EMPLOYMENT TRIBUNALS (SCOTLAND)

Case Number: 4108343/2021

Preliminary hearing held by video in Glasgow on 15, 16, 17 and 22 May 2023

Employment Judge M Whitcombe

Dr K Connaughton	**Claimant** **Represented by:** **Mr D Pansesar KC** **(Counsel)**
Greater Glasgow Health Board	**Respondent** **Represented by:** **Mr B Napier KC** **(Counsel)**

JUDGMENT ON A PRELIMINARY ISSUE

The judgment of the Tribunal is that the claimant was not the respondent's worker for the purposes of section 230 of the Employment Rights Act 1996, regulation 2 of the Working Time Regulations 1998 or the Working Time Directive.

REASONS

Introduction and background

1. The claimant is a general medical practitioner ("GP") practising from the Bridgeton Health Centre in the east end of Glasgow. Several GP practices are based at that health centre. The claimant is a partner in one of them, a partnership practice currently known as "Drs Connaughton and Sudomir".

2. The respondent is the largest Health Board in the UK and is commonly known as "NHS Greater Glasgow & Clyde". It has a statutory duty to provide primary medical services in the Greater Glasgow and Clyde area.

The claim

3. In a claim form (ET1) received by the Tribunal on 17 March 2021, the claimant sought compensation for leave taken on an unpaid basis in the period from 2011 until 2020, compensation for accrued but untaken entitlement to paid annual leave carried over from year to year, and a declaration of his entitlement to future paid leave. The claim is brought under the Working Time Regulations 1998 ("WTR"), the EU Directive 2003/88/EC on working time ("WTD") and under section 13 of the Employment Rights Act 1996.

4. In a response (ET3) received by the Tribunal on 13 April 2021, the respondent defends each of those complaints on the basis that the claimant lacks the necessary employment status to bring them. The respondent argues that the claimant is not its "worker", whether as a matter of domestic law or for the purposes of the WTD, and that the claimant therefore has no right to paid annual leave under that legislation.

The preliminary issue

5. This judgment deals with the critical preliminary issue of whether the claimant is and was the respondent's "worker" for the purposes of the above legislation.

Brief procedural history

6. This hearing was originally listed as a video hearing while the pandemic was ongoing. I decided that it would remain a video hearing because it reduced cost and inconvenience to the claimant's legal team. The respondent had a slight preference for a hearing in person but put it no higher than that.

7. The first case management hearing took place on 25 May 2021. Much of the time since then has been spent resolving several complicated disputes about the disclosure of voluminous documents from Scottish Ministers and the BMA. Since many of those disputes required an employment judge to read documents in respect of which privilege was claimed, they were resolved by EJ Kemp so that I could approach this hearing without any knowledge of the documents which he ultimately found to be privileged.

Evidence

8. I was provided with a collection of documentary evidence running to 4758 pages and a few additional documents during the hearing. Happily, all were in a digital format which was also used by the witnesses and the representatives. The bundle of 37 authorities ran to 835 pages and was also in digital format. That was much more manageable than the 11 lever arch files that would have been required if the hearing had been conducted with printed documents and I am extremely grateful for the way in which they were prepared and organised.

9. I heard from the following witnesses, all of whom gave evidence on oath or affirmation. They gave their evidence in chief primarily by reference to

written witness statements. All were cross-examined.

a. The claimant, **Dr Kevin Connaughton**.
b. **Ms Fiona Duff**, Senior Adviser to the Primary Care Directorate, Scottish Government. For more than 6 years she has advised the Scottish Government on Primary Care and Practice Management and the day to day running of General Practice. Before that, she was for 15 years the Primary Care Manager for NHS Highland and before that a GP Practice Manager or Fund Holding Manager for 11 years.
c. **Mr Michael Taylor**, Head of GP Contract Operations at the Scottish Government, responsible for "business as usual" elements of the 2018 General Medical Services (GMS) contract. He was involved in the negotiation of the terms of that contract.
d. **Ms Lorna Kelly**, currently National Strategic Lead for Primary Care at Health and Social Care Scotland, prior to that Interim Director of Primary Care at the respondent Health Board for about 18 months, and before that Head of Primary Care Support and Development for about 4 years from 2016.
e. **Dr John Nugent**, now retired but formerly Senior Medical Officer and Clinical Director of the Primary Care Division of the Scottish Government. He had a key role in negotiations with the BMA on behalf of the Scottish Government regarding the terms of what became the 2018 General Medical Services (GMS) contract. He also spent 25 years as a partner in a GP partnership in Drumchapel from 1989 until 2014 before undertaking roles as Associate Medical Director and Clinical Director for the respondent Health Board.

10. The parties also provided an extremely helpful statement of agreed facts.

11. I found all of the witnesses to be honest and sincere. They all reflected carefully on the questions they were asked and none of them were evasive in any way. The claimant's perception of his obligations and the respondent's actions did not always tally with the contemporaneous

documentary evidence, but that is not a criticism of his honesty. I am sure that his evidence faithfully expressed the reality of the situation as he saw it.

The facts

12. Many relevant facts were either agreed, or else not actively disputed. Where facts were disputed I made my findings on the "balance of probabilities", in other words a "more likely than not" basis. If I concluded that a fact was more likely to be true than untrue, then it was treated as being true for the purposes of my decision.

Health Boards - statutory background

13. Under the National Health Service (Scotland) Act 1947 and The National Health Service (Scotland) Act 1978 it is and has been the duty of every Health Board (or predecessor organisation) to promote the improvement of the physical and mental health of the people of Scotland. Further, those statutes required Health Boards and their predecessors to provide or secure primary medical services to patients in their areas. That can be done by making arrangements with medical practitioners. See originally section 34 of the 1947 Act and now section 2C of the 1978 Act.

14. The respondent, Greater Glasgow Health Board ("GGHB"), is a statutory body established by order made under section 2(1)(a) of the NHS Scotland Act 1978 as amended by the Primary Medical Services (Scotland) Act 2004. The functions of Health Boards in relation to primary medical services are set out in section 2C(1) of the 1978 Act, as amended. Every Health Board:

    a. *must*, to the extent that they consider necessary to meet all reasonable requirements, provide or secure the provision of primary medical services as respects their area; and
    b. *may*, to such extent, provide or secure the provision of primary medical services as respects the area of another Health Board.

15. For the purpose of securing the provision of primary medical services a Health Board may make such arrangements for the provision of the services as they think fit and may make contractual arrangements with any person.

16. The file of documents contained extracts from Hansard dating from 1948 but I was not referred to any of them and I make no findings in relation to them.

1990s

17. In about 1990 arrangements were made between Health Boards and individual GPs to provide general medical services. They were contained within the NHS (General Medical and Pharmaceutical Services) (Scotland) Regulations 1974, as amended. Schedule 1 set out the terms of service for doctors, covering a variety of matters relating to the provision of medical services, including the people for whose treatment the doctor was responsible, the services which should be rendered and the required availability to patients.

18. The terms of service were later subject to the NHS (General Medical Services) (Scotland) Regulations 1995 under which arrangements for GPs to provide services within a Health Board area were made directly between the Health Boards and individual GPs. That entailed an application process for admission to the list of qualified practitioners for the Health Board where that doctor intended to practise. It was then known as the “medical list” and is now known as the “performers list”. Each Health Board holds its own performers list.

19. Arrangements were put in place under the “Scottish Office Home and Health Department National Health Service General Medical Services Statement of Fees and Allowances Payable to General Medical Practitioners in Scotland from 1 April 1990”. They were known colloquially, and more briefly, as “the Red Book”. The Red Book was prepared under the NHS (General Medical

and Pharmaceutical Services) (Scotland) Regulations 1974 as amended, and subsequently the NHS (General Medical Services) (Scotland) Regulations 1995. It was a small loose-leaf binder.

20. Funding for practices came from the Scottish Office Department of Health to GP Practices via the Health Board. It was an unlimited government budget and did not come from Health Board funding.

21. The Red Book set out how many partners a practice could have. The practice received a Basic Practice Allowance, Capitation Fees and Staff Reimbursement Costs. Health Boards reimbursed 70% of practice staff costs. Practices required the permission of the Health Board if they wished to recruit or replace a member of staff such as a nurse, or to take on another GP. There were some GP specific payments, such as a postgraduate education allowance and seniority payments.

Introduction of the 2004 General Medical Services ("GMS") Contract

22. In 2004 negotiations between the BMA and the Scottish Government resulted in a Standard General Medical Services (GMS) Contract, issued by the Scottish Executive Health Department.

23. Since then, as a result of changes made by section 4 of the Primary Medical Services (Scotland) Act 2004, Health Boards have had the power to enter into a contract under which primary medical services are provided by a contractor. The terms of those contracts are defined by the NHS (General Medical Services Contracts) (Scotland) Regulations 2004.

24. The 2004 GMS contract was a contract for the provision of primary medical services and other services. It sets out the terms of the relationship between the Health Boards and their GP contractors and incorporated the contents of an agreement reached at a national level on behalf of all four of the UK nations.

25. Guidance was issued by the BMA General Practitioners Committee. The guidance explained that the 2004 GMS Contract provided greater flexibility in the way that its contractors could be structured. Contractors could be single-handed GPs, partnerships or certain types of limited companies. That was very different from the previous arrangements, under which contracts were between the relevant primary care organisation and individual GPs, known as "principals".

26. Under the 2004 contract, patients were on a practice's list, not a particular GP's list. The 2004 contract also gave more power to contractors to run practices in the way that they wanted. After 2004, it was for the GP practice to decide what expenses and staff costs to fund. The 2004 contract did not specify any limit on the number of partners that a GP Practice could have. That was at the discretion of the practice. Practices no longer required the permission of the Health Board to hire staff, so practices could decide the types and numbers of staff they wished to employ and what they would be paid. Staff terms and conditions were decided by the practice. Practices did not need to inform the Health Board who they employed or what they were paid.

27. The system for claiming reimbursement of staff costs was not continued under the 2004 contract. It was for the practice to decide what staff costs and other expenses to fund from the money received from Health Boards. The remaining funding represented profit.

28. It became the Health Board's responsibility to provide an out of hours service and so practices could opt out of providing out of hours cover if they wished. That allowed practices to focus on providing services between 0800 and 1800 Monday to Friday.

29. A Quality Outcomes Framework was introduced. That was intended to improve care for patients with chronic long-term conditions like diabetes and

asthma. Practices would receive more money if they met certain quality indicators. However, that scheme was discontinued in 2016 without any reduction in funding.

The Memorandum of Understanding of 10 November 2017

30. Negotiations in anticipation of a new GMS contract took place between the BMA's Scottish General Practitioners Committee and the Scottish Government. While the Scottish Government engaged with Health Boards to seek their views and to inform its negotiating position, Health Boards such as the respondent were not directly involved in negotiations.

31. In anticipation of what became the 2018 General Medical Services Contract, a memorandum of understanding was issued by the Scottish Government, the British Medical Association, the Integration Authorities and NHS Boards. It was jointly signed on 10 November 2017.

32. There would be a move away from the Quality and Outcomes Framework introduced in the 2004 contract.

33. The Scottish Government would also support a shift, over 25 years, to a new model for GP premises under which GPs would no longer be expected to provide their own premises. Proposals included the possibility of lease transfers and access to interest free loans of up to 20% of the use value of the property.

34. In relation to workforce, it was proposed that there would be an expansion of the capacity and capability of the "multidisciplinary team". Many of the staff working in those teams would be employed by the NHS Board. Some might be assigned to a single GP practice while others might work across a group of practices ("clusters"). Existing practice staff (for example, Practice Managers and receptionists) would continue to be employed directly by practices. These changes are ongoing at the time of writing.

35. A booklet was sent out to every GP in Scotland in early November 2017 setting out the detail of the proposed new contract. It was a joint BMA and Scottish Government document. A series of "roadshows" were set up to inform GPs about the new contract and to allow them to ask questions about it. The booklet highlighted the fact that the contract was intended to preserve independent contractor status, highlighted the perceived benefits of that approach and indicated that both the BMA and also the Scottish Government proposed that the GMS contract would continue as an independent contractor model. The perceived benefits were said to be independence from line management and the GPs' ability to control and adapt their working day and environment, including their teams, to meet the needs of their patients under their contract. The booklet referred to the results of a ballot of BMA members across the UK in 2015. Of 15,560 responses, 82% favoured retaining an independent contractor model.

36. The BMA then balloted its GP members in Scotland in an exercise which ran from early November 2017 until mid-December 2017.

37. On 18 January 2018 the BMA announced that it backed the new General Medical Services Contract and the Scottish Government proceeded with implementation. So far, only Phase 1 has been implemented. Phase 2, which would be concerned with separating out GP pay and expenses, was to be subject to further negotiation and a further vote. At the roadshows, some GPs had been concerned that Phase 2 might undermine independent contractor status for tax purposes and that they might become subject to IR35 arrangements.

