Ombudsman's Determination

Applicant	Mrs R
Scheme	Nationwide Pension Fund (**the Scheme**)
Respondent	Nationwide Pension Fund Trustee Limited (**the Trustee**)

Outcome

1. I do not uphold Mrs R's complaint, and no further action is required by the Trustee.

Complaint summary

2. Mrs R's complaint concerns the Trustee's decision not to award her a permanent incapacity early retirement (**PIER**) pension. She is also unhappy with the way her application was handled.

Background information, including submissions from the parties

3. The Scheme is governed by the Nationwide Pension Fund Rules (**the Rules**). Relevant sections from the Rules are set out in Appendix 1.

4. Mrs R worked part-time for Nationwide as a Customer Representative from February 1986 to February 2019.

5. Between 2013 and 2016, Mrs R suffered from neck and shoulder symptoms. In June 2016, she was referred by her GP for physiotherapy. Her condition deteriorated and she went on sickness absence from 23 February 2017.

6. From 1 June 2017, Mrs R started receiving Prolonged Sickness Benefit which was due to expire on 1 December 2018.

7. Nationwide referred Mrs R to Occupational Health (**OH**) for an assessment in July 2017. The OH report dated 24 July 2017 said:

> "In my opinion [Mrs R] is not fit to return to work due to her current physical symptoms which are continuing to impact on what she can achieve on a day to day basis. [Mrs R] had the assessment with the physiotherapist and recommendations were discussed regarding next steps and sent to her GP.

> However, currently the GP has recommended further exercise, which she is undertaking."

8. In August 2017, Nationwide referred Mrs R for an assessment regarding workplace adjustments with OH. The OH doctor's report dated 7 August 2017 said:

> "[Mrs R] finds all activities including those associated with work aggravate her symptoms. A return to work inside a reasonable timeframe does not appear likely and the business may need to review the employment situation. If a definitive employment decision is to be considered then it may be appropriate to assess whether [Mrs R] would be eligible to early payment of pension benefits or any other ill-health income related schemes."

9. The OH doctor subsequently requested a report from Mrs R's Consultant Orthopaedic Surgeon, Mr Dainton. In October 2017, Mrs R underwent a surgery.

10. In February 2018, Nationwide referred Mrs R for a PIER assessment to its independent medical adviser (**IMA**). She was 55 at the time. In her report dated 21 February 2018, the IMA, Dr Williams, concluded that Mrs R did not meet the criteria for a PIER pension because she was significantly better after the surgery.

11. Extracts from Dr Williams' report and other medical evidence are provided in Appendix 2.

12. The Trustee subsequently decided, on 16 March 2018, to refuse Mrs R's application for a PIER pension based on the IMA's report. This was on the basis that "if progress continues as the Consultant expects, a return to work doesn't seem at all unlikely".

13. On 29 May 2018, Mrs R challenged the Trustee's decision on the basis that the Trustee had reached its view without reading two "critical pre-existing" OH reports dated 24 July 2017 and 7 August 2017. She also said that she was still recovering from her surgery of 31 October 2017 and receiving post-operative physiotherapy.

14. Following this, the Trustee wrote to Mrs R on 8 June 2018, agreeing to reconsider the matter in light of the two reports that had not been taken into consideration when reaching the decision of March 2018.

15. The Trustee subsequently referred the matter to another IMA, Dr Thornton, for an assessment who issued their report on 13 June 2018. The IMA concluded that Mrs R did not meet the criteria for a PIER pension.

16. On 18 July 2018, the Trustee wrote to Mrs R informing her that her application was declined. Mrs R said she did not receive this letter, and the letter was re-sent to her on 27 September 2018.

17. On 28 September 2018, Mrs R raised a formal complaint under the Scheme's two-stage Internal Dispute Resolution Procedure (**IDRP**). In her submissions, Mrs R disagreed with the Trustee's decision to refuse her a PIER pension on the basis that

she did not meet the definition of "Incapacity" under the Rules. She also provided a report from her GP dated 16 August 2018 in support of her case.

18. Following the provision of the GP's report, the Trustee scheduled an OH telephone consultation for her. The OH report dated 2 October 2018 concluded:

> "This lady does appear to be proactive in following the recommendations of her health care team to try and improve her situation. She has now finished physiotherapy but advises she is continuing with her exercise programme. As per this ladies GP report dated 16 August states, I do not believe that she will be fit to return to work, and that her significant problems are going to remain longstanding and prevent her working…this type of health issue can be contributed to by many different factors and only her specialist would be able to indicate as to whether work played a role in her condition."

19. On 24 October 2018, the Trustee sent Mrs R its stage one decision. It said in summary:-

- It had considered afresh her concerns and the relevant medical evidence.
- Its role was not to re-assess her request in the light of "new or updated" medical evidence that had been created/provided since the decision she complained about. If she would like to re-apply or request a reconsideration of the view reached in July 2018, she could do so. But this would need to be considered separately from her IDRP and raised with the Scheme administrator rather than with it (the Trustee), as its role was to look back and consider the validity of the opinion that was reached in July 2018.
- The payment of a PIER pension depended on whether the member met the definition of "Incapacity" at the time of leaving Nationwide's employment. A view taken several months before that date would inevitably not be conclusive and the member was permitted to apply around the time they would leave employment with any medical evidence relevant as at that date, rather than by reference to a much earlier date.
- So, regardless of its decision in relation to her IDRP complaint, she was entitled to apply for a PIER pension at the date she would actually leave employment. If she did apply around that time, then she might support any such application with updated medical evidence, such as a report from her consultant, regarding her state of incapacity/health and her ability to carry on any employment in the period between her date of leaving employment and normal retirement age (**NRA**) of 65.
- The process started for Mrs R in August 2017. It took a number of months for Nationwide to receive a medical assessment from its IMA because the IMA was waiting for a report from her consultant following her operation in October 2017.

- In March 2018, it was concluded that Mrs R did not meet the criteria for a PIER pension, which she challenged on the basis that it had reached a view without having read two critical pre-existing OH reports dated 24 July and 7 August 2017.

- It agreed to reconsider the matter and asked the IMA to review both reports. The outcome was sent to Mrs R on 18 July 2018 and resent to her on 27 September 2018. It was sorry she did not receive the original letter.

- When reaching a view in July 2018, it considered all the relevant medical evidence and had to weigh up such evidence to determine whether or not, she was able to carry out any employment and, if so, whether or not this was likely to continue at least to her NRA.

- Clearly, at the present time, she was unable to carry out her employment so the likelihood of that continuing until NRA was the major issue. While she or others might disagree with its opinion, it did not consider the opinion was reached without a proper regard to the medical evidence and could not be said to be unreasonable when balancing the competing medical opinions at the time.

20. In December 2018, Nationwide held an Employment Review Meeting. In her submissions, Mrs R said:

    - Although she accepted that many factors contributed to her health conditions, it was work-related, linked to computer usage, “with a pattern developing over a period of time”.

    - In recognition of her loyal and conscientious commitment to Nationwide, she hoped it would allow her to retire on the grounds of PIER.

    - She was currently on sick pay. Her sick note was due to expire on 11 January 2019.

21. Nationwide subsequently referred Mrs R for a PIER assessment with OH. She was 56 at the time. In her application, dated 18 December 2018, Mrs R said that her pain and stiffness restricted her movements, and she was unable to perform work tasks, including housework and using IT equipment. She also provided medical reports to support her application.

22. On 28 February 2019, Mrs R’s employment was terminated, on the grounds of capability.

23. On 7 March 2019, Mrs R complained to the Trustee about the way her application had been handled. She said there were “double standards” in the process, and that she had not been kept properly informed of developments without the need to chase or feel concerned.

24. On 20 March 2019, the Trustee responded to Mrs R’s complaint and said in summary:-

- It was sorry to learn of the way Mrs R's application had been handled. It understood that OH had now written to her to offer an apology regarding this matter.

