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IDR Pay comparability study for MODOs

A report by Incomes Data Research

IDR

Pay Data | Intelligent Decisions

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Executive summary

IDR was commissioned in 2021 by the Office of Manpower Economics, on behalf of the Armed Forces Pay Review Body, to undertake a remuneration benchmarking exercise for Medical and Dental Officers in the Armed Forces. One of the key elements in any pay benchmarking exercise is to identify the most suitable comparator. This is more challenging for 'unusual' jobs or those where special working conditions mean it is difficult to identify direct comparators. In such cases, organisations find themselves having to identify 'best fit' comparators. This is the position facing Defence Medical Services (DMS) in respect of Medical Officers and Dental Officers (MODOs).

This study examines the comparative pay position for a number of MODO roles, including some where broad consensus has been reached on the most appropriate NHS comparators, and other more difficult-to-benchmark roles, primarily General Medical Practitioners (GMPs) and General Dental Practitioners (GDPs). On the latter, our approach goes beyond the scope of a typical role evaluation and benchmarking exercise and considers how closely the military roles match to comparable jobs in the civilian sector by identifying core underlying skills and features of the roles and seeking these in comparable roles.

To do this we first set out to establish the context and a solid foundation for this research to ensure we were fully informed about the pressures driving the study. This involved reviewing comparators used in previous MODO pay comparability studies, establishing whether they are still suitable and credible comparators, and understanding the issues and concerns raised by the Armed Forces Pay Review Body (AFPRB), DMS, the British Medical Association and the British Dental Association, relating to remuneration benchmarking and pay comparisons for MODOs.

This initial part of the study highlighted the need to deal with the unresolved issue of suitable NHS comparators for GDPs and GMPs. We therefore sought to obtain a detailed understanding of the GMP and GDP roles and career paths, covering both policy and what happens in practice, before seeking any comparators. The evidence for this came from DMS HR documentation, a survey of MODOs, and also, crucially, from semi-structured interviews

we conducted with military personnel with first-hand knowledge of employment policy and practice for GMPs and GDPs, including postholders.

Once we had established a clear view of the GMP and GDP roles, we undertook interviews with civilian GPs and dentists to learn about their jobs and gather evidence on the extent to which skills and responsibilities in their roles are enacted at similar levels by MODOs. We assessed the suitability of different NHS jobs as comparators for GDPs and GMPs according to how closely jobs matched across six factors: clinical skills and experience; management of resources; communications; service delivery; risk management and governance; decision-making and accountability. These factors were determined by us, as indicated by previous stages of the study.

MODO comparators

Following our review of previously identified comparators for MODOs and new work undertaking qualitative assessments of comparators for GDPs and GMPs, we outline our recommendations on civilian comparators below. These comparators were taken forward for the pay comparisons.

Table 1 IDR recommended civilian comparators for MODO roles

MODO role	NHS comparator
Doctors and dentists in training	
Foundation Doctor Year 1/2	Foundation Doctors Year 1/2
Core Training	Core Training
Specialty Training	Specialty Training
Dentists	
Dental Officer (OF2)	Associate (Performer Dentist)
Senior Dental Officer (OF2)	Partner (Providing-Performer Dentist)
Senior Dental Officer (OF3)	Partner (Providing-Performer Dentist)
Sub-regional Dental Officer (OF4)	Partner (Providing-Performer Dentist)
Principal Dental Officer (OF5)	BUPA Regional Clinical Dental Director
GPs	
Regimental Medical Officer (OF3)	Salaried GP
Unit Medical Officer (OF3)	Salaried GP
Deputy Senior Medical Officer (OF3)	GP Partner
Senior Medical Officer (OF4)	GP Partner
Regional Clinical Director (OF5)	Hospital Consultant
Consultants	
Consultant	Consultant

Note: we have used shading to indicate our view on the suitability as a comparator. Shaded are 'good' matches, unshaded indicates a 'fair' match.

Pay comparisons

The X-Factor[1] is excluded from our pay comparisons[2] and overall, these show that pay for Medical Officers is generally behind their comparators, while pay for Dental Officers and doctors in training is broadly in line with that for comparators. Figures 1 and 2 illustrate a summary of our analysis of the percentage variation between DMS pay and that for civilian comparators. We regard variations of more than -/+10% as significant.

Accredited MODOs

Figure 1 illustrates the percentage variation of DMS pay for accredited MODOs and their relevant comparator as outlined in Table 1. **It shows that pay for Medical Officers is generally behind that for civilian comparators. Pay for Medical Officers is ahead at the start of their career in rank OF2 but** falls behind with seniority, in some cases significantly.

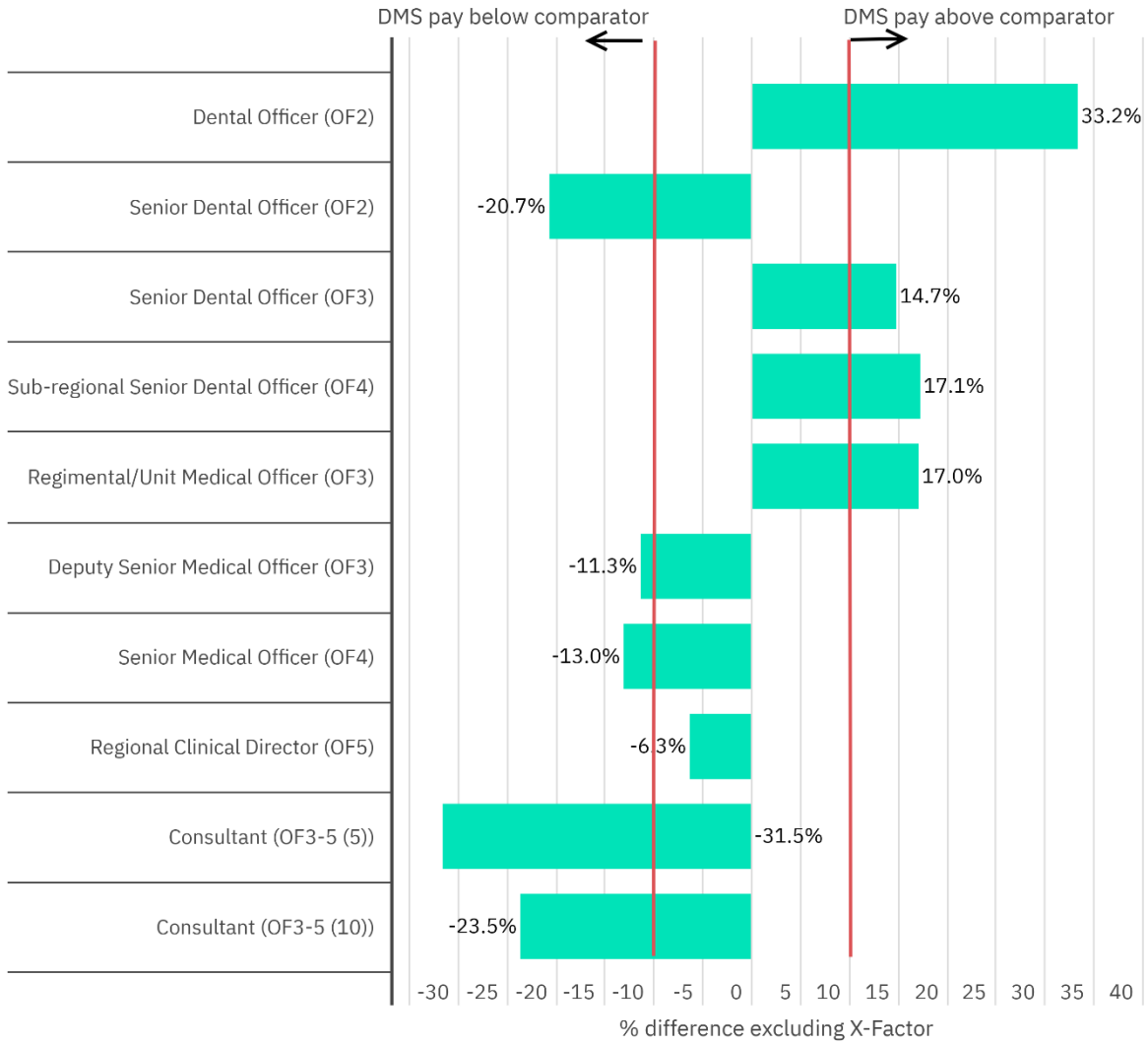
Pay for military dentists is generally ahead of that for civilian comparators, but with the important exception of that for Senior Dental Officers at OF2 where dental officers are being asked to take on additional responsibility due to restructuring of the military dental workforce, with fewer military dentists overall. Our assessment indicates that this role is closer to a Partner (Providing-Performer) than an Associate Dentist and consequently pay for the role is significantly behind that for civilian comparators (-20.7%).

Pay for military consultants is behind that for NHS consultants, significantly for at least the first five years.

[1]The X-Factor is a pensionable addition to basic military pay intended to reflect the balance of advantages and disadvantages of conditions of service experienced by members of the Armed Forces compared to workers in the civilian sector. It is currently worth 14.5%, with tapering for personnel above rank OF4.

[2]Pay comparisons both excluding and including X-Factor are provided in Chapter 2 for completeness.

Figure 1 Percentage variation of DMS pay for accredited MODOs versus civilian comparators

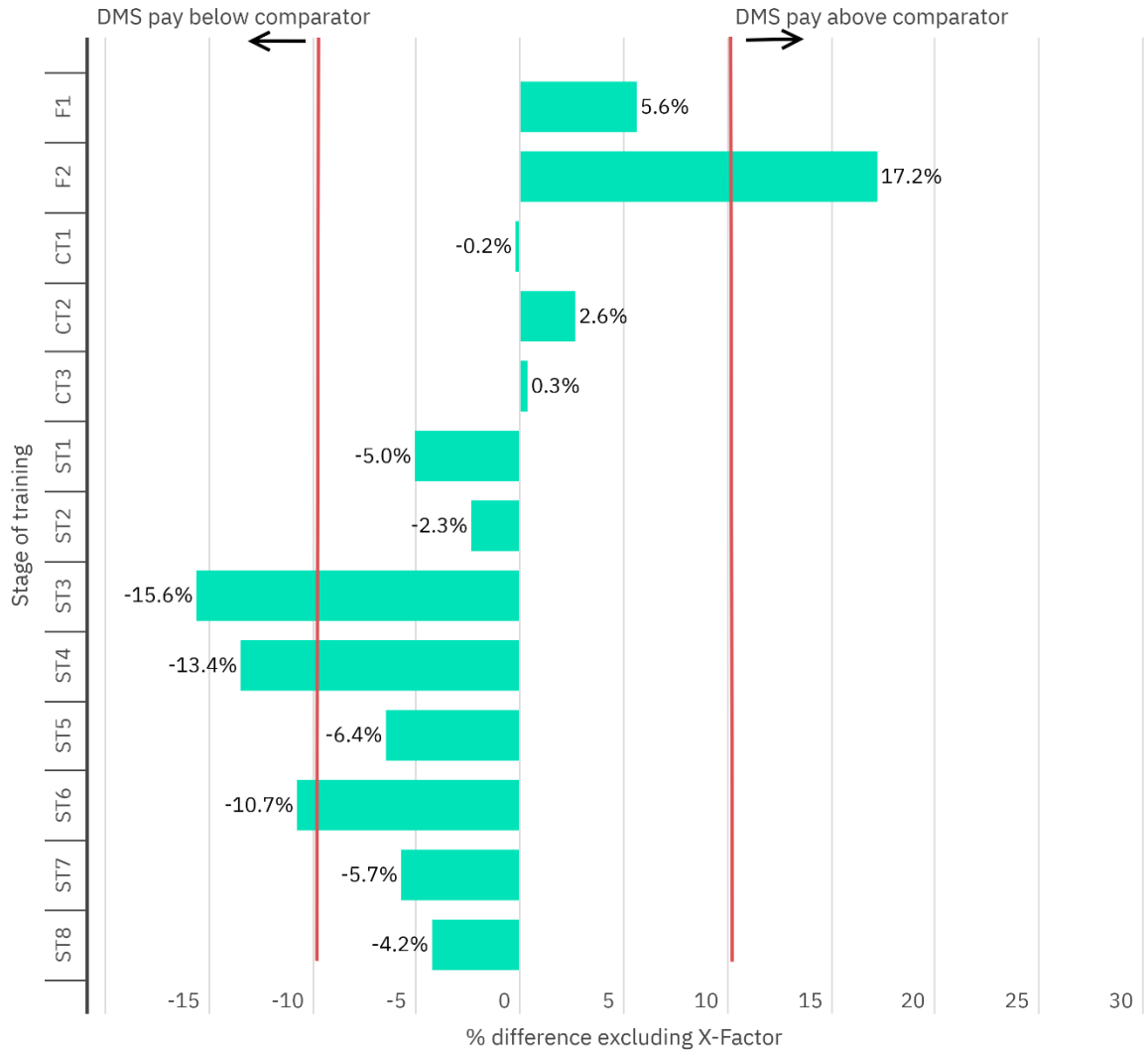


Note: variations within +/-10% are considered to be within market.

Junior doctors in training

Figure 2 illustrates the percentage variation between DMS trainee pay and that for NHS junior doctors in training and shows that pay is broadly comparable at most stages of training, except at the beginning of training in Foundation Year 2 where DMS pay is notably ahead (+17.2%) and at ST3/ST4 at the end of training when DMS pay is behind (-15.6% and -13.4% respectively).

Figure 2 Percentage variation between DMS trainee pay and that for NHS junior doctors in training



Note: variations within +/-10% are considered to be within market.

IDR commentary

In this commentary we provide our thoughts on the research, outlining the main challenges and limitations.

Difference in main purpose of the role

Our interviews with GDPs and GMPs highlighted an important distinction in the purpose of the role in military and civilian settings. In the military the main purpose of the role is to deliver primary care medical and dental services but with an overarching focus on occupational health, which means responsibility for assuring fitness to work and fitness to deploy through clinical interpretation dealing with both patients and the chain of command, in addition to the leadership and management of staff within the working group. In the civilian sector, dentists view the main purpose of their role is delivering routine and emergency dental care to patients under their care and GPs for delivering a full range of general practice healthcare to their community. We heard how this difference in the purpose of the role affects many aspects of the military GDP/GMP roles, including the application of clinical skills, accountability, risk and impact of the role on the organisation. While we heard about other differences, such as working hours, turbulence, deployments and early responsibility, we view these as falling under the scope of the X-Factor and do not directly affect operation of the role in the same way.

Issue of resolving comparators

Given the issues outlined above it is not surprising that the issue of suitable comparators for GDPs and GMPs has remained unresolved for so long. In our view, this study is the first to adopt a detailed, qualitative method for comparing military and civilian dentists and GPs, taking the approach of understanding the military roles first before seeking comparators in civilian employment. We believe our study has helped to clarify a number of issues surrounding the comparability of different civilian dental and medical roles to those in the military. However, our approach for identifying comparators for the other MODO roles was not as detailed as that adopted for identifying comparators for GDPs and GMPs and involved a desk-based review of jobs. It may be prudent to re-visit this in future research.

Data issues

Pay comparisons for GPs and Dentists face issues relating to the availability of reliable and detailed pay data. This is not a new issue, but it affects the ability to identify and use the best-matching data for pay comparisons.

General dental practitioners work in the private sector but have contracts with the NHS to supply specified services. They are under limited obligation to provide the NHS with details of their working hours and overall earnings. These limitations are partly overcome by NHS Digital undertaking a biennial survey of dentists, but it only covers around a quarter of practitioners. This limits the extent to which reliable summary pay figures can be obtained.

GPs are far more integrated into the NHS, even though many practices are private businesses. Consequently, GP practices are obliged to provide a wide range of detailed data inputs for all their staff. However, the quality and veracity of some of the data inputs, particularly around hours worked, again limits the extent to which reliable detailed summary pay figures can be obtained.

Looking to the future it may be possible to improve on the current quality of earnings data. The current dental contract is under discussion and one possible model is a more 'community' orientated contract, in contrast to the current fixed-price piecework model. Improved data reporting could be one of the conditions attached to any new contract. Even so, given the experience of the data inputs from GP practices it may be helpful for the relevant authorities to engage the services of a body that has experience in capturing labour market and earnings data as opposed to service-related inputs. This could go a long way to improving the scope and reliability of the required inputs to provide detailed and reliable summary earnings figures. This might involve the establishment of a working group involving NHS Digital, pay specialists and other key stakeholders to determine the best way forward.

NHS Digital Data used in the pay comparators is for the financial year 2019/2020.

1. Introduction

In March 2021 Incomes Data Research (IDR) was commissioned by the Office of Manpower Economics (OME) to undertake a pay comparability study to establish the pay position of Medical Officers and Dental Officers (MODOs) relative to civilian counterparts on behalf of the Armed Forces Pay Review Body (AFPRB) and the Ministry of Defence (MOD).

