EMPLOYMENT TRIBUNALS

Claimant: **Dr M Verma**

Respondent: **Blackpool Teaching Hospitals NHS Foundation Trust**

Heard at: Manchester **On:** 23-26 January 2023. Then in chambers on 11 April 2023.

Before: Employment Judge Leach
Mr A. Gill
Mr A. Clarke

REPRESENTATION:

Claimant: Ms M Tether (counsel)
Respondent: Mr M Smith (solicitor)

RESERVED JUDGMENT

The unanimous decision of the Tribunal is as follows:

1. The respondent failed in its duty to the claimant under section 20 Equality Act 2010 ("EQA) to make reasonable adjustments in that it applied PCPs requiring the claimant to travel to and from locations and to work at times that, by reason of the claimant's disability, placed her at a substantial disadvantage.

2. The claimant's remaining complaints under section 20 EQA fail and are dismissed.

3. The claimant's complaints under section 15 EQA fail and are dismissed.

Introduction

1. The claimant is a doctor who has worked for the respondent Trust since 2006. She is a specialist practitioner in Genitourinary medicine.

2. In 2011 the Genitourinary clinic in Blackpool moved from the main hospital (Blackpool Victoria) to the Whitegate Drive Health Centre (WDHC). Conveniently for the claimant, WDHC is only about a 10-minute walk from the claimant's home. Following that move, the claimant spent substantially all of her working time at WDHC.

3. In October 2016 the claimant raised grievances against some of her colleagues at WDHC. The respondent took a long time investigating these and it was not until March 2019 that the grievance process concluded. The claimant's grievances were not upheld.

4. In May 2017 the claimant began a period of sickness absence and was not fit to return to work until May 2019.

5. Return to work arrangements progressed very slowly. Initially the claimant worked from locations other than WDHC, principally Preston.

6. The claimant wanted to return to work at WDHC. Occupational health reports indicated the claimant had difficulties driving distances. They also indicated that the claimant's back condition was such that she should not be required to work in the evenings.

7. The claimant has not been provided with a full-time role based solely at WDHC, working between 9am and 5pm. The discrimination complaints arise out of this.

8. The claimant remains employed by the respondent although even by the date of hearing in January 2023 the parties had been unable to agree measures that provided for the claimant's return to work.

The issues

9. These were identified at a preliminary hearing (case management). The parties confirmed their agreement to these on the morning of day one, with some refinements that are included in the issues listed below – identified by underline.

> *Failure to make reasonable adjustments – section 21 Equality Act 2010*
>
> *1. At the time relevant to the claim, in relation to each condition relied upon by the Claimant:*

a. Did the Claimant have a physical or mental impairment? Subject to further clarification, as requested by the Respondent in its letter of 18 January 2022, the Claimant asserts that she has:

i. a muscular skeletal condition with lower back pain and sciatica;

and

ii. Anxiety/Depression/Post-Traumatic Stress Disorder (PTSD).

b. If so, did the impairment have a substantial adverse effect on the Claimant's ability to carry out normal day to day activities?

c. If so, had that substantial adverse effect lasted longer or was it likely to last longer than 12 months?

2. If the Claimant was a disabled person at the relevant time, was the Respondent aware, or ought it reasonably to have been aware, that the Claimant was a disabled person?

The respondent now accepts that at all relevant times the claimant had these disabilities and the respondent knew of them.

3. Did the Respondent apply a provision criterion or practice (PCP) of:

a. Working at the Preston Royal Hospital from 9 am to 5 pm (PCP a)?

b. Working at the Avenham Health Centre from 9 am to 5 pm (PCP b.)?

c. Working at the St Anne's Clinic from 5.30 pm to 8.30 pm after an afternoon clinic at Whitegate Drive Health Centre (PCP.c)?

d. Routinely working for three hours on a Saturday morning (PCP.d)?

e. Insisting that the Claimant cannot be permitted to return to work at all until a long-term job plan has been fully agreed (PCP e)?

4. Did PCP a, PCP b and/or PCP c put the Claimant at a disadvantage because it would have:

a. aggravated her lower back pain/sciatica;

b. caused her to suffer heightened levels of anxiety which exacerbate her PTSD, anxiety and depression; and/or

c. placed her at increased risk of sickness absence and action under the Respondent's Attendance Management Policy?

5. Did PCP d place the Claimant at a disadvantage because it would have deprived her of essential family time and thereby:

a. exacerbated her PTSD, anxiety and depression; and/or

b. placed her at increased risk of sickness absence and action under the Respondent's Attendance Management Policy.

6. Did PCP e. place the Claimant at a disadvantage by:

a. prolonging her sickness absence;

b. further exacerbating her PTSD, anxiety and depression; and/or

c. putting her at risk of action under the Respondent's Attendance Management Policy.

7. Was any disadvantage caused by PCPs a, b, c, d and/or e substantial?

8. If so, when did the Respondent's duty to take such steps as it was reasonable to have to take to avoid the relevant disadvantage arise in respect of each of the relevant PCPs?

9. If it is found that the Respondent was under a duty to make reasonable adjustments to avoid a relevant disadvantage caused by one or more of the forgoing PCPs:

a. has it failed to comply with the duty to make reasonable adjustments in relation to PCPs a, b, c and/or d by not accommodating the Claimant in a 10 PA job plan working from Whitegate Drive Health Centre?

b. has it failed to comply with the duty to make reasonable adjustments in relation to PCP e. by not allowing the Claimant to carry out 8 PAs at Whitegate Drive Health Centre while discussion over a 10 PA job plan continues?

10. When did the limitation period commence in relation to PCPs a, b, c and d? In particular:

a. Did the Respondent decide that the Claimant was not to be accommodated in a 10 PA job plan working from Whitegate Drive Health Centre and, if so, on what date?

b. Did the Respondent do an act inconsistent with accommodating the Claimant in a 10 PA job plan working from Whitegate Drive Health Centre and, if so, on what date?

c. If the Respondent took no such decision and did no such inconsistent act, when did the period in which the Respondent might reasonably have been expected to accommodate the Claimant in a 10 PA job plan working from Whitegate Drive Health Centre expire?

11. Was the claim in relation to PCPs a, b, c and d brought within three months of any alleged act of discrimination?

12. If not, would it be just and equitable to extend the limitation period?

Discrimination arising from disability – section 15 Equality Act 2010

13. Has the Respondent treated the Claimant unfavourably by insisting that she cannot be permitted to work at all until a long-term job has been agreed?

14. If so, has the Respondent treated the Claimant unfavourably because of her unwillingness to work at St Anne's Clinic between 5.30 pm and 8.30 pm and to work routinely on Saturday mornings?

15. If so, does the Claimant's unwillingness to work at St Anne's Clinic between 5.30 pm and 8.30 pm and to work routinely on Saturday mornings arise in consequence of her disability?

16. Has the Claimant treated the Claimant unfavourably by reducing her sick pay to half-pay and, from on or around 16 July 2022, nil pay) *?*

17. If so, has Respondent treated the Claimant unfavourably because of sickness absence from 9 August 2021.

18. If so, does the Claimant's sickness absence from 9 August 2021 arise in consequence of her disability?

19. If the Respondent has treated the Claimant unfavourably because of something arising in consequence of her disability, has it shown that the relevant treatment was a proportionate means of achieving a legitimate aim?

The Hearing

10. The parties provided substantial documentation in a main hearing bundle (960 pages) and an additional bundle of medical records (761 pages). References to page numbers below are to the main bundle unless otherwise stated.

11. The claimant gave evidence during the afternoon of day one and morning of day 2.

12. We heard from the respondent's 2 witnesses on the afternoon of day 2 and on day 3. The first of these was Dr Benedict Holden (BH), a consultant specialising in sexual health. Dr Holden started working for the respondent in April 2020, based in its Genitourinary Medicine and Sexual Health department ("Department"), the same department as the claimant. The second witness was Ms Vicky Buddo (VB), who was at all relevant times up to February 2022, the respondent's head of sexual health services and had organisational responsibilities for the Department. Both witnesses were involved in managing the claimant and in the proposals for the claimant to return to work.

Findings of Fact

13. The section below sets out our findings of facts relevant to the issues we need to reach decisions on.

14. The claimant is a doctor specialising in Genitourinary medicine. Her employment with the respondent Trust began in 2006. Between 2011 and May 2017 she worked, full time, based at WDHC.

15. The respondent Trust is based in Blackpool. Its headquarters are at Victoria Hospital in Blackpool although it provides health services at various locations in Lancashire, in addition to Blackpool itself.

16. In May 2017 the claimant began a period of sickness absence. The reason for the absence was stated to be *"work related stress."* Working relations between the claimant and the consultant who headed up the Department (Dr Sweeney) were poor. The claimant raised a grievance in October 2016 claiming that she was being bullied. That grievance was outstanding in May 2017.

17. It is not necessary for us to make substantial findings of fact about this grievance. We note:-

a. The main focus of the claimant's grievance, Dr Sweeney was (and is) the clinical lead at WDHC (pages 173-4).

b. the grievance process took until March 2019 to conclude.

c. That, according to the grievance appeal report (page 184) the claimant sought the following from the process:

i. Dr Sweeney to provide a sincere apology
ii. Ability to return back to Whitegate Drive Surgery
iii. Ability to work in a safe environment
iv. Cultural change within the service

d. Some shortcomings were noted in relation to Dr Sweeney's behaviour but it was not classed as bullying. Various other issues about which the claimant was aggrieved were not upheld either.

18. The grievance appeal report of March 2019, outlined a return-to-work strategy, particularly given that the claimant had, by then, been absent from clinical practice for 2 years. There is a Return to Practice Guidance that applies to doctors returning to practice after a long absence. This ensures a doctor is up to date with relevant clinical practice.

<u>The claimant's disabilities.</u>

19. We set out our findings about the claimant's disabilities.

20. By its amended response dated 10 August 2022 (at page 114) the respondent accepted that the claimant was at all relevant times disabled for the purposes of the Equality Act 2010 in that the claimant had the following impairments –

a. lower back pain and sciatica.
b. depression and post traumatic stress disorder (PTSD).

