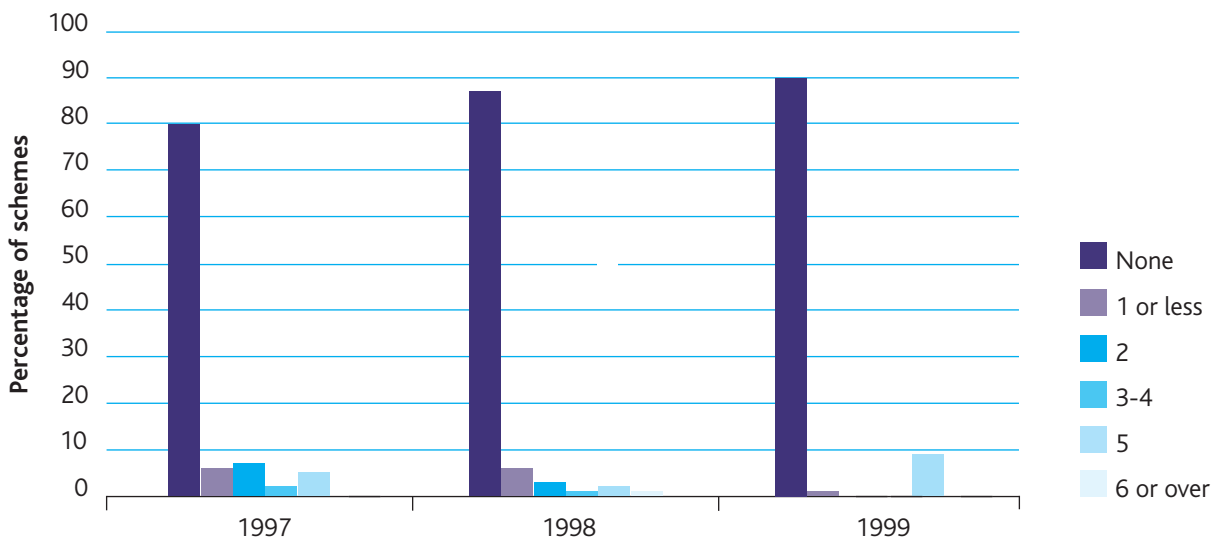
**Forms of Provision in Money Purchase Schemes Where Ill-Health Retirement is Available 1996-1999**



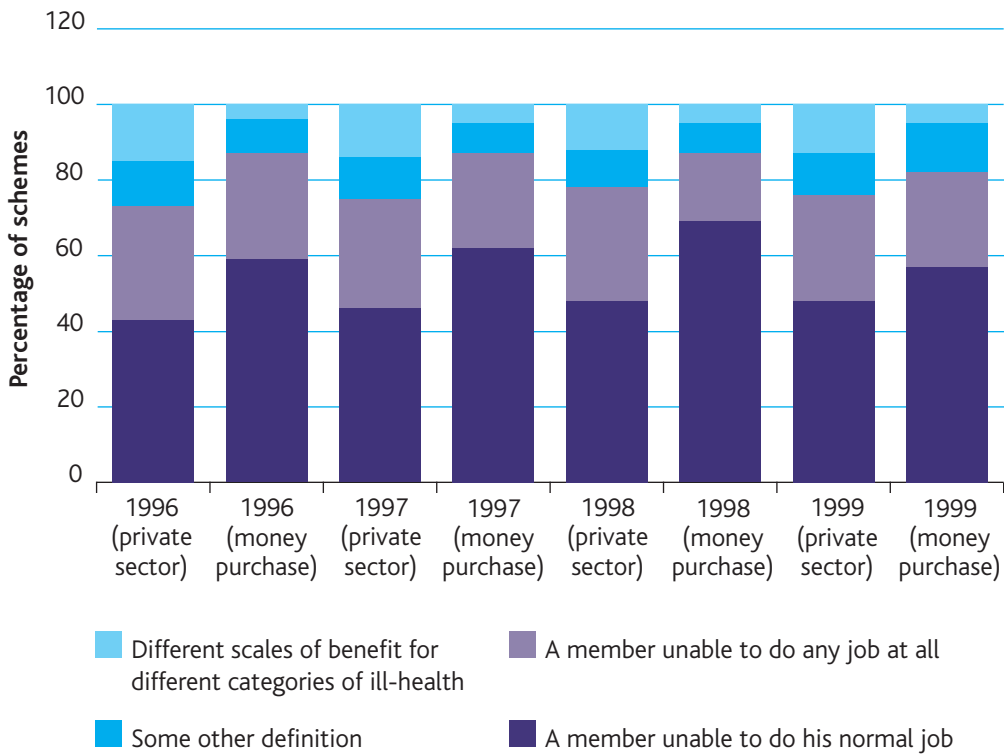
**Qualification for Ill-Health Retirement Demanded by Private Sector Final Salary Schemes 1997 - 1999**