38. The new GMS contract had several aims. One was to establish the roles of GPs in Scotland within the NHS. Another was to ensure that their workload was manageable and that they were supported with that. A third aim was to reduce the financial and legal risk to GPs through support from government, and a further aim was to make the profession more attractive to new GPs,

to be achieved largely by investment by the Scottish Government. A new practice income guarantee was intended to ensure practice income stability. Significant new arrangements would be implemented in relation to GP premises, IT and information sharing. The effect was intended to be a substantial reduction in risk for GP partners in Scotland with a substantial increase in practice sustainability. Sustainable general practice was considered to be critical to ensuring better patient care.

39. In order to reduce GP and practice workload, some tasks would be spread out within wider primary care multidisciplinary teams instead of GPs. Those multidisciplinary teams would be employed by Health Boards. GPs would retain their role in the provision of those services if needed and would suffer no financial loss, but services such as vaccinations, pharmacotherapy, physiotherapy and community services would be handled to a far greater extent by the wider multidisciplinary team.

Introduction of the 2018 General Medical Services ("GMS") contract

40. Following negotiations and agreement between the negotiating bodies of the BMA and the Scottish Government (outlined above), a new GMS contract was issued by the Scottish Government Health Department in 2018. It is a variation of the 2004 GMS Contract with effect from 1 April 2018 (see clause 36). It was incorporated into a contractual document issued to GP practices by the respondent in the exercise of its powers under section 17J(1) of the NHS (Scotland) Act 1978, as amended by the Primary Medical Services (Scotland) Act 2004. Section 17J gave Health Boards the power to enter into general medical services contracts for the provision of primary medical services. The legal framework for the contract is provided by the NHS (General Medical Services Contract) (Scotland) Regulations 2018, which set various preconditions which must be met before a Health Board can enter into a contract.

41. Clause 8 provides that if the Contractor is a partnership the contract is made

with the Contractor as it is from time to time constituted, and shall continue to subsist notwithstanding the retirement, death, expulsion or addition of any one or more partners.

42. Clause 11 records that, "The Contract is a contract for the provision of services. The Contractor is an independent provider of services and is not an employee, partner or agent of the HB. The Contractor must not represent or conduct its activities so as to give the impression that it is the employee, partner or agent of the HB."

43. Clause 12 records that, "The HB does not by entering into this Contract, and shall not as a result of anything done by the Contractor in connection with the performance of this Contract, incur any contractual liability to any other person."

44. Clause 13 provides that, "This Contract does not create any right enforceable by any person not a party to it."

45. Clause 17 prohibits a Contractor from giving, selling, or otherwise disposing of the benefit of any of its rights under the contract. However, the contract does not prohibit the Contractor from delegating its obligations arising under the contract where such delegation was expressly permitted by the contract.

46. In broad terms, in relation to partnerships, clauses 23.2 and 24.2 each provide that those partnerships must ensure that every member of the partnership has "sufficient involvement in patient care" for the duration of the contract.

47. The expression "sufficient involvement in patient care" is defined by clauses 30 to 35 of the contract and regulation 11(5) of the NHS (General Medical Services Contracts) (Scotland) Regulations 2018. In essence, it means regularly performing, or being engaged in the day-to-day provision of, primary medical services in accordance with a GMS contract (or certain

other defined arrangements which have no direct relevance to this case) for no less than a total of 10 hours in each week.

48. Unsurprisingly, many forms of leave including, for example, annual leave, maternity leave and sick leave are disregarded for the purposes of determining whether a person has "sufficient involvement in patient care" for the purposes of the contract.

49. No doctor in the partnership was obliged by the contract to provide anything by way of personal care beyond those 10 hours. Further, the contractual obligation was on the partnership, not upon the individual doctor. If a doctor failed to have "sufficient involvement in patient care" then that was a breach of the partnership's obligation rather than any owed to the Health Board by an individual doctor.

50. The contract does not specify when the 10 hours are to be done or precisely what must be done, other than the provision of "Primary Medical Services" which are not strictly defined. Practice partnerships must confirm in their annual return that they have complied with the terms of the GMS contract in this respect.

51. Clause 48 and schedule 4 set out the Contractor's and the Health Board's rights and obligations in relation to "essential services" to be provided in "core hours". The Contractor must provide services for the management of the Contractor's registered patients and temporary residents who are, or who believe themselves to be, ill with conditions from which recovery is generally expected, terminally ill or suffering from chronic disease. They are to be "delivered in the manner determined by the practice in discussion with the patient". The Contractor must also provide primary medical services required in "core hours" for the immediately necessary treatment of certain other defined categories of people.

52. "Core hours" are defined by Section A of the contract and by regulation 3(1)

of the 2018 Regulations as beginning at 0800 hours and ending at 1830 hours on any working day.

53. I do not accept the claimant's evidence that Schedule 4 provides that "there is a requirement for each General Medical Practitioner to provide a personal service, which cannot be delegated or substituted, to meet the needs of its patients." The requirements of Schedule 4 are all imposed on "the Contractor" rather than on any individual GP and they do not prohibit delegation or substitution. Subject to the specific rules summarised above, it was for the partnerships to decide how essential services within core hours were delivered. At their discretion, they could use locum doctors. Further, the Health Board did not have the power to remove any doctor, including the claimant, from providing services under the 2018 contract provided that they were medically qualified and on the "performers list".

54. Schedule 10 provides that no medical practitioner may perform primary medical services under the contract unless they:

    a. are included in the relevant Health Board's primary medical services performers list;
    b. are not suspended from that list or from the Medical Register;
    c. are not subject to an interim suspension order.

55. Schedule 11 prohibits the Contractor from sub-contracting any of its rights or duties under the contract in relation to clinical matters unless it has taken reasonable steps to satisfy itself that it is reasonable in all the circumstances and the proposed sub-contractor is qualified and competent to provide the service and has notified the Health Board in writing of its intention. However, the notification requirement does *not* apply to a contract for services with a health care professional for the provision of clinical services (clause 2).

56. While not strictly a term of the 2018 contract, it is convenient to mention at this point regulation 3 of the Primary Medical Services (Sale of Goodwill and

Restrictions on Subcontracting) (Scotland) Regulations 2004. It prohibits the sale of the goodwill of primary medical services provided by a GMS contractor.

57. I do not accept the claimant's evidence that the respondent retained a power to make unilateral changes to the terms of the contract itself. There is no express contractual power to do so, and I find that the evidence does not come close to establishing that it happened in practice. Elsewhere in these reasons I set out some occasions on which the respondent made certain *requests* during the Covid-19 pandemic, but I do not regard any of them as examples of the respondent making unilateral changes to contractual terms. I prefer Fiona Duff's evidence that any substantive changes to the contract would need to be negotiated between the BMA Scottish General Practitioners Committee and the Scottish Government.

Commencement of the claimant's career as a GP

58. The claimant is a General Practitioner ("GP") who qualified in July 1983. He then spent several years working in hospitals and a year working as a GP trainee in Biggar in South Lanarkshire. He started working as a locum GP in September 1989 and started as a locum in his current practice on 4 December 1989. The single-handed GP for whom the claimant was covering failed to return and after a selection process the claimant took over the practice on 1 September 1990.

59. To that end, on 12 August 1990 the claimant signed an application form for inclusion in the "Medical List", stating that he would be providing general medical services including maternity medical services and contraceptive services. He agreed to be bound by the terms of service in operation in his area and certified that he was "suitably experienced" within the meaning of section 21 of the NHS (Scotland) Act 1978. He undertook to visit patients and stated that he would operate from consulting rooms at Bridgeton Health Centre for 5 days or 26 hours per week. He stated on the application form

that he did not intend to practise in partnership.

60. Contrary to the position taken in the claimant's witness statement, he did not sign "an original contract". It was an application for inclusion in the "Medical List", sometimes known as "Form GP16(Scotland)". In 1990 there was no General Medical Services contract in place: instead, arrangements were made between Health Boards and GPs directly as individuals in accordance with "Terms of Service" set out in Schedule 1 to the National Health Service (General Medical and Pharmaceutical Services) (Scotland) Regulations 1974, as amended.

61. Having carried out a verification process and having checked the authenticity of supporting documentary evidence, the respondent confirmed that the claimant was to be included in the Greater Glasgow & Clyde Performers List with effect from 1 September 1990.

62. While in his witness statement the claimant asserted that from 1990 until 2004, he had responsibility to cover the practice 24 hours a day, 7 days a week, 52 weeks a year with no respite, he accepted in cross-examination that it was in fact a shared responsibility. The responsibility was shared with the other partners with whom he practised.

63. The claimant has had 3 partners during his time at Bridgeton Health Centre, from 1994 to 1996, from 1997 until 2005 and from 2010 onwards. None of those partners was ever full-time and so there have always been periods each week for which the claimant was the sole doctor. When he did not have a partner the claimant engaged several different doctors to do regular sessions on a locum basis.

Provision of services under the 2004 GMS contract

64. On 23 March 2004 the claimant signed a 2004 GMS contract. He did so as "Senior Partner", "on behalf of the Contractor". The Contractor was defined

in Schedule 1 as the partnership of "Dr R K Connaughton and Dr E McLellan". In fact, the part of Schedule 1 completed by the claimant appears to have been intended to deal with "individual" or "single handed practices" rather than partnerships, but that was an error on the claimant's part and neither side suggested that anything turned on it for the purposes of this hearing.

65. The claimant accepted in cross-examination that entering into a contract as a partner was not the only way in which he could have agreed to provide services as a GP. He actively chose not to continue single-handedly and chose to work in a partnership, explaining, "it was a case of sharing the workload really". He also accepted that partnership made it easier to coordinate things like holidays.

Provision of services under the 2018 GMS contract

66. On 14 March 2018 the respondent sent a letter to "Drs Sudomir and Connaughton" giving formal notice of variation of the GMS Contract. That was done in anticipation of the NHS (General Medical Services Contracts) (Scotland) Regulations 2018 which came into force on 1 April 2018. Paragraph 3 refers to the 2004 contract as "the contract between Dr Kevin Connaughton and the Board dated 1 April 2004" but it was common ground at this hearing that this was simply a mistake. The 2004 contract had not been with the claimant personally.

67. The claimant signed a copy of the contract on 18 December 2018. The title page described the "Contractor" as "Drs Connaughton & Sudomir Practice 46428". Every page is headed, "This Contract is between Greater Glasgow Health Board, commonly known as NHS Greater Glasgow & Clyde (The Board) and Drs Connaughton & Sudomir (Practice 46428)". Dr Sudomir signed under a section which said "(Note: Although not a contractual requirement, if the Contractor is a partnership, it is recommended that all of the partners comprising the partnership at the date the Contract is signed

(whether these partners are general partners or limited partners) should sign the Contract)". The claimant signed the contract under the heading "Contractor Signature". Schedule 1 (Partnership) records the name and details of the respondent in part 1, and the details of the Contractor in Part 2. Part 2 states, "The Contractor is a partnership under the name of Drs Connaughton & Sudomir…".

68. An updated contract was sent to the claimant on 28 February 2019.

69. The written terms summarised above fairly and fully reflected the reality of the situation, which was that mutual obligations bound the partnership and the respondent Health Board in a contractual relationship. It was also the reality of the situation that the claimant and the respondent did *not* owe each other legally enforceable mutual obligations, and were not by virtue of the 2018 GMS Contract in a contractual relationship.

The partnership agreement

70. The partnership agreement between the claimant and Dr Jolanta Sudomir was signed by both of them on 21 August 2012 and was effective from 1 September 2012.

    a. The business of the partnership was described as being "to carry on a General Medical Practice at the Premises…".
    b. The premises were defined as the Bridgeton Health Centre.
    c. Clause 12.2 states as follows: "During the absence of a Partner on annual leave, the other Partner shall generally undertake his or her duties, and a locum shall be employed to provide at least 50% cover (or otherwise as agreed), the cost of which shall be borne by the Partnership."
    d. The agreement defined the profit share. There were some transitional arrangements as Dr Sudomir joined the practice but in the long term the formula was for net profits to be divided between the partners in proportion to the number of sessions which each

worked in a normal working week. Initially, that was to be 8 sessions per week for Dr Sudomir and 10 sessions per week for the claimant. In other words, a 44%/56% split in the claimant's favour.

Practical aspects of the claimant's work

71. The claimant's practice currently has about 4,500 patients in its list. The practice has a turnover of £589,143 on the latest available figures.

72. As noted above, when the claimant was asked why he decided that he would enter into partnerships rather than continuing to practise single-handedly he replied that it was really a question of sharing workload. Partnership made it easier to coordinate workload and to organise leave, including holidays. The claimant was able to take holidays, although he was not paid for them by the respondent Health Board.

73. The partnership is free to make its own decisions regarding the staff directly employed by the practice, their numbers, specialisms and rates of pay. It is also a matter for the partnership to decide how the practice is run administratively, how appointments are allocated, and whether to have a receptionist, practice manager or nurse at all. The partnership has considerable autonomy on those administrative matters, as well as on matters of clinical judgment.

74. The practice IT system is provided and maintained by the respondent Health Board.

Engaging locums

75. When the claimant takes time off locum cover is arranged. The claimant stated that "*I must arrange for someone to cover me at my own expense*", but I do not accept that as an accurate characterisation. The true position is anticipated and provided for by the partnership agreement. The other

partner should in general undertake the claimant's duties and additionally locum cover of at least 50% shall be arranged. If for any reason the other partner cannot offer any cover at all then the requirement to obtain at least 50% locum cover still applies. It is therefore the *partnership* that is obliged to obtain locum cover at the *partnership's* expense. Those expenses will reduce net profits.

