General Optical Council

Third meeting in 2026 of the Council held in PUBLIC
on Wednesday 30 September 2026 at 10am via Microsoft Teams

AGENDA

Item no.	Item	Reference	Lead	Page No.	Finish time
1.	**Welcome, apologies and Chair's introduction**	Oral	Chair	-	10am - 10.05am (5 mins)
2.	**Declaration of interests**	C34(26)	Chair	4	
3.	**Minutes, actions and matters arising** 3.1 **Minutes – 24 June 2026** For approval 3.2 **Updated actions** For noting 3.3 **Matters arising**	C35(26) C36(26)	Chair	8	10.05am-10.10am (5 mins)
FOR DISCUSSION					
4.	**Thematic review on commercial practices and patient safety** For discussion	C37(26)	Director of Regulatory Strategy	16	10.10am-11.10am (60 mins)
11.10am - 11.25am Break (15 mins)					
FOR DECISION					
5.	**Annual report and financial statements 2025/26** For decision	C38(26)	Director of Corporate Services	136	11.25am-11.40am (15 mins)
6.	**Equality, Diversity and Inclusion annual report 2025/26** For decision	C39(26)	EDI Manager	203	11.40am-12.00pm (20 mins)
7.	**Lord Mann review of antisemitism and other forms of racism in the NHS and healthcare regulatory system** For decision	C40(26)	EDI Manager	305	12.00pm 12.20pm (20 mins)

8.	**Social Media Policy** For decision	C41(26)	Head of Communications & Engagement	344	12.20pm-12.30pm (10 mins)
9.	**ARC annual report 2025/26** For decision	C42(26)	Chair of ARC	353	12.30pm 12.40pm (10 mins)
12.40pm – 1.30pm Lunch (50 mins)					
10.	**Continuing Professional Development consultation response** For decision	C43(26)	Director of Regulatory Strategy	368	1.30pm-1.55pm (25 mins)
11.	**Significant preventable events and significant incident policy** For decision	C44(26)	Chief of Staff	453	1.55pm-2.05pm (10 mins)
FOR DISCUSSION					
12.	**Annual monitoring & reporting 2026 UK optical education report** For discussion	C45(26)	Education Policy Manager	499	2.05pm-2.35pm (30 mins)
13.	**Registrant and public perception survey** For discussion	C46(26)	Policy Manager	558	2.35pm-2.55pm (20 mins)
2.55pm - 3.05pm Break (10 mins)					
14.	**Q1 Financial Performance report and Q1 Forecast** For discussion	C47(26)	Chief Financial Officer	739	3.05pm-3.15pm (10 mins)
15.	**Business performance dashboard Q1 2026/27** For discussion	C48(26)	Chief of Staff	773	3.15pm – 3.25pm (10 mins)
16.	**Business Plan Assurance Report Q1 2026/27** For discussion	C49(26)	Chief of Staff	776	3.25pm – 3.35pm (10 mins)
FOR NOTING					
17.	**Chair's report** For noting	C50(26)	Chair	780	3.35pm-3.45pm

					(10 mins)
18.	**Chief Executive and Registrar's report** For noting	C51(26)	Chief Executive and Registrar	784	3.45pm-3.55pm (10 mins)
19.	**Council forward plan** For noting	C52(26)	Chair	805	3.55pm-3.57pm (2 mins)
20.	**Any other business (Items must be notified to the Chair 24 hours before the meeting)**	-	Chair	-	3.57pm-4pm (3 mins)
Meeting Close – 4pm					
Date of next meeting – Wednesday 9 December 2026					

	Own interests				Connected Persons interests
	Current interests	**Professional memberships**	**Previous interests**	**GOC committee memberships**	
Raymond **CURRAN** Registrant member (OO)	• Head of Ophthalmic Services, Strategic Planning and Performance Group, DoH, Northern Ireland • Member, Northern Ireland Ophthalmic Qualifications Committee • Task and Finish group member of the Digital Health and Care Policy Directorate of Department of Health NI Artificial Intelligence Steering Group (1. Policy & Governance and 2. Transformation & Innovation).	• Honorary Life Fellow, College of Optometrists • Member, Association of Optometrists	• Council Member and Trustee, College of Optometrists • Member of Senate, Ulster University • Past-President, Northern Ireland Optometric Society • NICE Fellow 2021-23	• Council Member • Member: Audit, Finance and Risk Committee • Member: Registration Committee	• None
Kathryn **FOREMAN** Lay Member	• Deputy Chair Assurance & Appointments Committee – General Pharmaceutical Council • Investigations Panel Member – Architects Registration Board • Lay Member Police Misconduct Panels – NW Police & Crime Commissioners	• Law Society (non- practising)	• Non-Executive Director- Primary Care 24 (Merseyside) Ltd • Lay Member Health & Care Professionals Council (ended December 2023) • Associate Midlands and Lancashire Commissioning Support Unit (2022-23)	• Lay Council Member • Member: Advisory Panel – Registration Committee Member, Audit, Finance and Risk Committee	• None
Lisa **GERSON** Registrant (OO)	• Clinic Tutor: Cardiff University • Observer status: Regional Optical Committee (ROC) meetings across Wales • GOC representative to Optometry Wales	• Member of AOP • Member of College of Optometry	• Chair: Optometry Wales • Member: GOC Hearings Panel • Member/Acting Chair: GOC Investigation Panel • Member: GOC Education Visitor Panel • College Counsellor: College of Optometrists • Trustee: College of Optometrists • Trustee: AOP • Employee: Ronald Brown Group • Employee: Boots Optician • Primary Care Supervisor: Cardiff University	• Registration Committee Chair • Nominations Committee Chair • Council lead for FtP	• None
Inderpal **GHUMAN** Council Associate (OO)	• Council Member, AOP • Specialist Optometrist, Moorfields Eye Hospital NHS Foundation Trust • Association of Optometrists Councillor (Early Career Designate)	•	• Johnson and Johnson, Vision Institute	• Council Associate, Audit Finance and Risk Committee	• None
Kalwant **GREWAL** Lay Member	• Saxon Weald, Member Audit and Risk Committee and Asset Management & Development Committee • PHA Homes Chair of the Audit and Risk Committee	• ACCA	• None	• Lay Council Member • Member: Advisory Panel – Companies Committee	• None

	Own interests				Connected Persons interests
	Current interests	**Professional memberships**	**Previous interests**	**GOC committee memberships**	
	• Sapphire Independent Housing Chair of the Finance, Audit and Risk Committee • British Acupuncture Council Chair of the Finance, Risk and Audit Committee • Regulatory Advisory Group Independent Chair • Democracy Boundary Commission Cymru Deputy Chair of the Governance and Audit Committee • General Council of the Bar in England and Wales Vice Chair of the Audit and Risk Committee • London Borough of Lewisham Independent Person • Royal College of Veterinary Surgeons Independent Member of the Audit and Risk Committee • Architects Registration Board, Education Accreditation Panel				
Fahima **KIRK** Council Associate (DO)	• Dispensing Optician, Specsavers • Local Outreach Coordinator (volunteer), Vision Care Charity • Talk and Support Facilitator (volunteer), RNIB charity • Student Contact Lens Optician at ABDO College	• Member of ABDO		• Council Associate, Audit Finance and Risk Committee	• None
Ros **LEVENSON** Lay member	• Chair of The Expert Advisory Group for the OSIRIS B project at Queen Mary University of London • Chair of The SKILL mix-ED Study Steering Committee at St George's University of London/Kingston University.	• None	Chair of the Patient and Lay Committee (APLC) at the Academy of Medical Royal Colleges (AoMRC)	• Lay Member: Council • Member: Nominations Committee • Member: Standards Committee • Council lead for Thematic Reviews	• None
Siddhant **MAJITHIA** Council Associate (OO)	• Ophthalmic Director and Store Partner, Specsavers, Newark	•	• Ophthalmic Director and Store Partner, Specsavers, Towcester • Store Manager, SpecSavers, Fosse Park	• Council Associate, Audit Finance and Risk Committee	• None
Frank **MUNRO** Registrant (OO)	• Chair: Community Low Vision Service Short Life Working Group (CLVSSLWG) • Director Munro Eyecare Limited (T/A Munro Optometrists) • Founder member, Optometry Scotland • Optometric Advisor, NHS Lanarkshire • Lead Optometrist, Glasgow City Health & Social care Partnership • Visiting Lecturer, Glasgow Caledonian University • Visiting Lecturer, Edinburgh University (MSc Ophthalmology programme)	• Past President and Honorary Life Fellow, College of Optometrists • Member, Association of Optometrists • Member, Optometry Scotland • Hon Fellow, Association of Dispensing Opticians • Member, British Contact Lens Association	• Past Chair, NHS Lanarkshire Optometric Advisory Committee • Past President, College of Optometrists • Past Chair, Optometry Scotland • Past Chair, Scottish Committee of Optometrists • Past Chair, NHS Education for Scotland Optometry Advisory	• Registrant Member: Council • Chair: Education Committee • Member: Audit, Finance and Risk Committee • Member: Investment Committee	• None

	Own interests				Connected Persons interests
	Current interests	**Professional memberships**	**Previous interests**	**GOC committee memberships**	
	• Member, Greater Glasgow & Clyde Prescribing Review Board		Board		
Tim **PARKINSON** Lay Member	• Director: Tim Parkinson Limited (consultancy not to optical sector or organisations linked to optical sector)	• Fellow: Chartered Management Institute • Membership of the Institute of Water	• None	• Lay member: Senior Council member • Chair: Investment Committee • Chair of Remuneration Committee	• None
Prof. Hema **RADHAKRISHNAN** Registrant (OO)	• Professor and Member of Senate and the Board of Governors: University of Manchester • Member of Advisory Board: Zeiss Vision group • Research funding and collaboration with Optegra Eye Hospital group and Zeiss Vision Group • Associate Editor, Translational Vision Science and Technology, an Association for Research in Vision and Ophthalmology Journal.	• Member: College of Optometrists- • Member: Association of Optometrists • Principal Fellow: Higher Education Academy • Member- The Association for Research in Vision and Ophthalmology	• Editorial board member Optometry in Practice, a College of Optometrists journal • External examiner- Aston University Undergraduate and Masters Optometry programmes	• Registrant member: Council • Member: Advisory Panel – Education Committee	
Poonam **SHARMA** Registrant (OO)	• Lead Optometry Adviser, NHSE (London); • since 01/04/2017 • Occasional locum optometrist, various high street optical practices; since 1998 • Mentor, Social Mobility Foundation: since 2023 •	• Member of AOP • Member of College of Optometrists		• Member: Council • Chair: Companies Committee • Council lead for regulatory reform	• None
William **STOCKDALE** Registrant (DO)	• Director, Optomise Ltd • Own an organisation in the Optical Sector - Optomise Ltd 50% Shareholding.	• Member of ABDO • Member of FODO • Member of ONI	• Own an organisation in the Optical Sector - Telford Opticians 50% Stake • Chair: Optometry Northern Ireland • Member of a consultative body in the Optical Sector Member BSO Ophthalmic Committee. • Non-Executive Director FODO	• Member: Council Member • Member: Nominations Committee • Chair: Advisory Panel – Standards Committee	• None
Dr Anne **WRIGHT** CBE Lay Chair	• None	• None	• Vice-Chancellor and Chief Executive Sunderland University 1990-98 (Sunderland Polytechnic until 1992) • Chair, National Lottery Commission 2005-13 • Member, Bar Standards Board 2012-17 • Lay Vice-Chair, Nursing and Midwifery Council 2013-20	• Chair: Council	• None

	Own interests				Connected Persons interests
	Current interests	**Professional memberships**	**Previous interests**	**GOC committee memberships**	
			• Member, Armed Services Pay Review Body 2002-08 • Chair, School teachers Review Body 2008-11		
Catherine (Cathy) **YELF** Lay Member	• Director, Understanding Cardiomyopathy CIC • Trustee, Countess of Brecknock Hospice Trust • Trustee - Action Against AMD • Chair of Planning Committee at Longparish, Hampshire Parish Council	•	• Interim Chair, Action Against Age-relate Macular Degeneration (AMD) a charity with a commercial subsidiary, Foresight Research Ltd, the aim of which is to acquire, aggregate and analyse OCT images from optometry practices. • CEO of Macular Society • Trustee of the Association of Medical Research Charities.	• Council Member • Member: Advisory Panel - Companies Committee • Member Investment Committee	None

GENERAL OPTICAL COUNCIL
Minutes of the Public Council
Meeting held on 24 June 2026 at 10am via Microsoft Teams

Present:	Dr Anne Wright CBE (Chair), Raymond Curran, Kathryn Foreman, Lisa Gerson MBE, Kalwant Grewal, Ros Levenson, Frank Munro, Tim Parkinson, Professor Hema Radhakrishnan, Poonam Sharma, William Stockdale and Cathy Yelf MBE. Inderpal Ghuman and Fahima Kirk (Council Associates). John Cappock (Independent Member and Chair of Audit, Finance and Risk Committee).
GOC Attendees:	Kayleigh Allen (Head of FtP (Legal)), Carole Auchterlonie (Director of Regulatory Operations), Steve Brooker (Director of Regulatory Strategy), Rebecca Bryan (Head of Investigations), Marie Bunby (Policy Manager), Tom Eustice (Operations Manager, Triage), Nicole Fitzgerald (Communications Manager), Toby Ganley (Policy Manager (Standards)), Kiran Gill (Chief Legal Officer), Philipsia Greenway (Director of People and Improvement), Nadia Habib (Governance and Compliance Manager) *(Minutes),* Nazia Khanom (Governance and Compliance Officer) *(Minutes),* Vikki Julian (Head of Communications and Engagement), Terry Koranteng (Information Governance Officer), Andy Mackay-Sim (Chief of Staff), Claire Marchant-Williams (Head of Case Progression), Leonie Milliner (Chief Executive and Registrar), Joanna Murphy (EDI Manager), Marc Stoner (Director of Corporate Services), Charlotte Urwin (Head of Policy, Strategy and Standards) and Adiam Weldensae (Lawyer).
External Attendees:	Siobhan Carson (Senior Scrutiny Officer, Professional Standards Authority (PSA)), Paul Chapman-Hatchett (Clinical Advisor, Optical Consumer Complaints Service (OCCS)) (attended for item 7 only), Sue Clark (Consultant, OCCS) (attended for item 7 only), Gareth Davies (Director of Medistat) (attended for item 8 only), Olivier Deneve (Head of Policy and Public Affairs, College of Optometrists), Max Halford (Clinical and Policy Director, Association of British Optometrists), Jennie Jones (Head of OCCS) (attended for item 7 only), Kathy Jones (Policy Consultant, Association of Optometrists), Selina Powell (Features Editor, Optometry Today), and Alan Tinger (Director of Membership Services, Federation of Ophthalmic and Dispensing Opticians (FODO)).

