Armed Forces' Pay Review Body

Service Medical and Dental Officers

Supplement to the Thirty-Seventh Report – 2008

Chairman: Professor David Greenaway

Cm 7347
£13.90

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

May 2008

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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
Dr Anne Wright CBE
Lord Young of Norwood Green

The secretariat is provided by the Office of Manpower Economics.

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

Contents

GLOSSARY OF TERMS

BDA British Dental Association

BMA British Medical Association

CEA Clinical Excellence Awards

CPI Consumer Prices Index

DDS Defence Dental Services

DOs Dental Officers

DMS Defence Medical Services

DDRB Review Body on Doctors' and Dentists' Remuneration

GAD Government Actuary's Department

GDP General Dental Practitioners

GDS General Dental Services

GMP General Medical Practitioners

GMS General Medical Services

HMM Higher Medical Management

HMRC HM Revenue and Customs

JPA Joint Personnel Administration

MOs Medical Officers

MOD Ministry of Defence

NHS National Health Service

PAs Programmed Activities

PDS Personal Dental Services

PRMPs Pre Registration Medical Practitioners

RPI Retail Prices Index

ARMED FORCES' PAY REVIEW BODY
2008 DMS REPORT – SUMMARY

Key recommendations

- **A 2.2 per cent increase for all DMS Medical and Dental Officers (and all DMS Reserve equivalents), except GMPs and GDPs;**
- **A 3.7 per cent increase for DMS GMPs and GDPs (and DMS Reserve equivalents);**
- **The parties should present joint proposals on targeting the value of NHS Local Clinical Excellence Awards within DMS Consultants' pay for our 2009 Report;**
- **An increase in X-Factor from 13 to 14 per cent plus revised tapering arrangements;**
- **A 2.2 per cent increase in the values of DMS National Clinical Excellence Awards and Distinction Awards, and DMS Trainer Pay, plus the introduction of DMS GMP Associate Trainer Pay (implementation date to be advised).**

Evidence for this Report

We examine a range of evidence for the Defence Medical Services under our terms of reference. We draw on DMS manning, recruitment and retention, NHS pay comparisons, NHS pay recommendations from DDRB, our independent research, meeting DMS personnel on our visits, and the written and oral evidence from the Ministry of Defence and the British Medical and Dental Associations. We set the evidence into the context of DMS and NHS developments as they impact on our pay comparisons. Our 2007 DMS pension valuation, supported by GAD's research, suggests that current complexities do not allow an informed, robust judgement on any change to the adjustment levels and we wish to review a more appropriate methodology.

Manning, recruitment and retention

While we welcome MOD's refinements of DMS manning requirements, manning levels continued to be significantly below requirement at 1 April 2007. Trained Medical Officer strength was 36 per cent below requirement, many Consultant specialties had deficits above 50 per cent, there was a 20 per cent shortfall of GMPs, and Dental Officer trained strength was 6 per cent below requirement. Medical Officer recruitment failed to meet targets for Cadets and Direct Entrants in 2006-07 for the fifth consecutive year. Dental Officer recruitment was close to the 2006-07 recruitment target. After several years of stable Outflow, 2006-07 saw increases in Medical Officer Overall Outflow (to 5.1 per cent) and Voluntary Outflow (more than doubled to 2.5 per cent). Dental Officer Outflow also increased significantly with Overall Outflow at 9.4 per cent and Voluntary Outflow at 5.9 per cent. Factors influencing DMS retention are similar to those across the Armed Forces, namely high operational commitments resulting in separation and impact on family life. DMS support to operations was considered sustainable but fragile with continued reliance on the deployment of DMS Reserves.

Pay comparability

Pay comparability is an essential part of our remit and informed by Capita's independent research and evidence from MOD and the BMA/BDA. We note some improved NHS earnings data and have set out our approach to enable the parties to present consistent future evidence. For DMS Consultants, we see pay comparability achieved when accounting for 11 Programmed Activities and a 5 per cent On-Call Supplement. Comparisons with GMPs suggest that the DMS have fallen behind earnings for General Medical Services' non-dispensing GMPs in 2005-06. A range of NHS earnings data were presented for GDPs although most worked in mixed NHS and private practice. Junior Doctors' pay remains comparable with the NHS. Drawing on their evidence, the parties presented differing pay proposals.

Recommendations

We conclude that DMS recruitment and retention continues to be under pressure, operational commitments are high and we should recognise the key DMS contribution. Our overall pay recommendation of 2.2 per cent is guided by DDRB recommendations and should also apply to all other DMS pay elements. DMS GMPs and GDPs (the latter by virtue of maintaining the pay link with GMPs) should receive 3.7 per cent to reflect the earnings gap with NHS GMPs and growing risks to retention – we wish to monitor pay comparisons for our 2009 Report. We recommend the parties present proposals on incorporating the values of NHS Local Clinical Excellence Awards in DMS Consultants' pay. As with the main remit group, since the last review of X-Factor the DMS have also experienced a change in the net disadvantage – the increase to 14 per cent and revised tapering arrangements should apply to the DMS. We recommend the introduction of GMP Associate Trainer Pay on a date to be advised. Our recommendations are consistent with the Government's approach to public sector pay, achieving its CPI inflation target and MOD's affordability evidence. We estimate that our recommendations add £8.2 million to the DMS paybill.

Looking ahead

Delivering DMS capability remains crucial when under such sustained operational pressure. We strongly advocate further work is required on alternative approaches to DMS manning, attracting recruits, offering attractive careers, developing supporting pay structures and delivering non-remuneration measures. We reiterate our view that reform of DMS pay and careers is long overdue particularly if MOD is to maximise its return on investment. We have requested evidence for our 2009 Report covering manning data, working hours, non-remuneration measures and pay comparisons.

INTRODUCTION

1. For this report we reflect on developments in, and examine the evidence relating to, the Defence Medical Services (DMS). We arrive at our recommendations drawing on the Government's policy on public sector pay, Ministry of Defence (MOD) evidence on affordability, pay recommendations for National Health Service (NHS) doctors and dentists by the Review Body on Doctors' and Dentists' Remuneration (DDRB), and our independent assessments of pay comparisons with NHS earnings, DMS manning, recruitment and retention. We also set out our views on taking the DMS forward.

2007 recommendations

2. Our 2007 recommendations (submitted on 26 March 2007 and accepted in full by the Government on 10 May 2007) were:

    - A 2.0 per cent increase for all DMS Consultants, General Medical and Dental Practitioners (GMPs and GDPs), Higher Medical Management staff, Associate Specialists, Junior Doctors (including GMP Registrars), Cadets and all DMS Reserve equivalents;
    - A 2.0 per cent increase for DMS Trainer Pay; and
    - No increase to the values of DMS Clinical Excellence Awards and Distinction Awards.

3. On 22 October 2007, the British Medical and Dental Associations (BMA/BDA) wrote to us questioning our independence in making the 2007 recommendations. In their view, the process and outcomes had been subject to Government interference. We guard our independence jealously. We therefore responded on 25 October 2007, and again in oral evidence, making it clear to the Associations that we operate independently of Government in our processes and in arriving at recommendations. We also assured the BMA/BDA that their evidence was given full consideration alongside all other evidence presented.

DMS AND NHS DEVELOPMENTS

DMS developments

4. MOD provided us with updates on a range of DMS developments. The *Defence Health Programme* (2007-2011) continued to improve the quality of services focusing on medical support to operations and delivering sufficient numbers of Service personnel fit for the operational task. The *Defence Health Change Programme* sought to adapt to the envisaged environment in 2015 – specifically establishing command and organisation structures to deliver capability to the front line. MOD also reported on the *Defence Medical Information Capability Programme* which responded to advances in preparing and protecting personnel by improving information collection.

5. The partnership between MOD and the Department of Health established how the two Departments work together to improve healthcare monitored by the Partnership Board. Closer working arrangements were helping to ensure military medicine was considered in the development of health policy. MOD's *Managed Military Health System for Force Generation* was optimising healthcare to maximise the number of personnel fit for employment by fast-track treatment, rehabilitation, mental health services and improved reporting.

6. On 18 February 2008, the House of Commons Defence Committee published its Report on Medical Care for the Armed Forces[2]. The Committee reported that the Armed Forces received high quality clinical care on operations, high quality rehabilitation services in the UK and that DMS personnel working with the NHS provided "world-class" care. It found healthcare for families abroad to be of high quality and that veterans had priority access to the NHS. While recognising that mental health services were a vital responsibility for the DMS and that progress had been made including on a preventative approach, the report raised concerns over the identification and treatment of veterans' mental health needs. The Committee acknowledged improvements in ward management and welfare support at the Royal Centre for Defence Medicine, Birmingham and refuted inaccurate media reports. MOD's decision to base secondary care around units embedded in NHS Trusts was endorsed by the Committee on clinical, administrative and financial grounds. It added that care had not suffered and that DMS personnel experienced a much broader range of cases. We note that the Committee concluded that DMS Reserves played a critical role in delivering healthcare, particularly meeting operational commitments, but that Reserves' recruitment and retention needed to remain buoyant.

