SPICe Briefing
The National Health Service in Scotland: Subject Profile

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This briefing is intended to be an introductory text to the NHS in Scotland. It includes:

- A brief history of recent reforms

- The current organisation of the NHS in Scotland

- Governance and accountability arrangements

- Regulation, inspection, complaints and enforcement

- Funding

It also examines some key issues that may be topical in the coming session of Parliament.

The Scottish Parliament
Pàrlamaid na h-Alba

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INTRODUCTION

The National Health Service (NHS) was established in Britain in 1948 and provides the vast majority of health care in Scotland. The NHS in Scotland carries on the principle of collective responsibility by the state for the provision of comprehensive health services free at the point of use. Services are funded from central taxation and access is based on need. The main legislation providing the legal framework for the NHS in Scotland is the National Health Service (Scotland) Act 1978 (c.29).

Health policy was, in the main, devolved to the Scottish Parliament under the terms of the Scotland Act 1998. However there are some areas of health policy which remain reserved to Westminster, namely:

- Abortion
- Xenotransplantation (the use of non-human organs for transplantation)
- Embryology, Surrogacy and Genetics
- Medicines, medical supplies and poisons (although decisions on the funding of prescription drugs are devolved)
- Welfare foods (e.g. milk tokens to low income families)
- The regulation of the health professions
- Health and safety.

While the remainder of health is devolved to the Scottish Parliament, there are a number of areas where the Scottish Government chooses to work with some/all of the other UK health departments. This is usually where there is a recognised mutual interest and some examples include the negotiation of GP contracts and vaccination programmes.

DEVOLVED HEALTH POLICY

The NHS is a term which encompasses a variety of different services. Such services can broadly be divided into:

- public health
- primary care
- secondary care, and
- tertiary care.

Public Health

Public health is often defined as "the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society" (HMSO, 1988). It is the part of the NHS which is generally tasked with improving and protecting the health of populations as opposed to individuals. Public health measures include, but go beyond, the provision of traditional health services, and public health professionals work to affect all of the determinants of health. These determinants include individual behaviours such as smoking and diet, as well as life circumstances like housing, education and the environment. As a result, public health is closely linked with other organisations responsible for these determinants, such as local authorities.

The national lead for improving public health lies with the Chief Medical Officer, a post which sits within the Government. In addition to this, NHS Health Scotland is a special health board with a remit to improve Scotland's health. Locally, however, each area NHS Board has a Public

Health Department and a Director of Public Health who holds a place on the Board (see 'Current Organisation of the NHS in Scotland' for more information on NHS Boards).

Primary Care Services

'Primary care' refers to the services provided by health professionals in either clinics and practices, or sometimes in a patient's home. Primary care is normally the first point of contact with the NHS and primary care professionals are considered the 'gatekeepers' to secondary and tertiary services. An estimated 90% of patient contact is handled at this level.

Within primary care there are 4 practitioner services: medical, dental, pharmaceutical and optical. These practitioners are usually independent of the NHS and are contracted by local NHS Boards to provide their particular service. Their contracts are negotiated on a national basis (either at a Scottish or UK level) but NHS Boards still have some scope to negotiate local contracts or to employ practitioners directly as salaried NHS employees.

General Medical Practitioners (GPs) normally work together as partners in a local practice. Practices are responsible for employing their own administrative and practice nursing staff but the team also includes NHS employed community nursing staff such as health visitors. Every UK citizen has the right to be registered with one of these practices and the services offered at these points are free of charge. There are approximately 16.7 million GP consultations per year and 7.5 million practice nurse consultations in Scotland per year (ISD Scotland, 2011a). Some services provided by other practitioners are chargeable (e.g. dentists and opticians) although eye and dental check-ups were made free in 2006.

Secondary Care

'Secondary Care' is mainly hospital-based health care provision. Services range from emergency care (via Accident & Emergency) to non-emergency treatment (usually through outpatient departments or elective treatment). In recent years there has been a move towards providing more care and treatment in outpatient departments, or on a day case basis, as well as preventing unscheduled inpatient admissions. An increasing amount of secondary care is being provided by Nurses and Allied Health Professionals (e.g. dieticians and physiotherapists). Annually, there are approximately 1.4m hospital episodes in Scotland and over 4.5m outpatients are seen at consultant clinics (ISD Scotland, 2011b). Staff within secondary care are usually directly employed by the NHS.

