[2016] UKFTT 222 (TC)

TC04998

Appeal number: TC/2011/06697

ZERO-RATING – whether "use as a hospital or similar institution" – VATA 1994 Schedule 8 Group 5 Note 4 – appeal allowed

FIRST-TIER TRIBUNAL
TAX CHAMBER

PENNINE CARE NHS TRUST **Appellant**

- and -

THE COMMISSIONERS FOR HER MAJESTY'S REVENUE & CUSTOMS **Respondents**

TRIBUNAL: JUDGE JENNIFER DEAN
MR JULIAN STAFFORD

Sitting in public at Manchester on 5 – 7 October 2015

Mr Andrew Hitchmough QC, Counsel for the Appellant

Mr Peter Mantle, Counsel for the Respondents

DECISION

The appeal

1. The Appellant appeals against a decision dated 29 July 2011 issued by the Commissioners of Revenue and Customs ("the Commissioners") that the construction services and materials received by the Appellant in the course of the construction of a mental health residential unit are not subject to zero rating for the purposes of VAT.

The Issue

2. Both parties agreed that the issue in this appeal is whether Prospect Place Low Secure Mental Health Unit ("the Unit") was intended for use as a hospital or similar institution. HMRC contend that it was and therefore the supplies were standard rated. The Appellant contends that the use of the Unit satisfies paragraphs (b) and/or (g) of Note (4) and the exception for use as a hospital or similar institution does not apply; accordingly the supplies were eligible for zero rating.

Legislation

3. Section 30(2) VATA 1994 zero rates supplies of a description specified in Schedule 8.

4. Item 2 of Group 5 to Schedule 8 specifies:

"The supply in the course of the construction of–

(a) a building designed as a dwelling or number of dwellings or intended for use solely for a relevant residential purpose or a relevant charitable purpose…"

5. Note 4 to Group 5 provides that:

"Use for a relevant residential purpose means use as–

(a) a home or other institution providing residential accommodation for children;

***(b) a home or other institution providing residential accommodation with personal care for persons in need of personal care by reason of** old age, disablement, past or present dependence on alcohol or drugs or past or **present mental disorder**;*

(c) a hospice;

(d) residential accommodation for students or school pupils;

(e) residential accommodation for members of any of the armed forces;

(f) a monastery, nunnery or similar establishment; or

(g) an institution which is the sole or main residence of at least 90 per cent of its residents,

except use as a hospital*, a prison* ***or similar institution*** *or an hotel, inn or similar establishment."*

(emphasis added).

6. HMRC clarified in its skeleton argument that it accepts that but for the use as a *"hospital…or similar institution"* exception, the Unit would have been used for a *"relevant residential purpose"* by reason of the application of one, or other, or both of paragraphs (b) and (g) of Note 4.

Agreed facts

7. We were provided with a statement of agreed facts which included, inter alia:

(a) The Appellant is an NHS Foundation Trust which provides services to people with mental health issues.

(b) In December 2009, the Appellant commenced construction of a new low secure mental health unit ("the Unit"). Practical completion of the Unit occurred in February 2011 with occupancy at the Unit beginning in May 2011. The Unit cost a total of £9,626,567.80 plus VAT to complete.

(c) In the course of the construction of the Unit, the Appellant received supplies of construction services and associated materials ("the goods and services").

(d) By letter dated 29 July 2011, the Respondents issued the disputed decision rejecting the Appellant's view of the purpose of the Unit and ruling that the goods and services were subject to the standard rate of VAT.

(e) The Unit provides services for up to 45 adult males who are suffering from severe and enduring mental health disorders including schizophrenia and other personality disorders. All residents at the Unit are compulsorily detained under certain sections of the Mental Health Act 1983 (as amended) ("the Act").

(f) The average length of stay for residents at the Unit is approximately two years.

(g) The majority of residents at the Unit have free access at all times to communal facilities such as lounge and TV areas, the outdoor courtyard, recreation facilities and certain kitchens. However, they are not free to leave the Unit unless specifically permitted as part of their regime.

(h) There are four consultant psychiatrists allocated to the Unit who work on a part time basis. Together they constitute the equivalent of two full-time consultants.

(i) The Unit is allocated one "Staff Grade Doctor" (who is specialised in psychiatric care and performs similar duties to the consultants on the Unit but does not have the same level of responsibility) and one "trainee psychiatrist."

(j) A GP attends the Unit for 6 hours a week to provide general health care for residents who are unable to leave the Unit and, during weekends, the Unit has access to a "Senior House Officer" who is situated at a nearby hospital should general medical assistance be required.

(k) The Unit employs one psychologist. The psychologist is unable to prescribe any medication to residents.

