

Wales Council of the Blind

REHABILITATION OFFICERS FOR VISUAL IMPAIRMENT

Addressing a workforce crisis in Wales.

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Forewords

Vision is the most fundamental sense we use in living our daily lives. From the moment we wake up and wonder what time it is and choose what clothes to put on, to the moment we get into bed and reach for a book to read to calm us to sleep. Losing sight in a sighted world is not something most people can imagine and, for many, is a truly frightening prospect. Yet it happens to at least 100 people a day.

If this happened to any of us we would surely want the support of a trained professional who can listen to our anxieties and fears, who can give calm, practical advice from the outset and who can teach us new skills as we learn to adapt to our new circumstances. That professional is the Rehabilitation Officer for Visually Impaired People (ROVI). Given that 100 people lose their sight each day it may surprise you to learn there are just 38 such professionals working in Wales today.

This vital report sets out the state of affairs today and proposes the action required to ensure the people get the services they are entitled to and deserve.

*- Simon Labbett, Chair, Rehabilitation Workers
Professional Network*

The Welsh Rehabilitation Officer Forum fully endorses and welcomes the findings in this report. For the last 10 years WCB have sought funding for our training and supported us with the professional registration of the workforce here in Wales. This has required all practising rehabilitation workers to register with the UK professional body, and to meet the standards set out by them. This means all Rehabilitation Officers in Wales meet the Qualification

Framework guidelines set out by Social Care Wales as an allied professional.

Professional registration requires all Rehabilitation Workers to continue with their professional development and gives the public reassurance by providing oversight into the high level of risk involved in this role.

The Welsh Rehabilitation Officers Forum has many concerns that are highlighted in this report. We would like to see Welsh Government and local authorities invest in the workforce and take a detailed look at how processes with regard to referrals, assessments, plans and rehabilitation delivery are carried out, to ensure all people with a vision impairment, no matter where they live, have timely access to early intervention and preventative services by a qualified registered worker.

- Ian Moran, Chair, Welsh Rehabilitation Officers Forum

About this report

When WCB was commissioned to look into the pattern of service provision for people with sight loss in Wales we had not anticipated the enormous challenges we all faced in 2020 and 2021. These challenges have tested the various agencies involved in the provision of support – in health, social care, and the third sector – who all have, in various ways, adapted to circumstances and delivered services against the odds at a time when they were at risk of being overshadowed by the predominant public health priority.

So, instead of being a clear picture of what is being delivered in 'normal' times, this report has become something of a special case, but one that highlights the continuing importance of the various services and their adaptability to new pressures. Some changes in practice are perceived as positive, others not so. Through consultation with the Wales Vision Forum, we took the decision to separate the specific pandemic-related issues into their own chapter so that they can be considered as special cases while not being lost.

The data informing this report come, for the most part, from interviews with 38 Rehabilitation Officers for Visual Impairment covering all 22 local authorities. It's important to stress here that we did not interview service users for this report, although case studies are given in the appendix 5. Furthermore the importance of the role of the ROVI was not in question. Rather, we aimed here at getting closer to the issues around CPD, qualification, and workforce planning. Quotations from contributors are embedded within the narrative.

Throughout this document are recommendations for improvement, but we have created key recommendations

in the Executive Summary. One key recommendation is to establish an advisory board. This board could allocate the other recommendations to appropriate agencies as it sees fit.

This report focuses on rehabilitation services for adults. Habilitation workers for children and young people are not covered.

EXECUTIVE SUMMARY and RECOMMENDATIONS

The role of the Rehabilitation Officer for Visually Impaired (ROVI) is to build confidence; provide emotional support; regain lost skills and teach new skills; and maintain and promote independence and choice. These skills will enable people with sight loss to live safely and contribute to society as active citizens.

Rehabilitation is about helping people to do things for themselves and live safe, independent lives. Early intervention is crucial to reduce the need for ongoing support from already overstretched services. Early intervention also helps to tackle loneliness and social isolation, which are priorities for Welsh Government.

The **Social Services and Wellbeing (Wales) Act 2014** came into force on 6 April 2016. The Act places a statutory duty on local authorities for the first time to provide a preventative approach to meeting people's care and support needs, including minimizing the effects of impairments. It is not possible to deal with sight loss without Rehabilitation as those new to the situation have to learn new ways to accomplish essential tasks and to be introduced to a range of equipment and techniques to avoid injuries and falls and mitigate or defer the need for longer term care. The Codes of Practice to the Act provide specific advice to health boards and local authorities about

reablement and habilitation (Part 2 Code of Practice paragraphs 182-186) [4].

In **Healthier Wales** the Welsh Government sets out the ambition to bring health and social care services together, so that they are designed and delivered around the needs and preferences of individuals, with a much greater emphasis on keeping people healthy and well

Growing concerns

The importance of ROVIs in providing effective interventions for people with sight loss.

This report stresses the fact that the ROVI is the only qualified worker to make an assessment of need in the case of people with sight loss and to deliver specific interventions. The cost benefits are known from research: rehabilitation interventions have been shown to remove the need for continual and costly support from other social care services and health.

While we often talk of a 'postcode lottery' of services, in the case of rehabilitation we must be careful to restrict that to an assessment of *availability*, not *quality*, of service. The quality of service is governed by a recognised qualification and, shortly, a recognised set of quality standards so that it shouldn't matter where you live - the service you receive will be of a high standard.

See sections:

Introduction - why do we need rehabilitation officers?;
Introduction - The financial value of rehabilitation;
Current and Future Capacity: Professional Standards and the importance of a ROVI being a qualified worker.

The scarcity of ROVIs

If we recognise that the ROVI is the worker who can provide the necessary assessment and delivery of interventions, we must also recognise that there is a crisis looming. Wales is already under-resourced and the impending loss of workers through retirement creates a crisis situation where local authorities will be failing people with sight loss.

See section:

Current and Future Capacity - the scarcity of
Rehabilitation Officers

Lack of adequate supervision

There is variable pattern of supervision of ROVIs (specifically supervision regarding cases). Some ROVIs operate in isolation from the social care team and go unsupervised. This poses risks to the public and to the ROVI.

See section:

Current and Future Capacity - the importance of the team and professional support.

Unskilled staff

There are currently 30.3 FTE out of the recommended 44.9 ROVIs and set to fall to less than 10 by 2030 if no action is taken. This scarcity of ROVIs will pass the burden of work onto unskilled staff – that is to say staff that have not undergone the rehabilitation training necessary to carry out the appropriate needs assessments and interventions. This will most likely be inefficient and costly in the long term.

See sections:

Introduction - the financial value of rehabilitation;
Current and Future Capacity - Professional Standards and the importance of a ROVI being a qualified worker.

People are being signposted away

There is a concern that people in some areas are being signposted away from rehabilitation. We know that ROVIs are not given access to each case that highlights sight impairment, perhaps resulting in longer-term problems for the service user. This tendency is an indication of a lack of understanding of the purpose the ROVI serves in making

full specialist assessments and delivering early interventions.

See section:

Current and Future Capacity - Valuing and understanding the role of the ROVI.

There are no data on numbers of people going through or missing the service

The lack of available consistent data or data gathering means that the signposting away problem is hard to verify. Where the single point of access simply refers people to external support there is a gap in data. Data on people being assessed by social care is available from the case management system. ROVIs do not always have access to this database.

See section:

Client Outcomes and Recording Service User Experiences

Waiting lists / waiting times

Waiting lists are the prevailing anxiety of service managers, often resulting in artificial ways of reducing the numbers of people with sight loss waiting for support from a ROVI. Without gaining access to the daily working methods of each local authority it is difficult to determine the paths individual service users take, particularly from referral into social services. We suspect some authorities will direct some individuals straight out to support in, for instance, the third sector and others might have a route into Direct Payments via a third party provider. These might be being used as a way of avoiding putting individuals on the waiting list for ROVI support. The former is putting pressure on the third sector to solve problems

out of their remit and the latter simply places the individual in a situation of on-going support at a cost to the local authority.

See section:

Current and Future Capacity - waiting lists and referral rates.

No clear referral routes

There is variation in referral opportunities to address unmet need. Where the ROVI cannot provide a service and identifies a risk that needs addressing as a matter of urgency, there is a postcode lottery of provision to meet those needs.

See sections:

Referral Pathways to ROVI Support;
Appendix 7 - Risk assessment tool.

Key recommendations

Oversight of profession

There needs to be formal recognition of the ROVI's responsibilities and the safety of the public. The forthcoming regulation of the profession under the Professional Standards Authority should be recognised by Social Care Wales to encourage the standards to be adopted by each local authority.

Supervision

Furthermore, the requirement for professional supervision of ROVIs is implicit in these standards. Where there is no supervisor available to support the ROVI in relation to their

role, a peripatetic ROVI supervisor should be engaged for the purpose.

Regional working

Consideration should be given to sharing resources across county boundaries, with supervision for example. This could fall within the remit of the Regional Partnership Boards.

Better data capture and outcome measurement

Data need to be captured on the referrals to outside agencies where someone presents with sight impairment. All inquiries for support should be logged, including the actions taken, and made available for inspection by sensory teams in order to identify situations where individuals who could benefit from ROVI support are being inappropriately forwarded on to other agencies.

The outcomes measure tool developed in Rhondda Cynon Taf should be adopted across Wales, particularly where no similar tool is used, and the data gathered for Wales-wide analysis. Service User satisfaction data should be routinely recorded and used for service improvement.

Clear pathway with routes to other services for unmet need

Unmet need (a need that cannot be met by the ROVI) must be dealt with by other skilled workers such as a mental health worker. These workers or agencies must be quickly and clearly identified to enable swift referrals into support where the ROVI cannot safely provide an intervention.

Promoting understanding of role and what to expect

Better information needs to go out to the public and affiliated workers to ensure a fuller understanding of the ROVI's purpose. The public needs to know what they can expect from the service and how to access it. They need to gain an understanding of the kinds of intervention available to them so that they don't fall at the first hurdle – namely, the What Matters conversation. The affiliated workers must understand how the ROVI fits within a larger social care context so that ROVIs are not treated as an afterthought. They must understand that the ROVI can provide support that reduces the pressure on other services.

Strong workforce development plan

The scarcity of ROVIs needs to be anticipated and addressed through a workforce development plan for each local authority. Although this study looks at the short-term problem of staff retiring from an already under-strength workforce, the problem does not go away – it needs to be kept under review.

Rehabilitation Course and Apprenticeships

The creation of the satellite Rehabilitation course can help to address the shortage of trained ROVIs. By making the course available in Wales, it is more easily taken up by people already working in associated fields. It can also be responsive to demand; since the workforce is a small one there is only an occasional need to refresh the workforce with newly trained officers. The Apprenticeship model, as used in England, would offer a cost effective way of getting people trained up when demand for new officers is anticipated. A similar apprenticeship model could be established in Wales with Welsh Government support.

Investment in Continuing Professional Development

Greater investment in CPD is essential for maintaining a robust and well-informed service. Local authorities and third sector providers should recognize the value in nurturing their workforce and release more time and money to allow ROVIs to take up CPD opportunities.

Establish an advisory board

To establish an advisory board with representatives from local authorities, local health boards, Third Sector, Social Care Wales and Welsh Government to implement the above recommendations.

Acronyms

BCU	Birmingham City University
CPD	Continuing Professional Development
CVI(W)	Certificate of Visual Impairment (Wales)
ECLO	Eye Clinic Liaison Officer
FTE	Full time equivalent (no. employees)
IAA	Information, Advice and Assistance
LVSU	Low Vision Service Wales
NVQ	National Vocational Qualification
OT	Occupational Therapist
PSA	Professional Standards Authority
RNIB	Royal National Institute for Blind people
RPB	Regional Partnership Board
ROVI	Rehabilitation Officer for Visual Impairment
RWPN	Rehabilitation Workers Professional Network
SCW	Social Care Wales
SPoA	Single Point of Access
SSIA	Social Services Inspection Agency
WCB	Wales Council of the Blind
WCCIS	Welsh Community Care Information System
WCDeaf	Wales Council for Deaf People
WLGA	Welsh Local Government Association
WROF	Welsh Rehabilitation Officers Forum

INTRODUCTION

First of all, some words from service users:

“Timely access to mobility training meant that I didn’t build up a fear of going outside and avoided feeling completely trapped because of my sight loss. I just know that without the ROVI’s help I would still be struggling with my sight loss.”

“The ROVI gave me the reassurance that I needed as I was in shock and struggling to come to terms with my sight loss”

“The training from the ROVI has helped me to feel more confident and take part in a wider range of activities. I am now able to catch a bus back and forth to the resource centre, independently. This has meant that I now attend local groups and meet others with sight loss from whom I have learnt so much. If it wasn’t for help from my ROVI I wouldn’t be able to go out and about as much as I can.”

- See Appendix 5: ROVI case studies

Wales Council of the Blind and the wider sight loss sector are concerned about the reducing numbers of Rehabilitation Officers for the Visually Impaired (ROVIs) in Wales. The recommended number is 1 per 70,000 residents. In actuality, there are 30.3 FTE out of the recommended 44.9 FTE ROVIs currently employed. This shortfall will exacerbate an already challenging scenario where Covid restrictions have created both a backlog of cases and additional cases due to lost skills and the impact of reduced services in primary and secondary healthcare. The impact of the pandemic has resulted in more people living with sight loss feeling isolated and

lonely as a result of a reduction in confidence and life skills.

These ROVI numbers have fallen from 34.2 FTE in 2018 to 30.3 currently, showing that there is a critical situation in Wales where provision of this key service is dangerously low. It is essential that local authorities act now to heed the warnings that have come from the third sector since 2014. Failure to act could result in the loss of this specialist service. ROVIs are the only specialists qualified to work within social care with adults with sight loss. This threatens the independence and wellbeing of future generations of blind and partially sighted people in Wales.

WCB has brought together professionals from the Welsh Rehabilitation Officers Forum (WROF) and the Third Sector in the form of a task and finish group to look at the concerns around falling numbers of rehabilitation officers and the proposed rehabilitation course. This group will form part of the membership of a Welsh Government-led advisory board, proposed below, to implement recommendations.

An opportunity for improvement presents itself now that the Regional Partnership Boards are undertaking the second round of Population Needs Assessments throughout Wales. Welsh Government, in its Supplementary Advice for Regional Partnership Boards [March 2021] advises that consideration be given to:

“Sensory Impairment – the need for Rehabilitation Officers for the Visually Impaired (ROVIs). There has been some work done by the Wales Vision Forum and Wales Council of the Blind about this, which could potentially be drawn upon.”

This present report represents the work alluded to above, and we would hope that RPBs and local authorities give it their fullest attention, as it highlights some of the issues around the following:

- Scarcity of trained rehabilitation officers in Wales and workforce planning;
- Continuing Professional Development;
- A Wales-based rehabilitation degree;
- Consistent screening of service users;
- Outcome and experience measures for service users;
- Recognition of the importance of ROVI support;
- Support for the workforce.

Importantly, we ask the newly formed Welsh Government to take this work forward as a priority and to form the aforementioned advisory board.

What does the rehabilitation officer do?

The key competencies of the ROVI cover:

- Assessment
- Eye conditions
- Low vision
- Orientation and mobility
- Independent living skills
- Communication skills

See Appendix 1 for a fuller description of these competencies.

The financial value of rehabilitation

Research into the “Sight for Surrey” vision rehabilitation service in 2015/16 evidenced a cost of £1,300 per referral. Evidence of the cost savings made by effective rehabilitation can be found in research by the Office for Public Management’s study to assess the economic impact and value of vision rehabilitation services in England [1].

The report *Demonstrating the Impact and Value of Vision Rehabilitation* evidenced that the financial value resulting from rehabilitation may significantly outweigh the financial costs of delivering remedies from the health and social care sector. This equates to an average saving of £4,487 per referral.

Visual impairment is strongly associated with falls and hip fractures. The rate of falls in older people with visual impairment is 1.7 times higher than other older people of the same age, with hip fractures 1.3 - 1.9 times higher. A home safety assessment, modification and coping strategy programme reduces these risks by 41%. Given that falls in Wales are estimated to cost the NHS £67

million per year, and that half of those are directly attributable to sight loss, early rehabilitation interventions are likely to have an enormous impact. [2, 3]

Local authorities must recognize the longer-term cost benefits of employing ROVIs and invest in the profession.

Legal Framework

The **Social Services and Wellbeing (Wales) Act 2014** came into force on 6 April 2016. The Act places a statutory duty on local authorities for the first time to provide a preventative approach to meeting people's care and support needs, including minimising the effects of impairments. It is not possible to deal with sight loss without Rehabilitation as those new to the situation have to learn new ways to accomplish essential tasks and to be introduced to a range of equipment and techniques to avoid injuries and falls and mitigate or defer the need for longer term care. The Codes of Practice to the Act provide specific advice to health boards and local authorities about reablement and habilitation (Part 2 Code of Practice paragraphs 182-186) [4].

In **Healthier Wales** the Welsh Government sets out the ambition to bring health and social care services together, so that they are designed and delivered around the needs and preferences of individuals, with a much greater emphasis on keeping people healthy and well [5].

SECTION A: REHABILITATION SERVICES

A1: CURRENT AND FUTURE CAPACITY

What level of service is currently available in Wales?

The Wales Vision Forum's *State of the Nation report: Services to adults with sight loss in Wales* [6], evidenced a postcode lottery of rehabilitation services across Wales, impacting negatively on blind and partially sighted people.

- Only 6 local authorities in Wales currently meet the Association of Directors of Adult Social Services and Social Services Improvement Agency's minimum standard of 1 ROVI per 70,000 of the population (see Table 1).
- In some areas of Wales people with sight loss are waiting upwards of 12 months to see a ROVI.
- People are only seen in a timely manner where the minimum standard of 1 ROVI per 70,000 is met.

There is already a backlog of people in Wales waiting for vision rehabilitation intervention. The reasons for this are complex, but include:

- Vision rehabilitation is not always seen as a high priority by local authorities, resulting in a shortage of specialist ROVIs. This number is in decline.
- In some areas referral pathways are clearer than in others, creating more referrals to the service. For example, during the pandemic the ROVI in Torfaen has provided training to social care colleagues on the ROVI role and referral pathways and the benefits

they bring. This has resulted in more referrals to the ROVI.

- A ROVI must undertake a two-year foundation degree course. The cost of this training is expensive (£12k) and many Local Authorities, over many years, have been unwilling to commit funding for this purpose.
- The process of issuing Certificates of Visual Impairment (CVI) can be slow, impacting on the offer of rehabilitation support and Registration.
- Individuals are largely unaware of their rights, and the nature of support that should be available.
- In response to coronavirus, some local authorities had suspended face-to-face rehabilitation services, and ROVIs were unable to carry out normal duties.
- During the coronavirus pandemic, in every authority in Wales assessments were being carried out over the telephone and rehabilitation plans were being drawn up that could not be delivered. We therefore predict an increase in the number of people with sight loss waiting for rehabilitation as a result of Covid 19.

The scarcity of Rehabilitation Officers

The decline in the number of Rehabilitation Officers for Visual Impairment in Wales has resulted in many blind and partially sighted people failing to receive the vision rehabilitation support that they need in a timely manner. With the number of blind and partially sighted people expecting to increase from 121,000 to 146,000 by 2030 (20%) this situation will worsen dramatically if no action is taken. It is essential that local authorities invest in this workforce now.

The Social Services and Wellbeing (Wales) Act 2014 places a statutory duty on local authorities to provide a

preventative approach to meeting people's care and support needs, including minimising the effects of impairments. Rehabilitation is the only recognised package of support available to people with sight loss. Individuals have to learn new ways to accomplish essential tasks and to be introduced to a range of equipment and techniques to avoid injuries and falls and mitigate or defer the need for longer-term care.

This report updates the figures given in the State of the Nation – Services for Adults with Sight Loss in Wales report in 2018. These are correct as at 31st March 2021. It is worth noting that the total in 2018 was 34.2 FTE, showing a loss of 3.9 FTE in 3 years. 12 local authorities met the minimum standard previously; now only 6 do.

