Armed Forces'
Pay Review Body

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Service Medical and Dental Officers

Supplement to the Forty-Third Report 2014

Chair: John Steele

Cm 8858

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

May 2014

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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:

John Steele (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

The secretariat is provided by the Office of Manpower Economics.

[1] John Steele is also a member of the Review Body on Senior Salaries.

Contents

GLOSSARY OF TERMS

AFPS15	Armed Forces' Pension Scheme 2015
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
PA	Programmed Activity
PMS	Personal Medical Services
RAF	Royal Air Force
RN	Royal Navy
SDSR	Strategic Defence Security Review
UK	United Kingdom

ARMED FORCES' PAY REVIEW BODY
2014 DMS REPORT – SUMMARY

We recommend:

- **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;**
- **The retention of the Medical Officer 'Golden Hello' scheme, with amendments to the eligible cadres;**
- **The removal of increment levels 20-29 from the OF3-5 non-accredited Medical Officer pay scale.**

Evidence for this Report

Our terms of reference require us to consider a range of issues before making our recommendations on pay for Medical and Dental Officers (MODOs) in Defence Medical Services (DMS). We take into account: the need to recruit, retain and motivate suitably able and qualified people; the economic position in the UK; the Government's policy on public sector pay; DMS workforce levels; comparisons with relevant pay levels in the National Health Service (NHS); and the recommendations for this year 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 discussions with DMS personnel serving in Afghanistan as well as those providing medical care in the UK.

Workforce data

MOD provided staffing figures at April 2013 showing MODO staffing was at 83 per cent (804) of trained requirement (963).

At first glance, the staffing situation for Medical Officers (MOs) appears more positive than in recent years, with a 20 per cent shortfall against requirement at April 2013 compared with 28 per cent a year earlier. The improvement, however, is mainly due to a reduction in the requirement and actually hides an increase in outflow. This increase in outflow (up to 85 MOs in 2012-13 from 60 the previous year) with a significant proportion being voluntary outflow is cause for considerable concern. The situation was described by MOD as "fragile".

There was also a 50 per cent shortfall in the number of MO Reserves and, although the Defence Medical Services 2020 (DMS20) requirement is lower than at present, without improvement in recruitment the staffing level will not meet future needs.

Staffing levels for Dental Officers (DOs) are at 94 per cent of requirement. With a reduction in requirement over the next few years there is projected to be a surplus of DOs against DMS20 targets for 2018. While there is therefore no cause for immediate concern, the individual Services will nevertheless need to monitor staffing levels for this cadre carefully.

Pay comparability

We believe that DMS pay should be broadly comparable with that in the NHS to allow MOD to continue to recruit, retain and motivate sufficient numbers of MODOs. MOD, the BMA and the BDA provided limited pay comparability data this year. The BDA claimed that DO pay was falling behind that of their civilian counterparts by between £8,700 and £21,662. MOD assumed that, due to pay restraint, pay levels of MODOs and their NHS counterparts would not have changed significantly since last year and therefore should continue to be broadly comparable. Our analysis found that there remained broad pay comparability between all DMS cadres and their NHS counterparts. We note, however, that negotiations now underway between the National Health Service (NHS), the Department of Health and the BMA over doctors' remuneration and conditions of employment could impact on pay comparisons with MOs in the future.

Recommendations

MOD and the BDA made the same proposal for the overall uplift, of one per cent across the board. BMA proposed that its members should be awarded an increase of 2.1 per cent (in line with the Consumer Prices Index at December 2013) to prevent a further reduction of pay in real terms. 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 consistent with the approach we took for the main remit group.

Looking ahead

DMS is facing a period of considerable change. Implementation of the post-SDSR structures and the return to a contingency stance will present considerable challenges. The reported increase in voluntary outflow of MOs in the latest available period (2012–13) is a cause for concern, and we hope that DMS senior management undertakes an exercise to receive timely updates of voluntary outflow data and to gain a full understanding of why and when MODOs leave the Service voluntarily, so informing appropriate strategies to help reverse this worrying trend.

Data from the DMS Continuous Attitude Survey showed a decline in morale for DMS personnel, especially DOs, over the last year with pension arrangements being one of the main areas where satisfaction levels have fallen. MOD maintained its policy of treating MODOs the same as the main remit group in relation to the pension and related arrangements. We remain concerned about the potential impact this will have and wish to remain informed of DMS personnel's attitudes to the new pension and any implications this has for retention.

The ending of combat operations in Afghanistan may reduce the professional appeal to some, particularly in Emergency Medicine. Conversely, increased stability could make joining and remaining in the Armed Forces more attractive and provide opportunities for alternative ways of working which could also boost recruitment and retention for others. DMS already makes more use of Reserves than other areas of defence, but will face significant challenges to reach the goals under Future Reserves 2020 (FR20) and DMS20.

MOD stated that the New Employment Model (NEM) offers an opportunity to consider alternative ways of working for MODOs, and provided us with some initial thoughts on the form this might take, such as flexible working and alternative career paths. We would like to receive more developed strategic thinking and evidence of progress on this for our next Report. There is a real opportunity to radically shift the employment model and delivery structure of DMS, to encourage improved recruitment and retention.

INTRODUCTION

1. This report sets out the evidence we received and our recommendations for Medical and Dental Officers' (MODO) pay from 1 April 2014. 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 followed last year by an award of one per cent. Our recommendations aim to maintain broad pay comparability with National Health Service (NHS) doctors and dentists to allow Defence Medical Services (DMS) to recruit, retain and motivate suitably qualified personnel.

2. Our review follows the Government's announcement that its policy of public sector pay restraint, following the pay freeze, will be extended by a further year to include 2015–16. The Government said that pay should be uplifted by up to one per cent on average. MOD proposed that any award should be applied across the board to MODOs, consistent with its proposal for the rest 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, including the redundancy programmes currently operating across the Armed Forces. The fourth redundancy tranche announced in January 2014 included around 170 DMS Personnel.

BACKGROUND

DMS developments

4. The Armed Forces, and the Defence Medical Services in particular, continue to go through a period of substantial change including: implementation of Defence Medical Services 2020 (DMS20) following the SDSR; Future Reserves 2020 (FR20); the forthcoming New Employment Model (NEM); and the Armed Forces Pension Scheme 2015 (AFPS15). In addition, the drawdown from Afghanistan by the end of 2014 and the preparation for return to contingency and rebasing are already presenting new challenges for the DMS.

5. The DMS20 project aims to shape the Armed Forces medical component for 2020 and will result in some Regular cadres increasing in size, others reducing and others becoming a Reserve Forces capability. 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 project will also reflect changes in medicine and the reduction in the size of the Armed Forces. MOD has said that the NEM will present an opportunity for restructuring Terms of Service for both Regular and Reserve DMS personnel, although discussions on these are still in the early stages. DMS already make more use of Reserves than many other areas of defence, but nevertheless face significant challenges to reach the staffing level goals under FR20 and DMS20 due to an ageing population, problems in recruiting, and the end of current operations.

6. During this period of uncertainty and change, the results of the DMS Continuous Attitude Survey (DMSCAS) survey provided by MOD have shown that morale for MODO personnel has declined over the last year, especially amongst Dental Officers (DOs). MODO personnel are less satisfied than a year ago with career and line management and particularly with pension arrangements, which could all impact on retention rates.

[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."

NHS developments

7. We keep up-to-date with developments in the NHS that are relevant to the DMS to assist in our assessment of broad pay comparability. We note that:

    - the Doctors and Dentists Review Body (DDRB) reported that, in general, recruitment and retention of doctors and dentists were not a cause for major concern. However, evidence was emerging of difficulties in recruiting doctors for some medical specialties, including Emergency Medicine, and also in some geographic areas;
    - the four countries in the United Kingdom are each planning new and distinct contractual arrangements for dentists;
    - discussions are still on-going about changes to junior doctor and consultant contracts. Changes to consultants' contracts are partly aimed at supporting seven day working in the NHS and include a review of Clinical Excellence Awards (CEAs); and
    - levels of motivation of civilian doctors and dentists do not appear to have fallen over the last year, but the DDRB are looking at ways to obtain more thorough evidence on this.

Our 2014 Report

8. We considered what approach we should take for making recommendations for MODOs. As for the main remit group, we confirmed that, as usual, we would take account of all the evidence we received, including that on recruitment and retention, morale and motivation, pay comparability, affordability, and the wider economy. This is consistent with our terms of reference as an independent review body. We have been conscious of the particular risks to retention of MODOs as changes under DMS20 are implemented and wider changes to defence take effect.

OUR EVIDENCE BASE

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

    - The Government's evidence on its public sector pay policy and the overall economic context, as submitted to all pay review bodies;
    - Recommendations on NHS doctors' and dentists' pay by the DDRB;
    - MOD's written evidence on MODOs. This covered staffing, recruitment, retention and DMSCAS;
    - Written evidence from the British Medical Association (BMA) and the British Dental Association (BDA);
    - Oral evidence from the Surgeon General and his team, and from the Chairs of the BMA and BDA Armed Forces Committees;
    - Research into MODO and NHS pay comparisons undertaken by the Office of Manpower Economics; and
    - Our discussions with DMS personnel on our visits during 2013, in the UK and on operations in Afghanistan.

10. Our visits enable us to meet MODOs and hear their views, both on issues specific to the DMS and on those applying more widely across the Armed Forces. We are grateful to those who participated in our visits. In 2013 we visited the Royal Centre for Defence Medicine and the Institute of Naval Medicine. We also met DMS Regular and Reserve

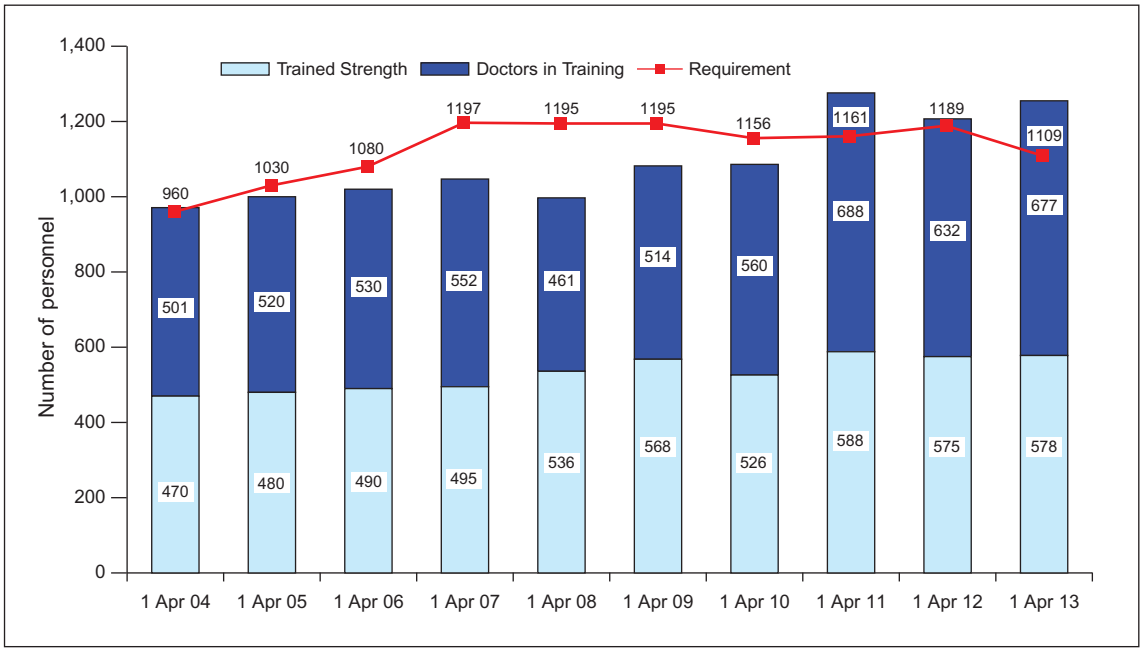
personnel as part of our visits to other establishments. We appreciate the work of MOD and the Services in arranging our visits. A full list of AFPRB visits can be found in our 2014 Report (Appendix 4)[2] for the main remit group. We heard a number of issues raised by MODOs; for example, on the erosion of the overall pay and reward package, on career management, and concerns about the future pension scheme.

Staffing

11. At 1 April 2013 there was a requirement for 963 trained MODOs. The charts below show the changes in the requirements and staffing levels of Medical Officers (MOs) and DOs over the last decade. At 1 April 2013 there were:

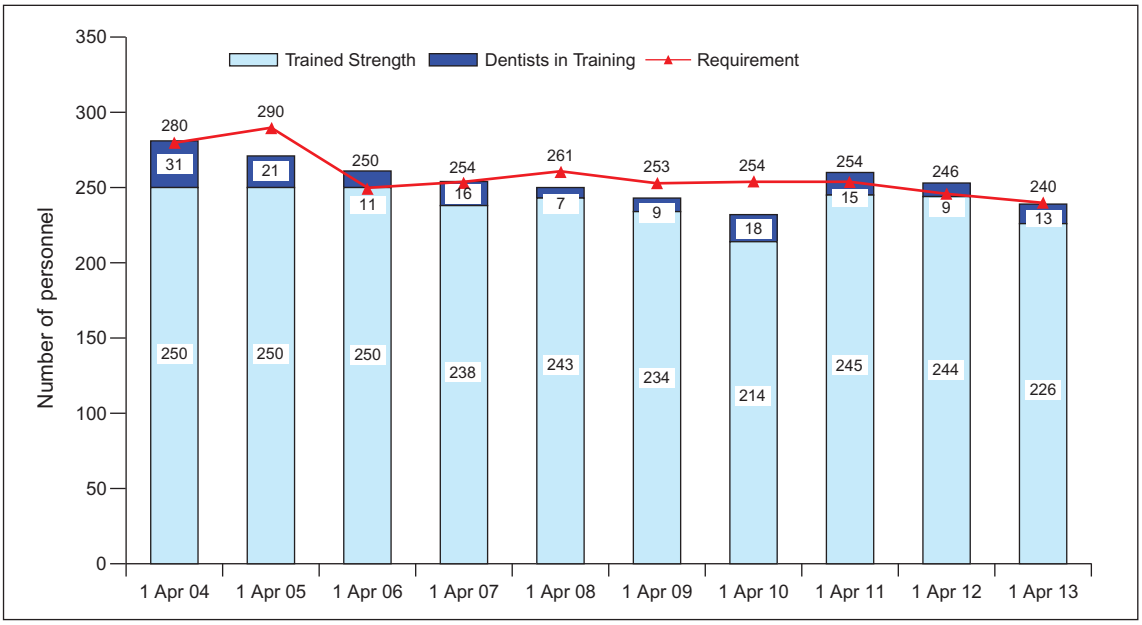
- 578 trained MOs, a deficit of 20 per cent against the requirement of 723. This is an increase of 3 trained MOs from 1 April 2012 while the requirement reduced by 80 over the same period.
- 677 MOs in training, including:
  - 126 General Duties Medical Officers;
  - 326 MOs undertaking Core or Higher Specialist Training
  - 116 Foundation Year MOs; and
  - 109 Medical Cadets enrolled as undergraduate medical students.
- 226 trained DOs, 94 per cent of the 240 requirement.

