Agenda Item No:	**9**
Date of Meeting:	**28/03/2013**

NHS
East and North Hertfordshire
Clinical Commissioning Group

Paper Title:	**Francis Enquiry - The Mid Staffordshire NHS Foundation Trust, Lessons and Recommendations**

Decision ☒ **Discussion** ☒ **Information** ☒ **Follow up from last meeting** ☐

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Report signed off by:	

Purpose of the paper:	The Mid Staffordshire NHS Foundation Trust Public Inquiry, led by Robert Francis QC examined the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire hospital between January 2005 and March 2009. Published on 6th February 2013 it makes 290 recommendations designed to change the failings it found and aims to create a common patient centred culture across the NHS, with a zero tolerance approach to providing poor and unsafe care to patients and criminal prosecution for breaching fundamental care standards. All organisations are asked to consider the recommendations and announce at the earliest practicable time, their decision on the extent to which they accept the recommendations and what they intend to do to implement those accepted. This Report provides a summary of the key elements and recommendations within the Report that have direct implications for the Clinical Commissioning Group (CCG).
Conflicts of Interest involved:	None
Recommendations to the Board	The Board is asked to consider the recommendations and review the gap analysis and decide which recommendations it will accept and apply to the work of East & North Herts CCG.

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Francis Inquiry - The Mid Staffordshire NHS Foundation Trust
Lessons and Recommendations
28th March 2013

1 Purpose of the Paper

1.1 To inform the Board in relation to the Francis Inquiry

2 Appendices

2.1 Gap analysis against recommendations

3 Terms / Acronyms Used in the Report – this section is mandatory as papers are made available to the general public

Initials	In full
CCG	Clinical Commissioning Group
NCB	National Commissioning Board
CQC	Care quality Commission
CHC	Community Health Council
Monitor	Authorises and regulates NHS Foundation trusts
PCT	Primary care Trust
SHA	Strategic Health Authority
FT	Foundation Trust
HOSC	Health Overview and Scrutiny Committee

4 Latest Summary Position, as at date: 20th March 2013

5 Executive Summary and Main Body of Paper

5.1 Introduction

The Mid Staffordshire NHS Foundation Trust Public Inquiry, led by Robert Francis QC examined the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire hospital between January 2005 and March 2009. Published on 6th February 2013 it makes 290 recommendations designed to change the failings it found and aims to create a common patient centred culture across the NHS, with a zero tolerance approach to providing poor and unsafe care to patients and criminal prosecution for breaching fundamental care standards. All organisations are asked to consider the recommendations and announce at the earliest practicable time, their decision on the extent to which they accept the recommendations and what they intend to do to implement those accepted.

This Report provides a summary of the key elements and recommendations within the Report that have direct implications for the Clinical Commissioning Group (CCG). It does not cover other far reaching recommendations for the wider system, which include professional regulation, medical training and education, coroners and inquests, the Health and Safety Executive, or requirements for providers and Department of Health Leadership.

It is therefore recommended that members read the second Public Inquiry Report by Robert Francis in order to fully appreciate the breadth of the recommendations made and the issues identified. The Francis Inquiry makes clear the expectations on commissioners; to

drive quality improvements, effectively monitor the quality of service provision, hold providers to account, re-provide services where there are concerns and advise regulators where fundamental standards have been breached.

The challenge for the CCG will be in ensuring that bureaucracy is kept to a minimum, whilst being determined to see real quality improvements across all providers.

Background:

Two independent inquiries were carried out by Robert Francis, following appalling failings in the care provided to patients in Mid Staffordshire Hospital between 2005 and 2009 where more people died than at similar Trusts.

The first inquiry published in 2010 found that the most basic elements of care were neglected, while the Trust focused on cost cutting and hitting government targets.

The second inquiry examined the failure of regulators, supervisory and commissioning bodies to recognise, escalate and act on the poor care patients were receiving.

Recommendations for Commissioners:

Commissioners of services must ensure that services are well provided and are provided safely

Commissioners supported by the National commissioning Board (NCB)and clinicians should develop enhanced quality standards for local providers, over and above the fundamental standards determined by the CQC. These can be incentivised.

Local commissioners must be adequately resourced to enable proper scrutiny and enable audits, inspections and investigations as required of services or individual cases. Commissioners must have access to complaints, quality accounts and providers quality risk profiles and concerns should be shared with regulators

The responsibility for driving improvement in the quality of services rests clearly with commissioners.

