OUTER HOUSE, COURT OF SESSION

[2026] CSOH 112

P1227/25

OPINION OF LADY HOOD

in Petition of

MICHAEL HOWE

Petitioner

for

Judicial Review of Tayside Health Board's Attention Deficit Hyperactivity Disorder Assessment Policy

Petitioner: Dailly, (sol adv); Drummond Miller LLP
Respondent: E Campbell KC, D Clark, advocate; NHS Scotland Central Legal Office

20 November 2026

Introduction

[1] The petitioner is 39 years of age. He suspected that he may have Attention Deficit Hyperactivity Disorder ("ADHD"), and therefore attended his General Practitioner, who concluded that an assessment ought to be carried out. No assessment has yet been carried out, and thus no diagnosis has been made, nor any treatment offered consequent upon any such diagnosis. The respondent is Tayside Health Board (which also operates under the name NHS Tayside), and the petitioner resides within the respondent's geographical area. The petitioner believes that the reason why an assessment has not been carried out, is

because of a policy adopted by the respondent in or around 2021. In the current petition he seeks to challenge that policy on a number of grounds.

[2] At the substantive hearing, both parties adopted their note of argument, as well as making oral submissions. Parties were agreed that, were I to find in favour of the petitioner on the merits, the appropriate remedies might most usefully be discussed at a By Order hearing.

[3] A preliminary issue arises on the pleadings. The petitioner asserts that the date on which the grounds giving rise to this petition first arose was 26 August 2025, that being the date when the respondent was said to have determined a complaint by the petitioner against the respondent's policy, and to have failed to provide a time-frame for an ADHD assessment. I prefer the respondent's analysis that the petitioner's challenge here is to the purported policy itself, and not to any particular decision taken thereunder. Since the petitioner contended that this policy was introduced in 2021, this means that the proceedings have not been brought timeously. However, the respondent did not resist the petitioner's fallback argument that the court should exercise its equitable discretion under section 27A(1)(b) of the Court of Session Act 1988 to permit the proceedings to be brought within a longer time-frame. I am content that this is appropriate in all the circumstances of the case, and will proceed to consider the merits of the petition.

Factual circumstances

[4] The relevant details of the respondent's organisational framework are vouched by the affidavit evidence lodged, and are not seriously challenged by the petitioner. I therefore accept that NHS Boards and local authorities are required to integrate the planning and delivery of certain adult health and social care services. Perth and Kinross Health and Social

Care Partnership (PKHSCP) is one of three Health and Social Care Partnerships in which the respondent is involved. Within that body, Perth city is one of three Community Mental Health Teams (CMHTs), and is the one in whose geographical area the petitioner currently resides.

[5] With regard to the petitioner's particular circumstances, there was no dispute between parties that the petitioner had attended his GP, that his GP had made a referral for an ADHD assessment, and that no such assessment had yet been carried out. I accept the petitioner's affidavit evidence that a referral for an ADHD assessment was originally made by a GP in 2019 when he was living in England, and that in 2023 a fresh referral was made by his new GP after the petitioner moved into the respondent's geographical area. Both the petitioner and his wife also provided evidence in their affidavits as to the symptoms which the petitioner experiences, which had led him to suspect that he may have ADHD, and to seek assessment.

[6] Parties differed sharply, however, on two matters. Firstly, as to the nature of the respondent's approach or policy to referrals for ADHD assessment in the absence of a co-occurring mental health condition, and whether or not that arose from an alteration in 2021 (as the petitioner averred). Secondly, as to the approach or policy of other Health Boards in Scotland to such referrals. I will therefore discuss these two disputed issues in more detail when setting out my decision, and the underlying reasoning.

[7] The respondent also provided affidavit evidence as to potential future changes to service provision in its geographical area, which the petitioner again did not seriously challenge. I therefore accept that: (i) a previous clinical lead for Mental Health and Learning Disabilities within Dundee HSCP produced a report in February 2026, which was the culmination of previous work and made recommendations as to delivery of services to

neurodivergent adults; (ii) separately, at NHS Tayside level, there is currently a review of Mental Health and Learning Disabilities services, with work on strategy and implementation; and (iii) the Scottish Government have been working on a redraft of the Mental Health and Learning Disabilities delivery plan, which may be complete by autumn 2026.

Remedies sought

[8] In these proceedings, the petitioner seeks the following remedies:

- declarator that the respondent's ADHD Assessment Policy (which the petitioner said should be characterised as a "Provision, Criterion or Practice" or "PCP") was *ultra vires* of the National Health Service (Scotland) Act 1978 and the Patient Rights (Scotland) Act 2011 *et separatim* was irrational and unreasonable;
- declarator that the respondent's PCP discriminated against the petitioner by treating him unfavourably by reason of his disability and symptoms of ADHD, contrary to sections 15 and 29 of the Equality Act 2010;
- declarator that the respondent's PCP discriminated against the petitioner, and other adults with perceived ADHD symptoms, in comparison to non-disabled persons requiring medical health assessments from the respondent, contrary to sections 13, 19, 23 and 29 of the 2010 Act;
- declarator that the respondent ought to have made reasonable adjustments to its PCP to ensure that adults with a disability or perceived disability because of ADHD were able to access medical health assessments and treatment for ADHD in terms of section 20 and 29(7) of the 2010 Act;

- declarator that the respondent failed to properly exercise its duties to undertake an adequate equality impact assessment in terms of section 149 of the 2010 Act and the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 before implementing its PCP *et separatim* failed to properly consult service users about its PCP at common law;
- reduction of the respondent's PCP insofar as it operates to exclude adults with ADHD only symptoms, such as the petitioner, from accessing medical assessments for ADHD;
- the expenses of the petition; and
- such other orders as may seem to the court to be just and reasonable in all the circumstances of the case.

By the time of the oral hearing, the petitioner no longer sought an order for specific performance of the duty to undertake an equality impact assessment, which had originally been sought within the petition.

The legislative provisions

[9] Sections 2C and 121A of the National Health Service (Scotland) Act 1978 provide as follows (in so far as relevant):

> "**2C Functions of Health Boards: primary medical services**
>
> (1) Every Health Board-
> (a) must, to the extent that they consider necessary to meet all reasonable requirements, provide or secure the provision of primary medical services as respects their area; and
> (b) may, to such extent, provide or secure the provision of primary medical services as respects the area of another Health Board,
> and primary medical services provided, or the provision of which is secured, by a Health Board under or by virtue of this subsection may be performed outside their area.

(2) For the purpose of securing the provision of primary medical services under subsection (1), a Health Board may make such arrangements for the provision of the services as they think fit [...]

