British Medical Association
British Dental Association

Memorandum of Evidence to the Armed Forces Pay Review Body

19 January 2017
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Chapter one – Evidence from the British Medical Association

Summary of key points of BMA evidence

- 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.

- At this stage it is unforeseeable when, where and in what exact form a new contract for consultants (in England and potentially Northern Ireland) will be put in place, and will not be known before October 2017 at the earliest, so we request that the AFPRB make its recommendations on the basis of the current contractual arrangements for armed forces doctors.

- Historically, DMS staff have maintained broad pay comparability with doctors employed by the NHS. In recent months we have learned that MOD are seeking to undertake a pay comparability review to assess medical officer and dental officer (MODO) pay in line with developing pay reforms within the NHS. The BMA are keen to constructively engage and collaborate with MOD on this piece of work and have started making arrangements to begin this process.

- Salaries have declined 6.0 and 5.3 per cent for GPs and consultants, respectively, against the Consumer Prices Index (CPI) over the last decade.

- We are not proposing a specific figure for the 2017/18 pay award, however we believe that armed forces doctors should be treated in line with the wider economy, where pay settlements continue to run at higher than the public sector pay policy cap, at around 2% currently.
Our approach to independent pay review

1.1 In previous evidence rounds, the BMA has made plain its strong opposition to Government restriction on pay review bodies. Once again, we must register that while we are aware of the wider economic factors involved in the pay review process, and the pressure which the government is exerting to ensure restraint on public sector pay, the BMA 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. We ask that the AFPRB continue to monitor the widening disparity between public sector pay and the wider economy.

1.2 The Secretary of State for Defence wrote to AFPRB on 10 August 2016 reaffirming the government’s position on public sector pay, which remains well below comparable wage inflation in the wider economy. It was noted that this position, despite having been in place since 2010, was now intended to protect jobs and reflect the challenging fiscal environment following the UK’s vote to leave the EU. Although we are not proposing a specific figure for the 2017/18 pay award, we disagree with the government’s position on public sector pay, and believe that armed forces doctors should be treated in line with the wider economy, where pay settlements continue to run higher than the public sector pay policy cap, currently at around 2%.

Pay erosion

1.3 The historically low rate of inflation in the last two years has ensured that DMS doctors have received a small real terms pay increase, although these are likely to be less than 1%, on average, for the period. However, 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 2.3% during 2017. The OBR also forecast that wage growth in the wider UK economy will increase to 2.4% (from 1.7% October 2016), compounding the disadvantage to DMS doctors and the public sector.

1.4 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>
</tr>
</thead>
<tbody>
<tr>
<td>2006/7</td>
<td>8.8</td>
<td>6.6</td>
<td>2.6</td>
</tr>
<tr>
<td>2007/8</td>
<td>2.0</td>
<td>2.0</td>
<td>2.2</td>
</tr>
<tr>
<td>2008/9</td>
<td>2.2</td>
<td>3.7</td>
<td>3.8</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Year</th>
<th>DMS GPs</th>
<th>Consultants</th>
<th>CPI Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009/10</td>
<td>1.5</td>
<td>1.5</td>
<td>2.3</td>
</tr>
<tr>
<td>2010/11</td>
<td>0</td>
<td>0</td>
<td>3.5</td>
</tr>
<tr>
<td>2011/12</td>
<td>0</td>
<td>0</td>
<td>4.3</td>
</tr>
<tr>
<td>2012/13</td>
<td>0</td>
<td>0</td>
<td>2.6</td>
</tr>
<tr>
<td>2013/14</td>
<td>1.5</td>
<td>1.5</td>
<td>2.7</td>
</tr>
<tr>
<td>2014/15</td>
<td>1.0</td>
<td>1.0</td>
<td>1.5</td>
</tr>
<tr>
<td>2015/16</td>
<td>1.0</td>
<td>1.0</td>
<td>0.1</td>
</tr>
<tr>
<td>2016/17</td>
<td>1.0</td>
<td>1.0</td>
<td>0.7</td>
</tr>
</tbody>
</table>

*Average CPI rate for April to November 2016*.3

Figure 1 - Erosion in basic pay for DMS GPs and Consultants since 2006

Workforce: Retention and recruitment

1.11 Top line staffing data up to 1 July 2016 provided to the BMA shows a shortage in trained medical officers against DMS 20 Liability in both primary care (14.8%) and secondary care (23.8%) (Table 2). Recruitment and retention has increasingly become a serious concern as recruitment targets have -barring one occurrence - consistently been missed over the last decade. AFPRB recognised and reported this issue as having a detrimental impact on MODOs and urged government to address the retention of armed forces doctors as vital to the sustainability of DMS.