It covers the following MODOs:

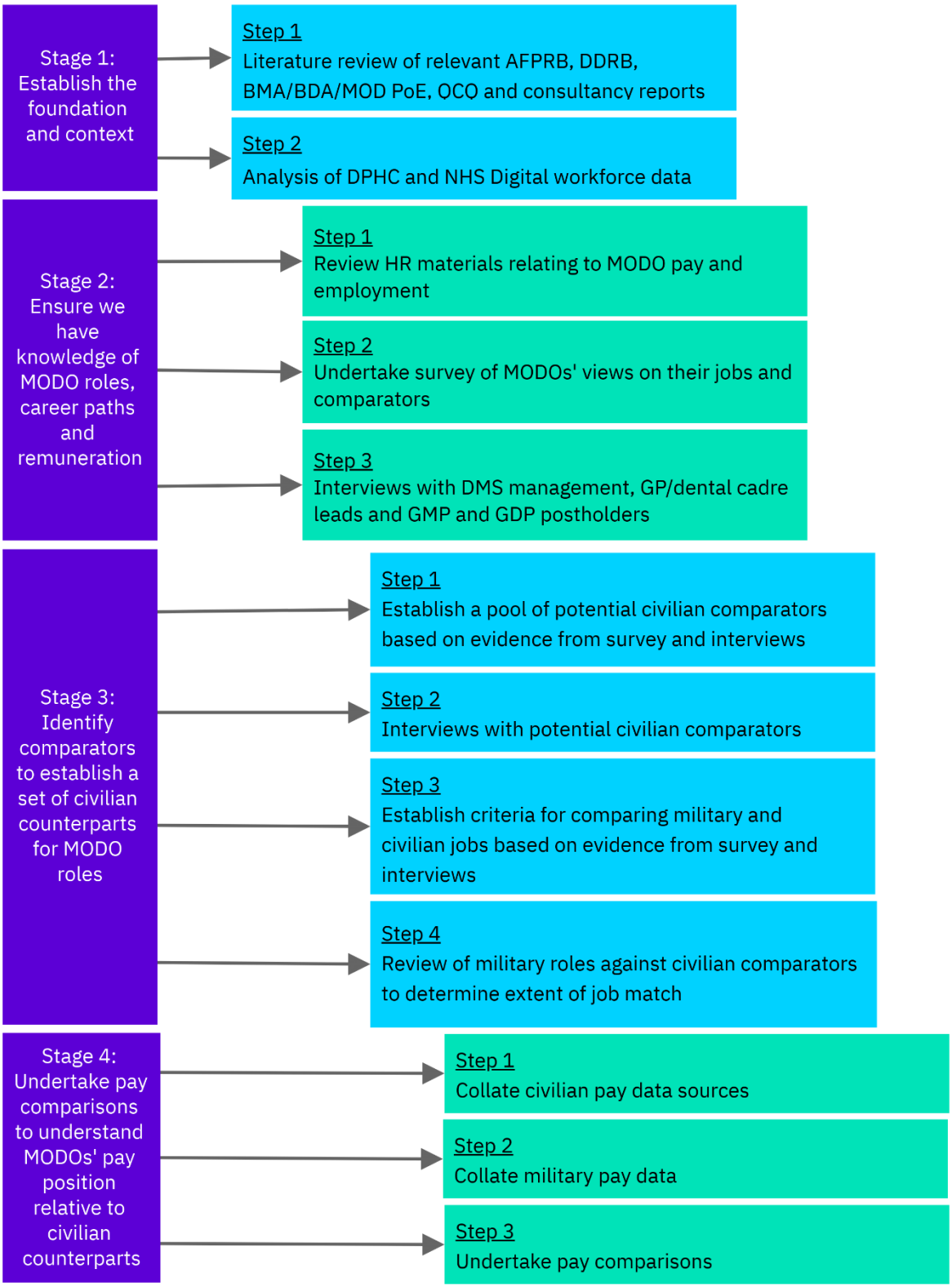
- Foundation Year Dental Officers and Medical Officers
- Specialty Trainees (Medical Officers)
- General Dental Practitioners (GDPs)
- General Medical Practitioners (GMPs)
- Consultants

The exercise was complicated by an ongoing and unresolved issue of what roles might be relevant comparators for General Medical Practitioners (GMPs) and General Dental Practitioners (GDPs).

1.1. Methodology

The project involved a number of key stages and elements of work as outlined in Figure 3, alongside discussions with key stakeholders, drafting and delivering a methodology report and interim outputs, as well as feedback and dialogue between IDR, OME and MOD project teams.

Figure 3 Illustration of project stages and steps



Note: Step 2 of Stage 3 involved two interview phases conducted between 13 April and 2 June 2021 and 5 January and 11 March 2022.

As shown in Figure 3, Stages 1 and 2 focussed on establishing the context and a solid foundation for undertaking benchmarking comparisons and obtaining a detailed understanding of GDP/GMP roles, pay progression and career paths. **Stage 1** involved a desk-based literature review and desk-based analysis of workforce/staffing data.

Stage 2 involved a review of HR materials, discussion and clarifications from the OME/MOD project team, an electronic structured survey of MODOs, interviews with DMS management, GP/dental cadre leads and GDP/GMP postholders. The survey asked individual postholders about their job and career as a MODO in DMS. It was designed by IDR with input from both the OME and MOD and was distributed by the MOD via various communication channels. It ran between 13 and 30 April 2021 and received responses from 609 MODOs in total.

For the interviews, we carried out semi-structured 60-minute telephone interviews with 11 DMS managers[3], eight military GDPs OF34-OF5, 15 military GMPs OF3-OF5 and two civilian GMPs between 13 April and 7 May 2021. IDR provided a matrix of the types of postholders we sought to speak to, and the MOD booked them in. All interviewees were given the questions ahead of their interview, providing them with the opportunity to review the questions and consider their responses. Most interviews were recorded for note-taking purposes and information from all the interviews has been entered into a data capture spreadsheet.

Stage 3 involved establishing a pool of potential civilian comparators for military GDP/GMPs and assessing their suitability. The initial list of civilian comparators was devised by IDR using knowledge from previous pay comparison studies and new knowledge gained in earlier stages of the project. We sought assistance from the BMA and BDA in contacting civilian GPs and dentists that met our criteria, which included a mix of junior and senior roles, salaried and self-employed and within different settings.

[3]Deputy Commander of UK Stratcom, Surgeon General, Director of Medical Personnel and Training, Director of Healthcare, Assistant Head Personnel in the People and Workforce Team of HQ DMS, Defence Advisor of General Practice/GMP Cadre Lead, Principal Dental Lead/GDP Cadre Lead, Head of Single Service Navy, Head of Single Service Army, Head of Single Service RAF, Armed Forces remuneration lead.

In total we interviewed nine civilian dentists (although one of whom is currently in a military role), three regional clinical directors at BUPA Dental Care, 14 civilian GPs (including one who works as a locum GP for the MOD and a salaried GP who was interviewed solely about their role as a PCN Clinical Director) and two civilian GMPs. As with the military interviews, we provided a matrix of the types of postholders we wished to speak to, and all interviewees were sent the questions in advance. We entered information from the interviews into the same data capture spreadsheet.

Our approach for assessing the suitability of different civilian jobs as comparators for GDPs and GMPs is fundamentally based on job evaluation methodology; whereby jobs are assessed against specific criteria – namely job factors that will be key to matching. Our assessments involve a level of judgement since there is no precise scientific way or formula for comparing jobs.

The job factors are designed to reflect the core, underlying skills, and features[4] of the military roles and are outlined in Table 2. The factors are not designed to be mutually exclusive and are a method of being able to compare jobs based on key characteristics. The factors were determined using information from the semi-structured interviews conducted with military managers and postholders during April and May 2021, as well as additional supporting information obtained from HR policies and other related documents.

[4] The interviews highlighted other elements which we consider are linked to the X-Factor and have therefore been excluded from our assessment. These are hours of work, deployment, turbulence and having a dual role as both an Officer and a GDP/GMP.

Table 2 Job factors used in the assessment of comparators

Clinical skills and experience
This factor considers the level and breadth of professional knowledge required and its application to the role, as well as the level of training and experience required to perform the role effectively.
RATIONALE – the above factor aims to reflect what we have learnt about the level of skills, qualifications, training, and experience required to practice in the military, as well as reflecting any specialities.

Management of resources
This factor considers the extent of management responsibilities in respect of controlling or directing staff (including contractors), budgets, medical equipment, and supplies (including medicines), and other tangible/physical assets.
RATIONALE – the above factor aims to reflect responsibility for resources.

Communications
This factor considers the communication skills required with both the immediate and wider working groups, including the level of interaction, influence and persuasion and difficult/sensitive nature of the topic.
RATIONALE – this factor aims to capture communications/liaison with patients, colleagues and also commanders relating to health/fitness reports and/or deployability.

Service delivery
This factor considers the effect of the role on the services delivered, accountability for results and contribution to overall organisational strategic goals.
RATIONALE – this factor aims to capture the impact of the role on both patients/service users and the wider DMS strategic aim for occupational health and fitness to deploy.

Risk management and governance
This factor considers the management of clinical risks and governance (including audit of other professionals' practice), operational risks and financial risks.
RATIONALE – this factor aims to reflect risk management and level of governance required. It encompasses both clinical and non-clinical risk and governance.

Decision-making and accountability
This factor considers the level of decision-making, use of judgement, and accountability of the role, including the level of independent action.
RATIONALE – this factor aims to reflect lone and autonomous judgements and the impact of decisions made on both personnel and the Service.

Our approach for undertaking the comparability assessments was for the review panel (IDR) to discuss and agree how closely each of the individual job factors match between the military role and potential civilian comparator, with a rating scale of 1 to 5; with 5 representing the closest match. In some cases, the match is weaker on the basis of greater responsibility for the military role, and in others a low rating is due to greater responsibility in the civilian role. The combined score indicates the overall suitability of the comparator. Those with a total combined score of 24 or more (i.e., 80%+) are deemed a 'good'

comparator, and those below this level a 'fair' comparator. Where fair comparators have been identified, less weight should be put on the pay comparison findings.