- It understood that OH was awaiting reports from her GP and an independent specialist consultant in support of her case. Once this information had been received, it would consider this further.

- It would oversee the progress of her application and take steps with OH to avoid any further unnecessary delays as it appreciated her employment notice period had expired.

25. On 4 November 2019, another IMA, Dr Wylie assessed Mrs R's case and issued his report. In his view, Mrs R was likely to benefit from further treatment for her right shoulder and physical therapy for her neck and restricted movement. If the latter was not effective, further specialist investigation and treatment might be indicated. He concluded that Mrs R was not at that time indefinitely incapable of carrying on her occupation or comparable employment either with Nationwide or with any other employer, because of physical or mental impairment.

26. On 30 December 2019, Mrs R further appealed under stage 2 of the IDRP. The summary of her position is set out in paragraphs 27 to 43 below.

27. Mrs R said she wanted the stage two decision-maker, the Trustee's Disputes Sub-Committee (**the Committee**), to ensure the assessment was under fairer and more transparent criteria. There had been little compassion or recognition shown to the fact that her employment had ended by reason of capability due to ill health and that all her specialists involved in her case acknowledged she was currently unable to work.

28. She was seeking changes to the whole PIER process to ensure no other applicants would suffer in the same way she had. She was also seeking compensation for the "diabolical treatment" she had received through mismanagement, incompetence, unreasonable timescales and acute stress suffered, where duty of care, ethics and consideration of her welfare had been totally absent from the equation.

29. Her first PIER application took 15 months (from 18 July 2017 to 24 October 2018) to consider. The OH report of 7 August 2017 was omitted in the decision-making process, she did not receive the rejection letter and there was little collaboration between Nationwide and the pensions team regarding her application. She wanted to know why these mistakes were made and to prevent these in the future.

30. Her second PIER application took 14 months (from 24 October 2018 to 20 December 2019). Again, there were delays and errors and she had to get a representative to deal with her case.

31. An opinion from an independent Consultant in Orthopaedic and Trauma Surgery, Mr David, was sought by an IMA, Dr Wylie. The request was that the criteria used to

formulate his opinion, on the probability of recovery, be expressed as a percentage level rather than merely stating ‘on balance’.

32. She wanted to know what evidence the Trustee put most weight on when reaching its decision. She believed the fact that she had anaemia was felt to be irrelevant, although she strongly believed it had a bearing on the treatment being put forward by Dr Wylie.

33. She was told to put all exercises on halt due to her anaemia, pending diagnosis of the condition as opposed to other possible illnesses. She resumed her exercises in early August 2019, albeit reduced to 2 to 3 times a week reflecting the state of her anaemia. Contrary to Mr David and Dr Wylie’s view, her anaemia did impact on the treatment proposed.

34. She was continuing to receive treatment, and her next review was due in February 2020.

35. The PIER process was biased in favour of the employer. After more than three years of treatment that had failed to work, Dr Wylie, who had no expertise in the field, suggested she would be able to return to work before her NRA.

36. She found it very unfair that with three years left until her NRA, the Trustee declined her application, because it would take her up to two years to complete NHS treatment. She would then be nearly 60.

37. She would like to submit her application again and for the Trustee to consider it and exercise discretion regarding her eligibility for PIER.

38. She wanted to see the minutes from the Trustee’s meeting to demonstrate how the decision was reached and wanted reassurance on propriety and professional conduct.

39. There were a number of factual errors contained in OH’s report which were subsequently corrected but were a subject of a complaint.

40. She was having doubts as to whether Dr Wylie was the right person to be formulating any opinion on her conditions.

41. She wanted the Trustee to seek another opinion from her specialists whether any return to work after treatment would result in a reoccurrence or exacerbation of her condition. This needed to be expressed as a percentage level not on the balance of probabilities.

42. She wanted to be compensated for the suffering and stress caused.

43. As she lost her job, she should not have suffered a penalty by being forced to access her pension early with a reduction.

44. On 17 February 2020, the Committee sent Mrs R its decision. The summary of its decision is set out in paragraphs 45 to 69 below.

45. The Committee's role was to reconsider Mrs R's application for PIER, in accordance with the Rules and the medical evidence. It must weigh up the medical evidence and expert medical opinions to determine whether she met the criteria under the Rules.

46. Under the Rules, NRA was 65 in respect of post-2011 CARE membership and 60 for any other period of membership. In considering the test of Incapacity, it must consider whether it was likely that Mrs R would continue to meet the criteria at least until age 65, not 60.

47. It noted that the original decision, dated 20 December 2019, incorrectly said that Mrs R had three years until her NRA.

48. It accepted that the medical evidence supported a conclusion that Mrs R's current condition prevented her from carrying out her normal employment, and any other reasonable alternative employment. It also accepted that her current earnings capacity was substantially reduced.

49. It had then considered whether it was likely to continue until at least Mrs R's 65th birthday, so for at least eight years.

50. On the one hand, it noted the evidence from her GP who said her situation was unlikely to improve. However, the GP's report expressly deferred to specialist colleagues' expertise.

51. It also noted that Mrs R's surgeon, Mr Dainton, last saw her in April 2018 and said that he had little to offer her surgically to improve her situation. He said it was difficult to predict whether her condition was likely to be permanent as most cases of adhesive capsulitis settled down and the natural history of it was generally considered to be self-limiting. However, this was not always the case and because of this, it was very difficult to predict how her symptoms might change.

52. This evidence was balanced against the specialist opinions obtained from Mr David and Dr Wylie.

53. It noted Mr David advised that Mrs R could benefit from further treatment options, such as further injection therapy and further treatment aimed at her neck. If these options were explored, Mr David advised that there was scope for improvement in her neck and back symptoms.

54. Dr Wylie opined that the treatment pathway identified by Mr David might take between six months and two years. He advised that on the balance of probabilities, if Mrs R followed the treatments outlined, she could return to her previous role or a reasonable alternative one before age 65.

55. While it was mindful of the evidence from her GP and Mr Dainton's view that it was difficult to predict if her condition would improve, it placed significant weight on the expert opinions of the specialist orthopaedic consultant and the specialist consultant in occupational medicine.

56. It concluded that at the date Mrs R left pensionable service, she was unable to carry out her normal employment or any other reasonable alternative employment and her earnings capacity was substantially reduced. But it was not possible for it to form an opinion that it was likely, on the balance of probabilities, based on the medical evidence available, that this would continue until her NRA. As such, it was unable to accept her application for PIER.

57. It recognised that HR could have worked more closely with the pensions team in relation to her application. It noted that there was a meeting between HR, the pensions team and the Union when the process was explained. It was then understood that the Union explained the process to Mrs R.

58. It noted Mrs R had concerns regarding Dr Wylie's qualifications and expertise. However, he was qualified to provide his opinion to it, and it was entitled to rely on that opinion as it was not medically qualified. When Dr Wylie felt he required further information from her specialists this information was requested and he was provided with advice in the specific area of medical expertise.

59. Where the opinions of one or more medical professionals conflicted, it was entitled to prefer one opinion over the other. It had relied on Dr Wylie's expertise and advice in this area. Since Mrs R's eligibility for PIER relied on her capacity for employment, it was appropriate to seek advice of a specialist, Mr David.

60. Dr Wylie responded to all Mrs R's concerns and provided further comments. So, it was satisfied that Dr Wylie acted reasonably in this regard.

61. It noted Mrs R had expressed concerns that the state of her anaemia was felt to be irrelevant. However, Dr Wylie did consider the impact of anaemia on her ability to return to work.

62. It noted Mrs R's comment that the medical evidence was assessed on the basis of a balance of probabilities rather than on a fixed percentage basis. However, it was satisfied that this approach was consistent with the Rules and legal requirements.

63. It noted Mrs R believed the process was biased towards Nationwide. But Nationwide was not involved in the decision-making process. The decision was for the Trustee to make.

