Department of Health

Equality Analysis

NHS Pension Scheme access arrangements introduced by The National Health Service Pension Scheme (Amendment) Regulations 2014.

March 2014

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Equality Analysis

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NHS Pension Scheme access arrangements introduced by The National Health Service Pension Scheme (Amendment) Regulations 2014.

Introduction :

The Department of Health has been working closely with HM Treasury (HMT), other public sector pension schemes, independent sector providers, NHS employers, Trade Unions and with both the current NHS Pension Scheme Governance Groups and Staff Passport Group to design and implement changes to access to the NHS Pension Scheme (NHS PS).

This work includes the development of necessary changes to the various regulations governing the NHS PS.

General Introduction in terms of the Equality Analysis

The Public Sector Equality Duty (PSED) places a duty on public bodies and others carrying out public functions. It aims to ensure that public bodies consider the needs of all individuals in their day to day work – in shaping policy, in delivering services, and in relation to their own employees. The PSED is set out in section 149 of the Equality Act 2010, and it applies across Great Britain to public bodies listed in Schedule 19 to the Act (and to other organisations when they are carrying out public functions).

The general equality duty that is set out in the Equality Act 2010 requires public authorities, in the exercise of their functions, to have due regard to the need to:

(1) eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act;

(2) advance equality of opportunity between people who share a protected characteristic and people who do not share it; and

(3) foster good relations between people who share a protected characteristic and people who do not share it.

The following characteristics are protected characteristics:

- **Age**
- **Disability**
- **Gender reassignment**
- **Marriage and civil partnership**
- **Pregnancy and maternity**
- **Race**
- **Religion or belief**
- **Sex**

- **Sexual orientation**

All protected characteristics need to be considered against the first limb. All protected characteristics (except for marriage and civil partnership) need to be considered against the second and third limbs.

The PSED does not specify how public authorities should analyse the effect of their existing and new policies and practices on equality, but doing so is an important part of complying with this general equality duty. This analysis sets out the Department's view on how the proposed policy on access affects the matters to which the general duty requires public authorities to have due regard.

Policy Context

Currently over 90% of NHS clinical services are delivered by traditional NHS organisations, and the NHS is the largest employer of staff with experience in this area. Employees of NHS bodies have access (on a non-compulsory basis) to the NHS Pension Scheme which is a statutory, contracted out occupational scheme; both members and their employers are required to pay contributions to cover the cost of Scheme benefits. The Scheme currently has approximately 1.3 million active members who pay a range of contributions to the pension scheme.

Those who commission services for, and in, the NHS ("NHS commissioners") must secure health services from the provider or providers that are most capable of delivering high quality services to their populations and provide best value for money in doing so. These providers can come from the public, private or voluntary sectors.

At present there are two main impediments to non-traditional NHS providers "entering the market to provide NHS services" on the same basis a traditional NHS bodies (the "level playing field" problem). Firstly, the non-availability of membership of the NHSPS prevents non-traditional NHS providers from being able to recruit the required calibre of employee. Secondly, the previous version of "Fair Deal" applied only to members who were not compulsorily transferred from a traditional NHS organisation to a non-traditional one. Instead of retaining membership of the NHSPS, such staff were offered a 'broadly comparable' pension. A "broadly comparable" pension could, based on analysis by the Government Actuary Department and Monitor, cost up to 14% more than the NHSPS. This situation meant that where non-traditional NHS organisations were unable to offer a broadly equivalent pension, there was a significant restriction on labour mobility and a corresponding restriction on the provision of a more flexible health services close to the people who need them.[1]

The policy intention is to enable non-traditional NHS organisations that provide NHS services to have access to the NHSPS and to enable those who are members of the scheme but move to such a non-traditional provider to retain their membership of the Scheme.

As part of that policy, access to the NHSPS is to be afforded to non-traditional NHS bodies that provide NHS services pursuant to certain types of contract with an NHS commissioner. Those contracts are an NHS standard contract, an APMS contract, and a contract entered into by a local authority pursuant to its functions under the National Health Services Act 2006 relating to the improvement and protection of public health and which the Secretary of State agrees to treat as a qualifying contract for these purposes.

The policy is also affected through a revision of Fair Deal – "New Fair Deal". New Fair Deal enables staff under TUPE/Compulsory transfer from the NHS to remain in the NHS PS.

What are the intended outcomes of this work?

[1] See Annex H monitor findings – NHS Pensions and Impact on Independent Providers (TUPE eligible staff)

The intended outcomes are:

(1) to offer access to the NHS PS for staff working in non-NHS organisations providing NHS clinical services (Independent Providers (IPs)), where they deliver services under an APMS contract or a NHS Standard Contract or a contract entered into by a local authority pursuant to its functions under the National Health Services Act 2006 relating to the improvement and protection of public health and which the Secretary of State agrees to treat as a qualifying contract for these purposes. Such access will be afforded to both clinical and non-clinical staff delivering those services;

(2) to enable IPs to recruit and retain staff to deliver NHS services as they will have the ability to offer their employees membership of the NHSPS;

(3) to allow members of the NHSPS who are subject to a compulsory transfer to a non-traditional NHS organisation to retain membership of the NHSPS, thus removing a key barrier;

(4) to ensure that widened access to the NHSPS is subject to suitable controls i.e.by requiring the provision of information, governing termination of membership, guarantees underwriting contributions payable to the Scheme and interest charges for late payment of contributions: some of these mechanisms are of general application across the Scheme.

Who will be affected?

1. **Employees of IPs** - the group of staff who will benefit from this policy change are staff who are engaged in NHS services to other healthcare providers delivering NHS Clinical services on an NHS Standard Contract/APMS Contract or a local authority pursuant to its functions under the National Health Services Act 2006 relating to the improvement and protection of public health and which the Secretary of State agrees to treat as a qualifying contract for these purposes. The degree to which IP staff will have access to the NHS PS is a decision for the IP employer– based on the framework agreement provisions (Annex 1).

2. **New IP Employers** – they will be able to offer the NHS PS to staff delivering clinical services - under an APMS contract or a NHS Standard Contract or a contract entered into by a local authority pursuant to its functions under the National Health Services Act 2006 relating to the improvement and protection of public health and which the Secretary of State agrees to treat as a qualifying contract for these purposes, and it covers both clinical and non-clinical staff delivering that clinical service.

3. **Current NHS Employers** – they may lose staff to IPs as the pension barrier is reduced, but it may also enable improved focussed services in the NHS as providers seek to improve the quality of services to respond to the new Competition and Choice Framework. In addition current NHS Employers will also be required to deliver both the:

   (a) Interest payment required for late payments of NHS Pension contributions

   (b) Cap on final pensionable pay to ensure that there is no manipulation of the scheme because it is final salary for officers.

4. **Users of NHS Clinical Services** – there should be increased ability to access services from a wider range of organisations including Community Interest Companies, Mutuals, Social Enterprise and Voluntary bodies as the barrier to entry of NHS PS access is removed and commissioners may choose the provider best able to meet patients' needs.

5. **Commissioners** - who are subject to their own duties in relation to quality and this should mean that they commission services from the provider who will deliver the best available services. The SofS role is to broaden the choice of providers available to commissioners including CCGs.

   Whilst SofS has no direct relationship with CCGs – NHS England oversees them. SofS has to keep NHS England's performance under review, and to assess annually how effectively NHS England has carried out its functions, including in particular its function under section 13E. NHS England carries out performance assessments of CCGs annually, and this must include in particular an assessment of how each CCG has carried out its duty under section 14R.

An equality analysis was undertaken for the H&SC Act 2012. This can be found at http://services.parliament.uk/bills/2010-11/healthandsocialcare/documents.htm1.

In relation to outcomes, DH sets the outcomes framework, and this is referred to in the mandate to NHS England, which means it has a statutory duty to seek to demonstrate progress against the outcomes indicators in the Outcomes Framework. The key point is that an increased range of providers better enables NHSE and CCGs to commission services which better meet patients' needs which should go towards reducing inequalities as outlined in the health inequalities analysis.

Evidence

What evidence have you considered?

1. Evidence presented by monitor, IPs at workshop events and by way of survey, Trade Union evidence and discussions with NHS Employers.

   This evidence has been used in policy development and refinement. The annexes include further information supplied by GAD, gathered from workshops with the independent providers, Monitor's findings and evidence gathered by the Staff Passport Group.

   Whilst there is available data on the membership of the NHS PS by the protected characteristics, there is little if any evidence from the independent sector other than the findings offered to Monitor. Going forward , this policy will require NHS BSA to set up monitoring systems and, in line with HMT requirements for New Fair Deal, data will become available over time that will be used in the review process.

2. Evidence emanating from the dialogue with stakeholders based upon the data made available. This dialogue has taken place since the Proposed Final Agreement was made in 2012 through the Staff Passport Group in the main, and this group consists of Trade Unions, Employers both NHS and IP, HMT and Cabinet Office.

3. Evidence emanating from the interaction with the Social Partnership Forum, the Independent Sector Review Group and the Pension Governance Group managed by NHS Employers: the access review has also been discussed generally at the NHS Staff Council given the link with that group and the Staff Passport Group, which is a sub-group of the Social Partnership Forum.

4. Evidence from the NHS PS administrators (the NHS BSA) and further data from the Electronic Staff Record system: this was used to as a baseline for understanding the demographics by characteristic of the membership to the NHS PS, however there is little if any data for IPs.The Electronic Staff Record (ESR) the HR and payroll system that covers all NHS employees other than those working in General Practice, two NHS Foundation and only covers persons who already have access to the NHS PS. ESR was fully rolled out across the NHS in April 2008.

Following the regulatory consultation a number of changes have been made to the regulations to respond to concerns raised, some of which were the implications by age of the final pension pay control,

impact on employers in terms of burden. These include:

IP access

- The requirement for IPs to provide a guarantee will be subject to a risk assessment rather than mandatory. The size and nature of the guarantee is to be determined by SofS and therefore more flexible in application.
- Definition of qualifying contract extended to include local authority contracts relating to delivery of public health services.
- Grace period in respect of secondments extended from 12 months to three years. The intention is to prevent unwanted unpicking of contracts as the organisation transits to IP status.
- Employees who are already in receipt of an NHS pension at the point where IP access is granted will not have their pension considered for abatement provided they remain inactive members of the scheme (i.e. do not re-join or opt out immediately if auto-enrolled). The intention is to stop pensioners who are not subject to abatement because their employer does not participate in the scheme, having their pension reduced even though their employment arrangements have not changed. A similar exception exists in relation to pensioners whose employment transferred to an NHS employer as a result of TUPE.
- The administration requirements relating to annual pension returns for IPs have been simplified.

Final pay control

- SofS when determining whether a pay rise is inordinately high must have regard to past experience of pay progression in the NHS rather than anticipated progression.
- In the event that a member changes jobs, pay increases awarded by a former employer, including those in other health services are no longer in scope.
- Where the controls are engaged as a result of a clinical excellence award, the scheme administrator rather than employers will recover the relevant charge from the awarding body (ACCEA) directly.

Interest charging

- Interest will be compounded with yearly rather than monthly rests. The calculation is simplified whilst the difference in interest payable is negligible.
- Where the case is considered exceptional, SofS will have the flexibility to waive all or part of an interest charge.

The full Government response will be published on the Government website.

In terms of the effect with respect to protected characteristics:

Race, **Religion or Belief and marriage and civil partnership –** We do not consider that the proposals identify any specific equality impacts in relation to race, religion or belief and marriage and civil partnership. In reaching this conclusion, DH has considered the available evidence from the NHS PS data used for the valuation process on race, religion and belief. There is little if any data for IPs on this aspect, but because the IPs are likely to be drawn from a broad church of organisations such as CICs, voluntary sector, mutual the demographics of these organisations may be slightly different. The available evidence from the valuation data on membership by ethnic grouping is attached below.

Scheme membership by ethnic grouping

Ethnic grouping	Proportion of scheme members	Proportion in working population	Proportion working in public sector
White	83.6%	90.2%	90.2%
Mixed	1.3%	0.9%	0.8%
Indian	4.3%	2.4%	2.4%
Pakistani	1.2%	1.1%	0.7%
Bangladeshi	0.3%	0.5%	0.4%
Chinese	0.6%	0.4%	0.3%
Other Asian	2.3%	1.0%	1.2%
Black / Black British	5.2%	2.2%	2.8%
Other	1.2%	1.3%	1.2%
Total	**100.0%**	**100.0%**	**100.0%**

There is no available data on marriage and civil partnerships and nothing was brought to the attention of DH through the consultation or regulatory workshop session with stakeholders. If any impacts are brought to DH's attention we will consider the impact.

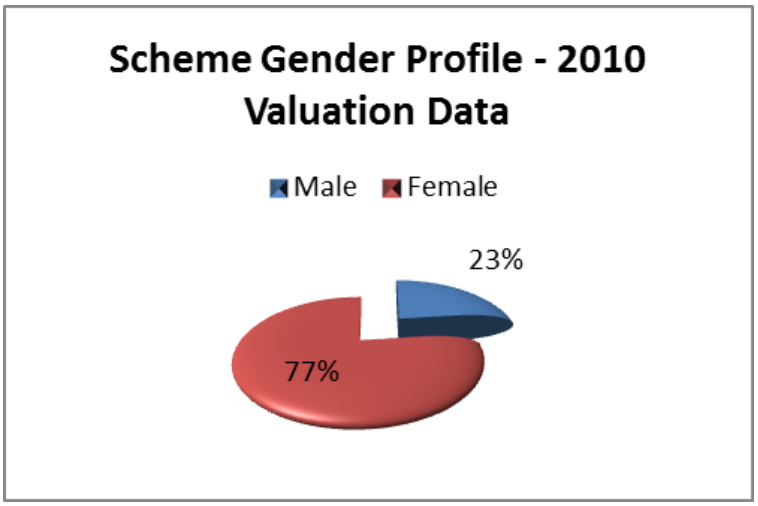
Whilst developing this policy, DH has considered carefully the duties to advance equality of opportunity and foster good relations between persons who share a protected characteristic and those who do not. It is recognised generally that this policy would appear to be a positive step, extending access to the NHS pension scheme to those new types of organisations and their employees, delivering NHS services in non-NHS organisations. The expectation is that this, over time, will improve the advancement of equality and foster improved relations between people who share a protected characteristic and those who do not.

