EMPLOYMENT TRIBUNALS (SCOTLAND)
Case No: 4104206/2023

Held in Stornoway on 5, 6, 7 and 8 February 2024
With members' meeting on 1 March 2024

Employment Judge M Robison
Tribunal Member L Brown
Tribunal Member J McCaig

Ms D Mihaylova	**Claimant** **Represented by** **Mr C Adjei** **Barrister**
Western Isles Health Board	**Respondent** **Represented by** **Mr K Gibson** **Advocate**

JUDGMENT OF THE EMPLOYMENT TRIBUNAL

The judgment of the Employment Tribunal is that the claims for disability discrimination and unfair dismissal are not well founded and are dismissed.

REASONS

1. The claimant lodged a claim in the Employment Tribunal for unfair dismissal and disability discrimination on 4 August 2023 following her dismissal. The respondent resists the claims, asserting that the claimant was dismissed for a potentially fair reason namely capability.

2. The claimant is a consultant psychiatrist who was dismissed following the development of a condition and surgery, which subsequently meant that she could not do on-call at night as required by her contract. Although the respondent concedes that the claimant is a disabled person for the purposes of the Equality Act 2010, they did not accept that removing on-call from her duties was a reasonable adjustment and submit that any unfavourable treatment was objectively justifiable.

3. At the outset of the hearing, Mr Adjei advised that there had been a narrowing of the issues for the claimant's part and specifically she relies only on one adjustment which she asserts would have been reasonable. Accordingly the list of issues for determination, which had been agreed by the parties, was adjusted, and the outstanding issues for determination are discussed in the course of this judgment.

4. It had been decided, at a previous preliminary hearing, that witness statements would be utilised. In line with paragraph 19 of the Presidential Guidance on the preparation and use of witness statements, as no reading day had been allocated to read witness statements, the panel read each witness statement before that witness was called.

5. At that preliminary hearing, it had also been decided that the respondent would give evidence first. Accordingly, the Tribunal heard evidence from Mr N Fayers, chief officer of the Integrated Joint Board; Dr F McAulay, medical director; Mr M Hutchison, associate director for mental health services and the claimant's line manager; and Dr M Watts, director of public health, dismissing officer. The Tribunal thereafter heard evidence from the claimant.

6. A joint file of productions was lodged, which was referred to in the witness statements and during oral evidence.

Findings in fact

7. On the basis of the evidence heard and the documents lodged the following relevant facts are admitted or proved.

8. The claimant was employed by the respondent as a consultant psychiatrist from 1 September 2020 until her dismissal, effective 21 July 2023.

9. The claimant was initially employed on a fixed term basis. Her contract was made permanent on 1 August 2021.

Respondent's requirement for consultant psychiatrists

10. The respondent has a clinical and statutory requirement for two full time consultant psychiatrists to provide both inpatient and community

psychiatric care, with the need for one in two weekly on-call to ensure 24/7 consultant psychiatric services. The expectation is that one of these consultants would have a specialism in general adult psychiatry and the other in old age psychiatry. The claimant's specialism is in general adult psychiatry.

11. The role of the consultant psychiatrist for the respondent includes: one in two on-call rota; acting as responsible medical officer (RMO) for inpatients in the acute psychiatric unit (APU) (as required by the Mental Health Act); weekly ward rounds; outpatient clinics - in Stornoway (weekly), Uist (monthly) and Barra (every two months); attending to patients in police custody; reporting to the sheriff; and home visits to patients in crisis on Harris and Lewis.

12. The second full-time permanent consultant psychiatrist had retired in 2018. The respondent had been unable to recruit a full time replacement. Between 2021 and 2023 the vacant post for a consultant psychiatrist was advertised eight times with no applicants. Accordingly, that post was filled from 2018 with locums.

13. Consultant psychiatrists are in short supply in Scotland, there being a 60% vacancy rate at this time. General psychiatry is the specialism with the most vacancies across Scotland. It is therefore difficult to recruit consultant psychiatrists particularly for remote, island-based locations. Part of the difficulty is that the consultant requires to cover a number of disciplines.

14. This means that the board must rely on locums. There are framework agreements with agencies to supply locums at a capped cost, but such are the difficulties of supply, that health boards such as the respondent require to go "off framework" to agencies which are not party to the framework agreement, meaning that the costs are much higher.

15. The respondent has had meetings with the Scottish Government to discuss the recruitment challenges and the impact on services associated with high locum costs. A specialist meeting with the Mental Welfare Commission and the clinical lead for the Scottish Government took place on 13 October 2022 to discuss these particular challenges.

Claimant's health

16. In September 2021, the claimant was diagnosed with myelopathy. She had periods of long-term sickness absence between 7 September 2021 and 3 November 2021; 26 November 2021 and 21 February 2022; and 23 January 2023 and 26 June 2023. During the claimant's absence on sick leave, the respondent engaged an additional locum consultant psychiatrist to cover her duties.

17. On 8 October 2021, the claimant was declared unfit for work by occupational health. Further occupational health assessments took place in October and November 2021.

18. In March 2022, the claimant began a phased return to work following surgery for her condition. That followed a return to work meeting which took place on 21 March 2022, when reliance was placed on an occupational health report dated 10 March 2022. This report stated that the claimant's symptoms could take between 18 and 24 months to reduce. The report confirmed that the claimant was fit to return to work with restrictions. Recommended restrictions were discussed at the meeting, and included a phased return to work, starting with 10 hours the first week, with a blend of homeworking and hospital; and driving restricted to no longer than 30 minutes. The claimant agreed that this was reasonable and would allow her to drive to the hospital, the health centre and surrounding areas. She commented that the community psychiatric nurses (CPN) could give her a lift for longer journeys, as they had done in the past (for other consultants). The claimant was advised that locum cover was organised for the phased return to work period.

19. Given a second locum consultant was engaged to assist the claimant's phased return to work, it was arranged that the claimant would manage a backlog of follow up waiting lists. This created pressures on the one medical secretary who was tasked with arranging three sets of outpatient clinics, booking travel for clinics, managing diaries, taking calls and typing letters for three consultants. Each locum creates additional agency, travel and in some cases accommodation costs.

20. The phased return did not go as planned, due to the claimant being off with covid in May and a family emergency in June.

21. In June 2022, at a further return to work meeting Mr Hutchison stated that given there were two locums covering the service in addition to the claimant, the phased return could not continue indefinitely and that at some point one of the locums would to be released. The claimant's intention to return to full time working was noted. It was agreed that the two locums would be retained to allow a trial of one in two on-call, with the claimant working only office hours until she was able to return to on-call duties.

