Armed Forces' Pay Review Body

Service Medical and Dental Officers

Supplement to the Thirty-Sixth Report – 2007

Chairman: Professor David Greenaway

Cm 7066
£13.50

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

May 2007

Cm 7066 £13.50

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Armed Forces' Pay Review Body

TERMS OF REFERENCE

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

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

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

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

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

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

The members of the Review Body are:

Professor David Greenaway (Chairman)[1]
Robert Burgin
Alison Gallico
Dr Peter Knight CBE
Professor Derek Leslie
Neil Sherlock
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.

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ARMED FORCES' PAY REVIEW BODY
2007 DMS REPORT – SUMMARY

Key recommendations

- **A 2.0 per cent increase for all Service Medical and Dental Officers and all DMS Reserve equivalents;**
- **No increase to the value of DMS National Clinical Excellence Awards and Distinction Awards; and**
- **A 2.0 per cent increase to DMS Trainer Pay.**

Evidence for this Report

Under our terms of reference we examine evidence for the Defence Medical Services (DMS) relating to manning, recruitment and retention, and pay comparisons with the National Health Service (NHS). We draw on written and oral evidence from the Government, MOD and the British Medical and Dental Associations (BMA/BDA), plus our independent research into pay comparability, DDRB's recommendations for 2007-08 and our 2006 visits to military units. We note the DMS is undergoing a change programme covering DMS management, training reform and non-remuneration measures. We also note continuing NHS developments relevant to our pay comparisons.

Manning, recruitment and retention

Against the background of work underway by MOD to revise DMS manning requirements to support operational capability, we assessed the manning position as at 1 April 2006. This showed trained Medical Officer strength at 490 – a shortfall of 55 per cent against a requirement of 1,080 – with 530 in training. Dental Officer strength, at 250, was slightly below the requirement with 11 Dental Officers in training. Shortages in Consultant specialties persisted with deficits up to 57 per cent in the larger specialty cadres and there was a 34 per cent shortfall of GMPs. DMS Reserve Medical Officer manning was at 380 against a requirement of 770. Recruitment of Medical Officers improved to 88 during 2005-06 but was below target for Cadets and Direct Entrants. Dental Officer recruitment met the target in 2005-06. Overall Outflow of Medical Officers fell sharply in 2005-06 to 2.6 per cent and Voluntary Outflow halved to 1.2 per cent – the lowest rates for four years. The DMS Continuous Attitude Survey and a BMA cohort survey pointed to the importance of pay/allowances to retention and to limited commitment to a DMS career. Support to operations continued to be "very stretched" and length of deployments continued to threaten retention.

Pay comparability

Maintaining pay comparability with the NHS is critical to DMS recruitment, retention, motivation and morale. Our comparisons continue to be constrained by the lack of NHS data which, although improving, remains patchy. NHS Partners provided independent analyses for Consultants' NHS comparator pay based on differing numbers of Programmed Activities and example analyses including On-Call Availability Supplements and NHS Local Clinical Excellence Awards. However, the parties provided conflicting assessments – MOD compared base pay and noted acceptable career variations but invited our views on NHS pay additions, and the BMA/BDA argued that pay gaps across a career required varying DMS increases of between 0 and 8.8 per cent. For GMPs, 2004-05 NHS earnings data were available but NHS Partners were concerned about coverage and reliability; MOD noted NHS and DMS differences but suggested awaiting firm evidence; and the BMA/BDA argued that NHS data showed a 4.8 per cent pay gap across a DMS career. NHS Partners and the parties accepted that there were no definitive NHS data for GDPs therefore pointing towards maintaining the pay link with DMS

GMPs. The parties agreed that DMS and NHS Junior Doctors' pay was broadly comparable. We conclude from the evidence available that DMS base pay levels following the 2006 pay award are broadly comparable with the NHS, although variations occur across DMS careers and specialty groups.

Recommendations

In reaching our conclusions we were mindful of the Government's evidence on public sector pay, the Chancellor's suggestion that recommendations should be consistent with the Consumer Prices Index (CPI) inflation target of 2 per cent, MOD's view of affordability, the prevailing economic conditions, DDRB's recommendations, and an encouraging position on DMS manning, recruitment, and retention. DDRB's recommendations for NHS doctors and dentists for 2007-08 are weighted to the lower paid NHS doctors and dentists and result in a 2 per cent increase in the pay bill for NHS Hospital and Community Health Services medical staff. We do not consider direct matching is appropriate, nor do we judge that the evidence points to a differential approach as the best way of meeting the specific needs of the DMS remit group. We recommend, therefore, a 2.0 per cent increase for all Service Medical and Dental Officers and DMS Reserve equivalents. To align with NHS values we recommend no increase to DMS National Clinical Excellence Awards and Distinction Awards but a 2.0 per cent increase to DMS Trainer Pay. We estimate that our recommendations add £3.5 million to the DMS pay bill.

Looking ahead

We note that DMS pay structures will be considered as part of MOD's wider Strategic Remuneration Review. We consider it right that MOD should keep these under review to be able to respond to changing circumstances at the earliest opportunity. For our part, we will be seeking to improve our comparability evidence base by establishing appropriate DMS pay comparators, specifically considering the make-up of comparators for Consultants, GMPs and GDPs. We look forward to the outcome of the parties' discussions on handling Local Clinical Excellence Awards in the DMS. We will also give further consideration to the DMS pension valuation in response to the report we have commissioned from GAD. For our 2008 Report, we request further evidence on Sustainable Experience Profiles, non-remuneration measures and X-Factor.

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
DH	Department of Health
DMS	Defence Medical Services
DDRB	Review Body on Doctors' and Dentists' Remuneration
GAD	Government Actuary's Department
GDP	General Dental Practitioners
GMP	General Medical Practitioners
HMM	Higher Medical Management
JPA	Joint Personnel Administration
MDHU	Ministry of Defence Hospital Unit
MOs	Medical Officers
MMRR	Medical Manning and Retention Review
MOD	Ministry of Defence
NHS	National Health Service
PAs	Programmed Activities
RAF	Royal Air Force
RN	Royal Navy
TA	Territorial Army
TSC	Department of Health Technical Steering Committee

Introduction

1. This report sets out our recommendations for the Defence Medical Services (DMS) from 1 April 2007 and the evidence on which they are based. This comprises evidence under our terms of reference on: the Government's approach to public sector pay and affordability considerations applying to the Ministry of Defence (MOD); DMS manning, recruitment and retention; and pay comparisons with the National Health Service (NHS). We again commissioned independent advice on pay comparability and a periodic valuation of DMS pensions compared to those available in the NHS. Our conclusions and recommendations are reached against a backdrop of continuing high operational commitments, low DMS manning levels and a DMS change agenda.

2006 recommendations

2. Our recommendations from 1 April 2006 (submitted on 12 April 2006) were:

   - A 6.6 per cent increase plus the Review Body on Doctors' and Dentists' Remuneration (DDRB) recommended increase for accredited DMS Consultants, General Medical and Dental Practitioners (GMPs and GDPs), Higher Medical Management staff and DMS Reserve equivalents;
   - A 2.2 per cent increase for all DMS Junior Doctors in training (including GMP Registrars), Cadets and DMS Reserve equivalents, and a 2.4 per cent increase for Associate Specialists; and
   - A 2.2 per cent increase to the values of DMS Clinical Excellence Awards, Distinction Awards and Trainer Pay.

