Armed Forces'
Pay Review Body

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Service Medical and Dental Officers

Supplement to the Forty-Second Report 2013

Chair: Professor Alasdair Smith

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

May 2013

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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.

Members of the Review Body are:

Professor Alasdair Smith (Chair)[1]
Mary Carter
Professor Peter Dolton
The Very Revd Dr Graham Forbes CBE
Vice Admiral Sir Richard Ibbotson KBE CB DSC
Paul Kernaghan CBE QPM
Judy McKnight CBE
John Steele

The secretariat is provided by the Office of Manpower Economics.

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

Contents

GLOSSARY OF TERMS

AHP	Allied Health Professionals
AFPS	Armed Forces' Pension Scheme
AFPRB	Armed Forces' Pay Review Body
BDA	British Dental Association
BMA	British Medical Association
BME	Black and Minority Ethnic
CEA	Clinical Excellence Award
DDRB	Review Body on Doctors' and Dentists' Remuneration
DO	Dental Officer
DMS	Defence Medical Services
DMSCAS	Defence Medical Service Continuous Attitude Survey
DMS20	Defence Medical Services 2020
EDP	Early Departure Payments
FR20	Future Reserves 2020
GDP	General Dental Practitioner
GDS	General Dental Services
GMP	General Medical Practitioner
GMS	General Medical Services
GP	General Practitioner
GPMS	General and Personal Medical Services
MO	Medical Officer
MOD	Ministry of Defence
MODO	Medical and Dental Officers
NEM	New Employment Model
NHS	National Health Service
OF	Officer
OME	Office of Manpower Economics
PA	Programmed Activity
PDS	Personal Dental Services
PMS	Personal Medical Services
RN	Royal Navy
SDSR	Strategic Defence Security Review
UK	United Kingdom

ARMED FORCES' PAY REVIEW BODY
2013 DMS REPORT – SUMMARY

Recommendations

- **A one per cent increase in basic pay to all ranks within the Medical and Dental Officer cadre;**
- **A one per cent increase in General Medical Practitioner and General Dental Practitioner Trainer Pay and Associate Trainer Pay;**
- **A 0.5 percentage point increase in X-Factor from 14.0 per cent to 14.5 per cent, in line with the main remit group;**
- **That MOD reconsiders how to best include Medical and Dental Officers in the future Armed Forces Pension Scheme.**

Evidence for this Report

Our terms of reference require us to consider a range of issues before making our recommendations on pay for personnel in Defence Medical Services (DMS). We take into account: the need to recruit, retain and motivate suitably able and qualified people; UK economic data; the Government's policy on public sector pay; workforce levels; comparisons with relevant pay levels in the NHS; and the recommendations from the Review Body on Doctors' and Dentists' Remuneration (DDRB). We received written and oral evidence from the Ministry of Defence (MOD) and the British Medical and Dental Associations (BMA and BDA). We also consider evidence gathered during our visits programme, which includes DMS personnel serving in Afghanistan as well as those providing medical care in the UK and bases overseas.

Workforce data

The 2011–12 data on the DMS workforce showed a mixed picture. MOD told us that DMS "appears to be in manning balance" although it acknowledged there were shortages in specific groups. The number of trained Medical Officers (MOs) fell slightly, resulting in a shortfall against requirement of 28 per cent, compared with 24 per cent in the previous year. Significant shortages persisted within some key specialties. Dental Officer (DO) staffing increased to 99 per cent against a slightly reduced requirement.

Recruitment of MOs met its target, the lowest in a decade, but DO recruitment failed to meet its modest target. Some 60 MOs left, 7.5 per cent of overall requirement. There was no significant change in DO losses. MOD said that Defence Medical Services 2020 (DMS20), the strategy on the future shape of DMS, would include plans to address any shortages.

Pay comparability

We believe that DMS pay should be broadly comparable with that in the NHS so that MOD can continue to recruit, retain and motivate sufficient numbers of MODOs. MOD stated that the pay levels of MODOs and their NHS counterparts were broadly comparable. For the most part, BMA and BDA agreed that there was broad parity between the pay levels for the NHS and the DMS. We agree that there is reasonable pay comparability between the two groups. This was the case in our last full review in 2010 and the public sector pay freeze means for many relative pay levels have remained constant since.

Recommendations

MOD, BMA and BDA made the same proposal for the overall uplift, of one per cent across the board. Workforce data, evidence of broad pay comparability between the NHS and DMS and the recommendations made by DDRB lead us to conclude that a recommendation of one per cent across the board is appropriate this year. This is also consistent with the approach we took for the main remit group.

X-Factor is an addition to pay which recognises the special conditions of service experienced by members of the Armed Forces compared with civilian employment. We did not receive evidence relating to the X-Factor specifically for DMS personnel, but set out our recommendation for the main remit group in our main Report. We recommend that this 0.5 percentage point increase to the X-Factor should apply equally to MODOs.

We are concerned about the possible unintended consequences of including MODOs in the future Armed Forces Pension Scheme (AFPS) without any adaptation to account for their unique career structure. The scheme design includes early departure payments which appear to incentivise MODOs to retire early from the Armed Forces, at a point in their careers when they are of most value. This will incur costs in funding the early departure payments and potentially also in funding incentives to counteract the effects of the early departure payments. Once MODOs have joined the new AFPS in 2015, the decision will be very hard to reverse. We recommend that MOD reconsiders whether the new AFPS is an appropriate pension scheme for MODOs, or whether modifications could be made to account for their career structure.

Looking ahead

We look forward to being kept informed about the change programmes MOD told us about this year, as it plans for medical services equipped to deal with the military's requirements for 2020. This should include more information about Future Reserves 2020 and how this will affect DMS; and the introduction of the new Defence Primary Healthcare system. We again encourage MOD to give further thought to practices such as flexible employment patterns to help ensure that Service life is attractive to the increasingly diverse recruitment pool. We will report on developments next year.

INTRODUCTION

1. This Report sets out the evidence we received and recommendations we make for Defence Medical Service (DMS) pay from 1 April 2013. This year's review was conducted against the background of a difficult economic climate, over ten years of continuous operational involvement in Afghanistan and, for most within this cadre, three years without a pay award. Our recommendations aim to maintain broad pay comparability with National Health Service (NHS) doctors and dentists; and to allow DMS to recruit, retain and motivate suitably qualified personnel.

2. Our review was conducted at a time of continuing economic fragility and follows the Government's announcement that a period of public sector pay restraint would follow the pay freeze. The Government said that pay should be uplifted by one per cent on average, and MOD proposed it should be applied across the board to Medical and Dental Officers (MODOs), consistent with its proposal for the remainder of the remit group.

3. The implementation of major changes from the 2010 Strategic Defence and Security Review (SDSR) has continued over the past year. One of the main developments has been the redundancy programmes across the Armed Forces. The third redundancy tranche for the Army, which will involve some DMS personnel, was announced in January 2013.

BACKGROUND

DMS developments

4. The Armed Forces continue to undergo substantial changes following the SDSR and with the planned drawdown in Afghanistan. The changes in the size and shape of the Armed Forces overall will impact on DMS. The Defence Medical Services 2020 (DMS20) project aims to shape the Armed Forces medical component for 2020. In line with the vision set out in the Defence Reform Review[1] in June 2011, DMS20 aims to achieve the right mix of uniformed and non-uniformed healthcare providers. The programme will also reflect changes in medicine and the reduction in the size of the Armed Forces. In oral evidence, MOD acknowledged that a consequence of DMS20 would be cost savings as a result of reducing the numbers of DMS personnel required. MOD also told us about the Defence Primary Healthcare project, which aims to produce a single, integrated tri-Service primary healthcare system by April 2014. MOD said that this will maintain the standard of primary healthcare to military personnel and entitled civilians at home and overseas. It also stated that the new system will offer fulfilling career opportunities to uniformed and civilian medical personnel.

