Armed Forces'
Pay Review Body

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Service Medical and Dental Officers

Supplement to the Forty-Fifth Report 2016

Chair: John Steele

Cm 9251

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April 2016

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Armed Forces' Pay Review Body

TERMS OF REFERENCE

The Armed Forces' Pay Review Body provides independent advice to the Prime Minister and the Secretary of State for Defence on the remuneration and charges for members of the Naval, Military and Air Forces of the Crown.

In reaching its recommendations, the Review Body is to have regard to the following considerations:

- *the need to recruit, retain and motivate suitably able and qualified people taking account of the particular circumstances of Service life;*
- *Government policies for improving public services, including the requirement on the Ministry of Defence to meet the output targets for the delivery of departmental services;*
- *the funds available to the Ministry of Defence as set out in the Government's departmental expenditure limits; and*
- *the Government's inflation target.*

The Review Body shall have regard for the need for the pay of the Armed Forces to be broadly comparable with pay levels in civilian life.

The Review Body shall, in reaching its recommendations, take account of the evidence submitted to it by the Government and others. The Review Body may also consider other specific issues as the occasion arises.

Reports and recommendations should be submitted jointly to the Secretary of State for Defence and the Prime Minister.

The members of the Review Body are:

John Steele (Chair)[1]
Brendan Connor
Tim Flesher CB
Paul Kernaghan CBE QPM
Professor Ken Mayhew
Judy McKnight CBE
Vilma Patterson MBE
Rear Admiral (Ret'd) Jon Westbrook CBE

The secretariat is provided by the Office of Manpower Economics.

[1] John Steele is also a member of the Review Body on Senior Salaries.

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GLOSSARY OF TERMS

AFPRB	Armed Forces' Pay Review Body
BAME	Black, Asian and Minority Ethnic
BDA	British Dental Association
BMA	British Medical Association
CEA	Clinical Excellence Award
CPI	Consumer Prices Index
CST	Chief Secretary to the Treasury
DDRB	Doctors' and Dentists' Review Body
DMS	Defence Medical Services
DMS20	Defence Medical Services 2020
DMSCAS	Defence Medical Services Continuous Attitude Survey
DNRC	Defence National Rehabilitation Centre
DO	Dental Officer
FR20	Future Reserves 2020
GDP	General Dental Practitioner
GMP	General Medical Practitioner
GMS	General Medical Services
GP	General Practitioner
GPMS	General and Personal Medical Services
MO	Medical Officer
MOD	Ministry of Defence
MODO	Medical and Dental Officers
NEM	New Employment Model
NHS	National Health Service
PAs	Programmed Activities
PMS	Personal Medical Services
SDSR	Strategic Defence and Security Review
SG	Surgeon General
VO	Voluntary Outflow

ARMED FORCES' PAY REVIEW BODY 2016 SERVICE MEDICAL AND DENTAL OFFICERS REPORT – SUMMARY

We recommend from 1 April 2016:

- **A one per cent increase in basic pay to all ranks within the Medical and Dental Officer cadre;**
- **A one per cent increase in the value of military Clinical Excellence Awards;**
- **A one per cent increase in General Medical Practitioner and General Dental Practitioner Trainer Pay and Associate Trainer Pay; and**
- **The retention of the Medical Officer 'Golden Hello' scheme, and its expansion to include all consultant cadres where the projected staffing deficit in 2018 is ten per cent or higher.**

Evidence for this Report

Our terms of reference require us to consider a range of issues before making our recommendations on pay for Medical and Dental Officers (MODOs) in Defence Medical Services (DMS). We take into account: the need to recruit, retain and motivate suitably able and qualified people; the economic situation in the UK; the Government's policy on public sector pay; DMS workforce levels; comparisons with relevant pay levels in the National Health Service (NHS); and the considerations of the Doctors and Dentists Review Body (DDRB). We received written and oral evidence from the Ministry of Defence (MOD), the British Medical Association (BMA), and the British Dental Association (BDA). We also consider evidence obtained during our visits programme, which included discussions with serving DMS personnel.

Workforce data

MOD provided staffing figures at 1 July 2015 showing MODO staffing was at 88 per cent (781) of DMS20 liability (887). There was a deficit in trained MOs of 18 per cent (597 MOs) against a DMS20 requirement of 730. This compared with a 19 per cent shortfall a year earlier. While there was an increase in the number of MOs, much of the improvement was due to a reduction in liability, and overall staffing figures hide the significant shortfalls that exist in some specialities. Both voluntary outflow (VO) and overall outflow reduced, to a total of around 75 MOs in 2014-15 compared with around 100 MOs the previous year. However, with around half of total outflow being voluntary, improving retention remains vital to the future sustainability of DMS. For DOs, staffing was at 117 per cent (184 DOs) of the DMS20 requirement of 157. MOD regarded the increase in outflow of DOs from 25 in 2013-14 to 30 in 2014-15 as sustainable in terms of meeting the reduced DMS20 liability by 2018.

Staffing figures for 1 July 2015 showed there were 240 Reserve MODOs against a future requirement of 549, with a 57 per cent shortfall in the number of MOs. MOD stated these figures demonstrated the challenge ahead in terms of recruitment and retention of Reserves but that a number of remunerative and non-remunerative measures were being taken to reach the target. The BMA was particularly concerned that failure to meet the Reserve recruitment targets, together with staffing shortages in Regular personnel, could present a significant risk to Defence. The BMA requested again this year that we conduct a Review into the future shape and feasibility of the Medical Reserve. As stated in our 2015 Report, we support such a review but consider that the BMA should work with the Surgeon General's (SG's) office to commission it.

Pay comparability

To allow MOD to continue to recruit, retain and motivate sufficient numbers of skilled staff, MODOs' pay should be broadly comparable with that in the NHS. The BDA stated that DOs pay had fallen behind civilian counterparts for the last few years. However, MOD asserted that its recommendations for MODOs this year would maintain broad pay comparability with NHS staff. Our own analysis supported this view.

Following a two-year Government imposed pay settlement in 2014 for salaried staff in England, Wales and Northern Ireland, DDRB was able this year to make recommendations for the whole of its remit group for all countries in the UK. We note its recommendations this year for a one per cent pay award for all salaried doctors and dentists and for a one per cent increase in pay, net of expenses, for all independent contractor General Medical Practitioners (GMPs) and General Dental Practitioners (GDPs) for all countries of the UK for 2016-17. We also note DDRB's recommendations and observations in its July 2015 Report in respect of the proposed changes to the junior doctors' and consultants' contracts.

Recommendations

MOD proposed an increase in basic pay for MODOs in line with our recommendation for the main Armed Forces pay award. The BMA and the BDA both proposed an award above the rate of inflation, but did not state what that award should be. They also said that MODOs should receive at least the same award as the rest of the Armed Forces. Staffing data and our consideration of broad pay comparability between the NHS and DMS, including the recommendations made by DDRB, lead us to recommend a one per cent across the board increase this year. This is consistent with the approach we took for the main remit group. Although MOD proposed that GMP and GDP Trainer Pay and Associate Trainer Pay be held at existing levels (as there was no recommendation on this from DDRB last year), as DDRB recommended an increase of one per cent in the NHS this year, we believe it appropriate to do likewise. Also in its 2016 Report, DDRB recommended an increase of one per cent in the value of consultants' Clinical Excellence Awards (CEAs) and Distinction Awards. We therefore similarly recommend a one per cent increase in the value of military CEAs and Distinction Awards for 2016-17.

The BMA and the BDA suggested in their evidence to us that MODOs should have their mandatory professional body fees (PBFs) reimbursed. This is the policy for civilian doctors and dentists working for DMS and will be for Allied Health Professionals (not on bespoke pay spines) from 1 April 2016. We strongly suggest MOD gives this proposal very careful consideration. We believe the reimbursement of PBFs would be a cost effective way for MOD to demonstrate its support of MODOs and could go some way to improving morale in these important cadres.

Looking ahead

Having already experienced a period of significant change with restructuring under DMS20 and the cessation of combat operations in Afghanistan, MODOs continue to operate under considerable uncertainty. While VO of MOs had reduced over the last year, it still remained high and SG acknowledged there was no room for complacency on staffing numbers, particularly in certain specialities. Information gathered from personnel on the reasons why they do not serve a full career must be used by SG to help to address retention issues.

We believe there is more scope for the application of flexible and part-time working in DMS to help improve recruitment and retention, particularly of female personnel. We urge MOD and SG to work together with the BMA and the BDA to explore how options for flexible and part-time working can be applied and extended to personnel throughout DMS. The demographics of those entering medical and dental school mean that work needs to continue to engage with members of Black, Asian and Minority Ethnic communities to build trust and improve

understanding to increase the numbers who might consider a career in the DMS. MOD needs to continue work to ensure there is an inclusive culture in the Armed Forces so that individuals from all backgrounds are able to reach their potential and remain for a full career.

The 2015 Strategic Defence and Security Review confirmed that Reserves will continue to play a vital role in the Armed Forces in the future. With the Medical Reserve being so understaffed, particularly in certain specialities, MOD will need to continually monitor the effectiveness of its remunerative and non-remunerative measures. It must also build on the good progress made by continuing to work in partnership with the NHS to increase interest in the Reserves from the NHS workforce. We were interested to hear the BMA's suggestion to change the way the daily rate of pay is calculated for Reserves to make such service more attractive. We consider that the method of paying DMS Reserves is worthy of further investigation, and of a formal response from MOD, as we believe it could help recruitment into the DMS Reserves.

