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Commissioning better eye care

Clinical commissioning guidance from

The College of Optometrists and The Royal College of Ophthalmologists

Adults with low vision

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Commissioning better eye care: clinical commissioning guide from The College of Optometrists and The Royal College of Ophthalmologists

This resource is to help those designing and commissioning eye care improve the value of their services.

It was produced by the Colleges using a template provided by the Department of Health's Right Care team led by Professor Sir Muir Gray. In addition to the Right Care team, The Royal College of General Practitioners, the National Association of Primary Care, the UK Vision Strategy and partners in the eye health sector have supported the Colleges to produce this guidance.

It is arranged in to the following sections:

- Summary and recommendations
- Introduction
- What is low vision?
- What are the causes of and scope of prevention for low vision?
- How many people have low vision?
- What are the best value diagnostic tests?
- What are the best value treatments?
- How can individuals and carers be best supported long term?
- Successful systems of care: pathways and service models
- How to compare services based on activity, quality and outcome

Children and people with learning or cognitive difficulties have specific low vision needs that go beyond the scope of this guidance. Commissioners should work closely with patients, patient groups and clinicians in their area to design specific low vision services for these people.

Summary: low vision

- Low vision affects every aspect of someone's life, from the ability to prepare food to recognising friends' faces. Older people with low vision are more likely to be depressed and to fall.
- The primary aim of low vision services is to enable people with loss of vision to regain or maintain as much independence and autonomy as possible.
- Low vision services achieve this through a wide range of tools depending on individuals needs including: rehabilitation, visual aids, emotional support and advice.

Recommendations

- Every part of the country should have access to a low vision service.
- Low vision services should not only be open to people who meet visual acuity thresholds or who register as sight impaired. Low vision services can mitigate the practical, emotional and occupational or educational impacts of sight loss for people who do not meet the criteria to register as sight impaired.
- Access to low vision services should be prompt and flexible. Early intervention is key to getting the best outcomes. Flexibility means service users can access the service from multiple routes and should be entitled to reassessments as their vision changes.
- Integration is particularly important for low vision services. Effective low vision services adapt to individual needs and work as seamlessly as possible with other services, including hospital eye units, education, social care, voluntary organisations and stroke, rehabilitation and fall teams. Serious consideration should be given to the provision of an eye care liaison officer (ECLO) in every eye clinic in order to facilitate this.
- Commissioners should ensure low vision services have dedicated funding in their programme budget for eye health and explore the possibility to jointly fund and provide the service with health, local authority and voluntary sector resources.

What is low vision?

Low vision is an impairment of visual function that cannot be remedied by conventional spectacles, contact lenses or medical intervention and which causes restriction in everyday life¹. Low vision includes, but is not limited to, those who are registered as sight impaired.

Types of vision loss that can result in low vision include peripheral loss, central loss, distorted vision, blurred vision and hazy vision. The impact of low vision varies from person to person and will affect people in different ways.

Low vision can affect people's ability to perform everyday tasks, such as reading, writing, shopping, watching television, driving, crossing roads or recognising faces. There is a link between sight loss and reduced wellbeing. People living with sight loss report having lower feelings of wellbeing². Older people with sight loss are almost three times more likely to experience depression than people with good vision³ and more likely to fall⁴.

People with low vision in education can find it difficult to engage with the curriculum and in incidental learning.

What are the causes of low vision and what is the scope for prevention?

Low vision can be caused by a wide variety of congenital, hereditary or age-related eye conditions or may be a consequence of trauma. Visual problems can also be a result of other health conditions, such as stroke, or be associated with a learning disability. The most common causes of low vision amongst adults are age-related macular degeneration, diabetic retinopathy and glaucoma.

Low vision can best be prevented by:

- improving general ophthalmic public health to ensure people look after their eyes, for example by not smoking and having regular sight tests to detect eye disease early
- improving the quality of diabetic retinopathy screening services
- effective eye care to prevent avoidable sight loss.

How many people have this?

It is estimated that 1 in 5 people aged 75 and 1 in 2 aged 90 and over are living with sight loss⁵. There is no definitive data on how many people have low vision. In 2011, 299,000 people in England were registered as sight impaired (blind or partially sighted)⁶. Of those, two thirds were over 75 and more than a fifth were of working age. Around a third had an additional disability, with physical disabilities and then hearing impairment being the most common. One in ten adults with a learning difficulty are thought to have a sight impairment⁷. In 2010, there were 34,492 people registered as sight impaired in Scotland, three quarters of who were over 65 and 32% had additional disabilities⁸.

