



# **CLINICAL GOVERNANCE STANDARDS**

## **for Mental Health and Learning Disability Services**

### **Structures and Strategies**

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August 2001, CRU no. 017. Edited by Adrian Worrall.



## **Foreword**

It was a happy day when we within the NHS were instructed to place clinical governance – the necessity of assuring constant improvement in the quality of our services – at the head of the agenda for mental health and learning disability services. I believed, like many others, that important though fiscal issues are, too great an emphasis had been placed on the financial, as opposed to the clinical, aspects of the services.

Trusts now have a clear responsibility constantly to improve the quality of their services. Many have already achieved much, but some have found it more difficult and still have some way to go.

These new standards, carefully and comprehensively set out, will help both trusts which have already made considerable progress and those still grappling with the impact of the clinical governance process, critically examine their services and identify areas for further development. This document should be of value to commissioners, managers and practitioners.

The Royal College of Psychiatrists is extremely pleased that the Clinical Governance Support Service, based at the College Research Unit, is so successfully supported by participative trusts. It is the only national body with a specific remit for supporting clinical governance in mental health and learning disability services.

Feedback, both from review policies and legislation and from use of these standards in CGSS reviews, will be incorporated in an annual revision of these standards. In the meantime, I hope that all concerned with clinical governance – which means all of us – will find these of interest and value.

**Dr Sheila Mann**  
**Clinical Governance Lead**  
**Royal College of Psychiatrists**

## The Development of Clinical Governance Standards

### Background

These standards cover key aspects of clinical governance relevant to trusts providing mental health and learning disability services. This is the first version of an evolving set of standards that will annually incorporate trust feedback and new policy and legislation.

The standards are the basis for the CGSS self and external peer reviews. The aim of the reviews is to gradually improve the quality of services using the principles of the clinical audit cycle. The standards represent ideal practice and as such the level of service they described is not expected to be found universally.

### Methods

The development involved three main processes: a review of key documents; consultation with CGSS members; and editing. We used the information from members to supplement the standards derived from the literature review. This ensured that the standards were up-to-date and that they took account of the views of relevant staff.

#### i. Review of key documents

These included standards and information from the Health Advisory Service, the Commission for Health Improvement, the Clinical Governance Support Service, the Royal College of Psychiatrists, the Clinical Negligence Scheme for Trusts, the Clinical Standards Board for Scotland and a range of documents from regional and local trusts. The CHI's *Acute clinical governance reviews: review issues* was particularly relevant. Generic standards were selected rather than standards specific to acute services or other specialty areas. We derived about 350 statements that formed the basis of the first draft of the standards.

General statements are classified as standards, and more specific statements as criteria within these. Each standard has typically four or five criterion statements. In this document standards are in bold text and relevant criteria are given in plain text below these.

#### ii. Consultation

Members were asked to rate each standard as "very important", "important" or "not important". They were also asked to suggest new standards. More general feedback was also obtained during an induction event.

#### iii. Editing

Low rated standards were removed. Other editing criteria included: ease of measurement; achievability, e.g. how achievable statements were; and local adaptability, e.g. how adaptable statements were to variations in local practice. These reduced standards will be adapted into data collection tools for use on self and external peer reviews.

The standards will now be further developed and updated annually as part of their use in service reviews.

## **Important note and disclaimer**

Mental health and learning disability services are organised and provided in many different ways. These standards attempt to be generic but may not apply well to all services. We have classified the standards to describe various topics within clinical governance, but they could be classified in other equally appropriate ways. Each section begins with a higher order standard and then continues with more specific standards, in bold text, and relevant criteria below these. Criteria are not comprehensive, but are generally given as examples of good practice relating to the standard.

These are best practice statements and consequently we would not expect services to meet every standard. There are some statements that are based upon legal requirements. This document is not intended to act as a legal guide in any way. This is not intended to be a guide to the CHI review or to represent any methods CHI are using.

