Trust Wide Involvement Operational Group
Meeting Minutes

Monday 6th August 2012
11AM – 3PM, Maudsley Boardroom

In Attendance:

Ray Johannsen-Chapman (**RJC**)	Co-Chair Strategic Patient & Public Involvement Lead
D Rosier (**DR**)	Co-Chair Service User Consultant
Carmine De Rosa (**CD**)	Service User Consultant
Angela Mitchell (**AM**)	Blog Outreach SUC
Paul Paterson **(PP)**	Members' Council Representative
Liz Dalton (**LD**)	Food Project Service User Consultant
Martin Saunders **(MS)**	Southwark Link
Gillian Ashwood (**GA**)	Recruitment and Selection Training Project Worker
Bridget Jones (**BJ**)	Service User Consultant – Operational Lead Food Project
Andrea Woodside (**AW**)	Recruitment & Selection
Reagan Edminston **(RE)**	PPI Lead B&D CAG (part-time)
Julie Connolly **(JC**)	Service User Consultant Croydon
Stefano Peria (**SP)**	Psychosis SUAG
Nuala Conlan **(NC)**	Engagement Lead MHOAD
Sarah Morgan **(SM)**	Service User Consultant Blog Work

Apologies:

Alice Glover (**AG**)	MAP/Psychological Med CAGs
Kim Clarke (**KC**)	PPI lead for Addictions CAG
Bill Berry (BB)	Patient Experience Manager
Vanessa Bray (VB)	Vice Co-Chair TWIG Ops & Food Lead
Chris Andersen (CA)	Service User Consultant Food project
Jane White (JW)	Service User Consultant Food project

Item	*Business Item*	*Action by*	*Date*
1.	**Apologies** Received as above.		
2.	***Matters Arising*** Minutes of the meeting on were agreed as an accurate record		
3.	**<u>Involvement Register Update</u>** RJC updated the group on the IR – discussion about the 40% surcharge doubt as to whether this amount is collected. If so, where is it? It appears that it is accounted for from some budgets but not all. The 40% surcharge was originally implemented to cover H/R's cost for Sue Folan IR facilitator. The IR membership started small with the rationale that the increase of numbers would overtime reduce the 40% surcharge. Lack of overall management for the IR may indicate why the surcharge has not been actively integrated into further financial development of the IR.		

	D and RJC hoping to present to the Trust Executive in November to state the case for their support to financially develop the IR	RJC & D	Nov 2012
4.	**Blog Update** Aim to increase subscribers – **AM –** time table set to archive outcomes – Questionnaire to finalise and agree to discover what they like least and most. Suggestions to improve. **SM –** Problems responding to the targets – issues around the getting the Twitter account to function the idea is that any updates on Twitter will link to the Blog – update for next meeting		
5.	**Members Council** **PP –** provided update about the MC – indicated that he missed some of the MC's business due to other commitments – gave the group an overview of the MC operates and he felt that could or should function within the Trust. PP to provide further MC updates at the next meeting		
6.	**PSUIG Update** CdR – Provided an outline of the training provided by PSUIG The training workshop consists of evidenced based best practice examples of service user involvement. PSUIG involved service users in the development of the workshop and in the presentation. The involvement of service users has generated very good feedback and is in keeping with PSUIG's strategic vision. The topics were: What defines our approach to user involvement? Why involve service users? How can involvement benefit service users and overcoming obstacles? The training workshop has been delivered to 7 teams across the Trust and we plan to deliver the workshop in Lewisham. The overall results of the feedback suggest the workshop increased participants' confidence to undertake involvement activities.		
7.	**PEG (Patient Experience Group) Meeting** **RJC** gave an outline of PEG – why and how it started, the areas it generally focuses on, and highlighting the strength of its membership. PEG does not formally report to any body within the Trust – but the Medical Director is the Chair and that determines its power. PEG and both TWIGs need to find a formal route for reporting.		
8.	**Project updates - Food Project (non borough)** **BJ** Indicated that there had been communication with Aramark when talking through action plans.		

	Lambeth: audit almost completed Croydon: Re-audit – BJ unsure of position Lewisham: Lambeth now provide Lewisham with food – access to greater range Southwark: on-hold Eating disorder unit: happy with the food		
10	**Content Analysis** Update 13 new service users trained, small group of co-facilitators		
11.	**Information Stalls** **JA** explained that she has worked under the supervision of Ros Byfield run a number of stalls in GP practices. The Practices had little information on mental health awareness only information on physical health. We gave out information leaflets about mental health awareness. Very positive feedback from patients and staff – highlighting the need for greater collaboration between SLaM and GPs. Ros Byfield is compiling a report together for Trust Leads on the outcomes.		
13.	**Recruitment and Selection** Training was reduced – difficult to maintain quality – new Service User pilots because the programme has been slightly tweaked. H/R have shown some concerns – question is how to increase participation?		
14.	**CQUIN's** **RJC** The Trust has to meet CQUIN targets, one domain is patient experience; SLaM's targets are, nationally the most demanding. There is money attached so we have to hit them. RJC explained the CQUIN demands. RJC to discuss with Paul Calaminus and Julia Gannon what would be the most appropriate way for TWIG Ops to be involved.	RJC	
15.	**PPI Leads Update** **RE –** Provided update from the B&D CAG due to her role being P/T her aims include the focus on developing Service User Involvement events and the community meetings in the wards and patient information leaflets. Reworking our patient information leaflets to ensure the language and content is right, the aim of the information group is around language accessibility. The overall objective is to ensure that all teams within the CAG undertake their PEDIC patient experience surveys. **NC –** developed strategy for involvement within the MHOAD CAG with the aim to embed engagement across the CAG Lewisham memory service set-up Service User Group (inclusive of carers)		

	Undertake work with Hear-Us to establish Links Works in the Older Adults units NC asked whether there was any places available for the recruitment and selection for SUs from MHOAD?		
16.	**Any other business** None		
17.	**Dates of *next* meeting:** 12th November 11am to 3pm in the Board Room		

Advance Statements for TWIG ops

An Advance Statement is a written expression of the wishes of a person who experiences mental illness regarding their treatment and care. It is drawn up when the person feels they are well and competent, to be taken into account in the event of them facing a crisis (Rethink, 2007). Advance Statements differ from Advance Directives as they are broader.

An Advance Statement includes active and positive suggestions whereas an Advance Directive is a refusal of certain types of treatment. As the Mental Health Act can override the directive, a statement is more commonly used for people with mental health difficulties.

Many SLaM CMHTs will have Crisis Plans and many service users will carry crisis cards. It is recommended that when completing an Advance Statement for TWIG ops that the individual also takes these documents into account and that their care co-ordinator is aware of the statement in order to avoid any contradiction in requests.

An Advance Statement is intended to be an act of empowerment, where service users can feel more confident that their wishes will be implemented when they are unwell. This will be more likely if doctors and care co-ordinators are informed and involved. Also, a study at the Maudsley in 2005 showed that people who had an Advance Statement experienced a reduction in the number of compulsory admissions under the Mental Health Act (Rethink, 2007).

It is legally binding if it is written when the person is understood to 'have necessary capacity'. However it can be overridden by a section under the Mental Health Act. Doctors also have the right to replace one treatment with another if the first request is not available, or if it is illegal or may cause harm.

In conclusion, Advance Statements are worth having in conjunction with crisis plans as they are user led. They can increase the likelihood of a person's wishes being adhered to and therefore reduce their level of distress.

I include an example containing the information as recommended by the British Medical Association's Code of Practice. Copies should be retained by the individual, TWIGops and the person's care co-ordinator. It is also recommended that the people who have been named on the form are aware of the fact. They should be signed and witnessed, and able to be withdrawn or altered at any time at the person's will.
VKBray 23/04/12

Advance Statement for TWIG ops

Name: Mary Bloggs

Address: 85 Southwark Street, Southwark, London SE22

Phone: 0207 7777777

Care co-ordinator: Judy Smith, Central Team CMHT, Southwark, 0207 6666666

GP: Dr Jones and partners, Southwark SE22

IN THE EVENT OF A CRISIS (with details):
I would like you to contact :
Joe Bloggs, brother, 07788 999333

I nominate the following individual/group as my advocate:
Mental Health Club, Southwark

My next of kin:
Joe Bloggs, brother

If I am treated I would like the following:

- **What has worked:** Codeine, Amisulpride
- **What has not worked:** Clormazepam

My physical health needs:
I have asthma and need to have an inhaler

My cultural/spiritual needs:
I need to be allowed to pray at X time
At home I would like the following to happen:
(Children/pets/security etc)
Ask my brother to feed my cat

I would also like the following to be taken into account:
No restraints as I will panic and have an asthma attack
DATE: 23/11/11
SIGNED:
WITNESS: