Armed Forces'
Pay Review Body

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Service Medical and Dental Officers

Supplement to the Forty-Sixth Report 2017

Chair: John Steele

Cm 9449

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

July 2017

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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]
Brendan Connor
Tim Flesher CB
Paul Kernaghan CBE QPM
Professor Ken Mayhew
Lesley Mercer
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

BAME	Black, Asian and Minority Ethnic
BDA	British Dental Association
BMA	British Medical Association
CEA	Clinical Excellence Award
CPI	Consumer Prices Index
DDRB	Review Body on Doctors' and Dentists' Remuneration
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
GDC	General Dental Council
GDP	General Dental Practitioner
GMP	General Medical Practitioner
GMS	General Medical Services
GP	General Practitioner
GPMS	General and Personal Medical Services
MIP	Medical Incremental Progression
MO	Medical Officer
MOD	Ministry of Defence
MODO	Medical and Dental Officers
NHS	National Health Service
PAs	Programmed Activities
PMS	Personal Medical Services
PBF	Professional Body Fees
PVR	Premature Voluntary Retirement
SDSR	Strategic Defence and Security Review
SG	Surgeon General
SQPs	Sustained Quality Payments
UK	United Kingdom
VO	Voluntary Outflow

ARMED FORCES' PAY REVIEW BODY 2017 SERVICE MEDICAL AND DENTAL OFFICERS REPORT – SUMMARY

We recommend from 1 April 2017:

- **a one per cent increase in basic pay to all ranks within the Medical and Dental Officer (MODO) cadre;**
- **a one per cent increase in General Medical Practitioner (GMP) and General Dental Practitioner (GDP) Trainer Pay and Associate Trainer Pay; and**
- **a one per cent increase in the value of military Clinical Excellence Awards and legacy Distinction Awards.**

We also recommend that:

- **the Golden Hello scheme for regular MODOs is retained for GMPs and maintains the current eligibility for consultant cadres;**
- **Medical Incremental Progression becomes an automatic payment by no later than 1 April 2018; and**
- **a pay comparison exercise is carried out, in line with the proposal set out in paragraphs 40 to 42 of this report.**

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 situation 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 deliberations of the Review Body on Doctors' and Dentists' Remuneration (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 obtained during our visits programme, which included discussions with serving DMS personnel, both Regular and Reserve.

Workforce data

MOD provided staffing figures at 1 July 2016. The DMS20 requirement was for 879 trained MODOs: it had 589 trained MOs, a deficit of 19 per cent against the DMS20 requirement of 723 (compared to a deficit of 18 per cent in July 2015); and 179 trained DOs, 115 per cent of the DMS20 requirement of 156 (117 per cent in July 2015). In addition, there were 698 MOs in training. Specialties that remain significantly understaffed include emergency medicine, intensive care medicine, rheumatology and rehabilitation, general surgery and anaesthetics. MOD was unable to provide accurate overall outflow figures for MOs, but believed that voluntary outflow (VO) of MOs was close to 35 in 2015-16. Overall outflow of DOs in 2015-16 was around 15. For Reserves, at July 2016 there were 238 trained MOs against the FR20 requirement of 505, and 32 trained DOs against a requirement of 49. MOD acknowledged the continuing challenge of MODO Reserve recruitment.

Pay comparability

To allow MOD to continue to recruit, retain and motivate sufficient numbers of skilled staff, MODOs' pay should be broadly comparable with that in the NHS. Our analysis of pay comparability continues to support the view that MODO pay is at the very least broadly comparable with NHS staff, but with changes to contractual arrangements in the NHS, we think it appropriate to revisit the current assumptions on the relevant NHS comparators. Our report sets out a programme of work for future consideration of pay comparability of MODOs.

DDRB's main report for 2017-18 covers England, Wales and Northern Ireland: Scotland is to be considered in a supplement to the main report later in the year. The main recommendations in DDRB's report were for a base increase of one per cent to the national salary scales for salaried doctors and dentists; and an increase of one per cent in pay, net of expenses, for independent contractor GMPs and GDPs.

Recommendations

MOD proposed an increase in basic pay for MODOs in line with our recommendation for the main Armed Forces' pay award. During oral evidence, both the BMA and BDA argued for a pay award at least in line with inflation: anything below was seen as a 'pay cut'. Staffing data, our consideration of broad pay comparability between the NHS and DMS, including the recommendations made by DDRB, and the arguments for treating DMS staff in line with our main remit group, lead us to **recommend a one per cent across the board increase this year**. Although MOD proposed that GMP and GDP Trainer Pay and Associate Trainer Pay should be treated in line with the DDRB 2017 Report, we consider there to be a strong case for increasing their value in line with the main MODO pay award, in order to maintain the relativities between MODO base pay and its various additions to pay. Similarly, we recommend that MOD Clinical Excellence Awards (CEAs) and legacy Distinction Awards should be increased by one per cent, in line with our main recommendations for MODO base pay.

MOD is undertaking further work to assess the effectiveness of the Golden Hello scheme for MODOs. In the meantime, we are content to endorse its proposal that the Golden Hello scheme for regular MODOs is retained for GMPs and maintains the current eligibility for consultant cadres, and recommend accordingly. We recommend also that Medical Incremental Progression (MIP) becomes an automatic payment by no later than April 2018, although we are seeking assurances from MOD that the number of increments within the pay scale does not leave it open to any objections under age or gender discrimination.

Our report sets out the programme of work needed to take forward our consideration of pay comparability in future. This will be informed, in part, by changes to contractual arrangements in the NHS, but the parties will also need to make proposals on what the appropriate comparators are within the NHS. For GMPs and GDPs, we see strong arguments that an appropriate comparator is someone with a hybrid career, beginning as a salaried GMP/associate dentist, before becoming a practice partner/owner.

Looking ahead

We remain concerned about the scale and pace of changes being delivered through the various strands of the People Programme. There is a growing risk that the morale of our remit group will be impacted adversely, potentially damaging recruitment and retention. We consider the adoption of flexible and part-time working practices being considered as part of the People Programme as fundamental to the sustainability of DMS, particularly given that flexible working options are available to NHS staff, many of whom work alongside MODOs. 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 (BAME) communities to build trust and understanding to encourage greater numbers to consider a career in DMS. It is important that there is an inclusive culture in the Armed Forces so that individuals from all backgrounds

are able to reach their potential and remain for a full career. We noted in our main report that the current BAME targets do not distinguish between UK and non-UK BAME groups. We believe that this distinction is not sufficiently recognised by MOD in achieving a balanced and representative workforce.

DMS relies heavily on the use of Reserves, and we welcome the continuing close liaison between MOD and NHS Employers in respect of this group. Future working between the parties will need to take account of any NHS contractual changes. We support the BMA's proposal for a review into the feasibility of the future shape of the Medical Reserve, but as this is outside our remit, we suggest (as last year) that the Surgeon General's office and the BMA work together to initiate such a review. We have noted MOD's response to the BMA's proposal for a change in the way that the daily rate of pay is calculated for Reservists. Consideration of the daily rate of pay forms part of MOD's work on the Flexible Engagements System, and we ask MOD to keep us informed of any emerging developments. We also note that many employers in both the private and public sectors use a daily rate calculator based on actual annual working days excluding holidays and weekends.

Our report sets out the complicated picture regarding the potential reimbursement of professional body fees (PBFs) for Service personnel. We ask MOD to set out a consistent policy for how it will consider the reimbursement of PBFs and report back to us for our next review.

We stress again the importance of a more proactive and constructive dialogue between the BMA/BDA and DMS. We saw little evidence of this during oral evidence, and urge the parties to work together on issues of common interest and will be looking for progress when we take evidence prior to our next report.

DMS remains a valuable part of the overall Armed Forces both in the care it provides to the ongoing health of Service personnel and the wider support it provides during operational commitments. The Reserves' manning situation remains a significant concern and it is important that MOD assess the viability of DMS20 to ensure that the overall capability of DMS is appropriate and can support the future requirements of the UK Armed Forces effectively.

INTRODUCTION

1. This Report sets out the evidence we received and our recommendations for Medical and Dental Officers' (MODOs') pay from 1 April 2017. As context for our review, we noted the following: the UK economy continued to grow in 2016 but the economic picture at the end of the year was particularly uncertain following the outcome of the EU referendum; the Government continued with its policy of public sector pay restraint; and continuing change for Defence Medical Services (DMS) and the rest of the Armed Forces. 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 to basic pay for all MODOs in line with its proposal for the main Armed Forces' remit group. It also said that General Medical Practitioner (GMP) and General Dental Practitioner (GDP) Trainer Pay and Associate Trainer Pay and Clinical Excellence Awards (CEAs) should be treated in line with the 2017 Report by the Review Body on Doctors' and Dentists' Remuneration (DDRB). 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 deliberations of NHS doctors' and dentists' pay by the Review Body on Doctors' and Dentists' Remuneration (DDRB). Last year DDRB recommended a base increase of one per cent to the national salary scales for salaried doctors and dentists in the UK; and for both independent contractor GMPs and GDPs in the UK, an increase in pay, net of expenses, of one per cent. All the UK countries accepted those recommendations.