7. Other DMS developments included progress on flexible working proposals to improve work-life balance and implementation of new arrangements under *Modernising Medical Careers* involving changes to the length of training, type of posts and examination requirements. MOD also reported that the Higher Medical Management cadre continue to grow with 27 OF5s and OF6s in post with entry based on the skills and competencies for DMS strategic management. MOD and the BMA/BDA recognised the importance of maintaining pay and career incentives to OF5 and OF6.

8. From April 2008, the *Defence Dental Services* (DDS) will restructure under a 1-Star lead to continue to deliver effective military dentistry contributing to force generation. MOD acknowledged that manpower shortages had affected the achievement of key performance indicators. The BDA noted that manpower shortages affected the dental fitness of the Services (particularly in the Army), delayed periodic dental inspection and led to the closure of dental centres.

NHS developments

9. We continue to monitor those developments in the NHS which are relevant to the DMS remit group and which influence our remit on broad pay comparability. We note that:

- Since 2000, all NHS Consultants, GMPs, GDPs (in England and Wales), salaried dentists (in England) and doctors and dentists in training have been working under new contracts. New contractual arrangements were under consideration for salaried dentists in Wales, Scotland and Northern Ireland, and Non-Consultant Career Grades were to be balloted on a new contract;
- DDRB concluded that there were no major NHS recruitment and retention concerns though motivation and morale had been affected by the Government's staging of the 2007 award and the difficulties experienced with the Medical Training Application Service;
- The numbers of salaried GMPs continued to rise with DDRB pointing to the parties being able to negotiate their annual pay review when agreeing their terms and conditions;
- Development of a new remuneration structure for GMP Trainers continued; and
- For GDPs, DDRB again recommended that the parties jointly work on dental expenses, focusing on the non-staffing element.

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[2] *Medical Care for the Armed Forces* – House of Commons Defence Committee, The Stationery Office HC327, 18 February 2008.

2007 DMS PENSION VALUATION

10. We conduct DMS pension valuations as part of our remit to ensure broad pay comparability. These periodically value DMS and NHS pensions to establish the relative advantage of DMS pensions, expressed as a percentage of pay, which informs our comparability assessments. The current relative advantage of DMS pensions means that for pay comparability purposes NHS comparator pay is reduced by 11 per cent for all DMS Doctors in Training (and Non-Accredited Medical Officers up to increment Level 10) and by 8 per cent for all accredited Consultants, GMPs and GDPs (and Non-Accredited Medical Officers on increment Level 11 and above). The two adjustments are intended to reflect the relative DMS advantage over a career.

11. In 2006, we commissioned the Government Actuary's Department (GAD) to advise us on the DMS pension valuation. This work was completed after we submitted our 2007 DMS Report although this delay had no impact as the valuation would apply to pay comparisons for this report. To enable the parties to take an early view, we published GAD's Report on our website[3]. We anticipated in our 2007 Report that GAD's work, compared to earlier valuations, would be complicated by: (i) accounting for the split between the old and new DMS pension schemes; (ii) limited availability of up-to-date NHS pay data and pay profiles following reforms; (iii) application of the earnings cap; (iv) lack of current data to support assumptions; and (v) methodological considerations.

Results

12. In its report, GAD confirmed that the valuation was far more complicated than previous reviews. Changes in methodology, the review of benefit structures for both the Armed Forces and NHS schemes, the lack of available data and the required assumptions were some of the difficulties posed. Variables including career profiles, pension scheme membership and treatment of benefits (post 60 only, all benefits, or a combination) were used by GAD to produce permutations of possible adjustment levels. The sensitivities in these results (Appendix D of GAD's Report) highlight the difficulty in determining an appropriate level of adjustment. GAD blended its results to produce single adjustment figures for Major and below and ranks above Major by: combining career profiles; giving equal weight to Consultants, GMPs and GDPs; and applying assumptions on scheme membership and treatment of the earnings cap.

Conclusion and way forward

13. As with the pension valuation for the main remit group in our 2007 Report, we have applied a degree of judgement to GAD's DMS pension valuation. Given the complexities of changes to DMS pay and pensions and NHS pay, and the sensitivities of the results to changes in assumptions, we conclude that there is insufficient information to make an informed, robust judgement that could apply until our next valuation. Consequently and as an interim measure ahead of further work (see paragraph 78), we have applied the current levels of pension adjustment to comparator pay for our pay comparisons in this report.

[3] *Comparison of the Pension Arrangements for Service Medical and Dental Officers* – Government Actuary's Department, June 2007, www.ome.uk.com.

EVIDENCE FOR THIS REPORT

Evidence base

14. Our recommendations and conclusions are drawn from an extensive evidence base comprising:

- MOD's written evidence on DMS manning, pay proposals and affordability;
- The BMA/BDA's written evidence including pay proposals;
- Oral evidence from the Deputy Chief of Defence Staff (Health), Surgeon General and from the British Medical and Dental Associations;
- Recommendations on NHS doctors' and dentists' pay by the Review Body on Doctors' and Dentists' Remuneration;
- Independent research into DMS and NHS pay comparisons commissioned from Capita Health Service Partners;
- The Government's evidence on its approach to public sector pay as submitted to all Pay Review Bodies;
- X-Factor evidence to our main review from MOD and the BMA/BDA and Incomes Data Services[4] – a full analysis is in our 2008 Report[5]; and
- Our visits to DMS personnel during 2007.

15. We are grateful to MOD and the Services for arranging our 2007 visits. These enabled us to hear first hand the concerns of DMS personnel across all ranks and particularly those of DMS Medical and Dental Officers. We visited: the Royal Centre for Defence Medicine, Birmingham; 202 (Midlands) Territorial Army Field Hospital, Birmingham; the Defence Medical Rehabilitation Centre, Headley Court; and medical facilities at Camp Bastion in Afghanistan. We also met DMS Regular and Reserve personnel as part of our visits to other UK and overseas units (a full list of AFPRB visits can be found in the 2008 Report, Appendix 4).

DMS manning evidence

16. MOD's DMS Department Personnel Policy Steering Group has been refining manning requirements for Medical and Dental Officers. MOD announced, on 27 March 2007, the requirement for 1,074 Medical Officers (MOs) and 254 Dental Officers (DOs). In its written evidence, MOD also included 123 General Duties Medical Officers in an overall requirement of 1,197 MOs. Looking forward, we welcome MOD's comments in evidence that further work and resources are being committed to improving the information supporting manpower planning.

17. At 1 April 2007 there were 495 trained Medical Officers, against a total requirement for 1,197, a deficit of 36 per cent against the trained requirement. In addition, there were 552 MOs in training (Chart 1). The strength of Medical Officers, both trained and those in training, has changed very little since April 2005.

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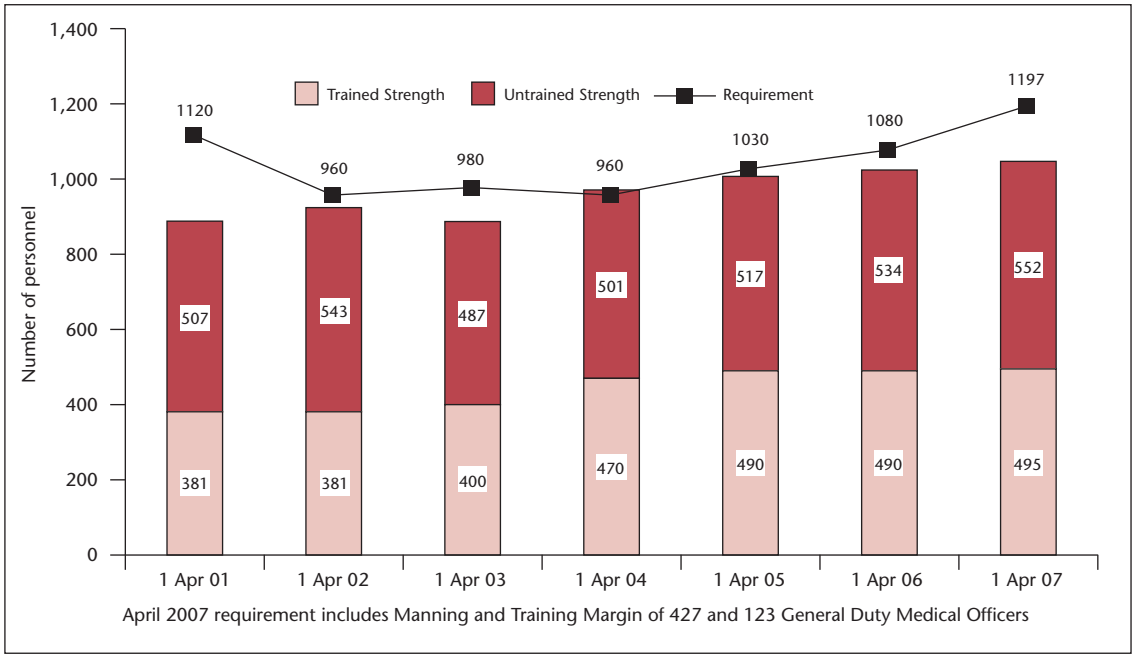
[4] *A review of the X-Factor, a report for the AFPRB* – Incomes Data Services, August 2007 published on www.ome.uk.com.

