NHS pension scheme – senior clinician flexibility

Consultation response

As the membership association for all NHS trusts and foundation trusts, our submission is based on member feedback, and has been developed utilising views, comments and documentation from well over 100 of the 223 trusts across England. Views have been gathered predominantly in the past three months, in which time trust boards have made clear to us that the impact of pensions tax issues are among their most critical concerns. In summary:

- We welcome the government's renewed urgency in responding to the pensions tax issue, and support the principle of providing additional flexibilities to NHS pension scheme members to mitigate the impacts of the scheme on individual members of staff and on frontline care.
- We believe that the proposals outlined in this consultation may have a generally positive effect on senior clinicians' ability to manage annual tax liability, in cases where they can show a reasonable expectation of incurring a charge.
- However, pension flexibilities need to be made available to all staff affected by, or at risk of being affected by, annual allowance taxation. This must include NHS managers who have been excluded from these proposals, despite being equally susceptible to large and unpredictable tax bills. Moreover there is an argument for extending a range of flexibilities across the whole workforce.
    - Not extending the flexibilities to senior non-clinical roles risks deterring clinicians from taking on leadership roles which deprives the NHS of valuable clinical leadership. Vacancies in senior leadership teams and high turnover in director posts is not conducive to the provision of stable leadership and will have an impact on quality of care.
    - Trust leaders consider equitable treatment among all staff groups as an essential part of the offer to their workforce.
    - Additionally, younger staff new to the NHS are more likely to leave the NHS pension scheme than older, more experienced colleagues, due in part to the disproportionate impact of high contribution rates on their levels of disposable income. Pension flexibilities should also be available to lower paid NHS staff to ensure equitable treatment and to support enhanced job satisfaction and workforce retention.

Response to online questionnaire

The case for pension flexibility

1. Who do you think pension flexibility should be available to?

Pension flexibility should be available to all NHS staff affected by or at risk of being affected by pensions tax issues, including managers and other senior staff. Flexibilities should also be open to lower paid staff who may struggle to afford pensions contributions.

Impact on clinical capacity

Tax liabilities incurred as a result of pension contributions exceeding the annual allowance have been widely reported as contributing to consultant doctors reducing their hours, opting out of the NHS pension scheme, or taking early retirement. Trusts are reporting larger gaps in rotas, higher spending on agency staff and locums, and growing waiting lists as a result of a reduction in the amount of extra work consultants are willing to take on. These are often relied upon by trusts to keep waiting times down for patients.

The NHS relies heavily on discretionary effort from frontline staff to deliver services and mitigate the performance challenges trusts are facing. Consultants often take on additional, non-contractually mandated sessions – or "programmed activities" (PAs) – to help clear growing waiting lists, and trusts have named the pensions crisis as a key factor in declining performance on key targets such as the 18 week wait and other performance benchmarks. Multiple trusts have taken steps to reduce activity in operating theatres to mitigate the service pressures created in part by consultants reducing PAs in surgical and critical care specialties.

Our members have emphasised the need to consider pension tax impact on senior nursing and other clinical staff. While staff on higher Agenda for Change pay rates are very unlikely to be affected by the taper, promotions and some increases in pay can cause annual allowance tax growth beyond the standard £40,000 limit and leave senior clinical staff worse off as a result of career advancement (as outlined in our response to question 4 below). Trusts have shared a number of examples of senior non-medical staff avoiding promotions – particularly to director level – or considering taking this action. This hurts both the individual financially, and the trust operationally as it is unable to fill key vacant posts with the right people at the right time. One HR Director outlined the issue as follows:

A wide range of roles are affected – and this will continue as in time salaries over 50k will be affected by the life time allowance. Work needs to be completed on the new A4C salary progression as well – as there are fewer but bigger increases in the salary scale and this could potentially result in an annual allowance charge if there had also been a promotion.

The cumulative impact of rising demand for services, anticipated winter pressures, and a reduction in clinical capacity, particularly among consultants, is affecting trusts' ability to match supply to demand and is threatening their operational resilience at the moment. Trust leaders have expressed serious concerns about the ramifications of this issue for the winter season, as reported in the media over the past month, and shown below in feedback provided by an HR Director:

We are experiencing service pressures as a result of some of our consultants stepping back from activity and reducing their PAs particularly in our surgical and critical care services. The exact impact is difficult to quantify due to other factors, including workforce supply pressures in theatres, but we have had to take steps to mitigate the potential consequences by reducing activity and services for periods of time.