**Qualification for Ill-Health Retirement Required by Money Purchase Schemes 1997 - 1999**

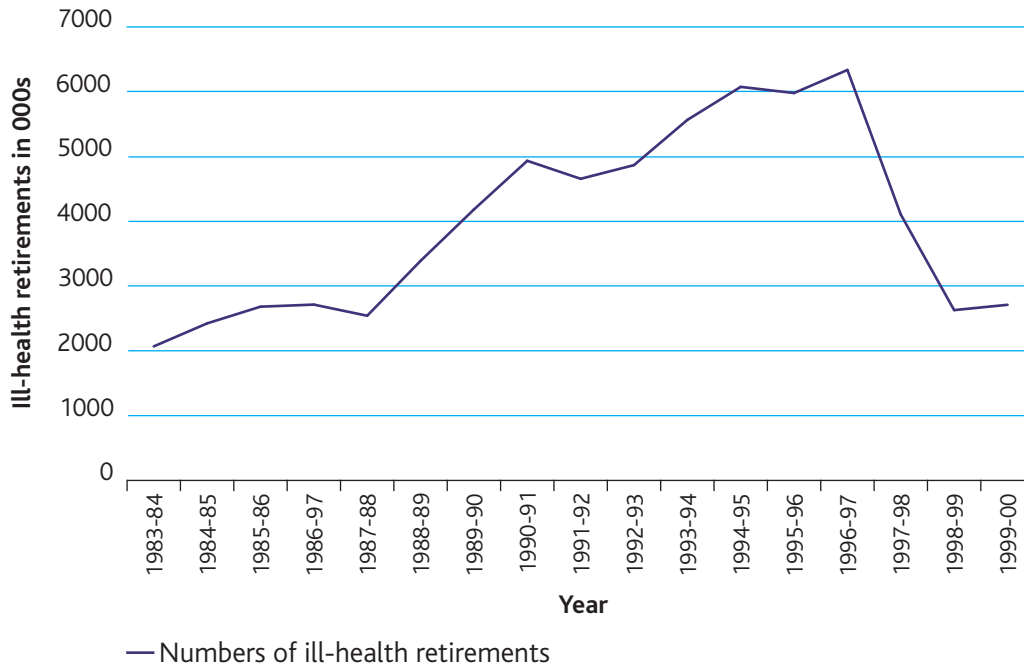


**Qualification for Ill-Health Retirement by Category (Percentage of Schemes) 1996-1999**  
**Private Sector and Money Purchase Schemes Compared**