3. The Government responded on 24 July 2006 deciding to implement the following DMS pay awards:

   - From 1 April 2006, a 2.2 per cent increase for all DMS Medical and Dental Officers (and DMS Reserve equivalents), a 2.2 per cent increase to DMS Clinical Excellence Awards, Distinction Awards and Trainer Pay, and a 2.4 per cent increase for DMS Associate Specialists; and
   - From 1 November 2006, a consolidated payment of £6,500 for all DMS accredited Medical and Dental Officers (and DMS Reserve equivalents).

4. In evidence for this report, the British Medical and Dental Associations (BMA/BDA) welcomed the 2006 awards but expressed considerable concern that our recommendations were not implemented in full for accredited groups and disappointment at the Government's "inexplicable delay" in responding to our report.

5. We consider that the Government's staging of pay awards poses a considerable risk to morale and retention at a time when DMS trained strength is significantly under requirement and when pay proposals agreed by the parties are specifically designed to counter on-going retention concerns. Staging also risks undermining the Armed Forces' confidence in their pay determination arrangements. Undue delays in responding to our reports exacerbate these risks.

Evidence for this Report

6. Our evidence base comprised:

   - Written and oral evidence from MOD, Deputy Chief of Defence Staff (Health), Surgeon General and from the British Medical and Dental Associations;
   - The Government's overall evidence on its approach to public sector pay and the Chancellor's letter of July 2006 to all Pay Review Body Chairs;
   - Independent research into DMS and NHS pay comparisons;
   - Independent advice on the relative values of DMS and NHS pensions;
   - DDRB's 2007 Report; and
   - Our visits to Armed Forces' personnel during 2006.

7. In 2006 we visited the Ministry of Defence Hospital Unit (MDHU) at the Royal Haslar Hospital in Gosport, and DMS Regular and Reserve personnel in UK units and operational units in Iraq. These visits enabled us to hear personnel's views on the DMS and wider concerns across the Armed Forces. We are grateful to all those who organised and participated in our visits.

DMS developments

Managing the DMS

8. MOD updated us on developments underway in the DMS to help address manning shortfalls. The *Defence Health Programme* continued to focus on managing and delivering medical support to operations and sufficient numbers of Service personnel fit for task. The *Defence Health Change Programme* aimed to adapt the DMS to the environment envisaged in 2015 through reviewing management structures and medical processes, developing closer working arrangements with the NHS and professional bodies, improving management information and records, enhancing capability through the Royal Centre for Defence Medicine, and improving clinical and administrative efficiency. Under the Government's wider agenda to improve public services, MOD and the Department of Health had established working arrangements monitored through a Performance Partnership Agreement and a Partnership Board.

9. Since April 2005, the *Defence Dental Services* (DDS) has been responsible for delivering effective primary dental care and contributing to personnel requirements for operational capability. The BDA noted in evidence that the DDS was subject to MOD review of the required number of uniformed personnel.

10. MOD commented that there were 28 DMS Officers on the *Higher Medical Management Pay Spine* building to the cadre envisaged in the 2002 Medical Manning and Retention Review. MOD added that the Higher Medical Management career route provided an incentive to "high flyers" and that these incentives needed to be maintained relative to DMS accredited payscales.

Training reform

11. *Modernising Medical Careers* is changing postgraduate training for all medical students by introducing a structured two-year foundation programme followed by specialist training. DMS trainees would also enter the relevant single-Service Entry Officers' Course after foundation training. The new arrangements will reduce the length of training and change the posts required for accreditation and licensing requirements. Work was underway to ensure the special requirements of the military were taken into account by developing new curricula and assessment processes. MOD considered these initiatives might have a positive impact on recruitment and retention. However, the BMA/BDA considered that DMS Junior Doctors would need to remain in training for an additional 12 months and it was important that this did not adversely impact on their commissioning, promotion and military training.

Other non-remuneration measures

12. Under the Service Personnel Plan, MOD was examining flexible working, including career breaks, homeworking and part-time working. The BMA/BDA looked forward to MOD's work as about a third of the DMS were female further increasing the demand for flexible working. Operational effectiveness was an important consideration in such arrangements although MOD recognised that flexible working contributed to recruitment, retention and overall effectiveness of the Armed Forces. We welcome MOD's efforts to introduce flexible arrangements which support recruitment and retention, particularly with the growing feminisation of the UK's medical workforce.

13. We have commented in recent reports on the change to DMS pension arrangements in 2005. For new entrants and those transferring, retention bonuses were introduced at significant amounts (varying according to specialty) for a specified return of service. These bonuses replaced the Immediate Pension available under the old DMS pension scheme. MOD has placed great store in the retention benefits of the new arrangements and, in this context, we note that 34 per cent of eligible DMS personnel transferred to the new DMS pension scheme.

DMS pension valuation

14. We trailed in our 2006 DMS Report that, as new DMS pension arrangements were now in place, we would undertake our periodic valuation of DMS and NHS pensions. These valuations enable us to take account of the relative advantage of DMS pensions, expressed as a percentage of pay, when establishing NHS comparator pay for our pay comparability assessments. This in turn informs our judgement on DMS pay recommendations. To account for the relative advantage of DMS pensions NHS comparator pay is currently 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). We reiterate from our main remit report that Armed Forces' personnel have non-contributory pension schemes with no deductions from their pay to fund schemes.

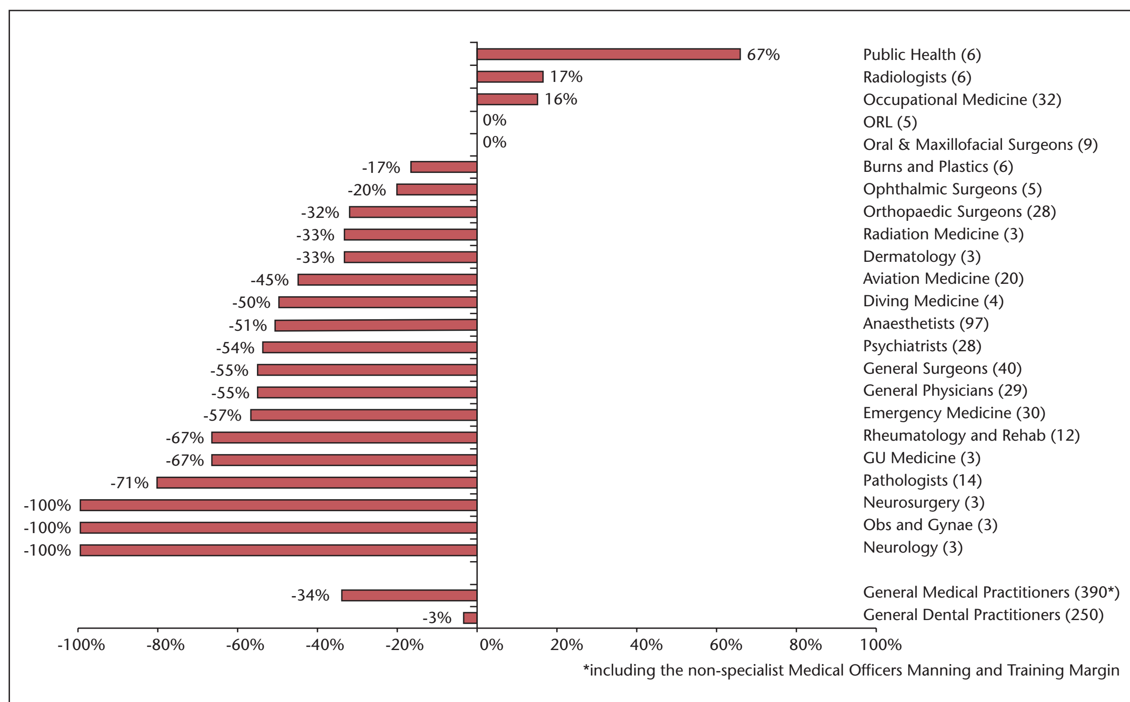
15. We commissioned the Government Actuary's Department (GAD) to advise us on the DMS pension valuation. GAD's work has been complicated by several factors: (i) accounting for the split between the old and new DMS pension schemes; (ii) limited availability of up-to-date NHS pay data and pay profiles following reforms; (iii) application of the earnings cap; (iv) lack of current data to support assumptions; and (v) methodological considerations. We have discussed these factors with GAD and, at the time of writing, await their final report. We comment later on the importance of establishing appropriate NHS comparators (including handling relative pension values) and therefore wish to await GAD's final report before drawing conclusions. Any change would feed into the DMS pay comparability evidence for our 2008 DMS Report and we would therefore publish GAD's report and inform the parties of our conclusions in time to provide 2008 evidence.