Table 1: The ROVI workforce in Wales

Local authority	No. of ROVI s (FTE)	Population estimate	Minimum standard (1:70,000)	Comp. to min. standard
Isle of Anglesey	1	70,043	1	Met
Gwynedd	1.8	124,560	1.8	Met
Conwy	1.4	117,203	1.7	-12%
Denbighshire	2.0	95,696	1.4	+43%
Flintshire	0.8	156,100	2.2	-74%
Wrexham	1.0	135,957	1.9	-47%
Powys	1.8	132,435	1.9	-5%
Ceredigion	1	72,695	1	Met
Pembrokeshire	2	125,818	1.8	+11%
Carmarthenshire	2	188,771	2.7	-26%
Swansea	0.5	246,993	3.5	-86%
Neath	1*	143,315	2	-50%
Bridgend	2	147,049	2.1	-5%

RCT	3	241,264	3.4	-12%
Merthyr Tydfil	0.8	60,326	0.9	-11%
Cardiff	1	366,903	5.2	-81%
Vale of Glamorgan	1	133,587	1.9	-47%
Caerphilly	2.2	181,075	2.6	-15%
Blaenau Gwent	0.6	69,862	1	-40%
Torfaen	1	93,961	1.3	-23%
Monmouthshire	1.4	94,590	1.4	Met
Newport	1	154,676	2.2	-55%
Totals	30.3	3,027,187	44.9	

*1 FTE Mobility Officer

Percentage (-%) indicates below minimum standard KPI and (+%) indicates above.

Green = met or exceeds; Yellow = falling below; Red = critically low

Waiting lists and referral rates.

The concept of the waiting list in this report refers to the list of clients in a local authority who have conducted What Matters conversations or similar and have been referred to the sensory teams, where they await sensory assessments. In this report the figures have been reported by the ROVIs themselves and should not be regarded as official figures.

We have received the numbers on waiting lists for all 22 local authorities as reported by ROVIs. 1,145 people with sight loss are on waiting lists across Wales. 4 authorities claim they have no one on their waiting lists; 9 have 25 people or less; 5 have over 100 people. This is against a background of an estimated 121,000 people with sight loss in Wales.

Regarding active caseloads, all local authorities reported their figures. 687 people are undergoing planned ROVI interventions.

13 out of 22 authorities reported referral rates. These authorities alone reported 1,767 referrals made to sensory teams across Wales 2020/21. All authorities reported anecdotally a drop in the numbers of referrals received, a drop attributable to the pandemic.

12 Authorities reported a total of 1,534 assessments carried out during the same period.

(It's worth noting that these data are hard to interpret because not all local authorities reported their assessments AND referrals).

From our survey we have ascertained that some local authorities don't have a waiting list, which is a matter of

concern when you consider the numbers of people with sight loss in those areas. How are they recording unmet needs? Is it the case that these authorities are putting undue pressure onto ROVIs to close cases as quickly as possible? Or is it simply that they regard a new referral as an active case, for example where the ROVI is situated within the Third Sector and they treat all inward referrals as active cases?

Unmet need, where the ROVI reaches a limit on the support they can give to achieve independence in a particular activity, can be addressed by the ROVI recommendation that the client receives Direct Payments or support from another service, internal or external. However, there are inconsistencies between authorities in the addressing of unmet need: some are averse to the Direct Payments route since it implies a failure on the part of their service, or perhaps an ongoing financial burden to the authority; some authorities have services to refer people into, such as for assistance with shopping, while others don't.

Recommendation: to look at how local authorities record unmet needs and identify the services they can refer people into to meet these. This could include a survey of the uptake of Direct Payments.

Where ROVIs have access to waiting lists there are positive outcomes for clients:

“The ROVI manages the waiting list. By having control of the waiting list we have been able to flag urgent cases and safeguarding issues.”

Waiting lists can have a negative effect on morale, particularly where the ROVI is not directly involved in managing them.

Recommendation: All ROVIs are given access to the waiting lists and have a role in managing them.

Valuing and understanding the role of the ROVI.

Many ROVIs feel as if their ability to evaluate risks to the client is not being recognized in the way that it is with other social care professionals. There is not enough awareness amongst other staff of the ROVI's role in determining risk amongst clients with sight impairment. The ROVI needs to be recognized as being on a par with other key workers in this regard.

“I [the ROVI] would like to be involved in decisions about referrals. Currently this is done by the manager, who does not understand our role. The ROVI can be missed out of the loop without relevant information.”

The current pandemic has pushed priorities into other areas and this, according to some, has had a negative impact on their role:

“Covid has created a situation where our colleagues value the role of the ROVI less now than before.”

ROVIs spend years building an understanding at managerial level of the work they do. This work can sometimes be completely undone when new managers take over. Measures need to be put in place to ensure a continuity of understanding. Better awareness within social care teams generally would go some way to ensuring this.

There are concerns that some ophthalmologists do not fully understand the benefits of referral to the ROVI via the

CVI(W). Delays in completing and issuing CVIs are impeding the patient's access to support from a ROVI.

“We need to educate trainee ophthalmologists on the role of the ROVI.”

Pan-sensory commissioning.

In some local authorities there has been a move towards pan-sensory commissioning of services. There is concern that this will dilute the specialisms and risk providing a poorer service for people with sight loss. There is an instance where the ROVI contract went from a sight loss charity to an organization that supports dDeaf/HoH people. The worker was redeployed under TUPE to the new contract holder. The result is that the ROVI no longer enjoys specialist supervision by a senior ROVI from their previous employer. There is a loss of organizational knowledge and experience.

This approach can also be negative for hearing impairment:

“Not happy that sensory teams became generic. This had a huge impact on Hearing Impairment team. Sensory team has become more generic.”

<p>Recommendation: Pan-sensory contracts should be avoided but where they do exist, the ROVI must be included in the package and consideration should be given to maintaining a high quality of supervision and expertise.</p>

Case studies.

Members of the Wales Vision Forum collected case studies from all 22 local authorities in Wales that highlight the difference that timely intervention from a ROVI can make to blind and partially sighted people. [See Appendix 5]. These show the packages of interventions conducted by ROVIs and should be read together to understand the range of the work.

Recommendation: WROF to develop an online awareness raising module on understanding the role of the ROVI to be undertaken by other workers who would potentially refer service users to the service. This would include other practitioners in social care and those in health and the third sector who work with people with sight loss.

The importance of the team and professional support.

Supervision.

“No support or supervision from local authority.”

“Isolated working – support needs to be in place for those assessments that go wrong. Previously these would be shared in the office with the team. Home working can be isolating.”

As with all roles, it is essential that ROVIs are supervised by someone who understands their work. ROVIs are reporting a varied picture of supervision ranging from none at all, through supervision by non-specialist line-managers who don't understand their role, to supervision by Senior ROVIs.

“Local authorities should also work with specialist third sector organisations to develop models of professional supervision to supplement support

offered by non-specialist line managers. In North Wales ROVIs are employed by the third sector but work in social services, and are managed by a social services manager but receive professional supervision from a third sector employer.”

- Making a Difference – realistic options for improving services for people with sensory loss. SSIA/WCB 2014.

Half of local authorities employ 1 or fewer ROVIs. Where this is the case it would be beneficial to have a peripatetic ROVI supervisor employed, perhaps, by WROF to provide professional supervision to otherwise isolated workers. Alternatively, supervisors can be procured from neighbouring authorities where possible, but the extra workload must be accounted for. This further highlights that there are not enough ROVIs working in Wales.

“Regional supervision could work – it could help with working to national standards – the same standards would be applied across a region.”

The Rehabilitation Workers Professional Network has issued guidance on the supervision of ROVIs that forms part of the standards applied for under the Professional Standards Authority. The guidance gives five reasons for its introduction:

- 1) Occupational risk;
- 2) Lack of appropriate professional supervision;
- 3) Limited understanding of factors that make case management of vision rehabilitation work different from other preventative interventions;
- 4) Professional isolation and work-related stress;
- 5) The supervision needs of professionals who are visually impaired.

The full guidance is available at
[https://www.rwpn.org.uk/resources/Documents/RWPN_supervision_guidance \(1\).pdf](https://www.rwpn.org.uk/resources/Documents/RWPN_supervision_guidance_(1).pdf)

Recommendation: Local authorities in Wales should recognize the RWPN Supervision Guidance for Vision Rehabilitation and Habilitation Workers and adopt it within their own sensory teams.

Recommendation: WROF to explore employing a peripatetic ROVI to provide supervision to isolated workers.

Peer support and networking.

The importance of maintaining team meetings was stressed:

“The ROVI should have regular meetings with the sensory team. The ROVI worked throughout Covid.”

“Too many things have happened without my [the ROVI’s] knowledge.”

Many ROVIs work in isolation. The pandemic had opened up opportunities for ROVIs to meet online and offer peer-to-peer support. This has proved invaluable to many at a time when their role had changed greatly and when they might have felt most abandoned as professionals.

“We all work differently – so we can learn from each other.”

“Networking is important for mental health. There could be a pattern of problems for workers in the future.”

It is important that employers release ROVIs for networking opportunities that raise awareness of the purpose of the ROVI to a wider network and promotes the referral pathways into the service.

“We have good support locally for professionals. But we’d also like a group like Bridgend’s VI Professional Network.”

Recommendation: Groups of sensory loss professionals should be set up across all Local Health Board areas, to include ROVIs, other social care, health and third sector workers.

The WROF AGM and Conference provides good opportunities for networking and CPD. WROF could look to develop this conference to incorporate some of the themes listed within the training recommendations given in *A2: What do rehabilitation officers require?*

Support from the professional network has had a positive impact:

“WROF does a great job of keeping us together. Great for training and networking in Wales – this needs to continue after pandemic.”

“Big thanks to WROF for keeping the lines of communication going and for continuing to promote the role of the ROVI and fight for increased ROVIs and equal footing – support appreciated as working from home has been isolating.”

Recommendation: WROF to work with WCB to rejuvenate the WROF website.

Support from managers.

It has been essential that the ROVI can access the support needed to maintain their skills and to feel confident about their role at a time when they are not always able to carry it out to the same extent. There is a strong impression that managers are often failing to understand the role of the ROVI:

“My concern is that management has lack of knowledge of what the ROVI does. I feel like we are being bullied and pressured to reduce lists when they don’t understand our role.”

“Management needs to attend meetings to understand the role.”

“Lack of understanding – managers don’t understand complexity and variation of sight loss.”

“[The managers] adopted a different approach to the ROVI compared to other social care workers as they didn’t understand the ROVI role fully.”

Recommendation: All officers responsible for managing ROVIs should sign up to the RWPN – this is free to managers. This would help them to gain a better understanding of this critical role.

Where the ROVI sits within Social Care.

Local authorities vary in the way they view the ROVIs place in the larger social care picture. We find instances of

a fully integrated team that works collaboratively and understands the ROVI's value within that team. There are instances where the ROVI sits in the Sensory Team but the team operates largely independently from the larger department. Some ROVIs sit in the third sector organization contracted to the local authority and receive direct referrals from the local authority. Some work in complete isolation from the local authority and simply react to referrals.

As previously stated, the ROVI often feels marginalized as a worker. This happens where their role is not sufficiently understood or valued within the Social Care department as a whole. ROVIs report various benefits to being connected to other areas of social care, such as the Occupation Therapist. There is a need for professional support both from within the social services department and from external sources such as training providers and professional bodies (including WROF and RWPN), with the latter offering networking opportunities to share practice and raise concerns.

“The role sits more with the reablement team – such as OT team and not as an add-on to social care.”

“The ROVI joint team sits within reablement. Being in the team is positive on both sides.”

“Community resources teams may be the way forward but we don't want to get lost within health; the sensory loss team is the best model because it's good to have the focus on VI and there are the benefits of knowing and understanding sight loss.”

ROVIs working in isolation are conscious that service users experiencing stroke, learning disability or dementia might be missing out on sight-specific interventions:

“Profile of ROVI needs to be raised to other social care workers. For example, the service user might have dementia but do they also have sight loss? Are they checking for sight loss?”

Bridgend, in response to Welsh Government’s A Healthier Wales, established a network of health social care teams – called the Community Resource Team- that includes the ROVI. It ensures integrated working that delivers a package of care that meets a variety of needs. In this model the ROVI sits within the Sensory Team and their expertise will be drawn upon as required from other teams such as the reablement unit and the acute clinical team. This organized model acknowledges the role of the ROVI and is regarded as good practice by the ROVIs concerned. This ensures that, unlike in other local authorities, the ROVI is not marginalized and there is widespread awareness of their purpose. Other authorities may wish to map the services they provide with a view to creating an integrated service that recognizes the ROVI and refers service users to them when sight loss is identified. There needs to be a robust means of identifying sight loss to ensure that people are not missing out on the specialist support of the ROVI.

See Appendix 3 for a fuller description of the Bridgend model.

Recommendation: Directors of Social Services should foster amongst their social care teams a greater awareness and understanding of the ROVI role and how it relates to other social care disciplines.

Professional Standards and the importance of a ROVI being a qualified worker.

The Social Care Wales website categorizes rehabilitation as an Allied Professional Service. Of these workers “some are employed within social care and need to register to practise, but they are not required to register with Social Care Wales.” There is a voluntary register for ROVIs in the UK managed by a professional body, the Rehabilitation Worker Professional Network (RWPN). All of Wales’ practising ROVIs operating under the aegis of a local authority are registered with RWPN, thanks to continued financial support from Welsh Government via WCB. WROF takes the position that registration should be mandatory, not voluntary as it is currently.

“Mandatory registration will encourage people to become a ROVI as it will be a recognized profession.”

The ROVI profession in the UK, as regulated by the Rehabilitation Workers Professional Network, will soon be quality assured and overseen by the Professional Standards Authority. The RWPN will have to meet the twelve standards set out by the PSA to gain the quality assurance mark:

An application has gone in to the Professional Standards Authority to put in place a set of quality standards governing the profession. These include:

- code of ethics and professional conduct; and
- concerns and complaints policy.
- a Continuing Professional Development policy.

The latter shall be handled by an independent Registration and Professional Standards Committee.

The purpose of the registration is:

- To protect the public from poor practice and promote public confidence in the vision rehabilitation profession;
- To establish a professional register of Vision Rehabilitation Workers to recognize an individual's commitment to continuing professional development and to safeguard the public.

Recommendation: This is the first pragmatic step towards rehabilitation being recognized by Social Care Wales as a regulated service. Once this process of quality assurance is established, WROF should approach Social Care Wales again.

Rehabilitation Assistants.

“Let's not stop unqualified workers operating, but ensure there's a training pathway for existing employees.”

ROVIs are concerned that some of their role is being undertaken by officers who have not received the specialist training of a ROVI. There are instances where rehabilitation assistants can productively carry out some aspects of the ROVI's role under ROVI supervision. An example exists where the assistant is allocated work by the ROVI and is supported and guided with all referrals.

“We never really had [a ROVI assistant] because the line between what an assistant can do and a ROVI can do is difficult to draw and being able to maintain the importance of VI people receiving support from a

qualified ROVI makes getting an assistant a bit complicated.”

We would like to see rehabilitation assistants undertaking Year 1 of the Rehabilitation Foundation Degree as a minimum. This is an opportunity to properly distinguish between the full set of competencies a ROVI obtains and the more limited competencies of an assistant. The course could press home these distinctions to ensure that roles are clearly defined in the workplace. RWPn should identify what distinguishes an assistant’s role from that of a ROVI and determine the level of training they should undertake to earn that title, such as successful completion of a number of core competencies. There is a strong case for the establishment of an NVQ for this purpose.

We have identified a number of additional workers who operate alongside - or in place of - the ROVI such as OT Support Workers (VI), reablement officers, living skills instructors, mobility officers, and sensory assistants. These workers, whether or not they work alongside the ROVI, are not qualified as specialists in sight loss:

“Feedback from service users is variable – should be having someone with experience of sight loss working with clients.”

When non-ROVIs are requested by ROVIs to undertake interventions as part of the package of support, the ROVI must undertake a risk assessment. Since the ROVI is qualified to evaluate risks specific to the circumstances of blind and partially sighted people, they are best placed to ascertain whether or not a non-ROVI could carry out an intervention.

Conversely, a risk assessment might highlight dangers that the ROVI could not safely provide an intervention for.

For example, a risk assessment might reveal that it would be dangerous to carry out mobility training. This should be recorded as an unmet need and logged in the client management system to be taken up by other professionals.

[See Appendix 7 for RWPN's Risk Assessment tool.]

Recommendation: that ROVIs in Wales adopt the RWPN Risk Assessment tool.

Recommendation: that RWPN defines the agreed set competencies required of the ROVI assistant including any training requirements.

Recommendation: that existing assistant workers are offered a career development pathway, possibly using the NVQ or apprenticeship model.

A2: WORKFORCE PLANNING

In recent years, we have seen a decline in the number of vision rehabilitation officers in Wales. As a result, many blind and partially sighted people are failing to receive the vision rehabilitation support that they need in a timely manner. This crucial support reduces the pressure on other services such as health and wider social care services. We are already under-resourced in this field and there are no clear plans for workforce renewal. With the number of blind and partially sighted people expecting to increase from 121,000 to 146,000 by 2030 (20%), coupled with the improvement of referral routes, this situation will worsen dramatically if no action is taken by local authorities. It is essential that local authorities invest in this workforce now as almost half (15) of the current workforce is set to retire in the next 5 years.

There are two key things to be achieved: 1) the development of new ROVI posts to fill the quota required to meet minimum standards and 2) the development of a ROVI degree delivered in Wales to meet this shortfall along with the number of places falling empty due to retirement. (See A3: Wales-based Rehabilitation Degree below). One solution to the shortfall is to create trainee ROVI posts that transform into qualified ROVI posts on qualification. It would make sense to create these posts at the earliest opportunity while there are still qualified ROVIs in place to supervise them.

<p>Recommendation: that local authorities develop trainee ROVI posts to prepare for the 50% drop in practising professionals expected over the next 5 years.</p>

ROVI assistants, which have not been taken into account in this survey, provide valuable support to the ROVI but are not qualified to perform the full ROVI role. Where

desired, assistants might wish to achieve full ROVI status. This would help to alleviate the current problem of numbers of ROVIs. Some assistants would need to carry out the entire Foundation Degree while others would have already passed some modules covering core competencies but would need to complete others to achieve the qualification. It might be productive to work with BCU to see if a pathway to completing the course might be made available to such workers. This would make best use of existing workers and their skills as they are already working in the field of rehabilitation. Perhaps a long-term ambition is to create a career progression whereby assistants move on to become ROVIs and a new assistant takes their place.

<p>Recommendation: that existing ROVI assistants are encouraged to complete a Foundation Degree in Rehabilitation Work.</p>
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Throughout March 2021, Wales Council of the Blind interviewed 38 ROVIs (local authority funded, third sector or private):

ROVIs in post (FTE)	Leave within 3 years	Leave within 5 years	Leave within 10 years	No ambition to leave
30.3	8	7	7	16

There are 4 first year students enrolled on the Rehabilitation Work (Visual Impairment) – FdSc at Birmingham Central University and 2 on the second year. However, there are currently 5 vacant posts in Wales in Carmarthenshire, Conwy, Monmouthshire, Swansea and Powys.

The minimum standard of 1 ROVI per 70,000 could possibly be reduced in instances where referral pathways

to and from the third sector and LVSW are well established and where the quality of these services is adequate. In addition to this, many rural counties will require more than 1 ROVI per 70,000, as much of their time is spend on the road. These factors will need to be considered by each local authority when developing a workforce plan. For example, Anglesey has 1 ROVI (which meets the minimum standard) and has established referral pathways to third sector and LVSW. However, Powys, due to the size of the County and there being no regional sight loss charity, would require more ROVIs per population. They have also planned for the future and have 2 students enrolled on the Rehabilitation Work (Visual Impairment) – FdSc.

Recommendation: Every local authority adopts the minimum standard of 1 ROVI to 70,000 (minimum standard) and makes a commitment to invest in training of ROVIs by January 2022.

Recommendation: All local authorities invest in the ROVI workforce and develop a workforce plan for the next 3, 5 and 10 years.

A3: WALES-BASED REHABILITATION QUALIFICATION

Currently, the only recognized qualification that entitles you to practise as a ROVI is via the Rehabilitation Work (Visual Impairment) FdSc, delivered by Birmingham Central University. There are limited spaces on this course due to an increased demand resulting from funded places created via the Apprenticeship Levy in England. Our recommendation for three cohorts of 10 students each could not be met by the course in Birmingham. WROF and the Wales Vision Forum suggested a Wales-based course to address this problem.

Core skills

The core skills of the Rehabilitation Worker role are common to all jobs and are essential components in achieving a qualification. The core skills are described in Appendix 1.

Support for Wales-based ROVI degree.

We have explored the possibility of running a Wales-based Rehabilitation Foundation Degree in an attempt to address the concerns documented around workforce planning. It was felt by many that a course delivered in Wales would be both more accessible, being closer to the workplace, and address the particularities of services in Wales.

