[2019] UKFTT 576 (TC)

TC07370

VALUE ADDED TAX – supply of staff or supply of services consisting in the provision of medical care – provision of pharmacist led clinical services – article 132(1)(c) Principal VAT Directive – exemption for medical care – item 3 and note (2A) group 7 schedule 9 Value Added Tax Act 1994 – appeal allowed

FIRST-TIER TRIBUNAL
TAX CHAMBER

Appeal number: TC/2018/01569

BETWEEN

MEDACY LTD — **Appellant**

-and-

THE COMMISSIONERS FOR HER MAJESTY'S REVENUE AND CUSTOMS — **Respondents**

TRIBUNAL: JUDGE ROBIN VOS
SONIA GABLE

Sitting in public at Alexandra House, Manchester on 20 August 2019

Shaun Hockey, Director for the Appellant

Miss Isabel McArdle, counsel, instructed by the General Counsel and Solicitor to HM Revenue and Customs, for the Respondents

DECISION

INTRODUCTION

1. There can be a fine line between a supply of services and a supply of staff which enables some other person to provide those services. This is an important distinction where the services in question are exempt from VAT given that the supply of staff is standard rated.

2. In this case the Appellant, Medacy Ltd ("Medacy") claims that the services it is supplying through its pharmacists to various GP practices amount to exempt medical care whereas HMRC are of the view that the only supply by Medacy is a supply of staff.

3. HMRC have therefore issued VAT assessments for each of the four VAT periods from 12/16 – 09/17 totalling £34,721 representing the output tax which they say should have been charged in relation to the supplies in question.

4. Medacy has appealed against each of the assessments on the basis that it is providing exempt medical care.

5. There was some confusion as to the possibility of there being a second issue for the Tribunal to consider which is whether any supply by Medacy of the services of its founder and director, Shaun Hockey is in any event exempt from VAT. It was however agreed that it made no difference whether the supplies related to Mr Hockey or to an employee of Medacy and that the only question for the Tribunal to determine was whether the pharmacist led clinical services were a supply of exempt medical care or a standard rated supply of staff.

THE EVIDENCE AND THE APPELLANT'S APPLICATION TO ADMIT ADDITIONAL DOCUMENTS

6. Shortly before the hearing, the Appellant had provided a number of additional documents on which it wishes to rely at the hearing. These comprised various promotional/ marketing documents (some of which had already been provided), a transcript of a WhatsApp Group chat (running to some 300 pages), an email relating to a complaint about Medacy's services and a sample timesheet. HMRC did not object to the Tribunal admitting these documents as part of the evidence.

7. Mr Hockey's main reason for the late production of these documents was that, due to financial constraints, Medacy had dispensed with the services of its adviser and that he had only recently appreciated the relevance of the documents.

8. Given that the documents were produced in time for HMRC to review them (albeit not in detail) and that the documents were relevant to the issue which the Tribunal had to decide, the Tribunal accepted that it would be in accordance with the overriding objective of the Tribunal rules (to deal with cases fairly and justly) to admit these documents as part of the evidence.

9. The Tribunal had before it a bundle of correspondence and documents produced by HMRC, including the documents mentioned above.

10. In addition, Mr Hockey gave oral evidence and was cross-examined by Miss McArdle. For the most part, Mr Hockey's evidence was straightforward and consistent with the documentary evidence. His answers to one or two questions put to him by Miss McArdle were less forthcoming. However, these related to matters which were not particularly significant in the context of the issue which we have to decide. In general we have therefore accepted Mr Hockey's evidence at face value.

THE RELEVANT LEGAL BACKGROUND

11. Article 132(1)(c) of the Principal VAT Directive (Council Directive 2006/112/EC) exempts from VAT:

> "(c) the provision of medical care in the exercise of the medical and paramedical professions as defined by the Member State concerned;"

12. This is reflected in group 7 of schedule 9 to Value Added Tax Act 1994. As far as pharmacists are concerned, item 3 of group 7 exempts:

> "the supply of any services consisting in the provision of medical care by a person registered in the register of pharmaceutical chemists kept under the Pharmacy Act 1954 or the Pharmacy (Northern Ireland) Order 1976."

13. Note (2A) to group 7 confirms that:

> "Item 3 includes supplies of services made by a person who is not registered in either of the registers specified in that item where the services are wholly performed by a person who is so registered."

14. It is apparent that the purpose of note (2A) is to ensure that the exemption is available not only where services consisting of medical care are provided directly by an individual but also where they are supplied by some other person such as a company which employs the individual.

15. There is no dispute in this case as to whether the activities carried out by the pharmacists employed by Medacy amount to "medical care". On the evidence before us we have no reason to doubt this and so we proceed on the assumption that such activities do indeed amount to medical care.

16. The question however is whether Medacy is itself providing (in the wording of item 3 of group 7) services consisting in the provision of medical care or whether, as HMRC believe, it is only supplying staff to GP practices which are in turn themselves providing the medical care.

17. Miss McArdle and Mr Hockey referred us to three cases, one decided by the Upper Tribunal and two later cases decided by the First-tier Tribunal.