It is unclear how developments in the NHS, particularly in relation to seven-day working, the implementation of the new junior doctors' contracts and the ongoing negotiations on the consultants' contracts, will affect DMS staffing. We wish to be kept informed of any effect this has on the recruitment and the retention of both Regular and Reserve MODOs.

INTRODUCTION

1. This Report sets out the evidence we received and our recommendations for Medical and Dental Officers' (MODOs') pay from 1 April 2016. This year's review was conducted against the background of a slowly improving economic climate, the Government's policy of continued public sector pay restraint, and continuing change for Defence Medical Services (DMS) and the rest of the Armed Forces. Our recommendations aim to maintain broad pay comparability with National Health Service (NHS) doctors and dentists to allow DMS to recruit, retain and motivate suitably qualified personnel.

2. In its evidence, MOD proposed a uniform increase to basic pay for all MODOs in line with its proposal for the main Armed Forces remit group. It proposed, however, that General Medical Practitioner (GMP) and General Dental Practitioner (GDP) Trainer Pay and Associate Trainer Pay and Clinical Excellence Awards (CEAs) were held at existing rates. In addition to considering evidence from the Government, MOD, the British Medical Association (BMA) and the British Dental Association (BDA), and gathering our own evidence directly from the remit group on visits, we also take into account the considerations of NHS doctors' and dentists' pay by the Review Body on Doctors' and Dentists' Remuneration (DDRB). Last year DDRB did not make any recommendations to Government for salaried staff in England, Wales or Northern Ireland. This was due to the 2014 Government-imposed pay settlement whereby only salaried staff in England, Wales and Northern Ireland who were not eligible for incremental pay received a one per cent non-consolidated payment for both 2014-15 and 2015-16. Scotland did, however, accept DDRB's recommendation last year of a one per cent increase to basic pay for all salaried doctors and dentists. All the UK countries accepted last year's recommendation for an increase of one per cent in pay, net of expenses, for independent contractor GMPs and GDPs.

BACKGROUND

DMS developments

3. MOD told us that Defence had transitioned from a campaign footing, reducing in size and that DMS had adapted to provide appropriate healthcare. DMS have to provide healthcare in response to contingency operations, enduring operations and within the 'firm base'. Perhaps the most high profile recent example of this was the deployment to Western Africa in response to the Ebola outbreak, while maintaining support to many other smaller-scale operations worldwide.

4. The evidence we received also highlighted some of the findings from the 2015 DMS Continuous Attitude Survey (DMSCAS), stating that MODOs' morale had improved compared with last year, that they felt valued by their patients, were clear about their roles, and were broadly content with their pay. The Surgeon General's (SG) office started work on trying to better understand why MOs leave DMS before serving a full career, by collating returns on the reasons given for submitting their notice to terminate. MOD provided details of six strategic initiatives that would affect staff in the DMS:

    - Defence Medical Services 2020 (DMS20) – SG's primary mechanism for developing the future DMS staffing component to meet the operational capability needs of Defence by 2020. DMS20 resulted in an overall manpower requirement reduction of 700 Regulars (from around 7,500 to around 6,800) and 1,150 Reserves (from 5,150 to 4,000). For MOs the DMS20 requirement is 710 Regulars and 500 Reserves.
    - Future Reserves 2020 (FR20) – DMS engaged with NHS Employers to standardise HR policies on the employment and use of Reserves. Coherent tri-Service marketing material was produced, and improvements made to training arrangements. Also, NHS Employers and the Army's 2nd Medical Brigade produced a map of all 238 NHS

Trusts, highlighting the 135 Trusts employing Reserves, and launched it together with the DMS NHS Reserve Champions Network. The NHS and FR20 are very closely linked: if the NHS cannot maintain its outputs, then the ability of DMS to recruit, retain or deploy specialist Reserves could be placed at risk. Therefore DMS are looking to find out what additional resources would be helpful for NHS managers of Reservists.

- New Employment Model (NEM) – aims to modernise terms and conditions of service, which could help to reduce the impact of Service life on individuals and their families. MOD initiated a flexible duties trial which allows personnel to temporarily reduce their liability to deploy for up to three years, and/or work less than full time (by using unpaid leave). Eleven Defence Healthcare, Education and Training personnel started on the trial in February 2016.
- Defence National Rehabilitation Centre (DNRC) – a new centre near Loughborough, closer to DMS headquarters. The DNRC is due to open in 2018 and will aim to deliver improved rehabilitation services compared with those currently provided at Headley Court in Surrey. MOD noted that some concerns remain over the staffing of certain specialties due to the change of location.
- Directorate of Healthcare Delivery and Training – Joint Medical Command and Defence Primary Healthcare were consolidated into one 'pillar' responsible for all healthcare (primary and secondary), and medical education and training.
- Contingency operations – the impact on the DMS workforce will need to be monitored, while ensuring standards are maintained. The potential for a higher proportion of staff to be held at readiness could affect morale and retention.

NHS developments

5. We keep up-to-date with developments in the NHS that are relevant to DMS to assist in our assessment of broad pay comparability. We note that:

    - In 2014 the Government imposed a two-year pay settlement on salaried staff in England, Wales and Northern Ireland whereby only those at the top of pay scales and therefore not eligible for incremental pay received a one per cent non-consolidated payment for 2014-15 and for 2015-16. The Scottish Government, however, accepted DDRB's recommendations of a one per cent increase to all pay scales for salaried staff for both 2014-15 and 2015-16.
    - All countries accepted DDRB's recommendations for an increase of one per cent in pay, net of expenses, for independent contractor GMPs and GDPs for 2015-16.
    - In July 2015 DDRB published its Report containing *recommendations* on contract reform for junior doctors (and dentists) (recognising that much of the detail required further negotiation between the Health Departments and the BMA) and *observations* on the pay-related proposals for reforming consultants' contracts in England, Wales and Northern Ireland. DDRB was asked to make *observations* only in relation to the changed contracts for doctors and dentists in training for Scotland. The remit was linked to a desire to facilitate the delivery of healthcare services seven days a week, in a financially sustainable way. DDRB was broadly supportive of the proposed changes but urged the four countries of the UK to work together in order to make progress on the contracts and pledged their support for UK-wide contracts for junior doctors and consultants as they felt this was in the best interests of patients.
    - Negotiations on changes to junior doctors' contracts broke down at the end of 2015 and junior doctors in England took industrial action on 12 January and 10 February 2016. Under the new contract, the basic pay of junior doctors would increase by an average 13.5 per cent. As the contract would be cost-neutral compared with the

existing paybill, this increase in basic pay would be balanced by changes to other elements of pay, including the definition of core/premium time and the associated pay rates. Automatic increments would end and pay would be based on the stage of training, rather than time served.

- Negotiations on changes to consultants' contracts were ongoing in England and Northern Ireland at the time of writing. The potential changes partly aim to support seven-day working in the NHS and include proposals for locally determined performance pay, replacing local CEAs.
- Pilot schemes are underway in England and Wales for new contractual arrangements for dentists to be paid on a per capita basis.
- In its 2016 Report, DDRB stated that there were ongoing problems with recruiting into specialities such as chemical pathology, emergency medicine, psychiatry, acute medicine and general practice. Some of the difficulties appeared to be UK-wide while others appeared more localised. Certain geographical locations had greater problems with recruitment, particularly more rural areas and those with few economic opportunities. The potential new junior doctors' contract provides for the use of flexible pay premia to address hard-to-fill vacancies by speciality and geography, and Recruitment and Retention Premia are likely to remain local flexibilities as part of the revised consultant contract.
- The BMA and the BDA both cited low levels of morale affecting their members and this was picked up by DDRB on visits. They explained that issues around the junior doctors' contract were likely to have a negative effect on the morale of all remit groups. DDRB said that the annual pay uplift recommendation would give an important signal of their value.
- Affordability and delivery of efficiency savings continued to be a key focus for all health departments. Pay restraint alone could not deliver these savings so the emphasis was on making transformational change, whilst maintaining service levels.

Our 2016 Report

6. At the start of this round, we confirmed that we would take account of all the evidence we received, including that on recruitment and retention, morale and motivation, pay comparability, affordability, and the wider economy, adhering to our terms of reference when considering our recommendations for MODOs. We have kept in mind the particular risks to the retention of MODOs as changes under DMS20 continue to be implemented and wider changes to Defence take effect. We have also kept abreast of developments in the NHS on the direct comparator groups, as these could have a significant knock-on effect on the recruitment and retention of MODOs.

OUR EVIDENCE BASE

7. We considered evidence from a range of sources including:

- The Government's evidence on its public sector pay policy and the overall economic context, as submitted to all Pay Review Bodies;
- The Government's reaction to last year's recommendations on NHS doctors' and dentists' pay by the DDRB;
- MOD's written evidence on MODOs, covering staffing, recruitment, retention and DMSCAS;
- Written evidence from the BMA and the BDA;
- Oral evidence from SG and his team, and from the BMA and BDA Armed Forces Committees;

- Research into MODO and NHS pay comparisons undertaken by the Office of Manpower Economics; and
- Our discussions with MODOs on our visits during 2015, in the UK and abroad.

