Department
of Health

THE SENIOR SALARIES REVIEW BODY (SSRB)

REVIEW FOR 2014

WRITTEN EVIDENCE FROM THE HEALTH DEPARTMENT FOR ENGLAND

October 2013

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WRITTEN EVIDENCE FROM THE HEALTH DEPARTMENT FOR ENGLAND

Prepared by

Department of Health

Human Resources

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Executive Summary

The health and social care sector is facing significant challenges to deliver against increasingly ambitious quality and safety agendas, for example in response to the Robert Francis report. These challenges are set within the context of significant on-going financial constraints and the Government has made it very clear that continued pay restraint is an essential part of meeting these challenges.

Evidence provided to the SSRB in previous years majored on Very Senior Managers (VSMs) in Strategic Health Authorities and Primary Care Trusts. Following their abolition in March this year, the evidence provided this year is predominantly concerned with VSMs employed by the Department of Health's arms-length bodies (ALBs), which include both Executive Non-Departmental Public Bodies (ENDPBs) and Special Health Authorities (SpHAs). These bodies vary greatly in size, complexity and range of functions and are considered to be closer to central government than the NHS in terms of accountability. All ALBs however have vital national responsibilities and many have essential roles in improving the quality and responsiveness of NHS services. For example, the largest of them, NHS England, has been entrusted with a £95bn plus budget and a key national leadership role in the management of the entire NHS system.

It is therefore clear that the ALB VSMs may appropriately be described as system leaders for the health and social care system and their pay should be commensurate with their national responsibilities and at a level to enable ALBs to compete for and share the best talent within their respective partner organisations and relevant recruitment pools. We argue that the VSM pay framework, introduced in 2012 specifically for ALB VSMs, including the flexibilities available within it, continues to deliver rates of pay that are in line with relevant comparators and remain competitive within the NHS market.

We also argue that as system leaders, the pay of VSMs must be viewed within the wider health and social care context, including the NHS, and should reflect similar pay restraint experienced by other NHS staff. Our evidence to both the Doctors and Dentists' Pay Review Body and the NHS Pay Review Body, firmly supported by the views of employers, is that, while the Government's stated policy for public sector pay is that awards will average 1%, any pay increase for NHS staff in 2014 can be afforded only in exchange for changes to national contracts that make more efficient use of the overall paybill. We urge the SSRB to keep this wider context in mind when considering the need for any increase in ALB VSM pay.

We believe the only justification for an increase in VSM pay in 2014/15 would be clear and compelling evidence of issues with recruitment, retention and motivation. Chapter three of the evidence considers these issues but due to the impact of transition there is insufficient evidence to draw definitive conclusions at this stage including any evidence that there is a compelling case to support a requirement for a pay uplift at this time.[1]

Remuneration of ALB VSMs is governed by the 2012 ALB VSM Pay Framework, which is underpinned by a job evaluation system for all VSM posts. The framework was devised to accommodate all ALBs with the provision for larger ALBs to include a range of VSM posts below Board level as well as, Chief Executives, Executive Board members and other senior managers reporting directly to the chief executive.

One of the guiding principles of the framework states that:

"executive remuneration should fairly reward each individual's contribution to their organisation's success and should be sufficient to recruit, retain and motivate executives of sufficient calibre. However, organisations should be mindful of the need to avoid paying more than is necessary in order to ensure value for money in the use of public resource".

Now that the framework has achieved the key purpose of effectively facilitating the establishment of the new ALBs, the department believes the time is right to conduct a review of the framework to ensure it remains fit for purpose in terms of both its design and application.

We welcome observations from the SSRB on how the VSM pay system could be made more effective in light of the principle set out above. In particular, if the SSRB believes any pay increase for VSMs is necessary, we welcome views on how this could be made affordable, for example by adjustments to the framework or by any increase in pay being non-consolidated for all or some VSMs. We also urge SSRB to take account of the evidence submitted to the NHSPRB and DDRB which includes the option of any award being deferred to allow negotiations to take place on contract reform. As system leaders we would expect VSMs to set an example to the rest of the service.

[1] Data protection considerations mean that the most of the pay data in this evidence has been aggregated at above the level of individuals. However, more detailed, individual information on pay and turn-over has been provided on a confidential basis to help the SSRB to come to its conclusions

Chapter One – VERY SENIOR MANAGERS: THE SYSTEM-WIDE CONTEXT

The Remit

1.1 The Chief Secretary to the Treasury's letter of 23 July 2013 set out the Government's overall remit to the SSRB for the 2014/15 pay review round. The letter emphasised the Government's belief that the case for continued pay restraint across the public sector remains strong. The Chief Secretary highlighted two important reasons in support of this case:

- *Recruitment and retention*: the Government believes there are unlikely to be significant recruitment and retention issues for the majority of public sector workforces over the next year;
- *Affordability*: the Government believes pay restraint has a crucial role in helping the UK back onto the path of fiscal sustainability and in protecting jobs and supporting the quality of public services.

1.2 The Chief Secretary invited the SSRB to consider what pay award was justified in this context and in the light of all the evidence available to it. Dr Dan Poulter, the Parliamentary Under-Secretary of State at the Department of Health, wrote to the SSRB on 22 August 2013 to emphasise the crucial importance of affordability for the NHS. His letter explained that while the cost of the VSM paybill is significantly less in total than that of other staff groups in the NHS (and less than the previous Strategic Health Authority and Primary Care Trust paybill), he looked to VSMs as system leaders to share in and support the policy of pay restraint elsewhere in the public sector.

The Wider NHS

1.3 Chapter two and Annex A sets the issue of affordability within the broader context of the NHS as a whole. Whilst the budget for ALB VSM pay is not part of the NHS pay budget, it is important that account is taken of the wider NHS VSM community as we are defining ALB VSMs as system leaders. As Dr Poulter acknowledges, the overall VSM paybill is a small fraction of the NHS total. However, the NHS is facing the most difficult financial challenge in its history whilst at the same time having to raise its game across a whole range

of indicators of productivity, efficiency and above all the unquantifiable measure of compassion.

1.4 The SSRB may be particularly interested in the new approach to leadership, where the NHS Leadership Academy (NLA) is developing and launching a number of programmes designed to ensure that there is leadership support at all levels of the NHS and that it is focused on achieving safe, compassionate care through the development of an open, learning-oriented culture. DH is working closely with the NLA to ensure that, as system leaders, ALB VSMs are provided with the necessary development and support to enable them to perform their leadership role. To this end we are establishing a collaborative talent management programme between DH and its ALBs to ensure we are able effectively to identify, develop and deploy our best leaders across the system.