Chart 1: Strength and deficit/surplus of Medical Officers 2004–2013



[2] *Armed Forces' Pay Review Body Forty-Third Report 2014,* https://www.gov.uk/government/organisations/office-of-manpower-economics

Chart 2: Strength and deficit/surplus of Dental Officers 2004–2013

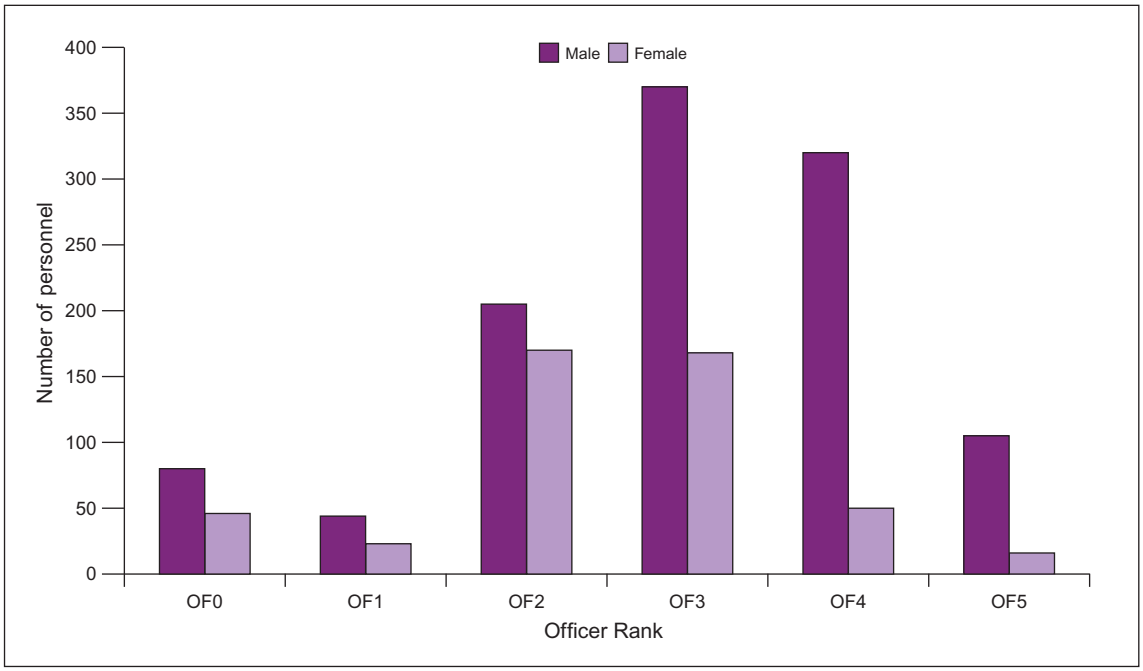


12. For consultants, there were 240 trained staff against a requirement of 324 in April 2013. This represents an overall shortfall of 26 per cent compared with 30 per cent a year earlier, with most of that improvement due to a reduction in requirement. There was a requirement of 340 Accredited General Medical Practitioners (GMPs) and a trained strength of around 280, a shortfall of 18 per cent. MOD suggested that a combination of remunerative and non-remunerative measures will be needed to improve this situation.

13. MOD provided us with evidence on the age, gender and rank profiles of MODOs at 1 April 2013. The proportion of women remained steady at around 29 per cent, although the picture for new recruits is slightly more balanced. Gender balance varies considerably with rank (and therefore, to some extent, with age) as shown in Chart 3. In the secondary healthcare cadre, 87 per cent of Consultants are male.

14. MOD did not provide us with information on the ethnic breakdown of MODOs. We remain concerned at the lack of data on the proportion of MODOs from Black and Minority Ethnic (BME) groups. As we commented in our 2013 Report, there are increasing numbers of students from BME backgrounds studying medicine and dentistry. It is important both that MOD recruits from the widest possible pool, and that the Armed Forces reflect the society they serve. If MOD does not understand the composition of its DMS workforce, it cannot hope to monitor and improve the situation. MOD also needs to ensure that the culture within the Armed Forces is one that enables all Service personnel to fulfil their potential.

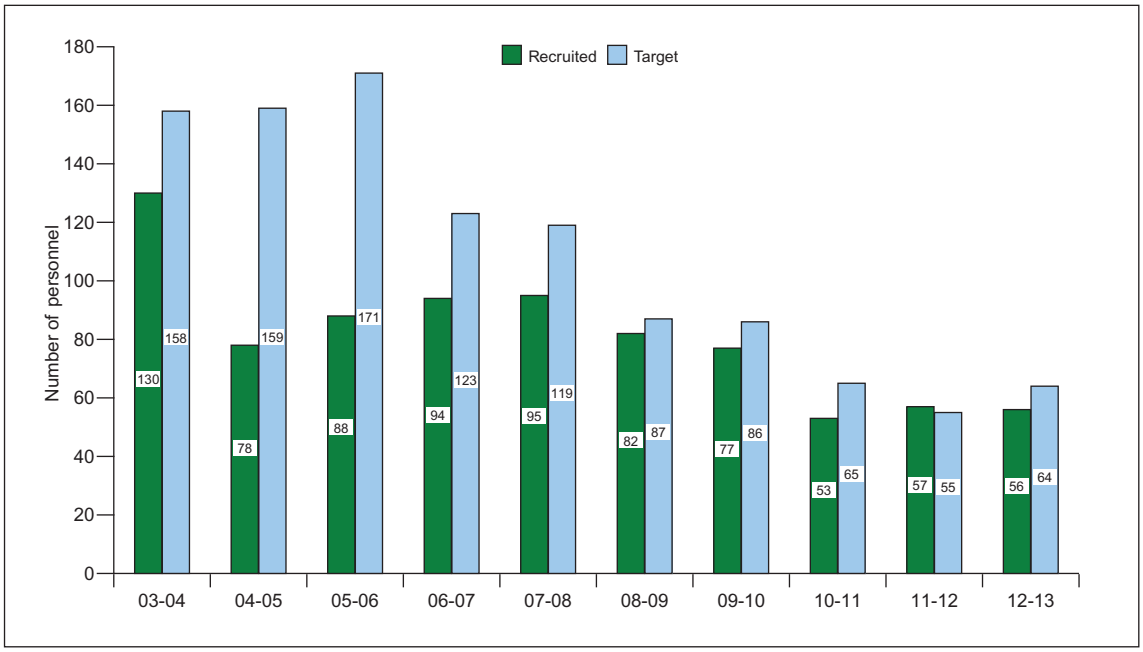
Chart 3: MODO Gender distribution by Rank[3] – 1 April 2013



Recruitment

15. While the recruitment target for MO Cadets in the twelve months to 31 March 2013 was met, that for direct entrants was missed. Trends in MO recruitment are shown in Chart 4. DO recruitment was lower than in previous years as the transition to new structures began. The new arrangements will see a move away from cadetships to a bursary scheme (at least for Army MODOs), and we will be interested to learn what impact this has on recruitment.

