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Adult Low Vision Service Quality Framework

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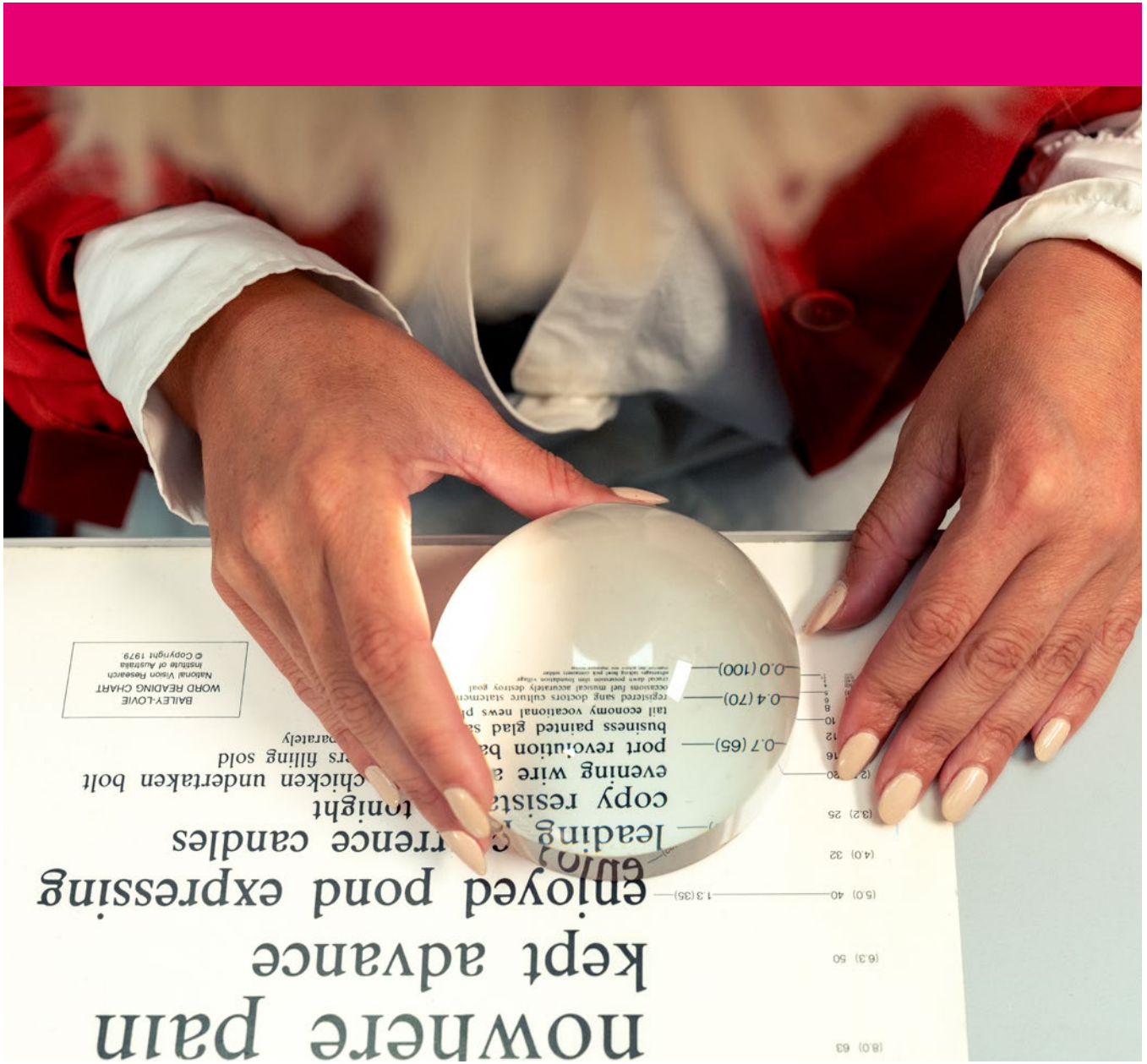
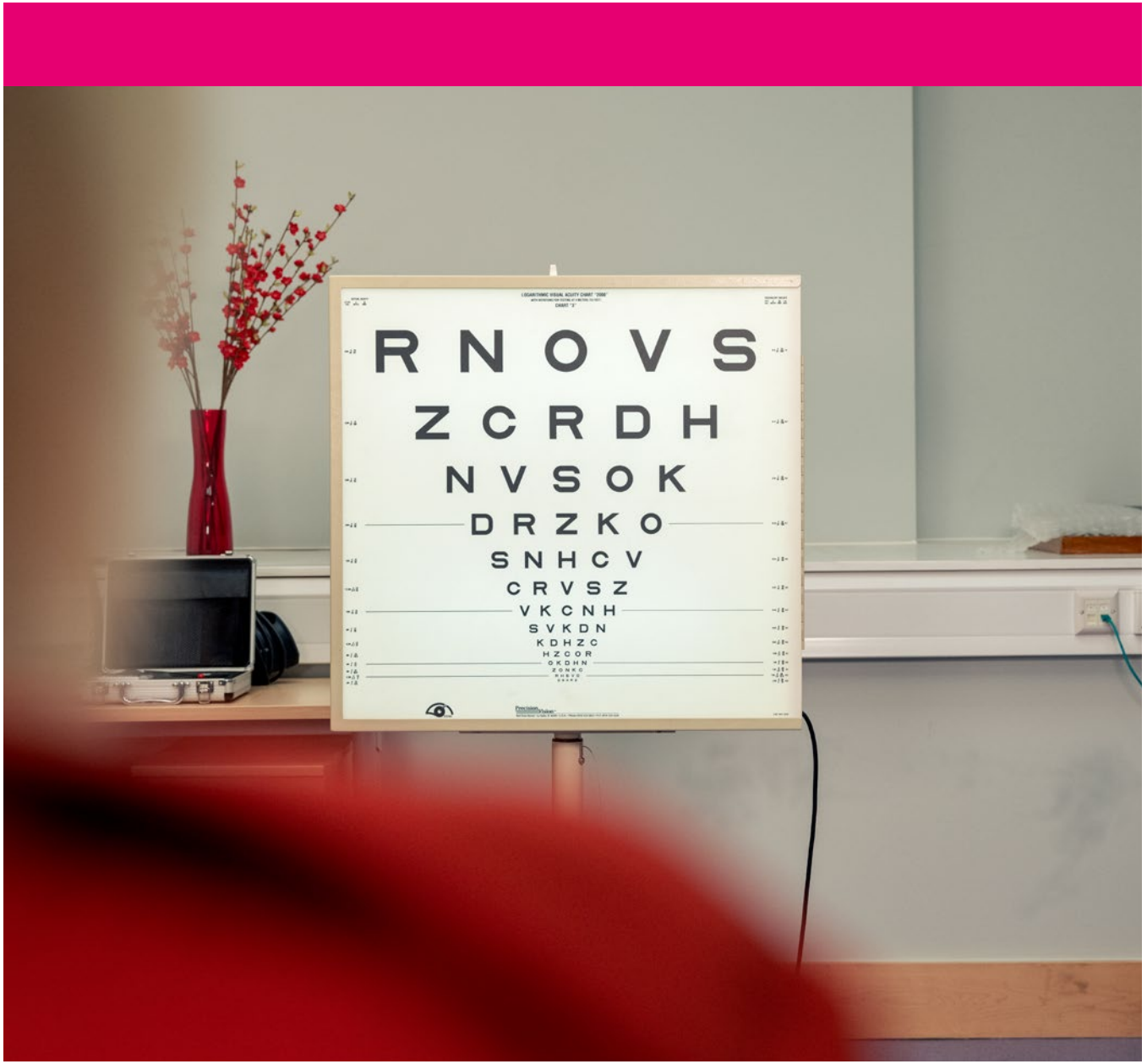