The New System

1.5 Our evidence last year sought to explain the new structures and model of management in the health and social care system due to come into effect on 1 April 2013. At the time of writing, midway through the process of transition, it was not possible to provide a complete picture of the new organisations, including the numbers, roles and remuneration of the VSMs leading them. We are now able to provide a more complete and accurate picture. The system is continuing to evolve, adapt and change in response to the challenges highlighted above, but the structures established in April 2013 are not likely to change significantly in the next year.

1.6 The commissioning of most hospital services has now been entrusted to some 211 clinical commissioning groups (CCGs) made up of general practices together with nurses and other secondary care clinicians who are in the best position to know the health needs of their local populations and to ensure provision of them in the most effective way. They are accountable to NHS England, which itself commissions primary care and some highly specialised services. These commissioning bodies have a key role in driving up the quality of patient services.

1.7 Patient services, other than primary care services, are provided by NHS Trusts and NHS Foundation Trusts – there are currently 100 of the former and 145 of the latter with the aspiration that all should become Foundation Trusts subject to achieving the standards of both patient care and financial stability required by the system regulators, Monitor and the Care Quality Commission (CQC). The NHS Trust Development Authority (NHS TDA) has a key role in managing

the performance of NHS Trusts and helping them to achieve Foundation Trust status.

1.8 NHS England, Monitor, CQC and the NHS TDA are four of the ALBs that employ VSMs within the SSRB's remit. All four have crucial roles within the new system and to function effectively, it is critical for them to work closely together.

1.9 Particular mention has been made of NHS England, the NHS TDA, CQC and Monitor because of their key roles and responsibilities within the new NHS system architecture but that is in no way intended to detract from the vital roles played by other DH ALBs. **Health Education England** is another new ALB with the crucial role of planning the NHS workforce and promoting its training and development. Bodies like the **NHS Business Services Authority (BSA)** and **NHS Blood and Transplant** deliver a range of services without which the NHS could not function while the guidance and information provided by the **National Institute for Health and Care Excellence** and the **Health and Social Care Information Centre** also have crucial roles in driving up the quality of patient care. Smaller ALBs like the **NHS Litigation Authority,** the **Human Fertilisation and Embryology Authority**, the **Human Tissue Authority** and the **Health Research Authority** have specialised roles of national importance.

1.10 This evidence does not seek to provide a full description of every ALB but rather to emphasise their importance as national organisations and in many cases as key components within the reformed structures of the new NHS. They undertake an extraordinarily wide and diverse range of functions, encompassing highly specialised services on the one hand to responsibilities affecting the entire health and social care system on the other. This level of responsibility is reflected in the size, budgets and complexity of each ALB. Those at the head of the ALBs – the VSMs – can therefore properly be regarded as national system leaders to whom more local organisations, both providers (NHS Trusts and NHS Foundation Trusts and other NHS-funded provider organisations) and commissioners (CCGs) can look for leadership in issues of behaviour and business conduct as well as pay and terms and conditions. This is considered further in chapter 3.

Chapter Two – FINANCIAL CONTEXT

2.1 This chapter sets out the overall financial position for the NHS and ALBs in 2014/15. This provides the data around one of the critical considerations for pay review decisions, namely affordability. Chapter three provides further data around VSM pay, including possible recruitment and retention issues that might influence any decisions on pay.

2.2 Although it is acknowledged that the total paybill for VSMs is much less than for other NHS staff groups, it also argued that VSM pay cannot be seen in isolation from what is happening in the wider system and it is therefore important that the SSRB is clearly sighted on the overall financial challenges.

2.3 Detailed information about NHS finances is set out at Annex A. Although the NHS has received a better Spending Review settlement than most other parts of the public sector, it is facing the biggest financial challenge in its history.

ALBs

2.4 Although the health sector will continue to be protected in the forthcoming Spending Round, the pressures in the system and the need to maximise resources for the front line mean that every area of DH and national ALB direct spending will be under review - in particular, administration spend. 2014-15 is the journey to the next Spending Review and while there is no specific target for administrative savings in 2014-15 it is clear that ALB business plans need to "contain" their pay bills so that they are affordable beyond 2014-15. The last ALB Review reduced administration budgets by a third, and initial discussions with HM Treasury suggest they will be looking for a further stretching minimum reduction of 10% when setting the system envelope for 2015-16.

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Chapter Three – ALB VSM PAY

3.1 We have evidenced the critical leadership role ALB VSMs play in the new system. The following chapter provides evidence around the current pay position and any implications for recruitment and retention.

Wider Context

3.2 The SSRB is aware that it is Government policy in general to devolve decisions on pay as far as possible to employers who are best placed to judge what level of pay and other aspects of the total reward package are required to recruit, retain and motivate their workforce to deliver the highest possible quality of service to their patients. Employers have previously preferred to use national contracts for staff on Agenda for Change or medical or dental contracts, but as our evidence to the NHS Pay Review Body and the Doctors' and Dentists' Review Body shows very clearly, the unprecedented financial challenges facing the NHS mean that employers now see as vital the need for greater flexibility and to make more effective use of a staff pay bill, which can account for up to 70% of an employer's total costs.

3.3 The SSRB will also be aware that there are no national contracts for VSMs in NHS Trusts and NHS Foundation Trusts so NHS provider organisations are free to set their own rates of pay for their VSMs. The pay of VSMs in NHS Trusts (except in ambulance trusts that have not attained Foundation Trust status – see para 4.10 - and NHS Foundation Trusts are not within the remit of any pay review body. The new local commissioning bodies (CCGs) also have freedom to set their own rates of pay for their VSMs.

3.4 ALBs currently have a degree of autonomy in order for them to function effectively. However, all ALBs are accountable to the Department of Health and VSM pay is governed by the ALB VSM Pay Framework and overseen by the DH ALB Remuneration Committee chaired by the Permanent Secretary. It follows that the pay of ALB VSMs falls under the Government's strategy for restraint in senior public sector pay. It was against this background of public and Ministerial concern about high levels of public sector pay that the Government commissioned the SSRB, in 2011, to review the pay of ENDPB Chief Executives.

3.5 The report of this review includes an important statement of its aims which is worth quoting in full:

"Against such a background [i.e. the need to reduce the deficit] we are fully aware of the need for restraint in senior public sector pay. However, whilst the current financial circumstances impact strongly on short-term considerations, the position could change in the longer term. We have taken the view that, although we must reflect the need for restraint, we should not frame our recommendations solely in the light of the present exceptional circumstances. Our aim has been to develop a pay structure that is sustainable in the long term. In doing so we have also been mindful that some (though by no means all) of these senior posts must recruit from highly competitive, sometimes international, labour markets. We have tried to strike a balance between these sometimes competing considerations as we arrived at our conclusions."