18. The first case is *Sally Moher t/a Premier Dental Agency v HMRC* [2012] UKUT 260 (TCC). In that case, the appellant supplied dentists with temporary dental staff, mainly nurses.

19. The Upper Tribunal decided that the supply made by the appellant was a supply of staff to the dentist and that it was the dentist who was supplying medical care to the patients. The decision is short but the key reasons for the Upper Tribunal's decision at [13-14] were as follows:

> "13. For the respondents, Miss Jessica Simor of counsel argued that the tribunal's conclusion that the appellant's supplies were of staff and not of medical services was a finding of fact, unassailable in this tribunal unless it could be shown to be irrational, a task which the appellant had not even attempted. The tribunal had, she said, examined all the relevant evidence, particularly about the contractual relationship between the appellant and the dentists, had considered the appellant's concession that once assigned to a dentist the nurses and auxiliaries

were under the dentist's control and merely did as they were directed, and had correctly concluded from all those factors that the appellant supplied staff to the dentists, and it was the dentists who supplied the medical care to their patients.

> 14. In our judgement those arguments are unanswerable; indeed, it is difficult to see how one could rationally conclude that the appellant was making supplies of medical care, once it is accepted that the nurses and auxiliaries were under the control of the dentist to whom they were assigned. This is so even if (assuming, in the appellant's favour) that the nurses were to be regarded as employees of the appellant. The appellant did not control – or even know – whether, and if so, the extent to which, the dentist directed a nurse or auxiliary to carry out other duties which themselves were not exempt supplies, such as acting as receptionist or assisting with cosmetic dentistry. Even in relation to dental services which were exempt, the appellant did not dictate the treatment offered to the patients, or play any part at all in determining what treatment was offered or how it was provided, nor did she supervise the nurses and auxiliaries. She had no relationship, contractual or otherwise, with the patients to whom the medical care was provided. It is in our view beyond argument that her supply was of staff to dentists, who (as the tribunal found) assumed all the responsibility for directing the nurses as to what they should do, and for determining the treatment to be offered to the patients and the manner of its delivery. That the staff (and, indeed, the appellant herself) had a medical qualification cannot affect the nature of the supply. The tribunal correctly concluded that the appellant could not benefit from the exemption, and that the respondents were right to refuse the payment."

20. It is worth pausing to note that, in approaching its analysis of the supply in *Sally Moher*, the First-tier Tribunal [2011] UK FTT 286 (TC) at [35] relied on the decision of the High Court in *Customs & Excise Commissioners v Reed Personnel Services Ltd* [1995] STC 588 where Laws J said at [595] that:

> "There may be cases, generally (perhaps always) where three or more parties are concerned, in which the contract's definition (however exhaustive) of the parties' private law obligations nevertheless neither caters for nor concludes the statutory question, what supplies are made by whom to whom. Nor should this be a matter for surprise: in principle, the incidence of VAT is obviously not by definition regulated by private agreement. Whether and to what extent the tax falls to be exacted depends, as with every tax, on the application of the taxing statute to the particular facts. Within those facts, the terms of contracts entered into by the taxpayer may or may not determine the right tax result. They do not necessarily do so. They will not do so where the contract, though it tells all the parties everything that they must or must not do, does not categorise any individual party's obligation in a way which inevitably leads to the conclusion that he makes certain defined supplies to another. In principle, the nature of a VAT supply is to be

> ascertained from the whole facts of the case. It may be a consequence, but is not a function, of the contracts entered into by the relevant parties."

21. Although the Upper Tribunal does not say so in so many words, it is apparent that its approach was also to look at all of the relevant facts and not just the terms of the contractual documentation (in respect of which there was in that case, in any event, little evidence).

22. The Upper Tribunal's decision in *Sally Moher* was referred to by the First-tier Tribunal in *Rapid Sequence Limited v HMRC* [2013] UKFTT 432 (TC). That case was similar to *Sally Moher* in that it related to the provision of temporary staff but the significant difference was that the staff were doctors performing anaesthetic services for NHS hospitals and therefore exercised their own judgement in relation to the medical care provided to the patients.

23. Nevertheless, the First-tier Tribunal concluded that Rapid Sequence was supplying staff to the hospitals and was not supplying services which amounted to medical care. The Tribunal explained its conclusion at [48] as follows:

> "48. We do not believe the factual scenario is any different in substance to that in *Moher v HMRC*; in both cases the medical care in question was provided by the medical professional concerned, not by the person who made the arrangements for those services to be provided by a locum. Rapid Sequence provides its services to the relevant NHS Trust. The doctor provided by Rapid Sequence, whilst exercising his own judgement as to how to perform his services does so in the hospital under the direction and control of the relevant NHS administrators or medical staff. As far as the patient is concerned, he is receiving services from a doctor working under the supervision of the NHS Trust, not Rapid Sequence. Rapid Sequence plays no part in deciding how the doctor concerned provides his services. The matters referred to in paragraph 39 above are, as submitted by Mr Peretz, no more and no less than one would expect of a business providing temporary staff and do not indicate any measure of control by Rapid Sequence over how the doctors provided perform their services. Our conclusion on the second question is therefore that the services provided by Rapid Sequence do not amount to medical care within the meaning of Article 132(1)(c)."

24. The final case, referred to principally by Mr Hockey, is *City Fresh Services Limited v HMRC* [2015] UKFTT 0364 (TC). Two dentists had set up a partnership which had entered into a contract to provide primary dental services to their local NHS Trust. Sometime later they decided they would prefer to provide the services through a company rather than a partnership. However, there would have been significant complications in transferring the contract with the NHS Trust from the partnership to the company and so the dentists set up a company and then arranged for the partnership to sub-contract the delivery of the dental services under the NHS contract to the company. The result of this was that the company supplied services to the partnership and the partnership supplied services to the NHS Trust.

25. HMRC argued that the appellant company was providing staff to the partnership and that the partnership was providing dental services. The First-tier Tribunal rejected this saying at [41]:

> "41. The *Sally Moher* decision stressed the need to consider the essential nature of the supply being made, in our view it is very difficult

> to characterise the supply being made from City Fresh to CDP as anything other than a supply of dental services by City Fresh to CDP to allow CDP to fulfil its obligations under its contract with the NHS Trust; exactly the same supply as had been made by CDP to the NHS Trust before City Fresh was set up."

26. In our view, none of these cases provide a great deal of assistance in reaching a decision as to the nature of the supply made by Medacy to the various GP practices. Both *Moher* and *Rapid Services* were cases where there was no evidence that the appellants had agreed to provide anything other than temporary staff. The question was really whether this was enough to enable the appellants to be treated as providing the underlying medical care undertaken by those temporary staff members.

27. *City Fresh*, on the other hand, is at the other end of the spectrum in that the appellant was providing the entirety of the medical care which the partnership had agreed to provide to the NHS Trust whereas the pharmacists working for Medacy are only providing a small part of the medical care offered by the relevant GP practices.

28. Having said that, we do think that these cases provide some helpful principles in approaching our analysis of the supplies made by Medacy. These are as follows:

(1) A supply by a non-natural person to another non-natural person may still be a supply of services consisting in the provision of medical care (*City Fresh* at [35] and note (2A) to group 7 of schedule 9 to Value Added Tax Act 1994).

(2) It is necessary to look at all of the relevant facts and not just the contractual provisions (*Reed Personnel Services Limited* / *Moher*).

(3) One of the most important factors is who controls or supervises the activities of the relevant individual(s) (*Moher* at [14], *Rapid Sequence* at [48] and paragraph 6.3 of VAT notice 701/57).

29. With these principles in mind, we now turn to consider the nature of the supplies being provided by Medacy to the GP practices which are its clients.

THE SERVICES PROVIDED BY MEDACY

Medacy's history

30. Medacy started life in 2004 as a supplier of locum services. This still represents about half of Medacy's business and Medacy charges VAT at the standard rate in respect of such services.

31. However, in around 2015/16, Medacy identified that there was a large knowledge gap within GP practices about how pharmacists could help patients derive maximum benefit from their prescribed therapies whilst reducing medication related risks and improving pharmaceutical care services.

32. As a result of this, Medacy launched a new service for GP practices which it describes as pharmacist led clinical services. These services now account for approximately half of Medacy's business and the proportion is expected to grow.

33. Locum services and the pharmacist led clinical services are two distinct strands of Medacy's business. There are separate procedures, administrative arrangements and documentation relating to each side of the business.

The pharmacist led clinical service

34. Once a GP practice expresses an interest in the pharmacist led clinical service, a member of Medacy's senior management team visits the practice to understand their needs. Medacy have a menu of pharmaceutical services which it is able to provide, some of which the GP practice may be aware of and some of which may be new to them.

35. Having carried out this initial assessment, Medacy will put together a written proposal setting out the services which it thinks will make the biggest difference to the GP practice within the constraints of an agreed budget.

36. The GP practice is free to choose the services which it wishes to receive and the number of hours of a pharmacist's time which it is willing to pay for.

37. Once the scope of the services are agreed, this is recorded in a contract between Medacy and the relevant GP practice. We look in more detail at the terms of this contract below.

38. In order to fulfil its obligations under the contract, Medacy will identify a qualified pharmacist who is an employee of Medacy to provide the agreed clinical services working both at the GP practice and remotely. The pharmacist will, generally speaking, be working alone, exercising their own judgement in providing the clinical services.

39. Medacy provide a practice launch pack to explain the benefits to the practice of the services which the pharmacist will provide and also to agree with the practice detailed protocols for three key areas which will be dealt with by the pharmacist including hospital discharge letters, outpatient treatment requests and medication reviews. These protocols seek to agree how the pharmacist will work with the GP practice in relation to these areas and also dictate the process which the pharmacist will follow in respect of each of these tasks.

40. In addition, Medacy produces an "on-boarding document" for the pharmacist who will be providing the services. This sets out the purpose of the service, the individuals at Medacy who are available to support the pharmacist, the key responsibilities of the pharmacist and the relevant training requirements.

41. A member of Medacy's senior management team will attend the relevant GP practice for the launch of the service. There is then a formal review of the service with the GP practice after one month, sometimes after three months and after six months. How often subsequent reviews take place will depend on the outcome of previous reviews.