Table 2 – Regular Forces staffing figures 2016

<table>
<thead>
<tr>
<th>Specialty</th>
<th>2016 DMS 20 Liability</th>
<th>Manning Strength (1 July 2016)</th>
<th>Shortage %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary Healthcare</td>
<td>311</td>
<td>237</td>
<td>24</td>
</tr>
<tr>
<td>Primary Healthcare</td>
<td>413</td>
<td>352</td>
<td>15</td>
</tr>
</tbody>
</table>

1.10 We are concerned that given the nature of a medical career, the longstanding difficulties that the DMS has with workforce planning and increasing shortfalls in both the secondary care and primary care cadres, the MOD need to proactively address an existing and deteriorating recruitment and retention crisis. According to the MOD Armed Forces Continuous Attitude Survey 2016 (DMSCAS), dental and healthcare provision is the second highest retention factor for active Service personnel. Additionally, 48 per cent of respondents now cite mental health provision as a reason to remain in the armed forces. The BMA feels that these findings strongly reflect the vital role doctors and dentists play in the long term success of not only the DMS, but the armed forces overall.

1.12 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 AFPRB that the New Employment Model (NEM) will provide the necessary arrangements to address this issue. The BMA now understands that part time working arrangements, as well as flexible approaches to annual leave (e.g. calling forward leave, transferring leave between serving spouses and enhanced leave options) have now been included in the NEM, but remain varied across the three services. We welcome these new policies as potentially making DMS careers more attractive to MOs, retaining skilled and valued doctors, and stemming the flow of leavers who cite work-life balance issues as reasons for giving notice.

1.14 The BMA believes that the continued shortfall in numbers threatens to put at risk the delivery of the “gold standard” level of service which service members can expect and deserve to receive both at their home base and operationally.

1.15 Reservists continue to play an increased role under the DMS 20 proposals. Medical reservists will make up to 50 per cent of the DMS workforce provision in the adaptive force, with some specialties, such as neurology and urology being provided entirely by the reserve forces. The 2016 Reserve staffing figures (Table 3) show significant shortages across the primary and secondary healthcare cadres, making it clear that there are fundamental recruitment problems throughout the medical reserves. Without improved recruitment incentives for existing NHS consultants and GPs, there is little prospect of the workforce requirement being met. This, coupled with staffing shortages in the DMS regular cadre, presents a significant risk to defence.

Table 3 – Medical Reserve Forces staffing figures 2016

<table>
<thead>
<tr>
<th>Specialty</th>
<th>2016 DMS 20 Liability</th>
<th>Manning Strength (1 July 2016)</th>
<th>Shortage %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary Healthcare Consultants</td>
<td>325</td>
<td>165</td>
<td>49.3</td>
</tr>
<tr>
<td>Primary Healthcare consultants/Medical Officers</td>
<td>176</td>
<td>84</td>
<td>53.3</td>
</tr>
</tbody>
</table>

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4 Ministry of Defence Armed Forces Continuous Attitude Survey 2016

5 Reserves in the Future Forces 2020: valued and valuable, July 2013

6 ibid
1.16 Data from DMSCAS 2016 shows that regular Service personnel are more likely to consider joining the reserve forces than they were in 2015. Those likely to consider joining full-time has increased by 2%, whilst those likely to consider joining part-time has increased by 3%. This may be related to financial incentives introduced for reserve forces under the MOD FR20 programme. Given the vital role of the DMS in the armed forces, we would like to see incentives such as this continue to address the significant staffing problems in the medical reserves and the difficulties associated with recruiting doctors to the Reserve Forces.

1.17 While the BMA recognises that money is by no means the main motivator for staff to join the Reserves, we believe that a simple amendment to the way daily rate of pay for reservists is calculated might encourage more doctors and dentists to volunteer. Currently, reservists are paid at a daily rate which is calculated by dividing the MODO annual salary by 365 days. However, as most regular MODOs work, on average, 220 days a year, we believe that a more logical way of calculating the daily rate would be by dividing the annual salary by 220 days rather than 365 days. While this would lead to a higher daily rate of pay for reserves, it would not increase the annual salary nor would it generate significant additional cost as most reserves work an average of only 19 days a year. We ask the AFPRB to endorse this approach.