BACKGROUND

DMS developments

3. MOD told us that the Strategic Defence and Security Review 2015 (SDSR15) outlined the changing longer-term context for Defence. It highlighted the range of complex and diverse risks and threats facing the UK, and the adaptable, versatile and agile capabilities required in response: this included medical and dental provision to ensure the UK Armed Forces are fit to fight and appropriately supported. It was right to strike a balance between Defence's requirement to provide a more cost effective and efficient medical capability with tolerable risk and the political and Service expectations for the best care, noting the Surgeon General's declared ambition to deliver "world class" provision.

4. The evidence we received also reported some of the findings from the 2016 DMS Continuous Attitude Survey (DMSCAS). The response rate to the survey from our remit groups was 44 per cent for Medical Officers (MOs), and 73 per cent for Dental Officers (DOs). It indicated that morale within the MO cadres had increased with 62 per cent stating that morale was good where they worked, a significant increase of 21 percentage points from the 2015 DMSCAS; the equivalent result for DOs in 2016 was 59 per cent, up 23 percentage points from 2015. Motivation, however, remained a concern with 31 per cent of MOs and 25 per cent of DOs being dissatisfied with work-life balance. Nevertheless, DMSCAS showed that MODOs were satisfied with their level of pay, with 75 per cent of MOs and 71 per cent of DOs indicating that when compared to pay within the NHS, they felt their pay was reasonable.

5. MOD identified five strategic initiatives that would affect staff in the DMS:

    - DMS Change Programme – established to look at options for enhancement and efficiency identified within the SDSR15, including: the generation of a medical Defence Engagement capability; civilianisation of 39 "firm base" MO posts;

further civilianisation of DO posts; and the transfer of Regular liability for all Otorhinolaryngology and Ophthalmology consultant posts to the Reserves.

- Deployed Operational Capability Report – an independent assessment of the DMS to measure how medical support is delivered within the Armed Forces. It will include: consideration of the consultant employment model and how military consultants are placed within the NHS; further developing DMS's ability to deploy and integrate with allies and partners; and the retention of female personnel.
- Defence National Rehabilitation Centre (DNRC) – a new centre near Loughborough, closer to DMS headquarters than current facilities. The DNRC is due to open in 2018 and will aim to deliver improved rehabilitation services compared with those currently provided at Headley Court in Surrey. MOD noted that some concerns remain over the staffing of certain specialties due to the relocation of this facility.
- Future Reserves 2020 (FR20) – DMS engaged with NHS Employers to standardise HR policies on the employment and use of Reserves. Coherent tri-Service marketing material was produced, and improvements made to training arrangements.
- Future FR20 Work Strands – DMS Communications and Marketing Working Group meets regularly to review what additional resources would be helpful to the managers of Reserves in NHS trusts.

NHS developments

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

- Last year all countries in the UK accepted DDRB's recommendations for a base increase of one per cent to the national pay scales for salaried doctors and dentists and a one per cent increase in pay, net of expenses, for independent contractor GMPs and GDPs for 2016-17.
- It continues to be a period of change and challenge for the NHS across the UK. New and innovative approaches will be required to meet the needs of an increasing and ageing population, within the context of continuing Government financial restraint. Sustainability and Transformation Plans are being drawn up which seek to better integrate primary and secondary care, and shift the focus from hospital to community-based care.
- On 6 July 2016 the Secretary of State for Health announced that, despite having been rejected at ballot, the new junior doctors' contract would be introduced in England, in a phased rollout with new terms starting to apply from October 2016 (for new appointments and, when contracts of employment expire, as juniors move through training).
- Negotiations on changes to consultants' contracts in England and Northern Ireland were continuing at the time of finalising this report.
- Pilot schemes are underway in England and Wales for new contractual arrangements for dentists to be paid on a per capita basis.
- In its 2017 Report, DDRB stated that problems remained with recruiting doctors into some specialities, such as emergency medicine, psychiatry, and general practice, and also into some locations. DDRB noted the "stubbornness" of recruitment issues and that non-pay solutions had been ineffective, adding that pay-related options should also be considered.
- The BMA and the BDA both cited low levels of morale affecting their members mainly due to workload pressures. The BMA said that the junior doctors' industrial action in England also had a negative impact on morale but that the annual pay award was seen as an important signal of the remit groups' value.

Our 2017 Report

7. At the start of this round, we confirmed that 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, adhering to our terms of reference when considering our recommendations. We have continued to keep in mind the particular risks to retention as changes under DMS20 are implemented and wider changes to Defence take effect. We have also kept abreast of developments in the NHS on the direct comparator groups, as these could have a significant knock-on effect on the recruitment and retention of MODOs.

OUR EVIDENCE BASE

8. 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 DDRB recommendations on NHS doctors' and dentists' pay;
    - MOD's written evidence on MODOs, covering staffing, recruitment, retention and DMSCAS;
    - written evidence from the BMA and the BDA;
    - oral evidence from the acting Surgeon General (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 Regular and Reserve MODOs on our visits during 2016, in the UK and abroad.

9. Our visits enable us to meet MODOs and hear their views, on issues specific to the DMS and on those applying more widely across the Armed Forces. As ever, we are grateful to those who participated in our visits and appreciate the work of MOD and the Services in arranging them. In 2016 we visited the Tactical Medical Wing, RAF Brize Norton and 243 Field Hospital, Bristol. We also met DMS Regular and Reserve personnel as part of our visits to other establishments in the UK and abroad. A full list of AFPRB visits can be found in our 2017 Report for the main remit group at Appendix 4.[1] Several issues were raised by MODOs including: workload, short notice of deployments, the long distances involved in travelling to Medical Reserve Units, and the pay of Reserves compared to Regulars.

Staffing

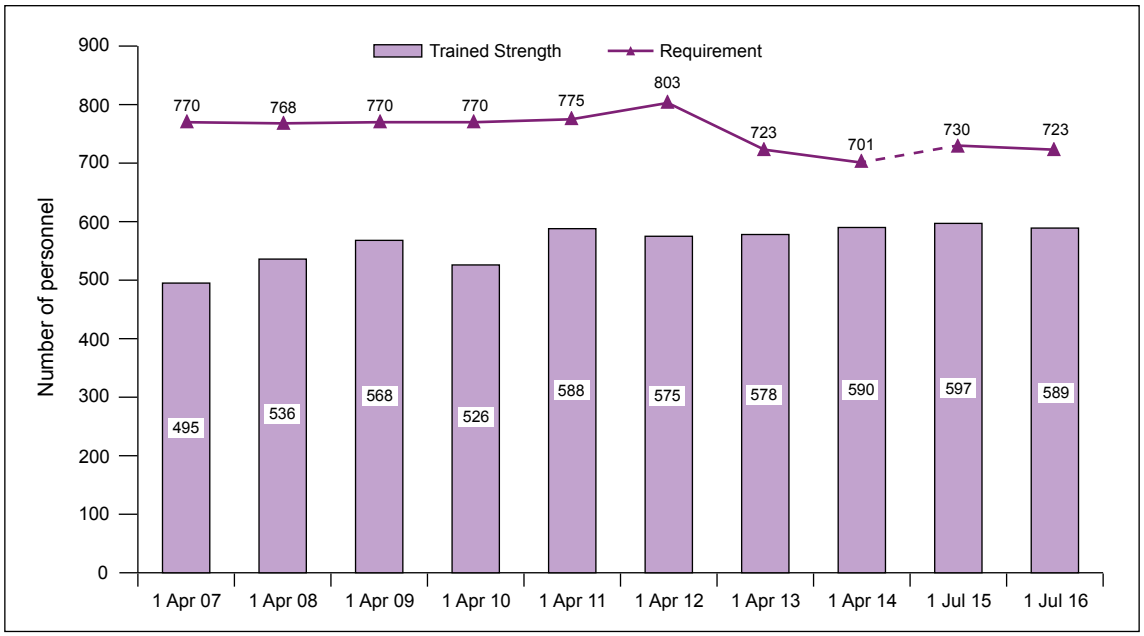
10. The DMS20 requirement was for 879 trained MODOs at 1 July 2016. The charts below show the changes in the requirements and staffing levels of MOs and DOs over the last decade. At 1 July 2016 there were:

    - 589 trained MOs, a deficit of 19 per cent against the DMS20 requirement of 723. This is a decrease of eight trained MOs from 1 July 2015.
    - Of this 723, there was a DMS20 requirement of 328 GMPs but the current trained strength was 285, a shortfall of 13 per cent. Consultants made up the remaining requirement of 395 MOs, but the current trained strength was 304, a shortfall of 23 per cent.

