Neutral Citation: [2023] UKFTT 00547 (TC)

Case Number: TC08846

FIRST-TIER TRIBUNAL
TAX CHAMBER

Taylor House, London

Appeal reference: TC/2019/05352

VALUE ADDED TAX - Exemptions - Health and welfare - Principal VAT Directive 2006/112/EC Article 132 - VAT Act 1994 Sch 9 Group 7 - Whether services provided by cosmetic clinic were exempt? - No - Appeal dismissed

Heard on: 28-30 November 2022
Judgment date: 23 June 2023

Before

TRIBUNAL JUDGE CHRISTOPHER MCNALL
MR DUNCAN MCBRIDE

Between

ILLUMINATE SKIN CLINICS LTD

Appellant

and

THE COMMISSIONERS FOR HIS MAJESTY'S REVENUE AND CUSTOMS

Respondents

Representation:

For the Appellant: Melanie Hall KC, and Ciar McAndrew, both of Counsel, instructed by Campbell Dallas

For the Respondents: Paul Marks, a litigator of HM Revenue and Customs' Solicitor's Office.

DECISION

1. The Appellant runs a private (ie, non-NHS) clinic ('the Clinic') offering a range of aesthetic, skincare and wellness treatments. It advertises that its services include fat freezing, thread lifts, chemical peels, fillers, facials, intravenous drips and boosters.

2. This is our decision in relation to its appeal, made by way of an Appeal Notice dated 16 August 2019, against a decision of HMRC made on 3 April 2019 (following a visit on 13 February 2019), upheld at departmental review on 18 July 2019, that supplies made by the Appellant clinic during the period 12/16 were not exempt from VAT, and therefore (i) refusing the Appellant's claim (made on 9 February 2017) for a VAT credit in relation to period 12/16 and (ii) raising a best judgment assessment for underpaid output tax.

3. HMRC's position is that all the Clinic's supplies should have been standard rated.

4. The Grounds of Appeal accept that "where there is no medical purpose behind a treatment, and it is carried out for purely cosmetic purposes, the supply is taxable", but go on to say "however such treatments are not routinely carried out by the business, and any turnover from such cosmetic procedures are therefore comfortably below the threshold required for VAT registration. [The] business is therefore, at best, partially exempt, and not wholly taxable ... and therefore [not] liable to register and account for VAT."

5. The Appellant was registered for VAT on 29 August 2014, was deregistered on 2 May 2017, and has not subsequently re-registered.

THE LAW

6. Item 1 of Group 7 of Schedule 9 of the VAT Act 1994 ('Item 1') exempts:

> "The supply of services consisting in the provision of medical care by a person registered or enrolled in any of the following:
>
> (i) The register of medical practitioners."

7. Item 4 of Group 7 of Schedule 9 ('Item 4') exempts:

> "The provision of care or medical or surgical treatment and, in connection with it, the supply of any goods, in any hospital or state-regulated institution".

8. Before us, there was dispute as to whether the Appeal concerned only Item 1, or extended to Item 4:

> (1) In her opening submissions, and in response to a question from the Tribunal, Ms Hall KC remarked that "since the concept of medical care referred to in Item 1 and Item 4 is the same", then the submissions as to "medical care" which she was to make in relation to the scope of Item 1 should apply equally to Item 4. However, she also pointed out that, "so far as material to this appeal, the only relevant difference is that Item 4 also permits exemption for closely related activity". Item 4 was therefore, from the Appellant's point of view, in issue, but as "a contingent alternative case";
>
> (2) HMRC's Skeleton Argument proceeds only on the basis of Item 1, because, "for the purposes of this appeal, the Clinic was not regulated by the CQC for the period under appeal". That factual proposition is correct, because the appellant was not registered with the CQC until 13 August 2018.

9. Whether the scope of this appeal does actually extend beyond Item 1 to Item 4 must therefore be resolved.

10. In our view, this dispute is to be resolved only with reference to Item 1:

(1) The principal focus should be on the Grounds of Appeal. These do not identify either Item, but assert that the services "were carried out by a registered medical professional". That can only be read as a reference to Item 1. There is nothing which can be read, even inferentially, as a reference to Item 4;

(2) The Grounds of Appeal reflect the Appellant's representatives' letter of 27 April 2018 which only makes reference to Item 1;

(3) This Tribunal decides actual disputes, not hypothetical ones. The scope of the dispute has to be governed by the actual scope of the decision, and that is one for 12/16;

(4) Given that Item 4, as a matter of fact, was incapable of application to the Clinic in relation to period 12/16, then Item 4 cannot be engaged in relation to period 12/16.

11. In consequence, if this appeal is decided adversely to the appellant in relation to Item 1, then its appeal must be dismissed.

12. Any comments which we make in relation to Item 4 will therefore be non-binding, but perhaps of assistance to the parties in resolving any issues which may arise in relation to other periods which are not the subject matter of this dispute.

13. In relation to Item 1, the scope of the dispute is a narrow one. During ADR, the parties agreed that the Appellant's sole director and shareholder, Dr Shotter, complies with Item 1 in terms of qualifications (ie, she is on the register of medical professionals). As such, the only point in dispute is whether those supplies constitute "medical care" within the proper meaning and effect of the legislation: see Paragraph 15(b) of the Appellant's Outline of the Case.

14. In relation to Item 4, and at this point solely for the sake of completeness, we note that, at their Alternative Dispute Resolution appointment, the parties agreed that, for the purposes of Item 4, the clinic is CQC registered (ie, that is a state-regulated institution).

15. Group 7 of Schedule 9 is intended to incorporate the provisions of Article 132 of the Principal VAT Directive ('the PVD') into domestic legislation, and we are invited to interpret Items 1 and 4 compatibly with Article 132(1)(c) of the PVD.

16. Article 132 of the PVD captures "Exemptions for certain activities in the public interest". Article 132 is subject to Article 131, which stipulates that Article 132 (inter alia) shall apply "in accordance with conditions which the Member States shall lay down for the purposes of ensuring the correct and straightforward application of those exemptions and of preventing any possible evasion, avoidance, or abuse".

