MANAGING MEDICAL RETIREMENTS IN THE POLICE SERVICE

Briefing Note
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The views expressed in this briefing note are those of the authors, not necessarily those of the Home Office (nor do they reflect Government policy).

Introduction

Currently police officers can retire with a maximum pension:
- on completion of 30 years’ service;
- on completion of 25 years’ service (with pension payable from age 50);
- on reaching compulsory retirement age (55 for the majority of officers);
- on grounds of ill-health at any age.

Loss of staff through medical retirement has significant cost implications for annual police budgets (HMIC, 1997; Audit Commission, 1997; and Poole, 1997). Medical retirements currently constitute 31% of all retirements for police officers (1999/2000); this figure is a substantial reduction in recent years; however, today levels of medical retirement vary widely between forces, ranging from 6% in Staffordshire to 56% in Greater Manchester (1999/2000).

The Treasury-led ‘Review of Ill-Health Retirement in the Public Sector’ (July 2000) made a number of recommendations aimed at ensuring that medical retirement provisions are properly used by public sector employees. Among those recommendations, two that could be expected to reduce the number of police officers taking medical retirement are:
- making greater use of alternative, restricted duties where possible;
- increasing access to multi-disciplinary occupational health services, to prevent employees’ health from deteriorating to the extent that officers need to be medically retired.

In early 1999, the Association of Chief Police Officers’ Equality Sub-Committee, the Home Office Police Personnel & Training Unit (PPTU) and National Police Training Unit (NPT), expressed interest in research into the management of police sickness absence and medical retirements. The aim of the research was to provide information on the range of initiatives that have been implemented by different forces to target these problems. Research on medical retirements was combined with work on the management of sickness absence because the two are closely related.

Methodology

The study comprised four main components:
- literature review and secondary data analysis (HMIC data);
- postal survey to all forces;
- telephone interviews with personnel and occupational staff;
- focus group discussions about local initiatives.

Thirty-eight forces took part in the postal questionnaire; 25 forces participated in telephone interviews. The focus groups comprised a mixture of 6-8 sergeants and civilian line-managers in five forces. Forces were selected according to the range of initiatives recently implemented. The forces also indicated a range of sickness levels, and changes in these levels (increases and decreases) over the last few years, and were drawn from rural and urban, northern and southern regions. The full methodology is described in more detail in ‘Arnott & Emmerson, (2001), In Sickness and in Health: Reducing Sickness Absence in the Police Service’.

Research findings

Force responses indicated that there were 20 forces undertaking specific initiatives to reduce medical retirement costs. Techniques included:
- greater use of restricted duties;
- development of leaving schemes;
- more stringent controls on the medical retirement process as a whole.
Use of restricted and recuperative duties

Ten forces in the postal survey indicated that when officers are certified as ‘disabled’, and unable to continue in their current role, the forces encouraged greater use of restricted posts, rather than automatic medical retirement. This strategy has been supported by Her Majesty’s Inspectorate of Constabulary (HMIC, 1997), the Public Accounts Committee (PAC, 1998), and the Treasury (2000) as an important way to retain staff, while helping the individual to complete the full 30 years’ of service. It is especially relevant in light of the expected removal of police exemptions to the Disability Discrimination Act (1995)\(^2\). However, it was reported that high levels of civilianisation are making it difficult to identify suitable posts for disabled officers. Focus groups also highlighted that available posts were often inconsistently delegated, depending on the number of medical retirements that were agreed earlier in the year.

Implementation issues: The following issues need to be considered when determining the benefits of retaining any individual in a restricted post.

- **Priorities** - consider those on long-term waiting lists, and the competence of the individual.
- **Equality issues** - ensure consistency in allocation, according to the needs/abilities of the individual, rather than quota systems according to financial constraints. The Disability Discrimination Act (1995) will have equality implications for the police; when current exemptions are removed, forces will be required to seek posts for disabled officers.
- **Cost implications** - the benefits of retaining staff can be calculated on a cost-neutral basis (i.e. balance the cost of the annual pension and lump sum against additional cost of officer salaries in a civilian position, likely length of service, potential days lost to sickness and end of service pension).
- **Reviews** - duties should be subject to a stringent review and monitoring procedures by occupational health services in cases where the individual’s condition may improve or deteriorate.
- **Managing staff wishes and needs** - agreement with the individual remains paramount to effective re-deployment.
- **Changes in sickness absence levels** - if officers are able to cope with restricted duties then the level of sickness absence may not rise.

