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Community Low Vision Service in Scotland

Considerations and Recommendations for Implementation

September 2026

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Contents

Foreword

For many people, the impact of sight loss extends far beyond what can be measured in a clinical assessment. It can affect confidence, independence, mobility, work, relationships and the ability to carry out the everyday tasks that most of us take for granted. The way in which support is offered at that point therefore matters enormously.

Having been involved in the development and provision of low vision services in Lanarkshire, I have seen the value of providing support closer to home and of giving patients the time needed to understand what their sight loss means for them personally. Low vision care is not simply about providing a magnifier or completing an assessment. It is about listening to what someone is finding difficult, identifying what may help them remain independent, and making sure they are connected to the wider support they may need.

Scotland now has an important opportunity to build on that experience and develop a national Community Low Vision Service which is accessible, sustainable and centred around the needs of patients.

Community optometry is well placed to play a significant role in this. Practices are embedded within communities across Scotland and are already familiar and accessible points of care for many patients. However, a successful service will depend on more than location alone. Practitioners must have sufficient time, appropriate training, effective digital referral pathways, access to suitable low vision aids and a funding model which allows the service to be delivered properly.

It is equally important that clinical care does not sit in isolation. People experiencing sight loss may need rehabilitation, mobility support, social care, emotional support, assistive technology and advice from third sector organisations. A national service should help patients move between these elements of support more easily, rather than expecting them to navigate a complex system themselves.

The Community Low Vision Service Short Life Working Group has considered these issues from a range of professional and service perspectives. The recommendations in this paper are intended to support Scottish Government in developing a model which is practical to implement, makes effective use of the existing workforce and, most importantly, provides a better and more consistent experience for people living with sight loss.

There is considerable experience across Scotland on which to build. The opportunity now is to bring that learning together and establish a service which patients can access locally, confidently and at the point when support can make the greatest difference.

Frank Munro
Optometry Scotland
Chair, Community Low Vision Service Short Life Working Group

Executive Summary

The development of a national Community Low Vision Service represents an important opportunity to improve access to low vision support, strengthen patient independence and make more effective use of community and hospital eye care services.

Scottish Government has confirmed that the service will be delivered by community optometrists and dispensing opticians and will include specialist assessment, practical support, low vision aids and signposting to wider services. This direction is consistent with the wider policy aim of shifting care closer to home, making better use of established community capacity and supporting more appropriate use of Hospital Eye Services. [1]

Sight loss in Scotland

193,674

people currently living with sight loss affecting daily life

234,172

projected by 2036

RNIB estimate

Optometry Scotland supports this policy direction and the development of a nationally coordinated service. This paper provides recommendations for the design and implementation decisions required to ensure that the service is accessible, sustainable and deliverable across Scotland.

The need for a national service is clear. RNIB estimates that 193,674 people in Scotland are currently living with sight loss that affects daily life, with this figure projected to increase to 234,172 by 2036.[2] Scotland's ageing population is also likely to increase demand, as many of the leading causes of sight loss are associated with age.[3]

Community optometry provides a strong foundation for delivery. It offers established and geographically distributed infrastructure, existing relationships with patients and a workforce already delivering NHS-funded general and enhanced eye care services. Scottish experience, including the NHS Lanarkshire low vision service, provides practical learning on community delivery and links with rehabilitation and sensory support. Implementation of other enhanced community eye care services, including the Community Glaucoma Service, also offers relevant learning on workforce readiness, NHS Board engagement, patient pathways and operational support. Published evidence from the established Welsh Low Vision Service further demonstrates that community-based assessment, provision of aids, follow-up and onward referral can improve access and deliver sustained patient benefit. [5,7,8]

The emerging Scottish model provides a coherent basis for further development. Its success will depend on translating the national policy commitment into practical arrangements that support provider participation, equitable access and consistent implementation.

The following considerations will be important to successful and sustainable implementation.

The financial model
must reflect the full resource required to deliver a comprehensive low vision service. Initial assessments are expected to take approximately one hour and extend beyond the face-to-face consultation to include functional assessment, low vision aid selection, patient education, documentation, care planning and onward referral.[5,6] Optometry Scotland's indicative practice-cost modelling supports a minimum fee of £150 for an initial or full assessment and £85 for a standard face-to-face follow-up of up to 30 minutes, with the full assessment fee applying where a significant change requires comprehensive reassessment. Separate provision will also be required for registration and ongoing administration, domiciliary, mobile, remote and island delivery, low vision aids, training and digital infrastructure. A sustainable approach will support provider participation, service capacity and equitable access, while reducing the risk that an otherwise well-designed service is not viable in practice.

The workforce model
should make effective use of both optometrists and dispensing opticians within their respective scopes of practice. Training and accreditation should be proportionate, accessible and quality assured, with recognition of relevant prior learning and recent experience. Clear arrangements will also be required for practitioner listing, payment, governance and ongoing professional development.

Service design
should support local access, patient choice and continuity of care. National standards should be applied consistently, while local arrangements retain sufficient flexibility to reflect differences in population need, geography and workforce availability. Phased rollout should be based on clear readiness criteria and should not result in prolonged gaps in access.

Domiciliary care
should form part of the national service, but should not be a mandatory requirement for every accredited provider. Formal referral arrangements should enable patients who cannot attend practice to access providers with the appropriate domiciliary expertise, capacity and infrastructure.

The service
should operate as an integrated pathway rather than a standalone clinical intervention. Patients should receive timely access not only to assessment and low vision aids, but also to rehabilitation, social care and third sector support. The future development of community-based Certification of Visual Impairment should therefore be planned in alignment with the Community Low Vision Service, supported by a clear timeline and defined responsibilities.

Implementation
will require coordinated development of procurement, training, digital infrastructure, payment systems, governance and local pathways. Clear national oversight, accountability and alignment across workstreams, NHS Boards and delivery partners will be required. These elements should be tested with community practitioners and in place before implementation begins in each area. Proportionate data collection and evaluation should be built into rollout so that early learning can inform service refinement and wider implementation.

These considerations inform seven recommendations to Scottish Government:

1. Adopt a sustainable financial model, including minimum fees of £150 for an initial or full assessment and £85 for a standard follow-up, with separate arrangements for administration, domiciliary and remote delivery.

2. Design the service to support local access, patient choice, cross-boundary provision and flexible referral arrangements.

3. Set out a clear national approach and timeline for community-based Certification of Visual Impairment, aligned with the wider low vision pathway.

4. Establish an integrated workforce model that enables both optometrists and dispensing opticians to deliver care within their respective scopes of practice.

5. Coordinate procurement, training, digital infrastructure, funding and rollout so that all required operational components are in place before service delivery begins.

6. Maintain early and ongoing engagement with Optometry Scotland, ABDO, PSD Scotland and relevant stakeholders throughout service development and implementation.

7. Establish the CLVS as an integrated health and social care pathway, with early involvement of rehabilitation, social care and third sector partners and a clearly defined coordination function to support patients across the pathway.

These recommendations are intended to support, rather than delay, implementation. Addressing them during the design phase will help reduce delivery risk, support practitioner participation and improve the likelihood of consistent access across Scotland.

Optometry Scotland is committed to working constructively with Scottish Government, delivery partners and wider stakeholders to translate the policy commitment into a practical and sustainable national service. With appropriate workforce, funding, pathway and implementation arrangements, the Community Low Vision Service can improve access, support patient independence and establish a more coherent and effective low vision pathway across Scotland.

Policy Context and Strategic Opportunity

1.1 Strategic Context

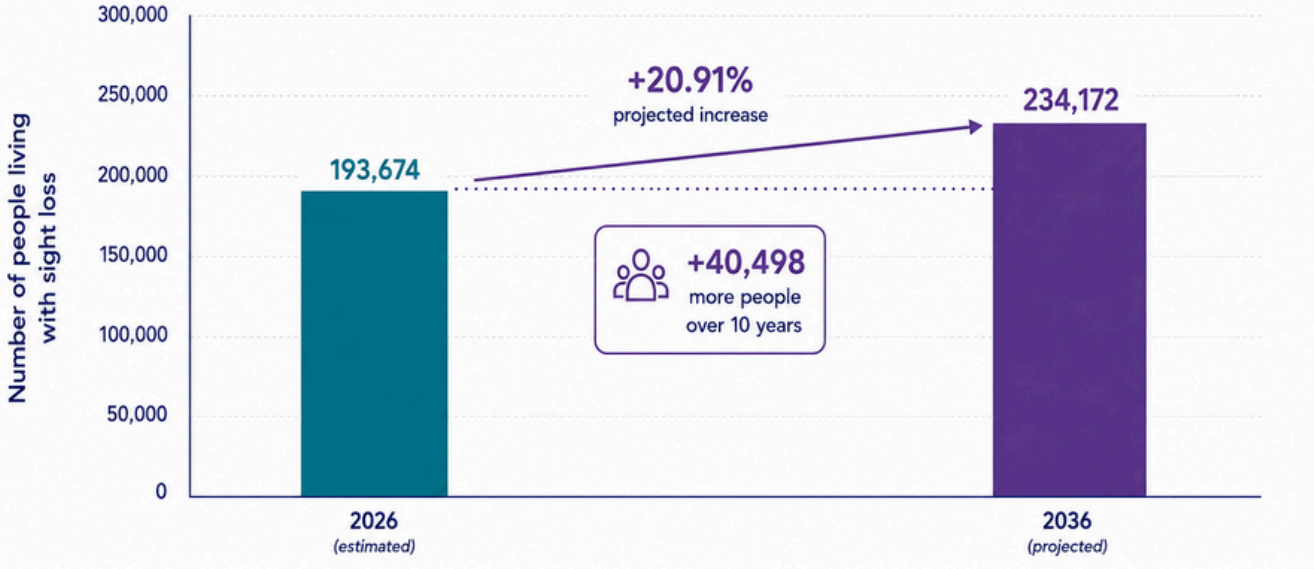
The development of a Community Low Vision Service (CLVS) aligns strongly with the Scottish Government's wider policy direction to shift the balance of care towards primary and community settings, improve access and make more appropriate use of hospital services. In February 2026, the Scottish Government confirmed that development work had begun on a national Community Low Vision Service, with care to be delivered closer to home by community optometrists and dispensing opticians. The service is intended to provide specialist assessment, practical support, low vision aids and signposting to wider services, while reducing reliance on hospital-based care. [1]

Low vision represents an area of significant and growing need. Scotland's population is ageing, with the number of people aged 75 and over projected to increase by approximately 300,700 over the next 25 years to mid-2049.[3] Many of the leading causes of sight loss are strongly associated with age, and this demographic change is therefore likely to increase demand for low vision support.

