



NHS Pension Scheme

*Consultation on the NHS Pension Scheme,
Additional Voluntary Contributions and Injury
Benefits (Amendment) Regulations 2013*

Government response

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Introduction

The Department of Health published for consultation a draft Statutory Instrument titled The National Health Service Pension Scheme, Additional Voluntary Contributions and Injury Benefits (Amendments) Regulations 2013.

The Statutory Instrument proposes a series of amendments to the NHS Pension Scheme regulations that in summary:

- accommodate the new structure and function of NHS administration that the Health & Social Care Act 2012 creates from 1 April 2013;
- apply increases to member contribution rates required by Government from 1 April 2013;
- revoke cost sharing provisions and associated requirements to undertake historic valuations;
- close the Injury Benefit Scheme in respect of injuries or diseases occurring on or after 31 March 2013 and introduce transitional arrangements in respect of injuries or diseases occurring before that date;
- introduce new industry wide requirements on the auto-enrolment of members;
- streamline employer options for payment of redundancy costs and link entitlement under the regulations to entitlement under terms and conditions;
- make further miscellaneous and technical amendments.

This document sets out the Government's response to the comments received through consultation. Views were received on some but not all of the proposed changes.

1. Consultation process

- 1.1 The consultation ran from 20 November 2012 to 12 February 2013.
- 1.2 Both the draft regulations and a document explaining the proposed changes were published on the NHS Business Services Authority's (NHSBSA) website. The NHSBSA is the administrator of the NHS Pension Scheme. An impact assessment and equality analysis examining the proposed increases to member contributions and Injury Benefits Scheme was also published. Responses were invited by email or post.
- 1.3 As part of the governance arrangements underpinning the NHS Pension Scheme, the major Trade Union organisations were formally notified of the consultation. A workshop was held on 16 January 2013 attended by Trade Union and NHS employer representatives to explain the proposals and receive comments on the draft regulations.
- 1.4 A total of 3,198 responses were received. The vast majority of respondents were individuals working within the NHS as general practitioners, hospital doctors or consultants. Of these, 3,155 responded using a template from the British Medical Association.
- 1.5 Representations were also received from the following organisations:
 - The British Dental Association
 - The British Medical Association
 - Cambridgeshire Local Medical Committee
 - Derby and Derbyshire Local Medical Committee
 - NHS Business Services Authority (the scheme administrators)
 - NHS Employers
 - The Royal College of Midwives
 - The Royal College of Nursing
 - UNISON
- 1.6 Responses were also received from individuals working within the Scottish and Northern Ireland health services.

2. Increase to member contribution rates from 1 April 2013

2.1 The consultation proposed a series of increases to member contribution rates from 1 April 2013. These increases are the second of three years of successive rises planned as part of the Government's programme of reforms to address the affordability and fairness of public service pensions. The proposed new rates are set out at paragraph 2.9 below.

Background

- 2.2 The Independent Public Service Pensions Commission, chaired by Lord Hutton, concluded in its report¹ that reform is necessary and that there needs to be a fairer distribution of the cost of public service pensions between employees and other taxpayers.
- 2.3 Expenditure on public service pensions over the last decade has increased by a third to £32bn. The costs of pensions are increasing as people live much longer than previous generations – the average 60 year old is living ten years longer now than they did in the 1970s. Pensions are therefore in payment for longer.
- 2.4 These additional costs have generally fallen to the taxpayer. The view of the Government is that this is unfair and unaffordable. There needs to be a fairer balance between what employees pay and what other taxpayers contribute towards a public service pension.
- 2.5 The Commission was asked by Government to consider the case for delivering savings on public service pensions within the spending review period. It concluded that it would be more effective to increase member contributions rather than alter the level and range of benefits provided by pension schemes².
- 2.6 The Government's 2010 Spending Review announced that public service workers would be asked to contribute more towards their pensions. The Spending Review set out plans to increase the level of employee contributions within public service pension schemes, including the NHS Pension Scheme.
- 2.7 Each public service pension scheme is required by HM Treasury to deliver savings equivalent to an average increase of 3.2 percentage points in employee contributions over the same period. The increase in member contributions would be phased over three years from 2012-13 to 2014-15 in order to allow reasonable time for members to adjust.

¹ Independent Public Service Pensions Commission: Final Report (10 March 2011)

² Independent Public Service Pensions Commission: Interim Report (7 October 2010), ch. 8

- 2.8 In developing an approach to structuring the increases, the Department has sought to protect the low paid, apply increases progressively and limit the level of member opt-out that higher contribution rates may generate.

Proposed new rates from 1 April 2013

- 2.9 The Department proposed to implement the following employee contribution rates from 1 April 2013.

2013-14 employee contribution rates before tax relief (gross)

Full-time pay	2012-13 contribution rate (gross)	2013-14 contribution rate (gross)	Contribution rate increase (percentage points)
Up to £15,278	5%	5%	0
£15,279 to £21,175	5%	5.3%	0.3
£21,176 to £26,557	6.5%	6.8%	0.3
£26,558 to £48,982	8%	9%	1.0
£48,983 to £69,931	8.9%	11.3%	2.4
£69,932 to £110,273	9.9%	12.3%	2.4
Over £110,273	10.9%	13.3%	2.4

- 2.10 The first pay band tier is increased in order to map onto Agenda for Change pay point 4 (£15,279). The Government's commitment of no increase for those earning up to £15,000 is preserved. Additional protection can be afforded to the low paid and new starters because the NHS has more high earners than other workforces. For 2013-14, all staff earning a full-time equivalent salary of up to £15,278 will have no increase, whilst those earning between £15,279 and £21,175 will see a minimal 0.3% increase. This approach is intended to avoid the risk of opt-out which is more prevalent amongst lower earners.
- 2.11 The progressive structuring of contribution rate increases is designed to take account of the fact that over their career, higher earners in final salary schemes generally get double the value in pension benefits per pound of contribution paid than lower earners. The following table shows the actual contribution rate paid by members once tax relief is applied.

2013-14 contributions after tax relief (net)

Full-time pay	2012-13 contribution rate net of tax relief	2013-14 contribution rate net of tax relief	Net contribution rate increase (percentage points)	Additional cost (£ per month)
£10,000	4%	4%	0	0
£15,000	4%	4%	0	0
£20,000	4%	4.24%	0.24	4
£25,000	5.2%	5.44%	0.24	5
£30,000	6.4%	7.2%	0.8	20
£40,000	6.4%	7.2%	0.8	27
£60,000	5.34%	6.78%	1.44	72
£80,000	5.94%	7.38%	1.44	96
£130,000	6.54%	7.98%	1.44	156

- 2.12 In reply to these proposals, a number of respondents questioned the need to increase member contributions at all.

Scheme 'surplus'

- 2.13 Some respondents point to the current cash flow position of the NHS Pension Scheme as evidence that the scheme is in surplus and increases unnecessary.

"These increases are being made at a time when we are told that the NHS pension scheme is providing a surplus to the Treasury, and is predicted to do so for years to come."

Hospital consultant

- 2.14 The NHS Pension Scheme has built up future pension promises (liabilities) of around £127bn as assessed at last actuarial valuation in 2004. As the scheme is unfunded (i.e. there is no 'pot' of money or assets set aside from which to pay pensions), the Government pays pensions from the public finances as they fall due.
- 2.15 It is true that at the moment annual scheme income from contributions exceeds annual expenditure on pension benefits in payment, creating a £2 billion positive cash flow which some respondents identify as being a 'surplus'. However, this is not an indication of the scheme's long-term sustainability as those paying contributions to create the 'surplus' are also building up pension promises that will need to be paid in the future.
- 2.16 This 'surplus' is expected to decrease as the NHS workforce that has been growing reaches a plateau and a generation of members reach retirement and start to draw their pension. The current gap between contributions made and benefits paid out is set to disappear by 2016.

Cost sharing & valuations

- 2.17 Concerns were expressed that the increases are not the product of a formal valuation of the scheme and so have little valid justification. Many point towards the existence of cost sharing provisions which was introduced as a mechanism to resolve excessive

scheme cost pressures and suggest that it ought to have been used in determining any contribution increases.

“The RCN confirms again its opposition to the forced increase in employee contributions over the three years to 2015. This increase (an average 3.2% on contributions) is not related to the scheme valuation and was imposed at the same time as there was an existing cost sharing agreement set in place by the discussions leading to the 2008 section.”

The Royal College of Nursing

“The proposed changes are unnecessary because the existing cost-sharing approach to funding the NHS Pension Scheme that was agreed in partnership in 2007 would have been the mechanism to deal with any need to increase contribution rates or amend benefit structures. Unfortunately this procedure, which had been jointly agreed, has been unilaterally dismantled by Government.”

British Dental Association

- 2.18 The cost sharing arrangements were intended to ensure that additional cost pressures such as those associated with people drawing their pensions for longer than expected would be shared between employees and employers up to a capped limit. Beyond this cap, the cost would be borne by employees by increasing their contributions and/or reducing the value of pensions received in the future.
- 2.19 Similar points were raised in the consultation regarding the 2012-13 contribution increases. In response the Government set out a rationale, drawing on Lord Hutton’s conclusions, as to why the current cost sharing provisions do not provide a fair or sustainable method for addressing the cost of increasing life expectancy of members. This rationale is restated below.
- 2.20 Prior to the introduction of cost sharing arrangements, the response of public service pension schemes to addressing future costs pressures associated with increasing life expectancy of members has been limited. Before 2008 schemes typically raised employer contributions, but employee contributions and benefits remained relatively unchanged.
- 2.21 Over recent decades, the unanticipated increases in longevity therefore produced unexpected gains for members and consequently extra costs for future generations of taxpayers. Lord Hutton noted that this is unfair – “pension schemes need to adjust to changing circumstances in a way that does not unfairly advantage, or disadvantage, one generation³”. Cap and share reforms capped the taxpayer cost going forward, but did not address past cost increases which were paid by other taxpayers.

“However, these [cap and share] reforms have not fully addressed the underlying issues of sustainability and fairness. Although some existing members of some schemes have had increases in their pension ages, to reflect increasing longevity, most have not. Cap and share cannot take account of the increases in cost of pensions over recent decades because people have been living longer. Also, untested, complex cap and share arrangements cannot of themselves, address the underlying issue of structural reforms, nor significantly reduce current costs to taxpayers.”