(l) There are about nine nurses on the Unit on the day shift (7:30am to 7:45pm) and three on the Unit during the night shift (7:30pm to 7:45am). All nursing staff at the Unit are Registered Mental Health Nurses with either a diploma or a degree in Nursing.

(m) The Unit employs three full time occupational therapists and two full time technical instructors.

(n) Whilst the Unit is a low secure unit, all residents are compulsorily detained at the Unit under certain sections of the Act.

(o) Referrals to the Unit are made via a number of different routes. Most of the residents at the Unit will be transferred to the Unit from Psychiatric Intensive Care Units, medium secure and acute mental health units operated by either the Trust or other local NHS services.

(p) One of the admission criteria for the Unit is that the resident must have a primary diagnosis of having a serious mental illness. Without such a diagnosis being made beforehand, the Unit cannot accommodate a resident.

(q) The Unit does not accommodate anyone who is in an acute stage of mental illness. All residents referred to the Unit will have been prescribed drugs for their mental illness as part of their diagnosis. The medication prescribed to patients is kept under review during their time at the Unit.

(r) All residents at the Unit suffer from chronic mental illness which, by its very nature, cannot be cured.

(s) The care at the Unit is provided under an approach called the Core Care Pathway ("CCP"). The CCP involves three different progressive phases:

- An Engagement and Assessment phase just prior to the arrival of the resident. The Engagement and Assessment does not seek to diagnose illness, rather to gauge the level and type of care needed for each resident;

- A Recovery and Intervention phase; and
- A final Social Inclusion phase.

(t) During all three phases at the Unit what is provided to the residents includes:

- Psycho-education;
- CBT;
- Goal setting;
- Education about the relationship between drug and alcohol use and mental health;
- One to one sessions which focus on psychological support, coping strategy enhancement, collaborative goal setting and personal and social care;
- Budgeting advice;
- Teaching residents about personal hygiene;
- Teaching residents to shop and prepare meals for themselves;
- Teaching residents the need to respect others;
- Lessons on healthy living;
- Assistance in enrolling in relevant vocational classes and work placements;
- Socialisation; and
- The provision of musical outlets through music projects which promote expression, increased confidence, self-esteem, role identity and development.

Evidence

8. We heard oral evidence from Ms Gemma Denise Kirk, the Senior Occupational Therapist at the Unit, and Mr Mr Dilshad Jauffur, the Directorate Manager. We also had a witness statement from Mr Bill Harrison the Unit Manager who has since retired, the contents of which were dealt with by Mr Jauffur.

9. Ms Kirk drew a distinction between acute medical treatment and that provided by the Unit which she described as "*long-term accommodation in conjunction with personalised care*". Ms Kirk explained in her written evidence that due to the chronic

nature of residents' mental illnesses the care provided by the Unit is not treatment in the "usual" sense of the word but rather it focussed on reducing the distress associated with mental illness, developing coping strategies and improving the residents' quality of life and daily functioning. In oral evidence Ms Kirk clarified that the expression "*personal care*" referred to residents who struggle with one or more complex daily living skills such as budgeting and feeding. She explained that it is "*individual and bespoke*" (transcript day 2 page 60) and depends on the particular resident's needs at a particular time.

10. Ms Kirk agreed that the Unit provides a safe and secure environment. However she drew the distinction between that provided at the Unit and that at a Psychiatric Intensive Care Unit ("PICU") which has a far more restrictive environment due to the high level of safety required, for instance sharp objects and toiletries would be removed at a PICU.

11. In describing the Unit's objective Ms Kirk explained:

"What we do is enable them to live better with their condition…what all of the interventions that we deliver does for the residents…I think it helps them to live better with their diagnosis, that unfortunately can't change or won't change"

(Transcript day 2 page 122)

12. Ms Kirk stated that the work done by the Unit helps residents to understand about the positive symptoms they suffer and the causes of the re-occurrence of such symptoms. A great deal of work is also put into the negative symptoms which can prevent social inclusion, for instance by teaching the basics of self-care. In respect of negative symptoms, by way of example Ms Kirk explained:

"…there's a whole set of symptoms that come with schizophrenia called negative symptoms, which impact significantly on somebody's ability to perform the activities they need to perform on a day-to-day basis to be able to live an independent life. Medication doesn't treat or help those symptoms…"

(Transcript day 2 page 33)

13. Ms Kirk explained that, in her opinion, there is nothing that can be done to prevent the illness of a resident getting worse and the treatment at the Unit cannot prevent symptoms re-emerging as a result of unexpected or difficult events in life occurring. However the aim of the Unit is to prepare the residents for life in the community and provide them with a "*toolbox of skills*" to use (Transcript day 2 page 37). Ms Kirk confirmed that the Unit would normally intervene at a time when the worst symptoms of mental health disorders have been brought under control by medication.