22. By mid-July 2022 the claimant was working her contracted hours and had begun to trial on-call, with participation in the rota in an arrangement whereby she would be the first on call over the week-end as a test, backed up by one of the locums.

23. On 20 July 2022, a further occupational health report noted that the claimant was "now back to working her contracted hours" and had "commenced a slow build up to her on call duties; with participation in the rota commencing the previous week-end". That report also noted that the claimant had "experienced an exacerbation in her symptoms recently". It was noted that "call outs could pose a future challenge as [the claimant] requires to take medication in the evenings to help manage her symptoms. Unfortunately drowsiness is a side effect and this could be problematic if she needs to drive". It was suggested that it may be possible for her to get a lift/transport if she needed to drive.

24. By the beginning of August 2022, the claimant had returned to full time duties, including on call.

Removal from on-call rota

25. On 19 August 2022, the occupational health nurse recommended that the claimant be removed from the on-call rota. She advised that as a result of the pain relieving medication taken in the evening, the claimant continued to find the on-call aspect of her duties challenging. She recommended she

refrained from participating in the on-call rota for a period of six months, if operationally feasible, to be followed by a further OH review.

26. That same day, 19 August 2022, at a return to work progress meeting, the claimant expressed reservations about her ability to respond to on-call night time calls due to medication making her sedated. She advised that CPNs had been advised to let her phone ring to allow her time to hear and respond. She advised of an informal arrangement with the CPNs that they would give her a lift if a home visit was required.

27. In terms of her recovery, she said that she had been "up and down". The OH adviser who attended the meeting advised that although there were challenges they were "manageable", but that the next step would be to consider a reasonable adjustment to have no on-call. She suggested no overnight duties at this time.

28. The claimant advised that improvements for 18-24 months following surgery could be expected, but after that the position was likely to be permanent. She advised that having conducted tests, she was on the lowest possible dose of medication during the night to have the desired effect. The occupational health nurse advised that the claimant may always have to take the medication.

29. Mr Fayers advised that a reasonable adjustment would be for no on call, subject to review after around six months. He advised he would work up proposals and that they would meet again to discuss those proposals following the claimant's imminent annual leave.

30. On 29 August 2022, the respondent wrote to the claimant in relation to on-call duties, summarising what had been discussed and agreed at the meeting, and advised that it had since been concluded that her on-call allowance could not be maintained for the six month period pending the review.

31. After this meeting the claimant was on annual leave for around two and half weeks. A second locum was again engaged to deliver the on-call one

in two to accommodate the temporary adjustment of removing the claimant from on-call.

Locum cover

32. On 5 September 2022, the respondent wrote to the claimant to advise that the on-call arrangements which had previously been agreed had to be revisited due to cost implications. This followed discussions which Mr Fayers had with the respondent's finance director about fiscal problems in covering the on-call and confirmation that reserves could not be deployed.

33. A meeting was arranged to discuss this development which took place on 16 September 2022, when the respondent met with the claimant to explain that funding was an issue and that long term locum cover was no longer viable. Mr Fayers advised that while at the meeting on 19 August 2022 he "could see a way forward in the short term…that [was] no longer an option", because the cost of engaging a second locum consultant to cover the claimant's on call was a projected deficit of £750,000.

34. He sought an opinion from the claimant's neurosurgeon to determine if the claimant was capable of making informed decisions when called out and fitness to drive during the night. This was to inform a further occupational health report.

35. That report, dated 26 October 2022, confirmed that the claimant should not be carrying out on-call duties; or duties that required the claimant to be on her feet for prolonged periods; and that the claimant should not be driving.

Stage 2 meeting

36. By letter dated 31 October 2022, the claimant was invited to a stage 2 meeting under the respondent's attendance management policy. That policy sets out procedures for dealing with sickness absence. It sets out the formal procedure which involves three stages, which would normally be followed sequentially but there may be circumstances when it is appropriate to enter the process at stage 2 or 3.

37. At stage 1, the manager will meet with the employee to discuss matters including the impact of their attendance on the organisation and service delivery. One or more review meetings may be arranged to discuss progress.

38. At stage 2, reasonable adjustments must be explored which "will normally include: adjustments to the workplace and/or workstation; reduction in working hours; redesign or modification of duties; redeployment in line with local redeployment policies".

39. At stage 3 "before termination of employment is considered all reasonable adjustments and other options should have been explored".

40. The stage 2 meeting with the claimant was arranged to discuss "any previously identified support measures; whether alternative or additional adjustments, including redeployment are appropriate; the advice from occupational health and consideration of the position of your ongoing employment".

41. The claimant was shocked to receive this letter not least because stage 1 of the process had not taken place. Further she was not expecting to be considered under the attendance policy given that she was not absent but working full-time (without on-call) at that time.

42. On 23 November 2022, a stage 2 meeting was held, when it was noted that neither the claimant nor her neurosurgeon knew the likely timescales for improvement. The claimant said that improvement could be two months or two years; and with regard to on-call, not much had changed since the meeting in August. The claimant advised that she was looking to get support from Access to Work to assist with the cost of travel requirements.

43. The claimant was advised at this meeting that as reasonable adjustment the respondent was employing one locum to fill one vacancy and a second to make the on-call arrangements work. She was advised that: the forecasted expenditure for locums was around £750,000, around £325,000 of which was associated with backfilling the on-call requirements; the respondent anticipated a £1.6m deficit, with locum costs

a considerable part of that despite Scottish Government rules which did not permit the respondent to be in deficit; that the Scottish Government and Mental Welfare Commission had confirmed that they were obliged to provide a 24/7 consultant psychiatrists provision; that the adjustment to cover on-call could not continue for financial reasons without a known time frame when she could safely resume on-call; that they would require to consider alternatives and whether redeployment was an option.

44. On 2 December 2022, the respondent advised of the outcome of the stage 2 meeting, stating that the claimant was not currently capable of fulfilling the full range of duties required of the post on health grounds; and they did not know when she would be fit enough to resume the full range of duties, although that was not anticipated to be in the short term. Given that and the financial cost of the associated adjustments which were significant and not sustainable, she was to be referred to a stage 3 hearing. The potential outcomes were stated to be: a further period of review; permanent redeployment; or dismissal on grounds of capability. The claimant was advised of her right to appeal if she was dissatisfied with this outcome.

Redeployment

45. The respondent's redeployment policy sets out "the process of securing suitable alternative employment for an employee who is identified will be displaced, at a stated future date, from their post as a result of organisational change, or following application of formal processes relating to capability (whether due to ill-health or performance or in advance of the non-renewal of a fixed term contract upon expiry. It is however recognised that there may be other circumstances where [the respondent] determines that redeployment may be appropriate". The policy states that "access to redeployment should be limited to three months in the first instance".

