Armed Forces' Pay Review Body

Service Medical and Dental Officers

Supplement to the Thirty-Fifth Report – 2006

Chairman: Professor David Greenaway

Cm 6777

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Service Medical and Dental Officers

Supplement to the Thirty-Fifth Report 2006

Chairman: Professor David Greenaway

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

June 2006

Cm 6777

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Twenty-First Report	Cm. 1815, February 1992
Supplement to Twenty-First Report	Cm. 1941, May 1992
Twenty-Second Report	Cm. 2150, February 1993
Twenty-Third Report	Cm. 2461, February 1994
Supplement to Twenty-Third Report	Cm. 2586, July 1994
Twenty-Fourth Report	Cm. 2761, February 1995
Twenty-Fifth Report	Cm. 3091 – I, 1996
Annex to the Twenty-Fifth Report	Cm. 3091 – II, 1996
Supplement to Twenty-Fifth Report	Cm. 3258, May 1996
Twenty-Sixth Report	Cm. 3537, February 1997
Supplement to the Twenty-Sixth Report	Cm. 3655, June 1997
Twenty-Seventh Report	Cm. 3834, January 1998
Supplement to the Twenty-Seventh Report	Cm. 3942, July 1998
Twenty-Eighth Report	Cm. 4242, February 1999
Supplement to the Twenty-Eighth Report	Cm. 4213, June 1999
Twenty-Ninth Report	Cm. 4565, February 2000
Supplement to the Twenty-Ninth Report	Cm. 4566, June 2000
Thirtieth Report	Cm. 4993, February 2001
Supplement to the Thirtieth Report	Cm. 4994, April 2001
Thirty-First Report	Cm. 5361, January 2002
Supplement to the Thirty-First Report	Cm. 5362, March 2002
Thirty-Second Report	Cm. 5717, January 2003
Supplement to the Thirty-Second Report	Cm. 6090, December 2003
Thirty-Third Report	Cm. 6113, January 2004
Supplement to the Thirty-Third Report	Cm. 6182, April 2004
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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:

Professor David Greenaway (Chairman)[1]
Robert Burgin
Alison Gallico
Dr Peter Knight CBE
Professor Derek Leslie
Professor the Lord Patel of Dunkeld KB
Neil Sherlock
Air Vice Marshal (Retired) Ian Stewart CB
Dr Anne Wright CBE

The secretariat is provided by the Office of Manpower Economics.

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

Appendix 3

Previous Reports of the Armed Forces' Pay Review Body

First Report	Cm. 4954, April 1972
Second Report	Cm. 5336, June 1973
Supplement to Second Report	Cm. 5450, October 1973
Third Report	Cm. 5631, May 1974
Supplement to Third Report	Cm. 5729, September 1974
Second Supplement to Third Report	Cm. 5853, January 1975
Fourth Report	Cm. 6063, May 1975
Supplement to Fourth Report	Cm. 6146, July 1975
Second Supplement to Fourth Report	Cm. 6420, March 1976
Fifth Report	Cm. 6470, May 1976
Supplement to Fifth Report	Cm. 6515, July 1976
Sixth Report	Cm. 6801, April 1977
Seventh Report	Cm. 7177, April 1978
Supplement to Seventh Report	Cm. 7288, December 1978
Eighth Report	1979
Supplement to Eighth Report	Cm. 7603, June 1979
Second Supplement to Eighth Report	Cm. 7770, November 1979
Ninth Report	Cm. 7899, May 1980
Supplement to Ninth Report	Cm. 7956, July 1980
Tenth Report	Cm. 8241, May 1981
Supplement to Tenth Report	Cm. 8322, July 1981
Eleventh Report	Cm. 8549, May 1982
Supplement to Eleventh Report	Cm. 8573, June 1982
Twelfth Report	Cm. 8880, May 1983
Supplement to Twelfth Report	Cm. 8950, July 1983
Thirteenth Report	Cm. 9255, June 1984
Supplement to Thirteenth Report	Cm. 9301, July 1984
Fourteenth Report	Cm. 9526, June 1985
Supplement to Fourteenth Report	Cm. 9568, July 1985
Fifteenth Report	Cm. 9784, May 1986
Supplement to Fifteenth Report	Cm. 9866, July 1986
Sixteenth Report	Cm. 126, April 1987
Supplement to Sixteenth Report	Cm. 176, July 1987
Seventeenth Report	Cm. 357, April 1988
Supplement to Seventeenth Report	Cm. 396, June 1988
Eighteenth Report	Cm. 579, February 1989
Supplement to Eighteenth Report	Cm. 667, April 1989
Nineteenth Report	Cm. 936, February 1990
Supplement to Nineteenth Report	Cm. 1065, May 1990
Twentieth Report	Cm. 1414, January 1991
Supplement to Twentieth Report	Cm. 1529, May 1991

Table 2.8: **Annual salaries inclusive of the X-Factor for Higher Medical Management Pay Spine: OF5**

Increment level	Military salary
	£
Level 15	108,106
Level 14	107,445
Level 13	106,773
Level 12	106,106
Level 11	105,441
Level 10	104,773
Level 9	104,102
Level 8	103,437
Level 7	102,769
Level 6	101,769
Level 5	100,773
Level 4	99,765
Level 3	98,769
Level 2	97,773
Level 1	96,765

Trainer Pay

The annual rate of GMP and GDP Trainer Pay from 1 April 2005 is £7,019.92.

Distinction Awards

A+	£57,039
A	£38,027
B	£15,211

Clinical Excellence Awards

Bronze	£17,789
Silver	£27,987
Gold	£38,643
Platinum	£54,626

Contents

Table 2.4: **Annual salaries inclusive of the X-Factor for Service Medical and Dental Officers: OF2**

Increment level	Military salary		
	Accredited Medical Officers	Non-Accredited Medical and Dental Officers	Dental Officers
	£	£	£
Level 5	60,371	54,078	60,371
Level 4	59,017	52,695	59,017
Level 3	57,666	51,308	57,666
Level 2	56,312	49,928	56,312
Level 1	54,958	48,556	54,958

Table 2.5: **Annual salaries inclusive of the X-Factor for Service Medical and Dental Officers: OF1 (PRMPs)**

	Military salary
	£
OF1	36,756

Table 2.6: **Annual salaries inclusive of the X-Factor for Medical and Dental Cadets**

Length of service		Military salary
		£
Cadets	after 2 years	16,626
	after 1 year	14,958
	on appointment	13,297

Table 2.7: **Annual salaries inclusive of the X-Factor for Higher Medical Management Pay Spine: OF6**

Increment level	Military salary
	£
Level 7	114,858
Level 6	113,803
Level 5	112,752
Level 4	111,694
Level 3	110,635
Level 2	109,588
Level 1	108,529

Table 2.3: **Annual salaries inclusive of the X-Factor for Non-Accredited Medical Officers (OF3-OF5)**

Increment level	Military salary
	£
Level 29	86,563
Level 28	85,844
Level 27	85,129
Level 26	84,414
Level 25	83,695
Level 24	82,979
Level 23	82,264
Level 22	81,548
Level 21	80,837
Level 20	80,121
Level 19	79,406
Level 18	78,694
Level 17	77,979
Level 16	77,263
Level 15	76,544
Level 14	75,832
Level 13	75,117
Level 12	74,402
Level 11	73,686
Level 10[a]	72,974
Level 9	72,255
Level 8	70,806
Level 7	69,354
Level 6	68,321
Level 5	67,299
Level 4	66,277
Level 3	65,251
Level 2	61,816
Level 1	58,407

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

ARMED FORCES' PAY REVIEW BODY 2006 DMS REPORT – SUMMARY

Key recommendations

- **A 6.6 per cent increase, plus the DDRB recommended increase, for accredited DMS Consultants, General Medical and Dental Practitioners, Higher Medical Management staff and DMS Reserve equivalents;**
- **A 2.2 per cent increase for all DMS Junior Doctors in training (including GMP Registrars), Cadets and DMS Reserve equivalents, and a 2.4 per cent increase for Associate Specialists;**
- **A 2.2 per cent increase to the values of DMS Clinical Excellence Awards, Distinction Awards and DMS Trainer Pay.**

Evidence for this report

Our terms of reference require us to examine evidence on manning, recruitment and retention, and pay comparisons. In the case of the Defence Medical Services (DMS) we make comparisons with the National Health Service (NHS). Our recommendations draw on written and oral evidence from the Government and the British Medical and Dental Associations, evidence from our visits and independent research into pay comparability. We also take into account DDRB's recommendations for 2006-07.

