Title: Access to the NHS Pension Scheme for Independent Providers of NHS Clinical Services **IA No:** 8057 **Lead department or agency:** Department of Health **Other departments or agencies:**	**Impact Assessment (IA)** **Date: 0**7/01/2014 **Stage:** Final **Source of intervention:** Domestic **Type of measure:** Primary legislation **Contact for enquiries:** NHS Pension Policy Team, 2W09 Quarry House, Quarry Hill, Leeds LS2 7UE

Summary: Intervention and Options

RPC Opinion: Not Applicable

Cost of Preferred (or more likely) Option				
Total Net Present Value	**Business Net Present Value**	**Net cost to business per year** (EANCB on 2009 prices)	**In scope of One-In, Two-Out?**	**Measure qualifies as**
£m	£m	£m	No	N/A

What is the problem under consideration? Why is government intervention necessary?

The Health and Social Care Act (2012) signalled a change in the 'traditional' model of NHS Clinical provision, from one provided by the NHS, to one performed by a range of providers from both the NHS and the independent sector. NHS organisations are entitled to and required to automatically enrol into the NHSPS all the eligible staff they recruit. IPs often find it prohibitively expensive to build in pension benefits into their reward packages that are comparable with NHSPS. One of the key barriers to delivering a 'Fair Playing field' in this emerging clinical market, is access to the NHS Pension Scheme which is seen as a key recruitment and retention incentive to staff.

What are the policy objectives and the intended effects?

To support delivery of a fair playing field in pension access between different providers of NHS services by increasing access to the NHSPS among staff delivering NHS services in IPs. To maintain access as an established part of the reward package for most staff delivering NHS services. The effects of this should be ensuring the continued viability of the NHSPS, to deliver continued access for all clinical and admin staff delivering those services through enabling the portability of pension provision, and to support and build on the HMT led New Fair Deal policies.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

9 Key options were considered (see page 7 RAG rating table) these were reduced to the 5 below;
Option A - 'Do nothing' - No reforms of the existing arrangements
Option C - Variant 1 - IPs engaged in the provision of NHS clinical services required to provide all staff (wholly or mainly employed in NHS work) with NHSPS access as a 'term of business'
Option C - Variant 2 - IPs engaged in the provision of NHS clinical services free to decide on use of NHSPS, and if opting in, which of their staff (wholly or mainly employed on NHS work) should be joined.
Option C - Variant 4 - As above but if opting in, required to enrol all staff (wholly or mainly employed on NHS work)
Option C - Variant 5 - IPs engaged in the provision of NHS Clinical services free to decide on use of NHSPS (Preferred Option - further details on this in Evidence Base.)

Will the policy be reviewed? It will be reviewed. **If applicable, set review date:** Month/Year

Does implementation go beyond minimum EU requirements?			Yes / No / N/A		
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	**Micro** Yes/No	**< 20** Yes/No	**Small** Yes/No	**Medium** Yes/No	**Large** Yes/No
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent) N/A			**Traded:**	**Non-traded:**	

I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) that the benefits justify the costs.

Signed by the responsible Minister: Dan Poulter Date: 05/03/2014

Summary: Analysis & Evidence

Policy Option 1

Description: C5 - Optional access – Opt for NHSPS Access at one of three levels: Level 1 – Scheme Direction access only, for those IP staff with a Fair Deal obligation, Level 2 – Closed IP employer access, for those staff with previous entitlement to NHSPS within 12mths of joining the IP, Level 3 – Open IP employer access, for all of an IPs eligible employee's.

FULL ECONOMIC ASSESSMENT

Price Base Year	PV Base Year	Time Period Years	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	**High:** Optional	**Best Estimate:**

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional		Optional	**Optional**
High	Optional		Optional	**Optional**
Savings	£0.1bn			

Description and scale of key monetised costs by 'main affected groups'

- IPs – more beneficial than 'broadly comparable' pension scheme which cost on average 14% more
- Commissioners – ensure VFM by offering increased competition in the market, 14% savings possible
- Employee – enable continued access to NHSPS at the same cost
- NHSPS - £0.1bn p/a contribution that would otherwise be lost to private sector pension provision

Other key non-monetised costs by 'main affected groups'

- IPs – reduction in admin costs, average cost of administering NHSPS £16 per member, lower than for private sector scheme cost of £41 to £47 per member
- Patient – opens up the market ensuring better VFM and increased patient choice

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional		Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate				

Description and scale of key monetised benefits by 'main affected groups'

- IPs – more cost effective to use the NHSPS rather than funding a 'broadly comparable' scheme.
- Commissioners – ensure value for money due to increased competition in the market.
- Employee – contributions for transferring staff will continue as under previous employment.
- NHSPS – contributions will increase thus ensuring overall Scheme viability.

Other key non-monetised benefits by 'main affected groups'

- IPs – enhanced recruitment and retention terms to staff through continued access to NHSPS.
- Commissioners – increased choice and competition over who can deliver NHS services.
- Employee – improved employment and mobility options if they are able to retain access to NHSPS.
- NHSPS – membership retained and Scheme continues to be viable.

Key assumptions/sensitivities/risks **Discount rate (%)**

The assumption that the majority of staff will want to retain or join the NHSPS may not occur, however it is believed that this will not be the case with the benefits to staff having access to the scheme ensuring continued membership. There is a risk that the NHSPS will see a shortfall in contributions overtime, however this will be mitigated by NHSPS valuations, carried out every 4 years. If contributions are falling and pay outs exceed this, then measures will be taken to ensure viability.

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			In scope of OIOO?	Measure qualifies as
Costs: 0	**Benefits:** 0	**Net:** 0	No	N/A

Evidence Base

Access to the NHS Pension Scheme for Independent Providers

Three high level options were considered in terms of extending access to the NHSPS with a number of sub options within each;

Option A – No reform of current NHSPS access arrangements

Option B – Access to the NHSPS is extended to non-NHS providers of NHS clinical services delivered under an NHS Standard Contract for clinical services (or an alternative personal medical services (APMS) contract), but for existing members of the Scheme only. There are three potential variants of Option B:

1) Access would be a 'term of business' for organisations looking to provide NHS Clinical contracts, and providers would be required to auto-enrol eligible staff into the Scheme.
2) Access would be optional for organisations providing NHS Clinical Services signing a new NHS standard contract, and they would be able to choose which eligible staff have access.
3) Access would be optional for organisations providing NHS Clinical Services signing a new NHS standard contract, but if they choose to access the Scheme, they would be required to offer access to **all** eligible staff.

Option C – Access to the NHSPS is extended to non-NHS providers of NHS clinical services delivered under an NHS Standard Contract for Clinical Services (APMS) contract. This would allow IPs to offer access to both existing NHSPS members and staff with no previous access. There are four potential variants of Option C:

1) Access would be a term of business for organisations looking to provide NHS Clinical contracts, and providers would be required to auto-enrol eligible staff into the Scheme.
2) Access would be optional for organisations providing NHS Clinical Services signing a new NHS standard contract and they would be able to choose which eligible staff have access.
3) Organisations providing clinical services signing the new standard contract would be required to offer the Scheme to **all** eligible existing members as a term of business. However, providers would have the flexibility to choose whether they want to offer access to staff without previous membership, and can pick which staff they offer access to.
4) Access would be optional for any qualified provider (AQP) organisations but if they choose to access the Scheme, they would be required to offer access to **all** eligible staff.

After careful consideration the options were reduced down to 4, however, DH sought to develop a further variation of Option C that would embrace the advantages of both variations:

Option C - Variation 5 - *Access would be optional for AQP organisations. If they choose to 'opt in; they would be required to offer access to **all** existing members of Scheme. They can also choose whether to offer access to staff without existing access, but again they would be required to offer access to **all** eligible staff.*

In line with the principles of Option C, Variation 5 would allow IPs to offer access to all staff that are wholly or mainly engaged in the provision of NHS Clinical services and thereby would remove the NHS's competitive advantage in terms of the FPF pensions.

This option would also use the flexibilities inherent in variation 3 of Option B, which allows IPs to offer alternative pension arrangements to staff without prior membership of the Scheme. However, it would not provide the IPs with a significant access advantage over NHS organisations, as they would be required to provide/offer access to all eligible staff once they had decided on the level of access they required. Importantly, this extra flexibility is likely to encourage more IPs to participate in the Scheme and thus enhance labour mobility by facilitating stable member participation levels in the NHS Market.

Finally, this option shares many of the other positive aspects of Option C Variation 4, including a low risk of extending the balance sheet and the potential for a neutral rather than negative affect on the HMT income. This leads to the conclusion that option C Variation 5 would satisfy the most criteria for the purposes of this analysis.

The Department of Health favours option C5 because it believes it will best help:

- secure increased efficiency and patient choice in line with Health Act 2012 aims, by encouraging IPs to engage in the provision of NHS Clinical Services and removing pension barriers to that engagement.

- ensure that all providers of NHS Clinical Services (public and private) are treated neutrally, in terms of access to NHS contracts and the NHS PS

- maintain NHS PS membership and contribution income over time, following future increases in IP engagement

- avoid a 'flight to the bottom' in NHS pension provision, by ensuring that NHS PS remains available to all staff providing NHS clinical services, whatever the setting

- enhance and complete New Fair Deal changes to 'level the pensions playing field' in NHS clinical services provision, by making NHS PS available to non-transfer of undertakings (Protection of Employment) regulations (TUPE) as well TUPE transferred staff

- minimise the risk of legal challenge and costs on grounds of unequal treatment of IPs (if the pensions playing field was only partly levelled by New Fair Deal access),

- minimise the risk of legal challenge and costs on grounds of reducing IPs ability to compete, if NHS PS access was not optional but required, as a 'term of business', and

- achieve the best achievable match of stakeholder policy aims

Additional analysis of the options and variations can be found further into this document.

Extract from the business case detailing Option C5

Impact on future pension fund/taxpayer liabilities

Option C5 - 'Optional access to NHS PS for Independent Providers', with a further two-tier optional take-up of:

(a) 'existing' staff (wholly or mainly employed on NHS work) with NHS PS access within the past 12 months only, or

(b) 'existing' staff PLUS other staff (wholly or mainly employed on NHS work)

shows a small increase in short/medium term contribution income, but a reassuringly similar out-turn for projected scheme liabilities as the current baseline, at both 2020 and 2040.

13. Looking more closely at the tables in annex C, reveals a wider range of possible out-turns for three slightly different possibilities, 'do nothing', 'New Fair Deal plus non-TUPE transferred staff on Clinical Services only', and 'New Fair Deal plus ALL other IP staff including new recruits'. All staff offered access would have to be engaged wholly or mainly in the provision of NHS services.

14. The results estimated depend on the levels of TUPE and competition turnover assumed and the amount of access for Independent Provider staff actually achieved. However, an interesting comparison is revealed between the current GAD 'do nothing' baseline model and GAD models 4(c) and 5(c) on pages 53 and 55 of this document.

Option	Contributions £bn			Scheme Liabilities £bn	
	2015	2020	2040	2020	2040
Baseline (access unchanged)	8.8	8.4	7.3	277	244
Access for new Fair Deal (TUPE) staff plus all other staff on NHS clinical services (assumes a 75% take-up and high TUPE level)	9.0	8.5	6.9	278	242
Access for new Fair Deal (TUPE) staff plus all other staff on NHS clinical services (assumes a 50% take-up and high TUPE level)	8.9	8.4	6.9	278	240

15. **GAD model 4 (c)**, with access assumed at 75%, reveals contribution income very similar to current baseline initially, with a gradual decline by 2040 and fairly similar scheme liabilities up to 2040.

16. **GAD model 5 (c)**, with access assumed at 50%, again shows contribution income up to 2040 in the same range as current baseline, but with scheme liabilities little changed at 2020 and significantly lower by 2040.

Affordability conclusions

17. The results from annex B, reveal that the DH preferred 'Option C variant 5'[1], under which IPs choose whether to use the NHS PS, and then decide which of two possible levels of staff access best suits their needs, provides the closest approach to current baseline projections. In effect, this means that a key concern, that the scheme balance sheet should not be extended, would be met.

18. The results from annex C, at paragraphs 15 and 16 above, are similar but try to estimate actual out-turns under different levels of possible IP take-up. The useful indication this gives is that, at a level of IP take-up of 75% (with the expected high TUPE) the balance sheet is again not extended with, if anything, scheme liabilities slightly reduced.

19. If IP access take-up of 50% is assumed (with the expected high TUPE), scheme liabilities are actually reduced by 2040. This is significant, in that 50% take-up is one of the Monitor conclusions and is mirrored in the survey of IPs.

20. The above conclusions give the Department confidence that the NHS PS balance sheet will not be extended by these access proposals, and that the DH preferred option C variant 5, provides the best balance of financial risks, as well as the best policy match achievable across the range of stakeholders.

21. We have committed to a 'Post Implementation Review' of the IP Access project with the Staff Passport Group and HMT. These reviews are planned at 1and 5 years. The review will include the developed BSA processes and regulations, in practice, and the relative costs of IP v Trusts.

It is intended that these reviews will take place at least after the first and the fifth years from the April 2014 implementation and will consider:

- how well the policy has been implemented,
- the impact that it has had on the health labour market and
- any changes that may be necessary.

[1] (see section 4, page 14 of this business case)

FULL ACCESS REVIEW OPTIONS – RAG CHART

Option and Associated Variation	Policy Issues		Feedback from Providers		Financial Implications		Legal Risk
	Balances the Fair Playing Field for pensions?	Facilitates labour mobility in the NHS Market?	Summary of Independent Sector Feedback	Summary of NHS employer Feedback	Risk of extending the balance sheet	Impact on short term cash flow	
Option A - *No reform of the existing access arrangements*	**No**	**No**	**Negative**	**Positive**	**Base**	**Base**	**Med**
Option B, variation 1 *Term of business - existing members only*	**Partially**	**Partially**	**Negative**	**Neutral**	**Low (-£4bn to £0bn)**	**Negative**	**High**
Option B -Variation 2 *Optional access - providers can choose which staff have access (existing members only).*	**Partially**	**Partially**	**Very Positive**	**Negative**	**Very Low (-£9bn to £0bn)**	**Negative**	**Low**
Option B - Variation 3 *Optional access – if providers 'opt in' they are required to offer access to all existing members.*	**Partially**	**Partially**	**Positive**	**Neutral**	**Very Low (-£9bn to £0bn)**	**Negative**	**Low**
Option C -Variation 1 *Term of business – providers required to offer access to all eligible staff (including those with without previous NHS Pension entitlement).*	**Yes**	**Yes**	**Negative**	**Neutral**	**Medium (£0bn to £9bn)**	**Positive**	**High**
Option C -Variation 2 *Optional access - allows providers to choose which eligible staff can access*	**No**	**Partially**	**Very Positive**	**Negative**	**Low/ Medium (-£9bn to £9bn)**	**Neutral/ Positive**	**Low**
Option C -Variation 3 *Term of business - providers required to offer access to existing members, but can select which staff without previous NHS Pension entitlement they offer access to.*	**Partially**	**Yes**	**Negative**	**Negative**	**Low/ Medium (-£4bn to £9bn)***	**Neutral/ Positive**	**High**
Option C -Variation 4 *Optional access - if providers 'opt in' they would be required to offer access to all eligible members.*	**Yes**	**Partially**	**Neutral**	**Neutral**	**Low (£-9bn to £9bn)**	**Negative/ Neutral**	**Low**
Option C -Variation 5 *Optional access - If providers 'opt in' they are required to offer access to all existing members. They can also choose between offering access to all staff without previous NHS entitlement, or none*	**Significant Improvement**	**Yes**	**Positive**	**Neutral**	**Low (-£9bn to £9bn)**	**Negative/ Neutral**	**Low**

Background and Context

Summary of issues

1. The *Health and Social Care Act 2012 (2012 Act)* signalled a sea-change in the 'traditional' model of NHS Clinical provision, from one provided by the NHS, to one performed by a range of providers from both the NHS and the independent sector.

2. The legacy of the traditional model is that NHS providers remain the largest employers of clinical staff, employing around 90% of the NHS workforce. For example, out of the £110bn healthcare spend in 2010/11; just 7.5% was non-NHS. Inevitably, this forces new providers entering the market, especially those needing to recruit experienced staff, to develop reward packages that are competitive with those available in the NHS.

3. NHS organisations (and for historic reasons, GP practices) are entitled and required to automatically enrol into the NHS Pension Scheme (NHSPS) all the eligible staff they recruit. However, (non-GP Practice) Independent Providers (IPs) often find it prohibitively expensive to build pension benefits into their reward packages that are comparable with the NHSPS. Equivalent pension cover costs for IPs range from 22 to 24% of total staff costs (compared with 14% for NHS organisations and GP Practices) and this can make it difficult for them to develop reward packages that can attract experienced NHS staff. This is especially so for smaller providers such as Social Enterprises, which specialise in the outsourcing of former NHS services using inherited staff. Such individuals invariably have high levels of NHS PS membership and this reduces the competitiveness of many IPs, resulting in a 'playing field' tilted towards the NHS and away from the development of a more plural NHS market.

4. The previous Secretary of State for Health favoured addressing the obstacles this issue placed in the way of achieving the policy aims of the 2012 Act by extending NHS PS access for IPs. He reached agreement with the Chief Secretary to the Treasury (CST) to develop proposals to work in tandem with HMT plans to revise Fair Deal, so that TUPE transferred staff would have automatic access to their former scheme (e.g. NHS PS). Following agreement on fundamental reforms to the NHSPS, CST also indicated willingness to see proposals developed by a partnership-working group of representatives from the DH, HMT, NHS Employers and NHS Trades Unions, that would permit IPs engaged in the provision of NHS clinical services access to the scheme for new recruits not covered by TUPE. Staff offered NHS PS access would need to be wholly or mainly employed on NHS work. CST made it clear that any such proposals must limit risks to taxpayers and as part of this process, HMT have asked for a full business case to support the work.

Options for Reform

A range of options have been considered to identify appropriate terms under which access should be made available to non-NHS organisations. These are detailed below:

Option A – No reform of current NHSPS access arrangements

Option B – Access to the NHSPS is extended to non-NHS providers of NHS clinical services delivered under an NHS Standard Contract for clinical services (or an APMS contract), but for existing members of the Scheme only. There are three potential variants of Option B:

4) Access would be a 'term of business' for organisations looking to provide NHS Clinical contracts, and providers would be required to auto-enrol eligible* staff into the Scheme.
5) Access would be optional for organisations providing NHS Clinical Services signing a new NHS standard contract, and they would be able to choose which eligible staff have access.
6) Access would be optional for organisations providing NHS Clinical Services signing a new NHS standard contract, but if they choose to access the Scheme, they would be required to offer access to **all** eligible staff.

Option C – Access to the NHSPS is extended to non-NHS providers of NHS clinical services delivered under an NHS Standard Contract for Clinical Services (or an APMS contract). This would allow IPs to offer access to both existing NHSPS members and staff with no previous access. There are four potential variants of Option C:

5) Access would be a term of business for organisations looking to provide NHS Clinical contracts, and providers would be required to auto-enrol eligible staff into the Scheme.
6) Access would be optional for organisations providing NHS Clinical Services signing a new NHS standard contract and they would be able to choose which eligible staff have access.
7) Organisations providing clinical services signing the new standard contract would be required to offer the Scheme to **all** eligible existing members as a term of business. However, providers would have the flexibility to choose whether they want to offer access to staff without previous membership, and can pick which staff they offer access to.
8) Access would be optional for AQP organisations but if they choose to access the Scheme, they would be required to offer access to **all** eligible staff.

*Eligible staff in the context of options B and C refers to staff that are 'wholly or mainly' engaged in NHS services.