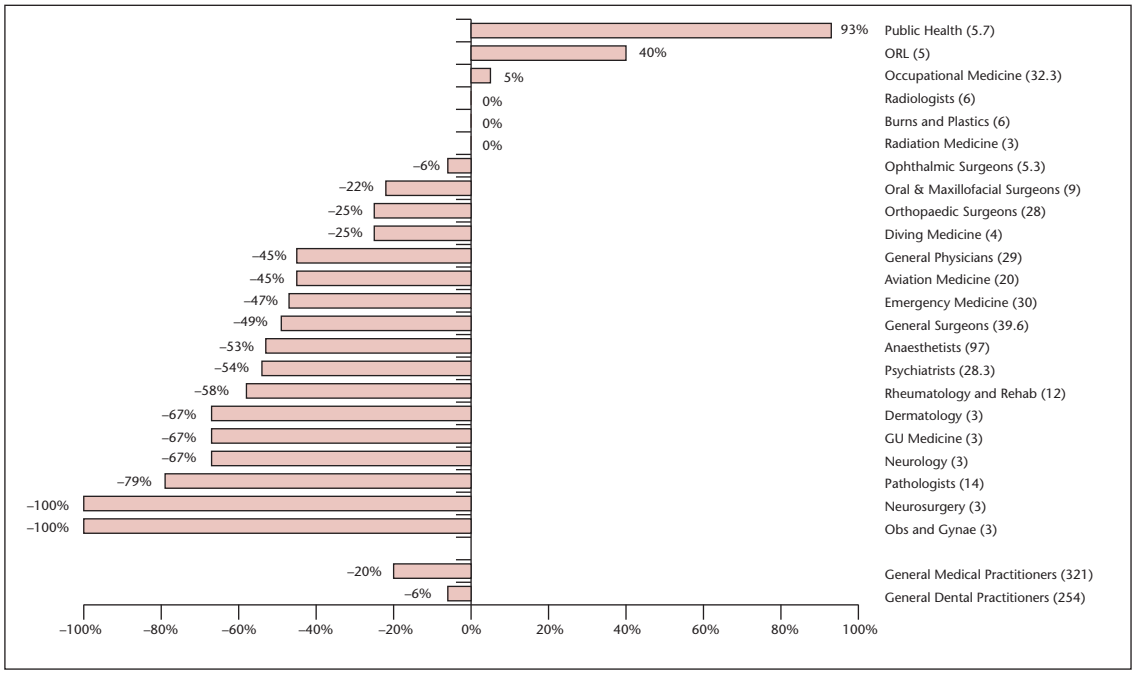
[5] *AFPRB Thirty-Seventh Report 2008* – The Stationery Office Cm 7315, February 2008, published on www.ome.uk.com.

Chart 1: Strength and deficit/surplus of Medical Officers 2001-2007



18. Chart 2 shows trained manning against requirement by specialty at 1 April 2007. Manning levels for Medical Officers vary greatly by specialty. Operational Pinch Points with significant shortfalls include Anaesthetists (53 per cent), General Surgeons (50 per cent), Emergency Medicine (47 per cent), General Physicians (45 per cent), Rheumatology and Rehabilitation (58 per cent), and Psychiatrists (54 per cent). There was also a 20 per cent shortfall of GMPs. MOD considered there was little realistic chance of these deficits closing in the next five years.

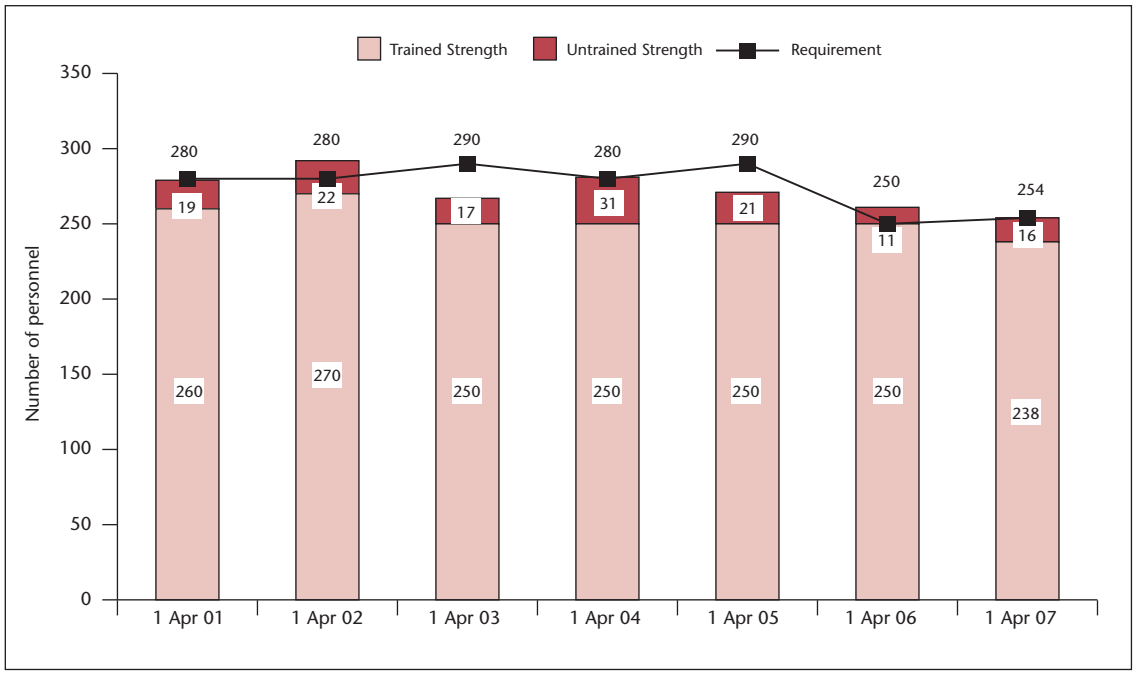
Chart 2: Deficit/surplus of trained DMS Personnel, against requirement, by specialty, 1 April 2007



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

19. There were 238 trained Dental Officers, 6 per cent below the requirement of 254. There were a further 16 DOs in training (Chart 3).

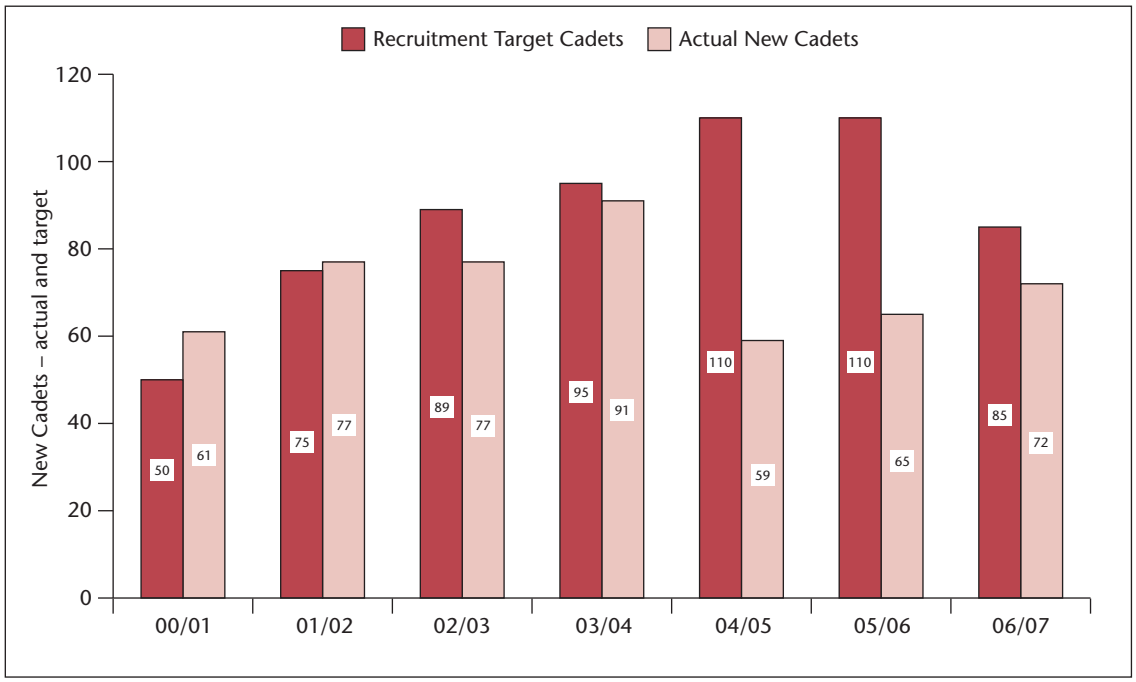
Chart 3: Strength and deficit/surplus of Dental Officers 2001-2007



Recruitment evidence

20. The DMS recruited 94 Medical Officers in the year to 31 March 2007, an increase of 6 from the previous year. However, this represented just 76 per cent of the target of 123. There was more success recruiting Cadets (72 against a target of 85) than Direct Entrants (22 against a target of 38). In addition, 27 Dental Officers were recruited in the year to 31 March 2007, an increase of 8 from the previous year and just 2 short of the target of 29. Although there was a shortfall of Direct Entrants (11 against a target of 17) the target for Cadets was exceeded (16 against a target of 12).