RNIB estimates that 193,674 people in Scotland are currently living with sight loss that affects daily life. This is projected to increase by 20.91% to 234,172 people by 2036. [2] While these figures represent the wider sight loss population rather than the future CLVS caseload, they demonstrate the scale of need and the importance of planning for sustainable access to support.

Figure 1. Projected increase in people living with sight loss in Scotland, 2026 to 2036

The number of people living with sight loss in Scotland is projected to rise by over 20% in the next 10 years.



This projected increase will place additional demand on low vision services, highlighting the need for sustainable, accessible and well-resourced community low vision provision across Scotland.

Source: RNIB Sight Loss Data Tool: Scotland (2026)
Projections based on 2024 population estimates.

A community-based service offers a practical response by supporting earlier and more local access to care, improving patient experience, reducing avoidable reliance on hospital services and strengthening links with health, social care, rehabilitation and third sector support.

Community optometry provides a strong and established foundation for delivery, with geographically distributed infrastructure, existing patient relationships and a workforce already delivering NHS-funded general and enhanced eye care services across Scotland. This creates a clear opportunity to develop a national low vision service that is locally accessible, scalable and aligned with wider priorities around integration, prevention and sustainability.

1.2 Background and Development to Date

The development of a national low vision service in Scotland has progressed over a number of years, with significant work undertaken before the programme was paused due to funding constraints. This included consideration of service design, training and accreditation, fee modelling and procurement arrangements for low vision aids, developed through collaboration between Scottish Government, delivery partners and the sector.

This work was informed by the 2017 independent review of low vision service provision in Scotland, commissioned by the Scottish Government. The review identified significant variation in access, capacity and service models across Scotland, including greater scarcity of provision in some rural areas, variation in waiting times and weaknesses in integration and signposting between services.[4]

Development has also drawn on established service models.In Scotland, the NHS Lanarkshire service provides practical experience of delivering low vision care in community settings, supported by targeted upskilling and collaboration with wider services.

More widely, the Welsh Low Vision Service provides a mature, nationally coordinated primary care model. It includes structured training and governance, low vision assessment and follow-up, mobile provision, electronic records and referrals, and a direct role for both optometrists and dispensing opticians within their respective scopes of practice.[5]

These models demonstrate the value of combining clinical assessment with timely access to low vision aids, follow-up and clear onward pathways to wider support.

Following its inclusion in the Scottish Government's 2026–27 budget, development work on the national Community Low Vision Service has now restarted. [1] Scottish Government has confirmed that the service will be delivered in community settings by optometrists and dispensing opticians and will include specialist assessment, practical support, low vision aids and signposting to wider services.[1]

There is therefore a strong foundation on which to build. The priority now is to ensure that the

final model can be implemented effectively, at scale and in a way that is sustainable within community settings.

Alignment with related elements of the patient pathway, including Certification of Visual Impairment, will also be important. Coordinated development will support a more coherent patient journey and reduce the risk of fragmentation between assessment, certification and access to wider support.

1.3 Scope of this Paper

> This paper focuses on the design and implementation considerations required to support a sustainable national Community Low Vision Service for adults in Scotland. It does not seek to provide a full service specification or detailed operational model. Instead, it identifies the principal workforce, funding, access, pathway, infrastructure and implementation issues that should inform the next phase of development.
>
> The position for children and young people, including the interface with VINCYP and transition into adult services, will require separate consideration.

Current Direction of Travel and Emerging Service Model

The emerging model reflects a structured and nationally coordinated approach, with the broad direction established and a number of detailed components continuing to be refined as programme development progresses.

Scottish Government has confirmed that the Community Low Vision Service will be delivered in community settings by optometrists and dispensing opticians and will include specialist assessments, practical support, low vision aids and signposting to wider services.[1]

Current programme discussions indicate that the developing model is likely to include a workforce of appropriately trained and accredited practitioners, supported by training and accreditation delivered through PSD Scotland. A phased rollout aligned to NHS Board geographies is also anticipated, alongside provision for patients who require care in a domiciliary setting.

The financial framework is expected to recognise different elements of service delivery, including practitioner participation, assessment and follow-up. The detailed structure and level of payment remain important areas for further development to ensure that the service is sustainable and workable in community practice. These will need to reflect the full cost of delivery and are considered further in Section 3.2 and Recommendation 1.

National procurement and supply arrangements for low vision aids are also being developed, with the intention of providing an appropriate and consistent range of aids across Scotland. This will need to support timely provision, including supply of aids at the point of assessment.

Digital infrastructure will be required to support patient records, ordering, referrals, claims and service monitoring. Current programme discussions indicate that OpenEyes is being considered as a potential platform for the service, although the final configuration and its integration with community practice workflows remain under development.

Current programme discussions indicate that implementation is not expected before early 2028.
The timing of practitioner training and initial service delivery will depend on the coordinated development of the service specification, procurement arrangements, accreditation, digital systems and payment processes.

Overall, the emerging model provides a coherent basis for further development. The priority now is to ensure that its individual components are aligned and capable of being implemented effectively within real-world community practice settings.

Key Risks and Delivery Constraints

This section outlines the principal risks and delivery constraints associated with implementation of the Community Low Vision Service, based on the emerging model described above.

The purpose is to support early consideration and mitigation of the practical issues that could affect workforce participation, access, consistency and long-term sustainability. These risks are intended to inform the design considerations and recommendations set out in the sections that follow.

3.1 Workforce and Accreditation

Workforce design will be central to successful implementation and will require careful calibration to balance quality, access and scalability.

The proposed approach includes a defined cohort of trained and accredited practitioners, providing a structured basis for consistent national delivery. However, an unnecessarily restrictive approach to workforce eligibility or accreditation could constrain capacity and reduce flexibility in areas where workforce availability and patient demand differ across Scotland. This will be particularly important during phased implementation, when the ability to mobilise available and appropriately skilled practitioners may influence the pace and reach of rollout.

A related and more immediate consideration is the role of dispensing opticians. Scottish Government has confirmed that both optometrists and dispensing opticians are expected to contribute to the Community Low Vision Service.[1] However, there remains a need for clear and practical arrangements to support dispensing optician participation, including appropriate mechanisms for registration, listing, payment, digital access and governance.

Dispensing opticians bring relevant expertise in low vision assessment, the selection, fitting and optimisation of low vision aids, and ongoing patient support. The Welsh WGOS 3 service demonstrates that appropriately trained optometrists and dispensing opticians can deliver low vision care within their respective scopes of practice as part of a nationally coordinated and quality-assured service.[5]

There is also evidence of interest across the dispensing optician profession in further skills development. The GOC Registrant Workforce and Perceptions Survey 2025 found that 30% of dispensing optician respondents planned to gain additional qualifications or skills.[11] However, this is UK-wide evidence and the level of current interest specifically in delivering the Community Low Vision Service in Scotland has not yet been established.

Early workforce engagement should therefore include a targeted assessment of dispensing optician interest, geographic distribution and capacity to participate in the service. This would provide a stronger basis for training numbers, workforce planning and phased rollout than relying on wider UK workforce survey data alone.

> Without clear arrangements for participation, there is a risk that the potential contribution of this workforce will not be fully utilised. This could reduce the number and geographical distribution of available providers and place avoidable pressure on the optometrist workforce.

The wider workforce model must also support effective integration with rehabilitation services, social care and third sector organisations. Community optometrists and dispensing opticians should be positioned as central clinical providers within a broader network of care, rather than as a standalone service. Without clear pathways and coordination, there is a risk that patients receive clinical assessment and aids but are not connected effectively to the wider support required to maintain independence.

Accreditation requirements will be an important determinant of practitioner participation. Training should be proportionate, accessible and tailored to the respective roles of optometrists and dispensing opticians. It should recognise relevant prior learning and current experience where these can be demonstrated, while maintaining consistent national standards and appropriate quality assurance.

A balanced approach will support practitioner confidence, reduce unnecessary duplication and enable delivery at scale without compromising consistency or patient safety.