If you have any questions about these standards please contact Adrian Worrall at the Royal College of Psychiatrists' Research Unit.

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# 1. Clinical Governance Strategy and Structures

**1 The trust is committed to implementing clinical governance to improve care and the service users' experience**

**1.1 The trust has the structures and accountabilities to lead this**

1.1.1 The trust has a multi-disciplinary clinical governance committee with service user and carer representation

1.1.2 The trust has appointed a person to lead clinical governance

1.1.3 The chair of the clinical governance committee is a member of the trust board

1.1.4 There is a clear line of accountability from the chief executive level

1.1.5 Clinical governance is a standing item on the trust board agenda

**1.2 The clinical governance committee regularly reports to the trust board**

1.2.1 The clinical governance committee provides an annual clinical governance report to the trust board

1.2.2 The report identifies progress and development needs in each component area of clinical governance

**1.3 The trust has an up-to-date written clinical governance strategy. This specifies:**

1.3.1 Roles and responsibilities of staff

1.3.2 Timescales for implementation of clinical governance objectives

1.3.3 Cross organisation arrangements and inter-agency issues, including with primary care and social services

1.3.4 The skills and knowledge necessary to implement clinical governance, training needs and ways to address these

1.3.5 Dedicated staff time and budgets to support clinical governance

1.3.6 Arrangements for reviewing clinical governance progress

1.3.7 Expected outcomes for the implementation of clinical governance, e.g. service user care and experience, improved safety, etc.

1.3.8 Systems for quality improvement, e.g. service development is informed by an annual evaluation of clinical governance activities

1.3.9 The strategy relates to and specifies other service development priorities including: the health improvement programme; the National Service Frameworks for mental health and older adults;

the learning disabilities white paper, Valuing People; the NHS Plan

1.3.10 Each clinical directorate has a clinical governance plan which links to the clinical governance strategy

**1.4 Clinical team members understand their roles and responsibilities in relation to clinical governance**

1.4.1 Clinical teams meet regularly to discuss clinical governance issues and review progress

## 2. Service User and Carer Involvement and Experience

- 2 **The trust is committed to communicating with service users and carers and understanding their needs and priorities**
- 2.1 **The trust has the structures and accountabilities to lead consultation and service user and carer involvement**
  - 2.1.1 The trust has established a committee dedicated to service user and carer consultation and involvement or this is an explicit duty of other management committees
  - 2.1.2 The trust has appointed a person to lead service user and carer consultation and involvement
  - 2.1.3 The committee reports regularly to the clinical governance committee
- 2.2 **The trust has mechanisms to involve a range of service users and carers, or their representative organisations, in the planning and monitoring of services. These include:**
  - 2.2.1 Consultation with service user representatives or groups
  - 2.2.2 Lay/citizen representation on the trust board and clinical governance committee
  - 2.2.3 Service user and carer surveys
  - 2.2.4 Use of validated instruments to find out service users' views e.g. Carers' and Users' Expectations of Services (CUES)
  - 2.2.5 Patient councils or panels
  - 2.2.6 Complaints procedures and suggestion boxes
- 2.3 **The trust has an up-to-date written strategy for service user consultation and the provision of information for service users**
  - 2.3.1 The strategy describes ways to meet the information needs of service users, relatives and carers
  - 2.3.2 The strategy describes links with local user/community groups
  - 2.3.3 The strategy describes mechanisms for incorporating service user feedback
  - 2.3.4 The strategy was developed in consultation with service users and carers
- 2.4 **Service users, and carers with appropriate consent, are provided with information about their care. For example this includes information about:**
  - 2.4.1 Diagnosis and condition
  - 2.4.2 Treatment alternatives, including drug and psychotherapy treatments and side effects
  - 2.4.3 Services and expected waiting times

