British Medical Association
British Dental Association

Memorandum of Evidence to the Armed Forces Pay Review Body

October 2017
The BMA values and attaches considerable importance to the integrity and independence of pay review bodies both for doctors in the NHS and their counterparts in the armed forces. Review Bodies must be able to make independent recommendations free from partisan political influence and pressure.

In January 2017 the BMA submitted evidence to AFPRB alongside the British Dental Association. This was a comprehensive document that included evidence on MO manning, pay erosion, pay comparability, pension benefits and NHS developments. At the request of the AFPRB, we have further highlighted key developments since that submission to align with a new timetable for providing evidence. However, we have been unable to provide substantially new information as the results of the most recent DMS CAS and up to date manning figures have not been made available to the BMA in time for this submission.

We are also limited in our ability to provide a fully considered pay recommendation while the Government’s approach to public sector pay remains unclear and the AFPRB has not received its remit letter from the Treasury. Other review bodies, including the DDRB, have delayed their evidence timetable to take account of this. We therefore reserve the right to submit supplementary evidence on pay once the Government’s approach to public sector pay has been confirmed.

This evidence covers the following areas:

- Medical Incremental Progression (MIP) payments
- Flexible working bill
- Medical Officer Pay

**MIP payments**

We support the introduction of MIP awards and the automation of this process through incremental phases at career points of one year’s service, 6 years’ service and 11 years’ service after promotion to OF3, by April 2018. The MIP applies to all regular armed forces general medical practitioners and dental officers but excludes medical reserves. As per the Ministry’s publication, reserves are fully integrated within the Defence Medical Services (DMS) and play a pivotal role in strengthening the DMS, particularly at a time of reliance on reserve forces, the BMA proposes that MIP is applied to all DMS doctors, including medical reserves and would encourage the AFPRB to consider recommending the remit of MIP to be extended to ensure parity for all medical officers.

**Flexible working bill**

The BMA has consistently highlighted the need for more flexible working arrangements in the DMS to address recruitment and retention problems and in recent years, the MOD has repeatedly reassured the BMA and the AFPRB that the New Employment Model (NEM) will provide the necessary arrangements to address this issue. It is therefore encouraging to see progress being made on the Armed Forces (Flexible Working) Bill that makes provision for part-time working by members of the regular Armed Forces and their service to be subject to geographical restrictions. The BMA would like to recommend that the AFPRB not only apply this Bill to regulars but to all DMS, specifically reserves.

**Medical Officer Pay**

Since the January report to AFPRB we have received a request to submit a brief outlining staff group comparators between Armed Forces Medical Officer and Dental Officer (MODO) and their civilian counterparts. The absence of definitive data and
sufficient time to obtain this data has resulted in minimal input. We recommend AFPRB consider taking an approach that will allow for more detailed analysis of the pay comparators in the coming year.

Recent developments of the lift in public sector pay cap for police and prison officers begins to address the issue raised by the BMA that pay has remained well below comparable wage inflation in the wider economy since 2010. The most recent British Social Attitudes survey found that nearly half of Britons support increased spending as the tolerance for austerity is diminishingiii. There is recognition that the implications of the public sector pay cap has had significant detrimental impacts on recruitment and retention across the public sector. A recent study by the Institute of Fiscal Studiesiv concluded that pay restraints on higher paid and better educated public sector workers mean that these groups have fared least well compared to their private sector counterparts. If this trend continues it would become increasingly more difficult for the public sector to recruit highly skilled and highly educated professionals, such as doctors.

Real terms incomes for DMS doctors are likely to return to significant decline with the Office for Budget Responsibility (OBR) forecasting inflation to increase sharply to 3.7% during 2017v. The OBR also forecast that wage growth in the wider UK economy will increase to 2.4% (from 1.7% October 2016vi), compounding the disadvantage to DMS doctors and the public sector.

In recent submissions we have used a simple measure to highlight the fall in DMS incomes over the last decade. Salaries have declined 6.0 and 5.3 per cent for GPs and consultants, respectively, against the Consumer Prices Index (CPI) for the same period (table 1). For a 40-year-old doctor at increment level 10 with five years of experience since appointment, the real pay of a DMS GP has fallen by £6,768 since 2006. For a DMS consultant, the real terms decline in pay is £5,614 (figure 1).