21. More recently (just one working day before this hearing) the respondent also accepted that, at the relevant time, it knew that the claimant had those disabilities. We have not seen a copy of a written admission but we record that admission here.

22. Even so, we need to make findings about the extent to which the claimant's disabilities prevented her from carrying out certain tasks. These are relevant to the efforts that both parties claim to have made to try to ensure the claimant's return to work.

23. The claimant has experienced pain from her back since 2006. Whilst initially the expectation was that she would recover, the claimant continued to experience difficulties. We note:-

a. 2008 – "clinically restricted lumber spinal movement with pain on flexion, extension and right lateral flexion."
b. 2012 – marked pain in the lumber spine and referred pain down the right leg (page 278 - medical bundle)
c. 2013, an MRI scan was taken showing significant degeneration of discs and an opinion that the claimant would benefit from injections (page 282, medical bundle).
d. 2014. Suspected sciatica – severe pain radiating down her left side to ankle. The orthopaedic consultant to whom the claimant was referred, noted that "on examination today she is tender at the back of the L5/S1 spine. Flexion is limited to the extent she can only touch her knees." He did not warent a further MRI scan, expected some improvement in movement and ability but also opined that th claimant may have to restrict her work activities "until she is fully recovered." And that he would provide the claimant with a notre for amended duties. (page 284 - medical bundle)
e. December 2015 – some stiffness and pain on movement in the claimant's lower back, fit to continue in her role but likely to struggle with evening clinics (724).
f. There are no records indicating that the claimant required medical interventions in relation to her back pain between December 2015 and early 2021.
g. In early 2021 the claimant attended on her GP who in turn referred the claimant to a consultant neurosurgeon.
h. In August 2021 the consultant neurosurgeon reported back to the claimant's GP. (page 43- medical bundle). He reported that the claimant has significant back pain and with pain down the right thigh to the knee. It summarised previous problems as follows: *"nearly a 10 year history of low back problems which settles with conservative treatment."* The report noted that the claimant reported that she had some changes to her working environment and a requirement for her to do some clinics in Preston *"which involves longer travel and longer working days which flares up her pain. When she's*

not working or travelling her pain is much better controlled." The report indicated an intention to carry out a further MRI scan.

24. The claimant was referred to the consultant neurosurgeon again, after an MRI scan was carried out. The consultant reported the reassuring news that there was no indication from the MRI scan of any change from a scan done in 2014. The consultant advised the claimant to *"continue with symptomatic management and exercise."*

Occupational Health reports.

25. A number of occupational health reports have been commissioned. We note the following comments and opinions about the claimant's back condition.

a. July 2020 – report of Dr Richardson, consultant occupational health physician. The report included the following question and answer about travel:-

Dr Verma has not worked clinically for three years and is required to undergo retraining under return to practice guidance which is likely to involve travel across Lancashire, predominantly in Preston, Lancaster and Morecambe. Can you please confirm if Dr Verma is able to travel to these venues either by car or A roads or alternatively by public transport?

There is not a medical answer response to this. Covid 19 has added an additional complicating layer regarding travelling by public transport. Normally Dr Verma would walk to her place of work which is within 10 minutes of where she lives.

b. November 2020. A further OH report was provided by a Dr Ferguson. The claimant initially objected to its release and required some amendments. A copy of a revised report is at pages 557-560 of the Medical Bundle. It includes the following:

Dr Verma is fit to drive a car and reported driving on "familiar routes within Blackpool". However, Dr Verma expressed that she does not feel confident driving a car on "motorways or A roads'. She reported anxiety surrounding a road traffic collision that occurred many years ago. Dr Verma may wish to consider additional driving lessons to help develop her confidence. Funding for transport, and perhaps driving lessons, may be available through the Access to Work Scheme. Alternatively; management may want to help with paying for private transport.

The claimant did not agree with the suggestion of additional driving lessons to develop confidence. We also note that this report (which has not been agreed by the claimant) focusses on the claimant's mental impairment rather than the physical impairment

c. The claimant attended on another occupational health physician, Dr Atkinson and a report was received in May 2021 (page 335). Whilst Dr Atkinson was asked questions about the claimant's ability to drive, this report did not provide

a clear answer, focussing instead on the information provided to him by the claimant, that her place of work was WDHC.

> *You have asked how far she can drive and on what sort of roads, it is clear that a combination of the previous road traffic accident has made driving on busy roads difficult, as you know she also has chronic low back pain and prolonged sitting, especially in a car, will always be expected to worsen this. Once she returns to her normal work then driving will not be an issue, at present her transport is being funded and this is enabling her to retrain and I suspect that further exploration of the fine detail of exactly what road she can drive on is of limited relevance now but could conceivably just aggravate a situation which is starting to settle. Since these things, particularly the low back pain, will vary from day to day anyway I am not sure that there is anything extra that I can add to this that would be either useful or accurate. Driving is not proving an obstacle to her return to work and it seems more productive to be encouraging her in this direction.*
>
> *I think that the sort of support which would be required to allow her to drive confidently on busy roads would take much longer than the period that she is needing to travel to other hospitals to have any chance of success and therefore this is perhaps a topic best left alone.*

d. A further report was provided by Dr Atkinson in October 2021. On this occasion he was very clear about the expectations that could be placed on the claimant travelling in a car, either as a driver or a passenger.

> *Your third question was whether there were any treatments or reasonable adjustments the Trust could consider which would enable Dr Verma to travel to work in Preston either as a passenger or driver. The short answer to this is no there are none. As above there is certainly no medical treatments that I know that would improve back pain to this degree, similarly there are no sensible adjustments that would work either. Breaking down the journey into two separate 20 minute component separated by 30 minutes rest conceivably might work but given that this would have to happen in both directions this is hardly practicable I would have thought.*
>
> *I can confirm that in completing this report I have had access to the email chain forwarded from Tom Carver with Dr Verma's comments. On a non-medical note I can confirm that the journey from Blackpool to Preston and back again, if undertaken at times of rush-hour traffic will take longer than 40 minutes, predictably, this is a journey I have undertaken on many occasions.*

<u>What the claimant can and cannot do.</u>

26. The claimant's physical condition causes pain and discomfort. Only the claimant knows the extent of that pain and discomfort and the impact on her. Even so, we are required to make findings of fact about what places the claimant at a

disadvantage and what adjustments would remove or reduce that disadvantage. As far as the claimant's physical disability is concerned the disadvantage is the pain she suffers and the worsening of that pain. These are our findings:-

a. The claimant manages her pain through painkillers and sometimes also the use of a TENS machine (GP report of January 2021 at page 282).
b. The claimant's pain is sometimes worse than at other times, whatever activities she has been carrying out. However, there are no effective medical treatments that will improve the claimant's condition.
c. The pain is not increased by undertaking a full-time working role; because if she was not working, she would still be undertaking activities at the house or locally and those activities would involve a similar amount of movement. We base this on the views expressed by Dr Atkinson about the potential for evening work. We also note that neither the claimant nor any practitioner has indicated that the claimant's condition might be improved (or her pain reduced) were she to carry out less than full time hours. We do note a potential conflict here with the consultant's opinion quoted at paragraph 23 h. above but take that as a reference to persistently working long hours and travelling.
d. A lack of movement or maintaining the same position for extended periods can be particularly problematic for the claimant. We note here particularly the report of Dr Atkinson and his clear view that sitting in a car for prolonged periods is problematic for the claimant.
e. Frequency or repetition of activity is also problematic. The claimant is able to undertake some tasks as long as she does not do so with too much frequency or intensity. See for example Dr Atkinson's report of 28 October 2021 (at page 650) where he opines that the claimant would be able to perform clinical procedures such as coil fitting as long as the clinic involves only a few being fitted and not sustained physical activity over 2 or more hours.
f. A combination of sensible movements, sitting and standing and walking is the best option for the claimant during the day. We have not seen a medical report that states this, but we consider that to be a common-sense conclusion from the medical reports and other evidence provided (including the claimant's evidence when being cross examined about trips to India (see below).
g. Whatever the claimant has done during the day, she will often be in some discomfort in the evenings. The extent of that discomfort changes, sometimes improving and sometimes deteriorating. The claimant's condition (or rather the pain that the condition causes the claimant) is sometimes better and sometimes worse; for example, the claimant does sometimes drive to the local supermarket in the evening. On other occasions she remains at home, with pain relief from a TENS machine.
h. We have not seen evidence that there has been overall deterioration in the physical condition over the past 8 or 9 years at least. The medical evidence shows the opposite.

27. During cross examination the claimant was asked about her long-distance travel to India. These are our findings:-

a. Once every 2 years or so the claimant and her husband travel to India to see friends and family.
b. The claimant can manage this long journey.
c. This long journey it is not routine. We accept the claimant's evidence that she is willing to make this effort to see her family and friends and that, whilst on the plane, she can (and does) get up sometimes and walk around, so that she is not sitting in one position for extended periods.

PTSD and Depression

28. This was first diagnosed in October 2017 (report at page 167 of medical bundle) following referral from the claimant's GP to a consultant psychiatrist. The pychiatrist's report notes no previous history of psychiatric illnesses. The psychiatrist recommended psychological therapies and there is confirmation (page 170 of medical bundle) that the claimant received this "*for anxiety and work related stress*"

29. In her witness statement the claimant provides evidence of some previous episodes affecting her mental wellbeing (particularly 2010-2012) but nothing before 2017 to indicate an ongoing condition.

30. The report of October 2017 notes that the claimant became distressed when discussing the way that she says she was treated by her manager (which we take to be Dr Sweeney).

31. By 2019 the claimant stated that she was ready to return to work. Whilst there was some difference in the opinions of occupational health practitioners, overall the view was that the claimant's disability did not prevent a return to WDHC, although some monitoring of the claimant would be required.