76. That is the theory, but in practice locum cover can sometimes be difficult to arrange. I was not given any detailed examples and the evidence on this point was rather anecdotal, but I accept the general thrust of the claimant's evidence that arranging locum cover for a planned holiday is often a question of "cobbling together" cover from more than one person. It is also rare to be able to get cover quickly. The claimant gave one example of a time when he had booked a 3 week holiday only for the covering locum to decide on the first day that he would not cover the absence after all. However, the claimant was able to obtain a replacement locum after 3 days. On balance, my finding is that although it can sometimes be difficult to obtain locum cover it is certainly not impossible. I do not accept the claimant's argument that he is personally obliged to return to the practice if locum cover fails. The obligation to provide services lies with the partnership, as the contractor under the GMS contract.

77. The locum has to be on the performers list maintained by the respondent, but I do not accept that this a significant limitation or obstacle. Any properly registered GP interested in working as a locum would find it a simple matter to gain admission to the performers list, provided that they were not the subject of a suspension order or an interim suspension order, which can be taken to be very rare. I find that any restricted availability of locum cover is more likely to be a simple question of supply and demand. The supply of locum cover is not significantly restricted or controlled by the respondent.

78. The evidence was that locum cover was often not available until 0830 whereas core hours began at 0800. However, this would only impact on the

partnership's obligation to provide essential services within core hours if no other doctor were present on site from 0800. Even if that were the case, there was no evidence that the respondent would regard the partnership as being in breach of its obligations if it had made reasonable efforts to obtain locum cover for a particular period but had not been able to do so for the first 30 minutes of core hours.

79. Where locums were used to cover for sickness absence, reimbursement could be claimed from the respondent if the sickness absence exceeded two weeks.

80. A partnership can engage a locum GP without seeking approval from or even informing the respondent Health Board. The locum must be appropriately qualified and on the Performers List, but the respondent has no other interest in or control over the identity of the locum selected by the contractor. The contractor is obliged to take reasonable steps to satisfy themselves that the locum is appropriately qualified and competent. That obligation derives from Schedule 11 of the 2018 GMS Contract, which deals with "Sub-contracting of clinical matters" (also considered above).

Taking holidays

81. The claimant took holidays as set out in paragraph 15 of his Grounds of Claim. His complaint is that the respondent did not pay him for those periods of leave. He also feels aggrieved that he has to arrange cover and that holiday is "never fully true, guaranteed holiday".

82. The claimant accepted that the partnership agreement contained provisions dealing with the taking of holiday by a partner, including arranging cover. The relevant term is set out above.

83. Neither the claimant personally, nor the contracting partnership, are obliged to notify the respondent Health Board when a GP partner takes leave.

There is no set leave entitlement and there is no obligation to inform the Health Board of leave planned or taken. There is no obligation to coordinate leave with nearby practices. The respondent has no knowledge of whether or when the claimant took leave, or whether it was unpaid. That is a matter entirely up to the partnership. The leave taken by the claimant or any other member of the partnership has no bearing on the funding which the practice receives.

Tax

84. For the whole of the time that the claimant has worked as a GP, whether single-handedly or in partnership, he has been taxed as an independent self-employed person. However, UK tax law recognises only two types of status in this situation: employed and self-employed. There is no equivalent of "worker" in the sense used in the Employment Rights Act 1996 or the Working Time Regulations 1998 so far as HMRC is concerned. It is well-known that HMRC might regard someone as self-employed for tax purposes even if they have a different status in employment law.

Integration

85. The primary care services provided by the contractor are fully integrated into the NHS. The respondent Health Board is not a client or customer of the contractor. General practice has always been fully integrated into the NHS.

Control

86. There is no line management relationship between the claimant or his partnership and managers employed by the respondent Health Board.

87. There is an appraisal scheme. A national standard scheme requires every doctor to have an annual appraisal as a national safeguard for standards of

services. The scheme is overseen by NHS Education for Scotland. The appraisers are nominated by Health Boards. Health Boards then provide revalidation information to the GMC, who revalidate the doctor. In the context of a regulated profession, I do not regard an appraisal system as a significant form of control over, or supervision of, work.

88. While the contract requires the claimant to work in the practice personally for a minimum of 10 hours in a normal working week, there is no obligation to do any greater degree of work than that personally. Those 10 hours do not all have to be done at the same practice. There is no direction regarding precisely when those hours must be done, other than over the course of a week. Importantly, the obligation lies with the partnership to ensure that a minimum 10 hours of work is done by each GP in the partnership. If there were a persistent breach of that obligation then the respondent could and probably would take action against the partnership as the contractor, but not against the individual doctor concerned.

89. If the respondent had concerns about an individual doctor, then they would almost always be raised with the practice, rather than directly with that individual doctor. The exceptions would be if there were concerns about clinical practice, or with continued inclusion on the Performers List. They might be raised directly with the GP concerned. The possibility that the respondent could refer an individual GP to the GMC was suggested in evidence, but if that were to happen then it merely demonstrates the lack of control exercised over individual doctors by the respondent itself.

90. The respondent's Performer's List does not contain any information regarding any individual GP's days or hours of work.

91. The purpose of the 10 hour requirement was not to give Health Boards control over GPs, but rather to prevent practices from being taken over by companies. The claimant agreed with that proposition in cross-examination and it is also supported by an article in the British Medical Journal (BMJ

2008; 337: a749) first published on 9 July 2008. The then Scottish Health Secretary Nicola Sturgeon informed a meeting of BMA representatives that "legal loopholes" which might allow private firms to bid to run GP practices in Scotland would be closed. The requirement was introduced in 2010 or 2011.

92. The respondent has no power to direct which GPs should work at which times, or on what days, or for how many hours. The respondent has no power to remove a particular GP from providing services under the contract, provided that they were appropriately qualified and on the performer's list.

93. As a Health Board, the respondent has no real power to instruct GPs how to provide their services, whether in terms of clinical judgment, or in terms of managing other services. Whereas regulation 119 of the NHS (General Medical Services Contracts) (Scotland) Regulations 2018 states that contractors *must* comply with all relevant legislation, it only requires contractors to *have regard* to all relevant guidance issued by the Health Board and the Scottish Ministers. Contractors are not obliged to follow that guidance. That statutory provision is given contractual effect by clause 73 of the 2018 GMS contract. It is a question of guidance rather than direction.

94. GP practices are free to decide who they wish to employ, how much those people are paid, their appointment procedures and all other administrative arrangements. The respondent does not have the power to instruct GPs how to do their jobs, either clinically or as managers of services within their practices.

95. The claimant argues that the practical reality is that the respondent exercises greater control than that and relies on a number of documents which, in his view, demonstrate a greater level of control than that strictly conferred by the terms of the contract between the respondent and the partnership.

a. I am not persuaded that the letter dated 3 December 2020 to all GP practices in the Greater Glasgow and Clyde area from the respondent's Interim Director of Primary Care, the Deputy Medical Director for Primary Care and the Chair of the Glasgow Local Medical Committee supports the claimant's argument. The letter was written against the background of rising Covid-19 case numbers in the winter of 2020. It gives notice that, with the agreement of the Glasgow Local Medical Committee, where expected demand exceeded available capacity to the extent that existing approaches were likely to be overwhelmed, GP Practices "may be asked" to provide additional support to the community pathway. Practices were also encouraged to continue to take up shifts with "the Centres and the Hub". I do not share the claimant's view that the letter demonstrated that the respondent had the *power* to redeploy GPs unilaterally. I regard this letter as a *request* for continuing voluntary support and also notification that other forms of additional support might be requested if demand exceeded capacity. It was not an instruction and did not use the language of instruction.

b. I do not accept the claimant's suggestion that the respondent had a general power to change contractual terms unilaterally. There was no evidence that it ever had such a wide and general power. The only power to vary unilaterally was that reflected in clause 108 where the respondent was "reasonably satisfied" that it was necessary to vary the contract in order to comply with certain specified legislation.

c. The point appeared to narrow in cross-examination to focus on communications about opening on public holidays. However, I find that was a matter of local agreement between the respondent and the Glasgow Local Medical Committee. So far as individual practices were concerned, it remained a request: they were "asked" to provide GMS Services during core hours on Easter Friday and Monday or to make arrangements with "buddy practices" to cover that. While it is

true that the letter requires practices that felt unable to open, or that wished to make an alternative arrangement to "buddying", to agree that with the Clinical Director locally, there was no suggestion that practices could be compelled to open against their wishes. Once again, the context was the unprecedented pressure on the NHS caused by the Covid-19 pandemic.

d. For those reasons, I do not accept the claimant's evidence that the respondent had a power to redeploy him unilaterally to another pathway of care.

Dr Sudomir

96. The respondent had been notified in March 2021 that Dr Sudomir would be taking a break from the practice to care for family members in Poland. The respondent's view was that this would be a period of special leave or sabbatical such that there would be no breach of the contractor's obligation to ensure "sufficient involvement in patient care" (i.e. the 10 hour rule). That was not an issue. However, the respondent received no news of Dr Sudomir's return. Attempts to contact her failed. By 3 May 2022 more than a year had elapsed since the respondent had any knowledge that Dr Sudomir had worked as a GP in the UK, which was a requirement of remaining on the Performer's List. GPs in Scotland may be removed from the Performer's List under regulation 10 of the NHS (Primary Medical Services Performers Lists) (Scotland) Regulations 2004.

97. The respondent therefore contacted the practice to ensure that the claimant, as the remaining partner, was aware of the implications for the partnership. If Dr Sudomir remained a partner then there was a risk that the respondent would terminate the GMS Contract with the partnership. The respondent was seeking to work with the contractor to avoid that consequence. Two possible options were offered:

a. to stay on as a partnership contractor provided that an advertisement

was placed to recruit another partner; or

b. to change to an individual GMS contract.

98. Ultimately, Dr Sudomir voluntarily withdrew from the Performers List at the respondent's suggestion because she was unable to comply with its requirements. She also resigned from the partnership.

99. I do not regard this as an example of the respondent exercising any more than the most basic control over the partnership in which the claimant worked. It was simply a necessary consequence of Dr Sudomir's failure to comply with the minimum requirements of continued inclusion on the Performer's List. The language used by non-lawyers in some of the relevant correspondence is a little loose, but I am satisfied that the respondent was concerned about the implications for the GMS contract with the partnership of Dr Sudomir's failure to meet the minimum requirements for continued inclusion on the Performer's List. The requirement to have provided GP services somewhere in the UK within the previous 12 months was a simple, "bright line" rule intended to ensure a minimum level of current competence. In my assessment that enforcement of a basic minimum standard does not represent a significant degree of control over the claimant or the partnership.

Patient lists

100. Each practice has a designated practice area, covering certain postcodes. Other practices may also cover some or all of those postcodes, in which case a patient would have a choice of practices with which they could register and could choose whichever they preferred. The claimant did not know what other practices covered the same postcodes as him. The contract sets out ways in which a practice can change its practice boundary, but the respondent Health Board cannot make a change itself.

101. Patients are not supplied by a Health Board. It is the patient's own decision

whether to register with a practice at all and if so which one. A practice can refuse to take on a patient for good and non-discriminatory reasons, particularly if they live outside the practice area. While the assumption of the 2018 GMS Contract is that a practice will normally accept patients if they register, it is not the Health Board's obligation to supply patients, it is up to patients to register. The Health Board does not guarantee any minimum number of patients.

102. The obligation to register patients lies with the practice, or in other words, the contractor. There are some limited exceptions, for example where the patient does not live in the contractor's practice area, but otherwise the contractor may only refuse an application for registration if it has reasonable grounds for doing so which do not relate to race, gender, social class, age, religion, sexual orientation, appearance, disability, or medical condition. This obligation derives from paragraph 14 of Schedule 6, Part 1 of the National Health Service (General Medical Services Contracts) (Scotland) Regulations 2018.

103. Asylum seekers are supported to register with a practice in a way that results in a fair spread of new patients among practices. Only asylum seekers resident within the partnership's practice area are supported to register. This typically amounts to 7 or 8 asylum seekers each year being supported to register with the claimant's practice.

104. The respondent is not under any obligation to make patients register with a given practice. If a particular practice's patients were to leave, then there is no obligation on the respondent to replace them. While the expectation of a 2018 GMS Contract is that a practice will provide services to patients in a defined area there is no fixed level of patient numbers. The 2018 GMS Contract does not specify a defined number of patients per contractor or per GP in a partnership. That had been a feature of arrangements prior to 2004, but not since then.

105. The practice has a discretion whether to register patients who live outside their area or to agree to keep patients who have moved out of their area.

106. It is theoretically possible that a patient might be allocated to a particular practice in certain circumstances. However, it is extremely rare, generally applying only to patients whose behaviour had been very difficult. The claimant did not dispute the suggestion in cross-examination that there have not been any formal allocations of patients by the respondent Health Board to the claimant's practice.

107. Practices are not free to discard patients from their lists provided that those patients reside within the relevant catchment area. Practices have no control over the funding per patient in their area, or the calculation of the global sum. They do, however, have control over their overheads and other expenditure and are to that extent able to influence profit. Practices that are partnerships are also obviously in control of the share of profits allocated to each partner.

Practice income (NHS)

108. It is the Scottish Government which has primary control over the rates which influence practice earnings, not Health Boards such as the respondent. Payments are made by Health Boards in accordance with Schedule 21 to the 2018 GMS Contract. Practice funding is determined by a capitation payment known as the "global sum" based on the size and characteristics (for example, age) of the practice population. There are also additional payments for enhanced or additional services, which can be set nationally or locally by the Health Board concerned. Uplifts are agreed each year between the Scottish Government and the Scottish General Practitioners Committee, and the formula is set out in the GMS Statement of Financial Entitlements. It is also possible to claim reimbursement for the cost of locum cover for GP sick leave and maternity leave. The largest single element of funding is the global sum, which accounted for about 86% of the funding of

the practice of Drs Connaughton and Sudomir in 2021/2022.

109. That funding is intended to cover the costs of running the practice including the employment of practice staff and the costs of providing the range of services required under the contract. Additionally, partnerships may claim reimbursement of some additional costs, for example staff sick leave or maternity leave in accordance with specified rates. The respondent does not have control over the pay of staff employed in the practice – that is a matter for the partnership to decide. In 2021/2022 the claimant's practice received £589,143 from the respondent for delivery of the contract.

110. Those are the factors driving partnership income, but the claimant's personal income will obviously be affected by two further factors of considerable importance:

    a. The practice overheads and other expenses.
    b. The share of partnership profits to which he is entitled under the partnership agreement.

111. The respondent has no control over any partner's individual earnings and does not receive information about that, save for pension purposes.

112. The GMS Statement of Financial Entitlements provides a "Minimum Earnings Expectation". If necessary, practices may receive additional funding to ensure that they can pay their partners the specified minimum earnings. That is only used where practices can provide evidence that individual partners are earning less than the minimum and make a claim for additional funding as a result. In 2019/2020 that Minimum Earnings Expectation was £84,630 per annum per whole time equivalent GP partner in practice (including superannuation). It is offered under the terms of a scheme devised by the Scottish Government. However:

    a. the claimant has never needed to invoke the Minimum Earnings Expectation, and this arrangement has never applied to him.
    b. In cases where it does apply, the respondent does not receive

information on individual partner earnings or details of claims.

113. To a large extent, the respondent therefore gives effect to income formulae set not by the respondent itself, but rather by the Scottish Government, both in terms of the Global Payment which constitutes 86% of practice income of Drs Connaughton and Sudomir on the most recent figures available, and also the Minimum Earnings Expectation, were that ever to become relevant to either of the partners in that practice.

Practice income (private)

114. The partnership can charge fees for non-NHS work which is not covered by the terms of the GMS Contract. One example given repeatedly in evidence was the preparation of a medical report or carrying out a specialist occupational medical examination. The charges are set by the partnership and the respondent has no control over them.

115. Section 64 of the NHS (Scotland) Act 1978 provides that the permission of the Secretary of State is required for the use of NHS accommodation or facilities for the purpose of providing medical services to private patients. Permission will be granted unless, in the opinion of the Secretary of State, anything for which permission was sought would interfere with the giving of full and proper attention to NHS patients. Grants of permission may include terms relating to the payment of charges for the use of NHS accommodation.

116. This has been applied to the claimant's partnership, though not to him personally. In 2012 Dr Sudomir, then a locum GP in the practice, applied for permission to carry out private cosmetic treatments like Botox and dermal fillers. Permission was granted on the condition that private work of that sort would not interfere with services provided under the GMS contract. Had the private income exceeded 10% of total income then the rent subsidy provided by the respondent would have been reduced.

117. There is more than one way in which the claimant or his partnership could undertake private work. There is no restriction on him doing that in practice core hours, and the practice has provided some private services within the practice premises. Permission was requested and granted. If the claimant or his partnership wished to provide private services from non-NHS premises then no permission would be required. Private medical reports can be dealt with during core hours without permission and the partnership will be paid privately for that. Theoretically, the claimant could work entirely in private practice save for the 10 hours of work required by his partnership's agreement under the 2018 GMS contract, although that is far from the reality. Until recently the claimant was registered to do NHS Opthalmic work separately from the partnership's GMS Contract and he could provide that privately too.

118. While there was no specific data for the claimant's own practice, Fiona Duff accepted that for most practices private income is less than 5% of total turnover. NHS work takes up the vast majority of a GP's time and private work tends to be done in evenings or on days off. Mr Taylor believed that the UK average was around 7%.

Sale of the Practice

119. It has been a longstanding NHS rule dating from 1948 that GPs cannot sell the goodwill in their practice. The rationale is that otherwise retiring partners would expect an income on retirement. That would in turn be an obstacle to GPs entering the profession, who would have to pay out to buy into a practice.

120. GPs leaving the profession are able to sell their equipment and any stock. That is not likely to be of great value. If they own their premises then they are able to sell them. Neither the claimant nor the partnership in which he works own the practice premises.

Vulnerability and the need for protection

121. I do not accept that the claimant is or was at any relevant time a vulnerable person, liable to be exploited by the Health Board.

122. The claimant was a member of the BMA and the BMA negotiated with the Scottish government on behalf of all GPs in Scotland. It is now well-established that the claimant disagrees with the position adopted by the BMA in the negotiations which led to the 2018 contract and believes that the BMA did not act in his best interests. The BMA is nevertheless a strong, effective and democratic trade union. In the negotiations which led to the 2018 contract the BMA sought to give effect to the views of its members and to reach an agreement which was in their best interests.

123. While some members, such as the claimant, disagreed with the BMA's negotiating position and voted against the 2018 GMS Contract, that was a minority position. The views of BMA members were established democratically by ballot. In a survey carried out across the UK in 2015, 82% of BMA members indicated a desire to maintain independent contractor status. I did not hear any evidence to suggest that the position would have been different if members of the BMA based in Scotland had been balloted separately from their colleagues in the rest of the UK, or that the popularity of independent contractor status had declined among BMA members since 2015. When the terms of what later became the 2018 GMS Contract were put to a ballot in late 2017, the majority of BMA members in Scotland voted in favour.

124. Where the views of trade union members conflict, it will often be impossible for a trade union to negotiate and act in a way which gives effect to the views of all of its members. The democratic approach is to seek to give effect to the wishes of the majority of members. I am not persuaded that the claimant is properly regarded as vulnerable simply because he disagreed with the position taken by the BMA and about 82% of its members.

The objectives of the negotiating parties

125. The 2018 contract was negotiated between the Scottish Government and the BMA. Neither individual doctors nor Health Boards took any direct part in those negotiations. The claimant suggested that the BMA and the Scottish Government had not negotiated in good faith, and that contractual terms had been structured and presented in a way intended to defeat worker status and the associated employment rights. At an earlier stage in proceedings, more than 7000 pages of documents concerning the contract negotiations were sent to the claimant's solicitors by the BMA and the Scottish Government. The following paragraphs set out my findings on those documents. It must be remembered that they reflect thoughts, discussions and negotiating positions which were not necessarily reflected in the terms of the 2018 GMS contract, once finalised.

126. The joint intention of the BMA and the Scottish Government was that young medical students and doctors could regard becoming a GP as a good career option. One issue was that whereas Consultants received a regular salary on a defined salary scale, GP partners were paid a share of profits. Consultants also have time built into their contracts for professional learning. Initial discussions considered whether GPs could be offered something similar. The possible views of the profession were also discussed.

127. One rhetorical question in the notes of a workshop meeting on 10 April 2017 was "Will this make GPs appear more like 'employees' of the Health Boards – any HMRC implications?" According to Fiona Duff, whose evidence I accept, this question was triggered by a proposal for GPs to work for 40 hours a week, and the possibility of pay and other conditions which would give them parity with Consultants. However, the 40 hour week proposal did not become part of the 2018 GMS contract, which requires the practice to be open from Monday to Friday between 0800 and 1830. It is a matter for

the practice to decide how that time is covered.

128. I accept Fiona Duff's evidence that it was well-known to the negotiating parties that the vast majority of GPs wished to be independent contractors, and discussions proceeded on that basis. The issue was not simply tax status. The flexibility and adaptability of practices under an independent contractor model were also attractive. In contrast, direct employment by a Health Board was perceived as rather "monolithic".

129. I also accept the evidence of Fiona Duff and Michael Taylor that there was no conscious intention to defeat worker status or the employment rights which would arise from that status. I did not think that their evidence was contradicted by any of the documents generated during the negotiation process and I found them to be cogent and convincing witnesses, despite skilful and effective cross-examination by Mr Panesar KC. Although tax status was a point of discussion, there was no discussion of worker status or employment rights. The negotiators did not receive legal advice regarding the impact of the 2018 GMS contract on the employment status of GPs. Rather, they took it for granted that the employment status of GPs was that of independent contractor. I am not persuaded that any clauses were inserted, or other techniques of drafting deployed, with the aim of defeating arguments in favour of worker status.

130. The Scottish Government had a long-term aim that over 25 years the model would no longer presume GPs providing their own practice premises. The position in 2016-2017 was that about 40% of practices owned their own premises and the remainder had private leases. Long leases were a potential obstacle to new GPs joining the practice and existing GPs retiring. The intention was to shift to a position where partners would not be tied to long leases. A "Hub Co" model was initially discussed but was not implemented. The preferred model of the profession was to remain independent contractors, but the possibility that GPs could become tenants of the Health Board was also discussed.

131. It was also thought that a salaried model would be more expensive overall for the Scottish Government, although the evidence to support that theory was primarily derived from the costs of running "2C Practices", which were troubled independent practices which transferred to the Health Board until they could once again be transferred back to independent practice. It is easy to see why costs might be especially high in practices facing those difficulties. Lorna Kelly highlighted the locum costs in 2C practices.

132. The negotiators did not undertake any formal costing of a model under which GPs would be employed and salaried, but it was taken as a given that it would be more expensive. There was no discussion of the cost of worker status during the negotiations. The Scottish Government pursued an independent contractor model because it believed that would be most attractive to the medical profession, rather than because of cost.

Legal principles

133. Section 230 of the Employment Rights Act 1996 defines the terms "employee" and "worker" for the purposes of the employment rights contained in that Act. It provides as follows.

> ***230 Employees, workers etc.***
>
> *(1) In this Act "employee" means an individual who has entered into or works under (or, where the employment has ceased, worked under) a contract of employment.*
>
> *(2) In this Act "contract of employment" means a contract of service or apprenticeship, whether express or implied, and (if it is express) whether oral or in writing.*
>
> *(3) In this Act "worker" (except in the phrases "shop worker" and "betting worker") means an individual who has entered into or works under (or, where the employment has ceased, worked under)—*
>
> *(a) a contract of employment, or*
>
> *(b) any other contract, whether express or implied and (if it is express) whether oral or in writing, whereby the individual undertakes to do or perform personally any work or services for another party to the contract whose status is not by virtue of the contract that of a client or customer of any profession or business undertaking carried on by the individual;*
>
> *and any reference to a worker's contract shall be construed accordingly.*

134. That definition in subsection (3) above is replicated in regulation 2 of the Working Time Regulations 1998. It is also well established that the extended definition of "employment" in section 83(2)(a) of the Equality Act 2010 ("a contract personally to do work") is effectively the same (***Bates van Winkelhof v Clyde & Co*** [2014] ICR 730, SC at paragraph 31), albeit without the express exception for clients and customers.

135. The question whether work is performed by an individual as an employee, a worker in the extended sense (s.230(3)(b) ERA 1996, above) or as an

independent contractor is a question of fact to be determined by the first level tribunal (***Uber v Aslam*** [2021] UKSC 5 at paragraph 118).

136. In ***Bates van Winkelhof v Clyde & Co LLP*** [2014] ICR 730, SC, paragraph 38, Lady Hale said that there was no substitute for an application of the words of the statute to the facts of the individual case, although there might not be 'a single key to unlock the words of the statute in every case' (a view originally expressed by Maurice Kay LJ in ***Hospital Medical Group Ltd v Westwood*** [2013] ICR 415, CA, at paragraph 18).

137. The key elements of the definition were distilled by Lord Legatt in ***Uber BV v Aslam*** [2021] UKSC 5, at paragraph 41.

a. There must be a contract, whether express or implied, and, if express, whether written or oral.
b. That contract must provide for the individual to carry out personal services.
c. Those services must be for the benefit of another party to the contract who must not be a client or customer of the individual's profession or business undertaking.

138. Although not mentioned in the statutory definition, the weight of authority suggests that some degree of mutuality of obligation is also a requirement for "limb (b)" worker status to arise. There is disagreement over whether that is a freestanding requirement or merely an aspect of one or more of the three elements of the statutory definition unpacked at "a." to "c." above. In the recent case of ***NMC v Somerville*** [2022] EWCA Civ 229, Lewis LJ suggested that no purpose was served by introducing an additional concept of an obligation to perform some minimum amount of work. On that basis, perhaps mutuality of obligation has a role to play in cases where there is doubt as to whether a contract exists at all, but not otherwise.

