Image shows a collage of four photos. Top left photo shows an eye test chart. Top right shows a man and a woman at an outdoor table looking at a portable digital magnifier. Bottom right photo shows a woman zooming into some text on a mobile device which says news. Bottom left image shows a woman using a dome magnifier on a near vision test chart. 

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# Adult Low Vision Service Quality Framework

# Good Practice Guidelines 2024

## 

## Contents

[Introduction 7](#_Toc160814989)

[Section 1 – Environment 9](#_Toc160814990)

[Content overview 9](#_Toc160814991)

[1.1 Service location 10](#_Toc160814992)

[Useful links 1.1 13](#_Toc160814993)

[1.2 Buildings and facilities 14](#_Toc160814994)

[Useful links 1.2 20](#_Toc160814995)

[1.3 Lighting and glare 21](#_Toc160814996)

[Useful links 1.3 22](#_Toc160814997)

[1.4 Confidentiality 23](#_Toc160814998)

[Useful links 1.4 24](#_Toc160814999)

[1.5 Awareness of the service 25](#_Toc160815000)

[Useful links 1.5 27](#_Toc160815001)

[Section 2 – Staff and staff training 28](#_Toc160815002)

[Overview 28](#_Toc160815003)

[2.1 Additional qualifications 29](#_Toc160815004)

[Useful links 2.1 31](#_Toc160815005)

[2.2 Ongoing training 33](#_Toc160815006)

[Useful links 2.2 36](#_Toc160815007)

[2.3 Sight loss awareness 37](#_Toc160815008)

[Useful links 2.3 38](#_Toc160815009)

[2.4 Criminal records check 39](#_Toc160815010)

[Useful links 2.4 40](#_Toc160815011)

[2.5 Business continuity planning 41](#_Toc160815012)

[Useful links 2.5 42](#_Toc160815013)

[Section 3 – Accessing the service 43](#_Toc160815014)

[Overview 43](#_Toc160815015)

[3.1 Referring and self-referral 44](#_Toc160815016)

[Useful links 3.1 46](#_Toc160815017)

[3.2 Who can access the service 47](#_Toc160815018)

[Useful links 3.2 48](#_Toc160815019)

[3.3 Booking appointments 48](#_Toc160815020)

[Useful links 3.3 51](#_Toc160815021)

[3.4 Eligibility for NHS services 51](#_Toc160815022)

[Useful links 3.4 52](#_Toc160815023)

[3.5 Patients with additional needs 53](#_Toc160815024)

[Useful links 3.5 56](#_Toc160815025)

[3.6 Contacting the service 58](#_Toc160815026)

[3.7 Communication 59](#_Toc160815027)

[Useful links 3.7 60](#_Toc160815028)

[3.8 Telemedicine 60](#_Toc160815029)

[Useful links 3.8 61](#_Toc160815030)

[Section 4 – Multidisciplinary working 63](#_Toc160815031)

[Overview 63](#_Toc160815032)

[4.1 Understanding the Low Vision Pathway 64](#_Toc160815033)

[Useful links 4.1 65](#_Toc160815034)

[4.2 Patient-centred care 65](#_Toc160815035)

[Useful links 4.2 67](#_Toc160815036)

[4.3 Linking services 67](#_Toc160815037)

[Useful links 4.3 74](#_Toc160815038)

[4.4 Information sharing between services 74](#_Toc160815039)

[Useful links 4.4 76](#_Toc160815040)

[4.5 Integrated health care 77](#_Toc160815041)

[Useful links 4.5 79](#_Toc160815042)

[4.6 Transfer of care between areas 80](#_Toc160815043)

[Useful links 4.6 81](#_Toc160815044)

[Section 5 – Establishing needs 82](#_Toc160815045)

[Overview 82](#_Toc160815046)

[5.1 Needs-based assessment 83](#_Toc160815047)

[Useful links 5.1 84](#_Toc160815048)

[5.2 Eye health information 84](#_Toc160815049)

[Useful links 5.2 85](#_Toc160815050)

[5.3 Emotional wellbeing 86](#_Toc160815051)

[Useful links 5.3 87](#_Toc160815052)

[5.4 Safeguarding 89](#_Toc160815053)

[Useful links 5.4 90](#_Toc160815054)

[5.5 Charles Bonnet Syndrome 90](#_Toc160815055)

[Useful links 5.5 91](#_Toc160815056)

[5.6 Falls 92](#_Toc160815057)

[Useful links 5.6 93](#_Toc160815058)

[5.7 Cerebral visual impairment 93](#_Toc160815059)

[Useful links 5.7 94](#_Toc160815060)

[5.8 Certification 95](#_Toc160815061)

[Useful links 5.8 96](#_Toc160815062)

[5.9 Patient advocates 97](#_Toc160815063)

[Useful links 5.9 99](#_Toc160815064)

[5.10 Routine review 102](#_Toc160815065)

[Useful links 5.10 103](#_Toc160815066)

[5.11 Follow ups 104](#_Toc160815067)

[5.12 Families and carers 105](#_Toc160815068)

[Useful links 5.12 107](#_Toc160815069)

[Section 6 - Assessing visual function 108](#_Toc160815070)

[Overview 108](#_Toc160815071)

[6.1 Valid sight test and up-to-date refraction 109](#_Toc160815072)

[Useful links 6.1 110](#_Toc160815073)

[6.2 Ongoing eye examinations 111](#_Toc160815074)

[Useful links 6.2 112](#_Toc160815075)

[6.3 Red Flag symptoms 112](#_Toc160815076)

[Useful links 6.3 113](#_Toc160815077)

[6.4 Measuring distance and near acuity 113](#_Toc160815078)

[Useful links 6.4 115](#_Toc160815079)

[6.5 Assessing visual function 116](#_Toc160815080)

[Useful links 6.5 117](#_Toc160815081)

[6.6 Measuring contrast sensitivity 117](#_Toc160815082)

[Useful links 6.6 118](#_Toc160815083)

[6.7 Visual fields 119](#_Toc160815084)

[Useful links 6.7 120](#_Toc160815085)

[6.8 Other tests 121](#_Toc160815086)

[Useful links 6.8 122](#_Toc160815087)

[Section 7- Optical and non-optical aids 124](#_Toc160815088)

[Overview 124](#_Toc160815089)

[7.1 Optical low vision aids 125](#_Toc160815090)

[Useful links 7.1 126](#_Toc160815091)

[7.2 NHS-funded low vision optical aids 126](#_Toc160815092)

[Useful links 7.2 129](#_Toc160815093)

[7.3 Information about LVAs not funded by NHS 129](#_Toc160815094)

[Useful links 7.3 131](#_Toc160815095)

[7.4 Training on low vision aids 132](#_Toc160815096)

[Useful links 7.4 133](#_Toc160815097)

[7.5 Batteries and maintenance 133](#_Toc160815098)

[7.6 Advanced low vision aids 134](#_Toc160815099)

[Useful links 7.6 135](#_Toc160815100)

[7.7 Lighting 135](#_Toc160815101)

[Useful links 7.7 137](#_Toc160815102)

[7.8 Managing glare 137](#_Toc160815103)

[Useful links 7.8 139](#_Toc160815104)

[7.9 Non-optical low vision aids 139](#_Toc160815105)

[Useful links 7.9 141](#_Toc160815106)

[7.10 Referral for further support 141](#_Toc160815107)

[Useful links 7.10 142](#_Toc160815108)

[7.11 Use of contrast and contrast enhancement devices 143](#_Toc160815109)

[Useful links 7.11 144](#_Toc160815110)

[7.12 Visual and non-sighted strategies 144](#_Toc160815111)

[Useful links 7.12 145](#_Toc160815112)

[Section 8 – Assistive technologies 146](#_Toc160815113)

[Overview 146](#_Toc160815114)

[8.1 Vision enhancement 147](#_Toc160815115)

[Useful links 8.1 149](#_Toc160815116)

[8.2 Navigation and orientation 149](#_Toc160815117)

[Useful links 8.2 151](#_Toc160815118)

[8.3 Reading support 152](#_Toc160815119)

[Useful links 8.3 154](#_Toc160815120)

[8.4 Referral for technological support 155](#_Toc160815121)

[Useful links 8.4 see also Useful links 4.3 157](#_Toc160815122)

[Section 9 - Reports and records 158](#_Toc160815123)

[Overview 158](#_Toc160815124)

[9.1 Storing and sharing data 159](#_Toc160815125)

[Useful links 9.1 163](#_Toc160815126)

[9.2 Record keeping 164](#_Toc160815127)

[Useful links 9.2 165](#_Toc160815128)

[9.3 Consent 166](#_Toc160815129)

[Useful links 9.3 167](#_Toc160815130)

[9.4 Report writing 168](#_Toc160815131)

[Useful links 9.4 170](#_Toc160815132)

[9.5 Standard operating procedure (SOP) 171](#_Toc160815133)

[Useful links 9.5 173](#_Toc160815134)

[Section 10 – Ongoing service review 174](#_Toc160815135)

[Overview 174](#_Toc160815136)

[10.1 Frequency of service evaluation 175](#_Toc160815137)

[Useful links 10.1 177](#_Toc160815138)

[10.2 Demographics review 178](#_Toc160815139)

[Useful links 10.2 179](#_Toc160815140)

[10.3 Quality assurance review 180](#_Toc160815141)

[Useful links 10.3 182](#_Toc160815142)

[10.4 Patient feedback 183](#_Toc160815143)

[Useful links 10.4 185](#_Toc160815144)

[10.5 Financial Review 185](#_Toc160815145)

[Useful links 10.5 186](#_Toc160815146)

[10.6 Data on missed appointments 187](#_Toc160815147)

[Useful links 10.6 189](#_Toc160815148)

[10.7 Planning and evaluating the service 190](#_Toc160815149)

[Useful links 10.7 192](#_Toc160815150)

[10.8 Implementing service evaluation findings 193](#_Toc160815151)

[Useful links 10.8 195](#_Toc160815152)

[References 196](#_Toc160815153)

[A to Z of Useful Links 207](#_Toc160815154)

[Appendix A - Template service leaflet – patient 234](#_Toc160815155)

[Appendix B - Template service leaflet – professional 235](#_Toc160815156)

[Appendix C -Template referral letter 236](#_Toc160815157)

[Appendix D - Magnifier range 237](#_Toc160815158)

[Appendix E - Magnifier instruction leaflets for patients 238](#_Toc160815159)

[Appendix F - Glare shield demonstration range 242](#_Toc160815160)

[Appendix G - Template for local services leaflet 243](#_Toc160815161)

[Appendix H - Example of a privacy statement 246](#_Toc160815162)

[Appendix I – Templates for a low vision report and patient action plan 250](#_Toc160815163)

[Appendix J -Template for service improvement plan 253](#_Toc160815164)

[Appendix K Teleconsult template 255](#_Toc160815165)

# Introduction

RNIB published its Eye Care Support Pathway report, with the help of many key partners, in November 2023.

The report highlights people’s needs at four key stages in their eye care journey:

* Having my initial appointment
* Having my diagnosis confirmed
* Support after my diagnosis
* Living well with my diagnosis

Support should be available at each of these stages to enable patients to:

* Understand my eye care journey
* Understand my diagnosis
* Access emotional and practical support

The pathway creates a structure to ensure good support from a patient's perspective; it also allows integration of non-clinical care into existing eye care pathways. It is the first step in ensuring better and more consistent patient support. The report can be accessed through this link [The Eye Care Support Pathway (rnib.org.uk)](https://media.rnib.org.uk/documents/APDF-IN230702_Eye_Care_Support_Pathway_Report.pdf).

Access to low vision services is one of the key elements of support that clinical services are able to refer patients in to. The Adult Low Vision Service Quality Framework provides evidence of best practice in the provision of these low vision services and dovetails with the Eye Care Support Pathway. It was developed with, and endorsed by, key stakeholders to enable providers and commissioners of low vision services to know what ‘good’ looks like.

Applying this framework across the UK would ensure all patients get the same level of care, vital early intervention and ongoing access to help. It also should ensure all patients are aware of the assistance available to them at the earliest possible opportunity. It runs alongside all four key stages of the Eye Care Support Pathway and means patients are able to access emotional and practical support at any point in that journey.

Good Practice Guidelines: for use with RNIB Adult Low Vision Service Quality Framework explains the framework’s criteria. This document has been developed in collaboration with key stakeholders and contains references and links to information and evidence that supports good practice. Providers and commissioners can use the information in this guidance to help implement the framework in order to audit current services and plan new services. It is intended that this would be used in combination with appropriate training and peer-support networks to ensure adherence to best practice.

The information in this guidance will be reviewed on a three-year cycle but if you are aware of any changes or amendments that need to be made, please notify us through our email contact. This document is also available with accessible hyperlinks and can be requested via email.

Email contact for any queries: [eyecare.professionals@rnib.org.uk](mailto:eyecare.professionals@rnib.org.uk)

# Section 1 – Environment

This section covers the physical environment of the service, including location, the internal and external building, signage and improving ways in which to access the service. It also covers the public-facing information on how to access the service (see also Section 3 – Accessing the service).

## Content overview

1.1 Service location

1.2 Buildings and facilities

1.3 Lighting and glare

1.4 Confidentiality

1.5 Awareness of the service

## 1.1 Service location

|  |
| --- |
| **Core:** The service should be in a convenient and accessible location for patients (Equality Act 2010). In order to comply with this the service must have **at least one** of the following:   * Disabled parking bays nearby. * Access by public transport. * An area to drop off patients. * Parking facility either onsite or nearby.   These may be charged for.  **Core:** Information on service location and how to access the service should be available to the patient in an accessible format. Location information should be available on the services website if applicable.  **Ideal:** Services should ideally have **all** of the following:   * Disabled parking bays nearby. * Access by public transport. * An area to drop off patients. * Parking facility either onsite or nearby.   These may be charged for.  **Ideal:** An option for domiciliary service provision should be available where the patient meets local primary care eligibility criteria, or where hospital transport is not available for the local low vision service, taking into consideration patients who have complex and additional needs and who would find hospital transport challenging. |

### Point to consider 1:

**Can all patients who would benefit from this service access it? What are the barriers to accessing the service?**

There is a legal duty under the Equality Act 2010 to ensure that reasonable adjustments are made to deliver equality of access to healthcare services for disabled people (Equality Act, 2010). Services should be able to accommodate access to conveniently located, co-ordinated care across primary care, hospital, community, rehabilitation, support and voluntary services (UKOA/RNIB, 2018) and workplaces and premises should be accessible to all persons with disabilities (Al Jubeh, 2020).

In order for the service to be accessible to patients who have sight loss it is essential it is in an appropriate location. We need to consider that blind and partially sighted people may have other disabilities too.

Consider how patients who are unable to drive, or have someone bring them to the appointment, will access the service.

Consider how patients who use wheelchairs will access the service.

#### For new services:

* Ensure the location is easily accessible by public transport from the service catchment area.
* Ensure that there is disabled parking nearby and a drop-off zone outside of the building for those using taxis.
* Ensure there is parking available locally that allows for the appointment length and for possible delays.
* Arrange for patients to access hospital transport if the service is located within a hospital.
* Ensure there is step-free access.

#### For existing services:

Consider how patients currentlyaccess the service and whether this meets the criteria, or whether there could be improvements based on the above points. It is a good idea to ask for patient feedback on the accessibility of the building.

### Point to consider 2:

**How do patients know how to access the service? What would make this easier?**

Not all barriers to accessing a service are physical, some are due to lack of accessible information. Information and communication should be in an accessible format for anyone with disabilities – this includes any computer-based communications. (Al Jubeh, 2020). It is a legal obligation to provide information in accessible format (NHS Accessible Information Standard, 2016) (NHS Scot Charter, 2022) (NHS Wales, 2013) so that patients can access the service easily. A good way to do this is to provide a service information leaflet in accessible format, this can be electronic or hard copy. Your standard operating procedures (SOP) should state how preferred format is noted on the records and the process to get information transcribed or translated where necessary. For more information on SOP see section **9.5 Standard operating procedure (SOP)**. For more information on accessible information see **1.5 Awareness of the service** and **3.7 Communication.**

An example of a service information sheet is available in **Appendix A - Template service leaflet – patient**

Typically, the service information leaflet should provide the following details:

* Full address and phone number of the clinic
* Local public transport
* Map
* Information about parking
* Information about drop-off zones
* Information about hospital transport (if appropriate)
* Information about local transport for people with disabilities (if available)
* Information of how to cancel an appointment
* Information on travel assistance e.g., free bus checker phone apps

### Point to consider 3:

**It can be very costly providing domiciliary services, but without these services or adequate parking/drop off zones consider who will be excluded from accessing your service?**

When commissioning new services, it is important to consider the location of the centre with regards to positioning of local parking and the availability of a dedicated drop off area. These provisions can be a significant factor when it comes to enabling patients with additional mobility needs to access the service.

However, with an aging population, even with the above measures in place, an increasing number of people are likely to struggle to get to a clinic without assistance or possibly even get there at all.

Therefore, when reviewing an existing low vision service, we should consider whether there is a domiciliary provision for those in need (CCEHC Impact survey, 2021) or whether one can be put in place. This should also be the case when designing a new service, particularly where hospital transport is not available. This will ensure the service is accessible for all.

Patients who have complex health issues often have sight loss and mobility impairment in combination or rely on carers to support them. People with learning disabilities are 10 times more likely to have sight loss (SeeAbility, 2016). Some 33 per cent of all people with dementia are estimated to have sight loss (Bowen, 2016); this group of people may well have significant difficulty accessing a service without domiciliary options. Not considering a domiciliary option - where there is no access to hospital transport - will prevent these patients from accessing the service.

## Useful Links 1.1

Guidelines for accessible services

[UKOA/RNIB Patient Standards for Ophthalmology Services](https://uk-oa.co.uk/wp-content/uploads/2018/09/UKOA_Publications_Patient_Quality_Standard_200918.pdf)

[World Blind Union/CBM Global Disability Inclusion Accessibility=Go! A Guide to Action](https://worldblindunion.org/wp-content/uploads/2021/12/Accessibility-GO-A-Guide-to-Action-WBU-CBM-Global-Dec2021.pdf)

[Clinical Council for Eye Health Commissioning (CCEHC) Guidance](https://www.college-optometrists.org/clinical-council-for-eye-health-commissioning" \l "tab-informationandguidance-ce7cc8fd)

**Accessible information**

[RNIB | Creating accessible information and communication resources for health and social care](https://www.rnib.org.uk/living-with-sight-loss/independent-living/accessible-nhs-and-social-care-information/creating-accessible-information-and-communication-resources-for-health-and-social-care/)

[RNIB | My info my way](https://www.rnib.org.uk/get-involved/support-a-campaign/my-info-my-way/)

Wales

[Wales standards for accessible information for people with sensory loss](https://www.gov.wales/sites/default/files/publications/2019-04/all-wales-standards-for-accessible-communication-and-information-for-people-with-sensory-loss-large-print_0.pdf)

England

[NHS England Accessible Information Standard](https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/accessibleinfo/)

Scotland

[Making Information Accessible - Disability Information Scotland](https://www.disabilityscot.org.uk/publication/making-information-accessible/#guidelines-for-producing-accessible-printed-and-electronic-information)

[Public Health Scotland Accessible information policy](https://publichealthscotland.scot/publications/accessible-information-policy/)

Northern Ireland

[Web Content Accessibility Guidelines (WCAG) – DWP Accessibility Manual](https://accessibility-manual.dwp.gov.uk/accessibility-law/web-content-accessibility-guidelines)

[Department of Health - Making Written Information Easier to Understand for People with Learning Disabilities](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215923/dh_121927.pdf)

[Mencap’s Make it Clear](https://www.advocacyproject.org.uk/wp-content/uploads/2014/06/make-it-clear-apr09.pdf)

[RNID | Accessible Information Standard](https://rnid.org.uk/information-and-support/support-for-health-and-social-care-professionals/accessible-information-standard/)

[Accessible patient information: Patient Information Forum (PIF)](https://pifonline.org.uk/)

[Government Guidance Understanding accessibility requirements for public sector bodies](https://www.gov.uk/guidance/accessibility-requirements-for-public-sector-websites-and-apps)

England

[NHS Constitution for England](https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england)

Scotland

[NHS Scotland The Charter of Patient Rights and Responsibilities](https://www.gov.scot/publications/charter-patient-rights-responsibilities-revised-june-2022/)

Northern Ireland

[Every Customer Counts - promoting accessible services](https://www.equalityni.org/everycustomercounts#:~:text=The%20Equality%20Commission%20has%20developed%20the%20%22Every%20Customer,are%20to%20disabled%20people.%20THREE%20STEPS%20TO%20SUCCESS%3A)

Wales

[Accessible Information Standard - Public Health Wales](https://phw.nhs.wales/services-and-teams/equality-and-human-rights-information-resource/accessible-information-standard/)

## 1.2 Buildings and facilities

|  |
| --- |
| **Core:**  The building and facilities should be appropriate for any assessments and interventions being offered. They should be designed or adapted for the needs of people with vision impairment and any other disabilities and should also have space for accompanying carers.  **Core:**  Infection control policies must be implemented.  **Core:**  Trip hazards should be eliminated, or, if not possible, must be clearly marked.  **Core:**  The service should be well signposted from entrance to site using accessible signage. |

### Point to consider:

**Is your reception and clinic space safe, appropriate, and clean? How easy is it for your patients to navigate through the clinic?**

This aspect of the low vision service is important to ensure that the patient is safe in the clinic and the facilities are fit for purpose.

Key guidelines relating to these criteria:

* Patients have the right to be cared for in a clean, safe, secure and suitable environment (The NHS Constitution, 2021).
* Premises where care and treatment are delivered are clean, suitable for the intended purpose, maintained and where required, appropriately located, and that the equipment that is used to deliver care and treatment is clean, suitable for the intended purpose, maintained, stored securely and used properly (Care Quality Comission, 2022).

To be fit for purpose you should consider the following:

**Safe facilities**

The safety of patients and staff is paramount, and the service should follow all relevant local and national guidance. Some specific ideas are below, but it is a good idea to refer to your professional guidance as found in **Useful links 1.2**

* The area is safe and appropriately adapted for all patients and staff.
* There should be appropriate facilities to carry out the assessments required including space for equipment, patients and carers and access to electrical points and internet.
* All relevant safety checks are carried out such as PAT (Portable Appliance Testing), fire safety - and emergency exits should be clear.
* The area should be well maintained and subject to health and safety standards.
* Ensure all relevant insurance policies are up to date.

**Appropriate Infection control**

There should be an appropriate infection control policy in place such as the NHS England National Infection Prevention Control Manual, or guidance from your professional body, details of which can be found under **Useful links 1.2** at the end of this subsection.

Things that should be considered are:

Wipe-clean flooring

Access to appropriate PPE (Personal Protective Equipment)

Access to hand-washing facilities

* Equipment and surfaces to be disinfected between patients
* Single-use equipment should be used as needed and disposed of appropriately
* Suitable waste disposal arrangements are in place

**Adaptations for people with sight loss**

The low vision service should be suitably adapted so barriers to care are minimised.

NHS Wales recommendations state that:

‘It is important to recognise that environmental factors influence effective communication with people who have sensory loss. It is important to check that the healthcare environment is accessible and that it encourages effective communication. This should include lighting, colour contrasting and background noise’ (NHS Wales, 2013).

RNIB Visibly Better spaces standards recommend the following (UKOA/RNIB, 2018):

* Good use of natural light and ability to block sun using blinds etc.
* Glare is managed.
* Good use of general light, ensuring sufficient lux levels (at least 100 lux) and avoiding dark shadows on the floor.
* Consider use of task lighting where people are signing forms etc.
* Good use of contrast - ensuring that key features and furniture have sufficient contrast with their environment, e.g., adding high contrast strips to the edges of steps can make them much easier to detect and help to reduce falls, chairs in waiting areas have sufficient contrast with flooring/walls.
* Contrasting door furniture and surrounds (handles, frames).
* Clear high contrast, large font signage.
* Floors are not shiny/reflective.
* Patient areas are not cluttered nor have obstacles.

NHS Wales also indicates that signage adaptation is important:

“Good signage is important in ensuring that people with sensory loss are able to access the healthcare they need. To minimise their anxiety and any confusion, all signs should be clear and easy to understand” (NHS Wales, 2013).

This should include signage to the clinic, as well as within the clinic area. Things to consider are:

* + High contrast, bold print signs
  + Tactile signs
  + Assistive technology such as NaviLens (please see **Useful links 1.2** for details)
  + Audio warning beacons and audio signage

It is important to all patients that they know who they are talking to and what their role is in the service. Name badges of staff should be displayed in a way that is visible for those with reduced sight along with verbal introductions each time. Information can be found in **Useful links 1.2** below.

**Equity of access for all users:**

The service should be accessible to all, and no-one should be directly or indirectly discriminated against as a result of access issues. It is a good idea to map out a patient journey to identify where there may be issues. Guidance on how to do this can be found on the [GOV.UK Creating an experience map](https://www.gov.uk/service-manual/user-research/creating-an-experience-map) webpage (Crown, 2018)

Key points:

* No-one should be directly or indirectly discriminated against on the basis of their disability. This means that reasonable adjustments should be made to ensure that all users can access medical services (Equality Act, 2010).
* Services should be able to identify, and make reasonable adjustments for, patients with dementia, communication needs and learning difficulties, which may include specialist clinics, flexible appointment times, shorter wait times, or longer appointments, taking into account patient passports or similar e.g. ‘This is Me’ (UKOA/RNIB, 2018) see also section **3.5 Patients with additional needs**.
* The clinic environment should be person-centred so adjustments can be made according to specific individual needs. Consideration needs to be given on how to adapt the service for combinations of disabilities. Some general provision improves accessibility for all such as:
  + Accessible toilet facilities
  + Accessible emergency exit information
  + Staff should be trained in emergency procedure to ensure everybody is safe

**Accessibility for wheelchair users:**

Many patients attending a low vision service may also be wheelchair users. Reasonable adaptations for these patients should include:

* Step-free access to the clinic (it is important to consider the whole route if the clinic is inside a larger building such as an hospital).
* Space to manoeuvre a wheelchair into and out of the consulting room with a large enough area to accommodate the turning circle inside each room.
* Ensuring medical instruments on adjustable stands to allow for the height of the wheelchair.

**Accessibility for hearing impaired patients:**

The clinical environment should be adapted for people with hearing impairment. Things to consider from an environment perspective are:

* Hearing loops.
* Assistive equipment such as conversation listeners.
* Internet facility to allow for assistive equipment connectivity.
* Good lighting.

Further RNID guidance on adaptations is discussed in section **3.5 Patients with additional needs**.

**Accessibility for people with learning disabilities:**

People with learning disabilities face many barriers to care. From an environment perspective the following adaptations should be considered:

* Quiet waiting area and clinic environment or flexible appointment times
* Enough space to enable carers to attend with the patient
* Internet facility to enable connection of assistive technology
* Further information can be found in the Royal College of Ophthalmologists’ guidance on patients with learning disabilities under **Useful links 1.2**.
* Information from SeeAbility on accessible eye care can be found under **Useful links 1.2.**

**Accessibility for patients with dementia:**

There is a strong link between dementia and sight loss; it is therefore vital that the clinic environment takes this into consideration. It is estimated that at least 33 per cent of people with dementia also have sight loss (Bowen, 2016).

Clinics can often be very busy places due to the high demand for treatment. They can be designed or adapted in ways that help people with dementia manage their surroundings, retain their independence, and reduce feelings of confusion and anxiety. (Royal College of Ophthalmologists, 2015)

The following aspects should be taken into consideration (SCIE, 2023):

* People with sight loss and dementia often take longer to move around and can become distressed by noise, confusing signage and crowds.
* They will often attend with a carer, as will many other patients in the department.
* Quiet rooms for people with dementia - and a specific pathway for identifying and managing their clinic visit - are often helpful.
* Good lighting gives a better sense of their surroundings, but glare control is also important.
* Use clear, simple signage.
* Use of contrast and colour can reduce the risk of falls.
* Good internet access to enable connectivity with accessible technology.

## Useful links 1.2

**Professional guidelines:**

[NHS Constitution for England](https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england)

[HCPC | Managing risk: infection prevention and control](https://www.hcpc-uk.org/covid-19/advice/applying-our-standards/managing-risk/)

[HPCP | Protecting the health and safety of others](https://www.hcpc-uk.org/standards/meeting-our-standards/health-safety-and-wellbeing/protecting-the-health-and-safety-of-others/)

[GOC Standards of Practice](https://optical.org/en/standards-and-guidance/standards-for-optical-businesses/1-2-patient-care-is-delivered-in-a-suitable-environment/)

[Care Quality Commission (CQC) Premises and Equipment](https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-15-premises-equipment)

[College of Optometrists - Infection control](https://www.college-optometrists.org/clinical-guidance/guidance/safety-and-quality/infection-control)

[UKOA/RNIB Patient Standards for Ophthalmology Services](https://uk-oa.co.uk/wp-content/uploads/2018/09/UKOA_Publications_Patient_Quality_Standard_200918.pdf)

[All Wales Standards for Accessible Communication and Information for People with Sensory Loss](https://gov.wales/sites/default/files/publications/2019-04/all-wales-standards-for-accessible-communication-and-information-for-people-with-sensory-loss-large-print_0.pdf)

[SCIE | Dementia-friendly environments](https://www.scie.org.uk/dementia/supporting-people-with-dementia/dementia-friendly-environments/)

**Navigation aids:**

[NaviLens](https://www.navilens.com/en/)

**Legal requirements:**

[Equality Act 2010](https://www.gov.uk/guidance/equality-act-2010-guidance)

[Disability Rights UK](https://www.disabilityrightsuk.org/about-us)

**How to make adaptations**

[GOV.UK Making your service more inclusive](https://www.gov.uk/service-manual/design/making-your-service-more-inclusive)

[GOV.UK Creating an experience map](https://www.gov.uk/service-manual/user-research/creating-an-experience-map)

**For visual impairment adaptations:**

[RNIB | accessible housing and buildings](https://www.rnib.org.uk/nations/walescymru/how-we-can-help/visibly-better-designing-accessible-housing-and-buildings/)

**For hearing impairment adaptations:**

[RNID | Communicating Well with Residents who have Hearing Loss](https://rnid.org.uk/wp-content/uploads/2020/05/A1422_Info-sheet_Communicating-well-with-residents-who-have-hearing-loss_v03.pdf)

[RNID | Accessible Information Standard](https://rnid.org.uk/information-and-support/support-for-health-and-social-care-professionals/accessible-information-standard/)

**For cognitive impairment adaptations:**

[Royal College of Ophthalmologists’ guidance on patients with learning disabilities](https://www.rcophth.ac.uk/resources-listing/eye-care-for-adults-with-learning-disabilities-2015/)

[Royal college of Ophthalmologists’ standards for patients with dementia](https://www.rcophth.ac.uk/resources-listing/quality-standard-for-people-with-sight-loss-and-dementia-in-an-ophthalmology-department-2015/)

[Accessible name badges – Hello my name is](https://www.hellomynameis.org.uk/)

[RNIB | Resources on dementia and sight loss](https://www.rnib.org.uk/professionals/health-social-care-education-professionals/social-care-professionals/dementia-and-sight-loss/)

[SeeAbility | Eye care professionals](https://www.seeability.org/eye-care/eye-care-professionals)

## 1.3 Lighting and glare

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| **Core:**  There should be appropriate lighting internally and externally.  **Ideal:**  Glare should be minimised where possible and clinic spaces should ideally be fitted with dimmer switches. |

### Point to consider:

**Is the lighting in your clinic space and reception appropriate for the work you are doing? Is it adjustable for patients with special requirements?**

It is important to check that the healthcare environment is accessible and that it encourages effective communication. This should include lighting, colour contrasting and background noise (NHS Wales, 2013).

Clinic spaces should be well lit to avoid falls and injuries, as well as to ensure that the assessment is done in optimal conditions and the effect of lighting on tasks can be demonstrated to the patient.

Good lighting can support individual safety and orientation by illuminating areas of risk, such as steps and making it easier to find and use doors (Thomas Pocklington Trust, 2021).

Ideally, lighting should be adjustable to allow for tests that require a darkened environment and also to ensure the comfort of patients who have a significant degree of light sensitivity. This can be achieved using blackout blinds, vertical blinds, dimmer switches and diffusing shades on lights. Glare sources such as spotlights and highly reflective surfaces should be minimised.

Test charts should be illuminated as per manufacturers recommendations. It is important that you obtain the manuals for equipment being used and ensure that the room lights can be adjusted appropriately. Given the wide range of equipment available it has not been possible to attach any guides to this document.

Sustainability should also be considered by choosing lighting that is energy efficient.

## Useful links 1.3

**General lighting recommendations and guidelines:**

[UKOA/RNIB Patient Standards for Ophthalmology Services](https://uk-oa.co.uk/wp-content/uploads/2018/09/UKOA_Publications_Patient_Quality_Standard_200918.pdf) (page 6)

[TPT lighting guide for in and around the home](https://www.pocklington-trust.org.uk/wp-content/uploads/2021/10/Lighting-Guide-2021-FINAL.pdf) (also applicable in public spaces)

## 1.4 Confidentiality

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| **Core:**  All consultations and any other discussions requiring the sharing of sensitive information or personal details should be carried out in a private area.  **Core:**  Clinical records, either electronic or paper, and any patient database should be secure and stored as per GDPR regulations. |

### Point to consider:

**How confidential is your reception area and clinic space? Can private matters be discussed, and confidentiality respected? Can other people see what information is on your computer screen?**

Patients have the right to privacy and confidentiality and to expect the NHS to keep their confidential information safe and secure (The NHS Constitution, 2021) (NHS Scot Charter, 2022).The environment should be conducive to discussion and the patient’s privacy should be respected, particularly when discussing sensitive and personal issues (NICE Guidance, 2012).

Important or sensitive discussions should be held in a suitable area, away from noise, distractions, and interruptions. Any area designated for the provision of a service, whether in hospital, community, or high street optometry practice, should allow for patient privacy and confidentiality. This can be difficult in some existing services, but you should consider how this might be improved and how it can be embedded in the design of new facilities.

Other aspects which should also be considered to protect patient privacy include: each patient’s privacy include:

* Appropriate information governance training to avoid data breaches, and to ensure data integrity. This should include GDPR and NHS data tool kit regulations around sharing data securely between professionals where required. See also section **9.1 Storing and sharing data**
* Computer screens should be arranged such that they cannot be viewed by the public.
* Teleconsultations or telephone conversations should be in a confidential area.
* Professionals should be careful not to discuss cases in front of members of the public or with professionals who are not involved in the care of that patient.
* Where and how patient paper records may be stored should be considered. There should be a lockable area that only authorised personnel can access.

## Useful links 1.4

**General**

[NICE Guidance for Patient Experience in Adult NHS Services](https://www.nice.org.uk/guidance/cg138/chapter/1-guidance)

England: [NHS Constitution for England](https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england)

Scotland: [NHS Scotland The Charter of Patient Rights and Responsibilities](https://www.nhsinform.scot/care-support-and-rights/health-rights/patient-charter/the-charter-of-patient-rights-and-responsibilities)

NI: [Department of Health Northern Ireland Code of Practice on Protecting the Confidentiality of Service User Information](https://www.health-ni.gov.uk/publications/code-practice-protecting-confidentiality-service-user-information)

Wales: [NHS Wales Shared Services Partnership - Supporting Guidance - Patient Centred Care](https://nwssp.nhs.wales/a-wp/governance-e-manual/putting-the-citizen-first/health-and-care-standards-with-supporting-guidance/person-centred-care/supporting-guidance-patient-centred-care/)

**Clinical**

[GOC Confidentiality Standards for Optometrists and Dispensing Opticians](https://optical.org/optomanddostandards/14-maintain-confidentiality-and-respect-your-patients-privacy/)

[UKOA/RNIB Patient Standards for Ophthalmology Services](https://uk-oa.co.uk/wp-content/uploads/2018/09/UKOA_Publications_Patient_Quality_Standard_200918.pdf)

[RWPN Code of Ethics and Professional Conduct](https://www.rwpn.org.uk/resources/Documents/RWPN%20Code%20of%20Ethics%20and%20Professional%20Conduct.docx%20(1).pdf)

[NHS England Data Security and Protection Toolkit](https://www.dsptoolkit.nhs.uk/)

**Information governance**

[Information Commissioner’s Office - GDPR](https://ico.org.uk/for-organisations/)

[ABDO GDPR guidance](https://www.abdo.org.uk/news/updated-gdpr-guidance-for-members/)

[AOP GDPR guidance](https://www.aop.org.uk/advice-and-support/regulation/uk/data-protection/gdpr-advice)

[GOC GDPR guidance](https://optical.org/en/about-us/accessing-information/our-policies/data-protection/)

[College of Optometrists GDPR guidance](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge,-skills-and-performance/patient-records/data-protection-act-2018-and-eu-general-data-prote)

## 1.5 Awareness of the service

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| **Core:**  Service information should be provided including contact details, referral processes and benefits of the service for all key stakeholders. This should be available in accessible formats such as large print, braille and audio. |

### Point to consider:

**How do patients and professionals know that your service exists, what it does and how to get an appointment? Getting this right means that referrals will be appropriate, and appointments optimised.**

In order for a low vision service to be fit for purpose it is essential that it should be part of the wider network of services and support. This includes ensuring all key stakeholders are aware of the service, how to refer into it and how the services can work together holistically. This will be expanded upon further in section **3 Accessing the service**

Low vision services should work as seamlessly as possible with other services including primary care (GPs, community optometrists, dispensing opticians), community, HES, education, social care, voluntary and charity organisations, and stroke, learning disability, habilitation, rehabilitation and falls teams (CCEHC Low Vision, 2017).

Referral to low vision services should be as easy as possible and allow for self-referral, especially for those who have existing conditions and need a reassessment. Pathways need to include routes where patients can easily get back to ophthalmology if there is suspicion of change in pathology (CCEHC Low Vision, 2017). This could be via advice or guidance, PIFU facility or direct referral, whichever is deemed most appropriate.

When a new service is set up connection should be made with the following services as well as any other specific local services. A directory of these should be kept up to date:

* Rehabilitation services for sensory needs
* Local optometry and ophthalmology services
* Local GP practices
* Local sight loss society
* ECLO (Eye Care Liaison Officer) at your local hospital

For existing services, it is a good idea to check regularly whether details and contacts for local services are still correct and that there is, wherever possible, joined up working and communication.

There are also a number of other professionals and services that may come into contact with people who have sight loss so it may be helpful to ensure that these are also all aware of the service. These might include:

* Local falls teams
* Local dementia care team
* Carers’ hubs
* Local pharmacists
* Care navigators
* Social prescribers
* Citizen’s Advice Bureau

To make sure your service can be contacted easily ensure that your details are correct and kept up to date on local society websites and on Sightline directory.

Any information about the service also needs to be in accessible format so that barriers to accessing services are minimised (NHS Accessible Information Standard, 2016). For any services that have a website it is essential to comply with accessibility guidelines for digital interfaces so that anyone with additional needs can access web content (Web Content Accessibility Guidelines (WCAG), 2018).

Special consideration should be made to those groups of patients that are under-served. Consider how the service information will be disseminated to these groups. It is a good idea to look at your local demographics and identify any groups that are consistently not presenting in the service. Key opinion leaders that might help to promote up take of appointments can then be identified, advice and guidance for this can be found through BAME vision (see **Useful links 1.4)**. Communication can be facilitated by the use of translation services such as Language Line.

The appendices contain two service leaflets templates (one for patients and one for professionals) and a referral template that can be adapted for your service.

See: **Appendix A - Template service leaflet – patient**

**Appendix B - Template service leaflet – professional**

**Appendix C Template referral letter**

## Useful links 1.5

**Professional guidance**

[Clinical Council for Eye Health Commissioning (CCEHC) Guidance](https://www.college-optometrists.org/clinical-council-for-eye-health-commissioning#tab-informationandguidance-ce7cc8fd)

**Local information database:** [Sightline Directory](https://www.sightlinedirectory.org.uk/)

**Accessible information** see **Useful links 1.1**

**Underserved population support**

[RNIB | Transcription Services](https://www.rnib.org.uk/living-with-sight-loss/independent-living/reading-and-books/transcription-services/)

[LanguageLine UK - Interpreting & Translation Services](https://www.languageline.com/en-gb/)

[GOV.UK Regional ethnic diversity - Ethnicity facts and figures](https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/national-and-regional-populations/regional-ethnic-diversity/latest) (England and Wales)

[BAME Vision | Black, Asian, and Minority Ethnic Community](https://bamevision.org/about-us)

# Section 2 – Staff and staff training

This section covers the levels of qualification, knowledge and awareness that staff working in a low vision service should have. It also includes topics such as safe recruitment and the importance of criminal records safety checks and how to ensure service provision is protected from any staffing issues.

