Armed Forces' Pay Review Body

Service Medical and Dental Officers

Supplement to the Thirty-Ninth Report – 2010

Chairman: Professor David Greenaway

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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
Mary Carter
The Very Revd Dr Graham Forbes CBE
Alison Gallico
Dr Peter Knight CBE
Professor Derek Leslie
Judith McKnight CBE
John Steele
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

AFPRB	Armed Forces' Pay Review Body
AFPS	Armed Forces' Pension Scheme
BDA	British Dental Association
BMA	British Medical Association
CEA	Clinical Excellence Award
DDRB	Review Body on Doctors' and Dentists' Remuneration
DDS	Defence Dental Services
DMS	Defence Medical Services
DO	Dental Officer
GDP	General Dental Practitioner
GDS	General Dental Services
GMP	General Medical Practitioner
GPMS	General and Personal Medical Services
MO	Medical Officer
MOD	Ministry of Defence
NHS	National Health Service
OME	Office of Manpower Economics
PA	Programmed Activity
PDS	Personal Dental Services
SDR	Strategic Defence Review

ARMED FORCES' PAY REVIEW BODY
2010 DMS REPORT – SUMMARY

Key recommendations from 1 April 2010:

- **DMS Accredited Consultants (OF3-OF5), Higher Medical Management (OF5 and OF6) staff, Accredited General Medical and Dental Practitioners (OF3-OF5), Accredited Medical and Dental Officers (OF2) and Reserve equivalents – no increase;**
- **Non-Accredited Medical Officers (OF3-OF5), Non-Accredited Service Medical and Dental Officers Levels 2-5 (OF2) and Reserve equivalents – an increase of 1 per cent;**
- **Non-Accredited Service Medical and Dental Officers Level 1 (OF2), Service Medical and Dental Officers (OF1) and Medical and Dental Cadets and Reserve equivalents – an increase of 1.5 per cent;**
- **DMS Trainer Pay and GMP Associate Trainer Pay – an increase of 1 per cent;**
- **No increase to the value of DMS National Clinical Excellence Awards and Distinction Awards.**

Evidence for this Report

To fulfil our terms of reference we consider a wide range of evidence. This includes economic indicators, the Government's public sector pay policy, manning, recruitment and retention, comparisons with NHS peers, and the recommendations from the Review Body on Doctors' and Dentists' Remuneration (DDRB). We receive oral and written evidence from the Ministry of Defence and the British Medical and Dental Associations (BMA/BDA). We also give due weight to evidence we hear directly from Defence Medical Services (DMS) personnel working under sustained operational pressure in Afghanistan as well as those making an essential contribution on medical care and rehabilitation in the UK.

Manning, recruitment and retention

In 2009, DMS manning generally continued the positive trend of recent years. As at 1 April, the trained strength of Medical Officers was 74 per cent of the trained requirement – an increase of 32 trained Medical Officers. Trained Dental Officer manning was 92 per cent of requirement. This is accounted for by increased numbers obtaining accreditation. DMS recruitment continued with some success but still fell short of targets for Medical Officers and Dental Officers. In the year to 31 March 2009, 82 Medical Officers were recruited, against a target of 87, of which 54 were Cadets[2], against a target of 60. Outflow decreased to 6.2 per cent for Medical Officers but increased to 5.1 per cent for Dental Officers. While the DMS has been able to meet all of its operational commitments, this has only been achieved by augmenting the Regulars with a mix of Reserves, NHS and contract staff. Both MOD and BMA/BDA recognised in their evidence that pay was not the only solution to manning shortfalls and that non-pay related measures may have a role to play in addressing retention.

[2] Medical and dental cadetships are available to students on accredited degree courses for up to their last three years of study.

Pay comparability

Our approach to pay comparability looks at parity with NHS earnings. MOD evidence stated there was broad pay comparability between the DMS and NHS. This view was not shared by the BMA/BDA, who asked the Review Body to improve all DMS rates to current NHS levels. The BMA/BDA also sought a pay increase in line with AFPRB's main remit group on grounds of maintaining morale and motivation. On balance we believe that broad pay comparability has been achieved and we consider that the link which has been made over several years between DDRB recommendations and those for the DMS remains appropriate this year. Accordingly, we have recommended pay increases which mirror those made by DDRB.

Recommendations

Our recommendations reflect the evidence presented to us with particular reference to evidence that recruitment and retention within the DMS are satisfactory. Historically, the DMS has been undermanned and this remains the case. However, we are not convinced that a differential award relative to NHS comparators would address this issue. We are mindful of the pressures on DMS staff both on operations and elsewhere, but judge that recommendations in line with those for NHS doctors and dentists are appropriate as the key comparator groups. We will however keep this under review in future rounds.

Looking ahead

In the light of the current economic uncertainty and pressure on public spending, the Strategic Defence Review will present new challenges for the Armed Forces, including the DMS. We encourage MOD to make progress on measures outside of pay to help DMS recruit and retain the highly skilled and motivated personnel needed to address current and future challenges.

INTRODUCTION

1. This Report sets out our recommendations on pay in the Defence Medical Services (DMS) from 1 April 2010 together with the supporting evidence. The context for our recommendations is one of continuing economic uncertainty, sustained commitment to operations in Afghanistan and continued manning shortfalls. 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 suitably qualified personnel.

BACKGROUND

DMS developments

2. MOD's evidence reported on progress with non-pay related initiatives aimed at addressing manning shortfalls and improving morale and motivation in the DMS. A revised merit-based promotion arrangement, to replace the present length of service based process, will be implemented for the 2010 promotion round. This aligns DMS with the rest of the military and MOD reports that this has been welcomed by Medical and Dental Officers.

3. MOD's DMS "Top Structures – Next Steps" project and the Midlands Medical Accommodation Project continued, with co-location of the Surgeon General's Headquarters and Joint Medical Command scheduled for completion in spring 2010. The aim is to create a new community of professional excellence – clinical, research and training, near Lichfield, drawing together the currently dispersed components of DMS. A close geographic community will encourage long-term life and career choices and provide respite from operational service demands.