Disability – Although traditionally a high proportion of members retire within a few years of the normal pension age of 60, there is evidence that increasing numbers continue in pensionable employment after the 52+ (and even the 60+) 'retirement window', and are free to do so until age 75. The final pay checks and employer charge where there are excessive pay awards are designed to control the pension costs, for all scheme employers and members. The cost of such increases cannot otherwise be recovered through increased contributions in respect of that person's membership, meaning the additional costs fall to all other employers and members given the mutuality of the scheme.

It is therefore not anticipated that this policy will have an adverse effect in terms of disability.

Whist developing this policy, DH has considered carefully the duties to advance equality of opportunity and foster good relations between persons who share this protected characteristic and those who do not. It is recognised generally that this policy would appear to be a positive step for those with disabilities as compared to others by extending access to the NHS pension scheme to those new types of organisations and their employees, delivering NHS services in non-NHS organisations. The expectation is that this will, over time, improve the advancement of equality and foster improved relations between people who share a protected characteristic and those who do not: this will form part of the review.

Sex – We do not consider that these proposals, and no evidence has been identified during the development and consultation phases, to demonstrate that there are any specific equality issues by sex. The general breakdown for the NHS PS identified below shows that the NHS PS membership is 77% female and 23% male. What is not understood is the general breakdown by IPs by gender. This data will become available over time as IPs join the NHS PS and it will be possible to analyse the available data.



Analysis by part-time/full-time status – Given that females are more likely to work part-time than males this aspect was also considered carefully. This policy will be applied to part-time and full time members of the NHS PS and should have a similar effect. Further consideration has been given to the implication of the final pensionable pay control – this has been given consideration by the Government Actuaries Department and was explored at length in the Regulatory workshop held with the Governance Group members including employers and Trade Unions.

Whilst developing this policy, DH has considered carefully the duties to advance equality of opportunity and foster good relations between persons who share a protected characteristic and those who do not. It is recognised generally that this policy would appear to be a positive step, extending access to the NHS pension scheme to those new types of organisations and their employees, delivering NHS services in non-NHS organisations. The expectation is that this will generally improve the advancement of equality and foster improved relations between people who share a protected characteristic and those who do not over time and this will form part of the review at years one and five.

Gender re-assignment– This policy does not make any distinction on the basis of gender reassignment and therefore it is assumed that there will be no impact. This data is difficult to retrieve for both the NHS PS and no data is available for the IPs.

Whilst developing this policy, DH has considered carefully the duties to advance equality of opportunity and foster good relations between persons who share a protected characteristic and those who do not. It is recognised generally that this policy would appear to be a positive step, extending access to the NHS pension scheme to those new types of organisations and their employees, delivering NHS services in non-NHS organisations. The expectation is that this will generally improve the advancement of equality and foster improved relations between people who share a protected characteristic and those who do not over time and this will form part of the review at years one and five although it is likely that this data will remain very limited on gender-reassignment.

Sexual orientation – This policy will be applied equally to members from all sexual orientations, although there is little, if any, data from a sexual orientation perspective on the NHS PS or for IPs. No issues were raised on this particular characteristic during the regulatory consultation either by the responses or through the regulatory workshop.

Whilst developing this policy, DH has considered carefully the duties to advance equality of opportunity and foster good relations between persons who share a protected characteristic and those who do not. It is recognised generally that this policy would appear to be a positive step, extending access to the NHS

pension scheme to those new types of organisations and their employees, delivering NHS services in non-NHS organisations. The expectation is that this will generally improve the advancement of equality and foster improved relations between people who share a protected characteristic and those who do not over time and this will form part of the review at years one and five.

Pregnancy and Maternity - We do not consider that the proposals outlined above and the available evidence from both the business case and the pension data raise any specific equality issues for members in relation to pregnancy and maternity. No issues were raised on this particular characteristic during the development and regulatory consultation phases, either by way of formal responses or through the regulatory workshop.

Whilst developing this policy, DH has considered carefully the duties to advance equality of opportunity and foster good relations between persons who share a protected characteristic and those who do not. It is recognised generally that this policy would appear to be a positive step, extending access to the NHS pension scheme to those new types of organisations and their employees, delivering NHS services in non-NHS organisations. The expectation is that this, over time, will generally improve the advancement of equality and foster improved relations between people who share a protected characteristic and those who do not over time: this will form part of the review at years one and five.

Age – The current age profile of NHS PS members as set out in the 2010 and 2012 valuation data is identified below in Graph 1.1. The data shows that 30% of the scheme membership was over 50 in 2010.

It is important to consider this data as the potential for age discrimination by the application of the final pensionable pay control was raised during the policy development and through the regulatory consultation. Given final pensionable pay is likely to impact on the older end of the workforce, this was considered from that perspective.

Final pensionable pay control was an important part of the control mechanism for the NHS PS ensuring that pension scheme benefits fit suitably with the mutuality of the scheme. Given that the Scheme is based on employer and employee contributions it is important this control applies equally across the workforce. This mechanism is present in a number of other public sector schemes. This matter was discussed and modified carefully through on-going discussion and debate with all employers (NHS and IP) and Trade Unions.

The control is not targeted on any one age group. DH considers that the operation of the proposed final pay controls is not discriminatory, on age or any other grounds, because of careful consideration in the suitable design. The control regime will apply irrespective of the member's age on termination of pensionable employment. From 1 April 2014, the last four years of a member's pensionable employment will be checked, whether the member is, for example age 50, and deferring their NHSPS benefits for payment at normal pension age 60, or already age 60 and retiring with an immediate age pension.

All types of 'live' pension benefit will fall to be checked; including any awarded on ill-health retirement grounds as outlined above, which may be paid at any age subject to medical criteria and the minimum period of qualifying service. All NHS PS death benefits will however be excluded from the check. Other NHSPS benefit arrangements involving pay averaging, and any pay increase awarded prior to 1 April 2014, will escape the final pay control checks, irrespective of whether such a pay rise may appear to have been excessive.

The final pay checks and employer charge are designed to control the pension costs, for all scheme employers and members, of higher than normal pay increases made to particular individuals shortly before retirement. The cost of such increases cannot otherwise be recovered through increased contributions in respect of that person's membership, meaning the additional costs fall to all other employers and members given the mutuality of the scheme.

Any employer charge levied as a result of an excessive pay award falls solely on the employer; the member will always receive full NHSPS benefits in respect of the employee contributions they have paid, even if the pensionable pay figure reported by the employer, and used by the BSA to calculate benefits, exceeds the relevant CPI+4.5% cap level. The CPI+4.5% cap level was selected very carefully after close consideration across a range of potential options and detailed discussions with stakeholders. It was designed to allow normal average NHS salary increases of CPI+1.5% p.a., without additional charges, plus a further 3% p.a. average incremental increases under the Agenda for Change pay scales. Examples of how this might work in practice were shared with the Governance Group and this paper is attached at Annex 4.

An over-cap pay increase during a member's final three years of service will be considered for additional employer contributions whatever the age of the member on termination of service. Also there will be no detrimental impact on member benefits, whatever the rate of pay increase or employer charge levied. The consultation document clarifies that employers should be aware that a claim of age-discrimination might be brought against them if it could be shown that age had been a criteria in offering (or not) a member promotion, or if they have refused to pay an older person the same increase in pay that would have been made available if that member had been younger.

Also in the consultation some employers suggested that allowing the new pay control to 'bite' on a member's final three years of service, irrespective of their age at termination, risked perverse impacts and unexpected employer charges well before the period most members might be expected to retire. The Department understands these concerns but cannot exclude deferred periods of service without giving rise to potential age discrimination. Excluding deferred members would also present a significant 'loophole', by means of which employees and employers arranging a large pay increase could avoid an employer charge by leaving service or opting-out of the scheme at a suitable point. In practice, few members leaving service do so after receiving a large pay increase and many of those who do leave on deferment, eventually return to the NHS and scheme membership, which will 'cancel out' the effect of an earlier excessive pay increase.

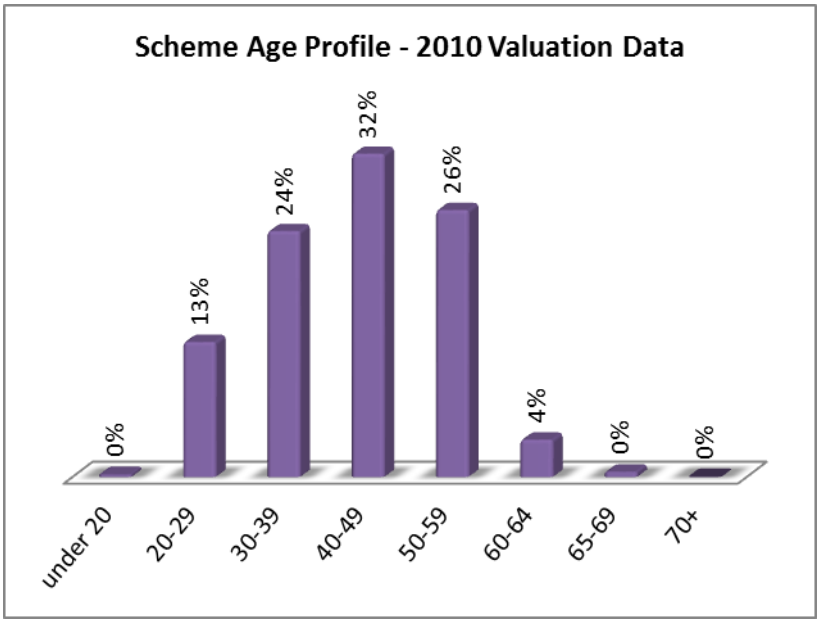
As above - when considering these aspects of the policy DH have considered carefully the duty to advance equality of opportunity and foster good relations between people who share a protected characteristic and those who do not. It is recognised that this policy is generally a positive step, extending access to the NHS pension scheme to those delivering NHS services in non-NHS organisations and as such will improve the advancement of equality and foster improved relations between people who share a protected characteristic and those who do not. We believe this is the case for both employees and employers.

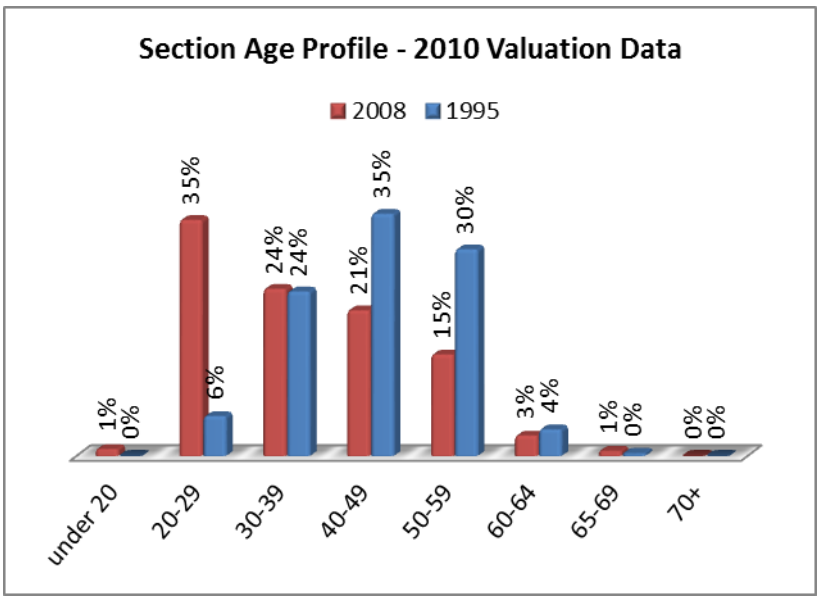
The following changes were made to the regulations in response to comments-:

Final pay control

- SofS when determining whether a pay rise is inordinately high must have regard to past experience of pay progression in the NHS rather than anticipated progression.
- In the event that a member changes jobs, pay increases awarded by a former employer, including those in other health services are no longer in scope.
- Where the controls are engaged as a result of a clinical excellence award, the scheme administrator rather than employers will recover the relevant charge from the awarding body (ACCEA) directly.

1.1. Scheme Age Profile – based on 2010 Valuation Data





Engagement and involvement

During the policy development there have been regular monthly meetings with HM Treasury, independent sector providers, NHS employers, Trade Unions at the Staff Passport Group to consider the design and implementation requirements to deliver the access changes to the NHS PS. Employer representatives from IPs and NHS organisations also attended those meetings. Equality considerations were considered as an integral part of the overall discussions throughout the two-year development phase and the consultation phase, and the Staff Passport Group and Technical Advisory Group of the NHS PS Governance Group were provided with the draft equality analysis to enable input from all parties.

In terms of being aware of the policy changes, Ministers, NHS Employers, Trade Unions, NHS England

and HEE have been engaged through the Social Partnership Forum. This group is chaired by Ministers, and has employer and Trade Union representation as well as the representative bodies.

Additionally the current NHS Pension Scheme Governance Group has been engaged on the changes, in particular the control mechanisms of late payment on interest charges and final pensionable pay given these will also affect current members in the NHS and all employers.

Across Government other department and other public sector pension schemes have been updated and informed of changes and HMT have formally signed off the business case and final changes to the conditional guarantee. They have also endorsed the overall review approach.

