**Community-based vision rehabilitation provision in England**

**Abstract**

Sight loss is more common among older than younger people. With an ageing population and increasing pressure on health and social care services, preventive and rehabilitation services are being prioritised. However, evidence around community-based vision rehabilitation services is underdeveloped. The focus of this article is on the prevalence, organisational models and capacity of community-based vision rehabilitation services in England that are wholly or partly funded by local authorities (LAs).

Eighty-nine of the 152 (57%) LAs responded to an online survey about vision rehabilitation services. Services vary widely in: the type of provider, type of support offered, structure and skills of the team delivering interventions, caseloads and waiting times. Voluntary organisations appear to experience more pressure on budgets and staffing ratios than LA in-house services. The article discusses implications for practice.

**Keywords**

Visual impairment, sight loss, community-based vision rehabilitation, adults, national survey

**Background**

Sight loss is more prevalent among older than younger people and can have a profound impact on all aspects of well-being including daily functioning and mental health. With the UK’s ageing population, the number of people with sight loss is set to rise significantly. There are almost two million people in the UK currently living with sight loss. By 2050 this number is estimated to double to almost four million people (Access Economics, 2009). The total direct National Health Service (NHS) expenditure linked to eye health and the total indirect cost of sight loss to the UK economy (e.g. the cost of providing informal care to those living with sight loss) in 2013 was estimated to be around £2.64 billion and £5.3 billion respectively (RNIB, 2013).

To manage increasing demand and respond to financial pressure on services, preventive and rehabilitation services have dominated health and social care policies for over a decade (Department of Health [DH], 2005, 2006, 2007). In 2010, DH guidance on eligibility criteria for adult social care urged LAs to invest in early intervention and prevention:

Before proceeding to determine eligible needs, councils should consider whether an individual might benefit from a short period of re-ablement or intermediate care to increase what they are able to do for themselves before an assessment of longer-term need is undertaken. (DH 2010, p.18)

To support this policy, the Adult UK sight loss pathway (Vision 2020 UK, 2013) provided a process map to promote a unified best practice response across local authorities in the UK. This process map which was endorsed by the UK Vision Strategy (UK Vision Strategy Advisory Group, 2013) and ADASS (Association of Directors of Adult Social Services) guidance (ADASS, 2013) made it clear that vision rehabilitation should not be dependent on FACS (Fair Access to Care Services) eligibility criteria. More recently, the Care Act 2014 took this one step further by replacing existing legislation concerned with care and acknowledging, for the first time, rehabilitation services for blind and partially sighted people in statutory guidance. The Care Act requires LAs to promote well-being and independence to prevent people reaching a crisis point, whether or not their needs meet the new eligibility threshold (DH, 2014a). Moreover, in line with the ADASS guidance (ADASS, 2013), the Care Act 2014 has highlighted the importance of assessments being carried out by professionals with relevant experience and training:

Local authorities must ensure that their staff have the required skills, knowledge and competence to undertake assessments and that this is maintained … Local authorities *should* [emphasis in original] consider whether additional relevant expertise is required on a case-by-case basis, taking into account the nature of the needs of the individual, and the skills of those carrying out the assessment. (DH 2014b, p.82)

Underlying these policies is the assumption that by maximising people’s ability to live independently in their own homes, such services would reduce the number of people entering the care system and their needs for on-going care and support:

Effective interventions at the right time can stop needs from escalating, and help people maintain their independence for longer. (DH 2014b, p.9)

The interest in prevention and rehabilitation is not unique to the UK. Other countries such as the USA and Australia have developed rehabilitation programmes with the specific objective of reducing an individual’s need for ongoing support (Rees et al., 2010; Soucy-Moloney & Paskin, 2001; Deremeik et al., 2007).