46. It also states that under the heading "capability" that "the process to be followed where redeployment process is unsuccessful" is set out in the respondent's capability policies.

47. On 28 November 2022, the claimant completed a re-deployment form. When asked to list the type of posts which might interest her in order of

preference, she wrote only "consultant psychiatrist". The claimant acknowledged that redeployment could be challenging due to her specialism. No redeployment opportunities were identified.

48. On 9 January 2023, claimant went on sick leave due to the stresses of the attendance policy procedure.

Stage 3 meeting

49. On 27 January 2023, a stage 3 meeting took place chaired by Dr M Watts, director of public health. The figure for the cost of the second locum consultant was by that time revised to £366,000 per annum.

50. Dr Watts decided to obtain further reports relating to the claimant's health before making a final decision.

51. In a medical report dated 3 February 2023 from the claimant's neurosurgeon he advised that:

- the claimant was still "experiencing waxing and waning symptoms of her cervical myelopathy"
- the recovery period from surgery for this condition can vary, but "in general a *potential* recovery period of 18 months to 2 years could be expected before neurological recovery reached its endpoint, although most recovery was accomplished within the first six months, and improvement beyond that point is slower and more unpredictable"
- he saw no clear physical reason why she should not be fit for routine clinical work of seeing patients, and general administration work, but that may be more challenging and taxing if her upper limb symptoms were prominent
- The main issue appeared to be difficulty driving at night-time due to drowsiness from Pregabalin use. Although there was no neurological (ie physical) reason to restrict driving, he could not comment objectively on the effect of Pregabalin on alertness, and ability to make clinical decisions, although the drowsiness at night-time reported by the claimant was a recognised side effect
- if that persisted in being a major obstacle to driving/employment,

reducing/stopping the Pregabalin and if necessary replacing with a different drug could be considered.

52. A further occupational health report, dated 14 March 2023, was prepared by a consultant occupational health physician. He had the benefit of the neurosurgeon's report. In response to the question "whether, and when if not now, will [the claimant] be able to do the job of consultant psychiatrist with on call for which she is employed", he answered "it is possible that [the claimant] may eventually return to her role as before though at present it is difficult to predict the time frame for same".

Claimant's dismissal

53. The claimant was dismissed by letter dated 27 March 2023 which stated that in coming to the decision to dismiss, the following was taken into account:

"1. Your attendance record: you have been employed since 1 August 2021 and during this time you have had sickness absence from your post of consultant psychiatrist equating to one hundred and fifty five days absent, albeit not all at once. You currently remain on sickness absence to the present date.

2. The content and outcome of the supportive discussions and formal management of your absence: your manager, Mike Hutchison had remained in regular contact with you throughout this process until he himself went on long term sickness. Nick Fayers, Chief Officer, then took over the management of your sickness absence, as has our occupational health staff. Both Mr Hutchinson and Mr Fayers have been supportive throughout the formal management of your absence; extensive efforts have been made by management to support your return to work during your recovery period with additional consultant staffing brought in on temporary contracts to cover the out of hours commitment, and changes made in day to day duties to reduce the time on your feet.

3. Current occupational health reports including any other health professional's advice: you were assessed by the occupational health physician on 21/10/22 and 02/03/23, the latter appointment having the advantage of a report from Mr Canty, your consultant neurosurgeon. It is noted that the potential period for recovery of 18 months to 2 years in the

processional view of Mr Canty, although he does then note that most recovery is achieved within the first six months and improvement beyond that point is slower and more unpredictable; the occupational health physician reports that there has been no significant change between the two appointments above. The side effects relating to your medication appear to continue to impact on your ability to drive at night. They recognise that you should be able to continue with routine clinical work and administrative tasks unless your upper limb symptoms are prominent. However, the recommendations from occupational health remain that you are fit to work with restricted duties ie no out of hours/on call duties, no driving for work purposes, and no duties requiring you to be on your feet for prolonged periods; as of 14/3/23, the occupational health physician was unable to give a time frame of when you could return to work in line with your contract. This advice remains the same up to present date.

4. What adjustments have been considered and put in place, and if any requested adjustments were not supported, the rationale for this: the occupational health physician recommended a workplace risk assessment, hybrid working, paced working with appropriate breaks and Access to Work to support travel. These measures have been taken forward on a short term basis with the hope that your recovery would continue to progress; based on occupational health recommendations, given the physical demands of the job and your health conditions, there are no further reasonable adjustments which could be made; it is not possible to remove on-call from your role nor is it possible to predict the cases you would be required to be involved in; it is not possible to remove the Out of Hours from your role nor is it possible to remove the driving element from your role.

5. What opportunity has been given to improve: management has allowed sufficient time to maximise your recovery by utilising temporary short term consultant locums to cover on call and travel functions.

6. The likelihood of improvement in the foreseeable future: the latest occupational health advice, following your telephone consultation with Dr D Reetoo on the 14th March 2023, is that you are able to return to restricted duties as outlined above and are not able to return to your contractual duties now or in the foreseeable future.

7. The needs of the service and work difficulties created by the absence: your role of consultant psychiatrist is a demanding role with the main purpose being to provide care to patients in the Western Isles. The psychiatry department is unfortunately not able to sustain this level of ongoing sickness absence. We also need to consider the impact of your absence on your other colleagues carrying out or supporting a similar role and taking on additional cases/work due to your ongoing absence. Absence such as long-term sickness does put additional pressure on the service and impacts on your colleagues. Agency locums are having to be used which does not necessarily provide continuity of service and creates a cost pressure on the mental health budget".

54. The letter continued, "After considering carefully all of the information and evidence that has been presented including the most recent report from occupational health and from Mr Canty, I confirm my view that you will be unable to achieve and maintain the expected standard of attendance in your current or other roles and that all reasonable adjustments including redeployment have been considered and implemented where appropriate. On that basis, I regretfully conclude that termination of your contract on grounds of capability is the only remaining option".

Claimant's appeal

55. The claimant appealed against her dismissal. An appeal hearing was arranged for 12 June 2023 but was then postponed. Attempts were made to rearrange the appeal hearing for 9 August 2023 (but in error an invite was not sent to the claimant) and 21 August 2023.

56. An occupational health report was received from the claimant's occupational health physician, on 17 August 2023, relevant to the appeal. This recorded that the claimant's symptoms, as at 5 July 2023, had not changed since March; that her symptoms continued to wax and wane; that she was still reliant on Pregablin during the night; with no time frame identified for ceasing or recommendation that this be changed; and restrictions advised then were no overnight out of hours on-call duties and no driving for work purposes; although there was no barrier to carrying out

day time clinical duties including during the week-end.

