**Draft response to the Department of Health and Social Care’s consultation on the proposed models for the NHS Pension Scheme’s contribution structure**

1. 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.

GPs prior to the introduction of the 2015 scheme have always had their contributions based on their actual earnings across all their practitioner roles. Since the introduction of the 2015 scheme, there has been the introduction of annualisation. This does not affect type 1 or type 2 GPs. However, it penalises those GPs that solely work as Locum. This leads to their income been annualised as if they were to work all 365 days in the year this leads to unachievable annualised incomes.

Annualisation is therefore highly unfair for GPs that choose to Locum. Many do so as they are unable to commit to full time working e.g. single parent families. These penalises these GPs as they pay a higher contribution for no additional benefits often forcing them out of the scheme as it is too expensive.

Annualisation did not exist in the 95 or 2008 schemes. I believe all GPs should pay a contribution tier based on their annual actually income from all their practitioner roles. Locum GPs are an essential element of the workforce, supporting flexibility for both the locum GPs when their personal circumstances are best suited to that way of working, and the GPs in teams they provide cover for, as well as covering unplanned absences among the e GP workforce.

1. 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.

In addressing the proposed models, whilst I recognise the removal of the 14.5% and 13.5% tiers from all of the proposed models, I believe that the proposed tiered structure remains inappropriate. I firmly believe that, given all pension scheme members will be moved to a career averaged revalued earnings (CARE) scheme from 1 April 2022, this eradicates any justification for tiered employee pension contributions, let alone the steep tiering proposed within the proposed models.

Under the CARE system, it ensures all members should in effect pay the same amount per £1 of pension. There is therefore no need for any tiering model. I would therefore advocate a totally flat structure of pension model based on a fair yield percentage that did not create surpluses within the scheme, as has already been the case.

1. 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.

I would highlight that this question is not as relevant to GPs but would note that I agree with this proposal as this would more fairly reflect the contributions of members and help to avoid punitive charges to doctors on their earnings. Notwithstanding my lack of support for any tiering within the scheme, if tiering is going to be in place, it is only fair that pay rises are taken into account regarding the different tiers. Furthermore, whilst doctors are not on the AfC payscales, given the majority of staff within the NHS scheme are, I would feel that this is a fair barometer to measure our contribution tiers against.

1. 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.

I would dispute the need for any phasing in over the next two years. Phasing just adds unnecessary complexity and delays achieving the aim of flattening the structure. It was already agreed by the advisory board in 2018 to remove the top two tiers of the NHS pension scheme following the cost floor breach. This has already been significantly delayed, and phasing would simply prolong this detriment for doctors.

1. 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.

I believe that it does achieve these aims. I would though re-emphasise that the policy objectives are unwarranted with regard to the proposed contribution tiering, given that the scheme is within a CARE system and, as such, these tiers are unnecessary.

1. 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?

I would highlight again that the tiered structures proposed by the Department of Health and Social Care would retain unjustified steep tearing within the scheme. In addition to the points identified in response to question 2, it is also clear that these proposed models are unfair relative to other pension models. At the top end of the pay scales, doctors pay almost twice as much a year in contributions for a similar pension compared to civil servants or high court judges.

The tiers being proposed therefore are inherently unfair and are not required to ensure fairness within the scheme, instead clearly reducing the value of doctors remaining within the pension scheme and continuing to work. This will have the effect of demoralising staff and increasing the likelihood of doctors taking early retirement at a time where the NHS can ill-afford to lose these experienced doctors. Regardless of age, a flat structure would be fair for all members within the scheme.

The issues outlined above are further heightened by the effect of the excessive taxation that is incurred by higher earners within the NHS pensions scheme. Indeed, the previous modelling produced by the Government’s Actuary Department failed to factor in the significant impact of either the annual or lifetime allowance when suggesting the current contribution structure.

Any new contribution structure must take into account all applicable taxes and not just income tax relief. Indeed, the current tiered contribution structure in effect completely removes tax relief from employee contributions in its entirety and yet, the Annual Allowance (AA) and Lifetime Allowance (LTA) seek to remove this non-existent tax relief for a second and third time.

As a result of these taxes being unfairly applied, doctors feel forced to reduce their working hours at a time when waiting lists are at their highest for many years and the NHS is already facing a huge staffing crisis. Furthermore, it is important to emphasise the negative impact of the NHS pension being less attractive as a package over time on recruitment as well as retention.

This has affected the career choices of not only doctors nearing retirement, but junior doctors much earlier in their career, who are increasingly looking to alternative forms of work outside of the NHS. The decisions that are therefore made now to keep a significant degree of tiering going forward will only worsen retention and "churn" of junior doctors, leading to a very high cost of training vs return to the UK taxpayer if they leave NHS work at an early stage. These proposed changes to the scheme will not be enough to assuage the concerns of doctors regarding the proposed value of their pension.

The Government announcement for the reformed pension scheme for the judiciary, in response to similar issues with recruitment and retention to those found within the NHS, would seem to be a reasonable alternative approach.  Early indications are that this has already started to reverse the recruitment and retention difficulties in the judiciary.

However, given the current staffing issues already faced by the NHS, should Government wait until the inevitable conclusion of the current trends, whereby the NHS would find itself unable to function as a result of this staffing crisis, it would be too late to rectify the situation, as senior doctors will already have been left with little option but to retire and it will be incredibly difficult to persuade them to return to the NHS with a change in policy. The introduction of a similar tax unregistered defined benefit pension scheme across the UK for those affected in the NHS, to mitigate the current punitive pension taxation system, would ensure that the scheme remains sustainable.

Without this change in scheme design, the further flattening of the proposed contribution tiers is a necessity for the NHS scheme to ensure that a greater number of scheme members are paying closer to the average yield of the scheme. The current proposed models represent a clear missed opportunity to create a fair scheme that encourages all members to participate and be treated fairly. Under the current proposals, the Government would be missing a crucial opportunity to at least address some of these issues by not implementing a flatter contribution structure for employee contributions.