Control Mechanisms

Any extension of the Scheme's terms of access needs to be on a controlled basis, and it is necessary to ensure that this is done in a fair and safe way. A range of control mechanisms have been developed alongside the options outlined above to ensure that there would be no unintended extension of the NHSPS beyond the policy intention. For the sake of clarity, the proposed measures are briefly outlined in the sequence they would impact upon a new organisation joining the Scheme, and include:

- ***Control mechanisms that would bite before an IP can begin offering access to the Scheme*** – These includes provision of a 'bond' by the IP, with the purpose of protecting the taxpayer from employers that are unable to pay contributions in accordance with NHS Pension Regulations.
- ***Control mechanisms that become effective while an IP employs active members of the Scheme*** – These include arrangements for IPs to declare the level of Pensionable Pay used for NHS clinical services and auditing processes to support this.
- ***Control mechanisms that take effect when a member of staff leaves retirement*** – This refers to a mechanism that would limit the risk associated with final salary manipulation by charging employers for the capital cost of any 'excessive' increase in final pensionable earnings in the run up to retirement.

Criteria used to Evaluate the Options.

Following a review of the materials produced to date, the following criteria have been used to evaluate each option:

Does the option facilitate a Fair Playing Field for Pensions?

As highlighted above, evidence suggests that existing NHSPS access arrangements skew the NHS market in favour of NHS employers. This issue is highlighted as a key objective in the terms of reference of the Partnership Review, which states that the review should 'support the plurality of provision of NHS services based on 'Fair Playing Field' (FPF) principles. It is therefore a crucial criterion in terms of this analysis.

The most appropriate option from FPF perspective will be the one that facilitates a balanced a playing field for pensions as opposed to one that tilts it towards NHS organisations, or conversely, towards IPs.

Does the option encourage labour mobility?

Labour mobility is another important area to consider in the context of this review. Feedback from employers and staff alike suggests that access to the NHSPS is often an important factor for staff moving roles, particularly in the later stages of their career.

This is sometimes the case even where staff are offered benefits that may be comparable to the NHSPS. Various reasons have been suggested for this, including members desire to retain pension continuity, or wanting to remain a member of the 'NHS family' due to the low levels of trust in new health providers reward schemes. However, the link between pension portability and the flow of skills and experience in the emerging market is clear.

In terms of this analysis, the extent that an option encourages labour mobility in the NHS market is evaluated by looking at whether it would encourage IPs to offer access to the NHSPS. Several factors can affect this, such as the terms of access on offer, or whether the arrangements are perceived as being over bureaucratic.

Do non-NHS providers support this option?

Non-NHS provider buy-in will be crucial for the implementation of the chosen option, particularly in terms of ensuring that employers comply with Schemes admin requirements and (where relevant) understanding whether IPs will choose to opt into the arrangements (see labour mobility above).

Evidence for this criterion is drawn from previous representations from IPs and related groups, but also from two workshops held by DH on 16 April and 16 July last year. These workshops were held with the objective of discussing issues in relation to the review, and were attended by representatives from social enterprises, private sector organisations and GP practices. Evidence gathered included information from the results of survey issued after the 16 April workshop, which asked participants to identify their preferred option.

Do NHS providers support this option?

Input from incumbent NHS providers has also been considered, with evidence drawn from a further workshop and associated survey that was held with NHS employer representatives on 15 May.

In particular, feedback from NHS organisations suggested that while they accepted that the NHS holds a competitive advantage in terms of pensions, they were also concerned about other FPF issues that may tilt the playing field in favour of IPS - such as a comparative lack of flexibility over terms and conditions and training obligations. While there was recognition that this may be counteracted by more favourable tax arrangements in the NHS, on the whole they were generally unsupportive of options that would erode their existing competitive advantage, or at worst provide the IP with a pension advantage.

Will this option cost the taxpayer more?

A key objective of the review is that any change to the terms of access should involve limited additional financial risk to the taxpayer, and therefore should not significantly 'extend the balance sheet' in terms of NHSPS liabilities. The Government Actuary's Department (GAD) has carried out modelling that analysed the impact of the various options on the NHSPS's liabilities over the short and long term, which has been used as part of this evaluation. This modelling assumes that effective control mechanisms would be in force to ensure that employers only pension staff working on NHS services – for more detail see section 3 on the proposed control mechanisms.

What impact will the option have on short-term cash flow to HMT?

GAD's modelling work also looked at the impact on NHSPS's contribution yields. Existing contribution yields from the NHSPS are currently greater than the benefits paid out to retired members, and while this trend will be reversed in coming years, the excess currently accrues to HMT and is fed into wider Government spending considerations.

Options that would significantly reduce receipts from contributions (for example by reducing the membership of the Scheme) will have a negative short-term impact on Government finances - which is particularly undesirable in the current fiscal climate.

Is the approach legal?

The options have also been analysed in terms of the potential legal risks involved in implementation. In particular, DH requested legal advice to clarify whether there is a risk associated with those options that would make access to the NHSPS a term of business. The advice identified a clear risk that access as a term of business could be subject to legal challenge, but was also clear that where providers have a 'commercial choice' about whether to opt in to the Scheme, there was a low risk.

Options Appraisal

- ***This section evaluates each option based on the criteria outlined in the section above***
- ***This appraisal is not intended to recommend a specific option, but to facilitate discussion within the review group and reach consensus on a preferred approach.***

OPTION A - *no reform of the existing NHSPS access arrangements*

- The 'do nothing' approach would restrict access outside the NHS except for where staff transferred under TUPE. This means that organisations delivering NHS services under AQP would have no access to the Scheme.
- This option would ignore the direction of travel set out in the Health Bill by not addressing the FPF issues that are of critical importance to increasing the plurality of NHS providers. In addition, depending on the level of market penetration by IPs, labour mobility for experienced NHS staff would reduce over time due to an overall reduction in Scheme availability.
- This option was heavily rejected by representatives from IPs, with every respondent from the provider survey without access to the Scheme citing difficulties with the existing arrangements - particularly in terms of recruiting experienced staff.
- On the other hand, NHS employers clearly favoured this option, questioning why NHS organisations would want give away a valuable competitive advantage in a commercial environment.

Summary: Option A fulfils very few of the criteria, and therefore is unlikely to be appropriate going forward.

OPTION B- *Access to the NHSPS extended to non-NHS providers of NHS clinical services - but for existing NHS Pension members only.*

Variation 1 - *Access as a term of business*

- Crucially, this variation would put a contractual requirement on organisations to offer access to the Scheme, and would involve a significant legal risk if implemented.
- However, this and the other variations of option B would support FPF principles by alleviating the difficulties felt by IPs when recruiting existing members. Given that most experienced NHS

staff already have access to the Scheme, this would have marked overall impact of the FPF. That said, the playing field would remain tilted towards the NHS for staff without previous membership.
- Option B also facilitates labour mobility by removing a key concern of staff about leaving NHS employment. However, it could also encourage behaviours where newly qualified staff become unwilling to join IPs until they have secured NHSPS access through employment within the NHS.
- The GAD modelling identified low levels of risk associated with all variations of option B. This is because option B is likely to reduce scheme participation overall due to many new starters not having access. By the same token, this option also risks a negative impact on the Scheme's cash flow due to reduction in contributions.
- While IP feedback generally supported option B, they were strongly opposed to this variation, as it would remove much of their flexibility to utilise the NHS tariff to provide varied reward packages where appropriate.
- However, feedback from NHS employers indicated that while they were not supportive of extending access, if pressed they would look for an extension with similar 'auto enrolment' requirements akin to those in the NHS - and as such would prefer this variation.

Variation 2: *Access would be optional and IPs can choose which eligible staff have access.*

- By allowing IPs to make a commercial choice, this option would remove the legal risk associated with variation 1.
- However, this variation would also markedly increase the flexibility available to IPs by giving them full discretion over which staff (or staff groups) they can offer access. This risks creating an 'inverse' effect on the playing field by allowing independent organisations to have far more flexibility than the NHS. That said, in practice it is likely that they would plan on offering access to existing recruits anyway due to the aforementioned FPF issues.

Variation 3 – *Access optional but if IPs 'opt in' to the Scheme, they would be required to offer access to* ***all*** *eligible staff.*

- Variation 3 arguably provides 'the best of both worlds' in terms of option B.
- This avoids the legal risk associated with variation 1, and allows IPs that do not want to offer access to the Scheme the flexibility to develop their own reward packages.
- In addition, where IPs do choose to opt in to the arrangements, they would not have a significant FPF advantage over NHS providers due to the requirement to offer access to all eligible staff.

Summary: Compared to Option A, Option B better supports the direction of NHS travel under the Health Bill, and has a particularly low risk of extending the balance sheet. However, this option may not do enough to facilitate a FPF and involves a short-term risk to HMT cash flows. That said, of the three variations of Option B, variation 3 fulfils the most criteria for the purpose of this analysis.

OPTION C*- Access extended to non-NHS providers of NHS clinical services delivered under an NHS Standard Contract for Clinical Services or an APMS contract (previous NHS PS members and new staff).*

Variation 1 - Access as a Term of business

- By making access to Scheme a term of business, this variation of option C would completely remove the competitive advantage NHS employers hold in terms of pensions. This option would also provide both a balanced playing field for pensions, and facilitate labour mobility.
- However, like variation 1 of Option B, this option would also involve a high risk of legal challenge.

- This option was also unpopular with independent providers, with almost 60% stating that it would be detrimental to their organisation and only one identifying it as their preferred option. That said, feedback from NHS employers suggests that this was their preferred variation in terms of Option C.
- GAD has suggested that this variation may increase short-term cash flow to HMT because staff currently providing NHS services that don't have access would suddenly become eligible to join. However, this would be at the risk of the extending the Governments overall balance sheet, regarding which GAD have attached a medium risk.

Variation 2 - *Access would be optional and providers can choose which eligible staff have access*

- This option would provide IPs with full discretion to offer access to any or all of their employees that are 'wholly or mainly engaged' in NHS services.
- While this option would allow non-NHS providers to recruit experienced staff, it would also significantly tilt the FPF towards the IPs by providing them with significantly more discretion over who they offer access. It would therefore facilitate a playing field that is skewed against NHS providers (which are required to auto-enrol staff into the Scheme).
- This was predictably the least favoured option overall for NHS providers, and the most popular for IPs. In the latter's case, 75% of organisations preferred this option, citing the flexibility as a particular boon to their operational effectiveness.
- GAD rated this option as low/medium risk in terms of extending the balance sheet. This highlights the likelihood that where IPs are given the flexibility to choose which staff can access the Scheme, they would not extend access unless they felt they had due to the relatively high (14% of pensionable pay) employer contribution costs associated with the Scheme. This may lead to less skilled staff groups in particular being excluded.

Variation 3 - *Organisations would be required to offer the scheme to* ***all*** *eligible staff who are existing members of the NHS PS. They would also be able to choose which staff without previous access can join the Scheme.*

- This approach would mitigate some of the inverse playing field risk associated with variation 2 by not giving IP's the flexibility to choose which existing members can access the Scheme.
- By the same token, it would do more to facilitate labour mobility, as existing members would have guaranteed pension portability.
- However, arguably this option would not do enough to balance the playing field away from IPs as they would still have the flexibility to 'pick and choose' which staff without prior access could access to the Scheme.
- Finally, this variation would also have a high legal risk attached due to the term of business requirement.

Variation 4 - *Access would be optional for AQP organisations but if they choose to opt in they would be required to offer the scheme to* ***all*** *eligible staff.*

- The final variation of option C seeks to retain a basic level of commercial choice for independent providers while removing any element of discretion in terms of which staff are offered access. This would put IPs in a very similar position to the NHS, and therefore facilitate a balanced playing field. GAD modelling also suggests that this option would carry a low risk of extending the balance sheet.
- While this option is likely to be grudgingly accepted by the NHS, there was concern from IPs about its lack of flexibility, which offers providers a stark choice between full access to the NHSPS or completely withdrawing their existing pension reward strategy for staff working on NHS services. This was reflected by the survey where only 57.1% of responses thought this variation would be beneficial compared to the existing arrangements.

- If this figure was reflected in terms of 'opt in' to the new arrangements, over 40% of non-NHS organisations would offer no access to the Scheme at all. This would restrict labour mobility in the NHS market by reducing availability of the NHSPS and may also reduce cash flow to HMT by reducing the Scheme's overall membership.

Summary: Compared to Option B, Option C has the potential to neutralise the competitive advantage held by the NHS in terms of pensions access and therefore will better support the direction of travel under the Health Bill. However, depending on the variation selected, this option may risk tilting the playing field toward IPs. On balance, Variation 4 avoids this risk while fulfilling the most criteria.

Conclusion

In terms of the evaluation criteria set out in Section 4, it appears that **Option B, Variation 3** and **Option C, variation 4** are likely to be the most appropriate options going forward.

Both options have distinct advantages, with the Option C variation providing a fully balanced playing field and the Option B variation offering a level of flexibility that is likely to be embraced by IPs. However, both also have drawbacks; with the Option B variation not doing enough to provide a balanced playing field for pensions and the Option C variation arguably falling short in terms of promoting labour mobility. As such, none of the options offer a 'magic bullet' in terms of finding an ideal solution to pensions access.

However, DH has sought to develop a further variation of Option C that would embrace the advantages of both variations:

Option C - Variation 5 - *Access would be optional for AQP organisations. If they choose to 'opt in; they would be required to offer access to **all** existing members of Scheme. They can also choose whether to offer access to staff without existing access, but again they would be required to offer access to **all** eligible staff.*

In line with the principles of Option C, Variation 5 would allow IPs to offer access to all staff that are wholly or mainly engaged in the provision of NHS Clinical services and thereby would remove the NHS's competitive advantage in terms of the FPF pensions.

This option would also use the flexibilities inherent in variation 3 of Option B, which allows IPs to offer alternative pension arrangements to staff without prior membership of the Scheme. However, it would not provide the IPs with a significant access advantage over NHS organisations, as they would be required to provide offer access to all eligible staff once they had decided on the level of access they required. Importantly, this extra flexibility is likely to encourage more IPs to participate in the Scheme and thus enhance labour mobility by facilitating stable member participation levels in the NHS Market.

Finally, this option shares many of the other positive aspects of Option C Variation 4, including a low risk of extending the balance sheet and the potential for a neutral rather than negative affect on the HMT income. This leads to the conclusion that option C Variation 5 would satisfy the most criteria for the purposes of this analysis.

The Department of Health favours option C5 because it believes it will best help:

- secure increased efficiency and patient choice in line with Health Act 2012 aims, by encouraging IPs to engage in the provision of NHS Clinical Services and removing pension barriers to that engagement.

- ensure that all providers of NHS Clinical Services (public and private) are treated neutrally, in terms of access to NHS contracts and the NHS PS

- maintain NHS PS membership and contribution income over time, following future increases in IP engagement

- avoid a 'flight to the bottom' in NHS pension provision, by ensuring that NHS PS remains available to all staff providing NHS clinical services, whatever the setting

- enhance and complete New Fair Deal changes to 'level the pensions playing field' in NHS clinical services provision, by making NHS PS available to non-TUPE as well TUPE transferred staff

- minimise the risk of legal challenge and costs on grounds of unequal treatment of IPs (if the pensions playing field was only partly levelled by New Fair Deal access),

- minimise the risk of legal challenge and costs on grounds of reducing IPs ability to compete, if NHS PS access was not optional but required, as a 'term of business', and

- achieve the best achievable match of stakeholder policy aims

The Scheme Actuary (The Government Actuary's Department (GAD)) has confirmed that all estimates of NHS provider pension costs and of NHS PS contributions and liabilities reported in this business case are made in accordance with the latest NHS Scheme valuation and other data available to scheme managers. All liability figures derive from the most recently estimated NHSPS total liability of £247bn, as at 31/3/12, produced for resource accounts purposes. Figures are based on a gross discount rate of 4.85% pa. All forecasts and projections used have been prepared using central GDP assumptions provided by the Office of Budget Responsibility for the fiscal sustainability report 12 July 2012.

Extracts from the Business Case on Access to the NHSPS for Independent Providers

Strategic case

1. Currently over 90% of NHS clinical services are delivered by traditional NHS organisations, and the NHS is the largest employer of staff with appropriate experience in this area. These organisations provide good, dependable NHS services but there is a need to provide opportunities for new independent providers (IP) to compete, improve patient choice, control costs and drive up quality.

2. The 2012 Health and Social Care Act facilitates a shift in the traditional model of the NHS clinical provision from one where NHS organisations *provide* NHS services, to one where the NHS *funds* services, performed by a range of providers from both NHS and Independent Providers (IPs). Health Ministers believe that increasing the plurality of NHS service provision encourages innovation and helps keep services *"free to patients at the point of delivery"*. NHS clinical services commissioned from the Independent sector include:

- *"for the market" contracts* – where existing volume guaranteed NHS services are directly commissioned, to encourage competition, and

- *"in the market" contracts* - where patients are offered a choice of existing and new services from accredited ('any qualified') providers, with no fixed volume guarantee

3. It is possible that competition will increasingly make *"for the market"* healthcare services the standard approach.

4. However, a significant barrier to increased plurality in the NHS currently is pension access. Whilst the NHS has progressively opened up its contracting to new IPs, development has been slow with, for example, just 7.5% of the £110bn healthcare spend in 2010/11 accounted for by non-NHS providers. This is partly due to the perception of staff, particularly professionally qualified clinical staff, that the NHS PS is *better* than the private sector alternatives available. This means that qualified employees resist moves away from the traditional NHS organisations, which significantly restricts labour mobility and the provision of more flexible health services close to the people who need them.

5. For this reason, the Department believes, based on IP feedback that if appropriate action is not taken to widen scheme access to IP, not only through New Fair Deal for TUPE transferred staff but also for appropriate non-TUPE staff, the policy aims of the 2012 Act will not be fulfilled. This is why a "do-nothing" option was discarded at an early stage of the partnership review.

6. A typical private sector pension scheme is nowadays a 'defined contributions' arrangement with lower employer costs and risks. However, where NHS PS access is a specific requirement, either because of TUPE obligations or recruitment difficulties, IPs have until now been forced to pay the significantly higher employer contributions required to fund 'broadly comparable' pensions. IPs believe that the significantly lower cost of NHS PS for NHS Trusts and GP Practices discriminates against them and restricts their ability to compete.

7. Historically, the reasons for this difference in treatment in the NHS are clear. The Secretary of State has control of NHS Trust funding and, to a large degree, their pay and reward mechanisms. In addition, their workload has been pre-dominantly NHS focussed, making it easier to ring-fence the pay pensioned in NHS PS. Whilst GP businesses have more independence than NHS Trusts, they have also been a key part of the NHS since inception, and, to a degree, operate under 'Trust-like' direction and controls. This stability amongst the traditional NHS providers helps ensure that contributions are properly paid, and accrued liabilities met. This is in contrast with the potential position for new IPs, who may need or choose to 'dip in and out' of the NHS and suffer peaks and troughs of demand, making it more difficult for them to reliably meet their NHS PS obligations.

8. The historical rationale still has its part to play but the impact of equal treatment and level playing field legislation, particularly in Europe, makes it increasingly difficult to justify a NHS PS status quo that sees access largely confined to traditional NHS Trusts and GP businesses.

9. NHS healthcare providers inevitably recruit many staff from the traditional NHS organisations. In some cases, staff will be prepared to move voluntarily to the new IP without continued access to NHS PS. However, skilled staff with a significant investment in NHS PS may be unwilling to move to IPs without continuation of NHS PS access.

10. For the reasons referred to in Monitor's finding and elsewhere in this business case, IPs wanted, at a minimum, NHS PS access for staff compulsorily transferred to them on TUPE terms. Currently, such staff cannot access NH PS and must be offered a 'broadly comparable' pension at costs GAD have estimated to be up to 13% more than those in NHS Trusts. Under New Fair Deal proposals, this significant improvement to NHS PS access arrangements is now in sight, and will scale back the legal and other risks referred to and elsewhere in this business case.

11. However, New Fair Deal alone, will not completely resolve the risk of unequal treatment challenge where IPs need to recruit specialist and senior NHS staff not protected by TUPE. New Fair Deal will also go only part of the way to securing the most level playing field achievable for NHS providers and therefore the best support for development of a more efficient and plural NHS provider network.