Having identified a set of civilian comparators, **Stage 4** involved undertaking the benchmarking pay comparisons. IDR obtained relevant earnings and salary data for use in the pay comparisons from a wide range of sources as follows:

- published pay scales and pay framework for MODOs and NHS comparators
- bespoke data provided by Defence Statistics on behalf of the MOD detailing averages for full-time gross basic pay for Accredited GMPs and GDPs by rank. Salaries include gross basic pay plus X-Factor and any pay supplements. Employer and pension contributions, allowances, and other types of financial assistance, including expenses, trainer pay, and Clinical Excellence Awards are excluded
- DMS pay scales for non-accredited GDPs and GMPs
- DMS pay scales for accredited consultants
- published pay scales and pay frameworks for NHS doctors in training
- published pay scales and pay frameworks for NHS consultants
- NHS Digital data on earnings estimates for GPs, dentists and for non-basic pay elements for other junior doctors in training and consultants in England[5]

In some cases we have made adjustment to the data in an effort to overcome shortcomings in earnings estimates for Dentists and GPs. Data on civilian dental comparators is drawn from NHS Digital and does not provide dental earnings estimates by both age and working hours combined (e.g., Partner/Providing-Performer Dentist, England, age <35, 40<45 hours) therefore IDR calculated an hours adjustment to arrive at an estimate of earnings for dentists working 40-45 hours a week. This is increasingly important with age, since anecdotal evidence and new evidence from the civilian interviews indicates that civilian dentists do not work full-time hours as they get older. IDR also calculated an adjustment to estimate full-time working for salaried GPs.

[5] Sources as follows: GP Earnings and Expenses Estimates 2019/20 - NHS Digital; Dental Earnings and Expenses Estimates 2019/20 - NHS Digital; and Table 1 - Average Annual Earnings by Staff Group, in NHS Trusts and CCGs in England.

2. Pay comparisons

In this section of the report we present the pay comparisons based on civilian comparators identified in the early part of the study.

2.1. General Dental Practitioners

The pay comparisons are based on the 'best fit' comparators identified by IDR as part of this study, namely:

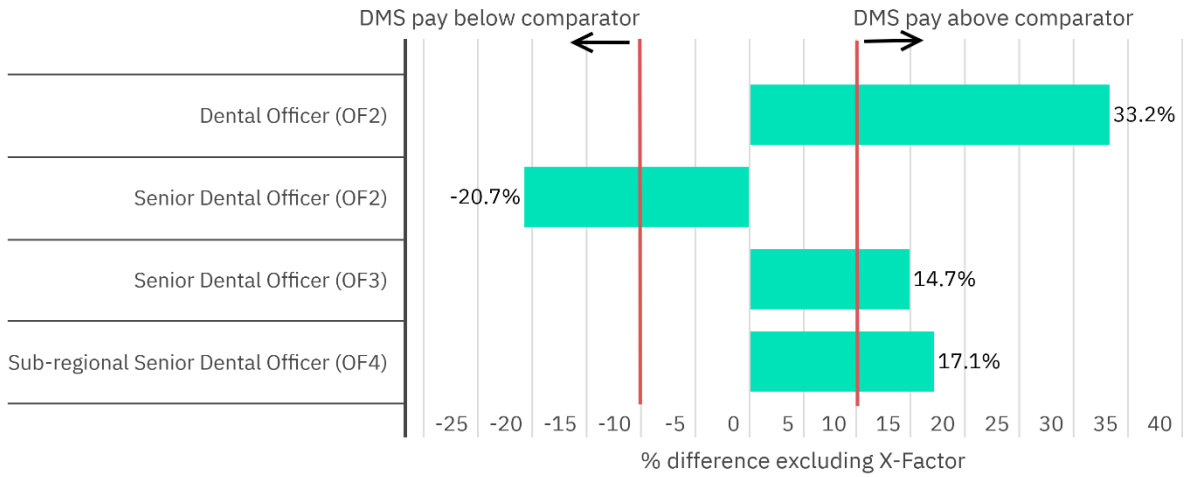
- Dental Officer (OF2) → Associate Dentist (Performer)
- Senior Dental Officer (OF2) → Partner (Providing-Performer Dentist)
- Senior Dental Officer (OF3) → Partner (Providing-Performer Dentist)
- Sub-regional Dental Officer (OF4) → Partner (Providing-Performer Dentist)
- Principal Dental Officer (OF5) → BUPA Regional Clinical Dental Director[6]

Key results

- Pay comparisons for dentists are complicated by the large number of contracted (i.e. self-employed) general dental practitioners rather than salaried NHS practitioners. As a result, basic pay figures are not available for civilian dentists and instead we must rely earnings estimates.[7]
- The comparisons detailed in Figure 4 and Table 3 compare median gross pay for DMS GDPs, as provided by the MOD and adjusted to exclude the X-Factor, with data on average earnings for dentists by age in England, as obtained from NHS Digital and adjusted for full-time hours.
- The analysis shows that DMS pay for Dental Officers at OF2 is significantly ahead (33.2%) of that for their comparator, which is Associate Dentist. Meanwhile pay for Senior Dental Officers at OF2 is significant behind (-20.7%) that for their comparator, which is a Providing-Performer Dentist. Pay for senior military dentists at ranks OF3 and OF4 is ahead of average earnings for Partner/Providing-Performer Dentists.

[6]Note comparator pay data for Partner (Providing-Performance Dentist) is provided by age and we differentiate matching based on the age bracket that most closely represents the military role. Note no data is available for the Principal Dental Officer (OF5) role.
[7]NHS Digital Dental Earnings and Expenses Estimates are based on anonymised tax records for self-employed dentists who undertake NHS work.

Figure 4 Pay comparison DMS GDP pay versus dental average earnings



Note: variations within +/-10% are considered to be within market.

Table 3 Pay comparison DMS GDP pay versus dental average earnings

DMS role	DMS median gross basic pay 2022	DMS median gross basic pay X-Factor adj.[1]	Civilian job match	Median civilian earnings, FT adj.[2]	Variation incl. X-Factor	Variation excl. X-Factor
Dental Officer (OF2)	£78,992	£68,989	Associate/Performer Specialist Dentist, England, age <35	£51,800	52.5%	33.2%
Senior Dental Officer (OF2)	£80,658[3]	£70,444[3]	Partner/Providing-Performer Dentist, England, age <35	£88,865	-9.2%	-20.7%
Senior Dental Officer (OF3)	£121,328	£105,963	Partner/Providing-Performer Dentist, England, age <35 + >=35<45	£92,352	31.4%	14.7%
Sub-regional Senior Dental Officer (OF4)	£128,491	£112,220	Partner/Providing-Performer Dentist, England, age >=35<45	£95,839	34.1%	17.1%
Principal Dental Officer (OF5)	£135,788	£123,584	-	-	-	-

[1]Data provided by MOD on median pay by trade and rank at 1 April 2022 adjusted by IDR to exclude X-Factor. Note at the time of writing the 2022/23 pay round had not been concluded and there was no general pay award in 2021/22.
[2]Data from Dental Earnings and Expenses Estimates 2019/20 (NHS Digital) adjusted to represent full-time working.
[3]Upper quartile figure for Accredited GDP OF2 gross basic pay as no breakdown available by job role within rank.
[4]No salary or earnings data available for BUPA Regional Clinical Directors.
Note: we regard variations of more than -/+10% as significant.

2.2. General Medical Practitioners

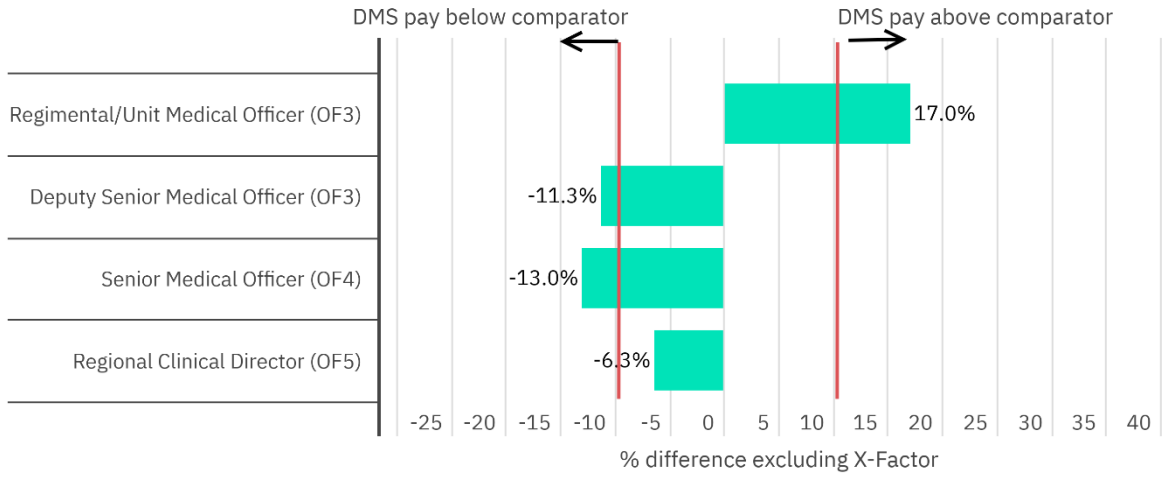
The pay comparisons are based on the 'best fit' comparators identified by IDR as part of this study, namely:

- Regimental/Unit Medical Officer (OF3) → Salaried GP
- Deputy Senior Medical Officer (OF3) → GP Partner
- Senior Medical Officer (OF4) → GP Partner[8]
- Regional Clinical Director (OF5) → Hospital Consultant

Key findings

- Table 4 and Figure 5 compare DMS gross pay with earnings estimates for GPs in England produced by NHS Digital
- Pay for most GMP roles is behind that for relevant comparators, with one exception, Regimental/Unit Medical Officers at OF3
- Pay for Regimental/Unit Medical Officers at OF3 is ahead (17.0%) of average earnings for salaried GPs but pay for other GMPs is behind average earnings for GP Partners
- Pay for Regional Clinical Directors at OF5 is broadly in line with that for Hospital Consultants with a similar level of experience

Figure 5 Pay comparison DMS GMP pay versus GP average earnings



Note: variations within +/-10% are considered to be within market.