The number of people with low vision will be higher than the number of people who are registered as sight impaired. Some people who are eligible to register do not do so for a variety of reasons, for example some are not offered the opportunity to register and some decline. Furthermore, as stated above, someone can have visual loss that affects their daily living without reaching the thresholds required to register as sight impaired.

The number of people with low vision is projected to increase as the population ages because most causes of low vision become increasingly common with advancing age.

What are the best value diagnostic tests?

The impact of low vision is assessed through a combination of discussions with the service user (and in some cases their family and carers) and clinical examination.

The discussion with the service user should examine how sight loss affects their everyday life, for example their ability to carry out everyday tasks (like cooking), their mobility and communication. 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 should also be noted. Assessment should pick up any problems with glare, adapting to changes in light or having hallucinations as a result of Charles Bonnet Syndrome⁹. The assessment should also note any visual aids, support or treatment the service user already has and a discussion with the service user about what they want to achieve from low vision support¹⁰.

Clinical assessment should include¹¹:

- An eye examination or evidence of recent examination or referral for an eye examination according to local protocols to confirm that the condition that has led to reduced vision has been treated optimally.
- A functional vision assessment which should include: a discussion of symptoms and issues, a refraction, assessment of best corrected distance and near visual acuity, reading ability, contrast sensitivity¹² and the effect of light on these parameters.
- If appropriate, an assessment should also be made of central visual field, peripheral visual field, and/or colour vision.

Clinical assessment should be done sensitively and adapted to fit the service users' ability so that tests are not upsetting or inaccurate¹³. LogMAR charts are more appropriate for measuring visual acuity than Snellen charts. Specific low vision charts, such as the Bailey-Lovie, exist to test near visual acuity. Sensitivity to contrast can be measured using a Pelli-Robson chart or low contrast electronic test. To assess visual fields, fixation monitoring should be turned off and the fixation target adapted to improve its visibility. In many cases, it may be enough to plot binocular fields or confrontation fields.

Given a large minority of those with low vision will have a physical disability or hearing impairment, services need to give careful consideration to how to ensure their diagnostic services are accessible and how to adapt communication.

What are the best value treatments?

There is no good evidence on the cost effectiveness of low vision treatments but interventions have been shown to improve useful vision and people's ability to carry out daily living activities¹⁴.

Low vision services commonly provide information on¹⁵:

- any eye conditions that are affecting the person's vision
- assistance with certification and registration
- welfare benefits and other financial support
- social care enablement services
- specialist education services
- relevant voluntary sector organisations.

They also frequently provide:

- emotional support
- best correction with spectacles
- low vision aids, including electronic aids, with advice on how to use them
- changes to the service user's environment
- follow up appointments as necessary
- an introduction to rehabilitative techniques

There is good evidence that providing low vision aids improves reading ability and strong evidence that patients value and use aids¹⁶. Broadly, a low vision aid is any piece of equipment used by people with low vision to enhance their vision, including:

- magnifiers –including hand and stand magnifiers, illuminated magnifiers, telescopic lenses for both distance and near, and spectacle mounted magnifiers
- electronic aids - such as closed circuit television systems (CCTVs) or specialised computer adaptations as well as mobile electronic aids, including some mobile phones, computer devices and e-readers.
- non-optical aids - such as typoscopes and large felt tip pens
- appropriate lighting.

There is mixed evidence on whether or not service users benefit if they receive training in how to use aids properly, for example through home visits or follow up appointments^{17,18,19,20}.

There is good evidence that rehabilitative techniques (such as steady eye strategy and eccentric viewing) improve the near visual acuity of people with visual loss, their reading speeds and their ability to carry out daily living tasks^{21,22,23}.

There is also a link between sight loss and reduced psychological wellbeing, particularly for older people. Over one-third of older people with sight loss are living with depression²⁴ and low vision services should have access to emotional support and counselling.

Low vision services commonly offer advice on how to adapt living and working environments, such as finding the best lighting or using colour contrast to help navigation.

