

Sight loss in older people

The essential guide for general practice

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Royal College of
General Practitioners

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In memory of Alan Suttie, former Chief Executive of Fife Society for the Blind, an inspiration to the authors Anne and Barbara and a true champion for older people with sight loss.

Foreword

Sight loss is an increasing health concern in the UK. With an ageing population, the number of people with eye conditions is projected to rapidly increase over the coming years.

The Royal College of General Practitioners has recognised the importance of addressing this issue, selecting eye health - with a particular focus on ageing and sight loss - as one of our key clinical priorities until March 2016.

An essential part of our clinical priority work is ensuring that GPs have the knowledge, skills and confidence to effectively diagnose and either treat or refer people with an eye condition or sight loss.

This guide is an ideal learning tool to help general practice teams increase their knowledge and awareness of the particular sight issues facing older people. It includes helpful hints, tips and advice on making general practices more accessible to all people with sight loss.

The authors Dr Anne Sinclair, Dr Barbara Ryan and Dr Darran Hill also provide guidance on how to support people with sight loss, and the links between age, sight loss and other conditions such as diabetes and dementia.

I hope that all professionals working within general practice will find this booklet an invaluable resource, both as a knowledge reference, and as a source of practical ideas for improving patient care and service. I would encourage all GPs and their practice team colleagues, whatever their experience and level of expertise in the field of sight loss, to read this guide and apply the learning points to their work.



Dr Maureen Baker CBE

Chair of Council

Royal College of General Practitioners

Introduction

“Sight loss in older people: the essential guide for general practice” provides professionals working in general practice with a text to help them recognise sight loss and update their knowledge on the links between sight loss and other common health conditions. We also highlight the need and routes for early detection and appropriate referral, and suggest how services provided by general practices can be made more accessible for older people with sight loss.

We would like to thank all the organisations and individuals who reviewed the text and provided invaluable suggestions.

Following consultation with GPs, the guide includes an executive summary of the main learning points that are covered in each chapter to enable you to understand quickly what to do and how to put it into action.

For the purposes of simplicity and clarity, we have used the term “sight loss” throughout, and intend it to include all causes of sight loss. When we refer to “sight impairment” and “severe sight impairment”, we are using the terms of the Certificate of Vision Impairment which is described in the first chapter.

As an ophthalmologist, an optometrist and a GP registrar we have drawn on our professional and personal experience in the fields of eye health and sight loss and we hope that this guidance will be a valuable resource and reference within your practice.

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Executive summary

1. Identifying and assessing sight loss

Sight loss is very common in older people. In the UK, the prevalence of sight loss is increasing as the population ages.

When people start to lose their sight they often report difficulty reading small print, cooking, mobility, taking medication and recognising faces. Visual acuity, contrast sensitivity and visual field may be affected.

Macular degeneration, glaucoma and diabetic retinopathy are the most common causes of certifiable sight loss among older people in the UK. Uncorrected refractive error and cataract are the most common causes of avoidable sight loss in the UK. There are variations in the prevalence of common eye conditions between different ethnic groups.

Ophthalmologists determine whether a person is eligible to be certified as sight impaired or severely sight impaired. People with visual acuity $\leq 6/60$ can be certified sight impaired (partially sighted) and $< 3/60$ can be certified as severely sight impaired (blind).

2. General health and sight loss

Sight loss may be due to, or present alongside, other health conditions. Health professionals should consider the key issues affecting people with conditions such as:

- **Stroke:** check for gross field loss and diplopia. Ask when their last sight test was.
- **Diabetes:** encourage screening. Suggest low vision aids that may help patients self-medicate.
- **Falls:** when was their last sight test? The right glasses and good lighting at home are essential.
- **Dual sensory loss:** affects one in 20 people aged over 75. Has their hearing been checked?
- **Learning disabilities:** sight loss is common among people with learning disabilities. Ask when their last sight test was.
- **Depression:** more prevalent in people with sight loss. Consider intervention and vision rehabilitation services.
- **Dementia:** may conceal undetected sight loss. Ask when their last sight test was.
- **Visual hallucinations:** are common in sight loss. Patients may fear mental health problems or dementia, and it is important for them to understand that there are other causes.

- **Sleep:** obstructive sleep apnoea is linked with eye conditions.
- **Smoking:** cessation programmes help reduce the risk of sight loss in age-related macular degeneration (AMD).

3. What practice staff can do to support people with sight loss

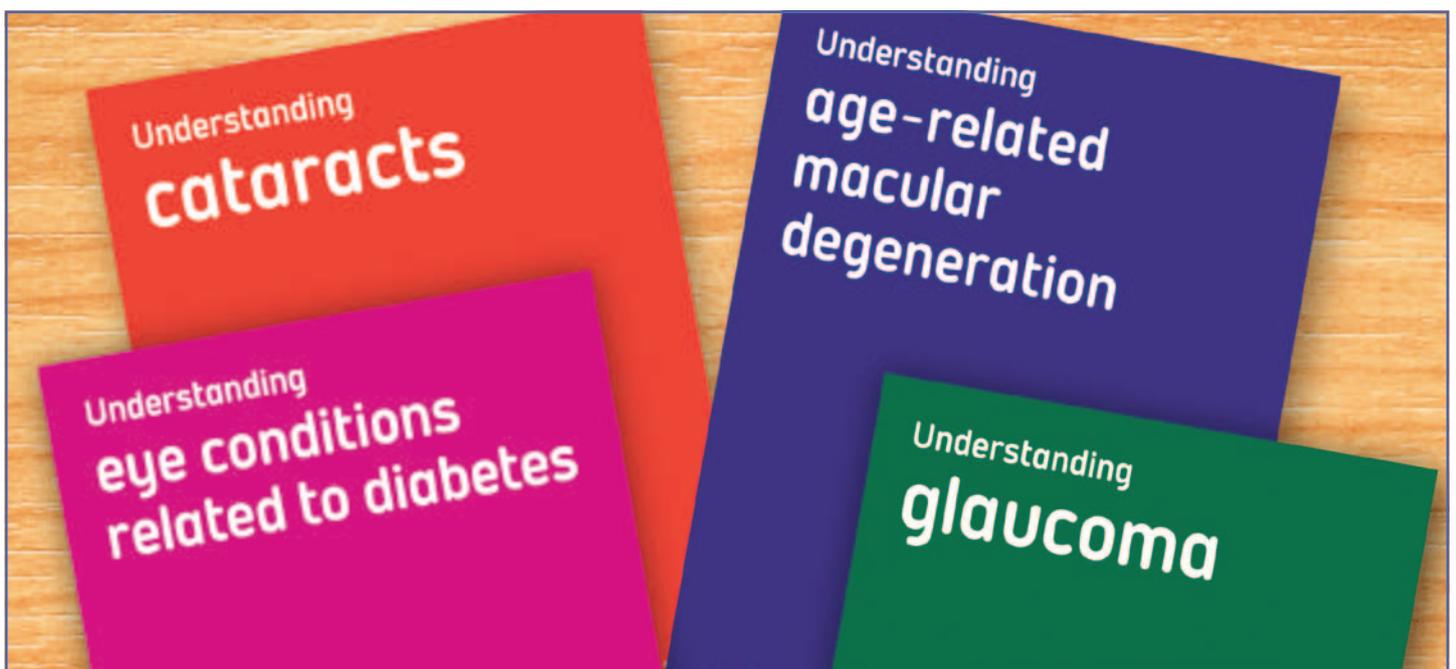
GPs and practice staff should refer individuals with reduced vision to a community optometrist for a sight test. Early detection and referral facilitates diagnosis, treatment and rehabilitation.