Tertiary Care

Tertiary care refers mainly to the provision of specialist services for people with an existing disease which requires higher levels of expertise and support services. An example of this would be cancer services such as those provided at the Beatson Oncology Centre in Glasgow. Tertiary care services are usually provided in a limited number of locations around the country and some services are so specialised that they may only be provided on a national basis e.g. liver transplantation.

Scotland has also developed 'Managed Clinical Networks' as a means of providing tertiary care (together with elements of primary and secondary care). Managed Clinical Networks (MCNs) are groups of health professionals and organisations (e.g. local health services, social service departments and support groups) working together to provide treatment and care to patients. MCNs are permitted to co-ordinate their work with health professionals and organisations across NHS Board boundaries. Examples of MCNs in Scotland include the 3 regional cancer networks and the national Scottish muscle network (for people with neuromuscular disorders).

KEY SCOTTISH NHS REFORMS

There have been many changes to the NHS in Scotland over the last two decades and the following sections aim to summarise the main developments since 1997.

1997-1999 – THE UK LABOUR GOVERNMENT

In 1997, the incoming UK Labour government inherited a national health service which in the preceding years had undergone radical changes under the Conservatives. These changes were geared towards introducing elements of market economics to the NHS in a bid to improve cost-effectiveness and efficiency. Such elements included the creation of NHS Trusts and a purchaser/provider split, whereby fundholding GPs purchased care on behalf of their patients from providers such as Acute Hospital NHS Trusts. This system was opposed by Labour and the party's 1997 manifesto contained a pledge to abolish what was then known as the 'internal market'. In line with this manifesto commitment, the new UK Labour Government signalled the end of the internal market by abolishing GP fundholding and contracting for services, removing the autonomy of NHS Trusts and replacing competition with a culture of 'partnership'.

1999- 2007 – THE SCOTTISH LABOUR/LIBERAL DEMOCRAT GOVERNMENT

In the first and second sessions of the Scottish Parliament, the Labour/Liberal Democrat coalition continued this policy drive, culminating in 2004 in the abolition of NHS Trusts entirely. The coalition also created 'Community Health Partnerships' as a means of strengthening primary care and achieving greater integration within the NHS and between health and social care. These changes were seen as the final stage in dismantling the internal market.

The functions of the NHS Trusts were incorporated into 'Operating Divisions' of NHS Boards which became responsible for overseeing primary and secondary care. However, unlike Trusts, Operating Divisions have no independent legal status so this left a single tier of governance and accountability in the shape of the 14 area NHS Boards.

Around this time, there was increasing public concern over service reconfigurations and the centralisation of services. The then Health Minister, Malcolm Chisholm MSP, convened an expert group tasked with looking at how NHS services could be developed in the longer term. In May 2005, the 'Kerr Report' was published and set out its vision for the NHS as:

> "[The NHS] should deliver safe, high quality services that are as local as possible and as specialised as necessary" (the National Advisory Group on Service Change, 2005, pg 64)

One of the key themes to emerge from the Kerr report was support for the concept of 'shifting the balance of care' closer to the community and away from acute services. Some of the mechanisms suggested for achieving this included anticipatory care (where care is geared towards preventing unscheduled admissions to acute care), preventing future ill-health and improvements in the management of long-term chronic conditions. The Executive issued its response in the publication of 'Delivering for Health' which generally endorsed the Kerr report (Scottish Executive, 2005).

2007-2011 – THE SNP GOVERNMENT

When the SNP government came to power in 2007, there was no manifesto pledge for a radical reorganisation of the NHS. Instead, the SNP government maintained the structure established by the previous administration and built upon this with promises of shorter waiting times and more accessible and accountable health services. The manifesto included a pledge to operate a 'presumption against the centralisation of core hospital services' (SNP, 2007). This was evident

in the decision to reverse the closure of A&E departments at Monklands and Ayr hospitals. A decision subsequently backed by the newly established 'Independent Scrutiny Panels'.