64. While it appreciated that Mrs R might have been apprehensive about exploring further treatment options, its role was not to convince her of the success of the treatment options proposed by the specialists. It was required to consider whether the treatments appeared to be reasonable and available within an appropriate timeframe. It sought advice from Dr Wylie about the "real world" timeframes and he confirmed it might take between six months to two years on the NHS. Consequently, it concluded that it would be reasonable for her to explore the available treatment options.

65. It was clear that the level of service Mrs R had received fell significantly below the standard of service she was entitled to expect. It apologised for this and the lack of

support that was shown in the initial stages of her application. However, some delays were out of OH's and its control.

66. In typical cases, OH requested a report from a member's GP to prepare its advice. However, in Mrs R's case, there was a significant delay obtaining the GP report, for which the GP apologised. This delay was out of OH's or its control.

67. Further delay was caused by OH's need to request a further report from Mrs R's specialists, and to arrange for her to have a consultation with a specialist orthopaedic surgeon. OH first started searching for an appointment in January 2019, but it ultimately took until August 2019 to book a suitable appointment for her. An appointment made in April 2019 for Mrs R was cancelled by the consultant's receptionist without any explanation provided.

68. However, there had been delays by OH and there were errors contained in Dr Wylie's report.

69. It upheld this element of Mrs R's complaint and offered her £2,000 for the distress and inconvenience caused.

Summary of Mrs R's position

70. Aside from many errors that have been made regarding her PIER applications, she believes that the Trustee has not made the decision in the right way.

71. All medical professionals involved in her case and the Trustee have accepted that her condition currently prevents her from carrying out her normal employment and any other reasonable alternative one. There was also acceptance that her current earning capacity was substantially reduced. So, she wants The Pensions Ombudsman (**TPO**) to undertake a reassessment of her case.

72. She religiously exercised but was advised by her previous physiotherapist to halt all exercise due to her acute anaemia.

73. She questions Dr Wylie's qualification and expertise to issue his opinion. His opinion should have been expressed as a percentage level and not on the balance of probabilities.

74. The appointment with Mr David lasted 30 minutes and he believed her neck could be the problem which came as a complete shock to her. Despite rigorous and routine examinations undertaken by her GP and Mr Dainton, no neck issues were previously identified.

75. The treatment undertaken by Mr Dainton, and indeed physiotherapy, was recommended and funded by Nationwide's private healthcare. A question she would have posed to Dr Wylie is how she "would have been able to obtain the prescribed treatment through the NHS, without a referral, when [her] GP and Consultant believed nothing further could be done for [her]".

76. She was no longer having physiotherapy as this ceased in September 2018. So, the main issue is her anaemia having an impact on her condition.

77. Mr David was seeing her in a private capacity commissioned by Medigold Health and would not undertake the treatment regime he was putting forward, as she could not afford to fund this privately, hence the need to convince her GP and specialist.

78. The test and the definition of 'Incapacity' needs to be examined as she does not agree it should be applied in her case. She wants TPO to determine whether applying the criteria under the Rules is reasonable and fair.

79. Given that her PIER application has been rejected, she assumes "the door is closed" to reconsidering her case in the future. Perhaps this can be reconsidered retrospectively, if Mr David's opinion proves to be wrong.

Summary of the Trustee's position

80. It provided a thorough and comprehensive response to Mrs R as part of the IDRP and explained why it did not consider there to be any grounds to uphold her complaint.

81. Given that Mrs R has not provided anything significantly new that was not already fully considered by it, it stands by its previous decision.

82. Mrs R has criticised the Rules as "unfair", in particular the proviso to the definition of 'Incapacity'. It is bound by the Rules and there is no legal basis for members or TPO to criticise it based on the perceived fairness or otherwise of the Rules. It is not a matter that falls within the jurisdiction of the Pensions Ombudsman.

83. Mrs R's application was considered by the initial decision-maker in accordance with a valid delegation made by it as provided for in the Rules.

84. The initial decision-maker obtained and considered medical evidence from and on behalf of Mrs R and obtained further medical reports from two specialist medical consultants.

85. Mrs R's application was then independently reconsidered by a separate Committee when she appealed the decision. Consequently, it does not consider there to be any grounds to uphold Mrs R's complaint.

Adjudicator's Opinion

86. Mrs R's complaint was considered by one of our Adjudicators who concluded that no further action was required by the Trustee. The Adjudicator's findings are summarised in paragraphs 87 to 105 below.

87. Member's entitlements to benefits when taking early retirement due to ill health are determined by the scheme rules or regulations. The scheme rules or regulations determine the circumstances in which members are eligible for ill health benefits, the

conditions which they must satisfy, and the way in which decisions about ill health benefits must be taken.

88. Mrs R's application for PIER was governed by Rule 1.7 (see Appendix 1). Essentially, the Rules state that a member might apply for a PIER pension at any time before their NRA of 65 on the grounds of Incapacity. Incapacity was defined as:

> "Mental or physical disability through ill-health or injury which, in the opinion of the Trustees (having regard to medical evidence and evidence obtained from the Member's Employer) is such that-
>
> - He or she cannot carry out their normal employment or any other reasonable alternative employment with the same or any other employer (whether or not an Employer as defined in the General Rules); and
> - The Member's earning capacity is substantially reduced; and
> - It is likely to continue at least until the Member's Normal Retirement Age.
>
> Provided that:
>
> (1) If the Member has not undergone such treatment as the trustees consider (having regard to medical evidence) it is reasonable to expect the Member to undergo, then the Trustees may determine that the test for incapacity has not been met."

89. Before making its decision, the Trustee was required to obtain a report from its IMA on whether the Incapacity criteria were met and review the medical evidence from a lay perspective.

90. The process started for Mrs R in July 2017 when she was seen by OH who concluded that she was currently unfit for work and it might be appropriate for Mrs R to be assessed for a PIER pension. However, further medical evidence was required from her surgeon regarding her current condition.

91. This was shared only with the IMA, Dr Williams, who made reference to it in her report of February 2018. Mrs R's condition post-surgery was described as "significantly better… and she is in a lot less pain". The IMA concluded that as Mrs R had made a good recovery from her surgery, she did not meet the criteria for incapacity. She was of the view that Mrs R would eventually return to work as the function of the shoulder should return in time.

92. The Trustee subsequently rejected Mrs R's application saying, "if the progress continues as the Consultant expects, a return to work doesn't seem at all unlikely".

93. Mrs R challenged the Trustee's decision on the basis that it had overlooked two OH reports from July and August 2017. On that basis, the Trustee referred her case to

another IMA, Dr Thornton. Dr Thornton concluded that both reports were historic and had no bearing on Mrs R's current situation or long-term prognosis. He also said that as Mrs R was significantly better after the surgery, she did not meet the criteria for a PIER pension.

94. In September 2018, Mrs R further challenged the Trustee's decision under the IDRP. She disagreed with the decision and provided her GP's report supporting the view she had a "poor prognosis for a full recovery to computer and administrative work, given that her symptoms have been so closely related to work" and that her restriction would be permanent.

95. Following this, the Trustee arranged a telephone consultation with OH who concluded, "I do not believe that she will be fit to return to work, and that her significant problems are going to remain longstanding and prevent her working…this type of health issue can be contributed to by many different factors and only her specialist would be able to indicate as to whether work played a role in her condition".

96. The stage one decision-maker concluded that if Mrs R submitted a new application, this would allow her to provide fresh evidence from her specialists regarding her current condition. This would also be prudent as her employment was being reviewed and her sick note was due to expire on 11 January 2019. In the Adjudicator's view, this approach was not unreasonable as Mrs R's employment was being reviewed on the grounds of capability at the time.

97. Mrs R submitted a fresh application in December 2018. The opinion of another IMA, Dr Wylie, was obtained. Nationwide also commissioned a report from an independent consultant orthopaedic surgeon, Mr David, to reassess her condition. Mr David was of the view that further gains could be achieved with treatment aimed at Mrs R's neck, an x-ray examination and a further course of physical treatment. His view was that currently her condition should not be considered permanent.