Economic case

1. There is evidence that IPs are well placed to offer a range of NHS clinical services in ways that provide significant improvements in terms of choice and convenience for patients. The Government believes that greater patient choice and control results in better NHS care, access, outcomes and experience for all. NHS commissioners control both contracts and prices and so can challenge providers to improve and spread innovative practice.

2. If we are to achieve these important aims we need to foster a more diverse healthcare market, and facilitate an environment in which IPs wishing to enter the market feel they can compete on a more truly 'level playing field'. Health Ministers believe that this makes an overwhelming argument for allowing new providers and their staff broadly equal access to NHS PS. Ministers also believe that the debate needs to move on from one of defending the status quo, to one of managing IP access arrangements that will improve NHS services whilst protecting taxpayers and the scheme.

Current NHS PS access arrangements

NHS Trusts and GP Practices

3. Almost all staff in NHS Trusts are automatically joined in the NHS PS. Uniquely, medical, dental and ophthalmic GP contractors are also automatically joined in the Scheme provided the contractor is comprised in a form that qualifies them to hold a GP primary care contract.

4. The above arrangements perpetuate a model of primary care services delivered by GP Practice businesses and excludes otherwise similar IPs, e.g. 'Virgin Care', who deliver NHS clinical services under an 'alternative personal medical services' (APMS) contract.

Access via SofS Direction

5. NHS PS access is already available to certain non-statutory organisations by way of 'Directions' approved by the SofS for Health, made under the Superannuation Miscellaneous provisions Act 1967 ((s.7 (1) or 7(2)). Directions are individually made under existing policy agreed with the HMT to facilitate the 'off-shoring' of former NHS functions, and their successful continuation. Such Directions confer NHS PS employing authority status on the organisation on either an 'open' or a 'closed' basis. The majority of Directions are made on the 'closed' basis to provide NHS PS access for TUPE transferred staff, with appropriate restrictions as to the NHS PS cover available.

6. Health Ministers believe that Directions will continue to be the best way to provide appropriate safeguards for staff TUPE transferred to an IP following the change proposed in New Fair Deal (see paragraph 10 below). The additional control provided by a Direction will make it easier to ensure that NHS PS is protected and that staff covered are protected if e.g. the IP ceases trading. However, the making of Directions is a lengthy and labour intensive process for applicants and administrators alike and the evidence suggests that this limited form of access will not on its own do enough to level the playing field away from the traditional NHS providers.

Retention of NHS PS via Fair Deal

7. Current Fair Deal arrangements are a pan-public sector policy that, amongst other things, requires employees to receive a "broadly comparable" pension arrangement when they are TUPE-transferred from a public to a private sector organisation.

Current Fair Deal provides significant protection to former NHS PS members but both staff and employers have typically seen a comparable pension as 'second best' to one from the NHS PS. In addition, the up to 13% higher cost of providing a comparable pension has deterred many IPs from competing for NHS contracts.

8. The current Fair Deal arrangements have worked in tandem with the policy for access to the NHS PS via SofS Direction, however,

- Directions policy covers transferring staff only and, as such, the employer is currently required to offer new recruits alternative pension arrangements, creating the potential for two-tier workforce and other tensions, and
- Profit making organisations (other than GPs) have been excluded from Directions access altogether, which makes it very difficult for them to tender for NHS contracts

Value of NHS PS to existing providers

9. It has been estimated that the additional cost to Independent Providers of providing a comparable pension scheme on the open market is on average, between 8 and 13% of an employee's salary. This is very much more than the employer contributions cost of the NHS PS to NHS Trusts and GP Practices, at 14%. Other estimates of the additional cost to provide a comparable pension scheme reach as high as 36% of an employee's salary, although this depends on issues such as the size of the organisation and the staff demographic. Given that staff costs might typically be around 60% of the total contract price, the cost disadvantage to IPs with no access to NHSPS is estimated to lie in the range 7.5% to 22% of their total contract cost. Whilst the Government's pension reforms from 2015 will reduce the overall cost of providing equivalent pension provision, a significant cost differential or 'subsidy' will remain in favour of existing providers who have automatic access to NHS PS.

New Fair Deal and 2015 Schemes - Proposed Final Agreement

10. The Chief Secretary to the Treasury (CST) has confirmed proposals to implement a New Fair Deal, which will see NHS staff who are TUPE transferred to a non-NHS organisation able to retain access to the NHS PS, rather than being offered a broadly comparable pension arrangement. Coverage under New Fair Deal will also include 'for profit' providers.

11. The NHS expects that New Fair Deal will significantly reduce the 'pensions barrier' for staff compulsorily transferred to IPs under TUPE. However, this change alone will have no impact for staff who, were it not for the loss of NHS PS, would otherwise like to move *voluntarily* to an IP. This means that, even after New Fair Deal introduction, a significant 'pensions subsidy' will remain in respect of new recruits to IPs. This means that, without further change to NHS PS access arrangements, the NHS provider 'playing field' will continue to be skewed in favour of existing NHS Trusts and GP Practices.

Commercial case

Aims

1. A key aim in any widening of access to NHS PS is to support the Health Act 2012 and wider government initiatives such as New Fair Deal, through improved, more consistent protection of staff moved or wanting to move to new NHS providers.

2. Any solution needs to:

- support Health Act 2012 aims for more effective and efficient delivery of improved patient services and choice
- facilitate better labour mobility within the clinical market and protect the pension rights of staff moving to IPs
- provide NHS PS access arrangements that are commercially realistic and 'level the playing field' with existing NHS providers
- minimise change or disadvantage for existing NHS providers
- manage the risks of legal challenge to NHS PS and wider government by ensuring that appropriate, practical and provider-neutral terms of access are available to ALL organisations and all staff engaged in the provision of NHS clinical services
- protect NHS PS and taxpayers from any unplanned increases in pension liabilities

Partnership Review of access options

3. The NHS PS proposed final agreement, published December 2012, committed to a partnership review of the rationale for wider access to the NHS PS and possible solutions. The group includes representatives from the Department of Health, Treasury, NHS Employers and the NHS Trades Unions.

Five key options considered by the access review partners

4. The review partners have looked at a wide range of access options during the last year, nine in total.

5. The five key options drawn from the original 9 (the others being discarded by the review partners at an early stage) are:

Option A 'do nothing' - no reform of the existing access arrangements (beyond the revisions to Fair Deal)

Option C variant 1 - IPs engaged in the provision of NHS clinical services required to provide all staff (wholly or mainly employed on NHS work) with NHS PS access, as a 'term of business'

Option C variant 2 - IPs engaged in the provision of NHS clinical services free to decide on use of the NHS PS and, if opting in, which of their staff (wholly or mainly employed on NHS work) should be joined

Option C variant 4 - IPs engaged in the provision of NHS clinical services free to decide on use of the NHS PS but, if opting in, required to enrol all staff (wholly or mainly employed on NHS work)

Option C variant 5 - IPs engaged in the provision of NHS clinical services free to decide on use of the NHS PS and, if opting in, whether this is limited to,

- staff (wholly or mainly employed on NHS work) who have recent (i.e. within the last 12 months) NHS PS access only, or

- staff with recent NHS PS access AND other staff (wholly or mainly employed on NHS work),

Note that an IP choosing NHS PS access for one or both of the sub-groups bulleted above would be required to offer it to ALL their eligible staff in those groups who are wholly or mainly employed on NHS work.

The five key options in more detail

(A) Options that the review partners have discarded*:*

Option A – "Do nothing" – no reform of existing NHS PS access arrangements

6. All the review partners believe that option A is untenable since this will fail to address the identified barriers to IPs entering the market and thus will fail to meet the policy aims of the 2012 Act. When the SPG Review Partners first met, 'do nothing' was effectively pre-New Fair Deal and therefore meant no change in NHS PS access terms, for either TUPE or non-TUPE staff. The Department believes that this would have left ministers at significant financial risk, both on legal grounds, in the event of unequal treatment/anti-competitive challenges from IPs providing NHS clinical services, and on grounds of lost opportunity costs, through lack of IP NHS engagement. These risks stem partly from the 8-13% higher (than NHS Trust) employer contributions costs, IPs currently have to pay in respect of TUPE-transferred staff on existing Fair Deal terms.

7. Health ministers believe that these are among the reasons the Chief Secretary to the Treasury indicated to the Secretary of State for Health in his letter dated 21 December 2011, that he would have no objection in principle to the development of new NHS PS access arrangements for the staff of any qualified providers of NHS clinical services.

8. The higher pension costs described above discourage IPs considering engaging in the provision of NHS clinical services, and through this, risk legal challenge and lost opportunity costs for the NHS and NHS PS. Ultimately, this may impact both choice and outcomes for patients, if services stay with traditional NHS providers that could be more effectively provided by new IPs.

9. The imminent introduction of New Fair Deal will significantly improve this original "Do nothing" option, by putting IPs undertaking outsourced and other NHS contracts, on a more fair and level playing field with NHS Trusts and GP Practices in respect of the staff it chooses to recruit on TUPE transfer terms. However, whilst the need to level the playing field is currently greatest for TUPE transferred staff, there remains a similar case for non-TUPE staff recruited by IPs. Crucially, this problem is likely to be greatest for doctors and other key experienced/skilled NHS staff, with significant NHS PS membership and for whom the scheme is more likely to be an important factor when considering movement between public and private sector employers.

10. Although smaller in numbers, key staff especially GPs and other senior doctors, are vital 'cogs in the machine' for any clinical health services organisation. If IPs face recruitment difficulties with such staff that lead to the loss of valuable NHS contracts, the risk of legal challenge, eventually, remains significant. Even IPs who might choose to 'ignore' this problem, e.g. to avoid unpopularity with healthcare commissioners, may find themselves with individual staff who raise their concerns about any 'unequal' pension treatment. IPs finding themselves in this position could simply 'get their heads down' and tell staff that the lack of good quality NHS PS cover was due to ministers reluctance to fully level the playing field. Perversely, that would leave all risks with ministers, rather than challenging IPs to raise their own pension standards by making NHS PS available to all staff, subject to proper controls and governance.

11. Paradoxically, the potential for legal challenge, certainly without Fair Deal, and to a lesser degree, even with it in place, may not spring from IPs alone. NHS Trusts, in particular Foundation Trusts, may also find themselves financially disadvantaged if they begin to lose NHS work because IPs lack either New Fair Deal or the planned wider access to NHS PS. This would arise from the lower, e.g. NEST level, pension costs available to IPs if, despite the lack of that flexibility, they manage to attract NHS business. The effect would be serious without New Fair Deal and still significant with it if access remains restricted to staff transferred on TUPE terms.

Option C variant 1 - IPs engaged in the provision of NHS clinical services required to provide all staff wholly or mainly employed on NHS work NHS PS access, as a 'term of business'

12. This option would squarely address the level playing field issue, by requiring NHS PS membership for all eligible IP staff in the same way as for NHS Trust staff. However, the option would also duplicate in part the effect of New Fair Deal for staff subject to TUPE-transfer terms. The option would also pre-suppose that no IP has a preferred pension or other reward arrangement for its staff, and place obligations on them that might then unreasonably increase their business costs. The Department's legal advisors have confirmed that an option that would compel IPs to use NHS PS for some or all of their eligible staff would also be the one most likely to be seen as potentially reducing an IP's competitiveness, in a european context especially. More specifically, requiring NHS PS access as a 'term of business' could be seen as a breach of regulation 4 of the Public Contracts Regulations 2006 and/or article 56 of the Treaty on the Functioning of the European Union (TFEU). In other words, whilst it is open and right for the Secretary of State for Health to be able to require NHS employers to offer the NHS PS to all eligible staff, it is not and cannot be open to the Secretary of State to make that decision on behalf of external NHS providers.

(2) Options that have become frontrunners with the review partners:

Option C variant 2 - IPs engaged in the provision of NHS clinical services free to decide on use of the NHS PS and, if opting in, also which of their staff wholly or mainly employed on NHS work should be joined

13. Not surprisingly, the IP Survey that was carried out reveals that this option would best suit IPs. This is because it would give them the maximum flexibility when recruiting their staff and tailoring reward packages. The effect of this should be that IP 2012 Act engagement, and use of NHS PS would be optimal, since IPs could use NHS PS without the full compulsion involved in option C1. It follows that option C2 would also present the least risk of legal challenge to NHS PS from IPs, although perhaps not NHS Trusts. This is because it would again avoid the full compulsion under option C1 but see NHS PS available to IPs who need to use it for New Fair Deal and/or the recruitment of other non-TUPE staff. Inevitably, there would be a risk that the very flexibility available under option C2 may make it the one most likely to create equal-treatment/two-tier workforce issues in IPs.

14. Staff and NHS Employer representatives oppose this option because it would secure too little certainty about continuity of NHS PS cover for staff moving from traditional NHS employers to IPs and too much flexibility in comparison with NHS Trusts and GP Practices. The Department agrees that option C2 would 'tilt the playing field too much the other way'', in favour of IPs and against traditional NHS Trusts and GP Practices. Effectively, IPs would be spared Trust and GP Practice obligations to offer NHS PS to all their eligible staff. Over time, this could provoke a formal challenge from the traditional NHS providers (especially Foundation Trusts) if they lose business to IPs because of their ability to opt in to NHS PS but then 'cherry pick' that provision for a few favoured staff.

Option C variant 4 – IPs engaged in the provision of NHS clinical services would be free to choose whether they provide NHS PS but, if they do so, must provide it for all their staff wholly or mainly employed on NHS work

15. By removing the 'term of business' requirement, this option would immediately be more acceptable to IPs, and to a degree to NHS Trusts and staff representatives, than option C1. IPs can still choose whether to opt-in to NHS PS, but if they do, would then be treated more like the traditional NHS

organisations. This makes option C4 a compromise of stakeholder positions in that IPs can engage in 2012 Act work without being *forced* to use NHS PS but if they do opt-in they are treated like Trusts and required to provide NHS PS for all their eligible staff. The downside for an IP is that, by needing to opt-in to NHS PS for even one key member of staff, they are then obliged to offer access to everyone. This would extend even to those persons who might have been happy to move to them voluntarily. Such people might even consider NHS Trust/Practice defined benefit scheme contributions 'too high', and prefer a different form of reward package.

16. However, the freedom to opt-in to NHS PS (or not) does reduce the risk of legal challenge, as compared with option C1, and also reduces the likelihood that IPs will be discouraged from engaging in NHS clinical services provision. However, the IP is still subject to a high degree of compulsion if they do opt-in to NHS PS. In the end, this means that option C4 is not really so different than option C2 (from the IPs perspective) and therefore may not completely remove the risk of discouraging them from 2012 Act aims. It may also be insufficient to eliminate the risk of legal challenge, if an IP comes to believe that the approach is losing them business to NHS Trusts and GP Practices.

Option C variant 5 – IPs engaged in the provision of NHS clinical services would be free to choose whether or not they provide the NHS PS and, if they do so, can choose whether to provide it for staff who have had access to NHS PS within the previous 12 months only or for all staff. However, where access is provided, it must be for all staff in the chosen group(s). All staff offered NHS PS must be wholly or mainly employed on NHS work.

17. This approach is slightly less acceptable to staff and NHS Trust representatives than option C4. Both stakeholders believe that it would be less effective in levelling the pensions playing field and staff representatives in particular think it may result in fewer staff being able to access NHS PS. However, this approach is also more palatable to IPs, who are more likely to offer the Scheme under this approach.

18. Health Ministers acknowledge that there are pros and cons to both this option and option C4 above and that the differences are relatively small. However, those differences are crucial in striking the right balance between facilitating a level the playing field for pensions and improving labour mobility within the system, and Health Ministers believe strongly that option C5 provides the best compromise of advantages gained and risks avoided.

19. The advantage of option C5 over C4 is that it offers IPs more flexibility by allowing them the *discretion* to decide whether to offer the NHSPS to existing members or all staff. However, if an IP chooses access they will then be required to operate it (as closely as legal advice allows) under the same 'all staff' obligations required of NHS Trusts and GP Practices. Effectively, the obligation on IPs to use NHS PS will be proportionate to the circumstances, so that there is:

- **full compulsion for IPs to offer staff the NHS PS for all those eligible under New Fair Deal circumstances** – where the IP *causes* the loss of NHS PS by virtue of their transfer action, but only
- **partial compulsion for IPs to offer affected staff the NHS PS if they choose to opt-in for specific groups of staff** – meaning that the IP remains able to choose access (or not) but must offer NHS PS to all eligible staff in those groups they opt-in for in other words. In short, if one eligible member of a chosen staff group is offered NHS PS, the IP must offer it to all their eligible staff in that group

20. In short, the Department believes that the compromise of option C5 will deliver the best possible result for staff and NHS providers (both public and private) by being the approach:

- most likely to retain and encourage a high level of NHS PS membership, whatever the setting, and
- able to produce the most level playing field achievable within law

Independent Provider Access Survey

21. Between 29 October and 13 November, the Department of Health ran a survey of Independent Providers (IPs) of NHS clinical services. The survey was designed to inform the work being taken forward by the review group, by engaging with a wide sample of IPs on the options for reform. This business case looks at the results in the context of the five 'frontrunner' options described above.

Overview of Survey response

The response of provider organisations to the Survey has proved useful.

22. The least popular proposal with IPs, with strong opposition, was option C1, which would require NHS PS provided as a 'term of business' to ALL eligible staff.

23. The most popular proposal with IPs was option C2 , which would give them the maximum flexibility, first whether to opt-in to NHS PS and second, which staff to offer it to. There was also significant support for the slightly less flexible option C5. This offers IPs the freedom to choose first whether to provide NHS PS and then, whether to provide it to ALL eligible employees or just those staff with recent exposure to it, subject to the obligation to offer NHS PS to ALL eligible staff, not just a favoured few.

24. Interestingly, the survey also showed that the majority of IPs do not support a 'do nothing' option. For example, 92% of employers with existing access to the Scheme, i.e. generally those organisations with TUPE transferred staff, preferred some kind of reform to the status quo. This reflects previous feedback DH has received about the difficulty many IPs have in recruiting experienced NHS staff.

Health ministers conclusions and preferred choice

26. NHS and wider Government aims under the Health Act 2012, to secure the widest possible range of innovative, high quality and efficient providers of NHS services will require the best possible level of staff and provider support. Whilst both the Trades Union preference for option C1 - access as 'a term of business' and the IP preference for option C2 - maximum freedom to choose access and the staff to be included, have their advantages, neither commands sufficient across-the-board support or reduction in legal and financial risks for them to be adopted.

27. Health ministers believe therefore that the only realistic options are C4 or C5 and that a substantial balance of advantages lies with option C5. As the full access review options RAG chart on page 7 shows, all stakeholders including IPs and NHS Trusts reacted neutrally or better to option C5. In addition, by requiring IPs who opt-in, to offer the NHS PS to ALL their eligible staff in either the 'existing staff' and/or the 'new recruit' groups, this option offers the closest legally safe approach to those terms already applying to the staff of existing NHS providers.

