Impact survey on the commissioning and provision of low vision assessment services in England

Background

The impact of COVID-19 has resulted in many low vision assessment clinics being cancelled, and assessments carried out via remote consultations. Initial returns have shown a significant fall in certifications of visual impairment during lockdown periods[1]. Service provision has been challenging, with deployed clinical staff, patients and some practitioners shielding, and lower clinic numbers to maintain distancing.

Our online survey was conducted for five weeks from 5th April 2021 to gain an understanding of the impact on low vision assessment services in England between April 2020 – March 2021.

Summary of Survey Findings

Prior to the pandemic

- No consistency in use of service specifications within contracts.
- Majority of services (59%) have low vision assessment protocols in place.
- Clarity needed for thresholds for low vision assessment referral pathways.
- Access to domiciliary low vision assessment is limited or not available.
- 45 of 49 (92%) trusts that responded reported access to an Eye Clinic Liaison Officer (ECLO).
- 21 of 23 (91%) charities that responded reported access to an ECLO.
- 11 of 45 (24%) of optical practices that responded reported access to an ECLO.

Since the pandemic:

- No consistent response to lockdowns/ delays caused by the COVID-19.
- Low vision assessment services provided by Trusts affected the most compared to those provided by charities or optical practices.

- 20% of patients were not contactable to arrange a remote consultation.
- 22 of 49 (45%) of hospital trusts expected their backlog to be cleared within 4 months.
- 12 of 23 (52%) of charities expected their backlog to be cleared within 4 months.
- No backlog reported by primary care optical practices providing low vision assessments.

Common Themes from comments received

- No consistent response to lockdowns/ delays caused by the COVID-19.
- Telephone consultations have reduced time spent for face-to-face appointments and allowed remote follow-up.
- Positive patient feedback on these changes, less support for remote low vision assessments.
- ECLOs played an invaluable role in contacting patients and coordinating services during the pandemic.

CCEHC Recommendations

1. **Manage low vision assessment backlogs by:**
    - risk assessment of patients waiting to prioritise those in greatest need.
    - triage to interim support by another part of the system.
    - aiming to clear backlogs within 6 months.

2. **Review existing low vision service provision (demand and capacity), protocols and pathways to**
:
    - scope potential for more integrated services.
    - incorporate remote consultations for prioritisation and follow-up as appropriate e.g., patient initiated follow up, access to advice and guidance, review to check managing with existing aids/ new requirements.
    - ensure there is domiciliary provision for those in need.

- ensure ECLOs are core members of the low vision service team and link across primary, community, hospital and social care.
- include provision of information on digital assistive aids (e.g., digital magnifiers) and signposting to IT courses for those who are visually challenged.

3. **Develop system wide services specifications and quality standards for integrated low vision care to:**

    - ensure consistent access and availability of services.
    - offer a choice (where possible or appropriate), across primary, community, local authority and hospital services.
    - provide processes for governance, audit, engagement, service improvement, and review of services provided.
    - identify a dedicated (ring fenced) low vision budget that can be accessed system wide (primary, secondary and tertiary) to ensure a sustainable service.

The CCEHC would like to thank the many respondents who completed the survey and provided detailed commentaries describing their response to minimise the impact of the pandemic. Many providers have tried to ensure safe services and looked to innovative solutions. The learning from COVID is already changing the way some low vision services are delivered.

We encourage all commissioners and providers of eye health services to review their current low vision assessment service provision, particularly use of remote consultations for pre-assessment review and follow-up / monitoring; and their processes for ensuring equitable access to services meeting consistent standards of care. The development of more integrated low vision services has significant benefits for patients, practitioners and organisations across health and social care'

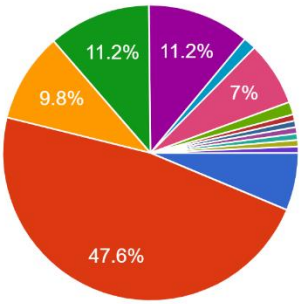
[1] Sight impairment and severe sight impairment certifications and registrations update. https://www.rcophth.ac.uk/2021/03/sight-impairment-and-severe-sight-impairment-certifications-and-registrations-update/

Survey Responses

1. Identification questions

1.a. Please indicate your professional background.

