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of Health

The National Health Service Pension Scheme (Amendment) Regulations 2014

Response to consultation

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Author:

Strategy & External Relations Directorate, Pay Pensions & Employment Services, Cost centre: 13710

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NHS staff and employers; independent, voluntary sector and “traditional” NHS Trust providers of NHS clinical services

Contact details:

NHS Pensions Policy Team
Department of Health
Room 2W09, Quarry House
Quarry Hill
Leeds, LS2 7UE

nhsregsapr14@dh.gsi.gov.uk

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Introduction

The Department of Health published for consultation a Statutory Instrument titled 'The National Health Service Pension Scheme (Amendment) Regulations 2014'.

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

- introduce new scheme access requirements for Independent Providers of NHS clinical services;
- introduce pensionable pay controls across both Independent Providers and other NHS employing authorities, to limit excessive pay rises that would otherwise distort final salary benefit calculations;
- enable interest and an administration fee to be charged on late payment of contributions by both Independent Providers and other NHS employers;
- apply increases to member contribution rates required by Government from 1 April 2014;
- accommodate HMRC Lifetime Allowance tax charge protection;
- make other miscellaneous & technical amendments.

This document sets out the Government's response to the comments received through consultation. Views were received on all of the proposed changes except the final section; miscellaneous and technical amendments.

1. Consultation Process

- 1.1 The consultation ran from 2 December 2013 to 10 February 2014.
- 1.2 Both the draft regulations and a document explaining the proposed changes were published on the gov.uk website, as well as the scheme's administrator's (NHS Business Services Authority) website. Impact assessments and equality analyses examining the proposed increases to member contributions, and the access provisions were prepared and are published alongside this response. Responses to the consultation were invited by email or post.
- 1.3 As part of the governance arrangements underpinning the NHS Pension Scheme, the major NHS Trade Unions were formally notified of the consultation. A workshop was held on 8 January 2014, facilitated by the Governance Group, which explained the proposals and received comments on the draft regulations. The workshop focused on the access provisions, and was attended by representatives from Trades Unions, NHS employers and independent providers of NHS clinical services.
- 1.4 A total of 45 responses were received. Amongst those were responses from individuals working within the NHS as managers, general practitioners, hospital doctors or consultants, and a nurse.
- 1.5 The majority of respondents (28) were writing on behalf of organisations or individuals engaged in providing NHS clinical services. A list of these respondents is available at Annex A.

2. Increase to member contribution rates from 1 April 2014

- 2.1 The consultation proposed a series of increases to member contribution rates from 1 April 2014. These increases are the third of three years of successive rises planned as part of the Government's programme of reforms to address the sustainability 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 Commissions, 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 that 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 The Government laid out a series of preferred parameters within which individual public service pension schemes develop their approach to achieving the required savings:

- There should be no increase in employee contributions for those earning less than £15,000 on a Full Time Equivalent basis;
- There should be no more than a 0.6 percentage point increase in 2012-13 for those earning up to £21,000, and no more than a 1.5 percentage points increase in total by 2014-15;
- There should be no more than a 2.4 percentage points increase in 2012-13 for high earners, and no more than 6 percentage points increase in total by 2014-15.

2.9 Within these parameters, the Department developed a preferred approach to structuring the increases, based on the principles of seeking 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 2014

2.10 The Department proposed to implement the following employee contribution rates from 1 April 2014.

Proposed 2014-15 employee contributions before tax relief (gross)

Full-time pay	2013-14 contribution rate (gross)	2014-15 contribution rate (gross)	Contribution rate increase (percentage points)
Up to £15,431	5%	5%	0%
£15,432 to £21,387	5.3%	5.6%	0.3%
£21,388 to £26,823	6.8%	7.1%	0.3%
£26,824 to £49,472	9%	9.3%	0.3%
£49,473 to £70,630	11.3%	12.5%	1.2%
£70,631 to £111,376	12.3%	13.5%	1.2%
Over £111,377	13.3%	14.5%	1.2%

2.11 The first pay band tier is increased in order to map onto Agenda for Change pay point 4 (£15,432). 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 2014-15, all staff earning a full-time equivalent salary of up to £15,431 will have no increase, whilst those earning between £15,432 and £49,472 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.

2.12 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.

Proposed 2014-15 contributions after tax relief (net)

Full-time pay	2013-14 contribution rate net of tax relief	2014-15 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	4.24%	4.48%	0.24%	4
£25,000	5.44%	5.68%	0.24%	5
£30,000	7.2%	7.44%	0.24%	6
£40,000	7.2%	7.44%	0.24%	8
£60,000	6.78%	7.5%	0.72%	36
£80,000	7.38%	8.1%	0.72%	48
£130,000	7.98%	8.7%	0.72%	78

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

Rationale for increasing member contributions

- 2.14 A number of respondents submitted views generally rejecting the need to raise contributions.

“UNISON strongly disputes that there is any evidence-based justification for the third year of increases to NHS Pension Scheme members’ contributions.”

Unison

“With the planned introduction of a CARE scheme in 2015...increases to the tiered contributions in 2014 are not justified.”

Consultant Radiologist

“RCN members continue to have grave concerns over the Government introduction of a 3.2% average increase in employee contributions over the period 2012/12 to 2014/15. An increase of this scale has no direct link to scheme benefits or liabilities and was taken outside of the NHS Scheme Governance arrangements.”

Royal College of Nursing

“This consultation has not arisen following a valuation of the NHS Pension Scheme and actuarial evidence so the RCM does not agree that there has been a rationale presented to justify increasing member contributions.”

The Royal College of Midwives

- 2.15 The increases to member contributions in 2014-15 complete the third of three years of phased increases to member contributions to the existing final salary scheme, before the move to the CARE (career average revalued earnings) scheme design from 1 April 2015.
- 2.16 The increases are needed to ensure that the scheme meets the requirement for all public service pension schemes to deliver savings equivalent to an average increase of 3.2% in employee contributions over three years from 2012-13 to 2014-15. The

rationale behind the increases is the need to ensure the longevity and sustainability of the scheme, and all public service pension schemes, in the longer term.

- 2.17 There was also a perception in some responses that the increase in member contributions constituted a tax on public service workers as part of the Government's approach to deficit reduction.

“UNISON believes the increases being imposed on member contribution rates have been devised to counteract the effect of the financial crisis, for which NHS Pension Scheme members were not responsible.”

Unison

- 2.18 This was not the Government's intention. Although the NHS Pension Scheme has no assets, the current level of contributions is based on an actuarial valuation using a method called SCAPE (Superannuation Contributions Adjusted for Past Experience). The contributions made by employers and pension scheme members are paying for the new pension promises being made to scheme members by the Government.

- 2.19 The increase is therefore not a tax but a consequence of the fact that the pension benefit individuals receive on retirement are increasing in value, mainly due to increasing life expectancy, and have done so over the previous decades. The cost of this has mostly been met by taxpayers. The increase in member contributions is designed to create a fairer balance between what employees pay and what other taxpayers contribute towards a public service pension.

“Because most of the increased costs to date, driven by longevity improvements in particular, have been financed by employers in the form of increased contributions, there is an argument that employees should pay a greater share of the extra cost, as they are the principal beneficiaries of this unexpected increase in the cost of their pension.”

Independent Public Sector Pensions Commission: interim report

Previous reform to the NHS Pension Scheme introduced in 2008

- 2.20 A number of respondents commented that the NHS Pension Scheme has already undergone changes designed to make it more sustainable for the future. They argue that the introduction of the 2008 scheme reforms means that contribution increases are unnecessary.

“In 2008 negotiated reforms were undertaken to the NHS Pension Scheme that would yield large savings for taxpayers and were estimated to reduce the future costs over the period to 2060 by £67 billion. The scale of these savings makes further radical reform avoidable.”

North Tees and Hartlepool NHS Foundation Trust

“The BMA is disappointed that the Government has gone back on the 2008 negotiated reforms to the NHS Pension Scheme that were already yielding large savings for taxpayers and were estimated to reduce the future costs over the period to 2060 by £67 billion. The blanket approach to change ignores the varying stages of reform and different funding profiles of the public sector pension schemes, particularly the NHS Pension Scheme.”

