SPPA

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Firemasters

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Dear Sir or Madam

SCOTTISH FIRE SERVICE CIRCULAR No 2/2003

FIREFIGHTERS PENSION SCHEME

This circular advises Fire Authorities on the introduction of an independent qualified Medical Adviser, and other matters.

It should be brought to the attention of your fire authority, pension managers, brigade medical officers/occupational health managers and Human Resources; and to all members of the FPS.

1. **Purpose of this circular**

1.1 To give guidance regarding the changes in procedures arising from the implementation of Recommendations 14, 17, 18 and 19 of the Review of Ill Health Retirement in the Public Sector (HM Treasury, July 2000) (http://www.hm-treasury.gov.uk/mediastore/otherfiles/76.pdf). These deal with the definition of permanence and requirements that the medical assessment of ill health retirement should be in two stages with an independent medical practitioner qualified in occupational health carrying out a second assessment and making a recommendation on whether or not the pension scheme criteria are satisfied. (Extracts from the Treasury Review are annexed at A).

1.2 The proposals outlined in this guidance have been discussed and agreed with the Pensions Sub-Committee of the Central Fire Brigades Advisory Councils for Engaland and Wales and Scotland (CFBAC).

2 Ill-health Retirement

2.1 When conducting the Review of Ill Health Retirement in the Public Sector, the reviewers considered that 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 pension scheme criteria specifies he/she must be incapable of doing to qualify for ill health retirement. Non-medical factors should not be allowed to influence the medical judgement. It was felt that the physician who has advised an employer up to the point of consideration of an employee's retirement may face a conflict of interests and come under pressure to make a biased judgement. Similarly, the employee's GP or hospital specialist are ethically bound to be sympathetic to their patient.

2.2 With this in mind the review recommended that the final assessment for ill health retirement (pension award) should be conducted at arm's length from the employer to ensure that any assessment is based on objective and impartial medical evidence by an independent occupational health physician. Where such arrangements do not exist steps would need to be taken to put them in place. In the case of pay as you go schemes, such as the Firefighters Pensioins Scheme, it is expected that the doctor's independence will be protected, if a number of employers share the costs and he is not therefore under an obligation to any of them.

2.3 In addition, the current review of injury awards by the Treasury is also expected to pick up on this and to recommend that all decisions on injury awards be made by an independent occupational health physician.

2.4 The independent occupational health physicians should preferably be an accredited specialist in occupational health medicine and on the Specialist Register of the General Medical Council. The minimum requirement will be that the physician will hold a diploma in occupational medicine or be an associate of the Faculty of Occupational Medicine, or equivalent.

2.5 A range of options for implementing these requirements was discussed by the CFBAC Pensions Sub Committee who considered that the most suitable way forward would be to introduce arrangements for peer review or to use a second practitioner as a shared resource.

2.6 Whichever option is adopted the independent qualified medical practitioner appointed to conduct the review must be in a position to certify that:

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

(b) he/she is not acting, and has not at any time acted, as the representative of the scheme member, the employer or any other party in relation to the same case.

2.7 This builds on the requirement in Rule H1 that the employer, before making a decision on retirement benefit cases where ill-health may be relevant, must obtain the opinion of at least one qualified medical practitioner selected by them. This has normally been the brigade medical advisor who may or may not have qualifications in occupational health. In future the medical practitioner selected for the opinion required under Rule H1 must be qualified in occupational health medicine.

2.8 The opinion, which should be given in the form of a certificate, must give the approved medical practitioner's opinion as to:-

- whether a person has been disabled;
- whether any disablement is likely to be permanent;
- whether any disablement has been occasioned by a qualifying injury;
- the degree to which the person is disabled.

- whether a person has become capable of performing the duties of a regular firefighter; or
- any other issue wholly or partly of a medical nature.

2.9 Whilst it is intended that the requirements will be **statutory** by amendments to the Firemen's Pension Scheme Order 1992 (drafting of the necessary statutory instrument will begin asap) Fire Authorities are asked to instigate action to put the new systems in place on a voluntary basis on receipt of this circular.

