Policy paper

Association of Optometrists

Health inequalities in the detection and severity of glaucoma

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Recommendations for improving early diagnosis and protecting sight for communities most at risk of glaucoma



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Executive summary

This report explains how glaucoma is being detected later and at a more severe stage for people living in more deprived areas of the UK. It also highlights that people of Black African or Black Caribbean heritage are at least doubly at risk.

Glaucoma can cause permanent sight loss if it is not found and treated early. Because early glaucoma often has no symptoms, regular sight tests are one of the most important ways to find it before serious damage is done. Evidence shows a clear inequality of diagnosis across the UK.

People in more deprived communities are less likely to access routine eye care and are more likely to be diagnosed only when glaucoma has already caused more advanced visual field loss. Some ethnic minority communities also appear to face greater risk, lower awareness, and lower engagement with eye care services. The reasons for this disparity remain unclear, but issues of trust, awareness, access, and how services are designed around the needs of local communities have been suggested as drivers.

Community optometry has a central role in closing this health equality gap. Most glaucoma referrals into secondary care are generated by community optometrists, and patient survey evidence shows that many people who are diagnosed with glaucoma are first identified through community optometry, often through a funded NHS sight test. This means that optometrists are already an important route into glaucoma care, but they are not being used to best effect by local health systems.

The wider policy environment creates an opportunity to act on this. The Government's 10 Year Health Plan for England, the neighbourhood health framework, and recent GIRFT best practice guidance all support a shift towards prevention,

community-based care, better use of data, and more efficient pathways. These themes fit closely with the role community optometry could play in identifying people at higher risk of glaucoma earlier, particularly through targeted outreach programmes and better integration with local NHS pathways.

In the report, we further argue that improving outcomes will require more than simply encouraging people to attend for regular sight testing. If awareness activity leads to more people being diagnosed earlier, the system must be ready to manage that increase in demand. This means strengthening glaucoma pathways to include primary eye care more widely, improving referral systems, supporting community-based monitoring post-diagnosis where appropriate and ensuring that hospital eye services have capacity for treating the more complex cases.

Summary of recommendations

1. **Run targeted public awareness campaigns, working with community leaders and health champions**
2. **Include sight tests in NHS Health Checks at age 50**
3. **Commission a targeted glaucoma outreach service**
4. **Collect better qualitative data**
5. **Strengthen local glaucoma pathways**
6. **Update and promote NICE guidance on opportunistic glaucoma testing**
7. **Use data to target action**
8. **Plan capacity before increasing demand**

Introduction

Glaucoma is a group of eye conditions where the optic nerve is progressively damaged. It is commonly associated with raised intraocular pressure (IOP) and typically develops gradually over several years, mainly affecting peripheral vision first, it will progress to more widespread loss of sight. It is one of the world's major causes of blindness if left untreated.

In the UK, there are half a million people living with glaucoma and 10% of all blindness is due to some form of the condition[1]. The most common type of glaucoma in the UK is Primary Open Angle Glaucoma (POAG), affecting 2% of individuals older than 40 years and 10% of individuals older than 75 years, it is particularly prevalent in black African or black Caribbean people.[2] Globally, it is estimated that people of African descent have a 2.8 times higher prevalence of glaucoma compared to those of European descent. Adding to this, glaucoma patients of African descent have younger disease onset, more rapid progression, and overall worse outcomes compared to their European counterparts.[3] By 2032, the amount of people in the UK with glaucoma is expected to increase by 17% from 718,000 currently to approximately 843,000 cases.[4],[5]

Vision lost to glaucoma is permanent. If not diagnosed early enough, visual field loss can adversely affect the quality of life of patients and is a major risk factor for blindness.[6] Often symptomless in the early stages, progression is usually slow, and it can easily lay undetected until it is too late. It is essential to regularly see an optometrist so that early glaucoma diagnosis can trigger treatment and careful monitoring - preventing avoidable sight loss.

There is good evidence of a disparity in access[7][8][9][10][11] [12]. A systematic review of the literature from 2025 found that most studies note higher prevalence, greater visual field loss, and reduced access/delays in treatment for deprived areas. The effects of this disparity are wider than vision loss [13][14]. People living with the condition are [15]at greater risk of falls and have a higher chance of experiencing loneliness[16].