GPs and practice staff also have a role in referring to rehabilitation services. NHS funded low vision services offer magnifiers, tints, lights and other equipment on loan free of charge. These may be based in hospitals, multi-disciplinary centres, voluntary organisations or optometry practices. Rehabilitation services in social services or voluntary organisations provide equipment and adaptations to the home, training and support for daily living, mobility and orientation skills training. Condition specific, local and national, voluntary organisations provide a range of services and advice.

Advice on driving is important; the minimum visual acuity standard for driving with spectacles or contact lenses is 6/12 with both eyes open.

4. Making general practices more accessible

Colour and contrast in decoration, noting if a person has sight loss in their record, clear signage and large print information improves access for patients with sight loss. Alternatives are needed to self-check-in systems or electronic display boards in waiting rooms to call patients. An offer to guide a patient with sight loss to a consulting room is helpful.



Chapter 1 – Identifying and assessing sight loss

What you will learn

- How to recognise the early signs of sight loss in your patients.
- How visual function is affected and assessed in people with sight loss.
- Aspects to consider when determining the impact of sight loss on a patient's life.
- The main causes of sight loss that lead to a Certificate of Vision Impairment.
- The criteria, process and benefits of registration of sight loss.

Sight loss is common amongst older people and can affect their general health and wellbeing. Because older people might put their sight difficulties down to ageing, they might not mention them to health professionals. Therefore, it is important that general practitioners look for unrecognised and unreported sight loss, even when it is not the primary complaint.

Fifty percent of sight loss is preventable or avoidable [1], and early referral to optometry and ophthalmology services can ensure that patients are diagnosed and treated appropriately. When sight loss cannot be prevented, timely referral to optometry, ophthalmology, low vision and social care rehabilitation services can be life-changing.

Assessment of visual function

The majority of patients with sight loss will have reduced visual acuity (VA). While difficulty with reading or hobbies is often the first issue that people report, there may also be problems with distance tasks such as seeing street signs, driving or watching television. Recognition of faces and expressions is also commonly affected.

Distance visual acuity

General practitioners are familiar with distance visual acuity testing and most practices will have a Snellen chart for this purpose. Failure to position the chart at its correct distance or use of the wrong glasses will give erroneous results.

In terms of self-care and mobility, there is a huge difference between a vision of 6/60 and “hand movements”. Care should be taken to obtain an accurate assessment between these levels by testing at closer distances if necessary.

Near visual acuity

General practice premises may use newspapers and magazines to check near vision if specialist charts are not available.

Visual fields

People who have peripheral visual field loss, for instance from glaucoma or stroke, are often unaware of the defect. Visual field loss can have implications for activities such as driving, and safety risks, such as falls [1]. In the surgery, a quick confrontation visual field test, performed with both the patient's eyes open, can detect gross peripheral visual field loss. Many falls prevention interventions concentrate on central visual acuity problems, but peripheral field loss increases the risk of falls and the risk of injury caused by falling [2].

Contrast sensitivity

Contrast sensitivity is the ability of the visual system to distinguish between an object and its background. Cataract, macular degeneration, glaucoma and diabetic eye disease can all affect contrast sensitivity. Mobility may be problematic, particularly with navigating kerbs and stairs and reduced contrast sensitivity is a significant risk factor for falls [3].

Driving at night often becomes difficult. Patients may not be able to read poorly contrasting text (such as on food packaging or information leaflets) and have difficulty cooking and eating. Ophthalmic clinicians use a Pelli-Robson chart to measure contrast sensitivity. Letters are all the same size but they reduce in contrast as the patient reads down the chart. Although it may not be appropriate to incorporate this test into a GP surgery, knowledge of the importance of contrast sensitivity can help in understanding a patient's visual symptoms.



Contrast sensitivity testing using a Pelli-Robson chart. Letters are all the same size but they reduce in contrast as the patient reads down the chart

Assessing the impact of sight loss

When considering the impact of sight loss on a patient's daily life, the following aspects are worthy of consideration:

- **Reading and hobbies** – letters, TV listings, computer screens, phone displays, knitting and sewing.
- **Cooking** – buying and preparing food, pouring liquids, risk of burns or scalds, seeing dials on cooker/microwave, reading instructions/sell by dates.
- **Mobility** – going out alone, crossing roads, using public transport, risk of social isolation.
- **Communication** – telephone, writing, computer use, recognising friends, risk of social isolation.
- **Medication** – taking tablets, self-injecting, measuring blood sugar, reading prescriptions, instilling eye drops.
- **Emotional impact** – loss of confidence, risk of depression.

Certification and registration as sight impaired or severely sight impaired

Certification of Visual Impairment (CVI) is an important gateway to services, and GPs are ideally placed to give advice about the process and its potential benefits. GPs can make a referral to a consultant ophthalmologist for certification if their patient meets



the criteria or needs the status of their registration changed. When signed by a consultant ophthalmologist, the Certificate of Visual Impairment is the formal notification required by social services departments (in England, Wales and Northern Ireland) to register someone as sight impaired or as severely sight impaired [4]. In Scotland the equivalent form is the BP1 certification form, which has the same criteria for vision but currently uses the terminology “partially sighted” and “blind”. While registration is a voluntary process and people can decline to be registered, it is definitely in their best interest to accept registration, to facilitate access to the services available to support their independence.

