

Developing Sustainable Glaucoma Monitoring Pathways: Dual LOC Case Study

Transforming Glaucoma Care Through Community Monitoring

Executive Summary

Northumberland, Tyne and Wear Local Optical Committee (NTW LOC) and Ashton, Leigh and Wigan Local Optical Committee (ALW LOC) have implemented community-based glaucoma monitoring services to reduce pressure on Hospital Eye Services (HES) by transferring clinically stable, low-risk patients into accredited optometry practices within the community.

The services provide structured discharge from HES with defined management plans, ensuring safe monitoring, appropriate recall and timely escalation where needed. Across these pathways, over 80% of patients were safely managed within community practice, releasing hospital capacity while maintaining high clinical standards and excellent patient satisfaction.

These models demonstrate how strong collaboration between LOCs, primary care optometrists and HES can deliver scalable, patient-centred glaucoma care closer to home while protecting specialist hospital capacity.

Introduction

Across England, thousands of low-risk patients remain on hospital glaucoma clinic waiting lists, despite being clinically stable and suitable for community review.

NTW LOC and ALW LOC have taken decisive steps to change this, implementing a community-based glaucoma monitoring enhanced service across their areas that shifts routine care closer to home while protecting hospital capacity for patients with sight-threatening disease.

These pathways demonstrate how structured collaboration between LOCs, primary care optometrists and HES can deliver safe, scalable and patient-centred glaucoma care.



Background

Both areas faced significant pressure on secondary care glaucoma clinics, with increasing numbers of stable, low-risk patients requiring long-term follow-up.

This resulted in long glaucoma waiting times for both new referrals and follow up appointments. In line with national drivers for care closer to home and improved outpatient transformation, each Integrated Care Board (ICB) commissioned a glaucoma monitoring service in January 2025 delivered by accredited optometrists within the community. The provider for both services is Primary Eye Care Services Limited (PES).

The services focus on monitoring the following conditions:

Area	Conditions monitored within the service
Northumberland, Tyne and Wear	<ul style="list-style-type: none"> - Glaucoma suspect - Untreated primary ocular hypertension (OHT)
Ashton, Leigh and Wigan	<ul style="list-style-type: none"> - Glaucoma suspect - Untreated primary ocular hypertension (OHT) - Early primary open-angle glaucoma (POAG) - Primary angle-closure suspect - Treated primary ocular hypertension - Secondary ocular hypertension

The patients seen within the services are initially managed and diagnosed by the HES. They are then discharged into the community service, if deemed suitable, with a defined management plan, baseline data, and a target date for follow-up. All patients are considered clinically stable and stratified as 'low-risk' using GLAUC-STRAT-FAST.

The services enable optometrists to conduct a glaucoma assessment and determine stability of the condition, recall interval, and escalation where appropriate.

Both pathways directly support reduced demand on HES clinics, more efficient use of specialist ophthalmology capacity and a shift towards multidisciplinary glaucoma care.

Service Model

1. Patient Referral and Transfer

There is a structured process for transfer into the pathway, which includes:

- Identification of suitable low-risk patients by Boston House Eye Unit (Wigan, Wrightington and Leigh [WWL] Trust) in ALW and the Newcastle Eye Department (Newcastle upon Tyne Hospitals [NuTH] Trust) in NTW.
- Provision of baseline clinical data including visual acuity (VA), intraocular pressure (IOP), central corneal thickness (CCT), optical coherence tomography (OCT), Visual fields (VF), diagnosis and a management plan.
- Allocation of a target appointment date to support timely review.

Referrals are managed through the provider IT platform (PES). Optometric practices must formally accept patients on the IT platform before appointments can be booked. Prior to acceptance, all relevant clinical information is shared, including clinical history, date of diagnosis, current and previous treatments, target IOPs, most recent OCT scans and visual field results.

The accepting optometrist reviews the information to confirm that the patient falls within their scope of competence and that sufficient information is available to safely undertake ongoing monitoring before formally accepting the patient into the pathway. If these criteria are not met, the optometrist may reject the referral and/or request further information.