## Overview

2.1 Additional qualifications

2.2 Ongoing training

2.3 Sight loss awareness

2.4 Criminal records check

2.5 Business continuity planning

## 2.1 Additional qualifications

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| **Core:**  The service should be provided by optometrists, dispensing opticians, orthoptists, ophthalmic nurses, ophthalmologists, or Vision Rehabilitation Specialists (VRS), formerly known as ROVIs. Low vision practitioners should have a relevant post graduate qualification or appropriate experience working in a low vision service and they should meet the training requirements of the local service provider. Student practitioners may also provide low vision services under suitable supervision. |

### Point to consider:

**How do you know that the practitioners employed in the service are qualified to support the patients?**

The UK vision strategy gave the following guidance: Low vision assessment is a specialist area. The critical factor to a successful and effective visual impairment assessment and subsequent rehabilitation interventions is that they should be conducted by specialist qualified professionals (UK Vision Strategy, 2013).

It is important to note that in this section we are referring to low vision assessment, not only the supply of optical aids. However it is important to note that the supply of spectacles or contact lenses to patients who are registered as sight impaired, or severely sight impaired, must only be carried out by or under the supervision of an optometrist, dispensing optician or doctor (COO Low Vision webpage, 2022) as per the Opticians Act 1989 [Opticians Act 1989 (legislation.gov.uk)](https://www.legislation.gov.uk/ukpga/1989/44).

The following professionals are suitably qualified to provide a low vision assessment:

* **Optometrist**

Optometrists (previously known as ophthalmic opticians) are trained to examine the eyes to detect defects in vision, signs of injury, ocular diseases or abnormality and problems with general health, such as high blood pressure or diabetes. They make a health assessment, offer clinical advice, prescribe spectacles, contact lenses or optical aids and refer patients for further treatment when necessary (COO website, 2022).

* **Dispensing optician**

A dispensing optician is a registered healthcare professional and plays various roles within an optical practice to help patients.

The core role of a dispensing optician (DO) is to advise on, fit and supply the most appropriate spectacle frames and lenses for each person. (ABDO website, 2019). They are also trained to prescribe and dispense low vision aids.

* **Orthoptist**

Orthoptists, in the UK, are the experts in diagnosing and treating defects in eye movement and problems with how the eyes work together, called binocular vision. These can be caused by issues with the muscles around the eyes or defects in the nerves enabling the brain to communicate with the eyes. (BIOS website, 2023). Orthoptists are also trained to prescribe and dispense low vision aids.

* **Ophthalmologist**

Ophthalmology is a branch of medicine/surgery dealing with the diagnosis, treatment and prevention of diseases of the eye and visual system. Ophthalmologists work with other medical and healthcare professions, often leading the multidisciplinary team. Ophthalmologists are experts in the diagnosis, treatment, surgery and management of eye disease to preserve the sight of patients and their quality of life (RCOphth website, 2023).

* **Vision Rehabilitation Specialist**

Vision rehabilitation specialists (previously known as ROVIs or rehabilitation workers) identify, deliver and evaluate professional rehabilitation interventions to visually impaired people to enhance their skills and confidence to maximise their independence.

They assess and provide support plans to help people at risk from harm or becoming dependent on others due to their sight loss.

They act as an advocate for visually impaired people and the organisation to help promote accessible services; equality; social integration and understanding of the impact of sight loss (RWPN Core Skills webpage, 2023). They are trained in aspects of low vision aids, including prescribing and dispensing.

* **Trainees**

An important part of training for the professions above is face-to-face experience in low vision clinic settings. Trainees may prescribe and dispense low vision aids during the course of their studies but only with supervision present in the clinic.

**Additional qualifications and training**

Professionals may have completed core competencies around low vision, but there is still a requirement when working in a specialist area to ensure that your knowledge and skills are appropriate for your work. This may require additional specialist qualifications, or supervised practice and experience in a low vision clinic.

Professional guidance for optometrists states that they should recognise, and work within, their limits of competence (AOP Clinical Governance webpage, 2016) and refer the patient if they do not have sufficient expertise to assess a patient with low vision (COO Low Vision webpage, 2022).

Registrant orthoptists must know the limits of their practice and when to seek advice or refer to another professional (HCPC, 2023). Core competencies are clearly detailed by BIOS (BIOS, 2021)

Vision rehabilitation specialists should recognise their own boundaries and limitations of professional competence and advise service users and action referrals to appropriate professionals/services where needs fall outside of their own expertise (RWPN, 2021).

Information about low vision qualifications that are available for each of the professional groups can be found under the section **Useful links 2.1** below.

## Useful links 2.1

**General guidance:**

[UK Vision Strategy | Adult UK sight loss pathway Appendix C](https://www.adass.org.uk/media/4817/adult_uk_sight_loss_pathway_word_with_charts_final.pdf)

**Optometry and dispensing optics:**

[Opticians Act 1989 sale of optical appliances](https://www.legislation.gov.uk/ukpga/1989/44/section/27)

[College of Optometrists: Assessing and managing patients with low vision](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge,-skills-and-performance/assessing-and-managing-patients-with-low-vision#Dispensinglowvisiondevices)

[College of Optometrists: What is an Optometrist?](https://www.college-optometrists.org/qualifying/a-career-in-optometry/what-is-an-optometrist)

[ABDO: What is a dispensing optician?](https://www.abdo.org.uk/for-the-public/what-is-a-dispensing-optician/)

[AOP: For Employees](https://www.aop.org.uk/advice-and-support/clinical/clinical-governance/managing-risk-in-practice/for-employees)

**Orthoptists:**

[BIOS: What is an Orthoptist?](https://www.orthoptics.org.uk/patients-and-public/what-is-an-orthoptist/)

[HCPC Orthoptists](https://www.hcpc-uk.org/standards/standards-of-proficiency/orthoptists/)

[BIOS Low Vision Core skills and competencies](https://www.orthoptics.org.uk/wp-content/uploads/2021/11/BIOS-Low-Vision-Core-skills-and-competencies-January-2021.pdf)

**Ophthalmology:**

[Royal College of Ophthalmologists: Discover Ophthalmology Careers](https://www.rcophth.ac.uk/our-work/ophthalmology-careers/)

**Vision rehabilitation specialists:**

[RWPN Core skills and Job Descriptions](https://www.rwpn.org.uk/core_skills)

[RWPN Code of Ethics and Professional Conduct](https://www.rwpn.org.uk/resources/Documents/RWPN%20Code%20of%20Ethics%20and%20Professional%20Conduct.docx%20(1).pdf)

**Information on low vision qualifications that are available:**

**Optometrists:**

Professional and higher certificate in low vision - [College of Optometrists Higher certificate in Low vision](https://www.college-optometrists.org/professional-development/further-qualifications/higher-qualifications)  professional

**Dispensing opticians:**

[ABDO Diploma in the Assessment and Management of Low Vision](https://www.abdo.org.uk/wp-content/uploads/2020/04/ABDO-Low-Vision-Syllabus-WEB-MAR20.pdf)

**Orthoptists and other eye care professionals:**

[University of Sheffield Health Sciences School Low vision](https://www.sheffield.ac.uk/health-sciences/continuing-professional-development/cpd-opportunities/low-vision)

**Vision rehabilitation specialist (VRS) low vision courses:**

There are no additional qualifications in this area but a VRS must complete a module as part of their qualification and undertake additional low vision supervised practice and/or take up relevant CPD training.

[RWPN - Training](https://www.rwpn.org.uk/training/)

## 

## 2.2 Ongoing training

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| **Core:**  All staff working in low vision clinics should know their scope of practice, and as well as complying with local service requirements ensure that their Continuing Professional Development (CPD) reflects the responsibilities and competencies required to provide good quality up-to-date care.  **Ideal:**  This should include speciality training such as interactive low vision specific CPD or peer review case discussions with other low vision practitioners and low vision multidisciplinary team. |

### Point to consider:

**How do you know whether members of your team are up to date and aware of current knowledge in this area?**

All health and social care professionals must complete set learning outcomes (previously known as core competencies) to become a practitioner, however, it is very important that these skills are maintained by completing appropriate Continuing Professional Development (CPD).

Personal and professional development helps manage your own learning and growth throughout your career. Continuous learning helps open up new doors in your career, keep your skills and knowledge up to date and ensure you practice safely and legally (NHS CPD webpage, 2023). Service specifications [SOP] should include requirements for training accreditation and CPD for staff providing the service (CCEHC SAFE, 2018).

CPD can take the form of webinars, workshops, online modules, peer discussion groups, conferences and lectures. However, this list in not exhaustive. CPD for each professional group is governed by their regulatory body and details can be found under **Useful links 2.2** at the end of the subsection. When working in a specialist area it is important that the practitioner’s personal development plan reflects the need to keep up to date in this area.

**Specific CPD low vision competencies:**

In addition to any mandatory CPD competencies there are also some areas that specifically relate to low vision practice. The UKOA/RNIB patient standards for ophthalmology guidelines sets out key components of low vision support. These could essentially be used as the basis for areas that low vision CPD should cover. Details can be found in the **Useful links 2.2** section below.

Other areas that should be covered include those detailed below. Links to useful sources of information can all be found in the **Useful links 2.2** section below.

* CBS (Charles Bonnet Syndrome) awareness - It is important that anyone working in low vision services has up to date knowledge of CBS and CBS sources of support. The charity Esme’s Umbrella is a good source of information. See also section **5.5 Charles Bonnet Syndrome.**
* Magnification options - CPD should include updates on magnification options, including both optical and digital options. These courses are often available through GOC CPD dashboard, professional organisations, third sector organisations and magnifier distributors.
* Assistive technology - Technology can be key to supporting patients with low vision, but it changes very quickly. All practitioners should have a working knowledge of assistive technology and know who can give advice and support to their patients. Relevant training is available through technology providers as well as through third sector organisations. See also section **8 Assistive technologies.**
* Sight loss support agencies - Understanding the wide range of sight loss support agencies is essential when supporting patients with low vision. Understanding and keeping up to date on the network of support in your area is vital. A review of the local and national support should be carried out yearly. See also section **2.3 Sight loss awareness.**
* Emotional support - There are training courses available in emotional support and suicide awareness that can be extremely helpful for practitioners to enable them to support patients with the emotional impact of sight loss. Training is available from a variety of NHS and third sector organisations. See **Useful links 2.2.**
* Research updates - Knowing the latest research will enable you to be aware of all possible options for your patients. This can be via professional peer-reviewed journals or professional body research updates. Alternatively/additionally you could join a special interest research group such as the European Society for Low Vision Research and Rehabilitation (ESLRR). See **Useful links 2.2**
* Peer discussion groups- Joining any peer discussion group ensures your skills keep up with generally accepted practice. Working in isolation can often cause practitioners to become out of touch with normal practice and the latest knowledge. Peer discussion is a non-judgemental way of learning from each other in a safe space. Many training providers offer general peer discussion groups; RNIB runs low vision specific peer discussion groups online and face-to-face. To join the RNIB low vision peer network, please email [eyecare.professionals@rnib.org.uk](mailto:eyecare.professionals@rnib.org.uk)
* Safeguarding adults at risk - Safeguarding is everyone’s business due to the potential risks for patients with sight loss it is very important that safeguarding training is a high priority. This training is offered by professional organisations, local authorities and the NHS. See also section **5.4 Safeguarding.**

## 

## Useful links 2.2

**General guidance**

[NHS Health Careers | Continuing professional development (CPD)](https://www.healthcareers.nhs.uk/career-planning/career-planning/developing-your-health-career/continuing-professional-development-cpd)

[Clinical Council for Eye Health Commissioning (CCEHC) Guidance](https://www.college-optometrists.org/clinical-council-for-eye-health-commissioning#tab-informationandguidance-ce7cc8fd)

[UKOA/RNIB Patient Standards for Ophthalmology Services](https://uk-oa.co.uk/wp-content/uploads/2018/09/UKOA_Publications_Patient_Quality_Standard_200918.pdf)

**CPD for professionals**

[NHS England eLearning hub](https://portal.e-lfh.org.uk/)

[Opticians Act 1989 Continuing Education and Training](https://www.legislation.gov.uk/ukpga/1989/44/section/11A)

[GOC CPD requirements for DOs and Optometrists](https://optical.org/media/qo3pshey/cpd_a-guide-for-registrants_v2_june-2022.pdf)

[College of Optometrists Introduction to CPD](https://www.college-optometrists.org/professional-development/continuing-professional-development-cpd/introduction-to-cpd)

[ABDO CPD](https://www.abdo.org.uk/cpd/)

[HCPC What is CPD](https://www.hcpc-uk.org/cpd/what-is-cpd/)

[RWPN CPD scheme](https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.rwpn.org.uk%2Fresources%2FDocuments%2FRWPN%2520CPD%2520scheme%2520description%25202022%2520(1).docx&wdOrigin=BROWSELINK)

**Specific low vision areas**

CBS

[Esme's Umbrella (charlesbonnetsyndrome.uk)](https://charlesbonnetsyndrome.uk/)

Research

[European Society for Low Vision Research and Rehabilitation](https://www.eslrr.org/)  or [International Society for Low Vision Research and Rehabilitation](http://islrr.org/)

Safeguarding

[College of Optometrists Safeguarding children and adults at risk](https://www.college-optometrists.org/clinical-guidance/guidance/safety-and-quality/safeguarding-children-and-vulnerable-adults)

[ABDO | Safeguarding Regulatory requirements](https://www.abdo.org.uk/regulation-and-policy/advice-and-guidelines/regulatory/safeguarding/)

Scotland health and social care training for safeguarding -

[NHS Scotland | Turas | Public Protection](https://learn.nes.nhs.scot/64316)

## 2.3 Sight loss awareness

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| **Core:**  All patient facing staff, including non-specialist staff and volunteers, should have sight loss awareness training to understand:  • how the low vision assessment fits in with the wider low vision service.  • what other services and support are available.  • how to identify patients that may benefit from additional support and know how to refer or signpost them as needed.  • how to guide and greet patients with vision impairment.  • how to ensure the service is accessible in all aspects.  • how to communicate well with people with vision impairment. |

### Point to consider:

**Are all your team members aware of the social, emotional and functional impact of sight loss - and how this might affect a patient’s ability to access services, as well as adopting the advice the service provides?**

When providing a low vision service, it is important that all team members have an awareness of how sight loss can impact someone so they can ensure the service is accessible at all points of contact and is appropriate for the needs of the patients. This includes knowing how to meet, greet and guide patients and knowing the importance of preferred format and good communication (UKOA/RNIB, 2018).

It is important that patients are aware of who professionals are and what their responsibilities are. All staff involved in care who meet the patient should introduce themselves clearly, with name and role (UKOA/RNIB, 2018). Name badges are helpful but also introducing yourself to all patients even if they have met you before is important. The “Hello, my name is…” by Dr Kate Granger used a viral social media campaign to highlight that introductions are about making a human connection and are the first step to providing truly person-centred, compassionate care (Granger K, 2023).

Team members should know how to adapt the service to cover the needs of the individuals and to ensure that the service is embedded in the network of sight loss services. The Seeing it My Way principles provide a useful guide for this (UK Vision Strategy Seeing it My Way, 2011):

* That I have someone to talk to
* That I understand my eye condition and the registration process
* That I can access information
* That I have help to move around the house and to travel outside
* That I can look after myself, my health, my home and my family
* That I can make the best use of the sight I have
* That I am able to communicate and to develop skills for reading and writing
* That I have equal access to education and life-long learning
* That I can work and volunteer
* That I can access and receive support when I need it

Team members should have sight loss awareness training covering all aspects of the impact of sight loss; how to recognise someone that would benefit from more support; what support is available; and how patients can best access help. RNIB provides this training, to find out more email [eyecare.professionals@rnib.org.uk](mailto:eyecare.professionals@rnib.org.uk). Training can also be available through various sight loss societies and via RNIB’s ECLO service which provides sight loss awareness for their ophthalmology services. Details of training providers are in **Useful links 2.3**

## Useful links 2.3

**General guidance**

[UKOA/RNIB Patient Standards for Ophthalmology Services](https://uk-oa.co.uk/wp-content/uploads/2018/09/UKOA_Publications_Patient_Quality_Standard_200918.pdf)

[UK Vision Strategy | Seeing it My Way](https://www.adass.org.uk/media/4816/seeing-it-my-way-booklet.pdf)

[Hello My Name Is | A campaign for more compassionate care](https://www.hellomynameis.org.uk/)

**Guiding people with sight loss**

[RNIB | How to Guide People with Sight Loss booklet](https://media.rnib.org.uk/documents/How_to_guide_people_with_sight_loss_2022.pdf)

[RNIB / TPT / Guide Dogs Sighted Guiding Guidance - Visionary](https://www.visionary.org.uk/latest/policy-guidance-from-rnib-guide-dogs-and-tpt-re-sighted-guiding/)

[Guide Dogs Sighted guiding instructional videos](https://www.guidedogs.org.uk/getting-support/information-and-advice/sighted-guiding-instructional-videos/)

**Training for accessible information provision:**

Accessibility support services: [RNIB | Accessibility Advice for Business Services](https://www.rnib.org.uk/professionals/business-professionals/)

[My info my way | RNIB](https://www.rnib.org.uk/get-involved/support-a-campaign/my-info-my-way/)

[Patient Information Forum (PIF) | Events and Training](https://pifonline.org.uk/events-and-training/)

**Sight loss awareness training**

[RNIB | Professionals](https://www.rnib.org.uk/professionals/)

[Visionary](https://www.visionary.org.uk/our-offer/) is the umbrella organisation for local sight loss societies; you may be able to signpost patients to local training.

[Partially Sighted Society](https://www.partsight.org.uk/) also provides training.

To find your local ECLO service you can search [Sightline Directory](https://www.sightlinedirectory.org.uk/)

## 2.4 Criminal records check

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| **Core:**  Ensure compliance with all relevant criminal record checks where services are being provided. For example, this will typically include enhanced checks for all staff involved in direct patient care and appropriate criminal records checks for all other team members. |

### Point to consider:

**How do you know that all team members are honest and that your patients are safe in their hands?**

The Disclosure and Barring Service (DBS), or Disclosure Scotland check, enables service providers to make safer recruitment decisions and ensure their patients are safe. This is important in low vision services because of the potentially vulnerable nature of the ‘at-risk adults’ using these services. There is also a high proportion of patients who are older or who have learning disabilities. Many patients are reliant on gatekeepers for care.

If you are working within a Care Quality Commission (CQC) accredited organisation, then a DBS check for all staff in contact with patients is a requirement. In addition to this all, professional registered practitioners are required to declare any criminal proceedings, previous or current, in order to stay on the relevant register.

## Useful links 2.4

[CQC DBS checks for registration](https://www.cqc.org.uk/guidance-providers/registration/dbs-checks-cqc-registration)

England and Wales: [GOV UK Disclosure and Barring Service](https://www.gov.uk/government/organisations/disclosure-and-barring-service)

Scotland: [GOV Scotland Apply for basic disclosure](https://www.mygov.scot/basic-disclosure/apply-for-basic-disclosure)

Wales: [Wales DBS Cymru - an umbrella body for the DBS](https://dbscymru.co.uk/)

NI: [Northern Ireland Disclosure and Barring Service](https://www.nidirect.gov.uk/contacts/disclosure-and-barring-service-dbs)

GOC requirements: [GOC Make a declaration](https://optical.org/en/registration/make-a-declaration/)

HSCP requirements: [HCPC Health and character declarations](https://www.hcpc-uk.org/registration/health-and-character-declarations/)

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## 2.5 Business continuity planning

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| **Core:**  There should be a business/service continuity plan in place to ensure against any breaks, or disruption, in provision of the low vision service. |

### Point to consider:

**If there is a disruption to service, do you know what to do to make sure your patients are affected as little as possible?**

A break in service can have a direct impact on the quality of life and wellbeing of patients, therefore planning should be in place to ensure that this is avoided.

Business Continuity Management (BCM)/Business Continuity Plan (BCP) are locally developed plans that look at possible causes of disruption to a service and any mitigations that can be used to provide alternative support where necessary.

NHS organisations and providers of NHS-funded care must be able to maintain continuous levels in key services when faced with disruption from identified local risks such as severe weather, fuel or supply shortages or industrial action. BCM gives organisations a framework for identifying and managing risks that could disrupt normal service (NHS Commissioning Board, 2013).

There may be templates authorised by the commissioning or provider organisation but, if not, you should consider the following aspects:

* Who is responsible for the service and how they would be contacted in an emergency. Roles of staff and other key stakeholders. The BCM plan should include the names and contact details of any person or organisation that is integral to the plan. This may be different depending on the various scenarios.
* How is the plan implemented? (Assessing damage, contacting all key stakeholders, implementing service recovery plans, risk assessments for resumption of services.)
* What are the key components that are required for the service to run? (Staff availability, infrastructure, financial security, IT, other business partners, suppliers, plus other local dependencies).
* What might cause the service to temporarily close? (National or local disasters such as terrorism, natural disasters, fire, flooding, pandemic or rioting.)
* How can you prevent interruption? (Including staff planning and cover, careful management of contract details, alternative accommodation, health and safety risk assessments and action plan.)
* Also consider when this plan may be implemented (how long a pause in service would be acceptable without seriously impacting patient care?).

## Useful links 2.5

[NHS England Business continuity](https://www.england.nhs.uk/ourwork/eprr/bc/)

[NHS Scotland Business Continuity Framework](https://www.sehd.scot.nhs.uk/emergencyplanning/Documents/BusinessContinuity.pdf#:~:text=BCM%20is%20a%20process%20which%20provides,to%20%E2%80%9Ccatch-up%E2%80%9D%20when%20an%20event%20occurs.&text=BCM%20is%20a%20process,when%20an%20event%20occurs.&text=a%20process%20which%20provides,to%20%E2%80%9Ccatch-up%E2%80%9D%20when%20an)

# Section 3 – Accessing the service

This section covers who is eligible for the low vision service and how patients can access it, including how to contact the service between appointments. It also covers communication, telemedicine and how to accommodate patients with additional needs.

## Overview

3.1 Referral and self-referral

3.2 Who can access the service

3.3 Booking appointments

3.4 Eligibility for NHS services

3.5 Patients with additional needs

3.6 Contacting the service

3.7 Communication

3.8 Telemedicine

## 3.1 Referring and self-referral

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| **Core:**  The service can be accessed and re-accessed by referral from any health or social care professional.  **Core:**  Referral should be initiated early on the sight loss journey and should be part of a pre-agreed pathway. All new referrals should have a current sight test - within agreed NHS testing intervals - to ensure that low vision referral is appropriate, and difficulties cannot be corrected by optometric input.  **Ideal:**  Patients should be able to self-refer into the service. A triage facility should be available in these circumstances to identify those patients whose needs may be more appropriately met by other services (for instance, where red flag symptoms are present or when a valid sight test has not already been carried out). |

### Point to consider:

**How easy is it for patients to access the service when they need it? Are they referred appropriately and in a timely manner by health and social care professionals? Can they re-access the service just as easily if required?**

Access to low vision services should be prompt and flexible. Early intervention is key to getting the best outcomes (COO/RCOphth, 2013) so that patients can access low vision services at the time when they first start to be impacted by their sight loss. This will help to prevent loss of skills, confidence and motivations and be ongoing to respond to changes in circumstances (UKOA/RNIB, 2018).

Referrals made by other health and social care professionals involved in the care of the patients should be seamlessly incorporated into the eye care and sight loss pathway with other clinical services (hospital eye units, education, social care, voluntary organisations and stroke, learning disability, and falls teams) (UKOA/RNIB, 2018) and should be embedded as early into the pathway as possible (UK Vision Strategy, 2013) (CCEHC Low Vision, 2017).

To prevent waste of resources these referrals should be appropriate and therefore practitioners making the referrals may need to be trained appropriately either by service leads or using an external training resource such as RNIB sight loss awareness training e-learning, how to access these resources can be found in [**Useful links 3.1**](#_Useful_Links_3.1) below. This would include how to identify those that need the help of low vision services and in particular ensuring that the patient has already been checked by their primary care professional and appropriate diagnosis, and any urgent red flag symptoms have been assessed. Ideally there should be a way of patients self-referring too.

The following factors should be considered when ensuring appropriate referral pathways (CCEHC Low Vision, 2017):

* Agreement on whole system pathways for low vision to minimise duplication and streamlining processes.
* Low vision services working as seamlessly as possible with other services, including primary care, community, hospital eye services (HES), education, social care, voluntary and charity organisations, and stroke, learning disability, habilitation, rehabilitation and falls teams.
* Timely referral to low vision services from primary care, community ophthalmology or the voluntary sector supported by ECLOs.
* Agreement of a communication plan so that all practitioners and patients are engaged and informed of guidelines for signposting users to key services.

The key to this is to integrate the services, with defined referral pathways, such as those from LOCSU, BIOS and CCEHC which can be found under the **Useful links 3.1** heading below.

When developing or reviewing a low vision service, it is important to consider all the local stakeholders so you can discern which partners you need to work with to ensure patients are referred to the service and no-one is missed. Depending on the terms of commissioning patients may access the service via:

* Ophthalmology
* Optometry
* Local sight loss societies
* GPs
* Social services
* Visual Rehabilitation Specialists
* Condition specific organisations such as Stroke UK or Diabetes UK
* Eye condition specific organisation such as Glaucoma UK, Retina UK and Macular Society.
* Other local services and national databases for people who have sight loss

It is therefore important that not only are you aware of these stakeholders but that they are aware of your service too, referral process and criteria.

Flexibility means service users can access the service from multiple routes and should be entitled to reassessments as their vision changes (COO/RCOphth, 2013). For services where self-referral is possible it is important that you have a triage system in place to ensure that eligibility and appropriateness of the referral is established. In the worst-case scenario, patients may attend for routine, non-urgent low vision appointment when in fact they need the attention of optometry or ophthalmology to diagnose and treat active pathology. A triage template can be found in [**Appendix C – Triage template for self-referral or re-referral into the low vision service**](#_Appendix_C_-Template)

## Useful links 3.1

[UKOA/RNIB Patient Standards for Ophthalmology Services](https://uk-oa.co.uk/wp-content/uploads/2018/09/UKOA_Publications_Patient_Quality_Standard_200918.pdf)

[Clinical Council for Eye Health Commissioning (CCEHC) Guidance](https://www.college-optometrists.org/clinical-council-for-eye-health-commissioning#tab-informationandguidance-ce7cc8fd)

[BIOS Low Vision Pathway](https://www.orthoptics.org.uk/wp-content/uploads/2021/11/BIOS-Low-Vision-Pathway-9-11-21.pdf)

[Adult UK Sight Loss Pathway Appendix C UK Vision strategy](https://curriculum.rcophth.ac.uk/wp-content/uploads/2014/12/2013_PROF_252_-Adult_UK_sight_loss_pathway.pdf)

[LOCSU Low Vision Pathway](https://locsu.co.uk/what-we-do/pathways/low_vision/)

To access RNIB sight loss awareness eLearning module, email [eyecare.professionals@rnib.org.uk](mailto:eyecare.professionals@rnib.org.uk)

## 3.2 Who can access the service

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| **Core:**  Access to the service should be based on clinical needs and should be available to anyone who is experiencing difficulties performing daily tasks due to their vision after correction with spectacles or contact lenses, or if they are unable to wear prescribed correction for any reason. It should be available at any point in the sight loss journey, regardless of whether or not they meet certification criteria or are still undergoing active treatment.  **Core:**  Where there are inclusion/exclusion criteria based on age or geography, they should be re-directed to an appropriate provision such as paediatric low vision service or a local low vision service. |

### Point to consider:

**Is it clear to potential referrers and the administrators in your team who should be accessing the service and who should be seen in alternative services?**

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 or medical intervention and which causes restriction in that person's everyday life. Such a person's level of functioning may be improved by providing low vision services including the use of low vision aids, environmental modification and/or training techniques (CCEHC Low Vision, 2017). Access to support services should not be driven by clinical parameters and certification status alone, but also by social, emotional, psychological, educational and occupational effects (UKOA/RNIB, 2018) and should not be limited to those who are registered as sight impaired or severely sight impaired (CCEHC Low Vision, 2017) (COO/RCOphth, 2013).

Anyone within the age criteria of your service, who is having difficulties with day-to-day tasks due to visual impairment, should be able to access the low vision service. Access should be needs based which means that if the patient or someone caring for that individual identifies that there is an issue, they have a need to be assessed. Some services are commissioned for adults only or children only. Where there are age criteria for accessing a service the service provider should be aware of the counterpart service and should be able to directly refer those that have low vision but do not meet the age criteria for their service to the appropriate alternative. This is important in order to prevent patients being lost from the system at transition. A suitable service for children should be provided as their needs are different to the adult population.

## Useful links 3.2

[Clinical Council for Eye Health Commissioning (CCEHC) Guidance](https://www.college-optometrists.org/clinical-council-for-eye-health-commissioning#tab-informationandguidance-ce7cc8fd)

[UKOA/RNIB Patient Standards for Ophthalmology Services](https://uk-oa.co.uk/wp-content/uploads/2018/09/UKOA_Publications_Patient_Quality_Standard_200918.pdf)

## 3.3 Booking appointments

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| **Core:**  The booking system should be accessible and efficient and offer flexibility for appointments.  **Ideal:**  Patients should ideally be contacted if they have missed an appointment to explain the process of rebooking. Patients with multiple missed appointments should be contacted to find out reason for missed appointment and support to attend discussed.  **Ideal:**  There should be more than one way to access the appointment system such as accessible online booking, telephone booking and in person. |

### Point to consider 1:

**The booking system should be easy to navigate by patients and practitioners and should be able to support the needs of its users.**

The law requires service providers to make reasonable adjustments when seeing a person with a disability (Equality Act, 2010) which means all NHS services should be accessible, this includes the booking system and all communications. This ensures that ‘people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand, and with support, so they can communicate effectively with health and social care service’ (CCEHC Low Vision, 2017). This includes access to interpreters when needed for people who use BSL or who do not have English as their first language. Standard operating procedures (SOP) should embed accessibility in all aspects.

NHS information must be provided in an accessible format (CCEHC Low Vision, 2017). Patients’ communication needs should be recorded in a standard and highly visible way and ensure that is respected for future interactions (UKOA/RNIB, 2018). A standard process should be collecting data on the patient’s preferred format and ensuring this is flagged on the system and followed in any communication that is required, such as recall communications, clinic reports and appointment confirmation.

The NHS accessible health information standard toolkit provides useful guidance for this, the link for which can be found under [**Useful links 3.3**](#_Useful_Links_3.3) at the end of this subsection. However, in summary, healthcare professionals should routinely be providing oral information, an opportunity for asking questions, and accessible information e.g., email, large print (minimum font size 14 for all patients), braille, electronic/online or audio. In Wales, patients have the right to request written information in the Welsh language under the Welsh Language Act (NHS Accessible Information Standard, 2016)

Communicating in a person’s preferred format is essential in order to ensure:

* Patients are at the centre of their care and understand their options and can make informed decisions.
* Patients are aware of where the service is, how to get there, what they need to do to prepare for their appointment, what advice they have been given and when their appointment is. This reduces wasted appointments, waiting times and missed opportunities to support patients effectively.

Consider how you might be able to provide alternative formats including how to develop, produce, provide and fund these. Alternative formats to consider are:

* Telephone recalls
* Audio transcribed reports
* Large and bold print letters
* Braille communication (in grade 1 or 2 as needed)
* Electronic communication
* Plain English
* Easy Read
* BSL
* Translated information for people who do not have English as their first language

Local and national transcription services are available including through the RNIB, the link for which can be found under [**Useful links 3.3** below](#_Useful_Links_3.3)**.**

### Point to consider 2:

**If the same patient has missed several appointments is there a specific reason for this? Could it be that they are unable to access the service or unable to access the information sent to them about the appointment?**

Under the Equality Act 2010, public sector organisations have to make changes in their approach or provision to ensure that services are accessible to disabled people as well as everybody else. The NHS has to make it as easy for disabled people to use health services as it is for people who are not disabled (NHS Reasonable Adjustments, 2023).

Reasonable adjustments can mean alterations to buildings by providing lifts, wide doors, ramps and tactile signage, but may also mean changes to policies, procedures and staff training to ensure that services work equally well for people with learning disabilities. Remember that patients who have sight loss may also have other additional requirements and we must make sure that people with disabilities are not disadvantaged.

Where multiple missed appointments have been detected for an individual the team should refer to local protocols or fail to attend (FTA) policies, for managing these situations, which will include investigating why the patients is failing to attend, the risk of not reallocating an appointment and considering adaptations that might help avoid appointment wastage. For information on monitoring wasted appointments please see section **10.6 Data on missed appointments**

## Useful links 3.3

[NHS England Accessible Information Standard](https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/accessibleinfo/)

[UKOA/RNIB Patient Standards for Ophthalmology Services](https://uk-oa.co.uk/wp-content/uploads/2018/09/UKOA_Publications_Patient_Quality_Standard_200918.pdf)

[Clinical Council for Eye Health Commissioning (CCEHC) Guidance](https://www.college-optometrists.org/clinical-council-for-eye-health-commissioning#tab-informationandguidance-ce7cc8fd)

[RNIB | Transcription Services](https://www.rnib.org.uk/living-with-sight-loss/independent-living/reading-and-books/transcription-services/)

[NHS Mental Capacity Act](https://www.nhs.uk/conditions/social-care-and-support-guide/making-decisions-for-someone-else/mental-capacity-act/)

[GOV.UK Equality Act 2010](https://www.gov.uk/guidance/equality-act-2010-guidance)

[GOV.UK Guidance on Reasonable adjustments](https://www.gov.uk/government/publications/reasonable-adjustments-a-legal-duty/reasonable-adjustments-a-legal-duty)

[NHS England Reasonable adjustments](https://www.england.nhs.uk/learning-disabilities/improving-health/reasonable-adjustments/)

## 3.4 Eligibility for NHS services

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| **Core:**  NHS low vision services must be free to access at point of contact for anyone who has difficulties with activities of daily living because of their vision despite having the best corrected vision (see also section **3.2 Who can access the service**). |

### Point to consider:

**Are your services free of charge or are there any hidden costs to the patient?**

There is a range of commissioning models for low vision services including community and hospital-based services. However, if your service is an NHS commissioned service there is a requirement that provision of care is free of charge. (Health and Social Care Act, 2012). We understand that similar provisions are likely to apply in the nations but for any specific clarification you can email us on eyecare.professionals@rnib.org.uk

Where clinically necessary the HES must supply all optical low vision aids (LVAs) to patients on loan, without any charge to the patient. LVAs issued on loan will remain the property of the hospital. When LVAs are loaned, hospitals may wish to obtain an undertaking from the patient to return them if/when they are no longer required. However, the collection of a deposit payment from the patient is not permitted in respect of loan items. Where clinically necessary, the following should also be issued on loan to patients: post cataract temporary spectacles, temporary tinted spectacles, and recumbent spectacles (DoH Ophtahlmic Services, 2006)

However, there are a number of areas where regulations allow that charges may be imposed for services, which includes optical services. It should be noted that the National Health Service (Charges for Optical Appliances) Directions 2016 only covers the dispensing of glasses and contact lenses, it does not cover the provision of low vision equipment.

**Useful links 3.4** below provides guidance for when community-based services are provided in primary care settings.

## Useful links 3.4

[Optical Charges for Hospital Eye Service Patients](https://www.bipsolutions.com/docstore/pdf/15076.pdf)

[Health and Care Act 2022 (legislation.gov.uk)](https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted)

**Guidance for primary care settings:**

**England:** [The National Health Service (Charges for Optical Appliances) Directions 2016](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/509822/Optical_directions_2016_acc.pdf) sets out the maximum charges for spectacle lenses and contact lenses.

**Scotland**: [Your entitlement to NHS ophthalmic services](https://www.nhsinform.scot/care-support-and-rights/nhs-services/ophthalmics/your-entitlements-to-nhs-ophthalmic-services)  this guidance is regarding spectacles and contact lenses, but not low vision aids.

LVAs are provided by the NHS and provided according to need. [NHS Scotland Accessing and Using the NHS](https://www.nhsinform.scot/care-support-and-rights/health-rights/access/accessing-and-using-the-nhs-in-scotland)

**Wales:** [Wales Law Ophthalmic services](https://law.gov.wales/public-services/health-and-health-services/ophthalmic-services) is the information regarding provision of optometry services; the following link gives the details of entitlement to free low vision services in Wales [NHS Wales Eye Care](https://www.nhs.wales/service-area/eye-care-wales/)

**NI**: [nidirect | Eye care](https://www.nidirect.gov.uk/articles/eye-care) is the information regarding provision of optometry and eye care services in Northern Ireland

## 3.5 Patients with additional needs

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| **Core:**  The appointment system must be flexible enough to enable reasonable adaptation for those patients with additional needs. Patients with additional needs, such as dual sensory loss or dementia, should be identified as early as possible during the booking process in order to tailor the assessment to their needs. Regular review of data for missed appointments for patients with additional needs should be in place (see also section **10.6 Data on missed appointments)** |

### Point to consider:

**Are people with additional needs able to access the service as easily as anyone else?**

Under the Equality Act 2010, public sector organisations have to change their approach or provision to ensure services are accessible to people with additional needs as well as everybody else. (NHS Reasonable Adjustments, 2023) (Reasonable adjustments (gov.uk), 2020). Reasonable adjustments can mean alterations to buildings by providing lifts, wide doors, ramps and tactile signage, but may also mean changes to policies, procedures and staff training to ensure that services work equally well for people with learning disabilities (Reasonable adjustments (gov.uk), 2020).

Examples of reasonable adjustments could include:

* Preferred format (NHS Accessible Information Standard, 2016)
* Flexible appointments (UKOA/RNIB, 2018)
* A pre-appointment visit so patients can become familiar with the surroundings (UKOA/RNIB, 2018)
* Quiet rooms, and a pathway for managing their clinic visit can be helpful (UKOA/RNIB, 2018)
* Changes to lighting, colour schemes, floor coverings, assistive technology, signage, wide doorways, colour contrasts, minimising reflections and glare and notice boards (UKOA/RNIB, 2018)
* Good use of natural light and ability to block sun using blinds etc. so glare is managed (UKOA/RNIB, 2018)
* Good use of general light, ensuring sufficient lux levels (at last 100 lux) and avoiding dark shadows on the floor (UKOA/RNIB, 2018)
* Consider use of task lighting where people are signing forms etc (UKOA/RNIB, 2018)
* Good use of contrast - ensuring that key features and furniture have sufficient contrast with their environment, e.g. adding high contrast strips to the edges of steps can make them much easier to detect and thus reduce falls, chairs in waiting areas have sufficient contrast with flooring / walls (UKOA/RNIB, 2018)
* Contrasting door furniture and surrounds (handles, frames) (UKOA/RNIB, 2018)
* Clear high contrast large font signage (UKOA/RNIB, 2018)
* Floors are not shiny / reflective (UKOA/RNIB, 2018)
* Patient areas are not cluttered nor have obstacles. (UKOA/RNIB, 2018)
* Making sure there is wheelchair access in hospitals (NHS Reasonable Adjustments, 2023)
* Providing easy read appointment letters (NHS Reasonable Adjustments, 2023)
* Giving someone a priority appointment if they find it difficult waiting in their GP surgery or hospital (NHS Reasonable Adjustments, 2023)
* Longer appointments if someone needs more time with a doctor or nurse to make sure they understand the information they are given (NHS Reasonable Adjustments, 2023)

RNID provides guidance for communicating with people who have a hearing impairment. This recommends:

* Start by asking the patient if they need to lipread
* Make sure you have face-to-face contact, so the patient can easily see your lip movements
* Get the resident’s attention before you start speaking, by gently tapping them on the arm
* Find a place to talk that has good lighting, away from noise and distractions (where possible)
* Speak clearly, not too slowly, and use normal lip movements, facial expressions and gestures
* Get to the point: use plain language and don’t waffle
* Keep your voice down: it’s uncomfortable for a hearing aid user if you shout and it looks aggressive
* Make sure what you’re saying is being understood
* If the [resident] doesn’t understand what you’ve said, don’t keep repeating it – try saying it in a different way instead
* Use assistive equipment – for example, a conversation listener – if available
* Be patient and take time to communicate properly
* Writing may help if you are having difficulty communicating – avoid capital letters and use a thick pen if a patient has sight problems

Below are some examples of patients who may potentially need adjustments to access low vision services. However, this is not an exhaustive list:

* Autistic Spectrum Disorder (ASD) / Autistic Spectrum Condition (ASC)
* Attention Deficit Hyperactivity Disorder (ADHD)
* Mental health concerns
* Physical disabilities
* Learning disabilities
* Sensory impairments
* Dementia
* People who are house bound
* People who do not have English as their first language
* Underserved communities
* Homeless people
* Patients with brain-based visual impairment (otherwise known as cortical visual impairment)

Many of these groups have an increased risk of sight loss. It is important to consider their needs when providing low vision services and the impact that their additional needs may have at all stages of the process. Non-attendance policies should be sufficiently flexible to account for specific patient needs and include communication with patient and GPs on decisions (UKOA/RNIB, 2018).

The records for each individual should be flagged to identify that they have additional needs or where possible, services should use the patient passport which includes amongst others, the patient’s personal details as well as medication, allergies, communication needs, likes and dislikes and next of kin information (NHS , 2018). The best way to do this will depend on your local clinical records system and whether the service providers have access to the patient’s other medical records, however patient’s communication needs should be recorded in a standard and highly visible way and ensure that is respected for future interactions (UKOA/RNIB, 2018).