We are conscious that some commentators have suggested that the NHS should not be 'treated as a special case' in regards to the pensions tax issue, given the fact that other sectors, including the police and judiciary, have been affected by similar concerns. While we understand the concern about pension tax implications across the public sector, the Department's consultation document affirms the specific impact on the NHS and care quality, recognising "that the fixed structure of the NHS pension scheme combined with (tax relief thresholds) to those on the highest incomes, could create unintended consequences for NHS service capacity and delivery of patient care".

However the impact of the current pension regime is exacerbated by workforce shortages throughout the NHS and, in particular, the need for trusts to rely on discretionary work from senior medical staff to manage demand for services. A full-time job plan for a consultant consists of 10 PAs, but in many – if not most – cases, senior medical staff will work additional PAs, waiting list initiative shifts or take on other forms of extra work to help their trust to meet patient demand.

The widely reported pattern is of consultants giving up this type of work to manage their personal finances. Recent surveys importantly suggest between 30-40% have taken this action. This reflects poorly on the design of the wider tax system in combination with NHS pension scheme membership. It should also raise awareness across government of the extent to which we are asking NHS staff to 'go the extra mile', in the midst of rising demand for services and over 100,000 unfilled posts across the sector.

Impact on trust leadership

The impact of the pensions tax issue on NHS services is very clear, however the reason for this cannot be reduced to a singular issue of consultants, senior nurses or other clinical staff reducing their hours or retiring early. A crucial component of trusts' ability to provide high quality and safe care is stable and effective leadership. There is much evidence to demonstrate the strong link between continuity of leadership and quality of care. While consultants have been at the centre of the debate about pensions so far, trusts tell us that other high paid staff, including those working in executive roles, senior laboratory staff, scientists and others on higher Agenda for Change bands are affected by the annual allowance taper and reduced thresholds and are consequently considering leaving the service, reducing their income, turning down promotions or declining to take on additional responsibilities.

A large number of trusts have board members affected by this issue with many organisations seeing experienced leaders consider early retirement or turn down on-call shifts. Providers have described this as disruptive to planning and the operation of day to day services. One trust has seen two senior appointees decline membership of the NHS pension scheme, and others have expressed concern that the pull of the private sector will be stronger for those in senior management roles if the NHS pension scheme – a significant benefit and a component of the overall reward package to recruit and retain executive talent in the NHS – becomes less attractive.

This trend also runs counter to the drive in the NHS to encourage more clinicians to move into leadership roles. Under current proposals, consultants accepting director roles and consequently moving from a consultant contract to Very Senior Manager (VSM) terms risk losing the pension flexibility available under their previous role. Others will hold a primarily clinical post and carry out a small amount of management work each week, and staff working in clinical roles which are not patient facing are not accounted for in the proposals.

Not extending the flexibilities to senior non-clinical roles risks deterring clinicians from taking on leadership roles which deprives the NHS of valuable clinical leadership.

Vacancies in senior leadership teams and high turnover of directors is not conducive to the stable leadership required to develop inclusive and compassionate cultures within the NHS, to support improvements in care or to generate strategic input to the implementation of the long term plan. Trust leaders have also expressed concern about the impact that uncertainty around pensions tax changes is having on their ability to carry out effective succession planning.

Maintaining equity across the NHS workforce

Trusts are committed to treating their whole workforce equitably regardless of role or level of seniority, and have expressed concerns that not extending the flexibilities across the workforce may create feelings of disparity between consultants and other staff groups, including other senior leaders and more junior members of staff. Trust leaders stress the importance of ensuring all members of staff at their trust feel valued, and the present situation poses a threat to the work trusts are doing to raise morale among their workforce.

Trust leaders also consider equitable treatment among all staff groups as an important part of their offer to their workforce. The proposal to include only senior clinicians is widely considered as being damaging to the efforts trusts make to foster inclusivity and diversity.

Younger, lower paid staff have the highest proportion of opt outs from the pension scheme due to the affordability of member contributions and trust leaders suggest that enabling lower paid staff to start to make a more affordable contribution to the pension scheme would make a significant impact on retention at this level, where turnover rates are also high. Additionally, there are concerns that without extending the flexibilities across the workforce, there is the potential to exacerbate pay inequality, including the gender pay gap, given the demographic make up of the different staff groups in the NHS.

