

Working in the Peri-retirement Period; possible changes to working practices including retire and return

Introduction

Consultants are the most highly qualified members of the secondary care workforce and will often have worked for over thirty years in their specialty. That is commonly the case for those nearing a stage in their career where they may be considering retirement. As part of their experience, they will have accumulated a wide range of expertise and often worked under various care-delivery models across their career. The value that they bring to the NHS is immense; in addition to driving productivity in secondary care their contributions and leadership have become even more evident throughout the COVID-19 pandemic. Going forward the NHS faces a challenge of immense proportion: a system already approaching the limits of its' ability to deliver prior to the pandemic, a vast backlog of elective care accumulated during the pandemic together with a population and its' associated medical needs growing faster than the supply of consultant staff.¹ The NHS faces a crisis of service delivery now and for the foreseeable future. Such a crisis mandates that all resources are used wisely and effectively, and that includes the rich resource that consultants represent. It is essential that employers are acutely aware of the importance of retaining consultants in the workforce, and steps they should take to support those considering retirement in addition to those who may have already retired.

It should be borne in mind that, from the employers perspective, consultants who retire and return represent a sound investment in productivity. There should be no reason at all that such a consultant should have an inflexible or poorly rewarded contract offer. It is also worth noting that, while most consultants who retire and return come back to work for the same employer, there is no requirement to rejoin the same trust as they were employed in prior to retirement. Consultants could decide to join other trusts, particularly if the contract offer by their original employer is unattractive.

This guidance focuses primarily on returning to employment by an NHS trust following retirement. In reality this is not the only route that consultants could use to return to work following retirement. Some consultants may decide that their interests are best served by returning to work in a locum capacity post-retirement. It is likely that locum employment will deliver higher rates of pay and potentially more control of working times/patterns. In addition, others have chosen to set up chambers to establish contracts with local commissioners to provide clinical services for NHS cases. Again, it is likely that this also will deliver more advantageous rates of pay and greater individual control. It should be noted that there are hurdles to be overcome regarding legal, professional and organisational issues.

1 BMA report on consultant workforce shortages and solutions <https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/workforce/consultant-workforce-shortages>
BMA consultant retention in Scotland 2021 report: <https://www.bma.org.uk/media/3840/bma-scotland-consultants-retention-report-feb-2021.pdf>
Royal College of Radiologists' UK Workforce Report 2020: https://www.rcr.ac.uk/system/files/publication/field_publication_files/clinical-radiology-uk-workforce-census-2020-report.pdf
Letter to the Prime Minister on NHS workforce from NHS Confederation: <https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/Letter-to-PM-on-workforce.pdf>



This guidance sets out in detail some of the key drivers for consultants leaving the workforce, in addition to ways in which employers can support consultants to delay retirement and retain them in the workforce. Alongside outlining key principles for retaining consultants and the changes that can be made to encourage consultants to stay in the workforce there is information on returning to work post-retirement. It is important that employers engage with consultants throughout this process – each individual may have a different reason for considering retirement; a flexible offer is important, some organisations recommend starting this conversation at age 55 some organisations recommend starting this conversation before consultants reach the minimum pension age, which for most consultants is 55 or aged 50 for those with mental health officer status, so that they can consider all their options.²

Retaining older consultants in the workforce will help with the inevitable workload pressures awaiting the NHS for the foreseeable future. Retention of older consultants is not a solution in isolation, active recruitment of new consultants is also needed – there is an ample sufficiency of work for both groups. Traditionally NHS organisations have largely considered that consultant staff could only be replaced at retirement by a like-for-like replacement; budget constraints have mandated that increases in numbers were tightly policed. That is no longer a sustainable strategy. Organisations must embrace the new reality that *all* available staff are needed if current workload demands are to be met.

Who does this guidance cover?

Historically, employers may have only considered those specialties where there is considerable difficulty in consultant recruitment as requiring attention in respect of additional measures to keep consultants in the workforce. Given the size of the current clinical backlog this can no longer be considered a suitable approach, and we anticipate that **all** consultant staff should be actively encouraged and supported to remain in employment/return to employment by their employer. Alternatives should be offered to encourage consultants to stay in the workforce and create circumstances where they will want to maximise their participation.

