Civil Service Pensions

Medical reviews and appeals guide

Civil Service Pensions Schemes
Civil Service Injury Benefit Scheme

Contents

Medical retirement and early payment appeals

1 Background

1.1 The Medical Retirement Appeals process relates solely to the following.

- A decision on whether to issue a medical retirement or refusal certificate.
- A decision to award medical retirement benefits at the lower tier level (applies only to premium, classic plus, nuvos, and alpha members).
- A refusal to issue a member a medical retirement certificate retrospectively.
- A refusal to issue a medical retirement certificate for early payment of a preserved award (EPPA) (applies only to classic members).

Please note: successful appeals against refusal of medical retirement allow the member to receive medical retirement benefits. These are backdated if the member's service was terminated before the conclusion of the appeal.

2 Ill health retirement criteria

The criteria applied when considering a case under the medical appeal process are the same as for medical retirement, but depend on whether the person is a member of classic or premium, classic plus, nuvos or alpha.

2.1 Ill health retirement criteria in classic

The criteria for ill health retirement in classic are that an individual is prevented by ill health from discharging his/her duties and that the ill health is likely to be permanent.

2.2 Ill health retirement criteria in classic plus, premium and nuvos

There are two levels, or tiers, of ill health retirement. Which tier is given depends on the effect of the incapacity on the member's ability to carry out work. The medical adviser can recommend a provisional award at the rate most appropriate at the time if they are unable to decide which of the criteria is met.

The criteria are as follows.

- **Upper tier:** an individual has suffered a permanent breakdown in health and the resulting incapacity prevents them from discharging their own job and of undertaking any other gainful employment.
- **Lower tier:** an individual has suffered a permanent breakdown in health and the resulting incapacity prevents them from discharging their own job or a comparable job.

Please note: if the member has taken partial retirement then they are not eligible for upper tier even if the criteria for rule E.7 3 (b) in nuvos and D.4.3 (a) in classic plus/premium have been met.

2.3 Ill health retirement criteria in alpha

There are two levels, or tiers, of ill health retirement. Which tier is given depends on the effect of the incapacity on the member's ability to carry out work. The medical adviser can recommend a provisional award at the rate most appropriate at the time if they are unable to decide which of the criteria is met.

The criteria are as follows:

- **Upper tier**: an individual has suffered a permanent breakdown in health and the resulting incapacity prevents them from discharging their own job and of undertaking any kind of employment.
- **Lower tier**: an individual has suffered a permanent breakdown in health and the resulting incapacity prevents them from discharging their own job or another similar role.

Please note: if the member has taken partial retirement then they are not eligible for upper tier even if the criteria for 'total incapacity for employment' may have been met.

2.4 Ill health retirement in partnership

A member of the partnership money-purchase scheme may receive ill health retirement benefits from the partnership scheme, if the Scheme Medical Adviser (SMA) assesses their breakdown in health is permanent and they are incapable of doing their own or a comparable job.

An explanation of the terms mentioned above is in Appendix A.

3 Process

The procedure has three separate stages. The appeal may be upheld at any of the three stages.

3.1 Stage one Action by member

3.1.1 Members must appeal in writing by completing part one of form APP1 and returning it to their employer or former employer.

3.1.2 The member must appeal within **three months** of the date when the employer notifies them in writing about the content in the medical retirement or refusal certificate. The employer must issue a medical appeal form (APP1 P1) with their decision.

3.1.3 Members wishing to appeal against a refusal to grant medical retirement retrospectively or EPPA must do so within **three months** of the date when the employer tells them that their application was not successful. Where a member is unfit to make an appeal personally a relative, friend or trade union representative may, with the member's consent, appeal on their behalf during the three-month period.

3.1.4 Members can appeal with or without any significant new medical evidence to support their case. However, failure to submit such evidence at this stage of the appeal means that it is most unlikely that the case can progress beyond stage two. If the member is not supplying significant new medical evidence with their appeal, they should indicate this on the form.

Please note: if the member cannot meet the three-month deadline because of delays beyond their control, employers may ask the Scheme Administrator (MyCSP) to consider allowing them an extension on their behalf.