Development of leaving schemes

Focus group discussions suggested that one of the major groups of officers seeking medical retirements were those who had lost motivation with their job. However, the nature of the pensions arrangements gives officers no incentive to resign. Maximum pension benefits are available after 30 years’ service, or in the event of medical retirement after 26½ years’ service. Although all police pensions are fully index linked, it is only enjoyed from the age 55 in the case of normal retirement; in cases of medical retirement, index linking is applied with immediate effect. Early retirement with an immediate pension – other than on completion of 30 years’ service – is only possible for those who have completed 25 years’ service, and who are aged 50 and over. Although the regulations provide for retirement after 25 years’ service, with pension paid from age 50, there is no provision for early retirement at age 50 with less than 25 years’ service. There is also no provision for redundancy. The stepped accrual of service enhancements that apply in the event of medical retirement, while a common feature of public sector pension schemes, create incentives for officers to leave at particular stages in their service.

Some forces have developed schemes for officers wishing to leave the service, offering advice on health issues, financial investments, and career and training opportunities, to help officers identify the range of their transferable skills, and prepare them for alternative employment. One such scheme is the ‘Leaving with Dignity’ initiative by West Yorkshire Police – Box 1 gives more information about this scheme.

**Box 1: West Yorkshire’s ‘Leaving Service with Dignity’ scheme**

This scheme provides career-counselling and outplacement services to officers wishing to leave the police, and is advertised in the *Force Weekly Bulletin*. Officers may request an information pack directly from the outplacement consultants, Capita, and then submit an application to the force via the occupational health unit. An interview is conducted to explore the underlying issues and reasons for the officer’s interest in the scheme and whether there are, in fact, any organisational issues that could be addressed to resolve the problem without the officer leaving. Officers are then referred back to Capita for 4 half-day one-to-one career counselling sessions. These sessions include:

- Review of their current situation to assess what is motivating them to change;
- Identification of transferable skills and barriers to change;
- Raising awareness of the options available to them; how to obtain further information regarding these options;
- Examination of the job market

Capita maintain a database of 20,000 jobs, and appropriate opportunities will be discussed with the individual. Should the officer wish to proceed, they will then resign, and receive three months of outplacement support which will include tailored training sessions on finance, aspirations, skills and opportunities.

**Uptake:** By April 2001, 18 information packs had been sent out; seven completed and returned to Capita; five referrals were taking place.

Three other forces offered similar packages to this, although at the time of the study, the schemes had not

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\(^1\) ‘Restricted duties’ refers to a permanent change in role, where the officer is unlikely to ever be fully fit for full operational duty.

\(^2\) This will require forces to make ‘reasonable ‘adjustments’ if their employment arrangements place disabled persons at a substantial disadvantage compared with non-disabled persons.
been running long enough to evaluate their success. Although there appears to be a perception to the contrary, deferred pension benefits can be transferred out into a private pension or other occupational pension schemes. Deferred pensions are also index linked, although payable only from age 60. It will, however, always be difficult to encourage officers to resign when they will no longer qualify for a full pension – payable in most cases before age 55.

More stringent controls

Review of policies and management processes

Many forces had revised their policy documents to define, within the provisions of the pension regulations, stricter criteria for medical retirement, and a clearer illustration of the retirement process, including flow charts of necessary lines of referral. They were also adhering more strictly to these policies and closely monitoring cases, with a resulting reduction in the numbers of medical retirements. Discussion of cases separately to medical retirement decisions in almost all cases; all ‘facts’ are fully investigated. Causal links must be established for the award to be granted. According to research undertaken by the MPS, they have reduced their medical retirements from an annual total of 500 to 260 in 1999/2000.

