**RWPN registrant-members COVID-19 survey –**

**1st October 2020**

Our COVID-19 survey was set to all full members of RWPN (i.e. registered Vision Rehabilitation and Specialist Habilitation Workers) in the week of 21st September 2020.

**Individual personal circumstances**. It is important to acknowledge that there are members who are currently not able to carry out home visits for personal reasons or reasons related to their PA. We recognise that this is a frustrating and difficult time for those professionals and that any findings presented here should not be used to imply that these professionals should be working in any other way than they are at present. Whilst we would want to support any member who feels they are able to resume a more normal working (where it is safe to do so), we would also want to support any member who is in the opposite position and feels that their personal circumstances are not being acknowledged.

**Survey results**

1. **Response rate**

We received **170** responses to our survey, which (at 47% of full members) is a really excellent response, and one that allows us to use these findings with confidence that they represent the state of play for the workforce. This response rate was around 45% **(135)** of our England members, 54% (**21**) of our Scotland members, 37% (**10**) of Wales members and 50% (**2**) of NI members. (2 did not state).

77% of the total said they worked under statutory contract and 23% worked for non-statutory providers in the four nations. Knowing the type of service provided matters because voluntary sector organisations had to make different decisions from statutory workers around how staff were employed during lockdown.

1. **Frontline Worker?**

87.5% of all full members felt they were front line workers and 12.5% said they were not. 91% working in statutory provision and 71% working in the non-statutory sector felt they were front line workers.

One respondent said their team had been “classified like reablement home care staff who perform personal care” allowing a greater level of access to clients than the standard care management structure.

1. **Current work pattern**

Because individuals' work situations are so varied this question produced a number of nuanced responses which are hard to capture in a brief summary.

Across all respondents

* 43% doing some outdoor O&M and some home visiting
* 21% doing at least 50% of outdoor O&M and home visiting
* 15% doing some outdoor O&M and no home visiting
* 11% doing no home visits but willing and able to do so
* 8% currently not able to do home visits “due to my or my PA’s situation”
* 2% only essential visits in extreme circumstances

There was no significant variation across the nations. The higher percentage of those not currently carrying out home visits but willing do so were working in non-statutory provision.

Some respondents work with children and some in residential settings so their situation was also driven by those settings. Some people volunteered the information that they were only undertaking one visit per day, and it is likely that more would have indicated this if we had given it as an option. 2 respondents in local authorities are still redeployed outside sensory work.

All-in-all **64% of professionals are undertaking some regular** **O&M and home visiting** and **79% are doing some regular visiting of some description**. This included a handful of respondents who told us they had resumed home visiting in the last week. The word “essential” was mentioned frequently. One respondent commented “our guidance has been to undertake a visit only when **not** to do so would be detrimental to the safety and wellbeing of the client”. Yet the response of another was “essential! – it’s all getting to the point of essential now” may reflect how the definition of essential is changing over time and client needs have grown. A very small number of respondents said their local authorities are not allowing home visits or only “in life-threatening situations”. And it must not be forgotten that at least 12 colleagues are not able to do home visits and not all feel that their situation is understood, (including by some fellow professionals).

1. **Work capacity**

Across all respondents

* 60% “doing roughly the right amount of visits given the situation”
* 30% “not doing as many visits as I feel able or want to”
* 7.5% “I am not currently able to undertake home visits due to my (or my PA’s) situation
* 2.5% “I am doing more visits than I feel capable of or want to”

Of those saying they were saying the balance is about right, the balance was broadly the same across England, Wales and Scotland.

Of those who were able to, and felt they wanted to do more, again the balance was the same across the nations but 30% in this category were from the non-statutory sector (though they made up 23% of respondents).

60% of respondents saying the balance of working practice is about right is reassuring, especially from the point of view of professional morale. With roughly one third wishing they were able to do more (a view we would imagine is shared by those unable to work for personal reasons), this is a concern.

A number of respondents highlighted the lack of available interpreters and other supporting services as a barrier to home visiting.

1. **Client time on the waiting list for majority of clients**

Across all respondents

* 68% waiting time has grown
* 13% waiting time has reduced
* 11% waiting time stayed roughly the same
* 8% don’t know

The percentage of respondents across the four nations who said waiting times had grown was: Scotland 76% of respondents, Wales 70%, England 64%, NI 50%.