Manning evidence

16. At 1 April 2006 there were 490 trained Medical Officers (MOs), a deficit of 55 per cent against the requirement of 1,080. In addition, there were 530 MOs in training. There were also 250 trained Dental Officers (DOs) which was slightly below the requirement, with 11 in training.

17. The manning position varies by specialty. There were large deficits in the following key Operational Pinch Point specialties: Emergency Medicine (57 per cent deficit); General Surgeons (55 per cent); General Physicians (55 per cent); Anaesthetists (51 per cent); and GMPs (34 per cent). Chart 1 shows trained manning against requirement by specialty at 1 April 2006.

Chart 1: Deficit/surplus of trained DMS Personnel, against requirement, by specialty, 1 April 2006



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

18. MOD told us, in oral evidence, that revised DMS manning requirements to support two medium-scale and one small-scale operation or one large-scale operation would be published shortly. These would better reflect the operational task with a slight reduction in overall numbers and a different operational balance across specialties. The DMS would become less reliant on DMS Reserves to support a large-scale operation. MOD added that it was on target to achieve overall DMS manning balance by 2010-11 but that specialty shortages would persist.

Recruitment evidence

19. The DMS recruited 88 Medical Officers in the year to 31 March 2006, an increase of 10 from the previous year, but just 51 per cent of the 171 target for 2005-06. There was more success recruiting Cadets (65 against a target of 110) than Direct Entrants (23 against a target of 61). Over the same period, the DMS recruited 19 Dental Officers (against a target of 20), of which 12 were Cadets and 7 Direct Entrants. Since it was introduced in November 2002, 45 Consultants and GMPs have been recruited under the Golden Hello scheme. MOD still found the scheme a useful means of recruiting Consultants and GMPs but it was under review to ensure that it targeted appropriate medical specialties.

20. All the single Services failed to meet their recruitment targets for 2005-06:

- The Royal Navy missed targets for both Cadets and Direct Entrants although the number of Cadets recruited increased from 2004-05;
- The Army recruited the same number of Cadets and Direct Entrants as in 2004-05 but remained below target; and
- The RAF reported a substantial increase in Direct Entry recruitment, albeit against a substantially larger target while Cadet numbers reduced slightly.

21. The Royal Navy met its target for Direct Entry recruitment of Dental Officers but missed its target for Cadets. The Army met its target for Direct Entry Dental Officers and slightly exceeded its target for Cadets. The RAF met its target for Cadets but missed its target for Direct Entry Dental Officers.

Retention evidence

22. The retention evidence submitted by MOD showed:

- Overall Outflow of Medical Officers fell sharply during 2005-06 to 2.6 per cent, compared with 5.9-6.9 per cent in each of the previous four years;
- Fewer than 30 Medical Officers left the DMS, compared with over 50 in each of the four previous years;
- Voluntary Outflow of Medical Officers more than halved, to 1.2 per cent, from 2.5 per cent in 2004-05; and
- Overall outflow of Dental Officers was at 7.4 per cent in 2005-06, with Voluntary Outflow at 3.5 per cent. Both these figures represent an increase from 2004-05.

23. The DMS Continuous Attitude Survey results for 2006 indicated that:

- 58 per cent of Medical Officers and 44 per cent of Dental Officers felt their salary was better or similar to that of NHS colleagues;
- 73 per cent of Medical Officers and 67 per cent of Dental Officers felt they received a fair salary for the work they did at that time;
- 84 per cent of Medical Officers and 93 per cent of Dental Officers felt that their pay and allowances package influenced their decision to remain in the Armed Forces;
- 43 per cent of Medical Officers and 33 per cent of Dental Officers stated that the pay and allowances package had persuaded them to remain in the Armed Forces for a further three or more years; and
- 79 per cent of Medical Officers and 100 per cent of Dental Officers stated that length of deployments was a major area of consideration that would lead to premature retirement.

24. A BMA cohort study[1] was set up in 2002 to track DMS doctors at significant points in their careers. The June 2006 study attracted responses from only 44 DMS doctors. The results showed that half of respondents were satisfied with working for the DMS and with their current pay/allowances package, and a majority felt they received a fair salary for their work and were satisfied with their pensions. However, the study indicated that very few doctors would continue in the DMS, transfer to a full career commission, extend their commission for a further three years or join the Reserves after leaving the Services. In oral evidence, the BMA suggested that the difficulty of retaining senior DMS doctors was shown by many "keeping their options open" by not opting to take retention bonuses under the new DMS pension scheme.

25. The BDA pointed to two factors that would impact on the ability to recruit and retain sufficient numbers of DMS GDPs. First, a shortage of dentists across the UK as a whole, which is likely to continue for at least the next decade and, second, many newly registered dentists in England would not be eligible to serve in the Armed Forces because of nationality qualifications.

National Audit Office Report – GMP case study

26. As part of its 2006 Report on Recruitment and Retention in the Armed Forces[2], the National Audit Office conducted a series of case studies on Operational Pinch Points which included General Medical Practitioners. The study highlighted the GMP military role, persistent manning shortages over the last five years, the difficulties in attracting Direct Entrants and retaining existing personnel, operational commitments which breach harmony guidelines, and competition from improved pay and working arrangements in the NHS. The NAO examined the initiatives in place to support GMP manning including Golden Hellos, financial support for Medical Cadets, new DMS pay and pensions, and work underway on flexible working, sabbaticals and moving between Regular and Reserve service. The NAO concluded that, depending on revised manning requirements, GMPs would remain an Operational Pinch Point until at least 2010.