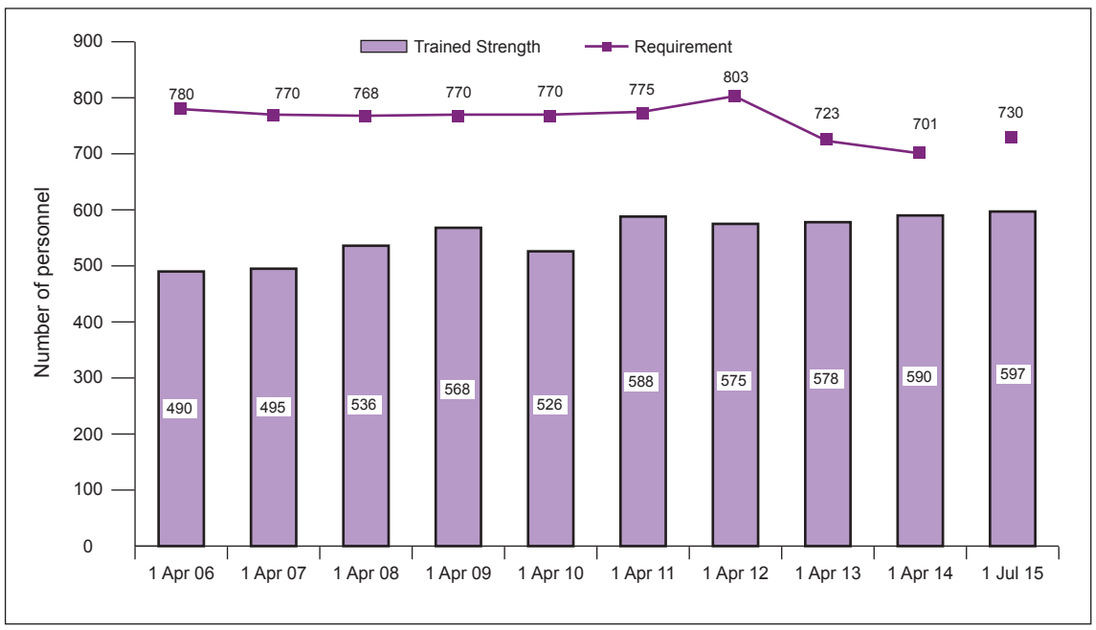
8. Our visits enable us to meet MODOs and hear their views, on issues specific to the DMS and on those applying more widely across the Armed Forces. We are grateful to those who participated in our visits and appreciate the work of MOD and the Services in arranging them. In 2015 we visited Headquarters 2nd Medical Brigade in York, and 212 Field Hospital in Sheffield. We also met DMS Regular and Reserve personnel as part of our visits to other establishments in the UK and abroad. A full list of AFPRB visits can be found in our 2016 Report for the main remit group at Appendix 4.[1] We heard a number of issues raised by MODOs; for example, on recruitment problems, staff shortages and gapping which resulted in increased workloads, and a general feeling that the overall military offer had been eroded.

Staffing

9. The DMS20 requirement was for 887 trained MODOs at 1 July 2015. The charts below show the changes in the requirements and staffing levels of MOs and DOs over the last decade. At 1 July 2015 there were:

- 597 trained MOs, a deficit of 18 per cent against the DMS20 requirement of 730. This is an increase of seven trained MOs from 1 April 2014.
- 720 MOs in training, including:
  - 156 General Duties Medical Officers;
  - 301 MOs undertaking Core or Higher Specialist Training
  - 80 Foundation Year MOs; and
  - 183 Medical Bursars enrolled as undergraduate medical students.
- 184 trained DOs, 117 per cent of the DMS 20 requirement of 157.

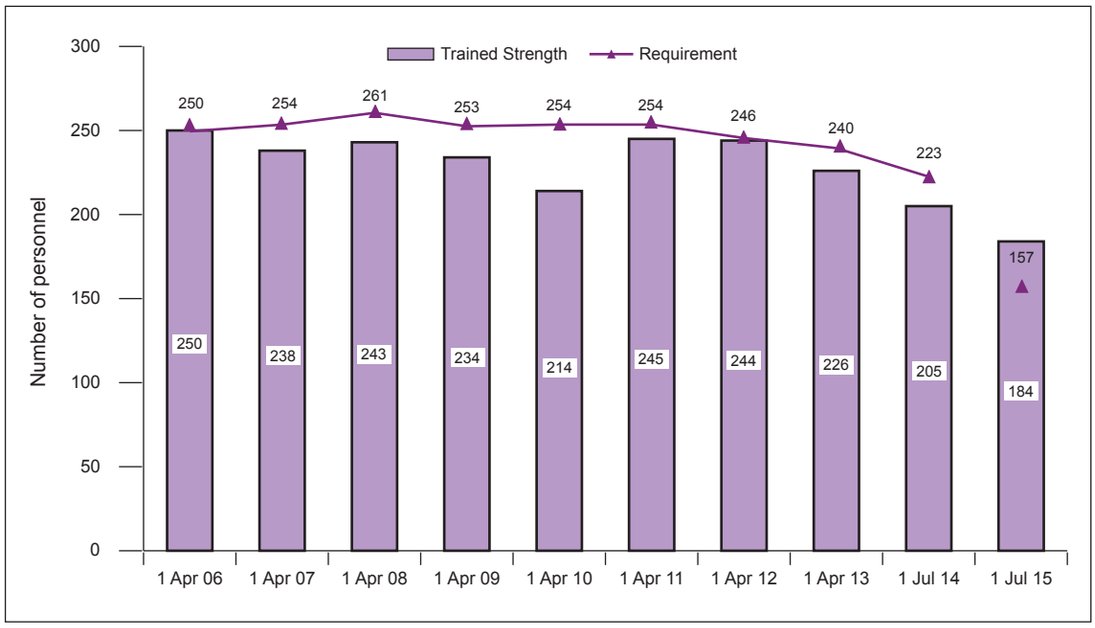
Chart 1: Strength and deficit/surplus of Medical Officers 2006-2015[a]



[a] The requirement for 2015 relates to DMS20, for previous years it is the requirement for that particular year.

[1] *Armed Forces' Pay Review Body Forty-Fourth Report 2015,* https://www.gov.uk/government/organisations/office-of-manpower-economics

Chart 2: Strength and deficit/surplus of Dental Officers 2006-2015[a]



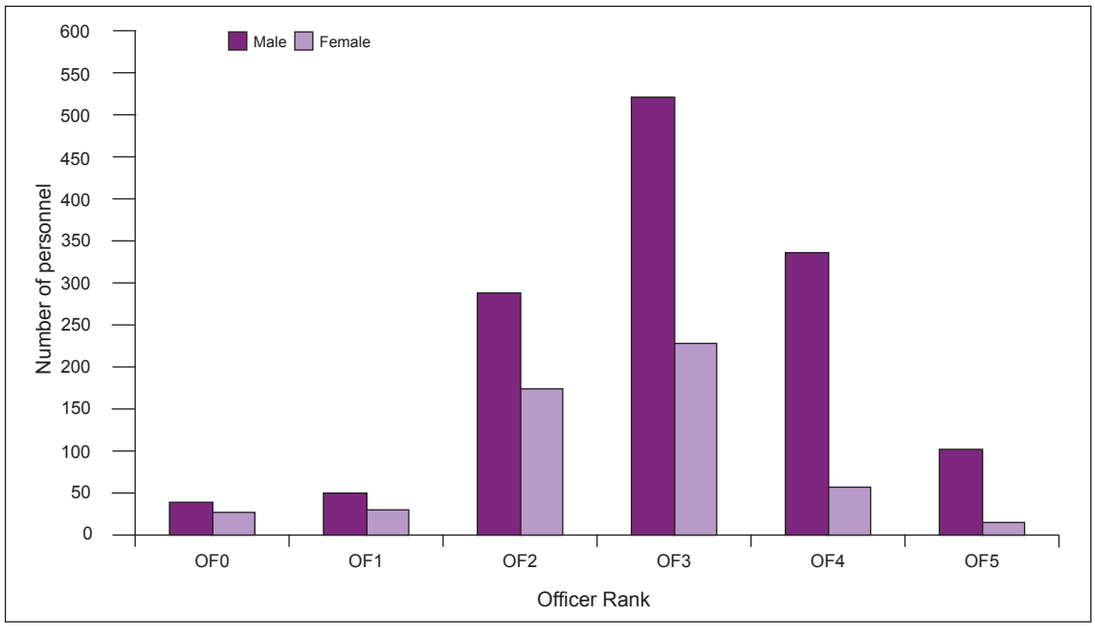
[a] The requirement for 2015 relates to DMS20, for previous years it is the requirement for that particular year.

10. For consultants, there were 241 trained staff in July 2015 against a DMS20 requirement of 311. This represents an overall shortfall of 22 per cent compared with 28 per cent a year earlier. There was a DMS20 requirement of 332 Accredited GMPs and a trained strength of around 290, a shortfall of 13 per cent. MOD advised that a proposed one-year extension to the GMP training pathway, which could have resulted in a year (2018) when no GMPs would become accredited, has been withdrawn.

11. MOD provided evidence on the age, gender and rank profiles of MODOs at 1 April 2015. The proportion of women remained steady at around 28 per cent, although the picture for new recruits under training is improved. Gender balance varies considerably with rank (and therefore, to some extent, with age) as shown in Chart 3. Around 50 per cent of students entering UK medical schools are female.

12. MOD again provided us with some useful information on the ethnic breakdown of MODOs. Around 91 per cent of MOs and 95 per cent of DOs were of White background. While the proportion of MODOs from Black, Asian and Minority Ethnic (BAME) groups may compare favourably with the Armed Forces overall, it does not reflect the patterns of those studying medicine and dentistry, nor those of society at large. The ability to attract and retain female recruits and personnel from BAME backgrounds is particularly important for DMS.

