Response to Refreshing the NHS Outcomes Framework 2015/16 August 2014

The Optical Confederation represents the 12,000 optometrists, 6,000 dispensing opticians, 7,000 optical businesses and 45,000 ancillary staff in the UK, who provide high quality and accessible eye care services to the whole population. The Confederation is a coalition of five optical representative bodies: the Association of British Dispensing Opticians (ABDO), the Association of Contact Lens Manufacturers (ACLM), the Association of Optometrists (AOP), the Federation of Manufacturing Opticians (FMO) and the Federation of (Ophthalmic and Dispensing) Opticians (FODO). As a Confederation we work with others to improve eye health for the public good.

Question 1: *What are your views on the effectiveness of using outcomes measures to drive improvement in the health and care system?*

A1. They are absolutely essential – what gets measured is what gets done. However for this very reason it is important to ensure that the right things are measured.

Question 2: *Do you agree with the proposed approach to refreshing the Outcomes Framework?*

A2. Yes. But, as we pointed out before the outcomes framework was established five years ago, the five domains leave one serious omission: preventing illness and keeping people healthy. We are disappointed that there is no proposal in this document to correct this omission.

Prevention is what much of the NHS does, in particular in primary care. Some of Primary Care is about Domain 1 (preventing people from dying prematurely) and Domain 3 (Helping people to recover from episodes of ill-health or following injury), but a lot of it is not, for example oral health, community hearing services and community Eye Health Services. For these services the aim is to help people stay well throughout their life, rather than helping them recover from illness or to prevent them dying prematurely.

The omission of prevention from the framework overlooks and essentially de-prioritises the essential services that keep people functioning in their daily lives, in work and in society.

Question 3: *What are you views on assessing NHS England's progress against the NHS Outcomes Framework?*

A3. The process is appropriate in so far as it goes, but, as described in answer 2, omits much of health care which has great benefit for individual and population health and well-being.

We welcome therefore the recognition that the outcomes frameworks for the NHS,public health and social care are "inter-related" and that they need to be "aligned effectively".

However, this has certainly not been the case for the past five years and there is nothing in paragraphs 9 – 13 which gives reassurance that the NHS will in the foreseeable future (ie in the next five years) recognise and play its full part in delivering the other outcomes frameworks – and be held account for doing so – as a result of this review.

Question 4: *Do you agree with the Department's proposal to measure mortality in people with both common and serious mental illness in the NHS Outcomes Framework?*

A4. Yes – This is important. It is also important to recognise the impacts that sensory impairment - eg visual impairment and hearing impairment – can have on both common and serious mental health, particularly in the elderly: it can lead to isolation, loneliness and social exclusion.

Question 5: *What are your views on our proposal to reflect quality of life for people with mental health problems in the NHS Outcomes Framework?*

A5. We agree.

Question 6: *What are your views on the importance of recovery of quality of life for those with mental illness?*

A6. This is crucial. There is little point in being "cured" and then experiencing low quality of life if this too can be ameliorated.

Question 7: *Do you agree with the long term direction regarding mental health indicators within the NHS Outcomes Framework?*

A7. Yes.

Question 11: *Do you agree with the long term direction that the Department of Health is taking regarding indicators for children and young people in the Outcomes Framework?*

A11. Yes. However, despite the NHS England's intention to move from a sickness service to a health service, and despite clear recommendations from the National Screening Committee, it is remains the case that paediatric screening for amblyopia is not universally carried out to ensure children can have problems remedied and maximise their potential through education and contribution to society.

We would like to see the NHS and Clinical Commissioning Groups deploying their influencing role through Health & Well-being Boards and local authorities to ensure that effective screening is in place for all children at start of school age.

Question 12: *What are your views on our selection criteria for inequalities indicators in paragraph 47?*

A12 We are concerned at the suggestion that the selection critieria should "reflect areas of particular policy interest". There should be no possibility of inequality indicators being selected at the whim of a particular minister or senior official, or lobbying group. If an area has been defined as an area of major inequality, for whatever reason, and the NHS could make a significant difference, it will already have been reflected in the first two criteria. We question whether this additional catch-all is of anything other than political value and therefore whether it is appropriate.

Question 13: *What views do you have on how we are applying these criteria to identify inequalities indicators?*

A13. We agree.