14. As regards medication, Ms Kirk stated that the proportion of time discussing and dealing with this issue is small in proportion to the other activities that take place on the Unit. The medication may be tweaked while a resident is on the Unit as it may be once the resident has left.

15. On the issue of staff Ms Kirk explained that it is a core skill of anyone working with people with mental health difficulties to build therapeutic relationships and that the MDTs work with residents to attain a better understanding of their illness as it impacts on many areas of a person's life. Psycho-education is offered to residents; the goal is for the resident to understand and be better able to deal with his illness. The theory is, the better the knowledge a resident has of their illness, the better they can manage to live with their condition. A "Dual Diagnosis" (which means the condition of suffering from a mental illness and a co-morbid substance abuse problem) nurse provides one on one education sessions relating to the relationship between mental illness and substance misuse. Ms Kirk describes these sessions as in the nature of counselling and education rather than medical treatment for addiction issues. A Dual Diagnosis Nurse Care Team Meeting Report for a resident dated 28 March 2012 demonstrated the focus of a session on assisting the resident to cope with stress and other issues without the need for drugs and alcohol.

16. Ms Kirk also highlighted that whilst the nurses at the Unit help to administer medication and are involved in the observation and management of medication, they also accompany residents to the theatre, the pub and on other social outings. Ms Kirk could not say whether or not the nurses build on their professional training in the course of their duties to form therapeutic relationships at the Unit although she agreed that she used her own training to build up relationships. Ms Kirk clarified that the one to one sessions with nurses do not involve any element of diagnosis or treatment of underlying conditions but rather they give the resident an understanding of the illness with the aim to enable the resident to better cope with it. The assessments that take place during the sessions are not informed diagnoses (which have already been made) but a review of how the resident appears on a day-to-day basis and providing a toolkit of coping strategies.

17. Residents are taught social skills such as the ability to interact with members of the community and the importance of healthy living. Residents are required to undertake some form of physical activity whilst at the Unit and are encouraged to enrol in community college classes if their level of ability allows.

18. Most residents will have been in the formal care system for some time before they arrive at the Unit and therefore their medication will usually have been prescribed prior to their arrival and will be continued during their stay. The medication is essential to control the worst symptoms of the residents' mental health disorders. From time to time the medication may need to be changed as the dosage may no longer be right or side effects may have developed such as blood pressure or cardiac issues or hallucinations which means it is no longer safe to take the medication. Ms Kirk explained that the medication is given to manage the symptoms as distinct from improving or preventing their worsening. She agreed that the MDT would keep anti-psychotic medication under review and make changes if necessary.

19. Ms Kirk explained the different types of symptoms; positive symptoms include those such as hearing voices and negative symptoms are those such as lack of motivation. She stated that medication is a pre-condition to enable the resident to function on a day-to-day basis. Any changes to medication are discussed with the

resident and their MDT and are then prescribed by the consultant psychiatrist on the MDT who assesses the correct dosage. Ms Kirk explained that no changes are forced on a resident, as the long-term goal is that the resident can take responsibility for his own medical regime.

20. Ms Kirk stated that the residents will leave the Unit with the same diagnosis with which they entered, The Unit cannot do anything to improve the mental health issues and residents will normally remain on prescribed medication for the rest of their lives. What the Unit does is provide residents with a safe environment where they can learn life skills that enable them to better live with their conditions and leave with the symptoms in a manageable format.

21. Mr Jauffur is presently the Directorate Manager responsible for the management of the Unit although he is not based at the Unit. Mr Jauffur exhibited the statement of Mr Bill Harrison, a former Unit Manager who did not give evidence. Mr Harrison's witness statement set out the background to the Pennine Care NHS Foundation Trust, construction of the Unit and its facilities. He provided information about the residential nature of the Unit, staffing and the nature of care provided.

22. Mr Jauffur agreed with and adopted the contents of Mr Harrison's statement. He added that that the residents' illnesses cannot be cured nor symptoms improved; the symptoms will manifest as part of the illness and the Unit aims to assist residents with coping with those symptoms.

23. Mr Jauffur drew a distinction between doctors who work at the Unit who do not perform the role of a "typical doctor" when compared with a doctor working in an acute mental health ward in a hospital.

24. Mr Jauffur explained that he did not think that the interventions provided by the Unit have a direct impact on the manifestations of positive or negative symptoms nor was he aware of any research to show that there is an indirect impact on the symptoms that would prevent deterioration.

25. Mr Jauffur agreed that nurses on the Unit use their professional skills. He explained that psychological support covers a broad spectrum; the Unit encourages further training to deliver specific therapies such as CBT but the nurses are not qualified CBT nurses. He agreed that psychiatrists play a very important role and that they use their professional skills in their employment at the Unit.

