Global Counsel

Are investor assumptions around NHS insourcing set to be challenged?

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Investors have long been active in the NHS insourcing market, but does the new NHS Long Term Workforce Plan and a potential Labour government challenge existing assumptions around the market's growth trajectory?

KEY INSIGHT

Structural and operational pressures – which have long been drivers for growth in the insourcing market – are here to stay, and any easing of these will occur from a high base. However, political scrutiny and pressure is growing and, in the context of the recent NHS Long Term Workforce Plan and a potential Labour government, this raises the risk of greater regulatory intervention. In order to ensure market sustainability, investors should look to explore advocacy strategies with management teams to meet these challenges.

THE GROWTH OF THE UK INSOURCING MARKET

What is insourcing?

Insourcing is a form of activity which utilises existing NHS facilities to conduct procedures, with staff contracted and deployed by independent sector entities. Insourcing has primarily been used by NHS trusts as a managed solution to increase elective activity, utilising available capacity to move a greater volume of patients through care pathways. Unlike outsourcing to external, independent providers, insourcing allows trusts to retain a portion of NHS tariff income, while simultaneously maintaining control over patient pathways and clinical standards.

Growth trajectory and drivers

The UK insourcing market has seen substantial growth since the end of the emergency response to the pandemic; data from Mansfield Advisers indicates a market value of £295 million in 2023 - significantly higher than the £44 million value posted in 2019 – with major market players demonstrating sustained financial growth, particularly in major surgical specialties, ophthalmology, gastroenterology, dermatology, diagnostics and audiology.

Overall demand for insourcing services has primarily been driven by the following, with expectation that these pressures will continue in the medium to long term:

Record waiting times: Compounded by the effects of the pandemic, the NHS treatment backlog has reached record rates. Under significant political pressure (and pressure from the central NHS), trusts are being tasked with making substantial headway – incentivised by the Elective Recovery Fund - despite ongoing resource restraints. Current data shows that, as of July 2023:

- → 7.5 million people are on waiting lists for NHS consultant-led elective care.
- → More than 3 million people are waiting longer than the statutory target of 18 weeks for treatment, with nearly half a million waiting over a year.
- → Median referral-to-treatment waiting times have nearly doubled since the months before the pandemic, rising from 7.5 weeks (February 2022) to 14.1 weeks.

High staff vacancy levels: Despite notable increases in staff numbers – primarily through a high volume of international recruitment – vacancy rates have long been high across the NHS. Overall NHS vacancy rates stand at 112,000 (as of June 2023), with retention of senior and long-serving staff proving highly challenging. This continues to pose significant challenges for trust leaders, directly affecting the delivery of both elective and emergency care.

Declining NHS productivity rates: Years of stagnant NHS capital investment – coupled with a limited appreciation of the need for appropriate skill mix and operational management - has begun to have a serious impact on NHS productivity. Data from the National Audit Office shows that NHS productivity rates have fallen by 23% in the past year, despite record numbers of staff entering the NHS. Subsequently, in order to provide short term productivity improvements, trusts have increasingly turned to insourcing as a means to tackle the elective care backlog.

Financial pressures: The NHS has been set a highly ambitious efficiency target for 2022/23 to 2024/25, with HM Treasury looking for 2.2% efficiency improvements per year. This is alongside a requirement for Integrated Care Boards (ICBs) to reach financial balance in the medium term. The efficiency target required of NHS trusts is substantially higher than the historic average (0.9%) and the target set out in the 2018 NHS Long Term Plan (1.1%); in this context, the ability to retain a percentage of activity-based tariff income through insourcing has become more attractive.

CHALLENGES TO EXISTING GROWTH ASSUMPTIONS

The operational and financial challenges facing the NHS – likely to continue for the remainder of this decade – indicate commensurately robust growth rates for insourcing firms.

However, growing scrutiny of firms' models, along with implementation of the NHS Long Term Workforce Plan and Labour's potential approach, could act as notable headwinds in the medium term.