	Welcome and Apologies
1.	The Chair welcomed those in attendance. Apologies were received from Fahima Kirk and Siddhant Majithia.
	Declaration of Interests C19(26)
2.	The Chief of Staff advised that registrant Council members had an unavoidable conflict for the item on testing of sight, however they were not required to declare any interests at this meeting beyond those captured in the register. Council was

	reminded that it had the duty to act in the best interests of the GOC in such circumstances.
3.	Raymond Curran declared an interest in the testing of sight item, as the consultation, if approved, could lead to GOC consulting with devolved administrations, including Northern Ireland. Such a briefing would likely be directed to him, in his capacity as Head of Ophthalmic Services, Strategic Planning and Performance Group, Department of Health (DoH) Northern Ireland. In addition, Raymond indicated that he would delegate any DoH NI response to the consultation to a member of his team, taking no active part in that process. The Chair noted the declaration and confirmed that the interest did not preclude participation in the meeting or consideration of the item as the decision Council was considering was whether to consult. It was agreed that Raymond would continue to assess interests with the Chief of Staff ahead of any decisions around the testing of sight item.
4.	The Chair of Council requested that her declaration of past interests should be amended to include Vice-Chancellor and Chief Executive of the University of Sunderland.
	Minutes of the meeting held on 11 March 2026 C20(26)
5.	The minutes were approved as an accurate record of the meeting subject to the following amendment: Minute 8 to change from “tested budget assumptions” to “received assurance that budget assumptions were tested.”
	Action points update C21(26)
6.	Council **noted** updates on previous actions. There were no further comments or updates.
	Matters arising
7.	There were no matters arising.
	Consultation on the proposed draft updated statement on the testing of sight C22(26) *William Stockdale left the meeting after this item.*
8.	The Director of Regulatory Strategy presented the item. Council welcomed the reference to the PSA’s Right-Touch Regulation principles and emphasised the need for balanced and proportionate regulation. Council noted concerns that prohibiting the separation of sight test components could be a backward step and stressed the importance of providing clear information to registrants and stakeholders. It highlighted the distinction between refraction and visual acuity and sought clarification on whether the wording was prescribed in law or, if it was GOC wording, whether it could be amended to improve clarity.
9.	Council agreed that stakeholder feedback would be critical to informing any final decision and reiterated that public protection should remain the primary consideration. Council also noted the difference in what is included within a sight test across the nations due to the contracting/commissioning arrangements and the need to clearly explain the implications of the revised position for registrants. It was observed that the current statement predates developments such as teleoptometry and that there is limited evidence on eye health outcomes across

	different service delivery models. Council highlighted the importance of capturing patient perspectives through the consultation process. Council thanked the Policy and Standards team for their work on the consultation proposals.
10.	Council **approved**: • a public consultation on (i) the proposed draft updated statement on the testing of sight and (ii) proposed draft revisions to supervision/delegation standards in our Standards of Practice for Optometrists and Dispensing Opticians and Standards for Optical Students; and • delegated final approval of the consultation documents (annexes 1 and 2) to the Chief Executive and Registrar in consultation with the Chair of Council, if Council requests minor changes to the documents at the meeting.
11.	Council took a break at 10.57am and returned at 11.10am.
	External communications strategy C23(26)
12.	The Head of Communications and Engagement presented the item. Council discussed the Communications Key Performance Indicators (KPIs) and noted that several of the impact measures were becoming more established. It suggested reviewing patient and public communication and outreach needs and emphasised that communications should be measured not only by activity delivered, but also by its impact on stakeholder trust, public confidence and understanding of regulation.
13.	Council questioned whether the proposed delivery expectations were realistic given the size of the Communications team and whether the balance of activity was appropriate.
14.	Council **approved** the external communications strategy and **delegated** any minor amendments to the approval of the Chief Executive and Registrar.
15.	**Action: Head of Communications and Engagement would review the measures and consider whether additional indicators of impact could be included.**
	Member code of conduct C24(26)
16.	The Chief of Staff presented the item. Council noted that the PSA's new standards would place greater emphasis on organisational culture and leadership. Council thanked the Director of Regulatory Operations and Speaking Up Champion for their work on speaking up and safeguarding.
17.	Council: • **approved** the revised member code of conduct; • delegate any minor amendments to the code for approval by the Chief of Staff (in consultation with the Chair of Council); and • approved a revision of the Council scheme of delegation to remove the reference to 'investigations policy'.
	Council took a break at 11.49am and returned at 12.00pm.

	Optical Consumer Complaints Service Annual Report C25(26)
18.	Jennie Jones from the OCCS presented the item. Council discussed the quality of Artificial Intelligence outputs and noted that an increase in complaints could reflect greater public awareness and visibility of the OCCS. Council noted that achieving higher feedback response rates can be challenging without incentives and were advised that a 10% response rate is broadly in line with benchmarking against other organisations. The Director of Regulatory Operations agreed to follow up regarding the OCCS's approach to complaints concerning protected titles.
19.	Council **discussed** the report.
20.	**Action: The Director of Regulatory Operations to follow up regarding the OCCS's approach to complaints concerning protected titles.**
21.	Council took a lunch break at 12.53pm and returned at 1.30pm.
	Fitness to Practise Unfair Outcomes Research – Analysis and Findings C26(25) *Raymond Curran encountered an internet outage and therefore was not present for part of this discussion.*
22.	The EDI Manager introduced the item. Gareth Davies from Medistat presented the item. Council noted the analysis, which found limited evidence of disproportionality, with case-specific factors being much stronger predictors of outcomes than EDI characteristics. Council was assured that there was no evidence of systemic unfairness in Fitness to Practise (FtP) decision-making.
23.	Council noted the importance of improving EDI data quality and registrant confidence in providing such information. It welcomed ongoing work to strengthen data collection and communication. Council highlighted the need for continued monitoring and ongoing measures to support fair and impartial decision-making.
24.	Council: • **noted** the findings of the independent analysis across triage, investigations and hearings; • took assurance that there is currently little evidence of meaningful disproportionality in FtP outcomes, while recognising the limitations of the available data; and • agreed the proposed next steps to strengthen data quality, deepen analysis and maintain ongoing assurance.
	Financial performance report Q4 2025/26 / Q4 forecast - C27(26)
25.	The Director of Corporate Services presented the item. Council noted the positive year-end financial position and sought greater clarity on the reasons for underspends and budget variances. This included assurance that the variances had not impacted service delivery or key priorities. Council highlighted opportunities to improve financial reporting, including reviewing balance sheet figures, examining the increase in net current assets, and including prior-year outturn data to support trend analysis. It welcomed the improvements already underway to forecasting, reporting and reserve management.
26.	Council:

	• **noted** the financial performance for the year ending 31 March 2026.
27.	**Action: The Chief Financial Officer to review the balance sheet for inaccuracies and amend figures and total for future reports.** **Action: The Chief Financial to include prior-year outturn data to be included in the report.**
	Business performance dashboard Q4 2025/26 C28(26) and Business Plan Assurance Report Q4 2025/26 - C29(26)
28.	The Chief of Staff combined and presented both items to assist with scheduling for the day. Council discussed the red-rated FtP timeliness measures and was advised that legacy cases continued to affect performance, although improvements had been made in investigation decision median times, case management and hearings operations.
29.	Council also discussed the balance between activity and outcome measures, particularly in relation to public protection, and sought assurance on the high strategic risk rating for register accuracy. It was advised that register accuracy remains a critical risk due to its importance for public protection and the organisation's low tolerance for errors. Assurance was also provided that performance measures align with PSA reporting requirements.
30.	Council: • **noted** the reports and agreed that the scope and effectiveness of performance reporting could be reviewed further in future.
31.	**Action: Governance and Compliance Manager to update the action tracker to reflect the corrected corporate complaints data, noting that there were three referrals rather than seven referrals.**
	Advisory Panel Minutes – 22 May 2026 (Companies, Education, Registration and Standards Committees) - C30(26)
32.	The Chair of the Advisory Panel and the Chairs of the Committees provided an update.
33.	Council **noted** the minutes.
	Chair's report - C31(26)
34.	The Chair presented the report and summarised its key points.
35.	Council **noted** the report.
	Chief Executive and Registrar's report - C32(26)
36.	The Chief Executive introduced the report and highlighted key areas of work and progress since the previous Council meeting.
37.	Council **noted** the report.
	Council forward plan C33(26)
38.	Council **noted** the forward plan.

39.	Council took a lunch break at 1.20pm and returned at 2.00pm.
	Any Other Business
40.	None received.
	Date of the next meeting
41.	Council noted the date of the next public meeting was **Wednesday 30 September 2026.**
	Close
42.	The meeting ended at 3.09pm.

C36(26)

COUNCIL

Actions arising from strictly confidential Council meetings

Meeting Date: 30 September 2026 **Status:** For noting

Lead Responsibility and Paper Author: Nadia Denton, Governance Officer

Purpose

1. This paper provides Council with progress made on actions from the last strictly confidential meeting along with any other actions which are outstanding from previous meetings.

2. The paper is broken down into 3 parts: (1) action points relating to the last meeting, (2) action points from previous meetings which remain outstanding, and (3) action points previously outstanding but now completed. Once actions are complete and have been reported to Council they will be removed from the list.

Part 1: Action Points from the Council meeting held on 24 June 2026

Reference	By	Description	Deadline	Notes
C23(26)	Head of Communications and Engagement	would review the measures and consider whether additional indicators of impact could be included		**COMPLETED** the strategy has been published
C25(26)	Director of Regulatory Operations	to follow up regarding the OCCS's approach to complaints concerning protected titles.		**COMPLETED**
C27(26)	Chief Financial Officer	to review the balance sheet for inaccuracies and amend figures and total for future reports.		**COMPLETED**
C27(26)	Chief Financial	to include prior-year outturn data to be included in the report.		**COMPLETED**
C29(26)	Governance and Compliance Manager	to update the action tracker to reflect the corrected corporate complaints data, noting that there were three		**COMPLETED**

		referrals rather than seven referrals.		

Part 2: Action points from previous meetings which remain outstanding

Reference	By	Description	Deadline	Notes
None				

Part 3: Action points previously outstanding but now completed

Reference	By	Description	Deadline	Notes
C04(26)	Chief of Staff	Chief of Staff to circulate the government letter on AI to Council.	**June 2026**	Completed.
C11(26)	Director of Corporate Services	Director of Corporate Services to include near-miss data to quarterly reports to ARC.	**June 2026**	Completed – reporting process is currently being reviewed and may be subject to change.

General Optical Council

COUNCIL

Commercial practices and patient safety: a thematic review

Meeting: 30 September 2026 **Status:** For noting

Lead responsibility: Steve Brooker (Director of Regulatory Strategy)
Paper Author(s): Angharad Jones (Policy Manager), Marie Bunby (Policy Manager) and Charlotte Urwin (Head of Strategy, Policy and Standards)
Council Lead(s): Ros Levenson and Dr Hema Radhakrishnan

Purpose

1. To enable Council to discuss our thematic review report into commercial practices and patient safety (annex 1).

Recommendations

2. Council is asked to receive and note the report.

Strategic objective

3. Thematic reviews contribute towards the achievement of the following strategic objective: Preventing harm through agile regulation. However, this thematic review will also contribute to the other two strategic objectives: creating fairer and more inclusive eye care services; and supporting responsible innovation and protecting the public. This work is included in our 2026/27 Business Plan.

Background

4. Council approved the business case for undertaking this first thematic review at their meeting on 16 September 2025. The focus on commercial practices and patient safety reflected ongoing registrant concerns that some business practices (such as short appointment times, overbooked clinics, sales targets and financial incentives) may affect clinical judgement, quality of care and professional autonomy. Other issues such as pressure to buy and unclear pricing may also affect patient confidence and create access barriers, potentially affecting long-term eye health.

5. We undertook our review to help us understand the nature and extent of these types of commercial practices and their impacts, and to identify any interventions that we and the wider sector can take to help mitigate against these. The review focused on 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.

Analysis

6. Throughout the process, we have engaged with a range of stakeholders to understand their views and inform our thinking, including on the recommendations. This has included optical businesses, the Advisory Panel, Companies Committee, Council leads, the Chair of Council, internal GOC teams, and professional and representative bodies such as the Association of British Dispensing Opticians (ABDO), the Association of Optometrists (AOP), The College of Optometrists and the Federation of Optometrists and Dispensing Opticians (FODO).

7. We have used a mixed methods approach to evidence collection, including new primary research such as analysis of sight testing data for children, a price transparency exercise and analysis of Trustpilot reviews. All of these have benefited from our new data science capability. We also commissioned research with individual registrants, business registrants, non-registered staff, patients and patient representative organisations which is published on the GOC website[1].

Recommendations in the report

8. Our recommendations are informed by the review evidence and identify where collaboration with employers, professional bodies and other stakeholders will support delivery. The areas of work for the GOC focus on our statutory functions: education and training, registration, standards of professional and business conduct, and fitness to practise. We have engaged with internal teams on formulating these recommendations. Some of the work we have identified will be incorporated into work already planned, while other aspects will need to be scoped and factored into business planning. The review of the Standards for Optical Businesses will begin later this year, and Council will be asked at a future meeting to review proposed changes to the standards prior to public consultation.

9. The sector wide recommendations are actions that we would like the professional/representative bodies, employers, commissioners and NHS bodies to consider progressing. In relation to the recommendations for the professional/representative bodies, we met with ABDO, AOP, The College of Optometrists and FODO in finalising these and they are generally supportive of the recommendations, and we will continue to engage with them on the recommendations once the report is published.

10. One area that we would like to highlight for discussion is our recommendation that commissioners consider the impact of General Ophthalmic Services (GOS) fees on the delivery of eye care and registrant wellbeing. We have directly addressed this

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

issue because we repeatedly heard through our research and stakeholder engagement that the GOS fees contribute to commercial practices such as high patient numbers and sales targets in order to maximise revenue. Although GOS funding decisions sit outside our remit, we accept that we do have a responsibility to highlight to government if GOS fees are putting public protection at risk.

11. As part of its discussion, Council may wish to consider whether there are any other regulatory levers we could use to address the issues raised in the report.

Finance

12. In March 2025, Council approved £40k from the strategic reserves for this thematic review. The funds were spent on commissioning research during the 2025/26 financial year. No additional funds are required to implement the recommendations for the GOC.

Risks

13. Some stakeholders may have concerns about the proposed recommendations, albeit from different perspectives. Individual registrants may consider that the recommendations should go further, particularly in relation to the requirements placed on business registrants, while business registrants may feel that some of the proposed actions are unnecessary. Government stakeholders may view any commentary on GOS fees as beyond our regulatory remit. We have sought to manage these risks by ensuring that the report clearly sets out the rationale for the recommendations, including the supporting evidence base, considerations of proportionality, and intended impact. In addition, early engagement with key stakeholders including the professional bodies, and Companies Committee, as well as reflecting findings from key pieces of research, have enabled us to test our approach and ensure that the final recommendations are appropriately balanced and proportionate.

14. One particular risk is that the report could be interpreted as overly negative about the contribution of optometrists and/or optical businesses at a time when the NHS is planning to move more care into primary care, which could inadvertently impact on patient safety. We have sought to manage this risk through careful balancing of our findings and being clear that our review found no direct causal relationship between commercial practices and patients suffering harm, such as missed diagnosis or safety incidents. The report also highlights high levels of public trust and patient satisfaction.

15. We have recommended that we monitor and keep under review concerns relating to referrals for cataract and refractive surgery. The former is a politicised issue that has attracted negative media scrutiny for the profession. We have managed this risk by limiting our remarks to those that represent the differing stakeholder policy positions.

Equality Impacts

16. The report highlights inequalities related to commercial practices and patient safety covering both patients (e.g. access to services and patient experiences) and registrants (e.g. the impact of targets on wellbeing). An impact assessment is not required as we are not proposing any new policies or processes as part of the report. However, as part of implementation, follow-on pieces of work (such as our review of our business standards) will include completion of impact assessments as required.

Devolved nations

17. The report is UK-wide in scope, and we have highlighted any differences between nations where appropriate. We requested data from all four UK nations in relation to sight tests for young children and received it from England, Northern Ireland and Scotland.

Communications

External communications

18. Following Council, we will finalise the report for publication. The report includes an executive summary. We will prepare a designed version of this summary, incorporating the recommendations, which will be translated into Welsh and published as a standalone document.

19. Following publication of the report, we will implement a targeted communications plan to disseminate the findings and recommendations and support constructive engagement with the sector. This will include issuing a targeted press release for both the optical sector and wider national press, a launch event or webinar, and briefings with key stakeholders across the four nations including professional and representative bodies, commissioners and NHS bodies and relevant parliamentarians. We will also engage with regulators, consumer bodies and the CMA. We will publish a series of blogs and ebulletin articles for individual, student and business registrants, which will help reinforce regulatory expectations and future work we will undertake including the review of business standards.

