obstacles to obtaining a Certificate of vision impairment. is the process fit for purpose?

Simon Mahoney – February 2023

[totally

blind author and

blind veteran]

Executive Summary.

1. People with significant levels of sight loss can be certified by their consultant ophthalmologist as either Sight or Severely Sight impaired. With the patient's consent, the certificate is shared with others (Social Services, GP and centralised data monitoring – CVI Office at Moorfields) to provide additional support and health care for the individual plus national data on the prevalence of such sight loss. The patient can also opt for registration with their local Social Services which acts as a passport to significant further financial and practical assistance.

However, it is unclear whether this Certification, Sharing and Registration pathway refreshed by the Department of Health in 2017 is working effectively.

> *ESLO [employee of sight loss organisation] 12 – don't talk to me about CVIs. They are a nightmare to get.*

2. Various data suggests that:

Despite increase in eye clinic appointments (and an aging population), Certification has remained fairly static over several years;

- That some 50% of those eligible have not been certified;
- That some 50% of those certified are not registered.

3. The consequences of possible failures of the pathway and such extreme under-estimation of sight loss impacts on:

- Potentially around one million individual patients and the risk to their future lives without the various help and benefits available;
- Decisions on the performance, funding and provision within the eye health sector, other public bodies and agencies, the voluntary and charitable sectors, employers and service providers.

4. This informal study adds further perspective on the situation, its likely shortfalls and makes the following proposals:

- Eye clinics/hospitals should:
    - Ensure that all staff (from consultants to receptionists) understand sight loss and the significance of CVIs beyond medical considerations;
    - have a mandatory duty to explain the Certification, Sharing and Registration pathway plus the full range of potential benefits to all patients potentially eligible for Certification. Such explanations must take account of the individual patient's accessibility needs and personal/emotional circumstances.
    - ensure that, Subject to patient agreement, consultant Ophthalmologists have a mandatory duty to certify all patients with the required levels of visual acuity and field of vision unless such sight impairment is likely to recover.
    - monitor Certification data and make adequate financial provision for the process;
    - Monitor the effectiveness and timeliness of the Certification and Sharing stages to ensure robust data assists those allocating resources both locally and nationally.
- A single Government agency (perhaps the Disability Office in the Cabinet Office) should assume responsibility for collating, maintaining and communicating accessible details of all benefits accruing from the Registration, Sharing and Certification pathway for use by the eye clinics/hospitals, The Royal College of Ophthalmologists (RCOphth), other public agencies including Local Authorities, the VCS [Voluntary and Charitable Sector] and the patients themselves.

5. **Conclusion.** The various benefits, adjustments, structures, means and enablers flowing from an effective pathway can reduce/delay reliance of people with sight loss on the "State" (other public services, health, social/unpaid care, social security benefits, employment support and more). In contrast, the inadequate prioritisation, narrow "silo-thinking and flawed data all evident in pathway failures risk increased demand on the public purse , wider public health failures and loss of independence/increased social disadvantage.

Introduction

6. The experience of losing all or part of one's site is often a combination of various health treatments, numerous medical interventions plus highly personal, emotional, stressful and unique life-changes. One example study (Portia et al 1999 [1] considered sight loss and emotions up to and including suicide. Fortunately, there are health and social structures aimed at reducing such extreme consequences for these vulnerable individuals through informed patient consent and involvement, timely and reassuring empathetic advice and information plus access to support, various benefits and protection.

7. For these structures to work effectively, the main pathway to help should start with the Certificate of Visual Impairment [CVI] (replaced the BD8 in England in 2005) issued by consultant ophthalmologist. Subsequently, Sharing of information and Registration should create the bridge between the eye clinic and support provided by the public sector (Social Services and more) plus the voluntary and charitable sector (VCS).

8. However, despite various recent guidance, there is anecdotal and other evidence that eye clinic/hospital staff may have limited understanding of the value of the pathway: its potential benefit for people with significant sight loss and the implications for provision and funding of services within the health sector and other agencies.

> *VIP [Visual Impaired Person] 9 – I asked my consultant for a CVI and he told me that I was only asking because Universal Credit was not enough.*
>
> *VIP 18 – I am totally blind. I visited the clinic. They still tried to wheel me in for an eye test.*

9. A study by Boyce et al 2019 [2] found numerous short comings in eye care across three hospitals. This included inconsistency between and within the different eye departments, limited understanding amongst ophthalmologists and poor administration. It seemed that the CVI was perceived as the conclusion of sight loss rather than part of the pathway to multi-sector support.

