

DDRB - 2020/21 pay round

Written evidence from NHS Providers

About NHS Providers

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS trusts and foundation trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate. NHS Providers has all trusts in voluntary membership, collectively accounting for £84bn of annual expenditure and employing more than one million staff.

Our submission

We welcome the opportunity to submit evidence to the Doctors' and Dentists' Remuneration Review Body (DDRB), on behalf of NHS trusts and foundation trusts to inform the 2020/21 pay round. For the purposes of this submission, we have drawn on several information sources, through a survey of NHS HR directors in December 2019.¹ and various forms of national workforce data.

Key messages

- Pay rises for doctors are needed to support improved recruitment, retention and morale, with the vast majority of HR directors surveyed (85%) calling for 2% or more.
- SAS doctors are in need of greater recognition and reward. Workforce directors believe a new contract should be a priority, with 87% saying a new multi-year deal is important or very important.
- The new junior doctor contract agreement has been welcomed, but is presenting some implementation challenges for trusts, with 59% saying new rest and rostering requirements have caused difficulties finding cover, and 52% saying this has caused a local cost pressure.
- HR directors are concerned by the potential for division if the government chooses to target pay rises by medical grade, with 76% not supporting such an approach.
- Most HR directors believe greater use of staff in 'new roles' can support productivity improvements (79%), followed by improved use of technology (70%), enhanced support for staff mental health and wellbeing (64%), and an improved physical environment (51%).

¹ In December 2019, NHS Providers ran an online survey of HR directors in NHS trusts and foundation trusts. Data is based on 57 responses, representing 25% of the provider sector, with all regions and trust types represented in the survey.

- Medical shortages cannot be ignored amidst other recruitment priorities in the NHS. Some specialties (psychiatry, emergency medicine) continue to struggle to fill training posts, while pensions issues have highlighted an overreliance on senior consultants working additional shifts.
- There is an increasing mismatch between the resources and workforce available in the NHS and what staff are being asked to do, with unrealistic workloads and high levels of burnout threatening the wellbeing of doctors across the service.
- While the government has called on the DDRB to consider a “trade-off” between more staff and better pay, focusing on pay while underinvesting in recruitment and retention, or vice versa, is unlikely to provide a sustainable solution to workforce challenges in the NHS

DDRB Remit for 2020/21

In his remit letter to the DDRB, the Health and Social Care Secretary has asked for pay recommendations to be considered within the context of “affordability assumptions underpinning the NHS Long Term Plan”, indicating that funding for any increases in pay will be found from within the current five-year settlement for the NHS. Repeating a message from the 2019/20 pay round, the letter says the fixed nature of the budget means there is “a direct trade-off between (levels of) pay and staff numbers”, when considering further investment in the workforce.²

We note the government’s focus on reaching a multi-year contract deal for specialty and associate specialist (SAS) doctors, following a positive conclusion to recent negotiations on a new contract for junior doctors. This is likely to impact the scope of pay recommendations made for this broad professional group by the DDRB in 2020/21. The remit letter does not refer to stalled talks over a new consultant contract, or give an indication of renewed efforts to negotiate (from either side) in the future.

The DDRB is also asked to evaluate “planned workforce reform and productivity improvements” when considering its pay recommendations, as well as the potential targeting of any funds made available.

Finally, it should be noted that in 2019, both the British Medical Association (BMA)³ and Hospital Consultants and Specialists Association (HCSA)⁴ raised concerns about the efficacy of the pay review process overseen by the DDRB. In March last year, the BMA’s consultants’ committee voted to withdraw from the process of submitting evidence in 2020/21.⁵

We believe there is value in having a process of doctors’ pay assessment from a body that is independent from government, which takes into account evidence from a wide range of relevant sources and interested parties. This process must feature a strong level of engagement from the consultants’ body

² <https://www.gov.uk/government/publications/review-body-on-doctors-and-dentists-remuneration-remit-letter-2020-to-2021>

³ <https://www.bma.org.uk/news/media-centre/press-releases/2019/january/bma-warns-that-doctors-are-being-short-changed-by-a-pay-body-that-is-no-longer-independent>

⁴ <https://hcsa.com/media/127379/HCSA-DDRB-submission-2019-final.pdf>

⁵ <https://www.hsj.co.uk/workforce/bma-consultants-to-pull-out-of-doctors-pay-review-body/7024565.article>

which represents tens of thousands of senior medical professionals across the NHS. We urge the DDRB, government and doctors' unions to work together to restore faith in the review process.