Box 2: Medical retirement process

The Metropolitan Police (MPS) have a team of three people, who focus exclusively on the medical retirement process. The team investigates all contributory factors to cases of medical retirement, and presents on a weekly-basis to the Occupational Health Business Director, who acts as the ‘Police Authority’ under the Police Pensions Regulations, and makes the final decision on medical retirement cases. Decisions to refer the statutory questions to the selected medical practitioner are made at the weekly meetings. Injury awards are considered separately to medical retirement decisions in almost all cases; all ‘facts’ are fully investigated. Causal links must be established for the award to be granted. According to research undertaken by the MPS, they have reduced their medical retirements from an annual total of 500 to 260 in 1999/2000.

Role of the Force Medical Officer

The Force Medical Officer (FMO) is responsible for providing medical advice on management decisions, and is therefore vital to maintaining tight control of the retirement process. However, conflicts of interest have previously arisen between the occupational health advisory role of the FMO and when the FMO is used as a GP service. The Treasury-led review of ill-health retirement in the public service (2000) recommended that two doctors should be involved in medical assessment, one being an independent occupational physician. This issue was also highlighted by a number of survey respondents and focus groups participants, who felt that the role of the FMO should be purely advisory for management decisions, and should be completely separate from the occupational health unit (OHU). This would however, require expansion of current OHU facilities.

Implementation Issues: Where occupational health doctors do not have the specialist knowledge required to make a satisfactory prognosis on likely recovery and capabilities of an individual officer, several forces suggested the benefits of referring the individual to an appropriate consultant for a second opinion. This procedure entailed a high cost (circa. £600 per case). However, it provided a more detailed understanding of the medical condition, the level of disablement, likelihood of recovery, and potential capabilities with regard to recuperative or restricted duties. Referees’ opinions could also be employed to support appeal hearings. Some forces have explored the possibility of joint procurement of this service.

Legal issues

The main legal issue surrounding the eligibility for medical retirement revolves around the definition of ‘permanent disablement’ and ‘ordinary duties’ as defined within the Police Pension Regulations (1987).

‘Permanence’

Regulation A12 defines ‘disablement’ as “inability, occasioned by infirmity of mind or body, to perform the ordinary duties of a male or female member of the force”, ‘permanently disabled’ is defined as “being disabled at the time when the question arises for decision and...that disablement being at that time likely to be permanent” – i.e. no reasonable prospect of recovery in the foreseeable future. There is scope for interpretation of the regulations on this point, and definition varies between forces. Home Office guidance suggests that forces regard disablement as being permanent, however some forces have interpreted permanence as being, in excess of a year. The Treasury-led report recommends however, that permanently disabled should be interpreted more strictly, to mean disablement until normal pensionable age.

‘Ordinary duties’

There is no definition of the term ‘ordinary duties’ in the Police Pensions Regulations (1987). One opinion was that this should be a balance of competence and skills and the posts available, and should entail a broad
definition, not just operational duties. However, this has not been supported in recent court judgements and is highlighted in Box 3.

**Box 3: Recent case law in medical retirement appeals: R v Sussex Police Authority ex parte Stewart (29 November 1999)**

The case concerned an ex-police officer who was subsequently requested to return to work on the basis that she was fit to do so. The Police Authority’s case was that within the generic definition of what constitutes the ‘ordinary duties of a constable’ the former officer could be found a meaningful/productive role within the police. However, the Court’s view was that essentially the role of constable related to operational patrol (or related) activities and if the individual was not fit to perform these tasks, she was not fit to fulfil the ordinary duties of a constable under the regulations. The Police Authority sought permission (from the House of Lords) to appeal to the House of Lords, on the grounds that (1) it is for the Police Authority to decide the question of permanent disability, not the individual, and that (2) under Regulation A20, there is scope for forces to retain unfit officers in appropriate roles. Permission to appeal was refused in November 2000.

Under the regulations, disablement, and the permanency of this disablement, should be considered as two separate issues (current practice by West Midlands Police). In accordance with the *R v Sussex Police Authority* interpretation of ‘ordinary duties’, even when an officer is certified as ‘permanently disabled’, there is no obligation for a force to set a date for retirement, when there are duties that the officer is capable of undertaking.

