NHS Eyecare Services Programme

Recommended Standards for Low Vision Services

Outcomes from the Low Vision Working Group, Commissioned by Dept of Health

Facilitated by the NHS Eyecare Services Programme in partnership with RNIB

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Recommended Standards for Low Vision Services

A Low Vision Service is a rehabilitative or habilitative process which provides a range of services for people with low vision to enable them to make best use of their eyesight and visual function to achieve maximum potential.

Design principles

1. Low Vision Services should reflect a multi-disciplinary, multi-agency approach that co-ordinates with other health, social care and voluntary providers in the area, including services provided at the client's residence, school or other appropriate location. This methodology ensures efficient and professional delivery of services.

2. The services delivered should be based upon needs identified by clients and/or carers and be sufficiently flexible to meet the disparate needs of its client group, including those with additional disabilities, for example, learning disabilities. There should be evidence of user participation in agreements on the setting up and implementation of pathways and protocols.

3. Registration as sight impaired or severely sight impaired should not be a pre-requisite to accessing low vision services.

4. Locally designed guidelines, pathways and protocols should be underpinned, whenever possible, by evidence based knowledge and accepted guidance. This should conform with and contribute to local governance arrangements for health and social care.

5. Timescales should be agreed and monitored, by relevant parties.
   - Each part of the process should be subject to an appropriate booking procedure.
   - The client should be advised of current waiting times along with highlighted 'not later than' times/dates (e.g. We will contact you no later than: day/ month/year). Contact should ideally be made within 10 working days.

   Note: Local commissioners and service providers will need to identify acceptable timescales for each stage of the

protocol/care pathway. Timescales recommended Standard 8.5 Progress in sight – National standards of social care for visually impaired adults. ADSS Oct 2002 are for clients to be seen within 10 working days of referral or receiving their CVI, RVI or LVL.

- A client's low vision needs should be reviewed as appropriate. Regular eye examinations should also be recommended.

Local arrangements should be drawn up; but the following is an example of what clients may require:

Initial action upon referral to Low Vision Services:

- Provided with information regarding and description of the service, outline of the processes involved, and what is likely to happen.
- Access to help, advice, support line, ensuring appropriate formats and languages used (Note: This could be access to a national or local service).
- Details of current waiting times (Note: How long will I be expected to wait before I can be assessed?)
- Booking of appointments at each stage of the process. Clients should be informed of likely duration of each stage of the assessment process.
- Access to counselling (Note: it may be appropriate for a client to access counselling or help line services urgently to help relieve their fears or to help them come to terms with sight loss. In some instances it may be appropriate for this to be in advance of the low vision assessment).
- Provision of a single contact point for information on all aspects of the service, irrespective of where a client may be on the care pathway.

Referral, assessment and service

6. Referral to low vision services should be open to any health or care professional based upon locally developed guidance. This should also include self-referral and subsequent requests for review.

   The guidance should be devised with input from local professionals including ophthalmologists, optometrists,

dispensing opticians, orthoptists, occupational therapists, general practitioners, rehabilitation workers, social services, voluntary services, potential users and others.

7. Clients should be able to access the service irrespective of the degree of sight loss or reduction in vision, as early as possible to minimise negative impact on quality of life. The definition of a person with low vision is one who has an impairment of visual function for whom full remediation is not possible by conventional spectacles, contact lenses, medical or surgical intervention and which causes restriction in that person's everyday life. The perception of what constitutes a restriction in a person's everyday life will vary between individuals. It is therefore unwise to define strict limits to access the service based upon clinical or social criteria.

8. It is essential that there is a diagnosis of the associated eye and/or systemic condition(s). Practitioners should ensure that all appropriate medical interventions are being or have been employed; and patients must be given appropriate and understandable information regarding the importance of a medical eye examination, as well as their particular condition. Diagnosis can occur either prior to or simultaneous to accessing the low vision service, without impact on access to service.
   Clients may refuse to be referred to another professional at any stage of the process, even if informed it is in their best interests. If this situation arises, the records should be documented accordingly and the client informed that they could still proceed with referral at a later date.