It is important to complete the Oliver McGowan Mandatory Training for health and social care workers which explains how to support people with ASD and learning disabilities appropriately. The rules described in this training are transferable to any patient. The link can be found in the section below.

## Useful links 3.5

[GOV.UK Guidance on Reasonable adjustments](https://www.gov.uk/government/publications/reasonable-adjustments-a-legal-duty/reasonable-adjustments-a-legal-duty)

[NHS England Reasonable adjustments](https://www.england.nhs.uk/learning-disabilities/improving-health/reasonable-adjustments/)

[UKOA/RNIB Patient Standards for Ophthalmology Services](https://uk-oa.co.uk/wp-content/uploads/2018/09/UKOA_Publications_Patient_Quality_Standard_200918.pdf)

[NHS England Patient Passport](https://www.england.nhs.uk/blog/a-patient-passport-thats-all-about-me/)

For patients with communication impairments:

[NHS How to care for someone with communication difficulties](https://www.nhs.uk/conditions/social-care-and-support-guide/practical-tips-if-you-care-for-someone/how-to-care-for-someone-with-communication-difficulties/)  this web resource gives information about how you can support people who have communication difficulties for any reason. It includes resources for alternative ways of communicating.

For patients with learning disabilities:

SeeAbility has a wide range of resources that can be used to support patients with sight loss and learning disabilities – in audio and easy read.

[SeeAbility | Resources](https://www.seeability.org/resources)

[Health Education England | The Oliver McGowan Mandatory Training on Learning Disability and Autism](https://www.hee.nhs.uk/our-work/learning-disability/current-projects/oliver-mcgowan-mandatory-training-learning-disability-autism) CPD for professionals in supporting patients who have ASD or learning disabilities

For patients with dementia:

[OT | Providing eye care for patients with dementia](https://www.aop.org.uk/ot/in-practice/practitioner-stories/2022/05/18/providing-eye-care-for-patients-with-dementia)

[SCIE Sight loss - Dementia and sensory loss](https://www.scie.org.uk/dementia/living-with-dementia/sensory-loss/sight-loss.asp)

[Vision 2020 | RCOphth Quality standards for people with sight loss and dementia in an ophthalmology department](https://www.rcophth.ac.uk/wp-content/uploads/2020/08/Quality-standard-for-people-with-sight-loss-and-dementia-in-an-ophthalmology-department.pdf)

For patients who do not have English as their first language:

[BAME Vision | Black, Asian, and Minority Ethnic Community](https://bamevision.org/about-us)

For patients who are homeless:

[Vision Care Charity for Homeless People | United Kingdom](https://www.visioncarecharity.org/)

For patients with hearing impairment:

[Sense | For people with complex disabilities](https://www.sense.org.uk/)

[RNID | Communication tips if you have hearing loss](https://rnid.org.uk/information-and-support/hearing-loss/living-with-hearing-loss/communication-tips/)

For patients with brain-based visual impairment:

[Make It Easier to See | Cerebral visual impairment and brain based visual problems](https://makeiteasiertosee.co.uk/)

Video resources:

[Reasonable adjustments make the biggest difference to people’s health and wellbeing | YouTube](https://www.youtube.com/watch?v=IQynWG4LCnw)

## 3.6 Contacting the service

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| **Core:**  In between appointments, the service should be contactable within working hours, for both appointment and clinical queries. In the case of part time clinics patients should be informed of how to seek help outside of clinic hours.  **Ideal:**  Patients should be given more than one way of contacting the service such as telephone and email. |

### Point to consider:

**How easy is it for patients to contact you between their scheduled appointments? Is this route also available to patients with additional needs?**

In order for patients to be supported effectively it should be possible for them to directly contact the service between appointments. This means that patients will be able to get help as and when they need it. This might be to replace broken aids or to get additional help should their circumstances change. The low vision service should also be embedded in the low vision support in the area and, therefore, be in a good position to signpost or refer patients to other services too.

Service contact details should be provided in a format that is accessible for all, as the NHS Accessible Information Standard states, and should be issued to patients before they leave. Contact options should ideally include:

* Email address
* Phone number
* General admissions contact details

It is also important that other allied professionals such as the local ECLO, ophthalmology service, local optometry services and local sight loss society know how to contact the service. You should consider annually checking your details are correct on the Sightline Directory below.

### Useful links 3.6

[Sightline Directory](https://www.sightlinedirectory.org.uk/)

See also links for accessible information in **Useful links 3.7**

## 3.7 Communication

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| **Core:**  All communications with patients should be accessible and in their preferred format as per the relevant accessible information standard for the region of the UK you are working in. This might include large print, braille, audio and translation to Welsh.  **Core:**  Patient’s preferences for formats for all communications should be recorded on patient notes, including sending of communications to family member/carer.  **Ideal:**  Communications should also aim to meet cultural and diverse needs and languages to ensure the service reaches harder to access groups. |

### Point to consider:

**Are your patients able to access the information they need in order to make informed and meaningful decisions about the care they receive?**

Information is only helpful if it is communicated in a format that is meaningful and accessible to the patient. Much of this has been covered earlier on in this document in section **1.1 Service location** and section **1.5 Awareness of the service** in terms of accessing the service. We raise it here in the context of all information (appointments, letters, reports, instructions, treatment options and general patient information) so that patients can attend their appointment, understand their options, make choices and participate fully with interventions.

A core value of NHS provision is that patients are centre to the care provided. No decisions should be made without input from the patient. Therefore, the patient should have an understanding of the care and treatment options making an informed decision possible.

Many of the resources have been given in previous sections but for ease they are again listed below.

## Useful links 3.7

[RNIB | Creating accessible information and communication resources for health and social care](https://www.rnib.org.uk/living-with-sight-loss/independent-living/accessible-nhs-and-social-care-information/creating-accessible-information-and-communication-resources-for-health-and-social-care/)

[UKOA/RNIB Patient Standards for Ophthalmology Services](https://uk-oa.co.uk/wp-content/uploads/2018/09/UKOA_Publications_Patient_Quality_Standard_200918.pdf)

[Clinical Council for Eye Health Commissioning (CCEHC) Guidance](https://www.college-optometrists.org/clinical-council-for-eye-health-commissioning#tab-informationandguidance-ce7cc8fd)

[NHS England Shared decision making](https://www.england.nhs.uk/personalisedcare/shared-decision-making/)

[NHS England Shared Decision Making: Summary Guide](https://www.england.nhs.uk/publication/shared-decision-making-summary-guide/)

## 3.8 Telemedicine

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| **Core:**  Telephone/video consultations could be considered as an option for triage or continued care for appropriately selected low vision patients. Where possible suitable patients should be followed up in their preferred modality (e.g., by telephone) if deemed appropriate by the practitioner. |

### Point to consider:

**If teleconsultations are an option in your service, what is the justification and how do you determine who is suitable for this?**

COVID–19 adjustments have resulted in the development of telemedicine options in low vision assessments. This enabled service continuity during lockdown, but some ongoing benefits have been identified while recognising that this should not replace face-to-face multi-disciplinary services.

Research shows that teleconsultations in low vision can be effective when used alongside other methods of low vision rehabilitation, such as hospital low vision clinics, mobile clinics in hard‐to‐reach areas and providing additional training in low vision for community optometrists. Telephone low vision service is safe and easy to access for many patients with visual impairment, but it is not yet able to provide the holistic, multidisciplinary, low vision assessment which can be provided in person (Patel, 2021).

Teleconsultations may be particularly beneficial for:

* Underserved communities
* Housebound individuals
* Business continuity purposes
* Triage requests for appointments to maximise capacity in the face-to-face clinic.

Practitioners should use their professional judgement to decide whether it is in the patient's best interests to offer remote consultations (The College of Optometrists, 2020). Patient safety is the primary concern. Practitioners should ensure the patient knows who they are speaking with, what the purpose of the consultation is and what choices they have. Practitioners should also make sure that they keep their knowledge on remote consultations up to date with regular relevant training (GOC Remote Consultations, 2020). While this guidance is for optometrists it is transferable to low vision assessment models too.

[**A suggested template for virtual consultation is included in Appendix K.**](#_Date:__Appendix)

## Useful links 3.8

[Lockdown low vision assessment: an audit of 500 telephone‐based modified low vision consultations](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8014140/)

[College of Optometrists Remote consultations](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge,-skills-and-performance/remote-consultations#Remoteconsultations)

[GOC High level principles for good practice in remote consultations and prescribing](https://optical.org/media/kyxni0v3/high-level-principles-for-remote-prescribing.pdf)

There is evidence to show that acuity can be measured remotely:

[Evaluation of a Home-Printable Vision Screening Test for Telemedicine](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7791401/)

# Section 4 – Multidisciplinary working

This section ensures that the low vision service works within an integrated system with patient centred care at the heart. It covers how services should link together and share information.

## Overview

4.1 Understanding the low vison pathway

4.2 Patient centred care

4.3 Linking services

4.4 Information sharing between services

4.5 Integrated health care

4.6 Transfer of care between areas

## 4.1 Understanding the Low Vision Pathway

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| **Core:**  Where several practitioners are involved in the care of a patient, they should ensure that the patient is aware of who they are and what their role is in the service.  **Core:**  It is essential to check that the patient understands that the low vision assessment does not include an eye health check or sight test and these need to be completed in addition. |

### Point to consider:

**How well do your patients understand the role of low vision services in their overall care and do they know who is who in the service?**

It is essential that patients understand what the purpose of the service is and who is who within it. Patients should be informed what to expect from their low vision service and practitioners should always introduce themselves.

It is good practice to wear a clear text name badge, however effective communication is particularly important for people with sight loss who may not be able to read name badges or paper communication. All staff involved in care who meet the patient should introduce themselves clearly, with name and role (UKOA/RNIB, 2018). The ‘Hello my name is’ campaign’s central theme is: “An extension of the campaign is how a simple introduction is the first step on the ladder of a therapeutic relationship.” See link for this in **Useful links 4.1**

There should be opportunities for the patient to ask questions, and the practitioners should check the understanding of the patient at each step.

Additionally, it is also important to inform the patient that the low vision service does not replace any other eye care. Patients should also be informed whether they will have a GOS eye examination at the same appointment or whether this needs to be provided elsewhere beforehand.

## Useful links 4.1

[UKOA/RNIB Patient Standards for Ophthalmology Services](https://uk-oa.co.uk/wp-content/uploads/2018/09/UKOA_Publications_Patient_Quality_Standard_200918.pdf)

[Hello My Name Is | A campaign for more compassionate care](https://www.hellomynameis.org.uk/)

## 4.2 Patient-centred care

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| **Core:**  All professionals involved in the care of the patients with sight loss should work collectively with patient needs at the centre of shared decision making. |

### Point to consider:

**How does your service link with other sight loss services to provide a holistic and seamless approach to care?**

Health and Social care professionals should enable the patient to experience a seamless service; one designed to ensure transition from NHS diagnosis and interventions, through emotional support, information, reablement (visual impairment rehabilitation), maximising residual vision and other social care supports, to full autonomy, independence, health and wellbeing (UK Vision Strategy, 2013).

However, patients may find navigating a service that involves several appointments and multiple practitioners difficult. They can be confused between primary eye care, secondary care and additional clinics such as virtual clinics and low vision assessments. In this case, it is important practitioners explain clearly who they are, what their role is and what the appointment is for. This should be stated at the time of booking, upon arrival and, ideally, in a report afterwards. It is important to ensure that patients attend all appointments and understand their treatment and care plans. It will also ensure that services can be delivered consistently across an area and integrated across pathways, resulting in less duplication and waste (CCEHC Low Vision, 2017).

All referrals and interconnections should be person-centred and based on needs identified, with the consent of the patient. No decisions should be made without input from the patient while understanding the care and treatment options (NHS Shared decision-making, 2019) available.

The ‘Hello my name is’ campaign covers key points about the importance of person-centred care in its four main values, with this being central to two of them:

* Patient at the heart of all decisions - “No decision about me without me”
* See Me – “see me as a person first and foremost before the disease or the bed number”.

These words ring true in healthcare as the most important person is the patient and everything should be done with them in mind. (Hellomynameis, 2024)

Informed consent is the only meaningful consent in a person-centred service. Providing patient-centred care also means including the views of relatives and carers where appropriate (UKOA/RNIB, 2018). For instance, information should only be shared with friends or relatives, if the patient consents to this.

It is a good idea to note down who attends appointments with the patient, who is legally entitled to access the patient’s information and who the patient wishes to be involved. It is essential this information is updated on each visit.

In cases where the patient is an adult that lacks capacity, then their advocate should be involved in all decision-making. It is essential the service finds out who is legally entitled to make decisions for the patient before sharing medical information.

Ideally there should be a communication plan that shares information securely with relevant practitioners (optometrists, ophthalmologists, dispensing opticians, orthoptists, GPs, support services, education services, employment services, rehabilitation services, social services), to keep all informed, to co-ordinate and prevent duplication of care. Always ask patient consent before sharing information beyond the healthcare team (e.g., education, voluntary sector services) (UKOA/RNIB, 2018). The use of secure email where any sensitive information is shared is important.

Service integration is key to this, using defined referral pathways such as those published by BIOS, LOCSU and CCEHC which recommend the Adult Sight Loss Pathway as developed by UK Vision Strategy recently revised by LOCSU. Links to which can be found below in [**Useful links 4.2**](#_Useful_Links_4.2)**.**

## Useful links 4.2

[NHS England Shared decision making](https://www.england.nhs.uk/personalisedcare/shared-decision-making/)

[NHS England Shared Decision Making: Summary Guide](https://www.england.nhs.uk/publication/shared-decision-making-summary-guide/)

[BIOS Low Vision Pathway](https://www.orthoptics.org.uk/wp-content/uploads/2021/11/BIOS-Low-Vision-Pathway-9-11-21.pdf)

[LOCSU Low Vision Pathway](https://locsu.co.uk/what-we-do/pathways/low_vision/)

[UKOA/RNIB Patient Standards for Ophthalmology Services](https://uk-oa.co.uk/wp-content/uploads/2018/09/UKOA_Publications_Patient_Quality_Standard_200918.pdf)

[UK Vision Strategy | Adult UK sight loss pathway Appendix C](https://www.adass.org.uk/media/4817/adult_uk_sight_loss_pathway_word_with_charts_final.pdf)

[Clinical Council for Eye Health Commissioning (CCEHC) Guidance](https://www.college-optometrists.org/clinical-council-for-eye-health-commissioning#tab-informationandguidance-ce7cc8fd)

## 4.3 Linking services

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| **Core:**  A low vision service must include integrated care where needed. Services should identify other agencies and services that may be of benefit to their patients and where possible establish a referral pathway, or alternatively, have the ability to signpost. In areas where an ECLO service exists it is sufficient to refer the patient to the ECLO for this purpose.  **Ideal:**  There is a direct integration between low vision services and other services and agencies. |

### Point to consider:

**Does your service ensure that patients are linked with all services that may help them?**

While this framework focuses on the quality and provision of low vision assessments and optical, or digital, aids, it is crucial that low vision services are part of a network of professionals, services and agencies, supporting patients with sight loss.

Effective low vision services should adapt to individual needs and work as seamlessly as possible with other services, including hospital eye units, education, social care, voluntary organisations, stroke rehabilitation and falls teams. Serious consideration should also be given to the provision of an ECLO in every eye clinic in order to facilitate this (COO/RCOphth, 2013)

Previously we have covered the direct services that are involved in providing low vision support and how to embed this in the commissioning of these services. However, beyond this there are multiple other services that may be of benefit to low vision patients and, as the selection is unique to the area and the individual, it is important service providers ensure they know what is available in their area.

Integrating services in this way means that patients get access to appropriate care as soon as needed. We know that early intervention is essential and central to good quality services and better outcomes.

Information on local arrangements should be readily available and low vision practitioners should ensure patients know how to access these services (COO/RCOphth, 2013). The Standard Operating Procedure (SOP) should identify how a service will integrate with other services in the local area and nationally. See section **9.5 Standard Operating Procedure (SOP).** Where possible, links should be created directly through local referral pathways, whereas for others this may not be possible (especially where these are third sector organisations or services outside of the ICS). In these cases, referral may be arranged, or patients can be signposted with clear instructions and information given. Referral should include why the person is being referred and the urgency of that referral.

Consent will be covered in section **9.3 Consent** but, whenever referral to another agency is considered necessary or recommended, this should be done with informed consent unless the patient is deemed to lack mental capacity. See section **4.4 Information sharing between services** for information on capacity and section **9.3 Consent.**

The following (non-exhaustive) list contains examples of key stakeholders that low vision practitioners should consider working seamlessly with:

This table has three columns and 22 rows.

|  |  |  |
| --- | --- | --- |
| **Service/ professional** | **Role** | **References** |
| Rehabilitation worker for sensory needs | Supporting patients with practical advice for activities of daily living including mobility training  [RWPN Core skills and Job Descriptions](https://www.rwpn.org.uk/core_skills) | [Rehabilitation Workers Professional Network RWPN](https://www.rwpn.org.uk/) |
| Primary care optometry and dispensing | Ensuring that the patient has access to eye care and provision of spectacles and contact lenses where appropriate | [College of Optometrists](https://www.college-optometrists.org/)  [ABDO | Association of British Dispensing Opticians](https://www.abdo.org.uk/) |
| Eye Care Liaison Officer (ECLO) | ECLOs are there to provide patients with up-to-date information and put them in touch with useful services by making referrals on their behalf. They assist in the CVI process too | [Eye Care Liaison Officers (ECLOs) | RNIB](https://www.rnib.org.uk/professionals/health-social-care-education-professionals/health-professionals/the-benefits-of-eclos/) |
| Mental health services and charities | Support patients through the emotional impact of sight loss  Through confidence building or more formal counselling | [Samaritans](https://www.samaritans.org/)    [RNIB Talk to somebody](https://www.rnib.org.uk/your-eyes/navigating-sight-loss/sight-loss-and-wellbeing/talk-to-somebody/)  [MIND](https://www.mind.org.uk/)  [NHS Mental health services](https://www.nhs.uk/nhs-services/mental-health-services/)  [Sign Health | The Deaf Health Charity](https://signhealth.org.uk/)    [Macular Society Counselling service](https://www.macularsociety.org/support/counselling/)  [Retina UK Talk & support service](https://retinauk.org.uk/information-support/talk-support/) |
| GPs | General practitioner – central to co-ordinate all the patient’s health care needs | [Royal College of General Practitioners (RCGP)](https://www.rcgp.org.uk/) |
| Falls teams | Provide holistic approach to support patients at risk of falling to prevent falls.  Each area has a different service, so contacts need to be made locally | [Age UK Elderly fall prevention](https://www.ageuk.org.uk/information-advice/health-wellbeing/exercise/falls-prevention/) |
| Ophthalmology | Responsible for diagnosis and management of active pathology. It is therefore vital that there is correspondence between medical care and low vision provision | [Royal College of Ophthalmologists](https://www.rcophth.ac.uk/) |
| Social care services | Social services - Social services refers to the department of your local council that is responsible for the welfare and safeguarding of vulnerable children and adults | [NHS Care and support help from social services and charities](https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/) |
| Occupational therapists | Helps people with disabilities maximise their potential in undertaking daily living tasks | [NHS Occupational therapy](https://www.nhs.uk/conditions/occupational-therapy/) |
| Third sector organisations for people with sight loss | There are many local and national charities that support people with sight loss | Database for all services for visually impaired people local and national:  [[Sightline Directory](https://www.rnib.org.uk/sightline-directory/)](https://www.sightlinedirectory.org.uk/)    Local societies - [Visionary](https://www.visionary.org.uk/)  National charities:  [RNIB](https://www.rnib.org.uk)  [Thomas Pocklington Trust (TPT)](https://www.pocklington-trust.org.uk/)  [Guide Dogs](https://www.guidedogs.org.uk/getting-support/)  [The Partially Sighted Society | Helping People with a Visual Impairment](https://www.partsight.org.uk/)  Veterans:  [Blind Veterans UK](https://www.blindveterans.org.uk/) |
| Orthoptics | Orthoptists are responsible for supporting patients with eye conditions that affect the eye muscles. Many orthoptists are also involved in providing low vision services and helping those with sight loss | [BIOS | British and Irish Orthoptic Society](https://www.orthoptics.org.uk/) |
| Speech and language therapists | Speech and language therapy provides treatment, support and care for children and adults who have difficulties with communication, or with eating, drinking and swallowing | [RCSLT Speech and language therapy](https://www.rcslt.org/speech-and-language-therapy/) |
| Employment services | Access to work is the government scheme to support people in work; third sector organisations also have support for employment | [Government Access to Work](https://www.gov.uk/access-to-work)  [RNIB Equality and employment](https://www.rnib.org.uk/living-with-sight-loss/equality-and-employment/)  [TPT Employment](https://www.pocklington-trust.org.uk/employment/)  [Government Job Centre Plus](https://www.gov.uk/contact-jobcentre-plus) |
| Welfare rights and benefits | Social services can support with this but also a range of third sector organisations | [RNIB Money and benefits](https://www.rnib.org.uk/living-with-sight-loss/money-and-benefits/)  [Citizens Advice Bureau](https://www.citizensadvice.org.uk/)  [Blind Veterans UK | Welfare benefits for people with sight loss](https://www.blindveterans.org.uk/sight-loss-resources/welfare-benefits-for-people-with-sight-loss/) |
| Technology services | Access to work can provide advice and support for people in work  Third sector organisations can also support | [Government Access to Work](https://www.gov.uk/access-to-work)  [RNIB Assistive technology](https://www.rnib.org.uk/your-eyes/navigating-sight-loss/assistive-technology/)  [Henshaws Assistive Technology](https://www.henshaws.org.uk/hints-and-tips-category/technology/?gad_source=1&gclid=EAIaIQobChMIw9LVoNPfgwMVN5ZQBh1EIwYhEAAYASAAEgK8cfD_BwE) |
| Eccentric viewing support | Macular Society provides services to support patients who use this scanning strategy | [Macular Society Skills for seeing](https://www.macularsociety.org/support/skills-seeing/) |
| Safeguarding | Local protocols are in place that need to be implemented | [Government Working together to safeguard children](https://www.gov.uk/government/publications/working-together-to-safeguard-children--2)  [Government Safeguarding policy: protecting vulnerable adults](https://www.gov.uk/government/publications/safeguarding-policy-protecting-vulnerable-adults) |
| Interpreters | Many patients will require the support of interpreters including sign language | [NHS England Interpreting and translation in primary care](https://www.england.nhs.uk/primary-care/primary-care-commissioning/interpreting/) |
| Carers support services | There are a range of organisations in the third sector supporting carers – this is vital in supporting patients with sight loss | [NHS Support and benefits for carers](https://www.nhs.uk/conditions/social-care-and-support-guide/support-and-benefits-for-carers/) |
| Sport and leisure | Quality of life is improved when leisure and sport needs are supported.  There is a range of organisations that provide this support | [British Blind Sport](https://britishblindsport.org.uk/)  [Vocal Eyes Opportunities for blind and partially sighted people to experience and enjoy art and heritage](https://vocaleyes.co.uk/)  [Travel Eyes International Group Holidays for Blind & Sighted Travellers](https://www.traveleyes-international.com/)    [RNIB Music](https://www.rnib.org.uk/living-with-sight-loss/community-connection-and-wellbeing/leisure/music/) |
| Peer support groups | Peer support is beneficial for many people with sight loss they are provided by local and national organisations | [Sightline Directory](https://www.sightlinedirectory.org.uk/) |

## Useful links 4.3

[College of Optometrists and Ophthalmologists Clinical Commissioning Guide for better eye care: Adults with Low Vision](https://www.college-optometrists.org/getmedia/4867ed01-7eab-42d8-bece-f9204989639c/clinical-commissioning-guidance-adults-with-low-vision.pdf)

[LOCSU Low Vision Pathway](https://locsu.co.uk/what-we-do/pathways/low_vision/)

## 4.4 Information sharing between services

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| **Core:**  Referrals should be made with patient consent unless deemed to be in the best interest of the patient (such as when a safeguarding threshold has been reached) in which case need for consent can be reconsidered.  **Core:**  Where appropriate there should be a clear process in place for referral, re-referral and GDPR-compliant information sharing all components of the low vision service. |

### Point to consider:

**What is your Standard Operating Procedure (SOP) for gaining consent to share information? Do patients understand the decisions that are made, and can they give informed consent?**

Consent is key to providing patient-centred services. The patient should be given enough information so they can make informed decisions and give consent to interventions, assessments and referrals.

Consent is required in all cases - unless the person does not have capacity to consent, or if they themselves or someone else is at immediate risk if action is not taken, such as when a safeguarding threshold has been met. It is important to note that making a ‘poor’ decision does not mean a person lacks capacity – people will not always make the decision you think they should.

Having capacity is the ability to use and understand information to make a decision and communicate any decision made. A person lacks capacity if their mind is impaired or disturbed in some way, which means they’re unable to make a decision at the time. Some examples of how a person’s brain or mind may be impaired include mental health conditions, dementia, severe learning disabilities, brain damage from stroke or injury and intoxication (NHS Assessing Capacity webpage, 2023).

The Mental Capacity Act (2005) says (Mental Capacity Act, 2005):

* Assume a person has the capacity to make a decision themselves unless it’s proved otherwise
* Wherever possible, help people make their own decisions
* Do not treat a person as lacking the capacity to make a decision just because they make an unwise decision
* If you make a decision for someone who does not have capacity it must be in their best interests
* Treatment and care provided to someone who lacks capacity should be the least restrictive of their basic rights of freedom

The test for capacity is:

a) The person can understand and remember information given to them

b) They can use that information to make a decision

c) They can communicate that decision [this may not be verbal communication]

It is important to remember that some people may usually have capacity but under certain circumstances they don’t (for instance when they are suffering from shock). The supporting references under the [**Useful links 4.4**](#_Useful_Links_4.4)below can provide you with more information in order to assess for capacity and how to gain consent.

Even when consent is given, there is still a duty to share data safely to protect the person from accidental loss of data, or information being shared to someone other than the intended recipient.

Organisations should be NHS data protection-compliant and must follow GDPR rules. Following the rules and guidelines protects the patient from harm, or surprise, that might arise from sharing or storing data without consent. For more information on this see links below and also sections **9.1 Storing and sharing data** and **9.3** **Consent**.

## Useful links 4.4

**Consent and capacity**

[NHS Consent to treatment - Assessing capacity](https://www.nhs.uk/conditions/consent-to-treatment/capacity/)

[NHS Mental Capacity Act](https://www.nhs.uk/conditions/social-care-and-support-guide/making-decisions-for-someone-else/mental-capacity-act/)

[College of Optometrists Consent](https://www.college-optometrists.org/clinical-guidance/guidance/communication,-partnership-and-teamwork/consent)

[GOC Obtain valid consent](https://optical.org/optomanddostandards/3-obtain-valid-consent/)

[ABDO Consent](https://www.abdo.org.uk/regulation-and-policy/advice-and-guidelines/updates/r1-2-2-consent/)

[Rehabilitation Workers Professional Network RWPN - Professional Standards](https://www.rwpn.org.uk/Professional-Standards)

[SCIE | Mental Capacity Act | Independent Mental Capacity Advocate (IMCA)](https://www.scie.org.uk/mca/imca)

[GOV.UK Independent mental capacity advocates](https://www.gov.uk/government/publications/independent-mental-capacity-advocates)

[Mental Capacity Act 2005 (legislation.gov.uk)](https://www.legislation.gov.uk/ukpga/2005/9/contents)

**Data sharing**

[NHS England Confidentiality Policy](https://www.england.nhs.uk/publication/confidentiality-policy/)

[NHS Data Security and Protection Toolkit](https://www.dsptoolkit.nhs.uk/)

[NHS Digital Keeping data safe and benefitting the public](https://digital.nhs.uk/data-and-information/keeping-data-safe-and-benefitting-the-public)

## 4.5 Integrated health care

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| **Core:**  Any other medical conditions a patient may have which could impact their eyes or their vision, or where sight loss may impact their ability to manage their medical condition should be taken into consideration. Low vision services must liaise with the GP and/or any other care providers involved to highlight any risk factors that are associated with their vision impairment and treatment adherence. |

### Point to consider:

**How does your service liaise with other medical services caring for mutual patients?**

It is very common for people with low vision to have other long-term conditions or disabilities. Services that are well integrated should consider the connections between those other conditions and vision (COO/RCOphth, 2013) and ensure where there is overlap there is communication between services. For example, patients who have sight loss due to diabetic eye disease and are under the care of diabetes services as well as low vision.

Conveying information that will enable patients to manage their underlying condition (such as talking glucose monitors) means that everyone involved in their care is aware of potential risks and mitigations. A similar case would be patients who have sight loss associated with stroke who may find the use of low vision aids and adaptations can assist with their rehabilitation (COO/RCOphth, 2013).

Fundamentally if there isn't communication between those supporting the patient with different aspects of their general health then opportunities might be missed, and adherence to treatment and engagement with recommendations may well be impacted too. For example, management of multiple medications.

It is a good idea to liaise with carers and care teams involved in the support of your patients, for example, care home staff should know about the level of vision of the person they care for. Find out who is supporting the patient, check consent with the patient and share relevant information (both with and from) that will enable the patient to experience a holistic, seamless service. See also sections **4.4 Information sharing between services** and **9.3 Consent**as well as **Useful links 9.1**.

This interconnection between services is also important in terms of ensuring that risks can be identified and where necessary you are able to liaise with the relevant service even when it is something outside of the sphere of your work. For instance, identifying that the patient has signs of depression, while not specific to the low vision assessment, you still have a responsibility to ensure that the patient gets the help they need. Similarly, if you identify a potential safeguarding concern, or a lack of compliance to treatment for diabetes, this should not be overlooked and must be flagged.

This concept underpins the Making Every Contact Count agenda. It recognises that staff across health and care, local authority and voluntary sectors have thousands of contacts every day with individuals and are ideally placed to support health and wellbeing (MECC, 2023). This way professionals can optimise the contact they have with a patient and work together with allied health and health and social care professionals to ensure that no opportunity is missed.

An awareness of other supporting agencies, public and third sector, in your local area and nationally, is important to facilitate this. Some suggestions are listed below in [**Useful links 4.5**](#_Useful_Links_4.5).

## Useful links 4.5

[College of Optometrists and Ophthalmologists Clinical Commissioning Guide for better eye care: Adults with Low Vision](https://www.college-optometrists.org/getmedia/4867ed01-7eab-42d8-bece-f9204989639c/clinical-commissioning-guidance-adults-with-low-vision.pdf)

[Making Every Contact Count (MECC) | Health Education England](https://www.hee.nhs.uk/our-work/population-health/our-resources-hub/making-every-contact-count-mecc)

Diabetes:

[NHS Help and Support with Type 2 Diabetes](https://www.nhs.uk/conditions/type-2-diabetes/finding-help-and-support/)

[Diabetes UK](https://www.diabetes.org.uk/)

[NHS Diabetic Eye Screening Service](https://www.nhs.uk/conditions/diabetic-eye-screening/)

Stroke:

[NHS Stroke Service Model](https://www.england.nhs.uk/publication/national-stroke-service-model-integrated-stroke-delivery-networks/)

[Stroke Association](https://www.stroke.org.uk/)

Mental health:

[MIND](https://www.mind.org.uk/)

[Anxiety UK](https://www.anxietyuk.org.uk/)

[Samaritans](https://www.samaritans.org/)

Multiple Sclerosis:

[MS Society UK](https://www.mssociety.org.uk/)

[NHS Multiple Sclerosis](https://www.nhs.uk/conditions/multiple-sclerosis/)

Dementia:

[Alzheimer's Society](https://www.alzheimers.org.uk/)

[Age UK](https://www.ageuk.org.uk/)

[Dementia UK](https://www.dementiauk.org/)

Learning disabilities:

[Mencap](https://www.mencap.org.uk/)

[Government guidance for learning disabilities](https://www.gov.uk/health-and-social-care/learning-disabilities" \l "guidance_and_regulation)

[Government Learning disabilities: applying All Our Health](https://www.gov.uk/government/publications/learning-disability-applying-all-our-health/learning-disabilities-applying-all-our-health)

Local learning disability partnerships – these are commissioned locally and can be found on your local social services website

Hearing or dual sensory loss:

[NHS Deafblindness](https://www.nhs.uk/conditions/deafblindness/)

[Sense | For people with complex disabilities](https://www.sense.org.uk/)

[Deafblind UK](https://deafblind.org.uk/)

[RNID](https://rnid.org.uk/)

Community nurse services:

[NHS England Community nursing](https://www.england.nhs.uk/nursingmidwifery/delivering-the-nhs-ltp/community-nursing/)

## 4.6 Transfer of care between areas

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| **Core:**  When a patient is relocating, the current service provider should inform the patient of the process to re-register with their new local low vision service provider. This is likely to be via their GP, new ophthalmology service or local primary care optometrist.  **Ideal:**  A direct referral with summary report to the new service would be ideal. |

### Point to consider:

**How do you ensure that patients are not lost to follow up when they move areas?**

Assisting patients to transfer to an alternative service if they move out of the area is an important step in preventing people becoming lost to follow up. In your Standard Operating Procedure (SOP) you should have outlined the process. This should include:

1. Identifying the equivalent service in the patient’s new location. As services in England and NI are locally commissioned this can sometimes be challenging but using the Sightline Directory search engine can be a good first step. Alternatively, if there is an ECLO in your service they will be able to facilitate.
2. If the alternative service is not embedded in the hospital service, you may need to provide the patient with details of their low vision aids and recommendations to take with them.
3. Making a direct referral is always preferable to ensure a smooth transfer of care.
4. If direct referral is not possible then explaining the process required to transfer via the patient’s new GP or ophthalmologist, giving them the information in preferred format and checking their understanding is the minimum required.

## Useful links 4.6

[Sightline Directory](https://www.sightlinedirectory.org.uk/)

[Visionary](https://www.visionary.org.uk/our-offer/)

# Section 5 – Establishing needs

This section covers all aspects of a needs-based assessment including how to involve patient advocates, families and carers.

## Overview

5.1 Needs-based assessment

5.2 Eye health information

5.3 Emotional wellbeing

5.4 Safeguarding

5.5 Charles Bonnet Syndrome

5.6 Falls

5.7 Cerebral Visual Impairment

5.8 Certification

5.9 Routine review

5.10 Follow ups

5.11 Patient advocates

5.12 Families and carers

## 5.1 Needs-based assessment

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| **Core:**  There should be a needs-based assessment to determine the aims and objectives of the low vision assessment. This should be driven by patient preferred outcomes which should be co-produced by the patient and practitioner and should reflect patient preference and safety.  **Core:**  All relevant needs must be included in a personalised plan. |

### Point to consider:

**How do you know what the low vision targets are for each patient?**

Sight loss has a functional impact (what does it stop them doing?), an emotional impact (how it makes them feel?) a social impact (the repercussions in terms of their day-to-day activities, personal life and independence) and sometimes a financial impact. How these affect each individual should be assessed through a combination of discussions with the service user (and in some cases their family and carers) and clinical examination (COO/RCOphth, 2013).

Healthcare professionals should develop an understanding of the patient, by asking about and addressing their domestic, social, work and driving situation, the impact of patients’ physical and visual disabilities, general health and any cognitive impairment on care, their psychological adjustment to vision loss and any evidence of possible depression (UKOA/RNIB, 2018). They should specifically ask about and note down their ability to carry out everyday tasks (like personal care, cooking and history of any burns), their mobility and communication as well as other issues such as whether the patient lives alone, how mobile they are, if they have had a fall and what medication they are taking. The needs assessment should pick up any problems with glare, adapting to changes in light or having hallucinations as a result of Charles Bonnet Syndrome (COO/RCOphth, 2013).

The importance of a methodical and thorough discussion during the initial consultation cannot be underestimated (Macnaughton J. L., 2019) and is the cornerstone of personalised care that follows service users and meets their needs and risks (CCEHC Low Vision, 2017).

Consider using SMART target techniques in your support plan. This means that your goals are: (Asana , 2023)

* **S**pecific – what is the aim?
* **M**easurable – what will the change be?
* **A**ccepted – agree the aim and intervention with everyone
* **R**ealistic –avoid false expectations
* **T**ime bound – state when it will be achieved

An example of a low vision patient plan can be found in **Appendix I - Template low vision report**

## Useful links 5.1

[College of Optometrists and Ophthalmologists Clinical Commissioning Guide for better eye care: Adults with Low Vision](https://www.college-optometrists.org/getmedia/4867ed01-7eab-42d8-bece-f9204989639c/clinical-commissioning-guidance-adults-with-low-vision.pdf)

[UKOA/RNIB Patient standards for ophthalmology services](https://uk-oa.co.uk/wp-content/uploads/2018/09/UKOA_Publications_Patient_Quality_Standard_200918.pdf)

[Clinical Council for Eye Health Commissioning (CCEHC) Guidance](https://www.college-optometrists.org/clinical-council-for-eye-health-commissioning#tab-informationandguidance-ce7cc8fd)

[SMART Goals | Asana](https://asana.com/resources/smart-goals)

## 5.2 Eye health information

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| **Core:**  Practitioners should check that patients understand their confirmed eye condition and where possible should be able to provide condition specific information. Information given should be from a reliable source and in an accessible format. |

### Point to consider:

**How do you ensure that your patients understand their eye condition and the implications of this?**

It is a common occurrence in a low vision clinic that we meet patients who do not fully understand their eye condition, treatment options or the implications of the condition. A classic example is the AMD patient who thinks that ‘nothing further can be done’ means that they will ultimately lose all their vision. While explaining eye conditions and medical treatment is not the purpose of a low vision clinic, it can make a big difference to the patient’s emotional wellbeing if they have a good understanding of their situation. It also means that you are in a better position to be able to explain how to make the best use of residual vision and maximise visual performance. Often there is also more time in the low vision clinic to discuss questions they have not been able to ask their consultant.

Depending on the qualifications of the low vision practitioner it may not be within their professional competencies to discuss these medical aspects. In these situations, linking the patient with the ECLO to liaise with the medical team may be an option or directly with the medical secretary of the consultant if there is no ECLO.

Where the diagnosis is known giving the patient information in their preferred format from reliable sources can prevent scrolling through potentially misleading internet information. [**Useful links 5.2**](#_Useful_Links_5.2) below provides some reliable sources of information, much of which is free to download or order from the providing organisations. This is not exhaustive but building up a file of useful sources can be very helpful to save time in clinic.

## Useful links 5.2

General eye condition guides

[RNIB | Eye conditions](https://www.rnib.org.uk/your-eyes/eye-conditions-az/)

Glaucoma information

[Glaucoma UK | Help & Support For People Living With Glaucoma](https://glaucoma.uk/about-glaucoma/)

CBS information

[Esme's Umbrella - Managing your Charles Bonnet Syndrome](https://charlesbonnetsyndrome.uk/managing-your-charles-bonnet-syndrome-cbs/)

General eye condition and health information

[NHS Health A to Z](file:///C:\Users\PSmith\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\Health%20A%20to%20Z%20-%20NHS%20(www.nhs.uk))

Brain based visual impairment

[Make It Easier to See | Cerebral visual impairment and brain based visual problems](https://makeiteasiertosee.co.uk/)

Macular conditions

[Macular Society - Additional resources](https://www.macularsociety.org/support/resources/)

Inherited retinal conditions

[Retina UK - Information & support](https://retinauk.org.uk/information-support/)

Inherited eye conditions

[Gene Vision - A resource for patients and doctors about rare genetic eye disorders](https://gene.vision/)

General advice about eye health

[Vision Matters - National Eye Health Week](https://www.visionmatters.org.uk/)

[Look After Your Eyes](https://lookafteryoureyes.org/)

## 5.3 Emotional wellbeing

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| **Core:**  Practitioners should be aware of the potential emotional impact of sight loss and should provide an assessment of emotional wellbeing using appropriate questioning and, where indicated, patients should be referred for emotional support and further formal assessment. |

### Point to consider:

**Do you explore the emotional well-being of every patient using your service?**

We know that at least four in every 10 patients attending a low vision service will have depression (Nollett, 2016).

Without the right support for the emotional impact of sight loss the patient may not be able to take on board low vision intervention and recommendations, and at worst may suffer an emotional crisis. It is vital that this is addressed as a priority.

There may be an organisational policy for depression screening, but if not then consider including the Whooley questions as a minimum. These are evidence-based questions to help you identify appropriate patients so they can get the support they need.

The questions are (Whooley MA, 1997):

* During the last month have you been bothered by feeling down, depressed or hopeless?
* During the last month have you been bothered by little interest or pleasure in doing things?

Answering yes to either of these should result in a referral for more support and exploration of the patient’s mental well-being.

Some services may prefer to include quality of life questionnaires that are administered either before or during the assessment. There are multiple options available, however some useful links can be found below.

It is important to note that there are many aspects to the emotional well-being of patients attending a low vision clinic. Exploring with the patient other symptoms such as anger, shock, denial and bartering is important too. (BACP, 2024) For more information about directing patients to appropriate support can be found in **Useful links 5.3** below. Patients may benefit from a range of support including peer support groups, telephone support groups, 1-2-1 counselling online, telephone or face to face or confidence building courses.