Chart 4: Medical Officer recruitment 2003-04 to 2012-13



[3] 'OF0' is used to define those on Medical and Dental Cadetships – those at Medical School in receipt of pensionable salary.

Retention

16. Perhaps the most striking aspect of the evidence we received from MOD this year was the sharp increase in the outflow of MOs. Outflow increased to 85 in 2012-13 compared with 60 the previous year and 39 the year before that; figures of considerable concern for such a small group. Voluntary outflow was greater than non-voluntary, which is a particular concern in relation to retention. MOD's evidence stated that it considered voluntary outflow at the current level to be unsustainable. Outflow rates have increased over a number of years, and we are concerned that it will take a comparatively long time to reverse the trend. Compared with the position for MOs, the outflow of DOs was considered by MOD to be manageable as the liability was reducing, but will nevertheless require close monitoring.

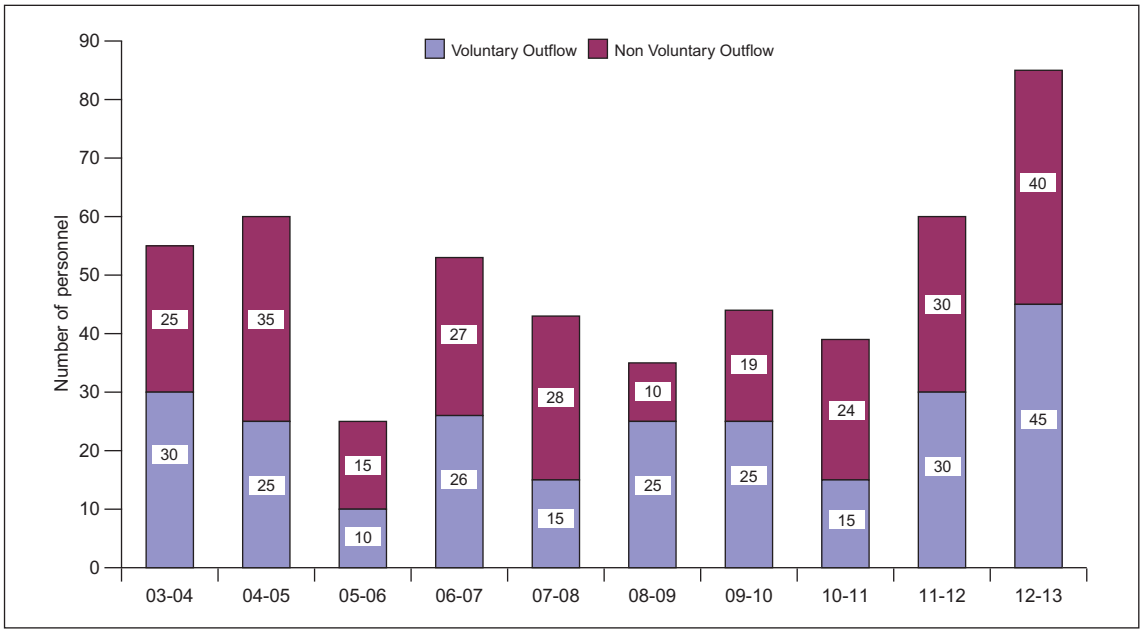
17. We were somewhat surprised that, during oral evidence, the Surgeon General and his team did not have up to date demographic and monitoring data on MODOs. We would regard ready access to such data as imperative for helping to understand recruitment and retention issues among this group.

18. Following our oral evidence session with the Surgeon General, we remain concerned that DMS have not yet acquired an understanding of the outflow of MODOs. It would be useful to establish the characteristics of those who leave voluntarily, how long they have served and why they are choosing to go, to determine what actions might be taken to stem the flow. With such a small cadre, we consider that exit interviews should be undertaken with each MODO who leaves.

19. Results from DMSCAS suggested that the top three retention factors for MODOs were: postings of choice; pay; and pensions. The recent and forthcoming changes to the Armed Forces are likely therefore to have a significant impact on recruitment and retention. The ending of combat operations in Afghanistan and the move to a contingency footing and rebasing will place a different set of demands on DMS. Opportunities to be involved in front-line trauma care could be reduced and may therefore lessen the appeal of remaining in the Armed Forces, for certain MOs in particular. The forthcoming new Armed Forces Pension Scheme (AFPS15) has also caused concern among MODOs, some of whom perceive it to be a worsening of their terms and conditions. In our last Report we expressed our concerns that the introduction of AFPS15 could have an unintended impact on the retention of MODOs at a key point in their career. While MOD provided information on which of the two existing pension schemes that MODOs were on, we think it important that senior management in DMS gain an understanding of how the forthcoming change will affect each group. This could help to inform strategies to aid retention.

20. Recent survey results for the main remit group indicate that the provision of healthcare is one of their most important retention factors. The BMA and the BDA stressed to us the importance of continuing uniformed healthcare provision for the military. They did not consider that civilian contractors would be able to understand fully the unique circumstances of Service personnel nor deliver the same level of care.

Chart 5: Medical Officer outflow 2003–04 to 2012–13



Morale and motivation

21. We were pleased to receive a full set of DMSCAS data this year. This information helps our understanding of this cadre and the issues concerning them. While MODOs were generally content with their pay, satisfaction with pension arrangements dropped considerably from the previous year, and there was also a decrease in satisfaction with career prospects, career management and with the level of engagement of senior management regarding their careers. For DOs there were significant decreases from the previous year in morale, engagement, and the feeling of being valued by DMS colleagues. The BMA and the BDA thought that career management was a significant problem for MODOs.

22. The DMSCAS question on the pension scheme relates to current satisfaction with current pension arrangements. However, the steady decline in satisfaction over the last few years is likely to be due, to some extent, to the forthcoming introduction of AFPS15. The recent and future changes to the annual and lifetime tax allowances for pension schemes may also be affecting levels of satisfaction. Unlike their NHS counterparts, MODOs do not receive an increase in take home pay equivalent to the pension contributions they would have paid if they opt out of their pension scheme, as the Armed Forces scheme is non-contributory. However, MODOs can leave the Services, take advantage of early departure payments and avoid potential tax bills as a result of the annual and lifetime allowance arrangements, by opting out of the NHS pension. We are concerned that the remit group is not fully aware of the value of the pension both the current scheme(s) and AFPS15 – and hope that DMS senior management has a communications strategy and monitors the situation, with plans in place to stem any potential increases in outflow.

23. During our oral evidence session with the Surgeon General, we were surprised to hear that he considered morale among MODOs to be good. This did not coincide with our interpretation of the DMSCAS results or with many of the views we heard on visits. Also, while they did not undertake similar in-depth surveys to those they did last year, the BMA and the BDA told us that they did not consider morale to be high among the remit group.

24. The BDA told us in its oral evidence session that the loss of uniformed support staff such as dental nurses and hygienists was having a large impact on the morale of DOs who were increasingly being required to undertake such roles themselves. Additionally, concern was expressed that numbers were being cut ahead of workloads reducing, causing further dissatisfaction.

Operational commitments

25. MODOs continued to face a high operational tempo, providing high-profile medical support in Afghanistan alongside other commitments. The 2013 DMSCAS reported that 81 per cent of respondents had some experience of operational deployment, with 67 per cent of MOs and 38 per cent of DOs having deployed at least once in the previous five years. Personnel in some specialties will be called upon to deploy more often than others, but overall MOD reported that DMS personnel were satisfied with their operational deployment intervals.