The concept of independent living is supported in research too. The need to move away from dependency-based services to services that focus on promoting independence has long been argued by scholars of disability studies (Morris, 1997; Barnes, 1997; Barnes, & Mercer, 2006; Campbell & Oliver, 2013) and research focusing on older people (Baker, 2006; Lewin et al., 2006). Research shows that people with visual impairment have an increased need for emotional support (Gosney et al., 2010) and rates of depression among older visually impaired people is at least twice those of the general population (Burmedi et al., 2002). There is some evidence that rehabilitation can be an important contributor to the quality of life, independence and emotional well-being for people with visual impairment (Binns et al., 2012; Horowitz et al., 2003; Rees et al., 2010; Lee et al., 2008; Orellano et al., 2012; Hooper et al., 2008); it can reduce depression (Horowitz et al., 2003, Girdler et al., 2010) and affect patterns of coping (Boerner et al., 2006) over time; and that people with the highest quality of life scores tend to have less difficulty with independent living skills, activities and mobility (Guide Dogs, 2007). There are also some strong messages in the existing research that self-management programmes improve adaptation to vision loss (Rees, 2010) and belief in the ability to manage everyday tasks (Binns et al., 2012) and that group-based, problem solving ‘health education’ programmes are more effective than individual interventions (Binns et al., 2012). Access to rehabilitation services is also reported to be variable in terms of geographical location, model of service delivery and the content of a rehabilitation programme (Percival, 2011; Culham et al., 2002).

Despite strong indicators of the potential for vision rehabilitation services to have a positive impact on people’s daily life and emotional well-being, a recent review of the international literature on vision rehabilitation services (Rabiee et al., 2015) found that much of the existing evidence in this field has hitherto been dominated by research focusing on low vision rehabilitation which is mostly hospital based and is focusing on functional ability (e.g. Reeves et al., 2004; Walter et al., 2007). Robust evidence of the impact and cost-effectiveness of community-based vision rehabilitation services is patchy and limited in both scope and quality (Rabiee et al., 2015). It is worth noting that different countries organise their vision services in different ways and some international examples of health service-based services, in particular those with multidisciplinary approaches, may have more in common with local authority (LA) commissioned services than they do with UK low vision services.

This article draws on a wider study (Rabiee et al., 2015) investigating the evidence base for community-based vision rehabilitation services in England. The study was designed to inform a future full scale evaluation study (Craig et al., 2008) to determine the effectiveness and cost-effectiveness of vision rehabilitation services for people with visual impairment. This article provides an overview of the prevalence, organisational models and capacity of local authority funded community-based rehabilitation provision available at the time of the study to people with visual impairment in England.

**Methods**

The study was carried out in England between October 2012 and September 2014, focusing on rehabilitation services funded by LAs and offered to people over the age of 18. It comprised four stages. Stage 1 was a review of the existing national, international and grey literature on vision rehabilitation services published since 2000, excluding studies that were exclusively on low vision services. Stage 2 comprised scoping workshops with people with visual impairment and key professionals involved in delivering or managing vision rehabilitation services. This was followed in Stage 3 by a national survey of LAs and voluntary organisations providing vision rehabilitation services that are funded by LAs. The final stage involved case studies of three models of vision rehabilitation services. This article uses data from stage three - the national survey. Other findings are reported elsewhere (Rabiee et al., 2015).

The survey took place in two parts. In Part 1, directors of adult social care were emailed via the publicly available list of ADASS contacts to identify services that were wholly- or part-funded by English LAs. Additional efforts were made to supplement the responses from ADASS contacts to locate services (e.g. requests via Vision 2020 UK networks and Visionary newsletter and searches using RNIB’s sightline directory and LA websites). In Part 2, the aim was to survey services identified in phase 1 to obtain detailed information on the characteristics of services.