20. We will also follow up directly with the patient bodies that contributed to the research, both to thank them for their input and to explain how their evidence has informed the report. This will help maintain constructive relationships and support further engagement as we move into implementation and for future work.

21. We will monitor the external response after publication, including media coverage, stakeholder feedback, website engagement, social media activity and direct enquiries, and use this insight to help inform our approach to future reviews.

Internal communications

22. We have kept relevant staff updated on progress with the thematic review and have worked with the teams that will have a role in implementing the recommendations, including fitness to practise, education and standards. We will organise a lunch and learn for staff once the report is published.

Next steps

23. We will publish the report following the Council meeting and implement the communications plan.

24. We will shortly begin identifying candidate topics for the second thematic review and plan to bring a recommendation to Council in March 2027 following engagement with statutory advisory committees and stakeholders.

Attachments

Annex 1: Commercial practices and patient safety: a thematic review

C37(26) ANNEX ONE

Commercial practices and patient safety: a thematic review

XXX 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 all[1].

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 Services 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 role[2]. 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 services[3].

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

- 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 regulation[4] 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 research[5], 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

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 strategy[6]. 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 care[7].

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

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 lenses[8].
- 14% of those who said they felt uncomfortable visiting an opticians mentioned pressure to buy glasses or contact lenses[9].
- 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 this[10].
- 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 care[11].
- 24% felt under pressure to sell a product or provide a service which they considered was not needed by the patient[12].

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.

[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

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 wait[13]. 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 population[14]. 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 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

[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

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 dissatisfied[15].
- 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 care[16].
- 23% of registrants said that they have 'sometimes' (14%) or 'frequently' (10%) been asked to overbook clinics (25% in 2025)[17].

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 groups[18]. 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

[15] Public perceptions research 2026
[16] Registrant workforce and perceptions survey 2026
[17] Registrant workforce and perceptions survey 2026
[18] Public perceptions research

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.

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 care[21].

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 research[22] 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.

[19] Public perceptions research 2026
[20] Registrant workforce and perceptions survey 2026
[21] Registrant Workforce and Perceptions Survey 2024
[22] Public perceptions research

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 awareness[23].

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.

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 difficult[24].
- 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 Ireland[26].

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.

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

- 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 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 five[27].
- 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[28].
- 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 0-5[32].

[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 services[33].

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 services[34]. 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 research[35], 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 surveys[36] 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 overbooked[37]. 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 analysis[38] 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 test[39] 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 research[40] 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 2014[42], it recently concluded a market investigation into veterinary services for household pets[43] and has begun a market study into private dental services[44]. 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 guidance[45] 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;

- 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.

Introduction

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

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.”

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 interest[49], 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 Practice[50] 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 revenue[51].

Patient experience of pressure selling

77. In our 2026 public perceptions research[52], 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

78. Our lived experience research[53] 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 commissioned[54] 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 report[55] 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 1[56]

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.

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 survey[57], 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 safety[58] 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

- 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 survey[59] 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

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 safety[60] 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 study[61] 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 Zealand[62] 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.

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 survey[63], 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 safety[64] 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 Authority[65] (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 report[66] 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

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 report[67] 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

102. The Centre for Health and the Public Interest (CHPI) published a report[68] 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 article[69] 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

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) Review[70] (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

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

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

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

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.

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 appointments[72].

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.

131. The College of Optometrists opened a consultation[73] 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 statement[74] 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 availability[75].

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 safety[76] 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

135. In our 2025 LinkedIn conversation[77] and survey[78] 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

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 safety[79], 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 survey[80], 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

(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 safety[81], 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

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 circumstances[82] 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 population[83]. This environment could therefore have a disproportionate negative impact on such patients.

147. Our qualitative research into commercial practices and patient safety[84] 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

149. In our LinkedIn conversation[85] 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 survey[86] 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

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 survey[87], 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 blog[88] 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 registrants[89] 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 safety[90] 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

156. Our LinkedIn conversation and survey[91] 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

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 study[92] 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 safety[93] 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

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).

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.

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 requirements[96] 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 Optics[97] 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

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

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

- 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.”

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 Practice[98] 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 consultation[99].

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 safety[100] 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

194. An unpublished Optometry Northern Ireland report[101] 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 safety[102] 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 statement[103] 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

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 Regulations[104] sets a maximum of 20 eye examinations (both primary and supplementary) in any working day. A Scottish Government circular issued in 2018[105] 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 research[106], ‘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

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 businesses[107] 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 2026[108], 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 2026[109] 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 2025[110]). 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

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 circumstances[111], 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 safety[112] 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

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 needs[117].

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 survey[118], 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 survey[119] but this was not mentioned as being specific to appointment times. In our 2024 registrant survey[120], 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 safety[121] 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
[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

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 safety[122] 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

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

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

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

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

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 sector[124], 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
[124] Veterinary services for household pets: Final decision report - GOV.UK

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 Practice[125] 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 guidelines[126] 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.

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 England[127] 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 businesses[128] 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.

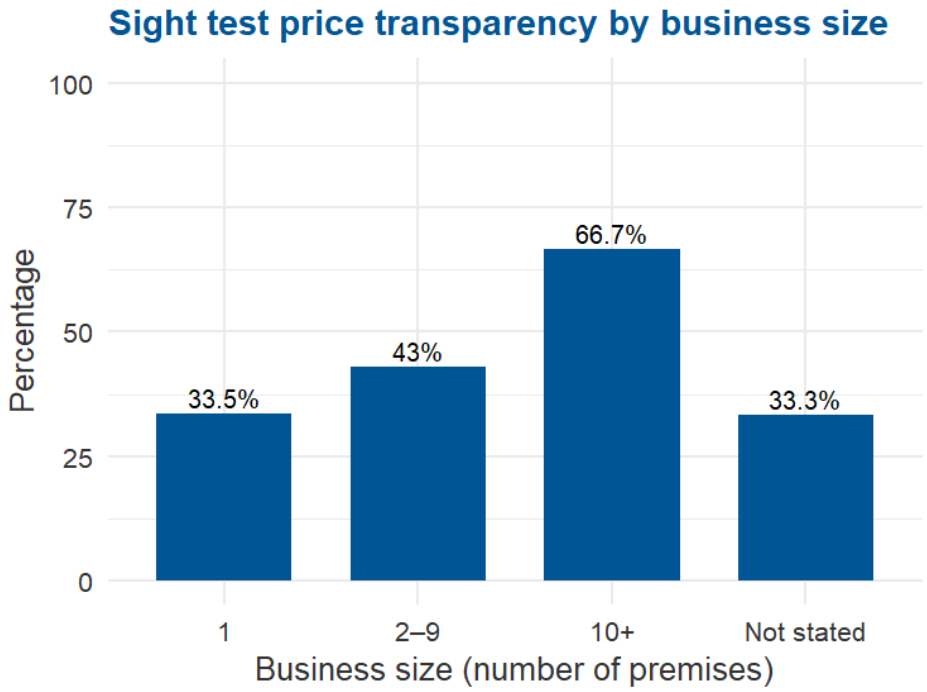
255. Of note, we searched for 324 business registrants before reaching our desired sample of 255 with functioning websites for analysis purposes. This indicates that a sizeable minority of optical businesses do not have websites.

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*

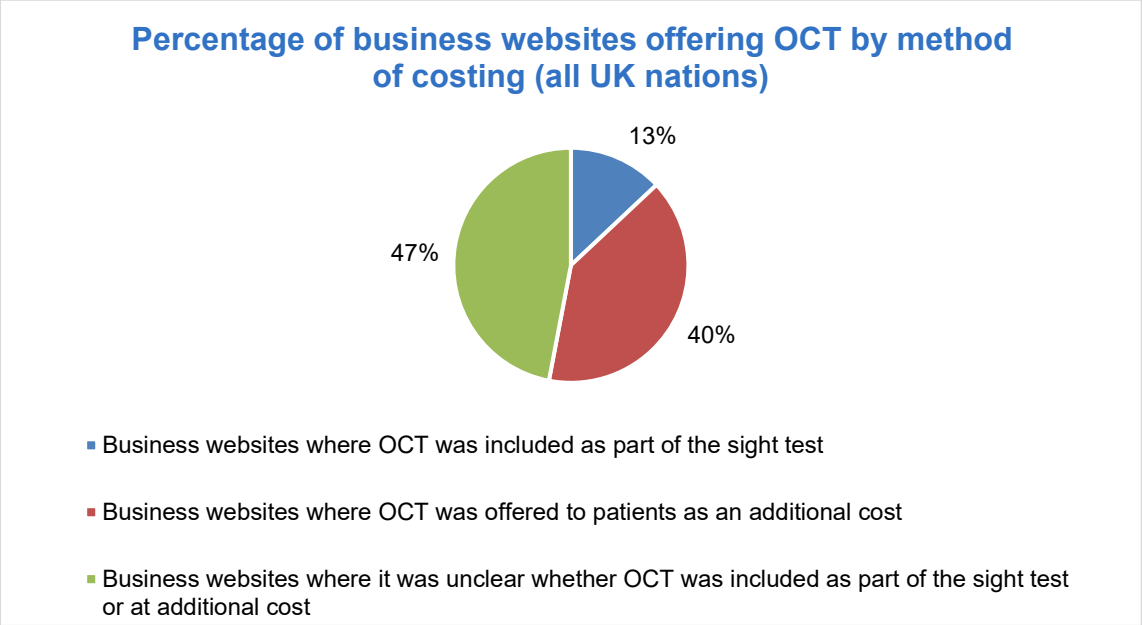
260. Some businesses explained their prices with reference to sight test duration, use of optometrists throughout and the range of tests and technologies used.

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

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 survey[129] 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 England[130] and the National Health Service (GOS) Regulations 2006 for Scotland[131] 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

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 research[132] 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 safety[133] 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 report[134] 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 safety[135] 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 research[136] 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 research[137] 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 report[138] 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) 2024[139] 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 2025[140] 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 review[141] 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

- 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

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'

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

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 development[143], 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 service[145]. If a child is not tested at school, the NHS in England recommends that they should be taken to an opticians for a sight test[146].

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 optometrist[147]. 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

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 studies[148] and anecdotal evidence[149] 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

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 Practice[150] 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 care[151].

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 2025[152].

[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.

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 England[153]. 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 0-5[154]. 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.

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

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 dataset[155]. 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.

- 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 safety[156] 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 study[157] 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)

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

344. A 2023 study[158] 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 research[159], 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 Association[160] 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

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.

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 alone[162].

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.

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.

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 appointment[163] 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 young[164].

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 test[165]. 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

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

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 launched[167] 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. Evidence[168] 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 sources[169] 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 way[170].

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 tactics[171]. 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.

Raising awareness of existing standards and guidance

395. Our Standards of Practice for Optometrists and Dispensing Opticians and guidance on speaking up[172] and care of patients in vulnerable circumstances[173] 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

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 bodies[174] 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 is consulting on its Guidance for Professional Practice and await the outcome of that consultation.

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 2023[175]: 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 research[176]: 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 report[177].

LinkedIn conversations

LinkedIn conversations and surveys

420. In October 2025 we started a conversation[178] 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 survey[179]. 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 LinkedIn[180] 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.

Public
C38(26)

Council

General Optical Council

GOC annual report and accounts 2025-26

Meeting: 30 September 2026 **Status:** For approval

Lead responsibility: Leonie Milliner, Chief Executive and Registrar
Paper Author(s): Nicole Fitzgerald, Communications Manager; Andy Mackay-Sim, Chief of Staff; Marc Stoner, Director of Corporate Services; Manori Wickremasinghe, Chief Financial Officer

Purpose

1. To present the annual report and accounts 2025-26 for Council approval.

Recommendations

Council is asked to:

- **approve** the annual report and accounts 2025-26;
- **approve** the letter of representation; and
- **delegate** any minor revisions to the Chief of Staff (in consultation with the Chair of Council).

Strategic objective

2. The GOC annual report and accounts addresses all three of the GOC strategic objectives: creating fairer and more inclusive eye care services, supporting responsible innovation and protecting the public, and preventing harm through agile regulation.

Background

3. Under the provisions of the Opticians Act 1989, we are required to produce and lay before Parliament an annual report which sets out how we have contributed to public benefit and our annual accounts. We are also required to submit an annual report, accounts and return to Charity Commission. The report and accounts are attached as **annex 1**.

4. The annual report has been reviewed by the external auditor HaysMac, and the Council is asked to note the internal auditor's opinion contained in section three of the report. The Council is required to approve a letter of representation, which is attached as **annex 2**.

5. As part of its sign-off, various sections required approval by the relevant committees of Council. Remuneration Committee approved the sections covering member fees and its role as a committee in July 2026. The Audit, Finance and Risk Committee

(ARC) reviewed the report, including the external auditor's findings at its meeting on 7 September 2026.

Analysis

6. The annual report and accounts are critical tools for promoting transparency, accountability and public engagement, as they set out how the Council has used registrant fees to fulfil its statutory functions as a regulator and a charity. Alongside the EDI annual report, they are the core documents that we produce to showcase the work and achievements of the GOC. In addition, they contain several key governance statements, that demonstrate how the GOC conducts its business and fulfils its role in protecting the public.

7. The annual report (and the EDI annual report) will be professionally laid out by an external designer.

Finance

8. Production of the annual report is part of the business-as-usual activity for the GOC and carries no financial implications beyond the resources allocated as part of our annual budget. The accounts are a core finance document, and ensure that Council members, as trustees, are fully conversant with the financial statements that underpin GOC activity.

Risks

8. Failure to produce a set of auditable accounts or an annual report would be considered a critical failure in governance, and poses a significant risk in financial, reputational and operational terms. This risk is mitigated by ensuring that the organisation is appropriately resourced to produce these reports and that they are subject to the appropriate approvals by Council and its committees.

Equality Impacts

9. No policy or procedure is being implemented; therefore, no Equality Impact Assessment is required. The report is supported by a complementary EDI annual report, which covers the GOC's activities in this area in more detail.

Devolved nations

10. The report contains no specific implications for devolved nations, though it covers GOC activity across the UK. It will be translated into Welsh, as part of complying with the revised Welsh Language Standards.

Other Impacts

11. There are no significant impacts identified.

Communications

External communications

12. The annual report and accounts 2025-26 will be published on the GOC website and promoted via our usual communications channels, including press and social media. Key stakeholders will be advised of it. A copy will be submitted to the Privy Council, and it will be laid before Parliament.

Internal communications

13. Staff will be informed via IRIS, the intranet, and by the Chief Executive and Registrar weekly bulletin when published. A message to all members will be issued when available.

Next steps

14. Referral to the Privy Council and submission to the Charity Commission as part of the annual return.

Attachments

Annex 1: GOC Annual Report for Year End 31.03.26
Annex 2: GOC letter of representation for HaysMac

General Optical Council Annual Report, Annual Fitness to Practise Report and Financial Statements for the Year Ended 31 March 2026

Registered as a charity by the Charity Commission in England and Wales
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Presented to Parliament pursuant to section 32A(2) of the Opticians Act 1989 as amended by schedule 2 paragraph 3 of the Health Care and Associated Professions (Miscellaneous Amendments) Order 2008

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Message from the Chair and Chief Executive

April 2025 marked the start of our new five-year corporate strategy, ‘safe and effective eye care for all.’ Our ambition remains to be a world-class regulator - agile, robust and effective in the deployment of our regulatory responsibilities, well regarded by stakeholders and continuing to meet all the Professional Standards Authority’s (PSA) Standards of Good Regulation - sustaining our success, building on our strengths and addressing the areas where we wish to improve.

