BRITISH BROADCASTING CORPORATION RADIO 4

TRANSCRIPT OF “FILE ON 4” – “THE RIGHT PLACE FOR REG?”

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WINTERTON: He was a very private man. He's left us some enigmas, I think is the best word. We started to go through photographs and we came across some people that feature more than once, and we have no idea who they are. We just wished he'd have got his box of photos out earlier when we could have said, well, who is this person? Which is a shame, because some of the photos obviously meant a lot to him. He kept them locked up in a box, and essentially the box was Reg.

WRIGHT: And you've got the box here with you.

WINTERTON: Yeah, the box is here.

ACTUALITY WITH BOX

WRIGHT: It's a sort of old fashioned, metallic brief case.

WINTERTON: Yes it is, and has mainly old photographs, people that we don't know. We don't know who that person is.

WRIGHT: You've got his birth certificate there.

WINTERTON: Yes, that's his birth certificate, yes. Reginald Herbert Thompson, 7th May 1924.

WRIGHT: I'm in a semi-detached house in Leicester, talking to Brian Winterton and Christine Clapham about their Uncle Reg.

WINTERTON: That picture must have been the group of fellow sailors that he worked with. Yeah, top middle there, that's Reg.

WRIGHT: That's Reg? He looks, he's so handsome. They're all looking quite buff and ripped and a few of them are shirtless and it looks like they're having a really good time.

WINTERTON: There's a lot of them. There's a photograph of him, for example …

WRIGHT: Wow, so this is him in his Navy uniform.

WINTERTON: Yes, he must have been in his early twenties. He was Royal Navy, but he served on an aircraft carrier. There was a real love of ships, do you think, Christine?

CLAPHAM: Definitely, definitely, yes.

WRIGHT: Reg never married and he lived alone. In his later years, his neighbours watched out for him. Reg never had any children, but he had a strong bond with Brian and Christine, both in their sixties.

CLAPHAM: We were extremely lucky in our childhood that we had two fathers.

WRIGHT: You were that close, you felt like he was a father to you?

CLAPHAM: Without doubt, always.

WINTERTON: He always seemed to have an idea to involve himself with us as children. For example, gemstones.

CLAPHAM: Oh yes, gemstones. He built a lapidary machine for me to cut and polish gemstones. It was the best thing I ever had as a present in my life. It was brilliant.

WRIGHT: Brian lives about 15 minutes away from Reg.

WINTERTON: The bungalow where he lived in Oadby, he must have been about 35 years old when he bought the bungalow.

WRIGHT: How long had he lived there in Oadby?

WINTERTON: From 1959. The bungalow itself was almost like a time capsule.

MUSIC – WALK IN WINTER 6

WRIGHT: Reg had slept in the same bed for almost sixty years, but that settled life was about to be turned upside down. In the space of ten weeks, Reg would ricochet from one hospital to another, sometimes staying only for a matter of hours. It's a series of events which has deeply upset his family. And it all started with that most common of incidents, a moment anyone with an older relative will recognise - a fall at home. Reg's nephew Brian told us what happened.

WINTERTON: It was the 21st December, we had a phone call from his neighbour saying that he'd been taken to hospital. He'd had a fall late the previous evening; he'd been basically on the floor for quite a few hours in the bathroom. I think the neighbour had called several times for an ambulance, and when they finally arrived, they convinced him that he should go in to be checked over because he'd been on the floor. He didn't want to go, I have to say.

WRIGHT: Reg was taken to Leicester Royal Infirmary - or LRI, as it's known. It's the city's main hospital, and the Accident and Emergency department is one of the busiest in the country. It was winter and ambulances were queuing up outside. The doctors found no serious damage from the fall, but they did find a chest infection, so they gave him antibiotics. Eight hours after he'd arrived, Reg was admitted to Ward 33 - an acute unit for frail, older patients.

WINTERTON: I went to see him Christmas Eve, and while I was there, one of the nurses or doctors actually came around, I think it was the consultant, checking him over. I could see he wasn't well. I mean, when somebody's holding themselves like that …

WRIGHT: So he had his arms folded round his ribs?