17. In relation to Article 132(1)(c), and Item 1, on 9 December 2022, the Court of Appeal handed down its reserved decision in *Mainpay Ltd v HMRC* [2022] EWCA Civ 1620. Whipple LJ (with whom Green and Nugee LJJ agreed) helpfully set out the legal framework (at Paras [5]-[8])) in the following terms:

> "Legal Framework
>
> "The Directive
>
> The PVD replaced the Sixth VAT Directive (77/388/EC) ("Sixth Directive"). Article 132(1) of the PVD (previously Article 13A(1) of the Sixth Directive) provides for exemption from VAT of certain supplies. Mainpay no longer seeks to rely on limb (b) of Article 132(1), which relates to medical services provided in a hospital setting by a

body governed by public law (which it is not). Mainpay now relies only on limb (c) of Article 132(1), which relates to non-hospital medical services:

> "1. Member States shall exempt the following transactions:
> …
> (c) the provision of medical care in the exercise of the medical and paramedical professions as defined by the Member State concerned…."

[...]

Domestic Legislation

Section 4(1) VATA provides that VAT is charged on any supply made in the United Kingdom which is a taxable supply. Section 4(2) provides that a taxable supply is any supply which is not an exempt supply.

Effect is given to the exemptions at Article 132(1) by Group 7, Schedule 9 to VATA.

Although there was discussion of Item 4 of Group 7 at earlier stages, it is now accepted that Item 4 adds nothing and that this appeal hinges on Item 1 which exempts from VAT supplies which fall within the following description:

> "1. The supply of services consisting in the provision of medical care by a person registered or enrolled in any of the following—
> (a) the register of medical practitioners; …".

18. At Para [61], the Court of Appeal said:

"**Meaning of Medical Care**

The FTT considered a number of cases relating to medical care for the purposes of Article 132(1)(b) and (c) at FTT [10]-[17]. The UT encapsulated much of that case law in a series of propositions set out at UT [89]. No challenge is raised to the content of any of those paragraphs, which accurately set out the law. Indeed, by his helpful note produced for the Court, Mr Firth echoes much of what the FTT and UT said in these paragraphs.

But Mainpay's arguments have moved on; before I turn to them, I record three basic propositions of law which are not in dispute:

i) First, the exemptions constitute independent concepts of community law which must be placed in the general context of the common system of VAT (Kügler [25]).

ii) Secondly, the exemptions are to be interpreted strictly (but not restrictively) since they constitute exceptions to the general principle of taxation (Kügler [28]).

iii) Thirdly, the analysis of what is being supplied depends, in any given case, on economic realities of the transaction, that being a "fundamental criterion" for the application of the common system of VAT (see Airtours Holiday Transport Ltd v HMRC [2016] UKSC 21; [2016] 4 WLR 87 at [48], citing Case C-53/09 and C-55/09 Revenue and Customs Commissioners v Loyalty Management UK Ltd and Baxi

Ltd [2010] ECR I-9187; [2010] STC 2651 at [39]-[40]); the contracts are the most useful starting point in that exercise, but not necessarily the end point: see WHA Ltd v Revenue and Customs Commissioners [2013] UKSC 24; [2013] 2 All ER 907. The UT recognised this approach in terms at UT [96], see paragraph 33 above, and their encapsulation of the approach was not subject to any challenge in this appeal."

19. The Upper Tribunal decision is reported at [2021] UKUT 0270 (TCC). It is a decision of Mellor J and Judge Guy Brannan. At [89]-[90] (with Paragraph [89] having been expressly approved by the Court of Appeal) the Upper Tribunal said:

" 89. The scope of the exemptions for medical care contained in Article 132(1)(b) and (c) of the Directive (and its predecessor Article 13A(1)(b) and (c) of the Sixth Directive) have been the subject of a number of decisions by the CJEU. The main principles can be summarised as follows:

(1) The exemptions envisaged in Article 13 of the Sixth Directive are to be interpreted strictly since they constitute exceptions to the general principle that VAT is to be levied on all services supplied for consideration by a taxable person: e.g. Kügler C-141/00 (“ Kügler”) at [35].

(2) Those exemptions constitute independent concepts of Community law whose purpose is to avoid divergences in the application of the VAT system from one Member State to another (Card Protection Plan C-349/96 at [15], Commission v France C-76/99 at [21] and Kügler at [52]).

(3) As regards the place where the services must be supplied, in contrast to Article 132(1)(b) which concerns services encompassing a whole range of medical care normally provided on a non-profit-making basis in establishments pursuing social purposes such as the protection of human health, Article 132(1)(c) applies to services provided outside hospitals and similar establishments and within the framework of a confidential relationship between the patient and the person providing the care, a relationship which is normally established in the consulting room of that person: Kügler at [35] and EC Commission v United Kingdom C-353/85 at [33];

(4) Article 132(1)(b) and (c) have separate fields of application and are intended to regulate all exemptions of medical services in the strict sense. Article 132(1)(b) exempts all services supplied in a hospital environment while Article 132(1)(c) is designed to exempt medical services provided outside such a framework, both at the private address of the person providing the care and at the patient's home or at any other place: Kügler at [36];

(5) The application of Article 132(1)(c) is not dependent on the legal form of the person supplying the medical care. Thus, a limited company supplying medical care through medically qualified staff fell within the exemption: Kügler at [41];

(6) The concept of 'provision of medical care' does not lend itself to an interpretation which includes medical interventions carried out for a purpose other than that of diagnosing, treating and, in so far as possible, curing diseases or health disorders: W v D C-384/98 at [18].

(7) Although the provision of medical care must have a therapeutic aim, it does not necessarily follow that the therapeutic purpose of a service must be confined within an especially narrow compass. Thus, medical services effected for prophylactic purposes may benefit from the exemption under Article 132(1)(c). Even in cases where it is clear that the persons who are the subject of examinations or other medical interventions of a prophylactic nature are not suffering from any disease or health disorder, the inclusion of those services within the meaning of provision of medical care is consistent with the objective of reducing the cost of health care, which is common to both the exemption under Article 132(1)(b) and that under (c) of that Article: d'Ambrumenil C-307/01 ("d'Ambrumenil") at [58].

(8) It is the purpose of a medical service which determines whether it should be exempt from VAT. Therefore, if the context in which a medical service is effected enables it to be established that its principal purpose is not the protection, including the maintenance or restoration, of health but rather the provision of advice required prior to the taking of a decision with legal consequences, the exemption under Article 132(1)(c) does not apply to the service: d'Ambrumenil at [60].

(9) Article 132(1)(b) does not include any definition of the concept of activities 'closely related to hospital and medical care'. That concept does not, however, call for an especially narrow interpretation since the exemption of activities closely related to hospital and medical care is designed to ensure that the benefits flowing from such care are not hindered by the increased costs of providing it that would follow if it, or closely related activities, were subject to VAT: Commission v France C-76/99 at [22]-[23].