Our shift in focus from our previous ‘Fit for the Future’ strategy to a more outward-facing vision is reflected in our Annual Report and Accounts for 2025–26. This was an important year for us as we began delivering our new corporate strategy, which sets out our vision of safe and effective eye care for all through three strategic objectives: creating fairer and more inclusive eye care services, supporting responsible innovation and protecting the public, and preventing harm through agile regulation.

During the year, we supported registrants to deliver high-quality care following the implementation of our new Standards of Practice. This included publishing guidance on maintaining appropriate sexual boundaries and caring for patients in vulnerable circumstances, helping registrants to apply the standards confidently and consistently in their day-to-day practice.

Engagement and collaboration were central to delivering our commitment to preventing harm through agile regulation. This saw us leading discussions on the impact of commercial practices on patient safety and registrant wellbeing, and a consultation on proposals to reform our Continuing Professional Development (CPD) scheme. Together, these initiatives will help inform our future regulatory approach and ensure it remains proportionate, responsive and focused on public protection. We are grateful for the constructive engagement we have received from registrants, patients, businesses, professional bodies and our wider stakeholders throughout the year.

Our work continued to be informed by evidence and insight. We published research exploring registrants' experiences of bullying, harassment, abuse and discrimination; and barriers that some people face in accessing eye care services. These findings reinforce the importance of continuing to work with the sector to improve experiences for registrants and outcomes for patients.

Supporting responsible innovation while protecting the public remained a key priority. We led research into the testing of sight, helping to inform future policy development while ensuring that public protection remains at the forefront of our work. We also introduced a streamlined international registration process for overseas qualified optometrists with qualifications assessed as being of an equivalent standard to those in the UK, significantly reducing the time required for overseas applicants to register with us.

To support the ongoing implementation of our education and training requirements (ETR), we extended our funding of the knowledge hub for a further three years. This will provide continued practical support to qualification providers as the first cohorts of students move towards graduation.

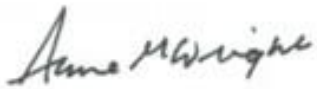
We also published our response to our consultation on proposals to modernise business regulation, setting out how regulation could be extended to all businesses carrying out specified restricted functions. While any changes remain a matter for Parliament through reform of the Opticians Act, we remain committed to liaising constructively with stakeholders to refine and further develop our proposals.

Creating fairer and more inclusive eye care services underpinned our work throughout the year. We strengthened our commitment to equality, diversity and inclusion (EDI) as both a regulator and employer. Alongside developing a refreshed EDI action plan and launching an updated EDI policy, we increased awareness training across our workforce, equipping colleagues with the confidence to make fairer, more inclusive decisions in their day-to-day roles.

During the year we welcomed Marc Stoner as Director of Corporate Services, whose directorate incorporates our finance, facilities, IT and registration functions. We were also pleased to welcome Raymond Curran and Poonam Sharma as registrant Council members, and Kalwant Grewal, Ros Levenson and Cathy Yelf as lay Council members. Frank Munro was reappointed as a registrant member for a further four-year term.

One of the strongest indicators of our performance this year was meeting all 18 of the Professional Standards Authority's Standards of Good Regulation for the fourth consecutive year. This provides independent assurance that we continue to fulfil our role in protecting the public and maintaining high standards in eye care.

As we embark on the second year of our 2025–30 strategy, we remain focused on delivering safe and effective eye care for all. We would like to thank registrants, Council and committee members, GOC colleagues, and our many stakeholders for their commitment and support over the course of 2025-26. Together, we will continue to work towards our vision of safe and effective eye care for all, ensuring that patients and the public remain at the heart of everything we do.





Dr Anne Wright CBE

Chair

Leonie Milliner

Chief Executive and Registrar

Introduction

About us

We are the regulator for eye care services in the United Kingdom. Our charitable purpose and statutory role are to protect and promote the health and safety of the public by promoting high standards of professional education, conduct and performance amongst optometrists and dispensing opticians, those training to be optometrists and dispensing opticians, and bodies corporate conducting business in optometry or dispensing optics in the UK.

We have four core functions:

- setting standards for optical education and training, performance and conduct;
- approving qualifications leading to registration;
- maintaining a register of individuals who are qualified and fit to practise, train or carry on business as optometrists and dispensing opticians; and
- investigating and acting where registrants' fitness to practise, train or carry on business may be impaired.

Who we regulate

As of 31 March 2026, there were 35,589 optometrists, dispensing opticians, student opticians and optical businesses on our register.

Total number of registrants in each GOC category

	31-3-2026	%	31-3-2025	%	31-3-2024	%	31-3-2023	%	31-3-2022	%	31-3-2021	%
Optometrist	19,361	54%	18,725	54%	17,698	52%	17,401	52%	16,932	51%	16,267	50%
Dispensing optician	6,729	19%	6,805	20%	6,594	20%	6,912	21%	7,060	21%	7,190	22%
Student optometrist	5,212	15%	5,163	15%	5,307	16%	5,145	15%	4,990	15%	4,640	14%
Student dispensing optician	1,336	4%	1,268	4%	1,254	4%	1,267	4%	1,331	4%	1,383	4%
Business	2,951	8%	2,934	8%	2,852	8%	2,921	9%	2,861	9%	2,796	9%

registrant											
TOTAL	**35,589**	**100%**	**34,895**	**100%**	**33,705**	**100%**	**33,646**	**100%**	**33,174**	**100%**	**32,276**	**100%**

We report separately on the diversity of our registrants and registrants subject to fitness to practise investigations, the latest report is available on our website.

Our income

Most of our income comes from registrant fees and is used to further our charitable purpose. The table below sets out the fees that registrants are required to pay for entry or retention on our register.

In 2025-26, there was an increase in the main registration fee for optometrists, dispensing opticians, and body corporates of 2.5%, to £415, in line with inflation. The discount for low-income fees increased to £125, meaning that the low-income fee will increase to £290, a 1.75% cost increase. Fees for students remained at £30. In the previous year, registrant fees were increased in line with inflation to £405. Between 2020 and 2023, registration fees remained frozen at £360.

Annual registrant fee

Fee levels	2025/26	2024/25	2023/24	2022/23	2021/22	2020/21	2019/20
Optometrists	£415	£405	£380	£360	£360	£360	£350
Dispensing opticians	£415	£405	£380	£360	£360	£360	£350
Corporate bodies	£415	£405	£380	£360	£360	£360	£350
Students	£30	£30	£30	£30	£30	£30	£30
Low-income fee	£290	£285	£260	£260	£260	£260	£250

About this report

This annual report sets out the activities we have undertaken from 1 April 2025 to 31 March 2026 to fulfil our statutory role and charitable purpose, and financial statements for the year ended 31 March 2026. In preparing this report, the trustees have complied with the Charities Act 2011 and applicable accounting standards. The statements are in the format required by the Charities Statement of Recommended Practice (SORP 2019) FRS 102. We have complied with the guidance of the Charities Act 2011 to have due regard to the public benefit guidance published by the Charity Commission in determining the activities we undertake.

Section 1: How We Deliver Public Benefit

Our Mission and Strategic Objectives

Our mission is to protect the public by upholding high standards in eye care services. 2025-26 marked the first year of our new corporate strategy for 1 April 2025 to 31 March 2030, which sets out our vision of safe and effective eye care for all. Our priorities for 2025-30 are organised under the following three strategic objectives and ensure that we deliver public benefit through our work:

- Creating fairer and more inclusive eye care services
- Supporting responsible innovation and protecting the public
- Preventing harm through agile regulation

This section of our annual report describes how we delivered public benefit in the first year of our 2025-30 corporate strategy and outlines our ambitious programme of work and investment in strategic projects to support the effective realisation of our long-term objectives.



Highlights of 2025/26

Supporting registrants to deliver safe and effective care

Following the introduction of the new Standards of Practice in January 2025, we published two new pieces of guidance in December 2025 on maintaining appropriate sexual boundaries and care for patients in vulnerable circumstances. The guidance provides registrants with additional support in interpreting some of the changes we introduced in the new standards including clarification that adjustments to meet the needs of patients in vulnerable circumstances are not the same as “reasonable adjustments” as required by law and emphasising that all sexual misconduct is serious. Both pieces of guidance were published following a public consultation.

Supporting the implementation of the Education and Training Requirements

Most students commencing their training as an optometrist or dispensing optician are now studying on new, integrated qualifications which meet our education and training requirements (ETR) introduced in 2021. For optometry students, this is generally a GOC approved masters-level qualification, and for dispensing optics students, a GOC approved degree-level or equivalent qualification, both of which integrate greater experience of working with patients, inter-professional learning, and teamwork vital in the formation of an optical professional well-prepared to take responsibility for decisions and actions; engage in research-informed clinical practice and able to respond effectively to changing patent and service-user needs in each of the four nations.

We continue to work closely with providers of GOC approved qualifications in their transition to the ETR, especially those qualifications delivering approved qualifications under the former ‘handbooks’ (the Accreditation and Quality Assurance Handbook: Routes to Registration). Following the publication of the ETR, we have seen a significant increase in interest from providers wishing to gain GOC-approval of their pre- and post- registration qualifications. In July 2025, we approved the BSc (Hons) Clinical Optometry under the Accreditation and Quality Assurance Handbook: Routes to Registration in Optometry (2015) and MOptom (Hons) Optometry under the Requirements for Approved Qualifications in Optometry or Dispensing Optics (2021). Both qualifications are offered by Teesside University. By March 2026 we had 12 qualifications progressing through the staged application process.

During 2025-26 we started to develop new, proportionate and targeted quality assurance and enhancement arrangements to support providers’ compliance with the ETR. We are grateful to providers of GOC approved qualifications and to the Optometry Schools Council (OSC) and the Opticians Academic Schools Council (OASC) for their feedback and continuing engagement as we develop plans for increased collaboration with providers through the Quality Assurance and Enhancement Method (QAEM).

To further support providers of GOC approved qualifications, academic staff, students and the wider stakeholder community in their transition to the ETR in 2025/26, and following a competitive tender process, we continued to support a co-led education-focused knowledge hub for further three years, until July 2028, operated by the Sector Partnership for Optical Education (SPOKE). The focus of the hub for the next three years will be to provide practical materials and support to enable qualification providers to successfully implement the ETR as the first cohorts of students move towards graduation.

We also approved three projects led by the SPOKE to support education providers' transition to the ETR. These include guidance on 'Fitness to train and reasonable adjustments', an online toolkit for learners entitled 'Getting the most from the multi-disciplinary team', and tools for learners of specialist qualifications entitled 'Inclusive education for specialist qualifications'.

Understanding the impacts of commercial practices on patient safety

Our 2025 Workforce and Perceptions Survey found that registrants who experience time or commercial pressures are more likely to report difficulties in providing patients with the sufficient level of care they need.

In response, we launched a thematic review on commercial practices and patient safety, following findings from our research and wider engagement which highlighted that some commercial practices may pose a risk to patients and potentially put undue pressure on registrants. Our aim in carrying out the review is to help us understand the nature and extent of these practices and their impacts, and to identify any interventions that we and the wider sector can take to help mitigate against these.

We have engaged with stakeholders, including registrants, businesses, optical sector organisations and patient representative bodies and will publish a full report on the findings this year.

Conducting new research into lived experiences of registrants and patients

We published new research exploring the lived experiences of registrants who have experienced harassment, bullying, abuse or discrimination at work, and the impact this has on them and their ability to provide safe patient care.

The qualitative research was commissioned following the findings from our recent Workforce and Perception surveys which highlighted the high incidences of bullying, harassment, abuse and discrimination in the optical workplace.

The research revealed the impacts of mistreatment and identified various barriers to reporting. Participants had often experienced multiple forms of mistreatment, such as discrimination, harassment, abuse, and physical, verbal or cyber bullying. We have strengthened our standards of practice to help promote more inclusive workplace environments and ensure businesses support those who have faced these negative behaviours.

We also commissioned lived experience research with patients and non-patients (who had not had a sight test in the past two years) to examine inequalities in access and experiences of eye care services. Participants, all who had at least one ‘vulnerability’, reported various challenges to accessing eye care services and discussed having specific needs that influenced their sense of satisfaction with their experiences of having a sight test/eye examination.

As a first step, we published new guidance for registrants on caring for patients in vulnerable circumstances to support them in delivering safe and effective care for all. We will continue to work with the wider sector to tackle inequalities in accessing eye care.

Delivering public benefit for registrants and the public

We launched an independent support service, run in partnership with Victim Support, to support people who have raised a fitness to practise concern, agreed to be a witness, or are registrants going through the fitness to practise process.

We also continue to fund the Optical Consumer Complaints Service (OCCS), which is a free and independent service that provides mediation for consumers (patients) and professionals in the optical care sector. We published an FtP Focus edition focusing on the role of our FtP triage team and the OCCS.

Consulting on reforms to the CPD scheme

Our current CPD cycle began on 1 January 2025, with the first provider audit and registrant reviews taking place in April and September 2025. We audited the records of 13 CPD providers and reviewed the records of 909 registrants across both of these audit and review periods.

We launched a consultation on proposed reforms to our Continuing Professional Development (CPD) scheme for fully qualified optometrists and dispensing opticians, with some changes expected to begin from the 2028–30 CPD cycle.

The proposed changes would shift the CPD scheme away from a minimum points-based system towards one which is more outcomes-focused with registrants having greater freedom to design their own CPD approach. We would also leverage the role of business registrants in supporting CPD, as businesses have a closer relationship with registrants and are well placed to identify and support individuals’ learning and development needs.

We will review all the feedback received and publish a response later this year.

Streamlining international routes to registration

Following an independent evaluation, we implemented a new streamlined approach to managing applications from eye-care professional qualified outside of the UK, enabling optometry professionals with non-UK qualifications of equivalent standard to proceed directly to registration without the need for further training for the first time.

Applications received from individuals with a relevant qualification(s) from the United States and Canada will be considered for direct entry to the GOC register with immediate effect. In many other cases, applicants will be able to join the register after completing a short GOC approved qualification lasting no longer than one year, designed for graduates/professionals with non-UK optometry qualification(s).

Countries that fall significantly short of meeting the Education and Training Requirements (ETR) or not included within the evaluation exercise will not be applicable for either of the above routes.

This new process will significantly reduce the time required for overseas optometrists to register with us.

Seeking views on business regulation

We published our response to our public consultation on an updated framework which would extend regulation to all businesses carrying out specified restricted functions.

Based on the feedback provided, we have decided:

- any charities or university eye clinics providing specified restricted functions like sight testing should be regulated by the GOC;
- the existing requirement for some bodies corporate to have a majority of registrant directors should be removed since it is no longer justified, anti-competitive, outdated and acts as a barrier to entry to the market;
- all businesses should have a head of optical practice who should be a fully-qualified GOC registrant and an employee of the business;
- we will seek a power for uncapped financial penalties as part of our fitness to practise process; and
- mandatory participation by businesses in the Optical Consumer Complaints Service (OCCS) is necessary to deliver public protection and would be a proportionate solution.

Responsibility for agreeing any changes to the Opticians Act rests with Parliament, and the pace and outcome of any changes, including those required to modernise business regulation, is determined by the UK Government. In the meantime, we remain committed to working in partnership with stakeholders to refine and further develop our proposals.

Research on testing of sight

We published research on a risk-based framework for the testing of sight, which concluded that the separation of sight testing components by person, time or place may pose some risks for both the NHS and patients. However, in the context of a routine eye examination, the likelihood of these risks occurring was considered to be low.

The research was undertaken as part of our commitment from our 2022 **call for evidence** on the Opticians Act 1989 to consider updating our **2013 statement on the testing of sight**.

Joint statement on use of Artificial Intelligence (AI) in health and care professional education

We signed a joint statement on principles relating to the use of Artificial Intelligence (AI) in education and training, alongside five other health and care regulators. The statement includes a set of guiding principles for providers of health and care education to proactively consider during the design and delivery of their educational programmes.