A Public Health Indicator (PHI) for preventable sight loss was introduced in England in April 2013 [5] and has been used in Wales since June 2013. Its aim is to measure the numbers of all people who are certified sight impaired (SI) or severely sight impaired (SSI) and the numbers of people who have lost their sight from one of three major causes of preventable sight loss in the UK: glaucoma, age-related macular degeneration (AMD) and diabetic retinopathy. The number of people being certified currently offers the best practical measure of tracking eye health outcomes, despite the figures probably being an underestimate.

Although people with sight loss can usually access some social care services without registration, the CVI triggers the local authority to contact the patient to offer registration which is then followed by an assessment of visual impairment needs. This is a statutory requirement and should therefore be provided to anyone who goes on the register, regardless of their level of need. Note that this assessment precedes any full community care assessment of eligible needs which may exist. Depending on the person’s circumstances, registration may also entitle them to financial or other benefits.

Categories for Certification of Visual Impairment

Guidelines for sight impaired or partially-sighted:

- Visual acuity of 3/60 to 6/60 with a full visual field
- Visual acuity of up to 6/24 with moderate restriction of visual field
- 6/18 or better with gross field defect (for example hemianopia).

Guidelines for severely sight impaired or blind:

- Visual acuity < 3/60 with a full visual field
- Visual acuity > 3/60 but < 6/60 with a very contracted field of vision
- Visual acuity of better than 6/60 with a very constricted visual field.

The causes of sight loss

Chart 1 shows the causes of sight loss that led to certifications for severe sight impairment in England and Wales for the year ending March 2008 [6]. Data on sight impairment certifications for the same year show similar percentages. Macular degeneration, glaucoma and diabetic eye disease are the most common causes of certifiable sight loss.

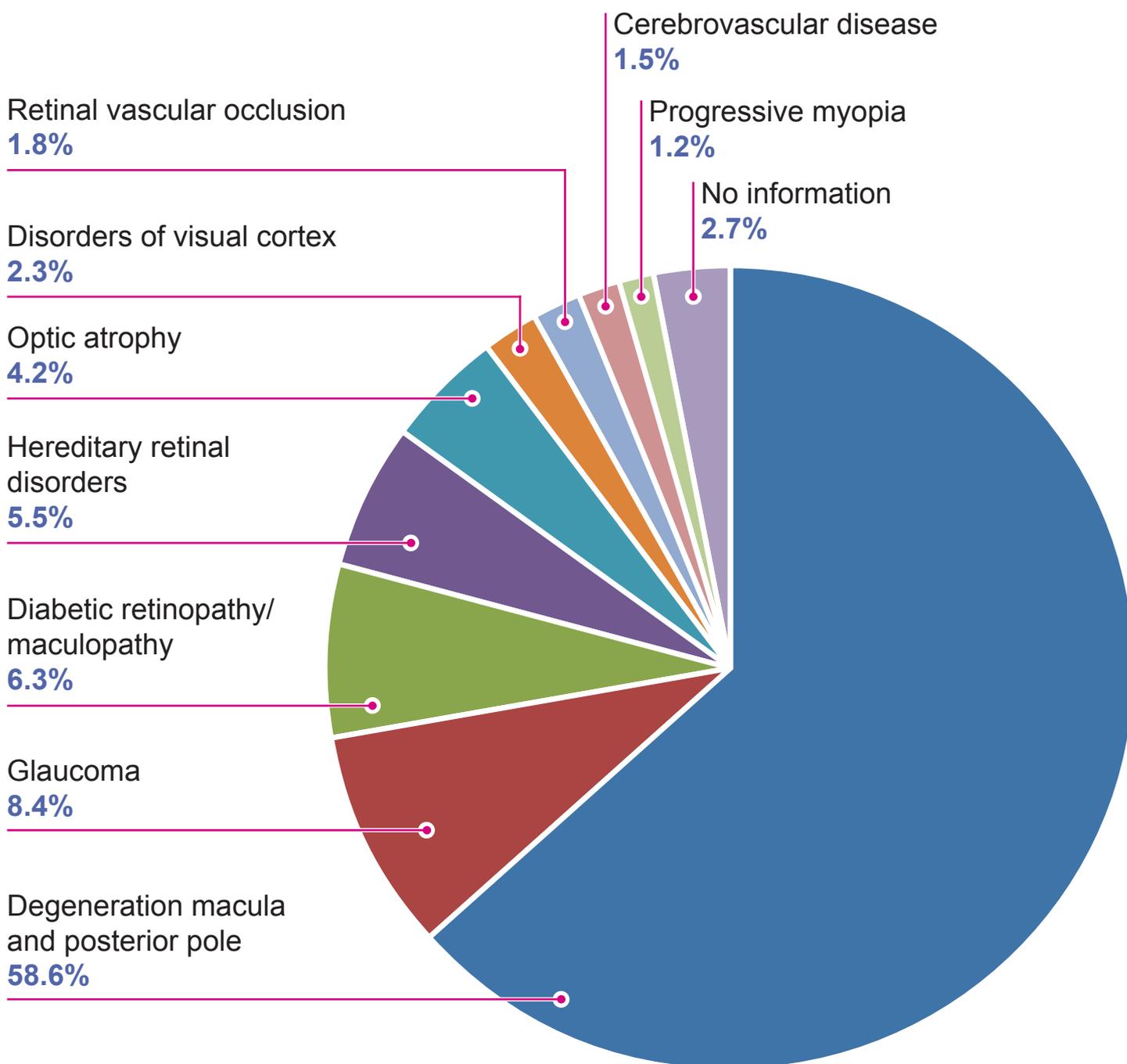


Chart 1. Main causes of severe sight impairment (blindness) certifications in England and Wales 2007–2008

Prevalence among black and minority ethnic communities

Among older people living in the UK, white people have the greatest risk of developing AMD. Asians have a higher risk of cataracts compared to other population groups. Black and Asian populations have a greater risk of diabetic eye disease than other population groups and the risk of glaucoma is much higher for the black population compared to the white population [7] [8] [9].

How common is sight loss?