(10) The provision of medical care which does not meet all the requirements laid down in order to benefit from the exemption from VAT under Article 132(1)(b) is not, as a matter of principle, excluded from the exemption laid down in Article 132(1)(c). It is not apparent from the wording of Article 132(1)(b) that that provision is intended to limit the scope of Article 132(1)(c). Article 132(1)(b) covers all services supplied in a hospital environment while Article 132(1)(c) covers services provided outside such a framework, both at the private address of the person providing the care and at the patient's home or at any other place, in the context of the exercise of medical and paramedical professions as defined by the Member States: Peters C-700/17 at [21], [27] and [28].

90. As regards the exemption contained in Article 132(1)(b), it is clear to us that the supply which is exempted is that made by ("*undertaken by*") a body governed by public law (or under social conditions comparable with those applicable to bodies governed by public law) by other bodies which are hospitals, centres for medical treatment or diagnosis and other duly recognised establishments of a similar nature."

20. At Para [63] of *Mainpay*, the Court of Appeal rejected the taxpayer's proposition, said to be founded on Paragraph 27 of *Kügler*, and its description of the scope of the medical exemption, that mere involvement in medical services by qualified personnel is sufficient to qualify for exemption.

21. At Para [66] the Court of Appeal remarked that a "narrow approach, permitting exemption only to apply to a supply of services which are, in and of themselves, within the definition of medical care, is consistent with the principle that exemptions are to be construed strictly as exceptions to the general rule [...] and that words of extension cannot be read in (see eg Case C-366/12 Finanzamt Dortmund-West v Klinikum Dortmund GmbH [...])".

22. At Para [67], the Court said that "medical" care means "diagnosing, treating and, in so far as possible, curing diseases or health disorders" and (at Para [69]) concluded that "the supply in question must be of medical care, coming within the established meaning of that term [...]which requires that the services have a therapeutic aim, that they consist of the diagnosis, treatment or cure of disease or ill-health."

23. Given that the decision in *Mainpay* was not handed down until after we had heard this appeal, we subsequently invited both parties to make written submissions as to what, if anything, should be derived by us from *Mainpay*. Both parties made helpful submissions.

24. Both parties pointed out that the factual issues in *Mainpay* - a case concerning the provision of staff to the NHS and whether this supply of staff was an exempt supply of medical care - were somewhat different from those which we were called upon to consider (with the parties differing as to how different from this case the facts really were). However, it does not seem to us that the approach to the law adopted by the Court of Appeal (and the Upper Tribunal) in *Mainpay* was one which was limited to *Mainpay's* facts. It seems to us that the legal guidance articulated was intended by both appellate jurisdictions - the Court of Appeal and the Upper Tribunal before it - to be of general application. Hence, a precise dissection of the factual differences between the present appeal and *Mainpay* is an unproductive exercise.

25. The Appellant accepted that *Mainpay* is of general relevance to the present appeal, "because it reaffirms well-established principles which govern the scope of the medical care exemption and upon which the Appellant relies".

26. The Appellant also expressly agreed with and adopted the reasoning in Paragraphs 76 and 78 of the Court of Appeal's judgment, and submitted that the question of whether the medical care exemption is engaged in any given case will turn on the particular facts.

27. We agree. Those paragraphs of the Court of Appeal's decision endorse (unsurprisingly) a decision-making approach which should be informed by a strong focus on the facts of the case. The Court of Appeal accepted a submission that the outcome of many of the reported decisions can be seen to have been influenced by the particular facts, judged (as the Court of Appeal said) "through the lens of commercial and economic reality" so as to determine whether the appellant is making supplies of medical care or not.

28. We are bound by the Court of Appeal's analysis of Item 1 (as well as, so far as adopted by the Court of Appeal, the Upper Tribunal's analysis). We remind ourselves that we (as a fact-finding Tribunal) must focus on the facts, and that, as part of our overall evaluative exercise, we should not forget to look at the facts through the lens of commercial and economic reality (which is an approach regularly encountered in relation to VAT). That is what we have done.

29. Besides *Mainpay*, further binding guidance on the correct approach to exemptions in general was articulated by the Court of Appeal in *Expert Witness Institute v Customs and Excise Commissioners* [2001] EWCA Civ 1882; [2002] 1 WLR 1674 at Para [17] (Chadwick LJ, with whom Longmore LJ and Harrison J agreed), which was subsequently approved by the Court of Appeal (Longmore, Etherton and Pitchford LJJ) in *HMRC v Insurancewide.com Services Ltd* [2010] EWCA Civ 422) at Para [83]:

> Before leaving the case law, it is important to comment on the proper application of the numerous statements in the European cases, some of which are cited above, that the

exemption in Article 13B(a), like the other exemptions in Article 13, should be interpreted strictly since it constitutes an exception to the general principle that turnover tax is levied on all services supplied for a consideration to a taxable person. As Advocate General Fennelly said, in paragraph 24 of his opinion in *Card Protection*, this does not mean that a particularly narrow interpretation will be given to the terms of an exemption. As Chadwick LJ said in *Expert Witness Institute v Customs and Excise Commissioners* [2001] EWCA Civ 1882, [2002] STC 42 at paragraph [17], the Court is not required to give the words in the exemption the most restricted, or most narrow, meaning that can be given to them. I agree with his observation, in paragraph [17] of his judgment, that:

> "A 'strict' construction is not to be equated, in this context, with a restricted construction. The court must recognise that it is for a supplier, whose supplies would otherwise be taxable, to establish that it comes within the exemption, so that if the court is left in doubt whether a fair interpretation of the words of the exemption covers the supplies in question, the claim to the exemption must be rejected. But the court is not required to reject a claim which does come within a fair interpretation of the words of the exemption because there is another, more restricted, meaning of the words which would exclude the supplies in question."

30. We apply that guidance.

31. Finally, the scope of Items 1 and 4 have been considered by this Tribunal on at least three occasions over the last decade or so: (in date order) *Ultralase Medical Aesthetics Ltd v HMRC* [2009] UKFTT 187 (TC) (Judge David Porter and Ms Ann Christian); *Skin Rich Ltd v HMRC* [2019] UKFTT 0514 (TC) (Judge Jeannette Zaman and Mrs Rayna Dean); *Window to the Womb (Franchise) Ltd v HMRC* [2020] UKFTT 201 (TC) (Judge Jonathan Cannan).