10. The 2021 guidance issued by the RCOphth seems to acknowledge problems and potential causes: limited awareness of the pathway amongst some consultants and the time pressures in busy clinics (likely to be exacerbated by increased appointment demand described below).

11. It is also feasible that clinic staff resist Certification as representing "failure" of their professional interventions. Anecdotal evidence suggests that the cessation of fees for Certification (in some instances) in 2003 might have contributed.

> *VIP 10 – I struggled to get my CVI and now, even though I have glaucoma and AMD, my consultant refuses to give me an appointment.*

12. Lack of patient understanding is also likely to be important. However, a major contributing factor may be the difference between clinic staff focussing simply on various medical conditions rather than perceiving/explaining the entirety of sight loss from the perspective of their patients.

> *VIP 5 – I do not think the eye clinic staff have a clue about sight loss. I once had to say to a receptionist - this is an eye clinic, I am blind, please tell me you are not pointing (when asked for directions to a chair).*
>
> *VIP 3 – when I first went to my SLO [Sight Loss Organisation] I remember vividly recalling that this was the first time I had been in an environment that dealt with sight loss. As I had been going to the eye clinic frequently for two years this was a little strange.*

13. The final Registration stage of the pathway also appears to falter, perhaps again because patients don't understand the significance of that step and the practical and financial help it will bring.

14. From a data perspective, the table at Annex A suggests that, while eye clinic appointments have increased over recent years (perhaps in line with the ageing population), the number of patients certified has remained broadly static. While failings risk undermining the life prospects of individual patients, consequences for public health data, funding and provision are equally profound. Small studies suggest that perhaps 50% of eligible patients are not certified and, perhaps, 50% of those who are certified aren't registered. While speculative, it is possible that current registration data only captures some 25% of those who would be eligible. If such under-estimation is nationally applicable, there are significant risks for the health sector: performance assessment, funding and provision. Similar associated implications would apply to other public and VCS organisations. Finally, the business and employment sectors may be proportionately under-prepared in making adjustments for their employees and customers.

15. This small informal study doesn't attempt to resolve the data questions or provide a definitive cause for any under-Certification or Registration. It does offer a further perspective of commentary on the pathway through anecdotal evidence from a wide range of certified visually impaired (VIPs) and employees of sight loss organisations (ESLOs). The methodology and data is outlined at Annex A and respondents' comments are shown in italics within the paper.

16. The issues for policy and decision makers are:

- whether the current pathway is working effectively for both patients and health professionals;
- Whether there is adequate robust data to reach such a conclusion;
- Whether further action is needed to increase effectiveness.

What should be happening.

17. In 2017, the Department of Health replaced the 10-year-old Certificate of Visual Impairment (CVI) with a new version accompanied by Explanatory Notes covering the three main steps of the process (¶ numbers refer to these Notes). Significantly, the Notes emphasize the importance of Certification for the patient's independence and well-being plus formal referral to Social Services for a needs assessment: "Certification should therefore not be seen as the end of the treatment pathway for patients but as a gateway to support and services" (¶ 2).
In 2021, the RCOphth issued their own guidance on Certification for ophthalmic services https://www.rcophth.ac.uk/wp-content/uploads/2021/12/Low-Vision-Guide.pdf (Chapter 4). Further information is also available from the NHS website and the RNIB.

Certification.

"The CVI formally certifies someone as sight impaired (previously referred to as partially sighted) or as severely sight impaired (previously referred to as blind) " (¶ 1). The Notes include information on completion of the CVI plus the nature and standards of the visual acuity and field of vision tests (¶12 to 19, 29 to 37)and the process for de-certification (¶ 42).

18. Process. While consultant ophthalmologists assess visual acuity and field of vision, the professional skills of specialist occupational therapists and/or rehabilitation officers might be better placed in assessing functionality. the notes of 2017 state that Ophthalmologists have a responsibility to assess the ability to carry out routine tasks and live their daily lives. It is hard to credit their competence in this activity without training. When asked about the criteria for assessing such functionality, the RCOphth was not able to respond. A retired ophthalmologist commented that, as far as he was aware, the cvi is awarded on medical evidence alone.