There is broad overall support for bringing a satellite version of the Birmingham City University Rehabilitation Foundation Degree to Wales instead of resurrecting the Newport University course. This is the preferred option as explained below.

A Birmingham Central University satellite Foundation Degree.

- Birmingham City University (BCU) course has been running for many years and is accepted universally as the qualification towards employment as a rehabilitation worker in local authorities and non-statutory agencies across the UK.
- Tutors are already in place. We would just need to source local ROVIs for the placements and mentoring.
- The BCU course recognized by RWPB.
- Existing ROVIs could achieve a full degree via top-up modules (working with DeafBlind clients and children).
- Modules are already developed including on-line material as a result of the pandemic.
- Training materials are devised and updated by BCU.
- Since the BCU course is generic and does not provide a focus on Wales, we would need to address this by including a focus on Welsh-based services such as LVSW, Optometry, Social Care and the Third Sector.
- The model is sustainable. It can be run as and when demand dictates.

On-the-job training.

We want to see Local Authorities funding on-the-job training to become a rehabilitation officer. Because the profession is small in Wales (45 ROVIs FTE needed according to the SSIA Benchmarking Guidelines) there is little point in encouraging it as a career option for school leavers. It would be more effective to encourage the role amongst existing social care employees. We have identified a number of people who would be keen to undertake a Wales-based course. To support this approach, the BCU entry requirements specify that a set written paper may be submitted in lieu of formal qualifications for applicants with relevant and significant work experience in the disability sector.

Local authorities would be well advised to make provision for a trainee (ROVI) to take over when ROVI retires, and not to wait until the ROVI has left. With half of the authorities with one ROVI FTE or fewer it is essential that workforce planning takes place at the earliest opportunity.

“We need employment at the end of training.”

“They need to be employed when training to learn practical stuff. Appoint a trainee then upgrade that post at the end of the 2 years.”

“I’m keen to supervise a student on the course. It’s good to host student placements in Wales.”

“We can lead the way here.”

Sustainability could be achieved through a model that brings Birmingham City University in as required. Evidence shows us that this would need to commence in September 2022 with a minimum of 10 students. With

minimum standards suggesting we should have 45 FTE ROVIs across Wales, in the knowledge that we expect 15 to retire in the next 5 years, we would want to see 30 ROVIs trained between 2022-25.

“Is it a sustainable model? Birmingham City University could be parachuted in as and when required is the best option.”

The Rehabilitation Degree and the apprenticeship model.

Currently the only provider of the two-year training course is Birmingham City University (BCU). In England, the on-the-job training element of the apprenticeship mirrors the Foundation Degree programme. <https://www.bcu.ac.uk/courses/rehabilitation-work-visual-impairment-fdsc-2021-22>.

We would want to see this operating in Wales under the Welsh Government apprenticeship support. More information on the Apprenticeship in England is given at <https://www.instituteforapprenticeships.org/apprenticeship-standards/rehabilitation-worker-visual-impairment/>

“It’s a big barrier not having an apprenticeship in Wales.”

WCB and Guide Dogs met with Welsh Government in 2020 to discuss the apprenticeship model as a possible option for funding the ROVI Foundation Degree for Welsh candidates. In England, the role of the ROVI is included within their scheme. An independent evaluation of the Apprenticeship Levy in Wales is due in Autumn 2021. In the light of the course being delivered in Wales along with the evidence of need for additional ROVIs, we hope that

Welsh Government would consider our proposal for the Foundation Degree being a candidate for apprenticeship support as part of this evaluation.

“Without this funding we are concerned that we will not catch up.”

ROVIs are mindful of the financial barriers faced by local authorities and the reluctance to finance training:

“If Local Authority didn’t have to pay for training it would be attractive.”

Without centralized support for apprenticeships the onus is placed on Local Authorities and the Third Sector providers to pay for the training themselves. Additional cost is known to be a barrier to increasing the workforce. We would like to see Welsh Government providing financial assistance to support this apprenticeship model.

Recommendation: A Wales-based rehabilitation course is established to meet workforce requirements over the next 5 years. These places to be funded by Welsh Government through support for apprenticeships.

A4: CLIENT OUTCOMES and RECORDING SERVICE USER EXPERIENCES

Client outcomes are a way of establishing the success of a care plan by identifying the goals desired by the client and the relative success in achieving them after ROVI intervention. 15 out of 22 local authorities explicitly stated that they use some method of recording client outcomes. Some enter these into case notes or the client's care plan record; others enter them onto an integrated assessment form following the What Matters outcome goals – these are not necessarily specific to rehabilitation.

There are some less formal ways of registering outcomes that are usually entered into the case notes. In some cases, outcomes are not measured against an individual baseline, therefore making progress more difficult to measure objectively. There is currently no way of collecting all-Wales data on outcomes.

Some third sector providers, contracted to deliver ROVI services to the local authority, see outcome measures as a tool for reporting back to their commissioners on achievements in their contracted work:

“Third Sector and private sector are under more pressure to report outcomes.”

This principle could equally be applied to in-house ROVIs so that the value of the ROVI interventions is understood in the larger social care environment. This would help the argument to train and employ more ROVIs.

In North Wales Society for Blind, which holds contracts to deliver ROVI services in Anglesey and Gwynedd, a system of measuring outcomes is adopted within the society to establish a baseline at the start of their

engagement with the client and then to score their outcomes at the end of the intervention. The outcomes are person-centred, derived from a What Matters conversation. This process is coupled with an independent follow-up call to the client to ask them to score their outcomes from their own perspective. This is carried out 4 months after the end of the intervention – the period of time being considered to be long enough for proper reflection upon their situation, but not so long that it would be difficult to determine the cause of the outcome.

This model shows how a consistent and objective measuring tool benefits both the client, by being person-centred and based on achieving personal goals, and the service itself by providing clear data to be used for internal monitoring. This, if adopted nationally, would also provide a map of outcomes across Wales.

The use of outcomes enables the ROVI to make an objective decision to close a case. Some ROVIs warned against the quick closing of cases, arguing that the important thing is that the agreed outcomes are met before closing the case. Because the interventions sometimes take place over a long period, ROVIs should not feel pressured to close the case too early. Regular supervision enables the ROVI to go through individual cases with their managers and to discuss how to achieve the outcomes. This works best where the manager fully understands the role of the ROVI.

An All-Wales Outcome Measures Tool.

“A consistent IT system would help with regional working.”

There is a mixed response from ROVIs regarding the adoption of an all-Wales outcome measures tool. Some

don't use outcome measures and some have their own versions established already, sometimes adapted from models from outside of sensory loss. Those who would wish to adopt such a system would require it to work within their existing IT record systems (these are given in Table 2 below). Some ROVIs point out that the tool needs to be simple to use.

Importantly, the RWPB has agreed the toolkit developed by RCT for use by ROVIs throughout the UK. It works with the four core domains of rehabilitation:

- Low vision
- Communication
- Activities of daily living
- Orientation and mobility

The outcomes are set by the ROVI in consultation with the client in relation to their package of care. For example the client may state that they wish to be able to go shopping, but are currently unable to. The ROVI might suggest a mobility element in their package of care to address this, specifying their current level of ability in the tool according to the following:

1. Unable and unsafe
2. Able but unsafe
3. Achieved with support
4. Achieved independently
5. Achieved above expectation

After the intervention has been completed, the ROVI assesses their progress along the same scale. For example, after mobility training, the client is now able to go shopping independently.

This model would need to be 'sold' to each local authority social services department. Ideally, this would be the model adopted throughout Wales. However, where existing models are used effectively it would be a challenge and, perhaps, unnecessary to encourage change. Another tool, developed by North Wales Society for the Blind, is used in 3 local authorities in Wales. The RCT model is currently in use within 2 local authorities and a third has expressed an intention to adopt it.

One benefit of the RCT toolkit is that the outcomes entered also generate a plan automatically.

The advantages of a commonly used toolkit are clear: data can be extracted to measure trends across Wales such as areas where outcomes are not being achieved. Where outcomes are good the ROVI's importance is reinforced within the social care sector, particularly where outcomes have reduced the need for support from other disciplines. Consistent data gathering will enable meaningful reporting to the Eye Care Collaboration Groups, something that was not achieved despite being requested in the Eye Health Care Delivery Plan.

One ROVI commented that their system, being not specifically related to rehabilitation, does, however, marry up with the National Wellbeing Outcomes Framework. The creation of a national rehabilitation outcome measure toolkit should take into account an alignment with the framework in the same way.

Another ROVI pointed out that their system allows for outcomes that are not ROVI interventions, such as signposting, referral into the third sector, advice only, and so on. Any all-Wales system should allow flexibility of this sort.

Recommendation: roll out the toolkit within Cym Taf Morgannwg UHB area (since each local authority there uses WCCIS) and pilot a reporting mechanism into the Eye Care Collaboration Group for the area.

There are currently 6 different client management tools. (PARIS, WCCIS, Care First, Eclipse, Flow and Oracle). 15 authorities have adopted WCCIS, with two more authorities moving to it shortly. Given that it is unlikely that all authorities in Wales would work on a common platform, it is important that an all-Wales tool would be designed to operate on all platforms so that data can be extracted for the whole of Wales.

Similarly, there are a number of differing metrics used to measure outcomes. Some use a scale of 0-10 to indicate roughly where the client is situated for a given task; others use a scale linked to a description of various levels of ability. For data compatibility, it may be expedient simply to align these different metrics, rather than to change individual variants to a single system.

Recommendation: that local authorities agree a common scale of outcome measures so that comparisons can be made between authorities.

Recommendation: RCT IT specialists work to ensure the toolkit is portable to other IT systems (see table below).

Table 2: IT Systems used for case management.

Local Health Board	Local authority	IT System	Provider*
Betsi Cadwaldr UHB	Anglesey	WCCIS	TS
	Conwy	WCCIS	TS
	Denbighshire	PARIS	TS
	Flintshire	PARIS	TS
	Gwynedd	WCCIS	TS
	Wreccsam	WCCIS	TS
Powys Teaching HB	Powys	WCCIS	LA
Hywel Dda UHB	Carmarthenshire	Eclipse	LA
	Ceredigion	WCCIS	LA
	Pembrokeshire	Care First	LA
Cwm Taf Morgannwg UHB	Bridgend	WCCIS	LA
	Merthyr	WCCIS	LA
	RCT	WCCIS	LA
Aneurin Bevan UHB	Blaenau Gwent	WCCIS	LA
	Caerphilly	WCCIS	LA
	Monmouthshire	Flow (moving to WCCIS)	TS
	Newport	WCCIS	LA
	Torfaen	WCCIS	TS
Cardiff and Vale UHB	Cardiff	Care First (moving to WCCIS)	TS
	Vale of Glamorgan	WCCIS	TS
Swansea Bay UHB	Neath Port Talbot	Oracle Dashboard	TS
	Swansea	WCCIS	LA

* Provider of ROVI officer: TS = Third Sector; LA = Local Authority

We have identified that not all third sector ROVIs have access to the client management system within their respective local authorities. This means that some ROVIs are perhaps left out of the loop when it comes to managing waiting lists, for example, and active caseloads. This also requires the ROVI to create their own case files for each client, separate to the local authority's, creating unnecessary duplication of work.

It's worth noting that shortly there shall be 4 RPB areas that will share the same (WCCIS) system.

Recommendation: That third sector providers of ROVIs to local authorities are given access to the client case records to minimize the duplication of effort concerning reporting, resulting in a more streamlined system that also demonstrates the value of the ROVI interventions to the local authority.

Recording service user experiences.

The need to gather data on service users' experiences is outlined in *Code of practice in relation to the performance and improvement of social services in Wales* [7]:

Understanding user experience and outcomes

5.6 This provides local authorities with information on the quality of people's experiences of social care, as well as how and if they are achieving their well-being outcomes.

5.7 This data will be gathered through a range of nationally prescribed approaches. Local authorities

should also gather their own data to reflect their own locally defined priorities.

15 out of 22 local authorities do not gather service users' satisfaction data regarding ROVI services. While these may be gathered informally through the case review stage by the ROVI, there appears to be a considerable gap where the local authority is not conducting an ongoing review of what service users feel about the ROVI interventions.

While there are some forms of feedback being used, these appear not to be formal methods of gathering data for experience measures. For example, one ROVI reported that they do conduct user satisfaction surveys on an ad-hoc basis while another gathers case studies, which really are only aimed at highlighting the importance of the role to senior managers and others.

One authority gathered satisfaction surveys and were able to write a digital story on one user's experience of ROVI intervention.

Some managers align the service user feedback to supervision sessions with the ROVI by telephoning the client prior to the supervision. This way, the comments can be taken on board by the practitioner. This is good practice. However, we have already noted that not all ROVIs are supervised regularly by someone who understands their role.

Some local authorities carry out client evaluation at various levels (across the authority in general, at social services level, or at sensory team level). Quality assurance officers may or may not be involved in this process. However, while some teams apply these data

usefully as part of the ROVI supervision process, others do not inform the ROVI about client feedback at all.

Some teams will actively conduct random checks on service user experiences while others operate entirely reactively by recording compliments or complaints that come in under the client's own volition.

Some send out questionnaires or client evaluation forms such as that given in Appendix 4 or leave them with clients at the end of their intervention. (Incidentally, these need to be in an accessible format). As mentioned elsewhere, one third of sector providers will contact the client after four months to check on their satisfaction with the service. This is good practice.

Recommendation: WROF to create an all-Wales user satisfaction survey to give a base level of data that has consistency across Wales.

Recommendation: that service user feedback be aligned to supervision cycles for service improvement purposes and positive reinforcement. Where appropriate, it should be used to deliver an improvement to an individual's support package.

Recommendation: that data gathered used to gain a picture across Wales and invested back into service improvement.

A5: CPD – WHAT DO REHABILITATION OFFICERS REQUIRE?

The “Training Needs Analysis for the Rehabilitation Officers” conducted by WCB in 2010 sought

“to establish the level of continuous professional development training currently available to ROVIs in Wales” and “to learn from ROVIs in Wales what further training/development they feel they need to better do their jobs.”

http://www.wcbccd.org.uk/downloads/rehab_report_2011.pdf

The interviews conducted throughout March this year have indicated the training undertaken by ROVIs and their suggestions for further training.

WCB has been funding the ROVI’s voluntary membership to RWPN since 2015. This has given them access to CPD provided by RWPN to its members. We have also funded WROF to commission specific training for its members.

The training undertaken by ROVIs in 2020/21.

“Using RWPN site – I’ve done most of the training on there that has been recommended – dementia and sight loss was useful.”

Incidentally, one ROVI reported difficulties accessing online Zoom training as their authority only allows them to use Microsoft Teams, which is not used by the training provider. Since online training is likely to be continued, due to its efficacy, this is a limitation that needs addressing by local authorities and training providers. It’s

worth noting in this regard that disabled people have reported accessibility problems with certain online platforms – this should be taken into account as well. WCB and WCDeaf have produced guidelines on making online meetings and training events accessible [8].

IT skills.

ROVIs recognized the importance of keeping their skills up-to-date. Some have gone on webinars to improve their understanding of the technology their clients use. For example, online shopping has been important for many people during the pandemic, so some ROVIs have required training in the use of these shopping apps so that skills can be passed onto the client. Also, many clients would like to use devices such as Alexa, smartphones and tablets, many of which undergo frequent updates and modifications.

Since the demise of RNIB's Online Today project, an important referral pathway into clients' IT training has been lost. Therefore the onus is greater on the ROVI to offer this training themselves. Some regional societies have been continuing to offer digital technology training but this is not available everywhere in Wales.

Cyber-security presents itself as an important topic for ROVIs' clients, given that they are often vulnerable people and unfamiliar with the risks attached to these new technologies. Some ROVIs have undertaken training in this area.

Training has increased knowledge of technology whilst working from home. Training webinars provided by RNIB, Guide Dogs and Macular Society have been useful for many ROVIs.

Vision Support also provided their ROVIs with technology training sessions, as well as a session on Counselling and Conflict Management.

Other training attended included webinars on equipment delivered by HumanWare and Digital Communities Wales.

ROVIs attended online sessions on technology in the virtual Sight Village trade fair.

Other training.

- Managing during Covid and having conversations webinar.
- Service user wellbeing as we come out of the pandemic.
- Webinars about specific eye conditions such as Charles Bonnet Syndrome by Esmee's Umbrella, and webinars by Retina UK, Macular Society and others.
- Dementia training such as a virtual dementia tour from Dementia UK.
- Training on Braille. ROVIs' Braille questions answered.
- Some workers have access to NHS online training portal. This gave them, for example, training in conflict resolution and improving communication with clients.
- Learning Disability
- Stroke
- Suicide awareness
- Personality disorder
- Safeguarding
- domestic abuse such as a police-run Woman's Aid group session on safety and domestic violence.
- Vicarious trauma training.
- Honour-based crime.

ROVIs' training suggestions.

Some ROVIs have suggested a three-year training cycle so that they can be updated on new developments and to refresh their skills similar to the refresher model used by LVSW.

The following list of training suggestions has the number of ROVIs who suggested them in brackets. This is a rough indicator of the priority of training needs:

- Complex needs/disabilities (7) (brain injury (5), learning disabilities (6), hearing loss / Deafblind (6), younger people (2))
- Complex Eye Conditions and treatments (8) – including cerebral visual impairment and Charles Bonnet Syndrome
- Mental health (6) (not emotional support due to sight loss)
- Technology and Communication (13)
- Lighting (see below) (16)
- Low Vision (6)
- Mobility refresher training (5) – including skills for parents of young children / babies; ramble-tag for social social distancing
- Processes of Transition (1)
- Welfare benefits – what's available to clients (2)
- Diabetes and sight loss (2)
- Stroke – walking pattern re: gait – impact for mobility training on stroke (1)
- Dementia (1)
- Teaching skills (train-the-trainer) – to deliver courses more confidently (1)

Lighting.

A lighting assessment can be quite technical and since ROVIs provide recommendations to service users, a refresher is needed around the latest lighting products including LEDs. Lighting training should be refreshed every 3 years to enable up-to-date lighting assessments.

Recent technological advancements include WiFi bulbs that can be connected to Alexa to allow the user to control the lighting from their smartphones or by speech.

Advances in technology such as this are becoming commonplace and need to be incorporated into the ROVIs' skillset if it is to form part of their core competencies.

CPD packages for ROVIs and others.

ROVIs noted that individual training packages might be taken up by other workers such as Support Workers, Welfare Assistants, and OTAs or adopted by ROVIs as refresher courses.

“Yes – training modules are useful - lost some of my skills as I am assessing so much - totally forgot how to use Braille.”

WCB has had feedback from people with sight loss that shows they would like to see IT and digital inclusion assistance. This requirement has been highlighted further through the pandemic, so it would be beneficial if there were to be a package to develop this knowledge for ROVIs and third sector providers.

“We want a module on IT and apps that other workers can attend such as third sector workers.”

Similarly, other packages have been suggested:

“I would like to see a module on helping people to engage with their local community and sport and recreation.”

By offering additional packages to non-ROVIs, there is the opportunity to reinforce the role of the ROVI in participants’ minds and to increase the likelihood of referrals.

“Yes. I support additional training, especially if it promotes the role of the ROVI to outside participants.”

“Reablement therapist could also benefit from training - not just bump-ons - need full assessments.”

“A Wales-specific one would be really good.”

Making training opportunities known.

Some ROVIs report that WCB Sylw bulletin has pointed out training opportunities to them. Some were made known through the RWPN website and the NHS portal, while ROVIs conducted their own searches for relevant training. Specialist organisations would have advertised their training opportunities via their own mailing lists, which would include ROVIs in Wales.

ROVIs reported that it would be easier to have one place to go for links to training. This could be a good use of the WROF website.

<p>Recommendation: WROF and RWPN need to develop a training plan to offer the above training suggestions.</p>
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Recommendation: implement a three-year cycle of refresher training focused on the core competencies. For example 2 training days per year dealing with one competency shared with additional training needs such as those identified within this report.

Recommendation: Revive the WROF website to allow posting of training opportunities.

Recommendation: WROF looks to develop or identify training opportunities for non-specialist workers that complement the role of the ROVI.

A6: ADAPTING TO THE PANDEMIC

Telephone assessments and well-being contact.

There were some lessons learned from the pandemic. While some local authorities seemed to retreat from all contact while they dealt with what they felt were more pressing priorities, others adapted their working patterns to make use of remote working and contact with clients via telephone and video conferencing.