32. By April 2021, Dr Atkinson was clear in his expert view (page 336):

> *Clearly things have gone significantly and badly wrong in the past, I see little point in exploring this, this will achieve nothing but could potentially be destructive. I'm sure that the better aim here is to concentrate on the very many positives available which mean that I can see no reason why she cannot successfully return to her normal workplace having completed a period of supervised practice to upskill her again the following two years absence from clinical practice essentially.*
>
> *I understand that she should have finished her supervised period of practice (I'm assuming this is what you refer to when you mention remediation) by the end of June approximately. She does have trouble driving for a combination of reasons but I understand that NHSI are funding taxis, and have been since the beginning of the year and are willing to do this until she has completed the process of retraining.*
>
> *She has been receiving excellent treatment for her symptoms associated with trauma, of particular help has been the clinical psychologist I hear. This*

has worked extremely well and has probably been a large part of the reason why she it is been possible for her to be able to draw a line under things, she tells me that she has met the medical manager with which she first had a disagreement and would have no problem doing so in the future. Working at Whitegate Drive will not be a barrier, although associated with some of the initial problems she has moved forwards a long way with these and there is nothing specific about the location that I would expect to cause her any problem or recurrence of her symptoms. It also has the advantage of being within 10 minutes of where she lives and this means of course that she does not necessarily need to drive to get there.

As mentioned at the start of this report I'm sure that this would have been a very difficult and complex case that I've seen her a year or more ago, this is no longer the case for whatever reason things have settled enormously and she is now well.

33. A medical report in November 2021 noted that the claimant was in low mood and was preoccupied with the ongoing employment situation. The doctor's view that it was the employment situation that was maintaining the claimant's low mood and anxiety, that the claimant should continue to take anti depressant medication and that he was hopeful for an improvement to the claimant's mental health once the employment position had improved. (pages 123-126 of Medical bundle).

34. The claimant has a dislike of driving on busy roads (motorways and A roads). We have considered references in medical reports on this issue. Whilst the claimant objected to Dr Ferguson's report, our finding is that it included a measured and sensible recommendation to obtain additional driving lessons to develop the claimant's confidence.

35. We find that this dislike arises from a "near miss" that the claimant experienced whilst a passenger in a car driven by her husband. It has limited her confidence whilst driving so that she restricts her driving to familiar routes around Blackpool. We accept that the claimant's conditions of depression and PTSD will impact on her confidence including whilst driving. Whilst initially the claimant's objections to proposals that she drive long distances arose from concerns about the claimant's mental impairment, it is the claimant's physical impairment particularly that prevents her from driving with any frequency for long periods.

<u>Steps taken towards the claimant's return to work</u>

36. An occupational health assessment took place on 6 April 2019. The report that followed the assessment is dated 8 April 2019. It made clear the claimant's wish to return to work at WDHC. The report also noted (1) the claimant's discomfort in driving on motorways and that was an obstacle to her working at other locations (2) that there are no medical reasons as to why redeployment would be necessary. The report notes these factors specifically in response to a question put by the respondent as to whether redeployment to a role at a different location within reasonable travelling distance was

necessary – as it would separate her more from the people against whom she had raised grievances.

37. The report noted that the claimant was willing to see a line drawn under the issues and to return to WDHC. *"She feels as long as there are rules regarding people's behaviour she wishes to return to Whitegate Drive health centre."* (page 199)

38. The day after this report (9 April 2019) VB sent an email (Page 201) to the respondent's HR team indicating that the claimant could be supported with retraining in the Preston and Lancaster clinics. In that email, VB also indicated that the permanent arrangements would include those locations. The HR reply (from Lesley Smith Payne – interim director of workforce (LSP)) included the following:-

> *"I am meeting with Dr Verma and her rep next week re next steps so the alternative opportunities don't need to be discussed widely just a view of what roles we potentially have within sexual health that may be deemed suitable. It can be as simple as we have half a SAS role in Preston and 2 days in Lancaster. We still are a long way from a RTW date as we need the OHS advice and then the retraining plan. That, said it would be really helpful if I could have some broad options of an alternative role within the service or secondment opportunity."*

39. Following a meeting, LSP wrote to the claimant by email dated 22 May 2019. In this email LSP outlined a return-to-work plan which might include retraining at a different location to WDHC depending on the type and extent of training required. The email also includes the following paragraph: "*Following successful retraining we would then facilitate your return to your substantive role putting in place interventions which we have discussed to enable you to return to Whitegate Drive and work professionally with Dr Sweeney, your colleagues and peers."*

40. More detail was provided in this email and with a promise of a retraining plan to follow. As the claimant presented as fit to work, it was agreed to reinstate the claimant's pay from then.

41. We observe here that, whilst the claimant expressed her wish to return to WDHC, the respondent's focus in its email of 9 April 2019, was on finding a role for the claimant in different locations. and that it needed to find a role for the claimant rather than her returning to the role that she had prior to the commencement of her sick leave. However, by 22 May 2019 the respondent told the claimant that she would return to her *"substantive"* role at WDHC The claimant had by that stage been absent for about 19 months.

42. Despite this indication that the claimant would return to WDHC, we find there was some resistance to this within the respondent. We base this on the following:-

a. The respondent's Head of HR – Kevin Moynes (KM) made clear in discussions that the claimant would not be returning to work at WDHC (note of discussion with KM is at page 211). Whilst we find that the attitude of the respondent had

changed by late 2020, it was the view of influential individuals within the respondent Trust that the claimant should not return to WDHC. It was also a position that was restated by KM in July 2021 (notes of meeting of 8 July 2021 at 564)

b. A decision was made to provide the claimant with a work plan which would have required the claimant to be based whole time (or substantially whole time) at Preston (see below). It wasn't just KM therefore who showed some resistance to the claimant's return to WDHC. Also see our comments about the email of 9 April 2019 above.

43. There were delays in the retraining plan and other plans to get the claimant back in to the workplace. We note even as late as 10 December 2019, the respondent was writing to the claimant about plans for a return to work but with no clear, agreed plan in place. This delay was caused in part by disagreement between claimant and respondent about what the claimant had done and was required to do (including for regulatory reasons) to enable her to return to clinical practice after such a long absence.

44. Further delay to the process was caused (or contributed to) by a relapse in the claimant's health in February 2020. She was certified as fit to return to work in September 2020.

45. The respondent commissioned another medical report in November 2020. This report expressed some caution about the claimant returning to work at WDHC. Whilst the report noted that it was possible, it also stated that it would require careful assessment because there was a risk of it triggering further mental health problems. The report also noted the claimant's lack of confidence in driving a car outside of Blackpool and suggested additional driving lessons to help develop confidence or funding for private transport (which we have taken to mean taxis) (this is the report of Dr Ferguson noted at paragraph 24b above).

46. Two return-to-work meetings took place on 9 and 16 December 2020. At the first meeting the claimant was introduced to 2 senior doctors who were to be her supervisors. Dr Dwivedi is a consultant in sexual health. She was to supervise the claimant's contraception clinical practice; BH (also consultant in sexual health) was to supervise the claimant's Genitourinary Medicine (GUM) practice. By this stage the claimant had been absent from work (and any clinical practice) for over 3 years although for some of that time, she had indicated she was ready and able to return to work and therefore been in receipt of full pay.

47. We observe from the notes of these return to work meetings (pages 255 – 261):-

a. The claimant was informed of changes to both clinical areas over the previous years and a learning/update strategy was discussed. The claimant was told about various learning resources available to her.
b. The claimant was informed that the services were running differently during the COVID pandemic.
c. The claimant had not completed some tasks which needed to be done to facilitate a return to work. We note particularly that on the 16 December 2020 the claimant told others present at the meeting that she had been unable to complete a COVID risk assessment that she had been provided with on 9 December 2020 because she needed the assistance of her husband to do this. We also note that on 9 December she had been tasked with contacting NHS IT support. On the 16 December she had to be told again to do this as it had not been progressed. The claimant was not doing all that was reasonably expected of her to assist a return to work. We find this was because of the claimant's mental state at the time. She was not being intentionally difficult.
d. It was agreed that the claimant would return to work (on a phased/managed plan) on 21 December 2020. The return-to-work plan was to be emailed to the claimant on 16 December 2020 and she would provide her comments the following day.

48. The return-to-work plan required the claimant to work out of Preston as well as an afternoon clinic in Burnley. It did not include sessions at WDHC. The respondent made arrangements for taxis to take the claimant to Preston and Burnley.

49. The timetable for returning to work is at page 264. Each of the first 2 weeks required one day's travel to Royal Preston Hospital (RPH). The third and fourth weeks required 2 days' travel to a location called Avenham in Preston as well as a day in Burnley. The final week required the same amount of travel as weeks 3 and 4 but on one of the days spent at Avenham, the claimant was also timetabled for a late (evening) clinic at RPH. The timetable was updated over the following 6 months but continued to involve a combination of working at RPH, Avenham and Burnley together with some time for learning and administration.

50. On 16 December 2020, the claimant commented on the return-to-work plan, noting particularly her view that there needed to be greater focus on GUM clinics as that what her job plan contained. VB replied the following day. Her replied included the following comment

> *Initially the return to work plan will not reflect your job plan of 3.5 years ago as we are supporting you around refresher training. Once this is completed and you feel confident and competent to conduct your own clinics your job plan will be reviewed and updated. I am confident on your return you will see that clinical practice has changed dramatically during the pandemic and we are now utilising digital innovations to meet patient need.*

51. On 18 December 2020 the BMA raised concerns, on the claimant's behalf, about the intended length of the claimant's working day, given that it also included

travel time at the start and finish of the day. These concerns were raised again in the early stages of the return-to-work plan.

52. The claimant needed supervision. She needed to shadow appropriate senior doctors. It was the respondent's practice to require its doctors to work from more than one location. The claimant needed to attend clinics that were appropriate to the supervision and observations required. However there was no clinical need for all sessions to be in locations other than WDHC. A conscious decision was taken by the respondent that it was best to facilitate the return to work, away from WDHC *"so that Dr Verma felt that those who were supervising and assisting her progress were as objective as possible and not influenced by the previous concerns regarding her performance or her subsequent grievance or allegations regarding the culture of the department."* (VB statement at para 8)

53. In the early stages of the return-to-work plan (January 2021) the claimant and the BMA raised concerns about the claimant being required to attend clinics until 5pm and then having to travel home. On 12 January 2021, the claimant herself emailed BH directly and raised some concerns. We find this email to be an important benchmark and set it out in full below.