The Department of Health favours option C variant 5 because it believes it will best help:

- secure increased efficiency and patient choice in line with Health Act 2012 aims by encouraging IPs to engage in the provision of NHS Clinical Services and removing all pension barriers to that engagement.
- ensure that all providers of NHS Clinical Services (public and private) are treated neutrally in terms of access to NHS contracts and the NHS PS
- maintain NHS PS membership and contribution income over time following increases in IP engagement
- avoid a 'flight to the bottom' in NHS pension provision by ensuring that NHS PS remains available to all staff providing NHS Clinical Services, whatever the setting

- enhance and complete New Fair Deal changes to 'level the pensions playing field' in NHS Clinical Services provision, by making NHS PS available to non-TUPE as well TUPE staff

- minimise the risk of legal challenge and costs on grounds of unequal treatment of providers (if the pensions playing field was only partly levelled by New Fair Deal access),
- minimise the risk of legal challenge and costs on grounds of reducing IP competiveness (if NHS PS access was not optional but required, as a 'term of business', and

- match all stakeholder policy aims

Potential impact of the NHS PS Access development on other (private sector) pension providers and the internal market of wider public service pension schemes

28. Legal advice provided to the DH makes it clear that opening the scheme to Independent Providers directly involved in competition to provide NHS clinical services on a 'free choice basis' will be:

- an effective means of avoiding any charge of unequal treatment through differential access to NHS PS' and the costs arising from any resultant Court action, and

- provide no new risk of a charge (i.e. by private pension providers) of 'anti-competitiveness' through forced use of the NHS PS as 'a term of business'

29. The Department is also satisfied that the proposed changes to NHS PS Access arrangements will pose no risk of setting unwanted precedent for other public service schemes – for example access to the Teachers Pension Scheme where there may be private sector involvement in free schools and universities. This is because the proposals are designed to support the development of an emerging and unique 'NHS Clinical Services Market' that is increasingly focused on patient choice. Pension arrangements for outsourcing of other purely 'back office' functions will not be affected. The new policy will also be limited to those staff groups currently able to access the NHS PS in existing, traditional, NHS employing authorities.

Affordability

Balance Sheet Exposure

1. Vital concerns for wider government and the NHS PS in any extension of access are the potential risks and impacts for NHS Scheme members and employers in terms of their contributions and membership, and on taxpayers who underpin all NHS expenditure. The taxpayer risk can be linked to the level of the government's 'balance sheet exposure' that will follow any change in access arrangements. In simple terms, if exposure remains broadly unchanged following the inclusion of new NHS providers, the impact on NHS and wider budgets will be minimal, with any minor impacts manageable over the long-term through Scheme Valuations.

2. If the level of exposure is significantly increased, e.g. through the pensioning of private healthcare monies 'sucked in' to NHS PS, inadvertently or otherwise, overall costs could rise, with impact for current scheme employers, members and taxpayers.

3. The Scheme Actuary (the Government Actuary's Department (GAD)) has carried out extensive modelling to estimate the following possible impacts on the future contribution income and liabilities of the NHS PS. The broad outcomes are summarised under 'financial implications' in each of the original nine review options shown in the full access options review RAG chart, on page 7 of this document.

Option	**Projected Contributions**			**Projected Liabilities**	
	2015 £bn	2020 £bn	2040 £bn	2020 £bn	2040 £bn
A	8.8	8.4	7.3	277	244
B1	8.8	8.3	6.9	277	238
B2	Likely to be slightly lower than B1				
B3	Likely to be slightly lower than B1				
C1	9.0	8.6	7.4	278	248
C2	8.9	8.5	7.1	278	243
C3	Likely to be between C1 and C2				
C4	9.0	8.6	7.2	278	245
C5	Likely to be similar to C2				

4. The figures in the table above summarise estimates based on a wide range of assumptions and approximations, detailed in papers provided by GAD to the Staff Passport Group in June, July and September 2012. The figures are shown in 2015 GDP terms, by discounting back in line with the ONS projections of GDP growth after 2015.

5. The table provides an indication of whether the NHS PS will increase or reduce in scope because of a chosen access option. However, the figures do not allow for changes in membership behaviour or membership profile that may occur because of increasing member contributions, currently being introduced, or the reformed scheme design that will apply from April 2015.

6. The tables of estimated contribution income impacts and scheme liability impacts contained in annex B have been extended, to provide HMT with some sensitivity indications and to underline the likely figure of total NHS PS liabilities.

Detailed GAD assessments

7. GAD' s detailed contribution income and scheme liability assessments, illustrate the possible impact of the main options considered by the Staff Passport Review Group.

8. Annex A illustrates the projected NHS PS contribution and liability impact of all 8 main options, i.e. excluding option A – 'do nothing', by comparing the current expected 'baseline' contribution and liability results for NHS PS up to 2040, i.e. assuming we do nothing in NHS PS to change current access arrangements, with a range of possible change options.

9. Annex B considers a smaller group of three main options taking into account the effects of proposed changes to New Fair Deal, that is:

- a 'do nothing' option,
- a New Fair Deal access for TUPE transferred staff, plus access for non-TUPE transferred staff' option, and
- a New Fair Deal access for TUPE transferred staff, plus access for non-TUPE transferred staff AND access for new recruits' option

These results are overlaid with projections showing the possible impact of varying Independent Provider rates of new access take-up, and turnover due to TUPE transfers, and competition with existing providers.

10. Looking more closely at the Indendent Provider Access survey, three key results drawn out below reveal interesting contribution and scheme liability differences.

Option	**Contributions £bn**			**Scheme Liabilities £bn**	
	2015	**2020**	**2040**	**2020**	**2040**
Option A - baseline (i.e. access arrangements unchanged)	8.8	8.4	7.3	277	244
Option C variant 1 - Access as a 'term of business'	9.0	8.6	7.4	278	248
Option C variant 5 (the DH preferred option)	8.9	8.5	7.1	278	243

11. **Option C1 - Access as a 'term of business'** shows a small increase in projected scheme contribution income over the current 'baseline' projection, but significantly higher scheme liabilities forecast up to 2040. (Please note that, with HMT agreement, the baseline figures assume no NHS growth and a gradual decline in NHS PS numbers.)

12. **Option C5 - 'Optional access to NHS PS for Independent Providers',** with a further two-tier optional take-up of:

(a) ‘existing’ staff (wholly or mainly employed on NHS work) with NHS PS access within the past 12 months only, or

(b) ‘existing’ staff PLUS other staff (wholly or mainly employed on NHS work)

shows a small increase in short/medium term contribution income, but a reassuringly similar out-turn for projected scheme liabilities as the current baseline, at both 2020 and 2040.

13. Looking more closely at the tables in annex B, reveals a wider range of possible out-turns for three slightly different possibilities, ‘do nothing’, ‘New Fair Deal plus non-TUPE transferred staff on Clinical Services only’, and ‘New Fair Deal plus ALL other IP staff including new recruits’. All staff offered access would have to engaged wholly or mainly in the provision of NHS services.

14. The results estimated depend on the levels of TUPE and competition turnover assumed and the amount of access for Independent Provider staff actually achieved. However, an interesting comparison is revealed between the current GAD ‘do nothing’ baseline model and GAD models 4(c) and 5(c) on pages 61 and 63 of this business case respectively.

Option	**Contributions £bn**			**Scheme Liabilities £bn**	
	2015	**2020**	**2040**	**2020**	**2040**
Baseline (access unchanged)	8.8	8.4	7.3	277	244
Access for new Fair Deal (TUPE) staff plus all other staff on NHS clinical services (assumes a 75% take-up and high TUPE level)	9.0	8.5	6.9	278	242
Access for new Fair Deal (TUPE) staff plus all other staff on NHS clinical services (assumes a 50% take-up and high TUPE level)	8.9	8.4	6.9	278	240

15. **GAD model 4 (c)**, with access assumed at 75%, reveals contribution income very similar to current baseline initially, with a gradual decline by 2040 and fairly similar scheme liabilities up to 2040.

16. **GAD model 5 (c)**, with access assumed at 50%, again shows contribution income up to 2040 in the same range as current baseline, but with scheme liabilities little changed at 2020 and significantly lower by 2040.

Affordability conclusions

17. The results of the survey, at paragraphs 11 and 12 above, reveal that the DH preferred 'Option C variant 5', under which IPs choose whether to use the NHS PS, and then decide which of two possible levels of staff access best suits their needs, provides the closest approach to current baseline projections. In effect, this means that a key concern, that the scheme balance sheet should not be extended, would be met.

18. The results from annex C, at paragraphs 15 and 16 above, are similar but try to estimate actual out-turns under different levels of possible IP take-up. The useful indication this gives is that, at a level of IP take-up of 75% (with the expected high TUPE) the balance sheet is again not extended with, if anything, scheme liabilities slightly reduced.

19. If IP access take-up of 50% is assumed (with the expected high TUPE), scheme liabilities are actually reduced by 2040. This is significant, in that 50% take-up is one of the Monitor conclusions and is mirrored in the survey of IPs..

20. The above conclusions give the Department confidence that the NHS PS balance sheet will not be extended by these access proposals, and that the DH preferred option C variant 5, provides the best balance of financial risks, as well as the best policy match achievable across the range of stakeholders.

New NHS PS access controls for Independent Providers

21. With current NHS services predominantly provided by traditional NHS organisations, and NHS PS access available only to their employees and to self-employed GP contractors, current balance sheet exposure is a known quantity. The extension of NHS PS to IPs, who are likely to undertake a mix of NHS and other work and not be subject to national pay scales) obviously has the potential to make balance sheet exposure less certain. However, the projected results above indicate that this is unlikely to exceed current baseline, "do nothing", estimates.

22. Under any form of increased access though, the introduction of Secretary of State controls and sanctions, limiting the earnings pensionable in the NHS PS, will be key. The Department is working with the NHS Business Services Authority to develop a number of controls for new IP access to the NHS PS. These controls have been designed to manage potential risks discussed in the Partnership Review, and are set out in some detail in the following Programme Management section of this Business case.

Programme management

IP access contributions and benefits package

Scheme contributions - standard and 'additional' rates

1. Tiered employee contributions and fixed employer contributions will be payable at the same rates applicable to other NHS employers. However, regulation amendments will provide for an additional charge to be levied on an IP who the Secretary of State determines, after taking advice from the Scheme Actuary, has created additional costs for the NHS PS due to the accrual of pensionable pay in one or more scheme years exceeding a new IP pensionable pay cap described below.

Interest on delayed contributions

2. NHS PS regulations will be further amended to provide for the payment of interest by IPs and other NHS PS employers who delay pay-over of NHS PS employer and/or scheme contributions beyond the due date for payment of contributions in NHS PS 1995 and 2008 regulations. The due date is normally the 19th day of the month following the month in which the contributions were deducted, although provision will be made for an interest charge to be varied or waived if the BSA, on behalf of the Secretary of State, is satisfied that this is appropriate..

3. Interest on sums delayed will be charged at the higher of:

   - the annual increase in the retail prices index, or
   - SCAPE (superannuation Contributions Adjusted for Past Experience discount rate set by the Treasury) discount rate

4. The SCAPE discount rate is currently set to CPI + 3% and is equivalent to the discount rate that would be used for a scheme valuation at the current time, compounded at monthly intervals.

5. The Teachers Pension Scheme (TPS) has operated such an interest charging facility in regulations for many years, and colleagues at the Department for Education described the regime as a 'useful punitive tool' that incentivises prompt pay over and reduces the perceived value of poor administration and compliance.

6. TPS interest powers are, nevertheless, used quite regularly, and aside from the odd provider complaining that the charges were unfair ("we were only a day late" etc) they are not aware of any particular issues. There is a facility in TPS regulations to waive an interest charge in appropriate cases and this will be mirrored in NHS PS regulations, providing a 'safety valve' for 'exceptional cases'.

Scheme benefits package - assuming wider IP NHS PS access becomes available

7. IP employees wholly or mainly employed on NHS work and joining the NHS PS would be entitled to the same package of NHS PS benefits available to (GP) 'practice staff'. This package is the same as that available to NHS Trust employees, with the exception of NHS Injury Benefits and NHS Redundancy benefits. These two benefits are excluded because of the requirement for the NHS employer concerned to fund payment, which, for GP employers was impracticable.

Scheme benefits package changes

8. NHS Injury Benefits - entitlement will change for all NHS employees from 31 March 2013. Under the new arrangements, a new 'Injury Allowance' (IA), payable for up to 12 months, will become available and the former personal and dependents permanent lifetime benefits withdrawn. The new IA will be available to all NHS staff subject to Agenda for Change (AfC) terms and conditions, at the cost of the local employer, and so in future may include some GP Practices, provided that they formally afford their staff AfC terms and fund the IA benefits.

9. NHS redundancy benefits – entitlement for traditional NHS employers is expected to change from 1 April 2013, so that those employers who have traditionally had access to NHS Redundancy benefits will retain that access, subject to the necessary funding, together with a new declaration that the employee's written terms and conditions include redundancy benefits. IPs will also be able to access redundancy benefits, subject to the contractual condition being met, and the early retirement benefits from NHS PS being paid for prior to release.

10. The new arrangements will provide IPs engaged in the provision of NHS clinical services with the flexibility to offer staff transferring to them from traditional NHS organisations matching benefits, subject to meeting all NHS PS costs.

NHS PS and taxpayer safeguards for extension of NHS PS access to Independent providers

11. Any extension of NHS PS access to AQP/APMS will require stringent monitoring and regulation, to ensure no extension of the government's balance sheet. The following amendments to NHS PS regulations and new administrative regimes for the proper control of extended access to the Scheme are being developed for introduction from October 2013:

- NHS commissioning and procurement arrangements involving a new 'NHS Standard Contract'. The new contracts require agreed standards of training, qualification and care and performance of providers and are subject to annual review. Poor or inappropriate performance under a contract will lead to withdrawal by the relevant NHS commissioner. The intention is to include provision within the contract that requires employers offering the NHS PS to comply with the associated administrative arrangements. Failure to comply could be seen as a breach of contract and lead to termination.

- IPs wishing to become a NHS PS employing authority in respect of their NHS contract must be engaged in the provision of NHS clinical services and will be required to formally apply (opt-in) to the NHS Business Services Authority. The opt-in arrangements will be similar to those successfully used in 1995 and 2008 NHS PS regulations to extend access to Out of Hours Providers (OOHP) since 2004.

- IP staff wholly or mainly employed on NHS work will then be able to access the NHS PS, until 2015 only on the final salary 'employed officer' basis (current NHS PS GP CARE style benefits will not be available). Membership will be on the basis that:

    - the individual could currently access the NHS PS if they were employed by another NHS PS employing authority, and

    - they are 'wholly or mainly' engaged in NHS work

  Once an IP providing NHS clinical services gains NHS PS employer status, they will be able to offer access to all relevant staff wholly or mainly engaged on NHS work. Essential non-clinical staff who assist their employer in the provision of NHS clinical services will also be able to access the NHS PS.

- The ‘wholly or mainly’ requirement will be managed with a ‘light touch’; enabling IPs to deploy their staff flexibly, across what is likely to be a mix of NHS and non-NHS work. However, IPs will also be subject to an overall ‘pensionable pay cap’ for any Scheme year. This means IPs will need to manage their overall pensionable pay outcome within a defined percentage NHS contract-funding cap, by adjusting the numbers of staff working full or part-time on their NHS contract work.

- For example, an IP that employs large numbers of staff and needs to deploy them on both NHS work and a significant amount of non-NHS work will be able to create a separate part-time contract for each person to suit each type of work. These arrangements will be very similar to those available to existing NHS PS part-time members, in accordance with existing NHS PS regulations. The arrangements will enable IPs to comply with their overall pensionable pay cap for NHS funded work. Conversely, an IP that is able to dedicate particular individuals to NHS funded work for a high percentage of total employment, e.g. 75% or more of total pay, will be able to set up a single NHS focussed contract and meet their pensionable pay cap obligation.

- The NHS PS pensionable pay cap for IPs will be a maximum of 75% of the IPs total NHS income under its NHS standard contract(s). This percentage had been arrived at in discussion with IP and NHS Trust stakeholders and excludes employer ‘on costs’, whilst providing sufficient flexibility to accommodate the variable nature of new IP organisations. Also excluded from this maximum pensionable amount will be any NHS related pay for employees working on an NHS contract(s) who:

    - opt out of the Scheme,
    - are ineligible for the NHS PS, or
    - have been excluded from the NHS PS by their IP employer

- Excess pensionable pay accruing to an individual scheme member in an IP organisation will not normally be limited (capped) due to the pension expectation created and the employee contributions that person has paid. However, the BSA will calculate an additional employer contribution charge using GAD tables to assess the value and cost to the NHS PS of the excess NHS PS benefits derived from any pensionable pay exceeding the pensionable pay cap in a scheme year. Scheme year pay *will* fall to be reduced in the event that the employer does not or cannot pay the additional employer contribution charge. The aim of this mechanism will be to discourage the pensioning of pay in excess of an IP’s cap and to prevent re-distribution of ‘excluded’ income to other NHS PS members of the IP’s staff

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- In determining whether an IP has exceeded the pensionable pay cap for any Scheme year, pensionable pay amounts *below the cap* in one or more of up to three Scheme years prior to the year in which the excess has occurred, may be ‘carried forward’ by the IP to offset a year in excess. However, provisions will be made in regulations for the Secretary of State to exclude from NHS PS employing authority status (from a forward date) an IP that persistently exceeds their pensionable pay cap.

- At the beginning of each scheme year, regulations will require IPs to estimate in respect of both ‘zero-volume’ and fixed price contracts for that year, the:

- number of NHS Standard Contracts they hold and the ID number(s)

And their expected,

    - NHS funding for those contracts for that year

    - Numbers of staff wholly or mainly engaged in NHS work for those contracts
    - Pensionable earnings for staff wholly or mainly engaged in NHS work for that year,
    - Non-pensionable expenses in relation to NHS work for that year
    - Employee contributions for that year
    - Employer contributions for that year

- Estimates must be authorised and signed off by the IP 'Responsible Officer', e.g. Chief Executive, Managing Director or Finance Director

- Regulations will also require IPs to lodge a bond, indemnity or guarantee to the value of 3 months of their estimated NHS PS Employer and Employee contributions, with the amount reviewable monthly and subject to a requirement to notify to the BSA an adjusted amount in the event of any shift in annual contributions value exceeding 10%.

- Regulations will authorise BSA to tightly monitor monthly pay over of IP contributions against estimates and utilise bonds/indemnities to meet any shortfalls.

- BSA will also be authorised to require additional relevant information if necessary and to make spot checks of NHS contract amounts and staffing.

- Regulations will further authorise termination of an IPs NHS PS employing authority status from a forward date in the event of a failure to meet contribution obligations exceeding 3 months. NHS PS membership up to the point of termination will be protected.

- At the end of each scheme year, IPs will be required to update their member pension records with the BSA and confirm actual out turn figures for that year, including:

    - Total NHS funding received for the relevant contracts
    - Total non-pensionable expenses incurred for the relevant contracts
    - Total NHS PS pensionable earnings for the relevant contracts
    - Total NHS PS employer contributions
    - Total NHS PS employee contributions
    - An explanation of the pensionable to non-pensionable ratio

- All out-turn schedules must be authorised and signed off by the IP 'Responsible Officer'

- As described above, regulations will provide for IPs who do exceed the pensionable pay cap for any Scheme year (after taking into account any 'under pensioning' in the three carry forward years) to be charged an additional scheme contribution rate in respect of that year, calculated by the SofS in accordance with guidance provide by the Scheme Actuary. Since this amount will reflect higher liabilities, not extra scheme costs, the amount of an additional scheme contribution levied on an IP will be excluded from scheme valuations and paid directly to HMT.

- The NHS PS 2015 'Proposed Final Agreement' makes clear that current NHS PS final salary pensions will remain available to non-GP members for service up to 2015 and that these benefits will continue to be linked to salary until the member leaves service. In addition, members with 10 or less calendar years to their current pension age at 1 April 2012 will be able to remain subject to their current pension arrangements and not move to 2015 CARE arrangements.

- Members entitled to final salary benefits have benefits tied to their salary shortly before exit/retirement. Therefore, any large rises in salary at this time can materially increase the benefits they receive and hence the cost of providing the benefits. This applies equally to IPs and existing NHS employers.