Our views on the 2020/21 pay awards

Pay awards for doctors in 2020/21 will be formed within the context of contractual negotiations with medical professional groups: those concluded for junior doctors in 2019 and those which are ongoing with SAS doctors. The government's confirmation that funding for pay deals will come from within the ring-fenced (five year) NHS England budget and its claim of a trade-off between better pay and more staff are appear to be setting the context for moderate pay rise offers. This is presumably the case both for 2020-21 pay uplifts and for the scope of multi-year deals.

In our 2017 report, *There for us*, trust leaders made it clear that workforce issues were their number one concern – greater than finances – with both formal and informal surveying of our membership since this point underlining this position. Ongoing and enhanced investment in NHS staff is a critical need, with pay rises a key factor within any programme of funding. Asked about the level of pay needed to improve medical recruitment and retention in 2020/21, 85% of HR directors responding said at least 2% was needed, with a slightly larger proportion of that group (43%) suggesting 3% was appropriate for the next financial year (35% favoured a 2% rise and 7% said pay should be increased by 5% or more).

SAS contract negotiations

Our survey of trust HR directors ahead of this pay round in December 2019 underlined the importance of a successful conclusion to the government's negotiations with SAS doctors. An overwhelming majority of respondents (87%) categorised improved terms and conditions for doctors within these grades as important or very important.

Negotiations for a multi-year deal come at an important time, given the mounting evidence of challenges faced by SAS doctors across the country. Initial findings from the General Medical Council (GMC)'s first survey of SAS and locally employed doctors shows that these professionals are more likely than other members of staff to experience bullying, harassment and undermining behaviour from their colleagues.^{6, 7} SAS and locally employed doctors are also more likely than colleagues in consultant or training posts to experience feelings of isolation, impacting the extent to which they feel valued by their employer or the NHS as a whole.⁸

Efforts to improve recognition and reward for these medical professionals are not simply contingent on better pay. Trusts are working hard to improve their offer for doctors at this level, and the ongoing implementation of the updated SAS charter within trusts should provide some assistance towards these

⁶ https://www.gmc-uk.org/About/Our-first-survey-of-specialty-and-associate-specialist-and-locally-employed-doctors?utm_source=Employers%20handling&utm_medium=Email&utm_campaign=SAS_LE_results

⁷ <https://www.nhsstaffsurveys.com/Page/1064/Latest-Results/2018-Results/>

⁸ https://www.gmc-uk.org/-/media/documents/fair-to-refer-report_pdf-79011677.pdf

efforts. However HR directors have told us they struggle both to recruit to this level, and to improve feelings of recognition. One HR director told us, specifically, their organisation “struggle(s) with SAS working with seniority or autonomy feeling devalued by the trust grade title”.

There is hope re-opening the associate specialist grade will help to provide further opportunities for SAS doctors. Trusts have given their support for this change, and there appears to be a general consensus in favour across the sector. However, this must be supported by a new, funded multi-year contractual agreement which tackles all of the relevant issues around recognition and reward.

Junior doctors agreement

We were pleased by the government and BMA reaching a new multi-year contract agreement for junior doctors in 2019: a particularly welcome development to bring a period of dispute between the two sides – and a government imposed contract for all junior doctors employed in trusts – to an end. The guaranteed four-year pay rise and significant level of support for the new deal in the BMA’s member referendum (82%), provides a solid basis for the government and its arms-length bodies, trusts, the BMA and other professional representatives to focus on improving recruitment, workplace morale and other non-contractual elements of juniors’ working lives.

We believe that it is too early to draw definitive conclusions on the impact of the deal agreed last June. However, trusts have expressed concern around the practical difficulties involved with early implementation of certain elements of the deal, including the new rest and rostering requirements. While slightly less than a third of respondents (29%) said the deal has made no impact at this stage, 59% said rest and rostering requirements – including new limits on consecutive shifts and weekend working – have caused difficulty finding cover.