139. The EU Working Time Directive (No.2003/88) ("WTD") does not define "worker". However, the CJEU mas made it clear that the concept of 'worker'

in the WTD has an autonomous meaning specific to EU law. It must be defined in accordance with objective criteria which distinguish the employment relationship by reference to the rights and duties of the persons concerned (***Union Syndicale Solidaires Isère v Premier Ministre*** [2011] IRLR 84, ECJ). The essential feature of an employment relationship is that, for a certain period of time, a person performs services for and under the direction of another person in return for remuneration. The same definition applies in cases concerned with free movement and equal pay. The classification of a person as an "independent contractor" under national law does not prevent that person from being classified as an employee under EU law if their independence is merely notional, thereby disguising an employment relationship.

140. The WTR must be interpreted in a way which gives effect to the WTD. Additionally, the claimant relies directly on the WTD itself.

141. The classification of a person as an "independent contractor" under national law does not prevent that person from being a worker under EU law if their independence is merely notional (***Yodel Delivery Network Ltd*** Case C-692/19, CJEU). A person can be a worker for the purposes of the WTD where they are in a "hierarchical relationship" with the other party as evidenced by the fact that they were permanently supervised and assessed (***Sindicatul Famila Constanta*** [2019] ICR 211, CJEU).

The approach

142. The courts have long been concerned to avoid employment rights being defeated by techniques of drafting, such as the insertion of substitution clauses, or clauses denying obligations to provide or to accept work, even where those terms did not begin to reflect the real relationship. See for example Elias P in ***Consistent Group Ltd v Kalwak*** [2007] IRLR 560, EAT and Lord Clarke in ***Autoclenz v Belcher*** [2011] ICR 1157, SC. In the latter case Lord Clarke highlighted the need to examine the relative bargaining

power of the parties when deciding whether the terms of any written agreement in truth represented what was agreed. The true agreement would often have to be gleaned from all the circumstances of the case, or which the written agreement is only a part.

143. That approach was extended by the Supreme Court in ***Uber BV v Aslam*** [2021] ICR 657. At first instance, the ET had relied on ***Autoclenz*** principles to look beyond written documentation purporting to show that drivers were independent contractors. The Supreme Court emphasised that Lord Clarke's judgment in ***Autoclenz*** made it clear that the question whether a contract is a 'worker' contract is not to be determined by applying ordinary principles of contract law. The rationale was that the rights asserted by the claimants were not contractual rights but rather statutory rights. Therefore, the Tribunal's task was primarily one of statutory interpretation rather than contractual interpretation. Further, that interpretative exercise should give effect to the purpose of the legislation, which was to protect vulnerable individuals who had little or no say over their pay and working conditions because they are in a subordinate and dependent position in relation to a person or organisation which exercised control over their work. It would be inconsistent with the purpose of the legislation to treat the terms of a written contract as the starting point (let alone the end point) in determining whether an individual fell within the definition of 'worker'.

144. It is not the case that the terms of any written agreement should be ignored, because the conduct of the parties and other evidence might show that the written terms were in fact understood to be a record, maybe an exclusive record, of the parties' rights and obligations towards each other. However, there is no legal presumption that a contractual document contains the whole of the parties' agreement and no absolute rule that terms set out in a contractual document represent the parties' true agreement just because an individual has signed it. Any terms which purport to classify the parties' legal relationship or to exclude or limit statutory protections by preventing the contract from being interpreted as a contract of employment or other

worker's contract are of no effect and must be disregarded (***Uber***, paragraph 85).

145. Since ***Uber***, courts and Tribunals will focus on the practical reality of the working relationship and will be much less concerned with any inconsistency with written documentation. Key questions will now be whether the relationship is one of subordination and dependence, having regard to the legislative purpose of protecting those who have little or no influence on the terms under which they work.

146. In ***Ter-Berg v Simply Smile Manor House Ltd*** [2023] EAT 2, HHJ Auerbach suggested that it would not necessarily be an error for a Tribunal, when explaining its reasons, to start with a consideration of the terms of any document said to amount to a written contract. It *would* be an error though for the Tribunal to confine its consideration to those terms, to treat them as conclusive, or to treat them as giving rise to a presumption. Clauses in written agreements denying an intention to create an employment or worker relationship would be void under s.203(1) ERA 1996 if their object was excluding or limiting the operation of the legislation. Further, if the facts otherwise pointed to the conclusion that the relationship was one of employment or a worker relationship, such a clause could not affect that legal conclusion. In marginal cases, in which the tribunal found the clause to be a reflection of the genuine intentions of the parties, it may be taken into account as part of the overall factual matrix when determining the correct legal characterisation of the relationship.

147. The quest in every case is to ascertain what was in truth and reality agreed by the parties. Where there is what purports to be a written agreement, ***Uber*** did not mean that its terms were necessarily irrelevant in every case. Consideration must be given to whether there are circumstances or features of the wider picture which indicate that those written terms may not reflect the true reality of what was agreed. The consideration of that reality was not constrained by normal principles of contract law (***Ter-Berg*** at paragraph

38). ***Uber*** does not mean that written terms to which the parties have ostensibly signed up should generally now be disregarded and it did not signify that the law had developed to the point where the question was simply one of status, with no role at all for contract (paragraph 43).

148. In ***Sejpal v Rodericks Dental Limited*** [2022] EAT 91 HHJ James Tayler suggested that it should not be hard to determine worker status provided that a structured approach was adopted and robust common sense applied. The starting point, and constant focus, must be the words of the statute. Concepts such as "mutuality of obligation", "irreducible minimum", "umbrella contracts", "substitution", "predominant purpose", "subordination", "control" and "integration" were tools which sometimes helped in applying the statutory test but were not themselves tests. A focus on the statutory language revealed that there must be a contract (or, in limited circumstances, a similar agreement) between the worker and the putative employer. That agreement is not to be analysed by applying undiluted common law principles. The true nature of the agreement must be ascertained and contractual wording, which might have been designed to make things look other than as they are, must not be allowed to detract from the statutory test and purpose. Some of the concepts would be irrelevant in particular cases, or relevant only to a component of the statutory test.

Personal service

149. Determining whether a contract includes an obligation of personal performance is a matter of construction and is not necessarily dependent on what happens in practice. As the Court of Appeal observed in ***Redrow Homes (Yorkshire) Ltd v Wright*** [2004] ICR 1126, CA, it does not necessarily follow from the fact that work *is* done personally that there is an *undertaking* that it be done personally. However, the conclusions in ***Redrow*** must now be read subject to ***Uber***, and the instruction to focus on the reality of the relationship and the agreement. Those authorities can perhaps be reconciled in this way: what matters is not what was *done*, but rather what

was *agreed*. The former may well be important evidence of the latter, especially if the putative worker was in a position of vulnerability and unequal bargaining power, with little or no influence over the written contractual terms.

150. Conversely, the presence of a substitution clause in contractual documentation may not be inconsistent with worker status if there is no evidence of such a clause being operated or intended to operate in practice (see e.g. ***Autoclenz*** and ***Uber***, considered above).

151. It is also necessary to consider the extent of the power of delegation, since some substitution clauses remain compatible with an obligation of personal performance where the right is "fettered" or limited in some way. An *unfettered* right to substitute is inconsistent with personal performance, but a *conditional* right may not be, depending on the precise contractual arrangements and the extent to which the right is limited or occasional. In ***Byrne Brothers (Formwork) Ltd v Baird*** [2002] ICR 667, EAT, the power to delegate work was found to be exceptional and limited: when carpenters were unable to work they could provide an alternative worker but only with the express approval of the main contractor. The EAT also reasoned that it was common sense and common experience that an individual carpenter or labourer offered work on a building site was understood by both parties to be attending in person to do the work.

152. In ***Pimlico Plumbers Ltd v Smith*** [2018] UKSC 29, there was no express right of substitution but plumbers could swap assignments between themselves. The Supreme Court held that the ET permissibly concluded that this was a limited right of substitution. The substitute had to be another Pimlico Plumbers operative who was already bound to Pimlico Plumbers Ltd by obligations identical to those owed by the claimant. The ET had been entitled to conclude that this limited right of substitution was not inconsistent with an obligation to perform services personally.

153. In ***Stuart Delivery Ltd v Augustine*** [2022] ICR 511, CA, at paragraphs 39 to 41, Lewis LJ summarised the position as follows. The issue was whether the claimant was under an obligation personally to perform the work or provide the services. An unfettered right to substitute another person to perform the work was inconsistent with an undertaking to do so personally. A conditional right might or might not be inconsistent with personal performance, depending on the precise contractual arrangements and, in particular, the nature and degree of any fetter on a right of substitution, or the extent to which the right of substitution is limited or occasional. Sir Terence Etherington MR's guidance in ***Pimlico Plumbers Ltd v Smith*** [2017] ICR 657 summarised the principles to be derived from case law but was not intended to lay down strict rules or to establish a rigid classification. A right of substitution limited only by the need to show that the substitute is as qualified as the contractor to do the work will, subject to any exceptional facts, be inconsistent with personal performance. A right to substitute only with the consent of another person who has an absolute and unqualified discretion to withhold consent will be consistent with personal performance.

Dominant feature test

154. Some authorities have focussed on the question whether the "dominant purpose" of the contract was the provision of personal services. However, as Elias P observed in ***James v Redcats (Brands) Ltd*** [2007] ICR 1006, EAT, the "dominant purpose" test has some difficulties because it may not always be clear what the dominant purpose of a contract is, and "purpose" can include both immediate and longer-term objectives. Instead, Elias P suggested that a better approach would be to ask whether the "dominant feature" of the contractual arrangement was the obligation to perform work personally, in which case the contract would sit in the employment field and the individual concerned would be either a worker or an employee. If, however, the dominant feature was a particular outcome or objective and the obligation to provide personal services was an incidental or secondary consideration, it would lie in the business field. This approach was endorsed

by the Supreme Court in ***Pimlico Plumbers*** (above) to the extent that it was helpful to assess the significance of a right of substitution by reference to whether the dominant feature of the contract remained personal performance on the part of the putative worker, although that did not replace the statutory test.

155. In ***Gunny v Great Ormond Street Hospital for Children NHS Foundation Trust and others*** (EAT/0241/17) Choudhury P considered a group working arrangement, under which a group of consultant neurologists provided reports to a private healthcare company. The contract was between all the consultants in the group jointly and the HCA Group. Permissibly, the ET had found that the formality of the group arrangement did not necessarily mean that there was no individual obligation to provide personal performance. The ET had correctly treated the group arrangement as a relevant factor but its analysis had not stopped there. Permissibly, the ET had found that the claimant was not employed under a contract personally to do work for the purposes of section 83(2)(a) of the Equality Act 2010.

156. In ***Bryne Brothers (Formwork) Ltd v Baird*** [2002] ICR 667, the EAT also held that the basic effect of section 230(3)(b) of the Employment Rights Act 1996 was to "lower the pass mark", such that cases in which the evidence failed to reach the level necessary to qualify as employment might nevertheless reach the level necessary for worker. However, in ***Redrow Homes (Yorkshire) Ltd v Wright*** the Court of Appeal suggested that those comments had been addressed to the client or customer exception only. In ***Windle v Secretary of State for Justice*** [2016] ICR 721, CA, Underhill LJ indicated that his remarks in ***Byrne Brothers*** had been of more general application. On that basis the IDS Handbook (Vol.3, Chapter 2, paragraph 2.144) suggests that it might follow that even where there is a wide-ranging right of substitution which would be incompatible with employee status, there could still be limb (b) worker status if there was an obligation to do at least some of the work personally.

Client or customer exception

157. In this case the respondent does *not* argue that the claimant falls outside the definition of worker because of the 'client or customer exception' in section 230(3)(b) of the Employment Rights Act 1996 and its equivalents. There is no need to set out any of the authorities on that point.

Mutuality of obligation

158. Several cases, including ***Byrne Brothers*** (above) have suggested that mutuality of obligation is a necessary element of a limb (b) worker contract, as well as a contract of employment. Other cases, including ***Cotswold Developments Construction Ltd v Williams*** [2006] IRLR 181, EAT, held that a claimant need not show mutuality of obligation to be found a worker. The comments in ***Byrne Brothers*** had been made in the context of deciding whether there was sufficient mutuality of obligation to establish that there was a contract in existence at all, rather than in the context of deciding what type of contract it was. The focus of the statutory wording was not on the obligation owed by the employer (save to ensure that there was a contract) but rather on the individual or purported worker. The real question when deciding whether the claimant was a worker was therefore whether there was some minimum amount of work that he or she was obliged to perform personally. ***Singh v Members of the Management Committee of the Bristol Sikh Temple*** (EAT/0429/11) took a similar approach, as did ***Sejpal v Rodericks Dental Ltd*** [2022] EAT 91.

159. However, in ***Windle v Secretary of State for Justice*** [2016] ICR 721 the Court of Appeal indicated that mutuality of obligation *was* of relevance when determining whether a contract was of the right type to fall within limb (b).