42. Medacy provides additional support to the pharmacists providing the clinical services by telephone, through its website and through a WhatsApp group. The main purpose of the WhatsApp group is to provide peer-to-peer support in relation to clinical questions which the pharmacists have whilst carrying out their duties. As will be seen further below, it is also used by Medacy for monitoring the services provided by the pharmacists which may lead to discussions about the service with the relevant GP practice. This WhatsApp group comprises only those pharmacists involved in providing clinical services and not pharmacists who are working as locums provided by Medacy.

The contract between Medacy and the GP practices

43. We were provided with two versions of the contract between Medacy and the relevant GP practices. The first is a signed contract with a particular GP practice which is dated 1 March 2017. This is shortly after HMRC launched their enquiries which have led to this appeal but before HMRC's initial visit which took place in May 2017.

44. The second contract is a proforma contract which Medacy now uses as the template for its agreement with the GP practices. This agreement broadly follows the format of the March 2017 contract but some of the wording has been changed. Mr Hockey's evidence was that these changes were intended to clarify the nature of the services being provided and that the changes were made shortly after the March 2017 agreement was put in place.

45. Miss McArdle based her submissions on the template contract and so we will look first at that agreement.

46. The key provisions of the template contract are as follows:

(1) The background section explains that "the Practice wishes to appoint Medacy to provide pharmacist led clinical services on the terms of this Agreement as described in Schedule 3".

(2) The "Services" are defined as "the services to be provided by Medacy under this Agreement, as set out in Schedule 1 and Medacy's obligations under this Agreement, together with any other services which Medacy provides or agrees to provide to the [Practice]."

(3) There is also a definition of "Pharmacists' Duties" which "means the services that the [Practice] requires from the Pharmacist(s) placed in it pursuant to this Agreement, which are more particularly described at Schedule 3 and which may be varied from time to time by agreement between Medacy and the [Practice]".

(4) Clause 3.1 confirms that "Medacy shall use reasonable endeavours to provide the Services to the practice in accordance with Schedule 1".

(5) Clause 4.1 imposes certain obligations on the Practice including the following:

"…

(b) … co-operate in good faith and without delay with any reasonable request from Medacy in relation to the provision of pharmacist led clinical services to the Practice;

(c) provide and/or procure, for Medacy, its agents, sub-contractors, consultants and employees and the Pharmacists, in a timely manner and at no charge, access to the Practice's premises, office accommodation, data and other facilities as reasonably required in connection with this Agreement;

(d) request hours from Medacy in a timely manner and in accordance with Medacy's reasonable requests and reasonable procedures;

…

(k) not request services/actions from Medacy that go beyond the scope of this Agreement or that would otherwise be inappropriate to a Pharmacist's role and professional status."

(6) Clause 7.3 limits Medacy's total liability to the practice to 125% of the average annual charges paid by the Practice under the Agreement.

(7) The Practice also agrees in clause 7.4(c) to "take out and maintain such insurance policies with reputable providers as a prudent and circumspect business would in relation to the risks associated with the activities envisaged by this Agreement".

(8) The practice may terminate the Agreement on one month's notice.

(9) Schedule 1 sets out the services to be provided by Medacy. The key provisions are as follows:

"**Schedule 1 – The Services**

1. The aim of the service

The main aim of the service to be provided by Medacy is to ensure that medication is optimised for each patient to maximise clinical benefits and minimise detrimental effects of medication.

2. Medacy's responsibilities

2.1 Medacy shall use reasonable endeavours in order to procure the attendance of one or more Pharmacists at the Practice in order to perform the clinical services listed in Schedule 3 and shall use reasonable endeavours in order to meet the Practice's reasonable request for a particular number of Pharmacist hours at particular times during the working week.

2.2 Medacy shall be responsible for:

(a) providing pharmacist led clinical services to the Practice in line with this Agreement;

(b) taking reasonable steps prior to placing the Pharmacist with the practice in order to ensure that the Pharmacist is registered with the General Pharmaceutical Council of Great Britain; and

(c) the training, support and management of Pharmacists, to the extent that Medacy deems reasonably necessary in order for Medacy to fulfil its obligations under this Agreement.

(d) Offering continued professional development to all Pharmacists engaged in the service.

(e) Providing cover for planned and unplanned absence.

…

3. Mechanism for the Practice to request an alternative Pharmacist

3.1 Subject to paragraphs [3.2] and [3.3] below, if the [Practice] (acting reasonably) wishes to request an alternative Pharmacist to replace any Pharmacist(s) placed with it pursuant to this Agreement, then the Practice shall make such request in writing to Medacy giving the reasons for its request. Medacy will use reasonable endeavours to accommodate the Practice's request for a replacement Pharmacist.

…

3.3 If (a) in Medacy's opinion, the practice unreasonably requests an alternative Pharmacist pursuant to paragraph 2.1 above; and/or (b) one or more Pharmacists decline to be placed at the practice then Medacy, acting reasonably, may at its sole discretion (acting reasonably) suspend its provision of Services under this Agreement and/or terminate this Agreement, such action to be

without prejudice to Medacy's right to be paid in respect of any provision of Services up to that point.