- For these reasons regulations will provide for IPs and all existing NHS PS employers to become subject to a new 'final pensionable pay' control, where the final three years of pensionable pay for benefit purposes will be monitored for increases of:

    - more than CPI+4.5% in any one of those 3 years, or

    - more than three times CPI+4.5% between year one and year three

- BSA will monitor pension awards for any excess over the above final pay controls and employers will be charged a capital sum for any benefits payable on the amount of the excess, calculated using tables provided by the Scheme Actuary

- Member benefits in such circumstances will be payable on the unlimited (i.e. on final pay both under and over the new limit) final pay figure, subject to prior payment of the employer capital charge

- If the employer capital charge is not paid, benefits for IP membership will be adjusted to exclude the amount of any benefits arising from an excess over the annual CPI+4.5% control

12. Regulations will be further amended from the date of the introduction of IP access, to close-down an existing 'loophole' through which certain IPs have been able to maintain membership of NHS PS for some of their staff transferring to them on a voluntary basis. The loophole is the (currently lawful) arrangement of a 'secondment', from a traditional NHS organisation (with existing NHS PS access) with which the staff member is also legally employed. The amendment will make such secondments, for the sole purpose of maintaining NHS PS access, unlawful, so that IPs needing NHS PS access for such staff will only be able to secure it through the new, controlled IP route. Such employers will be allowed one year to make new arrangements for pensioning staff in accordance with the standard IP access arrangements or face withdrawal from the scheme as a NHS PS employing authority.

Annex A

GAD ACCESS MODELLING FOR THE STAFF PASSPORT GROUP

Estimates of potential contribution income and scheme liabilities for the 8 main options reviewed in the Staff Passport Group

1. GAD have previously provided figures to DH showing the impact of different access models to the NHSPS on the progression of the liabilities and the contribution yield. These figures have been produced using a wide range of assumptions to indicate possible outcomes in different scenarios. HMT have reviewed these figures and are concerned about scenarios that show an increase in the liabilities of the NHSPS relative to continuation of the current access arrangements.

2. This note has been prepared for DH to be used in a note they are preparing for HMT to provide more detail on what they consider to be the more likely scenarios for the progression of the liabilities. The intention is to provide greater clarity regarding the modelling figures HMT should be considering when looking at different scheme access models.

Options/Variants

3. In previous documents, provided by DH, a number of different variants are being considered as follows:

1. Option B variant 1 – Access as a term of business for existing staff only
2. Option B variant 2 – Providers can choose which staff have access, but only for existing staff
3. Option B variant 3 – Providers can choose whether to offer access to existing staff, but if they do they must offer it to them all
4. Option C variant 1 – Access as a term of business for all staff, including new recruits
5. Option C variant 2 – Providers can choose which staff to offer access to
6. Option C variant 3 – Access as a term of business for existing staff, but optional for new recruits
7. Option C variant 4 - Providers can choose whether to offer access to staff, but if they do they must offer it to them all including new recruits
8. Option C variant 5 - Providers can choose whether to offer access to existing staff, but if they do they must offer it to them all. They can also choose whether to offer it to new recruits but if they do they must offer it to all eligible staff

Background

4. The most likely assumptions for each variant have been based on information supplied by DH and summarised below:

a. A paper by put together, for the 13 March 2012 SPG, entitled “Likely Trends in Independent Sector Provision”. This paper noted that, excluding core GP services, independent sector provision at significant scale was confined to:

(i) elective hospital procedures and diagnostics;
(ii) in-patient mental health and eating disorder services; and
(iii) community services.

Independent sector provision in elective procedures grew rapidly from early 2006, but has been around 35,000 cases a month for the last two years. This is around 7.5% of all Choose & Book referrals. Active demand management by commissioners and the high

cost of entry are likely to prevent any material expansion (at the aggregate level) in this area.

Mental health service provision has grown substantially and in 2010/11 UK wide spending was estimated as £14.2bn, of which £974m was with the independent sector (around 7%). The paper suggests that any significant expansion in the independent sector provision has ended due to need for commissioners to secure better value for money and manage demand.

The Right to Request programme has resulted in around £900m pa of services moving to new social enterprises, of a total spend of approximately £10bn pa (as advised in Richard Parr's covering email). However, NHS provision is expected to remain the dominant provision for the foreseeable future.

b. An e-mail on 14 June 2012, which contained details of healthcare spend with non NHS bodies. The information provided relating to 2011/12 was:

   (i) Total spend with non NHS bodies was £7.7bn
   (ii) 40% of this spend, c. £3bn, was for purchase from local authorities whose staff join the LGPS
   (iii) Approximately £3.1bn related to the conventional private sector, of which around £1.5bn is the potential pensionable pay bill

c. From the 2010/11 Department of Health report and accounts, annual spend on healthcare was around £100bn. Therefore, the private sector, which could potentially receive access, accounts for around 3% of total spend. Total non NHS spend amounts to just over 7.5%.

5. Within the modelling we have therefore looked at increasing initial access by around 3% where previously excluded staff will be allowed to join. We have also looked at future TUPE and competition transfers of up to 7% of the total workforce, consistent with the current levels of non NHS spend. However, under certain options and variants choice of access to the NHSPS is at the provider's discretion and this means a suitable assumption is much more difficult to estimate.

6. DH are looking to survey providers to obtain a better indication of the numbers, and salary roll, of staff currently excluded from NHSPS access. This information can be used to further refine the model calculations to determine whether the assumed 3% uplift is appropriate.

Baseline

7. The modelling by GAD estimates the contribution yield and NHSPS liabilities at future points in time, calculated in 2015 GDP terms i.e. the figures are discounted back to 2015 by the expected growth in GDP since 2015. A baseline for the calculations has been carried out assuming the membership of the NHSPS remains stable. This provides the following baseline position:

	2015 £bn	**2020 £bn**	**2040 £bn**
NHSPS contributions	8.8	8.4	7.3
NHSPS projected liabilities		277	244

Option B Variant 1

8. Current NHSPS members would continue to be given access. Overall membership would be expected to reduce as leavers, from private sector providers, are replaced with new joiners who do not have access to the scheme. Option B does not allow for staff currently excluded from the NHSPS, who would have been entitled to access under this scenario, to have access.

9. Reasonable assumptions might be 5% of staff transferring under TUPE, with 5% pa staff turnover and 2% of staff transferring as a result of competition, again with 5% pa staff turnover. From the previous modelling this gives:

	2015 £bn	**2020 £bn**	**2040 £bn**
NHSPS contributions	8.8	8.3	6.9
NHSPS projected liabilities		277	238

Option B Variant 2

10. As for the above, except providers have the choice whether to give access. This increases the likelihood that contributions and liabilities will be lower in future than the figures under variant 1 above.

Option B Variant 3

11. Very similar to option B variant 2 and again more likely to result in contributions and liabilities lower than shown in the table under variant 1 above.

Option C Variant 1

12. All staff given access, including new recruits, as a term of business. Under this access option staff currently excluded from access may be given access. Allowing access to currently excluded staff will lead to an increase in the coverage of the NHSPS, but any net turnover of transferred staff (for example as a result of cost cutting by the private provider) will reduce coverage.

13. Reasonable assumptions for this variant might be a 3% initial uplift in coverage, for those currently excluded (see point 3 in background), combined TUPE and competition transfers of 6%, with annual net turnover of 1% (assuming only a small amount of gradual cost reduction). Using our previous model with these assumptions leads to the following:

	2015 £bn	**2020 £bn**	**2040 £bn**
NHSPS contributions	9.0	8.6	7.4
NHSPS projected liabilities		278	248

Option C Variant 2

14. Although potentially the same as variant 1 immediately above, employers have the option of which staff to offer access too. Therefore, it is likely that some staff will not be given access and hence the contribution and liability figures will be lower than in the table above.

15. Reasonable assumptions for this might therefore be a 2% initial uplift (i.e. assuming some of the currently excluded remain excluded), combined TUPE and competition transfers of 6% with a net turnover of 5% pa (as a greater number of staff are not given access). From the previous modelling this gives the following:

	2015 £bn	**2020 £bn**	**2040 £bn**
NHSPS contributions	8.9	8.5	7.1
NHSPS projected liabilities		278	243

Option C Variant 3

16. This is a term of business for current staff, but optional access for new entrants. This will result in figures somewhere between those in variant 1 and 2 above due to the flexibility around access for new entrants.

Option C Variant 4

17. Providers have the option of offering access, but if they do it must apply to all eligible staff. Potentially if all providers offered access this would be the same as variant 1 above, but in reality we would expect some providers not to provide access. Therefore, reasonable assumptions might be a 3% initial uplift in coverage, for those currently excluded (see point 3 in background), combined TUPE and competition transfers of 6%, with annual net turnover of 5% (where this turnover rate reflects some providers opting over time not to give access). From the previous modelling this gives the following:

	2015 £bn	**2020 £bn**	**2040 £bn**
NHSPS contributions	9.0	8.6	7.2
NHSPS projected liabilities		278	245

Option C Variant 5

18. Very similar to variant 4 above but the decision between providing access for new joiners is separate to the decision regarding current staff. Therefore, it would be expected that the figures for this variant may be slightly lower than variant 4 and more like variant 2.

Future Review

19. The purpose of the modelling was to inform DH and HMT about the impact of different approaches to NHSPS access. The choice of access option and variant can affect the likely

development of NHSPS contribution yield and liabilities. For HMT a concern exists around the expansion of the liabilities beyond those they have planned for.

The assumptions used above to consider the modelling are based on basic analysis of historic data. These could prove to be inappropriate as future experience may be materially different, particularly as changes to the Fair Deal policy, the NHSPS scheme reforms and the ability for increased competition within the NHS begin to take effect. This uncertainty, combined with the options that show an expansion of the liabilities relative to the baseline figures, cause concern for HMT.

20. It is worth noting that the choice of access option need not be a onetime solution. An ongoing review of experience, and in particular comparison of the initial uplift in membership as well as TUPE and competition transfer rates and net turnover relative to those assumed in the modelling, can be undertaken to determine whether it appears the access option selected is leading to a faster increase in NHSPS liabilities than expected. Should this prove to be the case, the access approach could be re-visited and amended if necessary to control the growth.

GAD ACCESS MODELLING FOR THE STAFF PASSPORT GROUP

1. Estimates of potential contribution income and Scheme liability impacts for 3 main Access Review option groupings

1. **No change to NHS PS Access terms (assumed to equate to no change in NHS PS coverage since this route is expected to result in negligible reshaping of the market)**
2. **New Fair Deal (TUPE staff) plus transferred non-TUPE staff working on NHS clinical services**
3. **New Fair Deal (TUPE staff) plus all staff working on NHS clinical services**

Note - the modelling in this annex was produced to illustrate sensitivity of contribution income and balance sheet exposure to differing proportions of NHSPS membership transferring through TUPE or by transfer of services to IPs It does not therefore directly correlate to the variants as labelled in the rest of this business case, which considers the principles by which members involved in such transfers might be provided with (or excluded from) scheme access, rather than the actual volumes involved.

2. The tables provided in this note are extended versions of those originally provided by GAD to the Department of Health to give an indication of the impact different assumptions for transfer of services from the NHS and different scenarios for access to NHSPS might have on the contributions received by the NHSPS in future. The extensions in this note have been requested by HMT to provide some sensitivity indications and to incorporate some estimates of total NHSPS liabilities in the various scenarios. We have also extended the tables from those provided in the 4 July 2012 note, to show 75% access under scenario 3 as requested by DH. This note encapsulates the work carried out so far looking at potential impacts of different methods of scheme access, however further work may be required as this work progresses.

3. The figures in this note are based on a Pensionable Payroll of £40bn in 2015, and in all cases allow for salary inflation of 4.25% per annum from that date[2]. The contribution and liability figures are then provided in 2015 GDP terms by discounting the figures to reflect expected GDP growth[3] over the period 2015 to 2040. The note is not intended to provide any advice on the appropriate assumptions for the future of NHS service provision, or to provide any comment on scheme access models and should be read in conjunction with the further GAD note in this Business case, at Annex B.

Assumptions/Limitations

4. The main assumptions within the modelling undertaken to provide the tables below are:

Pensionable Payroll for 2015/16	£40bn
Member and Employer Combined Contribution Rate	21.9% of Pensionable Payroll
Projected Expenditure long-term forecasts thereafter[4]	OBR estimates to 2014/15 and our

[2] We have not varied this assumption in line with the OBR assumptions (see note 2) as the latter are applied to the public service as a whole and it is unclear to what extent they are appropriate for the NHS.

[3] Using the central GDP assumptions provided by OBR for the fiscal sustainability report published on 12th July 2012.

[4] Our long term forecasts are slightly lower than that in the existing short term OBR forecasts as we have not sought to vary our longer term model for the purposes of this note. The projected expenditure each year feeds into the projected liability and the impact of the differences in the short term/long term models is small in this context.

Liability discount rate[5]	4.85% per annum
Pensionable Payroll Increase Rate (from 2015)	4.25% per annum
Baseline active membership size	Static at 2015 levels
Assumed Member Movements	Occur over a 5-year period

Contributions

5. The levels of contribution income shown in the tables below are heavily dependent upon the assumptions shown within the tables, the assumed combined contribution rate and the assumption that under the baseline the active membership would remain the same size with payroll just increasing with payroll inflation. If these assumptions are not borne out the actual contributions received by NHSPS could be significantly different.

Liabilities

6. The liability figures are based on a roll-forward of the liability as at 31 March 2012 as calculated for resource accounts purposes (£247bn). The projected liability as at 2015 is £284bn. The roll-forward allows for projected expenditure and contribution receipts but makes no specific allowance for member deaths, withdrawals, transfers or changes in retirement behaviour as a result of any changes to scheme access or transfers of NHS services. In fact, the projected expenditure is based on current scheme benefits and does not anticipate the 2015 scheme reforms.

7. We believe (from having had sight of the work undertaken by our GAD colleagues for OBR) that this is not an unreasonable assumption to make in the context of the figures in this note although it should be noted that over longer projection terms the impact of the reforms is likely to mean that the benefit expenditure is overestimated in this note and thus the run down of the liabilities will be slower than indicated (ie the longer term liabilities may be higher than shown here). In addition, the same projected expenditure has been used to roll forward the liabilities in each of the scenarios considered and hence does not allow for any change in expenditure that might result from a change in the access to the NHSPS. This could have a material impact on the projected liability figure; with a greater impact the further into the future the liability is projected. The liability figure is also highly dependent upon the GDP growth rate used to discount the figures to 2015 GDP terms, a lower rate would increase the liability figure and vice versa.

[5] All liability figures have been derived from the most recently estimated NHSPS total liability of £247bn as at 31/3/12 as produced for resource accounts purposes. This is based on a gross discount rate of 4.85% pa.

Scenarios

1. **Only TUPE'd (non-NHS) staff (both support and clinical) have access to NHSPS (via closed directions). Thus the NHSPS will have declining coverage due to (i) competition and (ii) turnover in contractor organisations.**

   Key assumptions will be the proportions of staff (support and clinical) TUPE transferred, the turnover in the contractor organisations (with no offset from future joiners) and the proportion of staff exiting due to competition.

(i) Clinical support (pathology) included in TUPE'd staff

No	Description	TUPE			NHSPS contribution			Projected liability	
		Transferred	Turnover p.a.	Competition Transferred	£bn 2015	£bn 2020	£bn 2040	£bn 2020	£bn 2040
1	Baseline	0%	n/a	0%	8.8	8.4	7.3	277	244
2	Low TUPE Low Turnover	5%	5%	2%	8.7	8.2	6.9	276	236
3	Low TUPE High Turnover	5%	20%	2%	8.7	8.0	6.8	276	233
4	High TUPE Low Turnover	10%	5%	1%	8.7	8.2	6.7	276	234
5	High TUPE High Turnover	10%	20%	1%	8.7	7.8	6.5	276	227

(ii) Clinical support (pathology) included in competition

No	Description	TUPE			NHSPS contribution			Projected liability	
		Transferred	Turnover p.a.	Competition Transferred	£bn 2015	£bn 2020	£bn 2040	£bn 2020	£bn 2040
1	Baseline	0.0%	n/a	0%	8.8	8.4	7.3	277	244
2	Low TUPE Low Turnover	3.3%	5%	3.7%	8.7	8.0	6.8	276	235
3	Low TUPE High Turnover	3.3%	20%	3.7%	8.7	7.9	6.8	276	232
4	High TUPE Low Turnover	6.7%	5%	4.3%	8.7	7.9	6.6	276	231
5	High TUPE High Turnover	6.7%	20%	4.3%	8.7	7.7	6.5	275	226

(iii) Sensitivity result for (i)

		TUPE transferred + 1%					TUPE turnover + 1%					Competition transferred + 1%				
No	Description	NHSPS contribution			Projected liability		NHSPS contribution			Projected liability		NHSPS contribution			Projected liability	
		£bn 2015	£bn 2020	£bn 2040	£bn 2020	£bn 2040	£bn 2015	£bn 2020	£bn 2040	£bn 2020	£bn 2040	£bn 2015	£bn 2020	£bn 2040	£bn 2020	£bn 2040
2	Low TUPE Low Turnover	8.7	8.1	6.8	276	236	8.7	8.1	6.8	276	236	8.7	8.1	6.8	276	235
3	Low TUPE High	8.7	7.9	6.7	276	231	8.7	8.0	6.8	276	233	8.7	7.9	6.7	276	231

	Turnover															
4	High TUPE Low Turnover	8.7	8.1	6.6	276	234	8.7	8.1	6.6	276	233	8.7	8.1	6.6	276	233
5	High TUPE High Turnover	8.7	7.8	6.4	276	226	8.7	7.8	6.5	276	227	8.7	7.8	6.4	276	226

For each set of sensitivity figures we have only changed a single assumption and left the remaining assumptions unchanged. For example in No.2 under the TUPE transferred + 1% column we have increased the TUPE transfer rate by 1% but left the TUPE turnover and Competition Transferred assumptions as they were in table (i).

The sensitivity figures highlight the relatively minor impact small (c. 1%) changes in the TUPE transfer, TUPE turnover and competition rates have.

2. **TUPE'd staff have access to NHSPS (via closed directions) as for 1. Plus any other employee of a non-NHS, clinical provider organisation moving directly from NHS employment and continuing to perform NHS funded services may have access. This will cover contractors and AQPs (to the extent new employees, performing clinical services, were in NHSPS immediately prior to joining the contractor or AQP) and future joiners of employers currently excluded from NHSPS membership (eg Social Enterprises or existing private sector). It is not envisaged that this option will allow those in the latter sector and currently excluded from membership to access the NHSPS so there would be no immediate increase in NHSPS coverage.**

   Key assumptions will be the proportion of staff (support and clinical) transferred through TUPE or via competition, the proportion of staff whose employer does not grant NHSPS membership, the net turnover in the new employer and the proportion of new staff joining employers currently excluded from the NHSPS.