2. Clinical Examination requirements

Across both areas, primary care optometrists are required to complete a comprehensive glaucoma assessment, including:

- Detailed history and symptoms.
- Visual acuity (VA).
- Intraocular pressure (IOP) using Goldmann tonometry (Perkins contact tonometry can be used if Goldmann tonometry is not possible due to patient mobility etc).
- Full threshold visual field assessment (VF) with equipment capable of producing a report. (For NTW any visual field analyser with a full-threshold 24-2 programme is acceptable such as Humphrey SITA Fast 24-2 or Henson 8000/9000 Zata Fast 24. For ALW, full threshold testing is required; 24-2 testing is not specifically stipulated).
- Fundus photography of optic nerve head and Optical Coherence Tomography (OCT) imaging of optic nerve head and macula.
- Optic nerve head assessment using slit lamp biomicroscopy (pupil dilation required for all patients unless contraindicated/ risk of angle closure).
- Anterior chamber assessment using Van Herick's technique.

Clinicians record all findings on the provider IT platform, upload all imaging and test results, and make a stability decision based on the management plan. The examining optometrist discusses the findings and outcome with the patient.

3. Clinician accreditation

Accreditation requirements for optometrists include:

- Glaucoma-specific certification (WOPEC Glaucoma Level 2 or College of Optometrists Professional Certificate in Glaucoma for NTW and Professional Certificate in Glaucoma or Manchester Royal Eye Hospital equivalent qualification for ALW).
- Ongoing Continuing Professional Development (CPD) requirements including CPD developed in conjunction with HES colleagues to ensure a cycle of continuous learning is embedded to support service delivery.

4. Governance and IT infrastructure

The provider IT system supports digital referral management, recall tracking and failsafe processes to identify patients who have not been booked, have not attended (DNA), or whose review date has exceeded the agreed target timeframe.

The platform enables the secure upload of diagnostic test results and images as well as the generation of outcome letters to patients and GPs. Clinical records are available for audit, governance, and oversight. Both services require evidence of IOP stability, no VF progression and OCT RNFL stability before continuing monitoring. Standardised OCT, VF and IOP requirements support safe decision-making across all practices.

The optometrist refer patients back to HES where there is evidence of disease progression or where findings fall outside the agreed management plan. Clear urgent and routine escalation pathways are in place to ensure timely secondary care review when required.



Pathway Implementation

The examining optometrist determines the clinical outcome and recall interval in line with the agreed management plan and service specification, including whether the patient is stable, unstable, or requires escalation. Where clinically appropriate, patients may be discharged from the service into routine sight testing.

All clinical results, including OCT imaging and visual field plots, are uploaded to the IT platform and are available for audit, governance and oversight. Additionally, if the optometrist is no longer working or takes extended leave, then the patient information can easily be transferred to another providing optometrist as all the data is on the IT platform.

Service Activity and Outcomes

1 January 2025 to 31 December 2025

Northumberland, Tyne and Wear Service Data

During 2025, 97 patients were monitored through the NTW glaucoma monitoring service, with 103 clinical consultations delivered.

The majority of patients were safely managed within primary care:

- 81.4% (79 patients) continuing within the community monitoring service with no requirement for escalation to secondary care.
- 7.2% were discharged in line with management plans.
- 11.4% required referral back to secondary care, including 9.3% for glaucoma progression and 2.1% for non-glaucoma related reasons.

Patient experience was consistently positive. All 35 respondents (100%) to a patient satisfaction questionnaire would recommend the service to a friend or family member, with 94.2% rating their experience as 6 or 7/7 on a 1-7 scale with 7 being excellent, citing clear communication, shorter waiting times and care delivered closer to home.

“ I particularly liked the way the [optometrist] explained everything he was doing and why.

He shared all of the images of my eyes with me. I very much appreciated attending a venue much closer to home and in a much less pressurised environment.

Patient comment ”

“ Excellent friendly service, not rushed, time taken to explain everything fully including results. Came away satisfied and reassured.”

Patient comment ”

“ The appointment was local to my home so no issue with travel or parking. Quick and on time, so less personal time spent attending.

Patient comment ”

Service Activity and Outcomes

1 January 2025 to 31 December 2025

Ashton, Leigh and Wigan Service Data

In ALW, 42 patients were monitored through 43 clinical consultations in 2025.