3.2 Financial Viability

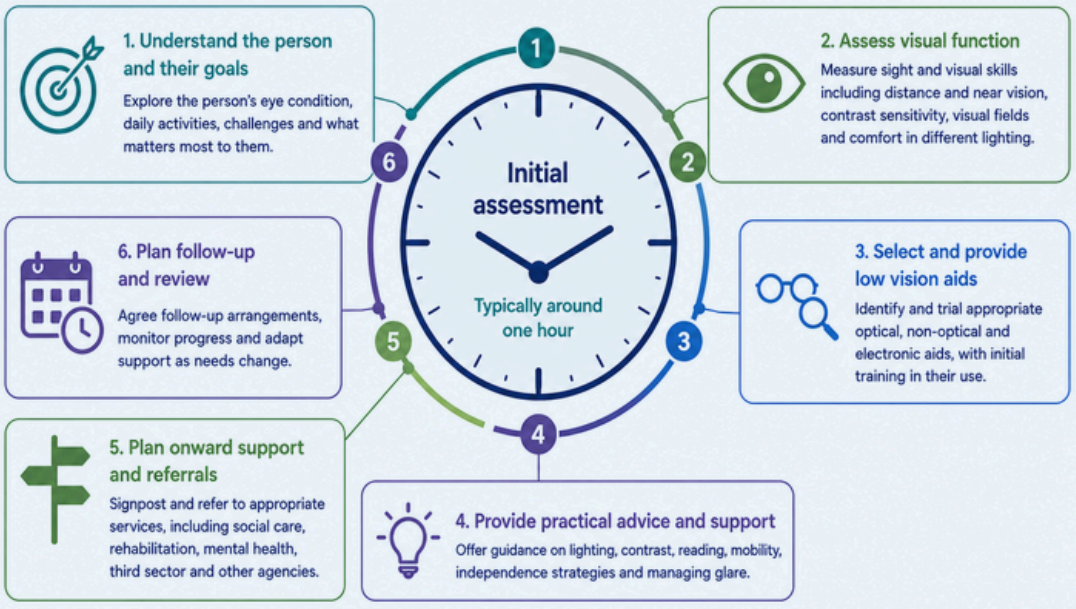
The financial model underpinning the Community Low Vision Service will be a critical factor in determining provider participation, service capacity and long-term sustainability.

Low vision assessments are longer and more complex than routine community eye care appointments. Scottish Government's previous service design work assumed that an initial low vision assessment would take approximately one hour and would include discussion of the patient's eye condition and functional needs, selection and provision of low vision aids, practical advice, follow-up planning and onward referral to wider support services.[6] Current NHS Wales guidance similarly indicates that a community low vision assessment normally requires around one hour.[5] The typical components of an initial assessment are illustrated in Figure 2.

The resource commitment extends beyond the face-to-face appointment. Delivery may include preparation and review of relevant information, clinical documentation, demonstration and instruction in the use of low vision aids, ordering or issuing aids, care planning, onward referral and liaison with rehabilitation, social care, third sector services and family members or carers. Ongoing activity may also include annual recall, patient enquiries, aid replacement and troubleshooting, reporting and service administration.[5,6]

Figure 2. Typical components of an initial Community Low Vision Service assessment

A holistic, goal-focused and person-centred assessment, tailored to the individual's needs and everyday goals.



The initial assessment is typically around one hour and combines functional assessment, low vision aid selection, practical advice, patient education and planning for onward support and follow-up. Sufficient time is required to understand the individual's priorities and discuss the impact of sight loss in a sensitive, person-centred and unhurried way.

Low vision assessment also requires a sensitive and person-centred approach. Patients may be adjusting to permanent or progressive sight loss and discussing changes to their independence, confidence and ability to undertake everyday activities. Sufficient appointment time is therefore required to communicate information clearly, understand the patient's priorities, manage expectations and allow questions to be explored without the consultation feeling rushed. This is integral to the quality and effectiveness of the service rather than an additional or optional element of care.

To inform its recommendations, Optometry Scotland has undertaken an indicative bottom-up assessment of the cost of providing protected clinical capacity within a community optometry practice. The model includes practitioner and support-staff costs, premises, equipment, IT, insurance, training, maintenance and other operating overheads. It indicates a central operating cost of approximately £169 per available clinical hour, based on an illustrative single-clinician practice model and the allocation of full annual operating costs across 1,750 clinical hours.[12]

This modelling does not represent a nationally audited cost survey and individual practice costs will vary. However, it demonstrates that a one-hour assessment fee of £150 would represent a pragmatic minimum rather than full recovery of the central modelled cost. It would provide a more sustainable basis for participation than earlier proposals while remaining below the modelled average hourly cost.

Follow-up appointments should also be funded separately. Current Welsh service guidance indicates that a face-to-face low vision follow-up normally requires between 15 and 30 minutes. Follow-up may include reviewing how the patient is managing with low vision aids, addressing difficulties, providing further instruction, reconsidering support needs and checking the progress of referrals.[5] Applying the indicative Scottish practice cost of approximately £169 per hour to a 30-minute appointment produces a cost of approximately £85.

On this basis, the core fee structure set out in Table 1 is recommended.

Table 1. Recommended core funding model for the Community Low Vision Service

Service component	Recommended fee	Basis
Initial or full low vision assessment	£150	Approximately 60 minutes of protected clinician time, including functional assessment, patient education, low vision aid selection, care planning, documentation and onward referral. This remains below the central modelled practice cost of approximately £169 per available clinical hour.
Standard face-to-face follow-up	£85	Up to 30 minutes of clinician time, including relevant reassessment, review of low vision aid use, further instruction, documentation and consideration of wider support needs.
Full reassessment following significant change	£150	Applicable where a significant change in vision, functional need or personal circumstances requires the equivalent of a comprehensive new assessment.
Annual patient registration and ongoing administration	To be agreed separately	Should recognise registration, annual recall, records maintenance, reporting, patient enquiries, low vision aid replacement and ongoing support.
Domiciliary, mobile, remote and island provision	Separate additional payment	Should reflect travel time, mileage, ferry or air travel where necessary, equipment transport, administrative coordination and lower appointment density.
Failed-to-attend or late cancellation provision	Proportionate payment	Should recognise the loss of protected extended clinic capacity where an appointment cannot reasonably be refilled, and the complex circumstances of patients utilising the service which may mean last minute cancellations are more common.

The distinction between a standard follow-up and a full reassessment should be clearly defined within the service specification. The full assessment fee should apply where the

practitioner is required to repeat the broader functional assessment, reconsider rehabilitation goals or substantially revise the patient's low vision aid and support plan.

A separate annual registration and administration payment will also be required. Scottish Government's previous service model recognised registration, annual recall and ongoing support as distinct funded activity.[6] The final payment should reflect the actual responsibilities placed on providers and should not assume that patient enquiries, aid replacement, service reporting and wider administration can be absorbed within the assessment tariff.

The assessment and follow-up fees should relate specifically to clinical service delivery. Low vision aids, training and accreditation, digital infrastructure, essential assessment equipment, domiciliary travel and any separately commissioned coordination or key-worker function should be funded outside these tariffs. Fees should be profession-neutral, with the same service activity attracting the same tariff whether delivered by an accredited optometrist or dispensing optician.

There is a risk that a financial model which does not adequately recognise appointment duration, clinical complexity, person-centred communication, administration, follow-up activity and the additional requirements of domiciliary and remote provision will undermine the practical deliverability of the service.

Inadequate remuneration may limit provider participation and reduce the number of appointments that practices are able or willing to make available. It may also make it more difficult to recruit and retain both optometrists and dispensing opticians to deliver the service, particularly where accredited practitioners must balance CLVS activity with existing NHS-funded and private care.

These effects are likely to be more pronounced in rural, remote and higher-cost locations, where lower patient density, travel requirements and higher operating costs may reduce the viability of provision. This could result in uneven geographical coverage and longer waits for patients in areas where access is already more difficult.

> Without clear arrangements for participation, there is a risk that the potential contribution of this workforce will not be fully utilised. This could reduce the number and geographical distribution of available providers and place avoidable pressure on the optometrist workforce.

The combined effect of limited participation, reduced appointment capacity and weaker provision in higher-cost areas could lead to inequitable access across Scotland. Conversely, a sustainable and proportionate funding framework will support provider participation, workforce capacity and consistent geographical coverage, while helping to ensure that patients receive a high-quality service regardless of where they live.

The proposed fees should be reviewed following an initial period of service delivery using actual information on appointment duration, follow-up activity, administration,

non-attendance, domiciliary provision and provider costs. All fees should subsequently be uplifted through the established annual review process.

3.3 Service Design and Access

Service design will have a direct impact on how patients experience the CLVS and how effectively it integrates with existing care pathways.

The proposed use of geographic allocation and phased rollout provides a logical structure for implementation. However, care should be taken to ensure that geographic allocation models do not unnecessarily restrict patient choice, cross-boundary access, or continuity of care where existing clinical relationships or referral pathways are already established.

Patients should, wherever possible, be able to access services through local providers. Previous review of low vision services in Scotland found that community-based provision was associated with substantially shorter waiting times than some hospital-based services, supporting the principle of delivering care closer to home where appropriate.[4] There is also a risk that variation in local implementation may impact the pace and consistency of rollout, as seen in previous service implementations such as the Community Glaucoma Service.

Similarly, the approach to domiciliary provision requires careful consideration. While ensuring access for patients who are unable to attend practice settings is essential, a model that requires all providers to deliver domiciliary care may act as a barrier to participation. There is a risk that a lack of flexibility in domiciliary provision may limit both access and participation, particularly where existing referral mechanisms between providers are not utilised or adapted for this service.

3.4 Operational Delivery

Procurement, training and digital infrastructure are closely interdependent and will need to progress in a coordinated way.

The development of a national low vision aid catalogue is a significant element of the service model and is likely to sit on the critical path for delivery. This process will require sufficient time to ensure that the range of aids is clinically appropriate, up to date and inclusive of both optical and digital solutions.

At the same time, training arrangements must be developed and delivered at sufficient scale, while digital systems are configured to support clinical recording, ordering, claims and reporting. If they progress at different rates, there is a risk of delays, duplication or inefficiencies during rollout, which may affect practitioner readiness and the consistency of service delivery across Scotland.