Manning, recruitment and retention

MOD continues work to define the Deployable Medical Capability and, in the meantime, we make our assessments in relation to current requirements. As at 1 April 2005, Medical Officer strength stood at 1,000 – a shortfall of 18 per cent which widened to 21 per cent by 1 July 2005. Dental Officer strength was 270 against a requirement of 290 at 1 April 2005 – a shortfall of around 7 per cent which widened to just under 10 per cent by 1 July 2005. Undermanning in critical Consultant specialties was between 40 and 60 per cent in the worst cases and 31 per cent for General Medical Practitioners. DMS Reserve Medical Officer manning has been in steady decline since 2002 with significant shortfalls, for example by July 2005 the Territorial Army strength was only 310 against a requirement of 680. Recruitment of Medical Officers was below target in 2004-05, but there were encouraging signs early in 2005-06 with a similar picture for Dental Officers. Outflow and Voluntary Outflow for Medical Officers had been steady although the parties' evidence pointed to a combination of high operational commitments and specialty shortages impacting on retention. BMA surveys indicated that 48 per cent planned to leave the DMS within five years and that few mid-career personnel extended their DMS service. Dental Officer outflow in the first part of 2005-06 already exceeded that for 2004-05. A BDA survey suggested that restoration of the pay link with DMS GMPs had been a major factor in maintaining morale and retention. Across the DMS, outflow undermined the achievement of sustainable experience profiles and MOD continues to lose expensively trained Officers without having gained a reasonable return on its investment.

Pay comparability

The DMS Continuous Attitude Survey showed the importance of the package and comparability with the NHS to decisions to stay in the DMS. Our pay comparisons continue to be constrained by an incomplete picture on NHS earnings. We have, however, drawn on the parties' evidence and an update commissioned from NHS Partners. MOD and the BMA/BDA

used data on the number of Programmed Activities worked by DMS and NHS Consultants to indicate a 6.6 per cent gap between DMS and NHS pay over a career. They also argued that emerging data showed significant earnings increases for NHS GMPs and that, in the absence of definitive comparator data, the link between DMS GDPs and GMPs should be maintained. The evidence indicated that DMS and NHS Junior Doctors' pay was broadly aligned. The parties' evidence was, in the main, borne out by NHS Partners. We will work to improve the evidence base for comparisons as more comparator data become available.

Recommendations

MOD and the BMA/BDA proposed a 6.6 per cent increase, plus the DDRB recommended increase, for accredited DMS doctors and dentists and DMS Reserve equivalents. They proposed increases in line with DDRB's recommendations for those in training (Juniors, GMP Registrars and Cadets), Associate Specialists and DMS Reserve equivalents. We consider that current DMS manning levels, continuing risks to retention in a competitive market, improving return of service and the need to keep pace with significant changes in NHS pay levels all require an appropriate pay response. We consider that an award as proposed by the parties, which takes account of DDRB's recommended increases, would deliver comparable pay levels for 2006-07 and we recommend accordingly. We also recommend increases in line with DDRB to DMS Clinical Excellence Awards, Distinction Awards and DMS Trainer Pay. We estimate that our recommendations add £9.9 million to the DMS pay bill.

Looking ahead – the medium term

MOD aims to achieve DMS manning balance by 2010 against a background of competing for resources within the MOD budget and under the 2007 Spending Review. Tight medical and dental labour markets, continuing NHS pay and career developments, and the feminisation of the professions will present challenges and require the DMS to offer a balanced package of pay and non-pay measures. MOD has placed great store in the retention positive aspects of new DMS pension arrangements. Achieving pay comparability with the NHS, following significant change to pay arrangements, remains important to DMS recruitment and retention. The evidence, however, points to differing comparisons and manning positions across Consultant specialties and between GMPs and GDPs. Targeting our pay recommendations is constrained and we look to MOD to take advantage of the opportunities presented by Joint Personnel Administration to review DMS career and pay structures.

Table 2.2: **Annual salaries inclusive of the X-Factor for accredited GMPs and GDPs (OF3-OF5)**

Increment level	Military salary
	£
Level 35	102,426
Level 34	102,076
Level 33	101,806
Level 32	101,371
Level 31	101,021
Level 30	100,667
Level 29	100,397
Level 28	99,963
Level 27	99,609
Level 26	99,258
Level 25	98,900
Level 24	98,550
Level 23	98,192
Level 22	97,846
Level 21	97,484
Level 20	97,057
Level 19	96,612
Level 18	96,167
Level 17	95,721
Level 16	95,280
Level 15	94,831
Level 14	92,976
Level 13	92,531
Level 12	92,090
Level 11	91,579
Level 10	91,071
Level 9	90,560
Level 8	88,695
Level 7	88,188
Level 6	86,896
Level 5	85,596
Level 4	84,304
Level 3	83,005
Level 2	81,150
Level 1	80,545

Appendix 2

1 April 2005 military salaries including X-Factor for DMS Officers

All annual salaries are derived from daily rates in whole pence and rounded to the nearest £, calculated on a 365-day year.

Table 2.1: **Annual salaries inclusive of the X-Factor for accredited consultants (OF3-OF5)**

Increment level	Military salary
	£
Level 32	111,566
Level 31	111,329
Level 30	111,095
Level 29	110,858
Level 28	110,624
Level 27	110,157
Level 26	109,690
Level 25	109,223
Level 24	108,087
Level 23	106,952
Level 22	105,821
Level 21	104,686
Level 20	103,554
Level 19	102,419
Level 18	101,288
Level 17	99,857
Level 16	98,433
Level 15	97,006
Level 14	95,579
Level 13	94,155
Level 12	92,732
Level 11	89,600
Level 10	86,476
Level 9	83,351
Level 8	80,574
Level 7	77,792
Level 6	75,008
Level 5	72,398
Level 4	71,383
Level 3	70,346
Level 2	66,915
Level 1	63,517

GLOSSARY OF TERMS

BDA	British Dental Association
BMA	British Medical Association
CEA	Clinical Excellence Awards
DDS	Defence Dental Services
DH	Department of Health
DMS	Defence Medical Services
DDRB	Doctors & Dentists Review Body
GDP	General Dental Practitioners
GMP	General Medical Practitioners
JPA	Joint Personnel Administration
MDHU	Ministry of Defence Hospital Unit
MMRR	Medical Manning and Retention Review
MOD	Ministry of Defence
NHS	National Health Service
RAF	Royal Air Force
TA	Territorial Army

Table 1.8: **Recommended annual salaries inclusive of the X-Factor for Higher Medical Management Pay Spine: OF5**

Increment level	Military salary
	£
Level 15	117,618
Level 14	116,899
Level 13	116,169
Level 12	115,442
Level 11	114,720
Level 10	113,993
Level 9	113,263
Level 8	112,540
Level 7	111,814
Level 6	110,726
Level 5	109,642
Level 4	108,544
Level 3	107,460
Level 2	106,376
Level 1	105,281

Trainer Pay

The recommended annual rate of GMP and GDP Trainer Pay from 1 April 2006 is £7,174.36.