Submissions

HMRC's submissions

26. On behalf of HMRC Mr Mantle submitted that as an exception to the general principle that VAT is to be levied on all goods and services supplied for consideration by a taxable person, Item 2 is to be strictly construed. Strict construction is not to be equated with a restricted construction, in the sense of giving the text the most narrow meaning (see *Expert Witness Institute v CCE* [2002] STC 42 CA per Chadwick LJ at [17]). When a zero-rating provision contains an exclusion from the provision, such as

the "hospital or similar institution" exclusion in Note 4, that exclusion should be interpreted fairly but more widely and in no way restrictively.

27. Mr Mantle highlighted the High Court authority of *HMRC v Fenwood Developments Ltd* [2006] STC 644 ("*Fenwood*"), the ratio of which is binding on the FTT and which established that when interpreting the "hospital or similar institution" exception:

(i) The starting point is the ordinary meaning of the word "hospital";

(ii) The context of Group 5 and in particular the other aspects of the definition of "relevant residential purpose" in Note 4 are also important. All the paragraphs of Note 4 expressly or implicitly refer to residential accommodation;

(iii) Definitions of "hospital" in other statutes are not helpful in interpreting Note 4.

28. It was submitted that understanding the basis upon which residents at the Unit have been detained under the Act is important in this case, not as an aid to construing Note 4 but rather to understand the purpose for which residents could lawfully be and were detained.

29. The words "hospital or similar institution" (in particular "similar institution" should not be interpreted in a manner which renders them either of no effect or of restricted effect. "Use as a hospital or similar institution" should not be interpreted so expansively as to render paragraphs (a) to (g) of Note 4 of no effect.

30. The understanding of "hospital" is not fixed by reference to, or frozen in time in the 1990s or earlier. When a word is given its ordinary meaning, that meaning may change over time in accordance with common usage and understanding. It can apply to new circumstances and embrace modern developments.

31. In *Fenwood* the Chancellor examined a number of dictionary definitions and found the common element within them was *"the provision of medical treatment or care"* (see [16]).

32. As regards the decision of the VAT and Duties Tribunal (VATT) in *General Healthcare Group Ltd* (VATD 17129) ("*General Healthcare*") the Tribunal at first instance adopted a "badges" approach. It was submitted by Mr Mantle that this approach inevitably begins to move away from the ordinary usage of the word hospital. The VATT explicitly based its chosen "badges" on a non-statutory definition of hospital in HMRC's Notice 701/6/97 and the VATT's badges approach was not endorsed or adopted by the High Court in *Fenwood*. The Chancellor's reference in *Fenwood* (at [13] & [18]) to the submission that *"a hospital is a building used for treatment for the cure or amelioration of a medical condition as opposed to personal care"* should not be treated as the applicable definition of *"hospital"*; it would be wrong in principle for a court to substitute its own definition for the ordinary meaning

absent a statutory definition. Furthermore such an approach could omit relevant considerations.

33. It is accepted by HMRC that a contrast between medical treatment and care and personal care is important. However the phrase "*cure or amelioration of a medical condition"* does not fully capture the scope of medical treatment, the aim of which can be to prevent the worsening of an illness or its symptoms.

34. Regard must be had to the facts relating both to medical treatment provided and to the personal care provided in an institution. However the Chancellor in *Fenwood* did not refer to or endorse a "balancing exercise" in place of consideration of the words *"use as a hospital or similar institution"* being applied to the facts as found by the VATT.

35. The necessary exercise is predominantly one of applying the relevant words of the exception: - whether the words of the exception in Note 4 do or do not as a matter of ordinary usage of the English language cover the facts which have been agreed or proved, bearing in mind that "*similar*" must not be interpreted restrictively.

Submissions on the facts and evidence

36. Mr Mantle highlighted that the witnesses had expressed opinions on the issue to be determined by the Tribunal. He submitted that it is the evidence of fact and the Tribunal's application of the legislation to its own findings of fact that must decide the issue in this appeal.

37. Mr Mantle highlighted the significant number of medically trained staff employed on the Unit. He noted that all residents are compulsorily detained under the Act and that most are detained under section 3 which permits a person to be detained only if a number of specified grounds are all satisfied. The first ground requires that a person:

"…is suffering from a mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital."

38. Other specified grounds also include reference to medical treatment. *"Mental disorder*" is defined as "*any disorder or disability of the mind*" but does not include alcohol, drug dependence and learning difficulties (see MHA 1983 S1-3 as amended). We were referred to the definition of medical treatment which includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care. Mr Mantle also highlighted s145(4) of the Act which provides that:

"Any reference in this Act to medical treatment, in relation to mental disorder, shall be construed as a reference to medical treatment the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more symptoms or manifestations."