[1] *Armed Forces' Pay Review Body, Forty-Sixth Report 2017.*

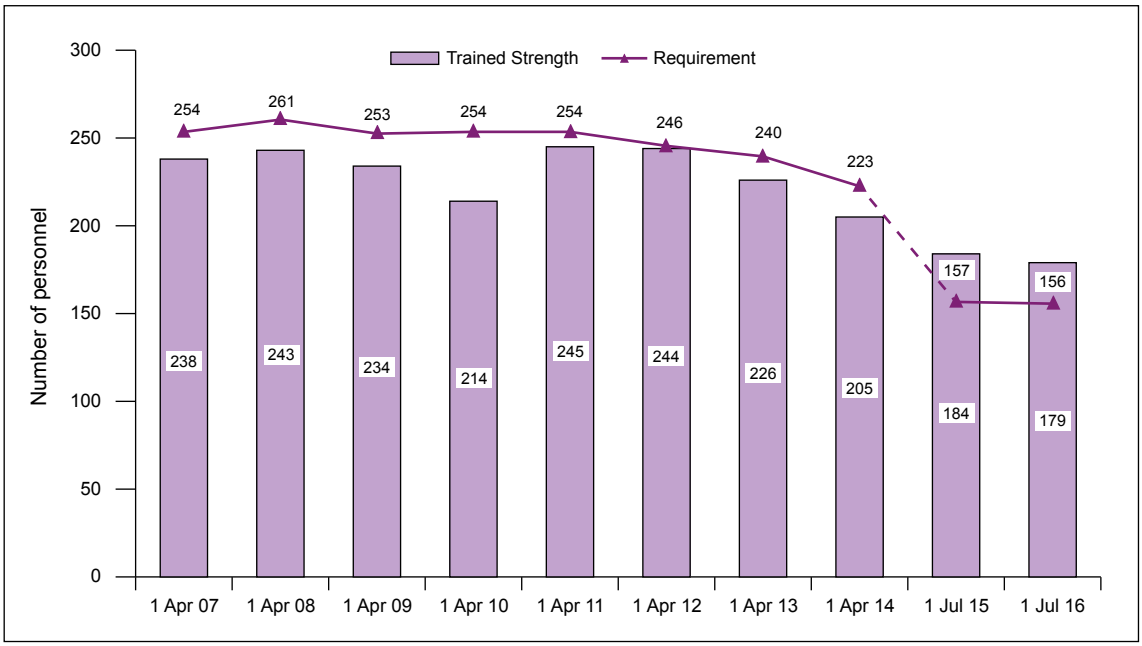
- 698 MOs in training, including:
  - 132 General Duties Medical Officers;
  - 332 MOs undertaking Core or Higher Specialist Training;
  - 103 Foundation Year MOs; and
  - 131 Medical Bursars enrolled as undergraduate medical students.
- 179 trained DOs, 115 per cent of the DMS 20 requirement of 156.

Chart 1: Strength and deficit/surplus of Medical Officers 2007 – 2016[a]



[a] The requirement for 2015 onwards relates to DMS20, for previous years it is the requirement for that particular year.

Chart 2: Strength and deficit/surplus of Dental Officers 2007 – 2016[a]

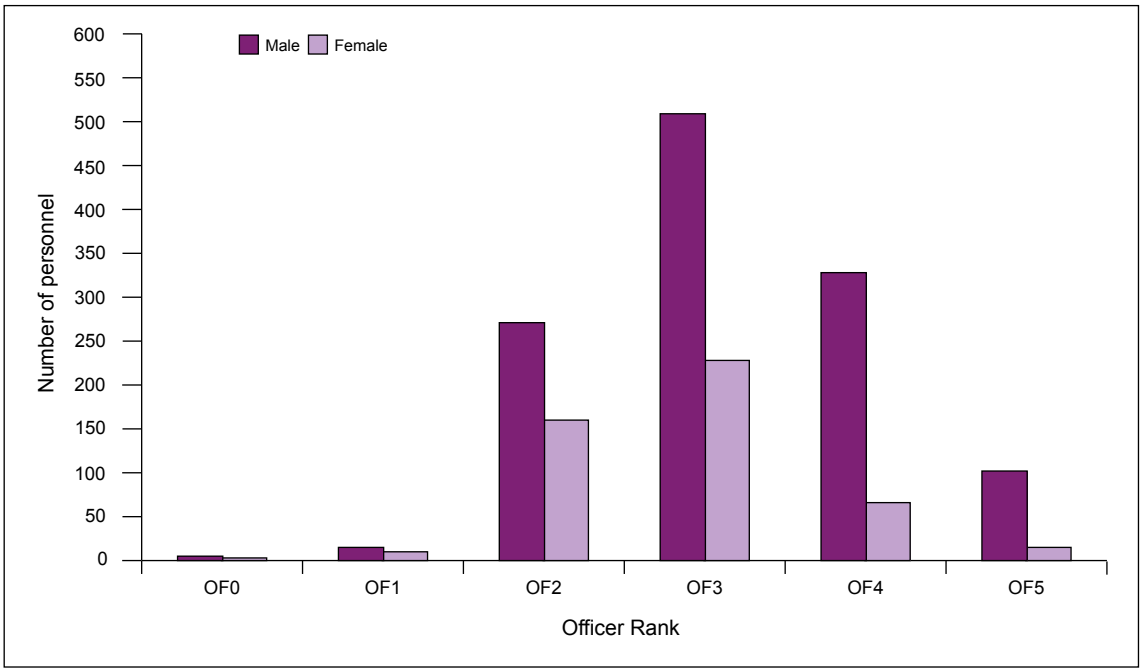


[a] The requirement for 2015 onwards relates to DMS20, for previous years it is the requirement for that particular year.

11. MOD provided evidence on the age, gender and rank profiles of MODOs at 1 April 2016. The proportion of women was 35 per cent, an increase from 32 per cent in 2015. Gender balance varies considerably with rank (and therefore, to some extent, with age) as shown in Chart 3. Currently, around half of students entering UK medical schools are female.

12. MOD again provided us with information on the ethnic breakdown of MODOs. It said that 90 per cent of MOs and 94 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, it does not reflect the patterns of those studying medicine and dentistry, nor those of society at large. The ability to attract and retain female recruits and personnel from BAME backgrounds is particularly important for DMS. **We noted in our main report that the current BAME targets do not distinguish between UK and non-UK BAME groups. We continue to believe that this distinction is not sufficiently recognised by MOD in achieving a balanced and representative workforce.**

Chart 3: MODO gender distribution by rank – 1 April 2016

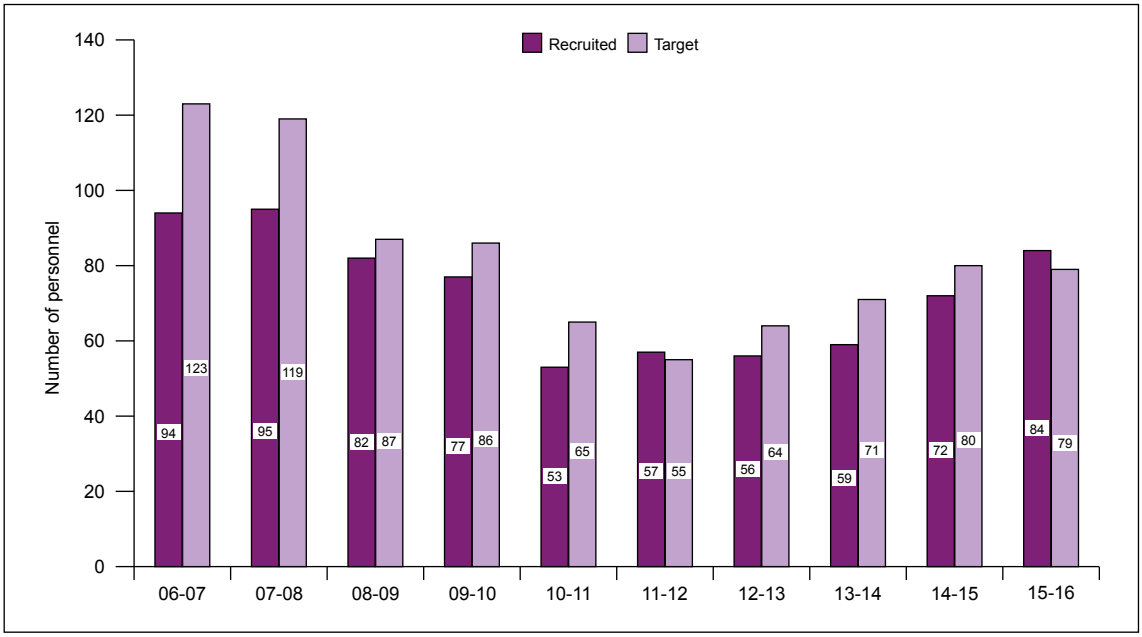


Recruitment

13. The recruitment of MO Bursars/Cadets was almost on target in the twelve months to 31 March 2016 (71 against 74), whilst that for direct entrants was exceeded (recruiting 13 against a target of 5). Trends in overall MO recruitment are shown in Chart 4. Over the last ten years, the overall target has only been reached twice. This consistent shortfall in recruiting will have a detrimental, cumulative impact on DMS. DO recruitment in the year to March 2016 remained similar to previous years (a total of 10[2] compared with 11 for the year to March 2015).