Low Vision Services

Low Vision Services are multidisciplinary and designed to identify and support the health and social care needs of people with low vision. This framework should ensure the delivery of an equitable service to people with low vision and different needs and is designed to be used alongside our Good Practice Guidelines, where you will find extra context and explanation of our approach.

Application

This Low Vision Service Quality Framework is designed to assist services in providing an equitable service to all people with low vision. It is intended for the use of all delivery models of low vision services across the UK, whether hospital, community or third sector-based, or a specific national provision. It is targeted at NHS services but almost all sections will be relevant to private and third sector services too.



Introduction – six operating principles

We developed the Adult Low Vision Service Quality Framework and Good Practice Guidelines to set out and define best practice for low vision services – in any setting – in the UK. Written in consultation with patients, individual practitioners, key sector stakeholders and organisations, the framework reflects accepted good practice. You can use the framework to audit and develop current services and as a benchmark to guide the commissioning, or recommissioning, of services.

In this document, we set out both the core activities and standards (core criteria) expected of any low vision service. It also gives details of ideal service provision (ideal criteria).

Our accompanying Good Practice Guidelines provide additional clarification and recommendations – from research and experts in the field – for each section of the framework.

The following six operating principles should be common to all low vision services:

1. Inclusivity / accessibility
2. Transparency
3. Person-centred
4. Impartiality
5. Multi-disciplinary / integrated
6. Sustainable

While principles in this framework may apply to everybody with low vision, it has been developed for adult low vision services only.

We want the Adult Low Vision Service Quality Framework to ensure that patients with low vision have early and equitable access to good quality, fit-for-purpose low vision services across the UK.

Terminology

We describe key terms used in this framework below, but a further extensive glossary of terms can be found in the Good Practice Guidelines.

Low vision: 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.

Low vision service: A multi-disciplinary service designed to identify and support the health and social care needs of people with vision impairment. This includes an assessment with a low vision practitioner, provision of low vision aids, training in their use, and direct working with, or established referral pathways to, other key services.

Low vision assessment: A holistic assessment of the rehabilitation and habilitation needs of a person with low vision. This should include full assessment of all relevant aspects related to the patient's vision impairment and measurement of visual function. It should recommend solutions centred around the patient's needs including – but not limited to – magnifying devices, vision strategies and identification and referral, or signposting to additional support services.

Low vision practitioner: A qualified practitioner with knowledge and understanding of ocular pathology who measures visual function, recommends low vision aids, and provides low vision support and advice. Practitioners create appropriate management plans based on the functional, social and emotional impact of vision impairment on an individual.

Patient with low vision: An individual with a diagnosis of low vision or reduced sight who is supported by low vision services. Patients are often referred to as 'service users', but we use the term 'patient' following consultation with users of the service.

Why this framework helps delivery of the best service and support

This framework and the accompanying Good Practice Guidelines should be used to ensure the service you are providing, commissioning, or designing aligns to the general consensus of what a good low vision service should be. It enables you to systematically evaluate your service in terms of care and delivery. As with all health care provision, maintaining good practice requires a built-in review process and an opportunity for reflection. Ultimately, it provides reassurance for your patients that they are receiving the best service and support.

How this framework and guidelines should be used

Both existing and aspiring low vision services, local authorities and commissioners should use this quality framework as guidance. Existing service provision should be assessed against the criteria below to highlight both strengths and potential areas for improving or building upon existing practice. Where the service is provided and run by different people, you may wish to share out who completes the assessment of the service against the framework.

For example:

Sections 1,2 and 10
– service provider or manager

Sections 4,5,6,7,8 and 9
– clinical lead practitioner

Section 3
– service provider and service commissioner

We do understand that as a service provider there are some criteria or parts of criteria that are out of your capability to change due to environmental, demographic, contractual, historical or financial restrictions of current services. However, it is important that all services aim to meet the core criteria and signpost or refer to other providers where appropriate.

We recommend the framework is used as a checklist and should be used in conjunction with the accompanying Good Practice Guidelines. The guidelines provide information, resources and evidence-based practice or legal guidelines for each section of the framework so that services understand what is meant by each of the criteria and how to achieve it. Section 10 covers ongoing review of the service. Auditing all aspects of the service including patient feedback is a key part of clinical governance as a way of evaluating, developing and quality assuring service provision. A template for an action plan can be found in the good practice guidelines to facilitate reviewing the service (audit) and obtaining feedback.