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[1] *BMA Tripartite Cohort Study of Doctors in Defence Medical Services, 2006* – BMA Health Policy and Economic Research Unit, October 2006.
[2] *Recruitment and Retention in the Armed Forces* – National Audit Office, 3 November 2006.

Reserve Medical and Dental Officers

27. The evidence on DMS Reserve manning showed that (no information was available on Reserve Dental Officers):

    - Medical Officer strength declined steadily from 550 at 1 April 2002 to 380 at 1 April 2006 against a static requirement of 770;
    - Medical Officer trained strength for the RAF (15) and Royal Navy (59 against a requirement of 86) was at the lowest level since 1 April 2002. The Territorial Army (TA) Medical Officer strength as at 1 April 2006 was unchanged at 310 against a requirement of 680; and
    - Recruitment of Reserve Medical Officers fell significantly between 2003 and 2006 from 54 to 32. No DMS Reserve outflow data were provided.

28. The BMA/BDA commented that DMS Reserves were a fundamental element of operational planning, performed a vital role and that the DMS relied on their contribution. This was reinforced by MOD, in oral evidence, by commenting that, short term, DMS Reserves were key to addressing Regular manning shortfalls and would continue to be deployed on operations, particularly in Operational Pinch Points. MOD added that, generally, civilian employer support was "holding firm" and that £3 million had been invested to improve communications and support. However, the BMA/BDA raised specific concerns that NHS employer support for Reserve liability was waning due to the increasing business focus in the NHS and its target driven approach. They highlighted the need to cover absences (compounded by medical workforce shortages and lack of contingency capacity) and that, if given the choice of equal candidates, the NHS might select those with no Reserve liability.

Operational commitments

29. MOD's evidence emphasised that the DMS regards support to operations as its first priority. Supporting concurrent operations in Iraq and Afghanistan and other worldwide commitments was "sustainable" but MOD acknowledged that DMS Consultant and GMP cadres were "very stretched". It commented that additional operational commitments would not be sustainable and noted that medical commitment was increasing in line with the increased commitment to operations in Afghanistan. As at September 2006, the DMS had 90 Medical Officers deployed across the Services. MOD reported there were sufficient numbers of Dental Officers to support current operations with 8 Dental Officers deployed every 3 months (32 per year) and 3 DOs on standby. No Reservist DOs were currently deployed.

30. Based on current manning trends and key specialty shortfalls through to 2010, MOD anticipated that DMS Reserve Consultants and GMPs would continue to be required for small and medium-scale operations. There will be a Reserve-led enhanced medical facility in Afghanistan although this would constrain the ability to call-up Reserves in future years. Some flexible use of Specialist Registrars in their final two years of training might be available at MOD's discretion.

DDRB recommendations from 1 April 2007[3]

31. DDRB's 2007 recommendations for NHS doctors and dentists responded to the evidence on: NHS affordability constraints; a stable recruitment and retention environment; the benefits of NHS pay reform; the lack of earnings data; and the reduction in Junior Doctors' earnings due to the restrictions on hours worked imposed by the Working Time Directive. DDRB structured its recommendations to give proportionately higher benefit to those NHS doctors and dentists who earned the least. The effect of its recommendations would be to increase the overall pay bill for NHS Hospital and Community Health Services medical staff by 2 per cent. The recommendations relevant to DMS groups include the following:

- A £1,000 increase to the pay scales for NHS Consultants (on both old and new NHS contracts), Staff Grades and Associate Specialists;
- NHS Consultants' Clinical Excellence Awards, Distinction Awards and Discretionary Points should remain at their 2006-07 values;
- An increase of £650 to Junior Hospital Doctors' pay scales which, when multiplied by the average out-of-hours banding multiplier (1.56) gave an average £1,000 increase. The supplement for new GMP Registrars should be reduced to 55 per cent (in line with the trend of the average supplement for Junior Hospital Doctors), although those Registrars currently receiving the supplement should keep their existing entitlement at 65 per cent;
- No increase for independent contractor GMPs due to the marked benefits arising from the new GMP contract, sizeable increases reported in GMPs' profits in recent years and the lack of evidence to predict how any change would affect earnings;
- A 2.0 per cent increase in the GMP Trainer Grant;
- A £1,000 increase to the salary range for salaried GMPs (actual salaries of individual GMPs are negotiated locally) and to the pay scales for Salaried Dentists in Primary Dental Care Services; and
- A 3.0 per cent uplift to the gross earnings base under the new NHS contract for 2007-08 for GDPs in England and Wales allowing for a 2 per cent increase in GDPs' earnings. A 3.0 per cent increase to gross fees and payments for GDPs in Scotland.

32. On 1 March 2007, the Government announced that it accepted DDRB's recommendations but that the award would be staged, consistent with the approach to most Pay Review Bodies' recommendations. The staging allowed for NHS doctors and dentists in England and Wales to receive a 1.5 per cent increase from 1 April 2007 (or the full DDRB recommendation if it delivered less than 1.5 per cent) and the remainder from 1 November 2007. At the time of our report, the detailed impact for each NHS group had yet to be finalised by the Department of Health but it estimated that overall NHS earnings growth would be around 4.5 per cent for 2007. On 13 March 2007, the Scottish Executive announced that all NHS staff in Scotland would receive recommended increases in full.

[3] *Review Body on Doctors' and Dentists' Remuneration, Thirty-Sixth Report 2007*, Cm 7025.

NHS developments

33. We monitor NHS developments that impact on the DMS remit group and our approach to broad pay comparability. We note the following:

    - In 2003, a new NHS Consultant contract was introduced to improve job planning and better manage workloads. By 2006, the Health Departments estimated that take-up of the new contract was over 90 per cent and numbers on the old contract continued to fall. NHS Employers reported that the average number of NHS Consultants' Programmed Activities (PAs) under the new contract decreased from 11.17 (October 2004) to 10.83 (October 2005);
    - Following the introduction of two-year Foundation programmes and a single specialist training grade under *Modernising Medical Careers*, NHS Employers and the BMA had agreed the pay scales for Foundation House Officers but negotiations continued on the pay for the specialist training grade (Specialty Registrars);
    - Negotiations between NHS Employers and the BMA on the uplift to the new General Medical Services' contract formally broke-down in January 2007. DDRB concluded that it should make recommendations for NHS GMPs who were still within its remit;
    - At the time of DDRB's Report, Staff and Associate Specialists/non-consultant career grades were due to be balloted on a new contract; and
    - The Department of Health reported that 89 per cent of new contract offers for GDPs in England and Wales had been signed. The contracts with Primary Care Trusts would provide a given number of Units of Dental Activity that would aim to free time, release capacity and lower costs. Scotland continued to use the fee-per-item service. Negotiations between NHS Employers and the BDA were underway on new contractual arrangements for Salaried Primary Dental Care Services.

Pay comparability evidence

34. The parties agree that maintaining pay comparability with the NHS is critical to DMS recruitment, retention, motivation and morale. Under our terms of reference we consider *broad* comparability alongside other evidence to reach our recommendations that are fair to Service personnel and to the taxpayer who ultimately funds them. To achieve broad comparability with the NHS we compare pay levels in the current year (for this Report as at 1 April 2006 and at 1 November 2006 to account for staged NHS and DMS pay awards) and pay movements over the coming year (2007-08) in the light of DDRB's recommendations for the NHS. This is consistent with our methodology for our main remit group and reduces any "time-lag" between changes in NHS and DMS pay.