39. Mr Mantle relied on the contrast drawn by the High Court in *Fenwood* between "*personal care*" and "*medical treatment and associated care*". He submitted that

"*personal care*" is concerned with assistance with bodily functions such as washing, dressing and feeding together with associated support.

40. We were referred to the staff on the Unit and their job descriptions. Mr Mantle noted that multi-disciplinary teams ("MDTs") were allocated to each resident. Each team is led by a consultant psychiatrist and includes 1 or 2 named nurses and an occupational therapist. In addition to day to day work there are regular clinical team meetings ("CTMs") at which a resident's MDT comes together.

41. Mr Mantle submitted that the job descriptions underline the crucial role played in the Unit by medically trained staff and he highlighted that the job descriptions make frequent reference to treatment in addition to references to rehabilitation; by way of example Mr Mantle relied on the following examples:

- Consultant psychiatrists take *"clinical responsibility for inpatients"* and lead the MDT including undertaking *"direct responsibility for…medical treatment (including medication)…"* and *"regularly assessing the clinical state of inpatients"*;

- The speciality psychiatrist registrar's clinical duties include *"providing routine medical and psychiatric care for up to 25 inpatients"* and *"regularly assessing the clinical state of the inpatients"*;

- Charge nurses *"assist in developing and maintaining a Low Secure service committed to addressing rehabilitation needs of men with severe mental illness…"*;

- The main duties of the Occupational Therapist include carrying out *"appropriate assessment and treatment of allocated patient"* and *"provide clinical and other support to the LSU team."*

42. Mr Mantle submitted that a diagnosis is not a prerequisite in order for an institution to be a hospital. Assessments are made of residents at the Unit both prior to and throughout their stay. He submitted that these assessments are relevant to treatment and rehabilitation, not just to personal care.

43. Mr Mantle contended that where the disorder and treatment are such that treatment takes a considerable period of time to take effect, the length of the resident's stay does not indicate that the building is not used as a hospital or similar institution. The physical layout and "atmosphere" are all matters that the Tribunal can take into account.

44. Although a resident cannot be cured, Mr Mantle submitted that the treatment and rehabilitation received in the Unit will improve his condition, enabling him to be discharged to community supported living or possibly independent living. The use of the Unit therefore falls within the meaning of "*hospital or similar institution*".

Appellant's submissions

45. On behalf of the Appellant Mr Hitchmough submitted that the Unit is clearly used to provide residential accommodation and all residents have an enduring mental illness. The use of the Unit therefore falls within Note 4 paragraph (b) and (g).

46. It is equally clear that personal care is provided to the residents who are in need of such care as a result of their mental illness.

47. Mr Hitchmough agreed that in the absence of a statutory definition of "*hospital or similar institution*" the issue is whether these words, as a matter of ordinary usage of the English language, apply to the facts.

48. However, the exception must not be construed in such a manner as to render ineffective any of the specific examples in Note 4 as to what is clearly a residential use. In support of this argument Mr Hitchmough cited the VAT Tribunal decision in *General Healthcare* (at [16]):

"All hospices have certain points in common with hospitals; all care homes resemble both hospitals and hotels to a certain extent; residential accommodation for school pupils may not be as similar to prisons as it used to be, but the two are still not entirely dissimilar. Those superficial degrees of similarity cannot be enough to bring the exception into play, or there would have been no point in enacting Note (4)(c), (b) and (d) in the first place."

49. Mr Hitchmough submitted that, relying on the approach taken by the Tribunal in *General Healthcare* (at [15]), the question as to whether *"the words, as a matter of ordinary usage of the English language, cover or apply to the facts which have been proved"* can be answered by identifying what reasonable people would regard as the characteristic "badges" of a hospital. Those badges include diagnosis, treatment, in-patient facilities, the presence of medically qualified staff, atmosphere and length of stay.

50. Mr Hitchmough contended that the Tribunal's approach in General Healthcare is consistent with that of the Chancellor in *Fenwood* who stated (at [16]):

"Accordingly the starting point must be the ordinary meaning of the word 'hospital'"

51. The Chancellor went on to state agree that the following phrase reflected the proper construction of the relevant words in the appropriate context:

"a hospital is a building used for treatment for the cure or amelioration of a medical condition as opposed to personal care; the former is likely to require short term occupation, the latter long-term residence."

Stating at [18]:

"The contrast is between a home or institution providing residential accommodation with personal care for those who need it for the prescribed reason and an institution providing medical treatment and associated care, usually on a short term basis."