Distinction Awards

A+	£58,294
A	£38,864
B	£15,546

Clinical Excellence Awards

Bronze	£18,180
Silver	£28,603
Gold	£39,493
Platinum	£55,828

Table 1.4: **Recommended annual salaries inclusive of the X-Factor for Service Medical and Dental Officers: OF2**

Increment level	Military salary		
	Accredited Medical Officers	Non-Accredited Medical and Dental Officers	Accredited Dental Officers
	£	£	£
Level 5	65,685	55,268	65,685
Level 4	64,211	53,856	64,211
Level 3	62,740	52,436	62,740
Level 2	61,269	51,027	61,269
Level 1	59,794	49,625	59,794

Table 1.5: **Recommended annual salaries inclusive of the X-Factor for Service Medical and Dental Officers: OF1 (PRMPs)**

	Military salary
	£
OF1	37,566

Table 1.6: **Recommended annual salaries inclusive of the X-Factor for Medical and Dental Cadets**

Length of service		Military salary
		£
Cadets	after 2 years	16,991
	after 1 year	15,286
	on appointment	13,589

Table 1.7: **Recommended annual salaries inclusive of the X-Factor for Higher Medical Management Pay Spine: OF6**

Increment level	Military salary
	£
Level 7	124,965
Level 6	123,819
Level 5	122,673
Level 4	121,523
Level 3	120,370
Level 2	119,231
Level 1	118,081

Introduction

1. We report on the evidence and our pay recommendations for the Defence Medical Services (DMS) from 1 April 2006. Our terms of reference require us to examine evidence on manning, recruitment and retention, and pay comparisons, in the case of the DMS, with the National Health Service (NHS). The evidence must be seen in the context of high operational commitment, manning levels significantly below requirements and competition with the NHS where contract and pay arrangements are changing rapidly. All these factors continue to present risks to recruitment and threats to retention. We set out our views on the evidence and our resulting recommendations below.

2005 recommendations

2. Our 2005 DMS Report, submitted on 18 April 2005, was accepted in full by the Government on 25 May 2005 and the following recommendations implemented from 1 April 2005:

   - A 3.225 per cent increase for all Service Medical and Dental Officers, including Medical and Dental Cadets and Reserve Medical and Dental Officers;
   - A 3.225 per cent increase to Distinction Awards and Trainer Pay, and the introduction of DMS Clinical Excellence Awards; and
   - The collection of comprehensive data on DMS Junior Doctors' working patterns.

Evidence for this Report

3. We considered evidence from the following sources:

   - Written and oral evidence from the Ministry of Defence (MOD), Deputy Chief of Defence Staff (Health), Surgeon General and from the British Medical and Dental Associations (BMA/BDA);
   - Our visits to Armed Forces' personnel during 2005, including a visit to The Princess Mary's Hospital in Cyprus and operational units in Iraq and Afghanistan;
   - Independent research into DMS and NHS earnings commissioned to inform our assessment of comparability; and
   - Recommendations of the Review Body on Doctors' and Dentists' Remuneration (DDRB) in its 2006 Report.

4. Our visits enable us to meet DMS personnel and hear their views first hand on issues specific to the DMS and those applying across the Armed Forces. We would like to thank all those who contributed to our visit programme.

DMS developments

Non-pay measures

5. MOD provided updates on initiatives being developed to address DMS manning shortfalls. The Defence Health Programme (2005-2009) aims to deliver medical support to operations and sufficient numbers of Service personnel fit for task. Several change projects underpinned the programme: delivering trained medical manpower for operational capability; developing Military Medicine and the Royal Centre of Defence Medicine; optimising healthcare to maximise numbers fit for task; and the development of computerised medical information. Short term shortfalls in capability to support current operational commitments would be covered by using civilian agency contractors or working with operational allies.

6. MOD considered that arrangements within MOD Hospital Units (MDHUs) were working well. New command and control arrangements were helping to ensure a strong military ethos and unit cohesion. MOD remained committed to strengthening the relationship with the Department of Health (DH) under the 2002 "Concordat" supported by the Joint MOD/DH Partnership Board. In April 2005, the Defence Dental Agency was replaced by Defence Dental Services (DDS). MOD told us that the new organisation was operationally focused and aimed to deliver effective military dentistry. The BDA warned, however, that "high calibre" OF3s considered the DDS a "shrinking organisation" unable to meet their expectations for higher professional training.

Pensions

7. We reported in 2005 that a new Armed Forces' Pension Scheme with associated bonus arrangements for Medical and Dental Officers was introduced for new entrants on 6 April 2005. Serving personnel have the option to transfer on 6 April 2006 with MOD making information available to inform their decisions. The BMA/BDA were concerned that information had not been adequately communicated and that this had had a destabilising effect on personnel. As the new DMS arrangements are now in place, we will commission our periodic valuation of DMS pensions against NHS arrangements for our 2007 Report. In the course of consultations on the basis of DMS comparability, the BMA/BDA observed that DMS and NHS salaries have different "abatements/deductions" which appear to disadvantage DMS Officers. Our research will examine the relative value of pension arrangements.

Higher Medical Management pay spine

8. MOD told us that the Higher Medical Management pay spine for OF5s now provided the only route, through single Service selection, for those with the potential to reach the highest management positions and gain promotion to OF6. In 2004-05, 11 Officers were selected with a further 10 to be selected during 2005-06 and an eventual cadre of around 30 Officers. The BDA's survey of DMS Dental Officers indicated some frustration at the difficulty of meeting the selection criteria when on a clinically-focused career pathway. MOD planned, and the BMA/BDA welcomed, further investigation of the possibility of a limited number of OF6 clinical practice posts.

GMPs' and GDPs' Sustained Quality Payments

9. Sustained Quality Payments were incorporated into pay scales in 2003 (for GMPs) and 2004 (for GDPs) and we asked MOD to monitor the numbers achieving qualification and receiving payment. MOD informed us that the majority of those receiving payment – 145 of 193 GMPs and 94 of 144 GDPs – had achieved the appropriate qualification. We look forward to MOD's development of benchmarks similar to the *NHS Quality and Outcomes Framework* for GMPs on which to base appropriate payments.

Manning evidence

10. MOD told us that DMS manning requirements were based on Defence Planning Assumptions and that work continued on redefining the Deployable Medical Capability. We await the outcome of this work and, in the meantime, report on the manning position in relation to current requirements. In considering the manning position, the BMA/BDA commented on factors influencing the wider medical and dental workforce. They noted that DMS manning should be seen in the context of recruitment and retention constraints across the UK medical workforce that were likely to persist for many years. These included continued national shortages of Consultants, GMPs and Dentists, the growing numbers of female and part-time medical practitioners, and the importance of maintaining a work/life balance. Against this background, the BMA/BDA pointed to the additional constraints of fitness, age and nationality required for the DMS.

Table 1.3: **Recommended annual salaries inclusive of the X-Factor for Non-Accredited Medical Officers (OF3-OF5)**

Increment level	Military salary
	£
Level 29	88,640
Level 28	87,903
Level 27	87,173
Level 26	86,439
Level 25	85,702
Level 24	84,972
Level 23	84,238
Level 22	83,505
Level 21	82,778
Level 20	82,045
Level 19	81,311
Level 18	80,581
Level 17	79,851
Level 16	79,117
Level 15	78,380
Level 14	77,654
Level 13	76,920
Level 12	76,186
Level 11	75,456
Level 10[a]	74,726
Level 9	73,847
Level 8	72,365
Level 7	70,879
Level 6	69,825
Level 5	68,781
Level 4	67,733
Level 3	66,686
Level 2	63,178
Level 1	59,692

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

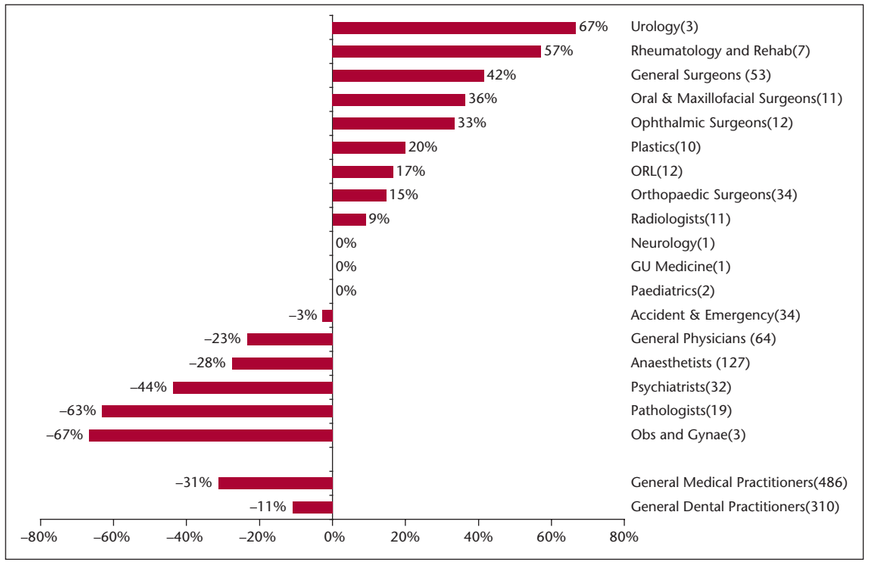
Table 1.2: **Recommended annual salaries inclusive of the X-Factor for accredited GMPs and GDPs (OF3-OF5)**