There is also a risk that separate workstreams or Short Life Working Groups develop elements

of the service in isolation. Without clear coordination and shared oversight, decisions on procurement, training and digital infrastructure may not align with the final service specification or with the practical requirements of community delivery.

3.5 Certification of Visual Impairment and Patient Pathways

Certification of Visual Impairment (CVI) is an important component of the wider patient pathway, providing a formal route to registration and helping connect people with appropriate social care, rehabilitation and third sector support.

Through programme discussions, Scottish Government has indicated that enabling optometrists to undertake certification forms part of its longer-term policy direction. Current indications suggest that the development of CVI processes may follow the initial rollout of the CLVS rather than being introduced alongside it.

While this may be necessary from a programme perspective, it creates a risk of fragmentation if the two elements are not clearly aligned. Patients accessing low vision services may also require timely certification alongside wider support, and unclear or delayed pathways could result in duplication, additional appointments or slower access to appropriate services.

There are also unresolved questions regarding which practitioners should be authorised to undertake certification, what training or accreditation should be required, and how the process should integrate with digital systems and existing clinical pathways. These issues will require careful consideration to ensure that arrangements are clinically appropriate, accessible and supported by clear governance.

> Without a coordinated approach, including defined responsibilities and a transparent implementation timeline, the CLVS may not operate as part of a fully integrated patient pathway.

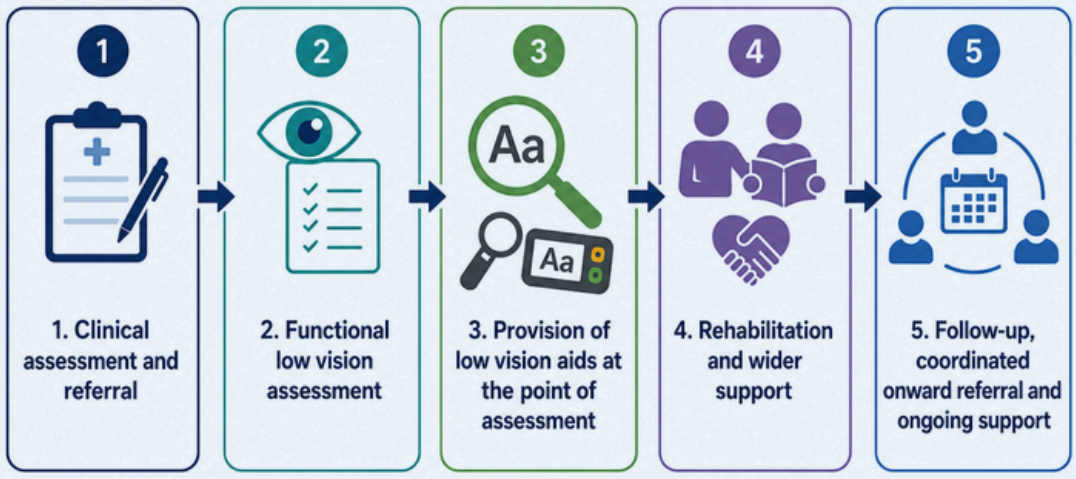
Key Considerations for a Sustainable Model

This section sets out the key design considerations required to support a sustainable and deliverable Community Low Vision Service, based on the risks identified in Section 3.

The workforce model should connect the core community clinical workforce with rehabilitation, social care, Hospital Eye Services and third sector support. The 2017 Scottish review identified access, capacity and effective integration between providers as priorities for future low vision provision.[4] The current Welsh model demonstrates how community-based assessment can be connected with low vision aid provision, follow-up and onward referral to wider support, while NHS Lanarkshire provides Scottish practical experience of closer integration between community optometry and local rehabilitation services. [5,9]

The proposed care pathway is illustrated below.

Figure 3. Proposed patient pathway for the Community Low Vision Service



This pathway supports coordinated care across community optometry, Hospital Eye Services, rehabilitation services, social care and the third sector, helping ensure patients receive assessment, appropriate low vision aids and access to wider support.

This pathway would support a coordinated approach across community optometry, Hospital Eye Services, rehabilitation services, social care and the third sector. It would help ensure that patients receive not only clinical assessment and appropriate low vision aids, but also timely access to the wider support required to maintain independence and quality of life.

Effective coordination across the pathway will be important. Where a link worker or equivalent coordination function is included within the wider service model, its role should be clearly defined to support communication between services, facilitate access to appropriate support

and help patients navigate the system.

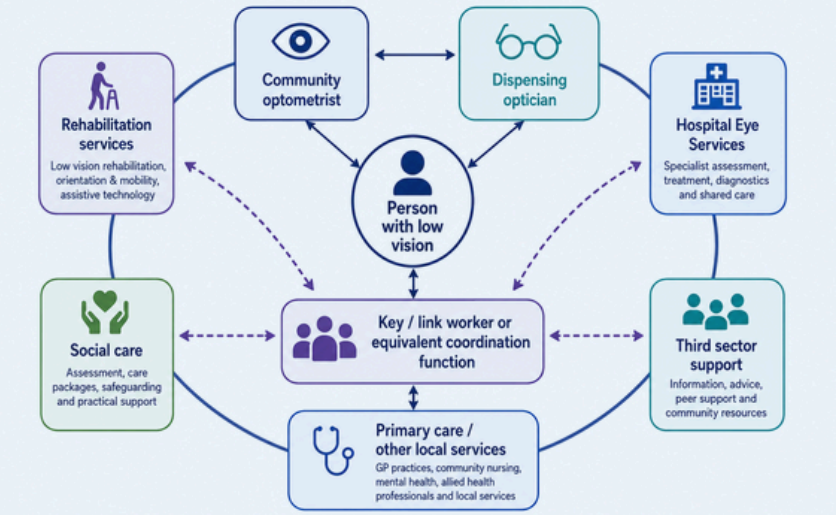
4.1 Workforce Model

A sustainable workforce model should include effective links with local authority rehabilitation services and other professionals supporting people with sight loss within their home and community. This reflects the need for the CLVS to operate as an integrated model of care, in which clinical provision is connected with wider health, social care and third sector support. The 2017 Scottish review identified effective integration between providers as an important consideration for future low vision service planning. [4]

The service model should also include a clearly defined key/link worker or equivalent coordination function. This function should support communication between community optometry, rehabilitation, social care, Hospital Eye Services and relevant third sector services; help patients navigate the pathway; facilitate timely onward referral and access to support; and promote continuity between clinical assessment and longer-term rehabilitation and social care.

The precise form of the coordination function should reflect existing local structures and capacity rather than requiring a single nationally prescribed post. However, national service standards should define the expected responsibilities, referral relationships and communication arrangements. Experience from NHS Lanarkshire provides practical evidence of the value of coordinated working between community optometry and local rehabilitation services. [9]

Figure 4. Proposed integrated workforce model for the Community Low Vision Service



This model places community optometry at the core of clinical delivery while connecting patients to rehabilitation, social care, Hospital Eye Services and wider support through an integrated coordination function.

Within this wider model, optometrists and dispensing opticians should form the core community clinical workforce. Both professions are expected to contribute to delivery of the CLVS, reflecting their established roles in community eye care and low vision support. [1] The workforce model should be sufficiently flexible and scalable to make effective use of both professions while responding to differences in population need, geography and local workforce availability.

Accredited dispensing opticians should play an integral role in service delivery and should be able to work independently within their scope and competence, without a routine requirement for optometrist supervision. This should include undertaking low vision assessments, assessing functional needs, selecting and optimising low vision aids, and providing practical instruction and ongoing support. Optometrists should contribute their wider clinical expertise, including refraction, ocular health assessment and onward clinical management where required.

The two professions should therefore be positioned as complementary providers, with clear service protocols supporting collaboration, shared care and onward referral where a patient's needs extend beyond the competence or scope of an individual practitioner. This is consistent with the established Welsh model, which enables both optometrists and dispensing opticians to deliver accredited community low vision services. [5]

Early workforce mapping should identify the number, geographic distribution and potential capacity of optometrists and dispensing opticians who may be able to participate in the service. This should include direct engagement with both professions to assess current interest in CLVS delivery, relevant experience, training needs and any practical barriers to participation. This information should be used to inform training numbers, geographic coverage, phased rollout and any targeted recruitment or support required in areas where workforce capacity is more limited.

Clear governance and administrative arrangements will also be required to enable dispensing opticians to participate fully, including an appropriate listing or approval mechanism. This should be developed alongside the training pathway and service specification so that workforce readiness is not delayed by unresolved administrative requirements.

4.2 Training and Accreditation Approach

Training and accreditation will play an important role in supporting consistent, high-quality care while enabling the workforce to participate at sufficient scale.

Low vision forms part of the existing education and competence base of both optometrists and dispensing opticians. Additional training should therefore build on this foundation and focus on the knowledge, skills and service-specific processes required to deliver the CLVS consistently across Scotland.

An appropriate, quality-assured training model delivered through PSD Scotland would

provide a practical route to accreditation. The programme should be accessible to both professions and should reflect their respective scopes of practice and roles within the service. [5] It should also support effective integrated working across the wider low vision pathway.

The training pathway should include a structured mechanism for recognising existing professional competencies, relevant low vision qualifications, prior learning and recent experience. This should operate within an agreed quality-assurance framework, with clear criteria for demonstrating current competence. Recognition of prior learning should reduce unnecessary duplication without weakening consistency or clinical governance. ABDO should be involved in developing these arrangements to ensure that the existing education, qualifications and experience of dispensing opticians are properly understood and taken into account.

