

Low vision co-management

Summary

The provision of low vision aids is often seen as a Cinderella subject by many optometrists, and much of the supply is undertaken by dispensing opticians or even unqualified volunteers. The provision of LVAs is patchy, with many areas offering no service at all, yet optometric practices are well suited to this service.

The extent of the need for this provision is unquantified, and is likely to be substantial, but the outcome for the recipients may be a substantial improvement in the quality of life. By seeing better many can become more independent and thus reduce dependence on other state services. In this way the total cost of the care of the patients will be not be increased by the additional cost of the low vision service.

As with many of the co-management schemes, multi-disciplinary working is essential, and optometrists need to keep an open mind about “who does what”. Unlike many of the other schemes the active involvement of the voluntary sector is a probability and an asset.

Optometrists are ideally suited to provide low vision services. They have the necessary core skills, and are located in the community. This is particularly important in this service as the recipients are likely to have mobility problems.

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Background

Definitions

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 their everyday life.

A low vision service is a rehabilitative process, which provides a range of services for people with low vision to enable them to make maximum use of their eyesight to achieve maximum potential.

A low vision aid is any piece of equipment used by people with low vision to enhance their vision.

Low vision training is any individually tailored tuition in the use of low vision aids¹.

The size of the problem

Low vision is a disability which can substantially reduce the independence of the person, and handicap their lifestyle significantly. The total number of visually impaired persons in the UK is unknown, with many not being registered as blind or partially sighted.

RNIB published figures are as below:

	ONS Population Estimates	Estimates for 1996 based on RNIB prevalence rates Breakdown of VIPs by age group					Registered Blind & Partially Sighted People as at 31st March 1997		
	All ages	0 to 15	16 to 64	65 to 74	75 plus	Total VIPs	Blind	PS	Total
England	49089100	20110	138410	104830	634020	897370	158590	138176	296766
Wales	2921100	1200	8340	6960	40640	57140	8955	8458	17413
Scotland	5128000	2060	14960	11100	59710	87830	22777	11049	33826
N. Ireland	1663300	830	4430	3050	16090	24400	3634	2514	6148
UK Total	58801500	24200	166140	125940	750460	1066740	193956	160197	354153
GB Total	57138200	23370	161710	122890	734370	1042340	190322	157683	348005

89% of the visually impaired are over 60, and with increasing mobility problems this impairment can be disabling, leading to dependence on others. Thus the provision of LVAs, sometimes as simple as a magnifier, can lead to substantial improvements in the quality of life. A number of studies have shown that falls in the elderly are associated with poor vision^{2,3}. Life expectancy is increasing, but there is, as yet, no cure for some of the visually disabling conditions of old age, such as age related macular disease.

LVA provision is patchy, with many areas (perhaps as many as 40%) offering no service at all. Where LVAs are provided this may be through the secondary sector, yet attendance at the HES may be problematic for the elderly visually impaired, who, almost by definition, will not be able to drive. There is also the issue of funding- LVAs can be expensive and provision through the HES budget may impinge on other spending, but failure to provide these aids may increase expenditure through social services. There has been a reluctance to establish community based NHS low vision services and any optometrist who dispenses an aid to a patient currently has to charge a private fee for this sometimes complex and time consuming work. In many cases this may be prohibitive as the aids can have a high unit cost.

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All optometrists receive training in the optics and dispensing of low vision aids, guidance in vision enhancement and patient assessment techniques. In many respects a low vision assessment is simply an extension of a normal eye examination and requires just extra time, enthusiasm and interest from the practitioner, rather than significant additional training.

A framework for LVA services has been outlined by a multi-disciplinary working group this document was endorsed by the Secretary of State for Health. It recommends the establishment of a Local Low Vision Services Committee by each PCT. It also recommends:

- a person with low vision should be able to use low vision services at any stage after low vision has been identified
- access should not be exclusively determined by clinical parameters such as visual acuity
- that the person's GP should be kept informed
- that a full eye examination by an ophthalmologist or optometrist has been carried out. There should be re-examination annually by an optometrist or OMP
- services should be provided as close to the person's own home as practicable
- mechanisms should ensure inter-agency referral and information exchange to ensure a seamless service
- those supplying low vision aids should ensure that the user is trained in the optimal use of their vision and the LVAs
- all elements of the service should be subject to regular, professionally conducted clinical or service audit.

The College of Optometrists has produced a framework for a multi-disciplinary approach to low vision⁴.