4. The Practice's requirements

4.1 The practice requests Medacy to provide Pharmacists for the hours and to provide the clinical services specified below:

[there is then a space for the number of pharmacist hours per week to be inserted]

5. Key performance indicators

[This section lists a number of key performance indicators and targets]."

(10) Schedule 2 sets out Medacy's charges. These are based on an hourly rate. In addition, there is a "recruitment fee" which is payable if one of Medacy's pharmacists becomes an employee of the GP practice.

(11) Schedule 3 lists the services to be provided. There are two headings as follows:

"**Schedule 3 – Description of the Service**

Schedule 3 – Pharmacist's Duties"

[There then follows a list of core services to be provided, a separate section for practice specific requests and a further section listing services which Medacy is able to provide but which are outside the scope of the relevant agreement.]

47. We will not list all of the changes between the March 2017 contract and the template contract. It is sufficient to say that it is clear that the changes are designed to try to emphasise the fact that Medacy is providing clinical services rather than supplying a pharmacist who will then in turn provide certain services.

48. For example, in the background section, instead of the Practice wishing to appoint Medacy to provide pharmacist led clinical services, the March 2017 agreement states that "the Practice wishes to appoint Medacy to procure and support the services of one or more qualified Pharmacists to work in its General Practice". Similarly, paragraph 2.1 of schedule 1 refers to Medacy procuring "the attendance of one or more Pharmacists at the Practice in order to perform the Pharmacist's Duties" and paragraph 2.2. of schedule 1 confirms that Medacy is responsible for providing Pharmacists to the Practice".

Medacy's insurance cover

49. Mr Hockey drew attention to the fact that Medacy has its own medical malpractice and professional indemnity insurance cover and documents relating to this were included in the evidence provided to the Tribunal.

50. From this, it can be seen that the cover is for a total of £5 million. Medacy's business is described as "pharmacist led services to GP practices, GP federations and clinical commissioning groups". One of the endorsements to the policy restricts cover to "pharmacist related placement activities".

The Appellant's submissions

51. Mr Hockey was at pains to stress the difference between the locum services provided by Medacy and the pharmacist led clinical services as his belief is that HMRC's approach to this

matter has resulted from an inability to understand that there are two completely different sides to Medacy's business.

52. In this context, Mr Hockey explained that the introduction of pharmacist led clinical services represented a fundamental change in the way in which GP practices operate. The pharmacist would not be providing cover for an absent member of the GP practice. Instead, it was a completely new post, carrying out some services which would otherwise have been done by the GPs (thus freeing up GP time) and some completely new services which had not previously been carried out by the practice but which would benefit the practice.

53. Mr Hockey referred to the time which was invested in identifying the needs of the practice and designing a bespoke solution in support of his argument that Medacy is ultimately responsible for supplying the medical care provided by its pharmacists and not just for supplying the pharmacist who then assisted the GP practice in providing the medical care. He pointed out that, in the case of a locum or the simple provision of staff, there would be no need to go through this exercise as it would be entirely up to the client how it wished to use the relevant member of staff. However, in this case, Medacy is proposing and agreeing with the practice exactly what services should be provided, with the scope of services only being able to be changed with the agreement of both parties.

54. Mr Hockey also drew attention to the fact that the pharmacists are employed by Medacy and that Medacy takes responsibility for their actions, thus requiring it to put in place expensive medical malpractice insurance. He submits that this would not be necessary if Medacy were purely supplying staff rather than providing medical care services.

55. Mr Hockey accepts that the decisions in *Moher* and *Rapid Sequence* indicate that control and supervision of the pharmacists is a relevant factor in determining whether Medacy is providing medical care services or is simply providing a member of staff. However, he submits that, unlike in those cases, Medacy has sufficient control and supervision over the activities of the pharmacists to mean that it is indeed supplying medical care services and not just supplying staff. In support of this, he referred to the following:

(1) The on-boarding document given to the pharmacist which explains the services to be provided, the familiarisation process with the practice which the pharmacist should follow and the training which the pharmacist is required to undertake.

(2) The detailed protocols which set out how the pharmacist must carry out certain core services.

(3) The regular review meetings Medacy undertakes both with the practice and with the pharmacists.

(4) The WhatsApp group, website and telephone support provided by Medacy to assist its pharmacists in providing the services.

(5) A suggested daily schedule provided by Medacy to its pharmacists which gives guidelines to the pharmacist as to how they should organise their day in order to make sure that all of the relevant services are provided.

56. Mr Hockey identified a number of other factors which, in his view, support his case that Medacy is supplying medical care services as follows:

(1) The practice can terminate the service on one month's notice if they are unhappy.

(2) Medacy Clinical Services has its own infrastructure including an Operations Director and a Senior Pharmacist who oversees the pharmacists who are involved in providing the clinical services.

(3) Medacy have to deal with complaints from the GP practices about the level of service provided. In this context, Mr Hockey referred specifically to an email from one GP practice complaining about the failure to process a number of discharge letters.

