Department of Health

From Ben Gummer MP
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Dear Mr Nelson

Thank you for your letter of 10th July 2015 following the inquest into the death of Mr Moulton. I was very sorry to hear of Mr Moulton's death and wish to extend my sincere condolences to his family.

You have two main concerns in this case – the first focusses on the ineffective communication between paramedic and nursing staff during the handover of Mr Moulton to A&E at Fairfield General Hospital (FGH). You state that this resulted in Mr Moulton being incorrectly triaged by the nursing staff and not receiving the most effective care.

The second concern is over the lack of communication between the North West Ambulance Service (NWAS) and the Hospital Trust, when NWAS paramedics were called to provide assistance to Mr Moulton after he had been seen in difficulty in the grounds of the Hospital.

I consider that both of your concerns are for local comment and resolution and I note that you have sent a copy of your report to the NWAS. I am aware that NWAS has already responded, addressing the issues you raise and asking that you redirect your specific concerns to FGH for its consideration also.

Further to this however, I am able to provide some relevant comment and guidance from a national perspective, which I hope you will find of use.

Regarding your first concern, you point out that the Trust has now implemented improved handover procedures between paramedics and A&E staff which should ensure that the triage nurse sees any patient notes made by the paramedics and documents this action. However, you suggest that this could be further improved if the triage staff could, not only see but retain a copy of the paramedic notes.

NWAS has advised that its staff always leave a patient report form (PRF) at every hospital following a patient transfer. A copy of this form also remains with the patient following admission.

FGH has very specific patient handover procedures which require NWAS to leave a copy of the PRF with the hospital receptionist for placing with hospital documentation which is subsequently passed to the triage nurse once the patient has been booked in. A verbal handover of the patient is also provided to the triage nurse. Such robust procedures should ensure that FGH triage staff have access to important patient information whenever required.

As the above has demonstrated, the actual detail of patient handover processes and procedures are a matter for each local Trust to decide. However, I can assure you that the Department of Health does expect all ambulance trusts to have effective clinical handover procedures in place with local acute trusts. This includes conveying information such as the patient's vital signs, history, injuries, name and age and documenting this action.

In addition, the Royal College of Physicians, on behalf of NHS England and the Health and Social Care Information Centre, has prepared, "Professional guidance on the structure and content of ambulance records".

Such records should include relevant clinical risk factors, presenting complaints or issues and safety alerts. All ambulance trusts are currently working to embed these standards into operational practice.

A copy of the guidance can be accessed from:

http://www.england.nhs.uk/wp-content/uploads/2014/12/amblnce-rec-guid.pdf

In addition, NHS England's review of urgent and emergency care proposes a fundamental shift in the way urgent and emergency care services are provided. Their vision is to deliver more emergency care closer to home, in centres with the very best facilities and expertise, thereby helping to avoid unnecessary journeys to, or stays in, hospital.

For this vision to be successful there needs to be effective, timely and appropriate transfer of key patient information that follows the patient through the healthcare system. NHS England is working with partners to develop an enhanced summary care record to enable greater access to patient care plans, including end of life care records, special patient notes and mental health crisis notes.

I note that this case also raises issues about the standard of nursing care, which, in this instance, you consider amounted to neglect. Whilst I cannot comment personally on a matter which is for the local Trust to address, I can confirm that all nurses must register with the Nursing and Midwifery Council (NMC) and meet set professional standards so they are fit for practise in the UK.

All registered nurses are expected to be familiar with and to uphold the standards in the NMC's publication: *The Code: Professional standards of practice and behaviour for nurses and midwives.* If an allegation is made about a nurse who may not meet the professional standards required in the UK, as set out in *The Code,* the NMC has a duty to investigate and, where necessary, take action to safeguard the health and well-being of the public. In serious cases this action can include removing the nurse from the NMC's register thereby preventing them from practising in the UK.

I am grateful to you for bringing the circumstances of Mr Moulton's death to my attention and hope that you find this reply helpful.

BEN GUMMER