NHS developments

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

    - DDRB reported that, in general, recruitment and retention of doctors and dentists was not a cause for major concern. However, evidence was emerging of difficulties in recruiting doctors for some medical specialties and for general dental practitioners in recruiting associates;
    - there were some signs of reducing morale among doctors and dentists;
    - a new contract for doctors and dentists in training is being discussed by the Government and medical professions; and

[1] The Defence Reform Review in June 2011 stated: 'the Whole Force Concept seeks to ensure that Defence is supported by the most sustainable, effective, integrated and affordable balance of regular military personnel, reservists, Ministry of Defence civilians and contractors.'

- the Government is also seeking changes to the consultant contract, partly as a result of the recommendations in DDRB's recent review,[2] but also for other reasons such as to support seven day working in the NHS.

Our 2013 Report

6. As in our Report on the main remit group, we considered what our approach should be to making recommendations for DMS groups. We heard concerns on visits about our independence, but personnel recognised the continuing difficult economic and fiscal position the country faces. The Government's announcement of a further two years of pay restraint is disappointing for Service personnel, and for many of those in the DMS follows three years of pay freeze.

7. Our role is independent both of Government and of Service personnel. Our terms of reference ask us to have regard to 'the need to recruit, retain and motivate suitably able and qualified people taking account of the particular circumstances of Service life'. Our approach includes taking full account of MOD's affordability constraints and the Government's wider evidence on the economy and pay restraint, but we also consider recruitment and retention, motivation and pay comparability.

OUR EVIDENCE BASE

8. We considered evidence from a wide range of sources including:

   - The Government's evidence on its public sector pay policy and the economic context, as submitted to all Pay Review Bodies;
   - Recommendations on NHS doctors' and dentists' pay by the DDRB;
   - MOD's written evidence on DMS workforce, recruitment and retention;
   - Written evidence from the BMA and BDA;
   - Oral evidence from the Surgeon General, DMS and from the Chairs of the BMA and BDA Armed Forces Committees;
   - Research into DMS and NHS pay comparisons undertaken by the Office of Manpower Economics; and
   - Our visits to DMS personnel during 2012, in the UK, overseas and on operations in Afghanistan.

9. Our visits enable us to meet DMS personnel and hear their views on issues specific to the DMS and those applying across the Armed Forces. We are grateful to those who participated in our visits. In 2012 we visited DMS Whittington in Lichfield and also met DMS Regular and Reserve personnel as part of our visits to other UK and overseas units. We appreciate the work of MOD and the Services in arranging our visits. A full list of AFPRB visits can be found in our 2013 Report (Appendix 4)[3] for the main remit group. We heard a number of issues raised by DMS personnel, for example on base pay, X-Factor and recruitment gaps of specialist staff.

10. We also heard about issues affecting DMS groups such as Veterinary Officers and Allied Health Professionals (AHPs). These included concerns about career structure for some and about an inconsistent approach to payment of professional fees, on which we comment later in this Report. We will review Veterinary Officers pay in our main Report next year and will review AHPs a year earlier than planned, in 2014–15.

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[2] *Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants, http://www.ome.uk.com/DDRB_Reports.aspx*

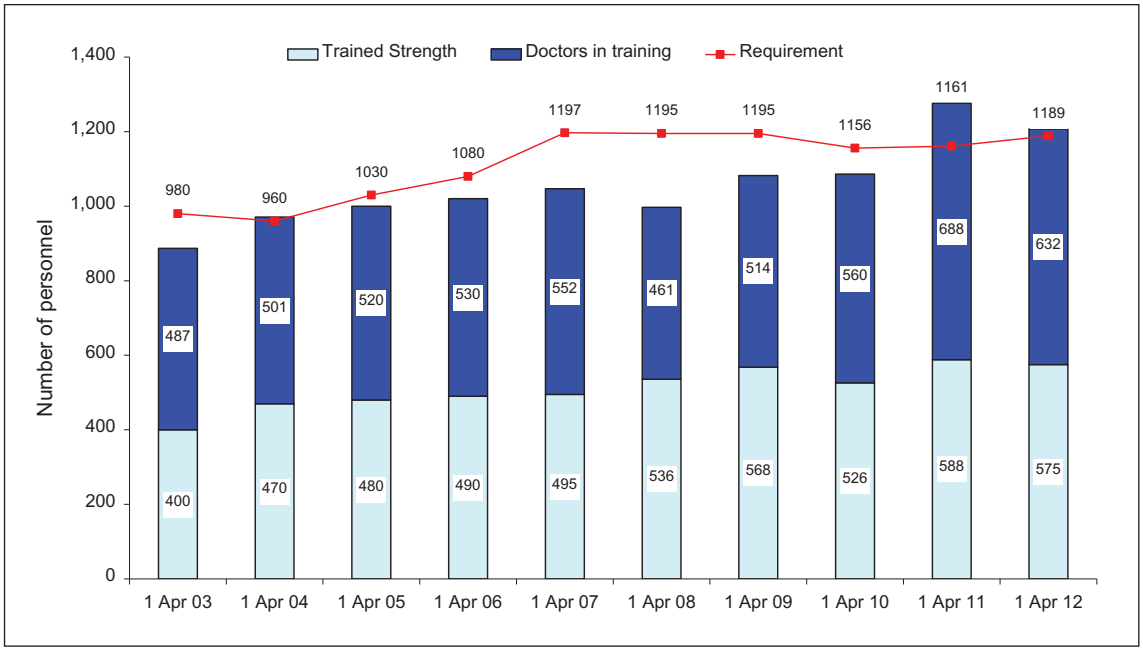
[3] *Armed Forces' Pay Review Body Forty-second Report 2013,* www.ome.uk.com

Workforce

11. Overall DMS regular strength at 1 April 2012 was 8,267 which represented 99 per cent of its needs. Within this there was a requirement for 1,189[4] Medical Officers (MOs) and 246 Dental Officers (DOs). The charts below show the changing levels of MOs and DOs over the last decade. At 1 April 2012 there were:

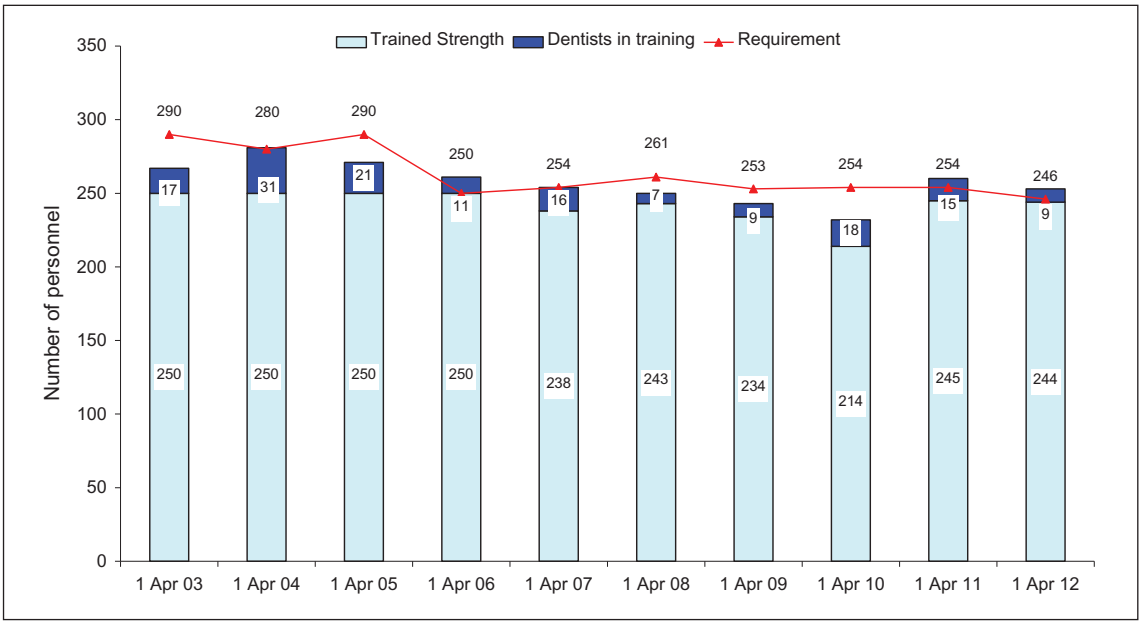
    - 575 trained MOs, a deficit of 28 per cent against the trained requirement of 803. This is a reduction of 13 MOs from 1 April 2011.
    - 632 MOs in training, of which:
        - 133 were General Duties Medical Officers;
        - 382 MOs were undertaking core training or on Higher Professional Training pathways; and
        - 117 MOs were undertaking the mandatory two year Foundation programme.
    - 244 trained DOs, 99 per cent of the 246 requirement.