143 responses

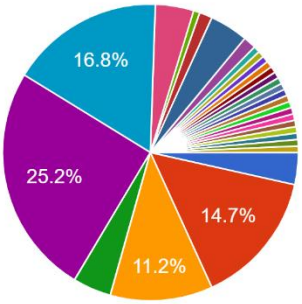


- Ophthalmologist
- Optometrist
- Orthoptist
- Dispensing Optician
- Eye Clinic Liaison Officer
- Nurse
- Rehabilitation Officer Visual Impairment
- Other

1/2

1.b. Capacity in which you are responding? Click main role only

143 responses

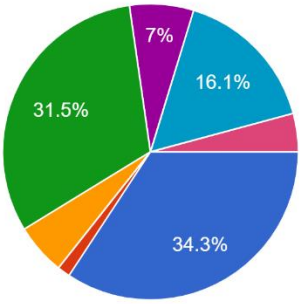


- Clinical Director
- Service Lead
- Eye Clinic Liaison Officer (ECLO)
- Optical Practice LV Service lead
- Primary Care Practitioner
- Secondary Care Practitioner
- Local Optical Committee Lead
- Local Eye Health Network Chair

1/4

1.c. Your organisation?

143 responses

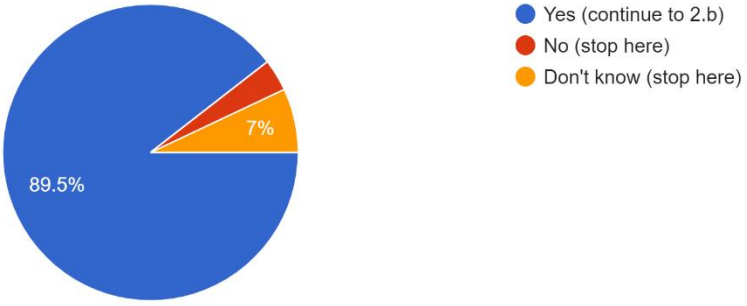


- Trust
- Commissioner
- Local Authority
- Optical Practice
- Local Optical Committee
- Charity
- Other

2. These questions relate to the Low Vision Assessment Service in your area – PRE-COVID-19 (UP TO 31 MARCH 2020).

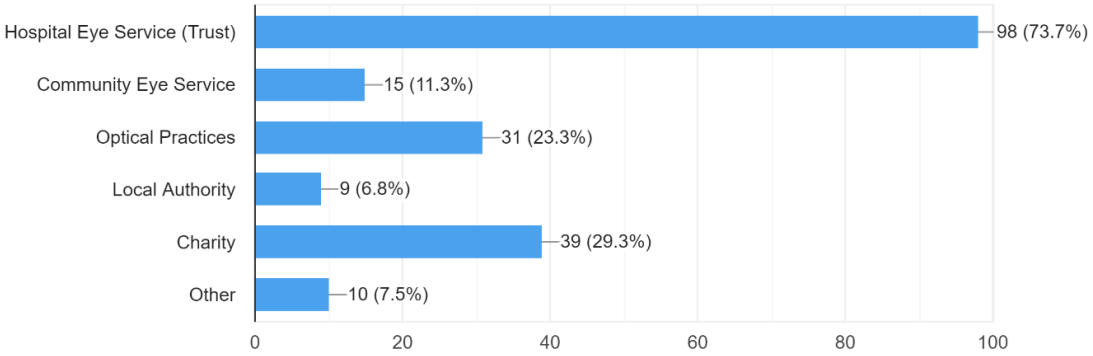
2.a. Was there a Low Vision (LV) assessment service in your area?

143 responses



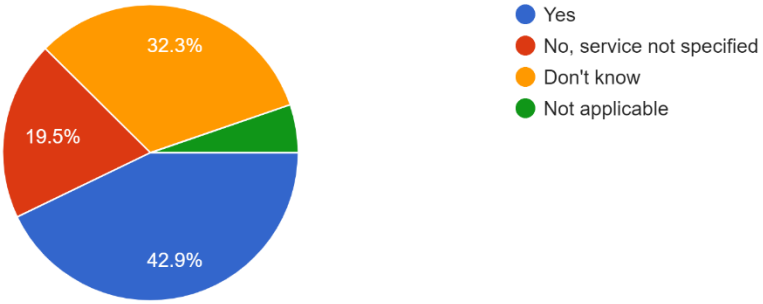
2.b. Which organisation(s) provided the LV assessment service(s) in your area? Please click all in your area.

133 responses



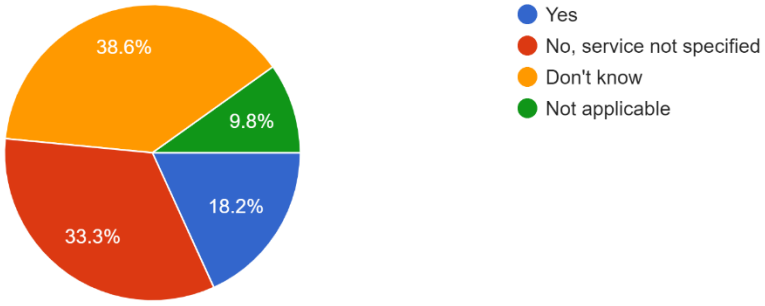
2.d. Were any LV assessment services provided under a specific service specification within a NHS contract with the Hospital Eye Service (Trust)?