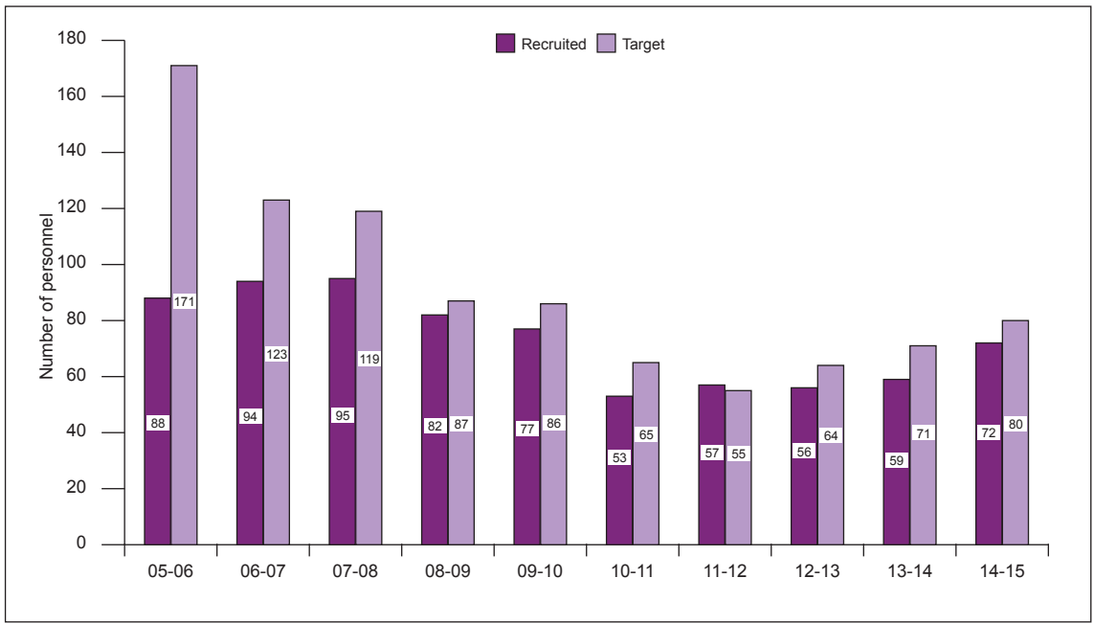
Chart 3: MODO Gender distribution by Rank – 1 April 2015



Recruitment

13. The recruitment target for MO Bursars/Cadets was nearly met in the twelve months to 31 March 2015 (recruiting 58 against a target of 59), although that for direct entrants was missed. Trends in MO recruitment are shown in Chart 4. Over the last ten years, the target was only reached once. This consistent missing of the recruitment target will have a detrimental, cumulative impact on DMS. DO recruitment was higher than in previous years (a total of 11[2] compared with four for the year to March 2014).

Chart 4: Medical Officer recruitment 2005-06 to 2014-15



[2] These 11 include four Bursars.

Retention

14. Overall outflow of MOs reduced in 2014-15, to a total of around 75 compared with around 100 in 2013-14. However, outflow remained higher than in 2010-11 and 2011-12. Voluntary outflow (VO) remained at around half of total outflow, so improving retention remains vital to the future sustainability of DMS. The work underway by SG's office to gain a better understanding of why some MOs choose not to serve a full career should help to inform policies in this respect. For the fourth year in succession, Regular DO outflow increased (from around 25 in 2013-14 to around 30 in 2014-15), but MOD considered that this remained sustainable, and it was on track to meet the reduced DMS20 liability by 2018. The BDA reflected that uniformed dental staff were worried that there may be further cuts in the near future. MOD told us that there were no plans for further redundancies of uniformed dental staff. On our visits we heard concerns that the dental cadre was being reduced to an unrealistic level, and that the quality of service would suffer. The BDA emphasised the importance of dental health in the overall healthcare of Service personnel in ensuring that they are fit to deploy.

15. MOD's evidence suggested that female MODOs tended to leave the Service relatively early in their careers. While the written evidence did not provide any specific proposals for measures that could be adopted by DMS, schemes were being developed under NEM and SDSR15, that could help with the retention of female MODOs. Options to allow Regular personnel to work part-time are being considered, which is welcome as this is something MOD had not previously viewed as a viable option. We were also told that work was underway on the development of a 'Flexible Engagements System' to potentially allow personnel to temporarily adjust their availability for deployment to match their personal circumstances. Easier transfer between Reserve and Regular Service in both directions, could also aid retention and is to be welcomed.

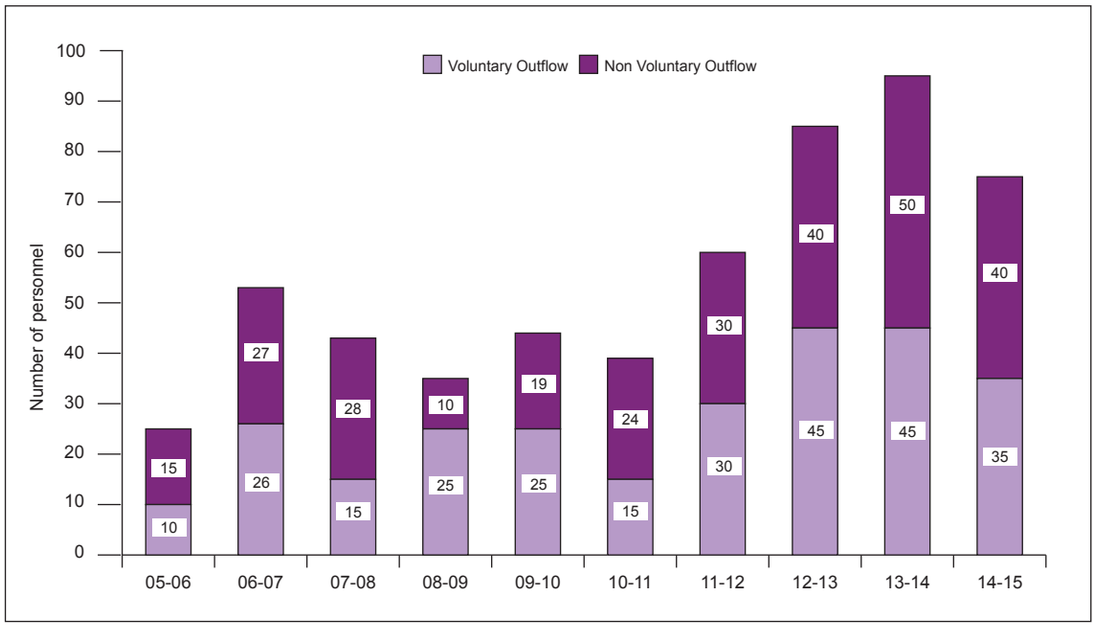
16. We were concerned to read in the evidence from MOD that it considered that there may not be as much demand from MODOs for flexible working options as had previously been thought. The BMA and the BDA's evidence placed strong emphasis on the need for flexible working. They considered it to be important for retention that personnel could be able to move more easily between full and part-time working, and between the Regulars and Reserves. In late 2015, a small pilot scheme was introduced giving the opportunity for ten MOs from across the Services to undertake less than full-time specialist training, to help the retention of personnel who may have otherwise left. All the available places were filled, by female MOs. We welcome this and wish to be kept informed of progress. We believe that the nature of the work undertaken by MODOs, and the read-across to NHS roles, could provide further opportunities to adopt more flexible ways of working which could in turn improve recruitment and retention.

17. Unfortunately, MOD's evidence again gave no consideration to how to improve both recruitment and retention of personnel from BAME backgrounds. In our Report on the main remit group we noted that in April 2015 the Prime Minister announced, as a step towards achieving a more diverse Armed Forces, a recruitment target of ten per cent for BAME individuals. MOD also set a recruitment target of 15 per cent for women by 2020. This is the first time such targets have been set. The announcements also made clear that the Services would "make the changes necessary to enable our Armed Forces to work flexibly, reflecting the realities of modern life". MOD told us that separate action plans relating to the recruitment and retention of BAME individuals had also been produced by each Service. Recruitment is the responsibility of the individual Services rather than DMS, but we were still disappointed to see in the evidence that DMS were content to let the demographic changes in those going to medical and dental schools merely filter through into a more diverse workforce, rather than introducing specific initiatives. There does not seem to be much evidence of success from this filtering approach as yet.

18. In previous Reports, we suggested that exit interviews be held with each MODO who submitted their notice to terminate, so that DMS management could better understand the characteristics of those leaving and their reasons in order to determine what actions could be taken to try to stem the outflow. Since October 2014, quarterly reports have been sent to SG's headquarters which summarise these data. Early results suggested that the main reason stated for leaving, by both male and female MOs, was the desire to provide greater stability for their family. We look forward to receiving further analysis of these data in the future.

19. Results from DMSCAS suggested that the top three retention factors for MODOs were: postings of choice; pay; and work/life balance. The introduction of the Armed Forces Pension Scheme 2015, together with changes to pension taxation rules have also impacted on MODOs' intention to remain in service, and could have tangible impacts in the not too distant future. The pension tax rule changes resulted in a number of MODOs facing a tax charge last year, and it is expected that the number will increase, which could in turn result in some MODOs deciding to shorten their career in the Armed Forces to avoid a large tax charge.