The statement also helps to provide education providers with clarity and an understanding of regulator views on the use of AI in health and care professional education. We will work closely with education providers to support how the principles are considered as part of our normal quality assurance processes.

Commitment to Equality, Diversity and Inclusion (EDI)

We remain committed to promoting equality, diversity and inclusion, central to our role as a regulator and as a responsible employer. Over the past year we have continued to reflect on our progress and identify where we can go further. This has informed the development of a refreshed EDI action plan for 2026–27, which will support the delivery of a more ambitious EDI strategy for 2025–30.

Alongside this, we have taken practical steps to strengthen inclusion across the organisation. A key focus has been on creating more opportunities internally for employee voice and representation. This includes the introduction of a GOC employee Parent and Carers Staff Network, providing a dedicated forum for colleagues to share experiences, influence policy, and shape support for those balancing work with caring responsibilities. We also reintroduced informal, wellbeing and engagement coffee sessions, creating inclusive spaces for GOC employees to connect, share knowledge and build relationships across teams.

This year we also launched our updated EDI policy, setting clearer expectations and reinforcing our commitment to an inclusive culture. We have also significantly increased EDI awareness training across the workforce. This has focused on building understanding of bias in decision-making and equipping colleagues with the confidence to make fairer, more inclusive choices in their day-to-day work.

To strengthen the contribution of all employees in the successful realisation of our corporate strategy, we began the implementation of a new employee Performance and Behaviours Framework (PBF). The aim of the PBF is to improve fairness, transparency and consistency in our performance and reward processes. With the EDI Manager now established in post, we have strengthened alignment between EDI activity and organisational priorities, enabling a more proactive and joined-up approach in embedding EDI.

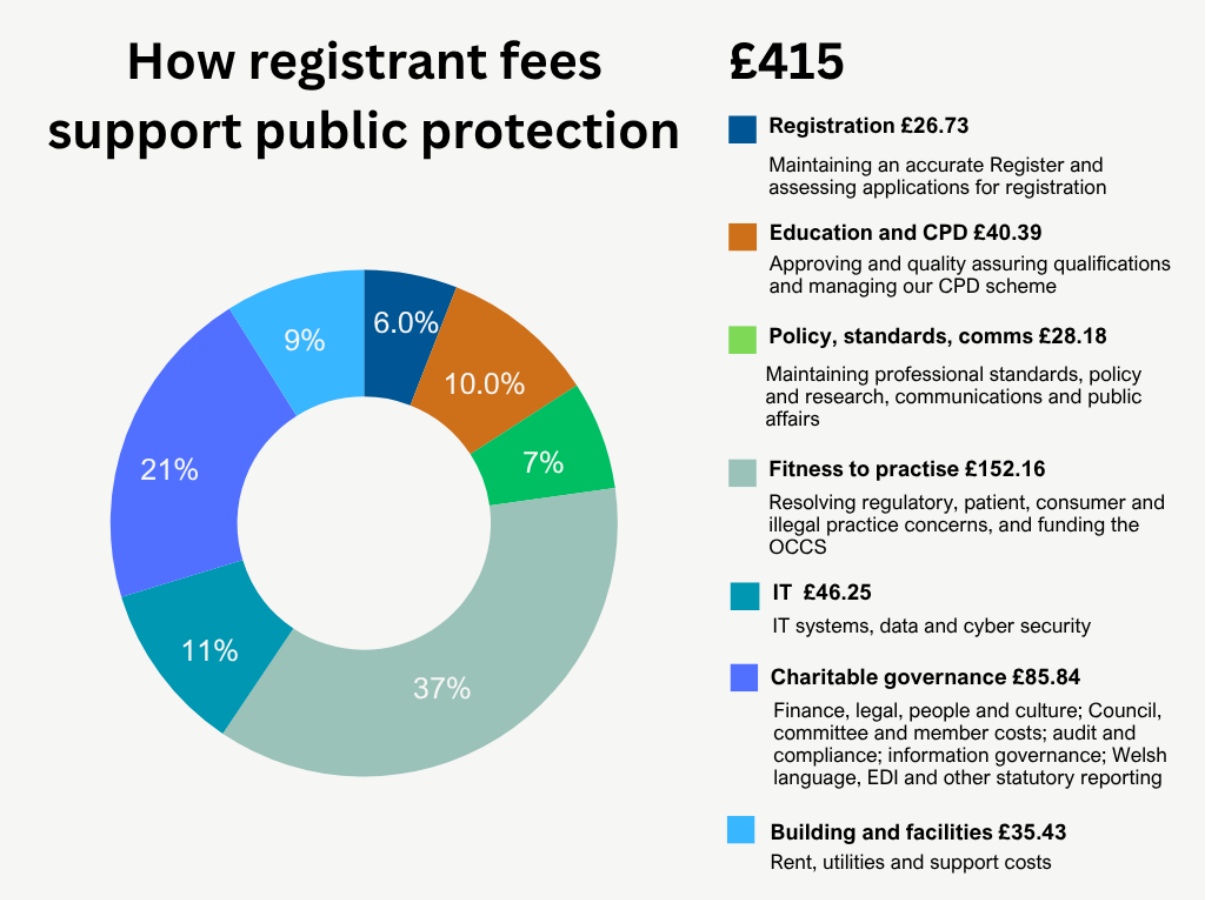
Alongside our internal work, we continued to embed EDI into our regulatory activity and engagement with external stakeholders. This included strengthening our

understanding of where unfair outcomes may exist through the work of our Unfair Outcomes Working Group, using research and engagement to better understand the experiences and needs of different communities, and considering equality impacts as part of policy development and consultation activity. These actions support our aim of being a fair, inclusive and evidence-led regulator that serves registrants, patients and the wider public.

While a separate annual EDI report will provide further detail on our progress, these activities mark an important step in moving from intention to consistent practice across the organisation.

Delivering value for money

In July 2025 we moved to a new, smaller, more economical offices at level 29, One Canada Square. The new office offered a dual-purpose suite of hearings and meeting room spaces and collaborative workspaces for our staff. We also introduced a new contracts and procurement policy, to ensure we achieved value for money in our purchase of goods and services. With the launch of our new Corporate Strategy in April 2025, we also launched a new Directorate structure to address capability gaps, generate internal efficiencies and align our organisational structure to our strategy, to support its successful execution.



Meeting all PSA Standards of Good Regulation for fourth year running

We were delighted to learn that for the fourth year in a row, we met all 18 of the Professional Standards Authority's (PSA) Standards of Good Regulation, providing assurance that we are on the right path to delivering safe and effective eye care for all. The PSA's report highlighted progress in several key areas, including our commitment to EDI through our Unfair Outcomes Working Group, research with the public as part of our business regulation consultation, and sustained performance in responding to illegal practice cases.

Appointments to our Council and Senior Management Team

Frank Munro was reappointed to our Council as a registrant member for a further four-year term. We also appointed five new Council members; Raymond Curran and Poonam Sharma as registrant members; and Kalwant Grewal, Ros Levenson and Cathy Yelf appointed as lay members.

Council appointed John Cappock as the independent chair of the Audit, Finance and Risk Committee (ARC) in June 2026.

We appointed Marc Stoner as Director of Corporate Services, leading our finance, facilities and IT teams, as well as our registration function. Marc's role also supports the GOC's Investment Committee and Audit, Risk and Finance Committee. He previously served as the Director of Resources at the Architects Registration Board, having served as its Acting Chief Executive in 2020.

Our Plans for 2026/27

Our five-year corporate strategy included several important pieces of work, some of which will span several years, designed to protect the public and uphold public confidence in the professions and businesses we regulate.

The 2026-27 financial year marks the second year of our five-year corporate strategy. It demonstrates how we will protect the public and ensure registrants can contribute to their full professional capabilities across each part of the UK and achieve our ambition to become a world-class regulator.

Delivering our statutory responsibilities

We will continue to deliver agile, robust and effective regulation that protects the public by upholding high standards in eye care services, supports professionals to deliver quality care, and meets the needs of the UK health system. We will do this through expert and efficient execution of our core functions:

1. **Setting standards for the performance and conduct of our registrants**
   Following last year's update of our Standards for Optometrists and Dispensing Opticians, we will now begin work to review the Standards for Optical Businesses, including commissioning research, stakeholder engagement and developing proposed changes ahead of taking proposals to Council. We also plan to consult on proposals to update our 2013 statement on the testing of sight and standard on supervision, making any changes in line with our strategic objective of supporting responsible innovation and protecting the public.
2. **Maintaining a register of individuals who are fit to practise or train as optometrists or dispensing opticians, and bodies corporate who are fit to carry on business as optometrists or dispensing opticians**
   This year we expect to register nearly 36,000 individuals and businesses. We will also launch a major upgrade to MyGOC, our online platform for registrants.
3. **Approving qualifications leading to registration**
   Following the introduction of our ETR, we will develop new international registration processes to support applications for registration from professionals qualified overseas. Reflecting the maturity of our education reforms we will continue to consider applications from providers to deliver new qualifications in dispensing optics and optometry, in line with our statutory processes.
4. **Investigating and acting where registrants' fitness to practise, train or carry on business may be impaired**
   We will continue to embed improvements we have made in the delivery of our fitness to practise function, to improve timeliness in case resolution and in our

communication with, and the support we provide to witness and registrants involved in the process.

Supporting registrants to provide safe and effective eye care for all

We will publish the outcomes of our annual surveys of registrants and the public. We use these findings to help us to track trends in the sector and we know that other organisations value the insights gained from our commissioned research to better understand the eye care workforce and patient expectations. We will continue to engage with a wide range of individuals and organisations to deepen our understanding of the eye care sector, including by visiting different practices and care settings around the UK.

We will publish the final report of our thematic review on commercial practices and patient safety which will help us understand the nature and extent of these practices and their impact on patients and the public. The review will identify recommendations for action that either we or the wider sector can take to help support the delivery of safe and effective eye care for all. We also plan to scope topics for a second thematic review.

We have published a consultation on a discussion paper on how we set registrant fees to improve transparency and ensure financial stability whilst being fair and proportionate to registrants, including those on a low income. We will share the findings from this later this year.

We will continue to administer our CPD scheme, which gives registrants the ability to tailor their professional learning and development, maximising opportunities for deployment of their professional capability for the benefit of patients and the public. We will publish the findings from our consultation on changes to the scheme for 2028 onwards and beyond, to modernise our CPD requirements towards a more flexible, less prescriptive system which maximises registrants' ability to undertake learning and development relevant to their professional scope of practice and which supports career progression and acquisition of post-registration qualifications.

Creating fairer and more inclusive eye care services and contributing to the wider healthcare agenda

We will scope proposals for strengthening service user and patient voice across our regulatory functions, which we hope will lead to a better balancing of professional, commercial and user insights in the delivery of our regulatory responsibilities. This will put the needs of patients and the public at the heart of our regulatory approach.

We will improve understanding of, and keep up to date with developments in, the use of AI in eye care and in regulation and use that understanding to produce guidance

for registrants. Where appropriate, we will deploy AI to achieve internal efficiency gains in our business processes.

While reform of our current legislation will not take place during this Parliament, we will continue to engage with and influence Department of Health and Social Care on healthcare regulatory legislative reform in preparation for forthcoming changes.

Delivering our ambitions

We will continue our public duty and commitment to progress equality, diversity, and inclusion (EDI), which underpins all our work. We will implement our ambitious EDI action plan in support of our corporate strategy. We will maintain strong governance procedures, supporting the work of our Council and committees to ensure they inform decision making and identify and manage any risk appropriately. We will continue to invest in our staff, building an engaging, inclusive culture where everyone feels valued, including continuing to implement our new performance and behaviours framework.

As part of developing our corporate strategy for 2025-30, we also produced a financial strategy to enable the following financial objectives:

- Financial sustainability and stability
- Transparency and accountability in financial management
- Maintain appropriate reserves for contingencies and strategic initiatives
- Deliver value for registrants' money
- Maintain a low to moderate risk appetite in our financial management.

Our budget for 2026/27 will draw on reserves to offset a planned deficit, consistent with our five-year financial strategy to 2030. This strategy aims to balance our income and expenditure over the five years of our corporate plan, to support delivery of our long-term aims. This kind of long-term planning means we can deliver greater value for registrants' money, whilst helping to keep increases to registrants' fees at below inflation.

Our internal controls, audit function and risk management approach

Internal controls

Our internal controls include responding to corporate complaints and speaking up (otherwise known as whistleblowing) referrals, the declaration and management of interests, fraud prevention, risk management, safeguarding, monitoring information governance requests, and other associated compliance activities.

Corporate complaints

Our corporate complaints policy has two tiers. Complainants are entitled to refer a complaint they have been unable resolve informally with the team to stage one for an appeal. If they feel that we have not resolved it at stage one they can request a stage two appeal.

Between April 2025 – March 2026 we received:

Seven stage 1 corporate complaints, two of which were upheld and three partially upheld.

This is a small reduction in the number of complaints we received in 2025/26 (seven stage 1 complaints versus eleven in the previous year). Complaints that were upheld or partially upheld identified timeliness and a lack of clarity communicated as the most common issue. Where complaints are upheld or partially upheld, lessons learnt have been cascaded to managers to improve our services.

Freedom to speak up

We have a freedom to speak up policy for employees, members and workers. These are sometimes referred to as whistleblowing policies in other organisations.

We received two referrals via our freedom to speak up policy in 2025/26. This is a significant reduction from the number of referrals received in 2024/25 (ten) and 2025/26 (four). However, the reportable criteria has altered following the introduction of the revised policy in December 2024. The numbers now refer to those referrals that required a formal response. Where advice or signposting is required, these will be reported thematically to SMT and our Audit, Finance and Risk Committee (ARC) on a regular basis from 2026-27 onwards. Both referrals requiring a formal response related to member-executive relations. In both cases, lessons learnt were identified and have been captured in the development of a new member code of conduct for 2026-27.

2025-26 also saw the appointment of a Freedom To Speak Up Guardian, following a competitive recruitment process. Nadia Denton was appointed to this role from 17 November 2025.

Highlights since Nadia's commencement of the role includes inclusion of a new 'Freedom to speak up about the GOC' page on the GOC website; communication to Council and Committee members to alert them to the existence of the page; cross organisational engagement with colleagues about barriers to speaking up and attendance at the National Guardian's office London network meetings.

Internal audit function

The Audit, Finance and Risk Committee (ARC) supports the Council by reviewing the GOC's internal audit arrangements. Its responsibilities include appointment of the internal auditor, approval of the annual audit plan and reviewing the outcomes of the audits undertaken. It also receives an annual report from the internal audit function.

In 2025/26 the internal auditor was TIAA. ARC received the annual report on 12 May 2026 and noted the Head of Internal Audit Annual Opinion:

"TIAA is satisfied that, for the areas reviewed during the year, General Optical Council has reasonable and effective risk management, control and governance processes in place.

This opinion is based solely on the matters that came to the attention of TIAA during the course of the internal audit reviews carried out during the year and is not an opinion on all elements of the risk management, control and governance processes or the ongoing financial viability or your ability to meet financial obligations which must be obtained by General Optical Council from its various sources of assurance."

Risk management

Our approach to risk management is set out in our risk management policy. The risk management policy and risk appetite statement were last approved by Council on 28 June 2022. The policy was due for review in June 2025, though this has been deferred following the appointment of a new Director of Corporate Services. The policy will be revised in 2026-27.

We consider that an effective risk management strategy and policy are fundamental to the achievement of all our strategic objectives and is an essential part of good governance.

Both Council and the ARC discuss and review the principal risks and uncertainties regularly throughout the year. The risk register was revised extensively through 2025-26 to capture the current risks under the new corporate strategy 2025 – 2030. Council reviewed the updated register at its strictly confidential meeting on 16 December 2025.