35. In previous reports we cited the lack of reliable and comprehensive NHS pay data as a constraint on our assessment of pay comparability. For this report, we note that there have been improvements in the availability of NHS data for some groups but gaps still exist. Our evidence base for pay comparability comprises an independent update report commissioned from NHS Partners; the parties' own assessments; and improved information on the numbers of Consultants' Programmed Activities and On-Call Availability rotas in both the NHS and DMS.

36. The parties' comparability evidence has followed the previous methodology of adjusting pay comparisons for X-Factor and pensions. We have, however, brought our pay comparability methodology in line with our main remit group approach. We now: (i) reduce DMS salaries by the appropriate X-Factor amount across the various DMS pay scales including the taper; and (ii) reduce NHS salaries to account for the relative pension advantage for the DMS over the NHS, including where applicable non-pensionable NHS pay to avoid double-counting when reading across into the DMS where all base pay is pensionable. Alongside further consideration of the DMS pension valuation required for 2008 evidence, we will review the handling of pensionable and non-pensionable pay elements in the NHS and DMS.

NHS Partners

37. We commissioned NHS Partners to produce an independent report updating their 2005[4] and 2006[5] comparability reports taking account of any new data on careers and earnings. NHS Partners' 2007 main findings[6] on the data and comparisons were:

- **Consultants** – NHS Partners provided a range of NHS base pay comparisons using 10, 11 and 12 PAs adjusting for non-pensionability of PAs above 10. They advised that the distribution of PAs by age or length of service would facilitate better pay profiles. On this basis, DMS Consultants' pay is generally well above NHS comparator pay for 10 PAs; above the NHS using the NHS average of 10.83 PAs; ahead of the NHS for 11 PAs at and beyond age 40; and generally in line with the NHS for 12 PAs – lagging behind at the start of a career but moving ahead in the final stages. NHS Partners noted that 12 PAs was the equivalent of working 48 hours a week (the maximum number of hours allowed under the European Working Time Directive) restricting time available for private practice necessitating consideration when better data were available;
- Better information on On-Call Availability rotas worked in the NHS and DMS was available. NHS Partners presented example NHS comparators which included an On-Call Availability Supplement of 5 per cent. Improved data from the Advisory Council on Clinical Excellence Awards on the distribution of NHS Local Clinical Excellence Awards (CEAs) for March 2006 showed that 41.5 per cent of eligible NHS Consultants received no award with 32.3 per cent receiving between 1 and 4 local awards. NHS Partners provided an example profile indicating the impact of these high value additions to the NHS pay comparisons. For On-Call Availability Supplements and Local CEAs, NHS Partners concluded that data by age or length of service would enable more detailed pay profiles for NHS Consultants to be developed;
- **General Medical Practitioners** – new data on NHS GMP earnings in 2004-05 under the new General Medical Services' contract indicated that GMPs' average net income was £97,825 compared to DMS GMPs' average pay at 1 November 2006 of £91,695. However, NHS Partners warned that there was still some debate about the reliability of the data for comparator purposes. They specifically noted that average net earnings were produced for all General Medical Services' GMPs (including dispensing, non-dispensing, full and part-time) and also included income from private work and an amount in respect of employer NHS pension contributions. They added that the absence of any age related information only increased the difficulty in making pay comparisons with the DMS and that, for the future, variations by practice list size might be considered;

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[4] *A Report on Defence Medical Services Pay Comparability* – NHS Partners, February 2005, www.ome.uk.com.
[5] *Defence Medical Services Pay Comparability Update Report* – NHS Partners, February 2006, www.ome.uk.com.
[6] *Defence Medical Services Pay Comparability Update Report* – NHS Partners, February 2007, www.ome.uk.com.

- **General Dental Practitioners** – the mix between NHS and private practice, the shift from General Dental Services' contracts to Personal Dental Services' contracts and the implementation of new pay arrangements for both contracts made it difficult to establish total earnings and therefore pay comparisons. A range of NHS comparisons was provided including the average General Dental Services' GDP net income (and subsets of these for first party, second party and non-associates) and NHS earnings with a "reasonable level of NHS commitment". Generally, NHS earnings decreased with age as NHS commitment reduced; and
- **Junior Doctors in training** – the continued reduction of working hours for Junior Doctors in the NHS had led to reduced NHS earnings. Comparisons using a range of out-of-hours bandings showed that pay for DMS Junior Doctors (including those training to be GMPs) was ahead of NHS comparators throughout their training.

Parties' evidence on pay comparability

38. We are grateful to the parties for producing extensive information to underpin their pay proposals. We summarise their views below by each DMS group.

39. **Consultants** – MOD continued to favour comparisons on 12 PAs as this took account of additional elements of NHS pay and reflected DMS workload including on-call and deployments. MOD concluded that the 2006 DMS pay award achieved broad comparability with the NHS although its comparisons suggested that DMS Consultants early in their careers lagged behind the NHS by £8,000 per annum before moving ahead by the same amount later in service. MOD added, in oral evidence, that this pattern was appropriate for the DMS as it encouraged retention of experienced Consultants.

40. MOD invited us to consider whether On-Call Availability Supplements and Local CEAs should be reflected in DMS pay. An MOD survey[7] indicated that the average frequency of on-call rotas for DMS Consultants was between 1 in 5 and 1 in 8, which would be considered a medium frequency rota in the NHS and would attract a 5 per cent supplement. A survey of NHS Consultants in one Trust with a MOD Hospital Unit suggested that only very small numbers of NHS Consultants reached the higher levels of Local CEAs. MOD noted that values of NHS Local CEAs were incorporated into DMS pay in 1997 and subsequently extended in 2000 but that such awards were essentially a performance bonus recognising local contribution in the NHS and therefore could not be directly read across to the DMS. MOD told us in oral evidence that it intended to discuss Local CEAs with the BMA/BDA and present proposals as necessary for our 2008 Report.

41. The BMA/BDA based comparisons on 11 PAs adding, in oral evidence, that this was "a conservative estimate" which accounted for DMS workload and deployments. Their comparisons included the value of NHS Local CEAs (assuming one is paid every three years) which, they calculated, produced a DMS pay deficit against the NHS of 4 per cent over a DMS career. When looked at in 5-increment bands, the BMA/BDA comparisons indicated pay deficits of between 0 and 8.8 per cent. The BMA/BDA's pay profile, influenced by the pattern of Local CEAs, suggested that DMS Consultants were on level terms with NHS comparators during the early years of service before falling behind later in the career, reversing the career earnings pattern presented by MOD. In oral evidence, the BMA/BDA accepted the difficulties of reading across NHS Local CEAs to the DMS but argued that their evidence was a realistic effort to move forward on establishing appropriate NHS comparators. The BDA/BMA did not include the value of On-Call Availability Supplements within NHS comparators but suggested that this would be addressed in evidence for our 2008 Report.

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[7] Conducted by the Defence Medical Education and Training Agency in August 2006.