This guidance is therefore intended to cover all consultants and sets out the ways that employers can retain them, in addition to factors consultants should take into account when considering retirement and returning to the NHS.

Supporting consultants to delay retirement – steps employers can take

Retaining consultants in the workforce in the peri-retirement period offers advantage to organisations and to component departments within it. Organisations are able to increase their clinical capacities, departments are able to deliver more easily their service and training obligations and workloads are shared amongst a greater number of staff, reducing the burden on individual staff members. The stresses imposed by on-call work are frequent precipitants of consultant retirements; this must be recognised by avoiding such work in the peri-retirement group. However, while it is sensible to avoid the stressors that lead to retirement – without that those staff won't be retained – it is equally important to avoid imposing additional burdens, such as greater frequencies of on call work, on the rest of the consultant workforce within a department. Alongside the retention of staff in the peri-retirement period must be active consultant recruitment processes to ensure that the burden of out of hours work does not increase and where possible decreases.

General Principles for Retaining Consultants

Employers should **accept the principle that retaining consultant medical staff in the workforce is a beneficial thing** – employers are unlikely to be able to meet their recruitment requirements without holding on to their existing staff. Retained employees, moreover, are already completely familiar with the employer's business processes, there is no lag period for learning or delay while productivity comes up to its maximum value.

Be clear – employers should tell consultants that they need and want to retain them. Few will consider staying on with an employer if they do not realise that the employer would like them to remain.

² Royal College of Physicians report 'Later careers: stemming the drain of expertise and skills from the profession': www.rcplondon.ac.uk/projects/outputs/later-careers-stemming-drain-expertise-and-skills-profession

Employers should let their workforce (in general rather than by individual) know that they would like consultants in the peri-retirement period to stay on.

Everyone in an organisation needs to understand why retention is a beneficial thing. It is important that both the managerial staff and employees within the organisation all understand the value of retention. This may be important, both to ensure that the opportunity to retain staff is harnessed throughout the organisation and also to ensure that other staff do not feel that they are being overlooked if they do not fall into a “retention” group.

In addition, it should be acknowledged that there will be a continuing requirement for increased numbers of consultant staff into the future: organisations should be clear that retention policies will be available for younger consultants when they reach an appropriate stage in their careers.³

Younger consultant staff must not be adversely impacted. It is essential that younger consultants feel helped rather than impacted by the retention of older consultants: failure to adequately address this issue will undermine support within departments for retention policies. Consultants at an earlier stage in their career should not be expected to shoulder the additional on-call burden, for instance, when this is relinquished by their consultant colleagues nearing retirement. On call frequencies or the frequency of other out of hours work must not rise as a consequence of retention of older consultants. Departments must either continue their recruitment of new consultant staff to maintain the present frequency or, where new recruitment is not possible, those on call gaps must be offered as locum slots.

Organisations must accept that, in order to retain consultant staff, employers need to be flexible and accommodating. A range of potential offers is likely to have a greater success rate than a single response. Individual flexibility will help too.

Organisations should not discourage or penalise. The employer’s objective should be to try to encourage staff to remain with the organisation: positive persuasion is needed rather than trying to impose barriers to leaving.

Organisations need to recognise that they are trying to persuade, there is little point in making an offer that is seen as a penalty, for example by offering someone more flexibility during the day but requiring them to take up more night shifts as a result. While it is important to ensure that the organisation gains some value from these arrangements it must be borne in mind that carrot is likely to be more effective than stick in encouraging employees to stay on. Equally, organisations should not make the process difficult to accomplish, staff may well decide it has become too burdensome.

Organisations should not offer something no-one wants – different employees or groups of employees may prefer different things. It is important that employers make a retention offer that is seen as desirable, useful and appropriate by the group that is targeted for retention. If the offer is seen as not embodying those features it will not encourage uptake.