The programme should also be designed with implementation capacity in mind. Flexible delivery, including an appropriate balance of online learning, practical training and assessment, would support participation across urban, rural and island communities and reduce avoidable pressure on practitioners and employers. Training places should be sufficient to support the planned pace of rollout and should not create unnecessary geographic gaps in service provision.

Ongoing continuing professional development should be embedded within the service model. This should include proportionate requirements for maintaining competence, responding to changes in clinical practice and technology, and completing any service-specific updates required through audit or service development.

4.3 Service Accessibility and Patient Choice

Ensuring that the CLVS is accessible to patients across Scotland should be a central design consideration.

Patients should, wherever possible, be able to access care locally and through providers with whom they already have an established clinical relationship. This supports continuity of care, improves patient experience and aligns with the wider shift towards community-based delivery.

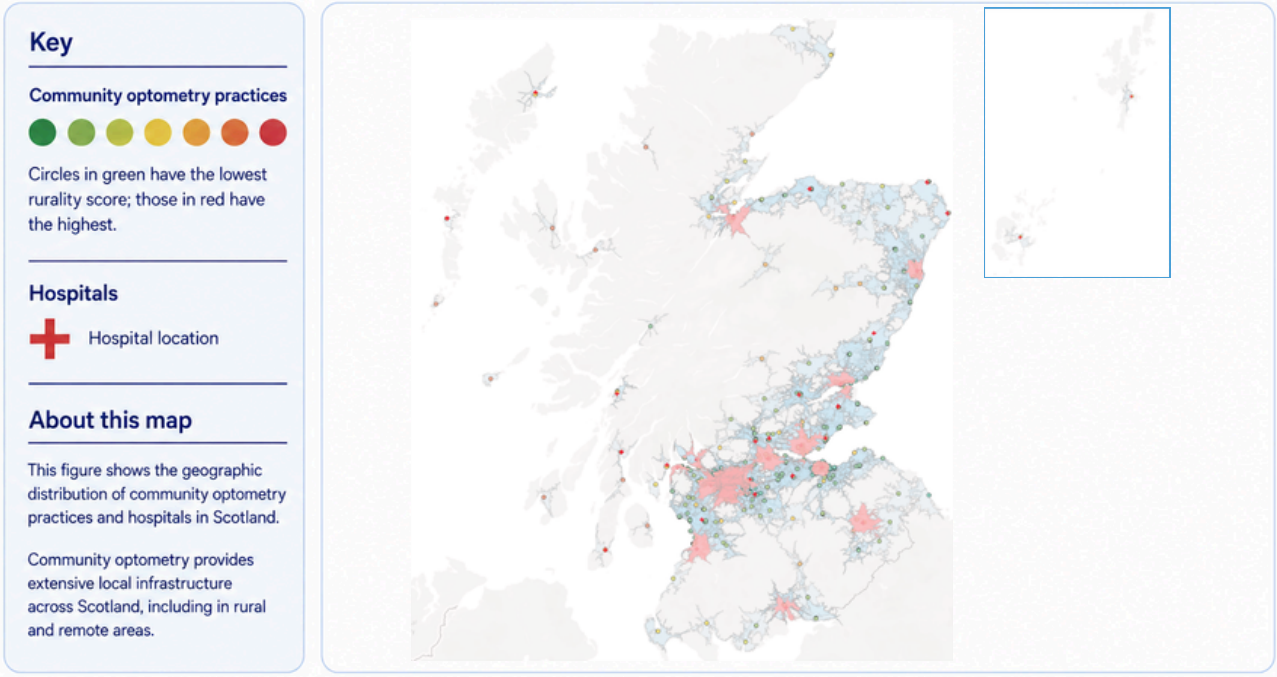
The 2017 review of low vision provision in Scotland identified geographic inequalities in access, including greater scarcity of services in rural areas, variation in waiting times and unequal access to low vision aids. It also found that community-based schemes had the potential to provide high-capacity services across a wide geographic area and shorter waiting times than some other models. [4]

A national service will require an appropriate approach to geographic planning to ensure adequate coverage and efficient use of available workforce capacity. However, geographic allocation should not operate as an unnecessarily rigid boundary. Patients should retain reasonable choice of accredited provider, including the option to attend their usual community optometry practice where that practice delivers the service and can meet their needs.

This flexibility will be particularly important during phased rollout, when availability may differ between areas. Arrangements should allow cross-boundary access and referral between accredited providers where this would reduce travel, avoid delay or support continuity of care.

Patient information should clearly explain how to access the service, which providers are available and what options exist when the nearest provider is not suitable or accessible. The service should also be monitored for variation in travel distance, waiting times and access across urban, rural and island communities so that gaps can be identified and addressed as rollout progresses.

Figure 5. Geographic distribution of community optometry practices and hospitals in Scotland



Source: Mapping of Optometry Practice Locations and Rurality Scores, prepared for Optometry Scotland by the AOP Policy Team, 2025.

4.4 Role of Domiciliary Care

Domiciliary provision is essential to ensure equitable access for patients who are unable to attend a community practice because of significant visual impairment, reduced mobility or co-morbidities.

However, requiring every accredited provider to deliver domiciliary care may create a barrier to participation and reduce overall service capacity. The service model should therefore allow patients to be referred to accredited providers with the appropriate domiciliary expertise,

workforce and infrastructure.

Domiciliary delivery also involves additional resource beyond the clinical assessment itself, including travel time, mileage, transport of equipment, administrative coordination and lower appointment density. These requirements may be particularly significant in remote, rural and island areas, where ferry or air travel and overnight accommodation may also be necessary. The standard assessment and follow-up tariffs should therefore apply to the clinical activity only, with separate and sufficient payments provided for the additional costs of domiciliary, mobile, remote and island delivery.[6]

A flexible domiciliary model would help protect patient access while allowing providers to participate according to their capacity and specific circumstances.

4.5 Integration with the Wider System

The effectiveness of the CLVS will depend fundamentally on its integration with the wider health, social care and third sector system. This should be treated as a core design principle rather than an additional element of the service.

A well-designed model should include clear and consistent links between community optometry, Hospital Eye Services, primary care, rehabilitation services, local authorities and third sector organisations. The 2017 review of low vision provision in Scotland identified integration and effective signposting between providers as important considerations for future service planning. [4]

The patient pathway should support timely onward referral according to individual need. This may include access to rehabilitation, mobility support, emotional wellbeing services, benefits advice, assistive technology and local or national sight loss organisations. Access to appropriate support should not be unnecessarily delayed while a patient awaits certification or another part of the clinical pathway.

> “Clinical assessment and low vision aids are only one part of the journey; effective integration with the wider support system is crucial to its success. Blind and partially sighted people should have timely access to rehabilitation, mobility training, emotional support, assistive technology, benefits advice and third-sector services.”
>
> **James Adams**
> Director, RNIB Scotland

The current Welsh service demonstrates how community low vision assessment can be connected with referral to social care, health services and voluntary organisations as part of

a holistic model of provision.[5] Scottish experience provides further practical learning: the NHS Lanarkshire Low Vision Service operates through close partnership between community optometry and local rehabilitation services, with direct communication following assessment to support onward rehabilitation and home-based support. [9]

Integration should be supported by clear referral routes, defined professional responsibilities and access to accurate, regularly maintained information on local and national services. This would help practitioners direct patients to appropriate support and reduce the risk of fragmented or duplicated care.

A coordinated model would ensure that patients receive not only clinical assessment and low vision aids, but also access to the wider support needed to maintain independence, confidence and quality of life.

4.6 Technology and Modern Low Vision Support

The CLVS should reflect the evolving nature of low vision care, including the increasing role of electronic and digital assistive technologies alongside traditional optical and non-optical aids.

Optometrists and dispensing opticians are well placed to support this aspect of care through assessment of functional need, selection and optimisation of low vision aids, practical instruction and follow-up. Ensuring that the service model enables both professions to contribute will support effective use of workforce skills and help patients make appropriate use of available technology.

Modern low vision support should include consideration of mobile device accessibility functions, software applications and other digital tools that may assist with reading, communication, navigation and day-to-day tasks. Some of these options are widely available at low or no additional cost and can provide useful support when matched appropriately to individual need.

The service should also consider access to more advanced electronic magnification and other higher-cost assistive technologies where these provide additional benefit. These devices may require trial, individual assessment, maintenance and ongoing support, and should therefore be reflected appropriately within the procurement and supply model.

Emerging technologies, including AI-enabled tools, may offer future opportunities to support independence. However, these should be introduced on the basis of evidence, clinical appropriateness, accessibility, information governance and value for money rather than assumed benefit.

Technology should complement, rather than replace, personalised assessment, rehabilitation and practical support. The final service model should ensure that patients receive

appropriate instruction and follow-up so that aids and digital tools are used safely and effectively.

4.7 Certification of Visual Impairment

Certification of Visual Impairment is an important component of the wider care pathway, providing a formal route to registration and helping connect people with appropriate social care, rehabilitation and third sector support.

Development of the CVI pathway is expected to follow the initial rollout of the CLVS. The two elements should nevertheless be clearly aligned, with a transparent timeline for CVI development, so that patients experience a coherent route into certification and wider support.

The workforce model for certification will require careful consideration. Appropriate access should be balanced with training, clinical governance and clear links to low vision services. The model should also ensure that patients are not required to navigate unnecessary additional appointments or disconnected pathways.

The current NHS Wales model provides a useful example of how community-based certification can operate within a wider low vision pathway. It enables appropriately listed optometrists to undertake certification in primary care for eligible patients aged 16 and over, while retaining referral to secondary care where diagnosis, permanence of sight loss or treatment outcomes remain uncertain. Patients identified for certification are also offered access to a low vision assessment, although certification is not dependent on accepting that assessment. [5]

While the Welsh approach offers relevant learning, the Scottish model should be designed around Scotland's own workforce, governance, legislation and service infrastructure. It should support accessible community-based certification while maintaining clear clinical criteria and effective links to the wider patient pathway.

