Armed Forces'
Pay Review Body

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Service Medical and Dental Officers

Supplement to the Forty-Fourth Report 2015

Chair: John Steele

Cm 9045

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

March 2015

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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
Tim Flesher CB
Paul Kernaghan CBE QPM
Professor Ken Mayhew
Judy McKnight CBE
Vilma Patterson MBE
Rear Admiral (Ret'd) Jon Westbrook 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.

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GLOSSARY OF TERMS

AFPRB	Armed Forces' Pay Review Body
AFPS15	Armed Forces' Pension Scheme 2015
BAME	Black, Asian and Minority Ethnic
BDA	British Dental Association
BMA	British Medical Association
CEA	Clinical Excellence Award
CPI	Consumer Prices Index
DDRB	Doctors' and Dentists' Review Body
DMS	Defence Medical Services
DMS20	Defence Medical Services 2020
DMSCAS	Defence Medical Services Continuous Attitude Survey
DNRC	Defence National Rehabilitation Centre
DO	Dental Officer
FR20	Future Reserves 2020
GDP	General Dental Practitioner
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
PRMP	Pre-registration Medical Practitioners
SG	Surgeon General
UK	United Kingdom
VO	Voluntary Outflow

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ARMED FORCES' PAY REVIEW BODY
2015 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; and**
- **The retention of the Medical Officer 'Golden Hello' scheme, and its expansion to include all cadres where the projected staffing deficit in 2018 is 15 per cent or higher.**

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 considerations of the Doctors and Dentists Review Body (DDRB). We received written and oral evidence from the Ministry of Defence (MOD), the British Medical Association (BMA), and the British Dental Association (BDA). We also consider evidence gathered during our visits programme, which included discussions with serving DMS personnel.

Workforce data

MOD provided staffing figures at July 2014 showing MODO staffing was at 86 per cent (795) of trained requirement (924). There was a deficit in trained MOs of 16 per cent against requirement compared with 20 per cent a year earlier. While there was an increase in the number of MOs, most of the improvement was due to a reduction in liability. Voluntary outflow remained at the same high level as last year, but overall outflow increased. The level of outflow of MOs is unsustainable and is a cause for considerable concern. For DOs staffing was at 92 per cent of liability and MOD regarded the level of outflow as manageable as it moved towards the lower DMS20 liability.

There was a 68 per cent shortfall in the number of MO Reserves. While the DMS20 liability is lower than that at 1 July 2014, without a great deal of improvement the staffing level would still be short of liability (only 39 per cent staffed against DMS20 liability as at 1 July 2014). MOD told us that a number of remunerative and non-remunerative measures were being implemented to attempt to improve the situation. If recruitment targets are not met then it would lead to more pressure on existing DMS personnel. BMA did not think that the targets could be reached and proposed that we commission an independent review into the future shape of the medical Reserve. We believe that such a review would be worthwhile but consider that the Surgeon General's (SG's) team would be better placed to commission this.

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Pay comparability

MODOs' pay should be broadly comparable with that in the NHS to allow MOD to continue to recruit, retain and motivate sufficient numbers of capable staff. The BDA stated that DOs received a 2.5 per cent increase in pay over the previous five years against the CPI that rose by 14.5 per cent over the same period. MOD considered that its proposals would maintain broad pay comparability between MODOs and their NHS counterparts. Our analysis also found that there remained broad pay comparability between DMS cadres and their NHS counterparts.

Last year the Government did not accept the recommendation from the DDRB but instead imposed a pay settlement whereby salaried staff in England not eligible for incremental pay received a one per cent non-consolidated payment for both 2014-15 and 2015-16. This two-year approach resulted in a constrained remit for the DDRB this year and it made the following recommendations which are relevant to DMS groups for 2015-16: an increase in pay, net of expenses, of one per cent for independent contractor General Medical Practitioners and General Dental Practitioners for all countries of the United Kingdom; and an increase in basic pay of one per cent to the national salary scales for salaried doctors and dentists in Scotland. We note that DDRB will submit a further report in the summer regarding doctors' contracts.

Recommendations

MOD proposed an increase in basic pay for MODOs in line with our recommendation for the main Armed Forces pay award. The BMA and the BDA both proposed an award above the rate of inflation, but did not state what that award should be. They also said that MODOs should receive at least the same award as the rest of the Armed Forces. Staffing data, our consideration of broad pay comparability between the NHS and DMS, including 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.

Looking ahead

Having already experienced a period of significant change, the Defence transition to a contingency stance will bring major challenges to the delivery of military healthcare. Service Medical and Dental Officers continue to operate under considerable uncertainty. Voluntary outflow of MOs remained high, and overall outflow was regarded as unsustainable.

We believe there is more scope for better understanding of DMS needs by single Service recruiters and a need to take account of DMS requirements, and SG's views, in their approach to recruitment. If recruitment is unsuccessful, there is an impact on the service provided and an increased burden on those delivering it. The demographics of those entering medical and dental school mean that work needs to continue to engage with members of Black, Asian and Minority Ethnic communities to build trust and improve understanding to increase the numbers who might consider a career in the DMS.

We recognise some of the difficulties with the application of flexible working elsewhere in the Armed Forces, but this should not prevent MOD from investigating and adopting more flexible approaches to working in DMS. Measures such as MOs spending half their time in the NHS and the other half in DMS, easing the transition between Regular and Reserve Service and vice-versa, and taking full advantage of the flexibilities that already exist should be explored further. Adopting practices such as these appears to be essential to ensuring the long term future of DMS and would, we believe, go some way to improving the recruitment and retention of female MODOs in particular. MOD should also examine the terms and conditions of Reserve service. MOD needs to view DMS differently from the mainstream Armed Forces, and ensure that the single Services work together to ensure that collectively they recruit and retain sufficient skilled personnel. It is also important that MOD ensures that the culture within the Armed Forces is one that enables all Service personnel to fulfil their potential.

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INTRODUCTION

1. This Report sets out the evidence we received and our recommendations for Medical and Dental Officers' (MODOs') pay from 1 April 2015. This year's review was conducted against the background of a difficult, but improving, economic climate, the Government's policy on public sector pay restraint, and substantial and continuing change for Defence Medical Services (DMS). Our recommendations aim to maintain broad pay comparability with National Health Service (NHS) doctors and dentists to allow DMS to recruit, retain and motivate suitably qualified personnel.

2. In its evidence, MOD proposed a uniform increase across the board to MODOs, in line with its proposal for the rest of the remit group, noting that they (like others in the Armed Forces) retain incremental progression. Ordinarily, in addition to considering evidence from the Government, MOD, the British Medical Association (BMA) and the British Dental Association (BDA), and gathering our own evidence directly from the remit group on visits, we also take into account the considerations of NHS doctors' and dentists' pay by the Doctors and Dentists Review Body (DDRB). Last year the Government did not accept the recommendation from the DDRB to increase incremental pay points for salaried doctors and dentists by one per cent in England and Wales. The Government instead imposed a pay settlement whereby salaried staff in England who were not eligible for incremental pay received a one per cent non-consolidated payment for both 2014-15 and 2015-16.