Chart 4: Medical Officer recruitment 2000-01 to 2006-07



21. Since its introduction in November 2002, 40 GMPs and 10 Consultants have been recruited under the Golden Hello scheme, including 4 GMPs and 1 Consultant between October 2006 and April 2007. Although the numbers recruited under the scheme are lower than forecast, MOD still finds Golden Hellos a useful means of recruiting personnel, and since June 2007 has expanded the scheme to cover 11 specialties.

22. The BDA highlighted the operational commitments, on-call duties, military training and postgraduate qualifications required of Armed Forces dentists compared with their civilian counterparts all of which made recruitment more difficult. The BDA also pointed out that many newly registered dentists would not be eligible to serve in the Armed Forces because of nationality qualifications. More positively, the BDA noted a net increase in Army DOs which they linked to the appointment of a qualified Dental Officer to full-time recruiting duties.

Retention evidence

23. The retention evidence submitted by MOD showed:

- Overall Outflow of Medical Officers increased sharply during 2006-07 to 53 or 5.1 per cent of total strength, compared with 25 in 2005-06 or 2.6 per cent of total strength;
- Voluntary Outflow of Medical Officers also increased sharply during 2006-07, to 27 or 2.6 per cent of total strength, compared with 15 in 2005-06 or 1.2 per cent of total strength;
- Both Voluntary and non Voluntary Outflow for Medical Officers have now returned to the levels seen during the period April 2002 to April 2005; and
- Overall Outflow of Dental Officers was at 9.4 per cent of total strength in 2006-07, with Voluntary Outflow at 5.9 per cent. This is the third consecutive year where outflow rates have risen.

24. The DMS Continuous Attitude Survey asks personnel whether they agree or disagree with a range of statements. The figures below represent the percentage who agreed with each statement minus those who disagreed. A negative number means that the percentage disagreeing with the statement is larger than that agreeing. The results for 2007 show:

- 28 per cent of GDPs, 6 per cent of Consultants and – 8 per cent of GMPs[6] felt they were able to strike the right balance between work and home life;
- 47 per cent of GDPs, 46 per cent of Consultants and 33 per cent of GMPs were satisfied with their current post;
- 63 per cent of GMPs and 50 per cent of both Consultants and GDPs felt deploying too frequently was a major area of consideration that would lead to premature retirement;
- 75 per cent of GMPs, 62 per cent of GDPs and 59 per cent of Consultants felt that deployments being too long was a major area of consideration that would lead to premature retirement;

[6] 38 per cent of GMPs agreed or strongly agreed that they were able to strike the right balance between work and home life while 46 per cent disagreed or strongly disagreed (a negative balance of 8 per cent – excepting neutral responses).

- 95 per cent of GMPs, 77 per cent of Consultants and 62 per cent of GDPs felt that the current operational demands were overloading the DMS;
- 43 per cent of GDPs, 7 per cent of Consultants and –19 per cent of GMPs felt their salary was reasonable in comparison with people in similar jobs in the NHS;
- 59 per cent of GDPs, 25 per cent of Consultants and 19 per cent of GMPs felt their pay was fair considering their duties and responsibilities; and
- 78 per cent of Consultants, 69 per cent of GDPs and 60 per cent of GMPs said that their pay and allowances package would influence their decision to stay in the DMS.

25. The BMA presented the results of its survey[7] of DMS doctors in November and December 2007. This showed that, although a majority felt that the Service lifestyle and ethos was a positive aspect of Service life, there was dissatisfaction with overstretch, the impact on spouses' careers, separation from and impact on family life, and the quality of accommodation. Almost 40 per cent plan to leave the DMS during the next five years, mostly at the end of a short or medium career commission rather than through Voluntary Outflow. 40 per cent were satisfied with their pay/allowance package while over a third were dissatisfied.

Operational commitments

26. MOD commented on the priority for the DMS to support operations which at present was sustainable but fragile. Consultant and GMP cadres were very stretched and operations were supported by cross-Service manning and deploying all qualified DMS personnel, including Reserves, to avoid breaking harmony guidelines. MOD predicted the numbers of DMS personnel qualifying through to 2012 would reduce manning deficits but, with high operational tempo, Reserve Consultants and GMPs would be required for small and medium scale operations. Over 1,400 DMS Reserves had deployed to Iraq and 217 to recent Afghanistan operations reducing the capacity to call-up Reserves in later years. The BMA/BDA added, in oral evidence, that in 2007 50 per cent of medical cover on operations was provided by Reserves. A consequence of prioritising manning for operations was the extended use of civilian medical practitioners and locum cover for UK services. MOD considered there were sufficient numbers of Dental Officers to support operations – 11 Regulars were currently deployed to Iraq and Afghanistan with no Reserves deployed.

27. The BMA/BDA highlighted that continued manning shortages meant DMS specialties faced a high rate of deployment with substantial numbers exceeding harmony guidelines. The BMA survey suggested: average deployment for Regulars was around 34 days per year, up to 51 days for GMPs; an average of 36 days was spent on military activity other than deployment; and 20-30 per cent were dissatisfied with the level of separation and the impact on family life.

[7] *Survey of Defence Medical Services (DMS) Doctors* – BMA Health Policy and Economic Research Unit, January 2008.

Reserve Medical and Dental Officers

28. The BMA/BDA commented on the vital role DMS Reserves played on operations particularly while the DMS was undermanned. Reserve forces themselves were undermanned with the BMA/BDA pointing to the influence on morale and retention of active service and the attitude of employers – the latter dependent upon the economic and service delivery requirements within the NHS, lack of capacity and attitudes in GMP partnerships. Respondents to the BMA's survey indicated that half of Reserves had been mobilised since 2001, non-mobilised Reserves did just under 20 days military training per year and half of Reserves had qualified for training bounties.

Government's approach to public sector pay and affordability

29. MOD's evidence repeated that the Government's approach to public sector pay expected pay awards to be guided by the CPI inflation target. In its main evidence to us the Government recognised that public servants were vital to delivery of good public services but argued that consideration should be given to public finances, other spending pressures and the level of inflation in the wider economy.

30. MOD's strategic management evidence also pointed to the need to recruit and retain, to sustain motivation and morale, to maintain a competitive remuneration package and to achieve affordability within the resources available under the Comprehensive Spending Review. MOD's DMS evidence continued to emphasise affordability by commenting that a 2.5 per cent increase in the total paybill was assumed for planning purposes and that pay awards above this level would require compensating cuts to other Defence priorities. MOD's 2.5 per cent paybill increase comprised 2 per cent for the core pay settlement in line with the Government's policy and 0.5 per cent for other pressures, including X-Factor and any differential award for DMS GMPs.

DDRB recommendations from 1 April 2008[8]

31. DDRB's 2008 recommendations for NHS doctors and dentists take into account the stable recruitment and retention environment, motivation and morale following the staged 2007 award and the latest economic indicators. Recommendations relevant to DMS groups include the following:

- An increase of 2.2 per cent for all NHS salaried doctors and dentists, Consultants' Clinical Excellence Awards, Distinction Awards and Discretionary Points, the salary range for salaried GMPs, GMP Trainer Grant and GMP Educators' pay scales (termed GMP Associate Trainers in the DMS);
- An increase of 2.2 per cent in the global sum for independent contractor GMPs (2.7 per cent including practice expenses) with a corresponding reduction in the correction factor where appropriate[9];
- A decrease to the GMP Registrars' supplement of 5 per cent (down to 50 per cent) due to the reduced average supplements paid to hospital doctors; and
- A 3.4 per cent increase to the gross earnings base for independent contractor GDPs (2.2 per cent increase in income).

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[8] *Review Body on Doctors' and Dentists' Remuneration, Thirty-Seventh Report 2008*, Cm 7327, April 2008, www.ome.uk.com.

[9] Global sum covers essential services and all baseline core practice running costs. Because of the way in which the contracts are structured this uplift will not affect all practices equally. Only a minority will actually receive an increase – DDRB 2008 Report, paragraphs 3.32 and 3.33 refer.