British Medical Association

- 2.21 Previous reforms of public service pension schemes have been insufficient to reverse the increasing costs associated with rising longevity. HM Treasury analysis³ of historic data from the Office for National Statistics shows that there have been huge increases in the cost of public service pensions over the past 30 years, from less than 1% of GDP in 1970 to nearly 2% now. Spending on public service pensions has begun to fall, as a result of all the reforms that have been implemented to date, including cap and share, higher pension ages for new entrants, and, more recently the change in indexation from RPI to CPI. However, even with all of these reforms, costs remain historically high. This is supported by the National Audit Office's analysis⁴.
- 2.22 The Government's view is that the 2008 reforms to the NHS Pension Scheme did not allow for the costs of increases in longevity to be managed fairly or sustainably. The agreement allowed then active members to remain in their existing arrangements with a pension age of 55 or 60, despite the improvements in longevity which they had benefited from. Future generations of NHS workers and taxpayers would have to pay for this, with a limited contribution made by beneficiaries in the form of higher contributions before retirement. For those with a pension age of 65, there was no provision for adjusting this to meet further longevity improvements. This cannot be fair.
- 2.23 The Government is of the view that the contributions made by members towards their pensions should generally reflect the benefits they receive and the costs incurred in providing them – including how long their pension is likely to be in payment.

Impact of increasing member contribution rates

- 2.24 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 the scheme as contributions are lost.

“The increase [in member contributions] has occurred alongside a period of NHS pay restraint which has seen the real value of our members pay fall. Since 2009 the loss in real terms has been in the region of 9%. The proposed rise for nurses of 0.3% for nurses earning between £15,432 and £49,472 may appear small but it is the compound effect of the rise that impacts on members.”

Royal College of Nursing

“Three successive years of contributions increases will do nothing to encourage individuals to save into the NHS Pension Scheme, particularly at a time of pay restraint which has seen a huge drop in the real value of our members' pay.

³ HM Treasury (November 2011), *Public service pensions: good pensions that last*, p6

http://webarchive.nationalarchives.gov.uk/20130410173120/http://www.hm-treasury.gov.uk/d/pensions_publicservice_021111.pdf

⁴ National Audit Office (December 2010), *The Impact of the 2007-08 changes to public service pensions*.

<http://www.nao.org.uk/report/the-impact-of-the-2007-08-changes-to-public-service-pensions/>

UNISON wants to ensure that members are encouraged to save in the NHS Pension Scheme and this is why we do not agree with the proposed increases.”
UNISON

“The third year of contribution increases is coming at a time when there has been continued pay restraint in the NHS, including a two year pay freeze and a pay cap of 1% last year. The RCM fears that the cumulative effect of pay restraint and high inflation combined with a third year of pension contribution increases will result in some NHS employees having no option but to opt out of the NHS Pension Scheme as they will be unable to afford it.”

Royal College of Midwives

- 2.25 Similar concerns were raised in response to both the 2012-13 and 2013-14 contributions increases. It remains the case that as an unfunded scheme, the exchequer 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.
- 2.26 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.
- 2.27 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.
- 2.28 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 continually 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.

“NHS Employers is not aware that the Governance Group has received any evidence to suggest that scheme opt-outs have increased as a result of employee contribution rate increases”.

NHS Employers

- 2.29 The latest data, and the trend throughout the period of increasing employee contributions, shows that there has only been a small increase in opt-outs, which are in-line with assumptions. The proposed 2014-15 increases have therefore been determined using the same approach as for the 2012-13 and 2013-14 increases. Given that opt-out rates have minimally increased, the data does not indicate that a change in approach is required.
- 2.30 One respondent pointed out the difficulty of implementing the contributions increases when there are also pay increments due to limitations in the electronic staff record system (ESR); meaning manual calculations must be made by either local payroll or pensions staff. The Department will explore this issue with NHS employers.

Disproportionate rises for higher earners

- 2.31 A number of responses to the consultation came from hospital consultants 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 tiered contributions for higher paid NHS health care staff are unfair and inequitable. They compare very poorly with those for other public sector staff and there is no good reason why health care staff should be discriminated against in this manner.”

Consultant Forensic Psychiatrist

“Focussing the largest increases on higher paid staff will disproportionately affect clinical academics.”

Universities & Colleges Employers Association

“There will be an increase in average member contributions from 6.6% to 9.8% of total pensionable pay in the NHS Pension Scheme over the three years to 2014-15. However, the impact on higher paid staff will be much greater, at the same time the scheme value has dropped for many.”

North Tees and Hartlepool NHS Foundation Trust

“There are big disparities in the proportion of the overall scheme benefits that members fund in the different public service pension schemes. Contribution rate tiers are higher and steeper for NHS Pension Scheme members. Under current plans, by April 2015, the NHS scheme will have seven tiers of contributions with a top rate of 14.5%, while the indicative contribution rates for the Principal Civil Service Scheme have four tiers with a top rate of 9%.”

British Medical Association &

North Tees and Hartlepool NHS Foundation Trust

(not a joint response, but a common paragraph to both organisations' responses)

“GPs, unlike consultants, are effectively in a CARE scheme so don't benefit from the final salary advantage that was used as the justification for steep tiering of doctors' pension contributions. As a part-time female GP my contributions count towards a relatively scaled down pension even though they may be as much as a full time male colleague.”

General Practitioner

- 2.32 The Department does not accept suggestions that the distribution of increases is 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.

- 2.33 High earners are also 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.

- 2.34 Net of tax relief, the proposed 2014-15 contribution rates mean that a member on a salary of £60,000 will only actually contribute 0.06% more than a member earning £30,000. The Department does not consider this a disproportionate outcome for high earners, as illustrated by the table below.

2014-15 contributions after tax relief (net)

Full-time pay	2013-14 contribution rate net of tax relief	2014-15 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	4.24%	4.48%	0.24%	4
£25,000	5.44%	5.68%	0.24%	5
£30,000	7.2%	7.44%	0.24%	6
£40,000	7.2%	7.44%	0.24%	8
£60,000	6.78%	7.5%	0.72%	36
£80,000	7.38%	8.1%	0.72%	48
£130,000	7.98%	8.7%	0.72%	78

- 2.35 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.
- 2.36 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.
- 2.37 The rules governing general practitioners' pensions are relatively complex; most if not all GPs have a period of service early in their careers that count as "officer" (final salary) service rather than "practitioner" (CARE) service – mainly during time in training when they are employed rather than self employed. This mixed service is subject to a number of calculations undertaken when the pension comes into payment, worked out in a way which always gives the most favourable outcome to ensure no detriment.
- 2.38 Part-time GPs are not disadvantaged; the practitioner CARE portion of a GP's pension is 1.4% (for 1995 section service) and 1.87% (for 2008 section service) of total uprated career earnings. Scheme contributions are paid on actual earnings, and the pension is calculated using those same actual earnings, after index linking at the annual rate of pensions increases plus 1.5%; the work pattern is therefore irrelevant to these calculations. For the periods of officer service referred to above, part-time service is accrued in strict proportion to the hours worked.

- 2.39 A GP respondent referred to having to also pay the 14% employer contribution on top of the contributions made as a scheme member;

“I do not think it is fair that doctors pay such a high proportion of their pay into contributions. As a GP I already pay the “employers” contribution of 14%. I do not think that on top of this I might be asked to pay another huge amount as “employee” contributions.”

General Practitioner

- 2.40 As employers, GP practices are required to pay the 14% employer contribution for all staff who are members of the NHS Pension Scheme, including GP partners who own the practice itself. As part of the contractual and payment arrangements agreed with the GP’s Committee of the BMA in 2004, GP practices are provided with the necessary funding to fully meet the required employers pension contributions as part of the “global sum” payment. It is therefore wrong for GP partners, who are in effect both employer and employee, to imply that they are required to fund their own employer contribution rather than the Government.

- 2.41 The consultation invited respondents to propose alternative ways of delivering the required savings through increased employee contributions within the parameters at paragraph 2.8 above.

- 2.42 In terms of NHS Pension Scheme contribution rates, the BMA proposed an alternative approach which essentially froze contributions at the 2013-14 rates for 2014-15. This proposal would not deliver the required savings equivalent to an average increase of 3.2% in employee contributions over three years from 2012-13 to 2014-15 and we are therefore unable to accept this proposal.

“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. This can be done 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 freezing contributions from April 2014.”

British Medical Association

- 2.43 NHS Employers’ response to this aspect of the consultation included both an alternative solution and a concluding paragraph which stated “NHS Employers confirms its support for the Department of Health to set out salary and pensionable earnings bands and corresponding employee contribution rates in regulations in line with its consultation proposals for 2014-15”.

- 2.44 The alternative solution (in addition to the Department’s existing proposal) involved an adjustment to the upper threshold of tier 4 (currently £49,472) to reflect the increase in the personal tax allowance in 2014-15 to £10,000.