Table 1 - Pay award for consultants and GPs compared with the Consumer Prices index (CPI) since 2006

<table>
<thead>
<tr>
<th>Year</th>
<th>Consultant award (per cent)</th>
<th>GP award (per cent)</th>
<th>Consumer Price Index (per cent)</th>
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<tr>
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</tbody>
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*Average CPI rate for April to November 2016vii.

Figure 1 - Erosion in basic pay for DMS GPs and Consultants since 2006
As noted above, while we are not currently proposing a specific pay award we will be providing supplementary evidence towards the end of the year once the BMA has had an opportunity to fully assess the Government’s approach to public sector pay and the historical decline in real earnings. To conclude, with the absence of new data and given the restrictions of short submission timeframes, the BMA will be unable to submit a full evidence submission however we have highlighted key areas and emphasise the negative impact of the pay cap and encourage AFPRB to take this into consideration.

1 Ministry of Defence: https://www.gov.uk/government/groups/defence-medical-services#rehabilitation-services
3 British Attitudes Survey http://www.bbc.co.uk/news/uk-40408576
4 Institute of Fiscal Studies: https://drive.google.com/file/d/0B59chPQfmltT1aUp1b3JyUnh2QUSEZmIGMGQyM05sOW5meHBl/view

BDA PAPER OF EVIDENCE FOR 2018 ARMED FORCES PAY AWARD

References:

A. http://content.digital.nhs.uk/article/2021/Website-Search?productid=21525&q=dental+earnings+and+expenses&sort=Relevance&size=10&page=1&area=both#top


Issue

1. Informing HQ SG and the AFPRB to assist in determining appropriate uniformed dental officer salaries for FY 17/18.

Recommendations

2. The AFPRB should be invited to acknowledge:

a. Seventeen healthcare provider unions including the BDA have expressed deep disappointment at the government's failure to deal with the ongoing public sector pay crisis. The unions insist that another year of pay restraint is unacceptable and risks damage to the health service, its patients and its workforce.

b. The government has confirmed imposed uplifts for GDPs of 1.14% including expenses, and 1% pay rise for Foundation Dentists. The BDA has consistently argued these derisory uplifts will continue to jeopardise the long term sustainability of NHS general dental practice.

c. The BDA oppose the government’s pay cap in relation to all dentists and would like to see the independent review bodies (including the AFPRB) be able to make independent recommendations, without knowing that only 1% will be accepted.

to recommend:

a. A 2018 Pay Award of no less than 1% for all uniformed dental surgeons that recognises the demand for pay restraint in the public sector.

and to note:

a. The recommended Pay Award falls below CPI and that the incomes of uniformed dental surgeons continue to fall in real terms.

b. In simple financial terms, the holders of NHS dental contracts for general dental services and personal dental services have seen a 4% increase in personal earnings making uniformed careers appear less attractive.

c. Uniformed dental surgeons continue to request early release from their current contracts and view external career prospects, terms and conditions, and remuneration more favourably than continued commitment to Defence.
Limitations

4. This paper carries a distinct limitation that cannot be addressed given the timeline for submission of this draft. The Annual Report on Dental Earnings and Expenses, produced by NHS Digital (formally the NHS Information Centre for Health and Social Care) and detailed at Reference A, addresses national dental earnings. NHS Provider-Performer dentists’ gross earnings figure (net of practice expenses) has not been updated since release of the BDA’s 2016 submission that underpinned the 2017 Award. This is a significant limitation in determining the 2018 Award. The required figures, pivotal to this year’s submission, are not likely to be released until the middle of September 2017.

5. The National Association of Specialist Dental Accountants and Lawyers (NASDAL) benchmarking statistics are published annually in March. They reflect the finances of dental practices and dentists for the most recent tax year and are signposted at Reference B. They provide a detailed picture of dental practice finances, sourced directly from a national sample (some 25%) of dentists working privately and in the NHS. In NHS practices, the average net profit per principal (Provider and Performer) increased by nearly 4% from £129,265 in 2015 to £134,102 in 2016. Associates (Performers) however have seen profits flat-lining for more than a decade and the 2016 Report quoted average associate profits down by almost 1% to £68,024. The BDA attributes this to greater market penetration by Dental Bodies Corporate (DBC) and market forces with many practices feeling they cannot increase private patient fees. Additionally, profitability has been threatened by the costs of regulatory compliance. The result - associate incomes continue to be squeezed.