1.18 As we argued last year, we continue to believe that the AFPRB should commission an independent review of the feasibility of the medical reserve proposals as a matter of urgency. The BMA, as the trade union representing all doctors in the NHS is an invaluable source of knowledge and expertise about NHS doctors and we would be willing to assist with this work.

**Pay comparability and Overarching BMA Position**

1.19 Historically, DMS staff have been aligned to an analogue of their NHS counterparts. In recent months we have learned that MOD are seeking to undertake a pay comparability review to assess MODO pay in line with developing pay reforms within the NHS. The BMA are keen to constructively engage and collaborate with MOD on this piece of work and have started making arrangements to begin this process. Unfortunately due to timescale, we are unable to provide detailed comparability evidence in this year’s submission, as this work is yet to begin and we do not want to precipitously provide comparators without discussion with colleagues in MOD and the BDA. In AFPRB’s 2016 report\(^7\), a similar lack of comparability evidence was noted by all parties (MOD, BMA and BDA), however was cited as unsurprising given the impending changes due to take place to NHS pay and conditions. As it was in 2016, this situation remains unchanged.

1.20 At this stage it is unforeseeable when, where and in what exact form a new contract for consultants (in England and potentially Northern Ireland) will be put in place, and will not be known before October 2017 at the earliest, so we request that the AFPRB make its recommendations on the basis of the current contractual comparators for armed forces doctors.

1.21 Table 4 shows DMS and NHS pay comparators used for 2015-16. These figures include adjustments for additional PAs, on-call availability supplements, DMS X-Factor compensation pay and pensionability.

\(^7\) The Armed Forces Pay Review Body 45th Report Supplement for Medical and Dental Officers
Table 4 – Consultant 2015-16 pay comparisons

<table>
<thead>
<tr>
<th>Comparator</th>
<th>Average Income £</th>
<th>Adjusted Average Income £</th>
<th>Lead/Deficit of DMS %</th>
</tr>
</thead>
<tbody>
<tr>
<td>DMS</td>
<td>118,316</td>
<td>113,906</td>
<td>-</td>
</tr>
<tr>
<td>NHS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 PAs</td>
<td>100,660</td>
<td>99,928</td>
<td>14.0</td>
</tr>
<tr>
<td>11 PAs + 5% On Call</td>
<td>105,236</td>
<td>104,504</td>
<td>9.0</td>
</tr>
<tr>
<td>11 PAs + 5% On Call + CEA</td>
<td>117,405</td>
<td>116,673</td>
<td>-2.4</td>
</tr>
</tbody>
</table>

1.22 Table 5 shows DMS and NHS GMP pay comparators for 2013-14. Despite the availability of 2015-16 DMS pay scales, data for NHS GMP pay was unavailable beyond 2013-14. Due to this reason, DMS data for the same year was used to produce last year’s comparison.

Table 5 – GMP 2013-14 Earnings (United Kingdom)

<table>
<thead>
<tr>
<th>Comparator</th>
<th>Practice</th>
<th>Population</th>
<th>Average Income £</th>
<th>Median Income £</th>
<th>Lead/Deficit of DMS %</th>
<th>Lead/Deficit of DMS %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Average</td>
<td>Median</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Income</td>
<td>Income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DMS</td>
<td></td>
<td>-</td>
<td>108,306</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>GMS</td>
<td>Dispensing</td>
<td>3,350</td>
<td>109,200</td>
<td>106,900</td>
<td>-0.8</td>
<td>1.3</td>
</tr>
<tr>
<td>GMS</td>
<td>Non-Dispensing</td>
<td>17,600</td>
<td>93,500</td>
<td>91,300</td>
<td>15.8</td>
<td>18.6</td>
</tr>
<tr>
<td>GMS</td>
<td>All</td>
<td>20,900</td>
<td>96,000</td>
<td>93,600</td>
<td>12.8</td>
<td>15.7</td>
</tr>
<tr>
<td>PMS</td>
<td>Dispensing</td>
<td>1,500</td>
<td>120,300</td>
<td>114,300</td>
<td>-10.0</td>
<td>-5.2</td>
</tr>
<tr>
<td>PMS</td>
<td>Non-Dispensing</td>
<td>9,850</td>
<td>104,700</td>
<td>100,900</td>
<td>3.4</td>
<td>7.3</td>
</tr>
<tr>
<td>PMS</td>
<td>All</td>
<td>11,350</td>
<td>106,800</td>
<td>102,700</td>
<td>1.4</td>
<td>5.5</td>
</tr>
<tr>
<td>GPMS</td>
<td>Dispensing</td>
<td>4,850</td>
<td>112,600</td>
<td>108,900</td>
<td>-3.8</td>
<td>-0.5</td>
</tr>
<tr>
<td>GPMS</td>
<td>Non-Dispensing</td>
<td>27,450</td>
<td>97,500</td>
<td>94,500</td>
<td>11.1</td>
<td>14.6</td>
</tr>
<tr>
<td>GPMS</td>
<td>All</td>
<td>32,300</td>
<td>99,800</td>
<td>96,500</td>
<td>8.5</td>
<td>12.2</td>
</tr>
<tr>
<td>GPMS Salaried GPs</td>
<td>8,650</td>
<td>54,600</td>
<td>51,200</td>
<td>98.4</td>
<td>111.5</td>
<td></td>
</tr>
</tbody>
</table>