Action by employer

3.1.5 The employer must forward the complete case file to the Scheme Medical Adviser (SMA) immediately.

3.1.6 Applications for medical advice must be made using the form APP 1.

No.	Documents required
1	The original application papers and the SMA's decision (including evidence gathered by the occupational health provider and SMA correspondence).
2	Full occupational health records. This includes reports to management from your occupational health provider, the clinical notes (including notes of any consultations) upon which such reports are based, and any reports from your employee's doctors that your occupational health provider has obtained. The last two should be contained in a sealed Medical-in-confidence envelope.
3	Part one of the APP1 form completed by the member and the new medical evidence. This must be from a registered medical practitioner. Copies of reports previously considered do not represent new evidence and are not acceptable. Complete reports are needed. Extracts or part reports are not acceptable. If the appellant wishes, the medical evidence can be submitted in a sealed envelope for the attention of the medical adviser.

Please note: any documents sent by post to the SMA should be enclosed in two sealed envelopes.

3.1.7 Failure to include any of this material will result in the case being returned by the SMA. You must not send any other files (for example personal, HR or Pension files) to them.

Action by the SMA

3.1.8 A senior physician will consider the appeal in the light of the medical evidence previously considered plus any additional reports provided by the appellant and recommend whether the original assessment is supported or overturned. This will usually, but not always, be the senior physician who made the original decision. If the appeal is not supported and the member has not been examined by the SMA as part of the decision making process he or she will be offered an appointment, whenever practicable, to gather any additional information and to explain the reasons for the recommendation.

3.1.9 The SMA will inform the employer of the result of the Stage one review and of any further action to be taken. They will aim to clear all cases within 10 working days of receipt. If the senior physician upholds the appeal, the employer must decide whether to accept the assessment, informing the member accordingly. If the employer rejects the senior physician's findings, they must give a full explanation to the member of why they do so.

Please note: where the appeal is against the award of lower tier benefits in premium, classic plus, nuvos or alpha, the pension scheme rules provide that the final decision on tiers rests with the medical adviser, not the employer.

3.1.10 Where the senior physician upholds an appeal against a decision to award lower tier benefits (for example, he or she decides to award upper tier benefits), the employer should inform the member accordingly.

3.2 Stage two

3.2.1 Where the appeal is not supported, the senior physician will forward all the papers to the SMA. The SMA establishes whether a reasonable case for appeal exists. If not, the appeal is rejected at this stage with an explanation to the employer of the deficiencies. The deficiency may cover a range of issues. The most likely are that there are gaps in the supporting documentation provided by the employer or the member, or that further medical evidence is required in some form.

3.2.2 The employer may resubmit rejected cases once they have remedied any deficiencies on their part. Such a resubmission must be made **within three months** of the letter notifying them of the rejection and deficiencies.

3.2.3 Similarly, where there are deficiencies in the supporting material provided by the member, or where further medical evidence is required, the employer must bring this to the member's attention as soon as the SMA advise them of such. The member will have **three months** to remedy any deficiencies from the date of the employer's notification.

Please note: it is for the member to source, provide and pay for any further medical evidence identified as being required by the SMA not the employer.

Please note: if the member cannot meet the three-month deadline because of delays beyond their control, the employer may ask the Scheme Administrator to consider allowing them an extension on their behalf.

3.2.4 The SMA will inform the employer of the result of the initial review and any further action within **10 working days**. Any further evidence submitted for consideration after the initial review will necessitate a further review as part of this stage. This further review will be completed **within 20 working days**.

3.2.5 If a reasonable case has been made the SMA will determine whether the procedural and medical elements have been properly applied, and may uphold the appeal and provide a replacement medical retirement or refusal certificate. If it is unclear that the criteria for medical retirement is satisfied, the SMA will refer the case to an independent Medical Appeal Board to consider.

3.2.6 If the member cannot make a reasonable case within the three months allowed to correct any deficiencies, the appeal fails on procedural grounds.

3.2.7 If the SMA upholds the appeal, the employer must decide whether to accept the assessment, and inform the member. If the employer rejects the findings, they must give a full explanation to the member of why they do so.

3.2.8 If the SMA overturns a decision to award lower tier benefits (for example, they decide to award upper tier benefits), the employer must inform the member.

3.2.9 If the appeal fails at this stage and the member has any concerns about the way the process has operated in their case, they should refer to the Internal Disputes Resolution (IDR) procedures.

Please note: the IDR procedures allow the member to appeal about the procedural aspects of their medical appeal, not the medical decision that resulted from it. Information about the IDR procedures can be found on the Civil Service Pensions website: www.civilservicepensionscheme.org.uk under 'Contact us'.

