AISMA response to NHS Pension consultation dated 11 September 2019

The Association of Independent Specialist Medical Accountants is a national network of over 75 firms providing expert advice to GP partners in medical practices, sessional GPs, salaried GPs, locums, hospital doctors, specialists and consultants. Our members advise on accounting, taxation, practice management and pension issues affecting the medical profession

In preface to the responses below, it must be said that the document is unclear and misguided. The examples of pension growth and taper are poor, and it is not possible to check the figures as full assumptions behind their calculation have not been given. There also appears to be the quite startling assumption that pensioning, say, 50% of one's income means the accrual of benefits for the year will be 50%, when that is not the case at all.

Whilst consultation is welcome, the application of any change in a reasonable manner, at reasonable cost to all involved, means the involvement of individuals with a full understanding of the situation. Even if the persons responsible for constructing the document understand how NHS pensions work, the unsuitable use of terminology fills no discernable reader with confidence that solutions will be reached that simplify matters or make decisions for medics easier to take.

A complete re-think is required, and that must involve the provisions of the pensions tax legislation. The provisions of the NHS Pension regulations for the 2015 scheme are unintelligible. There is no consistency between schemes in revaluation methods and rates. This makes it impossible for any person on the "Clapham omnibus" to have the slightest chance of understanding what their pension position, whether a highly paid clinician or not, is or will be. Progressively more complex pension regulations and tax legislation have resulted in sometimes quite ridiculous situations. The following is a real-life case concerning an extremely hard-working hospital consultant:

High level Clinical Excellence Awards were applied for and granted. This led to consecutive pensionable pay increases in 2013/14 of £34,000 and in 2014/15 of £38,000. Even without tapered allowances in those two years, this caused excess taxable pension growth of £157,568 and £253,988 respectively and further tax liabilities of £70,906 and £114,295, a total of £185,201. The net pay in those years, after deducting the usual tax, national insurance and pension contributions, was £96,362 and £98,353, a total of £194,715. Across the two years, therefore, this incredibly hard-working NHS consultant, before he had put food in his mouth or clothes on his back, had effectively only £9,514 of take-home pay from total gross earnings of just over £406,000. These figures are not made up! Had the consultant actually taken his pension at 31 March 2015, the employer would have been liable to an eye-watering amount of Final Pay Control charge. It is essential such charges are taken into consideration when suggestions are made for recycling employer pension contributions.

The many clients we speak to who are affected annually by the issues concerned in this consultation would welcome a simplified system that was fairer and allowed a reduction in their fees for professional accountancy, tax and pensions advice. We

would therefore urge fundamental changes to the taxation system rather than uninformed tinkering with the NHS Pension regulations, which does not provide the help that is sought.

4. Consultation questions

The department would like to receive responses on the following consultation questions, including evidence (where available) to support the response:

4.1 The case for pension flexibility

Question 1

Who do you think pension flexibility should be available to?

- NHS GPs and consultants who may be affected by the annual allowance tax charge
- Other NHS clinicians who may be affected by the annual allowance tax charge
- Non-clinicians in the NHS who may be affected by the annual allowance tax charge
- All members of the NHS workforce, regardless of their tax position
- Other group
- None of the above

Please provide evidence to support your views.

It would seem far more appropriate to open the flexibility up to all members. We accept that annual allowance issues predominantly affect higher paid members and that many of those are clinicians. But there are two counts of discrimination at play here. Firstly, clinicians are not the only highly paid members of the NHS Pension Scheme. There are also highly paid administrators and managers in the NHS who may also be affected. It is easy to imagine subsequent tribunal/court cases being brought because the flexibilities were targeted at specific groups, thus discriminating against other groups who may also suffer charges. Secondly, to grant favourable terms to one element of a workforce selects wrongly against others. For instance, whilst it is unlikely that lower paid workers will suffer annual allowance issues, there may be many, if only for a temporary period, who would welcome the ability to opt out of the scheme and have the employer pass on the value of the unspent employer pension contribution. All employees should be treated equally. The evidence is already before you. Whilst the transitional protection of existing benefits was a legitimate aim, discrimination occurred because it was established that there was no reason one age group should have more protection than another. In this case, why should one sector of the workforce have more flexibility than another?