References

1. Low Vision Concensus Group. Low Vision Services. Low Vision Services 1999; Low Vision Services:1-31.
2. Ivers RQ, Cumming RG, Mitchell P, Attebo K. Visual impairment and falls in older adults: the Blue Mountains Eye Study. J Am Geriatr Soc 1998;46:58-64.
3. Jack CI, Smith T, Neoh C, et al. Prevalence of low vision in elderly patients admitted to an acute geriatric unit in Liverpool: elderly people who fall are more likely to have low vision [see comments]. Gerontology 1995;41:280-5.
4. Framework for a Multidisciplinary Approach to Low Vision. 2002. The College of Optometrists.

Low vision development

The development of a low vision co-management scheme

Overview

In many respects the establishment of a low vision aids scheme is more problematical than many of the other co-management schemes.

- The uptake of optometrists interested in providing these aids is likely to be lower than many of the other schemes. However this may also be seen as an advantage as it allows a higher volume of patients in each participating practice, with a commensurate increase in experience based skills, and possibly permits the stocking of a wider range of aids
- Unlike most co-management, “products” have to be stocked and provided, which requires agreement on which aids will be stocked, who is responsible for the start-up costs, and how these are re-ordered
- Patients are likely to be less mobile, sometimes house-bound and so allowance has to be made for domiciliary visiting (could be 20% or more)
- There will need to be involvement of a disparate group of organisations, some non-medical. (q.v.)
- From which budget do fees and charges fall - primary or secondary sectors of the NHS, or Social Services, or even the voluntary organisations?

Each scheme will need to evolve to meet the local need, and should be designed to promote independence for the visually handicapped.

In any proposal the delivery system should ensure that the process reaches acceptable levels of quality, but also that it is patient centred. Initial discussions should include representatives of visually impaired persons themselves to ensure that any proposed service meets their needs. It should also be planned to allow for expansion as the number of the elderly increases, and be accessible to those who need the service.

Registration as blind or partially sighted should not be a necessary requirement for access to the service.

With all co-management schemes it is important to ensure that all members of the patient care team work together to produce a system which is patient centred, but has the approval of all of the team. In low vision it is essential, especially with respect to the relationship with social services and the local voluntary sector.

The team approach

In any modernisation agenda it is vital to ensure that all interested parties are consulted, and feel that they are part of the process. A list should be produced which includes all of those who are party to the present arrangements, and those who will be affected by any change. It would include ophthalmologists, optometrists, dispensing opticians, social services, the voluntary sector, self help groups, LOC, LMC, HA, PCT, clinic managers, orthoptists, carers and anyone else who can conceivably be considered as having an interest. If there are persons in the area, from whichever group, who have experience in the provision of LVAs they should be considered for inclusion.

This will form the main group who will be consulted over the process of change, but a smaller change management team would need to be formed to design the new pathways. It is vital at this stage that careful consideration is given to those who are invited to participate in this group, and optometrists should be prepared to be participants but not the prime movers. This group will also need to consider funding, so those with access to this (HA/ PCT/ Social Services) should be attending.

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An analysis of the current arrangements, including costs, should be undertaken as a preliminary task, although it may be difficult to determine how much the existing provision costs. A business case for the service may need to be prepared.

Home visits may be undertaken to assess both the environment (lighting etc.) and subsequently to discuss the use of the provided LVA, plus possibly to determine if other aids (both visual and others) would be useful. These visits may be carried out by different members of the team, for example the optometrist and/or home visit volunteers from the local voluntary sector. Provision may need to be made for the recovery of loaned LVAs from those who have no further use for them.

A patient pathway flow diagram will assist in the planning, and this should show how the service is accessed, who does what, who can refer into the scheme, and at what point. It may also need to address the wider assessment of the needs of the patient. The whole service to the patient needs to be integrated- visual aids are only part of the overall care of the visually impaired person- and this may include mobility advice, benefits, home adaptation etc.

Co-ordinator

It could be advisable to have a co-ordinator who will ensure that appropriate patients are identified by all of the “referring agencies” and directed to the optometrist who can provide the service most conveniently for that individual.

Referring agencies could include hospital based ophthalmologists and optometrists, community optometrists who are not participants in the scheme, GPs, social service departments, community nurses, and the voluntary sector (for example local societies for the blind).

The co-ordinator could also be responsible for maintaining a list of aids stocked by each practice, so that these can be re-located for trial by individual patients in another optometrist’s area. The co-ordinator may also arrange the ordering of top-up stocks for optometrists when these are issued to patients, and for the dispersion of returned aids when these are no longer required by the issuing practice. One area has each aid supplied marked with a tracking number, which is used to see which individual aids have been supplied most often, and can help in deciding when to replace them.