Crucially, a recent patient survey conducted by Glaucoma UK, found that over three quarters of respondents had their disease detected by a community optometrist practice, with the majority of those via a funded GOS sight test[17]. Further to this, a study from 2015 by El-Assal et al[18] compared patient outcomes from before and after the implementation of the new GOS contract in Scotland introduced in 2006. It found that the new referral refinement pathways enabled by the new contract served to reduce waiting times in secondary care and improved early diagnosis. While these figures are based upon patients who have already been identified as potentially having glaucoma, it highlights the importance of optometry in helping to combat avoidable sight loss.

Pathways and patient awareness must be improved to prevent many thousands of vulnerable people from losing their sight needlessly each year. Through this report, the AOP will articulate ways to: support our members to enable better detection; increase patient awareness and; ultimately provide better outcomes for people with glaucoma in the areas of the UK that need it the most.

What the evidence tells us

"Late diagnosis remains a major risk factor for glaucoma-related vision loss, with over 40% of patients in the UK experiencing preventable vision impairment due to delays in treatment."[19]

Deprived populations of the UK are measured via some well-established metrics: Scottish Index of Multiple Deprivation[20]; Townsend index[21]; or the ACORN classification[22]. Many studies using these indexes have concluded, with statistical significance, that patients living in areas with the highest levels of deprivation have poorer glaucoma outcomes, with delayed diagnosis and more advanced visual field loss at presentation. To illustrate, Rathore et al found that advanced visual field loss at diagnosis in deprived areas is 18% of patients compared to 11% in the least deprived areas[23]. In addition, one study found poorer quality of life in more deprived patients at diagnosis[24]. More data is needed on the environmental drivers for this prevalence.[25]

The other known risk factors for glaucoma such as race/ethnicity and genetic susceptibility, have been studied alongside socioeconomic status[26] where consistency in associations was found. While there are overlaps between deprived populations and communities that are more genetically susceptible, it remains a complex picture[27]. That said, a literature review from 2025 concluded that most studies find higher prevalence and worse outcomes from glaucoma among ethnic minorities[28].

Indeed, a targeted study from 2016 found that South Asian and black African and black Caribbean patients generally present later, with more advanced disease[29]. The black African and black Caribbean population showed a peak number of affected individuals in the 55–59 age group, reflecting a younger demographic distribution, with only about 16% aged ≥65.[30] Differing priorities for health outcomes, lower intentions to attend screening, alongside attitudes, perceived control, and anticipated regret are all cited as potential drivers for the lack of engagement with eye care services among these groups[31] [32].

Evidence of progression disparity once a glaucoma patient has been identified and in a treatment pathway is less clear. With one study finding no disparities in disease progression[33] while others found gaps in uptake of the most common treatment (Prostaglandin analogues (PGA), first line eye drops to release pressure)[34]. Another paper found avoidable inequalities post-diagnosis with 37% of eligible glaucoma-blind patients from deprived areas found to be unregistered for a Certificate of Visual Impairment, with barriers cited as administrative failure, frailty, and a fundamental lack of awareness [35].

We know that most glaucoma referrals to secondary care in England are generated by community optometrists.[36] However, those in more affluent areas are found to access NHS primary eye health services substantially more than socio-economically deprived areas.[37] In short this means that the opportunistic eye health case finding provided by optometrists, is simply not being utilised in the populations that need it most.

Exploring the drivers for this, there is evidence that more deprived socioeconomic groups have less glaucoma awareness and fewer optometrist visits in the years preceding diagnosis[38]. A paper from 2015[39] indicated that mistrust and/or poor knowledge of optometrists and their clinical credentials among deprived and ethnic communities underpinned this lack of engagement. However, there is still a need for more data on the reasons why patients may not attend for regular eye tests. If we understand the drivers, we can better target and guide the vehicles of care.

Overall, the evidence strongly suggests that both socioeconomic disadvantage and ethnic minority status contribute to delayed diagnosis, reduced uptake of regular sight tests (that act as a case finding mechanism for glaucoma), and a reduction in access to timely treatment in UK glaucoma care. Case finding, public awareness and clear referral pathways are instrumental in helping to reverse the trend of poorer outcomes for these vulnerable populations.

Wider policy context

There are external policy trends and factors that could significantly affect high street optometry's ability to tackle these social disparities in glaucoma care. Some provide opportunity, while others bring a need for caution.