BACKGROUND

DMS developments

3. Defence transition to a contingency stance will bring major challenges to the delivery of healthcare. DMS will need to continue to provide healthcare for those suffering injury and illness from operations, provide care across the UK estate and be ready to deploy on operations. MOD told us that while there was dissatisfaction among doctors in the NHS, the financial pull to work there could increase, as changes in service delivery were implemented. This means it will be vital to get the offer right to ensure DMS can fully deliver the required level of medical and dental care. MOD told us of six strategic initiatives that would affect staff in the DMS:

    - Defence Medical Services 2020 (DMS20) – aims, by 2018, to match staffing to the requirement for 2020. It will result in some Regular cadres increasing in size, others reducing, and others becoming a Reserve Forces capability. DMS20 aims to achieve the right mix of uniformed and non-uniformed healthcare providers. Implementing the project meant that some DMS personnel (mostly General Dental Practitioners (GDPs)) were included in the fourth tranche of the redundancy programme during 2014. MOD acknowledged the impact this could have on morale. In other areas, such as emergency medicine and general surgery, numbers were well below the 2020 requirement and it will be very challenging to reach the target.
    - Future Reserves 2020 (FR20) – identified 40 measures to sustain and grow the Reserves. In recent years, DMS has provided some of the best examples of Regular and Reserve integration, particularly on operations in Afghanistan. However, DMS Reserves are significantly understaffed and, with the end of operations in Afghanistan, a perceived lack of opportunities to deploy could reduce the attractiveness of the Reserve offer.
    - New Employment Model (NEM) – aims to modernise terms and conditions of service. MOD's evidence highlighted the potential for improved opportunities to work flexibly, which would be of particular interest to many in DMS.

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- Defence National Rehabilitation Centre (DNRC) – a new centre, closer to DMS headquarters. The DNRC is due to open in 2018 and will aim to provide improved rehabilitation services than those currently provided at Headley Court. MOD noted that some concerns have been expressed over staffing the new centre due to the change of location.
- Defence Primary Healthcare – brought all primary and intermediate healthcare from the single Services into one organisation and incorporated 194 medical and 149 dental centres.
- Headquarters Surgeon General (SG) Senior Structures Reorganisation – a two-star healthcare delivery and training post was created from two existing two-star roles to operate alongside the medical policy and operational capability post.

4. During this period of uncertainty and change, the results of the DMS Continuous Attitude Survey (DMSCAS) survey provided by MOD indicated that morale remained low for MOs and decreased further for DOs, probably due to the redundancy programme. MODOs appeared to be concerned about recent and future organisational change, and covering for gapped posts was impacting negatively on quality of life.

NHS developments

5. 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:

- last year the Government did not accept the recommendation from the DDRB to increase incremental pay points for salaried doctors and dentists by one per cent in England and Wales. Staff who were not eligible for incremental pay received a one per cent non-consolidated payment for 2014-15. This imposed pay settlement for salaried staff in England covered both 2014-15 and 2015-16. The Scottish Government, however, did accept all of DDRB's recommendations for 2014-15 and has asked for Scotland-specific recommendations from DDRB for 2015-16 (see below);
- in its 2015 Report, DDRB stated that there were no problems with the recruitment of doctors and dentists at undergraduate level. However, some specialities, such as emergency medicine and psychiatry, had on-going recruitment difficulties for all grades of doctors across the United Kingdom. There were also some geographically-specific recruitment issues, particularly in some rural and deprived areas. The lack of trainees choosing to go into General Practice was cause for concern in Scotland and England;
- negotiations on changes to junior doctor and consultant contracts had stalled in October 2014. Potential changes to junior doctor contracts involved proposals to end time-served incremental progression and a shifting of the balance of pay away from banding payments towards basic pay. Negotiations on changes to consultants' contracts were partly aimed at supporting seven day working in the NHS and included proposals for locally determined performance pay, replacing local Clinical Excellence Awards (CEAs);
- pilot schemes were underway in England and Wales for new contractual arrangements for dentists to be paid on a per capita basis;
- the NHS pension scheme continued to provide significant benefits but the remit group would be contributing more in future for somewhat smaller benefits;
- staff survey results showed that levels of motivation for hospital doctors were holding up. However, BMA and BDA reported low levels of morale among doctors and dentists generally and this was also picked up by DDRB on visits. Increasing

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workloads, pension changes and the Governments rejection of DDRB's central recommendations last year were all thought to be contributing to the low levels of morale; and

- affordability continued to be an issue for the NHS resulting in an on-going challenge to meet the growth in demand for services.

Our 2015 Report

6. 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, when considering our recommendations for MODOs. 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

7. We considered evidence from a 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;
    - the Government's reaction to last year's 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 BMA and BDA;
    - oral evidence from SG and his team, and from 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 2014, in the UK and abroad.

8. 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 and appreciate the work of MOD and the Services in arranging them. In 2014 we visited DMS Whittington, Lichfield and 202 Field Hospital, Birmingham. We also met DMS Regular and Reserve personnel as part of our visits to other establishments. A full list of AFPRB visits can be found in our 2015 Report (Appendix 4) for the main remit group.[1] We heard a number of issues raised by MODOs; for example, on the gapping of posts and tempo of work, and the perceived erosion of the overall pay and reward package.

Staffing

9. At 1 July 2014 there was a requirement for 924 trained MODOs. The charts below show the changes in the requirements and staffing levels of MOs and DOs over the last decade. At 1 July 2014 there were:

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[1] *Armed Forces' Pay Review Body Forty-Fourth Report 2015,* https://www.gov.uk/government/organisations/office-of-manpower-economics

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- 590 trained MOs, a deficit of 16 per cent against the requirement of 701. This is an increase of 12 trained MOs from 1 April 2013 while the requirement reduced by 22 over the same period.
- 680 MOs in training, including:
  - 135 General Duties Medical Officers;
  - 354 MOs undertaking Core or Higher Specialist Training
  - 102 Foundation Year MOs; and
  - 89 Medical Cadets enrolled as undergraduate medical students.
- 205 trained DOs, 92 per cent of the requirement of 223.