[…]

12IA Duty to ensure appropriate staffing

(1) It is the duty of every Health Board and the Agency to ensure that at all times suitably qualified and competent individuals, from such a range of professional disciplines as necessary, are working in such numbers as are appropriate for—
(a) the health, wellbeing and safety of patients,
(b) the provision of safe and high-quality health care, and
(c) in so far as it affects either of those matters, the wellbeing of staff.

(2) In determining what, in a particular kind of health care provision, constitutes appropriate numbers for the purposes of subsection (1), regard is to be had to—
(a) the nature of the particular kind of health care provision,
(b) the local context in which it is being provided,
(c) the number of patients being provided it,
(d) the needs of patients being provided it, and
(e) appropriate clinical advice."

[10] Sections 3, 4, 5 and 20, and the Schedule, of the Patient Rights (Scotland) Act 2011 are (in so far as relevant) to the following effect:

"**3 Patient rights**

(1) It is the right of every patient that the health care received by the patient be as described in subsection (2).

(2) Health care is to—
(a) be patient focused: that is to say, anything done in relation to the patient must take into account the patient's needs,
(b) have regard to the importance of providing the optimum benefit to the patient's health and wellbeing,

[…]

4 Patient rights: further provision

(1) In construing the right of a patient under section 3(1), the matters set out in subsection (2) below must be taken into account.

(2) The matters are—
(a) the rights of other patients under section 3(1),
(b) the desirability of action delivering health care being proportionate, and otherwise appropriate, to the circumstances of each case,
(c) those specified in section 20(1)(a) and (b).

5 Duty to uphold the health care principles

(1) For the purposes of the rights conferred by section 3, each relevant NHS body must—
(a) in performing its health service functions, uphold the health care principles in so far as they are relevant to the function being performed.

[…]

20 Protections and limitations

(1) Nothing in this Act prejudices—
(a) the exercise of clinical judgement,
(b) the effective and efficient use of the health service organisation and resources.

(2) Subject to subsection (3), nothing in this Act prejudices any other enactment or rule of law.

(3) Nothing in this Act gives rise to—
(a) any liability to pay damages,
(b) any right of action for specific implement,
(c) any right of action for specific performance of a statutory duty,
(d) any right of action for interdict,
(e) any right of action for suspension.

(4) The rights conferred on a patient by this Act are in addition to, and do not affect, any other rights in relation to health care that a patient has, or may acquire, under any other enactment or rule of law.

(5) Subsection (4) does not affect the generality of subsection (2).

[…]

Schedule: Health care principles to be upheld by relevant NHS bodies and relevant service providers

[…]

paragraph 5

Support necessary to receive or access health care is available".

[11] Sections 6, 13, 15, 19, 19A, 20, 21, 23, 29 and 149 of the Equality Act 2010 provide as follows (in so far as relevant):

"**6 Disability**

(1) A person (P) has a disability if—
(a) P has a physical or mental impairment, and
(b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.

(2) A reference to a disabled person is a reference to a person who has a disability.

(3) In relation to the protected characteristic of disability—
(a) a reference to a person who has a particular protected characteristic is a reference to a person who has a particular disability;
(b) a reference to persons who share a protected characteristic is a reference to persons who have the same disability.

(4) This Act (except Part 12 and section 190) applies in relation to a person who has had a disability as it applies in relation to a person who has the disability; accordingly (except in that Part and that section)—
(a) a reference (however expressed) to a person who has a disability includes a reference to a person who has had the disability, and
(b) a reference (however expressed) to a person who does not have a disability includes a reference to a person who has not had the disability.

(5) A Minister of the Crown may issue guidance about matters to be taken into account in deciding any question for the purposes of subsection (1).

(6) Schedule 1 (disability: supplementary provision) has effect.

[…]

13 Direct discrimination

(1) A person (A) discriminates against another (B) if, because of a protected characteristic, A treats B less favourably than A treats or would treat others.

(2) If the protected characteristic is age, A does not discriminate against B if A can show A's treatment of B to be a proportionate means of achieving a legitimate aim.

(3) If the protected characteristic is disability, and B is not a disabled person, A does not discriminate against B only because A treats or would treat disabled persons more favourably than A treats B.

[...]

15 Discrimination arising from disability

(1) A person (A) discriminates against a disabled person (B) if—
(a) A treats B unfavourably because of something arising in consequence of B's disability, and
(b) A cannot show that the treatment is a proportionate means of achieving a legitimate aim.

(2) Subsection (1) does not apply if A shows that A did not know, and could not reasonably have been expected to know, that B had the disability.

[…]

19 Indirect discrimination

(1) A person (A) discriminates against another (B) if A applies to B a provision, criterion or practice which is discriminatory in relation to a relevant protected characteristic of B's.

(2) For the purposes of subsection (1), a provision, criterion or practice is discriminatory in relation to a relevant protected characteristic of B's if—
(a) A applies, or would apply, it to persons with whom B does not share the characteristic,
(b) it puts, or would put, persons with whom B shares the characteristic at a particular disadvantage when compared with persons with whom B does not share it,
(c) it puts, or would put, B at that disadvantage, and
(d) A cannot show it to be a proportionate means of achieving a legitimate aim.

(3) The relevant protected characteristics are—
age;
disability;
gender reassignment;
marriage and civil partnership;
race;
religion or belief;
sex;
sexual orientation.

19A Indirect discrimination: same disadvantage

(1) A person (A) discriminates against another (B) if—
(a) A applies to B a provision, criterion or practice,
(b) A also applies, or would apply, the provision, criterion or practice to—
(i) persons who share a relevant protected characteristic, and
(ii) persons who do not share that relevant protected characteristic,
(c) B does not share that relevant protected characteristic,
(d) the provision, criterion or practice puts, or would put, persons with the relevant protected characteristic at a particular disadvantage when compared with persons who do not share the relevant protected characteristic,
(e) the provision, criterion or practice puts, or would put, B at substantively the same disadvantage as persons who do share the relevant protected characteristic, and
(f) A cannot show that the provision, criterion or practice is a proportionate means of achieving a legitimate aim.

(2) The relevant protected characteristics for the purposes of this section are—
age;
disability;
gender reassignment;
marriage and civil partnership;
race;
religion or belief;
sex;
sexual orientation.

20 Duty to make adjustments

(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.

[…]

(6) Where the first or third requirement relates to the provision of information, the steps which it is reasonable for A to have to take include steps for ensuring that in the circumstances concerned the information is provided in an accessible format.

(7) A person (A) who is subject to a duty to make reasonable adjustments is not (subject to express provision to the contrary) entitled to require a disabled person, in relation to whom A is required to comply with the duty, to pay to any extent A's costs of complying with the duty.