Growing NHS and media scrutiny

Compared to outsourcing, insourcing has limited public and political awareness, even among NHS policymakers. However, those policymakers and commissioners with knowledge of the practice have rarely publicly commented on its use and benefits, only privately accepting the need to rely on insourcing providers to tackle elective backlogs. A strong groundswell of advocates within the NHS is somewhat lacking, potentially exposing the sector to growing criticism.

Criticism of insourcing practices has been growing in the past 18 months. In January 2022, NHS England issued guidance "strongly discourag[ing]" the use of insourcing outside its official frameworks, or "where temporary workers are paid escalated rates", citing the fact that insourcing "does not provide access to additional workforce, rather escalated pay rates attract workers from elsewhere". There is also growing concern of a 'ripple effect' on agency staff rates, driving up costs at a time of financial pressure for trusts.

Media scrutiny of insourcing has also increased, with the Financial Times, The Guardian and the Health Service Journal highlighting concerns over value for money and conflicts of interest among staff employed by – or owning – insourcing firms. Continued growth in the market, along with pressure on agency spend, is likely to attract further media interest and stir greater political attention, potentially increasing the risk of measures designed to limit implementation.

FIG 1: NHS SECONDARY CARE VACANCY NUMBERS

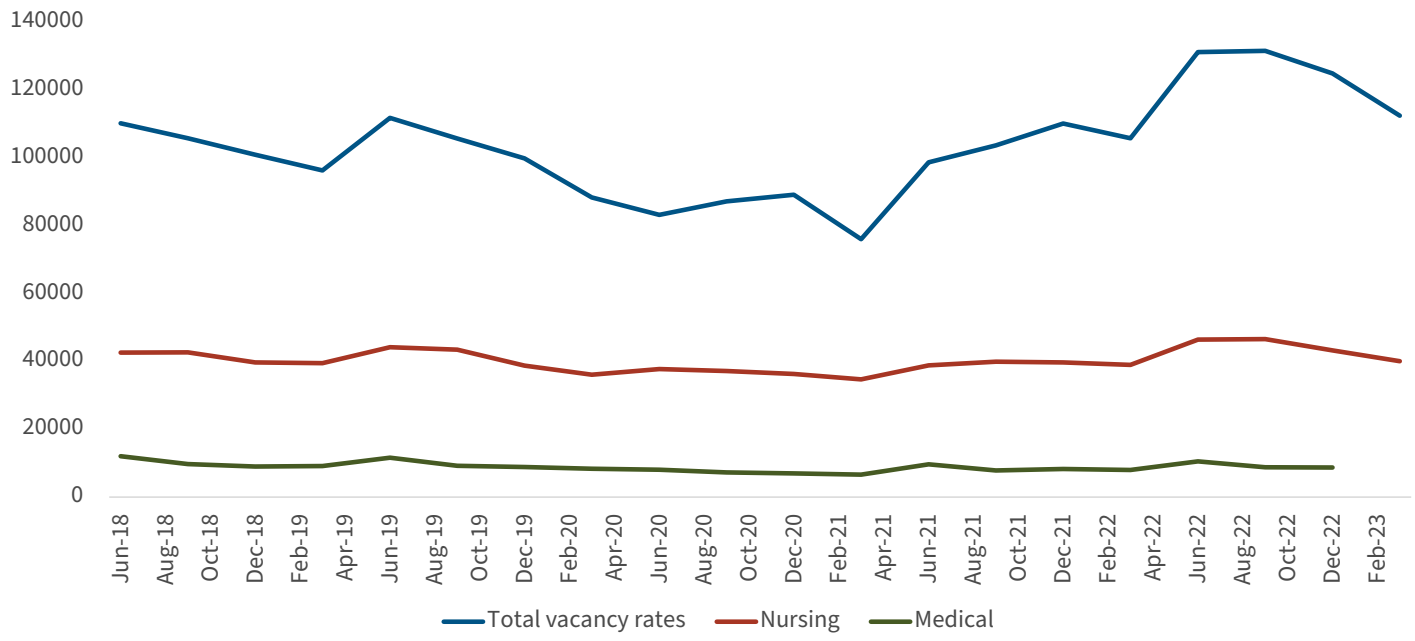


FIG 2: EFFECTIVE CHANGE IN FTE STAFF BY GROUP (DEC 2019 - DEC 2022)