(4) Medacy's pharmacists are employed by Medacy under permanent contracts and are paid a salary. However, the GP practices are charged an hourly rate.

(5) Medacy's agreement with the GP practices to meet certain targets in relation to specific key performance indicators.

57. Turning to the cases, Mr Hockey submits that *Moher* is not relevant as, in that case, the appellant clearly had no control or supervision in relation to the services provided by the dental nurses. He explained that this would be similar to providing a pharmacy technician to a pharmacist. In contrast, he says that the pharmacists provided by Medacy are not under the control of the GP practices but are exercising their own independent judgement under the supervision and control of Medacy.

58. Turning to *Rapid Sequence*, Mr Hockey again submits that this case is not relevant as the appellant was clearly only providing locums and did not itself take any responsibility for the services provided by those locums, as demonstrated by the fact that Rapid Sequence did not have its own indemnity insurance. In addition, the anaesthetists in *Rapid Sequence* were not working on their own but were working as part of a team within the relevant NHS hospital. Medacy's pharmacists, on the other hand, are working and seeing patients alone.

59. Mr Hockey placed reliance on the decision in *City Fresh* but only to illustrate the fact that medical care services can be provided by a company and do not have to be provided directly by an individual medical practitioner.

HMRC's submissions

60. Miss McArdle submits that, following the Upper Tribunal decision in *Moher*, the key issue is who controls the individual who is providing the services. She noted however that it is important to look at other relevant issues such as the terms of any contracts, who is actually providing any medical care and whether there is any relationship between the person making the supply and the ultimate patient.

61. One factor which *Moher* makes it clear is irrelevant according to Miss McArdle is the employment status of the individual who is providing the services. The fact that the pharmacists are employees of Medacy does not therefore in her view have any impact on the nature of the supply made by Medacy.

62. Looking in more detail at what is meant by control, Miss McArdle argues that it is apparent from *Rapid Sequence* that this means day to day control in the sense of allocation of resources. As with the pharmacists, the anaesthetists in *Rapid Sequence* exercised their own professional judgement in carrying out their clinical services. However, the First-tier Tribunal drew attention to the fact that all of the administration was dealt with by the relevant NHS Trust which decided what work the locums should do on a day to day basis.

63. Miss McArdle also points out that the fact that Rapid Sequence got involved in certain performance issues was not enough to persuade the Tribunal that Rapid Sequence took responsibility for the actions of the doctors it provided.

64. Looking in more detail at who controls the pharmacists, Miss McArdle submits that it is clear that the GP practice has control over the day to day activities. In support of this, she referred to the following:

(1) The GP practice decides what services to buy. Although the practice may not discuss this with the pharmacist on a day to day basis, the key point is that the GP practice has identified in advance the services which it wants to receive.

(2) The protocols provided by Medacy require the pharmacist to defer to the GP practice in relation to certain aspects of the way in which the services are provided.

(3) The GP practice has the ability to request more hours and so can allocate more tasks.

(4) The evidence shows that it is the GP practices which allocate specific tasks and not Medacy. In this context, Miss McArdle referred to an exchange within the Medacy WhatsApp group in September 2018 where Caroline Pond (Medacy's Operations Director) asked their pharmacists how many tasks a day they were asked to perform and what the mix of tasks was. Miss McArdle argues that this clearly shows that Medacy were not even aware of the tasks which the pharmacists were carrying out, let alone had any input into the allocation of these tasks.

(5) As far as the WhatsApp group is concerned more generally, Miss McArdle says that this is just a way of providing technical support and is not evidence of any control or supervision being exercised by Medacy. In any event, she points out that it is clear from some of the WhatsApp exchanges that the pharmacists are in some circumstances advised to check with the relevant GP before a clinical decision is made.

(6) Turning to the email complaint, Miss McArdle suggests that this provides further evidence that the GP practices are in control of the allocation of tasks.

65. In relation to the email of complaint, there was some confusion over the precise circumstances but Miss McArdle suggested that the email indicated that, in relation to the particular GP practice, the services being provided related to cover for staff holiday/sickness rather than the provision of a new service.

66. Turning to the contract, Miss McArdle submits that this is clearly an agreement to supply staff to meet the practice's needs and not an agreement to provide the services themselves. Paragraph 2.1 of schedule 1, for example, specifically refers to Medacy procuring the attendance of one or more pharmacists at the practice in order to perform the clinical services set out in schedule 3. Schedule 3 goes on to describe the duties of the pharmacist; she argues that it is, in effect, just a job description and not a description of the services to be provided by Medacy.

67. All of this, says Miss McArdle, ties in with the marketing material which talks about meeting the needs of the GP practices, making life easier for the GPs, tailoring their services to their wishes and therefore giving them control over the services.

68. The review meetings with the practice are, in Miss McArdle's view, also consistent with a supply of staff rather than a supply of medical care services. The real purpose of these meetings is to check that the practice is happy with the particular individual provided. This is not dissimilar to the involvement by Rapid Sequence in performance issues which was rejected by the First-tier Tribunal as evidence of taking any responsibility for the actual services provided by the relevant individuals.