2.10 Rule H1(2)will be amended to require the Fire Authority to consider the opinion of an independent qualified medical practitioner before determining the medical questions contained in that Rule. In addition, in the glossary of expressions in Schedule 1, Part 1 a reference to "independent qualified medical practitioner" will be added, explaining what is meant by "independent", specifying the requirement that the person must be a person qualified in occupational health medicine and listing the relevant qualifications. The qualifications are listed at Annex B. Medical certificates must carry a "Statement of Independence". Model forms contained in Annexe 7 to the Commentary on www.safety.odpm.gov.uk/fire/pensions/index.htm will be amended to contain the relevant statement when the appropriate amendments have been made to the Firemen's Pension Scheme Order 1992. For the time being, however, a "free-standing" form containing the necessary statement has been prepared (see Annex C of this Circular). This form should be completed by the independent medical practitioner and attached to any current certificates as appropriate.

2.11. Previous guidance regarding occupational health schemes recommended that all Brigade Medical Advisors should have occupational health qualifications. Recommendation 19 of the Treasury Review is mandatory and any BMA appointed from the date of this circular should hold an appropriate occupational health qualification. These qualifications are listed at Annex B.

3. Suggestions for implementation

3.1 How independence is achieved is a matter for the Fire Authority to determine. It is recognised that there will be additional costs but there are no additional central funds available to meet them; however, you may wish to consider adopting one of the following:

(a) set up an arrangement whereby brigade medical advisors from neighbouring brigades review cases on a reciprocal basis;

(b) employ an extra medical practitioner for this purpose who is a shared resource with other brigades;

(c) where the brigade uses an outside contractor for occupational health matters – the medical practitioner that deals with the employee during employment should differ from the one reviewing the case and signing any certificate to be used for the determination of an award under Rule H1.

3.2 It is expected that normally the independent medical practitioner would conduct a paper review of the case, only conducting a medical examination where he/she considered it essential.

4. Disagreement between Medical Advisors

4.1 Questions have been asked about process and the handling of cases where there is disagreement between the medical practitioners. There is no intention to make the decision of either the BMA or the independent medical practitioner binding on the Fire Authority and, as now, it will be for managers to reach a decision based on the evidence before them.

4.2 Where there is disagreement it will be necessary to ensure that the recommendations are evidence based and the medical practitioners should be asked to provide documentation to support their recommendation as appropriate.

4.3 It may also be helpful to call a case conference involving individuals with an interest in the case; e.g. medical practitioners, personnel and managers so that any concerns can be addressed before a decision is made.

5. **Permanently disabled**

5.1 Recommendation 15 of the Treasury Review recommended that the definition of permanently disabled should be taken to mean "incapable until the normal date of retirement". In terms of the Firemen's Pension Scheme this would mean in the case of divisional officer or more senior rank, on attaining the age of 60, or in the case of station officer or a lower rank, on attaining the age of 55. Permanence may be difficult to determine. We take the view that since Rule A10(1) defines references to "permanently disabled" as reference to (the firefighter) "being disabled at the time when the question arises for decision and to his disablement being at that time likely to be permanent", the test should be that, at the time the question arises for decision, it is more likely than not that this person will be incapable of performing efficiently the duties of the relevant employment until age 55/60. An amendment will be made to the Firemen's Pension Scheme.

5.2 It is recognised that there may be difficulties arising from this definition in relation to injury award cases under Rule B4 and that there may need to be a distinction made in the definition of "permanent" for ill health and injury award cases. This will be considered further once the Review of Injury Benefits referred to in paragraph 2.2 above has been completed.

6. **Best Practice**

6.1 Where possible the new arrangements will be kept under review and lessons learned and best practice identified will be circulated.

Yours faithfully

Jim Preston

Extracts from Review of Ill Health Retirement in the Public Sector (HM Treasury, July 2000)

3. Tackling the increase in Ill Health Retirement

Scheme Rules and procedures

Paras 3.29 to 3.31

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.