Appointment of the independent Medical Appeal Board

3.2.10 Within five working days after the appeal being escalated following completion of stage two, the SMA will nominate an independent Medical Appeal Board chair. This is normally an accredited specialist in occupational medicine who practices in a region of the UK likely to be convenient for the member. The Independent Medical Appeal Board Chair is selected from a list approved by the Scheme Manager (Cabinet Office). Boards will not be held outside the UK.

Please note: the list of approved Medical Appeal Board chairs consists of accredited specialist occupational health doctors, none of whom are employed by or directly involved with the SMA. Only doctors who have had no previous involvement in the case in question will be asked to chair a Medical Appeal Board.

3.2.11 The SMA will provide the independent Chair with:

- copies of all the relevant papers;
- a summary of the case and the key issues to be determined;
- any necessary background relating to the rules of the Civil Service Pension Scheme (CSPS) and/or the Civil Service; and will
- ask the Chair to arrange an appointment for the member as soon as is practicable.

3.2.12 The SMA will provide the employer with an estimate of when the appointment is likely to take place together with an information sheet on the procedure that they should pass on to the member.

3.3 Stage three

3.3.1 The independent Chair will:

- appoint a second accredited specialist to make up the Medical Appeal Board;
- arrange for the Board to see the member in an appropriate clinical setting;
- give the member at least two weeks' notice of the appointment where practicable; and
- advise the SMA of the date, time and venue of the Medical Appeal Board.

3.3.2 The SMA will copy this information to the employer. Members may be accompanied to the Medical Appeal Board by a relative or friend or, for example, a Trade Union official. If a member does not wish to attend a Medical Appeal Board, or fails to attend two appointments, the Board will consider the case on a papers only basis.

3.3.3 Having considered all the evidence, which may include an examination of the member, the Medical Appeal Board will, as soon as is practicable, prepare a full clinical report:

- outlining the key features of the case;
- stating whether they uphold or reject the appeal; and
- providing reasons for their recommendations.

Please note: the decision of the Medical Appeal Board completes the medical aspects of the appeals procedure.

Please note: where the Medical Appeal Board upholds a medical retirement in premium, classic plus, nuvos, or alpha recommending that the award should be at the lower tier, the Board's assessment will be taken as final, with no further avenue of medical appeal **on this issue**.

3.3.4 The SMA will forward the Medical Appeal Board's findings and any appropriate certificate to the employer.

3.3.5 The employer will then decide whether to accept the Medical Appeal Board's findings and will inform the member accordingly. If the employer rejects the Board's findings, they must give the member a full explanation of why they made that decision.

3.3.6 This completes the medical retirement appeal arrangements. If the member has any concerns about the way the process has operated in their case, they should refer to the Internal Dispute Resolution (IDR) procedures.

Please note: the IDR procedure allows the member to appeal about the procedural aspects of their medical appeal, not the medical decision that resulted from it. Information about the IDR procedure can be found on the Civil Service Pensions website: www.civilservicepensionscheme.org.uk.

Upper tier review appeals

4 Background

4.1 The upper tier review appeal process relates solely to a decision that the conditions for upper tier top-up benefits are no longer satisfied. The individual can appeal against this decision. When considering the appeal there are two different outcomes open to the Scheme Medical Adviser (SMA).

- Uphold the appeal returning the case to MyCSP confirming that upper tier criteria are satisfied.
- Reject the appeal and then the case is automatically referred to an independent Medical Appeal Board for a further review.

5 Process

The procedure has two stages.

- Appeal to the SMA
- Subsequent appeal to an independent Medical Appeal Board.

Please note: this differs from the three stage medical retirement appeal process, because before recommending that the conditions for upper tier benefits are no longer satisfied, the SMA will have already offered the member a consultation and a senior physician will have considered the case.

5.1 Stage one

Action by member

5.1.1 Members must appeal in writing using the annex form issued with their decision outcome letter. They should return the appeal to the Scheme Administrator (MyCSP) at the address shown on the annex. The member must appeal **within three months** from the date that the Scheme Administrator notifies them of the initial decision in writing. If the member cannot make a reasonable case within the three months allowed, then the appeal would fail on procedural grounds.

Please note: where a member is unfit to make an appeal personally, a relative, friend or Trade Union representative may, with the member's consent, appeal on their behalf during the three-month period.

Please note: members can appeal with or without any significant new medical evidence to support their case. However, failure to submit such evidence means that it is most likely that the appeal will be unsuccessful.