“The natural place to revise the tier 4 to tier 5 threshold is at £47,846 – which is calculated by linking the point at which someone starts to pay tax at 40% (i.e. £41,865) to pensionable pay net of contributions (i.e. $£41,865 \div [1 - 12.5\%]$).”

NHS Employers

The impact of lowering the upper threshold of tier 4 from £49,472 to £47,846 would mean that members earning between £47,846 and £49,472 are moved from tier 4 (9.3%) to tier 5 (12.5%). Contribution rates (gross) for affected individuals would rise from 9% in 2013-14 to 12.5% in 2014-15, an increase of 3.5% which is more than double the rise proposed for any of the other tiers, and 3.2% higher than the Department's proposed increase of 0.3% for members in tier 4.

- 2.45 This alternative, additional, proposal in fact delivers more than the required 3.2% savings. The Department's view is that the general approach of ensuring a fair outcome across members means that rises should be kept to the minimum necessary to achieve 3.2% savings, which the Department's proposal achieves. There is also the possibility that changing tiers 4 and 5 in this way may lead to more opt-outs amongst the narrow group of members affected. For these reasons, the Department is unable to accept NHS Employers' proposal.
- 2.46 The majority of respondents also commented on the future structure of contribution rates that would apply to membership once reformed scheme arrangements are introduced in April 2015. The approach to contribution rates after 2015 is subject to ongoing discussion with Trade Union and employer representatives and is beyond the scope of this consultation.

Conclusion

- 2.47 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.
- 2.48 The vast majority of respondents were of the view that the proposed increases are unfair and unnecessary; as well as disproportionate for high earners. 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 2014-15 contribution rates mean that a doctor on a salary of £60,000 will only actually contribute 0.06% more than a nurse earning £30,000. The Department does not consider this a disproportionate outcome for high earners.
- 2.49 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 2014.

3. Lifetime Allowance Limit: Fixed & Individual Protections 2014

- 3.1 An individual can save as much as they like towards their pension but there is a limit on the amount of tax relief available. The lifetime allowance limit is the maximum amount of pension saving that a person can build up that benefits from tax relief. If the person builds up pension savings worth more than the lifetime allowance then a tax charge is payable on the excess.
- 3.2 The Finance Act 2013 amends the Finance Act 2004 to reduce the Lifetime Allowance Limit (LTA) from the current £1.5m level to £1.25m with effect from 6 April 2014. Transitional measures include two new protection facilities for individuals who would be affected by the new lower limit.
- 3.3 'Fixed Protection 2014' and 'Individual Protection 2014' work in a similar fashion to existing protections. The approach in NHS Pension Scheme regulations has been to supplement the Finance Act 2004 requirements with bespoke provision dealing with the administration of the LTA. The intention is to make clear the duties of the member and the scheme administrator regarding the quantification, deduction and payment of such charges.
- 3.4 The Fixed Protection 2014 facility is already available to members, however Individual Protection 2014 is subject to the passage of the Finance Bill 2014. The proposed amendments accommodate these new protection facilities within scheme regulations in a way that is consistent with the handling of other existing LTA protections.
- 3.5 Only a couple of comments were received on these amendments, with respondents in favour of the proposed changes. The Universities and Colleges Employers Association in particular welcomed the advance notice of how the scheme proposes to account of Individual Protection 2014.

"We appreciate the additional clarity that the draft regulations provide and that DH is ensuring that members can make full use of the new HMRC protections. It is also appreciated that the draft regulations are being made available in advance of the final Individual Protection regulations being laid."

Universities and Colleges Employers Association

- 3.6 Legislation enabling Individual Protection 2014 will not be in place before the draft NHS Pension Scheme amending regulations are laid before Parliament. Accordingly we will withdraw those parts of the regulations that relate to Individual Protection 2014 and confirm our intention to make these changes at an appropriate time later this year. However all other proposed changes concerning Lifetime Allowance protection will be made.
- 3.7 In addition, the Universities and Colleges Employers Association suggested changes to how the scheme administers Lifetime Allowance protection.

"In terms of notifying NHSPS once HMRC protection has been obtained, this process needs to be clearly communicated to employers and members. It may be

better for NHSPS to request information from members at the time protection is granted so it can be stored on the member's personal record rather than waiting until retirement. This would reduce the likelihood that protection is inadvertently lost, for example through automatic re-enrolment, and means it is more likely that the member has the information to hand."

Universities and Colleges Employers Association

- 3.8 We have considered this suggestion with the scheme administrator and conclude that the current arrangements remain appropriate. Whilst it might be practicable for members to inform NHS Pensions when they receive a protection certificate, the information is of no value to the scheme administrator without a check that the protection is still valid at the point that it is used – i.e. at a benefit calculation event. It is for this reason that the current process requests a copy of the certificate when it is required.
- 3.9 Moreover it remains the responsibility of members in receipt of protection to understand the terms of that protection and act accordingly. Even if notification of protection is held on file, the administrator is not required to inform the member as to courses of action that would preserve their protection in response to events such as automatic re-enrolment. That would constitute financial advice which the administrator is unable to give.

4. Scheme access for Independent Providers of NHS clinical services

Access Review

- 4.1 The consultation proposed opening the NHS Pension Scheme to Independent Providers (IP) of NHS clinical services from 1 April 2014, following an Access Review and recommendations to Ministers carried out by the NHS Staff Passport Group (SPG).
- 4.2 The SPG comprises representatives from the Department of Health, HM Treasury, NHS and independent sector employers, and the NHS Trades Unions. Ministers have accepted its recommendations, subject to suitable controls and a careful post-implementation review of the new arrangements.

Background

- 4.3 The Health and Social Care Act 2012 marked a key stage in the development of greater patient choice through delivery of NHS services from a wider range of providers, including IPs, made up of private sector providers, social enterprises and charities.
- 4.4 However, until now, the ‘pensions playing field’ has arguably been tilted away from new IP and towards NHS employers, with the latter able to join staff in the NHS defined benefit pension scheme at relatively low employer cost. IPs have been unable to join the Scheme, and faced up to double the cost to provide the “broadly comparable” pensions often needed to attract the staff required to deliver high quality NHS clinical services.

New Fair Deal

- 4.5 The Government’s reforms to the Fair Deal policy, introduced by HMT in October 2013, have done much to level the pensions’ playing field, with IPs now able to meet compulsory transfer obligations through the Scheme at the same cost as NHS organisations for staff wholly or mainly engaged in NHS work.
- 4.6 However, reforms to Fair Deal alone are insufficient to encourage the greater staff mobility required for a truly plural NHS market. For these reasons, the proposed final NHS agreement on 2015 pension scheme reforms, affecting all public service schemes, included a commitment to review access to the Scheme for new providers of NHS clinical services.

Summary of IP access proposals

- 4.7 From 1 April 2014, IPs who are not already Scheme employers and who meet relevant eligibility criteria (see paragraph 4.9 below) will be able to apply to the Scheme Administrator to become “NHS Scheme employing authorities” and auto-enrol their eligible employees in the Scheme.

4.8 Eligible IPs will be able to select the range of employees to be included in the Scheme from two options:

- “closed approval” basis – eligible employees who, within the 12 months before entering employment with the IP, were entitled to NHS Scheme membership, and
- “open approval” basis – all of an IP’s eligible employees

IP eligibility criteria

4.9 IPs requiring access to the Scheme will need to:

- apply to the Scheme Administrator for IP employing authority status from a forward date
- hold one or more NHS Standard or Alternative Primary Medical Services (APMS) contracts, or a public health related Local Authority contract to provide NHS clinical services
- automatically join in the Scheme all eligible staff, according to their declared access option
- confirm that they are seeking Scheme access for employees who are primarily engaged in the delivery of NHS clinical services.
- confirm that staff enrolled under either access option are engaged in NHS clinical services for more than 50% of their time
- arrange, if required by the Scheme Administrator following a risk assessment, an “IP guarantee” (for example a ‘bond’) with selected banks and other institutions, to provide cover for their estimate of 3 months’ employee and employer contributions, including a 10% margin for growth

4.10 The IP’s “open” or “closed” access selection will apply to all staff providing NHS contracts for clinical services for more than 50% of their time. The access level chosen will apply to all of the IP’s NHS contracts. IPs will be able to change their access option, subject to certain criteria and notice periods.