(8) A reference in section 21 or 22 or an applicable Schedule to the first, second or third requirement is to be construed in accordance with this section.

[…]

21 Failure to comply with duty

(1) A failure to comply with the first, second or third requirement is a failure to comply with a duty to make reasonable adjustments.

(2) A discriminates against a disabled person if A fails to comply with that duty in relation to that person.

(3) A provision of an applicable Schedule which imposes a duty to comply with the first, second or third requirement applies only for the purpose of establishing whether A has contravened this Act by virtue of subsection (2); a failure to comply is, accordingly, not actionable by virtue of another provision of this Act or otherwise.

[…]

23 Comparison by reference to circumstances

(1) On a comparison of cases for the purposes of section 13, 14, 19 or 19A there must be no material difference between the circumstances relating to each case.

(2) The circumstances relating to a case include a person's abilities if—
(a) on a comparison for the purposes of section 13, the protected characteristic is disability;

[…]

29 Provision of services, etc.

(1) A person (a 'service-provider') concerned with the provision of a service to the public or a section of the public (for payment or not) must not discriminate against a person requiring the service by not providing the person with the service.

(2) A service-provider (A) must not, in providing the service, discriminate against a person (B)—
  (a) as to the terms on which A provides the service to B;
  (b) by terminating the provision of the service to B;
  (c) by subjecting B to any other detriment.

[…]

(6) A person must not, in the exercise of a public function that is not the provision of a service to the public or a section of the public, do anything that constitutes discrimination, harassment or victimisation.

(7) A duty to make reasonable adjustments applies to—
  (a) a service-provider (and see also section 55(7));
  (b) a person who exercises a public function that is not the provision of a service to the public or a section of the public.

[…]

149 Public sector equality duty

(1) A public authority must, in the exercise of its functions, have due regard to the need to—
  (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
  (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
  (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

(2) A person who is not a public authority but who exercises public functions must, in the exercise of those functions, have due regard to the matters mentioned in subsection (1).

(3) Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to—
  (a) remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
  (b) take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;
  (c) encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

(4) The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons' disabilities.

(5) Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to—
(a) tackle prejudice, and
(b) promote understanding.

(6) Compliance with the duties in this section may involve treating some persons more favourably than others; but that is not to be taken as permitting conduct that would otherwise be prohibited by or under this Act.

(7) The relevant protected characteristics are—
age;
disability;
gender reassignment;
pregnancy and maternity;
race;
religion or belief;
sex;
sexual orientation.

(8) A reference to conduct that is prohibited by or under this Act includes a reference to—
(a) a breach of an equality clause or rule;
(b) a breach of a non-discrimination rule.

(9) Schedule 18 (exceptions) has effect."

[12] Regulation 5 of the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 is to the following effect:

"**5. Duty to assess and review policies and practices**

(1) A listed authority must, where and to the extent necessary to fulfil the equality duty, assess the impact of applying a proposed new or revised policy or practice against the needs mentioned in section 149(1) of the Act.

(2) In making the assessment, a listed authority must consider relevant evidence relating to persons who share a relevant protected characteristic (including any received from those persons).

(3) A listed authority must, in developing a policy or practice, take account of the results of any assessment made by it under paragraph (1) in respect of that policy or practice.

(4) A listed authority must publish, within a reasonable period, the results of any assessment made by it under paragraph (1) in respect of a policy or practice that it decides to apply.

(5) A listed authority must make such arrangements as it considers appropriate to review and, where necessary, revise any policy or practice that it applies in the exercise of its functions to ensure that, in exercising those functions, it complies with the equality duty.

(6) For the purposes of this regulation, any consideration by a listed authority as to whether or not it is necessary to assess the impact of applying a proposed new or revised policy or practice under paragraph (1) is not to be treated as an assessment of its impact."

Decision

The first disputed issue of fact: whether the respondent had a policy in the terms which the petitioner contends

[13] Parties were in dispute over the respondent's approach or policy in respect of referrals for assessment (such as that made by the petitioner's GP) of patients with suspected ADHD, who did not have a co-occurring mental health condition.

The petitioner's position

[14] It was the petitioner's contention that in or around 2021 the respondent had adopted a new policy for those with suspected ADHD who did not have a co-occurring mental health condition. That policy was said to be that such patients were placed on a static or moribund waiting list which was maintained in paper form, outwith the digital system: those on this waiting list were essentially then forgotten about, with no assessment or treatment being offered to them. Indeed, it was said, the creation of this paper waiting list

and the placing of the petitioner (and others) upon it, prevented them from being assessed: the petitioner was thus being denied health services. In asserting that this was the factual position, the petitioner relied upon his own affidavit, together with the respondent's reply of 4 September 2025 to a Freedom of Information (FOI) request, and the replies to correspondence sent by the petitioner's local MSPs raising concerns on the petitioner's behalf. The respondent's reply to the FOI request *inter alia* stated: that 610 individuals were awaiting an ADHD assessment across Perth and Kinross; that while assessments had been undertaken in respect of individuals referred into the service with a co-occurring presentation, over the past 3 calendar years there had been no assessments carried out for those patients complaining solely of ADHD; and that a considerable increase in referrals for ADHD (visible both locally and nationally) had prompted a significant service redesign. The petitioner contended that material subsequently lodged by the respondent in these proceedings showed only a *de minimis* number of assessments having taken place in Perth and Kinross of those presenting with suspected ADHD but no co-occurring mental health condition.

The respondent's position

[15] The respondent disputed the petitioner's characterisation of the factual situation, relying primarily upon a detailed affidavit from Chris Lamont, senior service manager for mental health services in Perth and Kinross, but also on supporting documentation. The respondent asserted that the true position was as follows. CMHTs were neither designed nor originally commissioned to deal with neurodevelopmental conditions, such as ADHD: rather, CMHTs were primarily intended to serve persons with severe and enduring mental health conditions. However, the respondent's practice was that when a GP referred a

patient (who did not have a co-occurring mental health condition) for an ADHD assessment, that referral would be accepted by the CMHT for that geographical area, even although strictly speaking the criteria for acceptance were not met. Such referrals would be classified by the CMHT as routine, with the patient being placed on a waiting list: but there were two more urgent classification levels which would require that a patient be seen within a short time-frame, and in practice these consumed most of the CMHT capacity. Usually, when a patient with a mental health condition is referred, but does not meet the criteria, the referral would be declined altogether: that was not done when an ADHD assessment was being sought in the absence of a co-occurring mental health condition. Accordingly, the respondent's policy was one of clinical and resource-based prioritisation. This was not a new policy, nor one which has been altered. What had altered, is that between 2019 and 2021 there had been a substantial nationwide increase in referrals for neurodevelopmental conditions (including ADHD), which was both unprecedented and unpredicted. A paper issued in January 2025 by the Royal College of Psychiatrists in Scotland indicated that services had been designed to treat complex mental health conditions such as those affecting up to three in every one hundred people, but that around one in every ten people may be affected by a neurodevelopmental condition: indeed, a further 2025 paper from the policy lead and vice chair of the Royal College, and a Scottish Parliament Information Centre ("SPICe") briefing paper in the same year, suggested that the proportion of the Scottish population affected by neurodevelopmental conditions may be even higher. Evidence to the Scottish Parliament's Equalities, Human Rights and Civil Justice Committee from the Royal College of Psychiatrists had confirmed that an unprecedented increase in demand was being experienced by all economically developed countries, and that no country had yet found a way to respond to the new levels of need.