Force personnel respondents commented that medical retirement had become an issue increasingly based on the legal interpretation of the pension regulations. Therefore, who drafted the submissions to medical referees had become vital. Many forces were increasing using their force solicitor for this, West Midlands Police have set up an informal consortium of forces, which meets quarterly to disseminate ideas, information and best practice. The group includes legal, personnel and medical representatives. The existence of such a group demonstrates a need for such communication on a national basis. Suggestions were made to set up a series of regional networks to feed into a national forum.

**Case preparation for appeals**

Five forces indicated that they were trying to improve the consistency and quality of case appeal preparation, through greater collaboration and sharing of legal expertise between forces. This integrated approach to appeals has increased the percentage being won by police forces and police authorities (currently circa. 40% of appeal cases), while maintaining greater consistency and transparency of the process. Developments have included:

- **Greater knowledge of case law and the retirement process:** Two forces had appointed a researcher to compare forces’ approaches to the medical retirement process; West Midlands are currently developing a database of precedents and specialist knowledge on the case law surrounding medical retirements.

- **Quality of medical referees:** Some forces suggested that referees were often lacking understanding of various terms in the regulations. Although guidance is issued to referees, it was considered that a bank of suitable referees should be developed. It was also proposed that like the fire service, tribunals should be convened for this purpose, although this would be expensive, it would provide a more consistent and reliable system than exists at present.

- **Claiming back the cost of referee fees in cases where the appellant loses:** In cases where medical retirement is refused, or the injury award agreed is deemed insufficient, the individual may appeal this decision. Claiming back the costs of appeals helps to discourage unjustified claims.

- **Surveillance:** The gathering of evidence by forces to contest an appeal against a rejected medical retirement decision, via the covert observation of the appellant, assists forces in the medical appeals process, and engenders subsequent savings in pension costs. Surveillance helps to convey a strong message that medical retirement will only be considered where there is no alternative option, and has been used in a small number of high-profile cases. However, this approach has potential legal implications with regard to the Human Rights Act, in particular Article 8: i.e. the right to respect for private and family life, therefore proper protocols must be developed before employing such methods. Four forces indicated that they made occasionally used such techniques; six were considering this as a possible option, whereas 15 forces stated that they would not make use of such methods on moral and legal grounds.

**Case reviews and injury awards**

Injury awards, based on loss of earnings potential rather than simply the degree of mental or physical impairment, can constitute a significantly higher expense than that awarded through the basic medical retirement pension. However, in many cases, an officer’s health and earnings potential may improve following retirement, and many forces indicated that the were making increased use of Pension Regulation K2, to assess whether an individual’s health has improved/deteriorated after retirement, and therefore reduce ongoing costs. It was suggested that this should be used more regularly as a standard component of the retirement process.

**Implementation issues:** By reviewing awards, earnings potential may have decreased, but there is also the possibility it may have increased. Officers may also refuse to attend a review, especially if they are still
waiting for an appeal. In light of this, it was considered that officers should be exempt from this review over a certain age, or where they had already completed 25 years’ service.

Conclusions and points for action

Actions to reduce costs should include:

- Exploring options for restricted duties prior to considering medical retirement, taking into consideration both individual and organisational impacts. Comprehensive costing models should be developed to assess the benefits of releasing or retaining staff, taking into account the expected medical retirement costs and possible injury awards, in comparison to the costs of maintaining the officer in restricted duties.

- Actively using sickness monitoring groups to encourage greater communication and consistency of decisions. Identified restricted duties should require a system of clearly defined periods of review.

- Investigating the provision and demand for out-placement and leaving schemes, to encourage alternative methods of leaving the force, other than medical retirement.

- Amending the Police Pensions Regulations – for example, replacing the current appeals system with appeals panels.

- Establishing a distinction between the force medical officer and the occupational health unit; where possible, the force medical officer should purely act in an advisory capacity on managerial decisions, i.e. questions of disablement.

- Using ‘second opinions’, where the force medical officer lacks the specialist knowledge to answer questions of disability, permanence, and identifying potential roles and capabilities. This resource could potentially be shared between forces, through regional groups around the country.

- Distinguishing between different stages in the process, i.e. the question of disablement, agreement to medically retire, and granting of injury awards.

- Claiming back the cost of the referee’s fee, where the individual loses the appeal.

- Implementing a structured process of review following retirement.

Related PRC papers


References