4. Following an extensive review of the Army's deployable medical capability, initial implementation has begun on "Improving Medical Support to a Brigade", an initiative designed to meet the demands of current and future expeditionary operations. MOD is currently taking a more flexible approach to manning in critical cadres by using loan liability to reduce the defence manning deficiency. This allows a Service to hold numbers above its single Service requirement (but within overall DMS requirement). To improve career management of small cadres in secondary health care, the Joint Medical Command has agreed a way forward with single Service employers. Opportunities to share training and knowledge and improve career development have been made available to DMS personnel by the MOD/UK Health Departments Partnership Board.

5. We were given further evidence this year on the changing demographics of those entering medicine and dentistry. For example, over half of entrants to university courses in these areas are female. Retention would be improved by arrangements to allow both men and women to manage their careers more flexibly. MOD evidence confirmed that owing to other priorities progress on flexible working has been delayed to future planning rounds. The development of alternative career schemes will make an important contribution to this.

NHS developments

6. We keep up to date with developments in the NHS which are relevant to the DMS and may influence our approach to broad pay comparability. We note that:

- Surveys[3] of medical and dental staff carried out in England and Scotland indicate they are generally more satisfied with their pay, job and conditions than in the past;
- DDRB had no major concerns about recruitment and retention. Where there appear to be motivation issues, DDRB is not convinced these are pay-related;
- A new consultant merit award scheme, Scottish Clinical Leadership and Excellence Awards, with ten levels of local awards and three levels of national awards, will be introduced in Scotland from 1 April 2010;
- NHS Employers have carried out a scoping study to consider new contractual arrangements for doctors and dentists in training; and
- There has been continued, though slow, implementation of the new Specialty doctors and Associate Specialist contract (introduced April 2008).

OUR EVIDENCE BASE

7. We considered evidence from the following sources:

- The Government's evidence on its public sector pay policy and the economic environment as submitted to all Pay Review Bodies;
- Recommendations on NHS doctors' and dentists' pay by the DDRB;
- MOD's written evidence on affordability and DMS manning, recruitment and retention;
- The BMA/BDA written evidence including their pay proposals;
- Oral evidence from the Surgeon General, the Director of Strategic Change, DMS and from the BMA/BDA;
- Our assessment of prevailing economic conditions;
- Research into DMS and NHS pay comparisons undertaken by the Office of Manpower Economics; and
- Our visits to DMS personnel during 2009, in the UK and overseas, and on operations in Afghanistan and Iraq.

8. Our visits enable us to meet DMS personnel and hear their views first hand on issues specific to the DMS and those applying across the Armed Forces. We are grateful to those who participated in our visits. In 2009 we visited the MOD Hospital Unit in Portsmouth and we also met DMS Regular and Reserve personnel as part of our visits to other UK and overseas units, including in Afghanistan and Iraq. We appreciate the work of MOD and the Services in arranging our 2009 visits and for the inclusion of DMS personnel. A full list of AFPRB visits can be found in our 2010 Report (Appendix 5)[4] for the main remit group.

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[3] *2008 NHS Staff Survey in England, 2008 NHS Staff Survey in Scotland* and Office of National Statistics *Omnibus Survey* covering Great Britain, which also goes by the name of *Opinions*. There was no staff survey for Wales in 2008 and Northern Ireland does not carry out a staff survey.

[4] *Armed Forces' Pay Review Body Thirty-Ninth Report – 2010*, www.ome.uk.com

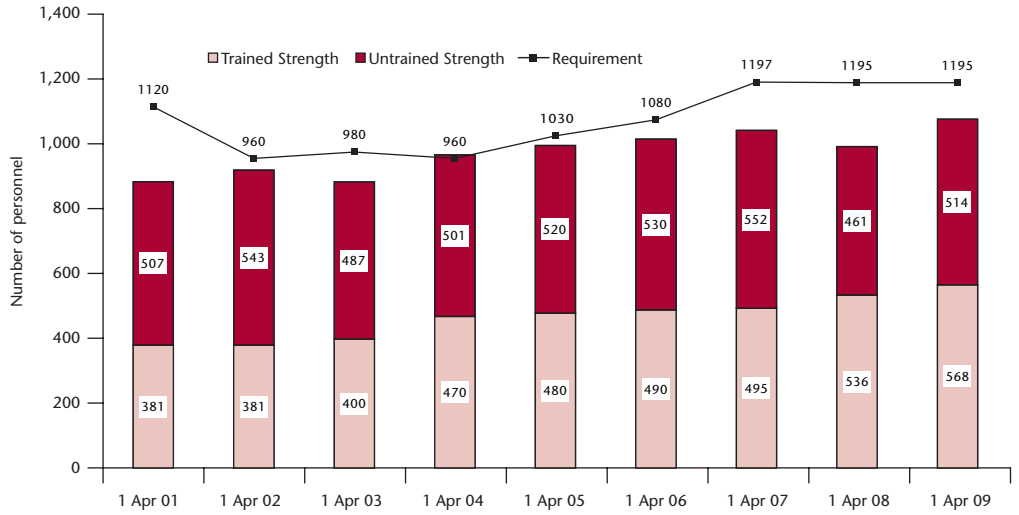
9. Owing to the limitations of MOD's Joint Personnel Administration system, we were unable to receive some of the more detailed data that was provided in 2009. At the oral evidence session with MOD, the Surgeon General made a commitment to improve the quality of data that we receive in 2011.

DMS manning evidence

10. At 1 April 2009 there was a requirement for 1,195 Medical Officers (MOs), including 107 General Duties Medical Officers, and 253 Dental Officers (DOs). Charts 1 and 2 below show the manning positions of MOs and DOs respectively:

- 568 trained MOs, a deficit of 26 per cent against the trained requirement of 770[5]. This represents an increase of 32 MOs.
- Compared with a year earlier there were a further 514 MOs in training, an increase from 461.
- 234 trained DOs, 8 per cent below the requirement of 253. There were a further 9 DOs in training.