Waiting times had increased in responses from 66% of statutory providers and 68% for non-statutory providers

1. **Effect of COVID on levels of demand for the service**

Across all respondents

* 39% demand has remained largely the same
* 26% demand has slightly increased
* 13.6% demand has greatly increased

(=39.6% an increase of some kind)

* 13% demand has slightly decreased
* 8.4% demand has greatly decreased

(=21.4% a decrease of some kind)

37% of statutory providers felt there was an increase in demand at some level, and 42% of non-statutory respondents felt there had been an increase in demand.

**RWPN’s current position**

It has been encouraging that 4-nation voluntary sector organisations have not only worked with us during the crisis, but have taken our lead on matters related to rehabilitation working practices. We, in turn, have learned much from what you have been telling us about the day-to-day impact of COVID-19 on your clients and on you.

Our position is that rehabilitation and habilitation with blind, partially sighted and deafblind people must include elements of face-to-face contact if we are to: ensure their physical and mental wellbeing; safeguard against any manner of risk; deliver safe independence training. RWPN’s Assessment of Professional Risk can be found via our [website](https://www.rwpn.org.uk/resources/Documents/VRW%20professional%20risk%20matrix%20%282%29.docx). It categorises the range of risks involved in our professional practice, including the risk of not undertaking intervention.

Phone assessments and increased use of technology certainly have a role to play and we should maximise their use where possible, but the communication difficulties inherent in sight and hearing loss will always exclude some from these options and especially the most vulnerable and isolated of our clients.

Apart from care settings, a blanket prohibition on home visiting has not been part of COVID-19 health and social care restrictions for the administrations of the four nations. The more recent local measures may be the new normal for a considerable length of time and, to date, health and social care restrictions (outside care settings) are not included in local prohibitions. Our survey has found that demand for rehabilitation is growing in many areas and waiting times are growing in almost all settings. Even if NHS eye treatments become restricted once more, the evidence is pointing to a growing number of referrals where the social, physical and emotional consequence of sightloss and are creating emergency scenarios.

**Therefore, where it is safe to do so for the worker and the client (and where the client is willing) a home visit should be considered. Such visits should be risk assessed according to nation guidelines, employer guidance and in line the guidance endorsed by RWPN, RNIB, Guide Dogs, Thomas Pocklington Trust and Visionary.** We believe there is no justification for redeployment of sensory professionals to non-sensory services within a local authority setting and any universal prohibitions on home visiting should be reconsidered.

**Actions we are taking**

* Sharing results of this survey with employers and sector campaigning organisations. A better shared understanding of the current state of services will support better targeted advocacy on behalf of our service users.
* Ensuring that our guidance is kept up-to-date and reflects practice across the four nations. In England the guidance is shortly to be supported by ADASS. RNIB has recently written to all 151 local authorities in England to promote the guidance and re-iterate ADASS’s 2016 guidance on vision rehabilitation and the recent Ombudsman’s judgement. In Scotland we are working with sector colleagues to disseminate a Scottish version of the COVID guidance via the Scottish government’s See Hear network.
* Supporting individual members where issues arise with employers in relation to COVID practice. We have already supported individuals in a couple of settings where they have wanted to return to more normalised work routine but were meeting resistance from their manager. Responding more generally, one member suggested we work more closely with unions (which, for the majority, is Unison). Unions and professional bodies bring different skills to resolving difficulties. We believe our role is to explain what the job entails, its working practices, risks and demands, how these risks are managed and explore how any proposed changes to working conditions affect the ability to carry out the professional role and its effects on the welfare of the individual and their clients. The role of the union is around employment law and legal rights. Where all parties are talking, there is a better chance of resolution.
* Sharing risk assessments. RWPN’s guidance appears to have been well received and has supported risk assessments being drawn up relating to home visiting and O&M. Where we have permission to share risk assessments, these will be posted on our website.
* Raising the profile of vision rehabilitation as part of a much wider drive to highlight the value of rehabilitation, particularly where COVID has impacted on waiting times and demand. RWPN is a member organisation of the Community Rehabilitation Alliance, a grouping that includes the Royal College of Occupational Therapists, the Chartered Society of Physiotherapists and national charities. This is our shared manifesto [here](https://www.csp.org.uk/system/files/publication_files/001669_PUK%20MANIFESTO%202019_MOB%201ST_0.pdf).
* CPD opportunities. We will continue to flag up useful CPD resources. Our on-line AGM on Thursday 12th November will include a webinar from Debbie James on services for Deafblind people, especially during the pandemic. Members will also be receiving an Zoom invitation very shortly to an initial training event we are putting on with Sight and Sound Technology.
* Research. We will input into research that looks at the short and long term impact on blind and partially sighted people of COVID and COVID-related measures.