[8]Note comparator pay data is for GP Partner is provided by age and we differentiate matching based on the age bracket that most closely represents the military role. Note no pay comparison is provide for Principal Dental Officer (OF5) as no data is available for the comparator.

Table 4 Pay comparison DMS GMP pay versus GP average earnings

DMS role	DMS median gross basic pay 2022	DMS median gross basic pay X-Factor adj.[1]	Civilian job match	Median civilian earnings, FT adj.[2]	Variation incl. X-Factor	Variation excl. X-Factor
Regimental/Unit Medical Officer (OF3)	£118,359	£103,370	Salaried GP, up to age 49	£88,368[3]	33.9%	17.0%
Deputy Senior Medical Officer (OF3)	£122,602[4]	£107,076	GP Partner, aged under 40	£120,764	1.5%	-11.3%
Senior Medical Officer (OF4)	£127,234	£111,121	GP Partner, aged 40-49	£127.095	-0.1%	-12.6%
Regional Clinical Director (OF5)	£133,772	£121,568	Hospital Consultant, 8 (after 19 years completed)	£129,254[5]	3.5%	-5.9%

[1]Data provided by MOD on average pay by trade and rank at 1 April 2022 adjusted by IDR to exclude X-Factor. Note at the time of writing the 2022/23 pay round had not been concluded and there was no general pay award in 2021/22.
[2]Data from GP Earnings and Expenses Estimates 2019/20 NHS Digital).
[3]Includes an additional hours' adjustment worth £8,570.
[4] Upper quartile figure for Accredited GMP OF3 gross basic pay as no breakdown available by job role within rank.
[5] Basic pay based on 40 hours effective from 1 April 2022 plus mean annual non-basic pay per person, as published in Table 1 - Average Annual Earnings by Staff Group, in NHS Trusts and CCGs in England (12 month period April 2021 to March 2022).
Note: we regard variations of more than -/+10% as significant.

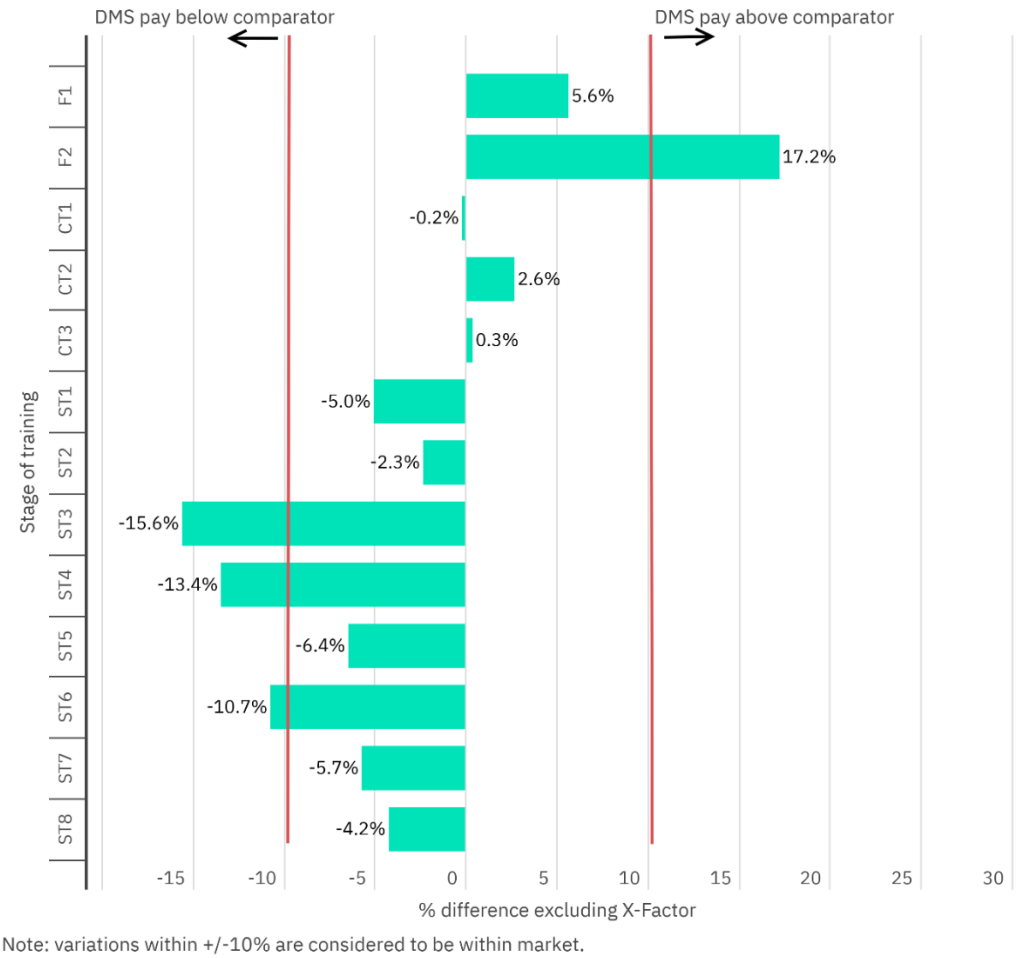
2.3. Junior doctors in training

The pay comparisons in this section are based on previously agreed comparators for doctors in training[9] and compare DMS salaries for junior doctors in training excluding 14.5% X-Factor payment against total pay for the relevant stage in the NHS.

Key results

- Table 2 below shows a comparison of DMS salaries for doctors in training (excluding the X-Factor to allow for like-for-like comparison) against NHS basic pay plus average non-basic pay in NHS Trusts and CCGs in England.
- Pay at DMS for doctors in training is broadly in line with pay for NHS doctors in training at most stages but significantly ahead at Foundation Year 2 (+17.2%) and behind at ST3/ST4 Speciality Registrar level (-15.6% and -13.4% respectively).

Figure 6 Pay comparison DMS versus NHS junior doctors in training



Note: variations within +/-10% are considered to be within market.

[9] See Annexe A: Section 1 Pay and Conditions Circular (M&D) 1/2020.

Table 5 Pay comparison DMS versus NHS junior doctors in training

DMS, 1 April 2022[1]			NHS doctors in training, 1 April 2022				% Variation incl. X-Factor	% Variation excl. X-Factor
DMS non-accredited scale	DMS salary incl. X-Factor	DMS salary excl. X-Factor	NHS scale[2]	a. basic pay (40hrs)[3]	b. non-basic pay[4]	NHS total (a+b)		
OF1 (1)	£45,801	£40,001	F1 (1)	£29,384	£8,487	£37,871	20.9%	5.6%
OF2 (1)	£60,505	£52,843	F2 (2)	£34,012	£11,077	£45,089	34.2%	17.2%
OF2 (2)	£62,214	£54,335	CT1 (3)	£40,257	£14,186	£54,443	14.3%	-0.2%
OF2 (3)	£63,931	£55,835	CT2 (3)	£40,257	£14,186	£54,443	17.4%	2.6%
OF2 (4)	£65,663	£57,347	CT3 (4)	£40,257	£16,920	£57,177	14.8%	0.3%
OF2 (2)	£62,214	£54,335	ST1 (3)	£40,257	£16,920	£57,177	8.8%	-5.0%
OF2 (3)	£63,931	£55,835	ST2 (3)	£40,257	£16,920	£57,177	11.8%	-2.3%
OF2 (4)	£65,663	£57,347	ST3 (4)	£51,017	£16,920	£67,937	-3.3%	-15.6%
OF2 (5)	£67,385	£58,851	ST4 (4)	£51,017	£16,920	£67,937	-0.8%	-13.4%
OF3-5 (1)	£72,778	£63,562	ST5 (4)	£51,017	£16,920	£67,937	7.1%	-6.4%
OF3-5 (2)	£77,028	£67,274	ST6 (5)	£58,398	£16,920	£75,318	2.3%	-10.7%
OF3-5 (3)	£81,305	£71,009	ST7 (5)	£58,398	£16,920	£75,318	7.9%	-5.7%
OF3-5 (4).	£82,582	£72,124	ST8 (5)	£58,398	£16,920	£75,318	9.6%	-4.2%

[1]Data from the Tri-Service Directed Letter dated 20 July 2020 detailing DMS regular medical and dental officers' salaries 2020-21. Only those earning less than £24,000 received a pay rise in 2021/22. Note at the time of writing the 2022/23 pay round had not been concluded and there was no general pay award in 2021/22.
[2]Matching of DMS staff on the non-accredited scale to NHS junior doctors aims to reflect the level of experience, hence there are two sets of matches for OF2 rank staff.
[3]NHS Junior Doctors in England on the 2016 Contract, as published on the BMA website on 1 July 2022.
[4]Basic pay based on 40 hours effective from 1 April 2022 plus mean annual non-basic pay per person, as published in Table 1 - Average Annual Earnings by Staff Group, in NHS Trusts and CCGs in England (12 month period April 2021 to March 2022).
Note: we regard variations of more than -/+10% as significant.