DMS Reserves

26. There was a 50 per cent shortfall in the number of MO Reserves in April 2013, spread across both GMPs and Consultants. While the liability is set to decrease under DMS20, without improvement the staffing level would still be insufficient to meet the requirement. MOD's written evidence to us suggested that a combination of remunerative and non-remunerative measures would be required to improve the situation. During oral evidence the Surgeon General said that he would be meeting with the Medical Director of the NHS to explore the measures they could take to improve recruitment into the Reserves. Support from the NHS and innovative approaches will be required to meet the recruitment targets, although we are concerned by the lack of progress over the last year and have asked MOD to provide a clear strategic plan for the future use of Reserves in the DMS.

27. The BMA and the BDA considered that the proposals under DMS20 to increase the reliance on Reserves to staff the DMS, particularly in certain areas, were not achievable. Staffing levels were very low, and it was not thought that the monetary rewards were sufficient to attract GMPs and Consultants from private practice in the civilian sector. During oral evidence, they suggested that it might be better to concentrate on trying to attract potential Reservists at a younger age, getting them involved and bought in to military life early in their careers. Reservists need to experience the best aspects of Regular service, plus they need strong support from both MOD and their NHS employer.

Government's approach to public sector pay and affordability

28. The Government's evidence on the general economic context, submitted for our Report on the main remit group, stated that the UK economy grew slightly during 2012, with further growth expected for 2013. The UK was recovering from a recession deeper than that experienced by any other developed nation apart from Japan. Inflation had reduced over the previous year, with further decreases forecast. The labour market had shown signs of improvement, with unemployment gradually falling and employment increasing. Wage growth remained relatively weak overall. The Government considered that its policy of public sector pay restraint had been a key part of the fiscal consolidation so far. The evidence also referred to the announcement in Budget 2013 that Government policy was that public sector pay awards in 2015–16 would be limited to an average of up to one per cent.

29. The Government's perspective on affordability was that MOD had balanced its budget on the basis of a series of difficult decisions rigorously controlling spending on all aspects of defence. It said that any increases in the level of Armed Forces' pay above the one per

cent stipulated in the remit letter during the period of pay restraint would drive the defence programme out of balance, leading to damaging reductions elsewhere in the defence budget.

DDRB recommendations for 1 April 2014[4]

30. The DDRB's 2014–15 recommendations were also made against the background of this public sector pay policy. Evidence demonstrated that recruitment and retention of NHS doctors and dentists were not a cause for major concern generally, although there were some problems within some specialities and some geographical locations. In that context, the 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 GMPs, 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 GMPs income after allowing for movement in their expenses. This would result in an uplift of 0.28 per cent applied to the overall value of General Medical Service contract payments for 2014–15 for GMPs;
- for independent contractor General Dental Practitioners (GDPs) in England, the gross earnings base be increased by a factor intended to result in an increase in GDPs income of one per cent after allowing for movement in their expenses. This would result in an uplift of 1.8 per cent applied to the overall value of the gross earnings base under the contract for 2014–15 for GDPs in England;
- for independent contractor GDPs in Wales, the gross earnings base be increased by a factor intended to result in an increase in GDPs income of one per cent after allowing for movement in their expenses. This would result in an uplift of 1.74 per cent applied to the overall value of the gross earnings base under the contract for 2014–15 for GDPs in Wales;
- for independent contractor GDPs in Scotland, the overall value of item-of-service fees be increased by a factor intended to result in an increase of one per cent to GDPs' income after allowing for movement in their expenses. This would result in an uplift of 1.71 per cent to be applied to item-of-service fees in Scotland for 2014–15;
- for independent contractor GDPs in Northern Ireland, the overall value of item-of-service fees be increased by a factor intended to result in an increase of one per cent to GDPs' income after allowing for movement in their expenses. This would result in an uplift of 1.76 per cent to be applied to item-of-service fees in Northern Ireland for 2014–15;
- an increase of one per cent applied to the minimum and maximum of the salary range for salaried GMPs; and
- an increase of one per cent applied to GMP trainers' grant.

BMA evidence on real value of MO pay

31. In its evidence to us, the BMA expressed concern at the decline of pay in real terms for DMS MOs and their NHS counterparts. It claimed this was caused by the three-year pay freeze, one year longer than for the rest of the public sector, followed by a period of pay restraint with pay awards of one per cent, well below the level of inflation. The

[4] *Review Body on Doctors' and Dentists' Remuneration, Forty-Second Report,* Cm 8832, March 2014.

BMA argued that DMS GMPs and Consultants saw their pay fall by 7.5 per cent and 6.8 per cent respectively in real terms since 2006 when compared with the Consumer Prices Index (CPI).

Pay comparability

32. Our remit requires us to have regard to the need for Armed Forces pay levels to be "broadly comparable" with those in civilian life. DMS staff, unlike most other Service personnel, have direct comparators in the NHS. However MOD, the BMA and the BDA provided little detailed comparability evidence this year. As for 2013, the main pay analyses by cadre that follow have been produced by our secretariat.

Summary of pay comparisons by DMS group

33. Our comparisons examine levels of DMS and NHS pay (at 1 April 2013 where data are available). The following adjustments have been made to provide a consistent basis for the comparisons: (i) remove the appropriate level of X-Factor from DMS salaries; (ii) make an upward adjustment to DMS salaries to recognise that the DMS has a relative pension advantage over the NHS;[5] and (iii) where applicable, make downward adjustments to elements of the NHS comparator, recognising that all DMS base pay is pensionable, but there are elements of NHS comparator pay which are not.

Consultants[6]

34. Average DMS pay in 2013–14 was £111,662.[7] 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.[8]
- Additional PAs – any programmed activities worked over the base 10 PAs are paid *pro rata* and are non-pensionable. The National Audit Office carried out a census of NHS trusts which showed they paid for, on average, 11.2 PAs a week which is consistent with earlier measurements for PAs worked.[9] In 2009 AFPRB and the parties agreed to use one additional PA in NHS comparator pay to make a total of 11 PAs for comparison purposes.
- On-Call Availability Supplement – average DMS commitments according to last available data[10] were 1 in 7, considered a medium frequency rota in the NHS and attracting a 5 per cent pensionable supplement to base pay. Inclusion of this payment was also agreed by AFPRB and the parties in 2009 as the appropriate NHS comparator.

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5 This is calculated using the same approach as for last year, but differently from earlier DMS Reports where NHS salaries were adjusted downwards.

6 Unless stated otherwise the data have been adjusted as set out in paragraph 33.

7 Assuming Consultants start at increment level 5 at age 35 and progress to increment level 30 at age 60.

8 10 PAs is 40 hours of work per week and deemed a full-time post.

9 This figure is published in a NAO report: National Audit Office. *Managing NHS hospital consultants* HC 885. TSO, 6 February 2013.
Available at: http://www.nao.org.uk/wp-content/uploads/2013/03/Hospital-consultants-full-report.pdf

10 MOD 2008 MODO Paper of Evidence.

- Employer-based (Local) Clinical Excellence Awards (CEAs)[11] – these pensionable awards were introduced in the NHS in 2003 as a replacement for the Discretionary Points scheme. Local awards (levels 1 to 8 plus some level 9) are funded by local NHS employers, who are now obliged to award 0.2 (previously 0.35 until 2011)[12] of an award per eligible NHS Consultant (following their first year as a Consultant). These awards are not an automatic element of a consultant's earnings, but must be applied for, so are different to other elements of remuneration. The parties had been discussing the introduction of a merit based award system within the DMS. However, the NHS is currently reviewing CEAs at all levels and the parties are waiting for this to conclude.