Financial Situation

6. Despite considerable changes to Government since the EU Referendum and BREXIT announcements, the situation for Government finances remains largely unchanged. The Treasury continues to commend public sector pay restraint and the Government is committed to funding pay awards to a maximum of 1% for four years from 2016-17. Despite the 1% pay award in 2017, for which the BDA is very grateful, the value of earnings continue to be eroded in real terms against a background of a Consumer Price Inflation rise of 2.6% to June 17. This still gives a cumulative CPI increase of 11.7% (TBC) using published data between 2010 and 2015. The BDA recognises that this is an ongoing national issue and the AFPRB has very limited opportunity to make any significant award in the current public sector pay environment.

Current Expectations on Dental Officers

7. In addition to providing dental teams to support operations and military exercises, Defence Dentistry is required to deliver a well prepared and highly deployable military force through delivery of high quality dental care in the required quantities that satisfy their patients and the chain of command. Defence continues to recruit personnel primarily from the population of that carries the greatest index of social deprivation and the greatest burden of oral diseases. Neither the population under care nor its clinical providers are replicated in the civilian sector. Defence Dentistry remains a target driven organization delivering high quality care to a highly mobile and internationally distributed population demonstrating rapid turn over.

8. The relentless pursuit of financial efficiencies is palpable at all levels in Defence, no less so in DPHC, and is regarded by the majority of personnel as comparable to running a financial enterprise
or business. This is an interesting trend that refutes claims made against previous BDA submissions that uniformed dental surgeons are not under the same business pressure as their NHS counterparts - the pressures are different but definitely there. Financial savings emergent from cuts to equipment and materiel are marginal because some 95% of the running costs are manpower related. Uniformed dentists direct and manage Defence Dentistry at all levels – at HQ, at regional level and at individual practices. Personnel are expected to deliver the required outputs cognisant of costs therein. Many are working extended days to cover the lost outputs resulting from gapping and the churn in uniformed, civilian and indeed locum manning.

9. The concurrent strategies of replacing uniformed dental officers with salaried civilian dental practitioners (CDPs) and workforce substitution through the use of dental therapists (DTh) have seen very limited success with persistent shortfalls in civilian manning despite continuous and considerable recruiting effort. Two years into a three year pilot study, only two of nine DTh posts have been filled for any significant period. DTh were nationally conceived to deliver high volume low complexity items of dental care but there is a significant national shortage of clinically current applicants. Continued reliance is consequently placed on locum CDPs and DTh; a very expensive way to deliver the required clinical outputs. Their availability is highly variable by region and their implicit costs continue to stretch the available budget. The concept of using Reservists to deliver dental care has made little headway with only a 15% positive return from the serving personnel. This is still regarded as an ineffective and unachievable alternative to the current routine primary dental care model delivered by the agreed mix of uniformed and civilian clinical providers.

Manning and Morale

10. In the absence of a DMS CAS 17 Report, there is no contemporary evidence of improvement to manning or morale. The BDA remains very concerned over the low levels of morale and satisfaction within the DDS workforce and continues to monitor applications for Premature Voluntary Release (PVR) from all three Single Service Dental Branches.

11. The three Branches remain subject to manpower reductions and organizational restructuring under Defence Primary Healthcare (DPHC). Current outflow of dental officers exceeds predictions and risks undershooting the future manpower target determined as part of Future Force planning. A number of applications for early release (PVR), made by older uniformed dental surgeons approaching the end of their commissions (contracts), have provided a small stream of applicants for continued employment in CDP posts. This manpower resource and its migration from the uniformed to civilian sector is finite and somewhat unpredictable. It will be time limited by the requirement to rebalancing the clinical workforce under SDSR direction. It is evident that many of those leaving the AF perceive better employment conditions, including personal remuneration, in the civilian sector.

12. The BDA and the Single Service Dental Branches are aware of the views that are impacting on all aspects of morale and job satisfaction in the DMS. The results of the 2017 Continuous Attitude Survey (DMS CAS 17) have not been released to date but the 2016 DMS CAS 16 continues to demonstrate very low satisfaction and morale levels despite some improvement from the appalling levels in 2014. There has been a drop of 7% to 56% positive for morale and satisfaction levels remain at 58%. The lack of confidence in the ability of the DMS leadership to deliver effective change in these turbulent times has fallen by 13% to only 36% positive.