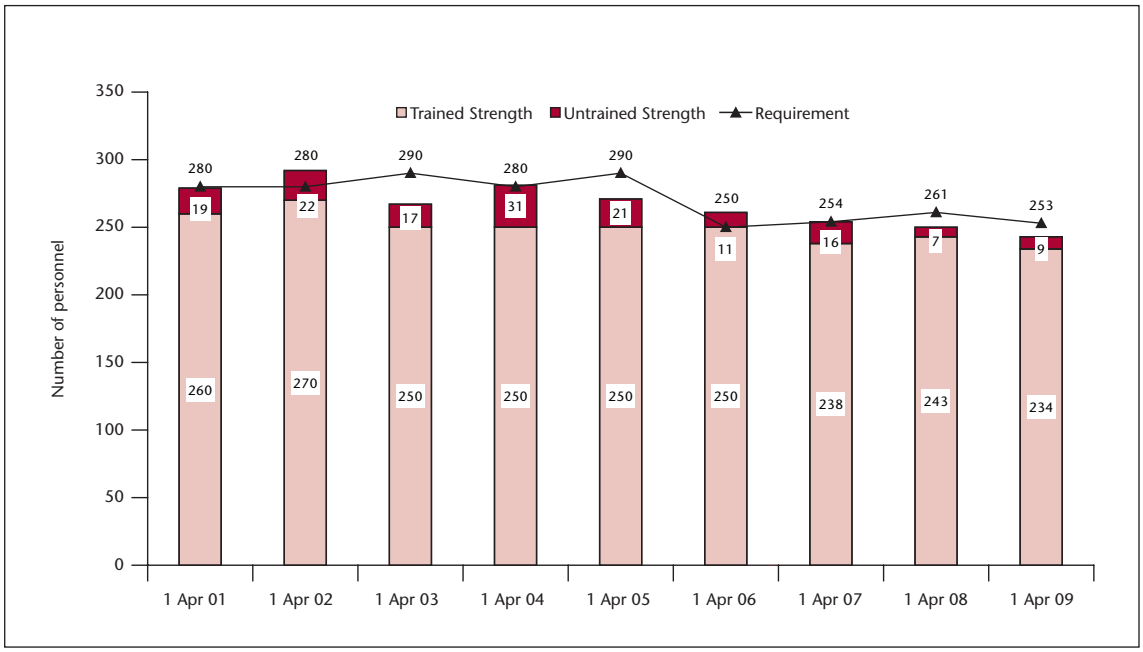
Chart 1: Strength and deficit/surplus of Medical Officers 2001-2009



From 2006 onwards the requirement includes a Manning and Training Margin (425 at 1 April 2009)

[5] The overall requirement for Medical Officers is made up of a trained requirement of 770 and a Manning and Training Margin of 425.

Chart 2: Strength and deficit/surplus of Dental Officers 2001-2009

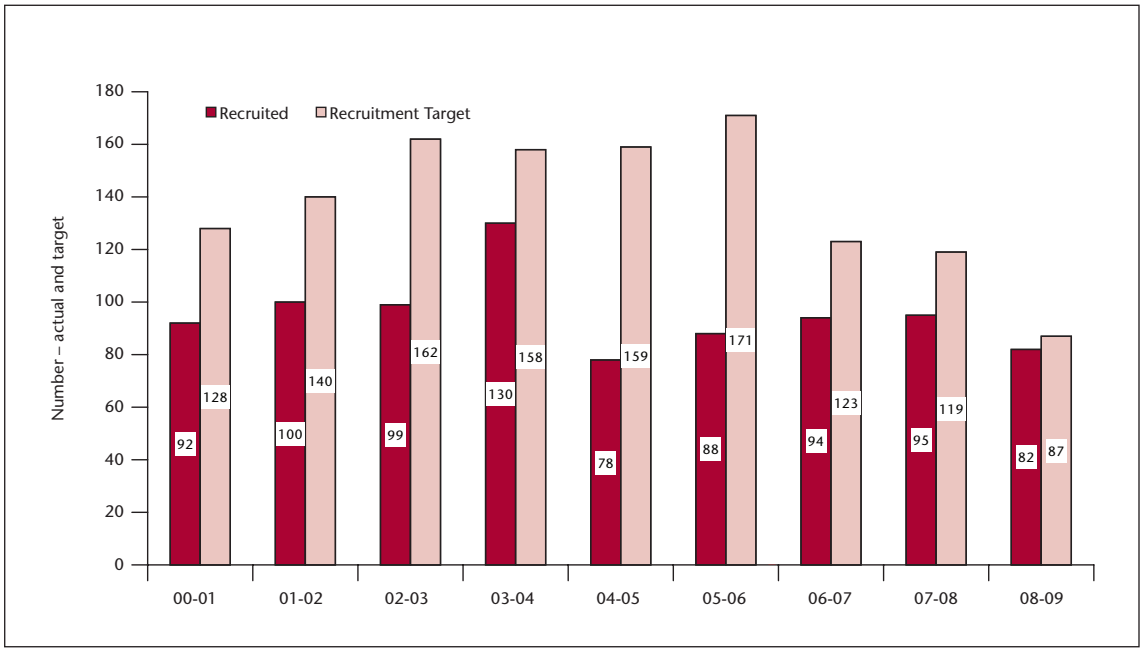


Recruitment evidence

11. DMS recruitment continued to fall short of targets for both MOs and DOs. In the year to 31 March 2009, 82 MOs were recruited against a target of 87. There was more success recruiting Direct Entrants (28 were recruited against a target of 27) than Cadets (54 recruited against a target of 60). Recruitment of DOs was less successful: 16 were recruited against a target of 31. Targets for both Direct Entrants and Cadets were missed.