35. Table 1 shows that adjusted average 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 2013 derived from the Electronic Staff Register show average total earnings for consultants of £110,602.

Table 1: Consultant 2013–14 pay comparisons

Comparator	Average Income	Adjusted Average Income[a]	Lead / Deficit of DMS[b]
	£	£	%
DMS	115,985	**111,662**	–
NHS			
11 PAs	100,660	99,928	11.7
11 PAs + 5% On Call	105,236	104,504	6.9
11 PAs + 5% On Call + CEA	117,405	116,673	–4.3

[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[13]

36. Based on 2013–14 salary scales, the annual average DMS salary across a career is £108,306. However, the latest available NHS GMP pay information is for 2011–12. Therefore, DMS pay data from the same year were used when making the comparisons. Average DMS salaries for 2011–12 were £107,233 when adjusted, the same as in 2010–11 as a result of the pay freeze. In April 2013, there were 282 DMS GMPs.

[11] 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. MOD states in its evidence that a similar proportion of its staff are in receipt of a (national) clinical excellence award to staff in NHS England. However, award amounts are different. There are no employer-based CEAs for MOs and they are excluded from applying for them in any NHS Hospitals in which they might work. This was taken account of when the MO Consultant Pay Spine was created – an element of the pay scale compensates for lack of access to employer-based CEAs.

[12] This is the proportion used for calculating the income comparisons as it more accurately reflects the awards for the current population.

[13] Unless stated otherwise the data have been adjusted as set out in paragraph 33.

37. The total population of independent contractor NHS GMPs is all General and Personal Medical Services (GPMS) GMPs.[14] Average net profit for this group was £103,000, 1.2 per cent lower than 2010-11.[15] This equates to a lead of around 4.1 per cent for average pay for DMS GMPs with NHS GMPs or over 7.4 per cent when comparing median pay. Table 2 shows average DMS pay (adjusted for X-Factor and pensions) against the range of NHS GMP comparators.

Table 2: GMP 2011–12 Earnings (United Kingdom)

Comparator	Practice	Population	Average Income £	Median Income £	Lead / Deficit of DMS[a] %	
					Average Income	Median Income
DMS	–	–	**107,233**	–	–	–
GMS[b]	Dispensing	3,400	112,500	111,600	–4.7	–3.9
	Non-dispensing	18,050	95,700	94,000	12.1	14.1
	All	**21,450**	**98,300**	**96,200**	**9.1**	**11.5**
PMS[c]	Dispensing	1,600	123,200	117,000	–13.0	–8.3
	Non-dispensing	9,900	109,700	106,300	–2.2	0.9
	All	**11,500**	**111,600**	**107,700**	**–3.9**	**–0.4**
GPMS[d]	Dispensing	5,000	115,900	113,400	–7.5	–5.4
	Non-dispensing	27,950	100,700	97,800	6.5	9.6
	All	**32,950**	**103,000**	**99,800**	**4.1**	**7.4**
GPMS	Salaried GPs	7,650	56,800	53,600	88.8	100.1

[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[16]

38. DMS GDP average adjusted salary across a career based on 2013–14 pay scales is £108,306. However again the latest available NHS pay data are from 2011–12. Therefore DMS comparisons use 2011–12 data. Average adjusted DMS salary for 2011–12 was £107,233 (as for GMPs). In April 2013, there were 226 DMS GDPs.

39. The latest 2011–12 HM Revenue and Customs earnings data[17] include NHS and mixed NHS/private practice dentists, but exclude dentists who derived their income wholly from private practice. Income is split by classification[18] and contract type and illustrates the range of average earnings on offer in the civilian sector. Average net profits in 2011–12 were 4.5 per cent lower than those in 2010–11. Table 3 shows DMS GDP pay against a

[14] In previous evidence, the BMA, the BDA and MOD agreed that independent contractor NHS GMPs were the appropriate comparator, specifically all General and Personal Medical Services (GPMS) GMPs.
[15] These are HM Revenue and Customs income data (earnings minus expenses and before tax) which include NHS and mixed NHS/private practice GMPs, but exclude GMPs who derived their income wholly from private practice. *GP Earnings and Expenses 2011–12* published by the Health and Social Care Information Centre, September 2013.
[16] Unless stated otherwise the data have been adjusted as set out in paragraph 33.
[17] Dental Earnings and Expenses, England and Wales, 2011/12 produced by the NHS Information Centre for health and social care.
[18] 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.

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.

Table 3: GDP 2011–12 Average earnings (England & Wales)

Dental type	Contract	Population	Average Salary / Net profit £	Change 10-11 to 11-12 %	Lead / Deficit of DMS[a] %
DMS		–	**107,233**	–	–
Providing-performer	GDS	4,300	104,700	–4.4	2.4
	PDS	550	165,700	5.3	–35.3
	Mixed GDS/PDS	400	128,300	–5.9	–16.4
	All	**5,250**	**112,800**	**–3.8**	**–4.9**
Performer only	GDS	12,950	61,000	–1.0	75.8
	PDS	1,450	70,300	–7.1	52.5
	Mixed GDS/PDS	1,600	60,700	–2.4	76.7
	All	**16,050**	**61,800**	**–1.7**	**73.5**
All dentists	GDS	17,300	71,900	–3.9	49.1
	PDS	2,000	96,100	–6.2	11.6
	Mixed GDS/PDS	2,000	74,500	–6.8	43.9
	All	**21,300**	**74,400**	**–4.5**	**44.1**

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

40. In its evidence again this year 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 £112,800 despite having fallen by 3.8 per cent from 2010–11. National Association of Specialist Dental Accountants and Lawyers 2011–12 data showed a higher average net income of £125,696 for all providing-performer practices (including wholly private practices) in England and Wales, the same level as for the previous year. We do not, however, consider this an appropriate comparator as DMS DOs do not carry a comparable business risk (although the BDA disputes this). Despite making these pay comparisons, the BMA and the BDA continued to agree that pay parity with the internal comparator (DMS GMPs) was the overriding priority for DOs.

Junior Doctors in Training

41. Junior Doctors' base pay is supplemented in most cases by an out-of-hours band multiplier[19] 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 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[20] from 2010 showed that over 80 per cent of posts received either a Band 1A (1.5 multiplier) or 1B (1.4 multiplier) supplement, with an average of 1.43.

[19] 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.

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

42. 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. The Government has recently announced a renegotiation of the contract for Junior Doctors which aims to conclude by October 2014.

Table 4: Junior Doctors in Training 2013–14 pay comparisons

Age	DMS Scale	DMS Salary[a] £	NHS Scale	NHS Salary[b] £
24	OF 1 (1)	40,344	F1	31,299
25	OF 2 (1) Non-Acc	53,296	F2	38,821
26	OF 2 (2) Non-Acc	54,801	ST 1 min	41,484
27	OF 2 (3) Non-Acc	56,314	ST 2	44,022
28	OF 2 (4) Non-Acc	57,839	ST 3	47,568
29	OF 2 (5) Non-Acc	59,356	ST 4	49,711
30	Non-Acc MO Level 1	64,107	ST 5	52,379
31	Non-Acc MO Level 2	67,851	ST 6	54,884
32	Non-Acc MO Level 3	71,618	ST 7	57,471
33	Non-Acc MO Level 4	72,743	ST 8	60,056
34	Non-Acc MO Level 5	73,868	ST 9	62,642
35	Consultant Level 5 (Entry)	85,586	Consultant	75,249

[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).

