## Case for change/efficiency savings

**Q1. How much money has got to be saved? (from the slide used at the event)**

- Current government policy is to protect the NHS - overall NHS spending will increase by 0.4% in real terms to 2015
- However, they are also seeking £20bn in efficiency and productivity savings by 2014
- Next year we have £882m (baseline allocation) increasing at approx £9m (1%) per year until 2015
- However:
  - Demand for health and social care services is increasing in Oxfordshire
  - The cost of providing services is increasing
- If the NHS in Oxfordshire do nothing – it will be £179m overspent by 2014

**Q2. Who will undertake assessments (i.e. of social need)? How will the differences in power, budgets and resourcing between health and social care be managed to ensure there are sufficient good quality and a wide enough range of services to meet the needs once assessed?**

**How will the problems of having to pay for social care services and not for health services be managed?**

These points and questions were raised during the event workshops. The NHS and Council are working together to address these issues.

**Q3. How will Transforming Adult Social Care (which is a way of purchasing individual social care – i.e. not free) and already set up and active, be managed with healthcare, especially as latter, so far, is free?**

As above in Q2.

**Voluntary Sector**

**Q4. Regarding the “Picture of Health” – Where is the voluntary sector which plays such a major part in maintaining health?**

This was a design error and the picture of health has now been rectified to include the voluntary sector. Please visit the CAHO section of the PCT website to see the
Q5. Can you explain why there is no mention of the voluntary sector organisations input in your CAHO plan. This is unacceptable given that the voluntary sector provides the most cost effective services and efficiency savings. The NHS should stop looking inwardly and start recognising that the voluntary sector is an obvious partner in meeting the needs of the community in the future.

Voluntary sector organisations have been involved in the development of the CAHO programme and its workstreams. The Oxfordshire Carers Forum is a key partner in the development and delivery of the self care training programme. Mind, Restore and Age UK have also been involved in developing strands of work.

The PCT is currently in discussions with a range of partners about piloting an approach to self care that relies heavily on third sector providers to support people to deliver their self care plan objectives.

Another example of the PCT working with voluntary sector organisations to deliver services is the ‘Keeping People Well’ programme. This programme is designed to prevent people becoming unwell and to also help people who are experiencing mental ill-health progress towards recovery. ‘Keeping People Well’ consists of two new day-time services; the Well-being service and the Recovery service which are being provided by Oxfordshire Mind and Restore respectively.


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Q6. We hear the rhetoric around greater engagement with (and investment in) the voluntary sector to provide services in the community. To date I have seen little evidence of this. What will be done to ensure the present effective and efficient voluntary sector services are included in both the development and delivery of future health services?

We need to continue to develop ways of working with and learning from the voluntary sector. For service redesign initiatives the PCT aims to work closely with the voluntary sector. This is evident in mental health, neurological conditions, self-care and a number of other areas; however we need to continue to do this going forward.

We would encourage people to register on “Talking Health” so they can keep up-to-date with work we are carrying out in their area of interest. Details are available here: [http://www.oxfordshirepct.nhs.uk/have-your-say/public-involvement/default.aspx](http://www.oxfordshirepct.nhs.uk/have-your-say/public-involvement/default.aspx)
Q7 We have heard interesting proposals about a future where health and social services work closely in an integrated fashion, but increasingly the voluntary sector is expected to provide services in the local communities, and what plans do you propose integrate them?

Some of the plans outlined seem to rely heavily on medical time – how does this chime with medical training numbers and the European working time Directive?

Working in a more integrated way with voluntary organisations is a necessity in the future. See response to above question.

Workforce planning is being undertaken as plans for the CAHO initiatives are being developed to ensure the full range of skills are available.

Q8 This is all very “wish list” and “broad brush” at this stage. How will the PCT – in conjunction with social care – consult us on detailed proposals, as they emerge?

The PCT is already engaging with the public in plans developing from CAHO and will continue to do so moving forward. An example of this on-going engagement and involved is the ‘whole system pilot’ – this is work around bringing urgent and specialist care out of hospital where clinically appropriate.

As part of this project;
- We launched a consultation on our Talking Health website
- We engaged with local stakeholders
- Meetings were arranged with local groups
- In depth interviews were conducted with local people
- Over 200 people were contacted about the consultation

As an outcome of the consultation, we are writing a recommendation report, which will inform the pilot. This report will be published on the Talking Health website.