Organisations should make their retention offers trust-wide – individual local deals will give the retention process a poor local reputation; it may be regarded as biased. Employers should embrace a policy of staff retention that applies to all. To have a process that becomes discredited will damage its’ standing in the eyes of the workforce an employer is trying to retain. Moreover, it should also be recognised that by having a visible and clearly expressed policy it will likely make the Trust a more attractive employer for consultants compared to other Trusts who lack such a policy.

A clear trust-wide offer establishes in the minds of all consultants that they will be able to access such a policy when they reach an appropriate stage of their career. It must be seen as applicable to all in order to achieve staff buy-in.

Organisations should not lag behind other competing employers. All NHS employers in almost all specialty areas are likely to be affected by the need to retain consultant medical staff to a greater or lesser extent. If nearby employers are quick to adopt attractive retention policies that may be something

3 BMA report 'Consultant workforce shortages and solutions: Now and in the Future': www.bma.org.uk/media/3429/bma-consultant-workforce-shortages-and-solutions-oct-2020.pdf

that attracts staff to want to work for them. Staff may consider other employment offers – from other employers – if those employers are seen as enlightened, by offering attractive employment conditions not offered by their current employer.

Organisations should not make half an offer, Staff need to be retained, they are unlikely to be retained by an offer that does not offer them what they want or enough of what they want, or is so couched with conditions that it is seen as lacking clarity. The object of retention policies is to persuade consultant medical staff content to stay with their employer; employers need to ensure policies that are designed to help retention are actually seen by consultants as a useful encouragement to remain.

Organisations should be timely – a rubicon is crossed once staff begin their planning to leave; it may be helpful to try to prevent that mental first step from being taken. Once an employee begins to consider or make preparations to leave then the opportunity to retain them may already have been lost. Moreover, consultants report that many employers will not confirm the opportunity to retire and return until the consultant has actually formally committed to retirement. This uncertainty may mean that some consultants delay retirement – and presumably continue to work in circumstances where they now feel less comfortable to work – while others are lost to retirement without returning at all. Retire and return offers should be clear before the point of actual retirement.

Organisations should be inclusive – treat all staff fairly, whilst paying attention to their specific circumstances where appropriate. It is crucial that these principles apply to all staff regardless of background, and that all staff feel that they are a valued part of the consultant workforce. Treating all staff fairly must also mean that younger consultants do not feel penalised as a consequence of an organisations efforts to retain older staff. Younger consultants should, under no circumstances, have to accept a greater frequency of OOH work or on call duties. Organisations should strive to recruit new consultants so as to maintain on call/OOH rota frequency alongside their efforts to retain older consultants. There is more than sufficient work, for the foreseeable future, to fully occupy all staff. The acceptability of retention efforts will be undermined amongst younger consultants if they are disadvantaged as a consequence of those efforts.

Techniques: Acting prior to retirement to encourage consultants to stay

It's likely that keeping consultants in the “mainstream” workforce will maximise their hours of delivered clinical work. If an employer's ambition is to deliver the greatest number of working hours, this seems likely to be a successful strategy. Steps employers might take to encourage consultants not to retire should include:

Pension – pay employer contribution to the employee on leaving pension scheme. Currently much attention is focused on pension issues, particularly those related to or precipitated by pension taxation. Many consultants have received huge additional taxation charges as a result of Annual Allowance breaches secondary to pension growth. There are sound reasons for offering full employer contributions to employees who are forced to leave the NHS pension scheme, perhaps by very large additional tax charges. It should be recognised that a large proportion of the likely recipients of additional tax charges will be older consultants. For many of that group of consultants they may be able to choose between staying in employment or retirement. Even where consultants retire and return to work post-retirement (see below) it is likely that the employer would have been able to access a greater amount of working time from that consultant if they could have been persuaded not to retire.