133 responses



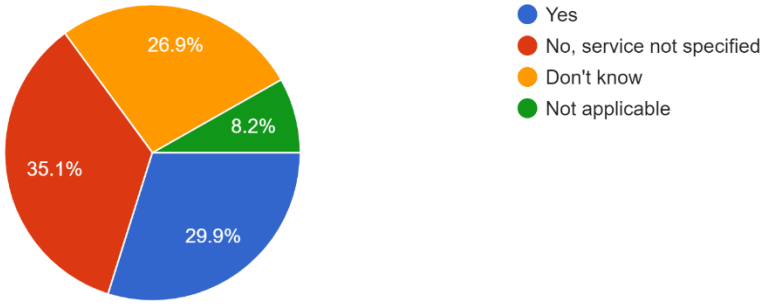
2.f. Were any LV assessment services provided under a specific service specification by Local Authorities or within a contract by Local Authorities?

132 responses



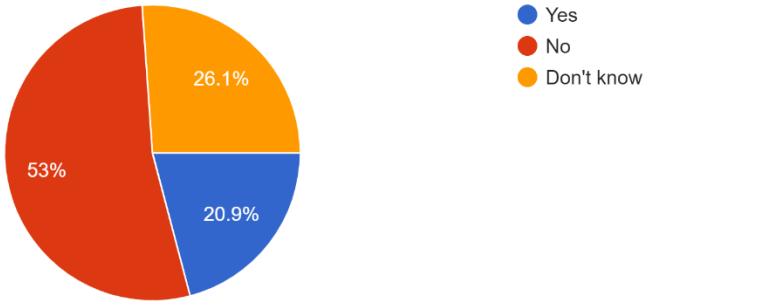
2.g. Were any LV assessment services provided under a specific service specification within a contract with Charity organisations?

134 responses



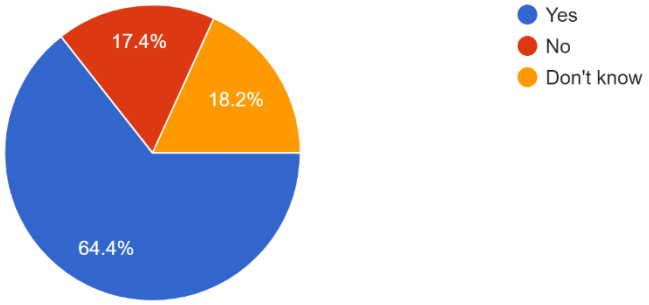
2.h. a. Did this include a domiciliary LV assessment service for the housebound?

134 responses



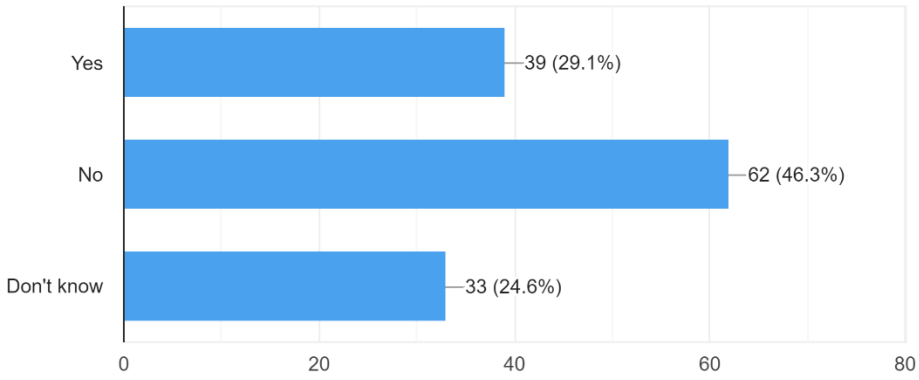
2.j. Did the service include LV assessment for children and young people?

132 responses



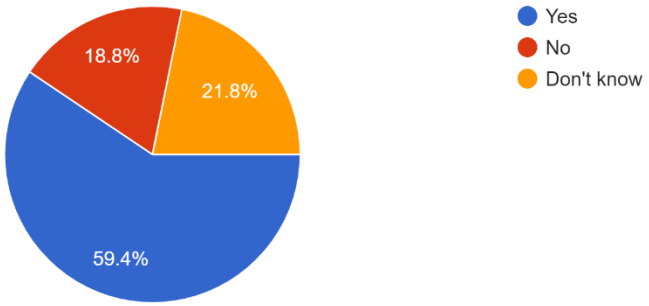
2.k. Were there any local referral thresholds in place for a LV assessment?