Independent Public Sector Pensions Commission interim report

- 2.22 The Government is committed to creating a fairer distribution of costs between employees and other taxpayers. Lord Hutton concluded that “cap and share on its own will not deliver the type of wide-ranging structural reforms that are needed or significant

³ Independent Public Service Pensions Commission: Interim Report (7 October 2010), p.96

reductions in current costs for taxpayers”⁴. In particular ‘cap and share’ requires future longevity costs to be paid for by whoever is an active member at the time the longevity improvement is identified with no change to the age at which benefits already built up can be taken. This inevitably means future generations shoulder a greater proportion of the costs. Ahead of the Government’s proposed long-term scheme reforms, Lord Hutton’s report established that there is a clear rationale for increasing member contributions to begin creating a fairer balance now.

2.23 The Public Service Pensions Bill proposes a new mechanism for managing future cost pressures fairly and sustainably in conjunction with other reforms to control longevity costs such as linking member retirement age to their state pension age for service accrued under the new 2015 scheme arrangements. The Bill also requires scheme regulations to provide for regular scheme valuations conducted in accordance with HM Treasury directions. The results from such valuations drive the operation of the new cost cap mechanism.

2.24 With the current requirements to undertake scheme valuations linked to the operation of the current cost sharing mechanism, revocation of the latter means that no practical purpose is served in conducting historic valuations. The Government’s view is that actuarial resources should instead be focused on conducting valuations to inform establishment of the new, reformed public service pension schemes. This approach was acknowledged by some respondents.

“UNISON acknowledges the Cost Cap and Floor and Ceiling that will apply to the reformed NHSPS post 2015 and that the existing scheme regulations need to be revoked in so far as they apply to the previous actuarial valuation and cost-sharing processes with all future resources being best spent on the upcoming actuarial valuation needed to establish the new schemes.”

UNISON

2.25 However in removing the cost sharing provisions, several respondents were concerned that there remains a statutory requirement to consider the advice of employer and employee representatives when considering changes to contribution rates.

“we are concerned by the removal of the requirement to consider the advice of employer and employee representatives when the cost sharing mechanism is in play and only consider the advice of the scheme actuary.”

The Royal College of Midwives

2.26 Such representation is provided for in the design of the new employer cost cap mechanism. The Public Service Pension Bill explicitly permits scheme regulations to provide a procedure through which employers and members (or their representatives) reach an agreement on the steps required to bring scheme costs back within set parameters. Further, HM Treasury have confirmed that public service employers, scheme actuaries and trade unions will be involved in considering the approach to valuations⁵.

⁴ Independent Public Service Pensions Commission: Interim Report (7 October 2010), p.48

⁵ HM Treasury (November 2012), *Actuarial valuations of public service pension schemes*, para 1.9

Impact of increasing member contribution rates

- 2.27 A significant number of respondents commented on the impact of increasing contribution rates further. Concerns were raised that the scheme would become either unaffordable or unattractive as an investment for retirement. Respondents warned that members opting out in significant numbers, particularly amongst high earners, threatens the overall financial viability of scheme as contributions are lost.

“With all the increases in the cost of living over the past three years, inflation of food and energy prices in particular, combined with a pay-freeze I am finding that I cannot afford to continue to pay more than 10% of my income into a pension scheme, no matter how highly regarded it may be. We need the money to live! Therefore, come April I will be opting out of the NHS pension scheme and will have to leave the future to chance.”

IT Manager

“my pension contribution over the last few years has doubled, and the benefit I will receive from this is reduced. Like many of my colleagues in the 40 - 50 year old age group, I am getting advice as to at what point remaining in the scheme becomes unviable, and when excessive contributions would be best invested elsewhere. If large numbers of consultants of this age group left the scheme, it would become unviable for all.”

Hospital Consultant

- 2.28 Similar concerns were raised in response to the 2012-13 contribution increases. It remains the case that as an unfunded scheme, HM Treasury would be responsible for financing any shortfall between contributions and pension payments. For those on low incomes, leaving the NHS Pension Scheme would represent a worsening of their pension arrangements.
- 2.29 Even with these further contribution rate increases, the NHS Pension Scheme remains an excellent investment for retirement. The Government Actuary’s Department calculate that members can generally expect to receive around £3 to £6 in pension benefits value for every £1 contributed.
- 2.30 It should also be borne in mind that if members leave the scheme they will lose the current NHS employer contribution to their pension – currently 14%. Members would also give up death-in-service benefits which may mean needing to review their life insurance arrangements.
- 2.31 In determining the distribution of contribution increases, a key Government objective is to limit any commensurate increase in instances of members choosing to opt-out from the scheme. Consequently the Department has reviewed opt-out data from the scheme administrators to evaluate the impact of the first year of increases which were applied from 1 April 2012. Trade Unions and NHS employer representatives have also reviewed this data.
- 2.32 This data shows that there has only been a small increase in opt-outs, which are in-line with assumptions. The proposed 2013-14 increases have been determined using the same approach as that for the 2012-13 increases. Given that opt-out rates have minimally increased, the data does not currently indicate that a change in approach is required.

- 2.33 Whilst acknowledging the availability of this data, some respondents commented that it would be helpful to review additional sources of information quantifying the impact of member opt-out:

“We remain conscious that a key indicator in terms of opt-out will not just be numbers of staff but will also be the resulting loss of yield to Government over both years. To date the data we have received is in respect of member opt-out (numbers and pay grades) rather than yield.”