4.11 Access to the NHS Scheme will cost IPs and their eligible staff members the same as it does for all other Scheme employers and members. From 1 April 2014 employer contributions are 14% of pensionable pay and member contributions range from 5% to 14.5%, according to earnings.

Pension benefits built up by IP employees

4.12 IP scheme members will become entitled to the same personal and dependents benefit package available to other Scheme members. This will include redundancy pensions for IPs who provide them for staff who are over minimum pension age. The IP will be required to pay the capitalised lump sum representing the cost of early payment before the benefits can be paid.

Financial controls for new IPs

4.13 In order to protect the taxpayer and existing NHS employers, the full cost of opening the Scheme to IP employers and their staff will be closely monitored, in particular at

four-yearly Scheme Valuation points, in order to ensure that they bear an appropriate share of total costs.

4.14 Other routine controls will include:

- IPs will be allowed to pension up to, but normally no more than, 75% of their gross income from all their NHS clinical services contracts.
- IPs unable to justify excess pensionable pay over 75% will be required to pay an employer contribution surcharge on the excess income pensioned, of 12%
- The Scheme Administrator will be able to call for additional information from IPs and to make spot checks of pay and pension records if necessary.
- Evidence of an IPs non-compliance with regulations may lead to the adjustment of overall or individual pensionable pay figures and/or the termination of the IP's NHS Scheme employing authority status

4.15 The Secretary of State (normally the Scheme Administrator acting on behalf of) may withdraw access and terminate membership of staff if an IP fails in its duties and/or obligations under Scheme regulations.

Withdrawal of secondment to IPs

4.16 From 1 April 2017, arrangements by which Scheme employers can currently retain scheme membership for staff by seconding them to a non-NHS organisation will end, if those staff could now become scheme members using access under the new IP arrangements.

4.17 From April 2014 until 31 March 2017, a 'grace period' will apply to staff already seconded, so that current NHS contracts can remain valid until their expiry date. However, new staff seconded to organisations without employing authority status, on or after 2 April 2014, will only be accepted on an exception basis, with the agreement of the Secretary of State.

Financial controls for all NHS employers

4.18 From 1 April 2014, to facilitate IP employer access whilst protecting taxpayers and the scheme, some new financial controls will apply to all NHS Scheme employers.

Interest and administrative charges

4.19 Administration charges and interest will be introduced for Scheme employers who pay contributions late. Charges will apply only to arrears outstanding as at 1 April 2014 or later, and employers will pay no interest or administration charges if they pay their scheme contributions by the existing due dates, for example the 19th day of the month following deduction, for regular employee and employer contributions. The administrative charge will be £75 and reflect the cost to the Scheme Administrator of recovering delayed and unpaid contributions. The interest rate charged will be the Consumer Prices Index (CPI) + 3%, compounded annually.

Final pensionable pay increase cap

- 4.20 For members of the 1995 final salary section of the Scheme only, employers will in future be charged an “excess employer contribution” for the cost of pension (but not death) benefits calculated on pensionable pay increased beyond a new pay increase ‘cap’. The cap will be equal to the level of the CPI + 4.5%. The employer charge will apply to increases made above this cap, in one or more of the final three years prior to retirement. The cap will apply only for the purposes of the excess employer contribution, which will be the capital cost of the benefits due to the excess pay, obtained by multiplying the excess benefits by an age-related unisex factor, e.g. 20 for a member aged 60. The member’s pension benefits will NOT be reduced and will continue to be calculated on uncapped pay.

Determination of employer calculated final pensionable pay where this appears inordinately high

- 4.21 Existing powers in Scheme regulations allowing the Scheme Administrator (rather than the local employer) to determine final pay for benefits for part-time members where appropriate, will be extended to include the final pay in the 1995 regulations and reckonable pay in the 2008 regulations of whole-time members. Any pay determined excessive will be disregarded when calculating member benefits, and the Scheme contributions on that excess refunded to the employee and the employer.
- 4.22 When determining whether a member’s pay is inordinately high, the Administrator will be required to have regard to experience of typical NHS employment pay and progression in the ten years prior to retirement for members in similar positions.

Guarantees, indemnities and bonds

- 4.23 Existing powers allowing imposition of a guarantee, indemnity or bond for certain employers who fail to pay their scheme contributions will be made stronger and more flexible. The Scheme Administrator will in future be able to consider use of a guarantee for employers with a *previous history* of late or unpaid contributions, not just a current non-payment issue. However, if the Administrator considers a guarantee is necessary, they will now be able to impose a requirement that is proportionate to the circumstances, rather than the current all-liabilities requirement.

Responses to the proposal to open the Scheme to IPs providing NHS clinical services

- 4.24 In reply to the above proposals, over 40 organisations and individuals responded on over 20 different aspects of the changes.

Support for opening the scheme to Independent Providers

- 4.25 The overwhelming majority of those who commented on the merit or otherwise of opening the NHS Scheme to IPs, were in favour of the proposals and believed they represented a significant step forward in protecting the pension rights of staff moving around the wider healthcare sector, for example:

“This Trust is supportive of the widening of scheme access for independent providers of NHS clinical services, to the NHS pension scheme as this addresses some of the level playing field issues and TUPE issues which have been barriers to changes to and reconfiguration of provision of services to patients.”

Chesterfield Royal Hospital NHS Foundation Trust

“We would like to commend the extension of the access to the scheme for Independent Providers (IP) of NHS Clinical services. With the movement of staff between the independent providers and probably also back to NHS as contracts for clinical services are reviewed, this enables staff to maintain one pension scheme whoever their employer is.”

Guild of Healthcare Pharmacists

“We have many issues recruiting new, especially clinically qualified staff and suitably qualified senior management positions can also be problematic. This is largely due to the lack of NHS Scheme membership and, on this basis we would strongly welcome the ability to offer the scheme to our staff from April 2014”

Medway Community Health Care CIC

- 4.26 However, a few respondents described concerns contrasting with the positive views expressed above. For example:

“The NHSPS has always been identified as a beneficial tool for recruitment and retention of staff in the NHS. By extending the exclusivity of the NHSPS to IP’s it is weakening the NHS employer’s position.... There will be no security in the future of any IP - could be taken over, merged with another company or go into administration. No clear protection arrangements in place.”

University Hospital of South Manchester NHS Foundation Trust

“I do not support this. Whilst it may introduce a level playing field for independent providers, nothing is being done to address the constraints of NHS providers to make them on a level playing field therefore this widens the gap between NHS providers and independent providers further...”

Non-Clinical Partner / Practice Manager, Whitecliff Group Practice

- 4.27 The Department is pleased that the majority of responses were positive, whilst understanding that some existing NHS providers and GP practices might prefer it if IPs had been required to share their obligations to provide Agenda for Change (AfC) pay rates and the NHS Scheme to all eligible staff. The Department and the NHS is committed to providing good quality pensions and pay to all of its employees but cannot require private sector organisations to pay the same rate, where employees move to them voluntarily. However, the Department believes that the routine availability of the scheme and AfC in NHS Trusts and many GP practices will ensure that they remain attractive to staff and, over time, encourage increasing take-up by the private sector providers.

Freedom for IPs to choose their scheme access level

- 4.28 A number of respondents were pleased that IPs would be able to choose whether to provide the scheme to all their staff or just to those employees who had been eligible to join the NHS scheme within 12 months of joining IP employment. For example:

“In particular, we welcome the three level structure [note that ‘level one’ in the consultation document was New Fair Deal only access] proposed by the DH as a sensible system that enables independent sector providers to adopt a solution that is appropriate for their organisation and staff.”

Virgin Care

4.29 Not everyone agreed with this,

“...a key aim is to avoid a pensions ‘race to the bottom’, though we believe that by allowing too much flexibility for private sector providers to pick and choose which staff should be given access to the NHS pension scheme, this will remain an issue.”

Staff Side of the Social Partnership Forum Staff Passport Group

4.30 And a small number of respondents, whilst pleased to be able to offer the scheme believed they should have complete freedom of choice as to the employees who would be offered access.