One major national policy that provides opportunity can be found in the Government's 10 Year Health Plan for England[40] published in July 2025. The plan features three key "shifts" in care designed to bring about radical change: hospital to community, analogue to digital and sickness to prevention. These shifts offer the chance for optometry to shine – particularly around community care and prevention. In terms of glaucoma, screening and monitoring of patients in community practice could release significant financial and operational benefits for the NHS[41]. If late-stage glaucoma diagnosis can be avoided, the costs associated with severe disease, and the risk of falls can be lowered significantly[42].

Additionally, the neighbourhood health framework [43]model that has emerged from the 10 Year Plan also brings an opportunity for optometry. Structurally, it is split into a three-pronged "reform agenda" and a series of core aims. The framework is designed to support local systems in delivering the three key shifts described above. It urges collaboration between ICBs and local authorities as they work with other local partners, effectively enabling local systems to determine optimum models. Within the context of this framework, community optometry could benefit patients by being integral to delivering targeted interventions to reach those most at risk of sight loss from glaucoma based upon local demographic challenges – i.e. the case could be made for formally enabling optometrists to operate outreach services in areas with higher deprivation and/or larger ethnic communities where glaucoma has greater risk.

Also worth noting in this space is the Getting it Right First Time (GIRFT)[44] initiative. Described as "*a national NHS England programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change*", it consists of a series of "deep dive" reports into specific NHS specialisms and how they operate. Using a best practice

approach, the reports make efficiency recommendations largely driven by the clinicians themselves.

In May 2026, the Best Practice Guidance for Glaucoma Services[45] was published. With a focus on quality considerations and potential new ways of working across the entire pathway, the report covers: detection; treatment and support; lifelong monitoring where required; and discharge where clinically appropriate. The guidance maps out a number of key features that should be included within a complete glaucoma pathway, the optimum use of Single Point of Access (SPoA) Models (a triage system for referrals and treatment choices), the need for bidirectional data flow with interoperable IT systems, and standardised patient datasets.

This report provides a timely opportunity to harness the reach and expertise of community optometry in helping to identify those patients most at risk, getting them into the system.

The *Diagnostics Asynchronous Virtual Review Assessment Pathway* (DAVRAP) model described within the report and is favoured by GIRFT as the standard best practice. In this model, patients attend a specialised site (a secondary care led diagnostic hub) for diagnostic testing and then leave. The test results will then be reviewed by health care professionals, making a clinical decision at a later date. The intention is to improve productivity by filtering severity and risk stratifying patients to reduce the need for face-to-face consultations.

GIRFT acknowledges and advocates for examples of optometry delivered services - such as Glaucoma Enhanced Case-Finding Services (GECFS) and Glaucoma Repeat Measures Service (GRMS) – noting that these are effective and provide an alternative, scalable option alongside the DAVRAP model. Further, there is a clear message running through the report that the GOS sight test remains an incredibly effective health intervention that is fundamental to the whole eye care eco-system.

There is therefore an opportunity within the context of these GIRFT recommendations to further embed the role that community optometrists can play in protecting the sight of the populations most at risk through the conception of a targeted “glaucoma outreach” service. Community optometrists could be commissioned to do outreach and awareness raising activities within the neighbourhoods identified as most vulnerable to having undiagnosed glaucoma. This would further embed optometry into glaucoma pathways and build trust with secondary care, commissioners and the communities they serve.

All of these moving parts have potential to affect patient behaviour and optometric practice. If handled correctly, we have an opportunity to close the glaucoma care gap for populations that need it most.

Conclusion and potential solutions

Developing glaucoma is not a direct consequence of being from a less affluent population or from a particular ethnic minority. However, stage of presentation and genetic propensity for the disease can be used as a stark measure of where inequities in care can result in adverse health and social outcomes for the most vulnerable.

Working across the full spectrum of eye health and eye care systems, these populations need a better awareness of the signs and symptoms and to be supported towards an understanding of the risks and implications of glaucoma. Further, optometrists need to be enabled to better identify, refer and manage these patients.

The obstacles to better outcomes for these populations are a step before referral-refinement and disease-management pathways can realise their impact. This means that the focus of any recommendations must be aimed at encouraging deprived populations and certain susceptible ethnic communities to take up regular eye examinations with their optometrist. A better understanding of their own risk of glaucoma, the implications of late diagnosis, and a clearer picture of what optometric care brings could make a huge difference.

The patient awareness aspect of finding solutions to this cannot be overstated. A comprehensive review of eye health promotional activity[46] from 2025 highlighted a diverse range of strategies to raise patient awareness of the importance of eye health can be effective. It concludes that a singular targeted message promoted via multiple different settings such as hospitals, clinics, schools, community events, and online platforms can reach most socio-economic groups. However, this is tempered by the paper being clear that the promotional activity must be backed up with robust systems of follow up and policy integration for it to achieve success.