42. **General Medical Practitioners** – MOD commented that the average superannuable income of full-time independent contractor NHS GMPs (rather than salaried GMPs) remained the appropriate comparator and, therefore, it was a source of frustration that the Department of Health Technical Steering Committee (TSC) data did not exclude part-time NHS GMPs. MOD's evidence showed that, from a comparable base in 2002-03, NHS GMP salaries had increased by 48 per cent in the three years to 2005-06 compared with only 28 per cent for DMS GMPs. However, MOD argued that it would not know the extent to which the 2006 DMS pay award had addressed this disparity until 2006-07 data became available. In oral evidence, MOD recognised "intuitively" that NHS GMP pay had increased but the current evidence was not conclusive until the "time-lag" effect worked through.

43. The BMA/BDA also drew on Department of Health TSC data concluding that in the first year of the new NHS contract (2004-05) average net income for all General and Personal Medical Services' GMPs was £97,188. They estimated that this figure was likely to be understated due to the inclusion of part-time GMPs. The BMA/BDA considered the TSC data to be robust as it rolled forward the methodology used before the new NHS contract to establish NHS earnings net of expenses for pension purposes. They compared, for 2004-05, the average NHS earnings across the career of a DMS GMP and estimated a deficit against NHS earnings of an average of 4.8 per cent (although no adjustments were made for X-Factor and pension value). The BMA/BDA suggested that its profile showed that the pay disparity was greatest in the early years and that it was not until 29 years after DMS accreditation that parity was restored. They expected this disparity to grow as further TSC data became available showing the effect of increased NHS earnings.

44. **General Dental Practitioners** – MOD and the BMA/BDA agreed that the continuing move out of NHS work into private practice made establishing robust pay comparisons extremely difficult. As a result of this move, the percentage of income derived from the NHS reduced from 54 per cent in 2003-04 to 48 per cent in 2004-05. Average net earnings (both NHS and private practice income) for General Dental Services' first party associates in 2004-05 were £105,300 with non-associates earning £86,000 (growing at 11 per cent per annum). The BMA/BDA claimed that any large increase to DMS GDPs' salaries to restore comparability would be divisive. The parties supported retaining the link with DMS GMPs' pay that has existed since 2003.

45. **Junior Doctors in training** – MOD's evidence showed that, when comparing the average NHS out-of-hours band pay multiplier (1.56), the pay for DMS Junior Doctors was generally higher than their NHS counterparts apart from those in Bands 2A and 3. It added that the majority of DMS Junior Doctors were not in these bands and would rotate between posts. The BMA/BDA commented that, even allowing for the compensation for out-of-hours work, many junior DMS doctors are likely to be working long hours.

Pay proposals for 2007-08

46. Pay proposals were set into the context of the Government's overall approach to public sector pay and the Chancellor's letter of 13 July 2006 to all Pay Review Body Chairs. These suggested that recommendations should be consistent with the Consumer Prices Index inflation target of a 2 per cent increase. The Chancellor's letter also argued that the effect of higher oil prices on CPI would be temporary and without it "underlying inflation" would, at July 2006, have been below 2 per cent.

47. MOD considered that the 2006 DMS pay awards, even though staged, were designed to address pay disparity with NHS counterparts. MOD proposed for 2007-08 that we should recommend in line with DDRB recommendations and take into account a wider range of considerations for GMPs. In oral evidence, however, MOD clarified that it sought only increases informed by DDRB recommendations and no case was being

made for differentiation. On *affordability*, MOD added that the financial position in defence remained tight with current and future defence capability being provided within Departmental Expenditure Limits. MOD considered overall pay proposals would be affordable if informed by the CPI target for inflation of 2 per cent, our 2007 recommendations for the main Armed Forces remit group and DDRB recommendations. It estimated a 2 per cent pay recommendation would cost £3.5 million plus additional costs for DMS Reserve equivalents.

48. On a general note, the BMA/BDA commented that DMS doctors and dentists delivered high quality care to military personnel in challenging environments, yet typically earned less than NHS colleagues. They considered that comparable pay levels helped retain DMS Officers, avoiding an "exodus to the NHS", and thereby supported DMS capability. The BMA/BDA pointed to the need for our pay recommendations to match those recommended by the DDRB and argued cases for additional recommendations for DMS Consultants and GMPs/GDPs.

49. Specific proposals from MOD and the BMA/BDA for DMS Regulars (and DMS Reserve equivalents) were as follows:

- **Consultants** – MOD proposed awards in line with DDRB recommendations and that pay comparisons should continue to be based on 12 PAs. It also invited our views on incorporating On-Call Availability Supplements and Local CEAs into comparisons;
- The BMA/BDA considered that DMS Consultants required increases of between 0 and 8.8 per cent, in addition to DDRB recommended increases, to be applied variably in 5-increment bands across the DMS pay scale. These proposals drew on NHS and DMS career pay comparisons based on 11 PAs and accounted for NHS Local CEAs;
- **GMPs** – MOD invited us to consider, in addition to the factors influencing its overall proposals, that 2004-05 earnings data for all GMPs from the NHS TSC indicated an absolute and percentage pay disparity between the NHS and DMS, and to consider the extent to which the 2006 DMS pay awards had addressed this disparity. In oral evidence, MOD clarified that there was no "concrete" evidence on NHS earnings to justify a differential approach;
- The BMA/BDA, also drawing on 2004-05 NHS earnings data, proposed a 4.8 per cent increase to represent the difference between career NHS and DMS earnings in addition to the DDRB recommended increase;
- **GDPs** – MOD and the BMA/BDA proposed maintaining the link between DMS GMPs' and GDPs' pay;
- **Higher Medical Management (HMM) Pay Spine** – MOD proposed that, to maintain an incentive, the pay spine should receive an uplift in line with that for DMS Consultants. The BMA/BDA proposed that HMM staff received the same uplift as other accredited DMS Consultants and GMPs/GDPs; and
- **Other DMS pay** – MOD and the BMA/BDA proposed increases in line with DDRB recommendations for Associate Specialists, Junior Doctors, DMS National Clinical Excellence Awards and Distinction Awards, DMS Trainer Pay, and Medical and Dental Cadets.

Recommendations for 2007-08

Overall pay recommendations

50. Our DMS pay recommendations seek to support manning, recruitment and retention and ensure that broad comparability with NHS comparators is maintained. The background for our deliberations continues to be sustained pressure on DMS resources from high levels of operational commitments although DMS manning, recruitment and retention have shown signs of stabilising during 2005-06.

51. We assess the evidence for the DMS in the context of the Government's overall approach to public sector pay, the Chancellor's July 2006 letter to Review Body Chairs and MOD's affordability evidence. The Government's and MOD's detailed evidence was set out in our 2007 Report for the main remit group. From that evidence, we note the Government's continuing emphasis on the role of pay in delivering public sector services, on the economic and fiscal conditions, on the modernisation agenda including pay reform and on the concept of "total reward". MOD's evidence set out the modernisation agenda for the DMS and the extensive development plans in hand. We also note that pay reform in the DMS over the last five years has significantly improved the overall package or "total reward" which we take into account in our remit on comparability. We note MOD's reiteration of the continuing pressures on Defence budgets and therefore the affordability of pay recommendations.