When consultants are forced to leave the scheme but continue to work they are effectively doing the same work, when compared to a colleague who has been able to remain in the scheme, but for 20.6% less reward – ie a reduction in the Total Reward Package equivalent to the value of the employer pension contribution. This is not reasonable. Quite apart from this, paying the employer contributions to the employee helps to retain the consultant as a full or part-time employee, by removing the financial disbenefit otherwise incurred by leaving the pension scheme and by avoiding the financial incentive towards retire and return.

Allow consultant staff to go part time. Full time consultant staff have the right to request to work part-time but there is presently no contractual right to work part-time. At various times of life all of us may have difficulty balancing working lives alongside other responsibilities. At such times it may be more practical for consultant staff to become part-time workers. Those times may be when consultants have caring responsibilities – that may be childcare but equally may be the care of older relatives – but there will be a range of other circumstances where part-time work would allow consultants to address a range of responsibilities rather than be forced to choose only that with the highest priority. Going part-time may also be a way of supporting doctors who are managing health conditions or disability to remain an active part of the workforce.

Allow those consultants to relinquish parts of their role that they can no longer comfortably or safely sustain. Consultants may occupy their role for thirty years, perhaps even longer. Evidence shows that the prevalence of long-term health conditions and disability increases with age; this needs to be recognised as a possibility when considering career planning. However, everyone's individual needs and circumstances can realistically be expected to change somewhat over the course of their working lives, as can their individual capacity to cope with particular demands of a role. This may include the additional pressures of working in urgent and emergency, on-call and night-time working.

Consultants who may need to make changes to their established ways of working may find the prospect of this stressful. Some may be anxious about their ability to fulfil the requirements of their role without certain changes. If proper support is available to ensure that appropriate adjustments to ways of working can be made, then consultants can often continue to work at, or very close to, their former capacity. But if this support is not available, that stress may encourage consultants to consider retirement instead. The net result is that instead of retaining a significant proportion of that consultant's expertise and availability, they are removed from the workforce entirely. It is sensible, therefore, to seek solutions that allow for flexibility in the roles that individual consultants may or may not carry out, including possibly removing night-time and on-call working. This option may particularly benefit consultants managing ongoing health conditions and may be considered a 'reasonable' adjustment in terms of disability equality law, but the benefits of this type of flexibility will also apply to other groups.

It should also be recognised that attempting to continue accommodating work that can no longer be performed comfortably may be detrimental to an individual's health, increasing the risk of long-term absence, illness or burnout. There are also potential benefits to assigning particular tasks based on a realistic understanding of individual strengths and capabilities: adjusting the distribution of tasks in this way is likely to increase overall productivity within departments.

Consultants can still contribute to OOH work within their departments, even where this work is no longer on-call work. Many departments run evening and weekend elective clinical sessions; staff might be offered the opportunity to take up some of that work, on a regular basis, in exchange for relinquishing their on-call commitment. Such a quid pro quo may help demonstrate to colleagues the value of a flexible approach to role distribution, particularly to those consultants who may need similar consideration either now or later in their working lives. Broadly, these consultants should be valued for what they still contribute, rather than criticised for what they don't. Gaps should be filled by concurrent recruitment – while recognising that it will be a smaller gap if consultants are retained.

Support staff going through menopause. The proportion of NHS doctors who are women has grown every year since 2009 and this trend is expected to continue. Nearly 4 in every 10 (36%) of consultants were women in 2018 compared with only 3 in every 10 (30%) in 2009. Every specialty group has seen an increase in the proportion of women; in some specialities, eg psychiatry, there are now more women than men. Women also make up more than half of all medical students, meaning the proportion of women in the workforce is likely to grow going forward.

The female workforce may face additional challenges around their wellbeing, which employers need to address. A BMA survey of doctors found that over 90% of respondents reported that menopause symptoms impacted their working lives and 38% said these changes were significant. Over 65% reported that menopause impacts both their physical and mental health. Worryingly, almost half (48%) of respondents said they had not sought support and would not feel comfortable discussing their menopausal symptoms with their managers. This failure to support doctors is leading to doctors stepping down from senior positions or leaving medicine earlier than intended.