Chart 1: Strength and deficit/surplus of Medical Officers 2005-2014

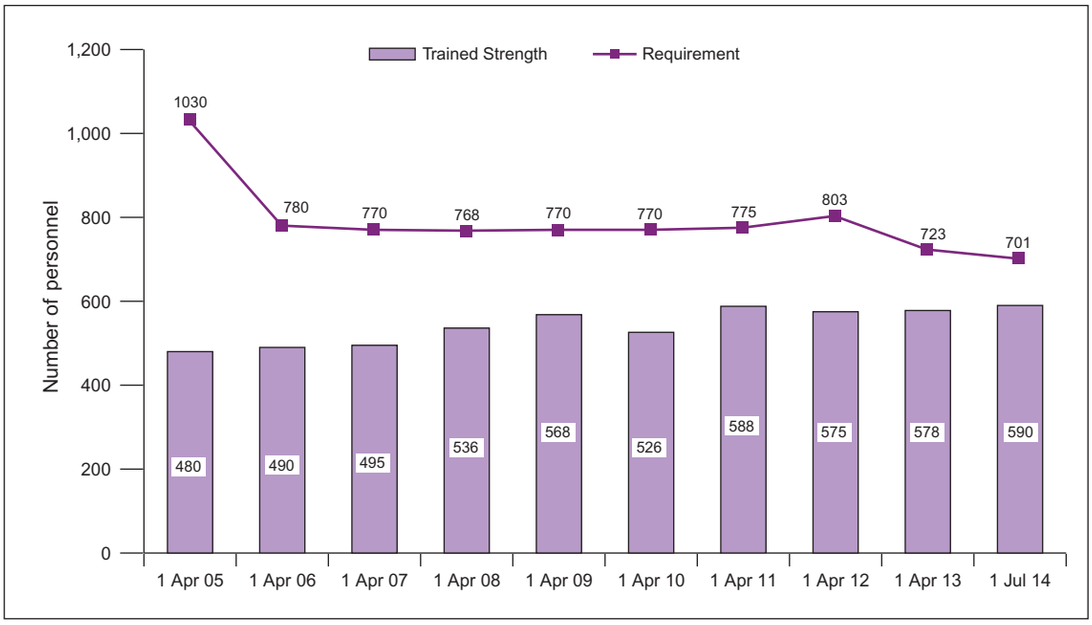
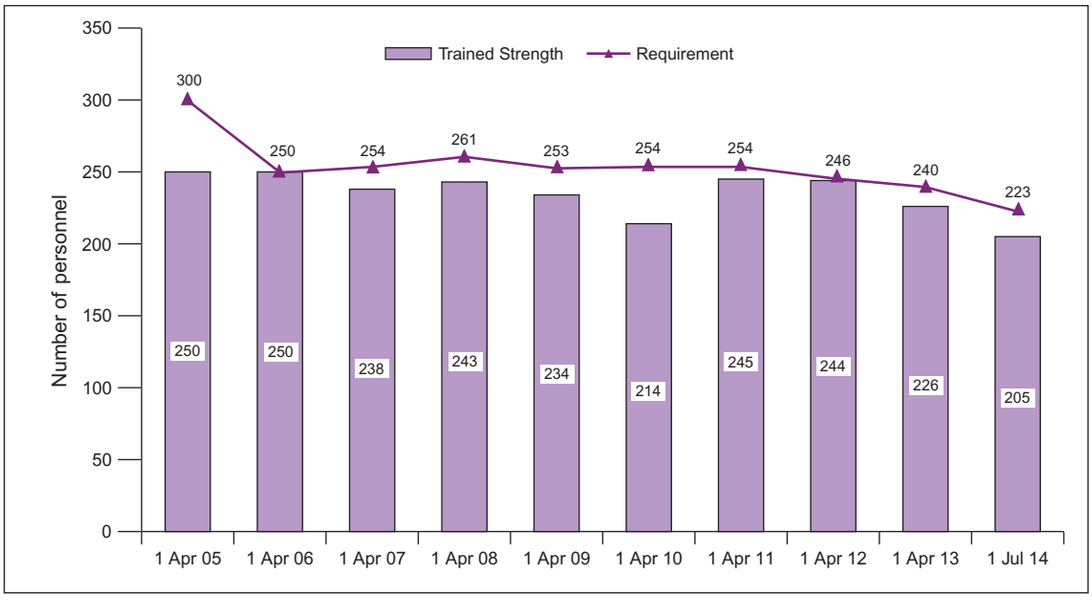


Chart 2: Strength and deficit/surplus of Dental Officers 2005-2014



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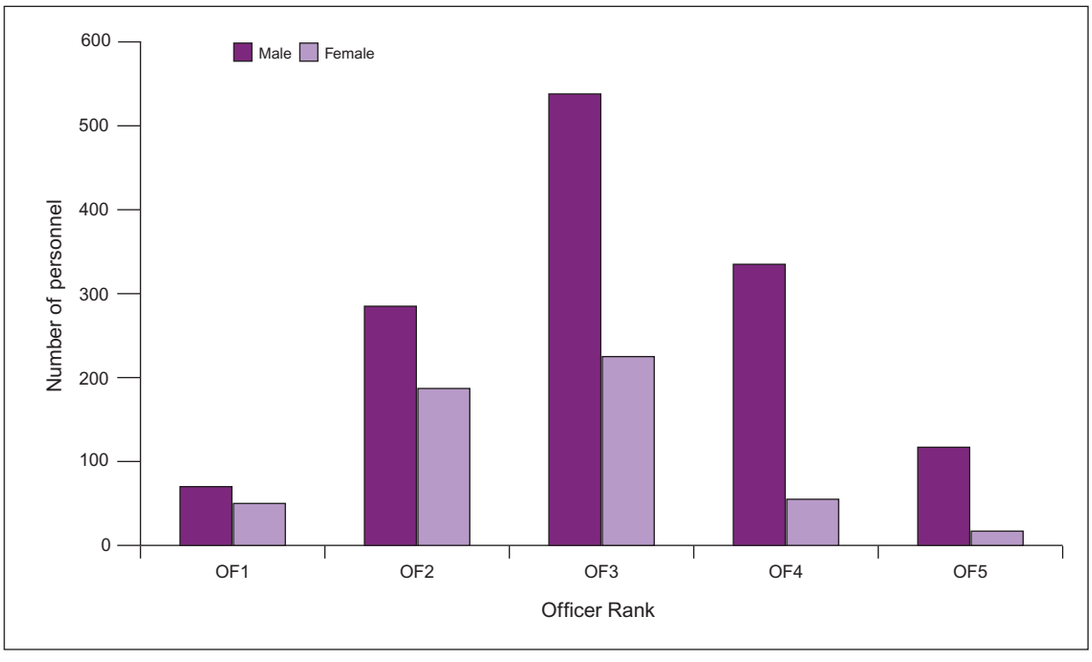
10. For consultants, there were 229 trained staff against a requirement of 317 in July 2014. This represents an overall shortfall of 28 per cent compared with 26 per cent a year earlier. There was a requirement of 333 Accredited General Medical Practitioners (GMPs) and a trained strength of around 295, a shortfall of 11 per cent. MOD noted that a proposed one-year extension to the GMP training pathway could result in a year (2018) when no GMPs would become accredited. This could pose an operational risk to DMS.

11. MOD provided us with evidence on the age, gender and rank profiles of MODOs at 1 April 2014. The proportion of women remained steady at around 28 per cent, although the picture for new recruits under training 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, 86 per cent of Consultants are male. Around 60 per cent of students entering UK medical schools are female.

12. This year, MOD also provided us with some useful information on the ethnic breakdown of MODOs. Around 90 per cent of MOs and 93 per cent of DOs were of White background. While the proportion of MODOs from Black, Asian and Minority Ethnic (BAME) groups may compare favourably with the Armed Forces overall (where only three per cent were from UK BAME backgrounds), it does not reflect the patterns of those studying medicine and dentistry, as well as society at large. The ability to attract and retain female personnel and personnel from BAME backgrounds is particularly important for DMS.

