UNIVERSITIES & COLLEGES EMPLOYERS ASSOCIATION

NHS Pension Scheme: increased flexibility

The Universities and Colleges Employers Association (UCEA) represents approximately 170 universities and other Higher Education Institutions plus associated HE employers in the UK on employment, reward and HR related issues including pensions. The Higher Education (HE) sector employs almost 400,000 staff across the UK and the employees of individual institutions are provided with a range of DB pension schemes including the NHS Pension Scheme.

Scheme Name	Type of Scheme	Staff covered
Universities Superannuation Scheme (USS)	Multi-employer funded hybrid DB/DC scheme	Mainly academic & related professional staff in pre-92 universities, plus some such staff in post-92 universities
Teachers' Pension Scheme (TPS) and Teachers Pension Scheme (Scotland/Northern Ireland)	Multi-employer, unfunded DB scheme	Mainly academic staff in post-92 universities as scheduled employers
NHS Pension Scheme (NHSPS), NHS Pension Scheme (Scotland) and HSC Pension Scheme (Northern Ireland)	Multi-employer, unfunded DB scheme	An option for clinical academics in university hospitals or medical schools through Direction body status
Superannuation Arrangements for the University of London (SAUL)	Multi-employer funded DB scheme	Professional services staff in pre-92 London universities
Local Government Pension Schemes (LGPS) and Local Government Pension Scheme (Scotland/Northern Ireland)	Funded DB schemes. Universities participate in their local fund	Mainly professional services staff in post-92 universities as scheduled employers. Plus some pre-92 universities as admitted bodies
Self-Administered Trusts (SATs)	Single & multi-employer schemes, varied in type; many are funded DB schemes, some are DC schemes including GPP and Stakeholder, as well as NEST and other master trusts.	Professional services staff in pre-92 universities. Each scheme is run by a single employer for the relevant staff.

Executive summary

UCEA has prepared this consultation response on behalf of the higher education sector having sought views from university medical schools that employ staff who are members of the NHSPS.

We understand the need to ensure individuals are incentivised to save for their retirement and that mechanisms are required to limit pension tax relief for higher earners, however evidence suggests that the tapered annual allowance (TAA) (coupled with other aspects of the UK tax system) is having unintended consequences for the delivery of some important NHS services.

While university medical schools are generally in favour of flexibilities for all NHSPS members affected by pension tax issues, as well as those impacted on affordability grounds, it is noted that the proposed flexibilities will add significant layers of complexity of administering the scheme, and ultimately will only mitigate the impact of the TAA on affected staff and the NHS as a whole. University medical schools would therefore favour the exploration of a combination of other options including a simpler version of choosing a personal accrual rate where the employer continues to pay their full contribution, a zero-accrual option and an option for members to choose their own pensionable salary cap.

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

The proposed flexibility, if it is going to be introduced, should be made available to any member of the NHSPS that is impacted by the pensions taper, no matter what their job role and this includes individuals employed at a university medical school. It does not seem right that certain groups of staff should have options available to them through the NHSPS scheme rules to potentially mitigate the impact of the TAA while other similarly affected members do not have those same options available to them.

Furthermore, in our view there is also a strong argument that the scheme should extend the proposed flexibilities in one form or another to other groups of staff. For example, staff who have or are considering opting-out of the NHSPS on affordability grounds could be offered a simple 50:50 option.

In addition, medical schools have highlighted issues with the cliff edges created by the salary tiers for each member contribution band, particularly for individuals that receive a promotion and/or pay rise that moves them from the 9.3% salary tier to the 12.5% salary tier. This leads to a 34% increase in member contributions which often completely wipes out pay rises. Options should be developed to help members mitigate the impact of moving up a contribution salary tier, we understand that the Scheme Advisory Board has been looking at this issue in particular.

One further point is that member affordability is an issue in all the public service schemes. For example, many universities have raised similar issues with affordability in relation to the Teachers' Pension Scheme which is often offered alongside the NHSPS (and the Local Government Pension Scheme which already offers a 50/50 option).

With the NHS being one of the largest employers in the UK, it seems right and appropriate that the NHSPS should take a leading role in developing and promoting options to address affordability to ensure that pensions related issues do not have a negative impact on the NHS from a staff recruitment, resourcing and retention perspective and that all NHS staff no matter what role they perform have the opportunity to accrue a defined benefit pension and all the accompanying ancillary benefits that is affordable and does not lead to unexpected tax bills.

2. **Do you think the proposal for a more tailored approach to pension accrual is flexible enough for senior clinicians to balance their income, pension growth and tax liability? Please set out the reasons for your answer.**

The consultation proposals offer a degree of flexibility to balance income, pension growth and a tax liability. However they are very complicated from a communications, financial planning and administrative perspective, they will place significant burdens on individuals, employers and the scheme administrator and will ultimately only mitigate the impact of the pensions taper at best. There is no guarantee that members using this type of option will be able to prevent their breaching the TAA.

Medical schools have commented that allowing staff to choose an accrual rate as at 1 April each year based on 10% increments will require extensive reconfiguring of payroll and HR systems, which will in turn have significant time and cost implications for employers. For example, employers with payroll systems that do not allow for retroactive accounting, may have to find a manual solution. There is also the assumption that any backdated amount of arrears due would be capable of fitting within the employer's monthly payment payroll system, which may not be the case and could send records into claim, which is not a desirable outcome.

A further layer of administration complexity comes with members being able to adjust their accrual rate upwards at the end of the year. University medical schools are concerned that members will choose to accrue at the minimum level, then create an administrative burden and spike in work levels by requesting information from their employer to enable them to revise their accrual rate upwards towards the end of the year. It should be noted that the impact of this administrative burden would be compounded if the facility was opened to all NHSPS members, so careful consideration needs to be given in relation to flexibilities for staff on grounds of affordability.

An additional complication is that university medical schools are direction employers and currently rely on NHS Pensions for the updating of records, as they do not have access to Pensions Online. Thought would need to be given as to how NHS Pensions wish to be notified on any adjustment to accrual to ensure member choices are accurately recorded.

No consideration seems to have been given to members with appointments across more than one employer and how this will be managed. Additionally, university medical schools commented that it may be difficult for them to certify that the member meets the eligibility test for flexible accrual. There are also significant doubts about the proposed modeller in terms of its capabilities and stated delivery date. This means that staff will expect assistance from their employer, which employers would find extremely difficult both in terms of accessing sufficient member data and not being able to provide financial advice.

A further point relates to the option to pay unused employer contributions as a one-off lump sum. This potentially causes issues where universities offer more than one pension scheme, notably the Universities Superannuation Scheme, the Teachers' Pension Scheme and the Local Government Penson Scheme where they have taken a position that they will not offer any form of cash supplement for staff who have opted-out of pension saving due to pension tax issues. University medical schools recognise that the ability for participating employers in the NHSPS to offer unused contributions as a lump sum will require them to review their policy on cash supplements in general, as it will be difficult to continue a university wide policy of not offering cash supplements when the NHSPS scheme rules allow some form of employer contribution recycling.

From an individual member perspective, they will likely need to get information from their employer and/or NHS Pensions to work out a suitable accrual rate and may also need to

seek financial advice. Even by choosing a lower accrual rate there is no guarantee that the member will not still trigger the taper. The option to potentially receive unused contributions will also still be counted as taxable income for tapering purposes which another added complication in managing this issue.

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

It is our view that the proposed flexibility in its current form is too complicated from a variety of perspectives and will only go a small way to mitigating the issues it is being introduced to address. From a purely administrative perspective a 50:50 option is far less complex. An alternative option could be for the member to still choose an accrual rate based on 10% increments but with the employer continuing to pay the full contribution rate of 23.68%. At the year-end unused contributions could be used to uplift the accrual or pay the individual concerned a one of lump sum. This would at least remove some of the administration complexity, but not all, and, for the short term at least, consideration would need to be given as to how this would fit with the contribution rebate being provided to employers, including medical schools, that have been granted government funding to help meet the additional cost of higher NHSPS contributions since April this year.

We also believe that the government should reconsider offering a zero accrual option. A similar option known as Enhanced Opt-Out (EOO) has been introduced in the Universities Superannuation Scheme (USS) whereby members affected by pension tax issues can cease future accrual but pay 2.5% of salary (instead of 9.6%) to retain their death in service and incapacity cover. Where staff have taken out EOO their employing university often also pays a cash supplement. As there is no future pensions accrual under EOO any salary supplement payable has no impact on the members earnings for tapering purposes and there are no issues with potentially breaching the lifetime allowance. A further option that should be considered is for members to set their own pensionable salary cap. Again USS has introduced a similar option known as the Voluntary Salary Cap.

We understand that the Treasury is to review the operation of the annual allowance taper to support the delivery of public services. One suggested change is that negative Pension Input Amounts could be carried forward to offset future tax charges. We also note that the Office of Tax Simplification has recently issued a policy paper in which it suggests that the annual allowance should apply to defined contribution schemes and the lifetime allowance should apply to defined benefit schemes. We would urge the Treasury to take a pragmatic approach to this issue so that solutions can be developed which balance the needs of the government, pension scheme members, their employers and tax payers.

It should also be noted that this problem is exacerbated by a number of issues that combine to negatively affect these individuals; it is not just caused by the impact of the TAA. These issues include the additional rate of income tax, the removal of the personal allowance, higher NHSPS member contributions and the benefit structure of the scheme itself. Focusing on the TAA alone will not necessarily reduce the impact on these individuals and meet the government's objectives.

4. **We're proposing 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? Please set out the reasons for your answer.**

University medical schools are generally in agreement with this proposal in principle but note that this does lead to administrative complexity as HR and payroll systems would need to be reconfigured. It is also not clear how an employer is to determine what constitutes a large pay rise. In addition it is not clear what happens if a phasing period is agreed and then the member moves to a different employer or receives a subsequent pay rise. It was also noted

that affected members would need to understand the implications to their accruing pension benefits and ultimately their pensions in retirement of phasing large pension increases. Such an option could also impact on gender pay gap reporting.

It should also be noted that pay increases impact on other groups of NHSPS member, not just high-earning staff. In particular when certain individuals move contribution salary tier, where pay rises can be completely wiped out by significant increases in the member contribution. This is particularly acute for members with earnings around £48,000 where an increase in salary can mean they face a 34% increase in their contributions as these increase from 9.3% to 12.5%. Options should therefore be developed to address this issue.

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 proposal? Please set out the reasons for your answer.**

University medical schools are in agreement with this proposal. In addition, it is our view that the scheme pays facility needs to be better explained and communicated to members of the NHSPS. While it will not necessarily always be the best option in every scenario, utilising scheme pays and remaining a member of the scheme has some important advantages over opting-out, notably that the individual concerned will not lose their ill health and death in service cover. Continuing to build up a generous CARE benefit and paying any tax through scheme pays, while acknowledging the resulting reduction in pension, is often more beneficial than receiving a cash supplement. In addition, reductions in accrued pension as a result of the scheme paying a tax charge can help to mitigate or avoid lifetime allowance charges whilst also reducing income tax payable when the NHSPS finally comes into payment.

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