57. The claimant withdrew her appeal on 21 August 2023 prior to the appeal hearing due to the "detrimental impact [the process] had on her physically and mentally", with "stress and anxiety becoming very overwhelming for her" up to the date of the hearing.

Locum costs and the respondent's budget

58. Costs for locums average around £30,000 per fortnight (with an example in April 2023 of £26,892 for one week, which included a bank holiday). The respondent regularly re-tests the market to seek to reduce costs.

59. The total budget for mental health services for 2022/23 was £2,843,881 and from that for psychiatry the budget was £520,986. Actual locum costs for 2022/23 were £1,073,308 for two locums, including the second locum to cover for the claimant, including on-call.

60. The budget for mental health services for 2023/24 is £4,314,314, with a psychiatry budget of £611,775, and a projected locum spend of £1,179,076 for two locum consultant psychiatrists engaged since the claimant's dismissal.

61. Overspend in mental health services has consequences for service provision and the financial impact on other aspects of the service, because it requires efficiency savings elsewhere in the organisation.

62. The requirement to secure locums, and changing locums, creates significant disruption with direct impact on both inpatient and community care, specifically in terms of continuity of care, functioning of local multidisciplinary team arrangements and decision making in relation to complex patient presentation. Lack of consistency, created by the absence of a clinician with established working practices creates concerns for CPNs and in the APU.

Tribunal deliberations and decision

63. The claimant claims unfair dismissal and disability discrimination. We considered first the question of the failure to make reasonable adjustments

because the outcome of that question had an impact on our conclusions in respect of the claim for unfavourable treatment arising from disability and unfair dismissal.

Failure to make reasonable adjustments

64. The claimant argues that there has been a failure to make reasonable adjustments contrary to s.20 and s.21 EqA. Section 20 sets out the employer's positive duty to make reasonable adjustments to address disadvantages suffered by disabled people. The relevant requirement is set out at s.20(3) which states that "the first requirement is a requirement, where a provision, criterion or practice (PCP) [of the employer] puts a disabled person at a substantial disadvantage in relation to a relevant matter in comparison with persons who are not disabled, to take such steps as it is reasonable to have to take to avoid the disadvantage". A failure to comply with the duty amounts to discrimination under s.21(2).

65. The duty will be triggered only where the employer knows or ought to know that any potential applicant is disabled, and where the employer knows or ought to know that they are likely to be placed at a substantial disadvantage by the PCP as well (schedule 8 (work: reasonable adjustments), part 3 (limitation on the duty), paragraph 20 (lack of knowledge of disability), subparagraph (1)(b)).

66. In this case the respondent accepts that it applied a PCP to the claimant, namely requiring consultant psychiatrists to fulfil on-call duties which included night-time on-call duties.

67. The claimant argues that the PCP put the claimant at a substantial disadvantage in comparison to persons who are not disabled, by reference to the fact that her pain relief medication prevented her from being able to fulfil night-time on-call duties, which led to her being dismissed. The respondent accepts that the claimant was put to a substantial disadvantage in terms of a risk of dismissal; and also that it had actual or constructive knowledge of the substantial disadvantage.

68. Mr Gibson explained that the respondent's position is slightly more

nuanced to the extent that the main reason for the claimant not being fit to do on-call was the risk around making proper clinical decisions if woken at night while sedated by the effect of the medication she was taking. To that extent, they accepted that the claimant was at risk of dismissal as a result. This distinction is of course not material, because they accept that the claimant was substantially disadvantaged by the PCP and that they knew that would or could be the case.

69. The issue for determination by the Tribunal then was whether was it reasonable for the respondent to make the adjustments contended for, by making alternative arrangements for the provision of services during night-time on-call duties.

70. While the claimant had initially relied on four reasonable adjustments, by the time of the hearing, she relied on only one. The sole question then in this regard is whether, by failing to employ two locums on a job share basis, the respondent failed to take such steps as were reasonable to avoid the substantial disadvantage (caused by the application of the PCP).

71. Mr Gibson set out the relevant law and legal principles to be taken into account, with which Mr Adjei did not disagree. We therefore accept that the reasonableness of the adjustment is a fact-sensitive question; that the test is objective to be determined by the Tribunal, and this will depend on all the circumstances of the case; that it is thus not a band of reasonable responses type test; but rather the employment tribunal may substitute its own opinion for that of the employer and decide if the employer's resources should be spent in a particular way.

72. Although not an exhaustive list, the factors to be taken into account when determining if an adjustment is reasonable are suggested in EHRC Employment Code of Practice, namely:

a) The extent to which the adjustment would have ameliorated the disadvantage;
b) The extent to which the adjustment was practicable;
c) The financial and other costs of making the adjustment, and the extent to which the step would have disrupted the employer's activities;
d) The financial and other resources available to the employer;

e) That availability of external financial or other assistance; and

f) The nature of the employer's activities and the size of the undertaking.

73. Mr Gibson's position was broadly that the adjustment proposed was neither affordable nor practicable. Mr Adjei's arguments broadly had three elements: first, the respondent did not even try to engage job share locums; second they did not have detailed costs or reasoning in regard to weighing the costs before making the decision to dismiss; and third, there was a lack of evidence about the impact on other services.

74. On the matter of the attempt to get job share locums, there was a dispute about whether the two incumbent locums were asked whether they would be prepared to job-share.

75. When this was suggested by the claimant in the stage 3 meeting, Mr Fayers did not dismiss it out of hand, but said that he would explore the possibility of job share locums. He said that he would ask the two incumbents. He indicated misgivings at the time about them accepting such a significant reduction in earnings, but did not dismiss the suggestion. That was what he said he would do at the stage 3 meeting, and Mr Fayers stated in evidence that he had done so.

76. Mr Adjei invited us not to accept his evidence. He submitted that it was not reflected in the contemporaneous documents and nothing was said about this in the outcome letter. Further, despite it being clear this argument would be relied on by the claimant, nothing was said about this in the witness statements of Mr Fayers or Dr Watts, rather it was covered in oral evidence. No-one else was aware of the locums being spoken to.

77. Although we were invited to find that the two locums were not asked, the claimant did not advance any positive evidence whether they were asked or not. We accepted Mr Fayers evidence that they had subsequently been asked following the stage 3 meeting, not least because this was confirmed by Dr Watts, but also because he said that was what he was going to do. We therefore accepted that the two locums had been asked if they would consider job sharing.

78. Arguably that disputed fact is not material, because, if Mr Fayers had not asked the two incumbent locums directly, we were prepared to accept, on the basis of the evidence that we heard, that they would not have agreed to work on a job share basis. As Mr Adjei himself recognised, it was highly unlikely that incumbent locums would agree to reduce their earnings given they were already being paid for full-time hours plus on call which was the arrangement they signed up for.