Based on preliminary findings from the literature review and scoping workshops (stages 1 and 2), a draft questionnaire was designed using ‘Qualtrics’ software ([*http://www.qualtrics.com*](http://www.qualtrics.com)), a comprehensive online survey package, and piloted with three vision rehabilitation services, two LA in-house services (where local authorities deliver their own service) and one ‘contracted-out’ service (a voluntary organisation paid to deliver the service for the LA). The final questionnaire comprised five sections including: organisation and structure of the vision rehabilitation service and skill mix within the service; access, referral and assessment practices; type and reach of service provided; assessing and measuring outcomes of the service; and costs and charges and experience of change.

As far as possible the questions had closed responses, so that results could be compared across services to gain a national picture. Questions requiring a qualitative open response were confined to instances where more explanation might be required and questions designed to allow respondents to comment about their service. The survey was distributed at the end of November 2013 and closed at the end of January 2014. Data were analysed using SPSS. Descriptive statistics were used to analyse data on the extent and type of services nationally, to identify gaps and to provide more detailed information on individual vision rehabilitation services.

Ethical approval from SCREC (Social Care Research Ethics Committee), ADASS Research Group approval and research governance from the three LAs taking part in the case studies were obtained for this project.

**Results**

*Response rate*

The initial email to ADASS contacts and follow-up in Part 1 provided basic information for approximately 95 per cent of LAs. In total, 89 of the 152 LA areas (57%) responded across the country to Part 2 of the survey; two refused to take part and 87 completed the questionnaire. The timing of the distribution of the questionnaire (i.e. before the Christmas/New Year period) was unavoidable within the constraints of the project timetable and may have had an impact on responses. However, the response rate is similar to that of other surveys which obtained information from LAs (e.g. Local Government Association, 2014; Cabinet Office, 2014).

*Main provider, type and location of vision rehabilitation services*

Table 1 shows the two main types of providers were LA in-house (61% of services) and voluntary (not for profit) organisations with LA funding (28% of services). Other providers including joint health and social care, pilot social enterprises, private (for profit) organisations and other arrangements (e.g. ‘LA trading company’) made up the remaining services. A minority of LAs which provided the core service in-house, contracted out some elements of the service (e.g. home safety checks, home visiting/befriending services and provision of basic equipment).

Table 1: Main provider of vision rehabilitation service

|  |  |  |
| --- | --- | --- |
|  | **Number of services** | **Percentage of services** |
| Local authorityVoluntary (not for profit) with LA fundingJoint health and social carePilot social enterprisePrivate (for profit) with LA fundingOtherTotal | 5324322387 | 61283223 |

NB: percentages do not total 100 due to rounding.

Table 2 shows the majority of services (81%) described their core team delivering vision rehabilitation as ‘specialist’, either in vision impairment, sensory impairment or physical and sensory impairment. The majority of teams (60%) were based in a local authority setting, reflecting the type of provider.

Table 2: Type and location of vision rehabilitation services

|  |  |  |
| --- | --- | --- |
|  | **Number of services** | **Percentage of services** |
| *Type of core team delivering vision rehabilitation:*Specialist sensory impairment teamSpecialist vision impairment teamPart of generic adult social care teamSpecialist physical and sensory impairment teamOther specialist multi-disciplinary team (for example, a stroke team) Lone workerMulti-disciplinary re-ablement teamOther Total*Where the core service is based:*Local authority settingIndependent organisation settingHealthcare settingOther Total | 33285333227947252579 | 4235644433603236 |

NB: percentages do not total 100 due to rounding or where more than one option could be selected.

*Skill mix within teams*

There was a range of professional skills represented in teams. Just over a third of managers were described as being specialist in vision impairment and a further 18% in sensory impairment. Managers included in the ‘other’ category included a speech and language therapist, specialist in strokes and managers without a background in vision impairment.

The most typical profession found within all teams was rehabilitation officers for visual impairment (ROVIs) (92% of services). Included in the ‘other’ skills category in teams were registration and equipment advisers, advocacy/welfare rights worker, dual sensory impairment workers, link-worker and independent living worker (Table 3).

