Armed Forces' Pay Review Body

Service Medical and Dental Officers

Supplement to the Thirty-Eighth Report – 2009

Chairman: Professor David Greenaway

Cm 7569
£14.35

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Presented to Parliament by the Prime Minister and Secretary of State for Defence by Command of Her Majesty

May 2009

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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:

Professor David Greenaway (Chairman)[1]
Robert Burgin
Alison Gallico
Dr Peter Knight CBE
Professor Derek Leslie
Air Vice Marshal (Retired) Ian Stewart CB

The secretariat is provided by the Office of Manpower Economics.

[1] Professor Greenaway is also a member of the Review Body on Senior Salaries.

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GLOSSARY OF TERMS

AFPS Armed Forces' Pension Scheme

BDA British Dental Association

BMA British Medical Association

CEA Clinical Excellence Award

CPI Consumer Prices Index

DDS Defence Dental Services

DO Dental Officer

DMS Defence Medical Services

DDRB Review Body on Doctors' and Dentists' Remuneration

GAD Government Actuary's Department

GDP General Dental Practitioner

GDS General Dental Services

GMP General Medical Practitioner

GMS General Medical Services

HMM Higher Medical Management

HMRC HM Revenue and Customs

JPA Joint Personnel Administration

MO Medical Officer

MOD Ministry of Defence

NHS National Health Service

PA Programmed Activity

PDS Personal Dental Services

PMS Personal Medical Services

PRMP Pre-Registration Medical Practitioner

RPI Retail Prices Index

TSC Technical Steering Committee

ARMED FORCES' PAY REVIEW BODY
2009 DMS REPORT – SUMMARY

Key recommendations

- **A 1.5 per cent increase for all DMS Medical and Dental Officers (and all DMS Reserve equivalents);**
- **A 1.5 per cent increase to the value of DMS National Clinical Excellence Awards and Distinction Awards. The numbers of DMS Awards should be increased to 38; and**
- **A 1.5 per cent increase to DMS Trainer Pay and GMP Associate Trainer Pay.**

Evidence for this Report

Our terms of reference require us to examine a range of evidence on the Defence Medical Services. We assess evidence on economic circumstances, the Government's public sector pay policy, manning, recruitment and retention, pay comparisons with the NHS, and the recommendations for NHS doctors and dentists from the DDRB. We receive written and oral evidence from the Ministry of Defence and the British Medical and Dental Associations. These provide an extensive evidence base on which to draw our recommendations.

Manning, recruitment and retention

We are encouraged by the signs of improvement in DMS manning. At 1 April 2008, the trained strength of Medical Officers was 70 per cent of the trained requirement – an increase of 41 trained Medical Officers. Trained Dental Officer manning was 93 per cent of requirement. Outflow decreased to 4.3 per cent for Medical Officers and to 4.4 per cent for Dental Officers – almost all of the decrease was driven by reduced Voluntary Outflow. Despite these improvements, specialty shortages continued at significant levels – Psychiatrists (51 per cent), Anaesthetists (48 per cent), Emergency Medicine (43 per cent), General Surgeons (38 per cent) and General Medical Practitioners (18 per cent). The BMA/BDA pointed to a 55 per cent shortage of those available to deploy. DMS recruitment also failed to meet targets for Medical and Dental Cadets but recruitment of Direct Entrant Medical Officers increased. The DMS Continuous Attitude Survey indicates general satisfaction with DMS pay. While pay is important to DMS retention, MOD and the BMA/BDA agreed that the frequency of deployment was an additional factor.

Pay comparability

Improving NHS earnings data and general agreement between the parties on the comparators enable us to make a much clearer assessment of DMS pay comparability. Our overall conclusion is that broad comparability is being achieved for all DMS groups and we agree with the parties that the driver for pay movements should be recommendations from DDRB. For DMS Consultants, the parties agreed on the composition of the NHS comparator but were unable to agree on the methodology for incorporating the value of NHS Local Clinical Excellence Awards. We have concerns with both of the proposed methodologies and we will monitor the data showing the NHS distribution of these Awards in future comparability assessments. For GMPs, MOD and the BMA/BDA agree that the NHS comparator should be all General and Personal Medical Services' GMPs. The latest NHS earnings data suggests that DMS GMPs were behind the NHS in 2006-07 but subsequent NHS increases have been subdued. We therefore wish to await definitive data before assessing the gap and we will consult with

the parties on the choice of comparator. Evidence on GDPs pointed to improved availability of NHS earnings data but still showed an unclear picture on commitment to NHS and private practice. We agree with the parties to continue the pay link between DMS GMPs and GDPs. DMS Junior Doctors' pay is comparable with the NHS.

Recommendations

Our recommendations draw on prevailing economic circumstances, the improving position of DMS manning, our view that broad comparability with the NHS is being achieved and the NHS pay recommendations from DDRB. We recommend a 1.5 per cent increase for all DMS Medical and Dental Officers (and all DMS Reserve equivalents) and all other DMS pay elements within our remit. We also recommend an increase in the number of DMS National Clinical Excellence Awards and Distinction Awards to match the proportions available in the NHS. Our recommendations are consistent with the Government's public sector pay policy and MOD's affordability evidence. We estimate that our recommendations add £3.0 million to the DMS paybill.

Looking ahead

We look forward to sustained improvement in DMS manning. We have commented extensively in previous reports on the need for DMS pay and career reform. In this regard, we note MOD's challenging agenda to improve DMS careers. Retention of experienced DMS personnel remains crucial to delivering operational capability. We applaud MOD's success in delivering support to operations through creative solutions including use of DMS Reserves, configuring services with other nations and using contract medical staff. This could be a model for the future which takes some pressure off the DMS manning deficit. We also note MOD's efforts to improve DMS management information. This will help consideration of how we approach DMS pay comparability and handling the value of DMS pensions.

INTRODUCTION

1. In this report we set out recommendations on pay in the Defence Medical Services (DMS) from 1 April 2009 and the evidence base which supports them. The background to our recommendations is one of rapidly changing economic conditions, continuing DMS manning shortages and pressures on the DMS from enduring operational commitments. Our aim, within our terms of reference, is to maintain broad pay comparability with National Health Service (NHS) doctors and dentists and to enable the DMS to recruit, retain and motivate personnel. We take account of a wide evidence base, including the Government's policy on public sector pay, Ministry of Defence (MOD) evidence on manning, recruitment and retention, our visits to DMS personnel and awards for NHS doctors and dentists recommended by the Review Body on Doctors' and Dentists' Remuneration (DDRB).

2008 recommendations and Government response

2. Our recommendations for 2008, accepted in full by the Government on 22 May 2008, were:

    - A 2.2 per cent increase for DMS Consultants, Higher Medical Management staff, Non-Consultant Career Grades, accredited OF2s, Junior Doctors in training (including GMP Registrars) and Cadets, plus all DMS Reserve equivalents;
    - A 3.7 per cent increase for DMS General Medical and Dental Practitioners (GMPs and GDPs) at OF3 and above (and DMS Reserve equivalents);
    - The parties to present joint proposals on targeting the value of NHS Local Clinical Excellence Awards (CEAs) within DMS Consultants' pay for our 2009 Report;
    - An increase in X-Factor from 13 to 14 per cent with revised taper arrangements; and
    - A 2.2 per cent increase to the value of DMS National CEAs, Distinction Awards and DMS Trainer Pay, and the introduction of GMP Associate Trainer Pay.

DMS AND NHS DEVELOPMENTS

DMS developments

3. MOD's evidence sets out a series of measures aimed at strengthening DMS management and reported on progress with non-remunerative initiatives to address manning shortfalls. MOD's DMS 'Top Structures – Next Steps' project was described as a 'vital transformation programme' which will take forward development of the functions, structure, leadership, responsibilities and outputs of a Joint Medical Service. Extensive developments are planned to the Royal Centre for Defence Medicine and Whittington Barracks, Lichfield which would become the military home of the DMS providing joint and integrated medical support for the Armed Forces by 2014. Changes to the DMS structure would, through Joint Command and single-Service leads, contribute to developing DMS careers and play a role in supporting manning and retention.

4. The Surgeon General and his Senior Executive Team were developing a Strategic Plan for the DMS to ensure delivery of healthcare, health advice and operational medical capability. The Defence Health Change Programme also continued to adapt to future requirements through to 2015. MOD's partnership with the Department of Health has developed to include specifically the Armed Forces, their dependents and veterans in the

NHS Operating Framework, contracts with NHS regional centres for a surge capability in prosthetics, NHS Support to Operations (which allowed NHS clinicians to deploy without having to join the Regular or Reserve forces) and closer integration of training. MOD and the Department of Health have also agreed to recognise DMS Reserve Consultants' experience as counting towards eligibility for NHS Clinical Excellence Awards.