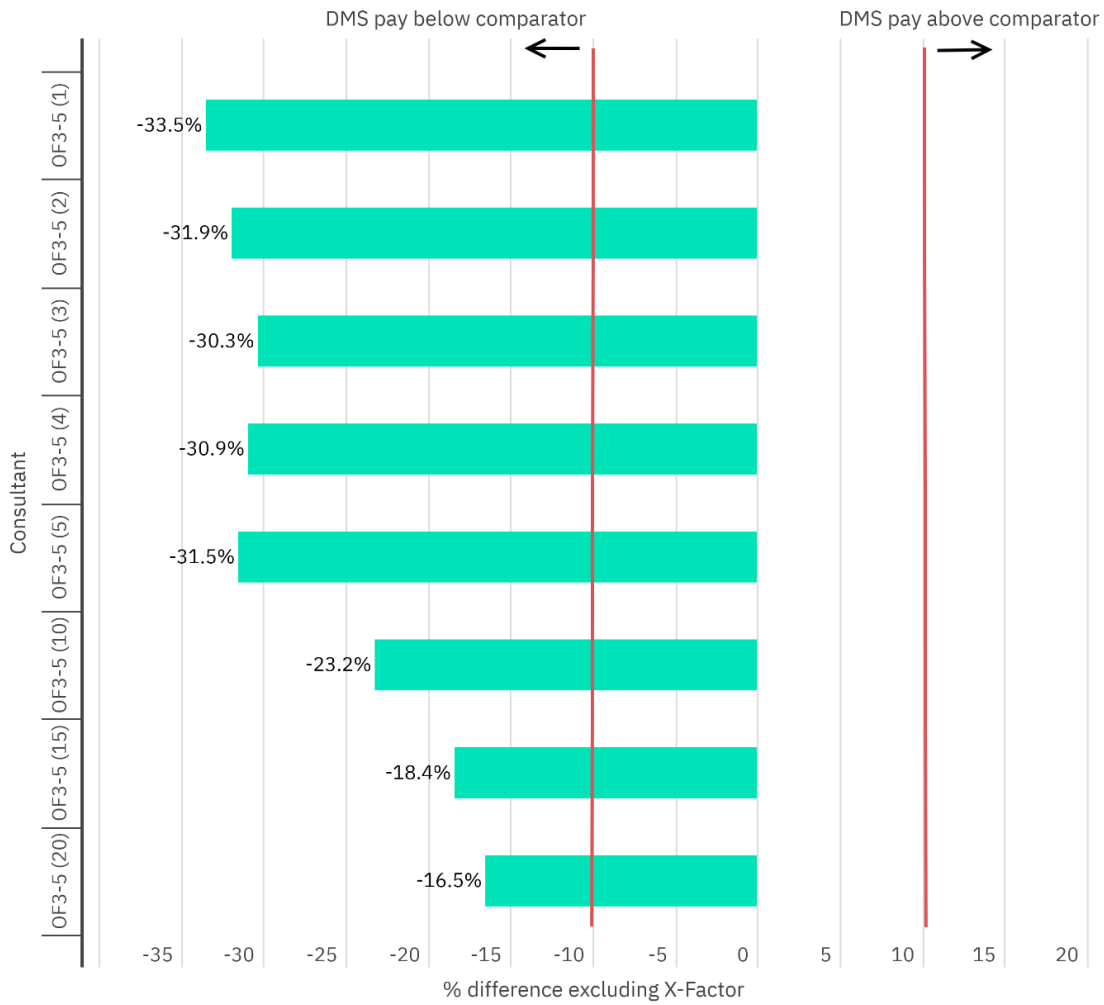
2.4. Consultants

The pay comparisons in this section are based on previously agreed comparators for consultants and compare the DMS scale for consultants against the pay point for NHS consultants at the relevant years of experience.

Key results

- Table 5 details a comparison of the DMS salaries for consultants (excluding the X-Factor) against NHS basic pay plus average non-basic pay average earnings in NHS Trusts and CCGs in England based on elements received by the majority consultants (which includes additional hours, band supplement and on-call)
- DMS pay for consultants is behind that for NHS consultants, significantly for at least the first five years

Figure 7 Pay comparison DMS versus NHS consultants



Note: variations within +/-10% are considered to be within market.

Table 6 Pay comparison DMS versus NHS consultants

DMS, 1 April 2022[1]			NHS consultants in England, 1 April 2022				% Variation incl. X-Factor	% Variation excl. X-Factor
DMS scale	DMS salary incl. X-Factor	DMS salary excl. X-Factor	NHS scale England (years completed)	a. basic pay (40hrs)[2]	b. non-basic pay average earnings	NHS total (a+b)[3]		
OF3-5 (1)	£86,210	£75,292	1 (start)	£84,559	£28,733	£113,292	-23.9%	-33.5%
OF3-5 (2)	£90,400	£78,952	2 (after 1)	£87,207	£28,733	£115,940	-22.0%	-31.9%
OF3-5 (3)	£94,634	£82,650	3 (after 2)	£89,855	£28,733	£118,588	-20.2%	-30.3%
OF3-5 (4)	£95,912	£83,766	4 (after 3)	£92,503	£28,733	£121,236	-20.9%	-30.9%
OF3-5 (5)	£97,163	£84,859	5 (after 4)	£95,143	£28,733	£123,876	-21.6%	-31.5%
OF3-5 (10)	£114,532	£100,028	6 (after 9)	£101,431	£28,733	£130,164	-12.0%	-23.2%
OF3-5 (15)	£127,526	£111,376	7 (after 14)	£107,722	£28,733	£136,455	-6.5%	-18.4%
OF3-5 (20)	£136,424	£119,148	8 (after 19)	£114,003	£28,733	£142,736	-4.4%	-16.5%

[1]Data from the Tri-Service Directed Letter dated 20 July 2020 detailing DMS regular medical and dental officers' salaries 2020-21. Note at the time of writing the 2022/23 pay round had not been concluded and there was no general pay award in 2021/22.
[2]NHS Consultants in England on the 2003 Contract, as published on the BMA website on 1 July 2022.
[3]Basic pay based on 40 hours effective from 1 April 2022 plus mean annual non-basic pay per person, as published in Table 1 - Average Annual Earnings by Staff Group, in NHS Trusts and CCGs in England (12 month period April 2021 to March 2022).
Note: we regard variations of more than -/+10% as significant.

Appendices

Appendix A – GDP comparator matrix

The following table summarises the outcomes of our qualitative assessments of civilian comparators for GDP roles. Our assessments involved examining how closely each of the individual job factors match between the military role and civilian comparator, with a rating scale of 1 to 5; with 5 representing the closest match. The overall combined score indicates the overall suitability of the comparator, with 75% and over representing a 'good' comparator.