The publication of 'Better Health, Better Care' set out the SNP Government's vision of creating a 'mutual NHS', where patients are treated as co-owners of the NHS (Scottish Government, 2007). This included a number of proposals to shift ownership and accountability, including the piloting of elections to NHS Boards and the introduction of the Patient Rights (Scotland) Bill with its key policy of a statutory treatment time guarantee. The policy drive to shift the balance of care from secondary care to the community was also retained by the SNP administration. Other key policy developments taken forward by the SNP Government included:

- the abolition of prescription charges
- establishing dementia as a national priority and the creation of a dementia strategy
- the publication of the NHS Quality Strategy (Scottish Government, 2010b)
- a commitment to protect the health budget.

CURRENT ORGANISATION OF THE NHS IN SCOTLAND
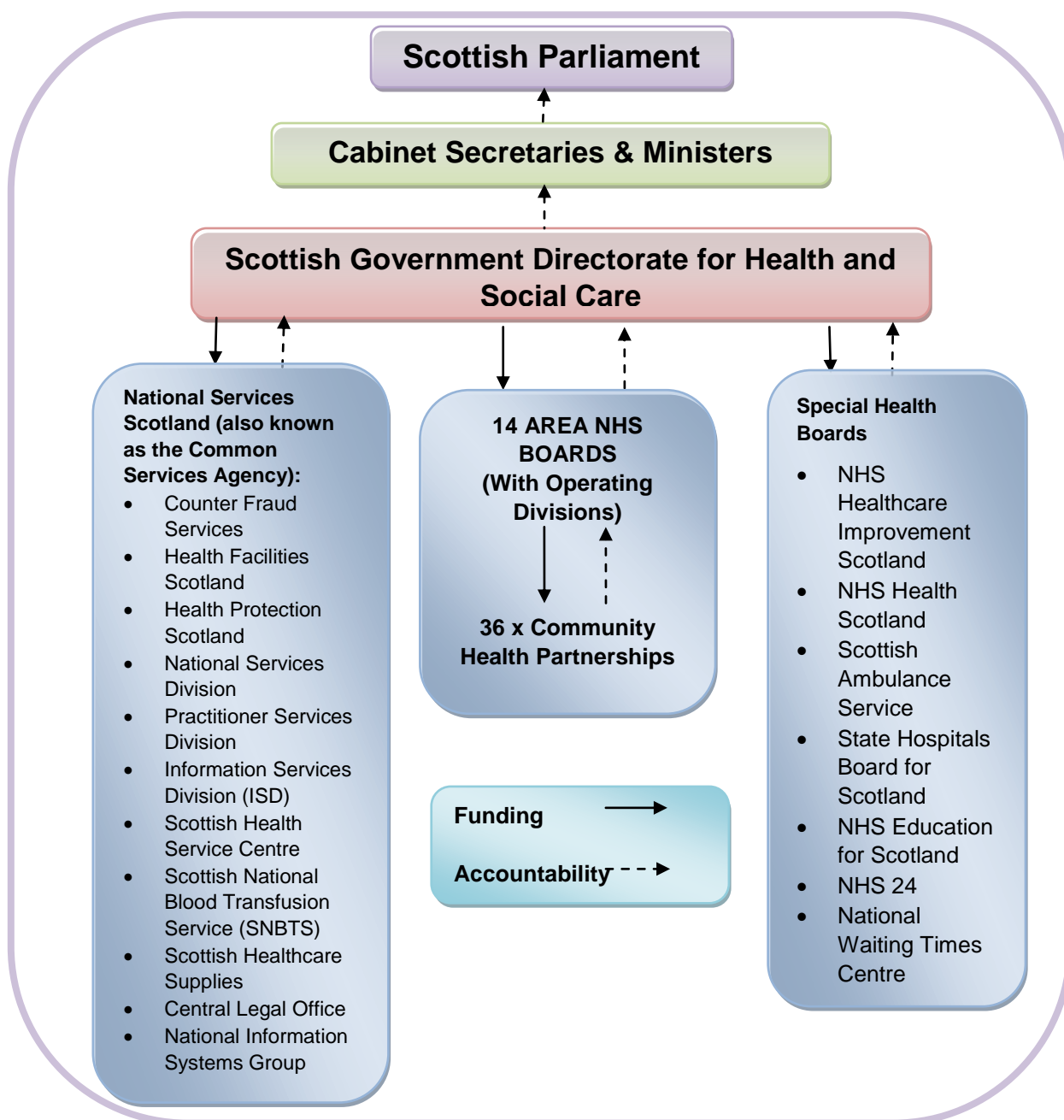
SCOTTISH GOVERNMENT DIRECTORATE FOR HEALTH AND SOCIAL CARE