5. We have commented in previous reports on the need to make progress on flexible working in the light of the increasing feminisation of the medical and dental workforces. MOD reviewed current flexible arrangements under its Terms and Conditions of Service Review. Resulting actions included more effective communication to spread current best practice and tri-Service agreement to deliver part-time working by enabling Regular personnel to move to the Reserves to complete an Additional Duties Commitment.

NHS developments

6. We keep abreast of developments in the NHS which are of significance to the DMS and which influence our approach to broad pay comparability. We note that:

- NHS Consultants, GMPs, GDPs (in England and Wales) and salaried dentists (in England and Wales) have all been working under new contracts since 2000. New contractual arrangements are expected to be in place soon for salaried dentists in Scotland and new arrangements are under active consideration for salaried dentists in Northern Ireland. Northern Ireland is also in the latter stages of introducing a new contract for GDPs. Following agreement at ballot, new contractual arrangements are being implemented for specialty doctors and associate specialist grades (formerly non-consultant career grades). Negotiations for new contractual arrangements for doctors and dentists in hospital training are due to commence in the near future;
- Recruitment and retention of NHS doctors and dentists were satisfactory overall according to the DDRB, with only minor, local shortages in a few categories;
- On motivation and morale the results from the NHS Staff Survey suggested more dissatisfaction than DDRB had expected. However, when the NHS results were benchmarked with those from the wider economy, the findings indicated that NHS staff were generally at least as satisfied as other employees; and
- The GMP trainers' grant is likely to be moved to a tariff-based system, and a pilot study considering the options for funding is underway.

EVIDENCE FOR THIS REPORT

Evidence base

7. We draw on an extensive evidence base to inform our recommendations and conclusions comprising:

- The Government's evidence on its public sector pay policy and the economic environment as submitted to all Pay Review Bodies;
- Our assessment of prevailing economic conditions;
- Recommendations on NHS doctors' and dentists' pay by the DDRB;
- MOD's written evidence on affordability and DMS manning, recruitment and retention;
- The British Medical and Dental Associations' written evidence including their pay proposals;

- Oral evidence from the Surgeon General, Deputy Chief of Defence Staff (Health) and from the BMA/BDA;
- Research into DMS and NHS pay comparisons undertaken by the Office of Manpower Economics; and
- Our visits to DMS personnel during 2008, in the UK and overseas, and on operations in Afghanistan and Iraq.

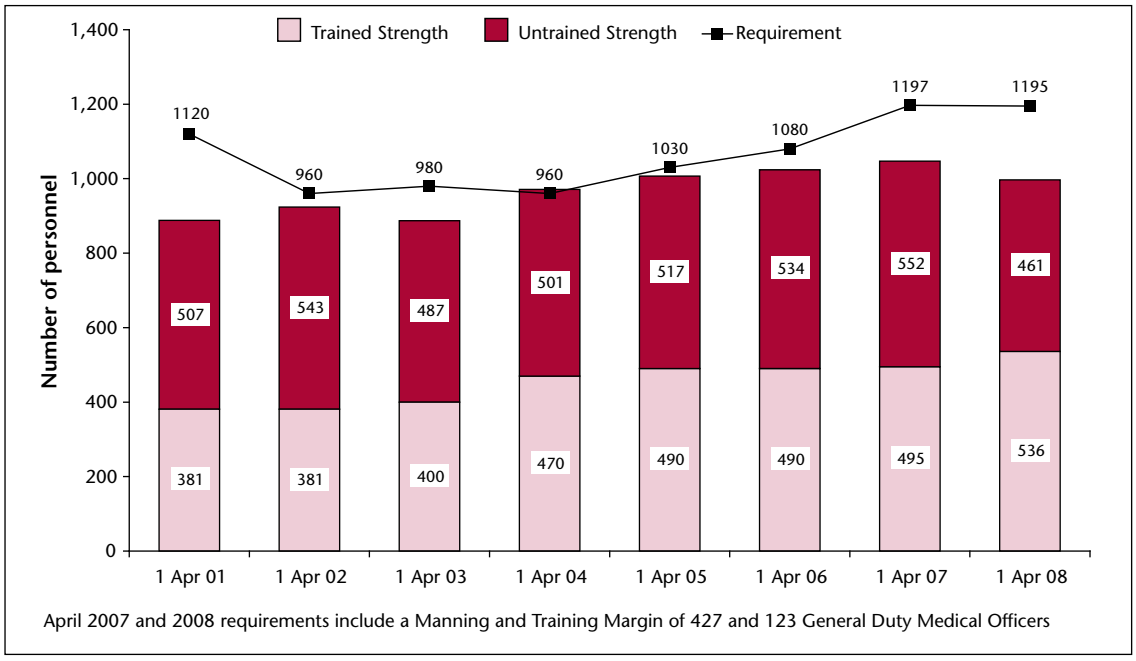
8. We are grateful to the MOD and the Services for arranging our 2008 visits and for the inclusion of DMS personnel. We visited the Royal Centre for Defence Medicine, Birmingham and we also met DMS Regular and Reserve personnel as part of our visits to other UK and overseas units, including in Iraq, Afghanistan and Cyprus. We are grateful to those DMS personnel across all ranks who participated in our visits. A full list of AFPRB visits can be found in our 2009 Report (Appendix 4)[2] for the main remit group.

DMS manning evidence

9. At 1 April 2008 there was a requirement for 1,195 Medical Officers (MOs), including 123 General Duties Medical Officers, and 261 Dental Officers (DOs).

10. At 1 April 2008 there were 536 trained MOs, a deficit of 30 per cent against the trained requirement of 768[3]. However, compared with a year earlier this represents an increase of 41 MOs. There were a further 461 MOs in training (Chart 1).

Chart 1: Strength and deficit/surplus of Medical Officers 2001-2008



April 2007 and 2008 requirements include a Manning and Training Margin of 427 and 123 General Duty Medical Officers

11. There were 243 trained DOs, 7 per cent below the requirement of 261. There were a further 7 DOs in training (Chart 2).

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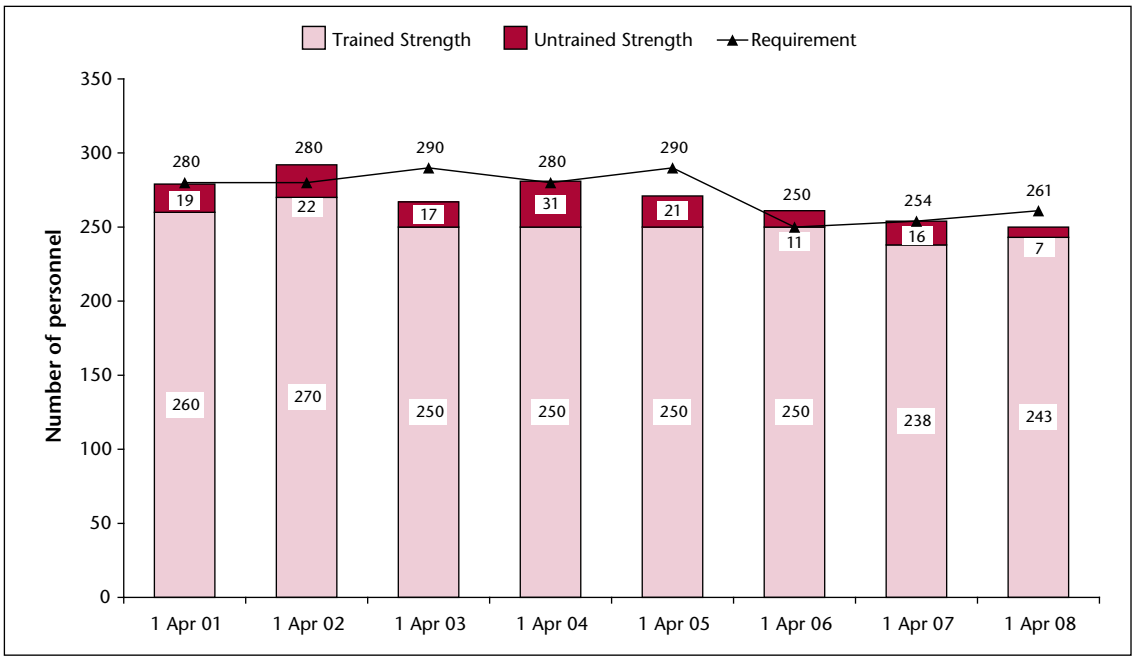
[2] *Armed Forces' Pay Review Body Thirty-Eighth Report – 2009*, www.ome.uk.com