12. Since the introduction of the Golden Hello[6] scheme in 2002 over 50 GMPs and Consultants have been recruited, including 2 GMPs and 2 Consultants since April 2008. Although the numbers recruited using this method are lower than expected, MOD continued to view the scheme as a useful and cost effective means of recruiting Consultants and GMPs who become deployable within six months of entry.

Chart 3: Total Medical Officer recruitment 2000-01 to 2008-09



[6] £50,000 Golden Hello available for Consultants in selective specialties and GMPs.

Retention evidence

13. The retention data provided by MOD showed:

- Overall 35 MOs left the Services during 2008-09, 6.2 per cent of trained strength. This is a reduction from 8.0 per cent in 2007-08 and 10.7 per cent in 2006-07; and
- Overall 12 DOs left the Services during 2008-09, 5.1 per cent of trained strength. This compares with 2007-08 when 11 DOs (4.5 per cent) left the DMS.

Operational commitments

14. Afghanistan remains the focus of operational activity and continues to place a significant demand on medical capabilities across the whole of the DMS. Shortfalls continue to exist despite the draw-down of medical support to operations in Iraq, completed in August 2009. Owing to the need to maintain operational readiness (aspects of which can only be manned by Regulars) alongside other permanent overseas commitments, some Regular personnel go directly onto standby following their mandatory post deployment stand-down.

15. MOD has continued to seek opportunities to support Regulars on deployment using Medical Reserves and Medical and Dental Officers from military allies. This has led to, for example, a brief reduction in the commitment for UK personnel to Afghanistan in summer 2009, when a number of Danish medical personnel were deployed.

16. Where UK uniformed operational support cannot be delivered or multi-national agreement to provide a specific capability cannot be obtained, Contractors on Deployed Operations have been used. These personnel are provided by a private company contracted to the MOD. Additionally, a partnership arrangement with the NHS has been developed, which has already contributed some specialist staff. In oral evidence the Surgeon General confirmed that he had sufficient numbers of Reserves, Regulars, NHS and contract staff to meet operational commitments.

DMS Reserves

17. *The Strategic Review of Reserves*[7] recognised the enduring and extensive use of Reserves, and in oral evidence the Surgeon General confirmed his reliance on Reserves to support operational commitments. Their vital and significant contribution to DMS operational output can be illustrated by the 69 Reserves who worked alongside 177 Regulars during April to October 2009 in Afghanistan.

18. The BMA was concerned about the impact on morale arising from inconsistent support from NHS employers in releasing doctors to fulfil Reserve Forces' training commitments. For example, some doctors had to take a fortnight's annual leave or even unpaid leave, adversely impacting on pension. In oral evidence, the Surgeon General emphasised that the partnership with the NHS was generally working well. We welcome the evident MOD commitment to work closely with NHS employers, which should improve support for Reservists.

19. From April 2010 the manning of one of the deployed field hospitals will alternate between the Regular and Reserve cadres. When it is the turn of the Reserves, it is estimated they will fill 40-70 per cent of the hospital posts. MOD will review this approach and report back to us next year. Reserves will continue to deploy to small and medium scale operations, rather than just large scale as mandated for at present. MOD believes that this is viewed positively by Reservists.

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[7] Published 28 April 2009.

20. Both MOD and Department of Health are fully supportive of a new initiative that allows Reserve Consultants to submit evidence of Reserve employment in applications for NHS employer-based and National Clinical Excellence Awards (CEAs). The Surgeon General indicated in oral evidence that he expected the forthcoming Strategic Defence Review (SDR) would provide the opportunity to acknowledge the critical role of Reserves and confirmed that the Service Personnel Planning Board was currently trying to improve support to Reservists.

Government's approach to public sector pay and affordability

21. The Government's evidence for our main remit group focused on the wider economic context. The impact of the global financial crisis on economic activity was more severe than expected, and public finances were profoundly affected by an unprecedented public sector borrowing requirement, with 2010-11 expected to be another difficult period for the global economy. The Government considered that given this context, Pay Review Body decisions for 2010-11 would have medium term implications for workforces and public finances. The Government's message was one of a need for pay restraint.

22. In evidence submitted to all Pay Review Bodies in October 2009, the Government proposed settlements in the range of up to 1 per cent for all public sector workforces (excluding senior staff and workforces subject to fixed 3 year pay deals). It proposed that senior staff should not receive a pay rise. However, for the Armed Forces, no pay settlement figure was proposed.

23. The Government emphasised that labour market indicators supported restraint. Recruitment and retention would improve, with public sector pay packages being seen as relatively attractive. Pay restraint would be a key factor in protecting public service quality. We were asked to recommend a settlement consistent with the Government's public sector pay policy, recognising Departmental affordability and the fragility of public finances. It would have to meet the need to recruit and retain personnel, and to sustain their motivation and morale by maintaining a competitive remuneration package, while recognising the special circumstances of the Armed Forces.

DDRB recommendations for 1 April 2010[8]

24. DDRB's 2010-11 recommendations took account of the global recession and uncertain outlook for the economy as a whole, together with the relatively healthy recruitment and retention of NHS doctors and dentists. It concluded that at best, modest increases to pay could be justified. Recommendations relevant to DMS groups include the following:

- An increase of 1.5 per cent to the national salary scales for foundation house officers (years 1 and 2) and their equivalents (house officers and senior house officers);
- An increase of 1 per cent for registrars, salaried General Medical Practitioners (GMPs) and General Dental Practitioners (GDPs), specialty doctors and associate specialist grades, the GMP Trainer Grant and GMP Educators' pay scales;
- No increase for consultants;
- No increase to the net income of independent contractor GMPs and GDPs. After allowing for movement in expenses this translates into gross uplifts of 1.34 per cent to the GMS contract and 1.44 per cent to the GDP contract; and
- No increase to the values of CEAs, Distinction Awards and Discretionary Points.