WINTERTON: Yeah, and coughing. You know that somebody's not really all that well. I was quite amazed when this consultant said, yes, he's all right, he can be discharged today, we'll get a care package together. My first thoughts were, what planet are you living on? This is Christmas Eve. You're not going to get a care package in place at all before the New Year.

MUSIC – DARK MATTERS 4

WRIGHT: In the end, Reg spent Christmas Day at Leicester Royal Infirmary. Three days later, he was transferred to the Evington Centre at Leicester General Hospital. It's a community hospital which specialises in helping older patients to recuperate. Reg saw in the New Year at the Evington Centre. Eleven days into his stay, Christine and her sister Jill paid their uncle a visit.

CLAPHAM: When we got to The Evington Centre, he was all packed up, ready to be discharged. I was shocked and dismayed, because he wasn't talking coherently. He was dressed, yes, but clearly disorientated, not making any sense, not Uncle Reg. So I went and found a member of staff and she said, 'Oh, yes, he's being discharged this afternoon.' I said, 'Well, he's not well enough,' and she just said, 'Well, he's met the criteria.'

WRIGHT: Did you feel that he was well enough to leave?

CLAPHAM: In no way. We actually said to them, he's not at all well enough to come out, and we give him 48 hours before he's back again.

WRIGHT: Two days later, Brian received a phone call from Reg's neighbours, who'd popped in to check on Reg and found him deeply distressed. Brian drove to the bungalow to help.

WINTERTON: I rang the NHS Helpline and they were trying to get me to do an assessment of the patient. And quite by chance, my mobile phone rang and it was a member of the SPA - Single Point of Access - team where you phone up for dressings to wounds, catheter change, etc, etc, etc. She'd come to check up on how he was. She was a nurse, so I went to the door, let her in. She took one look at him, she was horrified by his condition, so she phoned for the ambulance to come and get him on that night. She was very good. She's somebody that really did deserve more credit.

WRIGHT: So Reg ended up back in hospital - not quite as soon as his niece had predicted, but not far off. He'd been at home for just 52 hours. The woman who sent Reg back to A&E was a district nurse - one of 4,400 post-graduate-educated, experienced nurses who lead teams delivering healthcare in people's homes. I went to Sheffield to see one of these teams in action.

ACTUALITY WITH COMMUNITY MATRON

NOBLE: We've got a conference room here. This is where everyone sits and eats their lunch.

WRIGHT: And wearing blue nurses' uniforms. And you've got a white lapel - what does that signify?

NURSE: Community nurses, yeah, that's our uniform, yeah.

NOBLE: We've got three small offices ….

WRIGHT: Luke Noble is a community matron. As well as visiting patients in their homes, he can send in community nurses, healthcare assistants, physios, occupational therapists, phlebotomists and even pharmacists. A lot of his work is about trying to keep older patients well enough to stay at home. But, like the district nurse who raised the alarm about Reg, Luke sometimes sees patients who are still unwell, even after they've been discharged from hospital.

NOBLE: It's not uncommon for people to get sent home. There's bed pressures in hospital. They arrive home and a few days later they're back in hospital because a pneumonia hasn't resolved or they've picked up a UTI and discharged on the day without someone checking their bloods before they went home. It does happen. It feels obvious from the outside. Patients come home telling you that there were no beds and that they felt they were sent home early because of bed pressures.

WRIGHT: How regular an occurrence is it?

NOBLE: I would say, thinking back over the last two or three months, I can think of two or three occasions where I've seen someone who's come home and been readmitted shortly after. Nothing's cut and dry, but it does make you wonder sometimes whether people are being rushed out of hospital before it's safe to do so.

WRIGHT: What about during winter?

NOBLE: It's always winter now for the NHS [laugh]. Bed pressures are all year round. A&E is always full. It doesn't seem to make much difference whether it's winter or summer.

WRIGHT: For Reg Thompson, the intervention of a district nurse was vital. She recognised that he was too sick to stay at home and got him sent to A&E. So two days on from being discharged, he was back at the Leicester Royal Infirmary for the second time in three weeks. He was admitted to Ward 23, a unit which specialises in caring for older people.

WINTERTON: It might be unkind, but I refer to it as the death ward.

WRIGHT: The death ward?

WINTERTON: Yeah.

WRIGHT: Why?