Commissioners need to identify whenever possible alternative sources of provision

Commissioners should be able to stop services that do not accord with the contract and stop services in breach of fundamental standards or require it to be provided in a different way.

Commissioners not the providers should decide what needs to be provided in conjunction with clinicians, GPs and other commissioning bodies.

Commissioners not the providers should decide what needs to be provided in conjunction with clinicians, GPs and other commissioning bodies.

Commissioners should in contacts, require the boards of providers to seek and record the views and advice of its nursing and clinical directors, of the impact on the fundamental standards of proposed major change to clinical or nurse staffing arrangements.

Commissioners must involve the public in commissioning and enable their views to be taken into account and therefore must improve their public profile through public membership lay members, patients forums, public patient surveys

GPs must take on a monitoring role on behalf of their patients or providers . They require internal systems enabling them to be aware of patients concerns, so that they do not just consider individual cases and must keep themselves informed of the standards of service available at various providers.

Commissioners should apply fundamental standards to each item of service commissioned agree a method of measuring compliance and redress for non-compliance. In selecting indicators the focus should be on what is reasonably necessary to safeguard patients and engage closely with patients, past, present and potential but require convincing evidence NCB will develop metrics in conjunction with commissioners

Commissioners should ensure decision making process are transparent and hold public meetings

Consideration should be given to commissioning patient advocates and support services for complaints against providers

In performance management of providers there must be clear and unambiguous lines of referral and information

Commissioners must require providers to ensure that through identity labels and uniforms that a healthcare support worker is easily distinguishable from that of a registered nurse.

The key findings from the Inquiry, on which the priorities for commissioners have been based, are summarised below:

- Wider system – warning signs ignored/not escalated nor recognised by a range of external organisations, including CQC, CHC, Monitor, PCT, SHA. In respect of the PCT and SHA he comments that both organisations were in transition during this time.
- The Board and other leaders within the Trust failed to appreciate the enormity of what was happening. Reacted too slowly if at all to some matters of concern and downplayed the significance of others.
- Clinicians were not engaged
- Patients not heard with inadequate processes for dealing with complaints and Serious Incidents

Poor Governance

- Lack of clinical governance and risk management
- Lack of focus on standards of service
- Inadequate risk assessment
- Inadequate nurse staffing levels and poor leadership
- Wrong priorities focused on by the Trust - prioritised finances and Foundation Trust (FT) application over the quality of care

Lessons learned

- Negative culture
- Lack of openness
- Lack of consideration for patients
- Defensiveness
- Looking inwards not outwards
- Secrecy
- Misplaced assumptions
- An acceptance of poor standards
- A failure to put the patient first in everything that is done.

Key actions required to address issues:

- Common values putting the patient first – the NHS Constitution reinforced through leadership training
- Simplifying regulation – transferring the functions of regulating the governance of healthcare providers and the fitness of persons to be directors, governors (or equivalent) from Monitor to the CQC.
- Clearer fundamental core CQC standards
- Enforcement of compliance – compliance reported in Quality Accounts, with the cessation of services by commissioners which are not consistently meeting these.
- Non-compliance that leads to death or serious harm prosecuted as a criminal offence
- Changes to the FT application process, with the requirement to meet all criteria and proceeded by a CQC inspection.
- Disqualification of Directors deemed to be unfit
- Effective complaints and incidents process, with the requirement that complaints and incidents that potentially breach a fundamental standard being made accessible to the CQC, Commissioners, HOSC communities, and Health Watch.
- Learning from complaints must be made known to complainants and the public
- Enhanced public and patient engagement – this must be stronger with better information provision and access arrangements for Heath Watch.
- Health Overview and Scrutiny Committees to be given power to inspect providers
- Openness transparency and candour should become a statutory obligation and should be imposed on healthcare providers, doctors and nurses, through codes of conduct.
- Directors must be truthful in any information given to a regulator or commissioner, with it being made a criminal offence to deliberately mislead or omit key information given to a regulator
- Focus on compassion in nurse recruitment with pre training requirements and revalidation requirements
- Healthcare workers should be registered
- Fitness to practise requirements to be strengthened
- Quality accounts to declare compliance against fundamental standards, signed by all Directors and scrutinised by the CQC
- Leadership college or training systems to be established.