> *VIP 4 – I was told by my consultant that if it was down to her she would give me a certificate but she did not have that discretion.*
>
> *VIP 6 – after a furious row the consultant gave me a CVI, He did not explain anything about it though.*
>
> *VIP 7 – I keep falling over and bumping into things. I am a danger to myself and others. They refuse to give me a CVI*
>
> VIP 12 –I went into the clinic for a cataract op. they messed up the left eye. They promised to take extra care with the right. They let a student loose on me. Both eyes are now messed up. They could not give me a CVI quick enough.
>
> *VIP 15 – I started going to a sight support group. I realized that many people could see better than me and they had a CVI. I asked my consultant and he was not interested, I changed my consultant and was given one immediately.*
>
> *VIP 16 – I was given my CVI and it was for SSI Blind. Why was I not certificated as partially sighted long before?*

19. Explaining. Specific responsibilities were placed on hospital staff to explain the importance of certification to patients (¶ 4) and, taking account of the likely needs of these patients, the Notes highlighted the obligations and legal duties to comply with the NHS Accessible Information Standard and Equality Act 2010 (¶9). "The patient should be actively involved".

> *VIP 1 - I was registered partially sighted in 1988. . .The benefits of registration were not explained to me as far as I remember. Rather I have discovered these as I have gone along.*
>
> *VIP 2 – I was registered in 2020 and nothing was explained. I had to find out for myself.*
>
> *VIP 11 – I asked for my CVI after I was told about it by the lady in the ticket office at the train station.*

"An Eye Clinic Liaison Officer (ECLO) might also complete parts of the form" (¶ 15) emphasizes the potential importance of the ECLOs but suggests reliance on their full-time availability in all relevant clinics.

> *ESLO 18 - an ECLO was recently appointed to the local hospital and the number of CVIs have increased significantly.*
>
> *ESLO 9 – it used to be a nightmare. Since the appointment of ECLOs things have improved out of all recognition.*

Individual's state of mind is also recognized as a factor in their understanding: "an emotional and upsetting time for the patient " (¶ 16). Information to be made available to patients is specified (¶ 23). Clinics invariably rely on pamphlets rahter than proactive communication by the staff.

VIP sixteen – I asked my consultant why I was not warned about Charles Bonnet Syndrome [hallucinations]. He replied there were pamphlets. After a long silence he commented that perhaps that was not appropriate.

However, the RCOphth guidance suggests that some patients are not being offered the Certification for which they are eligible , that trainee ophthalmologists have an important role in prompting their consultants (Extract at Annex B) and that ineligible patients can be referred to their local Social Services for help and support (even without Certification).

> *ESLO 11 – two consultants are as good as gold, as for the rest, you might as well as whistle as ask for a CVI.*
>
> *ESLO 6 – I have lost count of the people who are clearly visually impaired whom we have encouraged to demand a CVI*
>
> *ESLO 7 – oh we spend much of our time coaching our members on what to say to get a CVI*

One recent study (Rahman et al 2020)[7] suggested that increasing appointment numbers reduced opportunity to explain Certification to patients and that some consultants were insufficiently aware of the benefits of the pathway .

> *ESLO 13 my sister is clearly severely sight impaired. I persuaded her to ask for a CVI. She saw a nurse who agreed she needed a CVI. She has to wait 6 months to see an ophthalmologist. That is yet another delay before she gets any help. Providing the ophthalmologist is there when she goes.*

The RNIB website reminds readers that they can also seek a second opinion.

There is anecdotal information that sight loss can be associated with other health conditions so requiring cross-referrals between health professionals and that sight loss may also be obscured by some health conditions (e.g. dementia).

20. **Data.** Hospitals are encouraged to retain data concerning certification for local audit (¶ 26) and that CVI's should be retained until the patient moves to another area or is deceased (¶ 27). It is assumed that the "Tell Us Once" scheme is sufficient to advise hospitals when a patient has died. However, it is unclear as to whether there is reliable data as to the total numbers of living people who are certified or, although eligible and suitably informed, have declined Certification.

One report, Bartlett et al 2021 [5] estimated that only 49% of those eligible for a CVI were certified. If such estimation applied more widely, it would suggest that "official" Certification figures need doubling to be accurate. This perception of under-certification is potentially reflected by The table at Annex A which shows that whilst the number of eye clinic appointments has risen by some 25% over recent years, the number/proportion of CVIs issued since 2011 has remained broadly static? (Unfortunately, the Moorfields Certification Office was unable to provide data before 2011).

One possible explanation of reduction in Certification may be, According to another recent study(Rahman et al 2020)[7], that such was due to improved treatment of eye conditions, particularly diabetic retinopathy and AMD (despite apparent long-standing lack of equipment and software standardisation within the retinopathy screening programme).

Although there has been an increase in eye clinic appointments, it is not known whether some groups (e.g. those from ethnic minorities, from deprived areas/households) are proportionally represented and hence in the Certification data.

> *VIP 14 – I had no idea that people could be treated so badly in this day and age.*

21. **Costs.** The Notes address fees (¶ 38- 41) but it appears that local contractual arrangements will determine whether CVI completion is part of consultants' normal work duties or are additional to such and so attract an extra fee (as was apparently the case pre-2003).

> *ESLO 3 – when I was working in the registry we always knew which consultants were going on holiday as their CVIs would come in for registration in one big batch.*
>
> *ESLO 4 – it was common knowledge that consultants would save their CVIs up and cash them in for holiday money.*
>
> *ESLO 2 – it is a no brainer that the number of CVIs would drop once the consultants stopped being paid for them.*

22. **Issues.** The RCOphth guidance reflects the anecdotal evidence that not all eligible patients are being offered Certification. Causes may include:

- Inconsistency of consultant understanding, time and funding;
- explanations that are not forthcoming, unempathetic and/or inaccessible.

Any resultant unreliability of Certification records may undermine hospital/clinic performance and other data thus impacting on financial provision.

23. **Proposals.** It would seem appropriate that eye clinics/hospitals should:

- Ensure that all staff (from consultants to receptionists) understand sight loss and the significance of CVIs beyond medical considerations;
- have a mandatory duty to explain the Certification, Sharing and Registration pathway plus the full range of potential benefits to all patients potentially eligible for Certification. Such explanations must take account of the individual patient's accessibility needs and personal/emotional circumstances.
- ensure that, Subject to patient agreement, consultant Ophthalmologists have a mandatory duty to certify all patients with the required levels of visual acuity and field of vision unless such sight impairment is likely to recover.
- monitor Certification data and make adequate financial provision for the process. this should include the creation of a central data base.

24. **Other.** The Notes also cover specific groups:

- children and young people (¶ 7 and 8).
- Blind veterans - Referrals to BVUK encouraged under the Armed Forces Covenant (¶ 17).

Sharing.

25. **Process.** With the patient's permission, information about their Certification is shared with "their local authority, their GP and the RCOphth Certifications Office at Moorfields Eye Hospital" (¶ 4) in a "timely manner" (¶ 5) ("within 5 working days") ¶ 22.

> *ESLO 5 – sometimes the consultants could be very slipshod with the CVIs. One CVI arrived at the office to be registered four years after it was issued*

26. **Explaining.** Again, the Notes place responsibility on hospital staff to explain the benefits of sharing the information and obtaining their permission. The obligations regarding accessible information apply.

> *VIP 8 – I have a CVI but no idea what to do with it.*

> *VIP 17 – I was given my CVI. I have no idea where the other parts went, I was never asked to give my consent for their distribution to other people.*

27. **Benefits.** Those Sharing benefits include potential better health care (GP), the registration process below (Local Authorities) and improving national data (Moorfields).

28. **Data.** The records held at Moorfields are "used for epidemiological analysis and reported via an NHS England Public Health Indicator" (¶ 6). It is understood that Moorfields collates the number of CVIs issued per year. The Royal College of Ophthalmologists (RCOphth) guidance emphasizes the significance of the shared data: "The authorities that fund services for people with sight impairment use the epidemiological information gathered during the registration process to help determine the need for services. The World Health Organisation Global Action Plan stresses the importance of collecting this data in each country for use in priority setting and resource allocation2. Therefore, certification and registration of those who are eligible is important to ensure adequate provision of relevant health and social services."

There appears to be no data as to the number of patients not consenting to the sharing of their Certification.

there is no data on the number of people who decline a CVI.

In the absence of a central data base there is no way of determining the total of people still living with a CVI.

