Curing the NHS backlog - is insourcing the answer?

Blog post by Margaux Nieuwjaer and Hampton Toole, 4 November 2022

Whilst attention in the UK has been directed towards several months of political turmoil, a key issue in the months to come is overcoming the NHS workforce and backlog crisis. These issues may lead to the use of creative solutions across the UK, including frequently used but seldom understood 'insourcing' models.

Insourcing is a form of activity practised by providers independent of the NHS, which uses existing NHS facilities to conduct procedures using staff employed by independent sector entities. The insourcing model was codified in October 2018 with the Insourcing of Clinical Services framework agreement, published by NHS England's Shared Business Services. The framework establishes a list of recognised insourcing providers to ensure quality and efficient pricing while saving time and money on regulatory due diligence. This system has several advantages for the NHS. It combines the efficiency imperatives implemented by traditional outsourcing providers (where both staff and facilities are independently provided) whilst reducing capital spending, as it utilises pre-existing NHS clinical settings. Moreover, the insourcing model typically uses existing NHS staff outside of their working hours, rather than a separate workforce. This fact is key in the context of an NHSE spending cap on agency staff of £2.3 billion. Policies related to insourcing are politically salient, given the extent of the NHS backlog. In September, NHS Digital reported that full-time nursing vacancies in England jumped from around 39,000 in 2021 to nearly 47,000 in 2022, while Scotland saw a 38.1% increase in nursing and midwifery vacancies between March 2021 and March 2022. Moreover, data from the 2021 NHS staff workforce survey indicates that only 32.2% of staff were satisfied with their level of pay; 37.2% of those surveyed stated there are enough staff at their organisation for them to do their job appropriately.

Numerous policies have been implemented to improve efficiency and equity of care as well as adequate workforce supply. For instance, Northern Ireland developed a cross-border health agreement with the Republic of Ireland, with those travelling south of the border able to claim compensation for costs incurred during medical treatment. Additionally, workforce recruitment is an imperative agenda item for the Scottish government this winter, as the government has ringfenced £8 million for staff recruitment. As part of its mandate to improve health service performance, England has introduced Integrated Care Systems (ICSs) which are motivated by the Elective Recovery Fund (ERF), which rewards efficiency with additional funding awards. In this way, insourcing has represented an integral part of the policy landscape, as it has been deployed where providers and staff utilise NHS infrastructure during the evenings and weekends to complete low-risk elective procedures. Even so, this model has only been implemented on a limited scale, but merits more attention given the extent of the NHS elective backlog.

In a broad sense, understanding how insourcing may be received in various contexts is a question of defining the term and whether its independent provision allows it to count as NHS activity. Whilst the model is more readily acceptable in Northern Irish, and Welsh contexts based on their

acceptance of independent sector provision, factors such as public opinion may influence the rollout of contracts and funding across the UK. This is notable in the context of Integrated Care Systems (ICSs) in England, a new model which has shifted the procurement landscape to a regional level. In Scotland, insourcing has been used but not heavily documented, likely a result of public opinion pressures. Finally, insourcing frequently draws upon a pool of staff employed by the NHS already. The insourcing workforce will continue to navigate existing contractual arrangements and wellbeing concerns in pursuit of the pay increase which insourcing can provide.

The state of the NHS today means that creative and innovative solutions may be necessary in the months to come, with policymakers desperate to fix the high-profile deficiencies of the health service in tandem with high inflation and potential recession. The flexibility and attractiveness of insourcing as a model, and the potential merits of future efficiency incentives and government contracts in the future, should be kept in mind by providers and investors alike.