52. The general economic position is also important to our deliberations. We observe the prevailing economic conditions, at January 2007, as indicated by inflation measures of CPI at 2.7 per cent, RPIX at 3.5 per cent and RPI at 4.2 per cent. The Average Earnings Index, excluding bonuses, in the three months to January 2007 was at 3.6 per cent – public sector at 3.1 per cent and the private sector at 3.7 per cent. Median pay settlements at December 2006 remained around 3 per cent.

53. DMS manning, recruitment and retention stabilised during 2005-06. While there are substantial overall manning and specialty deficits, these have levelled off and in some cases reduced partly as a result of reducing requirements. Further revisions to manning requirements are expected. Shortages reflect those in the wider medical and dental labour markets and will present long term challenges to the DMS as they do to the NHS. The DMS shortages tend to be in deployable specialties which experience the retention-negative impact of separation and diminished quality of life. Shortages are mirrored in the DMS Reserves (overall and by specialty) who are also in demand to support operational capability.

54. We note that recent DMS pay awards have, alongside other measures, had some influence on reducing Overall Outflow. The Medical Officer Voluntary Outflow rate continues on a downward trend to 1.2 per cent – the lowest level in recent years – although we note signs of increased Outflow for Dental Officers. However, the Continuous Attitude Survey and the BMA cohort study still point to fragile commitment to the DMS. The upward trend in recruitment is encouraging. Medical Officer recruitment in 2005-06 improved on previous years but remained below targets for new entrants and Direct Entrants. Dental Officer recruitment met 2005-06 targets. MOD considered that, overall, DMS manning balance was achievable by 2010-11 although specialty shortages would persist. The improving trends in recruitment and retention will need to be maintained or enhanced to achieve manning balance.

55. Our pay comparability evidence draws on established profiles and emerging NHS data sources. On a general note, the evidence suggests DMS base pay levels following the 2006 DMS pay award are broadly comparable with the NHS, although variations occur across DMS careers and specialty groups. We draw this conclusion primarily from NHS Partners' assessment of the current position. The parties' evidence presents an inconsistent picture on pay comparability, with the exception of recognising the need to keep pace with DDRB recommendations. The parties' comparisons use the same NHS earnings data but use different career and pay reference points for the compilation of NHS comparators.

56. We comment later (paragraph 65) on the need to establish agreed NHS comparators. In the meantime, we rely on DDRB's recommendations as the most appropriate comparator for the DMS remit group. DDRB's 2007-08 recommendations have introduced a degree of complexity in that they are weighted towards the lower paid NHS doctors and dentists. We do not consider direct matching is appropriate given the different DMS pay structures and profiles. We therefore draw on the 2 per cent increase in the pay bill for NHS Hospital and Community Health Services medical staff arising from DDRB's recommendations as an appropriate measure of NHS pay movements.

57. In reaching our conclusions we are mindful of the Government's evidence on public sector pay, the Chancellor's emphasis on consistency with the CPI inflation target, MOD's view of affordability and DDRB's recommendations. We conclude that, in the absence of any convincing case for a differential approach, our recommendation should apply across-the-board to meet the specific needs of the DMS remit group. We therefore recommend a 2 per cent increase for DMS Consultants, GMP/GDPs and Higher Medical Management staff, Junior Doctors, accredited OF2s, Associate Specialists, and Medical and Dental Cadets (including DMS Reserve equivalents where applicable).

Recommendation 1: We recommend a 2.0 per cent increase from 1 April 2007 for DMS Consultants, General Medical Practitioners, General Dental Practitioners, Higher Medical Management staff, Associate Specialists, 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.

Consultants' National Clinical Excellence Awards and Distinction Awards

58. Since 2005, the DMS has run a system of National Clinical Excellence Awards that mirrors the NHS scheme using the top four NHS awards. MOD's evidence commented on the successful completion of the 2006 DMS Awards round and sought an uplift in line with DDRB recommendations. The BMA/BDA noted that, unlike NHS Awards, DMS Awards were not pensionable. The DDRB recommended that NHS CEAs and Distinction Awards should remain at 2006-07 levels. We consider that the value of DMS Awards should be in line with those available to NHS equivalents and therefore recommend no increase from 1 April 2007. The number of available awards should remain at 32.

Recommendation 2: We recommend no increase to the value of DMS National Clinical Excellence Awards and Distinction Awards from 1 April 2007. The 2007-08 levels are shown at Appendix 1.

DMS Trainer Pay

59. The BMA/BDA commented on the Department of Health's review of pay arrangements for NHS GMP Trainers. They provided the results of a BMA survey of NHS arrangements[8] and pointed to the BMA's evidence to DDRB on the importance of a pay award to support NHS recruitment, retention and morale. The BMA/BDA told us that DMS Trainers were delivering trained GMPs to support operational capability, were most affected by retention concerns, and were experiencing increased educational responsibilities and workload. They concluded that DMS Trainers should be rewarded as in the NHS. MOD informed us that further work was planned to make the career of DMS Trainers more attractive and in the meantime supported an increase in DMS Trainer Pay in line with the DDRB recommendation.

60. The DDRB noted the work being taken forward in the NHS to develop a new remuneration structure for GMP Trainers and recommended a 2.0 per cent increase to the level of the NHS GMP Trainer Grant. We look forward to the outcomes of these developments in the NHS and the DMS for our 2008 DMS Report and, in the interim, recommend that DMS Trainer Pay should increase by 2.0 per cent from 1 April 2007.

Recommendation 3: We recommend that DMS Trainer Pay be increased by 2.0 per cent from 1 April 2007. The rate is at Appendix 1.

Cost of recommendations

61. We estimate that the cost of implementing our pay recommendations for 2007-08 is £3.5 million (including the Employers' National Insurance Contribution and superannuation liabilities). This costing is based on the Officer strengths of the medical and dental branches of the Armed Forces in 2007-08 as forecast by MOD. To the extent that strengths differ in practice, the cost of implementing the recommendations will also differ.

Looking ahead

62. In our 2006 Report we commented on the fundamental changes made to NHS pay since MOD introduced new DMS pay arrangements in 2003 following the Medical Manning and Retention Review. We were concerned that DMS pay structures constrained our ability to target pay recommendations to ensure broad pay comparability with the NHS and to respond to continuing manning and retention difficulties. We considered it essential that MOD should review pay and career structures at an early stage to take advantage of the flexibility under Joint Personnel Administration (JPA).

63. In evidence for this report, MOD pointed to its Strategic Remuneration Review as the vehicle to develop a new, more flexible pay spine for the Armed Forces. The current thinking was to map the various DMS cadres onto a new pay spine. However, this would be a complex task and delivery under JPA was unlikely, therefore, before 2011. In oral evidence, MOD commented that the current pay structure favoured those later in a career to retain experienced doctors and dentists who added considerable value to the DMS, particularly on operations. Younger DMS doctors were more interested in experiencing the challenges of operational deployments than in pay levels. The BMA/BDA also stated in oral evidence that no major structural change was required, adding that comparability was generally achieved until accreditation and then a gap opened with the NHS. They added that targeting by DMS specialty was potentially divisive in the military and that the overall package was important, encompassing pay, career progression and pensions.

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[8] *Review of GP training practices, Survey of current GP Trainers and trainees* – BMA Health Policy and Economic Research Unit, November 2006.