Royal College of Nursing

- 2.34 The Department will be able to share an estimate of the pensionable paybill and expected yield in the NHS pension scheme during discussions on the contribution rates for 2014-15, to demonstrate that the proposals align with the central parameters for each public service scheme.

Disproportionate rises for higher earners

- 2.35 The vast majority of responses to the consultation were received from hospital doctors and general practitioners who expressed the view that the steepness of contribution rates applicable to the upper pay tiers is unfair. Respondents felt that NHS high earners contribute disproportionately more than lower earning colleagues and typically more than other public servants with similar earnings and pension outcomes.

“The repeated increases in contribution rates constitute a double unfairness, penalising both higher paid NHS staff, who, due to steep tiering of contributions, will pay disproportionately more for their pensions than lower paid colleagues, and NHS staff as a whole, who will contribute more than many other public sector workers for similar pensions.”

BMA members (using template response)

“Whilst we fully support the need to protect our lower-paid colleagues, this means that dentists face an increase that led to their NHS pension contributions almost doubling over a three year period. This is a shocking and completely unreasonable outcome.”

British Dental Association

- 2.36 Headline comparison of contribution rates paid by other public servants does not recognise the fact that pensions are part of wider remuneration packages. The structure of local government, NHS, teaching and civil service workforces vary as do the terms and conditions, pay levels and pensions that apply within those sectors. For instance average salaries differ considerably – for a secondary school teacher this is around £36,000 a year, whilst a nurse on average earns around £31,000 and a civil servant £23,000.
- 2.37 In the civil service, pension contribution rates are lower but this is accounted for when setting pay levels for civil servants. In essence, salaries are lower than they would otherwise be in recognition of lower pension contributions. It is therefore misleading to compare the pension contribution rates of public servants earning similar salaries.
- 2.38 In terms of NHS Pension Scheme contribution rates, the BMA proposed an alternative approach that would address what many of its members consider are unfairly steep rises for higher earners. This alternative would exempt those earning £48,983 and above from further rises.

“The BMA urges the UK Government to tackle unfairness in public sector pensions, particularly towards the NHS Pension Scheme, now and for the longer term by reducing the disproportionate impact of the 2012-13 to 2014-15 increases on the upper tiers of employee contributions in the NHS Pension Scheme by capping the upper tiers of NHS staff contributions at the April 2012 levels.”

British Medical Association

- 2.39 The Department does not accept suggestions that the distribution of increases are unfair and disproportionate to higher earners. Lord Hutton concluded that in a final salary scheme high earners tend to get more value in pension benefits per pound contributed than lower earners. The Department’s objective in setting contribution rates is to make adjustment for this so that the outcome is fair across members. This means greater contribution rate rises for higher earners than lower earners in recognition of the greater value that such individuals derive from the scheme.
- 2.40 High earners are likely to benefit from higher rate tax relief on their pension contributions. This meant that before contributions were raised in April 2012, members with full-time earnings over £60,000 actually paid a contribution rate that was lower than colleagues who earned half that amount, once tax relief had been taken into account.
- 2.41 Net of tax relief, the proposed 2013-14 contribution rates mean that a doctor on a salary of £80,000 will only actually contribute 0.18% more than a nurse earning £30,000. The Department does not consider this a disproportionate outcome for high earners.

2013-14 contributions after tax relief (net)

Full-time pay	2012-13 contribution rate net of tax relief	2013-14 contribution rate net of tax relief	Net contribution rate increase (percentage points)	Additional cost (£ per month)
£10,000	4%	4%	0	0
£15,000	4%	4%	0	0
£20,000	4%	4.24%	0.24	4
£25,000	5.2%	5.44%	0.24	5
£30,000	6.4%	7.2%	0.8	20
£40,000	6.4%	7.2%	0.8	27
£60,000	5.34%	6.78%	1.44	72
£80,000	5.94%	7.38%	1.44	96
£130,000	6.54%	7.98%	1.44	156

- 2.42 A majority of respondents also commented on the future structure of contribution rates that would apply to membership once reformed scheme arrangements are introduced in 2015. The approach to contribution rates after 2015 is subject to discussion with Trade Unions and is beyond the scope of this consultation.

Impact on part-time workers

- 2.43 Several respondents commented that the proposed increases disproportionately affect part-time workers. Employees who work part-time have their contributions based on their “full-time equivalent” salary rather than their actual earnings. This creates a difference in contribution rates between full and part time workers with the same level of income. NHS Employers observed that basing contributions on full-time equivalent

salaries rather than actual earnings may disadvantage some part-time employees who do not receive higher rate tax relief on their contributions.

"I understand that increased contributions are necessary but these levels of increase are extremely unfair to part time staff. Please re-think these increases for part time workers or use their real salaries to assess the contribution rate NOT the full time equivalent salary."