Chart 5: Medical Officer outflow 2005-06 to 2014-15



Morale and motivation

20. The information we receive on the findings from the DMSCAS helps our understanding of MODOs and the issues concerning them. DMSCAS results for 2015 suggested that MODOs' morale had improved over the previous year. They felt valued by their patients, were clear about their roles, and were broadly content with their pay. MOD considered that settling in to the new Directorate of Healthcare Delivery and Training organisation, and the reduction in operational churn over the previous year had contributed to the reported improvement in morale. However, respondents were not satisfied with opportunities for sport and adventurous training, and were not confident that Reserve staffing could be increased to meet the FR20 target.

21. The BMA and the BDA thought that while morale had improved according to the DMSCAS results, this was from a very low base, and needed further improvement. Changes in how military healthcare was being provided, with increased use of civilians, meant that there were fewer uniformed medical and dental personnel available to deploy, which also impacted on morale.

22. We have previously been concerned that the relationship between SG and the BMA and the BDA was distant and less than constructive. We hope that with the recent changes in personnel, a more positive and productive dialogue can be established, with perhaps some joint initiatives around flexible working being investigated.

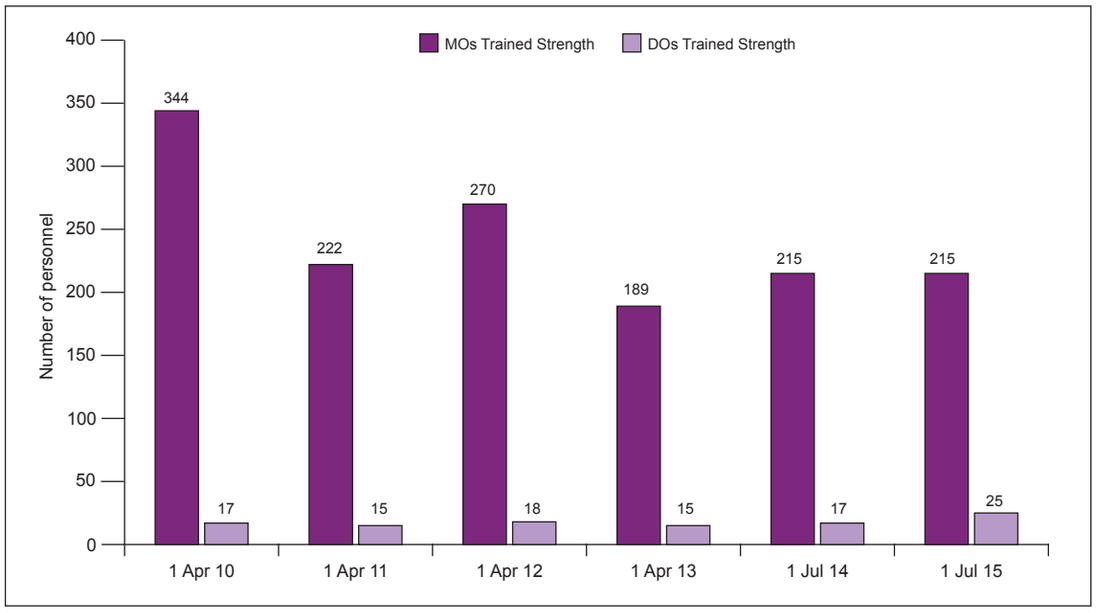
Operational commitments

23. The 2015 DMSCAS reported that 59 per cent of MOs and 41 per cent of DOs had deployed at least once in the previous five years, both lower than the previous year's statistics. The majority of MODOs were satisfied with their deployment intervals. MOD stated that as larger scale operations have drawn down, the gaps between deployments should increase. However, personnel could find that they are held 'at readiness' for long periods, which may have different and unintended impacts on their lives. The possible reduction of opportunities to deploy could affect recruitment and retention of MODOs, who may believe that there would be less 'professional challenge' on offer. SG's office told us it was aware of this and was taking steps to mitigate this, and ensure that the lessons and best practice gained from operations in Iraq and Afghanistan are not lost.

DMS Reserves

24. FR20 set out a requirement for around 550 trained MODOs. Chart 6 shows that at July 2015 there were 215 trained MOs, against the FR20 requirement of 500, and 25 trained DOs against a requirement of 50.

Chart 6: Trained strength of Reserve Medical and Dental Officers 2010 to 2015



25. There was a 57 per cent shortfall in the number of MO Reserves against DMS20 liability. MOD stated that a number of remunerative and non-remunerative measures were being implemented to attempt to improve the situation. It considered that the recent Financial Retention Incentive for ex-Regular Army and RAF personnel to join the Reserves may help, as will DMS Reserves receiving a payment for recruiting another qualified doctor or dentist. At the time of writing, the third financial incentive has still not yet come to us for endorsement, but it would potentially offer a taxable, one-off payment on completion of phase one training. Non remunerative measures include consideration of reducing the mandatory annual training commitment, potential flexibility around the age requirement for DMS Reserve Consultants and MOD funding training courses. MOD has also undertaken work to improve engagement with NHS Employers.

26. The BMA told us that it was planned that Reservists would make up around half of the total DMS20 requirement, with some specialties being provided exclusively by Reserves. (For MOs, the DMS20 requirement will be 710 Regulars and 500 Reserves.) There were already significant shortfalls and the BMA considered that there were fundamental recruitment problems across medical Reserves. The BMA said that the failure to recruit sufficient numbers of Reserves, coupled with staffing shortages in the Regular DMS cadres, could present a significant risk to Defence. As it argued last year, the BMA again requested that we commission an independent review into the future shape and feasibility of the Medical Reserve. We agreed that such a review was worthwhile. However, as it is outside our remit we consider that the BMA should work with SG's office to commission it.

27. In our 2015 Report, we highlighted a proposal from the BMA regarding a change to the way the daily rate of pay was calculated for Reservists. While money was not the main motivator for staff to join the Reserves, the BMA suggested that, as the existing daily rate was well below what many experienced Doctors would earn in the NHS, the change could encourage more to volunteer. Reserves are paid on a daily rate which is calculated by dividing the MODO salary by 365 days. The BMA argued that, as most Regular MODOs worked an average of 220 days a year, a fairer way of calculating the daily rate would be to divide the annual salary by this number. This would lead to a higher rate of pay for Reserves but the BMA considered that it should not cost MOD a great deal, as most Reserves work an average of 19 days a year. However, we were told that the change would not be made by MOD as it would be too expensive, and would have to apply to all, not just those in the medical Reserves. We consider that the method of paying DMS Reserves is worthy of further investigation, and a formal response from MOD, as we believe it could increase recruitment to the DMS Reserves.

Government's approach to public sector pay and affordability

28. The Government's evidence on the general economic context, submitted for our 2016 Report on the main remit group, stated that the UK economy grew faster than that of any other major advanced economy in 2014, at 3.0 per cent. Gross Domestic Product grew by 0.4 per cent in the third quarter of 2015 and was 2.1 per cent greater than in the same quarter a year earlier. Employment levels continued to rise in 2015 and unemployment to fall, continuing recent trends. Annual average weekly earnings growth for the whole economy was 2.0 per cent in the three months to November 2015. The Consumer Prices Index (CPI) inflation figure was at 0.2 per cent in the year to December 2015, having been stable at around zero for the previous ten months. The Government said that public sector pay restraint had been a key part of fiscal consolidation so far, and it would continue to be so. It announced in the July 2015 Budget that the policy on public sector pay restraint would continue and that it would fund public sector workforces for a pay award of one per cent for four years from 2015-16.

29. The letter we received from the Chief Secretary to the Treasury (CST) stated that the case for public pay restraint remained strong and continued restraint would protect jobs in the public sector. The CST said that the Government expected pay awards to be applied in a targeted manner to support the delivery of public services and to address recruitment and retention issues. He also said that the Government would focus on progression pay as part of its ongoing aim of reforming public sector pay.

DDRB recommendations for 1 April 2016[3]

30. DDRB was asked to make recommendations for all of its remit groups for 2016-17. For England and Northern Ireland, it was asked to also consider the case for targeting to support recruitment and retention. The DDRB's recommendations were made against the background of the continued policy of public sector pay restraint. DDRB noted the consensus view of the parties that targeting their recommendations would risk demotivating a large part of its remit group and concluded that it should not target on the basis of recruitment and retention for 2016-17. It acknowledged that issues existed in some specialities and locations and unless parties provided evidence that other (non-remunerative) approaches were working then there would be merit in testing a targeted pay approach in future years to see whether that was more effective. It also noted that funds set aside for the pay uplift could be used differently to alleviate workload pressures. In that context, the DDRB made the following recommendations for 2016-17 which are relevant to DMS groups:

    - An increase to basic pay of one per cent to the national salary scales for salaried doctors and dentists for all countries in the UK;
    - An increase of one per cent in pay, net of expenses, for independent contractor GMPs and GDPs for all countries of the UK;
    - An increase of one per cent in consultants' Clinical Excellence Awards, Discretionary Points and Distinction Awards; and
    - An increase of one per cent to the GMP trainers grant in line with the main pay recommendations for GMPs.

Pay comparability

31. Our terms of reference require us to "have regard for the need for the pay of the Armed Forces to be broadly comparable with pay levels in civilian life". DMS staff, unlike most other Service personnel, have close comparators in the form of doctors and dentists in the NHS. As for last year, MOD, the BMA and the BDA provided little detailed comparability evidence. However, this is unsurprising given devolved pay and recent developments regarding NHS pay and conditions. As for 2015, the main pay analyses by cadre that follow have been produced by our secretariat.