4.2 Proposed pension flexibility

Question 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.

Yes, but it seems flawed. Whilst the greater flexibility is welcome, the document infers throughout that amending the level of contributions to, say, 50% also changes the accrual of pension benefits to 50%. This is incorrect. Assuming there is not a complete overhaul of the calculation of benefits in all the schemes, current calculation means pensioning 30% of pay could still accrue 50% of the increase in pension had 100% been pensioned. This is because final salary pensions are still linked to current whole-time equivalent pay, and GP CARE pots still get bonus uplifts above inflation. Indeed, there is the strange situation for officer members with 1995 final salary service who have transitioned into the 2015 scheme and then receive an increase in pensionable pay that, regardless of what percentage above zero they decide to pension in the 2015 scheme, the pension growth in the 1995 scheme will be exactly the same because of the final salary link. The following example may illustrate:

Fully protected 1995 officer member. Pay at 31 March 2020 (for easy reckoning) £102,000 with 32 years of service. Elects to pension 50% of pay and pays £6,885.00 contributions (still at 13.5%).

Pay at 31 March 2021 has increased because a threshold has been passed to £108,000.

Officer pension still based upon whole time equivalent pay, so the £108,000 will be used, but only 6 months service will be added

Pensions will be:	31 March 2020 £102,000 x 32/80 =	£40,800
	31 March 2021 £108,000 x 32.5/80 =	£43,875

Had 100% been pensioned, the benefits would have been:

	31 March 2021 £108,000 x 33/80 =	£44,500

As can be seen, pensioning 100% increases the pension by £3,700. Pensioning 50% increases the pension by £3,075, not half of the £3,700 (£1,850). The situation is perhaps even stranger for transition members. A further example should help illustrate:

If the above member had transitioned to the 2015 scheme in April 2015, no extra service would go into the 1995 scheme:

By virtue of the final salary link, the benefits would be:

31 March 2020 £102,000 x 32/80 = £40,800

31 March 2021 £108,000 x 32/80 = £43,200

Because 1995 benefits are calculated using whole time equivalent salary, the above accrual would be the same if the member has pensioned 10% in the 2015 scheme or 100%.

Planning for consultants is a little more straightforward than for GPs as reasonable projections of pensionable pay may be made. But even that is fraught with uncertainty. Despite the phasing of new pensionable awards as proposed, if 100% had originally been chosen, large annual allowance charges may still arise. Similarly, annual allowance pension growth in the 2015 scheme is partially governed by the CPI figure for the September before the year in question AND from the September falling in the applicable year. If the in-year September CPI spikes, then it can render the choices made before the start of the year useless.

Planning for GPs is a lottery for all but those with the very best specialist advisers. By virtue of out of date records because of PCSE's underperformance, very few GPs are aware of what their current position is. There is no solid ground from which to work forward. Further, their pensionable pay for any particular year is based upon profit and not salary. Profits are taken from practice accounts completed many months after the applicable year. Normal commercial influences mean profits can vary significantly from year to year, even if the same amount of work is done. For these reasons, forming an impression of what might be a reasonable percentage of pay to pension so as not to accrue a pension charge is a game of chance. In addition, it is highly unlikely that PCSE would be able to process in year changes to the rate of pensioning to ensure that higher contributions would be collected in a timely manner so that tax relief can be claimed in the year. Such underperformance has caused much heartache for many GPs already. By not collecting pension contribution shortfalls in a timely fashion, a GP's pay for threshold income purposes increases, thus increasing the taper and the exposure to the annual allowance. Compensation must be available to GPs affected in this way, which will occur much more frequently if the proposed retrospective changes must be made in the year. Whilst flexibility is consequently welcome, its practical application before the pension year end will be highly complex and very expensive to examine.