It is for this reason that, using the SSRB review as our starting point, DH decided that all VSM posts, and not just CEO posts, should be subject to a dedicated job evaluation scheme (JES) to ensure a more robust and consistent approach to pay levels for all ALB VSM posts.

3.6 The unequivocal evidence of chapter two and of the economic evidence submitted by the Treasury is that the "exceptional circumstances" referred to in the SSRB report remain in place and that in fact the financial challenge facing the system is now even more acute. However, the SSRB report also recognised the difficulty with VSM pay of striking the "right balance" between "sometimes competing considerations." This goes right to the heart of the issue: supporting the Government's overarching priority of reducing the deficit by (amongst other means) keeping tight control over public sector pay while at the same time ensuring that the VSM reward package is sufficiently competitive to recruit, retain and motivate the very high quality of individuals required to lead organisations that our evidence clearly acknowledges are of crucial national importance.

Recruitment and Retention

3.7 For 2013/14 the SSRB recommended and the Government accepted a pay increase of 1% for all VSMs. For 2014/15 and 2015/16, the Government has said that public sector pay awards should average no more than 1%. The Government has asked the SSRB to consider the evidence carefully – "In particular what award is justified." Our evidence last year was unable to establish meaningful conclusions about VSM pay. This was the inevitable

consequence of submitting evidence half-way through the most radical and extensive structural reform programme in the history of the health and social care sector.

3.8 The new ALBs were still being established and had not finalised their structures or completed all their VSM appointments while some established ALBs were also undergoing significant change. Furthermore, the new ALB VSM pay framework had been introduced in May 2012 and it was therefore too early to draw conclusions about the effects of the new pay system on recruitment, retention and morale of VSMs subject to it. It would also have been very difficult to know what influence to attribute to the new pay framework in comparison with other factors, including the reduction in numbers of VSM posts as a result of the abolition of the strategic health authorities and primary care trusts.

3.9 Furthermore, many VSMs moving from the abolished organisations to the new organisations had their pay protected through the application of an enhanced recruitment and retention premia (RRP) under specific arrangements agreed with HMT. This decision was taken to minimise redundancies and associated costs. This has enhanced retention of VSMs making it difficult to conclude that the pay points and ranges under the new pay framework were inadequate for the purposes of recruitment and retention.

3.10 All VSM posts in the new ALBs were evaluated under the new pay framework. Consequently, apart from a small handful, VSMs who transferred to the new ALBs whilst retaining their pre transfer pay and terms and conditions, moved into new posts that were subject to the 2012 pay framework. However, it does remain the case that there will be a number of current VSMs who are covered by the 2006 ALB VSM pay framework and the Government continues to believe that its migration strategy of not moving everyone onto the new framework is the correct one to avoid the significant costs involved in protecting pay of all VSMs who would lose pay by the change and awarding pay increases to all gainers. Any changes will be phased in over a period of time in a manageable and affordable way. We already ensure that when posts become vacant, the post is evaluated under the new framework. We do not believe that any VSM has so far been migrated from the 2006 or local pay framework to the 2012 VSM pay framework.

3.11 The overwhelming majority of ALB VSMs are covered by the 2012 framework. However, a small number may be employed on one of two other pay frameworks: the 2006 VSM pay framework (that applied to SHAs, PCTs and

ambulance trusts as well as special heath authorities (SpHAs); and in the case of some ENDPBs (which were not required to adopt the same framework as SpHAs), local very senior manager pay arrangements.

3.12 The evidence we are providing this year is more complete and comprehensive than last year, but there are still some factors which require the data to be interpreted with caution. These include the numbers of VSMs in receipt of RRP based on their pay in their previous roles (and therefore not a reliable indicator of genuine difficulties with recruitment). In addition, for the vast majority of posts in the newly formed ALBs, they have not needed to go out to the external market which in turn means that salary levels have not been tested. The vast majority of VSMs in the new ALBs transferred from SHAs and PCTs and it will probably be several years before a proper assessment can be made of the effect of the new ALB VSM framework in particular, on VSM recruitment, retention and morale.

3.13 Historically, ALBs have had very low staff turn-over rates. We believe this might be the result of a combination of a competitive total reward package and highly stimulating, interesting and rewarding work. It will not be meaningful statistically to consider turn-over data in the new ALBs possibly for several years. However, in the ALBs established prior to the transition, a similar pattern of low turn-over as in previous years should be noted. For a number of these organisations there are relatively few VSMs, so a single resignation can result in a 20% turn-over figure. The high turn-over in CQC reflects the need for that organisation to make changes in response to challenges in the Robert Francis report.

2012 ALB VSM Pay Framework

3.14 We welcome the support the SSRB has given to the principles on which the new VSM pay framework is based, in particular to pay being based on an analytical job evaluation system, led by remuneration committees independent of the VSMs to which the system applies. It is supported by expert assessors in the NHS Business Services Authority and overseen by a DH remuneration committee chaired by the permanent secretary and itself including a DH non-executive director. We believe the VSM pay framework played a key role in facilitating the transition to the new ALB structures and incorporates sound principles which will provide a reliable basis for deciding VSM pay in the future.

3.15 In their report last year, the SSRB, while being generally supportive of the new pay framework, suggested there could be problems in a few areas and these comments require a response. The SSRB reported that Managers in Partnership (MiP) had raised concerns about the accuracy of some job evaluation scores and about assessors encroaching on the role of remuneration committees in setting spot rates. We take these criticisms extremely seriously since a fair and objective job evaluation process is at the heart of the pay system.

3.16 The VSM pay framework makes it clear that that the job evaluation process should be led by the remuneration committee of the ALB. However, it is a requirement that the evaluation must be undertaken with the involvement of BSA's trained assessors. This ensures that there is a concentration of expertise together with an important element of consistency and impartiality. Some discussion and dialogue may be needed between the respective parties as part of the process before agreement is reached. The process provides for a right of appeal and for any disputes that cannot be resolved locally to be referred to the DH remuneration committee. While it is natural for there to have been some teething troubles while BSA and ALB remuneration committees gained experience of what at the time of the submission of last year's evidence had been a very recently introduced system, we have found no evidence to substantiate any suggestion of unwarranted interference by BSA with the evaluation process or that any of the outcomes of the process had been inappropriate. We are not aware of any appeals against the outcome of the job evaluation.