WINTERTON: Our father had been in that ward as well. It needed a sign above it, 'All hope abandon, ye who enter in' and if you're familiar with Dante, that's what that ward was like. It was chaos. He was basically semi-conscious or unconscious. I'd say the care was at best minimal.

WRIGHT: Did you speak to any of the staff working there about this?

WINTERTON: What staff? I never spoke to a single member of staff while he was in that ward for two weeks. They were basically unavailable.

WRIGHT: On top of that, the hospital somehow had Reg's 93 year old brother as the next of kin, but he was living in a care home 200 miles away in Wales. After fourteen days at the LRI, Reg was moved to Melton Mowbray Community Hospital, thirty miles from his home in Leicester. It was his fourth hospital in five weeks.

WINTERTON: It's not somewhere you can just pop over and see. But we never got the opportunity. Shortly after his arrival, the staff there were so concerned with his poor state of health, they sent him straight back.

MUSIC - BEREFT

WRIGHT: So, less than two hours after leaving the LRI, Reg was back there. His fifth hospital in five weeks. He'd been sent back because staff at Melton Mowbray thought Reg was delirious and dehydrated. His breathing, heart rate and temperature were all high, and he had below normal oxygen levels. The nurse was worried he might have sepsis. Reg's family believe the LRI transferred their uncle too soon. Acute

WRIGHT cont: hospitals like the LRI are expensive and NHS England has set targets to reduce the amount of time patients spend in acute beds. There are good clinical reasons for this. If they stay too long, older patients are at risk of what doctors call deconditioning. Professor David Oliver is a consultant geriatrician at the Royal Berkshire Hospital and the Vice President of the Royal College of Physicians.

OLIVER: Nobody's saying hospitalisation is a bad thing per se, but there are well recognised harms of hospitalisation. People can become immobile unless we really focus on getting them out of bed early and into shoes and day clothes. They can become confused, they can become depressed, and it's a very de-personalising experience for a lot of people.

WRIGHT: But Professor Oliver says there's also huge pressure on hospital beds.

OLIVER: I think we have to start by looking at the overall number of beds we have in the NHS, and we've lost about a quarter of our beds in the past three decades, at a time where the number of people being admitted has probably doubled. And we already have, in England in particular, just about the fewest beds per thousand people, fewest hospital beds in the whole of the western world.

WRIGHT: Is there a discrepancy between England and the rest of the UK?

OLIVER: If you look at the UK in general, it's about 2.8 beds per thousand, but Wales, Scotland and Northern Ireland have proportionately more beds per thousand than we do in England, although they may argue they've got higher levels of population deprivation. But if you take England out of that picture, we're down at about 2.5 beds per thousand, which is as low as it gets in the OECD nations. So we've got few beds, rising admissions to those beds, and with population ageing, the kind of patients that are coming into hospital are totally different to when I started out as a doctor 30 years ago - far more older people with far more complex needs, and it bedevils every western health system. But the difference is if you go to, say, Holland, they have twice the beds we do, or Germany, three times the beds we do.

ACTUALITY IN HOSPITAL

MARSH: We're going to our emergency assessment floor. We have Acute Admissions Unit, Acute Frailty Unit and an Emergency Frailty Unit.

WRIGHT: Dr Rachel Marsh is the Clinical Director of Emergency and Specialty Medicine at Leicester Royal Infirmary. She's been investigating Reg's family's complaint about his care. She agreed to talk to me and showed me one of the places where Reg was assessed.

MARSH: So, the Acute Frailty Unit is for patients that primarily are frail, who probably will need admission to hospital. The building has been designed to try and make it frailty friendly. We have means of closing the back screens so all the equipment can be hidden and less likely to pull on it or get confused by it.

WRIGHT: Like all the geriatricians I've spoken to while making this programme, Dr Marsh is adamant that the pressure on beds does not affect clinical decisions about who is fit to be discharged. But Reg Thompson's family are sceptical, so I asked Dr Marsh whether she thought he might have been discharged too soon.

MARSH: I think it's important to say that when we're discharging somebody to a community hospital, we're not discharging them home, we're discharging them where they can continue to receive medical treatment. It's a less intense level that we have here and have support. But inevitably, when you have patients that are frail and, or have multiple conditions, there is also an element of unpredictability about somebody's condition. So at the time, it seemed it was appropriate that the patient, Mr Thompson, was suitable, his level of needs in care were suitable at the time. What we can't tell is what's going to happen in the future.