Each of the three CMHTs in PKHSCP has a community consultant psychiatrist, but they are expected to concentrate on the most acute and unwell patients. There is a national shortage of consultant psychiatrists. It must also be understood that traditionally ADHD assessments have primarily been carried out by consultant psychiatrists, although other disciplines may also be involved: the assessment typically occurs across several sessions, taking around 4 hours in total. This can be compared to an assessment for a non-neurodevelopmental condition routine referral, which normally takes less than 30 minutes and which often does not require the involvement of a consultant psychiatrist. Until 2019, because the number of referrals for neurodevelopmental condition assessments were small, these could be absorbed into a consultant's clinical case load, or be managed in primary care. This was especially so, because usually the patients involved did have a co-occurring mental health condition. However, the recent increase in referrals for suspected neurodevelopmental conditions had essentially overwhelmed the existing processes. In 2021, PKHSCP had employed Advanced Nurse Practitioners (ANPs), and some patients with suspected neurodevelopmental conditions but no co-occurring mental health condition were seen by an ANP. However, there are difficulties in recruiting such staff, and they also have to provide care and treatment to patients with significant mental health issues. A pilot project had also been run in the north Perthshire locality of a new pathway for provision of services to those referred for a neurodevelopmental condition assessment (who did not have a co-occurring mental health condition): funding had been requested to implement that, but this was on hold because of the more wide-ranging strategy work being undertaken at NHS Tayside level. Existing staff have been trained to provide support to those with neurodevelopmental conditions on the CMHT caseloads. An e-pathway is also being set up to provide

information to patients prior to any formal referral by a GP, including information around self-management.

[16] With regard to the specific suggestion by the petitioner that there was a separate, paper-based, waiting list, the respondent again relied primarily upon the affidavit evidence of Chris Lamont. This was to the effect that from around 2021, a separate waiting list has been maintained for referrals for ADHD assessments, but these referrals are all accepted and classified as routine (as described above). Maintaining this waiting list allows the situation to be monitored by each CMHT, and care offered when there is capacity to do so. Each of the three CMHTs was attempting (whether by way of a paper list or an Excel spreadsheet) to monitor the number of patients affected, since it was not possible to extract the information from the current digital system. Difficulties in extracting data from the clinical system had led to an inaccuracy in the respondent's reply to the FOI response, in so far as it stated that over the previous 3 years no assessments had been carried out of patients with suspected ADHD but no co-occurring mental health condition. A time-consuming manual search had now been carried out, which had revealed that assessments had been carried out for a small number of such patients, although it remained difficult to place a precise number on this. The FOI response had not, however, said that a decision had been taken not to offer ADHD assessments to persons without a co-occurring mental health condition.

[17] Affidavit evidence from Donna Mitchell, chief finance officer for Perth and Kinross HSCP and the Perth and Kinross integrated joint board, was also provided, detailing the financial position of the Perth and Kinross CMHT. In short, without additional external funding being provided, any new investment in respect of ADHD assessments would require the diversion of resources from other services. It was the evidence of Chris Lamont that the redirection of resources which would be needed to more aggressively address the

waiting list for neurodevelopmental condition assessments would impact upon the provision of services to patients with severe mental health issues, such as individuals expressing suicidality, those with acute psychosis, and individuals undertaking risk-taking behaviours and potentially posing a risk to the general public. Accordingly, the risk associated with taking such a decision had been assessed to be too great. Since other HSCPs and Health Boards were facing the same pressures as the respondent and the HSCPs in which the respondent is involved, it was impractical to attempt to deal with the issue through a shared service arrangement.

Decision on the first disputed issue of fact

[18] In this factual dispute between parties, I prefer the evidence of the respondent. It is perhaps understandable that an individual in the petitioner's position may have perceived that the position was simply that, as a matter of policy, no assessment was to be offered to him: he did not have access to the more detailed information as to the respondent's approach, and the broader context in which they were operating. The petitioner's attempts to gain a greater understanding through his elected representatives and FOI requests unfortunately did not entirely succeed in so doing. However, in the current proceedings I have had the advantage of affidavit evidence from key professional personnel within the respondent's organisation who have detailed knowledge of the broader context, the current approach in the respondent's area, and relevant future plans. This was also supported by documentation discussing the national (and, to some extent, international) picture. Taken together, this evidence painted a much more nuanced picture of a complex situation. I accept the evidence of the respondent's witnesses as both credible and reliable, and the petitioner has not been able to present contrary factual evidence which undermines that.

I therefore accept that the key aspects of the factual position in this regard may be summarised as follows. Before 2021, when a GP made a referral for an ADHD assessment (where there was no co-occurring mental health condition), the respondent's approach was that such referrals were accepted by the CMHT, and classified as routine in terms of the prioritisation system. That approach continued and did not change in 2021, and no new policy to different effect was adopted by the respondent at that time. However, from around 2019 or 2020, the broader context changed, because there was a significant increase in the numbers of such referrals, both nationally and in the respondent's locality. This meant that whereas previously such referrals could be absorbed within the caseload of the relevant clinicians, this was no longer the case. Because referrals to the CMHT which are classified as a higher priority consume most of the capacity, this means that unfortunately patients in the position of the petitioner may not be seen for an assessment, or at least may wait a long time for this. Whilst the respondent placed patients in the petitioner's position on a dedicated waiting list from around 2021, I am satisfied that this did not reflect any substantive change in the respondent's underlying policy or approach: it was simply an administrative action which allowed better monitoring of the position, and makes it easier for assessment and care to be offered when there is capacity. A number of steps are being taken at various levels to find a new approach to the provision of services to those seeking an ADHD assessment which will be more appropriately responsive to the recent widespread increase in demand for ADHD assessments.