> *Dear Dr Holden,*
>
> *Hope you had a lovely Christmas. Wishing you a very happy and safe New year!*
>
> *I wanted to thank you for all your support so far with my return to work; I have found you to be supportive.*
>
> *In particular, I appreciated your acknowledgement of the need to factor in my feedback into the return-to-work plan (attached), and fully understand you had to create the first draft in a short timeframe.*
>
> *As such, my comments are as follows:*
>
> *1. There is a noticeable difference between my last agreed job plan in respect of GUM to CASH ratio and the proposed timetable.*
>
> *2. My last agreed job plan is primarily GUM (80% of my work entails GUM and 20% is contraception/CASH).*
>
> *3. As drafted, I'm due to attend five CASH clinics instead of two as per my last agreed job plan and so would ask that this be amended, to reflect my role.*
>
> *4. I am aware that Dr Dwivedi has two CASH clinics on a Monday at Preston that I am willing to attend and which will also meet 20% of CASH/contraception.*
>
> *5. Also, when undertaking evening clinics was proposed, this prompted me to review the previous occupational health advice from Dr Mansour & Dr Richardson confirming I should not be doing evening clinics as a*

reasonable adjustment. (I have enclosed copies of the OH reports confirming the above on a strictly confidential basis, only for yourself and Vicki & not to be shared with anyone else.)

6. I suffer from long-standing medical health conditions (musculoskeletal) that can be quite debilitating and my symptoms tends to worsen as the day progresses (severe lower back pain with sciatica as a result of two episodes of lumber disc prolapse associated with sciatica, residual chronic ankle pain and tennis elbow).

7. Whilst its absence wasn't too problematic for the first couple of weeks, travel time will need to be factored in as the number of working days increases.

In light of the above, please could the timetable be adjusted to reflect my feedback, ahead of my return from leave on Monday 18th?

54. We make the following findings:-

a. The claimant was generally pleased with the return-to-work arrangements.
b. She wanted the ratio of work to change as she wanted more emphasis on GUM and less on contraception medicine.
c. Her expectation that this process of supervision should reflect the proportion of activities in a job plan of some 4 years ago was unreasonable.
d. She made clear that she was unable to carry out evening clinics and referred to the OH position in 2016 (copy reports from 2016 having been enclosed – page 285)
e. She was willing to continue to travel to Preston but noted that where this became more frequent/long term, the respondent would need to make some allowance for travel time.

55. Reviews in the form of return to work meetings took place. We note the following:-

a. At such a meeting on 20 January 2021 the claimant provided positive feedback about working with BH and Dr Dwivedi. She raised concerns about working until 5pm and then travelling home from Burnley or Preston by car.
b. At a meeting on 17 February 2021 the claimant was still generally positive as were her supervisors. However it was agreed that the claimant was not at that stage ready to work independently.

56. The respondent told the claimant and the BMA that it would arrange for an occupational health appointment specifically to consider the claimant's concerns about working and travelling in to the evening. (email from LSP to BMA and Claimant dated 15 January 2021 – page 288 and from BH to Claimant dated 18 January – page 292). It was observed that the previous OH advice provided by the claimant was from 2016. Up to date advice was required.

57. The next OH report was received by the respondent on 19 May 2021. It is the report from Dr Atkinson we have referred to at para 25c above. It states that prolonged sitting especially in a car, worsens the claimant's back pain and that the claimant would have an ongoing difficulty with working after 5pm. In a follow up email Dr Atkinson was asked if his opinion about working after 5pm would change if the claimant was not required to start work until lunchtime. In his reply (19 May 2021 at page 350) he says not. This is because most people tend to get up at approximately the same time of the day, even if not starting work until a few hours later*. "Having got up whether working or not, the day has started and from this point on her low back pain is likely to increase as the day goes on. Therefore, I suspect she might still have difficulty if working a clinic which did not finish until 7pm."*

58. On 2 June 2020 the claimant was provided with an updated provisional timetable. We note that no late clinics were included although the claimant was still required to attend clinics at RPH, Avenham and (Wednesdays only) Burnley. We also note that this was a 4-week timetable and that a job plan to work to after a reintroduction to practice was yet to be agreed (see email from BH of 11 June 2021)

59. Included in the bundle is a document dated June 2021 called *"Supporting returning to practice summary. Dr M Verma Specialty Doctor Sexual Health."* The noted "next steps" in this report were *"to have a job plan developed based in Preston 8.5DCC/1.5SPA to include an evening."*

60. A meeting, called a Progress Review Meeting took place on 9 June 2021. Various people including the claimant, VB, BH as well as the respondent's medical director and the respondent's director of workforce, were present. Whilst the claimant was not at that stage in a position to return to independent practice, generally the mood of the meeting was that she soon would be and that these arrangements should be made. Workplace locations were not discussed except that it was noted that the support for the claimant of being provided with taxis to travel to Preston and Burnley was continuing. At that stage the claimant did not complain about this arrangement. However we also accept that the claimant was at that stage expecting to return to WDHC (in the main at least) once she resumed independent clinical practice.

61. Thoughts therefore turned to a more permanent job plan to apply once the return-to-work plan had been successfully completed. Even though the claimant had expressed her expectation that she would return to WDHC (and the respondent had indicated in 2019, that would be the plan) the respondent told the claimant that there was no clinical need for an additional doctor in WDHC. At this stage the respondent put forward 3 options, each of which required work at Preston being a combination of GUM clinics (at RPH) and contraception clinics (Avenham). This is what the claimant was told about WDHC:

> *Unfortunately there is no need for an extra clinician in Blackpool Monday to Friday 9 to 5.*

> *There is no longer a walk-in service, footfall has significantly decreased with the introduction of on-line testing, you don't undertake HIV provision and there are no rooms. The nursing team have been upskilled, we now have 2 GP trainees, There simply isn't the space in clinic to accommodate another doctor and the patient flow to justify their presence.*

62. 2 of the 3 options required an evening clinic on a Monday. The third option (described as the "less than ideal" option) included 2 telephone clinics. All 3 included 1.5 SPAs (see below). The options are set out at page 443. In relation to those options that included an evening clinic, the claimant was told as follows (page 442)-

> *So – the main message I was given from your occupational health report was that you couldn't work past 5pm under any circumstances. So despite the service needing doctor cover for essential core services running after 5pm, a 10 session job plan with no twilight hours has been put together. If we were constructing the ideal job plan for service delivery in line with the commissioners intentions, we would have expected at least one 7 pm finish, and that could have been after a late start, so not a long day, just a late finish. However that wouldn't have been within the occupational health guidance – so reasonable adaptations have been made to accommodate your restrictions.*

63. The claimant was upset that she was provided with proposals that required her to work at Preston rather than returning to WDHC. In a Teams meeting with BH she said she had been told she would return to WDHC. BH did not recall any meetings when she had been told this. Both are right. The claimant was told that she would return to WDHC (see para 39 above). She was told this prior to the commencement of BH's employment with the respondent and therefore before he became the claimant's manager. We note that it was the third (less than ideal) option that the respondent was pursuing in correspondence that followed in June and July 2021. Options one and 2 were not being pursued.

64. In a review meeting on 8 July 2021 the claimant and her BMA representative acknowledged that some adjustments were included in the third option proposal (the provision of taxis and no evening working) but stated in clear terms that the claimant was based in WDHC, that is only 5 minutes' walk from the claimant's house. The BMA stated that the taxi ride to Preston – which can take an hour – had not helped the claimant's health. The respondent agreed to consider obtaining more occupational health advice.

65. Following that meeting and further review of the Occupational health information, the respondent drafted a letter to the claimant. It is in the bundle at pages 569-571. The draft is dated 13 July 2021. It was not sent. The draft set out a broad job plan for a return to WDHC. That broad job plan provided for full time work but included 2 evening shifts (with no morning work on the 2 days that the claimant was being asked to work evenings) and a Saturday morning shift. According to the draft, it would start

from October 2021 following the retirement of a doctor who undertook clinics at WDHC.

66. The terms of the draft letter also raised concerns about the claimant's return to work at WDHC; the potential impact on the claimant and the potential impact on other employees working there, given the breakdown in relations in the lead up to the claimant's grievance and long-term absence from May 2017.

67. The intended signatory to that letter is Kevin Moynes ("KM"), (although some or all the letter may have been drafted on his behalf) . We have already noted that KM expressed strong views against the claimant returning to work at WDHC. KM did not attend the Tribunal as a witness.

68. We find that the clinics that would have been proposed had the draft letter been sent were ones that would become available at WDHC, from October 2021. Later in the chronology, job plans around working at WDHC are proposed and the respondent's stated position (in relation to the job plans proposed at a later date) is that there was not a requirement for a doctor such as the claimant to carry out many of these clinical sessions. We do not find that to be the position in relation to the job plan set out in the draft letter on 13 July 2021.

69. The proposed timetable would have provided the claimant with a full time (10 PA) job plan based mainly at WDHC. It included 1.5 SPAs (see below) but it also included 2 evening clinics on days when the claimant was not required to start work until noon. One of the evening clinics was at St Annes, not WDHC.

70. The claimant began a further period of sickness absence on 10 August 2021 and has not returned to work since. Prior to her sickness absence she emailed the respondent's medical director (Dr Gardner, who had attended the meeting of 8 July 2021)

> *As mentioned before in our last meeting, the long commute is significantly impacting my physical and mental health. However, I did not see this captured in the minutes of our last meeting hence I am reiterating this in writing, to you.*
>
> *It has now been 8 months since the Trust requested that I undertake this long commute for remedial training, which was meant to be only for a brief period.*
>
> *You are aware that my remedial training has finished and I have been back to independent practice for last 2 months.*
>
> *This long commute is taking a huge toll on my well-being: particularly worsening my sciatica, back pain and is causing heightened levels of anxiety to be left in such a difficult situation.*

As promised in writing by my organisation before, I would appreciate if I am returned back to my base at Whitegate Drive without any further delay.