[2] These ten include five Bursars.

Chart 4: Medical Officer recruitment 2006-07 to 2015-16



Retention

14. The MOD was unable to provide us with accurate overall outflow figures for MOs, but said it believed that voluntary outflow (VO) of MOs was close to 35 in 2015-16, and broadly the same as in 2014-15. Overall outflow of DOs in 2015-16 was around 15 (30 in 2014-15). The BDA said there had been a spike in Premature Voluntary Retirements (PVRs) of DOs: it said that it was concerned that a tipping point may have been reached where more stress and pressure, loss of career prospects, reducing support and the general perception of a degradation of the quality of Service life could lead to damaging levels of attrition.

15. MOD said that work-life balance had been a reason stated consistently by MODOs leaving voluntarily. It noted the particular pressures on uniformed DOs following the civilianisation of certain dental posts, which reduced the capacity to flex uniformed dental teams across the base to meet business needs. MOD also noted the results of DMSCAS that showed that 43 per cent of respondents had indicated that they would serve for fewer than seven years, with an additional 20 per cent undecided. The main reasons given for leaving prior to the end of engagement cited by MODOs were: career progression, work-life balance/family commitments; and dissatisfaction due to the lack of opportunities for part-time working. In this regard, MOD described its Flexible Duties trial that allowed successful applicants to work Less Than Full Time, and said that early feedback from both individuals and those working around them had found the working trial to be a positive experience. As a result it was likely to be extended beyond the initial trial period and work was underway to broaden its scope to already accredited MODOs. We welcome this progress given its potential to improve recruitment and retention and look forward to future updates.

16. Another potential factor affecting retention highlighted by MOD was the recent changes to pensions. Changes to taxation arrangements such as the lifetime allowance, combined with the potential for large increases in taxable earnings (as they may be eligible to receive non-pensionable Clinical Excellence Awards that can increase their taxable earnings in particular years), could affect decisions to stay for a full career, in order to avoid a large tax charge. We agree with MOD that the Armed Forces Pension Scheme remains amongst the very best available. **As we note in our main report, we think MOD should do more to improve the communication of pension benefits – both**

absolute and relative to those available outside the Services – as part of the overall employment package. Properly communicated, this has the potential to provide significant retention benefits for relatively little cost.

17. Once again, MOD's evidence failed to provide proposals on how to improve recruitment and retention of personnel from BAME backgrounds. Whilst the statistics in the MODO cadres were better than the Armed Forces overall and there had been a small increase of one percentage point to ten per cent from last year, MODOs significantly lagged the BAME demographic profile in medical schools and the NHS. **We would welcome action by MOD to introduce specific initiatives to further improve diversity in the MODO workforce.**

Motivation and morale

18. The information we receive on the findings from the DMSCAS helps our understanding of MODOs and the issues concerning them. The results for 2016 indicated a significant improvement over the previous year, with 62 per cent of MOs stating that morale is good where they work, up 21 percentage points from 2015; the equivalent return for DOs in 2016 was 59 per cent, up 23 percentage points from 2015. MOD said that the reduction in operational deployments and the associated increased stability at home could have contributed to this greatly improved outcome. However, as MOD noted earlier, overall motivation remained a concern, with 31 per cent of MOs and 25 per cent of DOs dissatisfied with work-life balance; and only 35 per cent of MOs and 27 per cent of DOs confident that senior leadership will secure a positive future for the DMS.

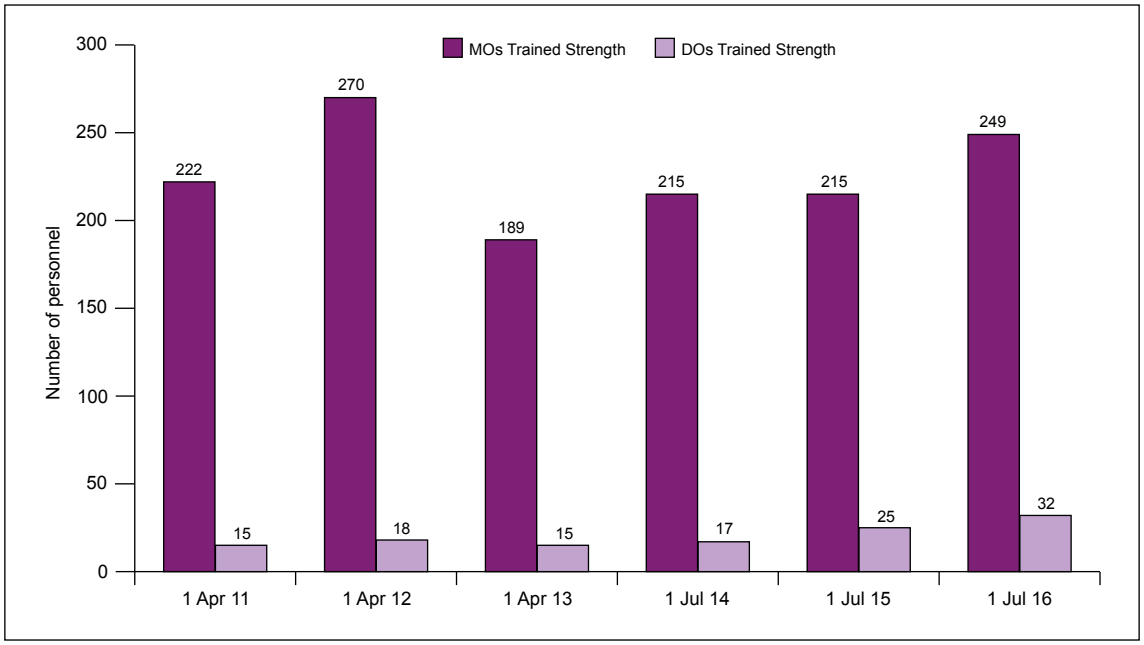
19. In last year's report, we set out our hope for a more constructive and productive dialogue between the Surgeon General's office and the BMA/BDA. During oral evidence, it was clear to us that much more remains to be done to improve the relationship between the parties, **so we again encourage them to work together on areas of common interest. We look forward to hearing of progress in our next round.**

DMS Reserves

20. FR20 set out a requirement for 554 trained MODOs. Chart 5 shows the trained strength of Reserves over the last six years. At July 2016 there were:

    - 249 trained Reserve MOs, a deficit of 50 per cent against the FR20 requirement of 501.
    - Of this 501, there was an FR20 requirement of 156 GMPs, but the current trained strength was 75, a significant shortfall of 52 per cent. Consultants made up the remaining requirement of 345 MOs, but the current trained strength was 174, a significant shortfall of 50 per cent.
    - 32 trained Reserve DOs, a deficit of 35 per cent against the FR20 requirement of 49.

Chart 5: Trained strength of Reserve Medical and Dental Officers, 2011 to 2016



21. MOD said that its staffing figures did not include 183 medical trainees who are not yet fully accredited GMPs or consultants, but it did confirm there were currently no trainee dentists within the Reserves. At the time of writing, MOD said it was preparing the case for a Recruitment Incentive for particular shortfall cadres: we remain open to consider such proposals, and will report any outcomes in due course. We noted earlier that MOD is working with NHS Employers to improve engagement with trusts regarding the employment and use of Reserves.

22. The BMA told us that it was planned that Reservists would make up around half of the total DMS20 requirement, and exclusively provide some specialties. Noting existing significant shortfalls, the BMA considered that there were fundamental recruitment problems across medical Reserves. It said that without improved incentives for existing NHS consultants and GMPs, there was little prospect of the medical workforce requirement being met. The BMA again requested that we commission an independent review of the feasibility of the Medical Reserve. We can only restate our view, that whilst we agree such a review is worthwhile, we consider it to be outside our remit and we believe that the BMA should work with SG's office to commission it.

23. In both our 2015 and 2016 Reports, we highlighted a proposal from the BMA regarding a change to the way the daily rate of pay was calculated for Reservists. While money was not the main motivator to join the Reserves, the BMA suggested that the change could encourage more to volunteer. Currently, Reserves are paid on a daily rate which is calculated by dividing the MODO salary by 365 days. The BMA argued that, as most Regular MODOs worked an average of 220 days a year, it would be more logical to calculate the daily rate by dividing the annual salary by this number. Although this would lead to a higher rate of pay for Reserves, the BMA considered that it should not cost MOD a great deal, as most Reserves work an average of 19 days a year. In response, MOD said that such a change could prove divisive with Regular MODOs and the remainder of the Reserves, as the existing pay cap could force a lower than one per cent award for other groups. It also noted that the proposal raised other issues, for example when a Reservist is mobilised or works on a full-time commitment. It concluded that due to the current complexities, a change in the Reserve daily rate of pay should not be considered at this time. However, MOD said that the daily rate of pay issue was also a consideration within the Flexible Engagements System, noting there was a need to

achieve congruence between Regulars "dialling down" their commitment, and Reservists who "dial up", to ensure that those working similar hours are paid broadly the same. We ask that MOD keeps us informed on any implications for a daily rate of pay as the Flexible Engagements System develops. We note that many employers in both the private and public sectors use a daily rate calculator based on the actual annual working days excluding holidays and weekends.