During the policy development there have been a number of workshops led by DH for independent providers and NHS Employers provided a separate workshop for NHS organisations only to raise their position/concerns. This provided opportunities for all parties to raise any considerations into the policy, including any perceived equality difficulties. All feedback has been utilised to support the policy development and final position.

There is a statutory obligation to consult on changes to the regulations governing the NHS PS and the consultation ran for a ten week period from 2 December 2013 to 10 February 2014.

There is a review process built into the policy work at years one and five as set out in the Framework Agreement and as agreed with HMT. This is included at annex E within Annex 5, and the review includes an explicit intent to support and build on the HMT led New Fair Deal policy for providers of NHS clinical services to ensure proposals comply with an equality analysis. The review will be considered further by all the parties to the agreement and potentially revised if appropriate and if agreed by the parties and we will reconsider carefully the equality requirements.

How have you engaged stakeholders in gathering evidence or testing the evidence available?

We have gathered data from the NHS PS administrators (the NHS BSA), GAD and the DH policy teams working with AQP and other providers. This available data has been used throughout the policy development to consider fully the options against a range of factors including financial, and equality considerations. However it is fair to say that the evidence available for IPs is extremely limited and as organisations join the NHS PS more will be available for analysis. Additionally we have carried out a number of workshops with independent providers to explore possibilities that deliver against requirements. This feedback is included at Annex 2 and during this consultation no equality concerns were raised with DH as part of that process.

In addition, Monitor outlined the case for the access work and this is outlined at Annex 3[2]. This work was an important element within the context of the Fair Playing Field Review and this work continues to link closely to that review.

During the regulatory consultation key questions were raised on the access at HMT's request:

a) *Whether current and prospective NHS employers believe that the scheme admissions and control arrangements proposed could be simplified, without weakening the safeguards ensuring public expenditure is protected and to ensure that the NHS PS is used only for employers and staff engaged in NHS work?*
b) *What groups of staff in IPs in particular expect to recruit with the support of NHS PS*

[2] This evidence was provided to DH from Monitor and not published as part of the FPFR

membership?

c) *Whether there might be a case for limiting the new IP access to specific staff groups, now or in the future?*
d) *We would also be interested to know how "traditional" and existing NHS employers see the proposed changes impacting upon them; and how any impacts could best be managed?*

The summary of the consultation responses and the Government Response will be published alongside this Equality Analysis on the Government website.

By way of synopsis, the majority of respondents commented on the access provisions, including the final pay control proposals that will apply to all employers. The principle of scheme access for Independent Providers was very much welcomed by IP respondents, which included Care UK, Virgin Care and Serco. Concern was expressed though at the requirement for all IPs to provide a mandatory conditional guarantee to offset the risk of contributions default. As a result of the consultation responses, and our further engagement with HMT, we have now modified the approach so that a conditional guarantee may be required based on a risk assessment of the IP by NHS BSA, similar to New Fair Deal provisions, rather than being required automatically.

Responses also sought further confirmation as to how the final pay controls would work in practice amid suggestions that such measures may disadvantage career progression and reward strategies. Of particular concern was the basis on which excessive pay increases are determined and the prospect of liability for past pay awards transferring between employers. Accordingly we have refined the policy such that past experience of pay progression, rather than anticipated future progression, is the key consideration when determining whether a pay rise is inordinately high. We have also removed from scope of the controls pay increases made by a former employer to cover situations where the member takes up a post with a new employer.

How have you engaged stakeholders in testing the policy or programme proposals?

We have been working with HM Treasury, other public sector pension schemes, independent sector providers, NHS employers, Trade Unions and with both the current NHS Pension Scheme Governance Groups and Staff Passport Group over a two year period to design and implement the changes required to deliver the access changes to the NHS PS. They considered the proposals from a variety of angles including "level playing field", financial, legal, equality and appropriateness as well as the overall ability for the policy to deliver on the aims given the lack of access to the NHS PS for non-traditional providers has been identified by Monitor as acting as a barrier to entry by IPs, making it difficult for these providers to recruit experienced staff.

In addition we have carried out a ten week statutory consultation.

We have carried out a number of workshops with independent providers to explore possibilities that deliver against all requirements including equality to identify issues associated with granting IPs access to the NHSPS, including equalities issues.

We have utilised feedback that has been collected from stakeholders through established NHS Pensions engagement channels, such as Social Partnership Forum and, and through the Independent Sector Reference Group. As outlined above the Social Partnership Forum is chaired by ministers and includes employer and trade union representatives. The Independent Sector Reference Group is a DH internal group supporting IPs in responding to the fact that NHS commissioners must secure health services from a range ofproviders, whether from the public, private or voluntary sectors, that are most capable of delivering high quality services to their populations and provide best value for money in doing so. It is clear that in contracting with a provider, the commissioners must act transparently and without discrimination. The commissioners are also subject to the PSED.

For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:

- The review was agreed as part of the Proposed Final Agreement on the reform of the NHS PS for England and Wales. – formally agreed from 4th July 2012 with Trade Unions and employers
- Monthly meetings with Staff Passport Group since January 2012
- Meetings with the Governance Group – in 2012 and 2013
- Consideration at the Social Partnership Forum – 26th November 2013
- Regulatory Workshop - 8th January 2014
- Consultation throughout with Government Actuaries Department (GAD)
- Both the Staff Passport Group and Technical Advisory Group were consulted on a draft version of the Equality Analysis – January 2014
- Respondents to statutory consultation by 10th Feb

Summary of Analysis

The access review was an important aspect of the NHS Proposed Final Agreement – and these provisions will be welcomed as improvement for staff, for IP employers and ultimately improved quality of services for service users. Increasing access to the NHS PS, and thereby increasing the range of providers from whom NHS services can be commissioned, has as its overall aim the continuous improvement in the quality of services provided to patients. This is because the policy aims to enable patients to receive services from the provider best able to meet their needs, regardless of whether the provider is from the public, independent or voluntary sector.

It is an integral part of the Fair Playing Field Review response led by Monitor, and will be important to IPs, NHS staff, Trade Unions and Monitor.

The outcomes and changes following the regulatory consultation have been referred to above and the full Government response is published on the website.

There was no evidence or concerns raised to suggest there are significant issues in equality of treatment for any of the protected characteristics, and equally nothing raised to suggest that the policy did not support **elimination of unlawful discrimination**, harassment, victimisation and any other conduct prohibited by the Act; **advancement of equality of opportunity** between people who share a protected characteristic and people who do not share it; and **fostering good relations** between people who share a protected characteristic and those people who do not share it.

There is limited data, particularly for IPs, to draw absolute conclusions on equality considerations and the review process will be particularly important in gathering evidence from IPs, as well as any learning that emerges from the on-going monitoring of the Fair Playing Field Review by Monitor.

Impact of proposals on eliminating discrimination, harassment and victimisation, advancing equality of opportunity, or promoting good relations between groups

The policy is generally identified as a positive step forward by removing the pension barrier for staff which will increase access to the NHS PS, and thereby increasing the range of providers from whom NHS services can be commissioned. This has as its aim the continuous improvement in the quality of services provided to patients. This is because the policy aims to enable patients to receive services from the provider best able to meet their needs, regardless of whether the provider is from the public, independent or voluntary sector.

This policy covers all persons from diverse backgrounds and with various protected characteristics. It will fully support the Government's agenda to eliminate discrimination, harassment and victimisation,

whilst advancing equality of opportunity, and promoting good relations between groups, and between different employers.

In order to ensure that information is equally available to persons with protected characteristics (such as disability), next steps will include DH continuing to work with the scheme administrators and employers – both NHS and IP.

Information on access to the NHS PS will be promulgated so that they new providers and therefore their staff are able to access information. In order to achieve this it should be made available in a wide variety of formats as and where appropriate.

What is the overall impact?

The NHS Pension Scheme will respond fully and equitably to all staff engaged in clinical services – be they provided by NHS organisations or through independent providers - by enabling equal access to the NHS PS. The access review was an important aspect of the NHS Proposed Final Agreement – and these provisions will be welcomed as improvement for staff and for IP employers as well as ensuring that appropriate monitoring mechanisms are in place for the NHS PS. This provision will ultimately improve the quality and range of services for service users. Increasing access to the NHS PS, and thereby increasing the range of providers from whom NHS services can be commissioned, has as its overall aim the continuous improvement in the quality of services provided to patients. This is because the policy aims to enable patients to receive services from the provider best able to meet their needs, regardless of whether the provider is from the public, independent or voluntary sector.

When considering the policy DH have considered carefully their duty to advance equality of opportunity and foster good relations between people who share a protected characteristic and those who do not. It is recognised that this policy is generally a positive step, extending access to the NHS pension scheme to those delivering NHS services in non-NHS organisations and as such will improve the advancement of equality and foster improved relations between people who share a protected characteristic and those who do not. We believe this is the case for both employees and employers.

It is fair to say that whilst there is data by the protected characteristics for the NHSPS workforce and pension membership is available there is limited data for the IP comparator workforce. This should improve as and when IPs take the opportunity to enable their staff to join the NHS PS.This data will then be included in the review process at stages years one and five.

Addressing the impact on equalities

We have been working, and will continue to work, with the partners involved in the NHS PS Governance arrangements, including trade unions and with independent providers to establish if any further action is required to address any impact on persons with protected characteristics which may be identified.

The results of the consultation are published in the Government response and are available on the Government website.

Further information and relevant policies can be found at:

HM Treasury Guidance

https://www.gov.uk/government/publications/fair-deal-guidance

FAQ's on New Fair Deal

http://www.nhsbsa.nhs.uk/Documents/Pensions/FAQs_New_Fair_Deal_in_the_NHS_for_IPs.pdf

BSA Application Guidance for Pension Direction

http://www.nhsbsa.nhs.uk/Pensions/4327.aspx

Staff Passport Group Webpage

http://www.socialpartnershipforum.org/about-spf/spf-sub-groups/spf-staff-passport-group/

NHS Pension Scheme specific guidance on New Fair Deal – to complement the HMT guidance will be on the government website shortly.

In addition, the review mechanism for the access review will enable on-going consideration in terms of the policy. The scope of the review aims to consider -:

- Coverage and effectiveness of regulations
- Ease of implementation
- Uptake of access to the NHS Pension Scheme to establish the opt-in levels
- Impact on existing NHS access arrangements
- Effectiveness of new control mechanisms
- Instances of disputes / challenges
- Impact on the government's balance sheet
- Impact of the new Hutton arrangements

The review group will need to identify what data will be required in order to assess progress against the overall policy aims agreed by the partners, including to support and build on the HMT led New Fair Deal policy for providers of NHS clinical services to ensure these proposals can deliver on-going understanding of the emerging implications including any equalities impacts in line with the Public Sector Employers Duty (PSED). As outlined, this places a legal duty on public bodies and others carrying out public functions. It aims to ensure that public bodies consider the needs of all individuals in their day to day work – in shaping policy, in delivering services, and in relation to their own employees. The PSED is set out in section 149 of the Equality Act 2010, and applies across Great Britain to public bodies listed in Schedule 19 to the Act (and to other organisations when they are carrying out public functions).

For the record
Name of person who carried out this assessment:
Julie Badon

Date assessment completed:

7th March 2014

Name of responsible Director/Director General:
Gavin Larner, Director of NHS Pay, Pensions & Employee Relations

Date assessment was signed:

Annex 1

New IP Access Framework agreement

A. Background

The Access Review Group was formed following the publication of the Proposed Final NHS Agreement on reforms to the NHS PS in December 2011, which included the consideration of an option for reform of the NHS Pension Scheme's (NHSPS) terms of access for Independent Providers of NHS Clinical services (IP)[3]. The Staff Passport Group, considering this review, includes representatives from the Department of Health, HM Treasury, NHS Employers and the NHS Trades Unions. The terms of reference (ToR) for the review as set out in the Proposed Final Agreement, agreed in July 2012, are at Annex A.
In line with the review ToR, the group has worked to develop a joint set of recommendations that has the support of all parties involved in the review. This document also outlines an implementation timescale, the policy aims, and guidance on technical issues including control mechanisms that would support the recommendations and practical implementation. The Regulations will follow the usual consultation process and cover England. Wales would be able to use the provisions if they choose to do so .

Implementation timescale - this section aims to describe and provide indicative timescales for each of the stages to take the review forward, from agreeing the recommendation; through setting it into regulation; to monitoring the implementation and conducting a formal review.

a. business case submission – submitted March 2013
b. agreement on translation of recommendation into draft regulations– complete
c. production of guidance – available before 1st April 2014
d. monitoring – commence from implementation date
e. conduct of formal review – one year and five years from implementation date

Partnership working is recognised as a key aspect of the review, and it is expected that this will remain throughout all the stages.

This framework agreement sets out the understanding of the partners and other key stakeholders, building on the arrangements set out in the review ToR. The review will be carried out under the auspices of the Social Partnership Forum in the Staff Passport Group. The NHS Pension Scheme Governance Group will be kept informed of progress, particularly

[3] 'IP' means non-NHS providers delivering NHS clinical services under an APMS contract or an NHS Standard Contract (including services procured under 'Any Qualified Provider' (AQP))

on final pensionable pay and interest payment changes that will apply to all, and will sign off the outcomes of the Review.

B. Policy Aims

- To support delivery of a fair playing field in pension access between different providers of NHS services by increasing access to the NHSPS among staff delivering NHS services in IPs
- to avoid a "flight to the bottom" in pensions in the NHS by maintaining NHSPS access as an established part of the reward package for most staff delivering NHS services (i.e. those meeting the 'wholly or mainly'[4] test - see below)
- To ensure the continued viability of the NHSPS by encouraging increased participation by IPs , thus maintaining scheme membership levels
- To deliver continued access to the NHSPS for staff delivering NHS clinical services, for clinical and admin staff delivering those services, enabling portability of pension provision on movement of staff through different providers of NHS clinical services
- to support and build on the HMT led New Fair Deal policy for providers of NHS clinical services
- to ensure proposals comply with equality requirements

C. Joint recommendation

The review group's joint recommendation is that the NHSPS's terms of access should be extended to allow IPs to offer their staff access to the Scheme providing that those staff are 'wholly or mainly' engaged in NHS work.