Almost two million people in the UK are living with sight loss. It is predicted that by 2050 the number of people with sight loss in the UK will double to nearly four million. Over half of this sight loss is avoidable, mostly due to cataract and uncorrected refractive error [1]. This increase is mainly due to the age profile of the population; more than 80 per cent of sight loss occurs in people over the age of 60 years and this group is increasing in size [1]. Certification data shows similar figures, with almost 75 per cent of new certifications occurring in the over 65 age group [10] [Chart 2].

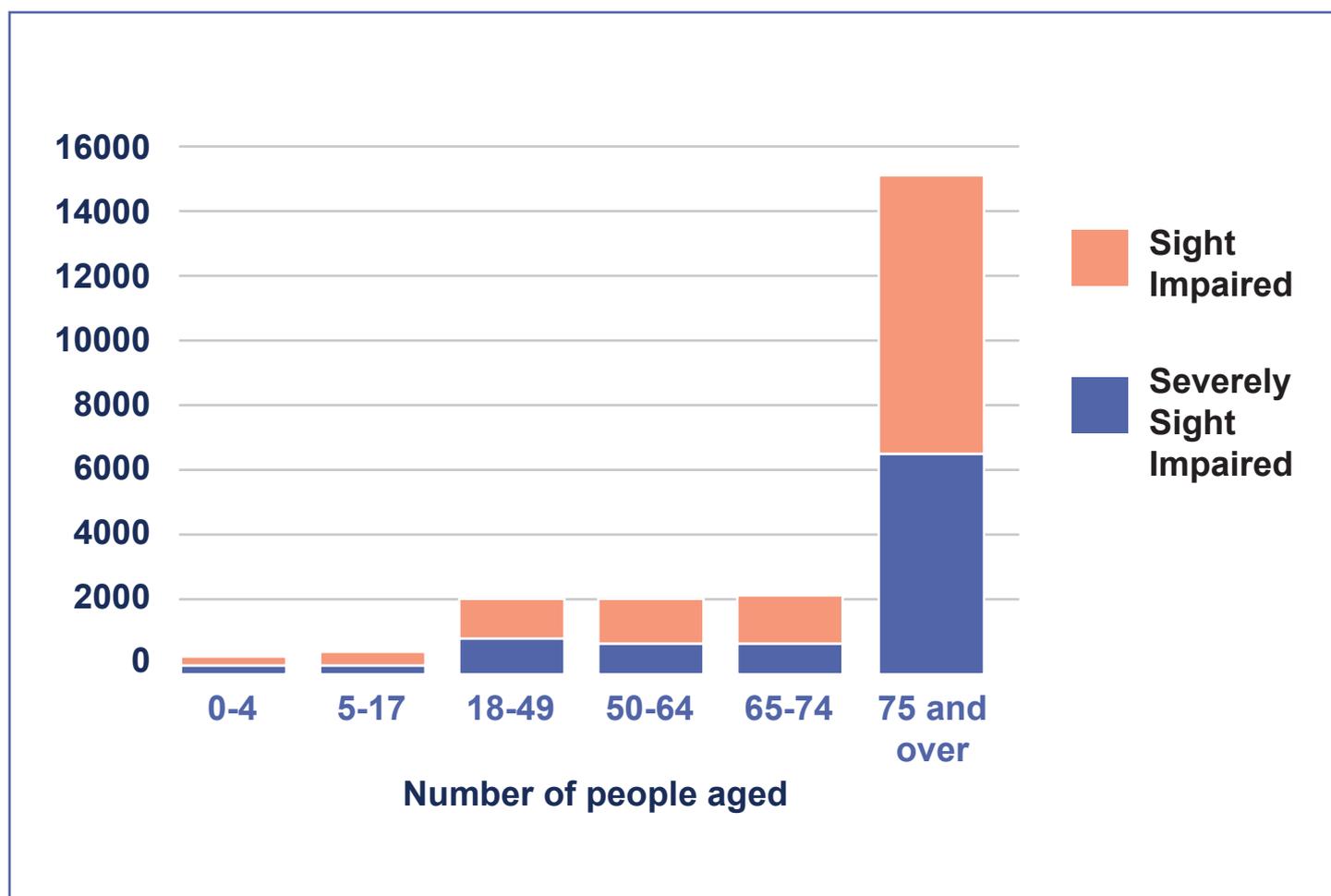


Chart 2. Number of all new certifications by age in England and Wales, April 2012–March 2013

In the UK:

- 4 in 5 people with sight loss are over 60 [\[1\]](#).
- 1 in 5 people aged 75 or over are living with sight loss [\[1\]](#).
- 1 in 2 people aged 90 or over are living with sight loss [\[1\]](#).
- 2 in 3 people living with sight loss are female [\[1\]](#).
- Sight loss is more common in people with learning disabilities than in the general population [\[11\]](#).

Summary of the main points

- Sight loss is common in older people, and as the numbers of older people in the population increase the prevalence is likely to increase too.
- When people start to lose their sight they often report difficulty reading small print, cooking, mobility, taking medication and recognising faces.
- Visual acuity, contrast sensitivity and visual field may be affected.
- Macular degeneration, glaucoma and diabetic retinopathy are the most common causes of certifiable sight loss among older people in the UK.
- There are variations in the prevalence of common eye conditions between different ethnic groups.
- Ophthalmologists determine that a person is eligible for certification.
- People with visual acuity $\leq 6/60$ can be certified sight impaired (partially sighted) and $< 3/60$ can be certified severely sight impaired (blind).

Chapter 2 – General health and sight loss

What you will learn

- How sight loss may co-exist with other health conditions.
- The relevance and importance of asking “When was your last sight test?”

The effects of deteriorating general health and sight loss are interwoven and complex, particularly in older people. For example people with macular degeneration are twice as likely to fall [12], which may lead to reduced mobility, isolation and the development of depression. People with sight loss are twice as likely to self-report having another long-standing physical or mental impairment, illness or disability [13]. Other co-morbidities such as hearing loss or dementia can be compounding factors.

While many older patients may not attend general practice with a primary complaint of sight loss, a careful analysis of their history may reveal that this is complicating their health difficulties.

Stroke

Patients with stroke may have a variety of visual symptoms which are likely to adversely affect stroke rehabilitation, and quality of life. An estimated three in five (60 per cent) of stroke survivors in the UK live with sight loss immediately after their stroke and the vision problems experienced have an impact on reading, self-care and navigation [14]. Early vision assessment and provision of information to stroke patients and carers is important.