3.17 In their 2013 report, the SSRB also reported a concern, again evidently raised by MiP, that development pay was being used inappropriately in a number of managing director posts in commissioning support units (CSUs). Development pay allows ALB Remuneration Committees the option of paying individuals less than the full rate for the job while they are developing into the role and are not required to fulfil all of the responsibilities of the post. Again, we have found no evidence to confirm this. We obtained information from 15 CSUs and in only one case was the managing director receiving development pay.

3.18 The 2012 pay framework is based on the original SSRB recommendation to establish a common framework for determining the pay of ENDPB chief executives. That framework was developed further by DH to provide greater granularity of evaluation and levels to accommodate the diversity of roles within the transforming health and social care sector. Pay arrangements were established with narrow pay ranges attached to the 41 evaluation levels. This structure has served transition well in that these pay arrangements plus the

RRP policy has enabled the retention of VSMs with the critical skills and experience to lead and manage the new health and social care system.

3.19 It is our considered view that the pay framework was primarily developed to evaluate Chief Executive and Executive Board level roles. During transition it has been necessary to use the pay framework for roles at levels below the executive board and as a consequence significantly more roles have been included within the framework than might have been expected. Now that the new ALBs are fully established, we have concluded that there is a need to review the framework to ensure it remains fit for purpose in both design and application. We are of the firm view that the evidence suggests that the upper limit of £225,000 (increased by 1% from 1 April 2013) and the flexibilities below are sufficient to address the pay needs of ALBs. We would therefore not be proposing to look at increasing the current upper limit. We would welcome views from the SSRB on these matters.

3.20 Based (as we believe the SSRB accepts) on sound principles, the VSM pay framework also includes important flexibilities, including the availability of RRP, as the SSRB acknowledged in their report on "locality pay" for VSMs by recommending that there was no need for additional locality pay measures to be added to the pay framework. The availability of performance-related pay (currently restricted by the Government to the top 25% of performers and to a maximum of 5% of reckonable pay) also adds to the attractiveness of the overall VSM reward package. Annex D shows that the NHS Pension Scheme (to which most VSMs belong) will remain highly competitive, even after the 2015 changes, and a further attractive element of total VSM reward.

3.21 Having confirmed the principles and integrity of the VSM pay framework and its attractiveness as a total reward package, it remains to consider the need for any further increase in VSM pay following the 1% increase in 2013. As noted, the letter from the Chief Secretary to the Treasury suggested that there are unlikely to be significant recruitment and retention issues for the majority of public sector workforces over the next year and that pay restraint remains a crucial part of consolidation plans that will help to put the UK back onto the path of fiscal sustainability. In supporting this, the Parliamentary Under-Secretary for Health (Dr Dan Poulter) emphasised the need for "system leaders" to "share in and support the policy of pay restraint elsewhere in the public sector."

3.22 To assist the SSRB in reaching its conclusions, we have sought to address the data requirements set out in paragraph 6.21 of last year's report and in the letter of 26 July requesting our evidence (some of this information as noted cannot be published for data protection reasons). We suggest that, in the context of the paramount importance of pay restraint, the need for system

leaders to support this policy and the unprecedented financial challenge facing the system, there would need to be very clear evidence of recruitment and retention problems to justify any pay increase for VSMs in 2014. The data in our view does not provide any such evidence.

Motivation and Morale

3.23 We wrote to ALB Chairs seeking information from their local remuneration committees about:

- the current pay levels based on the 2012 VSM pay framework enabling ALBs to recruit retain and motivate VSMs of the calibre required to lead the organisations;
- their role; and
- their relationship with the DH Remuneration Committee.

3.24 Within the context that the majority of VSMs in the new ALBs transferred from SHAs and PCTs, it is difficult to assess fully whether salaries are pitched at a level sufficient to attract the necessary calibre of external candidates. It does appear that VSM salaries are sufficiently attractive when candidates are from Civil Service or NHS pools. However, some concern was expressed about the competitiveness of salaries for the most senior posts within organisations, and also for those more specialised posts such as IT and Legal where candidates are more likely to come from the private sector.

3.25 There is evidence that ALB Remuneration Committees do not feel they have enough autonomy. In addition it was expressed that the DH Remuneration Committee was overly bureaucratic and did not respond promptly enough to requests for salary approvals.

3.26 We are aware of these issues and clearly we want to get the balance right between appropriate departmental oversight and assurance and delegated authority to ALBs. It is for this reason that the relationship and respective roles and responsibilities will form part of the review of the framework.

Conclusions on VSM Pay

3.27 Chapter four provides comparative data to evidence the following conclusions.

3.28 We have suggested that in the context for this year's evidence of the significant issues relating to the affordability of a pay uplift for VSMs as a result of the financial challenges facing the system, there would need to be clear and unequivocal evidence of serious recruitment and retention problems to justify any increase in VSM pay. We do not believe that there is any such evidence. Furthermore, there is no substantive evidence at this time to indicate that VSM pay in the ALBs is falling behind or ceasing to be competitive.

3.29 There continue to be a number of pay flexibilities available to ALBs, including RRP of up to 10% (exceptionally, with CST approval, RRP in excess of 10% can be awarded) and non-consolidated performance awards. We would welcome views from the SSRB on how any pay award, should the SSRB consider such an award to be justified, could be made more affordable. For example, consideration could be given to suspension of PRP in exchange for a 1% pay increase; or to making any pay award non-consolidated for some or all VSMs; or to make no consolidated pay award but increase the amount available for PRP. Additionally, non-pay recruitment and retention interventions should continue to be considered by ALBs, including effective talent management, leadership development and resource sharing, including secondments. We would welcome the views of the SSRB on these alternative solutions to addressing recruitment and retention issues.

3.30 We also urge SSRB to take account of the evidence submitted to the NHSPRB and DDRB which includes the option of any award being deferred to allow negotiations to take place on contract reform. As system leaders we would expect VSMs to set an example to the rest of the service.

3.31 We see no evidence that ambulance trusts are being hindered in their aspirations to become Foundation Trusts by any issues relating to VSM pay.

Chapter Four – PAY DATA

4.1 This chapter sets out some data to enable the SSRB to compare ALB, Senior Civil Servant (SCS) and NHS levels of pay with a view to drawing conclusions on the resulting impact on ALB VSM recruitment and retention.