Looking forward for a positive response from you.

71. In October 2021 the respondent received further OH report from Dr Atkinson (see relevant reference to this at 25d above).

72. Also in October 2021 the claimant began early conciliation and subsequently issued her claim on 11 December 2021.

73. Following receipt of the further OH report, by letter dated 24 November 2021, the respondent provided 3 different return to work proposals (page 677). We summarise these:-

a. Proposal one - to remain at Preston full time.
b. Proposal 2 - to work at WDHC but with one evening clinic (at a different location – at St Annes which is a few miles down the coast from Blackpool) and one Saturday morning clinic
c. Proposal 3 – to work at WDHC but on a less than full time (4/5) basis.

74. Each of these proposed job plans included 1 SPA. We note that previous work plans had included 1.5 SPAs. We make findings about job plans and SPAs next.

Job Plan

75. Doctors are subject to a job planning process. There is a senior doctor job plan policy (369-410) which applied to the claimant.

76. This is what we find (based on the evidence we heard and from the job plan policy) ;-

a. A doctor's job plan is (or should be) reviewed on an annual basis. See page 395.
b. Part of the review will be what clinics doctor will cover, whether job plan in existence remains relevant and optimum.
c. The claimant had not had a job plan review since before May 2017 when the claimant had been carrying out all her clinical activities at WDHC. Those had been a combination of GUM and contraception clinics with an emphasiss on GUM.
d. The claimant was not a specialist in some areas of sexual health. She was unable to carry out HIV clinics. Such clinics could not be part of the claimant's job plan even though a number of these were held at WDHC.
e. Whilst the claimant did carry out contraception clinics, there was some complex contraception activity that the claimant was unable to carry out and was carried out by a consultant with relevant expertise.
f. A full-time job plan is broken down in to 10 sessions called Professional Activity sessions (PAs).

SPAs

77. Some of the PAs are called SPA's(Supporting Professional Activities). These are sessions which a doctor can devote to learning/keeping up to date and maintaining competence. According to the respondent's job plan policy (at page 383) a full-time specialty doctor such as the claimant would normally be allocated 1.5 SPAs out of the total of 10 PAs as a minimum.

78. At page 904, is a schedule to the terms and conditions of specialty doctors which deals with Job Planning. This requires a partnership approach to job planning between doctor and employing Trust. It refers to a "minimum of one SPA" to be included in a Job Plan. This is not inconsistent with the respondent's own policy which normally allocates 1.5 SPAs.

79. Given the terms of the respondent's own policy (and the inclusion of 1.5 SPAs in previous proposed plans) we find it surprising that each of the 3 options put to the claimant in November 2021 only included 1 SPA.

Saturday morning clinic

80. One of the options put to the claimant in November 2021 involved the claimant working at a clinic at WDHC on a Saturday morning.

81. The respondent ran a Saturday morning clinic at WDHC because there was a demand for relevant health services there on a Saturday morning.

82. The claimant objected to working on a Saturday morning. The objections are summarised in an email from the BMA dated 18 February 2022 which was a formal grievance raised on the claimant's behalf.

> *" Routinely working for three hours on a Saturday morning. The feature of this PCP which puts Dr Verma at a substantial disadvantage in comparison with persons who are not disabled is that Dr Verma's mental health impairment gives her an acute need to have down-time and to spend time with her husband, who works from Monday to Friday in Carlisle and plays a crucial part, when he is at home over the weekend, in helping Dr Verma cope with her mental ill-health.*
>
> *A requirement to work routinely on Saturday mornings would deprive Dr Verma of this essential family time and would therefore exacerbate her PTSD, anxiety and depression and place her at increased risk of sickness absence and action under the Trust's Attendance Management Policy.*

83. The claimant also gave evidence at the Tribunal about her objection. She told us that she relied on the support of her husband and that helped with her mental health; that her husband was often not home until late in the evening during the week because he held a senior position at an NHS Trust in Carlisle and had a significant daily commute to Carlisle and back. Weekends, therefore, when she could spend time with her husband, were important to her.

84. She also accepted that her husband would run errands over the weekend including shopping for groceries and cooking. They would not be together when her husband carried out some errands.

85. We have not seen medical evidence to indicate that the claimant cannot work at a local clinic on a Saturday morning or that her mental impairment would be adversely affected.

86. We find (based on the evidence provided) that working on a Saturday morning clinic at WDHC would not put Dr Verma at a substantial disadvantage. On this point we find that Dr Verma refused to accept this flexibility because she was insistent that she be permitted to work at WDHC during day-time hours, weekdays only. The claimant expressed her refusal to work Saturday mornings by reference to her mental health but it was not her mental impairment that that prevented her, it was her refusal to compromise on this aspect.

87. Working for 3 hours on a Saturday morning would also involve some compromise to the claimant's home life; but it would not place the claimant at a significant disadvantage in comparison with persons who do not have a disability.

Travel to Preston, Burnley, Avenham and St Annes.

88. These are locations other than WDHC at which the Department holds clinics. There may be other locations, but these are the ones we learned of.

89. The respondent requires its clinical practitioners to work from more than one location and we heard evidence of clinicians in the Department (including BH) who do this. This is confirmed by a term in the claimant's contract (which we are sure is standard and applicable to other doctors employed by the Trust)

> *" Your principal place of work is GUM-BVH with a requirement to attend weekly clinics at Fleetwood and Poulton. Other work locations including off site working may be agreed and incorporated in your Job Plan where appropriate. You will generally be expected to undertake your Programmed Activities at the principal place of work or other locations agreed in the Job Plan. Exceptions will include travelling between work sites and attending official meetings away from the workplace.*
> *You may be required to work at any site within your employing organisation, including new sites provided that they are within a reasonable travelling distance from your home address."*

90. This contract is dated 2009. The reference to GUM-BVH is to Blackpool Victoria Hospital. As already noted, the claimant's principal place of work changed in 2011 to WDHC.

91. In her evidence, VB accepted that travel to RPH and Burnley by any method other than a car would be difficult from the claimant's home or from WDHC.

92. We also heard evidence from VB that travel by public transport to Avenham from the claimant's home or WDHC was a viable option; that there was a direct train from Blackpool to a station that was a 10-minute walk from Avenham.

93. The claimant was asked whether she had considered the option of travel to Avenham by public transport. She answered that she had but that she would not be prepared to travel by train because she would be too anxious that the train would be late.

94. We did not hear any evidence about travel from the claimant's home or from WDHC to St Annes. All members of the Tribunal know that St Annes is a few miles down the coast from Blackpool. However, St Annes featured in the various options provided to the claimant as an evening clinic. The evidence was focussed on the viability of an evening clinic for the claimant not the viability of travel to St Annes.

95. The claimant's disabilities limit the locations at which she can work. They do not however restrict her to work at WDHC and no where else.

<u>The claimant's grievances and proposals (from both sides) for the claimant to return to work pending resolution.</u>

96. As noted above, the claimant raised a grievance in February 2022. One of the issues raised in her grievance was the respondent's decision to reject a proposal made by/on behalf of the claimant (on 7 February 2022) for her to return to work on a phased return basis and increasing her working hours to 8 PAs based at WDHC. She would then remain on 8 PAs at WDHC pending an outcome of the ongoing discussions about agreeing a full time (10 PA) job plan.

97. There was some dispute at the final hearing about whether the claimant's proposal included her receiving pay for 8 PAs or for 10 PAs. We find that the claimant's proposal was that she would work 8 PAs pending agreement but would at all times be paid for 10 PAs. We find that she was asked that at a grievance hearing in March 2022 and that is what she confirmed (notes at page 773).

98. The respondent put some proposals to the claimant

a. On 25 February 2022 it was put to the claimant that she could return on 8 PAS and that this would be reviewed at the next Job Plan meeting. The claimant was told: *"that if she accepts the 8 PA job plan now, that would not preclude the possibility of 1 or 2 further PA's being added to her job plan in future should clinic space become available and should that otherwise be reasonable at the particular time."* This option was repeated during the grievance process. The claimant rejected the option.

b. Much later, in the appeal outcome letter of 30 December 2022 (and therefore shortly before this final hearing) the respondent put a further option to the claimant – that she could return on the basis of 8 PAs and receive pay protection (therefore be paid for 10 PAs) for 12 months. As at the date of the final hearing, the claimant had not accepted the option.

99. It is frustrating that the parties could not reach enough of an agreement to enable the claimant's return at this stage, although we also note that the claimant continued to submit fit notes throughout 2022 stating that she was not fit to work due to *"work related stress".* (examples at pages 686,707,778,807). We find, on balance, that a resolution of the dispute about the job plan would have led to an improvement in the claimant's mental health so that at some point (although perhaps not immediately on resolution) the claimant would have been able to return to work. We base this on the medical report of November 2021 noted at paragraph 33 above.

100. However, we are far less confident that the claimant's stress at work condition would have improved sufficiently to enable her return to work, in the event of an ongoing dispute but short term "fix" such as those proposed by the respondent in April 2022 and December 2022. We note the claimant's refusal of these options when put to her and the continuation of her sickness absence following those refusals.

Payments during sickness absence

101. The claimant's NHS terms and conditions include terms providing for payment of salary during periods of sickness absence. The terms are in line with those seen in many large public sector employers and they are generous. They provide 6 months payment of full salary and another 6 months payment of half salary. The claimant has been able to rely on these terms on more than one occasion over the previous 6 or so years.

102. During the claimants most recent period of long-term absence, her pay reduced from full pay to half pay in January 2022 and then from half pay to nil pay in July 2022.

Staffing and resource requirements at WDHC.

103. There was considerable dispute between the parties on these topics.

104. We refer to our earlier findings about the attitude within the respondent, to the claimant's return to WDHC. These findings are supported further by the fact that none of the 3 job plan options put to the claimant in June 2021 involved any PAs at WDHC. That is where the claimant had been based, was close to her home and where she had expressed an intention to return. There are 30 PAs across the options put in June.