The position for children and young people should also be clarified, including the interface with VINCYP and transition into adult services.

Learning from Existing Models

Established low vision services provide relevant evidence and practical learning to inform the design and delivery of a national model in Scotland. In particular, the Welsh Low Vision Service and existing Scottish provision, including NHS Lanarkshire, demonstrate how low vision care can be delivered within community settings. Experience from the implementation of other enhanced community eye care services in Scotland also provides useful learning for rollout.

Welsh Low Vision Service

The Welsh Low Vision Service is a well-established national model, delivered through a coordinated network of accredited practitioners across all Health Boards. It demonstrates the feasibility of community-based low vision provision supported by structured training, consistent clinical protocols, electronic records, audit and national governance. Both optometrists and dispensing opticians are able to deliver the service within their respective scopes of practice. [5]

> **Evidence from the Welsh service**
>
> Published evaluation of the Welsh service found that community-based low vision rehabilitation was effective and improved geographical access to care. A later study also found that improvements in visual disability were maintained over time among an older patient population. [7,8] These findings provide useful evidence that low vision care can be delivered effectively in community settings and can provide sustained patient benefit.

A key feature of the Welsh model is the connection between low vision assessment, provision of aids, follow-up and onward referral to wider support. However, the Welsh approach should not be treated as a model to be replicated without adaptation. Scotland has different geography, workforce distribution, governance arrangements, legislation and service infrastructure. The most relevant elements should therefore be considered and adapted to the Scottish context.

North Lanarkshire Low Vision Service

In Scotland, the NHS Lanarkshire Low Vision Service provides relevant practical experience of community-based low vision delivery within an integrated local pathway. The service operates through a network of community optometry practices working closely with rehabilitation and social care services. Patients are normally assessed within two weeks of referral, with practices holding stock of low vision aids to support timely provision and providing advice on electronic aids and accessibility functions where appropriate. Following assessment, optometrists can make direct contact with local rehabilitation teams to support further assessment, home adaptations and ongoing support. [9]

Historic patient feedback from the service also indicates generally positive experience and perceived benefit from low vision aids, although these data are older and should be interpreted as service-development evidence rather than a current evaluation. [10]

Community Glaucoma Service

Experience from the Community Glaucoma Service also provides relevant implementation learning. In particular, it demonstrates that a nationally agreed service does not automatically result in consistent local implementation. Workforce readiness, NHS Board engagement, patient transfer arrangements, communications and operational support can all influence the pace and consistency of delivery.

The principal learning from these models is summarised below.

Table 2. Learning from existing low vision service models

Model	Relevant learning	Implications for Scotland
NHS Wales WGOS 3	Nationally coordinated community delivery; participation by optometrists and dispensing opticians; structured training, governance, low vision aid provision, follow-up and referral pathways.	Provides a strong comparator, but relevant elements should be adapted to Scotland's workforce, geography, legislation and infrastructure.
NHS Lanarkshire	Community-based delivery supported by established local relationships and direct links with rehabilitation and sensory support services.	Provides valuable Scottish service learning, while further verified activity and outcome data would strengthen its use in national service design.
Community Glaucoma Service	Local readiness, NHS Board engagement, workforce capacity and patient transfer arrangements can affect the pace and consistency of implementation.	CLVS rollout should include clear national oversight, early provider engagement, realistic sequencing and active management of local variation.

Taken together, these examples reinforce the value of community-based delivery, effective use of optometrists and dispensing opticians, proportionate training, timely access to low vision aids and clear links to wider support. They also demonstrate that implementation arrangements are as important as service design.

The Scottish model should therefore draw selectively on established evidence and service experience, while being designed around Scotland's own policy context, workforce, geography and service infrastructure.

Implementation Approach and Delivery Considerations

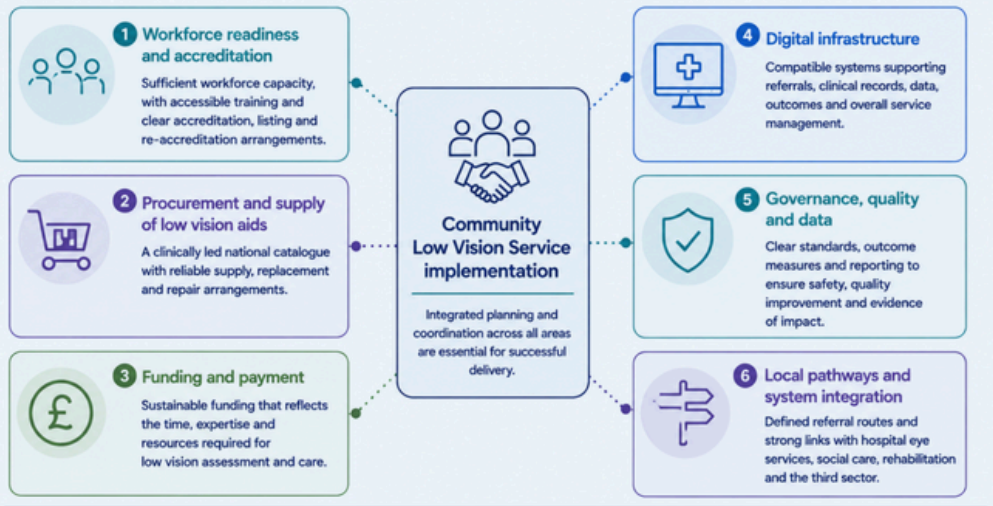
The successful implementation of a national Community Low Vision Service will depend on the alignment of workforce, funding, procurement, training, digital infrastructure and governance arrangements. These elements should be developed around a patient-centred model that supports local access, continuity of care and effective links to wider services. While the broad direction of the service is established, a number of detailed components remain under development. The sequencing and coordination of these elements will therefore be critical to ensuring that the service can be introduced safely, consistently and at sufficient scale.

Implementation should be supported by clear national oversight, defined responsibilities and regular engagement with practitioners, NHS Boards and wider partners. This will help ensure that emerging arrangements are workable within community settings and that operational issues are identified before they affect delivery.

Successful implementation will depend on coordinated development across these interconnected areas, as illustrated below.

Figure 6. Key interdependencies for successful implementation of the Community Low Vision Service

These interconnected areas must develop together to enable consistent, equitable and sustainable delivery across Scotland.



Strong leadership, partnership working and early engagement with stakeholders will be critical to align these interdependencies and support a phased, consistent and equitable national rollout.

6.1 Phased Rollout and Delivery Approach

A phased rollout approach is appropriate given the scale and complexity of the service. It would allow training capacity, workforce readiness, procurement, digital systems and local pathways to develop alongside service introduction. It would also provide an opportunity to

test operational arrangements and apply learning from early phases before wider implementation.

> Early evaluation should include actual appointment duration, the proportion of patients requiring follow-up or full reassessment, administrative workload, non-attendance, domiciliary activity and provider delivery costs. This information should be used to review the fee structure and wider service arrangements before rollout is extended.

The pace and sequencing of rollout are likely to be influenced by workforce availability, practitioner readiness, local referral pathways and the capacity of NHS Boards and delivery partners. Current programme discussions indicate that smaller NHS Board areas may be capable of implementation within a single phase, while larger areas may require delivery through a number of cohorts.

A degree of flexibility will therefore be required within the overall national approach. However, local variation should not result in avoidable delays, inconsistent standards or prolonged gaps in access. Clear criteria will be needed to determine rollout sequence, readiness and progression between phases.

Effective implementation will require a balance between national consistency and local responsiveness. National standards, funding arrangements and governance should remain consistent, while local delivery arrangements should be capable of reflecting differences in population need, geography and available workforce.

6.2 Workforce Mobilisation and Training Capacity

The availability of a suitably trained and geographically distributed workforce will be a key determinant of the pace and reach of implementation.

The accessibility and capacity of training delivered through PSD Scotland will directly influence how quickly service capacity can be established. Training provision should therefore be planned alongside the proposed rollout sequence, with sufficient places and delivery flexibility to support participation across urban, rural and island communities.

Early engagement with the existing workforce, including both optometrists and dispensing opticians, will be important in establishing likely participation before training and rollout assumptions are finalised. This should assess interest in delivering the CLVS, relevant experience, geographic distribution, training needs and the capacity of employers to release staff for training and service delivery.

Engagement should be undertaken in partnership with relevant professional and representative bodies so that workforce planning is informed by current evidence rather than assumptions about likely uptake.

Workforce mobilisation should take account of practitioners with recent low vision experience or previous service-specific training, subject to agreed arrangements for demonstrating current competence.

Workforce mobilisation will also depend on the practical arrangements surrounding participation. Clear information will be required on accreditation, listing, remuneration, governance, expected activity and the time commitment associated with service delivery. These arrangements should be communicated sufficiently early to allow practitioners and employers to make informed decisions.

Developing an early understanding of likely uptake across both professions will support training planning, inform rollout assumptions and help identify areas where additional recruitment, targeted support or alternative delivery arrangements may be required.

6.3 Procurement and Supply of Low Vision Aids

The procurement and supply of low vision aids will be a significant operational dependency and is likely to sit on the critical path for implementation.