Medical assessment

Paras 3.35 to 3.38

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.

4. Recommendations

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".

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.

Annex B

Occupational Health Medicine – Qualifications

Diploma in Occupational Medicine (D Occ Med)

The Faculty of Occupational Medicine (FOM) established the Diploma in Occupational Medicine specifically for doctors working part-time in occupational medicine or who have an interest in occupational health as it affects other branches of medicine. Although the Diploma demonstrates a level of competence appropriate to a generalist (often a GP) working in occupational health, it does not form part of the formal training route to specialist accreditation. The qualification enables a practitioner to recognise when he/she should seek specialist assistance on occupational health matters.

Associate of the FOM (AFOM)

Associateship of the Faculty of Occupational Medicine is obtained on passing the required examination. To be eligible to enter for the examination candidates are normally expected to have spent not less than six months in one, or more, full or part time posts in occupational medicine. It is an obligatory qualification for doctors seeking specialist status and demonstrates a degree of competence above that of the Diploma for those doctors in part time practice or not seeking specialist recognition.

Membership of the FOM (MFOM)

Membership of the Faculty of Occupational Medicine is awarded to Associates on satisfactory completion of the Higher Specialist Training (HST) and acceptance by the FOM of a dissertation, thesis or substantial published work submitted for that purpose. It is an essential requirement for those seeking Specialist Accreditation. HST has a minimum duration of 4 years and must take place in supervised posts approved by the Faculty of Occupational Medicine and is subject to regular scrutiny by the regional dean.

Fellowship of the FOM (FFOM)

The Board of the Faculty of Occupational Medicine awards Fellowships to those Members who made a significant contribution to the speciality and who demonstrate above average experience and expertise in the speciality.

…….. **FIRE AUTHORITY**

FIREMEN'S PENSION SCHEME ORDER 1992

Statement of Independence

This form should be completed by the independent medical practitioner qualified in occupational health medicine selected by the Fire Authority to provide the written opinion required under Rule H1(2).
It should be attached to the Medical Certificate given by that medical practitioner

Name of firefighter ……..

Brigade number …….. Date of Certificate ……..……

In the attached Certificate I have given my written opinion as requested by the Fire Authority under Rule H1 in respect of the above firefighter.

I am qualified in occupational health medicine as required by the Firefighters' Pension Scheme*

I have not previously advised, or given an opinion on, or otherwise been involved in this particular case for which the Certificate has been requested.

I am not acting, and have not at any time acted, as the representative of the above-named person, or the employer, or any other party in relation to this case.

Signed ……... Date …….

Name ……

Qualifications ……...

Signatory's official stamp

** Certification under the Order may only be provided by an independent medical practitioner qualified in occupational health medicine. This means holding a diploma in occupational medicine (D Occ Med) or an equivalent qualification issued by a competent authority in an EEA State (which has the meaning given by the European Specialist Medical Qualifications Order 1995) or being an Associate, a Member or a Fellow of the Faculty of Occupational Medicine or an equivalent institution of an EEA State.*

Flow chart incorporating new procedures for assessment and decision making process in ill health retirement cases

Step 1

This is the same as current procedures. The brigade medical advisor (or medical practitioner from an external contractor) considers whether or not the firefighter is permanently incapacitated

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Step 2

The case is passed to the second stage independent qualified medical practitioner who then conducts a review of the case. The review can be a purely paper review or can include a medical examination. The independent medical practitioner gives a medical opinion for the purposes of Rule H1 of the Firemen's Pension Scheme Order 1992.

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Step 3

The medical opinion is passed to the Fire Authority who take account of the medical evidence and make a decision about retirement and award.

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Step 4

Responsibility for making the final decision rests with the fire authority. If the two medical practitioners give conflicting medical opinions then it is still for the fire authority to make the final decision considering the medical evidence put before them. The fire authority may in some cases find it helpful to conduct a case conference including both medical practitioners in a discussion about the case prior to making a decision.