Summary of pay comparisons by DMS group

32. Our comparisons examine levels of DMS and NHS pay (at 1 April 2015 where data were available). The following adjustments have been made to provide a consistent basis for the comparisons: (i) remove the appropriate level of X-Factor from DMS salaries; (ii) make an upward adjustment to DMS salaries to recognise that the DMS has a relative pension advantage over the NHS;[4] and (iii) where applicable, make downward adjustments to elements of the NHS comparator, recognising that all DMS base pay is pensionable, but there are elements of NHS comparator pay which are not.

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[3] *Review Body on Doctors' and Dentists' Remuneration, Forty-Third Report,* March 2016.

[4] This is calculated using the same approach as for last year, but differently from earlier DMS Reports where NHS salaries were adjusted downwards.

Consultants[5]

33. Average DMS pay in 2015-16 was £113,906.[6] Total pay within the NHS is composed of the following elements:

- Programmed Activities (PAs) – these form the basis of NHS Consultant comparator pay with base pay linked to Consultants undertaking 10 programmed activities per week.[7]
- Additional PAs – any programmed activities worked over the base 10 PAs are paid *pro rata* and are non-pensionable. The National Audit Office carried out a census of NHS trusts which showed they paid for, on average, 11.2 PAs per consultant a week, which is consistent with earlier measurements for PAs worked.[8] In 2009, AFPRB and the parties agreed to use one additional PA in NHS comparator pay to make a total of 11 PAs for comparison purposes.
- On-Call Availability Supplement – average DMS commitments according to last available data[9] were 1 in 7, considered a medium frequency rota in the NHS and attracting a five per cent pensionable supplement to base pay. Inclusion of this payment was also agreed by AFPRB and the parties in 2009 as the appropriate NHS comparator.
- Employer-based (local) CEAs[10] – these pensionable awards were introduced in the NHS in 2003 as a replacement for the Discretionary Points scheme. Local awards (levels 1 to 8 plus some level 9) are funded by local NHS employers, who are now obliged to award 0.2 (previously 0.35 until 2011)[11] of an award per eligible NHS consultant (following their first year as a consultant). These awards are not an automatic element of a consultant's earnings, but must be applied for, so are different to other elements of remuneration. The parties had been discussing the introduction of a merit-based award system within the DMS. However, any changes will wait until the future of CEAs in the NHS has been agreed.

34. Table 1 shows that adjusted average DMS pay is ahead of NHS comparator pay when both additional PAs and on-call availability supplements are included. It is only when the value of local CEAs is taken into account that NHS pay moves ahead. Pay scales for NHS consultants did not increase on 1 April 2015, therefore the NHS data in the table are the same as last year.

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5 Unless stated otherwise the data have been adjusted as set out in paragraph 31.

6 Assuming Consultants start at increment level 5 at age 35 and progress to increment level 30 at age 60.

7 10 PAs is 40 hours of work per week and deemed a full-time post.

8 This figure is published in a NAO report: National Audit Office. Managing NHS hospital consultants HC 885. TSO, 6 February 2013. Available at: http://www.nao.org.uk/wp-content/uploads/2013/03/Hospital-consultants-full-report.pdf

9 MOD 2008 MODO Paper of Evidence.

10 National Awards (level 9/Bronze to level 12/Platinum) in the NHS and DMS are funded centrally and considered separately from the pay comparability exercise. MOD states in its evidence that a similar proportion of its staff are in receipt of a (national) clinical excellence award to staff in NHS England. However, award amounts are different. There are no employer-based CEAs for MOs and they are excluded from applying for them in any NHS Hospitals in which they might work. This was taken account of when the MO Consultant Pay Spine was created – an element of the pay scale compensates for lack of access to employer-based CEAs.

11 This is the proportion used for calculating the income comparisons as it still more accurately reflects the awards for the current population.

Table 1: Consultant 2015-16 pay comparisons

Comparator	Average Income £	Adjusted Average Income[a] £	Lead/Deficit of DMS[b] %
DMS	**118,316**	**113,906**	–
NHS			
11 PAs	100,660	99,928	14.0
11 PAs + 5% On Call	105,236	104,504	9.0
11 PAs + 5% On Call + CEA	117,405	116,673	-2.4

[a] NHS Additional PAs are adjusted for non-pensionability.

[b] Comparisons made with X-Factor and pension adjusted DMS average salary and adjusted NHS salaries.

General Medical Practitioners[12]

35. Based on 2015-16 salary scales, the annual average DMS salary across a career is £110,482. However, the latest available NHS GMP pay information is for 2013-14. Therefore, DMS pay data from the same year were used when making the comparisons. Average DMS salaries for 2013-14 were £108,306 when adjusted. In July 2015, there were 290 DMS GMPs.

36. The total population of independent contractor NHS GMPs is all General and Personal Medical Services (GPMS) GMPs.[13] Average net profit for this group was £99,800, 2.2 per cent lower than 2012-13.[14] This equates to a lead of around 8.5 per cent for average pay for DMS GMPs with NHS GMPs or around 12.2 per cent when comparing median pay. Table 2 shows average DMS pay (adjusted for X-Factor and pensions) against the range of NHS GMP comparators.

[12] Unless stated otherwise the data have been adjusted as set out in paragraph 31.

[13] In previous evidence, the BMA, the BDA and MOD agreed that independent contractor NHS GMPs were the appropriate comparator, specifically all General and Personal Medical Services (GPMS) GMPs.

[14] These are HM Revenue and Customs income data (earnings minus expenses and before tax) which include NHS and mixed NHS/private practice GMPs, but exclude GMPs who derived their income wholly from private practice. *GP Earnings and Expenses 2012-13* published by the Health and Social Care Information Centre, September 2014.

Table 2: GMP 2013-14 Earnings (United Kingdom)

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

[a] Comparisons made with X-Factor and pension adjusted DMS average GMP salary.

[b] GMPs working under a General Medical Services (GMS) contract.

[c] GMPs working under a Personal Medical Services (PMS) contract.

[d] GMPs working under either a GMS or PMS contract.

General Dental Practitioners[15]

37. DMS GDP average adjusted salary across a career based on 2015-16 pay scales is £110,482. However again the latest available NHS pay data are from 2013-14. Therefore DMS comparisons use 2013-14 data. Average adjusted DMS salary for 2013-14 was £108,306 (as for GMPs). In July 2015, there were 184 DMS GDPs.

38. The latest 2013-14 HM Revenue and Customs earnings data[16] include NHS and mixed NHS/private practice dentists, but exclude dentists who derived their income wholly from private practice. Income is split by classification[17] and contract type and illustrates the range of average earnings available in the civilian sector. Average net profits in 2013-14 were 1.2 per cent lower than those in 2012-13. Table 3 shows DMS GDP pay against a range of NHS dental comparators and highlights how DMS pay is ahead when compared against NHS performer only dentists but behind when providing-performers are chosen as the comparator group.

[15] Unless stated otherwise the data have been adjusted as set out in paragraph 31.

[16] Dental Earnings and Expenses, England and Wales, 2013-14 produced by the NHS Information Centre for health and social care.

[17] The main types are: Providing-performer dentists (previously practice owner, non-associate or first-party associate). They are under contract with the Primary Care Trust/Local Health Board, also performing dentistry; and Performer only dentists (previously second-party associate, assistant or locum). They work for a practice owner, principal or body corporate.

Table 3: GDP 2013-14 Average earnings (England & Wales)

Dental type	Contract	Population	Average Salary/ Net profit £	Change 12-13 to 13-14 %	Lead/Deficit of DMSa %
DMS			**108,306**	–	–
Providing-performer	GDS	3,700	106,500	2.4	1.7
	PDS	350	183,900	-0.8	-41.1
	Mixed GDS/PDS	300	141,300	-4.7	-23.4
	All	**4,350**	**115,200**	**1.0**	**-6.0**
Performer only	GDS	14,450	59,400	-0.7	82.3
	PDS	1,200	73,500	1.2	47.4
	Mixed GDS/PDS	1,450	61,800	2.3	75.3
	All	**17,150**	**60,600**	**-0.3**	**78.7**
All dentists	GDS	18,150	69,000	-1.0	57.0
	PDS	1,600	98,500	-0.7	10.0
	Mixed GDS/PDS	1,750	75,400	-0.5	43.6
	All	**21,500**	**71,700**	**-1.2**	**51.1**

[a] Comparisons made with X-Factor and pension adjusted DMS average GDP salary.

39. In its evidence, the BDA emphasised the decline in DOs' pay in real terms and stated that this would continue given the Government's announcement on continued public sector pay restraint. It stated that the value of real earnings for DOs had been eroded over the previous six years compared with the CPI that rose by 13.9 per cent.

Junior Doctors in Training

40. Junior doctors' base pay is supplemented in most cases by an out-of-hours band multiplier[18] which varies depending on hours worked and work intensity. The European Working Time Directive (48 hour or less working week) which came into force from August 2009 greatly influenced working patterns and has resulted in a steady reduction in the average pay supplement received by junior doctors in the NHS. Latest available data[19] from 2010 showed that over 80 per cent of posts received either a Band 1A (1.5 multiplier) or 1B (1.4 multiplier) supplement, with an average of 1.43.

41. Pay levels for DMS trainees remain ahead of junior doctors in the NHS (consultant pathway in receipt of an average supplement) at all points as shown in Table 4.

[18] An additional payment (introduced in December 2000) made on top of basic pay as remuneration for out of hours duties undertaken by hospital doctors in training. Total salary is calculated by applying a multiplier (ranging from 1.2 to 2.0) to basic salary.