The national catalogue should be clinically led, sufficiently broad to meet a range of functional needs and capable of being updated as products and technology develop. It should include an appropriate mix of optical, non-optical and electronic solutions, while remaining practical for use within community settings. [5]

Where clinically appropriate, patients should receive low vision aids at the point of assessment. Immediate provision allows practitioners to demonstrate and optimise the aid during the consultation, provide instruction to the patient and any carer or family member, and confirm that the selected solution is suitable before the appointment concludes. This approach is consistent with established community low vision provision. [5]

To support this model, accredited providers will require access to an appropriate working stock of aids, supported by reliable replenishment arrangements. Clear processes will also be needed for ordering, delivery, returns, repairs, replacement and disposal, with responsibilities defined across practitioners, suppliers and the national delivery system.

Procurement arrangements should recognise that different categories of aid may require different approaches. Traditional optical aids may be suitable for standardised stock and replenishment, while electronic or higher-cost devices may require individual approval, trial arrangements, maintenance support or alternative supply routes.

The catalogue and supply model should also allow proportionate flexibility where a patient's needs cannot be met through the standard range. Any exception process should be clear, timely and supported by appropriate clinical governance.

Procurement timescales should be coordinated with practitioner training, digital system

development and rollout planning. Trained practitioners should not be expected to begin delivery without access to the aids, ordering processes and support arrangements required to provide a complete service.

Regular review of the catalogue, supplier performance and practitioner feedback will be important to ensure that the range remains clinically appropriate, reliable and responsive to patient need.

6.4 Digital Infrastructure and Systems

Digital infrastructure will play an important role in supporting clinical delivery, ordering, referrals, claims, data capture and service monitoring.

The final system should be designed around the practical requirements of community delivery. It should provide accredited optometrists and dispensing opticians with equitable, role-based access to record assessments, document care plans, order and track low vision aids, make onward referrals, including into the CVI pathway where appropriate, submit claims and support appropriate follow-up without unnecessary duplication or administrative burden.

Current programme discussions indicate that OpenEyes is being considered as a potential platform for the service. However, the final configuration should be tested with community practitioners and should reflect the workflows of both optometrists and dispensing opticians before implementation.

Clear arrangements will also be needed for information governance, patient consent, professional access and the secure sharing of relevant information across community optometry, Hospital Eye Services, rehabilitation services, social care and other appropriate partners.

Where possible, the system should connect with existing referral and reporting processes rather than requiring practitioners to enter the same information into multiple platforms. Interoperability and proportionate data requirements will be important to support participation and efficient delivery.

Over time, the digital model should be capable of aligning with Certification of Visual Impairment processes and the wider patient pathway. This should be considered during system design, even though CVI development is expected to follow the initial rollout of the CLVS.

> Digital systems, user testing, training and support arrangements should be in place before practitioners begin delivering the service. Rollout should not proceed in an area until the system can support the full patient pathway and associated operational processes reliably.

6.5 Alignment of Timelines and Dependencies

Implementation will depend on the coordination of several interdependent elements, including workforce training, procurement, digital system development, payment arrangements and local pathway readiness.

Scottish Government has indicated through programme discussions that different aspects of the service may be progressed through separate workstreams or Short Life Working Groups. This provides an opportunity to advance key components in parallel and draw on relevant expertise from across the sector.

Given the interdependencies between these areas, ongoing coordination and alignment will be important to ensure that outputs are consistent and support the overall service model. Clarity around responsibilities, sequencing and decision-making will help reduce the risk of delays or operational gaps.

The relationship between CLVS rollout and the later development of Certification of Visual Impairment processes will also be relevant. Even where delivery is staged, a clear view of how these elements will align over time will support planning, system readiness and a coherent patient pathway.

6.6 Domiciliary Delivery Arrangements

A flexible model should enable patients who are unable to attend practice to be referred between accredited providers, including to practitioners or organisations with appropriate domiciliary expertise and capacity. These referral arrangements should be formalised within the service specification, with clear responsibilities for accepting referrals, sharing relevant information, follow-up and continuity of care.

Domiciliary provision involves additional resource beyond the clinical assessment itself. This includes travel time, mileage, transport and setup of equipment, administrative coordination and the reduced number of appointments that can be delivered within a working day.

Previous Scottish Government planning recognised that low vision was likely to involve a higher proportion of domiciliary activity than routine GOS and that the specialist domiciliary workforce was limited. It also identified that provision in some remote and island areas could require ferry or air travel and overnight accommodation.[6]

The funding model should therefore include a distinct and proportionate arrangement for domiciliary care, rather than assuming that the standard non-domiciliary fee will adequately support delivery. It should also avoid creating incentives to delay care while sufficient patients are accumulated to make a visiting session financially viable.

A flexible and adequately funded referral model would help protect access for patients who

require care at home, while allowing providers to participate according to their workforce, infrastructure and capacity.

6.7 Urban, Rural and Island Delivery Considerations

Scotland's geography will require different approaches to service coverage across urban, rural, remote and island communities.

In areas with greater workforce availability and established infrastructure, implementation may be supported by shorter travel distances and a wider choice of accredited providers. In remote, rural and island areas, smaller patient numbers, wider geographic dispersal and more limited workforce capacity may make it more difficult to establish and sustain local provision.

A combination of delivery models is therefore likely to be required. This may include practice-based care, cross-boundary access, referral between accredited providers, shared provision and planned visiting arrangements where there is insufficient local capacity to support a permanent service.

Rollout should ensure that lower patient volumes do not result in prolonged gaps in access. Remote and island delivery may also require additional operational support where travel between communities is significant or where practitioners must transport equipment over longer distances. [6]These additional requirements should be reflected in both the funding model and rollout planning, rather than being absorbed within the standard clinical tariff.

Early engagement with providers will be important in assessing local readiness and understanding where standard delivery arrangements may not be sufficient. This should inform workforce planning, rollout sequencing and any additional support required to maintain equitable access across Scotland.

6.8 Data, Monitoring and Continuous Improvement

Data and monitoring arrangements will form an important part of service implementation and ongoing development.

The routine collection of activity, access, clinical outcome and patient experience data will support understanding of how the service is operating in practice. This should include information on workforce participation, waiting times, travel and access, low vision aid provision, referrals to wider support services and variation across urban, rural and island communities.

Data collection should be aligned with existing systems and reporting processes wherever possible. This will help minimise administrative burden and support consistent data capture

across providers.

Monitoring should also support early identification of variation in access, quality or delivery. Findings from the initial phases should inform service refinement and help determine whether any changes are required before wider rollout.

A clear feedback mechanism should enable learning from patients, practitioners, NHS Boards and wider partners to be incorporated into ongoing service development.

This approach will support continuous improvement, provide assurance on service quality and outcomes, and establish an evidence base to inform future service development and investment.

Recommendations

Based on the considerations set out in this paper, the following actions are recommended to support the effective and sustainable implementation of the Community Low Vision Service. These are intended to support delivery at scale, maximise use of the existing workforce, and ensure that the service is accessible, consistent and integrated within the wider system.

These recommendations are intended to support ongoing development and implementation of the service and to inform the next phase of delivery in collaboration with the Scottish Government and wider stakeholders.

1

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Recommendation 1: Adopt a Sustainable Financial Model

Scottish Government should adopt a financial model that reflects the full cost of delivering the Community Low Vision Service in community settings and supports sustainable provider participation across Scotland.

A minimum fee of £150 should be provided for an initial or full low vision assessment. This reflects the approximately one-hour appointment requirement and the wider professional input involved, including functional assessment, low vision aid selection, patient education, care planning, documentation and onward referral. It is also supported by Optometry Scotland's indicative community practice-cost modelling, while remaining below the central modelled cost of providing one hour of protected clinical capacity.

A fee of £85 should be provided for a standard face-to-face follow-up appointment of up to 30 minutes. This should apply where the practitioner is reviewing the patient's use of low vision aids, addressing difficulties, providing further instruction, reconsidering support needs or checking the progress of referrals. Where a significant change in vision, functional need or personal circumstances requires a comprehensive reassessment, the full £150 assessment fee should apply.

The assessment tariff should provide sufficient protected time for a sensitive and person-centred consultation. It should not create pressure to abbreviate or rush discussions about permanent or progressive sight loss, changes to independence, functional needs, patient priorities or wider support.
The financial model should also include:

- a separate annual registration and administration payment which reflects the responsibilities placed on providers, including annual recall, records maintenance, reporting, patient enquiries and ongoing low vision aid support;

- proportionate provision for appointments which are not attended or are cancelled at short notice, recognising the loss of protected extended clinic capacity;
- separate and sufficient funding for domiciliary, mobile, remote and island delivery, including travel time, mileage, ferry or air travel where required, equipment transport and lower appointment density; and
- national funding for training, accreditation, digital infrastructure, essential assessment equipment and low vision aids, rather than requiring practices to absorb these costs within the clinical fee.

The service specification should define clearly the activity covered by each payment and the circumstances in which a standard follow-up becomes a full reassessment.

The proposed fees should be reviewed following early implementation using actual service data on appointment duration, follow-up activity, administration, non-attendance, domiciliary provision and provider costs. All fees should thereafter be uplifted through the established annual review process.

2

Recommendation 2: Service Design and Accessibility

Scottish Government should design the service to support local access, patient choice and continuity of care.

Geographic planning and phased rollout should provide adequate coverage without creating unnecessarily rigid boundaries. Patients should be able to access accredited providers across NHS Board boundaries where this would reduce travel, avoid delay or maintain continuity of care.

Domiciliary provision should form part of the national service, but should not be a mandatory requirement for every accredited provider. The service specification should support referral to providers with the appropriate domiciliary expertise, workforce and infrastructure.

Referral arrangements should be supported by clear responsibility for accepting and coordinating domiciliary cases so that patients are not disadvantaged where their usual provider does not offer home-based care.