Undertaking CPD training in emotional well-being is important for anyone working in a low vision clinic. Courses are available through major sight loss and mental health charities.

See also section **5.4 Safeguarding**

## Useful links 5.3

**Depression Screening Resources**

[Cardiff University: Sight Loss Patients with Depression Routinely Overlooked](https://www.cardiff.ac.uk/news/view/191612-sight-loss-patients-with-depression-routinely-overlooked)

Whooley screening questions for depression: [Whooley et al: Case-Finding Instrument for Depression](https://whooleyquestions.ucsf.edu/sites/g/files/tkssra5196/f/Whooley%20et%20al.JGIM%201997.pdf)

[Whooley Questions](https://whooleyquestions.ucsf.edu/)

Stages of loss in sight loss

[The five stages of grief | BACP](https://www.bacp.co.uk/about-therapy/what-therapy-can-help-with/five-stages-of-grief/)

**Quality of Life Questionnaires**

[Visual Function Questionnaire (VFQ-25)](https://www.rand.org/health-care/surveys_tools/vfq.html)

[Impact of Visual Impairment Scale (IVIS) | National Multiple Sclerosis Society](https://www.nationalmssociety.org/For-Professionals/Researchers/Resources-for-MS-Researchers/Research-Tools/Clinical-Study-Measures/Impact-of-Visual-Impairment-Scale-(IVIS))

[Low Vision Quality of Life Questionnaire (LVQOL) Design and measuring the outcome of low-vision rehabilitation](https://pubmed.ncbi.nlm.nih.gov/11124300/)

**Emotional support sources**

[RNIB | Sight loss counselling - professional support](https://www.rnib.org.uk/living-with-sight-loss/community-connection-and-wellbeing/sight-loss-counselling/)

[Glaucoma UK | Care & support](https://glaucoma.uk/care-support/)

[Retina UK Talk & support service](https://retinauk.org.uk/information-support/talk-support/)

[Macular Society Emotional support for macular disease](https://www.macularsociety.org/support/events/webinars/previous-webinars/2022/emotional-support-macular-disease/)

[MIND Information and support](https://www.mind.org.uk/information-support/)

[Anxiety UK](https://www.anxietyuk.org.uk/)

[Samaritans](https://www.samaritans.org/)

[Papyrus UK Suicide Prevention | Prevention of Young Suicide](https://www.papyrus-uk.org/)

[Shout | UK's 24/7 Crisis Text Service for Mental Health Support](https://giveusashout.org/)

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## 5.4 Safeguarding

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| **Core:**  Safeguarding policies and procedures should be in place and followed. All staff should have safeguarding training for the patient groups that they are working with in accordance with the organisation’s safeguarding policy. |

### Point to consider:

**Do all your team members know what to do in the circumstances where a safeguarding concern occurs? Do you have safeguarding policies in your Standard Operating Procedure (SOP)?**

Safeguarding is protecting an adult’s right to live in safety, free from abuse and neglect (Government Safeguarding Strategy, 2019). It should be noted that this is a framework for adults with low vision and the following information relates to adults only, the guidelines for safeguarding children differ and are not within the remit of this document.

Safeguarding is everyone’s business. Any medical or allied health service can at times discover safeguarding risks and concerns. In low vision, given the additional needs of many of the patients, the incidents of safeguarding are potentially higher than average. Many of our patients rely on the support of carers and family members for the management of their personal affairs which means that they are at an increased risk of abuse. In addition, we know the incidence of depression is high in this population (Nollett, 2016) and therefore it is unfortunately the case that we will see patients who have suicidal ideation. We need to know how to spot the signs of abuse or identify suicide risks. We also need to know what to do in these stressful situations. There needs to be a clear understanding of the local safeguarding policies and protocols.

There are several providers of safeguarding training including the College of Optometrists, ABDO, and Health and social care professionals’ council. In addition, there is NHS training for those employed within the hospital eye services and the NHS safeguarding app can provide an excellent resource. Links to these resources can be found in [**Useful links 5.4**](#_Useful_Links_5.4).

Managing suicidal ideation can be very stressful but is made easier by having a systematic approach and framework to explore the situation. Many people incorrectly believe that exploring these feelings with a patient can make the situation worse and therefore an opportunity to save their life may be missed. There is professional training available through Samaritans and as with all aspects of care, practitioners should only work within their own scope of practice, seeking help for the patient from the most appropriate professional. The SOP should include guidance within the safeguarding policy around managing these situations which states the limits of the service role, referral criteria and process and the details of local safeguarding services. The practitioner should be aware that where there is immediate risk to life, they should call 999.

## Useful links 5.4

[Safeguarding strategy 2019 to 2025: Office of the Public Guardian](https://www.gov.uk/government/publications/safeguarding-strategy-2019-to-2025-office-of-the-public-guardian/safeguarding-strategy-2019-to-2025-office-of-the-public-guardian)

[College of Optometrists | Safeguarding training](https://www.college-optometrists.org/qualifying/scheme-for-registration/sfr-additional-information/before-you-qualify/safeguarding-training#:~:text=Safeguarding%20training%20is%20considered%20good%20practice%20for%20all,Health%20Board%20or%20the%20National%20Performers%20List%20%28England%29.)

[ABDO - adult safeguarding training](https://www.abdo.org.uk/adult-safeguarding/#:~:text=The%20ABDO%20Adult%20Safeguarding%20course%20will%20introduce%20the,manage%20and%20process%20any%20concerns%20that%20may%20arise.)

[NHS England Safeguarding app](https://www.england.nhs.uk/safeguarding/nhs-england-safeguarding-app/)

Further assistance can be found in the NHS Future Safeguarding hub [NHS Futures Safeguarding hub](https://future.nhs.uk/safeguarding/groupHome)

[Samaritans | Suicide Prevention Training Courses](https://www.samaritans.org/how-we-can-help/workplace/workplace-staff-training/half-day-courses/course-handling-suicidal-conversations/)

## 5.5 Charles Bonnet Syndrome

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| **Core:**  Charles Bonnet Syndrome should be discussed. |

### Point to consider:

**Do you discuss Charles Bonnet Syndrome (CBS) with all the patients that attend your service?**

We know that up to 30 per cent of patients attending a low vision service will have experienced CBS, but many do not know what it is and may be too frightened to tell anyone. Unfortunately, this is compounded by a general lack of awareness in health and social care professionals. Some patients who experience these hallucinations are still incorrectly being referred to psychiatrists rather than being correctly diagnosed with CBS.

Asking some straight-forward questions normalises the situation, gives an opportunity to disclose symptoms that the patient has been holding in and gives an opportunity to prepare patients for the possibility of developing this in the future.

Asking “Do you ever see anything that isn't really there, or others tell you is not there?” opens the discussion. If they say yes, you should check whether any other senses are involved. If they can hear, taste, smell or touch the image then referral to their GP is appropriate to explore medical concerns. If the image is just visual, then discussing CBS and providing information and support is appropriate. It may be sensible to consider other factors that might be making their symptoms worse such as sending them along to their GP for a medicine review or considering their emotional well-being.

If they do not get hallucinations, it is still important to give information about CBS so that they are prepared should it happen to them.

## Useful links 5.5

[Esme's Umbrella (charlesbonnetsyndrome.uk)](https://charlesbonnetsyndrome.uk/)

[RNIB | Charles Bonnet syndrome](https://www.rnib.org.uk/your-eyes/eye-conditions-az/charles-bonnet-syndrome/)

[NHS Charles Bonnet syndrome](https://www.nhs.uk/conditions/charles-bonnet-syndrome/)

## 5.6 Falls

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| **Core:**  Falls or risk of falls should be discussed. |

### Point to consider:

**Do you check with each patient regarding their recent falls history or anxiety around falling?**

The risk of falling is significantly higher for those with sight loss (Black, 2005). It is recommended that as part of the assessment we should routinely check with each patient whether they have a history of falls or have nearly fallen and explore the reasons for this. Low vision services should integrate with falls prevention services (COO/RCOphth, 2013) to give patients the best support.

There are questions that can help open this conversation:

1. In the past year have you had one or more falls?
2. In the past year have you been worried that you may fall or nearly fallen?

In addition, consider what other risk factors exist such as co-morbidities.

If someone has experienced one or more falls, or is worried about falling, then you should go on to explore the circumstances and context to determine the best way to prevent further falls. This may include looking at their orientation and mobility skills, referring to a falls team, sensory needs home assessments and considering the spectacle lens type. Bearing in mind not all falls are due to vision.

An estimation of the frailty of the patient using the Rockwood frailty scale can be a useful guideline to help identify patients at risk of falls see [**Useful links 5.6**](#_Useful_Links_5.6) below.

It is important to remember that patients at risk of falling may be frighted to go out or unable to go out unaccompanied. This can quickly result in social isolation and have a significant impact on their quality of life, and health and well-being.

## Useful links 5.6

[Rockwood frailty scale](https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2022/02/rockwood-frailty-scale_.pdf)

[TPT Falls in Older People with Sight Loss: a review of emerging research](https://www.pocklington-trust.org.uk/sector-resources/research-archive/falls-in-older-people-with-sight-loss-review/)

[College of Optometrists Vision and falls](https://www.college-optometrists.org/category-landing-pages/falls/focus-on-falls)

[Falls Risk Assessment Tool (FRAT)](https://www.physio-pedia.com/Falls_Risk_Assessment_Tool_(FRAT)) is a more extensive questionnaire that can been used to explore falls:

[NICE: Falls risk assessment](https://cks.nice.org.uk/topics/falls-risk-assessment/management/falls-risk-assessment/#assessing-risk-of-falling)

## 5.7 Cerebral visual impairment

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| **Core:**  Consider the impact of cerebral or brain-based visual impairment. |

### Point to consider:

**Does your service consider the needs of patients who have a brain-based visual impairment?**

Cerebral visual impairment (CVI), or brain-based visual impairment, is a form of visual impairment due to damage to the visual processing regions of the brain. While these patients may do well on a standard letter or picture chart, they find it difficult to understand what they are seeing.

This can affect mobility, face recognition, identifying objects and following movement. It commonly affects children with other health conditions such as cerebral palsy.

A functional vision assessment can be very helpful in identifying the difficulties the patient is experiencing that a standard visual acuity test may not reveal. There are inventories that are designed to specifically investigate the possible diagnosis and aspects of processing that the patient is having difficulties with. These can be found in the **Useful links 5.7.**

There are five standard screening questions can be included in pre-assessment questionnaires. These are:

* Do you have difficulty walking down stairs?
* Do you have difficulty seeing fast-moving objects?
* Do you have difficulty seeing something that is pointed out in the distance?
* Do you have difficulty locating an item of clothing in a pile of clothes?
* Do you find copying words or pictures time-consuming and difficult?

The answer to each question is graded Never, Rarely, Sometimes, Often, Always or N/A.

CVI should be considered if the answer is often, or always, to three or more. However, this should then be followed by a detailed investigation with one of the inventories/questionnaires designed for the purpose. Resources for this can be found below in the **Useful links 5.7**

Staff should have training in this area in order that appropriate support can be offered for this type of sight loss. The service should include resources and referral routes for patients identified as having suspect CVI.

## Useful links 5.7

Information for professionals

[Ulster University Cerebral Visual Impairment Assessment](https://www.ulster.ac.uk/research/topic/biomedical-sciences/research/optometry-and-vision-science/vision-resources/professionals/cerebral-visual-impairment-assessment)

[RNIB | Cerebral visual impairment and PMLD](https://www.rnib.org.uk/professionals/health-social-care-education-professionals/education-professionals/cerebral-visual-impairment-and-pmld/)

[Cerebral Visual Impairment | Dr Gordon Dutton](https://cvi.aphtech.org/?page_id=553)

[Cerebral Visual Impairment: Career-Long Professional Learning](https://www.ssc.education.ed.ac.uk/courses/vi%26multi/cvi21.html)

[How can we assess a child for CVI? – Make It Easier To See](https://makeiteasiertosee.co.uk/how-can-we-diagnose-cvi/)

Information for patients

[Ulster University Vision Resources for parents](https://www.ulster.ac.uk/research/topic/biomedical-sciences/research/optometry-and-vision-science/vision-resources/parents)

[Make It Easier to See | Cerebral visual impairment and brain based visual problems](https://makeiteasiertosee.co.uk/)

[Little Bear Sees - Helping children with cortical visual impairment (CVI) learn to see](https://littlebearsees.org/)

[The Cerebral Visual Impairment Society](https://cvisociety.org.uk/)

[CVI Scotland](https://cviscotland.org/)

## 5.8 Certification

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| **Core:**  All practitioners should be aware of the criteria for certification as sight impaired or severely sight impaired and the benefits of certification followed by registration. The benefits of certification and registration should be discussed with all eligible patients. Paperwork should be completed if authorised or the patient should be referred to someone who is authorised to do this. |

### Point to consider:

**Do all your patients know whether they are eligible for registration and the associated benefits?**

Many patients who are suitable for registration are unaware of their eligibility and/or the benefits of being registered. As part of the assessment process, it is important to establish whether each individual is eligible and spend time explaining this to the patient.

The service should have a defined process in the Standard Operating Procedure (SOP) on how to enable patients identified as being eligible to be certified and registered. One suggestion would be to arrange for referral to their ophthalmologist with the consent of the patient. Alternatively, if there is an ECLO consider referring to them, they will be able to liaise with the medical team and support the patient through the process. Finally in some areas it is possible for suitably qualified optometrists to complete the registration process for those who are eligible under the local protocol (NHS Wales, 2022).

Patients who are eligible, but decline should be given information in their preferred format about the benefits of registration and help from social services, so that they can take time to consider their options.

A conversation with the patient to understand their reasons for declining registration is beneficial as it may be based on anxieties about stigma, cultural factors or misunderstandings. Where this is the case more explanation may help. Information to help with this conversation can be found in **Useful links 5.8**

It is just as important that patients should be informed that even if they decline certification and registration they are still entitled to help from social services and referral can be made on their behalf.

## Useful links 5.8

[RNIB | Registering as sight impaired](https://www.rnib.org.uk/your-eyes/navigating-sight-loss/registering-as-sight-impaired/)

[RNIB | The criteria for certification](https://www.rnib.org.uk/your-eyes/navigating-sight-loss/registering-as-sight-impaired/the-criteria-for-certification/)

[RNIB Starting Out series – Benefits, concessions and registration booklet](https://media.rnib.org.uk/documents/APDF-SE180905_Benefits_Concessions_and_Registration-v001_cCPrRtX.pdf)

[RCOphth Sight impairment and severe sight impairment certifications and registrations update](https://www.rcophth.ac.uk/news-views/cvi-and-registrations-update/)

[Macular Society | Why register as sight impaired?](https://www.macularsociety.org/about/media/news/2018/march/why-register-sight-impaired/#:~:text=How%20can%20I%20register%3F%20A%20hospital%20consultant%20ophthalmologist,confidentially%20to%20adult%20social%20services%20and%20your%20GP.)

[GOV.UK Registering vision impairment as a disability](https://www.gov.uk/government/publications/guidance-published-on-registering-a-vision-impairment-as-a-disability)

[RCOphth Eye Clinic Liaison Officers (ECLOs) are vital to supporting patients with sight loss](https://www.rcophth.ac.uk/news-views/eye-clinic-liaison-officers-eclos-are-vital-to-supporting-patients-with-sight-loss/)

Registration in Wales

[NHS Wales Certificate of Visual Impairment](https://www.nhs.wales/sa/eye-care-wales/eye-care-docs/cvi-lvsw-ehew-clinical-manual-nov23-pdf/)

## 5.9 Patient advocates

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| **Core:**  To ensure that services are accessible to people of all needs and backgrounds there should be access to, patient advocates, translators and sign language interpreters. |

### Point to consider:

**How does your service support patients to access advocacy services?**

All possible efforts must be made to ensure effective communication with patients (Government Language Interpretation webpage, 2017). Patients with additional needs sometimes require additional advocacy support to enable them to have an equitable access to care. These are services that can support patient’s additional needs such as translators, advocates and interpreters.

**Interpreters**

Even a person with good conversational fluency in English may not be able to understand, discuss or read health-related information proficiently in English. They may be reluctant to request or accept professional interpreting and translation services due to fear of costs, inconvenience, or concerns about confidentiality. Where language is a problem in discussing health matters a professional interpreter should always be offered, rather than using family or friends to interpret (Government Language Interpretation webpage, 2017).

Some of these services are detailed below and further information for each can be found in the [**Useful links 5.9**](#_Useful_Links_5.9).

BSL interpreters: There may be local provision through your Integrated Care Board (ICB) or information can be found through Sense or RNID.

Language Translators: You should contact your local ICB to see what is available. Telephone translation services such as Language Line, used by NHS 24 Scotland may be an option.

**Care navigators**

This service provides patient advocacy and support for older people who are unable to get to appointments without assistance, and/or need help with compliance. They help patients navigate through encounters with different health care services, agencies and professionals. These are commissioned according to postcode with some areas having this service, but not all.

**ECLO service**

ECLOs liaise between patients and their medical team and all other sight loss related services. They can be an advocate and support for the patient throughout. You can find your local ECLO through the Sightline Directory or by calling 0303 123 9999.

Patient liaison and advice services (PALS/ PASS/ PCC): These are independent advocacy services available in each hospital. Information for each hospital trust service should be available to patients.

Buddy schemes: Several sight loss charities, such as the Macular Society and Glaucoma UK provide buddy schemes that can support patients through treatment.

**Mental Capacity support** (see alsosection **4.4 Information sharing between services**)

The Mental Capacity Act 2005 requires services to ensure that those patients who do not have capacity are supported to make decisions that are in their best interests. To help with this they have introduced the role of IMCA (independent mental capacity advocate). IMCAs provide a legal safeguard for those who lack capacity by representing them where there is no family member or friend who can appropriately and independently represent the patient. It is important to remember that some patients can have capacity that varies and may temporarily lack capacity (such as when in shock or in certain circumstances).

Guidance for test of capacity is described by the Mental Capacity Act 2005 states that:

1. Does the person have an impairment of their mind or brain, whether as a result of an illness, or external factors such as alcohol or drug use?
2. Does the impairment mean the person is unable to make a specific decision when they need to? People can lack capacity to make some decisions but have capacity to make others.

A person is considered to have capacity if they can:

* + Understand the information about the decision.
  + Retain that information.
  + Use the information to make a decision.

It should be considered that a person has capacity unless proved otherwise. Patients should be allowed to make decisions for themselves whenever possible and this includes allowing them to make a decision that others might consider unwise. An unwise decision is not evidence of lack of capacity.

It is important to enable patients to make decisions by adapting to their needs such as using information in preferred formats, further explanations or giving more time to process information.

When an advocate is required, it is important to check on what basis the advocate has authorisation to act on behalf of that person. This includes documenting power of attorney for health on the records. This will safeguard the patient and ensure that their best interests are central to decisions.

The Oliver McGowan mandatory training for health and social care workers gives a valuable insight to the lived experience of patients who have additional needs. It covers aspects of consent, how to listen to advocates and how to work in the best interests of the patient. Links to this training are below.

## Useful links 5.9

**England:**

Interpreters:

[NHS England Interpreting and translation in primary care](https://www.england.nhs.uk/primary-care/primary-care-commissioning/interpreting/)

Advocacy

[RNIB | NHS Eye Care Services: How To Get The Help You Need](https://shop.rnib.org.uk/NHS-Eye-care-services-How-to-get-the-help-you-need-90510)

[NHS Someone to speak up for you (advocate) - Social care and support guide](https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/someone-to-speak-up-for-you-advocate/)

[NHS What is PALS (Patient Advice and Liaison Service)?](https://www.nhs.uk/nhs-services/hospitals/what-is-pals-patient-advice-and-liaison-service/)

**Scotland:**

Interpreters:

[Health Scotland - Interpreting Communication Support and Translation National Policy](https://www.healthscotland.scot/media/3304/interpreting-communication-support-and-translation-national-policy.pdf)

Advocacy:

[PASS Scotland (Patient Advice and Support Service Scotland)](https://pass-scotland.org.uk/)

**Wales:**

Advocacy:

[HOPE | Age Cymru](https://www.ageuk.org.uk/cymru/our-work/advocacy/hope---helping-others-participate-and-engage/)

[Age Connects Wales](https://www.ageconnectswales.org.uk/)

[Llais Wales](https://www.llaiswales.org/)

**Northern Ireland:**

Advocacy:

[Patient and Client Council Northern Ireland - Advocacy](https://pcc-ni.net/advocacy/)

**UK wide resources:**

Support for people with disabilities:

Complex needs sensory impairment

[Sense | For people with complex disabilities](https://www.sense.org.uk/)

Hearing loss

[RNID](https://rnid.org.uk/)

Sight loss

[RNIB](https://www.rnib.org.uk)

[Guide Dogs](https://www.guidedogs.org.uk/getting-support/)

Learning disabilities

[Mencap | Access Learning Disability Advice and Support](https://www.mencap.org.uk/advice-and-support)

[SeeAbility](https://www.seeability.org/)

Autism

[National Autistic Society](https://www.autism.org.uk/)

Migrants:

[GOV.UK Migrant health guide](https://www.gov.uk/government/collections/migrant-health-guide)

General advice and support:

[Healthwatch | Advice and information](https://www.healthwatch.co.uk/advice-and-information)

[Sightline Directory](https://www.sightlinedirectory.org.uk/)

Treatment Buddy services:

[Macular Society - Treatment buddies](https://www.macularsociety.org/support/treatment-buddies/)

[Glaucoma UK | Buddy Support Schemes | Care & Support](https://glaucoma.uk/care-support/buddy-scheme/)

Interpreters

[LanguageLine UK - Interpreting & Translation Services](https://www.languageline.com/en-gb/)

Mental capacity advocates

[SCIE | Mental Capacity Act | Independent Mental Capacity Advocate (IMCA)](https://www.scie.org.uk/mca/imca)

[GOV.UK Independent mental capacity advocates](https://www.gov.uk/government/publications/independent-mental-capacity-advocates)

[Mental Capacity Act 2005 (legislation.gov.uk)](https://www.legislation.gov.uk/ukpga/2005/9/contents)

CPD for professionals:

[Health Education England | The Oliver McGowan Mandatory Training on Learning Disability and Autism](https://www.hee.nhs.uk/our-work/learning-disability/current-projects/oliver-mcgowan-mandatory-training-learning-disability-autism)

## 5.10 Routine review

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| **Core:** Routine review intervals should be determined by local low vision service policy but as a minimum patients should have access to the service if their needs change.  **Core:** There should be facility for patient-initiated follow-ups (PIFU) where no set recall is instigated. If this option is preferred, then practitioners should ensure that the patient understands the process.    **Ideal:** Patients should be offered an annual low vision assessment to ensure that they are still able to perform daily tasks with the aids prescribed. This should be offered even if there is no change in visual acuity, as it is feasible that the patient living situation, general health or visual goals may have changed. If required by the patient, annual/subsequent low vision assessments should follow the same criteria as initial assessments. |

### Point to consider:

**Do patients know when they should have follow-ups or review appointments?**

The review and follow-up protocol should be set out clearly in the Standard Operating Procedure (SOP). This may differ from service to service but should include either standard recall periods or a facility for patient-initiated follow-ups (PIFU) (NHS England PIFU, 2023).

There are different types of follow-ups and reviews, this section refers to routine reviews only. See section **5.11 Follow ups** for information on follow ups.

Reviews are usually standard routine general assessments, either every 12 months or two years. Some services may choose to adopt a PIFU protocol which means that appointments are requested by the patient to reduce wasted clinical time. There is research to suggest that routine reviews are preferable for low vision patients (Macnaughton J., 2022).

If a standard general review is recommended, the timing of this should be discussed with the patient and the process of booking this appointment explained.

If PIFU is adopted, then the patient should be given full details of how to arrange a follow-up appointment when required. Consideration should be made regarding the patient’s ability to identify when they need a review and their ability to access the service, for instance in the case of patients who require gatekeepers. This will enable the service to identify those patients who are not suitable for this option. A suitable alternative should be made available to those patients that PIFU is not appropriate for. There are helpful resources on NHS Future national eye health hub that explains good practice in discharging patients and setting up PIFU options. Details can be found in the useful links section below.

## Useful links 5.10

[NHS England Patient initiated follow-up](https://www.england.nhs.uk/outpatient-transformation-programme/patient-initiated-follow-up-giving-patients-greater-control-over-their-hospital-follow-up-care/)

NHS future accounts can be created on this link and then search for PIFU guidance and SOP templates: [FutureNHS Collaboration Platform](https://future.nhs.uk/system/login?nextURL=%2Fconnect%2Eti%2FNationalEyeCareHub%2Fview%3FobjectId%3D29667120)

Evidence base:

[OPO Abstract | Change in rehabilitation needs and activity limitations over time of adults with acquired visual impairment following entry to a low vision rehabilitation service in England - Macnaughton](https://onlinelibrary.wiley.com/doi/full/10.1111/opo.12950?casa_token=Fv_TcQMpkl0AAAAA%3AjMuSrs7tusXVl6sSDJhGeq37ySQ-S7lffHyW7QFHcw9O5JHoBLwj4QvgUB6PZi8SgdvHIe2T1-Log4Mq)

[RCOphth | NHS planning guidance aims for 25% cut in outpatient follow ups alongside increase in elective activity](https://www.rcophth.ac.uk/news-views/nhs-planning-guidance-aims-for-25-cut-in-outpatient-follow-ups-alongside-increase-in-elective-activity/)

## 5.11 Follow ups

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| **Core:** Routine review intervals should be determined by local low vision service policy but as a minimum patients should have access to the service if their needs change.  **Core:** There should be facility for patient-initiated follow-ups (PIFU) where no set recall is instigated. If this option is preferred, then practitioners should ensure that the patient understands the process.    **Ideal:** Patients should be offered an annual low vision assessment to ensure that they are still able to perform daily tasks with the aids prescribed. This should be offered even if there is no change in visual acuity, as it is feasible that the patient living situation, general health or visual goals may have changed. If required by the patient, annual/subsequent low vision assessments should follow the same criteria as initial assessments. |

### Point to consider:

**Does your service have a process in place to ensure that patients can be followed up appropriately based on the needs of the individual?**

Follow ups may be required between review or PIFUs depending on the needs of the individual. Factors that influence this include but are not limited to:

* Predicted progression of the sight loss
* Prescribing of complex aids
* Inconclusive results
* Trials of equipment for specific activities
* Complex needs
* Identified risk factors
* Emotional state of the individual

Follow-ups are usually between one and three months of the initial assessment; these are opportunities to check on concerns unresolved by the low vision assessment. They may be face-to-face or via teleconsultation. Patients should not be discharged by the service until all recommendations are acted on.

A follow up may not include a full low vision assessment but instead usually focuses on one or two aspects identified as requiring monitoring. For instance, a patient prescribed an aid for a specific high risk activity (such as monitoring blood sugar) to ensure the intervention is successful and to review options if it hasn’t been.

The practitioner should consider the outcome of the low vision assessment and plan for any follow up that is required. They should ensure the patient is aware of any recommendation for follow up and how this will be arranged. The follow up requirement should be clearly detailed on the action plan so the patient has a record to refer to, with enough explanation that any other practitioner will be able to follow up should the need arise.

Patients should also have a way of communicating with the service if they are having difficulties with any recommended interventions and feel that they need a follow up. Some services include a standard telephone contact call between one and three months after the low vision assessment to proactively give the patient opportunity to ask questions or raise concerns. This is ideal but with current financial constraints this may not be possible for some services.

## 5.12 Families and carers

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| **Core:**  Family, friends and care workers should be included in discussions with consent of the patient where appropriate.  **Core:**  Carers should be offered appropriate information and support related to the patient’s needs. |

### Point to consider:

**How does your service support and involve carers and a patient’s family and friends?**

Carers, family and friends are often very important to low vision patients in terms of accessing services, implementing recommendations and complying with treatment therefore patient-centred care should also extend to them (UKOA/RNIB, 2018).

However, there are issues around patient consent to allow others to access their personal information, or be involved in the appointments. Some patients may have appointed friends or relatives with power of attorney for their health and welfare. It is important to note on the patient record who is authorised to act on behalf of the patient; this should be updated at each visit or interaction.

This links very closely with the consent process and assessing capacity in section **4.4 Information sharing between services** and also **5.9** **Patient advocates**. See information below in **Useful links** **5.12** - this can also be found in previous sections but is detailed below too.

In low vision services it can be very helpful to have carers, friends or family, present at the assessment as another pair of ears and to support the patient. However, always check the patient is happy with who is present at each assessment. Wherever possible avoid using family members as interpreters (Government Language Interpretation webpage, 2017). See section **5.9 Patient advocates** regarding the use of interpreters.

Family members and carers may also need support regarding the impact of their loved one’s sight loss on their life and well-being. Looking after someone else can be difficult, confusing and exhausting. Giving appropriate information to carers can make a huge difference to all involved. General support for carers can often be found through local Carers Hubs or carers support agencies. Information about what is available in your area can be found through the Citizens Advice Bureau (CAB) services or social services. Emotional support for family and carers of people with sight loss is available through some of the sight loss charities including RNIB and the Macular Society.

Where consent is clearly documented, it might also be helpful to arrange for copies of letters and reports to the patient’s carer or supporter. Always check consent for this on each occasion.

It is good practice to ensure that carers are aware of their rights and support available to them. For example, check whether they have been offered a carer’s needs assessment. See details in the useful links below.

## Useful links 5.12

Capacity

[NHS Mental Capacity Act](https://www.nhs.uk/conditions/social-care-and-support-guide/making-decisions-for-someone-else/mental-capacity-act/)

Consent

[College of Optometrists Consent](https://www.college-optometrists.org/clinical-guidance/guidance/communication,-partnership-and-teamwork/consent)

[GOC Obtain valid consent](https://optical.org/optomanddostandards/3-obtain-valid-consent/)

[NHS Consent to treatment - Assessing capacity](https://www.nhs.uk/conditions/consent-to-treatment/capacity/)

[ABDO Consent](https://www.abdo.org.uk/regulation-and-policy/advice-and-guidelines/updates/r1-2-2-consent/)

Support for Carers

By country

[Citizens Advice: Carers: help and support England](https://www.citizensadvice.org.uk/family/looking-after-people/carers-help-and-support/)

[Citizens Advice Carers: help and support Wales](https://www.citizensadvice.org.uk/wales/family/looking-after-people/carers-help-and-support/)

[Citizens Advice Carers: help and support Northern Ireland](https://www.citizensadvice.org.uk/about-us/northern-ireland/)

[Citizens Advice Scotland](https://www.citizensadvice.org.uk/scotland/)

UK-wide

[NHS Support and benefits for carers](https://www.nhs.uk/conditions/social-care-and-support-guide/support-and-benefits-for-carers/)

[Carers UK | Needs assessment](https://www.carersuk.org/help-and-advice/practical-support/needs-assessment/)

[Macular Society Counselling service](https://www.macularsociety.org/support/counselling/)

[RNIB | Sight loss counselling - professional support](https://www.rnib.org.uk/living-with-sight-loss/community-connection-and-wellbeing/sight-loss-counselling/)

Power of Attorney

[GOV.UK Lasting power of attorney](https://www.gov.uk/lasting-power-attorney-duties/health-welfare)

# Section 6 - Assessing visual function

This section explains the importance of having had a recent sight test and ongoing eye examinations. It covers how to assess visual function including measuring acuity, contrast sensitivity and consideration of other tests.

## Overview

6.1 Valid sight test and up-to-date refraction

6.2 Ongoing eye examinations

6.3 Red Flag symptoms

5.4 Measuring distance and near acuity

5.5 Assessing visual function

6.6 Measuring contrast sensitivity

6.7  Visual fields

6.8  Other tests

**6.1 Valid sight test and up-to-date refraction**

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| **Core:**  Patients must have a valid sight test including refraction before  attending the low vision service (unless the sight test or refraction is integrated with the service – e.g., a NHS GOS sight test is taking place at the same time as the low vision visit.)  **Core:**  Any active pathology should be under investigation or have been  investigated.  **Ideal:**  Patients should supply the results of this test - in particular,  refraction results and best corrected visual acuity - or give consent to  the low vision practitioner requesting access to this information. |

### Point to consider:

**How does your service ensure that all patients have up to date spectacles or contact lenses, and that any active eye condition is under the appropriate medical investigation and treatment?**

You should ensure the patient has had a valid eye examination, which determines their refraction and ocular health, before performing a low vision assessment (COO Low Vision webpage, 2022) (ABDO Low Vision webpage, 2019).

For the purpose of a low vision assessment, assume that ‘valid’ means as close to the low vision assessment date as possible, but as long as the prescription is within date patients shouldn’t be prevented from using the service. This is because we have to work within the limitations of the minimum testing intervals for NHS patients.

Low vision refers to an impairment of visual function that impacts a person’s quality of life. This may be permanently reduced vision that is not fully correctable through surgery, pharmaceuticals, spectacles or contact lenses. Or it may be temporarily reduced due to uncorrected refractive error or while waiting for surgery. Based on this, it is therefore a pre-requisite that new patients have the most up to date spectacles or contact lenses to rule out correctable vision loss. Having the optimal refractive correction also forms the basis for making the most of residual vision.

Equally important is ensuring that patients have regular eye health checks. This will ensure that all causes of sight loss have been discovered and treatment options investigated. While it is also appropriate to refer patients to low vision services when waiting for, or during, medical treatment, it is vital that low vision intervention is not offered without the appropriate eye health diagnosis.

Some services provide GOS eye care in addition to low vision, whereas other services may be provided by professionals who are not qualified to provide GOS eye care or who do not have a GOS contract. Your Standard Operating Procedure (SOP) should state the process for your service.

For services that provide GOS eye care it is important to discuss with the patient that they have the option of bringing with them a valid prescription from their own optometrist or using the GOS facility at the low vision service. If eye tests are provided as part of the service all GOS governance protocols should be followed as per the GOC standards of practice and the NHS primary eye care contracts, links can be found below in [**Useful links 6.1**](#_Useful_Links_6.1).

For services that do not provide GOS eye care the SOP should include:

* How to ensure patients are receiving appropriate eye care.
* How to ensure that patients have appropriate optical correction for refractive error.
* A process by which the practice can access relevant information with the consent of the patient.
* How your service explains to the patient the need to attend both optometry and low vision services.

## Useful links 6.1

GOS and eye test standards and guidelines:

[GOC Standards](https://optical.org/en/Standards/)

England: [LOCSU | NHS GOS contract for sight testing](https://www.locsu.co.uk/what-we-do/policy/general-ophthalmic-services/)

Scotland- [GOV Scotland Eyecare - Primary care services](https://www.gov.scot/policies/primary-care-services/eyecare/)

Wales- [NHS Wales Eye Care](https://www.nhs.wales/service-area/eye-care-wales/)

NI- [nidirect | Eye care](https://www.nidirect.gov.uk/articles/eye-care)

Eye testing intervals and voucher entitlements:

England, Scotland and Wales: [ABDO | Voucher values: England, Scotland and Wales](https://www.abdo.org.uk/voucher-values/vouchers-at-a-glance-england-wales/)

Northern Ireland [nidirect | Eye care](https://www.nidirect.gov.uk/articles/eye-care)

## 6.2 Ongoing eye examinations

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| **Core:**  Low vision practitioners should confirm that patients are having ongoing regular sight tests as well as reviews with the ophthalmology clinic, if relevant, to make sure that any changes to their pathology or refraction are appropriately managed. |

### Point to consider:

**How do you ensure that patients attending your service understand the role of the various eye care services and the importance of ongoing care alongside low vision?**

Patients attending low vision services often have multiple specialities involved in their eye care and given the strong link between sight loss and systemic conditions it is likely that they may have other teams input too. This results in multiple health and social care appointments which can be difficult for patients to manage. In addition, people with sight loss who do not receive appointments and reports in accessible format may be confused as to who does what, and what recommendations have been made. It is therefore understandable that patients may want to reduce or streamline their care providers or may simply not understand why they are having optometry, ophthalmology and low vision appointments.

In order to safeguard the patient’s wellbeing, it is important to ensure that the patient is accessing all recommended care. This will prevent avoidable sight loss or health complications.

Your SOP should include your protocol on how you inform patients regarding the purpose of the low vision service and the importance of the other services. It should also include the process by which the service checks that the patient is attending all recommended appointments, this process could simply be ensuring that each patient is asked about their recent eye care history. It is important to check the patient’s understanding of their eye care and health care. This is particularly important where the NHS sight test is carried out by another service or where the low vision service is based in the community without direct access to the patient’s medical records. A link to a useful resource that can be given to patients in England is listed below.

## Useful links 6.2

[RNIB | Practical information and advice if you're worried about your eyes](https://www.rnib.org.uk/your-eyes/worried-about-your-eyes/)

## 6.3 Red Flag symptoms

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| **Core:**  There are clear and documented procedures in place for patients reporting any red flag symptoms to be referred immediately to an eye health professional. |

### Point to consider:

**Do you check for red flag symptoms at each appointment and what is your protocol when a patient discloses a red flag symptom?**

If your service does not include a sight test you should have protocols in place to identify patients who might be at risk of avoidable sight loss. This would include being aware of red flag symptoms and preferably checking for these symptoms routinely. All services should have a process in place for urgent referral, should a patient disclose a red flag symptom but is not having a routine sight test as a part of the assessment. Ignoring these symptoms can cause avoidable sight loss or avoidable harm from general or ocular health issues. For example, symptoms of retinal detachment should be managed in the usual way regardless that the purpose of the visit is for a low vision assessment.

Practitioners should be aware of the possible signs of serious eye and general health problems and seek advice, from a suitably qualified professional, on the most appropriate way to deal with what is being reported by the patient. To aid this they should note what the symptom is and when it started. A rule of thumb is the more rapid the onset the more urgent the investigation needs to be. The College of Optometrists’ links below show how urgently different findings should be referred. Information on red flag symptoms can be found in the **Useful links 6.3**

If your service provides GOS eye tests and an urgent eye health issue is identified during the sight test the usual referral processes for the region should be followed. The practitioners should be aware of the local wet AMD and other urgent referral pathways.

## Useful links 6.3

Referral guidelines

[College of Optometrists | Urgency of referrals table](https://www.college-optometrists.org/clinical-guidance/guidance/guidance-annexes/annex-4-urgency-of-referrals-table)

[College of Optometrists | Clinical Management Guidelines](https://www.college-optometrists.org/clinical-guidance/clinical-management-guidelines)

[LOCSU Services Directory Clinical Pathways](https://locsu.co.uk/what-we-do/locsu-service-directory/)

Wales services [NHS Wales Eye Care](https://www.nhs.wales/service-area/eye-care-wales/)

Scotland services [NHS Scotland | eyes.scot](https://www.eyes.scot/)

Northern Ireland [nidirect | Eye care](https://www.nidirect.gov.uk/articles/eye-care)

Red flag symptoms

[RNIB | Key information if you've noticed changes in your vision or eye health](https://www.rnib.org.uk/your-eyes/worried-about-your-eyes/noticing-changes-in-your-eyes/)

## 6.4 Measuring distance and near acuity

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| **Core:**  Distance and near visual acuity (VA) should be measured using appropriate vision charts suitable for the patient’s age, acuity, language skills and cognitive ability. All measurements should be made with their preferred glasses or contact lenses, if worn. |

### Point to consider:

**How do you measure visual acuity accurately at the relevant working distances for each patient? Do you have appropriate equipment for the purpose of measuring visual acuity in patients with sight loss?**

Accurate measurement of high contrast acuity at distance is central to determining the level of impairment for registration purposes, and at near to indicate an appropriate level of magnification (Latham K., 2022). It is also important to measure the patient’s habitual visual acuity as this gives an insight into the real functional impact. The clinician should have access to a high contrast chart that can measure a range of lower acuities which can be achieved by having a chart with a wide range of available letter sizes and/or the ability to use the chart at shorter working distances.

The most appropriate chart is a LogMAR chart as the mathematical design of the chart enables a simple calculation to be made that allows for the working distance. This is not possible when using a Snellen Chart (COO/RCOphth, 2013) (Lovie-Kitchen, 2015). Another advantage of a LogMAR chart is the arrangement of five letters on every line which means that it can be used to assess whether a patient can read smoothly giving a functional assessment of saccadic eye movements from one letter to the next. Some patients with central or ring scotomas find it very difficult to keep to the line and this makes their vision less ‘usable’ in real world tasks. In addition, the task is consistent from line to line and test-retest accuracy is improved.

Landolt C or tumbling E LogMAR charts are also available for patients who have communication impairments or learning disabilities or who do not have English as their first language. An alternative chart is the Lea vision tests based on simple pictures; these are ideal for people with learning disabilities and calibrated to Landolt C charts.

There is a range of near acuity charts available, but it is essential to use a chart that includes letters or symbols larger than standard reading cards used in primary eye care. Near acuity can be measured in terms of the physical size of print on the page (N point, Sloan M), or angular size at the eye (logMAR). A conversion chart is available on page 69 of The Practical Management of Visual Impairment (Macnaughton J. , 2018). However, it must be remembered that converting one scoring convention to another introduces some inaccuracy in the score. Wherever possible, the vision should be noted in the format in which it is measured, including details of the test and working distance that was used. Using a conversion chart can be useful in comparing progression in vision where different measures have been used.

Some of the most common near vision charts include:

* The Bailey-Lovie word reading chart (LogMAR design)
* The MNREAD chart - (LogMAR design)
* The Maclure Reading chart- appropriate for children or people with lower levels of literacy.

For some patients, functional vision assessment and alternative visual assessment techniques are required. In these cases, although the same level of accuracy may not be possible, it is very important that assessment is attempted using adapted charts.

Some examples of other tests are below, with useful links at the end of the section:

* iPad Kays pictures
* Sonksen Silver
* Lea Test
* Preferential looking - Cardiff Cards, Lea Gratings
* Functional vision assessment tool
* Berkeley Rudimentary vision test (BRVT)

Bradford box can be used to make an assessment of functional vision and is particularly helpful in cases where CVI is suspected or known.

## Useful links 6.4

Research on appropriate charts:

[OPO Is it time to confine Snellen charts to the annals of history? Lovie‐Kitchin 2015](https://onlinelibrary.wiley.com/doi/abs/10.1111/opo.12252)

Picture and matching charts:

[Kay Pictures - Specialising in Paediatric Vision Testing](https://kaypictures.co.uk/)

[LEA SYMBOLS® 15-Line Distance Chart](https://www.leatest.com/catalog/distance-vision/lea-symbols%C2%AE-15-line-distance-chart)

[The Sonksen logMAR Test of Visual Acuity: Testability and reliability | Alison Salt](https://www.academia.edu/12917391/The_Sonksen_logMAR_Test_of_Visual_Acuity_I_Testability_and_reliability)

Preferential looking charts:

[LEA GRATINGS®, a Preferential Looking Test](https://www.leatest.com/catalog/grating-acuity-visual-adaptation/lea-gratings%c2%ae-preferential-looking-test)

Functional vision assessments for people with complex needs:

[SeeAbility | The Bradford Visual Function Box](https://www.seeability.org/resources/bradford-visual-function-box)

[SeeAbility | Functional Vision Assessment (FVA)](https://www.seeability.org/resources/functional-vision-assessment-fva)

Charts designed for very poor acuity levels:

[The Berkeley Rudimentary Vision Test](https://journals.lww.com/optvissci/Fulltext/2012/09000/The_Berkeley_Rudimentary_Vision_Test.7.aspx)

The following book chapters are useful references for measuring visual acuity for patients with low vision:

The Practical Management of Visual Impairment by Jane Macnaughton (2018) chapters 3 and 5

Low Vision Principles and Practice by Dickinson et al (Dickinson, 2023)

## 6.5 Assessing visual function

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| **Core:**  In addition to formal charts, or where formal vision testing is not possible, services should be able to assess functional vision using real world tasks. This could be achieved with food packaging, notice boards, timetables, or newspapers. It could also include information for managing other health conditions and medications such as measuring blood sugar and drawing insulin. |

### Point to consider:

**Do you have a range of real-world samples to assess visual function and the appropriateness of devices being demonstrated?**

Low vision aids are prescribed in order to enable patients to carry out their activities of daily living, so using real world samples in the demonstration of low vision aids enables the practitioner to assess how appropriate the device will be for the intended task (Macnaughton J. , 2018).

Suggestions include but are not limited to:

* Newspaper
* Train timetables and tickets
* Food packaging
* Medicine instruction leaflets
* Crossword puzzles
* Large print books
* Maps
* Playing cards
* Knitting patterns
* Sheet music
* Appointments letters
* Invoice and receipt examples

Some daily activities carry more risk for the patient, such as managing their health (measuring blood glucose or checking dosage of insulin). Understanding the patient’s daily tasks gives the target level of acuity that will be required for each individual.

Many real world tasks are not high contrast and so high contrast acuity tests are not always predictive of the ability of the patient to carry out these tasks. For example, food packaging can have instructions on multi-coloured glossy labels.

## Useful links 6.5

Chapter 2 [The Practical Management of Visual Impairment | Request PDF (researchgate.net)](https://www.researchgate.net/publication/329220638_The_Practical_Management_of_Visual_Impairment)

## 6.6 Measuring contrast sensitivity

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| **Core:**  Measurement of contrast sensitivity should be carried out, or at least considered, with every patient. |

### Point to consider:

**Do you have the facility to measure contrast sensitivity and is it part of your standard assessment protocol?**

As our world is not black and white or viewed in ideal illumination, measuring visual acuity is not sufficient in terms of understanding how well someone is able to see or use their vision in real world situations.

Contrast sensitivity measurement enables the practitioner to have a better understanding of visual function. The links below in [**Useful links 6.6**](#_Useful_Links_6.6) provide useful information on how and why you should measure contrast sensitivity.

There are charts available for patients who are verbal and non-verbal, as well as for patients where English is not their first language. In addition, there are portable charts for patients to be assessed at their home.

Without assessing contrast sensitivity, it is very likely that the vision of some patients will be overestimated. Measurement of contrast sensitivity should be considered for patients with symptoms which outweigh those predicted by high contrast acuity, or who have suffered multiple falls. Contrast sensitivity measurement is therefore useful to assess functional vision in some eye conditions (Rubin, 2006) (Latham, 2012).

## Useful links 6.6

Further reading:

[Optometry and Vision Science: Guidelines for Predicting Performance with Low Vision Aids](https://journals.lww.com/optvissci/Abstract/2012/09000/Guidelines_for_Predicting_Performance_with_Low.14.aspx)

[Clinical Procedures in Primary Eye Care - 9780702077890 | Elsevier Health](https://www.uk.elsevierhealth.com/clinical-procedures-in-primary-eye-care-9780702077890.html) (chapter 3)

Macnaughton, J. (2018) *The Practical Management of Visual Impairment*. Melton Mowbray: CLEARVIEW Training.

Dickinson, C et al (2023) Low Vision. Principles and Management.

Elsevier Ltd.

[Ophthalmic Epidemiology: Measuring Contrast Sensitivity in Specific Areas of Vision - A Meaningful Way to Assess Quality of Life and Ability to Perform Daily Activities in Glaucoma](https://pubmed.ncbi.nlm.nih.gov/31116620/)

[Ophthalmol Clin North Am: Contrast sensitivity](https://pubmed.ncbi.nlm.nih.gov/12809156/)

[The Low Vision Patient: illumination, glare and contrast Elizabeth Bartlam (ABDO)](https://www.abdo.org.uk/wp-content/uploads/2012/06/CET161.pdf)

## 6.7 Visual fields

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| **Core:**  A patient’s visual field must be considered during all assessments and testing of fields should be carried out when appropriate. |

### Point to consider:

**Do you have access to, or facility to, assess visual fields and a protocol that includes visual fields testing? How do you determine when a visual fields assessment is of benefit?**

The visual fields assessment gives an important understanding of the patient’s residual vision which cannot be predicted by high contrast acuity or contrast sensitivity. In some cases, a confrontation test will be the only meaningful assessment possible, but it is important that the practitioner is aware in all cases of whether the patient has visual fields restriction. Without that information it maybe that a complete understanding of risk factors and full impact of the patient’s sight loss will not be possible. If the assessment is based purely on high contrast acuity and a patient’s reported symptoms, it is possible to miss serious risk factors.

The College of Optometrists’ guidance on assessing the vision of low vision patients makes it clear that the practitioner should consider confrontation in cases where severe sight loss prevents automatic assessments (COO Low Vision webpage, 2022).

Loss of peripheral vision increases the risk of falls - particularly if the lower field is restricted. Functional visual fields testing is relevant to fully assess the impact and potential risks associated with an individual’s sight loss (Subhi, 2017).

Measurement of 30 degrees of central field is useful for monitoring eye conditions and 60 degrees of peripheral field provides useful information in terms of mobility. In some cases, a 10-degree central field test is indicative of reading potential. However, in the context of a low vision assessment where an understanding of the functional vision is of greatest importance using confrontation or binocular measurement such as Esterman gives a helpful insight into functional visual fields (Tabrett, 2012).

Suggested methods of field assessment:

* Esterman test on an automated field analyser such as Humphrey
* Goldmann perimetry (particularly useful for patient with neurological sight loss)
* Confrontation test
* Amsler charts
* Automated central fields analysers such as Humphrey, Dicon or Henson.

## Useful links 6.7

General guide for visual fields assessment

[Clinical Procedures in Primary Eye Care Chapter 3 - Assessment of Visual Function](https://www.sciencedirect.com/science/article/pii/B9780750688963500079)

[Assessing and managing patients with low vision - College of Optometrists (college-optometrists.org)](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge,-skills-and-performance/assessing-and-managing-patients-with-low-vision#Assessingpatientswithlowvision)

Binocular visual fields

[OPO Important areas of the central binocular visual field for daily functioning in the visually impaired - Tabrett 2012](https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1475-1313.2012.00892.x)

[Functional visual fields: a cross-sectional UK study to determine which visual field paradigms best reflect difficulty with mobility function](file:///C:\Users\PSmith\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\e018831.full.pdf%20(bmj.com)) (Subhi, 2017)

Goldman perimetry

[Goldmann Perimetry | Field of Vision p31-44 | Barton and Benatar](https://link.springer.com/chapter/10.1007/978-1-59259-355-2_4)

Confrontation test

[American Academy of Ophthalmology Recording confrontation visual fields](https://www.aao.org/education/image/recording-confrontation-visual-fields)

## 6.8 Other tests

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| **Core:**  In order to provide a full and thorough assessment any additional tests must be carried out based on the needs of the individual such as colour vision and binocular vision. |

### Point to consider:

**Do you have facilities to assess all aspects of visual function? Does your protocol set out the need for additional tests to be performed where indicated on a person-centred approach?**

No two people experience sight loss in the same way, but sight loss can be categorised. Categories include:

* Central loss – affects the ability to see detail such as face recognition and reading, affects colour perception.
* Peripheral loss- primarily affects mobility and orientation.
* Contrast loss- difficulty determining an object from its background.
* Cortical visual impairment – processing impairment.

In reality, most people will have a combination of these. For instance, someone with cataract and AMD will have both central vision loss and contrast loss.

Also, many patients report that their vision varies according to the light intensity, with glare causing veiling luminance and reduced contrast affecting their functional vision. Some aspects like these cannot be formally measured but functional vision assessment questionnaires and careful symptoms and history can be employed to detect these challenges.

The College of Optometrists’ guidance makes it clear that these additional tests should be carried out where appropriate. (COO Low Vision webpage, 2022).

Depending on the eye condition, needs assessment and patient reported challenges, a different battery of tests would be indicated. These additional tests should be chosen in a person-centred way, determined by carefully considering their situation, their abilities and their level of vision.

In addition to the standard kit mentioned previously for high contrast vision assessment and contrast sensitivity testing, as well as alternatives for people with additional needs, you should also consider having available/access to the following tests if they are within your scope of practice. Alternatively, they you can request them from their primary eye care provider if that is not you.

It is important that practitioners understand how the results of these tests may be used to predict risks and challenges for the patient. Some of these additional tests are listed below:

* Colour vision tests such as the PV16 Jumbo button colour vision test (RNIB, Colour vision deficiency, 2023) (RCO, 2021)
* Glare sensitivity (RNIB, Light Sensitivity, 2023) (Aslam, 2007)
* Binocular vision tests
* Dynamic retinoscopy (may be relevant to some patients with learning disabilities) (Cregg, 2001)
* CVI screening inventories (Ulster University, 2023)
* PCA investigation (UCLA, 2023)

## Useful links 6.8

Assessing and managing patients with low vision

[College of Optometrists: Assessing and managing patients with low vision](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge,-skills-and-performance/assessing-and-managing-patients-with-low-vision#Dispensinglowvisiondevices)

Colour vision

[RNIB | Colour Vision Deficiency (CVD), also known as colour blindness](https://www.rnib.org.uk/your-eyes/eye-conditions-az/colour-vision-deficiency-cvd-also-known-as-colour-blindness/)

[RCOphth Low Vision: the essential guide for ophthalmologists](https://www.rcophth.ac.uk/wp-content/uploads/2021/12/Low-Vision-Guide.pdf)

[Colour Vision Assessment (including CAD and additional tests) | City, University of London](https://researchcentres.city.ac.uk/applied-vision/avot/individual-tests/colour-vision-assessment-including-cad)

Dynamic retinoscopy

[Invest Ophthalmol Vis Sci | Accommodation and refractive error in children with Down syndrome: cross-sectional and longitudinal studies](https://pubmed.ncbi.nlm.nih.gov/11133848/)

PCA

[UCL | Posterior cortical atrophy | Dementia Research Centre](https://www.ucl.ac.uk/drc/pca-support-group/posterior-cortical-atrophy#tests)

CVI

[Ulster | Cerebral Visual Impairment Assessment](https://www.ulster.ac.uk/research/topic/biomedical-sciences/research/optometry-and-vision-science/vision-resources/professionals/cerebral-visual-impairment-assessment)

Glare

For patients [RNIB | Light sensitivity (photophobia)](https://www.rnib.org.uk/your-eyes/eye-conditions-az/light-sensitivity-photophobia/)

For professionals [Acta Ophthalmologica Scandinavica | Principles of disability glare measurement: an ophthalmological perspective](https://onlinelibrary.wiley.com/doi/10.1111/j.1600-0420.2006.00860.x)

# Section 7- Optical and non-optical aids

This section covers optical and non-optical aids including the training and advice that should be given when issuing them. It also covers lighting, use of contrast and how to manage glare.

## Overview

7.1  Optical low vision aids

7.2  NHS funded low vision optical aids

7.3  Information about LVAs not funded by NHS

7.4 Training on low vision aids

7.5  Batteries and maintenance

7.6  Advanced low vision aids

7.7 Lighting

7.8  Managing glare

7.9  Non-optical low vision aids

7.10 Referral for further support

7.11 Use of contrast and contrast enhancement devices

7.12 Visual and non-sighted strategies

## 7.1 Optical low vision aids

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| **Core:**  A wide range of optical low vision aids for distance and near tasks, in a large range of powers should be available for demonstration and training at point of assessment. |

### Point to consider:

**Do you have a demonstration kit that will cover the full range of magnification needs, both distance and near? Do the majority of your patients have the opportunity to try out and have training on the magnifier that is being prescribed for them?**

In **Appendix D** **Magnifier range** you will find a recommended list for a demonstration kit. As well as keeping demonstration devices it is good practice to be able to issue the magnifier on the same day so that there is no gap between prescribing and starting to use the device.

Keeping a range of magnifiers on site also means that the service will qualify for bulk order discounts which is important from the perspective of good financial stewardship. We appreciate that many services will have storage issues, but we recommend that you keep a stock of magnifiers to issue. This need for storage should be built into the design of new services.

Please note Appendix D will be updated on a yearly basis but there may also be changes in technology, innovation and availability during that time. Also, it is for low vision aids only and does not include other equipment and daily living aids. These are more specific to the interventions from the vision rehabilitation workers for independent living required under the care act, links to which can be in [**Useful links 7.1** below](#_Useful_Links_7.1).

This list is intended to represent the basic recommendations in terms of maximising residual vision through optical management only. It is based on recommended kit lists from the following established services and existing frameworks:

* LOCSU adult low vision pathway equipment list (LOCSU, 2023)
* RNIB low vision service London
* ABDO Low Vision Kit (ABDO Low Vision webpage, 2019)

## Useful links 7.1

Daily living equipment guidance

[GOV.UK Care Act factsheets](https://www.gov.uk/government/publications/care-act-2014-part-1-factsheets/care-act-factsheets#factsheet-1-general-responsibilities-of-local-authorities-prevention-information-and-advice-and-shaping-the-market-of-care-and-support-services)

[Legal Framework for Equipment Provision | London Borough Occupational Therapy Management Group](http://londonadass.org.uk/wp-content/uploads/2016/06/LBOTMG-equipment-provision-guidelines-MARCH-2016-FINAL.pdf)

[Care Act 2014 (legislation.gov.uk)](https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted)

Low vision kit lists

LOCSU [LOCSU Low Vision Equipment List Feb 23](https://locsu.co.uk/wp-content/uploads/2023/02/LOCSU-LV-Equipment-List-Feb23.pdf)

ABDO [ABDO Low Vision Kit List](https://www.abdo.org.uk/wp-content/uploads/2020/11/224005-ABDO-Low-Vision-Kit-DOCUMENT-i.pdf)

## 7.2 NHS-funded low vision optical aids

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| **Core:**  In NHS funded services, optical magnification aids to resolve essential daily living activities should be offered free of charge on a long-term loan basis.  **Core:**  These services should provide an NHS funded repair and replacement service along with details of the magnifier provided should the patient wish to purchase additional aids.  **Core:**  Each device issued should be justifiable and the service should consider how to recycle devices where possible from a financial and environmental sustainability perspective.  **Ideal:**  Devices should be issued on the day of the assessment and demonstration models should be the same as the devices issued.  **Ideal:**  The quantity of devices issued should be based on patient needs and outcomes as established during the assessment. |

### Point to consider:

**Do your patients receive magnifiers for their essential needs free of charge? Do you issue a copy of the details of the magnifiers that have been prescribed? Do your patients know what to do if their device is broken? Is sustainability built into your service?**

All services should provide, or loan, essential low vision aids free of charge. This would include devices to aid activities of daily living such as reading, self-medication, cooking and orientation and mobility. Ideally it would cover hobbies too, but this will depend on local funding rules. All aids required to reduce risks and support needs identified by the assessment should be offered free of charge. It is important to note here that this means some patients may require more than one magnifier and new service should ensure that funding enables this or for existing services where this is not the case funding should be reviewed.

In England, the requirement that NHS services are provided free of charge is set out in section 1(4) of the NHS Act 2006 which provides that:

“The services provided as part of the health services in England must be free of charge.” There are a number of areas where regulations indicate that charges may be imposed for services, including optical services. These regulations (The National Health Service (Charges for Optical Appliances) Directions 2016) only cover the dispensing of glasses and contact lenses. They do not cover the provision of low vision equipment. If NHS bodies did charge for low vision equipment, it is not clear the basis on which such charges could be levied. (NHS England, 2006)

In Wales, eligibility for funded devices can be found in the service manual a link to this in the **Useful links 7.2** This states that up to five devices can be issued but according to identified needs only (NHS Wales, 2023).

In Scotland the patient charter states that NHS services for eye care are free (NHS Scotland, 2023) (NHS Scot Charter, 2022).

Devices should, whenever possible, be issued from stock and they should be the same model that was used in the assessment as different designs may not have the same benefits as the one shown to work in the assessment.

Your SOP should give details of what happens when a device is lost or broken. It is good practice to cover at least one replacement if the device cannot be repaired or is lost. Ensuring that your patients know what they are entitled to and how to get help is the most important factor here.

It is also good practice to give the patient details of the magnifier you are issuing and any others that may not be covered by the NHS but have been identified as beneficial for the patient. This means that the patient can order duplicates or additional magnifiers. The details should include power, make, and model of the magnifiers.

With regards to devices, sustainability, both environmental and financial, must be considered. This should be built into any new service and where possible should be reviewed, and change implemented, in an existing service. For example, recycling is built into the service specification for the Low Vision Service Wales with a requirement to return for recycling all redundant aids. Sustainability needs to be embedded in all aspects of care in order to protect our environment and to be good financial stewards of public money (RCO , 2013), (AOP, 2022) (NHS England, 2023) (NHS Scotland, 2022) (NHSWales, 2021)

Some ideas of how this can be achieved are:

* Recycling. Low vision aids should be recycled where it is possible to adequately disinfect them. This could either be by donating returned magnifiers to charities or by re-issuing to patients. Packaging should also be recycled where possible.
* Minimising waste. Ensure that magnifiers are only issued where there is an identified need and where possible find a solution that can cover several targets to reduce the number of aids issued. Ask patients to return any low vision aids that are not being used and to bring all their low vision aids with them to each appointment to avoid duplication.
* Bulk ordering. Ordering in bulk reduces the cost to the NHS.

## Useful links 7.2

NHS funding

Wales: [NHS Wales General Ophthalmic Service (WGOS) : Service Manual Low Vision and CVIW](https://www.nhs.wales/sa/eye-care-wales/eye-care-docs/wgos-3-service-manual-updated-links-pdf/) section 9

England - [National Health Service Act 2006 (legislation.gov.uk)](https://www.legislation.gov.uk/ukpga/2006/41/contents)

Scotland- [Accessing and using the NHS in Scotland | NHS inform](https://www.nhsinform.scot/care-support-and-rights/health-rights/access/accessing-and-using-the-nhs-in-scotland)

NI - [nidirect | Eye care](https://www.nidirect.gov.uk/articles/eye-care)

Sustainability

[Recycling.co.uk | Recycling Spectacles](https://recycling.co.uk/recycling-spectacles/)

NHS England green policy - [NHS England | Greener NHS: Suppliers](https://www.england.nhs.uk/greenernhs/get-involved/suppliers/)

NHS Scotland - [NHS Scotland climate emergency and sustainability strategy: 2022-2026](https://www.gov.scot/publications/nhs-scotland-climate-emergency-sustainability-strategy-2022-2026/)

NHS Wales- [NHS Wales decarbonisation strategic delivery plan | GOV.WALES](https://www.gov.wales/nhs-wales-decarbonisation-strategic-delivery-plan)

## 7.3 Information about LVAs not funded by NHS

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| **Core:**  It is appropriate to inform patients of devices (such as bioptics) that have been identified as potentially suitable for the patient’s needs, even if they are not available under NHS funding. The patient should be advised how to purchase these and the possible benefits. If patients may be eligible for funding through Access to Work, Disabled Student’s Allowance (DSA), or any other applicable benefit, then they should be given information about how to apply for these. Where appropriate, referral to ECLO or local or national advice services for further support in the application processes should be arranged. At all times the patient’s best interests should be considered. |

### Point to consider:

**Do you provide information to patients about providers of non-funded low vision aids (LVAs) and possible sources of funding?**

It is important that at all times the best interests of the patient are considered, and this includes ensuring they are aware of all options that might help them, even if some of these options are not NHS funded. Patients can be vulnerable to online scams or drawn to commercial products that are not suitable for them, in their search for solutions. It is safer for the patient that they are directed to reputable providers that sell responsibly. Unfortunately, with NHS financial restrictions it is not possible to provide some specialist low vision aids and designer options for glare shields.

There are various magnifiers, and optical and electronic aids that may be of benefit to some individuals with specific tasks or activities, or there may be patients that are prepared to pay towards more expensive aids that may be more aesthetic or convenient.

Practitioners should therefore be aware of good quality alternatives to the standard range and also keep up to date with innovations. This will ensure that patients know the full range of possibilities even if some of these are chargeable. It is however vital that patients know where there is cost involved and are clear that these are options only. Standard low vision aids should be free of charge for the patient’s main targets and to address any risks identified. Some services may choose to fund the more expensive aids, but this will be decided on a local level.

These privately funded alternatives include but not limited to:

* Fashion glare shields
* Peli Prism
* Bioptics
* Portable electronic vision enhancement system (digital/video magnifiers)
* Desktop electronic vision enhancement system (digital/video magnifiers)
* Wearable technology
* Computer accessibility software

Practitioners should be aware of organisations that may be able to provide charitable grants that may fund these items that are not covered by the NHS, links can be found in **[Useful links 7.3](#_Useful_Links_7.3)** below. Patients who would benefit from this should be given information and assistance to apply for this support. Form filling and applications for support can be very time consuming and complex and accuracy is vital, therefore this is beyond the remit of a low vision service but signposting to local or national support is the responsibility of the low vision practitioner or ECLO.

Often patients find this prohibitively difficult and linking them to support can facilitate access to more help. Whenever possible direct referral is ideal rather than signposting.

Magnifiers and electronic aids used for work or study may be funded through Access to Work or through Disabled Student Allowance (DSA). Access to Work and DSA assessments cover the full range of support available to an individual on a person-centred basis. This may be funding for transport, funding a support worker or funding for equipment. Further information can be found in [**Useful links 7.3**](#_Useful_Links_7.3) below. As a minimum this would be to identify local resource centres or national organisations that can offer advice and support and refer or signpost patients so that they can try products and explore options without committing to the expense. An alternative might be to direct the patient to the ECLO if this service is available in your area.

## Useful links 7.3

DSA: [GOV.UK Disabled Students' Allowance application forms and notes for 2022 to 2023 full-time students](https://www.gov.uk/government/publications/disabled-students-allowance-application-forms-and-notes-for-2022-to-2023-full-time-students)

Access to Work: [Government Access to Work](https://www.gov.uk/access-to-work)

Turn2us: [Turn2us | Grants for people with a visual impairment](https://www.turn2us.org.uk/About-Us/News/Grants-for-people-with-a-visual-impairment)

RNIB: [RNIB | Grants](https://www.rnib.org.uk/living-with-sight-loss/money-and-benefits/grants/)

Other organisations: [RNIB | Grants from other organisations](https://www.rnib.org.uk/living-with-sight-loss/money-and-benefits/grants-from-other-organisations/)

## 7.4 Training on low vision aids

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| **Core:**  Patients should be given appropriate instructions on optimal usage and care of any devices issued including guidance around posture, handling, working distance and reading stands. |

### Point to consider:

**Do you ensure that patients know how to use their low vision aids effectively?**

The use of low vision aids is not intuitive. Unless training is given at the time it is prescribed, it is possible that the aid will not be used effectively or used at all. This means that the person’s needs are not met and there is waste in terms of NHS funding (both the appointment and the cost of the device). If possible, training should be given using a real-world sample of whatever the task is that the magnifier has been prescribed for e.g. a newspaper, or medicine packet. It is ideal to have a follow up phone call to check on how the patient is getting on with the device between one and three months later.

After supplying any device, you should provide the patient with full instructions on the following (COO Low Vision webpage, 2022):

* Tasks the device has been issued for
* How to use the device, including:
  + how far the device should be held from the eye and the object
  + which spectacles, if any, to use with it
  + any specific advice on lighting
* The initial programme of low vision training, including:
  + reading or skill practice
  + aftercare
  + what post-supply support is available
* Care, storage and cleaning of the device, including maintenance of batteries and integral lamps if appropriate.

The importance of training patients to use low vision aids is documented in Low vision: Principles and Practice. The author makes the point that low vision prescribing uses a task-orientated approach and the completion of this is not in the identification of a suitable low vision aid but in checking that the patient can use it for the task. Therefore, training is an essential part of the process. (Dickinson, 2023)

In **Appendix E** **Magnifier instruction leaflets for patients** you will find examples of user instruction leaflets.

## Useful links 7.4

Useful range of magnifier instruction booklets -  [Milton Keynes University Hospital | Patient Leaflets](https://www.mkuh.nhs.uk/patients-and-visitors/patient-leaflets)

Macular society low vision aids guide - [Macular Society - Low vision aids](https://www.macularsociety.org/support/daily-life/low-vision-aids/#tips)

Training patients in the use of magnifiers. Low vision. Principles and Practice. (Dickinson, 2023)

## 7.5 Batteries and maintenance

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| **Core:**  Magnifiers should be set up with batteries when issued and the patient given training on how to change the batteries and maintain the device. Patients will be responsible for replacing batteries at their own expense. |

### Point to consider:

**Do patients know how to clean and maintain their magnifiers?**

For low vision aids to be used effectively it is important that they are clean, free from scratches and where there is intended to be illumination the bulbs and batteries are in working order. It is a good idea to ask the patient to bring in any magnifiers that they have been using so that an assessment of how well they have maintained previous magnifiers can be made.

Magnifiers should be issued with batteries installed, and care instructions and advice regarding the use of an optical quality cleaning cloth. Most magnifiers are provided by the manufacturers in a soft case that doubles as a cleaning cloth which should be pointed out to the patient if appropriate. Any information issued needs to be provided in the patient’s preferred format. Patients who are unable to replace batteries or bulbs should be aware of how to contact the service for additional support. It should be noted that for some patients noticing when a magnifier is dirty or scratched can be difficult and therefore discussing this with friends and family is also very helpful so that they can assist when required.

This is important to avoid unnecessary waste and to ensure that the patients get the full benefit of the devices prescribed. Demonstrating the difference between with and without the light function on the magnifier will help the patient understand the need to keep the bulbs and batteries up to date.

Patients should be advised that they are responsible for looking after their devices and replace batteries at their own expense.

Information given on safe storage of batteries away from children especially any alkaline button cell batteries that may be in the devices.

## 7.6 Advanced low vision aids

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| **Core:**  Practitioners should be aware of the limits of their scope of practice and refer on to other practitioners for assessments and supply of specialist devices and solutions beyond their experience level. |

### Point to consider:

**Do practitioners know the limits of their practice, and where appropriate know when to refer patients to specialist practitioners?**

As with all areas of health and social care practice it is important that practitioners are aware of their limits. Patients should be referred to specialist clinics where the assessment and the ideal device is beyond the practitioner’s scope of practice. This requirement is based on the code of conduct of the regulatory bodies for each of the professions involved in this work. There is no definitive list of devices that this applies to as it depends on the skill set of the individual practitioner, but this might include some telescopic devices, spectacle mounted devices and Peli Prisms for hemianopia. This transfer of care should not affect the patient’s right to NHS funded assessment and devices.

It is important to note that the Opticians Act 1989 states that only optometrists are permitted to prescribe and dispense spectacle mounted devices such as spectacle-mounted telescopes (Crown, 1989).

It is a good idea to find out the details of specialist low vision practitioners in your area, so referral can be made smoothly when necessary.

## Useful links 7.6

BIOS: [HCPC : Standards of conduct, performance and ethics](https://www.hcpc-uk.org/standards/standards-of-conduct-performance-and-ethics/) Section 3

VRS: [RWPN Code of Ethics and Professional Conduct](https://www.rwpn.org.uk/resources/Documents/RWPN%20Code%20of%20Ethics%20and%20Professional%20Conduct.docx%20(1).pdf) Code of conduct point 3.8.1.2

Optometrists and dispensing opticians: [GOC Standards of Practice](https://optical.org/en/standards-and-guidance/standards-for-optical-businesses/1-2-patient-care-is-delivered-in-a-suitable-environment/)

section 6

Supply of optical aids and devices

[Opticians Act 1989 (legislation.gov.uk)](https://www.legislation.gov.uk/ukpga/1989/44/contents)

## 7.7 Lighting

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| **Core:**  Appropriate lighting should be discussed with patients as per their needs.  **Ideal:**  Lighting solutions should be demonstrated to patients. |

### Point to consider:

**Does your protocol include discussion regarding good lighting? Do you have a selection of task lighting for demonstration purposes or know of local resource centres for this purpose?**

Lighting is key in helping patients make the most of their vision. Too much lighting or the wrong type of lighting can make vision worse, as can too little lighting. Consideration should be given to the right type of lighting for the task and is dependent on the individual’s type of sight loss and eye condition. For some people excess light or spotlights can cause scattered light inside the eye, producing a veiling luminance that reduces acuity. For others it maybe that they have a longer light-dark adaptation period that means changes in light levels, even between rooms within their home, can cause significant difficulty.

A useful guide on lighting can be found in Chapter 10 The practical management of Visual impairment (Macnaughton J. , 2018). The author explains that the combination of the aging eye, low vision and conventional room lighting can cause significant difficulty and therefore a discussion of how to adapt lighting and who can help is very important.

ABDO produced a CPD article about lighting and glare which covers this topic well (Bartlam, 2015).

There are a range of patient booklets available including those from RNIB, Thomas Pocklington Trust, Macular Society and Guide Dogs. (Macular society , 2023) (Thomas Pocklington Trust , 2021) (Guide Dogs, 2023).

A discussion about lighting should be included in the assessment, and where possible a demonstration of suitable lighting should be given. It is ideal to include details of this discussion in any referral that is made to the sensory needs’ rehabilitation service. The discussion should include general lighting and also task lighting. It should also take into account the level of glare and contrast sensitivity in a person-centred approach.

Where possible demonstrating the effect of adjusting the lighting can be very helpful to the patient. This could be as simple as having a range of task lights and demonstrating the benefits (or otherwise) of using additional lighting on the person’s reading speed. Showing how spotlights can be counterproductive and simple adaptations can make a big difference.

Controlling excessive lighting and light is as important as having enough light. The management of glare is covered in section **7.8 Managing glare.**

## Useful links 7.7

For Patients:

Lighting guide from Thomas Pocklington Trust: [Lighting in and around the home - Thomas Pocklington Trust (pocklington-trust.org.uk)](https://www.pocklington-trust.org.uk/sector-resources/a-guide-to-better-lighting-for-people-with-visual-impairment/)

Lighting guide from Guide Dogs: [Guide Dogs | Lighting](https://www.guidedogs.org.uk/getting-support/information-and-advice/life-skills/making-the-most-of-your-vision/lighting/)

Information for your patients: [RNIB | Starting Out series – Making the most of your sight booklet](https://media.rnib.org.uk/documents/SO_MTMofYS_2021.pdf)

Macular Society lighting booklet for patients: [Macular Society | Lighting](https://www.macularsociety.org/support/daily-life/practical-guides/home/lighting/)

Series of videos for patients: [VisionAware | Minimizing Glare](https://visionaware.org/everyday-living/home-modification/lighting-and-glare/videos-better-lighting-for-better-sight/)

Book references and articles:

The Practical Management of Visual Impairment by Jane Macnaughton (2018) chapter 10

[The University of Manchester | Low Vision: Principles and Management](https://research.manchester.ac.uk/en/publications/low-vision-principles-and-management)

[The Low Vision Patient: illumination, glare and contrast. Elizabeth Bartlam (ABDO)](https://www.abdo.org.uk/wp-content/uploads/2012/06/CET161.pdf)

## 7.8 Managing glare

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| **Core:**  A range of glare shields should be available for demonstration and provision on long term free loan. Advice should be given on managing glare such as the use of a brimmed cap.  **Ideal:**  These should be assessed in the environment in which the symptoms are present. |

### Point to consider:

**Do you have a range of glare shields and give advice on managing glare?**

Many patients who have sight loss are affected by glare. In some cases, this can cause discomfort (discomfort glare) and in some cases glare causes the vision to be significantly reduced (disability glare), or there may be a combination of both. Therefore, glare advice and management are very important in terms of enabling patients to optimise their vision.

See sections **6.6 Measuring contrast sensitivity** and **7.7** **Lighting** and also **7.11 Use of contrast and contrast enhancement devices** as these topics are interconnected.

There should be a range of glare shields, or fitovers, that are available to demonstrate for patients identified as having glare symptoms. Ideally, they should be demonstrated in the environment in which they are to be used wherever possible. There may be a need for more than one level of tint depending on the severity of the symptoms and the person’s requirements. For example, dark tint for outdoors and lighter tint for indoors. For some patients the look of glare shields can be off putting as it is synonymous with stereotypes of visual impairment or they may feel it marks them out as a target of thieves. If this is the case encourage the patient to trial the glare shields to see whether the colour and depth of tint recommended works for them and direct them to more aesthetically acceptable wraparounds that can be purchased privately.

For patients who have glare due to a lack of iris referral to a contact lens specialist may be considered for artificial iris contact lenses (Dickinson, 2023).

Glare shields should be discussed alongside other non-optical glare management strategies. Additional advice and information should include (Dickinson, 2023) (Macnaughton J. , 2018) (Bartlam, 2015):

* The use of a hat with a brim or sports visor.
* Use of vertical blinds at windows.
* Considering the reflective surfaces in work or kitchen areas which may cause glare in combination with certain types of lighting.
* Consider the positioning of computer workstations with respect to the position of the windows or light sources.
* Typoscopes can be used to reduce glare reflected from white pages when reading.
* Exploring how lighting is set-up in the home or work environment.

A recommended glare shield demonstration kit can be found in **Appendix F** **Glare shield demonstration range**.

## Useful links 7.8

For patients:

[RNIB | Light sensitivity (photophobia)](https://www.rnib.org.uk/your-eyes/eye-conditions-az/light-sensitivity-photophobia/)

[RNIB | Five steps to getting the right glasses for light sensitivity](https://www.rnib.org.uk/your-eyes/eye-conditions-az/light-sensitivity-photophobia/five-steps-to-getting-the-right-glasses-for-light-sensitivity/)

[Macular Society - Protecting your eyes](https://www.macularsociety.org/support/daily-life/practical-guides/healthy-living/protecting-your-eyes/#:~:text=Glare%20is%20the%20discomfort%20to%20vision%20caused%20by,which%20scatter%20light%20as%20it%20enters%20the%20eye.)

Articles:

Glare control: [The Low Vision Patient: illumination, glare and contrast. Elizabeth Bartlam (ABDO)](https://www.abdo.org.uk/wp-content/uploads/2012/06/CET161.pdf)

Non optical strategies: [RNIB | Colour and contrast for people with sight loss](https://media.rnib.org.uk/documents/Colour_and_contrast_for_people_with_sight_loss_2020.pdf)

## 7.9 Non-optical low vision aids

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| **Core:**  Relevant non-optical and daily living aids should be discussed, and patients should be referred accordingly to their sensory needs team / VRS for assessment and provision of suitable equipment.  **Ideal:**  The relevant non-optical and daily living aids should be demonstrated prior to referral to the sensory team / VRS. |

### Point to consider:

**Does your protocol include the discussion of non-optical aids appropriate to each individual? Do you have a defined referral pathway to the local VRS team?**

In order to support the patient with all their desired outcomes it is important to have a good knowledge of non-optical aids, as not all tasks are amenable to optical devices. For most patients a combination of optical and non-optical aids will provide the best options for their activities. The strategies used in low vision include bigger, brighter, bolder, audio and tactile solutions. Some solutions combine two or more of these approaches. For instance, a patient may find the combination of the use of colour contrast, good task lighting and a liquid level indicator is the solution to enabling them to make hot drinks.

Ideally, the service should have a demonstration kit that includes common non-optical aids. If this is not possible then the practitioner should refer the patient to a local resource centre or direct them to safe online information. This means that before the patient has their sensory needs rehabilitation assessment, they are already aware of some of the possible options available to them. Patients should be made aware that some of these may be available through social services, but others may need to be purchased. Demonstrating some of these aids can also provide choice for patients that may face a significant wait for sensory needs assessment through social services.

Referring patients to peer support groups or courses, such as Living Well with Sight Loss, may help patients to learn about non optical aids from other people with sight loss.

Suggestions of items for the demonstration kit would be:

* Liquid level indicator
* High contrast tape
* Typoscopes
* Bumpons
* Large print books and puzzles
* Black felt tip pens
* Reading stands
* Clipboards
* Yellow lined paper
* Talking scales and thermometers
* Pill boxes
* Talking watches and clocks
* Clear face watches
* Examples of symbol canes
* Smart phone apps

## Useful links 7.9

Patient information:

[RNIB | Practical adaptations](https://www.rnib.org.uk/living-with-sight-loss/independent-living/practical-adaptations/)

[RNIB | Adapting your home](https://www.rnib.org.uk/living-with-sight-loss/independent-living/adapting-your-home/)

[RNIB | Cooking](https://www.rnib.org.uk/living-with-sight-loss/independent-living/cooking/)

[RNIB Online Shop](https://shop.rnib.org.uk/)

[RNIB | Starting Out series – Making the most of your sight booklet](https://media.rnib.org.uk/documents/SO_MTMofYS_2021.pdf)

[TPT Housing guide for people with sight loss](https://www.pocklington.org.uk/resources/useful-guides/housing-guide-for-people-with-sight-loss/)

[RNIB | Living Well with Loss courses](https://www.rnib.org.uk/your-eyes/navigating-sight-loss/living-well-with-sight-loss-courses/?gad_source=1&gclid=EAIaIQobChMIh7-M0vLxgwMVhwaLCh3h3AYOEAAYASAAEgI-GPD_BwE)

## 7.10 Referral for further support

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| **Core:**  Where needs are identified but the service is unable to offer solutions, those patients identified as benefiting from further support (as per section **4.3 Linking services**) are referred appropriately, including referral for sight impairment certification or change of registration status. |

### Point to consider:

**Do you have clear referral pathways to other agencies to ensure all needs are met? Do you routinely identify those patients eligible for certification and registration or change of registration level, and ensure that they have enough information to make an educated decision about their options?**

For many patients it is not possible to resolve all their needs by the provision of optical aids and/or non-optical aids. Referral to other specialist agencies is therefore sometimes necessary. The practitioner should identify targets that they are unable to resolve and suitable specialist services that can help. Alternatively, patients can be referred to an ECLO, if available, with an explanation as to the needs identified that cannot be resolved with optical aids.

It is good practice to have a direct referral pathway to key stakeholder agencies such as the local sensory needs service, local society for visual impairment, ECLO and emotional support services. In some cases, the patient may decline direct referral, but it is a good idea to give the patient relevant information about recommended local or national services in their preferred format. This will mean the patient has access to the information and can self-refer if they change their mind.

The SOP should have a policy that includes a process for referral to other agencies. This should include referrals to other clinical services, social care services and third sector agencies. The policy should reference information governance (IG) and confidentiality safeguards.

The practitioner will need to be aware and follow local protocols concerning referrals to secondary care and registration.

Further details of, and useful links to other agencies are given insection **4.3 Linking services**.