## e) The Changing Incidence of Ill-Health Retirements: Teachers' Scheme (E&W) 1983 - 1999

**The Changing Incidence of Ill-Health Retirement Rates for Teachers (E&W) 1983 to 1999**



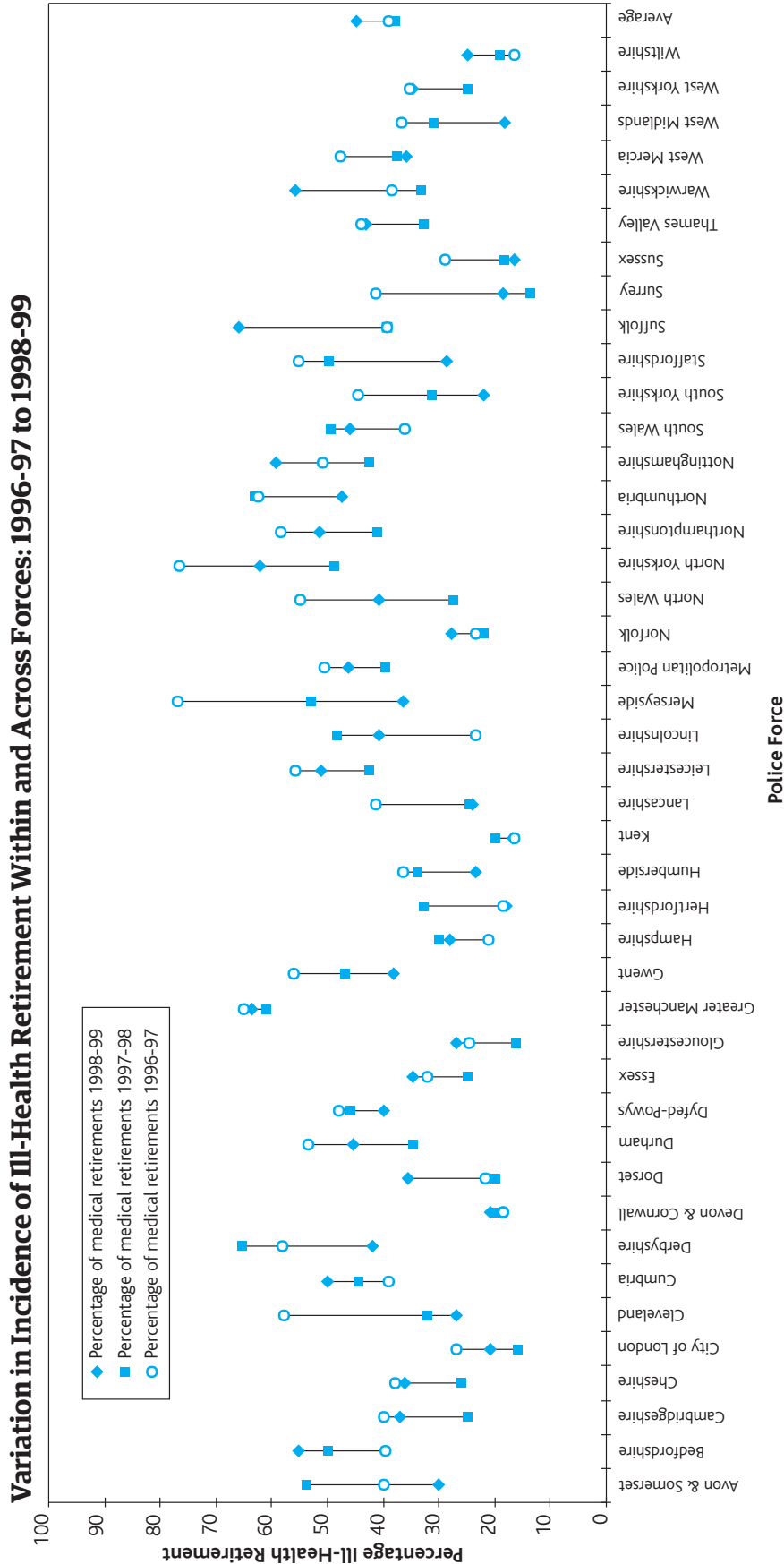
**NB:** This assumes a non-volatile level of scheme membership of around 550,000 over the time period  
 Source: DFEE Pensions

## f) The Changing Incidence of Ill-Health Retirements: NHS Scheme 1969 and 1994

Age last birthday at start of year	Ill-health retirement rate per 1000 members	
	1994	1969
<b>Males – administrators (Groups 1 &amp; 5)</b>		
32	1.2	0.3
37	2.3	0.6
42	4.4	1.1
47	8.3	1.8
52	17.5	4
57	26.5	10*
<b>Female – Nurses (Group 10)</b>		
32	2.7	1
37	4.4	1.5
42	6.8	2.5
47	12.8	4.5
52	27.6	8.5
57	46	15*