13. The continued demands for changes to DDS structure and delivery capability are especially noticeable in decreased clinical resilience, slow creeping civilianisation, difficulty in recruiting suitable personnel and incessant gapping of clinical posts. Collectively, the result is an expectation placed on the uniformed cadre to cover under-manning, as well as ensuring that their own
responsibilities and targets are achieved. In addition to the extra workload there is real
dissatisfaction demonstrated by the DMS CAS 16 over essential parts of routine support to dental
personnel. The figures show only 32% positive over Training, Education and confidence in career
progression and advancement.

14. The prospect of further redundancies and far less opportunity to build a career with fewer
commissions to the next career stage, has meant that uniformed dental surgeons holding Short
Service Commissions, are in some cases 5-7 years behind their counterparts who chose to enter
hospital care or general practice. The uniformed DOs feel that their ethos of delivery of care as
military personnel gives them a far greater awareness of the special needs of the military population
they serve. This is not always seen in the same way by their civilian colleagues. The requirement to
work flexibly, as a requirement of each Single Service, almost always with different support staff, is
very frustrating. There is an emerging feeling that dentists in civilian practice have many more
advantages and have the means to change to meet both their delivery requirements and their
personal income expectations.

15. The concerns identified by the DMS CAS, each Single Service and the BDA are not unique.
They have been repeatedly reported in the surveys and in BDA pay submissions. Unfortunately there
has been very little concrete remedial action taken, in a climate of continuous pay restraint,
denigration of both military and professional identity and a perceived indifference from the DPHC
leadership on the first rate care that Defence Dentistry continues to deliver. This care has been
delivered to a constantly refreshed population that is largely subject to awful health inequalities
prior to recruitment.

16. Premature Voluntary Release (PVR) statistics will be reported separately by HQ Surgeon
General but the BDA is aware that all three Services continue to experience applications for release
from current contracts. A number of reasons have been given by individuals for their PVR
applications but the BDA remains concerned that a tipping point is imminent where further stresses,
loss of career prospects, loss of support and general degrading of Service life could lead to further
requests for PVR. An additional finding and concern emergent from DMS CAS 16 was the large
number of personnel who have expressed an intention of only remaining in uniform for no more
than 5 years.

17. Despite the issues and negative attitudes expressed in the previous paragraphs, the results
for personal accomplishment, the achievement of oral healthcare objectives and for population
health outcomes all remain at good levels. The organizational environment remains hostile but
Defence Dentistry has yet again achieved excellent results with the highest fitness levels on record
being attained. It is very gratifying that patient attitude surveys and the Armed Forces CAS
continuously show the very high regard that the current delivery system and its people are held in,
and how they contribute to the retention of service personnel across the board. These unintended
findings are important as the Armed Forces seek to recruit, train and then retain soldiers, sailors and
air personnel under Future Force planning. There is a concomitant risk if DPHC and Defence
Dentistry remains to be seen as an easy targets for cost savings in the Joint Force Command Budget.

Dental Earnings in the UK (note Limitations above)

18. There has been extensive press coverage over the loss of earnings experienced by NHS
dentists, with a figure of a reported 35% fall in the last decade. The BDA has highlighted this issue as
without parallel in the public sector. Although multi-factorial, as independent contractors, the dental
profession have invested extensively in the future of dental practices. This is a lamentable situation
when compared to the massive investment in the rest of healthcare. The BDA estimates that
Government has taken £170 million out of NHS dentistry in England contributing to declining incomes.

19. NHS Digital, formerly known as the NHS Information Centre for Health and Social Care (HSCIC), functions as part of the Government Statistical Service. It published the latest report on Dental Earnings and Expenses, England and Wales, Scotland and Northern Ireland 2014/15 in September 2016. The report was produced by NHS Digital in conjunction with the Dental Working Group and for the first time as a single UK report. The analysis is not totally comparable between England and Wales against Scotland and NI as there were different contractual arrangements in each devolved administration.

20. In the absence of more recent verified data from the NHS, figures derived from Reference A remain extant and detail the 14/15 pre-tax earnings for NHS Provider-Performer dental surgeons. The BDA considers that the Provider and Performer remains the appropriate civilian analogue for uniformed dental surgeons. After deduction of practice expenses, average pre-tax earnings are 117,400. This is a 1.8% increase over 13/14 but is not seen as statistically significant. It would be inappropriate for the BDA to speculate on the forthcoming announcement that will detail 15/16 pre-tax earnings amongst NHS Provider-Performers but any upward or downward tendency may be identifiable from the incomes derived by private dental surgeons. This will be addressed at para. 22.