9. There should be a tailored low vision assessment for each client following referral
   - At the point of initial contact with LV services an appropriate comprehensive range of services available should be discussed or highlighted, using appropriate methods. The client should then discuss whether they wish to be considered for all of them or be allowed to choose to access those that they feel are appropriate. If a service is declined at any stage, this should not preclude the client from being offered and/or accepting it at a later stage.
   - Once a client has been referred, a full assessment of their needs should be undertaken by means of an appropriate

comprehensive Low Vision service. Following this assessment a care and delivery plan can be agreed with the client. Following the initial assessment it will be necessary to review the range of services to consider appropriateness and whether other services might be indicated.

The exact content of the low vision assessment should be subject to local agreement/protocols and to include all aspects of a client's needs relating to health and social care, as appropriate.

10. A Low Vision Assessment should always offer:
    - An eye health examination, or evidence of recent examination or referral for examination according to local protocols. (see Appendix 1)
    - A functional visual assessment (see Appendix 2).

11. The following should be offered, as appropriate to the user, following assessment:
    - Prescription/provision of appropriate optical/non-optical aids. The sale and supply of some low vision aids is restricted to certain professionals (*see Appendix 3) or requires appropriate supervision. The supply/loan of aids should be governed by local protocol.
    - Advice on lighting, contrast and size, filters, tactile aids, electronic aids and other non-optical aids (see Appendix 4).
    - Training and/or therapy to enable optical and non-optical aids and other techniques to be used effectively.
    - Links to broader rehabilitation services, such as home assessment and mobility as well as possible referral to structured therapy programmes, counselling, education and employment services.
    - A review of benefits, welfare rights, concessions, support groups, (both local and national). (See Appendix 5)

Information

12. Information should be provided in a format that is appropriate to the need of each client. The information should enable clients to make informed decisions about their care.

Note: Standard 7 ‘Progress in Sight – National Care Standards of social care for visually impaired adults’. ADSS Oct 2002 highlights the need to present information in a variety of formats including the recommendation that written material should be presented in a clear typeface with a minimum 14 point font size.

13. Information should be communicated to other professionals involved in client care e.g. GP, Care Assistant, District Nurse, family, Carers, educational establishment and referral source with appropriate prior consent from the client. Information should be in an accessible format for all individuals.

14. All professionals interacting with a client within a Low Vision Service should use a health/care record, which can be shared, with appropriate prior consent from the client.

Service improvement, monitoring and evaluation of the service

15. Local commissioners will wish to ensure that service improvement, modernisation techniques and learning from related areas are considered, implemented and evaluated. It is also important to have in place appropriate measures and recording systems to identify the current position, have on-going information about number of persons referred and treated, client demographics, inter-professional communications as well as provision of data to allow evaluation of the service. Some of this information will already be collated by the Commissioning Organisation but in some cases more detailed audits may be necessary. Service User opinions should be sought.

16. Local commissioners should ideally be working towards producing an evidence based concise annual report on the service, which should be available in the public domain.

Training

17. All persons who wish to participate in the delivery of the service should be suitably trained or undergo a training programme agreed locally as part of the protocol, leading to

accreditation to participate in the scheme. The training programme should be designed to meet the needs of the local service, and to ensure quality and a seamless service between health and social care. It should also include knowledge of working with people who have learning, communication and multiple disabilities.

A mechanism for ongoing accreditation should be built into the training programme. Training programmes should reflect lessons learnt from monitoring and evaluation.

Training should be of a multi-disciplinary nature, ensuring all persons involved understand the different and related roles. This increases useful communication and mutual understanding of all groups. This will enhance the integrated service and ensures clients receive efficient care at all stages.

18. It is good practice for commissioners to ensure that all personnel involved in the service with sole access to clients should have an appropriate check carried out by the Criminal Records Bureau. This is particularly important when dealing with vulnerable groups.

Communication

19. The client should expect that information relating to the health or welfare of any client should be respected and remain confidential between personnel within the service, unless disclosure is specifically permitted by the client or is required by law.

Appendix 1

Recommendations for Eye Health Examination

The Eye Health Examination may be completed by more than one professional, as appropriate, in line with clinical duties.

The examination should be tailored for each client, at the judgement of the ophthalmologist or relevant professional.