Chart 1: Strength and deficit/surplus of Medical Officers 2003–2012



[4] The overall requirement for Medical Officers is made up of a trained requirement of 803 and a Manning and Training Margin of 386.

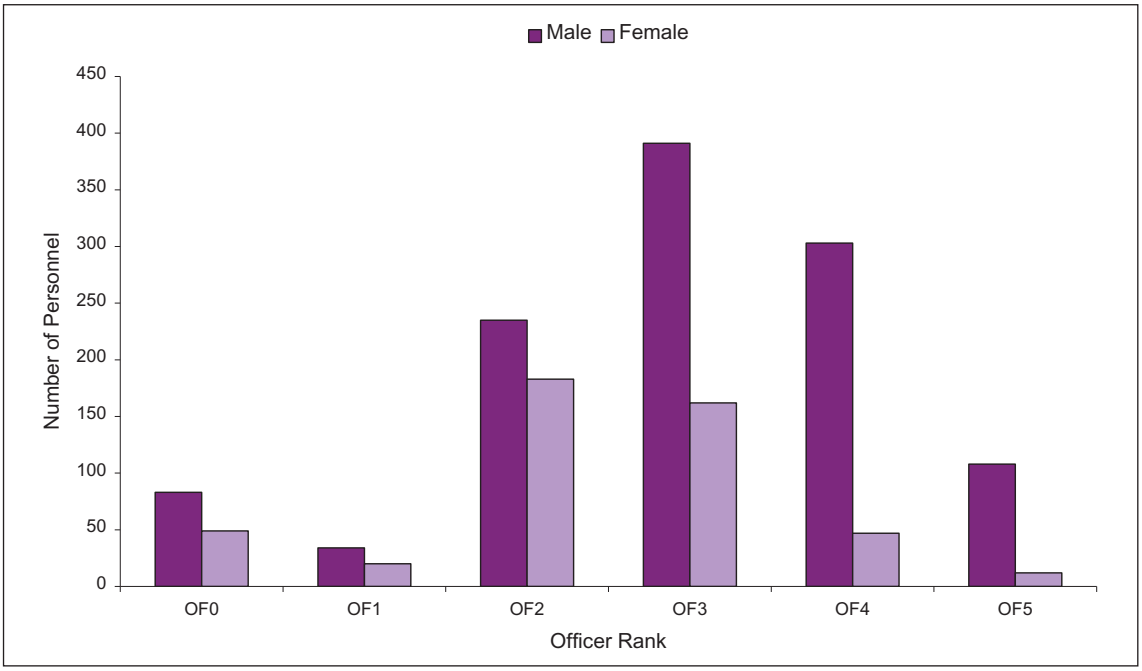
Chart 2: Strength and deficit/surplus of Dental Officers 2003–2012



12. At a trained strength of around 300, DMS Consultants were 30 per cent below requirement at 1 April 2012, a slight improvement on 2010 and 2011 figures of 34 per cent and 31 per cent respectively. Shortages persist in some specialties including Anaesthetists and General Surgeons. DMS General Medical Practitioners (GMPs) were 19 per cent understaffed overall despite a surplus within the RN. This was an increase from 12 per cent in 2011. In oral evidence MOD said it was looking to redistribute the make-up of MODOs across the single Services.

13. MOD's evidence contained useful data on age, gender and rank profiles of MODOs at 1 April 2012. The proportion of women fell slightly to 29 per cent from 30 per cent a year earlier, although for new recruits the figure is 41 per cent. There remains a disparity across both age and also rank as shown in Chart 3 which is more acute within the Consultant cadre. The average age of MODOs was 37 for men and 32 for women.

Chart 3: MODO Gender Distribution by Rank – 1 April 2012

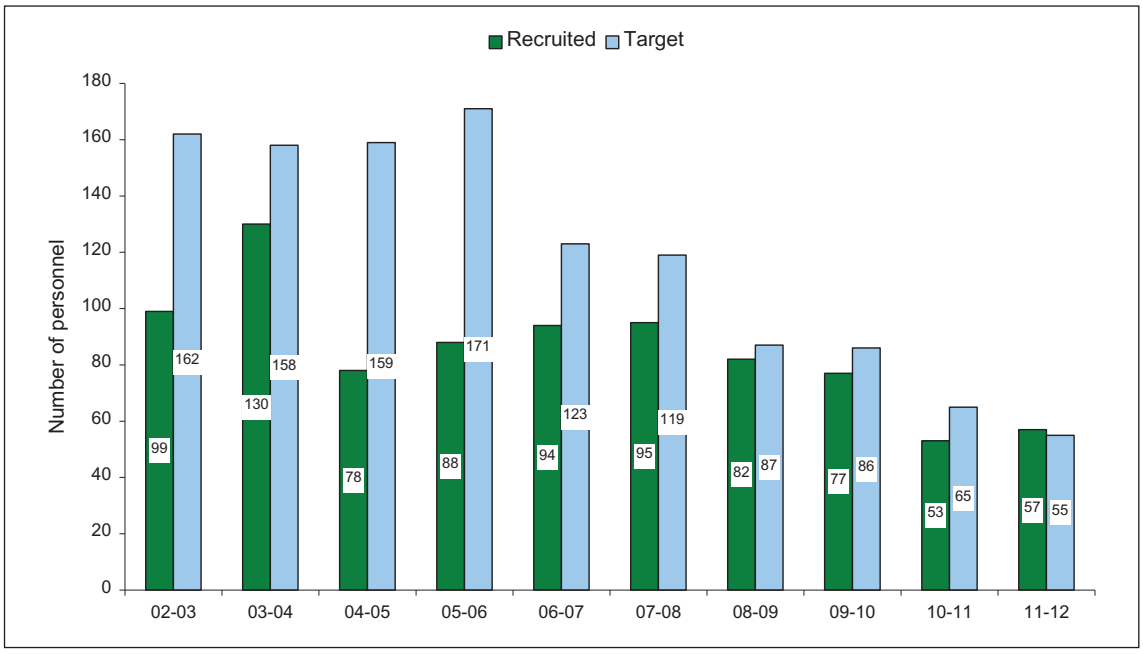


Recruitment and retention

14. Recruitment of MOs in the twelve months to 31 March 2012 was met against the lowest target for over a decade as shown in Chart 4. There were 15 Direct Entrants (against a target of 15) and 42 Cadets (against a target of 40) recruited across all Services. A high level of interest from medical undergraduates is expected to continue as they face increasing tuition costs. Proposed reductions in cadetships in favour of bursaries may, however, impact on future MO recruitment. Recruitment of DOs was less successful with only 10 recruited against a target of 16.

15. This year we were disappointed not to hear more about progress on implementing non-remunerative measures aimed at recruiting and retaining DMS personnel. Women outnumber men at medical and dental schools, and there are increasing numbers of students from black and minority ethnic (BME) backgrounds studying medicine and dentistry. The proportion of female and BME students entering to study medicine or dentistry presents a challenge and an opportunity for MOD. We would welcome proposals from MOD to increase the recruitment of these traditionally under-represented groups, as they continue to constitute a growing proportion within the wider NHS. We also encourage MOD to monitor retention.