32. The Government accepted DDRB's 2008-09 recommendations in full on 7 April 2008.

Pay comparability evidence

33. We have commented before on the importance to DMS recruitment, retention, motivation and morale of maintaining pay comparability with the NHS. We assess the comparability evidence alongside that for all elements under our terms of reference. For clarity, we repeat here our approach to achieve broad comparability with the NHS. We compare DMS and NHS pay levels as at 1 April 2007, where available, and pay movements for 2008-09 in the light of DDRB's recommendations for the NHS. This is consistent with our methodology for our main remit group and helps reduce any "time-lag" between changes in NHS and DMS pay. To ensure comparable pay we: (i) remove the appropriate X-Factor levels from DMS pay scales; (ii) adjust NHS salaries to account for the relative pension advantage for the DMS over the NHS; and (iii) where applicable, we adjust non-pensionable NHS pay elements to avoid double-counting. We note that the parties have taken varying approaches to making these adjustments and we intend to consult with them to ensure that a consistent approach is taken for future comparisons.

Capita Health Service Partners

34. We commissioned Capita Health Service Partners (formerly NHS Partners) to update[10] their previous reports (2005-2007) which provide an independent assessment of pay comparability between the DMS and NHS. Career profiles are used where available to establish robust comparators between the two groups. Capita also advised us on the improving quality and availability of NHS data for:

- **Consultants** – better NHS earnings data, information on the distribution of Local Clinical Excellence Awards (CEAs) and National Audit Office information on private practice earnings;
- **GMPs** – updated data on NHS GMP earnings for 2005-06 and for practice workloads and salaried GMPs;
- **GDPs** – data available for associate and non-associate dentists working within both Personal Dental Services and General Dental Services; and
- **Private practice** – Capita also commented on the lack of private practice earnings data which for many doctors and dentists can substantially supplement NHS pay.

Summary of pay comparisons by DMS group

35. In addition to advice from Capita we also received detailed pay comparability evidence from the parties to support their pay proposals. We summarise the views of all by each DMS group below.

[10] *DMS Pay Comparability Update Report* – Capita Health Service Partners, February 2008, www.ome.uk.com.

Consultants

36. **Capita** – Programmed Activities (PAs) underpin basic pay in the NHS. Capita state that over a career average DMS Consultant pay of £98,051 is ahead of NHS pay by £18,000 per year for those working 10 PAs, by £10,000 per year for 11 PAs and by £2,000 per year for 12 PAs. DMS Consultants are in line with those in the NHS working 11 PAs early in their career, from ages 41-51 they are in line with NHS Consultants working 12 PAs but move ahead for the remainder of a DMS career. Capita also illustrate the effect of factoring additional elements of pay into the NHS comparator. Introducing the value of a 5 per cent On-Call Availability Supplement over a career DMS Consultants enjoy a lead (per year) over the NHS of £14,000 against 10 PAs and of £6,000 against 11 PAs. However, they receive £2,000 less per year when compared to 12 PAs plus a 5 per cent On-Call Availability Supplement. When the value of Local Clinical Excellence Awards (CEAs) is factored into NHS pay, across each year of their career DMS personnel: are £7,000 ahead compared to 10 PAs; fall £1,000 behind NHS Consultants working 11 PAs; and receive £9,000 less when compared to 12 PAs.

37. **MOD** – the basis for MOD's NHS comparator has changed from 12 to 11 PAs following a reduction in the average number of PAs worked in the DMS from 11.5 in 2005-06 to 10.9[11] in 2006-07. MOD also introduces a 5 per cent On-Call Availability Supplement into NHS comparator pay, stating average DMS on-call commitments of 1 in 7 would attract a medium frequency rota in the NHS. MOD concludes that over a career the comparative pay difference between the DMS and NHS is slightly in favour of the DMS by £5,700 per year. MOD excludes the value of Local Clinical Excellence Awards from any pay comparisons, stating the management of such awards would be impractical. However, in oral evidence MOD indicated that further consideration might be given to including and targeting the value of such awards within DMS Consultants' pay.

38. **BMA/BDA** – 11 PAs continued to form the basis for the BMA/BDA's pay comparisons based on the BMA's 2008 survey of DMS Consultants[12]. The BMA/BDA stated that NHS Trusts receive funding for, and are obliged to award, at least 0.35 CEAs per eligible Consultant per year and on average each Consultant will receive just over one CEA every three years[13]. For this reason, the BMA/BDA also included the value of Local CEAs in NHS comparator pay and suggest that over a 26 year career NHS Consultants have a pay lead of 2.2 per cent over the DMS. While excluding On-Call Availability Supplements from pay comparisons, the BMA/BDA agreed with MOD that DMS Consultants work medium frequency rotas which would equate with a 5 per cent Supplement.

General Medical Practitioners

39. **Capita** – a survey of 2005-06 GMP earnings[14] under the new General Medical Services (GMS) contract showed that the average net income for all General and Personal Medical Services' GMPs was £110,000 (£101,000 when adjusted for pensions). Non-dispensing GMS GMPs (the largest single group of GPs), considered by Capita as the most reliable indicator of NHS GMP earnings, received on average £94,000[15]. NHS earnings data include full and part-time GMPs and also include income derived from private practice. Comparable DMS average salaries in 2005-06 were £84,000.

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[11] Average number of Programmed Activities in the NHS is 10.83.
[12] Average PAs for DMS 11.4 and average PAs for NHS 11.1 – *Survey of Defence Medical Services (DMS) Doctors* – BMA Health Policy and Economic Research Unit, January 2008.
[13] *The New NHS Consultant Reward Scheme: Clinical Excellence Awards* – Department of Health, 2003.
[14] Earnings and Expenses Enquiry survey commissioned by the NHS Technical Steering Committee and produced by the Health and Social Care Information Centre.
[15] See paragraph 33 for application of the pension adjustment.

40. **MOD** – MOD reaffirmed independent contractor NHS GMPs as the appropriate comparator, specifically the 2005-06 NHS earnings figure of £110,000 for all General and Personal Medical Services' GMPs. MOD cited DMS GMPs' extra responsibilities and their contribution to significant clinical/managerial outputs as evidence for this comparator. Since comparability was deemed to be achieved in 2002-03, MOD suggested that the latest data showed an average £22,000 lead in favour of the NHS with gaps at all stages of a DMS career.

41. **BMA/BDA** – the BMA/BDA agreed with MOD that independent contractor NHS GMPs are the correct comparator but, unlike MOD, they used non-dispensing GMS GMPs (as do Capita) for their pay comparisons. Using the NHS Technical Steering Committee 2005-06 data they indicated a £8,957 (or 9.6 per cent) deficit in earnings for the DMS, doubling from the 4.8 per cent deficit in 2004-05. The BMA/BDA argued that shortfalls were more acute early in DMS careers, compounded by year-on-year increases in the NHS, and that parity was not achievable over a DMS career.

42. **National Audit Office** – a recent NAO Report[16] examining the new GMP contract claimed that costs were £1.8bn higher than expected for its first three years. The contract, introduced in 2004, offered incentives for GMP practices (including reducing the amount of out-of-hours care) to improve the quality of patient care. Since its introduction, the pay of GMP partners had increased on average by 58 per cent compared to a 3 per cent rise for salaried GMPs.

General Dental Practitioners

43. **Capita** – the majority of dentists are self employed practitioners working in practices delivering dental care through the NHS and/or privately. Most dentists now work in a mixed economy delivering both NHS and private dental care and there is evidence that the amount of private practice has increased with NHS income accounting for only 42 per cent of earnings in 2005-06 compared to 48 per cent in 2004-05. The shift towards Personal Dental Services (PDS) contracts from General Dental Services (GDS) contracts continues with the former accounting for 37 per cent of GDPs in 2005-06. While the picture remains complex there is improving evidence on GDP earnings. Latest HMRC information (which includes income from private practice) covering dentists working on GDS and PDS contracts for 2005-06 shows that average earnings[17] for: first party associates (practice owners) had increased from £97,000 to £105,000; second party associates rose to £56,000 from £52,000 in 2004-05; and non-associates was £87,000, up from £79,000 a year previously. Capita show comparisons using current DMS salaries compared with 2005-06 NHS earnings across four age bands. DMS pay was ahead of second party associates at all ages but behind that of first party associates. The DMS were behind non-associates up to age 44 but then moved ahead later in a DMS career.

44. **MOD** – the importance of maintaining the link with DMS GMPs was again emphasised. MOD quoted 2005-06 HMRC earnings data but considered it too early to fully assess the effects of the new NHS contract. MOD pointed to increasing DMS GDP outflow after recent years of stability and the continuing attractiveness of civilian employment.

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[16] *NHS Pay Modernisation: New Contracts for General Practice Services in England* – National Audit Office, February 2008, www.nao.org.uk.

[17] See paragraph 33 for application of the pension adjustment.

45. **BMA/BDA** – their evidence highlighted the mixed picture following the introduction of the new NHS contract. The move to independent practice and an associated reduction in NHS income makes comparisons with civilian pay impossible. 2005-06 earnings data suggests income for GDS first party associates of £114,000 with non-associates' GDS income increasing to £95,000. The National Association of Specialist Dental Accountants put principal's private practice income at £130,000 in the year to March 2006. The BMA/BDA conclude that, with no single robust comparator and DMS GDP pay lagging behind NHS groups, the priority was to maintain pay parity through the link with DMS GMPs.