6. Conclusion:

The first inquiry stated it should be patients – not numbers – which counted. The second inquiry upholds that view, it calls for a culture of change and requires all commissioning, service providers, regulatory and ancillary organisations in health care to consider the recommendations and announce its decisions on the extent to which it accepts the recommendations and what it intends to do to implement them. Thereafter publish on at least an annual basis a progress report. It also outlines the key role that commissioners need to play in ensuring the delivery of safe, effective care that patients are satisfied with.

7. Recommendation

The Board is asked to consider the recommendations and review the gap analysis and decide which recommendations it will accept and apply to the work of East & North Herts CCG.

Item 9 Francis Report Appendix 1

Francis Inquiry Gap analysis

		Are we meeting it?	Why not / Further work	Resources needed	Responsible Person
	Commissioners should be accountable to their public for the scope and quality of services they commission. Acting on behalf of the public requires their full involvement and engagement:				
135	There should be a membership system whereby eligible members of the public can be involved in and contribute to the work of the commissioners.	Yes; Patient leader/GP champion Co-partnership model Six Locality Patient Commissioning Groups Members should be endorsed by their practices and preferably be members of PPGs Leadership training of patients & GPs Two way communication & involvement	Set up and operating Work in progress to improve uptake of patients from all practices; 90% of practices have virtual and/or standing groups. Approx 80% of practices are represented on PCGs First cohort of patients trained; GP champions in training; plans to undertake further training. Early days- some involvement in CCG projects e.g. HomeFirst; need to beat the drum to put into practice what we aspire to.	engagement resource needed to hold the ring and co-ordinate work of groups admin support External and internal expertise required to design and undertake 2 patient leadership courses / workshops a year	LD
	There should be lay members of the commissioner's board.	Not at present	CCG board keen to appoint from membership and further personal development work needed with patients		LD

		Are we meeting it?	Why not / Further work	Resources needed	Responsible Person
		Patient member on Quality Sub-Committee	Patient Representative Network for Quality set up to support patient member	Ongoing knowledge –based training to increase members understanding	
	Commissioners should create and consult with patient forums and local representative groups. Individual members of the public (whether or not members) must have access to a consultative process so their views can be taken into account.	Informal arrangements in place to complement work of Healthwatch ; Refreshed concordat being developed with Health Overview & Scrutiny Committee Stakeholder Forum established with voluntary sector and local authorities Website has dedicated area for public engagement with input from patient members. This will be used to promote engagement.	Local consultative meetings with forums and voluntary groups planned in Spring on commissioning strategy following a CCG wide workshop. This will be part of an ongoing consultative process. Regular email newsletter aimed at members - planned launch end of March	Engagement lead with locality commissioning leads	LD
	There should be regular surveys of patients and the public more generally.	Annual Patient Surveys of GP services undertaken by PPGs as part of DES PP & annual report published on practice websites. Commissioners to date have not commissioned separate surveys of patient experience in secondary care	CCG Board need to consider options on how to measure the experience of patients following inpatient stay in local acute & MH providers; this could be aligned to the CCG priorities relating to elderly frail and end of life care	Independent surveys will have significant finance resource implications but CCG could combine external expertise for survey work with input from patient groups and local practices to make sure cost-effective	LD
	Decision-making processes should be transparent: decision-making bodies should hold public meetings.	CCG Board meetings are held in public and attendees are invited to put questions to the board.	Public meetings are not necessarily the best means of demonstrating transparency. Use of focus groups and conversation café events are		LD

		Are we meeting it?	Why not / Further work	Resources needed	Responsible Person
		AGM also provides the opportunity for public to engage and question decision-making	better mean of involving / consulting people prior to decision-making CCG Board could consider holding an annual meeting with members of patient groups.		
7.	All NHS staff should be required to enter into an express commitment to abide by the NHS values and the Constitution, both of which should be incorporated into the contracts of employment.	?	Check JD's	Not if added prospectively	HE
8.	Contractors providing outsourced services should also be required to abide by these requirements and to ensure that staff employed by them for these purposes do so as well. These requirements could be included in the terms on which providers are commissioned to provide services	?	Check contracts	Not if added prospectively	JW
12.	Reporting of incidents of concern relevant to patient safety, compliance with fundamental standards or some higher requirement of the employer needs to be not only encouraged but insisted upon. Staff are entitled to receive feedback in relation to any report they make, including information about any action taken or reasons for not acting.	Variable at present	Re-launch contract hot-line to GP practices & develop template to capture concerns ensuring feedback loop in place		NP
17.	The NHS Commissioning Board together with Clinical Commissioning Groups should devise enhanced quality standards designed to drive improvement in the health service. Failure to comply with	No	Work needed with AT to develop both developmental & enhanced standards, with view to inserting in Quality Schedule 2014-15		SR