It is important to note this finding does not indicate a philosophical rejection of the contract terms from HR directors. In previous submissions, we have made clear that there has been support from member trusts for the legitimate concerns raised by junior doctors in the 2015-16 industrial relations dispute.⁹

Issues around work-life balance are high on the agenda of HR directors seeking to improve the experience of junior doctors working within their organisations. Changes to contractual terms to limit the amount of consecutive shifts or night shifts junior doctors are working are only right to have been made, and the revised deal has correctly ensured trainees are paid extra when working multiple weekends. Moreover, we have underlined the importance of addressing staff burnout throughout this document and hope the rest and safe working protections included within this agreement contribute to wider efforts to make an impact in this area.

⁹ <https://nhsproviders.org/media/4137/nhs-providers-ddrb-written-evidence-final.pdf>
<https://nhsproviders.org/media/605848/nhs-providers-ddrb-written-evidence-2019-20-final.pdf>

At an operational level within trusts, changes to rostering frameworks will inevitably cause a shift in the way senior leaders seek to ensure an appropriate level of staffing at any given time. The government's confirmation of central funding for the new deal was essential, but it is not clear that all costs have been met. Instead, 52% of respondents stated that new rest and rostering requirements had caused an additional local cost pressure for their trust.

It is critical that implementation and impact is monitored very closely as issues around cost and staffing could grow. One HR director argued there is now "an impossible challenge in designing rotas that are compliant and safe for patients", with another stating that "the move to 1:3 weekends will create a significant cost pressure, even if the additional numbers of doctors required could be recruited - this is largely considered to be both unachievable and unaffordable."

The implementation timeline has also caused issues for trusts, with one HR director citing "massive pressures on support teams and system providers to make changes without fully understanding the wider impact and (to) plan things accordingly in terms of costs".

While very few respondents reported improvements in recruitment and retention (2%) and juniors feeling better paid (21%) following the agreement, changes in pay will take time to be felt and it is too soon to put much stock in these particular findings. But problems with implementation and, in particular, the costs associated with rest and rostering requirements, are issues which must be quickly addressed by government – in consultation with the trusts and the BMA – to ensure the new deal becomes an unqualified success.

Targeting, productivity and trade-offs

Trusts do not favour pay targeting between medical staff grades in 2020/21, with HR directors suggesting this approach is likely to cause division. Over three-quarters (76%) of respondents said they do not support differentiated pay increases, against only 11% of respondents saying SAS doctors should be given larger awards than consultants, or vice versa. This is a notable shift from responses to a similar survey question in December 2018, when 59% supported targeting against 34% who said it risked creating division or contributing to industrial relations disruption.

We believe this change most likely has a strong link to concerns arising from pension tax issues in the NHS: concerns which have intensified throughout the past 10-12 months. Trusts have (almost universally) relayed to us their anxiety around the fairness and equality implications of proposals to address pensions issues – both in the case of local 'workarounds' and national 'solutions' – as the most senior clinical members of staff are offered benefits others are unable to take up. Given the very public debate and high levels of staff demoralisation reported in discussions around pension issues, it is unsurprising HR directors are wary of the prospect of further examples of 'unequal' treatment between different staff groups.

While the Secretary of State's remit letter discusses the need for both "workforce growth and improved productivity", it does not provide further insight on the government's expectations for productivity

increases in the coming year. Evidence will be provided on this point in DHSC's submission to the DDRB, but we can assume that targets will be set to reflect ambitious overarching expectations for the service to find efficiencies within the current NHS funding settlement.

There are a range of factors that go into improving workforce productivity. First and foremost, however, we will repeat our point from last year's evidence: that there is an increasing mismatch between the resources and workforce available in the NHS and what staff are being asked to do. It is our view that the substantial number of vacancies in NHS trusts and the burgeoning demand for patient care are combining to create a required level of discretionary effort that staff are no longer willing or able to give.

Asked specifically about interventions to improve workforce productivity, most HR directors cited greater use of staff in 'new roles' as the best enabler (79%), followed by improved use of technology (70%), enhanced support for staff mental health and wellbeing (64%), and an improved physical environment (51%).