Advice on welfare and financial support also form an important part of low vision services.

How can individuals and carers be best supported long term?

Flexible access, early intervention and well integrated, patient-centred services are key to supporting people with low vision in the long term.

A person with low vision should be able to use the service at any stage after low vision is identified. Access to services should not be exclusively determined by clinical parameters such as visual acuity or certification but should take account of social, emotional, psychological, educational and occupational effects. Patients should be able to access low vision assessment and services, regardless of whether or not they have been certified as being visually impaired or whether they have reached the end of the pathway for their underlying eye condition.

Early intervention is seen as an important factor in getting the best outcomes for people using a low vision service²⁵. Without support early on people can lose their skills, confidence and motivation rapidly after they suffer sight loss and vision can decline further while users are waiting to access the service. People of working age who develop low vision are at considerable risk of becoming unemployed, but early intervention may allow them to remain in employment with suitable adaptations and improve the prospects for employment for those who are not working.

Support should be ongoing to help the patient respond to changes in their condition, their overall health and their circumstances and should not be rationed to a single low vision assessment or visit from a support worker.

Low vision services need to integrate very well with other eye care services. The majority of low vision patients are referred in to the service as part of their treatment for an underlying eye condition, such as AMD, glaucoma or diabetic retinopathy.

However, integration needs to go much broader than that. People may be referred to low vision services by optometrists, GPs, social workers, rehabilitation workers and others. Furthermore, it is very common for people with low vision to have other long term conditions or disabilities. Well integrated services should consider the connections between those other conditions and vision. For example, there are low vision devices to help people with diabetes to measure their blood sugar levels and draw up their insulin. If someone has a visual impairment as a result of another medical condition (e.g. stroke) the use of low vision aids and adaptations can assist with their rehabilitation. Sight loss is one of the major causes of falls^{26,27} so low vision services should integrate with falls prevention services. Learning disability health facilitation teams can help raise awareness of sight loss issues and help integrate services.

An important aspect of low vision services, particularly in the hospital setting, is the availability of an eye clinic liaison officer (ECLO). ECLOs are often employees of charitable organisations who are contracted on a sessional basis. Their ability to

counsel people with low vision, spend more time with the person and provide information on and liaison with other agencies (social, benefits, patient groups) can be very valuable.

Correspondence from the low vision service should be shared with the service user but also with other teams involved in their care (such as the GP, falls team, visual impairment specialist in social services, care teams within the voluntary sector, specialist education services) and vice versa.

Helping carers to understand the patient's eye condition and its impact on vision and lifestyle can also be valuable and carers themselves may need emotional support²⁸. This can be provided as part of a low vision service.

Successful systems of care: pathways and service models

There is currently no standard model of delivery in the UK and international evidence does not recommend one model²⁹. Low vision is delivered by a wide variety of providers using different strategies to operate at the interface between the health, social care and the voluntary sectors, offering different aids, rehabilitation and at different intensities

However, under the UK Vision Strategy a cross-sector group of low vision practitioners and patient representatives has developed an integrated [model Adult UK sight loss pathway](#) which lays out the principles of a quality integrated system of service responses³⁰.

The Local Optical Committee Support Unit has developed an [adult community optical low vision service pathway](#)³¹.

Integrated low vision services span health and social care and voluntary services. There is much potential for those clinical commissioning groups, local authorities and voluntary groups to jointly fund and provide the services. Low vision services should be a dedicated part of the programme budget for eye health.

Examples of service models: Welsh community model

Since its introduction in 2004, the community Welsh low vision service has demonstrated a positive impact on service users' visual ability, positive feedback from users, a reduction in waiting times with no significant difference in effectiveness when compared to hospital services^{32,33}.

The service is provided by community optometrists, dispensing opticians and ophthalmic medical practitioners. The clinicians must complete additional training and an assessment to be accredited before they can participate. Once accredited, the clinicians are provided with £1000 worth of low vision equipment and aids. Services users can access the scheme through multiple routes: a sight test, the hospital eye service, GPs, rehabilitation workers, teachers, social workers, voluntary organisations, self-referral or a family or friend. Clinicians were paid £67 for an assessment and this fee covered any follow ups in the first year (figures for 2011). The service also developed so that information was shared with low vision rehabilitation teams in social care who could then integrate with the low vision service.