Administrator

- 2.44 Similar concerns were highlighted by respondents to a previous consultation regarding the increases in 2012-13 to employee contributions. The Department's view is that the current approach provides a fair outcome for part-time workers.
- 2.45 The contribution rate for part-time workers is set according to the full-time equivalent salary of their role. This is because their pension will be calculated based on the full-time equivalent salary. A part-time worker would then pay contributions at that rate from their actual part-time pay. Finally, the part-time worker's length of service would be scaled down as a proportion of its full-time equivalent length.
- 2.46 To illustrate, compare the pensions of two nurses who are doing the same role – one working full-time earning £30,000, and one whose full-time equivalent pay is £30,000 but who is working part-time at half of full-time hours and earning £15,000:
- The full-time nurse pays a 9% contribution (£2,700) on £30,000 and earns 1/80th of this as pension - worth £375 per annum.
 - The part-time nurse pays a 9% contribution (£1,350) on £15,000 which is half of £30,000 and earns half of 1/80th of this as pension - worth £187.50 per annum.
- 2.47 £187.50 is half of £375. This is fair and equitable as the part-timer is working half the hours of the full timer, is earning half the pay of the full timer, is paying pension contributions that are half those of the full timer and is getting a pension that is half that of the full timer.
- 2.48 As pensions are calculated based on full-time equivalent salary, the use of actual earnings would mean that a part-time worker contributes proportionately less per hour worked than a full-time member of staff, but receive the same amount of pension for that service.
- 2.49 In summary, the current approach was agreed with the NHS Trade Unions as the best way forward when tiered contribution rates were introduced.

"To date part time workers have had their pension contributions calculated at the whole time equivalent rate. There appeared to be some justification in this as it ensure that part time workers were not disadvantaged in pension terms for their reduced years of service and career progression."
Royal College of Nursing

Conclusion

- 2.50 The Government's view is that the rationale for increasing member contributions still stands. The cost of pensions is increasing as people live longer in retirement. It is unfair and unaffordable for these additional costs to be met by the public purse. There needs

to be a fairer balance between what employees pay and what other taxpayers contribute towards a public service pension.

- 2.51 The vast majority of respondents were of the view that the proposed increases are unfair and disproportionate for high earners. In this context, the British Medical Association proposed an alternative structuring of the contribution rates with the top three earnings tiers exempted from any further increase.
- 2.52 The Department does not accept this conclusion. In a final salary scheme, high earners tend to get more value in pension benefits per pound contributed than lower earners. It is therefore fair that high earners contribute proportionately more. Once tax relief is accounted for, the proposed 2013-14 contribution rates mean that a doctor on a salary of £80,000 will only actually contribute 0.18% more than a nurse earning £30,000. The Department does not consider this an unfair or disproportionate outcome for high earners.
- 2.53 In addition, scheme membership data demonstrates that the rate of opt-outs is negligible following the first tranche of increases applied from 1 April 2012. The Department therefore remains of the view that the contribution rates proposed are appropriate and intends to implement these with effect from 1 April 2013.

3. Injury Benefit Scheme

- 3.1 The consultation proposed reforms to the NHS Injury Benefit Scheme. This followed a partnership review of provisions conducted by NHS Employers and Trade Unions under delegation from the Department of Health and the Scottish Government. The review was set up in response to concerns that the current arrangements were no longer fit for purpose and asked the partners to agree joint recommendations for the revision of NHS injury benefit arrangements in ways that could feasibly be replicated for staff transferred outside the NHS. Recommendations for change were proposed by the review partners, agreed by the NHS Staff Council and accepted by Ministers for implementation from 31 March 2013.
- 3.2 In summary, scheme regulations would be amended in order to close the Injury Benefit provisions to applicants who sustain a work-related injury or disease on or after 31 March 2013.
- 3.3 For injuries or diseases suffered on or after 31 March 2013, employers will be able to pay eligible employees a new Injury Allowance under their contractual terms and conditions. The criteria for awarding the new allowance, and the level payable, will be similar to the temporary injury allowance currently payable by employers under NHS Injury Benefits regulations but limited to a maximum payment period of 12 months for each relevant injury or disease.
- 3.4 Eligibility for this new allowance will be set out in employment terms and conditions rather than regulation. Accordingly a new section will be inserted into the NHS Terms and Conditions of Service Handbook that governs NHS employment contracts. Where staff are engaged on other locally agreed contracts, employers will need to make similar amendments to these contracts to ensure entitlement is established.
- 3.5 As a transitional measure, eligible persons with NHS work-related injuries or diseases suffered before 31 March 2013 can still submit a claim under current provisions at any time until 30 March 2038. Claims considered between 31 March 2018 and 30 March 2038 will be restricted to those for which there has been a late onset of symptoms and will need to be supported with robust evidence from the claimant.
- 3.6 Some respondents commented that because the new allowance was restricted to a maximum duration of 12 months, it would not provide the same level of protection in instances where the individuals suffer a permanent reduction in their earning ability as a consequence of work-related injury.
- 3.7 The Injury Allowance arrangements recommended by the Review Partners do not seek to replicate the original permanent benefits. The new arrangements confirm in terms and condition of employment a transparent top-up to sickness benefits for staff injured during NHS work. It is expected that external employers will be able to replicate these arrangements where staff transfer outside the NHS.
- 3.8 Concerns were raised that individuals who were entitled under the current regulations may become excluded from claiming the new injury allowance if their employer does not include eligibility in local terms and conditions of service.

“Our concern relates to doctors working Primary Care (GPs and Salaried GPs) and doctors holding Honorary NHS Contracts who would not be covered by the new arrangements. A similar risk may exist for doctors employed on local contracts where the scheme is not included in their terms and conditions of service. It is our view that the scheme should cover all NHS staff/practitioners currently included and also groups excluded from the current arrangements, for example GP Locums.”