98. There was a difference in opinion between Mrs R's GP and Mr David. The GP was pessimistic about Mrs R's prognosis and considered a return to her work was highly unlikely. The specialists concluded that her incapacity was not permanent. However, a difference of medical opinion was not sufficient for the Pensions Ombudsman (**the PO**) to say that the Trustee's acceptance of the IMA's opinion meant that its decision was not properly made. The weight which was given to any of the evidence is for the decision-maker to determine, including giving some of it little or no weight[1].

99. Mrs R raised a number of concerns with Dr Wylie's report and the decision-making process. The Adjudicator carefully considered all her points, and she did not identify any issues with Dr Wylie's report. He provided a comprehensive analysis of Mrs R's medical history, treatments undertaken and treatments available. He considered carefully all the medical reports from her specialists and provided his view as an

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

occupational health expert, on whether Mrs R satisfied the incapacity criteria. In the Adjudicator's opinion, Dr Wylie applied the criteria under the Rules correctly.

100. Mrs R said the Rules were unfair, but the Trustee must follow the Rules.

101. Mrs R said her condition was not improving. In and of itself that did not mean that the Trustee's decision was not properly made. The Trustee's decision could only be assessed by reference to the medical evidence which was or could have been available at the time the decision was taken. Mrs R had to satisfy the definition of incapacity under the Rules at the time her employment was terminated. As her specialists considered her incapacity was not permanent, it was not unreasonable for Dr Wylie to attach more weight to this opinion over the opinion of her GP who was not an expert in this field.

102. The Adjudicator also considered the way Mrs R's application was handled. She appreciated that Mrs R submitted two applications that both took several months to conclude. She carefully reviewed the case file and the explanations provided by the Trustee in its stage two decision (see paragraphs 45 to 69) regarding the handling of the process. In her view, the Trustee took appropriate steps to explain there were issues and put things right for Mrs R. It considered Mrs R's medical evidence and discussed her case in detail a few times. It referred her case to three different IMAs who all concluded that her incapacity was not permanent. Having reviewed the IMAs' reports, she did not identify any errors or omission of fact or misunderstanding of the Rules. The Adjudicator also noted that Nationwide sought clarifications from Dr Wylie and he provided this clarification in addenda to the report.

103. The Trustee conceded that OH had caused some delays and took responsibility for this. However, some delays as explained by the Trustee, were out if its, or OH's control as these were related to, for example, waiting for medical evidence or issues with arranging Mrs R's appointments or errors contained in Dr Wylie's report. The Adjudicator noted the Trustee paid Mrs R £2,000 in recognition of the above identified issues and apologised that the service she had received fell below the standard expected. In her view, the award was sufficient given the circumstances of the case, and it was unlikely that if the case was considered by the PO, a further sum would be awarded.

104. While the Adjudicator appreciated that Mrs R would be very disappointed, her view was that there are no justifiable grounds for her to say that the Trustee's decision was not properly made or that the process it undertook, in reaching its decision, was flawed.

105. As Mrs R considered that her condition was not improving, she might wish to consider submitting a new application from deferred status. Consequently, it was the Adjudicator's opinion that this complaint should not be upheld.

106. Mrs R did not accept the Adjudicator's Opinion and the complaint was passed to me to consider. Mrs R provided her further comments which do not change the outcome. I agree with the Adjudicator's Opinion and note the additional points raised by Mrs R.

107. Mrs R said in summary:-

- The point regarding the ethics of the secretary to the Trustee managing and considering her application and IDRP must "raise alarm bells". She does not believe this is an acceptable arrangement irrespective of what the Rules say. She wants to see evidence that her appeal was handled with propriety.
- She is surprised that the PO does not consider medical evidence, merely the role of the decision maker.
- She wants to know how the Adjudicator reached her view and if she has considered recent audits, reviews, legal and other professional advice.
- She wants more onus to be put on the scrutiny of the decision making process.
- She will not be taking further action with other organisations until her case has been determined by the PO.
- She has noted that the PO is unlikely to reach a different decision to the one made by the Adjudicator. Nevertheless, she feels she has a duty to expose, for the sake of others, the truly shocking treatment she experienced at the hands of the Trustee.
- She has not been given reassurance in the Opinion that the Trustee has put systems in place to mitigate the risks of further maladministration of future ill health applications.

The Ombudsman's Decision

108. At the outset, it is important to highlight my role. I am not tasked with reviewing the medical evidence and deciding whether Mrs R should in fact receive a PIER pension. That decision is made by the Trustee in accordance with the Rules, and in particular Rule 1.7 and the definition of 'Incapacity". The latter provides that 'Incapacity' means, "mental or physical disability through ill-health or injury which, in the opinion of the Trustees (having regard to medical evidence and evidence obtained from the Member's Employer)" and as such whether Mrs R met the conditions for Incapacity is a matter to be determined by the Trustee, in its opinion and having regard to medical evidence and evidence from her employer. As such, my role and that of the Adjudicator is to look at the process followed by the Trustee.

109. When considering how a decision has been made by the Trustee, I will look at whether:

- the appropriate evidence had been obtained and considered;

- the applicable Rules have been correctly applied; and
- if the decision was supported by the available relevant evidence.

110. Providing that the Trustee has acted in accordance with the above principles and within the powers given to it under the Rules, I cannot overturn its decision merely because I might have acted differently. It is not my role to review the medical evidence and come to a decision of my own as to Mrs R's eligibility for PIER pension. I am primarily concerned with the decision-making process.

111. In order to be eligible for PIER pension, the Trustee must be satisfied that Mrs R's incapacity is reduced seriously enough to prevent her from following her normal employment "or any other reasonable alternative employment". It must also be satisfied that Mrs R's earning capacity is substantially reduced and that this will continue until the member's NRA.

112. The Trustee initially declined Mrs R's application on the basis that she had made a good recovery from her surgery and if she continued getting better a return to work would be possible. At IDRP, Mrs R challenged the decision on the basis that her GP supported her application for PIER pension. Nationwide referred her case to three different IMAs who all concluded that her incapacity was not permanent. Having reviewed the IMAs' reports, I did not find any errors or omission of fact or misunderstanding of the Rules.

113. I have considered the relevant evidence, including the medical evidence pertaining to Mrs R's condition at each time she applied for a PIER pension and also when she appealed the decision. For the same reasons as given by the Adjudicator, outlined in paragraphs 87 to 105 above, I find that the Trustee's decision, based on the IMA's report, in the first instance, and then on appeal, was reached in a proper manner based on the evidence available. That is, the IMAs, and subsequently the Trustee, asked themselves the right questions, considered all of the relevant factors, while disregarding any irrelevant ones. The Trustee, after properly directing itself, arrived at a decision that any other decision-maker might make, based on the evidence available to it.

114. I have every sympathy for Mrs R that her condition has not improved since she left her Nationwide employment. I do not doubt that the incapacity she experiences has increased. However, given that I am only permitted to review the way in which the Trustee handled Mrs R's applications at the time, I am unable to comment on the progression on her incapacity thereafter.

115. I appreciate that this outcome will be disappointing for Mrs R, however the IMAs and the Trustee have acted in accordance with the relevant Rules. At the time of her applications, she did not meet the criteria for a PIER pension.

116. I note Mrs R raised an issue with the Trustee's secretary's integrity and independence. I do not doubt the Trustee's integrity and have not seen any evidence to suggest it acted without integrity. It initially considered her application and at IDRP

the delegated Committee reviewed her case properly. The secretary was allowed to deal with her application on behalf of the Trustee.

117. If Mrs R wishes to, she may submit a new PIER application, for the early release of her deferred pension on the grounds of ill health which will take into consideration her current health.

