Memorandum of evidence to the Armed Forces Pay Review Body

January 2015
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1. Chapter one – Evidence from the British Medical Association

Executive summary

- 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 political pressure.

- Real terms pay for DMS GPs and consultants has fallen 7.6 and 6.9 per cent, respectively, against the Consumer Prices Index (CPI) measure of inflation since 2006.

- The BMA consider armed forces doctors deserve at least an award above inflation to counteract the historical decline in real terms pay, although we have not indicated a specific figure by way of a pay increase.

- It is essential that the MOD develops robust policies and procedures to ensure that future retention bonuses can be put in place when they are required and that there is ongoing analysis of the required value of the bonus in order for it to be effective.

- Part time working arrangements have now been excluded from the NEM (New Employment Model) due to the need for regulatory changes to the Armed Forces Act and flexible working arrangements are still in a ‘concept’ stage. The DMS should work with the BMA to develop proposals to ensure recruitment and retention of highly skilled medical officers.

- AFPRB should commission an independent review of the feasibility of the medical reserve proposals as a matter of urgency. The BMA is willing to assist with this work.
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. In addition, the BMA wrote to the Secretary of State for Health in England on 21 March 2014 setting out the “deep sense of outrage” felt by doctors at the decision not to implement the DDRB’s recommendations in full, not least as the recommended one per cent was still a real terms pay cut for NHS doctors. Most recently, the BMA wrote to the Chief Secretary on 21 August 2014 to remind the Government of the DDRB’s role in giving the medical profession “some assurance that their standards of living will not be depressed by arbitrary Government action”.

1.2. Implementation of DDRB’s recommendations has become more complicated by differences in approach to public sector pay policy throughout the UK. In particular, BMA anger toward the Westminster Government has been directed at their deliberate conflation of pay progression and cost-of-living uplift. By contrast, the Scottish Government has sought to clearly distinguish its provisions for pay by recognising both incremental pay and cost of living at the same time as urging the DDRB “to be as free as possible in considering the issues and making recommendations”.

1.3. 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 extraordinary and ill-founded political pressure.

1.4. The Secretary of State for Defence wrote in a letter to AFPRB on 12 September 2013 to reiterate that the armed forces were excluded from Government action to address automatic pay increases purely as a result of time served. The BMA does not accept the Government’s assertion that incremental pay progression is an arbitrary reflection of time served and we have been resolutely clear in our evidence to the parallel DDRB. We do however think that incremental pay is especially critical to the recruitment and retention of doctors in the armed forces.

Pay erosion

1.5. Despite receiving an uplift to their basic pay in each of the last two years, these increases have been insufficient to prevent further decline in real earnings for DMS GPs and consultants against the Consumer Prices Index (CPI) measure of inflation over the same period (table 1).

1.6. Since 2006, the salaries of DMS GPs and consultants have fallen 7.6 and 6.9 per cent, respectively, against the Consumer Prices Index (CPI) over the same period (table 1). In recent evidence rounds, we have referenced the decline in real earnings using the example of a 40 year old doctor at increment level 10 with five years of experience since appointment. Using this same standard the real pay of a DMS consultant has fallen by £7,164 since 2006. For a DMS GP, the real terms decline in pay is £8,404 (figure 1).

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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>
<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>1.4*</td>
</tr>
</tbody>
</table>

*Average CPI rate published by ONS from April to December 2014.

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

1.7. Throughout the UK economy industry wide pay settlements ranged from 0 to 3.5 per cent in 2014. Average weekly earnings for the whole economy grew 1.4 per cent in the latest three month period (latest available October 2013).

1.8. Inflation in 2015 is predicted by the Office for Budget Responsibility (OBR) to increase at 1.2 per cent per annum by the CPI measure. However earnings are forecast to increase by 2.0 per cent for the same period.

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2015 pay award

1.9. In our evidence last year we stated that DMS doctors were delivering high quality care, valued by their patients, at a time of considerable uncertainty among the armed forces and the DMS in particular. We believe they deserved better than the sub-inflation award they received which resulted in a further decline in their real earnings.

1.10. Evidence on DMS quality of care continues to support the case for a greater pay increase. 80 per cent of respondents to the AFCAS (Armed Forces Continuous Attitude Survey) of all serving personnel rated healthcare provision as the second most important factor in increasing their intentions 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: 79 per cent of personnel were satisfied with the way they were treated by medical staff; and 72 per cent were satisfied with the effectiveness of the treatment they received.