134 responses

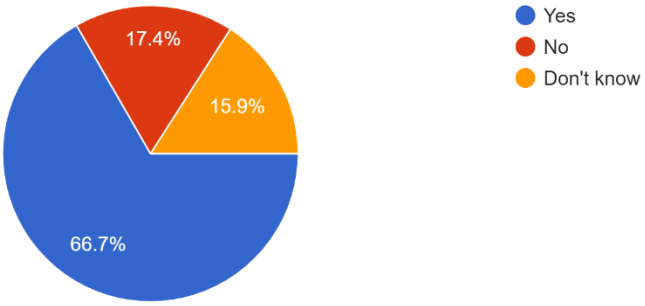


2.l. Did the service have a protocol for LV assessment?

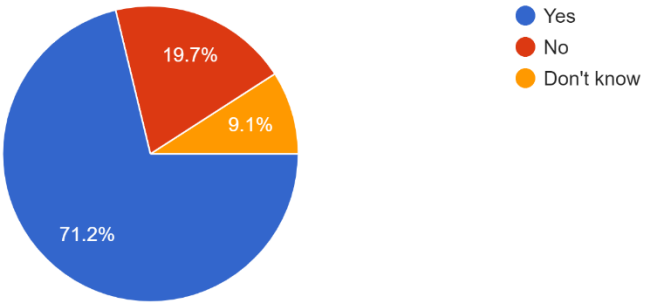
133 responses



2.m. Did the service make provision to support patients with information on digital assistive aids (e.g. what is available, how to use them, where to them)?
132 responses

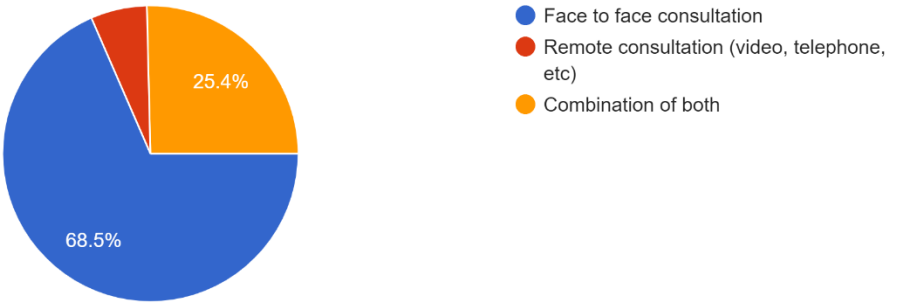


2.n. Did the LV assessment include access to an Eye Clinic Liaison Officer (ECLO)?
132 responses



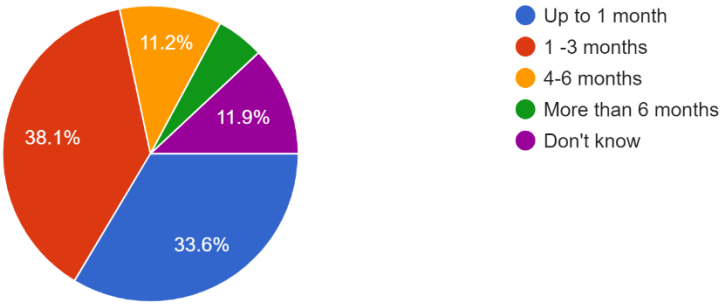
- 45 of 49 (92%) trusts that responded reported access to an ECLO.
- 21 of 23 (91%) charities that responded reported access to an ECLO.
- 11 of 45 (24%) of optical practices that responded reported access to an ECLO.

2.o. How was the LV assessment service delivered? Please click the ONE that applied for MOST patients?
130 responses



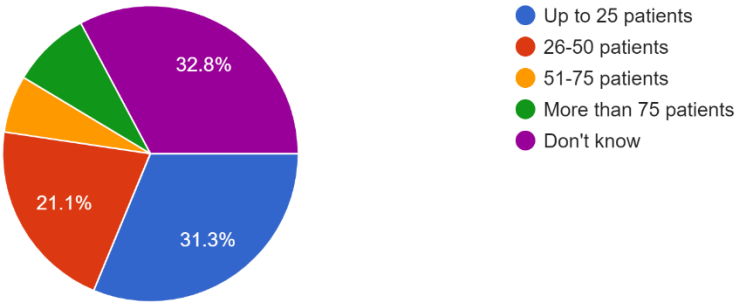
2.q. What do you think was the average waiting time from referral for a new LV assessment for MOST patients?