We are also engaging with Staff who have experience working within this pilot. This will provide further information.

Q9. Is there an event planned that includes GP consortia representations and our audience of today? This seems essential

As the plans for the Oxfordshire GP Commissioning consortia progress it is likely that other similar events will be developed.
**Q10.** In terms of prevention and self-care, how much of the PCT budget is spent on Public Health? Will this be ring-fenced when the P.H. service transfers to OCC, including support for carers?

NHS Oxfordshire has an annual budget of over £898 million. For every £100 spent, £1 is spent on public health and health promotion.

Future funding this is subject to on-going national debate and the exact position is not known at present. Budgetary information is not yet finalised and the Department of Health will undertake a national survey of this using data from all PCTs after which it may be possible to give a meaningful estimate.

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**Q11.** In terms of support for carers, what steps are you taking to ensure that the breaks on prescription funding which is currently in the Public Health budget, will be transferred and ring-fenced when this Public Health transfers to Oxfordshire County Council?

See as above

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**Q12.** How to enable self-management by people unable to speak up or voice their wishes, or make choices? E.g. Transforming Adult social care will provide brokers, who are *not* ultimately independent, and in theory will then turn to independent advocacy to help people to gain information, assess their rights, make choices.

The Oxon NHS has over the years undermined this independent support to individuals e.g. PALS does *not* fill this role. Will this be taken into account?

The pilot self care programme developed through the CAHO work is providing training for carers as well as patients – so that carers can support the development of self care plans for friends and family members with less capacity (as well as creating their own). We are also piloting provision of training to help people to put together a self care plan with professionals in secondary community and primary care – and this will encourage them to involve carers as well as patients.

The Government announced in the White Paper that Local Involvement Networks (LINks) will become HealthWatch, supported and led by HealthWatch England, an independent consumer champion within the Care Quality Commission (CQC). Local HealthWatch will ensure that the views of patients, carers and the public are represented to commissioners and provide local intelligence for HealthWatch England. It will work alongside the role of public members and governors of foundation trusts in influencing providers. Local authorities will be able to commission HealthWatch to provide advocacy, advice and information to support people if they have a complaint and to help people make choices about services.

The primary role of HealthWatch England will be:

- Promoting, and supporting, the involvement of people in the commissioning, provision and scrutiny of local care services;
- Enabling people to monitor services and to review the commissioning and provision of local care services;
- Obtaining the views of people about their needs for, and their experiences of, local care services; and
• Making reports and recommendations about how local care services could or ought to be improved, to persons responsible for; commissioning, providing, managing or scrutinising local care services.

**More information on HealthWatch England**

Under the new Health and Social Care Bill, Local Authorities formal scrutiny powers will be extended to cover all NHS-funded services, including, for example, primary medical dental or pharmacy services and independent sector treatment centres, as well as any NHS commissioner. The powers will also include scrutiny of local public health services. They will include the ability to require any NHS-funded providers or commissioners to attend scrutiny meetings, or to provide information. In this way local democratic scrutiny will be increased very substantially.

The Bill also aims to give local authorities greater freedom to discharge their scrutiny powers in the way they deem to be most suitable – whether through continuing to have a specific health Overview and Scrutiny Committee, or through a suitable alternative arrangement.

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**Your Local Services**

**Q13.** You can’t provide enhanced services e.g. in the “Akbar Future” example, without skilled specialists i.e. cardiologist and radiologists, and, expensive equipment. Why would this be more cost-effective than in hospital? You’d have to move specialists and equipment to GP “centres”. Is this realistic? Is it more expensive?

**Who says the current system is failing?** Patient satisfaction rates in this area are generally high. How can it stay the same but save money without such major change? Is this a possibility too?

The services that are being considered are those already provided in a primary care setting under enhanced service agreements and are not ‘specialist’ services. Most general primary care health issues, such as minor illnesses and long term conditions, can be managed by the team at the surgery. Some practices are also contracted to provide additional services (known as enhanced services) for their patients; for example undertaking minor surgical procedures such as injecting joints for pain relief, removal of toe nails and removal of certain types of cysts and lumps; testing patients for suspected Deep Vein Thrombosis, testing for arrhythmia, inserting contraceptive devices etc. In order to be able to provide these services the practice must be able to demonstrate that their premises are suitable, meet national set standards and that they have the required skills to be able to provide the service/treatment.