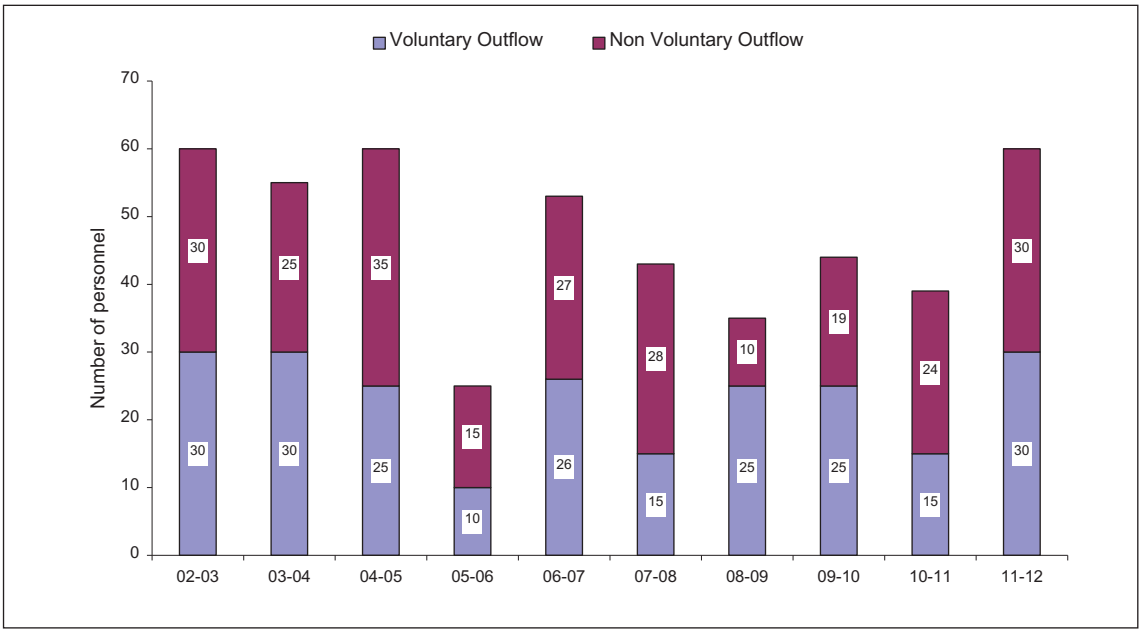
Chart 4: Medical Officer recruitment 2002–03 to 2011–12



16. Some 60[5] MOs left during 2011–12, 7.5 per cent of requirement. This figure represents an increase from 39 (5 per cent of requirement) in 2010–11, but remains around the long term average of 7.2 per cent. Voluntary outflow of MOs was 30 or 3.7 per cent. Chart 5 shows the outflow of MOs over the last decade. Overall outflow for DOs in 2011–12 was 10 (4 per cent) compared to 9 (3.5 per cent) in 2010–11. Family commitments and qualification for immediate pension under the 75 Pension Scheme were the main outflow drivers for MODOs.

[5] From 2012 Defence Analytical Services and Advice (DASA) methodology rounds to the nearest 10.

Chart 5: Medical Officer outflow 2002–03 to 2011–12



17. During oral evidence the Surgeon General said there was a steadily increasing number of women entering defence medicine and dentistry, especially as GPs. While recruitment appeared to be heading in the right direction, more should still be done. The New Employment Model (NEM) should help to improve the offer, potentially resulting in increased opportunities for flexible working or following alternative career paths. BMA and BDA considered that improved individual career management plus the introduction of flexible working would be useful non-remunerative measures that could aid retention.

Morale and motivation

18. The DMS Continuous Attitude Survey (CAS) provides contextual information on Service morale and factors affecting retention within the DMS. Drawing on evidence from the 2012 DMS CAS, MOD highlighted:

    - a workforce who felt valued for its contribution, capabilities and commitment; and
    - an understanding and general acceptance by MODOs of the pay freeze and the Government's policy on public sector pay.

19. We received only a subset of the survey data and note that on levels of satisfaction the 2012 results showed:

    - a reduction of 8 percentage points for satisfaction with pay compared with 2011; and
    - a fall of 6 percentage points for satisfaction with pension arrangements compared to a year previously.

20. We welcome submission of this useful information for assessing the morale and motivation of personnel working within DMS. However, given the important information such surveys provide, we would find it helpful in the future to have access to the full range of DMS CAS results.

21. BMA evidence included the results of an online survey of a sample[6] of MOs. They highlighted:

- Workload – Consultants worked an average of 50.3 hours, 6.6 hours more than they expected to work. GMPs worked an average 54.7 hours, 9.0 hours above that expected. Over half of respondents claimed to have worked longer hours in 2012 than 2011 and reported staff shortages as one of the main reasons.
- Morale – changes to the size/structure of the Armed Forces and the proposed changes to pensions had the most negative impact on morale. 61 per cent stated that their overall morale had reduced compared with a year earlier.

Operational commitments

22. DMS Medical and Dental Officers continued to face a high operational tempo, providing high-profile medical support in Afghanistan together with other commitments. The 2012 DMS CAS reported that 78 per cent of respondents had some experience of operational deployment, with 57 per cent of MOs and 33 per cent of DOs having deployed at least once in the previous three years. Personnel in some specialties will be called upon to deploy more often than others, but overall, MOD reported that operational commitments were being met, with harmony guidelines rarely breached.

DMS Reserves

23. DMS is often seen as demonstrating good practice in the integration of Reserves and Regulars. For example, MOD told us that at Camp Bastion there was complete integration of Regulars and Reservists providing secondary care to personnel. MOD expected that there would be a greater reliance placed on medical Reservists in the future. In its Future Reserves 2020 (FR20) consultation paper, MOD said it would need the Reserves to deliver a range of capabilities, including providing skills such as neurosurgery (which have been needed on recent operations but are not routinely needed at high readiness and are better drawn from civilian life). It said that specialist medical Reserve units would be based near large hospitals where MOD could more easily recruit medical personnel. FR20 also identified additional medical tasks such as the establishment of a very high readiness humanitarian relief hospital.

24. BMA and BDA said that if MOD wanted to attract more Reserves, it would need to offer an improved package, which met the needs of individuals and employers. We note these concerns and believe that MOD has a significant challenge in expanding the numbers of DMS Reservists, when the pool of available candidates is relatively small. MOD said that its change programmes, including DMS20, will examine how to recruit and retain the optimum combination of Regulars and Reservists.

25. The MODO cadre creates unique challenges and, indeed, opportunities for the MOD in the closer integration of Regular and Reserve personnel. The majority of qualified doctors and dentists in the UK are paid from public funds, primarily in the NHS. Thus, it should be possible for Government to create a regime within which employers are engaged with and committed to ensuring Reserve personnel are fully supported in discharging their obligations.

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[6] Sample of 323 Armed Forces MOs from the BMA membership selected. Survey ran from 8 November 2012 to 3 December 2012. 117 responses were received, a response rate of 36 per cent.

Government's approach to public sector pay and affordability

26. The Government's evidence for the main remit group emphasised the difficult fiscal position of the UK and confirmed that the overriding priority was to return the economy to sustainable growth. Official statistics showed that the economy had been contracting. The Government's view was that there was a strong case for public sector pay restraint. Therefore its policy was that all public sector pay awards should be an average of one per cent for each of the two years following the pay freeze.

27. Our remit letter from the Secretary of State for Defence set out the Government's policy in relation to the Armed Forces specifically. It defined basic pay as the combination of base pay and X-Factor. It also said that increases in Specialist Pay and compensatory allowances were within the policy that limits the average increase for Service personnel to one per cent. In oral evidence the Secretary of State said that the one per cent restraint on pay was necessary in a period of adjustment of public expenditure and that public sector pay had got out of kilter with the wider economy. He emphasised that if pay increased by more than one per cent, savings would have to be found in other parts of the MOD budget, such as equipment and training.