Under the proposed approach, IPs can choose from two levels of access or maintain the default position where they comply with the New Fair Deal only:

Either;

1: Access for existing members: IPs are required to **auto-enrol into the NHSPS:**

- from the date of commencement as a NHSPS employing authority, all existing eligible staff who were entitled to participate in the NHSPS at any time in the previous 12 months, and
- from the date of recruitment, all new eligible staff who were entitled to participate in the NHSPS at any time in the 12 months before joining the IP.

Staff should be 'wholly or mainly' engaged in NHS work to retain access.

Or;

[4]Wholly or mainly, for the purposes of the access regulations, will mean approved NHS Standard or APMS contracted NHS clinical services work, amounting to [an annual] average of at least 51% of the person's IP contract obligations.

2: Access for all eligible staff. IPs are required to offer access to all staff who are eligible to join the NHS PS and are 'wholly or mainly' engaged in NHS work.

With a default position of

- **Compliance with the New Fair Deal only.** At a minimum, IPs are required to comply with the terms of the HMT 'Fair Deal' guidance, which will require providers to auto-enrol in the NHS PS, all staff who are eligible to join the scheme and have been transferred out of the NHS under the *Transfer of Undertaking (Protection of Employment)Regulations or other Compulsory Transfer*.

The policy will be implemented through amendments to the NHSPS Regulations, with supporting guidance and suitable training produced to support staff and IPs. This includes the basis and mechanisms through which IPs will access the Scheme and what they need to know in order to comply with the NHS PS requirements – including the Employer Charter. Annex B outlines the jointly agreed position on withdrawal from the NHSPS under the revised arrangements, which covers both compulsory and voluntary circumstances Individual employees will be able to seek redress where they understand themselves to be wholly or mainly engaged in NHS work and yet are not being enabled to access the NHS PS. A summary of the process for seeking redress is set out in Annex D together with the Internal Disputes Resolution Procedure. Where NHS BSA receives a number of similar concerns from an organisation they may choose to invoke the "spot audit" control mechanism.

The new IP access policy will be formally reviewed one year and five years after implementation, to establish how well the policy aims have been delivered, assess any unintended consequences and consider if any further changes need to be made. HMT will be engaged in that review process. The terms of Post Implementation Review are attached at Annex E.

D. Process and Governance

The agreed approach will be supported by a series of control mechanisms, which are intended to support HMT requirements so that there is no extension of the scheme liabilities. This includes:

- Enforcement of a "Pensionable Pay Limit" defined by each provider, and based on the proportion of total NHS funding paid to the provider for NHS clinical services under their NHS Standard or APMS contract(s) that can normally be pensioned in the NHS PS.

- The proportion of an IP's pensionable to non-pensionable pay will normally be expected to lie in the range 60-75% and BSA will undertake spot audits/seek additional information from IP's whose pensionable pay proportion falls outside this expected norm.

- Final Salary Risk Mitigation designed to protect the taxpayer from the risks around Final Salary benefit manipulation.[5]

- Requirement for IPs to provide a bond and/or indemnity scheme to protect scheme finances in the event of insolvency.

- Introduction of Interest/administration charges for late payment of contributions for all NHS PS employers.[3]

- Development of a set of principles for employers to determine which staff will have entitlement to the Scheme – and specifically, how to determine which staff may be considered 'wholly or mainly' engaged in the provision of NHS services. This work will include arrangements to ensure compliance by providers with the terms of access for individual employees.

The same Governance arrangements that apply to the NHS PS will be in place to support the access provisions. These Governance arrangements will be changing in line with the requirements of the Public Service Pension Act 2013. They will be used to ensure that the policy aims of the wider access review, set out in this proposed framework agreement, are delivered through regulation and associated guidance and process. Annex C provides more detail on the control mechanisms

E. Implementation issues

The basis of the access review set out in this framework agreement, will be set out in NHS PS regulations. This will require the usual regulatory consultation process and will both clearly define the policy position and provide the legal basis for commencement of the policy.

The Regulations currently enable Wales to operate similar arrangements if required.

The NHS BSA will have responsibility for ensuring that the system administration can effectively support the policy including monitoring and supporting IDS requirements.

The main policy and handling issues which DH/NHS BSA are working on and which will be in

Regulations and have further guidance to support implementation include:

- Application process for IP Employers Bond / guarantee;
- Member records and potential system changes;
- Interest where payment of contributions is late[6];
- Annual certificate and up front schedule of data processes;
- Restricting increases in pay in the final four years[7];
- Contract requirements and associated issues;
- Policing and governance;

[5] The control measure will be developed within the NHS PS governance group as it will apply to all pension scheme employers.

[6] This is being progressed through the NHS Pension Scheme Governance Group

[7] This is being progressed through the NHS Pension Scheme Governance Group

- Management Information and other reporting obligations;
- Effective communications plan that will include:

  Phase 1 - (between now and implementation) – Communication through education and training for employers and staff and further engagement with the IP sector
  Phase 2 – (post agreement/pre implementation) – Communication through consultation on Regulations and raising awareness of the guidance and policy. There will be an on-going need for training for IP employers
  Phase 3 – (post implementation) - Developing clear literature that provides the implementation guidance and clarity on the IDS and post implementation review process.

F. Access post implementation review

The partners will agree what information is collected for the review and at what frequency. Withdrawal data will be part of this information. Monitoring and evaluation of the policy and implementation of wider access will remain the responsibility of the Staff Passport Group with relevant oversight from the NHS PS governance group and the Scheme Advisory Board from under new Governance arrangements, as required by the Public Services Pension Act 2013. Wider reward practice will be part of the scope of the review. Annex E clarifies the Post Implementation Review ToR.

G. Interdependencies

This section aims to describe those areas of other policy development where outcomes are not yet fully available or may change over time where there may be an implication for the access review:

- Fair Playing Field Review led by Monitor
- New Fair Deal by HMT – published on the 7th October 2012
- Proposed control mechanisms that may have an impact on established compliance requirements for existing providers, for example, final salary manipulation and interest charges.
- Governance arrangements under the 2015 NHSPS
- Any implications or modifications required, stemming from the Equality Analysis.

Annex A

PARTNERSHIP REVIEW OF ACCESS TO THE NHS PENSION SCHEME TERMS OF REFERENCE

1. Context

The NHS Pension Scheme Heads of Agreement contained provision for continuation of the Fair Deal on Public Service Pensions by allowing staff transferring from the NHS under TUPE to retain membership of the NHS Pension Scheme. As part of the pension announcement made by Danny Alexander, the Chief Secretary in the House on the 20th December, he stated that "*the Government will consider what practical options might be available to reform the terms of access to the NHS pension scheme, in particular for NHS staff who move to a non-NHS Any Qualified Provider delivering NHS service.*"

The Heads of Agreement included provision for a partnership review of the implementation of the (access under Fair Deal) provisions for staff working in "any qualified provider" (AQP) to be carried out. The background to the Chief Secretary's announcement and the review was the recognition that the roll out of competition "in the market" through AQP would mean that in future NHS staff might potentially move to non NHS providers not through TUPE but through the effects of competition. Lack of access to the NHS pension scheme for non NHS AQPs may also act as a barrier to entry by making it difficult to recruit experienced staff.

Work is on-going between DH and HMT to ensure the full implications of this are properly understood and could be effectively managed. The key HMT concerns are that any extension of access should not increase risk to the taxpayer and a need to understand the possible implications for extending the Government's balance sheet and the associated fiscal implications.

2. Governance and Timescales

The review will be carried out under the auspices of the Social Partnership Forum Staff Passport Sub Group. The NHS Pension Scheme Governance Group will be kept informed of progress and will sign off the outcomes of the Review before they are reported to the Secretary of State for Health. It is anticipated this will be reported to the Governance Group on the 31st July.

Following the completion of the initial phase, further work will be required to model the fiscal impacts of different models as the proposals are developed. It is envisaged that there will be the need for further work by the Staff passport Group as the approach to improving access is developed. However, as any change to terms of access to NHS pensions may impact on the Government's balance sheet, the timescale and scope of any potential next steps will be subject to other fiscal considerations that Treasury Ministers need to take into account. Any recommendations will also need to be considered in light of wider developments across the NHS provider landscape.

Objectives of the Partnership Review

The review will inform the discussions between the Department of Health and HM Treasury to implement the Chief Secretary's statement on 20 December, recognising that access to the NHS Pension Scheme is a matter for the Secretary of State with the agreement of HM Treasury. The review should:

- Be based on fair playing field principles to support plurality of provision in the NHS.
- Bring together evidence to understand risks and limitations within the current system.
- Identify and develop workable options that could enable wider access to the NHS PS for staff working in AQPs, APMS services and for staff working in other services funded under the National Contract for NHS services (for example, where commissioners have used outsourcing, procurement or tender routes), while ensuring that access to the NHS Pension Scheme is aligned to the provision of NHS services.
- The group will consider a range of options as to the most appropriate and practical terms under which access should be granted, and under which access should be limited. These will include consideration of the following options. This is not an exclusive list and further options may be developed :
    - An approach where there is no reform to the current access to the NHSPS.
    - An approach where access is linked to provision of AQP and other NHS services by the staff concerned for only those who have active membership of the NHSPS and is limited by reference to the organisation's NHS turnover (or other appropriate and practical limit).
    - An approach where access is linked to provision of AQP NHS services by the staff concerned (where there is no requirement of previous membership to the NHSPS) and is limited by reference to the organisation's NHS turnover (or other appropriate and practical limit).

- Consider potential behavioural effects and incentives on different provider groups.
- Ensure the potential new arrangements can be practicably implemented by AQPs and other appropriate providers and are achievable through regulations.
- Ensure the potential new arrangements consider how to limit opportunities for avoidance / manipulation while being monitored, managed and maintained through current pension administration processes.
- Determine the degree of retrospection for the application of new arrangements
- Examine whether employers admitted to the NHS PS under these arrangements should offer membership to all qualifying staff
- Examine whether there should be a framework making access to the NHS PS a term of business for AQPs and other appropriate providers
- Carry out an initial assessment of the potential impact on the Government's balance sheet of different options, and identify clear and robust mechanisms to ensure that financial risk to the taxpayer is limited.
- Address the issue of limiting final salary risk in relation to accrued rights and those with protection of their current arrangements.
- Risk assess proposals and options against workforce and system factors
- Make recommendations on the position of qualifying staff of AQPs and other appropriate providers who are members of the NHS Pension Scheme and are transferred under TUPE to another provider

- Identify an appropriate monitoring system providing assurance that employers comply with the terms of access a quality assurance provision so that where employers do not follow the Regulations as required this can quickly be identified and the employer is held responsible.
- Consider the potential implications for other Government schemes, and ensure that options fit within wider public service pension policy.
- Carry out an equality impact assessment of the different options.
- Consider the interaction between options for reforming access in this review and access for staff under fair deal transferring from the NHS.

Access Partnership Review Group Composition

It is proposed that the group is constituted with the following representative:

- Staff Side (including representatives from the NHS Pension Scheme Governance Group)
- NHS Employers including
- DH (secretariat) , HMT (as observers)
- Government Actuary's Department
- NHS Pensions Agency

Secretariat to be provided by Department of Health.

Ways of Working

It is proposed that:

The Access Partnership Review Group meets as required

- Meeting frequency should be reviewed

- The group meet either:
  - Via teleconference
  - As part of Staff Passport group meetings where practical

It is recommended that work of this review Group should be a standing agenda item at future Scheme Specific Design and Staff Passport meetings enabling this group to report back on progress and receive feedback from the wider groups.

Annex B

Pensions Access Review: Proposed Arrangements for Employer Withdrawal or Limited Withdrawal from the NHS Pension Scheme (NSHPS) v.2.0

Section 1 – Introduction:

1. The Access Review Group has agreed to consider issues around employer withdrawal from the NHSPS in the context of the wider policy proposals relating to the extension of access to the NHS Pension Scheme (NHSPS). Building on comments received from an earlier discussion paper, this document outlines the proposed approach to total and partial employer withdrawal by non-NHS Clinical Providers (IPs).

2. Broadly speaking, IPs that opt into the revised access arrangements can be withdrawn 'compulsorily' or 'voluntarily'. This paper is primarily concerned with the proposed approach for voluntary withdrawal – however an outline of the position on compulsorily withdrawal is also provided.

   Overlap with the new Fair Deal

3. Under the revised access arrangements, some IPs will have access to the NHSPS under terms of the new 'Fair Deal for Staff Pensions' which will require the employer to provide the Scheme to staff they receive under the Transfer of Undertaking (Protection of Employment) Regulations. These staff will be protected and identified separately under the terms of the new Fair Deal.

4. IPs will be contractually obliged to comply with the terms of the new Fair Deal, and in cases of non-compliance the contracting authority have a duty to take appropriate measures.

Section 2 - Compulsory Withdrawal

5. There are two circumstances where an IP might have their access to the NHSPS withdrawn without their consent. These are where they:

   - no longer comply with the terms of the NHSPS regulations e.g. they don't hold an NHS Standard Contract
   - consistently fail to comply with the Scheme's control mechanisms (for example, they fail to pay contributions within the required timeframe)

6. Where an IP is compulsorily withdrawn, staff would lose entitlement to the Scheme and become 'deferred' members.

7. The measures for compulsory withdrawal are key components of the proposed control mechanisms, and are designed to ensure there is no unintended extension of the Scheme's liabilities.