Further, for those ethnic minority communities where glaucoma risk is greater, the Race Equality Foundation asserts that health promotional messaging is doubly difficult. Their work on methods to best engage these populations[47] suggests models that include using community leaders as “health champions” to promote and deliver important healthcare messages. Targeted awareness campaigns that involve faith leaders[48] could also help to educate and encourage vulnerable populations to engage with optometry.

A natural conclusion to make strides in reducing these disparities would be the roll-out of a national glaucoma screening programme. However, when this was last considered by the UK National Screening Committee in 2019, the report states they cannot recommend population screening for POAG in adults due to inadequate supporting evidence.[49] While the evidence may not reach the threshold for a national screening program, gathering and providing some of the data assembled in this paper could make a compelling case for a more targeted approach.

To use a current example of a more nuanced method of screening, the NSC recently recommended that Prostate Cancer Screening should not take a blanket, full population age-based approach due to concerns about false positives, overdiagnosis, and overtreatment[50]. Instead, the recommendation is to focus in on genetic susceptibility and family history only, with men who meet the criterion to be tested every two years between the age of 45 and 61. A similar targeted system for glaucoma should be explored, working with the sector to craft the essential inclusion criteria.

As for existing NHS systems and guidance, the commissioning of the Integrated Glaucoma Pathway across every ICB area in England, a refresh and strengthening of the NICE Guidance for Opportunistic testing[51] could make strides. However, there will need to be careful consideration given to the fact that some Black African and Black Caribbean people will get glaucoma younger with more rapid progression. Furthermore, treatment options can more difficult to pinpoint in Black African and Black Caribbean people, due to some tests for Glaucoma often requiring different standards to the rest of the population.[52],[53] Additionally, having sight tests included within the routine NHS health checks[54] offered to patients at various milestone ages could be a useful vehicle to screen these populations for early signs of glaucoma.

However, caution must be exercised for any plans that encourage underrepresented groups to take up sight testing, as doing so without wider system change, could overburden the existing infrastructure. Therefore, provision must be put in place to manage the necessary uptick in early diagnosis – such as [55].

Where patients are caught early enough, in many cases they can be kept in the lower risk categories for sight loss and are more likely to be suitable for ongoing management in community optometry. This will ensure that the hospital glaucoma services have capacity to manage the more complex cases.

We must be bold in ensuring that these measures are adopted if any meaningful dent is to be made in the unacceptable levels of health inequalities found in glaucoma care across UK society.

Recommendations

1. **Run targeted public awareness campaigns, working with community leaders and health champions where appropriate**

   Campaigns should explain glaucoma risk, the importance of regular sight tests, and the crucial role of optometry. Evidence suggests they should be delivered across trusted local settings, including community venues, faith groups, wider health services and via appropriate online channels. Using local community leaders can help build trust, tailor messages, and reach people that may not currently engage with routine eye care.

2. Include sight tests in NHS Health Checks at age 50[56]

This would create a practical opportunity to identify glaucoma risk earlier for men and give patients clear information about prevention and follow-up.

3. Commission a targeted glaucoma outreach service

Community optometrists, supported by Local Optical Committees and local NHS systems, should be enabled to deliver outreach in areas with higher deprivation and higher glaucoma risk.

4. Collect better qualitative data

Further work should explore why people in deprived communities and higher-risk ethnic groups do not attend regular sight tests, including barriers linked to cost, awareness, trust, access, and service design.

5. Strengthen local glaucoma pathways

Integrated Glaucoma Pathways should be commissioned consistently so that earlier detection leads to timely referral, diagnosis, monitoring, and treatment.

6. Update and promote the NICE guidance for opportunistic testing for glaucoma[57]

Guidance should be refreshed and communicated clearly to eye health professionals, commissioners, and relevant NHS partners.

7. Use data to target action

Local systems should use demographic and deprivation data to identify communities at greatest risk and design services around local need.

8. Plan capacity before increasing demand

Awareness campaigns and outreach should be linked to service planning so that hospitals and community providers can manage an increase in early diagnoses safely.

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The AOP is the voice of the optical profession, representing 80% of practising optometrists.

The AOP elevates the work of its members, safeguards their interests and champions eye health across the UK.

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