[8] *Review Body on Doctors' and Dentists' Remuneration, Thirty-Ninth Report 2010*, Cm 7837, March 2010, www.ome.uk.com

Pay comparability evidence

25. Our remit requires us to have regard to the need for the Armed Forces to have pay levels 'broadly comparable' with those in civilian life. For the DMS, unlike most other service personnel, there are direct comparators in the NHS. The BMA/BDA highlighted several pay differentials across cadres between the DMS and their NHS counterparts, which they said have existed for a number of years resulting in a cumulative pay deficit for the DMS. MOD, however, considered that pay was broadly comparable between civilian and military medical and dental personnel.

26. As in past years we considered comparisons between levels of DMS and NHS pay (at 1 April 2009 where data are available) and anticipated movements in pay in the NHS for 2010-11 following DDRB's recommendations. The following adjustments are made to the data to improve the basis of the comparisons: (i) remove the appropriate level of X-Factor from DMS salaries; (ii) make a downward adjustment to NHS salaries to recognise that the DMS has a relative pension advantage over the NHS; and (iii) where applicable, make downward adjustments to the NHS comparator, recognising that all DMS base pay is pensionable, but there are elements of NHS comparator pay which are not.

Summary of pay comparisons by DMS group

27. The following paragraphs summarise for each DMS group the pay comparability evidence, including that used by the parties to support their pay proposals.

Consultants[9]

28. Average DMS pay in 2009-10 was £101,712[10]. 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[11].
- Additional PAs – any programmed activities worked over the base 10 PAs are paid *pro rata*. The parties agree that one additional PA should continue to be used in comparator pay, although the average number of PAs worked in the DMS reduced further to 10.6 in 2008-09 from 10.9 and is now slightly below the latest available NHS figures of 10.8[12].
- On-Call Availability Supplement – NHS Consultants are paid a supplement for being available to work during on-call periods. Average DMS on-call commitments remain 1 in 7 which is considered a medium frequency rota within the NHS and would attract a 5 per cent supplement to basic pay. This is agreed by the parties as the appropriate level to be included for pay comparability.

NHS comparator pay comprising 11 Programmed Activities plus a 5 per cent On-Call Availability Supplement is £95,858 on average across a career. This gives a lead of almost £6,000 or 6.1 per cent for DMS personnel.

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[9] Unless stated otherwise the data have been adjusted as set out in paragraph 26.
[10] Assuming Consultants start at increment level 5 at age 35 and progress to increment level 30 at age 60.
[11] 10 PAs is 40 hours of work per week and deemed a full-time post.
[12] Latest NHS data published in 2005.

29. Employer-based (Local) Clinical Excellence Awards[13] were introduced in the NHS in 2003 as a replacement for the Discretionary Points scheme. 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). The BMA/BDA and MOD are discussing options on incorporating the value of employer-based CEAs within the DMS Consultant pay structure and have reached broad agreement that a merit-based system be introduced, but were not in a position to propose a firm methodology for us to consider this year.

30. The BMA/BDA confirmed in oral evidence that, although they support a merit-based approach, further discussions would take place on the qualification criteria. They reaffirmed their view that a system needs to be designed to prevent DMS personnel from losing out year on year (and therefore on career earnings) compared to their NHS colleagues. The Surgeon General confirmed MOD's view that the NHS scheme, which rewarded merit, should be mirrored in the DMS, although a lack of absolute clarity on the NHS approach, including recent changes to it, meant further examination would be required before any method was introduced.

31. MOD's methodology for establishing an average CEA value used 2008 data from the Advisory Committee of Clinical Excellence Awards on the proportion of NHS Consultants receiving awards across levels 1-9. These were then applied across the DMS Consultant cadre to obtain a weighted average value of around £4,000. MOD pay comparisons of 11 PAs plus a 5 per cent On-Call Availability Supplement plus an average employer-based CEA award suggest that NHS pay is £100,129. This is a lead of around £1,600 or 1.6 per cent for DMS personnel.

32. We welcome the dialogue between the parties about CEAs, and accept that further discussion is required before a definitive approach is agreed. However, we look forward to receiving firm proposals for our 2011 Report.

General Medical Practitioners[14]

33. Pay comparisons are made using 2007-08 data, the latest available, which were published by the NHS Technical Steering Committee[15]. Data for this period include earnings and expenses for both full and part-time GMPs and relate to both NHS and private practice (but not wholly private practice) income. NHS comparator data are GMP net income i.e. earnings less expenses. Average DMS salaries for 2007-08 were £93,729 when adjusted.

34. Both the BMA/BDA and MOD continue to agree that independent contractor NHS GMPs are the appropriate comparator. In evidence the parties have used all General and Personal Medical Services (GPMS)[16] GMPs when making pay comparisons. Average net income for this group was £97,586, 1.5 per cent lower than 2006-07. This equates to a deficit of around 4 per cent for DMS GMPs, narrowing from 7 per cent a year earlier.

35. In their evidence the BMA/BDA highlighted the substantial increases in income witnessed by NHS GMPs following the introduction of the new GMS contract in 2004 and claim that DMS earnings continue to lag behind their NHS counterparts, resulting in significant lost income. The latest gap of 4 per cent has further compounded the cumulative loss according to the BMA/BDA.

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[13] 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.
[14] Unless stated otherwise the data have been adjusted as set out in paragraph 26.
[15] *GP Earnings and Expenses 2007-08 Provisional Report* produced by the NHS Technical Steering Committee, September 2009.
[16] GMPs working under either a General Medical Services or Personal Medical Services contract.

36. MOD confirmed in evidence that pay between DMS and NHS GMP colleagues was converging and highlighted the two-year lag in available data. NHS GMP net income has seen a reduction since 2006-07 resulting in the pay gap narrowing for the second consecutive year. Despite an element of dispensing undertaken by some DMS personnel, MOD were of the view that a comparator comprising both dispensing and non-dispensing GMPs was appropriate.

General Dental Practitioners[17]

37. In 2006-07 new NHS contractual arrangements in England and Wales were introduced which changed both the way General Dental Services (GDS) dentists were remunerated and how they were classified[18]. In 2007-08, the year for which latest data are available (as for GMPs) and therefore the year used for making pay comparisons, the average DMS GDP salary was £93,729.