Focus is needed on effective organisational interventions to support employees going through menopause. Such measures might include allowing doctors experiencing these symptoms to work flexibly and placing an equal focus on supporting employees with the mental, as well as the physical, symptoms of menopause. Line managers and staff undergoing menopause should seek advice from occupational health teams as necessary. Adjustments to the workplace such as improving room ventilation and easy access to cool drinking water and toilet facilities can make symptoms far more manageable. Attention should also be given to developing cultures where those experiencing symptoms can speak openly and access the support they need. Employers should raise awareness about menopause and provide training for line managers. Ways should also be explored to bring staff together in an informal setting to share their thoughts, eg through a “Menopause Cafe”.

Employers and managers need to be aware that experiences of menopause vary, for example people who are non-binary, transgender or intersex may also experience menopause. Every individual who is affected by menopausal symptoms should be treated with sensitivity dignity and respect and be able to access support if needed.

Make positive use of the vast experience that long-serving consultants have acquired. Consultants are, by dint of their long training, very experienced. Consultants who are in the peri-retirement stage of their career are vastly experienced, having worked for over thirty years in their specialty area and have likely also worked under a variety of care-delivery methods during that time. Such experience should be recognised and, where possible, used rather than allowed to go to waste; this is particularly relevant in relation to the COVID-19 pandemic and its’ effects.

Mentoring for recently appointed consultant staff has been a useful and welcome development of the past few years. Mentoring has a supportive dimension in respects of its’ advisory and facilitative discussion; it also has the potential for practical support insofar as the mentee can be assisted in the development of aspects of their clinical practice. Mentors can assist newly appointed consultants in the development of, for example, their practical surgical skills in respect of particular procedures. That might go so far as to formalise the arrangement of a surgeon in the prelude to retirement helping the development and easing the transition of their newly appointed consultant replacement. It need not be such a direct replacement: mentoring applies equally well to helping more broadly to refine the practical techniques and hone the skills of newly appointed consultants.

The effects of the COVID-19 pandemic suggest that this role has a particular value at present. The focus of the NHS in delivering COVID care has seriously disrupted many training programmes: the necessary concentration on urgent COVID care has meant that trainees have been unable to achieve the necessary competencies in many practical procedures. The difficulty in acquiring those practical skills applies both for trainees and possibly also for recently appointed consultants, who may have preferred to have greater experience in respect of some procedures prior to appointment. This suggests a place where mentoring might be able to assist by providing the opportunity for personalised assistance/supervision of practical procedures by experienced practitioners. Such personalised assistance could apply to recently appointed consultants but could equally assist trainees in the development of their practical skills.

The pandemic suggests potential further roles for long-serving consultants. Many changes to clinical and other practices have been introduced as necessary responses to the COVID outbreak; there is interest in preserving some of these introductions or perhaps continuing to develop them into the future. While it may not be possible to predict the shape of the future exactly it is clear that there is, at present, an appetite for system change within the NHS. Consultants in the peri-retirement period have long experience of working within the NHS in general and the local NHS in particular: they are a powerful element of local organisational memory and may well have experience of previous iterations of system design. It seems wasteful if local health systems do not take the opportunity to use that experience to help inform and shape current system redesigns.

It should be noted that these mentor /advisor roles, in addition to other educational roles such as educational supervision of trainees, are suitable for consultants in the peri-retirement period, both before actual retirement and after retirement and return to work.

Returning to the workforce after retirement

Clarify and Widen Retire and return. Many employers offer “retire and return” arrangements. Consultants retire from their full or part-time roles and return to work post-retirement, usually with a reduction in delivered clinical sessions. Consultants are able to access pension payments and take up paid employment alongside that. Despite those arrangements being long established there is great variability in how those arrangements are interpreted and applied. Such a lack of clarity regarding the nature of the offer means that some employees do not seek out such an alternative or perhaps are not offered it, their clinical skills and contribution to organisational output are lost as a result.