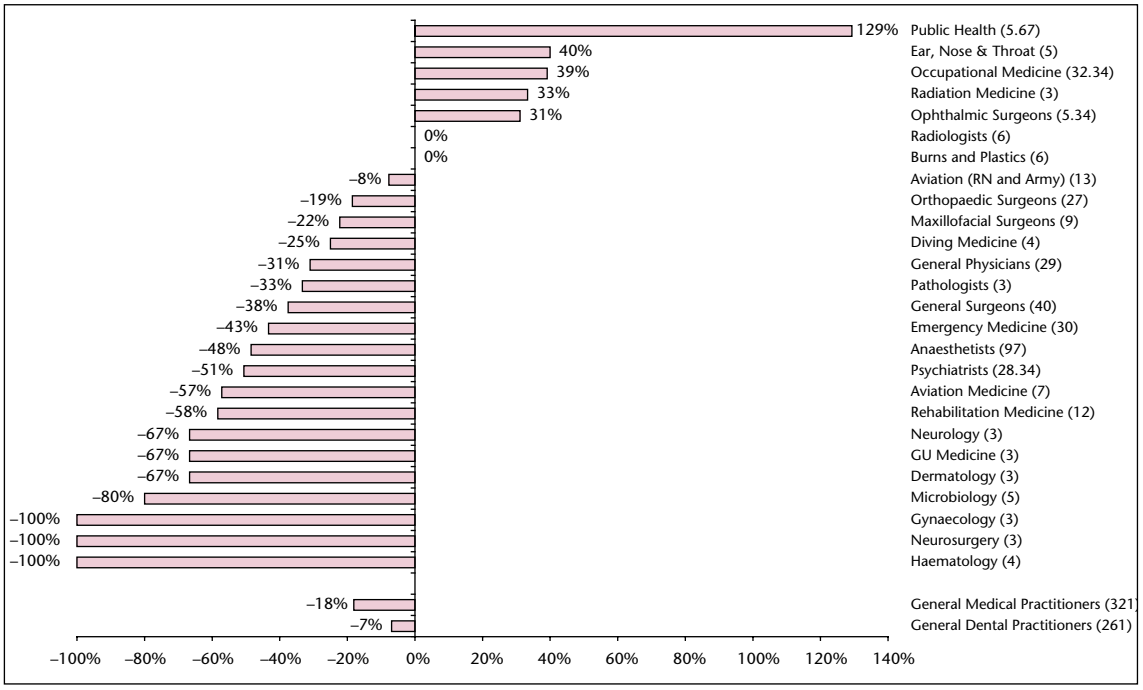
[3] The overall requirement for Medical Officers is made up of a trained requirement of 768 and a Manning and Training Margin of 427.

Chart 2: Strength and deficit/surplus of Dental Officers 2001-2008



12. Chart 3 shows trained manning against requirement by specialty at April 2008. Although overall manning levels had improved, there were still significant shortfalls in a number of key specialties. These included Psychiatrists (51 per cent), Anaesthetists (48 per cent), Emergency Medicine (43 per cent) and General Surgeons (38 per cent). There was also an 18 per cent deficit of GMPs. In addition, not all of the trained strength is able to deploy in specialty, some being medically downgraded and others filling Command and Staff posts. The BMA/BDA highlighted that, after accounting for those unable to deploy, the DMS manning deficit had grown to 55 per cent. Both the MOD and BMA/BDA expected these significant shortfalls to continue for a number of years.

Chart 3: Deficit/surplus of trained DMS Personnel, against requirement, by specialty, 1 April 2008



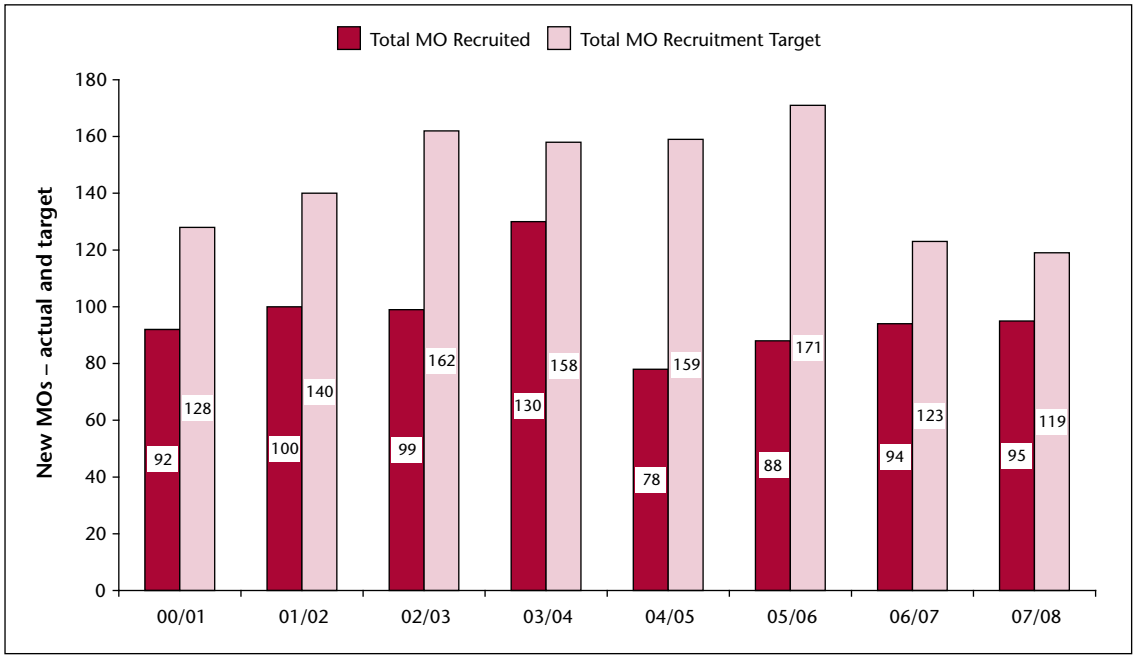
The figure in brackets after the specialty indicates its regular manpower requirement e.g. the requirement for Radiologists is 6.

Recruitment evidence

13. DMS recruitment continued to fall short of targets for both MOs and DOs. In the year to 31 March 2008, 95 MOs were recruited, one higher than the previous year and the highest number since 2003-04. However, this represented just 80 per cent of the target of 119. There was more success recruiting Direct Entrants (30 were recruited against a target of 34) than Cadets (65 recruited against a target of 85). 18 DOs were recruited: this represented a fall from 27 in 2006-07 and was just 60 per cent of the target. Targets for both Direct Entrants and Cadets were missed by over a quarter in each case.

14. Since its introduction in 2002, 44 GMPs and 13 Consultants have been recruited through the Golden Hello scheme, including 4 GMPs and 3 Consultants since April 2007. Although the numbers recruited using this method are lower than expected, MOD continued to view the Golden Hello scheme as a useful and cost effective means of recruiting Consultants and GMPs who become deployable within six months of entry.

Chart 4: Medical Officer (MO) recruitment 2000-01 to 2007-08



Retention evidence

15. The retention data provided by MOD showed:

- Overall Outflow of MOs decreased during 2007-08 to 43, 4.3 per cent of total strength and 8.0 per cent of trained strength. This compares with 53 in 2006-07, or 5.1 per cent of total strength and 10.7 per cent of trained strength;
- The reduction in the Overall Outflow of MOs was all accounted for by a fall in Voluntary Outflow which fell to 15 (1.5 per cent of total strength and 2.8 per cent of trained strength) in 2007-08 from 26 the previous year (2.5 per cent of total strength and 5.3 per cent of trained strength); and
- Overall Outflow of DOs decreased during 2007-08 to 11, 4.5 per cent of trained strength. This compares with 24 in 2006-07, 10.1 per cent of trained strength. As with MOs the reduction in Overall Outflow was accounted for by a reduction in Voluntary Outflow (just 2 DOs in 2007-08, compared with 15 in 2006-07).