Outcomes showed:

- 81.0% patients continued within the community monitoring service.
- 2.4% were discharged in line with management plans.
- 16.7% required referral to secondary care, including 14.3% for glaucoma progression and 2.4% with red flag symptoms or signs requiring urgent HES referral.

All patient experience respondents (100%) would recommend the service to a friend or family member, with feedback highlighting personalised care and clear explanations.

Overall Impact

Across both pathways, over 80% of patients were safely managed in community optometric practice, releasing hospital capacity while maintaining high clinical standards and excellent patient satisfaction.

Referrals back to HES were appropriate and targeted, ensuring timely escalation for patients showing disease progression.

These pathways have laid the foundation for expanding community glaucoma monitoring across the wider region.

The model demonstrates how any ICB can safely shift low-risk glaucoma care into primary care while maintaining quality and reducing pressure on overstretched HES clinics.

Key Challenges and Enablers

1. Equipment Requirements

No specific equipment is mandated beyond the requirement for practices to have visual field analysers capable of performing a full-threshold 24-2 programme for NTW and a full-threshold programme (not limited to 24-2) for ALW. This flexibility supported wider participation across practices. Additionally, patients are required to have OCT scans and Goldmann tonometry readings.

2. Workload and Data Quality

Accurate and comprehensive data entry on the IT platform is essential for clinical safety and governance. While initially perceived as time-consuming, practices reported that recording became significantly more efficient once clinicians were familiar with the system.

Ashton, Leigh and Wigan LOC

In ALW, the Glaucoma Enhanced Referral Service (GERS), which includes glaucoma repeat measures and enhanced case finding, were commissioned 12 months prior to the introduction of the glaucoma monitoring service. This phased commissioning played a crucial role in building relationships and trust between primary and secondary care.

Historically, secondary care had concerns regarding the quality of optometric glaucoma referrals. However, GERS led to positive outcomes and demonstrable improvements in referral quality, enhancing hospital confidence in optometrists' clinical capabilities. This confidence-building was one of the biggest challenges in implementing the glaucoma monitoring service.

Additionally, to upskill the local optometric workforce, Greater Manchester ICB funded 75% of the cost of the Professional Certificate in Glaucoma training for 47 practitioners, with the optometrists funding the remaining 25%. Completion of professional glaucoma qualifications or WOPEC Glaucoma Level 2 provided assurance to ophthalmologists, the ICB and PES that optometrists were competent to safely monitor glaucoma patients. The certification also gave optometrists confidence in their clinical decision-making.

The majority of patients managed within the pathway are glaucoma suspects or individuals with stable, low-risk glaucoma and glaucoma-related conditions.

In addition, glaucoma specific CPD has been delivered virtually plus a full day in-person CPD event is planned for May 2026. This CPD has been organised and funded by the Greater Manchester (GM) Optometry Excellence Programme and supported by Manchester Royal Eye Hospital. GM Optometry Excellence Programme has also established a Glaucoma Support Network for all practitioners providing ECF or glaucoma monitoring in the area, the network fosters peer discussion to boost confidence and reduce practitioner isolation. GM Optometry Excellence Programme is part of wider Excellence programmes for all primary care disciplines in GM which works collaboratively with LOCs to identify priorities.



Northumberland, Tyne and Wear LOC

In NTW, pre-COVID-19 discussions between the LOC and the Newcastle Eye Department, run by Newcastle upon Tyne Hospitals (NuTH) Trust, highlighted significant capacity constraints within secondary care glaucoma clinics, compounded by limited glaucoma consultant availability within the ophthalmology department.

In response, the CCG (now ICB) commissioned a basket of enhanced services, including ECF, GRR and glaucoma monitoring, supported by a single point of access email for all referrals. The introduction of ECF was instrumental in building practitioner confidence, particularly in optic nerve head assessment and OCT interpretation, which underpinned the safe delivery of the glaucoma monitoring service.

Both LOCs reported that discharges from HES into the optometry services were implemented gradually, using a phased or “drip-feed” approach. This incremental transfer of patients allowed confidence to build across both primary and secondary care teams and supported safe, sustainable implementation of the pathway. However, bulk discharge can also be managed safely in areas with multiple participating practices, where patient distribution reduces the risk of overwhelming individual providers.