## Useful links 7.10

See also **Useful links 4.3**

Database to search for service details [Sightline Directory](https://www.rnib.org.uk/sightline-directory/)

See **Appendix G Template for local services leaflet**

## 7.11 Use of contrast and contrast enhancement devices

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| **Core:**  Where appropriate, discussion of the use of contrast in the environment and for activities of daily living should take place. Demonstration of devices such as contrast enhancement spectacles and tints should be offered where potential benefit has been identified.  **Ideal:**  Provision of contrast enhancement devices under NHS funding should be available. |

### Point to consider:

**Do you discuss with your patients the benefits of enhancing contrast, contrast enhancing devices and environmental adaptations where appropriate? Do you have demonstration contrast enhancement aids?**

When a patient has been identified as having poor contrast sensitivity or reports multiple falls it is important to discuss enhancing contrast along with lighting and glare control. Patients can report improved comfort but reversing the contrast on text (white on black for instance) as this reduces scattered light inside the eye (this can also have the effect of reducing the required magnification too) (Macnaughton J. , 2018). Typoscopes can have a similar effect to reverse contrast and are quick to demonstrate in the consulting room.

There are simple adaptations that can be made to the environment that can enhance contrast such as use of good task lighting, colour contrast along edges, table mats and kitchenware. More information can be found in the guides from Thomas Pocklington Trust in **Useful links 7.11**.

Use of contrast in everyday tasks should also be discussed with the patient such as serving food on colour contrasting plates. More information for patients can be found in RNIB’s Making the most of your sight booklet; Guide Dogs has a section on its website for patients: the links can be found in **Useful Links 7.11**.

Contrast enhancement can also be made using blue blocking shields which reduce scattered light by cutting short wavelength light. Alternatively, electronic vision enhancement systems (EVES) can be used to enhance or reverse contrast (Miller, 2023).

## Useful links 7.11

For patients:

[Guide Dogs | Making the most of your vision](https://www.guidedogs.org.uk/getting-support/information-and-advice/life-skills/making-the-most-of-your-vision/)

[RNIB | Starting Out series – Making the most of your sight booklet](https://media.rnib.org.uk/documents/SO_MTMofYS_2021.pdf)

For practitioners:

[College of Optometrists | Electronic vision enhancement for low vision](https://www.college-optometrists.org/professional-development/college-journals/optometry-in-practice/all-oip-articles/volume-18,-issue-2/2017-06-electronicvisionenhancementforlowvision)

[OPO Are wearable electronic vision enhancement systems (wEVES) beneficial for people with age‐related macular degeneration? A scoping review - Miller - 2023](https://onlinelibrary.wiley.com/doi/10.1111/opo.13117)

## 7.12 Visual and non-sighted strategies

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| **Core:**  Where appropriate advice and referral to specialist support in mobility strategies or training in visual strategies such as eccentric viewing should be provided. |

### Point to consider:

**Do you identify patients who would benefit from training in visual and mobility strategies? Do you know who can provide this specialist support?**

Practitioners should be aware of the range of visual or mobility strategies that may be of help for some patients. These include:

* Mobility and orientation training with canes
* Trailing techniques
* Scanning techniques for hemianopia including some that are computer-based programmes
* Eccentric viewing and steady eye strategy
* Occlusion for double vision
* Vision training

The service should have referral routes into providers of this training either locally with social services vision rehabilitation specialists or to specific services such as hemianopia rehabilitation clinics. In addition, local or national charities may also provide mobility training.

Skills for seeing from the Macular Society is a useful resource for patients identified as potentially benefiting from eccentric viewing and steady eye strategy training, link below in **Useful links 7.12**

Sighted guiding and cane skills resources from Guide Dogs are useful resources to supplement formal mobility training from social services vision rehabilitation specialist services: follow the link below in **Useful links 7.12**

## Useful links 7.12

Eccentric viewing and steady eye strategy

[Macular Society - Skills for seeing](https://www.macularsociety.org/support/daily-life/skills-seeing/)

Mobility training and strategies

Cane training [Guide Dogs | Getting Around Safely | Life Skills](https://www.guidedogs.org.uk/getting-support/information-and-advice/life-skills/getting-around-safely/)

Trailing [Guide Dogs | Trailing Technique | Life Skills](https://www.guidedogs.org.uk/getting-support/information-and-advice/life-skills/getting-around-safely/trailing/)

Scanning techniques

[RNIB | Stroke-related eye conditions](https://www.rnib.org.uk/your-eyes/eye-conditions-az/stroke-related-eye-conditions/)

UCL [UCL's Eye-Search - free therapy for visual search problems](https://www.eyesearch.ucl.ac.uk/)

Durham University research [Durham University - DREX](https://www.durham.ac.uk/departments/academic/psychology/research/services/drex/)

# Section 8 – Assistive technologies

This section covers the different categories of assistive technologies available and referring for further advice and support. Many mainstream technological devices have built-in accessibility options that can be life-changing for people with sight loss and there is an expanding range of devices designed specifically for blind and partially sighted people. Unfortunately, patients may assume that as their vision deteriorates technology becomes less available to them.

A good low vision service should be able to advise and guide patients to all possible options that may help them with their day-to-day activities and hobbies. Assistive technology is a fast-moving field; it is vital that practitioners stay up to date, for example by reading articles, listening to podcasts and webinars and attending conferences.

In areas where NHS funding is available, electronic aids should be available on free permanent loan. Demonstration aids should be available to show patients and training should be given in a similar manner to that given when optical aids are prescribed.

Assistive technologies can be broadly divided into three categories, covered in this section: vision enhancement, navigation and orientation and reading support. We also cover advice about referring patients for technology support.

## Overview

8.1  Vision enhancement

8.2  Navigation and orientation

8.3 Reading support

8.4  Referral for technological support

## 8.1 Vision enhancement

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| **Core:**  Practitioners should be able to discuss technological solutions which aid vision enhancement including digital magnifiers, wearables, and apps. They should be able to refer patients to appropriate agencies for further information and purchase as appropriate.  **Core:**  If electronic magnifiers are available for loan in the area a range of suitable aids should be stocked for demonstration.  **Ideal:**  Electronic aids should be available on free permanent loan. |

### Point to consider:

**Does your service support patients in finding out about the latest technological advancements in vision enhancement?**

Practitioners should be aware of the current technological options for vision enhancement such as magnification and image manipulation. They should know who to direct the patient to in order to get the help they need, as well as having knowledge around the general pros and cons of the types of aids.

In areas where NHS funding is not available, it is good practice to, as a minimum, support patients to make the most of the technology they already have, including smartphones and tablets. While detailed discussion around technology is beyond the remit of a low vision assessment, practitioners should know sources of local patient support for technology training, help with purchasing technology and funding. This may be the local society or national sight loss charities. Links to information and support can be found below.

The practitioner should have a good understanding of:

**Digital magnifiers:**

Digital or electronic video magnifiers enable you to zoom into and magnify images and text on a screen, as well as change the contrast or make other modifications to the image. Devices come in a range of size and magnification strength. Handheld magnifiers are portable and great when out and about, whereas the larger magnifiers or desktop versions suit longer periods of reading.

**Wearable technologies:**

Wearable electronic vision enhancement systems provide hands-free magnification and image enhancement, producing significant improvements in acuity and contrast sensitivity. These are devices that can be worn such as spectacles or belts, examples include SightPlus, IrisVision and eSight (Miller, 2023).

**Software and accessibility features:**

Computers, tablets and smartphones all contain built-in accessibility features or access to downloadable software. Accessibility features are designed to help people with sight loss and other additional needs, use technology more easily.

Examples are built-in electronic magnification, contrast options, a text-to-speech feature may read text out loud, and speech-recognition features which allows users with limited mobility to control the computer with their voice.

**Applications (Apps):**

Applications are available for smart phones, tablets and computers to help assist people with sight loss with daily activities. This includes electronic magnifier apps that can be used for distance and near tasks and built-in accessibility magnification options.

## Useful links 8.1

Tech support

[RNIB | Technology Support](https://www.rnib.org.uk/living-with-sight-loss/assistive-aids-and-technology/tech-support-and-information/technology-support-and-training/technology-support-we-offer/)

[TPT Assistive and Inclusive home technology for people with sight loss](https://www.pocklington-trust.org.uk/supporting-you/useful-guides/assistive-and-inclusive-home-technology-for-people-with-sight-loss/)

[Henshaws Digital Enablement](https://www.henshaws.org.uk/sight-loss-support-team/adult-services/digital-enablement/)

[Guide Dogs Technology for visual impairment](https://www.guidedogs.org.uk/getting-support/information-and-advice/how-can-technology-help-me/)

[Macular Society Connect by Tech](https://www.macularsociety.org/support/daily-life/connect/)

[AbilityNet](https://abilitynet.org.uk/)

[TAVIP (Technology Association for Visually Impaired People)](https://www.tavip.org.uk/supporting-you/)

Technology suppliers and exhibitions

[IrisVision](https://irisvision.com/)

[Vision Aid](https://www.visionaid.co.uk/) ([SightPlus](https://www.visionaid.co.uk/sightplus), [eSight](https://www.visionaid.co.uk/esight-4), [Oxsight](https://www.visionaid.co.uk/oxsight))

[Sight Village exhibitions](https://www.qac.ac.uk/exhibitions/sight-village-2024-schedule/1080.htm)

[Sight and Sound Technology](https://www.sightandsound.co.uk/) ([Envision](https://www.sightandsound.co.uk/envision-glasses/))

[Give Vision](https://www.givevision.net/)

[Humanware](https://www.humanware.com/en-united_kingdom/home)

## 8.2 Navigation and orientation

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| **Core:**  Practitioners should be able to discuss technological solutions to help with orientation (the recognition of objects and the position of things in relation to the user) and navigation (planning and following a route and avoiding obstacles), including wearables, apps and smart canes.  They should be able to refer patients to appropriate agencies for further information and purchase as appropriate. |

### Point to consider:

**Does your service support patients in finding out the latest technological advancements in navigation and orientation?**

Practitioners should be aware of the current technological options for navigation and orientation. They should know how to direct the patient for them to get the help that they need. It is also important to be aware of the general pros and cons of the types of aid.

For example, issues with relying on satellite technology, mobile phones, battery life, cost of device and data and accuracy. The importance of conventional mobility and orientation strategies should also be emphasised to ensure that patients always have the skills to use when technology is not available.

GPS Navigation apps

These come in several different forms and are often free to download. Many apps help to plan journeys by aiding in the discovery of new locations and providing more in-depth information about the surroundings. Finding the right app for the patient’s specific circumstance and experience level can go a long way in helping to ensure they become an effective navigator. Examples of navigation apps can be found below in the **Useful links** **8.2** section.

**Wearable technologies:**

* Visors and belts

Visor-style wearables are not designed as mobility aids but instead should be used when stationary. They can be a useful aid to understand the environment and make choices such as where to go next or the location of specific things (for example fire exits, toilets and seating). Examples are LIDAR scanners and naviBelt.

* Spectacle-mounted

These are spectacle mounted devices that use built in cameras and speakers to describe the visual world and aid navigation. Examples are Orcam and Envision Glasses.

* Wristband

A combined sonar and augmented reality wristband wearable is available that can be connected to an app to assist navigation. This is not a standalone device and is designed to be used in conjunction with canes or other mobility strategies. There are also a number of smartwatches available for similar purposes.

* Smart canes

These are long canes with ultrasonic detector that will provide hazard alerts to a mobile phone. They may also have the capability of providing details about the surroundings (shops, bus stops and landmarks). Patients should be informed about the need for proper long cane training before purchasing these devices.

Supplying the above devices is unlikely to be the remit of the service but ensuring patients are given, or are signposted, to information is essential.

## Useful links 8.2

[Henshaws Out and About](https://www.henshaws.org.uk/hints-and-tips-category/out-about/)

[RNIB | Wearable technology: smart glasses and head mounted cameras](https://www.rnib.org.uk/living-with-sight-loss/assistive-aids-and-technology/tech-support-and-information/wearable-technology-smart-glasses-and-head-mounted-cameras/)

[Sunu Band (Vision Aid)](https://www.visionaid.co.uk/sunu-band-premium)

[WeWALK Smart Cane](https://wewalk.io/en/) and smartphone app

[Freethink Smart Cane](https://www.freethink.com/hard-tech/smart-cane-for-the-blind)

Navigation apps

[RNIB | GPS Navigation](https://www.rnib.org.uk/living-with-sight-loss/assistive-aids-and-technology/everyday-tech/navigation-and-communication/what-is-gps-navigation/)

[Blind Square](https://www.blindsquare.com/)

[NaviLens](https://www.navilens.com/en/)

[Lazarillo](file:///C:\Users\PSmith\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\Guide%20Dogs%20–%20Best%20apps%20for%20navigating%20public%20transport)

[Wayfindr - Accessible Indoor Audio Navigation](https://www.wayfindr.net/)

[Henshaws GoodMaps Explore: Indoor navigation with a smartphone](https://www.henshaws.org.uk/hints-and-tips/goodmaps-explore-indoor-navigation-with-a-smartphone/)

[GoodMaps](https://www.goodmaps.com/)

[Guide Dogs – Best apps for navigating public transport](https://www.guidedogs.org.uk/getting-support/information-and-advice/how-can-technology-help-me/best-apps-for-navigating-public-transport/)

## 8.3 Reading support

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| --- |
| **Core:**  Practitioners should be able to discuss technological solutions for reading as an alternative to vision enhancement, including being able to discuss Optical Character Recognition (OCR) software. Knowledge should include accessibility software on mainstream devices, e-readers, braille displays, apps, audio solutions and wearables. Practitioners should be able to refer patients to appropriate agencies for further information and purchase as appropriate. |

### Point to consider:

**Are your practitioners aware of the latest technological options to assist with reading? Do you discuss this with your patients?**

The technological options for reading are vast and range from mainstream device such as eReaders that enlarge the font, through to sensory substitution options which may be more suited to patients with limited usable vision or physical barriers to using handheld magnifiers.

It is important for low vision practitioners to have a working knowledge of the range of sensory substitution options available which can be used alongside or as an alternative to vision enhancement.

The practitioner should understand the overall principles of Optical Character Recognition software (OCR) and the general pros and cons of the different approaches. An understanding of what is appropriate for the individual person is as important in this field as it is in the prescribing of optical magnifiers.

Consideration of the type of reading (size of text, duration, importance) should be factored into any suggestions, for example, someone who is spot reading occasionally may prefer a different option than someone who is studying for an exam. The individual’s hearing ability should also be given consideration. The practitioner should be aware of cost and offer suggestions of how the patient may be able to access funding.

The following is a list of the types of solution currently available, further information on each type can be found in the **Useful links 8.3** below:

**eReaders**

These are devices that can electronically display text from a book or newspaper download. There is a wide range of mainstream devices available as well as computer and tablets/iPads which can also have this functionality, therefore the importance of trying them before buying is important. Factors such as glare from the light or reflections from the screen causing a reduction in contrast can be a problem for some patients, however many devices have the ability to adjust the brightness or reverse the contrast. The range of font sizes may be crucial for others. Some eReaders also have the capability to play audio books too which gives flexibility depending on the task or how the person is feeling. eReaders are useful for people who require image enhancement or magnification.

**Reading machines using OCR**

These can be standalone, computer-based or portable devices. These machines and devices convert text images to audio. The text can normally be typed, handwritten or printed.

**Refreshable braille devices**

It is possible for braille to be generated electronically on devices connected to mobiles and tablets, or via a computer with an appropriate screen reader. These displays are generally lightweight and portable.

**Audio books**

RNIB and Calibre offer talking books free of charge in various formats such as downloads, discs and flash drives. RNIB Talking Books are also available through Alexa-enabled devices.

Additionally, audio books are available on Borrow Box which can be accessed via local libraries or via the popular mainstream app Audible which requires a monthly membership fee.

**Wearables**

Wearables can take the form of either headsets or smartglasses. Some enhance the image to make it easier to see, whereas others use OCR and AI to convert text to audio. These have been described in earlier sections in more detail.

**Mobile phone and tablet apps**

There are some free and some chargeable mobile phone apps that use OCR technology to convert text to audio. These are appropriate for spot reading, or for correspondence and menus, but not for reading books. Some apps are specifically for people with sight loss, such as SeeingAI and Envision AI; others are mainstream accessibility features.

## Useful links 8.3

eReaders:

[RNIB | eBooks](https://www.rnib.org.uk/living-with-sight-loss/assistive-aids-and-technology/everyday-tech/reading-and-writing/ebooks-and-digital/)

[BorrowBox – Your library in one app](https://www.borrowbox.com/)

Mobile phone/screen readers:

[Guide Dogs – Google Talkback](https://www.guidedogs.org.uk/getting-support/information-and-advice/how-can-technology-help-me/google-talkback/)

[Guide Dogs – Apple Books](https://www.youtube.com/watch?v=hO-JXxxkNhI&feature=youtu.be)

[Guide Dogs – Apple Book Creator](https://www.guidedogs.org.uk/getting-support/information-and-advice/how-can-technology-help-me/apps/book-creator-for-ipad/)

Reading machines:

[AbilityNet Vision impairment and Computing](https://www.abilitynet.org.uk/factsheets/vision-impairment-and-computing#simple-table-of-contents-19) (section 10 – reading machines)

Braille displays:

[RNIB | guide to braille displays for blind and partially sighted people](https://www.rnib.org.uk/living-with-sight-loss/assistive-aids-and-technology/everyday-tech/reading-and-writing/an-rnib-guide-to-braille-displays-for-blind-and-partially-sighted-people/)

[RNIB | Reading Services](https://readingservices.rnib.org.uk/)

[Guide Dogs – what is braille](https://www.guidedogs.org.uk/getting-support/information-and-advice/how-can-technology-help-me/what-is-braille/)

Audio books:

[Calibre Audio](https://calibreaudio.org.uk/)

[RNIB | Talking Books](https://www.rnib.org.uk/living-with-sight-loss/independent-living/reading-and-books/talking-books/)

[BorrowBox – Your library in one app](https://www.borrowbox.com/)

[Audible](https://www.audible.co.uk/?ref_pageloadid=not_applicable&ref=a_hp_t1_nav_header_logo&pf_rd_p=5ab93e15-48e3-4f02-8bc8-739cc674fa84&pf_rd_r=X9M00RF1PWY1MJ0YHVJ8&pageLoadId=vkrkCl27ml1wzMQr&creativeId=fd449be1-b925-4b49-a701-e1f297f8c121)

Wearable technologies:

[RNIB | Wearable technology: smart glasses and head mounted cameras](https://www.rnib.org.uk/living-with-sight-loss/assistive-aids-and-technology/tech-support-and-information/wearable-technology-smart-glasses-and-head-mounted-cameras/)

Mobile phone and tablet apps:

[Henshaws 40 Apps for People with Visual Impairment](https://www.henshaws.org.uk/wp-content/uploads/2021/07/app_guide_2020_FREE.pdf)

[Guide Dogs Reading Apps and Technology](https://www.guidedogs.org.uk/getting-support/information-and-advice/how-can-technology-help-me/apps/reading-apps/)

[RNIB | Reading Services](https://readingservices.rnib.org.uk/)

See also **Useful links 8.1** section

## 8.4 Referral for technological support

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| --- |
| **Core:**  Practitioners should have an established referral pathway to national and/or local services that support patients to learn how to use technology, develop their skills and find sources of potential funding. |

### Point to consider:

**Does your service know how to get support for patients who would like to use technology options but are facing barriers such as lack of training or financial restrictions?**

The main barriers for patients in using assistive technology are the challenge of learning new skills, the fear of using new devices and cost.

Practitioners should be able to signpost, or refer, patients to organisations that can help them. It is important practitioners are aware of what is locally available and direct patients accordingly.

However, it is also good to have an understanding of what national sight loss charities can offer too. Vision Rehabilitation Specialists (VRS), or ECLOs, may also be useful as they will be able to provide details of local sight loss charities and what technological equipment and support is available locally.

VRSs and ECLOs may also be able to provide advice on:

* Training courses (often face-to-face) and support to get started
* Advice on accessibility settings for specific devices
* Support and advice for selecting appropriate devices
* Funding options such as Access to Work, DSA (Disabled Students’ Allowance) grants and charitable grants

**Demonstration kits**

Ideally the service should have a range of electronic devices available for demonstration. In particular those devices that provide vision enhancement options. For demonstration purposes, an iPad, or tablet, with a selection of apps for people with sight loss or with accessibility features switched on should also be available for demonstration purposes. You may wish to purchase one for use in your clinic or you may be able to get these on loan from your local society. However, it is worth remembering that the technology can date quickly so older iPads or tablets may have compatibility issues with apps and software.

## Useful links 8.4 see also Useful links 4.3

Training resources:

[Guide Dogs Tech for All learning programme](https://www.guidedogs.org.uk/getting-support/information-and-advice/how-can-technology-help-me/tech-for-all-learning-programme/)

[TAVIP Training Directory](https://www.tavip.org.uk/resources/training-directory/)

[RNIB | Technology Support](https://www.rnib.org.uk/living-with-sight-loss/assistive-aids-and-technology/tech-support-and-information/technology-support-and-training/technology-support-we-offer/)

[Henshaws Digital Enablement](https://www.henshaws.org.uk/sight-loss-support-team/adult-services/digital-enablement/) (training )

Support and advice:

[Guide Dogs Apple accessibility features](https://www.guidedogs.org.uk/getting-support/information-and-advice/how-can-technology-help-me/ios-accessibility-features/)

[TAVIP Knowledge Base](https://www.tavip.org.uk/knowledge-base/)

[RNIB | Technology information](https://www.rnib.org.uk/living-with-sight-loss/assistive-aids-and-technology/everyday-tech/)

[Henshaws Assistive Technology](https://www.henshaws.org.uk/hints-and-tips-category/technology/?gad_source=1&gclid=EAIaIQobChMIw9LVoNPfgwMVN5ZQBh1EIwYhEAAYASAAEgK8cfD_BwE)

[RNIB | Confident Living Series Booklets: Technology](https://media.rnib.org.uk/documents/Confident_Living_-_Technology_2022.pdf)

Funding resources:

[RNIB | Grants from RNIB](https://www.rnib.org.uk/living-with-sight-loss/money-and-benefits/grants-from-rnib/)

[RNIB | Grants from other organisations](https://www.rnib.org.uk/living-with-sight-loss/money-and-benefits/grants-from-other-organisations/)

[Access to Work (Government): get support if you have a disability or health condition](https://www.gov.uk/access-to-work)

[Disabled Students' Allowance (DSA) application forms and notes (Government)](https://www.gov.uk/government/publications/disabled-students-allowance-application-forms-and-notes-for-2022-to-2023-full-time-students)

# Section 9 - Reports and records

This section covers how data should be recorded and stored safely and accurately and the importance of report writing. Good record keeping is essential to good patient care. Low vision services need to consider carefully how they communicate and work with other allied services such as the social services sensory needs team and the patient’s medical providers. Reports and record keeping are vital for seamless holistic care and also to enable patients to take an active role in decisions for their health and social care support. This means that reports and record keeping needs to be a focus in this framework.

## Overview

9.1  Storing and sharing data

9.2  Record keeping

9.3  Consent

9.4  Report writing

9.5  Standard operating procedure (SOP)

## 9.1 Storing and sharing data

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| **Core:**  Patient records are kept securely and managed in accordance with GDPR, data protection and relevant standards of practice policies. If a subject access request is made by the patient, the information should be provided in the patient’s preferred format. |

### Point to consider:

**Do you store your patient records securely? Could anyone access the information who should not access it? Do you know what your patient’s rights are with respect to the data you store?**

Regardless of the format of the records, as per the Data Protection Act 2018, patients have the right to know that their information is safe, accurate and only shared with people who have a legitimate need for that information (Gov Data Protection, 2023).

The Data Protection Act requires that data is:

* Used fairly, lawfully and transparently.
* Used for specified, explicit purposes.
* Used in a way that is adequate, relevant and limited to only what is necessary.
* Accurate and, where necessary, kept up to date.
* Kept for no longer than is necessary.
* Handled in a way that ensures appropriate security, including protection against unlawful or unauthorised processing, access, loss, destruction or damage.

Patients have the right to access the information stored about them and to request that incorrect or inaccurate information is updated. Patients also have the right to say what that information is used for and who can access it (CCEHC Low Vision, 2017). There are some caveats here in terms of medical data being stored according to indemnity guidelines and shared when there is a significant safeguarding concern. In addition, capacity guidelines need to be considered in the context of decisions around the data that is stored.

Consent for storing data needs to be considered at every patient interaction and is not a one-off decision made by the patient. For more information on consent with respect to personal data see section **9.3 Consent.**

Sharing data with other professionals and agencies is often required but should always be justified and carried out safely. Therefore, it is important that there is effective sharing of data at every stage of the patient’s pathway to ensure good communication and secure interchange of relevant information between health, care and education professionals and their patients - ideally provided by electronic patient records. When a patient has to move from one service to another (for instance, moving out of the area) there should be a smooth transition and sharing of that data (CCEHC Low Vision, 2017).

The organisation is the record holder (data controller), but each practitioner has responsibilities under the Data Protection Act 2018 (DPA 2018) and the EU General Data Protection Regulations (GDPR). All staff should undergo data security training.

Key points are (COO Patient Records, 2022):

* Keeping accurate patient data.
* Using the data for the specific purposes for which it was recorded.
* Amending inaccurate data and responding to objections from patients if the use of the data causes harm or distress.
* Keeping the data confidential and secure.
* Enabling patients, or an applicant acting on behalf of a patient, to access their data for the length of time that you keep the records. The applicant has a right to see the data, either because they have written authority from the patient or because they have Power of Attorney. Access to the record must be given within the time limit set out in the act and the GDPR requires that, if a patient asks for a copy of their record, this must be provided free of charge in most instances.
* Helping the patient to understand their record by explaining its content and abbreviations.
* Satisfying yourself that there is no further need of the record before destroying it.
* Disposing of any records securely.
* Noting that, if you, or your organisation, acquire a patient record, the obligations under the Data Protection Act and GDPR transfer to you as the new owner.
* Keeping the data no longer than necessary.

Suggested lengths of time for retaining records: [ the following table has two columns and three rows]

|  |  |
| --- | --- |
| **Type of record** | **Recommended period of retention** |
| Adult patients | 10 years after they were last seen, even if the patient has subsequently died. |
| Children and young people | 10 years after they were last seen or until the patient’s 25th birthday, if later.  If the child or young person has died, keep the records for 10 years after they were last seen. |

All organisations that have access to NHS patient data and systems must use the NHS Data and Security Toolkit to provide assurance that they are practicing good data security and that personal information is handled correctly (NHS Digital Data webpage, 2023).

The seven principles of data protection are (NHS Digital Data webpage, 2023):

1. Lawfulness, fairness and transparency – why are you sharing the data or what is the lawful reason for sharing?
2. Purpose limitation - the data is only shared for the stated purpose.
3. Data minimisation - share only the information that is needed for the purpose.
4. Accuracy - ensure that all data is accurate.
5. Storage limitation - store data only for the time that it is needed and no longer, and only for the time that the person has consented to.
6. Integrity and confidentiality - ensure that you are proactive about protecting the data you store and share.
7. Accountability – you should be able to prove you are doing all of the above, there should be an audit trail.

If you follow these guidelines, no patient should suffer harm either directly or indirectly as a result of the data you share or store. They will not be surprised by organisations contacting them that they were unaware held their data.

Each of the relevant professional organisations has guidelines on record keeping and the safe storage of data, links can be found at the end of this subsection in **Useful links 9.1 .**

Some services use paper records and some use computer databases. Regardless of the format you should be confident that the data you store is secure. On a computer this should be password protected and compliant with computer data protection guidelines. It is important to remember to lock the computer screen when stepping away even for a few moments to prevent unauthorised access. Paper records should be in a lockable cabinet and must never be left out on work services or in line of view of anyone who does not have a legal reason to access them.

It is a good idea for all staff to have cyber security and information governance training, in order to help protect other people’s data.

Your standard operating procedure (SOP) should include a data protection policy and the whole team should be aware of the contents of this policy. This should include how to prevent data breaches but also how to report a data breach should it occur. Learning from near-misses is also very important in the longer term.

All staff should be trained in how to respond to a subject access request (SAR) as well as company policy around the process. All team members should know who takes responsibility for preparing the information that is stored such as redacting information that the subject is not entitled to see and ensuring that it is given in an accessible format.

The service should consider how they store information in such a way that the information about an individual is located in one place on the system. In addition, there should be a policy in place ensuring all staff know how to act on a requested update of stored data.

It is good practice to note and keep up-to-date information on the record regarding who is authorised to act on behalf of the patient and request information or amendments to the patient’s records. For example, if the patient lacks capacity or there is an appointed power of attorney. There is more detail regarding this in section **5.9 Patient advocates**

## Useful links 9.1

Regulations

[Data Protection: The Data Protection Act](https://www.gov.uk/data-protection)

[Data Security and Protection Toolkit](https://www.dsptoolkit.nhs.uk/)

[NHS Digital A Guide to Confidentiality in Health and Social Care](https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/codes-of-practice-for-handling-information-in-health-and-care/a-guide-to-confidentiality-in-health-and-social-care)

Northern Ireland

[Northern Ireland Department of Health Good Management Good Records](https://www.health-ni.gov.uk/articles/introduction-good-management-good-records)

Scotland

[Scottish Government Records Management: NHS Code of Practice](https://www.gov.scot/publications/scottish-government-records-management-nhs-code-practice-scotland-version-2-1-january-2012/)

England

[NHS England Information governance resources](https://www.england.nhs.uk/ig/ig-resources/)

Wales

[NHS Wales Governance Policy](https://dhcw.nhs.wales/ig/ig-documents/ig-framework/all-wales-information-governance-policy-v1-pdf/)

Professional body guidelines

[College of Optometrists: Confidentiality](https://www.college-optometrists.org/clinical-guidance/guidance/communication,-partnership-and-teamwork/confidentiality)

[College of Optometrists: Patient Records](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge,-skills-and-performance/patient-records/useful-information-and-links)

[HCPC | Our expectations for your record keeping](https://www.hcpc-uk.org/standards/meeting-our-standards/record-keeping/our-expectations-for-your-record-keeping/)

[Rehabilitation Workers Professional Network RWPN - The Profession](https://www.rwpn.org.uk/The-Profession)

[ABDO | Changes to Data Protection Law Information and Guidance](https://www.abdo.org.uk/regulation-and-policy/advice-and-guidelines/regulatory/data-protection/oc-changes-to-data-protection-law-information-and-guidance/)

[FODO | Data protection and Freedom of Information Act](https://www.fodo.com/members/guidance/category-3/data-protection-and-freedom-of-information-act/)

[LOCSU External Data Protection and Privacy Policy](https://locsu.co.uk/privacy-policy/)

## 9.2 Record keeping

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| **Core:**  Low vision assessment records should be kept of each clinical episode including all data relevant to the patient’s ongoing care. Records should be accessible immediately for all clinical staff when required. |

### Point to consider:

**Are your records accurate? Are they easy to follow for subsequent practitioners?**

Standards of practice for all relevant professions require good record keeping. It is a way of logging clinical data, target setting, prescribing decisions and information shared with the patient. This means that there is an accountability, a clear audit trail and reliable information for subsequent practitioners for the patient’s ongoing care. Good records can form the basis for research which can drive good practice and change (COO Patient records, 2022).

Records do not only cover paper or computer records. The Data Protection Act (DPA) 2018 states that records can take the shape of many forms of media including but not limited to digital, paper, images, audio, emails, scanned records, text messages and websites with relevant information. The DPA 2018 defines a health record as something consisting of data concerning health which has been made by or on behalf of a health professional in connection with the diagnosis, care or treatment of the individual to whom the data relates (NHS England Records Management Code, 2021).

Records should be clear, accessible and contemporaneous. In line with data protection regulations, only information that is relevant to the patient’s ongoing care should be stored.

For a low vision assessment, the minimum contents should be:

* Name and contact details of the patient
* Name of the practitioner
* Date of interaction
* All relevant test results
* Presenting symptoms and signs
* Advice given
* Equipment issued
* Recommendations
* Referrals
* Consent
* Recall/follow up recommendations

If the patient is attending for a GOS sight test there are additional details required including eligibility for NHS eye care.

Most services will have computerised records, but paper records are still being used in some services. Many NHS contracts require the provider to use computerised records in order to facilitate communication between services and compliance reporting. IT systems for storage, retrieval and transmission of service user information should be in use for administration, clinical records, outcome information and other data to support service improvement, audit and revalidation. Therefore, if starting a new service, a computerised database and clinical records would be considered best practice. Whatever format the records take it is essential that they are accessible to all colleagues immediately to ensure that provision of care is not hindered by access issues.

For many of the professional groups there are specific guidelines for what should be included in patient records. It is the responsibility of the professional to comply with standards of practice for their profession. Links to these can be found below.

## Useful links 9.2

Optometrists:

[College of Optometrists: Patient Records](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge,-skills-and-performance/patient-records)

Dispensing opticians

[ABDO Clinical requirements for record keeping](https://www.abdo.org.uk/regulation-and-policy/advice-and-guidelines/clinical/patient-records/)

Optometrists and dispensing opticians

[GOC Maintain adequate patient records](https://optical.org/optomanddostandards/8-maintain-adequate-patient-records/)

Vision Rehabilitation Specialists

[Rehabilitation Workers Professional Network RWPN - Professional Standards](https://www.rwpn.org.uk/Professional-Standards)

Orthoptists

[HCPC Orthoptic Record keeping](https://www.hcpc-uk.org/standards/meeting-our-standards/record-keeping/)

NHS England and Wales

[NHS England (and Wales) Records Management Code of Practice](https://transform.england.nhs.uk/information-governance/guidance/records-management-code/)

NHS Scotland

[Scotland Records Management Code of Practice](https://www.informationgovernance.scot.nhs.uk/wp-content/uploads/2020/06/SG-HSC-Scotland-Records-Management-Code-of-Practice-2020-v20200602.pdf)

NHS NI

[Northern Ireland Department of Health Good Management Good Records](https://www.health-ni.gov.uk/articles/introduction-good-management-good-records)

## 9.3 Consent

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| --- |
| **Core:**  Patients should be given information on data storage, usage and sharing of personal information. Informed consent at each patient interaction is essential. |

### Point to consider:

**Do you have a consistent approach for informing patients about how their data are stored, used and shared and do you have a way of recording this at each visit?**

Consent is central to clinical treatment but also to data storage, usage and sharing. This section is specifically about consent to store, use and share patient’s personal data. Professional guidance on this is available for all professionals who provide low vision services, information for which can be found below in **Useful links 9.3**. General guidance on consent to share information is discussed in more detail in section **4.4 Information sharing between services.**

Consent and capacity need to be considered simultaneously. Capacity is also discussed in detail in section **4.4 Information sharing between services**.

The service should have a privacy statement used in the consent process. This should be provided in the patient’s preferred format and efforts made to ensure that the patient fully understands what will happen with their personal information.

In essence, patients have the right to:

* Know what is being stored about them.
* Where it is being stored.
* What it will be used for.
* Who it will be shared with.
* How long it will be kept.

They also have a right to request copies of data stored and to have incorrect data amended.

They have a right to withdraw consent, remove their data from mailing lists, recall systems and other non-clinical aspects of their data use.

You should ensure that your patients have access to your privacy statement in an accessible format, so that they can make an informed decision regarding the storage of their data. See **Appendix H Example of a privacy statement.**

## Useful links 9.3

Consent and capacity

[NHS Consent to treatment - Assessing capacity](https://www.nhs.uk/conditions/consent-to-treatment/capacity/)

[NHS Mental Capacity Act](https://www.nhs.uk/conditions/social-care-and-support-guide/making-decisions-for-someone-else/mental-capacity-act/)

[College of Optometrists Consent](https://www.college-optometrists.org/clinical-guidance/guidance/communication,-partnership-and-teamwork/consent)

[GOC Obtain valid consent](https://optical.org/optomanddostandards/3-obtain-valid-consent/)

[ABDO Consent](https://www.abdo.org.uk/regulation-and-policy/advice-and-guidelines/updates/r1-2-2-consent/)

[Rehabilitation Workers Professional Network RWPN - Professional Standards](https://www.rwpn.org.uk/Professional-Standards)

[SCIE | Mental Capacity Act | Independent Mental Capacity Advocate (IMCA)](https://www.scie.org.uk/mca/imca)

[GOV.UK Independent mental capacity advocates](https://www.gov.uk/government/publications/independent-mental-capacity-advocates)

[Mental Capacity Act 2005 (legislation.gov.uk)](https://www.legislation.gov.uk/ukpga/2005/9/contents)

Data sharing

[NHS England Confidentiality Policy](https://www.england.nhs.uk/publication/confidentiality-policy/)

[NHS England Data Security and Protection Toolkit](https://www.dsptoolkit.nhs.uk/)

[NHS Digital Keeping data safe and benefitting the public](https://digital.nhs.uk/data-and-information/keeping-data-safe-and-benefitting-the-public)

## 9.4 Report writing

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| **Core:**  A summary report detailing the findings, recommendations and outcomes of the low vision assessment – in plain English – should be offered to patients and, if required, should be provided in the patient’s preferred format. Copies of the report should be sent to other professionals involved in the patient’s care with consent from the patient.  **Ideal:**  A report should be issued if patient is discharged. |

### Point to consider:

**What information do you give to your patients to help them follow advice and recommendations? What information do you share with other professionals involved in the care of that individual, bearing in mind every contact matters?**

During a low vision assessment there is a large amount of information given, and recommendations made. This may be about equipment issued or referrals to other services that might be of benefit to the patient. We need to consider that often patients attending the service are also impacted emotionally as well as functionally from their change in vision and this can result in them struggling to recall all the information they have been given. It is difficult to take in lots of new information and it is good practice to provide a report in the patient’s preferred format to enable them to have something as a reminder of the outcomes of the assessment (Oxtoby, 2019).

Sharing the outcomes and findings of a low vision assessment supports the Make Every Contact Matter agenda as it ensures that care for patients is holistic, patients are safeguarded and no opportunity is missed to support, treat or protect a patient. This programme advocates that all professionals using their day-to-day interactions with patients to spot opportunities to open conversations around health, well-being and life-style changes. For more information on Make Every Contact Matter see **Useful links** **9.4**.

In addition to the service user, correspondence from the low vision service should also be shared with other teams involved in their care and vice versa. Helping carers to understand the patient’s eye condition and its impact on vision and lifestyle can also be valuable (COO/RCOphth, 2013). To avoid confusion, it is important that any copies of reports sent to other professionals, that do not require direct action from the recipient, should be marked as For Information Only. Actionable items should be noted at the start of the report.

Other professionals to consider that may benefit from having access to the low vision outcomes include (but not limited to):

* Falls teams
* Vision rehabilitation professionals
* Primary care optometrists
* Ophthalmologists
* GPs
* Carers
* Voluntary sector organisations and service providers
* DSA advisors for adults in further education
* Workplace adjustments advisors

Reports should include (but are not limited to):

* Description of current functional vision
* Agreed goals and recommendations
* Equipment loaned – what for, how to use and how to maintain
* Agreed referrals
* Information about other services for signposting
* Possible problems and what to do if these occur
* Contact details of the service and how to re-access the service

The patient’s preferred format should be followed for all correspondence (RNIB Accessible Information Standard, 2016). Please see the information on this in Sections **1.1 Service location** and **3.7** **Communication**.

A template for a low vision assessment report is included in **Appendix I** **Template low vision report.**

In addition, practitioners may need to write specific referral letters to other agencies where issues have been identified that are either beyond the remit of the low vision service or cannot be addressed with optical aids and visual strategies. This should be in addition to any standard report that is produced to ensure that action points are not missed.

## Useful links 9.4

(See also **Useful links 1.1**)

[RNIB | Creating accessible information and communication resources for health and social care](https://www.rnib.org.uk/living-with-sight-loss/independent-living/accessible-nhs-and-social-care-information/creating-accessible-information-and-communication-resources-for-health-and-social-care/)

[RNIB | My info my way](https://www.rnib.org.uk/get-involved/support-a-campaign/my-info-my-way/)

[Making Every Contact Count (MECC) | Health Education England](https://www.hee.nhs.uk/our-work/population-health/our-resources-hub/making-every-contact-count-mecc)

[College of Optometrists - How to write a good referral letter](https://www.college-optometrists.org/professional-development/college-journals/acuity/all-issues/winter-2019/2019-02-howtowriteagoodreferralletter_c-70310)

## 9.5 Standard operating procedure (SOP)

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| **Core:**  Standard operating procedure should be in place in order to ensure effective and efficient running of the service. |

### Point to consider:

**Do you have a set of policies in place to ensure smooth and efficient running of the service from a business and clinical perspective? Do the whole team know these policies? How frequently are they reviewed?**

A standard operating procedure (SOP) is a type of practice manual that contains a specific set of practices that are required to be initiated and followed when specific circumstances arise (Sathyanarayana Rao, 2011). They may sit as an addition to the organisation-wide SOP if the service is part of a large hospital, or organisation, offering multiple services. It is essential for continuity of care and to ensure the smooth and efficient running of any service.

A SOP is designed to improve safety and quality of a service without increasing costs. It should be kept up to date and be accessible to all staff. The name of the person responsible for the SOP, review date and next review date should be clearly marked.