Employers should have clear and transparent policies regarding retire and return for consultants. Rather than relying on departmental or even individual offers – which make the process look and feel either haphazard or even unfairly applied – employers should agree a local policy that applies consistently across the organisation and is clearly flagged to all employees. There are several areas where such **clarity is needed**

- **To whom does this apply?** In the case of consultants it is clear that this should be applied to all consultants, across all specialty groups. It should not rely on an individual offer.
- **What contract is offered?** In all cases this should be the 2003 consultant contract Terms and Conditions of Service. No other local contract should be accepted.
- **What is the length of the contract?** Many consultants are deterred from seeking retire and return arrangements because they have only been offered a short contract of employment. Such brief and possibly precarious contracts of employment are unattractive and discouraging. Employers have, in the past, shied away from offering a longer contract period fearing that it would establish enduring employment rights. This seems to be unnecessary caution; there is little evidence that long term contracts of employment in this context have become problematic for employers. Moreover, there are examples amongst trusts to offer open-ended contracts for nursing colleagues who have retired and subsequently returned to NHS employment under Agenda for Change contractual arrangements. It is not acceptable the different standards are applied for consultants in respect of their length of employment contract.
- **What point on the salary scale is offered?** Most consultants retire at the top of the consultant salary scale. Some employers offer retire and return arrangements that remunerate consultants at other points on the consultant salary scale. This is not appropriate: employers gain an employee of immense experience - experience of both the clinical specialty and of the local healthcare system – that allows that consultant to function at maximal productivity from the point of engagement. There is no justification for the offer of remuneration at a lower level; such offers should be rejected. The reduced reward makes the employment offer less attractive – particularly where employers may need to maximise the number of consultants returning to employment after retirement in order to support an inadequate supply of consultant personnel. Employers should offer consultants their equivalent paypoint pre-retirement on return to work.
- **How much can be earned?** Some employers insist that consultants who have taken up an offer of retirement and return to work may not earn more from their new employment than they earned before retirement. This is not the case. It is true that there are restrictions on earnings during the first calendar month immediately following retirement (vide infra). Beyond that there are no restrictions on earnings. Keeping in mind that organisations want to maximise the delivered hours of work from retire and return consultants it seems illogical to impose restrictions via earnings limits on the number of hours that can be worked.
- **Pension – pay employer contribution to the employee.** There are sound reasons for offering full employer contributions to employees who return to the workforce after retirement. Consultant returnees to the workforce bring enormous experience and productivity that benefits an organisation’s performance: they should not be discouraged from returning by a reduced Total Reward Package in comparison to their other colleagues. Pension benefits are part of that Total Reward Package, if returnees are not offered employer pension contributions as part of their package they are, in effect, working for 20.6% less than their other colleagues who remain in the pension scheme(s). Moreover, it should be noted that members of the 2015 pension scheme are able to rejoin the scheme after retirement, should they return to work, which will secure the employer pension contributions for those members. It is not reasonable to offer lesser effective per hour remuneration, by withholding employer pension contributions, to consultant returners who have service in other NHS pension schemes.

- **Length of service** – As noted, returners often have long service within the NHS, before rejoining the NHS for a further period of service. It is inappropriate to require that they complete a further period of service before they can access previously held entitlements such as annual leave or the ability to apply for new style LCEAs.
- **Annual Leave** – Consultant returners have, as noted, long service in the NHS. The 2003 TCS specifies that consultants are allowed six weeks plus two days of annual leave per year, exclusive of public Holidays and extra statutory days – the additional two days of annual leave per year are awarded after seven years' service as a consultant; service duration is specified but not continuous service. The terms and conditions of service also recognise that consultants are entitled to two days statutory days leave per year in addition. These statutory days may, by local agreement, be converted to a period of annual leave. Consultant returners, where they had longer than seven years of service in the consultant grade prior to retirement, should continue to receive six weeks plus two days of annual leave per year plus two statutory days leave per year.
- **Local CEAs** – The benefits of old-style LCEAs are crystallised into pension upon retirement. It is not appropriate that old-style CEAs should be retained after retirement. However, new-style Local Clinical Excellence Awards can be applied for by retire and return consultants. This is the case whether they have been offered a permanent contract, or a fixed term contract. Our interpretation of schedule 30 is that a further period of a year of renewed employment is NOT required before such a consultant becomes eligible to apply for and for receipt of new-style LCEAs (or successor). Consultants who retire and return should have amply fulfilled the schedule 30 TCS requirement for at least one year of service at consultant level. Note: Schedule 30 does not specify one year of *continuous* service nor one year of service *in the current post*.