Table 3: Professional skills within teams

|  |  |  |
| --- | --- | --- |
|  | **Number of services** | **Percentage of services** |
| *Manager of service (based on 79 responses):*Specialist in vision impairmentSpecialist in sensory impairmentGeneric social workerOccupational therapist (OT) Specialist in physical and sensory impairmentOther Total*Other skills represented in teams:* ROVISenior ROVIAssistant ROVISocial workerCommunity care officerEye clinic liaison officerAssistive technology specialistOTOtherTotal | 2814111011579602316161411741265 | 3518141311992352525221711618 |

NB: percentages do not total 100 due to rounding or where more than one option could be selected.

A comparison of LA in-house and voluntary sector organisations shows clear differences between the two types of providers in terms of the composition of the team delivering vision rehabilitation, with greater diversity present in the type of team delivering the service within LA in-house services. The most common type of team found within LA in-house services was a broad sensory impairment team (57%) compared with 13% of voluntary sector teams, whereas three-quarters of voluntary sector teams (75%) described themselves as specialist vision impairment teams (compared with 20% of LA in-house teams) (Table 4).

Table 4: Type of core team delivering vision rehabilitation in two main providers

|  |  |  |
| --- | --- | --- |
|  | Percentage of LA in-house  | Percentage of Voluntary (not-for-profit) with LA funding |
| Specialist vision rehab team | 20 | 75 |
| Specialist sensory team | 57 | 13 |
| Specialist physical and sensory impairment team | 7 | 0 |
| Multi-disciplinary re-ablement team | 2 | 4 |
| Other specialist multi-disciplinary team (e.g. a stroke team) | 4 | 0 |
| Part of generic adult social care team | 7 | 4 |
| Lone worker | 2 | 4 |
| Other | 2 | 0 |

NB: percentages do not total 100 due to rounding.

The background of team managers also differed between LA in-house and voluntary sector teams. As Table 5 shows, there was a fairly even spread across different professional groups for the in-house team managers.

Table 5: Manager of vision rehabilitation service in two main providers

|  |  |  |
| --- | --- | --- |
|  | **Percentage of LA (in-house)** | **Percentage of Voluntary (not-for-profit) with LA funding** |
| Specialist in vision impairment | 22 | 67 |
| Specialist in sensory impairment | 20 | 13 |
| OT - not specialist in vision impairment | 17 | 4 |
| Generic social worker | 24 | 0 |
| Other professional - not specialist in vision impairment | 17 | 17 |

NB: percentages do not total 100 due to rounding.

*Referral, screening and assessment, caseloads and waiting list*

While ‘open access’ was reported to be a feature of 89% of services, initial access to the service was most commonly by a referral from a health or social care professional (94% of services), and might include a certificate of visual impairment (CVI). Other referral routes were through voluntary organisations, education or housing departments. A quarter of services, contrary to the recommended practice (DH, 2010), required people to have a FACS community care assessment to determine their eligibility to receive the service, thus linking vision rehabilitation to a person’s eligibility to receive other social care services.

Staff with specialist skills in vision impairment were involved in assessment in 95% of services, although 11% reported that assessments might at times be carried out by someone without specialist skills. In 40% of services the initial screening of referrals was sometimes carried out by staff without specialist skills in vision impairment. One service reported this to be the predominant position.

The majority of services (97%) described the support they provided as open-ended, rather than time prescribed. The way in which people could re-access the service was commonly by re-activating formal intake procedures (67%), although a number of reasons for being able to by-pass waiting lists were described (e.g. moving house). Two-thirds of services reported having a waiting list for their service, with an average waiting time of 10 weeks (see Table 6).

Fifty-nine services reported annual caseloads. These varied widely - between 16 and 2000. It became apparent from focus groups with practitioners in the final stage of the study that services measured caseload differently; some recorded the number of people supported and others the number of episodes of support provided (with people receiving multiple episodes), which may explain the very wide variation observed. Detailed data on caseload are therefore not reported here.