Please note: if the member cannot meet the three-month deadline because of delays beyond their control, the Scheme Administrator (MyCSP) may consider allowing them an extension.

Action by the Scheme Medical Adviser (SMA)

5.1.2 The SMA will consider the appeal in the light of current information and any new medical evidence provided by the individual. The physician who considers the appeal will be a different physician from the one who made the original decision.

5.1.3 If there are, deficiencies in supporting medical evidence the SMA will bring this to the individual's attention. The individual will have **three months** to remedy any deficiencies from the date of the notification.

Please note: it is for the appellant to source, provide and pay for any further medical evidence.

5.1.4 The SMA may require a further consultation.

Please note: the pension scheme rules provide that the final decision on tiers rests with the SMA , not the Scheme Administrator or the Cabinet Office Civil Service Pensions team.

5.1.5 The SMA will inform the Scheme Administrator of the result of the initial review and any further action within **10 working days** of its receipt. Any further evidence submitted for consideration after the initial review will necessitate a further review as part of this stage. **This further review will be completed within 20 working days**. If the SMA is unable to support the appeal, they will refer the case to an independent Medical Appeal Board to consider.

5.2 Stage two

Appointment of the independent Medical Appeal Board

5.2.1 **Within five working days** of the appeal being escalated following completion of stage two, the SMA will nominate an Independent Medical Appeal Board Chair (normally an accredited specialist in occupational medicine) who practices in a region of the UK likely to be convenient for the member. Independent Medical Appeal Boards will not be held outside the UK.

Please note: the list of approved medical appeal board Chairs consists of accredited specialist occupational health doctors, none of whom are employed by or directly involved with the SMA. Only doctors who have had no previous involvement in the case in question will be asked to chair a medical appeal board.

5.2.2 The SMA will provide the independent Chair with:

- copies of all the relevant papers;
- a summary of the case identifying the key issues to be determined; and
- any necessary background relating to the rules of the CSPS and/or the Civil Service.

They will ask the Chair to arrange an appointment for the member as soon as is practicable.

5.2.3 The SMA will provide the Scheme Administrator with an estimate of when the appointment is likely to take place, together with an information sheet on the procedure that they should pass on to the member.

5.2.4 The independent Chair will:

- appoint a second accredited specialist to make up the Medical Appeal Board;
- arrange for the Board to see the member in an appropriate clinical setting;
- give the member at least two weeks' notice of the appointment where practicable; and
- advise the SMA of the date, time and venue of the medical appeal board.

5.2.5 The SMA will copy this information to the Scheme Administrator. Members may be accompanied to the medical appeals board by a relative, friend, or, Trade Union official. If a member does not wish to attend a Medical Appeal Board, or fails to attend two appointments, the board will consider the case on a papers only basis.

5.2.6 Having considered all the evidence, which may include an examination of the member, the medical appeals board will, as soon as is practicable, prepare a full clinical report:

- outlining the key features of the case;
- stating whether they uphold or reject the appeal; and
- giving the reasons for their recommendations.

Please note: the decision of the independent Medical Appeal Board completes the medical aspects of the appeals procedure.

5.2.7 The SMA, will forward the medical appeal board's findings and any appropriate certificate to the Scheme Administrator who will notify the individual of the outcome.

5.2.8 This completes the upper tier appeal arrangements. If the member has any concerns about the way the process has operated in their case, they should refer to the Internal Disputes Resolution (IDR) procedures.

Please note: the IDR procedure allows the member to appeal about the procedural aspects of their medical appeal, not about the medical decision that resulted from it. Information about the IDR procedure can be found on the Civil Service Pensions website: www.civilservice.gov.uk/pensions.

Injury benefit formal appeals

6 Background

6.1 The formal injury benefit appeal process relates solely to:

- The medically assessed level of apportionment for injuries sustained on or after 1 April 2003.
- The medically assessed level of earnings impairment for injuries sustained on or after 1 April 2003.

Please note: unless previously supplied, the employer should give the appellant details of the scheme's qualifying criteria. It will also be helpful to provide a copy of this guide. The member should be encouraged to give a copy of whatever is provided to their medical carer as background.

7 Criteria

7.1 The criteria applied when considering a case under the formal medical appeal process are the same as for injury benefit.