16. The DMS Continuous Attitude Survey asked personnel whether they agree or disagree with a range of statements. The 2008 results below (2007 in brackets) identified some significant year on year changes for GMPs in relation to how fair they felt their pay was. They showed:

- 55 per cent (59) of GDPs[4], 49 per cent (19) of GMPs and 24 per cent (25) of Consultants felt their pay was fair considering their duties and responsibilities;
- 43 per cent (43) of GDPs, 3 per cent (-19) of GMPs and 2 per cent (7) of Consultants felt their pay was reasonable compared with people in similar jobs in the NHS and other organisations;
- 67 per cent (71) of GDPs, 60 per cent (42) of GMPs and 47 per cent (51) of Consultants felt their pay was reasonable compared with other professionally qualified Service personnel;
- 52 per cent (46) of Consultants, 44 per cent (47) of GDPs and 29 per cent (33) of GMPs were satisfied with their current post;
- 28 per cent (28) of GDPs, 14 per cent (6) of Consultants and 2 per cent (-8) of GMPs felt they were able to strike the right balance between work and home life;
- 55 per cent (50) of GDPs, 54 per cent (63) of GMPs and 49 per cent (50) of Consultants felt that deploying too frequently was a major factor that would lead to premature retirement; and
- 73 per cent (75) of GMPs, 61 per cent (62) of GDPs and 53 per cent (59) of Consultants felt that deploying for too long was a major factor that would lead to premature retirement.

Operational commitments

17. MOD confirmed that supporting operations in both Iraq and Afghanistan, along with other permanent overseas commitments, continued to stretch both Consultant and GMP cadres. In the 12 months to January 2009, DMS support to operational commitments was sustained only by drawing on a combination of DMS Reserves, contractors and multi-national partners. DMS Reserves played a substantial role in medical deployments, providing up to 70 per cent of the manning in Field Hospitals at Camp Bastion. One-third of secondary care doctors in Iraq and Afghanistan were Volunteer Reserves. Reserve deployment was planned so that a TA Field Hospital would deploy once every five years.

18. MOD described as 'fragile' the ability to continue such a tempo and commitment. To provide operational support for niche specialties, MOD used contractors and had introduced a new initiative with the NHS, 'NHS Support To Operations', to deploy NHS clinicians without them being required to join the Regular or Reserve forces. MOD also sought additional flexibility by using Specialist Registrars in their last two years of training in some Consultant disciplines, but this approach could delay their qualification. Investment in multi-national assistance continued with Denmark providing a complete Hospital Squadron in Afghanistan against a UK commitment. In oral evidence, MOD considered that this mixed approach was appropriate for sustained operations, such as those in Iraq and Afghanistan.

19. The BMA/BDA reported that the challenges associated with manning shortfalls were compounded by the continued high operational tempo.

[4] 72 per cent of GDPs agreed or strongly agreed that considering their duties and responsibilities their pay was fair while 17 per cent disagreed or strongly disagreed (a positive balance of 55 per cent – excepting neutral responses).

Reserve Medical and Dental Officers

20. We note the continuing reliance upon DMS Reserves in delivering operational capability. With regard to Reserves' pay and conditions, the BMA/BDA made two suggestions. First, that Reserves should be allowed to choose between receiving their annual Training Bounty tax-free or opting for their pay to be pensionable. Second, that the BMA/BDA intended to explore the extension of Reserves' non-pay benefits e.g. eligibility to apply for a railcard like their Regular colleagues. These are matters outside our remit and therefore should be referred to MOD as the employer.

Government's approach to public sector pay and affordability

21. The Government's evidence for our main remit group emphasised that the macroeconomic context for pay decisions had substantially changed. It noted that economic growth was forecast to be negative in 2009 before picking up in 2010 and 2011. The Government added that CPI inflation had fallen by the end of 2008 and that the average of independent forecasts put CPI inflation at 1.7 per cent by the end of 2009. While the Government considered that the UK had a strong economic foundation from which to handle the challenges, it emphasised that decisions taken in the next year would be critical in determining the UK response and who would bear the inevitable cost of the adjustment.

22. Against this economic background, the Government reiterated its policy that public sector pay awards should help recruit and retain quality workforces, be affordable, offer value for money and be guided by the CPI Inflation target of 2 per cent. It endorsed the Bank of England view that pay restraint across the economy would be key to low and stable inflation. The Government added that Pay Review Body workforces, making up 40 per cent of the public sector, played an important role in setting the direction of public sector pay. It considered the relative attractiveness of employment in the public sector would strengthen further as labour market conditions worsened.

23. The Government's evidence stressed that expenditure should stay within the Comprehensive Spending Review settlement which, overall, allowed for spending growth of 1.9 per cent per annum in real terms between 2008-09 and 2010-11. The Government regarded this as the tightest settlement in nearly a decade.

DDRB recommendations for 1 April 2009[5]

24. DDRB's 2009-10 recommendations took account of an unexpectedly sharp downturn in the economy and overall satisfactory recruitment and retention of NHS doctors and dentists. Recommendations relevant to DMS groups include the following:

- An increase of 1.5 per cent to the national salary scales for doctors and dentists, the GMP Trainer Grant and GMP Educators' pay scales, CEAs, Distinction Awards and Discretionary Points;
- An increase of 2.29 per cent to the overall gross uplift in General Medical Services contract payments for independent contractor GMPs (1.5 per cent after allowing for movement in expenses);
- An increase of 0.21 per cent to the gross earnings base under the new contract for independent GDPs in England and Wales (1.5 per cent after allowing for movement in expenses); and
- An increase of 0.21 per cent to gross fees, commitment payments and sessional fees for taking part in emergency dental services in Scotland and in Northern Ireland.

[5] *Review Body on Doctors' and Dentists' Remuneration, Thirty-Eighth Report 2009*, Cm 7579, March 2009, www.ome.uk.com

25. The Government accepted DDRB's 2009-10 recommendations in full on 31 March 2009.

Pay comparability evidence

26. We are required to maintain broad comparability with the civilian sector alongside the other factors covered by our terms of reference. For DMS pay comparability, there is a direct read across to civilian counterparts working within the NHS. Evidence from MOD and the BMA/BDA continued to emphasise the importance of maintaining broad comparability with the NHS and the role this plays in the morale and retention of DMS personnel. As in previous reports, our approach to achieving broad comparability with the NHS is repeated here for ease of reference. We make comparisons between DMS and NHS pay levels (at 1 April 2008 where data is available) and movements in pay in the NHS for 2009-10 following DDRB's recommendations. Our method is consistent with that used for the main remit group.

27. To ensure comparable pay when looking at both the DMS and NHS we: (i) remove the appropriate level of X-Factor from DMS salaries; (ii) adjust NHS salaries to account for the relative pension advantage of the DMS over the NHS; and (iii) where applicable, adjust all NHS non-pensionable items of pay to avoid double counting when reading across to DMS salaries where all base pay is pensionable. Following consultation with the parties we are pleased to note that their evidence takes a more consistent approach to pay comparability calculations.

28. In our 2008 DMS Report, discussing the GAD valuation of DMS pensions, we said that, given the complexities of changes to DMS pay and pension arrangements (including the bonus payments offered under AFPS05) and NHS pay, and the sensitivities of the results to changes in assumptions, we were unable to make a judgement that could apply until the next scheduled valuation in 2012. This meant we continued to apply the levels of adjustment based on the 2000 GAD valuation of DMS pensions which predates the introduction of AFPS05. The new methods discussed from paragraph 66 onwards of this report are motivated to address this issue.

29. Since 2005 and up until this report, we commissioned Capita Health Services Partners (formerly NHS Partners) to provide an independent assessment of pay comparability between the DMS and NHS, using career profiles where available. In addition, at our request, Capita commented on developments in the quality and availability of NHS data. In our 2008 Report, however, we set out a much clearer definition of the make-up of NHS comparators. This enabled our Secretariat to undertake the pay comparability analyses for this report.

Summary of pay comparisons by DMS group

30. The following summarises for each DMS group our pay comparability analysis and those from the parties used to support their pay proposals.

Consultants

31. **Our assessment** – average adjusted DMS pay in 2008-09 is £100,209 a year, assuming Consultants start at increment level 5 at age 35 and progress to increment level 30 at age 60. The NHS comparator has been built up to show the effects of the following pay components:

- Programmed Activities (PAs) – these form the basis of NHS Consultant comparator pay. The average number of PAs worked in the DMS reduced to 10.9 in 2007-08, roughly in line with NHS figures of 10.83[6]. We have agreed with the parties that 11 PAs constitute the basis for pay comparisons. The data shows that average NHS pay for 11 PAs is £90,335 and that DMS pay is £9,874 or 10.9 per cent ahead of NHS pay. Based on 11 PAs, DMS Consultants are in line with NHS counterparts early in their career before moving ahead for the remainder of a DMS career;
- On-Call Availability Supplement – average DMS commitments are 1 in 7. This is considered a medium frequency rota within the NHS and would attract a 5 per cent supplement to basic pay. For our 2008 Report, we also agreed with the parties that accounting for this On-Call Supplement together with 11 PAs should be the appropriate NHS comparator. Across a career, pay comparisons show average NHS comparator pay is £94,442, giving DMS a £5,767 or 6.1 per cent lead;
- Local Clinical Excellence Awards[7] – these were introduced in the NHS in 2003 as a replacement for the Discretionary Points scheme. Local level awards (levels 1 to 8 plus some level 9) are funded by NHS employers, who are obliged to award 0.35 of an award per eligible NHS Consultant (following their first year as a Consultant). Using the approach previously employed by Capita[8], average NHS pay is £105,471, leaving average DMS pay £5,262 or 5.0 per cent behind the NHS.