1.11. The latest data from the DMS CAS (Continuous Attitude Survey) gives indications of the destabilising impact of DMS restructuring on MOs. The DMS CAS also shows a reduction in the proportion of DMS doctors that think their pay is fair. The overall picture for armed forces doctors, where 38 per cent of DMS CAS questions showed a decline of five or more percentage points since 2013, implies a worsening of their service conditions.

1.12. We note that many parts of the economy have returned to making pay awards above inflation during 2014 with earnings forecast to increase by an average 2 per cent next year. Armed forces doctors deserve at least an award above inflation to counteract the historical decline in real terms pay, although we have not indicated a specific figure by way of a pay increase.

Pensions

1.13. In our evidence last year, we raised concerns about the impact that the new Armed Forces Pension Scheme may have on doctors’ intentions to remain in the armed forces. The BMA met with the Armed Forces pension team and Surgeon General’s department representatives in January 2014 to discuss measures to retain highly trained medical officers under the 2015 scheme. The MOD proposes to use targeted retention bonuses in specialities where evidence emerges that there will be a workforce shortage. The proposed retention bonus replaces the current arrangement of retention payments at specific points in a career (Figure 2) and is a significant change to the proposition for individuals. The DMS CAS results support this analysis, with future pension arrangements stated as the fourth most common reason why respondents would not choose to extend their armed forces career.

1.14. We are concerned that given the nature of a medical career, the longstanding difficulties that the DMS has with workforce planning and existing shortfalls in both the secondary care and primary care cadres, the MOD is ill prepared to respond proactively to shortages before a retention crisis emerges. It is essential that the MOD develops robust policies and procedures to ensure that the retention bonus can be put in place at short notice and that there is ongoing analysis of the required value of the bonus in order for it to be effective. We would also expect these retention bonuses to be in place

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from April 2015 when the new pension scheme comes in to effect in order to address long standing manning shortages.

Figure 2 – Armed Forces Pension Scheme 2005 Medical Officer and Dental Officer bonus scheme

**AFPS 05 BONUS SCHEME**

1.15. High level manning data up to October 2014 provided to the BMA show a shortfall in trained medical officers of 19 per cent (table 2). While this appears to show some improvement in manning figures on previous years, once again this has been presented to the BMA in a way that does not allow interrogation of the data. The stated DMS 20 requirements do not relate to the final DMS 20 report figures as suggested and the designation ‘Primary Healthcare consultants/Medical Officers’ does not provide an accurate picture of GP manning (which has had longstanding manning shortages) as this also includes Public Health consultants, Occupational Medicine consultants, GDMOs (General Duties Medical Officers) and doctors working in the Staff and Command cadre.

**Table 2 – Regular Forces manning figures**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>2014 DMS requirement</th>
<th>October 2014 Manning (trained strength)</th>
<th>Shortfall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary Healthcare Consultants</td>
<td>317</td>
<td>222</td>
<td>30%</td>
</tr>
<tr>
<td>Primary Healthcare consultants/Medical Officers</td>
<td>507</td>
<td>447</td>
<td>12%</td>
</tr>
</tbody>
</table>

1.16. It is clear, however, that there remain shortages in key specialties that require recruitment under the DMS20 proposals which is unlikely to improve given the recruitment crisis throughout the UK. For
example, an unprecedented third round of recruiting was required in General Practice in 2014 following only an 88 per cent fill rate of training posts. It is anticipated that vacancies will remain and this has prompted HEE (Health Education England) to commission a review of the primary care workforce. In addition, Emergency Medicine consultants remain on the Migration Advisory Committee shortage occupation list which allows organisations to recruit from outside the European Economic Area. Given the residency rules governing entry into the Armed Forces, this option is not available to the DMS and it is difficult to see how the DMS will ever achieve full manning provision in this specialty.

1.17. 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 NEM (New Employment Model) will provide the necessary arrangements to address this issue. The BMA now understands that part-time working arrangements have been excluded from the NEM due to the need for regulatory changes to the Armed Forces Act and that flexible working arrangements are still in a ‘concept’ stage. The delays in the development of these proposals is restricting the DMS from offering more flexible working arrangements to individuals which is impacting on its ability to retain staff now. This is particularly acute to the medical workforce, where over 50 per cent of entrants to medical school are now female.