Question 14: *What are your views on the most effective ways of assessing inequalities in healthcare?*

A14. It is important to ask patients and "seldom held" groups directly.

Question 15: *Do you agree with the Government's long term view on improving how we measure outcomes for inequalities and marginalised groups?*

A15. Yes.

Question 17: *What are your views on highlighting negative experiences of care for patients rather than only focussing on positive ones?*

A17. It is clearly important to learn from both positive experiences and negative experiences. It is also essential not to simply highlight the positive or expose the negative, but to learn from them.

However, the way in which patients are asked to provide this information will need to be framed carefully, to ensure that genuinely negative experiences are identified, rather than patients feeling under pressure to provide an example and simply – in their keenness to co-operate – identifying one particular aspect of care which was less good than the others. This would give a skewed picture of the outcomes of care.

In order to develop an understanding of both positive and negative experiences we suggest piloting this approach in a number of clinical areas to see how effective or useful this approach is.

Question 18: *Do you agree on the Department's plans for the long term direction for improving patient experience?*

A18. Yes.

Question 19: *What are your views on more effective methods to assess patient safety other than incident reporting?*

A19. We recognise the problems which the journal of Public Health Research identified in December 2013. It is however very difficult to measure patients' safety other than through near misses, never events and incident reporting. We look forward to continuing to engage in this debate as NHS England develops its thinking. Inspection and tick-box systems are probably not the answer and, to be effective, would be unaffordable for the NHS in any case.

Question 20: *What are your views on the importance of hip fractures during hospital care as a measure for patient safety in the NHS Outcomes Framework?*

A20. We agree.

Question 21: *Do you agree on the Department's plans for the long term direction in terms of improving patient safety?*

A21. Yes.

Question 22: *What views do you have on the removal of indicators if their data is deemed to be inaccurate or unreliable?*

Q22. In principle we agree that this is the right approach. However it is important not to use this as a reason to omit "difficult indicators": it may be important to first question why in some cases data is inaccurate or unreliable, and to revise the indicator or how the data is collected. We therefore welcome the Department's proposal to "replace them as soon as a suitable place holder is identified."

Question 23: *Do you agree with the current indicator inclusion criteria*

A23. Yes.

Question 25: *Do you agree with the Government's plans to work towards further alignment between the Outcomes Frameworks?*

A25. Yes – this is very important.

As we said in answer to Question 3, we welcome the recognition that the outcomes frameworks for the NHS, public health and social care are "inter-related" and that they need to be "aligned effectively".

However, we do not necessarily agree with the statement (paragraph 57) that "these other frameworks reflect the different delivery systems on account of early models for a public health adult social care". The three frameworks are inter-connected and in our view "different delivery systems and accountability models" has been used as a smoke-screen for the NHS to duck its responsibilities in these areas. Greater clarity about how the NHS should contribute – even if it is only using influence – to these other indicator frameworks will be a very important step forward in improving health and social care outcomes.

Question 26: *What views do you have on alignment between Outcomes Frameworks?*

A.26. There needs to be much more clarity about this. It needs to be made explicit that the NHS Outcomes Framework does not include all indicators that NHS England and CCGs have to be accountable for: All three outcomes frameworks, taken together, do.

Question 27: *What are the biggest issues regarding accessibility to NHS Outcomes Framework data?*

Question 28: *What is your opinion on how the NHS Outcomes Framework can be made more accessible and available to all?*

A27-28. Two truisms all too often apply to outcomes measurement: "what gets measured gets done" but also "what can be easily measured isn't always what matters". It is therefore essential to consider what matters and how data in relation to what matters can be easily accessed.

A significant amount of care is provided to people which should be taken into account in the Outcomes Framework but is not at present, especially all the preventative care which does not follow illness or injury or necessarily prevent people dying prematurely. Sensory impairment is just one glaring example of where effective community and NHS intervention pays dividends in terms of wider NHS outcomes, health, well-being, social inclusion and independence.

It is imperative therefore to clarify NHS commissioners' roles in respect of delivery of the two other outcome frameworks (public health and social care), as well as the NHS Outcomes frameworks.

Finally, the issue is not so much one of accessibility but of follow-up and ensuring that action is taken and that people in positions to influence change are held to account for doing so.

September 2014