The second disputed issue of fact: whether the respondent's approach differs from that of other Health Boards?

[19] The petitioner contended that most other Scottish Health Boards had less restrictive thresholds for accessing an ADHD assessment than the respondent. In support of this, the petitioner relied upon the summaries of the assessment criteria for the fourteen different Health Boards, as recorded in the responses to the Scottish Government's 2025 baseline survey. Whereas Perth and Kinross recorded a threshold of "complex and severe mental ill-health", it was said that eleven of the fourteen Health Boards required only a GP referral, mental health diagnosis, or mental ill-health and functional impairment. Indeed, GP referral and self-referral were recorded to be the threshold for another area within the respondent's Health Board area.

[20] The respondent's counsel noted that the responses to the baseline survey were no longer up-to-date, and had not been intended to offer the level of detail which would be appropriate for court proceedings. In any event, it was submitted that careful consideration of some of these responses did not support the conclusion that most other Health Boards had a less restrictive approach than the respondent. Counsel for the respondent also drew attention to other sources in order to undermine the petitioner's contention, namely: (i) the information in the 2025 SPICe briefing paper, which suggested that there were lengthy waiting lists in other Health Board areas for neurodevelopmental assessments;
(ii) a January 2026 report by the Scottish Parliament's Health, Social Care and Sport Committee, which recorded evidence of patients on a waiting list for a neurodevelopmental condition assessment for years and of waiting lists having been closed in many areas, and also evidence of thresholds set in some areas before an assessment could be carried out; and
(iii) a March 2026 report on neurodivergence by the Scottish Parliament's Equalities, Human

Rights and Civil Justice Committee, which recorded patients experiencing lengthy waiting lists, and suggesting that in two Health Board areas diagnostic assessments for adult services had ceased.

[21] Having considered the evidence relied on by parties, I do not find it established that the respondent is an outlier in its current approach to referrals for an ADHD assessment where the patient does not have a co-occurring mental health condition. It was clear that the baseline survey carried out by the Scottish Government, by attempting to understand the current service levels in different Health Board areas, was itself part of a response to the increase in persons seeking assessment for neurodevelopmental conditions. The summary of the questionnaire responses presented in tabulated form did not have the level of detail which is now available to the court with regard to the respondent's approach, making a fair and accurate comparison difficult. However, even considering this table (especially as clarified by the underlying questionnaire responses in their slightly longer form), the picture which emerged was of Health Boards attempting to prioritise service provision against a backdrop of limited resources and capacity. A number of Health Boards seemed to take a broadly similar approach to the respondent.

The petitioner's legal grounds of challenge

[22] The petitioner's legal grounds of challenge were predicated on the respondent's policy being, as a matter of fact, as he described it. For the reasons already given, I do not accept that it was. Given my conclusions on the disputed factual issues, the petitioner's legal grounds of challenge may therefore be dealt with more briefly.

Whether the respondent's policy was ultra vires in terms of the 1978 Act and the 2011 Act

[23] It was accepted on behalf of the petitioner that the duties set out in sections 2C and 121A of the 1978 Act, and in sections 3 and 5 of the 2011 Act, are broad in their terms, and afforded the respondent considerable discretion in discharging these statutory duties.

[24] Section 2C of the 1978 Act requires the respondent to provide or secure the provision of primary medical services "to the extent that they consider necessary to meet all reasonable requirements". Section 121A of the 1978 Act places upon Health Boards a duty to ensure appropriate staffing. In interpreting a provision worded in similar terms to section 2C of the 1978 Act, the Court of Appeal of England and Wales accepted that the body subject to such a duty has scope to exercise judgment, and in doing so is entitled to take into account the resources available and the demands thereon: in short, it is not an absolute duty (*R* v *North and East Devon Health Authority, ex parte Coughlan* [1999] Lloyds Rep Med 306 per Lord Woolf MR, at 314). The general point that broadly-worded target duties enshrined in legislation give the public authority subject to them a discretion to prioritise the various demands upon it, having regard to considerations of finite resources and availability of staff, has also been emphasised in cases such as *R (on the application of G)* v *Barnet London Borough Council* [2003] UKHL 57; [2004] 2 AC 208, per Lord Nicholls of Birkenhead at 218-219, and per Lord Hope of Craighead at 235. Indicators that a statutory provision was intended to be a target duty have been said to be that the public authority has a wide discretion as to fulfilment of the duty, that the duty is intended to benefit the community, and that the public body may be unable to fulfil it for reasons outwith its control or in circumstances which it could not anticipate (see *R (on the application of AA)* v *National Health Service Commissioning Board* [2023] EWCA Civ 902; [2023] PTSR 2001, per Popplewell LJ at 2017-2019). As Baroness Hale of Richmond has observed, a distinction must be drawn

between a duty to provide services to a particular individual, and a general duty owed to the population as a whole: target duties such as the latter do not (for example) "give any particular child a right to be provided with a particular service" (*R (Ahmad)* v *Newham London Borough Council* [2009] UKHL 14; [2009] PTSR 632 at 636-637).

[25] Section 3 of the 2011 Act sets out the right of each patient to receive health care which is patient focused and which has regard to the importance of providing the optimum benefit to the patient's health and wellbeing. Section 5 of that Act provides that for the purposes of the rights conferred by section 3, NHS bodies must uphold the health care principles set out in the schedule in so far as these are relevant to the health service function being performed. Those principles include, at paragraph 5, "[s]upport necessary to receive or access health care is available", and it was this particular principle which the petitioner sought to rely upon in this case. However, in construing the right of a patient under section 3(1) of the 2011 Act, the rights of other patients must be taken into account (section 4(2)(a)). The legislation also specifically provides that nothing in the 2011 Act prejudices the exercise of clinical judgment, or the effective and efficient use of the health service organisation and resources (sections 4(2)(c), 20(1)).

[26] In all of the circumstances, I have concluded that the two sets of statutory provisions founded upon by the petitioner in these proceedings are broad target duties, and that neither constitutes an absolute duty to provide to each patient every type of care or treatment which they might seek. I accept (for the reasons already given) that the respondent's current approach to providing ADHD assessments for patients without a co-occurring mental health condition is one of clinical and resource-based prioritisation, and that it cannot be said to be significantly out of step with the practice and situation in other Scottish Health Boards. Moreover, the respondent is exploring high-level changes to its

service provision to meet the challenges which are currently being felt both at a local and national level. For all of these reasons, I am not satisfied that the respondent's approach is rendered unlawful by either sections 2C and 121A of the 1978 Act, or by sections 3 and 5 of the 2011 Act.