8. IPs that are compulsorily removed from the NHSPS due to non-compliance will be referred to the relevant contracting authority and/or Monitor, in its role as sector regulator for health care

Section 3 - Voluntary Withdrawal

Overview

9. IPs that provide access to the NHSPS in respect of staff not covered by New Fair Deal will be undertaking a long-term commitment, and the Department expects them to look to withdraw them from the Scheme in exceptional circumstances only.

10. This may be due to changing circumstances within their organisation (be they market driven or otherwise) that could not be fully understood at the time of the initial decision. For example, some IPs may suffer a reduction in NHS turnover and look to reduce their pension costs as a possible alternative to making redundancies. This may be a risk where they are unable to justify their pensionable pay levels as proportion to the value of clinical work they provide, and are then required to pay market rates for any excess. More generally, employers may decide that they could attract staff more effectively by offering an alternative reward package.

11. Another important consideration is that some staff working with IPs may have accepted a job offer on the understanding that they could retain access to the NHSPS while they provide NHS services. Arguably, it would be unfair for employers to withdraw staff from the Scheme without their consent. In addition, the prospect of losing access may actually discourage staff from moving posts in the first place.

12. Given the above and other considerations, the review group has sought to agree an approach on voluntary withdrawal that will:

- Not act as a disincentive to provide access to the Scheme.
- Enable active members to retain a reasonable expectation that they will not have their access withdrawn while they remain 'wholly or mainly' engaged in NHS work.
- Protect the Scheme finances and ensure the arrangements are not prohibitively costly for the Scheme administrator to implement
- Limit any risk of employers 'gaming' the proposed approach

Proposed Approach

13. Based on the principles outlined above, the review group has agreed the following approach to voluntary withdrawal. The proposals are that employers looking to withdraw or limit their access to the Scheme will need to follow separate procedures for:

a) Contributing members of the scheme ('active members') and;
b) New starters and eligible employees who have previously chosen not to participate in the Scheme

IPs looking to withdraw entirely from the Scheme would need to follow both the active and new starter procedures, whereas those looking only to limit access would follow only the new starter procedure.

Active Members

14. IPs seeking to withdraw access from active members can look to reach an agreement with these staff. However, employers will not be entitled to withdraw members without their consent. Employers would be required to provide proof of employee consent to their withdrawal and provide the contractor and the BSA with a notice period of 6 months.

New Starters and other Eligible Staff

15. IPs can apply to limit the terms of access for new starters and employees who have chosen not to contribute to the Scheme. There will be two possible routes to limit access in this way:

Route 1. Withdraw access for new starters

- Access to the Scheme would be withdrawn for new starters from a forward date.
- IPs would need to apply to the Scheme administrator, providing a notice period of at least 6 months prior to withdrawal.
- Eligible staff who are not contributing to the Scheme can use the notice period to 'use or lose the scheme' before their entitlement is withdrawn – this includes staff recruited during the notice period.
- Employers would need to be aware of, and take their own legal advice on any potential two-tier workforce issues.

Route 2. Downgrade their terms of access from level 2 to level 1

- IPs that originally selected level 2 access, (which requires them to offer access to all eligible staff) would switch to level 1 (which requires them to offer access only to eligible staff who had had entitlement within 12 months of joining the IP), for later commencement dates.
- This route would allow employers to continue to offer access to new starters, but only those with previous NHS entitlement.
- The administration requirements would be the same as for route 1.

IPs that choose to limit their access through either of the above routes, but later reapply for extended access would be expected to offer the Scheme to eligible staff they had recruited in the interim period. This mitigates the risk of 'gaming' by shutting down any temptation to deny access to particular staff/groups of staff for a period, prior to the re-opening full access from a later date.

Summary

16. These withdrawal arrangements aim to strike a balance between providing active members of the Scheme with clear protections and providing IPs with the flexibility to limit access to new staff in the future.

17. An implication of the proposed approach is that, unless IPs reach agreement with their active NHS Scheme members, they should be prepared to administer the Scheme while they remain an IP (or until such a time as all active members have left the Scheme). However, feedback from Independent sector representatives suggests that on its own this approach is unlikely to prevent IPs from participating in the new access arrangements.

18. Employers will need to be clear about the potential long-term implications of opting into the Scheme - which will be clearly reflected in the associated guidance.

Annex C

IP Access – summary of new compliance controls

Extending NHS Pension Scheme (NHS PS) access to Independent Providers (IP) of NHS clinical services will require stringent regulation, compliance and monitoring controls, to ensure no extension of the government's NHS Pension Scheme (NHS PS) balance sheet. The following new controls and procedures will apply from the effective date of the new access regulations:

- IPs must primarily be providers of NHS clinical services and satisfy the criteria for NHS Pension Scheme (NHS PS) employer status. If they do, both their clinical and any non-clinical staff will be able to join the NHS PS, subject to criteria

- IPs must be holders of a 'NHS Standard Contract' or an APMS Contract, and not already be able to access the NHS PS under an existing NHS PS access route

- IPs applying to become a NHS PS employer in respect of one or more of the above must apply to NHS Pensions for approval and may do so either:

  Level one - IPs are required to **auto-enrol into the NHSPS:**
  - **f**rom the date of commencement as a NHSPS employing authority, all existing eligible staff who were entitled to participate in the NHSPS at any time within the previous 12 months, and
  - from the date of recruitment, all new eligible staff who were entitled to participate in the NHSPS at any time within 12 months of joining the IP.

  Level two - in respect of all their eligible staff

- An approved IP will be obliged by the regulations to auto-enrol into the NHS PS all their staff in the relevant group above. Staff who are enrolled may opt-out of the NHS PS if they wish

- IP staff who are joined in the NHS PS must be 'wholly or mainly' employed on NHS work, which will mean NHS employment averaging at least 51% of their total IP engagement. IP staff employed on NHS work for less than 51% of their time can still be joined in the NHS PS if their NHS and non-NHS work is dealt with under separate/split employment contracts

- Total NHS PS pensionable pay for its staff engaged on NHS work will normally fall within a range of 60-75% of the IPs total NHS income under NHS standard/APMS contract(s), excluding otherwise pensionable pay for employees who:
  - opt out of the NHS PS
  - are ineligible for the NHS PS, or
  - have been excluded from the NHS PS by their IP

- IP's will be asked to submit additional information where total NHS pensionable pay falls above or below the normal range of IPs' total NHS income under the relevant contract.

- NHS Pensions will also make spot checks and will require sufficient additional information/justification from an IP whose pensionable pay proportion is higher, or significantly lower, than the maximum 75%.

- Failure to pay an additional scheme contribution levied for excess pensionable pay in any scheme year may result in the IP losing its NHS employer status.

- On the commencement of an NHS contract(s), and at the beginning of each scheme year, IP employers will be required to confirm to NHS Pensions:

    - The NHS Standard/APMS contract(s) they hold and the ID number(s)

Together with specified pensions data for their staff information including the IP's expected,

- NHS funding for the contract(s) for the year
- Numbers of staff 'wholly or mainly' engaged in NHS work for the contract(s)
- Pensionable pay for staff wholly or mainly engaged in NHS work for the year,
- Non-pensionable expenses in relation to NHS work for the year
- Employee contributions for the year
- Employer contributions for the year

- IPs will also be required to submit out-turn figures based on the above to NHS Pensions, following the end of each scheme year

- All above IP returns must be authorised and signed-off by the IP responsible officer who is signatory to the relevant NHS contract(s)

- IPs will be required to lodge a bond, indemnity or guarantee with a relevant institution when they apply for NHS PS employer status. The bond etc. must be 3/12 of the estimated annual value of their NHS PS employer and employee contributions, and be adjusted within 1 month of any increase in the guarantee amount that exceeds 10%

- NHS Pensions will closely monitor monthly pay over of IP contributions against estimates/out turns for any shortfall, and require additional information/make spot checks in respect of any IP whose monthly payment or bond etc. amount appears incorrect

- NHS Pensions will be authorised to notify termination of an IP's NHS PS employing authority status from a forward date, in the event of a failure to complete pension

records and/or meet contribution obligations for a period exceeding 3 months. NHS PS membership up to the point of any termination will be protected

- NHS PS regulations will also be amended so that IPs and all other NHS PS employers who pay employer and/or employee scheme contributions late in any month will incur a NHS Pensions administration charge plus interest. Interest will accrue at the rate of CPI+3% for each day contributions are paid late, compounded at monthly intervals. CPI rate for any scheme year will be the figure drawn from the Office for National Statistics report, for the February immediately prior to that scheme year

- Existing employer contribution debts will also begin to accrue interest/administration charges from the date the regulations become effective

- Scheme members entitled to NHS PS final salary benefits under the 1995 section of the scheme, including' protected' members entitled to remain in that section after April 2015, will have benefits linked to their NHS PS final pensionable pay shortly before exit/retirement

- For these reasons, regulations will provide for IPs and all existing NHS PS employers to become subject to a new final pay control, wherein the final four years of pay will be monitored for any increase of:

  - more than CPI+4.5% in any one of the final three years for NHS PS benefit purposes, or
  - more than three times CPI+4.5% between the start of 'year one' and 'year three'

- NHS Pensions will monitor pension awards for any excess over the above figures and employers will be charged a capital sum for any benefits payable on the amount of the excess, calculated using tables provided by the Scheme Actuary

- Member benefits in such circumstances will remain payable on the unlimited final pay figure

An IP who wishes to withdraw from NHS PS employer status altogether, or to reduce the level of its NHS PS access, from level two to level one, may do so. However where they are looking to remove access from staff who are already members they must seek the agreement of staff. In all cases they should provide at least 6 months' notice of that change to NHS Pensions and to the staff who may be affected
Where an IP wishes to upgrade their access level, or possibly where they reapply for NHSPS employer status, having previously withdrawn, NHS BSA would require a 3 months notice period.

Annex D

Introduction

This section is intended to detail the process in circumstances where there is a dispute between the IP Employer and the member/potential member; in particular, situations where an individual claims to have been refused access (unfairly) to the NHS Pension Scheme.

In this situation, the first course of action would be for the potential member to raise a complaint directly with their line manager, in accordance with internal grievance procedures.

The second level of recourse would be the Internal Dispute Resolution Procedure for the Independent Provider.

If that still does not deliver an agreed position then the potential member has a further recourse to the NHS BSA IDR process. This part of the dispute aims to ensure that the IP is fulfilling access requirements as set out in the NHS Pension Scheme Regulations and based on their agreed level of access to employees.

Once all dispute processes have been exhausted in terms of IDR then the potential member could request the Pension Ombudsman to investigate and give a decision on any complaint or dispute of fact or law.

NHS BSA will not adjudicate in “wholly or mainly” access decisions although they will investigate complaints where an individual contends unfair refusal of access

SPG25JUNE02

NHS PENSION INTERNAL DISPUTE RESOLUTION PROCEDURE

The Internal Dispute Resolution (IDR) Procedures

Introduction

The IDR procedures for dealing with complaints and disputes comply with the relevant Pensions Act 1995 (as amended) legislation that applies to **all** pension schemes. The aim is to give complainants a response which answers and resolves concerns appropriately.

Who can complain?

Anyone who has dealings with the NHS Pension Scheme, for example:-

- Someone who receives or is expecting to receive benefits from the Scheme;
- An NHS employee or an employee of an IP;
- An employee of an IP who believes they are entitled to join the Scheme; and
- Anyone nominated by the member / potential member to represent them.

To whom is the complaint made?

If a complaint is unconnected with pension scheme membership then the member must pursue the employer's grievance / disputes procedures.

If the complaint is related to pension issues, a member/potential member or their representative can submit their complaint by completing form DRP1. If a 3rd party is making the complaint on their behalf, NHS BSA will ask for a form of authority from the member/potential member.

SPG25JUNE02

What happens next?

Normally, a Disputes Officer will review the papers and carefully consider each point made and inform the member / representative of the outcome in writing. This is known as Stage 1 IDR.

The aim is to:-

- explain the decision;
- refer to any regulations or law affecting the decision;
- refer to any other papers which were important in reaching the review decision and indicate where any discretion under our regulations has been given; and
- give the name and address of the person reviewing the case and to whom any further letter should be sent.

NHS BSA aim reply within 2 months or explain why this is not possible if we are unable to do so.

In situations where the dispute centres on an allegation by an IP employee that they are being unjustly refused access to the NHS Pension Scheme, NHS BSA will initially deal with the Stage 1 IDR by undertaking a course of action which will colloquially be known as “red letter action”.

This “red letter” is intended to mirror the process already in place for GP Providers and remind the IP employer:-

- of their obligations;
- the rules surrounding employee access / “the wholly or mainly test”, etc;
- the implications of non compliance;
- next-steps if the dispute is not resolved.

Because we at this stage only have the employees version of events, the “red letter” will also ask the IP employer for their observations.

On receipt of this response, NHS BSA will then inform the complainant of the action taken and the response provided by the IP employer.

If the dispute has been resolved, no further action is necessary.

If a dispute remains, then the member will be invited to make a complaint under stage 2 of the IDR process. A Stage 2 IDR must be applied for within 6 months of the IDR1.

The second review will be carried out by a Disputes Manager, who will reply within 2 months or explain why this is not possible if they are unable to do so.

Stage 2 IDR is likely to involve further contact with the IP employer for their further comments and a warning that if they do not comply and there is evidence to suggest that they are administrating access in a manner which breaches scheme rules, the ultimate sanction is withdrawal of access for that employer. However, it is not envisaged that we would not normally take this action until the Pensions Ombudsman had given their view on the complaint (if, of course, the complaint actually reaches that stage).

What other avenues are there?

Only when stages 1 and 2 of the IDR process have been exhausted can a member/potential member can ask the Pensions Ombudsman to investigate and give a decision on any complaint or dispute of factor law.

A member/potential member can also ask The Pensions Advisory Service (TPAS) to help at any stage of their complaint / dispute.