“We request clarification as to whether IPs will have discretion about offering NHSPS to ALL joiners with previous entitlement to NHSPS within 12 months of joining the IP? For example, if an IP recruits, a previously NHS, professional accountant to “wholly or mainly” support an NHS contract, are they obliged to offer them NHSPS access? In the event that the 2014 regulations are highly prescriptive about this, IPs could be driven to establish a number of special purpose companies, each with differing ‘Access Levels’, so that their needs on differing contracts can be met. ”

Serco

4.31 The Department understands these contrasting positions but needs to implement arrangements that take into account the full range of stakeholder opinions and strike the best balance between:

- Option 1: requiring IPs providing clinical services to use the NHS scheme for all their staff, for example, even if they had already reward arrangements in place that their staff preferred
- Option 2: allowing IPs unlimited freedom to pick and choose which of their staff would be offered the pension scheme, and
- Option 3: allowing IPs to choose whether they use the NHS scheme, and if so at what level, but then requiring them to offer that to all their staff in all of their NHS contracts under that access level

4.32 The first option would see the Scheme seeking to intervene in the management of contracts those organisations and their staff. For example, compulsory Scheme membership could return former NHS employees to a position they had specifically chosen to move away from.

4.33 The second option 2 would have provided IPs with maximum flexibility, but was unacceptable to most current NHS providers, who are obliged to offer the scheme to

all staff. This was discussed in depth at the Staff Passport Group, and staff representatives in particular preferred to see scheme membership as a criterion for participation in NHS contracts. There was a general consensus that use of the scheme in this manner may lead to two-tier workforce pay and other equal treatment issues.

- 4.34 The third option 3 leaves decisions about use of the scheme in private sector IPs ultimately with those organisations, whilst making it possible and indeed encouraging IPs to provide their staff engaged in NHS clinical services with the same NHS scheme benefits available to NHS providers.
- 4.35 The Staff Passport Group recommended and the Department believes that option three is the most realistic and best balanced alternative available, and is the one likely to secure the greatest continuity of scheme membership over the medium to long term. However, IPs who may be thinking about setting up a range of companies so that they can select a different access level for each separate NHS contract must understand that that would fly in the face of the agreements reached in the Staff Passport Group.
- 4.36 As outlined in paragraph 4.2 there will be a review process in the first and fifth year following implementation. This will continue to consider the proposed approach and monitor how it is working in practice.
- 4.37 The regulations will seek to prevent apparently different companies (that are essentially one and the same company) from adopting varying access levels under each contract if it appears to the Secretary of State that the companies are in fact the same. The reasons for this are that an ‘access level per contract’ approach would in practise allow IPs to micro-manage scheme access, so that one particular employee or group of employees could be granted access whilst another similar employee or group of employees is excluded from membership.
- 4.38 Some very specific questions were raised by IP representatives about the likely impact of the new scheme access alternatives on NHS contract bidding processes, for example:

“Bidders will be concerned to know if offering “New Fair Deal staff only” pension terms will be judged by NHS commissioners to be less attractive, compared to other bidders who may be offering “closed” or “open” IP access. Alternatively, bidders may wonder if offering more than “New Fair Deal” access will be commercially risky, because any other approach would probably lead to increased pension costs.”

and

“We would welcome clarification of the ways in which commissioners will deal with competitive tenders where incumbent providers bid on the basis of TUPE transferring staff (currently pensioned under the provider’s GAD approved broadly comparable scheme) moving to the NHS Pension Scheme under New Fair Deal and a bulk transfer shortfall is deemed likely to arise.”

Association of Pension Lawyers

4.39 In responding to these questions it may be helpful to briefly reprise the three levels of access that IPs will need to consider in the future.

A. New Fair Deal - this level of scheme access is provided under the government's policy for dealing with pensions when staff are compulsorily transferred from a public sector scheme to an independent provider. In simple terms, staff compulsorily transferred from the NHS to an IP must, from 7 October 2013, be offered access to the NHS Scheme, normally arranged by means of a Pension Direction.

B. IP Access "closed" approval – this level of scheme access is optional. In simple terms, an IP that has been approved by the Scheme Administrator as a NHS employing authority can choose to routinely join in the NHS Scheme ALL their staff who have moved to their employment voluntarily and had, within the 12 months prior to joining the IP, been entitled to join the NHS Scheme

C. IP Access "open" approval – this level of access is also optional. An IP that has been approved by the Scheme Administrator as a NHS employing authority can choose to routinely join in the NHS Scheme ALL their staff, whether or not they have previously been entitled to join the NHS scheme

4.40 An IP is *obliged* to join compulsorily transferred New Fair Deal staff in the NHS Scheme. However, a decision as to whether or not an IP should also *choose* to offer the NHS Scheme to staff who join them voluntarily, is a strategic one they must make, taking into account the particular circumstances of the contract they are bidding for, including market position, costs and any recruitment and retention issues.

4.41 IPs wishing to view more information and guidance about obtaining a Pension Direction can do so at <http://www.nhsbsa.nhs.uk/Pensions/4327.aspx>

4.42 IPs wishing to apply to the NHS Scheme Administrator for approval as a NHS Scheme employing authority will shortly be able to view more information at <http://www.nhsbsa.nhs.uk/Pensions/4082.aspx>

4.43 IPs wishing to view more information about HM Treasury's New Fair Deal, including specific guidance for circumstances in which earlier fair deal, broadly comparable pensions and bulk transfer terms have applied, can do so at <https://www.gov.uk/government/publications/fair-deal-guidance>. This will be complemented by guidance specific to the NHS Pension Scheme which will be published on the gov.uk website shortly.

Should IP access be restricted to particular staff groups, for example doctors and nurses?

4.44 During the earlier stages of the Access Review, stakeholders considered whether IP scheme membership should be restricted, for example to clinical staff, or to staff who had been able to join the scheme within the 12 months prior to joining the IP. Some IPs argued that not everyone wanted NHS scheme membership any way and that most non-clinical staff would be prepared to work for an IP without the incentive of scheme membership. Others argued that some staff needed to maximise the pay they receive and would be reluctant pay NHS scheme contribution rates. However,

most stakeholders wanted to see scheme membership available to the maximum numbers and healthcare groups. For example:

“In order to deliver high quality services to the NHS we need to recruit staff with the best skills and experience from a wide range of staff groups. We consider all staff groups including support staff and those in back office functions to have an important role and would not wish to limit access to the NHSPS to particular staff groups.”

Provide

“In response to the questions in part 1.19, [the scheme] would be unfair and harder to administer if only some groups of staff are covered”.... one rule for all would be much safer. Staff from any part of the NHS could be involved...”

South Tees Hospitals NHS Foundation Trust

“We strongly believe that there should be the greatest possible compulsion placed on IPs to provide the NHS pension to their staff providing services to the NHS. Any changes that would give IPs even greater flexibility by enabling them to offer the NHS PS only to certain groups of staff, rather than all those delivering NHS services, places IPs at an even greater competitive advantage...”

Staff Side of the Social Partnership Forum Staff Passport Group

IP requirement to provide a three months contribution guarantee

- 4.45 The Department consulted on proposals that required all IP’s applying for NHS Scheme employer status to have in place a three months contribution guarantee, secured through approved banks and other institutions. No IP application would have succeeded without a guarantee in place. The guarantee requirement was intended to protect the scheme and tax payers against the risk of an IP defaulting on payment of scheme contributions. This would leave the scheme committed to payment of benefits to the IP employee, who would almost certainly have paid their own contributions to the IP from pay.
- 4.46 The guarantee requirement has been unpopular with IPs from the early stages of the Access Review and a number of comments have been received in consultation. For example:

“IHAS/NHSPN supports the suggestion that IPs should not need to provide a bond unless they have failed to pay charges already. IHAS/NHSPN also agree that bond requirements may be harder to meet by smaller/new providers. New providers are key to innovating and being more efficient and so we need to encourage them to enter the market, not put up barriers.”

NHS Partners Network/Independent Healthcare Advisory Services

“As a small social enterprise we have looked at the annual cost of providing the guarantee, which could be as much as 2% per annum of the funds guaranteed. For Ripplez, the approximate contribution guarantee required would be The interest we receive currently on such a deposit is only 0.3% per annum.”

Ripplez

“...guarantees create imbalance in the fair playing field between IPs and ‘NHS’ providers in any of the forms proposed, with a direct impact on a provider’s cash

flow and any returns, adding additional costs to IP delivery compared to an NHS provider. We understand that the scheme will secure contractual mechanisms requiring commissioners to deduct and pay over an IP's unpaid pension contributions. With this protection in place, it is our view that the automatic requirement for bonds for access would be unfair and should be restricted to instances where there have been clear past failures by a provider to pay scheme contributions.”