Commitment to these approaches will help with productivity, and there should be some optimism for improvement over time, given the growing consensus over the need for more capital investment (both in estates and IT), and introduction of more support staff in a range of healthcare settings. Increased awareness of mental health issues in the NHS workforce has been supported by some policy interventions, including expansion of the NHS Practitioner Health programme¹⁰, but efforts to make progress in this area are inevitably hampered by the overall lack of investment in mental health services. Ultimately, it will be difficult to meaningfully increase the overall level of productivity of the NHS workforce without filling many of the tens of thousands of vacancies throughout the service, an issue which we expand upon in the section below.

Finally, in last year's evidence, we argued that focusing on pay while underinvesting in recruitment and retention, or vice versa, is unlikely to provide a sustainable solution to workforce challenges in the NHS: a position which we stand by. Ultimately the question of pay versus staff numbers is one of affordability and choice, and as such is one for the government to decide.

Our assessment of the other workforce pressures facing the NHS

Pay and reward needs to be viewed alongside the other workforce challenges in the NHS. Improved pay offers will only make the desired impact if they're accompanied by a programme of work to improve the recruitment, retention and morale of doctors across the country.

¹⁰ <https://www.england.nhs.uk/2018/10/nhs-to-prioritise-doctors-mental-health/>

Pensions and other consultant reward issues

Pension tax issues have been a consistent source of frustration for senior NHS staff and trusts over the past 12-18 months. Tax liabilities incurred as a result of pension contributions exceeding the annual allowance have been widely reported as contributing to consultant's reducing their hours, opting out of the NHS pension scheme, or taking early retirement. Trusts are reporting larger gaps in rotas, higher spending on agency staff and locums, and growing waiting lists as a result of a reduction in the amount of extra work consultants are willing to take on.¹¹

We have been struck by the volume of contact received on pension issues, with trusts emphasising the significant time and sheer complexity involved in efforts to address the problems involved. At a national level, the government has backed four separate 'solutions' over the past six months:

- a '50:50' proposal, allowing senior clinicians to half their contribution and accrual rate;
- a consultation on comprehensive scheme flexibilities for senior clinicians (from April 2020), replacing the 50:50 idea.¹²;
- an endorsement of, and push for local 'workaround schemes' which reimburse staff for lost employer contributions through additional salary.¹³; and
- a one-year-only tax bill payment for all 2019/20 annual allowance breaches.¹⁴

Feedback from the majority of trusts suggests policies put forward thus far have not had the desired impact, or have failed to inspire trust on the part of medical professionals, other senior clinicians or senior managers. Our submission to DHSC's consultation on flexibilities for senior clinicians expands upon this.¹⁵

Ministers in the newly elected government, the Department of Health and Social Care and the Treasury appear to be making a genuine commitment towards solving the pensions problem, whether through the introduction of increased contribution and accrual flexibilities, tax changes, or both. It is important that work in this area does not ignore the need to improve work-life balance for senior medics, particularly with a new generation of younger doctors – likely to hold different expectations over working hours – preparing to complete their training and join the consultant workforce.

It is not within the DDRB's remit to resolve this issue and – as mentioned above – further action is indeed being actively considered to address the concerns of the sector. But it is clear that pensions issues have revealed the extent to which senior medical professionals are stretched beyond any reasonable limit. The NHS relies heavily on discretionary effort from frontline staff to deliver services and mitigate performance challenges, with most consultants taking on additional, non-contractually mandated sessions – or

¹¹ <https://www.telegraph.co.uk/news/2019/10/29/patients-facing-longer-waits-surgery-winter-surgeons-cut-hours/>

¹² <https://www.gov.uk/government/consultations/nhs-pension-scheme-increased-flexibility>

¹³ <https://www.ft.com/content/f467a35c-0175-11ea-be59-e49b2a136b8d>

¹⁴ <https://www.england.nhs.uk/publication/action-on-2019-20-pension-tax-impacts-letters-from-simon-stevens-and-amanda-pritchard/>

¹⁵ <https://nhsproviders.org/media/688733/nhs-providers-consultation-response-dhsc-proposed-pension-scheme-flexibilities-1-november-2019.pdf>

“programmed activities” (PAs) – to help clear growing waiting lists. Consultants are increasingly aware of the short and long-term financial disincentives involved in taking on additional PAs or waiting list initiative (WLI) sessions and as such the NHS is facing a major loss in clinical capacity.