32. In *Ultralase* the taxpayer provided surgical and cosmetic treatments for patients in hospitals and in its own private clinics. Most of the treatments were cosmetic, based around enhancing a patient's appearance, such as face lifts, hair removal and anti-cellulite treatment. It was held that the relevant test was the purpose for which the supplies were made. If cosmetic intervention was required in circumstances where it did assist 'health disorders', then, the Tribunal held, that assistance should be available in a hospital and so ought to be exempt. The appeal was allowed in part.

33. In *Skin Rich* the taxpayer supplied Botox treatments and dermal fillers (together characterised as 'injectables') and nail fungus treatment (done using a medical-grade laser) at a skin culture and aesthetics clinic. Those were not exempt, because they were not carried out for a principal purpose of diagnosing, treating, and, so far as possible, curing diseases or health disorders. The injectables were given as an end in themselves, and were not given as ancillary to another (medical or surgical) treatment. But, at Paragraph 126, the Tribunal remarked:

> "We were not satisfied that the principal purpose of the Injectable treatments was not cosmetic. However, where they were administered by trained practitioners to improve a client's appearance and make them feel better about themselves, we conclude that such a treatment is of a medical nature and can comprise "care" within Item 4."

34. *Window to the Womb* concerned packages of ultrasound scans for pregnant women in the 16-40 week gestation period. Packages included a "Well-being scan", which provided confirmation of single/multiple pregnancy, heartbeat check, detection of some abnormalities, growth check, position of baby and placenta, and a well-being report. All franchisees were registered with the CQC to carry out a 'regulated activity' at specified premises and were

required to use qualified sonographers registered with the Health and Care Professions Council. The scans were carried out in addition to NHS scans and were not clinically indicated.

35. The Tribunal held that the question was, looking at the supply, whether the principal purpose for which a typical customer purchased a scan package was the diagnosis, monitoring, treatment or prevention of illness. That was the case in relation to the different packages of scans, which were not just reassurance, but were the women herself choosing to monitor her medical condition. The supplies were exempt.

36. None of the First-tier Tribunal decisions are formally binding on us, but should be taken into account. They traverse similar ground, albeit with differing levels of intensity. We have found the more recent discussions in *Skin Rich* and *Window to the Womb* more helpful than the significantly earlier discussion in *Ultralase*.

THE EVIDENCE

37. We were provided with a hearing bundle of documents coming to 1241 pages, as well as some information after the hearing about the Appellant's CQC status.

38. We also read and considered an additional document, being the report of the House of Commons Health and Social Care Committee, published on 2 August 2022 (HC 114), on "The impact of body image on mental and physical health".

39. The first day and a half of the hearing were occupied with submissions as to the appropriate law. The only witness from whom we heard was Dr Sophie Shotter, who is the Appellant's founder, sole statutory director, owner and medical director.

40. We heard from her on the afternoon of the second day. It is a matter simply to record that the overall balance of the hearing - half a day's evidence from the one and only witness book-ended by two and a half days of submissions (in relation to an authorities bundle containing 19 decisions of the Court of Justice of the European Union, two decisions of the superior courts of record, and three of the First-tier Tribunal) does not at first blush reflect the fact that this Tribunal is a fact-finding jurisdiction, and the parties seemed in broad agreement that our task was to apply the relevant legal tests to the facts as found.

THE BURDEN AND STANDARD OF PROOF

41. The Appellant bears the burden of establishing that it qualifies for the exemption.

42. In relation to disputed matters, the standard of proof is the usual civil standard - namely, the balance of probabilities, or whether something is likelier than not.

THE FACTS

43. On the basis of the evidence which we have read and heard, we make the following findings of fact as to relevant matters. We will make and discuss some other findings of fact in our Discussion section.

44. Dr Shotter qualified as a doctor and is registered with the GMC. She was training to become an anaesthetist, and passed the primary exams for admission to the Fellowship of the Royal College of Anaesthetists. But in about 2012, she decided to focus on what she terms 'aesthetic medicine'. A lot of this concerns Botox (which is a proprietary name for botulinum toxin, and which we simply use as shorthand) and 'fillers'. In April 2013, she attended a course on Botulinum Toxin and Dermal Filler materials offered by a body called 'Cosmetic Courses'. She has a postgraduate diploma in aesthetic medicine from Queen Mary University London.

45. She began practising as what she calls 'an aesthetic doctor'. Initially, she treated patients from her own home, as well as offering treatments from three beauty salons. During this period, she was a sole trader, trading as 'Adaptive Aesthetic Medicine'.

46. She was not satisfied with the working environment in those salons, and wanted to operate from dedicated premises of her own.

47. Between 2012 and 2014 she was combining this work with her work in the NHS. But in 2014, she left the NHS and established the Appellant.

48. She has continued her professional development in the aesthetic sphere, and is studying for a postgraduate diploma in clinical dermatology, and is a full member and trustee of the British College of Aesthetic Medicine.

49. Doing the best that we can, on the basis of the Appellant's accountant's letter of 17 March 2017, the following treatments were being offered in March 2017, and we have worked on the basis that they were also being offered in period 12/16:

(1) Botox

(2) Dermal fillers

(3) CoolSculpting

(4) Microsclerotherapy (for thread veins on the body)

(5) Prescription skincare

(6) Chemical peels

(7) Microdermabrasion

(8) Thread lifting

(9) Thermavein (for facial thread veins and removal of skintags etc)

(10) Aqualyx

(11) Platelet-rich plasma treatment.

50. The accountant's letter is to the effect that all these supplies should have been exempt.

51. Other services were being offered, but these were described in that letter as "Vatable" (by which we take it to mean, standard-rated):

(1) Environ retail skincare

(2) Environ facials

(3) Jane Iredale make-up.

52. Since 12/16, the Appellant has diversified to other treatments: private GP services (since March 2020) and nutritional services (since early 2021). We all not called upon to consider those.

53. Until 2017, Dr Shotter was carrying out all the treatments herself.

54. In October 2016, Dr Shotter saw about 55 patients.

55. Although treatment was not generally administered at the first appointment, it was sometimes.

56. A client is able to come to the clinic and be treated on the first occasion, without any 'cooling-off' period. This is what is recording in the clinical notes as having happened to a patient who was treated with Aqualyx for a double-chin, and Dr Shotter said in her oral evidence that there had been instances, although "several years ago", when she had treated patients at the initial consultation.

57. At least some of the treatment is 'client-led', in the sense that it is possible for a client to specify the treatment that they want, and, even after discussion of the risks and benefits, to insist on it being undertaken. This is what happened in April 2016 when a patient came to the clinic complaining that they were suffering from fibromyalgia (ie, suffering from something already diagnosed by somebody else), and had read of the benefits of B vitamins. The clear inference is that B vitamins were what they wanted, and B vitamins is what the treatment plan said they were going to get. It is also what happened in October 2016, when a patient came to the clinic complaining that her lines and wrinkles had not disappeared completely, but insisted on going ahead with Botox despite being warned that more Botox was "likely to cause a relatively 'frozen' look".

58. The clinic does not routinely write to a client's GP afterwards to say that a client had been to see them, and to explain what had been done. That only happens when someone has a health condition which might be managed by their GP, and if the client gives permission.

59. The overwhelming majority of the clinic's clients - about 85-90% - identify as women. Most of its clients are in their mid-thirties or above. The clinic is not licensed to treat under 18s.

60. Beginning on 13 August 2018, the Appellant was registered with the Care Quality Commission in relation to a series of premises.

61. Since September 2018, the Clinic has operated in a suite of rooms in a business centre. It works by appointment only.

62. The Clinic was inspected by the CQC on 5 October 2020, and was rated as "Good" in terms of being "Safe", "Effective", "Caring", "Responsive" and "Well-led" at "Caring for adults over 65 years" and "Caring for adults under 65 years" (latterly, these were varied to include "Treatment of disease, disorder or injury"; "surgical procedures"; and "diagnostic and screening procedures".

DISCUSSION

Item 1

63. Dr Shotter holds a number of medical degrees, beginning with an MBChB in medicine and surgery from the University of Leeds. HMRC accept that Dr Shotter is a skilled and ethical professional. We agree. She is committed to her work and the business which she directs. She is a determined and competent business person. She established the Appellant, has applied a clear-eyed business vision to it, and has been the driver of its growth and success.

64. But we have no hesitation in deciding that the services which the Appellant offers are not exempt within the proper meaning and effect of the legislation.

65. We do not accept that what is being done is "diagnosing, treating and, in so far as possible, curing diseases or health disorders".

66. According to the Oxford English Dictionary, "diagnosis" is "determination of the nature of a diseased condition; identification of a disease by careful investigation of its symptoms and history; also, the opinion (formally stated) resulting from such investigation."

67. There is very little evidence of diagnosis in the above sense. Diagnosis in the above sense did not invariably take place even in relation to the small number of clients for whom we were provided with details.

68. The weight of the evidence - written and oral - is that people are not using the Appellant's services because of diagnoses - arrived at following careful investigation of symptoms and history, by an appropriately qualified medical practitioner, in an appropriate setting - but rather simply because they want to use the Appellant's services.

69. Put differently, the catalyst for use of the Appellant's services is not "diagnosis", but is something else instead. Although we perhaps do not need to go further, the evidence is that people are actuated to use the Appellant's services because they want to - not because they are encouraged to do so by a medical practitioner.

70. This is very important to the overall analysis because diagnosis is the starting point of medical care, and the backdrop against which medical treatment takes place. Without diagnosis, "treatment", in the sense captured by the exemption, is not something which is being done responsively to a disease or a health disorder. It is an activity which is being done 'untethered' from an anterior diagnosis.

71. Although some assertions were made in her oral evidence by Dr Shotter which, it is fair to say, cannot be corroborated by contemporary documents in evidence - see below - we do not consider that her evidence was given untruthfully. It is simply that it cannot be corroborated, albeit in circumstances where corroborative evidence could, almost certainly, have been provided. This weakens the evidence in support of the appeal overall. However, it does not tend to any conclusion that Dr Shotter was not a truthful witness, and it is important to note that we were not invited by HMRC to arrive at any such conclusion. In our view, Dr Shotter was a truthful witness, but her evidence was, in our impression, extensively affected by an over-emphasis on a characterisation of her clinic's work so as to support the Appellant's appeal.

72. As part of the overall analysis, there are significant problems with the documentary evidence, and these weaken the Appellant's case overall.

73. Firstly, there is a selectivity to the documentary evidence which we have been shown. We have seen only a small sample of documents relating to a small sample of patients for 12/16.

74. HMRC were critical - both in the review letter, their Statement of Case, and the hearing - of the relatively small volume of documents provided. However, ultimately, we do not consider this criticism to be entirely well-founded. At ADR in January 2020, the parties agreed that HMRC were to conduct a further site visit to inspect a sample of records for one month in each year of review - namely, 2016-2019 inclusive - with each such month to be a representative period, and to include "a broad spectrum of treatments", and Dr Shotter was to provide statements "by up to 5 long-standing patients" which did not need to be part of that sample. Records were provided for October 2016, April 2017, July 2018, and September 2019, and HMRC chose a sample. In December 2020, HMRC chose a sample consisting of every 8th treatment where possible, "or the next one down if the value is less than £150 or if it is a duplicate of a previous supply". HMRC also chose a few instances which HMRC considered to be unusual; or with a high value.

75. We are not conducting a regulatory audit of the Appellant's business, and proportionality may well have a part to play in a case of this kind.

76. But, and on the other hand, the Appellant controlled the evidence which it wished to place before the Tribunal. The Appellant bears the burden, and the Directions were that the Appellant was to disclose all documents upon which it intended to rely.

77. We have worked on the simplest basis, which is that the documents relating to 12/16, taken as a sample, are genuinely representative of the overall work in 12/16.

78. The second problem is that the written evidence which we have seen, even taken as a representative sample, is quite sparse and unrevealing in content, especially in terms of corroborating the Appellant's core position that the primary purpose was the protection, maintenance or restoration of the health of the person concerned.

79. Whilst the written evidence does not, on its own, determine the appeal, and has not done so here, it is nonetheless an important part of the evidence, especially in circumstances such as these where it is reasonable to suppose that written evidence would be kept. We must take this written evidence as we find it, and consider its weight, and the extent to which it discharges the Appellant's burden.

80. We reject the Appellant's arguments, made by its accountants in their letter of 1 May 2019, that the quality of the Appellant's evidence is either:

> (1) HMRC's fault, because HMRC has not given specific guidance to taxpayers as to what it deems necessary in terms of records to evidence exemption; or
>
> (2) Is an artefact of Dr Shotter having worked for the NHS, in "a fast-paced environment .. [which] means writing the minimum in terms of details on the patient, and more about the treatment plan. This is especially true where the patient is often re-attending in a private clinic setting, as the practitioner gets to know the patient more intimately and does not feel the need to write certain information down, even where they know it and it informs their diagnosis. This is certainly the case with Dr Shotter ...".

