Case No: 2409100/2021

EMPLOYMENT TRIBUNALS

Claimant: Mr Fahmy Fahmy

Respondent: Countess of Chester NHS Foundation Trust

Heard at: Liverpool

On: 17 – 21 & 24 July 2023; 1 & 15 December 2023; deliberations on 22, 24, 25 & 26 January 2024; oral Judgment on 26 January 2024.

Before: Employment Judge Liz Ord
Tribunal Member Michelle Plimley
Tribunal Member Rob Alldritt

Representation:

Claimant: Ms Sarah Keogh (Counsel)
Respondent: Ms Louise Quigley (Counsel)

1. **JUDGMENT** was given orally on 26 January 2024 and the written record was sent to the parties. A request for written reasons, in accordance with Rule 62(3) of the Employment Tribunals Rules of Procedure, was made.

2. Whilst the Judge was writing those reasons, she discovered that there was an inconsistency in part of the written record and the oral reasons given. This relates to victimisation in paragraph 5.3, the relevant part of which records that:

   "The respondent did not subject the claimant to the following detriments because he raised that grievance:
   .. ….

   5.3.2 Exclusion or continued exclusion from ACA work."

3. Accordingly, in the interests of justice, this element of the decision has been reconsidered and varied as follows:

   Paragraph 5.3.2 is deleted.

   A new paragraph 5.2.4 is inserted, so that the relevant part of paragraph 5.2 reads:

The respondent subjected the claimant to the following detriments because he raised that grievance:

………

5.2.4 Exclusion or continued exclusion from ACA work.

4. The following reasons are now provided:

REASONS

The Complaints and Issues

1. The claimant brings complaints of:

   1.1. Detriment following protected disclosure as per section 47B of the Employment Rights Act 1996 (EPA);

   1.2. Discrimination arising from disability as per section 15 of the Equality Act 2010 (EA);

   1.3. Failure to make reasonable adjustments as per sections 20 and 21 of the EA;

   1.4. Victimisation as per section 27 of the EA.

2. The respondent raises jurisdictional issues of time limitation.

3. A list of the complaints and issues, as agreed between the parties, is contained in the annex attached at the end of these reasons.

Evidence

4. The Tribunal had before it the following documentary evidence:

   4.1. A documents bundle of 1,706 pages, 8 sound bite files, an e-mail chain from 17.12.2020, closing submissions from the Claimant and the Respondent.

   4.2. Witness statements:

      4.2.1. On behalf of the Claimant from:

         4.2.1.1. Professor Fahmy Fahmy (the Claimant); Helen Osgood (BMA Employment Advisor 2019 to 2021).

      4.2.2. On behalf of the Respondent from:

         4.2.2.1. Claudia Harding Mackean (Clinical Lead for Breast and Plastic Surgery); Michelle Greene (Divisional Medical Director of Planned Care); Matthew Dobson (Service Manager for Plastic

Surgery and Trauma and Orthopaedics); Elizabeth Whitelaw (Directorate Manager); David Coyle (Chief Operating Officer); Nicola Peate (Substantive Directorate Manager in Planned Care).

5. It heard evidence on oath from the following:

   5.1. On behalf of the Claimant: Professor Fahmy Fahmy; Helen Osgood.

   5.2. On behalf of the Respondent: Claudia Harding Mackean; Michelle Greene; Elizabeth Whitelaw; David Coyle; Nicola Peate.

The Law

6. We are grateful to the parties for providing comprehensive submissions on the law, much of which is re-produced below, and all of which has been taken into consideration.

7. **Time Limits**

Time Limits re: detriment arising from protected disclosure

Section 48 of the Employment Rights Act 1996 provides:

(1A) "A worker may present a complaint to an employment tribunal that he has been subjected to a detriment in contravention of section 47B.
……
(3) An employment tribunal shall not consider a complaint under this section unless it is presented –

(a) before the end of the period of three months beginning with the date of the act or failure to act to which the complaint relates or, where that act or failure is part of a series of similar acts or failures, the last of them, or

(b) within such further period as the tribunal considers reasonable in a case where it is satisfied that it was not reasonably practicable for the complaint to be presented before the end of that period of three months.

(4) For the purposes of (3) –

(a) where an act extends over a period, the "date of the act" means the last day of that period, and

(b) a deliberate failure to act shall be treated as done when it was decided on; and, in the absence of evidence establishing the contrary, an employer, a temporary work agency or a hirer shall be taken to decide on a failure to act when he does an act inconsistent with doing the failed act or, if he has done no such inconsistent act, when the period expires within which he might reasonably have been expected to do the failed act if it was to be done.

Time limits re: discrimination - s123 Equality Act 2010 provides:

(1) Subject to section 140B proceedings on a complaint within section 120 may not be brought after the end of—

(a) the period of 3 months starting with the date of the act to which the complaint relates, or
(b) such other period as the employment tribunal thinks just and equitable.
…
(3) For the purposes of this section—

(a) conduct extending over a period is to be treated as done at the end of the period;
(b) failure to do something is to be treated as occurring when the person in question decided on it.

(4) 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, or
(b) if P does no inconsistent act, on the expiry of the period in which P might reasonably have been expected to do it.

Both section 48 ERA and section 123 EA are subject to extensions for ACAS early conciliation.

It was said in **Hendricks v Commissioner of Police of the Metropolis** [2003] IRLR 96 that:

"What the applicant has to prove, in order to establish conduct extending over a period, is (a) that the incidents are linked to each other, and (b) that they are evidence of *"an ongoing situation or continuing state of affairs"* [at 52].

In **Robinson v Royal Surrey County Hospital NHS Foundation Trust** UKEAT/0311/14/MC at paragraph 65 it was said that different types of discrimination may in principle be taken together as constituting conduct extending over a period.

Protected disclosure detriment

8. **Protected disclosures**

Section 43A ERA provides that a 'protected disclosure' means a qualifying disclosure (as defined by section 43B) which is made by a worker in accordance with any of sections 43C to 43H. Section 43C deals with disclosures made to an employer.

Section 43B provides:

"(1) In this Part a "qualifying disclosure" means any disclosure of information which, in the reasonable belief of the worker making the disclosure, is made in the public interest and tends to show one or more of the following—
…
(d) that the health or safety of any individual has been, is being or is likely to be endangered,
…"

In **Williams v Michelle Brown AM** UKEAT/0044/19/OO HHJ Auerbach considered the questions that arise in determining whether a qualifying disclosure has been made:

“ It is worth restating, as the authorities have done many times, that this definition breaks down into a number of elements. First, there must be a disclosure of information. Secondly, the worker must believe that the disclosure is made in the public interest. Thirdly, if the worker does hold such a belief, it must be reasonably held. Fourthly, the worker must believe that the disclosure tends to show one or more of the matters listed in sub-paragraphs (a) to (f). Fifthly, if the worker does hold such a belief, it must be reasonably held.

In **Kilraine v London Borough of Wandsworth** [2018] ICR 1850 the Court of Appeal confirmed (at paragraphs 35-36) that there was a need for the information disclosed to have sufficient factual content and specificity to show that one of the matters in section 43B is engaged. Whether any particular statement meets that standard is a matter for evaluative judgment by a tribunal in light of all the facts and the particular context in which it is made.

In **Norbrook Laboratories (GB) Ltd v Shaw** [2014] ICR 540 it was confirmed by the EAT (at paragraph 22) that two communications can, taken together, amount to a protected disclosure, even if taken on their own they would not qualify.

When considering whether there is a reasonable belief of a disclosure in the public interest, **Chesterton Global Ltd v Nurmohamed** [2018] ICR 731 gives guidance that the circumstances to consider include:

The numbers whose interests are served by the disclosure;
The nature of the interest affected and its importance;
Whether the matter complained of was deliberate; and
The identity of the alleged wrongdoer.

A two stage test must be applied, asking first whether the claimant subjectively believed that the disclosure was made in the public interest, and secondly whether that belief was reasonable (**Ibrahim v HCA International [2020] IRLR 224**).

Similarly to a reasonable belief in the public interest, a reasonable belief that the disclosure tends to show a matter within section 43B requires consideration whether the employee believed that the information disclosed meets the requirements of the section, and then a consideration whether that belief is objectively reasonable, taking into account the personal circumstances of the discloser (**Korashi v Abertawe Bro Morgannwg University Local Health Board** [2012] IRLR 4).

9. **Detriments**

Section 47B ERA provides:

(1) A worker has the right not to be subjected to any detriment by any act, or any deliberate failure to act, by his employer done on the ground that the worker has made a protected disclosure.”

The concept of a detriment must be construed widely, and the threshold for establishing a detriment is low (**The Edinburgh Mela Ltd v Purnell** UKEAT/0041/19).

In considering whether the detriment is done on the ground that the worker has made a protected disclosure, the test is whether the protected disclosure materially influences (in the sense of being more than a trivial influence) the employer's treatment of the whistleblower (**NHS Manchester v Fecitt** [2012] IRLR 64).

10. **Discrimination arising from disability**

Section 15 EA provides:

"(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."

The approach to take in section 15 cases is helpfully summarised in **Pnaiser v NHS England** [2016] IRLR 170 at paragraph 31:

A Tribunal must first identify whether there was unfavourable treatment and by whom: in other words, it must ask whether A treated B unfavourably in the respects relied on by B. No question of comparison arises.

The Tribunal must determine what caused the impugned treatment, or what was the reason for it, focussing on the mind of A. An examination of the conscious or unconscious thought processes of A is likely to be required, just as it is in a direct discrimination case. Again, just as there may be more than one reason or cause for impugned treatment in a direct discrimination context, so too, there may be more than one reason in a section 15 case. The 'something' that causes the unfavourable treatment need not be the main or sole reason, but must have at least a significant (or more than trivial) influence on the unfavourable treatment, and so amount to an effective reason for or cause of it.

Motives are irrelevant. The focus of this part of the enquiry is on the reason or cause of the impugned treatment and A's motive in acting as he or she did is simply irrelevant.

The Tribunal must determine whether the reason/cause (or, if more than one), a reason or cause, is "something arising in consequence of B's disability". That expression 'arising in consequence of' could describe a range of causal links.

The more links in the chain there are between the disability and the reason for the impugned treatment, the harder it is likely to be to establish the requisite connection as a matter of fact.

This stage of the causation test involves an objective question and does not depend on the thought processes of the alleged discriminator.

The alleged discriminator does not need to know that the 'something' that causes the treatment arises in consequence of the disability.

Knowledge is required of the disability only.

It does not matter in which order these questions are addressed.

The threshold to be applied to unfavourable treatment is relatively low (**Trustees of Swansea University Pension and Assurance Scheme v Williams** [2019] ICR 230 at paragraph 27). Paragraph 5.7 of the Equality Act 2010 Code of Practice on Employment provides:

"For discrimination arising from disability to occur, a disabled person must have been treated 'unfavourably'. This means that he or she must have been put at a disadvantage. Often, the disadvantage will be obvious and it will be clear that the treatment has been unfavourable; for example, a person may have been refused a job, denied a work opportunity or dismissed from their employment. But sometimes unfavourable treatment may be less obvious. Even if an employer thinks that they are acting in the best interests of a disabled person, they may still treat that person unfavourably."