Proposed pension flexibility

2. Do you think this proposal is flexible enough to balance their income, pension growth and tax liability?

We support the offer of contribution and accrual flexibilities to NHS staff, but the precise proposals are far from ideal as an overall package for the workforce. While the proposals in this consultation should enable senior clinicians to better manage their pensionable pay, they do not address the overall workforce capacity issue caused by the annual allowance and taper. Trusts have expressed concern at a feeling among staff that working additional hours no longer pays, and while the flexibilities help to reduce the tax burden, they do not incentivise extra work. Trust leaders warn that they cannot rely on individuals who have reduced their hours to quickly return to previous working patterns once the flexibilities come into effect. A trust medical director explained to us that:

We have no confidence that people are likely to step back up to previous levels of clinical contribution even when resolved which is of particular concern in specialities where there is not workforce resource to recruit… We do not expect to be able to restore the additional capacity from waiting list initiatives and have already seen our backlog of cases grow significantly.

Staff who are unclear on the impact of additional hours, pay rises or promotions on their potential tax liability may still leave the pension scheme 'just in case' if the flexibilities are perceived to be complicated and difficult to navigate. A lack of clear advice available to pension scheme members has exacerbated fears among staff of the unknown tax bills they may receive as a result of their pensions contributions, and so we welcome proposals to introduce comprehensive advice to pension scheme members about their potential tax liability.

The flexibilities are a complex way to manage tax liability and in practice it will be difficult for staff to predict how much they need to reduce their contributions by and the impact of in-year increases in contributions being backdated to the whole of the year. This may discourage staff from taking up these flexibilities in lieu of managing their income through reducing hours or opting out of the scheme altogether. Trusts are also concerned about the potentially significant administrative burden of budgeting for and applying flexibilities.

The wider context of this is that staff consider the NHS pension a core part of the overall package of remuneration in the NHS. The employer contribution is a component of a member's overall salary and so while flexibilities may reduce the risk of receiving large tax bills, it is widely perceived by medical staff as being unfair that they are required to take a pay cut to avoid incurring liability for tax on their pension contributions.

Local "workaround" schemes in 2019/20

While some trusts are addressing loss in income for senior staff by recycling employer contributions, there are mixed views among trusts about whether this is the best way forward. Some have expressed concern that this widens inequalities in pay and reward between different staff groups, others feel that it will incentivise people to leave the pension scheme, and others suggest that it is unlikely to lead to consultants increasing their hours, as individuals will have more money in their pay packet and be inclined to do less work, rather than more.

Some members tell us this mixed approach to the recycling of contributions may lead to unhelpful competition between trusts that are and aren't using this approach, with several organisations taking a principled stance against any "workaround" scheme which disproportionately benefits one staff group. Our briefing for trusts in August this year described the common approaches some trusts had taken or were considering taking.

We support the freedom for trusts to take forward these options and, from the information provided to us, the proportion of organisations choosing to do so appears to be steadily increasing. We are happy to work with the Department of Health and Social Care (DHSC) and NHS England/Improvement to support our members in implementation. However, we should exercise caution about their anticipated impact on senior staff capacity this winter. We are concerned that some organisations are legitimately reporting slow uptake of local schemes due to a combination of the time needed to seek advice on legality; the difficulty of passing complex new policies through internal governance procedures; and lower than anticipated interest from clinicians in certain trusts.

We must remain clear that the adoption of these policies will not be enough to truly solve this issue now or in the long run.

3. If not, in what ways could the proposals be developed further?

The majority of trusts which provided feedback for this consultation do not believe these proposals will be sufficient to solve the current pensions tax issues impacting the NHS. While not directly within the scope of this consultation, related efforts to review the operation of the annual allowance taper are considered the overriding priority by our members. Policy options to be considered include:

a) Removing the annual allowance taper

This is seen by trusts as the simplest and most effective action government could take. Removing the taper would nullify a complex and confusing system for tax liability calculation which can introduce an effective 100% marginal rate on people earning above the threshold income of £110,000, presenting the disincentive for senior staff taking on additional work or promotions. An annual allowance system without the taper would still have the effect of taxing high earners, however they would more easily be able to prepare for charges against a flat pensions 'cap', and not be penalised for undertaking additional NHS work.