There is strong feedback from ROVIs that telephone contact is suitable for initial contact prior to a home visit. Telephone assessments are not seen as an option and ROVIs are insisting that this should not be a convenient or cheap alternative to a full face-to-face assessment.

“Initial assessments could be conducted over the phone as people are nervous about seeing the ROVI face-to-face. The initial telephone contact helps to reduce anxiety of the client ahead of a full assessment. The conversation can build confidence and allow the client get to know you - it’s important that they know who you are.”

“Initial telephone contact to get a What Matters conversation started as soon as possible and create a plan. This is a more efficient use of time to have a more detailed conversation before you go out. You can flag up key areas to assess in more depth and to rule some areas out.”

Another suggested that telephone contact is good:

“We’ve seen it as a positive as we have reconsidered what we do as a service and contacted loads more people that we wouldn’t have contacted previously.

Zoom and Skype meetings have saved time and are a different way of working. Will do a lot more on the phone so that the actual visit is really targeted – more information gathered over the phone. Do same job but adapt it better.”

Another ROVI stresses that telephone contact has been a positive step. However, the medium of telephone is not to be used for assessments:

“I can’t do assessment over the phone in the same way.”

“It’s essential that a ROVI carries out face-to-face assessments.”

“Continue to deliver service as best we can – we do not want assessments by phone to become the norm – we do not want ROVI service to be watered down or changed as a result of the pandemic as this will have a negative impact on service user.”

“I’m worried that telephone assessments will become the norm – managers and heads of service who don’t understand sight loss will just see that a person has come off the waiting list and not the recognize the quality of intervention – not just about the numbers.”

Some have seen the restrictions as a mix of good and bad. Despite the lack of home visiting, the restrictions have forced adaptations to the assessment process that brought new skills:

“Natural resistance to a home phone call – we’ve all had to adapt our telephone conversations so that we develop strategies to be more inquisitive to investigate need. Don’t like doing assessment over

the phone – we need to see the client face-to-face but we have gained out of necessity [due to Covid restrictions] other skills to determine need; we conduct an investigative telephone conversation before visiting.”

There is a risk that telephone discussions, where the client is in the comfort of their own home, may paint a ‘rosier picture’ to the ROVI:

“People feel more comfortable in their own homes”.

“People will tell you what they think you want to hear – more difficult to get to the nub of it over the phone.”

Recommendation: All assessments must take place face-to-face in the person’s home. While telephone contact can productively form part of the initial conversations with service users, it should not be used to carry out assessments, but to build up a rapport prior to a home visit.

Home visits and resuming normal services.

At the time of interviewing, many ROVIs were unsure about how and when they will return to full visits to clients’ homes. They report that they may be working in a different way and are wondering if their employers have plans for them to continue working from home. This may arise when managers do not understand the ROVI’s role.

ROVIs have, at various times, been able to resume visits. This has, in some cases, required a different approach to managing waiting lists such as prioritizing urgent cases.

“Very frustrating as we have been kept in. We have done the work we can do – worked in the community

from September to December – only now doing outside mobility. Not enabling us to do our job. I understand it's about safety but it is frustrating. I'm now treated as key worker so now you can see emergency cases. This is essential for people with sight loss as it includes cooking skills and other daily living skills.”

“Starting to visit now. Service users go on waiting list unless absolutely urgent as waiting list is so large.”

“Looking forward to going back out. Did go out to deliver mobility training last summer.”

“Got full PPE and measures in place. We're assessing and delivering full service. With mobility training we have to look at whether it is realistic and safe.”

However, what is perceived as urgent can differ between managers and the worker on the ground. One worker stressed the importance of mobility training, which is all the more urgent where routes and buildings have been adjusted so radically:

“Mobility training focused within local community at the moment to keep everyone safe.”

“Mobility should be classed as critical and I'm disappointed they [managers] said no – management do not understand sight loss.”

Uncertainty over what the ROVI will be dealing with after lockdown is a concern for some, with mobility training being a priority area to tackle:

“What will the needs of clients be as we come out of the pandemic – a lot of people have just been stuck in for 12 months? Will there be a huge demand and will we be able to cope with demand?”

“I still don’t know how we will do mobility training if social distancing still goes on.”

“Major concerns about their mobility. How is their mobility going to be affected? There’ll be muscle wastage - people are not moving as well as they did previously.”

“It will take a while to adapt. There’ll be a transitional period and workers will have to protect themselves and people with sight loss. How long will it take to return to where we were? Mobility training will change – how can we adjust to this?”

“There’s definitely going to be more work. People need to take responsibility for their safety. ROVIs will use PPE and stay safe.”

The lack of opportunities to deliver training in daily living skills and mobility poses a threat to the client. The rebuilding of lost skills will be another burden on the ROVI:

“There’ll be a loss of skills amongst clients. They’ll be more prone to trips and accidents.”

“Pandemic has impacted on their balance and fitness and their ability to be mobile – where does the ROVI focus first?”

“ROVI will need to build confidence of clients. There will be a period of adjustment for client and ROVI.”

“Skills have slipped back where routes have changed.”

“I’ve seen a deterioration in morale since Christmas – ‘gate fever’ – the client won’t step over gate – petrified of catching COVID. I’m concerned that mobility skills aren’t there – concerned that people haven’t had eyes checked. We will see major problems. Cataract waiting lists will increase pressure on Social Care.”

Impact on mental health for worker and clients.

Many ROVIs are concerned that both workers and service users are at risk of suffering mental ill health as a result of the prolonged pandemic. The **Report on the impact of Covid-19 on disabled people in Wales** reads:

“Physical distancing, social isolation and social and economic impacts are known to worsen mental health consequences. Evidence also suggests that some groups have experienced significant increases in depression and anxiety as a consequence of social distancing requirements (Autistica, 2020; National Autistic Society, 2020; Equality, Local Government & Communities Committee Consultation, June 2020; RNIB, 2020). Research about the psychological impact of mass trauma suggests people from marginalized groups experience particular harm to their mental health.”

- Professor Debbie Foster (Commissioned by the Disability Equality Forum of the Welsh Government and co-produced by a Steering Group of disabled people from Wales).

RNIB Cymru’s research is cited in that same report:

“66% of blind and partially sighted respondents [are] feeling less independent now compared to before lockdown.”

ROVIs have reported to WCB similar anecdotal evidence:

“People with sight loss have lost their confidence.”

“Mental health has been affected.”

“Staff have also suffered, as they’ve not been able to go out to do their job.”

“A lot of service users have lost a lot of confidence – not been easy with shopping and the environment has changed. These have huge implications for people who aren’t aware how the shopping experience has changed.”

Where contact with the ROVI is reinstated, improvements are reported. Many ROVIs carried out wellbeing calls and this has been greatly appreciated by the service users:

“Contact from ROVI has improved mental health for clients.”

“People are so isolated and mental health has worsened. People can’t access computers and can’t read books, making for long days.”

“Looking forward to getting back to work.”

Even in ordinary times, people with sight loss are more than twice as likely to have experienced unhappiness of depression compared to the UK average. (See *Understanding Society longitudinal study*, University of Essex, 2012-18).

Recommendation: It is important that managers are mindful of the mental health impacts on workers and service users.

Adapting to the pandemic and emerging from it.

“The Local Authorities mustn’t forget what we have gone through.”

There have been a number of factors affecting the ROVI’s work, including:

- Reduction in CVIs due to reduction in non-urgent hospital appointments;
- Fewer referrals from Low Vision Service Wales due to a period of no service;
- Referrals from the Third Sector have dropped due to their reduction in service;
- Self-referrals have dropped due in part to reluctance to have people visit the home;
- ECLO services would be seeing fewer patients resulting in a drop in referrals;
- Inability to visit clients’ homes to conduct assessments and interventions;
- Home working has exacerbated the isolation some ROVIs experience.

ROVIs have reported their concerns about a concentration of workload arising from suspension of face-to-face services during the pandemic:

“What will our referral rates be like? I presume that a lot of people haven’t attended optometry or an ophthalmologist – could see more patients who have

deteriorated because of not wanting to take up treatment.”

“Hoping that once Covid eases we will get in touch with people on list – we’re expecting an increase in referrals.”

“There’ll be more work as people have become increasingly isolated. I expect an increase in caseload.”

“Extra workload expected once people feel better and situation improves. We expect a huge flurry of referrals.”

“There is a reduction in CVIs – no one is completing the CVIs. I’m concerned that people aren’t currently being referred from the hospital. Social Workers are not going out and the client is not willing for people to come into home. Clients are nervous.”

Additionally, ROVIs report their fears that clients’ confidence has dropped due to lockdown and that they shall need to be re-taught skills, particularly in a changed environment. In a consultation on active travel {reference} participants with sight loss raised concerns of changes to the built environment during the pandemic. Many people reported a lack of confidence in getting out and about. “The ROVI training has helped me to avoid dangerous routes. Mobility training from my ROVI has been invaluable - money should go into training ROVIs.”

The above factors could contribute to the likelihood that there will be a surge in referrals as restrictions are lifted.

“I’m concerned about increased waiting lists and increased workload.”

“It’s a struggle having so many people waiting. We have a need for a third ROVI because our referrals increased greatly.”

“Can’t tackle things from start to finish so waiting list has gone up and case-loads grow.”

“People have worked under very difficult circumstances and cope with change differently. Don’t know if there are any implications to that. I’m concerned that we could be bombarded – is there a hidden group of people that haven’t had the services they need and we will be inundated?”

Many ROVIs have not been able to go out to assess people in their homes during the pandemic – the only interaction has been through the telephone. This has highlighted the risk to the client where a timely intervention is needed.

“3 Priority 1 referrals last week [in March]. Because we are now able to respond in a timely way the intervention is more successful. When people were kept waiting we have missed opportunities – critical timely access to the service is needed.”

Renewed take-up of optometric services is expected to have an impact on workload and waiting lists:

“I do envisage more work – more people on waiting list as hospitals are working more efficiently. More people visiting opticians, so we are expecting a lot of referrals over the next few months.”

“When clinics open fully we will be inundated.”

Waiting lists have changed in quite different ways between authorities. As noted above, waiting lists appear to have been cleared in some authorities, perhaps due to telephone assessments being used in place of home visits, and others have increased because they could not visit the client during the pandemic. Some may have decreased because the individuals themselves have not wanted to have visits to their homes at this time:

“Over the period of the pandemic I have been keeping in touch with the waiting list – why is the waiting list smaller or others bigger? There is a big variation in waiting lists – some LAs don’t have waiting lists.”

Another states the importance of staffing levels to tackle waiting lists:

“The waiting list is just there – we need more members of the team.”

For some, the opportunity to make wellbeing check on clients via telephone has been a positive outcome of Covid restrictions.

“People on waiting list have been telephoned many times during the pandemic.”

But it comes with a price:

“We have conducted screening calls and spoken to people so not concerned [about wellbeing] but mainly concerned about caseload and catching up. For LAs that don’t employ enough ROVIs this can be a daunting task.”

“Been difficult to give as good a service as you can – ROVI told not to visit but others areas people have visited.”

There has been no consistent service across Wales because different Local Authorities have exercised different approaches to client and worker safety during the pandemic. Where the ROVI service is not regarded as a critical service, there has been a tendency to limit the workers to home working and providing no face-to-face service. There is a risk here: the emphasis on remaining safe under Covid can unnecessarily impact on the service user’s general wellbeing and mental health.

“You have weigh-up quality of life and mental health.”

Other authorities have recognized the crucial role of the ROVI and enabled them to do face-to-face support, albeit following strict Covid guidance. Clearly, some authorities regard the ROVI as added value only, not critical support:

“Our community team has gone out all throughout pandemic but ROVIs are not considered as part of this team. The managers need to recognize the need for the ROVI service.”

Conversely, where the local authority fully recognizes the importance of the ROVI intervention, they have made the necessary adjustments:

“There is an increased waiting list and people waiting a long time during Covid. Visits are carried out as safely as possible. It’s harder to control the home setting so Covid risk assessments forms have to be completed.”

“No real concerns as still going to people with PPE so work has continued.”

“Have been carrying out essential visits only in full PP - single visits (no joint) – where safe.”

In various local authorities some ROVIs worked over the gaps in the pandemic between lockdowns when they carried out mobility training. Some made a limited number of visits in exceptional circumstances. There was delivery of essential equipment on the doorstep. Some ROVIs worked solely from home. There has not been a consistent service across Wales.

Importance of vaccination.

The vaccination programme, with its prioritization of older people and front line workers, has some way to enabling services to operate again and to build confidence around health and safety.

“Vaccines have helped to raise confidence – can only do so much over the telephone.”

In January 2021, Guide Dogs Cymru and Wales Council of the Blind wrote to each local authority to recommend that they include ROVIs, habilitation specialists and orientation and mobility specialists in their front line health and social care professional staff group for early vaccination. At the point of interviewing in March, all 38 ROVIs had been offered a vaccination, and by the end of March 36 of these had received both vaccinations.

However, while some ROVIs insist that vaccines within the caring professions should be mandatory, others are

mindful that this is a matter of personal choice for a number of reasons, including health.

SECTION B: REFERRAL PATHWAYS TO ROVI SUPPORT.

Overview.

This information has been gathered from interviews with ROVIs and subsequently checked by them for accuracy.

There is a range of pathways in use across Wales. Despite their variety, they do share a great deal of common ground. Perhaps a useful and appropriate perspective onto pathways is to regard the service user as situated at the centre of a range of organisations and support. Seen in this light, it would be possible to map the referral routes between the various agencies as a web around the service user, rather than perceiving each individual pathway as a linear route. This would also avoid using the cliché of the service user 'journey', which unhelpfully suggests that there is a linear progress from dependency to independence. Life is more complicated than that and the various agencies in reality support a more fluid relationship between each other allowing, for instance, a service user to return to services when their circumstances change.

Given that local authorities tend towards maintaining their autonomy, there seems little hope in attempting to encourage a set of consistent pathways across Wales. Rather, it would be more pragmatic to accept the varieties but find ways to encourage improvement where weaknesses reveal themselves. Having a Wales-wide perspective should enable local authorities to recognize those weaknesses and identify possible solutions offered in other areas. For example, some ROVI teams provide LVSW practitioners with their own templates for client data, suited to their own needs, while others have little influence on the data attached to the referrals coming to them, receiving the standard LV referral form or, in some

cases, basic contact information. Networking opportunities that bring together LVSW practitioners and ROVIs across Wales would open up possibilities for improvement in this regard. The Eye Care Collaboration Groups, for example, could provide an opportunity to share best practice at a regional level.

Self-referral.

The self-referral routes would generally begin with a call to the local authority resulting in being put through to social services SPoA or equivalent. At this point, the What Matters conversation begins in earnest and is a critical moment for the client because the questioning will often be geared towards identifying support that the client already has from a partner, for instance, thus removing the need for support from the local authority. While this is obviously designed to reduce the pressure on the service, it is a point of risk as far as the client is concerned because they would not normally be conversant with the structures and terminologies of social care in order to provide the answers that would trigger referrals to the support they need. Also, in the absence of sensory-specific trigger questions, the risk to the client and the authority is in not identifying early interventions from ROVIs that would normally reduce unnecessary demands on social care. Early intervention benefits both parties, so it is crucial that this What Matters conversation identifies sight problems reliably.

“The client reaches the contact assessment team which completes a generic form over phone but not necessary sight-loss oriented – needs work done on how contact and assessment team handle sight loss enquiries.”

CVI referrals.

CVI completion and distribution continues to be problematic. A separate study could look at the nature of this specific process within the hospital eye clinics. It seems that the CVI passes through a number of hands before arriving with, ideally, the ROVI. We would like to ascertain who completes its various parts, whether or not the patient leaflet is included in the patient copy (we know this is rarely the case), and what other information is sent to the patient. During the pandemic we hear that many CVIs are not signed by the patient, raising questions around consent, and we understand that only a third of CVIs are sent to the LVSW [367 out of 1,080 in 2020/21]

CVIs are not perceived as a referral method by some authorities. It is sometimes regarded as purely a piece of paperwork for filing after registration. The CVI should universally be seen as passport to additional services.

Referrals to and from LVSW.

LVSW practitioners will refer people to the ROVI service normally using the LV record card [see Appendix 9]. Conversely, a number of referrals into LVSW come directly from the CVI while others come from ROVIs, Third Sector organisations, and other optometrists. Additionally a number are self-referrals, presumably as a result of signposting from ROVIs or Third Sector organisations.

More about the LVSW is given in a forthcoming report.

ECLO referrals.

The ECLO can provide important information and emotional support in the eye clinic or community-based venue post-diagnosis. While most ECLOs will be required

to refer patients via the SPoA or equivalent, some are able to contact the ROVI directly as a double-check.

The pathway is strong into social care. Referral into third sector organisations is variable.

Recommendation: WCB to develop a patient leaflet applicable to each local authority outlining what pathways are available to patients and what services each agency offer them.

Betsi Cadwaladr

Isle of Anglesey

- Self-referral: individual goes through the call centre. They complete the What Matters conversation before it goes to ROVI.
- CVI: goes to SPoA and is referred to the ROVI. ROVI goes out and visits as result of CVI. There is a backlog of visits to register clients currently. It is recognized that if the ROVI does not go out and visit they could miss things.
- ECLO: completes core data of local authority What Matters form. This is sent to authority and then on to the ROVI.
- LVSW: Optometrist completes What Matters form and sends to Local Authority SPoA, who then sends on to the ROVI. Domiciliary visits – the optometrist can telephone the ROVI directly.

Gwynedd

- Self-referral: Via social services (or some directly to North Wales Society for the Blind). NWSB ROVI undertakes an assessment of need.
- CVI: Gwynedd Social Services automatically registers individual and sends letter with registration card to client, with notification that they will be contacted by NWSB who will offer support. NWSB contacts client to undertake a screening call to establish priority before allocating to a ROVI.
- ECLO: via social services, referral to NWSB.
- LVSW: via social services, referral to NWSB.
- Other referrals come from GPs, community nurses, home carers to NWSB.

Conwy

- CVI: These come to the Single Point of Access team – it's put onto WCCIS and then sent on to early intervention and prevention team who, in turn, sends to sensory loss team as a referral. The ROVI contacts people to talk about registration.
- Self-referral: SPoA team conducts What Matters conversation and refers sight loss cases to sensory loss team and on to ROVI.
- ECLO: no clear referral pathways identified.
- LVSW: referrals mostly by email directly to the ROVI. ROVI sends to SPoA for processing before they can offer support.

Denbighshire

- Self-referrals: Formally, the SPoA completes a What Matters form that includes trigger questions for referral to the sensory loss team. Duty Team within Adult Social Services calls client to explain role and to assess need and explain when the client will be seen.
- CVI: Goes to SPoA, who contacts the sensory loss team. ROVI telephones client to discuss registration and possible support.
- ECLO: referral to SPoA and then onto the sensory loss team.
- LVSW: not many referrals into Local Authority.

Flintshire

- Self-referrals: SPoA asks about sight loss as part of questionnaire. Referral onto ROVI in North Wales Deaf Association.

- CVI: Sent to Flintshire SPoA who put it on a list. The ROVI is informed and the ROVI or ROVI assistant contacts client about registration.
- ECLOs: To SPoA who conducts What Matters conversation and refers as appropriate to NWDA.
- LVSW: to SPoA and on to ROVI at NWDA.

SPoA will contact the Third Sector ROVI with any questions.

Wrexham

- Self-referral: The client rings Initial Response team (there are no trigger questions). If they are identified as having sight loss, they are sent through to the ROVI.
- CVI: straight through to admin in Initial Response Team. The ROVI is made aware of referral and the client is put on waiting list. The ROVI takes them off when necessary. Admin contacts the client regarding registration (within 2 weeks) – contact by telephone and large print. They also collect basic information about the client.
- ECLOs: Completes a What Matters form and sends to the Initial Response Team who refers on to sensory team.
- LVSW: Completes What Matters form and sends to SPoA and also email a copy to ROVI.

Powys Teaching Health Board.

Powys

- Self-referral: contact centre (ASSIST) completes What Matters conversation for core data. Refer to Sensory Team.
- CVI: comes directly to the Powys Sensory Team. The ROVI speaks to the client about registration.
- ECLOs: Contact centre (Assist) completes What Matters conversation for core data. Refer to Sensory Team.
- LVSW: No referrals coming.
- All other referrals: via ASSIST – Care and Repair, RNIB, floating support (WAG funded), other opticians.
- In-house colleagues: through ASSIST or direct to Sensory Team.