29. **Issues.** Inaccurate/incomplete data may result in:

- poorer health, work and life outcomes for visually impaired people;
- Under-estimation of levels of severe visual impairment nationally;
- Inaccurate clinic/hospital performance data.
- Incorrect assessment of various health initiatives and interventions.
- inadequate funding/provision for visual impairment across the health sector and other public, private and voluntary sectors.

30. **Proposals.** Eye clinics/hospitals should:

- Monitor the effectiveness and timeliness of the Certification and Sharing stages to ensure robust data for those allocating resources both locally and nationally.
- Establish a central data base which will facilitate the provision of up to date information once the certification and registration pathways are working as they should.

registration.

31. **Process.** While Certification and initial sharing rest with the hospital staff, responsibility for the third stage of the pathway moves to others: "With the permission of the patient the CVI is shared so that their local authority or an organisation working on their behalf, is able to make contact (¶ 1("within 2 weeks ¶ 22)".

The NHS website clarifies the process for patients: "upon receiving the certificate, your local social services team will contact you to ask whether you want to be added to its register of visually impaired people. If you say "yes" then you become registered."

32. **Explaining.** Responsibility passes to the Local Authority or other organisation "to offer and explain the benefits of registration on a local sight register and to ensure support and services are accessible as appropriate" (¶ 1). The Equality Act 2010 requirements regarding accessible information will also apply.

33. **Benefits.** The Notes continue: "Registration is voluntary, and whilst it is **essential** to obtain some benefits and concessions, it is not a prerequisite for accessing support from social services" (¶ 3; author's **Bold**). The Notes also state "If the person consents to registration they will be included on the local authority's register and be provided with a registration card. With the person's permission the registers can also be used by the local authority to ensure information about services is made accessible to that person, such as whether they would benefit from receiving accessible voting materials for elections. Where there is an appearance of need for care and support, local authorities must arrange an assessment of those needs in a timely manner" (¶ 11).

The RCOphth guidance further emphasizes the value of Registration: "While registration is a voluntary process and people can decline to be registered, it is in their best interest to accept registration, to facilitate access to the services available. However, if consent has not been given, the person should still be offered a needs assessment."

The NHS website adds: "After you're registered, social services will contact you again to arrange for an assessment to be carried out. The aim is to assess your needs and find out what help you require to remain independent, such as help with cleaning and cooking, or help with mobility and transport. "Registering as visually impaired isn't compulsory, but it can help you to get a range of benefits, including:

- benefits to help with any costs relating to your disability or illness
- Assistance in continuing in employment
- Access to assistance through the return to work legislation
- a reduction in the TV Licence fee
- help with NHS costs
- help with Council Tax and tax allowances
- reduced fees on public transport"
- help with telephone line rental and costs

The RCOphth helpfully differentiates between the benefits available for different levels of Certification and Registration: "People registered as either SI or SSI may be entitled to:

- Free NHS sight tests
- Railcards and other rail or travel concessions
- Local travel schemes
- Free directory enquiry services from BT
- Protection under the Equality Act
- Free postage on items marked 'articles for the blind'
- Free assessment by social service (However, if consent has not been given, the person should still be offered a needs assessment)

In addition if someone is registered as SSI they may be entitled to:

- Free loan of radios, cassette players and TV sound receivers
- Help with telephone installation charges and line rental
- Personal Independence Payment (PIP)
- Attendance Allowance
- Carer's Allowance
- Employment and Support Allowance
- Tax credits
- Housing Benefit
- Council Tax disability reduction
- Universal Credit *

- Pension Credit
- Free ticket for a guide at theatres, galleries and tourist attractions."

> *VIP 13 – I had a BD8 in 1984. They will not update it to a CVI. DWP refuse to accept it as evidence of a current medical condition and refuse to give me Pips.*

It should be noted that other benefits include specific legal status as a disabled person (Equality Act 2010 (Disability) Regulations 2010, SI 2010, no.2128, section 7) and, for those eligible, Blind Person's (tax) Allowance. The RCOphth guidance notes that benefits vary with time and refers readers to the RNIB benefits and concessions of registration.

Certification also contributes to road safety: "patients certified as sight impaired or severely sight impaired must not drive." (¶ 21).

34. **Data.** "The Care Act 2014 requires local authorities to establish and maintain a register of people who are sight impaired or severely sight impaired." (¶ 10) . Again, the "Tell Us Once" system may help maintain this register.