7.2 A person is eligible for a permanent injury benefit when they suffer ***a qualifying injury that impairs their earning capacity***. Impairment of earnings capacity is assessed when the person is leaving employment (including moving to a lower grade or undertaking part-time working because of the injury). See the – CSIBS rules for more information). Impairment of earnings capacity is a medical assessment of the extent to which the member's earnings capacity for the remainder of their expected working life has been impaired by the qualifying injury, and must always be carried out by the Scheme Medical Adviser (SMA). It is part of the overall evidence that the Scheme Administrator (MyCSP) or the employer must look at when making a decision about awarding injury benefits.

Impairment of earning capacity is assessed in five bands:

Not appreciably affected	10% or less (no award is made)
Slight impairment	11% - 25%
Impairment	26% - 50%
Material impairment	51% - 75%
Total impairment	over 75%

7.3 The assessment of impairment to earning capacity relates only to the effects of the qualifying injuries sustained.

8 Apportionment

8.1 In addition to an impairment of earnings assessment, for qualifying injuries sustained on or after 1 April 2003, the Scheme Administrator or the employer must ask the SMA to advise on whether the illness is 'wholly' (more than 90%) or 'mainly' (more than 50% but less than 90%) attributable to the nature of the duty.

8.2 If the SMA considers that the illness is less than 50% attributable to duty, it cannot be considered as 'mainly' attributable to duty and the injury benefit claim will fail.

8.3 Where a person meets the mainly attributable test then the SMA will go on to apportion the extent to which their duties caused their injury.

Apportionment is assessed in three bands:

Low	50 – 70% attributable to duty
Medium	71 – 90% attributable to duty
High	above 90% attributable to duty

9 Process

The formal injury benefit appeal procedure has only one stage; however, two separate appeals can be made within the appropriate period (12 months of the initial award decision).

Any appeal should be made **within 12 months of the initial Award decision**. The second appeal may be notified up to and including the day, the 12-month period ends. Under these circumstances, the appeal process may go beyond 12 months in its entire duration.

Action by the Member

9.1.1 All appeals must be made in writing. The letter of appeal should set out the basis for the appeal (for example, against the level of apportionment/or impairment of earnings capacity).

9.1.2 New medical evidence must be presented with the appeal. Failure to include new medical evidence will result in the case being returned to whom?

Please note: it is for the appellant to source, provide and pay for any further medical evidence not the employer.

Action by Employer/ the Scheme Administrator (MyCSP)

9.1.3 Applications for injury benefit appeals should be made using the form CSIBS2.

9.1.4 The following flagged documents must be submitted with each application.

No.	Documents required
1	**The new medical evidence.** • This must be from a registered medical practitioner. Copies of reports previously considered do not represent new evidence and are not acceptable. • Complete reports are needed. Extracts or part reports are not acceptable. • If the appellant wishes, the medical evidence should be submitted in a sealed envelope for the attention of the Scheme Medical Adviser (SMA).
2	**All relevant information relating to the previous consideration of the case** whether held by the employer or by their occupational health adviser (including the complete sickness absence record and a job description).
3	**All other paperwork** previously submitted by the employer as part of the original application (including SMA correspondence).

Please note: any documents sent by post to the SMA should be enclosed in two sealed envelopes.

9.1.5 Failure to include any of this material will result in the case being returned to the referror. The employer must not send any other files (for example personal, HR or Pension files) to the SMA.

9.1.6 Approaches to the Scheme Administrator or the employer about procedural irregularities, for example, where it seems that available information was not seen by the person making the final decision or by the SMA, are not part of these appeals procedures. For all practical purposes, such approaches may be dealt with in an administrative ad hoc way as they occur.

Action by the SMA

9.1.7 Whether considering a first or second appeal there are three different options open to the SMA.

- Uphold the appeal returning the case to MyCSP or the employer for a final decision.
- Reject the appeal (it goes no further) remitting the case back to the authorising authority/ employer for a final decision. Referring a borderline case to a physician independent of the medical adviser for a further paper-based assessment. Either the chief medical adviser or deputy chief medical adviser to the contract would only make such a referral. The independent physician may uphold or reject the case at this final stage, remitting it back to the authorising authority/employer for a final decision.

9.2 A first appeal

9.2.1 A senior physician will consider the appeal in the light of the new medical evidence provided by the member. The senior physician who considers the first appeal will be different from the one who made the original decision.

9.2.2 The appeal is normally considered based on the information submitted. However, a consultation may be required if the physician considers it necessary.