160. In ***NMC v Somerville*** [2022] ICR 755, the Court of Appeal rejected the

argument that there had to be an obligation on the putative worker to perform a minimum amount of work in order for a contract to fall within regulation 2(1)(b) of the Working Time Regulations 1998. The statutory definition of worker did not indicate that there must be some distinct, superadded obligation to provide services independent from the provision of services on a particular occasion. The fact that the parties were not obliged to offer, or accept, any future work was irrelevant.

Submissions

161. Submissions were made primarily in writing, supplemented by oral submissions. Both sides also made supplementary submissions at my invitation in relation to ***Manning v Walker Crips Investment Management Ltd*** [2023] EAT 79, which was first reported after the parties had finished their submissions but before this judgment was drafted. That process had just been completed when ***Plastic Omnium Automotive Limited v Horton*** [2023] EAT 85 was reported. Once again, I invited further submissions to take account of that.

The claimant's submissions

162. The contract plainly did not reflect the reality of the situation. The fact that the contract is with the partnership is no bar to worker status, nor does it change the reality of the very onerous personal service which the claimant had to provide. The relationship was not one of client or customer. The autonomy and ability of GPs to make a profit was highly limited and they had to dedicate the vast majority of their working week and lives to caring for the patients of the Board on their list in highly prescribed circumstances.

163. Mr Panesar KC highlights the policy behind the legislation, which was to extend the benefits of certain employment rights to workers who were liable, whatever their formal employment status, to be required to work excessive hours, or to suffer unlawful deductions from earnings, or to be paid too little

(***Byrne Brothers (Formwork) Ltd v Baird*** [2002] ICR 667, EAT). Employment relationships are generally characterised by an imbalance of economic power, leaving employees (and workers) vulnerable to exploitation. In order for the rights conferred to be effective, and to achieve the social benefits intended by Parliament, they must be enforceable in practice (***R (Unison) v Lord Chancellor (EHRC intervening)*** [2017] ICR 1037, SC).

164. Relying on ***Autoclenz*** principles, Mr Panesar KC argues that the Tribunal must concentrate on the reality of the situation, of which the terms of the contract are only a part. A sensible and robust view must be taken to avoid undermining substance, asking "what was the true agreement between the parties?" The relative bargaining power of the parties was relevant to the question whether the terms of any written agreement represented what was truly agreed. A purposive approach must be taken, bearing in mind the purpose of the legislation. Drawing on ***Uber***, Mr Panesar KC emphasises that the determination of worker status is a wider exercise than contractual interpretation. The contract was not the starting point.

165. A practice or contractual right to allow a contractor to bring in specialist assistance is not inconsistent with a requirement to perform work personally (***Mirror Group Newspapers v Gunning*** [1986] ICR 145, 156C-D) and a limited or fettered right of substitution is not inconsistent with the requirement that work be performed personally, depending on the arrangements and limits (***Pimlico Plumbers*** in the Court of Appeal). A right to substitute only with the consent of another, who holds an absolute and unqualified discretion to withhold consent is consistent with personal service.

166. It is not the case that a contractor was required to be subordinate to be a worker (***Bates van Winkelhof v Clyde & Co LLP*** [2014] ICR 730) and there was no substitute for applying the words of the statute.

167. Clause 11 of the 2018 GMS Contract does not represent the reality of the contractual arrangement. While there might be a notional distinction in legal personality between the partnership and the claimant, the reality that the claimant and other GPs were obliged to provide work personally was clear. The distinction between a partnership and its partners was in any event thin, since the partners comprised the partnership in fact.

168. The test in s.230 ERA 1996 did not require the claimant to be a party to the contract, it was sufficient that the claimant "worked under" it.

169. The requirement to work personally was established. The terms of the 2018 GMS contract were determinative of the issue of personal service, at the very least for 10 hours. There was a non-delegable requirement to work 10 hours a week personally and the claimant had been providing far more than 10 hours of work a week for decades. That was the reality of working as a GP to meet the obligation imposed on GP practices to provide medical services to the patients on their lists.

170. Mutuality of obligation was not required to establish worker status. Even if it were, the claimant is obliged to work under the contract and the respondent is obliged to pay for it. The amount paid to the claimant was highly controlled under the terms of the contract. The respondent also paid some of the costs of carrying out that work. That was indicative of a worker relationship. GPs, like the Uber drivers, had no control over charges. GPs are not able to charge those on their list for the vast majority of the services provided by GPs, and payments are primarily determined by a capitation payment.

171. The respondent exerted extensive control over the standards and requirements of the premises from which a contractor was permitted to operate. The respondent funded the premises from which GPs work and will move in the longer term to a model under which GP premises will all be owned or run by the respondent. IT and phone systems were provided by

the respondent.

172. In reality, the work done by the claimant under the contract was highly controlled in relation to its quality, amount and the manner in which it was done. The claimant was not free to decide the people to whom he would provide medical services or what he would charge.

173. The right to delegate or substitute was, in reality, constrained and fettered.

174. The documents revealed that the negotiating parties did not really believe that GPs were independent contractors and accepted that in reality they had become workers. The maintenance of an "independent contractor" label was expedience, not the actual nature of the relationship. The negotiating parties were not concerned with the reality of the relationship. A salaried model could not be sold to the workforce politically and the government could not afford it. No other model than that of independent contractor was ever promoted or put to a vote.

175. There was a clear imbalance of economic power between GPs and the Health Boards they worked for. GPs required protection from excessive hours and a lack of holiday. GPs were in a hierarchical relationship with the respondent.

176. ***Manning v Walker Crips Investment Management Limited*** [2023] EAT 79 demonstrated that the express label used by the parties should be given little if any weight following ***Autoclenz*** and ***Uber*** (paragraph 94). The same case showed that the categorisation of a working relationship for tax purposes should similarly be given little or no weight (paragraph 105).

The respondent's submissions

177. Mr Napier KC makes two main points:

a. the absence of any contractual link between the claimant as an

individual and the respondent is fatal to him coming within the terms of the definition of "worker".

b. Even disregarding the absence of contractual connection, the claimant still does not satisfy the test of worker as outlined in ***Autoclenz***, ***Pimlico Plumbers*** and ***Uber***.

178. The claim is based on the relationship between the claimant and the respondent Health Board. The claimant has always accepted that there is no direct contractual link between him (as opposed to the partnership) and the respondent. The claimant accepted at this hearing that the 2018 GMS contract was signed by him on behalf of the Connaughton/Sudomir partnership and was a contract between the respondent and that partnership.

179. Under Scots law, partnerships have the capacity to contract in their own right and they have legal capacity, unlike partnerships under the law of England and Wales. It was an express provision of the 2018 GMS contract that it was to be governed by Scots law. Under Scots law, where a partnership enters into a contract for the provision of services it is not competent to sue the partner who provides the service because the liability is that of the firm, even if the partner acted as the agent of the firm when delivering the service (***Hamid Khowrowpour v Taylor*** [2018] CSOH 64).

180. The definition of "worker" in s.230(3)(b) ERA 1996 and regulation 2(1) WTR 1998 requires the existence of a contract between the putative worker and his or her employer, and there is no such contract. There must be a contract between the parties if the claimant is to meet the definition of worker (see e.g. ***Hospital Medical Group v Westwood*** [2013] ICR 415 at paragraph 75, ***Catt v English Table Tennis Association*** [2023] IRLR 1022, EAT and ***NMC v Somerville*** [2022] ICR 755).

181. The 2018 GMS contract cannot be relied on by the claimant because the statutory definitions require that the putative worker and their putative

employer are parties to the *same* contract, as is demonstrated by the use of the wording "another party to the contract". The obligation on the claimant to provide work personally derives from an obligation placed on the partnership, not on any obligation owed by him personally to the respondent. There is no contract from which rights could arise (***Tilson v Alstom Transport*** [2011] IRLR 169).

182. ***Uber*** was concerned with going beyond the terms of a written agreement and it was assumed that there must be a contract between Uber London and the drivers. There is no need or justification for finding a separate contract between a partner and the user of their services when a contract is made by a partner on behalf of the partnership of which he is a member.

183. The claimant also relies on the direct effect of WTD as a way of avoiding any limitation by reference to "contract" in the domestic legislation. The respondent accepts that it is well-established that provisions of domestic law which are not in accordance with EU law must be ignored (e.g. ***Kukukdeveci*** [2010] IRLR 346). However, that power has been lost since the repeal of section 2(1) of the European Communities Act 1972 in relation to cases brought after 31 December 2020 (Kerr J in ***Thukalil v Puthenveettil*** [2023] EAT 47 at paragraph 74).

184. Regardless, there is no definition of "worker" in the WTD itself and the relevant meaning is to be found in the case law of the ECJ and CJEU. It has an autonomous meaning specific to EU law. The position can be contrasted with that under the Part-Time Workers Directive where the national court must apply the rules of domestic law.

185. If the claimant can show that he is a "worker" within the meaning of EU law then the absence of a contract between him and the respondent would not remove him from the protection offered by the WTD.

186. The essential feature of an employment relationship is that for a certain

period of time a person performs services for and under the direction of another person in return for which he receives remuneration (***Union Syndicale d'Isere*** C-428/09 [2011] IRLR 84). In ***B v Yodel Delivery Networks Ltd*** [2020] EUECJ C-692/19_O the CJEU focussed on whether the independence of a "self-employed independent contractor" was fictitious, and whether it was possible to establish the existence of a relationship of subordination between that person and his putative employer. Subordination and the payment of remuneration were constituent elements of all employment relationships. The "essential feature" of an employment relationship is that for a certain period of time a person performs services for and under the direction of another person in return for which he receives remuneration (***Haralambidis*** [2014] EUECJ C-270/13).

187. For the claimant to be able to rely on the WTD and the EU conception of "worker" to avoid the requirement of a contractual relationship, he would have to show that the situation fell within the definition of "employment relationship" set out in ***Union Syndicale d'Isere***. That required a consideration of the "rights and duties of the parties involved" with the important qualification that there was an "essential requirement" to show that there was subordination. That notion of subordination carried with it a requirement that the putative worker could be removed from their duties by the putative employer with such removal being in the absolute power of the employer, exercisable at any time (***Danosa*** [2010] EUECJ C-232/09, ***Halawi v WDFG UK Ltd*** [2015] IRLR 50, Arden LJ at paragraph 39). While subordination might not be a requirement in order to meet the definition of "worker" in UK law (***Bates van Winkelhof v Clyde & Co. LLP*** [2014] ICR 730, Baroness Hale), it was a requirement of the EU definition (see above).

188. In ***Hashwani v Jivraj*** [2011] ICR 1004 Lord Clarke said that the CJEU drew a clear distinction between those who were, in substance, employed and those who were "independent providers of services who are not in a relationship of subordination with the person who receives the services". On that basis an arbitrator was excluded from the scope of the Framework

Directive. Although he had a direct contractual link with the parties who had appointed him, he did not give his service under a contract personally to do any work. The essential questions were those in ***Allonby*** [2004] ICR 1328, namely whether, on the one hand, the person concerned performs services for and under the direction of another person in return for which they receive remuneration or, on the other hand, they are an independent provider of services who is not in a relationship of subordination with the person who receives the services.

189. The respondent accepts that the provision of services through an intermediary does not necessarily disqualify someone from worker status under EU law if independence was merely notional (see ***Allonby***). In ***Allonby*** the question was answered by scrutinising the extent of any limitation on their freedom to choose their timetable and the place and content of their work. The fact that no obligation was imposed on them to accept an assignment was of no consequence in that context.

190. In this case, the independence of the claimant in relation to the Health Board was not "merely notional". He was free to conduct himself as he wished in delivering the medical services he provided to the respondent. Subject to the obligation he owed to *the partnership* to devote himself for a period of 10 hours per week to delivering patient care he could do as much or as little as he chose. It was the claimant's decision to undertake a heavy burden, it was not imposed on him by reason of the relationship he had with the respondent. The obligation to provide medical care was imposed on the partnership, not the claimant personally. Performance could have been contracted out to another medical professional if the claimant were prepared to carry the cost in terms of accepting a reduction in his drawings from the partnership.

191. The legal relationship is not decisive but nor is it entirely irrelevant (***Gunny v Great Ormond Street Hospital for Children NHS Foundation Trust*** [2018] UKEAT 0241_17_2802).

192. The respondent had no power to remove the claimant from providing services under the 2018 GMS contract since it does not control how the contracting partnership chooses to perform the obligations it has accepted under that contract. The right to ensure, as against the partnership, that appropriately qualified persons were providing medical services was not the same as placing those people as individuals in a relationship of subordination.

193. In ***Autoclenz*** the Supreme Court was concerned with a situation in which there was no doubt that there was a contractual relationship between the car cleaners and the employing entity, the issue was how that should be categorised. In ***Uber*** the Supreme Court emphasised that the purpose of the legislation was to protect vulnerable individuals, but the claimant in the present case was a professional person who ran, with a partner, a business with a turnover of over £589,000 in 2021/2022, based on fees from the Scottish Government, paid via the respondent. The claimant also had the advantage of being represented by the BMA, an effective and well-established trade union.

194. There was no relevant personal performance demanded of the claimant under the 2018 GMS Contract: the performance required of *the partnership* was distinct, and the obligation on the claimant to devote at least 10 hours per week to patient care was not owed by him to the respondent. The respondent had no sanction against the claimant personally if he failed to do it. The respondent's rights would be against the partnership.