105. At this stage the respondent was intent on the claimant not returning to work at WDHC. This was because of a reluctance to place her again in that workplace and concerns about relationship issues following the protracted grievance process. That position changed later in 2021, following further occupational advice and opinions.

106. By July 2021 the respondent became aware that a number of clinics at WDHC would need covering from October 2021. However, it was not until November 2021 that the respondent proposed job plans which required the claimant to work from WDHC (see earlier).

107. We accept the respondent's evidence that various changes had occurred within the Department including staffing changes as well as changes about how clinical care is given. There were periods when the claimant was absent for very long times. Practically she has not returned to clinical duties since her long-term absence began in May 2017.

108. Often, when employees become absent, even for long periods, the employer will retain that employee's post. Others may be appointed to carry out the role but on a temporary basis. Other ways to cover the post might also be used (locums, agency employees for example). There is no evidence here that the claimant's role was kept open and available for her, that clinics were covered on a temporary basis.

109. Between May 2017 and the time that steps were taken to return the claimant to work (early to mid-2021):

a. Various staff changes had taken place. A senior doctor called Dr Wasif left the respondent's employment in October 2021. She was based at WDHC. The respondent advertised and recruited a replacement at consultant level (Dr Malone). We accept that it was reasonable for the respondent to have done this, given the level of work that Dr Wasif had been carrying out. We also accept that the claimant did not have the experience/qualifications to carry out much of this work.
b. There had been some departures of medical staff based at Preston, leaving the Department short of doctors there.
c. More services were carried out remotely and therefore fewer patients were attending at WDHC. We accept the evidence of VB that, prior to the pandemic, walk in clinics had been held at WDHC when patients would attend and be examined and tested for sexually transmitted infections (STIs). The pandemic stopped this. The walk-in service was replaced with an online questionnaire and remote consultation together with testing kits sent by post to the patient. Many of these patients still needed to attend in person but due to the initial online process, numbers were reduced and attendances were pre booked.
d. Remote delivery of services also included telephone surgeries. VB accepted in evidence that the claimant could have carried out telephone surgeries for Preston whilst based elsewhere (WDHC for example). She told us (and we accept) that this work was usually carried out by senior nurses.
e. We accept the evidence of BH that more nurses had been trained to undertake some clinical duties that had previously been undertaken by doctors (including the claimant). Prior to her long-term absence

commencing May 2017, a lot of the claimant's activities had been undertaking GUM clinics. We accept that there was a reduced need for GUM work to be carried out by a trained doctor.

f. We also accept the need for the Department to provide evening and weekend clinics, given that a high proportion of patients with sexual health and contraception requirements, are young working adults.

110. Evidence was provided by BH that rooms were unavailable at WDHC that would have enabled the claimant to carry out clinics there on Wednesday and Friday mornings and on Thursday afternoons. A key issue restricting room usage was the size of consultation rooms at WDHC (rather than Preston) The consultation rooms at WDHC are only large enough to accommodate one couch for observations: either a couch suitable for male patients or one suitable for female patients. In her witness statement the claimant put forward a view that the same type of couch could be used, regardless of gender. Having considered the evidence from the claimant and from BH, we find that it would not be reasonable to expect the respondent to arrange clinics on that basis. Different style couches are required, dependant on gender.

111. We also accept as reasonable the explanation provided by BH as to why a Health Care Assistant (HCA) would need to occupy a second room during some clinics. Sometimes an HCA would need to be called in during a clinic as a chaperone or observer when intimate examinations were taking place. But other times during a clinic, the HCA would undertake administrative tasks in a separate room, using a computer to access the respondent's systems, for example, information from tests carried out at the clinic would need inputting.

112. We accept the respondent's position that there was no clinical space to set up and accommodate a clinic that the claimant could run, on Wednesday and Friday mornings.

Submissions

113. Both representatives provided written submissions and additional oral submissions. They have helped inform our findings and helped guide us on the applicable law as we note below.

The Law

Duty to Make Reasonable Adjustments (EQA s20)

114. The claimant makes claims under s20(3) EqA. This imposes a duty on an employer *"where a provision criterion or practice of* [the employer] *puts a disabled person at a substantial disadvantage in relation to a relevant matter in comparison with persons who are not disabled, to take such steps as it is reasonable to have to take to avoid the disadvantage."*

115. We note that, for the duty to make reasonable adjustments to apply, a claimant needs to show that s/he has been put to a substantial disadvantage in relation to a relevant matter in comparison to persons who are not disabled.

PCPs

116. For a provision criterion or practice to be a valid PCP for the purposes of s20, it must be more widely applied (or would be more widely applied).

117. Chapter 4 of the EHRC Code of practice on Employment 2011 at paragraph 4.5 says this in relation to PCPs:-

> *The phrase provision criterion or practice is not defined by the Act but it should be construed widely so as to include for example any formal or informal policies rules practices arrangements criteria conditions prerequisites qualifications or provisions. A provision criterion or practice may also include decisions to do something in the future - such as a policy or criterion that has not yet been applied - as well as a one off or discretionary decision."*

118. Whilst PCPs should be construed widely, there are limits. The word "practice" indicates some degree of repetition and where a PCP was identified from what happened on a single occasion, there must be some evidence of a more general practice. Paragraph 59 of the judgment in **Gan Menachem Hendon Limited v Ms Zelda De Groen UKEAT/0059/18:-**

> *So, while it is possible for a provision, criterion or practice to emerge from evidence of what happened on a single occasion, there must be either direct evidence that what happened was indicative of a practice of more general application, or some evidence from which the existence of such a practice can be inferred.*

119. Both representatives referred us to the decision in **Charles Ishola v. Transport for London [2020] EWCA Civ.112 ("Ishola").** We note particularly the following paragraphs of the judgment:

> *"35. The words "provision, criterion or practice" are not terms of art, but are ordinary English words. I accept that they are broad and overlapping, and in light of the object of the legislation, not to be narrowly construed or unjustifiably limited in their application. I also bear in mind the statement in the Statutory Code of Practice that the phrase PCP should be construed widely. However, it is significant that Parliament chose to define claims based on reasonable adjustment and indirect discrimination by reference to these particular words and did not use the words "act" or "decision" in addition or instead. As a matter of ordinary language, I find it difficult to see what the word "practice" adds to the words if all one-off decisions and acts necessarily qualify as*

PCPs, as Mr Jones submits. Mr Jones' response that practice just means "done in practice" begs the question and provides no satisfactory answer. If something is simply done once without more, it is difficult to see on what basis it can be said to be "done in practice". It is just done; and the words "in practice" add nothing.

36. The function of the PCP in a reasonable adjustment context is to identify what it is about the employer's management of the employee or its operation that causes substantial disadvantage to the disabled employee. The PCP serves a similar function in the context of indirect discrimination, where particular disadvantage is suffered by some and not others because of an employer's PCP. In both cases, the act of discrimination that must be justified is not the disadvantage which a claimant suffers (or adopting Mr Jones' approach, the effect or impact) but the practice, process, rule (or other PCP) under, by or in consequence of which the disadvantageous act is done. To test whether the PCP is discriminatory or not it must be capable of being applied to others because the comparison of disadvantage caused by it has to be made by reference to a comparator to whom the alleged PCP would also apply. I accept of course (as Mr Jones submits) that the comparator can be a hypothetical comparator to whom the alleged PCP could or would apply.

37. In my judgment, however widely and purposively the concept of a PCP is to be interpreted, it does not apply to every act of unfair treatment of a particular employee. That is not the mischief which the concept of indirect discrimination and the duty to make reasonable adjustments are intended to address. If an employer unfairly treats an employee by an act or decision and neither direct discrimination nor disability related discrimination is made out because the act or decision was not done/made by reason of disability or other relevant ground, it is artificial and wrong to seek to convert them by a process of abstraction into the application of a discriminatory PCP."

120. We must decide whether a PCP placed the claimant at a substantial disadvantage. We note the terms of section 212 EQA, that *"substantial means more than minor or trivial."*

121. Where we decide that a PCP puts the claimant at a disadvantage then we need to consider the issue of reasonable adjustments. We note here:-

a. There is no duty to take measures that would impose a disproportionate burden on the employer.

b. The test as to what is reasonable is an objective one – not therefore what an employer reasonably believes is (or is not) reasonable, but objectively what the Tribunal assesses as reasonable (**Smith v. Churchills Stairlifts plc [2005] EWCA 1220**).
c. The Tribunal must identify the practical step that was reasonable for the employer to have taken to overcome the substantial disadvantage identified. There must be sufficient specificity to the practical step identified.
d. The following guidance from the judgment of the EAT in **Project Management Institute v. Latif UKEAT/0028/07** (at paras 54 and 55)

> *the claimant must not only establish that the duty has arisen, but that there are facts from which it could reasonably be inferred, absent an explanation, that it has been breached. Demonstrating that there is an arrangement causing a substantial disadvantage engages the duty, but it provides no basis on which it could properly be inferred that there is a breach of that duty. There must be evidence of some apparently reasonable adjustment which could be made.*
>
> *We do not suggest that in every case the claimant would have had to provide the detailed adjustment that would need to be made before the burden would shift. However, we do think that it would be necessary for the respondent to understand the broad nature of the adjustment proposed and to be given sufficient detail to enable him to engage with the question of whether it could reasonably be achieved or not.*

Time Limits – reasonable adjustments

122. Section 123 of the EQA applies to reasonable adjustments complaints. This section provides that proceedings may not be brought after the end of the 3 months of the act complained of or such other period as the Tribunal considers as just and equitable. Allowance is made separately (section 140B EQA) for early conciliation.