However, a recent paper [2022] [3] suggests that some 45% of those with a CVI are not registered. a study by Pardon et al 2023 [4] reported similar results including one area where only 24% of patients went on to register.

35. **Issues.** It appears that various public sector organisations rely upon a charity to maintain the current and definitive list of benefits of the Certification, Sharing and Registration pathway. Improved visibility of and understanding of the whole range of benefits might be advantageous at every stage of the process when health sector and other public sector staff recognise the substantial consequences.

Proposal.

- A single Government agency (perhaps the Disability Office in the Cabinet Office) should assume responsibility for collating, maintaining and communicating accessible details of all benefits accruing from the Registration, Sharing and Certification pathway for use by the eye clinics/hospitals, other RCOphth, public agencies including Local authorities, the VCS and the patients themselves.

Annex A.

Project outline, methodology and results.

Project outline

The object of the survey was to see if the perception that current CVIs were more difficult to obtain than before 2003 was correct. The date could be important as the NHS contracts changed and many consultants ceased to be paid for completing CVIs. The removal of this incentive may have had some influence on the issuing of certificates.

Methodology

The questions asked were:

- What year did you receive your CVI?
- was your CVI offered or did you have to ask for it?

Respondents were asked for the date of their Certification to assess any significant change since 2003 when consultant ophthalmologists were no longer paid a fee for Certification.

Results/Findings

In all, 164 subjects were involved. They were drawn from a number of sight loss organisations in England. They were from the north west, north east, east midlands, west midlands, hone counties, south west, south, south east and London.

Some of the subjects contacted the project direct, others gave the information to their sight support organization.

Where there was uncertainty as to whether the CVI had been offered it was assumed that it had been, this was because it was considered it to be more likely that a struggle to obtain a CVI to be remembered and also to prevent bias in favour of not being offered.

This produced a body of data which was split into five year groupings. In order to provide consistency of results the number of CVIs offered was expressed as a percentage of the total for that year grouping. Many of the participants, both visually impaired person [VIP] and employees of sight loss organisations [ESLO], made comments many of which have been recorded and offered as anecdotal evidence. The employees ranged from receptionists to Chief Executive Officers of charities.

It also became apparent that there are still areas where consultants are still paid for completing and issuing CVIs. This is recognized in the CVI guidance of 2017 [2].

As far as is known none of these areas were involved in the survey although one area did comment that they knew of nobody who had had to request a CVI.

The outstanding result of the project was the degree to which the sight loss pathway varied in its effectiveness in providing timely support for vision impaired people [VIP]. It became apparent that there are centres of excellence and also areas where the disconnect between eye care and sight loss support was clear and obvious this is examined elsewhere [9].

The data collected was arranged in five-year groupings as follows,

pre-2000, 2000-4, 2005-9, 2010-14, 2015–19 and 2020 onwards.

Table of results

	Pre 2000	2000-4	2005-9	2010-14	2015-19	2020 onwards
Offered	76	57	69	55	49	43

the survey can be considered as only a crude snap shot although there are two clear points of interest.

First those before 2000 were invariably offered their CVI.

Second that a large proportion of people had to ask even after the issue of the CVI guidelines. This would appear to link with the steady proportionate decline in the issue of CVIs and the requirement to issue new guidance in 2021.

The increase of people asking is probably due to the influence of support groups and increasingly ECLOs. There is no evidence that this is due to the quality of the information at the eye clinics. Indeed, many clinics rely on pamphlets. The problem with pamphlets is that you need to know that you need to read them and also that they are available. Additionally, these pamphlets are invariably provided by sight loss charities and not the clinics per se.

Eye clinic appointments/Certification

Whilst the number of eye clinic appointments have risen considerably those of CVIs issued have remained more or less consistent since 2011.

The CVI Office refused to supply data for earlier years. All other information from RNIB. [see table 1]

In addition to the figures for eye clinic appointments there is also the RNIB estimate of the number of people joining the ranks of the visually impaired.

Ten years ago the RNIB thought 2 to 3 people an hour were beginning to lose their sight. This translates into between 18 and 25 thousand people a year.

Prior to 2020 they estimated that 250 people a day were beginning to lose their sight. That [headline banner on RNIB website]translated into 91,000 people a year.