Please note we have kept the points in the framework short for brevity, to avoid duplication and to facilitate service providers in completing the framework assessment. This recognises the time pressure that most service providers are under. However, when completing for the first time the accuracy of the review will be increased by clarifying each section with the information in the Good Practice Guidelines.

1. Environment

Activity	Criteria	Met	Part met	Not met
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 for a fee.			
	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 for a fee.			
	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.			

Activity	Criteria	Met	Part met	Not met
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.			
1.3 Lighting and glare	**Core:** There should be appropriate lighting internally and externally.			
	Ideal: Glare should be minimised where possible and clinic spaces should be fitted with dimmer switches.			
1.4 Confidentiality	**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.			
1.5 Awareness of the service	**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.			

2. Staff and staff training

Activity	Criteria	Met	Part met	Not met
2.1 Additional qualifications	**Core:** The service should be provided by optometrists, dispensing opticians, orthoptists, ophthalmic nurses and 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 should meet the training requirements of the local service provider. Student practitioners may also provide low vision services under suitable supervision.			
2.2 Ongoing training	**Core:** All staff working in low vision clinics should know their scope of practice, and as well as complying with local service requirements, should 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.			

Activity	Criteria	Met	Part met	Not met
2.3 Sight loss awareness	**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.			
2.4 Criminal records check (e.g. DBS, Access NI, Disclosure Scotland)	**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.			
2.5 Business continuity planning	**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.			

3. Accessing the service

Activity	Criteria	Met	Part met	Not met
3.1 Referring and self-referral	**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 recent eye examination has not already been carried out).			
3.2 Who can access the service	**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.			

Activity	Criteria	Met	Part met	Not met
3.3 Booking appointments	**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.			
3.4 Eligibility for NHS services	**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 section 3.2).			
3.5 Patients with additional needs	**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 section 10.6).			
3.6 Contacting the service	**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.			

Activity	Criteria	Met	Part met	Not met
3.7 Communication	**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.			
3.8 Telemedicine	**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.			

4. Multidisciplinary working

Activity	Criteria	Met	Part met	Not met
4.1 Understanding the low vison pathway	**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.			
4.2 Patient-centred care	**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.			
4.3 Linking services	**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.			
4.4 Information sharing between services	**Core:** Referrals should be made with patient consent unless deemed to be in the best interest of the patient (such as 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 between all components of the low vision service.			

Activity	Criteria	Met	Part met	Not met
4.5 Integrated health care	**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.			
4.6 Transfer of care between areas	**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 or new ophthalmology service or local primary care optometrist.			
	Ideal: A direct referral with summary report to the new service would be ideal.			

5. Establishing needs

Activity	Criteria	Met	Part met	Not met
5.1 Needs-based assessment	**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 and preferences must be included in a personalised plan.			
5.2 Eye health information	**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.			

Activity	Criteria	Met	Part met	Not met
5.3 Emotional wellbeing	**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.			
5.4 Safeguarding	**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.			
5.5 Charles Bonnet Syndrome	**Core:** Charles Bonnet Syndrome should be discussed.			
5.6 Falls	**Core:** Falls or risk of falls should be discussed			
5.7 Cerebral Visual Impairment	**Core:** Consider the impact of cerebral or brain-based visual impairment.			
5.8 Certification	**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.			
5.9 Patient advocates	**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.			

Activity	Criteria	Met	Part met	Not met
5.10 Routine reviews	**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.			
5.11 Follow ups	**Core:** Practitioner recommended follow ups on issued devices, referrals and / or any advice given should be differentiated and separated from routine reviews. These must be arranged at a suitable time interval as determined by the low vision practitioner and should be based on patient needs and outcomes.			
	Core: Follow ups should be offered until all identified needs have been discussed and addressed.			
5.12 Families and carers	**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.			