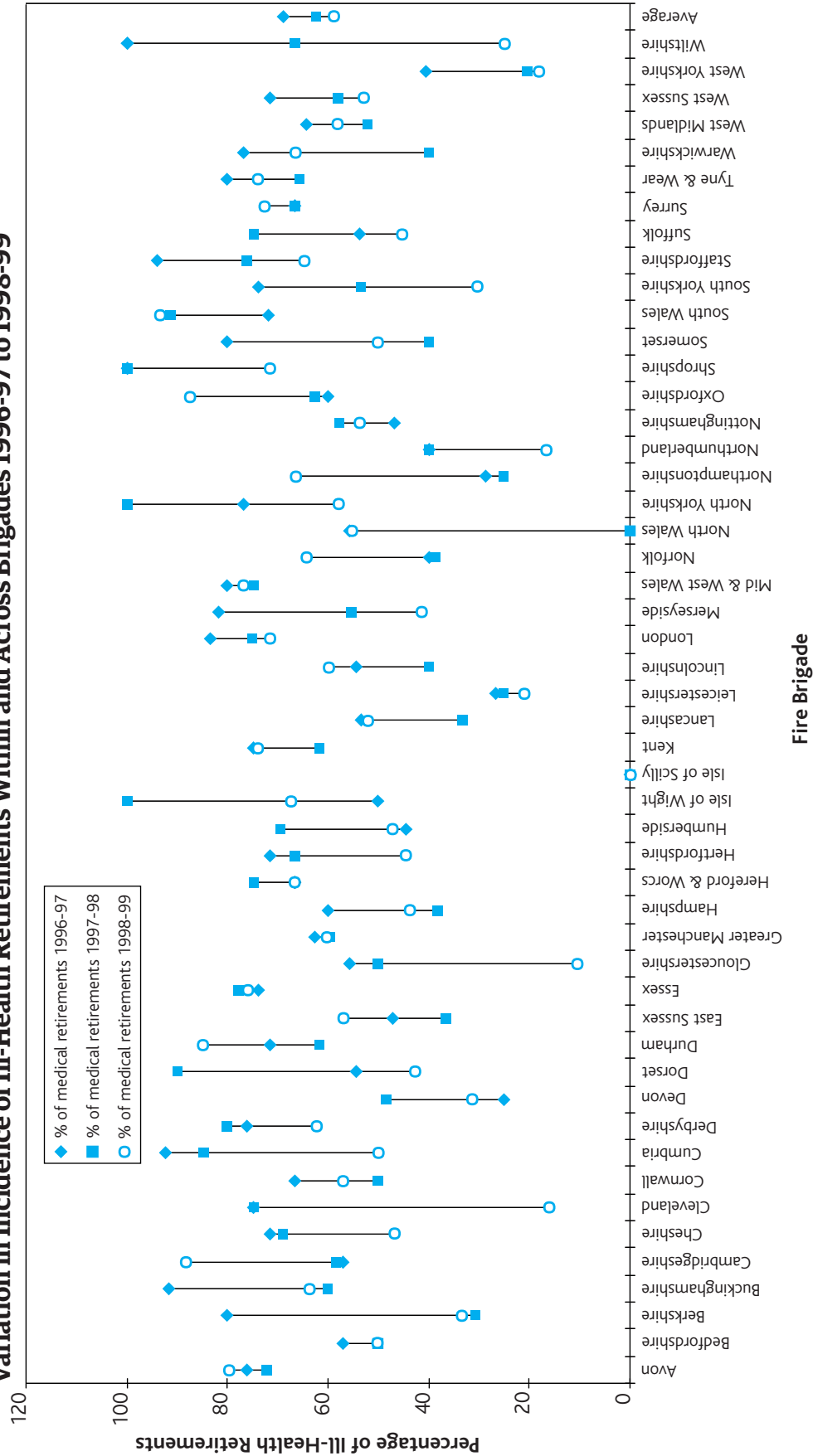
Note\*: The rates for age 57 in 1969 are taken from other NHS groups, as most retirements over 55 for groups 1 & 10 were assumed to be on age grounds at that time.