Decreased visual acuity

In addition to the vision loss associated with their stroke, many patients admitted for stroke rehabilitation have uncorrected refractive errors; one study found that 25 per cent did not have their glasses with them [15]. Routine optometry sight tests should continue after stroke to detect sight loss and vision problems and improve rehabilitation.

Eye movement disorders

Gaze and cranial nerve palsies are a common feature of stroke and while some recover spontaneously, a group of patients will have severe diplopia, which can affect their rehabilitation and activities of daily living (ADL) such as reading, mobility and depth perception. Referral to an orthoptist is necessary in this situation [16].

Visual field defects

Severe visual field defects, especially homonymous hemianopias, are common effects of stroke. Even minor strokes carry a risk of field loss, which may be asymptomatic but significant for driving. Recovery is maximal in the first month. Where field loss persists, the National Clinical Guidelines for Stroke recommend retraining strategies, such as teaching compensatory eye movements to improve ADL skills. Reading is difficult with hemianopias; left-sided field loss makes it difficult to find the start of a line and with right-sided loss the person is reading into their “blind side”. Homonymous hemianopia is a criterion for certification as sight impaired and the patient will no longer meet DVLA driving criteria.

Perceptual and processing deficits

Perceptual and processing problems can make the complex task of reading more difficult than tests of visual function would indicate. Facial and object recognition can also be affected. Visual hallucinations are a common finding in those with homonymous hemianopia and often a worrying symptom for the patient.

Diabetes

Diabetes is associated with an increased risk of retinopathy and patients should be encouraged to attend for regular retinopathy screening. In addition, sight loss may result from retinal vein [17] or artery occlusions, non-arteritic anterior ischaemic optic neuropathy [18], diabetic papillopathy [19], and cataract [20]. Cataract is more common and can occur at an earlier age in people with diabetes than people without diabetes. Fluctuations in vision may be due to variations in blood glucose levels.

Difficulty with simple tasks such as reading pharmacy or food labels, seeing a blood glucose monitor or setting an insulin delivery device at the correct number of units may interfere with diabetic control. Hence, support with alternative “easy to see” or talking devices can help patients manage their blood sugar control independently [21]. Where sight loss and lower limb neuropathy co-exist, there will be an increased risk of falls [22] [23], and exercise levels will be adversely affected.



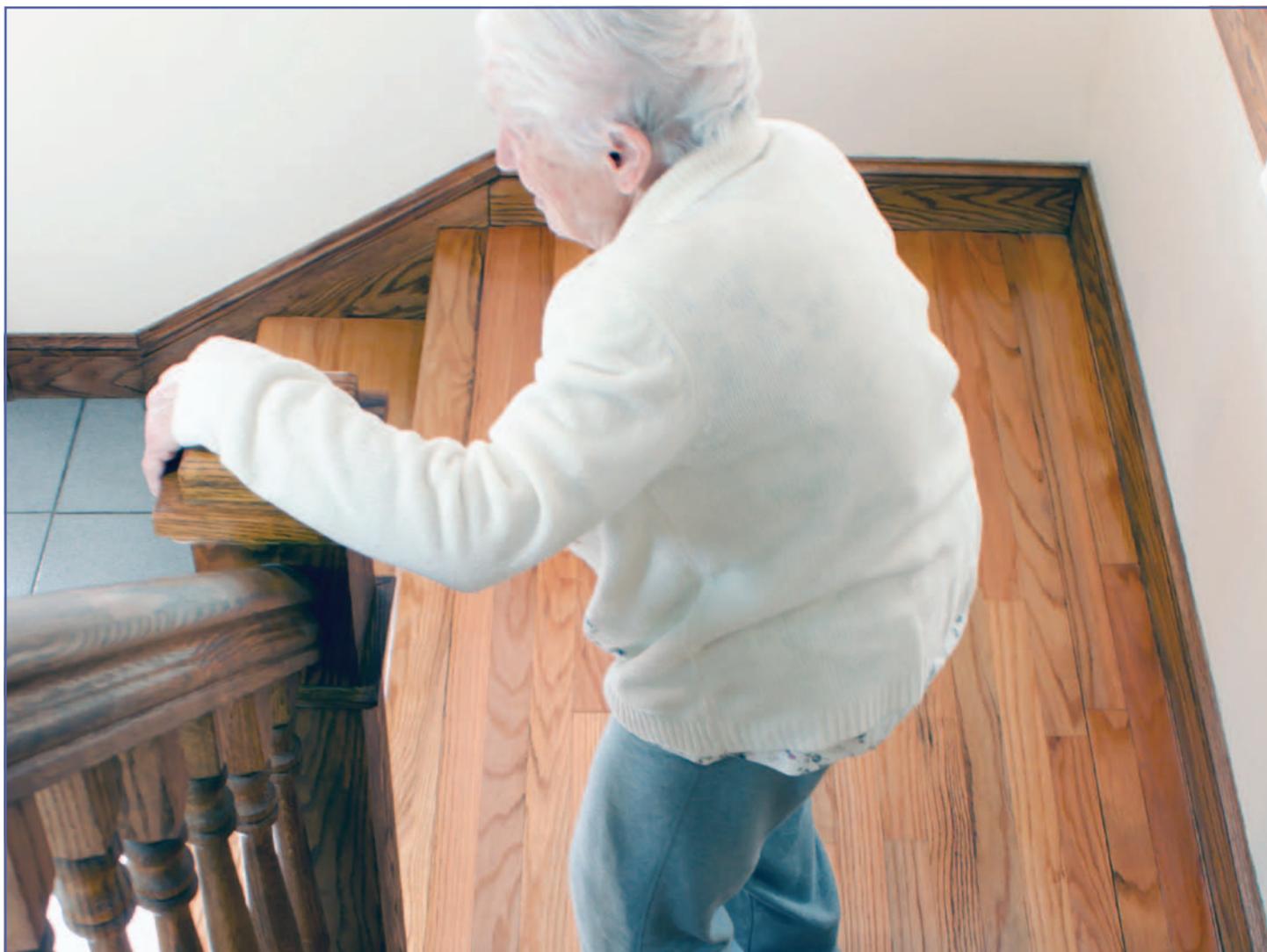
Using a stand magnifier to view an insulin syringe

Falls

Older people with sight loss are at a higher risk of falls than their sighted peers [24] [25] [26]. Almost half of all falls in the population with sight loss have been found to be directly attributable to their sight loss [27], although recurrent falls are seldom due to a single cause.