ARC also examines the arrangements for management of risk, providing assurance to the Council that risks are being identified and appropriately managed. This includes advising the Council on the assurances provided in respect of risk and internal controls. To assist with this role, ARC produces an annual report on its activities. The most recent of these reports was received by Council in September 2025.

The Senior Management Team (SMT) regularly monitors existing and emerging risks and identifies mitigating actions. We capture and monitor operational risks through our corporate, directorate and project risk registers.

We continue to maintain robust systems and procedures to mitigate the risk of failure to deliver our statutory functions, which are at the heart of protecting the public. This includes, for example, attention to the following risks:

- Failure to meet our duties in respect of information governance and information security.
- Failure to achieve FtP end to end timescale improvements.
- GOC education and training requirements for pre-and post-registration approved qualifications are not effectively implemented by providers.
- The register contains inaccurate information leading to reputational damage and potential harm to patients and / or registrants.

Horizon scanning and being alert to emerging operational and strategic risks are part of ongoing business oversight. This is important because some of our key risks come from the external environment, which means we must work with stakeholders to understand the risks and identify the actions we can take to manage them.

In 2024-25 the annual report identified the external financial environment as one of the principal risks we faced. This was driven in part by changes in the geopolitical landscape, including the announcement of trade tariffs by the US government. We have been closely monitoring the performance of our investments with our investment manager to minimise the impact of fluctuations in global stock markets. Increases in employer national insurance contributions also had an impact on us as an employer and will have impacted a number of our registrants. Economic pressures on employers and changes to fiscal policy and taxation by the UK government are key risks in the current era of economic uncertainty. We have been developing our approach to setting registrant fees in 2025-26, in order to provide greater transparency and certainty in respect to its long-term funding needs. A discussion paper was considered by Council in March 2026.

Internal risks included the substantial turnover of Council members in 2025-6, with over half of the Council being new appointments. While the new Council members will bring a wealth of skills, knowledge and expertise, there were risks associated with high turnover at a non-executive level, including a loss of institutional knowledge and an impact on established ways of working with the executive. To mitigate this, we offered a detailed induction programme, including sessions led from Council members who departed in 2024-25. The Chair of Council, Chief Executive and Registrar and Chief of Staff continue to assess induction and onboarding requirements into 2026-27. Council is also in the process of revising its code of conduct for members, to ensure that there is a clear set of expectations for members in respect to conduct and maintaining public confidence.

Safeguarding

Safeguarding is about protecting people from harm, abuse, neglect, or exploitation. It can apply to children, adults at risk, and vulnerable colleagues or stakeholders. As a regulator and charity, we take our safeguarding responsibilities seriously. Our safeguarding policy sets out how we respond to concerns about the safety and wellbeing of people at risk.

The Safeguarding Panel is responsible for overseeing any safeguarding concerns raised in relation to our work and ensuring that risk around safeguarding is monitored and managed. The Panel is comprised of the following staff:

- Director of Regulatory Operations (Chair)
- Chief Legal Officer
- Chief of Staff
- Head of Investigations
- Head of Case Progression
- Head of People and Culture
- Head of Registration
- Information Governance Officer.

The Panel reports on an exceptions basis to ARC. Alongside this statement in the annual report, the reporting to ARC is how we provide assurance to Council about the discharge of our safeguarding responsibilities.

Panel activity over 2025/26

The Panel met to consider six referrals. Five of these referrals were from Regulatory Operations, with one referral from Regulatory Strategy. All referrals related to individuals external to the GOC, although some areas of risk related to our employees.

As a result of their considerations, the Panel made three active referrals to the relevant safeguarding agencies, including the police and a local authority.

The issues referred to the Panel to date include domestic violence, self-harm/suicide, child abduction, potential harm to children and vulnerable persons.

The Panel has developed resources to aid its decision-making, including a risk assessment tool and guide to relevant referral routes.

The Panel meets quarterly to review themes in referrals and any wider matters about the operation of the Panel. So far, the Panel has identified the following areas for further work:

- Developing guidance for staff (particularly in FtP and Registrations) on handling high risk calls.

- Potential training on safeguarding for FtP panel members.
- A short guide for staff on resources supporting emotional wellbeing.

Our people

A high performing, engaged, and motivated workforce, working collaboratively translate our vision for ‘Safe and effective eye care for all’ into the actions we take on a day-to day basis to achieve our strategic objectives. Who are our people? All those who are engaged in our work; our members, employees, workers, and contractors (our workforce.) Each have a unique and important role in helping us together to secure our vision. We value the diverse perspectives and backgrounds our workforce brings, because a diverse workforce ensures greater creativity, stronger governance and accountability, and better decision-making, so that we can continue to deliver our statutory responsibilities for the benefit of patients and the public

In 2025–2026 we had three strategic priorities in relation to our investment in our people. First, the introduction of our employee Performance and Behaviours Framework (PBF). Second, the resolution of legacy employment arrangements through the structured transition of hearing panellists to worker employment status, and third, and the implementation of lessons learned to strengthen how employee relations cases are managed, improving consistency, capability, and outcomes. Alongside these priorities, our People and Culture team continued to build the talent pipeline, leadership capability, workforce planning framework and business partnering, helping us to operate with resilience and to drive a positive and consistent people and culture experience.

Workforce

As of 31 March 2026, we employed 115 employees, with an annual employee turnover of 11.6%, which is below the public sector average and a significant improvement on the previous year at 17.3%. In the same period voluntary turnover was at 4.4%.

In 2025/26, People and Culture introduced a more strategic approach to workforce planning. This provided greater organisational visibility of current and future resource needs, enabling more informed and inclusive decision-making. 2026/27 will see this foundational investment in workforce planning support improved forecasting, talent management, affordability and long-term sustainability of the workforce.

We continue to develop early-career talent, with the IT department offering its second structured apprenticeship programme.

Culture

Fostering a positive and inclusive internal culture remains a key priority, with equality, diversity and inclusion integral to our people and culture priorities. We have maintained a continued focus on inclusive recruitment and creating a workplace where everyone can thrive. During the year, we began an inclusive recruitment review, to support fair, transparent and accessible attraction and recruitment processes, helping to attract a diverse range of candidates and reduce bias at each stage of the employee lifecycle. Our staff networks continued to play a vital role in shaping this work, providing insight and lived experience, including the introduction of a new Parent and Carers Network. Through ongoing collaboration with our networks, we continue to hear voices and different perspectives, which creates awareness of issues that employees and leaders may not be aware of. They further help us build an inclusive internal culture that supports belonging, representation and opportunity for all employees.

Our focus on employee engagement continues to be informed through our employee pulse surveys, providing a regular snapshot of colleague sentiment across the organisation.

Recruitment and Retention

In 2025/26 we had 22 recruitment campaigns. 20 new people joined GOC and 13 left the organisation.

Flexible and agile working remains central to how we deliver our services, supporting the recruitment and retention of a balanced, skilled and geographically diverse workforce across the United Kingdom, while promoting a healthy work–life balance.

Driving High Performance

This year marked a significant milestone in the evolution of our employee performance management approach, with the introduction and embedding of the Performance Behaviours Framework (PBF).

Designed to complement objective-setting, the framework establishes a clear and consistent approach for assessing both ‘what’ employees achieve and ‘how’ they deliver their work. This dual focus is central to fostering a high-performance, values-led culture.

Following its development, significant progress has been made to embed the framework across all levels of the organisation. This has included the creation of comprehensive supporting guidance, the delivery of training for all staff on the

framework and in setting SMART objectives, and targeted development for line managers to build capability in holding effective performance and development conversations.

Together, these activities have established strong foundations for a more robust, consistent and behaviour-led performance management approach, which will continue to be enhanced through the 2026/27 performance cycle.

Learning and Development

Our employee learning and development strategy continues to be informed by robust training needs analysis and stakeholder engagement. We measure impact through participant feedback and by assessing how skills development supports delivery of our organisational objectives.

In 2025/26, learning and development activity was tightly focused on upskilling the workforce to support the embedding of the PBF. This included development activity to build understanding of the framework, support effective objective setting, and strengthen capability in having high-quality performance and development conversations. This targeted approach ensured learning investment was closely aligned to driving a consistent, fair and high-performance culture.

Alongside this core focus, additional training was delivered to support key organisational priorities. This included training to underpin the implementation of a pilot mentoring programme, helping to build internal capability and support development through peer learning, as well as specialist training to better equip members of the safeguarding panel in fulfilling their responsibilities.

These activities reflect a more focused and strategic approach to learning and development in 2025/26, balancing organisation wide capability building with targeted interventions to support specific programmes and governance requirements.

Reward and Recognition

In 2025/26, we continued to strengthen our reward and recognition approach through the annual review of employee benefits, ensuring our offering remains competitive, relevant and aligned to organisational and employee needs. This has included the transition to a new health cash plan provider and the provision of Women’s and Men’s Health services, enhancing the overall benefits package available to our employees.

Compliance and Governance

In 2025/26, we completed the comprehensive review of members’ employment status , following Council approval in 2024/25 to allocate strategic reserves to

support this work. The review assessed the status of current members and those whose terms ended in December 2024 and concluded that Hearing Panellists are workers. A further review of other roles was carried out and concluded. A structured programme of work was delivered to transition affected individuals to the appropriate worker employment status, resolving a longstanding legacy issue and strengthening compliance with employment and regulatory requirements.

The completion of this programme has improved clarity and consistency in employment arrangements, reduced organisational risk, and increased transparency for individuals impacted. Together, this work supports a fairer and more robust people framework, reinforcing trust and confidence in how employment and compliance matters are managed across the organisation.

Our structure, governance and management

Our legislation and our governance regulations

The General Optical Council is constituted as a body corporate under the Opticians Act 1989, as updated by amending legislation which came into effect on 30 June 2005.

We are also registered as a charity by the Charity Commission in England and Wales (registered charity number 1150137).

We are accountable to Parliament through the Privy Council, to the Charity Commission as our regulator and to our beneficiaries.

Our Council

The Council is the governing body of the GOC, and Council members are the charity trustees. They are collectively responsible for directing the affairs of the GOC, ensuring that it is solvent, well-run, and delivers on its charitable objectives for the public benefit.

All Council members share the same duty of public protection and oversee the full range of regulatory processes.

The primary functions of Council are:

- To protect, promote and maintain the health, safety and well-being of the public.
- To promote and maintain public confidence in the professions regulated under the Optician Act 1989.
- To promote and maintain proper professional standards and conduct for members of those professions.
- To promote and maintain proper standards and conduct for business registrants.

Our Council is comprised of 12 Council members, of whom six are registrants and six are lay members (see pages X and X). Membership is drawn from England, Wales, Scotland and Northern Ireland. Biographies can be viewed on our website.

Dr Anne Wright CBE served as Chair throughout 2025-26. She was appointed on 18 February 2021 and completed her first four-year term in 2025. She was reappointed by the Privy Council for a further four years (19 February 2025 – 18 February 2029).

Council appoints one of its members to act as Senior Council Member (SCM). The SCM reviews the Chair's performance, provides a sounding board for the Chair and serves as an intermediary for Council members, the Executive and stakeholders as necessary.

Tim Parkinson was appointed as SCM from 1 April 2025 and acted in that capacity throughout 2025-26.

Our governance structure

To exercise its powers, Council delegates certain responsibilities to committees with clearly defined authority and terms of reference.

Our governance structure in 2024-25 consisted of four non-statutory committees (Audit, Finance & Risk; Investment; Nominations and Remuneration) and four Council committees (Companies, Education, Registration and Standards). The four Council committees (sometimes referred to as statutory committees) met collectively as an Advisory Panel as well as separate Committees.

The attendance record of Council members at Council and committee meetings and the fees and expenses of Council members are shown on page X and X. The Council is committed to conducting the majority of its business in public.

Council business is only conducted in private if one of the following conditions set out in the standing orders apply:

- Any personal matter concerning a present or former registrant or application for registration, employee, Council member, panel or committee member, education visitor or advisor.
- Any matter which is deemed commercially sensitive, subject to legal professional privilege or relevant to the prevention or detection of crime and the prosecution of offenders.
- Any information given to the GOC in confidence.
- Risk of a financial or political nature (either to the GOC or others) where discussion in public would exacerbate the risk.
- Any other matter which is deemed by the Chair and Chief Executive and Registrar to require discussion in a strictly confidential meeting.

All Council members are required to take part in other activities such as induction, development sessions, recruitment, strategy, corporate performance and evaluation. All Council and committee members are required to engage in a performance review process. Council members undertook a significant amount of recruitment and induction activities in 2025-26.

Approximately two thirds of members (including Hearing Panel members, Council members and committee members) reached the maximum term of office permitted by legislation in 2024-25. This meant 2025-26 was a critical year for induction, training and transition for our members.

Council attended several development activities in the year, which served both as a refresher under the new corporate strategy and induction for new Council members. This included two days dedicated to sharing sector insight and organisational knowledge.

Scheme of delegation

Our scheme of delegation sets out those functions retained by Council, delegated to a committee, or delegated to the Chief Executive and Registrar. Council can delegate any of its functions apart from making rules. Council approved a revised scheme of delegation and standing orders on 16 September 2025.

Senior Management Team

The determination of pay and remuneration for the Chief Executive and Registrar and senior executive team (otherwise referred to as the Senior Management Team or SMT) is delegated to the Remuneration Committee by Council. An annual appraisal process is undertaken in line with the organisation's pay and reward policy, and pay is benchmarked against other regulators.

Decision-making powers are delegated to the Chief Executive and Registrar under the Opticians Act 1989 and other powers are delegated from Council. To exercise these powers, some are delegated by the Chief Executive and Registrar to other members of the Executive.

For 2025-26, SMT responsibilities were as follows.

The Director of Corporate Services, Marc Stoner, was appointed on 1 September 2026, and responsible for:

- Facilities
- Finance
- IT
- Registration
- Risk and audit.

Charlotte Urwin was acting Director of Corporate Services from 21 May 2025 to 31 August 2025.

The Director of People and Improvement, Philipsia Greenway, was responsible for:

- People and Culture
- Project Delivery and Continuous Improvement.

The Director of Regulatory Operations, Carole Auchterlonie, was responsible for:

- Triage (including contract management of the Optical Consumer Complaints Service)
- Investigations
- Hearings
- Legal.

The Director of Regulatory Strategy, Steve Brooker, was responsible for:

- Communications
- Education and CPD
- Strategy, policy and standards.

SMT, Council and its committees are supported by the governance team. The Chief of Staff oversees the governance function and is strategic lead for EDI. He reports directly to the Chief Executive and Registrar.

Effectiveness of governance

The GOC has adopted the Charity Governance Code as the method for assessing its effectiveness. The most recent self-evaluation was undertaken in December 2025, and the organisation judged itself to have complied with the majority of the code's recommended practice. Where it has not done so, the assessment identified the next steps to achieve compliance or explained how it met the key outcomes of the code via another method.

In addition to adopting the self-assessment, we commenced a long-term governance review in 2022-23. The stated objective of this review was to ensure that the GOC's governance structures, policies and procedures enable it to deliver its strategic objectives and statutory functions for the public benefit.

In 2025-26, this review saw revisions to policies and procedures, including:

- updated standing orders; and
- updated schemes of delegation for Council and the Chief Executive and Registrar.

In 2026-27, Council has committed to undertaking a governance effectiveness review, led by an external consultant.

Members' conduct

Council (in their role as trustees) and committee members have a duty to abide by the seven principles of public life (otherwise known as the Nolan principles):

- selflessness
- integrity
- objectivity
- accountability
- openness
- honesty
- leadership.

This includes a responsibility to:

- act impartially and objectively;
- take steps to avoid putting themselves in a position where their personal interests conflict with their duty to act in the interests of the charity, unless they are authorised to do so; and
- take steps to avoid any conflict of interest arising because of their membership of, or association with, other organisations or individuals.