Whether the respondent's policy is irrational and unreasonable

[27] Where a public body is acting within the scope of its discretion, in fulfilment of a target duty, it will still be subject to the control of the common law on rationality (*R (on the application of AA)* v *National Health Service Commissioning Board* [2023] EWHC 43 (Admin); [2023] PTSR 608, per Chamberlain J at 631, 635). It was accepted on behalf of the petitioner that establishing that the respondent had adopted a policy which was irrational in the *Wednesbury* sense would involve him surmounting a very high bar (see *Wordie Property Co Ltd* v *Secretary of State for Scotland* 1984 SLT 345, and *BBC* v *Chair of the Scottish Child Abuse Inquiry* [2022] CSIH 5; 2022 SC 184 at 197). In making his submissions, the petitioner's counsel sought to draw comparisons with the practice of other Health Boards: however, I have set out my conclusion on the factual position in that regard above. In any event, respondent's counsel was correct to observe that (whilst it may be a factor) taking a different approach from others would not, in itself, have inevitably rendered a policy irrational. More fundamentally, accepting as I do that the respondent's policy is one of clinical and resource-based prioritisation, and that changing that would be a complex process which would require diversion of resources from elsewhere, the words of Sir Thomas Bingham MR in the case of *R* v *Cambridge Health Authority ex p B* [1995] 1 WLR 898 at 906, are apt:

> "It is common knowledge that health authorities of all kinds are constantly pressed to make ends meet. They cannot pay their nurses as much as they would like; they cannot provide all the treatments they would like; they cannot purchase all the

> extremely expensive medical equipment they would like; they cannot carry out all the research they would like; they cannot build all the hospitals and specialist units they would like. Difficult and agonising judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients. That is not a judgment which the court can make."

The same point was echoed by Chamberlain J in the case of *R (on the application of AA)* v *National Health Service Commissioning Board* [2023] EWHC 43 (Admin); [2023] PTSR 608 at 633, where he observed that the court has neither the information, nor the expert knowledge, to judge whether a Health Board should divert resources from one of their statutory purposes to another. These considerations have equal force in the current case. In all of these circumstances, the petitioner has not established that the respondent's policy is irrational or unreasonable.

Does the respondent's failure to carry out an assessment of the petitioner amount to discrimination on their part?

[28] The petitioner's argument alleging discrimination had a number of parts to it, which I will discuss in turn. Each of these aspects was also argued to involve section 29 of the 2010 Act, which strikes at discrimination by a service provider. Disability is defined in section 6 of the 2010 Act. The petitioner having not yet been the subject of assessment, he has not been diagnosed with ADHD: the petitioner sought, however, to rely on his affidavit evidence to demonstrate a mental impairment with substantial and long-term adverse effects on his ability to carry out normal day-to-day activities. With respect to the indirect discrimination limb of his argument, reference was also made to section 19A of the 2010 Act. It was, however, accepted on behalf of the respondent that at least some of those awaiting an ADHD assessment will ultimately receive a diagnosis of this condition and will fall within the definition in section 6. In all the circumstances, the respondent did not seek to press any

overly-technical point and argue that the petitioner could not bring himself within the statutory definition in the absence of a formal diagnosis. I therefore proceed on the basis of that concession.

Direct discrimination

[29] The petitioner's argument in this regard can be summarised as follows. It was contended that the respondent had taken a conscious decision in 2021 to set up a static, paper-based, waiting list for patients without a co-occurring mental health condition who were seeking an assessment for ADHD (essentially refusing to carry out an assessment of those patients), and that this constituted direct discrimination in terms of section 13 of the 2010 Act. It was submitted on the petitioner's behalf that the discrimination was so obvious that no comparator was needed: but that if it were considered that a comparator was required, then the appropriate comparator would be non-disabled persons requiring health assessments and treatments (with patients who were addicted to alcohol and illicit drugs only providing a non-exhaustive example of this group).

[30] The first difficulty which the petitioner faces in making out this argument is that, for the reasons already given, I do not accept that the petitioner's characterisation of the factual situation is correct, and I prefer the respondent's evidence in this regard.

[31] In considering the application of discrimination law to the present case, particular assistance can be drawn from the case of *R (on the application of AA)* v *National Health Service Commissioning Board* [2023] EWCA Civ 902; [2023] PTSR 2001, and it is worth briefly sketching out its factual circumstances in order to understand why this is so. The defendant in that case was responsible for commissioning certain healthcare services, including gender identity development services for children and adolescents, and gender identity disorder

services for adults. The claimants sought to challenge the long waiting times for such services. These lengthy waiting times were found to be a result of: (i) a substantial increase in demand for such services in a short space of time, which had out-paced capacity; (ii) a clinical controversy on the treatment and services; (iii) difficulties of recruitment and retention of staff; and (iv) a need to redesign the commissioning model in the light of all of those factors. In the High Court, Chamberlain J found that the defendant was not in breach of its statutory duties, that the claimants had not been subject to direct or indirect discrimination, and that there had been no breach of the public service equality duty under section 149 of the 2010 Act (*R (on the application of AA)* v *National Health Service Commissioning Board* [2023] EWHC 43 (Admin); [2023] PTSR 608). The subsequent appeal was confined to a challenge of the lower court's conclusions on one of the statutory duties to which the defendant was subject: in any event, the decision of Chamberlain J in that regard was upheld (albeit on slightly differently expressed reasons): *R (on the application of AA)* v *National Health Service Commissioning Board* [2023] EWCA Civ 902; [2023] PTSR 2001. With regard to direct discrimination, Chamberlain J had noted that usually a claimant would be seeking to show that they had received less favourable treatment than an appropriate comparator, and that the reason for that less favourable treatment was the protected characteristic. In terms of section 23 of the 2010 Act, there must be no material difference between the circumstances of the cases being compared. The insuperable difficulty for the claimants in that case was that the four factors which were causing the long waiting times were particular to those specialist services, and so to compare the experience of those referred to other NHS services was not to compare like with like. I find that the petitioner in this case has the same difficulty. I accept that the reasons for the petitioner not yet having been offered an ADHD assessment are as described by the respondent, and are not because

of the existence of the protected characteristic of disability. I am not persuaded that this is a case where it is not necessary for the petitioner to identify a comparator. The respondent is carrying out a prioritisation exercise, and the petitioner has not established that the factors of a sudden and substantial increase in demand which has outstripped capacity, difficulties in recruitment of staff, and an identified need for a more fundamental redesign of service, apply generally to non-disabled patients requiring health assessments and treatment (or specifically to patients addicted to alcohol and illicit drugs who are seeking assessment and treatment). Accordingly, the petitioner has not established that because of disability, he is being treated less favourably than the respondent treats (or would treat) others, and thus he has not established direct discrimination in terms of section 13(1) of the 2010 Act.