The NICE clinical guideline on falls recommends that multifactorial assessments undertaken by falls services should include investigation of sight loss [28].

The risk of falls may be reduced through various interventions, including home safety changes and housing adaptation [29]. Poor contrast sensitivity increases the likelihood of falling and good lighting is essential in falls prevention for the elderly [30]. Ensuring appropriate spectacle use in certain groups is important [31]. For those who regularly take part in outdoor activities, changing from multifocal to single lens distance glasses lowers the rate of falls significantly. However, in frailer people, who spend more time inside, the provision of single lenses resulted in an increased risk of falls outside compared with wearing their usual multifocal glasses [32].



Good lighting can help prevent falls

Dual sensory loss

A high proportion of older patients with sight loss also have a hearing impairment. Of the estimated 250,000 deafblind people in the UK at least 222,000 are aged over 70 [33]. This equates to one in twenty patients aged 75 or over who attend a GP surgery. Around 30 per cent of people who report either deafness or blindness, and 69 per cent of those reporting both, have at least four other long-term health conditions [34].

Impairment of any sensory function can lead to isolation. Dual sensory impairment makes this increasingly likely. It is important to expedite referrals to sensory impairment teams in social services and to both vision rehabilitation services and audiology services, emphasising the dual sensory loss.

Many deafblind people communicate using clear speech but some use interpreters (for example British Sign Language or deafblind manual) or communicator guides. The combination of vision and hearing impairment makes lip-reading difficult, and audio information is difficult to use.

Learning disabilities

Problems with vision are more common among people with learning disabilities than in the general population, and sight loss is reported in 16-24 per cent of people who are learning disabled [35] [36]. Some vision problems may be attributable to the disabling condition but other cases are due to conditions such as cataract. In a large proportion of people with learning disabilities and sight loss, the cause is uncorrected refractive error [37]. A survey in Northern Ireland reported that 43 per cent of people with learning disabilities had no previous eye test [38]. It is important to ensure regular sight tests to address sight loss and to maximise quality of life.

Dementia

As the risk of both dementia and sight loss increase with age, some people live with both conditions. Sight loss may be under-diagnosed in people with dementia and vice versa, because the effects of each condition may conceal the presence of the other [39]. Hence, the cause of, and appropriate response to, sight loss may not be identified.

Impairment of near vision is associated with cognitive decline, probably by reducing participation in stimulating activities [40]. Memory is assisted by visual clues and without good vision dementia may be “unmasked”. Subtle cognitive impairment, often previously undetected, can have an adverse effect on low vision rehabilitation [41], as poor concentration makes the use of even simple magnifiers and technology problematic. Dementias also have a visual-spatial impact, and some forms of dementia have a direct effect on vision.

The co-morbidity of dementia and sight loss increases the risk of disability and depression [42]. People with dementia are less likely to have eye examinations, and late presentation may mean they are less likely to benefit from treatments, such as for AMD [43]. Sight tests are essential for correction of refractive error. Assessment of eye health and referral for treatments, such as cataract surgery, can reduce sight loss and improve quality of life.

Depression

Studies indicate that the prevalence of depression in older people with sight loss is between 13.5 and 33 per cent, and probably closer to the higher figure [44] [45] [46] [47] [48]. As depression influences the ability to benefit from rehabilitation strategies, treatment is important. There is evidence that specific vision rehabilitation services (low vision clinical services, mobility and other skills training, counselling, optical device use, and adaptive device use) significantly contributed to a reduction in depression among a sample of older adults with age-related sight loss [49]. The effectiveness of the treatment of depression in people with vision impairment is currently unknown, but a number of studies are being undertaken.



Visual hallucinations

Visual hallucinations may result from a wide range of causes including an eye condition. Patients with sight loss may fear that they are developing a mental illness or dementia, and it is important for them to understand that there are other causes. Hallucinations as a result of sight loss are known as Charles Bonnet Syndrome (CBS), named after an eighteenth century Swiss scientist and philosopher who first described the condition in his own grandfather.

Prevalence of CBS in people with sight loss varies from 10 to 20 per cent [\[50\]](#) [\[51\]](#) [\[52\]](#). While most cases settle with time, up to 40 per cent of people with sight loss have long-term visual hallucinations [\[53\]](#). Although CBS is widely considered a transient condition without adverse consequence, one third of people affected have negative experiences and outcomes such as frequent, fear-inducing, longer-lasting hallucination episodes, or attribution of hallucinations to serious mental illness [\[54\]](#).

Charles Bonnet hallucinations can be simple unformed flashes of light, colours or shapes. However, many people see more elaborate forms such as geometrical grids and lattices and others report seeing vistas, animals or people.

CBS only causes visual hallucinations. There are no associated auditory or tactile perceptions. Reduced acuity, poor contrast sensitivity, older age and female gender are risk factors for visual hallucinations.

Despite a long recognition of the syndrome, there is no evidence-based medical treatment. Current best practice is to identify the condition, provide an explanation of the symptoms and reassure the patient to reduce unnecessary anxiety. Some practical measures that may help include the patient getting up and making tea (ie. activity), or turning on a bright light if the room is dark. Occasionally medication can be effective.

Smoking

There is strong evidence that smoking is causally linked with age-related macular degeneration (AMD), and that the risk increases with the intensity of smoking. The risk for current smokers is two or three times that of never-smokers. Ex-smokers have a reduced risk [\[55\]](#). Smokers are also three times more likely to develop nuclear cataracts (the commonest type). Ex-smokers have a reduced risk [\[56\]](#).

Smoking, by accelerating atherosclerosis, is related to retinal artery occlusions, anterior ischaemic optic neuropathy and ocular ischaemia, all of which can cause visual loss. Smoking can also cause amaurosis fugax [\[57\]](#).

Referral to smoking cessation programmes is therefore strongly recommended, particularly for patients with AMD who have already lost sight in one eye.

Sleep disorders

Obstructive sleep apnoea (OSA) has been linked to several eye conditions, particularly primary open-angle and normal tension glaucoma, non-arteritic anterior ischaemic optic neuropathy and floppy eyelid syndrome. Patients with OSA should have routine sight tests, especially to screen for glaucoma, because up to 27 per cent of people with OSA have been reported to have glaucoma [58]. Blindness carries a significant risk of sleep disruption due to disorders of circadian rhythm. Melatonin may be helpful for some patients [59] [60].