Table 6: Waiting lists for vision rehabilitation services

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Number of services** | **Mean** | **Range** |
| Approximate number currently on waiting list | 41 | 40 | 2-147 |
| Approximate waiting time (in weeks) | 47 | 10 | 2-50 |

*Types of training and support offered*

Almost all services offered training in independent living skills, orientation and mobility, and the use of aids, adaptations and equipment. Ninety per cent offered training in communication; self- management courses were offered in just over a third (34%) of services. Voluntary sector services were more likely to be offering self-management courses than LA in-house services (39% and 25% respectively).

There was less uniformity over the type of support different services offered. As Table 7 shows, provision of aids, adaptations and equipment and an information/ signposting role were most commonly reported. Support from trained counsellors was less likely to be offered and out-of-hours support was offered by only a minority of services. Re-ablement support, arranging respite or 24 hour care, were included as the other types of support that some services offered.

Table 7: Type of support provided to service users

|  |  |  |
| --- | --- | --- |
|  | **Number of services** | **Percentage of services** |
| Information/signposting | 76 | 100 |
| Aids, adaptations and equipment  | 75 | 99 |
| Support for partners and carers | 61 | 80 |
| Emotional support | 60 | 79 |
| Support for leisure/social activities | 49 | 65 |
| Benefits/financial advice | 45 | 59 |
| Training/education advice | 45 | 59 |
| Employment advice | 43 | 57 |
| Facilitating peer support/group work | 38 | 50 |
| Volunteer support | 35 | 46 |
| Support for social relationships | 35 | 46 |
| Housing advice | 34 | 45 |
| Managing personal budgets | 27 | 36 |
| Personal assistants (PAs) | 19 | 25 |
| Counselling | 18 | 24 |
| ‘Out-of-hours’ support (for example, evenings and weekends) | 9 | 12 |
| Other | 12 | 16 |
| Total | 76 |  |

NB: percentages do not total 100 as more than one option could be selected.

While the managers in 45% of services did not feel that any specific groups of people were under-represented in their caseloads, 37% said that people with learning difficulties and 31% said that people from ethnic minorities were more likely not to be accessing services. A lack of information about the service and the lack of links with other services were reported as the main reasons for this.

*Working with other organisations and professionals*

To examine the ease of working with other organisations and professionals, participants were asked to report how easy or difficult they felt it would be for the team to work with other organisations on behalf of a client. Employment services, followed by other health professionals were most likely to be reported as ‘difficult’. Other adult social care services and eye clinic liaison officers (ECLOs), and voluntary/private organisations were cited as ‘easy’ to work with. Organisations or professionals in the ‘Other’ category included ‘health providers and commissioners of vision services’ - classed as ‘difficult’ - and fire services, Guide Dogs, low vision and children’s services classed as ‘easy’ to work with (Table 8).

Table 8: Ease of working with other organisations and professionals

|  |  |
| --- | --- |
| **Organisations/professionals****(number of responses)** | **Percentage (number) of services** |
|  | **Easy** | **Neutral** | **Difficult** |
| Eye clinic liaison officers (ECLOs) (71) | 68 (48) | 24 (17) | 9 (6) |
| Voluntary/private organisations (74) | 65 (48) | 34 (25) | 1 (1) |
| Health OTs (74) | 49 (36) | 41 (30) | 11 (8) |
| Benefits services (72) | 43 (31) | 49 (35) | 8 (6) |
| Housing services (74) | 34 (25) | 57 (42) | 10 (7) |
| Employment services (73) | 29 (21) | 47 (34) | 25 (18) |
| Training/education services (72) | 26 (19) | 58 (42) | 15 (11) |
| Other specialist teams (for example, stroke team) (74) | 45 (33) | 45 (33) | 11 (8) |
| (Other) adult social care (74) | 70 (51) | 29 (21) | 1 (1) |
| Other health professionals (for example, GPs) (74) | 23 (17) | 54 (40) | 23 (17) |
| Other (8) | 63 (5) | 25 (2) | 13 (1) |

NB: percentages do not total 100 due to rounding.