Increment level	Military salary
	£
Level 35	111,438
Level 34	111,059
Level 33	110,763
Level 32	110,292
Level 31	109,912
Level 30	109,526
Level 29	109,234
Level 28	108,759
Level 27	108,376
Level 26	107,993
Level 25	107,602
Level 24	107,222
Level 23	106,832
Level 22	106,456
Level 21	106,062
Level 20	105,598
Level 19	105,113
Level 18	104,631
Level 17	104,145
Level 16	103,664
Level 15	103,175
Level 14	101,160
Level 13	100,674
Level 12	100,193
Level 11	99,638
Level 10	99,087
Level 9	98,528
Level 8	96,499
Level 7	95,948
Level 6	94,542
Level 5	93,130
Level 4	91,725
Level 3	90,308
Level 2	88,294
Level 1	87,633

11. As at 1 April 2005, Medical Officer strength stood at 1,000[1] (480 trained and 520 untrained) against a total requirement on 1,220 and representing a shortfall of 18 per cent. Numbers had increased slightly in 2004-05 compared to 2003-04. By 1 July 2005, while Medical Officer manning had increased very slightly, the requirement also increased leaving the shortfall at 21 per cent. MOD added that Medical Officer strength had fluctuated over the past six years and that 2004-05 manning levels were the highest, but by a slight margin, since 2000-01. For Dental Officers, at 1 April 2005 total strength was at 270 (250 trained Dental Officers) against a requirement of 290. By 1 July 2005, total strength was 280 against a total requirement of 310 – a shortfall of just under 10 per cent (7 per cent of trained strength). MOD told us that Dental Officer total strength had remained above 90 per cent of requirement over the last six years, although the BDA suggested difficulties of gapping key posts.

12. Against the overall manning picture, each of the three Services reported continuing severe shortages within key specialties. Taking into account both trained and untrained strength, shortages were most acute in Anaesthetics (a 27 per cent shortfall), General Physicians (23 per cent), Psychiatrists (44 per cent), Pathologists (63 per cent) and General Medical Practitioners (31 per cent). Chart 1 illustrates specialty shortages as at 1 July 2005. MOD told us that it was guiding Medical Officers into key specialties and considering retrospective bursaries in shortfall areas. Medical Cadets were briefed on the limited range of specialties available. Training programmes would be modified in the DMS under *Modernising Medical Careers*. In the context of manning shortages, MOD and the BMA/BDA recognised that increasing numbers of women entering the medical workforce would require consideration of alternative working arrangements and family-friendly policies in the DMS.

Chart 1: Deficit/Surplus of DMS Personnel by Specialty, 1 July 2005



The figure in brackets after the specialty indicates its regular manpower requirement e.g. the requirement for Radiologists is 11.

[1] All manning figures are rounded to the nearest 10.

Recruitment evidence

13. The DMS recruited 78 Medical Officers of the 159 target in the year to 1 April 2005 – 59 Cadets (target 110) and 19 Direct Entrants (target 49). Dental Officer recruitment over the same period was 13 out of a target of 31 (4 Cadets against a target of 10 and 9 Direct Entrants against a target of 21). However, recruitment between 1 April and 1 July 2005 showed a more positive picture with 87 Medical Officers recruited, including 69 Cadets, and 17 Dental Officers recruited (9 Cadets). MOD told us it was encouraged by the July 2005 figures and pointed to Medical Officer recruitment already exceeding the whole of 2004-05. The BMA/BDA commented that Cadet schemes appeared to be well-recruited and would contribute to future DMS manning. Between November 2002 and July 2005 the Golden Hello scheme recruited 34 trained GMPs and 8 Consultants. MOD intended to review the scheme in 2006.

14. For the single Services the Medical Officer recruitment position varied:

- In the Royal Navy, Cadet recruitment was on target to July 2005 and the Direct Entrant target met for 2004-05;
- Army recruitment was less encouraging with entrants below target in each year since 2000-01, although the actual numbers recruited remained steady. However, early recruitment in 2005-06 had already reached 2004-05 levels; and
- In the RAF, Direct Entrant recruitment had improved and Cadet numbers were acceptable.

15. Recruitment of Dental Officers met the small Royal Navy targets in 2004-05. Direct Entrant targets in the Army had not been met since 2002-03, although Army recruitment of Direct Entrants and Cadets to 1 July 2005 was much more positive. The BDA suggested that Army recruitment had fallen dramatically compared to the ten-year average intake. MOD reported RAF Cadet recruitment had already met the target of 3 for 2005-06.

16. Given the low DMS manning levels and specialty shortage areas, maintaining recruitment levels will remain important. The position for the early part of 2005-06 is encouraging following a poor recruiting year in 2004-05. As Direct Entrant recruiting has only comprised a small element of DMS recruitment, the shortfall in Cadet recruitment during 2004-05 could create shortfalls in the sustainable experience profile in later years. We have become increasingly concerned about the creation of "black holes" across the Armed Forces and the expensive measures required to rectify these in the future. MOD will need to carefully monitor the effect and, more widely, we ask to be kept up to date with the recruitment targets required to underpin the revised Deployable Medical Capability and progress with appropriate recruitment strategies for both Cadets and Direct Entrants.

Retention evidence

17. In recent years, our reports have focused on the need to retain Medical and Dental Officers to support manning levels and capability. Evidence from MOD and the BMA/BDA again placed emphasis on retention and the necessity of maintaining comparability with the NHS to retain existing DMS personnel.

18. On the retention evidence, MOD commented that:

- Overall outflow of Medical Officers had averaged 6.4 per cent in the six years to 2004-05 – a high of 7.8 per cent in 2000-01 and a low of 5.5 per cent in 2004-05;
- Numbers were steady at between 60 and 70 Medical Officers leaving each year;

Appendix 1

1 April 2006 recommended levels of military salaries including X-Factor for DMS Officers

All annual salaries are derived from daily rates in whole pence and rounded to the nearest £, calculated on a 365-day year.

Table 1.1: **Recommended annual salaries inclusive of the X-Factor for accredited consultants (OF3-OF5)**

Increment level	Military salary
	£
Level 32	121,384
Level 31	121,125
Level 30	120,870
Level 29	120,614
Level 28	120,359
Level 27	119,851
Level 26	119,344
Level 25	118,833
Level 24	117,599
Level 23	116,366
Level 22	115,132
Level 21	113,898
Level 20	112,668
Level 19	111,431
Level 18	110,201
Level 17	108,646
Level 16	107,095
Level 15	105,543
Level 14	103,989
Level 13	102,441
Level 12	100,893
Level 11	97,484
Level 10	94,086
Level 9	90,688
Level 8	87,666
Level 7	84,640
Level 6	81,607
Level 5	78,767
Level 4	77,665
Level 3	76,537
Level 2	72,803
Level 1	69,105

- Our commissioned research on the comparative valuation of **DMS pensions** taking account of the new DMS pension scheme;

- **DMS manning requirements** arising from the revised Deployable Manning Capability; and

- Any progress with **future DMS pay arrangements**.

David Greenaway
Robert Burgin
Alison Gallico
Peter Knight
Derek Leslie
Naren Patel
Neil Sherlock
Ian Stewart
Anne Wright

12 April 2006

- Voluntary Outflow[2] of Medical Officers had remained steady at between 25 and 30 since 2001-02 with an exit rate of 2.3 per cent in 2004-05 compared to 3.4 per cent in 2003-04;

- Overall outflow of Dental Officers was at 5.9 per cent in 2004-05, with Voluntary Outflow at 1.9 per cent. MOD noted that outflow figures in 2005-06 already exceeded 2004-05 indicating outflow was set to increase and the BDA noted that outflow could be at its highest for ten years during 2005-06.

