Developing Sustainable Glaucoma Monitoring Pathways in Primary Care:

Learnings from Gloucestershire, Shropshire, Essex and Norfolk & Waveney

Ophthalmology continues to be the busiest outpatient specialty in the NHS, with glaucoma care contributing significantly to the growing demand on hospital eye services. The NHS 10-year plan promises a shift from hospital-based care to services delivered in the community, and there is increasing recognition of the potential for primary care optometry to play a central role in sustainable glaucoma monitoring. With both the clinical capability and professional interest, optometrists in primary care are well-positioned to support this transformation.

This case study explores the development of community-based glaucoma monitoring pathways in Gloucestershire, Shropshire, Essex and Norfolk & Waveney, highlighting how these areas have implemented models that improve access, reduce the burden on secondary care, and maintain clinical safety. Learnings from these initiatives offer valuable insights for wider adoption across England.

LOCs Across England Share Their Experiences

Gloucestershire LOC

Gloucestershire LOC has delivered community glaucoma services — Glaucoma referral filtering and monitoring focusing on untreated or low-risk ocular hypertension (OHT) — for over 15 years.

- **Model**: Accredited Optometrists monitor stable OHT patients according to a hospital defined management plan, retaining autonomy for routine management and decision-making within agreed clinical parameters. Strict referral back criteria ensure clinical safety and oversight.
- **IT**: Adoption of Opera has significantly improved communication, enabling direct transfer of clinical data between primary care optometrists and the hospital trust. Gloucestershire also benefits from a Community Ophthalmic Link, which allows optometrists direct access to hospital records, visual fields, imaging and correspondence in real-time, enhancing continuity of care.
- **Engagement**: Currently, 5–6 practitioners remain active in the service, reflecting the limited number of eligible patients.
- **Future Direction**: A newly appointed glaucoma consultant is seeking to expand the service to include treated OHT and low risk suspect glaucoma patients. This aims to address a backlog of patients with treated OHT and/or low risk treated glaucoma who are currently overdue hospital appointments.
- **Learning**: Maintain service quality by scaling proportionately, strengthen IT integration to support efficient data sharing, and foster collaboration between hospital and primary care through shared governance and regular communication.

Shropshire LOC

The Shropshire Local Optical Committee (LOC) is advancing several initiatives to improve glaucoma care and strengthen primary care optometry enhanced services. Previously, Glaucoma care was delivered by a community ophthalmic provider, but feedback from patients and practitioners highlighted significant issues and the need for reform.

Meanwhile, the local hospital trust, which faces long waiting times, prioritises moderate to high-risk glaucoma patients, leaving a gap in care for low-risk and stable cases. This has reinforced the importance of demonstrating how primary care optometrists can safely manage these patients in community settings.

The LOC has built strong relationships with the Integrated Care Board (ICB) and local trust, and over the past few years, has been actively upskilling the local workforce — including optometrists, dispensing opticians, and contact lens opticians — through funding secured by the Local Eye Health Network (LEHN). The LEHN has committed to funding further higher qualifications in the coming year, to include college higher qualifications in glaucoma, supporting workforce readiness for service implementation.

Primary Eyecare Services Limited (PES) secured the contract for all local enhanced eyecare services. The Glaucoma Repeat Readings (GRR) service launched in July 2025, followed by Glaucoma Enhanced Case Finding (ECF) in August 2025. The Glaucoma Monitoring service has been commissioned and is expected to be implemented at the start of 2026.

Discussions between Shropshire LOC, PES, the ICB and NHS Trust are shaping the Glaucoma Monitoring pathway, drawing on proven models from Cheshire and Hampshire. The plan will see low-risk, stable Ocular Hypertension (OHT) patients on treatment discharged to primary care optometry, monitored by local optometrists who hold a Professional Certificate in Glaucoma. These practitioners will perform a monitoring assessment, to a locally agreed protocol and provide interim recommendations for management.

Other initiatives include a targeted outreach campaign by the LOC, contacting all practices on their mailing list to invite expressions of interest in LEHN-funded further training. Priority was given to practices without a glaucoma-certified optometrist and practitioners working primarily in GOS settings who had not previously accessed LEHN funding. This approach aims to ensure equitable access and good coverage across the ICB footprint.

In partnership with the hospital trust, the LOC has also established a series of Managed Clinical Networks consisting of specialty-focused working groups meeting quarterly. Each working group is led by an optometrist with a specialist interest, or desire to develop in a particular area, working alongside a corresponding lead from the hospital trust. Group members participate in shared learning and shadowing across subspecialties such as eye casualty, medical retina, glaucoma and paediatrics. These meetings enable case discussions and professional development and improved communication between optometry and ophthalmology.