Not every practice provides enhanced services but they are suitable to be provided in a Primary Care setting (i.e a GP surgery). Currently if you are registered with a practice that has chosen not to provide the service you may have to travel to hospital to get treated.

The proposal is to encourage clinicians and GPs in primary care to provide these services for which they will be paid as providers. Therefore, more of these services
will be available to patients in a setting closer to home.

Due to reduced overhead costs it is possible for these services to be provided as effectively in primary care at a reduced cost.

**Q14. How will GP surgeries develop/improve on separate specialisms which may be devolved from hospitals? What incentives to encourage this will there be for GPs to spend money to achieve this? Or will they resist to save on their budgets?**

The services that are being considered are those already provided in a primary care setting under enhanced service agreements. These are not ‘specialist’ services. In the majority of cases GPs are already skilled enough to provide these services and would not require extra training.

The incentive for GPs to provide services within a locality rather than in secondary care is the impact that this will have on the financial balance of the health system as a whole and the provision of services in a setting closer to the patient.

**Q15. The reason people go to A&E is because there is no local service that we can have confidence in. Get rid of out of hours service. If you need a doctor at night it is quicker to go to A&E than wait for an after hours GP who may or may not turn up.**

**What percentage of health authority money is spent on patients and what on staff buildings, etc?**

**I feel concerned about services in Rural areas and heard nothing to make me feel more confident.**

The Out-of-Hours GP service is provided by Community Health Oxfordshire. The service receives approximately 8,500 calls per month. The GP out-of-hours service is based in Banbury, Bicester, Witney, Oxford, Henley and Abingdon. (getting stats on GP OOHs)

A&E Departments provide treatment for patients in an emergency. There are other types of facilities for people requiring less urgent care, such as Minor Injury Units and First Aid Units. These are located in Oxfordshire’s Community Hospitals.

For information about the allocation of NHS Oxfordshire’s budget, please refer to the 09/10 **Annual Report**.

It is anticipated that the provision of services in, GP practices - settings closer to the patient - will benefit those living in rural areas because access to services will be easier.

In Oxfordshire we are piloting a “whole system” approach to urgent and specialist care. This is taking place in Abingdon and will see health and social care more integrated to meet the needs of patient’s in the community. This new health and social care model of urgent care aims to provide care closer to home for patients who might otherwise have gone to hospital, to facilitate quicker discharge if a patient has been in hospital and requires support when they
leave and to enable patients to look after themselves more effectively when they get home. This model will offer more support to people living in rural areas, as there will be more facilities closer to home.

Once we have reviewed the success of the pilot in Abingdon, we will be looking ot role this out across Oxfordshire.

Urgent and Specialist Care Closer to Home

Q16. What is the difference between an Emergency Medical Unit (EMU) and the previous A&E departments of local hospitals? Why did you close them?

In Oxfordshire A&E Departments can be found at the John Radcliffe and Horton Hospitals. A&E Departments provide an immediate assessment and treatment for patients in an emergency. There are other types of facilities for people requiring less urgent care, such as Minor Injury Units and First Aid Units, which are located in Oxfordshire’s Community Hospitals. For more information, please see our website.

The remit on an EMU is very different to an A&E department and provides a very different function and support for patients. An EMU is being piloted currently at Abingdon Hospital; it is way of providing holistic care, integrating elements of health and social care in one setting. The EMU provides rapid assessment and management for patients referred by their GP who have an escalating urgent health need. The intention of an EMU is to provide early local specialist input into a patients care. Early specialist intervention means that a patient’s condition can be managed appropriately, closer to home, to avoid exacerbation and avoid an emergency admission into an acute hospital like the John Radcliffe. The EMU also provides support to enable early discharge from acute hospitals so patients can get home sooner and ensures that acute hospital beds can be used for patients who need that level of care.

Q17. What is the difference between an EMU and a cottage hospital A&E? What was the cost of shutting and re-locating from local to regional A&E? What will be the cost of reversing the process?

Please see above.

Q18. Who is to run EMU in local areas? The assumption is that it will be by the medical profession. Are they the right people?