The community model significantly increased access to low vision support in Wales. In the first 9 months after it was introduced, the number of appointments increased by over 51% yet at the same time waiting times fell significantly. Previously, half of service users waited 6 months or more for an appointment whereas after the community scheme began, 70% were seen within two weeks³⁴.

Examples of service models: Surrey integrated eye care pathway

Surrey is working to integrate low vision services into a visual impairment pathway alongside health and social care. In this model, patients who have problems with their vision can choose to visit an optometrist or GP for an initial assessment who can then refer directly to ophthalmology for further diagnosis and, if necessary, treatment for the underlying eye condition. People with low vision needs are then offered a range of interventions from low vision aids to more comprehensive support from the Surrey Association for Visual Impairment, a charity, including specialist rehabilitation, emotional support and help with certification. Where appropriate, service users are offered a social care assessment then support. The aim is that people with low vision will then be actively monitored in the community, perhaps by an Eye Care Liaison Officer or by using a virtual ward system.

Service models and training

Although not within the scope of this document, commissioners are also urged to consider the impact commissioning decisions can have on training opportunities for the medical and non-medical workforce delivering these services. It is hoped that the guiding principles with different examples of delivering low vision services can be used to help commissioners and providers provide the best service for their local needs.

How to compare services based on activity, quality and outcome

At present, commissioners cannot compare different low vision services in terms of cost, activity, quality and outcomes. Compiling an annual quality report for low vision is the first step to understanding these issues. The production of an annual low vision report as a collaborative initiative between commissioners, providers and other stakeholders (e.g. organisations representing patients with sight loss) is one way to ensure that there is an effective, efficient and safe population-based framework for low vision services. Commissioners can then use the report to inform commissioning decisions.

[Seeing It My Way](#) is a universal outcomes framework to assess services for sight impaired people³⁵. Developed by sight impaired people, it recommends ten outcomes and is included in the following section on measuring outcomes.

The RNIB has produced a [Low Vision Services Assessment Framework](#) which is a tool for assessing the quality of care offered by providers of low vision services³⁶.

Seven questions from the National Eye Institute Visual Function Questionnaire have been used together to evaluate outcomes in the Welsh Low Vision Service^{37,38}.

This section recommends objectives for a whole low vision service and how they should be measured with a view to being published in the annual report.

Objectives	Criteria	Outcomes	Standards
<p>Patients are able to make the best possible use of their residual vision in their daily life.</p>	<p>Performance against a recognised measure of visual functioning</p>	<p>Periodic audit of service users to assess the service's impact on visual functioning using a recognised questionnaire.</p> <p>Recognised tools include, amongst others: Seeing It My Way³⁹, the Manchester Low Vision Questionnaire, the Vision Related Quality of Life Questionnaire, and modified versions of the Massof Activity Inventory⁴⁰ and National Eye Institute Visual Function Questionnaire⁴¹.</p>	<p>Standards will depend on the tool used.</p>
<p>Patients are seen promptly</p>	<p>Timely assessment of patients following referral to the Low Vision Service, with provision for urgent assessment of patients who appear to be at imminent risk of harm</p>	<p>Periodic audit of service user records to measure waiting times for (a) urgent and (b) non-urgent referrals.</p>	<p>Baseline: 50% of non-urgent assessments should be undertaken within 6 weeks of referral and 95% within 18 weeks.</p> <p>Urgent assessments should be conducted within 2 weeks of referral.</p> <p>Achievable: 90% of assessments should be undertaken within 6 weeks of referral.</p>

<p>Patients eligible for social welfare support receive it promptly</p>	<p>The length of time it takes for those who are eligible for financial support to have their entitlements processed and paid.</p> <p>Monitoring this will require close working between the low vision service and local authorities responsible for administering payments.</p>	<p>Periodic audit to assess how long it takes service users to begin receiving financial support for which they are eligible.</p>	<p>Standards to be agreed.</p>
<p>Patients find the service meets their needs and is responsive to them.</p>	<p>Performance against a recognised measure of service user satisfaction</p>	<p>Periodic audit of service users to assess the extent to which they are satisfied with the service.</p> <p>A recognised tool, such as the Seeing It My Way framework⁴², should be used.</p>	<p>Standards will depend on the tool used.</p>

References

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