81. With respect, neither argument is viable. In relation to (1), and apart from bare assertion, no-one, including the author of the letter, has sought to identify the source of any such obligation on HMRC, breach of which would entitle an appellant to some 'benefit of the doubt' exemption. (2) is not evidence at all, and is not supported by the evidence which we heard.

82. We agree with HMRC that evidence as to a referral from a doctor or other medical practitioner, notes including evidence of diagnosis, the full treatment or healthcare plan considered, would all be potentially capable of supporting a claim to an exemption. Conversely, absence of these things, especially where they might be expected to exist, undermines the strength of a claim to an exemption, which is the taxpayer's claim to establish.

83. For present purposes, the important documents are the records from the latter part of 2016. Those were contemporary and completed by Dr Shotter at the time. They are good evidence of what was being done, and why.

84. A "Medical History" would be taken, including questions about "Has your appearance ever caused you to lose confidence" and "Have you ever been depressed about your appearance".

85. An A4 page records the "Initial Consultation". It records 5 things: the patient's age; "Patient Concerns"; "Examination"; "Diagnosis"; and "Plan".

86. By way of example, two such "Initial Consultations" read, in full, as follows:

Initial Consultation 1

Age:	[redacted]
Patient Concerns:	Recently treated for breast cancer - surgery and chemo. Chemo has heavily caused facial ageing.
Examination:	Fine lines and wrinkles to upper face. Lower face is heavy and loose skin.
Diagnosis:	Collagen loss secondary to chemo.
Plan:	1. 2ml Volume and Vycross to midface to lift and stimulate collagen. 2. 3 areas Botox.

Initial Consultation 2

Age:	[redacted]

Patient Concerns: Skin crepiness. Neck - so loose that wattle touches chest. Very upsetting. Excess far on arms and abdomen despite weight loss, with skin laxity on top.
Examination: Neck - very severe sagging. Solar elestosis ++ to face. Subcutaneous fat layer is very grabbable.
Diagnosis: Collagen loss. Excess fat.
Plan: 1. Aqualyx under chin
2. CoolSculpting x 8 cycles to arms and stomach
3. Facial volumesetion to stimulate collagen.

87. The "Diagnosis" sections on the various forms which we have seen read collagen loss; excess fat; atrophic scarring; verrucae; filamestous wart; tension headaches; solar elestosis; facial asymmetry; skin excess; volume loss.

88. These capture the scope of the Appellant's work in this period and give a clearer, more reliable, insight into the work of the clinic. None of these are diagnoses of any recognised health disorder.

89. They are very cursory documents. They could not properly be described as scientific documents. It is conspicuous that, apart from age, and except for a very few exceptions, neither they (nor the so-called "Medical History") record anything about the patient's physical attributes such as height, weight, or any measurements at all such as blood pressure. They do not record the administration of any tests. There is nothing in the notes to suggest that any of the patients had been referred to the Appellant by another doctor, or for diagnosis of a particular condition. There is nothing in the notes to suggest that the Appellant was minded to refer the patient to another professional.

90. In terms of diagnosis, there is no reference to the International Classification of Diseases (ICD) codes, released by the World Health Organisation (WHO), which were already extant in 2012 (ICD 10). Dr Shotter's evidence was that she only started to do this "in the context of explaining myself to HMRC". We cannot make any findings as to whether a record in (for example) a GP surgery or a hospital would have used such codes before (say) 2019, but simply note that this was not something which Dr Shotter did until HMRC's interest in the Clinic.

91. The scope and intensity of the Initial Consultation undertaken by the Appellant can usefully be set alongside and measured against the letter to Dr Shotter from a Consultant Vascular Surgeon in October 2015, in relation to a referral made to him by Dr Shotter for a patient complaining of bilateral thread veins. The consultant's letter is very different in tone and content from the Appellant's documents. In contrast to the tenor of the Appellant's notes, the consultant records the appearance of the veins ("mixed in colour"); their persistence; leg ache; absence of bleeding, ulceration or phlebitis; risk factors (there, a standing occupation and two pregnancies, previous liposuction, and a previous operation on a cruciate ligament); surgical history; allergies; physical examination, not only of the patient's legs, but her arms and ankles; the administration of a hand-held "Doppler" test ('which did not yield reflux at any of the standard saphenous sites); a conclusion that the patient could have further thread vein treatment, albeit that this would likely yield only temporary benefit.

92. We regard the Appellant's contemporary Initial Consultation diagnoses as an evidentially more reliable record than the spreadsheet subsequently populated and provided. So, for patient 702, treated on 15 October 2016 with Thermavein, the correct picture, as recorded at the time, was "Loss of collagen and elastin; Atrophic scarring; and verrucae'; and was not "Multiplae haemangiomas. Self conscious of appearance of these". The contemporary Initial Consultation form made no reference to the patient being self-conscious of anything. Nor did the Treatment

Note (which recorded "[Patient] very happy with progress of Thermavein treatments. Now significantly less lesions, but is keen to be rid of all lesions that he notices").

93. We disregard the entire right-hand column of the later spreadsheet which, under "Medical diagnoses" and almost without exception, refers to things such as "severe anxiety"; "loss of confidence'; or "self-conscious appearance". Those were not diagnoses which were noted at the time. They have been advanced, after the event, in what can best be described as an interpretative way.

94. The "Initial Consultation" record is also generally followed by a "Treatment Record". This is an A4 page with a diagrammatic record of (for example) an injection site.

95. As Dr Shotter told us, the template had either been supplied by a pharmaceutical company or was a stock image taken from Google. It was no more than a basic aide-memoire of what had been done. There are no measurements, nor any indication of the underlying anatomy, including the musculature or the location of facial nerves. For us, these (as well as the consultant's letter discussed above) captured some of what we consider to be a qualitative difference between attending this clinic for cosmetic treatment and going to see a GP or a consultant.

96. Looked at in terms of its documentary product, and objectively speaking, we would not describe the clinic as a healthcare setting, or its activities as healthcare activities.

97. We do not consider that there is much of evidential value to be gained from challenge or consideration whether Dr Shotter was or was not complying with the document "Good medical practice" issued by the GMC. We are not the GMC, and there is no evidence that Dr Shotter is in anything other than good standing with the GMC. We do not know the status of that document, which laid down, in a broad-brush way, requirements as to clinical record keeping. We do not consider that it is necessary for us to make any findings as to how the document applies to Dr Shotter's work or the Appellant's practice.