Government's approach to public sector pay and affordability

24. The Government's evidence on the general economic context, submitted in November 2016 for our 2017 Report on the main remit group, stated that following the outcome of the EU referendum, the UK economy was entering a new phase that would pose different challenges to the public finances. It said that public debt stood at its highest share of GDP since the late 1960s, and the deficit remained amongst the highest in advanced economies. The UK's economic performance was described as strong in recent years, with GDP having grown by 13.8 per cent since Q1 2010, and being 7.7 per cent bigger at Q2 2016 than at its pre-crisis peak. Inflation was close to zero throughout 2015, but in recent months had started to edge higher as past falls in fuel prices dropped out of the annual comparison. At 74.5 per cent, the employment rate was the highest on record, and unemployment had fallen to an 11 year low of 4.9 per cent. It said that earnings growth was fairly stable in the first half of 2016, and that in April to June 2016, total pay was up 2.4 per cent on the year in nominal terms and by 2.1 per cent in real terms. This marked the 21st successive month that average earnings had outstripped inflation, continuing the longest period of real wage growth since 2008. It said that, in the three months to June 2016, private sector total pay growth (including bonuses) stood at 2.5 per cent, while private sector regular pay growth (excluding bonuses) stood at 2.4 per cent. For the public sector, total pay growth (including bonuses) was 1.9 per cent in the three months to June 2016,with regular earnings (excluding bonuses) increasing by 1.7 per cent.

25. Our own analysis of the economy and recent forecasts noted that GDP grew by 0.6 per cent in the third quarter of 2016 and was expected to be close to 2 per cent in 2016 as a whole but to fall below 1.5 per cent in 2017. CPI inflation was at 1.6 per cent in December 2016, and forecast to increase to around 2.5 per cent by the end of 2017. Average earnings growth was stable at 2 – 2.5 per cent in 2016, with a pick-up to 2.8 per cent at the end of the year, and median private sector pay settlements were 2.0 per cent, with forecasts for 2017 at about the same level.

26. The Government said that its public sector pay policy would continue to play an important role in delivering its objective of reducing the deficit over an appropriate time frame, protecting jobs and maintaining public services. Following the 2015 Election, it announced that it would fund public sector workforces for pay awards of an average of one per cent for four years from 2016-17 to 2019-20.

27. The letter we received from the Chief Secretary to the Treasury (see Appendix 6 in our main 2017 Report) reaffirmed the Government's commitment to its public sector pay policy and said that it expected to see targeted pay awards in order to support the continued delivery of public services and to address recruitment and retention pressures, with no expectation that every worker would receive a one per cent pay award.

DDRB recommendations for 1 April 2017[3]

28. DDRB was asked to make recommendations for all of its remit groups for 2017-18. However, the Scottish Government was unable to provide evidence until after the Scottish draft budget and public sector pay policy had been published in November 2016. DDRB will therefore be considering Scotland separately with recommendations submitted in a supplement to the main Report later in the year. Recommendations in the main DDRB Report are therefore for England, Wales and Northern Ireland and they were made against the background of the continued policy of public sector pay restraint. While HM Treasury requested that pay awards were targeted to support the delivery of public services and to address recruitment and retention pressures, none of the parties submitted evidence to support targeting through national pay scales. DDRB concluded that it should not target its pay recommendations for 2017-18. However it recommended that better use be made of existing pay flexibilities and that the health departments, employers, workforce planners and deaneries in England, Wales, and Northern Ireland give serious consideration to developing a new mechanism for enabling targeted pay solutions, backed by extra national resources to address persistent, above average geographic and speciality shortages. In that context, DDRB made the following recommendations for England, Wales and Northern Ireland for 2017-18 which are relevant to DMS groups:

    - a base increase of one per cent to the national salary scales for salaried doctors and dentists;
    - an increase of one per cent to the minimum and maximum of the salary range for salaried GMPs;
    - an increase of one per cent in pay, net of expenses, for independent contractor GMPs and GDPs;
    - an increase of one per cent in consultants' Clinical Excellence Awards, Discretionary Points, Distinction Awards and Commitment Awards;
    - an increase of one per cent to the GMP trainers' grant; and
    - the rate for GMP appraisers to remain at £500.

Pay comparability

29. 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 many other Service personnel, have close comparators in the form of doctors and dentists in the NHS. In its evidence to us, the BMA replayed our own analysis of pay comparability from our 2016 Report. The BDA's evidence said that its preferred comparator for DO pay remained NHS provider-performers. As for 2016, the main pay analyses by cadre that follow have been produced by our secretariat.

Summary of pay comparisons by DMS group

30. Our comparisons examine levels of DMS and NHS pay (at 1 April 2016 where data were 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; 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.

[3] *Review Body on Doctors' and Dentists' Remuneration, Forty-Fifth Report*, March 2017.

Consultants[4]

31. Average DMS pay in 2016-17 was £115,045.[5] Pay within the NHS includes 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.
    - 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) of an award per eligible NHS consultant. There are two CEA comparators; the first one assumes that consultants receive on average one CEA every five years, the second assumes every three years.[10] 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.

32. 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 (3 yearly) is taken into account that NHS pay moves ahead. Pay scales for NHS consultants increased by 1 per cent from 1 April 2016.

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4 Unless stated otherwise the data have been adjusted as set out in paragraph 30.

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

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 previously stated in its evidence that a similar proportion of its staff are in receipt of a (national) CEA 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 will need to be kept under review but the current awarding pattern will fall somewhere between these two scenarios.

Table 1: Consultant 2016-17 pay comparisons

Comparator	Average Income £	Adjusted Average Income[a] £	Lead/Deficit of DMS[b] %
DMS	**119,499**	**115,045**	–
NHS			
11 PAs	101,667	100,927	14.0
11 PAs + 5% On Call	106,288	105,549	9.0
11 PAs + 5% On Call + CEA (5 yrly)[c]	112,605	111,865	2.8
11 PAs + 5% On Call + CEA (3 yrly)	118,577	117,837	-2.4

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

[b] Comparisons made with X-Factor and pension adjusted DMS average salary and adjusted NHS salaries. Percentage calculations are DMS adjusted average income minus NHS income divided by NHS income.

[c] If CEAs are awarded less frequently, then consultants will have fewer of them over the years – and consequently a smaller total value – than a frequency of every three years.

General Medical Practitioners[11]

33. Based on 2016-17 salary scales, the annual average DMS salary across a career is £111,587. However, the latest available NHS GMP pay information is for 2014-15. Therefore, DMS pay data from the same year were used when making the comparisons. Average DMS salaries for 2014-15 were £109,389 when adjusted. In July 2016, there were 285 DMS GMPs.

34. The total population of independent contractor NHS GMPs is all General and Personal Medical Services (GPMS) GMPs.[12] Average net profit in 2014-15 for this group was £101,500, 1.7 per cent higher than in 2013-14.[13] This equates to a lead of around 7.8 per cent for average pay for DMS GMPs with NHS GMPs or around 12.1 per cent when comparing median pay. Table 2 shows average DMS pay (adjusted for X-Factor and pensions)[14] against the range of NHS GMP comparators.

[11] Unless stated otherwise the data have been adjusted as set out in paragraph 30.

[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 2014/15* published by NHS Digital, September 2016.

[14] DMS salaries are calculated as an average over a career, whereas GPMS are averaged salaries for all doctors within a single year.

Table 2: GMP 2014-15 earnings (United Kingdom)

Comparator	Practice	Population	Average Income £	Median Income £	Lead/Deficit of DMS[a] %	
					Average Income	Median Income
DMS	–		**109,389**	–	–	–
GMS[b]	Dispensing[c]	4,700	113,400	110,000	-3.5	-0.6
	Non-dispensing	27,350	99,400	95,800	10.0	14.2
	All	**32,050**	**101,500**	**97,600**	**7.8**	**12.1**
GPMS	Salaried GPs	9,400	53,600	50,300	104.1	117.5

[a] Comparisons made with X-Factor and pension-adjusted DMS average GMP salary. Percentage calculations are DMS average income minus NHS income divided by NHS income.

[b] GMPs working under either a General Medical Services or Personal Medical Services contract.

[c] Non-dispensing partners of dispensing doctors are classified as dispensing doctors.