1.23 The BMA, BDA and MOD will undertake an extensive pay comparability review throughout 2017, with a view to submitting findings from this work in the 2018-19 AFPRB evidence submission round. Until such time, and as arrangements for the new NHS consultants contract (England and potentially Northern Ireland) are still under negotiation, we ask that AFPRB make recommendations and comparisons based on the current NHS contractual arrangements.

Pension and benefits

1.24 In our evidence to previous years’ AFPRB processes, concerns were raised about the impact that the new Armed Forces Pension Scheme may have on doctors’ intentions to remain in the armed forces.
The 2016 DMSCAS results continue to support this analysis, with pension satisfaction showing an additional 2 per cent decline compared to last year, and a 10 per cent decline overall since 2012\(^8\).

1.25 X Factor pay within the armed forces has not seen any significant change since 2010, and less than a third of Service personnel, including doctors, have reported current levels of X Factor compensation as inadequate\(^9\). Among those individuals who have given notice to leave the armed forces, the topline reason for departure has been the impact of Service life on family and personal life. We believe that in conjunction with various policies to maintain work-life balance, such as part-time and flexible working, adequate and rewarding X Factor pay for armed forces doctors is necessary for the sustainability of healthcare provision within the armed forces.

Non-pay related factors

1.26 The BMA has noted that the data from the 2016 DMSCAS shows that direct pay related factors are not the primary reasons given for joining the reserve forces. The BMA therefore proposes that there are several non-pay related factors which we would like the AFPRB to consider recommending, which we believe would have a positive impact on recruitment and retention:

i. The introduction of less than full-time/flexible working.
ii. The payment of professional fees, specifically: the GMC registration fee, re-training fees/requirements associated with entry to the GP Performers list, royal colleges and higher professional bodies as required by MODOs’ military roles.

1.27 As there are some specialities that require armed forces doctors to hold more than one professional subscription (e.g. maxillofacial consultants), we believe that subscription allowances should be increased to account for this. An increase for these specialities would tackle the disadvantage these doctors currently face in comparison to their colleagues, and would promote equality across all disciplines.

NHS developments

1.28 In September 2013 the BMA entered negotiations with NHS Employers about new contract arrangements for consultants and doctors in training in the NHS. It is not possible for us to update AFPRB further at the current time as it is not yet possible to know whether, when, where and in what exact form a new contract for consultants (in England and potentially NI) or junior doctors in training (in England only) might be put in place. We ask that AFPRB should make its recommendations on the basis of the current contract. We cannot make any specific comment on either contract other than to note negotiations are ongoing.

Conclusion

1.29 DMS doctors continue to deliver high quality care, which is valued by their patients, at a time of considerable uncertainty among the armed forces and the DMS in particular. We believe they

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\(^8\) Ministry of Defence Armed Forces Continuous Attitude Survey 2016


\(^9\) ibid
deserved better than the sub-inflation awards which they have received in previous years which has resulted in a further decline in their real earnings.

1.20 Evidence on DMS quality of care continues to support the case for a greater pay increase. 66 per cent of respondents to the 2016 DMSCAS\textsuperscript{10} of all serving personnel rated healthcare provision as the third most important factor in increasing their intentions to remain within the services (67 per cent of respondents rated dental provision as the second most important factor in increasing their intention to remain within the services). The importance of high quality medical care to personnel is supported by strong measures of satisfaction among service users. The DMS continues to score highly for the care it provides: 75 per cent of personnel were satisfied with the way they were treated by medical staff; and 81 per cent were satisfied with access to the treatment they received.