b) Increasing thresholds for the taper, adjusted income and annual allowance

An alternative or complementary solution would be to increase the various thresholds or caps on earnings and pensions growth that bring these policies into play for senior clinicians and managers. It is worth reiterating that the annual tax free allowance for pensions growth prior to initial policy change in 2011 was £255,000 and it may be concluded that the reduction to £40,000 (down to a minimum of £10,000 with tapering) has gone too far and affected people who were not intended to be captured. The taper threshold, and adjusted income threshold of £150,000 could also be raised. Calculated as a combination of total income, pension contributions, and "deemed pensions growth", this latter threshold captures a far higher proportion of staff than many perceive, leaving a sizeable proportion of NHS staff at risk of receiving annual allowance tax bills.

We appreciate these two options are outside of DHSC's direct control and somewhat separate to the proposals presented here. The commitment from the Treasury, aligned to the release of this consultation, to review the operation of the taper has been welcomed and accompanied by productive engagement with stakeholders, including NHS Providers. This work should proceed at pace, particularly given the impact revised tax rules could have on the development and implementation of NHS pension scheme flexibilities described in this consultation or subsequently introduced.

c) Extending pension flexibilities to managers and lower paid staff

Pension flexibility should be available to all staff affected by or at risk of being affected by the pensions tax issue, including managers and other senior staff. Contribution and accrual flexibilities, whether they mirror the proposals here for senior clinicians or take on an alternative form, should also be open to lower paid staff who may struggle to afford pensions contributions. As outlined in our answer to question 1 above, trusts have made it clear that not extending the flexibilities to senior non-clinical roles risks deterring clinicians from taking on leadership roles which deprives the NHS of valuable clinical leadership. Trust leaders also consider equitable treatment among all staff groups as an important part of their offer to their workforce. The proposal to include only senior clinicians is considered by many as potentially damaging to the efforts trusts make to foster an inclusive and supportive culture.

d) Applying policies with retrospective effect

We are receiving constant messages from trusts describing the effect annual allowance taxation has already had on individuals within their organisations, whether senior clinicians or managers. As many had reached the end of a three-year carry forward or 'grace period' in 2018/19, a large financial impact has been felt this year, with one very recent example provided by an individual who moved from a consultant post at one trust to a medical director position in another region:

My salary has not changed, in fact it went down by a small amount as a result of the move. However, in my previous Trust there was a chunk of pay that was a 'responsibility payment' for my role as a Divisional Lead of around £30,000 pa which was not considered pensionable.

On moving to take up my Executive MD post this part of my salary was rolled into my baseline pay so that it became pensionable. As a result, last weekend I received a pensions statement (AAPSS) which informed

me that my pension pot growth was £363,000 for the 18/19 year, taking me way beyond my lifetime allowance as well. This will now be taxed at 45% = £163,000. The so-called 'pension pot' doesn't exist of course, and as you can imagine this is now a huge problem for me. As someone who felt that my experience would enable me to take up a senior executive role in the NHS with the intention of trying to reverse the narrative of a failing NHS, I now feel betrayed by a punitive tax on my future.

Had I known this would happen I might have decided not to put my family through such a huge move – not to mention the Stamp Duty Land Tax paid as well - and I find it difficult to imagine that other medical staff are likely to follow in my footsteps.

The government should give serious consideration to applying a more comprehensive solution to the 2019/20 tax year, ensuring respite for valued NHS staff like the individual in this example.

4. We're prosing that large pay increases for high-earning staff should only be included in their pensionable income gradually. Do you agree or disagree with this proposal?

We agree with the principle of allowing large pay increases for staff to be included gradually as pensionable income. This should phase the impact of annual allowance tax bills, making these liabilities potentially easier to manage. This should be a flexibility provided to all staff that would benefit.

DHSC notes that substantial increases in pay "can create a spike in pension growth and a higher annual allowance tax charge that is not replicated in subsequent years". It adds that phased pensionability is "likely to be more helpful for higher earners… however, lower earners may prefer that their pension is calculated based on the full amount of their pay straightaway."

The consultation document indicates that the policy could apply to scheme members earning £90,000 or over who "experience a pensionable pay increase above CPI inflation of at least 5%". While this is only presented as an example, we would urge DHSC to closely consider what an appropriate earnings threshold should be, if any, on phased pensionability, applying rigorous modelling to ensure it does not leave out scheme members who would benefit.