DDRB recommendations for 1 April 2013[7]

28. DDRB's 2013–14 recommendations were also made against the background of this public sector pay policy. Evidence demonstrated healthy recruitment and retention of NHS doctors and dentists. In that context, DDRB made the following recommendations which are relevant to DMS groups:

    - a base increase of one per cent to the national salary scales for salaried doctors and dentists;
    - for independent contractor general medical practitioners, the overall value of General Medical Services contract payments be increased by a factor intended to result in an increase of one per cent to general medical practitioners' net income after allowing for movement in their expenses. This would result in an uplift of 2.29 per cent applied to the overall value of General Medical Service contract payments for 2013–14 for general medical practitioners;
    - for independent contractor general dental practitioners in Scotland[8], the overall value of item-of-service fees be increased by a factor intended to result in an increase of one per cent to general dental practitioners' net income after allowing for movement in their expenses. This would result in an uplift of 1.49 per cent to be applied to item-of-service fees in Scotland in 2013–14. This increase should be compounded with the outstanding uplifts for 2011–12 and 2012–13; and
    - DDRB made no recommendations on Clinical Excellence Awards.

Pay erosion

29. In their evidence to us, the BMA and BDA highlighted how MODOs had received below inflation awards between 2007 and 2009, followed by a three-year pay freeze for senior MODOs and NHS counterparts, one year longer than the rest of the public sector. The associations said that this resulted in an erosion of their pay in real terms, with DMS consultants and GMPs seeing their pay fall by 5.6 per cent and 6.3 per cent respectively in real terms since 2006 when compared against the Consumer Prices Index. The BMA and BDA data took no account of the value of any increments paid over this period.

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[7] *Review Body on Doctors' and Dentists' Remuneration, Forty-First Report,* Cm 8577, March 2013, www.ome.uk.com

[8] See Chapter 4 of DDRB Forty-First Report 2013. BDA asked DDRB to make recommendations in Scotland. BDA are negotiating with employers in other UK nations.

Pay comparability

30. Our remit requires us to have regard to the need for Armed Forces pay levels to be 'broadly comparable' with those in civilian life. The DMS, unlike most other service personnel, have direct comparators in the NHS. However, MOD, BMA and BDA provided little detailed comparability evidence this year. The main pay analyses by cadre that follow have been produced by our secretariat. This is the first time we have directly assessed levels of pay between DMS MODOs and their NHS counterparts since our 2010 Report.

Summary of pay comparisons by DMS group

31. Our comparisons examine levels of DMS and NHS pay (at 1 April 2012 where data are available). The following adjustments have been made to provide a consistent basis of the comparisons: (i) remove the appropriate level of X-Factor from DMS salaries; (ii) make an upward adjustment to DMS salaries[9] to recognise that the DMS has a relative pension advantage over the NHS; and (iii) where applicable, make downward adjustments to the NHS comparator, recognising that all DMS base pay is pensionable, but there are elements of NHS comparator pay which are not.

Consultants[10]

32. Average DMS pay in 2012–13 was £110,556.[11] Total pay within the NHS is composed of the following elements:

- Programmed Activities (PAs) – these form the basis of NHS Consultant comparator pay with base pay linked to Consultants undertaking 10 programmed activities per week.[12]
- Additional PAs – any programmed activities worked over the base 10 PAs are paid *pro rata* and are non-pensionable. The latest available DMS data from 2008–09 showed a reduction in the average number of PAs worked from 10.9 to 10.6, below latest NHS figures of 11.2.[13] In 2009 AFPRB and the parties agreed to use one additional PA in NHS comparator pay.
- On-Call Availability Supplement – average DMS commitments according to last available data[14] were 1 in 7, considered a medium frequency rota in the NHS and attracting a 5 per cent pensionable supplement to basic pay. Inclusion of this payment was also agreed by AFPRB and the parties in 2009 as the appropriate NHS comparator.
- Employer-based (Local) Clinical Excellence Awards (CEAs)[15] – introduced in the NHS in 2003 as a replacement for the Discretionary Points scheme. Pensionable awards (levels 1 to 8 plus some level 9) are funded by NHS employers, who are obliged to award 0.35 of an award per eligible NHS Consultant (following their first year as a Consultant). The parties had been discussing the introduction of a merit based award system within the DMS. However, following the announcement of the DDRB review of National Clinical Excellence and Distinction Awards for NHS consultants, no firm proposals were put forward.

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[9] This is calculated differently from previous DMS Reports where NHS salaries were adjusted downwards.

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

[11] Assuming Consultants start at increment level 5 at age 35 and progress to increment level 30 at age 60.

[12] 10 PAs is 40 hours of work per week and deemed a full-time post.

[13] The number of paid for PAs by NHS trusts, National Audit Office 2012 trust census. Figure published in NAO report – *Managing NHS hospital consultants (February 2013)*.

[14] MOD 2008 MODO Paper of Evidence.

[15] National Awards (level 9/Bronze to level 12/Platinum) in the NHS and DMS are funded centrally and considered separately from the pay comparability exercise.

33. Table 1 shows that adjusted DMS pay is ahead of NHS comparator pay when both additional PAs and on-call availability supplements are included. It is only when the value of local CEAs is taken into account that NHS pay moves ahead. Latest estimates of NHS staff earnings data at September 2012 derived from the Electronic Staff Register show average total earnings of £109,651.

Table 1: Consultant 2012-13 pay comparisons

Comparator	Average Income	Adjusted Average Income[a]	Lead / Deficit of DMS[b]
	£	£	%
DMS	114,384	**110,556**	–
NHS			
11 PAs	99,664	98,939	12
11 PAs + 5% On Call	104,194	103,469	6.8
11 PAs + 5% On Call + CEA	116,363	115,638	–4.4

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

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

General Medical Practitioners[16]

34. Pay comparisons are made using 2010–11 data, the latest available, as published by The Information Centre for health and social care.[17] Data for this period include earnings and expenses for both full and part-time GMPs and relate to both NHS and private practice (but not wholly private practice) income. NHS comparator data are GMP net income i.e. earnings less expenses. Average DMS salaries for 2010–11 were £111,148 (£107,233 when adjusted), the same as in 2012–13 as a result of the pay freeze.

35. In previous evidence, the BMA, BDA and MOD agreed that independent contractor NHS GMPs were the appropriate comparator, specifically all General and Personal Medical Services (GPMS) GMPs. Average net income for this group was £104,100, 1.5 per cent lower than 2009-10. This equates to a lead of around 3 per cent for DMS GMPs or over 6 per cent when compared against median NHS comparator pay. Table 2 shows average DMS pay (adjusted for X-Factor and pensions) against the range of NHS GMP comparators.

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

[17] GP Earnings and Expenses 2010/11 produced by the Technical Steering Committee, September 2012.

Table 2: GMP 2010–11 Earnings

Comparator	Practice	Population	Average Income £	Median Income £	Lead / Deficit of DMS[a] %	
					Average Income	Median Income
DMS	–	**273**	**107,233**	–	–	–
GMS[b]	Dispensing	3,400	115,200	113,200	–6.9	–5.3
	Non-dispensing	17,900	95,900	94,400	12	14
	All	**21,300**	**99,000**	**96,900**	**8.3**	**11**
PMS[c]	Dispensing	1,600	126,400	123,900	–15	–13
	Non-dispensing	10,050	111,400	107,900	–3.7	–0.6
	All	**11,650**	**113,400**	**109,500**	**–5.4**	**–2.1**
GPMS[d]	Dispensing	5,050	118,800	116,100	–9.7	–7.6
	Non-dispensing	27,950	101,500	98,700	5.6	8.6
	All	**33,000**	**104,100**	**100,900**	**3.0**	**6.3**
GPMS	Salaried GPs	7,550	57,600	54,500	86	97

[a] Comparisons made with X-Factor and pension adjusted DMS average GMP salary.
[b] GMPs working under a General Medical Services contract.
[c] GMPs working under a Personal Medical Services contract.
[d] GMPs working under either a General Medical Services or Personal Medical Services contract.