		Are we meeting it?	Why not / Further work	Resources needed	Responsible Person
	such standards should be a matter for performance management by commissioners rather than the regulator, although the latter should be charged with enforcing the provision by providers of accurate information about compliance to the public				
36.	A coordinated collection of accurate information about the performance of organisations must be available to providers, commissioners, regulators and the public, in as near real time as possible, and should be capable of use by regulators in assessing the risk of noncompliance. It must not only include statistics about outcomes, but must take advantage of all safety related information, including that capable of being derived from incidents, complaints and investigations	In part	Review of quality monitoring & data collection underway with HICS.	Yes likely to be a resource gap identified following review	SR
?40					
107	If the Health Protection Agency or its successor, or the relevant local director of public health or equivalent official, becomes concerned that a provider's management of healthcare associated infections is or may be inadequate to provide sufficient protection of patients or public safety, they should immediately inform all responsible commissioners, including the relevant regional office of the NHS Commissioning Board, the Care Quality Commission and, where relevant, Monitor, of those concerns. Sharing of such information should not be regarded as an action of last resort. It should	Yes	Via DoN but further work to ensure clarity re IPC	Improved/increased access to specialist advice	SR

		Are we meeting it?	Why not / Further work	Resources needed	Responsible Person
	review its procedures to ensure clarity of responsibility for taking this action				
118.	Subject to anonymisation, a summary of each upheld complaint relating to patient care, in terms agreed with the complainant, and the trust's response should be published on its website. In any case where the complainant or, if different, the patient, refuses to agree, or for some other reason publication of an upheld, clinically related complaint is not possible, the summary should be shared confidentially with the Commissioner and the Care Quality Commission.	No	Agree mechanism with providers re sharing complaint summaries of those not agreed or not published on website	Yes for this to be meaningful analysis of complaints will be required. Currently not provided within existing resource	SR
120.	Commissioners should require access to all complaints information as and when complaints are made, and should receive complaints and their outcomes on as near a real-time basis as possible. This means commissioners should be required by the NHS Commissioning Board to undertake the support and over-sight role of GPs in this area, and be given the resources to do so	In part	Agree mechanism with providers re sharing information Confirm again with AT that responsibilities for GP practices complaints (support & oversight) lie with them	As above CCG not resourced in relation to GP complaints ? not appropriate to hold this function	SR
123.	GPs need to undertake a monitoring role on behalf of their patients who receive acute hospital and other specialist services. They should be an independent, professionally qualified check on the quality of service, in particular in relation to an assessment of outcomes. They need to have internal systems enabling them to be aware of patterns of concern, so that they do not merely treat each case on its individual merits. They have a responsibility to all their patients to keep	Variable	No clear process. Met through GP Quality Leads disseminating information via localities Re-launch contract hot-line to GP practices & develop template to capture concerns. Monitor practices' use of hot-line.		NP

		Are we meeting it?	Why not / Further work	Resources needed	Responsible Person
	themselves informed of the standard of service available at various providers in order to make patients' choice reality. A GP's duty to a patient does not end on referral to hospital, but is a continuing relationship. They will need to take this continuing partnership with their patients seriously if they are to be successful commissioners				
124.	The commissioner is entitled to and should, wherever it is possible to do so, apply a fundamental safety and quality standard in respect of each item of service it is commissioning. In relation to each such standard, it should agree a method of measuring compliance and redress for non-compliance. Commissioners should consider whether it would incentivise compliance by requiring redress for individual patients who have received substandard service to be offered by the provider. These must be consistent with fundamental standards enforceable by the Care Quality Commission	In part current Quality schedule	as new fundamental standards not developed. However existing CQC Outcomes are being applied to the contact 2013/14 Standards need to be developed & applied to contracts 2014-15		SR
125.	In addition to their duties with regard to the fundamental standards, commissioners should be enabled to promote improvement by requiring compliance with enhanced standards or development towards higher standards. They can incentivise such improvements either financially or by other means designed to enhance the reputation and standing of clinicians and the organisations for which they work	In part current CQUIN	As above		SR