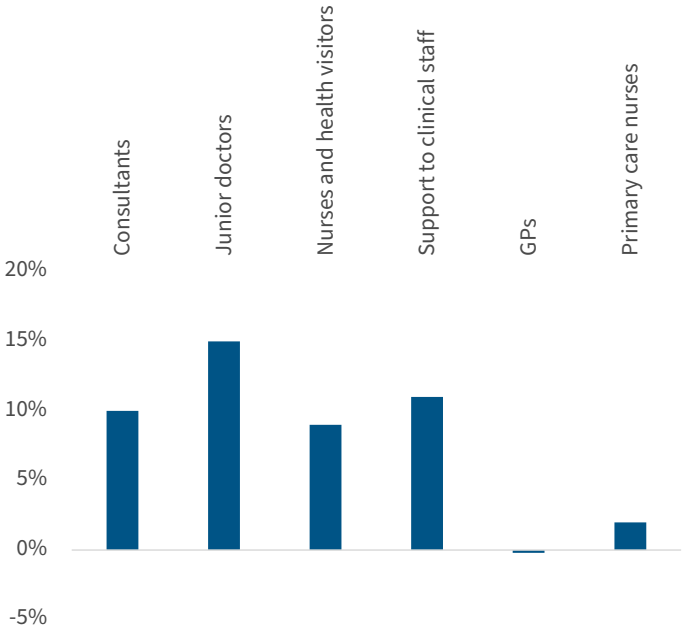
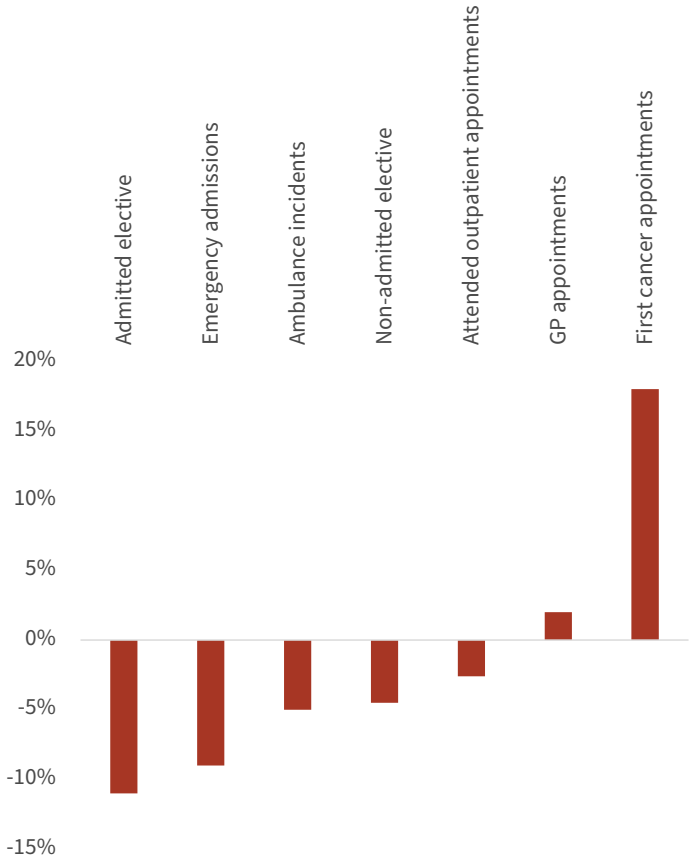


FIG 3: CHANGE IN NHS ACTIVITY BY TYPE (DEC 2019 - DEC 2022)



SOURCE: INSTITUTE FOR GOVERNMENT, PUBLIC FIRST AND HEALTH FOUNDATION ANALYSIS OF NHS ENGLAND DATA

Impact of implementation of the NHS Long Term Workforce Plan

The NHS Long Term Workforce Plan sets out substantial increases in the size of the NHS workforce, covering secondary care clinicians, GPs, nurses and pharmacists. Under full implementation, the NHS workforce in England would increase from around 2.6% to 2.9% per year, expanding the size of the workforce from around 1.4 million to nearly 2.3 million in 2036/37 (and providing a small surplus by this time). In part to address exposure to high marginal labour costs, along with growing global competition for staff, the plan also takes aim at overseas recruitment, pledging that, by 2031, 9-10% of the NHS workforce will be from outside the UK, rather than the current 25%.