118. I do not uphold Mrs R's complaint.

Camilla Barry
Deputy Pensions Ombudsman
20 March 2025

Appendix 1

The Nationwide Pension Fund Rules

As relevant, rule 1.7, 'Incapacity pension', provides:

(1) If-

- an Active Member leaves Service before 65; and
- the trustees determine that the Member is suffering, at the time he or she leaves Service, from Incapacity

that Member shall (having provided the Trustees with any evidence of Incapacity that they require) be entitled to a pension payable, subject to (3), (4) and (5) below, for the remainder of his or her life.

…

A Member shall apply for a pension under this rule prior to or within one month after leaving Service but the pension shall not begin until the Member leaves Service. The pension will begin on the date notified to the Member by the Trustees and will continue (subject to the review provisions set out below) for the rest of his or her life.

(2) If in the Trustees' opinion (based on medical evidence or other evidence of actual or potential earnings) a Member entitled to a pension under this rule retains some actual or potential earning capacity (even though significantly reduced) they may, in their discretion, reduce the amount set out in (1) to reflect all or part of the actual or potential earnings capacity of the Member, reflect all or part of the actual or potential earnings capacity of the Member. For the avoidance of doubt, a reduction under this rule may be applied by the Trustees whether or not a Member actually receives any earnings as a result of his or her retained earning capacity.

…

11.9 Delegation

"(1) The Trustees may delegate all or any of their powers, duties and discretions under the Scheme to any person or persons (whether or not a Trustee or Trustees) and on any terms (which may include power to sub-delegate). The Trustees may vary or revoke the delegation.

Subject General 10.4(3), the Pensions Act 1995, the Trustees will not be bound to supervise the action of the delegate or its sub-delegate, or be in any way responsible for any loss (however caused0 suffered as a result of any delegation or sub-delegation."

CAS-50220-W9V0

Definition of Incapacity

“Incapacity” means, in relation to a Member, mental or physical disability through ill-health or injury which, in the opinion of the Trustees (having regard to medical evidence and evidence obtained from the Member’s Employer) is such that-

- He or she cannot carry out their normal employment or any other reasonable alternative employment with the same or any other employer (whether or not an Employer as defined in the General Rules); and
- The Member’s earning capacity is substantially reduced; and
- It is likely to continue at least until the Member’s Normal Retirement Age.

Provided that:

(1) If the Member has not undergone such treatment as the trustees consider (having regard to medical evidence) it is reasonable to expect the Member to undergo, then the Trustees may determine that the test for incapacity has not been met;
(2) This definition shall also apply in respect of a Member who is a Deferred Pensioner, save that references to the Member’s Employer shall be to his or her employer at the time of his or her application for early payment of pension. In the event that the trustees are unable to obtain the information and evidence required from the Deferred Pensioner’s employer they may make a decision solely on the basis of the medical evidence provided.

Normal Retirement Age means:

(a) In respect Post-2011 CARE Membership the age of 65 years; and
(b) In respect of any other period of Membership the age of 60 years.

Appendix 2

Medical evidence

1. In her report dated 21 February 2018, the IMA, Dr Williams said:

   "Based on the evidence available and on the balance of probabilities, my opinion is that [Mrs R] is not permanently incapable of carrying on the member's occupation or comparable employment either with nationwide or any other employer because of physical or mental impairment. Her right shoulder problem has improved following shoulder surgery.

   A phased return to work could be considered following an assessment by Santia [OH]. There is no evidence provided to indicate that [Mrs R] is incapable of returning to her role when she has completed physiotherapy and active rehabilitation following her surgery. Following such surgery, active rehabilitation programs are required to help someone regain arm/hand function; pain and disability are likely to and have been shown to be resolving. In time, arm/shoulder function is likely to be regained. There is no reason to suspect that [Mrs R] will not be able to work again. I expect active rehabilitation may take 4 to 10 weeks following her surgery during this time she may be unfit to restart work but after this it should be feasible or been well [sic].

   My assessment is that [Mrs R] does not meet the criteria for a permanent incapacity early retirement pension. She has had surgery for her shoulder problem and should eventually be able to return to work as the function of the shoulder should return in time. A follow-up review with the occupational health department is advisable.

   …

   A follow-up appointment occurred in January 2018 with the Consultant Surgeon. The Consultant reports that [Mrs R] is significantly better since operation; she's in a lot less pain and he felt sure that she will continue to improve, he discharged her from the clinic.

   Reviewing Doctor's comments:

   The medical evidence indicates that [Mrs R] was significantly disabled in 2016 and 2017 because of right shoulder pain and restricted movements in her shoulder, arm and hand; she is right handed. She was unable to continue working because of this problem. Initially she gained some benefit from injection therapy, physiotherapy and medication but ultimately surgery was required to amend the problem with her right shoulder. On the basis of the medical report from her surgeon received January 2018, it appears that [Mrs R] has made a good recovery from her surgery."

2. In his report dated 4 April 2018, Consultant Orthopaedic Surgeon, Mr Dainton said:

   "I saw this lady in clinic today. At the request of the physiotherapist she still has some reduced internal rotation. Her internal rotation is to the lumbar spine compared with about T4 on her good side. She does have quite marked flexibility naturally and I have reassured her about this I think surgery would be a mistake and I think she will gradually continue to improve. She is going to start building up her general activities such as Yoga and hopefully she will eventually make a good recovery. I haven't arranged to see her again but would be more than happy to do so should there be further problems."

3. In his report dated 13 June 2018, the IMA, Dr Thornton said:

   "The occupational health reports are historic and have no bearing on her current situation or long-term prognosis. Having them available at the time of Dr Williams' assessment would have been highly unlikely to have made any difference to her conclusions. In Mr Dainton's report, he states that [Mrs R] is significantly better than she was before the operation, with improved range of movement in the shoulder in a lot less pain.

   I have not reviewed the original evidence that supported Dr Williams' recommendation but, on the basis of what is stated in her report, I agree that she is not permanently incapable of carrying on with her employment with Nationwide."

4. In his report dated 16 August 2018, a GP, Dr Trevail said:

   "The patient has had significant problems with adhesive capsulitis of her right shoulder, has had a right arthroscopic subacromial decompression dating back to the summer of 2013, leading to referral in August 2016. I believe that she has a poor prognosis for a full recovery to computer and administrative work, given that her symptoms have been so closely related to work.

   Other than associated neck pain and discomfort she has no relevant previous medical history.

   She has been under the care of the orthopaedic surgeon since July 2016, has had several steroid injections and in October 2017 an arthroscopic subacromial decompression.

   [Mrs R] is significantly restricted by ongoing pain and discomfort. She is unable to use a laptop computer or desktop computer and struggles with lifting or reaching above shoulder height. She also struggles with certain movements- e.g. closing car doors or any kind of hoovering, cooking or dishwashing.

   I do not believe that she will be fit to return to work and that her significant problems are going to remain longstanding and prevent her working.

I do not believe that she will be fit to return to work and that her significant problems are going to remain longstanding and prevent her working.

Management would need to consider removing her from administrative computer work and avoiding any lifting or reaching above shoulder height and I believe these restrictions would be permanent.

Having known [Mrs R] as her registered GP since the early 1990s I do not agree with the orthopaedic surgeon's latest letter which states that she will make a good recovery. Please note that this letter was dated in April 2018 and now some four months later her restricted movements and discomfort are ongoing."

5. In his report dated 22 March 2019, Mr Dainton said:

"In summary, I first met her in August 2016, I treated her for both impingement syndrome and adhesive capsulitis. At the time of surgery, she certainly had adhesive capsulitis which was October 2017. She did make an improvement following the surgery but has deteriorated since. I saw no sign of any rotator cuff tear. She has had both injections and surgery. I haven't considered any further investigations as I think I have little to offer this lady surgically to improve her. It's difficult to predict whether or not her problem is likely to be permanent as most cases of adhesive capsulitis do settle down and the natural history of adhesive capsulitis is generally considered to be self-limiting. However, this isn't the case always and because of this, I find it very difficult to predict how she will do. I am more than happy to discuss this further."