Patients would be provided with a list of participating optometrists (in large print!) and information on how the scheme works, what can be provided, and which would emphasise that a return to normal vision is not possible. A preliminary assessment form could also be provided.

Follow up after the first assessment is essential, and the co-ordinator would be responsible for maintaining a register of when patients had been seen (cf diabetes register). The co-ordinator may be responsible for ensuring that the system is audited and this should take into account the views of the users of the service.

Ophthalmologists

At the moment entry to the registers of the blind and partially sighted is through an ophthalmologist. A requirement to be registered may cause a blockage in the referral system, especially as many visually impaired patients are not on the register.

Ophthalmologists should be encouraged to refer patients to the LVA scheme when they have pathology which is likely to reduce vision in the future (such as ARMD) even if vision is above the levels for registration at the time of the consultation. As the waiting

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time for ophthalmology outpatient appointments may be long, dependence on this route as the entry to a LVA will delay the assessment and provision of the aids.

General practitioners

GPs can be encouraged to refer persons for “routine” sight tests where the cause of poor vision has not been identified, and thus into the LVA scheme if the vision is not remediable, or directly into the scheme if the cause is known. Consideration may also be given to the role of nurses in the process- should they be able to refer directly into the scheme, or via the GP?

As the “gatekeeper” of the patient’s health, the GP may be aware of problems in day to day activities, and can thus be the provider of important information to the optometrist. In the audit of the Fife scheme, GPs were the largest provider of referrals.

Optometrists

Many optometrists are not keen to be involved in the provision of LVAs, yet much of the process is merely an extension to the routine eye examination. In most cases an accurate refraction is essential to enable the patient to make best use of their residual vision, and any LVA which is provided. Schemes which do not encourage regular and accurate refraction fail the patient. Often the simplest of remedies- a high reading addition- is all that is required. Optometrists are conveniently located to deliver this process.

The optometrist should be part of the planning process, with input at every stage in the implementation of a new system, and in the ongoing management of the scheme. Adequate feedback to all concerned is part of this process. Training and accreditation will be essential.

The advantages of using optometrists are:

- graduate professional
- primary healthcare specialist
- economic & effective
- give advice on all eyecare-related matters
- under-utilised healthcare resource
- have the necessary communication skills
- committed to CET/ clinical audit/ clinical governance
- available in every community
- well equipped practices
- established recall systems
- flexible appointment times

As follow up is an essential part of the process, optometrists should be encouraged to ensure that patients return for these “aftercare” appointments. Training and accreditation will need to be part of the protocol.

Advantages to the whole process:

- there is a more seamless system
- there is more utilisation of the appropriate skills at every stage
- implementation of improved communications as part of the design process
- greater involvement in multi-disciplinary teamwork
- Social Services

In many instances visually impaired persons will already be known to social services, and may be being provided with other aids and services. Social services may be an important source of referrals to the scheme, and it is important that they are involved in the planning process. It is also in the patient’s interest for social services to be made aware (subject to

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consent) of all persons who are seen under the scheme. Impaired vision should not be seen in isolation as an optical problem, it is a lifestyle problem. The closer integration of social and NHS services (for example in level five PCTs) could assist in the delivery of appropriate services for the visually impaired.

Societies for the visually impaired

Most areas will have local societies for the blind, and local branches of national organisations, such as the RNIB, Partially Sighted Society, Retinitis Pigmentosa Society etc. Sometimes these will supply LVAs through their own resources, and all may wish to have an input as representatives of the “end user”. Their input is likely to be valuable.

Training

Training should be an integral part of any scheme, even if the necessary clinical skills of the optometrists do not extend much beyond those normally expected in community practice. It is essential that all optometrists are well acquainted with procedures as well as protocols, and they are aware of the activities of all of the other participants.

The Dorset protocol has been used as a model by some areas, and this is included after this section.

Accreditation

It is likely that in a system which relies on a more advanced usage of the skills of optometrists some form of accreditation will be necessary, with individual optometrists (not practices) being accredited once the training programme has been completed. Provision needs to be made to train and accredit optometrists moving into the area.

Audit

Audit is an essential ongoing feature of all co-management schemes. Initial audits will discover any procedural problems which can be discussed with the management team. Later audits will identify clinical problems, and fine tuning issues. Participants must be aware that they may be identified as not measuring up to the levels of performance required which will suggest changes to the accreditation or training, or in severe cases removal from the list of participating optometrists. The views of users should be sought in the audit process.

