NHS pension scheme contribution rates: DHSC consultation on member contribution rates

NHS Providers response

Link to full DHSC consultation document and proposals

Question 1: Actual vs notional WTE pay calculations

Do you agree or disagree that the member contribution rate should be based on actual annual rates of pay instead of members' notional whole-time equivalent pay? If you disagree or don't know how to answer, please explain why.

Agree.

We support the move to calculations of contribution rate based on actual annual pay as this sensibly addresses an existing flaw within the design of the scheme. As DHSC explains in the consultation documentation 'while current calculations based on whole time equivalent (WTE) pay make some sense for those on legacy 'final salary' pensions terms' this change is being proposed at this time to reflect the increasing number of scheme members on newer career average, revalued earnings (CARE) terms.

The greatest beneficiaries of this change should be those staff who work less than full time (hereafter described as 'part-time'). The proposed change to 'actual pay' calculations means pension contribution rates will more accurately reflect working patterns across the board and remove a disproportionate impact on take home pay for part-time staff.

DHSC noted particular impacts for older staff and women working in the NHS, given both groups are overrepresented within the broader cohort of part-time workers. While 78% of NHS pension scheme members are women (77% of NHS staff overall are women), female staff are also more likely than male colleagues to work part-time or pause NHS employment altogether to take on unpaid caring responsibilities. Additionally, it is common for staff to reduce their hours as they move towards the end of their careers in the NHS and the service relies on a significant number of clinicians who 'retire and return' to work, with many in this cohort re-joining the NHS under more flexible working arrangements.

Overall, this is an important correction to ensure improved conditions for part-time staff and to encourage more to work flexibly, particularly those who may otherwise consider leaving NHS employment. Concerns around early retirement, and the impact on the service, have been exacerbated by the pressure of working through COVID-19 for both staff and boards seeking to maintain adequate staffing capacity. In a survey carried out by NHS Providers last summer, 48% of trust leaders said they had already seen evidence of staff leaving their organisations due to early retirement, burnout, or other effects from working in the pandemic.

While we are conscious of the potential loss in pensions earnings growth for some staff working part-time via the new calculation method (as they move into lower contribution tiers), we agree with the government that the benefits of this particular proposal outweigh any drawbacks.

Question 2: Proposed changes to tiered contribution rates

Do you agree or disagree with the proposed member contribution structure set out in this consultation document? If you disagree or don't know how to answer, please explain why.

Disagree.

We disagree with the proposed changes to the member contribution structure set out by DHSC in this consultation as, on balance, we feel the potential damage caused by a loss in take home pay (at a time of increasing inflation) for some lower and middle banded NHS staff will outweigh the benefits this proposed new structure presents in other areas if it fails to act as an incentive for those staff to access the scheme and/or remain employed within the NHS. This negative effect will particularly be the case for some full-time working members of the NHS pension scheme, as changes to calculating contributions based on annual rates of pay will benefit many part-time staff (as discussed in the previous question).

It is worth noting our primary motivation in responding to this consultation, and other proposals around pensions reform on behalf of trusts, is to promote access to the NHS pension scheme in all parts of the workforce and ensure staff are continually attracted to joining the NHS and remaining in the service. This is particularly important at this time that staff feel it is affordable and beneficial to continue pursuing a career in the NHS, given heightened operational pressure as we will discuss further briefly below.

Impact on middle and lower-banded staff

During the government review and public debate over the impacts of pension taxation on NHS staff in 2019/20, we consulted extensively with member trusts on their priorities for NHS pension reform. At this time, responses to our surveys of trust leaders emphasised:

- the importance of addressing punitive taxation for higher earners and those gaining promotions; alongside
- the underlying the importance of applying any policy changes equitably for both clinical and non-clinical staff.

In March 2020, the government announced changes to pension tax rules which reduced the impact of the annual allowance taper and partly addressed the main issues trust boards had flagged to us, although some challenges around the effect of pension taxation on the NHS workforce certainly remain.

Feedback from trust leaders on pensions issues has consistently brought questions about fairness and equitable treatment within the scheme to the fore, as well as an emphasis on the importance of trust boards promoting a 'one workforce' ethos throughout their teams across different specialties and grades.

During discussions around potential policy reform in 2019/20, we were encouraged to hear from DHSC colleagues about informal proposals to introduce greater flexibility in the scheme for younger, lower paid members of staff in the NHS. This may have included an opportunity for staff to utilise a proportion of their pensions savings for costs associated with student loans or first home purchase, among other things.