		Are we meeting it?	Why not / Further work	Resources needed	Responsible Person
126.	The NHS Commissioning Board and local commissioners should develop and oversee a code of practice for managing organisational transitions, to ensure the information conveyed is both candid and comprehensive. This code should cover both transitions between commissioners, for example as new clinical commissioning groups are formed, and guidance for commissioners on what they should expect to see in any organisational transitions amongst their providers	Yes Principles already laid out by NCB for national transition	Quality transition document		HE
127.	The NHS Commissioning Board and local commissioners must be provided with the infrastructure and the support necessary to enable a proper scrutiny of its providers' services, based on sound commissioning contracts, while ensuring providers remain responsible and accountable for the services they provide.	In part	Contracts being further improved for 2013-14 but need monitoring to ensure all improvements delivered. Current HICS capacity insufficient to deliver this to the levels now required	Likely to need additional resources for increased levels of monitoring and scrutiny	SR
128.	Commissioners must have access to the wide range of experience and resources necessary to undertake a highly complex and technical task, including specialist clinical advice and procurement expertise. When groups are too small to acquire such support, they should collaborate with others to do so	In part	Have ability to buy in extra advice but some advice currently difficult to access		SR
129.	In selecting indicators and means of measuring compliance, the principal focus of commissioners should be on what is reasonably necessary to safeguard patients and to ensure that at least fundamental safety and quality standards are maintained. This requires close engagement with patients, past,	In part	Current metrics and quality reports need to be reviewed. Lack of trend & depth analysis of providers	NB Lynda needs to comment re this item	SR

		Are we meeting it?	Why not / Further work	Resources needed	Responsible Person
	present and potential, to ensure that their expectations and concerns are addressed.				
130.	Commissioners – not providers – should decide what they want to be provided. They need to take into account what can be provided, and for that purpose will have to consult clinicians both from potential providers and elsewhere, and to be willing to receive proposals, but in the end it is the commissioner whose decision must prevail	Yes	More work needed in this area as CCG develops		CCG Board
131.	Commissioners need, wherever possible, to identify and make available alternative sources of provision. This may mean that commissioning has to be undertaken on behalf of consortia of commissioning groups to provide the negotiating weight necessary to achieve a negotiating balance of power with provide	In part	Need to test market for all services contingency arrangements	May need resource	JW
132.	Commissioners must have the capacity to monitor the performance of every commissioning contract on a continuing basis during the contract period: • Such monitoring may include requiring quality information generated by the provider. Commissioners must also have the capacity to undertake their own (or independent) audits, inspections, and investigations. These should, where appropriate, include investigation of individual cases and reviews of groups of cases. • The possession of accurate, relevant, and useable information from which	In part	As per 127: Current HICS capacity likely to be insufficient to deliver this	Likely to need additional resources for increased levels of monitoring and scrutiny	SR

		Are we meeting it?	Why not / Further work	Resources needed	Responsible Person
	the safety and quality of a service can be ascertained is the vital key to effective commissioning, as it is to effective regulation. • Monitoring needs to embrace both compliance with the fundamental standards and with any enhanced standards adopted. In the case of the latter, they will be the only source of monitoring, leaving the healthcare regulator to focus on fundamental standards.				
133.	Commissioners should be entitled to intervene in the management of an individual complaint on behalf of the patient where it appears to them it is not being dealt with satisfactorily, while respecting the principle that it is the provider who has primary responsibility to process and respond to complaints about its services	Yes	Already able to act in this way		HE
134.	Consideration should be given to whether commissioners should be given responsibility for commissioning patients' advocates and support services for complaints against providers.	Yes	Already do so		HE
136.	Commissioners need to be recognisable public bodies, visibly acting on behalf of the public they serve and with a sufficient infrastructure of technical support. Effective local commissioning can only work with effective local monitoring, and that cannot be done without knowledgeable and skilled local personnel engaging with an informed public			Lynda to complete	LD

		Are we meeting it?	Why not / Further work	Resources needed	Responsible Person
137.	Commissioners should have powers of intervention where substandard or unsafe services are being provided, including requiring the substitution of staff or other measures necessary to protect patients from the risk of harm. In the provision of the commissioned services, such powers should be aligned with similar powers of the regulators so that both commissioners and regulators can act jointly, but with the proviso that either can act alone if the other declines to do so. The powers should include the ability to order a provider to stop provision of a service.	In part	Review the contracts to establish full extent of CCG powers. Can stop services but may be unable currently to substitute staff if provider disagrees		JW
138.	Commissioners should have contingency plans with regard to the protection of patients from harm, where it is found that they are at risk from substandard or unsafe services.	Yes	Immediate action can be taken if patients at risk within an individual service		JW
139.	The first priority for any organisation charged with responsibility for performance management of a healthcare provider should be ensuring that fundamental patient safety and quality standards are being met. Such an organisation must require convincing evidence to be available before accepting that such standards are being complied with.	In part	Contracts being further improved for 2013-14 but need monitoring to ensure all information required is accurate & validated, including greater on-site inspection. Current HICS capacity insufficient to deliver this	Likely to need additional resources for increased levels of monitoring and scrutiny	SR
140.	Where concerns are raised that such standards are not being complied with, a performance management organisation should share, wherever possible, all relevant information with the relevant regulator, including	Yes	Via Quality Surveillance meetings, attended by the CQC.		SR

		Are we meeting it?	Why not / Further work	Resources needed	Responsible Person
	information about its judgement as to the safety of patients of the healthcare provider.				
141.	Any differences of judgement as to immediate safety concerns between a performance manager and a regulator should be discussed between them and resolved where possible, but each should recognise its retained individual responsibility to take whatever action within its power is necessary in the interests of patient safety	Yes	See 140.		SR
142.	For an organisation to be effective in performance management, there must exist unambiguous lines of referral and information flows, so that the performance manager is not in ignorance of the reality	Yes	Quality issues will be flagged at Commissioning & performance meetings and DON will attend		SR
143.	Metrics need to be established which are relevant to the quality of care and patient safety across the service, to allow norms to be established so that outliers or progression to poor performance can be identified and accepted as needing to be fixed.	In part	Under review to ensure clearer information provision including trend analysis & local metrics that mirror the national quality dashboard Metrics are likely to be developed by NCB for use by CCGs.		SR
178.	The NHS Constitution should be revised to reflect the changes recommended with regard to a duty of openness, transparency and candour, and all organisations should review their contracts of employment, policies and guidance to ensure that, where relevant, they expressly include and are consistent with above principles and these recommendations	In part	Review contracts, policies & JD's	Not if prospectively applied	HE

		Are we meeting it?	Why not / Further work	Resources needed	Responsible Person
179.	"Gagging clauses" or non disparagement clauses should be prohibited in the policies and contracts of all healthcare organisations, regulators and commissioners; insofar as they seek, or appear, to limit bona fide disclosure in relation to public interest issues of patient safety and care.	In part	Make explicit in documentation	Not if prospectively applied	HE
198.	Healthcare providers should be encouraged by incentives to develop and deploy reliable and transparent measures of the cultural health of front-line nursing workplaces and teams, which build on the experience and feedback of nursing staff using a robust methodology, such as the "cultural barometer"	Yes	Proposed within 2013-14 CQUIN scheme and Francis recommendations overall included in Quality Schedule		SR
204.	All healthcare providers and commissioning organisations should be required to have at least one executive director who is a registered nurse, and should be encouraged to consider recruiting nurses as non-executive directors	Yes			SR
205.	Commissioning arrangements should require the boards of provider organisations to seek and record the advice of its nursing director on the impact on the quality of care and patient safety of any proposed major change to nurse staffing arrangements or provision facilities, and to record whether they accepted or rejected the advice, in the latter case recording its reasons for doing so.	Yes	Through Quality schedule (overall requirement for Francis recommendations to be met) & also through review of providers' CIPs.		SR
208.	Commissioning arrangements should require provider organisations to ensure	Yes	Included in 2013-14 contracts through overall requirement for		SR

		Are we meeting it?	Why not / Further work	Resources needed	Responsible Person
	by means of identity labels and uniforms that a healthcare support worker is easily distinguishable from that of a registered nurse.		Francis recommendations to be met		