32. **MOD** – following our 2008 recommendation that the parties should present proposals to reflect the value of NHS Local CEAs, MOD concluded that the only feasible way forward was to incorporate their value into the NHS comparator. MOD's methodology used 2007 NHS data from the Advisory Committee of Clinical Excellence Awards (ACCEA) which showed that 32 per cent of Consultants held no CEA, 42 per cent held an award between levels 1 and 4, and 13 per cent were in receipt of a level 5 to 8 award. These proportions were used to obtain a weighted average for the value of awards across a career. The resulting average NHS salary of £102,191 identified a deficit of £1,982 or 1.9 per cent for DMS Consultants.

33. **BMA/BDA** – as in previous evidence, the BMA/BDA included the value of Local CEAs in NHS Consultant comparator pay. The BMA/BDA used the same methodology employed by Capita with the exception that the value of each award was averaged over each three year period following eligibility i.e. on average an award was made every three years with the first award made 2 years after becoming eligible. This method showed an average NHS salary of £106,516, leaving the DMS £6,307 or 5.9 per cent behind their NHS counterparts.

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[6] Latest NHS data published in 2005.
[7] 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.
[8] Awards a local CEA every three years once eligible. Assumes becoming a Consultant in the NHS at age 35 and eligible for CEAs from age 36 with first award made at age 38.

General Medical Practitioners

34. In 2006-07, the year for which latest NHS pay data is available, and therefore the year used for making pay comparisons, the average DMS salary was £101,999[9] (£91,832 when adjusted). The most recent GMP Earnings and Expenses Enquiry[10] produced by the Technical Steering Committee (TSC) detailed 2006-07 NHS GMP earnings, the third year of the new General Medical Services (GMS) contract. Data included earnings and expenses for both full and part-time GMPs and related to both NHS and private practice income.

35. **Our assessment** – analysis of the TSC data shows:

- Average net income for all GPMS[11] GMPs was £107,667 (£99,054 when adjusted for pension differences), down 2.1 per cent from 2005-06;
- Non-dispensing GMS GMPs' net income (the largest single group of GMPs) was £99,580 (£91,614 when adjusted), down 3.0 per cent from 2005-06; and
- Salaried GMP income was £50,999[12] (£46,919 when adjusted).

36. Pay comparisons in Table 1 show that broad comparability has been achieved when using non-dispensing GMS GMPs as the NHS comparator. If all GPMS GMPs are used, however, the DMS faced a deficit of around 7½ per cent. A comparison based on 2006-07 data with NHS salaried GMPs shows DMS earnings are almost double that of the NHS.

Table 1: GMP 2006-07 pay comparisons

GMP Comparator	Numbers	2006-07 Average Income £	Adjusted Average Income £	Change 05-06 to 06-07	Lead/Deficit of DMS
DMS	386[13]	101,999	91,832	9.2%[14]	–
NHS					
Non-dispensing GMS Contractor GPs	20,088	99,580	91,614	-3.0%	0.2%
All GPMS Contractor GPs	33,887	107,667	99,054	-2.1%	-7.3%
GPMS Salaried GPs	5,069	50,999	46,919	..	95.7%

.. Comparable figures for 2005-06 are not available for salaried GPs due to methodological changes.

[9] Actual average unadjusted earnings were £98,207 due to staging of award in 2006-07. 2.2 per cent awarded from 1 April 2006 plus an additional £6,500 from 1 November 2006.
[10] Earnings and Expenses Enquiry survey commissioned by the NHS Technical Steering Committee and produced by the Health and Social Care Information Centre.
[11] GMPs working under either a General Medical Services (GMS) or Personal Medical Services (PMS) contract.
[12] Results for salaried GMPs are provisional.
[13] Comprises a trained strength of 263 and 123 personnel in training. Figures are as at April 2008.
[14] Figure based on changes to baseline salaries. Actual average earnings increased by 5.1 per cent during 2006-07.

37. **MOD** – independent contractor NHS GMPs and not salaried GMPs continued to be considered the appropriate comparator by MOD. In previous years, MOD used all General and Personal Medical Services' GMPs when making comparisons. In evidence for this report, MOD commissioned an independent study[15] to determine whether dispensing or non-dispensing GMPs were the appropriate comparator. The findings recognised that, despite differences such as financial considerations and the level of business risk, a typical military practice had similarities with a small to average sized civilian training, dispensing practice with a large occupational medicine commitment. MOD concluded that all (dispensing and non-dispensing) GPMS GMPs should be used for pay comparisons which, using 2006-07 TSC data, pointed to a differential of £7,222 in favour of the NHS. MOD suggested that net income had reduced for NHS GMPs since 2006-07. In the Department's view this, coupled with increases in salaries for the DMS, had led to a reduction in the disparity between military and NHS pay for GMPs.

38. **BMA/BDA** – the BMA/BDA also reaffirmed that independent contractor GMPs provided the appropriate comparator, but that all GPMS GMPs should be included – a move away from non-dispensing GMS GMPs as used in previous BMA/BDA evidence. The BMA/BDA comparisons also used the 2006-07 TSC data and showed that the average NHS net income for all GPMS GMPs was £107,667 (£99,054 adjusted) leaving DMS GMPs facing a deficit of around 7½ per cent (on the adjusted figure). The BMA/BDA stated that, as TSC data included a mix of both full and part-time GMPs, average net income was underestimated for pay comparison purposes.

General Dental Practitioners

39. 2006-07 was the first year of new NHS contractual arrangements in England and Wales which changed the way General Dental Services (GDS) dentists were remunerated[16]. Classifications of dentists were also changed[17].

40. **Our assessment** – the average DMS GDP salary in 2008-09 is £109,505 (£97,197 when adjusted for X-Factor). In 2006-07, the year used for making pay comparisons, the average DMS salary was £101,999[18] (£91,832 when adjusted). Table 2 contains the latest 2006-07 HM Revenue and Customs (HMRC) earnings data which included NHS and mixed NHS/private practice dentists, but excluded dentists who derived their income wholly from private practice. Income is split by dental type and contract type and showed:

    - GDS Providing-performers (29 per cent of all dentists) had an average income of £117,083 (£107,716 when adjusted);
    - All Providing-performers average net profit of £134,827 (£124,041 adjusted);
    - All Performer only dentists average net profit of £69,442 (£63,887 adjusted); and
    - All dentists' average net profit of £96,135 (£88,444 adjusted).

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[15] Carried out by Dr Wheatley – a member of the Royal College of General Practitioners and a representative on the Defence General Practice Education Committee.
[16] *Dental Earnings and Expenses, England and Wales 2006/07* – NHS Information Centre for Health and Social Care.
[17] Providing-performer dentist – previously practice owner, non-associate or first-party associate. Under contract with Primary Care Trust/Local Health Board and also performing dentistry. Performer only dentist – previously second-party associate, assistant or locum. Working for practice owner, principal or body corporate.
[18] This is the average salary for both DMS GDPs and GMPs as they are paid on the same pay scale.

Table 2: 2006-07 Average net profit by dentist and contract type, England and Wales

Dentist type	Contract type	Population	Average Net profit £	Adjusted average Net profit £
Providing-performer	GDS	5,633	117,083	107,716
	PDS[19]	1,920	172,494	158,694
	Mixed GDS/PDS	427	199,545	183,581
	All	7,980	134,827	120,041
Performer only	GDS	6,969	67,274	61,892
	PDS	3,723	73,229	67,371
	Mixed GDS/PDS	875	70,595	64,947
	All	11,567	69,442	63,887
All dentists	GDS	12,602	89,538	82,375
	PDS	5,643	107,003	98,443
	Mixed GDS/PDS	1,302	112,885	103,854
	All	19,547	96,135	88,444

41. NHS earnings data also showed that there was little difference in the average net profits of dentists according to levels of NHS commitment. Mainly private dentists (less than 25 per cent NHS commitment) and mainly NHS dentists (greater than 75 per cent NHS commitment) both had average adjusted net profits of around £95,000. Higher average gross earnings for those conducting greater levels of private work were offset by increased expenses, resulting in similar net profits.