Whilst these figures relate to the UK and not just England this does account for the increase in eye clinic appointments. It also makes the flat lining of the CVI figures something of a mystery.

Eye clinic appointments for England and CVIs

All years run from 1st April to 31st of March, 2nd column is eye clinic appointments for that year.

The 3rd column is the CIVs issued that year, The last column is the percentage of eye appointments that translate into a CVI.

Table 1 – eye clinic appointments and CVIs for England 2011-2020

year	appointments	CVIs	percentage
April 2020 – March 2021	5,442,790	16,499	0.003
April 2019 March 2020	7,910,853	23,285	0.029
April 2018 - March 2019	7,861,990	24,284	0.03
April 2017 – March 2018	7,615,766	22,844	0.029
April 2016 – March 2017	7,583,956	23,453	0.03
April 2015 – March 2016	7,352,038	22,973	0.031
April 2014 – March 2015	7,073,064	23,017	0,032
April 2013 – March 2014	6,807,664	22,911	0.033
April 2012 – March 2013	6,418,652	22,647	0.035
April 2011 – March 2012	6,281,564	22,501	0.035
April 2010 – March 2011	6,142,934		
April 2009 – March 2010	5,945,756		
April 2008 – March 2009	5,529,079	23,773	0.043
April 2007 – March 2008	5,179,045	23,185	0.044
April 2006 – March 2007	5,082,218		
April 2005 – March 2006	5,120,671		

Annex B.

Extract from RCOphth Guidance.

"Despite the importance of the process to individuals and to service provision, significant numbers of patients are not certified as having visual impairment, despite consultation with an ophthalmologist. In fact, it is often the patients attending clinics with a chronic eye condition who are certified late or not at all. This may be related to the difficulty in assessing fluctuations in visual function during successive treatments, or the perception by the ophthalmologist that certification/registration is an end-point which should not be considered while treatment is ongoing3 (Figure 1). The Royal College of Ophthalmologists (RCOphth) curriculum seeks to ensure appropriate knowledge and practical skills of trainees in this regard. Consultant ophthalmologists are the only professionals who may complete a certification form on behalf of a patient with visual impairment. Ophthalmologists in training have a responsibility to alert their consultant to a patient's need for registration. In a busy clinic, it can be all too easy to decide that "it can wait until the next review". With ever-improving treatments for chronic eye conditions, fewer patients may be reaching the criteria for SSI5, but still have significant sight problems requiring support. There is a danger of patients having investigations and beneficial therapies while their low vision needs are still overlooked.

The criteria for registration include both visual acuity and visual field measures. Patients with visual impairment due to visual acuity loss are more likely to be registered than patients with either visual field loss or mixed visual acuity/visual field loss. The ophthalmologist should therefore consider registration in patients with gross peripheral field loss, for example in glaucoma or hemianopia, and not rely simply on the visual acuity criteria.

It is vital that discussions are handled in a sensitive manner; encouraging the person by outlining the advantages but allowing them to make the decision for themselves, as it is a voluntary process.

Information in an appropriate format, e.g. large print, should be given so that the patient can, if necessary, reconsider their decision after further discussion with family or friends. The introduction of Eye Clinic Liaison Officers (ECLOs) in many ophthalmology departments has taken the pressure off eye clinic staff and ECLOs' assistance with the completion of CVI forms is of great benefit to all concerned. However, doctors must still be alert to their patients' certification/registration status."

References

[1] Portia et al 1999 – blindness, fear of sight loss and suicide

[2] Boyse et al 2019 Hospital study

[3] VI charity sector partnership 2022 reflections on the Certificate of Vision Impairment

[4] pardon et al 2023 **Confusion around Certification of Vision Impairment (CVI) and Registration Processes - are patients falling through the cracks?**

[5] Bartlett et al 2021 agreement between ophthalmologists and

optometrists in the certification of vision impairment –Eye volume 35, pages 433–440 (2021)

[6] dementia and disability unit, social care, aging and disability directorate 2017 Certificate of Vision Impairment explanatory notes for consultant ophthalmologist and hospital eye clinic staff

[7] Rahman et al 2020 recent trend in vision impairment certification in England and Wales

[8] Royal College of Ophthalmology 2021 low vision the essential guide for ophthalmologists.

[9] Mahoney 2020 Winging it Blind