Discrimination arising from disability

[32] Section 15 of the 2010 Act provides that a disabled person is discriminated against if the person is treated unfavourably because of something arising in consequence of their disability. It was argued for the petitioner that the general principles were elucidated in the case of *Trustees of Swansea University Pension and Assurance Scheme* v *Williams* [2018] UKSC 65; [2019] IRLR 306: in particular, the lack of a requirement for a comparison exercise to be carried out. It was submitted on the petitioner's behalf that in his case, "something arising in consequence of" disability is the need for the petitioner to undergo a medical assessment in order to access treatment for ADHD.

[33] Again, the petitioner's argument faces a number of difficulties, which I find that he is unable to overcome. Firstly, for the reasons already given, I do not accept that the factual situation is as the petitioner sought to prove. Secondly, and in any event, I am of the view that the diagnosis of a disability is such an integral part of the condition, that it would

constitute a part of the disability itself, and not something which *arises in consequence of* a disability for the purposes of section 15 of the 2010 Act. It was accepted for the petitioner that adopting the interpretation for which he had contended would necessarily mean that in certain circumstances it would be discriminatory for the NHS not to offer a particular treatment to a disabled person: but this seemed difficult to reconcile with the acknowledgment by petitioner's counsel that it cannot be the case that a patient could identify a particular treatment and hold a Health Board responsible for providing it on pain of being found to be discriminating against the patient. Accordingly, I conclude that the prioritisation exercise which the respondent is carrying out in respect of ADHD referrals (where the patient does not have a co-occurring mental health condition) does not constitute unfavourable treatment of the petitioner because of something arising in consequence of a disability (as would be required in terms of section 15(1)(a) of the 2010 Act). In any event, even were I wrong about that, section 15(1)(b) of the 2010 Act would have entitled the respondent to demonstrate that such treatment was a proportionate means of achieving a legitimate aim, thus bringing into play the broader arguments as to resources which I will discuss below in the context of the petitioner's indirect discrimination claim under section 19 of the 2010 Act.

Indirect discrimination

[34] The petitioner maintained a fallback position that the respondent was indirectly discriminating against patients such as the petitioner in terms of section 19 of the 2010 Act. This argument was predicated on the petitioner's contention that the respondent had created a static paper waiting list for patients such as the petitioner, which represented different treatment from that given to non-disabled patients. Counsel for the petitioner

accepted that since section 19(2)(d) of the 2010 Act permitted the respondent to seek to show that the application of the provision, criterion or practice in question was a proportionate means of achieving a legitimate aim, arguments on resources became relevant. Petitioner's counsel sought to counter such arguments in two ways, by submitting that: (i) general criticism in the Auditor General for Scotland's 2024/25 audit of the respondent gave rise to an inference that a failure to carry out ADHD assessments for patients such as the petitioner could be ascribed to poor management and governance on the respondent's part; and (ii) the respondent's trialling or exploration of other approaches to the assessment and treatment of ADHD in its area proved that there were no resource barriers to carrying out the ADHD assessment which the petitioner sought.

[35] The petitioner's argument fails at each of the hurdles it must surmount.

[36] For the reasons already given, I do not accept that the respondent's policy is, as a matter of fact, as the petitioner contended. Furthermore, I am not satisfied that the respondent's approach (properly understood) fulfils the definition of indirect discrimination set out in section 19(1) of the 2010 Act, even before one takes account of considerations of proportionality under section 19(2)(d) of the 2010 Act. The law on indirect discrimination has been neatly encapsulated by Baroness Hale as

> "an attempt to level the playing field by subjecting to scrutiny requirements which look neutral on their face but in reality work to the comparative disadvantage of people with a particular protected characteristic"

(*Chief Constable of West Yorkshire Police* v *Homer* [2012] UKSC 15; [2012] ICR 704 at 710). The situation complained of by the petitioner in the current case does not fall into that category. The discussion of the relevant issues by Chamberlain J in the case of *R (AA)* v *National Health Service Commissioning Board* [2023] EWHC 43 (Admin); [2023] PTSR 608 is again particularly instructive. There, the claimants argued that the PCPs were the arrangements made by the

NHS to meet the needs of patients suffering from gender dysphoria, which were said to put such patients at a disadvantage compared to patients suffering from other conditions (who did not face such long waiting times). However, as Chamberlain J observed (at 644-645), the arrangements under challenge which the claimants contended constituted the PCP applied only to those patients with gender dysphoria, whereas section 19(2)(a) of the 2010 Act requires that the PCP be applied by the alleged discriminator not only to a claimant, but also to persons with whom the claimant does not share the protected characteristic. Similarly in this case the petitioner contends that the PCP is the respondent's policy regarding referrals for ADHD assessments where there is no co-occurring mental health condition. The petitioner does not offer to prove that this is a PCP which is, or would be, applied by the respondent to other patients who do not have suspected ADHD without a co-occurring mental health condition. No appropriate comparator is identified in terms of sections 19(2) and 23 of the 2010 Act.

[37] In any event, the respondent's affidavit evidence would have satisfied me that its approach to prioritisation of resources was a proportionate means of achieving a legitimate aim, in terms of section 19(2)(d) of the 2010 Act. It is plain from the evidence that neurodevelopmental condition assessments generally require more substantial time and expertise than, say, the assessments needed to access addiction services. In many countries, including Scotland, there has been a significant increase in recent times in the number of persons seeking an assessment for a suspected neurodevelopmental condition. There is a recognition that processes may require to be altered, and resources to be differently deployed, in order to reflect the scale of that demand. In the meantime, the diversion of resources by the respondent from other mental health services would involve risk to other patients and potentially the wider public. While petitioner's counsel pointed to criticism of

the respondent in the Auditor General for Scotland's 2024/25 audit, on examination this seemed to be criticism of the respondent's progress in addressing broader issues previously raised (in what was described as a highly critical independent inquiry into mental health services, which published in February 2020). The petitioner provided no evidence that any criticism made in that audit (or, indeed, in the underlying inquiry) had impacted specifically upon the present provision of ADHD assessments in the respondent's area. It would be too big a leap for the court to assume such an impact, in the absence of any such evidence. Moreover, the respondent's exploration of other approaches is not proof that diversion of resources would not be necessary in order to adopt any such new approaches in all cases now: indeed, such an assertion was contradicted by the detailed affidavit evidence from those with knowledge of matters, to the effect that staffing and financial resources would be required to make these alternative approaches a reality in the future.