38. The latest 2007-08 HM Revenue and Customs earnings data[19] included NHS and mixed NHS/private practice dentists, but excluded dentists who derived their income wholly from private practice. Income was split by classification and contract type and illustrated the range of average earnings on offer in the civilian sector. While net profits were lower than those in 2006-07 direct comparisons could not be made as transitional payments made during the first year of the new contract had a one-off effect. The 2007-08 England and Wales data showed:

- All Providing-performers average net profit of £116,662;
- All Performer only dentists average net profit of £60,441; and
- All dentists' average net profit of £81,937.

39. Average unadjusted net profits for GDS Providing-performer dentists of £112,210 were highlighted in MOD evidence. However, they continue to view the internal comparator (DMS GMPs) as being more appropriate than comparisons with civilian dental earnings and asked us to maintain the link with DMS GMPs pay.

40. BMA/BDA evidence included references to figures for England (£126,527) and Wales (£131,287) relating to average unadjusted Providing-performer net profits. They also highlighted 2007-08 data from the National Association of Specialist Dental Accountants whose members represent one fifth of dentists working in all types of practices. This showed average unadjusted dental earnings of £148,000 within NHS practices in England and Wales and average private sector earnings of £137,000. All these figures served to demonstrate that pay for DMS GDPs has fallen further behind their civilian counterparts, according to the BMA/BDA. However, they agreed with MOD that the internal comparator (DMS GMPs) is the most appropriate.

Junior Doctors

41. In recent years DMS Junior Doctors have seen their pay move ahead of their NHS colleagues. This is partly due to the move towards capping working hours for NHS Junior Doctors in posts compliant with the European Working Time Directive at 48 hours. This legislation came into effect in August 2009 and 99 per cent of doctors in training are now in NHS New Deal compliant posts. The average out of hours band supplement[20]

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[17] Unless stated otherwise the data have been adjusted as set out in paragraph 26.

[18] 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.

[19] Dental Earnings and Expenses, England and Wales, 2007/08 produced by the NHS Information Centre for health and social care.

[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.

awarded to Junior Doctors has subsequently fallen further from 1.48 to 1.45[21], with a reduced maximum supplement of 50 per cent for compliant posts.

42. BMA/BDA's 2009 survey of DMS doctors[22] showed that working arrangements for DMS Junior Doctors have not changed substantially in recent years, with personnel working on average 48.1 hours per week. MOD evidence pointed out that few DMS Junior Doctors worked in areas that received a larger banding supplement within the NHS (Bands 2A and 3[23]), with most personnel operating within lower band positions. They also confirmed the move out of higher supplement posts into lower banding posts within the NHS. Pay comparisons showed DMS salaries continued to remain ahead of NHS counterparts with the exception of Bands 2A and 3.

Pension valuation methodology

43. We signalled in our 2008 and 2009 reports our intention to look at the options for pension valuations which would capture the DMS pay and pension arrangements, taking account of the 2005 (and any future) scheme changes. Such a valuation should consider the package across a whole career (including its potential impact on retention at key points), be transparent to the remit group, and be compatible with our approach to pay comparability. We had considered research by Professor Peter Dolton of the Royal Holloway College which assessed different methodologies, and one of our members, Professor Derek Leslie produced a valuable paper illustrating how one methodology, the Total Reward approach, might be applied to the DMS.

44. We shared Professor Leslie's methodology with the parties in 2009, with a view to their identifying an agreed methodology, which we had initially hoped to have in time for this round. It is clear, however, that this is a complex area, and we recognise the need to give the parties time to consider fully the issues it raises and to take such further professional advice as they judge necessary. Before proceeding we would hope to ensure an appropriate method which could command the broad support of both the DMS and the BMA/BDA.

45. In oral evidence the BMA/BDA assured us they were considering the question further, in the light of their own actuarial advice. They emphasised that accurate data were the foundation of any such methodology and undertook to return to us with a considered view for next year. The Surgeon General recognised that the Total Reward approach was conceptually attractive. He indicated that MOD was considering total reward in a wider context. The MOD had sought advice from the Government Actuary's Department, and in the light of this would look again with BMA/BDA at the issue of the appropriate treatment of pensions in overall pay comparability. MOD would wish to run any different valuation approach in parallel with the existing methodology. We urge the parties to work together, with a view to bringing forward an agreed methodology for pension valuation.

46. We recognise the parties' need to take actuarial advice, but we do expect them to bring forward proposals by the autumn 2010 so that we can give them proper consideration as part of our next round. In the meantime, we will consider any lessons which emerge from a planned conference by the Office of Manpower Economics (OME) in 2010 to gather expert views on approaches to total reward in the public sector[24]. The work of Professors Dolton and Leslie will contribute to this conference.

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[21] *NHS Employers Monitoring Summary* – March 2009.
[22] Health Policy and Economic Research Unit, Survey of Defence Medical Services doctors – report, January 2010.
[23] Band 3 (100% supplement) applies for doctors who are non-compliant with New Deal requirements. Band 2A (80% supplement) applies for over 48 hours of work where more than one third of hours are unsocial.
[24] The OME will make the papers available on its website after the conference.

MOD and BMA/BDA pay proposals for 2010-11

47. MOD proposed a pay award which would mirror DDRB recommendations for all DMS groups and all other DMS pay elements, noting that the Government had not proposed a settlement figure for the Armed Forces as it had for other public sector workforces. In a change of approach from previous years, the BMA/BDA proposed that the overall pay award should be linked to that recommended for the main AFPRB remit group, with extra uplifts informed by DDRB recommendations. They also argued for additional increases for selected groups to address perceived pay disparities with the NHS. In summary the parties' proposals were:

- Overall pay award – MOD proposed an increase in line with DDRB recommendations. The BMA/BDA sought an award which reflected that recommended for the wider Armed Forces;
- Consultants – the BMA/BDA sought an additional substantial uplift to the value of DMS National CEAs;
- GMPs – the BMA/BDA proposed uplifts in line with the DDRB net income recommendation for GMS contractors plus an additional uplift to make up what they regarded as a long-standing shortfall between DMS and NHS equivalents. MOD considered that DMS and NHS income was broadly comparable and proposed the DDRB net income recommendation be adopted;
- GDPs – both parties considered it appropriate to maintain the pay link with DMS GMPs;
- Higher Medical Management Pay Spine, Junior Doctors and Cadets – both parties proposed increases similar to those for their linked cadres; and
- Reserves – both parties proposed uplifts in line with those for Regulars.