General Dental Practitioners[15]

35. DMS GDP average adjusted salary across a career based on 2016-17 pay scales is £111,587. However again the latest available NHS pay data are from 2014-15. Therefore DMS comparisons use 2014-15 data. Average adjusted DMS salary for 2014-15 was £109,389 (as for GMPs). In July 2016, there were 179 DMS GDPs.

36. The latest 2014-15 HM Revenue and Customs earnings data[16] include NHS and mixed NHS/private practice dentists, but exclude dentists who derived their income wholly from private practice. Income is split by classification[17] and contract type and illustrates the range of average earnings available in the civilian sector. Average net profits in 2014-15 were 1.7 per cent lower than those in 2013-14. Table 3 shows DMS GDP pay against a range of NHS dental comparators and highlights how DMS pay is ahead when compared against NHS all dentist and performer only dentists, but behind when providing-performers are chosen as the comparator group.

Table 3: GDP 2014-15 average earnings (England & Wales)

Dental type	Population	Average Salary/ Net profit £	Change 13-14 to 14-15 %	Lead/Deficit of DMS[a] %
DMS		**109,389**	–	
Providing-performer	3,950	117,400	1.9	-6.8
Performer only	17,400	59,900	-1.2	82.6
All dentists	**21,350**	**70,500**	**-1.7**	**55.2**

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

[15] Unless stated otherwise the data have been adjusted as set out in paragraph 30.

[16] Dental Earnings and Expenses 2014/15 (for England and Wales) published by NHS Digital in September 2016.

[17] 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.

37. The BDA emphasised the decline in DOs' pay in real terms and pointed to NHS providing-performer GDPs as the group it considered to be the appropriate comparator. Whilst it had concerns about recent changes to pensions, it still saw the pension as a reasonable package.

Junior Doctors in Training

38. A new contract is currently being introduced in England with the first junior doctors moved across in August 2016. The *NHS Employers* website comments that overall average earnings are expected to remain around the same (as the contract negotiations took place within the existing pay envelope) and notes that some junior doctors will have pay protection.[18] The effects of the new contract on earnings will start to emerge in datasets across the next year as more doctors move across. In the outgoing contract (for which current data apply) base pay was supplemented, in most cases, by an out-of-hours banding 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.

39. Pay levels for DMS trainees remain ahead of junior doctors in the NHS (on the consultant career pathway in receipt of an average banding supplement) at all points as shown in Table 4.

Table 4: Junior Doctors in Training 2016-17 pay comparisons

Age	DMS Scale	DMS Salary[a] £	NHS Scale	NHS Salary[b] £
24	OF 1 (1)	41,566	F1	31,611
25	OF 2 (1) Non-Acc	54,911	F2	39,209
26	OF 2 (2) Non-Acc	56,461	ST min	41,899
27	OF 2 (3) Non-Acc	58,021	ST 1	44,462
28	OF 2 (4) Non-Acc	59,592	ST 2	48,043
29	OF 2 (5) Non-Acc	61,154	ST 3	50,209
30	Non-Acc MO Level 1	66,050	ST 4	52,819
31	Non-Acc MO Level 2	69,906	ST 5	55,432
32	Non-Acc MO Level 3	73,788	ST 6	58,044
33	Non-Acc MO Level 4	74,947	ST 7	60,656
34	Non-Acc MO Level 5	76,106	ST 8	63,268
35	Consultant Level 5 (Entry)[c, d]	85,305	Consultant	76,001

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

[b] NHS salaries include an average out of hours banding multiplier of 1.43 (adjusted for non-pensionability).

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

[d] The base pay assumption in the NHS is that full-time Consultants undertake 10 PAs per week (40 hours of work).

[18] More information is available at: http://www.nhsemployers.org/your-workforce/need-to-know/junior-doctors-2016-contract

[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.

Future pay comparability

40. MOD proposed that an independent pay comparison exercise be commissioned, in close consultation with the AFPRB secretariat, once the changes to the junior doctors' and consultants' contracts has been concluded. We agree that a fresh approach to looking at pay comparability is needed, and suggest that the following methodology be adopted:

    - Stage 1 – identify the specific staff groups within the NHS with which MODOs should be compared. This to be initially considered by BMA/BDA/MOD, prior to seeking our approval.
    - Stage 2 – for the identified NHS comparators, consider their typical career structures (age profile and journey through pay points and pay additions). For some groups, this stage would need to await the outcome of the current contract negotiations.
    - Stage 3 – identify sources of data of earnings for each of the NHS comparators, noting that total earnings are likely to vary initially as the rollout of contracts takes place. Our secretariat would be able to identify these data.
    - Stage 4 – under the current pay structure, compare the career profile and earnings of MODOs against the comparators identified in Stage 2. Again, our secretariat would be able to undertake this stage, with input from DMS/BMA/BDA on what a MODO career path looks like.
    - Stage 5 – MOD to bring forward proposals for amending the pay structure for MODOs to take account of the comparison in Stage 4, alongside its consideration of how the MODO pay structure should be amended to address its particular recruitment, retention and motivation requirements, and whether it should align with Pay16.

41. We ask the parties to take forward our suggested programme of work on pay comparison, and look forward to receiving the results of Stage 1. During our oral evidence sessions, we began exploring with the parties what the appropriate comparators should be for GMPs and GDPs. In our view, the key consideration is what is the alternative career path for a doctor or dentist who chooses to work within the NHS rather than work as a MO or DO. This may well involve someone beginning their career as a salaried doctor/associate dentist/performer-only GDP, before perhaps moving on at a later stage to become a practice partner/providing-performer GDP. The parties should also give consideration to what the appropriate contractual comparator is for consultants and junior doctors – we note that such arrangements differ between each country of the UK. There is, however, a strong argument for using England as the comparator, given the numbers of doctors working in that country compared to the rest of the UK and the fact that the majority of MODOs are based there. We ask that the parties report back to us on their findings for Stage 1 in advance of the next formal submission of evidence, so that we can progress our consideration of pay comparability.

42. We have requested over many years that MOD, BMA and BDA consider the most appropriate methodologies for pension valuation and pay comparability for DMS personnel, as we have concerns about the accuracy of the current pension adjustment figures used in our analysis. **Once again, the parties did not offer any evidence on this issue this year, so we ask them to address it in their evidence for the next round.** Given changes in recent years to the NHS Pension scheme, our working assumption is that the current methodology understates the advantage that DMS personnel have over comparators: if the parties believe that not to be the case, they need to set out their rationale supported by evidence for our next review.

PAY RECOMMENDATIONS FOR 2017-18

Overall pay recommendations

43. 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 MODOs.

44. When reviewing pay for MODOs, we consider information on pay levels relative to the NHS, and we believe our recommendations maintain comparability. We also take into account our recommendations for the main remit group, and those on NHS doctors' and dentists' pay made by DDRB. For 2017-18 DDRB was asked to make recommendations for all of its remit groups. For England, it was specifically asked to also consider the case for targeting to support recruitment and retention.

45. At July 2016, there was a deficit in trained MOs of 18 per cent against DMS20 requirement, unchanged from the previous year. Recruitment and retention initiatives will continue to be important as some specialties remain under-staffed and training pipelines are long. During oral evidence, MOD stressed that mental health is a growing issue in the Service personnel population, and noted that the recruitment of psychiatrists was a problem UK-wide. For DOs, at July 2016 staffing was 15 per cent above DMS20 liability.

46. In line with its pay policy announced in the Budget of July 2015, the Government said that it would fund public sector workforces for pay awards of an average of one per cent a year for four years from 2016-17. This report covers the second year of that policy, which follows previous public sector pay restraint policies in effect since 2011-12. We commented last year that we were concerned about the sustainability of the current ongoing pay restraint policy, and that continues to be our view, particularly given the developments in the private sector.

47. MOD proposed an increase in basic pay for MODOs in line with our recommendation for the main Armed Forces' pay award. The BMA did not propose a specific figure for the pay award, but said that Armed Forces' doctors should be treated in line with the wider economy, where it said that pay settlements were continuing to run at higher than the public sector pay policy cap, at around two per cent currently. The BDA commented that we had very limited opportunities to make any significant award in the current public sector pay environment. During oral evidence, both the BMA and BDA argued for a pay award at least in line with inflation: anything below was seen as a 'pay cut'. Staffing data, our consideration of broad pay comparability between the NHS and DMS, including the recommendations made by DDRB, and the arguments for treating DMS staff in line with our main remit group, lead us to **recommend a one per cent across the board increase** this year.

GMP and GDP Trainer Pay and Associate Trainer Pay

48. MOD proposed that GMP and GDP Trainer Pay and Associate Trainer Pay should all be treated in line with the 2017 DDRB Report. We note that the monetary value of these elements differ from their counterparts within the NHS, and that there is not a compelling case for increasing their value in line with the DDRB 2017 Report. Indeed, there is a strong case for increasing their value in line with the main MODO pay award, in order to maintain the relativities between MODO base pay and its various additions to pay. We therefore **recommend that GMP and GDP Trainer Pay and Associate Trainer Pay all be increased by one per cent**, in line with our main recommendation for MODO basic pay. We will, of course, keep a close eye on any DDRB related outcomes, so that we can continue to consider the implications for our own recommendations, including any implications for their timing.