Referral to the EMU is by any health professional, nurse, ambulance service or GP. The EMU service is being run by a multidisciplinary team including doctors, nurses, social care professionals and therapists. Following initial assessment by a nurse and or a doctor patients are then seen by the relevant specialist depending on their clinical need.
**Q19. Will you consider running another EMU pilot from the point of view of people living in rural communities outside the towns of the size of Abingdon?**

The purpose of the pilot is to assess the impact and effectiveness of the model. If it is successful then it is envisaged that it will be rolled out across Oxfordshire to cover patients across the county.

**Q20. A question this morning was not answered. We were told that 40-45% of attendances at A&E were unnecessary but when asked for qualification and figures nothing was discussed other than “parents take children to A&E when they could use a pharmacy”.**

In 2008/09 a number of GP’s and an A&E consultant did an academic piece of work where they reviewed over 600 patient records in A&E picked at random and covering both major and minor cases, children and adults. The results of this review strongly suggested that over 40% of patients attending A&E could have been managed locally by primary care, pharmacists, minor injury units or self care.

**Q21. Re: urgent and specialist care closer to home – which voluntary sector organisations were engaged in the EMU development and which if any are utilised in the delivery of this work?**

The EMU is part of a wider piece of work of the “whole system” pilot and there are many different services included within this project. For more information on the services involved in the “whole system” pilot please follow this [link](#).

Voluntary organisations have also been involved in developing training packages included in the pilot and for the self-care aspect of CAHO. Organisations include: Restore, MIND, Age UK and the Oxfordshire Carers Forum. We are also looking at how people, and through which type of organisation, would like to be supported going forward. This will be included in 7th edition of Oxfordshire Voice due out in June 2011.

**Q22. How is Joan’s condition assessed?**

In the scenario Joan has a care plan, which reflects her needs. Joan’s GP and a specialist heart failure nurse are involved in assessing her condition. She also has specialist tele-health equipment at home to monitor her health and well-being.

**Q23. What will happen to investment already made in hospitals? Redundant assets? How common are special services and workforce? In a regime of budget cuts why do we invest in developing new services instead of making better use of current infrastructure?**

The challenge for the whole health economy is to ensure the highest quality of care for all patients within limited resources available. This will be achieved in part by working smarter.

In order to deliver the best quality care we can, Oxfordshire’s health system must change. We are working with clinicians to re-engineer services, in line with the best clinical practice and by eliminating unnecessary steps in the patient pathway. With regard to hospital care, this will mean redesigning delivery and bringing care closer to
home, when it is clinically appropriate.

Hospitals will continue to receive investment, hospitals such as the John Radcliffe and Horton General Hospitals to provide essential emergency and specialist care. However, in the future there will be smaller more efficient hospitals with fewer beds due to enhanced recovery support and speedier discharge from hospital. Patients will receive some of their acute care within outreach clinics in the community. Most patients will receive their acute and rehabilitation care in local community hospitals or at home rather than going into hospital. Staff within hospitals will be trained in a number of new roles and skills to keep pace with the changes in services, workplace and technology.

It is also important to ensure people receive the right care, at the right time, in the right place: in the future patients will have quick access to appropriate health care from different services for their injury or illness. Patients will be supported by their GP and community teams and have rapid access to specialist services when needed. On leaving hospital, patients where necessary, will be supported by a care coordinator to help aid their recovery and rehabilitation in the community.

We will also be looking at workforce planning and money will be taken out of the system by reducing agency spend and natural turnover.

### Health and Social Care Working Together

#### Q24. Will personalised health plans apply to people with dementia?

Personalised Health Plans will apply to any adult who has continuing health and/or social care needs and would like to have one. This work is being developed by the CAHO team and commissioning managers to ensure a consistent approach.

The Integrated Community Teams (ICTs) (health and social care staff) will be trained to work with people to develop personalised plans.

Personalised care plans work well for people with dementia. People with cognitive problems often find personalisation particularly useful in managing their condition in the community longer as help can be targeted to their particular needs.

#### Q25. Who would design the care plan. Social worker or doctor/nurse?

Ultimately a self care plan belongs to the patient or carer and would be develop in conjunction with the health care professional. A wide range of professionals will be able to support a person to develop a self care plan. It is more likely that this work would be led by specialist community nurses, practice nurses and potentially pharmacists. The level of need of the patient will determine who is involved and the type of plan developed.