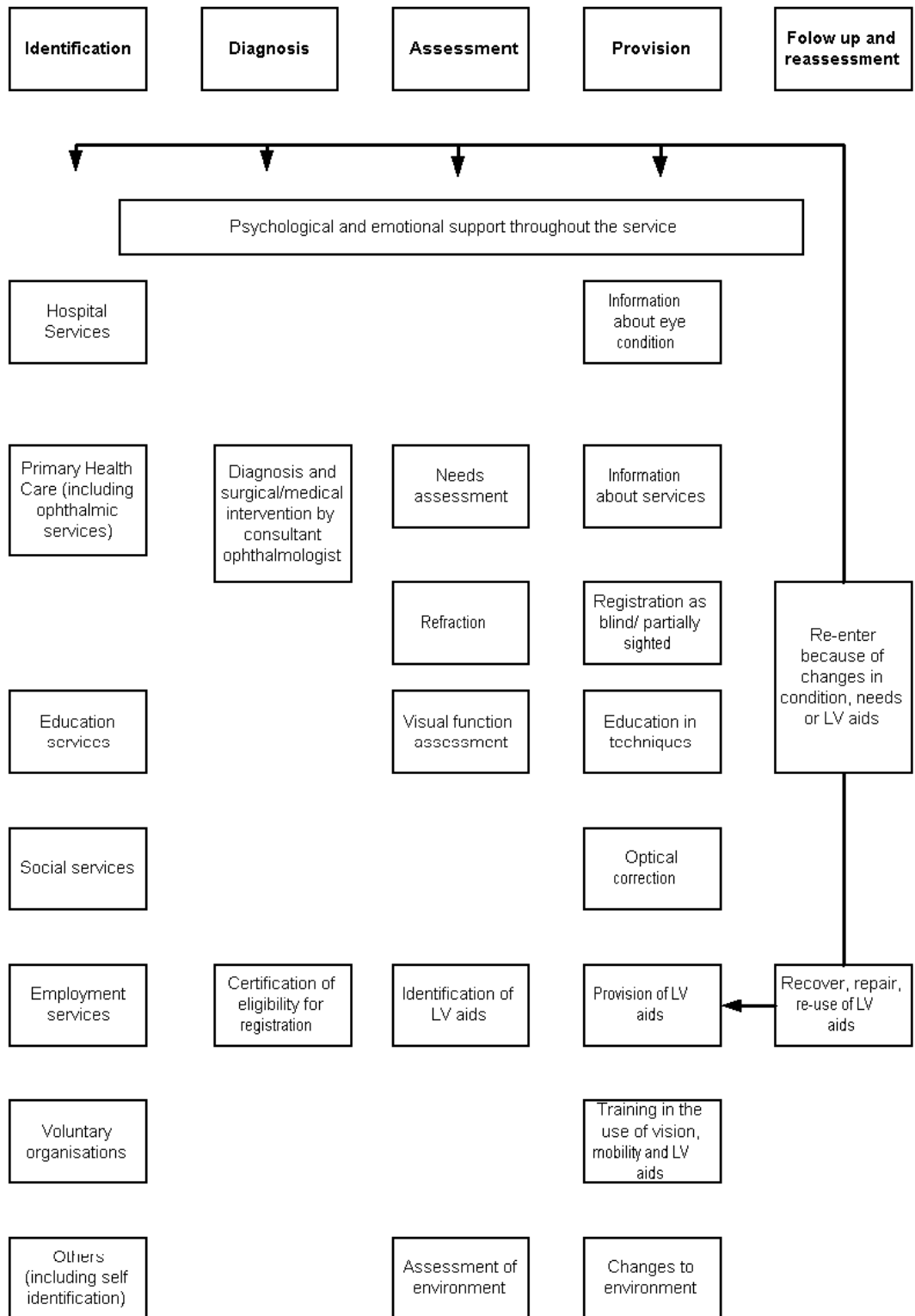
Fife has been audited.

Funding

The source of funding needs to be identified at the outset, and there must be a commitment for this funding to be continued. Some schemes have been shown to be effective, but have been discontinued because no long term resources were made available.

Initially the capital expenditure is likely to be high to ensure that all participating practices have a stock of the most popular aids, with availability for loan of more expensive sophisticated devices. Thereafter the financial resources will be devoted to fees to the optometrists and the ongoing provision of LVAs. If the system is successful the annual expenditure will rise as more people are introduced into the scheme, but this will be offset in the medium term by the recycling of LVAs returned.

Low vision



Low vision

A GENERAL LOW VISION SCHEME