ALBs

4.2 Table 4.1 below shows the minimum and maximum pay ranges for ALB VSMs and CSU VSMs (see Annex B for further detail).

Table 4.1

Organisation	**Minimum Pay Range £**	**Maximum Pay Range £**	**Average Pay £**	**Median Pay £**
All ALBs	70,000-74,999	235,000-239,999	122,967	115,000
All CSUs	85,000-89,999	180,000-184,999	117,336	115,000

4.3 Table 4.2 below compares the average pay of 3 VSM roles which commonly exist in both the ALBs and NHS Trusts/Foundation Trusts:

Table 4.2

Role	**ALBs**	**All Trusts**	**Largest Trusts By Income**
Chief executive	£167,600	£163,679	£206,775
Finance director	£142,408	£120,155	£146,839
HR Director	£119,360	£98,603	£122,688

Notes: ALB figures based on current pay. Comparator figures taken from the IDS NHS Boardroom Pay Report 2013.

Clinical Commissioning Groups (CCGs)

4.4 Apart from NHS Trusts and Foundation Trusts, the other major employers with whom the ALBs may be in competition for the recruitment of senior staff are clinical commissioning groups (CCGs). Unfortunately, pay data for CCGs is not collected centrally so will not be available until CCGs publish their first sets of annual reports in 2014. As noted, CCGs are free to set their own rates of senior pay but are encouraged to follow guidance produced by NHS England. NHS England has produced such guidance for the pay of chief officers and chief finance officers. The guidance does not apply to chief officer roles where being a clinician has been deemed an essential requirement.

4.5 NHS England has proposed 3 pay ranges for chief officers and chief finance officers, based on the population sizes of CCGs (Table 4.3):

Table 4.3

CCG level	Population size	Pay range for chief officer	Pay range for chief finance officer
Level 3	At or over 500k	£120k - £130k	£95k to £110k
Level 2	150k to 499k	£105k - £120k	£85k -£95k
Level 1	149k or below	£90k - £105k	£75k - £85k

4.6 The guidance provides for flexibility to award higher pay including RRP and for additional responsibilities and/or complexity. We will attempt to provide more detailed information on the pay of CCG senior managers in next year's evidence, based on what is available at the time, and also try to assess the extent to which there is competition between the ALB and CCG sectors (e.g. investigate movement of staff between the two sectors).

Senior Civil Service

4.7 While it is true that VSM pay in the NHS is generally higher than for roles of comparable seniority in the civil service, the close relationship of the Department of Health to its ALBs means that it is relevant to consider how ALB VSM pay compares with that in the Senior Civil Service. The SSRB may therefore wish to note that the overall median SCS salary is £77,000.

4.8 The median salaries by each SCS level are in table 4.4 below:

Table 4.4

SCS level	Median salary
1	£72,964
1A	£77,843
2	£97,900
3	£131,296

4.9 It is clear that it is only above SCS2 level (some 4% of the total) that SCS pay becomes comparable with the majority of ALB VSM posts. 75% of all SCS posts are at SCS1 level.

Ambulance Trusts

4.10 VSMs in ambulance trusts that have not attained Foundation Trust status remain within the SSRB's remit and we have collected information on their pay. The SSRB will wish to note that the VSM pay framework published in May 2012 does not apply to ambulance trusts so their VSMs, until their organisations become Foundation Trusts, remain on the terms of the 2006 pay framework. The ambulance trusts not expected to become Foundation Trusts for all of or a significant part of 2014 are:

- the London ambulance service
- North West ambulance service
- East Midlands ambulance service
- Yorkshire ambulance service
- East of England ambulance service.

4.11 The rates within the pay framework applicable to ambulance trust VSMs may be seen at Appendix E of the version published in June 2013 to reflect the 1% increase from 1 April 2013:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/211964/Pay_Framework.pdf

While it is important that the rates of pay under the VSM pay framework remain competitive, ambulance trusts (unlike ALBs) will become free to set their own rates of pay for their VSMs as soon as they become Foundation Trusts. In view of this, and the evidence from the pay of comparators and from recruitment and retention, we suggest that there is a strong case for ambulance trusts to be treated the same as ALBs in terms of supporting the Government's policy on pay restraint in 2014.

4.12 Table 4.5 below shows the average pay in non-Foundation Trust ambulance trusts for chief executives, finance directors and HR/workforce directors and corresponding pay in comparators.

Table 4.5

	Ambulance Trusts	FT Ambulance Trusts	All NHS Trusts
Chief Executives	£145,474	£148,750	£163,679
Finance Directors	£115,640	n/a	£120,155
HR/Workforce Directors	£96,932	£85,000	£98,603

Notes: Figures for "ambulance trusts" are based on current pay. Comparator pay is taken from the IDS NHS Boardroom Pay Report 2013.

NHS VSMs

4.13 The Electronic Staff Record does not enable us to separately identify the pay of NHS VSMs. However, the SSRB is aware that Incomes Data Services publishes annually (around the beginning of April) a fairly comprehensive report on boardroom pay in NHS Trusts and Foundation Trusts based on the published accounts of these organisations, the main draw-back being that by the time of publication the data is not completely up-to-date – so that the latest report is based on the accounts for the year ending 31 March 2012. As noted, executive pay in NHS Trusts and Foundation Trusts is not centrally controlled. However, the data shows that they were exercising considerable restraint over the pay of their VSMs. Table 4.6 below shows pay increases for chief executives, finance directors and "other directors" (non-medical):

Table 4.6

Trust type	No	Lower Quartile %	Median %	Upper Quartile %	Average %
Foundation Trusts					
Chief executive	75	0.0	0.0	3.5	2.2
Finance director	67	0.0	0.0	3.3	2.2
Other director	252	0.0	0.0	3.6	1.7
All directors	394	0.0	0.0	3.4	1.9
Non-foundation trusts					
Chief executive	45	0.0	0.0	0.0	0.9
Finance director	47	0.0	0.0	2.6	1.6
Other director	174	0.0	0.0	4.4	1.8
All directors	266	0.0	0.0	0.5	1.6
All trusts					
Chief executive	120	0.0	0.0	2.3	1.7
Finance director	114	0.0	0.0	2.7	2.0
Other director	426	0.0	0.0	3.8	1.8
All directors	660	0.0	0.0	2.6	1.8

4.14 The table above shows that the median increases for this group of directors were zero for the second year running.

4.15 Table 4.7 below is extracted from Table 1.2 in the IDS report showing median pay levels of executive directors by trust type:

Table 4.7

Median total remuneration					
Board position	**Acute & Specialist £pa**	**Ambulance £pa**	**Care Trusts £pa**	**Mental Health £pa**	**All hospital Trusts £pa**
Chief executive	167,500	142,650	132,500	152,500	157,500
Facilities director	101,250	-	-	96,750	98,750
Finance director	127,500	113,100	109,575	112,500	121,400
HR director	97,500	96,300	92,500	97,500	97,500
Nursing director	102,500	77,450	96,250	103,300	102,500
Operations director	112,500	107,600	97,500	105,700	107,500`