Virgin Care

- 4.47 The Department has listened to the concerns about providing guarantees described by IPs and worked to secure alternative means of providing scheme and taxpayer assurance against default on payment of pension contributions.
- 4.48 IPs will not now be routinely required to provide a guarantee as a criterion for scheme access. The Department is satisfied that many IPs would find it difficult to secure suitable guarantees at reasonable cost, and that providing such cover would, as claimed, tie up IP capital and potentially drive up costs to the NHS in a counter-productive way.
- 4.49 Instead, the first line of defence will be close working between the scheme and contract authorities, who will be notified immediately arrears of scheme contributions or other compliance issues arise, and recover unpaid scheme contributions from service fees due to the IP in the event of arrears building up. In addition, prolonged non-payment exceeding three months will result in the termination of the provider's NHS employing authority status.
- 4.50 Finally, the Scheme Administrator will retain the power to impose a guarantee where the IP has a current or previous history of payment problems, or he has grounds to believe that the provider is or may be unable to meet their obligations under the scheme.

Nature of an IP “qualifying contract”

- 4.51 A small number of respondents were concerned that the proposed confinement of an IP “qualifying contract” to an IP who holds either a NHS Standard Contract or an Alternative Personal Medical Services (APMS) contract, where that provider is not already able to pension APMS contracts, would be too restrictive. For example:

“We would urge the Department to revisit the definition of ‘qualifying contracts’ in the Regulations so that those services commissioned by Local Authorities are included and further, that the threshold, currently suggested at 75%, is not just applicable to income from the NHS Commissioning Board but also Local Authorities.”

Virgin Care

- 4.52 The Department agrees with respondents that an IP “qualifying contract” should mean all of its NHS-funded contracts, including Local Authority (LA) contracts where these are awarded to an IP in pursuance of a LA's public health obligations under the 2006 Health Act, funded by NHS England. The definition of a “qualifying contract” under the regulations has been amended accordingly.

- 4.53 IPs will be able to hold one or more NHS Standard, APMS or public health related Local Authority contracts or a mix of all three.

75% pensionable pay threshold

- 4.54 Several IPs had questions about the way in which the proposed 75% pensionable pay threshold would operate and what would happen if an IP expected to exceed the limit, for what it saw as legitimate reasons. For example:

“...we currently provide a Family Nurse Partnership programme, licenced by the Department. This service is a home visiting programme and our greatest expense is the cost of employing staff. Our forecast for next year is that pensionable salaries compared to NHS income will be 77%. The guidance was unclear as to whether we could get relief from the 75% cap if we can justify our operating model”

Ripplez

“We are not clear how the proposed 75% pensionable income rule will work?”

Medway Community Health Care CIC

- 4.55 The 75% pensionable pay threshold has been introduced to ensure that when services transfer from traditional NHS Trust to IP providers the pensionable pay that becomes pensionable under the scheme and attracts a 14% employer contribution remains broadly the same. The threshold figure chosen is the proportion of the total NHS funding that the IP receives in respect of its relevant NHS qualifying contracts. In the average NHS Trust setting, around a net 66% of total NHS funding remains available to spend as net pensionable pay for staff, once the organisation's expenses for premises, medical materials, national insurance and employer contributions to the NHS Scheme are deducted. This means that the 75% pay threshold chosen for the maximum pensionable pay limit should be relatively generous, given, in particular, that not all of an IPs staff may be engaged in the delivery of NHS clinical services for more than 50% of their time, and that a higher expenses ratio may often apply in some of an IPs contracts, so that an unusually low figure in other contracts can be offset.
- 4.56 However, the Department has accepted that it is possible that an IP may, in certain circumstances and in certain years, find that its pensionable pay level exceeds the 75% limit for legitimate reasons. For example, a nurse led community services operation in which premises, supplies and expenses other than pay are lower than average. In these circumstances, an IP will be able to provide the Scheme Administrator with additional relevant income and expenditure evidence of its pensionable pay total. If the Scheme Administrator is satisfied with the evidence provided, the IP will be able to pension either all or at least some of its pay in excess of the limit.
- 4.57 Where the Scheme Administrator is not satisfied with the evidence provided for some or all of their over limit pay, the IP will be required to pay an additional scheme contribution of 12% on the excess.
- 4.58 One respondent saw the imposition of an excess scheme contribution as an additional flexibility that traditional NHS providers could not share:

“IP’s may operate a very flexible payment structure, including bonus schemes/PRP/profit sharing, etc, resulting in significant fluctuations in salary year on year, not necessarily seen in NHS Trusts. Despite the ‘75% pensionable pay threshold’, IP’s have the option of paying a contribution surcharge on the excess, which could undermine the scheme’s stability.”

University Hospital of South Manchester NHS Foundation Trust

- 4.59 The Department understands the last point but, in practise, even an IP that is prepared to meet the 12% extra employer contribution charge in respect of pensionable pay over the 75% limit, will be unable to do so for long. The threshold regulations contain an additional provision that will authorise the Secretary of State to terminate an IP’s employing authority status if they continue to pension pay in excess of the 75% limit for any three years in a period of five years.

Control of IP secondment access

- 4.60 Several respondents expressed concern about the proposal to close down, within one year, arrangements under which a small number of IPs have secured scheme access for staff by arranging their secondment to the IP to perform NHS clinical services from an existing NHS Scheme employing authority. For example:

“Queries have been raised as to whether recruits hired to an existing RoE/secondment arrangement made prior to 1st April 2014, but joining after that date, will have scheme access?”

Capsticks

“Care UK has some secondment arrangements which will expire 18 months after 1 April 2014. Might the Department exercise its discretion to allow ROE/secondment to continue with access to the Scheme? Or will we be forced to undertake a TUPE transfer to deal with the last 6 months of the arrangements?”

Care UK

“The consequence of retaining the existing B3 prohibition alongside the new provisions may be to effectively outlaw those Retention of Employment/secondments that were expressly permitted, pursuant to the exercise of the Secretary of State’s discretion under regulation 8(7)?”

Association of Pensions Lawyers

- 4.61 Since the existing ‘scheme access via secondments’ used by a few IPs constituted a ‘loophole’ arrangement, the Department believed that permitting existing arrangements to continue for a further year until April 2015 was a measured response. However, several IPs noted that secondment arrangements may apply to NHS contracts exceeding one year (typically up to three) and that a grace period this length may mean prematurely unravelling and replacing existing contracts with the relevant commissioners.
- 4.62 The Department agrees that contract re-negotiation would be a perverse impact of seeking to regularise secondment access quickly, and so the regulations will now provide for a grace period" extended from one to three years.

- 4.63 The longer grace period will mean that scheme membership under the secondment arrangements may, if the organisations conclude this is appropriate for them, continue until 31 March 2017, for all staff seconded on or before 1 April 2014. The regulations will cover staff seconded on (not just before) 1 April 2014, to ensure that staff working on new contracts already arranged to commence from that date will be covered.
- 4.64 Any staff newly hired to such an arrangement after 1 April 2014 will be excluded from the 'grace period' and so cannot routinely be made pensionable. However, the Secretary of State has taken powers to approve secondment access in these and other circumstances if, exceptionally, he believes that such approval is appropriate.

Permitted secondment and powers to approve restricted secondment, exceptionally

- 4.65 The Department wishes to remind IPs and other employers that the introduction of changes from April 2014 for IP secondment access does not mean that all retention of terms and conditions of employment during secondment, including NHS Scheme membership, will cease after expiry of the extended 'grace period' in April 2017. Continued scheme access during formal secondment of an employee from an NHS employing authority to a non-NHS employing authority (where that person remains an employee of the NHS employing authority) will continue to be available in circumstances *other* than those described in regulation 3 of the 1995 regulations and regulation 2.B.2 of the 2008 regulations. Those circumstances are compulsory transfer from a NHS employing authority and work with an organisation that could from April 2014 (if it chose to) apply for IP employing authority status.
- 4.66 The new arrangements will also have no impact on the Secretary of State's existing powers to permit retention of access following a compulsory transfer, exceptionally. This will apply both to cases in which such authority has already been granted by the Secretary of State and any that might arise in the future.

Simplified scheme admission and access arrangements and requirement for IP staff to be more than 50% engaged in NHS clinical services

- 4.67 One of the specific questions posed to stakeholders in the consultation document was whether NHS employers believed that the scheme admission and access control arrangements proposed could be simplified, without weakening necessary safeguards for tax payers and the scheme. Some respondents appeared to be broadly satisfied with the proposals made, for example:

"In relation to the specific questions you have asked, the scheme controls seem adequate and not overly bureaucratic."