19. MOD's evidence, supported by that from the BMA/BDA, suggested that the continuing commitment to operational medical support, compounded by specialty shortages, led to a high rate of deployment and, therefore, had a detrimental effect on retention. However, MOD pointed to a range of non-remuneration initiatives to address manning shortfalls, including those under the Defence Health Programme and alternative provision for operations. In the longer term, revisions to the Deployable Medical Capability may provide a platform to better manage specialty shortages but in the meantime the pressures fall heavily, but unevenly, on individuals.

20. The *DMS Continuous Attitude Survey* conducted in July/August 2005 was based on a sample of 40 per cent of DMS Officers with replies received from 218 Medical Officers and 91 Dental Officers. The survey results indicated that:

    - Only 22 per cent of Medical Officers and 30 per cent of Dental Officers regarded the DMS as their lifetime career – a further 35 per cent of Medical Officers and 31 per cent of Dental Officers regarded the DMS as a stage in their professional career;
    - 84 per cent of Medical Officers and 90 per cent of Dental Officers considered the pay and allowances package would influence their decision to stay in the Armed Forces;
    - Pay and pensions were important to making decisions on length of service;
    - The numbers considering DMS pay better or similar to the NHS remained relatively unchanged since the last survey (52 per cent of Medical Officers and 59 per cent of Dental Officers); and
    - During the year to August 2005, 33 per cent of Medical Officers and 19 per cent of Dental Officers had been operationally deployed or at sea.

21. The BMA evidence drew on its 2005 survey[3] of DMS Officers first presented in evidence for our 2005 DMS Report. The survey indicated that 48 per cent planned to leave the DMS within five years and that, of these, 28 per cent planned to leave at the end of a short or medium career commission and 49 per cent through Voluntary Outflow. The BMA's Tripartite Cohort Study[4], tracking those at significant career points, suggested that three out of five mid-career respondents did not intend to continue or transfer to a full career commission when they reach the Immediate Pension Point and one-third intended to leave the DMS to work in the NHS or private practice. The study cited overstretch, separation and the impact on family life (including spouses' careers and children's education) as key to decisions to leave the Services. BMA focus groups also identified that increased workloads, excessive working hours, and poor career and promotion prospects significantly impacted on retention. The BMA concluded that the DMS salary package should compensate for reduced quality of life. It added that satisfaction with a DMS career diminished with length of service and that this was evidenced by personnel remaining committed to medical careers but not in the DMS.

[2] From 1 October 2005 the Services now term Premature Voluntary Release as "Voluntary Outflow" with no change to the methodology.
[3] *Health Policy and Economic Research Unit, 2005, Report of Armed Forces Doctors Survey,* BMA:London.
[4] The BMA Tripartite Cohort Study tracks medical student cadets who joined the DMS in 2002, doctors who will be coming to the end of their short service commission and doctors approaching the Immediate Pension Point.

22. The BDA commented on the highly competitive dental labour market characterised by increasing demand and an undersupply of dentists estimated to be 4,200 (whole-time equivalents). The Department of Health's strategy was to recruit an extra 1,000 whole-time equivalent dentists, many from the EU which would not be a recruitment source for the DMS. New NHS contracting arrangements might also push more dentists into private practice thereby placing greater retention pressure on DMS dentists. The BDA conducted a survey of DMS Dental Officers in June 2005 which attracted 186 responses. The results indicated that 86 per cent would expect to join independent/private practice, if leaving the DMS, and that restoring the pay link with DMS GMPs was a major factor in morale (85 per cent) and retention (79 per cent).

Reserve Medical and Dental Officers

23. An analysis of DMS Reserve manning suggests:

- Medical Officer strength has steadily declined from around 550 at 1 April 2002 to 380 at 1 July 2005 (including the RAF strength of 15) against a static requirement (excluding the RAF) of 770;
- By July 2005, the Territorial Army (TA) Medical Officer strength was 310 compared to a requirement of 680. The BMA/BDA indicated that the TA carried the main burden of supporting operations and was at its lowest strength ever;
- Recruitment of Reserve Medical Officers had fallen between 2003 and 2005, and outflow in 2003-04 (the latest available) was the highest in the last five years; and
- Reserve Dental Officer strength (in the Army only) had remained static since 2004 although at only 37 per cent of requirement.

24. MOD told us that, under the revised Deployable Medical Capability, the requirement for DMS Reserves would change and, in oral evidence, that the mass deployment of Reserves on operations would scale down with more used to fill Regular gaps. The BMA/BDA told us that operational tempo and the compulsory mobilisation of DMS Reserves since 2002 had disrupted home and work life. They welcomed improved compensation arrangements for mobilised Reserves but pointed to difficulties arising from the varying, and more commercial, attitude of NHS employers to Reserve service. The BMA/BDA commented that our last review of X-Factor in 2003 had not captured the major change in Reserves' deployment and that there was sufficient justification to support an interim increase to the current level. The professions' views on the significant change in the use of Reserves echo the concerns frequently aired on our visits. We consider it appropriate to review X-Factor for DMS Reserves, and Reserves more generally, as part of the review for our 2008 Report when we will be able to assess all the evidence and any changes since 2000. We will invite the BMA/BDA to contribute evidence to that review specifically for DMS Reserves.

DDRB recommendations from 1 April 2006[5]

25. The following recommendations of the Review Body on Doctors' and Dentists' Remuneration (DDRB) are of relevance to DMS groups (the DDRB was not asked to recommend on remuneration for NHS GMPs working under the new General Medical Services contract following an agreement between the Health Departments, NHS Employers and the BMA in December 2005):

- A 2.2 per cent increase for NHS Consultants on both "old" and new NHS contracts and a 2.2 per cent increase in Consultants' Clinical Excellence Awards, Distinction Awards and Discretionary Points;

[5] *Review Body on Doctors' and Dentists' Remuneration, Thirty-Fifth Report 2006,* Cm 6733.

branches of the Armed Forces in 2006-07 as forecast by MOD. To the extent that strengths differ in practice, the cost of implementing the recommendations will also differ.

Looking ahead – the medium term

60. MOD's target is to achieve DMS manning balance by 2010. The Department is continuing its work to identify the DMS required manning under the Deployable Medical Capability and to develop a tri-Service approach to management, with an appropriate senior management structure. There are a number of internal and external challenges to be faced. Internally, the DMS must compete for resources against other demands on the Defence budget and in the context of the 2007 Spending Review, which, we understand will be "zero-based". Externally, there will continue to be competition from a tight medical and dental labour market, characterised by the continuing development of NHS pay and career structures and the feminisation of the medical profession. If it is to compete in this environment, the DMS must be able to offer a balanced and attractive package of pay and non-pay measures.

61. MOD has placed great store on the retention positive aspects of the new DMS pension scheme. We will be able to judge its effectiveness from our visits and from the manning evidence for our subsequent reports. All the parties' evidence pointed to the importance to recruitment and retention of broad comparability with the NHS. This unanimity was a major influence on our 2006-07 recommendations. We note from the evidence, however, that comparability with NHS pay is more closely achieved at some career stages than others. Moreover, manning data indicate that shortages are more severe in some Consultant specialties than others and exist among General Medical Practitioners more so than General Dental Practitioners. In our view, this evidence points to a more targeted approach to the pay award than was proposed for 2006-07.

62. Our ability to respond in a targeted way is constrained, however, by the inflexibility of the current pay structures which has been acknowledged by MOD in its evidence. The BMA/BDA also suggested that consideration might be given to the DMS Consultants' pay profile. The current pay structures arose from the Medical Manning and Retention Review in 2002 which led to the investment of significant additional funds to establish comparability with the NHS on the basis of then anticipated DMS and NHS career structures. Since the Medical Manning and Retention Review, however, there has been a fundamental change in NHS pay arrangements. In our view, DMS pay arrangements need to be reviewed in the light of those changes.

63. In evidence, MOD told us that Joint Personnel Administration offers the opportunity to introduce the flexibility to target particular DMS groups or career stages to respond to recruitment and retention requirements. We consider it essential that DMS pay and career structures are reviewed at an early stage so that the DMS is ready to take advantage of JPA flexibilities as soon as roll-out is complete in 2008. We understand the difficulties of making structural changes in the interim, but urge MOD, and the professional associations, to consider whether the evidence supports a more targeted response to particular recruitment and retention challenges for 2007-08 rather than an across-the-board approach.