To make this fully transparent, we publish a register of Council and committee members' interests on our website.

There were no complaints regarding member conduct referred via the GOC corporate complaints policy in 2025/26.

Remuneration Committee statement 2025/26: **member and director remuneration**

The Remuneration Committee has been delegated the following responsibilities by Council:

- To advise Council on the payment of fees to members;
- To advise Council on the process to appoint or remove the Chief Executive and Registrar (or Chief Executive or Registrar if these functions are fulfilled by two different office-holders);
- To provide assurance to Council that there are adequate processes in place to determine executive remuneration, reward and performance management,
- and that these are in line with the GOC's values and principles;
- To approve the level of remuneration and payments to be made in relation to pensions, gratuities or superannuation schemes to the Chief Executive and Registrar and other members of the Senior Management Team (SMT)
- To approve the process of appraisal for the Chief Executive and Registrar and
- other members of the SMT;
- To approve relevant sections of the annual report in relation to Council members' remuneration and expenses ensuring that they meet best practice
- requirements;
- To approve a statement in the annual report about its membership, role and remit for the preceding year;
- To approve the expenses policy; and
- To ensure that all policies and work within the Committee's remit take account of and promote the GOC values and commitment to equality, diversity, and inclusion.

In 2025-26 the Remuneration Committee was comprised of

- Tim Parkinson (Senior Council Member and committee chair as of 1 April 2025, lay Council member)
- Lisa Gerson (committee member as of 1 April 2025, registrant Council member)
- Nigel Sully (committee member as of 1 April 2022, independent member)

To discharge its functions, it met on three occasions in 2025-26: 29 April 2025, 29 October 2025 and 10 February 2026.

In 2025-26 it fulfilled its duties by reviewing the member fee policy and schedule, which was approved by Council on 11 March 2026.

The Committee received regular updates on the planned implementation of the Performance and Behaviours Framework (PBF). This framework would be applied to all executive performance reviews, including SMT, and was intended to support greater consistency and clarity around performance-related pay.

The Committee also reviewed the process of appraisal for the Chief Executive and Registrar and other members of the SMT, including the outcome of the process. The Committee has satisfied itself that the level of remuneration in each case was proportionate and the policies and decisions aligned to GOC values.

The level of remuneration for Council members and SMT is reported in section three of the annual report (include page ref).

	Registrant or Lay Member	Home Location	Fees inc. VAT £	Expenses £	Council Meeting Attendance	Committee and Advisory Panel Meeting[1] Attendance
Dr Anne Wright CBE (Chair)	Lay (Chair)	England	49,999.92	nil	Public 4 out of 4 SC 4 out of 4	(The Chair of Council attends all committee meetings in an ex-officio capacity)
Raymond Curran	Registrant	Northern Ireland	13,962	602.10	Public 3 out of 4 (25 June 2025, did not attend) SC 3 out of 4 (24 June 2025, did not attend)	ARC – 5 out of 6 (8 July 2025, did not attend) AP – 2 out of 3 (13 November 2025, did not attend)
Kathryn Foreman	Lay	England	13,962	161.39	Public 4 out of 4 SC 4 out of 4	ARC – 5 out of 6 (2 September 2025, did not attend) AP – 3 out of 3
Lisa Gerson	Registrant	Wales	13,962	nil	Public 4 out of 4 SC 4 out of 4	Nom - 4 out of 4 Rem – 3 out of 3 AP – 3 out of 3
Ken Gill*	Lay	England	5,487.32	nil	n/a	n/a
Kalwant Grewal**	Lay	England	2,327	nil	Public 1 out of 1 SC 1 out of 1	n/a
Ros Levenson	Lay	England	13,962	28.70	Public 4 out of 4 SC 4 out of 4	Nom – 4 out of 4 AP – 3 out of 3
Frank Munro	Registrant	Scotland	13,962	653.03	Public 4 out of 4 SC 4 out of 4	Inv – 2 out of 2 ARC – 6 out of 6 AP – 3 out of 3

Tim Parkinson	Lay	England	16,461.96	567.94	Public 4 out of 4 SC 4 out of 4	Inv – 2 out of 2 Rem – 3 out of 3 AP – 3 out of 3
Hema Radhakrishnan	Registrant	England	13,962	438.10	Public 4 out of 4 SC 4 out of 4	AP – 3 out of 3
Poonam Sharma	Registrant	England	13,962	nil	Public 4 out of 4 SC 4 out of 4	AP – 3 out of 3
William[i] Stockdale	Registrant	Northern Ireland	13,962	1207.94	Public 4 out of 4 SC 4 out of 4	Nom 4 out of 4 AP – 3 out of 3
Cathy Yelf	Lay	England	13,962	nil	Public 4 out of 4 SC 4 out of 4	Inv – 2 out of 2 AP – 2 out of 3 (6 February 2026, did not attend)

Key:
Committees: ARC - Audit, Risk and Finance, **Inv** – Investment, **Nom** - Nominations, **Rem** – Remuneration,
Panel: AP – Advisory Panel
Attendance is only counted where an individual member is appointed as a committee member or chair. Some members changed committees through the financial year, and the stats will only show the number of meetings they were expected to attend

Senior Council Member renumeration is set at £16,462. From 1 April 2025 – 31 March 2027 the role is being fulfilled by Tim Parkinson.
All Council members are required to take part in other events such as strategy days, evaluations and performance appraisals, for which they receive no additional remuneration, and which are not included in the attendance figures.
*last day in post was 31 July 2025.
** was appointed as Council member on 1 February 2026.
John Cappock was appointed as independent Chair of ARC in June 2026. In this role he received £14,243 in 2025-26

Reference and administrative details

The GOC is the statutory regulator for the optical professions in the UK and is constituted as a body corporate under the Opticians Act 1989, as updated by its section 60 amending legislation which came into effect on 30 June 2005. On 12 December 2012, the GOC was registered as a charity by the Charity Commission in England and Wales (registered charity number 1150137).

GOC registered office is located at Floor 29, One Canada Square, Canary Wharf, London E14 5AA

Bankers	Lloyds Banking Group (incorporating Bank of Scotland) 4th Floor, 25 Gresham Street, London, EC2V 7HN	
Internal auditors	TIAA Ltd (from 31 March 2020) Artillery House, Fort Fareham, Newgate Lane, Fareham, PO14 1AH	
External auditors	HaysMac LLP 10 Queen Street Place, London, EC4R 1AG	
Investment Advisors	Royal Bank of Canada Brewin Dolphin Limited 12 Smithfield Street, London, ECIA 9BD	
Council	Anne Wright (Chair)	(appointed 19 February 2021 to 18 February 2025, reappointed 19 February 2025 to 18 February 2029)
	Raymond Curran	(appointed 1 April 2025 until 31 March 2029)
	Kathryn Foreman	(appointed 1 October 2024 until 30 September 2029)
	Kalwant Grewal	(appointed 1 February 2026 until 31 January 2030)
	Lisa Gerson	(appointed 1 May 2021 until 30 April 2025, reappointment confirmed for 1 May 2025 until 30 April 2029)
	Ken Gill	(appointed 1 January 2023 until 31 December 2027, resigned on 31 July 2025)
	Ros Levenson	(appointed 1 April 2025 until 31 March 2029)
	Frank Munro	(appointed 5 July 2021 until 4 July 2025, reappointment confirmed for 5 July 2025 until 4 July 2029)

Tim Parkinson	(reappointed 16 April 2024 – 15 April 2028)
Hema Radhakrishnan	(appointed 15 March 2024 until 14 March 2028)
Poonam Sharma	(appointed 1 April 2025 until 31 March 2029)
William Stockdale	(appointed 1 January 2023 until 31 December 2027)
Cathy Yelf	(appointed 1 April 2025 until 31 March 2029)

Senior Management Team

Leonie Milliner	Chief Executive & Registrar
Carole Auchterlonie	Director of Regulatory Operations
Steve Brooker	Director of Regulatory Strategy
Philipsia Greenway	Director of People and Improvement
Marc Stoner	Director of Corporate Services

Section 2: Our Fitness to Practise Report

What is fitness to practise?

A registrant is fit to practise, train or carry on business if they have the relevant skills, knowledge, health and character to perform their work and/or practise safely. The Standards define the standards of behaviour and performance that are expected of registrants. One of our core functions is to investigate and act when registrants' fitness to practise, train or carry on business may be impaired.

How we deal with concerns

Anyone can raise a concern with us if they think a registrant is not fit to practise (or train or run a GOC-registered business) and we receive concerns from members of the public, patients, carers, employers, the police and other registrants. If we receive information which could potentially call into question a registrant's fitness, we may need to investigate.

Overview of our fitness to practise performance

- Met all the PSA's Standards of Good Regulation for fitness to practise for the fourth-year running.
- Secured positive quality assurance from the annual independent audit of decisions.
- Introduced an independent support service for registrants and witnesses.
- Made further improvements in the efficiency and effectiveness of our hearings operations.

Our fitness to practise committee decisions

Outcome	Number of outcomes
No further action/ no case to answer	0
Facts found – No Misconduct	5
Misconduct found but not impaired	1
Impaired with no sanction	0
Warning	3
Fines	0
Conditional Registration	0
Suspension	17

Erasure	10

Removed from the GOC Register	1[1]

Stayed	0

Total	37

Triage

We received more concerns in 2025/26 than the previous year (607 in 2025/26, compared to 464 in 2024/25 – an increase of 31%). We opened 110 new investigations, representing an 18% conversion rate (compared to 29% the previous year).

Around 32% of concerns related to clinical issues and 28% related to registrants' conduct, with the remainder (40%) comprising business-related concerns, conviction/caution matters, health concerns and mixed-category cases. This compares with 2024/25, where around 42% of concerns related to clinical issues and 32% to conduct matters, suggesting that the increase in volume in 2025/26 was not driven by a corresponding increase in higher-risk clinical concerns.

Investigations

Over the past year, we have seen a 2% decrease in our investigation caseload, reducing slightly from 153 at the end of 2024/25 to 150 at the end of 2025/26.

Recognising the importance of timely outcomes, particularly for long-standing cases, we have continued to focus on progressing older investigations through the system. This strategic approach has had the following impact on case progression times:

- The median age for open investigations increased by 23% (from 39 weeks in 2024/25 to 48 weeks in 2025/26), in part reflecting the higher volume of cases opened in Q1 of 2024/25.
- The median time to a case examiner decision increased from 55 weeks to 58 weeks. This measure fluctuated during the reporting period and, after stabilising, began to trend downward.
- 29% of new investigations reached the representations stage within 25 weeks of the date of the investigation being opened.

[1] This case relates to a body corporate which was removed from the GOC's Register.

- 41% of new investigations reached the representations stage within 35 weeks of the date of the investigation being opened.
- The case examiner referral rate to a Fitness to Practise Committee increased, with 51 out of 103 decisions resulting in referral to a hearing (49.5%), compared with 43 out of 103 decisions in 2024/25 (41.7%). This is an 18.6% rise in cases referred to a hearing compared to 2024/25.
- 47% of cases were concluded within 78 weeks, compared with 58% in the previous year. This reduction reflected the impact of the legacy aged caseload.

We ended the year with 104 open cases over one year old (91 at the end of 2024/25). Of these, 37% are at post case examiner stage, meaning they are being prepared for disclosure, listed for hearing, or are awaiting a hearing date.

Including case examiner decisions, we ended the year with a 79-week median closure rate (71 weeks in 2024/25).

Hearings

During the reporting period, the hearings team continued to deliver timely and effective hearings, supporting both remote and in-person events. We scheduled 339 hearing days, concluding 37 substantive hearings. 78% of cases were listed within 30 weeks of referral (71% in 2024/25), demonstrating sustained progress in timeliness, while 89% of hearings concluded at the first scheduled sitting, reflecting strong case preparation and effective case management.

In addition to substantive hearings, we also supported 90 non-substantive hearings, including interim order applications, interim order review hearings, and registration appeal and restoration hearings.

93% of hearings were conducted remotely, enabling flexible access while maintaining fairness.

Section 3: Our Finance Report

Financial Review of the Year Ended 31 March 2026

Section 32 (2) of the Opticians Act 1989 provides that *'the accounts for each financial year of the Council shall be audited by auditors to be appointed by them and shall as soon as may be after they have been audited be published and laid before Parliament'.* Council prepares an annual financial report which identifies its financial position and is submitted to the government for scrutiny.

The Audit, Risk and Finance Committee (ARC) met six times this year, focusing on audit and risk at three meetings and on finance at the other meetings. The committee reviewed the systems of Council's internal financial controls and received an annual report from the internal and external auditors. It also reviewed financial performance, operational and compliance controls, and risk management.

2025/26 was the first year of the current five-year strategic plan in which business-as-usual surpluses and deficits are managed across the full strategic period. This has enabled a more effective cross-year approach to financial planning. The year began with a budgeted business-as-usual deficit of £0.1m and included plans to invest a further £0.8m from designated reserves, resulting in a planned net deficit of £0.5m. Actual performance was £1.1m better than budget. The principal driver of this favourable variance was a £0.5m increase in net gains on investments, reflecting favourable market conditions during the earlier part of the year. The outturn also benefited from increased income, including higher-than-expected interest income due to elevated interest rates, and savings across several business-as-usual cost areas. These were partially offset by additional costs arising from the delay to the future office accommodation project into 2025/26. Overall, financial performance for the year, measured by net income, was a surplus of £0.7m.

Income for the year was £12.6m (2024/25 £12.2m); £12.1m (2024/25 £11.7m) was related to annual renewal fees. During the year we incurred £12.9m expenditure (2024/25 £13.1m).

We continue to maintain a robust position regarding cash resources and investments, so the trustees have a reasonable expectation that there are adequate resources to continue in operational existence for the foreseeable future as a going concern.

Reserves policy

Council is responsible for making judgments about the appropriate level of reserves for the organisation to hold. This is to ensure that there is a prudent level of reserves to provide for unexpected variations in spending or income patterns or to fund exceptional future spending. Council will review these reserves at least annually, at

the time of setting the budget for each financial year in consultation with the Audit, Risk and Finance Committee and the Investment Committee.

The reserves policy was fully reviewed and updated during 2025/26, to support the realisation of our five-year corporate strategy.

All our reserves are unrestricted and as of 31 March 2026, the total reserves were £8.7m (2024/25 £8.0m). The target range for non-designated funds as per the reserves policy ranges from £2.3m to £4.3m. As of 31 March 2026, total non-designated funds net of tangible fixed assets was within this range at £3.9m (2024/25 £3.0m).

In setting the reserves policy, the Council has identified four designated reserves; complex cases legal reserve, strategic, research and special projects reserve, infrastructure/ dilapidation reserve, and deferred expenditure reserve. The complex cases legal reserve (£0.7m) is to provide for unforeseen and unbudgeted legal costs arising from complex fitness to practise cases. The strategic, research and special projects reserve (£3.0m) supports the investment in strategic and special projects, research and/or initiatives which facilitate the successful realisation of GOC's strategic plan. The infrastructure/dilapidation reserve (£0.6m) is designed to support the cost of exiting our current premises including dilapidation and reinstatement costs in accordance with the terms of our lease. The latest update of reserves policy introduced deferred expenditure reserve (£0.01m) to ringfence approved business as usual budget that have been deferred for operational reasons or run over multiple years.

During the year, £0.4m (2024/25 £1.2m) was spent from the strategic, research and special projects reserve for strategic projects. Those strategic projects are the education strategic review (ESR), employment status project, thematic review, unfair outcomes EDI report, arrears on pay project, and depreciation of capital projects, Several of these projects are multi-year programmes of work. All strategic projects are designed to bring long-term benefits to the organisation.

£0.4m expenditure was spent from the infrastructure and dilapidation reserve for the future office accommodation project. The project largely completed in 2025/26 with smaller level of work still outstanding.