3

Recommendation 3: Certification of Visual Impairment

Scottish Government should set out a clear national approach and transparent timeline for the development of community-based Certification of Visual Impairment.

Although the CVI pathway is expected to follow the initial rollout of the CLVS, both should be planned in a coordinated way so that patients experience a coherent route into certification, rehabilitation, social care and third sector support. Access to rehabilitation, social care and wider support should be based on patient need and should not be unnecessarily delayed pending certification.

The final model should clarify practitioner eligibility, training and governance requirements, the circumstances in which Hospital Eye Services involvement remains appropriate, and how CVI will align with digital systems and the wider patient pathway.

4

Recommendation 4: Workforce and Accreditation

Scottish Government should establish an integrated workforce model that enables both optometrists and dispensing opticians to act as direct providers of care within their respective scopes of practice. Clear and practical arrangements should be put in place to support dispensing optician participation, including appropriate listing mechanisms.[1,5]

Accreditation and training requirements should be proportionate and quality assured, recognising existing competencies and relevant prior learning where appropriate. This will support participation across the workforce, reduce unnecessary barriers to entry and enable delivery at scale.

Ongoing continuing professional development should be embedded within the service model to support consistency, quality and practitioner confidence. This should be proportionate and aligned to the roles of both optometrists and dispensing opticians.

5

Recommendation 5: System Infrastructure and Delivery

Scottish Government should align procurement, training and digital system development through clear and coordinated timelines to support efficient and timely implementation.

A national low vision aid catalogue should be developed, ensuring access to a clinically appropriate range of optical, non-optical and electronic aids that reflect current practice and patient need.

Service design should support the provision of low vision aids at the point of assessment, where clinically appropriate.

Digital infrastructure should support clinical delivery, ordering, referrals, claims, data capture and service monitoring. Systems should integrate effectively with existing pathways and minimise unnecessary administrative burden within community practice.

6

Recommendation 6: Engagement and Communication

Scottish Government should maintain early and ongoing engagement with Optometry Scotland, ABDO, PSD Scotland and other relevant stakeholders throughout service development and implementation.

Clear and consistent communication with the sector will be important to support awareness, practitioner readiness and confidence in the emerging model. Information should be provided sufficiently early to allow practitioners and employers to understand the service requirements and make informed decisions about participation.

Optometry Scotland is well placed to support this through its established links with community optometry providers and wider stakeholders across Scotland. Engagement should continue through appropriate programme structures, including Short Life Working Groups, and should ensure that practitioner insight is reflected in decisions on service design, training, funding, digital systems, procurement and implementation.

7

Recommendation 7: Integrated Care and Pathway Coordination

Scottish Government should develop the Community Low Vision Service as an integrated pathway, with rehabilitation, social care and relevant third sector partners involved from the early stages of service design and implementation.

The service model should include a clearly defined key/link worker or equivalent coordination function to connect community optometry with rehabilitation, social care and wider support services, help patients navigate the pathway and support continuity between clinical assessment and ongoing support.

The precise model should reflect existing local structures and capacity, while national service standards should define the function, responsibilities and expected links between services. This should include clear referral and communication arrangements across community optometry, Hospital Eye Services, local authority rehabilitation and social care services, and relevant third sector organisations.

Conclusion

The development of a national Community Low Vision Service represents a significant opportunity to improve access to care, support patient independence and make more effective use of community and hospital eye care services in Scotland.

There is a strong foundation on which to build. Previous development work, established service models and current programme activity provide a clear direction of travel. The priority now is to ensure that the final model is deliverable in practice, financially sustainable and capable of being implemented consistently across Scotland.

Effective use of the skills of both optometrists and dispensing opticians, within a wider network of rehabilitation, social care, Hospital Eye Services and third sector support, will be central to successful delivery.

The service should be designed as an integrated pathway rather than a standalone clinical intervention, supported by proportionate training, sustainable funding, flexible local and domiciliary access, and coordinated procurement and digital systems. This will help ensure that patients receive timely assessment, appropriate low vision aids, practical support and coordinated access to rehabilitation, social care and wider support.

A viable financial model will be essential to securing provider participation and maintaining equitable access. It should recognise the full resource required for initial assessment, follow-up, administration and domiciliary delivery, while providing sufficient protected time for sensitive, person-centred consultations that are not rushed. Early implementation should be used to test the proposed funding model against actual service activity and delivery costs.

A collaborative approach will remain essential. Continued engagement between Scottish Government, Optometry Scotland and wider stakeholders will help ensure that the service reflects real-world delivery, supports practitioner participation and responds effectively to patient need.

> **Optometry Scotland Commitment**
>
> Optometry Scotland is committed to working constructively with Scottish Government and partners to support the next phase of development and establish a Community Low Vision Service that is accessible, sustainable and capable of delivering lasting benefits for patients and the wider health and care system.

Appendix 1. Indicative Community Optometry Practice Cost Model

Purpose

Optometry Scotland has developed an indicative bottom-up model to illustrate the cost of maintaining available clinical capacity within a community optometry practice.[12]

The model has been used to inform the proposed minimum fee of £150 for an initial or full low vision assessment and the proposed fee of £85 for a standard face-to-face follow-up appointment.

It is intended to support consideration of the overall scale of practice costs associated with service delivery. It is not a nationally audited cost survey, and individual practice costs will vary according to factors including workforce structure, premises, geography, equipment, business model and service configuration.

Model assumptions

The model is based on an illustrative community optometry practice with:

- one optometrist;
- 2.5 support staff;
- provision for employer costs, including pension and payroll-related costs;
- provision for locum cover;
- 50 working weeks per year;
- 40 working hours per week, of which five hours are allocated to breaks; and
- 35 available clinical hours per week.

This produces a total of 1,750 available clinical hours each year.

The model reflects the full annual cost of operating the illustrative practice. It is therefore a full-cost allocation model rather than an assessment of the marginal cost of adding a single appointment.

The staffing structure is illustrative and reflects the operating model used for the underlying calculation. It should not be interpreted as a recommended staffing model for community optometry practices.

Table A1. Indicative annual community optometry practice costs

Cost category	Included costs	Indicative annual cost
Professional staffing	Optometrist salary and associated employer costs	£68,000
Administrative staffing	2.5 support staff and associated employer costs	£70,000
Locum provision	Cover for annual leave, sickness and other absence	£6,600
Premises and practice upkeep	Rent, rates and water, cleaning and utilities, repairs, renewals and refurbishment allocation	£58,000
Equipment	Equipment leasing, maintenance and depreciation	£34,500
IT, communications and administration	IT, telephone, postage and stationery, communications, accounting and bank charges	£38,800
Professional support and development	Insurance, professional fees and training	£11,000
Travel and motoring	Practice-related travel and motoring costs	£9,000
Total indicative annual operating cost		£295,900

Indicative cost of available clinical capacity

The total annual practice cost of £295,900 has been divided by 1,750 available clinical hours:

£295,900 ÷ 1,750 hours = £169.09 per available clinical hour

This produces the following indicative appointment costs:

Table A2. Indicative cost of available clinical capacity by appointment duration

Appointment duration	Indicative full cost
15 minutes	£42.27
30 minutes	£84.54
45 minutes	£126.81
60 minutes	£169.09

Figures may vary slightly due to rounding.

Application to the proposed CLVS fees

The model indicates that:

- a minimum fee of £150 for an initial or full low vision assessment would remain below the indicative full cost of providing 60 minutes of protected clinical capacity;
- a fee of £85 for a standard face-to-face follow-up appointment would be broadly aligned with the indicative cost of 30 minutes of protected clinical capacity; and
- the assessment and follow-up tariffs should not be expected to absorb costs arising from separately commissioned service components.

Separate funding should therefore be provided for:

- patient registration and ongoing administration;
- low vision aids and associated supply arrangements;
- training and accreditation;
- essential assessment equipment;
- digital infrastructure;
- domiciliary, mobile, remote and island delivery;
- travel and associated expenses;
- any separately commissioned key-worker or pathway coordination function; and
- proportionate provision for appointments which are not attended or are cancelled at short notice.

Limitations

This model is illustrative and should not be interpreted as a definitive national average or a comprehensive economic evaluation of the Community Low Vision Service.

The principal limitations are:

- it is based on one illustrative practice structure rather than a representative survey of Scottish providers;
- actual workforce, premises and equipment costs will differ between locations;
- the model allocates the full operating cost of the practice across the available clinical hours;
- it does not include initial practice acquisition or start-up costs;
- it does not separately quantify differences between urban, rural, remote and island delivery; and
- it does not include the additional national costs of programme management, procurement, digital system development, clinical governance or evaluation.

The proposed fees should therefore be reviewed using actual delivery data during the early phases of implementation. This should include appointment duration, follow-up and reassessment activity, administrative workload, non-attendance, domiciliary provision and provider costs.

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Frank Munro
Chair, Community Low Vision Service Short Life Working Group
Optometry Scotland

Maryam Hussein
Multiple Representative
Vision Express

Kathryn Morrison
Public Services Delivery Scotland

Joanne O'Hanlon
Optometry Scotland

Stephen Pollock
Domiciliary Representative
OutsideClinic

Linda Quinn
Hospital Eye Services Representative
NHS Borders

Brenda Rennie
ABDO Scotland

Richard Spruce
Optometry Scotland

Graeme Stevenson
ABDO Scotland

Eilidh Thomson
Optometry Scotland

Denise Voon
The College of Optometrists

Kevin Wallace
Association of Optometrists

Johnathan Waugh
Independent Representative

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Registered Office:
Clyde Offices, 2nd Floor
48 West George Street
Glasgow
G2 1BP

office@optometryscotland.org.uk
www.optometryscotland.org.uk

optometryscotland