195. The claimant (or more accurately the partnership) had a broad power to delegate the great majority of the services provided under the contract, and need not even inform the respondent if a locum was used. That right was not significantly restricted by the fact that the locum must be on the respondent's Performer's List. The respondent does not have an absolute discretion who to admit to that list and it is designed to ensure patient safety

against a legislative background. The list is open to any medical practitioner who has been approved for inclusion on another health board's performers list.

196. There was no subordination. The partnership (not the claimant) was required to "have regard" to the respondent's guidance, which did not equate to a power of command. The claimant did not have a line manager within the respondent.

197. The claimant's work was integral to the NHS, but he was not personally integrated. He was not part of the administrative structure. The lack of a contractual relationship was a point of distinction between this case and those of ***Hospital Medical Group v Westwood*** and ***Community Based Care Health Ltd v Narayan*** (EAT 0162/18).

198. The dominant feature of the contract (***James v Redcats (Brands) Ltd*** [2007] ICR 1006, EAT) could not be established in the absence of a contract. For mutuality of obligation to exist there had to be a contract, and here there was none.

Reasoning and Conclusions

"Worker" status under UK law

199. As many authorities have now emphasised, there is no substitute for an application of the wording of the statute. The question is one of statutory interpretation rather than contractual construction. The ultimate question, endorsed by the Supreme Court in ***Uber***, is "whether the relevant statutory provisions, construed purposively, were intended to apply to the transaction, viewed realistically" (***Collector of Stamp Revenue v Arrowtown Assets Ltd*** (2003) 6 ITLT 454, paragraph 35). The purpose of the legislation is to protect vulnerable workers from being paid too little for the work they do, from being required to work excessive hours, from being denied annual

leave or from being subjected to various other forms of unfair treatment.

200. The relevant question arising from section 230(3)(b) of the Employment Rights Act 1996 and regulation 2 of the Working Time Regulations 1998 is as follows:

Is the claimant an individual who has entered into or works under a contract of employment or any other contract, whether express or implied and (if it is express) whether oral or in writing, whereby the individual undertakes to do or perform personally any work or services for another party to the contract whose status is not by virtue of the contract that of a client or customer of any profession or business undertaking carried on by the individual?

201. The structured approach recommended by HHJ Tayler in ***Sejpal v Rodericks Dental Ltd*** [2022] EAT 91 raises these questions:

a. Has the claimant entered into or worked under a contract (or possibly, in limited circumstances, some similar agreement) with the respondent?
b. Has the claimant agreed to personally perform some work for the respondent?
c. Is the claimant excluded from being a worker because:
    i. the claimant carries on a profession or business undertaking; and
    ii. the respondent is a client or customer of the claimant's by virtue of the contract.

202. In relation to that, two important points must be made at the outset since they limit the scope of the relevant discussion:

a. the claimant does *not* rely on an *implied* contract between him and the respondent Health Board. The arguments in this case concern the true nature of an *express* contract. The claimant argues that the law does not require that he must be a party to that contract, as long as he "works under" it.

b. The respondent does not rely on the "client or customer exception".

203. The question therefore reduces to whether the claimant entered into or worked under a contract whereby he undertook to do or to perform personally any work or services for another party to the contract. The claimant's submission is that although it is accepted that the claimant did not "enter into" a contract with the respondent, it is sufficient that he "worked under" one to which he was not a party.

204. While the Supreme Court in ***Uber*** held that the question whether a contract is a 'worker' contract is not to be determined by applying ordinary principles of contract law, the Supreme Court certainly did *not* suggest that it was unnecessary for there to be any contract between the relevant parties at all. That would be a dramatic extension of ***Uber/Autoclenz*** principles for which there is currently no authority. It would effectively remove the contractual aspect of the statutory definition of worker altogether. ***Uber*** was concerned with the question whether the claimants were to be regarded as working under contracts with Uber London or whether, as Uber contended, they were to be regarded as performing services solely for passengers, under contracts made with passengers through the agency of Uber London. The Supreme Court rejected the argument that Uber London acted as a booking agent for drivers and having done so, found it difficult to see how the business could operate without Uber London entering into contracts with drivers under which drivers undertook to provide services: the fulfilment of private hire bookings accepted by Uber London. The question was therefore how to characterise those contracts. ***Uber*** is not authority for the proposition that it is unnecessary for there to be a contract between the worker and their employer at all.

205. Similarly, ***Autoclenz*** was concerned with a situation in which there was no doubt that a contractual relationship existed between the claimants and the respondent, the issue was how that should be categorised.

206. ***NMC v Somerville*** [2022] ICR 755, CA and more recently ***Catt v English Table Tennis Association*** [2023] IRLR 1022, EAT both proceeded on the basis that it was necessary for there to be a contract between the parties, meaning the parties to the litigation: the putative worker and their putative employer. In the latter case Eady P carried out an extensive review of the authorities, including the Supreme Court's ruling in ***Uber***, before examining whether the ET had addressed the key question whether the necessary contractual relationship between the parties existed. The error of law identified by the EAT was that the ET had focused on questions of vulnerability, subordination and dependency while losing sight of the contractual question.

207. ***Bates van Winkelhof v Clyde & Co LLP*** [2014] ICR 730, SC is authority for the proposition that Tribunals must carefully apply the words of the statute and that there is no substitute for that. Those words include "work or services *for another party to the contract*" (emphasis added). I therefore approach matters on the basis that the putative worker and the putative employer must be parties not just to *related* contracts, but to the *same* contract, otherwise the employer would not be "*another* party" to it.

208. In the claimant's submission, it is enough that the claimant "works under" the 2018 GMS contract without being a party to it. Mr Panesar KC highlights the words "works under" and "any other contract", but in my judgment that misinterprets the purpose of the words "any other contract" and fails to give meaning to the equally important phrase, "another party to the contract". The words must be read in their full context: "*an individual who has entered into or works under (or, where the employment has ceased, worked under) - (a) a contract of employment, or (b) any other contract…whereby the individual undertakes to do or perform personally any work or services for another party to the contract…*".

209. The words "any other contract" are to be contrasted with "a contract of employment", to extend the scope of the definition of worker beyond

common law contracts of employment (i.e. "limb (a)" situations) to include also other types of contract, in certain defined circumstances ("limb (b)" situations). I do not interpret "*works under…any other contract*" as meaning, in effect, "any other contract, whoever the parties". Mr Panesar KC's suggested interpretation does not account the words "…another party to the contract", which necessarily require a contract between worker and employer.

210. In ***Plastic Omnium Automotive Limited v Horton*** [2023] EAT 85, the ET had failed to consider who the parties to the agreement were. The real issue was that the contract was not between the parties to the litigation. The respondent had contracted with a service company set up by the claimant with its own legal personality. The claimant had worked "under" that contract, but it was not one between him and the respondent. The only legally permissible conclusion was that he was not a worker. I regard that situation as analogous to the one in the present case, where the respondent contracted with a partnership in which the claimant was a partner.

211. On behalf of the claimant, Mr Panesar KC emphasises the need to look at the reality of the situation, to look beyond the strict terms of the contract and to remember the policy of the legislation to protect those working in conditions of subordination and/or vulnerability. However, in my judgment those considerations only arise if a contract of some sort is found to exist between the parties to the litigation. That much is clear from the way in which the issues were expressed by Lord Legatt in ***Uber BV v Aslam*** [2021] UKSC 5, at paragraph 41 and the other cases referred to above. I do not accept that the need to determine the nature of the true agreement between the parties entitles a tribunal to overlook the fact that there is no contract (or other agreement) between them at all, whether express or implied.

212. Mr Panesar KC submits that ***Plastic Omnium*** is wrongly decided and should not be followed. However, it is binding on me, so Mr Panesar KC will

have to make that submission at EAT level or above. Further, I respectfully think that ***Plastic Omnium*** was correctly decided for the reasons already set out above. It is consistent with the approach recently taken by the President of the EAT in ***Catt v English Table Tennis Association*** [2023] IRLR 1022.

213. I therefore proceed on the basis that section 230(3)(b) of the Employment Rights Act 1996 and the equivalent elements of the Working Time Regulations 1998 require that the claimant and the respondent must be parties to the same contract. That approach is faithful to the language of HHJ Tayler's structured approach in ***Sejpal v Rodericks Dental Limited*** [2022] EAT 91 and consistent with the reasoning of Eady J in ***Catt v English Table Tennis Association Ltd*** [2022] EAT 125, referred to more recently by HHJ Tucker in ***Plastic Omnium Automotive Limited v Horton*** [2023] EAT 85.

214. Since Mr Panesar KC's submission was that the distinction between a partnership and one of its partners is "thin", it is relevant to set out some principles of partnership law as they apply in Scotland. The 2018 GMS Contract was expressly subject to Scots Law. The claimant's partnership agreement was also expressly subject to Scots Law. In Scotland, partnerships have their own legal personality distinct from the partners of whom they are composed (see section 4(2) of the Partnership Act 1890). Partnerships have their own legal capacity under Scots law. They can own property, hold rights and assume obligations. They can enter into contracts. They can also be sued and the liability of the partnership lies with that firm and not its individual partners, even if a partner acted as the agent of the firm when delivering a service (***Hamid Khowrowpour v Taylor*** [2018] CSOH 64). The firm has a separate legal personality and an individual partner has no title to sue for the enforcement of firm obligations (Gloag and Henderson, The Law of Scotland (15th edition) paragraph 45.12).

215. The position is therefore very different from that in England and Wales,

where a partnership is *not* a separate legal entity, distinct from the partners who compose it (see e.g. Lindley & Banks on Partnership, 21st edition, 1-14). This is the context in which the statutory definition of "worker" must be applied in this case. For those reasons, I do not accept Mr Panesar KC's submission that the distinction between a partnership and its partners is thin.

216. Mr Panesar KC did not argue that a contract should be implied between the claimant and the respondent, and I see no proper basis for doing so. There is no reason to think that a person who enters into a contract on behalf of a partnership to which he belongs intends at the same time, or instead, to enter into a contract with the same Health Board, but as an individual. Nor is there any basis on which to find that the Health Board would understand the relationship in that way. The metaphorical "officious bystander" would take the same view. The reality of the relationship is fully and sufficiently explained by the existence of a contract between the partnership and the Health Board and there is no need to imply a contract between an individual GP and the Health Board in order to give the arrangement "business efficacy". The 2018 GMS Contract did not misrepresent the reality of the situation: plainly the parties were the partnership and the respondent, not the claimant and the respondent.

217. In summary, my finding is that it is fatal to the claimant's assertion of worker status under UK law that there was no contract at all between the claimant and the respondent. Both as a matter of form and also in reality, the 2018 GMS contract was between the partnership and the respondent Health Board, not between the claimant personally and the respondent Health Board. That partnership is and was a separate legal entity with its own legal capacity, distinct from the partners. It follows that whatever the work or services done by the claimant for the Health Board may have been they were not, as the statute requires, "for another party to the contract" since he was not himself a party to that contract. The obligation in clause 24.2 to provide patient care and all other relevant obligations were imposed on "the

Contractor", the partnership. The obligation on the claimant personally to provide 10 hours of patient care also derived from an obligation owed by *the partnership* to the respondent. The claimant therefore failed to satisfy the definition in section 230(3)(b) of the Employment Rights Act 1996 and regulation 2 of the Working Time Regulations 1998.

Worker status in EU law

218. If the claimant falls within the EU law definition of "worker" then the limitation by reference to contract in the domestic legislation could be avoided, since the WTD has direct effect. Direct reliance on the WTD would make it unnecessary to decide whether the definition of worker in the domestic legislation could be read down to give full effect to the Directive, although I understood Mr Napier KC to accept that it would be possible under ***Marleasing*** principles and by analogy with ***Gilham v MOJ*** [2018] ICR 827, CA, approved by Baroness Hale in the Supreme Court when reversing the decision on other grounds.

219. A recap of the principles. The WTD does not define "worker". In ***Uber*** the Supreme Court noted the definition in ***Allonby v Accrington and Rossendale College*** (Case C-256/01) [2004] ICR 1328: "there must be considered as a worker a person who, for a certain period of time, performs services for and under the direction of another person in return for which he receives remuneration", and that the concept of worker did not extend to "independent providers of services who are not in a relationship of subordination with the person who receives the services". That definition was adopted in the EU case law specifically concerned with the WTD (***Union Syndicale Solidaires Isere v Premier Ministre*** [2010] ECR I-9961, paragraph 28, ***Fenoll*** [2016] IRLR 67, paragraph 29 and ***Sindicatul Familia Constanta*** [2019] ICR 211, paragraph 41). The latter case referred to "a hierarchical relationship between the worker and his employer". In ***Haralambidis*** [2014] EUECJ C-270/13 the Court said at paragraph 29, "it follows that subordination and the payment of remuneration are constituent

elements of all employment relationships, in so far as the professional activity at issue is effective and genuine". To that extent, it appears that the concept of subordination is of greater importance to the EU law definition of worker than it is to that under UK law. If independence is "merely notional", then the formal classification of a self-employed person under national law does not exclude the possibility that a person must be classified as a worker for the purposes of EU law (***Allonby*** paragraph 79).