64. In the meantime, for our 2007 Report we will be taking forward the following items with the parties to improve our evidence base:

- Emerging data to support our **DMS pay comparisons**, particularly for General Medical and Dental Practitioners, and the appropriate make-up of NHS comparators;
- Any changes to data on **DMS Consultants' and DMS Junior Doctors' working patterns** to enable accurate pay comparisons;

Recommendation 2: We recommend a 2.2 per cent increase in the pay scales for all DMS Junior Doctors in training (including GMP Registrars), Medical and Dental Cadets, and DMS Reserve equivalents from 1 April 2006. We also recommend a 2.4 per cent increase for Associate Specialists (Non-Accredited OF3-OF5 pay scale Levels 10-29) from 1 April 2006. The recommended pay scales are at Appendix 1.

Consultants' Clinical Excellence Awards and Distinction Awards

56. We endorsed the introduction of the DMS Clinical Excellence Awards (CEAs) scheme in April 2005 based on the top four NHS awards. MOD told us that DMS academic GMPs and civilian consultants would be included for the first time but Reservists were excluded. Entitlement to CEAs is a matter for MOD and it might wish to consider the BDA's view (from its 2005 survey) that DMS accredited dental specialists should have access to CEAs. MOD told us that current holders of Distinction Awards would be encouraged to apply for CEAs. We are pleased to note the first round of CEAs during 2005. We are content to recommend an increase from 1 April 2006 in DMS CEAs and Distinction Award values in line with DDRB's recommended increase as proposed by MOD. The number of available awards should be maintained at 32.

Recommendation 3: We recommend that the value of all DMS Clinical Excellence Awards and Distinction Awards be increased by 2.2 per cent from 1 April 2006. The recommended levels are shown at Appendix 1.

DMS Trainer Pay

57. We learned from MOD's evidence that, as at 1 November 2005, the DMS had 29 active training practices with 30 DMS Trainers (against a requirement of 41), 13 Civilian Trainers (requirement 19) and 18 accredited DMS Trainers not in clinical practice. The manning requirement was driven by maintaining an appropriate ratio of Trainers to Trainees. MOD reported that Trainer shortfalls led to 8 GMP Registrars undertaking their vocational training in NHS practices, which presents a risk to their retention. The BMA/BDA indicated that 5 DMS Trainers had resigned within the previous 18 months. They provided background evidence on NHS recruitment and retention which suggested Trainer remuneration should be reviewed. Dental Officers responding to the BDA's survey felt that Trainers should receive enhanced remuneration to reflect increased training responsibilities.

58. We are content to endorse the MOD and BMA/BDA proposal that DMS Trainer Pay should be increased in line with the increase in the NHS Trainer Grant. We note that the Department of Health has announced a review of pay arrangements for NHS GMP Trainers and MOD is considering changes to the career/pay structures of DMS Trainers to improve their attractiveness. We ask MOD and the BMA/BDA to present evidence for our 2007 DMS Report on the outcome of these reviews and any implications for DMS Trainer Pay.

Recommendation 4: We recommend that DMS Trainer pay be increased by 2.2 per cent from 1 April 2006. The rate is at Appendix 1.

Cost of recommendations

59. We estimate that the cost of implementing our pay recommendations for 2006-07 is £9.9 million (including the Employers' National Insurance Contribution and superannuation liabilities). This costing is based on the Officer strengths of the medical and dental

- A 2.4 per cent increase for NHS Staff Grades and Associate Specialists;
- A 2.2 per cent increase for NHS Junior Doctors with no change to out-of-hours banding multipliers and the GMP Registrars' supplement;
- A 2.2 per cent increase in the salary range for Salaried GMPs and a 2.2 per cent increase in the GMP Trainer Grant;
- A 2.4 per cent increase for Salaried Dentists in Primary Dental Care Services; and
- A 3 per cent increase in General Dental Practitioners' contract values (for England and Wales) and gross fees (for Scotland).

26. The Government accepted the DDRB's recommendations on 30 March 2006 for all NHS groups except Consultants whose award was staged with a 1 per cent increase from April 2006 and the remaining 1.2 per cent from November 2006. The Government said that it was determined to ensure that the NHS returned to financial balance over the next 12 months and it had therefore decided to stage the pay of Consultants who had had the biggest earnings increases from NHS pay reforms.

NHS developments

27. We monitor developments in the NHS, specifically those that influence our remit on broad pay comparisons between the NHS and DMS. In evidence to the DDRB, the Department of Health reported that take-up of the new NHS Consultant contract was "very good" with a BMA survey (May 2005) reporting 87 per cent take-up in England, 100 per cent in Wales and 96 per cent in Scotland. A Department of Health *National Survey of Consultant Contract Implementation* (October 2004) showed that NHS Consultants' job plans were based on an average of 11.17 Programmed Activities – the BMA survey reported an average of 11.16 Programmed Activities. We examine the effect on pay comparability with the DMS in paragraphs 31 to 45. Additional resources have been agreed for a new NHS contract for Staff Grades and Associate Specialists from 1 April 2006 with negotiations on-going.

28. In December 2005, the Health Departments, NHS Employers and the BMA's General Practitioners' Committee reached agreement on amendments to the new General Medical Services contract for 2006-07. These included increases to Primary Care Organisations funding allocations of over 9 per cent and investment for the agreed 2006-07 contract elements amounting to a maximum of 4.4 per cent (assuming 100 per cent achievement in all Directed Enhanced Services). The agreement also included: no cost of living or inflationary increases for practices; rewarding practices for improved patient access; investment in other Directed Enhanced Services; support for implementing practice-based commissioning; and broadening and strengthening the *Quality and Outcomes Framework*. A second stage of negotiations to review the Global Sum allocations formula for 2007-08 is now due to get underway, following publication by the Department of Health of the White Paper entitled *Our Health, Our Care, Our Say: A New Direction for Community Health Services* in January 2006.

29. *Under Modernising Medical Careers,* new two-year competency based Foundation Programmes were introduced in August 2005 to be followed by new structured specialist training programmes from 2007. Pay structures and terms and conditions for these new specialist training programmes will be negotiated by the Health Departments and the BMA. For the DMS, MOD was considering the implications of introducing Foundation Programmes, particularly arrangements for commissioning, promotion and military training.

30. A new NHS General Dental Practitioners' contract was implemented in England and Wales on 1 April 2006. According to the Department of Health, the new contract provides local commissioning arrangements, greater capacity, improved access by freeing dentists from the "item of service" system and more preventative care. The aim is to allow dentists more control over workload, while reducing bureaucracy and guaranteeing gross income from NHS work.

Pay comparability evidence

31. The parties' evidence places great emphasis on the need to maintain pay comparability between the DMS and NHS. The evidence stresses that pay comparability contributes to recruitment, retention, motivation and morale among DMS personnel. Our terms of reference require us to consider *broad* comparability, among other factors, in recommending DMS salaries that are both fair to Service personnel and to the taxpayer who ultimately funds them. We approach pay comparability with the NHS by looking at: (i) pay levels – a comparison in the current year (for this Report as at 1 April 2005); and (ii) pay movements – DDRB's recommendations for the NHS for the coming year (2006-07). We consider that this approach is consistent with our methodology for our main Armed Forces' remit group and enables us to take account of current rates of, and recommended changes in, NHS pay so reducing any "time-lag" in maintaining comparability for the DMS.

32. We noted in our 2005 Report that we did not have, at that time, a complete picture of DMS pay comparability. The lack of NHS pay data continues to constrain our assessments. However, our evidence base in regard to comparability continues to develop. For this report, we draw on the outcome of consultations with the parties on the NHS Partners' Report 2005[6], an updated report commissioned from NHS Partners and the parties' own assessments of pay comparability, including improved evidence on the working patterns of DMS Consultants and Junior Doctors in training.