As part of the Self Care workstream initiatives, training will be provided to staff, patients and carers about self care. Part of this training will be the development and agreement of a personalised plan.
Through the CAHO work we have developed a simple template for self care planning and patients, carers and health professionals are inputting into its design.

Q26. What is the meaning of “community” in these two phrases? “family and community” “integrated community teams”

- Family and community – community here would mean your wider network of support
- Integrated Community Teams – community here would be defined as outside of a hospital setting. In this context, health and social care professionals would work together in team to treat people in a non-hospital setting.

Q27. How do we have “specialist” staff in the community? Given that only 4% (on the last survey) of GPs feel confident when dealing with patients with Parkinson's Disease.

The Integrated Community Teams (ICTs) will comprise of health and social care staff. These teams will be made up of staff already in the community and will involve them working together more closely and across a manageable geographic patch.

Staff will include district nurses, podiatrists, physiotherapists (Musculoskeletal service), therapist in rehabilitation services as well as social care staff (social workers, domiciliary carers etc.).

Where there are fewer staff in the county – specialist community nurses (respiratory, heart failure, neurological conditions), learning disability staff – staff will continue to work on a countywide service basis, or patches larger than the ICTs.

Using Parkinson's as an example part of the role of the Community Specialist Neurological Nurse (Parkinson's) is to educate practice staff (GPs and Practice Nurses) about Parkinson so they can better support patients.

For more care to be accessible in community settings 'specialist' staff currently working in acute hospital sites will be expected to work outside the hospitals more often, ensuring the quality of care remains the same and that it is economic to do this.

Telehealth

Q28. How will telehealth monitor Joan's health condition (early dementia)? It is not like monitoring blood pressure!

Telehealth is a service provided by social services that provides alert and alarm services for people living at home.

CAHO is currently trialling the introduction of telehealth for people with respiratory disease and we hope to introduce it for patients with heart failure during 2011/12.

Whilst, you can’t monitor the progression of a mental health condition with telehealth, there are systems that can be installed to help people who have dementia and their carers. These include telehealth monitoring bed and door sensors so that if
someone with dementia gets up in the night or leaves the house an alarm will be raised.

**Miscellaneous**

**Q29. All the initiatives we’ve heard about will be more expensive to resource properly – can you say how the necessary resources will actually be freed up?**

The government has made it clear that from 2011/12 the NHS will not be receiving any significant new money for growth. This does not mean that there will be less money for health in terms of the overall budget - but in real terms, taking into account our ageing population, increased demand for health services, developments in new technology and other increase costs, it will feel like there is less money to go round. We will have to do more with less.

Nationally and locally the NHS will focus on Quality, Innovation, Productivity and Prevention (QIPP) initiatives to meet the financial challenge. QIPP is designed to deliver the vision of improving the health and well-being of people in Oxfordshire whilst ensuring value for money. The aims and objectives of Creating A Healthy Oxfordshire are integrated into this work.

The challenge for the whole health economy will be to ensure the highest quality of care for all patients within limited resources available.

- We need people to help us, by understanding the issues the health and social care system faces, knowing how to use the NHS the right way and doing what they can to keep themselves fit and well. The NHS is there when people need it, but patients have a responsibility to look after their own care.
- Cultivating a more patient centred health system - One that works for the patient in the most convenient and efficient way and supports patients to take responsibility for their own health. Ensuring that services are high quality but are deliverable within the limited resources available.
- Work smarter – In order to deliver the best quality care we can, Oxfordshire’s health system must change and eliminate unnecessary steps in the patient pathway. We need to maximise the skills of staff and use ways of working that are evidenced based.