79. While we accept that the respondent did not, in terms, advertise for two locums to job share the position, we consider that they should have done. The question then is whether that would have made any difference, that is if they had advertised would they have succeeded in securing two job sharing locum consultants?

80. Mr Adjei's position was that even if we accepted that the two incumbents had been asked, the evidence supported his contention that there was no basic attempt to get two job share locums in place. He submitted that there was no cogent evidence that the respondent tested the market place to determine whether it would be possible to get two job share locums. He submitted that although Mr Fayers said that he had a spreadsheet about market testing his position was contradicted by other witnesses. Dr McAulay said he had never tried to look for two locums to job share and this was also the position of Dr Watts and possibly also Mr Hutchison. The evidence was that Mr Fayers said he was going to look into it and Dr McAulay said you can get a locum to do anything. Dr McAulay asked what they were to advertise for, and Mr Hutchison understood that the locum was needed to cover on call only. At no point did Mr Hutchison say that it was impossible to get locum cover for on call only. The e-mails show that they did not know what it would look like (meaning the on call only locum ad), not that they could not do it.

81. Mr Gibson's position was that would have made no difference because the chances of recruiting two locums on this basis was "vanishingly small".

82. He relied on evidence which we heard evidence that there is a national shortage of consultant psychiatrists with 60% of consultant psychiatrist

vacancies unfilled. This is the highest vacancy rate of the specialities, putting them in a strong bargaining position.

83. With the respondent unable to fill one of the roles on a permanent basis, they had to secure locums through locum agencies, who we heard have a financial incentive to maximise the earnings of the locum; and the locum role attracts those who tend to want to maximise their earnings. They can earn large sums by doing a full-time role within normal hours and being paid for out of hours including night work at significant rates of pay. They earn at a substantial rate for 24 hours a day in one week and for ordinary working hours the next, with Mr Fayers saying they can cost £600,000 as opposed to consultant psychiatrist in a permanent post costing about £200,000 gross (this figure we understood to be based on pay at the top of the scale and employer on-costs). We heard evidence that the respondent is an attractive board for those who seek to maximise their earnings for that reason, and locums can maximise their earning power working full time. Most boards have larger staff and can cover on call through permanent consultant psychiatrists at less cost.

84. The respondent's evidence was that their experience was that locums would not be willing to come to a health board that is so far removed from the wider NHS for less money where they could not make up the short fall with other work when the evidence is that locums were motivated by earning potential. We heard that the respondent had already experienced difficulty recruiting consultant psychiatrists to the full time post, which is explained by a number of reasons in addition to the national shortage, namely: the one week in two commitment; the fact that the post carries too many specialities; and the fact that locums want more money than the respondent is willing to pay. Both Dr Watts and Mr Fayers spoke to staff testing the locum market regularly so as to discern the market position for purposes of checking on costs/value for money, which informed their view on whether job share locums were likely.

85. As further explored in evidence, the job-share position would be unusual to the extent that only the day time hours would be "job-share". The adjustment proposed was that the claimant would work full time hours each

day during the week, and that the two other consultant locums would share the day time hours of the other role, which would be around 20 hours per week. They would then have to cover the remainder of the "on call" elements of the role on a full time basis, each second week. It could be said that that this would make such a role unattractive to most, although perhaps not all.

86. Dr McAulay suggested in evidence that it was "possible" to get a locum to job-share, and indeed we assume that to be correct, if the respondent's budget was unlimited. Notwithstanding, Mr Gibson submitted that the idea that two locums might be persuaded simultaneously to job share in that context is simply not credible.

87. We thus heard evidence to support the proposition that the likelihood is that even if the respondent had advertised for two job share locums, such an advert would not have attracted any candidates and that it was more likely than not that they would not have been able to secure two job sharing locums. However, clearly since there was no evidence that the respondent actually specifically sought two job share locums to cover the post, we could not know that it would be impossible to have secured two locums on a job share basis.

88. Mr Gibson went on to argue that, even if able to get two locums to job share, the evidence is that the likelihood of being able to sustain that cover would be very low indeed. If they got two and one decided to leave for whatever reason the whole arrangement would fail and there would be an impact on the continuity of care. Then the same difficulties in recruitment would attend getting a replacement.

89. Mr Adjei pointed out that Mr Fayers did not say any thing about the arrangement being unstable at the time. Further, he relied on the fact that instability is built into the system anyway, because reliance on locums is inherently unstable.

90. We could not conclusively say that it would have been impossible for the respondent to secure locums on a job share basis since they did not specifically advertise such a post. We did however consider that it was

self-evident that the situation would be more precarious than with full-time locums, because if one job share locum moved on for whatever reason, the respondent would be put back into the position of having to find a job-share partner.

91. On the matter of affordability, the thrust of Mr Adjei's argument was that there had been a failure to weigh up the relative costs of the job share arrangement, and a failure specifically to identify what the costs would be or what savings would require to be made, so the respondent could not know whether it was affordable or not. In particular he argued that Mr Fayers already knew the financial position of the board and the projected locum costs and deficit in August 2022, when he had said that they could get locum cover, and there was no evidence about what happened in early September to cause the need to review the locum costs.

92. In regard to the failure to weigh up the relative costs, Mr Adjei relies on the fact that the respondent's witnesses have not provided figures as to the cost of the job share compared with the cost of two full-time locums, confirmed in cross examination and by the failure of Dr Watts to reference this in the outcome letter. Given the respondent's position that the decision (to dismiss) was informed by the need to reduce costs/deficit, he would have expected that there would be evidence about the relative costs and affordability. Although the respondent's witnesses now say it was not affordable, Mr Fayers did not say it was too expensive in the stage 3 meeting in response to this suggestion from the claimant, and Dr Watts did not say this in the outcome letter, which only makes reference to the costs of agency locums. The figures were not fed into the decision-making process; there was no evidence about the reasoning so that the submission that this adjustment was not reasonable on financial grounds is not supported by the evidence.

93. Further, Mr Adjei argued that while the respondent stated as at September 2022 that the respondent could not continue to put two locums in place to allow the claimant to come off on-call for six months, that is in fact what happened, notwithstanding the driver of a statutory duty in relation to the deficit.

94. To the extent that there was information about costs, Mr Adjie noted that the claimant was told that total locum costs were £750,000 and that the cost of on call which the claimant could not do was £325,000. That figure was increased to £366,000 in the management case at stage 3. In the claimant's schedule of loss, the claimant's salary was stated to be £145,365, and taking off the supplement for on-call of approximately £8,000 that reduces the claimant's salary to £137,000. Using the figure for the costs of covering locum on call of £366,000, Mr Adjie calculated that makes the costs of covering a full-time locum and the claimant's salary approximately £500,000.