6. Assessing visual function

Activity	Criteria	Met	Part met	Not met
6.1 Valid sight test and up-to-date refraction	**Core:** Patients must have a valid sight test including refraction before attending the low vision service (unless the sight test 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 must 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.			
6.2 Ongoing eye examinations	**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.			
6.3 Red Flag symptoms	**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.			
6.4 Measuring distance and near acuity	**Core:** Distance and near visual acuity (VA) should be measured using an 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.			
6.5 Assessing visual function	**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.			

Activity	Criteria	Met	Part met	Not met
6.6 Measuring contrast sensitivity	**Core:** Measurement of contrast sensitivity should be carried out, or at least considered with every patient.			
6.7 Visual Fields	**Core:** A patient's visual field must be considered during all assessments and testing of fields should be carried out when appropriate.			
6.8 Other tests	**Core:** 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.			

7. Optical and non-optical aids

Activity	Criteria	Met	Part met	Not met
7.1 Optical low vision aids	**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.			

Activity	Criteria	Met	Part met	Not met
7.2 NHS funded low vision optical aids	**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.			
7.3 Information about LVAs not funded by NHS	**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.			
7.4 Training on low vision aids	**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.			

Activity	Criteria	Met	Part met	Not met
7.5 Batteries and maintenance	**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.			
7.6 Advanced low vision aids	**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.			
7.7 Lighting	**Core:** Appropriate lighting should be discussed with patients as per their needs.			
	Ideal: Lighting solutions should be demonstrated to patients.			
7.8 Managing glare	**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.			
7.9 Non-optical low vision aids	**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.			

Activity	Criteria	Met	Part met	Not met
7.10 Referral for further support	**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) are referred appropriately, including referral for sight impairment certification or change of registration status.			
7.11 Use of contrast and contrast enhancement devices.	**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.			
7.12 Visual and non-sighted strategies	**Core:** Where appropriate advice and referral to specialist support in mobility strategies or training in visual strategies such as eccentric viewing should be provided.			

8. Assistive technologies

Activity	Criteria	Met	Part met	Not met
8.1 Vision enhancement	**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			

Activity	Criteria	Met	Part met	Not met
8.2 Navigation and orientation	**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.			
8.3 Reading support	**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.			
8.4 Referral for technological support	**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.			

9. Reports and records

Activity	Criteria	Met	Part met	Not met
9.1 Storing and sharing data	**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 patients preferred format.			
9.2 Record keeping	**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.			

Activity	Criteria	Met	Part met	Not met
9.3 Consent	**Core:** Patients should be given information on data storage, usage and sharing of personal information. Informed consent at each patient interaction is essential.			
9.4 Report writing	**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.			
9.5 Standard operating procedure (SOP)	**Core:** Standard operating procedure should be in place in order to ensure effective and efficient running of the service.			

10. Ongoing service review

Activity	Criteria	Met	Part met	Not met
10.1 Frequency of service evaluation	**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.			
10.2 Demographics review	**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.			

Activity	Criteria	Met	Part met	Not met
10.3 Quality assurance review	**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.			
10.4 Patient feedback	**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.			
10.5 Financial review	**Core:** Services should carry out review and feedback of the services finances.			
10.6 Data on missed appointments	**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 vulnerable adults who have not been brought to appointments.			
10.7 Planning and evaluating the service	**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).			
10.8 Implementing service evaluation findings	**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.			

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- NHS Tayside Low Vision Service
- Ulster University NHS Funded Low Vision Service
- University Hospital Coventry and Warwickshire NHS Trusts
- Low Vision Service: Sheffield Teaching Hospital
- RNIB Low Vision Service
- Guy's and St Thomas Hospital Trust
- Mid and South Essex University Hospitals Group

Further information

If you have any queries about this framework, please contact **Dr Louise Gow**, RNIB Clinical Lead for Eye Health, Optometry and Low Vision or **Preeti Singla**, RNIB Optometry and Low Vision Engagement Manager: **eyecare.professionals@rnib.org.uk**

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RNIB Helpline

Call: **0303 123 9999**

Email: **helpline@rnib.org.uk**

Or say, **“Alexa, call RNIB Helpline”** to an Alexa enabled device.

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