42. **MOD** – MOD considered that the internal comparator (DMS GMPs) remained more important than comparisons with civilian dental earnings, and therefore the link with DMS GMPs pay should be maintained. MOD noted, however, that the improved availability of NHS data could mean it would have to consider whether this remained the appropriate comparator in the future. Average unadjusted net profits for GDS Providing-performer dentists of £117,083 were highlighted.

43. **BMA/BDA** – their evidence included a range of dentists' earnings information drawn from the latest 2006-07 HMRC data. Average unadjusted net profits for each Providing-performer contract were highlighted, ranging from £117,083 for GDS dentists to £199,545 for those operating under a mixed GDS/PDS contract. The BMA/BDA commented that the data excluded information on wholly private practitioners – a potential comparator for DMS dentists. They also stated that HMRC data included part-time civilian earnings and therefore any comparisons made with full-time DMS earnings should be treated with caution. They continued to believe that the appropriate comparator was DMS GMPs.

[19] Personal Dental Services (PDS) contract.

Junior Doctors in Training

44. **Our assessment** – latest NHS Employers' monitoring data (March 2008) showed that the move towards a cap on working hours for NHS Junior Doctors of 48 hours (compulsory from August 2009 following the introduction of the European Working Time Directive) had resulted in a further reduction in the average out of hours band multiplier[20] from 1.52 to 1.48 within NHS compliant posts (98 per cent of doctors in training). This figure could reduce slightly in the future, but is not expected to fall below 1.45. Band B supplements (1.5 x salary) remained the most common banding for out of hours payments for doctors in hospital training, while GMP registrars received a supplement of 50 per cent. Comparisons pointed to DMS trainees remaining ahead of Junior Doctors in the NHS.

45. **MOD** commented on a continuing reduction in the average band multiplier to 1.48 as reduced working hours led to a move out of higher supplement bands 2A and 3 (where few DMS Juniors work) into Band 2B. Excluding these higher supplement bands, DMS Junior Hospital Doctors' salaries remained ahead of their NHS counterparts. The **BMA**/**BDA** considered that there was no evidence to suggest that working hours for this group had changed substantially for 2009.

MOD and BMA/BDA pay proposals for 2009-10

46. MOD and the BMA/BDA sought a pay award in line with or informed by DDRB recommendations for all DMS groups and all other DMS pay elements. The BMA/BDA argued for additional increases for selected groups to address pay disparities with the NHS and arrest what they saw as the growing DMS manning shortfall. In summary the parties' proposals were:

- Overall pay award – both parties sought an increase in line with those recommended by DDRB;
- Consultants – the BMA/BDA sought an additional 1.9 per cent interim increase across Consultants' pay spines to incorporate the value of NHS Local Clinical Excellence Awards. MOD considered that pay comparability with the NHS was achieved for Consultants;
- GMPs – the BMA/BDA argued that an additional increase was necessary to take account of improvements in NHS GMPs' pay between 2002-03 and 2005-06 under the new GMS contracts;
- GDPs – both parties argued for maintenance of the pay link with DMS GMPs; and
- Higher Medical Management (HMM) Pay Spine – the BMA/BDA requested an uplift corresponding to the greater of the uplifts recommended for accredited DMS Consultants and GMPs, and MOD proposed an uplift in line with DMS Consultants.

[20] 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.

RECOMMENDATIONS FOR 2009-10

Overall pay recommendations

47. Our recommendations aim to ensure the pay of DMS personnel is broadly comparable with pay levels in the NHS and thereby supports recruitment, retention and motivation. As with our main report, the economic climate has changed significantly providing a volatile backdrop after years of relative economic stability. The Government's evidence set out its view of the economic downturn and its public sector pay policy. We also take account of MOD's evidence on affordability and the specific evidence on circumstances for DMS doctors and dentists.

48. Our starting point for considering DMS pay is broad comparability with the NHS. We assess comparability with NHS pay levels as at April 2008 and, going forward, take account of pay movements in the NHS for 2009-10 as recommended by DDRB. Our recommendations in recent years have, in our view, achieved broad comparability on pay levels, although there continues to be a lag in NHS earnings data which therefore requires us to apply an element of judgement. As the evidence indicates pay levels to be broadly comparable, our main driver is to keep pace with pay movements guided by the 1.5 per cent increase recommended for NHS doctors and dentists by DDRB. We are mindful that MOD and the BMA/BDA place great store in matching the DDRB increase as an important element in achieving and maintaining comparability. This is also true of DMS personnel themselves.

49. We recognise how achieving broad comparability with the NHS influences DMS manning levels and particularly retaining experienced DMS doctors and dentists. It is therefore encouraging that DMS manning is starting to show improvements in a number of areas. These signs include an increase in the numbers of qualified MOs, DOs manning close to requirement and significant decreases in the rates of Voluntary Outflow for MOs and DOs. Maintaining low Voluntary Outflow rates is essential to DMS manning and retaining the experienced personnel required for operational capability. Despite improving manning overall, significant specialty shortages remained, and manning balance continues to be some way off and is projected for 2013-14. DMS recruitment of both MOs and DOs was below target, although we note some success in recruiting MO Direct Entrants. MOD and the BMA/BDA recognised the impact of the frequency and length of operational deployments on retention. The DMS Continuous Attitude Survey indicated that pay and allowances influence decisions to remain in the DMS and, generally, pay was viewed positively.

50. The external context is of a contracting economy and significantly weakening labour market at the end of 2008 and into early 2009. Employment levels fell substantially, unemployment increased and employers expected weaker employment prospects. However, it is unclear how significant the impact of these macroeconomic developments will be on DMS manning levels. The latest data, for February 2009, showed CPI inflation at 3.2 per cent and RPI inflation at 0.0 per cent – both significantly lower than their September 2008 peaks. Whole economy average earnings, including bonuses, increased by 1.8 per cent in the three months to January 2009 (public sector 4.0 per cent). Forecasts suggested lower prospects for average earnings growth in 2009. We note that median settlements remained around 3.5 per cent during 2008. While we do not expect to see any specific effects for the DMS and NHS until our 2010 Report, we note DDRB's view that, in the context of rapidly changing economic circumstances, NHS recruitment and retention are satisfactory.

51. Against the economic background, the Government's public sector pay policy remained essentially unchanged in that pay awards should help recruit and retain quality workforces, be affordable and offer value for money. In this regard, the Government placed increased emphasis on obtaining value for money from expenditure on public sector pay and stressed the attractiveness of public sector employment during times of economic uncertainty. We accept the importance of value for money from the paybill when there are many pressures on MOD's budgets. We have taken into account MOD's evidence on affordability of pay awards against other Defence expenditure pressures.

52. We conclude from all the evidence that a pay recommendation of 1.5 per cent, in line with that recommended by DDRB for the NHS, is appropriate to support DMS recruitment, retention, morale and motivation and maintain comparability with NHS doctors and dentists. Our recommendation is consistent with the Government's public sector pay policy and affordable within MOD's budgets.

Recommendation 1: We recommend a 1.5 per cent increase from 1 April 2009 for DMS Consultants, Higher Medical Management staff, General Medical and Dental Practitioners, Non-Consultant Career Grades, accredited OF2s, Junior Doctors in training (including GMP Registrars), and Medical and Dental Cadets (and all DMS Reserve equivalents). The recommended pay scales are at Appendix 1.

Proposals for additional pay increases

53. We have also considered the case for additional pay increases put forward by the BMA/BDA. As stated, we consider that pay is broadly comparable with the NHS and that we must apply our judgement to the parties proposals in the absence of complete and timely data.

DMS Consultants

54. Our 2008 recommendation urged the parties to agree on targeting the value of NHS Local Clinical Excellence Awards within DMS Consultants' pay. We welcome the parties' efforts in recent years to arrive at an agreed NHS Consultant comparator, for instance, in agreeing the basis of 11 Programmed Activities and an On-Call Supplement. In responding to our 2008 recommendation, we note that neither MOD nor the BMA/BDA considered it appropriate to replicate the NHS system in the DMS and the parties therefore incorporated the value of Local CEAs into NHS comparator pay. We agree with this approach.