64. We recognise that any development of DMS pay structures must be considered alongside wider developments across the Armed Forces. However, we continue to urge MOD to keep DMS pay and career structures under review so that it is able to respond to changing circumstances at the earliest opportunity. In our view, recent DMS pay awards have had a positive, if limited, impact on DMS manning levels but have not resolved structural concerns such as being able to leave the DMS early with an Immediate Pension under the old scheme thereby offering only a short return of service.

65. Turning to the evidence for our 2008 DMS Report, we will be undertaking further work on **DMS pay comparability** following NHS Partners' Report to establish agreed DMS pay comparators. Specifically:

- **Consultants** – the appropriate number of PAs and whether these cover On-Call Supplements. We also wish to consider the parties' proposals on handling Local CEAs including whether a bespoke DMS system is required and the degree to which DMS base pay includes average NHS CEA values;
- **GMPs** – further analysis of NHS earnings data as it becomes available to establish like-for-like comparators;
- **GDPs** – an assessment of the range of earnings data for NHS GDPs;
- **DMS Trainers** – further evidence on outcomes of reviews in the NHS and DMS; and
- **Pension valuation** – the handling of the relative pension value in our 2008 pay comparisons and a review of handling pensionable and non-pensionable pay.

66. We ask the parties to provide the following in evidence for our 2008 Report:

- **Sustainable Experience Profiles** so that we can gauge a clearer picture on DMS manning including the factors influencing exit points;
- Updates on **DMS non-remuneration measures**, particularly career management and the development of flexible working patterns; and
- Any specific DMS considerations for our **X-Factor** review including the interplay between X-Factor and NHS pay elements (e.g. for additional workload and on-call), the application of the X-Factor taper and the level of X-Factor for DMS Reserves.

David Greenaway
Robert Burgin
Alison Gallico
Peter Knight
Derek Leslie
Neil Sherlock
Ian Stewart
Anne Wright
Tony Young

26 March 2007

Appendix 1

1 April 2007 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	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 1.2: **Recommended 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 1.3: **Recommended 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 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	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 1.5: **Recommended annual salaries inclusive of the X-Factor for Service Medical and Dental Officers: OF1 (PRMPs)**

	Military salary
	£
OF1	38,343

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	17,342
	after 1 year	15,603
	on appointment	13,870

Table 1.7: **Recommended 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 1.8: **Recommended 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 recommended annual rate of GMP and GDP Trainer Pay from 1 April 2007 is £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

Appendix 2

1 April 2006 military salaries including X-Factor for DMS Officers

All annual salaries are derived from daily rates in whole pence and rounded to the nearest £, calculated on a 365-day year.

Table 2.1: **Annual salaries inclusive of the X-Factor for accredited consultants (OF3-OF5)**[1]

Increment level	Military salary
	£
Level 32	114,019
Level 31	113,778
Level 30	113,541
Level 29	113,296
Level 28	113,059
Level 27	112,581
Level 26	112,102
Level 25	111,624
Level 24	110,464
Level 23	109,307
Level 22	108,150
Level 21	106,989
Level 20	105,832
Level 19	104,671
Level 18	103,518
Level 17	102,054
Level 16	100,598
Level 15	99,141
Level 14	97,681
Level 13	96,229
Level 12	94,772
Level 11	91,571
Level 10	88,377
Level 9	85,184
Level 8	82,348
Level 7	79,504
Level 6	76,657
Level 5	73,989
Level 4	72,953
Level 3	71,894
Level 2	68,386
Level 1	64,915

[1] Salaries from 1 April 2006 to 31 October 2006. From 1 November 2006 a further £6,500 was added to each increment level.

Table 2.2: **Annual salaries inclusive of the X-Factor for accredited GMPs and GDPs (OF3-OF5)**[2]

Increment level	Military salary
	£
Level 35	104,678
Level 34	104,321
Level 33	104,047
Level 32	103,602
Level 31	103,244
Level 30	102,883
Level 29	102,605
Level 28	102,164
Level 27	101,799
Level 26	101,441
Level 25	101,076
Level 24	100,718
Level 23	100,353
Level 22	99,999
Level 21	99,630
Level 20	99,192
Level 19	98,736
Level 18	98,284
Level 17	97,827
Level 16	97,375
Level 15	96,918
Level 14	95,020
Level 13	94,568
Level 12	94,115
Level 11	93,593
Level 10	93,075
Level 9	92,553
Level 8	90,648
Level 7	90,129
Level 6	88,808
Level 5	87,480
Level 4	86,158
Level 3	84,830
Level 2	82,935
Level 1	82,315

[2] Salaries from 1 April 2006 to 31 October 2006. From 1 November 2006 a further £6,500 was added to each increment level.

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

Increment level	Military salary
	£
Level 29	88,640
Level 28	87,903
Level 27	87,173
Level 26	86,439
Level 25	85,702
Level 24	84,972
Level 23	84,238
Level 22	83,505
Level 21	82,778
Level 20	82,045
Level 19	81,311
Level 18	80,581
Level 17	79,851
Level 16	79,117
Level 15	78,380
Level 14	77,654
Level 13	76,920
Level 12	76,186
Level 11	75,456
Level 10[a]	74,726
Level 9	73,847
Level 8	72,365
Level 7	70,879
Level 6	69,825
Level 5	68,781
Level 4	67,733
Level 3	66,686
Level 2	63,178
Level 1	59,692

[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[3]	Non-Accredited Medical and Dental Officers	Accredited Dental Officers[3]
	£	£	£
Level 5	61,700	55,268	61,700
Level 4	60,316	53,856	60,316
Level 3	58,937	52,436	58,937
Level 2	57,550	51,027	57,550
Level 1	56,166	49,625	56,166

[3] Salaries from 1 April 2006 to 31 October 2006. From 1 November 2006 a further £6,500 was added to each increment level.

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

	Military salary
	£
OF1	37,566

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

	Length of service	Military salary
		£
Cadets	after 2 years	16,991
	after 1 year	15,286
	on appointment	13,589

Table 2.7: **Annual salaries inclusive of the X-Factor for Higher Medical Management Pay Spine: OF6**[4]

Increment level	Military salary
	£
Level 7	117,384
Level 6	116,307
Level 5	115,234
Level 4	114,150
Level 3	113,070
Level 2	112,000
Level 1	110,916

[4] Salaries from 1 April 2006 to 31 October 2006. From 1 November 2006 a further £6,500 was added to each increment level.

Table 2.8: **Annual salaries inclusive of the X-Factor for Higher Medical Management Pay Spine: OF54**[5]

Increment level	Military salary
	£
Level 15	110,486
Level 14	109,810
Level 13	109,124
Level 12	108,441
Level 11	107,763
Level 10	107,080
Level 9	106,390
Level 8	105,711
Level 7	105,029
Level 6	104,007
Level 5	102,988
Level 4	101,959
Level 3	100,941
Level 2	99,922
Level 1	98,893

[5] Salaries from 1 April 2006 to 31 October 2006. From 1 November 2006 a further £6,500 was added to each increment level.

DMS Trainer Pay

The annual rate of GMP and GDP Trainer Pay from 1 April 2006 was £7175.90.

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

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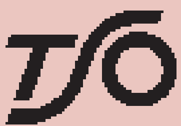

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