In Scotland, the Scottish Government Directorate for Health and Social Care has responsibility for health policy, the administration of the NHS, community care and some responsibility for social work. The Directorate is headed by the Director General for Health who is the Chief Executive Officer of the NHS. At the time of writing, this position was filled by an acting Chief Executive following the departure of Dr Kevin Woods.

The department is subdivided into Directorates alongside which, there is the Chief Medical Officer (CMO) who is the principal medical adviser to the Cabinet Secretaries and is also closely involved with the Chief Scientist Office (CSO). The CSO oversees the management and funding of research within the NHS in Scotland.

AREA NHS BOARDS

The responsibility for running the National Health Service in Scotland is predominantly devolved from the Scottish Government to the 14 area NHS Boards. The functions of the Boards can broadly be divided into:

- Strategy development
- Resource allocation
- Strategy implementation
- Performance management.

Collectively, the 14 area NHS Boards are responsible for around £7.5bn of the total £11.35bn health budget for 2011/12.

Each Board is made up of:

- **Non-Executive Lay Members** – appointed by Ministers after open competition
- **Non-Executive Stakeholder Members** – appointed and paid in the same way as lay members but are representatives of specific interests that must be represented on the Board (e.g. chair of the area clinical forum)
- **Executive Members** – hold a place by virtue of their employed position within the Board (e.g. Chief Executive or Medical Director).

The only exceptions to the above structure can be found in Fife and Dumfries & Galloway. In these two areas, elections to the Boards were piloted in May 2010. These pilots are being used to ascertain whether having a directly elected element on an NHS Board improves public participation in NHS decision making. An interim evaluation report has been published (Greer et al, 2011) and elections will only be rolled out to the rest of Scotland once the final evaluation has been laid before the Scottish Parliament and the necessary legislation for roll out has been passed.

The structures within the Board include 'Operating Divisions' and 'Community Health Partnerships'. Operating divisions took on the responsibilities of the former NHS Trusts, and Community Health Partnerships are committees or sub-committees of the Board (see below).

COMMUNITY HEALTH PARTNERSHIPS

Community Health Partnerships (CHPs) are the key mechanism for planning and delivering primary care and community based services. They are also intended to help improve the integration between health and social care services and to be central in 'shifting the balance of

care' away from the acute sector towards community based services. At present there are 36 CHPs in operation in Scotland.

The legislation[1] which underpins CHPs was not prescriptive in how they should operate or how they should be structured and recent research has found that their structures and functions differ (Scottish Government, 2010c; Audit Scotland, 2011). However, they generally fall into two categories; a health only structure, or a combined health and social care structure. The exact responsibilities and make-up of each CHP are outlined in their 'schemes of establishment'. Each CHP should also have a Public Partnership Forum made up of patient groups, voluntary organisations and members of the public. The forums are meant to give local communities a chance to influence local services.

As CHPs operate as committees or sub-committees of the area Board, their funding is devolved from the NHS Boards and varies in its extent between CHPs. Overall, it is estimated that CHPs directly manage 26% of the £13bn spend on health and social care (Audit Scotland, 2011).

SPECIAL HEALTH BOARDS

Special health boards provide services to the whole of Scotland, not just a local population. Table 1 briefly outlines each of the Boards and their functions.