Justification

Hardys & Hansons plc v Lax [2005] EWCA Civ 846, [2005] IRLR 726, [2005] ICR 1565: [32]

"The employer has to show that the proposal ……. is justified objectively notwithstanding its discriminatory effect. The principle of proportionality requires the tribunal to take into account the reasonable needs of the business. But it has to make its own judgment, upon a fair and detailed analysis of the working practices and business considerations involved, as to whether the proposal is reasonably necessary."

In determining whether the Respondent can justify the alleged unfavourable treatment the Tribunal should have regard to the principles set out in **MacCulloch v ICI** [2008] IRLR 846, EAT as approved in **Lockwood v DWP** [2013] EWCA Civ 1195, [2013] IRLR 941, [2014] ICR 1257:

"(1) The burden of proof is on the respondent to establish justification: see **Starmer v British Airways** [2005] IRLR 862 at [31].

(2) The classic test was set out in **Bilka-Kaufhaus GmbH v Weber Von Hartz** (case 170/84) *[1984] IRLR 317* in the context of indirect sex discrimination. The ECJ said that the court or tribunal must be satisfied that the measures must "correspond to a real need … are appropriate with a view to achieving the objectives pursued and are necessary to that end" (paragraph 36). This involves the application of the proportionality principle, which is the language used in reg. 3 itself. It has subsequently been emphasised that the reference to "necessary" means "reasonably necessary": see **Rainey v Greater Glasgow Health Board** (HL) [1987] IRLR 26 per Lord Keith of Kinkel

at pp.30–31.

(3) The principle of proportionality requires an objective balance to be struck between the discriminatory effect of the measure and the needs of the undertaking. The more serious the disparate adverse impact, the more cogent must be the justification for it: **Hardy & Hansons plc v Lax** [2005] IRLR 726 per Pill LJ at paragraphs [19]–[34], Thomas LJ at [54]–[55] and Gage LJ at [60].

(4) It is for the employment tribunal to weigh the reasonable needs of the undertaking against the discriminatory effect of the employer's measure and to make its own assessment of whether the former outweigh the latter. There is no "range of reasonable response" test in this context: **Hardy & Hansons plc v Lax** [2005] IRLR 726*, CA*."

11. **Reasonable adjustments**

Section 20 EA provides:

"(1) Where this Act imposes a duty to make reasonable adjustments on a person, this section, sections 21 and 22 and the applicable Schedule apply; and for those purposes, a person on whom the duty is imposed is referred to as A.

(2) The duty comprises the following three requirements.

(3) The first requirement is a requirement, where a provision, criterion or practice of A's 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…"

Section 212(1) provides that 'substantial' means 'more than minor or trivial'.

Paragraph 20 of Schedule 8 of the EA states as follows:

A is not subject to a duty to make reasonable adjustments if A does not know, and could not reasonably be expected to know—
……..

(b) [in any case referred to in Part 2 of this Schedule], that an interested disabled person has a disability and is likely to be placed at the disadvantage referred to in the first, second or third requirement.

As per **Secretary of State for the Department of Work and Pensions v Alam** [2010] IRLR 283, [2010] ICR 665, the EAT held that the correct statutory construction of s 4A(3)(b) involved asking two questions;

(1) Did the employer know both that the employee was disabled and that his disability was liable to affect him in the manner set out in section 4A(1)? If the answer to that question is: 'no' then there is a second question, namely,

(2) Ought the employer to have known both that the employee was disabled and that his disability was liable to affect him in the manner set out in section 4A(1)?

In **Ridout v T C Group** [1998] IRLR 628, the EAT recognised that this is not, of course, an unlimited duty – the duty is only to make such enquiries as are reasonable and what is reasonable will depend on all the circumstances.

More recently in the case of **AECOM Ltd v Mallon** [2023] EAT 104 Judge Sout in the EAT reviewed the authorities on knowledge and added the following observations:

"From those principles, we take the following additional points that are not already covered by the authorities to which we have referred: "(6) It is not incumbent upon an employer to make every inquiry where there is little or no basis for doing so … (7) Reasonableness … must entail a balance between the strictures of making inquiries, the likelihood of such inquiries yielding results and the dignity and privacy of the employee, as recognised by the code".

12. **Victimisation**

Section 27 EA provides:

"(1) A person (A) victimises another person (B) if A subjects B to a detriment because—

(a) B does a protected act, or
(b) A believes that B has done, or may do, a protected act.

(2) Each of the following is a protected act—

(a) bringing proceedings under this Act;
(b) giving evidence or information in connection with proceedings under this Act;
(c) doing any other thing for the purposes of or in connection with this Act;
(d) making an allegation (whether or not express) that A or another person has contravened this Act."

Findings of Fact

13. The facts are set out according to the broad issues to which they relate. Numbers in brackets are page references to the documents bundle.

14. The Claimant is a Consultant Plastic and Hand Surgeon, who has worked for the Respondent for over 20 years. He has diabetes and by ethnicity falls within BAME. The following events took place during the Covid pandemic.

Risk Assessment and non F2F work

15. On 18 March 2020 the Respondent circulated a risk assessment by email. (1620). This was not picked up by either the Claimant or his line manager, Claudia Harding Mackean (CHM). CHM was on annual leave and returned to work on 23 March 2020.

16. On 1 May 2020 there was a clinical leads meeting which discussed a risk assessment tool. CHM did not attend that meeting. On 4 May the risk tool was

sent to CHM by email, attaching the risk assessment tool, which she picked on 5 May.

17. Also, on 1 May the Claimant emailed Occupational Health and enquired whether individual risk assessments were being undertaken (381). There was a reply the same day saying they were being undertaken for staff with underlying health conditions (381).

18. On 5 May the Claimant emailed Sioned Rees and Nicola Peate (NP) (381) requesting that a risk assessment be instigated for him on an urgent basis. Ms Rees emailed CHM the same day at 15.33 asking her to do a risk assessment with the Claimant (382). CHM replied on 5 May at 15.54 saying yes, although it would have to be remote because she was in self-isolation.

19. CHM sent the risk assessment tool to three of the four consultant colleagues in Plastic surgery on 5 May at 17.24 (409), namely Aftab Siddiqui, Rishi Sharma and the Claimant (missing out Anca Breahna). The email said "The process requires that I complete this with you, but in the current circumstances would you prefer to complete it yourself and return it to me for discussion before I submit."

20. On 6 May NP sent a separate email to CHM attaching the Claimant's request of 5 May for a risk assessment saying she believed Michelle Greene (MG) had sent her the risk assessment (406). CHM replied, saying she had sent each of the consultants the form yesterday.

21. The Claimant returned his risk assessment to CHM on 7 May at 18.00 (409). CHM had had no training on risk assessments.

22. At 18.25 on 7 May, CHM queried with the Claimant his diabetes "complications" asking whether he had difficulties with glucose control despite oral medication. She said she was not sure about the scoring. The Claimant replied to CHM on 12 May saying "peripheral tingling/numbness" (409).

23. On 12 May CHM emailed MG (1631) saying that the Claimant had clarified his symptoms suggestive of peripheral neuropathy and that she thought he scored green for 3 separate issues.

24. The Claimant chased up CHM on 15 May (**1st disclosure**). He said he was asking for an update on the outcome of the risk assessment, stating that he felt: "concerned, worried and don't feel its appropriate or safe to continue any longer, with face to face contact with patients" (408). CHM sent this email to MG on 18 May at 13.28 asking to talk to her about the Claimant's risk assessment tool. That same day CHM gave permission for the Claimant to refrain from face to face (F2F) contact with patients whilst she sought advice from MG (414). MG responded that day and advised that the Claimant could not "unilaterally decide. It's a discussion" (408).

25. On 19 May the Claimant emailed Sorcha Holmes (413) suggesting that the Nuffield list for him for Thursday be suspended. The same day CHM sent an email to the Claimant with options that could be implemented (413). She offered him COVID light work at Nuffield or redeployment to non-clinical areas if he remained concerned. She asked the Claimant to liaise with his colleagues about how the on-call and elective theatre was going to be redistributed.

26. CHM also stated in the email that the risk assessment needed clarification. She said the Claimant did not meet the criteria for high risk. However, he did meet the criteria for moderate risk based on diabetes under the renal section, which would be addressed by mitigation of risk using PPE and doing lists in covid light areas, such as Nuffield.

27. On 20 May the Claimant sent an email to CHM (412) saying that his long standing diabetes carried its own risks and complications, and that he was worried and concerned about the potential mutual risks and the impact on him and others from any face to face treatments (**2nd disclosure**). He was happy to accept her suggestion of being redeployed to non-clinical areas. He suggested approaching one of the three senior trust grade registrars to act up while he provided a second opinion and on-call video/phone assessments.

28. CHM responded that day by email exploring and seeking clarification from the Claimant about how the arrangement would work. She also forwarded his suggestion to Sioned Rees (412). Ms Rees emailed the Claimant later that day (411) saying this wasn't quite what had been agreed and that the Nuffield was covid-light and therefore his list tomorrow morning should continue.

29. CHM sent another email to the Claimant on 20 May (1174) telling him that the Nuffield list should go ahead on 21/5/20. Sorcha Homes also emailed the Claimant that day (1174) saying the list should be going ahead. The Claimant replied the same day (1175) saying that if no other options were available, he would have no choice but to proceed. He queried whether staff at Nuffield had been screened. CHM replied that day to the Claimant (1175) saying she understood staff were screened and hoped he was assured the risks had been assessed and minimised.

30. The Claimant reluctantly did the Nuffield list, which went ahead on 21 May.

31. The C emailed CHM on 21 May (1176) (**3rd disclosure**). He said the value of a negative Covid screening was short lasting and didn't ensure Covid free staff or indeed the Claimant. It said the test offered very little reassurances. Also that the Trust provided no alternatives for the Nuffield patients and he had proceeded with the list, on this occasion for the sake of the patients and his own commitment. He couldn't hide his continuing disquiet, anxiety and concern. His on call arrangements would need to be sorted promptly to address his concerns. That same day the Claimant telephoned MG to have a discussion with her, but she was unavailable

32. In his cross-examination, the Claimant said he was concerned about the risks to himself, to patients and the rest of the staff. He was a credible witness and we accept his evidence. This was his mindset when writing the emails.

33. On 22 May at 7.23 the Claimant emailed MG and CHM commenting that MG had not retuned his phone call. He said that his on-calls and elective work needed prompt action and he was getting conflicting messages with no progress. He referred to CHM's offer of redeployment into non-clinical areas and asked for the rationale in the delay.