1.21 We note that many parts of the economy have returned to making pay awards above inflation, and we remain deeply concerned that the growing disparity between public sector pay and the wider economy is likely to become entrenched with the continuation of the government’s pay policy, whilst economic growth continues and earnings are predicted to rise. Whilst the BMA is aware of the external economic factors at play, we believe that MODO deserve a pay award in line with the growth of real earnings elsewhere.

\textsuperscript{10} ibid
2. Chapter Two – Evidence from the British Dental Association

Introduction

2.1 Despite the considerable changes to Government since the EU Referendum, the situation for Government finances remains unchanged and the Treasury continues to make significant savings from public sector pay. There is still consolidation for public sector spending and the Government will continue to fund the public sector workforce for a pay award of 1% for four years from 2016-17. Despite the 1% pay award in 2015, which the BDA is very grateful for, the value of those earnings continue to be eroded in real terms, even against a background of a much smaller Consumer Price Inflation rise of 1% to September 2016. This still gives a cumulative increase of 14.9% over the last six years. 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. The BDA remains very concerned over the very low levels of morale and satisfaction within the DDS workforce. The BDA is also monitoring the sudden spikes in Premature Voluntary Retirements from all three Single Service Dental Branches.

Defence Dental Services (Defence Primary Care Service)

2.2 The Defence Medical Services Continuous Attitude Survey (DMSCAS) 2016 continue to show that satisfaction levels and morale remain at very low levels despite some minimal 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 achieve effective change in these turbulent times has fallen by 13% to only 36% positive. The environment in Defence remains uncertain, especially within the Army Dental Service as they await the decision on serving numbers of Army personnel in the Army 2020 Review as a part of the Strategic Defence Review 2020. This decision has been delayed until next year in light of a succession of bad news in Defence. Unfortunately this will yet again have an effect on numbers of dental personnel as the Army once again changes to fit into its budget. The BDA can only hope that they handle this better than the complete debacle for Army dental care in previous rounds of cost cutting. 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 seen as a cheap, ineffective and unachievable alternative to current routine primary dental care.

2.3 The mistakes of previous badly planned and executed changes to DDS structure and delivery capability is especially noticeable in the slow creeping civilianisation, difficulty in recruiting suitable personnel and incessant gapping of posts; which has meant that the uniformed cadre have been placed under very real pressure 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 as shown by the DMSCAS 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. The views are equally low at 28% positive for current IT capability.

2.4 The BDA, in conjunction with the Single Service Dental Branches have been made aware of the views of their uniformed staff that are impacting on all aspects of morale and job satisfaction. The pressure to deliver high quality dental care in the required quantities that satisfy their patients, the chain of command and Defence Primary Health Care is regarded by considerable number of personnel as comparable to running a financial enterprise or business. This is an interesting trend as it refutes claims made against previous submissions that military DOs are not under the same business
pressure as the NHS. The prospect of further redundancies, far less opportunity to build a career, and far more limited number of commissions to the next career stage, has meant that DOs in primary care with a Short Service Commission, are in some cases 5-7 years behind their counterparts in hospital care. The uniformed DOs feel that their ethos of delivery of care as military personnel give them a far greater awareness of the special needs of the military. 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. The inability to take control and change obvious inefficiencies is equally frustrating and is effecting morale and work satisfaction. There is real feeling that dentists in civilian practice have many more advantages and have the means to change to meet their delivery requirements.

2.5 The concerns addressed to the DMSCAS, each Single Service and the BDA are not unique, and have been very evident for a considerable amount of time, as shown in previous submissions and DMSCAS reports. 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 indifference from the leadership on the first rate care they have delivered. This care has been delivered to a population that was subject to awful health inequalities prior to recruitment. Inevitably there has been a spike in Premature Voluntary Retirements with the Army and Royal Air Force having 5 each, and the Royal Navy with 1. The BDA is aware that there are additional Army DOs who have requested to PVR but were advised to wait until the announcement of the Army 2020 restructuring. There were a number of reasons given by individuals for their PVRs, but the BDA is concerned that a tipping point may have been reached where more stress and pressure, loss of career prospects, loss of support and general degrading of Service life could lead to very destructive level of departures. An additional point from the DMSCAS was the large number of personnel who have expressed an intention of only remaining in uniform for no more than 5 years.