95. We accept that there was a lack of clarity about what the costs were, confirmed by discussions during the hearing to try to ascertain the actual costs based on the figures supplied. We did not however accept that there was no evidence to explain the change of position between August and the September meeting. Although we did not hear specific figures, or about any formal decisions of the board, we did hear that Mr Fayers had spoken to the finance director who had expressed concerns about costings, and that was at least the catalyst for the change in position, although in any event we do not consider this to be material.

96. We accept that there was no specific evidence that the likely cost of two full time locums was more than two locums on job share plus the claimant's salary, and further that Mr Gibson conceded that the latter arrangement would be cheaper.

97. While it was not apparent from the evidence that the respondent used precise figures to weigh up the situation, what we do know from the evidence is that the costs of engaging locums was very high. We were shown the example of an invoice for locum costs (which would include agency fees) for just one week which was over £26,000, taking account of a locum working 24/7 and the fee being £135 per hour. We also heard evidence that it was the on-call element of the job sharing proposal that would be by far the most costly, and that was the element of the job sharing arrangement which would actually have to be undertaken full-time. Thus even if it would have been possible to attract locums on a job-share basis,

the savings in cost would relate only to 40 day time hours each week.

98. Further, Mr Fayer's evidence was that with a total budget for mental health services for 2022/23 of £2,843.681 of which the psychiatry budget was £520,986, at least £366,000 must be attributed to the costs of the claimant's adjustment (that figure as it transpired being an underestimate). As Mr Gibson pointed out, even on the lower figure, this was 62% of the psychiatry budget and 11.4% of the total budget for mental health.

99. Using the claimant's proposed figures of £500,000 for the claimant and a locum, which was significantly less than the figures suggested by the respondent, we accept that costs, relative to the budget for mental health services and for psychiatric service was disproportionately high.

100. Further, and of particular significance, the evidence was that there was no indication of when that might change or even if it might change, given the medical evidence about the claimant's likely recovery which might mean she no longer required to take the relevant medication to allow her to undertake on-call. It was apparent that there would be no change in the short or even medium term and indications from the evidence were that it was unlikely to change at all, that is that the claimant had recovered to the extent that was likely. Thus the costs of the adjustment were likely to continue for the foreseeable future.

101. On the matter of the practicality of making the adjustment, Mr Gibson submitted that, given the percentage of the mental health services budget, to maintain the adjustment would inevitably have a detrimental impact on other parts of the service. He relied on the decision of the EAT in *CC Lincolnshire Police v Weaver* UKEAT/0622/07, to argue that the Tribunal must take account of wider implications such as the effect of the proposed adjustment on the organisation or workforce as a whole, so that the cost of the adjustment could involve an assessment of the impact on budgets elsewhere.

102. Mr Adjei suggested that there was little if any evidence about the impact on the other services, and referred to Mr Fayers' evidence about the benefits of having three consultants to cover the role of two consultants

during the day time working hours, which related to addressing backlogs.

103. We did not accept that there was no evidence of any impact on other services. We took account of the fact that the evidence from the witness statements, confirmed during oral evidence, that there would be an impact on other services, such as the impact on the medical secretary, and on other clinical staff, in dealing with three and not two consultants, two of whom were locums. We heard evidence too about inconsistencies in care in the use of locums.

104. We accept as self-evident, that overspend in one department, when the budget was not unlimited, would impact on the rest of the budget and the rest of the service.

105. We conclude therefore that to continue to engage a second locum consultant in addition to the claimant was not a reasonable adjustment, and indeed nor was the proposed adjustment of engaging two locum consultants on a job-share basis a reasonable adjustment for the above reasons.

Discrimination arising from disability

106. Section 15 of the EqA states that a person discriminates against a disabled person if they treat the disabled person unfavourably because of something arising in consequence of that person's disability; unless it can be shown that the treatment was a proportionate means of achieving a legitimate aim. A disabled person will not be treated unfavourably simply because they could have been treated more favourably (*Williams v Swansea University* 2019 IRLR 306). A claimant cannot succeed unless it is shown that the respondent knew or reasonably ought to have known that the claimant was a disabled person.

107. In this case, the respondent accepts that they had actual or constructive knowledge of the claimant's disability at all material times, namely the claimant was disabled by reason of myelopathy (a physical impairment).

108. The respondent also accepts that that dismissal amounts to unfavourable treatment and that unfavourable treatment was partly because of the

something arising in consequence of the claimant's disability, namely the inability to fulfil night-time on-call duties.

109. The respondent submits that "it is oversimplistic to say it was solely because of the something as the respondent's reasons were more complex than that". It is not however necessary that any unfavourable treatment should be solely or even mainly because of the "something", so long as it had at least a significant (that is more than trivial) influence on the unfavourable treatment, so as to amount to an effective reason or cause of it (*Pnaiser v NHS England* 2016 IRLR 170 EAT).

110. Accordingly, the question for consideration was whether dismissal was justified as a proportionate means of achieving the legitimate aims.

111. The respondent relied on the legitimate aims of:
    a) operating within budgets;
    b) allocating resources as appropriate;
    c) effectively running healthcare services;
    d) meeting patient demand and needs; and
    e) complying with requirements on the respondent in terms of service provision.

112. The claimant accepted that the aims relied on were legitimate, so the focus was on the proportionality question.

113. On the proportionality question, Mr Adjei submitted that the Tribunal had heard evidence about operations in regard to budget, but very little evidence about the four other legitimate aims or why it was necessary to dismiss the claimant to achieve those aims. Absent evidence about impact on other services, his relied on evidence that the arrangement with three consultant psychiatrists had positives. He argued that there was no evidence that dismissal was necessary to achieve aims about operational budget, no evidence about the reasoning undertaken to reach that conclusion, and there was no evidence that it was not possible for them to operate within budget. He argued that the negative effect on the claimant was not balanced against achieving the legitimate aims; and there was no attempt to consider whether there were less discriminatory aims. There

was however a less discriminatory position proposed by the claimant which was to engage two job sharing consultants which would be cheaper than two full time consultants and had practical benefit to the claimant. The fact that the respondent had not tried to find job sharing consultants confirms that it was disproportionate to dismiss claimant, so the justification defence was not made out.

114. Mr Gibson argued that while cost is the context of his argument, costs should be weighed in the balance along with other factors. Relying on *Heskett and HM Land Registry v Benson and others* [2012] ICR 627, he submitted that the essential question is whether the employer's aim could fairly be described as no more than a wish to save costs. However, Tribunals cannot ignore the financial constraints under which an employer has to operate, and a need to work within a budget, that is to balance the books or avoid an outcome that is positively unaffordable, are potentially legitimate aims, which is more than just saving costs, and even keeping to a self-imposed budget is a legitimate aim.