It does not appear that agreement over a new consultant contract is on the horizon, nor does a resumption of meaningful talks seem to be a priority for those empowered to make it so. This is regrettable, as improved terms and conditions would help to restore a level of trust between the government and unions representing senior doctors. A new funded multi-year deal was seen as “important” or “very important” for 74% of HR directors responding to our survey.

There is, however, work ongoing to reform local clinical excellence awards (LCEAs), with the potential for a new approach to performance pay within organisations from April 2021. This is likely to be a greater focus for trusts next year, but feedback collected through our recent survey indicated a level of frustration for boards with current (interim) or historical arrangements.

Reform of local clinical excellence awards was rated as “important” or “very important” by 78% of HR directors responding, with many saying the current construction of awards is not “fit for purpose”. Multiple respondents suggested LCEAs are “divisive” and should not be available just for doctors; others focused on the benefits of greater trust freedom to determine performance; while the need for predictability and future planning around the pay bill was also emphasised. One HR director said, “clarity is required on what comes next, so that any changes (from April 2021) can be implemented in good time with appropriate and timely information being shared with the Consultant body.”

Medical shortages and recruitment

There are currently over 100,000 vacancies across NHS trusts¹⁶, with this number set to increase, absent a series of impactful policies to bolster workforce supply. The NHS people plan has rightly prioritised the nursing workforce, where a 12% vacancy rate (40,000 total unfilled posts) has led the government to introduce a significant programme of financial support for new and postgraduate students.

While this area of focus is correct, recruitment and retention challenges are also an ever present in the medical workforce. NHS England/Improvement vacancy data from the second quarter of 2019 shows over 9,300 unfilled medical posts (a 7% vacancy rate). There is mild encouragement in the fact this is an ever-so-slightly lower rate than at the same point in 2017 and 2018, but focus must be maintained for shortage specialties that remain stubbornly difficult to recruit to. Around one in ten specialty postgraduate training posts are unfilled, with this rate higher for psychiatry and emergency medicine posts in particular (14% unfilled for both in 2019).¹⁷

¹⁶ <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey/february-2015---june-2019-provisional-experimental-statistics>

¹⁷ <https://www.hee.nhs.uk/our-work/medical-recruitment/specialty-recruitment-round-1-acceptance-fill-rate>

In their combined workforce report, *closing the gap*, the Health Foundation, King's Fund and Nuffield Trust warned that NHS vacancies could more than double by 2030 without significant policy action to reverse these trends.¹⁸ The report emphasised that the NHS must seek to not only maintain, but significantly increase its reliance on international recruitment after Brexit, if it is to have any chance of closing the workforce gap over the next decade.

This is especially relevant for doctors as 28% of the current medical workforce is classified as international staff, higher than all other professional groups including nurses (17%) and managers (5%).¹⁹ In contrast to the nursing and midwifery workforce, the numbers of internationally trained doctors joining the medical register has been increasing in recent years²⁰ and the government has expressed confidence this trend will not be affected by Brexit. This is contingent on a fit for purpose future immigration system: more details are needed on the introduction of an "Australian-style" points-based system and an "NHS Visa" promised by the government, but liftings of restrictions in recent years for international doctors provides some hope for the future.²¹

Trusts increasingly emphasise the distinct challenges faced by rural and remote organisations in medical recruitment. Trusts serving rural communities can struggle to promote their offer to prospective medical staff, particularly in cases where trusts do not benefit from the same access to training infrastructure, and facilities provided by organisations in urban areas. A Royal College of Physicians study last year found that only 13% of consultant posts filled in 2018 were in trusts serving mainly rural or coastal areas.²²

While views on the use of recruitment and retention premia varies considerably between trusts, our survey found 57% of HR directors supporting the continuation of local recruitment and retention premia, with a number of respondents citing the need to support regions and localities which struggle to recruit. One HR director said, "we must try to help the trusts in geographically isolated areas of the country. It is not a level playing field. Trying to recruit a doctor to London or Cumbria is not the same." There may be a case for government to dedicate some funding towards solving this issue, though it is important further recruitment incentives based on geography are designed carefully to avoid unhelpful competition between trusts. This should be supported by work at a national level to promote the advantages of working in rural and remote trusts.