69. Miss McArdle also argues that it is irrelevant whether Medacy has its own medical malpractice insurance. She makes the point that, in *Rapid Sequence*, the anaesthetists had their own insurance and that this did not make any difference to the outcome.

70. Miss McArdle also does not accept that providing staff to do something new turns a supply of staff into a supply of services. In any event, she points out that many of the services being provided are not new but are simply being taken off the hands of the GPs and thus freeing up their time to do other things.

71. In summary, HMRC's case is that the key question is who has day to day control of the pharmacists, that it is clear that this rests with the GP practices and the GPs themselves and that this is consistent with the contract between Medacy and the GP practices and with their marketing materials. The supply is therefore a supply of staff and not a supply of medical care services.

Our decision

72. As Mr Hockey said whilst presenting Medacy's case, there is no bright line test which distinguishes between a supply of staff and a supply of services. Instead, we have to look at all of the relevant facts in order to determine the nature of the supply.

73. Bearing this in mind, it is inevitable that each case will turn on its own particular facts. As we have said, whilst we can draw some principles from the cases to which we have been referred as to how to approach our analysis, the facts of those cases do not provide any real assistance. *Moher* and *Rapid Sequence* clearly related to supplies of temporary staff with little or no control or supervision on the part of the person providing the staff. On the other hand, in *City Fresh*, the entirety of the services provided to the client had been sub-contracted to City Fresh.

74. It is clear to us that the supplies made by Medacy to the GP practices fall somewhere between these two extremes. There are factors which point both ways and which mean that the case is very close to the dividing line. On balance, we have come to the conclusion that it falls on the side of being a supply of services consisting in the provision of medical care (and therefore exempt from VAT) rather than being a standard rated supply of staff. We set out our reasons for this below.

75. Leaving to one side for a moment the question of control over the pharmacists, the way in which Medacy organises this part of its business and approaches each project has much more of a flavour of the provision of a service than the provision of a member of staff.

76. Medacy is proposing to GP practices an innovative way of using pharmaceutical care to make the practices more efficient and to benefit their patients. To this end, Medacy takes time to discuss with the GP practices what their needs are and what services will best help them. This is then turned into a bespoke proposal which results in agreed services to be provided.

77. The fact that the contract is based on a specific number of pharmacist hours and that Medacy is paid an hourly rate does not, in our view, detract from this being a supply of services as opposed to a supply of staff. It simply reflects the fact that the GP practice is working to a budget and that the budget will inevitably be reflected in the number of pharmacist hours which Medacy is prepared to devote to providing the agreed services.

78. We also consider that the fact that Medacy carries out regular onsite reviews with the practice indicates that it is providing a service rather than simply providing staff.

79. There was some inconsistency in the evidence as to the extent to which Medacy takes responsibility for the actions of its pharmacists. The contractual agreements make it clear that Medacy's responsibility is limited and that the GP practice should take out insurance in respect of the "activities envisaged" by the relevant agreement. It is not entirely clear what this means and, for example, whether it includes the clinical decisions taken by the pharmacists.

80. On the other hand, Mr Hockey's evidence was clear that the GP practices did not in fact have insurance which covered the activities of the pharmacists which is why Medacy has its own insurance.

81. Given the uncertainty of the wording of the contract, we accept on balance that, in this case, Medacy does have responsibility for the clinical decisions taken by its pharmacists. We can see no other reason why (in contrast to the position in *Rapid Sequence*) Medacy would otherwise spend a significant amount of money on medical malpractice insurance with a total cover of £5 million. As Mr Hockey pointed out, this would be unnecessary if Medacy was simply providing staff rather than providing a service.

82. The fact that an obligation is imposed on Medacy to meet certain targets in relation to key performance indicators also suggests that Medacy is ultimately taking responsibility for the activities of its pharmacists and the level of service which is being provided. It would not, for example, be expected where there is a supply of staff that the supplier would be responsible for ensuring that the individual dealt with a specific number of hospital discharge letters within a specific timescale. That would be something for the recipient of the staff member to deal with.

83. Medacy also has a senior team overseeing its clinical services business. In addition to Mr Hockey, there is an Operations Director and a Senior Pharmacist who oversee the services as well as various administrative staff. Again, if Medacy was only supplying staff, this level of senior oversight would be unnecessary.

84. Turning to control and supervision, there is no doubt in our minds that Medacy has much more involvement in what its pharmacists are doing and how they do it than was the case in either *Moher* or *Rapid Sequence*.

85. As in *Rapid Sequence*, the pharmacists are, generally speaking, exercising their own professional judgement when they make decisions about a patient's care. However, it is apparent from the WhatsApp group exchanges that if they need help and support in exercising that judgement or making those decisions, their first port of call is their colleagues at Medacy and not anybody within the relevant GP practice. Often the assistance from Medacy or its employees will resolve the issue.

86. Miss McArdle referred to one or two exchanges where the ultimate outcome was that the relevant issue should be referred to one of the GPs. Mr Hockey however explained that these were situations where clinical safety required a decision to be taken by a doctor. This is not evidence of control or supervision by the GPs but is more of an example of how Medacy and the GP practices interact in providing their respective services.