Chart 3: MODO Gender distribution by Rank – 1 April 2014



Recruitment

13. The recruitment target for MO Cadets was exceeded in the twelve months to 31 March 2014, although that for direct entrants was missed again. Trends in MO recruitment are shown in Chart 4. DO recruitment was also lower than in previous years (a total of four compared with six for the year to March 2013) as the transition to new structures continued.

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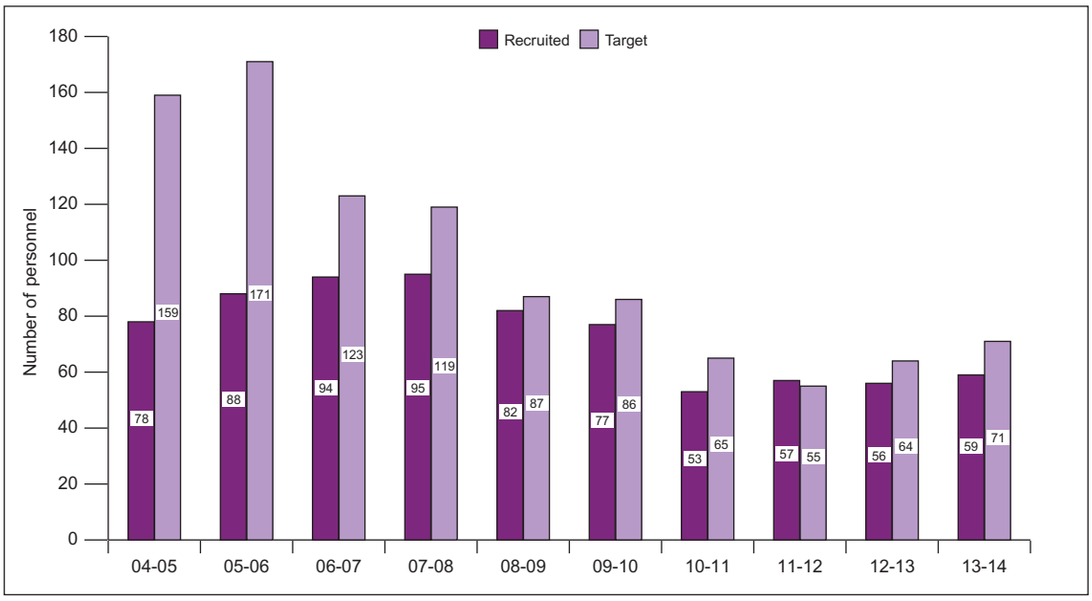
Chart 4: Medical Officer recruitment 2004-05 to 2013-14



Retention

14. While voluntary outflow (VO) remained the same as the previous year, the overall outflow of MOs increased again, to around 100 in 2013-14 compared with 85 in the previous year. VO was around half of total outflow which points to improving retention being critical to the future sustainability of DMS. MOD itself regarded the VO levels as unsustainable in the majority of MO cadres. MOD considered that the outflow of DOs (which increased from 17 in 2012-13 to 25 in 2013-14) as manageable, given the reducing liability, but it will require close monitoring to ensure that numbers do not fall below the required level.

15. MOD's evidence suggested that female MODOs tended to leave the Service relatively early in their careers. MOD considered that measures to allow improved flexibility of commitment, such as job-sharing or part-time working, together with easier transfer between Reserve and Regular Service and vice-versa, could improve the retention of female MODOs. However, no specific proposals were provided. We believe that the nature of the work undertaken by MODOs, and the read-across to NHS roles, could provide opportunities to adopt more flexible ways of working which could in turn improve recruitment and retention.

16. We were encouraged by the unanimous and shared recognition articulated in both our oral evidence sessions with the BMA/BDA and SG, that the issues of flexible and part time working are central to the delivery of a modern, relevant and viable DMS. We were told that the NEM programme was no longer pursuing the possibility of part-time Regular working, based on concerns in relation to the difficulty and complexity of providing an appropriate legislative framework. However, the demographic realities of the modern medical and dental professions, allied to the through career linkages between the DMS and NHS make it clear that 'a one size fits all' approach is not appropriate or sustainable in this instance. We urge MOD and the single Services to provide specialist support to SG to assist in developing flexible terms and conditions of service to enable DMS to continue to deliver a first class service over the coming decades. We believe there should be sufficient scope within existing Regular and Reserve terms and conditions to allow the adoption of flexible working practices. It could well be that lessons learned in this context by DMS could be adopted in other niche areas of professional expertise within the Armed Forces.

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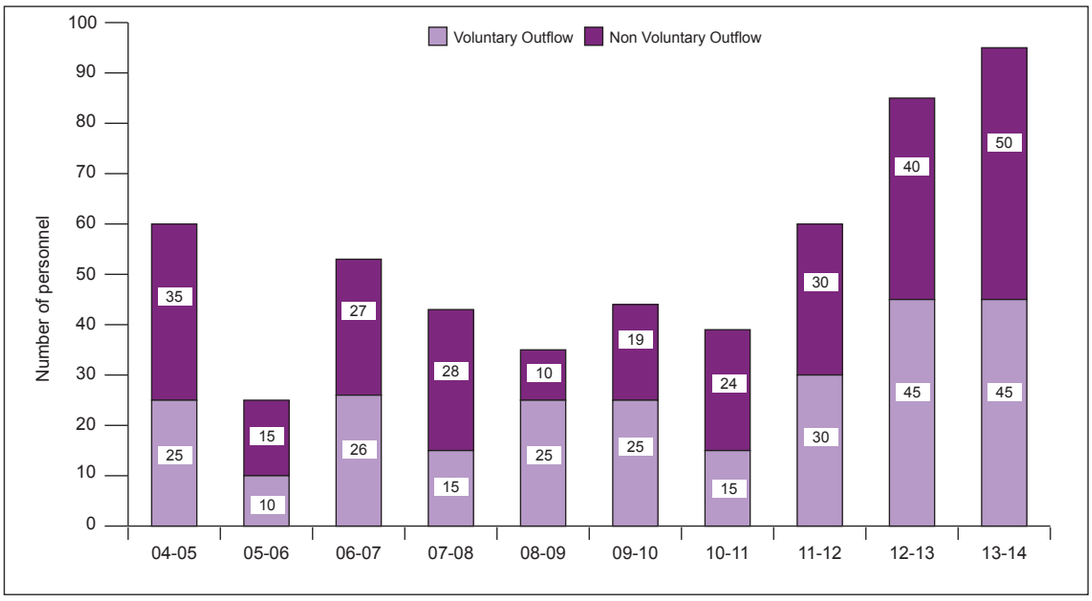
17. Unfortunately, MOD's evidence gave no consideration to how to improve both recruitment and retention of personnel from BAME backgrounds. While we were gathering evidence for our recommendations on the main remit group, the Chief of Defence Personnel told us of the efforts being made by the Armed Forces in engaging with members of BAME communities to build trust and improve understanding to try to encourage younger people from these communities to consider a career in the Armed Forces. MOD also needs to ensure that the culture within the Armed Forces is one that enables all Service personnel to feel comfortable in their working environment and fulfil their potential.