Restrictions on working

There is a view across the system that consultants taking up the option of retire and return can be subject to restrictions on the amount of earnings that they can make post retirement. In general this is no longer true. It is true to say that in the past there were two kinds of restriction that could be applied. One of these was *abatement*: abatement applied to all earnings on re-employment. On re-employment following retirement an individual's pension plus their earnings was not allowed to exceed their earnings pre-retirement. Abatement applied to all public sector schemes. Private sector pension schemes were generally not subject to abatement.

The second kind of restriction was known as *suspension*. Suspension was an Inland Revenue rule that specified the pension would be reduced if there was no break in service following retirement. A break in service could be as little as 24 hours, this was followed by a maximum working time of 16 hours per week for each of the weeks in the first calendar month post retirement. It was permissible to work more than 16 hours per week if a retiree had had a 28 day break post retirement. These broad restrictions were largely removed in around 2008 when it was appreciated but they were having a material effect on productivity.

Currently, under ordinary circumstances, those wishing to retire and return must have a 24 hour period without working. In the 1995 scheme this is followed by a maximum duration of work of 16 hours each week for the next calendar month. In the 2008 and 2015 schemes there is no requirement for a period of reduced hours of work on return to work but the 24-hour break in service still applies. There have been some changes introduced as temporary measures in response to the COVID-19 pandemic. From March 2020 after a 24-hour break in service the 16 hour rule no longer applies within the 1st calendar month after retirement from the 1995 scheme.

It should be noted that there are only three circumstances where restrictions are placed on earnings post retirement, they are –

- The retiree has MHO status (1995 section)*
- The retiree retired on the grounds of permanent ill health (95/08 section)
- The retiree retired on the grounds of redundancy “in the interests of the efficiency of the service” (95/08 section)

These restrictions apply to only a small number of consultants.

*abatement currently suspended during Covid (see below)



Business Services Authority

NHS Pension Scheme

Coronavirus: Temporary suspension of certain NHS Pension Scheme regulations

This factsheet explains how the temporary suspension of certain NHS Pension Scheme regulations will help those who are in receipt of an NHS pension, who return to work to help with the Coronavirus (COVID-19) outbreak. Some of the suspensions will also help those who returned to work before the outbreak.

Background

On 25 March 2020 the government passed emergency legislation, which temporarily suspends some of the regulations governing the administration of NHS Pensions. These measures will allow skilled and experienced members who have recently retired from the NHS to return to work, and also allow retired members who have already returned to increase their commitments if they wish to do so, without affecting their pension benefits.

The measures predominantly affect members of the 1995 Section, although a smaller number of members could be affected by draw down abatement in the 2008 Section and the 2015 Scheme. The measures include temporary suspension of:

- the 16-hour rule
- abatement for special class status holders in the 1995 Section
- drawn down abatement in the 2008 Section and 2015 Scheme

Following the end of the COVID-19 outbreak, a six-month notice period will be given to staff and employers at the end of which the suspended regulations will take effect again. Staff and employers will therefore have six months' notice to readjust their working patterns, where necessary.

It is important to be aware that all pension and re-employment pay is subject to income tax. Changes in pensionable pay may also affect the level of NHS Pension Scheme contributions that some members pay. A higher tiered rate may apply to those who are already contributing to the scheme who undertake work with a higher full time rate of pay and also to general practitioners whose pensionable earnings are higher as a result of increasing their commitment.

NHS Pensions-Covid 19 Factsheet-20200407-(V2)