Table 1: Special Health Boards and their functions

Name	Function
NHS Health Scotland	NHS Health Scotland is the agency responsible for improving population health. NHS Health is responsible for all aspects of health improvement including understanding the determinants of health, gathering evidence on how to improve poor health, disseminating evidence and evaluating activities aimed at improving health. Funding for NHS Health Scotland in 2011/12 is £20.2m.
NHS Healthcare Improvement Scotland (NHS HIS)	NHS HIS was previously known as NHS Quality Improvement Scotland and it is the body tasked with improving the quality of care in the NHS. Its functions include providing advice and guidance on effective clinical practice, setting standards for care and reviewing and monitoring performance. Funding for NHS HIS in 2011/12 is £17.2m.
NHS Education for Scotland (NES)	NES is responsible for designing, commissioning and quality assuring education, training and lifelong learning for the NHS workforce. Funding for NES in 2011/12 is £393.4m.
Scottish Ambulance Service (SAS)	SAS provides ambulance services for accidents, emergencies and non-emergencies. Funding for the SAS in 2011/12 is £197.7m.
State Hospitals Board for Scotland	The State Hospital provides high security forensic and psychiatric care at Carstairs in Lanarkshire. Funding for the State Hospital in 2011/12 is £33.2m.

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[1] National Health Service Reform (Scotland) Act 2004

Name	Function
NHS National Services Scotland (NSS)	NSS provides a range of services that are required nationally such as Scottish Healthcare Supplies, the Scottish Blood Transfusion Service and Health Protection Scotland. Funding for NSS in 2011/12 is £266m.
NHS 24	NHS 24 is an online and telephone based information and advice service. Funding for NHS 24 in 2011/12 is £59.4m.
National Waiting Times Centre	The National Waiting Times Centre is based at the Golden Jubilee Hospital in Clydebank. It receives referrals from across Scotland in order to reduce waiting times in key elective specialities such as orthopaedics. Funding for the national waiting times centre in 2011/12 is £39.1m

GOVERNANCE AND ACCOUNTABILITY OF NHS BOARDS

NHS Boards are accountable to Scottish Government Ministers, who are in turn accountable to the Scottish Parliament. There are various means in which the Scottish Government ensures good governance and performance from NHS Boards, these include:

- HEAT targets
- National guidelines and standards
- Annual accountability reviews.

HEAT TARGETS

HEAT targets are one of the key mechanisms for performance managing NHS Boards. 'HEAT' is an acronym relating to 4 key objectives:

- **H**ealth Improvement for the people of Scotland – improving life expectancy and healthy life expectancy
- **E**fficiency and Governance Improvements – continually improve the efficiency and effectiveness of the NHS
- **A**ccess to Services – recognising patients' need for quicker and easier use of NHS services
- **T**reatment Appropriate to Individuals – ensure patients receive high quality services that meet their needs.

Each objective has a number of targets and measures associated with it. Targets are measured nationally and reviewed on an annual basis with Boards. Each NHS Board produces a 'Local Delivery Plan' which contains a 'planned performance trajectory' showing how they will achieve the targets. The Scottish Government agrees the plan with Boards and this then forms an annual 'performance contract' (Scottish Government, 2010d).

Once a HEAT target has been achieved it becomes a 'HEAT Standard' and Boards are expected to maintain it. Further information on progress towards the HEAT targets can be found on the Scotland Performs website.

NATIONAL GUIDELINES AND STANDARDS

While, the management of the NHS is generally devolved to the NHS Boards, Boards do not operate entirely independently of the Scottish Government. As well as meeting HEAT targets, they are often expected to abide by national standards or guidelines. Within Scotland, standards and guidance to Boards comes from both the Government and some of its arms-length bodies. Sources of guidance include:

Scottish Government – for example, Chief Executive Letters to NHS Boards

- NHS HIS – produces standards for care and also incorporates organisations such as the Scottish Intercollegiate Guidelines Network (which produces guidelines on clinical practice) and the Scottish Medicines Consortium (advises Boards on the clinical and cost-effectiveness of newly licensed medicines)
- Health Protection Scotland – issues guidance on the management of infectious and environmental hazards.

ANNUAL ACCOUNTABILITY REVIEWS

Each year, the Cabinet Secretary for Health and Wellbeing (or the Minister for Public Health) will undertake an accountability review with each of the NHS Boards. Reviews are now open to members of the public who can submit questions to be answered by either the Cabinet Secretary/Minister or the Chair of the Board. During the review, the Cabinet Secretary may meet with other stakeholders (e.g. patient and staff representatives) and will also review performance against the Board's Local Delivery Plan and the HEAT targets.