(i) Clinical support (pathology) included in TUPE'd staff

No	Description	TUPE		Competition		Excluded[1]	NHSPS contribution			Projected liability	
		Transferred	Turnover p.a.	Transferred	Turnover p.a.		£bn 2015	£bn 2020	£bn 2040	£bn 2020	£bn 2040
1	Baseline	0%	n/a	0%	n/a	n/a	8.8	8.4	7.3	277	244
2	0% exclusion Low TUPE No net turnover	5%	0%	2%	0%	0%	8.8	8.4	7.3	277	244
3	0% exclusion Low TUPE Low turnover	5%	5%	2%	5%	0%	8.8	8.3	6.9	277	238
4	0% exclusion High TUPE No net turnover	10%	0%	1%	0%	0%	8.8	8.4	7.3	277	244
5	0% exclusion High TUPE Low turnover	10%	5%	1%	5%	0%	8.8	8.2	6.7	277	235
6	-1% exclusion Low TUPE No net turnover	5%	0%	2%	0%	-1%	8.8	8.5	7.3	277	245

7	-1% exclusion Low TUPE Low turnover	5%	5%	2%	5%	-1%	8.8	8.4	7.0	277	240
8	-1% exclusion High TUPE No net turnover	10%	0%	1%	0%	-1%	8.8	8.5	7.3	277	245
9	-1% exclusion High TUPE Low turnover	10%	5%	1%	5%	-1%	8.8	8.3	6.8	277	237
10	-2% exclusion Low TUPE No net turnover	5%	0%	2%	0%	-2%	8.8	8.6	7.4	277	247
11	-2% exclusion Low TUPE Low turnover	5%	5%	2%	5%	-2%	8.8	8.5	7.1	277	242
12	-2% exclusion High TUPE No net turnover	10%	0%	1%	0%	-2%	8.8	8.6	7.4	277	247
13	-2% exclusion High TUPE Low turnover	10%	5%	1%	5%	-2%	8.8	8.4	6.9	277	239

[1] The % excluded is the proportion of staff not given access to NHSPS by their employer - set to nil in above but can be varied

(ii) Clinical support (pathology) included in competition

No	Description	TUPE		Competition		Excluded [1]	NHSPS contribution			Projected liability	
		Transferred	Turnover p.a.	Transferred	Turnover p.a.		£bn 2015	£bn 2020	£bn 2040	£bn 2020	£bn 2040
1	Baseline	0%	n/a	0%	n/a	n/a	8.8	8.4	7.3	277	244
2	0% exclusion Low TUPE No net turnover	3.30%	0%	3.70%	0%	0%	8.8	8.4	7.3	277	244
3	0% exclusion Low TUPE Low turnover	3.30%	5%	3.70%	5%	0%	8.8	8.3	6.9	277	238
4	0% exclusion High TUPE No net turnover	6.70%	0%	4.30%	0%	0%	8.8	8.4	7.3	277	244
5	0% exclusion High TUPE Low turnover	6.70%	5%	4.30%	5%	0%	8.8	8.2	6.7	277	235

[1] The % excluded is the proportion of staff not given access to NHSPS by their employer - set to nil in above but can be varied

3. **TUPE'd staff have access to NHSPS (via closed directions) as for 1. Plus any other employee of any organisation performing NHS funded services may have access. This will cover contractors (to the extent employees are performing NHS funded services), AQPs and potentially those currently excluded from NHSPS membership within Social Enterprises or existing private sector.**

   Key assumptions will be the increase in pensionable payroll as a result of granting access to previously excluded employees, and the assumption regarding the proportion of staff whose employer does not grant NHSPS membership. Other key assumptions will be the proportion of staff (support and clinical) transferred through TUPE or via competition and the net turnover in the new employers.

(i) Clinical support (pathology) included in TUPE'd staff

No	Description	Initial Extra Access	TUPE		Competition			NHSPS contribution			Projected liability	
			Transferred	Turnover p.a.	Transferred	Turnover p.a.	Excluded	£bn 2015	£bn 2020	£bn 2040	£bn 2020	£bn 2040
1	Baseline	0%	0%	n/a	0%	n/a	0%	8.8	8.4	7.3	277	244
2.a	Full access 0% exclusion Low TUPE Low turnover	5%	5%	4%	1%	4%	0%	9.2	8.7	7.4	279	249
2.b	Full access 0% exclusion Low TUPE Low turnover	5%	5%	5%	1%	5%	0%	9.2	8.7	7.3	279	249
2.c	Full access 0% exclusion High TUPE Low turnover	5%	10%	4%	2%	4%	0%	9.2	8.7	7.1	279	246
2.d	Full access 0% exclusion	5%	10%	5%	2%	5%	0%	9.2	8.6	7.0	279	244

	High TUPE Low turnover											

2.e	Full access -1% exclusion Low TUPE Low turnover	5%	5%	4%	1%	4%	-1%	9.2	8.8	7.4	279	251
2.f	Full access -1% exclusion Low TUPE Low turnover	5%	5%	5%	1%	5%	-1%	9.2	8.8	7.4	279	250
2.g	Full access -1% exclusion High TUPE Low turnover	5%	10%	4%	2%	4%	-1%	9.2	8.8	7.2	279	247
2.h	Full access -1% exclusion High TUPE Low turnover	5%	10%	5%	2%	5%	-1%	9.2	8.7	7.1	279	246
2.i	Full access -2% exclusion Low TUPE Low turnover	5%	5%	4%	1%	4%	-2%	9.2	8.9	7.5	279	253
2.j	Full access -2% exclusion Low TUPE Low turnover	5%	5%	5%	1%	5%	-2%	9.2	8.9	7.5	279	252
2.k	Full access -2%	5%	10%	4%	2%	4%	-2%	9.2	8.8	7.2	279	249

	exclusion High TUPE Low turnover											
2.l	Full access -2% exclusion High TUPE Low turnover	5%	10%	5%	2%	5%	-2%	9.2	8.8	7.2	279	248
3.a	Full access 0% exclusion Low TUPE Low turnover	4%	5%	4%	1%	4%	0%	9.1	8.7	7.3	279	247
3.b	Full access 0% exclusion Low TUPE Low turnover	4%	5%	5%	1%	5%	0%	9.1	8.6	7.3	278	247
3.c	Full access 0% exclusion High TUPE Low turnover	4%	10%	4%	2%	4%	0%	9.1	8.6	7.0	278	244
3.d	Full access 0% exclusion High TUPE Low turnover	4%	10%	5%	2%	5%	0%	9.1	8.5	6.9	278	242
3.e	Full access -1% exclusion Low TUPE	4%	5%	4%	1%	4%	-1%	9.1	8.7	7.4	279	249

	Low turnover											
3.f	Full access -1% exclusion Low TUPE Low turnover	4%	5%	5%	1%	5%	-1%	9.1	8.7	7.3	279	249
3.g	Full access -1% exclusion High TUPE Low turnover	4%	10%	4%	2%	4%	-1%	9.1	8.7	7.1	279	245
3.h	Full access -1% exclusion High TUPE Low turnover	4%	10%	5%	2%	5%	-1%	9.1	8.6	7.0	279	244
3.i	Full access -2% exclusion Low TUPE Low turnover	4%	5%	4%	1%	4%	-2%	9.1	8.8	7.4	279	251
3.j	Full access -2% exclusion Low TUPE Low turnover	4%	5%	5%	1%	5%	-2%	9.1	8.8	7.4	279	250
3.k	Full access -2% exclusion High TUPE Low turnover	4%	10%	4%	2%	4%	-2%	9.1	8.8	7.2	279	247
3.l	Full access -2%	4%	10%	5%	2%	5%	-2%	9.1	8.7	7.1	279	246

	exclusion High TUPE Low turnover											
4.a	75% access 0% exclusion Low TUPE Low turnover	3%	5%	4%	1%	4%	0%	9.0	8.6	7.2	278	246
4.b	75% access 0% exclusion Low TUPE Low turnover	3%	5%	5%	1%	5%	0%	9.0	8.6	7.2	278	245
4.c	75% access 0% exclusion High TUPE Low turnover	3%	10%	4%	2%	4%	0%	9.0	8.5	6.9	278	242
4.d	75% access 0% exclusion High TUPE Low turnover	3%	10%	5%	2%	5%	0%	9.0	8.5	6.9	278	240
4.e	75% access -1% exclusion Low TUPE Low turnover	3%	5%	4%	1%	4%	-1%	9.0	8.7	7.3	278	247
4.f	75% access -1% exclusion Low TUPE Low turnover	3%	5%	5%	1%	5%	-1%	9.0	8.6	7.3	278	247

4.g	75% access -1% exclusion High TUPE Low turnover	3%	10%	4%	2%	4%	-1%	9.0	8.6	7.0	278	244
4.h	75% access -1% exclusion High TUPE Low turnover	3%	10%	5%	2%	5%	-1%	9.0	8.5	6.9	278	242
4.i	75% access -2% exclusion Low TUPE Low turnover	3%	5%	4%	1%	4%	-2%	9.1	8.7	7.4	279	249
4.j	75% access -2% exclusion Low TUPE Low turnover	3%	5%	5%	1%	5%	-2%	9.1	8.7	7.3	279	248
4.k	75% access -2% exclusion High TUPE Low turnover	3%	10%	4%	2%	4%	-2%	9.0	8.7	7.1	278	245
4.l	75% access -2% exclusion High TUPE Low turnover	3%	10%	5%	2%	5%	-2%	9.0	8.6	7.0	278	244
5.a	50% access 0% exclusion	2%	5%	4%	1%	4%	0%	8.9	8.5	7.1	278	244

	Low TUPE Low turnover											
5.b	50% access 0% exclusion Low TUPE Low turnover	2%	5%	5%	1%	5%	0%	8.9	8.5	7.1	278	243
5.c	50% access 0% exclusion High TUPE Low turnover	2%	10%	4%	2%	4%	0%	8.9	8.4	6.9	278	240
5.d	50% access 0% exclusion High TUPE Low turnover	2%	10%	5%	2%	5%	0%	8.9	8.4	6.8	277	239
5.e	50% access -1% exclusion Low TUPE Low turnover	2%	5%	4%	1%	4%	-1%	8.9	8.6	7.2	278	245
5.f	50% access -1% exclusion Low TUPE Low turnover	2%	5%	5%	1%	5%	-1%	8.9	8.6	7.2	278	245
5.g	50% access -1% exclusion High TUPE Low turnover	2%	10%	4%	2%	4%	-1%	8.9	8.5	6.9	278	242
5.h	50% access	2%	10%	5%	2%	5%	-1%	8.9	8.5	6.9	278	240

	-1% exclusion High TUPE Low turnover											
5.i	50% access -2% exclusion Low TUPE Low turnover	2%	5%	4%	1%	4%	-2%	9.0	8.7	7.3	278	247
5.j	50% access -2% exclusion Low TUPE Low turnover	2%	5%	5%	1%	5%	-2%	9.0	8.6	7.3	278	246
5.k	50% access -2% exclusion High TUPE Low turnover	2%	10%	4%	2%	4%	-2%	9.0	8.6	7.0	278	243
5.l	50% access -2% exclusion High TUPE Low turnover	2%	10%	5%	2%	5%	-2%	9.0	8.5	6.9	278	242

(ii) Clinical support (pathology) included in competition

No	Description	Initial Extra Access	TUPE		Competition			NHSPS contribution			Projected liability	
			Transferred	Turnover p.a.	Transferred	Turnover p.a.	Excluded	£bn 2015	£bn 2020	£bn 2040	£bn 2020	£bn 2040
1	Baseline	0%	0%	n/a	0%	n/a	0%	8.8	8.4	7.3	277	244
2.a	Full access 0% exclusion Low TUPE Low turnover	4%	6.70%	5%	4.30%	5%	0%	9.1	8.6	7.0	278	243
2.b	Full access 0% exclusion High TUPE Low turnover	4%	3.30%	5%	3.70%	5%	0%	9.1	8.6	7.2	278	246
3.a	75% access 0% exclusion Low TUPE Low turnover	3%	6.70%	5%	4.30%	5%	0%	9.0	8.5	6.9	278	241
3.b	75% access 0% exclusion High TUPE Low turnover	3%	3.30%	5%	3.70%	5%	0%	9.0	8.5	7.1	278	244
4.a	50% access 0% exclusion Low TUPE Low turnover	2%	6.70%	5%	4.30%	5%	0%	8.9	8.4	6.9	278	239

4.b	50% access 0% exclusion High TUPE Low turnover	2%	3.30%	5%	3.70%	5%	0%	8.9	8.5	7.1	278	242

Annex C

MONITOR FINDINGS – NHS PENSIONS AND THE IMPACT ON INDEPENDENT PROVIDERS

1.1 Definition and description of impact

Public providers of health care offer their employees access to the NHS pension scheme. The NHS pension scheme is a pay-as-you go scheme which means that current employees' contributions are used to pay pensions to current retirees. It is a defined benefit scheme which guarantees a particular proportion of staff salary as a pension. It is available to the following staff:

- NHS employing authorities (NHS Trusts, Foundation Trusts, PCTs, Health Authorities);
- GP practitioners (GMS,PMS, APMS and SPMS);
- Direction employers, conditional on approval by the Secretary of State;
- Joint NHS and Social Care partnerships to provide integrated health care, conditional on approval by the Secretary of State.

The NHS employer contribution rate to the NHS pension scheme is 14% of employees' income[6]. NHS providers cannot offer a different pension plan to their employees. Private and VCS sector providers are largely ineligible to the scheme. The following employers can apply to the Secretary of State to become "Direction employers" that can subsequently offer NHS pension membership to either ex-NHS staff or all staff depending on the type of direction[7]:

- Social enterprises
- Hospices
- Care in the community services
- University medical schools
- Institutes involved in research

UNISON estimates that only 1.5% of current scheme members are members through a Direction. Access to the NHS pension scheme may also depend on the type of contract.

Private and VCS providers are required to offer a "broadly comparable" pension plans for staff that are transferred from a public provider where the Transfer of Undertakings Protection of Employment regulations" (TUPE) applies. The TUPE regulation is based on an EU Council Directive on the approximation of the law relating to business transfers[8]. For TUPE-eligible staff, a comparable pension plan has to be provided. This requirement stems from the "Fair Deal" which is a non-statutory policy that applies to the provision of pension for public sector staff when they are compulsorily transferred to a non-public sector

[6] NHS BSA, (2012), NHS Pension Scheme: 2011/12 Tiered Employee Contributions Available http://www.nhsbsa.nhs.uk/Documents/Pensions/Tiered_contributions_2011-12.pdf

[7] NHS BSA, (2012), NHS Pensions Direction Employers Guide, Available http://www.nhsbsa.nhs.uk/Documents/Pensions/Direction_Employments_Guide_(V5)_10.2012.pdf

[8] The Transfer of Undertakings (Protection of Employment) Regulations 2006, (2006), Explanatory Note, Available http://www.legislation.gov.uk/uksi/2006/246/note/made

employer[9]. The Fair Deal policy applies where a public service is outsourced to be delivered by a private or VCS provider. For non TUPE-eligible staff, private providers and VCS can provide standard pension plans.

1.2 Differential treatment of providers

It is useful to distinguish TUPE-eligible staff and non-TUPE-eligible staff as the distortion applies to employees in different ways.

TUPE-eligible staff

To provide the same level of pension benefits for TUPE-eligible staff, private sector providers and VCS have to pay employer contributions that are higher than the standard 14% that NHS providers are paying. The reasons for the increase in cost are as follows:

1. The NHS scheme is a defined benefit scheme that is not funded and so no gains or losses arise from assets under or over performing. Under-performing assets can add greatly to the costs of private sector pension schemes as deficits need to be funded. In order to remove this risk a low risk investment strategy could be taken but this would result in lower expected future returns and hence would increase costs.

2. The NHS scheme is an unfunded pension scheme backed by the Government. It is therefore not covered by the Pension Protection Fund (PPF) and so no PPF levy is payable resulting in reduced employer costs each year

3. There are economies of scale in the administration of pension schemes which benefit the NHS pension scheme. In addition, the administration of the NHS Pension Scheme is funded by the NHS business service authority. The average administration cost of the NHS Pension Scheme of £16 per member is significantly lower than the average private sector cost of £41 to £47 per member[10].

Many defined benefits pension schemes operated by private employers are now closed to new entrants or closed to all employees. For those that are still open to employees employee contribution rates have generally increased over the past few years to help share the employer's increase cost of providing these benefits.

It is not straightforward to estimate the employer contributions required by private and VCS sector providers that would replicate the benefits of the NHS pensions scheme. An example calculation has been undertaken that would provide an annuity for a 45 year old male employee who retires at 65 with an employee contribution rate of 6.5%. In this case, the private and VCS provider would have to contribute 22%-24% of the employee's salary[11]. Private and VCS providers have indicated that contributions may be as high as 27%. This contribution is 8-13 percentage points higher than the contribution to the NHS pension plan to achieve the same level of benefits. As the TUPE regulation applies to the most important terms and conditions of employment, it is unlikely that private and VCS providers can mitigate the impact of the pension contribution by lowering wages.

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[9] HM Treasury, (2011), Consultation on the Fair Deal Policy, Available http://www.hm-treasury.gov.uk/d/consult_fair_deal_pensions.pdf

[10] Estimate for largest schemes, Independent Public Service Pensions Commission, (2011), Final Report

[11] Ernst & Young, (2012), NHS Pension Scheme Comments and observations, Note that the contribution rate can be applied to any salary level

In addition to pension costs, there is some uncertainty around bulk transfer arrangements when staff transfers from the public to the private sector. In principle, employees can choose to take their pensions to a new provider when changing employers. Employees may not want to accumulate pension entitlements with more than one fund and can therefore choose to consolidate their funds.

A bulk transfer is a special arrangement whereby enhanced transfer terms are negotiated with a prospective new scheme and employer, to allow the transferring members to be able to transfer their accrued pension benefits to the new employer's scheme and receive pension benefits of equivalent value to those earned in the NHS pension scheme immediately before transfer[12]. When employees are transferred from a public to a private provider, each employee can decide whether to take their pension entitlements to the new scheme or whether to leave them in the NHS pension scheme. The decision has to be made within a three month period.

The reason why the bulk transfer poses a financial risk to the private provider who takes over the service is the uncertainty around the valuation. The value of the potential bulk transfer payment is not known in advance of the transaction because

1. it is not known how many employees will choose to transfer their pensions and

2. The size of the pension liability depends on a range of factors and can therefore not be estimated without detailed information on the employee type, length of service, etc.

In the past, take up rates for staff offered bulk transfer options have varied very widely.

It may be even more difficult for small private and VCS sector providers to offer a comparable defined benefit pension. Defined benefit schemes imply that the employer takes on the risk of asset performance. Large providers may be able to take on such risks but for small providers the risk exposure may be too great to take on. Employees and employers pay contributions that can be invested and in a defined benefit scheme the final pension is fixed and private and VCS of the performance of the underlying investment. It may be difficult for small providers to take on such risks. The Independent Public Service Pensions Commission (2011) found:

"By leaving almost all risks with employers, [current public service final salary pension schemes] can make it difficult to attract new providers to achieve gains in the efficiency and quality of services.[…] Smaller private and voluntary sector employers are often unwilling to take on such risks.[13]"

Non-TUPE eligible staff

For non-TUPE-eligible staff, private and VCS providers are not obliged to offer equivalent pensions to TUPE-staff. Instead private and VCS provider can provide standard pension plans for non-TUPE-eligible staff as long as they adhere to the statutory minimum contribution rate of 3%[14].

[12] NHS Business Services Authority, (2006), NHS Staff Compulsorily Transferred out of the NHS under PPP, PFI or other programmes: Bulk Transfer of Pension Rights Available: http://www.nhsbsa.nhs.uk/Pensions/Documents/Pensions/TN10_2006.pdf

[13] Independent Public Service Pensions Commission, (2011), Final Report

[14] The Pension Regulation, (2012), An introduction to work-based pension changes, Available http://www.thepensionsregulator.gov.uk/docs/intro-to-work-based-pension-changes-2011.pdf

For non-TUPE-eligible staff it is not clear whether private providers are advantaged or disadvantaged. This depends strongly on labour market dynamics. In simplified terms, private providers will be disadvantaged if skilled labour is scarce and difficult to attract. In this case they will have to pay higher contribution rates to achieve the same level of employee benefits. Private providers are advantaged if skilled labour is abundant and therefore lower pension benefits do not prevent private providers from attracting sufficient staff. The advantage also depends on the extent to which potential employees value reduced pension contributions. If employees place a high value on current consumption (as opposed to future consumption), a lower pension contribution that translates into a higher salary may be preferred. Private providers would only be advantaged if the decrease in pension contributions does not have to be fully offset by an increase in the salary (i.e. if employees value an extra pound of salary more than an extra pound of pension contribution).

Data from the ACA pension trend survey (which covers all sectors and therefore is not specific to healthcare) indicates that the typical employer contribution for a defined contribution pension benefit ranges from 4.3% to 7%. No data has been found on data on healthcare specific employer contribution rates.

Overall, the following differences in pension provision can be identified:

- **TUPE-eligible staff:** Private providers are disadvantaged as they have to pay higher contributions to offer staff that transfer from NHS providers a broadly comparable pension. The difference in the contribution rate is likely to be around 8-13 percentage points.