Handling of IDR compliants

- All replies about complaints are as open and helpful as possible.
- NHS BSA ensure that:
  - decisions are not outside the powers of the Scheme’s regulations;

- that there has been no abuse of discretionary powers;

- the facts of the case and the reasoning behind the matter at issue are
  - clearly explained;

- there has been no breach of the 2 fundamental rules of natural justice which are
  - the right of appeal before a decision is taken affecting one's interest and;
  - the absence of bias on the part of the decision maker.

- NHS BSA have a duty to act fairly and reasonably at each stage of the decision making process, or subsequently under the review procedures.

- In practice decisions will largely follow well established and defined procedures, but the views, concerns or complaints of members will be given due and proper consideration.

Post Implementation Review - Access to the NHS Pension Scheme

Draft Terms of Reference

1. Background

Work is currently underway assessing the options for revising the access arrangements for the NHS Pension Scheme. This paper outlines the scope of a proposed Post Implementation Review to evaluate the success of the introduction of any such arrangements.

it will be important to test the impact of the revised access arrangements on the NHS clinical market and the effectiveness of financial and other governance controls. A formal policy review will be especially useful in view of:

- The wide range of stakeholders involved
- The significantly differing nature of the resultant impact on each stakeholder group
- The number and complexity of external (including macro-economic) factors that may affect access
- Any lack of control on these external factors
- The behavioural patterns that emerge as a result of a combination of the above

This proposed Post Implementation Review therefore aims to provide all stakeholders with:

- an evaluation the revised access policy to date
- an assessment of how successfully the arrangements have been implemented
- a summary of the feedback from all stakeholder groups
- where necessary further recommendations for how the new arrangements could evolve in order to better meet the policy's objectives.

2. Scope of Review

The precise scope of the review should be reviewed but at this stage it is proposed that the high-level scope includes:

- Coverage and effectiveness of regulations
- Ease of implementation
- Uptake of access to the NHS Pension Scheme to establish the opt-in levels
- Impact on existing NHS access arrangements
- Effectiveness of new control mechanisms
- Instances of disputes / challenges
- Impact on the government's balance sheet
- Impact of the new Hutton arrangements

To support this process DH will work closely with the NHS Standard Contract and Primary Care teams, and potentially NHS England, in terms of commissioning processes.

3. Adherence to Policy Aims

The review group will need to identify what data will be required in order to assess progress against the overall policy aims agreed by the partners:

- to support delivery of a fair playing field in pension access between different providers of NHS services by increasing access to the NHSPS among staff delivering NHS services in IPs
- to avoid a “flight to the bottom” in pensions in the NHS by maintaining NHSPS access as an established part of the reward package for most staff delivering NHS services (i.e. those meeting the ‘wholly or mainly’ test see below)
- to ensure the continued viability of the NHSPS by encouraging increased participation by IPs , thus maintaining scheme membership levels

to deliver continued access to the NHSPS for staff delivering NHS clinical services, for clinical and admin staff delivering those services, enabling portability of pension provision on movement of staff through different providers of NHS clinical services

- to support and build on the HMT led New Fair Deal policy for providers of NHS clinical services to ensure proposals comply with an equality analysis.

4. Timing of the Review

It is proposed that any Post Implementation Review is undertaken after year one and year five following the introduction of the new access arrangements. This should allow for both a short and longer term assessment of their effectiveness.

5. Undertaking the Review

It is anticipated that the review would involve discussions with the following:

- Trade Unions
- NHS Employers & NHS employers
- Independent Sector employers
- HM Treasury
- Department of Health (AQP / Pensions policy teams)
- NHS Business Services Authority

INDEPENDENT PROVIDER ACCESS SURVEY

Summary of feedback

1. Between 29 October and 13 November, the Department of Health ran a survey for independent providers (IPs) of NHS Clinical services. The survey was designed to inform the work being taken forward by the *Partnership Review of Access to the NHS Pension Scheme (NHSPS)*. The survey was designed to gather further information on the various options for reform. This summary looks at the results in the context of the 5 main options discussed in detail in section 4 of this business case. For ease of reference, those main option descriptions are summarised again below:

- Option A - 'Do nothing' – no reform of the existing access arrangements (i.e. new Fair Deal only)
- Option C, variant 1 - IPs required to provide all staff providing NHS Clinical Services with NHS Pension Scheme access, as a 'term of business'
- Option C, variant 2 - IPs free to decide on use of the NHS PS and, if opting in, also which of their staff providing NHS Clinical Services should be joined
- Option C, variant 4 - IPs free to decide on use of the NHS PS but, if opting in, required to enrol all staff providing NHS Clinical Services
- Option C, variant 5 - IPs free to decide on use of the NHS PS and, if opting in, also whether this is limited to:

    - staff with recent (i.e. within the last 12 months) NHS PS access only, or
    - staff with recent NHS PS access AND other staff,

2. Note that an IP choosing access for either group would be required to offer it to ALL staff in those groups

Information about the survey respondents:

3. The Department received 43 responses in total from a range of providers. Most of which held either 'Any Qualified Provider' (AQP) contracts, APMS contracts, or other NHS clinical contracts. Four of the respondents did not currently hold NHS contracts but intended to tender/apply in the future.

- Of the 43 responses received, around 56% were profit making organisations and 44% were from the 'not for profit' sector.
- From those organisations that chose to indicate what clinical services they provide, 33% said they exclusively carried out community services, while 10% 13% and 8% provided Acute, Primary and Mental Health Services respectively. A further 33% indicated that they delivered mixed services.
- Just over 50% of respondents said that they delivered services under AQP, whereas 30% said that they had applied or intended to apply in the future.
- 58% of organisations indicated that they already had access to the NHSPS for some staff (generally through TUPE closed directions), while the remaining 42% either did not have access or declined to complete the question.

4. The following notes summarise the feedback received. The results are calculated on the basis of those IPs that chose to answer that particular question.

Access as a term of business:

- Uniquely, Option C variant 1 proposes to make access to the NHSPS mandatory for IPs. Some initial feedback received as part of initial provider workshops suggested that a mandatory requirement might discourage IPs from offering clinical Services. The survey sought to understand whether this concern would be reflected in a wider sample.

- The results of the survey confirmed this initial feedback, suggesting that a significant proportion of IPs (44% and 37%) think that a mandatory requirement would make them less likely to participate in the market (see table 1 below).

Table 1

What impact would this option have on your participation in the market for the delivery of NHS services?	Less likely to participate	No Impact	More likely
Option C variant 1	44%	42%	14%

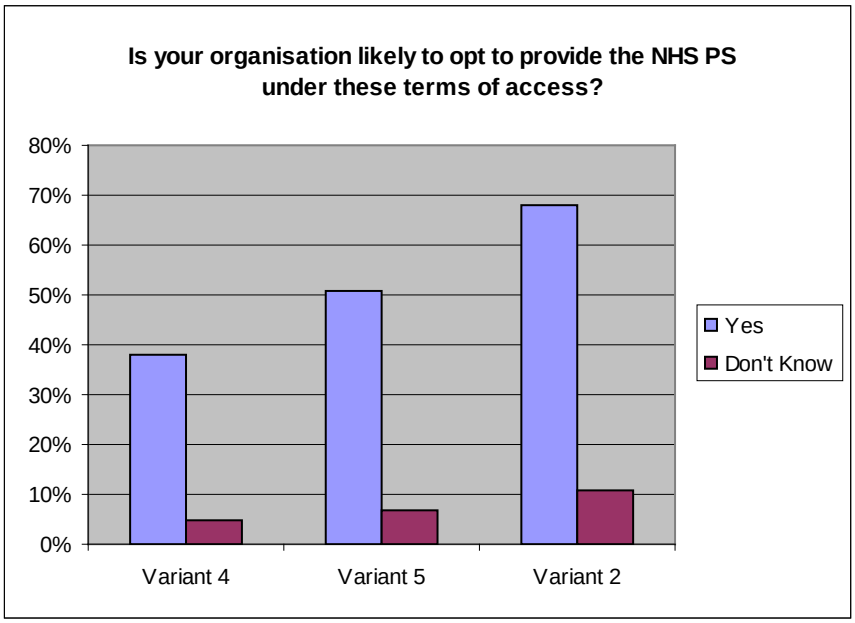
Optional Access:

- Options C 2, 4 and 5 set out options that would allow IPs to choose whether or not they offered access to the Scheme.
- The survey sought to understand the possible levels of 'opt in' under each variant. Higher levels of opt in would help facilitate labour mobility in the clinical market by allowing staff to maintain pension continuity when they move between employers.
- *Table 2* and *Chart 1* one sets out the results, which suggests that IPs are more likely to opt in to the variants that would provide them with flexibility over who they can offer access.
- Only 38% of respondents said they would opt in to the option offering the least amount of flexibility (option C variant 4) which would require them to offer access to all eligible staff upon opt in. In comparison, the full flexibility option (C variant 2) had a 68% opt in rate.
- the middle option (C variant 5) which offers two 'tiers' of access received a 51% opt in rate – an increase of 38% over option C variant 4. Within C variant 5, 48% of respondents suggested they would offer the scheme to existing members of the NHS PS only, whereas 40% said they would offer access to all staff. A further 12% were unsure at this stage. (see table 2 below)

Table 2

Q: Is your organisation likely to opt to provide the NHS PS under these terms of access?	Yes	No	Don't Know
Variant 4	38%	57%	5%
Variant 5	51%	42%	7%
Variant 2	68%	21%	11%

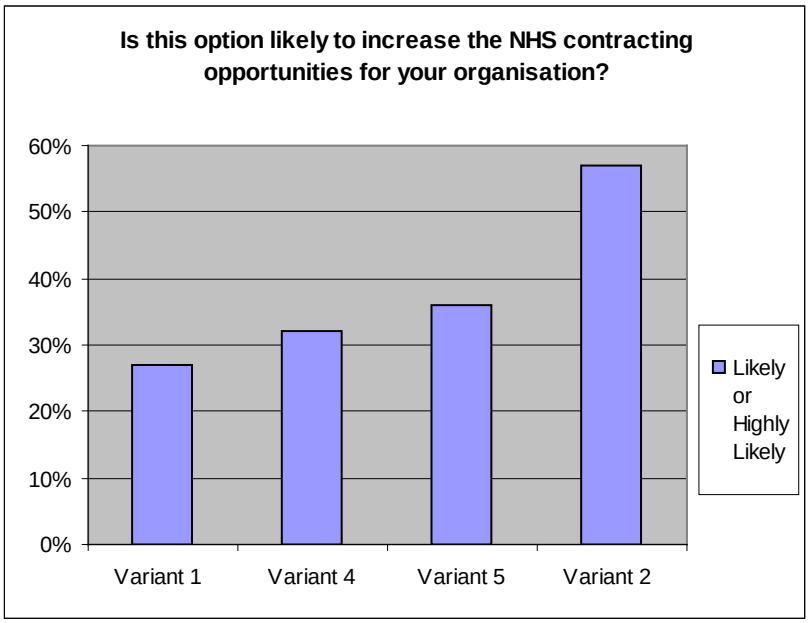
Chart 1:



Potential to Increase NHS Clinical Contracting Opportunities:

- A further question on the survey that applied to all 5 option variants looked at whether IPs felt the options would increase their NHS contracting opportunities. This may provide an indication of any perceived levelling of the playing field by IPs. Chart 2 below illustrates the response received.

Chart 2



Identifying an Overall Preference:

- The final two questions attempted to identify the overall preference of IPs by asking them to:
    1. rate each option on a scale of 1-10 and
    2. rank each option in order of preference.

- The second question included a 'do nothing' option (option A), so that could IPs indicate whether they would prefer the status quo (i.e. 'do nothing' not withstanding the extension of "Fair Deal')**.**

- *Charts 3 and 4* below identified the mean rating and ranking of each option. The charts suggest that the most popular option by far is variant 2, followed by either variant 5. Variant 1 is the least popular both in terms of rating and preference.

- Significantly, the results suggest that 74% of IPs would prefer some kind of reform as opposed to the status quo. This rises to 92% among those with existing Scheme access, which reflects previous feedback received by DH about difficulty recruiting experienced staff post TUPE. This may be an indication of future trends if, as predicted, the new Fair Deal facilitates an increase in the number of clinical services transferred to non-NHS providers.