	Comparability assessment factors												Total	
	Clinical skills and experience		Management of resources		Communications		Service delivery		Risk management and governance		Decision-making and accountability			
	S[1]	Rationale	S	Rationale	S	Rationale	S	Rationale	S	Rationale	S	Rationale	S	%
Dental Officer (OF2)														
Asso-ciate Dentist	5	Skills and experience required are a good match but with the caveat that civilians are likely to have more experience through length of service. Both have independence to practice	5	Good match- both roles have limited responsibility for monitoring and managing resources	4	Close match both roles require a similar level of communication, although military role has some additional interaction with the wider working group	3	The overall contribution to the organisation of the military role is slightly greater due to the additional occupational focus of the role	5	Good match since both roles are mainly only responsible for their own clinical work	4	Close match but civilian role has a slightly higher level of autonomous decision making due to the presence of a support structure in the military which is less evident in the civilian sector	26	87%
Comm-unity Dentist (SPDCS)	3	Core clinical skills are similar however community dentists deal with patients with complex behavioural characteristics which typically require additional training to perform the role effectively	5	Good match- both roles have limited responsibility for monitoring and managing resources	3	Communications for civilian role involves a higher frequency level of caring and understanding for patients with additional and often complex needs e.g., vulnerable adults; elderly; patients with learning and disabilities and phobic patients.	5	Good match - both roles have a wider contribution to their respective communities	3	Both roles have a degree of risk management, but the military role has an all-encompassing responsibility to ensure patients are fit to deploy	3	Civilian role requires a higher level of autonomous judgements since the role involves a greater level of lone working, outside the clinical setting	22	73%

Dental Officer (OF2) cont'd														
	Clinical skills and experience		**Management of resources**		**Communications**		**Service delivery**		**Risk management and governance**		**Decision-making and accountability**		**Total**	
	S[1]	Rationale	S	Rationale	S	Rationale	S	Rationale	S	Rationale	S	Rationale	S	%
Foundat-ion Dentist/ VDP	2	Poor match as DFT dentist still very early in their career with limited clinical experience and are not yet accredited or working fully independently	5	Good match- both roles have limited responsibility for monitoring and managing resources	3	Civilian communications with patients are likely to be overseen/moderated/ circumscribed by a more senior dentist	2	VT dentists unlikely to have a dedicated patient list, whereas the military role will be responsible for providing dentistry to named registered patients	3	VT dentists' clinical work is likely to be overseen, whereas the military role will be responsible for his/her own clinical work and risk management	2	VT dentist likely to refer/seek guidance on clinical decisions	17	57%

Senior Dental Officer (OF2)														
	Clinical skills and experience		**Management of resources**		**Communications**		**Service delivery**		**Risk management and governance**		**Decision-making and accountability**		**Total**	
	S[1]	Rationale	S	Rationale	S	Rationale	S	Rationale	S	Rationale	S	Rationale	S	%
Associate/Performer Dentist	4	Skills and experience required are a close match but with the caveat that civilians are likely to have more experience through length of service. Both have independence to practice at this level	1	Military dentists at this level have additional responsibilities as they are responsible for the dental centre (albeit a small/less-complex centre)	2	Same level of communications at the patient level but the military role requires higher level of communications outside the immediate working group and involves a degree of influence	1	Poor match since the military role has responsibility for the dental practice and ensuring patient population is fit to deploy, while the civilian role is typically only responsible for own clinical work	1	Poor match since the military role has responsibility for the wider governance and risk management for the dental centre	2	Military role has greater accountability for decisions/clinical success etc at the centre	11	37%
Partner/Providing-Performer Dentist - sole/small practice	4	Close match but civilians are likely to have more experience through longer service, and the military role has an additional occupational focus	4	Military role likely to be similar to partner role in sole/small practice since both roles involve responsibility for running the practice, managing staff/budgets etc	4	Both roles involve communications outside the working group, but civilian role has the added dimension relating to contract negotiation	4	Close match since both roles have an immediate impact on patients and the wider organisational remit	4	Close match but the military structure provides overarching risk management support and governance oversight through audits and mentoring, whereas partners are solely responsible	3	No formal/structural support network for partners as there is for the military role	23	77%

Senior Dental Officer (OF3)														
	Clinical skills and experience		Management of resources		Communications		Service delivery		Risk management and governance		Decision-making and accountability		Total	
	S[1]	Rationale	S	Rationale	S	Rationale	S	Rationale	S	Rationale	S	Rationale	S	%
Partner/ Providing-Performer Dentist (multi/ large partner-ship)	5	Good match- with the caveat military dentists have an occupational focus	4	Close match as both roles involve responsibility for running a practice, managing staff/budgets etc., including more than one site	4	Both roles involve communications outside the working group, but civilian role has the added dimension relating to contract negotiation with financial impacts	4	Civilian role has responsibility for service delivery at a large multi-chair practice or number of smaller dental practices, and consolidation of military dental centres is increasing the likelihood that the military role will be managing a large multi-chair centre	4	Close match but on the military side the structure provides a level of overarching risk management support and governance oversight through audits and mentoring, whereas partners are solely responsible in this respect	3	No formal/structural support network for partners as there is for the military role.	24	80%
Hospital Consult-ant (newly qual.)	3	Civilian role has a higher level of clinical skills and experience as an internal expert in chosen speciality	3	Military role likely to have greater responsibility for resources and staff than a newly qualified consultant with no departmental responsibilities	3	Military role communications cover a broader area/remit beyond patient care than those for newly qualified consultants	2	Military tole has wider remit in respect of service delivery and impact of the role on the organisation	2	Military role has additional responsibility for risk management and governance for other staff at the dental centre	5	Good match- both roles have a similar level of accountability and freedom to make autonomous decisions. Both have a degree of mentoring from a senior professional	18	60%

Senior Dental Officer (OF3)														
	Clinical skills and experience		**Management of resources**		**Communications**		**Service delivery**		**Risk management and governance**		**Decision-making and accountability**		**Total**	
	S [1]	Rationale	S	Rationale	S	Rationale	S	Rationale	S	Rationale	S	Rationale	S	%
Hospital Consult-ant (experi-enced)	2	Civilian role has a higher level of clinical skills and experience. Civilian is recognised as an internal expert in chosen speciality	4	Both have managerial responsibilities for staff development, supervision and resource management albeit the consultant is managing higher qualified medical staff	3	Both roles have a similar level of communication skills but there is a difference in the range of communications for experienced consultants, for example through teaching/training and communications with hospital management	2	Consultants with departmental management responsibilitie s have a greater level of responsibility in respect of service delivery	2	Consultants with departmental management responsibilities have greater responsibility for clinical risk since they oversee registrars and mentor junior consultants and risk management/gover nance of department, which is undertaking more complex treatments	3	Consultants have a slightly higher level of accountability and freedom to make autonomous decisions	16	53%

Sub-regional Senior Dental Officer (OF4)														
	Clinical skills and experience		**Management of resources**		**Communications**		**Service delivery**		**Risk management and governance**		**Decision-making and accountability**		**Total**	
	S[1]	Rationale	S	Rationale	S	Rationale	S	Rationale	S	Rationale	S	Rationale	S	%
Partner/ Providing-Performer Dentist (multi/ large partner-ship)	5	Good match- same level of clinical skills and experience but with the caveat military role has an occupational focus	4	Close match as both roles involve responsibility for running practices, managing staff/budgets etc across a number of sites with the caveat that military role will typically manage between 6 and 8 sites	4	Both roles involve communications outside the working group, but civilian role has the added dimension relating to contract negotiation with financial impacts	5	Good match- both roles have accountability for service delivery at multiple sites	4	Close match but on the military side the structure provides a level of longer-term risk management support and governance oversight which partners do not typically have	4	Close match but military role has support at a strategic level	26	87%
Hospital Consult-ant (experi-enced)	3	Civilian role has a higher level of clinical specialism with both dental and surgical/medical qualifications	3	Military role has a greater level of responsibility in this area as has responsibility for overseeing practices, managing staff/budgets etc across several sites	3	Military role has a wider remit in this respect since communications relate to critical matters for the whole dental service	3	Consultant has more direct and immediate responsibility for service delivery	4	Close match although the consultant is managing risk involving more complex treatments	5	Good match- both roles have a large degree of autonomy at an operational level	21	70%

Principal Dental Officer (OF5)														
	Clinical skills and experience		**Management of resources**		**Communications**		**Service delivery**		**Risk management and governance**		**Decision-making and accountability**		**Total**	
	S[1]	Rationale	S	Rationale	S	Rationale	S	Rationale	S	Rationale	S	Rationale	S	%
Partner/Providing-Performer Dentist (multi/large partnership)	5	Good match-same level of clinical skills and experience but with the caveat military role has an occupational focus	2	Military role is regional and has much broader level of responsibility	3	Military role communications likely to relate to critical matters for the wider dental service with a greater influencing requirement	2	Military role contributes in the medium to longer-term by being accountable for service delivery at a regional level	2	The roles have a different remit as partners are responsible for immediate/day-to-day risk management while in the military risk management and governance is longer-term/more strategic/provides oversight	2	Military role has greater responsibility in respect of decision-making and accountability	16	53%
Hospital Consultant (experienced)	3	Civilian role has a higher level of specialism with both dental and surgical/ medical qualifications	2	Military role has a greater level of responsibility in this area since it is regional	2	Military role communications likely to relate to critical matters for the wider dental service with a greater influencing requirement	2	Military role contribution is greater and more strategic	3	Military role is regional, more overarching rather than immediate and therefore has greater responsibility in this area	2	Military role has greater responsibility in respect of decision-making and accountability	14	47%

Principal Dental Officer (OF5) cont'd														
	Clinical skills and experience		Management of resources		Communications		Service delivery		Risk management and governance		Decision-making and accountability		Total	
	S[1]	Rationale	S	Rationale	S	Rationale	S	Rationale	S	Rationale	S	Rationale	S	%
Regional Dental Clinical Director (BUPA)	5	Same level of clinical skills and experience since civilians are often specialists in their field	4	Civilian role has a wider remit – more practices and resources to oversee	4	Civilian role requires communication at senior levels; collaborative working with practices; influence at org. level	5	Good match since both deliver over the medium-to-long term	4	Good match- both have significant responsibility for audit; clinical governance; standards at regional level. Scale of complaints/ investigations larger in the civilian sector	4	Both roles have significant levels of accountability and decision-making authority at a regional level	26	87%

[1]S – rating of extent of match 1 to 5; 5 being the closest
[2]Total score of each factor (max = 30)
[3]Proportion of the maximum score

Appendix B – GMP comparator matrix

The following table summarises the outcomes of our qualitative assessments of civilian comparators for GMP roles. Our assessments involved examining how closely each of the individual job factors match between the military role and civilian comparator, with a rating scale of 1 to 5; with 5 representing the closest match. The overall combined score indicates the overall suitability of the comparator, with 75% and over representing a 'good' comparator.