34. At 14.15 that same day, CHM emailed the Claimant (420) asking whether he had discussed cover for his F2F duties with his three consultant colleagues,

and if agreement had been reached for a senior trust grade to stand in for him for F2F on-call, he could proceed. However, the "non-clinical deployment" related to him working in an area of low risk such as Nuffield, not a non-clinical environment. She asked whether he had discussed his on-call plan with Anca, Rishi and Aftab.

35. The same day at 14.45 CHM emailed the Claimant and the other three consultant colleagues (1181) saying she needed to be sure that the on-call suggestion had been discussed between the four of them, and whether there was agreement. The Claimant did not immediately respond.

36. Also on 22 May at 17.13 CHM sent a WhatsApp message to the four consultants (425 half way down) saying that the suggestion to support the Claimant's on-call work needed discussion between the four of them and how to take it forward. She asked them to confirm.

37. At 22.59 that day the Claimant replied to CHM complaining that WhatsApp was not the appropriate forum for raising the issue. He said the focus had been on approaching a senior Trust grade doctor to act up during his on-calls with his remote support and there had never been a request for the involvement of his colleagues.

38. At 23.41 on 22 May CHM agreed that WhatsApp was not an appropriate forum for professional discussion, but said it was a means to message the group as there had been no response to her email.

39. On 25 May the Claimant emailed CHM and MG complaining about his sensitive and confidential information being shared with others. He commented on his risk assessment outcome being classed as Amber and referred to the Trust's protocol/policy dictating that such staff should be removed from patient facing roles. He informed them that, as from the 26 May he would be working in a non-facing patient role as per the Trusts' safety measures.

40. On the morning of 26 May there was a phone call between the Claimant and MG. There was also an email from CHM to the Claimant (430) to say changes needed to be made to his work but not by a registrar acting up because of the risks and the need for a consultant to be available in case of challenges. She agreed the Claimant could not do F2F work and suggested that he do proportionately more of the departmental non F2F duties. She suggested he talk to his colleagues about the changes and how it would work.

41. On 27 May at 16.44 CHM emailed the Claimant (1185) to say that following his risk assessment she agreed he should not do any F2F work with immediate effect. The on-call commitment would be covered by his consultant colleagues. At 17.17 she emailed the other 3 consultants (436), not including the Claimant in the email, to say the Claimant as of today would not be able to cover on-call or any direct F2F clinical contact. So that work would be equitable, he would provide work in another form such as triaging proportionately more referrals or taking on more remote clinical work. From 27 May the Claimant did not do any F2F work.

Risk Assessment and Guidance

42. There were several versions of the risk assessment. The Claimant completed the Risk Assessment Tool that he was sent (390 – 405) and signed it on 6 May. CHM signed it on 7 May.

43. The Claimant completed elements from the red, orange and green categories. In the red category under "diabetes" (396) he wrote: "Y (long standing Diabetes on oral medication). In the orange category under Renal disorder where it asked whether there was diabetes mellitus (398), he wrote: " Y (Diabetes Mellitus). In the green category where it asked "do you have diabetes controlled by diet or tablets with diabetic complications (401), he wrote "Y (Long standing Diabetes on oral medication). He also completed BAME information on the form (402) by writing Diabetes Mellitus & vitamin D deficiency.

44. The form set out actions for the red, orange and green categories as follows: red - "relevant staff should be supported to be at home inline with shielding guidance"; orange – "relevant staff should be removed from patient facing roles"; green – "social distancing and PPE". Under the BAME section it stated: "staff who are able to work from home are supported to do so."

Changes to work

45. The Claimant worked part time because of his disability and had a reduction in his planned activities. He reduced his work by one session in 2008 and by a further session in 2009 (376) and told the Respondent at that time that is was because of his health issues and particularly his diabetes. His three consultant colleagues, Aftab Siddiqui, Anca Breahna and Rishi Sharma all worked full time.

46. As noted above at paragraph 40, CHM emailed the Claimant on 26 May (430) to say changes needed to be made to his work, and agreed he could not do F2F. She suggested that he do proportionately more of the departmental non-F2F work, "as suggested previously", and that he should talk to his colleagues about the changes and how it would work. Whilst she said "as suggested previously", there had in fact been no previous discussion and this was accepted by CHM in evidence.

47. Again, as noted above at paragraph 41 CHM emailed the Claimant on 27 May (1185) agreeing he should not do any F2F work with immediate effect, and that his on-call commitment would be covered by his consultant colleagues. She also emailed the other three consultants (436) telling them the Claimant, as of today, would not be covering on-call or any direct F2F clinical contact. So that work would be equitable, he would do other work such as triaging, proportionately more referrals, or more remote clinical work. His on-call commitments would be covered by his three colleagues and details of their rate of pay for this would be confirmed. From then on, the Claimant swapped his F2F work for remote clinics, administration and triaging.

48. On 7 July NP emailed CHM at 13.08 (435-436) saying Aftab had told her that it was his understanding that the Claimant would be doing all the triaging (urgent/routine) and virtual clinic consultations whilst not participating in the on-call rota and theatre work, and that only when the Claimant's clinics were full, would patients be booked for Aftab, Anca and Rishi.

49. CHM replied the same day at @ 13.38 (435) to NP saying that "…clearly, if he cannot do F2F, then he needs to compensate and do more remote work, virtual clinics, triaging or referrals etc etc." "….the other 3 seem to be doing all their own work AND his although I'm assured by them that Fahmy is doing all the triaging, but yes he should be doing his fair share."

50. That day at 13.48 NP emailed CHM (435) confirming that the Claimant had additional clinical capacity set up every Thursday all day. She suggested that he could also run virtual clinics for a large number of urgent patients awaiting 1st appointment, who were on the new patient queue since the start of Covid.

51. The same day at 15.08 CHM emailed all four consultants, copying in NP, (439) to say: " If the F2F work and on-call work is all now being done by Anca, Aftab and Rishi, then that means Fahmy will be doing all the GP referral triage and admin and I am led to understand that this is happening. Obviously if Anca, Aftab and Rishi are doing more ward based work, F2F, on-call and theatre, then they can't also do their own clinics and admin, there has to be a trade-off, so I am assuming that Fahmy has taken on some of that work.

52. There had been no discussion with the Claimant over whether he was able to undertake this extra work and there was no offer of remuneration. No team job plan was done to distribute the overall work.

53. CHM accepted in cross examination that the Claimant had already replaced his F2F workload and was now doing additional work on top. She accepted it was "carelessly undermining" the Claimant. We find that he was being asked to work over and above his additional hours for no extra pay.

54. On 21 July NP emailed CHM about the four consultants' work (438). With respect to the Claimant she said, as far as she could tell, he was currently running two clinics per week amounting to two PAs (Programmed Activities).

55. On 22 July CHM chased up the four consultants (442, 443) asking them to clarify how they had redistributed the work between themselves. She said she was concerned to ensure they had equitable re-distribution of work.

56. On 24 July the Claimant responded to CHM copying in MG, Jo Keogh and NP (441). He said his colleagues were undertaking extra on-call cover, at additional remuneration. He himself was undertaking additional replacement clinics, at no additional remuneration. Also, his clinics were the only clinics in Plastic surgery set up for August. There were no other consultant clinics. He asked what the basis was of cancelling all his colleagues' clinics. There was no reply to him.

57. On 27 July NP emailed CHM (441) clarifying current operational activity across the department. With respect to the Claimant she said he was running two virtual clinics per week currently, with reduced numbers – his job plan pre-Covid involved eight clinics per month, and eight elective theatre sessions. She would have expected an additional two clinics per week, to replace this activity. She was not aware of any other activity being carried out, at that point.

58. On 18 August at 8.10 the Claimant emailed Helen Nowakowska (Business Performance Manager) and Lucy Doughty (456) saying this week was his week

of triaging GP referrals. He and his colleagues took it in turns to weekly triage referrals. Today, there were over 50 patients awaiting triaging.

59. Ms Doughty responded to the Claimant the same day at 11.11 (456) saying the referrals had not been looked at since 22 July. Anca had mentioned yesterday that there was an arrangement in place for the Claimant to now grade these referrals. The Claimant responded to Ms Doughty at 11.41(456), copying in MG, and saying he was not aware of any such arrangement. He said he would triage the referrals of his week and as many others as he could.

60. On 24 August Ms Nowakowska emailed the Claimant (457) saying all the referrals had been triaged.

61. The Claimant contacted the BMA. Helen Osgood (HO), a BMA Employment Adviser, emailed MG on 3 September (465) complaining about a number of matters including the Claimant's increased workload. She said the Claimant's colleagues had been encouraged to do less work and trade off their work to the Claimant. There was no reply.

62. On 16 September the Claimant emailed Ms Nowakowska and Ms Doughty, copying in MG and H Roberts). He said there were another 42 referrals that had not been triaged (457-8). The same day Ms Roberts replied to the Claimant (458-9) saying the 42 patients went back to 8 July, so nothing had been triaged since the last email. After he queried this wit her (458), she confirmed later that day, that one was from 8 July, one from 20 August and 40 from 24 August onwards.

63. The Claimant then emailed MG on 16 September (459) saying that it appeared that his colleagues had refrained from triaging and this was most likely to be a direct consequence of CHM encouraging them not to undertake their routine admin work. He said he would triage a proportion of the backlog but it was for the Trust to take responsibility for the other patients. He said he was being bullied as a consequence of the outcome of his health risk assessment. MG did not reply.

64. CHM accepted in cross examination that the Claimant was left to deal with unmanageable levels of triage work. We find this to be the case.

65. HO chased up MG on 25 September (467), and indicated to her that the other consultants passing their designated work on to the Claimant, remained an ongoing concern.

66. In November 2020, Mr Hamid was recruited on a locum basis to cover the Claimant's theatre and on-call F2F work.

67. On 11 December the Claimant raised a grievance, which included a complaint in relation to the additional work allocated to him.

68. On 17 February 2021, during the grievance hearing, the Claimant was asked by Jacqui Griffin to do a diary exercise from August, or whenever it was he started doing everybody else's admin and clinics (616).

69. The Claimant replied (616, 617 & 618) saying it was hard to go back a year now. He said he was the only one seeing new patients. He had raised the

workload a few times with MG and Jo Keogh and they had had the opportunity to discuss it at the time, but did not. They turned a blind eye. He thought there were enough emails to show the workload was unfair. He commented later on in the grievance hearing (627) that he would continue doing as much of the triaging as he could and would leave the rest for someone else. He felt the referrals had now dropped because of the third wave.

70. HO commented in the grievance hearing (616 & 617) that the Claimant had raised the workload as he went along, but got no resolution. Now some months down the line it was unreasonable to say all that information was wanted. She suggested that the Trust must have systems in place to know how much work was being put through to a consultant, and questioned “wasn’t that what managers did?”

71. On 18 February Jacqui Griffith sent an email to HO (633) saying that normal job plans had not been resumed and this was the reason none of the work the Claimant had been doing had been handed back to the wider team.