Plymouth Community Health Care CIC

- 4.68 A few IPs wanted further details as to how the Scheme Administrator intends to monitor the requirement for IP staff to be more than 50% engaged in NHS clinical services, for example:

"It is not currently clear how the admission of staff will be monitored to ensure those not wholly or mainly engaged in NHS work are refused entry to the Scheme. Monitoring will undoubtedly be complicated and resource intensive. We would

therefore support simplified arrangements providing appropriate financial controls.”

Provide

- 4.69 Other respondents expressed a general concern about the potential costs of IP monitoring and record keeping requirements, for example:

“We are unclear how you would resource the control arrangements proposed in the consultation documents and are concerned that the cost may be passed on to employees or organisations. We would therefore be supportive of simplified and less resource intensive arrangements which met the same ends”

Medway Community Health Care CIC

“We would encourage the DH to think about whether issues like spot checks could be best dealt with through Monitor's licence. It is important to monitor providers but also to keep reporting to a minimum so that information already being reported under the licence regime could also be used for the pension scheme.”

Independent Healthcare Advisory Services

- 4.70 The Department agrees that the best administration arrangements are simple and transparent ones that all parties can understand and carry out effectively. However, there is some tension between the natural desire of most IPs to operate in a 'light touch' regime that permits great flexibility and the needs of the Scheme and taxpayers to avoid inappropriate scheme use and manipulation of a final salary pension arrangement that, notwithstanding the 2015 move to a career average basis, other commitments mean will be in use for large numbers of members for many years to come.
- 4.71 As a result of consultation feedback, a number of procedural easements have been made, including the elimination of the mandatory guarantee requirement for the majority of IPs, allowing the Scheme Administrator to operate a greatly streamlined IP approval application process, and a reduction in the initial data gathering and end of year return requirements.
- 4.72 Other easements agreed ahead of consultation had included:
- adoption of the same, wholly or mainly NHS rule for (more than 50%) for IP access as that used applied to New Fair Deal assessments
 - measurement of that wholly or mainly rule at mainly annual intervals, to permit flexible day to day IP deployment of resources
 - measurement of the 75% pensionable pay limit across all of an IP's NHS contracts, rather than each contract individually, and
 - a focus on pension specific, rather than wider contract, issues for IP access data collection
- 4.73 It is difficult to agree further simplification measures ahead of implementation in what is a completely new organisational area. However, the Department is committed to regular post-implementation reviews of the policy and regulations, the impact for stakeholders and the scheme and the experience gained of administration procedures in the early months. The Scheme Administrator will monitor application and pension record keeping in particular and these and other issues will be discussed and revised

as required in the NHS Staff Passport Group, formally at 1 and 5 year intervals and at other times as required.

- 4.74 The Department agrees with respondents that sharing data with contract commissioners that may assist with pension assessments makes sense. The Department will ensure that further efforts are made in this regard to reduce duplication of data collection wherever possible.
- 4.75 In answer to further specific questions raised by respondents, the Scheme Administrator will monitor NHS engagement levels, permitted pensionable pay and payment of contributions by regular reviews of IP scheme data and receipts and close liaison with contract commissioners to determine the level of NHS funding flowing to each IP and compare this with average or relevant NHS Trust levels. Problems with the data will result in the Scheme Administrator making enquiries with the relevant IP and if necessary the contract commissioner(s). Where this proves insufficient to resolve the identified problems, the Administrator may also call for further information.
- 4.76 It is again important to remember that the wholly or mainly NHS rule applies in the main to mixed contract working where the IP employee undertakes both NHS and non-NHS work for their IP employer. In such circumstances the employee must over the course of a year work for more than 50% of their contracted time with the IP to be pensionable in the scheme and to remain eligible for membership, e.g. 19 hours or more per week under a 37 hours per week contract.
- 4.77 However, if the above proves problematic, and the IP employer and the employee are prepared to operate 'split' (i.e. separate NHS and non-NHS) contracts, a lower, effectively part-time, rate of NHS engagement is permitted since non-NHS, private sector earnings will then be kept separate.

Responses to the proposed regulation D3 excessive final pay control affecting ALL NHS employers

- 4.78 Some of the additional financial controls needed to permit the opening of the scheme to IPs will apply to all NHS employers for reasons of equal treatment and improved scheme management. The proposals impacting final pensionable pay assessment for benefit calculation purposes attracted the largest single number of responses to consultation. Some of these concerned the general principle of additional employer charges and controls in a mutual scheme, for example:

"Our view is that the employer contribution recognises that the 1995 section is a final salary scheme and no charges or compensations should be levied."

Chesterfield Royal Hospital NHS Foundation Trust

"In our view, the proposed changes will have an adverse financial impact through the employer's charge where an employee legitimately has an increase in salary prior to retirement. This will not be covered through the NHS payment mechanism and will represent a step change in operating costs."

Healthcare Financial Management Association

- 4.79 However, most respondents were particularly concerned about the effect of the new employer charge when increases in pensionable pay that will exceed the annual

permitted Consumer Prices Index (CPI) plus 4.5% level, are made in one or more of the final three years prior to retirement or termination of scheme membership. For example:

“...we understand the rationale for this proposal but in the present climate, 4.5% plus CPI is not an adequate differential and the proposal will penalise employers with a legitimate reason for increased pay, such as a clinical excellence award, or a phased retirement plan to move front line staff into non-front line roles attracting a different package in the interests of passing on skills and expertise.”

Derby Hospitals NHS Foundation Trust

“the introduction of the “virtual cap” is unfair to employees as it may stifle staff progression. It is also unfair to employers who may be charged for rewarding staff in a fair and equitable manner. Issues include salary sacrifice schemes open to all employees, however if an employee in their final 3 years cancels an expensive car this could result in an over cap pay award. There may also be impact on normal reward practices and salary sacrifice for younger staff not within three years of retirement, who opt out of the scheme, for example for tax reasons. At a much later date, would the Trust incur the virtual cap payment?”

South Tees Hospitals NHS Foundation Trust

“the RCM is slightly concerned by the proposal to charge employers for the cost of pension benefits calculated on any pay increases they make which are greater than the proposed cap of CPI plus 4.5% in any of the final three years before retirement. We are concerned that employers may withhold career progression from individuals who they believe are near to retirement... As individuals will only earn their increment for one year at a time they could do so one year, not the next, then earn it in a third year. If this happened there is a chance they could breach the cap and their employer will be charged.”

The Royal College of Midwives

“...it is acknowledged there is public benefit in protecting the Scheme from employers who award excessive pay rises in the last three years of service to increase final salary pension for specific members. However the proposed control will introduce perverse financial incentives for employers to withhold awards and staff benefits like salary sacrifice on the grounds it may create additional employer costs. There may also be a substantial risk of tribunal actions being taken (with additional costs/liability) alleging potential age discrimination against members seeking salary sacrifice/promotion close to retirement”.

Northumbria Healthcare NHS Foundation Trust

- 4.80 The Department acknowledges the strength and range of views expressed about the proposed final pay control but is satisfied that the numbers of members and their employers affected will be relatively small and that the arrangements implemented will be both fair and proportionate.
- 4.81 The final pay controls formed part of the discussions in the Access Review and were considered essential if the scheme was to be opened to IP employers, for whom the Secretary of State has little or no influence on pay awards and progression. The controls are being applied to all NHS employers for equal treatment reasons, and because of clear evidence from the Scheme Actuary that pay for benefit calculation

purposes increases disproportionately for a significant number of members in the final three years prior to retirement. The cost to the Scheme in lifetime benefit payments of these larger than average pay increases close to retirement are very significant, and cannot be recovered from increased member contributions during the short period involved. Currently, the additional costs fall to all employees and employers and contribute to increased contribution rates across the board.