MUSIC – WALK IN WINTER 6

WRIGHT: Whether Reg's move to Melton Mowbray was or wasn't appropriate, he was now back at Leicester Royal Infirmary, being treated for pneumonia. The hospital was running at 93% bed occupancy which, although no longer

WRIGHT cont: unusual in the NHS, is way above the recommended safe level of 85%. There was no bed for Reg on a medical ward, so he remained in an emergency bed for 24 hours. The hospital says he responded well to treatment, but a CT scan showed he had a fractured vertebra, which was put down to age-related osteoporosis.

WINTERTON: The question that one of the staff - I think she was a junior hospital doctor – asked was, had he had any falls? Well, of course the answer to that was yes, he had - numerous falls. If you'd have asked Reg – because I actually witnessed this – when they asked him had he had falls, it was, 'Oh no, only a couple of years ago.' Now, I knew that to be not correct, but I think elderly people, and particularly people like Reg, will say anything to get out of a hospital.

WRIGHT: So he was very keen to get home really?

WINTERTON: Oh yes, that's all he wanted.

WRIGHT: By now, Reg had already been admitted five times to three different hospitals in five weeks. Two weeks later, he was moved again - this time back to Melton Mowbray Community Hospital. Before he left, staff at the LRI assessed Reg. On the Early Warning Score they used, Reg was a one - no cause for concern. His notes mentioned the fracture and that he needed both a mobility frame and help to get around. But he was not flagged as being at risk of falls.

WINTERTON: A few hours after he arrives, we are informed that he's had a fall. I think he'd sustained cuts and bruises from the fall. The message that we got was that they weren't aware that he had the spinal fracture. Melton Mowbray were saying that the handover wasn't detailed enough for them to be able to gauge his needs and he suffered a fall as a result and he had to be returned to Leicester Royal Infirmary A&E that night.

WRIGHT: That must've been really frustrating for you, having seen him go to Melton Mowbray once already and returned within 24 hours, to see that happen again.

WINTERTON: It beggared belief.

WRIGHT: I asked Dr Rachel Marsh why Reg wasn't identified as being at risk of falls.

MARSH: I think I need to discuss that in more detail with the family and look at the falls risk assessment that was done at the time. But in general, you will have a risk of falls if you've fallen before and you're elderly. You might not have what we call a high risk of falls, and I think it depends on how it is worded.

WRIGHT: Reg was taken to a general ward for male patients, where he stayed for six days. His family praise the care their uncle received there, but they became more and more worried about Reg's condition.

WINTERTON: Well, he was obviously deteriorating. There was no doubt his condition in each place, the benchmark was getting progressively lower and lower and lower. I think I'd realised some time back that it wasn't going to end nicely, but you always cling to hope.

WRIGHT: Detecting frailty in older patients involves giving them what's known as a Comprehensive Geriatric Assessment. Patients receive a score, which helps doctors to identify their needs.

CONROY: So the score itself has got nine levels, you know, 1 through to 9 - 1 being fit, robust and 9 being really poorly, terminally ill, and it helps us to differentiate people of the same age with perhaps even similar conditions who have got completely different outlooks and in whom the treatment is going to be very different.

WRIGHT: That's Simon Conroy, a Professor of Geriatric Medicine at the University of Leicester and a geriatrician at Leicester Royal Infirmary. He didn't look after Reg, but he did help to develop the best practice guidelines by which geriatricians measure frailty.

CONROY: So the first stage is to identify how frail somebody is and we know, we know that the general public don't really like this term 'frailty', we get that, and I think a lot of that is due to probably a societal ageism. So we're hoping that the public eventually will start to come to terms with actually this is not labelling everybody as frail, but actually trying to identify where people are on a spectrum and tailor our treatment accordingly. Historically, older people would have been treated on the basis of their age – 'Oh, you're 85, you can't have or you're not going to benefit from,' or whatever it might be, and we know that's not true, we know that there are lots of older people who are in their nineties, who are fit, well, robust, running around, independent, running marathons, all sorts of things, and conversely that there are many younger people in their fifties or sixties that have got serious health conditions that make them much more disabled and unable to care for themselves.