RECOMMENDATIONS FOR 2010-11

Overall pay recommendations

48. Our pay recommendations seek to support recruitment, retention and motivation and ensure that broad comparability with NHS comparators is maintained. We take account of the economic conditions, MOD's evidence on affordability and evidence on the particular circumstances of DMS doctors and dentists.

49. When reviewing DMS pay, we consider data on comparability with the NHS, and our recommendations in recent years have, in our view, achieved broad comparability on pay levels. As personnel in the DMS usually compare themselves with colleagues in the NHS, our main driver is to keep pace with pay movements which will result from DDRB recommendations. We are mindful that MOD and, traditionally the BMA/BDA, emphasise that keeping pace with the DDRB recommendations is an important element in achieving and maintaining comparability.

50. DMS manning, recruitment and retention have, in general, shown improvements over the last year. The improvement in the number of trained MOs has resulted from more personnel becoming accredited and from a reduction in the outflow rate. However, there remained a 26 per cent shortfall against the requirement. DO manning remained close to requirement despite a slight increase in the outflow rate. Maintaining low Voluntary Outflow rates is essential to DMS manning and to retain the experienced personnel required for operational capability, especially given the current high operational tempo. Despite improving manning overall, significant specialty shortages remain, with manning balance not projected to be met in the next five years. DMS

recruitment of both MOs and DOs was below target. Both MOD and BMA/BDA, however, recognised that many of the retention issues for the DMS were not pay related. MOD provided some evidence on the non-remunerative measures it is undertaking to try to address existing shortfalls. MOD has also commenced work on the *DMS Strategic Plan*, which will form part of the SDR, to address the future shape and management of the DMS.

51. Uncertainty is expected to continue in the labour market and the wider economy through 2010. The latest data, for January 2010, showed Consumer Prices Index inflation at 3.5 per cent and Retail Prices Index inflation at 3.7 per cent. Whole economy average earnings, including bonuses, increased by 1.6 per cent in the three months to December 2009 (public sector 2.7 per cent).

52. Government evidence set out the implications of wider economic developments for public sector pay decisions. While pay awards should help recruit and retain quality workforces, pay restraint and value for money were the key themes. We accept the importance of value for money from the paybill when there are many pressures on MOD's budgets and have taken into account MOD's evidence on affordability of pay awards.

53. In their evidence this year, BMA/BDA proposed that we recommend an overall increase in line with that for the main Armed Forces remit group, plus additional rises informed by DDRB, and further uplifts for some cadres to reduce disparities with NHS comparators. However, in both written and oral evidence, BMA/BDA acknowledged that many of the reasons for people leaving the DMS are not pay related and bear similarities to those for the main group. These include increased separation and operational tempo, plus other family and lifestyle factors.

54. After full consideration of all the evidence gathered, we recommend an award in line with that recommended by DDRB for the NHS. We believe our recommendations reflect a balanced approach and will continue to support recruitment, retention, morale and motivation and will maintain broad comparability with NHS doctors and dentists. We note that over recent years the DMS have benefitted from improvements to NHS pay, and in some cases DMS awards have exceeded our main remit group awards. Our recommendations also take account of what is affordable within the current constrained financial environment.

55. We considered the case for additional pay increases put forward by the BMA/BDA. In general, we consider that DMS pay is broadly comparable with the NHS and do not recommend increases over and above those recommended by DDRB. However, we comment below on some of the specific proposals made for additional pay uplifts.

Recommendation 1: We recommend the following changes from 1 April 2010:

- **DMS Accredited Consultants (OF3-OF5), Higher Medical Management (OF5 and OF6) staff, Accredited General Medical and Dental Practitioners (OF3-OF5), Accredited Medical and Dental Officers (OF2) and Reserve equivalents – no increase;**

- **Non-Accredited Medical Officers (OF3-OF5), Non-Accredited Service Medical and Dental Officers Levels 2-5 (OF2) and Reserve equivalents – an increase of 1 per cent;**

- **Non-Accredited Service Medical and Dental Officers Level 1 (OF2), Service Medical and Dental Officers (OF1) and Medical and Dental Cadets and Reserve equivalents – an increase of 1.5 per cent.**

The recommended pay scales are at Appendix 1.

Proposals for additional pay increases

DMS Consultants

56. Neither MOD nor BMA proposed a change in the number of programmed activities (PAs) to be used as the NHS Consultant comparator, which remains at 11 PAs. The continued inclusion of the existing On-Call Availability Supplement as part of the Consultant comparator was also proposed. We are content with this approach.

57. During our programme of visits we met a number of DMS Consultants. They expressed concern and frustration over a number of issues of which communication was one. It is important, in our view, that a consistent and effective dialogue is maintained to ensure their views are understood and responded to appropriately. While outside the area we make recommendations on, we would encourage MOD to consider how best to ensure effective communications with all DMS staff is achieved, potentially as part of the forthcoming *DMS Strategic Plan*.

GMPs and GDPs

58. MOD and BMA considered that the most appropriate NHS comparator for GMPs remained all GPMS contractor GMPs, rather than salaried GPs. Available data suggest an income deficit of around 4 per cent for DMS GMPs compared with their NHS counterparts, although this may have decreased more recently. MOD considers this to be broadly comparable although BMA remained concerned over this gap, particularly as it has existed for some time.