- 4.82 The Department believes that it would be unfair for other employers and members who receive no gain from the increased benefits generated, to bear the costs. We are also satisfied that the employer who creates the increase in scheme costs should take account of and reimburse those costs, not the employee.
- 4.83 A number of respondents asked why the control was being introduced now, when a career average (CARE) pension arrangement is due to be introduced from April 2015. Respondents also wondered whether imposing the control on the 1995, but not the 2008 section final salary arrangements would be seen as discriminatory.
- 4.84 The move to a CARE arrangement *will* in the future remove the opportunities for excessive or disproportionate benefits to be generated. However, the transitional and protection arrangements that apply when the new scheme is introduced in April 2015 mean that a very significant number of scheme members, including many moving to new IPs, will remain entitled to accrue their benefits in the 1995 section of the scheme after 2015. Even the majority of other members who will be automatically transferred to the CARE scheme for their service from 2015, will retain significant deferred service in the 1995 section, for which a final salary on retirement link will be honoured.
- 4.85 The 2008 section of the scheme also contains a final 'reckonable pay' benefits arrangement, but this averages the best consecutive three years pay in the members last ten pay years and so the impact of any one high, single year, pay increase is significantly reduced. However, the introduction of further final pay controls for 2008 section service could be re considered, if future evidence suggests this is necessary. The existing CARE pension arrangements in the 1995 and 2008 sections of the scheme are also relatively proof against benefits manipulation and no further controls are under consideration.
- 4.86 The responses indicate that a number of employers believe that the proposed control will unreasonably restrict their freedom to pay normal, justified pay increases, for example on promotion or re-grading of staff close to the normal pension age of 60. The Department acknowledges that current employer flexibility in this respect will be reduced. However the proposed cap level of CPI+4.5% gives reasonable headroom to accommodate most increases to pensionable pay. A majority of staff are routinely receiving pay increases very much lower than the cap and those in receipt of normal pay increments the change in pay level is unlikely to trigger an employer charge. And for staff who are being rewarded for specific purposes, significant year-on-year increases remain possible without additional employer charges, for example a total of around 20% over a three year period, based on the CPI+4.5% annual limit. However, payment of a single year increase at that total level would recoup minimal extra pension contributions and so trigger an employer charge.
- 4.87 Several employers asked if promotion and re-grading increases might be excluded from the new pay control but the Department has concluded that it will be

impracticable to consider pay increases on a case-by-case basis, and that to attempt to do so for 'special cases' would quickly result in all significant pay increases being regarded as special.

- 4.88 Charging the employer for excessive pay increases, rather than for example unilaterally declaring the member's excess pay for benefits non-pensionable, does mean that an employer remains free to make an over-cap award, provided they are prepared to recognise and pay for the full pay *and* scheme costs of the increase.
- 4.89 Several respondents suggested that the proposed control might represent age discrimination, directly or indirectly. The Department is satisfied that the proposed final pay control does *not* discriminate on age grounds. This is considered in more detail in an equality analysis available at:
<https://www.gov.uk/government/consultations/amendments-to-nhs-pension-scheme-regulations>
- 4.90 An over-cap pay increase during a member's final three years of service will be considered for additional employer contributions whatever the age of the member on termination of service. Also there will be no detrimental impact on member benefits, whatever the rate of pay increase or employer charge levied. Employers should be aware that a claim of age-discrimination might be brought against them if it could be shown that age had been a criteria in offering (or not) a member promotion, or if they have refused to pay an older person the same increase in pay that would have been made available if that member had been younger.
- 4.91 Conversely, some employers suggested that allowing the new pay control to 'bite' on a member's final three years of service, irrespective of their age at termination, risked perverse impacts and unexpected employer charges well before the period most members might be expected to retire. The Department understands these concerns but cannot exclude deferred periods of service without giving rise to potential age discrimination. Excluding deferred members would also present a significant 'loophole', by means of which employees and employers arranging a large pay increase could avoid an employer charge by leaving service or opting-out of the scheme at a suitable point. In practice, few members leaving service do so after receiving a large pay increase and many of those who do leave on deferment, eventually return to the NHS and scheme membership, which will 'cancel out' the effect of an earlier excessive pay increase.
- 4.92 Other employers expressed concern about the potential impact of final pay control on "salary sacrifice" (SS) schemes. These schemes allow employees who accept lower pay in exchange for other non-cash rewards, to also benefit from lower pension contributions and national insurance. The employer normally also benefits from lower employer pension contributions and lower national insurance contributions. If a scheme member's benefits are later calculated using the lower pay after SS, those benefits will also be lower. However, if a member withdraws from their SS a year prior to retirement or deferment, and returns to higher pay, national insurance and scheme contributions, their benefits will be unaffected. Employers are concerned that under the new pay controls, a resumption of former, higher pay at this point may give rise to an excessive pay increase and employer charge and ask if these circumstances can be excluded from the control.

- 4.93 The Department has carefully considered the above arguments and concluded that SS schemes cannot be exempted from the final pay control. If a SS scheme is terminated earlier in career as, for example, it frequently would be for a 'child care vouchers' scheme, the higher than normal increase in pay at termination of the SS would be absorbed before the member's retirement and no employer charge will arise. Similarly, no employer charge will be generated if for example, a senior manager who has accepted an official car for SS purposes releases that car either on the last day of their service or three or more years before retirement. In the first case pay and benefits will be reduced but there is no step increase in pay and so no charge. In the second case, pay, scheme contributions and benefits built up will all resume their former levels, but since the change will fall outside the member's final three years, no employer charge would apply.
- 4.94 However, SS schemes terminated during the final three years of service for all reasons other than death must count for final pay control purposes.
- 4.95 A number of respondents were concerned about the impact of these changes on awards recommended under the consultants clinical excellence award (CEA) arrangements and asked if they would be exempted from final pay control. The Department has carefully considered the impact of pay controls for CEA and concluded that they should not be exempted. However, in response to consultation, any employer charge generated as a result of a national CEA recommended by the Advisory Committee on Clinical Excellence Awards (ACCEA) will be billed directly to the Department's funding body responsible for national CEA, not the local employer. However, pay increases due to local CEA recommended by the employer *will* count for pay control purposes, like any other local pay increase. It is worth remembering though that the majority of consultants who progress through CEA levels, one stage at a time, whether for a local or a national award, will not normally trigger a local employer or an ACCEA generated charge.

Pay control easements agreed before and during consultation

- 4.96 Normal moves between genuinely different employers and to a higher rate of pay will not be counted for pay control purposes.
- 4.97 Transfers to the Scheme in England and Wales from another health service scheme (for example Scotland or Northern Ireland) will also be excluded.
- 4.98 Excessive pay increases already agreed and paid to members before 1 April 2014 will not be counted for pay control purposes.

Responses to the proposed C1 (1995) and 2.A.12A (2008) regulations restricting inordinate pay affecting ALL NHS employers

- 4.99 There were few responses to the other main pay control proposed. This refers to the new provision under which the Secretary of State will be able to declare pay for benefit purposes for a whole-time member non-pensionable, if figures supplied by the employer produce a result which appears in appropriate or inordinate. One employer made the following point:

“...for the Scheme Administrator to determine the final pay of part-timers could cause difficulties for employers as they would be providing estimates for staff based on payroll data and staff make decisions relating to these estimates, which could then be disregarded by the NHSP. The assumption appears to be that the Department believes employers are too generous with their part-time calculations!”

South Tees Hospitals NHS Foundation Trust

4.100 The above response is not the reason for the new control. Like the similar provision already in place for part-time members, the new control will be used *on an exception basis only* where pay figures appear wholly inordinate having regard to experience for members in similar appointments and circumstances. If any pensionable pay is discounted, appropriate employee and employer contributions will be refunded.

4.101 This new provision does not overlap with the regulation D3 final pay control arrangements described above.

Interest and administration charges on delayed payment of contributions affecting all NHS employers

4.102 These arrangements prompted few responses, with the majority of employers already paying over their employee and employer contributions to the scheme on time, and clearly acknowledging that this is a reasonable expectation for any pension scheme.

4.103 A number of small additions have been made to clarify existing payment responsibilities and due dates in regulations. The majority of these changes have been made at the request of the Scheme Administrator for the avoidance of doubt, and to support the issue of improved guidance to employers.

4.104 Finally, interest on arrears of unpaid contributions will now only be compounded at annual, rather than the proposed monthly, intervals. This small change simplifies the calculation but slightly reduces the payment required from any employer whose contributions are delayed by more than a month.

Annex A – List of Organisational Responses

Association of Pension Lawyers
British Medical Association
Capsticks Solicitors LLP
Care UK
Chesterfield Royal Hospital NHS Foundation Trust
DAC Beachcrofts LLP
Derby Hospitals NHS Foundation Trust
Healthcare Financial Management Association
Independent Healthcare Advisory Services
Medway Community Healthcare
NHS Employers
NHS Partners Network
NHS Shared Business Services
North Tees and Hartlepool NHS Foundation Trust
Northumbria Healthcare NHS Foundation Trust
Plymouth Community Healthcare CIC
Provide
Ripplez CIC
Royal Brompton and Harefield NHS Foundation Trust
Royal College of Midwives
Royal College of Nursing
Serco
Social Partnership Forum Staff Passport Group
South Tees Hospitals NHS Foundation Trust
The Practice
Universities and Colleges Employers Association
University Hospital of South Manchester NHS Foundation Trust
Virgin Care