52. Mr Hitchmough submitted that the presence of some medical treatment cannot of itself bring the exception into play which is made clear by the reference to a hospice in Note 4(c). As stated in *General Healthcare* (at [22]):

"Were it otherwise, any care home that provided any kind of treatment would immediately lose zero-rated status for its buildings. If and when a cure for cancer is discovered, any hospice that started trying to cure some of its inmates instead of merely easing their passing would again lose zero-rated building status. That cannot be right."

53. We were referred to the Chancellor's rejection (at [15], [24] and [25]) of the submission that assistance might be derived in construing the VAT legislation from definitions used in other statutory contexts such as the Mental Health legislation.

54. We were invited to note the striking similarities between the function and use of the Unit and those institutions considered in the following authorities:

- *General Healthcare*
- *Fenwood*
- *The Hospital of St John and St Elizabeth* (VTD 19141); and
- *St Andrew's Property Management* (VTD 20499)

55. Mr Hitchmough made the following submissions from the evidence on the "badges" to be applied:

(i) Treatment:

The Unit does not hold medical equipment for diagnosis or treatment of medical conditions. It provides long-term accommodation in conjunction with personalised care to residents who will never be cured of their mental illness. The fundamental difference between mental health hospitals and establishments such as the Unit is that a mental health hospital is concerned with diagnosis and treatment. The Unit does not and cannot treat the illnesses in the conventional sense so that the residents are in any way cured; it seeks to equip the residents with life skills to help them live with their illness. The Unit helps those for whom hospital treatment can provide no further assistance. The assessments and the skill gaps they identify are fundamental to the course of care devised for and provided to residents. The medication taken by residents is not part of the care provided but a necessary pre-condition to enable a resident's engagement in the social care provided.

(ii) Diagnosis:

By the time the residents reach the Unit most have a stable diagnosis and prescribed drug treatment. The assessment at the Unit is not a matter of diagnosing but rather identifying the social problems of the resident as a result of their illness and assessing what care may assist with those problems.

(iii) In-patient facilities:

These are clearly available at the Unit and unlike a typical hospital there are no outpatient facilities.

(iv) Medical staff:

Although many staff are medically trained, it is not their medical skills that they use as part of their daily interactions with residents. Whilst nurses help to administer medication and monitor compliance with it, most of their time is spent in one to one sessions with a focus on social care. The staff at the Unit will play football with the residents or may go to the cinema with them.

(v) Length of stay:

The usual length of stay for residents is approximately 2 years.

(vi) Atmosphere:

The majority of residents have their own room keys. The objective of the Unit is that the residents should treat it as their home for the duration of their stay. Residents are encouraged to personalise their own and the communal space. There is a takeaway evening on Fridays, a staff member is a certified gym instructor and runs gym sessions and residents share a communal laundry where they do their own washing.

56. Mr Hitchmough submitted that following the guidance given in *Fenwood* and *General Healthcare* the only reasonable conclusion to be drawn is that the Unit is not used as a "*hospital or similar institution*". Any medical treatment provided is ancillary to the care package received by the patients and not of itself the reason for their admission.

Discussion and Decision

57. We took into account all of the evidence before us, both oral and documentary. The witnesses were called to give evidence of fact and we did not consider any views expressed by them in reaching our own independent conclusion. We took into account Mr Mantle's submission that we had not heard from employees such as the psychiatrists or nurses employed at the Unit. However we were satisfied on the evidence before us that we had a clear picture of the aims of and services provided by the Unit such that we could reach an informed decision.

58. We began by considering the authorities relied on by the parties. Our approach was to establish the general principles and guidance that can be taken from the authorities and then apply them to our findings of fact.

59. The general propositions we took from the authorities were as follows:

(i) The starting point should be the ordinary usage of the English language;

(ii) In the absence of a statutory definition of "hospital or similar institution" other statutes do not assist;

(iii) Superficial similarities are not enough to bring the exception into play and care must be taken not to construe the provision so as to render the exemptions in Note 4 ineffective;

(iv) The relevant words must be construed in the appropriate context by application to the facts.

60. We considered the "badges" approach adopted by the Tribunal in *General Healthcare.* On our interpretation the Tribunal was not attempting to define "hospital or similar institution" but rather, as Mr Mantle recognised, it was identifying the relevant factors to take into consideration in its application of the facts (at [21]):

"Helpful though we find these various definitions, we cannot treat any of them simply as substitutes for the missing statutory definition. We prefer the approach taken in direct tax law to the question of what constitutes a trade or adventure in the nature of trade – a phrase of considerable antiquity which has never been statutorily defined. What the Courts have done, down many decades, is to identify a number of "badges of trade", of varying importance, which one can look for when deciding how to classify the chance acquisition of millions of rolls of toilet paper in Berlin, or an incautious bid at the auction of an inappropriate mansion where one's parents happened to have been in service. That is how we propose to treat the words in Notice 701/6/97: not as a definition, but as evidence of what reasonable people (among whom the Commissioners are to be numbered) would regard as characteristic "badges" of a hospital. In their correspondence with the Appellant, the Commissioners also lay stress on staffing, treatment and the Funding Agreement; we shall take those into account as well." (emphasis added)

61. Therefore whilst we have not followed the "badges" approach as if it provided an exhaustive list of relevant criteria, we agree that there are a number of factors, none of which may be conclusive and all of which may carry varying degrees of weight but which are relevant to and assist us in reaching our decision.