[19] NHS Employers monitoring summary – March 2010. This was the last collection following notification from the Dept of Health that it was no longer required.

Table 4: Junior Doctors in Training 2015-16 pay comparisons

Age	DMS Scale	DMS Salary[a] £	NHS Scale	NHS Salary[b] £
24	OF 1 (1)	41,939	F1	31,299
25	OF 2 (1) Non-Acc	55,403	F2	38,821
26	OF 2 (2) Non-Acc	56,967	ST min	41,484
27	OF 2 (3) Non-Acc	58,540	ST 1	44,022
28	OF 2 (4) Non-Acc	60,126	ST 2	47,568
29	OF 2 (5) Non-Acc	61,702	ST 3	49,711
30	Non-Acc MO Level 1	66,641	ST 4	52,379
31	Non-Acc MO Level 2	70,533	ST 5	54,884
32	Non-Acc MO Level 3	74,449	ST 6	57,471
33	Non-Acc MO Level 4	75,618	ST 7	60,056
34	Non-Acc MO Level 5	76,788	ST 8	62,642
35	Consultant Level 5 (Entry)[c]	88,970	Consultant	75,249

[a] DMS salaries adjusted for X-Factor and pension.

[b] NHS salaries include an average Out of Hours band multiplier of 1.43 (adjusted for non-pensionability).

[c] A different pension adjustment is used for Consultants to Doctors in training.

RECOMMENDATIONS FOR 2016-17

Overall pay recommendations

42. Our pay recommendations aim to help MOD to recruit, retain and motivate sufficient capable personnel, and to ensure the maintenance of broad comparability with NHS counterparts. We take account of the economic conditions, the Government's evidence on public sector pay and evidence on the particular circumstances of Service MODOs.

43. When reviewing pay for MODOs, we consider information on pay levels relative to the NHS, and we believe our recommendations will maintain broad comparability on pay. We also take into account our recommendations for the main remit group, and the recommendations on NHS doctors' and dentists' pay by DDRB. In July 2015 DDRB published its Report containing recommendations on contract reform for junior doctors (and dentists) and observations on the pay-related proposals for reforming consultants' contracts. For 2016-17 DDRB was asked to make recommendations for all of the remit groups. For England and Northern Ireland it was asked to also consider the case for targeting to support recruitment and retention.

44. There was a deficit in trained MOs of 18 per cent against DMS20 requirement compared with 19 per cent a year earlier. The slight increase in the number of MOs was positive, but much of the improvement was due to the reduction in liability. Recruitment and retention initiatives will continue to be important as some specialties remain under-staffed and training pipelines are long. While outflow reduced, it remained a cause for concern. For DOs staffing was above DMS20 liability and MOD regarded the level of outflow as manageable as it moved towards meeting that target.

45. In the July 2015 Budget, the Government announced that its policy on public sector pay restraint would continue, and that it would fund public sector workforces for pay awards of one per cent a year for the four years from 2016-17. The impact of ongoing change in the move towards DMS20 structures and the transition from a campaign footing, meant that personnel remained uncertain over their future.

46. MOD proposed an increase in basic pay for MODOs in line with our recommendation for the main Armed Forces pay award. The BMA and the BDA both proposed an award above the rate of inflation, but did not state what that award should be. They also said that MODOs should receive at least the same award as the rest of the Armed Forces. Staffing data, our consideration of broad pay comparability between the NHS and DMS, including the recommendations made by DDRB, lead us to **recommend a one per cent across the board increase** this year. This is consistent with the approach we took for the main remit group.

47. As MOD had not seen DDRB's recommendations at the time it submitted its written evidence, it proposed that GMP and GDP Trainer Pay and Associate Trainer pay were held at existing levels. However, DDRB recommended an increase of one per cent for those in the NHS in its 2016 Report and we believe it appropriate to do likewise. We were told by the BMA and the BDA it could be difficult to persuade GMPs and GDPs to take on Trainer roles, and we consider that not increasing Trainer Pay could act as a further disincentive. There was a similar situation with CEAs. As DDRB recommended an increase of one per cent to consultants' CEAs and Distinction Awards, we consider it apposite to do the same. We therefore recommend an increase of one per cent to military CEAs and Distinction Awards. We consider that an award at this level should continue to support recruitment, retention, morale and motivation overall, and maintain broad comparability with NHS doctors and dentists.

Recommendation 1: We recommend the following changes from 1 April 2016:

- **A one per cent increase in basic pay to all ranks within the Medical and Dental Officer cadre.**
- **A one per cent increase in the value of military Clinical Excellence Awards.**
- **A one per cent increase in General Medical Practitioner and General Dental Practitioner Trainer Pay and Associate Trainer Pay.**

The recommended pay scales are at Appendix 1.

Golden Hello

48. MOD runs a 'Golden Hello' scheme which aims to encourage the recruitment of direct entrant accredited GMPs and consultants. It proposed to again hold the value of the payment at £50,000. Last year, we endorsed a proposal to expand eligibility of the scheme to all cadres with a DMS20 liability above ten where the deficit was 15 per cent or higher. This year, MOD proposed to expand the scheme to *all* consultant cadres where the projected staffing deficit in 2018 is ten per cent or higher against the DMS20 requirement, whatever their size. Even though very few personnel take up the Golden Hello, MOD told us that it was worth retaining as it represented good value for money. We regard the proposal as sensible and therefore endorse it. MOD intends to re-examine the amount on offer following the outcome of negotiations on NHS consultants' pay.

Recommendation 2: We recommend the retention of the Medical Officer 'Golden Hello' scheme, and its expansion to include all consultant cadres where the projected staffing deficit in 2018 is ten per cent or higher.

Cost of our pay recommendations

49. We estimate that the cost of our pay recommendations for 2016-17 is £2.2 million (including the Employers' National Insurance Contribution and superannuation liabilities).

LOOKING AHEAD

50. The Strategic Defence and Security Review published in November 2015 (SDSR15) set out a strategy for the Armed Forces for the duration of this Parliament. It announced the intention to increase spending on Defence and develop new capabilities. However, along with the rest of the Armed Forces, some uncertainty remains for Service MODOs and their families. The cessation of combat operations in Afghanistan, restructuring and reductions in staffing numbers under DMS20, the increasing civilianisation of medical and dental services, and forthcoming changes under NEM have all contributed to this. Staffing shortfalls in certain cadres and increasing numbers of personnel being held at high readiness have led to some personnel feeling under pressure. A perceived worsening of the military offer, including pension changes, and proposed changes to ways of working in the NHS all have the potential to impact on the recruitment, retention and morale of DMS personnel.

51. Both VO and overall outflow for MOs reduced over the last year, although the rates are still considered to be high. SG acknowledged that there was no room for complacency on staffing levels and that shortfalls in certain specialities could impact on deployable capability. We are pleased that SG receives quarterly returns from the single Services giving the reasons why MOs choose not to serve a full career, which are fed into the DMS Board. We hope that SG uses this information to address retention issues. We note that the main reason given for leaving is to provide greater family stability. SDSR15 announced the intention to "ensure that a career in the Armed Forces can be balanced better with family life" and we understand MOD has various work strands in place building on the NEM programme to try to achieve this.

52. We stated in our 2015 Report the importance of MOD exploring the options for part-time and flexible working for MODOs to encourage recruitment and retention, particularly of female personnel. The BMA, the BDA and ourselves see the adoption of flexible and part-time working practices as fundamental to the sustainability of DMS. We are pleased that, under the NEM, MOD has introduced additional options for flexible working in the Armed Forces and that a small pilot is being run for MOs to complete their specialist training on a part-time basis. Work is also underway to develop a 'flexible engagements system' which will allow personnel to temporarily adjust their availability for deployment to suit their personal circumstances. MOD's evidence seemed to suggest that because VO rates were similar for male and female MOs, there was potentially not as much demand for the option of part-time or flexible working from MODOs. However, SG confirmed that all the places on the pilot course had been taken by women. As stated in our 2015 Report, the provision of part time/flexible working could assist with the recruitment and retention of all staff who may wish to spend part of their time working for Defence and part of their time working for the NHS. Flexible working options are available to NHS staff, many of whom work alongside MODOs. We urge MOD and SG to work closely with the BMA and the BDA to look at how the options for part-time and flexible working, and the smooth transition between Regular and Reserve service (and vice-versa), can be applied and possibly extended to aid the recruitment and retention of MODOs.

53. Despite a larger proportion of MODOs being from a BAME background than in the rest of the military, the majority of MODOs are white males. The BMA, the BDA, and SG acknowledged the importance of being able to recruit more female personnel and those from BAME backgrounds, particularly considering the demographics of medical students. We are concerned, however, that MOD's evidence suggested that increased numbers of female and BAME individuals in medical school would automatically trickle down into DMS without any pro-active measures needing to be taken, although there is little evidence of this happening so far. As stated in our 2015 Report, work needs to continue to engage with members of BAME communities to build trust and improve understanding of the potential opportunities of serving in the Armed Forces and increasing the numbers who might consider a career in the DMS. MOD also needs to ensure there is an inclusive culture in the Armed Forces where individuals from all backgrounds are able to reach their full potential. We suggest MOD and SG work together with the BMA and the BDA to develop strategies and initiatives to increase the representation, recruitment, retention and progression of women and BAME individuals in DMS, both the Regulars and Reserves. In the future we would like to receive data showing trends in representation of these groups to enable us to more accurately measure progress in this area.