MOD, BMA and BDA pay proposals for 2014–15

43. MOD proposed that there should be an increase in basic pay for MODOs in line with the award for the main remit group. It proposed that the existing pay spines should be retained, and proposed maintaining the existing 'Golden Hello' scheme, but with some changes to eligible groups. It proposed that GMP and GDP Trainer pay should be increased in line with the overall award, but that MOD CEAs should be held at their existing rates until negotiations on the NHS CEA scheme had concluded. Additionally, it proposed that the highest increment levels from the OF3-5 Non-Accredited MODO pay range should be removed.

44. The BMA and the BDA highlighted the reductions in real income for MODOs since their pay freeze came into effect in 2010. They stated that MODOs continued to provide increasingly high standards of medical and dental care to Armed Forces personnel, despite the reductions in real income, difficulties around recruitment, retention and morale and increasing uncertainty caused by restructuring.

45. The BMA proposed an increase of 2.1 per cent for MOs. The proposal was in line with the CPI as at December 2013, and the BMA considered it to be appropriate to end the continuing decline in MOs' real incomes and to recognise that they were a highly specialised and skilled group. An increase below this level would deliver a further cut in real earnings. The BDA accepted that the current circumstances would not allow any significant change in pay and that it was important to maintain pay parity with Armed Forces MOs. The BMA again reiterated its position that it thought it was inappropriate for the Government to restrict our remit, particularly as we are obliged to take account of the economic climate when forming our recommendations.

46. In its submission the BMA mentioned that it no longer received the staffing and attitudinal data that it used to from MOD ahead of preparing its evidence for us. This meant that it did not have the detailed picture of the remit group that it had in earlier years. We have asked MOD to consider sharing what information it can, to allow the BMA and the BDA to submit the best possible evidence to us in future years.

Clinical Excellence Awards

47. As we noted in our last Report, the DDRB undertook a review of Consultant contracts and CEAs in July 2011. The review was published, together with the Government's response in December 2012. Negotiations have started between the NHS, the Department of Health and the BMA on pay, CEAs and conditions of employment for doctors. Once these have concluded, pay comparability between the NHS and MODOs will need to be reconsidered overall, and in respect of CEAs in particular. As there has been no change in the situation at the time of writing compared with last year, MOD, the BMA and the BDA proposed that we made no changes to the existing arrangements for military CEAs, therefore we are content that they remain at their existing levels.

RECOMMENDATIONS FOR 2014–15

Overall pay recommendations

48. Our pay recommendations seek to support recruitment, retention and motivation of 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 Service Medical and Dental Officers.

49. When reviewing pay for MODOs, we consider information on pay comparability with the NHS, and we believe our recommendations would maintain broad comparability on pay. We regard aligning our recommendations with those of the DDRB as an important element in achieving and maintaining this comparability, but take account of the full range of evidence we receive.

50. At first glance, the staffing situation for MOs in 2012–13 appeared more positive than in recent years, with a 20 per cent shortfall against liability compared with 28 per cent a year earlier. However, the improvement was mostly due to a reduction in liability. Also, a sharp increase in voluntary outflow compared with the previous year means retention remains fragile and is a cause for considerable concern. For DOs staffing was at 94 per cent of liability. However, MOD evidence suggested that there would be a surplus against DMS20 liability, so MOD thought that the individual Services would need to use the full range of staffing levers available to reduce numbers by 2018.

51. Although showing early signs of recovery, the wider economic situation remained difficult, and the Government's evidence stated that it intended to continue with its policy of public sector pay restraint. The impact of changes made under the SDSR continued to be felt, leading to personnel feeling uncertain over their future. The announcement of the fourth tranche of Armed Forces redundancies, in January 2014, included a number of DMS personnel in the RN and RAF.

52. MOD and the BDA made the same proposal for the overall uplift, of one per cent across the board. The BMA, however, proposed an uplift of 2.1 per cent, in line with CPI as at December 2013. We have not accepted the BMA's proposal, as we did not consider that there was sufficient evidence to justify treating MOs differently from the main remit group or NHS counterparts. Staffing data, our consideration of broad pay comparability between the NHS and DMS, and the recommendations made by DDRB lead us to **recommend a one per cent across the board** increase this year. This is consistent with the approach we took for the main remit group. We consider that an award at this level should continue to support recruitment, retention, morale and motivation, and maintain broad comparability with NHS doctors and dentists.

Recommendation 1: We recommend the following changes from 1 April 2014:

- **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.**

The recommended pay scales are at Appendix 1.

Golden Hello

53. DMS runs a 'Golden Hello' scheme which aims to encourage the recruitment of direct entrant accredited GMPs and Consultants. While the scheme has not been used very often in recent years, MOD stated that it regarded the scheme as good value for money against training an MO from scratch. MOD proposed to retain the scheme, but to change the specialties eligible to receive it. The revised scheme would target those areas requiring more than 10 personnel and that were forecast to be 15 per cent or more understaffed under DMS20 liabilities. We regarded this approach as sensible and therefore endorse this proposal.

Recommendation 2: We recommend the retention of the Medical Officer 'Golden Hello' scheme, with amendments to the eligible cadres.

Non-accredited Medical Officers

54. MOD's evidence to us included a proposal to remove the highest increment levels from the OF3-5 non-accredited MO pay scale. DMS20 does not include a future requirement for non-accredited MOs. The OF3-5 non-accredited MO pay scale has 29 increment levels. While progression beyond level 10 is only available on promotion to OF4, the long scale effectively allows those MOs who do not accredit to continue receiving incremental progression for most of their career. MOD proposed the removal of the highest levels (20-29). This would still allow trainees in even the most complex specialties sufficient time to accredit and still receive annual increments. Any personnel already on the highest levels would retain their existing arrangements. We invited MOD to provide further information about this group to ensure that the proposed action was appropriate. We were pleased to receive this, and to gain confirmation from the BMA during oral evidence that it did not consider this action to be unreasonable as the number affected was very small and was going to reduce over time.

Recommendation 3: We recommend the removal of increment levels 20-29 from the OF3-5 non-accredited Medical Officer pay scale.

Cost of our pay recommendations

55. We estimate that the cost of our pay recommendations for 2014–15 is £2.2 million (including the Employers' National Insurance Contribution and superannuation liabilities).

LOOKING AHEAD

56. DMS is facing a period of significant change. Implementation of the post-SDSR structures and the return to a contingency stance present big challenges. This is clearly generating considerable uncertainty and the DMSCAS this year provided evidence of low morale and satisfaction with both career and line management. Taken alongside concern about changes to pension arrangements, this will require MOD to give careful thought to retention of MODOs.

57. The reported increase in voluntary outflow in the latest available period (2012–13), is a cause for considerable concern. We urge DMS senior management to ensure that exit interviews are held with all MODOs who leave, and use the information to gain a complete understanding of why and when MODOs leave the Service, so informing appropriate strategies to help to reverse this worrying trend in voluntary outflow.

58. Last year we recommended that MOD reconsidered how best to include MODOs in the forthcoming AFPS15. MOD maintained its policy of treating MODOs the same as the main remit group in relation to the pension. The Surgeon General agreed with the one size fits all approach and said that any adverse impacts would be dealt with as they arose, using financial incentives. We remain concerned about the potential implications of this approach for retention and wish to remain informed of DMS personnel's attitudes to the new pension and any implications this has for retention.