*Measuring outcomes*

Not all services measured outcomes for service users or used standardised measurement tools when doing so. Just over half who responded to this question (58%) measured the impact of their service on service users. Fewer than half (43%) of these used a standardised measurement tool (e.g. the ‘Action ladder’, an adapted OT assessment tool). The use of standardised tools is of vital importance to effective outcome measurement to ensure the validity and reliability of results. Voluntary sector services were more likely to measure outcomes than LA in-house services (70% and 46% respectively); measuring outcomes perhaps linked to contractual status. Three-quarters of services (76%) used Performance Indicators (e.g. the number of referrals, group training sessions or contact hours) to assess their service.

*Costs and experience of change*

Data for overall budgets were poorly reported. Some participants considered the information to be confidential; others found it difficult to extract information for the rehabilitation service from their combined budget or provided partial information. Twenty-eight services reported annual budgets ranging from £13,000 to £800,000.

A majority of services reported that their budget had either decreased (23%) or stayed the same (71%) in the previous year with only four services reporting an increase. Changes in staffing ratios showed a similar pattern (see Table 9). While improvement in budgets or staffing ratios were attributed to changes in the configuration of the service, decreases in budgets and staffing ratios were mostly linked to austerity measures or financial cuts to services. Pressures on budgets were reported more often in the voluntary sector services than LAs: 27% of the former reported a decrease in their budgets in the last 12 months, compared with 14% of the latter. Similarly, 32% of voluntary sector services reported that staffing ratios had worsened over the previous 12 months compared with 18% of LA in-house services.

Table 9: Changes to budgets and staffing ratios compared with previous year

|  |  |  |
| --- | --- | --- |
|  | **Number of services** | **Percentage of services** |
| *Changes to budget:*Increased Decreased Stayed the sameTotal*Staffing ratios:*ImprovedWorsenedStayed the sameTotal | 41547666155071 | 6237192170 |

*Key concerns of**managers*

The final part of the questionnaire sought to identify managers’ main concerns about vision rehabilitation services. Sixty-two participants responded to this question; a number of key issues were identified. Concerns over budget cuts and associated changes were recurrent themes. Such changes were said to have had major negative impacts on services in a number of ways including staff shortages and pressures on types of staff, waiting times, and the type of service that teams were able to provide - in particular group work. Linked to concerns over budget cuts was a need to safeguard specialist assessments and a desire to expand rehabilitation opportunities, particularly in the areas of emotional support and counselling, and group work. The restrictions in budgets were felt to be linked to a lack of professional recognition of specialist vision rehabilitation skills. There was a perception among some managers that restructuring processes, especially where specialist teams had been disbanded in favour of generic teams, had further deteriorated the profile of vision rehabilitation services.

**Discussion and conclusions**

The need to provide rehabilitation services for people with sight loss becomes more pressing as the population ages. The existing research in this field has focussed on low vision services that are primarily hospital based. Robust evidence on the current state of community-based vision rehabilitation provision has hitherto been lacking. Drawing on findings from a national survey conducted as part of a major piece of research in this area, this article reports on the prevalence, organisational models and capacity of community-based rehabilitation services funded by LAs available at the time of the study to people with sight loss in England. While the findings reported in this article are from an English study, they highlight some areas of interest and concerns for commissioners and service managers elsewhere.

In brief, the findings show a diverse pattern of vision rehabilitation provision; the two dominant types of providers, accounting for almost nine out of ten services are LA in-house services and voluntary (not-for-profit) organisations. The remainder include arrangements such as joint health and social care, pilot social enterprise, and private (for profit) organisations. There is wide variation not only in the composition of teams and the range of management skills but also in the types of training and support services offered, waiting times and whether and how services measure the impact of their service on users. This variation means that it has not been possible in this study to identify a typical model of service provision. In general, services provided by the voluntary sector are most likely to be specialist in vision rehabilitation and to report greater pressures on budgets and staff ratios. The diversity of teams and the range of management skills found within LA providers, in particular, may reflect the wider changes in and pressures on adult social care. Specifically, in recent years there has been pressure to incorporate specialist services into existing models of delivery which have a more generic focus or within other ‘specialist’ services.