Junior Doctors in Training

46. **Capita** – NHS earnings have reduced slightly due to a reduction in the average out of hours band multiplier[18] applied. DMS Junior Doctors (training as Consultants and GMPs) continued to remain ahead of their NHS counterparts in terms of pay throughout their training. **MOD** confirmed Capita's findings that average hours worked in the NHS continued to reduce. Comparisons show DMS Junior Doctors' salaries were more advantageous than equivalent NHS roles except for Bands 2A and 3. However, there were few DMS Junior Doctors in those bands. Within the NHS numbers in Bands 2A and 3 have reduced significantly and the majority are expected to fall into Bands 1A and 1B by 2009. The **BMA/BDA** commented that at least 25 per cent of DMS Junior Doctors surveyed[19] worked a Band 2A rota (working most frequently at the most unsocial times) with 17.5 per cent working Band 2B. The BMA/BDA added that, while average duty hours were at the European Working Time Directive maximum of 48, on average 50.3 hours were actually worked per week.

MOD and BMA/BDA pay proposals for 2008-09

47. We received a range of pay proposals from the BMA/BDA and MOD. While they generally agreed that our task in ensuring pay comparability with the NHS should draw on DDRB recommendations for NHS doctors and dentists, this was supplemented by cases for individual DMS groups (including DMS Reserve equivalents) based on their own interpretation of pay comparisons as follows:

- Overall pay award – MOD put the overall pay award in the context of operational pressures. The BMA/BDA generally argued that pay disparities between the DMS and NHS remained, that the 2007 pay award had been disappointingly "sub-inflationary" and that the DMS consistently delivered high quality medical care with exceptionally high operational commitments;
- Consultants – the BMA/BDA sought a range of pay measures based on pay comparisons including additional recompense for On-Call Supplements at 5 per cent and inclusion of NHS Local CEAs in the NHS comparator. The latter was argued on the basis that NHS Consultants on average received just over one CEA every three years – the BMA/BDA recommended addressing the shortfalls after the 12 year point on the pay scale with pay increases of between 1.1 and 8.1 per cent (in 5-year bands);
- MOD pointed to broad comparability being achieved when accounting for 11 Programmed Activities and the On-Call Supplement. It considered the inclusion of NHS Local CEAs as impractical and questioned whether NHS performance-related payments should be read across to the DMS;

[18] The average out of hours band multiplier has reduced from 56 to 52 per cent – New Deal Monitoring Summary, September 2006.
[19] *Survey of Defence Medical Services (DMS) Doctors* – BMA Health Policy and Economic Research Unit, January 2008.

- GMPs – the BMA/BDA and MOD agreed that DMS pay was behind NHS earnings for 2005-06. The BMA/BDA put this difference at 9.6 per cent and MOD at an average of £22,000 (or 27 per cent). Neither party provided specific pay proposals;
- GDPs – MOD and the BMA/BDA proposed maintaining the link between DMS GMPs' and GDPs' pay – a range of NHS comparator data was provided;
- Higher Medical Management (HMM) Pay Spine – MOD and the BMA/BDA both highlighted the need to maintain the career incentive offered to feeder groups. MOD and the BMA/BDA continued to link the HMM Pay Spine increase to that for Consultants and GMPs;
- X-Factor – the parties' proposals suggested mirroring recommendations for our main Armed Forces remit group;
- Medical and Dental Cadets – the BMA/BDA suggested that, as there was no NHS comparator, pay should increase in line with the current Retail Prices Index. MOD suggested the increase should be in line with DDRB recommendations for NHS Junior Hospital Doctors;
- GMP Associate Trainer Pay – MOD proposed the introduction of GMP Associate Trainer Pay at 50 per cent of the rate of DMS Trainer Pay; and
- Other DMS pay – MOD and the BMA/BDA agreed increases should be in line with DDRB recommendations for Non-Consultant Career Grades and Junior Doctors (including DMS Reserve equivalents), DMS Clinical Excellence Awards and Distinction Awards, and DMS Trainer Pay.

X-Factor

48. We conducted a five yearly review of X-Factor for our 2008 Report on the main remit group. The analysis of military life showed a clear increase in the disadvantages for Service personnel, especially for those factors such as danger, turbulence, separation and hours of work which had the most priority among Service personnel and were also the components that most clearly set apart military personnel from those working in the civilian sector. However, we also factored in significant, targeted improvements such as the Operational Allowance, Longer Separation Allowance and the Operational Welfare Package which responded to changes in military circumstances. An analysis from IDS showed that over the same period there had been improvements for those in civilian life. The net effect of the changes in both military and civilian life led us to conclude that there had been a material change in the disadvantage experienced by those in the military since we last recommended a change to X-Factor in 2000 and that X-Factor should increase by 1 per cent to 14 per cent.

49. MOD conducted a review of the components of X-Factor which showed that the net deterioration experienced by Service personnel equally applied to Medical and Dental Officers. The BMA/BDA felt that the existing operational tempo meant that turbulence and danger had increased since 2002 which justified an increase in X-Factor and that any change should equally apply to DMS personnel. The BMA/BDA added that significant proportions of DMS Lieutenant Colonels and above were likely to be repeatedly deployed and therefore the X-Factor taper should be examined. The BMA/BDA also felt that factors justifying an increase in X-Factor for Regulars also applied to their Reserve counterparts. Specifically for Dental Officers, the BDA noted that unlike combatant Officers, DOs continue to be deployed at the same rate irrespective of seniority and so were disadvantaged by the tapering of X-Factor and that any change to X-Factor should also apply to DMS personnel, including Reserves.

RECOMMENDATIONS FOR 2008-09

Overall pay recommendations

50. We draw on a range of evidence in seeking to make recommendations that support DMS recruitment, retention and motivation. We specifically take into account our remit to achieve *broad* pay comparability with the NHS. We also assess the Government's and MOD's wider evidence on pay and affordability.

51. The overall DMS manning position has remained static for many years. From a low base in the 1990s, there have been frequent attempts to define the required establishment. However, each rebasing of requirements has delivered little substantial change in absolute manning levels. While manning levels have slightly increased since 2003, manning shortfalls and operational demands continue to challenge the DMS in delivering capability. At April 2007, the deficit of Medical Officers was at 36 per cent, many important Consultant specialties had deficits over 50 per cent, GMPs at 20 per cent (with single Service variations) and Dental Officers experienced a shortfall of 6 per cent. Medical Officer recruitment was below target for 2006-07 for both Cadets and Direct Entrants as it was in 2005-06. Dental Officer recruitment was close to target in 2006-07.

52. With manning at a low level and recruitment only achieving moderate levels, retaining existing DMS personnel is the main contributor to stable manning. After several years of stable DMS Outflow, 2005-06 saw a significant decrease in Outflow and Voluntary Outflow of Medical Officers. However, 2006-07 saw Outflow rise to 5.1 per cent and Voluntary Outflow more than double to 2.5 per cent with substantial numbers leaving at the end of commissions. Dental Officer Outflow continued to increase in 2006-07 to 9.4 per cent and Voluntary Outflow up to 5.9 per cent.

53. The factors influencing DMS retention continue to be driven, as they are across the Armed Forces, by high operational commitments resulting in separation and impacting on family life. While pay is an important retention factor, there are many other drivers which need urgent attention. As we noted in our 2007 Report, the prospect of achieving DMS manning balance would depend on maintaining improving trends in recruitment and retention – neither of these appears to have been achieved in 2006-07.

54. Our assessment of pay comparability draws on information from Capita, NHS earnings and the parties' views. These indicate pay levels with pay movements informed by DDRB recommendations – the latter an important tenet which contributes to retaining DMS personnel. In this respect, we note that 2007 DDRB recommendations were staged by the Government but our recommendations at the same level were not staged for the DMS. Using agreed DMS pay profiles, we continue to conclude that broad comparability is achieved for the majority of DMS doctors and dentists. However, assessing pay levels is complex and we draw particular attention to our detailed findings for DMS Consultants and General Medical and Dental Practitioners which are sensitive to the choice of comparators.

55. For Consultants, MOD and the BMA/BDA agreed that the NHS comparator should account for 11 Programmed Activities, which represents the appropriate DMS working pattern, and should include the On-Call Supplement valued at 5 per cent. We do not see merit in compensating for the On-Call Supplement separately as the BMA/BDA proposed but do agree that it should be included in the NHS comparator. We will continue to review the position of the On-Call Supplement and compensation under X-Factor to avoid double counting and have asked MOD for further data on DMS Consultants' working hours. We note that DMS pay arrangements do not need to match the NHS at every career point – a principle accepted when DMS pay scales were introduced in 2003. Using the same basis as the parties, Capita assesses that, on average over a career, DMS Consultants have a pay lead over the NHS which is behind in the early stages and ahead later in a career. We therefore conclude from the evidence that broad comparability is achieved for DMS Consultants when accounting for 11 Programmed Activities and an On-Call Supplement. This should be used as the NHS comparator for future comparisons. We comment below on the position of Local Clinical Excellence Awards.