54. DMS makes more use of Reserves than other parts of the Armed Forces and DMS20 will result in some cadres, such as neurology and urology, being staffed entirely by Reserves. The SDSR confirmed that Reserves will continue to play a vital role in the Armed Forces and that the target to grow the Reserve Force to a total of 35,000 by 1 April 2019 remains. The BMA told us again this year that DMS20 targets for Reserves were unsustainable and unachievable and MOD acknowledged that recruitment and retention of Reserves would be challenging. We note that there are several remunerative and non-remunerative measures in place to try to increase Reserve recruitment. MOD should continue to monitor the effectiveness of these measures and continue to build on the good progress it has made by working in partnership with the NHS to increase interest in the Reserves from the NHS workforce. A review into the feasibility of future shape of the Medical Reserve as suggested by the BMA, would appear to be worthwhile. However, as this is outside our remit, we suggest that SG and the BMA work together to initiate this review.

55. We are supportive of BMA and BDA's suggestion that mandatory professional body fees (PBFs) for doctors and dentists should be reimbursed. We strongly suggest MOD gives this proposal serious consideration. It will pay such fees for Allied Health Professionals not on bespoke pay spines, from 1 April 2016, and already does so for the civilian doctors and dentists it employs. We believe the reimbursement of mandatory PBFs would be a cost effective way for MOD to demonstrate its support of MODOs and could lead to an improvement in morale.

56. It is unclear how developments in the NHS, particularly in relation to seven-day working, the implementation of the new junior doctors' contracts and the ongoing negotiations on the consultants' contracts will affect DMS staffing. It could restrict the availability of Reserves to complete their training at the weekends or it could make the terms and conditions in the military seem more attractive than the NHS. We wish to be kept informed of any effect this has on the recruitment and retention of both Regular and Reserve MODOs.

57. MOD plans to carry out a detailed pay comparison between MODOs and their NHS counterparts once the current NHS pay negotiations are concluded. As pay comparability is part of our remit, we will be very interested to see the outcome of this work.

58. It is encouraging to see that response rates for the DMSCAS survey increased from 33 per cent in 2014 to 41 per cent in 2015 and that the results show an increase in MODOs' morale. We encourage DMS to continue to ensure staff understand the importance of

completing these surveys, that chains of command actively encourage staff to engage, and that action is taken to make participation as easy as possible. The use of best practice technology and timely feedback on planned action should help increase participation rates and enhance the value and standing of this survey among DMS staff.

59. The ability to be able to recruit, retain and motivate sufficient numbers of highly skilled MODOs for both Regular and Reserve Service will be crucial to the future sustainability of the DMS. We look forward to receiving further details on how the future delivery of military healthcare will be assured.

60. With new leadership in both the BMA and DMS there is an opportunity to develop a more proactive and constructive dialogue between the interested parties. This will be in their mutual interest and will help to achieve the stretching targets in both the Regulars and Reserves that DMS face in the near future.

John Steele	Ken Mayhew
Brendan Connor	Judy McKnight
Tim Flesher	Vilma Patterson
Paul Kernaghan	Jon Westbrook

March 2016

APPENDIX 1

1 April 2015 and 1 April 2016 military salaries including X-Factor

All salaries are rounded to the nearest £.

Table 1.1: Recommended annual salaries for accredited consultants (OF3-OF5)

Increment level	Military salary £	
	1 April 2015	1 April 2016
Level 32	*135,560*	136,915
Level 31	*135,297*	136,650
Level 30	*135,038*	136,388
Level 29	*134,771*	136,119
Level 28	*134,512*	135,857
Level 27	*133,991*	135,330
Level 26	*133,469*	134,804
Level 25	*132,947*	134,277
Level 24	*131,681*	132,998
Level 23	*130,419*	131,723
Level 22	*127,815*	129,093
Level 21	*126,365*	127,629
Level 20	*124,920*	126,169
Level 19	*123,470*	124,704
Level 18	*122,029*	123,250
Level 17	*120,201*	121,403
Level 16	*118,382*	119,566
Level 15	*116,772*	117,940
Level 14	*115,158*	116,310
Level 13	*113,553*	114,688
Level 12	*111,943*	113,062
Level 11	*108,405*	109,489
Level 10	*104,874*	105,923
Level 9	*101,344*	102,357
Level 8	*98,209*	99,191
Level 7	*95,066*	96,017
Level 6	*91,919*	92,838
Level 5	*88,970*	89,860
Level 4	*87,824*	88,702
Level 3	*86,654*	87,521
Level 2	*82,777*	83,605
Level 1	*78,940*	*79,729*

Table 1.2: Recommended annual salaries for accredited GMPs and GDPs (OF3-OF5)

Increment level	Military salary £	
	1 April 2015	1 April 2016
Level 35	*126,479*	127,744
Level 34	*126,083*	127,344
Level 33	*125,780*	127,038
Level 32	*125,287*	126,540
Level 31	*124,891*	126,140
Level 30	*124,491*	125,736
Level 29	*124,184*	125,426
Level 28	*123,695*	124,932
Level 27	*123,291*	124,524
Level 26	*122,895*	124,124
Level 25	*122,491*	123,716
Level 24	*122,095*	123,316
Level 23	*121,691*	122,908
Level 22	*119,831*	121,029
Level 21	*119,364*	120,557
Level 20	*118,809*	119,997
Level 19	*118,230*	119,412
Level 18	*117,657*	118,833
Level 17	*117,078*	118,249
Level 16	*116,505*	117,670
Level 15	*115,993*	117,153
Level 14	*113,864*	115,003
Level 13	*113,357*	114,490
Level 12	*112,849*	113,977
Level 11	*112,264*	113,386
Level 10	*111,682*	112,799
Level9	*111,097*	112,208
Level8	*108,960*	110,049
Level7	*108,379*	109,462
Level6	*106,897*	107,966
Level5	*105,406*	106,460
Level4	*103,925*	104,964
Level3	*102,434*	103,459
Level2	*100,310*	101,313
Level1	*99,614*	100,610

Table 1.3: Recommended annual salaries for non-accredited Medical Officers (OF3-OF5)

Increment level	Military salary £	
	1 April 2015	1 April 2016
Level 19	*91,095*	92,006
Level 18	*90,174*	91,076
Level 17	*89,253*	90,146
Level 16	*88,328*	89,212
Level 15	*87,505*	88,380
Level 14	*86,694*	87,561
Level 13	*85,875*	86,734
Level 12	*85,056*	85,907
Level 11	*84,241*	85,084
Level 10[a]	*83,426*	84,260
Level 9	*82,444*	83,268
Level 8	*80,790*	81,597
Level 7	*79,131*	79,922
Level 6	*77,953*	78,733
Level 5	*76,788*	77,556
Level 4	*75,618*	76,375
Level 3	*74,449*	75,194
Level 2	*70,533*	71,238
Level 1	*66,641*	67,308

[a]Progression beyond Level 10 only on promotion to OF4.

Table 1.4: Recommended annual salaries for accredited Medical and Dental Officers (OF2)

Increment level	Military salary £	
	1 April 2015	1 April 2016
Level 5	*75,386*	76,139
Level 4	*73,856*	74,595
Level 3	*72,331*	73,054
Level 2	*70,798*	71,506
Level 1	*69,269*	69,962

Table 1.5: Recommended annual salaries for non-accredited Medical and Dental Officers (OF2)

Increment level	Military salary £	
	1 April 2015	1 April 2016
Level 5	*61,702*	62,319
Level 4	*60,126*	60,727
Level 3	*58,540*	59,126
Level 2	*56,967*	57,537
Level 1	*55,403*	55,957

Table 1.6: Recommended annual salaries for Medical and Dental Officers: OF1 (PRMPs)

	Military salary £	
	1 April 2015	1 April 2016
OF1	*41,939*	42,358

Table 1.7: Recommended annual salaries for Medical and Dental Cadets

Length of service	Military salary £	
	1 April 2015	1 April 2016
after 2 years	*19,486*	19,681
after 1 year	*17,583*	17,759
on appointment	*15,689*	15,846

Table 1.8: Recommended annual salaries for Higher Medical Management Pay Spine: OF6

Increment level	Military salary £	
	1 April 2015	1 April 2016
Level 7	*140,572*	141,977
Level 6	*139,397*	140,791
Level 5	*138,227*	139,609
Level 4	*137,044*	138,414
Level 3	*135,865*	137,224
Level 2	*134,699*	136,046
Level 1	*133,516*	134,851

Table 1.9: Recommended annual salaries for Higher Medical Management Pay Spine: OF5

Increment level	Military salary £	
	1 April 2015	1 April 2016
Level 15	*131,705*	133,022
Level 14	*130,967*	132,277
Level 13	*130,219*	131,522
Level 12	*129,475*	130,770
Level 11	*128,734*	130,022
Level 10	*127,990*	129,270
Level 9	*127,237*	128,509
Level 8	*126,496*	127,761
Level 7	*125,752*	127,009
Level 6	*124,637*	125,884
Level 5	*123,526*	124,761
Level 4	*122,403*	123,627
Level 3	*121,292*	122,505
Level 2	*120,181*	121,383
Level 1	*119,059*	120,249

DMS Trainer Pay

GMP and GDP Trainer Pay	£7,981
GMP Associate Trainer Pay	£3,992

DMS Distinction Awards

A+	£61,075
A	£40,718
B	£16,287

DMS National Clinical Excellence Awards

Bronze	£19,048
Silver	£29,967
Gold	£41,377
Platinum	£58,491