It should include (but not limited to):

* Accessibility procedures
* Adverse incident log
* Appointment booking procedures
* Audit, feedback and evaluation procedures
* Business continuity plans
* Business plan
* Chaperone policy
* Clinical protocols
* Complaints procedure
* Consent policy
* Data Protection and management procedures
* Diversity and Inclusion procedures
* Equipment instructions
* Frequent DNA/WNB procedures
* Gifts register
* Health and safety policy
* Infection control procedures
* Invoicing procedures
* Job descriptions
* Kit and stock list
* Late arrivals procedures
* Mission statement
* Organisation structure document
* Public and patient involvement policy
* Procurement procedures
* Professional standards and code of conduct
* Recall procedure
* Recruitment procedure
* Registration and certification procedures
* Referral procedures
* Risk assessments including a personal emergency evacuation plan (PEEP)
* Safeguarding procedures
* Strategic plan
* Sustainability and recycling policy
* Training procedures
* Transfer and discharge procedures
* Workstation assessment procedure

For some services there may be a requirement to include procedures for GOS tests or regarding charging for certain parts of the service. It may also need to include other procedures specific to that setting such as hospital transport procedures or domiciliary policies.

The SOP should be the source of information to ensure that everyone knows what is expected of them and how to approach all aspects of the service for patients.

Quality in optometry provide a guide on how to make a practice manual. This is aimed at primary eye care but much of this is applicable to low vision settings. The link for this is below but please note this is only accessible by an account for primary care services.

When setting up an SOP consider what policies are required to define what you do; how you quality assure your service; how you safeguard your staff and patients and how you ensure good financial management.

## Useful links 9.5

[Quality in Optometry Policy Builder](https://www.qualityinoptometry.co.uk/login/?r=policy)

[Health Education England | Guidance on Standard Operating Procedures](https://www.hee.nhs.uk/our-work/doctors-training/standard-operating-procedures)

# Section 10 – Ongoing service review

This section covers the importance of regularly reviewing the service and the factors which should be audited, evaluated or monitored as part of the clinical governance of the service.

“Clinical governance is defined as: “A framework through which NHS organisations are accountable for continuously improving the quality of their services and safe-guarding high standards of care by creating an environment in which excellence in clinical care will flourish.”

“It's often thought of in terms of the seven pillars of clinical governance—clinical effectiveness, risk management, patient experience and involvement, communication, resource effectiveness, strategic effectiveness, and learning effectiveness.” (Gray, 2005)

Audit and feedback are at the heart of quality assurance. Without robust procedures for review, quality can slip, and best practice may be lost. Review processes enable a service to identify areas of weakness and put together improvement and development plans to keep the service in line with current knowledge and best practice. This should include both clinical and management aspects of the service. Without good business management, services can fail due to financial waste or poor leadership.

In order to effectively audit a service, a question must first be proposed and standards to measure it against selected. The service must then be reviewed against the question using an evidence-based method. The results should be used to create an action plan, and in cases where changes are required, there should be a subsequent review at a suitable time interval to assess whether the changes have been successful. This is true of any area of the service.

## Overview

10.1 Frequency of service evaluation

10.2 Demographics review

10.3 Quality assurance review

10.4 Patient feedback

10.5 Financial review

10.6 Data on missed appointments

10.7 Planning and evaluating the service

10.8 Implementing service evaluation findings

## 10.1 Frequency of service evaluation

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| **Core:**  The service evaluation process should be minimum every 12 months, although more frequently is desirable. However, where serious concerns are raised from a review, change should be implemented as soon as possible and reviewed more frequently until any issues are resolved.  **Ideal:** The service evaluation should be produced as a written report in order to monitor and track service improvements. |

### Point to consider:

**Do you audit your service at least once a year? How do you implement the findings, and do you adapt the frequency of review to the concerns raised?**

Audit is a key component of clinical governance and seeks to improve the quality and outcome of patient care by clinicians examining their practices against agreed standards and then modifying those practices, where indicated (Quality in Optometry, 2007-2023). It is a way to find out where healthcare services are doing well and where there could be improvements. This allows targeting of quality improvement where it will be most helpful and will improve outcomes for patients (NHS England Clinical Audit, 2023). It can also enable the service provider to check, and evidence contract compliance by monitoring the service against Key Performance Indicators (KPIs). It is a form of review and can be a useful source of information when viewed quarterly over the course of a year or more.

Audit is only of benefit if it is used as a cycle of audit, change management and re-audit. Issues identified are addressed and change implemented, then the success of any change or improvement is evaluated. Audits can be focused on specific aspects of a service or cover the whole service. (COO/RCOphth, 2013)

Stages to an audit should be (Goverment Clinical Audit webpage, 2020):

* Preparation
* Selecting criteria
* Measuring performance
* Making improvements
* Sustaining improvements

The environment must also be conducive to audit so that your team are receptive to any recommended changes. To do this, you need:

* Facilities such as technical support and time
* A culture that values creativity and openness
* A willingness to report and investigate errors and failures without fear

Services should be audited at least once a year and work with other stakeholders to ensure that there is continuous improvement planning. Review should include factors such as waiting times, referrals into and out of the service, and equipment loaned (CCEHC Low Vision, 2017). Services should compile an annual quality report as a collaboration between key stakeholders (provider, commissioner, other linked services and patients) (COO/RCOphth, 2013). Note: the report ‘Commissioning better eye care: Adults with low vision’, does not use the phrase audit but the key components include quality, accessibility, efficiency and effectiveness; it is, therefore, very much aligned with audit.

Services should therefore consider what are the essential points to review, how these can be compared to current best practice and how changes can be implemented and monitored.

This includes who is responsible for this and how frequently it should be done. For some contracted services this is dictated by the contract, but this does not prohibit the service from instigating reviews where there have been concerns raised or near misses. For example, a review of the service outward referral system might be indicated if there is a patient complaint regarding a communication failure.

It is important to have a procedure for annual service evaluation, but it is equally important to identify risk factors that would trigger a review more frequently. If there are serious concerns raised as a result of a service audit or review, there should be a process to ensure that an implementation plan is prioritised, and the success of the changes are reviewed at an earlier date than perhaps would be usual.

The service could produce its own template for service review or audit or use a template such as that from the Quality in Optometry website (Quality in Optometry, 2023) or the Quality Standard Service Improvement template from NICE (NICE, 2023). See **Useful links 10.1** below.

Audit and review skills are an essential part of clinical governance and therefore it is a good idea to ensure that the person responsible for clinical governance in your organisation has the appropriate training. This is usually available through professional bodies or through the NHS, some courses that have been identified are in the links below.

## Useful links 10.1

Audit in optometry

[Quality in Optometry - Audit](https://www.qualityinoptometry.co.uk/england/?page=13)

[Clinical Council for Eye Health Commissioning (CCEHC) Guidance](https://www.college-optometrists.org/clinical-council-for-eye-health-commissioning#tab-informationandguidance-ce7cc8fd)

Audit in NHS services

[NHS England Clinical audit](https://www.england.nhs.uk/clinaudit/)

[Clinical audit: descriptive studies (government guidance)](https://www.gov.uk/guidance/clinical-audit-descriptive-studies)

[Audit: how to do it in practice | The BMJ](https://www.bmj.com/content/336/7655/1241.full)

[NICE Audit and service improvement](https://www.nice.org.uk/About/What-we-do/Into-practice/Audit-and-service-improvement)

Leadership training courses

Orthoptists - [BIOS Advanced Orthoptic Clinical Practice – Competency Framework](https://www.orthoptics.org.uk/wp-content/uploads/2022/10/BIOS-AOCPF-2022.pdf) contains modules in evaluation and clinical leadership

Optometrists and dispensing opticians [LOCSU Training and Development – Leadership Skills](https://locsu.co.uk/what-we-do/training/leadership-skills/)

Dispensing opticians [ABDO Management and Leadership Training](https://www.abdo.org.uk/dashboard/business-hub/mlt/)

Ophthalmology and AHPs [University of Sheffield Clinical Leadership and Education in Ophthalmology](https://www.sheffield.ac.uk/ahpnm/cpd/opportunities/clinical-leadership)

Clinical governance [NHS England Governance, patient safety and quality](https://www.england.nhs.uk/mat-transformation/matrons-handbook/governance-patient-safety-and-quality/)

NHS learning offer courses in quality improvement for health and social care [NHS England QIL](https://www.qilearning.england.nhs.uk/terms)

## 10.2 Demographics review

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| **Core:**  Services should carry out regular review and feedback of the records to analyse the demographics and ensure equity of access by identifying high risk or under-represented groups and in order to develop a service improvement plan. |

### Point to consider:

**Is your service reaching everyone in the community that requires it? Are there barriers to accessing the service for some people?**

In order to evaluate whether your service is accessible to all in the community it is important to identify the demographics of the community. For instance, who are the high-risk groups, are there groups that may be considered harder to reach and are those accessing the service who would you expect (such as an older population or specific ethnic groups locally). This information is available through your local council and by checking the Sight Loss Data Toolkit for your area, the link can be found below (RNIB, 2023).

This local knowledge and an audit of your service can help identify any gaps in the demographics. Results can be analysed to understand why any gaps exist and consider what the barriers are for those communities accessing the service.

In order to establish this, you need to include audits of (but not limited to):

* Age
* Gender
* Ethnicity
* Socioeconomic status
* Disabilities

Then consider the following questions:

* Is this the profile that we would expect for this area?
* What outreach do we offer for any underserved groups identified?
* What barriers exist and what can we do to break down those barriers?

It is a good idea to reach out to organisations that can help you to find effective outreach strategies for specific groups. See **Useful links 10.2** below and also section **5.9 Patient advocates**

A template for service improvement can be found in **Appendix J Template for service improvement plan**

## Useful links 10.2

Sight loss data profiles

[RNIB | Sight Loss Data Tool - statistics on sight loss](https://www.rnib.org.uk/professionals/health-social-care-education-professionals/knowledge-and-research-hub/sight-loss-data-tool/)

Population data for England

[Office for National Statistics - Population profiles for local authorities in England](https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/articles/populationprofilesforlocalauthoritiesinengland/2020-12-14)

Population data for Scotland

[Scotland's Census 2022 - Rounded population estimates](https://www.scotlandscensus.gov.uk/2022-results/scotland-s-census-2022-rounded-population-estimates/)

Population data for Wales

[Wales Population and household estimates](https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/populationandhouseholdestimateswales/census2021)

Population data for Northern Ireland

[Northern Ireland Statistics and Research Agency | Population](https://www.nisra.gov.uk/statistics/population)

Organisations that support underserved communities

[BAME Vision | Black, Asian, and Minority Ethnic Community](https://bamevision.org/about-us)

[SeeAbility](https://www.seeability.org/)

[Vision Care Charity for Homeless People | United Kingdom](https://www.visioncarecharity.org/)

## 10.3 Quality assurance review

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| **Core:**  Services should evaluate patient records for quality assurance purposes, identifying Key Performance Indicators for the service and in order to develop a service improvement plan. |

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### Point to consider:

**How do you know that your service is performing to the highest clinical standards? Whose responsibility is it to monitor performance? Is the whole team involved in service evaluation?**

Quality assurance should be provided by comparing your practice with appropriate and current examples of good practice. If no formal evaluation is made, then quality is assumed rather than evidenced. Audit is usually generalised to the whole service but can be focussed on one area of concern as identified in a general audit, or as a result of patient feedback. It is recommended that you focus on areas of “high risk, high volume, or high-cost problems, or on national clinical audits, national service frameworks, or guidelines from the National Institute for Health and Clinical Excellence” and that you should derive standards from good quality guidelines (Benjamin, 2008).

Useful aspects to audit could include:

* Effective outcomes (CCEHC Low Vision, 2017)
* More appropriate and effective patient management (for example, an ECLO can liaise with patients and colleagues in the community, HES and social services to assist in the development of patient focussed more joined-up pathways) (CCEHC Low Vision, 2017)
* Patient safety (CCEHC Low Vision, 2017)
* Clinical audit (CCEHC Low Vision, 2017)
* Competence of the workforce (CCEHC Low Vision, 2017)
* Positive patient experiences (CCEHC Low Vision, 2017)
* Appropriate infrastructure and administration (equipment, premises, ordering, etc.) (CCEHC Low Vision, 2017)
* Effectiveness of the intervention (COO/RCOphth, 2013)
* The speed the service is accessed (COO/RCOphth, 2013)
* Identification of patients that are eligible for other support (COO/RCOphth, 2013)
* Service response to meeting patient needs (COO/RCOphth, 2013)

Patient outcome markers can also be created from the standards specified throughout the UKOA patient Quality Standards for Ophthalmology (link below) or the Seeing It My Way research findings (CCEHC Low Vision, 2017) listed in **2.3 Sight loss awareness.**

Quality in Optometry is an important audit toolkit; it’s used for NHS GOS compliance, clinical record keeping, information governance and infection control.

This is relevant to services providing GOS as part of the service but can also form a useful general quality basis for any eye care service. Information can be found in the **Useful links 10.3** section below.

Patient questionnaires can also be a useful way to evaluate the service (Court, 2009), links for which can be found below. See also section **10.4 Patient feedback**

Combining the advice in these documents audit should include:

* Record keeping
* The ‘Seeing it my way’ aspects covered in the assessment
* Professional competency
* Support staff competency
* Use of resources and connection between allied support
* Responsiveness
* Infection control
* Contract compliance

The RNIB Adult Low Vision Quality Framework is an audit tool and we recommend you use an action plan for each section as per the template in **Appendix J Template for service improvement plan.** This can form the basis of any additional audit questions where areas of development are identified.

## Useful links 10.3

See also **Useful links 10.1**

Audit tools

[Quality in Optometry - Audit](https://www.qualityinoptometry.co.uk/england/?page=13)

[Audit: how to do it in practice | The BMJ](https://www.bmj.com/content/336/7655/1241.full)

[NICE Audit and service improvement](https://www.nice.org.uk/About/What-we-do/Into-practice/Audit-and-service-improvement)

Standards for review in low vision outcomes

[Clinical Council for Eye Health Commissioning (CCEHC) Guidance](https://www.college-optometrists.org/clinical-council-for-eye-health-commissioning#tab-informationandguidance-ce7cc8fd)

[UKOA/RNIB Patient Standards for Ophthalmology Services](https://uk-oa.co.uk/wp-content/uploads/2018/09/UKOA_Publications_Patient_Quality_Standard_200918.pdf)

VFQ25

[National Eye Institute | Visual Function Questionnaire 25](https://www.nei.nih.gov/learn-about-eye-health/outreach-campaigns-and-resources/outreach-materials/visual-function-questionnaire-25)

The Manchester low vision questionnaire

[Evaluating the outcomes of low vision rehabilitation - ScienceDirect](https://www.sciencedirect.com/science/article/abs/pii/S0275540898000465)

Vision related quality of life questionnaire VQOL [Development of a questionnaire for measurement of vision-related quality of life - PubMed](https://pubmed.ncbi.nlm.nih.gov/9894804/)

The low vision quality of life questionnaire LVQOL [Design of the low vision quality-of-life questionnaire (LVQOL) and measuring the outcome of low-vision rehabilitation - PubMed](https://pubmed.ncbi.nlm.nih.gov/11124300/)

[Evaluating the Effectiveness of Low Vision Services in Wales | IOVS | ARVO Journals](https://iovs.arvojournals.org/article.aspx?articleid=2366906)

## 10.4 Patient feedback

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| **Core:**  Services should evaluate patient feedback (Patient Reported Experience Measures (PREMs)) for quality assurance purposes and should form the heart of the service improvement plan. |

### Point to consider:

**Is your service providing patient-centred care and is it designed with the input of people with sight loss? How do you know what your patients views and wishes are?**

Patients should be at the heart of every aspect of the service. Is the service appropriate for the needs of the patient and are they involved in designing, running and evaluating the services? Patients are best placed to tell you when there are barriers to care, access issues, concerns about communication and the perceived level of care.

Patient involvement is essential from the start of service development and within the annual review process. Each service should have its patient feedback process documented in the SOP to ensure feedback is recorded and combined with other quality assurance measures. There should also be a complaints and compliments policy and register from which information can be drawn when reviewing patient feedback.

Patient feedback can be obtained in various ways; one approach is using the formal Patient Reported Experience Measures (PREM) to compliments and complaints-recording. PREMs are a way of using standardised measures to assess patients’ perspectives regarding the process of care they receive from your service.

These cover aspects including:

* The information they received
* Levels of trust in staff
* Waiting times
* Provider hygiene

(Office of Health Improvement and Disparities, 2020)

PREMs gather patient views using questionnaires that can either be developed by the service specifically, or by using those that have been validated by other services (Kingsley, 2017)**.**

To develop suitable PREMs, you should include the following stages:

* Literature review of available tools.
* Development of questionnaire specific to your service – perhaps through focus groups or patient interviews.
* Piloting of the questionnaire.
* Review and amendments before a wider roll out.

Guidance on how to develop a patient feedback form can be found in **Useful links 10.4.** This is aimed at medical care, but the principles are transferable to low vision (GMC, 2020).

As the services are for people with sight loss, specific care needs to be taken to ensure that there are no barriers to patients being able to share their views. This includes the format of the questionnaire ensuring that, regardless of communication preferences, all patients can contribute if they would like to. Suitable approaches may be to offer a range of font sizes, easy to read resources, audio version or use of Microsoft Forms via email.

If feedback is received face-to-face with a patient, care must be taken to ensure that the patient feels comfortable giving negative feedback as well as positive feedback. It is always important to let the patient know what the information they provide will be used for and why their views are important for the development of the service. It is good practice to give an update to patients about changes that have been made based on their advice and feedback. This may be in the form of an accessible newsletter perhaps.

Other opportunities to obtain feedback from patients include investigation of (Did not Attend) DNA or (Was Not Brought) WNB incidents. Asking patients why they could not attend, or asking carers why they were unable to bring the patient, may provide insight into any access barriers and experiences of patients. See also **10.6 Data on missed appointments.**

All feedback from patients should include the Friends and Family Test (NHS, 2023). This is a way for the patient to provide a simple rating as to whether they would recommend the service to others. It provides a quick and reliable gauge of whether the service is valued by your patients.

It is important to give the opportunity to all patients and carers to give feedback while respecting that some may find this distressing and not wish to respond.

## Useful links 10.4

[GOV.UK Patient-reported outcomes and experiences study](https://www.gov.uk/guidance/patient-reported-outcomes-and-experiences-study)

[BJA Education | Oxford Academic | Patient-reported outcome measures and patient-reported experience measures](https://academic.oup.com/bjaed/article/17/4/137/2999278)

Example of medical feedback forms

[GMC Guidance on developing and implementing formal patient feedback tools](https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/revalidation-resources/guidance-on-developing-and-implementing-formal-patient-feedback-tools)

Friends and Family Test

[NHS Friends and Family Test (FFT)](https://www.nhs.uk/using-the-nhs/about-the-nhs/friends-and-family-test-fft/)

## 10.5 Financial Review

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| **Core:**  Services should carry out review and feedback of the services finances. |

### Point to consider:

**How do you know whether you are using resources responsibly? What are the sustainability policies that apply to your service?**

In the current financial climate, it is essential that NHS services consider the way they allocate resources and ensure the responsible distribution of equipment. This will help minimise waste.

In the current financial climate, it is essential that NHS services consider the way they allocate resources and ensure the responsible distribution of equipment. This will help minimise waste, maximise available NHS resources and help for future planning and viability of the service in the long term. At present, commissioners may find comparing different low vision services in terms of cost, activity, quality and outcomes a challenge, due to the huge variation of low vision services. Compiling an annual quality report for low vision is the first step to understanding these issues and is one way to ensure that there is an effective, efficient, safe, population-based framework for low vision services. Commissioners can then use the report to inform commissioning decisions (COO/RCOphth, 2013). Responsible financial management is key to the commissioning of good services.

A financial review should be conducted to identify the appropriate management of resources, as well as compliance to recycling policies in order to minimise waste. The service should include in their SOP details of financial management procedures and use of resources. If the service has been commissioned as a local contract, some of these procedures will already be in place as service KPIs, as these usually include financial targets.

Questions to ask in a review would be:

* Do we consistently stay within the allocated budget?
* How do we ensure value for money in goods purchased, staffing costs, and equipment used?
* Do we comply with recycling and sustainability policies?
* Is the current budget fit for purpose or does it compromise clinical care?
* Is there waste?

## Useful links 10.5

England: [NHS England | What is commissioning?](https://www.england.nhs.uk/commissioning/what-is-commissioning/)

Scotland: [National Services Scotland | Commissioning National Developments](https://www.nss.nhs.scot/specialist-healthcare/commissioning-services/commissioning-national-developments/)

Wales: [NHS Wales Health Specialised Services Committee | Commissioned Services](https://whssc.nhs.wales/commissioning/commissioned-services/)

Northern Ireland: [Belfast Health & Social Care Trust | Health service structure](https://belfasttrust.hscni.net/about/corporate-info/health-service-structure/)

General healthcare financial guidance:

Financial management in health care in (Sharma, 2022)

## 10.6 Data on missed appointments

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| **Core:**  Services should carry out review of missed or cancelled appointments, either in the centre or home visits, which occur at short notice. The goal should be to identify the cause and any trends in order to improve use of capacity and reduce any waste of NHS resources. There should be a policy in place regarding patients who frequently fail to attend and at risk persons who have not been brought to appointments. |

### Point to consider:

**Do you keep a record of appointments that were wasted due to ‘Did not attend’ (DNA) or ‘Were not brought’ (WNB)? Can you track the most common reasons for this and have included this in the audit and feedback of the service?**

There are many reasons why someone may not attend for their appointment or cancel at the last minute. In some cases, this is because they rely on others to bring them to appointments and in other cases, it may be due to other causes such as cognitive challenges e.g., memory loss.

There may also be cases where patients simply choose not to attend or cancel at the last minute without regard to the cost and waste.

NHS England have developed guidance for reducing DNAs and WNBs which can be found in the **Useful links 10.6** (NHS England, 2023)**.**

In this guidance they comment that this is a complex area which is multi-factorial. Some of the reasons for DNAs and WNBs they give are here:

**Reasons for DNAs within patients’ control include:**

* Patient has forgotten about the appointment.
* Patient has not attended because they felt they no longer needed the appointment.

**Reasons for DNAs outside of patients’ control include:**

* Patient unaware of appointment.
* Unclear, inaccessible or incorrect appointment information given to patient.
* Patient unable to attend but has difficulties cancelling or rearranging their appointment.
* Appointment booked a year or more ago and patient was not given a more recent reminder.
* Difficulty taking time off work (particularly when face-to-face appointments are offered as the only option).
* Transport issues.
* Difficulty arranging carers at the time of the appointment (either for the patient or for people they care for).
* Cost issues.
* Limited clinic hours making it challenging to find a suitable time to attend.
* Patient has not been brought to the appointment by a carer or guardian responsible for their care (‘was not brought’).

Whatever the reason, this represents wasted NHS money in addition to being disadvantageous for persons at risk who may have barriers to attending and potentially become lost to follow up. It can have a knock-on impact on other patients who have to wait longer to access the service.

Although non-attendance policies should be sufficiently flexible to account for specific patient needs, and include communication with patient and GPs on decisions (UKOA/RNIB, 2018), it is important to monitor this data in terms of accessibility and also service planning as well as crucially reducing the number of patients that are lost to follow up (CCEHC Low Vision, 2017).

The service should have a policy in the SOP for DNA and WNB which includes:

* Process around investigation of DNA or WNB for individuals who have missed more than one appointment.
* Policy of how to proceed when barriers to attendance are identified for individuals (considering transport, support to attend and special needs).
* How many DNAs will be accepted before the patients is no longer offered another appointment based on analysis of risk and taking into account personal circumstances of the individual.
* Monitoring of DNA and WNB trends.
* Identifying the common reasons for non-attendance.
* Safeguarding consideration where there is suspicion of poor practice, such as where external care providers may be putting patients at risk due to high levels of WNB appointment misses.

The information gained in evaluating and monitoring DNAs and WNBs will enable the service to reduce the risks of wasted appointments due to organisational barriers including (but not limited to):

* Not using the patient’s preferred format for letters and communication.
* Inaccessible websites, or where there is no alternative to website communication ensuring patients who are not IT-literate to be disadvantaged.
* Transport issues.
* Flexibility of appointments.
* Administration issues.

## Useful links 10.6

NHS guidance

[NHS England Reducing did not attends (DNAs) in outpatient services](https://www.england.nhs.uk/long-read/reducing-did-not-attends-dnas-in-outpatient-services/)

DNAs and low vision commissioning

[Clinical Council for Eye Health Commissioning (CCEHC) Guidance](https://www.college-optometrists.org/clinical-council-for-eye-health-commissioning#tab-informationandguidance-ce7cc8fd)

[UKOA/RNIB Patient Standards for Ophthalmology Services](https://uk-oa.co.uk/wp-content/uploads/2018/09/UKOA_Publications_Patient_Quality_Standard_200918.pdf)

WNB is an initiative that has been applied to children but it is just as relevant in adult services where patients are dependent on gatekeepers to access care. This article explains the background in children’s dentistry [British Dental Journal | Development and evaluation of a 'was not brought' pathway: a team approach to managing children's missed dental appointments](https://www.nature.com/articles/s41415-019-0621-z)

## 10.7 Planning and evaluating the service

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| **Core:**  The service should be patient-centred and, therefore, all services should have patient involvement and feedback in the planning, monitoring and development. This should be detailed in the Standard Operating Procedure (SOP). |

### Point to consider:

**Are patients truly at the centre of your service provision? How do you involve patients in the governance of the service? How do you plan and evaluate your service structure?**

Low vision services must be patient-centred (CCEHC Low Vision, 2017) (COO/RCOphth, 2013) (UKOA/RNIB, 2018) therefore patient input should be sought in the development of a new service and as feedback in an existing service. The views of patients should be central to the service. This is crucial to knowing whether the service is fit for purpose, provides for the needs of the patient and is accessible for all.

Services should have a planning policy in the SOP that covers how the service is developed from the start, if appropriate, and then ongoing. Services need to change with the requirements of the patients as well as taking into consideration current knowledge and good practice. The planning of a service should include what the purpose of the service is, how it delivers on that purpose and how it evaluates against the current knowledge, local requirements and patient perspectives. This includes keeping up to date with research and development in the area of low vision nationally and internationally. It is a partnership between practitioner, healthcare managers and patients with lived experience. An important question to ask is whether the service continues to be fit for purpose and equally important is how you justify the answer to that question.

This section relates to the involvement of patients in the governance of the service rather than the use of patient feedback which is detailed in section **10.4 Patient feedback**. This section is about how the service uses the views of people with lived experience to commission, develop and run services. Do you have patients involved at the design stage and patient representatives at management meetings? In addition, are they involved in developing, reviewing and holding the service accountable to KPIs.

NHS England states 10 principles with regards to public and patient involvement (NHS England, 2017)

**Principles of public and patient participation**

1. Reach out to people rather than expecting them to come to you.
2. Promote equality and diversity and encourage and respect different beliefs and opinions.
3. Proactively seek participation from people who experience health inequalities.
4. Value people’s lived experience and the strengths and talents that people bring to the table.
5. Provide clear and easy to understand information.
6. Take time to plan and budget for public and patient participation.
7. Be open, honest and transparent in the way you work.
8. Invest in partnerships, have an ongoing dialogue and avoid tokenism.
9. Review experience (both positive and negative) and learn from it.
10. Recognise, record and celebrate people’s contributions.

**“**Health and care professionals need to value disabled people’s expertise through properly recognising the value of lived experience and ensure disabled people’s voices are central to any plans right from the start.” (Fenney, 2022)

For patients to be able to meaningfully contribute they should be aware of what the role involves, be given clear information in their preferred format and be reimbursed for their time appropriately. They should be considered partners in the process and seen as subject matter experts.

This type of working in partnership is known as co-production.

“Co-production is a way of working that places the input from people using services on an equal footing with those who work in the system.” (Wellings, 2022). There is a wealth of resources to be found on the Kings Fund website the link is in **Useful links 10.7** below.

In terms of professionals involved in management and development of services it is important that they keep up to date with current best practice by having appropriate training, CPD and through membership of low vision peer support groups and organisations. See also section **2.2 Ongoing training**

Your SOP should include details of the people responsible for each aspect of service management, planning and development along with the requirements of their role. There should be regular meetings of the management team to ensure that the service continues to be fit for purpose and there is regular review of the improvement plan that has been developed through service evaluation.

Amongst other outputs, planning could include the following: (Faculty of Public Health, 2017)

* Business plan (financial and legal aspects)
* Strategic plan (where the service sits in the overall direction of the organisation)
* Service plan (day-to-day work of the service)
* Sometimes a project plan (for perhaps specific service improvement)

## Useful links 10.7

NHS England patient public participation

[NHS England Patient and Public Participation Policy](https://www.england.nhs.uk/publication/patient-and-public-participation-policy/)

King’s Fund Links:

[The King's Fund | How does the health and care system hear from people and communities?](https://www.kingsfund.org.uk/publications/health-care-system-people-and-communities)

Healthcare planning

[Health Knowledge | Health service development and planning](https://www.healthknowledge.org.uk/public-health-textbook/organisation-management/5d-theory-process-strategy-development/health-service-development-planning)

Involvement in low vision

[Clinical Council for Eye Health Commissioning (CCEHC) Guidance](https://www.college-optometrists.org/clinical-council-for-eye-health-commissioning#tab-informationandguidance-ce7cc8fd)

[UKOA/RNIB Patient Standards for Ophthalmology Services](https://uk-oa.co.uk/wp-content/uploads/2018/09/UKOA_Publications_Patient_Quality_Standard_200918.pdf)

## 10.8 Implementing service evaluation findings

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| **Core:**  Service evaluation is part of a cycle of continuous improvement. Where areas for improvement have been identified in the service, these should be discussed by the management team and patient representatives, addressed by an action plan, implemented and re-evaluated to ensure the effectiveness of any change. |

### Point to consider:

**When you have gathered data from audit, what do you do with that data? How do you implement identified changes?**

Audit or review data is only beneficial if it is acted upon and the process should be transparent but not confrontational, it should be used as an opportunity to improve not name and shame (Benjamin, 2008).

The various areas of service evaluation have been covered extensively in previous sections. This section focusses on how to form an action plan and implement change, followed by re-auditing to monitor progress.

This is in much the same way a medical treatment is prescribed and then the progress of the patient monitored, and dosage amended depending on the review outcomes. It can often be the case that improvements on paper look appropriate, but the reality is not as intended, and a rethink is required.

The key to successful service improvement is to ensure the whole team is involved in the process and understands the importance of service change. Change can be worrying but clear explanation and true involvement will highlight what needs to change and why. If the team understands the issues, it will be more likely to comply with policy and protocol change. Using the ADKAR model (Awareness, Desire, Knowledge, Ability, Reinforcement) to involve the team can be helpful (HEE, 2022). This technique ensures everyone understands that change is part of the process.

Audit and review data should be analysed with as little bias as possible and ideas to resolve issues canvassed from the management team and practitioners. The action plan should state the issue of concern, the data that backs up the concern and initial recommendations for service change.

Depending on the area of concern it may be a different person responsible for implementing the change – such as financial, clinical or strategic changes. There should be a timescale for implementation, depending on identified risk factors, and then a timescale for review. Reviewing the change should be carried out on the basis of risk. For example, where a high-risk issue has been identified this should be acted on as a matter of priority and reviewed with urgency.

Figure 1 Audit review cycle

Change management is crucial to service improvement and more information about this can be found in the links below. The key to change management is to look at what the barriers and facilitators are to change and use these to ensure a successful transition. The NHS has a useful guide to change management which states eight factors (NHS , 2012)

* Leadership by all.
* Spread and adoption.
* Improvement tools.
* Project and performance management.
* Measurement.
* System drivers.
* Motivate and mobilise.

All these factors will influence the success of an action plan, while many changes are minor and easily implemented some more significant structural changes may require more intense change management to ensure the right changes are made and implemented. See also **Appendix J -Template for service improvement plan**

## Useful links 10.8

[NHS England Change Model](https://www.england.nhs.uk/gp/national-general-practice-improvement-programme/change-model/)

Bristol Hospital Audit change implementation guide gives more guidance on how to make a change, to monitor and then maintain that change: [University Hospital Bristol How to implement change](https://uhbristol.nhs.uk/files/nhs-ubht/8%20How%20to%20implement%20change%20v3.pdf)

[Audit: how to do it in practice | The BMJ](https://www.bmj.com/content/336/7655/1241.full)

Health Education England has this useful set of resources

[Heath Education England | Change Management](https://library.hee.nhs.uk/learning-academy/learning-zone/change-management)

ADKAR model

[The Prosci ADKAR® Model](https://www.prosci.com/methodology/adkar)

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# A to Z of Useful Links

**A**

[ABDO - adult safeguarding training](https://www.abdo.org.uk/adult-safeguarding/#:~:text=The%20ABDO%20Adult%20Safeguarding%20course%20will%20introduce%20the,manage%20and%20process%20any%20concerns%20that%20may%20arise.)

[ABDO | Association of British Dispensing Opticians](https://www.abdo.org.uk/)

[ABDO | Changes to Data Protection Law Information and Guidance](https://www.abdo.org.uk/regulation-and-policy/advice-and-guidelines/regulatory/data-protection/oc-changes-to-data-protection-law-information-and-guidance/)

[ABDO Clinical requirements for record keeping](https://www.abdo.org.uk/regulation-and-policy/advice-and-guidelines/clinical/patient-records/)

[ABDO Consent](https://www.abdo.org.uk/regulation-and-policy/advice-and-guidelines/updates/r1-2-2-consent/)

[ABDO CPD](https://www.abdo.org.uk/cpd/)

[ABDO Diploma in the Assessment and Management of Low Vision](https://www.abdo.org.uk/wp-content/uploads/2020/04/ABDO-Low-Vision-Syllabus-WEB-MAR20.pdf)

[ABDO GDPR guidance](https://www.abdo.org.uk/news/updated-gdpr-guidance-for-members/)

[ABDO Low Vision Kit List](https://www.abdo.org.uk/wp-content/uploads/2020/11/224005-ABDO-Low-Vision-Kit-DOCUMENT-i.pdf)

[ABDO Management and Leadership Training](https://www.abdo.org.uk/dashboard/business-hub/mlt/)

[ABDO | Safeguarding Regulatory requirements](https://www.abdo.org.uk/regulation-and-policy/advice-and-guidelines/regulatory/safeguarding/)

[ABDO | Voucher values: England, Scotland and Wales](https://www.abdo.org.uk/voucher-values/vouchers-at-a-glance-england-wales/)

[ABDO: What is a dispensing optician?](https://www.abdo.org.uk/for-the-public/what-is-a-dispensing-optician/)

[AbilityNet](https://abilitynet.org.uk/)

[AbilityNet Vision impairment and Computing](https://www.abilitynet.org.uk/factsheets/vision-impairment-and-computing#simple-table-of-contents-19)

[Accessible Information Standard - Public Health Wales](https://phw.nhs.wales/services-and-teams/equality-and-human-rights-information-resource/accessible-information-standard/)

[Accessible name badges – Hello my name is](https://www.hellomynameis.org.uk/)

Accessible patient information: Patient Information Forum (PIF)

[Accessing and using the NHS in Scotland | NHS inform](https://www.nhsinform.scot/care-support-and-rights/health-rights/access/accessing-and-using-the-nhs-in-scotland)

[Access to Work (Government): get support if you have a disability or health condition](https://www.gov.uk/access-to-work)

[Acta Ophthalmologica Scandinavica | Principles of disability glare measurement: an ophthalmological perspective](https://onlinelibrary.wiley.com/doi/10.1111/j.1600-0420.2006.00860.x)

[Adult UK Sight Loss Pathway Appendix C UK Vision strategy](https://curriculum.rcophth.ac.uk/wp-content/uploads/2014/12/2013_PROF_252_-Adult_UK_sight_loss_pathway.pdf)

[Age Connects Wales](https://www.ageconnectswales.org.uk/)

[Age Cymru | HOPE](https://www.ageuk.org.uk/cymru/our-work/advocacy/hope---helping-others-participate-and-engage/)

[Age UK](https://www.ageuk.org.uk/)

[Age UK Elderly fall prevention](https://www.ageuk.org.uk/information-advice/health-wellbeing/exercise/falls-prevention/)

[All Wales Standards for Accessible Communication and Information for People with Sensory Loss](https://gov.wales/sites/default/files/publications/2019-04/all-wales-standards-for-accessible-communication-and-information-for-people-with-sensory-loss-large-print_0.pdf)

[Alzheimer's Society](https://www.alzheimers.org.uk/)

[American Academy of Ophthalmology Recording confrontation visual fields](https://www.aao.org/education/image/recording-confrontation-visual-fields)

[Anxiety UK](https://www.anxietyuk.org.uk/)

[AOP GDPR guidance](https://www.aop.org.uk/advice-and-support/regulation/uk/data-protection/gdpr-advice)

[AOP: For Employees](https://www.aop.org.uk/advice-and-support/clinical/clinical-governance/managing-risk-in-practice/for-employees)

[Assessing and managing patients with low vision - College of Optometrists (college-optometrists.org)](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge,-skills-and-performance/assessing-and-managing-patients-with-low-vision#Assessingpatientswithlowvision)

[Audible](https://www.audible.co.uk/?ref_pageloadid=not_applicable&ref=a_hp_t1_nav_header_logo&pf_rd_p=5ab93e15-48e3-4f02-8bc8-739cc674fa84&pf_rd_r=X9M00RF1PWY1MJ0YHVJ8&pageLoadId=vkrkCl27ml1wzMQr&creativeId=fd449be1-b925-4b49-a701-e1f297f8c121)

[Audit: how to do it in practice | The BMJ](https://www.bmj.com/content/336/7655/1241.full)

**B**

[BAME Vision | Black, Asian, and Minority Ethnic Community](https://bamevision.org/about-us)

[Belfast Health & Social Care Trust | Health service structure](https://belfasttrust.hscni.net/about/corporate-info/health-service-structure/)

[BIOS Advanced Orthoptic Clinical Practice – Competency Framework](https://www.orthoptics.org.uk/wp-content/uploads/2022/10/BIOS-AOCPF-2022.pdf)

[BIOS | British and Irish Orthoptic Society](https://www.orthoptics.org.uk/)

[BIOS Low Vision Core skills and competencies](https://www.orthoptics.org.uk/wp-content/uploads/2021/11/BIOS-Low-Vision-Core-skills-and-competencies-January-2021.pdf)

[BIOS Low Vision Pathway](https://www.orthoptics.org.uk/wp-content/uploads/2021/11/BIOS-Low-Vision-Pathway-9-11-21.pdf)

[BIOS: What is an Orthoptist?](https://www.orthoptics.org.uk/patients-and-public/what-is-an-orthoptist/)

[BJA Education | Oxford Academic | Patient-reported outcome measures and patient-reported experience measures](https://academic.oup.com/bjaed/article/17/4/137/2999278)

[Blind Square](https://www.blindsquare.com/)

[Blind Veterans UK](https://www.blindveterans.org.uk/)

[Blind Veterans UK | Welfare benefits for people with sight loss](https://www.blindveterans.org.uk/sight-loss-resources/welfare-benefits-for-people-with-sight-loss/)

[BorrowBox – Your library in one app](https://www.borrowbox.com/)

[British Blind Sport](https://britishblindsport.org.uk/)

[British Dental Journal | Development and evaluation of a 'was not brought' pathway: a team approach to managing children's missed dental appointments](https://www.nature.com/articles/s41415-019-0621-z)

**C**

[Calibre Audio](https://calibreaudio.org.uk/)

[Cardiff University: Sight Loss Patients with Depression Routinely Overlooked](https://www.cardiff.ac.uk/news/view/191612-sight-loss-patients-with-depression-routinely-overlooked)

[Care Act 2014 (legislation.gov.uk)](https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted)

[Care Quality Commission (CQC) Premises and Equipment](https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-15-premises-equipment)

[Carers UK | Needs assessment](https://www.carersuk.org/help-and-advice/practical-support/needs-assessment/)

[Cerebral Visual Impairment | Dr. Gordon Dutton](https://cvi.aphtech.org/?page_id=553)

[Cerebral Visual Impairment: Career-Long Professional Learning](https://www.ssc.education.ed.ac.uk/courses/vi%26multi/cvi21.html)

[Citizens Advice Bureau](https://www.citizensadvice.org.uk/)

[Citizens Advice Carers: help and support Northern Ireland](https://www.citizensadvice.org.uk/about-us/northern-ireland/)

[Citizens Advice: Carers: help and support England](https://www.citizensadvice.org.uk/family/looking-after-people/carers-help-and-support/)

[Citizens Advice Carers: help and support Wales](https://www.citizensadvice.org.uk/wales/family/looking-after-people/carers-help-and-support/)

[Citizens Advice Scotland](https://www.citizensadvice.org.uk/scotland/)

[Clinical audit: descriptive studies (government guidance)](https://www.gov.uk/guidance/clinical-audit-descriptive-studies)

[Clinical Council for Eye Health Commissioning (CCEHC) Guidance](https://www.college-optometrists.org/clinical-council-for-eye-health-commissioning#tab-informationandguidance-ce7cc8fd)

[Clinical Procedures in Primary Eye Care Chapter 3 - Assessment of Visual Function](https://www.sciencedirect.com/science/article/pii/B9780750688963500079)

[College of Optometrists](https://www.college-optometrists.org/)

[College of Optometrists and Ophthalmologists Clinical Commissioning Guide for better eye care: Adults with Low Vision](https://www.college-optometrists.org/getmedia/4867ed01-7eab-42d8-bece-f9204989639c/clinical-commissioning-guidance-adults-with-low-vision.pdf)

[College of Optometrists: Assessing and managing patients with low vision](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge,-skills-and-performance/assessing-and-managing-patients-with-low-vision#Dispensinglowvisiondevices)

[College of Optometrists | Clinical Management Guidelines](https://www.college-optometrists.org/clinical-guidance/clinical-management-guidelines)

[College of Optometrists: Confidentiality](https://www.college-optometrists.org/clinical-guidance/guidance/communication,-partnership-and-teamwork/confidentiality)

[College of Optometrists Consent](https://www.college-optometrists.org/clinical-guidance/guidance/communication,-partnership-and-teamwork/consent)

[College of Optometrists | Electronic vision enhancement for low vision](https://www.college-optometrists.org/professional-development/college-journals/optometry-in-practice/all-oip-articles/volume-18,-issue-2/2017-06-electronicvisionenhancementforlowvision)

[College of Optometrists GDPR guidance](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge,-skills-and-performance/patient-records/data-protection-act-2018-and-eu-general-data-prote)

[College of Optometrists Higher certificate in Low vision](https://www.college-optometrists.org/professional-development/further-qualifications/higher-qualifications)  professional

[College of Optometrists - How to write a good referral letter](https://www.college-optometrists.org/professional-development/college-journals/acuity/all-issues/winter-2019/2019-02-howtowriteagoodreferralletter_c-70310)

[College of Optometrists - Infection control](https://www.college-optometrists.org/clinical-guidance/guidance/safety-and-quality/infection-control)

[College of Optometrists Introduction to CPD](https://www.college-optometrists.org/professional-development/continuing-professional-development-cpd/introduction-to-cpd)

[College of Optometrists: Patient Records](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge,-skills-and-performance/patient-records/useful-information-and-links)

[College of Optometrists Remote consultations](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge,-skills-and-performance/remote-consultations#Remoteconsultations)

[College of Optometrists Safeguarding children and adults at risk](https://www.college-optometrists.org/clinical-guidance/guidance/safety-and-quality/safeguarding-children-and-vulnerable-adults)

[College of Optometrists | Safeguarding training](https://www.college-optometrists.org/qualifying/scheme-for-registration/sfr-additional-information/before-you-qualify/safeguarding-training#:~:text=Safeguarding%20training%20is%20considered%20good%20practice%20for%20all,Health%20Board%20or%20the%20National%20Performers%20List%20%28England%29.)