WRIGHT: The challenge is making sure that all the older patients arriving at hospital actually get an assessment.

CONROY: So when the hospital is really busy, there will be frail older people in many other parts of the hospital, and indeed that is the future, you know. So one of the kind of big questions for geriatrics as a speciality is how do we provide Comprehensive Geriatric Assessment to frail older people across the whole hospital, because there are just not enough geriatricians across this hospital or indeed across the country to be able to provide the care themselves.

WRIGHT: We don't know if Reg Thompson did or didn't have a comprehensive assessment, but even if he did, its existence and contents were never communicated to his family. That meant there was never a discussion about what to do if Reg became sicker. So he just kept bouncing - from one hospital to another. And as he got sicker, the frequency with which he was shuttled got faster and faster. On Valentine's Day, eight weeks after his initial fall, Reg was moved again - to St Luke's, a community hospital in Market Harborough. It was the fourth time he'd been transferred from an acute to a community hospital. Dr Rachel Marsh explained why it was so hard to see that Reg had been shuttling backwards and forwards. Part of it was IT systems.

MARSH: Our electronic systems don't enable us to easily see where people have been at other community hospitals. Obviously, if somebody's just been admitted from a community hospital, we know that and we've got some information, but the doctor won't necessarily be able to see on the system that they've been to multiple other hospitals. And we're working as a system to get round that issue.

WRIGHT: But Dr Marsh says there was a more fundamental problem.

MARSH: I think, looking at it overall, the individual care or the individual decisions in and of themselves in isolation, from the notes, seemed appropriate clinical decisions. But I think what happened was, nobody really stood back, because it was multiple teams, for people to realise the whole picture of what had happened, and to sort of stop and say, you know, Mr Thompson is clearly getting frailer, has had multiple episodes of illness and we need to have a conversation both with Mr Thompson and his family about what he wants, what level of escalation of care he would want and what his wishes are, and we didn't do that.

MUSIC – DARK MATTERS 4

WRIGHT: On February 24th, ten days after arriving at St Luke's community hospital, Reg was seen by an out-of-hours GP. It was just past midnight and his cough had worsened. Again, the doctor suspected sepsis. In the early hours, Reg was taken by ambulance to the Leicester Royal Infirmary for the fifth time. By mid-afternoon, doctors agreed Reg was well enough to be transferred back to St Luke's, so in 18 hours he was back where he'd started. But by the time he arrived, just after seven in the evening, Reg had already deteriorated and needed oxygen and antibiotics. Another out-of-hours GP, who was visiting another patient, examined Reg and called for an ambulance. This time he was taken to Kettering General Hospital. This was his sixth emergency hospital admission and his thirteenth transfer in nine weeks. The following morning, Brian and Christine went to visit him in Kettering.

CLAPHAM: He was in a bay in the A&E department. He was very distressed, very disorientated. I touched his arm and stroked him and said, 'It's Christine, it's Brian, we've come to see you.' The first thing they said to us was, 'We've got down that he has no family and no next of kin.' I said, 'I can assure you he has a family who loves him very much,' and I bent over him, stroked his arm and he just said to me, 'I'm done for.' And I said, 'Oh come on Uncle Reg, we don't want to hear talk like that.'

WRIGHT: So you said that you could see that your uncle was getting worse and worse.

WINTERTON: Yeah.

WRIGHT: And that it was becoming clear that he was unlikely to be able to go home. Did anybody from any of these hospitals ever have a conversation with you about end of life care?

WINTERTON: Nobody mentioned it at all. Not until the very end, when I received a phone call from Kettering Hospital, who said, you know, he's not … and I, well that call was at, what did I say it was, Chris? 3.15?

CLAPHAM: About 4 o'clock.

WINTERTON: 3.57 - I've still got the time on my phone. I had a phone call saying you need to come, he's not well.

WRIGHT: So it was in the middle of the night?

WINTERTON: Yes, it was. They said, 'You need to come, he's not at all well,' so I said, 'He's not going to recover, is he?' and that was when somebody finally said no. Apparently within minutes of them ringing, he died.