18. In our last Report, we suggested that exit interviews be held with each MODO who submitted their notice to terminate, so that DMS management could better understand the characteristics of those who were leaving to determine what actions could be taken to try to stem the outflow. We are pleased to note that, from October 2014, every MO submitting their notice will be interviewed by their single Service branch and a quarterly report sent to SG's headquarters.

19. Results from DMSCAS suggested that the top three retention factors for MODOs were: postings of choice; pay; and pensions. The new Armed Forces Pension Scheme (AFPS15), due to be implemented from 1 April 2015, had already caused concern among MODOs, some of whom perceived it to be a worsening of their terms and conditions. Satisfaction with pension arrangements has been generally reducing among MODOs in recent years, some of which may be due to the recent and future changes to the annual and lifetime tax allowances for all pension schemes. In our previous Reports 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. As AFPS15 does not include retention bonus payments, the change could result in some MODOs deciding to leave at key points, so MOD will need to monitor the situation, and take mitigating action if appropriate.

Chart 5: Medical Officer outflow 2004-05 to 2013-14



Morale and motivation

20. We were pleased to again receive a full set of DMSCAS data this year. This information helps our understanding of MODOs and the issues concerning them. MOD told us that MODOs were significantly more satisfied with their pay than the DMS overall. They felt that their pay compared well with other professionally qualified Service personnel and to

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counterparts in the NHS. MOD said that the bespoke MODO pay spine was a source of satisfaction which aided retention and should continue under any new pay system. The results relating to career prospects and support were much less positive, with MODOs being less satisfied with career-related indicators than in the previous year. Views we heard while on our visits supported the findings that MODOs were not satisfied with their career management. We also heard that many MODOs did not feel part of the military family.

21. During oral evidence, BMA and BDA told us that MOs, and DOs in particular, were feeling very vulnerable with another Strategic Defence and Security Review due after the election of May 2015, and rumours that there would be further reductions to staffing numbers. BMA and BDA stated that MODOs needed to feel valued, and a pay rise equivalent to the rest of the Armed Forces would go some way towards meeting that need. SG was confident that personnel could see an end to the gapping and that the recruitment processes had improved. He did not concur with the message we received on visits that some DMS personnel did not feel a sense of belonging to the wider military.

Operational commitments

22. The 2014 DMSCAS reported that 68 per cent of MOs and 43 per cent of DOs had deployed at least once in the previous five years and that the majority of MODOs were satisfied with their deployment intervals. MOD stated that the defence transition to a contingency stance will bring major challenges to the delivery of healthcare. DMS will need to continue to provide healthcare for those suffering injury and illness from operations and training as well as providing care across the UK estate and be ready to deploy on operations. BMA told us that the shortfall in GMPs meant some deployed on back-to-back tours, increasing their workload and making it more difficult to undertake training. It could also impact on the healthcare of personnel, although there is no evidence of this so far.

DMS Reserves

23. There was a 68 per cent shortfall in the number of MO Reserves. While the DMS20 liability is lower, without a great deal of improvement the staffing level would still be insufficient (61 per cent shortfall against DMS20 liability as at 1 July 2014). MOD told us that a number of remunerative and non-remunerative measures were being implemented in an attempt to improve the situation. On the financial side, MODOs are included in the overall scheme to encourage ex-Regulars back into the Army and RAF Reserves, and DMS Reserves can receive a payment for recruiting another qualified doctor or dentist. Non-remunerative measures included consideration of reducing the training commitment, potential flexibility around the age requirement for DMS Reserve Consultants, and MOD funding training courses. In recent years, DMS has provided some of the best examples of Regular and Reserve integration, particularly on operations in Afghanistan. However, DMS Reserves are significantly understaffed and a perceived lack of opportunities to deploy, with the end of operations in Afghanistan, could reduce the attractiveness of the Reserve offer; the use, and development, of clinical skills in the field under testing conditions can encourage clinicians to join the DMS Reserve. MOD told us that roadshows for the recruitment of Reserves had become more targeted and appeared to have been successful. However, if recruitment targets are not met then it will lead to more pressure on existing DMS personnel.

24. In its written evidence, the BMA proposed that we commission an independent review into the future shape and feasibility of the medical Reserve as a matter of urgency. BMA said that the failure to recruit sufficient numbers of Reserves, coupled with staffing shortages in the Regular DMS cadres, could present a significant risk to Defence. We

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explained that, while it appeared to be worthwhile, it was not within our remit to undertake such a review, and that it would be better commissioned by SG. BMA had suggested the review to SG's office, and was awaiting a response.

25. While money was not the main motivator for staff to join the Reserves, BMA suggested that a change to the way the daily rate was calculated might encourage more to volunteer. For many experienced doctors, the daily rate as a Reservist is well below what they would earn in the NHS. BMA explained that Reserves were paid on a daily rate which was calculated by dividing the MODO salary by 365 days. BMA argued that, as most Regular MODOs worked an average of 220 days a year, a fairer way of calculating the daily rate would be to divide the annual salary by 220. This would lead to a higher rate of pay for Reserves but should not cost a great deal, as most Reserves work an average of 19 days a year. We consider this to be a sensible suggestion and urge MOD to investigate it further.

Government's approach to public sector pay and affordability

26. The Government's evidence on the general economic context, submitted for our Report on the main remit group, stated that the economy grew by 0.8 per cent in each quarter of 2014, and was forecast to be 2.7 per cent higher overall over the previous year (later official data stated that economic growth was 0.7 per cent in the third quarter of 2014 and it was 2.6 per cent higher than in the same quarter a year earlier). The UK economy was said to be on the path of recovery with growth since the second quarter of 2013. Employment had increased markedly over the last year and unemployment continued to fall. Inflation remained low, with average earnings growth remaining weak. The Government considered that its policy of public sector pay restraint had been a key part of the fiscal consolidation so far, although the deficit and debt remained at unsustainable levels. The evidence again referred to the announcement in the 2013 Budget that Government policy was that public sector pay awards in 2015-16 would be "limited to an average of up to one per cent".

27. MOD stated that all the proposed measures on which it had submitted evidence were affordable within defence spending. The letter we received from the Chief Secretary to the Treasury stated that the case for continued pay restraint across the public sector remained strong. It said that pay awards should be applied to the basic salary based on the normal interpretation of basic salary in each workforce.

DDRB recommendations for 1 April 2015[2]

28. For 2015-16, DDRB was asked to make recommendations for all of the remit groups for Scotland but only for independent contractor GMPs and GDPs for England, Wales and Northern Ireland. The DDRB's recommendations were made against the background of the continued policy of public sector pay restraint. 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:

    - an increase in pay, net of expenses, of one per cent for independent contractor GMPs and GDPs for all countries of the United Kingdom; and
    - an increase in basic pay of one per cent to the national salary scales for salaried doctors and dentists in Scotland.

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2 *Review Body on Doctors' and Dentists' Remuneration, Forty-Third Report,* March 2015.