55. Despite substantial progress the parties were unable to agree on the final methodology and presented separate evidence which we have considered very carefully. The BMA/BDA proposed continuing our previous approach building in payments for all NHS Consultants. In our view this does not account for the large proportion of NHS Consultants who receive no award. MOD's methodology is based on the actual distribution of Local CEAs in the NHS in 2007 but in our view does not account for the obligation of NHS Trusts to award at least 0.35 new CEAs each year. We also note the concerns raised in the NHS on the accuracy of the distribution data. While the BMA/BDA used MOD's methodology to argue for an additional 1.9 per cent increase for all DMS Consultants, we conclude that, given concerns over the proposed methodologies and the data, broad pay comparability is being achieved with the inclusion of Local CEAs. We will, however, monitor the NHS distribution data in future comparability assessments and if necessary form our own judgement as to how Local CEAs fit into comparator pay.

GMPs

56. The choice of NHS comparator for GMPs influences any conclusions on pay comparisons. In our 2008 Report, we commented that the NHS comparator should be General Medical Services' non-dispensing GMPs as they constituted the largest NHS group. In evidence for this report, MOD and the BMA/BDA drew on the 2006-07 earnings of all General and Personal Medical Services' GMPs. At that time, the data suggested DMS GMPs' pay was around 7 per cent behind the NHS and the BMA/BDA proposed we corrected this shortfall. Given the lag in comparative NHS earnings data, we have not seen compelling evidence that the deficit requires addressing immediately. Authoritative information from the TSC on GMP net incomes is only available for 2006-07. However, given our knowledge of the settlements recommended and agreed by the DDRB for subsequent years, it is reasonable to assume that there has been little growth in GMP net incomes since then. Until more contemporary NHS data become available, our assessment of any pay gap necessarily relies on making forecasts of this nature. In the meantime, we welcome MOD's further work on the relative duties of NHS and DMS GMPs and may consult further with MOD and the BMA/BDA on the choice of NHS comparator.

The link between DMS GDPs' and GMPs' pay

57. Both MOD and the BMA/BDA saw merit in maintaining the pay link between DMS GDPs and GMPs. We understand MOD's and the BMA/BDA's concerns about the impact on recruitment and retention should the link be broken, and we are therefore content to endorse its continuation. However, under the current arrangements it would be difficult to target the two groups effectively should the evidence merit a differential approach.

Consultants' National Clinical Excellence Awards and Distinction Awards

58. We recommend on DMS National CEAs and Distinction Awards to ensure that they reflect arrangements in the NHS. DDRB recommended the value of these awards should be increased by 1.5 per cent and we consider this an appropriate uplift for DMS awards. The BMA/BDA continued to request that the value of DMS awards should be pensionable as they are in the NHS, but we repeat our view that it is a matter for MOD as the employer to determine which elements of pay are pensionable. Following the increase in the number of qualified DMS Consultants, MOD proposed increasing the numbers of DMS awards to reflect the proportion available in the NHS. We note that 13 per cent of NHS Consultants received awards and only 11 per cent in the DMS. MOD suggested, in oral evidence, that the increase in DMS consultant numbers warranted an additional 6 DMS awards, bringing the total to 38, and we are content to recommend accordingly. MOD should determine the proportions required at each level of award.

Recommendation 2: We recommend a 1.5 per cent increase to the value of DMS National Clinical Excellence Awards and Distinction Awards from 1 April 2009. The recommended levels are shown at Appendix 1. The numbers of DMS National Clinical Excellence Awards and Distinction Awards should be increased to 38.

DMS Trainer Pay and Associate Trainer Pay

59. Around a quarter of DMS GMPs work as GMP Trainers. The BMA/BDA commented that GMP Trainers' enhanced clinical, educational, managerial and leadership experience was highly marketable in the NHS and they were therefore disproportionately affected by DMS retention issues. They considered it critical to retention that DMS Trainer Pay reflected that available in the NHS. MOD noted the introduction of GMP Associate Trainer Pay in 2008 and added that it was too early to assess its impact, but it should

make the career of DMS Trainers more attractive. With these factors in mind, we recommend DMS Trainer Pay and Associate Trainer Pay be increased by 1.5 per cent.

Recommendation 3: We recommend that DMS Trainer Pay and GMP Associate Trainer Pay be increased by 1.5 per cent from 1 April 2009. The rates are at Appendix 1.

Cost of recommendations

60. We estimate that the cost of our pay recommendations for 2009-10 is £3.0 million (including the Employers' National Insurance Contribution and superannuation liabilities). This cost is based on the Officer strengths (including Reserves) of the medical and dental branches of the Armed Forces at the end of February 2009. To the extent that actual strengths through 2009-10 will vary from those at the end of February 2009, the cost of implementing the recommendations will also vary.

LOOKING AHEAD

61. MOD's evidence indicated that incorporating DMS cadres onto a single pay spine as part of the wider work of the Strategic Remuneration Review was not feasible, but it was exploring the degree of flexibility in the current system to target specific cadres. We recognise that in the current financial climate the scope may be limited, but we continue to believe that reform is required. It is particularly important that account is taken of how pay interacts with pension, the importance of retention bonuses and the impact of the opportunity of a second career in the NHS and in private practice. It is also important that further progress is made on the development and availability of flexible working practices, reflecting changes in the wider labour market and the increasing feminisation of the medical and dental workforces.

62. Much of the DMS is made up of small but critical cadres with long training pipelines, highlighting the importance of effective manpower planning. We note the major review of Army medical capability, looking to ensure the appropriate support for operations and we look forward to hearing about the outcome in the evidence for our 2010 Report. In addition we welcome the more flexible approach shown to manning in critical cadres across each of the Services and improvements to the way pinch points are to be identified.

63. The MOD highlighted the substantial role DMS Reserves played in medical deployments, providing up to 70 per cent of manning in Field Hospitals at Camp Bastion. Assuming the current operational tempo continues Reserves will continue to play an important role in support of future operations.

64. We also note the use of NHS contract staff and personnel from other nations in support of UK commitments. We welcome this creative and flexible approach to support operations while carrying a substantial manning deficit. Given the long-term manning deficits and the impact of the frequency of operational deployments on retention it is important to find enduring solutions in this area. This highlights the importance of the relationship that the DMS has with the NHS, and also shows that both can benefit from the innovative use of medical personnel.

65. In its evidence MOD recognised the importance of accurate DMS data to support the development of personnel policy. We welcome the improvements to the quantity and quality of DMS data which are now becoming available and which have improved our evidence base this year. These include a breakdown of DMS personnel by pension scheme, highlighting the number that have chosen to remain on AFPS75 rather than change to AFPS05, and a breakdown highlighting the different gender balance for the DMS compared with the Armed Forces as a whole. We have asked our Secretariat to discuss with MOD further improvements to the evidence base to inform our 2010 Report:

- Development of sustainable experience profiles for GMPs and GDPs;
- Data on exit points for DMS cadres either by age or by pay point;
- Distribution of numbers in training by cadre and a forecast of when they will become accredited; and
- An indication of hours worked.

66. In our 2008 Report we announced our intention to **review the options for DMS pension valuations** in a way that:

- Reflects changes to DMS pay and pension arrangements (including the bonus payments offered under AFPS05) and be flexible to respond to future changes;
- Captures the unique DMS pay and pension arrangements;
- Takes a career approach to capture significant effects at various career points;
- Is clear, transparent and understandable to the remit group; and
- Is compatible with our approach to DMS pay comparability.

67. We have undertaken research to look at the different options. These include a total reward approach which integrates the pension benefits directly into the remuneration package. We will consult with the MOD and BMA/BDA with a view to identifying an agreed methodology to feed into the evidence for our 2010 Report. We will welcome their active participation in this.

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23 April 2009

Appendix 1

1 April 2009 recommended levels of military salaries including X-Factor for DMS Officers

All salaries are rounded to the nearest £.