21. The key trend amongst NHS providers is the statistically significant drop in taxable income due to gross earnings falling and total expenses increasing. This appears attributable to both the growth of dental bodies corporate and some punitive Performer salaries and the cost of meeting additional regulatory obligations. These findings are in line with the more general trend for delivery of NHS and private dentistry for a Provider-Performer that shows a 15.7% decrease in earnings from £139,300 in 2009/10 to £117,400 in 2015. This data however is woefully out of date to determine market appropriate salary scales for 2018 and the BDA recommends that consideration be given to alternative data sources and emergent NHS data on its release.

22. NASDAL provides a more contemporaneous picture of dental practice finances, sourced directly from a national sample (some 25%) of dentists working privately and in the NHS. Reference B details an average net profit per principal (Provider and Performer) that increased by nearly 4% from £129,265 in 2015 to £134,102 in 2016. Associates (Performers) however have seen profits flat-lining for more than a decade and the 2016 Report quoted average associate profits down by almost 1% to £68,024. The BDA attributes this to greater market penetration by Dental Bodies Corporate (DBC) and market forces with many practices feeling they cannot increase private patient fees. Additionally, profitability has been challenged by the costs of regulatory compliance. The result-associate incomes continue to be squeezed. The BDA can only infer that the findings of NASDAL will be largely replicated when NHS Digital release their data for performance to Apr 16.

23. Turning to private dentistry, the figures for the private sector from the National Association of Specialist Dental Accountants (NASDAL) show an increase from £131,000 up to £141,000, an increase of 8%. There has been little change in the financial performance; however private practice continues to improve as they have the flexibility to adjust prices and costs compared with the NHS. NASDAL has reported dental practice sales continue to rise and goodwill value has again increased noticeably by 13% in 2015. The market is predicted to keep rising. These advantages are not available to military personnel.

The Dental Comparator Civilian/Military

24. The DMS CAS shows little change in the proportion of AF DOs that think their pay is fair.
25. The BDA is very aware that Defence accepted the medical officers’ pay spine as the appropriate internal pay comparator for dental officers in 2002 when medical and dental officers’ (MODO) pay scales became realigned under common terms and conditions of service. The BDA also recognise that review is overdue to ensure future validity. It should however be remembered that previous attempts to identify a better comparator for uniformed dental surgeons were unsuccessful.

26. The main reason for the comparator is that it must ensure that remuneration is maintained, at least at the current level, so that Defence retains sufficient high quality military and clinical providers. This is essential for the quantity and quality care that is needed for personnel who will deploy anywhere at any time for indeterminate periods to sometimes very hostile places. Quality is the main issue and must remain at the front of any planning. The BDA remain committed to the NHS Provider and Performer Dentist as the nearest appropriate civilian analogue. It will be for Defence to determine the validity of retaining the MODO pay spine on the evidence provided by the two professions but they must be cognisant of the likely sequelae of dismantling the current pay structures.

27. Defence Dentistry, already structured as a tri-Service entity, was subsumed into Defence Primary Healthcare (DPHC) shortly after the three single Service delivery medical organizations were amalgamated to reduce the overheads implicit in three separate delivery organizations. Defence Dentistry correctly still functions as a separate profession under its own Acts and Regulations but works to a common mission statement and to identical goals that seek to maximise the available military force. The symbiotic model is not replicated on the high street. The BDA also sees that the joint GMP/GDP pay spine as a unique and very acceptable internal pay comparator that is even more relevant today as DPHC is the only joint medical and dental delivery organization working closely together.

28. Under a separate initiative the BDA has been asked to concurrently consider whether there is a more appropriate available pay comparator or pay spine and will respond separately but the current alignment of MODO (or GMP/GDP) pay spines founded on annual review of the appropriate civilian comparators across the professions remains apposite. The BDA remains very content to be part of this process.

29. The BDA has reviewed all the historical data over comparators from:

   a. The Medical Manning and Retention Review 2002 by MOD,

   b. The Office of manpower Economics (OME),

   c. The BMA and the BDA.