1.18. The reasons for females having shorter military careers than their male counterparts are likely to remain fundamentally unchanged into the future. The implications of such gender disparities for recruitment and retention are already clear and we are concerned that more must be done to ensure that a military medical career is as attractive as possible. The BMA is prepared to work proactively with the MOD on this issue.

Reserves

1.19. Reservists represent 38% (5,170) of the total 13,530 DMS manpower requirement and will play an increased role under the DMS 20 proposals. Medical reservists will make up to 50 per cent of the DMS manning provision in the adaptive force, with some specialties, such as neurology and urology being provided entirely by the reserve forces. The most recent Reserve Manning data (table 3) show significant shortfalls across the primary and secondary healthcare cadres. While the caveats noted above about the interpretation of the Regular Manning data apply to the Reserve Manning data, it is 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 manning requirement being met, which coupled with manning shortages in the DMS regular cadre presents a significant risk to Defence.

Table 3 – Medical Reserve Forces manning figures

<table>
<thead>
<tr>
<th>Specialty</th>
<th>2014 DMS requirement</th>
<th>October 2014 Manning (trained strength)</th>
<th>Shortfall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary Healthcare Consultants</td>
<td>348</td>
<td>180</td>
<td>48%</td>
</tr>
<tr>
<td>Primary Healthcare consultants/Medical Officers</td>
<td>165</td>
<td>74</td>
<td>55%</td>
</tr>
</tbody>
</table>

8 Reserves in the Future Forces 2020: valued and valuable, July 2013
1.20. Data from the DMS CAS shows the lack of confidence that both DMS regular and reserve personnel have with the DMS’ ability to meet the FR20 requirements, with only 17 per cent of respondents reporting that they believe that Reserve manning in the DMS can be increased to achieve the ambitions set out in the FR20 (Future Reserves 2020) White Paper. Given the vital role of the DMS in the armed forces, the lack of consideration of the proposals for the medical reserves by the Council of the RFCA (Reserve Forces’ and Cadets’ Associations) External Scrutiny Team in the 2013 report that accompanied the FR20 White Paper was a failure of the original proposals. The RFCA committed to making the DMS a focus of their 2014 report, however, this did not happen and will not happen for a further two years. This is inadequate given the significant manning problems in the medical reserves and the difficulties associated with recruiting doctors to the Reserve Forces. We 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.

NHS developments

1.21. In September 2013 the BMA entered negotiations with NHS Employers about new contract arrangements for consultants and doctors in training in the NHS. The BMA ended contract talks in October 2014 over concerns that the crucial issue of safety for patients and doctors was not being effectively considered by NHS Employers. The Government has now referred both contracts to the DDRB, with a request for ‘observations’ on how the consultant contract could be changed to facilitate seven day services and ‘recommendations’ on a new pay system for junior doctors.

1.22. The BMA submitted evidence to the DDRB in December 2014 and further written and oral evidence will be provided in February 2015. The DDRB is due to report in July 2015. It is therefore inappropriate for the BMA to comment on comparability of NHS and Armed Forces doctors pay arrangements until this report is published.

2. Chapter Two – Evidence from the British Dental Association

Introduction
2.1. The pressure remains upon Government Finances and in accordance with Government Public Sector Pay Policy, there continues to be a 1% cap on pay in the public sector. The 1% pay award for 2014 across the board for the MOD was welcomed, however the fact remains that all Armed Forces (AF) Dental Officers (DO) have only received a 2.5% pay increase in total over the last five years. The value of those earnings continue to be eroded in real terms, especially against a background of the Consumer Price Inflation rising by 1.4% in 2014 and a cumulative increase of 14.5% over the same five years. The BDA recognises that the AFPRB has very limited opportunity to make any significant award in the current public sector pay environment. Despite this restriction the BDA feels it is essential that the AFPRB is aware of the very real groundswell of feelings within the Dental workforce.