	Comparability assessment factors												Total	
	Clinical skills and experience		Management of resources		Communications		Service delivery		Risk management and governance		Decision-making and accountability			
	S[1]	Rationale	S	Rationale	S	Rationale	S	Rationale	S	Rationale	S	Rationale	S	%
Unit/Reg Medical Officer (OF3)														
Salaried GP	4	Close match for clinical skills, not 5 since military GPs have a job requirement for additional specialist skills/areas	5	Good match- both roles typically have some supervisory responsibility for other staff (i.e., medics in the military and registrars in the civilian sector)	3	Military role will interact with commanding officers which requires a higher level of communications than salaried GP, where communications are mainly with patients and the immediate working group	4	Close match since both roles have a direct impact on patients and unit within which they are assigned. Not 5, military have occupational aspect/fitness to employ /deploy	5	Good match- both roles' primary focus will be clinical risk. Neither role has responsibility for governance of the centre	3	Military role likely to involve greater extent of lone working (and autonomous decision making), since they are attached but not necessarily based at a medical centre	24	80%
GP Partner	4	Close match for clinical skills, not 5 since military GPs have a job requirement for additional specialist skills/areas	2	Civilian role as the employer contributes to day to day financial and operational management, which includes line management responsibility for multi-disciplinary staff. Military role has supervisory responsibilities but less responsibility for other resources	3	Civilian communications with PCT/CCG etc likely to be more complex than that for RMO/UMO and involve an element of negotiation/persuasion	3	Partners' impact is broader and longer-term than UMO/RMO (since they are accountable for service delivery wholly or as part of a partnership) and have occ. aspect/fitness aspect	3	Partners have additional governance responsibilities and assume operational and financial risks linked to the survival and growth of the practice	2	Partner has wider remit in respect of decision-making and accountability, since they are ultimately the employer and contract supplier	14	47%

Deputy Senior Medical Officer (OF3)														
	Clinical skills and experience		Management of resources		Communications		Service delivery		Risk management and governance		Decision-making and accountability		Total	
	S[1]	Rationale	S	Rationale	S	Rationale	S	Rationale	S	Rationale	S	Rationale	S	%
Salaried GP	4	Close match for clinical skills, not 5 since military GPs have a job requirement for additional specialist skills/areas	2	Military role has a wider remit in this respect since they formalise/deputise for the SMO and will be responsible for managing a small team of staff or a specific budget/income level or a range of facilities (salaried GPs may have clinical supervisory responsibilities)	3	Military role will interact with commanding officers which requires a higher level of communications	3	DSMO has greater impact on services delivered and wider organisational strategy/aims and has the occupational aspect/fitness to employ/ deploy aspect	3	DSMO take on some governance and audit responsibilities whereas civilian role primary clinical risk	3	DSMO has wider remit in respect of decision-making and accountability	18	60%
GP Partner	4	Close match for clinical skills, not 5 since military GPs have a job requirement for additional specialist skills/areas	3	DSMO will have line management responsibilities, but partner has a wider remit in this respect, more akin to SMO	5	Good match-communication in both roles involves complex issues and an element of influencing/persuading outside immediate working group	4	Close match as both roles play a significant part in the delivery of services and achievement of strategic goals over the medium-longer term, although civilian has overarching responsibility for contract delivery	4	Civilian role has additional risks, such as financial, personal/reputational, employer liability and business liability, which are less evident in the military context	4	Close match since both roles have a similar level of accountability and freedom to make autonomous decisions, and responsibility for the practice (not 5 since DSMO only deputises)	24	80%

Senior Medical Officer (OF4) [PMO in Navy]														
	Clinical skills and experience		Management of resources		Communications		Service delivery		Risk management and governance		Decision-making and accountability		Total	
	S[1]	Rationale	S	Rationale	S	Rationale	S	Rationale	S	Rationale	S	Rationale	S	%
GP Partner	4	Close match for clinical skills, not 5 since military GPs have a job requirement for additional specialist skills/areas	4	Civilian role has a wider remit in terms of overarching responsibility. Also note civilian practice is typically larger in scale	5	Good match, since communication in both roles involves complex issues and influencing/persuading outside the immediate working group	5	Good match- both roles play a significant part in the delivery of services and achievement of strategic goals over the medium-longer term	4	Close match but need to take account of additional risks on the civilian side (see above) (much of which can be mitigated and could be balanced by SMO having sole responsibility for medicines procurement, dispensing and safety. Norm in NHS is non-dispensing.)	5	Good match- both roles have a similar level of accountability and freedom to make autonomous decisions, and overarching responsibility for the practice	27	90%
Hospital Consult-ant (newly qual.)	4	Both have substantial level of clinical expertise and are recognised as an internal expert in chosen speciality	3	Military role likely to have greater responsibility for resources and staff than a newly qualified consultant with some responsibility for junior staff and additional NHS responsibilities and external duties	4	Both roles have a similar level of communication skills but there is a difference in the range of communications for experienced consultants, for example through teaching/training and communications with hospital management	3	Newly qualified consultant with minor department responsibility would not have the wider remit in respect of service delivery and impact of the role on the organisation	3	Military role has greater responsibility for risk management and governance since newly qualified consultants typically share clinical governance activities including clinical audits with the team	2	Unlike a junior consultant, SMO is highly autonomous, makes executive and managerial decisions as well as clinical and is totally accountable, including for all clinical activity within the practice including dispensing	18	60%

Senior Medical Officer (OF4) *PMO in Navy cont'd														
	Clinical skills and experience		Management of resources		Communications		Service delivery		Risk management and governance		Decision-making and accountability		Total	
	S[1]	Rationale	S	Rationale	S	Rationale	S	Rationale	S	Rationale	S	Rationale	S	%
Hospital Consult-ant (experie-nced)	3	Military do not have the same level of specialist clinical knowledge and expertise as an experienced consultant	4	Close match since both have overall responsibility for the medical unit (i.e., medical centre(s) or department(s)) involving managerial responsibilities for staff development, supervision, and resource management, although likely to be a smaller team in clinical setting with additional line management support in from other departments (i.e., working with nurses who belong to another team)	4	Both roles have a similar level of communication skills but there is a difference in the range of communications for experienced consultants, for example through teaching/training and communications with hospital management	4	Close match since both roles play a significant part in the delivery of services and achievement of strategic goals over the medium-longer term; however not 5 since clinical role more strategic in this respect	3	Military role has both clinical and non-clinical risk management and governance responsibilities, whereas the consultant role is more focused on clinical risk and governance	4	Close match since both roles exercising discretion over a discrete department or broad area	22	73%

Clinical Regional Director (OF5)														
	Clinical skills and experience		Management of resources		Communications		Service delivery		Risk management and governance		Decision-making and accountability		Total	
	S[1]	Rationale	S	Rationale	S	Rationale	S	Rationale	S	Rationale	S	Rationale	S	%
Clinical Director PCN	3	Civilian role is expected to be an appropriately qualified clinician in a member practice of the PCN, but military role has a job requirement for additional specialist skills/areas	1	Poor match since civilian role does not have any direct management of resources in respect of this role	5	Good match- both roles influence a wider stakeholder group on matters critical to the organisations' goals and across a region of numerous medical centres and Stations/ garrisons	4	Close match since both roles focus on improving and developing services to their communities but not 5 since military role has greater individual accountability for results	2	Military role has more direct responsibility for risk management and governance; civilian role has responsibility for considering clinical risk when devising protocols but little responsibility for non-clinical risk	2	Military role has a greater level of autonomy	17	57%
Hospital Consult-ant (experi-enced)	3	Military are experts in their field of general practice but do not have the same level of specialist clinical knowledge and expertise as an experienced consultant	3	Military role has a greater level of responsibility in this area since it is regional, with responsibility for 19-20 medical centres	3	Military role communications likely to relate to critical matters for the wider DMS service with a greater influencing requirement	3	Military role contribution to service delivery is greater since it is regional and more strategic	3	Military role is regional and overarching rather than immediate and therefore has greater responsibility in this area	3	Military role has greater responsibility in respect of decision-making and accountability across a region	18	60%

[1]S – rating of extent of match 1 to 5; 5 being the closest
[2]Total score of each factor (max = 30)
[3]Proportion of the maximum score

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