The plan also takes aim at agency staffing costs, criticising trusts' excessive reliance on temporary agency staffing and tacitly conceding that NHS England's own price cap has failed to appropriately manage spend. The plan pulls few punches, stating that "the use of agency staff is expensive and offers poor value for money" and setting out how growth in training places and recruitment will, in FTE terms, reduce use of agency staff "9% in 2021/22 to around 5% from 2032/33 onwards".

All things being equal, successful implementation of the plan would challenge the existing insourcing model, dampening down a range of drivers of NHS trust demand. Indeed, even modest implementational success could reduce demand and, crucially, spark firmer calls from NHS England and HM Treasury for a clampdown on insourcing and agency staff costs.

However, meeting the plan's ambitions will prove highly challenging, not least due to high implementational and wage costs in the latter years of the plan's timeline, ambitious yet vague commitments around boosting productivity, and no current plans to improve productivity through significant capital or management investment. Deteriorating productivity, if not adequately addressed, will likely mean sustained growth of the insourcing market in the medium to long term.

Potential direction of a Labour government

The opposition Labour party, along with current shadow health secretary Wes Streeting, had long called for a long term workforce plan, and have subsequently offered tacit support to the government's recent publication. Should Labour win the next election, it is highly likely that they will pursue implementation of the plan broadly in its current form and along similar timeframes.

TABLE: INCREASES TO BE PROVIDED IN EDUCATION AND TRAINING BY PROFESSION (SELECT PROFESSIONS)

PROFESSION	BASELINE TRAINING INTAKE (2022)	PLANNED TRAINING INTAKE (BY 2028)	PLANNED TRAINING INTAKE (BY 2031)
Medical school places	7,500	10,000	15,000
GP training places	4,000	5,000	6,000
Nursing	29,860	40,000	53,858
Nursing associates	5,000	7,000	10,500
Midwifery	3,778	4,269	4,269
Health visitors (and others)	1,811	2,327	3,788
Advanced care practitioners	3,433	5,000	6,371
Allied health professionals	15,076	17,000	18,822
Pharmacists	3,339	4,307	4,970

On insourcing specifically, much remains unknown. Streeting has shown clear support for private sector capacity being harnessed to tackle existing backlogs, highlighting New Labour's use of the private sector to bring NHS waiting times to record lows. However, Streeting has made no public statements relating to NHS insourcing specifically and, should he follow New Labour's approach to staffing models, may instead wish to specifically favour approaches that add new staff to the NHS workforce, rather than re-deploy existing staff.

Additionality models

These approaches, which were highly favoured by the then Department of Health (particularly the commercial directorate led by Ken Anderson), focussed on "genuine additionality" of staff, rather than re-deployment or alternative contracting structure. For example, Shepton Mallet Independent Sector Treatment Centre, established in 2006 and covering Dorset and Somerset, primarily focussed on providing "genuine additionality of staff", alongside clinical services that delivered "high clinical standards and value for money".

Crucially, approval of the scheme rested on the treatment centre's delivery of 22 additional doctors and 52 trained nurses, recruited primarily from continental Europe. The centre was not permitted to recruit staff who had worked in the NHS in the past six months, with a strong focus on additionality throughout workforce planning strategies. Similar programmes were rolled out across England, led by other independent providers such as Vanguard and Netcare UK.

Although concerns were raised around integration with other NHS providers, along with clinical quality and care continuity, and additionality was eventually phased out of the model, Labour could nonetheless look to resurrect this in a bid to address vacancies and waiting times in a cost-effective manner.

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