134 responses



2.r. If you are directly involved in service provision, how many patients do you think your service was seeing per month for a face-to-face LV assessm...e likely LV assessment activity was in your area.

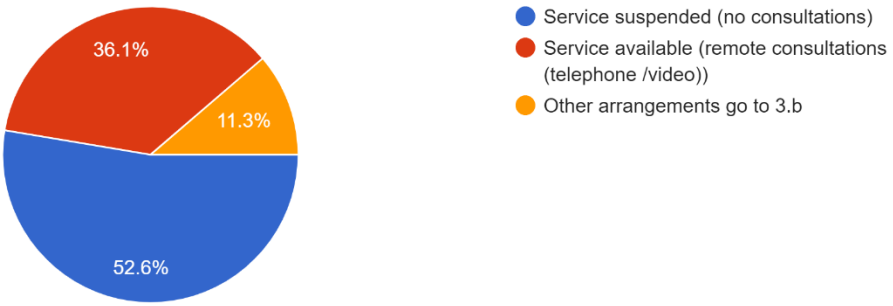
128 responses



3. These questions relate to the LV Assessment Service in your area - COVID-19 period April - June 2020 (inclusive).

3.a. How was the LV assessment service affected during first national lockdown (April - June 2020 inclusive)?

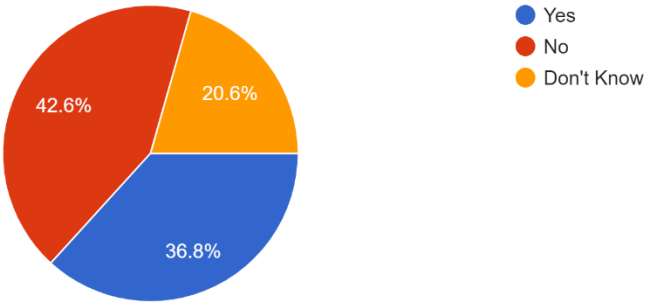
133 responses



4. COVID period July 2020 - March 2021 (inclusive)

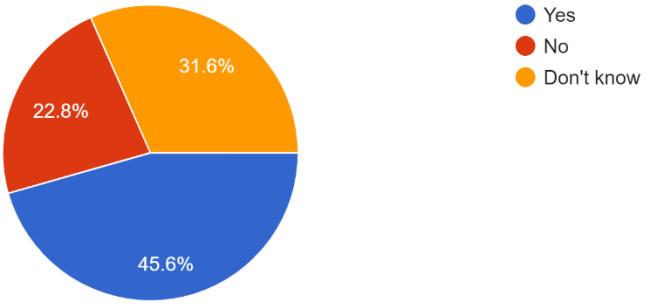
4.a. Did the full scope of the pre-COVID-19 Service get re-instated?

136 responses



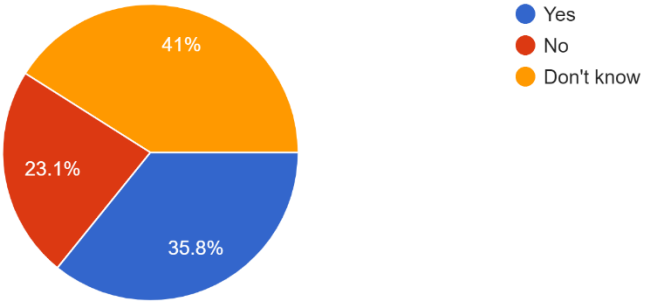
4.b. Were patients prioritised for LV assessment?

136 responses



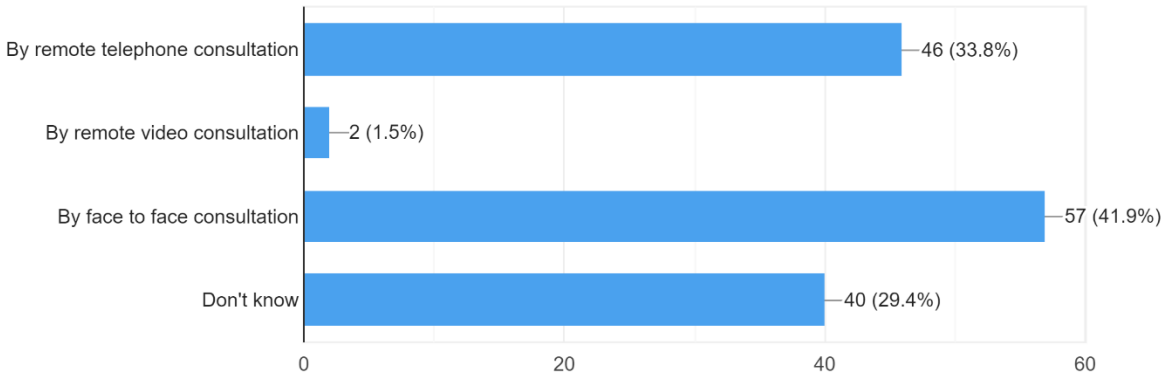
4.c. Did this involve a risk stratification of their need for a LV assessment?