72. The additional triaging work continued to be given to the Claimant until August 2021 (examples of triaging sheets at 1227). This was accepted by CHM in cross examination.

73. Going back to 27 May 2021, Matt Dobson (MD) emailed MG (805) regarding the Claimant’s job plan. He said that only the consultant on annual leave was carrying out fast track clinics. This was a reference to the Claimant. With respect to the Claimant’s work, he said “All MDTs and 2.5 SPA have been allocated as well as the 3x elective clinics as DCC. Elective clinics: Thursday am – 6 patients, Thursday pm – 3 patients, Friday am – 6 patients.”

74. The locums’ standard template was to see nine patients in clinic, ie more than the Claimant was seeing. The Claimant’s evidence was that virtual clinics took longer. Most of the patients were elderly and some had difficulty hearing remotely, which added to the time. He also said it took longer to get the patients’ consent remotely. The Respondent disputed this and said there had been a change, so that consent was given in writing on the day of theatre. Whilst the Claimant accepted this in cross examination, he said oral consent was still given remotely at clinics. We accept his evidence.

75. In August 2020 NP had tried to get consensus on how many patients it would be reasonable to deal with in an elective clinic. In her email to CHM (470) she said that Aftab had opined that 12 slots were reasonable for a single stream consultant telephone clinic. The Claimant disagreed.

76. On 8 October 2020 Sioned Rees had emailed MG (489) saying they were having difficulty getting the Claimant to increase the number of patients he was doing in clinics. Nonetheless, the respondent accepted the Claimant’s stance.

Communications with colleagues

May 2020 communications

77. On 22 May 2020 at 14.45 CHM emailed the Claimant and his three consultant colleagues (1181) saying she needed to be sure that the on-call suggestion

had been discussed between the four of them, and wanted to know whether there was agreement. There was no immediate response.

78. At 17.13 the same day CHM sent a WhatsApp message to the four consultants (425 half way down) saying that the suggestion to support the Claimant's on-call work and how to take it forward needed discussion between the four of them. She asked them to confirm that had been done. At 22.59 the Claimant replied complaining that WhatsApp was not the appropriate forum for raising the issue. At 23.41 CHM responded agreeing that WhatsApp was not an appropriate forum for professional discussion, but she said it was a means to message the group as there had been no response to her email.

79. On 25 May the Claimant emailed CHM and MG complaining about his sensitive and confidential information being shared with others.

80. As mentioned above at paragraph 41, on 27 May at 17.17 CHM emailed the other 3 consultants, not including the Claimant (436) to say the Claimant as of today would not be able to cover on-call or any direct F2F clinical contact. So that work would be equitable, he would provide work in another form such as triaging proportionately more referrals or taking on more remote clinical work. The Claimant's on-call commitments would be covered by the three of them and details of the rate of pay for this would be confirmed.

July 2020 communications

81. As mentioned above in paragraph 51, on 7 July at 15.08 CHM emailed all four consultants, copying in NP, (439) saying: " If the F2F work and on-call work is all now being done by Anca, Aftab and Rishi, then that means Fahmy will be doing all the GP referral triage and admin and I am led to understand that this is happening. Obviously if Anca, Aftab and Rishi are doing more ward based work, F2F, on-call and theatre, then they can't also do their own clinics and admin, there has to be a trade-off, so I am assuming that Fahmy has taken on some of that work.

82. As mentioned at paragraph 55 above, on 22 July CHM chased up the four consultants (442, 443) asking them to clarify how they had redistributed the work between themselves. She said she was concerned to ensure they had equitable re-distribution of work.

83. On 17 August the Claimant referred himself to Occupational Health (448) saying that, since his risk assessment, his work load and job plan were being discussed openly and shared with others. The privacy of correspondence had been breached. He felt devalued and felt he owed other colleagues a trade off. An appointment was arranged with Kathryn De Beger (Occupational Health and Wellbeing Manager)

Exclusion from ACA rota

84. Additional Clinical Activities (ACAs) were used by the Respondent to alleviate service pressures. They were used as a last resort as payment to consultants for them was at a premium. They were ad hoc arrangements. There was no rota as such.

85. There were three methods for offering ACAs: 1) - a joint decision to offer them made at departmental meetings; 2) - individual consultants offering them to resolve patient backlogs; 3) - service managers emailing clinicians when there was a breach or likely breach of patient waiting times. It is the third type that the Claimant was concerned about.

86. There were 3 types of ACA activity: 1) - Day Care (DC) which was F2F; 2) - out patients (OP) F2F; 3) - OP virtual. The Claimant could only do OP virtual at the time.

87. There is a record of ACAs from March 2020 to September 2021 (1113 – 1115). This was only prepared after the Claimant's grievance appeal. NP was asked about its accuracy in cross examination. She said it was compiled from financial records which showed the reason for the additional payment such as OP virtual. We accept this.

88. Further evidence of ACAs from 29 August 2020 to 17 April 2021 (807) is set out in a list prepared by MD, which details the type of activity and the consultant undertaking it. The numbers differ slightly to the March 2020 to September 2021 record, although they are in the same ball park. This list shows the Claimant doing just one ACA on 23 December 2020.

89. Whilst we find that the record of March 2020 to September 2021 may not be completely accurate, we accept that the numbers of ACAs shown is in the order of what was available at the time.

90. Looking at the OP Virtual, the following is recorded:

    March 2020 to August 2020 - none;

    September 2020 - 5;

    October 2020 - 6;

    November 2020 - 2;

    December 2020 - 1;

    January 2021 - 1.

    February and March 2021 - none;

    April 2021 - 2;

    May 2021 - none;

    June 2021 - 1;

    July 2021 - 1;

    August 2021 - 2

    September 2021 - none.

91. This amounted to 21 virtual ACAs. We accept that there were in the order of 21 virtual ACAs that the Claimant could have done over this 19 month time period.

92. From 14 June 2021, the Claimant was declared fit to return to F2F work by Occupation Health. Once he had returned, he was able to do F2F ACA Out Patient clinics. He would not have been able to do the DC operating ACAs, as he needed a period of theatre supervision after his absence from this work. There were about 30 OP F2F clinics between June 2021 and September 2021 according to the record. The Claimant was not offered any of these ACAs.

93. On 27 May 2021 MD emailed MG (805) indicating that, due to the Claimant's annual leave, a number of ACA clinics for fast track patients in September and October 2020 were held by the other consultants to pick up the backlog. The Claimant had gone on holiday at the end September/beginning October and had cancelled clinics on 24 and 25 September 2020 and 2 October 2020 (pp1698-1699). These fast track clinics were offered to the other consultant as ACAs (496). However, consultants on leave could still be offered ACAs, which they could arrange for a convenient time.

94. The Claimant was included in some of the email offers of ACAs. MD on 13 October 2020 included him in an offer of two ACAs (p492). The Claimant responded the same day to MD (1194) saying he was happy to help and could he be given confirmation of the current ACA rates. There was no reply.

95. On 22 October 2020 the Claimant was offered an extra clinic by Sorcha Holmes to see patients (497). NP in cross examination said that "Extra clinic" was synonymous with ACA. It was not part of the job plan and was outside the contract. We accept her evidence.

96. On 26 November 2020 MD sent out an email (1678) and included the Claimant, asking if anyone had capacity to review their patients during an ACA. On 17 December 2020, the Claimant was offered an ACA by Jane Ryrie (1694). This was the same ACA as was offered on 26 November 2020. An ACA clinic was set up for 23 December for the Claimant to cover this work (1693).

97. There is no other evidence of the Claimant being offered ACAs. Neither is there any evidence before us of the other consultants being offered ACAs to the exclusion of the Claimant. Whilst they might have been offered at meetings or been arranged for specific consultants' own lists, there is no evidence of this.

98. From November 2021, the Claimant was included in offers of ACAs, as shown in the email of 25 November 2021(954). There was no further issue over ACAs after that.

99. The lack of ACA offers formed part of the Claimant's grievance. MD provided some information on ACAs (494) following a request from HO (603). Liz Whitelaw (LW) had this information at the grievance meeting of 17 February 2021 (610) but did not share it following advice from the Divisional Manager, Jo Keogh not to disclose it. Instead she made out she did not have it but would get the data (615). She never did.

Grievance raised

100. On 9 December 2020 the Claimant sent a grievance letter to Alyson Hall, Director of Human Resources and Organisational Development (499). It was entitled "Formal Letter of Grievance". The main thrust of the grievance was that the Trust had:

- failed to implement a Covid risk assessment in a timely manner;
- failed to provide adjustments for the Claimant and take care of his safety in a timely manner;
- breached confidentiality by circulating a group email to his colleagues on 22 May 2020, followed by a chat group WhatsApp message that same day relating to his job plan discussions;
- treated the Claimant less favourably by telling him to undertake the work of his three colleagues and sending condescending, undermining and degrading emails projecting him as doing less work than his colleagues;
- failed to act despite the stress on him reported by Occupational Health and by his emails.

101. There was no acknowledgment and so on 8 January 2021 HO emailed Emma Taylor, an HR Business Partner, chasing up progress (568). Ms Taylor acknowledged the email that day and committed to finding out more (568). On 12 January Ms Taylor wrote a letter to the Claimant saying his grievance stage 1 had been assigned to Jackie Davies, Directorate Manager Planned Care, who would be supported by Jacqui Griffin, Medical Staffing. Val Wilkinson, Secretary, had been requested to support from an administrative perspective.

102. Over 14 and 15 January there were emails between Ms Wilkinson and the Claimant (572 - 573) trying to arrange a grievance meeting. On 26 January LW wrote the Claimant (575) inviting him to a formal grievance hearing on 2 February. She informed him that CHM, and Rachel Roberts, HR Advisor, would be present.

103. The meeting took place on 2 February (minutes at 583 - 594). During the meeting LW referred to it as an "informal fact find". The meeting minutes, taken by Ms Wilkinson, were signed by the Claimant as a true and accurate record on 10 March 2021 (594).

104. On 4 February there were email exchanges between the Ms Wilkinson and the Claimant (600 - 602) to arrange the next meeting, which was agreed for 17 February.

105. On 12 February HO emailed LW and Jacqui Griffin (603) requesting ACA information and any other additional paperwork. This was never supplied.

106. The second meeting took place on 17 February. Management notes for the meeting (609 - 610) were entitled "Informal grievance meeting". The minutes, taken by Ms Wilkinson (611 - 628) were signed by the Claimant on 29 March 2021 (628) as a true and accurate record.

107. Following the meeting, the Claimant sent his Occupational Health report from August 2020 to LW and Jacqui Griffin on 17 February (606).

108. The same day HO sent an email to LW (635) requesting a copy of the recording from the 17 February.

109. Also on 17 February, MD sent two emails to LW (629) providing information on ACAs.

110. On 18 February Ms Griffin sent an email to Ms Wilkinson (631) saying they should not share the recording of the meeting with anyone and once the notes had been agreed the recording should be deleted.