If an optometrist or doctor undertakes a sight test they are legally required under the Sight Testing (Examination and Prescription) (No.2) Regulations 1989 (SI 1999/1230) to perform, for the purpose of detecting signs of injury, disease or abnormality in the eye or elsewhere:

- an examination of the external surface of the eye and its immediate vicinity
- an examination of the inside of the eye
- additional examinations as appear to the doctor or optometrist to be clinically necessary.

The optometrist or doctor is legally required to give patients a statement informing them of the outcome of the sight test, whether or not they are to be referred, any prescription for spectacles and whether or not a change of spectacles is required.

GOS sight tests are undertaken by optometrists and ophthalmic medical practitioners contracted to do so by the PCT. Sight tests may be provided at opticians' premises or at the home of a client if the client is unable to leave home unattended because of mental or physical disability.

The exact format and content of the sight test will be determined by both the practitioner's professional judgement and the legal requirements, and may therefore consist of assessments such as:

- External Eye (Anterior Eye and Adnexa) Examination
- Internal/Posterior Eye Examination with mydriasis if necessary
- Pupil Reactions
- Refraction and Prescription
- Vision and Visual Acuities
- Accommodation

- Tonometry
- Visual Field Assessment if relevant using appropriate strategy
- Ocular Motor Balance
- Ocular Motility
- Convergence
- Diagnosis
- Registration [1] (sight impaired / severely sight impaired) if applicable

[1] Registration can only be completed by a Consultant Ophthalmologist

Appendix 2

Functional Visual Assessment

- Review of Needs
  History
  - Visual
  - Ocular
  - Medical
  - Social
  - Duration
  - Other Disability (Physical/Mental)

  Symptoms
  - Visual
  - Ocular
  - Medical
  - Social

  Current situation
  - Aids
  - Support
  - Treatment

  Assessment of needs/goal setting
  - Distance
  - Near
  - Mobility
  - Daily Living Skills
  - Other
- Distance vision
- Intermediate vision and/or other relevant working distances if appropriate
- Near vision
- Retinoscopy if appropriate
- Distance refraction or verification of distance prescription
- Distance visual acuity using LogMAR chart
- Contrast sensitivity
- Colour vision if appropriate
- Central visual function if appropriate (Amsler)
- Assessment of glare function
- Accommodation if relevant
- Near refraction or verification of near prescription
- Near/reading visual acuity

- Establishing magnification
- Low vision aids assessment, and dispensing
- Training in use of aids
- Visual field assessment if relevant
- Advice and referral if necessary

Appendix 3

Personnel Involved in Low Vision Services

- Carers
- Dispensing Opticians [1]
- General Practitioners [1]
- Occupational Therapists
- Ophthalmic Nurses
- Ophthalmologists [1]
- Optometrists [1]
- Orthoptists
- Rehabilitation Workers/Officers
- Social Workers
- Voluntary Workers

[1] The supply of certain appliances is restricted to these professionals, including spectacles and spectacle-mounted aids.

Appendix 4

Suggested List of Low Vision Aids and Independent Living Aids

Local arrangements will determine if the items are available or suitable information provided as an alternative.

These may include:

- Appropriate Range Spectacle Magnifiers
- Appropriate Range Hand Magnifiers (illuminated / non-illuminated)
- Appropriate Range Stand Magnifiers (illuminated / non-illuminated)
- Appropriate Range Telescopes (Spectacle/hand/binoculars)
- Appropriate Range Other Magnifiers (e.g. Chest)
- Appropriate Range Clip-on Loupes
- Appropriate Range Flat Field Magnifiers and Bar Magnifiers
- Magnifier Clamps
- CCTV Devices and other Electronic Aids
- Filters, sunglasses, overshields (with and without prescription)
- Bookstand and Clipboards
- Braille sample
- Bump-ons, selection tactile indicators
- Canes, sample
- Chopping boards, selection colours
- Clocks, watches
- Coin store
- Cutlery, large handle, selection
- Drinking Glasses, mugs – different colours
- Games e.g. Bingo card holder, cards, cups, dice, large raised dots
- Gardening implement set, large handle
- Jar opener, rubber grip
- Large Print Items, bills, books, diaries etc
- Lighting, full range including task lighting
- Liquid Level Indicators
- Mats – coloured rubber, coloured
- Medicine boxes/bottles, selection
- Newspapers, including large print, talking

- Out and about aids, taxi, help card
- Pad, black ruled
- Pens, black, thick felt tip, also selection of colours
- Scissors, coloured, large handle
- Stickers e.g. large arrow
- Talking Books
- Talking items- watch, calendar etc
- Typoscopes

NB: A client may require more than one appliance.