62. In starting with normal English meaning we derived assistance from the Chancellor in *Fenwood* who considered this at [16] and concluded that:

"The common element in all these definitions is the provision of medical treatment and care."

63. The Chancellor went on to consider the context of Group 5 and the definition of a relevant residential purpose in Note 4 (at [17] and [18]):

"Paragraphs (a),(b),(d),(e) and (g) all refer expressly to residential accommodation. Paragraphs (c) and (f) plainly imply the same quality.

In their normal meaning neither hospitals, prisons, hotels nor inns exist for the purpose of providing residential accommodation; nor are they normally occupied as residences by those who are accommodated therein. Thus the exceptions appear to me to be designed to exclude the specified institutions if and in so far as their use might actually come within the principal parts of the definition. Accordingly, it is necessary in each case to contrast the relevant paragraph of Note (4) with the relevant part of the exception…The contrast is between a home or institution providing residential accommodation with personal care for those who need it for the prescribed reason and an institution providing medical treatment and associated care, usually on a short term basis. Accordingly I accept the submission of counsel for Fenwood summarised in the last sentence in para 13 above as reflecting the proper construction of the relevant words in the appropriate context."

64. The submission referred to, and expressly accepted by the Chancellor, was that the focus of Note 4 in the context of Group 5 is *"on the intended use of buildings for residential accommodation, as opposed to short term occupation…a hospital is a building used for treatment for the cure or amelioration of a medical condition as opposed to personal care; the former is likely to require short term occupation, the latter long-term residence."*

65. We found the remainder of the authorities to which we were referred provided less assistance than *Fenwood*. The Tribunal in *Wallis* (which pre-dated *Fenwood*) relied on the provisions of the Mental Health Act in reaching its decision; an approach which was expressly rejected by the Chancellor in *Fenwood*. The Tribunal in *Hospital of St John and St Elizabeth* also reached its decision by reference to other statutes and the Court of Appeal majority decision in *General Committee of The Royal Midland Counties Home for Incurables at Leamington Spa* [1954] 1 Ch 530 was also an approach rejected by the Chancellor in *Fenwood*. The more recent decision of the Tribunal in *St Andrews Property Management Ltd* [2007] UKVAT V20499 (30 November 2007) seemed to us to be consistent with the approach in *Fenwood*.

66. We adopted the agreed facts. This was not an appeal in which HMRC contended that the witnesses for the Appellant were untruthful but rather the parties invited us to reach different conclusions in considering the facts.

67. The main area of contention was whether the care provided at the Unit affected the residents' illnesses through treatment, rehabilitation and mental health nursing such that it falls within the meaning of "*hospital or similar institution*".

68. It was clear from the evidence (and there was no real dispute between by the parties) that residents stay on the Unit on average for a period of two years. The residents have usually been diagnosed prior to their residence at the Unit and the Unit

does not accommodate those in an acute stage of illness although all residents will suffer from incurable and chronic mental health illnesses. The Unit has the personal aspects of a residence such as individual decoration, catering and laundry facilities. There is also a social aspect to the Unit in that residents go to the theatre, sporting events and the like with staff. In our view these facts applied to the relevant words point away from the Unit being a *"hospital or similar institution"*; their primary function is to care for the residents and provide a home. However we did not find these features decisive of the issue; in some circumstances the length of stay may be superficial when viewed against what was actually done during that stay, which is no doubt why the Chancellor in *Fenwood* couched his judgement in the following terms:

"The contrast is between a home or institution providing residential accommodation with personal care for those who need it for the prescribed reason and an institution providing medical treatment and associated care, usually on a short term basis…a hospital is a building used for treatment for the cure or amelioration of a medical condition as opposed to personal care; the former is likely to require short term occupation, the latter long-term residence…" (emphasis added)

69. The material aspects of cross-examination by HMRC in this appeal related to the type of treatment provided to the residents and by whom. The medical qualifications of staff at all levels was highlighted by Mr Mantle who queried why the Unit would employ professionals such as a consultant psychiatrist if not to utilise their skills. It seemed a matter of common sense to us that given the chronic nature of the residents' illnesses and the specialised skills required in the complex arena of mental health disorders that medically trained staff would be employed. We agreed with Mr Hitchmough's submission that we should not confine ourselves to simply looking at the qualifications of the employees but we should consider what they did. We also accepted, as stated by Ms Kirk in evidence, that certainly some, if not all of the staff would use their professional skills in the course of their duties. However we did not find that it automatically followed that the use of such skills tipped the balance from personal care to medical treatment.