98. The notes for late 2016 do differ to some degree from the so-called "Treatment Notes", the earliest of which are from March 2017 (ie, after the date upon which the claim for repayment was made). At least some of the 'treatment notes' were not written at the time, but were written retrospectively - on at least one occasion, three years later - on accountant's advice, and in response to the HMRC inquiry, rather than as part-and-parcel of the clinic's service at the time. That means that the evidential weight which can properly be placed on the treatment notes is extremely limited.

99. Dr Shotter may well be assiduously applying best practice (such as that recommended by the Joint Council for Cosmetic Practitioners and the Mental Health Foundation) in ensuring that anyone considering a cosmetic procedure is fully informed about what they can expect to achieve from it, and their psychological and emotional needs: but this does not change its tax status. The basic underlying thing - what is being done - remains the same.

100. Much emphasis was placed on Dr Shotter's training and experience, especially in terms of psychology. For example, she undertook a psychiatry placement as an undergraduate, and had worked in the NHS (whilst training as an anaesthetist) with patients who were psychologically vulnerable. The general thrust of this was to seek to characterise what is being done by her, or under her direction, in the clinics as of a psychological nature.

101. We accept that the innate character and temperament which led her to train as a doctor in the first place, will have been supplemented by the acquisition of additional skills through her learned experience in the NHS. But we do not consider that the appropriate tax treatment of what is being done should ultimately be made to depend on the identity of the person doing it, or whether that person has psychological training or experience.

102. Nor do we consider that it makes any difference that Dr Shotter, when she considers it appropriate, sometimes refers a client to another professional in a different field (for example, an opthalmologist or a consultant vascular surgeon). This is not something which people who go to the clinic are asking for, nor is it something which is necessarily inherent in the clinic's activity. Although it so happens that Dr Shotter has the ability to recognise that someone with leg veins might be better off seeing a vascular surgeon rather than undergoing micro-sclerotherapy, this is not about the clinic, or its core activity, but is about Dr Shotter, the fact that she qualified as a doctor, and happens to have the knowledge to know when the client's condition is one which is best served elsewhere.

103. It does not seem to us to matter if a document such as a consent form is completed (even one which records the patient's opinion that "my request for treatment is for medical reasons and/or the personal psychological features that are associated with my request") (i) because this is what the patient says, and not the Appellant; and (ii) because what the client is paying for, and the thing which is either subject to or exempt from VAT - the procedure - is the same procedure, regardless of whether it is preceded by form-filling and a discussion. As Dr Shotter pointed out "the process will unfortunately differ from business to business". Hers is a professionally-run business. Others may differ. But the actually thing being done to the client is basically the same in the Appellant's business as is any other business administering (for example) Botox.

104. Standing back, people are going to the clinic intending to have a cosmetic procedure done there. Even if they are unhappy with their appearance, they are not going to the clinic to see, or expecting to see, a psychiatrist, a counsellor or a therapist. The service being provided is and remains a cosmetic procedure even if (for example) it is being done by a person who is a good listener, or has the training and/or experience to engage with people's psychological or emotional needs.

105. The cosmetic treatments are not being provided essentially for medical purposes, but are for non-medical - cosmetic - purposes. The fact that people go to the clinic feeling unhappy with some aspect of their appearance, and (at least sometimes) are happier when something is done at the clinic about that aspect of their appearance, does not mean that the treatment is medical, or has a therapeutic aim. So, by way of example, the so-called 'localised fat reduction' - a technology-led targeting of fat pads which (in Dr Shotter's words) "can cause all sorts of problems confidence-wise and in terms of comfort" - is not the same as a weight-loss service.

106. As well as the written evidence discussed above, some of Dr Shotter's oral evidence captured what the clinic does very well. Speaking about one patient, she said:

> "....I consulted about three or four weeks ago and [the client] had a treatment with one of my team for skin tightening and then a treatment with me last week. He's in his early fifties; he's had a horrendous two years - long Covid - and then diagnosed with clinical depression from which he's just bouncing back. And as part of that he wants to feel like he can recognise himself in the mirror again and found me. And it was a very emotional, tearful, consultation".

107. This is a good example, because it captures several of the features which we have been discussing. The procedure is skin tightening. It is being done because the client has lost facial tone. But the client has not been diagnosed by his GP or another medical professional with loose skin. It is recorded that he has been diagnosed with depression, but that diagnosis was not made at this clinic, but was made by someone else, elsewhere. It could not have been made by Dr Shotter because that is not her job. We do not know what the prescribed treatment, if any, for this client's depression was. But it is not said that the prescription or even

recommended treatment for his depression included skin tightening. A procedure for tightening skin is available, and the client desires that it be done. The client wants it to be done because the client thinks that it may make him feel better about his appearance, and so happier overall. So, and even though skin tightening may perhaps end up making the client happier, and may even end up alleviating his depression, it is not medical treatment within the exemption. The same perhaps goes for talking about it to a sympathetic interlocutor - Dr Shotter - in a confidential environment. But the client is at the clinic to have his skin tightened: not to undertake counselling. He was just lucky to have encountered a compassionate individual.

108. The same could be said for the client, treated in April 2017, who was extremely tearful and struggling emotionally. The client's GP was aware of her condition, and had referred her (not to the clinic) for bereavement counselling. She had not been referred to the clinic for her perception of her sagging face which, she felt, had gotten worse since the bereavement because she was not sleeping well. After treatment, the client was recorded as being very happy with her skin progress, and as feeling gradually happier in herself: but that does not mean that the skin tightening should thereby be treated as medical care.

109. The same reasoning would apply even if the contemporary diagnosis recorded or made by the Appellant included, instead of depression, "anxiety" or "severe anxiety" "related to appearance"; "loss of confidence"; or "self-conscious appearance".

110. Even absent a formal diagnosis of depression, the basic picture is the same. As Dr Shotter said at another point in her oral evidence:

> "...I'm not there to diagnose a patient with depression. And bear in mind this is the patient's perception of depression. It doesn't actually mean that they've ever had a clinical diagnosis of depression by a GP or other health professional. This is the patient saying 'I'm a bit depressed about my appearance'".

111. This is also telling. It clearly differentiates, in Dr Shotter's own words, what the clinic does from what 'a GP or other health professional' does. It also highlights the general trend or purpose of the clinic's activity - helping people to feel better about their appearance, in contexts where their appearance is not itself a health condition, or threatening to their health in a way which mandates treatment of their appearance by a GP or another health professional.