General Dental Practitioners[18]

36. New NHS contractual arrangements for England and Wales were introduced in 2006–07 which changed both the way General Dental Services (GDS) dentists were remunerated and how they were classified.[19] In 2010–11, the year for which latest data are available (as for GMPs), the average adjusted DMS GDP salary was £107,233.

37. The latest 2010-11 HM Revenue and Customs earnings data[20] include NHS and mixed NHS/private practice dentists, but exclude dentists who derived their income wholly from private practice. Income is split by classification and contract type and illustrates the range of average earnings on offer in the civilian sector. Average net profits in 2010–11 were over 8 per cent lower than those in 2009–10. Table 3 shows DMS GDP pay against a range of NHS dental comparators and highlights how DMS pay is ahead when compared against NHS performer only dentists but behind when providing-performers are chosen as the comparator group.

38. In its evidence the BDA made reference to several civilian pay comparisons that were ahead of DMS GDP pay levels. Average net profits of NHS providing-performer dentists were £117,000 yet had fallen by 8.5 per cent from 2009–10. National Association of Specialist Dental Accountants and Lawyers 2010–11 data showed a higher average net income of £125,690 for all providing-performer practices (including wholly private practices) in England and Wales, also down (by 9 per cent) on the previous year. We do not however consider this an appropriate comparator as DMS DOs do not carry a comparable business risk. Despite making these pay comparisons, BMA and BDA continue to agree that pay parity with the internal comparator (DMS GMPs) was the overriding priority for DOs.

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

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

[20] Dental Earnings and Expenses, England and Wales, 2010/11 produced by the NHS Information Centre for health and social care.

Table 3: GDP 2010–11 Average earnings (England & Wales)

Dental type	Contract	Population	Average Salary / Net profit £	Change 09-10 to 10-11 %	Lead / Deficit of DMS[a] %
DMS		**234**	**107,233**	–	–
Providing-performer	GDS	4,650	109,500	–8.4	–2.1
	PDS	650	157,300	–4.0	–32
	Mixed GDS/PDS	450	136,300	–12	–21
	All	**5,750**	**117,200**	**–8.5**	**–8.5**
Performer only	GDS	12,200	61,600	–3.4	74
	PDS	1,350	75,700	–3.0	42
	Mixed GDS/PDS	1,500	62,200	–6.0	72
	All	**15,050**	**62,900**	**–4.2**	**70**
All dentists	GDS	16,850	74,800	–7.8	43
	PDS	2,000	102,500	–4.1	4.6
	Mixed GDS/PDS	1,950	79,900	–9.6	34
	All	**20,800**	**77,900**	**–8.2**	**38**

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

Junior Doctors in Training

39. Junior Doctors' base pay is supplemented in most cases by an out-of-hours band multiplier[21] which varies depending on hours worked and work intensity. The European Working Time Directive (48 hour or less working week) which came into force from August 2009 has greatly influenced working patterns and has resulted in a steady reduction in the average pay supplement received by Junior Doctors in the NHS. Latest available data[22] from 2010 show that over 80 per cent of posts received either a Band 1A (50 per cent) or 1B (40 per cent) supplement, with an average of 1.43, reduced from 1.45 a year previously.

40. Pay levels for DMS trainees remain ahead of Junior Doctors in the NHS (consultant pathway in receipt of an average supplement) at all points as shown in Table 4. A renegotiation of the contract for NHS Junior Doctors has recently been announced by the Government.

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

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

Table 4: Junior Doctors in Training 2012–13 pay comparisons

Age	DMS Scale	DMS Salary[a] £	NHS Scale	NHS Salary[b] £
24	OF 1 (1)	39,945	F1	30,989
25	OF 2 (1) Non-Acc	52,768	F2	38,436
26	OF 2 (2) Non-Acc	54,258	ST 1 min	41,073
27	OF 2 (3) Non-Acc	55,756	ST 2	43,587
28	OF 2 (4) Non-Acc	57,266	ST 3	47,096
29	OF 2 (5) Non-Acc	58,768	ST 4	49,219
30	Non-Acc MO Level 1	63,472	ST 5	51,779
31	Non-Acc MO Level 2	67,179	ST 6	54,340
32	Non-Acc MO Level 3	70,909	ST 7	56,901
33	Non-Acc MO Level 4	72,023	ST 8	59,460
34	Non-Acc MO Level 5	73,136	ST 9	62,022
35	Consultant Level 5 (Entry)	84,739	Consultant	74,504

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

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

Pension valuation

41. We undertook a valuation of the pension for the main remit group for our 2013 Report, to assess the value of the Armed Forces' Pension Scheme (AFPS) compared with civilian schemes as part of our consideration of broad pay comparability. There are wide variations in career paths within the military, so we adopted a 'sample career' approach to understand better the differential value of the pension to individuals depending on the nature of their Service career. The results suggest that for the majority of Armed Forces personnel, their pension benefits are, on average, more generous than comparative civilian pension benefits (between one per cent and six per cent depending on the career path). A small sub-set of individuals (Officers who stay in service to retire at age 55) appears to benefit from significantly higher relative levels of pension provision than those in alternative civilian careers.

42. We have requested over many years that MOD, BMA and BDA consider the most appropriate methodologies for pension valuation and pay comparability for DMS personnel. The associations said they regarded it as inappropriate to look at a pension valuation for this round, given that there will be changes to the pension scheme with the introduction of the Future Armed Forces Pension Scheme from April 2015. We did not, however, regard this as a barrier to our main pension valuation. We urge MOD, BMA and BDA to take account of our recent valuation and consider a methodology for valuing the pension for MODOs in time for our next DMS Report.

43. In its evidence, BMA stated that recent and forthcoming changes to pension tax arrangements will have a disproportionate impact on doctors. An individual's standard lifetime allowance for pension tax relieved savings decreased from £1.8 million to £1.5 million in April 2012 and will decrease further to £1.25 million in 2014. NHS doctors can opt to leave their pension scheme to avoid exceeding this limit, and will then stop paying employee contributions, so gaining extra disposable income. Medical Officers do not have this option, as their pension is non-contributory.

Changes to the Armed Forces Pension Scheme

44. The pension scheme is seen as an important retention factor by DMS personnel. Forthcoming changes to the pension scheme are a cause for concern for DMS personnel, as for the main remit group. We have an interest in the potential impact of the changes on retention. In an attempt to rectify a perceived shortcoming in the AFPS75, the current AFPS05 introduced commitment bonuses for MODOs, replacing the entitlement to early departure payments. The new pension scheme, to be introduced from 2015, will be a "one size fits all" arrangement for all members of the Armed Forces and does not include such a bonus. The BMA told us this will have a significant impact on retention in the DMS.

45. The current Armed Forces pension schemes are a valuable (and expensive) part of the overall remuneration of service personnel; and while the future AFPS will be somewhat less valuable, it will remain one of the best in the public sector. The pension valuation which we described in Chapter 5 of our main Report showed that the early departure provisions in the AFPS are, for longer serving personnel, a particularly valuable (and therefore expensive) feature of these schemes. Early Departure Payments (EDPs) meet the needs of long-serving personnel whose careers in the Armed Forces have to end well before normal retirement age and who may then find it difficult to establish a satisfactory second career.

46. It is not clear why a pension scheme which includes EDPs is appropriate for MODOs whose careers in the Armed Forces can continue to normal retirement age and who, if they choose to leave the Armed Forces, can make their second career in the NHS or in private practice. Indeed, as the BMA evidence indicates, EDPs may incentivise MODOs to retire from the Services at the point in their careers where they are of most value to the Armed Forces, and the retention payments in the current AFPS exist to counteract this effect.

47. When we raised this concern with MOD in oral evidence, it said that it was Government policy to have one pension scheme for all military personnel. It noted that the risks to retention were not unique to medical personnel and that other tools were available for retention.