British Medical Association

- 3.9 In principle, injury benefits are a matter more appropriately included in terms and conditions as a staff benefit. Where employers choose not to replicate NHS terms and conditions as set out in the handbook, then it is a matter for them to design appropriate employment packages to attract and retain staff. The recommendations made by the Injury Benefit Review partners cover those employees currently affected by the NHS Injury Benefit Regulations, they were not intended to extend cover to any new staff groups, for example self-employed GP Locums. Under the new arrangements, the existing cover in regulations for self-employed GP contractors was very lightly used and has now been withdrawn. However, it is expected that discussions with GP representatives will take place about use of the funding currently provided to Primary Care Trusts for new claims.
- 3.10 The Royal College of Nursing commented that the draft regulations had not captured precisely the intentions of the review partners that claimants between 31 March 2018 and 30 March 2038 must provide robust evidence to prove not only that the condition is attributable to duties performed prior to 31 March 2013 but that the condition has been subject of late onset – i.e. justification as to why the claim has been submitted after the closure date.
- 3.11 We are grateful for these observations and revised the draft regulations to take this point into account. Transitional benefit regulations 4(2A), 4(3C), 4(4A) and 4(5B) now require evidence to be "reliable, substantial and probative of the case". Regulation 18A now provides that no person shall be entitled to a (transitional period) benefit unless they claim within a period of six months of the date the person became aware, or the Secretary of State thinks that it is reasonable to expect that they could have become aware, that they may be a person who is entitled to apply for an injury benefit award under scheme regulations.
- 3.12 These revisions should mean that a genuine NHS-related 'late onset' condition (e.g. one which was caused some time earlier but only recently came to the claimant's knowledge) would be considered for an injury benefit award in accordance with the regulations. It would not permit instances where a claimant has known about their condition for some time but had simply neglected to apply for an injury benefit award in a timely manner. We expect this to cover the majority of cases that may arise, but as an additional safeguard to address exceptional situations we have included an additional flexibility permitting the Secretary of State to extend the six months period, where this appears appropriate.
- 3.13 The Royal College of Nursing also drew attention to the effect of the proposed changes to the reassessment of injury benefit awards where receipt of a pension or other social security benefits is a factor.

“The current process often sees receipts of DWP Employment and Support Allowance (ESA) lose both Permanent Injury Benefit (PIB) and ESA as a result of their claims and the way in which income is determined for each benefit.”

Royal College of Nursing

The draft regulations proposed two changes. The first of these, at new regulation 6A, provided that, for the purposes of assessing pensions and benefits listed in regulation 4(6), a pension or benefit that an injury benefit claimant was entitled to receive would in future be treated as payable in payment even if the person had elected to surrender or disclaim that pension or benefit. The second change proposed was to regulation 13, where in future an injury benefit award would be reviewed, not only if a pension or benefit mentioned in regulation 4(6) had commenced or ceased, but also where it had reduced.

- 3.14 The first change was aimed at capturing all relevant DWP entitlements, whether or not the person chose to claim them. The second change was intended to work in tandem with the first, allowing an injury benefit to be reassessed whenever DWP benefits reduce. This would have been in addition to existing provisions for review on commencement or cessation of a relevant pension or benefit.
- 3.15 In the light of these comments and similar observations from the scheme administrators, we have reviewed the proposed changes. It has proven difficult to achieve a complete solution. Experience has shown that routinely reviewing an allowance or award when a pension or benefit reduces, frequently creates a 'yo-yo' effect where an increase in injury benefit award is immediately followed by a reduction in DWP benefits, and vice versa. However, scheme administrators are usually able to address this effect, and review an injury benefit award where appropriate, by regarding corrections and other fundamental changes in a pension or benefit as a 'commencement' or 'cessation' under existing rules.
- 3.16 We have therefore concluded that the proposed change to regulation 13 would be ineffective and guarantee only that NHS employer costs rise, without providing improved income for the individual. However we agree that this means the proposal to change regulation 4(6) would be unhelpful, since that would remove the existing 'safety-valve' for any injury benefit claimant who cannot be protected from the 'yo-yo' effect described.
- 3.17 We have therefore withdrawn both proposed changes and accordingly the current arrangements for the management of benefit changes will continue unchanged, pending further consideration.

4. Locum practitioners

- 4.1 At present, where a GMS, PMS or APMS contractor employs a 'locum practitioner', the employer pension contributions for the locum are paid by the relevant Primary Care Trust or Local Health Board, rather than the practice itself.
- 4.2 This is in contrast to the superannuation arrangements for other persons employed by a primary medical care contractor, where they must pay the employer contributions on behalf of its NHS pension scheme members, whether they be employed practice staff, salaried general medical practitioners (GPs) or are the GP contractor/provider(s) themselves.
- 4.3 In the case of a single-handed practice, that sole contractor is responsible for the payment of both their own employer and employee contributions and the employer contributions in respect of practitioners and practice staff they employ. In the case of a practice partnership, the contracting partners are liable for payment of both their own employer and employee contributions and the employer contributions in respect of practitioners and practice staff they employ, by reference to their agreed practice partnership shares.
- 4.4 Primary Care Trusts (PCTs) are set to be abolished on 1 April 2013. The NHS Commissioning Board will take over current Primary Care Trust duties to contract for primary medical care services. However it is proposed that the NHS Commissioning Board will not pay the employer contributions for locum practitioners as PCTs currently do. Instead, it is intended that this responsibility be transferred to primary medical care contractors. In doing so, contractors will become responsible for paying employer contributions for all individuals who assist delivery of that primary medical care contract.
- 4.5 To support this, the consultation proposed transferring the cost of locum employer contributions into General Medical Services (GMS) Global Sum payments to contractors.