REGULATION, INSPECTION, COMPLAINTS & ENFORCEMENT

The NHS is not overseen by a single regulatory body in the same way that care services are (i.e. by Social Care and Social Work Inspection Scotland). Instead the roles of regulation, inspection, complaints and enforcement are divided between different bodies.

REGULATION AND INSPECTION

NHS Healthcare Improvement Scotland (HIS) has a key role in setting standards for care and treatment and then inspecting Boards' performance against them. However, NHS Boards still have a large degree of autonomy and HIS does not have the power to enforce sanctions against Boards who do not meet the standards (see 'Enforcement' below). One exception to this is that HIS is now responsible for the regulation of independent healthcare, a role which previously belonged to the Care Commission. In line with the powers the Care Commission had, HIS will register and inspect services against the national care standards. It can also take enforcement action against an independent healthcare provider and has the power to cancel a service provider's registration (NHS Healthcare Improvement Scotland, 2011).

HIS also incorporates the Healthcare Environment Inspectorate (HEI) which is responsible for inspecting hospital compliance with Healthcare Associated Infection standards. HEI undertakes one announced, and one unannounced inspection of each Scottish hospital every 3 years.

COMPLAINTS

Complaints about NHS services are dealt with in the first instance by NHS Boards, with possible referral to the Scottish Public Services Ombudsman (SPSO) if not resolved to the complainant's satisfaction. Patients may also pursue legal action through the civil courts. Forms of legal action include bringing a claim in respect of negligence or lodging a petition for judicial review.

The Patient Rights (Scotland) Act 2011 (the '2011 Act'), when in force, will give patients a right to complain and place a duty on Scottish Ministers to publish a comprehensive 'Charter of Patient Rights and Responsibilities'. This should outline all rights and responsibilities available to patients. The 2011 Act also provided for the establishment of the Patient Advice and Support Service, which will have a role in advising patients wishing to give feedback or make a complaint. At present, Health Rights Information Scotland publishes information on patient rights in Scotland and the Independent Advice and Support Service (IASS) provides advice to patients on their rights and how to make a complaint.

ENFORCEMENT

Only Scottish Ministers and the Scottish Courts have the power to enforce a particular action on an NHS Board. Ministers have a general power to direct Boards[2] as well as the power to intervene in the case of service failures. Scottish courts can also employ a number of legal remedies, such as an order to pay damages. While the SPSO would expect an NHS Board to comply with any recommendations it makes, it has no statutory powers to enforce those recommendations. The findings of HIS inspections are fed into the annual accountability reviews of Boards but it does not have the power to enforce a particular action on an NHS Board.

FUNDING OF THE NHS IN SCOTLAND

The total health budget for 2011/12 is £11.35bn. This now accounts for 33.9% of total Government spending. Since 2005/06, health spending has risen by 29.7% in real terms, which is at a significantly faster rate than the total Scottish budget which has risen by 24.2% (Payne, 2011).
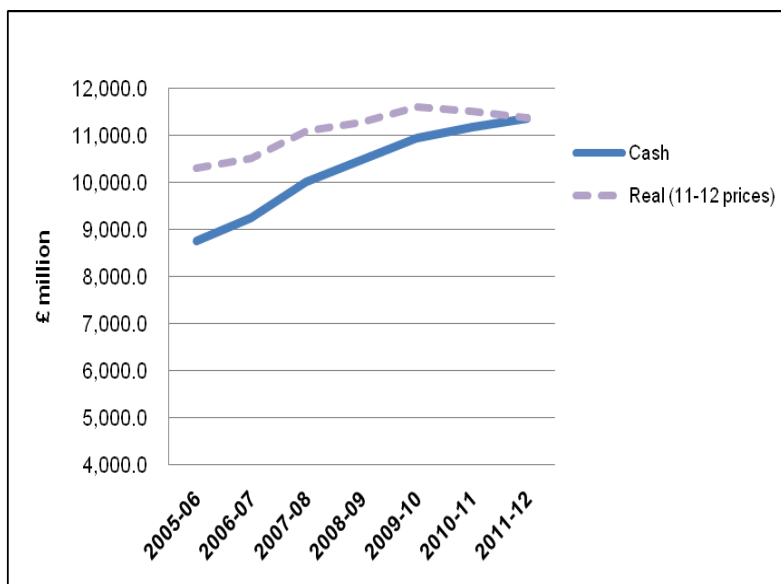
Figure 1: Total health spending 2005-06 to 2011-12 (cash and real terms)