2.6 Despite all the issues and negative attitudes expressed in the previous paragraphs the results for personal accomplishment and achievement of care objectives remain at good levels. The clinical environment remains hostile, however despite all these problems the DDS military/civilian clinical delivery force 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 results are a continuous process and are very unlikely to remain if the DDS structure and manpower continues to be seen as an easy target for cost savings in the Joint Force Command Budget.

**UK Dental Earnings**

2.7 NHS Digital, formally the NHS Information Centre for Health and Social Care (HSCIC), as part of the Government Statistical Service 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 the NHS Digital in conjunction with the Dental Working Group and for the first time this is a single UK report. However the analysis is not totally comparable between England and Wales against Scotland and NI as there were different contractual arrangements in each country.

2.8 The data for 2014/15 for the NHS Provider-Performer dentist (the current agreed comparator level) shows pre-tax earnings, after deduction of expenses, are at £117,400. This is a 1.8% increase that was again not seen as statistically significant. The key trend has seen a statistically significant drop in taxable income due to gross earnings falling more than total expenses. This remains in line with the
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 the current £117,400.

2.9 The figures for the private sector from the National Association of Specialist Dental Accountants (NASDAL) show an increase from £131,000.00 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 far greater 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. This advantage is not available to military personnel.

2.10 There has been extensive press coverage over the loss of earnings experienced by NHS dentists, with a figure of a 35% fall in the last decade. The BDA has highlighted this issue as without parallel in the public sector. A vital factor in this decline has been that every penny of investment in dentistry has been provided by the dentists themselves, which is a very sorry tale compared to the massive investment in the rest of health care. The BDA estimates that Government have taken £170 million out of NHS dentistry in England.

The Dental Comparator Civilian/Military

2.11 The comparator used by the BDA remains the NHS Provider Performer dentist, as set by the Medical Manning and Retention Review in 2002. The baseline from M2R2 shows that the AFDO pay has fallen behind their civilian counterpart at the same level as the 2015 submission. The DMSCAS shows little change in the proportion of AFDOs that think their pay is fair. The BDA was under the impression that there would be a proper review of the comparators in use, as the current one used in dentistry was agreed in 2004. The BDA was very happy to be part of this process however there has been an unexpected desire by the Treasury to get as much of this done within this submission. The BDA is of the opinion that there is not enough time and a more measured approach is the way forward and we have some reservations over the reasoning and aims of such haste. Any quick agendas can only be perceived as taking advantage of changed and difficult circumstances, and an opportunity to inflict savings. The environment in UK NHS dentistry is also in a state of total flux. The 60 pilot practices in England and Wales for yet another version of the dental contract, which is correctly moving towards prevention, have only just started. They will have absolutely no idea of how they will work, whether they will be successful or what they will earn until probably 2018, and also there will need to be more practices involved.

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

- The Medical Manning and Retention Review 2002 by MOD, OME, BMA/BDA.

Apart from the M2R2 report that re-set the pay levels to combat a catastrophic collapse in morale post DCS 15, there has been continuous agreement on comparators. There BDA sees three options to compare with our civilian colleagues. The BDA accepts that there advantages and disadvantages to each, but it is interesting to note that many military personnel see their civilian counterparts as having distinct benefits. The options are:

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

Whatever one that is used, they will all need to be supplemented with the X Factor percentage of total salary in any of the chosen categories. The BDA continues to see the best and most appropriate comparator as The Provider Performer Dentist delivering a mix 75% NHS and 25% private. The BDA also sees that the joint GMP/GDP pay spine as a unique and very acceptable pay comparator. This has been the case since 2003 and is even more relevant today as Defence Primary Health Care is the only joint medical and dental delivery currently working together in the same organisation.

2.13 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 deliverers. 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.

Pensions

2.14 There is still concern over the new pension 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

2.15 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 DMSCAS reports, the picture remains the same. The main change for 2016/17 is that there has been a noticeable rise in those wishing to leave prior to the set retirement age or end of commission. Their decision must be taken in the context that job conditions remain very difficult outside, especially in NHS delivery, even though there has been improvement for private practice. The latter option is the likely direction that military DOs will choose.

2.16 The future remains turbulent with more structural change, loss of military posts to meet Government imposed cost cutting and pay restraint or even restructuring of salary. The fixation with pay comparators is not seen as chance to improve remuneration, but as a method of reducing the bill. This will be yet another blow 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 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.