87. The existence of the suggested daily schedule, the on-boarding document for the pharmacists and the detailed protocols as to how the pharmacists should carry out certain tasks also show the significant involvement of Medacy in the work that the pharmacists are doing and, in particular, how they should do that work. The Tribunal noted in *Rapid Sequence* at [48] that Rapid Sequence did not exercise any measure of control over how the doctors performed

their services. Medacy on the other hand is quite prescriptive in its protocols as to how the core services should be provided.

88. Whilst Miss McArdle noted that there were elements of those protocols which required deference to the processes of the GP practice, this related only to a very small part of the processes outlined in the protocols and, in any event, can be explained by the need for Medacy and the GP practices to work together to ensure that there is a proper audit trail of the care provided to the patients using the systems adopted by the relevant GP practice.

89. Miss McArdle made much of the fact that Medacy's marketing material demonstrates that the aim of the service is to lighten the load of the GPs and to make their lives easier by providing services which they are able to choose. This, she says, gives the GP practices control over what the pharmacists do. In one sense this is true in that the pharmacists will only carry out those services which the GP practices have chosen. However, the fact is that there are two sides to the contract so that the GP practices have requested certain services and Medacy has agreed to provide them. The fact that the pharmacists will only do work which is within the scope of the agreement is not evidence of any control on the part of the GP practice over the work done by the pharmacists. It is just the result of the agreement they have reached with Medacy.

90. Miss McArdle has more of a point when it comes to the day to day allocation of tasks. It is clear from the evidence that work is passed to the pharmacists by the GP practice or by individual GPs. On the face of it, this is similar to the situation in *Rapid Sequence* where the Tribunal found as a matter of fact that, to the extent there was any day to day control over the doctors' activities, such control was exercised through the medical or administrative staff of the hospital concerned. However, whilst tasks may be passed on to the pharmacists by the GPs or by the GP practice, it seems to us inevitable given the nature of the services which Medacy has agreed to provide that this will be the case. It does not follow from this that Medacy is only providing staff rather than providing the underlying services.

91. Medacy has agreed to provide certain categories of service. In order to do this, the GPs and the GP practices must refer matters to the pharmacist which fall within the relevant categories. Medacy cannot allocate individual tasks as they are not theirs to allocate. However, unlike in *Rapid Sequence*, Medacy has a significant input into how the pharmacists structure their day in order to complete the relevant tasks and, in relation to the core services, into how those tasks are undertaken and completed.

92. It is recognised in *Rapid Sequence* at [48] that control does not just mean what the individual does but also how they do it.

93. Normally the terms of the contract between the supplier and the client would provide a clear indication of the nature of any supply. The problem in this case is that the contract is poorly drafted and contains internal inconsistencies. Some parts of the contract (for example, the background section and paragraph 2.2 of schedule 1) suggest that Medacy is supplying clinical services whilst other parts (such as paragraphs 2.1 and 4.1 of schedule 1) might be interpreted as an agreement to supply a pharmacist to work within the practice, particularly in the case of the contract entered into in March 2017.

94. Given these inconsistencies, the only way of making sense of the contract is to look at the way in which it is operated in practice. For the reasons set out above, our conclusion is that this is more consistent with Medacy providing medical services as opposed to supplying staff.

95. Miss McArdle specifically drew attention to the fact that the GP practices can request additional hours. We consider this factor to be neutral as it is consistent both with an agreement to supply staff and an agreement to supply services given that the extent of the services to be supplied is directly related to the budget which the GP practice has allocated and which in turn dictates how many pharmacist hours Medacy is willing to allocate to the provision of the services. If a GP practice is prepared to pay for more hours, Medacy can increase the level of service which it provides. This can however only be done if both the GP practice and Medacy agree.

96. Another specific provision in the contract which Miss McArdle relied on is the recruitment fee which is payable if a pharmacist becomes an employee of the GP practice. This, she says, is a classic provision in a contract for the supply of staff. Again, however, we consider this provision to be neutral. It is certainly consistent with an agreement for the supply of staff but it is equally consistent with an agreement for the supply of services. The bottom line is that Medacy does not want the GP practices poaching its staff or, at least, if they do, Medacy wishes to be compensated in some way.

97. As we said at the beginning of our discussion, there are factors in this case which point both ways. However, taking everything into account and looking at the picture as a whole, we are satisfied that Medacy's pharmacist led clinical services is a supply of services consisting in the provision of medical care within item 3 of group 7 of schedule 9 to Valued Added Tax Act 1994 and is therefore exempt from VAT.

RIGHT TO APPLY FOR PERMISSION TO APPEAL

98. This document contains full findings of fact and reasons for the decision. Any party dissatisfied with this decision has a right to apply for permission to appeal against it pursuant to Rule 39 of the Tribunal Procedure (First-tier Tribunal) (Tax Chamber) Rules 2009. The application must be received by this Tribunal not later than 56 days after this decision is sent to that party. The parties are referred to "Guidance to accompany a Decision from the First-tier Tribunal (Tax Chamber)" which accompanies and forms part of this decision notice.

ROBIN VOS
TRIBUNAL JUDGE

RELEASE DATE: 13 SEPTEMBER 2019