6. In his report dated 15 May 2019, Dr Trevail said:

"Summary of present active conditions-

She continues to suffer significant pain and discomfort. As a primary care physician I would defer to my specialist colleagues expertise on the proportion of this is caused by impingement syndrome or capsulitis. I don't believe that a rotator cuff tear has been identified but I'm sure this will be apparent from his report.

Summaries of investigations and treatments to date and what effect they have had-

[Mrs R] had arthroscopic subacromial decompression and EUA in October 2017. She has had steroid injection and physiotherapy. X-rays have shown degenerative changes. She has had some benefit from the interventions. She continues to suffer from significant pain, discomfort and restricted mobility in her shoulder.

Any further investigations of treatments being considered-

[Mrs R] has reached a plateau in her improvement and my understanding is that the orthopaedic surgeon does not feel that any further surgical intervention would be appropriate or helpful.

Is there anything further that can be done to assist your patient's return to work-

Given the chronic nature of her symptoms and the fact that the orthopaedic surgeon feels that he has exhausted therapeutic options I do not believe that anything further will assist her ability to return to her previous employment, which I understand involved desk and computer work.

Whether [Mrs R's] medical condition is likely to be permanent or to continue at least until her normal retirement age of 65-

Whilst her condition may slowly improve I think it is unlikely that she would gain full resolution and her symptoms are likely to be chronic and persistent.

Whether [Mrs R's] condition is likely to render her incapable of employment until her normal retirement age-

I believe that her situation is unlikely to improve therefore I believe she is likely to be incapable of employment until her normal retirement age."

7. In his report dated 22 August 2019, an independent Consultant in Orthopaedic and Trauma Surgery, Mr David said:

"[Mrs R] informs me that her husband took her to A&E in May 2017 because of a worsening of her symptoms [and this may be the reason why Mr Dainton re-injected her shoulder] and on 31st October 2017 he performed an operation. He manipulated her shoulder (MUA) and identified features characteristic of adhesive capsulitis on arthroscopy. He also performed an arthroscopic subacromial decompression and bursoscopy.

He reviewed her back in clinic in January 2018 and noted that her condition had improved significantly and she was discharged from follow up but returned to see him in April again at the recommendation of a physiotherapist. She was apparently reassured by Mr Dainton that it would take time for her symptoms to improve and she was recommended to yoga.

[Mrs R] informed me that she received physiotherapy from 13th September 2017 up until 10th September 2018. She has not received any further treatment since that time and nor has she seen Mr Dainton again.

SUBSEQUENT PROGRESS

She feels that her condition has improved a little bit further since she last saw Mr Dainton but that her recovery probably plateaued about a year ago. As previously stated she has not received any further treatment since September 2018. She has

however continued with her daily exercises up until this year and I gained the impression that she was not now performing these on a regular basis.

…

PRESENT SITUATION

She feels that she is restricted each and every day. She is aware of a weakness in both shoulders. She finds that she can lie on her right shoulder in bed but then her arm will become numb and she develops discomfort and she has to turn on to her left side and then develops symptoms on that side too. She describes how she was heavily reliant upon her husband for most day to day tasks whilst recuperating from her operation. She tells me that she can raise her right arm though will experience pain and this pain is often worse the day after she has performed such a manoeuvre and can last for weeks. Her pain tends to vary but she is aware of discomfort in the midline extending out towards both shoulders and in the right shoulder that extends down into the upper arm towards the deltoid insertion but not beyond… She can manage some cleaning, lifting and vacuuming though will be cautious with what she does do and is reliant on her daughter who lives at home with her and her husband. She tries to avoid carrying heavy shopping bags where possible and tells me that she would not carry a handbag over her shoulder when out walking because of pain and recognises that the pain will ease if she takes off her handbag. She tells me that she would not drive for more than 10 miles because of pain (and was driven by her husband today). She has not been able to return to cycling on account of discomfort. She avoids outdoor chores such as gardening or hanging clothes on a washing line.

Opinion

Although [Mrs R] talks of problems with both her shoulders, in fact she points repeatedly to the neck muscles and the neck itself as the site of symptoms. I very much doubt she has a shoulder problem per se affecting her left shoulder though may have some residual issues with the right shoulder given her reluctance to fully elevate the arm in either forward flexion or abduction: She has regained full external rotation and it is clear on reviewing the records that internal rotation has also improved too when compared with movements identified by Mr Dainton in his. clinic letter and thus I think she has responded well to treatment for the shoulder stiffness. However, she does have some residual activity-related discomfort that impacts on her ability to manage day to day tasks

The greatest restriction in movement seen on clinical examination today is in respect of her cervical spine with approximately 50% loss of most movements, perhaps more so extension and the difficulties that [Mrs R] describes when looking down as when preparing food or when looking up at customers in her work, would to my mind fit more with an ongoing neck rather than a shoulder problem. It is worth noting that she has not received an injection into her right shoulder since her operation and nor has she undergone any form of investigation (x-rays or scans) for

her neck. Physiotherapy was discontinued in September 2018 and she has not received any further input for her neck or shoulder since that time. She was discharged by Mr Dainton in April 2018 and has not been re-referred back to see him or an alternative specialist. If I were to see [Mrs R] in the clinical setting, I would recommend another injection into her shoulder (subacromial space). In my experience, it is not uncommon for patients to require a post-operative injection. Most patients, if not all patients have undergone injection therapy prior to surgery and an operation is recommended in those where problems recur but is not uncommon for patients to require a one-off injection post-operatively. Similarly, I think she is someone who could benefit from further treatment aimed at her neck. She should probably undergo an x-ray examination and a further course of physical treatment. Whether this involves a physiotherapist, osteopath or chiropractic is a moot point but if she receives such treatment and her problems persisted, then an MRI scan of the cervical spine and possibly a consultation with a spinal specialist would be indicated.

In the letter of instruction from Medigold Health dated 30th July 2019 I have been asked to consider specific points

1. Summary of relevant past medical history.

I think this is covered within the body of the report.

2 Summary of present active conditions, including, affecting the right shoulder/arm

2.1 Impingement syndrome

2.2 Rotator cuff tear

2.3 Adhesive capsulitis

Again, I feel this is covered above. I believe that [Mrs R] has features consistent with residual subacromial impingement. Mr Dainton describes the ultrasound scan as being unremarkable suggesting that certainly at the time the scan was performed there was no evidence of rotator cuff tear. Although she has a degree of restriction of full internal rotation, external rotation is good in range and most of the limitations in movements are, I believe, pain-related rather than representing stiffness as might be anticipated in a recurrence of adhesive capsulitis. Furthermore, [Mrs R] confirmed that she would be able to fully raise her arm albeit with discomfort.

3. Summary of investigations and treatments to date and what affect they have had on Mrs R’s condition.

This is covered above.

4. Are any further investigations or treatment being considered? If so when should they expect to occur?

To my knowledge, no further investigation or treatment has been proposed though I still believe the options stated above should be considered seriously as I feel there is scope for further improvement in both her neck and shoulder symptoms.

5. Is there anything further that can be done to assist [Mrs R's] recovery and return to work?

See above.

Nationwide have also specifically asked that I provide an opinion on:

6. Whether [Mrs R's] medical condition is likely to be permanent or continue at least until her normal retirement age of 65.

At present this is unclear but on balance I think further gains can be achieved with the treatment recommended above and, in this instance, I do not feel at this stage her condition should be considered permanent.

7. Whether [Mrs R's] condition is likely to render her incapable of employment until her normal retirement age.

For the same reasons, I think it inadvisable at this time to consider that she is incapable of working from now until normal retirement age: she will shortly be celebrating her 57th birthday and therefore has approximately eight or nine more years before she will be eligible for a state pension. She was working 10.5 hours per week up until the time she went on sick leave and I would be hopeful that she could return to work following the treatment recommendations given above."