48. We understand the reasons for the decision that all Service personnel should be in the same AFPS after 2015. For MODOs, however, the consequences of this decision are that the MOD will incur high pension costs to fund the provision of EDPs for MODOs and face potentially high further costs in the future to counteract the incentives which EDPs give MODOs to retire early from the Armed Forces. This does not seem to be a good use of public money. Once MODOs have joined the new AFPS in 2015, the decision will be very hard to reverse. We recommend that MOD give early reconsideration to the question of whether the new AFPS is an appropriate pension scheme for MODOs, or if modifications could be made to account for their career structure.

MOD and BMA and BDA pay proposals for 2013–14

49. MOD proposed that there should be an increase of one per cent to basic pay across the whole of the DMS workforce. While there could be some scope for a differential award, MOD considered that it would be overly complex to implement and would also be viewed as divisive by personnel. The proposal aligns with that made by MOD for the main remit group and reflects the majority of views heard in our discussion groups that any increase should be distributed evenly as an across-the-board percentage increase.

50. BMA and BDA acknowledged the Government's policy on public sector pay restraint. However, both highlighted the reductions in real-terms income for military doctors and dentists since their pay freeze came into effect. While BMA and BDA thought that their members deserved a greater increase than one per cent, they thought that the

Government's position on pay restraint made anything else impossible to achieve. The BMA also reiterated its position that it thought it inappropriate for the Government to restrict our remit, particularly as we are obliged to take account of the economic climate when forming our recommendations.

X-Factor

51. We conducted our five-yearly review of X-Factor for our 2013 Report on the main remit group. X-Factor is an addition to pay which recognises the special conditions of service experienced by members of the Armed Forces compared with civilian employment. Our review of X-Factor assessed changes since the previous review in 2008. We undertook a full examination of a wide range of evidence including MOD's assessment of changes for the military; independent research on civilian trends; and views of Service personnel and their families. Our independent analysis of the evidence led us to conclude there was a deterioration in the conditions of military life relative to civilian life. We therefore recommended that X-Factor should increase by 0.5 percentage point to 14.5 per cent.

52. We did not receive evidence relating to the X-Factor specifically for DMS personnel, but apply the recommendation to MODOs in line with the main remit group. We therefore recommend that the 0.5 percentage point increase to the X-Factor should apply equally to MODOs, and that Reservists should receive the full rate of X-Factor when mobilised.

Clinical Excellence Awards

53. DDRB undertook a review of consultant contracts and Clinical Excellence Awards in July 2011. The review was published, together with the Government's response in December 2012.[23] Recommendations accepted by Government include:

    - Rewards for clinical excellence should be linked to performance including patient feedback;
    - Rewards for clinical excellence should be capped nationally at £40,000 and locally at £35,000;
    - They should reward current excellence, not past performance;
    - A new 'principal consultant' grade should be introduced;
    - Progression through the current consultant grade should be based on performance and contribution rather than time served; and
    - Awards should continue to recognise excellence in medical education, teaching and research.

54. Following publication of DDRB's report, work began on considering how best to implement the recommendations, with discussions taking place with the BMA and NHS Employers. Once the outcome of this work is known, the Surgeon General will review the DMS CEA scheme and the remuneration of accredited Consultants. Care will need to be taken in administering any scheme, so that Service MODOs who spend time in the NHS do not get overlooked for appropriate recognition. As neither BMA and BDA nor MOD made any proposals regarding CEAs this year, and the implementation of DDRB's review of CEAs has not been started, we make no recommendation on CEAs this year. We look forward to receiving proposals in time for our next Report.

[23] The report can be found at: http://www.ome.uk.com/DDRB_CEA_review.aspx

Other DMS groups

Veterinary Officers

55. Our Report for the main remit group reflects on the evidence we received in relation to the Royal Army Veterinary Corps Veterinary Officers. On our visit to DMS Whittington, Veterinary Officers told us that they had concerns about their career structure, a lack of variety in their work and with pay at higher ranks. MOD told us that the non-remunerative measures it had already introduced needed more time to make an impact and that some of the predicted shortages had not materialised. We requested that MOD provide us with evidence for our next review to evaluate the effectiveness of the non-remunerative measures and to consider if any other action is necessary.

Allied Health Professionals

56. On our visits this year we continued to hear concerns raised by personnel in some Allied Health Professional (AHP) groups. Many expressed concern about the payment of professional fees. Some personnel have to register with their professional body in order to practice. We heard that there was an inconsistent approach, in that some groups were able to reclaim the cost of professional fees while others were not. The example of dental nurses, who were relatively low-paid and were unable to reclaim their fees, in spite of being required to register to practice, was raised on several occasions.

57. Last year we reported on the lack of professional recognition of clinical competence for Combat Medical Technicians and Medical Assistants. During the oral evidence session, the Surgeon General acknowledged that this was a genuine issue and that DMS was working towards establishing a 'Defence Medic' qualification that would be recognised by the Health and Care Professions Council. He also said that the review of AHPs was being brought forward by a year in order to help address some of the concerns expressed by Biomedical Scientists and other groups during our visits.

RECOMMENDATIONS FOR 2013–14

Overall pay recommendations

58. Our pay recommendations aim to help MOD to recruit, retain and motivate sufficient and capable personnel, and to ensure that broad comparability with NHS counterparts is maintained. We take account of the economic conditions, the Government's evidence on affordability and evidence on the particular circumstances of DMS doctors and dentists.

59. We have considered comparability with the NHS, and our recommendations in recent years have, in our view, maintained broad comparability on pay. We are mindful that MOD and, traditionally the BMA and BDA, emphasise that keeping pace with DDRB's recommendations is an important element in achieving and maintaining comparability.

60. DMS workforce data for 2011–12 showed a mixed picture. The number of trained MOs fell slightly, resulting in a deficit against requirement of 28 per cent, compared with 24 per cent the previous year. Shortages were spread over both primary and secondary healthcare. Within some key specialty cadres significant shortages persist. DOs increased to 99 per cent against a slightly reduced requirement. Recruitment of MOs was met against the lowest target in a decade, yet DO recruitment failed to meet its modest target. Losses of MOs increased to around 60 or 7.5 per cent of requirement in 2011–12, slightly above the long term trend. Losses of DOs also increased, but to a lesser extent to 4.0 per cent in 2011–12 compared with 3.5 per cent in 2010–11.

61. We also noted the difficult economic climate and the Government's policy of continued public sector pay restraint following the pay freeze. The impact of changes made under the SDSR began to be felt, leading to widespread feelings of uncertainty. The changes in the size and shape of the Armed Forces overall will impact on DMS, and some personnel could be affected by redundancy.

62. MOD, BMA and BDA made the same proposal for the overall uplift, of one per cent across the board. Workforce data, evidence of broad pay comparability between the NHS and DMS and the recommendations made by DDRB lead us to conclude that a **recommendation of one per cent across the board** is appropriate this year. This is also consistent with the approach we took for the main remit group. The award should continue to support recruitment, retention, morale and motivation, and maintain broad comparability with NHS doctors and dentists. Our recommendation also takes account of what is affordable within the current constrained financial environment.

Recommendation 1: We recommend the following changes from 1 April 2013:

- **A one per cent increase in basic pay to all ranks within the Medical and Dental Officer cadre; and**
- **A one per cent increase in General Medical Practitioner and General Dental Practitioner Trainer Pay and Associate Trainer Pay.**

The recommended pay scales are at Appendix 1.

X-Factor

63. We apply our X-Factor recommendation to MODOs in the same way as for the main remit group. We recommend a 0.5 percentage point increase to the rate of X-Factor be applied to all personnel covered by the scope of this Report.

Recommendation 2: We recommend a 0.5 percentage point increase in X-Factor from 14.0 per cent to 14.5 per cent. The recommended levels are incorporated in pay scales at Appendix 1.

Pension

64. We are concerned that the introduction of the new AFPS could have an unintended impact on the retention of MODOs at a key point in their career, if early departure payments apply as for the main remit group. This could be expensive to rectify, once introduced. We recommend that MOD give early reconsideration to the question of whether the new AFPS is an appropriate pension scheme for MODOs, or whether modifications could be made to account for their career structure.