## gg) Variation in Incidence of Ill-Health Retirements: Fire, Police and Local Authorities



Source: Home Office, Police Pensions Directorate

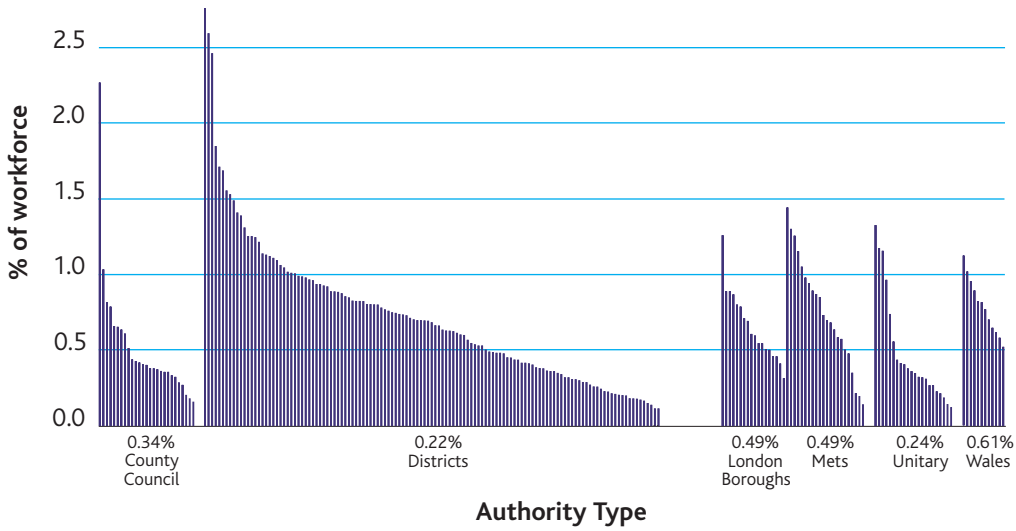
Variation in Incidence of Ill-Health Retirements Within and Across Brigades 1996-97 to 1998-99



Source: HM Inspectorate of Fire Services

**Ill-health Retirement as a Proportion of the Workforce 1998-1999**

In 1998-99, the upper quartile of local authorities had ill-health retirements as a proportion of the workforce of just 0.3%, less than half the average.



Source: Audit Commission survey 1999

## h) 1999 Survey of European Practice and Incidence of Ill-Health Retirement

### European Practice

#### Terms of Reference

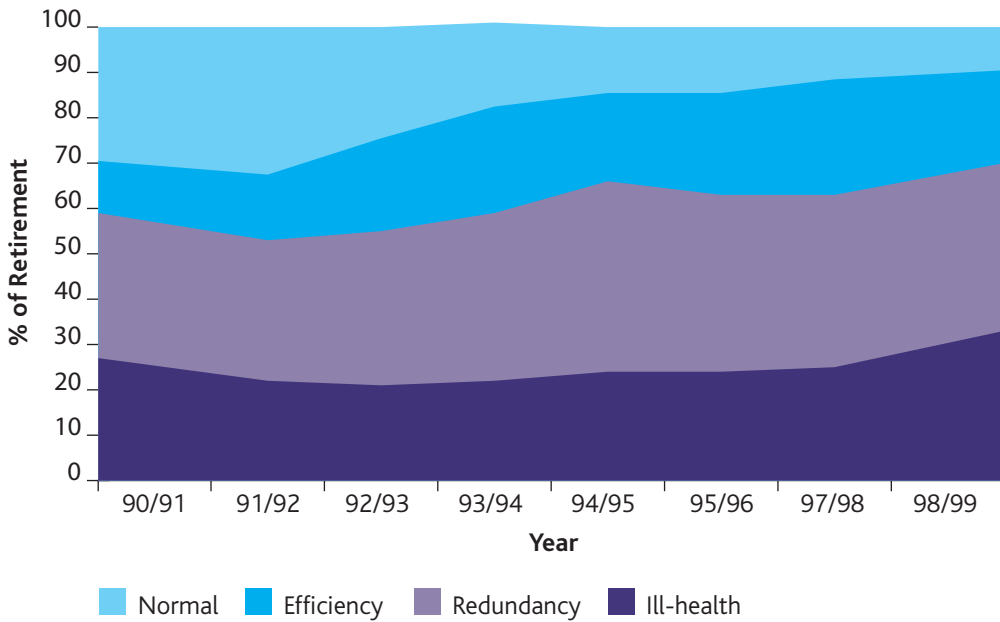
In 1999 a survey was carried out of ill-health retirements in the public sector in seven European countries: Germany, Belgium, Finland, France, Ireland, the Netherlands and Portugal. This told a similar story to the experience in this country. The main findings were that:

- ▶ enhancements to ill-health pensions and additional years are common in nearly all schemes;
- ▶ there was variation in the level of retirements on grounds of ill-health in relation to the total number of retirements: 50.4 per cent in Germany, 40 per cent in Finland and 25–32 per cent in Ireland. But rates were lower elsewhere: 14.9 per cent in France, 16.8 per cent in Belgium.
- ▶ Germany had experienced dramatic increases between 1975 and 1990, though the trend had slowed in more recent years.
- ▶ in Germany, distinctions were made between job-related incapacity covering employees whose capacity to carry out specific work was reduced, and incapacity where the employee cannot regularly or continuously carry out any kind of professional activity. In France, a disabled person is a person who is recognised as totally and permanently incapable of carrying on his or her activities on grounds of an infliction contracted or worsened during a period taken into account in the calculation of pension rights;
- ▶ few schemes could provide data analysing the main causes of ill-health, and few had taken steps to reduce the costs of these pensions.

One common theme was that when disability is declared, certain countries demonstrate it is possible to find intermediary alternatives through reinstatement in another activity or part-time work. Systems of flexible pensions or partial pensions also allow unhealthy people to carry on a professional activity in reasonable physical and financial conditions, without applying for ill-health pensions.

## i) New Audit Commission Survey Results: Incidence of Ill-Health Retirement Relative to Other Forms of Early Retirement

The commission's new survey shows that the proportion of retirees leaving earlier than their normal retirement age in 1998/99 is down to 67%, but that ill-health retirement rate is falling less rapidly than other forms of early retirement.



## j) Review Group Members

Our sincere thanks go to all review group members for their helpful, positive and co-operative approach to the contents of this review.

Cabinet Office	Barry Forrester
Cabinet Office	Julia Wood
CBI	Peter Humphrey
DETR: Local Government Pensions Unit	Terry Crossley
DETR: Local Government Pensions Unit	Bob Holloway
DfEE	Paul Bleasdale
DfEE	Penny Jones
Dudley Occupational Health NHS Trust	Dr Jonathon Poole
Home Office: Fire Policy Unit	Martin Hill
Home Office: Police Pensions Directorate	John Gilbert
Institute of Personnel Directors	Dr Derek White
MOD: Service Personnel Policy	Richard Williams
National Association of Pension Funds	Dr Anne Robinson
NHS Executive	Robin Heron
NHS Pensions Agency	Alec Cowen
Prison Service	Adrian Howlett
Scottish Office Pensions Agency	Ralph Garden
TUC	Joanne Segars

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Ministry of Defence: Surgeon General's Department	Dr Lillywhite, Captain Morgan
National Association of Pension Funds	David Hart
NHS Pensions Agency	Linda Bates
Railpen	Michael Goy
Sainsbury's	Geoff Pearson
The Employers' Organisation for Local Government	Charles Nolda, Tim Rothwell
The Post Office	Carolyn Ray
Unigate Pension Scheme	Chris Armitage
Unilever UK Pensions	Chris Lewin & team
West Midlands Police Force	David Williams & team

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