115. Reyling on *Birtenshaw v Oldfield* 2019 UKEAT 0288/18, he submitted that the Tribunal should normally accord a substantial degree of respect to the judgment of the decision maker as to what was reasonably necessary to achieve the legitimate aim in question, provided that the decision maker has acted rationally and responsibly.

116. Accepting that the respondent's stated aims were legitimate, we considered whether dismissing the claimant was a proportionate means of achieving those legitimate aims.

117. The arguments which are relevant to the reasonable adjustments question are relevant to this question. Indeed, we accept that had we concluded that the respondent had failed to make an adjustment that was reasonable, it is highly unlikely that we would have concluded that dismissal was proportionate.

118. We heard evidence in this case about the budgets within which the respondent required to operate. We heard evidence that the respondent has a statutory duty to operate without running a deficit. Although we

accept that the respondent did in fact operate with a deficit, we accept too that the respondent was answerable for that to the Scottish Government and Audit Scotland.

119. We heard evidence that the respondent was obliged to provide 24/7 consultant psychiatric cover. The claimant was unable due to her condition to work nights but the respondent had an obligation to ensure consultant psychiatric cover at nights. The adjustment made to accommodate her inability to work nights was to engage a second locum consultant to work alongside the claimant.

120. We heard evidence, discussed above, that the cost of maintaining that adjustment was a significant proportion of the overall budget for mental health services. We have concluded that will inevitably have an impact on the need to provide a range of mental health services to patients.

121. We accept that the costs therefore of not dismissing the claimant were significant and ongoing. While dismissing the claimant was very expensive self-evidently that did not involve the additional ongoing costs associated with employing the claimant. We accepted Mr Gibson's submission that the cost saving of dismissing the claimant was about £200,000 per annum, less the payment for on call duties. We accept that saving would reduce the deficit to a not insignificant extent, and might allow for additional spending elsewhere in context of the respondent operating at an expected deficit, or at least might lessen the need for cuts elsewhere.

122. We accept that this was a disproportionate spend which put pressure on colleagues in the service because decisions would have to be made not to fund parts of the service where they worked, or reduce funding to those services, so as to be able to facilitate the adjustment.

123. We heard evidence that the adjustment placed pressure on other staff, and in particular that while having three consultant psychiatrists meant that the backlog follow up appointments could be addressed, the service was set up to support two, putting pressures on the medical secretary. We heard unchallenged evidence that bringing more patients to the service created more demand on clinical staff administering the care such as CPNs.

124. Further we considered that the length of time over which adjustments would require to be maintained was highly relevant to the proportionality question. The respondent had prior to dismissal implemented adjustments with a view to supporting the claimant to return to the full range of duties. They had ascertained, through various occupational health reports informed by reports from the claimant's own neurosurgeon, when and whether the claimant was likely to be able to return to undertake on-call in particular, Regrettably the indications were, by the time of dismissal, that the claimant had recovered as much as she was likely to, so that the adjustments implemented were likely to be required into the foreseeable future. This we considered to be highly significant in our overall assessment of this case.

125. We accepted that the role of the Tribunal is to balance the needs of the business against the discriminatory effect on the claimant. On the question in particular about whether there was a less discriminatory means of achieving the aims being pursued, the claimant argues that to dismiss was a disproportionate means of achieving these aims because the respondent could have engaged two consultants on a job sharing basis.

126. We have discussed in detail above our conclusions about engaging consultants on a job sharing basis. We heard evidence that this could be precarious and result in inconsistent care. It would use a lot of resource to secure and maintain it. In any event, the adjustment would still involve three consultant psychiatrists and that had impact on support staff etc. Even if it were possible to have engaged job sharing consultants, even if such an arrangement could be maintained in the medium to long term, still we have concluded above that the costs of maintaining such an adjustment on a long term basis were disproportionate and unsustainable.

127. While we accept that the discriminatory impact of the decision on the claimant was serious, that is that she lost her job, given the conclusions above, we accepted that dismissal in the circumstances was proportionate, and that there was no less discriminatory way in which the respondent could have continued the claimant's employment while she was unable to undertake on-call at night.

Unfair dismissal

128. Turning to the unfair dismissal claim, s.98(1) ERA provides that, in determining whether dismissal is fair or unfair, it is for the employer to show the reason for dismissal and, if more than one, the principal one, and that it is a reason falling within s.98(2) or some other substantial reason of a kind such as to justify dismissal.

129. The respondent contends that the reason for the dismissal was capability, which is a reason falling within s.98(2) and a potentially fair reason, and/or some other substantial reason.

130. Mr Adjei accepts that the claimant was dismissed for reasons of capability, which is a potentially fair reason for dismissal. He does not however accept that the respondent has otherwise established that it was for "some of other substantial reason" because no alternative reason has in fact been advanced. It would appear that the respondent did not rely on that alternative reasoning in any event, so nothing turns on that.

131. The next relevant question identified in the list of issues was whether the respondent has reasonable grounds for its belief. Mr Adjei, relying on previous submissions, argued that the respondent did not have reasonable grounds for its belief, given the financial drivers were not evidenced so no reasonable grounds for believing that there was a need to dismiss for capability had been established.

132. We did not accept Mr Adjei's submission, but concluded that the respondent had adduced sufficient evidence to support their position that the reason for dismissal was capability, and given the evidence that the claimant could not work on-call at least at night, that we concluded was sufficient to support their reasonable belief.

133. We noted that the list of issues included the following:

1.2 Did the respondent dismiss the claimant in circumstances in which she could have fulfilled her role but for the Respondent failing to make one or more of the adjustments [contended for]?

1.5 If the Tribunal finds that there was a potentially fair reason, taking into

account the circumstances and the size and administrative resources of the Respondent, did the respondent act reasonably in treating it as sufficient reason for dismissing the claimant in accordance with equity and the substantial merits of the case?

1.6 Was the decision to dismiss the claimant within the bounds of reasonable responses available to the respondent?

134. We took the view that each of these "issues" was an aspect of whether the respondent had acted reasonably in the circumstances, and involved a discussion about whether dismissal was procedurally and/or substantively unfair, and whether dismissal in all the circumstances fell within the range of reasonable responses.

135. On substantive fairness, we considered whether the respondent dismissed the claimant in circumstances in which she could have fulfilled her role but for the respondent failing to make the adjustment contended for. Given that we have decided above that the adjustment contended for could not be said to be reasonable, and that there was no failure on the part of the respondent to make reasonable adjustments, we cannot accept that this decision by the respondent rendered dismissal unfair.