70. We considered the skills used by those employed at the Unit. The witnesses emphasised the aim of the Unit to take care of the residents and equip them with the skills to manage their illnesses as opposed to medically treating their illnesses. We were provided with details of three residents which demonstrated the types of interventions and assessments taken by the Unit generally together with specific examples where, for instance, on one occasion a resident was deemed a threat which led to the administering of medication (with the resident's consent) with the aim of preventing any further deterioration.

71. Medical treatment for cure is not relevant in this appeal given the incurable nature of the illnesses of the residents. HMRC argued that the illness is ameliorated by the assessment and review of residents' conditions and alterations to their medication. Mr Mantle also went one step further in arguing that preventing the deterioration of illnesses amounts to medical treatment such as to make the Unit fall within the scope of a hospital or similar institution. Mr Mantle urged us not to ignore

the high proportion of medically trained staff together with the wide variety and number of therapies provided.

72. In analysing the evidence we agreed with the Tribunal's view in *General Healthcare* at [22]:

"Taking "treatment" first, we cannot accept that the provision of some sort of treatment, without more, converts an institution into an institution similar to a hospital. Were it otherwise, any care home that provided any kind of treatment would immediately lose zero-rated status for its buildings. If and when a cure for cancer is discovered, any hospice that started trying to cure some of its inmates instead of merely easing their passing would again lose zero-rated building status. That cannot be right. …Putting it crudely, the staff are not there to mend the inmates' brains; they are there to re-educate them in how to use them."

73. In our view the assessments, reviews and therapies undertaken by the staff at the Unit are wholly distinct from diagnosis. Moreover, whilst we accept that residents were treated in that their medication could be altered or changed, we nevertheless found this to be ancillary to the care provided. It is a consequence of the residents' illnesses that they must be treated by medication; it does not, it seems to us, follow from that, that regular assessments of and tweaks to that medication, whether in the form of a higher/lower dosage or a change in the drug itself, lead to the conclusion that the Unit is a *"hospital or similar institution"*. From our understanding of the evidence, for instance the example given of a change to medication due to side-effects or a harmful rise in blood pressure, does not alter or improve the diagnosis or illness itself but rather it is an alteration (or treatment) designed to assist in the management of the symptoms of that illness. We considered HMRC's contention that such treatment prevents the deterioration of the resident. The evidence, which we accepted, did not support this proposition; Mr Jauffur did not agree that the Unit's interventions had a direct impact on symptoms of the residents' illnesses nor was he aware of any research to suggest that there is an indirect effect. Ms Kirk's evidence on the matter was cogent and compelling; she stated that medication does not help positive symptoms (such as hearing voices) and negative symptoms and such treatment cannot prevent symptoms (whether negative or positive) re-emerging. We considered the evidence that the facilities provided by the Unit help issues such as lack of motivation (negative symptoms). However the clear impression we had from the evidence was that the Unit could only help residents learn to manage the manifestation of symptoms of their illnesses; it cannot and does not prevent the deterioration of the illness itself. The example of a particular resident suffering an episode demonstrated that the illnesses and their symptoms are unpredictable and cannot be said to be either ameliorated or prevented from deterioration.

74. We noted that the judgment in *Fenwood* did not include preventing the deterioration of an illness as medical treatment. We concluded that either the issue was not considered or the absence of it was deliberate. Whatever the case, we agreed with Mr Hitchmough's submission that to include preventing the deterioration of an illness as medical treatment could lead to an absurd result; Mr Hitchmough gave the example of a person in an elderly care home suffering the onset of dementia whereby

if medication was provided to slow that onset the care home would lose its status. In our view that cannot have been the intention of the legislation.

75. We disagreed with HMRC's submission that although a significant part of what the Unit does is equip residents with life skills for the future there is also an element of improving or prevent worsening of their illnesses. We concluded that "personal care" is a term that must reflect current times; it may go beyond the basics of feeding and washing and, in our view, in the context of mental health illness the inclusion of the type of bespoke and specialist care provided by the Unit does not trespass into the arena of a "*hospital or similar institution*".

76. Taking all the factors into account, and giving each appropriate weight, we have concluded that the use of the Unit is not use as a "*hospital or similar institution*" and we therefore allow the appeal.

77. 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.

JENNIFER DEAN
TRIBUNAL JUDGE

RELEASE DATE: 31 MARCH 2016