30. Apart from the M2R2 report that re-set dental officer pay levels to combat the catastrophic collapse in morale post DCS 15, there has been continuous agreement on comparators. The BDA considers there to be three options with which to compare uniformed dental officers and their civilian colleagues. The options are:

   a. Provider-Performer Dentists. (Dentists who hold a contract with local NHS commissioners to deliver primary care dentistry.)
b. Performer Only Dentists. (Dentists who have a contract to a Provider for a percentage of the Providers contract value.)

c. Private Dentists (An essential part of any remuneration package, when considering the very large numbers of Dentists who provide a NHS/Private mix of care).

The BDA continues to see the best and most appropriate comparator as The Provider and Performer Dentist delivering a mix 75% NHS and 25% private care. Whatever one that is used, the civilian comparator will all need to be supplemented with the X-Factor percentage of total salary in any of the chosen categories.

**Current Situation of NHS Dentistry**

31. Defence will continue to compete for dental graduates who can opt for and move between the following professional groupings during their careers.

   a. General Dental Practice; usually as a self-employed contractor providing dental care to the general public.

   b. Community Dentistry; usually treating patients who have special requirements that mean they can't attend a high-street practice.

   c. Hospital Dentistry; usually treating cases of special difficulty or providing treatment to long-stay hospital in-patients and emergency treatment for short-stay patients. Treatment may be provided to the general public for teaching purposes.

   d. Armed Forces Dentistry; usually providing a comprehensive range of dental services for armed forces personnel and entitled civilians in the UK and abroad. Providers are expected to work austere and operational environments when required.

   e. Dental Public Health; usually carrying out non-clinical work, assessing the dental health needs of populations rather than individuals.

32. The BDA recognises that the majority of graduates will enter General Dental Practice, usually as Performers on completion of Foundation Training. It is abundantly clear that many will seek to become Provider and Performers, holding their own NHS contracts by either becoming principals in established practices or by establishing new practices at the earliest opportunity. All those holding NHS contracts can supplement their NHS income by delivering dental care under private arrangements at any time. Mixed practice is the norm.

33. The BDA is well aware of the alternative delivery model adopted by Dental Bodies Corporate that collectively own dental practices and provide care against a significant number of NHS contracts. Integrated Dental Holdings is the largest such provider delivering some 10% of all NHS oral healthcare and employ Provider Dentists to deliver the contracted units of dental activity.

33. The environment for UK NHS dentistry remains in flux across the devolved national administrations with recognised areas of over and under supply. The pilot practices in England and Wales for yet another version of the dental contract correctly moving towards prevention, have started but not reported. The Treasury and the profession have little idea how they will work;
whether they will be successful or what they will earn until probably 2018. The BDA considers there to be need for more practices to be involved.

Pensions

34. There is still concern over the new pension arrangements but it is accepted as a reasonable package. The issue over levels of tax thresholds and the size of pension pot will have an effect, as people consider length of time they wish to serve.

Discussion

35. The BDA reiterates the ongoing concern over morale and job satisfaction that have been evident for several years. Despite minor fluctuations in the results from successive DMS CASs, the working environment and the feelings are unchanged. The main trend for 2017/18 is the continuing flow of requests to leave prior to retirement age or the end of commission. The decisions to leave must be taken cognisant that employment conditions remain very difficult outside of Defence, especially under the NHS delivery system. There have been some improvements in the private practice and mixed practice settings and it is to that sector that exiting officers will gravitate. The last year however has seen a significant number of ‘senior’ leavers who wish to extend their working careers beyond the set military retirement age and are content to supplement pensions with paid employment as civilian GDPs working for Defence.

36. The internal employment environment remains turbulent with more structural change, loss of military posts to meet cost cutting initiatives, pay restraint now the prospect of restructuring salary scales. The fixation with pay comparators is not seen as the chance to improve remuneration, but as a method of reducing the pay bill. This is likely to be of further detriment to morale and retention. There has been so much reduction in numbers of military personnel that the structure is unlikely to survive another heavy blow to the people who do so much to maintain the United Kingdom’s Fighting Power. The BDA is only too aware of how difficult it is for the UK finances and accepts that pay restraint will remain. However any major changes to the current pay equivalence will have very serious consequences that will impact on the essential delivery of care.

M R C GALL

Chair BDA AF Committee