Going the Extra Mile for Insch

Chris Humphris

Insch Hospital sits in a valley in Aberdeenshire with Aberdeen 28 miles to the East, the Cairngorms to the South, and a rural expanse to the West and North. Insch itself is a large village. It has a single General Practice whose population of approximately 6,500 live in Insch itself, and a number of surrounding villages. Famous for its Pictish stones it has a lovely 1920s 'War Memorial Hospital.' The Practice is on the same site in a more modern seventies style super-portacabin.

For a hundred years or so the Practice provided all the services you would expect from a rural situation, and they supported the twelve or so in-patient beds in the Hospital. Then came the Pandemic and the local Health and Social Care Partnership decided that they could no longer staff these beds and needed to 'consolidate' the staff into other local Community Hospitals. Aberdeenshire has a considerable number of Community Hospitals, but Insch was the only one where they decided that they could not consider trying to re-open the beds without first conducting a review of services. They did initially close other Community Hospital beds for a short period but in the end, these were re-opened without any review. Just Insch!

When I first got in contact with the Friends of Insch Hospital and Community (important title) they were trying to navigate their way round a Strategic Needs Assessment exercise conducted by the Partnership. They were successfully running a 'I love Insch Hospital' campaign and getting good publicity for this. They had even got the First Minister of Scotland to visit and to say positive things about restoring services to Insch. They had rallied local people to put in a tremendous number of individual responses to the SNA questionnaire, whilst arguing for the restoration of the beds, and trying to engage directly with those making the decisions.

With a bit of help from me, the Friends prepared a Strategic Vision plan, working very closely with the local General Practice. We then managed to successfully argue that any 'Stakeholder' group set up to look at options for the future needed to have proper representation of the public. Five of us ensured that the push for beds to be part of any future local service was both acknowledged and agreed with. The favoured options were for a new building that would accommodate the in-patient beds as part of the development of local health and care services. AND The Integrated Joint Board decided back in June last year that it would push ahead with preparing plans for a capital scheme for a new building to create space for such beds. They didn't commit to this being at Insch, but it felt like some progress. But crucially they ruled out any idea of using the space in the hospital where the beds had been on an interim basis. Their judgement was that this space was simply no longer fit for purpose. The rooms were too small, lacked en-suite accommodation, and the corridors too narrow to evacuate patients in a bed in the event of fire. There are two ways of looking at this. Local people of course pointed out to the fact that the hospital had been used for in-patient beds for one hundred years. They had a reputation for providing a safe and good clinical environment with a good record on infection control. All this was true but did not sway the Board who were looking at what should happen now and in the future, and the standards that needed to apply.

The Board also agreed to work specifically with the Friends to identify an alternative space for the beds whilst plans for the new build progressed. How positive was that you are thinking! Sadly, not very. The Friends produced a plan to house the beds in a Modular building. They even offered to at least partially fund this. What an offer!

The Partnership turned round and pointed out that this new space was inconsistent with the NHS building plans for sustainable buildings, would cost them money to run and maintain, and to cap things, would need a higher level of staffing as the Hospital had not been operating to 'safe staffing' levels previously. We had hit the barrier of it being expected that there would be always two qualified nurses on duty, regardless of the number and needs of patients.

Where are we now? One year on from those Board decisions and we are told that the capital planning process has not really progressed. Even more worryingly despite our efforts to produce interim arrangements such as a modular building, we have not got agreement to anything here either. The result is that we believe that we have lost important local services and still have no certainty about what will happen in future. If in effect a decision that we will not have in-patient beds in future has been made, we need to know!

The Friends could just spend their time protesting about what has happened, and the situation we are now in. But we also want to try and be positive and continue to explore all options that could give us a clear and secure future for local health and care services. We are therefore looking at whether the opportunity to make a Community Asset Transfer is worth doing. Is the way to unlock at least some of the blockages that we have been facing? The Friends have commissioned me to look at this and will report to them around the end of September. Meanwhile we are exploring every opportunity to identify a feasible way forward. I am working with the Partnership on different staffing models to see whether there is a different approach that we could all agree to. (Looking of course at the experience of others on this!)

What have I learnt?

1) You must be in it for the long haul once the beds have been temporarily closed. It can take a long time to either get to a place where you can re-open the beds or produce an acceptable alternative.
2) There is a paradox that inevitably the local community and the relevant health body do not trust each other in such situations but they can only find an acceptable way forward if they are able to work together and learn to trust each other.
3) Any local group seeking to change the mind of a health body needs to either have considerable 'political' lobbying skills, or someone who understands how the local health system works, or preferably both.
4) It is difficult to simultaneously challenge the process or decision making of a health body and seek to work with them to agree on a way forward. If you choose to do both at the same time identify different people within your group to do this.

I hope that I have been able to help a number of local groups over recent years. I feel passionately that the NHS should not simply write off the beds in a small Community hospital. Instead, they should always seek to work with the local community to come up with the best possible arrangements for the future. In this way they can tap into the passion, enthusiasm and downright creative thinking and skills to produce something positive. These days, we need it!

Chris Humphris

Independent Management Consultant
Associate Member and Recent Chair of the CHA
Previous Chief Executive of Community Trusts