59. The move to an increasing component of future defence requirements coming from Reservists will also be an issue for DMS. The implementation of DMS20 will result in some cadres increasing in size, others reducing and some becoming Reserve-only. DMS already makes more use of Reserves than other areas of defence, but will face significant challenges to reach the goals under Future Reserves 2020 (FR20) and DMS20 due to an ageing demographic, problems with recruiting and the end of current operations. Many DMS personnel, both Regular and Reserve, are attracted to the Service by the potential opportunity to deploy on overseas operations. This is particularly the case for those in Emergency Medicine. The ending of combat operations in Afghanistan could potentially reduce the appeal to some. Conversely, increased stability could make joining and remaining in the Armed Forces more attractive, and provide opportunities for alternative ways of working which could also boost retention. The current employment model appears unsustainable. There needs to be a strategic plan, with a radical approach to address the situation.

60. MOD stated that the NEM offers an opportunity to consider alternative ways of working for MODOs, and provided us with some initial thoughts on the form this might take. The NEM also provides the opportunity to consider the pay structure for MODOs, with perhaps consideration of a more radical approach. Developing effective recruitment and retention strategies, which should encompass exit interviews and fully utilize monitoring data in respect of women and BME staff, are also necessary, not only to ensure that the DMS is more representative of society, but also to ensure that it is benefiting to the full from the best talent emerging from medical and dentistry schools. Prior to our next Report, we look forward to receiving a clear strategy and evidence of progress on all these issues.

John Steele
Mary Carter
Peter Dolton
Graham Forbes
Richard Ibbotson
Paul Kernaghan
Judy McKnight

March 2014

APPENDIX 1

1 April 2013 and 1 April 2014 military salaries including X-Factor

All salaries are rounded to the nearest £.

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

Increment level	Military salary £	
	1 April 2013	1 April 2014
Level 32	*132,889*	134,217
Level 31	*132,631*	133,957
Level 30	*132,377*	133,701
Level 29	*132,116*	133,437
Level 28	*131,862*	133,181
Level 27	*131,350*	132,664
Level 26	*130,839*	132,148
Level 25	*130,328*	131,631
Level 24	*129,087*	130,378
Level 23	*127,849*	129,128
Level 22	*125,296*	126,549
Level 21	*123,875*	125,114
Level 20	*122,458*	123,683
Level 19	*121,037*	122,247
Level 18	*119,625*	120,821
Level 17	*117,833*	119,011
Level 16	*116,050*	117,210
Level 15	*114,471*	115,616
Level 14	*112,889*	114,018
Level 13	*111,315*	112,428
Level 12	*109,737*	110,835
Level 11	*106,268*	107,331
Level 10	*102,808*	103,836
Level 9	*99,347*	100,341
Level 8	*96,274*	97,237
Level 7	*93,193*	94,125
Level 6	*90,108*	91,009
Level 5	*87,217*	88,089
Level 4	*86,094*	86,955
Level 3	*84,947*	85,796
Level 2	*81,146*	81,957
Level 1	*77,385*	78,158

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

Increment level	Military salary £	
	1 April 2013	1 April 2014
Level 35	*123,987*	125,226
Level 34	*123,598*	124,834
Level 33	*123,302*	124,535
Level 32	*122,818*	124,047
Level 31	*122,430*	123,655
Level 30	*122,038*	123,258
Level 29	*121,737*	122,955
Level 28	*121,258*	122,470
Level 27	*120,862*	122,070
Level 26	*120,474*	121,678
Level 25	*120,078*	121,278
Level 24	*119,689*	120,886
Level 23	*119,293*	120,486
Level 22	*117,470*	118,644
Level 21	*117,012*	118,182
Level 20	*116,467*	117,632
Level 19	*115,900*	117,059
Level 18	*115,339*	116,492
Level 17	*114,771*	115,919
Level 16	*114,209*	115,351
Level 15	*113,707*	114,845
Level 14	*111,621*	112,737
Level 13	*111,123*	112,234
Level 12	*110,625*	111,732
Level 11	*110,052*	111,152
Level 10	*109,482*	110,576
Level 9	*108,908*	109,997
Level 8	*106,813*	107,881
Level 7	*106,243*	107,306
Level 6	*104,790*	105,838
Level 5	*103,329*	104,363
Level 4	*101,877*	102,896
Level 3	*100,416*	101,420
Level 2	*98,333*	99,316
Level 1	*97,651*	98,627

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

Increment level	Military salary £	
	1 April 2013	1 April 2014
Level 29	*98,244*	99,226
Level 28	*97,447*	98,422
Level 27	*96,659*	97,625
Level 26	*95,866*	96,825
Level 25	*95,070*	96,021
Level 24	*94,281*	95,224
Level 23	*93,489*	94,424
Level 22	*92,013*	92,934
Level 21	*91,115*	92,026
Level 20[a]	*90,208*	91,110
Level 19	*89,301*	90,193
Level 18	*88,398*	89,282
Level 17	*87,495*	88,370
Level 16	*86,588*	87,454
Level 15	*85,781*	86,639
Level 14	*84,986*	85,836
Level 13	*84,183*	85,025
Level 12	*83,380*	84,214
Level 11	*82,581*	83,407
Level 10[b]	*81,782*	82,600
Level 9	*80,819*	81,628
Level 8	*79,198*	79,990
Level 7	*77,572*	78,348
Level 6	*76,417*	77,182
Level 5	*75,275*	76,028
Level 4	*74,128*	74,870
Level 3	*72,982*	73,712
Level 2	*69,143*	69,835
Level 1	*65,328*	65,982

[a] Levels 20-29 will be removed from 1 August 2014.

[b] 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 2013	1 April 2014
Level 5	*73,900*	74,639
Level 4	*72,401*	73,125
Level 3	*70,906*	71,615
Level 2	*69,403*	70,097
Level 1	*67,904*	68,583

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

Increment level	Military salary £	
	1 April 2013	1 April 2014
Level 5	*60,487*	61,092
Level 4	*58,941*	59,530
Level 3	*57,387*	57,961
Level 2	*55,845*	56,403
Level 1	*54,311*	54,854

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

	Military salary £	
	1 April 2013	1 April 2014
OF1	*41,113*	41,524

Table 1.7: Recommended annual salaries for Medical and Dental Cadets

Length of service	Military salary £	
	1 April 2013	1 April 2014
after 2 years	*19,102*	19,293
after 1 year	*17,237*	17,409
on appointment	*15,380*	15,533

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

Increment level	Military salary £	
	1 April 2013	1 April 2014
Level 7	*137,802*	139,180
Level 6	*136,650*	138,017
Level 5	*135,503*	136,858
Level 4	*134,344*	135,687
Level 3	*133,188*	134,520
Level 2	*132,044*	133,365
Level 1	*130,885*	132,194

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

Increment level	Military salary £	
	1 April 2013	1 April 2014
Level 15	*129,110*	130,401
Level 14	*128,386*	129,670
Level 13	*127,654*	128,930
Level 12	*126,924*	128,193
Level 11	*126,198*	127,460
Level 10	*125,468*	126,722
Level 9	*124,730*	125,977
Level 8	*124,004*	125,244
Level 7	*123,274*	124,507
Level 6	*122,181*	123,403
Level 5	*121,092*	122,303
Level 4	*119,991*	121,191
Level 3	*118,902*	120,091
Level 2	*117,813*	118,992
Level 1	*116,713*	117,880

DMS Trainer Pay

GMP and GDP Trainer Pay	£7,824
GMP Associate Trainer Pay	£3,912

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

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