Funding

- 4.6 Respondents raised concerns that the funding intentions disadvantage those practices who make more frequent use of locums and do not address the position for practices who operate under a Personal Medical Services (PMS) contract rather than a GMS one.

“Practices with less demanding workloads and less need for locums (often those serving less deprived populations) will see a rise in Practice income and profits. The proposed change will run directly counter to the government’s stated intention to direct resources to those most in need and may perpetuate social inequality.”

Derby and Derbyshire Local Medical Committee

“the transfer of the actual budget to cover this is not remotely likely to be proportionate to the need for locum cover of any particular practice which is dependent on a lot of things, not just the number of patients per doctor, for example if by bad luck more than one member of staff is off sick or pregnant at the same time, or if a doctor has period of bad health and needs to frequently take short sick leave – this kind of leave is not covered by locum insurance.”

A Locum General Practitioner

- 4.7 Other respondents commented that the proposed approach may mean that certain GMS practices in receipt of Minimum Practical Income Guarantee would not receive any additional funding with which to pay locum employer contributions.

“for those GMS practices still heavily dependent on the MPIG, transferring funding into Global Sums may only serve to reduce their correction factors; meaning that they would not actually receive any additional funding with which to pay these additional costs.”

Cambridgeshire Local Medical Committee

- 4.8 The British Medical Association suggested that “the money currently in primary care organisation (PCO) administered funds to cover this cost should be reinvested in the Global Sum Equivalent (not via the Global Sum only), as this is a straightforward cost to practices, with no element of profit”.
- 4.9 We recognise the need to ensure that funds spent by PCTs in respect of locum employer contributions are appropriately re-routed to practices. The Department has given this careful consideration and intends to announce details shortly.

Administration

- 4.10 A number of respondents expressed concerns that the proposal creates additional administrative burdens on practices and uncertainty for locums that their employer contributions have been made on time.

“Transferring the responsibility to practices for making the employers contributions for any locum they may engage, also means that locums become dependent on practices submitting the correct forms and payments at the correct time for each and every occasion they contract a locum, be that for one session or one month.”

Cambridgeshire Local Medical Committee

“Has any thought been given to how it will be ensured payments have been made by practices – this is could also be hugely bureaucratic to the pensions agency, not just to practices.”

A Locum General Practitioner

“We would also wish to see clear guidance on the means for individual locum doctors to assure themselves that such payments have been correctly made, and within the time limit that is required under the current regulations.”

British Medical Association

- 4.11 We recognise the need to ensure that arrangements for recording and remitting locum employer contributions are proportionate and robust. The NHS Pension Scheme administrator has prepared guidance for locums and practices as to the new process for recording and remitting locum employer contributions. This will be published during week commencing 18 March 2013.
- 4.12 In summary, the process comprises of the GP practice paying the 14% employer contribution to the locum when the locum invoices the practice. The locum will then, normally at the end of the month, forward the employer contributions, employee contributions, and any other additional contributions such as added years to their host board (the NHS Commissioning Board in England, or the relevant Local Health Board in Wales) along with their pension forms. The host board will, in turn, remit these contributions to the NHS Pension Scheme administrator in the normal way.

- 4.13 The Department does not accept suggestions that the change to locum superannuation arrangements be delayed to give practices and locums time to prepare. It is our view that the new administrative requirements summarised above are not unduly complicated and should be capable of being adopted into existing working practices straightforwardly.
- 4.14 The new arrangements will apply to locum GP service commencing on or after 1 April 2013. Locum GPs will then, in the usual way, have up to 10 weeks to apply and pay pension contributions to their host board to ensure that a period of locum service is included in their NHS Pension Scheme records. For example, in the case of a one week period of locum service from 1 to 7 April 2013, the locum GP will have until 16 June 2013 to apply to the host board with pension contributions.

Impact on supply of locums

- 4.15 Some respondents were concerned that the changes would serve to reduce locum prices and thus threaten the supply of good quality locums.

“It is highly likely that the result would be practices will be tempted to dodge the need to pay this by employing agency locums (or retired doctors) as currently the NHS pensions agency does not allow work through agencies to be pensionable under the NHS scheme. Otherwise practice may try to force down locum prices”

A Locum General Practitioner

- 4.16 The changes transfer the funds and responsibility for paying locum employer pension contributions from PCTs, which are being abolished, to practices. We do not envisage that this transfer should have an impact on the supply of locums. The engagement of locums is a commercial arrangement between practices and individual locums or agencies.

Other benefits for locums

- 4.17 Although this was not part of the consultation, some respondents took the opportunity to call for locums to have the same rights in terms of death-in-service and sickness benefits as other general practitioners employed by a practice.

“We would also like suggest that, as the governments (via NHSCB in England) are effectively divesting themselves of responsibility for these payments, then we would like to see locum practitioners given the same rights to sickness benefit and death in service benefits as Type 2 practitioners.”