134 responses



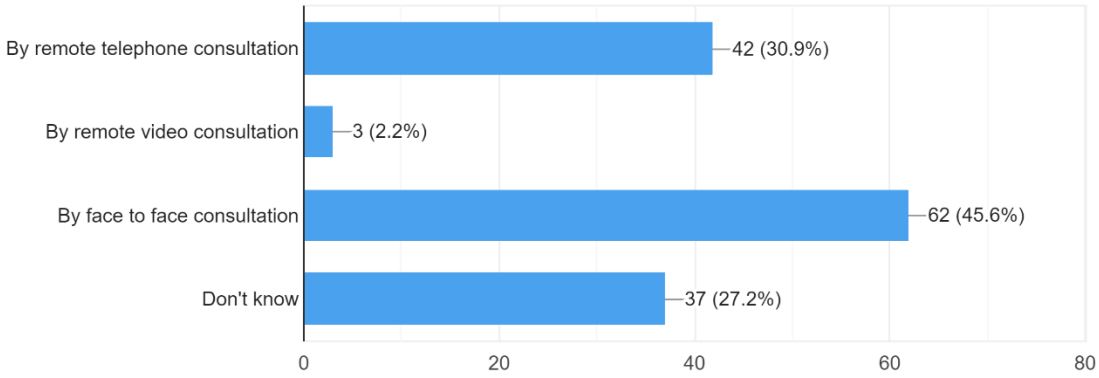
4.d. How was the service provided between July 2020 - December 2020 (inclusive)? Click ONE that applied to MOST patients.

136 responses



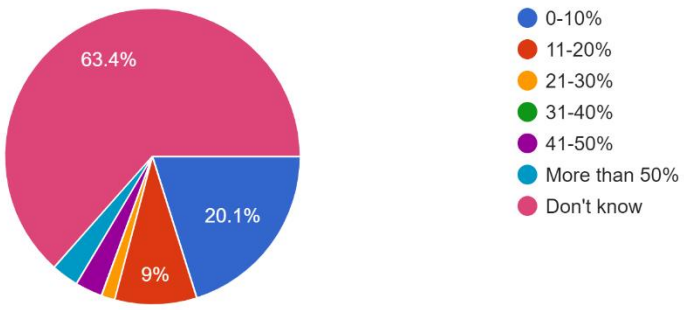
4.e. How was the service provided between January 2021 - March 2021 (inclusive)? Click ONE that applied to MOST patients.

136 responses



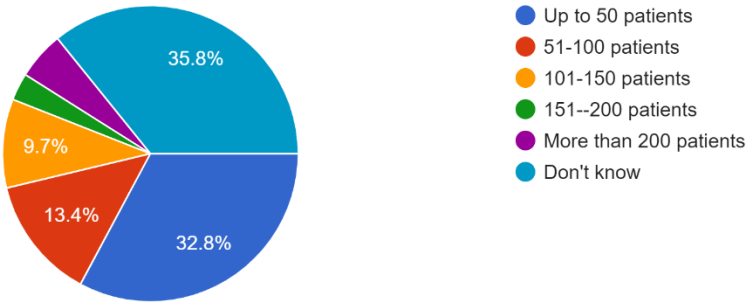
4.f. Approximately what % of patients were NOT contactable to arrange a remote consultation?

134 responses



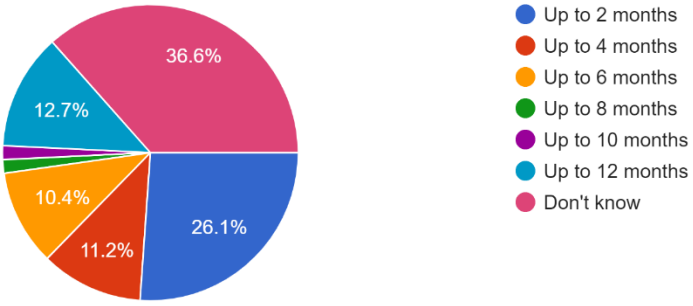
4.g. How many patients do you think were in your LV assessment service face to face backlog of patients waiting to seen?