We expect the NHS people plan's focus on workforce redesign, and subsequent cross-sector work in this area, to re-set expectations of required staffing numbers in different professions, within the context of increased multi-disciplinary working and enhanced flexibility for staff to work across systems. This work must always be accompanied by a blunt realisation of the workload pressures currently facing NHS staff. In last year's staff survey, only 22% of respondents reported they 'never' or 'rarely' suffered from unrealistic

¹⁸ <https://www.nuffieldtrust.org.uk/research/closing-the-gap-key-areas-for-action-on-the-health-and-care-workforce>

¹⁹ <https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/nhs-international-recruitment>

²⁰ <https://data.gmc-uk.org/gmcdata/home/#/reports/The%20Register/Stats/report>

²¹ <https://www.bma.org.uk/news/2019/may/government-widens-job-shortage-list>

²² <https://www.theguardian.com/society/2019/oct/13/nhs-consultant-shortage-rural-coastal-areas>

time pressures in their jobs and over two thirds said there is not enough staff at their organisation to enable them to do their jobs properly.²³ As discussed above, workload concerns highlighted by the pensions issue must be factored into an evaluation of the true nature of medical workforce shortages.

Staff experience

Issues around staff wellbeing and burnout remain salient given the challenging demand and performance picture for NHS trusts.

Pay reform is just one part of the programme of transformation needed to support a better resourced and more satisfied workforce. Data from the NHS staff survey suggest there is mounting pressure on the medical workforce with declining staff satisfaction. While rates of pay go some way towards ensuring the workforce feels valued and motivated, working conditions, including stress and work life balance, is critical.

Trusts have cited other priorities in respect of recruitment, retention, morale and work-life balance for staff, including supporting flexible working, improving working condition, and staff wellbeing. NHS Staff Survey statistics show that more than a third (40%) of staff have felt unwell due to work-related stress, and more than half reported working unpaid overtime.²⁴ The independent report on doctors' wellbeing carried out by Professor Michael West and Dame Denise Coia for the GMC explains the difficulties faced by doctors in detail, showing high rates of burnout and stress for medical professionals (particularly in A&E), and workload issues translating to trouble with sleeping, among other things.²⁵

Other challenges in respect of bullying and harassment remain and these have an impact on wellbeing and retention of staff. A fifth of staff (19%) have experienced bullying and harassment, the highest level since 2014. The importance of improving culture as part of efforts to address working conditions for doctors must be recognised.

The people plan highlights the welcome ambition for the NHS to be the best place to work, with a dedicated workstream addressing factors which contribute to the satisfaction of the NHS workforce. Trusts are working on measures to tackle all of these issues however chronic workforce shortages contribute to an increasing reliance on the discretionary effort of staff, overtime, and pressure on remaining doctors working in overstretched and understaffed services.

NHS people plan

Following the release of an interim plan last June, NHS England/Improvement will shortly publish a final plan, which we have referenced throughout our evidence. The plan – which is the first long-term system-wide healthcare strategy in a generation – will set out a range of measures the service will put in place to

²³ <https://www.nhsstaffsurveys.com/Page/1064/Latest-Results/2018-Results/>

²⁴ <https://www.nhsstaffsurveys.com/Page/1064/Latest-Results/2018-Results/>

²⁵ <https://www.gmc-uk.org/about/how-we-work/corporate-strategy-plans-and-impact/supporting-a-profession-under-pressure/uk-wide-review-of-doctors-and-medical-students-wellbeing>

address key challenges across the workforce. These measures include introducing a “new offer” for staff; improving culture and leadership; and devolving more workforce activity from the centre to systems and local areas, among other priorities.

We have fed in to most phases of the plan’s development through its advisory groups and we would note that NHSE/’s commitment to engaging all key NHS stakeholder bodies throughout this process has been a welcome development. We are aware of the likely need for investment attached to some of the forthcoming proposals, but we are optimistic that a strong framework will be put in place to improve the experience of people working in the NHS over time. We look forward to seeing more details and engaging with the implementation process once the final plan has been published.

Further information

We would be pleased to respond to supplementary questions from the DDRB and welcome the opportunity to discuss our evidence further at an oral evidence session.

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