Paragraph 3.11 of the consultation advises that death in service and ill-health benefits would continue to be paid in full. This appears to be being funded by adjustment to the rate of employer contribution paid and will be factored into the final scheme design. The experience of Aisma members suggests this will require a complex actuarial calculation. Whatever is determined, the adjustment must be capable of being incorporated into the type 1 GP certificate of pensionable profits and the type 2 GP self-assessment of pensionable pay. We are most uncertain that this will be a simple thing to do and will almost certainly create problems with PCSE making incorrect adjustments.

Question 3

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

1. The contribution rate must be capable of being reduced in year as well as increased.
2. A simpler method of calculating a GP's pensionable pay should be implemented that allows them to plan. Perhaps a method more akin to dentists should be considered, as it used to be before the new contract in 2004. GPs prized their SD86 in those days!
3. The growth of NHS pensions for the purposes of annual allowance tax should be examined. All schemes have their pension input period aligned with the tax year rather than the scheme accounting year. For all NHS schemes there is a different pension value at 31 March compared to 5 April, the latter governed by a CPI figure unknown at the start of the year, together with income from a later year that is also unknown. If those values could be aligned (to the simpler 31 March), then it would make planning easier. Obviously, retiring members should receive their full entitlement to benefits, but that is not quite the same thing as valuing them at any other particular time. This does not entail changing tax law, just pension regulations to make the pension calculation the same at 31 March as it is at 5 April, for the purposes of determining annual allowance charges only. For example, at present a GP's dynamised main practitioner pot has a different value at 5 April to the previous 31 March. Similarly, in the 2015 scheme, there is a different value at 5 April to the previous 31 March but calculated in a different manner to the aforementioned 1995 practitioners uplift. The Flexibility Value Earnings Credit, however, has the same value at 31 March and 5 April. This is confusing and inconsistent and should be examined.
4. The consultation suggests a 'modeller' will be provided to assist planning. However, tools such as the BMA Goldstone Pensions Modeller are only as good as the person feeding information into it. The experience of Aisma members suggests that most NHS pension members have insufficient understanding of the scheme(s) they are a part of or their own particular pensionable circumstances to enable them to properly complete such a tool. Unless in the correct hands, its use would be limited. Further, as mentioned above, it cannot predict future earnings and CPI rates, which makes a significant difference. Should models be made available, how and who will assess them? Within its membership AISMA has several advisers considered to be the foremost authorities on the NHS Pension Schemes in the country and may be able to assist. In addition, we understand that some employers commission or pay for advice on behalf of affected employees. A more widespread practice of this should be encouraged, but, again, the impact of doing so should be factored into the ability to recycle employer contributions back to the employee.
5. Permitting the flexibility as suggested will mean higher paid workers paying less in employee contributions. Tiered contributions reflect an implicit cross-funding of benefit accrual; in other words, higher paid workers are helping to fund the pensions of those paying a rate as low as 5%. The flexibilities suggested ought to mean a review of this approach or the sustainability of the scheme may be affected.
6. All members of the 2015 scheme accrue benefits on a CARE basis. Part time members and GPs not in the scheme all year have their contributions paid on

a whole-time/annualised basis. In a CARE scheme, this concept produces inconsistencies. For example, if there were two GPs with exactly the same pensionable pay of £45,000, producing exactly the same pension benefits, one could pay 9.3% and the other 14.5% depending upon what the working patterns are. Should annualisation and whole time equivalent be retained, detailed guidance must be provided to demonstrate exactly how this is to work when a member exercises the flexibilities or phases the pensioning of large pay increases.

7. Clearly amendments to pension tax legislation are the preferred option, but it seems clear that both pension regulations and tax legislation must be looked at simultaneously to achieve effective results. It seems sensible to assume that implementing such flexibility changes affects the costing of the scheme, as will the provision of maintaining full death in service and allowing for employer Final Pay Control charges etc. A flatter tier structure, allowing, say, just three tiered rates of 9%, 11% and 13% together with a flat tax relief rate of, say, 25% or 30% for all, together with the flexibilities proposed, and no pension tax charges, would provide certainty and choice and recoup the Exchequer significant sums. It would also make scheme costing and design considerably simpler for the actuaries.
8. There will undoubtedly be an impact on the overall financing of the NHS Pension Scheme dependent on the result of the compensation claim in the Judges and Firefighters cases but the need to create a solution now for GPs and other clinicians means that action must be taken prior to that impact being known

Question 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.