Hywel Dda University Health Board

Ceredigion

- Self-referral: All referrals go through the SPoA (Porth Gofal) who conduct a What Matters conversation with the client. They then send a referral to the triage team in adult social care. Where appropriate the referral is then passed onto the VI waiting list. ROVI manages waiting list and prioritizes the clients.
- CVI: CVI goes to SPoA. ROVI contacts client to offer registration, even if VI assessment is declined.
- ECLOs: ECLOs make referral via SPoA. ECLO in Aberystwyth will usually ring ROVI to advise and check if a referral is not already in the system.
- LVSW: Copy of record card faxed to contact centre, which contacts client to ask if they want ROVI support.
- Other optometrists: write to main council office.

Pembrokeshire

- Self-referral: SPoA asks is a set of questions where anything sensory-related results in a referral to the sensory loss team.
- CVI: Goes to sensory team and ROVI contacts client about registration and support.
- ECLOs: Referral to Senior ROVI or Contact Centre.
- LVSW: Email or fax of record card straight to sensory team.
- Education Departments: Email referrals to SPoA then on to Sensory Team.
- Other social care teams (adults' and children's): Email to SPoA then on to Sensory Team.

Carmarthenshire

- Self-referral: All referrals go through Delta Wellbeing (third party IAA). These are screened and referred to the sensory team that then allocates the client to a ROVI if necessary.
- CVI: go straight to Sensory Team. The ROVI offers an appointment as normal to discuss registration. This process helps to raise awareness of ROVI's role if needed in the future.
- ECLOs: Referral goes to IAA. There are very few referrals.
- LVSW: Referral to IAA then onto ROVi. Optometrists email ROVI directly with questions.

Swansea Bay University Health Board.

Swansea

- Self-referral: Calls made to Common Access Point in the morning are sent straight through to the sensory team who takes the What Matters data directly. In the afternoons this is conducted by the CAP, which then refers to the sensory team.
- CVI: goes straight to Sensory Loss team. The team then rings the client and offers an assessment and offers registration.
- ECLOs: refers to the CAP, which then sends to the sensory team.
- LVSW: Sent to CAP who then refers to Sensory Team.

Neath

- Self-referral: Gateway asks screening questions such as 'have you had a recent eye test' and 'have you had a recent LVSW assessment?' People with sight loss are then referred into sensory team and screened by manager.
- CVI: CVI received in social services and a booklet is sent to the client. Gateway then contacts the client to ask if they want to proceed with registration.
- ECLOs: Sent to Gateway then on to ROVI.
- LVSW: Sent to Gateway then on to ROVI.

Cwm Taf Morgannwg University Health Board

Bridgend

- Self-referral: Via Common Access Point (CAP). Referral to Sensory Team (within the wider Community Resource Team).
- CVI: All CVIs go straight to admin who record them on WCCIS then they are emailed to the sensory team inbox for allocation.
- ECLO: Referred to the Sensory Team.
- LVSW: Referred to the Sensory Team.
- Also referrals from other opticians, GPs, Princess of Wales Hospital (mainly stroke), Care and Repair, local community coordinators, BAVO, internal referrals from social workers, OTs, physiotherapists, pharmacy technicians, reablement, BridgeStart, ACT [see Appendix 3].

Rhondda Cynon Taff

- Self-referral: RCT's First Response Team receives all calls to the Council from the public, resolves them or signposts to the appropriate department. The SPoA receives all requests for social care, triages them, and uses a set of trigger questions on sight loss. SPoA team is aware of the ROVI and their role. Referral then goes to Sensory Loss team.
- CVI: SPoA receives CVIs, which are then sent to Sensory Team. ROVI then telephones client about registration and to offer assessment.
- ECLOs: First Response or SPoA first, then Sensory Team. Contact ROVI directly with questions.
- LVSW: SPoA first, then Sensory Team. Contact ROVI directly with questions.

- Other referrals from Care and Repair, Sight Life and internal teams directly to Sensory Team with SPoA notified for logging.

Merthyr Tydfil

- Self-referral: SPoA – may send contact to ROVI directly or may send to Adult Duty desk.
- CVI: Come directly to ROVI. ROVI will then contact for registration and support.
- ECLOs: Refer directly to ROVI.
- LVSW: Record card is faxed to Adult Duty desk then sent to ROVI.
- Health and Wellbeing Team: direct to ROVI.
- Additional referrals from Care and Repair, Visual Impairment Merthyr, Stay Well At Home Team. Direct to ROVI.

Cardiff and Vale University Health Board.

Cardiff

- Self-referral: Via SPoA who conducts an initial screening prior to referring to Sight Life, the local sight loss charity, who conducts an assessment of need. They offer information, advice and some initial support and, where more support is required, they refer on to Cardiff Council sensory team to consider a ROVI intervention.
- CVI: The CVI comes to the Council. The business support team contacts the individual directly by

telephone to offer registration. The CVI does not automatically trigger a referral to the sensory team.

- ECLOs: Refers to Sight Life directly, who then contacts the client and sends referral as necessary to Cardiff sensory team for ROVI support.
- LVSW: no established referral pathway.

Vale of Glamorgan

- Self-referrals: via Contact Centre. If sight loss is identified the referral goes to sensory loss team for prioritising and then to the ROVI.
- CVI: The CVI goes to Vale of Glamorgan Council. Once received ROVI does screening offering registration, other services and ROVI support.
- ECLO: Makes referral to Contact Centre where it is screened and forwarded to the Sensory Impairment Team for prioritizing.
- LVSW: Makes referral to Contact Centre where it is screened and forwarded to the Sensory Impairment Team for prioritizing.

Aneurin Bevan University Health Board.

Caerphilly

- Self-referrals: Via the Information, Advice and Assistance Team (IAA) who complete Part 1 of an Integrated Assessment via the What Matters conversation. The IAA can provide advice and signpost, if appropriate. If ROVI support is needed part 1 of the Integrated Assessment is assigned to the ROVI Team via WCCIS. This document is screened within the ROVI Team, and allocated to a

ROVI who will then make contact and, where appropriate, undertake a home visit.

- CVI: Posted directly from the eye-clinic to the ROVI team. Registration is completed by ROVI during home visits to Service Users.
- ECLO: Caerphilly What Matters form completed and sent to IAA. ECLO contacts ROVI if the case is urgent.
- LVSW and opticians: Either through IAA or direct to ROVI – either a telephone call referral or direct email to Senior ROVI attaching a Low Vision referral form template created by the ROVI.
- Supporting People: Refers Service Users to the IAA.
- Referrals from other teams: The OT and Social Worker can send an electronic link to the same case for access by the ROVI. This enables joint working upon the same case file, enables streamlined information-sharing and reduces duplication.

Blaenau Gwent

All referrals for Adult Social Services come through to the Information, Advice and Assistance (IAA) Team (the first point of contact):

- The IAA Team contact client and ask VI screening questions linked to Risk.
- The referral will be referred on by IAA Team and allocated for Sensory Support from OT support Worker (VI) or ROVI
- The client is allocated an OT Support worker (VI) or ROVI.
- The client is contacted and assessment undertaken
- (OT support Worker (VI) will also undertake OT assessment for Minor and Major

adaptations/provide OT equipment as part of their assessment)

- Self-referral: Referral made to IAA team.
- CVI: The CVI goes to the IAA Team who creates a referral for CRT Team and the client is allocated to OT Support Worker (VI), who contacts client to discuss Registration and undertakes initial assessment of needs. If necessary they refer onto ROVI.
- ECLO: Referral made to IAA.
- LVSW: Referral made to IAA, but record card not sent.
- GP: Referral made to IAA.
- District Nurses: Referral made to IAA.
- Social Services (eg. Social Workers, OTs, Physios: Referral made to IAA.
- Sight Cymru – Referral made to IAA.

Torfaen

- Self-referrals: First Point of Contact (FPoC) asks the client a set of questions provided by Sight Cymru. The referral is then made to the Sensory Team for screening by a VI Specialist Social Worker for a possible referral to the ROVI.
- CVI: The CVI is sent to the Sensory Team. A VI Specialist Social Worker contacts the client for registration and for a possible referral to the ROVI.
- ECLO: Via FPoC to be referred on to Sensory Team.
- LVSW: Not seen as a formal referral, but referral is made to FPoC.
- Social Services staff: (with access to WCCIS) create a task for the sensory team to be allocated by a manager.

- Sight Cymru: via SPoC to be referred on to Sensory Team.

Monmouthshire

- Self-referrals: made via Monmouthshire Social Services Adult Duty Team (3 teams: Monmouth, Abergavenny, and Chepstow). If identified with sight loss go direct to sensory impairment team.
- CVI: initially sent to Monmouthshire Social Services Contact Centre. Automatically send out registration cards. CVI emailed direct to ROVI and put on Flo.
- ECLO: Referrals made via Adult Duty Teams who put it on Flo and the referral is sent direct to ROVIs.
- LVSW: record cards sent direct to ROVI (attached to email). Logged onto Flo as ROVI referral.
- Social Services: received internally direct to ROVI from Social Workers, OTs and Physiotherapists.
- Other referrals: Care and Repair, GPs, Stroke Association, etc. made via Adult Duty teams. Logged onto Flo and sent direct to ROVI.

Newport

- Self-referral: Via Contact Centre where What Matters form is completed and sent on to First Contact team and then on to the ROVI, who then contacts client.
- CVI: Comes First Contact team. The team sends out registration booklet with a letter explaining that the client has two weeks to cancel registration.
- ECLO: Refers directly to the ROVI.
- LVSW: Most referrals are received by email.
- Other referrals: either directly to ROVI or through the above channels.

- Urgent referrals and referrals for equipment: sometimes by telephone.

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<https://gov.wales/sites/default/files/publications/2020-03/code-of-practice-in-relation-to-the-performance-and-improvement-of-social-services-in-wales.pdf>
8. Making Meetings Accessible for People with Sensory Loss

www.wcbccd.org.uk/downloads/Making%20meetings%20accessible%20for%20people%20with%20sensory%20loss.docx

APPENDICES

Appendix 1: The Rehabilitation Officer role

ROVIs are university trained and academically qualified to a minimum Foundation Degree level in Health and Social Care (FdSc Rehabilitation Work (Visual Impairment)) or equivalent.

The core elements of the Rehab Officer role include:

- **Assessment** – specialist assessment of a person's vision needs, identifying any visual difficulties and appropriate goals, agreeing and implementing the rehabilitation action plan, reviewing and recording progress.
- **Eye conditions** – non-medical knowledge and understanding of how the eye functions and the effects of eye conditions, regularly associated with other long term health conditions such as strokes, diabetes.
- **Low vision** – specialist knowledge and skills on low vision devices and magnifiers, high-tech video magnifiers and close circuit TV, the use of non-optical devices, and training a person to make the most of their vision by using specific sight strategies
- **Orientation and Mobility** – mobilising visually impaired people to get about safely both indoors and outdoors. Providing training in the use of mobility aids, such as white canes. Route training in specific areas e.g. teaching the route to the shops or work or college. Developing specific orientation techniques and building confidence to become an independent traveller.
- **Independent Living Skills** – developing a visually impaired person's activities of daily living. For example, kitchen skills, making a hot/cold drink, preparation of small snacks and cooking a meal, laundry, household tasks, managing money. Skills for managing personal care, such as applying make-up, shaving and dressing, and identifying and taking medication appropriately and safely.

- **Communication skills** – developing communication and information skills for visually impaired person whether they use written formats, and read large print, using the telephone, tactile formats such as Braille, accessing audible information, using IT equipment, tablets, mobile phones with specialist software and Apps that enable access to the internet and other information routes.

Appendix 2: Points of guidance for Single Point of Access staff.

Points of guidance for SPA when dealing with enquiries from individuals with sight or hearing problems.

Visual Impairment

General Points to consider when conducting a proportionate assessment

- Whilst many people are registered severely sight impaired or sight impaired, this is not an essential requirement for access to assessment and services.
- It is not essential at the enquiry / referral stage to know what the diagnosed eye condition is (if known). It is much more important to establish the impact the eye condition is having on the person's ability to function safely and independently.
- What or how a person sees will depend on the eye condition they have – different eye conditions will have a different impact on peoples' ability to carry out daily living activities.

Helpful questions to establish 'What Matters to an individual with sight loss.

1. Can you describe your sight loss / eye condition?

2. Have you lost your sight recently? For how long have you been having these difficulties?
3. Have you been to the Eye Clinic? / What have they told you at the Eye Clinic?
4. Do you live alone? (or are you often on your own?)
5. How are you managing around the house?
6. How are you managing in the kitchen?
7. How are you managing to make drinks?
8. How are you managing to prepare snacks or meals? (if a carer is doing these tasks, establish whether this is since / because of sight loss)
9. How are you managing to find your way around your home?
10. Have you had any falls?
11. How are you managing the stairs?
12. Do you go out at all? (If not, again, establish whether this is since / because of sight loss)
13. How do you manage outdoors?
14. Do you take any medication?
15. If yes, how are you managing?
16. How are you dealing with correspondence? (especially bills)
17. Can you use your phone? Are you confident you could use the phone to summon help in an emergency?
18. Any other problems? e.g. shopping, laundry
19. Have you had a visit from anyone in the Sensory Services team before?

Hearing Impairment

General Points to consider when conducting a proportionate assessment

- The majority of people with hearing impairment in the community are hard of hearing / deafened people who use hearing aids
- For any queries relating to hearing aids, refer people to the Audiology Clinic at the hospital. If people enquire about being tested for a hearing aid, they need to be referred to the Audiology Clinic at the hospital by their GP. [Audiology - Cwm Taf University Health Board](#)
- Cultural deafness is the term used to describe people who use British Sign Language as their first language, belong to the Deaf Community, and see themselves as a cultural and linguistic minority, rather than disabled
- Most contact with culturally deaf people will either be via visits to the office, (see Communication Tactics below) or Relay UK [Relay UK - homepage](#) | [Relay UK](#)
- It is acknowledged that undertaking a Proportionate Assessment over the phone with a hard of hearing / deaf person can be challenging, and that it will not always be possible to establish all the information required

Helpful questions to establish 'What Matters to an individual with hearing loss.

1. Do you wear a hearing aid?
2. Do you live alone? (or are you often on your own?)
3. Can you hear your front doorbell?
4. Are you missing callers at the door?
5. How do visitors gain access to your home? (i.e. are they leaving the door open or leaving a key in the door?)
6. Can you hear the phone ringing?

7. Can you follow conversations on the phone?
8. Are you confident that you could use the phone to summon help in an emergency?
9. Any other problems with the phone?
10. Do you have a smoke alarm?
11. If yes, can you hear it in every room in the house throughout the property?
12. Can you hear the smoke alarm at night when you take your hearing aid out?
13. Do you smoke?
14. Do you use your oven regularly? Is it gas or electric?
15. Can you hear the television?
16. Does the volume levels of the television affect other family members / neighbours?
17. How do you manage in group situations, with family / friends? Is your social life / activities affected by your hearing loss?
18. Any other problems?
19. Have you had a visit from anyone in the Sensory Services team before?

Communication Tactics

- Make sure you have the person's attention before speaking to them
- Maintain eye contact during your conversation; do not turn away from them whilst you are still speaking
- Do not hide your face whilst speaking e.g. behind a newspaper, hand over mouth
- Try and make sure you are facing the light
- Speak a little more slowly but keep the normal rhythm and flow of speech, to ensure your lip patterns are not distorted
- Begin and end words properly

- Use basic, familiar short words
- Repeat if necessary (no more than twice). On third attempt rephrase
- Give visual clues and try gestures
- Be prepared to write down (this is likely to be essential if a culturally Deaf person calls into the office)
- Avoid unnecessary background noise
- Don't shout (but you can raise your voice slightly)
- Never shout into someone's hearing aid
- Take time and be patient

Low Vision Record Cards

- High Street Optometrists undertake Low Vision Assessments on their premises and refer service users to the Sensory Team for further assessment and follow up work. This is done via a Low Vision Record Card which is faxed to the team.
- If the person is already known to the team, the Rehabilitation Officers in the team screen the Record Card to confirm that a specialist reassessment is required.
- The card is processed by Business Support and sent to SPA to undertake a proportionate / Adult Assessment.
- SPA should enter the source of referral on WCCIS as Optometrist.
- SPA are asked to contact the service users to undertake a proportionate assessment. The trigger questions below can be used as a guide.

General Points

- Whilst many people are registered blind or partially sighted, this is not an essential requirement for access to assessment and services.
- It is not essential at the enquiry / referral stage to know what the diagnosed eye condition is (if known). It is much more important to establish the impact the eye condition is having on the person's ability to function safely and independently.
- What or how a person sees will depend on the eye condition they have – different eye conditions will have a different impact on peoples' ability to carry out daily living activities.
- Using the questions below will help to establish some basic information in relation to sight loss which will help prioritise the referral. However, there is no need to follow the format or wording rigidly. It is important to follow the client's pace in a sensitive manner.
- It is also important to gain any other relevant information e.g. physical and mental health; carer / support networks

Trigger Questions

20. Can you describe your sight loss / eye condition?
21. Have you lost your sight recently? For how long have you been having these difficulties?
22. Have you been to the Eye Clinic? / What have they told you at the Eye Clinic?
23. Do you live alone? (or are you often on your own?)
24. How are you managing around the house?
25. How are you managing in the kitchen?

26. How are you managing to make drinks?
27. How are you managing to prepare snacks or meals? (if a carer is doing these tasks, establish whether this is since / because of sight loss)
28. How are you managing to find your way around your home?
29. Have you had any falls?
30. How are you managing the stairs?
31. Do you go out at all? (If not, again, establish whether this is since / because of sight loss)
32. How do you manage outdoors?
33. Do you take any medication?
34. If yes, how are you managing?
35. How are you dealing with correspondence? (especially bills)
36. Can you use your phone? Are you confident you could use the phone to summon help in an emergency?
37. Any other problems? e.g. shopping, laundry
38. Have you had a visit from anyone in the Sensory Services team before?
39. Do you have any hearing difficulties?
40. How is your physical health / mobility?

Certification and Registration of Visually Impaired children and young people

- The Certificate of Visual Impairment (CVI W) was introduced in Wales in April 2007 to replace Form BD8. The CVI W is completed by a Consultant Ophthalmologist at the Hospital Eye Clinic. The CVI W **certifies** someone as severely sight impaired (blind) or sight impaired (partially sighted) in the hospital setting, and a copy of the document is sent to the Social Services Department to **register** the person.

- The Local Authority has a statutory duty to maintain a register of blind and partially sighted people. However, registration is voluntary and the person can refuse to be registered, even if the CVI W has been completed. If the person refuses registration, we can still undertake an assessment and provide services.
- The Hospital Eye Clinics send a copy of the CVI W to the Sensory Team in RCT.
- See CVI process and Guidance notes

SPA advisers are asked to contact the child's family to undertake a Proportionate Assessment. It would be helpful to explain the following as an introduction.

"We have received a Certificate of Vision Impairment from the Hospital Eye Clinic for your son / daughter / grandchild. Someone from the Sensory Team will be arranging to visit to discuss registration with you. It is very helpful for us to have some background information, so that we are better able to judge how quickly someone needs to visit you".

The trigger questions below can be used as a guide. It won't be possible to follow the questions rigidly as the information required about the child's needs will depend upon their age. e.g. questions in relation to school won't be of relevance to a baby.

It is also important to allow the parent / family member to describe the situation in their own words.

1. Do you know what your child's eye condition is?
2. What advice have you been given by the Eye Clinic staff?
3. Have you been referred to any other professionals? e.g. opticians, Education Department

4. Are any other organisations involved with your child?
5. Do they wear glasses?
6. If of school age, which school do they attend?
7. Do they have any specialist support at school in relation to their vision?
8. How do you feel the eye condition is affecting them at home?
9. Any problems with mobility in the home?
10. How do they manage outside the house? (if age appropriate)
11. How do you / they manage meals? (not preparation but eating independently – dependent on their age)
12. Any problems with accessing leisure activities? e.g. toys, games, either independently or participating with siblings / friends (age appropriate)
13. Have they had a low vision assessment from the opticians? i.e. if they are old enough to be reading.
14. How do they respond to lights? i.e. bright sunshine, electric lights
15. Do they have any other health conditions?
16. Do you have any particular concerns or worries about your child's visual impairment you would like to discuss?

Appendix 3: Bridgend Community Resource Team

A Healthier Wales set out Welsh Government's vision for a future in which everyone in Wales is able to remain active and independent, in their own homes, for as long as possible. To make this vision a reality, long term workforce planning for the specialist ROVI workforce must be a priority. To achieve this the role of the ROVI must be recognised by other health and social care professionals and referred to in a timely manner.