134 responses



4.h. How long do you think it will take to clear the backlog on face to face LV assessment appointments?

134 responses



22 of 49 (45%) of trusts expected their backlog to be cleared within 4 months.

12 of 23 (52%) of charities expected their backlog to be cleared within 4 months.

5.a. If you have any further comments, please provide here.

Common Themes from Comments

Impact of COVID on service provision

- *A lot of patients were shielding or elderly and afraid to go out especially into the hospital environment. They were happy to have remote appointments, especially as hospital low vison appointments were suspended.*
- *Services differed across the whole of the country with people accessing different levels of service and some receiving no service at all.*

- *Hospital clinics have not yet restarted due to lack of room space.*
- *Paediatric service was managed via video consultations.*
- *There is no backlog where I work. It was cleared over the course of a couple of months after the first national lockdown. Patients currently wait approximately 1-4 weeks for a low vision appointment, as they did pre-COVID.*
- *We have already cleared our backlog of patients through face-to-face appointments, phone consultations and some patients stating they do not want/need to be seen.*
- *We have a community based low vision service which has meant patients have been able to be assessed in their local optical practices and have felt very safe due to the procedures we have put in place.*
- *We are in the process of setting up a process for patients to be seen by optometrists in primary care for this but as with everything this is taking some time!*

Remote consultations

- *A telephone low vision service with a new protocol and guidance got Trust approval. Although an NHS trust service, we work jointly with local RW/ROVIs (charity and provider of all home-based needs assessment) in an approved service agreement.*
- *Telephone clinics were surprisingly useful during the pandemic and will continue to be used by us but less frequently. They may become obsolete as patients are vaccinated and not shielding etc.*
- *Most patients were grateful that the service continued through a telephone service. Low vision aids could be easily posted out for patients with information leaflets. This method of care may continue for follow up patients who are managing with their magnifiers. Having an open communication pathway, where patients can contact the low vision service at the hospital provided reassurance. Creating e-referral pathways with the ECLO and adult social services made any transfer of care smooth and streamlined.*

Inequity of service provision

- *xxxx has a disjointed service, some areas have a good service provided by the community commissioned optometrists and a commissioned service from xxxx and home assessments pre COVID (telephone consultation post COVID). There are areas which had the LVA service removed due to loss of funding. There has been no service for people living in xxxx who attend xxxx. There is inequality across the county but also people's health and independence are put at risk.*
- *Local low vision centre has undergone change in last month owing to new contract - therefore no more domiciliary visits are allowed.*

Eye Care Liaison Officers (ELCOs)

- *We have moved to providing an ECLO service that is almost exclusively telephone. All patients have ECLO telephone intervention before their LVA assessment so to maximise the time with the optometrist and get the "ball rolling" with emotional and social support and registration. We sort out the CVI by post (we did this pre-pandemic too).*
- *ECLOs have been helping low vision provision in the department by completing some of the assessment (social needs) prior to their optometrist assessment to create clinic capacity and reduce the amount of face-to-face clinic time needed.*
- *Our ECLO has been an invaluable support.*

Rehabilitation Officer for Visual Impairments (ROVIs)

- *I do believe that the key to both visual impairment and low vision should be built around the rehabilitation process.*
- *We worked in tandem with the sensory impairment team and provided telephone consultations as needed. Very little back log currently. Clients were very happy to have remote appointments, especially as hospital eye service low vision appointments were suspended*.

- *Social services receive referrals from xxxxxx hospitals. Patients are not being referred for low vision assessment within these hospitals and as a rehabilitation service, our priority within a visual impairment (VI) assessment is low vision and the local authority designates a high percentage of its VI budget to low vision. There is no backlog. All low vision assessments are completed during VI assessment within the home and are reviewed 6 weeks later.*

Integration/ post COVID

- *We need a reminder of the local low vision assessments and routes that are available via referral and non-referral options. We, as primary care practitioners, need to have an idea of the timescale, how the patient is then contacted, and in which format their low vision assessments and reviews will take place.*
- *What is really lacking is a well-structured community service, with good accessibility regardless of postcode and transport. Most patients make private arrangements or just give up.*
- *We have transformed our way of running the service during COVID and have now transferred to new patient telephone assessment using a proforma and then a shorter face to face assessment. The pre consultation phone assessment has reduced time the patient needs to spend face to face, therefore reducing the COVID risks. This has worked well, and patients & their carers have given good feedback regarding the changes.*
- *A new post-COVID commissioned service should involve primary care providers along with the hospital eye service and the voluntary sector as appropriate. In my opinion the hub should be the local low vision society.*
- *It is time to revamp low vision service provision - current commissioning seems to be a win-lose situation - if local opticians are contracted the hospital or charity loses out when in fact there is so much unsatisfied demand out there everyone could be involved. I'd like to see a voucher system so that following a sight test a voucher is issued that the service user can take to any charity, hospital or optician of their choice to get a low vision assessment, a further voucher could then be used for basic optical / non-optical appliances.*

Full commentary from an integrated low vision service hosted by a sight loss charity.