59. The BDA reported that there was dissatisfaction among some GDPs over the 2009 pay award, particularly in comparison with their military colleagues. However, both BDA and MOD consider that, as GDPs are on the same pay spine, the link with DMS GMPs should be retained in any award: we agree that this is appropriate.

DMS Trainer Pay, Associate Trainers and Education Supervision

60. MOD considered that the introduction of Associate Trainer Pay in 2008 made the career of DMS Trainers more attractive and augmented the support for this group. It proposed that both GMP/GDP Trainer Pay and Associate Trainer Pay be increased in line with DDRB's recommendation of an increase of 1 per cent. We are content that this is a suitable approach. MOD is also investigating the potential to award Educational

Supervisor Grants to accredited GP Trainers, as is the practice in the NHS. Proposals will be submitted in evidence for 2011.

Recommendation 2: We recommend that DMS Trainer Pay and GMP Associate Trainer Pay should be increased by 1 per cent from 1 April 2010. The recommended levels are shown at Appendix 1.

Consultants' National Clinical Excellence Awards and Distinction Awards

61. We recommend on DMS National CEAs and Distinction Awards to ensure that they reflect arrangements in the NHS. This year BMA/BDA requested a substantial increase to the value of all DMS National CEAs to address the differential with the NHS. However, following our recommendation to increase the number of awards available in 2009, we consider that our recommendation on National CEAs should follow that made by DDRB. It recommended that there should be no increase in the value of these awards in 2010, reflecting the recommendations on Consultant pay, and we consider this to be appropriate.

Recommendation 3: We recommend no increase to the value of DMS National Clinical Excellence Awards and Distinction Awards from 1 April 2010. The recommended levels are shown at Appendix 1.

Cost of recommendations

62. We estimate that the cost of our pay recommendations for 2010-11 is £0.8 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 2010. To the extent that actual strengths through 2010-11 will vary from those at the end of February 2010, the cost of implementing the recommendations will also vary.

LOOKING AHEAD

63. MOD told us that the Deputy Chief of Defence Staff (Health) has taken personal responsibility for the development of a DMS Strategic Plan. The primary focus of this is to maintain healthcare delivery over the next five years. Drawing on the developing partnership with the civilian healthcare sector, the plan will focus and direct the development of DMS personnel to match future Defence needs. This should assist MOD in managing the implications for the DMS of the forthcoming Strategic Defence Review.

64. We noted earlier in this Report the work done so far on investigating an alternative methodology for valuing pensions within the DMS and NHS. This was shared with the parties in September 2009. An inherent part of this approach is an evaluation of the DMS pension which allows personnel to leave at a key milestone in a career, the immediate retirement point. The current career average abatement which we apply may not fully capture the benefits of this feature for individuals at key career points. We had therefore asked MOD and BMA/BDA to work together to consider a more appropriate methodology for assessing these pension benefits.

65. We recognise the need for the parties to take time to look at the complex issues this poses, and to seek their own actuarial advice, but this is an important issue on which we need to make progress. We welcome the commitments from MOD and the BMA/BDA to co-operate on finding an appropriate way forward. We do, however, expect proposals by autumn 2010 so that we can give them proper consideration in our next pay round.

66. This year, we were unable to receive the same detailed data on DMS personnel as we had in the previous year. In oral evidence, the Surgeon General committed to rectifying this for our next report. In particular, we would welcome timely and accurate data on manning and much more detail about the Reserves, who form such an important element of DMS manning.

67. Evidence we received this year suggested that pay was not the sole retention and motivation issue for DMS personnel. Demographics, lifestyle choices and operational commitments mean other issues of personnel policy and career design are becoming increasingly important. MOD acknowledges this and we note the progress made and further developments planned. Innovative approaches that help to fill key specialties, together with options for alternative career streams will be crucial to ensure continuing operational support. We look forward to receiving further evidence on the effectiveness of non-remunerative measures next year.

David Greenaway
Robert Burgin
Mary Carter
Graham Forbes
Alison Gallico
Peter Knight
Derek Leslie
Judy McKnight
John Steele
Ian Stewart

March 2010

Appendix 1

1 April 2010 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	96,973
Level 28	96,184
Level 27	95,403
Level 26	94,619
Level 25	93,830
Level 24	93,050
Level 23	92,265
Level 22	90,705
Level 21	89,819
Level 20	88,925
Level 19	88,030
Level 18	87,140
Level 17	86,250
Level 16	85,356
Level 15	84,561
Level 14	83,777
Level 13	82,985
Level 12	82,194
Level 11	81,407
Level 10[a]	80,619
Level 9	79,670
Level 8	78,071
Level 7	76,468
Level 6	75,330
Level 5	74,204
Level 4	73,074
Level 3	71,944
Level 2	68,160
Level 1	64,399

[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	59,626	72,849
Level 4	71,371	58,103	71,371
Level 3	69,897	56,570	69,897
Level 2	68,416	55,051	68,416
Level 1	66,938	53,804	66,938

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

	Military salary
	£
OF1	40,729

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	18,421
	after 1 year	16,573
	on appointment	14,733

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	£7,669
GMP Associate Trainer Pay	£3,834

DMS Distinction Awards

A+	£60,470
A	£40,315
B	£16,126

DMS National Clinical Excellence Awards

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

Appendix 2

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

All salaries are rounded to the nearest £.

Table 2.1: **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 2.2: **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 2.3: **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 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	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 2.5: **Annual salaries inclusive of the X-Factor for Service Medical and Dental Officers: OF1 (PRMPs)**

	Military salary
	£
OF1	40,127

Table 2.6: **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 2.7: **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 2.8: **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	£7,593
GMP Associate Trainer Pay	£3,796

DMS Distinction Awards

A+	£60,470
A	£40,315
B	£16,126

DMS National Clinical Excellence Awards

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

Appendix 3

2009 recommendations and Government response

Our recommendations for 2009, accepted in full by the Government on 20 May 2009, were:

- 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.

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