An example of good practice where this happens is Bridgend's Community Resource Team (CRT) where health and social care professionals work alongside each other. The CRT provides timely short-term assessment and is made up of:

The Short-Term Assessment and Reabling Team (STAR)

STAR offers a time-limited, short period of therapeutic and social care support in a person's own home. People accessing their services can receive support from a team of different professionals such as Physiotherapists, Occupational Therapists, Social Workers, ROVI's, and Dieticians, Speech & language and Pharmacy. These professionals can all be involved in the same case to enable someone to regain their independence at home. Following assessment, goals that help the individual achieve what matters to them will be agreed. These will support them to regain/maintain their independence and live as safely as possible in their own homes. Progress will be monitored regularly, and the support provided will be adjusted accordingly.

Reablement Unit

This is suitable for short periods with people who are likely to need more intensive support with daily activities than

possible in their own homes. The unit offers a time-limited stay, where individuals work with a team of different professionals such as ROVIS, Physiotherapists, Occupational Therapists, Social Workers. The aim is to restore the strength, confidence and independent living skills people need to return home and live as safely and independently as possible.

BridgeLink Telecare

This service is a home and personal alarm system. It can automatically call for help when needed or in an emergency.

The Acute Clinical Team (ACT)

Consultant physicians, nurses, physiotherapists, occupational therapists and social workers support ACT, and advanced nurses lead it, with a consultant geriatrician overseeing them. This team's purpose is to provide rapid assessment, diagnostics and treatment in the community, which avoids a hospital admission. This service refers to the ROVI service at the end or during their involvement.

Better at home

This gives rapid short-term support at home for people who are ready to leave hospital but are waiting for another community service to start.

Better at Home is available for up to 14 days and the Social Services 'Home Care Team' delivers it. The service links directly into the ROVI team, where sight loss is identified.

The Sensory Team

The Sensory team has a rehabilitative focus and includes 2 ROVI's, 2 Sensory Assistant's, 2 Sensory Social Workers and an Assistant Manager who is ROVI trained. The team works with adults of all ages (including those

with additional disabilities and complex needs) and we do complete registrations, basic assessments and lighting for children however we don't do any Rehab with children now.

Community Occupational Therapists

The CRT coordinates and manages the Community Occupational Therapists (COTs).

The Community Occupational Therapy Service works with disabled people of all ages, and they assess people's capacity for the usual activities of daily life. Assessment areas include:

- personal care
- household tasks
- the ability to care and be cared for
- the ability to live safely at home

Occupational therapists liaise with the ROVI team for advice, equipment or recommend home alterations relating to sensory loss. This team works very closely with ROVIs in Bridgend. ROVIs receive a number of assessments through this partnership working. The ROVI goes out as quickly as possible through the COT referral.

The Common Access Point

All contact for health and social services comes through the Common Access Point (CAP). Both the public and professionals can access the CAP, which gives:

- **information, advice and assistance** including direction to third sector and community services when they are the best places to address well-being needs
- **multi-disciplinary triage** including mental health services and urgent community response for people who need assessment or immediate service

CAP is aware of the role of the ROVI and refer people with sight loss to the sensory loss team.

The CRT also includes a Pharmacy team. ROVIs perform joint visits to look at a patient's medication and use of drops for example. The CRT also has a team of speech and language and dieticians. This has proved another valuable partnership for the ROVI.

This model provides an effective approach to timely access to a range of support and services and places the ROVI at the heart of early intervention for people with sight loss.

Appendix 4: Powys Client evaluation form.

1. On a scale of 1 to 5, how easy was it for you to contact us?

Needs improving
Excellent

Average

1	2	3	4	5
---	---	---	---	---

Comments

2. On a scale of 1 to 5, how happy are you with the waiting time before being seen?

Needs improving
Excellent

Average

1	2	3	4	5
---	---	---	---	---

Comments

3. Did the worker take time to get to know you and find out what was important to you?

- ☐ Yes
- ☐ No

Comments

4. If we provided you with equipment, did you find this helpful?

- ☐ Yes
- ☐ No

Comments

5. Was the information we provided helpful?

- ☐ Yes
- ☐ No

Comments

6. Do you feel more confident and independent because of our support/help?

- ☐ Yes
- ☐ No

Comments

7. Is there anything that you feel we could have done better?

- ☐ Yes
- ☐ No

Comments

8. What did we do well? Please provide details.

Comments

Please note that if you would like to make a formal complaint about our service, you can do this by:
[contact details]

Date response received

Management oversight/response to survey

Appendix 5: ROVI case studies.

These case studies were originally published as an appendix to “Rehabilitation for People with Sight Loss in Wales” developed by the Wales Vision Forum for the Cross Party Group on Vision Impairment.

Betsi Cadwaladr University Health Board

Isle of Anglesey

Mrs B is a 74-year-old married woman, she is registered Severely Sight Impaired (Blind), she suffers with Age Related Macular Degeneration wet type. Although she has been having Lucentis eye injections to reduce the deterioration these has not been successful. Mr B suffers from dementia and heart problems. Both have supported one another in the past, this is becoming increasingly difficult due to Mr B’s memory problems. All the family live away: the nearest is a four-hour drive. They live in a remote village with no local shops.

Mrs B has had ROVI support following assessment of need. Activities of daily living have become increasingly difficult due to her husband’s condition. Food in the freezer has been labelled: previously her husband would get the items. Oven and Combi microwave have been marked. These are also helping Mr B remember how to turn on and off. The washing machine/tumble drier is now marked: this is of benefit to both. Additional lighting has been fitted in the kitchen. All the above has enabled both to prepare and cook meals without additional support.

Mrs B in the past used a ‘Visum’ electronic reader to read her mail, magazines etc. As her vision has deteriorated further she is no longer able to use the equipment. She is

unable to rely on Mr B to read to her. Mrs B visited the North Wales Society for the Blind open day she had a demonstration of the Iris Vision Live talking scanner followed by a home visit by the company. Mrs B bought the equipment. She is finding it of great benefit.

Mrs B has had on-going intervention from the Rehabilitation Officer (ROVI). She has been signposted to the RNIB benefit service, Council Tax applied for reduction in tax as she has specialist reading scanner due to her disability, power company to register as disabled this will avoid her to not provide account number in an emergency, lunch club allowing both to have time apart enabling both to socialise and private company for cleaning service weekly.

Mrs B wears makeup. She was getting distressed as she was experiencing difficulty applying it and drying/styling her hair. The ROVI was able to advise on magnifying mirrors and suitable lighting for the bedroom. Client always wears jewellery but she was unable to locate matching earrings, for example. A tablet container was introduced, enabling her to place a pair of earrings in one compartment. This proved beneficial. The above mattered and was very important to Mrs B's self-esteem. She needed to be able to continue to do this independently.

Additional handrails have been fitted on ROVI request by the local authority in the shower unit and outside the front door.

During lockdown the Rehabilitation Officer regularly phoned to support and give information regarding local services such as shopping and prescription collection. This enabled both Mr B and Mrs B to keep independent during this difficult time

The service provided by the ROVI has allowed both to remain in their own home without a package of care. Without ROVI support Mrs B would be unable to manage independently. A person-centred rehabilitation programme has allowed Mrs B to maintain her independence at home, carry out tasks, and continue with the activities that matter to her. At present Mr B is still able to drive so they continue to go out in the car for rides and lunch occasionally.

Gwynedd

Mrs B is 38 years old, suffers from Retinitis Pigmentosa (RP), and has been registered as severely sight impaired. She was diagnosed in her mid-20s and was initially registered as sight impaired. She had passed her driving test and had been driving for a few years until she was registered. Her father suffers from AMD but is not aware that any other member of her family has a sight problem. Mrs B is married with an 11-year-old son.

When I first met Mrs B her son was 2 years old, and they lived quite remotely on the outskirts of the nearest town. Public transport was unavailable and they had to walk approximately $\frac{1}{2}$ a mile along a narrow but busy lane without pavements. Her husband worked throughout the day. She was very reliant on her mother, who was a shift worker. Mrs B used to work in retail but, following the deterioration in sight and having to give up driving, felt that she could not carry on.

Mrs B was very emotional and her mood was very low as she felt that she was no longer independent and had lost her confidence, and didn't know where to turn. Her husband and family had to carry out tasks around the house and outdoors which she found frustrating.

She has been receiving ongoing services from the Rehabilitation Officer (ROVI) since first being diagnosed as sight impaired.

The house they rented was very dark with not much natural light and the owner would not allow adaptations. Following an application to the housing association and support from the ROVI they moved to the nearest town where she would be closer to amenities and family.

She has completed mobility and orientation training and has now applied for her first Guide Dog. She travels independently around the town and uses public transport to travel further afield.

She received daily living training and a few adaptations and a lighting assessment were carried out in the new house. Following deterioration in sight an assessment was carried out and she is now awaiting adaptations to be carried out in the kitchen and bathroom through "Canllaw" Independent Living. She completed an IT training course through the local Blind society, and was also referred for benefit advice, counselling, Access to Work and other local and national services and organisations.

Mrs B has now regained her confidence and has been enjoying being able to carry out daily tasks independently, travelling and going places with her son and husband. She is looking forward to getting her Guide Dog.

She returned to education and received a Level 3 Diploma in Childcare, and worked as a nursery school leader and for a few years had her own Childminding business.

Her sight is deteriorating rapidly and she has given up her work, but is thinking of again returning to education and following another course. With the new adaptations in the

house and daily living training, she feels that she will carry on enjoying cooking etc.

Without a ROVI intervention Mrs B would have become more isolated and her mental health would have suffered, as she would have become more dependent on her husband and family. Over the last three years her husband's health has deteriorated significantly but she is now able to complete tasks herself that previously she had relied on him to carry out.

Conwy

This person is one of two clients that live in a supported accommodation with a team of support workers who provide 24/7 support. The person, who is middle-aged, moved to the home about a year ago after almost two decades in another care setting. The person is registered severely sight impaired, deafblind and has a learning disability. Staff at the home communicate with the person using hands-on signing and objects of reference. The individual does not use speech. It was reported that the person does not have any contact with their family because they do not wish to associate with the individual.

The home said their client had become institutionalised and learnt to depend on others. While in the previous care setting their client is said to have had no stimulus and not included in activities. Along with this the person was transported in a wheelchair despite not having any physical mobility issues. The home suspected that early challenging behaviour by the person may have influenced some of their practices of the previous care setting.

The person

- attended a school for the blind – no details regarding the institution or skills taught

- lost all vision after gouging out own eyes several years ago
- is tactile sensitive and would not tolerate wearing hearing aids or a wristwatch.

Outcomes included:

- To explore tactile communication methods that the person may have learnt in the past
- To advise and equip the person's support team develop the person's ability orientation within the care home and outdoors (not route specific – travelling alongside support staff)
- To be aware of aids that could increase independence.

The ROVI established a set of actions required to bring about these outcomes. These included demonstrating techniques to the home staff so that they could help the person gain the appropriate skills for independence.

Denbighshire

Mrs B has mental health issues, diabetes, arthritis and cataracts. She was scheduled to have cataract surgery, but this could not proceed, due to high blood sugar levels. The hospital advised that this needed to be better controlled, before an operation could go ahead. She was receiving support from the District Nurses with the administration of her insulin, as she was unable to do this independently due to severe sight impairment. A further appointment was given, for her to be seen at the eye hospital. Mrs B did not want to go because she did not feel that she could manage to get there and find her way around independently. She had no family or friends to support her.

Mrs B was at risk of further sight loss by not being able to attend the hospital appointment. The reason why she had such high blood sugars, was because of an inability to attend previous medical appointments.

Preventative Rehab services in the form of mobility training enabled her to attend her medical appointment, to have further medical treatment. This avoided a further deterioration in her eyesight, and loss of independence, potentially resulting in a costly package of care.

Flintshire

X has serious sight loss after cataract surgery using faulty lenses. Her eyesight deteriorated until she was no longer able to read her digital tablet screen.

A ROVI from the local society made six visits to carry out some interventions.

Noticing the incorrect use of a self-purchased cane, the ROVI stressed the need for a rehabilitation officer to train her in its proper use. X's partner was given a brief demonstration of proper guiding techniques as this was being conducted incorrectly.

The ROVI recommended talking to her GP for a new referral to her ophthalmologist for an updated CVI. The CVI, which should be upgraded to show Severely Sight Impaired, would enable access to other services including a Blue Badge for parking.

The ROVI was concerned that the risks associated with misuse of the roller-cane made obtaining ROVI support from the local authority more urgent.

X was experiencing difficulties with going out into the community; a lack of confidence; the overwhelming effect of bright, busy environments; and difficulty with socially engaging and conversing. She had stayed away from family occasions due to those pressures.

The ROVI addressed the problem of glare with two pairs of UV glasses, one for indoors and one for outdoors. Other accessories were introduced to help with telephoning, making drinks, cooking and eating.

The ROVI addressed X's mobility issues with cane training, including long cane training so that visits to a local friend were possible. They also dealt with safe mobility around the house to reduce the risk of falls.

Further mobility training was requested from the Sensory Team as her eyesight is deteriorating. This has not been forthcoming so, due to the urgency of the matter, it has been delivered by the local society.

An appointment was obtained with Moorfields Hospital to pursue updating of the CVI.

The intervention from a local society ROVI removed a number of barriers to independence and addressed risky situations by fostering skills and demonstrating solutions that only the qualified ROVI is trained to identify and solve.

Wrexham

I have been working with Miss A since February 2020 after she suffered acute vision loss. She is a migraine sufferer and would lose vision during migraines.

Miss A is registered sight impaired, and her eye condition is optic atrophy. She has extensive loss of visual fields including hemianopia.

Miss A required mobility training so she could take her daughter to school without support and also continue her day-to-day tasks of shopping, appointments and visiting friends.

Miss A's family live in Bangor, so she does not get to see them regularly. These visits decreased since COVID19, affecting Miss A's mental health as she suffers from depression and anxiety.

I was successful in a grant application for a tablet for Miss A. She was so happy about this as the tablet has really boosted her mood as she is able to make video calls with family and friends. She can now do her shopping and banking online, use social media and also listen to talking books and much more.

This simple piece of equipment together with training to support its use, gave Miss A, a way of communicating with friends and family. It also gave her the independence to deal with her daily living activities like shopping and banking independently, without having to rely on others.

Powys Teaching Health Board

Powys

Rachel is a Powys resident in her early 30s. She contacted Powys County Council because she felt her vision was changing. After this call, Rachel received a visit from one of our Rehabilitation Officers for Persons with Visual Impairment (ROVI). Our ROVI was then able to assess Rachel's home to see where she could support her. After assessing her home, our ROVI offered Rachel extra lighting and referred her to the Care and Repair agency. Rachel also received training on how to use a cane to aid her independence around her home, as well as on public transport. Rachel's rehabilitation was very successful and she felt confident and independent afterwards. So much so that she left a message for her ROVI to let her know that she was getting on a train by herself. Rachel was very happy with her experience and spread the message to all her friends, telling others how positive her experience was. Rachel now volunteers for a local and national charity helping to support others with vision impairments.

An animation of Rachel's story can be found here:

http://www.wcb-ccd.org.uk/wales_vision_forum.php

Hywel Dda University Health Board

Ceredigion

Mr X is a 47 year-old man, who underwent surgery for a pituitary tumour and woke up with no vision only perception of light. I was contacted by the eye clinic liaison officer at the Heath Hospital as I would be the ROVI covering his area. On discharge from hospital, I made contact and arranged a home visit. The impact on him and

his family was great. Loss of sight, loss of work, loss of independence and constant hospital appointments.

Actions carried out: contacted RNIB Welfare Rights team for benefit support to start claim process; Contacted GP to arrange all medication in Dossette box; liaised with RNIB Employment Adviser for support with dealing with his work's HR department; referred and worked with Occupational Therapy team as bathing was now an issue due to having to stand and balance difficulties; also liaised with local authority grants department to change broken decking (to access his front door) to a solid slabbed area to avoid risks of falling; liaised with local housing association as, even though he lived in a private house, access was along a terrace of social housing; paving surface to his home was full of pot holes - these were filled by housing association and I carried out mobility training using a cane to enable him to walk to car parking area, located at the top of a flight of steps; liaised with local authority and had steps edges painted and handrails installed - they also installed an additional disabled persons' car parking space; obtained a Blue Badge to enable his wife to park when attending appointments; taught his wife sighted guide technique to support her husband when out and attending appointments; issued appropriate VI aids to enable him to make himself hot drinks and regenerate meals. As time progressed a very small window of vision returned; I therefore arranged for Care and Repair Managing Better scheme to install better lighting within the home, sensor lights at front and back access. All of these actions / aids and adaptations were necessary as I carried out an holistic assessment and met his needs to this life-changing event, to enable him to remain as independent and as safe as possible.

Miss X is a 30-year-old single parent living with her son in social housing. She has had sight loss since birth due to a rare eye condition, however in recent times her vision has deteriorated to a point where she is certified as Severely Sight Impaired. Her sight loss was impacting on her ability to carry out her daily living tasks and she was beginning to lose her confidence, which was impacting her emotionally. Having carried out a VI assessment, I managed to find a support group specifically for her eye condition, albeit over the telephone as there are few numbers of people with the condition. She was burning herself more and more carrying out cooking skills and using her coal fire. I contacted the housing association and held a site visit where we discussed her difficulties and my recommendations.

The housing association agreed to alter her kitchen environment and take all my recommendations on board. Due to the timescale and obtaining quotes, it went on quite a while, therefore I provided VI aids and advice to enable her to manage in the meantime. The housing association also agreed to change her heating source. They removed the coal fire and installed a heat source pump. I explained that due to her sight loss, she would need a large heating thermostat. The company who installed the heating advised that it is all electronic and she only needs to press one button, which they changed to a good colour contrast button. Her kitchen was finally altered: she had an eye level oven; good colour contrast units; worktop; additional strip lighting; non slip flooring; induction hob and colour contrast door frame. I also requested they install a concrete step to aid getting in and out of front and back door due to tripping over the threshold and install sensor lights at front and back. I issued VI aids to gain more confidence within the kitchen and around the home. I facilitated her to attend VI workshops to enable her to meet others with a sight loss

as this peer support would assist her emotionally. I referred her son to the carers unit within the local authority as a young carer. I attended her son's primary school with her to explain her sight loss and to enable the school to support her, as she was unable to read his school reports or see him when a school function was being held. I taught her long cane skills to improve her mobility. I referred her to RNIB welfare rights to review her benefits and maximise her income. My ROVI input enables her to live with her son in a safe environment and for her to continue to be independent and care for her son.

Pembrokeshire

Mr A lives alone and is supported by his neighbours who have made a referral for care as they are unable to continue in their caring role.

Mr A was referred to the Adult Social Care team and Sensory Service as it was indicated that he had a visual impairment. A Sensory Assessment was completed and the following work undertaken:

Daily living skills – Mr A was finding it very difficult to prepare food and hot drinks. Following the assessment training was given in the use of a one cup machine which Mr A purchased privately. We were able to provide a talking microwave which Mr A was trained with and then could use to cook and re-heat meals. This intervention reduced the risk of Mr A burning himself from lifting/pouring a kettle and he was also able to continue with preparing his own food.

Personal Care – Mr A had a level access shower, but required additional grab rails. We were able to refer to Care and Repair for this to be completed and help to reduce the risk of falling in the shower.

Communication – Mr A was referred for a community alarm and we were able to provide a big button phone so that Mr A could remain in contact with services/friends etc. We also advised about using black marker pens to enable him to see any print that he wrote. We also referred Mr A to RNIB talking book service and the local talking newspapers.

Low Vision Service – Mr A had not received a low vision assessment so we were able to refer him for this service from the Optician in his area. Following on from this assessment Mr A was provided with the appropriate low vision aids to support him.

Refuse Collection – We referred Mr A for assisted refuse collection as he was unable to take his bin bags to the gate, but was able to put them outside the front door.

Social interaction – Mr A was offered to access the VIP group in the area. However, at that time he did not want to attend, but was pleased to know what was happening in his area.

Domestic tasks – Mr A had a cleaner who visited once a week, who also supported with shopping as and when required.

Outcome:

Once the assessment, equipment and training had been provided Mr A no longer required any care support. I was able to review Mr A one year later. He was still living on his own, without any care support.