Appendix 5

List of benefits and services at the time of publication, January 2007

Benefit or Assistance	Severely sight impaired	Sight impaired
Pension Credit, Housing Benefit, Council Tax Benefit	Based on income	Based on income
Additional Income Support	Yes	Yes
Additional Pension Credit	Yes	Yes
Blind Persons Personal Income Tax Allowance	Y	N/A
Disability Living Allowance (64 and under)	Yes	Yes
Attendance Allowance (65 and over)	Yes	Yes
Additional Housing Benefit or Council tax Benefit	Yes	Possible
Exemption from non dependants deduction from IS	Yes	Possible
Council Tax reduction	Yes	Yes
Incapacity Benefit	Yes	Yes
Working Tax Credit	Yes	Yes
Financial help towards Residential/Nursing home fees	Possible	Possible
Community Care Services/ Local Council Assistance	Yes	Yes
NHS Sight Test	Yes	Yes
NHS Prescription	Possible	Possible

Television Licence Reduction	Yes	N/A
Car Parking Blue Badge Scheme	Yes	Possible
Access to Work Equipment	Yes	Yes
Articles for the Blind Postage	Yes	Yes
Railcard	Yes	Yes
Local Travel Concessions	Possible	Possible
Free Directory Enquires	Yes	Yes
British Wireless for the Blind	Yes	N/A
Telephone Installation Charge and Line Rental	Yes	N/A
Low Vision Assessment	Possible	Possible
Low Vision Aids	Possible	Possible
RNIB Talking Books	Yes	Yes
Big Print Newspaper	Yes	Yes
Calibre	Yes	Yes
Postal Lending Library	Yes	Yes
Talking Newspapers Association UK	Yes	Yes
Local Talking Newspapers	Yes	Yes
Talk and Support	Yes	Yes

NB: Possible indicates may be available according to individual circumstance and/or local arrangements.

Further reading

ADSS, October 2002. **Progress in Sight – National Care Standards of social care for visually impaired adults.**

Association of Optometrists, 2002. **Low Vision Co-Management**, Available from: www.assoc-optometrists.org

Barry, R.J., Murray, P.I., 2005. Unregistered visual impairment: is registration a failing system? **British Journal of Ophthalmology**, 89, 995-998.

Better Regulation Task Force, September 2000. **Protecting vulnerable people**. Available from: http://www.brc.gov.uk

Boerner, K., Reinhardt, J.P., Horowitz, A., 2006. The effect of rehabilitation service use on coping patterns over time among older adults with age-related vision loss. **Clinical Rehabilitation**, 20, 478-487.

Casten, R.J., Maloney, E.K., Rovner, B.W., 2005. Knowledge and use of Low vision services among persons with ARMD. **Journal of Visual Impairment and Blindness**, 99,11.

The College of Optometrists, 2001. **Framework for a Multidisciplinary Approach to Low vision.**

Collins, J., Skilton, K., 2004. Low vision services in South Devon: a multi-agency, multi-disciplinary approach. **Ophthalmic and Physiological Optics**, 24, 355–359.

Criminal Records Bureau: http://www.crb.org.uk/

Culham, L., Ryan, B., Jackson, A.J., Hill, A.R., Jones, B., Miles, C.,Young, J.A., Bunce, C., Bird, A.C., 2002. Low vision services for vision rehabilitation in the UK. **British Journal of Ophthalmology**, 86, 743-747.

Current Low Vision Practice 2002, Low Vision Services Implementation Group

Department of Health. **Better Health in Old Age**

Department of Health, April 2004. **First Report of the National Eye Steering Group**

Department of Health, 2001. **NSF Older People, Executive Summary**.

Evans, B.J.W., Rowlands, G., 2004. Correctable visual impairment in older people: a major unmet need. **Ophthalmic and Physiological Optics**, 24, 161–180.