NHS Partners

33. Following consultations with our Secretariat on the NHS Partners' Report 2005, MOD and the BMA/BDA provided constructive feedback in November 2005 which was followed up in evidence for this report. For DMS Consultants, they agreed that the career profiles should be adjusted to assume appointment to a Consultant post at age 35 for the DMS and NHS and that the NHS comparator should be based on 12 Programmed Activities. MOD considered further work was required to assess Clinical Excellence Awards and the On-Call Availability Supplement. The BMA/BDA proposed that these elements should be accounted for within the NHS comparator as should an element for private practice. For General Practitioners, MOD commented on the need to find appropriate sources of earnings data, including private practice data for General Dental Practitioners.

34. We commissioned NHS Partners to update their 2005 Report[7] taking account of any new data on careers and earnings and the consultation with MOD and the BMA/BDA. NHS Partners' findings were reported to us in February 2006 – their main conclusions on the data and comparisons are:

- **Consultants** – information on Programmed Activities and On-Call Availability Supplements has improved the basis for comparisons but does not allow analysis by specialty or length of service. The lack of reliable data on private earnings constrains analysis of the impact of the new NHS contract. Comparisons of

[6] *A Report on Defence Medical Services Pay Comparability* – NHS Partners, February 2005 – www.ome.uk.com/downloads/NHS Partners Report 2005.pdf.
[7] *Defence Medical Services Pay Comparability Update Report* – NHS Partners, February 2006. The full report is published at www.ome.uk.com.

52. Since 2002, DMS manning has stabilised but at levels significantly below requirements – at July 2005 a Medical Officer shortfall of 21 per cent and a Dental Officer shortfall close to 10 per cent. These shortages are most severe in specialty areas crucial to operational capability for instance, some Consultant specialties are 40 to 60 per cent undermanned, there is a 31 per cent shortage of General Medical Practitioners and there are emerging concerns over General Dental Practitioners' manning. DMS recruitment during the early part of 2005-06 was encouraging, after being significantly below target in 2004-05. DMS outflow is stable, but fragile, with indications that insufficient numbers are staying in the DMS or taking up longer commissions. Outflow undermines achieving the appropriate sustainable experience profiles and there is a clear risk of losing expensively trained Officers without a reasonable return on MOD's investment. Operational tempo, specialty shortages, separation and quality of life are influencing morale and retention and we share MOD's view that the whole package, pay and non-pay, is important to retaining DMS personnel. The results of the *DMS Continuous Attitude Survey* show that the value of the package influences decisions to stay in the DMS.

53. Our pay comparisons for this report, were informed by better data on DMS and NHS Consultants' Programmed Activities which indicate that, averaged over a career, the impact of the new NHS contract has led to more favourable pay levels in the NHS. For GMPs, emerging data sources indicate the significant impact of the new NHS contract on NHS GMPs' earnings at a time when DMS GMP manning is at a low ebb. We continue to be constrained by the lack of data on NHS GDPs' earnings but are mindful of emerging manning concerns and, for 2006-07, we note that maintaining pay parity with DMS GMPs could be influential on retention. Overall, we agree with the parties' and NHS Partners' assessment that DMS pay is behind the NHS.

54. We assess the evidence together. In our judgement, current manning levels, continuing risks to retention in a competitive market, the need to improve return of service and the need to keep pace with significant changes in NHS pay levels all require an appropriate pay response. We accept that, for our 2006-07 recommendations, the options are limited to an across-the-board pay solution to ensure DMS personnel feel appropriately rewarded compared to the NHS and to avoid any adverse risk to retention of a differentiated award. We therefore agree with MOD and the BMA/BDA that a 6.6 per cent increase is required to bring DMS pay levels in line with the NHS and that the DDRB recommended increase should be applied to match NHS pay movements in 2006-07 for accredited DMS Consultants, GMPs, GDPs, Higher Medical Management staff and their Reserve equivalents.

Recommendation 1: We recommend a 6.6 per cent increase, plus the DDRB recommended increase, to the pay scales for accredited DMS Consultants, General Medical Practitioners, General Dental Practitioners, Higher Medical Management staff and DMS Reserve equivalents from 1 April 2006. The recommended pay scales are at Appendix 1.

55. For the remaining DMS groups, Junior Doctors in training (including GMP Registrars), Cadets and Associate Specialists, the evidence indicates a different position. Generally manning within these groups is adequate and the latest recruitment figures are encouraging. The parties acknowledge that DMS pay levels are broadly in line with the NHS. On this evidence, we therefore recommend these groups receive increases in line with the DDRB's recommendations for their NHS comparators.

- Consultants – to ensure DMS pay is comparable with the NHS across the entire career rather than at specific points taking account of the effect of the new NHS Consultant contract;

- GMPs – while recognising the absence of hard pay comparability evidence, the parties pointed to emerging data indicating a "significant" rise in NHS pay under the new contract, the risk of exacerbating the current manning shortfall and the risk of increased locum payments arising from the shortfall. MOD also noted the importance of DMS GMPs receiving the same pay increase as DMS Consultants;

- GDPs – in the absence of reliable data on NHS GDPs' earnings, to maintain the link with DMS GMPs' pay established under MMRR;

- Consultants, GMPs and GDPs on the Higher Management Pay Spines – on the same grounds as above for the individual groups; and

- DMS Reserve Consultants, GMPs and GDPs – to reflect the recommended increase for Regulars and acknowledging their importance to the functioning of the DMS.

48. MOD and the BMA/BDA recommended that, in order to maintain parity with the NHS, DMS Associate Specialists, Junior Doctors in training (including GMP Registrars), and Medical and Dental Cadets should receive the same increase as recommended by the DDRB.

Recommendations for 2006-07

Overall pay recommendations

49. We note the common ground in the evidence submitted by both parties. This reflects a more constructive working relationship between MOD and the BMA/BDA which is helpful to our deliberations particularly during a time of significant change in the DMS and NHS. We approach our recommendations for the DMS by considering a range of evidence across our terms of reference. In assessing the evidence we must find a balance between maintaining DMS recruitment, retention and morale and ensuring we are fair to the taxpayer. Our terms of reference require us to achieve broad comparability, in the case of the DMS with the NHS. In this respect we are grateful to the parties for their continuing confirmation that the new NHS contracts remain the appropriate comparators. We are also mindful of the Government's overall approach to public sector pay with settlements informed by low and stable inflation and targeted according to recruitment and retention needs.

50. The evidence covers two main themes: the continuing pressures on DMS manning and retention levels; and the need to maintain comparability at a time when NHS pay arrangements have undergone significant change. These themes have been the focus of our DMS considerations since the 2002 Medical Manning and Retention Review. This review re-based DMS pay arrangements but significant change has subsequently taken place in NHS contractual arrangements. It is important to MOD, as the employer, and to our remit group that our recommendations respond to these themes.

51. We were reminded in the evidence of the need to respond to market forces within the medical and dental labour markets. The market, both in the NHS and the private sector, remains competitive with overall shortages of qualified doctors and dentists which are particularly acute in certain specialties. The NHS has responded with an increasingly attractive package and MOD is aware of the need to maintain the market position of the DMS.

Consultants' base pay (using 12 Programmed Activities and adjusting for non-pensionability of those above 10) suggests DMS pay improves over time but lags behind the NHS, until age 55, by an average of £4,065 a year. NHS Partners added that numbers of Programmed Activities could change in the NHS and DMS requiring further monitoring. We comment below on the handling of additional elements of NHS Consultants' pay;

- **General Medical Practitioners** – emerging data suggest significantly differing changes to NHS GMPs' earnings and transition to the new contract will lead to uncertainty over earnings for some years to come. Salaried GMPs are growing in number but reliable earnings data are lacking;

- **General Dental Practitioners** – mixed NHS and private practice in dentistry continues to make comparisons difficult. Shifts to NHS Personal Dental Services have affected NHS data and a new NHS contract will change the basis of NHS earnings;

- **Junior Doctors in training** – lower working hours have reduced NHS earnings with DMS salaries closely matched to the NHS in comparisons based on grade average out-of-hours bandings. Data suggest similar amounts and patterns of out-of-hours working in the DMS and NHS. Pay comparisons for GMP Registrars are also favourable to the DMS; and

- **Earnings data sources** – Her Majesty's Revenue and Customs' data currently cover periods before the new NHS contracts but will remain an important source of data for future comparisons.