8. In his report dated 4 November 2019, the IMA, Dr Wylie said:

"[Mrs R's] GP, Dr Trevail, has provided a report dated 15/05/2019. In which describes [Mrs R's] ongoing significant pain and discomfort in the right shoulder. This was attributed to capsulitis and impingement, with further evidence of degenerative change on X-ray. He advises that, as a primary care physician, he would defer to his specialist orthopaedic colleagues regarding the causes of ongoing symptoms, and the apportionment of ongoing symptoms to each.

As requested by Nationwide, an independent orthopaedic report was commissioned to reassess [Mrs R's] right neck, shoulder and arm symptoms. There were some challenges in achieving an appointment with an independent specialist within the south-west, but [Mrs R] ultimately saw Mr Huw David, consultant orthopaedic surgeon with an interest in shoulder surgery, for assessment on 22/08/2019 in the Nuffield Hospital in Plymouth.

…

What is the prognosis?

The view of [Mrs R's] GP is that her recovery has plateaued and that her surgeon, Mr Dainton, had advised that no further treatment was indicated. He therefore concluded that there were no further treatment options that would enable [Mrs R] to return to her role with Nationwide.

However, the view of Mr David is that further investigation and treatment options were available. He considered that it would be inadvisable at this time to consider [Mrs R's] shoulder and neck symptoms are permanent, and that it would be premature to conclude that she is currently incapable of working until her normal retirement age.

Based on the information available to me, including considering the independent orthopaedic assessment as adding significant value in terms of likely prognosis and recovery, in my role as a consultant in occupational medicine I would concur with Mr David's assessment that it is too early to consider [Mrs R] permanently incapable of returning to her former role.

What is the impact on their ability to work now or in the future?

[Mrs R] worked 10.5 hours per week over two days prior to leaving employment.

In my opinion, it would be reasonable on the balance of probabilities to determine that [Mrs R] could yet, following the above treatment, and on the balance of probabilities, be able to return to these hours in her role as a customer representative before her normal retirement age.

Are there any adjustments that should be considered which would allow a return to work?

I would suggest that adjustments that could typically be considered, once [Mrs R] has been treated and sufficiently recovered from her ongoing symptoms, might include for example:

- Enabling [Mrs R] to undergo any further appropriate physical therapy, specialist investigation and treatment as required for the ongoing investigation and management of her neck/shoulder pain, including the ability to attend any appointments that may occur during normal working hours.

- I would suggest limiting [Mrs R's] activities to a light sedentary role, entirely in keeping with her role as a customer representative. I would ensure that Mrs R was not required to lift any items of more than 1 kilogram, or to use a trolley for transporting any heavier items within the working environment. I would suggest that manipulating/ lifting such item should be limited to be between waist and shoulder height.

- Enabling [Mrs R] to avoid standing or sitting for extended periods, and have the ability to change position as required, with micro-breaks of several minutes between clients and also longer breaks to mobilise and avoid stiffness/discomfort as required and as far as is practicable within the working day.

- I would suggest discussing [Mrs R's] work pattern and hours, to discuss whether working equivalent hours but shorter days may be more beneficial than working in her current working pattern.

- I would suggest that, due to the ongoing impairments caused by [Mrs R's] medical conditions, particularly if considered without the benefit of treatment, and their duration, it is probable that the disability provisions of the Equality Act 2010 may apply. This is of course a management and legal responsibility to determine.

Assessment

In my opinion, [Mrs R] is likely to benefit from further treatment for her right shoulder discomfort/ impingement.

[Mrs R] would also benefit from physical therapy for her neck discomfort and restricted movement. If the latter is not effective, further specialist investigation and treatment may be indicated.

Consequently, not all treatment that, on the balance of probabilities, may enable Mrs R to return to her occupation as a customer representative is complete. Consequently, it is not possible to say at this time that her condition and limitations are permanent.

Conclusions and Recommendations

Consequently, it is my determination that [Mrs R] is not at this time indefinitely incapable of carrying on her occupation or comparable employment either with Nationwide or with any other employer, because of physical or mental impairment.

9. The below Addendum of 25 October 2019 was attached to the above report (as amended) in response to [Mrs R's] below concerns. Further comments from Dr Wylie, were requested by the Trustee.

"1. The assumptions made that I [Mrs R] continue to be employed by Nationwide, which of course is not the case as my employment was terminated on 28th February 2019, by reason of capability due to ill health.

In the report, I have not stated that Mrs R continues to be employed by Nationwide. I was aware from [Mrs R's] prior communications that Nationwide had terminated her employment on 28 February 2019 and, with Nationwide, Mrs R and I already aware of this, I did not include this in my report. I have now added this for clarity.

2. Mr Dainton vs. Mr David opinions on diagnosis I treatment.

I must defer to the opinions of Mr Dainton and Mr David as they are accredited specialists in orthopaedic surgery and expert on the matters of orthopaedic assessment, examination, diagnosis and treatment. An independent second opinion, such as that given my Mr David, is sought because the clinical findings, diagnosis and prognosis are unclear. Mr David has now identified a possible cause for [Mrs R's] ongoing symptoms. In his expert opinion, this merits further investigation, and I have to consider his opinion in my assessment. His opinion is presented in detail, in the format of an expert witness giving independent, expert evidence in legal proceedings.

My remit from Nationwide, in assessing [Mrs R's] eligibility for PIER benefits, is to determine whether she is, indefinitely, incapable of carrying on her (former) occupation as a customer services representative, or comparable employment, either with Nationwide or with any other employer, because of physical or mental impairment, normally until [Mrs R's] normal retirement age of 65. In my opinion, until all reasonable investigation I treatment likely to result in improvement and return to work is complete, it is not possible to determine that [Mrs R] is indefinitely and/ or permanently unable to return to a customer services role, or a comparable role, in future and before her normal retirement age.

3. Recommendation of employment [Mrs R] could undertake.

If [Mrs R] considers further investigation as recommended by Mr David, and she were then then to undergo further treatment that proves successful and which significantly improves or resolves her residual symptoms, then a return to work may be possible. In my opinion, she may then be able to consider returning to a customer services role, or a similar light administrative role, with Nationwide or with another employer supported by appropriate adjustments.

I have suggested adjustments aimed minimizing the risk of a further recurrence of symptoms, or minimizing the risk of any residual symptoms. [Mrs R] may of course benefit from a new ergonomic assessment at that time, focused on the specific cause of her symptoms and her symptoms at that time (rather than those experienced at the time of her previous ergonomic assessment). Should such an assessment be helpful in supporting patients in return to work, these are available e.g. through Access to Work.

In my opinion, it is appropriate for me to comment on how a further return to work may be possible, into what role and what adjustments may be appropriate in supporting this.

4. Letters/ reports from Mr Dainton.

The letter dated 1 March 2019 has been forwarded to Mrs Rutter. This appears to be a medical report from Mr Dainton to Medigold Health requested with [Mrs R's] consent and subsequently forwarded to us. The letter appears to have been typed on 28/02/19 and sent on 01/03/19. A further copy of this report was sent by [Mrs R's] GP, although this copy is dated 22/03/19.

5. Amendments.

In preparing this report, I have reviewed [Mrs R's] comments and multiple GP and specialist letters/ reports, not all of which agree on dates and timescales. In forwarding the report to [Mrs R] prior to release, this offers the [Mrs R] the opportunity to correct any inadvertent errors of fact or typography made whilst completing the report from the letters/ reports made available to me, and remain unidentified by me on subsequent review. Noting the above, I have made the changes requested by [Mrs R].

6. Challenge to concurrence with Mr David's assessment that it is too early to consider permanent incapability of returning to my former role, when you have not examined me [Mrs R] and have obviously discounted the opinions of my Consultant and GP, when also my post with Nationwide was terminated due to ill health.