It would appear that the example threshold is too high to capture certain staff, particularly non-medical, from receiving punitive annual allowance tax bills after accepting a promotion accompanied by a large pay increase. For instance, a clinician with senior management responsibilities – likely below director level – employed on Agenda for Change band 8c or 8d will be earning between £64,000-£88,000 from April next year. In a scenario where this person is promoted to a band 9 post, a significant pay increase and rise in annual pension growth is a possibility that could result in a large one-off tax bill this policy is designed to avert. One trust reported a concern that the current proposals do not resolve this "penalty for success" for non-medical staff.

While we support the option of phased pensionability as a member choice, clarity is needed over the effect of this policy on members who leave the scheme or retire before the three-year period is complete. One trust told us "it is difficult at this stage to assess how it will work" given the complexities of applying to

several versions of the pension scheme and many others made the same point. Another trust suggested the sector needs to see this proposal "tested in practice" and we would ask for this to be incorporated into the Department's proposed modeller and wider work to help improve pensions tax education and understanding.

As with other proposed flexibilities set forward in this consultation, we believe there is no good reason not to extend this option to directors, including non-clinical staff on VSM pay terms.

Improving Scheme Pays

5. Currently, the NHS Pension Scheme has a notional defined contribution pot (NDC) approach to Scheme Pays deductions. We're proposing to replace this with the debit method. Do you agree or disagree with this?

We wholeheartedly support the principle of making Scheme Pays deductions more transparent but hold some concern about the trade-off described in DHSC's consultation, which could result in further reduction to the total reward package for scheme members using this option.

Member trusts, and other key stakeholders including the BMA, have expressed frustration with the way Scheme Pays operates. One consistent piece of feedback is the sheer extent to which compounding interest within Scheme Pays will reduce pension benefits, should this option be taken up at an early stage of one's career in the NHS. One trust cited an example provided by a member of staff, where a £6,000 tax bill was projected to translate to an £88,000 loan by the time of their retirement.

A number of trusts have raised questions over a perceived lack of fairness in a system which does not directly deduct annual allowance tax bills from the balance of an individual's 'virtual pension pot', but rather asks scheme members to take an expensive loan over multiple years to tackle a tax liability. Directors and senior consultants who consistently earn above both income thresholds relevant to the annual allowance will clearly see a much larger reduction to their ultimate pension level should they utilise the Scheme Pays option. The BMA has produced helpful examples of this, published on its website, underlining the even greater incentive for doctors to retire early or reduce their working hours if the facility is used for multiple years leading up to retirement.

A change to the "debit approach" proposed in this consultation does not tackle this issue, rather it would enable scheme members "to see the effect 'in real time'" of taking out this loan. We agree with this intention, with members expressing a view that any additional transparency would help staff. The Department makes an entirely reasonable assumption that the change would "support better informed financial planning and decision-making by members".

However, we are concerned that this sensible proposal is being presented as a potential trade off between greater transparency and value of pension benefits. The consultation states that "the current NDC method might be expected to produce an overall Scheme Pays deduction at retirement age around 2% lower than the debit approach".

The consultation says that the current and proposed new approaches to Scheme Pays are the two methods used across the public sector. It does not seem unreasonable to expect greater transparency for scheme members managing their pensions and taxation without the cost of reduced benefits at retirement. As such, we feel this question, and other ways of improving transparency should perhaps be further explored.

Equality Impact Assessment

6. To what extent will the proposal to target the flexibility to clinicians who have a reasonable prospect of an annual allowance tax charge have an impact on people with one or more protected characteristics?

The government's consultation document includes an equalities impact assessment examining the effect of several aspects of the proposals on people with one or more protected characteristics. We do not have either supporting or contradictory figures to add to its statistical analysis.

We accept DHSC's contention that "the aim of the policy is to mitigate the impact of the annual allowance on NHS capacity, not to advantage specific groups". However, its impact assessment makes clear that some groups, including male staff and high-earners, are more likely to be advantaged, while others, including disabled staff, are less likely to benefit from the proposals.

This is explained as a result of flexibilities being only provided to those members of the NHS pension scheme with a reasonable expectation of receiving an annual allowance tax charge. As stated in our answer to question 1 above, we do not agree with the decision to limit the application of these proposals alone – or a wider package of pension scheme flexibilities – solely to this group. The equalities impact described by DHSC's assessment should be considered as one of the reasons not to do so.