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29. DDRB will make recommendations on the proposed changes to junior doctors' contracts and will make observations on the proposed changes to the consultants' contracts in a further report to the Government in July 2015.

BMA and BDA evidence on the real value of MO and DO pay

30. BMA did not provide any information on pay comparability between Armed Forces MOs and their NHS counterparts in its evidence to us this year. BMA said it would be inappropriate to do so before the DDRB Report, which should contain recommendations on a new pay system proposal for junior doctors and observations on proposed revised consultants' contracts, is published. BDA again provided evidence on pay comparability using the NHS providing-performer dentist this year. BDA is aware that AFPRB does not consider this to be an appropriate comparator as DOs do not carry a comparable business risk.

Pay comparability

31. Our terms of reference require us to "have regard for the need for the pay of the Armed Forces to be broadly comparable with pay levels in civilian life". DMS staff, unlike most other Service personnel, have close comparators in the NHS. As for last year, MOD, BMA and BDA provided little detailed comparability evidence. However, this is unsurprising given devolved pay and recent developments regarding NHS pay and conditions. As for 2014, the main pay analyses by cadre that follow have been produced by our secretariat.

Summary of pay comparisons by DMS group

32. Our comparisons examine levels of DMS and NHS pay (at 1 April 2014 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;[3] 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[4]

33. Average DMS pay in 2014-15 was £112,779.[5] 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.[6]
- 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 per consultant a week, which is consistent with earlier measurements for PAs worked.[7] 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.

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

[4] Unless stated otherwise the data have been adjusted as set out in paragraph 32.

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

[6] 10 PAs is 40 hours of work per week and deemed a full-time post.

[7] 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

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- On-Call Availability Supplement – average DMS commitments according to last available data[8] were 1 in 7, considered a medium frequency rota in the NHS and attracting a five 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.
- Employer-based (local) CEAs[9] – 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 obliged to award 0.2 (previously 0.35 until 2011)[10] 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, any changes will wait until the future of CEAs in the NHS has been agreed.

34. 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. Pay scales for NHS consultants did not increase on 1 April 2014 following the Government's rejection of the DDRB recommendations, therefore the NHS data in the table are the same as last year.

Table 1: Consultant 2013-14 pay comparisons

Comparator	Average Income	Adjusted Average Income[a]	Lead/Deficit of DMS[b]
	£	£	%
DMS	117,145	**112,779**	–
NHS			
11 PAs	100,660	99,928	12.9
11 PAs + 5% On Call	105,236	104,504	7.9
11 PAs + 5% On Call + CEA	117,405	116,673	-3.3

[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[11]

35. Based on 2014-15 salary scales, the annual average DMS salary across a career is £109,389. However, the latest available NHS GMP pay information is for 2012-13. Therefore, DMS pay data from the same year were used when making the comparisons. Average DMS salaries for 2012-13 were £107,233 when adjusted, the same as in 2010-11 as a result of the pay freeze. In July 2014, there were 295 DMS GMPs.

8 MOD 2008 MODO Paper of Evidence.

9 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.

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

11 Unless stated otherwise the data have been adjusted as set out in paragraph 32.

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36. The total population of independent contractor NHS GMPs is all General and Personal Medical Services (GPMS) GMPs.[12] Average net profit for this group was £102,000, 1.0 per cent lower than 2011-12.[13] This equates to a lead of around 5.1 per cent for average pay for DMS GMPs with NHS GMPs or around 8.6 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 2012-13 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	3,350	111,000	109,000	-3.4	-1.6
	Non-dispensing	18,050	94,800	92,800	13.1	15.6
	All	**21,400**	**97,300**	**94,900**	**10.2**	**13.0**
PMS[c]	Dispensing	1,550	121,300	118,500	-11.6	-9.5
	Non-dispensing	9,900	109,500	106,400	-1.8	0.8
	All	**11,450**	**110,800**	**107,500**	**-3.2**	**-0.2**
GPMS[d]	Dispensing	4,900	114,300	111,100	-6.2	-3.5
	Non-dispensing	27,900	99,900	96,700	7.3	10.9
	All	**32,850**	**102,000**	**98,700**	**5.1**	**8.6**
GPMS	Salaried GPs	8,200	56,400	53,500	90.1	100.4

[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[14]

37. DMS GDP average adjusted salary across a career based on 2014-15 pay scales is £109,389. However, again the latest available NHS pay data are from 2012-13. Therefore DMS comparisons use 2012-13 data. Average adjusted DMS salary for 2012-13 was £107,233 (as for GMPs). In July 2014, there were 205 DMS GDPs.

38. The latest 2012-13 HM Revenue and Customs earnings data[15] include NHS and mixed NHS/private practice dentists, but exclude dentists who derived their income wholly from private practice. Income is split by classification[16] and contract type and illustrates the range of average earnings available in the civilian sector. Average net profits in 2012-13 were 2.4 per cent lower than those in 2011-12. Table 3 shows DMS GDP pay against a

[12] 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.

[13] 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.

[14] Unless stated otherwise the data have been adjusted as set out in paragraph 32.

[15] Dental Earnings and Expenses, England and Wales, 2012-13 produced by the NHS Information Centre for health and social care.

[16] 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.

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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 2012-13 Average earnings (England & Wales)

Dental type	Contract	Population	Average Salary/ Net profit £	Change 11-12 to 12-13 %	Lead/Deficit of DMS[a] %
DMS		–	**107,233**	–	–
Providing-performer	GDS	4,000	104,000	-0.7	3.1
	PDS	400	185,300	11.8	-42.1
	Mixed GDS/PDS	350	148,200	15.5	-27.6
	All	**4,750**	**114,100**	**1.2**	**-6.0**
Performer only	GDS	13,850	59,800	-2.0	79.3
	PDS	1,300	72,600	3.3	47.7
	Mixed GDS/PDS	1,600	60,400	-0.5	77.5
	All	**16,800**	**60,800**	**-1.6**	**76.4**
All dentists	GDS	17,850	69,700	-3.1	53.8
	PDS	1,700	99,200	3.2	8.1
	Mixed GDS/PDS	1,950	75,800	1.7	41.5
	All	**21,500**	**72,600**	**-2.4**	**47.7**

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

39. In its evidence, the BDA emphasised the decline in DOs' pay in real terms. It stated that DOs received a 2.5 per cent increase in pay over the previous five years against the CPI that rose by 14.5 per cent over the same period. The BDA uses the NHS providing-performer dentist for pay comparability purposes. It said that DOs' pay fell behind their civilian counterparts by between £8,700 and £21,662. We do not consider this an appropriate comparator as DMS DOs do not carry a comparable business risk.

Junior Doctors in Training

40. Junior doctors' base pay is supplemented in most cases by an out-of-hours band multiplier[17] 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[18] 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.

[17] 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.

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

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41. 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.