At the beginning of lockdown 1, we had 30+ new referrals waiting for a low vision assessment. Referrals come from variety of sources including Adult Social Care and NHS Falls Teams. For those that we had CVI's or referral information from their community optometrists, we arranged starter packs of equipment including a desktop daylight lamp with magnifier, antiglare glasses, 8D hand magnifiers plus a base for these and 2 daylight bulbs for the ceiling - these were delivered out to the patients along with large print literature about their eye condition. The rehabilitation officer rang a few weeks later to see how useful these packs had been. It became apparent that written instructions were required on how to use everything so large print instructions were prepared to go with any future equipment. We have also designed some 'how to' You tube videos.

Before June 2020, the low vision service was suspended although we were available to speak to people who rang the office with regarding eye health queries or who the sensory support team, supporting the Local Authority response directed to the service. Many of these queries related to eye health concerns, visual hallucinations, or broken magnifiers. We spent some time understanding how the College of Optometrists and NHS England guidance applied to the service and how the low vision service could function remotely. From the beginning of June 2020, we started to implement a formal triaging process where the lead optometrist and the rehabilitation officer rang new referrals and those who had been struggling with the packs of equipment already sent out.

We also started remote triaging everyone due to be offered a 2-year review. Anyone who could not be helped from this triage call was offered a 'remote consultation' (where the College of Optometrists vision chart, reading charts, contrast chart were sent out and an appointment call was arranged - so far only one person has not been at home for this specified appointment time) or added to list to be offered a F2F appointment once available.

F2F appointments started again in September 2020, but with very reduced capacity and prioritising those who could not be helped over the phone.

Since the end of December, we have increased the capacity and prioritised new referrals (plus the back log of new referrals from March 2020 onwards) and review patients who had been identified via triage calls as potentially would be better served by attending for an appointment. Before Covid, all review patients were offered F2F appointments; there was no other option regarding access to replacement magnifiers or to speak with the optometrist. We have now found approximately 3/4 of the review patients have been helped over the phone. It remains to be seen if they will ring and ask to come in as the situation improves and restrictions are lifted. We have also found that a number of the people who live on their own and were provided with basic low vision equipment just as we went into lockdown 1 have not realised its full potential until attending for a recent F2F appointment where its use could be demonstrated. Many people struggled as they didn't have anyone visiting who could help read the large print instructions we provided. They said 'yes they were using it' when rang by our team to follow up, but the reality has turned out to be different. These people have really benefited from attending for F2F appointment to run through that original equipment and to identify if anything else may be more suitable.

We continue to offer the option of a full remote consultation and now offer approximately 2 low vision clinics each week but with only 3 people attending a clinic. We are still allocating appointments to allow for the cleaning and change of patients so there is no-one else in the waiting room. We continue to run a triaging clinic a minimum of once week.

The majority of review patients that have been seen have had a substantial drop in vision since their last appointment and have been referred for a change of registration status. We have seen an increased number of CVI referrals since the end of December and anticipate this to continue to increase as the hospitals get through their backlog. Before Covid-19, the low vision clinic was completing paper-based, but to implement the remote triaging from home, we have been granted access to the services Charitylog IT system that houses the Client database, and we are now uploading low vision outcomes onto this system along with the wider support service provision. As

we have no access to the NHS spine, we started requesting past HES letters and GP summaries by NHS email from June 2020 to aid the remote triaging. From this experience we have noticed that the HES are not always informing the GP what has been occurring throughout the past 12 months regarding eye appointments or discharging patients. Often the last HES letter is dated months previous to Covid-19 despite patients reporting they have attended for injection appointments or CVI registration. Moving forward it would be helpful if community low vision services have access to the NHS Digital solution for primary eye care, both as a referral point and to allow review of patients past history. Despite the challenges, the circumstances brought together the different services provided by our organisation; and allowed Low Vision, Rehabilitation, Care Act Assessment and Vision Support (digital and counselling) to become more integrated than they were run before. The low vision clinics have supported over 570 people and provided 80 face-to-face appointments since the pandemic started. [Postscript: the service has noted a sharp rise in referrals from CVI registration and the Stroke Association since early June].