- 2.4.4 Facilities
- 2.4.5 Advocacy services
- 2.5 Information materials are easily understood e.g. they are jargon-free and in translation where necessary**
- 2.5.1 Information for service users and carers is presented in a variety of formats e.g. verbally; or using leaflets, posters and videos; and in computer-based formats
- 2.5.2 Service users and carers are involved in preparing and reviewing information materials
- 2.6 All service users have up-to-date written care plans as part of their care management programme, e.g. Care Programme Approach or Care Planning in Wales**
- 2.6.1 Service users are given copies of their care plans
- 2.6.2 Service users' health and social care needs are routinely recorded in the care plan
- 2.7 The trust has processes for effectively dealing with complaints**
- 2.7.1 The trust has a multi-disciplinary complaints committee with service user and carer representation
- 2.7.2 The complaints committee reports to the trust board
- 2.7.3 The complaints procedure is clearly advertised
- 2.7.4 Staff are made aware of complaints that are relevant to their work and the outcome of the complaints process
- 2.7.5 Complaints are monitored and used to inform service development, e.g. records of complaints are referred to in management meetings
- 2.7.6 There is a joint complaints policy between social care and mental health services
- 2.8 There are arrangements to find out about, and meet, service users' needs**
- 2.8.1 These include cultural, spiritual, disability and dietary needs
- 2.8.2 Questions are asked about expectations of friends and family
- 2.8.3 An interpreter is used when necessary who understands the signs and symptoms of major diagnoses and needs of different groups
- 2.9 Service users' rights to privacy and dignity are respected**
- 2.9.1 The trust ensures that in-patients may sleep, bathe and wash in privacy and in areas separate from the opposite sex
- 2.9.2 The trust provides in-patients with access to a telephone in a private area
- 2.9.3 There are arrangements for the safe-keeping of in-patient's property including their money

2.9.4 Single sex wards are provided for in-patients, or there are plans to replace any mixed sex wards with single sex wards in line with NHS Plan requirements. (This is not specified in the Welsh plan but is considered good practice.)

2.9.5 Hospital and community-based facilities are clean and comfortable



## 3. Clinical Audit

### **3 The trust is committed to the management and direction of the clinical audit programme**

#### **3.1 The trust has the structures and accountabilities to lead the clinical audit programme**

3.1.1 The trust has established a clinical audit committee

3.1.2 This committee is multi-disciplinary (e.g. it has representatives from the medical, nursing, therapeutic and other relevant professions) and has service user representation

3.1.3 This committee meets regularly

3.1.4 The trust has appointed a clinical audit lead

3.1.5 The committee reports regularly to the clinical governance committee

#### **3.2 The trust has an up-to-date written clinical audit strategy**

3.2.1 This audit strategy includes reference to locally agreed clinical audit procedures, e.g. regarding consultation on standards

3.2.2 The audit strategy is referred to in the trust's mental health strategy

3.2.3 The audit strategy includes national and local priority topics for clinical audit

3.2.4 Audit topics are identified from complaints procedures and adverse events, e.g. complaints about lack of privacy lead to an audit of service user rights as described in the Patients Charter

#### **3.3 A range of audits is conducted. These include:**

3.3.1 The use and side effects of major treatments, e.g. the diagnosis and dose for antipsychotic and antidepressant drugs

3.3.2 Aspects of the Care Programme Approach care plan or, in Wales, aspects of the written management plan or care plan

3.3.3 Rates of emergency readmission to psychiatric units (required nationally as a high level performance indicator, NHSE 1996b)

3.3.4 Implementation of the Mental Health Act, e.g. Section 5(2) required by the Mental Health Act Commission

3.3.5 NICE guidelines, e.g. attention deficit disorder

3.3.6 Delivery of electro-convulsive therapy (national guidance is available)

3.3.7 Use of procedures for the management of violence

3.3.8 Risk management procedures in accordance with Clinical Negligence Scheme for Trusts' standards

- 3.4 Audit has been carried out in each directorate/service over the last year in line with trust priorities**
- 3.5 The clinical audit committee or lead reports audit results and recommendations, e.g. using verbal presentations and in a written report**
  - 3.5.1 Audit findings and recommendations are reported to the trust board, clinical teams, the clinical governance committee and other interested parties
  - 3.5.2 Audit findings are used to inform service planning
- 3.6 Clinical teams and other relevant staff develop action plans in response to audit reports and recommendations**
  - 3.6.1 The area is re-audited to monitor improvements, e.g. audits are continued for 2 or more cycles
- 3.7 The trust participates in national audits, e.g. the trust funds practitioners' participation in multi-centre audits**
- 3.8 Clinical audit work cuts across organisational boundaries, e.g. some audit projects involve primary care, social services or voluntary services**
- 3.9 Staff and service users are involved in clinical audit**
  - 3.9.1 Service users and carers help identify audit topics and agree standards
  - 3.9.2 Managers and practitioners help identify audit topics, agree standards and action plans
  - 3.9.3 Clinical teams, rather than individual members only, are involved in clinical audit
- 3.10 All senior managers and practitioners have received training in clinical audit**
- 3.11 Clinical audit is sufficiently resourced**
  - 3.11.1 The trust has dedicated funds to support clinical audit
  - 3.11.2 Dedicated clinical audit personnel are available centrally

## 4. Clinical Risk Management

**4 The trust is committed to the management and direction of the clinical risk management programme**

**4.1 The trust has the structures and accountabilities to lead the clinical risk management programme**

4.1.1 The trust has established a risk management group or committee

4.1.2 This committee is multi-disciplinary (e.g. it has representatives from the medical, nursing, therapeutic and other relevant professions) and has service user representation

4.1.3 The committee meets regularly

4.1.4 The trust has appointed a risk management lead

4.1.5 The trust has appointed risk management leads within directorates/services

4.1.6 There is a named executive director of the trust board charged with responsibility for clinical risk management

4.1.7 The committee reports regularly to the clinical governance committee

**4.2 The trust has an up-to-date written strategy and procedures for clinical risk management**

4.2.1 This strategy has been agreed with the local authority and other relevant partner organisations

4.2.2 There are systems for reporting clinical incidents including "near misses"

4.2.3 The trust has written procedures for assessing clinical risks

4.2.4 The trust has written procedures for the identification, monitoring, assessment and management of serious incidents and clinical risk

4.2.5 Guidance and protocols have been developed in consultation with clinical staff for dealing with specific incidents and identified clinical risks

**4.3 The trust promotes an open, blame-free culture for reporting incidents**

4.3.1 Critical incident analyses use a systems approach i.e. the trust looks for systems improvements rather than scapegoats

4.3.2 The trust has provided information to staff regarding anonymous reporting of adverse events and "near misses" (this information may also relate to "whistle-blowing" and reporting unsafe practice)

**4.4 Staff understand their requirements in relation to clinical risk management**

4.4.1 This includes staff requirements to report risks and adverse events

4.4.2 Staff requirements for clinical risk management are included in the induction training

- 4.5 Partner organisations are involved in clinical risk management for individual service users whose care is provided by a number of services, e.g. social services attend discharge planning meetings for service users at risk**
- 4.6 Trust managers and clinicians learn from information collected on clinical risks**
  - 4.6.1 Incident reviews and other information on clinical risks informs action plans and service planning
  - 4.6.2 Information systems help managers identify trends in incidents
- 4.7 The risk management committee or lead provides reports on risks and incidents, e.g. using verbal presentations and in a written report**
  - 4.7.1 Findings and recommendations are reported to the trust board, clinical teams, the clinical governance committee and other interested parties
  - 4.7.2 Findings are used to inform service planning
- 4.8 The trust participates in the National Reporting Scheme. The Regional Office is notified of specific serious clinical incidents**
- 4.9 External risk management standards (e.g. CNST) are used for service evaluation or audit**

# 5. Evidence Based Practice

**5 The trust is committed to the management and direction of an evidence based practice programme**

**5.1 The trust has the structures and accountabilities to lead the evidence based practice programme**

5.1.1 The trust has established an evidence based practice committee

5.1.2 This committee is multi-disciplinary (e.g. this includes medical, nursing, therapeutic and other relevant staff) and has service user representation

5.1.3 The committee meets regularly

5.1.4 The trust has appointed a person to lead evidence based practice

5.1.5 The committee reports regularly to the clinical governance committee

**5.2 The trust has an up-to-date written strategy for implementing and monitoring evidence based practice**

5.2.1 The research strategy and evidence based practice strategy are referred to in the trust's mental health strategy

**5.3 The committee reviews national information on evidence based practice, such as NICE guidelines, NSFs and other agreed national guidelines, and adapts this where necessary to suit the local population and service**

5.3.1 The committee has led the development of local guidelines on the management of schizophrenia and the management of depression

5.3.2 The committee has led the development of integrated care pathways for the management of schizophrenia and depression

5.3.3 The committee involves clinical staff in the development of guidelines and care pathways

5.3.4 The committee has disseminated information on evidence based practice to local staff, e.g. local guidelines for the management of schizophrenia and depression have been disseminated to practitioners

**5.4 Evidence based practice is monitored, e.g. the prescribing of antipsychotic drugs is audited against local guidelines and protocols**

5.4.1 Where practice is found not to be evidence based, and good evidence exists, training and information are quickly provided

**5.5 The committee co-ordinates local research**

5.5.1 The committee has a local research strategy that includes national and local research priorities

**5.6 The findings of local research projects are effectively disseminated using a range of**

**methods, e.g. via an R&D newsletter, notice boards, intranet and internet**

**5.7 Staff have received the necessary training in evidence based practice**

5.7.1 Staff have received training in evidence based practice, the use of the specific clinical guidelines and protocols used by the trust

5.7.2 Staff have received training in critical appraisal

5.7.3 Staff have received training in the use of library and database facilities and search techniques

**5.8 Staff have good access to up-to-date information about the evidence behind the treatments they provide**

5.8.1 Staff have good access to clinical journals and books

5.8.2 Staff have access to the internet and know how to use the key sources of information e.g. Cochrane database and NeLMH

## 6. Staffing and Staff Management

- 6 The trust is committed to the management and direction of staff**
- 6.1 The trust has the structures and committees to lead this**
  - 6.1.1 The trust has appointed a person to lead staffing and staff management
  - 6.1.2 The committee reports regularly to the clinical governance committee
- 6.2 There is an up-to-date written human resource strategy which includes local and national priorities**
  - 6.2.1 The strategy is referred to in the clinical governance strategy
  - 6.2.2 The strategy addresses Working Together targets
  - 6.2.3 The strategy addresses Improving Working Lives targets
  - 6.2.4 The strategy specifically promotes equality of opportunity, e.g. in terms of gender, race, religion and disability
  - 6.2.5 The strategy addresses the retention of staff
- 6.3 There is an active recruitment policy to ensure vacant posts are filled quickly with well qualified candidates**
- 6.4 External human resource standards are attained (e.g. Investors in People)**
- 6.5 Workforce planning is linked to service planning**
  - 6.5.1 The clinical skill requirements within clinical teams are determined by the local health and social care needs assessment
  - 6.5.2 The skill mix of clinical teams is reviewed at least annually
- 6.6 All staff receive annual appraisal and personal development planning**
- 6.7 All clinical staff receive clinical supervision**
- 6.8 The trust has procedures for dealing with poor performance**
  - 6.8.1 Staff know procedures for reporting concerns about poor performance
  - 6.8.2 Staff are encouraged to report cases of poor performance and understand their obligations to do this. Trusts encourage this by promoting a blame-free culture where system faults are identified rather than individual scapegoats
  - 6.8.3 There is a forum where staff are able to express concerns about service users' care and these concerns are taken seriously
  - 6.8.4 Agencies are informed of poorly performing locums, bank and agency staff

6.8.5 There are mechanisms for dealing with poor performance, e.g. retraining, shadowing, and other remedial action

**6.9 The trust has a mechanism for formally recognising good performance**

**6.10 There are sufficient numbers of skilled staff to safely meet the needs of service users at all times, e.g. each shift always has an agreed minimum number of qualified staff**

6.10.1 Minimum 'safe' numbers and staff mix have been locally agreed for all service areas

6.10.2 There are suitable schemes of delegation and supervision operating at night

6.10.3 There are protocols for staff working in extended roles (e.g. nurse prescribing)

**6.11 There are strategies to protect staff and maintain safety**

6.11.1 The risk management strategy includes reference to reducing violence affecting staff

6.11.2 The trust complies with relevant health and safety legislation

6.11.3 The trust complies with directives on working time

**6.12 There is a system to ensure that clinical staff are registered and qualified. This requires that:**

6.12.1 Clinical staff registration and qualifications are checked on appointment

6.12.2 Clinical staff registration and qualifications are checked on revalidation

**6.13 Good staff morale is recognised as important and efforts to improve morale are made when necessary**

6.13.1 There is a forum in which staff can discuss morale issues with senior management

6.13.2 There are clear procedures for managing complaints from staff

6.13.3 There are employee support services e.g. occupational health services, grievance procedures, pastoral staff support

6.13.4 Staff sickness rates, vacancies and turnover are monitored and acted upon when necessary

# 7. Education, Training and Continuing Personal and Professional Development

- 7 The trust is committed to educating, training and the continuing personal and professional development of its staff**
- 7.1 The trust has the structures and accountabilities to lead education, training and the continuing personal and professional development of its staff**
  - 7.1.1 The trust has established an education or "CPD" committee
  - 7.1.2 The committee meets regularly
  - 7.1.3 The trust has appointed an education or "CPD" lead
  - 7.1.4 The committee reports regularly to the clinical governance committee
- 7.2 The trust has an up-to-date written strategy for education, training and the continuing personal and professional development of its staff**
  - 7.2.1 This strategy includes details for individual directorates
- 7.3 The trust is involved with partner organisations in education, training and "CPD"**
  - 7.3.1 There are partnerships with academic institutions
- 7.4 Joint training is organised with staff from other health and social care organisations where there is partnership working**
- 7.5 The training needs of staff have been formally assessed**
  - 7.5.1 The training needs assessment informs, and is referred to in, the training or workforce development strategy
  - 7.5.2 The training needs to implement clinical governance are specifically addressed
  - 7.5.3 Training needs are identified from clinical audit and risk management reports, a skills audit, staff appraisal, individual development plans and support and supervision systems
  - 7.5.4 Training needs have been assessed in the last year
- 7.6 Staff and multi-disciplinary teams participate in effective work-based training**
  - 7.6.1 All clinical staff participate in programmes that support continuing personal and professional development
  - 7.6.2 There are dedicated "CPD" budgets for all clinical staff
- 7.7 The trust provides support for staff looking to gain further and professional qualifications**
- 7.8 Basic skills and mandatory training requirements for clinicians are met, these include:**

- 7.8.1 Basic life support
- 7.8.2 Handling and moving
- 7.8.3 Dealing with fire
- 7.8.4 General health and safety
- 7.8.5 The management of violence, e.g. control and restraint techniques, breakaway techniques
- 7.8.6 Risk management
- 7.8.7 Clinical audit
- 7.8.8 Using service user feedback and complaints handling
- 7.8.9 Evidence based practice, including use of guidelines, and searching for effectiveness information
- 7.8.10 Performance appraisal
- 7.8.11 Care planning as part of their care management programme, e.g. Care Programme Approach or Care Planning in Wales
- 7.8.12 Use of service user outcome measures such as HoNOS
- 7.8.13 All clinical staff and managers receive training in clinical governance and its component activities
- 7.9 A record of training is kept to ensure that basic training has been provided to all clinicians**
- 7.9.1 Training is provided to clinicians where training needs have been identified
- 7.10 Appropriate training methods are used to ensure staff training is effective**
- 7.10.1 Whenever appropriate staff training is multi-disciplinary and multi-agency
- 7.10.2 Induction training is provided for temporary, locum and permanent staff before they have unsupervised access to service users
- 7.11 The trust attains external standards and accreditation**
- 7.11.1 Standards are maintained in line with guidance from professional organisations and other relevant bodies e.g. Investors in People (IIP), Royal Colleges, etc.

# 8. Information Management

**8 The trust is committed to the development and use of information to improve care and service users' experience**

**8.1 The trust has the structures and accountabilities to lead this**

8.1.1 The trust has a multi-disciplinary clinical information/health record committee with service user representation

8.1.2 The trust has appointed a person to lead clinical information management and technology

8.1.3 The trust has appointed a qualified librarian or information specialist to manage library and information facilities

**8.2 The trust has an up-to-date written strategy for information management and technology**

8.2.1 The trust has an agreed plan for the development of electronic clinical information systems

8.2.2 Clinical governance needs are prioritised within the information management and technology strategy, e.g. systems to support clinical audit and risk management

8.2.3 The strategy has been agreed with social services, primary care and other relevant partner organisations

**8.3 The information technology infrastructure offers good access to high quality and helpful information**

8.3.1 This information directly informs service strategies and plans

8.3.2 This information is used to support performance review and improvement

**8.4 Staff have access to training and support in access to and use of information**

**8.5 Staff have access to a well equipped library and quiet study area**

**8.6 The trust has systems for assuring data quality**

8.6.1 Quality indicators have been developed and are monitored and used to improve the quality of information

8.6.2 Clinical staff receive feedback on the quality of the information they provide

**8.7 The trust complies with NHS data collection requirements, e.g. data are collected for:**

8.7.1 National patient surveys

8.7.2 Patient charter monitoring

8.7.3 Common information core

8.7.4 National Service Frameworks

- 8.7.5 Our Healthier Nation targets for mental health
- 8.7.6 Mental health national performance indicators
- 8.7.7 Outcome measures e.g. HoNOS
- 8.7.8 Risk indicators are collected as part of a clinical information system
- 8.7.9 Progress has been made toward completing the mental health minimum data set
- 8.8 The trust complies with requirements to keep service user information confidential**
- 8.8.1 A Caldicott Guardian has been identified
- 8.8.2 Managers and practitioners are aware of trust guidelines on confidentiality, e.g. a written guideline has been disseminated
- 8.8.3 There are locally agreed protocols for the sharing of service user information with other agencies and services, e.g. social services, voluntary organisations and the private sector
- 8.9 Information management and technology reports are presented to the trust board**

Appendix A

**Feedback Form**

Any comments you may have will be incorporated, with the approval of network members, into future editions of this publication.

1. Have you found these standards useful ?                     Yes                     No

Comments:

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2. Do you have suggestions for new sections or topic areas you would like to see included in future versions?

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3. Do you have suggestions for new standards or criteria you would like to see included in future versions?

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4. Do you have any general suggestions about this document that would improve its usefulness?

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5. What is your job title/profession?

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Thank you for taking the time to complete this form. Your comments will be considered carefully. Please photocopy and return to:  
Adrian Worrall, Royal College of Psychiatrists' Research Unit, 6<sup>th</sup> Floor, 83 Victoria Street, London SW1H 0HW. Fax: 020 7227 0850

## Appendix B

### **Acknowledgements**

#### **Consultation and support**

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