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)	40,748	F1	31,299
25	OF 2 (1) Non-Acc	53,829	F2	38,821
26	OF 2 (2) Non-Acc	55,349	ST 1 min	41,484
27	OF 2 (3) Non-Acc	56,877	ST 2	44,022
28	OF 2 (4) Non-Acc	58,418	ST 3	47,568
29	OF 2 (5) Non-Acc	59,950	ST 4	49,711
30	Non-Acc MO Level 1	64,749	ST 5	52,379
31	Non-Acc MO Level 2	68,530	ST 6	54,884
32	Non-Acc MO Level 3	72,334	ST 7	57,471
33	Non-Acc MO Level 4	73,470	ST 8	60,056
34	Non-Acc MO Level 5	74,607	ST 9	62,642
35	Consultant Level 5 (Entry)[c]	83,624	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).

[c] A different pension adjustment is used for Consultants to Doctors in training.

MOD, BMA and BDA pay proposals for 2015-16

42. MOD proposed that there should be an increase in basic pay for MODOs in line with the main Armed Forces pay award. It also proposed the same award for GMPs and GDP Trainer Pay and Associate Trainer Pay, the retention (and some expansion) of the 'Golden Hello' scheme for certain MOs and that CEAs be held at existing rates until the future of the NHS scheme is made clear.

43. In written evidence the BMA and BDA both proposed a pay award above the rate of inflation but did not state what that rate should be. They argued that an above inflation rate award would help to counteract the decline in pay in real terms that MODOs have experienced over the last few years. It would also reward the high level of service MODOs have continued to provide despite the decline in real income, the low levels of morale and increased uncertainty caused by the restructuring under DMS20. They said their members should receive at least the same award as the rest of the Armed Forces. In oral evidence the BDA conceded that there were no grounds at the current time to justify an award above that of the rest of the Armed Forces. The BDA accepted that the Government's continuing policy of public sector pay restraint would not allow any significant change in pay and that it was important to maintain pay parity between Armed Forces MOs and DOs.

Clinical Excellence Awards

44. 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. The proposals then became part of the renegotiation of the consultant contracts. However, discussions between the parties (Government and the unions) collapsed in October 2014. Consequently, DDRB was given a remit to make observations on contractual changes for consultants and this CEA review will be part of that. Once DDRB has made its observations, pay comparability between the NHS and MODOs will need to be reconsidered overall, and in respect of CEAs in particular.

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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 2015-16

Overall pay recommendations

45. Our pay recommendations aim to help MOD to recruit, retain and motivate sufficient capable personnel, and to ensure the maintenance of broad comparability with NHS counterparts. We take account of the economic conditions, the Government's evidence on public sector pay and evidence on the particular circumstances of Service Medical and Dental Officers.

46. When reviewing pay for MODOs, we consider information on pay comparability with the NHS, and we believe our recommendations will maintain broad comparability on pay. We also take into account our recommendations for the main remit group, and the recommendations on NHS doctors' and dentists' pay by DDRB. Following the Government's rejection of DDRB's recommendation last year, for 2015-16 DDRB was asked to make recommendations for all of the remit groups for Scotland but only for independent contractor GMPs and GDPs for England, Wales and Northern Ireland. DDRB will make recommendations on the proposed changes to junior doctors' contracts and observations on proposed changes to the consultants' contracts in July 2015.

47. There was a mixed picture on the staffing situation for MODOs. There was a deficit in trained MOs of 16 per cent against requirement compared with 20 per cent a year earlier. While there was an increase in the number of MOs, most of the improvement was due to a reduction in liability. Voluntary outflow remained at the same high level as last year, but overall outflow increased. The level of outflow is regarded as unsustainable and is a cause for significant concern. For DOs staffing was at 92 per cent of liability and MOD regarded the level of outflow as manageable as it moved towards the lower DMS20 liability.

48. The Government's evidence stated that it intended to continue with its policy of public sector pay restraint. The impact of changes in the move towards DMS20 structures and the transition to a contingency stance continued to be felt, leading to personnel feeling uncertain over their future.

49. MOD proposed an increase in basic pay for MODOs in line with our recommendation for the main Armed Forces pay award. The BMA and BDA both proposed an award above the rate of inflation, but did not state what that award should be. They also said that MODOs should receive at least the same award as the rest of the Armed Forces. Staffing data, our consideration of broad pay comparability between the NHS and DMS, including 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 overall, and maintain broad comparability with NHS doctors and dentists.

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Recommendation 1: We recommend the following changes from 1 April 2015:

- **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

50. MOD runs a 'Golden Hello' scheme which aims to encourage the recruitment of direct entrant accredited GMPs and consultants. It proposed to again hold the value of the payment at £50,000. Last year, we endorsed a proposal to expand eligibility of the scheme to all cadres with a DMS20 liability above 10 where the deficit was 15 per cent or higher. This year, MOD proposed to expand the scheme to *all* cadres where the projected staffing deficit in 2018 is 15 per cent or higher against the DMS20 requirement. Even though very few personnel take up the Golden Hello, MOD told us that it was worth retaining as it represented good value for money. We regard the proposal as sensible and therefore endorse it. MOD intends to re-examine the amount on offer following the outcome of negotiations on NHS consultants' pay.

Recommendation 2: We recommend the retention of the Medical Officer 'Golden Hello' scheme, and its expansion to include all cadres where the projected staffing deficit in 2018 is 15 per cent or higher.

Cost of our pay recommendations

51. We estimate that the cost of our pay recommendations for 2015-16 is £2.1 million (including the Employers' National Insurance Contribution and superannuation liabilities).

LOOKING AHEAD

52. Having already experienced a period of significant change, the Defence transition to a contingency stance will bring major challenges to the delivery of military healthcare. Service Medical and Dental Officers continue to operate under considerable uncertainty. A perceived worsening of the military offer, including pension changes, low satisfaction with career prospects and support, and potential changes to ways of working in the NHS could all impact on retention.

53. The recruitment of MODOs is undertaken by the single Services, so SG has an influencing rather than controlling role. SG told us that he was encouraged that recent roadshows for Reserve recruitment have become more targeted and successful. We believe there is more scope for better understanding of DMS needs by single Service recruiters. If recruitment is unsuccessful, there is an impact on the service provided and an increased burden on those delivering it. The demographics of those entering medical and dental school mean that work needs to continue to engage with members of BAME communities to build trust and improve understanding to increase the numbers who might consider a career in the DMS.

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54. Voluntary outflow of MOs remained high, and overall outflow was regarded as unsustainable. We were pleased to note that exit interviews are now being held with all MOs who submit their notice to terminate their service, and hope that MOD uses the information gathered to address the reasons behind MOs leaving prematurely. The BMA, the BDA and ourselves see the adoption of flexible and part-time working practices as fundamental to the sustainability of DMS. MOD needs to view DMS differently from the mainstream Armed Forces, and ensure that the single Services work together to recruit and retain sufficient skilled personnel. It is also important that MOD ensures that the culture within the Armed Forces is one that enables all Service personnel to feel comfortable in their working environment and fulfil their potential.