- **Non-TUPE-eligible staff:** Private providers have the flexibility to offer non-public staff the minimum pension contribution (which is 3%)[15]. NHS trusts do not have the same flexibility. Foundation trusts have a greater level of flexibility but have generally stated that they would be disadvantaged if they did not offer access to the NHS pension scheme. Depending on the labour market, private providers may be advantaged as they can contribute 3% compared to 14% employer contributions or disadvantaged as they have to pay 22-24% compared to 14% to offer the same benefits. Private providers may also be advantaged if employees have a high discount rate and therefore value an increased salary more than a reduction in pension contributions so that the private provider is able to reduce overall costs while offering a competitive remuneration package.

1.3 How in principle could this factor harm patients and taxpayers?

The difference in pension costs creates a cost disadvantage for private providers with respect to TUPE-eligible staff. With respect to non-TUPE-eligible staff, the difference in pension costs may create a cost advantage or disadvantage (depending on labour market conditions) for private providers. The overall impact on private providers therefore depends on two factors:

- **The proportion of TUPE-eligible staff versus non-TUPE-eligible staff** – the higher the proportion of TUPE-eligible staff the greater the cost disadvantage;

- **Labour market conditions** and the need to provide substantial pension benefits to attract staff – the more difficult it is to attract high quality staff, the greater the cost disadvantage.

[15] The Pension Regulation, (2012), An introduction to work-based pension changes, Available http://www.thepensionsregulator.gov.uk/docs/intro-to-work-based-pension-changes-2011.pdf

A cost disadvantage can lead to restrictions on entry or expansion as private providers find it difficult to compete with public providers. In theory, two providers with the same cost structure but a different cost of pensions are not competing in a fair playing field as one has a higher cost base than the other. The provider with the cost disadvantage may therefore have to be more efficient and reduce cost elsewhere to provide the same level of service. Depending on the significance of the cost disadvantage, the cost disadvantage may "tip the scales" and prevent the private and VCS provider from entering the market or trying to expand services. Private and VCS providers may also be more likely to bid for those services where efficiency savings can be realised to make up for the cost disadvantage.

The cost disadvantage to non-public providers also implies that they do not provide an effective competitive constraint on public providers. The cost disadvantage could in principle lead to three types of behaviour:

- Public providers could choose to operate less efficiently than private providers but at equal costs;

- Public providers could operate at the same level of efficiency and the cost differential in service quality. As a result, they can provide a higher level of service at the same costs.

- Public providers could reduce the price if they operate at the same level of efficiency and quality as non-public providers.

All of these behaviours imply that the cost disadvantage of non-public providers allows non-public providers to operate at sub-optimal levels of efficiency, quality or cost. This demonstrates that the market is characterised by weak rivalry as the existence of non-public providers in the market does not provide a competitive constraint on public providers.

The Independent Public Service Pensions Commission (2010) found:
"Current pension structures, combined with the requirement to provide comparable pensions ("Fair Deal") are a barrier to non-public service providers, potentially reducing the efficiencies and innovation in public service delivery that could be achieved[16]."

1.4 Evidence of differential impact across providers

It is difficult to estimate the proportion of TUPE-eligible staff versus non-TUPE-eligible staff. It is likely that the proportion depends on the type of services that are provided. If a private and VCS provider enters the market by taking over an NHS-provided service, it is likely that the proportion of TUPE-eligible staff is close to 100% immediately after the take over. Over time this proportion may reduce. In contrast, an private and VCS provider that enters the market on the basis of the "Any Qualified Provider" scheme, the proportion of TUPE-eligible staff may be relatively low. Overall, it is likely that there a substantial number of cases where the proportion of TUPE-eligible staff is relatively high.

It is also difficult to tell whether labour market conditions lead to a cost advantage or disadvantage. It is likely that high quality staff will require substantial pension benefits as the perception of working for a private company among NHS staff can be negative. NHS staff also perceive a greater level of uncertainty when working for a private provider which causes scepticism that has to be overcome when attracting staff. Stakeholder comments have indicated that staff at higher grades or with long NHS service records place greater emphasis on the NHS pension scheme than those at lower grades. In contrast, some staff at

[16] Independent Public Service Pensions Commission, (2010), Interim Report

lower grades would value a lower contribution and a greater cash proportion of their salary. This may imply that private providers have an advantage in offering these employees competitive packages of remuneration by reducing the pension contribution and increasing the salary component to a lesser extent.

Stakeholders have also indicated that the labour market conditions depend on geographic proximity to NHS providers. The closer a private of VCS provider is located to an NHS provider, the more likely it is that they have to offer similar benefits to attract staff. However, VCS providers also find that some staff chooses to work for them because of the non-profit nature of their business so they can attract staff at lower pension contributions. Overall, flexibility of pension benefits is likely to be a cost disadvantage to private providers in at least some areas.

With respect to TUPE-eligible staff, the disadvantage to the private sector is likely to have an impact as pension costs represent a significant proportion of total operation costs. Pension costs are estimated to make up about 5%-8% of total operating costs even though the specific proportion is likely to vary substantially with the level of relative labour- and asset-intensities of services[17].

Table 1 below shows the impact on providers' operating costs for different shares of TUPE staff. The upper bound in the table are based on a TUPE-staff pension contribution of 27% of salary, pension costs that make up 8% of total operating costs and a non-TUPE-staff pension contribution of 3%. As a result, they illustrate the maximum changes in operating costs on the basis of pension costs. The lower bound table are based on TUPE-staff contributions of 25%, non-TUPE-staff contributions of 5% and pension costs that represent 5% of operating costs. They can therefore be interpreted as the lower bound.

Table 1: Illustration of impact on operating costs

Share of TUPE-eligible staff	Decrease/increase in operating costs due to pensions	
	Upper bound	Lower bound
25%	-2.9%	-2.0%
60%	1.9%	0.8%
100%	7.4%	3.9%

The case study below illustrates that pension costs can represent a large proportion of the total contract value.

Case study – Pension costs of TUPE-eligible employees

The purpose of this case study is to demonstrate the potential impact of TUPE-eligible staff on pension costs. The case study therefore provides additional empirical evidence for a set of specific circumstances. As it is not possible to generalise these costs (in particular the costs of bulk transfers), it is useful to consider a specific example.

Consider a healthcare provider who is on a 3-year contract to provide services for £17million per annum. Assume that total pensionable pay per annum is £7.2million. In this case NHS pension contributions would be £1 million reflecting an employer contribution of 14%. In contrast, the private sector contributions in this case are £1.94 million (reflecting 27% of employer contributions). The increase of £940,000 per annum represents 5.5% of the annual contract value. This is a substantial cost disadvantage.

[17] Based on sample data and stakeholder evidence.

For the same contract the bulk transfer shortfall risk has been estimated at £2.5million as 29 employees qualify for special class status and 8 for mental health officer status which implies that a shortfall of £66,000 per employee could be realised (if all of them choose to move). For the remaining 231 employees the risk of shortfall is £12,200 per employee so a total of £2.7million. Overall, the total cost risk to the provider is £5.2million of 10% of the total 3-year contract value.

These findings are supported by stakeholder evidence as, for example, the NHS Partner Network found that:

"The advantage for public sector providers derived from the NHS pension scheme […takes] two forms: firstly, the adverse impact on non-NHS providers of the cost of matching the scheme, which NHS providers themselves do not bear the full cost of; and second, the extent to which the attractiveness of the scheme creates a barrier to workforce flexibility and transfers. The estimated average magnitude of this is that it adds between 6% and 7% to independent providers' costs[18]."

With respect to non-TUPE-eligible staff, it is likely that the impact of private providers of not being able to offer the NHS pension scheme is negative. This is mainly due to the perception of the NHS pension scheme. The NHS pension scheme is an important factor in attracting employees. For instance, it is associated with a higher ratio of benefits payments to cumulative contributions by members[19]. The Independent Public Service Pensions Commissions found that final salary pension schemes have a strong retention power on senior staff. However, it is likely that some staff place a greater value on the scheme than others. For example, pension benefits may matter less for career choices of young people, as a survey indicates that 35% of the 18-34 age group agree that "I'm young enough not to have to worry about this yet"[20]. Private providers may be advantaged with respect to attracting younger staff, as they can trade-off pension benefits with salary levels. If staff value an additional pound of salary more than an additional pound of pension contribution, private providers can offer more competitive remuneration packages.

1.5 Evidence of distorted market dynamics

Evidence of distorted market dynamics is difficult to obtain as it pensions is one factor among a range of distortions. However, the following quotes from a wide range of stakeholders suggest that the market is indeed distorted as a result of the cost differential of pensions:

"Currently NHS organisations only pay part of the ongoing staff pension cost - the remainder being absorbed by the Treasury as part of the unfunded public sector pension liability" this is a "major cost factor." [Response to call for evidence, 2012]

"The advantageous terms of the NHS Pension Scheme are not, therefore, available to all staff working within local hospices. Many hospices have to offer differential pension entitlements as they cannot match the generous employer contribution rates for staff not entitled to participate in the NHS Pension scheme. Hospices have expressed concern that they could face potential challenge on equality grounds by offering different pension benefits to different staff undertaking similar roles within the same organisation." [VCS provider, Response to call for evidence, 2012]

[18] NHS Partner Network, (2012)

[19] Office of Health Economics, (2009), How fair?

[20] Future Foundation, (2011), Survey commissioned by life assurance company Friends life

“The considerable costs that would be incurred for the independent sector to match NHS pension arrangements place providers at a clear disadvantage and distract from what should always be the number one priority – delivering high quality patient care.” [Response to call for evidence, 2012]

“When it comes to staff contracts while social enterprise are committed to ensuring staff have fair terms and conditions, they do not have the same financial cushions as NHS providers to absorb these costs and the restrictions they present. This can be very limiting when it comes to reorganisation and restructuring services, which is so desperately needed if we are to meet the challenges we face.” [Response to call for evidence 2012]

“The NHS annual leave and pension scheme are recognised as being very positive benefits, which have the advantage of attracting and retaining staff. It also has the disadvantage of being a barrier to developing and implemental flexible structures as the TUPE arrangements for transfer of pension rights form the NHS to private sector are very costly. This is one of the reasons why joint ventures can be problematic. Essentially the benefits of NHS employment can make the service seem costly and inefficient.” **[**Response to call for evidence 2012]

In order to assess the impact of potential changes to access to the NHS pension scheme, DH has conducted a survey among private and VCS providers. Two of the main options that were considered are:

- Providers of NHS clinical services would be required to offer the NHS pension scheme (PS) as a term of business to all existing members who were entitled to participate in the Scheme in the previous 12 months. Where eligible staff are not classed as existing members, the provider can individually choose whether to offer them access.

- Access to the NHSPS would be optional for providers of NHS Clinical Services. Providers can choose which eligible staff they offer access to.

The survey indicates that more than 40% of providers indicated that they the first option is likely or highly like to increase the NHS contracting opportunities for their organisation. With respect to the second option close the respective proportion is even higher at more than 55%.

1.6 Summary of evidence and likely impact on patients and taxpayers

The evidence described above clearly demonstrates that private and VCS providers have a cost disadvantage if they employ TUPE-eligible staff. This can lead to lower entry by private and VCS providers as they need to provide services more efficiently than public sector providers (when considering this factor in isolation). As a result, provider diversity and pressure on incumbents is reduced.

The potential advantage or disadvantage with respect to non-TUPE-eligible staff is difficult to assess as it depends on labour market dynamics. As a result, it is not likely to be stable over time as labour market conditions change.

The overall impact therefore depends on the proportions of TUPE-eligible versus non-TUPE-eligible staff. As the proportion of TUPE-eligible staff in cases where private and VCS providers take over services is likely to be relatively high, there is a net cost disadvantage at least in those cases.

1. Whitecliff Group Practice :

- introduce new scheme access requirements for independent providers of NHS clinical services - I do not support this. Whilst it may introduce a level playing field for independent providers, nothing is being done to address the constraints of NHS providers to make them on a level playing field, therefore this widens the gap between NHS providers and independent providers further (or perhaps that is the intention).

2. Plymouth Community Healthcare CIC

1.19 The scheme controls seem adequate and not overly bureaucratic.

a. I would be expecting to recruit Medical and Clinical staff primarily
b. If this was considered it could lead to a 'two tier' system depending on the perceived value of the individuals staff groups contribution to the organisation.
c. Not relevant to PCH

I also wanted to ask a question of clarification regarding the "contribution guarantee". My organisation already has a closed scheme with NHSPS whereby the majority of our staff TUPE'd under the protection of the 'Right to Request' process. If we applied for Level 2 access, only offering the pension to those who were previously entitled to join – would our contributions be based upon the numbers of staff we would recruit in this way?

3. University Hospital of South Manchester NHS FT:

Section 1 – Introduction of new scheme access requirement for Independent Providers (IP) of NHS clinical services.

The NHSPS has always been identified as a beneficial tool for recruitment and retention of staff in the NHS. By extending the exclusivity of the NHSPS to IP's it is weakening the NHS employers position.

These IP's could potentially be administering the NHSPS for a very small number of employees. As has been reflected in GP Practices, pensions administration then becomes a part time add-on job for someone within the company. Given the increasing complexity of the legislation for the existing 1995 and 2008 Sections of the NHSPS, together with the implementation of the 2015 Section these IP's will require a huge amount of support from NHS Pensions. This will significantly affect and dilute the service already provided to NHS employers.

I envisage IP's turning to the 'parent' NHS Trust for significant support in administering the NHSPS for their employees or may be contracting in to this service. Thus creating additional workload for the Payroll/Pension Team and increased costs.

IP's may operate a very flexible payment structure, including bonus schemes/PRP/profit sharing, etc, resulting in significant fluctuations in salary year on year that you would not necessarily see across NHS Trusts. Despite the '75% pensionable pay threshold' IP's have the option of paying a contribution surcharge on the excess. This undermines the stability of the financial position of the NHSPS.

The level of NHSPS access – 3 options available – which can be changed at a future date adding further complexity to the administration for NHS Pensions, the IP and their employees.

No security in the future of any IP - could be taken over, merged with another company or go into administration. No clear protection arrangements in place.

When calculating redundancy payments we (the NHS Trust) normally refer to the employees NHSPS membership history statement, as a starting point. We are going to struggle to identify genuine NHS employments for inclusion in the redundancy payment calculation, and exclude IP posts. In instances where staff have the option to access their NHSPS retirement benefits on redundancy it will increase the NHS employer costs (as they will have accrued more Scheme service) if they are subsequently made redundant from an NHS post.

What has been the feedback from current IP's on the anticipated percentage of staff who would choose to join the NHSPS? This increased administration and monitoring costs to support this delivery may far outweigh the benefits of the additional Scheme contributions collected.

4. South Tees Hospitals NHS FT

In response to the questions in part 1.19, it would be unfair and harder to administer if only some groups of staff are covered by "fair deal", one rule for all would be much safer. Staff from any part of the NHS could be involved from catering to porters to medical and nursing staff.

Controls would be required to ensure that the administration of the pension scheme is carried out correctly by the new organisation, and training implication costs factored in.

The NHS pension scheme is extremely complicated to administer and the Electronic Staff Record (ESR) is key to ensuring the correct application of deductions and where necessary applying "deemed" pay calculations etc. Would standard payroll systems be capable of ensuring the correct application of the regulations and how would this be monitored. Recent issues concerning the level of pensionable pay the employer is required to calculate the pension deduction on when an employee is on sick leave against the amount the employee would pay (actual pay against a deemed amount). I very much doubt standard systems would be able to cope with this. NHS employers would therefore pay more than employers would in the independent sector

5. Medway Community Healthcare (IP)

We became an independent provider in April 2011and employ over 1,300 staff in the provision of NHS services to the population of Medway and beyond under a National community services contract. This contract does not allow us employing authority status. The staff who transferred to us under TUPE still have access to the NHS Pension Scheme under our directions status. The cost of providing a scheme equivalent to the NHS Pension scheme was prohibitive and therefore, newly recruited staff since April 2011 have only had the choice of join our new defined contribution scheme with a private provider, with significantly reduced benefits compared to the NHS pension scheme.

We have had many issues with recruiting and retaining new staff, especially clinically qualified staff such as Health Visitors and GPs. Recruitment to senior management positions with candidates who have substantial management experience is also problematic. We know that this is largely because we are not able to offer the NHS pension to these staff and on this basis would strongly welcome the ability to be able to offer the scheme to our staff from April 2014.

In answer to your specific questions:-

a) Whether current and prospective NHS employers believe that the scheme admission and control arrangements proposed could be simplified, without weakening the safeguards ensuring public expenditure is protected and to ensure that the NHSPS is used only for employers and staff engaged in NHS work?
We are unclear how you would resource the control arrangements you have suggested in the consultation documents and are concerned that the cost may be passed on to employees or organisations. We would therefore be supportive of simplified and less resource intensive arrangements which met the same ends

b) What groups of staff IPs in particular expect to recruit with the support of NHSPS membership?
Our key difficulties currently are recruiting and retaining experienced clinically qualified staff or non-clinical staff who have made a career in the NHS who will have had substantial previous membership of the NHS pension scheme

c) Whether there might be a case for limiting the new IP access to specific staff groups, now or in the future?
To improve performance we need to attract high quality staff. Key to this is being able to compete with other NHS providers in offering a high quality but affordable defined benefit pension scheme. Each organisation will need to determine which staff they need to offer this to in order to recruit and retain the best based on local circumstances. This would not work if subject to national control.

6. NHS Partners Network
NHSPN welcomes the move to open up the NHS pension scheme to independent providers of NHS
funded services. We believe this is a very important step in establishing a more levelled playing field.
The new scheme will help providers recruit the best staff and this will ultimately benefit patients by improving outcomes.
NHSPN also welcomes that members can join the scheme at different levels. However, we would
stress that members need to be able to move from one level to another easily. This will be important
to ensure that providers remain sustainable at all stages. It is particularly important in the early
stages of implementing this policy so providers can evaluate which level suits them best.
We would encourage the DH to think about whether issues like spot checks would be best dealt with
through Monitor's licence. It is important to monitor providers but also to keep reporting to a minimum so where information is already being reported under the licence regime, it would be
better if it could also be used for the pensions scheme.
What groups of staff will be recruited

NHSPN believes that pensions are fundamental to recruit the best non-clinical staff.

However, they
will be important for all staff delivering NHS services. It will be specially important for those members of staff who are already members of the NHS pension scheme and want to move to work

for an independent provider.

Should access be limited to specific staff groups?

Access should be open to all staff. This is for two reasons:

1. It is very important that the scheme is simple to run. Wherever an independent provider is deliver
an NHS funded service, that contract would be much easier to administer where all members of staff
are offered the same pension scheme;
2. The NHS pension scheme is attractive to all members of staff. It also allows the best members of
staff to move from one provider to another. NHSPN would want to encourage this.

Other comments/ impacts

NHSPN is concerned that incumbents do not seem to need to provide a bond. This seems unfair and
it unbalances the playing field. We suggest that independent providers should also not need to
provide a bond unless they have failed to pay the administrative charges already.
A bond would add costs and not value to the commissioner or reduce the amount of money available for reinvestment.
We are also concerned that the requirements for a bond may be harder to meet by smaller providers. NHSPN believes that new providers are key to innovating and being more efficient.
Therefore, we need to encourage smaller and newer providers to enter the market, not put barriers.

7. Ripplez CIC

Section 1.7 Ripplez CIC will be applying to join Level 3 NHSPS Access. We currently have a closed scheme only (EA 9713) for the original 10 staff who joined Ripplez under TUPE, and wish to open our scheme to include a further 27 staff who have joined our social enterprise since 1 April 2011;

Section 1.9 b) We expect to be able to recruit from the following staff groups with the support of NHSPS Membership:

Health Visitor

Midwives

School Nurses

Registered Nurses

Clinical Management;

c) As social enterprise providing only NHS services and trying to create a single set of terms of conditions for all staff, we would not be in favour of limiting new IP access to specific staff groups now or in the future;

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8. Serco

Issue 1 – Scope of services to the NHS that are covered by the 2014 Regulations

Throughout the document, the consultation refers to "NHS clinical services". There appears to be no definition of this, so we request further clarity over what will be within the scope of the proposed changes. More specifically, our Health business covers a wide range of services that are ultimately funded by the Department of Health, such as hard and soft Facilities Management. We believe that the principles that lie behind the 2014 proposed changes mostly also apply to these non-clinical services, ie encouraging greater flexibility in provision of these services and avoiding a pensions 'race to the bottom'.