[College of Optometrists | Urgency of referrals table](https://www.college-optometrists.org/clinical-guidance/guidance/guidance-annexes/annex-4-urgency-of-referrals-table)

[College of Optometrists Vision and falls](https://www.college-optometrists.org/category-landing-pages/falls/focus-on-falls)

[College of Optometrists: What is an Optometrist?](https://www.college-optometrists.org/qualifying/a-career-in-optometry/what-is-an-optometrist)

[Colour Vision Assessment (including CAD and additional tests) | City, University of London](https://researchcentres.city.ac.uk/applied-vision/avot/individual-tests/colour-vision-assessment-including-cad)

[CQC DBS checks for registration](https://www.cqc.org.uk/guidance-providers/registration/dbs-checks-cqc-registration)

[CVI Scotland](https://cviscotland.org/)

**D**

[Data Protection: The Data Protection Act](https://www.gov.uk/data-protection)

[Data Security and Protection Toolkit](https://www.dsptoolkit.nhs.uk/)

[Deafblind UK](https://deafblind.org.uk/)

[Dementia UK](https://www.dementiauk.org/)

[Department of Health - Making Written Information Easier to Understand for People with Learning Disabilities](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215923/dh_121927.pdf)

[Design of the low vision quality-of-life questionnaire (LVQOL) and measuring the outcome of low-vision rehabilitation - PubMed](https://pubmed.ncbi.nlm.nih.gov/11124300/)

[Development of a questionnaire for measurement of vision-related quality of life - PubMed](https://pubmed.ncbi.nlm.nih.gov/9894804/)

[Diabetes UK](https://www.diabetes.org.uk/)

[Disability Rights UK](https://www.disabilityrightsuk.org/about-us)

[Disabled Students' Allowance (DSA) application forms and notes (Government)](https://www.gov.uk/government/publications/disabled-students-allowance-application-forms-and-notes-for-2022-to-2023-full-time-students)

[Durham University - DREX](https://www.durham.ac.uk/departments/academic/psychology/research/services/drex/)

**E**

[England Online DBS Check Application](https://dbscheckonline.org.uk/)

[Equality Act 2010](https://www.gov.uk/guidance/equality-act-2010-guidance)

[Esme's Umbrella (charlesbonnetsyndrome.uk)](https://charlesbonnetsyndrome.uk/)

[Esme's Umbrella - Managing your Charles Bonnet Syndrome](https://charlesbonnetsyndrome.uk/managing-your-charles-bonnet-syndrome-cbs/)

[European Society for Low Vision Research and Rehabilitation](https://www.eslrr.org/)

[Evaluating the Effectiveness of Low Vision Services in Wales | IOVS | ARVO Journals](https://iovs.arvojournals.org/article.aspx?articleid=2366906)

[Evaluation of a Home-Printable Vision Screening Test for Telemedicine](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7791401/)

[Every Customer Counts - promoting accessible services](https://www.equalityni.org/everycustomercounts#:~:text=The%20Equality%20Commission%20has%20developed%20the%20%22Every%20Customer,are%20to%20disabled%20people.%20THREE%20STEPS%20TO%20SUCCESS%3A)

[Eye Care Liaison Officers (ECLOs) | RNIB](https://www.rnib.org.uk/professionals/health-social-care-education-professionals/health-professionals/the-benefits-of-eclos/)

**F**

[Falls Risk Assessment Tool (FRAT)](https://www.physio-pedia.com/Falls_Risk_Assessment_Tool_(FRAT))

[FODO | Data protection and Freedom of Information Act](https://www.fodo.com/members/guidance/category-3/data-protection-and-freedom-of-information-act/)

[Freethink Smart Cane](https://www.freethink.com/hard-tech/smart-cane-for-the-blind)

[Functional visual fields: a cross-sectional UK study to determine which visual field paradigms best reflect difficulty with mobility function](https://rnib.sharepoint.com/sites/Lowvisionservicesqualityassuranceframework/Shared%20Documents/General/Framework%20working%20documents/Good%20practice%20guidelines%20working%20documents/e018831.full.pdf%20(bmj.com)) (Subhi, 2017)

[FutureNHS Collaboration Platform](https://future.nhs.uk/system/login?nextURL=%2Fconnect%2Eti%2FNationalEyeCareHub%2Fview%3FobjectId%3D29667120)

**G**

[Gene Vision - A resource for patients and doctors about rare genetic eye disorders](https://gene.vision/)

[Give Vision](https://www.givevision.net/)

[Glaucoma UK | Buddy Support Schemes | Care & Support](https://glaucoma.uk/care-support/buddy-scheme/)

[Glaucoma UK | Care & support](https://glaucoma.uk/care-support/)

[Glaucoma UK | Help & Support For People Living With Glaucoma](https://glaucoma.uk/about-glaucoma/)

[GMC Guidance on developing and implementing formal patient feedback tools](https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/revalidation-resources/guidance-on-developing-and-implementing-formal-patient-feedback-tools)

[GoodMaps](https://www.goodmaps.com/)

[GOC Confidentiality Standards for Optometrists and Dispensing Opticians](https://optical.org/optomanddostandards/14-maintain-confidentiality-and-respect-your-patients-privacy/)

[GOC CPD requirements for DOs and Optometrists](https://optical.org/media/qo3pshey/cpd_a-guide-for-registrants_v2_june-2022.pdf)

[GOC GDPR guidance](https://optical.org/en/about-us/accessing-information/our-policies/data-protection/)

[GOC High level principles for good practice in remote consultations and prescribing](https://optical.org/media/kyxni0v3/high-level-principles-for-remote-prescribing.pdf)

[GOC Maintain adequate patient records](https://optical.org/optomanddostandards/8-maintain-adequate-patient-records/)

[GOC Make a declaration](https://optical.org/en/registration/make-a-declaration/)

[GOC Obtain valid consent](https://optical.org/optomanddostandards/3-obtain-valid-consent/)

[GOC Standards](https://optical.org/en/Standards/)

[GOC Standards of Practice](https://optical.org/en/standards-and-guidance/standards-for-optical-businesses/1-2-patient-care-is-delivered-in-a-suitable-environment/)

[Goldmann Perimetry | Field of Vision p31-44 | Barton and Benatar](https://link.springer.com/chapter/10.1007/978-1-59259-355-2_4)

[Government Access to Work](https://www.gov.uk/access-to-work)

[Government guidance for learning disabilities](https://www.gov.uk/health-and-social-care/learning-disabilities#guidance_and_regulation)

[Government Guidance Understanding accessibility requirements for public sector bodies](https://www.gov.uk/guidance/accessibility-requirements-for-public-sector-websites-and-apps)

[Government Job Centre Plus](https://www.gov.uk/contact-jobcentre-plus)

[Government Learning disabilities: applying All Our Health](https://www.gov.uk/government/publications/learning-disability-applying-all-our-health/learning-disabilities-applying-all-our-health)

[Government Safeguarding policy: protecting vulnerable adults](https://www.gov.uk/government/publications/safeguarding-policy-protecting-vulnerable-adults)

[Government Working together to safeguard children](https://www.gov.uk/government/publications/working-together-to-safeguard-children--2)

[GOV Scotland Apply for basic disclosure](https://www.mygov.scot/basic-disclosure/apply-for-basic-disclosure)

[GOV Scotland Eyecare - Primary care services](https://www.gov.scot/policies/primary-care-services/eyecare/)

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[RNIB | Adapting your home](https://www.rnib.org.uk/living-with-sight-loss/independent-living/adapting-your-home/)

[RNIB | Cerebral visual impairment and PMLD](https://www.rnib.org.uk/professionals/health-social-care-education-professionals/education-professionals/cerebral-visual-impairment-and-pmld/)

[RNIB | Charles Bonnet syndrome](https://www.rnib.org.uk/your-eyes/eye-conditions-az/charles-bonnet-syndrome/)

[RNIB | Colour and contrast for people with sight loss](https://media.rnib.org.uk/documents/Colour_and_contrast_for_people_with_sight_loss_2020.pdf)

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[RNIB | Confident Living Series Booklets: Technology](https://media.rnib.org.uk/documents/Confident_Living_-_Technology_2022.pdf)

[RNIB | Creating accessible information and communication resources for health and social care](https://www.rnib.org.uk/living-with-sight-loss/independent-living/accessible-nhs-and-social-care-information/creating-accessible-information-and-communication-resources-for-health-and-social-care/)

[RNIB | eBooks](https://www.rnib.org.uk/living-with-sight-loss/assistive-aids-and-technology/everyday-tech/reading-and-writing/ebooks-and-digital/)

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[RNIB | Eye conditions](https://www.rnib.org.uk/your-eyes/eye-conditions-az/)

[RNIB | Five steps to getting the right glasses for light sensitivity](https://www.rnib.org.uk/your-eyes/eye-conditions-az/light-sensitivity-photophobia/five-steps-to-getting-the-right-glasses-for-light-sensitivity/)

[RNIB | GPS Navigation](https://www.rnib.org.uk/living-with-sight-loss/assistive-aids-and-technology/everyday-tech/navigation-and-communication/what-is-gps-navigation/)

[RNIB | Grants](https://www.rnib.org.uk/living-with-sight-loss/money-and-benefits/grants/)

[RNIB | Grants from other organisations](https://www.rnib.org.uk/living-with-sight-loss/money-and-benefits/grants-from-other-organisations/)

[RNIB | guide to braille displays for blind and partially sighted people](https://www.rnib.org.uk/living-with-sight-loss/assistive-aids-and-technology/everyday-tech/reading-and-writing/an-rnib-guide-to-braille-displays-for-blind-and-partially-sighted-people/)

[RNIB | Helpful Apps](https://www.rnib.org.uk/living-with-sight-loss/assistive-aids-and-technology/everyday-tech/navigation-and-communication/helpful-apps/)

[RNIB | How to Guide People with Sight Loss booklet](https://media.rnib.org.uk/documents/How_to_guide_people_with_sight_loss_2022.pdf)

[RNIB | Key information if you've noticed changes in your vision or eye health](https://www.rnib.org.uk/your-eyes/worried-about-your-eyes/noticing-changes-in-your-eyes/)

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[RNIB | My info my way](https://www.rnib.org.uk/get-involved/support-a-campaign/my-info-my-way/)

[RNIB | NHS Eye Care Services: How To Get The Help You Need](https://shop.rnib.org.uk/NHS-Eye-care-services-How-to-get-the-help-you-need-90510)

[RNIB Online Shop](https://shop.rnib.org.uk/)

[RNIB | Practical adaptations](https://www.rnib.org.uk/living-with-sight-loss/independent-living/practical-adaptations/)

[RNIB | Practical information and advice if you're worried about your eyes](https://www.rnib.org.uk/your-eyes/worried-about-your-eyes/)

[RNIB | Professionals](https://www.rnib.org.uk/professionals/)

[RNIB | Reading Services](https://readingservices.rnib.org.uk/)

[RNIB | Registering as sight impaired](https://www.rnib.org.uk/your-eyes/navigating-sight-loss/registering-as-sight-impaired/)

[RNIB | Resources on dementia and sight loss](https://www.rnib.org.uk/professionals/health-social-care-education-professionals/social-care-professionals/dementia-and-sight-loss/)

[RNIB | Sight loss counselling - professional support](https://www.rnib.org.uk/living-with-sight-loss/community-connection-and-wellbeing/sight-loss-counselling/)

[RNIB | Sight Loss Data Tool - statistics on sight loss](https://www.rnib.org.uk/professionals/health-social-care-education-professionals/knowledge-and-research-hub/sight-loss-data-tool/)

[RNIB Starting Out series – Benefits, concessions and registration booklet](https://media.rnib.org.uk/documents/APDF-SE180905_Benefits_Concessions_and_Registration-v001_cCPrRtX.pdf)

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[RNIB | Stroke-related eye conditions](https://www.rnib.org.uk/your-eyes/eye-conditions-az/stroke-related-eye-conditions/)

[RNIB | Talking Books](https://www.rnib.org.uk/living-with-sight-loss/independent-living/reading-and-books/talking-books/)

[RNIB Talk to somebody](https://www.rnib.org.uk/your-eyes/navigating-sight-loss/sight-loss-and-wellbeing/talk-to-somebody/)

[RNIB | Technology information](https://www.rnib.org.uk/living-with-sight-loss/assistive-aids-and-technology/everyday-tech/)

[RNIB | Technology Support](https://www.rnib.org.uk/living-with-sight-loss/assistive-aids-and-technology/tech-support-and-information/technology-support-and-training/technology-support-we-offer/)

[RNIB | The criteria for certification](https://www.rnib.org.uk/your-eyes/navigating-sight-loss/registering-as-sight-impaired/the-criteria-for-certification/)

[RNIB / TPT / Guide Dogs Sighted Guiding Guidance - Visionary](https://www.visionary.org.uk/latest/policy-guidance-from-rnib-guide-dogs-and-tpt-re-sighted-guiding/)

[RNIB | Transcription Services](https://www.rnib.org.uk/living-with-sight-loss/independent-living/reading-and-books/transcription-services/)

[RNIB | Wearable technology: smart glasses and head mounted cameras](https://www.rnib.org.uk/living-with-sight-loss/assistive-aids-and-technology/tech-support-and-information/wearable-technology-smart-glasses-and-head-mounted-cameras/)

[RNID](https://rnid.org.uk/)

[RNID | Accessible Information Standard](https://rnid.org.uk/information-and-support/support-for-health-and-social-care-professionals/accessible-information-standard/)

[RNID | Communicating Well with Residents who have Hearing Loss](https://rnid.org.uk/wp-content/uploads/2020/05/A1422_Info-sheet_Communicating-well-with-residents-who-have-hearing-loss_v03.pdf)

[RNID | Communication tips if you have hearing loss](https://rnid.org.uk/information-and-support/hearing-loss/living-with-hearing-loss/communication-tips/)

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[Royal College of Ophthalmologists](https://www.rcophth.ac.uk/)

[Royal College of Ophthalmologists: Discover Ophthalmology Careers](https://www.rcophth.ac.uk/our-work/ophthalmology-careers/)

[Royal College of Ophthalmologists’ guidance on patients with learning disabilities](https://www.rcophth.ac.uk/resources-listing/eye-care-for-adults-with-learning-disabilities-2015/)

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[Samaritans](https://www.samaritans.org/)

[Samaritans | Suicide Prevention Training Courses](https://www.samaritans.org/how-we-can-help/workplace/workplace-staff-training/half-day-courses/course-handling-suicidal-conversations/)

[SCIE | Dementia-friendly environments](https://www.scie.org.uk/dementia/supporting-people-with-dementia/dementia-friendly-environments/)

[SCIE | Mental Capacity Act | Independent Mental Capacity Advocate (IMCA)](https://www.scie.org.uk/mca/imca)

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[Sense | For people with complex disabilities](https://www.sense.org.uk/)

[Shout | UK's 24/7 Crisis Text Service for Mental Health Support](https://giveusashout.org/)

[Sight and Sound Technology](https://www.sightandsound.co.uk/)

[Sightline Directory](https://www.sightlinedirectory.org.uk/)

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[Sign Health | The Deaf Health Charity](https://signhealth.org.uk/)

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[Sunu Band (Vision Aid)](https://www.visionaid.co.uk/sunu-band-premium)

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[TPT Assistive and Inclusive home technology for people with sight loss](https://www.pocklington-trust.org.uk/supporting-you/useful-guides/assistive-and-inclusive-home-technology-for-people-with-sight-loss/)

[TPT Employment](https://www.pocklington-trust.org.uk/employment/)

[TPT Falls in Older People with Sight Loss: a review of emerging research](https://www.pocklington-trust.org.uk/sector-resources/research-archive/falls-in-older-people-with-sight-loss-review/)

[TPT Housing guide for people with sight loss](https://www.pocklington.org.uk/resources/useful-guides/housing-guide-for-people-with-sight-loss/)

[TPT lighting guide for in and around the home](https://www.pocklington-trust.org.uk/wp-content/uploads/2021/10/Lighting-Guide-2021-FINAL.pdf)

[Travel Eyes International Group Holidays for Blind & Sighted Travellers](https://www.traveleyes-international.com/)

[Turn2us | Grants for people with a visual impairment](https://www.turn2us.org.uk/About-Us/News/Grants-for-people-with-a-visual-impairment)

**U**

[UCL | Posterior cortical atrophy | Dementia Research Centre](https://www.ucl.ac.uk/drc/pca-support-group/posterior-cortical-atrophy#tests)

[Ulster | Cerebral Visual Impairment Assessment](https://www.ulster.ac.uk/research/topic/biomedical-sciences/research/optometry-and-vision-science/vision-resources/professionals/cerebral-visual-impairment-assessment)

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[University Hospital Bristol How to implement change](https://uhbristol.nhs.uk/files/nhs-ubht/8%20How%20to%20implement%20change%20v3.pdf)

[University of Sheffield Clinical Leadership and Education in Ophthalmology](https://www.sheffield.ac.uk/ahpnm/cpd/opportunities/clinical-leadership)

[University of Sheffield Health Sciences School Low vision](https://www.sheffield.ac.uk/health-sciences/continuing-professional-development/cpd-opportunities/low-vision)

**V**

[Vision 2020 | RCOphth Quality standards for people with sight loss and dementia in an ophthalmology department](https://www.rcophth.ac.uk/wp-content/uploads/2020/08/Quality-standard-for-people-with-sight-loss-and-dementia-in-an-ophthalmology-department.pdf)

[Vision Aid](https://www.visionaid.co.uk/)

[Visionary](https://www.visionary.org.uk/our-offer/)

[VisionAware | Minimizing Glare](https://visionaware.org/everyday-living/home-modification/lighting-and-glare/videos-better-lighting-for-better-sight/)

[Vision Care Charity for Homeless People | United Kingdom](https://www.visioncarecharity.org/)

[Vision Matters - National Eye Health Week](https://www.visionmatters.org.uk/)

[Visual Function Questionnaire (VFQ-25)](https://www.rand.org/health-care/surveys_tools/vfq.html)

[Vocal Eyes Opportunities for blind and partially sighted people to experience and enjoy art and heritage](https://vocaleyes.co.uk/)

**W**

[Wales DBS Cymru - an umbrella body for the DBS](https://dbscymru.co.uk/)

[Wales Law Ophthalmic services](https://law.gov.wales/public-services/health-and-health-services/ophthalmic-services)

[Wales Population and household estimates](https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/populationandhouseholdestimateswales/census2021)

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[Web Content Accessibility Guidelines (WCAG) – DWP Accessibility Manual](https://accessibility-manual.dwp.gov.uk/accessibility-law/web-content-accessibility-guidelines)

[WeWALK Smart Cane](https://wewalk.io/en/)

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[World Blind Union/CBM Global Disability Inclusion Accessibility=Go! A Guide to Action](https://worldblindunion.org/wp-content/uploads/2021/12/Accessibility-GO-A-Guide-to-Action-WBU-CBM-Global-Dec2021.pdf)

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[Your entitlement to NHS ophthalmic services](https://www.nhsinform.scot/care-support-and-rights/nhs-services/ophthalmics/your-entitlements-to-nhs-ophthalmic-services)

## Appendix A - Template service leaflet – patient

**Template service leaflet**

**Practice address:**

**Telephone:**

**Email:**

**Practice Manager:**

**What is the [Low Vision Service]?**

The [Low Vision Service] is a service that helps you to make the most of your vision. Our staff will thoroughly assess your sight and how your sight loss affects your life and day-to-day activities. This centre is [is not] part of the hospital service and/but you will not be seeing an eye doctor so you should continue to attend all hospital appointments.

**Who will I see?**

[Details of practitioners and their roles e.g., optometrist, orthoptist, dispensing optician, Vision Rehabilitation Specialist]

**Who is eligible for this service?**

[Inclusion and exclusion criteria]

**How to get an appointment:**

[Details of how to get an appointment]

**How to get here:**

**Map**

**Transport links**

**Other helpful access information**

## Appendix B - Template service leaflet – professional

**What is the [low vision service]?**

The [low vision service] provides advice, support and equipment to help patients with low vision make the most of their sight. Patients will have a functional vision assessment, needs assessment, prescription and provision of low vision aids. Patients will be given training in the use of low vision aids and other visual strategies that are appropriate for them.

**Who would benefit from a low vison appointment? [include all exclusion and inclusion criteria here]**

Please refer anyone who is unable to carry out their activities of daily living due to visual impairment that cannot be corrected with spectacles or contact lenses. Patients do not need to be registered as sight impaired or severely sight impaired.

**How to refer to [low vision service]**

[details of how to refer including links]

**Who can refer patients into the [low vision service]?**

Any eye health, health or social care professional can refer into the service.

Patients can self-refer by calling [telephone number] or emailing [email address]

**Where is the [low vision service]?**

Address

Location details

Transport links

Map

## Appendix C -Template referral letter

Address

Telephone number

Date

Any patient reference

Patient details:

DOB:

Patient address:

Patient contact number:

The above-named patient attended for low vision assessment on [date].

Action required: [what is the nature of the referral or what action is required]

Diagnosis:

CVI status:

Spectacle prescription: [and VAs]

Presenting symptoms: [main concerns]

Clinical findings: [relevant data]

Low vision impact findings: [social, functional and emotional impact]

Low vision aids prescribed: [relevant LVAs]

Overview of outcomes: [overview of recommendations, also risks identified and suggested mitigations].

Signed: [name and qualifications of practitioner]

## Appendix D - Magnifier range

### Demonstration optical aids kit list

Full range of illuminated hand magnifiers 8D- 56D

Full range of illuminated stand magnifiers (or detachable stands for the illuminated hand magnifier range) 8D- 56D

Small and large dome magnifier

Full range of illuminated pocket magnifier and simple pocket magnifiers

Full range of simple hand and stand magnifiers 8D-56D

TV binoculars

X4, x8, x10 monoculars and clips for spectacles

X4, x8, x10 binoculars

Range of clip-on magnifiers

Full range of prismatic half eyes

Spectacle mounted telescope fitting set (depending on the service)

Hobby magnifiers

## Appendix E - Magnifier instruction leaflets for patients

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**Optical aids - hints and tips.**

Contents

[Stand magnifiers 1](#_Toc141444748)

[Hand-held magnifiers 2](#_Toc141444749)

[Telescopes, monoculars and binoculars 2](#_Toc141444750)

[Hints and tips for using magnifiers 3](#_Toc141444751)

**Stand magnifiers**

Magnifiers with a built-in stand give a fixed focus which means that you can keep it in focus without having to hold it steady. You do not need to hold the magnifier away from the page it should at all times be in contact with the page. If you find yourself lifting it up to see clearly then you need to speak to the low vision practitioner as the power is probably not right for you.

You may need to use your reading spectacles to get the clearest image. If you move close to the magnifier you will see more letters and words through the lens. Always view through the lens with your better eye as you will not be able to use both eyes at the same time for all but the very lowest power magnifiers.

You will need to read the page or book on either a tabletop, clip board or a book stand to keep it flat enough for the magnifier to work well. You may need a hand-held magnifier as well in order to read small items such as cooking instructions that you cannot put flat on a table.

**Hand-held magnifiers**

To use a hand-held magnifier correctly place it flat on the page and slowly draw it towards your eye until it focuses. By lifting the magnifier and print together nearer your eye you will be able to see more words in one view. The image may appear upside down if you are holding it too far away.

Alternatively, you can hold the magnifier up to your viewing eye, then look through the centre of the lens and place the print so that it touches the lens and then move it slowly away until it comes into focus.

Remember the distance between the lens and the print is often very short. If it doesn’t seem to be in focus it is likely that you are holding it too far away. You can only use one eye with most magnifiers and therefore it is important that you use your better eye.

The stronger the power of the magnifier the shorter the focus distance between the lens and the object you are looking at. The area that you can view through the lens becomes smaller too and much like looking through a keyhole, the closer your eye is the more you will be able to see through it.

**Telescopes, monoculars and binoculars**

Handheld telescopes, monoculars and binoculars are usually, but not always prescribed for distance vision activities. Your practitioner will have explained to you what your device has been recommended for.

They can be difficult to use at first and therefore it is important that you have training to use it. Your low vision practitioner should provide this when prescribing these aids.

Here are a few hints and tips that might help:

* Steady your hand against your eyebrow
* Keep your elbows in towards your side
* Look towards the object you want to see first and then put the device up to your eye. This will make lining it up quicker and less frustrating.
* Practice sitting down at home with pictures on your wall or mantelpiece. This is called spotting.
* Don’t expect it to help with moving objects such as buses. This is very tricky, and you would be better to use it for the indicator board than the actual bus.

**Hints and tips for using magnifiers**

Using a magnifier is often tiring, especially in the beginning, but it will not damage your eyes. Here are some useful hints and tips to make it easier:

* Shining a lamp directly onto what you are doing often makes it easier to see.
* If you find your eyes are getting tired, take a break and start again when you feel better.
* Magnifiers usually work best with your spectacles. If you are using the magnifier for close work, then use your reading spectacles. If it is for the distance use your distance spectacles.
* If you use a magnifier to make print bigger you can often only see one or two words or letters at a time. This can make it hard to keep your place. Try using your finger to mark each line. When reading the end of a line, return to the beginning of the same line with your finger before dropping down onto the next line.
* Holding a magnifier close to your eye and bringing what you want to see up to it will often help you see more letters and words. Whilst this is difficult to start with it gets easier the more you practice.
* Some people find moving the book or page from side to side easier than moving the magnifier or their eyes.
* If you are using your magnifier to read when sitting in a chair, put the book or newspaper you are reading on a clipboard to help keep the page flat and still. A cushion or a tray may be useful to provide support.
* Keep your magnifier clean by using the lens cloth provided.
* Use a range of magnifiers for different tasks as recommended by your low vision practitioners.
* If you are having problems using your magnifier, get in touch with your low vision service for further training.

## Appendix F - Glare shield demonstration range

**A range of frame sizes in the following options:**

Fitover

Wraparound (non fitover)

Flexible frames for people with additional needs

Clip-on

**Colours and density of tint:**

Neutral density filters: Dark, medium and light grey

Blue Blocker filters: Brown, Orange, Amber and Yellow

Green

Red

Polarised option

**Note:**

Ensure all tints have UV block

For some services with limited storage flippers with the lens tints and a range of frame styles are sufficient to use for prescribing purposes.

## Appendix G - Template for local services leaflet

**Useful local organisation information (template)- NB: this template is designed so that you delete or amend according to your patient and your service.**

**Name of service**

**You can contact us on**: [amend to suit the access routes for your service]

Phone:

Email:

**Your local society for people with sight loss is**: [ providing local support and advice, social activities and resources]

**Your local sensory needs service is**: [ help at home, advice about lighting and getting out and about]

**Your local ECLO/ patient advocacy service where ECLO isn’t available is:** [ point of contact at the hospital and support to get the help you might need]

**You can contact your hospital team on:**

**Other local hobby groups for people with visual impairment :**

[ sports groups, arts, talk and support etc]

**Talking books:**

RNIB Talking Books

Calibre

Local library

Audible

**Your local Citizen Advice Bureau is:**

**Comments:** [ tailored to the individual such as particular issues that require help – employment, education, financial support]

**National organisations for people with sight loss:**

**General support and advice services:**

* RNIB
* Guide dogs
* Thomas Pocklington Trust
* VICTA

**For help to get emotional support [delete as appropriate]**

* RNIB
* Local society provision
* Samaritans
* MIND
* Anxiety UK
* Shout
* Macular Society
* Retina UK

**Eye condition specific information and advice services [ delete as appropriate]**

* Glaucoma UK
* Macular Society
* Diabetes UK
* RDUK
* Retinal UK
* Esme’s Umbrella
* BUS
* Keratoconus Group
* Nystagmus Network
* CVI society
* Little Bear sees
* Make it easier to see
* Other:

**Driving advice – DVLA**

**Support to meet other people who are sight impaired:**

* RNIB living well services
* Local society groups

## Appendix H - Example of a privacy statement

An example of a privacy statement can be found by clicking on this link:

[Privacy policy | RNIB](https://www.rnib.org.uk/privacy-policy/)

Also from the ICO template below [Make your own privacy notice | ICO](https://ico.org.uk/for-organisations/advice-for-small-organisations/make-your-own-privacy-notice/)

[Insert organisation name] Privacy Policy

**Our contact details** [insert the contact details for your business. You could also include postal address, any main email addresses, phone numbers andweb addresses. Also, the date of the privacy notice]

Name:

Address:

Phone Number:

E-mail:

**The type of personal information we collect**

We currently collect and process the following information: [what information are you collecting]

* Personal identifiers, contacts and characteristics (for example, name and contact details)
* [Add to this list as appropriate]

**How we get the personal information and why we have it**

Most of the personal information we process is provided to us directly by you for one of the following reasons:

* [Add the reasons you collected personal information]

**[If applicable]** We also receive personal information indirectly, from the following sources in the following scenarios:

* [Add the source of any data collected indirectly and why you collected the personal information]

**We use the information that you have given us in order to** [list how you use the personal information].

**We may share this information with** [enter organisations or individuals].

**Under the UK General Data Protection Regulation (UK GDPR), the lawful bases we rely on for processing this information are:** [delete as appropriate]

(a) Your consent. You are able to remove your consent at any time. You can do this by contacting [contact details]

(b) We have a contractual obligation.

(c) We have a legal obligation.

(d) We have a vital interest.

(e) We need it to perform a public task.

(f) We have a legitimate interest.

**How we store your personal information**

Your information is securely stored [Give details of this]

We keep [type of personal information] for [time period]. We will then dispose your information by [explain how you will delete their data].

**Your data protection rights**

Under data protection law, you have rights including:

* **Your right of access** - You have the right to ask us for copies of your personal information.
* **Your right to rectification** - You have the right to ask us to rectify personal information you think is inaccurate. You also have the right to ask us to complete information you think is incomplete.
* **Your right to erasure** - You have the right to ask us to erase your personal information in certain circumstances.
* **Your right to restriction of processing** - You have the right to ask us to restrict the processing of your personal information in certain circumstances.
* **Your right to object to processing** - You have the the right to object to the processing of your personal information in certain circumstances.
* **Your right to data portability** - You have the right to ask that we transfer the personal information you gave us to another organisation, or to you, in certain circumstances.

You are not required to pay any charge for exercising your rights. If you make a request, we have one month to respond to you.

Please contact us at [insert email address, phone number and or postal address] if you wish to make a request.

**How to complain**

If you have any concerns about our use of your personal information, you can make a complaint to us at [Insert your organisation’s contact details for data protection queries].

You can also complain to the ICO if you are unhappy with how we have used your data.

The ICO’s address:

Information Commissioner’s Office

Wycliffe House

Water Lane

Wilmslow

Cheshire

SK9 5AF

Helpline number: 0303 123 1113

ICO website: <https://www.ico.org.uk>

## Appendix I – Templates for a low vision report and patient action plan

****

**RNIB**

Low Vision Centre

The Grimaldi Building

154a Pentonville Road

London. N1 9JE

**rnib.org.uk**

020 7391 2241

Low.vision@nhs.net

[Patient address]

Date:

Dear [patient details] ,

Further to your eye examination and low vision assessment today.

Below is a summary of the key points and report of the outcome of your assessment. I hope it is of help.

**Vision with spectacles:**

RE: LogMAR LE: LogMAR

**Contrast sensitivity:**Pelli-Robson: %

This indicates significant loss of contrast and the importance of good lighting was outlined/ This indicates normal contrast.

We also discussed and demonstrated how extra lighting focused on the page you are reading would enhance your reading.

**[Clinical details if required]**

**Spectacles:**

R: LogMAR

L: LogMAR

Add + N

Buying new spectacles will not improve your vision/ You should update your spectacles for…

**Eye health:**

I understand that your visual impairment is due to…. My findings were consistent with what we already know about your eye condition/ [information about their eye condition that is new].

**Sight Impairment registration**:

You are registered as SI/ SSI / You are not registered but are eligible it was recommended you discuss this with your consultant/ You are not eligible for registration.

**Low vision targets:**

Your main visual concerns are with [list of main targets]

**Low vision aids:**

We have issued the following low vision aids:

Type: Power: Manufacturer: Recommended for:

Information about how to use and look after your LVAs is attached.

**Other recommendations:** [specific advice and signposting for the individual]

The importance of regular ocular health review has been discussed.  We have suggested that your next appointment should be in 12 months. This is not a medical appointment and therefore you should continue as usual with any hospital appointments.

Yours sincerely,

Specialist Optometrist

Low Vision Centre

Cc: GP

Cc: Vision rehabilitation specialist

## 

## Appendix J -Template for service improvement plan

|  |  |
| --- | --- |
| **Section** | e.g., Section 1 Environment |
| **Audit findings** |  |
| **Change required** |  |
| **Implementation Plan**  **Who**  **What**  **When** |  |
| **Risk rating and timescale** |  |
| **Review details** |  |

**Sign off:**

Name:

Date:

## Appendix K Teleconsult template

**Telephone Low Vision Assessment (TLVA)**

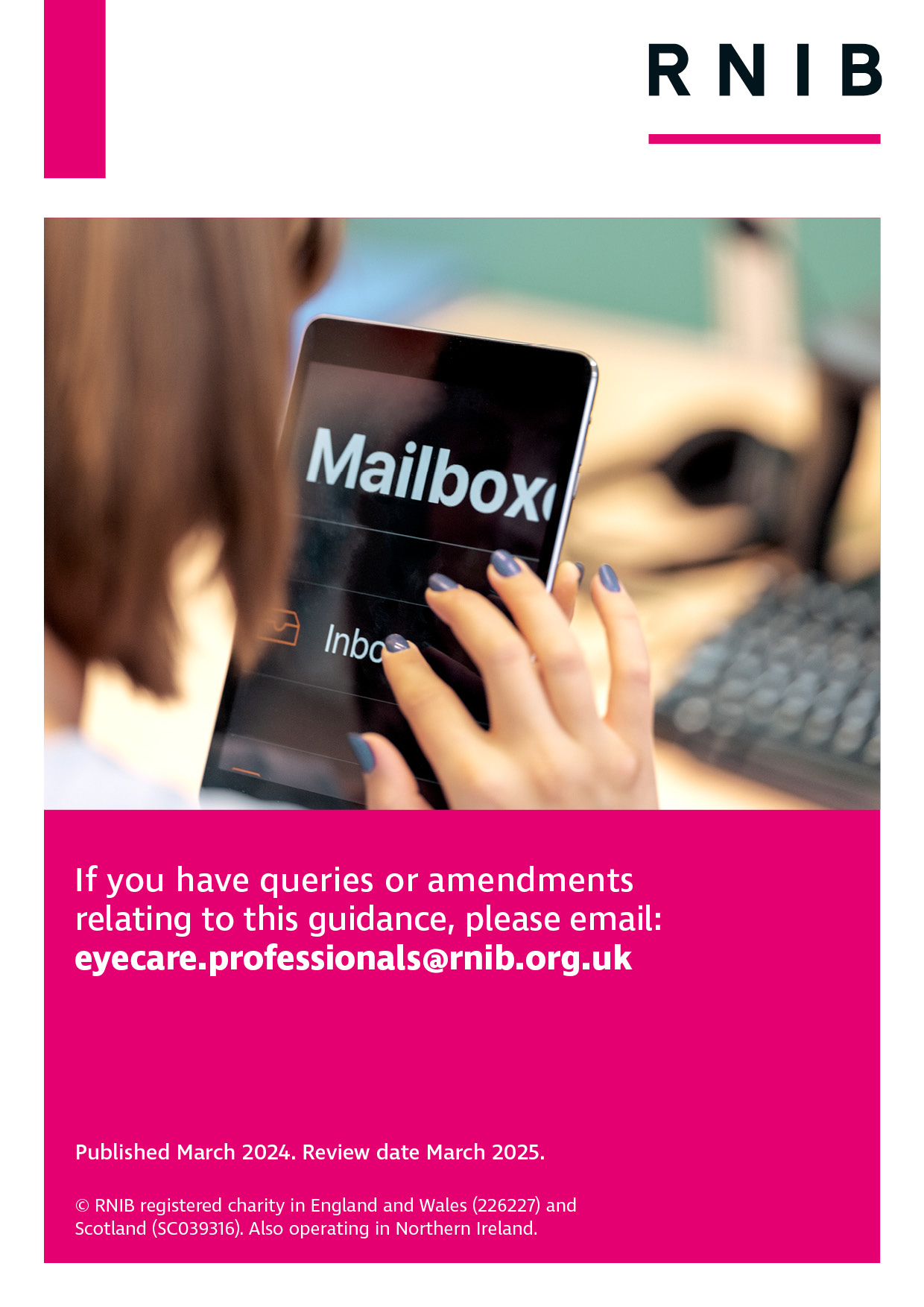
|  |  |
| --- | --- |
| Patient data |  |
| I.D. |  |
| D.O.B |  |
| Date of last eye examination |  |
| Date of L.V.A |  |
| Reason for T.L.V.A. (routine or other. If other, please specify) |  |

|  |  |  |
| --- | --- | --- |
| Medical, ocular and social history |  |  |
| P.O.H. | Eye condition | Stable/ progressive |
| H.E.S. | Data of last appt/ D | Date of next appt |
| G.H. | Condition | Medications |
| Eye health symptoms | Current | Actions required |
| Spectacle refraction | Last known rx and V.A. | Recommendations |
| Self-assessed V.A. | Distance  Near | Recommendations |
| Registration status | SSI/SI/NR | Recommendations |
| Social services | Previous | Current |
| Additional comments |  |  |

|  |  |  |
| --- | --- | --- |
| LVA assessment | Symptoms/difficulties | Aids/support/action |
| Contrast sensitivity |  |  |
| Labels |  |  |
| Mobility |  |  |
| Reading |  |  |
| Cooking |  |  |
| Glare |  |  |
| Computers |  |  |
| Other |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| LVA Type | Condition | How old? | Are they meeting your needs? Y/N? If N, please specify |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |
| 5 |  |  |  |
| Spectacle type |  |  |  |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |

|  |  |  |
| --- | --- | --- |
| Outcomes | Recommendations | Actions |
| LVAs |  |  |
| Spectacles |  |  |
| Non optical aids |  |  |
| Referrals medical |  |  |
| Referrals Social Services |  |  |
| Referrals other |  |  |
| Recall |  |  |

****