111. HO emailed Ms Griffin on 18 February (633 - 634) requesting a copy of the recording. Ms Griffin e-mailed back later that day (633) saying her understanding was that the recordings were made for the purpose of minute taking and would be deleted once the minutes were verified. She also noted that the 23 February was the ACAS deadline and there was no further meeting in the diary, so she would draft a letter as soon as possible.

112. On 22 February HO emailed Ms Griffin (638) saying she was looking forward to the outcome letter prior to the ACAS deadline of 23 February, and it was her understanding that the recording should be kept in case it was needed in evidence. Ms Griffin emailed LW (638) saying she was trying to put a response together, but it must come from the manager as this was the resolution of the investigation and the next steps as to what they were going to do to appease the Claimant.

113. On 2 March several versions of the outcome letter were drafted but not sent: version 1 (644-646); version 2 (647-650); draft with track changes (651-655); further drafts (656-663). The final outcome letter (664-667) was dated 2 March but was not sent until 19 March.

114. On 4 March HO emailed Ms Wilkinson, copying in Ms Griffin (673) saying they were still not in receipt of the outcome of the grievance.

115. On 16 March Ms Griffin emailed LW (685) about the "Outcome informal meeting V2.docx" saying she had made a lot of changes and saying LW could add whatever she needed to "but don't admit or apologise for anything as it can be taken as an admittance of failure."

116. On 19 March Ms Wilkinson emailed the Claimant (697) attaching the "outcome of informal grievance letter".

117. On 25 March CHM emailed LW (695) saying she was a bit concerned that she had not heard anything back yet regarding the grievance. Her BMA support had asked for an update.

118. HO emailed LW on 25 March (696) thanking her for the outcome letter and noting that LW had referred to it an informal grievance, whilst HO had understood it was a formal procedure. She informed LW that the Claimant was appealing and asked for the relevant Appeal Pro-Forma, which had not been sent.

119. On 26 March LW wrote to the Claimant (700) saying the purpose of the recording was to aid with minute taking. The same day Ms Wilkinson emailed the Claimant (701) sending him the "Appeals Guidelines & Registration of

Appeals Pro-forma" and the "Employee Registration of Appeal Prop-forma", as requested.

120. The Claimant submitted his appeal to Alyson Hall on 29 March (706), which she acknowledged on 30 March (716).

121. From 1 April to 11 May there was various correspondence trying to set a date for the appeal (755-763). It was agreed that it would take place on 12 May 2021, but in the event, it was cancelled on 11 May due to missing paperwork and its inappropriate designation as a grievance meeting rather than an appeal. HO emailed Emma Taylor on 10 May and told her it was not a grievance stage 1, which had already taken place, but an appeal meeting against the outcome (757).

122. On 28 June HO emailed Ms Wilkinson (771) suggesting 4 or 11 August for the appeal. She also chased for the management state of case, which had still not been received, and expressed her concern over the length of time it was taking to arrange a meeting, noting the time scales were outside the Respondent's procedure.

123. The management pro-forma and associated documents were sent to the Claimant on 8 July (774). Stephen Howe, Interim HR Business Partner, then arranged for the appeal hearing to take place on 4 August (776). On 2 August Mr Howe cancelled the appeal hearing (781) because David Coyle (DC), who was going to chair it, was no longer available.

124. On 20 September Sittu Ahmed, the Claimant's new BMA Employment Advisor, emailed Mr Howe (904-905) reefing to an arranged appeal hearing on 29 September and his inability to attend due to pre-arranged leave.

125. The appeal hearing eventually took place on 10 November with DC chairing it and the minutes (913-943) were signed as a true and accurate record by the Claimant on 10 January 2022 and DC on 14 January 2022 (943). The meeting continued on 7 December 2021 and the minutes (958-1,000) were signed as a true copy by the Claimant on 22 February 2022 (1,000). A further continuation took place on 14 December 2021 and the minutes (1003-1032) were signed as true copy by the Claimant on 1 March 2022 (1032). A fourth and final hearing took place on 15 March 2022 and the minutes (1064-1108) were signed as a true copy by the Claimant on 4 April 2022 (1108).

126. The appeal outcome letter was dated 9 May 2022 (1129-1135) and was emailed to the Claimant by Mr Howe on 10 May 2022 (1136).

Appraisal

127. Appraisals were undertaken of the medical staff and were needed for revalidation. The Claimant had never previously had anything on his appraisals other than "satisfactory with no concerns." He had a good appraisal initially for the year 2020, which was done by David Childs with no concerns noted (513).

128. It went for signing off to MG and she noted down some concerns on his appraisal form (668-669) on 20 January 2021. The concerns were: "cpd all external; there is no mention of him being non-patient facing since last year;

requires 360 this year - last one 2016". The responsible officers signed it off on 4 February 2021.

129. On 3 March 2021 Lesley Spruce, the Medical Appraisal and Revalidation Manager, sent the appraisal to the Claimant (677). The same day the Claimant responded saying he thought there had been a mix up and he raised some concerns. On 4 March he wrote again to Lesley Spruce summing up his response which was:

- His CPDs were not all external. There were at least two internal audits;
- His non-F2F was from 26 May 2020. (The implication being that, as the appraisal year was 2020, he had been doing F2F for part of the year ie up until then). He also said the non-F2F was a requirement.
- The 360 was not due until this year, so he did not understand the need to include it as it was not overdue.

130. Lesley Spruce sent the comments to MG on 4 March 2021 (675). MG responded on 5 March at 8.57 (726) saying that there was an imbalance of external and internal CPD.

131. The Claimant wrote back to MG and Lesley Spruce the same day at 9.31 saying he had done more CPD than required, making good use of the current difficulties, and that he had presented the two internal audits at national and international level. He sought clarification of "non-patient facing" and said it should not be a concern. It was simply a compliance with the risk assessment. He noted that Lesley Spruce had completed the 360 record box and clarified the revalidation date.

132. There were further email exchanges between the Claimant and MG including on 15 March 2021 from the Claimant, which set out again in detail why the three matters should not be concerns. There was no response and so he sent a chase up on 23 March (729). MG replied on 24 March saying that the comment about imbalance of CPD would remain. The form now contained one concern (693) which was the "need to maintain balance between internal and external over 5 year period".

133. The Claimant wrote back saying the form was still inaccurate (730) and on 25 March he wrote again saying he would have expected to be commended for doing extra CPD irrelevant of external or internal (731). There was no reply and so he chased this up, and on 7 April MG replied at 13.24 (732) saying the comment was based on judgment, she needed to point out any potentially preventable issues, and she had made no comment about the total amount of CPD he had undertaken. The Claimant replied on 26 April with further reasoning as to why this should not be a concern and saying he was finding it difficult to identify any issues to avoid. MG did not respond. The Form was not altered any further and remained with the imbalance as a concern.

134. Previously, when any comments were made on the appraisal form, it had not stopped the Claimant having the top "satisfactory" box ticked, as demonstrated in the previous year's appraisal form (379).

Phased return to work

135. On 28 April 2021, following a change to Government guidance, Jackie Davies (Directorate Manager) contacted the Claimant to arrange an Occupational Health referral (738). The Claimant responded that day agreeing to it (738).

136. The Occupational Health consultation took place on 14 June 2021 (834) and the Claimant was cleared to return to F2F work, but with surgery being built up over 4-6 weeks with supervision.

137. The Claimant chased up Ms Davies on 2 July 2021 (739) and 9 July 2021 (740), asking what the next steps were and asking whether he could start F2F clinics. On 12 July Ms Davies replied apologising for the delay (740), and saying she had asked MD to provide support to facilitate the documented outcomes, ie the return to F2F clinics and surgery with supervision. She said she thought it would be prudent to understand the position of the Royal College. There is no evidence that this was ever pursued with the Royal College.

138. On 12 July MD emailed the Claimant (741) to ask if he would like clinics changing to F2F. On 13 July the Claimant asked for a meeting to discuss the plan (884). On 6 August the Claimant returned to F2F work, but not surgery.

139. On 9 August MD sent an email to the Claimant arranging his return to F2F work meeting (743). The Claimant replied the same day (743) suggesting it be that coming Thursday. However, that did not happen.

140. On 17 August MD emailed the Claimant (745) asking if he was available on Thursday that week to meet with him and Jackie Davies. This was to discuss his job plan and phased return to work, and to set up a schedule regarding clinics/theatres/supervision and any adjustments required.

141. The Claimant responded on 18 August (746) saying he was on leave as from tomorrow and suggested meeting on 2 September. On 19 August Ms Davies replied (746) saying that she was on leave that week and suggested 9 September. The Claimant replied on 19 August (747) agreeing to the 9 September.

142. The meeting took place on 9 September, as evidenced by the emails from MD and the Claimant (747 & 748). The Claimant returned to surgery/operating on 16/9/21.

143. The Claimant contacted ACAS and a certificate was issued on 11 August 2021 (16). The claim form was issued on 12 August 2021.

Discussion and Conclusions

144. We have structured our conclusions to correspond with the numbering in the list of issues, and have reproduced parts of the issues below.

1. Time limits

1.1. Given the date the claim form was presented and the effect of early conciliation, any complaint about something that happened before 12 May 2021 may not have been brought in time.

The Claimant accepts that matters before 12 May 2021 are, on the face of it, out of time unless they formed part of conduct extending over a period, or alternatively, in the case of detriments following protected disclosures, they amounted to a series of similar acts or failures.

In considering this issue, we have noted that the various acts and failures started when the Claimant raised his concerns about working F2F with patients during Covid. The instances of the Claimant being undermined, his work being obstructed, and the delays in processes were all linked to the theme of him not doing F2F work.

This started with the request for a Covid risk assessment and continued up until the Claimant's full return to F2F work in September 2021, with the ACA matter extending beyond. The people responsible for the acts and omissions were linked, with MG's name appearing on many occasions. Given her seniority, her approach to the Claimant is likely to have influenced others.

We find that, on the basis of this continuous state of affairs, there was conduct extending over a period and there was a series of similar acts and failures. As they extended past 12 May 2021, the Claimant's complaints have been brought in time.

2. Protected disclosures

2.1. Did the claimant make one or more qualifying disclosures as defined in section 43B of the Employment Rights Act 1996? The Tribunal will decide:

2.1.1. What did the claimant say or write? When? To whom? The claimant says he made disclosures on these occasions:

2.1.1.1. [No longer relied upon]

2.1.1.2. On 15 May 2020, the claimant emailed Claudia Harding-Mackean of the Respondent stating that he felt: "concerned, worried and don't feel its appropriate or safe to continue any longer, with face to face contact with patients". (408)

2.1.1.3. On 20 May 2020, the claimant emailed Claudia Harding-Mackean again, stating that he was: "worried and concerned of the potential mutual risks and the impact on me and others from any face to face treatments". (412)

2.1.1.4. On 21 May 2020, the claimant expressed his serious health and safety concerns to Ms Harding-Mackean and Michelle Greene

(Divisional Medical Director – Planned Care) about doing face-to-face operations for "Nuffield patients". (1176)

2.1.2. Did he disclose information?

(2.1.1.2) The email of 15 May 2020 was about the Claimant's risk assessment outcome. It said that he was "concerned, worried and didn't feel it appropriate or safe to continue any longer with face to face contact with patients".