Essex LOC

South Essex was one of the earliest areas to commission a community Glaucoma Monitoring Service from Optometry, co-designed by the LOC, HES, and commissioners to tackle increasing numbers of overdue follow ups.

- **Model**: Patients are directed from hospital to accredited optometrists for follow-up, in the community. Using a shared clinical protocol and hospital-supplied template, optometrists perform the required tests and upload data to Opera (a secure digital platform that facilitates communication and data sharing between primary and secondary care). If the patient is deemed stable, they continue to be monitored in the community, as predetermined by the supervising ophthalmologist. Note: the original protocol required six-monthly intervals. Optometrists can also "red-flag" patients and request Advice and Guidance via Opera when clinical concerns arise.
- **Governance**: All test results are forwarded to the Hospital Eye Service (HES). HES ophthalmologists initially conducted a virtual review after every third appointment; following strong audit outcomes and high levels of trust, this has now been extended to every fifth appointment. The six-month recall has also been extended to annual recalls for stable, low-risk patients.
- **Accreditation**: Optometrists participating in the pathway are required to work a certain number of sessions in the hospital glaucoma clinic before the ophthalmologist signs them off. There is verbal agreement to change this to holding a Professional Certificate in Glaucoma, but this has not yet been implemented and agreed by the trust.
- **Impact**: The pathway has led to a reduced burden on secondary-care high levels of patient satisfaction, and no reported safety incidents. Around 9 practices are actively involved in service delivery.
- **Learning**: Joint audit and transparent governance are critical for building and maintaining confidence between hospital and primary care optometrists. This has also enabled several service modifications to improve service delivery.

In North East Essex, a variant model focuses on batch data gathering rather than direct clinical decision making.

- **Accreditation**: To be accredited the optometrist must hold the Professional Certificate in Glaucoma and also be formally signed off by the hospital ophthalmologist.
- **Model**: Accredited optometrists perform a set of tests specified by the hospital including visual fields and Optical Coherence Tomography (OCT) which are then reviewed by the HES.
- **Specifics**: These tests are conducted without decision making responsibility. The results are securely transferred to the HES via Opera for review by the Lead Ophthalmologist.
- **Issues**: Participation is limited to a small number of practices due to strict equipment requirements, including the use of a Humphrey Field Analyzer (HFA).
- **Patient Choice**: This is discussed and finalised during the last hospital appointment, after which the notes are then downloaded onto the Opera platform for the optometrist to access and subsequently liaise with the patient.

Learnings:

- Fewer optical practices participating in the North East Essex model due to restrictive equipment requirements.
- Hospital led accreditation, while effective in maintaining clinical relationships and confidence, can also act as a barrier to wider participation.

Norfolk and Waveney LOC

In Norfolk and Waveney, community-based monitoring for patients with suspected glaucoma and untreated OHT has been shown to be safe and effective. All patients are reviewed in the HES after five years of community-based monitoring for a formal reassessment.

Following an audit, the Trust expressed high confidence in the quality of the service and is now considering whether the five-year review needs to remain in-person or whether a virtual assessment may be appropriate. Stable treated OHT may also be suitable for inclusion within the service.

Further information can be found **here**.

Tips for LOCs Looking to Implement Glaucoma Monitoring Services

1. **Co-design pathways early** with the ICB, trust, and community provider to ensure shared governance and clarity.
2. **Upskill the workforce** ahead of service implementation, recognising the ongoing cost and resource implications of workforce training.
3. **Prioritise a wide and realistic equipment specification**, especially for field screening, and consider carefully whether mandatory dilation adds sufficient value to justify the extra cost.
4. **Start small, build quality**, and scale the service based on outcomes and available capacity.
5. **Create clear clinical protocols and escalation routes** with hospital clinicians to ensure safety and confidence.
6. **Use shared IT systems** to support consistent communication and virtual review.
7. **Embed joint audit cycles** to maintain trust and evidence service quality and outcomes.
8. **Improve equity of access** by including rural or under-represented practices where possible.
9. **Establish robust discharge and recall processes**, people attending for glaucoma monitoring requires more robust recall processes than for sight testing and this needs careful consideration by practice management teams.

Supporting Information

LOCSU Glaucoma Referral Clinical Pathways
NICE Guidance (NG81)

Aknowledgements

Gloucestershire LOC, Shropshire LOC
Essex LOC, Norfolk and Waveney LOC