9.2.3 The first appeal may uphold the original decision or result in an increase to the level of award.

9.3 A second appeal

9.3.1 Any second appeal is considered by a SMA physician different from either the one who gave the original advice and/or who considered the first appeal. In most cases, the physician considering the second appeal will be a senior physician.

9.3.2 Any second appeal may do as the first appeal but can, in addition, lower the level of apportionment and/or earnings impairment if the new medical evidence justifies it.

9.3.3 This completes the formal injury benefit appeal arrangement. If a member has any concerns about the way the process has operated in their case, they should refer to the Independent Disputes Resolution (IDR) procedure. Information about the IDR procedure can be found on the Civil Service Pensions website: www.civilservicepensionscheme.org.uk.

Injury benefit reviews

10 Background

10.1 There is no formal appeal procedure against the Scheme Administrator (MyCSP) or the employer decision in not deeming an injury as a qualifying injury (for injuries sustained at any time), and/or about the level of earnings impairment (for injuries sustained on or before 31 March 2003).

10.2 A member can request a review (informal appeal) against the Scheme Administrator or the employer decision in the following circumstances:

- not deeming an injury as a qualifying injury (for injuries sustained at any time); and
- about the level of earnings impairment (for injuries sustained on or before 31 March 2003).

Please note: unless previously supplied, the employer should give the appellant details of the scheme's qualifying criteria. It will also be helpful to provide a copy of this guide. The member should be encouraged to give a copy of whatever is provided to their medical carers as background.

11 Criteria

11.1 The criteria applied when considering a case in which a review has been requested (informal appeal) are the same as for injury benefit.

11.2 The criteria used in determining whether a person has suffered a qualifying injury depends on when they suffered their injury. For most purposes, a qualifying injury is one which occurs in the course of official duty, or an activity reasonably incidental to it and if:

- the injury was sustained before 1 April 1997 and is directly attributable to the nature of the duty;
- the injury was sustained between 1 April 1997 and 31 March 2003 and is solely attributable to the nature of the duty; or
- the injury was sustained on or after 1 April 2003 and is wholly or mainly attributable to the nature of the duty.

11.3 The final decision on whether or not a qualifying injury has occurred rests with the Scheme Administrator. The role of the Scheme Medical Adviser is to provide advice on the medical aspects of a case.

12 Process

The review request (informal appeal) should be made **at the earliest possible opportunity following the initial award decision**. **There is no strict time limit in respect of a request for review**.

The review may uphold the original decision or support the grounds of the review request.

12.1 Actions

Action by member

12.1.1 All requests for review must be made in writing. The review request should set out the basis for reconsideration (for example, in relation to the Scheme Administrator (MyCSP) or the employer decision in not deeming an injury as a qualifying injury

– for injuries sustained at any time, and/or about the level of earnings impairment – for injuries sustained on or before 31 March 2003). The review request should be made through the Scheme Administrator or the employer. Request for review should be based on fresh evidence. This evidence may relate to employment matters or alternatively medical aspects of the case. Fresh medical evidence would certainly be required where the Scheme Administrator or the employer decision not to grant an award has been predominantly based on medical advice provided by the Scheme Medical Adviser (SMA).

Please note: it is for the appellant to source, provide and pay for any further medical evidence, not the employer.

Action by employer/ the Scheme Administrator

12.1.2 Where the fresh evidence relates to employment matters, the Scheme Administrator or the employer may be able to undertake the review without resorting to further medical advice.

12.1.3 When the review request focuses on fresh medical evidence and/or employment matters and further medical advice is required, the employer should make an application to the SMA using form CSIBS2.

12.1.4 The following documents must be submitted with each application.

No.	Documents required
1	The new medical evidence. This must be from a registered medical practitioner. Copies of reports previously considered do not represent new evidence and are not acceptable. Complete reports are needed. Extracts or part reports are not acceptable. If the appellant wishes the medical evidence should be submitted in a sealed envelope for the attention of the medical adviser.
2	All relevant information relating to the previous consideration of the case whether held by the employer or by their occupational health adviser (including the complete sickness absence record and a job description).
3	All other paperwork previously submitted as part of the original application (including SMA correspondence as).

Please note: any documents sent by post to the SMA should be enclosed in two sealed envelopes.

12.1.5 Failure to include any of this material will result in the case being returned by the SMA. You must not send any other files (for example personal, HR or pension files) to them.