The Oxfordshire QIPP Plan outlines the changes to service provision in Oxfordshire required to provide high quality services that both meet the health needs of residents and can be delivered within the required resources. Some of the opportunities identified in the QIPP plan to improve efficiency and value for money are:

- Reviewing the provision of services and treatments that are shown to be clinically ineffective and inefficient and giving patients more information to make decisions about their treatment: in the future patients will be offered a choice of clinically effective and cost effective treatment options. Patients will have a new level of control in their choice of treatment options through the use of decision aids.
- Supporting and educating people with long term conditions to help themselves, prevent ill-health and hospital admissions: in the future patients with long term conditions will be able to enjoy a better quality of life, slower deterioration of their illness and fewer complications that require urgent or emergency care.
- Ensuring people receive the right care, at the right time, in the right place: in
the future patients will have quick access to appropriate health care from different services for their injury or illness. Patients will be supported by their GP and community teams and have rapid access to specialist services when needed. On leaving hospital, patients where necessary, will be supported by a care coordinator to help aid their recovery and rehabilitation in the community.

Q30. If it is all about integrating services, where were the social care representatives at the event? Did they help plan it?
The CAHO programme is about Oxfordshire whole health system and this involves social care. Representatives from social care sit on the CAHO Board and social care professionals are involved in developing initiatives. We did expect to have a representative from Social Care at the Q&A session. However, due to unforeseen circumstances this did not happen.

Q31. NHS Trusts – foundations or otherwise - Lack of knowledge between medical staff about what others are doing i.e. paediatric rheumatology surprised by what biomedical research does on same trust site.

If trusts are to make money, then all staff must know what the NHS Trust does to maximise services and look for new opportunities – could identify partnerships across departments to raise funds.

Sonia stated: “they will decide what services will be provided” – who, the PCT? Will the patient be included in this decision and does the statement above reflect an attitude problem and lack of inclusivity?

Communication and engagement are integral to the effective functioning of any organisation and become imperative in times of change.

NHS Oxfordshire is strongly committed to engaging with its population. We undertake a great deal of inclusive consultation and engagement with the public. The CAHO event is just one of the events we have held over the last 12 months. You can see examples of the work we have undertaken in the last year in our Real Accountability Report. You can also get involved in any of our consultations. The best way to do this is to join “Talking Health” our online forum for engagement.

We also engage with staff across the organisation and keep them up to date, via briefings, newsletters and meetings about the different aspects of the work of the PCT.

Q32. How will community hospital care and care at home be cheaper than current hospital services? Will this new model be provided by “contract” (independent/private) providers? If so and if the public were made aware of this, it’s unlikely they would agree with it. Please be transparent for all our benefit.

The CAHO initiatives and outcomes are NHS funded but maybe provided by a range (including private) of providers. One example of this is the new Community Hospital at Chipping Norton, which has been an NHS Oxfordshire commissioned venture and included services provided by the Order of St John.
NHS Oxfordshire is a transparent organisation and we involve the public in all aspects of our new developments. As such, the public would be aware of who we would commission to provide services in the future.

**Q33. Question for Sonia Mills. Shifting health services towards the “community” requires “cultural change”. As this “cultural change” may take between 7 years to 1 generation how does NHS plan to do this in 2 years? Does NHS see the role of the “3rd sector” becoming greater?**

We acknowledge that changing culture takes time. However, orienting care in the community is something that the NHS as a whole has been moving to for many years. NHS Oxfordshire has, over the last few years, increased the amount of services based in the community. Examples include enhanced services at GPs practices and community Chronic Obstructive Pulmonary Disorder (COPD) nurses. We know that embedding care in the community will take time to achieve, however, we feel that with the work we have already undertaken and the CAHO initiatives we are making good progress.

NHS Oxfordshire values the expertise of voluntary sector organisations. We are engaging voluntary sector organisations in work around the CAHO initiatives.

**Q34. There is no direct bus service from Oxford City Centre to the Churchill Hospital. This is a service that should be provided by the ORH Trust. For cancer patients who therefore have to walk into the Churchill from a distant stop in unacceptable. After chemotherapy, patient cannot walk back to the distant bus stop. Head and Neck services will be transferred from the JR to the Churchill in April 2011. Please provide a subsidised bus service PRIOR to that date.**

Thank you for your comment, this has been included in our report and the Oxford Radcliffe Hospitals NHS Trust is aware of the concerns raised.

**Q35. Have John Radcliffe Hospital thought of introducing the Enhanced Recovery Program (pioneered in Sweden) for surgery patients which considerably reduces patients’ stay in hospital? It is practiced in RBH FT with appropriate follow ups.**

Thank you for your comment. We are always interested in innovative evidence based techniques. This has been passed on to the Oxford Radcliffe Hospitals NHS Trust.

**Q36. What is happening to NHS Direct**

By 2013 the NHS Direct number will be replaced by a new free NHS 111 telephone number. People will be able to call 111 to get health advice and information about out-of-hours GPs, walk-in centres, emergency dentists and 24-hour chemists. NHS 111 is intended to work in an integrated way with local GPs, out-of-hours services, ambulance services and hospitals, for the benefit of patients and to help the NHS become more efficient.
NHS Direct will have an ongoing role, along with other providers, in helping to deliver the new NHS 111 Service and, in the interim, will continue providing local and national telephone and web-based services on behalf of its commissioners.

Q37. Please may I become a member of the Mental Health Foundation Trust? And how do I become a member?
To become a member of OBMH FT you can complete the online form http://www.obmh.nhs.uk/?page_id=45 or call the Membership Officer on 01865 782180 for further information. As a Member of the FT you can be involved in a number of Trust activities, apply to become a non-executive director and stand to become a Governor. The Trust Members’ Council represents the views of members and hold the Trust Board to account.

Q38. How will Julie Waldron ensure effective patient and public involvement in CHO services when OBMHT takes CHO over, and how will I, as a member of the public, be able to tell?
OBMH takes its commitment to public and patient involvement seriously and has a strong reputation for service user and carer involvement with a formalised structure and reporting process in place. There is a Trust wide Service User and Carer Involvement Group which gets involved in consultation on strategy, policy and service developments across the Trust. The Trust would look to roll out this model across the new organisation. There are a number of ways for patients to provide feedback and to be engaged with service developments. The Trust also ensures that its local communities are engaged in service developments through a range of activities including face to face and surveys. OBMH runs public events, you can find out more via http://www.obmh.nhs.uk/?page_id=319
You can also become a member of the Trust - http://www.obmh.nhs.uk/?page_id=45. You can also find out more through the Trust newsletter, the OBMH website, social networking sites or through speaking to members of staff.

Q39. If there's no decision about me without me, who decided that the flu/swine flu vaccine is combined, and will people also be offered for other vaccine?
The entire process of developing the seasonal flu vaccine is led, organised and overseen by the World Health Organization (WHO).

Each year, a vaccine is developed to protect against the strains of flu virus that are expected to be most prevalent that winter. This 'flu jab' is used not just in the UK, but throughout the Northern hemisphere. It gives good protection (70-80% reliability) against all strains of flu included in the vaccination and lasts for a year. This winter, the H1N1 strain of the flu virus is one of three strains of flu that the seasonal flu jab protects against. H1N1 is the same strain of flu behind last year's swine flu pandemic. The other two strains of flu this year's jab protects against are H3N2 and B.

It is important to realise that H1N1 is no different from other strains of flu as regards
the principles of creating a vaccine to protect against it. Its inclusion in this year’s seasonal flu jab poses no additional risk. It is included simply because it is one of the major flu strains circulating in Britain this winter. For more information about the way in which the seasonal flu vaccine is made and tested, see [NHS Choices web page about seasonal flu](https://www.nhs.org/)

**Q40.** If there will be reduction of support in the community for people with severe and enduring mental health issues, including supported housing, how will you care for people who become more ill?

**With the increase of unemployment how will you meet the increase in people needing mental health services?**

Our NHS services cost 8.4% of our GDP – more or less half of the USA and lower than Germany, France and Scandinavia. So why are we accepting that we have to cut?

The changes taking place in Oxfordshire mental health services were implemented to ensure clearer recovery outcomes for people with severe and enduring mental health issues and our commissioning strategy (Better Mental Health in Oxfordshire) is to improve the pathway for this group of people. To find out more about Better Mental Health in Oxfordshire, [visit our “Talking Health” website](https://www.talkinghealth.org/).

Implementation plans to deliver this are underway. We have recently completed a tendering process for the accommodation and housing pathway which, when implemented, will be the most efficient use of resources.

This strategy has gained national recognition in a time when there are reducing resources. Despite the national increase in unemployment our local board target for the % of people (aged 18 to 69) who are on CPA receiving secondary mental health services in paid employment has been reduced, added to this the IAPT target set has also been surpassed by 200%. We continue to commit resources (recently increased) as it is well evidenced that this has a significant positive impact on people’s mental health.