In the context of his risk assessment, we find this to be information.

(2.1.1.3) The email of 20 May 2020 told the Respondent that his long standing diabetes carried its own risks and complications and he was "worried and concerned about the potential mutual risks and the impact on him and others from any face to face treatments". We find this to be information.

(2.1.1.4) The email of 21 May 2020, as a whole, contained some factual information about Diabetes and risk, and the Claimant's peripheral complications. It said the value of a negative Covid screening was short lasting and did not ensure Covid free staff or indeed the Claimant. It referred to the Covid test offering very little reassurances. Also, it stated that the Trust provided no alternatives for the Nuffield patients. The Claimant told the Respondent that he had proceeded with the list, on this occasion, for the sake of the patients and his own commitment.

This is factual information.

2.1.3. Did he believe the disclosure of information was made in the public interest?

Taking the three emails together, the 2nd email, which is dated 20 May 2020, said the Claimant was worried and concerned about the potential mutual risks and the impact on him and others. In cross examination, MG agreed that the Claimant was concerned about others as well as himself.

The Claimant's mindset at the time he wrote all three emails was of concern for himself, other staff and patients.

We find that he made the disclosures in the public interest.

2.1.4. Was that belief reasonable?

Considering the matter objectively, we say the belief was reasonable. There were many people falling sick with Covid at the time, and the risk of contracting it was significant, particularly for vulnerable people.

2.1.5. Did he believe it tended to show that:

2.1.5.1. [No longer relied upon]

2.1.5.2. the health or safety of any individual had been, was being or was likely to be endangered?

Objectively speaking, we say yes. It tended to show that the Claimant's health and that of the patients he saw F2F was being or was likely to be endangered.

2.1.6. Was that belief reasonable?

Considering the matter objectively, we say yes. There were many people falling sick with Covid at the time, and the risk of contracting it was significant, particularly for vulnerable people.

2.2. If the claimant made qualifying disclosures, were they made to the claimant's employer (including, if relevant, a person authorised by his employer under s43C(2))?

Yes, the disclosures were made to the Claimant's employer.

If so, were they protected disclosures?

The three emails were protected disclosures.

3. Detriment (Employment Rights Act 1996 section 48)

We considered whether the protected disclosures materially influenced the Respondent's treatment of the Claimant, in the sense of being more than a trivial influence.

3.1. What are the alleged acts or deliberate failures to act that the Claimant relies on? 3.3 Did the Respondent subject the Claimant to each act or deliberate failure on the grounds that he made a protected disclosure?

3.1.1. During May 2020, was there a failure to implement the necessary changes to the claimant's duties and working arrangements, following the outcome of the risk assessment, in a timely manner?

The Claimant submitted his risk assessment to CHM on 7 May 2020. It clearly showed in the orange category, under the renal section, that he had diabetes mellitus. The form advised that staff in the orange category should not do F2F work.

CHM reviewed the risk assessment on 7 May. At that stage it should have been apparent to her that the Claimant needed to be removed from F2F work. However, instead of removing his F2F duties, she procrastinated and sought advice from her manager (MG). There was no need for this. The Claimant's answer in the orange category was sufficiently clear for her to act.

Whilst we accept that the process might have been concluded sooner, had the Claimant seen the email of 18 March, we note that CHM also failed to pick up this email and, in any event, this does not detract from the delays which ensued.

Accordingly, there was a failure to instigate necessary changes to the Claimant's duties in a timely manner.

What was the reason for the delay?

The 1st protected disclosure was on 15 May with the others following on 20 May and 21 May.

CHM was confused and was trying to abrogate her responsibilities to MG. She had received no training on risk assessments and did not want to take the decision on F2F work based on the information she had.

CHM sent the Claimant's email of 15 May to MG on 18 May, and MG responded saying the Claimant could not "unilaterally decide". This was a direct response to his 15 May email.

Despite CHM initially agreeing with the Claimant that he could refrain from F2F work whilst she sought MG's advice, the series of emails that followed, led to the Claimant having to undertake F2F work at the Nuffield centre on 21 May. This was a consequence of his 15 May email.

MG was annoyed with the Claimant challenging the fact he was still doing F2F work, and her email to CHM caused delay in adjusting his work. Consequently, we find that the decisions made about the Claimant's F2F work, and the delays that ensued, were influenced by his protected disclosures.

The Claimant succeeds on this allegation.

3.1.2. The claimant was unfairly allocated the additional clinics and administrative work of three full-time consultants, with no further remuneration.

The three protected disclosures influenced the decision to remove the Claimant from F2F work. That, in turn led to the Claimant being allocated the triaging and administrative work of three full-time consultants without further remuneration.

Although the Claimant's work was not specifically quantified, from the evidence before us, and the emails in particular, we find that he was unfairly allocated additional work. This was accepted by CHM in cross examination.

The Claimant succeeds on this allegation.

3.1.3. Details of the claimant's reallocated duties were communicated to the claimant's colleagues in an undermining manner.

CHM communicated with the other three consultants in May and July 2020 by email and WhatsApp about the Claimant's work and work pattern, without his consent and without discussing it with the Claimant. On at least one occasion she did not even copy him in.

The WhatsApp message was an inappropriate and unprofessional way to communicate messages about the Claimant's work and the emails were also

inappropriate in their content. CHM agreed in cross examination that she was carelessly undermining the Claimant.

The Claimant succeeds on this allegation.

3.1.4. The claimant was excluded from the ACA rota.

We do not believe that there was any link between the disclosures and the level of ACAs offered. The lack of ACAs was because the Claimant was not doing F2F work, and was also influenced by his grievance about the ACAs.

The Claimant does not succeed on this allegation.

3.1.5. The respondent failed to address the Claimant's grievance raised on 11 December 2020 in a timely fashion.

The disclosures were too remote to influence the delays in the grievance process.

The Claimant does not succeed on this allegation.

3.1.6. On 4 February 2021, the respondent noted "concerns" on the claimant's appraisal form for the first time in 20 years.

We find that MG was annoyed by the Claimant's emails and his challenge regarding him doing F2F work. This influenced MG in noting concerns on the Claimant's appraisal form.

The Claimant succeeds on this allegation.

3.1.7. Between June and September 2021, the respondent failed to promptly put in place/action a phased return to work plan for the claimant.

The disclosures were too remote to influence the delays in the Claimant's return to F2F work. We do not find a link.

The Claimant does not succeed on this allegation.

3.2. Did the claimant reasonably see that act or deliberate failure to act as subjecting him to a detriment?

We say yes. It was reasonable for the Claimant to see the following acts and omissions as being detrimental to him for the reasons given.

Failing to adjust the Claimant's work in a timely manner after the risk assessment, put the Claimant's health at unnecessary risk, to his detriment.

Allocating the Claimant additional work over and above his contractual hours without additional pay, when his colleagues were given additional pay, was hurtful and stressful and to his detriment.

Communicating messages about the Claimant's work and work pattern to the Claimant's colleagues was detrimental in that it undermined the Claimant and was disrespectful and hurtful.

Noting concerns on the Claimant's appraisal reflected negatively on his performance and professionalism, to his detriment.

4. ….

5. Discrimination arising from disability (Equality Act 2010 section 15)

5.3 The Claimant was absent from the workplace because he needed to shield during Covid and therefore he was unable to have F2F contact with patients. This absence and inability to have F2F patient contact is the "something" in this case.

5.1. Did the respondent know or could it reasonably have been expected to know that the claimant had the disability? From what date?

The Claimant had reduced his hours of work in 2008 and again in 2009 because of his disability, and he made the Respondent aware of this reason at the time. When he completed the risk assessment in May 2020 he stated he had diabetes. Therefore, the Respondent knew of his disability at all material times.

5.2. If so, did the respondent treat the claimant unfavourably.

We have focused on the reasons for the treatment and what was in the mind of the people carrying out the alleged treatment. We have kept in mind that there may be more than one reason for the treatment, but for the Claimant to succeed with causation, the "something" that allegedly caused the treatment must have had at least a significant (more than trivial) influence on that treatment. We have approached the causation test objectively.

We have considered each alleged unfavourable treatment in turn as follows:

5.2.1. During May 2020, there was a failure to implement the necessary changes to the claimant's work, following the outcome of the risk assessment, in a timely manner.

There is no evidence of this. The Claimant's risk assessment was completed on 7 May 2020, and he stopped seeing patients F2F on 26 May 2020. This short delay in implementing the necessary changes was because his line manager, CHM, was confused about what to do and did not fully understand the Claimant's entries on the risk assessment. It was not because of the Claimant's absence from the workplace or his inability to have F2F patient contact and, in any event, he did not stop F2F work until 26 May.

The Claimant does not succeed on this allegation.

5.2.2. The claimant, who is on a part-time contract, was unfairly allocated the additional clinics and administrative work of three full-time consultants, with no further remuneration.

Following the e-mails from CHM, suggesting the Claimant do more of the department's non-F2F work, such as triaging, referrals and remote clinical work, he was given additional remote clinics with no further remuneration and, for a period, all of his colleagues' triaging.

The Claimant was on a part-time contract and his three consultant colleagues were on full time contracts. Consequently, the additional work was significant and over and above what he was contracted to do. This was not an equitable and fair redistribution of the work and arose directly because of the fact he could not do F2F work.

The Respondent relies on three legitimate aims to justify their actions:

(i) Continued provision of healthcare services by the NHS during the Covid pandemic.

Whist we accept that this is a legitimate aim, we do not accept that overloading the Claimant with work was a proportionate means of achieving it.

(ii) Ensuring that the Claimant remained in employment, and on full pay, whilst he was unable to perform his contractual face to face duties.

Whilst we accept that this is a legitimate aim, by the terms of the Claimant's contract, he was entitled to be employed on full pay whilst doing non-F2F duties to the extent of his contractual hours. Giving him additional work, over and above these hours, was unnecessary to keep him in employment.

(iii) Ensuring an equitable distribution of work between the consultants in the Claimant's department for optimal efficiency of services to patients and with regard to the health and safety of those providing the services.

The Claimant's consultant colleagues were all paid additional remuneration for any additional clinics they undertook. The Claimant was paid nothing additional. The Claimant was on a part-time contract because of his disability, and putting pressure on him to undertake work over and above his contracted hours was unreasonable and inequitable. It also disregarded the impact such additional work might have on his health.

In summary, none of the above aims are justified.

We find that there was unfavourable treatment because of the non-F2F work and the Claimant succeeds on this allegation.

5.2.3. In July 2020, details of the claimant's reallocated duties were communicated to the claimant's colleagues in an undermining manner.

The reason for CHM's July email to the Claimant's colleagues was his inability to do F2F work. Had he been able to do F2F work, the communication would not have been made.

The communication undermined the Claimant and was disrespectful in the manner in which it was sent.

We can find no evidence of how this communication could be seen to be a proportionate means of achieving a legitimate aim.

We find that there was unfavourable treatment because of the non-F2F work and the Claimant succeeds on this allegation.

5.2.4. The claimant was excluded from the ACA rota.

There was no rota as such and the ACAs were offered in an ad hoc way. This is the basis upon which we have approached the issue.

There were about 21 virtual ACAs over a 19 month period and the Claimant did only one of them. The Respondent, via MD, Sorcha Holmes and Jane Ryrie offered the Claimant ACAs on just three occasions. Although he replied positively to the offer in October 2020, nobody replied to him. The offers in November and December 2020 were for the same ACA, which he took up.

The Claimant was able to do F2F work from mid June 2021 when there were about 30 F2F ACAs of which he was not offered any. It appears that his consultant colleagues were offered these various ACAs.

We note that LW had information on the distribution of ACAs at the time of the grievance meeting, yet made out disingenuously that she did not.

Putting all the above together, we find this is sufficient to show a prima facie case and the burden of proof shifts.

The respondent has not shown any good reason why the Claimant was not offered this work and has not demonstrated how this could be a proportionate means of achieving its legitimate aims.

We find that the reason for the dearth of ACA offers to the Claimant was because of his period of not doing F2F work.

We find there was unfavourable treatment because of the non-F2F work and the Claimant succeeds on this allegation.

5.2.5. The respondent failed to address the claimant's grievance raised on 11 December 2020 in a timely fashion.

There does not appear to us to be any connection between the delays and the fact the Claimant was not doing F2F work. The delays were for other reasons, particularly the nature of the grievance, in that it was against the Trust and they did not want to deal with the allegations made against them.

Therefore, as we do not find any link between the Claimant's inability to do F2F work and the delays in the grievance, the Claimant does not succeed with this allegation.

5.2.6. On 4 February 2021, the respondent noted “concerns” on the claimant’s appraisal form for the first time in 20 years.

Previously the Claimant had always had a satisfactory appraisal with no concerns and the 2020 appraisal, done by David Childs, initially had no concerns on it. It was only when it went to MG that she added concerns.

We believe that MG was irritated with the Claimant for standing up for his right to refrain from F2F patient work during Covid. The tone of her email of 15 May 2020 regarding his request to refrain from F2F work, and her wording saying he could not “unilaterally decide”, reflects this.

We find that, the Claimant not doing F2F work contributed to MG noting concerns on his appraisal.

The concerns were unjustified and they were not a proportionate means of achieving the Respondent’s legitimate aims.

We find there was unfavourable treatment because of the non-F2F work and the Claimant succeeds on this allegation.

5.2.7. Between June and September 2021, the respondent failed to promptly put in place/action a phased return to work plan for the claimant.

Following the change in Government guidance, the Claimant was contacted on 28 April 2021 to arrange an Occupational Health Assessment with a view to considering his return to F2F work. The Assessment took place on 14 June and he was cleared to return to F2F clinics, with surgery being built up over 4-6 weeks.

Despite the Claimant chasing up the relevant people, he was not given permission to return for several weeks. He eventually re-commenced F2F patient work on 6 August. The Respondent wanted a Return to Work meeting before the Claimant started surgery again. This did not taken place until 9 September, when he was cleared. He returned to surgery on 16 September

We find that there was a significant delay, both in returning to F2F clinics and returning to theatre. This is sufficient to shift the burden of proof to the Respondent. No reasonable explanation has been provided by the Respondent and no justification given regarding proportionate means of achieving their legitimate aims. Consequently, the Respondent has not discharged that burden.

Accordingly, we find that there was unfavourable treatment because of the non-F2F work, and the Claimant succeeds on this allegation.

6. Reasonable Adjustments (Equality Act 2010 sections 20 & 21)

6.1. Did the respondent know or could it reasonably have been expected to know that the claimant had the disability? From what date?

As stated in response to issue 5.1, the Respondent knew of the Claimant's disability at all material times.

6.2. A "PCP" is a provision, criterion or practice. Did the respondent have the following PCPs:

6.2.1. The practice of taking a "broad-brush" approach to risk assessments, failing to provide adequate training to staff undertaking the risk assessments and failing to take into account that those with disabilities were more at risk of Covid-19 complications, and therefore should have been prioritised;

The Respondent's risk assessment questions caused confusion and there was no adequate follow up with the Claimant to clarify his conditions and his concerns. There is no evidence that his situation, as an individual, was adequately discussed or considered. The specifics of his disability and any potential impacts arising from his ethnicity, do not appear to have been adequately taken into account.

The Respondent took a broad-brush approach to risk assessments, failed to give adequate training, and failed to take proper account of disabilities. This was a PCP.

The Claimant succeeds on this allegation.

6.2.2. The practice of communicating sensitive and important matters informally, including via WhatsApp and group emails;

We find that the informality of some of the communications were not the normal practice of the Respondent. Consequently, this was not a PCP.

The Claimant does not succeed on this allegation.

6.2.3. The criterion of only offering ACAs to individuals that are able to do face-to-face consultations;

In the Plastics department there was a practice on most occasions of not offering ACAs to the Claimant, who was the only consultant not able to do F2F. We find this was a PCP.

The Claimant succeeds on this allegation.

6.2.4. The policy of noting matters which have arisen from the Claimant's disability as "concerns" on his appraisal form.

We find that this was a one-off occurrence. It was not a PCP.

The Claimant does not succeed on this allegation.

6.3. Did the PCPs put the claimant at a substantial disadvantage compared to someone without the claimant's disability?

We have taken “substantial” to mean “more than minor or trivial”.

We have considered the alleged substantial disadvantages in turn, as follows:

6.3.1. In May 2020, was placed at undue risk because he should have been prioritised during the risk assessment process;

The Claimant had a disability, which should have indicated to the Respondent that he needed to be prioritised for assessment. This was even more so, given his ethnicity and what was known about Covid at the time. By not prioritising him, the Respondent put him at undue risk. This was a substantial disadvantage.

The Claimant succeeds on this allegation.

6.3.2. In May 2020, suffered distress and humiliation by his colleagues discussing his job plan via WhatsApp;

Not applicable because no PCP.

6.3.3. was not able to earn additional income by attending ACAs;

By not being allocated ACAs, which attracted an additional fee, the Claimant’s opportunities to earn were reduced. This was a substantial disadvantage.

The Claimant succeeds on this allegation.

6.3.4. On 4 February 2021, had alleged “concerns” included on his appraisal form.

Not applicable because no PCP.

6.4. Did the respondent know or could it reasonably have been expected to know that the claimant was likely to be placed at the disadvantage?

The Respondent knew about the Claimant’s disability and what the Government guidance and their own risk assessment said about vulnerability. It was reasonable to expect them to know that the Claimant would be put at risk if he was not assessed and taken off F2F work promptly.

It was obvious that the Claimant’s earning potential would be lessened if he were not offered paid ACAs. The Respondent knew this.

6.5. Did the respondent fail in its duty to take such steps as it would have been reasonable to have taken to avoid the disadvantage? The claimant says that the following adjustments to the PCP would have been reasonable:

6.5.1. having a more systematic and targeted approach to risk assessments during the pandemic, seeking out those who were at higher risk to ensure that they were prioritised and protected;

From the start of the pandemic, in March 2020, the Respondent ought to have had a risk assessment process in place, which prioritised their most vulnerable employees. This would have been a reasonable adjustment

The Claimant succeeds on this allegation.

6.5.2. avoiding the practice of communicating sensitive information via WhatsApp, instead ensuring appropriate safeguards were in place in line with the Data Protection Act 2018;

Not applicable because no PCP.

6.5.3. including the claimant in the ACA rota and treating him equally to the rest of his colleagues;

There was no good reason to exclude the Claimant from being offered remote clinic ACAs, and F2F clinic ACAs once he was cleared to return to F2F work. The Respondent should have included him in their offers. This would have been a reasonable adjustment.

The Claimant succeeds on this allegation.

6.5.4. adjusting its policy to account for absences from the work-place/inability to do face-to-face consultations caused by the combination of the Covid-19 pandemic and disability to avoid “concerns” being noted on appraisal forms.

Not applicable because no PCP.

7. Victimisation (Equality Act 2010 section 27)

7.1. Did the claimant do a protected act as follows:

7.1.1. The claimant raised a formal grievance on 11 December 2020, alleging unfair treatment as a result of having to shield.

This was a protected act.

7.2. Did the respondent do the following things:

7.2.1. unfairly allocate, or continue to unfairly allocate to the part-time claimant a significant and overwhelming workload of GP referral triage and administrative work of three full-time consultants with no additional remuneration;

We find that the additional work was due to CHM’s actions and was not influenced by the grievance. It started before the grievance and simply continued thereafter.

The Claimant does not succeed on this allegation.

7.2.2. exclude, or continue to exclude, the claimant from the ACA rota;

The original reason for exclusion from ACAs was the Claimant's inability to do F2F work, which occurred before the grievance. However, part of the grievance was about ACAs. MD was responsible, at least in part, for offering ACAs, and we find this connection to be sufficient to shift the burden of proof.

The Respondent has not demonstrated that the grievance did not contribute to the ongoing exclusion of the Claimant from ACAs.

The Claimant succeeds on this allegation.

7.2.3. on 4 February 2021, note "concerns" for the first time in 20 years on the Claimant's appraisal form and / or refuse to amend these;

We find that taking out the grievance added to MG's annoyance with the Claimant. This contributed to her noting the concerns on his appraisal form.

The Claimant succeeds on this allegation.

7.2.4. take over 9 months to process the Claimant's grievance raised on 11 December 2020;

We find that the grievance was delayed because of its nature, ie it was against the organisation and they did not want to deal with it. It was handled unprofessionally. Investigative interviews were not undertaken in a timely manner and management statements were not produced on time. It was treated with a lack of urgency. We believe this all came back to the subject matter.

The Claimant succeeds on this count.

7.2.5. between June and September 2021 fail to put in place/promptly action a phased return to work following the claimant's return from face-to-face shielding

MD was responsible for the Claimant's return to F2F work and, as noted above, he was also responsible for offering ACAs, which formed part of the Claimant's grievance. We find this connection to be sufficient to shift the burden of proof.

The Respondent has not offered sufficient evidence to explain the delay and has not proven that it was not contributed to by the Claimant taking out the grievance.

The Claimant succeeds on this allegation.

7.3. By doing so, did it subject the claimant to detriment?

Noting concerns on the Claimant's appraisal reflected negatively on his performance and professionalism, to his detriment.

Not been able to earn additional salary through ACAs was detrimental to the Claimant's earnings.

Having to go through the grievance process for over 9 months was detrimental to the Claimant in that it caused undue anxiety and uncertainty.

The delay in returning to F2F work caused uncertainty, to the Claimant's detriment.

____

Employment Judge Liz Ord

Date 9 March 2024

JUDGMENT SENT TO THE PARTIES ON

13 March 2024

FOR THE TRIBUNAL OFFICE

Notes

Public access to employment tribunal decisions
Judgements and reasons for the judgments are published, in full, online at www.gov.uk/employment-tribunal-decisions shortly after a copy has been sent to the claimant(s) and respondent(s) in a case.

ANNEX

Agreed List of Issues

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8. Time limits

8.1. Given the date the claim form was presented and the effect of early conciliation, any complaint about something that happened before 12 May 2021 may not have been brought in time.

8.2. Were the complaints concerning the alleged detriments (as set out at 3.1 below), acts of discrimination (as set out at 5.2 and 6.3 below) and acts of victimisation (as set out at 7.2 below) made within the time limit in section 48 of the Employment Rights Act 1996 and/or section 123 of the Equality Act 2010? The Tribunal will decide:

8.2.1. Was the claim made to the Tribunal within three months (allowing for any early conciliation extension) of the act to which the complaint relates?

8.2.2. If not, was there conduct extending over a period and/or, in respect of the detriment claims, a series of similar acts or failures to act?

8.2.3. If so, was the claim made to the Tribunal within three months (allowing for any early conciliation extension) of the end of that period?

8.2.4. If not, in respect of the detriment claims, was it reasonably practicable for the claims to have been brought in time, and if not, have they been brought within such further period as the Tribunal considers reasonable?

8.2.5. If not, in respect of the discrimination complaints, were the claims made within such further period as the Tribunal thinks is just and equitable? The Tribunal will decide:

8.2.5.1. Why were the complaints not made to the Tribunal in time?

8.2.5.2. In any event, is it just and equitable in all the circumstances to extend time?

9. Protected disclosures

9.1. Did the claimant make one or more qualifying disclosures as defined in section 43B of the Employment Rights Act 1996? The Tribunal will decide:

9.1.1. What did the claimant say or write? When? To whom? The claimant says he made disclosures on these occasions:

9.1.1.1. [No longer relied upon]

9.1.1.2. On 15 May 2020, the claimant emailed Claudia Harding-Mackean of the Respondent stating that he felt: “concerned, worried and don’t feel its appropriate or safe to continue any longer, with face to face contact with patients”.

9.1.1.3. On 20 May 2020, the claimant emailed Claudia Harding-Mackean again, stating that he was: “worried and concerned of the potential mutual risks and the impact on me and others from any face to face treatments”.

9.1.1.4. On 21 May 2020, the claimant expressed his serious health and safety concerns to Ms Harding-Mackean and Michelle Greene (Divisional Medical Director – Planned Care) about doing face-to-face operations for “Nuffield patients”;

9.1.2. Did he disclose information?

9.1.3. Did he believe the disclosure of information was made in the public interest?

9.1.4. Was that belief reasonable?

9.1.5. Did he believe it tended to show that:

9.1.5.1. [No longer relied upon]

9.1.5.2. the health or safety of any individual had been, was being or was likely to be endangered?

9.1.6. Was that belief reasonable?

9.2. If the claimant made a qualifying disclosure, was it made to the claimant's employer (including, if relevant, a person authorised by his employer under s43C(2))?

If so, it was a protected disclosure.

10. Detriment (Employment Rights Act 1996 section 48)

10.1. What are the facts in relation to the following alleged acts or deliberate failures to act by the respondent?

10.1.1. During May 2020, there was a failure to implement the necessary changes to the claimant's duties and working arrangements, following the outcome of the risk assessment, in a timely manner.

10.1.2. The claimant was unfairly allocated the additional clinics and administrative work of three full-time consultants, with no further remuneration.

10.1.3. Details of the claimant's reallocated duties were communicated to the claimant's colleagues in an undermining manner.

10.1.4. The claimant was excluded from the ACA rota.

10.1.5. The respondent failed to address the claimant's grievance raised on 11 December 2020 in a timely fashion.

10.1.6. On 4 February 2021, the respondent noted "concerns" on the claimant's appraisal form for the first time in 20 years.

10.1.7. Between June and September 2021, the respondent failed to promptly put in place/action a phased return to work plan for the claimant.

10.2. Did the claimant reasonably see that act or deliberate failure to act as subjecting him to a detriment?

10.3. If so, was it done on the ground that he made a protected disclosure?

11. Remedy for Detriment [to be determined at a separate hearing if liability is established]

11.1. What financial losses has the detrimental treatment caused the claimant?

11.2. Has the claimant taken reasonable steps to replace any lost earnings?

11.3. If not, for what period of loss should the claimant be compensated?

11.4. What injury to feelings has the detrimental treatment caused the claimant and how much compensation should be awarded for that?

11.5. Has the detrimental treatment caused the claimant personal injury and how much compensation should be awarded for that?

11.6. Is it just and equitable to award the claimant other compensation?

11.7. Did the ACAS Code of Practice on Disciplinary and Grievance Procedures apply?

11.8. Did the respondent or the claimant unreasonably fail to comply with it?

11.9. If so is it just and equitable to increase or decrease any award payable to the claimant? By what proportion, up to 25%?

11.10. Did the claimant cause or contribute to the detrimental treatment by their own actions and if so would it be just and equitable to reduce the claimant's compensation? By what proportion?

11.11. Was any protected disclosure made in good faith?

11.12. If not, is it just and equitable to reduce the claimant's compensation? By what proportion, up to 25%?

12. Discrimination arising from disability (Equality Act 2010 section 15)

12.1. Did the respondent know or could it reasonably have been expected to know that the claimant had the disability? From what date?

12.2. If so, did the respondent treat the claimant unfavourably in any of the following alleged respects:

12.2.1. During May 2020, there was a failure to implement the necessary changes to the claimant's work, following the outcome of the risk assessment, in a timely manner.

12.2.2. The claimant, who is on a part time contract, was unfairly allocated the additional clinics and administrative work of three full-time consultants, with no further remuneration.

12.2.3. In July 2020, details of the claimant's reallocated duties were communicated to the claimant's colleagues in an undermining manner.

12.2.4. The claimant was excluded from the ACA rota.

12.2.5. The respondent failed to address the claimant's grievance raised on 11 December 2020 in a timely fashion.

12.2.6. On 4 February 2021, the respondent noted "concerns" on the claimant's appraisal form for the first time in 20 years.

12.2.7. Between June and September 2021, the respondent failed to promptly put in place/action a phased return to work plan for the claimant.

12.3. Did the following things arise in consequence of the claimant's disability:

12.3.1. The claimant's absence from the work-place due to having to "shield" and inability to have face-to-face patient contact.

12.4. Has the claimant proven facts from which the Tribunal could conclude that the unfavourable treatment was because of any of those things?

12.5. If so, can the respondent show that there was no unfavourable treatment because of something arising in consequence of disability?

12.6. If not, was the treatment a proportionate means of achieving a legitimate aim? The respondent says that its aims were:

12.6.1. Ensuring the continued provision of healthcare services by the NHS during the COVID-19 pandemic;

12.6.2. Ensuring that the claimant remained in employment, and on full pay, while he was unable to perform his contractual face-to-face duties; and

12.6.3. Ensuring an equitable distribution of work between the consultants in the claimant's department for optimal efficiency of services to patients and with regard to the health and safety of those providing the services.

12.7. The Tribunal will decide in particular:

12.7.1. was the treatment an appropriate and reasonably necessary way to achieve those aims;

12.7.2. could something less discriminatory have been done instead;

12.7.3. how should the needs of the claimant and the respondent be balanced?

13. Reasonable Adjustments (Equality Act 2010 sections 20 & 21)

13.1. Did the respondent know or could it reasonably have been expected to know that the claimant had the disability? From what date?

13.2. A "PCP" is a provision, criterion or practice. Did the respondent have the following PCPs:

13.2.1. The practice of taking a "broad-brush" approach to risk assessments, failing to provide adequate training to staff undertaking the risk assessments and failing to take into account that those with disabilities were more at risk of COVID-19 complications, and therefore should have been prioritised;

13.2.2. The practice of communicating sensitive and important matters informally, including via WhatsApp and group emails;

13.2.3. The criterion of only offering ACAs to individuals that are able to do face-to-face consultations;

13.2.4. The policy of noting matters which have arisen from the Claimant's disability as "concerns" on his appraisal form.

13.3. Did the PCPs put the claimant at a substantial disadvantage compared to someone without the claimant's disability, in that he:

13.3.1. In May 2020, was placed at undue risk because he should have been prioritised during the risk assessment process;
13.3.2. In May 2020, suffered distress and humiliation by his colleagues discussing his job plan via WhatsApp;
13.3.3. was not able to earn additional income by attending ACAs; and
13.3.4. On 4 February 2021, had alleged "concerns" included on his appraisal form.

13.4. Did the respondent know or could it reasonably have been expected to know that the claimant was likely to be placed at the disadvantage?
13.5. Did the respondent fail in its duty to take such steps as it would have been reasonable to have taken to avoid the disadvantage? The claimant says that the following adjustments to the PCP would have been reasonable:
13.5.1. having a more systematic and targeted approach to risk assessments during the pandemic, seeking out those who were at higher risk to ensure that they were prioritised and protected;
13.5.2. avoiding the practice of communicating sensitive information via WhatsApp, instead ensuring appropriate safeguards were in place in line with the Data Protection Act 2018;
13.5.3. including the claimant in the ACA rota and treating him equally to the rest of his colleagues;
13.5.4. adjusting its policy to account for absences from the work-place/inability to do face-to-face consultations caused by the combination of the COVID-19 pandemic and disability to avoid "concerns" being noted on appraisal forms.
13.6. By what date should the respondent reasonably have taken those steps?

14. Victimisation (Equality Act 2010 section 27)

14.1. Did the claimant do a protected act as follows:
14.1.1. The claimant raised a formal grievance on 11 December 2020, alleging unfair treatment as a result of having to shield.
14.2. Did the respondent do the following things:
14.2.1. unfairly allocate, or continue to unfairly allocate to the part-time claimant a significant and overwhelming workload of GP referral triage and administrative work of three full-time consultants with no additional remuneration;
14.2.2. exclude, or continue to exclude, the claimant from the ACA rota;
14.2.3. on 4 February 2021, note "concerns" for the first time in 20 years on the claimant's appraisal form and / or refuse to amend these;
14.2.4. take over 9 months to process the claimant's grievance raised on 11 December 2020;
14.2.5. between June and September 2021 fail to put in place/promptly action a phased return to work following the claimant's return from face-to-face shielding
14.3. By doing so, did it subject the claimant to detriment?
14.4. If so, has the claimant proven facts from which the Tribunal could conclude that it was because the claimant did a protected act or because the respondent believed the claimant had done, or might do, a protected act?
14.5. If so, has the respondent shown that there was no contravention of section 27?