Issue 2 – implications of Level 2 Access

Under Level 2 Access, it appears that employers would need to **"automatically join in the NHSPS all eligible staff".** We request clarification as to whether the IP will have discretion as to whether to offer the NHSPS to ALL joiners with previous entitlement to NHSPS within 12 months of joining the IP. For example, in the event the IP recruits a professional accountant (who previously worked in the NHS) to "wholly and mainly" support an NHS clinical contract, would the IP be mandated to offer access to the NHSPS for that employee?

Issue 3 – Specific questions in consultation

Taking each question in turn below:

a) Whether current and prospective NHS employers believe that the scheme admission and control arrangements proposed could be simplified, without weakening the safeguards ensuring public expenditure is protected and to ensure that the NHSPS is used only for employers and staff engaged in NHS work?

Through an APMS provider, Serco has been administering staff membership of the NHSPS since April 2012. We have encountered significant difficulties in gaining access to the Pensions OnLine (POL) system. This has resulted in unnecessarily manual procedures and above normal levels of operational risk. We would request that steps are taken to encourage and facilitate IP access to the system.
Since the announcement of the New Fair Deal we have, during the bid phase for new business opportunities, struggled to provide adequate reassurance to our clients (and to our senior management) that the NHSPS will indeed be available for staff that will TUPE to us as part of any resulting contract. A cause of this uncertainty has been the timing of the application for each Closed Direction, which takes place only once the contract has been awarded. We consider that all parties, ie the procuring body, the contractor, and the staff, would benefit from greater certainty early on in the procurement process.
b) What groups of staff IPs in particular expect to recruit with the support of NHSPS membership?
At the present time, we envisage that the proposed changes will enable us to attract specialist nurses to support our community services business.
c) Whether there might be a case for limiting the new IP access to specific staff groups, now or in
the future?
We believe that such a case might be prudent, as the 2014 Regulations as they stand could require employers to offer the NHSPS to some staff even where high calibre staff can be attracted into their roles regardless of access to the NHSPS. This could have the result that IPs are restricted in their ability to provide best value for money to the NHS.
d) We would also be interested to know how "traditional" and existing NHS employers see the
proposed changes impacting upon them; and how any impacts could best be managed.
The most significant impact will be the difference between the pre-New Fair Deal position and the ability to obtain Closed Directions for specific TUPE transfers, which greatly levels the competitive playing field.
We have yet to fully assess the potential impact of Level 2 or 3 access. This will partly depend on clarification of our 'Issues 1 & 2' above. In the event that the 2014 Regulations are very highly prescriptive in practice, this could drive IPs to establish a number of Special Purpose Companies, each with differing 'Access Levels', so that their differing needs on different contracts are best met.
Issue 4 – Contribution Guarantee
We seek greater clarity over whether the requirement for a guarantee will be discretionary or mandatory. Secondly, we request sight of the format proposed for any PCGs or bonds that may be required, as Serco is unable to commit to providing these commitments without having had the ability to review them in detail.
Issue 5 – Other
Finally we request clarity on how Level 1 Access relates to Closed Directions that have already been applied for, or granted, under New Fair Deal. For example, does Level 1 replace all pre-existing Closed Directions?

9. The Practice

a) **Whether current and prospective NHS employers believe that the scheme administration and control arrangements proposed could be simplified, without weakening the safeguards ensuring public expenditure is protected and to ensure that the NHSPS is used only for employers and staff engaged in NHS work?**

The Practice believes that in order to simplify scheme admission and control arrangements the phrase “engaged in NHS work” needs to be clearly and comprehensively defined. Similarly, conditions such as the “wholly or mainly” condition needs to be clearly and comprehensively defined, as do the implications of the different levels of membership so that IPs can best assess which level is the most appropriate for them.

The implication that some employers and staff are not engaged in NHS work but are nevertheless members of the NHSPS should be addressed as part of the efforts to safeguard public expenditure. The Practice supports the monitoring of providers but the proposed amendments relating to the collection of additional data from IPs is contrary to the above exploration as to whether or not the control arrangements could be simplified.

b) What groups of staff IPs in particular expect to recruit with the support of NHSPS membership?

The Practice expects that membership of the NHSPS will allow it to compete with NHS organisations in attracting, recruiting and retaining both clinical and non-clinical staff. In relation to clinicians, membership of the NHSPS will be of particular benefit when bidding for consultant-led community services as currently The Practice finds that clinicians who are already members of the NHSPS either do not wish to join us as it would mean having to give up their pension benefits or wish to remain employed by the NHS and work additional sessions with another provider who can offer opportunities to enhance their career prospects and provide additional breadth of knowledge.
Similarly, in relation to non-clinical staff, The Practice has faced a number of administrative staff leaving employment with us in order to work for an NHS organisation so that they can benefit from the NHSPS. In addition, The Practice, through its Support Centre, has a number of staff who oversee the provision of primary and community care under numerous contracts (in a similar capacity to those employed in CCGs and CSUs) but who are not currently eligible for membership of the NHSPS. Membership of the NHSPS would be a benefit for attracting and retaining those talented managers whose work delivers economic and operational efficiencies for the NHS.

c) Whether there might be a case for limiting the new IP access to specific staff groups, now or in the future?

The Practice does not believe that there is a case for limiting the new IP access to specific staff groups as that would not be within the spirit of the Fair Deal. Furthermore, limiting IP access to the Scheme would be contrary to the policy intention of making it easier to retain and recruit staff to provide NHS services, regardless of whether they work in the private, charitable or public sector. In addition any limitation on IP access will prevent the free flow of labour to IPs who can provide varied career opportunities not usually available in the NHS.

d) We would also be interested to know how "traditional" and existing NHS employers see the proposed changes impacting upon them; and how any impacts could best be managed.

As an IP who has some employees eligible for and enrolled in the NHS pension scheme and some employees who are not, the benefits of being able to offer NHS pensions to a wider group of staff would help us to attract, recruit and retain those who would not previously have considered working for us without the NHSPS benefit.

However, as a small business there is a cost implication in making employer contributions for a wider pool of staff and the introduction of contribution guarantees will add an extra layer of expense to the cost for IPs in making the NHSPS available to staff. Similarly, the requirement to have a "suitable credit rating" is a move away from the intended level playing field as IPs do not have the benefit of a State-backed guarantee, as other NHS organisations do. Finally The Practice believes that the proposed changes need to be clear and simple to understand and implement with access to the NHS's own pensions team who can advise on all aspects of the eligibility, membership and implementation so that IPs do not need to incur the additional expense of taking legal advice for the interpretation of the rules and confirmation that they are operating in accordance with the legal obligations of the NHSPS.

10. SPG response (extracts)

- We believe, although it is outside the scope of this review, that there is already an unfair playing field, but it is caused by IPs not having to provide staff with Agenda for Change terms and conditions even when they are providing NHS services, rather than through a lack of IP access to the NHS PS.

- We believe that if IPs are allowed to pick and choose which staff can access the NHS PS, they will have a distinct advantage over NHS organisations. If the government is committed to a fair playing-field, cherry-picking of staff would be prevented, and the government would require IPs to provide staff with AfC.

- Paragraph 1.4 states that a key aim is to avoid a pensions 'race to the bottom', though we believe that by allowing too much flexibility for private sector providers to pick and choose which staff should be given access to the NHS pension scheme, this will remain an issue.
- Paragraph 1.14 states that IPs who want the NHSPS level 2 or 3 access will need to confirm they are seeking NHSPS access primarily for employees who are engaged in the delivery of NHS clinical services. However although this paragraph mentions 'back office' staff, the lack of clarity does little to reassure the staff side that employers won't 'cherry pick' staff. Also staff such as cleaners who are an essential part of clinical services delivery will not have access to the NHS PS, which we believe undermines the concept that healthcare is delivered by a multi-disciplinary team of clinicians and non-clinicians.
- We restate our previous point in reference to Para 1.19 C, which asks whether there might be a case for limiting the new IP access to specific staff groups. We strongly believe that there should be the greatest possible compulsion placed on IPs to provide the NHS pension to their staff providing services to the NHS. Any changes that would give IPs even greater flexibility by enabling them to offer the NHS PS only to certain groups of staff, rather than all those delivering NHS services, places IPs at an even

greater competitive advantage over NHS organisations and those IPs that choose to grant full access to the NHS PS.

11. Guild of Healthcare Pharmacists

Section 1

We would like to commend the extension of the access to the scheme for Independent Providers (IP) of NHS Clinical services. With the movement of staff between the independent providers and probably also back to NHS as contracts for clinical services are reviewed, this enables staff to maintain one pension scheme whoever their employer is.
It therefore important that IPs can enter the scheme at level 2 and should be able to move to level 3 at the soonest opportunity if appropriate for the staff they employ.

We would also like to comment on the following specific points:

Point 1.12 – those NHSPS staff that transfer to IPs must have access to their existing scheme with all the relevant protection applied post 2015 (when the new scheme takes effect) that would apply to a member still within the NHS.

Point 1.15 – we agree that the scheme needs protecting when IPs enter the scheme but this does depend on the grades of the staff entering the scheme. If the staff are in grades equivalent to bands 1-4 then there could be a net loss to the scheme because of the way that the scheme is funded at this time. Obviously if the staff are in grades that are equivalent to band 8 and above then there will be a net gain to the scheme.

This is backed up by points 1.18-1.21 which relate to the financial management of the scheme, and whether the staff are engaged in NHS work. It also protects the scheme from IPs that default on passing on the appropriate payments to the scheme.

12. Chesterfield Royal Hospital NHS FT

This Trust is supportive of the widening of scheme access for independent providers of NHS clinical services, to the NHS pension scheme as this addresses some of the level playing field issues and TUPE issues which have been barriers to changes to and reconfiguration of provision of services to patients.

We recognise that, through the proposed amendments, the Department is seeking to extend the NHS pension scheme to independent providers of NHS funded healthcare and in so doing, move towards a more level playing field. We support this change.

13. Provide

We would strongly welcome the ability to be able to offer the scheme to our staff from April 2014.

In answer to your specific questions:-

a) Whether current and prospective NHS employers believe that the scheme admission and control arrangements proposed could be simplified, without weakening the safeguards ensuring public expenditure is protected and to ensure that the NHSPS is used only for employers and staff engaged in NHS work?

It is not currently clear how the admission of staff will be monitored to ensure those not wholly or mainly engaged in NHS work are refused entry to the NHS Pension Scheme. Such monitoring will undoubtedly be complicated and resource intensive. We would therefore be supportive of simplified arrangements providing appropriate financial controls are in place.

b) What groups of staff IPs in particular expect to recruit with the support of NHSPS membership?
Our key difficulties currently are recruiting and retaining experienced clinically qualified staff or non-clinical staff who have made a career in the NHS who will have had substantial previous membership of the NHS pension scheme. We are also concerned that recruiting doctors and GPs will be an issue if we cannot offer access to the NHSPS in future.

c) Whether there might be a case for limiting the new IP access to specific staff groups, now or in the future?

In order to deliver high quality services to the NHS we need to recruit staff with the best skills and experience from a wide range of staff groups. We consider all staff groups including support staff and those in back office functions to have an important role and would not wish to limit access to the NHSPS to particular staff groups.

a) Does the definition of staff providing NHS Clinical Services include back office and corporate staff? We would argue that they have an essential role in supporting the provision of NHS Clinical Services.

14. Virgin Care

We currently employ more than 5,500 staff, many of whom have transferred across to our employment from incumbent NHS providers.

Introduction

We welcome the Department of Health's proposed changes within the draft National Health Service Pension Scheme (Amendment) Regulations 2014 ("the Regulations"), which we believe represent an important step towards creating a more level playing field amongst the various providers of NHS services.

In particular, we welcome the three level structure proposed by the DH as a sensible system that enables independent sector providers to adopt a solution that is appropriate for their organisation and staff.

In any event, Contribution Guarantees create imbalance again in the fair playing field between independent providers and 'NHS' providers. Provision of a Contribution Guarantee, in any of the forms proposed, has a direct impact on a provider's cash flow as well as any returns, adding additional costs to delivery by an independent provider compared to an NHS provider. Given that Fair Deal and open access to NHS pensions is meant to level the fair playing field between providers and encourage new entrants and in particular smaller and third sector providers, we believe this could inadvertently hamper efforts to make the playing field more fair.

Further, with the Monitor provider licensing due to come into force for all independent providers from 1 April 2014 which will financially regulate all providers and provide service continuity and competition protections to commissioners and patients alike, it would seem sensible for NHSPS to work with Monitor to create the necessary protections through the

Monitor licensing regime. [JD comment – the work I did on clarifying this could mean that many providers are outside the Monitor licensing regime.]

Furthermore, we understand that the NHSPS will from 1 April 2014 be given contractual mechanisms in the NHS Standard Contract to require commissioners to contractually deduct and pay over unpaid pension contributions in relation to that provider. With this direct protection in place, applicable to all providers, it is our view that the automatic requirement for performance bonds for any level of access would be unfair and should be restricted to instances where there have been clear failures by a provider in the past to pay NHS pension contributions.

Conclusion
We welcome the steps taken by DH to create a more level playing field and are keen to work constructively to ensure that the Regulations enable integration and support public health services.

15. Independent Healthcare Advisory Services

"NHSPN also welcomes that members can join the scheme at different levels. However, we would stress that members need to be able to move from one level to another easily. This will be important to ensure that providers remain sustainable at all stages. It is particularly important in the early stages of implementing this policy so providers can evaluate which level suits them best." IHAS agrees with the above comments from the NHS Partners Network and would add that a simple way needs to be identified on how the "mainly" engaged in NHS clinical services is determined. Independent providers would not separate the staff according to funding arrangements.

What Groups of staff will be recruited

Pension schemes are fundamental to the benefits package which assists in recruiting the best staff. It will be especially important for those members of staff who are already members of the NHS pension scheme and want to move to work for an independent provider.

Should access be limited to specific staff groups?

IHAS agrees with the comments made by NHSPN that access should be open to all staff. This is for two reasons:

1. It is very important that the scheme is simple to run. Wherever an independent provider is delivering an NHS funded service, that contract would be much easier to administer where all members of staff are offered the same pension scheme;
2. The NHS pension scheme is attractive to all members of staff. It also allows the best members of staff to move from one provider to another.

16. UCEA

Section 1: Introduction of new scheme access requirements for Independent Providers of NHS clinical services

Firstly it should be noted that although a number of university hospitals participate in the NHSPS, Fair Deal has never applied to HE employers and currently New Fair Deal does not apply either. A HM Treasury consultation on the subject of the extension of New Fair Deal to HE and FE took place in Summer 2013 but no response has yet been published. Until such time as any change in policy is suggested, and the relevant regulations laid, HE employers are proceeding on the basis that Fair Deal is a non-mandatory policy but one which they can choose to apply to any employees transferred to a private sector employer. We would recommend that the NHSPS regulations are drafted such that it is made clear that continuous membership of the scheme under Fair Deal is only mandatory for certain public sector employees or those whose employer chooses to apply Fair Deal and that not all Direction bodies are automatically required to apply New Fair Deal.

The consultation document states that:
"It will be important to ensure that the taxpayer and existing NHS employers are protected when access to the pension scheme is extended to new IPs. In simple terms this means that the full cost of extending the NHSPS to staff working in IPs on NHS work should be borne by those new employers and their staff."

We strongly agree with this statement but have some concerns. In terms of the impact upon HEIs and how these impacts could best be managed, HE employers would note the following:

- An increase in the number of participating employers, the application process, monitoring the new 'virtual cap' and the compliance regime including spot checks could all be expected to contribute towards an increase in administration costs. Alternatively if these new requirements are not adequately resourced there could be a fall in service levels affecting all staff and employers. We would wish to know how the additional services proposed in the consultation will be resourced and funded.

- We would not support any substantive change to the secondment process. It simply may not be practical for short secondments or those where relatively few staff are involved to require the secondment provider to go through the IP access process. For example, a clinical academic could be seconded to a research institute to undertake a specific project for 3 months and while the research institute may qualify for IP status by virtue of other work it undertakes for the NHS, the requirement for it to go through the application process, update payroll systems, implement accounting changes etc for a single employee for a short period of time may be viewed as disproportionate. This may in some cases prevent the secondment from taking place as the employee does not wish to lose continuous pensionable service. In addition the secondment provider may not wish to engage directly with the NHSPS when the existing process of payment via the main employer currently works well. It may be preferable to limit the potential risk to the scheme by allowing the existing employer to continue to be responsible for the payment of contributions in these cases.

- In relation to the extension of the Secretary of State's power to determine part-time final pay to whole-time members and to limit increases granted in the three years before retirement, consideration must be given to the pay scales and career paths of clinical academics in contrast to the majority of the NHS workforce. We would suggest that in these cases NHSPS discusses the remuneration package of the relevant individual with their employer before a decision is made that any pay increase is "excessive". This will not always be the case; it may be that the increase is legitimately awarded as a result of a promotion, acceptance of a Fellowship or the grant of a Clinical Excellence Award which has a significant one off increase in salary. We would not want employer charges

or the fact that a salary increase deemed excessive could be non-pensioned, to adversely impact clinical academics or HEIs. The demographic profile of clinical academics is such that, due to their seniority and length of service, they could be disproportionately impacted by these policy changes.

- The application of new measures to contain the risks to the scheme that may arise once IPs are admitted are reasonable, but communication with employers regarding these new requirements and how they may potentially impact them is vital. Detail of exactly what charges may apply and when, how much this might cost and examples of the application of the 'virtual cap' and 'excessive salary increases' as well as policy guidance will need to be provided. For example, would a clinical academic on receipt of a Clinical Excellence Award be deemed to have had an excessive salary increase?

- One additional way of managing the risks would be to delay the new provisions for IPs until 1 April 2015 when the new CARE scheme is introduced as this is the date from which the Government will require schemes to apply New Fair Deal.

- We agree that the requirement for a 'bond' should be applied to all IPs as a condition of participating in the scheme not just those with a previous history of non payment of contributions. NHSPS must have confidence that they can recover unpaid contributions in advance of such a scenario actually occurring.

- Although the NHSPS is an unfunded scheme, the Treasury has set out a valuation process which will see the creation of a notional surplus or deficit to be taken into account when assessing the cost of the scheme against the employer cost cap. Should the cap be exceeded, changes will be made to either the future accrual of benefits or employee contributions. This suggests that some account of this valuation methodology should be considered when an IP employer leaves the scheme as it could be that the contributions paid were later found to be insufficient to meet the actual cost of the benefits accrued by their employees. The IP should be required to make good any shortfall at the point of exit as it would not be possible to fund this through future contributions due from that employer. Otherwise there is the risk that over the longer term any notional deficit pertaining to non-participating employers will be picked up by the remaining employers or alternatively through adjustments to future benefits or contributions of members.

17. Care UK

5.Retention of Employment / Secondment arrangements

We note the effective requirement for ROE/secondment arrangements to be terminated if they were established with continuing access to the NHS Pension Scheme. Notwithstanding the one year grace period to achieve this, we foresee difficulties may arise as a result of certain employees being reluctant to TUPE transfer from the NHS to an IP, even with access to the NHS Pension Scheme. Are there any circumstances where the Department might feel able to exercise its discretion to allow ROE/secondment with continuing access to the NHS Pension Scheme? Care UK has some secondment arrangements which will expire 18 months after 1 April 2014. Would the Department consider allowing these arrangements to continue, or will we be forced to undertake a TUPE transfer to deal with the last 6 months of the arrangements?