Potential Savings:

Annual care costing £50 a week = £2600

Provision of equipment = £300 (one off cost)

Saving = £2300

Carmarthenshire

Mr. H's central nerve burst in his one eye and, with only 20% in his now functioning eye, Mr. H became severely sight impaired overnight. The Consultant Ophthalmologist asked the nurse to refer Mr. H to social services as part of the Certificate of Visual Impairment process. It was approximately 6 weeks after the Certificate was sent that Mr. H was visited by his ROVI.

“The ROVI explained how things could and would work and made me feel comfortable. The ROVI had marked my cooking hob and microwave and most importantly gave me the reassurance that I needed as I was in shock and struggling to come to terms with my sight loss”.

My sight loss also impacted on my wife as I was unable to carry out duties that I previously could. It took me a year to come to terms with everything and become skilled and useful. At the end of the year I thought it was time to pay something back. I worked closely with my ROVI and the clubs they support. I supported individuals within the clubs. The other benefit of the training is that it made me more aware and skilled and gave me the ethos of good practice and skill-base. My presence and active use in supporting others is entirely down to the support from my ROVI.

In the first year I needed to acclimatise and accept that I was going to have a completely new life – it was like moving to a different planet. I received plenty of practical help and advice from my ROVI and encouragement.

Practical help: I was taught long-cane training and my ROVI showed patience and allowed me to learn at my own pace, teaching me new routes, navigating steps, tactile paving, crossing, etc.

My loss equals my wife's loss as well. With help from the ROVI I am now able to help with things like shopping.

The Coronavirus Pandemic has brought back the fear and fright of the uncertainty of the first year of living with sight loss but I know I can always contact my ROVI, if I need additional support.”

Swansea Bay University Health Board

Swansea

Mr. D is severely sight impaired and has Retinitis Pigmentosa (RP). He has seen deterioration in his vision and enrolled on an IT training course at the Swansea Vale Resource Centre so that he could learn to use a computer with speech output. Mr. D was not able to get to the centre independently, so the resource centre referred him to a ROVI.

“I was seen by my ROVI fairly quickly and this made all the difference to me. My ROVI gave me mobility training so that I could get out and about including to the resource centre so that I could learn to use my PC. I have additional mobility problems not linked to my sight loss and the ROVI providing me with a white stick that helped me to balance, support my weight, and walk further.”

Having access to a ROVI in a timely manner has meant that Mr. D can improve his IT skills. He uses access software to read letters, keep him in touch with those who can help him and provide him with opportunities and activities to keep him occupied.

“The training from the ROVI has helped me to feel more confident and take part in a wider range of activities. I have had VI Gold sessions, for example, supported by Sight Life. My ROVI has given me more confidence in my life all together. I am now able to catch a bus back and forth to the resource centre, independently. This has meant that I now attend local groups and meet others with sight loss from whom I have learnt so much. If it wasn't for help from my ROVI I wouldn't be able to go out and about as much as I can.”

Mr. D has also received support to enable him to prepare and cook food for himself. All in all, support from ROVI and third sector has made a big difference to his life. “I also know who to turn to for support when I need it.”

Neath

J is an 81 year old, Welsh-speaking woman living alone in a small village near Port Talbot. She began losing her vision 3 years ago. She stated “I was [a secretary] at the time and had noticed that I was struggling to see print. I have been long-sighted most of my life and have worn glasses for reading since I was a teenager. But my glasses didn't seem to be helping and I had to squint to see print as it appeared very blurry. I put it down to tiredness initially then decided to get it checked out at my local opticians.”

J was seen by an Optometrist who subsequently referred her to the Ophthalmology department at Singleton Hospital. J was diagnosed with Age-related Macular Degeneration (AMD).

J has Dry AMD and has been registered Sight Impaired since February 2018. A Certificate of Vision Impairment (CVI) was completed by the Ophthalmologist and a copy

of the registration was then sent to Neath Port Talbot Social Services Team.

J continued to drive for a few weeks but soon began having difficulties distinguishing between red and green lights at traffic lights and was unable to judge safe distances on very sunny days. J voluntarily gave up driving and at that point felt that she had completely lost her independence.

Following receipt of J's CVI, she was referred to the Sensory Team and a member of the team contacted her to discuss the referral. It was established that J required support with daily living skills and also required mobility training. The referral was transferred onto my caseload and contact made within 24 hours of referral. During that initial telephone conversation, J described feeling devastated, angry and extremely frustrated. She openly described moments of feeling very low and being very tearful. It was agreed that I arrange a home visit to complete an assessment to provide J with aids, equipment and training to allow her to continue to be as independent as possible. As the referral had stated that J was Welsh speaking, she was offered the opportunity of an assessment completed through the medium of Welsh, which she accepted. She stated "Welsh is my first language and I find it so much easier expressing myself in Welsh." The remainder of the conversations/training were delivered in Welsh.

AMD causes a deterioration of the central field of vision used for activities such as reading and cooking. J had previously enjoyed reading but was now unable to access small print. She had resigned as secretary of her local chapel due to this difficulty and had been devastated to have to do so. She stated "I lost my husband 5 years ago and the chapel community and activities had given me

something to occupy my time. I have not told any of my chapel friends about my vision as I don't want them to feel sorry for me. I've always been extremely proud and also been the one helping others so admitting to them has been impossible for me to do." J had become dependent on her son reading her mail to her when he visited her a few evenings a week. This made her very frustrated as letters would be posted through her door and she'd have to wait for him to arrive before accessing the information contained within them, especially some of the most urgent or private matters. I recommended that J have a Low Vision Assessment and referred her for an assessment. Following the assessment, J received magnifiers to access print and was delighted to be able to access N8 (newspaper print) with the aid of a 12D HH Magnifier.

Though J was able to access print, she was still only able to read a few sentences at a time due to the smudge/black spot right in the middle of her vision. However, J's peripheral vision was intact; therefore I introduced her to eccentric viewing. This technique improved the quality and speed of her reading ability. J was delighted as it gave her ownership of her ability to access confidential letters and correspondence once again. J enquired about Braille and I explained that I am a qualified brailist and would be able to support her learning if necessary. However, it was agreed that J did not require the training as present as she is able to access print with LVAs.

J completed an assessment of daily living skills as she had lost her confidence when completing skills of daily living. J had become dependent on ready meals re-heated in the microwave and no longer felt safe completing chopping and other cooking skills involving the use of knives, and other sharp cooking utensils. J was unable to access the dials on her kitchen appliances and admitted to guessing the time on her microwave setting.

I assessed the lighting in J's kitchen. AMD affects both the rods and cones of the eyes making the ability to see in low lighting also detailed tasks very challenging. With her consent, I referred her to Care and Repair who fitted fluorescent lighting and also under-cupboard lights to provide additional lighting to complete details tasks on the work surfaces.

Bump-ons were applied to all kitchen appliances including the cooker, hob, microwave and the washing machine, so that J could safely facilitate the operation of each of the appliances independently. J struggles with colour and contrast, therefore I recommended replacing her existing chopping board to make chopping activities safer for her to complete. J now has access to a white chopping board for preparing darker foods and a dark chopping board for the preparation of lighter coloured foods e.g. onions. Chopping skills were also taught.

Completing a simple task of making a cup of tea had also becoming a real challenge as J was unable to see the water level in her cup. This had resulted in her burning both her hands and also her legs, as the excess water had travelled along the work surface and down onto the floor. J stated "I avoid making too many cups of tea as I'm scared of my son seeing burn marks on me. I know how worried he is about me and I can't risk him placing me into a care home. I'd be completely devastated and am determined to stay living independently for as long as I can."

I introduced J to a Liquid Level Indicator (LLI). This is a device which signals an audible alert when a liquid comes within a distance of the top of a cup or glass. It sits at the edge of the cup and emits a beeping sound as the liquid level comes close to the top. Another tone will sound once the cup is full. Other strategies were put in place including the teaching of pouring techniques which were

consolidated over a period of a few visits. With the aid of the LLI and pouring techniques J is now able to safely and confidently make herself a cup of tea. We have eliminated the risks of her burning and have given her the skills needed to complete the task independently.

J had been completely devastated at not being able to drive and had not used public transport for many years. She no longer felt confident to go out on her own and is dependent on her family to support her to access the community. We discussed mobility and the introduction of a long cane. However, initially, J was extremely reluctant to use a cane and stated “I don’t want to draw attention to myself and people feeling sorry for me.” She also stated “I thought they were only for totally blind people.”

We discussed J’s confidence navigating kerbs, steps and uneven surfaces. We also discussed her ability to travel somewhere unfamiliar and also about her confidence to travel in busier environments. J reported that she didn’t feel safe completing any of the skills and admitted to having fallen several times when travelling on uneven surfaces. We explored a variety of canes and discussed the functions of each one. J was given the opportunity of holding them and we worked hand-on-hand to complete some basic cane skill techniques indoors. I allowed J time for self-acceptance and after two sessions she was willing to ‘give it a go.’ J was taught a technique called constant contact which requires the cane user to sweep the cane along the ground, maintaining contact at all times. This enabled her to feel changes in the surfaces, edges of kerbs and steps, and also tactile paving. It also provided her with the tools for creating a protective barrier and allowed her to be able to navigate through narrow spaces. Once confident, these skills were developed further, allowing J the skills to navigate busier shopping centres and crowded supermarkets and eventually the bus route

from her village into Port Talbot town centre. J's determination allowed her the skills to become a safe, independent traveller and she no longer felt the need to hide behind her impairment. J has since joined the Macular Society and has become a befriender. She shares her experiences with others going through the same feeling of loss that she felt when first diagnosed as Sight Impaired.

Working with people like J and providing them with the tools to complete daily living skills and long cane training is a privilege. She now has the skills to continue to live alone, safely and independently and is back doing the things she loved including baking, walking and staying in touch and socialising with friends and family. She has also been re-instated and is vice-secretary of her local Chapel. She reported that having involvement with the community gives her life a sense of purpose again.

Cwm Taf Morgannwg University Health Board

Bridgend

Mrs D has an ulcerated pemphigoid, had her left eye removed and damage in her right eye. She is extremely susceptible to bright light and sunshine. She is registered as SSI. She lives within a valley that is small and isolated. Her husband passed away 3 years ago and she relied on him for all aspects of daily living. She has 2 sons that both live away however she has contact with them via facetime. During that period she lost her confidence, became very anxious, fell several times and stopped going out. Mrs D was at an all-time low, her mental health declined and had no support from anywhere. She had received orientation and mobility training (O&M) in the past when her husband was alive and used to have a Guide Dog. Her sons had concerns over her living independently and managing

within her home environment especially around her personal care, preparing food, cooking – leaving the gas cooker on and going out. Mrs D was at risk of falling in her shower as she had no grab rails or any adaptations. The house was very dark with very little lighting especially in the kitchen and bathroom.

Mrs D has been having on-going intervention from the ROVI including further O&M, activities of daily living (ADL) including a lighting assessment, training around communication and technology, low vision therapy (LVT) and emotional support. The ROVI signposted her to various third sector organisations including Care & Repair (C&R), “Booklink” and the Local Community Co-ordinator (LCC). She had a Healthy Homes Assessment from C&R which identified lots of issues. The LCC got her involved in various community groups and into the local gym. Mrs D has become more confident and is now able to go to the gym under the GP referral scheme.

Without ROVI support Mrs D would be unable to manage independently and would need a package of care. However, with a person-centred individual rehabilitation programme she has been able to maintain her independence at home and outdoors within her local community, carry out everyday tasks including those involving risk, re-establish new goals and manage her emotional well-being.

During lockdown she was unable to go out, got very low in mood, lost her confidence, became depressed and felt socially isolated. She has recently started mobility training again and got very anxious using her cane and struggled with the old routes she used to do. She has had several falls since and is having to re-learn routes and build her confidence back up.

If ROVI intervention hadn't been introduced a costly package of care would have had to have been put in place having a further impact on her medical and mental well-being.

Rhondda Cynon Taf

"I was an electrician by trade, unfortunately I had a stroke which affected my sight and I was just wandering about the house. I lived in Talbot Green for 30 odd years and I was trying to do the shopping by myself in the village and using an ordinary walking stick which I found difficult to manage kerbs and I was getting frightened by traffic.

I was seen by my doctors and told that there was a chance my brain would rewire itself and that I would be able to get some sort of vision back. I think they were waiting to see what would happen but I was just getting frustrated being in the house by myself for about three years.

I rang RNIB and they contacted Social Services on my behalf. Ian, a rehabilitation officer, came out and assessed me. He brought a cane and showed me how to use it over the next month or so. Ian took me shopping, took me to the Leisure Centre and helped me to understand where it was safe to cross the roads. Ian also showed me how to use trains and buses and manage getting on and off them safely.

I was getting a bit more confidence in walking about and realised with a cane I could work out where the kerb was so I wasn't walking into traffic. I felt like I was getting a better sense of where I was and what was around me.

I live in Talbot Green which is quite a busy shopping area. I had a mental map in my head of where the places were

and walking around them Ian would take me to a corner and say 'no, it's not safe to cross here'. He would then show me a different place a bit further along that was safer to cross and how to access the shops and make my way around the village.

I got a bit more confident and started doing things for myself. It was like I got my life back in a way. I was able to do stuff again. I'm able to get out and do things; I've got confidence to go and do things for myself. I now go shopping, on trips to Cardiff and I've caught trains and buses on my own.

My advice would be to look for what help is out there, don't be afraid to try anything and don't give up just keep trying. There are things out there it's unfortunate that they are not publicised much, but if you do look there are people who are out there willing to help you."

Merthyr Tydfil

Mrs. D has macular degeneration and is receiving treatment. She hasn't needed support from a ROVI as yet but, through her local club, has seen the difference that ROVI intervention has made to many of her members. The ROVI visits community groups and is there to provide advice and help. Our ROVI has been very helpful to me and others and is a true professional. I know that, if my sight deteriorates, I can always seek support from a ROVI and I now know exactly what I can ask for and how she can help. Knowing that this service exists has been a comfort to me and others.

Mrs. E attends in the same club and has received a range of support from her ROVI. "She has been marvellous – she has made my house safe by adding bump-ons to

appliances. She gave me mobility training, how to use my cane up and down steps, on the kerb on the road. This has helped me to be more independent and I am looking forward to more training after the pandemic.

My ROVI also referred me to an optician for a low vision aids assessment. The magnifiers they provided help me to read my post, medicines and food packaging. I have felt low during these difficult times and have rung my ROVI for a chat. She also telephoned me to see how I am coping. I have really appreciated this support.”

Cardiff & Vale University Health Board

Cardiff

Mr. Z suffered sudden sight loss owing to an underlying condition of Glaucoma. Mr. Z, when diagnosed, was seen by the ECLO and at the University Hospital of Wales, followed by a home visit. The ECLO made a referral to the ROVI team as a priority. Mr. Z waited 6 weeks to see one of the practising ROVIs.

“They introduced me to the outside environment. This is what I was feeling most anxious about.”

Mr. Z received mobility training. “I was taught how to navigate around commonly visited areas and how to manage a weekly shop. They also helped me with bus travel around the City.” They provided key help and guidance for health and safety around the home.

“I am aware that Cardiff now only has one ROVI and this causes me concern because as more people have sight loss than when I was first diagnosed. I worry that people will be waiting a long time to get the service that I truly

valued. I am concerned this will lead to an increase in anxiety, leading to stress affecting wellbeing and mental health, as well as social isolation and a subsequent loss of confidence.

What I think needs to be considered is that many sight conditions are progressive. An individual's needs are ever changing. If there is a significant change in vision, they will need additional support.

Timely access to a ROVI made a significant difference to my mental health and wellbeing. I suffered with depression and the step-by-step process of a conversation followed by intervention help me considerably. The longer you leave some dangling the greater the impact to their mental health and wellbeing. Therefore, timely intervention is critical."

Mrs E is a 59-year-old woman who is registered as Severely Sight Impaired. She had requested ROVI input for mobility sessions consisting of bus travel to Newport with the aim of orientating herself to Newport train station. The purpose of these sessions was that she was going on holiday and would be going from Newport train station and as she had never been she did not feel confident enough in carrying out the journey herself. Once I had visited her and carried out an assessment, I agreed to carry out a 6-week mobility training programme beginning with looking at the route and breaking it down into sections and ending the programme with Mrs E conducting the route on her own with myself observing.

During each session Mrs E would successfully negotiate the route consisting of road crossings, negotiating traffic lights, steps, stairs and orientation of the train station. By each session she would progress and become familiar with the route and her surroundings. It was also useful conducting sessions at the train station for staff members

as I could explain the needs required for her upon her arrival and for Mrs E to be reassured that with assistance she would be taken to her platform and onto her train safely.

With the 6-week programme completed Mrs E stated that she would like to continue with furthering her mobility with the ROVI agreeing to extend her mobility training, (which has been completed after a review), conducting bus travelling sessions around Cardiff. As Mrs E had gained confidence in being able to use public transport she wanted to visit places of interest and shopping centres safely and independently that she would not have thought about or attempted before receiving a rehab service.

Ms W. A telephone assessment has been completed with this lady and currently wellbeing advice calls are being made on a weekly basis. She has recently lost some of her vision with an as-of-yet unknown diagnosis. Following telephone assessment and continued wellbeing calls ROVI has identified that she is struggling at home and having difficulty with preparing herself a hot drink, meal preparation and is relying on her 15-year-old daughter for support in the kitchen. She also has a son, aged 12 who has special needs and both children are known to Children's Services and have been visited by their social worker during lockdown. Ms W suffers with anxiety and depression and is struggling to come to terms with sight loss and the ability to do 'everything'. VI input is urgently needed in order to help provide her with suitable aids and gadgets. These would be to help maintain safety at home and independence in carrying out daily living tasks as well as potential mobility training depending on current circumstances.

Mr M received 4 weeks VI input before lockdown consisting mainly of mobility training looking at cane

usage, road crossings, negotiating steps and stairs and low level kitchen skills. Further training is required around cooking skills looking at chopping/peeling skills and hob usage as currently he no longer uses his hob due to an incident and at present does not feel confident using without any input. Further mobility training also required most notably looking at routes into local village, chemist GP surgery and workplace (Heath Hospital) as these routes were not achievable before lockdown. Mr M lives alone with parents living in Hereford and has friends living in Penarth and around the city but is in contact with them via telephone. He suffers with mental health issues, depression and anxiety. Weekly wellbeing calls are being made by the ROVI but input is required to help maintain his wellbeing, independence and safety indoors and outdoors.

Vale of Glamorgan

Mr D was an active cyclist and had a keen interest in motorcycles before losing his sight. He had been driving since 1946. Mr D is 89 years old. He is registered as Severely Sight Impaired and has Age Related Macular Degeneration in both eyes with no central vision. He was having Lucentis injections for 7 years, but these have now stopped. He had recently been told by his consultant that there is nothing else that can be done for his vision as the Macular is now dry.

Mr D reports that he has Charles Bonnet Syndrome which creates the impression he can see animals such as a cat under the table and by the side of his chair which looks up at him and a purple pig which keeps his back to him. Mr D has also had a triple bypass in 2003 following a previous heart attack. He then had a stroke 3 years later.

His daughter (who lives abroad) contacted the Vale and said that her parents live in a very old town house and is very concerned that when her father goes up and down the stairs (especially with their toilet outside the property) he cannot see the bottom step and he may have a fall.

During the Initial ROVI Assessment and lighting assessment, referrals were made to Care and Repair for handrails outside the property, edging of the steps to be painted white leading from the back door to the outside toilet. Also, front porch steps needed to be painted. The pathway leading to the outside toilet was very poor so brighter lighting was installed. A flat steel railing was installed to provide additional support when walking down the front steps.

Indoors safety lighting was put in to provide extra lighting leading from the bedroom to the upstairs toilet. This was a major safety issue as Mr D was fearful that he may fall down the stairs during the night. A stick rail was installed along the stairwell wall on the right-hand side so that Mr D would have support when going down the 15 stairs. Mr D's wife mentioned that she was afraid to leave Mr D alone in the property when she had to go out and was continually worried that he may hurt himself. After a brief discussion Mr D agreed to a TeleV alarm system.

Quote from Mr D

"Safety is the primary object, I am for ever grateful for being gently persuaded to have a personal alarm, it now means my wife can go out and not be worried about me. Also having our clothes line in the back garden cemented in the ground means I can now help bring the washing in for my wife, one more less thing for her to do and it makes me feel useful again".

During the Initial ROVI Assessment Mr D said that he had difficulty with reading all print sizes especially his marine books. He had tried magnifiers with additional light, but they no longer helped as the letters are still jumbled up. As Mr D has been in the forces, I liaised with outside charities to provide a case for securing funding for a screen reader to enable Mr D to pursue his hobby of reading.