112. Helping someone to achieve goals in relation to their appearance - which is what this clinic does - is not treating someone's mental health status, but is going to their self-esteem and self-confidence. It is a misuse of language to say that this is healthcare in the sense that it would fall within Item 1.

113. We do not regard what is being done as "medical care", "coming within the established meaning of that term". Although what is done is being done with care, it is not, in our view, "medical". Nor do we accept that the services "have a therapeutic aim, that they consist of the diagnosis, treatment or cure of disease or ill-health." We agree with HMRC that clients sought the clinic's services primarily for aesthetic reasons, and in order to improve their appearance.

114. We reject the argument that what the Appellant is doing is part of the provision of "holistic care". It seems to us that this is a semantic attempt to seek to characterise what is actually being done as medical when it is not. That is to say, the change in language does not actually reflect any substantive change in the underlying supply.

115. If what is being done is not "diagnosing, treating and, in so far as possible, curing diseases or health disorders", then neither the provision of a pre-treatment consultation, nor being asked about previous medical history, or body image, or psychological/emotional challenge, turn what is being done into medical care, or change its tax status to exempt.

116. We heard evidence about the overall client experience. Although we did not hear from any of Dr Shotter's clients, the general preponderance of the evidence is that attention is paid to make sure that visiting the clinic is not an unpleasant experience. As far as we can tell, we are sure that great care is paid to the front-of-house impression, the cleanliness of the premises, their appearance and ambience, and the overall client experience.

117. Things are done to put the clients at ease, and to make them feel that what is being done is being done professionally and differently from elsewhere. But these are not things which change the tax status. They are simply incidents of the manner in which Dr Shotter chooses to provide the clinic's services, to attract clients, to position her business in the marketplace, and - it seems clear - to differentiate it (probably very successfully) from the sort of business criticised to the House of Commons Health and Social Care Committee by the Joint Council for Cosmetic Practitioners.

118. Whilst there has been Parliamentary attention to how people think and feel about their bodies, and the associated issue of the regulation or licensing of non-surgical cosmetic procedures, we do not consider that the regulatory status and/or licensing regime (or the underlying policy reasons for introducing such a regime) can be determinative, one way or the other. The management of the regulatory regime and/or imposition of a licensing regime is not obviously referable to the tax status of the regulated person, or the tax treatment of the regulated activity.

Item 4

119. For the reasons already set out in this decision, we do not consider Item 4 to be in dispute in this appeal.

120. But, if Item 4 were in dispute, we would have dismissed the appeal.

121. We adopt our discussion in relation to Item 1.

122. It is common ground, arrived at during ADR, that the clinic was, from the time of its registration with the CQC in 2018, a "state-regulated institution".

123. The first operative part of Item 4, which must be met to engage Item 4 at all, is that what is being done must be "the provision of care or medical or surgical treatment".

124. In our view, what is being done is neither medical nor surgical treatment.

125. There is scant guidance in the authorities as to the meaning of Item 4. In *Mainpay*, the taxpayer's reliance on Item 4 had fallen away by the Court of Appeal, which accordingly focuses its remarks on Item 1. At the lower stages of *Mainpay*, and in the other FtT decisions to which we were referred, insofar as there is reliance on Item 4, it is often treated in the round with Item 1, and is not subject to separate discussion. This is not surprising. If a claim to exemption under Item 1 succeeds, then there is no need to consider Item 4 at all.

126. VAT Notice 701/57 (Health professionals and pharmaceutical products") does not separately discuss Items 1 and 4. In any event, it is only HMRC's view of the legislation, and not binding on us. It does not add anything of substance to the submissions which we heard. All it does show - in its section 2.3 ("The definition of medical services and which services performed by health professionals are exempt from VAT") - and which is evident from this appeal - is that HMRC does not regard the activities of this clinic as akin to activities (which it characterises as being "for the primary purpose of protecting, maintaining, or restoring a person's health) such as laser eye surgery, hearing tests, pharmaceutical advice, services provided by osteopaths and chiropractors, and "services involving the diagnosis of an illness or the provision of analyses of samples forming an important part of the diagnosis".

127. As to the meaning of "the provision of care", we bear in mind (i) that this expression is drawn up so as to reflect the PVD's exemption of certain activities in the public interest, and (ii) we should apply the interpretative approach - set out above - that a strict construction is not to be equated with a restrictive construction.

128. Nonetheless, we must recognise "that it is for a supplier, whose supplies would otherwise be taxable, to establish that it comes within the exemption, so that if the court is left in doubt whether a fair interpretation of the words of the exemption covers the supplies in question, the claim to the exemption must be rejected."

129. Here, we do not consider that the Appellant has established that it comes within the exemption, either on the facts or on the law.

130. Ultimately, we are left in doubt whether a fair interpretation of the words "the provision of care" do cover the supplies in question, and therefore must reject the claim to the exemption.

131. The word "care" is followed by "medical" and "surgical". The latter two words connote activities where the main purpose is to protect, maintain or restore the health of the individual concerned. In our view "care" has to be read alongside, and in the same way, as the other two words (an application of the *noscitur a sociis* principle).

132. Its proper meaning, in this context, is one where an activity whose main purpose is to protect, maintain or restore the health of the individual concerned. For the reasons already set out in relation to our discussion of Item 1, we do not consider that cosmetic treatments of the type considered properly fall within this description, and so do not fall within the scope of Item 4.

133. For the avoidance of doubt, we do this mindful that we are not required to reject a claim which does come within a fair interpretation of the words of the exemption because there is another, more restricted, meaning of the words which would exclude the supplies in question.

134. As HMRC's non-binding, guidance-only, list of exempt activities in VAT Notice 701/57, there may well be difficult cases which are near to the line between exempt and non-exempt. We simply limit ourselves to saying that, in the light of our findings, we do not consider this Appellant to be near that line, and on the exempt side of it, whether in relation to Item 1 or (subject to the above remarks) Item 4.

CONCLUSIONS AND OUTCOME

135. Item 1 is not met. The Appellant's supplies do not constitute "medical care" within the proper meaning and effect of the legislation. The supplies should have been standard-rated.

136. HMRC were therefore correct to deny the VAT credit claimed by the Appellant in their VAT return for period 12/16, and were correct to raise a best judgment assessment under section 73(1) for output tax.

137. The appeal is therefore dismissed.

RIGHT TO APPLY FOR PERMISSION TO APPEAL

138. 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.

Dr Christopher McNall
TRIBUNAL JUDGE

Release date: 23rd JUNE 2023