Top 5 Learnings for LOCs

1. Consistent clinical protocols are essential

Standardised assessments and clear escalation triggers improve patient safety and build clinician confidence.

2. Strong digital infrastructure underpins safe delivery.

Robust IT systems, enable effective communication, centralised failsafe processes, and clear audit trails, supporting scalable and sustainable pathways.

3. Early collaboration is critical

Successful pathways depend on early engagement with HES and strong working relationships with ICBs.

4. Workforce upskilling must be planned ahead

Planning and investing in training before commissioning ensures optometrists have the skills and equipment needed to deliver care safely.

5. Patient satisfaction sustains services

Positive patient experience is a key driver for ongoing support and continuation of community-based services.

Additional Practical Learning Points

- Prime provider companies with their roots in primary care optometry, such as PES, provide essential management, oversight and clinical governance which offer assurance and confidence to commissioners and HES colleagues. They are also valuable intermediaries; queries by optometrists can be collated by the provider company and addressed collectively to the trust, reducing the administrative burden on trusts and ensuring smoother communication.
- Practices should consider accessibility, including locating OCT and visual field equipment on ground floors where possible to accommodate patients with reduced mobility.
- Allow time to become familiar with both the patient processes and the IT platform. Building additional appointment time initially and developing practice record templates which match the IT system template to support efficiency.
- From a practitioner perspective, delivering glaucoma monitoring services helps to keep clinical skills fresh and hone your professional practice.



Seeing patients within the monitoring service has enhanced my scope of practice, helped utilise my further qualifications, and has been a satisfying and enjoyable part of my workload.

John Davidson, Optometrist



Ongoing Commitments

- Long-term success requires ongoing engagement with trusts, especially when there are consultant team changes, including periodic reminders to continue patient transfers into the service.
- LOCs must actively support optometrists, recognising that delivery of glaucoma monitoring services represents a new and expanded role for many practitioners. Ongoing support is essential to build confidence, ensure consistency and maintain safe practice as optometrists adapt to this extended scope of care.
- ALW and NTW LOCs highlighted the importance of identifying solutions to practical barriers and remaining flexible to meet the needs of patients, practices and secondary care.

Future Directions

Both LOCs are exploring opportunities to:

- Expand monitoring to additional glaucoma patient cohorts.
- Further strengthen community-hospital relationships and communication links.

Following recent NHS Confederation project discussions in NTW, NENC ICB is considering both the ECF and stable glaucoma service as an initial blueprint for the wider ICB roll-out. Work is underway to map glaucoma activity data across trusts to fully understand demand and capacity pressures.

Conclusion

The experience of NTW and ALW LOCs demonstrates that well-governed primary care led monitoring pathways can safely and sustainably transform the delivery of glaucoma care. By transferring long-term monitoring of stable, low-risk patients into accredited optometric practice, these models have released meaningful capacity within HES while maintaining high clinical standards and robust governance.

Crucially, success has depended on strong, trusted relationships between primary and secondary care, developed through shared clinical oversight. The LOCs felt that phased implementation - the gradual “drip-feed” of patients into the service - enabled confidence to build across both primary and secondary care teams, supporting safe delegation of care. However, the transfer of a larger cohort of patients can also be implemented successfully, depending on local capacity and overall service design.

For patients, community-based monitoring delivers significant benefits, including improved access, reduced travel and parking burdens, shorter appointments, and continuity of care closer to home. For practices, enhanced services strengthen patient relationships, support ongoing professional development, and embed glaucoma care as a core component of advanced optometric practice. Patients frequently choose to book their routine sight tests with the same practice delivering the enhanced service.

These pathways have also driven workforce development, with growing numbers of optometrists pursuing glaucoma qualifications and expanding their scope of practice. Collectively, this demonstrates that primary care optometry is not only capable of delivering safe glaucoma monitoring but is essential to the long-term sustainability of glaucoma services.

NTW and ALW provide a practical, scalable blueprint that other LOCs and ICBs can adopt to relieve pressure on secondary care, maximise the existing workforce and deliver high-quality glaucoma care closer to home as part of an integrated eye care system.

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Supporting Information

[LOCSU pathways - GRR, GERS, ECF and Glaucoma monitoring](#)