In line with other research (Kaye & Connolly, 2013; RNIB 2014), the findings from the wider study highlighted the importance of having access to workers with specialist knowledge and skills. An important part of vision rehabilitation is identifying the potential for rehabilitation in people with sight loss. Our survey shows that the screening of the initial referral by staff with specialist skills is not universal practice. Screening by staff who do not have specialist vision rehabilitation skills runs the risk of people with sight loss not receiving the crucial support needed to maintain/increase independence because screening staff may not recognise their rehabilitation potential. The fact that a quarter of LAs restricted access to vision rehabilitation service to people who were FACS eligible also suggests that a large group of people with sight loss may have missed out on opportunities to develop independent skills. The recent Care Act 2014 has the potential to protect rehabilitation support for people with sight loss. It requires LAs not to restrict access to the service based on a person’s eligibility for care and support, and to ensure that the service is delivered by staff with the skills, knowledge and competence to understand the needs of the individual. Undoubtedly, achieving that potential depends on how effectively the Act is implemented.

Lengthy waiting lists for services, with average waiting times of eight to 10 weeks (and a maximum of almost a year), may compromise timely access to rehabilitation and risk care needs intensifying during this period. As re-accessing the service is generally through reactivating formal intake procedures, timely ongoing support to respond to changing circumstances may also be at risk.

The importance of close links and collaboration with other organisations and professionals is highlighted in this study as a crucial factor in ensuring a whole system approach is adopted. A clear message from managers participating in the survey is that vision rehabilitation should be supported by professionals with a range of skills and cross agency teams. This is considered to be particularly important with an ageing population as older people are likely to have other conditions that may impact on sight loss. Visibility of, and knowledge about, vision rehabilitation services among professionals in other teams were recurrent themes in managers’ responses to the open questions. They considered that raising the profile of vision rehabilitation services was key in enabling closer working with other services, improving relationships with commissioners and establishing vision rehabilitation as part of a formal care pathway.

Although there was a lack of transparency around budgets reported for vision rehabilitation services, the findings show that financial cuts experienced in the previous year by almost a quarter of services who responded to the questionnaire had created challenges in the way teams were able to work and the type of support they were able to offer; of particular importance is reduction in self- management courses and group work, both identified by the literature review as activities with potential to be effective in vision rehabilitation (Lee et al., 2008; Hooper et al., 2008; Binns et al., 2012). Concerns over budget cuts, and difficulties in collaborating with other organisations and professionals were both considered by most managers participating in the survey as being linked to lack of insight among professionals on the importance of vision rehabilitation skills.

Given that vision rehabilitation is being widely encouraged in England and elsewhere, the findings have crucial implications for practice. They suggest that greater consideration is needed to safeguard specialist assessment (including the initial screening of referrals) especially in the areas where vision rehabilitation is provided via a generic team. Raising the profile of specialist rehabilitation services and increasing understanding among health and social care professionals about the aims, potential and limitations of vision rehabilitation services may not only protect specialist provision but also help people with sight loss to access services earlier, before their condition becomes more complex. Moreover, given the prevalence of depression in people with sight loss and considering the weight of evidence of effectiveness of group-based self-management programmes within rehabilitation services, service providers need to evaluate current practice and ensure the workforce in vision rehabilitation services has appropriate skills to recognise and address psychological issues in its client group, or to be able to refer on to specialist services.

The next project, currently underway, will address some of the key issues addressed in this article by providing robust evidence on the effectiveness and cost-effectiveness of community-based vision rehabilitation services and producing best practice guidelines for providers and commissioners.

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