Chart 3

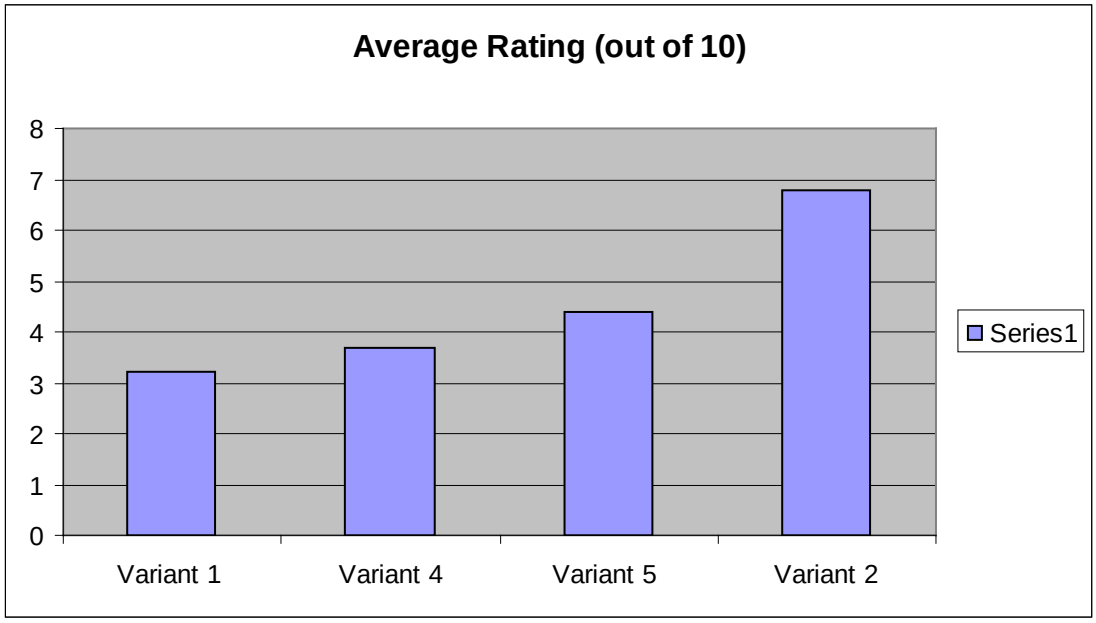
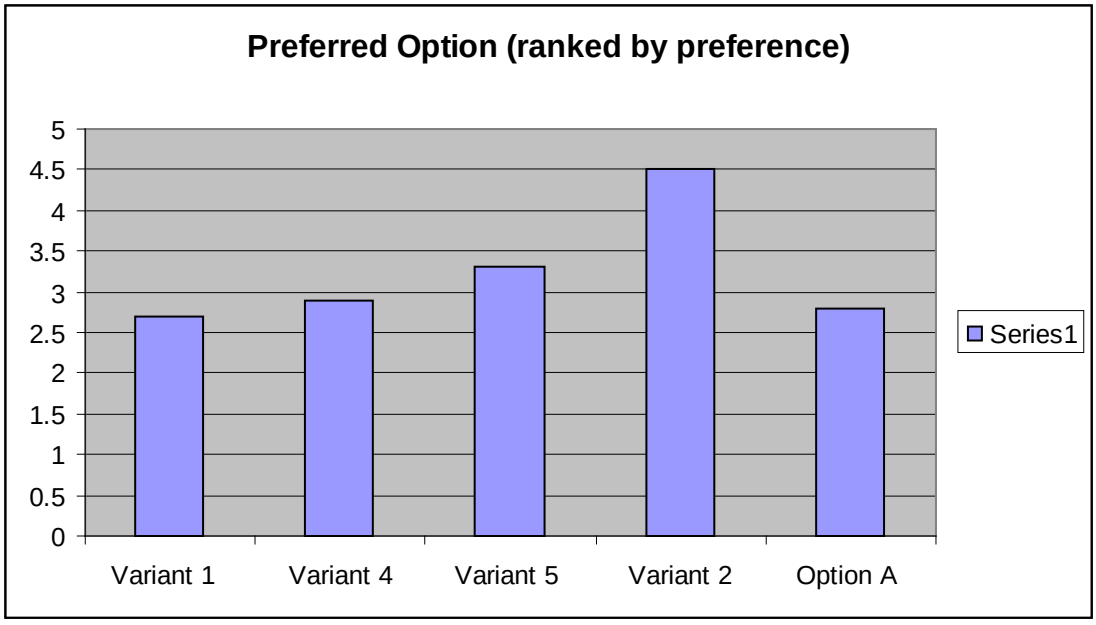


Chart 4



Overall level of IP support for options C4 or 5 (rather than the complete freedom of choice option C2)

5. An interesting final comparison drawn from the survey results shows a perhaps surprising level of IP support for option C4 and the Department's preferred option of C5. IPs would, as expected, prefer option C1, complete freedom to 'pick and choose' whether they use NHS PS and the staff they offer it to. However, the table below demonstrates a significant degree of realism, especially amongst those IPs with some current experience of NHS PS. These results are just one of the reasons why the

Department believes that allowing NHS PS access to IPs on a realistic basis will drive up usage over time.

- **84%** of IPs with existing access to the Scheme preferred Variations 4/5 over the ‘do nothing (i.e. fair deal only) ’ approach
- **92%** of IPs with existing access prefer at least one of the options to extend access over the ‘do nothing’ approach
- 31% of IPs without access to the Scheme preferred Variations 4/5 over the 'do nothing' approach.
- 43% IPs without access to the Scheme prefer at least one of the options to extend access over the ‘do nothing’ approach

Annex 3

MONITOR FINDINGS – NHS PENSIONS AND THE IMPACT ON INDEPENDENT PROVIDERS [March 2013]

1.1 Issues

Employees of public sector providers have access to the NHS pension scheme. This is a defined benefit scheme which guarantees a proportion of salary as a pension. Employees of independent sector providers typically do not have access to the NHS pension scheme.

The views of non-public sector providers were mixed on the cost implications of access to the NHS pension scheme. A number felt that, in offering terms and conditions to their employees, matching the NHS pension scheme placed additional burdens on their business. For example one provider stated:

> "The considerable costs that would be incurred for the independent sector to match NHS pension arrangements place providers at a clear disadvantage and distract from what should always be the number one priority – delivering high quality patient care." (VCS provider)

However others felt that matching the NHS pension did not affect their ability to recruit staff.

> "Opening NHS pension provision would be a cost to the organisation. We have not had difficulty recruiting nurses without the NHS pension so we do not see it as a significant issue." (VCS provider)

A number of respondents to the Review made representations about pension arrangements when bidding for tenders that would involve the transfer of staff under the "Transfer of Undertakings Protection of Employment Regulations" (TUPE).[8] The pension costs for a non-public sector provider associated with such transfers deterred some providers from bidding for such contracts.

> "Pensions relating to TUPE staff deter us from tendering, especially as often insufficient information is provided to enable us to accurately cost our bid." (Private sector provider)

We have examined these issues as part of the review, have quantified estimates of the cost implications of access to the NHS pension scheme, and looked at the impact of the Public Services Pensions Bill on the issue. These findings are set out below.

[8] Transfer of Undertakings (Protection of Employment) Regulations 2006 SI 2006/246

1.2 Findings

Public providers' pension contributions

Public providers of health care have to enrol their eligible employees automatically in the NHS pension scheme.[9] NHS providers cannot offer a different pension plan to their employees.

The NHS pension scheme is a pay-as-you go scheme which means that current employees' contributions are used to pay pensions to current retirees. The NHS pension is unfunded so the Government has to step in if contributions fall short of payments as benefits are fully guaranteed by Government.[10] A number of reforms have been introduced to address the long-term sustainability of the system as increasing life expectancy implies that the system is not self-financing in the long-term.

The NHS pension scheme is a defined benefit scheme which guarantees a particular proportion of staff salary as a pension. It is available to the following staff:

- NHS employing authorities (NHS Trusts, Foundation Trusts, PCTs, Health Authorities);
- GP practitioners;
- Direction employers[11], conditional on approval by the Secretary of State; and
- Joint NHS and Social Care partnerships to provide integrated health care, conditional on approval by the Secretary of State.

The NHS employer contribution rate to the NHS pension scheme is 14% of pensionable pay.[12]

Private sector providers' pension contributions

Private sector providers currently cannot offer their staff membership of the NHS pension. Pension requirements for private sector providers depend on whether their staff has been transferred from a public provider.

For staff that has been transferred from a public provider TUPE applies. For TUPE-eligible staff, private providers have to provide a pension plan that is broadly comparable to the NHS pension scheme. This requirement stems from the "Fair Deal" a non-statutory policy around pension provision for public sector staff when they are

[9] NHS Employers, Automatic and contractual enrolment, re-enrolment, opting in and opting out Available: http://www.nhsemployers.org/PayAndContracts/NHSPensionSchemeReview/Automatic%20enrolment%20in%20the%20NHS/Pages/Automaticandcontractualenrolment,re-enrolment,optinginandoptingout.aspx
[10] NHS BSA, (n.d.), Scheme Guide, NHS Pensions scheme, Available: http://www.nhsbsa.nhs.uk/Pensions/Documents/Pensions/SD_GUIDE_COMPLETE.pdf
[11] "Direction employers" are providers that are from the voluntary sector or operate on a not-for-profit basis that have been approved by the Secretary of State and therefore have access to the NHS Pension.
[12] NHS BSA, (2012), NHS Pension Scheme: 2011/12 Tiered Employee Contributions Available http://www.nhsbsa.nhs.uk/Documents/Pensions/Tiered_contributions_2011-12.pdf

compulsorily transferred to a non-public sector employer.[13] The private provider therefore has to offer staff that are transferred from the public sector a pension plan with comparable benefits but cannot offer continuing access to the NHS pension scheme.

For staff that have *not* been transferred from a public provider, non-public sector providers have some flexibility over the pension arrangements they offer their staff. However with the introduction of auto-enrolment employers over the next few years will move to a position where they will pay a minimum employer contribution of 8% of employee income.[14] [15]

VCS sector providers' pension contributions

VCS sector providers are, for the most part, unable to offer the NHS pension scheme to their employees currently. However, providers that are from the voluntary sector or operate on a not-for-profit basis can apply to the Secretary of State to become "Direction employers". Their application is then assessed by the Department of Health. Direction employers can offer NHS pension membership to either ex-NHS staff or all staff depending on the type of direction.[16] Providers that are eligible to become direction employers generally include:

- social enterprises;
- hospices;
- care in the community services;
- university medical schools; and
- institutes involved in research;

UNISON estimates that only 1.5% of current scheme members are members through a direction employer.[17]

If a VCS provider is not classed as a direction employer, the same pension requirements apply as for private providers:

- staff that are transferred from the public sector have to be offered broadly comparable pension plans to comply with TUPE regulation; and
- the minimum statutory pension contribution rate has to be paid for all other staff.

[13] HM Treasury, (2011), Consultation on the Fair Deal Policy, Available http://www.hm-treasury.gov.uk/d/consult_fair_deal_pensions.pdf
[14] The Pension Regulation, (2012), An introduction to work-based pension changes, Available http://www.thepensionsregulator.gov.uk/docs/intro-to-work-based-pension-changes-2011.pdf
[15] Department of Work and Pensions, (2012), http://www.dwp.gov.uk/docs/auto-key-facts-enrolment-booklet.pdf
[16] NHS BSA, (2012), NHS Pensions Direction Employers Guide, Available http://www.nhsbsa.nhs.uk/Documents/Pensions/Direction_Employments_Guide_(V5)_10.2012.pdf
[17] http://www.unison.org.uk/acrobat/20733.pdf

TUPE-eligible staff

We considered the costs for a private sector provider associated with taking on staff under TUPE regulations compared to the costs associated with a public sector provider or a not for profit provider for whom staff transfer under a direction.

Public sector pension contributions

Public providers contribute 14% of wages to the NHS pension plan for every employee. This contribution rate is revised periodically to take into account the overall long-term sustainability of the NHS pension scheme. The NHS pension scheme is a defined benefit scheme. Such a scheme guarantees a specific level of pension.

Private sector and VCS pension contributions

Private sector and VCS providers have to provide a broadly comparable pension for TUPE eligible staff. If they are not able to offer access to the NHS pension scheme under a direction, they have to offer an equivalent alternative. The cost of providing the same level of pension benefits for TUPE-eligible staff is estimated at 22-27**%** of wages. These figures are based on two sources of evidence:

- Private and VCS providers that have responded to the Review have indicated that pension contributions for TUPE-eligible staff can be as high as 27%.
- By way of example we have estimated the employer contribution rate that is required to achieve the same level of defined benefit (i.e. an annuity) for a 45 year old male employee who retires at 65 with an employee contribution rate of 6.5%. In this case, the private and VCS provider would have to contribute 22%-24% of the employee's salary.[18]

This estimate of the private and VCS sector contribution rate required to provide a broadly comparable pension of 22-27% is substantially higher than the contributions made by public providers (14%). There are a number of reasons for the higher cost:

1. There are economies of scale in the administration of pension schemes - this benefits the NHS pension scheme. In addition, the administration of the NHS Pension Scheme is funded by the NHS business service authority. The average administration cost of the NHS Pension Scheme of £16 per member is

[18] Review team estimate, range reflects the uncertainty around the estimate but magnitude of estimate is confirmed by stakeholder information

significantly lower than the average private sector cost of £41 to £47 per member.[19]

2. The NHS scheme is a defined benefit scheme that is not funded. The costs of a funded scheme on a scale sufficient to provide the same defined benefit are estimated to be significantly greater than 14 %.

3. The NHS scheme is an unfunded pension scheme backed by the Government. It is therefore not covered by the Pension Protection Fund (PPF) and so no PPF levy is payable resulting in reduced employer costs each year

In cases where non-public sector providers take over staff under TUPE, this can increase these providers' total costs by around 3.5-7.5%. This large range reflects the variation in the proportion of providers' costs which relate to staff costs. For example, capital-intensive acute providers employ relatively fewer staff, and the impact of pension costs in these services (under TUPE obligations) is around 3.5-4.5%, according to the review's modelling.

It may be especially difficult for small private and VCS sector providers to offer a comparable defined benefit pension. Defined benefit schemes imply that the employer takes on the risk of asset performance. Large providers may be able to take on such risks but for small providers the risk exposure may be too great to take on. The *Independent* Public Service Pensions Commission (2011) found that:

> "By leaving almost all risks with employers, [current public service final salary pension schemes] can make it difficult to attract new providers to achieve gains in the efficiency and quality of services.[…] Smaller private and voluntary sector employers are often unwilling to take on such risks."20

Additional one-off costs from TUPE transfers

In addition to ongoing higher costs when offering a broadly comparable pension to the NHS pension scheme, a private and VCS provider also bear the risk of incurring additional one-off costs associated with the transfer.

When offering new pension arrangements to transferring employees, these employees can decide to transfer their existing NHS pension benefits to the new provider or to leave them in the NHS pension scheme.

A bulk transfer is an arrangement that allows the transferring members to be able to transfer their accrued pension benefits to the new employer's scheme and receive

[19] Estimate for largest schemes, Independent Public Service Pensions Commission, (2011), Final Report
[20] Independent Public Service Pensions Commission, (2011), Final Report.

pension benefits of equivalent value to those earned in the NHS pension scheme immediately before transfer.[21]

The bulk transfer poses a financial risk to the private provider who takes over the service because the value of the potential bulk transfer payment is not known in advance. It depends on how many employees will choose to transfer their pensions and the size of the pension liability.