Whether the respondent ought to have made reasonable adjustments to its provision, criterion or practice

[38] There are three components to the duty in terms of section 20(2) of the 2010 Act to make reasonable adjustments. In this case the petitioner sought to rely upon the first of those three components, namely the requirement (where a PCP puts a disabled person at a substantial disadvantage in comparison with persons who are not disabled), to take such steps as is reasonable to avoid the disadvantage: section 20(3) of the 2010 Act. Section 29 of the 2010 Act also makes clear that a service-provider (and a person exercising a public function not involving service provision) is subject to the duty to make reasonable adjustments The petitioner contended that the respondent's duty to make reasonable adjustments was triggered in the present case, arguing that the practice of other Health

Boards, and the existence of a blueprint for an alternative approach, showed that a different approach was possible: which was said to be all that the petitioner required to show.

[39] This ground of the petitioner's challenge also fails. Firstly, for the reasons already given, I do not accept that, as a matter of fact, the respondent's policy is as the petitioner contends. Secondly, the practice upon which the petitioner seeks to rely is one which is said to apply only to those persons seeking an ADHD assessment who do not have a co-occurring mental health condition. However, as was explained by the Supreme Court in the case of *McCue* v *Glasgow City Council* [2023] UKSC 1; [2023] PTSR 220 (per Lord Sales JSC at 241) if a practice applies only to disabled people, and does not allow for any comparison to be made with the treatment of persons who are not disabled, then there is no scope for the application of section 20(3) of the 2010 Act. Thirdly, and in any event, there was no evidence that the respondent could have called upon the resources of other Health Boards and HSCPs, and there is considerable force in the respondent's argument that requiring a comprehensive redesign of the process by which the respondent provides assessments to those with a suspected neurodevelopmental condition would go far beyond the ordinary meaning of reasonable adjustments.

Did the respondent fail to properly exercise its duties to undertake an equality impact assessment?

[40] Section 149(1) of the 2010 Act obliges public authorities, in the exercise of their functions, to have due regard to certain matters which are set out in that subsection (narrated in full within para [11] above). Regulation 5 of the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 places a specific obligation on a public authority, where necessary in the fulfilment of that duty, to carry out an equality impact assessment in relation to a proposed new or revised policy or practice. Petitioner's counsel contended that

in or around 2021 the respondent came under an obligation to comply with these statutory provisions, and placed reliance on the case of *Bracking* v *Secretary of State for Work and Pensions* [2013] EWCA Civ 1345. It was accepted that there was no prescriptive form for an equality impact assessment.

[41] However, this ground of challenge again proceeded on the premise that the petitioner could establish that the factual situation was as he described, that is, that in around 2021 the respondent adopted a new policy of maintaining a static paper-based waiting list for ADHD assessments where the patient in question did not have a co-occurring mental health condition. Since, for the reasons which I have already set out, I do not accept that this was so, this is sufficient to deal with the challenge based on the 2012 Regulations. The petitioner's challenge in terms of section 149 of the 2010 Act was also tied to his characterisation of the factual situation: but as I have explained, I am satisfied that the current position is not the product of a decision taken by the respondent in 2021, but rather is the continuation of an existing approach. It must also be borne in mind that not every decision taken by a public body requires that an equality impact assessment be carried out (*McLean* v *Aberdeen City Council* [2025] CSIH 13 at para [9]). In any event, in the absence of direct or indirect discrimination, or discrimination arising from disability, it could not have been said that the respondent had failed to have due regard to the need to eliminate any discrimination prohibited by the 2010 Act (see section 149(1)(a) of the Act). It is also plain from the evidence that the respondent is aware of the issues currently being experienced by those in the petitioner's position, and is actively exploring how these might be tackled. In those circumstances, nor am I satisfied that it could have been said that the respondent had failed to have due regard to the considerations set out in sections 149(1)(b)

and (c) of the 2010 Act (see *R (on the application of AA)* v *National Health Service Commissioning Board* [2023] EWHC 43 (Admin); [2023] PTSR 608, per Chamberlain J at 648-650).

Whether there was a legitimate expectation that the respondent would consult on its policy

[42] The circumstances in which there is an obligation on a public body to carry out a consultation have recently been discussed in cases such as *Fanning* v *Secretary of State for Work and Pensions* [2025] CSOH 50; 2025 SLT 787 at 810-811, and *Mull Campus Working Group Ltd, Petitioner* [2026] CSOH 111 at paras [114], [117]. It was argued for the petitioner that in this case the respondent was obliged to consult prior to introducing a new policy in or around 2021. It was not suggested that this obligation arose from statute, and it was accepted that at common law there was no automatic or general duty to consult. However, petitioner's counsel contended that this was a case where the particular circumstances gave rise to a legitimate expectation of consultation. Since it was not contended that such a legitimate expectation sprang from a promise to consult, or an established practice, this required the petitioner to show that this was one of those exceptional cases where a failure to consult would produce conspicuous unfairness. The circumstances founded upon by the petitioner in this regard were said to be the profound impact of the respondent's new policy, and its discriminatory and disproportionate effect. The petitioner's case was argued to be akin to that of *B* v *Scottish Borders Council* [2022] CSOH 68; 2022 SLT 1311 (which involved closure of a day-care centre).

[43] This ground of challenge was again contingent upon the petitioner establishing that the respondent introduced a new policy, in the terms contended for, in 2021: for the reasons already given, I am not persuaded as a matter of fact that this is so. Accordingly, this ground of legal challenge also falls away. In any event, as the respondent's counsel

observed, those exceptional cases where it was held that a failure to consult would be productive of conspicuous unfairness and a legitimate expectation of consultation arose, can more readily be characterised as granular decisions affecting a narrow range of persons (*Fanning* v *Secretary of State for Work and Pensions* 2025 SLT 787 at 811). One might contrast the case of *B* v *Scottish Borders Council* [2022] CSOH 68; 2022 SLT 1311, mentioned above, with the case of *BB* v *Glasgow City Council* [2024] CSOH 44; 2024 SLT 667, where it was held that there was no common law duty to consult in respect of a proposed change to a local authority's charging policy. I consider that decisions, such as in the current proceedings, on the allocation of finite resources amongst patients with differing conditions (or suspected conditions) that involve a degree of clinical judgment, do differ from those exceptional cases where it has been held that there would be conspicuous unfairness from a failure to consult. The significance of the impact of such a decision on a particular patient is not enough in itself to give rise to a legitimate expectation, and for the reasons already discussed, the petitioner has not established that the respondent's actions are discriminatory or disproportionate.

Disposal

[44] In all of these circumstances, I shall therefore repel the petitioner's first to eighth pleas-in-law and refuse the petition. I shall reserve all questions of expenses.