Defence Dental Services (Defence Primary Care Service)
2.2. The concerns and predictions made by the BDA in the 2012 submission have unfortunately be proven to be very true, as morale and confidence for the future in the AF DO cadre has plummeted to appalling levels. The reasons behind this are varied and include the following: The unnecessarily quick transition of the DDS into the DPCS that has highlighted how unprepared and inept the DPCS non dental command structure was, and remains limited in its capability and understanding of delivery of primary dental care to Defence; the concurrent reduction of dental command personnel and expertise to meet overall DMS cost savings; the psychological effect of the extensive redundancy programme and loss of highly trained personnel in tranche 4 of the DMS 20 targets, before the reduction in the patient base. This has included loss of essential support staff and the removal of the entire Dental Hygienist cadre without provision of an alternative. Finally there has been the continuous threat of external delivery as an alternative to the current military/civilian mix that is seen by the AFDOs as a cheap alternative, and primarily a cost saving exercise that can only compromise the essential quality of care required for combat personnel.

2.3. The BDA has finally been given access to the Defence Medical Services Continuous Attitude Survey. A synopsis of the dental survey for AFDOs and Staff and Command (SC) illustrate the very significant fall in morale as follows: DO are 27% and SC are 28% positive (a fall of 5% and 18% respectively from 2013), and the perceived value of the two cadres by the DMS as: DO are 38% and SC are 16% positive (a fall of 10% and 28% respectively from 2013).

2.4. The BDA has already expressed their concern over the marginalisation and loss of professional identity of Dentistry within the DMS, and this was re-emphasised when the BDA National Council was briefed recently on how doctor centric the hierarchy and career prospects had become. The relentless pressure has again produced very disturbing figures over the perceived support from the DMS over career development as follows: DO are 19% and SC are 20% positive (a fall of 23% and 20% respectively from 2013). Confidence in the senior leadership of the DMS over future structure and strategy is even worse with DO at 13% and SC at 18% (a fall of 18% and 28% respectively from 2013). The failure of recruiting and especially the inept performance of the outsourced capability that is supposed to recruit for the Army has also been a significant part of the decline illustrated above.

2.5. Despite the awful figures in the previous paragraphs the figures for personal accomplishment remain good with DO at 85% and SC at 88% positive. The figures for value of contribution and achievement are also very high with DO at 91% and SC at 98% positive. The military /civilian primary care cadre have
continued to meet the required targets despite the very hostile environment, and it is very gratifying that patient attitude surveys and the MOD CAS continuously show the very high regard that the current delivery system and its people are held in.

**UK Dental Earnings**

2.6. 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 2012/13 in September 2014. The report was produced by the HSCIC in conjunction with the Dental Working Group and for the first time this is a single UK report. The report is an initial analysis and the calculations are subject to problems from the implementation of the new contract and the current Government Pilot Scheme for the next contract is also in considerable difficulty.

2.7. The data for 2012/13 for the NHS Provider-Performer dentist shows pre-tax earnings, after deduction of expenses, are at £114,100.00. This is a 1.2% increase that was 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 since 2006/07.

2.8. The figures for the private sector from the National Association of Specialist Dental Accountants (NASDAL) show a slight decrease at £124,086.00. The financial performance has changed very little, however private practice has started to improve as they have far greater flexibility to adjust prices and costs compared with the NHS.

2.9. The comparator used by the BDA remains the NHS Provider Performer dentist, and this was recently ratified by the BDA National Council, despite the ongoing difference of opinion with the AFPRB. The baseline from The Medical Manning and Retention Review shows that the AFDO pay has fallen behind their civilian counterpart at the same level as the 2013 submission. The DMS CAS shows a reduction in the proportion of AFDOs that think their pay is fair.

**Pensions**

2.10. The new Armed Forces Pension Scheme has had an effect upon retention of middle management with a significant loss of vital experienced officers. The proportion of AFDOs who are satisfied with their pension has increased slightly but remains at only 54% positive. The BDA concurs with the BMA that the MOD retention bonus scheme will not be able to react proactively to shortages before a retention crisis occurs.

**Discussion**

2.11. The DMS CAS has confirmed and highlighted the deep concerns of the BDA that were raised in the last submission. Morale and confidence in the DMS as a delivery capability is almost non-existent within defence dental personnel. The MOD can regard themselves very fortunate that despite the best efforts of the current delivery hierarchy, the dental work force continues to deliver the highest standard of care by a workforce that has excellent professional skills (both clinically and militarily) that cannot be matched by anyone else.

2.12. The future remains very unclear and public sector pay restraint will be a major factor for some time. The BDA, in consort with BMA, see that parity between AF Medical and Dental Officers as a priority, especially within the joint Defence Primary Care Service.