There is evidence that some providers are deterred from bidding for contracts because of possible pension obligations under TUPE, indicates that pension costs and access to the NHS pensions are significant factors that are limiting providers from offering services to NHS patients.

The risk associated with bulk transfers only applies if staff choose to leave the NHS pension scheme. In future, if independent sector providers have access to the NHS pension scheme for transferring staff, bulk transfers and their associated risks will largely disappear.

Non-TUPE eligible staff

Public sector pension contributions

As set out above, the contribution rate for public providers is 14% of pensionable pay for all staff that are members of the NHS pension scheme. Looking at a sample of public providers' annual accounts indicates that pension contributions as a proportion of overall labour costs vary between 10 per cent for some providers to 14 per cent for others. The figures are slightly lower than the 14 per cent employer contributions, as total labour costs include some items other than pensionable pay and the labour costs of temporary and agency staff.

Private sector and VCS pension contributions

For non-TUPE-eligible staff private and VCS provider must adhere to the statutory minimum contributions consistent with obligations under auto-enrolment. However, private and VCS sector providers are free to provider a higher level of pension benefits. Data from the Association of Consulting Actuaries pension trend survey, which covers all sectors and therefore is not specific to health care, indicates that the typical employer contribution for a defined contribution pension benefit ranges from 4.3% to 7%.[22] A review of VCS providers' contributions revealed a similar, although slightly wider range of contributions as a proportion of total wages.

In this case non-public sector providers may face a reduced burden relative to public sector providers. The review's modelling suggests their total costs may be reduced by

[21] NHS Business Services Authority, (2006), NHS Staff Compulsorily Transferred out of the NHS under PPP, PFI or other programmes: Bulk Transfer of Pension Rights. Available at: http://www.nhsbsa.nhs.uk/Pensions/Documents/Pensions/TN10_2006.pdf

[22] Association of Consulting Actuaries, (2011), Pension trends report, Available: http://www.aca.org.uk/files/2011_Pension_trends_report-3_January_2012-20111222162316.pdf

around 2.5-6%. This depends primarily upon the proportion of a provider's costs which are attributable to staff. For capital-intensive acute services, this reduction in total costs is estimated to be around 2.5-3.5%.

Whether private sector and VCS sector providers will provide a higher level of pensions depends on the labour market conditions. During the stakeholder consultation, private providers indicated that they had to offer competitive remuneration packages to attract staff.

A number of factors were mentioned by stakeholders that imply that some non-public sector providers have to offer competitive pension levels. In general, prospective staff will weigh up remuneration packages, including pensions, along with other factors including for some the desire to work for a not-for-profit provider, when deciding whether or not to take a job.

Location and seniority can also play a part in employee decisions. In general, the closer a private of VCS provider is located to an NHS provider, the more likely it is that they have to offer similar benefits to attract staff.

Staff at higher grades, or with long NHS service records, tend to put greater emphasis on the NHS pension scheme than those at lower grades. Pension benefits appear to matter less for career choices of young people, as a survey indicates that 35% of the 18-34 age group agree that "I'm young enough not to have to worry about this yet".[23] The Health care Financial Management Association (HFMA) also suggested that some staff want access to a lower contribution scheme so that they have more money in hand now.

Overall the NHS pension scheme appears to be an important factor in attracting employees. For instance, it is associated with a higher ratio of benefits payments to cumulative contributions by members.[24] The Independent Public Service Pensions Commissions found that final salary pension schemes have a strong retention power on senior staff.

Where the pension is an important factor, non-public sector providers will face the cost of offering equivalent pensions to the NHS scheme, but at higher contribution rates, as in the case of TUPE-eligible staff.

For example, one stakeholder stated that:

> "The advantage for public sector providers derived from the NHS pension scheme […takes] two forms: firstly, the adverse impact on non-NHS providers of the cost of matching the scheme, which NHS providers themselves do not bear the full cost of; and second, the extent to which the attractiveness of the scheme creates a barrier to workforce flexibility and transfers. The estimated average magnitude of this is that it adds between 6% and 7% to independent providers' costs." (Representative body)

[23] Future Foundation, (2011), Survey commissioned by life assurance company Friends life
[24] Office of Health Economics, (2009), How fair?

A number of VCS providers also expressed concerns around offering sufficient pension contributions:

> "The advantageous terms of the NHS Pension Scheme are not, therefore, available to all staff working within local hospices. Many hospices have to offer differential pension entitlements as they cannot match the generous employer contribution rates for staff not entitled to participate in the NHS Pension scheme. Hospices have expressed concern that they could face potential challenge on equality grounds by offering different pension benefits to different staff undertaking similar roles within the same organisation." (VCS provider)

Nevertheless we also found instances where non-public sector providers felt they were able to recruit staff without matching the terms of the NHS pension and instances where public sector providers felt disadvantaged because of the cost of the NHS pension scheme. Overall staff recruitment depends on the overall terms and conditions as well as pension entitlements. This is considered in the section of pay and other benefits.

1.3 Conclusions

We have seen evidence to suggest that the cost of taking on staff under TUPE obligations, without those staff being able to remain in the NHS pension scheme, places a significant potential cost burden on non-public sector providers. We have also received submissions that this cost burden deters some providers from tendering for services.

We have also seen evidence that on average private and VCS providers tend to pay lower employer contributions to pension schemes than public providers to the NHS pension scheme. However in tight labour markets private and VCS providers may have to match the NHS pension. In these cases, the inability to access the NHS pension scheme is a disadvantage to non-public sector providers. They must pay more for an equivalent pension.

EXCESS FINAL PAY CONTROL – EMPLOYER CHARGE

1. The proposed final pay control would apply to final salary 'officer' members of the 1995 section of the scheme only, for whom benefits are based on the *best of* the last three years pensionable pay.

2. The control would *not* apply to members of:

   a. the 2008 section of the scheme, *for whom final salary benefits are based on an average of their best three consecutive years pensionable pay*, or

   b. the career average arrangements in the 1995, 2008 and new 2015 sections of the scheme, *for whom benefits are based on an average of pay throughout career.*

How the pay control would work

3. The 'control period' tested would be the four final pay years prior to retirement, during which the maximum rise in pensionable pay, from one year to the next, would be 'CPI'+4.5%.

4. The 'CPI' rate used in relation to retirement during any scheme year will be the CPI rate declared in the February immediately prior to the year, for example, 2.8% at February 2013, for retirement at any point during the 2013-14 scheme year.

5. For the purposes of the following example, we will assume a retirement from 1 July 2013 and for simplicity, a CPI+4.5% rate of 7.3% for each of the three years prior to retirement; normally it would vary of course. This means pensionable pay in year 1 must not increase by more than 7.3% over year 0, and the same for year 2 pay over year 1 and year 3 pay over year 2.

1/7/2009	**1/7/2010**	**1/7/2011**	**1/7/2012**	**1/7/2013 retires**
Year 0	Year 1	Year 2	Year 3	
£50,000	£51,000	£52,000	**£56,500**	

6. In this example, the last year's pay is the 'best' and the increase in pensionable pay between years 0 and 1, and years 1 and 2 is below 7.3% and so attracts no employer charge. However, final pay for benefit purposes in year 3 (£56,500) has increased by 8.65% over year 2 (£52,000). The maximum permitted pensionable pay for year 3 is an increase (over year 2) of 7.3% rate, which is £55,796. This means that the employer has awarded an 'excessive' pay award

close to retirement and would become liable for a special scheme contribution charge on the pension benefits calculated on the 'excess' pensionable pay only. In this example:

- £56,500 actual pay less the maximum permitted pensionable pay of £55,796

  Result - excess pensionable pay of **£704.00**

Calculating the employer charge

7. The employer charge is arrived at by multiplying the 'excess' pension amount by a commutation factor supplied by the GAD (currently expected to be 21) and adding the amount of the 'excess' lump sum.

8. So if we assume for the purposes of this example that the scheme member is:

   - in the 1995 section of the scheme
   - retiring at that section's normal pension age of 60, and
   - has 36 years membership

   their **'excess' pension** will be 36/80 x £704.00 = **£316.80**, and

   their **'excess' lump sum** will be 3 x £316.80 = **£950.40**

   So, the employer charge will be:

   £316.80 x 21 = £6,652.80

   Total employer charge is £6,652.80 + £950.40 **= £7603.20**

9. Please note that **the member will always receive pension and lump sum benefits based on their unreduced pensionable pay, i.e. £56,500 in this example.**

Other scenarios

10. The precise calculations, and the resulting employer charge, will vary according to:

    - the amount of the excess pensionable pay awarded
    - the number of years of scheme membership accrued, and
    - whether the member's pay is deemed to be 'excessive in two, or even all three, of the scheme member's final three years prior to retirement.

Glossary

CIC – Community Interest Companies
A type of company for people who want to be involved in a business that benefits the community (the population as a whole or a specific group), rather than just the owners, managers or employees – a social enterprise.

Mutuals
An organisation that is owned by, and run for, the benefit of its members.
The 3 key characteristics of a mutual are;

- An organisation that has spun out of the public sector,
- Continues to deliver public services, and;
- Involves a high degree of employee control.

SPG - Staff Passport Group

- Considers the workforce implications of system reform,
- Develops tools and guidance to support change whilst ensuring that the employment standards agreed in the NHS staff passport and the NHS staff pledges are embedded in NHS policies.

The group is chaired jointly by a representative from the Department of Health and the NHS trade unions.

SPF - Social Partnership Forum
Membership consists of NHS Employers, NHS Trade Unions, NHS England, Health Education England and the Department of Health who meet to;

- discuss and debate the development and implementation of the workforce implications of policy.

First set up in March 1998, after a recognition of the positive contribution that partnership working can have on improving patient care by actively involving employers, employees and their trade unions in continuous dialogue around the entire decision-making process.

Governance Group
The Governance Group is a partnership group between nationally recognised NHS Trades Unions, health department representatives and employers.
The role of this group is to look at any issues arising from implementation and future NHS Pension Scheme valuations.

Technical Advisory Group (TAG)
This group focusses on the technical aspects of governance and is a partnership sub-group of the Governance Group, which in turn reports to the Staff Council.

NHS Staff Council
The national NHS Staff Council has overall responsibility for the Agenda for Change pay system and has representatives from both employers and trade unions.
Its remit includes:

- maintaining the Agenda for Change pay system
- negotiating any changes in core conditions for staff on Agenda for Change and reflecting these in the NHS terms and conditions of service handbook
- providing national support on interpreting the national agreement for employers and trade unions.

Independent Sector Review Group
This is a DH chaired group that meets with independent providers to discuss relevant changes in policy and consider topical matters.

EXPLANATIONS OF GRAPHS

Page 8 – Scheme membership by ethnic group

There is a table at the top of page 8 containing data on the Scheme membership by ethnic grouping. It shows the proportion of scheme members, the proportion in working population and the proportion working in the public sector, for each ethnic group.

Page 9 – Scheme Gender Profile – 2010 Valuation Data

There is a pie chart at the top of page 9 that shows the scheme gender profile breakdown of the NHS PS which identifies that the NHS PS membership is 77% female and 23% male.

Page 12 – Scheme Age Profile and Section Age Profile – based on 2010 Valuation Data

There are two bar charts on page 12, one containing a scheme age profile and the other containing a section age profile for 1995 and 2008.

Page 42

There is a table on page 42 that asks the question 'What impact would this option have on your participation in the market for the delivery of NHS services?' This is in relation to Option C variant 1. 44% said they were 'less likely to participate', 42% said it would have 'no impact' and 14% said 'more likely'.

Page 43 – Table 2 and Chart 1: Is your organisation likely to opt to provide the NHS PS under these terms of access?

Table 2 at the top of page 43 asks 'Is your organisation likely to opt to provide the NHS PS under these terms of access? The results from this feed into bar Chart 1 below it.

Optional access – Chart 1 sets out the results of Options C2, 4 and 5.

Column 1 - Option C variant 4
38% of respondents said they would opt in to the option offering the least amount of flexibility which would require them to offer access to all eligible staff upon opt in. 57% said no and 5% said they did not know.

Column 2 – Option C variant 5
51% of respondents said they would opt in to the option offering two 'tiers' of access, 42% aid no and 7% said they did not know.

Column 3 – Option C variant 2
68% of respondents said they would opt in to the option offering full flexibility, 21% said no and 11% said they did not know.

Page 44 – Chart 2: Potential to Increase NHS Clinical Contracting Opportunities

There is a bar chart on page 44 that details the response to the question 'Is this option likely to increase the NHS contracting opportunities for your organisation?'

Variant 1 – 27% believed variant 1 would increase their contracting opportunities (percentages are approximate)
Variant 4 – 32% believed variant 4 would increase their contracting opportunities (percentages are approximate)
Variant 5 – 37% believed variant 5 would increase their contracting opportunities (percentages are approximate)
Variant 2 – 58% believed variant 2 would increase their contracting opportunities (percentages are approximate)

Page 45

There are two bar charts on page 45. The first one looks at the average rating (out of 10) for each option. The charts suggest that the most popular option is variant 2, followed by variant 5. Variant 1 is the least popular both in terms of rating and preference.

Variant 1 – scored 3.2 (figures are approximate)
Variant 4 – scored 3.8 (figures are approximate)
Variant 5 – scored 4.4 (figures are approximate)
Variant 2 – scored 6.9 (figures are approximate)

The second bar chart looks at the preferred option (ranked by preference)

Variant 1 – 2.7 (figures are approximate)
Variant 4 – 2.9 (figures are approximate)
Variant 5 – 3.4 (figures are approximate)
Variant 2 – 4.5 (figures are approximate)
Option A –2.8 (figures are approximate)