Our pensions briefing in 2019 reflected the critical need for "a lasting solution to the pension problem (must) include a commitment to review flexibilities for lower paid staff who can struggle to afford high contribution rates". It is therefore disappointing that proposals such as these have not since been meaningfully pursued in this consultation. This ongoing lack of flexibility, combined with increased contribution rates for some lower and middle banded NHS staff, presents the main concern regarding the affordability of the contribution rate changes in question for lower paid scheme members.

Despite DHSC's acknowledgement that impacts on affordability are the primary downside of implementing these changes, we believe the proportional effects of reduced take home pay for some scheme members due to higher contribution rates are insufficiently explored in the consultation documents. For instance, the case examples used in the consultation document compare projected

increases in employee contributions for some staff favourably against the hypothetical impact on these individuals of moving to a 9.8% flat rate member contribution structure, which is not on the table in these proposals and would be unlikely to draw support from most stakeholders. The examples do not highlight the effect of the contribution rate increases on staff earning full-time salaries who will have the largest percentage rises (scheme members remaining in tier 3 and those moving from current tier 4 to tier 5).

It is important that any changes to the contribution rate structure do not encourage staff to opt-out of the NHS pension scheme. DHSC states that the only age group where scheme membership is not increasing as a general trend is among under 25s, while average membership rates are lower for 25–34-year-olds (88% average membership) than all other age groups below 60 (91% average membership). The consultation document notes that participation rates in the NHS scheme compare favourably to those in the private sector: a positive aspect of a scheme which yields significant benefits overall. However, it is also true that average participation rates in pension schemes across the public sector are over 90% in all age brackets, including those aged 22-29 (91% participation) and 30-39 (93%), meaning NHS pension scheme membership compares slightly less favourably for younger staff than in the public sector as a whole.

The context of rising costs of living and NHS staffing pressures

Changes to take home pay resulting from these proposals would be relatively modest for many of those affected, as indicated by the case examples provided in the consultation document. However it is worth emphasising the fact that any changes to take home pay will always be proportionately more significant to those who earn less and/or generally have less financial security than those with greater levels of income or wealth.

Reductions in take home pay are more significant, however, when considered against the wider context of increasing costs of living in recent months. In short, we would highlight that since this consultation was published, inflation has risen to its highest rate in a decade, impacting household budgets, gas and electricity bills have seen an acute rise (potentially reflected in inflation numbers), and the Bank of England has increased interest rates, affecting the cost of borrowing.

To provide an example of a compounding impact on the finances of NHS staff, a recently qualified band 5 nurse working full-time and remaining in tier 3 within the new contributions structure may see a reduction in take home pay of slightly less than £15 per month. However, this may feel like a more acute financial burden given monthly total earnings at this level in the NHS are over £40 lower in real-terms than at this point last year, due to high levels of inflation. Similarly, an advanced clinical

practitioner, experienced physician associate or pharmacist employed at the top of band 7 may see reduced take home pay of just over £25 per month from April 2022 due to these proposals but this is set against a real-terms monthly pay reduction of over £75 since this point last year. This does not also take into account the added financial burden of increased national insurance taxation in future years, which is reportedly coming under scrutiny within government.

It is incredibly important that policy changes affecting pay and reward in the NHS do not negatively affect staff satisfaction or general wellbeing or encourage staff to consider leaving the service at this critical time. This is vital in the context of the unprecedented operational pressures facing the service given the impact of the COVID-19 pandemic and the growing backlog of care. We have repeatedly stressed that workforce shortages are the most significant challenge trust leaders are dealing with at this time, and agree with the assessment of the Health and Social Care Committee, and others, that staffing gaps and the lack of a national long-term plan to address these, are the greatest threat to meeting current and future demand for patient care.

Finally, we would add a note of further caution towards the proposed changes to the contribution structure, given the difficulties the NHS pension Scheme Advisory Board (SAB) has experienced in reaching a consensus view despite significant time spent discussing the issue in recent months and years. The NHS benefits from particularly strong social partnership arrangements and changes to pay and reward structures are much more sensibly made when central bodies, trust boards and staff side representatives are able to present a united force and collectively espouse the benefits to the workforce.

Potential benefits for some higher earners

As noted above, our primary motivation in responding to this consultation is to promote access to the NHS pension scheme in all parts of the workforce and ensure staff are continually attracted to joining the NHS and remaining in the service. DHSC rightly points out that the proposed changes to contribution tiers "increases the value of NHS pension scheme membership for higher earners" (through the new top contribution rate of 12.5%).

As discussed above, we disagree with the proposed contribution rate changes overall, and do not necessarily support the view that "a high level of cross-subsidy between higher and lower earning NHS Pension Scheme members is no longer appropriate". However, we acknowledge a potential benefit to the attraction of remaining in the scheme and the NHS as a whole for some higher earning

members of staff under this new structure, and hope this potential benefit is realised if this proposal is confirmed.

Question 3: Agenda for change alignment

Do you agree or disagree that the thresholds for the member contribution tiers should be increased in line with Agenda for Change pay awards? If you disagree or don't know how to answer, please explain why.

Agree.

We support the proposal to align member contribution tiers to annual Agenda for Change (AfC) pay increases. As the consultation document states, AfC pay rises have "occasionally led to small increases in pay causing a net reduction in take-home pay" as the monetary effect of moving into a higher contributions tier outweighed the pay rises for some. This was notably the case following the agreement of a three-year AfC deal in 2018 where proportionately smaller pay rises in the first year caused frustration for some staff who suffered the 'cliff-edge' effect of moving into a higher contribution tier, reducing their take home pay.

This proposal does not appear to have any clear and significant downside and we note that – in this case – there is agreement from stakeholders across the Scheme Advisory Board, including NHS Employers, DHSC and NHS unions, vis a vis the benefit of this change.

We agree with the approach of aligning contribution tier increases to annual AfC awards specifically – rather than any other pay structure or calculation measure – given the considerable majority of staff in the NHS are employed through this structure. While this is not the case for medical staff and very senior managers, we appreciate the need for a consistent approach across all staff groups. We believe this method of alignment will be easier for trust leaders – particularly those working in payroll or HR teams – to engage with and explain to their staff than alternative approaches and support the principle expressed by DHSC that "it is important that the tiers are kept consistent for all members of the workforce".

Question 4: Phasing of changes

Do you agree or disagree that the proposed member contribution structure should be phased over 2 years? If you disagree or don't know how to answer, please explain why.

Agree in principle.

If the proposed contribution tier changes are ultimately confirmed, we agree with the principle of phasing these in over a period of time, to avoid larger, immediate losses in take home pay for staff who are worst affected by increased employee contributions. For instance, it is preferable that eventual employee contributions increases from 7.1% to 8.3% for staff earning between £22,549 and £26,823, and from 9.3% to 10.7% for staff earning between £42,121 to £47,845 are implemented not via one fell swoop, but through two separate tranches.

DHSC argues that "phasing the new member contribution in slowly would protect scheme affordability for some scheme members", and while we agree to an extent, the affordability benefits should not be overstated given wider financial conditions affecting NHS staff. We have discussed this at greater length in our answer to the primary contribution rate change proposal above, but it is worth noting specifically on this issue how the timing of phased rate changes through the new tier structure will impact staff as they await decisions from the annual pay review process.

In recent years, annual pay decisions for AfC staff have been consistently delayed until the summer, resulting in an announcement from the government between June and August applying to pay awards taking effect from April in the same calendar year. While backdated pay usually comes into effect for most staff fairly quickly, this process has been complicated further by delayed eligibility and funding decisions at times. While we're hopeful some of the complexities around funding pay awards are mitigated or resolved in future years, there seems little prospect for government decisions on pay to be made prior to the start of the financial year (1 April). This means that in both April 2022 and April 2023, many staff will see a temporary cut to their monthly take home pay as phased contributions rate increases come into effect prior to any potential pay increase determined by the government.

On balance, there is merit to phasing in any changes that are confirmed following the consultation process. However, as discussed above, it is important for the government to consider how all elements of financial security for NHS staff are affected at the current time by changes to income levels and the cost of living.

Question 5: Regulations and policy intent

Do you agree or disagree that the proposed draft amending regulations deliver the policy objectives of implementing the first phase of changes to the tiered contribution rate structure and the assessment of

a tiered rate using actual annual rate of pensionable pay for part-time members rather than notional whole-time equivalent? If you disagree or don't know how to answer, please explain why.

No response.

Question 6: further considerations

Are there any further considerations and evidence that you think the department should take into account when assessing any equality issues arising as a result of the proposed changes?

No response.