No, this should not be the default position. It should be an option. Members should be able to pension the full amount if they wish, but also have the option of phasing the pensionable amount as described. Final salary links on a whole-time equivalent basis for people with 1995 service must still be catered for under this proposal. How will employers' and NHS Pensions Agency systems deal with this?

Gradual changes as suggested would not be easy for employers to administer. We have seen numerous instances of employers even now not placing back-dated pay awards in the correct year for pension, and thus annual allowance, purposes. It is easy to envisage the phasing of pensionable increases would be incorrectly processed, particularly those done around the year end.

Further, what would be the definition of 'large pay increases' and how will the 'final salary' be calculated if the member retires in the year an increase is phased? Presumably any reduced pensionable pay through phasing will also reduce the impact on the employer for Final Pay Control purposes.

It is unclear how this proposal will apply to GPs. Their profits fluctuate all the time and will not be known until after the year end. Is it proposed to allow phasing for

increases in profits? The GP Certificate of Pensionable Profits can potentially be amended to accommodate this, but it seems clear that it would cause considerable confusion and error at PCSE.

Whilst we recognise that difficulties may arise with changes to a member's tax position, the only way to provide full flexibility is to offer retrospective post year elections to pension whatever level a member wishes; i.e. to pay full contributions in the year, but elect to reduce it after the year end.

4.3 Improving Scheme Pays

Question 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.

AISMA understands that creating pension debits on the NHS record entails a manual intervention each time. The extra cost of staffing required to support this proposal means it should be avoided, particularly as it will not produce the transparency desired. A scheme pays election for 2018/19 must be submitted to the NHS Pensions Agency by 31 July 2020. NHS Pensions must then include this in an AFT return by 31 December 2020 and pay the tax by 14 February 2021. This would then have to be manually included in a pension debit, which would not then find its way into the Total Reward Statement system until August or September 2021 and probably later. Including a pension debit therefore does not provide the transparency that is sought.

The NDC method should be retained, but the Total Reward Statements, Annual Benefit Statements and other pension estimates and so on should contain the information on a year by year basis of the tax paid by the scheme and the interest incurred to the statement date. If such an update is not possible because of incompatible systems, then a scheme pays summary should be provided annually for those with elections in place. The member can then assess their own net benefit.

What would make a very big difference to scheme pays would be the acceptance of late claims in certain circumstances. As has been highlighted in the consultation, when pension savings statements have not been issued prior to the deadline for scheme pays submission, an estimated scheme pays may be sent in that can subsequently be amended. Admittedly this serves a purpose. The issues with PCSE, however, can frequently mean that pension savings statements have not been issued for a particular year even when the deadline for amending the scheme pays is being reached. It would be amenable to all affected members if the NHS Pension Scheme accepted a scheme pays election up to 3 months after the issue of a pension savings statement, regardless of when it was issued.

Should a debit method be applied, we assume that the reduced amount will be considered for annual allowance purposes.

4.4 Equality Impact Assessment

Question 6

What impact, if any, do you think the following will have on people with one or more protected characteristics:

- The proposal to target the flexibility to clinicians who have a reasonable prospect of an annual allowance tax charge
- The proposal to provide flexible accrual to clinicians who have a reasonable prospect of an annual allowance tax charge
- Other proposals in the consultation document e.g. phasing pensionable pay increases and/or commissioning a modeller to help individuals understand their tax liability and flexibility options
- Adopting the debit method for scheme pays

There do not appear to be any immediately obvious impacts on people with protected characteristics. As noted above, however, there are clearly impacts on people of any characteristic not included in the very narrow definitions suggested for the flexibilities. In making a commitment to assist one sector of the workforce to address a problem, it seems wrong to not allow similar flexibility to others who may have their own different problems.

Question 7

Are there any further equality considerations that the department should be aware of from groups outside the data set?

As above.

5. How to respond

Comments on the proposals can be submitted online.

By email to: NHSPSconsultations@dhsc.gov.uk

Or by post:

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The consultation will close on 1 November 2019.