Recommendation 3: We recommend MOD reconsiders how to best include Medical and Dental Officers in the Future Armed Forces Pension Scheme.

Cost of our pay recommendations

65. We estimate that the cost of our pay recommendations for 2013–14 is £3.1 million (including the Employers' National Insurance Contribution and superannuation liabilities) of which £0.9m is due to X-Factor.

LOOKING AHEAD

66. Following a period of considerable uncertainty, there are further changes ahead for the Armed Forces. DMS20 will develop the strategy for the composition of DMS. The drawdown in Afghanistan and the decrease in the overall number of personnel in the Services will impact on the medical capability and capacity needed by defence. The intense environment of providing emergency care while deployed develops the skills of those Medical and Dental Officers. As the drawdown proceeds, there should be less requirement for front-line trauma care. As the Armed Forces move towards a contingency footing, there will still be a requirement for a set of medics with excellent trauma skills. Clinicians will need to maintain their expertise, perhaps by working in NHS trauma units.

67. As the overall size and shape of the Armed Forces become clearer and progress is made towards the vision outlined in Future Force 2020, further consideration will have to be given to the management structure of DMS. With changes to trauma care and other opportunities to integrate with the NHS and greater use of Reserves, there may be scope to integrate the management structures of DMS with NHS.

68. DMS already makes a great deal of use of Reserves and can be seen as an example of best practice in integrating Reserve and Regular forces. We are keen to hear how DMS will evolve its offer and further engage with NHS employers as the requirement for Reserves increases.

69. We have already noted the importance of non-remunerative measures aimed at improving retention. In its evidence, MOD said that the NEM had the potential to change ways of working and that the Surgeon General's headquarters were engaged with the NEM team to ensure that medical perspectives were examined when changes to terms and conditions of service were being considered. However, this does little to address current problems. We hope that DMS can consider what more can be done to improve recruitment and retention in the period before the benefits of the NEM are widely felt.

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March 2013

APPENDIX 1

Recommended military salaries from 1 April 2013, including X-Factor

All salaries are annual JPA salaries rounded to the nearest £.

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

Increment level	Military salary £	
	1 April 2012	1 April 2013
Level 32	*131,167*	132,889
Level 31	*130,911*	132,631
Level 30	*130,660*	132,377
Level 29	*130,401*	132,116
Level 28	*130,150*	131,862
Level 27	*129,644*	131,350
Level 26	*129,137*	130,839
Level 25	*128,631*	130,328
Level 24	*127,402*	129,087
Level 23	*126,177*	127,849
Level 22	*123,514*	125,296
Level 21	*122,113*	123,875
Level 20	*120,716*	122,458
Level 19	*119,315*	121,037
Level 18	*117,923*	119,625
Level 17	*116,157*	117,833
Level 16	*114,399*	116,050
Level 15	*112,843*	114,471
Level 14	*111,284*	112,889
Level 13	*109,732*	111,315
Level 12	*108,176*	109,737
Level 11	*104,757*	106,268
Level 10	*101,345*	102,808
Level 9	*97,934*	99,347
Level 8	*94,904*	96,274
Level 7	*91,867*	93,193
Level 6	*88,826*	90,108
Level 5	*85,976*	87,217
Level 4	*84,869*	86,094
Level 3	*83,738*	84,947
Level 2	*79,992*	81,146
Level 1	*76,284*	*77,385*

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

Increment level	Military salary £	
	1 April 2012	1 April 2013
Level 35	*122,378*	123,987
Level 34	*121,994*	123,598
Level 33	*121,700*	123,302
Level 32	*121,221*	122,818
Level 31	*120,837*	122,430
Level 30	*120,449*	122,038
Level 29	*120,151*	121,737
Level 28	*119,676*	121,258
Level 27	*119,284*	120,862
Level 26	*118,900*	120,474
Level 25	*118,508*	120,078
Level 24	*118,123*	119,689
Level 23	*117,731*	119,293
Level 22	*115,799*	117,470
Level 21	*115,347*	117,012
Level 20	*114,811*	116,467
Level 19	*114,252*	115,900
Level 18	*113,698*	115,339
Level 17	*113,139*	114,771
Level 16	*112,584*	114,209
Level 15	*112,090*	113,707
Level 14	*110,033*	111,621
Level 13	*109,542*	111,123
Level 12	*109,052*	110,625
Level 11	*108,486*	110,052
Level 10	*107,924*	109,482
Level 9	*107,359*	108,908
Level 8	*105,294*	106,813
Level 7	*104,732*	106,243
Level 6	*103,300*	104,790
Level 5	*101,860*	103,329
Level 4	*100,428*	101,877
Level 3	*98,988*	100,416
Level 2	*96,934*	98,333
Level 1	*96,262*	97,651

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

Increment level	Military salary £	
	1 April 2012	1 April 2013
Level 29	*96,973*	98,244
Level 28	*96,184*	97,447
Level 27	*95,403*	96,659
Level 26	*94,619*	95,866
Level 25	*93,830*	95,070
Level 24	*93,050*	94,281
Level 23	*92,265*	93,489
Level 22	*90,705*	92,013
Level 21	*89,819*	91,115
Level 20	*88,925*	90,208
Level 19	*88,030*	89,301
Level 18	*87,140*	88,398
Level 17	*86,250*	87,495
Level 16	*85,356*	86,588
Level 15	*84,561*	85,781
Level 14	*83,777*	84,986
Level 13	*82,985*	84,183
Level 12	*82,194*	83,380
Level 11	*81,407*	82,581
Level 10[a]	*80,619*	81,782
Level 9	*79,670*	80,819
Level 8	*78,071*	79,198
Level 7	*76,468*	77,572
Level 6	*75,330*	76,417
Level 5	*74,204*	75,275
Level 4	*73,074*	74,128
Level 3	*71,944*	72,982
Level 2	*68,160*	69,143
Level 1	*64,399*	65,328

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

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

Increment level	Military salary £	
	1 April 2012	1 April 2013
Level 5	*72,849*	73,900
Level 4	*71,371*	72,401
Level 3	*69,897*	70,906
Level 2	*68,416*	69,403
Level 1	*66,938*	67,904

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

Increment level	Military salary £	
	1 April 2012	1 April 2013
Level 5	*59,626*	60,487
Level 4	*58,103*	58,941
Level 3	*56,570*	57,387
Level 2	*55,051*	55,845
Level 1	*53,539*	54,311

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

	Military salary £	
	1 April 2012	1 April 2013
OF1	*40,528*	41,113

Table 1.7: Recommended annual salaries for Medical and Dental Cadets

Length of service	Military salary £	
	1 April 2012	1 April 2013
after 2 years	*18,831*	19,102
after 1 year	*16,992*	17,237
on appointment	*15,161*	15,380

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

Increment level	Military salary £	
	1 April 2012	1 April 2013
Level 7	*136,167*	137,802
Level 6	*135,027*	136,650
Level 5	*133,890*	135,503
Level 4	*132,743*	134,344
Level 3	*131,599*	133,188
Level 2	*130,466*	132,044
Level 1	*129,319*	130,885

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

Increment level	Military salary £	
	1 April 2012	1 April 2013
Level 15	*127,425*	129,110
Level 14	*126,709*	128,386
Level 13	*125,983*	127,654
Level 12	*125,261*	126,924
Level 11	*124,542*	126,198
Level 10	*123,819*	125,468
Level 9	*123,089*	124,730
Level 8	*122,370*	124,004
Level 7	*121,647*	123,274
Level 6	*120,565*	122,181
Level 5	*119,487*	121,092
Level 4	*118,397*	119,991
Level 3	*117,319*	118,902
Level 2	*116,241*	117,813
Level 1	*115,151*	116,713

DMS Trainer Pay

GMP and GDP Trainer Pay	£7,746
GMP Associate Trainer Pay	£3,872

DMS Distinction Awards

A+	£60,470
A	£40,315
B	£16,126

DMS National Clinical Excellence Awards

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