Table 1.1: **Recommended annual salaries inclusive of the X-Factor for accredited consultants (OF3-OF5)**

Increment level	Military salary
	£
Level 32	131,167
Level 31	130,911
Level 30	130,660
Level 29	130,401
Level 28	130,150
Level 27	129,644
Level 26	129,137
Level 25	128,631
Level 24	127,402
Level 23	126,177
Level 22	123,514
Level 21	122,113
Level 20	120,716
Level 19	119,315
Level 18	117,923
Level 17	116,157
Level 16	114,399
Level 15	112,843
Level 14	111,284
Level 13	109,732
Level 12	108,176
Level 11	104,757
Level 10	101,345
Level 9	97,934
Level 8	94,904
Level 7	91,867
Level 6	88,826
Level 5	85,976
Level 4	84,869
Level 3	83,738
Level 2	79,992
Level 1	76,284

Table 1.2: **Recommended annual salaries inclusive of the X-Factor for accredited GMPs and GDPs (OF3-OF5)**

Increment level	Military salary
	£
Level 35	122,378
Level 34	121,994
Level 33	121,700
Level 32	121,221
Level 31	120,837
Level 30	120,449
Level 29	120,151
Level 28	119,676
Level 27	119,284
Level 26	118,900
Level 25	118,508
Level 24	118,123
Level 23	117,731
Level 22	115,799
Level 21	115,347
Level 20	114,811
Level 19	114,252
Level 18	113,698
Level 17	113,139
Level 16	112,584
Level 15	112,090
Level 14	110,033
Level 13	109,542
Level 12	109,052
Level 11	108,486
Level 10	107,924
Level 9	107,359
Level 8	105,294
Level 7	104,732
Level 6	103,300
Level 5	101,860
Level 4	100,428
Level 3	98,988
Level 2	96,934
Level 1	96,262

Table 1.3: **Recommended annual salaries inclusive of the X-Factor for Non-Accredited Medical Officers (OF3-OF5)**

Increment level	Military salary
	£
Level 29	96,012
Level 28	95,232
Level 27	94,459
Level 26	93,682
Level 25	92,901
Level 24	92,128
Level 23	91,352
Level 22	89,807
Level 21	88,930
Level 20	88,044
Level 19	87,159
Level 18	86,278
Level 17	85,396
Level 16	84,511
Level 15	83,723
Level 14	82,948
Level 13	82,164
Level 12	81,380
Level 11	80,601
Level 10[a]	79,821
Level 9	78,881
Level 8	77,298
Level 7	75,711
Level 6	74,585
Level 5	73,470
Level 4	72,351
Level 3	71,232
Level 2	67,485
Level 1	63,761

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

Table 1.4: **Recommended annual salaries inclusive of the X-Factor for Service Medical and Dental Officers: OF2**

Increment level	Military salary		
	Accredited Medical Officers	Non-Accredited Medical and Dental Officers	Accredited Dental Officers
	£	£	£
Level 5	72,849	59,036	72,849
Level 4	71,371	57,527	71,371
Level 3	69,897	56,010	69,897
Level 2	68,416	54,506	68,416
Level 1	66,938	53,008	66,938

Table 1.5: **Recommended annual salaries inclusive of the X-Factor for Service Medical and Dental Officers: OF1 (PRMPs)**

	Military salary
	£
OF1	40,127

Table 1.6: **Recommended annual salaries inclusive of the X-Factor for Medical and Dental Cadets**

	Length of service	Military salary
		£
Cadets	after 2 years	18,149
	after 1 year	16,328
	on appointment	14,515

Table 1.7: **Recommended annual salaries inclusive of the X-Factor for Higher Medical Management Pay Spine: OF6**

Increment level	Military salary
	£
Level 7	136,167
Level 6	135,027
Level 5	133,890
Level 4	132,743
Level 3	131,599
Level 2	130,466
Level 1	129,319

Table 1.8: **Recommended annual salaries inclusive of the X-Factor for Higher Medical Management Pay Spine: OF5**

Increment level	Military salary
	£
Level 15	127,425
Level 14	126,710
Level 13	125,983
Level 12	125,261
Level 11	124,542
Level 10	123,819
Level 9	123,089
Level 8	122,370
Level 7	121,647
Level 6	120,565
Level 5	119,487
Level 4	118,397
Level 3	117,319
Level 2	116,241
Level 1	115,151

DMS Trainer Pay

GMP and GDP Trainer Pay	£7,592.65
GMP Associate Trainer Pay	£3,796.38

DMS Distinction Awards

A+	£60,470
A	£40,315
B	£16,126

DMS National Clinical Excellence Awards

Bronze	£18,859
Silver	£29,670
Gold	£40,967
Platinum	£57,912

Appendix 2

1 April 2008 military salaries including X-Factor for DMS Officers

All salaries are rounded to the nearest £.

Table 2.1: **Recommended annual salaries inclusive of the X-Factor for accredited consultants (OF3-OF5)**

Increment level	Military salary
	£
Level 32	129,228
Level 31	128,977
Level 30	128,729
Level 29	128,474
Level 28	128,227
Level 27	127,728
Level 26	127,229
Level 25	126,730
Level 24	125,520
Level 23	124,313
Level 22	121,689
Level 21	120,308
Level 20	118,932
Level 19	117,552
Level 18	116,181
Level 17	114,440
Level 16	112,708
Level 15	111,175
Level 14	109,639
Level 13	108,110
Level 12	106,578
Level 11	103,209
Level 10	99,848
Level 9	96,487
Level 8	93,502
Level 7	90,510
Level 6	87,513
Level 5	84,706
Level 4	83,615
Level 3	82,501
Level 2	78,809
Level 1	75,156

Table 2.2: **Annual salaries inclusive of the X-Factor for accredited GMPs and GDPs (OF3-OF5)**

Increment level	Military salary
	£
Level 35	120,570
Level 34	120,191
Level 33	119,901
Level 32	119,430
Level 31	119,051
Level 30	118,669
Level 29	118,375
Level 28	117,908
Level 27	117,521
Level 26	117,143
Level 25	116,756
Level 24	116,378
Level 23	115,992
Level 22	114,087
Level 21	113,643
Level 20	113,114
Level 19	112,563
Level 18	112,017
Level 17	111,467
Level 16	110,921
Level 15	110,433
Level 14	108,407
Level 13	107,923
Level 12	107,440
Level 11	106,883
Level 10	106,329
Level 9	105,772
Level 8	103,737
Level 7	103,184
Level 6	101,773
Level 5	100,354
Level 4	98,943
Level 3	97,525
Level 2	95,502
Level 1	94,839

Table 2.3: **Annual salaries inclusive of the X-Factor for Non-Accredited Medical Officers (OF3-OF5)**

Increment level	Military salary
	£
Level 29	94,593
Level 28	93,824
Level 27	93,063
Level 26	92,298
Level 25	91,528
Level 24	90,767
Level 23	90,002
Level 22	88,479
Level 21	87,616
Level 20	86,743
Level 19	85,871
Level 18	85,003
Level 17	84,134
Level 16	83,262
Level 15	82,486
Level 14	81,722
Level 13	80,949
Level 12	80,177
Level 11	79,409
Level 10[a]	78,641
Level 9	77,715
Level 8	76,156
Level 7	74,592
Level 6	73,482
Level 5	72,384
Level 4	71,281
Level 3	70,179
Level 2	66,487
Level 1	62,819

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

Table 2.4: **Annual salaries inclusive of the X-Factor for Service Medical and Dental Officers: OF2**

Increment level	Military salary		
	Accredited Medical Officers	Non-Accredited Medical and Dental Officers	Accredited Dental Officers
	£	£	£
Level 5	71,772	58,164	71,772
Level 4	70,316	56,677	70,316
Level 3	68,864	55,183	68,864
Level 2	67,405	53,700	67,405
Level 1	65,949	52,225	65,949

Table 2.5: **Annual salaries inclusive of the X-Factor for Service Medical and Dental Officers: OF1 (PRMPs)**

	Military salary
	£
OF1	39,534

Table 2.6: **Annual salaries inclusive of the X-Factor for Medical and Dental Cadets**

	Length of service	Military salary
		£
Cadets	after 2 years	17,881
	after 1 year	16,087
	on appointment	14,301

Table 2.7: **Annual salaries inclusive of the X-Factor for Higher Medical Management Pay Spine: OF6**

Increment level	Military salary
	£
Level 7	134,154
Level 6	133,031
Level 5	131,912
Level 4	130,781
Level 3	129,654
Level 2	128,538
Level 1	127,407

Table 2.8: **Annual salaries inclusive of the X-Factor for Higher Medical Management Pay Spine: OF5**

Increment level	Military salary
	£
Level 15	125,542
Level 14	124,837
Level 13	124,122
Level 12	123,410
Level 11	122,701
Level 10	121,989
Level 9	121,270
Level 8	120,561
Level 7	119,850
Level 6	118,783
Level 5	117,721
Level 4	116,647
Level 3	115,585
Level 2	114,523
Level 1	113,449

DMS Trainer Pay

GMP and GDP Trainer Pay	£7,480.45
GMP Associate Trainer Pay	£3,740.23 (introduced 1 December 2008)

DMS Distinction Awards

A+	£59,576
A	£39,719
B	£15,888

DMS National Clinical Excellence Awards

Bronze	£18,580
Silver	£29,232
Gold	£40,362
Platinum	£57,056

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