56. For General Medical Practitioners, we were presented with a range of NHS comparisons all drawing on NHS earnings data for 2005-06. We have focused on the General Medical Services' non-dispensing GMPs as the most appropriate NHS comparator because they constitute the largest NHS group (as also used by the BMA/BDA). We agree with the evidence from Capita, MOD and the BMA/BDA that the growth in NHS earnings at 2005-06 has opened a gap with DMS pay. This, alongside other factors specifically affecting DMS GMPs, supports an additional pay response as set out below. We also comment below on maintaining the pay link between DMS GMPs and GDPs.

57. Turning to the Government's evidence, we again note its view that pay settlements should be guided by its CPI inflation target of 2 per cent although the Government acknowledged that public sector pay needed to be sufficient to recruit, retain and sustain motivation. MOD's affordability evidence was framed around the Comprehensive Spending Review emphasising the consequential effects of pay recommendations exceeding its planning assumptions. However, we repeat our view that while MOD is under such financial pressure it faces difficult management decisions on the allocation of resources.

58. For our overall pay recommendation we must take all the DMS evidence together. While we have concerns about the direct impact pay has on absolute manning levels, it continues to play a part in supporting recruitment and retention. Both of these are under pressure in the DMS with low manning levels, recruitment consistently below target, and the trend in Outflow returning to previous rates indicating continuing risks to retention. Operational pressures continue and our recommendations seek to recognise the key contribution of DMS personnel. We consider that broad comparability has been achieved for most DMS groups. To maintain this going forward, we are guided by DDRB recommendations and therefore recommend a 2.2 per cent increase for all DMS groups, with the exception of GMPs and GDPs. We consider all our pay recommendations are in line with the Government's approach to public sector pay, including achieving the CPI inflation target, and are manageable within MOD's budgets.

Recommendation 1: We recommend a 2.2 per cent increase from 1 April 2008 for DMS Consultants, Higher Medical Management staff, 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.

DMS General Medical and Dental Practitioners

59. We note the emphasis placed on DMS GMPs throughout the parties' written and oral evidence. Current manning levels are very low and risks are presented to retention from the pull of well-publicised NHS earnings levels and a growing DMS operational role involving more deployments. We conclude that these justify an additional pay recommendation slightly above the level of increase for NHS doctors and dentists recommended by DDRB.

60. Three factors have influenced the level of this additional recommendation for GMPs. First, the gap with 2005-06 earnings does not account for the significant DMS pay increase in 2006-07 (equating to 6.6 per cent) which we should be able to assess for our 2009 Report. Second, NHS earnings are an average and therefore give us no indication of the pay profile over an NHS career and limit us to an across-the-board recommendation when it might be that targeting is a better approach. Third, the increasing use of salaried GMPs and the proportion operating under Personal Medical Services' contracts in the NHS might be shifting the appropriate comparator and we wish to keep this under review. These factors suggest some caution is required in recommending an additional pay increase for DMS GMPs (at OF3 and above) and we therefore recommend an increase of 3.7 per cent.

61. The additional recommendation would also apply to DMS GDPs whose pay is linked to that of DMS GMPs. We will continue to monitor emerging manning difficulties for DMS GDPs and some improving data on NHS earnings. In the meantime, we accept the parties' views that the pay link with DMS GMPs needs to be maintained.

Recommendation 2: We recommend a 3.7 per cent increase for DMS General Medical Practitioners and General Dental Practitioners at OF3 and above (and DMS Reserve equivalents) from 1 April 2008. The recommended pay scales are at Appendix 1.

DMS Consultants

62. We conclude above that broad comparability is achieved for DMS Consultants. However, we agree with the BMA/BDA's evidence that NHS Local Clinical Excellence Awards need to be accounted for in pay comparisons. There is a precedent for accounting for their values, as we did in their previous forms, and targeting them within DMS pay. We also note that Local CEAs form an important building block of NHS Consultants' pay and therefore influence retention.

63. MOD did not see merit in adopting a full Local CEA system in the DMS but, in oral evidence, indicated that their NHS value might be used to target specific DMS concerns. The BMA/BDA also indicated, in oral evidence, that further discussion with MOD on the options might produce acceptable alternatives, possibly including loyalty or commitment bonuses. In the absence of data on the profile of NHS Local CEAs and their link with local contribution, we are reluctant to make arbitrary decisions about how their value should be incorporated. We therefore recommend that the parties discuss the options for incorporating the value and make proposals (jointly if possible) for our 2009 Report.

Recommendation 3: We recommend the parties present joint proposals on targeting the value of NHS Local Clinical Excellence Awards within DMS Consultants' pay arrangements for consideration in our 2009 Report.

X-Factor

64. For the main remit group we recommended a 1 per cent increase in the level of X-Factor from 13 to 14 per cent. The parties told us that DMS personnel have experienced a similar change in net disadvantage since the last change to X-Factor. We conclude that X-Factor should also increase by 1 per cent for DMS personnel. We also recommended changes to the way in which the X-Factor taper operates for the main remit group. We have concluded that similar changes should be made to the taper for DMS personnel, after taking into account the different circumstances of the DMS where pay is decoupled from rank. For the main remit group we recommended no change to the rate of X-Factor for Reserves and we consider that DMS Reserves should continue to receive the same X-Factor payments as other Reserve personnel.

Recommendation 4: We recommend a 1 per cent increase in the level of X-Factor from 13 to 14 per cent from 1 April 2008 and the following revised taper arrangements:

1. **The full X-Factor should be paid up to and including increment level 22 for Consultants, GMPs/GDPs and Non-Accredited Medical Officers;**

2. **X-Factor should be set at 75 per cent of the cash values for increment level 22 and applied from increment level 23 for Consultants, GMPs/GDPs and Non-Accredited Medical Officers;**

3. **X-Factor for those on the OF5 Higher Medical Management Pay Spine should be set at 75 per cent of the cash value for increment level 22 of the Consultant pay scale;**

4. **X-Factor for those on the OF6 Higher Medical Management Pay Spine should be set at 50 per cent of the cash value for increment level 22 of the Consultant pay scale.**

The resulting recommended pay scales inclusive of X-Factor are at Appendix 1.

Consultants' National Clinical Excellence Awards and Distinction Awards

65. DMS National Clinical Excellence Awards mirror arrangements in the NHS using the top four NHS awards. There are 32 awards available under both the DMS Clinical Excellence Awards and original DMS Distinction Awards scheme. The BMA/BDA continued to highlight that the DMS Awards were not pensionable as were their NHS equivalents. MOD requested that the value of DMS Awards should be increased in line with NHS equivalents and the numbers should remain unchanged. DDRB recommended the value of NHS Awards be increased by 2.2 per cent and we are content to endorse the same increase for DMS.

Recommendation 5: We recommend a 2.2 per cent increase to the value of DMS National Clinical Excellence Awards and Distinction Awards from 1 April 2008. The recommended levels are shown at Appendix 1.

DMS Trainer Pay

66. The BMA's Survey of DMS doctors showed that a quarter of DMS GMPs worked as Trainers. The BMA/BDA added that, of all the DMS groups, the retention of GMP Trainers was most at risk. The evidence pointed to the onerous nature of the DMS Trainer role with increasing educational commitments and responsibilities compared with other GMPs. Both the BMA/BDA and MOD sought an increase in DMS Trainer Pay in line with that for the NHS. We note DDRB recommended a 2.2 per cent increase to the pay additions for NHS GMP Trainers with the prospect of a new NHS remuneration structure. We look forward to developments and, in the meantime, we are content to endorse the parties' proposals in line with DDRB recommendations.

67. In 2007, MOD informed us that further work was planned to make the career of DMS Trainers more attractive. As a result, in evidence for this report MOD proposed the introduction of GMP Associate Trainer Pay at half the value of DMS Trainer Pay. We welcome the payments aimed at DMS GMPs mentoring those in general training and to draw them through to full GMP Trainer roles. We are content to recommend the introduction of GMP Associate Trainer Pay although implementation will not be until later in 2008 with no retrospective entitlement.

Recommendation 6: We recommend that DMS Trainer Pay be increased by 2.2 per cent from 1 April 2008. We also recommend the introduction of GMP Associate Trainer Pay at half the rate of DMS Trainer Pay (implementation date to be advised). The rates are at Appendix 1.

Cost of recommendations

68. We estimate that the cost of our pay recommendations for 2008-09 is £8.2 million (including the Employers' National Insurance Contribution and superannuation liabilities). This cost is based on the Officer strengths (including Reserves from this report) of the medical and dental branches of the Armed Forces in 2008-09 as forecast by MOD. To the extent that strengths differ in practice, the cost of implementing the recommendations will also differ.

LOOKING AHEAD

69. With the Armed Forces under sustained operational pressure, it is increasingly important that DMS capability is delivered to support operations and to manage services in the UK to ensure the Armed Forces are fit for purpose. However, the DMS continues to be characterised by low manning levels, operational pressure and risks to retention. The position has remained the same for many years. In assessing broad pay comparability, we continue to consider that pay plays a role in retention but, despite a series of significant pay rises in recent years, DMS manning has only stabilised at low levels. The themes from evidence in recent years suggest work on wider aspects of the DMS is required including: alternative approaches to DMS manning and manpower planning; attracting sufficient recruits; offering DMS personnel attractive careers; developing supporting pay structures; and delivering on non-remuneration measures.