WRIGHT: All in all, Reginald Herbert Thompson was transferred thirteen times between five different hospitals in the final ten weeks of his life. He saw eleven different wards and travelled 158 miles. He died alone in the early hours of March 2nd at Kettering General Hospital.

CLAPHAM: I think what really upsets not just me, but all of the family, is that our loved one, our Uncle Reg was continually shuttled from hospital to hospital, from A&E department to wards many times, really like a piece of meat, and I don't think anybody would want that to happen to any of their loved ones.

WRIGHT: Dr Rachel Marsh is clear that this should not have happened.

MARSH: Well, I just think I'd like to say that we're very sorry that Mr Thompson had this experience, and it is not the care that we would have liked to give our patients. We have a lot to learn from this situation and Mr Thompson's case, and it's about improving our discussions and communications, having those discussions as people become frailer. Yeah. I'm sorry we didn't have that with Mr Thompson and his family.

WRIGHT: Dr Marsh will be meeting with the family to apologise in person. Leicestershire Partnership NHS Trust, which runs the community hospital in Evington, Melton Mowbray and Market Harborough, said they were:

READER IN STUDIO: Deeply sorry.

WRIGHT: … about the case. They say communication with Reg Thompson's family fell short of:

READER IN STUDIO: The standards we expect.

WRIGHT: The Trust is running staff workshops to improve the way they deal with families of patients close to death. The family of Reg Thompson just want to make sure that what happened to their uncle doesn't happen again. For that to be possible, the NHS needs to work out how it's going to cope with the needs of an ageing

WRIGHT cont: population. And, given that the number of frail older people is expected to double over the next twenty years, finding that solution has never been more urgent. In January, the NHS announced its long term health plan. The aim is to contain the pressure on hospitals by expanding community care. There's more money for GPs, as well as community hospitals and at home care. Matthew Winn is the Director of Community Health for NHS England. He tells me that the plan's ambition is unprecedented.

WINN: There are three really key and exciting new ways of operating that we are going to roll out across the country over a five-year period, and those are better support for people who are living in care homes and ensuring that the healthcare provision is exemplary for everybody in a residential and nursing home. Second area is proactive care in local communities, that is community health staff working hand-in-glove with general practitioners to really make sure that we don't just react to ill health, but we start to be proactive in supporting those that need our support the most. And then the third element is ensuring that we can respond within a two-hour time window for people who need urgent care, community support, and that is mainly people living in their own homes.

WRIGHT: How big a change is this plan going to be?

WINN: It's the first time in living memory that we have had above inflation and above NHS standard investment in primary and community healthcare services. So £4.5 billion of new investment above the normal investment that's already in place over every year, over the next five years, to invest in new services. So that's a first. This is ring-fenced, this is defined, new, national money and we have a plan and are implementing that plan to make sure that is hitting our local areas, starting from this year onwards.

WRIGHT: Meeting that ambition will require a major expansion of the NHS workforce. That is the biggest challenge. Right now, there are 40,000 vacancies in the NHS. Earlier this month, the NHS published its plan to plug those gaps. I asked Professor David Oliver, Vice President of the Royal College of Physicians, what he thought of the strategy.

OLIVER: I think the plan, whilst it's laudably ambitious, is short on meaningful action. I'm not sure the centre can really force individual organisations, who are under great pressure, to look after their people better. And also we've got to get immigration policy right because, at the moment, you need to be earning £30,000 or more to get a visa, a tier 2 visa, to come and work here. Well, lots of health staff don't earn that kind of money, and Brexit's causing uncertainty, which means that EU-trained staff no longer want to come here or stay here. So I think it's too little, too late, but it's better than nothing.

ACTUALITY IN CAR

NOBLE: We're heading to see a lady about her chest. One of my colleagues saw her yesterday and she said she felt her breathing wasn't as good as it normally was, so they asked if I'd pop in and see how she's doing.

WRIGHT: Hitting Matthew Winn's targets requires more community health teams, like the one Luke Noble works for in Sheffield. They deliver a care plan initiative called Okay to Stay. It's exactly the kind of scheme that the NHS long term plan wants to encourage.

NOBLE: So the Okay to Stay is a care plan that was developed about five years ago with the aim of trying to reduce unnecessary hospital admissions, particularly in elderly or frail individuals. It's really helpful for clinicians visiting patients that may not know them. It can be really hard to make a decision about whether someone is well enough to stay at home, but this plan has lots of information about what's normal for them, who helps look after them, past medical history and medication. The bits that are really helpful are the sections about the patient's wishes with regards to hospital admission.