123. Complaints of failures to make reasonable adjustments often relate to omissions rather than acts. Section 123(4) is relevant

> *"In the absence of evidence to the contrary, a person (P) is to be taken to decide on failure to do something-*
>
> a. *When P does an act inconsistent with doing it*
> b. *If P does no inconsistent act, on the expiry of the period in which P might reasonably have been expected to do it."*

124. Ms Tether referred us to the Court of Appeal's decision in **Matuszovicz v. Kingston upon Hull City Council [2009] EWCA Civ 22 (Matuszovicz).** We note particularly the conclusion at paragraph 21 of Lloyd LJ's judgment as well as Sedley LJ's judgment at 35-38.

s.15 EqA Discrimination arising from disability

> *(1) A person (A) discriminates against a disabled person (B) if—*
>
> *(a) A treats B unfavourably because of something arising in consequence of B's disability, and*
>
> *(b) A cannot show that the treatment is a proportionate means of achieving a legitimate aim.*
>
> *(2) Subsection (1) does not apply if A shows that A did not know, and could not reasonably have been expected to know, that B had the disability.*

125. Subsection 2 above does not apply to this case. The respondent now accepts it knew that the claimant had the disability.

126. In **Secretary of State for Justice and anr v Dunn UKEAT 0234/16** the Employment Appeal Tribunal ("EAT") noted 4 findings to be made, for the claimant to succeed in a section 15 claim:-

a. there must be *unfavourable treatment;*

b. there must be *something* that arises in consequence of the claimant's disability;

c. the unfavourable treatment must be *because of* (i.e. caused by) the something that arises in consequence of the disability; and

d. the alleged discriminator cannot show that the unfavourable treatment is *a* proportionate *means of achieving a legitimate aim*.

127. In **Paisner v.NHS England (UKEAT/0137/15/LA)** the EAT provided guidance to Employment Tribunals when considering these claims which we summarise below.

a. The Tribunal should decide what caused the treatment complained of – or what the reason for that treatment was.

b. There may be more than one cause. The "something" might not be the sole or main cause but it must have a significant impact.

c. Motives are irrelevant.

d. The Tribunal should decide whether the/a cause is "*something arising in consequence of"* the claimant's disability. There could be a range of causal links under the expression *"something arising in consequence of…"*

128. When deciding whether a measure is proportionate in the context of the legitimate aim being pursued (s15(1)(b) EqA above) a tribunal must weigh the real

needs of the employer against the discriminatory effect of the proposal. (see **DWP v. Boyers UKEAT/0282/19).**

129. One of the section 15 complaints is about the reduction and (more recently) cessation of pay during long term sickness absence. We note the judgments in 2 Court of appeal cases: **Meikle v. Nottinghamshire County Council 2004 EWCA 859** (Meikle) and then in **O'Hanlon v. HMRC 2007 EWCA 283 (O'Hanlon).**

130. Understanably Ms Tether relies on Meikle, referring particularly to paragraphs 66 to 68 of that judgment. In her submissions she notes that O'Hanlon was decided under the Disability Discrimination Act 1995 (DDA) which did not include a section 15 equivalent. We observe that Meikle was also a reasonable adjustments case under the DDA.

131. We note paragraphs 67-69 of the judgment in **O'Hanlon**:

> *67. In our view, it will be a very rare case indeed where the adjustment said to be applicable here, that is merely giving higher sick pay than would be payable to a non-disabled person who in general does not suffer the same disability-related absences, would be considered necessary as a reasonable adjustment. We do not believe that the legislation has perceived this as an appropriate adjustment, although we do not rule out the possibility that it could be in exceptional circumstances. We say this for two reasons in particular.*
>
> *68. First, the implications of this argument are that Tribunals would have to usurp the management function of the employer, deciding whether employers were financially able to meet the costs of modifying their policies by making these enhanced payments. Of course we recognise that tribunals will often have to have regard to financial factors and the financial standing of the employer, and indeed s.18B(1) requires that they should. But there is a very significant difference between doing that with regard to a single claim, turning on its own facts, where the cost is perforce relatively limited, and a claim which if successful will inevitably apply to many others and will have very significant financial as well as policy implications for the employer. On what basis can the tribunal decide whether the claims of the disabled to receive more generous sick pay should override other demands on the business which are difficult to compare and which perforce the tribunal will know precious little about? The tribunals would be entering into a form of wage fixing for the disabled sick.*
>
> *69. Second, as the tribunal pointed out, the purpose of this legislation is to assist the disabled to obtain employment and to integrate them into the workforce. All the examples given in s.18B(3) are of this nature. True, they are stated to be examples of reasonable adjustments only and are not to be taken as exhaustive of what might be reasonable in any particular case, but none of them suggests that it will ever be necessary simply to put more money into the wage packet of the disabled. The Act is designed to*

> *recognise the dignity of the disabled and to require modifications which will enable them to play a full part in the world of work, important and laudable aims. It is not to treat them as objects of charity which, as the tribunal pointed out, may in fact sometimes and for some people tend to act as a positive disincentive to return to work.*

132. In Meikle it was regarded to be a reasonable adjustment to extend enhanced sick pay; but the relevant facts of that case were that the employer had failed to make other reasonable adjustments and, had they been made, Ms Meikle would have returned to work without having to take a lengthy absence.

Burden of Proof – EQA Claims

133. We are required to apply the burden of proof provisions under section 136 EA when considering complaints raised under the EQA.

134. Section 136 states:

> *(1) This section applies to any proceedings relating to a contravention of this Act.*
>
> *(2) If there are any facts from which a court could decide in the absence of any other explanation, that a person (A) has contravened the provision concerned, the court must hold that the contravention occurred.*
>
> *(3) But subsection 2 does not apply if A shows that A did not contravene the provision."*

135. We have also considered the guidance contained in the Court of Appeal's decision in **Wong v. Igen Limited [2005] EWCA 142**. This case concerned the test as set out in discrimination legislation that pre-dated the EqA but the guidance provided in there remains relevant. The annex to the judgment sets out guidance.

136. We are also clear that the wording of the statute itself, s136 EqA is the key reference in relation to burden of proof when reaching decisions about whether there has been a contravention of the EqA.

137. Finally, on the issue of burden of proof, we are mindful of guidance from case law indicating that something more than less favourable treatment may be required in order to establish a prima facie case of discrimination; see for example **Madarassy v. Nomura International [2007 ICR 867]** where the following was noted in the judgment:

> "*The bare facts of a difference in status and a difference in treatment only indicate a possibility of discrimination. They are not, without more, sufficient material from which a tribunal "could conclude" that, on the balance of probabilities, the respondent had committed an unlawful act of discrimination."*

Discussions and Conclusions

138. The respondent accepts that at all relevant times the claimant had these disabilities and the respondent knew of them. As such, it is not necessary for us to consider further issues 1 and 2.

> *Issue 3. Did the Respondent apply a provision criterion or practice (PCP) of:*
>
> *a. Working at the Preston Royal Hospital from 9 am to 5 pm (PCP a)?*
>
> *b. Working at the Avenham Health Centre from 9 am to 5 pm (PCP b.)?*
>
> *c. Working at the St Anne's Clinic from 5.30 pm to 8.30 pm after an afternoon clinic at Whitegate Drive Health Centre (PCP.c)?*
>
> *d. Routinely working for three hours on a Saturday morning (PCP.d)?*
>
> *e. Insisting that the Claimant cannot be permitted to return to work at all until a long-term job plan has been fully agreed (PCP e)?*

139. Response to issue 3. The respondent disputes that the PCPs identified are valid PCPs for the purposes of section 20 EQA. In his submissions Mr Smith refers to the decision in Ishola, noting that each of the claimed PCPs was a "one off" decision made specifically about the claimant, rather than something that was or would have been more widely applied across a section of the workforce. Further, Mr Smith notes that none of the claimed PCPs was applied to the claimant. Each was put to her as an option.

140. For the claimant, Ms Tether disputes that these were one off decisions. The job plans consistently put to the claimant involved elements – one or more of the claimed PCPs – that meant that she could not comply with any of them.

141. We do accept a to d above as valid PCPs. These are our reasons:-

a. The respondent had a practice of requiring its clinical practitioners in the Department to work from more than one location. This meant that practitioners were required to travel to different locations. This was not something that was just applied to the claimant. It is the travel that potentially put the claimant at a disadvantage.

b. The respondent also had a practice of requiring the same clinical practitioners (not just the claimant) to sometimes take evening and weekend clinics, depending on clinical needs. It is these evening and weekend clinics that potentially put the claimant at a disadvantage.

c. The PCPs at issues 3a to d are effectively a subset of these wider PCPs and/or describe how the wider PCPs were applied to the claimant.

142. We do not however accept 3e as a PCP. We find that it is a description of the claimant's dispute with her employer (or an aspect of her dispute). Further, and as our

findings of fact make clear, the dispute is more nuanced than the claimant suggests in the wording of this proposed PCP. We note for example:-

a. The fact that the claimant did return to work to engage in clinical retraining and on a gradual return to work basis (January 2021)
b. The respondent's proposal that the claimant return to work on 8 Pas but with ongoing discussions to increase to 10.

143. In addition, we do not accept 3e as a PCP on the basis that, in so far as the respondent insisted on this at any stage in this drawn out process of the claimant's return to work, it was a one off decision. We have heard no evidence that this is something that the respondent did or would do to employees returning from a period of long-term absence due to sickness.

144. Given our findings under issues 3 a to d, we must consider and reach conclusions on issues 4 to 12.

> *Issue 4. Did PCP a, PCP b and/or PCP c put the Claimant at a disadvantage because it would have:*
>
> *a. aggravated her lower back pain/sciatica;*
>
> *b. caused her to suffer heightened levels of anxiety which exacerbate her PTSD, anxiety and depression; and/or*
>
> *c. placed her at increased risk of sickness absence and action under the Respondent's Attendance Management Policy?*

145. Response to issue 4. We comment on each of a, b and c separately.

146. In relation to a. – the opinion of Dr Atkinson is clear. The claimant would be at a disadvantage if required to undertake this journey, by car on a regular basis, either as a passenger or a driver. There is no reasonable alternative to travel by car.