Mobility training was also discussed, and Mr D said he had lost his confidence and was unable to walk in a straight line and kept veering off the edge of the pavement into the road as he was constantly tripping up on the uneven surfaces.

Mr D was initially given a symbol cane to introduce him to the long cane, to use when outdoors. He then progressed to a guide cane and finally long cane mobility training. Mr D has recently completed his mobility training with ROVI intervention. Mr D has always liked Nordic walking and him having mobility sessions has improved this greatly.

Quote from Mr D

“There have been some humorous times during my mobility training – things that were taught in mobility sessions, like moving safely around additional clutter on the pavements, bicycle docking racks and negotiating around scaffolding on the pavement. I did not think I could do it with my limited vision but with the reassurance I was given I was able to complete it, although it was still very daunting at times. The Rehabilitation Officer taught me to be more aware and drew my attention to crossing the road correctly, learning to go at a slower pace and trust my decisions again. I felt confident to be able to cross a busy junction using 3 zebra crossings on my own - remembering to stop at the kerb edge first and not to dash across the road (although at my age that would be a bit hard to do). I am very grateful to the local authority and

Sight Cymru for bringing a Rehabilitation Officer into my world, spending the extra time and care to teach me new skills and giving me more independence and my confidence back. My greatest joy is being able to send a photo and video by email to my daughter who lives abroad and to share my new mobility skills”.

Aneurin Bevan University Health Board

Caerphilly

Mrs C, a young woman diagnosed with Diabetic Retinopathy during the Coronavirus pandemic, has been referred to ROVI team via the Certificate of Visual Impairment. The ROVI met with the client to provide an holistic assessment and discuss registration (Severely Sight Impaired). Mrs C had recently qualified as, and was working as, an English teacher. She has left this role because of her sight loss. Mrs C had recently moved into a new home and was unfamiliar of her surroundings. She has no detailed vision but can make out objects.

Following an assessment by the ROVI, what mattered to her was being able to get out and about by herself and not rely on other people. During the pandemic the ROVI provided a focused work-plan on mobility training as this could be done safely outdoors. Mrs C explained that she has always been an independent person but felt restricted during the pandemic. She added that,

“Timely access to mobility training meant that I didn’t build up a fear of going outside and avoided feeling completely trapped because of my sight loss. I just know that without her [the ROVI] help I would still be struggling with my sight loss”.

Intervention with the ROVI meant that the client felt that her 'life wasn't over'. She became more motivated and confident to learn all of the necessary skills to regain her independence. Mrs C now has a more positive outlook on life and is looking at what opportunities there are in relation to work. ROVI has provided advice about Access to Work and support from the third sector on learning new IT skills. Sight loss has had an emotional impact on her life but ROVI intervention has enabled her to have a more positive outlook.

The ROVI provided lots of information and has supported Mrs C to do more for herself. "My ROVI has helped me to use my washing machine and microwave by adding bump-ons. This has meant that I no longer feel stuck and that I rely on everybody".

Blaenau Gwent

X from Blaenau Gwent attended the emergency Eye department X has recently lost her sight, (registered as Severely Sight Impaired) due to a rare condition called Leber's hereditary optic neuropathy which causes acute and sudden onset of sight loss. X has been receiving support from the Community Psychiatric Nursing Team who had requested CRT support for X in order for her to be able to adjust to her sight loss and received support to remain as independent as possible.

Contacting X immediately I soon realised how difficult life for this young mum had now become. Since the loss of her sight X has been experiencing difficulties both physically and mentally. She is managing to care for her small children as a recently single parent with the added tasks of managing around the home and slowly coming to terms with the realisation she cannot see clearly.

ROVI support was needed urgently! This came in the form of an Assistant ROVI in Blaenau Gwent who was the only support able to make home visits during the pandemic. A fantastic service was provided by the Assistant ROVI at this time.

The next day Callum (Assistive Technology Officer) from Sight Cymru made a home visit to X. Whilst with X, we enabled 'voice assistant' on both her mobile phone and tablet. X heard very well with this and was able to grasp the concept of the different tapping and swiping gestures. I have advised X that we will be looking to book her in for another visit in due course and have since communicated with the ROVI Assistant from Blaenau Gwent social services. During the chat we have discussed different options going forward I will be looking to work together to come to a resolution at help support X going forward. Speaking daily with X and ROVI Assistant we identified the most urgent needs of this young mum as Housing.

Re-Housing: she is now looking forward to moving into her new home and we are working together with Linc Cymru (Housing Association) to provide adaptations which will enable X to live as independently as possible. However, to enable X to achieve this the ROVI Assistant is planning adaptations to the new property and hope that we can create a safer environment for her and the children.

We considered all aspects of Daily Living i.e. Kitchen Assessment- Liquid Level Indicator, Coloured Food Boards, Boil Alerts etc., Lighting and Colour Contrasting. Blaenau Gwent have also funded an Oven Appliance for X which will be high level housing to create a safer kitchen environment.

X is a very determined young lady, although at present struggling to accept she needs certain aids to enable her

to achieve independent living. She is slowly adjusting to her situation and is receiving support from numerous agencies and organisations.

I have liaised with numerous Charities including: Children's Services, Children In Need, R.N.I.B. and Florence Nightingale Trust.

X is also being supported by the Sight Loss Advisor to apply for a grant from the RNIB in relation to purchasing some equipment specifically designed for people with a visual impairment i.e. a talking microwave, talking scales etc.

X finds it extremely difficult to use the environment and space around her confidently due to her sight loss and with this in mind ROVI Assistant is planning a more accessible kitchen that will enable X to maximise her independence and build confidence knowing she can carry out kitchen tasks safely and with her children to do the fun things that she recently thought impossible.

Assistant ROVI support/funding X can begin to look forward and achieve her goals to live as independent as possible.

Whilst working with X I also identified the difficulties she experienced with Communication/Technology. I again liaised with other agencies for funding and Blaenau Gwent supported me to purchase a one off payment for WiFi and also a iPad and iPhone.

X and I also liaised with Callum Briars at Sight Cymru who is supporting X to set up the new equipment.

Assistant ROVI Manager also liaised with other Councils to request ROVI Support and X has been in contact with Tamara Bartlett from Caerphilly who has met her and

carried out some outdoor mobility training. Tamara is also available once a week for other ROVI support if needed.

X has had a bus pass and Blue Badge. We also referred X for a Direct Payment and she is now employing 2 PA's 10 hours a week to support both X and her children with Social Activities/Daily Living Skills

Torfaen

Mr A is thirty-five years old and moved into a new area with his family a year ago. He has hereditary retinal dystrophy, rod and cone dystrophy and macular degeneration, and is registered as Severely Sight Impaired. Mr A said that his sight has been deteriorating very quickly and he has lost confidence in the home and going out. He admitted that he is being treated for depression and was struggling from day to day.

Mr A has been having difficulty in the home bumping into doorframes and furniture. I provided pre-cane skills training to reduce the risk of injury in the home.

Mr A relies heavily on his Guide Dog but realises that there could be a gap when his dog is ill or retires. We talked about routes that he would like to travel regularly. We agreed mobility training with a 130cm long cane. We trialled two cane tips and Mr A preferred the large roller ball because of the uneven pavement. Mr A struggles in bright sunlight, trialled a variety of UV shields and referred to the Low Vision Service. I also advised to use a peaked cap to shade his eyes. We worked around the local area building confidence in using the cane and orientation. After training Mr A became a confident traveller with Guide Dog and cane.

To improve safety in the garden, he was referred to Care and Repair and a number of changes were made to his home environment.

Mr A likes to help in the kitchen but has lost confidence with chopping and preparing food. A session on kitchen safety demonstrating kitchen equipment contributed to Mr A preparing food for the family, as he did in the past.

We looked at communication and Mr A had an iPhone. I demonstrated the accessibility settings on the iPhone and the app Seeing AI, that enables him to read cooking instructions. Mr A sometimes struggles with his Sky box. I provided the number for Sky Accessibility to register and receive instructions on how to use audio description. I referred him to Sight Cymru for support with access software for computers.

Mr A said that he was feeling far more confident after the training and he felt that he was ready to go back into the workplace. I referred him to Sight Cymru for a volunteer position to help build confidence and skills.

Monmouthshire

Mr B is 47 recently registered as Severely Sight Impaired Retinal Atrophy and Retinal detachment. He started having sight loss issues three years ago and had to finish work as HGV driver due to his sight loss. He lives alone in a first floor flat.

A referral was made to local authority social services requesting assessment of Rehab Officer for vision impairment to the recent deterioration in his sight he no longer able to cook or make hot drinks because he is frightened of burning or scalding himself.

The Rehab Officer (ROVI) telephoned Mr B whereby she identified that case was Critical and Home Assessment visit was arranged.

When the assessment was undertaken the Rehab officer observed that Mr B had issues with his mobility because he was clinging onto his furniture to move around his flat whereby he had previously said he was managing. Following further discussion around mobility issues he was reduced to tears and admitted he no longer felt safe within his own home in particular when using the stairs and in his bathroom.

It was agreed that referrals would be made to Care and Repair to install an additional handrail for the stairs to provide additional support he needed to use safely and independently. Referral for a brighter light fitting to replace the existing lighting, which was insufficient to his visual needs. A referral for bright coloured grab rail to be fitted on side of shower to provide support needed for him to use safely and independently.

Demonstrated some orientation and mobility techniques using trailing technique for safe and independent mobility within his flat. Demonstrated mobility canes and agreed upon mobility training.

Demonstrated and issued a liquid level indicator to support safety and independence when making hot drinks which made immediate boost to his confidence. In addition, provided details of a hot water dispenser. Referral made to Care and Repair for additional lighting for his kitchen area which included strip lighting and under cupboard lighting to light up worktop areas to provide brighter more efficient lighting for him to see better to prepare meals and drinks.

Marked up settings on his microwave and oven dials with bright coloured tactile markers (bump-ons) so that he could easily locate to cook confidently again. Another referral was made to Care and Repair for additional lighting in the kitchen included strip lighting and under cupboard lighting to light up worktop areas to provide brighter lighting levels for Mr B to be able to see better to prepare meals and drinks.

Demonstrated and trialled low vision aids magnifiers and task lamps and referral made to local optician for Low Vision Assessment with recommended aids that had benefited his reading vision.

Following the programme of ROVI intervention of Mr B who has since completed mobility cane training is able to travel outdoors safely and independently. And following completed work by Care and Repair as referred by the ROVI he stated that he now feels confident and safe and independent living in his flat.

Miss W is a young lady, is visually impaired and has learning disabilities. ROVI has worked with her on and off for over 12 years.

Miss W's family were moving abroad but Miss W did not want to move and therefore she was supported to move into sheltered housing and lived in a house with three other residents and had 24 hr. care, every day.

Over the years the ROVI has provided various support for Miss W, including, daily living, mobility, communication and advocacy but over the last couple of years, she kept saying she wanted to live in her own home and became more independent.

Therefore, I supported an application for Miss W to have a bungalow through the County Council. This was granted, and I was asked to provide guidance and advise on what was needed within the bungalow: new wet-room, kitchen, colour contrast, etc., which was accepted and undertaken.

Miss W was given the keys and moved in on the weekend and I agreed with Miss W and (Monmouth Housing), for her to move/settle in, and I would then visit to see if any further work/support was required to support her safety and independence.

Received phone call from Miss W's housing support worker (HSW) requesting advice and support for grants with regard to purchasing appropriate equipment for Miss W 's kitchen, to undertake daily living needs/tasks, whereby I advised either have similar equipment to what Miss W currently uses within the sheltered home or what Miss W would prefer herself -induction hob, washing machine; etc. and either way I would be able to provide advice, support and training if required.

The MHW also informed me that Miss W had settled in while and she is able to get to her old home by herself but, she was struggling to learn the distance to get back to her new home. HSW inquired about something being put to help identify the strip on the end of her path. She also informed me that Miss W had put on 5lb in weight in the last week and she was concerned about this and therefore Miss W would like to walk more often but feels that she has lost her confidence in going out and wants to build this up again.

I informed HSW that I would have to look at Miss W's kitchen and current equipment, support her to access her home safely and independently and look at the area and see what I think could assist with the identification of the

path way to her home these could support all Miss W's safety, independence and choice.

Newport

“When I was first registered, I had support and advice provided to me from the local authority and third sector, but my sight loss was such that I didn't need rehabilitation intervention. However, as my sight deteriorated, I became reliant on my husband and looking back this is when I could have benefited most from support from a Rehabilitation Officer for the Visually Impaired (ROVI). I was put on a waiting list but had to wait a very long time.

Whilst waiting, my husband died and I lost my support. I went two years before I had ROVI intervention. I lost self-confidence during this time and lost connection with the outside world, I felt that my independence had been lost. I became anxious and my mental health suffered. I needed drive and encouragement. I got this from the ROVI when they visited but it was two years too late. Looking back, early intervention - even knowing what support and services were available to me (a local club for example) - would have made a big difference to my wellbeing. I live in a remote area and felt cut off. Access to a ROVI has made a huge difference to my life now, I just wish I had received support at a time when I needed it the most”.

Appendix 6: Sample job description for Assistant ROVI

KEY OBJECTIVES

- To provide a variety of services to people with sensory impairment in their own homes which promote safety and independence
- To support the work of the specialist workers in the Sensory Services Team

SPECIFIC RESPONSIBILITY

1. To undertake specialist assessments of people with hearing impairment in the community and in care settings
2. To deliver and install environmental equipment to hard of hearing people in their own homes
3. Ensure the equipment is in working order prior to installation
4. Ensure service users are able to use the equipment safely and independently
5. Respond to queries in relation to faulty equipment
6. Arrange for equipment to be repaired or provide replacement equipment to ensure needs are met
7. To support other members of staff with equipment installation and trouble shoot unsuccessful installations
8. To undertake specialist assessment of people with visual impairments in appropriate cases
9. To work closely with Rehabilitation Officers (Visual Impairment) to support rehabilitation programmes in the community
10. To participate in the delivery of rehabilitation programmes in appropriate cases, reinforcing skills taught by the Rehabilitation Officers

11. To undertake the registration of severely sight impaired (blind) and sight impaired (partially sighted) people in appropriate cases
12. To identify needs which must be referred on to Rehabilitation Officers
13. To manage the administration, delivery and installation of the British Wireless for the Blind Fund equipment and RNIB Talking Book service
14. To deliver, install and demonstrate relevant equipment to visually impaired people and ensure they can use it safely and independently
15. To liaise and negotiate with a range of staff at Vision Products to ensure deliveries and installations run smoothly
16. To manage the satellite store of equipment at the team base
17. To identify other areas of concern and refer to other teams and agencies
18. To work in partnership with other relevant agencies
19. Providing support to groups of people with sensory impairment in the community
20. To ensure that written and computerized records are maintained within the policies and procedures of the Division
21. To carry out Health and Safety responsibilities in accordance with the Division's Health and Safety Responsibilities document
22. To undertake such other duties and responsibilities commensurate with the grade as may be reasonably required by the Service Director

Appendix 7: Risk assessment tool

Vision Rehabilitation Worker – Assessment of Professional Risk

This is an extract from the RWPN Assessment of Professional Risk matrix. An example domain is included for illustration purposes and has been de-tabulated.

The full document is available via www.rwpn.org.uk

Risk matrix:

Risk Matrix		I M P A C T				
		1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
↑ L I K E L I H O O D ↓	5 Almost Certain	5	10	15	20	25
	4 Likely	4	8	12	16	20
	3 Possible	3	6	9	12	15
	2 Unlikely	2	4	6	8	10
	1 Rare	1	2	3	4	5

Score	Likelihood (A)	Definition	Impact (B)	Descriptor
5	Is highly likely to occur at some time in normal circumstances.	Very High >80%	Critical long term damage or harm to service users/public Critical reputation impact Intervention by other agencies Huge financial impact	Catastrophic All potential benefits lost
4	Likely to occur at some time in normal circumstances.	High 0-80%	Major damage or harm to service users/public High reputation impact – national press and TV coverage Minor regulatory enforcement Major financial impact	Critical Loss of 80-100% of benefits
3	Likely to occur in some circumstances or at some time.	Medium 40-60%	Noticeable damage or harm to service users/public Extensive reputation impact due to press coverage External criticism likely High financial impact	Significant Loss of 50-80% of benefits
2	Is unlikely to occur in normal circumstances, but could occur at some time.	Low 20-40%	Minor damage or harm to service users/public Minor reputation impact Moderate financial loss	Marginal Loss of 25-50% of benefits
1	May only occur in exceptional circumstances, highly unlikely.	Very low <20%	Insignificant damage or harm to service users/public Little or no loss of front line service No reputation impact	Negligible Loss of <25% of benefits

The risks are grouped into seven domains as follows:

Domain1: Specialist Visual Impairment Assessment.

Domain 2: Low Vision Therapy.

Domain 3: Orientation and Mobility (O&M) Vision Rehabilitation Workers assess for, and teach, a wide range of strategies to equip blind and partially sighted people to move around the build environment. The build environment contains a number of variable environmental factors.

Domain 4: Activities of Daily living (ADL). Vision Rehabilitation Workers assess and teach strategies to address ADL outcomes. Blindness and low vision create a number of hazards, both from task itself and the failure to identify and address problems arising from an accident with the task.

Domain 5: Communication. Blind and partially sighted people, and especially people with additional disabilities such as hearing loss, processing disorders or memory problems, may face communication difficulties that are often overlooked. Difficulties may exist with both receptive and expressive communication.

Domain 6: Risks in behavioral and procedural practice.

Example domain:

Domain 1 Specialist Visual Impairment Assessment

HEADLINE RISK.

Inadequate specialist vision rehabilitation assessment.
Failure to prioritise assessment appropriately.

DESCRIPTION.

Unidentified, poorly quantified or poorly prioritized level of need will have significant effect on overall assessment outcomes and may not identify or accurately grade potential risk factors. Such risks might include, for example: failure to identify co-morbidities such as dementia, hearing loss or learning disability and their impact on function and risk; failure to identify the risk of depression and low mood resulting from sight loss; failure to identify key disability-benefits to service user; failure to identify risk of abuse or neglect exacerbated, or masked by sight loss

INHERENT RISK FACTOR.

12

Likelihood 4

Impact 3

IDENTIFY EXISTING CONTROLS & EFFECTIVENESS OF MITIGATION.

Existing controls:

Underpinning knowledge required to qualify, based on National Occupational Standards

<https://socialcare.wales/nos-areas/sensory-services>

adherence to Code of Ethics and Professional Practice; timely professional supervision from appropriate professional; regular update of knowledge through mandatory CPD; reflective accounts through practice;

observation/peer review.

Effectiveness of mitigation:

Reduced risk of: poor decision making; poor identification of need; inappropriate training outcomes; harm to service user, failure to identify financial support. Increased ability to: understand complex case situations where co-morbidities or safeguarding factors are present; work with service users to identify outcomes; transfer learning to a wider range of case situations; manage caseload and document risks and safeguards accurately

IS RISK DECREASING, INCREASING OR STATIC?

Decreasing

RESIDUAL RISK FACTOR.

6

L 2

I 3

RISK OWNER.

Employer/VRW

HEADLINE RISK.

Non-provision/delayed/ inappropriate rehabilitation plan in place.

DESCRIPTION.

Poor assessment outcomes may result in inappropriate, inadequate or dangerous rehabilitation intervention. The intervention may be poorly planned, executed, evaluated and documented in a manner that increases risk of harm to service user and professional. Delayed or non-provision of rehabilitation increases the risk of harm to the service user or render rehabilitation ineffective.

INHERENT RISK FACTOR.

16

Likelihood 4

Impact 4

IDENTIFY EXISTING CONTROLS & EFFECTIVENESS OF MITIGATION.

Existing controls:

Underpinning knowledge required to qualify, based on National Occupational Standards; adherence to Code of Ethics and Professional Practice; timely professional supervision from appropriate professional; regular update of knowledge through mandatory CPD; reflective accounts through practice; observation/peer review

Effectiveness of mitigation:

Increased ability to: evaluate complex case situations through discussion with supervisors, peers and service users; plan and execute safe rehabilitation intervention; transfer learning to a wider range of case situations; support services users to critically reflect on their own capacity to develop further independence skills.

IS RISK DECREASING, INCREASING OR STATIC?

Decreasing

RESIDUAL RISK FACTOR.

8

L 2

I 3

RISK OWNER.

Employer/VRW