MOD Clinical Excellence Awards

49. MOD also proposed that the value of MOD Clinical Excellence Awards (CEAs) should be treated in line with the 2017 DDRB Report. We understand that when MOD CEAs were introduced in 2005, the value of the awards was based on the top four NHS awards, abated by the amounts built into DMS pay in 1997 to account for the value of NHS local discretionary points. The 'abated' proportion of CEAs has therefore been directly affected by our own proposals on the MODO pay scales, rather than by DDRB's recommendations on CEAs. We note that in this year's evidence, MOD is proposing that the MODO pay scales be uplifted in line with the main remit group, rather than in line with the DDRB recommendations for consultants. There does not therefore remain an overriding argument for continuing to link the value of MOD CEAs to the DDRB recommendations on NHS CEAs. Indeed, we consider it more appropriate to maintain the relative value of MOD CEAs to MODO basic pay. We therefore **recommend that MOD CEAs (and legacy Distinction Awards) be increased by one per cent**, in line with our main recommendation for MODO basic pay. As with trainer pay, we will keep a close eye on any related DDRB outcomes for CEAs, so that we can continue to consider any impact for our own recommendations, including any implications for their timing.

50. The operation of the MOD CEA scheme is for MOD to determine, but as we make recommendations on the value of CEAs, we would welcome additional evidence on the way the scheme is run so that we can be assured that it is operating without discrimination. **We wish to be provided with data on the current distribution of CEAs by both gender and by BAME category, and how this distribution compares to the overall consultant population.** We would also find it helpful to be provided with evidence that sets out how decisions are made on the awarding of CEAs including the make-up of awarding committees, and any initiatives underway to encourage applications for awards from potentially under-represented groups. Lastly, it will be useful to know how the number of CEAs is flexed as the size of the consultant population changes.

Golden Hello

51. MOD runs a 'Golden Hello' scheme which aims to encourage the recruitment of direct entrant accredited GMPs and consultants. It proposed that the scheme for Regular MODOs is retained for GMPs and maintains the current eligibility criteria for consultant cadres. The value for the Golden Hello has remained unchanged since its introduction in 2002 at £50,000, and attracts a five year Return of Service. Payment is for fully accredited GMPs and consultants to the Regular DMS, where the projected staffing deficit in 2018 is ten per cent or higher against the DMS20 requirement. Across the Services, there were just 12 new recipients of Golden Hellos in 2015-16, compared to six the previous year, but MOD still believes the scheme provides value for money, noting the savings from not having to train Direct Entrants: as such, individuals will probably be hired from the NHS and been trained at public expense via that route. We discussed the scheme during oral evidence, and the parties were in agreement that it could benefit from better targeting. The BMA and BDA suggested that the current value was insufficient for some cadres. MOD's view is that further work needed to be undertaken to determine the effectiveness of the scheme by engaging with previous recipients. We look forward to receiving such evidence for our next review. In addition, we ask that MOD carries out an analysis of the likely outputs from its training pipeline, so that it can make an informed assessment of whether to better target the funding for the Golden Hello scheme for those specialties that will be in deficit, and report back to us in the next round. At this time, we are **content to endorse MOD's proposal that the Golden Hello scheme for regular MODOs is retained for GMPs and maintains the current eligibility for consultant cadres, and recommend accordingly**.

Medical Incremental Progression

52. MOD said that Medical Incremental Progression (MIP) was introduced as part of the incorporation of Sustained Quality Payments (SQPs) into the GMP and GDP pay spine in 2004. SQPs were subsequently replaced by Quality and Outcomes Framework payments in the NHS to reward and incentivise the provision of quality care and to help standardise improvement in the delivery of primary medical services. Within DMS, MIP was used to incentivise GMPs to become a Member of the Royal College of General Practitioners (MRCGP), and GDPs to be accredited with the General Dental Council (GDC). MOD said that the Defence Medical Services Board had endorsed a course of action to automate the award of MIP on the basis that all GMPs and GDPs were now mandated to be accredited with the MRCGP and GDC, and that quality was assured through professional revalidation, audits and 360 degree reporting. MOD therefore proposed the removal of the three levels on the current pay spine where individuals received MIP, instead consolidating their value into the annual increments. This resulted in a reduction in the number of pay spine points from 35 to 32, but maintained the existing top level of earnings, albeit reached three years earlier.

53. We are content to endorse MOD's proposal on MIP, but it does highlight to us the considerable length of the current pay scale. We note that the trend within the NHS is for reducing longer pay scales. We set out earlier in this report our thoughts on how pay comparability can be taken forward, and we wish the parties to consider the length of pay scales when considering how MODO pay might be restructured. **At the very least, we ask MOD to reassure us that the number of increments in the pay scale is not open to objection under age or gender discrimination.** For this year, however, we **recommend that Medical Incremental Progression becomes an automatic payment by no later than 1 April 2018**.

Recommendation 1: We recommend the following changes from 1 April 2017:

- **A one per cent increase in basic pay to all ranks within the Medical and Dental Officer cadre.**
- **A one per cent increase in GMP and GDP Trainer Pay and Associate Trainer Pay.**
- **A one per cent increase in the value of military Clinical Excellence Awards and legacy Distinction Awards.**

The recommended pay scales are at Appendix 1.

Recommendation 2: We recommend that the Golden Hello scheme for regular MODOs is retained for GMPs and maintains the current eligibility for consultant cadres.

Recommendation 3: We recommend that Medical Incremental Progression becomes an automatic payment by no later than 1 April 2018.

Recommendation 4: We recommend that a pay comparison exercise is carried out, in line with the proposal set out in paragraphs 40 to 42 of this report.

Cost of our pay recommendations

54. We estimate that the cost of our pay recommendations for 2017-18 is £2.1 million (including the Employers' National Insurance Contribution and superannuation liabilities).

LOOKING AHEAD

55. As noted in our main report, on levels of pay generally, our visit programme made clear that Service personnel are becoming increasingly frustrated with public sector pay policy. They feel their pay is being unfairly constrained in a period when costs are rising, private sector earnings are starting to recover, and the high tempo demands on the Armed Forces continue. We believe that our decision this year for an increase of one per cent in base pay taken alongside the incremental progression that the majority of staff receive, will broadly maintain their pay comparability with the civilian sector. In the case of MODOs, our analysis shows that they are, in general, earning in excess of NHS pay comparators, and we note the general satisfaction with pay amongst MODOs as reflected in the DMSCAS. Nevertheless, with the overall economic picture being very uncertain following the EU referendum, and if the private sector continues to recover with inflation continuing its upward trajectory, we could foresee recruitment becoming more challenging with a negative impact on morale. If there was clear evidence of this, we would need to consider very carefully whether a one per cent average limit on base pay was compatible with continued operational effectiveness.

56. We remain concerned about the scale and pace of the changes being delivered through the various strands of the People Programme. Service personnel are aware of the continuous change in the "offer" which are clearly being developed in the context of constrained resources, and we have noted the over-riding sense of uncertainty and an increasing view that the offer will only get worse with the main objective, they believe, being to save money. There is a growing risk that the morale of our remit group will be impacted adversely, potentially damaging recruitment and retention. Of course, there are positive elements within the People Programme: the Flexible Engagements System will allow Service personnel potentially to agree to have specified periods of time in which they do not have their normal liability for work or duty; and MOD told us about the current Flexible Duties trial that allows successful MO applicants to work less than full time. We have consistently noted the importance of MOD exploring the options for part-time and flexible working for MODOs to encourage recruitment and retention, particularly of female personnel, and welcome these developments. We consider the adoption of flexible and part-time working practices as fundamental to the sustainability of DMS, particularly given that flexible working options are available to NHS staff, many of whom work alongside MODOs.

57. DMS relies heavily on the use of Reserves with some cadres planned to be staffed entirely by Reserves, such as neurology, urology, otorhinolaryngology and ophthalmology. The BMA has told us that there are fundamental recruitment problems throughout the medical Reserves. Within the NHS, possible contractual change for consultants could result in more regular weekend working, so this could have implications for the availability of Reserves. We welcome the close working between MOD and NHS Employers in this area: future activities will need to take account of the impact of any such contractual change. As noted earlier, we support a review into the feasibility of the future shape of the Medical Reserve as suggested by the BMA, but as this is outside our remit, we urge SG and the BMA to work together to initiate this review. We discuss earlier in this report the issue of the daily rate of pay for Reserves.

58. In our main report, we set out our views on the reimbursement of professional body fees (PBFs). We believe that a coherent approach should be taken to the reimbursement of PBFs for all relevant groups, and support reimbursement of PBFs for Service personnel

where those PBFs are a necessary requirement for carrying out Service duties. We strongly believe that MOD should implement a mechanism to enable the reimbursement of PBFs for all cohorts where membership of a professional body is necessary given the nature of their role. However, we also recognise that MOD is currently operating within a constrained funding envelope, and there is a case for initially targeting the payment of PBFs of cohorts for where there are particular recruitment or retention issues. In relation to MODOs, we recognise that the picture is complicated: significantly comparator groups within the NHS do not have their PBFs reimbursed but are expected to pay from salary; civilian doctors and dentists employed by MOD however do have their PBFs reimbursed; and for some other groups (such as Allied Health Professionals) PBFs are only reimbursed for those Service personnel not on bespoke pay spines. In addition there are some specialties (such as maxillofacial consultants) that require doctors to hold more than one professional subscription. MOD's evidence considered the case for the reimbursement of PBFs for MODOs, commenting that it would act as a positive move towards increasing morale and retention for a relatively small investment, but despite this concluded the cost of £622,000 per year to be unaffordable at this time and potentially divisive. We also note that the automatic payment of MIP (described earlier in this report) is intended in part to incentivise membership of professional bodies, such as MRCGP or the GDC: arguably, reimbursement of PBFs will therefore become part of the pay scale. **We ask MOD to consider the issues highlighted on PBFs and set out a consistent policy for how it will consider the reimbursement of PBFs in its evidence for our next round.**

59. We set out in this report the action we consider needs to be taken by the parties in order to take forward our consideration of pay comparability. Ultimately, it may be necessary for the parties to revisit the current pay structure for MODOs, to better match the career earnings of NHS counterparts. We have noted that within the new junior doctor contract in England, there is provision for flexible pay premia for hard-to-fill specialties, such as general practice and psychiatry; and that this was funded from within the existing overall pay envelope for junior doctors. If there is to be a redrawing of the MODO pay arrangements, there could be an opportunity to take a similar approach for the specialties within DMS that are persistently difficult to fill through better targeting of the overall pay bill for MODOs.

60. For the next round, we plan to include MODOs within our main report. We consider it important that MODOs are seen as part of the overall remit group, and our proposal to include them within the main report was supported by both the BMA and BDA during oral evidence. As a result, we would expect under normal circumstances to submit our recommendations for MODOs alongside the rest of the Armed Forces around the beginning of February. We will continue to monitor NHS developments, including the reports and outcomes of the DDRB, to assess any implications for our MODO recommendations, including their timing.

61. In our last report, we set out our hope for a more proactive and constructive dialogue between the BMA/BDA and DMS. We saw little evidence of this during oral evidence with the parties: indeed, the acting Surgeon General accepted that more could be done. We urge the parties to work together on issues of common interest and will be looking for evidence of progress in our next report.

62. DMS remains a valuable part of the overall Armed Forces both in the care it provides to the ongoing health of Service personnel and the wider support it provides during operational commitments. The Reserves' manning situation remains a significant concern and it is important that MOD assess the viability of DMS20 to ensure that the overall capability of DMS is appropriate and can support the future requirements of the UK Armed Forces effectively.

John Steele	Ken Mayhew
Brendan Connor	Lesley Mercer
Tim Flesher	Vilma Patterson
Paul Kernaghan	Jon Westbrook

March 2017

APPENDIX 1

1 April 2016 and 1 April 2017 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 2016	1 April 2017
Level 32	*136,915*	138,285
Level 31	*136,650*	138,016
Level 30	*136,388*	137,752
Level 29	*136,119*	137,480
Level 28	*135,857*	137,216
Level 27	*135,330*	136,684
Level 26	*134,804*	136,152
Level 25	*134,277*	135,620
Level 24	*132,998*	134,328
Level 23	*131,723*	133,041
Level 22	*129,093*	130,384
Level 21	*127,629*	128,905
Level 20	*126,169*	127,431
Level 19	*124,704*	125,952
Level 18	*123,250*	124,482
Level 17	*121,403*	122,617
Level 16	*119,566*	120,762
Level 15	*117,940*	119,119
Level 14	*116,310*	117,473
Level 13	*114,688*	115,835
Level 12	*113,062*	114,193
Level 11	*109,489*	110,583
Level 10	*105,923*	106,982
Level 9	*102,357*	103,381
Level 8	*99,191*	100,183
Level 7	*96,017*	96,977
Level 6	*92,838*	93,767
Level 5	*89,860*	90,758
Level 4	*88,702*	89,589
Level 3	*87,521*	88,396
Level 2	*83,605*	84,441
Level 1	*79,729*	80,527

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

Increment level	Military salary £	
	1 April 2016	1 April 2017
Level 35	*127,744*	129,021
Level 34	*127,344*	128,617
Level 33	*127,038*	128,308
Level 32	*126,540*	127,805
Level 31	*126,140*	127,402
Level 30	*125,736*	126,993
Level 29	*125,426*	126,680
Level 28	*124,932*	126,181
Level 27	*124,524*	125,769
Level 26	*124,124*	125,365
Level 25	*123,716*	124,953
Level 24	*123,316*	124,549
Level 23	*122,908*	124,137
Level 22	*121,029*	122,239
Level 21	*120,557*	121,763
Level 20	*119,997*	121,197
Level 19	*119,412*	120,606
Level 18	*118,833*	120,022
Level 17	*118,249*	119,432
Level 16	*117,670*	118,846
Level 15	*117,153*	118,324
Level 14	*115,003*	116,153
Level 13	*114,490*	115,635
Level 12	*113,977*	115,117
Level 11	*113,386*	114,520
Level 10	*112,799*	113,927
Level 9	*112,208*	113,330
Level 8	*110,049*	111,150
Level 7	*109,462*	110,557
Level 6	*107,966*	109,045
Level 5	*106,460*	107,525
Level 4	*104,964*	106,014
Level 3	*103,459*	104,493
Level 2	*101,313*	102,326
Level 1	*100,610*	101,616

[a] This scale will reduce from 35 levels to 32 levels no later than 1 April 2018 (see paragraphs 52 and 53), with the automation of Medical Incremental Progression at levels 4, 8 and 14.

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

Increment level	Military salary £	
	1 April 2016	1 April 2017
Level 19	*92,006*	92,926
Level 18	*91,076*	91,987
Level 17	*90,146*	91,048
Level 16	*89,212*	90,104
Level 15	*88,380*	89,264
Level 14	*87,561*	88,437
Level 13	*86,734*	87,601
Level 12	*85,907*	86,766
Level 11	*85,084*	85,935
Level 10[a]	*84,260*	85,103
Level 9	*83,268*	84,101
Level 8	*81,597*	82,413
Level 7	*79,922*	80,721
Level 6	*78,733*	79,520
Level 5	*77,556*	78,331
Level 4	*76,375*	77,138
Level 3	*75,194*	75,946
Level 2	*71,238*	71,951
Level 1	*67,308*	67,981

[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 2016	1 April 2017
Level 5	*76,139*	76,901
Level 4	*74,595*	75,341
Level 3	*73,054*	73,785
Level 2	*71,506*	72,221
Level 1	*69,962*	70,662

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

Increment level	Military salary £	
	1 April 2016	1 April 2017
Level 5	*62,319*	62,943
Level 4	*60,727*	61,334
Level 3	*59,126*	59,717
Level 2	*57,537*	58,113
Level 1	*55,957*	56,517

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

	Military salary £	
	1 April 2016	1 April 2017
OF1	*42,358*	42,782

Table 1.7: Recommended annual salaries for Medical and Dental Cadets

Length of service	Military salary £	
	1 April 2016	1 April 2017
after 2 years	*19,681*	19,878
after 1 year	*17,759*	17,937
on appointment	*15,846*	16,004

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

Increment level	Military salary £	
	1 April 2016	1 April 2017
Level 7	*141,977*	143,397
Level 6	*140,791*	142,199
Level 5	*139,609*	141,005
Level 4	*138,414*	139,799
Level 3	*137,224*	138,596
Level 2	*136,046*	137,406
Level 1	*134,851*	136,200

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

Increment level	Military salary £	
	1 April 2016	1 April 2017
Level 15	*133,022*	134,352
Level 14	*132,277*	133,599
Level 13	*131,522*	132,837
Level 12	*130,770*	132,077
Level 11	*130,022*	131,322
Level 10	*129,270*	130,562
Level 9	*128,509*	129,795
Level 8	*127,761*	129,039
Level 7	*127,009*	128,280
Level 6	*125,884*	127,142
Level 5	*124,761*	126,009
Level 4	*123,627*	124,863
Level 3	*122,505*	123,730
Level 2	*121,383*	122,597
Level 1	*120,249*	121,452

DMS Trainer Pay

GMP and GDP Trainer Pay	£8,061
GMP Associate Trainer Pay	£4,032

DMS Distinction Awards

A+	£61,686
A	£41,125
B	£16,450

DMS National Clinical Excellence Awards

Bronze	£19,238
Silver	£30,267
Gold	£41,791
Platinum	£59,076

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