220. In this case, the independence of the claimant (or more accurately, the partnership) was not "merely notional". The claimant and the partnership were each free to decide how they would provide medical services. That freedom was not limited to matters of clinical judgment, it also extended to decisions about the staff that the practice would employ, what those members of staff would be paid and how they would be used. The freedom and independence also included the right to engage locum doctors to provide some of the services to whatever extent the partnership required, and the right for the partnership to decide how the work done by partners would be shared between them. The respondent had no say in those decisions and would not even be informed of the decisions made by the claimant, or the partnership, in relation to those matters. It was a largely unfettered right of substitution, exercised without reference to the respondent or the need for the respondent's permission. The need to ensure that a locum was appropriately qualified and on the Performer's List was not, in my view, a significant restriction. While GPs working within the practice were obliged to spend at least 10 hours in a normal week on patient care, that obligation was owed by the partnership to the respondent. The respondent had only indirect means of enforcing it, in that it could in principle take action against the partnership for breach of the GMS contract. It was a matter for the partnership to decide when partners would take annual leave and how much they would take.

221. The respondent did not have any power to remove the claimant from providing services under the 2018 GMS contract. That would be a matter for

the partnership and the partnership alone. Unless for some reason the claimant's involvement in the provision of medical services amounted to a breach of the practice's obligations under the 2018 GMS contract, the respondent would not have any basis upon which to object to his involvement. Even if the claimant's involvement did breach the partnership's own obligations, the respondent's remedy would be against the partnership and not directly or personally against the claimant. The theoretical possibility of a referral to the GMC under certain circumstances also demonstrates that the respondent had no power to act unilaterally to end or limit the claimant's involvement in the provision of medical services, but in any event a GMC referral would be a professional regulatory issue rather than an exercise of rights arising under contract.

222. Returning to the touchstones of worker status in EU law, my conclusion is that the independence of the claimant (through his partnership) was not "merely notional". It would not be accurate to characterise the relationship between the claimant and the respondent as one of "subordination" given the absence of contractual or other powers for the respondent to discipline or remove the claimant from involvement in the provision of services by the partnership. The respondent had no power to direct the claimant's work. I do not think that the relationship could properly be described as "hierarchical" in the absence of line management or something equivalent, giving rise to effective powers of direction and discipline. It would not be accurate to regard the claimant as "providing services for *and under the direction*" of the respondent, even if he received remuneration through his share of partnership profits.

223. For those reasons, I have concluded that the claimant did not satisfy the EU law definition of "worker", enabling him to rely directly on WTD. It is necessary for him to rely on domestic law.

Characterisation of the 2018 GMS contract under UK law

224. While the above conclusions are sufficient to determine the preliminary issue, I will go on to set out my findings in relation to the characterisation of the contract under principles of UK law, had the claimant and the respondent been parties to the same contract. I have already found that it is fatal to the claims based on worker status under UK law that the claimant and the respondent were not parties to the same contract.

Personal performance of work or services

225. I have no difficulty in finding that under the 2018 GMS Contract there was an obligation for the claimant to perform work personally. It is not important that the obligation was limited to a 10 hour a week minimum, since worker status does not depend on an obligation to perform personally any minimum amount of work. It is clear from ***NMC v Somerville*** [2022] ICR 755 that any amount of work will suffice.

226. The key issue is not so much the existence and nature of the obligation, but rather who owed that obligation to the respondent Health Board. Whatever freedoms the contractor had to delegate work, every member of the partnership was obliged to carry out no less than 10 hours of work each (normal) week personally. That was part of the definition of "sufficient involvement in patient care" for the purposes of clause 24. That meant regularly performing or being engaged in the day-to-day provision of primary medical services under the GMS contract, or certain other arrangements (clause 30). However, it was not the claimant's own obligation, it was the *contractor's* obligation (i.e. the partnership). That fails to satisfy the statutory definition which requires that "*the individual undertakes to do or perform personally any work or services for another party to the contract*". It was not the claimant ("the individual") who undertook to do so: the partnership undertook to ensure that it was done by all of the partners, including the claimant. If it was not done, then the partnership might be in breach of its contractual arrangements with the respondent, but not the claimant.

227. That was and is the reality of the situation. It is not the purely hypothetical result of contractual drafting designed to defeat arguments in favour of worker status. The purpose of the clause was to prevent GP practices from being run by commercial healthcare companies.

228. I also accept that the reality of the situation was that the claimant would, in practice, provide care for patients for much more than the 10 hour minimum each week. He worked full time for 5 days a week.

229. There are two reasons why, against that background, the claimant nevertheless fails to meet the statutory definition of worker:

a. the claimant and the respondent were not parties to the same contract.
b. Quite apart from privity of contract, the undertaking that the claimant would perform work personally was that of the contractor or partnership, and not the claimant himself.

230. Since the representatives have addressed many other tests of worker status developed over the years, I will do the same. However, I do not think that any of them add greatly to a focus on the statutory language in this case.

Customer or client exception

231. It is not necessary to consider the "client or customer exception" because the respondent does not rely on it.

Mutuality of obligation

232. I do not think that an analysis of mutuality of obligation has much to add in this case. The parties are agreed that the 2018 GMS contract was concluded between the partnership and the respondent. The parties are also agreed that there was no contract directly between the claimant as an individual and the respondent. The real issue is how to characterise the

contract which did exist. Plainly there was an obligation (owed by the partnership) that the claimant would undertake work and an obligation on the respondent to pay (the partnership) for that work. That is sufficient mutuality of obligation to found a contract and it would be sufficient mutuality to found a worker contract, if the claimant were a party to it.

Control, subordination, dependency and vulnerability

233. I give no weight to the claimant's tax status. It is irrelevant to the questions I have to decide (***Manning v Walker Crips Investment Management Limited*** [2023] EAT 79).

234. I give no weight to clause 11 of the GMS contract, which states that "The Contractor is an independent provider of services and is not an employee, partner or agent of the Health Board" because I must examine the reality of the situation. That clause does not expressly exclude worker status anyway.

235. The 2018 GMS contract also described the "practice" as "the business operated by the Contractor for the purpose of delivering services under the Contract". While I would give almost no weight to the label chosen in isolation, I find that it was accurate and consistent with the reality of the situation to characterise it as a business. The practice income was determined not just by the capitation payment and other formulae applied by the Scottish Government, but also by the decisions taken by the practice in relation to staffing, overheads and the way in which services would be provided. There was also an element of patient choice, in that potential patients would often have more than one GP practice with which they could register. Patient satisfaction, choice and recommendation would therefore have a bearing on the success of the practice. It was also a matter for the partnership to decide how many partners there should be, when they would work and how they should share the partnership profits. It was a matter for the partnership to decide how much of the work to contract out to locum doctors. It was a matter for the partnership to decide when partners would

take annual leave and how much leave they could take. In my judgment, those are all hallmarks of an independent business.

236. The contractor can decide how much to charge for private work, but that is only a very small proportion of total practice income. It is a factor of little weight.

237. While it is true that the practice's work and income are almost entirely derived from patients it is required to treat by the respondent, the respondent cannot stop the practice's work or divert work away from the practice unless the practice is in serious breach of its own contractual obligations.

238. The practice has only a very limited right to refuse to register a patient and it is only very rarely exercised.

239. The respondent exercises control over the standards and requirements of premises from which a contractor is allowed to operate, and the respondent also funds the premises from which GPs work. The respondent provides the telephones and IT systems on which the practice relies.

240. In contrast, the respondent exercises very little control over the claimant's work. That is not surprising given that the claimant is a skilled professional exercising clinical judgment and other forms of professional and managerial judgment. The partnership is required only to "have regard" to guidance issued by the respondent Health Board, not necessarily to follow it. The claimant does not have a line manager within the respondent Health Board. The respondent has no direct power of control over the claimant, either as a matter of strict contractual terms, or in reality. The respondent has no power to remove or prevent the claimant from supplying services under the 2018 GMS Contract. That would be a matter for the partnership. If the claimant ceased for some reason to be on the respondent's performer's list, failed to do the minimum amount of work personally, or caused a breach of the

contractor's obligations in some other way, then the respondent's remedy would be against the contractor, not the claimant personally. While that might well in practice put pressure on the partnership to rectify the default, the key point is that the claimant would be answerable to the partnership, not the respondent. If this possibility is properly regarded as control by the respondent at all, then it is only an indirect form of control, reliant on action by the partnership in order to be effective.

241. I turn to the issue of substitute performance. The practice has a broad discretion in relation to the use of locums, being able to decide whether, when and how much to use them. The respondent does not significantly restrict their availability, though market forces may do. The respondent has no right to reject a locum and would not even be informed when one was used. The requirement that a locum should be appropriately qualified and on the Performer's List is not in my judgment a significant fetter on the practice's right to provide care by using a substitute performer.

242. The claimant was represented in contractual negotiations by a powerful and effective trade union. While the claimant disagrees with his union's negotiating stance, it nevertheless reduced his vulnerability to exploitation. The BMA was fully involved in the negotiation of the new contract. The BMA had considerable bargaining power. The claimant's position is very different from and far less vulnerable than that of a less highly paid, non-unionised worker who is presented with an employer's carefully (or craftily) drafted terms and conditions with little option but to accept them.

243. The purpose of the legislation is to protect individuals who are vulnerable to exploitation in the workplace. I do not accept that the claimant falls into that category. The claimant chose to work in partnership, and to enter into the GMS Contract on that basis. The arrangement was not imposed on him by a Health Board exploiting an imbalance of power. It was open to the claimant to practise as a "single-handed" GP and to enter into a GMS Contract on that alternative basis if he wished. He runs (in partnership) a

business that turns over more than half a million pounds a year. He has a guaranteed personal income of £84,630 per year, although he has never had to rely on that guarantee. He can (through the partnership) employ staff, contract out work to locum GPs and make other decisions which directly affect his own earnings, workload and freedom to take leave.

244. While the features of this case do not all point in the same direction, on balance I am not persuaded that the claimant was vulnerable, dependent, or in a relationship characterised by significant subordination or control. The approach mandated by ***Uber*** is to ask "whether the relevant statutory provisions, construed purposively, were intended to apply to the transaction, viewed realistically". I have concluded that they were not.

Integration

245. There is no doubt, as the respondent accepts, that the claimant's work as a GP is integral to the provision of NHS healthcare and has been since its inception. However, I accept the respondent's submission that there is a distinction to be drawn between the integration of General Practice into the NHS and the question whether the claimant was personally integrated into the respondent's structure.

246. Key considerations include the fact that there was no contractual relationship at all between the claimant and the respondent. The claimant did not form part of the respondent's administrative structure and he did not have a line manager. He had a significant degree of autonomy. Overall, I am not persuaded that the claimant was personally integrated into the respondent's organisation, even if his work as a GP was an integral part of NHS care.

Dominant feature

247. As Mr Napier KC points out, the test concerns the dominant feature of the

contract, and here there is no contract involving the claimant to analyse. That aside, in my assessment it is not possible to say that the dominant feature of the 2018 GMS contract was the provision of GP services personally. It was one of many features, but not the dominant one. Reduced to a single sentence, the dominant aim, purpose and general character of the contract was to structure practice as a GP in a way that would be sustainable, stable, less risky and more attractive to new entrants to the profession.

248. I should make it clear that I do not treat the "dominant feature" test as any substitute for the questions crisply identified in paragraph 41 of ***Uber***. If those questions had been answered in the claimant's favour, and if there had been an undertaking by the claimant to perform work personally for the respondent, then it should not matter that the dominant feature of the contract was something else. For that reason, I do not think that the dominant feature test has anything to offer in this case.

Summary of conclusions

249. There are three broad reasons why I have found that the claimant is not a "worker" for the purposes of the complaints made in his claim form.

a. Section 230(3)(b) of the Employment Rights Act 1996 and regulation 2 of the Working Time Regulations 1998 each require that the claimant, as putative worker, should be a party to the same contract as the respondent, as putative employer. There was no direct contractual link between the claimant and the respondent and neither ***Uber*** principles nor ***Autoclenz*** principles entitle a Tribunal to ignore that.

b. The relationship did not fall within the scope of "worker" as understood in EU law. Consequently, neither reliance on the direct effect of the Working Time Directive nor a purposive interpretation of

the implementing legislation, the Working Time Regulations 1998, can help the claimant to avoid the difficulties of domestic law, as I have interpreted it.

c. While there was an obligation on partners such as the claimant to perform a certain amount of work personally, that obligation was owed to the respondent by the partnership, not by the claimant himself. Following ***Uber***, ***Autoclenz*** and ***Bates van Winkelhof*** it is probably sufficient to go no further than the issue of personal performance. If the many other tests are relevant then, even on an appropriately purposive interpretation, the claimant's situation was not one of such subordination, dependency or vulnerability that he required the protection of employment rights derived from worker status, nor was the personal performance of work the dominant feature of the 2018 GMS Contract.

Employment Judge: **M Whitcombe**
Date of Judgment: **17th July 2023**
Entered in register: **17th July 2023**
and copied to parties