Parties' evidence on pay comparability

35. **Consultants.** MOD and the BMA/BDA continue to agree that comparisons should be drawn with NHS Consultants on the new contract. MOD noted that NHS survey data suggested NHS Consultants' job plans covered on average 11.17 Programmed Activities per week. Data collected from MDHUs covering 86 per cent of DMS Consultants indicated that they worked, on average, 12 Programmed Activities – this average reflecting the difference in specialty breakdowns between the NHS and DMS. MOD therefore presented pay profiles based on 12 Programmed Activities, adjusted for X-Factor and pensions, which they considered would maintain broad comparability with, but not a lead over, the NHS and would account for most DMS Consultants participating in on-call rotas but not receiving the NHS On-Call Availability Supplement. MOD also invited us to take account of the non-pensionability of additional Programmed Activities in the NHS. MOD concluded that the DMS Consultants received, on average across a career, £6,226.04 per year or 6.6 per cent less than in the NHS.

36. The BMA/BDA also calculated the pay profile of DMS and NHS Consultants over a 25-year career and concluded, on the basis of 12 Programmed Activities, that NHS salaries were 6.6 per cent ahead of the DMS on average. They noted that the difference varied considerably across a career, significantly during the early part of a career, and that, in the longer term, consideration might be given to realigning DMS salaries with the NHS at various levels.

37. In constructing the NHS comparator, the BMA/BDA presented evidence on the inclusion of: (i) the NHS On-Call Availability Supplement at 5 per cent (based on data from NHS Trusts hosting MDHUs) as DMS Consultants were mainly in acute specialties requiring on-call work; and (ii) the value of NHS Clinical Excellence Awards (CEAs) awarded locally (based on 0.35 of a CEA per eligible consultant as in the NHS). NHS Partners provided examples of pay profiles showing that the inclusion of both these NHS additional payments widens the pay gap between DMS and NHS Consultants. We will continue to

monitor emerging data on these additional payments, particularly the distribution of CEAs across an NHS career.

38. The BMA/BDA also argued that the value of NHS Discretionary Points in DMS pay had been eroded over time. These had been replaced in the NHS by local CEAs. The first five NHS Discretionary Points were incorporated into DMS basic pay in 1997. When they were extended to 8 NHS points in 2001, the additional value was incorporated into DMS pay and targeted at the key retention point of Major plus 7 years. This extension to 8 points included no further abatement of Distinction Award levels on grounds of retention thereby further improving their value to award holders. The effect of including the appropriate values in DMS base pay, with subsequent uprating by DMS pay increases, is that payments have been made to all DMS Consultants whereas they are awarded according to contribution in the NHS. We conclude that amounts incorporated into DMS basic pay have kept pace with NHS increases.

39. As part of the BMA/BDA's response to NHS Partners' 2005 Report, they commented that the NHS 10 per cent limit on private practice earnings had been used to establish DMS salaries under the 2002 Medical Manning and Retention Review. NHS Partners noted that the new NHS Consultant contract no longer imposed this limit and that the new contract might significantly affect patterns of private practice. They added that basing the DMS pay comparisons on 12 Programmed Activities already equated to the maximum 48-hour week under the EU Working Time Regulations so reducing the time available for private practice. We will keep the position under review as more data emerge.

40. **General Medical Practitioners.** MOD again reported difficulty in obtaining hard evidence on NHS GMPs' earnings. It provided data from the Association of Independent Specialist Medical Accountants, drawing on accounts for 14 per cent of all GMPs in the UK, which indicated an 11 per cent profit rise in 2004-05. From these figures MOD concluded that earnings in the NHS in 2003-04 were 8.5 per cent above the average 2004-05 DMS GMPs' salary and 6.5 per cent above the 2005-06 DMS salary. The BMA/BDA also drew on these figures highlighting the rise of 11 per cent in GMPs' NHS and non-NHS "income". In the longer term, MOD and the BMA/BDA noted that data produced by the NHS Technical Steering Committee and that arising from the *Quality and Outcomes Framework* might provide additional evidence. They both agreed that the comparator should be independent NHS Practitioners not Salaried NHS GMPs.

41. **General Dental Practitioners.** MOD noted the Department of Health's estimate that the average net General Dental Service income of a "committed" NHS dentist was around £80,000 in 2005-06. However, it noted that most dentists undertook a mix of NHS and private work. Both MOD and the BDA commented that the complexity of NHS GDPs' pay arrangements meant that it was not possible to obtain reliable and up-to-date information on NHS and private practice income.

42. **Junior Doctors in training.** We base our comparisons for DMS Junior Doctors in training on NHS earnings comprising base pay and the out-of-hours payments under the banding arrangements introduced in 2000. Between 2000 and 2004 we recommended a DMS out-of-hours supplement to recognise the difference in total earnings between the NHS and DMS. In 2003, amounts were incorporated into DMS base pay for this purpose – £4,000 for OF2s and £2,000 for OF1s – which have since been uprated by our recommendations. For our 2005 Report, evidence of reducing DMS Juniors' working hours led us to conclude that the amounts built into DMS pay were adequate to reflect the relative pay advantage and disadvantage as DMS Juniors rotated through different intensity posts during training. In drawing this conclusion, we recommended that MOD collected accurate and comprehensive data on Juniors' working patterns to support our comparisons.

43. For this report, MOD collected comprehensive data covering 96 per cent of DMS Junior Hospital Doctors and commented on the continuing move away from rotas demanding Band 3 or 2A payments since 2003. MOD compared DMS earnings against average NHS payments (of 60 per cent of base pay) and each of the bandings from Band 2A to 3. It concluded that DMS salaries generally remained more advantageous than NHS counterparts based on the average NHS payment, apart from those in Band 2A and 3. It added that the majority of Juniors were not in these Bands and rotated through different posts during training. The BMA/BDA drew on their 2005 survey data, presented for our 2005 Report, which found that 63 per cent of DMS Junior Doctors worked over 50 hours a week and 36 per cent over the 56-hour limit under the NHS New Deal. The BMA/BDA noted that the NHS banding system rewarded the most intense and demanding posts.

44. We are grateful to MOD for responding to our request for comprehensive data on DMS Juniors' working patterns which provide a firmer basis for our pay comparisons. It is clear that, as intended, the new banding arrangements have helped to drive down working hours in both the NHS and DMS. NHS Partners confirmed MOD's view that NHS and DMS Juniors' (including GMP Registrars') pay was broadly comparable. We conclude that the amounts built into DMS Juniors' base pay are sufficient to maintain comparability with the NHS and we would ask MOD to keep us informed of any changing trends in DMS Juniors' working patterns that might influence pay comparisons.

General comment

45. Our pay comparisons for this report continue to be constrained by the lack of a complete picture on NHS earnings for comparator groups. We note that better data on working patterns for Consultants and Junior Doctors in training provide an improved base for pay comparisons. Emerging data sources for GMPs' comparisons have provided some indications of the pace of change in NHS earnings but data remain severely limited for GDPs' comparisons. As arrangements have changed in recent years, our comparisons with the NHS are becoming increasingly complex and varied. We are therefore grateful to the parties for their considered approach to the make-up of appropriate NHS comparators, particularly for Consultants. While the available data limit our present assessment, we consider the parties' evidence and the NHS Partners' Report has moved our evidence base forward so that in the longer term full comparisons can be made as better data becomes available. We comment below on the parties' interpretation of the pay comparability evidence and how these influence their pay proposals and our 2006-07 recommendations.

Pay proposals

46. MOD reminded us that the background for pay settlements was one of low and stable inflation and that any proposals for pay increases above inflation must be supported by strong evidence of a manning problem which could most appropriately be addressed through pay. From the DMS manning and pay comparability evidence, MOD concluded that decisive remunerative and non-remunerative action must be taken to ensure maximum retention now and in the future, and to support recruitment. With shortfalls in key specialties, MOD considered that action had to be taken to ensure that DMS Consultants were paid on a comparable level with the NHS for the work they undertake. MOD argued that it was constrained until the implementation of Joint Personnel Administration (JPA) in considering targeted pay supplements and had concluded, after careful consideration, that at this time variable increases across the pay spine to closer match NHS levels would be divisive and increase retention problems.

47. MOD and the BMA/BDA proposed a 6.6 per cent increase plus the DDRB recommended increase for specific DMS groups on the following grounds: