

General Optical Council

Commercial practices and patient safety

A thematic review

Report
October 2026



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Executive summary

Why we carried out this review

1. This thematic review considers the impact of commercial practices on the public's experience of, and registrants' ability to deliver, safe and effective eye care for all¹.
2. NHS and privately funded primary eye care in the UK is largely delivered by privately owned optical businesses. The combination of private contractor delivery of clinical eye care services and commercial retail sales is an inherent feature of the sector.
3. This can bring benefits to patients, registrants, commissioners and taxpayers. For example, it can spur innovation, which in turn can widen access and improve the quality of care, as well as offer new career opportunities to registrants. However, we know from our own research and evidence, as well as stakeholder conversations, that there are concerns about the extent to which these practices may be detrimental to the public's access to eye care, the delivery of safe and effective eye care for patients and on registrant wellbeing.
4. This review takes place against a backdrop of increased interest in professional services markets and healthcare. The Professional Standards Authority for Health and Social Care (PSA) report 'Safer care for all' made clear that regulators should intervene when profits are put ahead of the patient's best interests and consider taking a more interventionist role². Strengthening consumer rights has been a key government priority in recent years, including through legislative changes. The Competition and Markets Authority (CMA) has had a strong focus on healthcare services. As well as a landmark review of private healthcare in 2014, it has recently concluded a market investigation into veterinary services and begun a market study into private dental services³.

What we did

5. The review is framed around the following five topics:
 - sales targets and incentives;
 - booking practices;
 - sight test times;
 - transparency on pricing and eligibility for NHS financial support; and

¹ Commercial practices are ways in which a business is run to remain profitable. They are an integral part of how eye health is delivered on the high street and include decisions on how products are sold, appointments are managed and care is delivered.

² Professional Standards Authority for Health and Social Care (2023), [Safer care for all: Solutions from professional regulation and beyond](#)

³ [Private healthcare market investigation - GOV.UK](#) and [Private dental services market study - GOV.UK](#)

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- sight testing for young children.
6. We considered impacts on delivering safe and effective patient care and barriers to accessing care, especially among people in vulnerable circumstances.
 7. Reflecting our statutory objectives, the focus of this review is on public protection. Patient safety is core to public protection, but we have considered a range of harms in line with the PSA guidance on right touch regulation⁴ and our public sector equality duty.
 8. We gathered evidence from a range of sources including new primary research comprising fresh waves of our annual public perceptions and registrant surveys, commissioned qualitative research⁵, analysis of Trustpilot customer reviews, a review of information on sight test prices and eligibility for NHS financial support on optical business websites, and analysis of sight test claims data for children aged 0-5 years.

What we have found

9. This review found no direct evidence of harm to patients caused by commercial practices. However, it does identify potential long-term impacts on patients that are less visible, as well as impacts on registrants.
10. We revealed a paradox of satisfied patients but a profession under strain. Surveys show levels of public confidence and patient satisfaction with eye care services are high, but job dissatisfaction within the professions we regulate and experience of negative working conditions in optical businesses are both high.
11. For patients, selling products and services they may not need, or that may not be in their best interests, rushed appointments and pressure selling, could all act as deterrents from accessing eye care services, with possible consequences for longer-term eye health outcomes.
12. Registrants are concerned about the impacts of commercial practices on their ability to provide safe care as well as pressures which impact on wellbeing, such as an expectation to see high volumes of patients, and/or meeting employer-driven targets. Students and early career professionals appear particularly exposed to the negative impact of some commercial practices in optical businesses.
13. There are conflicting views expressed by individual registrants, employers and business registrants on operational matters such as booking practices, use of sales targets and incentives, and sight test times. While employers generally do

⁴ Professional Standards Authority for Health and Social Care (2025), [Right-touch regulation](#)

⁵ Shift Insight (2026), [Commercial practices and patient safety in the primary eye care sector](#)

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not consider there is a systemic problem, concerns among registrants are widely felt. At the least, this disconnect suggests a relationship between registrants, employers and optical businesses that is not working as well as it should.

14. The review highlights the importance of fostering the right culture and creating an environment that supports autonomous clinical decision-making and management of risk, aligns achievement of targets and payment of incentives with quality and customer service, and ensures the best interests of patients. Strengthening registrants' clinical autonomy and enhancing a more collaborative culture within optical practice which gives them greater voice in the design of business operations such as booking practices, the use of sales targets and incentives will be important to address the issues identified.
15. We want all businesses delivering restricted activities to be regulated by us and are working to strengthen oversight of businesses through the Department of Health and Social Care's legislative reform programme. This would close a gap in regulatory protection and create a level playing field for businesses.
16. Broad-scale economic conditions are challenging right across the UK and this is reflected in relation to consumer confidence, as well as pressure on health service budgets. The insufficiency of General Ophthalmic Services (GOS) fees was raised time and again across many of the issues we considered, and they appear to influence how eye care is being delivered. However, while GOS fees are a contributory factor, they do not explain all the negative impacts of commercial pressures highlighted in this report.
17. The review points to the need for a regulatory and professional environment in which commercial success, patient safety and workforce wellbeing are mutually reinforcing rather than competing priorities. Consistent themes across the five areas in focus highlight the need to strengthen standards and guidance, better prepare students for the commercial realities of the sector, support professional autonomy, foster the right cultures, improve transparency, and create more collaborative workplace environments where concerns can be raised and addressed effectively.
18. Collaboration with sector partners in preventing harm is a key theme of our 2025-30 corporate strategy⁶. As well as setting out a programme of activity for the General Optical Council (GOC), the recommendations section of this review identifies where stakeholders including professional bodies, employers and others, could help.

⁶ [GOC Corporate strategy 2025-30](#)

Section 1: Sales targets and incentives

Conclusions

- Sales targets and incentives are a legitimate business tool but should be designed to drive a culture which is aligned to the best interests of patients.
- Pressure to meet sales targets and incentives can be more pronounced for those working in multiples and registrants with less career experience.
- Pressure to meet sales targets and incentives can impact on the health and wellbeing of registrants and create risks for workforce capacity.
- There are conflicting views about incentives for referrals for cataract and refractive surgery and their impacts on patient choice, the quality of care and public trust.

19. Sales targets and incentives are commonly used across retail environments as a legitimate business tool to drive performance and motivate staff. However, issues arise when there is an overemphasis on commercial metrics or if these are not aligned to patients' best interests.
20. Sales targets and incentives can manifest to patients as pressure selling or negatively shape patient interactions in more subtle ways that undermine the trusted clinician-patient relationship and risk damaging the image of the sector. Our survey data indicates this dynamic appears to affect some patient groups more than others including those with vulnerabilities.
21. Pressure to purchase can deter people from using eye care, with consequential longer-term impacts on eye health and the prevention of sight loss. While these concerns may not pose immediate safety risks, they can contribute to poorer long-term eye health outcomes. Healthwatch found that people who reported being encouraged to purchase additional paid-for products or services were twice as likely to have avoided seeking eye care⁷.
22. Some registrants report feeling under pressure to sell certain types of glasses or contact lenses that will earn more money for the business, as well as pressure to sell a product or service which they considered was not needed by the patient. Those feeling these pressures also feel unable to provide safe patient care.
23. Pressure to meet sales targets and incentives can impact on the health and wellbeing of registrants and create workforce capacity risks. Our survey data

⁷ Healthwatch (2025), [Seeing clearly? Attending sight tests and accessing opticians](#)

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shows correlations with higher reported workload strain, long hours, stress-related absence, lower job satisfaction and intentions to leave the profession.

24. There are longstanding concerns in healthcare, reflected in work by the CMA and independent reviews, about situations where the commercial interests of businesses may lead clinicians to make recommendations or referrals that are not aligned to the best interests of patients or which limit patient choice. In this review, we received conflicting evidence about the nature, extent and impact of inappropriate incentive-based referrals for cataract and refractive surgery.

Key statistics

- 20% of respondents who purchased eyewear said that they felt pressure to purchase specific brands or types of glasses or contact lenses⁸.
- 14% of those who said they felt uncomfortable visiting an opticians mentioned pressure to buy glasses or contact lenses⁹.
- 17% of people who said that staff had encouraged them to take up additional paid-for services said that they had avoided getting eye care in the last two years, compared to 8% for those who had not experienced this¹⁰.
- Over 30% of registrants felt under pressure to sell certain types of glasses or contact lenses that will earn more money for the business or to meet commercial targets at the expense of patient care¹¹.
- 24% felt under pressure to sell a product or provide a service which they considered was not needed by the patient¹².

⁸ [Public perceptions research 2026](#)

⁹ [Public perceptions research 2026](#)

¹⁰ Healthwatch (2025), [Seeing clearly? Attending sight tests and accessing opticians](#)

¹¹ [Registrant workforce and perceptions survey 2026](#)

¹² [Registrant workforce and perceptions survey 2026](#)

Section 2: Booking practices

Conclusions

- Overbooking can support access to eye care for patients but needs to be managed well to ensure sustainable workloads and adequate testing times.
- Some booking practices appear to be reducing registrants' wellbeing.
- Greater support is needed for students and early career professionals.

25. Effective appointment scheduling can support access to care and safe and effective delivery of treatment. However, there is a balance to be struck between using clinical capacity to its best effect and creating a situation in which some patients and registrants feel rushed or under pressure.
26. A strength of the sector is that it is generally easy for patients to book sight tests in advance without long wait times. However, where patients have bad experiences, this may have wider consequences for ongoing engagement with eye care. Feeling rushed or dissatisfied with the level of communication or time within appointments may lead to patients not accessing routine eye care in the future, with the potential consequences on long-term eye health.
27. Long waits and crowded waiting areas may disproportionately disadvantage people with additional needs. Our lived experience research with patients in vulnerable circumstances highlighted psychological barriers to visiting opticians including the 'open' nature of the physical environment, having to sit next to strangers in waiting rooms, and concerns over the length of the wait¹³. Adults with a learning disability are ten times more likely to have an eye problem than the general population and for children with a learning disability this rises to 28 times more likely when compared with the general population¹⁴. This environment could therefore have a disproportionate negative impact on such patients.
28. Some booking practices appear to affect delivery of care and registrant wellbeing. A significant minority of registrants report that they had sometimes or frequently felt pressure to see high numbers of patients which had negatively affected their ability to deliver safe care. Reports of rushed appointments where things can be missed and reduced communication with patients are a source of anxiety. Evidence of shortened or missed breaks, inability to complete

¹³ Explain Research (2025), [Qualitative research exploring the lived experience of patients and non-patients accessing and using eye care services](#)

¹⁴ Emerson, E. and Robertson, J. (2011), [The Estimated Prevalence of Visual Impairment among People with Learning Disabilities in the UK](#). Improving Health and Lives: Learning Disabilities Observatory

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administrative tasks during working hours and difficulty in raising concerns, suggests that these pressures can also adversely affect wellbeing, including contributing to burnout and registrants wanting to leave the profession. Our survey evidence shows that students and early career professionals struggle most with pressures related to booking practices.

29. Business representatives do not consider staff are overworked, highlighting a lack of consensus which may come from a breakdown in communication between employers and registrants delivering care to patients. Businesses must make sure that booking practices and appointment scheduling support safe care, with appropriate contingency planning where demand exceeds capacity, and effective mechanisms for staff to raise concerns.

Key statistics

- 89% of patients were satisfied with how long they had to wait for their appointment, with only 3% saying they were dissatisfied¹⁵.
- 38% of registrants said they had 'sometimes' (21%) or 'frequently' (17%) felt under pressure to see a high number of patients every day which had impacted on their ability to provide safe patient care¹⁶.
- 23% of registrants said that they have 'sometimes' (14%) or 'frequently' (10%) been asked to overbook clinics (25% in 2025)¹⁷.

¹⁵ [Public perceptions research 2026](#)

¹⁶ [Registrant workforce and perceptions survey 2026](#)

¹⁷ [Registrant workforce and perceptions survey 2026](#)

Section 3: Sight testing times

Conclusions

- Patients are content with the time taken in their sight tests, but registrants widely report that sight test times can be insufficient.
- Short sight testing times can reduce registrant wellbeing.
- The GOC setting minimum sight testing times would not be appropriate.

30. All sight tests must contain minimum features, but duration of sight tests can vary significantly depending on factors including NHS commissioning, extent of delegation, the technology used and each patient's individual needs. Sufficient time enables optometrists to undertake appropriate clinical assessments, discuss treatment options and risks, answer questions, and support informed decision-making. It helps patients to feel listened to, contributing to a positive care experience and supporting trust and confidence in the professions.
31. Our public perceptions research indicates consistently high levels of patient satisfaction with the time provided during sight tests to deal with their needs properly, although this is lower among some groups¹⁸. However, approximately half of registrants report that the standard time allocated for sight tests has been insufficient to deliver safe patient care. This varies by practice setting, with those working in multiples and locum roles more likely to report insufficient time. Patient representative organisations were particularly concerned that appointments may be too short for some patients, especially those with learning disabilities or dementia, children, or those requiring additional explanation or support. The available evidence points less to clear, immediate patient safety incidents and more to issues with quality of patient communication and disproportionate effects on patients who need more time.
32. Across survey findings, qualitative research and fitness to practise evidence, registrants describe short appointment times, high clinic volumes and limited control over diaries as contributing to stress, reduced job satisfaction, missed breaks and burnout. These wellbeing concerns are closely linked to patient safety. Where registrants feel unable to spend sufficient time with patients, take appropriate breaks or exercise professional judgement about clinic capacity, there is a greater risk that care may be rushed, records may be incomplete, and clinical concerns may be missed. Sustained pressure on registrants may increase the likelihood of mistakes, weaken professional confidence and reduce willingness to raise concerns.

¹⁸ [Public perceptions research](#)

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33. Perspectives from business registrants suggest a different picture. Some report that longer appointment times are available where needed and that testing times have increased in recent years, indicating that experiences are not consistent across the sector and may vary by business model and setting.
34. Clinical autonomy is a key principle of our standards but some registrants feel this is difficult to maintain given the realities of their busy workplace environment. This issue is closely linked to booking practices, particularly where registrants do not feel they are in control of the diary. Responsibility for managing these risks cannot rest with individual registrants alone. While registrants remain accountable for their own professional decisions, employers and business owners have an important role in creating working conditions that enable safe practice, including realistic appointment times, giving staff autonomy to extend appointment times with individual patients where required, and clear routes for staff to raise concerns without fear of negative consequences.
35. We acknowledge calls from some stakeholders for the GOC to set minimum sight testing times (or to see a maximum number of patients per day). We have considered this but concluded hard rules would not be appropriate given the variability in formats of sight testing, the range of technologies and tests used and variety of patient needs.

Key statistics

- 89% of participants in our public perceptions survey were satisfied that their optometrist allowed sufficient time to deal with their needs properly, which has increased slightly since the previous wave (87% in 2025)¹⁹.
- 47% of optometrists said that the time allocated to them to carry out a sight test was insufficient to provide safe patient care (48% in 2025)²⁰.
- In our 2024 registrant survey, time pressures and short sight testing times were identified as the most common barrier to delivering safe care²¹.

¹⁹ [Public perceptions research 2026](#)

²⁰ [Registrant workforce and perceptions survey 2026](#)

²¹ [Registrant Workforce and Perceptions Survey 2024](#)

Section 4: Transparency on pricing and eligibility for NHS financial support

Conclusions

- Unclear pricing and a lack of transparency can limit access to eye care with a disproportionate impact on those in vulnerable circumstances.
- Price transparency is inconsistent across the sector.
- Eligibility for NHS financial support should be communicated more clearly.
- Most patients find the pricing of glasses and contact lenses clear, but pricing practices are a growing source of consumer complaints.

36. Clear and transparent pricing is important to maintain public confidence and reduce barriers to access to eye care, especially for people in vulnerable circumstances. People need to know the price of a sight test and if they are eligible for NHS financial support before deciding to make an appointment. Otherwise, this risks deterring or delaying access to eye care, raising potential wider implications for timely treatment and prevention of eye conditions.
37. Most respondents in our public perceptions research²² said they found sourcing the price of their sight test easy and people considered the pricing was clear when they last bought glasses or contact lenses. However, some can find the pricing of glasses and contact lenses confusing, unclear or misleading. There are recurring issues in complaints around unexpected charges, unclear pricing structures and optional extras being poorly explained. This led to some patients experiencing eye care as a high-pressure retail transaction.
38. Our review of 255 optical business websites found online transparency on both the price of sight tests and eligibility for NHS financial support is patchy. It was often unclear whether optical coherence tomography (OCT) scans were included in the standard sight test fee or charged separately. Even when information was provided on NHS financial support it was limited in detail or difficult to access. People are often unaware of, or uncertain about, their eligibility for financial support, pointing to the need to raise public awareness²³.
39. Businesses and individual registrants thought that NHS eligibility was explained clearly to patients at different points in the journey, for example, from booking, arrival at reception, pre-screening, during the sight test and at the point of any dispensing.

²² [Public perceptions research](#)

²³ Healthwatch (2025), [Seeing clearly? Attending sight tests and accessing opticians](#)

40. Strengthened consumer legislation and interventions by the CMA are reshaping public expectations around price transparency. Increasingly, patients will expect price transparency in eye care just as they see it in other professional services.

Key statistics

- 74% of respondents in our public perceptions research said they found sourcing the price of their sight test easy and only 3% found it difficult²⁴.
- 38% of business websites in our sample displayed their sight test price(s)²⁵.
- Prices for a sight test ranged from a minimum of £25 to a maximum of £125 and the median price of a sight test was £50 across England, Wales and Northern Ireland²⁶.

²⁴ [Public perceptions research 2026](#)

²⁵ We reviewed 255 optical business websites across England, Wales, Scotland and Northern Ireland from a sample of 324 GOC-registered business entities. This in-house study reviewed the online visibility of sight test prices and related information.

²⁶ Please refer to footnote 25.

Section 5: Sight tests for young children

Conclusions

- Early sight testing is important, but sight testing is unevenly provided across premises/contractors.
- Some optometrists may test children under five infrequently or not at all, leading to risks of deskilling.
- There are varying levels of awareness of optometrists' ability to test children under five, or to address eye care conditions, which may create barriers to accessing eye care.
- The barriers to access are multi-faceted, complex and extend beyond regulatory factors so stakeholders should convene to discuss solutions.

41. Access to sight tests and eye care for children under five is vital to ensure early diagnosis of eye conditions or reduced vision, which could negatively impact a child's educational performance or development. Although GOS sight tests are free for children and professional guidance is clear that children should not be refused care because of their age, our analysis of GOS data suggests that there are gaps in the provision of sight tests for children under five, and that testing activity is concentrated among a relatively small number of businesses/contractors.
42. Some optometrists may test children under five infrequently or not at all, creating deskilling risks. Given treating children is a core competency to enter the register, optometrists should maintain this competency to stay on the register, and paediatric care should not be viewed as an optional specialism.
43. Barriers to access may include commercial pressures, limited appointment time, lack of age-appropriate equipment, variations in practitioner confidence and experience, location, and instances where lack of oversight or training means parents are turned away by front of house staff.
44. Awareness of children's eye care services among parents and carers appears variable. Many may be uncertain about when and where to seek help for children's eye health concerns (including whether it is possible to test a child who cannot read), and sight testing among young children appears to be driven more by identified concerns than routine attendance. Improving public awareness of free sight tests and the role of optometrists could help support earlier access to care and treatment.
45. This is a multi-faceted and complex set of issues, only some of which have regulatory implications. There would be benefit in bringing together the wide

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range of stakeholders with an interest in these issues to identify the best ways to reduce barriers to parents and carers accessing sight tests for children.

Key statistics

- 3.2% of providers in England, 4.6% in Northern Ireland and 4.0% in Scotland do not carry out sight tests on children under five²⁷.
- Across England, Northern Ireland and Scotland, the top 10% of providers undertake around 40% to 55% of all sight tests for children under five, while many providers carry out only small numbers of tests each year²⁸.
- The average practitioner in Northern Ireland undertook approximately 22 child sight tests per year (approximately one sight test every two to three weeks), while the typical (median) practitioner undertook 17 child sight tests per year (equivalent to around one sight test every three weeks)²⁹.
- In England the average contractor undertakes 105 sight tests a year (approximately two a week), while the typical (median) contractor carries out 43 sight tests (fewer than one a week)³⁰.
- In Scotland the average practice undertook approximately 72 child sight tests per year (just over one a week), while the typical (median) practice undertook approximately 39 child sight tests per year (approximately three sight tests per month)³¹.
- In England there were between 1,048 and 1,665 sight tests per 10,000 children aged 0-5, while in Northern Ireland, there were about 900 sight tests per 10,000 children aged 0-5 and in Scotland 1,427 sight tests per 10,000 children aged 0-5³².

²⁷ We carried out an in-house analysis of GOS claims data obtained from England, Northern Ireland and Scotland. Data from Wales was not available due to the absence of an electronic claims system.

²⁸ Please refer to footnote 27.

²⁹ Please refer to footnote 27.

³⁰ Please refer to footnote 27.

³¹ Please refer to footnote 27.

³² Please refer to footnote 27.

Introduction

Background to the thematic review and existing GOC evidence base

46. NHS and privately funded primary eye care in the UK is primarily delivered by privately owned optical businesses, and to a lesser extent by charities or not-for-profit businesses. Delivery of NHS primary eye care services under the GOS contract with optical businesses is part of a longstanding and successful model of care. It is part of a wider NHS contract for primary healthcare services which includes pharmacies, GP practices and dental surgeries.
47. A distinguishing feature of the delivery of primary care eye services is that they are largely delivered in high street and other community settings, combining clinical service delivery with commercial retail sales. Local commissioning arrangements between optical contractors and commissioning bodies are a devolved matter and different arrangements and services are available, with different contractual arrangements in each UK nation.
48. The combination of private contractor delivery of clinical eye care services and commercial retail sales is an inherent feature of the optical sector. When it operates well, it can bring benefits to patients, registrants, commissioners and taxpayers. For example, private sector delivery of clinical eye care services can spur innovation, which in turn can widen access, promote new care pathways and improve the overall quality of care. Such incentives can encourage optical practices to invest, for example, in new diagnostic technologies, or update equipment more frequently, which may enable them to offer a broader range of clinical services for the benefit of patients. This could include locally commissioned enhanced care pathways or additional eye care services traditionally delivered by hospitals, or offering acute emergency eye care in the community, supporting prevention and treatment of a wider range of conditions with easy access. It can also encourage businesses to improve convenience for patients by extending opening hours, offering appointments at short notice, or expanding into locations that may otherwise have limited access to eye care. Further, it can drive improvements in customer service, keep prices down (which improves access to care) and create choice allowing patients to choose the care that best meets their needs in a convenient accessible location.
49. The commercial nature of the sector can also benefit registrants, by job creation and promotion, access to the latest equipment, greater clinical opportunities, improved career development and investment in training.
50. GOC surveys show high levels of public trust and satisfaction with eye care services. Our 2026 public perceptions survey found increasing satisfaction with services and more people having routine sight tests. These are significant

achievements in the context of patients becoming more demanding in their expectations and falling public confidence in some other healthcare services³³.

51. Our research shows that most registrants feel positive about their role, and satisfaction is even stronger among those doing more varied and engaging work, such as delivering enhanced services³⁴. There is also a clear drive across the sector to develop and grow, with gaining additional qualifications emerging as the most popular immediate career ambition. A strong sense of purpose continues to attract people into the sector, with 'helping people' standing out as one of the top two reasons for becoming an optometrist or dispensing optician.

Risks of commercial practices

52. However, registrants have long expressed concerns about the influence of some commercial practices on patient care. In our 2019 risk research³⁵, when likelihood and severity of impact factors were combined, 'time constraints with patients' and 'commercial or performance target pressure' were the two highest ranked risks across the study. The study highlighted the connection between these and other risks, and the relationship of these factors to stress, multiplying concerns around patient safety.
53. More recently, our surveys³⁶ have indicated widespread concern about the influence of some commercial practices on registrants' ability to deliver safe patient care. These concerns include the risk of missing diagnosis of eye health conditions due to short sight testing times and clinics being overbooked³⁷. Other concerns relate to targets and financial incentives to sell products and services that patients do not need, or which are not in their best interests. Where these practices contribute to registrants feeling unsafe at work due to stress and behaviours like bullying, this has a detrimental impact on wellbeing, which in turn can make it more difficult for registrants to provide safe and effective care.
54. An external analysis³⁸ of the business environment we commissioned in 2022 suggests that commercial considerations can pose risks to patients, if:
- they prevent optical professionals from providing the best care; or
 - they create incentives to prioritise revenue generation or cost-cutting over and above patient care, for example through product sales targets,

³³ [Public satisfaction with the NHS and social care in 2025: Results from the British Social Attitudes survey | Nuffield Trust](#)

³⁴ [Registrant surveys](#)

³⁵ [Risks in the optical professions](#)

³⁶ [Registrant surveys](#)

³⁷ Please refer to paragraph 137 for more information on the term overbooked.

³⁸ Europe Economics (2023), [Mapping of Optical Businesses: Report for the GOC](#)

unrealistic sight test³⁹ times, pressure to see a higher number of patients or under-investment in equipment.

55. Commercial practices can also create barriers to accessing eye care, particularly for people with vulnerabilities. For example, our lived experience research⁴⁰ found that concerns about pressure to buy and unclear pricing can deter those with vulnerabilities from visiting opticians. There are concerns that some businesses are refusing to test the sight of young children (i.e. five years old or under), partly due to commercial factors.

External environment

56. The Professional Standards Authority for Health and Social Care's (PSA) report 'Safer care for all'⁴¹ commented on regulation related to business practices in healthcare environments. It made clear that regulators should intervene when profits are put ahead of the patient's best interests and consider taking a more interventionist role: *"While scrutinising individual practices such as 'hard sell' tactics may be tricky for regulators, this does not mean that they should shy away from engaging with them altogether. There is a clear risk that the widespread use of these practices could undermine public trust; not only in the professionals using these tactics, but in the profession as a whole. They also risk creating conflicts for registrants between the demands of the employer and those of regulators. Regulators should tackle business practices that fail to put patients first, risk undermining confidence in the professions, or fail to allow registrants to exercise their professional judgement."*
57. Strengthening consumer rights has been a key government priority in recent years, including through legislative changes. The Competition and Markets Authority (CMA) has had a strong focus on healthcare services. As well as a landmark review of private healthcare in 2014⁴², it recently concluded a market investigation into veterinary services for household pets⁴³ and has begun a market study into private dental services⁴⁴. While optical care has its own regulatory and clinical context, these external developments provide a benchmark which will shift expectations in healthcare and other environments.

³⁹ The sight test within the meaning of the Opticians Act 1989 is often referred to as an eye test or eye examination across the UK nations.

⁴⁰ Explain Research (2025), [Qualitative research exploring the lived experience of patients and non-patients accessing and using eye care services](#)

⁴¹ Professional Standards Authority for Health and Social Care (2023), [Safer care for all: Solutions from professional regulation and beyond](#)

⁴² [Private healthcare market investigation - GOV.UK](#)

⁴³ [Veterinary services for household pets: Final decision report - GOV.UK](#)

⁴⁴ [Private dental services market study - GOV.UK](#)

Aim and scope of this thematic review

58. Our aim in carrying out this thematic review was to understand the nature and extent of commercial practices and their impacts, and to identify any interventions that we and the wider sector can take to help mitigate against this.
59. In deciding the scope of the review, we reviewed our existing evidence and sought advice from our statutory advisory committees. This led us to frame the thematic review around the following five topics:
- sales targets and incentives;
 - booking practices;
 - sight testing times;
 - transparency on pricing and eligibility for NHS financial support; and
 - sight testing for young children.
60. The topics examined in this review are closely interrelated, and this is reflected throughout the report.
61. We acknowledge that some similar pressures occur in other environments, such as in the hospital eye service, where some registrants work, but we decided to focus this review on primary eye care as this has been the focus of previous feedback from registrants and represents where most patients receive eye care and where most registrants work.
62. A deliberately broad-brush approach has been taken to the review. This has allowed us to consider a wide range of issues at a high level acknowledging that each of the topics could merit a detailed review of its own.
63. Reflecting our overarching statutory objective, the focus of this review is the impact of commercial practices on public protection. Patient safety is core to public protection, but PSA guidance⁴⁵ encourages regulators to consider a range of different types of harm, extending beyond physical harm. For example, it includes “harm to the physical, psychological and emotional health and wellbeing of members of the public”, as well as financial and other kinds of economic losses. Eye health concerns can have significant impacts on wider society, as vision loss or impairment may reduce people’s ability to work, travel independently, access education and services, and safely carry out everyday activities, while also increasing the risk of accidents, injuries, and associated social and economic costs. Therefore, when considering public protection in

⁴⁵ Professional Standards Authority for Health and Social Care (2025), [Right-touch regulation](#)

relation to the thematic review, we have considered a wide range of possible harms.

64. Many factors bear on these issues including external structural factors like GOS contract arrangements and fees. Especially in England and Northern Ireland, the contract fee is perceived by many stakeholders as underfunded and contributes to businesses relying on the sales generated by their retail activities to subsidise the cost of delivering the sight test. While we consider the relationship between GOS and commercial practices, decisions on GOS funding, which are a devolved matter, fall outside our regulatory remit and as an independent healthcare regulator, it is not our role to advocate on the profession's behalf for additional funding. However, if there is evidence that structural factors are putting public protection at risk, we accept a responsibility to highlight this to the relevant government.
65. We consider solutions through the lens of our statutory functions, which relate to education and training, maintaining the register, setting standards of professional and business conduct, and investigating and acting where fitness to practise may be impaired. These statutory functions are supported by our data analysis and research capabilities, which have provided much of the evidence base for the thematic review. Collaboration is a key theme of our 2025-30 corporate strategy, and we have identified where stakeholders including professional bodies, employers and others, could help.

Methodology

66. Our methodology (described in further detail in annex 1) included:
 - a literature review of existing evidence;
 - annual waves of our registrant and public perceptions surveys;
 - commissioned qualitative research with fully qualified registrants, business registrants, non-regulated eye care staff and patient representative organisations;
 - LinkedIn conversations on specific topics with associated qualitative surveys aimed at registrants;
 - case studies from the Optical Consumer Complaints Service (OCCS), our fitness to practise cases, and enquiries to our professional standards inbox;
 - analysis of a sample of NHS GOS data in England, Northern Ireland and Scotland on sight tests for children aged 0-5 years;

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- analysis of business websites to assess levels of price transparency and information on eligibility for NHS financial support;
 - analysis of negative online customer reviews on Trustpilot;
 - meetings with stakeholders, including optical businesses; and
 - requests for information and review of submissions from commissioners, other healthcare regulators, optical professional/representative bodies and large optical businesses.
67. This was a research study not a fitness to practise investigation. We have relied on primary research and information in the public domain and have not sought to obtain or review internal business documents.
68. We acknowledge the limitations of different evidence sources, including the self-selecting nature of survey samples. Data on complaints and negative online reviews is intended to illustrate the sorts of things that can go wrong, not how often things go wrong, but is still useful in highlighting risks.

Section 1: Sales targets and incentives

Overview

- Sales targets and incentives are commonly used across retail environments as a legitimate business tool to drive performance and motivate staff. However, issues can arise when there is an overemphasis on commercial metrics or if these are not aligned to patients' best interests. Patient feedback and quality indicators should form a core part of the targets and incentives mix.
- Sales targets and incentives can manifest to patients as pressure selling or negatively shape patient interactions in more subtle ways that undermine the trusted clinician-patient relationship and risk damaging the image of the sector. This dynamic appears to affect some patient groups more than others including those with vulnerabilities. Patient groups are concerned that some people may be deterred from using eye care, with consequential longer-term impacts on eye health and the prevention of sight loss.
- In our registrant survey, over three in ten respondents felt under pressure to sell certain types of glasses or contact lenses that will earn more money for the business or to meet commercial targets at the expense of patient care. A quarter felt under pressure to sell a product or provide a service which they considered was not needed by the patient. There is a correlation between experiencing these pressures and feeling unable to provide safe patient care.
- The data suggests these pressures are more pronounced among those working in multiples and among registrants with less career experience.
- Pressure to meet sales targets and incentives can impact on the health and wellbeing of registrants and create workforce capacity risks. Our survey data shows correlations with higher reported workload strain, long hours, stress-related absence, lower job satisfaction and intentions to leave the profession.
- There is longstanding concern in healthcare, reflected in work by the CMA and independent reviews, about situations where the commercial interests of businesses may lead clinicians to make recommendations or referrals that are not aligned to the best interests of patients or which limit patient choice.
- We have received conflicting evidence about the nature, extent and impact of inappropriate incentive-based referrals for cataract and refractive surgery, albeit the decision to perform the surgery and if it is in the patient's interests rests solely with the treating consultant. On managing conflicts of interest more widely, registrants appear to lack confidence and may need further support.

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69. Most primary eye care is delivered in a retail environment as well as a healthcare environment. As in other retail environments, optical businesses commonly set targets or offer incentives for staff. The main types of sales targets and incentives encountered in our review, included:
- individual, team or store key performance indicators (KPIs) for sales targets or customer care measures;
 - sales volumes for glasses, contact lenses and other products (sometimes referred to as a 'conversion rate');
 - upselling products or selling specific products that generate more profit such as designer frames, varifocals or coatings (sometimes referred to as 'product mix', 'average order value' or 'clinic value');
 - non-monetary incentives (for example, employee awards); and
 - referral arrangements with private providers of eye care services.
70. In a healthcare setting, there is heightened focus on the risks of targets and incentives posing ethical and clinical conflicts for practitioners, especially where they influence decisions about individual patients. Public trust in the profession would erode if the sector gained a reputation for putting profits above patients, for example by pressuring patients into purchasing products or services they do not need nor want, or by making inappropriate referrals. This risks wider implications, such as discouraging people from seeking eye care or not viewing optometrists as the first port of call for eye health issues therefore potentially increasing the risks of avoidable sight loss^{46 47}.
71. In its report, 'Safer care for all'⁴⁸, the PSA noted that business techniques used in other sectors to optimise profits such as sales targets and incentives were also used in the optical and pharmaceutical sectors and businesses had at points been criticised for putting profits ahead of the best interests of patients. The report stated that: *"For the optical sector this includes 'hard sell' tactics to persuade customers to sign up for laser eye surgery, up-selling expensive lenses, or not always giving patients their prescription so that they can buy glasses elsewhere."* It saw that putting undue pressure on health professionals to meet commercial targets is likely to create a conflict between the demands of

⁴⁶ Shickle D & Griffin M. *Why don't older adults in England go to have their eyes examined?* *Ophthalmic Physiol Opt* 2014; 34: 38–45. doi:[10.1111/opo.12100](https://doi.org/10.1111/opo.12100)

⁴⁷ Shickle D, Griffin M, Evans R, Brown B, Haseeb A, Knight S & Dorrington E. *Why don't younger adults in England go to have their eyes examined?* *Ophthalmic Physiol Opt* 2014; 34: 30–37. doi:[10.1111/opo.12099](https://doi.org/10.1111/opo.12099)

⁴⁸ Professional Standards Authority for Health and Social Care (2023), [Safer care for all: Solutions from professional regulation and beyond](#)

Section 1: Sales targets and incentives

the employer and patient interests. Further, while it should be clear that complying with professional standards must be the priority, it may be challenging for individual registrants to make this case, particularly where targets are set at a distance by a large corporation, and store managers may not be registrants and therefore not subject to the same professional standards.

72. As we explore later in the section, an overemphasis on commercially driven targets and incentives can also contribute to a workforce environment characterised by stress, burnout and fatigue, which may in turn adversely affect patient safety and care and workforce capacity.

Healthcare standards and regulation

73. The tensions described above are reflected in our standards (see box 1). Our Standards for Optical Businesses state that commercial targets must not affect patient care and commercial pressures must not inhibit registrants from exercising their professional judgement. Our Standards of Practice for Optometrists and Dispensing Opticians state that commercial targets and incentives must not compromise professional judgement or affect patient care.

Box 1: GOC standards

Our Standards for Optical Businesses provide that a business:

- 1.1.10: “Ensure that any operational or commercial targets do not have an adverse effect on patient care.”
- 1.3.2: “Ensures, so far as possible, that operational or commercial pressures do not inhibit staff from allowing patients the time they need to process any information given to them and the opportunity to change their mind.”
- 2.1.9 “Encourages staff to declare any conflicts of interest, where they arise, and withdraw themselves from such conflicts. The joint regulatory conflicts of interest statement sets out what is expected.”
- 3.1.3: “Makes sure that operational and commercial pressures do not unreasonably inhibit the exercise of professional judgement.”

Our Standards of Practice for Optometrists and Dispensing Opticians state:

- 16.2: “Avoid or manage any conflicts of interest which might affect your professional judgement. If appropriate, declare an interest, withdraw yourself from the conflict and decline gifts and hospitality.”
- 16.3: “Ensure that incentives, targets and similar factors do not affect your professional judgement. Do not allow personal or commercial interests and gains to compromise patient safety.”

Section 1: Sales targets and incentives

74. Other healthcare regulators have sought to address the potential conflicts between providing safe patient care and setting targets and/or incentives for their staff or being incentivised to provide particular treatments or procedures. In 2020, the healthcare regulators published a joint statement on conflicts of interest⁴⁹, setting out their expectations in relation to avoiding, declaring and managing conflicts of interest across all healthcare settings.
75. The College of Optometrists' Guidance for Professional Practice⁵⁰ states that the sale of glasses must not be contingent on performing a sight test, and provides clear guidance on financial interests and potential conflicts of interest.
- A47: "Sale and supply of spectacles or contact lenses must not be a condition for performing a sight test."
 - D23: "You must ensure that your financial and commercial practices do not compromise patient safety."
 - D25: "You must not accept inducements or gifts that may be seen as affecting your patient care or your recommendation of a course of action, for example referring a patient to a particular clinic."
76. The Association of British Dispensing Opticians (ABDO) advises that dispensing opticians must place the interests of the patient above commercial considerations. Products and services should be recommended only where they are professionally appropriate and where the registrant believes they will genuinely benefit the patient, rather than to achieve sales targets or improve practice revenue⁵¹.

Patient experience of pressure selling

77. In our 2026 public perceptions research⁵², 20% of respondents who purchased eyewear said that they felt pressure to purchase specific brands or types of glasses or contact lenses. This figure has fallen from 24% in the 2025 wave. Respondents more likely to state this included ethnic minorities, 25-44 year olds, those who say they are struggling financially, and those with an eye condition. The research also found that 14% of those who said they felt uncomfortable visiting an opticians mentioned pressure to buy glasses or contact lenses. This should be seen in the wider context that the perceived cost of glasses and contact lenses was the most cited reason for feeling discomfort.

⁴⁹ [Joint statement on conflict of interest](#)

⁵⁰ [Honesty and integrity - College of Optometrists](#)

⁵¹ Text provided by ABDO to the GOC in September 2026.

⁵² [Public perceptions research 2026](#)

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78. Our lived experience research⁵³ found that participants felt pressure to buy, such as a second pair offer, lens add-ons, or items they did not want and many felt staff were on commission, which added to the pressure. In the qualitative research commissioned⁵⁴ for this review, patient representative organisations described risks of commercial practices linked to rushed communication, reduced patient understanding and reduced likelihood of returning for routine care. While these were not felt to pose immediate safety concerns, they could result in long-term risks to eye health and preventable blindness.
79. A Healthwatch report⁵⁵ into the public's experience of eye care services found that 72% of survey respondents who had visited an opticians in the last two years said a staff member had suggested an additional product or service to them. The most frequently reported services offered were additional tests (64%), followed by non-reflective coating on glasses (38%) and an additional pair of glasses at reduced cost (37%). Those who said that staff had encouraged them to take up additional paid-for services were twice as likely to say they had avoided getting eye care in the last two years, compared to those who had not experienced this (17% vs 8%). This practice could therefore potentially impact on population eye health.
80. The OCCS identified 37 cases over a three-year period that possibly related to sales targets and incentives (see box 2 for example case studies). Most of the concerns related to the consumer feeling pressured to buy a more expensive product.
81. We reviewed around 180 negative online customer reviews on Trustpilot relating to price transparency and commercial pressures (see box 2 for example case studies). Customers reported problems of feeling pushed towards premium lenses or expensive frames and felt misled or pressured during the sales process. Collectively, these reviews suggest that some consumers experience eye care services less as a clinical encounter and more as a high-pressure retail transaction.

Box 2: Case studies: pressure-selling

OCCS complaint 1⁵⁶

The OCCS received a complaint from the parents of a child with autism. They felt that the sales assistant in the practice had gone out of their way to pressurise their child to buy expensive spectacles and an additional pair when this was not

⁵³ Explain Research (2025), [Qualitative research exploring the lived experience of patients and non-patients accessing and using eye care services](#)

⁵⁴ Shift Insight (2026), [Commercial practices and patient safety in the primary eye care sector](#)

⁵⁵ Healthwatch (2025), [Seeing clearly? Attending sight tests and accessing opticians](#)

⁵⁶ We have numbered the case studies to make clear where one ends and another starts – other references to complaint 1 etc do not mean that the complaint has been made by the same person.

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required. In addition, they said that the lenses had been upgraded to anti-glare without discussion.

The complainants were not content with the initial response from the head office. After input from the OCCS, the optical business agreed to refund the spectacles and apologised.

OCCS complaint 2

The OCCS received a complaint from the son of an adult patient who felt that his elderly parent had been sold unusable spectacles following an appointment in the patient's home. This situation had never arisen before and so the complainant felt that the staff at the domiciliary practice must be working on commission due to the sales tactics and the high price of the spectacles. The practice understood that the patient was happy with the situation until his son became involved.

Initially the practice was not prepared to give a refund as they did not consider that there had been a prescribing error, thought that procedures had been followed correctly, and that there had been no initial dissatisfaction from the patient. After the OCCS discussed the issue with the practice, the concerns were acknowledged and a refund given after a follow-up visit.

Trustpilot review 1

"The pressure that I was put under to order new frames (as well as £600 worth of lenses) was obscene. The entire experience changed from a clinical examination to a high pressure commercial sale. I even heard the staff whispering behind my back about how to get me to buy new frames. The staff themselves were delightful, but the pressure that they are obviously put under to up-sell means that [redacted] has lost me as a customer for ever."

Trustpilot review 2

"Disappointing service. I attended [redacted] for an eye test and to order new glasses. Unfortunately, I left feeling more like id just completed a business transaction than received professional eye care. I felt the staff were focused on selling the most expensive package rather than listening to my needs or clearly explaining my options. I repeatedly said I don't understand what you mean when explaining what they recommend. I wasn't given a clear understanding of what I was actually purchasing, and I left unsure about what glasses I have ordered. Now I'm waiting for my glasses to arrive, but I'm worried I may be disappointed, and by that point I've already paid in full. Overall, I didn't feel supported or properly informed as a customer, which is disappointing for a healthcare-related service."

82. Online reviews and complaints are a selective sample and represent one side's view of what happened but usefully indicate the types of issues that can occur

from the patient perspective. To support informed decision-making, registrants should explain to patients where additional tests are needed or if they might benefit from lens coatings or spare pairs of spectacles. However, supporting informed choices can cross a line into pressure selling and this may have potential wider consequences for people's ongoing engagement with eye care.

Impacts of pressure selling on patient care

83. In our 2026 registrant survey⁵⁷, 34% said they felt under pressure to sell certain types of glasses or contact lenses that will earn more money for the business and 31% said they have felt under pressure to meet commercial targets at the expense of patient care. If registrants felt these pressures, they were more likely to report difficulties in providing patients with the care they needed. For example, 67% of those feeling under pressure to meet targets at the expense of patient care said they 'sometimes' or 'frequently' found it difficult to provide patients with the care they need in the last 12 months compared to 22% who did not feel under such pressures.
84. Registrants who worked for multiples were more likely to agree with these statements. For example, 43% of those who worked for a multiple said that they felt under pressure to meet commercial targets at the expense of patient care, compared with 19% of those who worked at an independent practice. In relation to feeling pressure to sell products or services that will make more money for the business, 47% of those who worked at a multiple reported this, compared to 23% who worked at an independent practice.
85. Experience also appears relevant, for example, students and under-35s were more likely to report these pressures and those who had been on the register for 21 years or more were significantly less likely to report these pressures. For example, 42% of student optometrists said they felt under pressure to meet commercial targets at the expense of patient care, compared to 31% overall. In relation to feeling pressure to sell certain types of glasses or contact lenses that will make more money for the business, 44% of student optometrists and 40% of student dispensing opticians reported this, compared to 34% overall.
86. Our qualitative research into commercial practices and patient safety⁵⁸ found a mixed view about the role of sales targets and incentives. Practice-level targets were generally seen as positive by individual registrants and business registrants. Optometrists and dispensing opticians said they did not let targets impact clinical safety but thought commercial pressures subtly shaped patient interactions. On the other hand, concerns included that:

⁵⁷ [Registrant workforce and perceptions survey 2026](#)

⁵⁸ Shift Insight (2026), [Commercial practices and patient safety in the primary eye care sector](#)

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- commercial targets encouraged upselling, rushed appointments and unnecessary product recommendations; and
 - patients are often aware of commercial pressures which can damage trust and deter routine sight tests, risking undetected eye health issues.
87. Although a small sample, these themes were echoed in the LinkedIn survey⁵⁹ on this topic. Most respondents had daily or weekly sales targets, with a strong focus on converting sight tests into glasses or contact lens sales. These targets and incentives were seen to create significant stress and ethical dilemmas, with many feeling pressured to recommend unnecessary products or tests not in patients' best interests, undermining professionalism and care quality. Although concerned about impacts on patient care, respondents stressed that these targets did not affect the care they personally delivered.
88. The College of Optometrists consulted its Council and members of its Policy Advisory Panel about the topics in our thematic review. It also held a webinar for its members to discuss the findings of our 2025 registrant survey, where members were asked to share their views by a survey before the webinar and to post comments during the meeting. Nearly a third of survey respondents said their employer prioritised commercial targets over patient care. The College identified the GOS contract as a key driver of this environment and called on us to strengthen our standards for businesses.
89. The Federation of Optometrists and Dispensing Opticians' (FODO) survey of its members indicated that while there was a balance to be struck between providing a healthcare and commercial service due to the GOS funding model, they were confident that this did not impact on patient care and registrants acted in the best interests of patients in line with GOC standards. It continued that while incentives and targets exist within some business models, respondents did not view this as inherently negative, and this could in fact promote, rather than undermine, positive professional behaviour. Respondents did not consider there to be a culture of upselling or overselling products in the sector, noting registrants and optical staff were mindful of only recommending products that their patients needed. While sales is not a natural space for registrants, the emphasis across the board is on empowering registrants to make professional recommendations based on each patient's needs.

Impacts of pressure selling on registrant welfare

90. Our 2026 registrant survey demonstrates a link between these pressures and welfare at work. Those sometimes or frequently feeling under pressure to meet targets at the expense of patient care were more likely to report feeling unable to cope with workload (82% vs 50%), working long hours (76% vs 62%) and

⁵⁹ [LinkedIn post](#)

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taking leave of absence due to stress (30% vs 7%). There is also a link with job satisfaction: only 32% of those who felt under pressure to meet targets at the expense of patient care said they were satisfied at work, compared to 71% who did not feel under pressure. In the 2025 survey wave, too much pressure to meet sales targets was cited by 45% of respondents who said they planned to leave the profession within the next 12-24 months.

91. In our qualitative research into commercial practices and patient safety⁶⁰ optometrists and dispensing opticians often linked individualised targets and incentives to negative impacts including heightened stress, erosion of professional identity, reduced job satisfaction and damaging workplace culture. These concerns were echoed in the LinkedIn survey and The College of Optometrists' member survey. The College linked increased workloads, stress and burnout with potential consequences for patient care and patient trust. It saw groups more likely to be affected were locums, younger optometrists, those from ethnic minority backgrounds, and those who were pregnant.
92. A UK study⁶¹ explored how work-related stress could be effectively self-managed by optometrists and how employers could better foster a more supportive working environment. The study highlighted the prevalence of work-related stress amongst optometrists in the UK and the impact this can have on the mental health and wellbeing of registrants. In terms of interventions, respondents highlighted that one strategy within the workplace that could be adopted was clinicians influencing or controlling performance targets and operational aspects such as clinical set up and diary management to help reduce workplace stress. Respondents also identified actions for employers to reduce workplace stress which included a clinical and commercial business strategy to better balance these sometimes competing priorities. Part of this would include addressing some of the perceived imbalances towards the retail side of the business which contributed to unrealistic expectations on staff and stressful workloads.
93. Non-UK studies have also noted the increasing tension between commercial and clinical prioritisation often creating stress and ethical dilemmas for eye care staff. For example, a qualitative study in New Zealand⁶² looked at the changes that increased corporatisation brought to retail optometry and ways in which optometrists balance their identities as healthcare professionals with business

⁶⁰ Shift Insight (2026), [Commercial practices and patient safety in the primary eye care sector](#)

⁶¹ Retallic, N., et al. A qualitative analysis of strategies for managing work-related stress among optometrists in the United Kingdom. *Optom Vis Sci.* 2025 Aug 27;102(10):644–54. doi: 10.1097/OPX.0000000000002294. Epub ahead of print. PMID: 40892438; PMCID: PMC12520036.

⁶² Handy, J., et al. (2020). Managing professional identity within a changing market environment: New Zealand optometrists' responses to the growth of corporate optometry. *Kōtuitui: New Zealand Journal of Social Sciences Online*, 15(1), 204–216.

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considerations, and manage the ethical, commercial and practical tensions created by rapid changes in the market.

Sales of products or services that are not clinically needed

94. In the 2026 registrant survey⁶³, 24% of respondents said they have felt under pressure to sell a product or provide a service which they considered was not needed by the patient. This has risen slightly from 22% in the 2025 wave. These figures were higher among respondents working in multiples (33%) and domiciliary care (28%) compared to independent practices (16%).
95. Our qualitative research into commercial practices and patient safety⁶⁴ found that, while registrants would not sell products or services they considered harmful or unsafe, they may recommend products that are not clinically necessary. Examples included new glasses where there has been only a minimal prescription change, or additional lens coatings. Patient representative organisations also reported that patients can feel they are being upsold or treated primarily as commercial opportunities. Our lived experience research highlights that more vulnerable patients are often unsure whether they are being sold additional tests, scans, products or services based purely on financial rather than clinical considerations.
96. Given the broad-brush nature of this thematic review, we have not investigated sales of specific products or services that are not clinically needed.
97. Optical contractor fraud involves submitting claims to the NHS for optical treatments, services, or enhancements not delivered or clinically required. Risks of optical contractor fraud cited by the NHS Counter Fraud Authority⁶⁵ (NHSCFA) relating to this review include carrying out re-tests for patients earlier than clinically recommended and requesting patients to have new glasses when they do not need new glasses. NHSCFA reported an increase in information reports for contractor fraud from 11 in 2020-21 to 41 in 2024-25.

Conflicts of interest

Work by the Competition and Markets Authority

98. In 2014, the CMA published a report⁶⁶ on private healthcare following a two-year investigation. The report found that certain practices were distorting competition and resulting in adverse effects on the market. In relation to clinician incentives, the CMA considered that the competitive harm that potentially arises was that, despite caveats relating to patients' best interests,

⁶³ [Registrant workforce and perceptions survey 2026](#)

⁶⁴ Shift Insight (2026), [Commercial practices and patient safety in the primary eye care sector](#)

⁶⁵ [Optical contractor fraud | NHS fraud reference guide | NHS Counter Fraud Authority](#)

[Optical contractor fraud | Strategic Intelligence Assessment 2025](#)

⁶⁶ [CMA Private healthcare market investigation](#)

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such incentives might incline consultants to recommend treatment at a particular private facility rather than at another facility which may have equivalent or better facilities and/or which may be more competitive on price. Patients would not be aware about such incentives and in these circumstances, private hospital operators may choose to compete over the value and nature of rewards that they offered to attract referrals rather than on the basis of the quality or price of their services.

99. The CMA's market investigation led to the introduction of the Private Healthcare Market Investigation Order 2014, which applies to private patient units, private healthcare providers, and referring clinicians. One of the main aims of the order is to improve transparency for consumers. The Order also established the Private Healthcare Information Network (PHIN) to provide independent information for private patients on healthcare performance. In addition, it placed restrictions on benefits and incentive schemes offered by private hospital operators to referring clinicians.
100. In its 2025 report⁶⁷ into veterinary services, the CMA highlighted that the trusted professional relationship means that customers do not see vets as 'just another business' seeking to maximise profits. They expect the veterinary businesses' commercial activities to be exercised in a professional ethical context. It found that the lack of regulation of veterinary businesses means there is the potential for their commercial incentives, and their policies and practices, to conflict with vets' and veterinary nurses' regulatory obligations to provide appropriate and timely information about treatment and referral options, and to recommend the option which best meets the circumstances of the pet and its owner.

Referral arrangements for cataract surgery and refractive surgery

101. Referral arrangements for refractive surgery and cataract surgery have been raised with us as an area of concern, albeit the decision to perform the surgery and if it is in the patient's interests rests solely with the treating consultant. These arrangements may create, or appear to create, conflicts of interest where there is a financial link between the referring organisation or individual and the surgery provider. A feature of the eye care landscape is that some surgery providers operate as part of the same business group as the provider carrying out the sight test. Our individual and business standards are clear that conflicts of interest must be identified, managed appropriately and must not compromise patient safety. As patients may be unaware of business structures, ensuring transparency and informed patient choice are also important.

⁶⁷ [Veterinary services for household pets: Final decision report - GOV.UK](#)

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102. The Centre for Health and the Public Interest (CHPI) published a report⁶⁸ in 2025 examining what it termed were the hidden profits and conflicts of interest behind the outsourcing of NHS cataract care in England. The report pointed to a rapid growth in the amount of NHS funded cataract surgery provided by private companies and highlighted that most referrals for NHS cataract surgery are made by high street optometrists. The report raised concerns about incentives to refer patients to certain private providers for financial gain. This could take the form of free Continuing Professional Development (CPD) and additional revenue streams including fees for post-operative follow-up appointments, opportunities to carry out an NHS funded sight test during a follow-up appointment, and opportunities to sell new glasses or contact lenses in a follow-up appointment. The report suggested that the clinical need for post-operative follow-up appointments for such large numbers of cataract patients remained unclear.
103. The report estimated the annual gain to high street optometrists for referring NHS patients for treatment at particular private cataract clinics rather than NHS hospitals was around £17-21 million. The report stated that: “Any suspicion that financial incentives are distorting the clinical decision making of optometrists has the potential to undermine confidence in the provision of eye care services and overall confidence in the optometry profession. Not only can financial incentives lead to unnecessary referrals, which is a patient safety risk, they can also prevent patients from being given the opportunity to choose their preferred healthcare provider.”
104. The College of Optometrists disputed many of the CHPI report’s findings, arguing that the increase in independent sector procedures since 2019 reflects “a complex mix of factors” rather than unnecessary referrals. It also challenged the suggestion that the 30% increase in cataract procedures between 2021/22 and 2023/24 was “predominantly driven by inappropriate referrals or commercial motives”, stating that this interpretation overlooks demographic and incidence forecasts, ophthalmology audit data, NHS policy and the 2017 NICE guidelines, which emphasise quality of life rather than arbitrary visual acuity thresholds as the basis for referral. The College further noted that, although the CHPI report claimed optometrists were referring patients in exchange for financial benefit, “there is no substantial evidence given to back this up.”
105. The Royal College of Ophthalmologists published guidance in 2022 on contracting cataract surgery following a review of the growing number of independent sector providers. An article⁶⁹ references that a key point from the guidance is that commissioners should mitigate against any real or perceived

⁶⁸ Rowland, D. (2025) [Out of Sight – the hidden profits and conflicts of interest behind the outsourcing of NHS cataract care](#), CHPI

⁶⁹ [RCOphth Task and finish groups conclude work to explore cataract provision and growing role played by independent sector providers](#)

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conflicts of interest, for example, including where providers are incentivising optometrists to refer patients to particular providers in return for managing their post-operative care.

106. In terms of our own fitness to practise data, we have not received any complaints in relation to inappropriate cataract referrals. We have received complaints in relation to refractive surgery, but most have not progressed to investigation stage in the fitness to practise process. This is generally because they either related mainly to matters outside our remit (for example, they were in relation to the surgical decision-making by GMC-registered practitioners), or they did not meet the GOC's acceptance criteria threshold for formal investigation. The most common themes relate to consent, surgical outcomes, suitability for surgery and, occasionally, commercial pressures. However, no evidence was provided to demonstrate that any commercial pressures were impacting patient care or placing patients under undue pressure to undergo unsuitable procedures.

Conflicts of interest in the wider healthcare setting

107. Looking at conflicts of interest within the wider healthcare sector to help inform our regulatory approach, the Independent Medicines and Medical Devices Safety (IMMDS) Review⁷⁰ (also known as the Cumberlege review) published a report in 2020 looking at how the healthcare system in England responded to concerns raised by patients about a number of medical interventions that had caused harm. One theme was conflicts of interest and patient concerns around whether clinicians were being incentivised by, for example, manufacturers to recommend particular treatments or procedures.
108. The review called for improved transparency of payments to clinicians. It also proposed mandatory reporting by the pharmaceutical and medical device industries of payments to teaching hospitals, research institutions, and individual clinicians.
109. Following the IMMDS review, the Government consulted further on the issue of real and perceived conflicts of interests in the healthcare system and the disclosure of industry payments to healthcare professionals. The aim of the consultation was to ensure transparency around these types of relationships so public trust and impartiality of clinical decision-making was upheld.
110. Following the consultation, the Government stopped short of introducing new secondary legislation but instead will publish new guidance on how payments made by industry to healthcare professionals should be disclosed. It said this

⁷⁰ [Report of the Independent Medicines and Medical Devices Safety Review 2020, First Do No Harm](#)

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will help improve transparency within the healthcare sector and for patients, which will help them make more fully informed decisions about their care.

111. The PSA's report 'Safer care for all'⁷¹, highlighted the impact of conflicts of interest within healthcare but also noted that questions had been raised about the effectiveness of government and regulatory interventions. For example, scandals have still persisted with the IMMDS Review and the Paterson Inquiry both looking at how financial ties or incentives were prioritised ahead of safe patient care. The PSA called for a cross-cutting review across regulated professions to examine the effectiveness of current regulatory arrangements.

Conclusions

112. We have made the following conclusions related to sales targets and incentives:

- sales targets and incentives are a legitimate business tool but should be designed to drive a culture which is aligned to the best interests of patients;
- pressure to meet sales targets and incentives can be more pronounced for those working in multiples and registrants with less career experience;
- pressure to meet sales targets and incentives can impact on the health and wellbeing of registrants and create risks for workforce capacity; and
- there are conflicting views about incentives for referrals for cataract and refractive surgery and their impacts on patient choice, the quality of care and public trust.

113. These conclusions are discussed below.

Sales targets and incentives are a legitimate business tool but should be designed to drive a culture which is aligned to the best interests of patients

114. Sales targets and incentives are a legitimate business tool for motivating staff, rewarding achievement and supporting businesses' profitability. It would be surprising if such techniques were not used in the optical sector given it is a retail setting as well as a healthcare environment. However, issues can arise if there becomes an overemphasis on commercial metrics, if they drive the wrong culture or if specific targets and incentives are not aligned to patients' best interests. The CMA's findings into the veterinary services market apply equally to this sector: the trusted professional relationship means that patients do not see opticians as 'just another business' seeking to maximise profits.

⁷¹ Professional Standards Authority for Health and Social Care (2023), [Safer care for all: Solutions from professional regulation and beyond](#)

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115. Many registrants see commercial targets and incentives as influential and potentially harmful to the care they provide. While registrants may strive not to allow these pressures to compromise care, our research suggests that meeting targets and incentives can impact on the way registrants interact with patients. Patients may experience this as pressure selling but targets and incentives can also shape patient interactions in more subtle ways. Some patients think they are entering a retail environment where profits might be put ahead of patient care. Over time, such an environment could undermine trust in the professions and discourage people from seeking eye care with potential impacts on long-term eye health and avoidable blindness.
116. Targets and incentives based around conversion rates and other economic factors will always be present. However, to foster the right culture customer satisfaction and other indicators that place quality over quantity should form a stronger part of the mix. A greater focus on team-based rather than individual awards can also help with this. Giving registrants a voice in setting targets and incentives may also help to encourage behaviours that prioritise patient care.

Pressure to meet sales targets and incentives can be more pronounced for those working in multiples and registrants with less career experience

117. We have heard from registrants that pressure to meet targets can be more acute in multiples than in independent practices. GOC research indicates that registrants and non-registered staff working in multiples may experience highly pressurised environments, characterised by a focus on individual rather than team-based targets, close performance monitoring, and potential penalties if targets are not met. In our annual registrant survey, those working in multiples had lower job satisfaction rates and were significantly more likely to report feeling pressure to meet commercial targets at the expense of patient care.
118. Registrants working in independent practices have also raised concerns about the impact of commercial pressures, but generally to a lesser extent. While we hold all businesses to account, the structure of the market may give rise to different business practices and risks. This may require closer scrutiny when concerns are raised, alongside stronger data collection and monitoring by the business to identify red flags. The multiples, which have joint venture and franchise arrangements, have systems in place to monitor activity in each of their premises and in the past have directly raised concerns to us. We would expect these monitoring systems to increase in scale and sophistication based on business size but any business operating across multiple sites should maintain adequate arrangements to monitor activities in each location.
119. Our research also suggests that effectively managing commercial pressures may be harder for those with less career experience. For example, students and registrants under 35 years of age were significantly more likely to report

Section 1: Sales targets and incentives

difficulties. This may reflect that younger registrants are more likely to work in multiples, for example, in our registrant survey three-quarters of respondents with less than five years on the register worked at a multiple whereas less than one in five worked at an independent. For those with 21+ years on the register, over half work at an independent and less than four in ten work at a multiple. Therefore, there is a need to consider what further support may be needed to help students and newly qualified registrants manage effectively the transition into providing healthcare in a commercial environment.

Pressure to meet sales targets and incentives can impact on the health and wellbeing of registrants and create risks for workforce capacity

120. Many registrants see targets and incentives as necessary to support a viable business, given the perceived underfunding of the GOS sight test. However, many also report that working in an environment that combines retail and healthcare can contribute to stress, burnout, ethical conflicts and disillusionment, particularly where commercial priorities are seen to undermine their role as regulated healthcare professionals. Job dissatisfaction levels are also much higher amongst those who feel under pressure to meet targets.
121. Registrants report that business practices are often set by store managers who are neither clinicians nor subject to regulation and may prioritise a profit-driven culture over safe and effective patient care. There appears a disconnect between the perspectives of employers and the registrants who work for them on these issues. Our research evidence shows that registrants are extremely unlikely to raise complaints formally which may suggest a lack of faith that clinical concerns will be understood or taken seriously by management.
122. The nature of targets and incentives varies, but many registrants said that individual targets have a more negative effect on staff than team or practice based targets. They are more likely to contribute to stress, burnout, lower job satisfaction and a poorer workplace culture. Registrants say failing to meet targets can affect pay, career progression and, in some cases, job security.
123. The health and wellbeing of registrants is a regulatory concern as it impacts on their ability to provide safe patient care. A depleted, stressed, unmotivated workforce can also impact on workforce capacity in turn reducing the availability of care. This is pertinent as governments across all four nations aim to move more care into community settings to ease the pressure on secondary care.

There are conflicting views about incentives for referrals for cataract and refractive surgery and their impacts on patient choice, the quality of care and public trust

124. There are concerns that some referrals by optometrists for refractive surgery and cataract surgery may operate in ways that reduce patient choice, reduce the quality of care and damage public trust. There are conflicting views about

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the nature, extent and impact of such referrals. This involves a complex set of issues and there is limited information in the public domain. A detailed investigation exceeds the scope of this broad-brush review, but we recognise the potential for harm and intend to keep the issues under review.

125. Our standards of practice are clear that registrants must effectively manage any conflicts of interest which may sway their professional judgement. However, our research suggests that some registrants may not feel confident in recognising and balancing potential conflicts of interest and may need further support. We think our Standards for Optical Businesses could be more explicit in supporting registrants to navigate such issues and foster the right culture.
126. Issues relating to managing conflicts of interest in healthcare extend beyond eye care. We welcome and will continue to engage with government-led initiatives in this area to strengthen reporting and data collection requirements.

Section 2: Booking practices

Overview

- There is wide variation in booking practices across practice settings with a range of commercial, funding and operational factors influencing appointment management, especially patient 'did not attend' rates.
- Good booking practices are important to ensure that healthcare services balance access to care with the safe and effective delivery of treatment. Effective appointment scheduling can help maximise the use of available clinical capacity, reduce waiting times and support timely access to care, particularly for patients requiring urgent assessment or treatment.
- There are starkly differing views between stakeholders on the prevalence and impact of different approaches to managing and booking patient appointments. However, the scale of concern among registrants is notable, with just over a third reporting that pressure to see high numbers of patients has negatively affected their ability to deliver safe care.
- Some registrants experience pressure linked to busy diaries, high patient volumes, rushed appointments and have concerns about their ability to communicate effectively or maintain confidence in clinical care. Negative impacts on individual registrants' wellbeing are also widely reported.
- Students and early career professionals are more likely to report pressures relating to booking practices and need greater support.
- A strength of the sector is that patients can book appointments quickly. While delays are an inherent issue in healthcare environments, reports of negative patient experiences include late cancellations, long delays, communication issues, booking errors and crowded or rushed environments. Patient groups are concerned about patients being deterred from attending future sight tests.
- Crowded environments and long waits caused by booking practices can create greater disadvantage for patients with additional needs.
- Stakeholders point to a link between levels of GOS funding and overbooking, but this does not explain all poor booking practices.

Introduction

127. Our research and stakeholder engagement shows a range of booking practices being used across the optical sector, with overbooking appointments common to varying degrees. Approaches often differ by practice type and setting.

Section 2: Booking practices

Classifying booking practices accurately is challenging since the terminology is contested and there are many variations in approach with phrases such as overbooking and ‘ghost clinics’ used by registrants interchangeably.

128. We see booking practices as broadly falling into three categories:

- individual patients are booked into a maximum number of appointments per named optometrist per day;
- a ‘rolling’ clinic where patients are not booked in with a named optometrist, but seen by the next available optometrist – this is more common where there are multiple optometrists working on site; and
- a higher number of patients per day are booked in than clinic slots available either where:
 - total number of bookings slightly exceeds the maximum number of appointments to account for a limited number of no-shows; or
 - a full additional clinic (sometimes called a ‘ghost clinic’ or ‘ghost lane’) or much higher number of bookings than available appointments⁷².

129. Providers open for different times in different locations with different levels of staffing. As a result, providers reported clinic slots available per optometrist per day ranging between six and 19 (average 15), with between 30%-100% slots being booked each day and significant variations depending on local factors. Providers monitor diaries and flex these based on various factors including location, teams working that day and premises level support.

Healthcare standards and regulation

130. Our Standards for Optical Businesses do not directly address booking practices, although one standard indirectly does so (see box 3). Further information can be found in section 3 on sight testing times.

Box 3: GOC standards

Our Standards for Optical Businesses provide that a business:

- 3.1.4: “Allows staff sufficient time, so far as possible, to accommodate patients’ individual needs within the provision of care.”

⁷² These terms can mean different things to different people, but in essence, the concern is around a patient appointment booking for which no optometrist is allocated, requiring those working that day to cover these additional patients. Some terms like ‘ghost clinics’ are not recognised by representatives of businesses but are widely used by registrants in our research.

Section 2: Booking practices

131. The College of Optometrists opened a consultation⁷³ in June 2026 on its Guidance for Professional Practice in which it is proposing to introduce: “an explicit expectation that optical businesses must not use scheduling methods that compromise patient safety, such as routine overbooking or ‘ghost clinics’, and must allow sufficient time for individual patient needs, including for children, neurodivergent patients, and those with complex needs.” It considers that this matter is one of the most pressing issues facing the profession today.
132. A statement⁷⁴ from the Association of Optometrists (AOP) in 2020 clarifying its position on ghost clinics acknowledges that it may make good business sense to ensure that a clinic is busy and can safely see as many patients as possible, but it warned against doing this without considering “the historic no-show rate or appointment availability in a particular practice”. It advises practice owners/managers that “ghost clinics should not be run as standard or default practice”, that it is not acceptable to expect clinicians to work through their lunch break or to work longer hours to see additional patients.
133. ABDO believes that appointments should be booked only for genuine patients and allow sufficient time for safe, effective and patient-centred care. Clinical judgement, professional standards and patient care must not be compromised by unrealistic scheduling, overbooking or fictitious (‘ghost’) clinics. Booking systems should be transparent and accurately reflect clinician availability⁷⁵.

Prevalence of overbooking models

134. The challenges around terminology described at the start of this section make it difficult to establish prevalence of different booking practices. In general terms, the research report for our qualitative research into commercial practices and patient safety⁷⁶ found that:
 - overbooking and rolling clinics were widely reported in multiples and some individual and business registrants said that ‘ghost clinics’, where there were a higher number of clinics than optometrists, were also in place. These booking practices were driven by automated booking systems and designed to mitigate no-shows; and
 - independent optical businesses more commonly used manual booking methods (phone/email) and had greater control of diaries, with less overbooking taking place.

⁷³ [Help shape the College's updated Guidance for Professional Practice - College of Optometrists](#)

⁷⁴ [AOP statement on ghost clinics](#)

⁷⁵ Text provided by ABDO to the GOC in September 2026.

⁷⁶ Shift Insight (2026), [Commercial practices and patient safety in the primary eye care sector](#)

Section 2: Booking practices

135. In our 2025 LinkedIn conversation⁷⁷ and survey⁷⁸ on booking practices, most registrants told us that they were aware of overbooking and ‘ghost clinics’ occurring in optical businesses, describing it as extremely common, widespread, and routine, especially in large chains and multiples. Participants also suggested that overbooking or ‘ghost clinics’ happen frequently, with many stating it occurs daily or almost daily (see box 4 for example comments).
136. By contrast, feedback from FODO members presented a different picture. The vast majority said that their organisations did not use any form of booking system which double books patients in a clinic, and that they did not ask their staff to overbook clinics either. Some use practice management systems which prevent double booking of appointments. None of the providers recognised the term ‘ghost clinic’ or overworking registrants.

Box 4: LinkedIn survey: booking practices

Registrant 1

“Yes. Overbooking or ‘ghost clinics’ are taking place in parts of the optical sector. It is a worrying trend where multiple patients are booked into the same time slots to maximise profits or reduce downtime, often at the expense of safe and thorough patient care.”

Registrant 2

“Yes this practice occurs across many corporate multiple optical businesses, especially stores operated under large chains [redacted text]. In numerous locations, clinics are routinely overbooked, with appointment schedules often exceeding what can be safely managed within the allocated time. These systemic practices appear to be driven by commercial pressure to maximise throughput and profits, often at the expense of patient safety, staff wellbeing, and professional standards.”

Registrant 3

“It’s almost ubiquitous in multiples and commonplace even in some larger independents across the country.”

Overbooking and did not attend (DNA) rates

137. Overbooking is a business practice used in a range of healthcare settings where there is a regular rate of patients not attending scheduled appointments (referred to as a ‘did not attend’ (DNA) rate or failure to attend). Some practices

⁷⁷ [\(53\) Post | LinkedIn](#)

⁷⁸ [Project: Your opinions on overbooking/'ghost clinics' | General Optical Council](#)

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monitor what percentage of their patients did not attend appointments and use this information to inform appointment scheduling. DNA rates can vary widely in different locations even within the same business (we have informally heard rates varying between around 4% and 20%).

138. In our qualitative research into commercial practices and patient safety⁷⁹, many business registrants felt that commercial practices such as overbooking were not only essential to remaining financially viable but also had positive impacts on patients by ensuring wider access to care.
139. As wider context, the Opticians Act 1989 does not permit businesses to take deposits, which might allow them to recoup some lost revenue from DNAs. This is an area we are seeking to potentially change, subject to consultation, as part of the Department of Health and Social Care's regulatory reform agenda.
140. The College of Optometrists advised that they were aware of practices using appointment management strategies to reduce the number of 'did not attend' appointments and advised that these practices, *"should have a robust plan in place, agreed with their clinicians, to safely manage the clinic if all patients attend. It is essential that patient safety, waiting times and the wellbeing of the optometrist are considered and effectively managed when planning clinics. Appointment structures should primarily be aligned with clinical standards and not commercial metrics, with decisions informed by clinicians. Optometrists should also be given time for sufficient breaks and administration, such as making referrals and communications with clinical colleagues in other settings."*

Impact on patient experience

141. While the evidence does not clearly show direct or immediate patient safety harm from booking practices, it does indicate that poor scheduling, delays and rushed appointments can negatively affect patients' experience of care and may influence whether they return for routine eye care in future.
142. A strength of the sector is that it is generally easy for patients to book sight tests in advance without long wait times. In our 2026 public perceptions survey⁸⁰, for the first time we asked participants how satisfied or dissatisfied they were with how long they had to wait for their appointment. Almost nine in ten (89%) were satisfied, with only 3% saying they were dissatisfied. Older participants (aged 65+) were generally more satisfied than participants aged 16-34 (96% vs 82%), as were those from white backgrounds compared to those from an ethnic minority background (92% vs 80%).
143. Our analysis of negative Trustpilot reviews highlights the types of issues that can arise. This found concerns that can be linked to booking practices

⁷⁹ Shift Insight (2026), [Commercial practices and patient safety in the primary eye care sector](#)

⁸⁰ [Public perceptions research 2026](#)

Section 2: Booking practices

(including appointment reliability and communication) in around 180 reviews. Reviewers described significant disruption to their care due to poor scheduling processes, administrative errors or lack of communication. These problems included cancelled appointments at very short notice, failure to attend scheduled home-visits, long waits despite arriving on time, situations where patients were not informed about delays or rearranged appointments until they were already in the clinic, booking errors (wrong date, wrong patient details or lost records) and difficulty getting through to branches or receiving call-backs. These issues appeared particularly acute for older people, housebound patients, and carers, where booking practices had noticeable impact. Example comments are provided in box 5.

Box 5: Trustpilot reviews

Trustpilot review 1

“Terrible service! no text or phonecall to say that they're appointments are substantially running behind! Drove all the way there for my appointment 20mins early, there was only 4 chairs in the waiting area that were already being used, so already nowhere to sit...then told that they're running about 30mins behind on appointments which would leave me standing in a small waiting area for almost an hour...you couldn't make it up!”

Trustpilot review 2

“Do not book a late appointment! My appointment was cancelled first two times, asked to attend an earlier appointment on the third visit (given 1 minutes notice). Was then kept waiting anyway, and had a very rushed eye test and at the end of it was told to come back at another time to complete the test as the equipment had been shut down.”

144. Situations such as staff shortages, an unexpected number of walk-in patients or equipment failure may result in delays to appointments and patients having to wait longer than they would want for their appointment. Nevertheless, businesses should have management solutions in place to manage these situations and be able to communicate with patients quickly and clearly.
145. Where patients have bad experiences, this may have wider consequences for ongoing engagement with eye care. In our qualitative research into commercial practices and patient safety⁸¹, many individual registrants, non-registered staff and all patient representative organisations raised concerns around patients not accessing routine eye care in the future, due to feeling rushed or dissatisfied with the level of communication within appointments, and the potential

⁸¹ Shift Insight (2026), [Commercial practices and patient safety in the primary eye care sector](#)

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consequences on long-term eye health as a result of this. Similarly, patient representative organisations highlighted that crowded, noisy or rushed environments deter patients from returning.

146. Long waits and crowded waiting areas may disproportionately disadvantage people with additional needs. Our lived experience research with patients in vulnerable circumstances⁸² highlighted psychological barriers to visiting opticians including the 'open' nature of the physical environment, having to sit next to strangers in waiting rooms, and concerns over the length of the wait. Adults with a learning disability are ten times more likely to have an eye problem than the general population and for children with a learning disability this rises to 28 times more likely to have an eye problem when compared with the general population⁸³. This environment could therefore have a disproportionate negative impact on such patients.
147. Our qualitative research into commercial practices and patient safety⁸⁴ found that:
- some business registrants from independent practices actively rejected 'ghost clinics', viewing them as detrimental to patient experience;
 - no stakeholder group presented clear evidence of direct, immediate patient safety harm as a result of booking practices. However, many individual registrants, non-registered staff and all patient representative organisations raised concerns around patients not accessing routine eye care in the future, due to feeling rushed or dissatisfied with the level of communication within appointments, and the potential consequences on long-term eye health as a result of this; and
 - patient representative organisations highlighted that crowded, noisy or rushed environments deter patients from returning and may disproportionately disadvantage people with additional needs.
148. The research concluded that individual registrants and patient representative organisations more frequently described risks of commercial practices linked to rushed communication, reduced patient understanding and reduced likelihood of returning for routine care. While these were not felt to pose immediate safety concerns, they were said to have meaningful long-term risks to eye health.

⁸² Explain Research (2025), [Qualitative research exploring the lived experience of patients and non-patients accessing and using eye care services](#)

⁸³ Emerson, E. and Robertson, J. (2011), [The Estimated Prevalence of Visual Impairment among People with Learning Disabilities in the UK](#). Improving Health and Lives: Learning Disabilities Observatory

⁸⁴ Shift Insight (2026), [Commercial practices and patient safety in the primary eye care sector](#)

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149. In our LinkedIn conversation⁸⁵ on booking practices, most respondents reported that overbooking and ‘ghost clinics’ had a significantly negative impact on patients, with longer waiting times, rushed appointments and reduced quality of care, patient frustration and dissatisfaction, compromised patient safety, and loss of trust and confidence. Some comments also highlighted the potential for unnecessary referrals to the hospital eye service since overbooking did not allow sufficient time for thorough tests. Example comments are provided in box 6.

Box 6: LinkedIn survey: booking practices

Registrant 1

“1) px [patient] safety is at risk, the optom has to test quickly, this means things are likely to get missed as the optom isn’t able to give enough time to the px as there is another appointment booked at the same time. 2) patients routinely get called in late for their appointment, just last Saturday I had to call in several patients nearly 40 mins late due to extra appointments booked in by the manager and this happens regularly.”

Registrant 2

“...Patients may be unnecessarily referred into HES [hospital eye service] as extra tests e.g. ... tonometry, dilations etc may not be carried out, or may not feel they have time to seek out second opinion from colleagues. Diminishes the public perception of optometry further as the ghost clinic / overbooking practice is purely for financial gain for the companies doing so.”

Workforce pressure and registrant wellbeing concerns

150. Our 2026 registrant survey⁸⁶ found that those respondents who sometimes or frequently felt under pressure to see a high number of patients every day which had impacted on their ability to provide safe patient care were considerably more likely to be considering leaving the profession (around a quarter) when compared to those not reporting these difficulties (16%). The same was true for those who had sometimes or frequently been asked to overbook clinics.
151. These pressures are not evenly distributed. For example:
- of the 38% who said that they had ‘sometimes’ (21%) or ‘frequently’ (17%) felt under pressure to see a high number of patients every day which had impacted on their ability to provide safe patient care (same as in 2025), this was more common among those working in multiples, those working as

⁸⁵ [\(53\) Post | LinkedIn](#)

⁸⁶ [Registrant workforce and perceptions survey 2026](#)

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locums, those who had been on the register for 3-5 years, and those working in Scotland and Northern Ireland; and

- of the 23% who said that they have ‘sometimes’ (14%) or ‘frequently’ (10%) been asked to overbook clinics (25% in 2025), this was more common for those working as locums and those working in hospital settings, and less common for those working as an independent or sole practitioner.

152. In our 2024 registrant survey⁸⁷, a high volume of patients, overbooking and ‘ghost clinics’ were identified as key workplace challenges that acted as a barrier to delivering safe patient care. This pressure was particularly felt by newly qualified professionals. Qualitative feedback from registrants suggested they were struggling “to balance patient care with the demands of their employers” and that these issues contributed to job dissatisfaction, placing strain on their professional practice and mental health. This was supported by a blog⁸⁸ on ‘ghost clinics’ on the website of Prospect Union, arguing that optometrists are being put “in a compromising position between carrying out their employer’s request and/or breaching GOC standards which could lead to them losing their registration and be unable to practice” and calling on the GOC to investigate and put a stop to the practice.
153. Our lived experience research with registrants⁸⁹ who had experienced harassment, bullying, abuse or discrimination in their roles highlighted the speed at which they are expected to practise as challenging, with overbooked clinics (including a ghost lane) given as an example. Respondents reported missing lunch/breaks, eating quickly, putting off having a toilet break and/or not having enough management time.
154. Our qualitative research into commercial practices and patient safety⁹⁰ found that optometrists and dispensing opticians frequently reported that busy diaries led to rushed appointments, reduced communication and anxiety about missing clinical detail. Non-registered eye care staff similarly described pressure in busy environments and the risk of operational errors.
155. The research report concluded that individual registrants and non-registered eye care staff reported that high patient numbers contributed to personal stress, missed breaks, burnout, and some optometrists and dispensing opticians choosing to leave multiples or the profession altogether.

⁸⁷ [Registrant Workforce and Perceptions Survey 2024](#)

⁸⁸ [The ‘chilling issue’ of Ghost Clinics | Prospect](#)

⁸⁹ Explain Research (2025), [Qualitative research exploring the lived experience of optometrists and dispensing opticians in the UK facing harassment, bullying, abuse or discrimination at work](#)

⁹⁰ Shift Insight (2026), [Commercial practices and patient safety in the primary eye care sector](#)

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156. Our LinkedIn conversation and survey⁹¹ on booking practices found that:

- many respondents described feeling rushed, anxious, and unable to provide the standard of care they aspire to. Burnout, mental health deterioration, and physical exhaustion were frequently mentioned, with some stating they have considered leaving the profession or have already done so; and
- most respondents who raised concerns about overbooking or 'ghost clinics' with their employers found their concerns dismissed, ignored or met with indifference.

157. Example comments from the survey are provided in box 7.

Box 7: LinkedIn survey: booking practices

Registrant 1

"I am forced to rush tests to somehow deal with double booked patients at the same time. It's unsafe. I have to skip tests or fail to explain things properly or the patients will start to complain. I hear the staff outside saying I'm running late which impacts the public perception of the profession in my view when the truth is we are being run into the ground."

Registrant 2

"1) stressed due to running behind, worried about missing pathology and being investigated by the GOC 2) not able to get a full lunch 3) finishing late which means getting home late especially after a long commute 4) frustrated that I am not able to give the service and care that patients deserve 5) I am seriously thinking about leaving this profession, I would not recommend anyone to get into optometry"

Registrant 3

"Constant pressure of completing the clinic. Feels like I have to rush eye examinations as I don't have the time to see patients safely. I don't even have time to go to the toilet as I'm constantly working like a robot. No time to even sip water as the clinic is running behind and always have to catchup. Shorter lunch breaks as the clinic has run into lunch, I'll be lucky if I get 10 mins. Even during the lunch break I'm constantly getting interrupted to sign off kids collections and sign rx [prescription] copies, dealing with other queries. I have to do my admin during lunch time..."

⁹¹ [\(53\) Post | LinkedIn](#)

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Registrant 4

“...As a locum, companies blacklist you for refusing ghost clinics even though they state in writing that you have a right to decline them. So in reality, they are making you choose between seeing ghost clinics or not having work.”

Registrant 5

“I have been stopped from going to the toilet because patients are waiting. I’ve been told off by management for taking too long speaking to eye casualty. I’ve been asked by management with no optical degrees etc whether dilations are necessary. I miss my lunch breaks on a regular basis and I leave work late.”

158. We reviewed fitness to practise hearings decisions over a three-year period where commercial pressures were raised as a defence to the allegations. A case study relating to booking practices is provided in box 8 – this involved a student optometrist who falsified diary appointments, which they explained was because clinics always over-ran and they had insufficient time for lunch and completing administrative tasks such as referrals. An example of an enquiry received into our professional standards team is also provided in box 8.

Box 8: Fitness to practise case study: booking practices

A case heard in 2025 related to falsifying of diary appointments by a student optometrist over a six-week period, prior to admitting the incident and being dismissed. The registrant explained that they had worked in a busy multiple, which operated a rolling clinic (whereby the next free optometrist would take the next patient waiting). The rolling clinic always over-ran and the registrant would have to work through lunch and had insufficient time to complete their tasks, which included preparing for visits from The College of Optometrists, adding visual field results and catching up on referrals. They were given additional tasks and when they told management they were struggling, they were given an additional 30 minutes, but this meant that they missed out on the weekly staff training session. They said that they were not closely supervised after the first month and had to ask for support. They were finding it increasingly difficult to cope, and did not realise how hard it had been until they left the organisation. They said that they had created the false appointments to allow more time to catch up on patient notes and prepare for College visits, but recognised that this had broken the trust of their colleagues and supervisors.

The registrant admitted the facts. A finding of impairment was made and a suspension order of three months was given.

Professional standards case studies: booking practices

Case study 1

An optometrist working in a multiple contacted us to advise that they had a main clinic full of patients and their employer was trying to put a second clinic alongside it, with an extra patient in the mornings and afternoons. The justification given by the employer was that there may be 'DNAs' [did not attends] but the instruction was to see all patients even if there were DNAs. The registrant was concerned about the time this would take, being rushed and having to oversee their pre-registrant student and the shop floor. They wanted to know if there was any guidance in place related to these matters as they did not think it was safe or fair to see patients on top of full clinics, especially as the practice did not always get DNAs.

159. Booking practices are not always designed or controlled by the registrants responsible for delivering care, as structures may be determined by employers, practice managers or automated booking systems, with limited opportunity for clinicians to influence diary management. This may contribute to a feeling of reduced control over workload or create tension where registrants feel that booking arrangements do not adequately reflect the time needed to provide safe patient care.

Links to wider system and funding pressures

160. A 2014 study⁹² looking at the GOS contract found that the fee paid for GOS sight tests in England, Wales and Northern Ireland did "not cover the full cost of conducting the examination" and considered that, "The shortfall in sight test income means that Contractors may be tempted to fit as many appointments into the day as possible."
161. Our qualitative research into commercial practices and patient safety⁹³ found that many business registrants, particularly in multiples, saw overbooking and ghost clinics as commercially essential for financial viability and maximising appointment availability.
162. The research concluded that:
- across all stakeholder groups, booking practices were seen as interlinked and shaped heavily by the low GOS sight test fee in England, which was thought to drive a reliance on retail income (while noting that some

⁹² Shickle, D., Davey, C.J. and Slade, S.V. Why is the General Ophthalmic Services (GOS) Contract that underpins primary eye care in the UK contrary to the public health interest? *British Journal of Ophthalmology* 2015;99:888-892.

⁹³ Shift Insight (2026), [Commercial practices and patient safety in the primary eye care sector](#)

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individual and business registrants in Scotland and Wales said their GOS contracts reduced retail pressure); and

- while commercial drivers were largely thought to sit outside the GOC's remit, many stakeholders believed the GOC should strengthen its stance on expectations for safe practice in commercial environments and be more vocal in supporting wider sector change, such as lobbying for change to funding structures.

163. When asked about recommendations for the GOC and wider sector, many individual and business registrants felt that contemporary optical practice was deeply entangled with high patient numbers, to increase sales of glasses and make enough money to survive as a business. They felt that a structural change to GOS fees and NHS contracts in England was needed to prevent this.
164. It is interesting to note our 2026 registrant survey findings that 42% of respondents in Scotland said they felt under pressure to see a high number of patients every day which had impacted on their ability to provide safe patient care, compared to 38% in England. This figure should be seen in the context of the Scottish Government paying higher GOS fees than in England and setting a minimum eye examination time of 30 minutes per patient and a maximum of 20 eye examinations per day^{94 95}.

Conclusions

165. We have made the following conclusions related to booking practices:

- overbooking can support access to eye care for patients but needs to be managed well to ensure sustainable workloads and adequate testing times;
- some booking practices appear to be reducing registrants' wellbeing; and
- greater support is needed for students and early career professionals.

166. These conclusions are discussed below.

Overbooking can support access to eye care for patients but needs to be managed well to ensure sustainable workloads and adequate testing times

167. Good booking practices are important to ensure that healthcare services balance access to care with the safe and effective delivery of treatment. Effective appointment scheduling can help maximise the use of available

⁹⁴ [The National Health Service \(General Ophthalmic Services\) \(Scotland\) Regulations 2006](#)

⁹⁵ [PCA\(O\)\(2018\)01 - General Ophthalmic Services \(GOS\): GOS regulations amendments; optical voucher values; maximum number of daily GOS eye examinations and primary eye examination appointment times](#). This was reiterated in PCA(O)2025(04).

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clinical capacity, reduce waiting times and support timely access to care, particularly for patients requiring urgent assessment or treatment.

168. Overbooking or rolling clinics may enable practices to make more efficient use of clinical capacity and reduce the number of unused appointment slots. It may also increase access to care for patients who might otherwise not be seen, including those attending on a walk-in basis or requiring urgent assessment. Rolling clinics allow optometrists to adjust appointment length depending on each patient's needs, including those requiring additional support.
169. Businesses view these booking practices as essential for their financial viability. Empty consulting rooms benefit no-one, so overbooking may be appropriate if designed and managed in a way that supports wide access to safe and effective eye care. Good booking practices should ensure practitioners have a sustainable workload with sufficient time to carry out appropriate assessments, exercise professional judgement, communicate effectively with patients and complete record keeping and other tasks.
170. Where appointment schedules do not adequately reflect the time required to provide care, this creates risks to patient safety, quality of care and patient experience. We have noted concerns that high patient volumes can lead to rushed consultations, reduced quality of communication, and lower patient understanding, with potential consequences for follow-up care and long-term eye health. These impacts are not evenly distributed – patients with additional needs may be disproportionately affected by busy, crowded or time-pressured environments, raising concerns about equity of access and experience. Furthermore, qualitative evidence from registrants indicates that time pressures associated with overbooking can result in elements of the clinical assessment being rushed or omitted, which represents a potential risk to patient safety.

Some booking practices appear to be reducing registrants' wellbeing

171. The evidence consistently indicates registrant concern that booking practices are having a negative impact on working conditions. Reports of rushed appointments where things can be missed and reduced communication with patients are a source of anxiety. Evidence of shortened or missed breaks, inability to complete administrative tasks during working hours and difficulty in raising concerns suggests that these pressures can also adversely affect wellbeing, including contributing to burnout and registrants wanting to leave the profession. This may be made more acute in situations where registrants feel they don't have control over decisions on booking.
172. The review found contrasting perspectives across sector bodies. While The College of Optometrists views routine overbooking and 'ghost clinics' as 'one of the most pressing issues facing the profession today', business representatives refute the existence of 'ghost clinics' and do not consider staff are overworked.

Section 2: Booking practices

This lack of consensus may indicate a breakdown in communication between employers and registrants delivering care to patients.

173. While the design and operation of booking systems sit within the responsibility of businesses, booking practices fall within the scope of our regulatory interest where they may undermine patient safety or registrant wellbeing. Some of the experiences we have heard raise concerns about the environments in which some registrants work and their ability to deliver safe patient care. We will review our Standards for Optical Businesses to strengthen expectations in this area, including the need for booking practices and appointment scheduling to support safe care, with appropriate contingency planning where demand exceeds capacity, and effective mechanisms for staff to raise concerns.

Greater support is needed for students and early career professionals

174. Our survey evidence shows that students and early career professionals struggle most with pressures related to booking practices.
175. Our education and training requirements⁹⁶ set out the knowledge, skills and behaviours a student must demonstrate to join the register as a fully qualified optometrist or a dispensing optician. The Outcomes for Registration in our Requirements for Approved Qualifications in Optometry or Dispensing Optics⁹⁷ include at 6.1: “Undertakes efficient, safe and effective patient and caseload management.”
176. Optical students working on placement as part of their training depend highly on the quality of supervision in the practice; this will be shaped by the wider business environment as well as the individual supervisor. The Standards for Approved Qualifications in our Requirements for Approved Qualifications in Optometry or Dispensing Optics include at 4.9: “There must be policies and systems in place to ensure the supervision of students during periods of learning and experience in practice safeguards patients and service-users and is not adversely affected by commercial pressures.”
177. The Sector Partnership for Optical Knowledge and Education (SPOKE) guidance commissioned by the GOC to support implementation of our education and training requirements is that during a typical week of workplace clinical learning in a primary setting, a student might be expected to spend 20 hours in a testing room or dispensing clinic, interleaved with case discussions and feedback from one or more supervisors. They will also need to spend time documenting and reflecting on their experiences. Further, in the early days students will require more direct observation, and be able to see fewer patients, than students who are near to qualifying. The time needed for supervisors to

⁹⁶ [Education and training requirements](#)

⁹⁷ [Requirements for Approved Qualifications in Optometry or Dispensing Optics](#)

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fulfil their responsibilities in relation to the student(s) also needs to be factored into appointment scheduling.

178. As well as students, we would expect businesses to factor into their approach that less experienced staff will need time to adjust to the realities of a busy commercial environment and may take longer to complete sight tests.

Section 3: Sight testing times

Overview

- All sight tests must contain minimum features but duration of sight tests can vary significantly depending on factors including NHS commissioning, extent of delegation, the technology used and each patient's individual needs.
- There is high patient satisfaction with the time provided during sight tests to deal with their needs properly. When things go wrong, patient concerns often relate to feeling rushed and reduced understanding.
- In our registrant survey, nearly half of respondents report that the time available to them is insufficient to deliver safe patient care, with higher rates among those working in multiples and in locum roles. These findings are echoed in a member survey conducted by The College of Optometrists.
- Short sight testing times reduce registrant wellbeing by contributing to stress, reduced job satisfaction, missed breaks and burnout.
- There is no hard evidence that sight testing times are causing missed diagnosis, although any such patterns would be difficult to identify.
- As with booking practices, structural factors including GOS sight test fees are viewed by many stakeholders as a major driver of short sight testing times.
- Some stakeholders want the GOC to set minimum sight testing times. However, we do not consider it appropriate to do so due to the variety of sight test formats, differing patient needs, and impact of potential unintended consequences. Instead, the focus should be on empowering clinicians to make autonomous decisions, guidance from professional bodies on common clinical scenarios and addressing barriers to registrants speaking up about concerns.

Introduction

179. All sight tests must include minimum features but will vary in length for a range of reasons. One factor is whether some tasks are delegated by the optometrist. For example, it is often the case that in larger chains, tests such as intraocular pressure checks, visual field tests and retinal photographs/scans (sometimes referred to as 'pre-screening') are carried out by an optical assistant prior to the patient seeing the optometrist. In such formats, the business would not count these tests in the sight testing time. Optometrists working in independent practices are more likely to carry out such tests themselves as part of the appointment and would therefore count them as part of the sight testing time.
180. Sight testing times will also depend on the range of tests and technology used and may also depend on the needs of the patient (for example, where the

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patient has any additional needs or pre-existing eye conditions). Insights from our price transparency study include that GOS funded sight tests can involve fewer tests than private tests (due to their specification) and that some businesses advertise the duration of the test, including tests lasting an hour or more. Specifications for GOS sight tests also vary between nations.

181. Adequate testing times are important for both patients and registrants. Sufficient time enables optometrists to undertake appropriate clinical assessments, discuss treatment options and risks, answer questions, and support informed decision-making. It helps patients to feel listened to, contributing to a positive care experience and supporting trust and confidence in the professions.
182. From a professional perspective, having sufficient time for appointments can reduce the risk of errors, omissions and compromised clinical decision-making. Conversely, where appointment times are reduced or practitioners are required to see a high volume of patients within limited timeframes, there may be implications for patient safety, quality of care and professional standards. Time pressures may also contribute to stress, fatigue and burnout among registrants, which can adversely affect workforce wellbeing and retention.
183. The findings in this section are heavily linked with the previous section on booking practices (section 2). The amount of time available for a sight test is shaped not only by the length of the appointment itself, but also by wider decisions about clinic design, appointment scheduling, patient volumes and diary management.

The legal framework

184. Section 36(2) of the Opticians Act 1989 ('the Act') defines "testing sight" as "testing sight with the object of determining whether there is any and, if so, what defect of sight and of correcting, remedying or relieving any such defect of an anatomical or physiological nature by means of an optical appliance prescribed on the basis of the determination".
185. Sections 26(1) and 26(2) of the Act set out that when a sight test is performed, it shall be the duty of the person testing sight to:
 - perform examinations of the eye that are required for the purpose of detecting injury, disease or abnormality in the eye; and
 - immediately following the test, issue a written statement that the above examinations have been carried out, that the patient is / is not being referred to a medical practitioner and the reason for the referral (in practice, this is usually combined with the prescription mentioned below); and

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- provide a signed, written prescription for an optical appliance or a signed, written statement confirming that no optical appliance is necessary.

186. Further to this, regulation 3 of The Sight Testing (Examination and Prescription) (No. 2) Regulations 1989 provides that the person testing sight must conduct:

- an examination of the external surface of the eye and its immediate vicinity;
- an intra-ocular examination, either by means of an ophthalmoscope or by such other means considered appropriate; and
- such additional examinations as appear to be clinically necessary.

Healthcare standards and regulation

187. Our Standards of Practice for Optometrists and Dispensing Opticians and our Standards for Optical Students provide that patients are given sufficient time to deal with their needs and take an active part in decisions about their treatment. Our Standards for Optical Businesses provide that businesses should allow their staff sufficient time with patients and that operational or commercial pressures do not inhibit this. Relevant standards are outlined in box 9.

Box 9: GOC standards

Our Standards of Practice for Optometrists and Dispensing Opticians and our Standards for Optical Students provide:

- 1.1: “Give patients your full attention and allow sufficient time to deal properly with their needs.”
- 1.7: “Encourage patients to ask questions and take an active part in the decisions made about their treatment, prescription and aftercare.”

Our Standards for Optical Businesses provide that a business:

- 1.3.2: “Ensures, so far as possible, that operational or commercial pressures do not inhibit staff from allowing patients the time they need to process any information given to them and the opportunity to change their mind.”
- 3.1.4: “Allows staff sufficient time, so far as possible, to accommodate patients’ individual needs within the provision of care.”
- 3.4.2: “Facilitates the sharing of appropriate and relevant information in a timely manner.”

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188. Many of the healthcare regulators have standards of practice for their registrants which specify that sufficient time should be available for a patient.
189. The College of Optometrists' Guidance for Professional Practice⁹⁸ directs its members to allow sufficient time to perform the eye examination or sight test (A49). Please refer to paragraph 131 of section 2 of this report, which refers to the amendments that the College is has consulted on in relation to an expectation on businesses that they must allow sufficient time for individual patient needs, including for children, neurodivergent patients, and those with complex needs, suggesting that these patients "will reasonably require longer than a standard sight test appointment".
190. ABDO advises that appointment times (including contact lens appointments and those booked with dispensing opticians) should be sufficient to enable practitioners to provide safe, effective and thorough patient care, without compromising professional standards or causing concern that there is insufficient time to complete all necessary elements of the consultation⁹⁹.

Variation in sight testing times

191. Sight testing times vary considerably across and within practice models, reflecting differences in business arrangements, use of support staff and patient need.
192. Our qualitative research into commercial practices and patient safety¹⁰⁰ found that sight test lengths ranged from around 20 minutes in multiples to 45-60 minutes in some independent practices. Independents more commonly offered longer appointments, often because optometrists carry out all test components themselves. It was also reported that it was difficult to extend appointments in multiples due to the rigidity of the automated booking systems. This demonstrates the close relationship between sight testing times and booking practices (see section 2), as the ability to extend an appointment based on clinical need may depend on how appointment schedules and diaries have been configured.
193. FODO members reported sight testing times ranging between 25 and 60 minutes, with an average range of 25-30 minutes. At the majority of providers (nine of 13) pre-screening was performed by members of the team other than the optometrist, with one provider mentioning that the exact model is decided by the practice owner at a local level. Providers reported allowing longer slots for optometrists who required extra time, for example, for pre-registration trainees under supervision or newly qualified registrants.

⁹⁸ [Principles of the eye examination or sight test - College of Optometrists](#)

⁹⁹ Text provided by ABDO to the GOC in September 2026.

¹⁰⁰ Shift Insight (2026), [Commercial practices and patient safety in the primary eye care sector](#)

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194. An unpublished Optometry Northern Ireland report¹⁰¹ shared with us found that the average time spent on an eye examination was 36 minutes, although it was acknowledged that there was a wide range of reported times because of the difference in pre-screening activities being undertaken either by ancillary staff (most likely in multiples) or by the optometrist.

Views on appropriate length of sight test

195. Given this variation in current practice, there are also differing views on what constitutes an appropriate length of time for a sight test.
196. The College of Optometrists surveyed its members as to what length of time they thought would be optimal for a typical adult eye examination (without OCT imaging or visual fields). Responses varied between 25 and 40 minutes, with just under half suggesting 30 minutes, given increasing complexity and sufficient time for patient communication and referrals. Shorter testing times were only thought to be possible where tasks could be safely delegated, the patient was not 'complex' and/or no additional tests were required.
197. Our qualitative research into commercial practices and patient safety¹⁰² included the following recommendations from participants in relation to sight testing times:
- many individual and business registrants suggested introducing minimum sight test times (often 20-30 minutes) and stronger oversight or auditing;
 - other individual and business registrants cautioned against regulating testing times, arguing that patient needs vary; and
 - some individual registrants felt enhanced triaging processes could help sight test times being adjusted in advance if needed.
198. The College of Optometrists 2020 statement¹⁰³ noted that it does not set minimum/maximum appointment times as, "each clinician and practice should determine an appointment time that is appropriate for the practice set up, demographic and number of support staff available." It emphasises that the optometrist should be given "sufficient time to perform the examination thoroughly and safely", giving advice to optometrists on what to do if this does not happen, including reporting their concerns to the practice or head office. They suggest that if there is not a satisfactory response, concerns should be reported to the GOC, and they offer support in discussing the concerns with the optometrist.

¹⁰¹ Little, J.-A., et al., 'The role and activity of community optometrists in Northern Ireland for primary and enhanced eyecare services', Optometry Northern Ireland and Ulster University

¹⁰² Shift Insight (2026), [Commercial practices and patient safety in the primary eye care sector](#)

¹⁰³ [College responds to petition on examination testing times - College of Optometrists](#)

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199. The College recently noted that, “An appointment should allow the optometrist sufficient time to perform the required examination thoroughly and safely and with flexibility to meet patients’ needs, particularly those with complex conditions or additional support or access requirements.” The College regularly considers their position on testing times and is doing so as part of their current review of their guidance.
200. There is a different approach in Scotland where schedule 1 of the 2006 Regulations¹⁰⁴ sets a maximum of 20 eye examinations (both primary and supplementary) in any working day. A Scottish Government circular issued in 2018¹⁰⁵ set a guideline of 30 minutes as the minimum time for primary eye examinations: “Practitioners are reminded that the length of an eye examination will depend on the patient’s age and presenting signs and symptoms. As a general rule, the minimum time involved in providing a primary eye examination should be 30 minutes for those patients who attend for routine examinations with no specific symptoms and no prescription for glasses/contact lenses. For patients where additional tests and procedures are required because of their age or presenting signs and symptoms, the timing of the primary eye examination will increase.”
201. The circular noted the maximum eye examinations rule was under review, “in light of concerns that some practitioners may regularly be exceeding this number - with potential consequential risks to patient safety and quality of care.”

Impact on patient experience and quality of care

202. Concerns about sight testing times are primarily linked to their potential impact on patient experience, quality of care and clinical safety, although the evidence presents a mixed picture.
203. In our 2019 risk research¹⁰⁶, ‘time constraints with patients’ was the highest ranked risk across the study, when likelihood and severity of risk were combined. The research highlighted the perception that time constraints exacerbated other risks, multiplying concerns around patient safety: “...as time pressures increase, mistakes become more likely to occur. In the less severe cases, it was suggested that time constraints and pressure could lead to poor levels of customer service, poor administration and record keeping, poor communication with patients and colleagues or incorrect prescribing and

¹⁰⁴ [The National Health Service \(General Ophthalmic Services\) \(Scotland\) Regulations 2006](#)

¹⁰⁵ [PCA\(O\)\(2018\)01 - General Ophthalmic Services \(GOS\): GOS regulations amendments; optical voucher values; maximum number of daily GOS eye examinations and primary eye examination appointment times](#). This was reiterated in PCA(O)2025(04).

¹⁰⁶ Enventure Research (2019), [Risk in the optical professions, Final Report, General Optical Council](#)

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dispensing. However, at worst, participants suggested that it could lead to severe mistakes such as misdiagnosis and missed or inappropriate referrals.”

204. Our 2023 research mapping optical businesses¹⁰⁷ highlighted that one of the ways in which commercial considerations can pose risks to patients is if they create incentives to prioritise revenue generation or cost-cutting over and above patient care, for example, through unrealistic sight test times. It was noted that scope of practice for optometrists combined with greater numbers of patients in the at-risk category and additional management/compliance duties could be placing further pressure on consultation times. It was suggested that spending less time with patients could be contributing to an increase in inappropriate referrals to the hospital eye service, because optometrists do not have enough time to investigate fully. However, it was concluded that there was little concrete evidence to support that these theoretical risks were compromising patient care.
205. In our most recent registrant survey in 2026¹⁰⁸, 47% of optometrists said that the time allocated to them to carry out a sight test was insufficient to provide safe patient care (48% in 2025). This was more common among those working in multiples, locums, those registered with the GOC for 3-5 years, and those working in England and Scotland.
206. This was supported by a survey from The College of Optometrists which asked its members whether the time allocated for routine sight tests in their workplace was sufficient to deliver safe, good practice care, without undue pressure to see a high volume of patients. Of the 130 members that responded to the College survey, 50% agreed or strongly agreed and 24% disagreed or strongly disagreed. A higher proportion of registrants in England (26%) felt time was insufficient when compared with Scotland and Wales (both 20%). There were no differences by age group. The College Council and Policy Advisory Panel considered that a lack of time for appointments was a longstanding issue in primary care (compounded by high patient volumes as mentioned in section 2) and that this was an issue that needed to be addressed urgently in order for safe patient care to be delivered.
207. Conversely, our most recent public perceptions survey in 2026¹⁰⁹ found that almost nine in ten (89%) participants were satisfied that their optometrist allowed sufficient time to deal with their needs properly, which has increased slightly since the previous wave (87% in 2025¹¹⁰). This experience was not even across protected characteristics. For example, those aged 16-34 were less likely than all other age groups to be satisfied (82% vs 91% for those aged

¹⁰⁷ Europe Economics (2023), [Mapping of Optical Businesses: Report for the GOC](#)

¹⁰⁸ [Registrant workforce and perceptions survey 2026](#)

¹⁰⁹ [Public perceptions research 2026](#)

¹¹⁰ [Public perceptions research 2025](#)

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35-64 and 96% for those aged 65 and older). White participants were more likely to be satisfied than those from an ethnic minority background (91% vs 84%).

208. While survey findings provide insight into perceptions of available time, qualitative evidence offers a more detailed understanding of the potential effects of shorter appointments.
209. In our 2025 lived experience research with patients in vulnerable circumstances¹¹¹, dissatisfaction with the sight test / eye examination related to the feeling of being 'rushed through', which resulted in a sense that they were not receiving adequate care, feeling as though they had not been listened to and potentially that the test has not been performed appropriately. It was felt that the length of appointment should be considered for those with vulnerabilities.
210. Our qualitative research into commercial practices and patient safety¹¹² found contrasting views in relation to the impact that short sight testing times have on patient care. While business registrants, particularly those in multiples, felt shorter sight testing times were appropriate and did not compromise care, patient representative organisations highlighted concerns that appointments may be too short for some patients, especially those with learning disabilities, dementia, children, or those requiring more explanation.
211. The research concluded that:
- many business registrants felt that commercial practices such as short sight testing times had positive impacts on patients by ensuring wider access to care; and
 - individual registrants and patient representative organisations more frequently described risks of commercial practices linked to rushed communication, reduced patient understanding and reduced likelihood of returning for routine care. While these were not felt to pose immediate safety concerns, they were said to have meaningful long-term risks to eye health.
212. Evidence from patient feedback and complaints provides further insight into how shorter sight testing times may be experienced in practice. Our analysis of Trustpilot reviews found that concerns that can be linked to sight testing times related to quality, accuracy and thoroughness of sight testing appeared across around 90 reviews. A recurring pattern was that many consumers felt the clinical assessment was rushed, incomplete or inconsistent, with some

¹¹¹ Explain Research (2025), [Qualitative research exploring the lived experience of patients and non-patients accessing and using eye care services](#)

¹¹² Shift Insight (2026), [Commercial practices and patient safety in the primary eye care sector](#)

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reporting that key elements of the examination were missed or not explained. These worries often translated into incorrect prescriptions, poor visual outcomes or the need for repeat testing elsewhere. Example comments are provided in box 10.

213. Collectively, these reviews suggest that a minority of patients experience eye care that does not feel clinically robust or thorough, raising concerns about missed clinical findings, limited explanation of results and varying standards of professional communication.
214. The OCCS identified 13 complaints over a three-year period that specifically raised duration of the sight test as a concern, with many of these complaints mentioning that the customer felt “rushed”. The OCCS does not have details such as the length of the sight test in the cases. A case study relating to short sight testing times is provided in box 10.

Box 10: Case studies: sight testing times

Trustpilot review 1

“I felt the test was rushed, not given enough information, there was no peripheral exam, in fact there seemed to be little interest in my test, they just wanted to sell glasses. I was not given the choice of the optional photo, he just went ahead and took it.”

Trustpilot review 2

“Not up to expected standard. Eye examination very brisk with no mention of developing cataract nor tendency to high pressure in eye. Both of these items were raised BY ME with optician responding with little more than it’s alright and giving impression of wanting to finish examination as quickly as possible. Poor fitting of spectacles following long wait for fitting.”

Trustpilot review 3

“The examination was chaotic. The examination was conducted improperly, rushed, and chaotically, even though I paid for it. The optician didn't give me time to think and make an informed decision during the examination. The incorrect examination resulted in a greater defect than expected, which I disagree with! I'm dissatisfied and will be requesting a repeat examination!”

OCCS complaint 1

The OCCS received a complaint from a patient complaining that they had felt rushed during their eye test and there was a lack of explanation about the tests

being carried out and the findings. They did not have confidence in the outcome and so did not purchase glasses.

Following mediation, the consumer and the optical business agreed a resolution to the complaint, which involved the consumer returning to the practice for a further appointment with an optometrist that they had seen previously as they trusted their approach.

Registrant wellbeing concerns

215. Alongside potential impacts on patients, concerns about insufficient appointment times are also associated with negative effects on registrant wellbeing and job satisfaction. Evidence from general practice suggests that concerns about appointment length are not unique to eye care^{113 114}. GPs report that short consultation times can affect patient safety, workload, wellbeing and burnout^{115 116}, with many professional bodies calling for longer appointments to better meet increasingly complex patient needs¹¹⁷.
216. Findings from our registrant surveys show that time pressures have a negative impact on job satisfaction or ability to deliver safe care. In our 2022 registrant survey¹¹⁸, of the 747 registrants who indicated that they were very or quite dissatisfied in their job/role, 8% indicated 'short appointments / lack of clinic time' as a reason. Time pressures were also mentioned as a reason for dissatisfaction in the 2023 registrant survey¹¹⁹ but this was not mentioned as being specific to appointment times. In our 2024 registrant survey¹²⁰, time pressures and short sight testing times were identified as the most common barrier to delivering safe care. Qualitative feedback suggested they were struggling "to balance patient care with the demands of their employers" and that these issues contributed to job dissatisfaction, placing strain on their professional practice and mental health.
217. Our qualitative research into commercial practices and patient safety¹²¹ found that many optometrists and dispensing opticians felt short test times (alongside booking practices) contributed to high workload, increased pressure and concerns about mistakes. Some optometrists reported reduced job satisfaction

¹¹³ Bradley, S.H., et al. Great expectations? GPs' estimations of time required to deliver BMJ's '10 minute consultations'. *BMJ Open*. 2024 Feb 26;14(2):e079578. doi: [10.1136/bmjopen-2023-079578](https://doi.org/10.1136/bmjopen-2023-079578)

¹¹⁴ Royal College of General Practitioners (2019), [Fit for the Future - A vision for general practice](#)

¹¹⁵ Royal College of General Practitioners (undated), [Fit for the Future: A new plan for GPs and their patients](#)

¹¹⁶ General Medical Council (2025), [The state of medical education and practice in the UK: Workplace experiences](#)

¹¹⁷ [Appointments - Safe working in general practice - BMA](#)

¹¹⁸ [Registrant Workforce and Perceptions Survey 2022](#)

¹¹⁹ [Registrant Workforce and Perceptions Survey 2023](#)

¹²⁰ [Registrant Workforce and Perceptions Survey 2024](#)

¹²¹ Shift Insight (2026), [Commercial practices and patient safety in the primary eye care sector](#)

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and increased burnout, which meant they left multiples for independents. These concerns were frequently described alongside issues relating to booking practices (see section 2), with registrants often viewing appointment length and patient volumes as interdependent drivers of workload pressure and stress.

218. Optometrists who worked as locums felt they were particularly affected, as they had less control over diaries. They also wanted to be invited back, so felt pressure to perform quickly. The research concluded that individual registrants and non-registered staff reported that short sight test times contributed to personal stress, missed breaks and burnout, with some optometrists and dispensing opticians choosing to leave multiples or the profession altogether.
219. We reviewed hearings decisions over a three-year period where commercial pressures were raised as a defence to the allegations. A case study relating to short sight testing times is provided in box 11.

Box 11: Fitness to practise case study: sight testing times

A case heard by the GOC in 2025 related to a registrant director working in a joint venture partnership, where there was an internal investigation carried out by the main group. Amongst other areas, it was found that the registrant (or the student optometrist they were responsible for supervising) had performed inadequate internal and external eye examinations, recorded results for examinations that were not performed and recorded different/inaccurate results for tests performed. It was noted that the registrant had regularly been exceeding the benchmark number of 28 clinical interactions per day and on some dates exceeded 50 per day. The student optometrists he was supervising had also been exceeding the recommended number of examinations set by The College of Optometrists.

The registrant's evidence mentioned that he was suspended and received a written warning. On returning to work, the registrant worked with the other directors to address the concerns, including his propensity to work excessive hours. It was reported that he made changes to the clinics by setting fixed appointment times, so that they were no longer rolling clinics, which reduced the number of patients.

The registrant noted that his motivation for excessive appointments was not financial, but rather to meet the targets set by the main group, arguing that regional directors encourage them to see more patients and increase the number of supplementary tests performed. The registrant felt that, "he had succumbed to these commercial pressures." He also noted personal issues around the time of the internal investigation.

The registrant explained that he had previously been praised, "for the high number of tests that he performed and that management came into the Practice in 2019 to give him a box of chocolates for having the highest number of tests." Subsequently

he accepted that this was not the right approach and would not go back to testing such a high volume of patients, advising that his sight tests now take around 25 minutes per test, and he is able to better support the student optometrists and have a better working environment.

A finding of impairment was made and a suspension order of 12 months was given.

Structural and commercial influences on sight testing times

220. Stakeholders consistently emphasised that decisions about sight testing times are influenced by wider structural and commercial factors, rather than being determined solely by individual professional judgement. Our qualitative research into commercial practices and patient safety¹²² concluded that:

- across all stakeholder groups, sight test times were seen as interlinked and shaped heavily by the low NHS GOS sight test fee in England, which was thought to drive a reliance on retail income (while noting that some individual and business registrants in Scotland and Wales said their NHS contracts reduced retail pressure);
- many business registrants felt that commercial practices such as short sight testing times were essential to remaining financially viable (stakeholders often discussed sight testing times and booking practices together, with both being viewed as responses to the same commercial, operational and funding pressures); and
- while commercial drivers were largely thought to sit outside the GOC's remit, many stakeholders believed the GOC could strengthen its stance on expectations for safe practice in commercial environments, as well as being more vocal in supporting wider sector change, such as lobbying for change to funding structures.

221. The College of Optometrists advised that optometrists are aware of their responsibilities to provide care in a way that does not compromise patient safety and care, and for raising concerns where they thought that this might be at risk. However, optometrists reported feelings of, "...a power imbalance within workplaces and that decisions on testing times are ultimately outside of their control." Optometrists that attended the College's webinar and worked in primary care said that they felt pressure to reduce sight testing times.

222. The College suggested that the GOC should review its Standards for Optical Businesses, "to ensure that optometrists are better empowered to determine safe and appropriate appointment lengths, placing greater responsibility on

¹²² Shift Insight (2026), [Commercial practices and patient safety in the primary eye care sector](#)

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businesses to ensure appointment policies do not risk patient safety and that conditions support employee wellbeing. The GOC should also acknowledge the risk to patient and public safety if poor working conditions cause more optometrists to leave the profession, leading to gaps in accessible eye care.”

223. FODO members reported that appointment lengths have generally increased or remained stable over the last five years, with investments in new technology helping with electronic records, record keeping, phoropters, auto-refraction, OCT and OCT interpretation. One provider reported increasing appointment times by five minutes due to the introduction of OCT and to allow time to interpret the results, and increasing again during the pandemic which they found improved handover rates and retention.

Conclusions

224. We have made the following conclusions related to short sight testing times:

- patients are content with the time taken in their sight tests, but registrants widely report that sight test times can be insufficient;
- short sight testing times can reduce registrant wellbeing; and
- the GOC setting minimum sight testing times would not be appropriate.

225. These conclusions are discussed below.

Patients are content with the time taken in their sight tests, but registrants widely report that sight test times can be insufficient

226. A review of the available evidence suggests that sight testing times vary significantly, from 20 minutes to more than an hour. Independents are likely to have longer sight testing times, partly because the optometrist will usually perform the pre-screening activities as part of the sight test, whereas multiples are more likely to have other staff performing the pre-screening activities.
227. The evidence presents a mixed and at times conflicting picture of whether sight testing times are sufficient to support safe patient care. Our public perceptions research indicates consistently high levels of patient satisfaction with the time provided during sight tests to deal with their needs properly, although this is lower among some groups. Yet approximately half of registrants report that the standard time allocated for sight tests has been insufficient to deliver safe patient care. This varies by practice setting, with those working in multiples and locum roles more likely to report insufficient time.
228. Qualitative research indicates variability in views across the sector, with some business representatives considering shorter sight testing times to be appropriate and not compromising care, while others, including some individual registrants and patient representative organisations, identify clear risks

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associated with rushed communication and incomplete assessments. Across these sources, there is consistent concern among optometrists and dispensing opticians that pressures to work quickly may increase the risk of errors or omissions. Patient representative organisations were particularly concerned that appointments may be too short for some patients, especially those with learning disabilities or dementia, children, or those requiring additional explanation or support.

229. Overall, it is unclear whether or to what extent sight testing times are having a negative impact on patient safety. For example, there is no hard evidence of missed diagnosis on any scale. However, it would be evidentially challenging to identify such an issue if it did exist. Diagnosis and detection failures, and inadequate investigations appear regularly in our fitness to practise caseload. However, our caseload relies on referrals and deals with serious misconduct, and it would be difficult to isolate test times as a contributing factor. There is also a lack of published data, such as on referrals, that could be indicative.
230. The available evidence points less to clear, immediate patient safety incidents and more to issues with quality of patient communication and disproportionate effects on patients who need more time (e.g. those with learning disabilities, dementia, or children). Any assessment of the impact of sight testing times should also be considered alongside booking practices (see section 2). The overall patient experience, quality of communication and opportunity for clinical decision-making are shaped by both the length of appointments and the wider scheduling arrangements within which those appointments take place.

Short sight testing times can reduce registrant wellbeing

231. The evidence suggests that appointment length and wider time pressures are not only operational issues but have a direct bearing on registrant wellbeing. Across survey findings, qualitative research and fitness to practise evidence, registrants describe short appointment times, high clinic volumes and limited control over diaries as contributing to stress, reduced job satisfaction, missed breaks and burnout.
232. These wellbeing concerns are closely linked to patient safety. Where registrants feel unable to spend sufficient time with patients, take appropriate breaks or exercise professional judgement about clinic capacity, there is a greater risk that care may be rushed, records may be incomplete, and clinical concerns may be missed. Sustained pressure on registrants may increase the likelihood of mistakes, weaken professional confidence and reduce willingness to raise concerns. Supporting registrant wellbeing is therefore integral to maintaining safe and effective care.
233. Perspectives from business registrants suggest a different picture. Some report that longer appointment times are available where needed and that testing

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times have increased in recent years, indicating that experiences are not consistent across the sector and may vary by business model and setting.

234. The overall picture is that shorter sight testing times can contribute to high workload, increased pressure and concerns about mistakes. These pressures appear to have a negative impact on some registrants' wellbeing, including reduced job satisfaction and increased burnout, and in some cases influence decisions to leave certain practice settings. These impacts are particularly pronounced for locums, who often have less control over their working patterns and appointment structures, and feel pressure to perform quickly so that they are invited back.
235. The impact of these pressures is also not evenly distributed across career stages. Our survey findings suggest that registrants who have been on the register for three to five years are more likely to report that the time available to carry out sight tests is insufficient to provide safe patient care.
236. These findings are consistent with evidence from other areas of healthcare, such as general practice, where appointment times are similarly linked to workload pressures, wellbeing and burnout. This suggests that the challenges identified are not unique to the optical sector but reflect broader systemic pressures associated with delivering care within constrained timeframes.
237. Overall, we conclude that short sight testing times are having a negative impact on the wellbeing of some individual registrants, and that there is a tension between our professional standards and the realities of practising in busy workplace environments where registrants feel a lack of autonomy. This issue is closely linked to booking practices (see section 2), particularly where registrants do not feel they are in control of the diary. Impacts are not evenly distributed across the workforce, with wellbeing pressures more pronounced among those working in multiples, locums and early career registrants. Registrants often experience appointment length, patient volumes, diary management and overbooking as interconnected pressures rather than distinct issues. Concerns about short sight testing times are therefore difficult to separate from broader concerns about scheduling and workload.
238. Responsibility for managing these risks cannot rest with individual registrants alone. While registrants remain accountable for their own professional decisions, employers and business owners have an important role in creating working conditions that enable safe practice, including realistic appointment times, giving staff autonomy to extend appointment times with individual patients where required, and clear routes for staff to raise concerns without fear of negative consequences. There is evidence that sustained pressure may affect retention within the sector, with some registrants reporting that they have moved away from multiple practice settings, changed working patterns or

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considered leaving the profession. This suggests that wellbeing concerns linked to commercial and time pressures may have longer-term implications for workforce sustainability as well as individual registrants' health.

239. The Standards for Optical Businesses make clear that working environments must consistently support safe care and enable registrants to meet professional practice. However, we understand that registrants may not feel comfortable speaking up in situations where this is not the case. Further engagement with registrants, employers and professional bodies could help identify what good practice looks like and what additional regulatory, guidance or communications activity may be needed to support safe, sustainable working environments to support registrant wellbeing and safe patient care.

The GOC setting minimum sight testing times would not be appropriate

240. We acknowledge calls from some stakeholders for the GOC to set minimum sight testing times (or to see a maximum number of patients per day as referred to in section 2). We have considered this but consider hard rules would not be appropriate given the variability in formats of sight testing, the range of technologies and tests used and variety of patient needs.
241. We are concerned that if we were to set a minimum time, a possible unintended consequence is that it could inadvertently become the standard time, which could lower standards with risks to patient safety. We also note experience in Scotland where there is apparent non-compliance with the rule on the maximum number of patient appointments per working day.
242. Although we will consider if the Standards for Optical Businesses need to be strengthened, our initial view is that the existing standards already establish the key principles. Guidance and support by professional bodies have an important role to play in helping to translate our standards into common clinical scenarios.

Section 4: Transparency on pricing and eligibility for NHS financial support

Overview

- Clear and transparent pricing is important to maintain public confidence and reduce barriers to access to eye care, especially for people in vulnerable circumstances. People need to know the price of a sight test and if they are eligible for NHS financial support before deciding to make an appointment. Otherwise, this risks deterring or delaying access to eye care, raising potential wider implications for timely treatment and prevention of eye conditions.
- Most people find it easy to source the price of their sight test, although less than half know the price either before or when booking their appointment.
- Online price transparency for sight tests is patchy – in our review of 255 websites, only 38% displayed sight test prices. It was often unclear whether OCT scans were included in the standard sight test fee or charged separately. This is also a focus of negative online reviews and a fitness to practise case.
- Information on NHS financial support is also inconsistent with 62% of websites in our review providing some information. However, when information is provided it is often limited in detail or difficult to access. GOC and external research highlight that people are often unaware of, or uncertain about, their eligibility for financial support, pointing to the need to raise public awareness.
- All the multiples in our sample provided clear online pricing information for the sight test and NHS financial support, which is significant given that they deliver an estimated 75-80% of all sight tests.
- Most people considered the pricing was clear when they last bought glasses or contact lenses, but this is a growing focus of complaints and online reviews. Patients can find the pricing of glasses and contact lenses confusing, unclear or misleading. There are recurring issues around unexpected charges, unclear pricing structures, optional extras being poorly explained and patients experiencing eye care as a high-pressure retail transaction.
- Strengthened consumer legislation and interventions by the Competition and Markets Authority are reshaping public expectations around price transparency. We plan to work with stakeholders to improve transparency on price and NHS financial eligibility when we review our Standards for Optical Businesses.

Introduction

243. Price transparency supports our statutory objectives as where businesses are not clear and upfront about prices, public trust and confidence in regulated

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providers and professionals may be undermined. A lack of price transparency can also create barriers to care, as patients may delay or avoid treatment if they do not understand likely costs or when additional charges may apply.¹²³

244. Similarly, if people lack awareness of financial support available for NHS sight tests and vouchers that they are eligible for, they may delay or avoid treatment. This could widen health inequalities for patients in vulnerable circumstances.
245. The GOC does not have competition objectives, but we recognise that price transparency can support effective competition in markets by enabling patients to make informed choices and encouraging improvements in service quality. The Competition and Markets Authority (CMA) has recently taken an active interest in price transparency in professional services markets. Following its comprehensive review into the veterinary sector¹²⁴, it has ordered remedies designed to improve price transparency and consumer choice. The CMA is now turning its attention to the private dentistry market to explore similar issues.
246. The Digital Markets, Competition and Consumers Act 2024 has modernised and strengthened key aspects of consumer protection, including in relation to pricing practices. In this changing landscape, we consider it is important to review whether our regulatory framework, and specifically the standards we set, aligns with these broader changing expectations around price transparency.
247. For this thematic review, we chose to focus primarily on transparency on business websites about the price of sight tests and information on eligibility for NHS funded sight tests. Anecdotal evidence suggests these aspects are often less transparent than the costs associated with glasses or contact lenses, however we also summarise relevant information we gathered on this topic.

Healthcare standards and regulation

248. Our Standards for Optical Businesses outline expectations around pricing information focusing on clarity and accessibility. Our Standards of Practice for Optometrists and Dispensing Opticians state that clear information about costs must be given to patients in advance of purchase, and they must ensure communication and advertising does not mislead or confuse patients (see box 12).

¹²³ Shickle D & Griffin M. *Why don't older adults in England go to have their eyes examined?* *Ophthalmic Physiol Opt* 2014; 34: 38–45. doi:[10.1111/opo.12100](https://doi.org/10.1111/opo.12100)

¹²⁴ [Veterinary services for household pets: Final decision report - GOV.UK](https://www.gov.uk/government/news/veterinary-services-for-household-pets-final-decision-report)

Box 12: GOC standards

Our Standards for Optical Businesses provide that a business:

- 2.1.8: “Provides clear information to patients about costs of products and professional services.”
- 1.3.1: “Provides information that is accessible to patients in a way they understand, taking into consideration individual needs and requirements. This could include what might be necessary in specific contexts such as requirements in the provision of NHS services; additional needs of the patient such as a learning disability; and any speech or communication difficulties.”

Our Standards of Practice for Optometrists and Dispensing Opticians state:

- 16.5: “Be honest in your financial and commercial dealings and give patients clear information about the costs of your professional services and products before they commit to buying.”
- 16.6: “Do not make misleading, confusing, or unlawful statements within your communications or advertising.”

249. Two other healthcare regulators, the General Dental Council (GDC) and General Osteopathic Council (GOsC), address the issue of pricing in their standards. The GDC states that clear pricing must be given on the premises and online, and states that patients should not have to ask for this information. The GOsC also states that there should be clear information on pricing to avoid any disputes with patients.

250. The College of Optometrists’ Guidance for Professional Practice¹²⁵ states that optometrists must explain costs to patients in advance:

- C22: “You must explain to patients the costs of the professional services and products you are offering before they commit to payment.”
- C23: “You should itemise the costs of:
 - a) options available for lenses and frames
 - b) any additional features, such as coatings or tints on spectacles.”

251. ABDO’s advice and guidelines¹²⁶ states: “Items for sale should be clearly marked with their price. It is very important that members of the public who

¹²⁵ [Partnership with patients - College of Optometrists](#)

¹²⁶ Text provided by ABDO to the GOC in September 2026.

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might purchase the product or service are fully aware of prices and fees charged (C 4.1.2).”

252. In relation to NHS financial eligibility, the GOS model contract for England¹²⁷ states: “The Contractor shall ensure that there is displayed in a prominent position in its practice premises (in a part to which patients have access) - ...a notice supplied or approved by the Board, indicating to which descriptions of patients a payment may be made under the Charges Regulations...”
253. Registrants can satisfy our standards in different ways, for example, by providing price information online or in store. Businesses which do not display prices or NHS information online are not breaching our standards or GOS contract terms. However, we consider it is important for patients to be easily able to access sight test prices and to identify if they are eligible for NHS financial support before booking an appointment. While people could telephone or visit the business to find this information this is an unnecessary hurdle and creates psychological pressure to use the business.

Availability of pricing information for the sight test and other clinical services

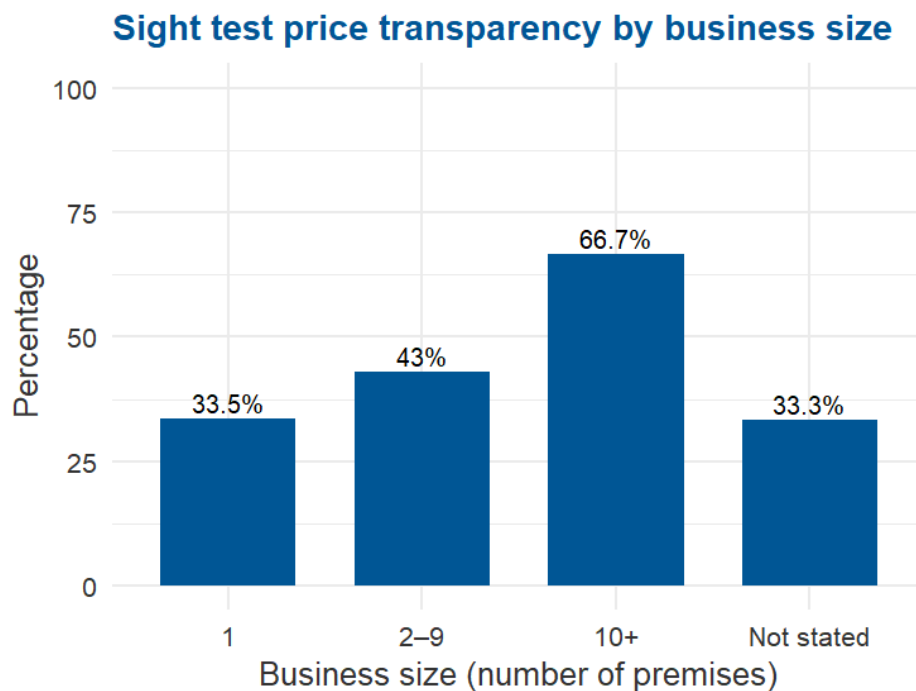
Sight test fees

254. Our research into the mapping of optical businesses¹²⁸ conducted in 2022 included a small-scale review of price transparency in relation to the sight test. This found that only seven out of 17 businesses had any price information about the sight test on their website. For this thematic review, we decided to review a much larger sample of 255 GOC business registrant websites looking for information about the price of sight tests and related services.
255. Of note, we searched for 324 business registrants before reaching our desired sample of 255 with functioning websites for analysis purposes. This indicates that a sizeable minority of optical businesses do not have websites.
256. We found that 38% of business websites across England, Wales and Northern Ireland displayed their sight test price(s). Scotland was excluded from this part of the analysis due to the universal free sight test there. We reviewed where the price was located on the website and found that one in five businesses provided this on the homepage, with the vast majority placing the price on a subpage or booking page that required multiple clicks to access.
257. Price transparency varied by business size. Chart 1 shows that in the sample, larger businesses (with 10+ premises) were more likely to display prices. Each of the large multiples clearly displayed sight test prices on their websites.

¹²⁷ [General Ophthalmic Mandatory Services Model Contract](#)

¹²⁸ Europe Economics (2023), [Mapping of Optical Businesses: Report for the GOC](#)

Chart 1: Sight test price transparency by business size



Sight test prices

258. We looked at the average sight test price before chargeable add-ons such as OCT scans or Optomap. Again, we excluded Scotland from this analysis.

259. Our findings show significant price variation (see table 1). The median price of a sight test was £50 across England, Wales and Northern Ireland. However, prices ranged from a minimum of £25 to a maximum of £125, and the interquartile range – the middle 50% of prices, an indicator of spread – was £26.

Table 1: Sight test prices in England, Northern Ireland and Wales

Countries	Websites*	Median price	Minimum price	Maximum price	IQR
England	54 (35%)	£50	£25	£120	£28.70
Northern Ireland	6 (24%)	£32.50	£25	£74	£20
Wales	5 (20%)	£49	£40	£125	£10

*Total number and percentage of websites in sample that displayed sight test prices

260. Some businesses explained their prices with reference to sight test duration, use of optometrists throughout and the range of tests and technologies used.

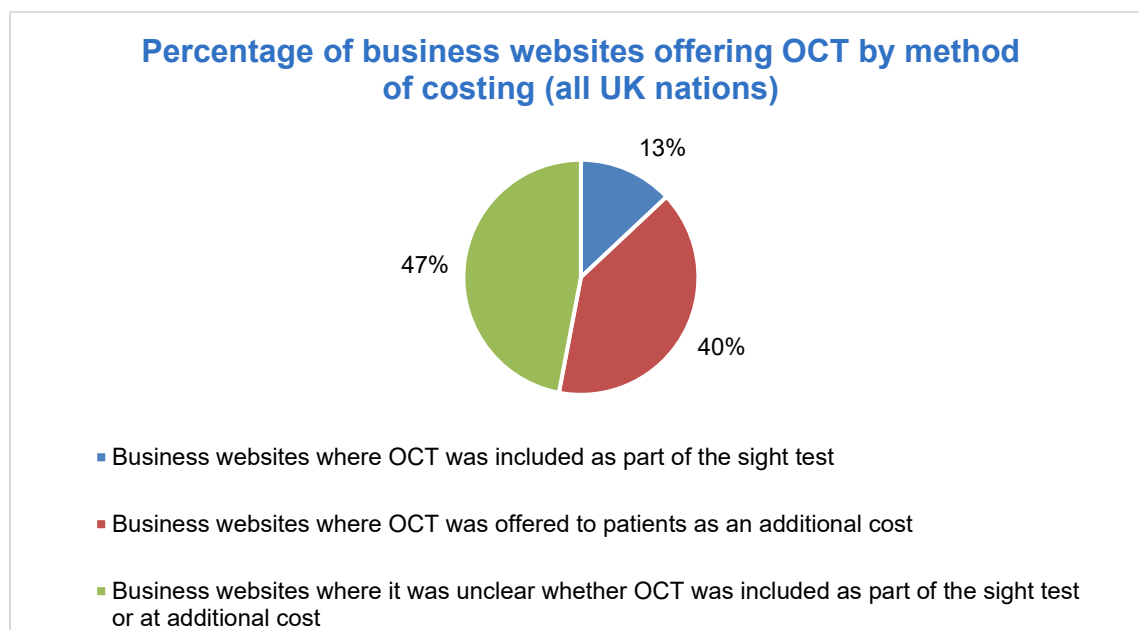
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These findings highlight that not all sight tests are the same and price transparency can support patients to choose the right service for their needs.

OCT scans

261. We also looked at the availability and pricing of one of the most common enhanced tests offered to patients as part of the sight test, the OCT scan. Businesses in all four nations were surveyed given that in Scotland patients may choose to pay for an OCT scan to supplement their free eye examination.

Chart 2: Percentage of business websites offering OCT by method of costing (all UK nations)



262. 73% of the websites we reviewed mentioned availability of OCT scans, so we then reviewed whether businesses clearly explained if the cost of the OCT scan was included in the price of the sight test or incurred an additional cost. Chart 2 shows that 13% of businesses included the OCT scan as part of the standard sight test fee, 40% of businesses offered this to patients as an enhanced test for an additional cost and it was unclear whether the remaining 47% of businesses included it as part of the sight test or at an additional cost.

263. Where additional OCT scan prices were displayed, the median was £25 and the interquartile range was £9. This is not an insignificant sum for patients and again indicates that price transparency would support informed choice.

264. Our analysis of Trustpilot reviews highlighted concerns about OCT scans being performed without it being explained that they are optional (see box 13). This issue also featured in a fitness to practise case heard in 2025 where patients were given a total sight test cost that included an OCT scan which should have been offered as an optional extra (see box 14). The Fitness to Practise

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Committee found that the lack of transparency amounted to misconduct because it breached trust and prevented patients from choosing between a routine and enhanced sight test.

265. In NHS funded sight tests, our understanding of GOS contract terms is that where the optometrist considers an OCT scan is necessary for the clinical management of a case this should be included in the test and not charged to patients at an additional cost. Our website review identified examples of businesses advertising OCT scans to NHS patients for supplementary fees. NHS patients may wish to pay extra for an OCT scan for peace of mind even if this is not clinically necessary, but they should only be charged supplementary fees if appropriate and be supported to make informed choices.

Box 13: Trustpilot reviews

Trustpilot review 1

“An additional cost OCT scan was also performed without it being explained that it is optional. I would have had the scan anyway, but it only became obvious at the end of the appointment that the optician was also revenue generating.”

Trustpilot review 2

“Beware hidden charges/expensive. Had a sight test under NHS on [date] January 2024. at [redacted]. When invoice was presented there was an additional charge of £35 for OCT? more in-depth examination. I had not requested this nor was I made aware that it would be done and what cost.”

Box 14: Fitness to practise case study: price transparency

A case heard by the GOC in October 2025 involved an individual registrant who was a director of the business during a period where misleading information was given to patients about the price of a sight test. The total cost given included the OCT scan which should have been offered as an optional extra for an additional fee as per the pricing structure of the sight test for that business. This lack of transparency meant patients were not given the option of choosing between a routine sight test and an enhanced sight test including the OCT scan. This was part of a broader set of allegations made against the registrant. In relation to this allegation, the Fitness to Practise Committee found that the registrant's behaviour amounted to misconduct due to a fundamental breach of trust regarding a lack of transparency about the price of a sight test.

Patient experience

266. In our 2026 public perceptions survey¹²⁹ 74% of respondents said they found sourcing the price of their sight test easy and only 3% found it difficult. 27% found out the price before booking their appointment and a further 18% while booking their appointment. 40% said they knew the price from previous visits indicating a large proportion of returning customers in the data.
267. Pricing for glasses and contact lenses was generally reported as clearer, but not consistently so. In our 2026 public perceptions survey, 80% said pricing was clear and transparent when they last purchased glasses or contact lenses, compared with 77% in 2025. Of those with four or more vulnerability markers, only 74% agreed compared to 83% with no markers. Those who couldn't afford essentials (68%) or struggling financially (74%) were also less likely to agree.
268. Looking at expected and final costs, our public perceptions survey 2026 found that 12% of those who purchased glasses or contact lenses as a result of their sight test disagreed that they paid the price they expected, with higher disagreement among those who did not know the price beforehand.
269. The OCCS identified 43 cases over a three-year period that could possibly relate to lack of transparency around costs. In their most recent annual report for 2025/26, there was a significant increase from 4% to 7% in the proportion of total complaints about 'costs, charges and commercial transparency'. The complaints mostly related to unclear pricing structures, unexpected charges, refund policies and the perceived value of costs or goods. Affordability remained a significant factor for consumers accessing optical care, with increased scrutiny of costs, value for money and the transparency of charges. They identified a rise in complaints relating to fees and discrepancies between expected and final prices. They thought that consumers also continued to expect clear communication and consistent standards across the optical journey. In the context of wider financial pressures, dissatisfaction with unclear communication or unmet expectations was more likely to result in escalation.
270. Our analysis of Trustpilot reviews found concerns that can be linked to lack of transparency around pricing and commercial pressure appeared across around 180 reviews. Many reviewers described a lack of clarity about the total cost of care until very late in the process, with some only learning the final price after undergoing a sight test or choosing frames. Collectively, these reviews suggest that some consumers experience eye care services less as a clinical encounter and more as a high-pressure retail transaction.

¹²⁹ [Public perceptions research 2026](#)

Professional perspectives

271. The professional/representative bodies generally reported limited concerns about price transparency. Their focus was on clear pricing of eyewear rather than displaying sight test prices online.
272. The College of Optometrists consulted its Council, Policy Advisory Panel and members, and little was raised about this issue, and it did not appear to be a concern in current practice.
273. FODO surveyed its members and found that providers stated that they clearly priced all products and services and were not aware of any price transparency issues. Some noted areas where patients could potentially be confused, for example, where opticians advertise a 'from' price for spectacles but need or choose to upgrade (e.g. for complex prescriptions or additions such as tints and lens design). In such cases, patients may end up paying more than anticipated and must rely on trust in their clinician to be sure they have been sold something appropriate for them.

Communication of NHS eligibility and financial support

274. As well as looking at sight test prices, we also investigated whether businesses provide information about NHS eligibility entitling patients to financial help towards the cost of the sight test and glasses or contact lenses. Our Standards for Optical Businesses outline that information should be given to patients in a way they understand and touch on the provision of NHS services. The GOS mandatory services model contract for England¹³⁰ and the National Health Service (GOS) Regulations 2006 for Scotland¹³¹ both contain a specific requirement for contractors to display information about financial support available under the NHS optical charging arrangements. However, they do not require contractors to proactively inform individual patients of potential eligibility or specify how this should be done.
275. Our review of optical business websites found that 62% provided some information about NHS eligibility or support. Among those providing information, 29% gave full eligibility criteria, 39% provided summary-level information and 32% relied on an external link, usually to NHS.uk or equivalent.
276. The quality and accessibility of this information varied. External links were often placed on booking pages, and many were broken because they pointed to NHS pages that were no longer live. This affects how easily patients can understand

¹³⁰ Clause 57.3: [GOS Model Contract Mandatory Services \(4\).pdf](#)

¹³¹ Paragraph 7 of Schedule 1: The National Health Service (General Ophthalmic Services) (Scotland) Regulations 2006

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whether they are eligible for a free sight test or help with the cost of glasses before deciding whether to book.

277. Our 2025 lived experience research¹³² found that participants with vulnerabilities were often unaware or did not know if they were eligible for any NHS financial help for their sight test or purchase of eyewear. They wanted clear and upfront information about possible NHS financial help.
278. Our qualitative research into commercial practices and patient safety¹³³ also found that patients were not always clear about the financial support available and what exactly the support covered. For example, patient representative organisations referenced instances where patients who were eligible for a free NHS sight test, were then charged for additional tests or scans in the belief that these would be covered as well. Some dispensing opticians and non-GOC-registered staff noted that promotional language, such as references to “free” sight tests, could occasionally be confusing for patients who are not entitled to free NHS sight tests.
279. A few business and individual registrants agreed with patient representative organisations that unclear information on NHS entitlements could deter people from seeking care, which could have longer-term impacts on eye health. One patient representative organisation also noted the impact that unclear information could have on attendance in more deprived areas, where word of mouth was a key driver to access.
280. A Healthwatch report¹³⁴ similarly found that limited awareness of available support may worsen cost-related barriers to care. It recommended that government and the NHS undertake targeted awareness raising as it is likely that those who are eligible for financial assistance are simply not aware of this. It also said the primary eye care sector should consider how staff can better support and raise awareness of NHS financial support.
281. By contrast, our qualitative research into commercial practices and patient safety¹³⁵ found that business and individual GOC registrants thought that NHS eligibility was explained clearly to patients at different points in the journey, for example, from booking, arrival at reception, pre-screening, during the sight test and at the point of any dispensing. However, some thought confusion could arise at times, particularly around NHS eligibility rules. The consensus was that businesses clearly explained eligibility and any confusion was usually down to,

¹³² Explain Research (2025), [Qualitative research exploring the lived experience of patients and non-patients accessing and using eye care services](#)

¹³³ Shift Insight (2026), [Commercial practices and patient safety in the primary eye care sector](#)

¹³⁴ Healthwatch (2025), [Seeing clearly? Attending sight tests and accessing opticians](#)

¹³⁵ Shift Insight (2026), [Commercial practices and patient safety in the primary eye care sector](#)

for example, patients missing information that had been sent or general confusion over displayed pricing.

282. Similarly, The College of Optometrists and FODO said that a lack of transparency around NHS eligibility had not been raised as a concern and generally patients were clearly advised about NHS eligibility or voucher entitlement.

Impact on patients in more vulnerable circumstances

283. Our lived experience research¹³⁶ found that costs and lack of price transparency were significant barriers to accessing eye care for people on lower incomes or those who considered themselves to be struggling financially. This made them feel vulnerable when accessing eye care and worried about how much they might have to pay. These were largely costs related to purchasing glasses or contact lenses following a test, but some participants also mentioned the cost of the sight test being prohibitive, including for example, add-ons during the test such as OCT scans.
284. The research found that these concerns could deter or delay people from going for a sight test. Participants wanted clearer information about the cost of sight tests, glasses and contact lenses. Some who were eligible for free sight tests were still deterred because they expected pressure to buy glasses afterwards.
285. Our 2026 public perceptions research¹³⁷ also shows differences by vulnerability and financial circumstances. Respondents with four or more vulnerability markers were less likely to agree that pricing for glasses or contact lenses was clear and transparent than those with no markers. Those who could not afford essentials or were struggling financially were also less likely to agree. Disagreement that people paid the expected price was higher among those with vulnerability markers, those struggling financially and those who did not know the price beforehand.
286. A Healthwatch report¹³⁸ found that one in seven people had avoided eye care because of cost, rising to 39% among those who said they were not at all financially comfortable, compared with 3% of those who were very financially comfortable. Of those who had not been for a sight test in the previous two years, 23% said it was because they could not afford to go.
287. These findings are relevant to considering the relationship between pricing information, affordability and access to care. Where people delay or avoid

¹³⁶ Explain Research (2025), [Qualitative research exploring the lived experience of patients and non-patients accessing and using eye care services](#)

¹³⁷ [Public perceptions research 2026](#)

¹³⁸ Healthwatch (2025), [Seeing clearly? Attending sight tests and accessing opticians](#)

appointments because of cost concerns, there may be implications for timely access to eye care.

Wider consumer protection context

288. Recent consumer protection developments provide context for considering price transparency in optical care. The Digital Markets, Competition and Consumers Act (DMCC) 2024¹³⁹ strengthened consumer protection and competition law, including expectations around clearer pricing information. Although not specific to optical care, the Act reflects a broader policy focus on giving consumers the total price at the outset and addressing practices such as drip pricing, where headline prices are followed by additional mandatory charges later in the purchasing journey.
289. The DMCC Act also enhanced protection for more vulnerable consumers by extending the definition of vulnerability to consider a consumer's individual circumstances such as whether they are unemployed, their financial situation, recently divorced or in mourning. To comply with this, businesses should consider their customer base and ensure business practices take account of any additional care that may be required to protect more vulnerable consumers.
290. The CMA published guidance in 2025¹⁴⁰ for businesses to help increase price transparency for consumers and comply with requirements under the DMCC Act. The aim of the guidance is to ensure that consumers can access information about pricing in a clear and timely way. The guidance sets out why this issue is important for consumers and for businesses: "Knowing what a product will cost is fundamental for them [consumers] to make good purchasing decisions like working out which product is best for them, and where to buy it. When businesses do not display their prices accurately or leave out essential pricing information that people need to know, it can make products appear cheaper than they are. This can undermine people's trust when they find out the real cost and prevent businesses from competing on a level playing field. Price transparency therefore not only benefits consumers but, by promoting competition, it also benefits fair-dealing businesses and the wider economy."
291. The CMA's work in the veterinary sector also shows how concerns about price transparency, consumer choice and overcharging can lead to stronger regulatory expectations. The review¹⁴¹ recommended:
- greater online price transparency, including comprehensive price lists for routine services such as consultations and common procedures;

¹³⁹ [Digital Markets, Competition and Consumers Act 2024](#)

¹⁴⁰ [CMA209 Unfair commercial practices, price transparency](#)

¹⁴¹ [Veterinary services for household pets: Final decision report - GOV.UK](#)

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- more consumer choice through written prescriptions, enabling consumers to buy online at lower prices;
- a comparison website to help consumers shop around more effectively;
- clear pricing for pet care plans, including total costs and how savings are calculated; and
- an enhanced compliance-monitoring role for the Royal College of Veterinary Surgeons.

292. While optical care has its own regulatory and clinical context, these external developments provide a benchmark for considering expectations around upfront and transparent pricing information, enhanced protections for vulnerable consumers and promoting consumer choice.

Conclusions

293. We have made the following conclusions related to pricing transparency and eligibility for NHS support:

- unclear pricing and a lack of transparency can limit access to eye care with a disproportionate impact on those in vulnerable circumstances;
- price transparency is inconsistent across the sector;
- eligibility for NHS financial support should be communicated more clearly; and
- most patients find the pricing of glasses and contact lenses clear, but pricing practices are a growing source of consumer complaints.

294. These conclusions are discussed below.

Unclear pricing and a lack of transparency can limit access to eye care with a disproportionate impact on those in vulnerable circumstances

295. Providing upfront information on pricing in a clear and transparent way is essential in upholding public confidence and ensuring people are not deterred from accessing care. As a regulator, there is little we can do to change the fact that the costs of eye care are unaffordable for some people. However, our patient and public research also identifies lack of price transparency as a key barrier to accessing eye care, and the sector can do something about this.

296. Our research indicates that more vulnerable patient groups, including those on low incomes, people with disabilities, and those experiencing difficult life events, are more likely to identify lack of price transparency as a barrier to attending regular sight tests. For example, these groups are less likely to

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consider pricing to be clear and easy to understand, and less likely to report that the price they expected to pay matched the amount they were ultimately charged. Here we note the stronger protections for vulnerable consumers set out in the DMCC Act, including the broader definition of vulnerability and provisions that encourage businesses to adopt a more tailored approach and provide additional safeguards for consumers in vulnerable circumstances. This mirrors the GOC's guidance on care of patients in vulnerable circumstances and the focus of our 2025-30 corporate strategy on creating fairer and more inclusive eye care services. Reducing health inequalities and improving health outcomes is also a key priority in the Government's 10 Year Health Plan, and we wish to support this goal alongside the wider sector.

297. Clear and transparent pricing enables patients and members of the public to make informed decisions about how and where to access care. It also helps reduce concerns about unexpected costs or uncertainty regarding prices in advance. This means it is not enough for pricing to be clear and transparent on the premises once someone arrives for a sight test. Instead, this information needs to be easily available online before someone makes an appointment.
298. While one of the main areas we have focused on is online price transparency, we recognise the continuing digital divide, with an estimated 2.8 million people (5% of the UK population) lacking internet access, and those affected disproportionately drawn from lower socioeconomic backgrounds, older age groups, and people with a limiting condition.¹⁴² Pricing information must therefore be communicated clearly by telephone, in-person and online.

Price transparency is inconsistent across the sector

299. Positively, our public perceptions research suggests that three-quarters of patients found it easy to source the price of their sight test. However, our review of optical business websites found that transparent pricing for the sight test is patchy, with only 38% publishing sight test prices online. When prices were published, they were often not prominently displayed, instead requiring multiple clicks and extensive scrolling to locate. Only one in five of the websites sampled which displayed the sight test price did so on the homepage.
300. Our review also found that online pricing information for OCT scans was often confusing. For example, in many cases, it was not clear whether the scan formed part of the sight test or attracted an additional charge. Businesses must be clear and transparent about whether additional scans and clinical services are included within the price advertised for the sight test, or whether they incur an additional cost. NHS patients should not be charged a supplementary fee for an OCT scan where one is necessary for the clinical management of a case.

¹⁴² [Exploring how people in the UK are affected by 'digital disadvantage'](#)

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Patients should be supported to make an informed choice as to whether any additional scans or clinical services are in their best interests.

301. Larger businesses, particularly those with ten or more practices, were more likely to publish clear online pricing for both sight tests and additional scans. All multiples in our sample provided clear online pricing information, which is significant given that they deliver an estimated 75-80% of all sight tests. By contrast, our review found that independent businesses were generally less likely to provide clear and comprehensive pricing information online. Some gave no indication of cost and instead directed consumers to enquire by email or telephone, while others provided only partial information.
302. We plan to improve price transparency through our forthcoming review of the Standards for Optical Businesses. We are conscious of compliance costs on small businesses. Also, that independent businesses often charge more for a sight test because they offer longer appointments, include additional tests and offer a personalised service centred on the optometrist. Some independent businesses also expressed concern that listing the price alone could deter patients and therefore preferred to explain in person why their fees were higher than those charged by some larger providers. While these concerns are understandable, we consider that businesses should be providing upfront information online about prices to help address barriers to access, enable patients to make informed choices and to maintain public confidence.
303. The review of our Standards for Optical Businesses will consider these issues in more detail including any contextual information which is necessary to support price transparency. We are mindful that not all optical businesses have a website and so we will also need to consider this dimension.
304. The DMCC Act and the CMA's reviews of the veterinary and dental sectors highlight shifting expectations on price transparency. Increasingly, patients will expect price transparency in eye care just as they see it in other professional services. As we undertake our review, we will be keen to work collaboratively with stakeholders to identify the best approach for this sector.

Eligibility for NHS financial support should be communicated more clearly

305. Individual and business registrants reported that NHS support is explained clearly to patients at various points in the patient journey, including booking, the sight test itself and, where relevant, dispensing. However, our review of business websites found that only 62% provided some information about NHS eligibility or support and less than a third of businesses sampled provided full information on NHS eligibility. Many other websites offered only high-level information or gave links to the NHS website. Often the links given did not work as they were incorrect or out of date. Overall, information about NHS eligibility

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was not sufficiently visible or easy to locate and, in many cases, appeared only as a pop-up on the booking page.

306. Both our patient and public research and a report by Healthwatch found that people in more vulnerable circumstances, who are more likely to be entitled to help, were often unaware of, or uncertain about, their eligibility for financial support. Patient representative organisations warned that poor communication of NHS entitlements, whether online or in person, could over time discourage regular sight testing among more vulnerable patients, with potential implications for long-term eye health. As cost is a barrier to access particularly for more vulnerable groups, who are likely to be entitled to financial support, it is important that businesses provide patients with upfront and comprehensive information about NHS eligibility. Again, people need to know this information before making an appointment to prevent this being a barrier to access.

Most patients find the pricing of glasses and contact lenses clear, but pricing practices are a growing source of consumer complaints

307. The evidence presents a mixed picture of current practice. In our public perceptions survey, 8 in 10 agreed the pricing was clear when they last bought glasses or contact lenses. While most people report positive experiences, OCCS data identifies pricing practices as a growing source of consumer complaints, including unexpected charges and unclear pricing structures. Our research and Trustpilot reviews indicate that issues can arise where expected costs differ from the final amount charged.
308. Individual and business registrants, non-registered staff and stakeholder organisations all acknowledged that pricing for glasses can at times be confusing or unclear to patients. Where confusion arises, it is most commonly linked to promotional language or add-ons such as lens enhancement.
309. Pricing for contact lenses is inherently more complex because of the wide range of products and levels of customisation available. As a result, businesses rarely publish comprehensive pricing online and instead discuss purchasing options directly with patients. Linking back to the section on sales targets and incentives the challenge here is for businesses to support patients in making informed decisions about the best solutions given their needs and budget.
310. While the focus of this review is on price transparency for the sight test, as our patient and public research shows, costs associated with visiting an optical business, whether for the sight test or for glasses and contact lenses, can act as a barrier to access. We know that patients and the public often equate optical businesses as both healthcare and retail providers which can also exacerbate the more negative perceptions around costs (and pressure to buy).

Section 5: Sight tests for young children

Overview

- Access to sight tests and eye care for children under five is vital to ensure early diagnosis of eye conditions or reduced vision, which could negatively impact a child's educational performance or development.
- Although GOS sight tests are free for children and professional guidance is clear that children should not be refused care because of their age, access to sight testing for children under five appears uneven across providers. Our analysis of GOS claims data indicates that 3.2% of providers in England, 4.6% in Northern Ireland and 4.0% in Scotland do not carry out sight tests on children under five.
- Child sight testing activity is concentrated among a relatively small number of businesses/contractors. Across England, Northern Ireland and Scotland, the top 10% of providers undertake around 40% to 55% of all sight tests for children under five, while many providers carry out only small numbers of tests each year.
- Some optometrists may test children under five infrequently or not at all, creating deskilling risks. Given treating children is a core competency to enter the register, optometrists should maintain this competency to stay on the register, and paediatric care should not be viewed as an optional specialism.
- Barriers to access may include commercial pressures, limited appointment time, lack of age-appropriate equipment, variations in practitioner confidence and experience, location, and instances where lack of oversight or training means parents are turned away by front of house staff.
- Awareness of children's eye care services among parents and carers appears variable. Many may be uncertain about when and where to seek help for children's eye health concerns (including whether it is possible to test a child who cannot read), and sight testing among young children appears to be driven more by identified concerns than routine attendance. Improving public awareness of free sight tests and the role of optometrists could help support earlier access to care and treatment.
- There are gaps in the existing data on numbers of sight tests for children under five which, if addressed, would provide greater insight into this area.
- This is a multi-faceted and complex set of issues, only some of which have regulatory implications. There would be benefit in bringing together the wide

range of stakeholders with an interest in these issues to identify the best ways to reduce barriers to parents and carers accessing sight tests for children.

Introduction

311. Sight tests are crucial for young children to detect and appropriately treat and manage conditions such as amblyopia, strabismus, myopia or hyperopia. Undetected conditions or reduced vision can negatively impact on a child's educational performance and social development¹⁴³, which can have lifelong implications.
312. In the UK, a child's eyes are checked at various points after birth, and then at ages one to two and half years old as part of their health and development review. The UK National Screening Committee recommends all children undergo vision screening at school entry (ages four to five years) as part of an orthoptic-led programme. These are basic vision tests and mainly detect conditions such as amblyopia (lazy eye)¹⁴⁴.
313. Wales, Scotland and Northern Ireland offer vision screening tests as part of their nationwide screening programmes, however, in England provision is patchy as not all local commissioning bodies (integrated care boards (ICB)) offer this service¹⁴⁵. If a child is not tested at school, the NHS in England recommends that they should be taken to an opticians for a sight test¹⁴⁶.
314. In all the UK nations, sight tests are free of charge (under the GOS contract) for children under 16 (and those under 19 in full-time education). Under the GOS contract, optometrists must provide a funded sight test to all eligible patients regardless of age or other factors. The College of Optometrists recommends that all children should be taken for sight tests from the age of three to four years old, every one to two years unless advised otherwise by their optometrist¹⁴⁷. These sight tests carried out by optometrists are more comprehensive than vision screening at schools and able to detect a range of conditions and check the health of the eye. Further, by the time children are screened in schools at age four to five, amblyopia may already have developed.

¹⁴³ [1.6 million school-aged children estimated to be living with an undetected vision problem - News - National Eye Health Week](#)

¹⁴⁴ [Vision defects - UK National Screening Committee \(UK NSC\) - GOV.UK](#)

¹⁴⁵ [BIOS survey shows 75,000 children a year miss out on in-school vision screening](#)

¹⁴⁶ [Eye tests for children - NHS](#)

¹⁴⁷ Association of British Dispensing Opticians (ABDO), The College of Optometrists and the Optical Suppliers Association in partnership with Mumsnet (April 2025), [Clarity for parents: Children's eye health in the UK](#)

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315. For this thematic review we chose to focus on testing of children under the age of five rather than older age groups. This is because academic studies¹⁴⁸ and anecdotal evidence¹⁴⁹ suggest that some children in this age group are being refused sight tests at their opticians based on their age.

Healthcare standards and regulation

316. Our Standards for Optical Businesses state that businesses must not discriminate on the grounds of age and that they must allow staff sufficient time to accommodate patients' needs. Our Standards of Practice for Optometrists and Dispensing Opticians similarly state that they must not discriminate on the grounds of age and more generally that commercial targets and incentives must not compromise professional judgement or affect patient safety (see box 15).

Box 15: GOC standards

Our Standards for Optical Businesses provide that a business:

- 2.2.5: "Promotes equality, values diversity and is inclusive in all dealings with staff, patients and others and does not discriminate on the grounds of gender, sexual orientation, age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief."
- 3.1.3: "Makes sure that operational and commercial pressures do not unreasonably inhibit the exercise of professional judgement."
- 3.1.4: "Allows staff sufficient time, so far as possible, to accommodate patients' individual needs within the provision of care."

Our Standards of Practice for Optometrists and Dispensing Opticians state:

- 5.1: "Be competent in all aspects of your work, including clinical practice, supervision, teaching, research and management roles, and do not perform any roles in which you are not competent."
- 10.2: "Refer a patient only where this is clinically justified, done in the interests of the patient and does not compromise patient care or safety. When making or accepting a referral it must be clear to both parties involved who has responsibility for the patient's care."
- 13.2: "Promote equality, value diversity and be inclusive in all your dealings and do not discriminate on the grounds of gender, sexual orientation, age,

¹⁴⁸ See paragraphs 343-344.

¹⁴⁹ [\(23\) Post | LinkedIn](#)

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disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief.”

- 16.3: “Ensure that incentives, targets and similar factors do not affect your professional judgement. Do not allow personal or commercial interests and gains to compromise patient safety.”

317. Other healthcare regulators’ standards do not address the issue of refusal to treat young children specifically, but many of their standards do refer to refusal to treat patients more generally.
318. The College of Optometrists’ Guidance for Professional Practice¹⁵⁰ provides detailed guidance for optometrists in examining younger children and provides advice on, for example, which tests to carry out and how to communicate effectively. The guidance also clearly states that they must not refuse to treat children: “You must not refuse to see a patient based on their age alone. You should arrange a transfer of care or a referral if a specialist assessment is in the patient’s best interests. You should make a reasonable attempt to include all appropriate tests. In exceptional circumstances, you may not be able to complete all the indicated tests for a very young child. In these situations, you should base your management on the findings you do have and act in the child’s best interests. Records should reflect what was attempted and why it was not possible to complete an examination, and details of a referral made if required.”
319. ABDO states that dispensing opticians have specialist expertise in children’s visual and eyewear needs and can provide care to children of any age. They are well placed to advise parents and carers on their child’s eyecare, promote awareness of children’s eye care services, and support access to the most appropriate care¹⁵¹.
320. Depending on the circumstances, refusal to treat children is likely to breach GOS contract obligations and equalities legislation.

Number of sight tests for children between 0-5

321. Since previous studies have been quite small in scale, we obtained anonymised data from GOS in England, Northern Ireland and Scotland on the number of sight tests undertaken for children between the ages of 0-5 from 1 September 2024 to 31 August 2025¹⁵².

¹⁵⁰ [Examining younger children - College of Optometrists](#)

¹⁵¹ Text provided by ABDO to the GOC in September 2026.

¹⁵² Commissioners in all four nations were contacted. Data was not available for Wales due to the absence of an electronic claims system.

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322. Each nation records data in different ways. In Northern Ireland we obtained data for both businesses and practitioners, while in England and Scotland data was available for businesses only.
323. To facilitate our analysis and reduce the burden of our request, for England we requested information from ten integrated care boards (ICBs). Two ICBs within the sample returned anomalous data, showing that over 98% of contractors in those ICBs did not undertake sight tests for children. We queried this data with NHS England and removed them from the analysis which follows.
324. In England we identified a total of 167,461 sight tests for children aged 0-5 in the remaining eight ICBs during the review period. Based on population data estimates in those ICB areas, there were between 1,048 and 1,665 sight tests per 10,000 children aged 0-5. Therefore, the highest-rate ICB undertakes around 1.6 times as many tests per child population as the lowest-rate ICB.
325. This may reflect variation in school screening programmes in England. In 2024, the British and Irish Orthoptic Society (BIOS) conducted a survey of child vision screening services in 138 local authorities in England¹⁵³. This found 57% were covered by child vision screenings services that followed Public Health England guidelines from 2017. A further 33.3% of local authorities offered screening services that either did not follow these guidelines, or we were not able to confirm whether they followed. 10% of local authorities did not have any form of vision screening for 4-5 year olds.
326. In Northern Ireland, 11,751 sight tests were recorded for children aged 0-5 during the review period. Based on population data estimates, this equates to about 900 sight tests per 10,000 children aged 0-5. Published statistics indicate that sight tests for children aged 0-5 account for approximately 2.5% of all sight tests undertaken in Northern Ireland, despite this age group representing around 7% of the population. However, in Northern Ireland there is a well-established hospital eye service with orthoptists and optometrists working together across all geographical areas in local locations. Children with low visions would be referred to hospital services from screening and health visitors. Since this information would not appear in the GOS data, the total number of sight tests for children will be higher than these figures suggest.
327. In Scotland, 42,905 NHS-funded sight tests were recorded for children aged 0-5 during the review period. Based on population data estimates, this equates to at least 1,427 sight tests per 10,000 children aged 0-5. Across all age groups, the dataset contains approximately 2.44 million sight tests, meaning that sight tests among children aged 0-5 accounted for approximately 1.8% of all NHS-funded sight tests in Scotland.

¹⁵³ [BIOS survey shows 75,000 children a year miss out on in-school vision screening](#)

Spread of sight tests across providers

328. In all three nations, a small but significant number of premises or contractors are not recording sight tests for children despite carrying out sight tests for adults.
329. In England, the data is available by contractor (contracting organisation) delivering sight tests. To identify active contractors, all those submitting GOS1 claims over the period for any age (i.e. adults or children) were included in our analysis. This helped to exclude purely domiciliary businesses.
330. The data from the eight ICBs shows 1,643 active contractors testing children under five, while 52 contractors (3.2%) did not carry out sight tests for that age group. As per an NHS Business Services Authority (NHSBSA) publication, there were 5,569 unique contractors nationally in 2022/23. If the 3.2% rate observed in our sample were representative nationally, this would imply approximately 175-180 contractors nationally may undertake no sight tests for children under five. However, this should be treated as illustrative only, as our extract covers a subset of ICBs rather than all of England, the NHSBSA figure is from 2022/23, and the contractor definitions may not be perfectly aligned.
331. In Northern Ireland, 264 premises who recorded sight tests for adults recorded at least one sight test for children aged under five, while 13 premises had no recorded activity for this age group. This suggests that 4.6% of premises recorded no sight tests for children under five during the review period. Domiciliary providers had been excluded from the data before it was sent to us.
332. In Scotland, 643 practices who recorded sight tests for adults (18-64 or 65+) recorded at least one sight test among children aged 0-5 (including 46 practices with suppressed values due to data privacy concerns), while 27 active practices had no recorded activity for children aged 0-5¹⁵⁴. This suggests that approximately 4.3% of active practices recorded no sight tests for children aged 0-5. Domiciliary providers had been excluded from the data before it was sent to us.
333. Sight testing activity is also unevenly distributed across providers. In England, across the eight ICBs at least 40% and as many as 55% of child sight tests are undertaken by the top 10% of contractors by volume while approximately 14% of contractors carried out ten or fewer sight tests during the year. In Northern Ireland the top 10% of premises account for approximately 46% of all sight tests, while approximately 24% of premises carried out fewer than ten. In Scotland, the top 10% of practices account for approximately 45% of all sight

¹⁵⁴ For the purposes of this analysis, we have included suppressed values as suppression reflects disclosure control to ensure data privacy rather than confirmed nil activity. There are higher levels of suppressed data in responses from health boards in primarily rural areas, which may be caused by smaller patient numbers, with the increased likelihood of potential identification from the data shared.

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tests for children aged 0-5, while approximately 15% of practices carried out ten or fewer sight tests for children aged 0-5 during the year.

334. The average practitioner in Northern Ireland undertook approximately 22 child sight tests per year, equivalent to around one sight test every two to three weeks. The typical (median) practitioner undertook 17 child sight tests per year, equivalent to around one sight test every three weeks. In England the average contractor undertakes 105 sight tests a year (approximately two a week), while the typical (median) contractor carries out 43 sight tests (fewer than one a week). In Scotland, the average practice undertook approximately 72 child sight tests per year, equivalent to around 1.4 sight tests per week. The typical (median) practice undertook approximately 39 child sight tests per year, equivalent to around three sight tests per month. See table 2 for further detail on number of child sight tests.

Table 2: Number of sight tests undertaken per year by contractor (England), practitioner (Northern Ireland) or practice (Scotland)

	Child sight tests per year		
Percentile	England	Northern Ireland	Scotland
25th	18	9	18
Median	43	17	39
75th	108	31	77
90th	288	45.9	178

335. In England, there is a significant gap (105 versus 43) between the average and median number of sight tests undertaken a year due to a small number of contractors towards the top end of the scale delivering significantly more sight tests than most contractors, which is driving up the average number of tests. In Scotland, there is also a significant gap (72 versus 39) between the average and median number of sight tests. This suggests that in both nations child sight testing activity is quite concentrated, with many contractors or practices seeing relatively few young children. In Northern Ireland, however, the gap between the mean and median is much smaller (22 versus 17), which suggests that sight testing is more evenly spread across practitioners.
336. Some degree of concentration would be expected in any healthcare system. Larger providers typically deliver higher volumes of care, while some practices may develop greater experience, confidence or local reputation for testing young children. The observed concentration therefore appears consistent with

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a mixed market in which paediatric activity is distributed across most providers but delivered at scale by a smaller number of higher-volume practices.

337. In Northern Ireland, data is also available on the number of active practitioners (individual optometrists) during this period. There were 647 active practitioners and 542 practitioners appeared in the child sight test dataset¹⁵⁵. Therefore, 16% of active practitioners recorded no sight tests for children under five during the review period. Activity per practitioner was broadly similar across small, medium and large businesses, suggesting that factors other than business size are likely to contribute to observed non-participation.
338. As the data for England and Scotland is based on contractors or practices and not individuals, we cannot say whether there are individual optometrists who did not test children in those contractors. However, given that the typical (median) contractor (England) and practice (Scotland) carries out fewer than one sight test on children a week, it is likely that some optometrists working in practices with testing numbers below the median did not test children in the year under review.

Understanding barriers to access

339. The GOS data highlights that some contractors/premises/practices are not testing children under five. This may be because children are not attending these providers for tests for understandable reasons such as location, opening hours or affordability, e.g. parents preferring providers which advertise free spectacles. This cohort of patients often require several pairs annually due to breakages, damage or growth of child making affordability an important factor.
340. Our review also suggests barriers to children accessing tests, including:
- optometrists lack the competence or confidence to carry out sight tests for young children;
 - optometrists lack the necessary equipment to carry out these tests appropriately;
 - commercial pressures mean the business has decided not to provide appointments, for example, because tests can take a long time to complete, some young children need repeat visits to complete their test, low value spectacle sales, and cost of specialist equipment;
 - GOS fees are perceived as insufficient to cover the cost to the business of delivering sight tests to young children;

¹⁵⁵ An active practitioner is defined as a practitioner who has submitted at least one GOS claim for any age group.

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- parents are being turned away by unregulated staff at reception; or
 - parents/carers awareness – they may not see the benefits of sight tests, especially if their child passes school vision screening. They may be unaware that sight tests for children under the GOS are free or that vouchers are available for spectacles. Social factors may also contribute, e.g. reluctance for their child to wear spectacles or fear of peer pressures/bullying.
341. Our qualitative research into commercial practices and patient safety¹⁵⁶ noted there were days where the business would make less money due to, for example, more appointments with children. Some optometrists noted how diary management could prioritise patients who were most likely to spend over routine check-ups or children's appointments.
342. GOC is supporting research by Teesside University and Aston University to capture the perspectives of practitioners and others on the provision of children's eye care in the community. The research, which is ongoing, is exploring practitioners' confidence, experiences, and attitudes towards examining children, and seeks to understand the key barriers and enablers influencing service delivery. Box 16 contains preliminary themes from a national survey and interviews with seven community optometrists.

Box 16: Preliminary themes from Teesside University and Aston University study

Overall narrative

Optometrists were motivated to provide child-centred paediatric eye care, but their ability to do so was influenced by their confidence and skills, available resources, parental engagement, and the wider organisation of paediatric eye care services.

1. Child-centred and adaptive clinical practice

Participants emphasised the importance of adapting communication, testing approaches, and the clinical environment to meet the individual needs of children. Flexibility, creativity, and rapport building were viewed as essential components of successful paediatric care.

"You meet the child where they are. You can't be too prescriptive about it."

2. Professional capability and confidence

Confidence in paediatric practice was strongly linked to practical experience rather than theoretical knowledge alone. Participants highlighted the value of hands-on learning, supervision, mentoring, and opportunities to develop specialist skills.

¹⁵⁶ Shift Insight (2026), [Commercial practices and patient safety in the primary eye care sector](#)

“I’ve done all the webinars, you know, but it’s the practical that is needed.”

3. Resource and commercial constraints

Participants described tensions between delivering high-quality paediatric care and the realities of funding, appointment times, equipment costs, and commercial pressures within practice settings.

“Not great from a commercial point of view. If I had a day full of kids, we’d be shut within a year.”

4. Access, referral pathways and continuity of care

Optometrists reported variability in referral pathways, limited communication with hospital services, and concerns about delays affecting children’s access to timely care.

“Sometimes the hospital doesn’t really communicate with the practice afterwards.”

5. Parental understanding and engagement

Parents were seen as central to children’s eye care, but participants described limited awareness of childhood eye conditions, misconceptions about treatment, and variable engagement with appointments and spectacle wear.

“A lot of parents say, ‘I didn’t know that we were allowed to bring them in this early’.”

6. Future models of paediatric eye care

Participants favoured more integrated community-based services, including greater collaboration with orthoptists, enhanced training opportunities, and improved referral pathways to support children and families closer to home.

“If the child needs to be referred for orthoptics, if you had an orthoptist working in a community hub that was free parking outside and closer to the locality...”

343. A 2021 study¹⁵⁷ investigated whether there were any barriers to accessing primary eye care for young children with typical development and those with autism in England. 400 optical businesses were contacted by phone and asked about the availability of sight tests for children. Out of 400, only three practices (fewer than 1%) refused to perform sight tests on children; 14% said they would examine a child of any age; and 85% specified a minimum age (typically five years old) at which they would carry out a sight test. Two main barriers cited by businesses were a lack of communication from the child and a lack of

¹⁵⁷ Wilson, S., et al. How accessible is primary eye care for children in England? *Ophthalmic Physiol. Opt.* 41, 1021–1033 (2021)

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appropriate equipment. Factors that enabled access for children with autism included adaptability and flexible appointment times.

344. A 2023 study¹⁵⁸ conducted with optometrists in England explored their views on sight tests for children under the age of five and any barriers to providing care. Key barriers identified were time and money, with participants stating that the GOS fee did not cover the extra time needed to sufficiently examine young children. Another barrier related to employers, as participants felt they could place restrictions on the sight testing time which created pressure on the optometrist to provide the care they wanted. Insufficient training and a lack of exposure could also result in reduced confidence in treating young children. Finally, a lack of age-appropriate equipment could also act as a barrier.
345. In our 2019 risk research¹⁵⁹, paediatric optometry was cited as a riskier area of practice for optometrists mainly because children's eyesight is still in the developmental stage, so any mistakes could result in long-term damage. GOC registrant participants said it was harder to conduct a sight test on children due to factors such as getting them to sit still and report accurately on how well they could see something during the test. As a result, some participants said they referred children elsewhere to avoid this risk.
346. A Mumsnet survey commissioned by ABDO, The College of Optometrists and the Optical Suppliers Association¹⁶⁰ highlights that UK parents are confused about when and where to go for children's eye care advice and treatment. One in twelve parents (8%) would visit their GP or call NHS 111 if their child was experiencing a slight change in vision rather than making an appointment at their local opticians. Over 80% would go straight to their GP or pharmacist for an eye infection issue and 71% would go to their GP or pharmacist for an eye discomfort issue instead of seeking advice at their local opticians.
347. The same survey found that parents were more likely to say that dental checkups were 'very important' for children (89%) compared to eye tests (79%). It also found that nearly a tenth of parents (9%) saw no reason to take their child to an optometrist unless they have cause for concern.

Professional perspectives

348. The College of Optometrists highlighted that all optometrists should see children; this is part of NHS-funded contractual obligations and that guidance is clear that optometrists should not refuse patients based on age, should carry

¹⁵⁸ Wilson, S., et al. An investigation of barriers and enablers to community eye care for children in England: A qualitative descriptive study. *Ophthalmic Physiol. Opt.* 43, 710–724 (2023).

¹⁵⁹ Enventure Research (2019), [Risk in the optical professions, Final Report, General Optical Council](#)

¹⁶⁰ Report by the Association of British Dispensing Opticians (ABDO), The College of Optometrists and the Optical Suppliers Association in partnership with Mumsnet (2025) [New report reveals children's eye health confusion - ABDO](#)

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out appropriate tests, and should arrange referral or transfer if needed. Parents and carers should be able to access regular eye tests for children from around age three to four, even where there are no obvious concerns. They identified that the main barriers were commercial pressures and, in some cases, non-clinical staff discouraging appointments for children.

349. FODO members said parents/carers could book an appointment for a sight test based on clinical need and that children can access prescription glasses from their practices within the voucher value. Commenting on potential access issues within the wider sector, respondents highlighted that some practices may schedule appointments for particular times of day for either commercial, clinical or access reasons (e.g. out of school hours). They also commented that, if children were refused, this might be because of confusion amongst front of house staff or because some registrants may lack the confidence to test young children owing to training and experience gaps.

Spread of sight tests across age groups

350. In both England and Northern Ireland sight testing activity increases substantially with age (see table 3)¹⁶¹.

Table 3: Sight tests by age group

Age group	Share of tests (England)	Share of tests (Northern Ireland)
0-2 years	3.8%	~7%
3-5 years	96.2%	~93%

351. The low volume of testing among children aged 0-2 is consistent with clinical and practical expectations. Parents may not recognise the benefits of sight testing at this age. Sight testing can be more challenging in younger children, requiring additional expertise and cooperation from both children and parents. Children under two may also struggle to communicate eye health issues or sight difficulties, contributing to it being more difficult for parents or carers to identify. The increase in testing activity from age three onwards is therefore unsurprising and aligns with established patterns of paediatric eye care delivery. Often in this very young age group, problems may mean the child is referred to the hospital eye service initially.
352. In Northern Ireland approximately 39% of practices tested children across the full 0-5 age range while 27% of practices only tested children aged 3-5. Most testing happens between 4-5, the age at which children start school and are therefore included in the school vision screening programme, thereby

¹⁶¹ The data received for Scotland was not broken down into smaller age groups.

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contributing to the concentration of activity observed among older children within the dataset. In England, approximately 65% of contractors tested children across both the younger (0-2) and older (3-5) preschool age groups, while 35% only tested children aged 3-5.

Prescription rates

353. In both England and Northern Ireland, the rate of prescription increases with age, consistent with greater detection of refractive error or eye health concerns as children get older. Prescription outcomes were examined for all recorded sight tests (see table 4). The proportion of tests resulting in a new or changed prescription is relatively high compared with what might be expected from routine population screening alone¹⁶².

Table 4: Prescription outcome

Outcome	England	Northern Ireland
New or changed prescription	21.9%	39%
No prescription required	30.9%	56%
Unchanged prescription	3.5%	~4%
Other / not classifiable	43.7%	Not recorded

354. This may indicate that attendance for sight testing among young children is selective rather than routine, with children more likely to present when concerns have already been identified by parents or carers, schools, health visitors or other healthcare professionals. Young children may struggle to identify themselves that they have an eye health concern. Given that only a relatively small proportion of children aged 0-5 attend a sight test annually, the dataset is likely to represent a population with a higher underlying probability of visual concerns than the general population.

355. In both England and Northern Ireland, the mean and median prescribing rates are broadly similar, suggesting that there are unusually high or low prescribing practitioners. However, the rate of prescription change between the two countries is very different. In Northern Ireland the mean prescribing rate was 39.4% and the median was 37.5%, while in England the mean prescribing rate was 19.8% and the median was 19%. This indicates that children in Northern Ireland are significantly more likely to be given a new or changed prescription than those in England. However, it should be noted that over 40% of outcomes

¹⁶² The data received from Scotland did not provide prescription rates.

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in England were recorded as 'other/not classifiable' and it is possible that the variation in prescribing rates is explained by this high result.

356. In England, however, there is meaningful difference in prescribing rates between the ICBs in our sample. Children tested in the highest prescribing rate ICB were around 1.7 times more likely to receive a new or changed prescription than children tested in the ICB with the lowest prescribing rate. Mean and median prescribing rates were generally quite similar, suggesting that these differences reflect broader area-level patterns rather than a small number of unusually high-prescribing contractors. Different patient demographics may also account for differences in prescription rates in different regions.

Conclusions

357. We have made the following conclusions related to sight tests for children under five:

- early sight testing is important, but sight testing is unevenly provided across premises/contractors;
- some optometrists may test children under five infrequently or not at all, leading to risks of deskilling;
- there are varying levels of awareness of optometrists' ability to test children under five, or to address eye care conditions, which may create barriers to accessing eye care; and
- the barriers to access are multi-faceted, complex and extend beyond regulatory factors so stakeholders should convene to discuss solutions.

358. These conclusions are discussed below.

Early sight testing is important, but sight testing is unevenly provided across premises/contractors

359. Providing sight tests to children under five is essential in upholding public confidence and ensuring that any eye health conditions are addressed appropriately at an early age. Although sight tests are free across the UK and professional guidance recommends testing from around age three to four, the data suggests that not all contractors or providers are involved in testing children under five, despite those providers testing adults.
360. The sector's ambition to be the first port of call for eye health risks being undermined if parents are refused sight tests for their children. Failure to access sight tests can lead to conditions worsening as well as unnecessary referrals to GPs and hospitals in the context of long waiting lists.

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361. It is not necessarily the case that providers are refusing children, because demand may vary. For example, a provider may be based in a city centre catering to office workers or may only offer appointments during the week or in school hours. However, our data demonstrates that a proportion of the sector has little or no engagement with young children. The data also shows that the top 10% of providers can undertake between two fifths and half of all children's sight tests in England, Northern Ireland and Scotland. This suggests a concentration of experience and provision in some providers, reinforcing access issues if those providers are not easily accessible to local parents or carers.
362. Some businesses may not provide sight tests for young children because they need a longer appointment¹⁶³ or because specialist equipment is needed to help children, particularly those who may not be able to read. In our view, all practices should have the equipment necessary to test a child's sight. Testing the sight of young children cannot be viewed as an optional extra.
363. It has been suggested to us that the economics of paediatric care are different than for adults. For example, an optometrist may not be able to complete the clinical assessments required to claim under the GOS contract. However, contractors or premises delivering eye care have an obligation to meet their public sector equality duty not to discriminate on the basis of age. In addition, the GOS contracts include guidance on what to do when an optometrist has been unable to complete all the clinical assessments of a sight test due to factors beyond their control, such as the patient being very young¹⁶⁴.
364. The focus of this section has been on access to routine sight tests for young children. Yet children with learning disabilities are 28 times more likely to have a serious sight problem, but four in ten have never had a sight test¹⁶⁵. The issues identified in this section, such as potential communication barriers, practitioner lack of confidence, lack of appropriate equipment or inability to provide sufficient appointment time are likely to be more acute for this group, leading to greater difficulties in accessing sight tests and addressing eye health issues.
365. Data on prescribing suggests that at least one fifth and nearly two fifths of children are given a new or changed prescription after their sight test. In fact, in Northern Ireland, prescribing rates for children are higher than for adults. This suggests that low prescribing is not a commercial reason for refusing sight tests, although there may be lower margin on the spectacles sold. Children are likely brought for testing because parents/carers or schools identify issues, there is a history of eye problems in the family, or vision screening detects

¹⁶³ See section 2 of this report for more information on booking practices

¹⁶⁴ NHS England, letter 2019 [avoidance-of-doubt-letter.pdf](#)

¹⁶⁵ [Eye care | SeeAbility](#)

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problems. As children are less likely to have routine sight tests, children presenting for a sight test are more likely to have difficulties and it is therefore important that they are addressed quickly and appropriately.

Some optometrists may test children under five infrequently or not at all, leading to risks of deskilling

366. Given the low number of tests carried out at many contractors or practices and that 16% of active practitioners in Northern Ireland recorded no sight tests for children under five during the review period, it is likely that some optometrists do not carry out sight tests on young children regularly. Testing infrequently, or not at all, may mean that they struggle to keep their knowledge and skills up to date and contribute to them feeling less clinically confident.
367. The GOC's requirements for approved qualifications describe the expected knowledge, skills and behaviours a dispensing optician or optometrist must have at the point they qualify and enter the register. These cover analysing visual function and using that information to develop a clinical management plan for children, as well as being able to manage and dispense appropriate spectacles for paediatric patients. As such, testing young children and being able to dispense to children are considered core competencies. Variety of patient needs, including paediatrics, is designed into education providers' planning for student placements for this purpose.
368. We understand that some optometrists will specialise after qualifying and in practical terms some consulting rooms in practices are more suitable for children than others. Working patterns will also influence if optometrists routinely see children. However, given treating children is a core competency to enter the register, optometrists should maintain this competency to stay on the register, and paediatric care should not be viewed as an optional specialism.

There are varying levels of awareness of optometrists' ability to test children under five, or to address eye care conditions, which may create barriers to accessing eye care

369. Our annual public perceptions survey continues to report that people would be more likely to visit an opticians/optometrist practice than a GP in the event of an eye problem (41% vs 36% 2025)¹⁶⁶. However, research suggests that most parents would go to a GP or pharmacist for a child's eye health issue. This suggests uneven awareness of an optometrist's ability to treat these conditions, which may in turn lead to parents accessing other services. Alternatively, parents may already be in more regular contact with GPs or pharmacists and therefore may turn to them for advice.

¹⁶⁶ GOC public perceptions research 2026 [Public perceptions research 2026](#)

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370. Shortly before or after a child is born a parent is provided with a personal child health record (PCHR). This usually has a red cover and is known as the 'red book'. The contents of the red book vary by nation, but it does not reference the importance of sight tests (unlike dental checks) which also means that parents may not understand the importance of a sight test and monitoring their child's eyesight. The College of Optometrists told us they are seeking changes to the red book, which should help improve awareness among new parents. A campaign was launched¹⁶⁷ in September 2026 by ABDO, Boots Opticians, the College and Specsavers (also supported by Fight for Sight, FODO, International Association for the Prevention of Blindness (IAPB) and the Optical Suppliers Association). This includes calling on national health and care service providers to update signposting guidance and include advice in the red book for parents/carers to take their child for regular sight tests from the age of three to four years.

The barriers to access are multi-faceted, complex and extend beyond regulatory factors so stakeholders should convene to discuss solutions

371. This is a multi-faceted and complex set of issues, and it has only been possible to scratch the surface in this thematic review. The range of potential barriers to accessing sight tests span parent/carer awareness and related factors, school vision screening and referral pathways, the GOS contract, specialist equipment, practitioner competence and confidence, as well as commercial factors.
372. Only some of these barriers have regulatory implications, so the GOC can only help address elements of the issue. Therefore, we see benefit in stakeholders coming together to discuss the issues and identify solutions to reduce barriers to parents and carers accessing sight tests for children.

¹⁶⁷ [Build your confidence in children's eye care, new CPD and resources now available - College of Optometrists](#)

Cross-cutting themes

373. The review reveals a paradox of satisfied patients but a profession under strain. Surveys show high levels of public confidence in the profession and patient satisfaction with eye care services but also reveal high job dissatisfaction within the professions we regulate and wide reporting of negative working conditions in optical businesses. Many registrants are concerned about the impacts of various commercial practices on their ability to provide safe care as well as pressures which impact on wellbeing, such as an expectation to see high volumes of patients, and/or meeting employer-driven targets.
374. Our review found no direct causal relationship between commercial practices and patients suffering harm, such as missed diagnosis or safety incidents. However, while there is good survey data on the patient experience, there is a deficit of quantitative data on the safety and effectiveness of eye care. Evidence¹⁶⁸ outside of eye care suggests that, when experienced by healthcare professionals, factors like burnout can impact patient safety.
375. The potential harms associated with commercial practices are not limited to immediate or direct clinical harm. There may be more subtle, longer-term effects that are less visible, such as patient disengagement. Registrants raised concerns about targets and financial incentives to sell products and services that patients may not need, or that may not be in their best interests. Patient groups have voiced concern about rushed appointments and pressure selling. Where this is the case, it may deter some patients from accessing eye care services, with possible consequences for longer-term eye health outcomes.
376. Increasing student numbers are growing the size of the professions we regulate. Yet, there is a risk that commercial practices may artificially suppress workforce capacity as those reporting burnout, fatigue and stress are more likely to plan to leave the profession. This is significant given the increasing focus on moving overburdened secondary healthcare services into primary care, which depends on a resilient and sustainable workforce that can deliver safe and effective services.
377. Students and early career professionals appear particularly exposed to the negative impact of some commercial practices in optical businesses. This highlights the importance of an education and training that prepares future registrants to identify and manage conflicts of interest, behave ethically when encountering commercial pressures and maintain professional autonomy. Although our education and training requirements include a standard that

¹⁶⁸ [The state of medical education and practice in the UK Workplace experiences 2025](#)

Panagioti, M., Geraghty, K., Johnson, J., et al. Association between physician burnout and patient safety, professionalism, and patient satisfaction: a systematic review and meta-analysis. *JAMA Intern Med.* 2018;178(10):1317-1330

requires providers of GOC approved qualifications to ensure that students' learning and experience in practice is not adversely affected by commercial pressures, our registrant survey indicates that 57% of those who joined the register within the last five years said their education and training did not equip them to manage commercial pressures while maintaining safe patient care well. Therefore, greater focus on supporting students and early career professionals is needed.

Culture

378. The conflicting perspectives offered by individual registrants, employers and business registrants on operational matters such as booking practices, use of sales targets and incentives, and sight test times is striking. While employers generally do not consider the issues identified in the report to indicate a systemic problem, survey findings and other evidence sources¹⁶⁹ suggest that concerns among registrants are widely felt. At the least, this disconnect suggests a relationship between registrants, employers and optical businesses that is not working as well as it should.
379. Our survey data shows that professionals working in multiples are more likely to experience a negative impact from some commercially orientated business practices, but it also shows that these issues are not just confined to larger optical businesses with multiple outlets, and that they are experienced in all parts of the UK.
380. Strengthening registrants' clinical autonomy and enhancing a more collaborative culture within optical practice which gives them greater voice in the design of business operations such as booking practices, the use of sales targets and incentives will be important to address the issues identified. We hope that this thematic review will support open conversations between business owners, employers and registrants on these issues.
381. More widely, our review highlights the importance of fostering the right culture. Regulatory standards and enforcement remain important, but they are not sufficient on their own to shape day-to-day behaviour within businesses. Creating an environment that supports autonomous clinical decision-making and management of risk, aligns achievement of targets and payment of incentives with quality and customer service and ensures the best interests of patients is essential.
382. In our proposed reforms to business regulation, we intend to introduce a role called 'Head of Optical Practice'. One of the benefits of this proposal is an ambition to foster healthier cultures by strengthening clinical leadership and

¹⁶⁹ Retallic, N., et al. A qualitative analysis of strategies for managing work-related stress among optometrists in the United Kingdom. *Optom Vis Sci.* 2025 Aug 27;102(10):644–54

accountability within optical businesses. We can also learn from other sectors, including financial services, on how the shifts in governance intersect with culture so that it shapes behaviour in a positive way¹⁷⁰.

383. An environment in which registrants feel comfortable speaking up about their concerns is a good indicator of culture. The registrant survey suggests that professionals are discussing concerns with colleagues and managers, but very few raise concerns through a formal process. The scale of concerns reported through the registrant survey is not reflected in fitness to practise referrals.

Structural factors

384. Broad-scale economic conditions are challenging right across the UK, with global drivers contributing to macroeconomic instability. This is reflected locally on high streets and in communities in relation to consumer confidence, as well as in local and national commissioning arrangements through GOS and other contracts, where health service budgets are under significant pressure.
385. As set out in the introduction, decisions on GOS funding fall outside our regulatory remit and as an independent statutory healthcare regulator, it is not our role to advocate on the profession's behalf for additional state funding for eye health services. However, the insufficiency of GOS fees was raised time and again across many of the issues we considered.
386. A strongly held view within the profession is that the low level of GOS fees, particularly in England, contributes to pressure to see high volumes of patients. Some have highlighted it as a factor in refusing sight tests for young children. When considered alongside findings on sales targets, use of incentives and short sight testing times, GOS fees do appear to influence how eye care is being delivered.
387. However, while GOS fees are a contributory factor, they do not explain all commercial pressures highlighted in this report. Fee levels vary across the four nations, yet our registrant survey data shows relatively limited variation between nations in reports of unsafe patient volumes. It would therefore be overly simplistic to assume that increasing GOS fees alone would resolve concerns about booking practices, sales pressure or commercial incentives.
388. Certainly, GOS fees would not excuse missing out essential procedures in order to compress sight test times, pressuring patients into buying products or services they do not need, or refusing to treat patients who are more expensive to serve.

¹⁷⁰ [Culture and governance | FCA](#)

Legislative reform would enable us to strengthen oversight of business practices

389. The PSA has highlighted the difficulty of regulators holding businesses accountable and scrutinising practices such as aggressive sales tactics¹⁷¹. We agree with this assessment and are working to strengthen oversight of businesses through the Department of Health and Social Care's legislative reform programme.
390. We want all businesses delivering restricted activities to be regulated by us. This would close a gap in regulatory protection and create a level playing field for businesses. As described above, the proposed Head of Optical Practice role would place responsibility for compliance with our standards with a senior registrant employed by each business, strengthening clinical influence in management decisions and helping to address concerns that commercial factors may be prioritised over delivery of safe and effective patient care.
391. We are supportive of the Department of Health and Social Care's regulatory reform agenda which will help modernise and strengthen our oversight of business practices. We are grateful for broad sector support for our proposals and share their frustration at the pace of regulatory reform. In the meantime, we need to make the best use of the existing regulatory framework to address the issues identified in this review.

¹⁷¹ Professional Standards Authority for Health and Social Care (2023), [Safer care for all: Solutions from professional regulation and beyond](#)

Recommendations

Work we will take forward

Review of the Standards for Optical Businesses

392. We will review our Standards for Optical Businesses to ensure that they support the achievement of the following outcomes:

- registrants always act in each patient's best interests with clinical care taking precedence over commercial considerations;
- registrants have autonomy to exercise professional judgement free from undue commercial influence and appropriately manage conflicts of interest;
- booking practices and appointment systems consistently support safe patient care and registrant wellbeing, while being sufficiently flexible to manage urgent/emergency eye care appointments or situations where a higher number of patients attend than expected;
- employers and business owners create and maintain an environment that supports employees' health and wellbeing, including managing workplace stress and encourages staff to raise concerns through effective internal complaints procedures and speaking up processes;
- patients can easily access clear information on costs and eligibility for free sight tests and vouchers in advance of booking sight tests and related services;
- patients are supported to make informed decisions about their treatment options and purchase decisions; and
- patients in vulnerable circumstances get the additional support they need, for example, more time or tailored communications.

Consideration of supplementary guidance

393. We will consider producing supplementary guidance if needed in future, including to support any new or strengthened standards.

394. We will review best practice by other regulators within and outside of healthcare to identify ways to strengthen support for registrants to speak up.

Recommendations

Raising awareness of existing standards and guidance

395. Our Standards of Practice for Optometrists and Dispensing Opticians and guidance on speaking up¹⁷² and care of patients in vulnerable circumstances¹⁷³ already outline our expectations in relation to managing conflicts of interest, ensuring patient safety is not compromised by meeting targets and incentives, and support for more vulnerable groups of patients. We will work collaboratively with the professional/representative bodies to raise awareness of these.

Review of education and training requirements

396. We will review how the education and training system can best ensure that newly qualified registrants are equipped to manage commercial pressures while maintaining safe patient care.
397. We will also work with education sector partners to consider how students can best be supported while on placement during their qualification.

Sight tests for young children

398. Working in partnership with Teesside University and Aston University, we will convene a stakeholder roundtable to discuss the issues in this review.

Improve evidence, monitoring and assurance

399. We will use the independent review of fitness to practise decisions we already commission to provide assurance about the quality of decision-making in cases about business registrants and commercial practices. We will also strengthen our data collection in this area to support monitoring and identify trends.
400. We will monitor and keep under review concerns relating to inappropriate referrals to services such as cataract surgery and refractive surgery. We will consider further activity if there is growing evidence of risk in this area.
401. As part of our research activities, we will continue to capture and monitor trends through our registrant survey and other data sources. We will focus on groups such as newly qualified registrants, who may be more likely to experience difficulties in prioritising patient care over commercial pressures and more broadly face challenges transitioning into full-time clinical practice.

Recommendations for the wider sector

402. Collaboration with sector partners in preventing harm is a key theme of our 2025-30 corporate strategy. The recommendations set out below identify where stakeholders including professional bodies, employers and others, could help to address the issues identified in this review and we are committed to continuing

¹⁷² [Speaking up](#)

¹⁷³ [Care of patients in vulnerable circumstances](#)

Recommendations

to work closely with the sector, and in particular to use our convening role to help others to work together effectively to progress relevant recommendations.

Recommendations for the professional/representative bodies

Support individual registrants and business registrants to manage commercial pressures and raise concerns

403. The professional/representative bodies¹⁷⁴ should consider reviewing and updating the guidance, advice and support they provide relating to the issues identified in this review.
404. In their role as CPD providers, the professional/representative bodies should use the professional development they provide to support registrants to manage the issues identified in this review.

Recommendations for optical businesses

Ensure commercial practices support safe and ethical patient care

405. Optical businesses should review their employee targets and incentives structures, booking practices and sight testing arrangements to ensure they foster the right culture, comply with our standards and create a clear focus on patient safety, patient experience and registrant wellbeing.

Strengthen oversight and assurance mechanisms

406. Optical businesses should collect and monitor internal data to identify potential risks, outliers and emerging concerns, and exercise appropriate oversight and auditing of areas such as sight testing times, target and incentive structures, and referral practices. Any concerns should be investigated promptly and appropriately, including referrals to the GOC as necessary.

Create a culture where staff can raise concerns and access support

407. Optical businesses should review their speaking up arrangements against the GOC's guidance and ensure these cover concerns about commercial practices.
408. Optical businesses should ensure that appropriate support is available for employees experiencing difficulties associated with the commercial environment in which the business operates.

Consider the needs of patients requiring additional support

409. Optical businesses should consider whether additional measures, such as enhanced triaging or pre-screening processes, are required to identify patients

¹⁷⁴ We note that The College of Optometrists has recently consulted on its Guidance for Professional Practice and await the outcome of that consultation.

Recommendations

who may need longer appointments or additional support, including patients in vulnerable circumstances.

Recommendations for commissioners and NHS bodies

- 410. Commissioners should consider the impact that current GOS contracts may be having on the delivery of eye care and workforce wellbeing.
- 411. Commissioners should maintain and analyse data on numbers of sight tests for children under five and follow up concerns with contractors as appropriate.
- 412. Commissioners and NHS bodies should seek to raise public awareness about eligibility for free sight tests and other financial support towards eye care costs.

Annex 1: Methodology

413. Throughout this report, we drew on a number of sources of evidence and we explain the methodology for some of our key evidence sources below.

Research with registrants

414. Our registrant surveys give us valuable insight into registrant views of working in clinical practice and perceptions of the GOC. Conducted by an independent research agency, we've held registrant surveys in 2016, and then annually between 2021 to 2026. Further information can be found on our website:

[Registrant surveys](#)

415. We also carried out lived experience exploring optometrists and dispensing opticians in the UK facing harassment, bullying, abuse or discrimination at work. Further information can be found on our website: [Lived experience research: exploring optometrists and dispensing opticians in the UK facing harassment, bullying, abuse or discrimination at work](#)

Research with the public

416. Our public perceptions research looks at the public's views and experiences of using eye care services in the UK. Conducted by an independent research agency, we've held public perceptions surveys annually in 2015-17, 2019 and 2021-26. Further information about the methodology for each individual survey can be found on our website: [Public perceptions research](#)

417. We also carried out lived experience exploring patients and non-patients accessing and using eye care services. This qualitative research sought feedback from vulnerable groups of patients to examine inequalities in access and experiences of eye care services. Further information can be found on our website: [Lived experience research: exploring patients and non-patients accessing and using eye care services](#)

Other research

418. Other research reports mentioned in this report include:

- mapping of optical businesses in 2023¹⁷⁵: this research was a mixed-method approach with the aim of building a comprehensive picture of the UK optical businesses market, assessing the benefits and risks of UK optical businesses, and estimating costs for different regulatory options to extend business regulation; and

¹⁷⁵ Europe Economics (2023), [Mapping of Optical Businesses: Report for the GOC](#)

- our 2019 risk research¹⁷⁶: this research was a mixed-method approach with the aim of understanding the main competency, conduct and contextual risks for optometrists and dispensing opticians, whether these risks have changed since 2010 and whether they are likely to change in the near future.

Qualitative research into commercial practices and patient safety

419. As part of this thematic review, we commissioned qualitative research exploring how commercial practices in the primary eye care sector influence patient safety, patient experience and the professional wellbeing of registrants. The fieldwork included in-depth qualitative interviews with 31 optometrists and dispensing opticians, 30 representatives from GOC registered businesses, ten non-registered eye care staff (for example, optical assistants, technicians or reception staff) and five patient representative organisations. Full details about the methodology can be found in section 2 of the research report¹⁷⁷.

LinkedIn conversations

LinkedIn conversations and surveys

420. In October 2025 we started a conversation¹⁷⁸ on LinkedIn to find out more about booking practices. We asked registrants to give us their views in response to the LinkedIn post or to complete a qualitative survey¹⁷⁹. We gave the option of the survey because we wanted to give the opportunity for registrants to be able to comment anonymously, rather than solely on a public forum where they might not feel comfortable giving their views.
421. We considered that this would be a helpful way to start off the topic to gather thoughts and understand the kind of issues that registrants felt they were facing. While we recognised the limitations of this research approach (for example, being a selective sample) and therefore were careful about how much weight we placed on it, this was a helpful way to gain qualitative data and inform our thinking before commissioning further research on the topic.
422. There were nine comments on LinkedIn in response to our post. We received 1,130 responses to the qualitative survey, 26 of which were from people responding on behalf of an optical business. The survey responses included over 5,900 individual comments. Our consultation platform includes artificial intelligence (AI) analysis capabilities, which we used as a starting point to summarise the comments received.

¹⁷⁶ Enventure Research (2019), [Risk in the optical professions, Final Report, General Optical Council](#)

¹⁷⁷ Shift Insight (2026), [Commercial practices and patient safety in the primary eye care sector](#)

¹⁷⁸ [\(53\) Post | LinkedIn](#)

¹⁷⁹ [Project: Your opinions on overbooking/'ghost clinics' | General Optical Council](#)

423. In February 2026 we started a conversation on LinkedIn¹⁸⁰ to find out more about sales targets and incentives. Again, we asked registrants to give us their views in response to the LinkedIn post or to complete a qualitative survey. We received 14 responses to the qualitative survey and did not receive any comments on LinkedIn in response to our post.

Online customer reviews

424. We carried out an analysis of publicly available Trustpilot reviews. Approximately 2,000 negative Trustpilot reviews were extracted from a range of optical providers. Only one-to-three-star reviews were included to focus specifically on complaints, concerns or negative experiences. The dataset spans reviews written between January 2021 and February 2026.

425. The methodology involved:

- scraping the review title, body text, star rating, provider name, date and permalink;
- removing all personally identifiable information such as reviewer names;
- combining title and body text into a single field and performed standard cleaning; and
- storing all data securely in CSV format.

426. To understand the main themes present in the review text, topic modelling was used to group reviews by similarity of content. The model identified ten themes, three of which strongly aligned with the thematic review scope:

- pricing, cost or upselling (around 180 reviews);
- appointments, delays or waiting times (around 180 reviews); and
- sight test or clinical examination quality (around 90 reviews).

427. Other topics (e.g. contact lenses, hearing aids, surgery, product faults) were out of scope and removed from further analysis. After filtering to only relevant topics, around 450 reviews remained.

Review of optical business websites

428. We conducted a review of GOC business registrant websites. This in-house study reviewed the online visibility of sight test prices and related information. It

¹⁸⁰ [Linkedin post](#)

provides an overview of pricing practices, the availability of NHS support information, how OCT services are presented, and geographical differences.

429. The dataset included 324 GOC-registered business entities, of which 79% (255) had a website with sufficient information to be included in the analysis. The remaining 21% (69) had no functional website or provided no online information relating to sight tests. The 255 businesses were made up of 155 businesses in England, 25 in Wales, 50 in Scotland and 25 in Northern Ireland.

Optical Consumer Complaints Service (OCCS) caseload

430. We asked the OCCS to review three years' worth of data between November 2022 and November 2025 for any connection with the topics raised in our review. The report provides relevant figures and case studies throughout.

Fitness to practise cases

431. We reviewed hearings decisions between January 2023 and February 2026 where commercial pressures were raised as a defence to the allegations and found these to be present in at least six cases. The report provides case studies throughout.

Analysis of enquiries to our professional standards inbox

432. We reviewed enquiries into our professional standards inbox for the three years prior to 4 February 2026 and identified those relating to the topics in this report.

Analysis of a sample of NHS England, NHS Northern Ireland and Public Health Scotland (PHS) data on the age profile of sight tests by contractor

433. We submitted data requests to NHS bodies in all four nations for anonymised data on sight tests and prescribing rates for children aged 0-5. Data for Wales was unavailable due to the absence of an electronic claims system. Further detail for England, Northern Ireland and Scotland can be found in section 5 of this report.

Meetings with stakeholders, including optical businesses

434. Prior to our thematic review starting, we met with leaders of businesses representing some of the larger joint venture partnerships, franchises and multiples. This was helpful context to understand the issues that are experienced as part of working in commercial practice and we used this to help design our qualitative research into commercial practices and patient safety.
435. We also met representatives of the four main professional/ representative bodies to discuss our draft recommendations.

Requests for information and review of submissions from commissioners, other healthcare regulators, and optical professional/representative bodies

436. We invited commissioners, healthcare regulators and optical professional/representative bodies to provide us with information relevant to this thematic review. Many of these organisations did not provide us with a formal submission, but pointed us to information (such as reports, standards and guidance) that was already published. We reviewed these and used them as appropriate in our report. Where formal submissions were provided (for example, those from FODO and The College of Optometrists), these have been referred to in the report.

Literature review

437. We used Google Scholar to search for articles relevant to commercial practices and patient safety, particularly those related to the topics in this report. We also searched the optical sector press and guidance from professional/representative bodies on their websites.

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