4.16 Table 4.8 below (Table 1.6 in the IDS report) shows chief executive median remuneration levels in foundation and non-foundation trusts by trust income:

Table 4.8

Trust Income	**Foundation trust £pa**	**Non-foundation trusts £pa**	**Differential %**
Under £100m	134,900	124,900	8.0
£100m to £125m	144,125	137,500	4.8
£125m to £150m	142,620	145,700	-2.1
£150m to £200m	150,450	142,500	5.6
£200m to £250m	163,300	147,500	10.7
£250m to £400m	180,000	167,500	7.5
Over £400m	212,500	191,400	11.0
All	**158,800**	**156,000**	**1.8**

Pay Data Conclusions

4.17 Pay comparisons should be treated with an element of caution. It could be argued that VSM posts in ALBs with whole system responsibilities like NHS England or CQC should be more highly remunerated than equivalent posts in local provider organisations, including NHS Foundation Trusts. However, on that basis SCS posts with national responsibilities should also be paid more. This illustrates the importance of taking into account factors other than job weight, including the degree of central control and influence over pay. Clearly where such central control is firmest (as in the SCS), pay rates tend to be

lower. Where pay decisions have been fully devolved (as with NHS Foundation Trusts), they tend to be higher. Within this diverse pay control environment the key test of adequacy is whether pay is at a level sufficient to recruit, retain and motivate staff of the talent and experience required.

4.18 ALBs are positioned closer to Government and the Department of Health than to NHS Trusts and Foundation Trusts. However, in terms of pay, the evidence would suggest that they are more aligned with the devolved sector. This may reflect the view of many ALBs that their primary recruitment pool for most ALB VSM is the NHS rather than the Civil Service. It will clearly be necessary to ensure that ALB VSM pay is kept under review to ensure it remains competitive with the relative markets, including the NHS. We do not yet have data on VSM pay in NHS Trusts and Foundation Trusts for 2013, but it is our expectation that the restraint exercised in the year to 31 March 2012 will continue in 2013 and beyond.

Annex A – NHS FINANCES

1. This chapter sets out the financial position for the NHS in 2014/15. Although as we have acknowledged the total paybill for very senior managers is much less than for other NHS staff groups, we also argue that their pay cannot be seen in isolation from what is happening in the wider NHS and it is therefore important that the SSRB is clearly sighted on the financial challenges facing the NHS as a whole.

2. Between 1999/00 and 2010/11 NHS revenue expenditure increased by an average of 5.5% in real terms. The first two years of the current spending review period (2011/12 and 2012/13) have shown subdued growth, averaging 0.7% per year in real terms.

3. Table 1.1 shows:
    - Outturn NHS revenue expenditure figures from 1999/00 to 2012/13;
    - Revenue Departmental Expenditure Limits (RDEL), as agreed in the 2010 and 2013 Spending Reviews, for 2013/14 to 2015/16.

Table 1.1 – NHS Revenue Expenditure since 1999/00

Year		Revenue Net NHS Expenditure (4)(6)(8) £bn	% increase	% real terms increase (7)
RB Stage 1(1)				
1999/00	**Outturn**	39.3	-	-
2000/01	**Outturn**	42.7	8.6	7.9
2001/02	**Outturn**	47.3	10.8	7.9
2002/03	**Outturn**	51.9	9.8	7.3
RB Stage 2(2)(5)				
2003/04	**Outturn**	61.9	-	-
2004/05	**Outturn**	66.9	8.1	5.2
2005/06	**Outturn**	74.2	10.9	8.9
2006/07	**Outturn**	78.5	5.8	2.8
2007/08	**Outturn**	86.4	10.1	7.4
2008/09	**Outturn**	90.8	5.0	2.2
2009/10	**Outturn**	97.8	7.8	4.9
Resource Budgeting - Aligned (3)				
2009/10	**Outturn**	94.4	-	-
2010/11	**Outturn**	97.5	3.2	0.6
2011/12	**Outturn**	100.3	2.9	0.6
2012/13	**Outturn**	102.6	2.3	0.8
2013/14	**Plan**	106.7	4.1	1.7
2014/15	**Plan**	109.6	2.7	0.8
2015/16	**Plan**	111.9	2.1	0.2

1. Expenditure figures from 1999-00 to 2002-03 are on a Stage 1 resource budgeting basis.
2. Expenditure figures from 2003-04 to 2009-10 are on a Stage 2 resource budgeting basis.

3. Expenditure figures from 2009-10 to 2010-11 are on an aligned basis.
4. Expenditure figures are not consistent over the period (1971-72 to 2014-15) and this should be noted when making comparisons between years.
5. Figures from 2003/04 include a technical adjustment for trust depreciation
6. Expenditure excludes NHS (AME)
7. GDP as @ 27/06/2013
8. Revenue is quoted gross of non-trust Depreciation and Impairments; prior to September 2007, revenue was quoted net of non-trust Depreciation and Impairments. This brings DH in line with HMT presentation of the statistics.

Share of resource going to pay

4. Table 1.2 shows the proportion of the increased funding that has been consumed by the Hospital and Community Health Services (HCHS) paybill over time.

Table 1.2 – Increases in Revenue Expenditure and the proportion consumed by paybill

Year	Increase in Revenue Expenditure (£bn)	Increase in HCHS Paybill (£bn)	Proportion of revenue increase on paybill (%)	Increase in HCHS paybill due to prices (%)	(£bn)	Increase in HCHS paybill due to volume (%)	(£bn)
2001/02	4.6	2.4	51	*7.0*	1.4	*4.7*	1.0
2002/03	4.6	2.4	51	*5.0*	1.1	*5.5*	1.3
2003/04	6.5	2.6	41	*5.0*	1.3	*5.4*	1.4
2004/05	5.0	4.5	91	*5.0*	2.3	*5.0*	2.3
2005/06	7.3	2.5	34	*5.4*	1.5	*3.4*	1.0
2006/07	4.3	1.3	30	*4.3*	1.4	*-0.3*	-0.1
2007/08	7.9	1.3	16	*3.5*	1.2	*0.2*	0.1
2008/09	4.4	2.5	57	*3.0*	1.1	*4.0*	1.4
2009/10	7.1	2.8	39	*1.8*	0.7	*5.1*	2.1
2010/11	3.0	1.5	49	*3.1*	1.1	*1.2*	0.4
2011/12	2.8	-0.5	-18	*0.9*	1.5	*-1.2*	-2.0
2012/13	2.3	0.6	26	*1.0**	0.4*	*0.5**	0.2*
Average	**5.0**	**2.0**	**39**	***4.2***	**1.2**	***2.8***	**0.8**

*. Provisional
1. Revised 2010/11 to 2012/13, following accounts restatements and exclude inter-company eliminations
2. Excludes ALB and DH core staff expenditure
3. Excludes GPs
4. Pay (price element) methodology changed from last year's evidence to maintain consistency of series.
5. Volume & Price estimates changes methodology in 2010/11 to make use of a more detailed staff group breakdown from ESR
6. Figures may not sum due to rounding.