147. In relation to b. (Avenham Health Centre) we prefer the evidence provided by VB. There is a reasonable alternative to travel by car. there is a direct train from Blackpool to a station within reasonable walking distance of Avenham. The claimant can (and does) undertake local journeys by car and on foot. That journey (being a combination of one short car journey or walk (from home to station) one short train journey and short walk from train station to Avenham) would not aggravate the claimant's lower back pain or cause heightened levels of anxiety, exacerbating her PTSD anxiety and depression.

148. In relation to c. the information from Dr Atkinson is clear – the claimant would be put at a disadvantage if required to work an evening shift, even where she had not been required to fulfil a full working day before then.

149. We have not heard any evidence about travel to St Annes but given our finding about the disadvantage caused by the hours, we do not need to make any finding about any disadvantage caused by that journey.

Issue 5. Did PCP d place the Claimant at a disadvantage because it would have deprived her of essential family time and thereby:

a. exacerbated her PTSD, anxiety and depression; and/or

b. placed her at increased risk of sickness absence and action under the Respondent's Attendance Management Policy.

150. Response to Issue 5. We do not accept the claimant's evidence that working for 3 hours, local to her home (WDHC) would exacerbate her PTSD, anxiety and depression and/or place her at increased risk of sickness absence. See our findings of fact at paragraphs 82 to 87 above.

Issue 6. Did PCP e. place the Claimant at a disadvantage by:

a. prolonging her sickness absence;

b. further exacerbating her PTSD, anxiety and depression; and/or

c. putting her at risk of action under the Respondent's Attendance Management Policy.

151. Response to issue 6. Not applicable – see our conclusions regarding PCP e.

Issue 7. Was any disadvantage caused by PCPs a, b, c, d and/or e substantial?

152. Response to issue 7. The disadvantages caused by the application of PCPs a and c, are/would be substantial. Those PCPs would have increased the claimant's pain and discomfort arising from her physical disability. That may also have led to increased absence due to sickness.

153. As for PCPs d and e - see earlier conclusions.

g. If so, when did the Respondent's duty to take such steps as it was reasonable to have to take to avoid the relevant disadvantage arise in respect of each of the relevant PCPs?

154. Response to issue 8. Ms Tether's submission on this is that the duty arose on 25 June 2021 which was the date of a job planning meeting between the claimant and Mr Holden. When that meeting took place, the respondent had received the first report from Dr Atkinson. We largely agree with this but would take into account a period of time following that meeting for the respondent to consider what options it would propose, having regard to its duty to make reasonable adjustments and the information learned in the meeting. We conclude that the respondent's duty arose in early July 2021.

Issue 9. If it is found that the Respondent was under a duty to make reasonable adjustments to avoid a relevant disadvantage caused by one or more of the forgoing PCPs:

a. has it failed to comply with the duty to make reasonable adjustments in relation to PCPs a, b, c and/or d by not accommodating the Claimant in a 10 PA job plan working from Whitegate Drive Health Centre?

b. has it failed to comply with the duty to make reasonable adjustments in relation to PCP e. by not allowing the Claimant to carry out 8 PAs at Whitegate Drive Health Centre while discussion over a 10 PA job plan continues?

155. Response to issue 9. We find that the respondent has failed in its duty to make reasonable adjustments, but we do not agree with the finite options posed by these issues. The claimant has wanted to ensure that she works, full time from WDHC but we do not find that to be only reasonable adjustment that would avoid the disadvantages caused by the PCPs.

156. We also note here our findings on job planning, the annual review of rotas and clinics for doctors and the possibility therefore of varying a doctor's duties to better accord with changing needs of the health services being delivered.

157. We find that the reasonable adjustments that the respondent should have made with effect from July 2021 are a combination of the following:-

a. Limiting the claimant's clinics to locations she can travel to.
b. Not requiring the claimant to hold evening clinics.
c. Increasing the number of SPAs to 1.5 or even to 2 (recognising the claimant's return from a very long absence and also the option to discuss and agree a reduction to 1.5 in the next Job Plan)
d. Agreeing that the claimant can fulfil one half or one PA doing GUM clinic work – even though that work is now generally covered by senior nurses. This element of the job plan could be expressed to be subject to ongoing review, noting it to be a temporary arrangement to facilitate the claimant's return to full time work.
e. Agreeing to a period of pay protection for a short time (12 months – as was proposed in the appeal outcome on 30 December 2022), with a commitment to review the claimant's job plan prior to the end of the pay protection period.

158. Adjustments d and e above would only need to apply if not possible to provide a full rota by making adjustments a to c above. It is clear to us that d and/or e would not need to cover more than 1 PA maximum out of the 10 PAs that make up a full-time working week.

Issue 10. When did the limitation period commence in relation to PCPs a, b, c and d? In particular:

a. Did the Respondent decide that the Claimant was not to be accommodated in a 10 PA job plan working from Whitegate Drive Health Centre and, if so, on what date?

b. Did the Respondent do an act inconsistent with accommodating the Claimant in a 10 PA job plan working from Whitegate Drive Health Centre and, if so, on what date?

c. If the Respondent took no such decision and did no such inconsistent act, when did the period in which the Respondent might reasonably have been expected to accommodate the Claimant in a 10 PA job plan working from Whitegate Drive Health Centre expire?

Issue 11. Was the claim in relation to PCPs a, b, c and d brought within three months of any alleged act of discrimination?

Issue 12. If not, would it be just and equitable to extend the limitation period?

159. Response to issues 10,11 and 12. It is difficult to identify a particular date, particularly having regard to:-

a. The ongoing investigations by the respondent through occupational health advisers
b. The protracted discussions including changing position of the respondent in terms of options
c. The claimant's sickness absences.

160. We considered whether the meeting of 8 July 2021 might be the date when it acted in a way that was inconsistent with the reasonable adjustments required. However, we also note that meeting ended in a proposal by the respondent to obtain more occupational health advice. We therefore looked to the position following the further OH advice (that was the further report of Dr Atkinson – see 26d above) and the 2nd set of 3 options communicated to the claimant by letter dated 24 November 2021.

161. Having regard to the ongoing investigations referred to above and the most recent report commissioned from Dr Atkinson of October 2021 (see 26d above) we find that the relevant act was sending that letter.

162. The relevant consequence of that decision, as far as this issue is concerned, is that the claim was brought within 3 months of the act complained of.

163. We also note here that if had found the relevant act to have been either the date of the meeting of 25 June 2021 or follow up meeting of 8 July 2021, then we would have had little hesitation in taking on board the comments of Sedley LJ in **Matuszovicz** and have had "sympathetic regard" to the difficulty that identifying a date of an omission in circumstances such as these.

Discrimination arising from disability – section 15 Equality Act 2010

> *Issue 13. Has the Respondent treated the Claimant unfavourably by insisting that she cannot be permitted to work at all until a long-term job has been agreed?*

164. Response to Issue 13. Mr Smith for the respondent accepts that this was unfavourable treatment.

> *Issue 14. If so, has the Respondent treated the Claimant unfavourably because of her unwillingness to work at St Anne's Clinic between 5.30 pm and 8.30 pm and to work routinely on Saturday mornings?*

165. Response to issue 14. The unfavourable treatment arose from the parties' failure to reach agreement about a full time (10PA) return to work. It was by that stage clear that:-

a. the claimant, would not move from an insistence that all her work was to be at WDHC and between 9am and 5pm, Monday to Friday.

b. The respondent had not put to the claimant a proposed return to full time work that either avoided altogether the PCPs that placed the claimant at a substantial disadvantage or included reasonable adjustments.

166. The claimant refused to work at an evening clinic at St Annes and at a Saturday morning clinic at WDHC. This meant that the parties could not reach agreement on return-to-work proposal 3 (of the second set of options – put to the claimant by letter dated 24 November 2021).

> *Issue 15. If so, does the Claimant's unwillingness to work at St Anne's Clinic between 5.30 pm and 8.30 pm and to work routinely on Saturday mornings arise in consequence of her disability?*

167. Response to issue 15. We refer here to our conclusions above; that the unwillingness to work during the evening does; the unwillingness to work on Saturday mornings does not.

> *Issue 16. Has the Claimant treated the Claimant unfavourably by reducing her sick pay to half-pay and, from on or around 16 July 2022, nil pay?*

168. Response to Issue 16. Yes. This is not disputed by the respondent.

> *Issue 17. If so, has Respondent treated the Claimant unfavourably because of sickness absence from 9 August 2021.*

169. Response to issue 17. Yes. This is not disputed.

> *Issue 18. If so, does the Claimant's sickness absence from 9 August 2021 arise in consequence of her disability?*

170. Response to issue 18. The claimant's fit notes during this period cite "work related stress." Having regard to the medical report in November 2021 (see para 33

above) we find the claimant's reaction to the ongoing dispute (and therefore her absence) to be because of her long-term mental impairment. So yes, this sickness absence did arise in consequence of the claimant's disability.

> *19. If the Respondent has treated the Claimant unfavourably because of something arising in consequence of her disability, has it shown that the relevant treatment was a proportionate means of achieving a legitimate aim?*

171. Response to Issue 19. An employer has a legitimate aim of encouraging employees back in to work and to limit its financial obligations to absent employees. We need to decide therefore whether the application of the respondent's sick pay scheme was proportionate in achieving those legitimate aims.

172. An important starting point for us in deciding on proportionality is the scheme itself. That is the contractual agreement between the parties and it was met. The scheme provides employees with considerable income protection during periods of sickness.

173. We then considered whether sticking to the limits of the scheme was not proportionate, given our finding in relation to reasonable adjustments that the respondent should have made. Our conclusion is that the decision to apply the scheme but to go no further, was proportionate. The failure to reach agreement about the claimant's job plan is the result of some inflexibility from both parties. The extent to which the claimant's income loss was caused by the respondent's failure to make reasonable adjustments can (and will) be an issue for remedy. We put this another way by reference to paragraph 66 of the judgment in Meikle; if the reasonable adjustments required by section 20 EQA had been made, the claimant might still have been absent for some or all of the time that she was in fact absent.

Employment Judge Leach

Date: 3 May 2023

RESERVED JUDGMENT & REASONS SENT TO THE PARTIES ON 4 MAY 2023

FOR EMPLOYMENT TRIBUNALS