Summary of the main points

Sight loss relates to many other factors including:

- **Stroke:** check for gross visual field loss and diplopia. Ask when their last sight test was.
- **Diabetes:** encourage screening. Suggest low vision aids that may help patients self-medicate.
- **Falls:** when was their last sight test? The right glasses and good lighting at home are essential.
- **Dual sensory loss:** affects one in 20 people aged over 75. Has their hearing been checked?
- **Learning disabilities:** sight loss is common among people with learning disabilities. Ask when their last sight test was.
- **Depression:** more prevalent in people with sight loss. Consider intervention and vision rehabilitation services.
- **Dementia:** may conceal undetected sight loss. Ask when their last sight test was.
- **Visual hallucinations:** are common in sight loss. Patients may fear mental health problems or dementia, and it important for them to understand that there are other causes.
- **Sleep:** obstructive sleep apnoea is linked with eye conditions.
- **Smoking:** cessation programmes help reduce the risk of sight loss in AMD.

Chapter 3 – What practice staff can do to support people with sight loss

What you will learn

- The rules about driving and sight loss.
- How early detection and referral facilitates diagnosis, treatment and rehabilitation.
- The services and organisations that can offer support and enable people with sight loss to maintain independence and wellbeing.
- Useful resources for your practice.

Advising on driving

Stopping driving can be a distressing consequence of sight loss and is associated with loss of independence and self-esteem, which can lead to depression [\[62\]](#).

The Driver and Vehicle Licensing Agency (DVLA) define eligibility in terms of visual acuity and also field of vision. The minimum visual acuity standard for driving, with corrective lenses is 6/12 with both eyes open.

The field of vision standard for group one drivers is 120° in the horizontal visual field with at least 50° on either side of fixation, and no significant defect in the binocular field within 20° of fixation. Drivers unable to achieve this level of vision or who have an eye condition affecting both eyes are required by law to inform the DVLA. This includes patients who have good visual acuity but bilateral field defects, or who have had bilateral pan-retinal photocoagulation laser treatment [\[63\]](#). Failure to report to the DVLA could result in a £1,000 fine and/or a criminal conviction for the driver. There are also consequences for being insured.

The DVLA requires that GPs ensure that their patients understand that their condition may impair their ability to drive and explain that they have a legal duty to inform the DVLA. Recording any advice given in the patient's record is advisable. The General Medical Council (GMC) guidance recommends that if a doctor cannot persuade their patient to stop driving they should inform the DVLA immediately and should inform the patient that this has been done. Further advice can be found on the GMC website [\[64\]](#). For patients, RNIB offer information [\[65\]](#).

The role of general practice

The GP is well placed to identify people with sight loss and refer patients to optometry or low vision services for assessment. Referral to ophthalmology may also be required

for diagnosis and, if indicated, certification [\[61\]](#). In some areas referrals to local vision rehabilitation services may be sent directly to them.

Optometrists

General practitioners are often the first professionals to be consulted by a patient with sight loss. Unless the practice has an in-house ophthalmology specialist, it is essential to refer to a community optometrist for a sight test which will detect any ocular abnormalities such as refractive error, cataract or glaucoma. Possible signs of medical conditions such as diabetes or hypertension may also be identified. GPs are also in a good position to encourage older people not presenting with sight loss to have regular sight tests.



A sight test is free at the point of access for people aged over 60. In Scotland, eye tests are available to everyone free of charge. A GP can refer a patient for an NHS sight test in a practice or at home if the person is unable to get to a practice. In some areas there are enhanced services that use the skills of primary care optometrists to triage, manage and/or prioritise patients.

Ophthalmologists

Ophthalmologists are the only professionals who may certify a patient as sight impaired or severely sight impaired and GPs can refer to them for certification. (see Chapter one for details of the certification process).

Eye Clinic Liaison Officers (ECLOs)

ECLOs can support ophthalmologists by providing information about resources for people with sight loss and give support at the time of diagnosis of an eye condition or sight loss. ECLOs are also known as sight loss advisers or sight loss support services, and in Scotland, vision support officers. They are a key resource in helping patients understand the impact of their diagnosis and providing patients, their carers and family members with support and access to statutory and voluntary services.

Low vision services

NHS funded low vision services offer magnifiers, tints, lights and other equipment on loan free of charge. Staff have an in-depth knowledge of local services for people with a sight loss and encourage people to make full use of the sight they have by providing training, equipment and advice.

These services may be provided in hospitals [\[66\]](#) multidisciplinary centres, community optometry practice or voluntary sector centres [\[67\]](#) [\[68\]](#) [\[69\]](#). In Wales, services are provided in optometry practices. GPs can usually refer directly into low vision services.



NHS low vision services offer magnifiers, tints, lights and other equipment on loan free of charge

Vision rehabilitation services

Vision rehabilitation services for people with sight loss are provided in the community by social services and voluntary organisations. While different care professionals may be called upon to provide a package of care and support for individuals, people with sight loss who have been registered and have received an assessment of visual impairment needs should be offered rehabilitation by a suitably qualified worker. Rehabilitation is a form of early intervention which should be available from the local authority for all who have received an assessment.



Early referral can enable the person to begin to adapt to their changing vision. Referral should be made urgently if an aspect of a person's life has been identified that may lead to them harming themselves or someone else (for example danger in the kitchen, risk of being knocked down or risk of falling).

Voluntary organisation services

Condition specific, local and national voluntary organisations provide a range of services and advice. Useful links for patients are given on [pages 30 to 31](#).

Vision rehabilitation services may recommend or provide equipment and adaptations to the home using the concepts of good lighting, contrast enhancement and enlargement. New lighting may be recommended (and, in some areas, installed), or non-optical low vision aids such as large number watches or phones, recommended.



A vision rehabilitation worker identifies problem areas and may develop a Daily Living Skills training programme to enable a person with sight loss to undertake the tasks they need to do around the home. This may include kitchen skills, personal care and general household tasks, including the use of low vision aids.

Orientation and mobility training may be provided for people who need it. The assessment and training will take into account the routes the person wants to travel, their level of vision, mobility aids, low vision aids, physical fitness, and/ or preparation for a guide dog.