12.1.6 Approaches to the Scheme Administrator or the employer about procedural irregularities, for example, where it seems that a piece of available information was not considered are not part of these review procedures. For all practical purposes, such approaches may be dealt with administratively as they occur.

Action by the SMA

12.1.7 There are three different options open to the SMA when considering a review application.

- To uphold the grounds for the review of the request remitting the case back to the Scheme Administrator for a final decision.
- Reject the review request (it goes no further) remitting the case back to the Scheme Administrator for a final decision.
- Referring a borderline case to the physician independent of the SMA for a further paper-based assessment. Such a referral would only be made by either the SMA's lead clinician or their deputy. The independent physician may support or reject the case, remitting it back to the Scheme Administrator for a final decision.

12.1.8 This completes the injury benefit review arrangements. If a member has any concerns about the way the process has operated in their case, they should refer to the Independent Disputes Resolution (IDR) procedure. Information about the IDR procedure can be found on the Civil Service Pensions website: www.civilservicepensionscheme.org.uk.

Annex A

Meaning of particular terms by scheme

Classic terms

Prevented – means having a significant incapacity. It does not mean 'unwilling', 'disinclined to' or 'inconvenient to' undertake the duty. The employer will have obtained occupational health advice to identify any employment adjustments to overcome the obstacles to working. The individual will usually have co-operated with this. The employer will only consider ill health retirements if they conclude that such adjustments are on balance unreasonable or unfeasible to implement. Collusion between employer and employee to manipulate the pension scheme is considered fraud.

Ill health – means a recognised medical condition that gives rise to the incapacity. Diagnosis must be supported by appropriate clinical findings.

Discharging his/her duties – means providing regular and efficient service in the normal duties of their responsibility level. It does not mean 'all work' in the Civil Service context.

Note: individuals do not have to be incapable of attending work, but rather incapable of providing acceptable levels of performance or attendance. What is 'acceptable' is governed by the requirement to make reasonable adjustments for those with health problems and, particularly if they are likely to fall within the scope of the Equality Act and equivalent legislation in Northern Ireland.

Likely – means 'on a balance of probabilities'. The permanence of the ill health does not have to be 'beyond reasonable doubt' but rather more likely than not. The Scheme Medical Adviser (SMA) takes into account the effect of standard treatment when considering the incapacitating effects of a condition. In doing this they take into account the chances of a successful outcome.

Permanent – means until scheme pension age. Not only does the ill health have to be permanent but also it has to result in permanent incapacity. Many permanent medical conditions (for example asthma, diabetes, epilepsy) do not usually prevent individuals from working normally.

Premium, nuvos, and alpha terms

Permanent – means until scheme pension age. Not only does the breakdown in health have to be permanent but it also has to result in permanent incapacity. Many permanent medical conditions (for example, asthma, diabetes, or epilepsy) do not normally prevent individuals from working normally.

Breakdown in health – means ill health caused by a recognised medical condition giving rise to the incapacity. Diagnosis must be supported by appropriate clinical findings.

Incapacity – means unable to work due to the breakdown in health.

Prevents – means having a significant incapacity. It does not mean 'unwilling', 'disinclined to' or 'inconvenient' to undertake the duty. The employer will have obtained occupational health advice to identify any employment adjustments to overcome obstacles to working. The individual will usually have co-operated with this. The employer will only consider ill health retirements if they conclude that such adjustments are on balance unreasonable or unfeasible to implement. Collusion between employer and employee to manipulate the pension scheme and is considered fraud.

Discharging their duties – means providing regular and efficient service in the normal duties of their responsibility level. It does not mean 'all work' in the Civil Service context.

Note: individuals do not have to be incapable of attending work but rather incapable of providing acceptable levels of performance or attendance. What is 'acceptable' is governed by the requirement to make reasonable adjustments for those with health problems and, particularly if they are likely to fall within the scope of the Equality Act and equivalent legislation in Northern Ireland.

Incapable of undertaking other gainful employment – the individual's functional ability to carry out any reasonable paid employment should have been impaired by more than 90%. That is, they may be capable of undertaking some types of job, but this is severely restricted by their loss of function caused by the illness.

Incapable of doing own job or a comparable job – means unable to turn up regularly to do a job at the same or equivalent grade level. They will however be capable of doing a range of other types of work.

Pension age – means the earliest age at which a member can take their pension without it being reduced because of early payment.

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