136. On the matter of procedural fairness, the claimant relied on three issues in particular to establish that dismissal was procedurally unfair.

137. The claimant argued that it was unreasonable to start the attendance procedure at stage 2. Mr Adjei accepted that the policy allows for the procedure to start at stage two. His argument apparently related to the genuineness of the reasons given by Mr Fayers. In his e-mail of 9 November 2022, Mr Fayers set out the reason as, "given the meetings currently undertaken with myself and Frank and more recently with Lena and myself alongside the occupational health report colleagues in HR have advised that this would be the most appropriate course of action". However, Mr Adjei argued that the Tribunal should accept Mr Fayers' answer in cross examination, that the reason to move to stage 2 was that following the meetings on 19 August and 16 September the claimant was told that that it was no longer possible to continue the arrangement, which

was following the occupational health report dated 20 July 2022. Mr Adjei took issue with the reference in re-examination to the reason advanced then relating to the various meetings held and reports obtained. He submitted that the meetings could not be categorised as stage 1 meetings because the provisions of the attendance policy had not been covered. He also relied on the fact that the claimant was thereby denied the right to appeal at stage 1. This, he submitted, not only would have given more time for her recovery and delayed dismissal, but would have given more time to look into the question of job share.

138. Mr Gibson noted that the attendance policy allowed for the process to be started after stage one. In particular, the stage two procedure was applied at the end of October 2022, by which time the respondent had followed the attendance policy procedure by obtaining occupational health reports and conducting meetings. It would not have been efficient to simply duplicate what had been done to tick boxes, he argued.

139. We did not agree that the decision to commence the attendance procedure at stage 2 was unreasonable. We did not see that there was any inherent contradiction in the reasons given by Mr Fayers in particular for starting the process at stage 2. This was a recommendation of HR apparently because the information, including various occupational health reports, which would have been gathered through the stage 1 process from October 2021 to October 2022, had already been gathered at various meetings before and after surgery, including at return to work meetings. Even if the respondent did not state in terms at the time that it was considered that the stage one procedures had already been undertaken, it could be assumed that was the rationale for HR advising that it was appropriate to start as stage two.

140. In any event, we accepted the various stages, the meetings and the occupational health reports obtained, were tantamount to the ground which would normally be covered at stage one. We accept that the policies outline in general terms what that stage will cover, and the fact that the claimant could point to aspects of the stage one procedure which had not been directly addressed did not render the decision to start the process at

stage two unreasonable. While we take the point that this did deprive the claimant of an appeal at that stage, we accepted Mr Gibson's submission that the claimant did, at the conclusion of stage 2, have the opportunity to appeal at that point, but that she chose not to.

141. The claimant also argued that the respondent had failed to allow the three month redeployment process to conclude before deciding to progress to stage 3. The claimant's position was that it is stated in the respondent's policies in terms that the process will require to be exhausted before termination is considered and that where a person is displaced the process to be followed where redeployment is unsuccessful is set out in the attendance policy, so redeployment comes first. The policy also confirms that reasonable adjustments must be considered before termination, but here termination was considered when the claimant was invited to the stage 3 meeting. Complying with the policy, would have given the claimant more time to find redeployment opportunities, it was argued.

142. Mr Gibson argued that the redeployment policy is not rigid and simply a policy and not a set of rules. The policy is flexible enough to allow redeployment to be considered and applied in an appropriate way in a particular case. The attendance policy states that "redeployment should only be considered where there is a likelihood of a suitable alternative role". In any event, the claimant would be on the respondent's redeployment register for the three months' notice period if dismissed, and starting the redeployment process before the conclusion of stage 3 was in fact beneficial to the claimant in that she was on the register a good deal longer than she would otherwise have been.

143. We came to the view that there was no breach of procedure here, or at least no unreasonable failure to follow the precise terms of the respondent's policy. Arguably, had the policy been followed to the letter, then a conclusion would have been reached long before that there were no redeployment opportunities. It was highly unlikely that there would be any other roles for the claimant to undertake with this particular respondent, given her specialism. Further, and perhaps more significantly, the process followed in this case allowed the claimant to be on the register

longer than the three month period. By the time of the outcome letter three months had passed since the claimant completed the relevant redeployment forms, and as Mr Gibson pointed out, she had a further three months of notice when she could have been considered for redeployment opportunities before her contract was terminated. It cannot therefore be said to have rendered the process unfair.

144. The claimant also argued that there was a failure on the part of the respondent to respond to the claimant's appeal against dismissal or invite her to attend an appeal hearing in a reasonable time scale.

145. The claimant's argument had two elements. The first relates to the unexplained delay between the claimant appealing on 13 April and the substantive response from the chief executive one month later. It is argued that delay is unexplained so it is unreasonable, given the claimant's appeal was to revisit the question of job share and to convince the respondent that it was viable. The second element is the delay of a further month. Mr Adjei argued that it is not sufficient to say that the outcome would be the same, because if dismissal was unfair the outcome would be different.

146. We did not consider that the time frames for holding the appeal were unreasonable such as to render dismissal unfair. The factual context around the appeal shows that there were contributions at both the claimant's end and the respondent's end to the delay, although we could not say that those delays were out of the ordinary. Given our conclusions above, even if job sharing consultants could have been engaged, we do not consider in any event delays in the process would have made any difference to the outcome. As Mr Gibson remarked, the obtaining of the occupational health report for the appeal confirmed that it was all the more likely that there would be no further progress in the claimant's recovery.

147. We concluded that there was no procedural unfairness in this case. We considered nevertheless whether the respondent acted reasonably in dismissing the claimant in all the circumstances of this case. Considering overall fairness, taking account of equity and the substantial merits of the case, including the size and administrative resources of the employer's

undertaking, we have concluded above that notwithstanding the position of the respondent as a public sector body, given the nature of the claimant's illness and her symptoms, given in particular the prognosis for recovery, and given the costs to the respondent of maintaining reasonable adjustments, whether with two full-time locums or job-sharing locums, that to dismiss the claimant in these circumstances fell within the range of reasonable responses. The claim for unfair dismissal must therefore also be dismissed.

148. The circumstances of this case are extremely unfortunate. The respondent has difficulty recruiting consultant psychiatrists and having recruited the claimant, who clearly enjoyed her job and living on the island, she became ill such that she could not perform all of her duties. It must be a matter of great regret to both parties that the arrangement could not continue. For those reasons, this was a difficult case, but ultimately we accepted that the adjustments made could not continue without an end in sight given the respondent's budgetary responsibilities.

M Robison

Employment Judge

15 March 2024

Date of judgment

Date sent to parties **19 March 2024**