British Medical Association

- 4.18 GPs who join the NHS Pension Scheme for a period of locum service automatically have a right to death in service benefits from the scheme whilst that period of service continues. Eligibility for death-in-service and other scheme benefits is linked to periods of active locum service for which contributions are paid. Given that locums are employed typically per unit of time (hour or session), active service is the duration of the contracted hours. Eligibility therefore ceases once those hours have been worked. Continuous death-in-service cover can be secured by arranging continuous employment as a salaried GP. Locums are treated no differently to other casually employed staff in the NHS.

5. Automatic enrolment

- 5.1 From 1 October 2012, the Pension Act 2008 and the Occupational and Personal Pension Schemes (Automatic Enrolment) Regulations 2010 require the automatic enrolment of workers into an occupational pension scheme to encourage and enable low to moderate earners to save more for their retirement. The NHS Pension Scheme already requires automatic enrolment of all eligible staff into the scheme upon starting employment with a scheme employing authority.
- 5.2 However to become fully compliant, the draft regulations proposed inserting a requirement from 1 March 2013 (when the first NHS employers are affected by automatic enrolment) to automatically enrol or re-enrol staff who opt out of the NHS scheme. Where such staff are ineligible for the NHS scheme, enrolment would be into an alternative pension arrangement chosen by the NHS employer, for example the Government backed scheme 'NEST'.
- 5.3 Respondents welcomed the confirmation that the NHS Pension Scheme will continue to be the default pension arrangement for NHS employed staff and medical or dental practitioners.

“UNISON supports the proposed amendments in the regulations to ensure that the NHSPS is the sole scheme for the purpose of pensions auto-enrolment and re-enrolment for staff eligible to join it.”
UNISON

- 5.4 UNISON advocated a review of the categories of staff ineligible to continue contributing in the NHS scheme and would therefore necessitate enrolment in alternative pension arrangements. The rationale is that there would be little practical benefit for such staff who for instance have reached the 45-year membership limit, to be enrolled into an alternative, comparatively inferior scheme for a limited period.
- 5.5 The Department does not accept the assertion that there is little benefit to individuals who are unable to continue membership of the NHS Pension Scheme. Enrolment in an alternative scheme gives such individuals the opportunity to boost retirement income further with the assistance of employer contributions. Individuals can of course opt-out if they feel it is in their interest to do so.
- 5.6 Respondents raised concerns about the potential for members who have opted-out for tax purposes to have their financial planning jeopardised by automatic enrolment back into the NHS Pension Scheme.

“an ever increasing number of doctors are finding it necessary to opt-out of further pension accrual to avoid being affected by the recently reduced Annual Allowance and Lifetime Allowance limits.”
British Medical Association

- 5.7 The BMA suggest that such individuals be either exempted from automatic enrolment or receive at least six months notice of their forthcoming enrolment date so that arrangements can be made to opt-out without incurring additional tax charges. We recognise this issue. Generally speaking, the scheme does not get involved in a member's personal tax affairs. It is for individuals and their advisers to plan and monitor their pension and tax arrangements. There is a role for employers to assist individuals

with timely communication about any forthcoming pension 'event' such as automatic scheme re-enrolment. We will work with the scheme administrators to highlight the importance of this to employers.

6. Other changes

Claiming unreduced pension benefits in lieu of a redundancy payment

- 6.1 Under various terms and conditions applying to NHS staff, qualifying members of the NHS Pension Scheme are entitled to claim unreduced pension benefits as an alternative to receiving a lump sum redundancy payment (in part or in full) from their employer. The draft regulations seek to better reflect this entitlement by inserting a requirement that on application for redundancy benefits, the employer certifies that entitlement to an NHS redundancy pension is provided for in that member's terms and conditions of employment.
- 6.2 The BMA expressed concerns that this certification requirement could remove the ability of members to exercise this entitlement where local employment contracts have been used.
- 6.3 Certification is a cross-check on eligibility, it is not intended to exclude categories of staff. It is for employers to ensure that local employment contracts include access to this provision as an alternative to receiving any lump sum redundancy payment otherwise provided for within that contract.

Unauthorised payments

- 6.4 The 2008 Section scheme regulations has provisions that prevent the administrator from making any payment which would constitute an unauthorised payment for the purposes of the Finance Act 2004. The regulations proposed introducing equivalent provisions for the 1995 Section scheme regulations.
- 6.5 UNISON argue that limited flexibility be given to make an unauthorised payment where it is clear that entitlement to receive a benefit would otherwise be prejudiced.

“For example, would it be fair to withhold a death in service lump sum payment to a beneficiary if through no fault of their own the payment was delayed beyond two years of the member's death?”
UNISON

- 6.6 In the light of these comments and similar concerns expressed by the scheme administrators, we have withdrawn this proposal pending further consideration.

Practitioner income

- 6.7 The draft regulations propose extending definitions of 'GP Performer' and 'Locum Practitioner' to ensure that advisory work undertaken for Clinical Commissioning Groups can be treated as pensionable income. In response the BMA asked for clarity as to how other aspects of practitioner work would be treated, citing the example of GP work undertaken for a local authority or in educational roles.
- 6.8 The proposed amendments extend the definitions to include practitioner income derived from health related functions exercised under Section 75 of the NHS Act 2006. Section 75 enables health services to be delivered jointly by NHS bodies and local authorities.

Where GPs participate in such arrangements, then income from that work is pensionable in the NHS Pension Scheme. We invite further discussion with the British Medical Association, through the NHS Pension Scheme governance arrangements, to explore other types of practitioner work that are appropriate to be included as pensionable income.