Summary of the main points

- Advice on driving is important; the minimum visual acuity standard for driving with spectacles or contact lenses is 6/12 with both eyes open.
- GPs and practice staff should refer individuals with reduced vision to a community optometrist for a sight test. Early detection and referral facilitates diagnosis, treatment and rehabilitation.
- NHS funded low vision services offer magnifiers, tints, lights and other equipment on loan free of charge. These may be based in hospitals, multi-disciplinary centres, voluntary organisations or optometry practices.
- GPs and practice staff also have a role in referring to rehabilitation services. Rehabilitation services in social services or voluntary organisations provide equipment and adaptations to the home, training and support for daily living, mobility and orientation skills training. Condition specific, local and national, voluntary organisations provide a range of services and advice. Useful links for patients are given on [pages 30 to 31](#).



Chapter 4 – Making general practices more accessible

What you will learn

- How to improve accessibility of premises and services for people with sight loss.
- How to welcome and guide people with sight loss.

Accessibility

Since the introduction of the Disability Discrimination Act (1995) [70] and subsequent Equality Act (2010) [71] access to public places for people with sight loss has improved. Providers of health services are required to make reasonable adjustments to make services accessible to people with a disability, including sight loss. Adjustments are not necessarily expensive, can benefit all patients, and save time and money.

Inaccessible communications can lead to errors in reading appointment times (with consequent possible delays in treatment) and/or in reading instructions for medicines (with consequences for health). Inaccessible buildings or systems to make and confirm appointments may put people off attending appointments.

Surveys of people with sight loss have led to guidelines for adaptations [72] [73], and the RCGP website offers guidance [74] [75], under the following headings:

Staff awareness

- Sight loss awareness training.
- Assistance and privacy with paperwork.
- Guiding ([see page 29](#)).

Information and communication

- Add an alert to the patient's electronic record to indicate that they have a visual problem.
- Consider alternatives where self-check-in systems or electronic display boards are used in waiting rooms to call patients.
- Identify and record patients' individual needs in terms of preferred format, including font size, braille and audio.

- Materials (for example appointment cards and letters) available for patients with sight loss should be audited.
- Provide information on local and national support services available for people with sight loss. Useful links to further information are given on [pages 30 to 31](#).

Physical environment

- Signage (eye-level, well-lit, large clear font, lower case except first letter, good contrast).
- Remove obstacles (pamphlet stands, toys).
- Enhance visibility of glass with signs or stickers, minimise glare.
- Contrasting colours and tones used in external and internal decoration.

Further information on accessible communication:

- RNIB's "See it right" guidelines to accessibility – contact RNIB's Helpline on **0303 123 9999**.
- All [Wales Standards](#) for communication and information for people with sight loss www.wales.gov.uk/topics/health/publications/health/guidance/standards/?lang=en
- [NHS England Accessible Communication project](#) www.england.nhs.uk/ourwork/patients/accessibleinfo-2/



Guiding the patient to the consulting room

When a GP practice knows a patient has sight loss, a personal greeting in the waiting room can give reassurance. It is useful for all general practice staff to be able to offer to guide patients with sight loss. Guiding is not difficult, but most people are understandably nervous if they have not had previous experience. Local or national voluntary organisations provide sight loss awareness and guiding training.

Tips for guiding

- Always ask the person if they want help.
- Stand side by side so that the person can locate your upper arm.
- Ask the person on which side they prefer you to walk.
- Start moving and walk one step ahead.
- Give commentary concerning hazards for example “we are approaching a flight of stairs going up”.



Guiding a patient to your room can be helpful

Summary of the main points

- Using contrast, clear signage and large print improves access for patients with sight loss.
- Recording that a person has sight loss on their patient record is important.
- Consider alternatives to self check-in systems or electronic display boards used in waiting rooms to call patients.
- Offering to guide a patient with sight loss to your room is helpful.

Chapter 5 – Sources of information

UK sight loss charities

Action for Blind People

0303 123 9999 • actionforblindpeople.org.uk

Fight for Sight

020 7264 3900 • fightforsight.org.uk

Guide Dogs

0118 983 5555 • guidedogs.org.uk

RNIB

0303 123 9999 • rnib.org.uk

RNIB Sightline Directory

A valuable search tool that has information to help find local and national organisations, services and support groups.

0303 123 9999 • sightlinedirectory.org.uk

The Partially Sighted Society

0844 477 4966 • partsight.org.uk

Thomas Pocklington Trust

020 8995 0880 • pocklington-trust.org.uk

Some condition specific charities

For information and peer support for people who have some eye conditions.

The Alzheimer's Society

0300 222 11 22 • alzheimers.org.uk

alzheimers.org.uk/site/scripts/documents_info.php?documentID=1408

([Sight in dementia information](#))

British Retinitis Pigmentosa Society

0845 123 2354 • brps.org.uk

Deafblind UK

01733 358100 • deafblind.org.uk

Diabetes UK

0345 123 2399 • diabetes.org.uk

International Glaucoma Association

01233 648170 • glaucoma-association.com

Macular Society

0300 3030 111 • macularsociety.org

Sense (for deafblind people)

0300 330 9256 • sense.org.uk

SeeAbility (for people with sight loss and multiple disabilities)

01372 755 045 • seeability.org.uk

Stroke Association

0303 3033 100 • stroke.org.uk

Local sight loss charities

Local sight loss charities exist in most areas to provide advice and support at a local level. They provide emotional support, peer support groups and activities; support at home and access to local services; benefit entitlement advice; sell or provide adaptive equipment including magnification and lighting along with training in their use. Some local societies offer mobility and orientation training whilst in other areas this is provided by the local authority.

Visionary

An umbrella organisation representing local sight loss charities.

0208 417 0942 • visionary.org.uk

Local sight loss data

Local sight loss data by region and local authority area is available on rnib.org.uk/datatool

RCGP clinical priority project

vision2020uk.org.uk/ukvisionstrategy/clinicalpriority

rcgp.org.uk/eyehealth

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When an older person has a problem with their sight they may not report the problem to any health professional, assuming it is a normal symptom of ageing. This guide has been written to assist professionals in general practice to recognise sight loss. It describes links between sight loss and other health conditions, emphasises appropriate referral, and suggests how to improve accessibility.

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Please contact the UK Vision Strategy team for further copies.

To view an accessible version of this guide, visit:
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