55. While the idea of introducing some form of part-time Regular working has been discounted by the NEM team as it would apparently require substantial changes to legislation, we (and the BMA and the BDA) believe there is sufficient scope within existing rules to introduce more intelligent ways of working flexibly. During oral evidence, BMA suggested the possibility of adopting a 'half-time' approach, whereby MOs would spend approximately half of their time working in the NHS, and the other half in DMS. We think MOD should investigate such an approach. Other measures such as easing the transition between Regular and Reserve Service (and vice-versa), and taking full advantage of the flexibilities that already exist should be explored further. MOD did tell us that it was looking at the viability of 'flexible duty commitment' with the Army. Adopting practices such as these appears to be essential in ensuring the long term future of DMS and would, we believe, go some way to improving the recruitment and retention of female MODOs in particular.

56. We also remain concerned over the potential impact on retention of serving MODOs of the new pension scheme. While AFPS15 is an excellent scheme, some MODOs may perceive it as a further worsening of their conditions. As it does not include retention bonus payments, the change could result in some MODOs deciding to leave at key points, so MOD will need to monitor the situation, and take mitigating action if appropriate.

57. 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 FR20 and DMS20 due to an ageing demographic, problems with recruiting, and the ending of operations in Afghanistan. BMA did not think that the targets could be reached and proposed that we commission an independent review into the future shape of the medical Reserve. We believe such a review would be worthwhile but, as this is outside our remit, we consider that SG's team would be better placed to take this forward.

58. The recruitment and retention of both Regular and Reserve MODOs over the next few years will be crucial to the sustainability of the DMS. Recruiting sufficient and capable Reserves appears to be a particular challenge. We look forward to receiving further details on how the future delivery of military healthcare will be assured.

John Steele	Ken Mayhew
Mary Carter	Judy McKnight
Tim Flesher	Vilma Patterson
Paul Kernaghan	Jon Westbrook

March 2015

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APPENDIX 1

1 April 2014 and 1 April 2015 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 2014	1 April 2015
Level 32	*134,217*	135,560
Level 31	*133,957*	135,297
Level 30	*133,701*	135,038
Level 29	*133,437*	134,771
Level 28	*133,181*	134,512
Level 27	*132,664*	133,991
Level 26	*132,148*	133,469
Level 25	*131,631*	132,947
Level 24	*130,378*	131,681
Level 23	*129,128*	130,419
Level 22	*126,549*	127,815
Level 21	*125,114*	126,365
Level 20	*123,683*	124,920
Level 19	*122,247*	123,470
Level 18	*120,821*	122,029
Level 17	*119,011*	120,201
Level 16	*117,210*	118,382
Level 15	*115,616*	116,772
Level 14	*114,018*	115,158
Level 13	*112,428*	113,553
Level 12	*110,835*	111,943
Level 11	*107,331*	108,405
Level 10	*103,836*	104,874
Level 9	*100,341*	101,344
Level 8	*97,237*	98,209
Level 7	*94,125*	95,066
Level 6	*91,009*	91,919
Level 5	*88,089*	88,970
Level 4	*86,955*	87,824
Level 3	*85,796*	86,654
Level 2	*81,957*	82,777
Level 1	*78,158*	78,940

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

Increment level	Military salary £	
	1 April 2014	1 April 2015
Level 35	*125,226*	126,479
Level 34	*124,834*	126,083
Level 33	*124,535*	125,780
Level 32	*124,047*	125,287
Level 31	*123,655*	124,891
Level 30	*123,258*	124,491
Level 29	*122,955*	124,184
Level 28	*122,470*	123,695
Level 27	*122,070*	123,291
Level 26	*121,678*	122,895
Level 25	*121,278*	122,491
Level 24	*120,886*	122,095
Level 23	*120,486*	121,691
Level 22	*118,644*	119,831
Level 21	*118,182*	119,364
Level 20	*117,632*	118,809
Level 19	*117,059*	118,230
Level 18	*116,492*	117,657
Level 17	*115,919*	117,078
Level 16	*115,351*	116,505
Level 15	*114,845*	115,993
Level 14	*112,737*	113,864
Level 13	*112,234*	113,357
Level 12	*111,732*	112,849
Level 11	*111,152*	112,264
Level 10	*110,576*	111,682
Level 9	*109,997*	111,097
Level 8	*107,881*	108,960
Level 7	*107,306*	108,379
Level 6	*105,838*	106,897
Level 5	*104,363*	105,406
Level 4	*102,896*	103,925
Level 3	*101,420*	102,434
Level 2	*99,316*	100,310
Level 1	*98,627*	99,614

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

Increment level	Military salary £	
	1 April 2014	1 April 2015
Level 19	*90,193*	91,095
Level 18	*89,282*	90,174
Level 17	*88,370*	89,253
Level 16	*87,454*	88,328
Level 15	*86,639*	87,505
Level 14	*85,836*	86,694
Level 13	*85,025*	85,875
Level 12	*84,214*	85,056
Level 11	*83,407*	84,241
Level 10[a]	*82,600*	83,426
Level 9	*81,628*	82,444
Level 8	*79,990*	80,790
Level 7	*78,348*	79,131
Level 6	*77,182*	77,953
Level 5	*76,028*	76,788
Level 4	*74,870*	75,618
Level 3	*73,712*	74,449
Level 2	*69,835*	70,533
Level 1	*65,982*	66,641

[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 2014	1 April 2015
Level 5	*74,639*	75,386
Level 4	*73,125*	73,856
Level 3	*71,615*	72,331
Level 2	*70,097*	70,798
Level 1	*68,583*	69,269

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

Increment level	Military salary £	
	1 April 2014	1 April 2015
Level 5	*61,092*	61,702
Level 4	*59,530*	60,126
Level 3	*57,961*	58,540
Level 2	*56,403*	56,967
Level 1	*54,854*	55,403

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

	Military salary £	
	1 April 2014	1 April 2015
OF1	*41,524*	41,939

Table 1.7: Recommended annual salaries for Medical and Dental Cadets

Length of service	Military salary £	
	1 April 2014	1 April 2015
after 2 years	*19,293*	19,486
after 1 year	*17,409*	17,583
on appointment	*15,533*	15,689

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

Increment level	Military salary £	
	1 April 2014	1 April 2015
Level 7	*139,180*	140,572
Level 6	*138,017*	139,397
Level 5	*136,858*	138,227
Level 4	*135,687*	137,044
Level 3	*134,520*	135,865
Level 2	*133,365*	134,699
Level 1	*132,194*	133,516

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

Increment level	Military salary £	
	1 April 2014	1 April 2015
Level 15	*130,401*	131,705
Level 14	*129,670*	130,967
Level 13	*128,930*	130,219
Level 12	*128,193*	129,475
Level 11	*127,460*	128,734
Level 10	*126,722*	127,990
Level 9	*125,977*	127,237
Level 8	*125,244*	126,496
Level 7	*124,507*	125,752
Level 6	*123,403*	124,637
Level 5	*122,303*	123,526
Level 4	*121,191*	122,403
Level 3	*120,091*	121,292
Level 2	*118,992*	120,181
Level 1	*117,880*	119,059

DMS Trainer Pay

GMP and GDP Trainer Pay	£7,900
GMP Associate Trainer Pay	£3,952

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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