70. The evidence highlighted several aspects of the DMS and the package which require attention. We are encouraged to hear more of MOD's efforts to improve manpower planning. In our view, low levels of DMS trained strength suggest all available manning configurations need to be considered to meet DMS capability including the balance between use of Regulars, Reserves, civilian practitioners, locums and other nations. In

this respect we note as did the Defence Committee that, while the Armed Forces operate outside Defence Planning Assumptions, DMS operational capability is reliant on Reserves plus UK services are supported by civilian and locum cover. This is likely to be the model for ongoing operational commitments for the foreseeable future.

71. We emphasise effective manpower planning as it underpins our continuing conclusion from the evidence that reform of DMS pay and careers is overdue. Effective DMS pay and career structures play an essential role in supporting manning to generate capability. We have advocated since 2006 that DMS pay and careers need urgent review to better reflect how the DMS is organised and how services are delivered. Current DMS career patterns do not deliver the required returns of service after qualification particularly as retention is influenced by expensive Immediate Pension arrangements, the potential pull of the NHS and operational pressures.

72. MOD should be maximising its return on investment. The focus should be on the key deliverers of DMS capability at Lieutenant Colonel and Colonel (and their equivalents). DMS careers need to be competitive with the NHS (and, in some cases, with private practice), to offer sufficient challenge and professional development, and to foster stability. Different approaches might also meet the different aspirations of younger, mid-career, and full career DMS doctors and dentists and to address changes in gender balance. We were encouraged by MOD's positive view in oral evidence about managing the DMS experience profile and enhancing DMS careers particularly in the context of the wider medical and dental communities. The integration of the DMS and NHS has produced some benefits as acknowledged by the Defence Committee. However, managing DMS professionals must reflect the reality that their chief reference point will be the world of medicine and dentistry. DMS personnel should not be viewed simply as another pinch point trade in designing effective career measures. In our view this work needs urgent priority and continued impetus.

73. MOD's evidence indicated that further work on pay structures was ongoing under its Strategic Remuneration Review for the Armed Forces as a whole. Delivery of any outcomes from this review would not be before 2011. We again stress the priority that should be attached to DMS pay structures. In the meantime, the pay comparability evidence presented continues to be clouded by different interpretations although we note some agreement on the make-up of NHS comparators and emerging NHS earnings data are helpful. Our analysis has clarified our views on appropriate NHS comparators and we look to the parties to present comparability evidence using the same methodology.

74. To accompany effective pay structures, continued emphasis should be given to a range of non-remuneration measures. It is clear from the evidence for the Armed Forces as a whole, the DMS Continuous Attitude Surveys and the BMA's survey of doctors that frequency of operations, separation and the impact on family life are influential to retention. These factors are exacerbated in the DMS by low manning levels. We have observed with other specialty shortage groups that if pay measures are to be effective they need to be accompanied by long term resolution of non-remuneration issues.

75. We continue to urge progress on all these areas. DMS recruitment and retention is a complex arena with many influencing factors. Our role is to price one of those important factors, DMS pay. We are constrained when there are many uncertainties surrounding the effectiveness of pay, particularly in retention, and the effectiveness of non-remuneration measures. A clearer view is needed to enable pay to play its part and to effectively target resources to areas of concern.

76. Turning to evidence for our 2009 DMS Report, we make the following information requests to improve the DMS evidence-base:

- Progress on further refinements to **DMS manpower planning**;
- The development of **"sustainable experience profiles"** where appropriate;
- Data on **exit points** for DMS cadres either by age or by pay points;
- Emerging data on the **impact of new DMS pension arrangements** on DMS careers compared with career patterns of those on the old DMS pension scheme. We would welcome views on whether the new retention bonuses offer value for money;
- Further details of the **distribution of numbers in training** by DMS cadres and any forecast of when they become accredited;
- Any breakdown of **working hours by DMS cadres**; and
- **Progress with non-remuneration measures** specifically those designed to enhance DMS careers, manage operational pressures and promote flexible working arrangements.

77. Our research programme also aims to improve the evidence-base. For our 2009 Report, on **DMS pay comparability** we will consider further refinements to the methodology taking into account emerging NHS earnings data and available DMS data as above. Our methodology for appropriate NHS comparators will be shared with MOD and the BMA/BDA to ensure they draw on the same information.

78. We also intend to review the options for **DMS pension valuations** to identify a more appropriate methodology linked to our pay comparisons. We will consult MOD and the BMA/BDA but, in the meantime, we put forward our broad conclusions that any revised method of valuation should:

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

David Greenaway
Robert Burgin
Alison Gallico
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Tony Young

14 April 2008

Appendix 1

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

All salaries are JPA salaries 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	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 1.2: **Recommended 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 1.3: **Recommended 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 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	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 1.5: **Recommended annual salaries inclusive of the X-Factor for Service Medical and Dental Officers: OF1 (PRMPs)**

	Military salary
	£
OF1	39,534

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	17,881
	after 1 year	16,087
	on appointment	14,301

Table 1.7: **Recommended 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 1.8: **Recommended 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 (implementation date to be advised)

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

Appendix 2

1 April 2007 military salaries including X-Factor for DMS Officers

All salaries are JPA salaries 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	123,013
Level 31	122,767
Level 30	122,525
Level 29	122,276
Level 28	122,033
Level 27	121,545
Level 26	121,057
Level 25	120,569
Level 24	119,385
Level 23	118,204
Level 22	117,023
Level 21	115,838
Level 20	114,657
Level 19	113,472
Level 18	112,295
Level 17	110,801
Level 16	109,315
Level 15	107,828
Level 14	106,338
Level 13	104,855
Level 12	103,369
Level 11	100,101
Level 10	96,841
Level 9	93,581
Level 8	90,687
Level 7	87,785
Level 6	84,878
Level 5	82,155
Level 4	81,097
Level 3	80,017
Level 2	76,437
Level 1	72,893

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

Increment level	Military salary
	£
Level 35	113,480
Level 34	113,114
Level 33	112,835
Level 32	112,381
Level 31	112,016
Level 30	111,647
Level 29	111,364
Level 28	110,913
Level 27	110,540
Level 26	110,175
Level 25	109,802
Level 24	109,437
Level 23	109,065
Level 22	108,703
Level 21	108,327
Level 20	107,880
Level 19	107,414
Level 18	106,952
Level 17	106,487
Level 16	106,025
Level 15	105,559
Level 14	103,622
Level 13	103,160
Level 12	102,698
Level 11	102,165
Level 10	101,636
Level 9	101,103
Level 8	99,159
Level 7	98,630
Level 6	97,281
Level 5	95,925
Level 4	94,576
Level 3	93,220
Level 2	91,286
Level 1	90,653

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

Increment level	Military salary
	£
Level 29	90,475
Level 28	89,722
Level 27	88,977
Level 26	88,229
Level 25	87,476
Level 24	86,731
Level 23	85,982
Level 22	85,233
Level 21	84,492
Level 20	83,743
Level 19	82,994
Level 18	82,249
Level 17	81,504
Level 16	80,755
Level 15	80,002
Level 14	79,261
Level 13	78,512
Level 12	77,763
Level 11	77,018
Level 10[a]	76,273
Level 9	75,375
Level 8	73,863
Level 7	72,346
Level 6	71,270
Level 5	70,204
Level 4	69,135
Level 3	68,066
Level 2	64,486
Level 1	60,928

[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	69,611	56,412	69,611
Level 4	68,199	54,971	68,199
Level 3	66,791	53,521	66,791
Level 2	65,375	52,083	65,375
Level 1	63,963	50,653	63,963

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

	Military salary
	£
OFI	38,343

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

	Length of service	Military salary
		£
Cadets	after 2 years	17,342
	after 1 year	15,603
	on appointment	13,870

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

Increment level	Military salary
	£
Level 7	126,448
Level 6	125,349
Level 5	124,254
Level 4	123,147
Level 3	122,045
Level 2	120,953
Level 1	119,847

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

Increment level	Military salary
	£
Level 15	119,407
Level 14	118,718
Level 13	118,017
Level 12	117,321
Level 11	116,628
Level 10	115,931
Level 9	115,227
Level 8	114,534
Level 7	113,837
Level 6	112,794
Level 5	111,755
Level 4	110,704
Level 3	109,665
Level 2	108,625
Level 1	107,575

DMS Trainer Pay

The annual rate of GMP and GDP Trainer Pay from 1 April 2007 was £7,319.42.

DMS Distinction Awards

A+	£58,294
A	£38,864
B	£15,546

DMS National Clinical Excellence Awards

Bronze	£18,180
Silver	£28,603
Gold	£39,493
Platinum	£55,828

Printed in the UK by The Stationery Office Limited
on behalf of the Controller of Her Majesty's Stationery Office
ID5801732 05/08

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