[Mrs R's] statement has been attached for convenience:

Finally and respectfully, I wish to challenge your concurrence with Mr David's assessment that it is too early to consider my permanent incapability of returning to my former role, when you have not examined me and have obviously discounted the opinions of my Consultant and GP, when also my post with Nationwide was terminated due to ill health. If your report is to show less bias (not helped to date by the litany of mistakes and errors made by Medigold Health, which have been fully documented with your colleague, Sam Clarke and indeed Nationwide) at least be kind enough to include Mr David's reply to question 6 which is repeated below for ease of reference:

Nationwide's Question

7. Whether [Mrs R's] medical condition is likely to be permanent or continue at least until her normal retirement age of 65.

Mr David's Response

At present this is unclear but on balance I think further gains can be achieved with the treatment recommended above and in this instance I do not feel at this stage her condition should be considered permanent.

My GP's response to the same question that my 'condition may slowly improve, I think it is unlikely that she would gain full resolution and her symptoms are likely to be chronic and persistent; has been totally disregarded despite his detailed knowledge of my case following numerous appointments with him over the period of years of my disability! A similar response was made by my GP in his first report dated 16th August 2018, which I assume you have had sight of. I fail to understand why the opinion of my GP is so readily dismissed when he has been my registered GP since the early 1990s!

Regretfully, neither [Mrs R's] GP nor I have the expert training in assessing, examining, diagnosing and treating orthopaedic conditions experienced by accredited specialists in orthopaedic surgery such as her orthopaedic consultant Mr Dainton, nor by the independent orthopaedic consultant Mr David. As stated above, the second opinion of another colleague is typically requested when the clinical findings, diagnosis and prognosis are unclear. Mr David has now identified a possible cause for [Mrs R's] ongoing symptoms, which he feels merit further investigation with a view towards treatment. My role in assessing [Mrs R's] eligibility for PIER benefits inevitably involves weighing the relative value of the assessment, diagnoses and opinions given by individual specialist doctors and by GPs and using this to come to a recommendation.

As a former GP myself, I do understand that [Mrs R] values her GP's understanding of her current symptoms and the weight she places in his opinion. However, we non-orthopaedic doctors refer patients to our orthopaedic colleagues as, as orthopaedic specialists, they are much more skilled at orthopaedic assessment and examination than [Mrs R's] GP or I are, with very few exceptions, ever now likely to be. This fact is also touched upon by [Mrs R's] GP in his most recent report dated 15 May 19, where he states he would defer to the opinion of orthopaedic colleagues.

Orthopaedic consultants are also experts in advising on investigation, treatment and prognosis. Consequently, when Mr David states that it is premature to consider that [Mrs R's] impairment is permanent, and further investigation and/ or treatment is indicated, it is my opinion as an accredited specialist in occupational medicine that this must be considered a highly significant conclusion."

10. The below Addendum dated 1 November 2019, was attached to the report.

Mrs R's further concerns were addressed by Dr Wylie below.

"All health experts involved in my case concur that I am currently incapacitated from work, a position that is maintained despite two years elapsing since my surgery.

Equally, there is no assurance that the treatment recommended only by Mr David is likely to be successful. This needs to be made more clearer in your report, perhaps linked further to the first paragraph of Section 3, where it is stated that any future role would need to be 'supported by appropriate adjustments'. Realistically, my employment prospects will continue to be severely limited, even if the treatment recommended by Mr David is successful."

"Currently [Mrs R] has neck, shoulder and arm pain, as described above, which currently prevents her from returning to her former role. Mr David has suggested further investigation and, until this is complete, it is not possible to determine an accurate diagnosis causing [Mrs R's] ongoing pain, its treatment and prognosis, i.e. it is not possible to determine the likelihood of a future return to work. While [Mrs R] may feel that her employment prospects are extremely limited, in my opinion it is not possible to come to that conclusion medically while further investigation has been recommended and remains outstanding."

"Little reference has been made to the impact of computer usage (including printers) on my condition, despite the point being impressed on Mr David. I reiterate again, on the occasions since my surgery, when I have been tempted to use a computer, my symptoms have rapidly returned, which does not bode well for a return to work, particularly when even the most basic administrative post will require a degree of IT use. I am therefore emotionally terrified of jeopardising the improvements that have been made to my mobility by operating such equipment, which is significantly contributing to my stress levels. Indeed, there is no reference in your report to the impact my disability is having on my mental wellbeing, exacerbated by the PIER process, despite this being identified by Nationwide via FUSION OH a year ago. Please therefore ensure this is captured in your report."

"While computer use is described as a significant issue for [Mrs R] in her employment, until further investigation and treatment are complete it is in my opinion premature to conclude that this impairment will continue in future. Additionally, should symptoms improve and a return to work is then possible, Access to Work assessment may be able to identify and support re-employment e.g. through the provision of software and equipment to enable minimal physical interaction with IT, e.g. through voice control."

Regarding health anxiety, such as concern regarding the potential of a worsening of or return of symptoms following a return to work, if this anxiety were significant and itself causing a bar to return, then further specialist assessment and treatment may be indicated before being able to assess whether this is a significant contributory factor preventing a return to employment.

Regarding the stress of the PIER process, stress in relation to management processes such as assessment of capability or eligibility for ill-health retirement would not normally be a factor in determining fitness for employment, as this stress would be expected to resolve once the relevant processes are complete.

“Furthermore, the points made to Mr David relating to my exercise regime and related acute anaemia, were disregarded by him and may have been overlooked by you. These are detailed in the email thread, the appropriate paragraph reproduced below for ease of reference:

'In addition it is mentioned under Subsequent Progress (page 3) that the impression was gained that I do not now perform exercise on a regular basis. This needs quantifying further and I apologise for not making this clear at my appointment. I wish to state that I was indeed religiously undertaking the exercise regime prescribed by my previous physiotherapist until June 2019 but was advised by my clinician to desist all exercise at that time due to acute anaemia. Pending diagnosis of the condition as opposed to other possible illnesses and undertook ECGs, together with a colonoscopy, gastroscopy and blood tests. Following improvements in my blood count I resumed my exercises again in early August albeit reduced to 2/3 times a week reflecting the state of my anaemia. I am receiving continued treatment for my condition and my next review is in February 2020.'

The above can be confirmed by my GP should there be any doubt in probity. I feel reference to my anaemia and the subsequent impact on any future prescribed exercises should be factored into your report if it is to be a true reflection on the state of my health. Incidentally you. or indeed Mr David. not having access to my medical records has probably contributed to confusion over dates and timescales: such records not being available to you could also result in the incorrect medical terminology being used in your report which, of course, I am not professionally qualified to make comment on, but is of concern to me.”

“[Mrs R] has clarified that she has undertaken an exercise programme, albeit temporarily suspended due to investigation and treatment for anaemia. She has kindly informed me that this programme has now resumed, and that she is able to undertake exercises 2-3 times /week.

Regarding anaemia, if this were significant and itself causing a permanent bar to return to work, then further medical reports would be indicated from [Mrs R’s] GP and any relevant specialists before coming to a further determination. However, anaemia that has been fully investigated, that is without a serious underlying cause and that has responded to treatment would not normally pose a bar to return to work in future. [Mrs R] appears to be in the treatment process, with a further review in February 2020 to assess the impact of treatment.

Regarding access to [Mrs R's] full GP record, under General Medical Council and Faculty of Occupational Medicine guidelines, this would not normally be requested as much of the material therein is not relevant to ill- health retirement processes unless access is specifically indicated. As I have received comprehensive reports from [Mrs R's] GP, orthopaedic specialist and an independent orthopaedic specialist I would not normally seek access to [Mrs R's] full GP records unless there was a specific clinical or statutory reason to do so.

Finally, the point I previously made in respect of reinstating my health care plan needs to be addressed of course by Nationwide.

I understand that such issues are for further discussion between [Mrs R] and Nationwide.

In summary, I trust this provides the clarification required by [Mrs R] and the further documentation of [Mrs R's] concerns and my opinion thereon for the benefit of the Trustees as requested by Nationwide in their response to [Mrs R]."