



Outcomes not Targets Consultation

Delivering Some of the Best Health in Europe

Joint response from the Association of British Dispensing Opticians, the Association of Optometrists and the Federation of Ophthalmic & Dispensing Opticians.

Introduction

Together ABDO, AOP and FODO represent over 10,000 optometrists, over 5,000 dispensing opticians and optical businesses in the UK who provide high quality and accessible eye care services to the whole population.

We support the move away from a centrally-led system of targets to measuring health outcomes.

As healthcare professionals delivering high quality eye care services to all age groups we believe that patients want accessible eye care, at a time and location that is convenient to them. For many eye conditions early detection and early treatment is crucial to minimise sight loss. Levels of avoidable blindness in the UK are currently at third world levels, and according to statistics from the RNIB a staggering 70% of blindness could have been prevented. Measuring outcomes such as reducing avoidable sight loss, improved quality of life for those with correctable eye problems, and reducing uncorrected refractive error amongst children will make a dramatic difference to the eye health of the nation.

6.1 Questions:

6.1.1 Removal of process targets

1. Do you support the phased removal of process targets and the move to a system of clinical and patient reported outcomes?
2. Do you consider central targets to have distorted priorities in the delivery of care services?

Yes, whilst targets for some services such as for the treatment of cataracts has been a success in reducing waiting times, targets should not exist at the expense of clinical priorities. For example early treatment of age related macular degeneration is vital to limit a patient's sight loss and cannot be restored if treatment is delayed. Therefore, with the current system there is the potential for some patients to have treatment delayed in favour of patients who have conditions which do have targets. We therefore would support a phased move to the removal of process targets and a move to a system of clinical and patient reported outcomes.

3. Which targets should we aim to remove as a matter of priority?
4. Are there important clinical areas that have been neglected as a result of central concentration on certain objectives?

Yes a commitment to eliminating avoidable blindness in the UK. The Government are signatories to the WHO Vision 2020 aim of eliminating preventable blindness by 2020, but here in the UK we have levels of avoidable blindness which an advanced country should be ashamed of. The UK Vision Strategy, published in April 2008,¹ sets out a framework for improving eye care services in the UK over the next five years. A key aim of the strategy is to improve the eye health of the nation through better education and awareness campaigns. This can be delivered through a nationwide public health campaign explaining the health benefits of regular eye tests, the availability of NHS eye care services and financial help through the NHS voucher scheme.

For too long eye care has taken a very low place in NHS and public health priorities. It is shocking that 70% of blindness in the UK could be prevented, when there is a cost-effective, easily accessible solution to stop this. Preventing low vision and blindness through regular eye tests for all will make significant long term cost savings for the NHS and social services. Regular eye examinations at key stages of a person's life would reduce the high levels of avoidable sight loss and improve the eye health of the nation. The lack of vision screening in schools and pre-school testing across the UK is a great cause of concern. The eyes are still developing until the age of 7 so if problems are picked up and treated early it can make a difference that lasts a lifetime.

5. Are there process measures that are currently fulfilling a purpose towards an aligned care pathway or that support a clinical outcome which should be retained?

6.1.2 Introduction of outcomes

6. Do you support the principles we have identified for the development of an outcome framework?

7. Do you agree that some data, e.g. referral-to-treatment times, should continue to be collected, but not have national targets applied to them?

Yes. We would like to see optometry and the outcomes we have identified to be included in an outcome framework. We would be happy to see the effectiveness of community eye care measured by clinical outcomes, patient satisfaction and measurable prevention of blindness. The Welsh Eye Care Initiatives have been assessed against outcome criteria and have been shown to be popular with patients, good value for the taxpayer and to have excellent clinical outcomes.²

Early treatment is vital for many eye conditions such as glaucoma and age-related macular degeneration. Therefore we agree that referral to treatment times are useful data especially when taken into consideration with measuring outcomes such as preventing blindness.

6.1.3 Types of outcomes

8. Do you support the use of patient reported outcome measures in elective treatment?

Yes – as indicated above.

9. Do you support the use of long term condition chronic disease scores for the longitudinal measurement of an individual's health status and the quality of care pathways or services?

¹ www.vision2020.org.uk

² Evaluation of the Primary Eyecare Acute Referral Scheme (PEARS) and the Welsh Eye Health Examination (WEHE), Cardiff University, Commissioned by the Welsh Assembly Government, 2008. The full evaluation report is available here; <http://www.wales.nhs.uk/sites3/news.cfm?orgid=562&contentid=9455>

10. Do you support the introduction of independently-sampled patient experience and outcome scores to rate the accessibility, responsiveness and quality of care provision; do you have views about existing patient-reported outcome measures and their suitability for national implementation?

We support the proposal in paragraph 4.1.5 to ensure that PCTs commission independent samples to gauge patient satisfaction with a range of healthcare services.

It is all too easy, even when it is dressed up as patient choice, to design services to suit the provider not the patient. Otherwise, more account would be taken of the convenience of community locations for eye care provision. For patients there are advantages in High Street locations, shopping Malls or secondary shopping areas as well as supermarkets. Patients are able to choose from a range of providers either close to where they work or live. This reduces the need for lengthy travel journeys, reduces the need to time off work or care for their families.

We support the introduction of measuring outcomes such as quality of care. Highly trained optometrists and dispensing opticians deliver high quality care to both private and NHS patients. Arguments against the use of community locations for eye care services such the monitoring of low risk glaucoma patients, on quality grounds are misguided attempts to prevent routine work being moved to the community. This often results in overstretched hospital eye clinics cancelling routine appointments for patients with clinically stable glaucoma. In some areas of the UK shared care schemes involving optometrists have been set up successfully. Community eye care schemes are cost-effective, provide high quality care, are easily accessible for patients, especially for many vulnerable patients who are unable to travel long distances, and provide a good patient experience.

We hope that the introduction of measurable outcomes that we have outlined above, will provide substantive data to support the need for more enhanced eye care services to be provided in the community and remove the vast regional variances of the availability of these services in the UK.

11. Do you support the specific outcome measures we have suggested to introduce at first, and would you recommend others?

6.1.4 Implementation

12. What are the main logistical barriers to the widespread collation of outcomes based information? How do we best sample, collect and validate patient reported outcome measures?

13. Are there hidden costs, benefits or pressures built in to the system which will aid or hinder the implementation of outcome measurements?

14. Do you support the publication of a wide range of anonymised aggregated outcome data to facilitate patient choice? Should we licence third parties to present this data to specific patient groups?

6.1.5 Alignment

15. Our stated objective is to ensure aligned objectives within a national health system. How do we ensure outcomes meet this objective across traditional boundaries of health and social care?

16. We also envisage movement towards more integrated pathways with total packages by episode treatment group for elective procedures and chronic diseases. What further development is required to identify outcomes to measure both episodic and longitudinal episodes of care?