5. On average, between 2001/02 and 2012/13, increases to the HCHS paybill have consumed 39% of the increases in revenue expenditure. Of this 39%, pay effects have consumed around 23% and volume effects around 16%.

6. HCHS pay is the largest cost pressure, accounting for 45% of revenue expenditure in 2012/13. On average it has also accounted for around 39% of the increases in revenue expenditure since 2001/02. As pay represents such a large proportion of NHS resources, managing the paybill is key to ensuring the NHS lives within the funding growth in has been assigned in the next 3 years.

Pressures on NHS funding growth

7. Different priorities compete for limited funding growth given to the NHS. They are grouped into three categories:

    - baseline pressures;
    - underlying demand;
    - service developments.

8. Baseline pressures cover the cost of meeting existing commitments that are essential for delivery of NHS services. They do not cover underlying demand, or increased levels of activity, which may arise due to demographic pressures or medical advance. Service developments are new areas of activity which arise due to new policies or ministerial commitments.

9. HCHS paybill pressures are the largest component of the baseline pressures and usually form the first call on NHS resources. Managing baseline pressures effectively allows the NHS to treat a growing, ageing population whilst making best use of the funding available.

Allocation of resources

10. Table 1.3 shows how funding increases have been allocated across baseline pressures, demand and service developments in previous Spending Review periods.

Table 1.3 – Disposition of Revenue Increase Across Expenditure Components

	Outturn			**Plan**	
	SR2004 £bn	**CSR2007 £bn**	**First 2 years of SR10 £bn**	**2013/14 £bn**	**2014/15 £bn**
Activity Growth	2.9	1.1	0.8	2.2	1.8
Service Development	1.6	1.7	0.3	0.5	0.5
HCHS Pay (Price only Component)	1.7	2.0	0.2	0.9	0.7
Secondary Care Drugs	0.3	0.4	0.3	0.4	0.0
Other (including central budgets)	0.3	0.1	-0.1	0.6	-0.5
Primary Care Drugs	0.3	0.3	-0.2	0.4	0.2
General Dentistry, Ophthalmic and Pharmaceutical Services	0.2	0.2	0.2	0.1	0.1
Procurement	0.1	0.1	0.9	0.3	0.1
General Medical Services	0.1	0.2	0.1	0.1	0.2
Funding for Social Care			0.5	0.2	0.2
Productivity	-0.3	-0.3	-0.4	-1.2	-1.3
Average annual increase in revenue	**7.2**	**5.7**	**3.7**	**4.2**	**2.5**

Note: SR2004 and CSR2007 activity growth numbers exclude purchases of healthcare from non NHS bodies, whereas they are included in the SR10 figures.

11. There is £2.5bn of increased revenue resources available in 2014/15 for the NHS to meet in-year pressures. This is lower than the previous 3 spending review periods, lower than the first two years of this spending review and lower than the planned disposition of resources for 2013/14.

12. The difficulty of allocating resources is therefore more acute than it has been in the previous 10 years. Of the £2.5bn available, demand pressures consume £1.8bn, even after an assumption that demand growth will be lower than in recent years due to the transformational activities being undertaken as part of QIPP. The remaining £0.7bn is assumed to be available for pay, with other cost pressures being absorbed by improved productivity (more than 4 times the rate of the previous 2 Spending Reviews).

13. A £0.7bn pay pressure is equivalent to an increase in pay costs of 1.5%. This contrasts with an underlying incremental cost pressure of 2% per annum contained within an assumption of overall pay drift of 2.5%.

14. Any increases in pay costs above this level would therefore have to be afforded by further increases in productivity and fewer staff employed. It is unclear how much further the NHS can go in reducing the number of non-clinical staff given the large reductions over the past 3 years and there is a real risk that underlying pay pressures in the system, even before any pay rise will have an adverse impact on the affordable clinical workforce.

Productivity

15. Improvements in workforce productivity are key to helping deliver the efficiency savings in this, and the next, spending review period. So far workforce productivity gains have contributed 12% of the total savings made in 2011/12 and 2012/13, compared to 23% which has come from pay restraint. The workforce productivity share of total savings is expected to grow to 26% in 2013/14 and 2014/15.

16. Despite improved productivity performance in the last two years, there still exists wide labour productivity variation at trust level.2 Levelling up performance as well as shifting the average trust performance upwards will help achieve the workforce productivity gains that are required. The level of resource assumed available for pay is predicated on this increased level of productivity in 2014/15.

[2] http://www.nuffieldtrust.org.uk/publications/anatomy-health-spending-201112-review-nhs-expenditure-and-labour-productivity

Conclusion

17. The NHS has received a better SR settlement than almost all other parts of the public sector, including a guarantee of real terms increases in funding in 2014/15. However, although generous compared to other departments, this represents the biggest financial challenge in the history of the NHS.

18. The NHS is delivering on this challenge and has so far met its savings targets in 2011/12 and 2012/13. There is still work to do in shifting the focus from centrally driven savings to transformational changes which will reduce the long term cost pressures on NHS services.

19. Pay competes for fewer and fewer available resources. Indicative pay cost growth of 1.5% in 2014/15 requires productivity higher than has been delivered over the last 3 Spending Review periods and reductions in the growth rate of demand in order to retain balance. Any increase in pay costs above this level will risk unfeasible reductions in clinical staff which may harm the ability to maintain access to and quality of NHS services to the public.

Annex B – VSM Pay in ALBs

Organisation	Minimum Pay Range £	Maximum[1] Pay Range £	Average Pay £	Median Pay £
ALB				
Care Quality Commission	110,000-114,000	235,000-239,000	151,697	133,616
Health Education England	95,000-99,999	190,000-194,999	123,517	115,000
Health Research Authority	120,000-124,999	120,000-124,999	120,000	120,000
Human Fertilisation and Embryology Authority	95,000-99,999	135,000-139,999	108,333	95,000
Health and Social Care Information Centre	90,000-94,999	180,000-184,999	120,574	115,599
Human Tissue Authority	70,000-74,999	100,000-104,999	83,379	80,093
Monitor	105,000-109,999	230,000-234,999	149,603	130,050
NHS Business Services Authority	105,000-109,999	150,000-154,999	123,831	117,500
NHS Litigation Authority	90,000-94,999	145,000-149,999	115,915	100,000
NHS Trust Development Authority	95,000-99,999	205,000-209,999	129,205	122,500
NHS Blood and Transplant	105,000-109,999	180,000-184,999	128,698	124,230
National Institute for Health And Care Excellence	105,000-109,999	180,000-184,999	125,255	117,500
NHS England	80,000-84,999	200,000-204,999	121,356	115,000
All ALBs	70,000-74,999	235,000-239,999	122,967	115,000
All CSUs	85,000-89,999	180,000-184,999	117,336	115,000

[1] The maximum pay range, does not in all cases relate to the CEO role.

Annex C – VSM Numbers by ALB

ALB	Number of VSMs
Care Quality Commission	6
17 CSUs	84
Health Education England	17
Health Research Authority	1
Human Fertilisation and Embryology Authority	3
Health and Social Care Information Centre	7
Human Tissue Authority	4.2
Monitor	8
NHS Business Services Authority	5
NHS Litigation Authority	5
NHS Trust Development Authority	31
NHS Blood and Transplant	9
National Institute for Health And Care Excellence	7
NHS England	211
Total	**398.2**

Ambulance Trusts	30

Annex D – NHS Pensions

Introduction

1. The Government is undertaking a range of changes to pensions for both public and private sector schemes. This includes changes such as single tier pensions, a review of the State Pension Age within the DWP Pension Bill 2013 and introduction of both auto-enrolment and the Public Services Pension Act 2013. This is a framework Act, building on the precedent of pensions legislation and based on the recommendations of the Independent Public Service Pensions Commission chaired by Lord Hutton. The Hutton report identified that people are living longer than ever before; today the average 60 year old can expect to live 10 years longer than in the 1970's, and therefore changes to public service pensions had to be made. As a result of improving life expectancy, the cost of pensions has increased by a third over the last 50 years. The Government's pension reforms aim to ensure public service pensions are sustainable, affordable and fairer to both public sector workers and taxpayers. The proposals for the 2015 scheme ensure that the NHS Pension scheme will continue to deliver a fair reward to staff and continue to support the retention and recruitment of staff.

Progress toward implementation of the 2015 scheme

2. Good progress has been made in partnership with the NHS Trades Unions, and NHS Employers in developing the new arrangements and agreeing the detailed business rules based on the Proposed Final Agreement. Additionally HMT have a process across the public sector schemes to ensure, where appropriate, there is consistency. We will use the business rules as a basis to develop the supporting regulations to implement reform to the NHS Pension Scheme. The regulations will follow a further consultation process. The 2015 reforms are based on the Proposed Final Agreement reached with the NHS Trade Unions, including Managers in Partnership (MiP) and published in March 2012. Long-term contribution rates remain under discussion, and all parties are working together to reach a common set of principles upon which any new proposals can be based.

3. DH have commenced the Valuation process, based on the available 2012 data, using the methodology to be confirmed in the HMT Valuation Directions which will be made under the Public Service Pensions Act 2013. The 2012 Valuation will need to be complete before the level of any pressure on the employer contribution from 2015 can be clear. The results are due to be published in spring 2014. In essence the key changes to be introduced in 2015 are:
    - career average; and

- higher pension age to align with state pension age.

Review into working longer

4. The NHS Pension Scheme Proposed Final Agreement included the provision that in the new scheme, for pension accruals post 2015, a member's Normal Pension Age (NPA) should be set equal to their State Pension Age (SPA). Since September 2012, to support implementation, there has been an on-going tripartite review between the Department of Health, NHS Employers and the NHS Trade Unions to address the impact of working longer in the NHS, with particular reference to staff working on the frontline and those with physically demanding roles.

5. The initial primary research, carried out by Bath University, identified a number of key findings that might feed into a final set of recommendations to DH. Further secondary research will provide evidence from NHS organisations, Trades Unions and NHS employees – the overall aim of this review is to identify and share examples of good practice that will enable staff to continue working to SPA. Partnership responses between unions and employers are being encouraged.

Changes in employee pension contributions

6. In addition to the new pension scheme from April 2015, in the Spending Review 2010 Government set forecasts for reducing net public expenditure on public service pensions through phased increases in members' contributions. The target savings to be delivered across all schemes were over a three year period from 2012/13 to 2014/15[3].The forecast savings for the NHSPS in particular were originally set out in Annex E of the Proposed Final Agreement (PFA) dated 9 March 2012 for 2012/13, 2013/14 and for 2014/15[4], attached at Annex B for ease of reference, based on an average 3.2 percentage point increase in member contribution rates being implemented by 2014-15.

7. Even with the increases in employee contribution rates, 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.

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[3] See table A.3 in https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/203828/Spending_Review_2010_-_statistical_annex.pdf

[4] See Annex E in https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/151957/dh_133003.pdf.pdf

8. It should also be borne in mind that if members choose to leave the scheme they will lose the current NHS employer contribution to their pension – currently 14%. Members would also give up their death-in-service benefits which may mean needing to review their life insurance arrangements.

9. 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 attached at Annex A. The evidence shows that there has been no significant change, and staff continue to value membership of the scheme. The auto-enrolment has also affected the opt-out position and it is difficult from the available data to disentangle the effect of the two policies. Overall, there has been an increase in scheme membership, in the region of 2.2% – 2.4%.

10. 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.Net of tax relief, the proposed 2013-14 contribution rates mean that a senior manager 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.

Table 1: Revised proposed increases in contribution rates as affecting VSMs

Full Time Equivalent pensionable pay	Contribution rate (before tax relief) 2013/14	Contribution rate (before tax relief) 2014/15	Contribution rate increase in 2014/15 (percentage point)
£49,473 to £70,630	11.3%	12.5%	1.2%
£70,631 to £111,376	12.3%	13.5%	1.2%
Over £111,376	13.3%	14.5%	1.2%

Table 2: Revised proposed increases in contribution rates net of tax relief as affecting VSMs

Full-time 2013/14 pay	2013/14 contribution net of tax relief	2014/15 contribution net of tax relief	Contribution increase net of tax relief (percentage point)
£60,000	6.78%	7.50%	0.72%
£80,000	7.38%	8.10%	0.72%
£130,000	7.98%	8.70%	0.72%

11. Separately the tax changes relating to lifetime allowance are having some impact on very high earners in the NHS PS. However there is no hard evidence to suggest that this is affecting the recruitment and retention of key staff roles, including senior managers.