Levels of funding to NHS Boards are determined by the Cabinet Secretary and Ministers, and approved by the Scottish Parliament. Allocations between the area NHS Boards are determined by the Government using the National Resource Allocation Committee (NRAC) formula (National Resource Allocation Committee, 2007). This is an update of what was known as the 'Arbuthnott formula'. NRAC is a weighted capitation formula which means that funding is allocated based on the population of the area and takes into account factors such as morbidity and deprivation in order to adjust for relative health need.

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[2] Section 2(5) of the National Health Service (Scotland) Act 1978

NRAC was established in order to provide a more transparent and fair mechanism for dividing resources between the 14 area NHS Boards. It was first used in 2009/10 and is being phased in. This is to avoid funding turbulence within NHS Boards. Full implementation of the formula is referred to as 'parity' although this has not yet been reached. NHS Boards are responsible for funding services and initiatives in their area within their NRAC allocation.

KEY ISSUES FOR THE NHS IN SCOTLAND

The following sections outline some issues for the NHS that may prove to be topical in the course of session 4 of the Scottish Parliament.

FUNDING PRESSURES

In January 2011, the Cabinet Secretary for Finance provided illustrative health budget figures for 2012-13 to 2014-15 (Cabinet Secretary for Finance, 2011). In terms of resource spending, the figures suggest a year on year increase in cash terms from £10,772m in 2011-12 to £11,598m in 2014-15. This means that health is the only area of spending showing an increasing resource budget (in cash terms). However, in real terms[3] this would mean a real terms decrease from £10,772m in 2011-12 to £10,728m in 2014-15 (Payne, 2011).

Some of the costs that the NHS has to bear tend to increase above inflation (e.g. pharmaceuticals and new technologies). This means that despite a relative degree of protection from budget cuts, the NHS will still face significant budgetary pressures. Current forecasts suggest that NHS Boards will need to achieve efficiency savings of at least 3% in order to break even (Scottish Government, 2011). This is in addition to annual efficiency savings of 2% since 2007/08.

SHIFTING THE BALANCE OF CARE

Over the last decade, the drive to 'shift the balance of care' from secondary care services towards the community has been a key Government policy. The rationale for the policy is based on both efficiency and effectiveness. For example, of the estimated £4.5bn spent on health and social care for older people, £1.3bn is spent by social work and £3bn is spent by the NHS. Almost half of the NHS spend (£1.4bn) is the cost of emergency admissions to NHS Hospitals (Scottish Government, 2010e).

This example demonstrates the need to shift the balance of care, both from the perspective of using money more effectively but also from the perspective of providing better care to service users. Progress towards shifting the balance of care has come into focus recently given the financial constraints being felt in the public sector. A look at indicators used to assess the shift casts doubt over progress.

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[3] Using March 2011 UK Treasury deflators
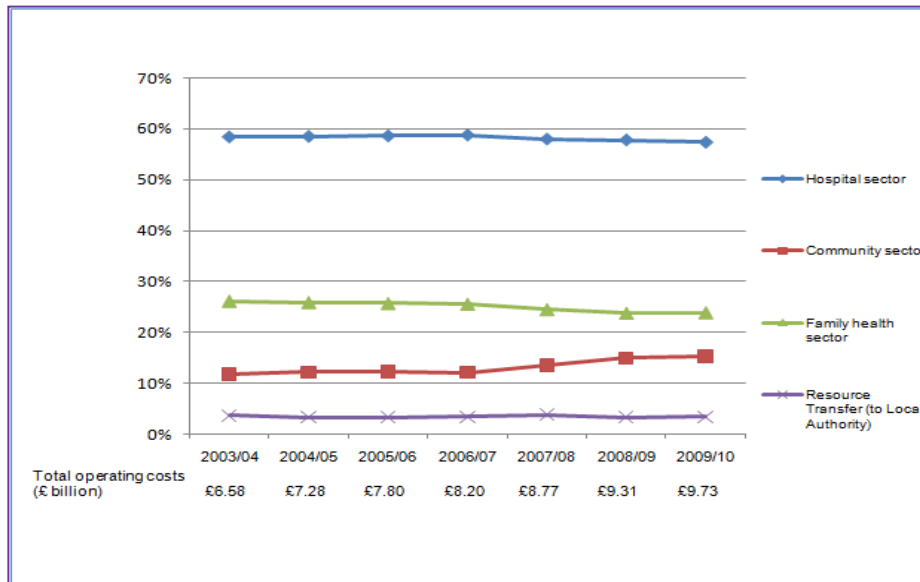
Figure 2: Percentage of total NHS operating costs by sector (Audit Scotland, 2011)

Figure 2 shows a fairly static picture in relation to the distribution of NHS resources. There has been a slight increase in the percentage of NHS resources being spent in the community but there has been no change in the percentage of NHS resources transferred to councils for social care.

Another indicator that is often used to assess the balance of care is the number of unscheduled/emergency admissions to hospital. Despite a drive to reduce the number of unscheduled admissions over the last decade, there has been an increase of 12% (n=55,652) since 2000/01 (ISD Scotland, 2011c).

COMMUNITY HEALTH PARTNERSHIPS

Community Health Partnerships were formed in 2004 and were seen as a key mechanism for moving services into the community and making the NHS more 'seamless'. There are 36 CHPs managing £3.2 billion in annual health and social work spending. However, a recent audit found a number of shortcomings in the functioning of CHPs and limited evidence of wide-spread sustained improvements in services (Audit Scotland, 2011). The overall findings included that:

- CHPs do not have the necessary authority to implement the changes required to meet the responsibilities invested in them, this includes influence over resources
- CHPs were set up in addition to existing partnership arrangements (e.g. Community Planning Partners) which has led to duplication and a lack of clarity about their role
- Cultural and operational differences between NHS Boards and councils act as a barrier to partnership working between health and social care
- At a national level, limited progress has been made in shifting the balance of care across the health and social care system.

Audit Scotland made a number of recommendations to the Scottish Government including that there should be a fundamental review of health and care partnership arrangements in Scotland and that the Government should work with NHS Boards and councils to help them measure CHP performance. Other recommendations to Boards and Councils included improving governance and accountability arrangements, having a clear joint strategy for delivering health and social care and clearly defining objectives for measuring the performance of CHPs. The report also recommended greater involvement by GPs in planning services.

The Cabinet Secretary for Health and Wellbeing was reported in the press as saying CHPs "have to change" (BBC News, 2011).

WORKFORCE

In 2010, the NHS in Scotland employed 134,964 whole time equivalent (WTE) staff and contracted services from an estimated 3,700 WTE GPs (ISD Scotland, 2011). The NHS spends £4.8bn on staff working in the hospital and community services (ISD Scotland, 2010a). This highlights that the NHS workforce is in many ways its key resource.

NHS Boards produce workforce plans annually and submit them to the Scottish Government. Workforce projections for 2010/11 showed an estimated reduction of 3790 staff across the whole of the NHS in Scotland (Scottish Government, 2010f). This is in addition to a recorded reduction of 855 WTE staff between 2009 and 2010 (ISD Scotland, 2010b). Updated projections are due to be published in the near future and there is a concern that there will be further reductions.

In April 2011, a survey by the Royal College of Nursing (RCN Scotland, 2011) reported that just 11% of nurses thought staffing levels were good where they worked and 96% reported working in excess of their contracted hours. 27% of nurses said they did so every shift. In addition, the British Medical Association has raised a number of concerns about the medical workforce, specifically in relation to reductions in the number of hospital trainee posts which may lead to a surplus of medical graduates and a gap in service provision. They also express concerns over junior doctor compliance with the European Working Time Directive (BMA, 2011).

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