Fletcher, D.C., Shindell, S., Hindman, T., Schaffrath, M., 1991. Low vision rehabilitation - Finding capable people behind damaged eyeballs. Rehabilitation Medicine - Adding Life to Years. **West. J. Med**, 154, 554-556.

Harper R., Doorduyn K., Reeves B., Slater L., 1999. Evaluating the outcomes of Low Vision Rehabilitation. **Ophthalmic and Physiological Optics**, 19, 3-11.

Haymes, S.A., Johnston, A.W., Heyes, A.D., 2002. Relationship between vision impairment and ability to perform activities of daily living. **Ophthalmic and Physiological Optics**, 22, 79–91.

Hinds, A., Sinclair, A., Park, J., Suttie, A., Paterson, H., Macdonald, M., November 2003. Impact of an interdisciplinary low vision service on the quality of life of low vision patients. **British Journal of Ophthalmology,** 87 (11), 1391-1396.

Gohdes D.M., Balamurugan A., Larsen B.A., Maylahn C., July 2005. Age-related eye diseases: an emerging challenge for public health professionals. **Preventing Chronic Disease** [serial online] Available from:
http://www.cdc.gov/PCD/issues/2005/jul/04_0121.htm

Lindsay, J., Bickerstaff, D., McGlade, A., Toner, A., Jackson, A.J., 2004. Low vision service delivery: an audit of newly developed outreach clinics in Northern Ireland. **Ophthalmic and Physiological Optics**, 24, 360–368.

Lomas, G.M., 1998. **Low Vision in the UK. Toward a framework for delivering Low Vision care.** The Partially Sighted Society

Low Vision Services Consensus Group, 1999. **Low Vision Services Recommendations for future service delivery in the UK**. Available from: http://www.lowvision.org.uk/publications.html

Margrain, T.H., Ryan, B., Wild, J.M., 2005. A revolution in Welsh low vision service provision. **British Journal of Ophthalmology,** 89, 933-934.

National Patient Safety Agency (NPSA), 2005. **Seven Steps to Patient Safety.** Available from: www.npsa.nhs.uk/health/resources/7steps

Pollard, T.L., Simpson, J.A., Lamoureus, E.L., Keeffee, J.E., 2003. Barriers to accessing low vision services. **Ophthalmic and Physiological Optics**, 23, 321–327.

Reeves, B.C., Harper, R.A., Russell, W.B., 2004. Enhanced low vision rehabilitation for people with age related macular degeneration: a randomised controlled trial. **British Journal of Ophthalmology,** 88, 1443-1449.

Roberson, G., 2006. Quality and Effectiveness in Referral letters. **Optometry in Practice,** 7, 83-87.

Rudduck, G., Corcoran, H., Davies, K., 2004. Developing an Integrated paediatric low vision service. **Ophthalmic and Physiological Optics**, 24, 323–326.

Russell, W., Harper, R., Reeves, B., Waterman, H., Henson, D., McLeod, D., 2001. Randomised controlled trial of an integrated versus an optometric low vision rehabilitation service for patients with age related macular degeneration: study design and methodology. **Ophthalmic and Physiological Optics,** 21, 36-44.

Ryan, B., Culham., 1999. **Fragmented Vision; Survey of low vision services in the UK**. London: Royal National Institute of the Blind.

Ryan, B.M., McCloughan, L., 1999. **Our better vision. What people need from low vision services in the UK**. London: Royal National Institute of the Blind.

Sinclair, A., Hinds, A., Sanders, R., 2004. Ten years of glaucoma blindness in Fife 1990–99 and the implications for ophthalmology, optometry and rehabilitation services. **Ophthalmic and Physiological Optics**, 24, 313–318.

Social Services Inspectorate, 1998. **A sharper focus: Inspection of services for adults who are visually impaired or blind**. UK

Stelmack, J., 2001. Quality of Life of Low-Vision Patients and Outcomes of Low-Vision Rehabilitation. **Optom. Vis. Sci**, 78, 335–342.

Welsh Low Vision Scheme Service Manual, May 2004. Available from: www.assoc-optometrists.org

Wolffsohn JS, Cochrane AL., December 2000. Design of the low vision quality-of-life questionnaire (LVQOL) and measuring the outcome of low-vision rehabilitation. **American Journal of Ophthalmology** 130 (6), 793-802.