WRIGHT: What does having that information mean?

NOBLE: If you're visiting a patient you've never met before and have very little information on, you end up being quite risk averse. You might send someone to hospital more readily than if you knew them well and knew their wants and wishes and knew the support they normally had at home.

WRIGHT: We're just here, so we've just pulled up at a row of terraced houses.

NOBLE: Yep, this is us.

ACTUALITY IN HOUSE

NOBLE: We're going to do your blood pressure and stuff. Have you been having any pain in your chest or anything?

LADY: No.

NOBLE: No? Do you ever get palpitations?

LADY: Yes, yes, I get them when my heart, I think my heart's going to come out.

NOBLE: Leap out your chest. Okay. And is there anything that seems to set them off or make them worse or …?

LADY: No, I don't suppose I know, it just happens.

NOBLE: It just happens. I'm just going to wrap this round your arm ….
Bye!

LADY: Bye.

ACTUALITY OF DOOR CLOSING

NOBLE: That's a good example of the type of people we see. She's unwell, she's got a lot of chronic health conditions.

WRIGHT: It's not quick. You must have been in there for about half an hour.

NOBLE: Yeah, visits can take longer.

WRIGHT: Delivering at-home emergency care within two hours will take a lot more Lukes, and they're already thin on the ground. Since 2010, the number has almost halved - and the problem is especially acute in England. So how will the NHS manage to build a pipeline for all these nurses? I asked Crystal Oldman, Chief Executive of the Queen's Nursing Institute, which represents community nurses.

OLDMAN: This is something that I know that NHS England are working on, and I believe they're also taking note of what happened in Wales, which led them to understand that a doubling of the number in training was required.

WRIGHT: But at present there's no concrete figure as to how many district nurses we'll need in order to be able to fulfil that plan?

OLDMAN: That's absolutely correct. Currently we're not training enough district nurses, that is one thing we do know.

WRIGHT: And that shortage could soon get worse. Currently, becoming a district nurse means doing a one-year top-up course, funded by Government. That's about to be replaced with a two-year apprenticeship, funded by employers. Crystal Oldman fears that this switchover will create a gap in the supply chain.

OLDMAN: September 2019 is going to be the last year where we have any confidence that the Government will be supporting the district nurse programme under the continuing professional development fund. In 2020, the district nurse apprenticeship programme starts, and this is a two-year programme. So come 2021, there will be no district nurses qualifying for the whole of England.

WRIGHT: Isn't 2021 a really crucial year in the NHS long term plan?

OLDMAN: It absolutely is, so just at the point where all the services are in place to take care of more people in the community, we've then got a year when there are no district nurses qualifying.

WRIGHT: But if you're not training any district nurses, how can you deliver the plan?

OLDMAN: It will be impossible to deliver the long term plan without sufficient resources to train district nurses.

WRIGHT: So on a scale of one to ten, with one being not very worried at all and ten being really quite worried, how worried are you about this pipeline?

OLDMAN: I'm absolutely at a ten.

WRIGHT: I put those concerns to Matthew Winn.

WINN: We're fully aware that there is, at the moment, a potential gap between the new funding ways of delivering the specialist qualification for district nurses and the existing ways of funding that training. We will find a solution and Crystal is quite right to identify there are currently some problems around that.

WRIGHT: How worried are you about this staffing issue, really?

WINN: I'm an eternal optimist. I know that we have the right plan. We will make sure that we spend the money wisely and getting the right workforce is one of our key challenges.

MUSIC – BURNED LAND 4

WRIGHT: Matthew Winn tells me he's going to fight until his hair goes grey to make this plan work. But will the determination of NHS leaders really be enough? Finding the money to train nurses depends on the Government delivering a full and thorough spending review by the end of this year, and district nurses are just one part of the

WRIGHT cont: staffing challenges. The NHS already needs to find five thousand more GPs by 2020. Achieving that will require a huge political effort. The question is whether a minority Government, with a new Prime Minister, facing a possible no-deal Brexit by the end of October, will really be able to meet that challenge.