£0.03m expenses were identified as complex legal costs during the year and funded through the complex cases legal reserve.

The reserves policy is revised every three years, to enable us to manage financial risks and create capacity for long term strategic projects. We maintain reserves at an appropriate level according to the Charity Commission guidelines.

Investment policy

The working capital policy recognises that all deposits must be secure, liquid and not exposed to currency risk. The investment policy statement recognises the additional needs of the GOC, as we seek to ensure that funds provide reasonable returns

within acceptable risk profiles. The Investment Policy was approved by Council in March 2023 and annually reviewed by the Investment Committee. The last review was in December 2024.

Trustees have wide powers of investment outlined in the Trustee Act 2000, which includes the power to delegate some responsibilities to an investment manager. We have appointed Brewin Dolphin as investment advisers to ensure we can make best use of the proceeds to meet our strategic aims and for future financial stability. The investment officer (Director of Corporate Services) continues to manage the short-term cash reserve and liaise with the investment managers in respect of the investment strategy.

Statement of Trustees' Responsibilities

The trustees are responsible for preparing the trustees' report and the financial statements in accordance with applicable law and United Kingdom Generally Accepted Accounting Practice (United Kingdom accounting standards), including Financial Reporting Standard 102, the financial reporting standard applicable in the UK and Republic of Ireland.

The law applicable to charities in England and Wales requires the trustees to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the charity and of the income and expenditure of the charity for that period. In preparing these financial statements, the trustees are required to:

- Select suitable accounting policies and then apply them consistently;
- Observe the methods and principles of the Charities Act;
- Make judgements and estimates that are reasonable and prudent;
- State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements; and
- Prepare the financial statements on the going concern basis, unless it is inappropriate to assume that the charitable company will continue on that basis.

The trustees are responsible for keeping adequate accounting records that are sufficient to show and explain the charity's transactions, disclose with reasonable accuracy at any time the financial position of the charity and enable them to ensure that the financial statements comply with the Charities Act 2011, the Charities (Accounts and Reports) Regulations 2008 and the provisions of the charity's constitution. They are also responsible for safeguarding the assets of the charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The trustees are responsible for the maintenance and integrity of the charity and the financial information included on the charity's website. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Each of the trustees, who held office at the date of approval of this trustees' report, has confirmed that there is no information of which they are aware which is relevant

to the audit but of which the auditor is unaware. They have further confirmed that they have taken appropriate steps to identify such relevant information and to establish that the auditors are made aware of such information.

Approved by the trustees on DATE, and signed on their behalf by

Dr Anne Wright CBE
Chair, GOC

Independent Auditors Report to the Trustees of General Optical Council

Statement of Financial Activities for the Year Ended 31 March 2026

	Notes	Unrestricted Funds £'000	Total 2025/26 £'000	Total 2024/25 £'000
Income from:				
Charitable activities	4	12,129	12,129	11,699
Investments	5	479	479	478
Total		**12,608**	**12,608**	**12,177**
Expenditure on:				
Raising Funds	12	49	49	48
Charitable activities	6	12,835	12,835	13,062
Total resources expended		**12,884**	**12,884**	**13,110**
Net (expenditure)/income before gains and losses on investments		**(276)**	**(276)**	**(933)**
Net gains/(losses) on investments	12	936	936	193
Net Income / (expenditure)		**660**	**660**	**(740)**
Reconciliation of funds:				
Total funds brought forward		7,995	7,995	8,735
Total funds carried forward		**8,655**	**8,655**	**7,995**

There are no recognised gains or losses other than those recognised above. All activities are continuing.
All the transactions in 2025-26 and 2024-25 were unrestricted.
The notes on pages xx to xx form part of these financial statements.

Balance Sheet for the Year Ended 31 March 2026

	Notes	2025/26 £'000	2024/25 £'000
Fixed assets:			
Tangible fixed assets	11	439	381
Investments	12	10,302	9,414
Total fixed assets		**10,741**	**9,795**
Current assets:			
Debtors	13	757	765
Short term deposits		9,400	8,950
Cash at bank and in hand		883	1,557
Total current assets		**11,040**	**11,272**
Current liabilities:			
Creditors: amounts falling due within one year	14	(13,126)	(13,072)
Net current liabilities		**(2,086)**	**(1,800)**
Total assets less current liabilities		**8,655**	**7,995**
Net assets		**8,655**	**7,995**
Represented by:			
Unrestricted funds:			
Designated funds	16	4,329	4,650
General funds	16	4,326	3,345
Total funds		**8,655**	**7,995**

The notes on pages xx to xx form part of these financial statements.
The financial statements were approved and authorised by the Council on DATE and were signed on its behalf by:

Dr Anne Wright CBE
Chair, GOC

Cash Flow Statement for the Year Ended 31 March 2026

	2025/26 £'000	2024/25 £'000
Cash flows from operating activities:		
Reconciliation of net (expenditure) / income to net cash flow from operating activities:		
Net income / expenditure for the reporting period (as per the statement of financial activities)	660	(740)
Depreciation	209	279
Loss on disposal of fixed assets	29	61
(Gains) / losses on investment income	(936)	(193)
Dividends, interest and rents from investments	(479)	(478)
Decrease / (Increase) in debtors	9	(91)
Increase/ (decrease) in creditors	53	941
Net cash provided by (used in) operating activities	**(454)**	**(221)**
Cash flows from investing activities:		
Dividends, interest and rents from investments	479	478
Purchase of tangible fixed assets	(296)	(377)
Proceeds from sale of investments	2,306	2,305
Movement in short term deposit account (more than three months)	(450)	(1,500)
Movement in Cash held in investment	13	39
Purchase of Investments	(2,272)	(2,298)
Net cash provided by (used in) investing activities	**(220)**	**(1,353)**
Change in cash and cash equivalents in the reporting period	**(674)**	**(1,574)**
Cash and cash equivalents at the beginning of the reporting period	1,557	3,131
Cash and cash equivalents at the end of the reporting period	**883**	**1,557**
Cash and cash equivalents at the end of the reporting period		
Cash at bank and in hand	**883**	**1,557**

The notes on pages xx to xx form part of these financial statements.

Notes to the Financial Accounts for the Year Ended 31 March 2026

1. GENERAL INFORMATION

The GOC is constituted as a body corporate under the Opticians Act 1989, as updated by amending legislation which came into effect on 30 June 2005. We are also registered as a charity by the Charity Commission in England and Wales (registered charity number 1150137). Our registered office is at Level 29, One Canada Square, London, E14 5AA

2. ACCOUNTING POLICIES

The principal accounting policies adopted, judgements and key sources of estimation uncertainty in the preparation of the financial statements are as follows:

The financial statements have been prepared in accordance with accounting and reporting by Charities SORP, applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102, effective 1 January 2019), Charities SORP FRS 102, and the Charities Act 2011.

We are required to submit the accounts to the Privy Council who lay them before Parliament.

The GOC meets the definition of a public benefit entity under FRS 102.

3. JUDGMENTS IN APPLYING ACCOUNTING POLICIES AND KEY SOURCES OF ESTIMATION UNCERTAINTY

Estimates and judgements are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. Although these estimates are based on management’s best knowledge of the amount, events or actions, actual results may ultimately differ from those estimates. The trustees consider the following item to be an area subject to estimation and judgement.

Depreciation:
The useful economic lives of tangible fixed assets are based on management's judgement and experience. When management identifies that actual useful economic lives differ materially from the estimates used to calculate depreciation, that charge is adjusted retrospectively. As tangible fixed assets are not significant, variances between actual and estimated useful economic lives will not have a material impact on the operating results. Historically no changes have been required.

i. GOING CONCERN

The trustees (Council members) consider there are no material uncertainties about the charity’s ability to continue as a going concern.

With respect to the next reporting period, 2026/27, the most significant area of uncertainty relates to the continued volatility of market values of investments where majority of our reserves are held. The short to mid-term outlook for financial markets may create a risk to our ambitious performance plans, although our budget for 2026-27 and anticipated registrant fee income indicates that we will have sufficient funds to deliver our regulatory functions and business plan. In reviewing our financial position, reserve levels and future plans, Council members' have confidence that the charity remains a going concern. The financial statements have been prepared on a going concern basis.

ii. **INCOME**

All income is recognised once the charity has entitlement to income, it is probable that income will be received, and the amount of income receivable can be measured reliably.

Our income mainly comprises fees from registered optometrists, dispensing opticians and bodies corporate. Fees charged for annual retention are payable in advance between January and March each year and are recognised in the period to which they relate.

We also receive registration fees from students, which are payable for the year or period ending 31 August in line with the academic year and credited in the accounts for the year to which they relate.

Investment income is recognised when interest or dividends fell due and is stated gross of recoverable tax.

Sales and other income are recognised when the related goods or services are provided.

iii. **EXPENDITURE**

Resources are expended directly in pursuit and support of the charitable aims of the organisation. Expenditure on charitable activities comprises of Fitness to Practise, legal compliance, registration and education and standards related cost. Expenditure is recognised on an accruals basis as a liability is incurred.

Expenditure is allocated to a particular activity where the cost relates directly to that activity. However, the cost of overall direction and administration of each activity is apportioned based on staff time attributable to each activity.

Support costs include governance costs and other support costs. Governance costs include those incurred in the governance of the organisation and its assets and are primarily associated with constitutional and statutory requirements. Costs include direct costs of external audit, legal fees and other professional advice.

Support costs have been apportioned between all activities based on staff head counts. The allocation of support and governance costs is analysed in table six below.

Resources expended are included in the statement of financial activities on an accrual's basis. All liabilities are recognised as soon as there is a legal or constructive obligation committing the charity to expenditure.

iv. **FIXED ASSETS**

Tangible fixed assets are stated at cost, net of depreciation.

Expenditure is capitalised where the cost of the asset, or group of assets, exceeds £1,000.

The website development project costs are capitalised as a fixed asset only where they lead to the creation of an enduring asset delivering tangible future benefits whose value is at least as great as the amount capitalised.

An impairment review is undertaken of the net asset value of the website at each balance sheet date. Expenditure to maintain or operate the development website is charged to the statement of financial activities.

v. **DEPRECIATION**

Assets are depreciated in equal instalments over the following periods:

IT equipment	3 years
Website/intranet/online renewal	3 years
Office furniture and equipment	10 years
Leasehold improvements (office fit-out) Over the lease term	

Depreciation is provided to write off the cost, less residual value, of the assets evenly over their estimated useful lives.

vi. **INVESTMENTS**

Investments are a form of basic financial instruments and are initially shown in the financial statements at their transaction value and subsequently measured at their fair value as at the balance sheet date. Movements in the fair values of investments are shown as unrealised gains and losses in the statement of financial activities.

Investments comprise shares, funds, cash, or deposits held as investments. The investments are limited to cash in instant access or term deposits and permitted investments in line with the investment policy approved by Council in December 2024.

vii. **FINANCIAL INSTRUMENTS**

The Charity only has financial assets and financial liabilities of a kind that qualify as basic financial instruments. Basic financial instruments are

initially recognised at transaction value and subsequently measured at their settlement value.

viii. **DEBTORS**

Trade and other debtors are recognised at the settlement amount due after any trade discount offered. Prepayments are valued at the amount prepaid net of any trade discounts due.

ix. **CASH AT BANK AND IN HAND**

Cash at bank and in hand includes cash and short-term highly liquid investments with a short maturity of three months or less from the date of acquisition or opening of the deposit or similar account.

x. **CREDITORS AND PROVISIONS FOR LIABILITIES**

Creditors and provisions are recognised when the charity has a present legal or constructive obligation as a result of a past event. They are recognised when it is probable that a transfer of economic benefit will be required to settle the obligation and a reliable estimate can be made of the obligation.

Where a present obligation exists for FTP cases as a result of a past event and estimate can be made of the obligation, then this is provided for. The accuracy of the provision will depend on the assumptions made about the progress of individual cases and is subjected to a significant degree of uncertainty.

xi. **FUNDS AND RESERVES**

All of our funds are unrestricted and can be expended at our discretion to help deliver our objectives.

We have set designated funds aside as follows:

- Complex cases legal costs reserve – established to provide for unforeseen and unbudgeted legal costs arising from complex fitness to practice cases.
- Strategic, research, and special projects reserve – established to support investment of strategic and special projects, research and/or initiatives which facilitate the successful realisation of the GOC's strategic plan.
- Infrastructure & dilapidations reserve – established to support the costs of our current premises including dilapidation and reinstatement costs.
- Deferred expenditure reserve – established ringfence approved business as usual budget for the delivery of one-off or cyclical projects that have been deferred for operational reasons or run over multiple years.

xii. **TAXATION**

We are not registered for VAT and VAT on expenditure is expensed as part of the cost of the goods or services supplied.

xiii. **OPERATING LEASES**

The annual rentals are charged to the statement of financial activities over the term of the lease.

xiv. **EMPLOYEE BENEFITS**

Short-term benefits - Short-term benefits, including holiday pay, are recognised as an expense in the period in which the service is received.

Employee termination benefits - Termination benefits are accounted for on an accrual basis and in line with FRS 102.

Pension scheme - Council contributes to a defined contribution pension scheme for the benefit of its employees under an auto-enrolment scheme, the assets of which are administered by Royal London, the pension scheme used for GOC staff, and Smart Pensions for members who were identified as workers.

The assets of the schemes are held independently from those of the Charity in an independently administered fund. The pensions costs charged in the financial statements represent the contributions payable during the year.

	2025/26 £'000	2024/25 £'000
4.Income from charitable activities		
Registration and renewal fee	12,113	11,672
Continuing Education Training provider	16	27
Total	**12,129**	**11,699**

	2025/26 £'000	2024/25 £'000
5. Income from Investment		
Interest from fixed deposits	217	252
Dividend income	262	226
Total	**479**	**478**

6. Charitable activities	Direct Cost £'000	Support Cost £'000	Total 2025/26 £'000
Fitness to practise (Note 6a.)	4,724	2,890	7,614
Registration	830	759	1,589
Education	1,254	858	2,112
Policy & standards	481	323	804
Communications	394	322	716
Total	**7,683**	**5,152**	**12,835**

Comparative figures below:

6. Charitable activities	Direct Cost £'000	Support Cost £'000	Total 2024/25 £'000
Fitness to practise (Note 6a.)	5,233	2,135	7,368
Registration	958	743	1,701
Education	1,490	897	2,387
Policy & standards	629	333	962
Communications	371	274	645
Total	**8,681**	**4,381**	**13,063**

The following table analyses the Fitness to Practise costs:

6a. Fitness to practise including Legal compliance	2025/26 £'000	2024/25 £'000
Legal fees on investigations	403	549
Other investigation costs	2,237	2,245
Hearing costs	1,535	1,886
Dispute mediation	282	275
Legal compliance	267	278
Support costs	2,890	2,136
Total	**7,614**	**7,369**

7. Support costs	Management £'000	Governance £'000	Facilities £'000	HR £'000	Finance £'000	People & Improvement £'000	IT £'000	2025/26 Total £'000
Fitness to practise	152	458	617	468	277	113	805	2,890
Registration	40	120	162	123	73	29	212	759
Education	45	136	183	139	82	34	239	858
Policy & Standards	17	51	69	52	31	13	90	323
Communications	17	51	69	52	31	12	90	322
Total	**271**	**816**	**1,100**	**834**	**494**	**201**	**1,436**	**5,152**

Comparative figures below:

7. Support costs	Management £'000	Governance £'000	Facilities £'000	HR £'000	Finance £'000	IT £'000	2024/25 Total £'000
Fitness to practise	78	390	481	359	255	572	2,135
Registration	27	136	167	125	89	199	743
Education	33	164	202	151	107	240	897
Policy & Standards	12	61	75	56	40	89	333
Communications	10	50	62	46	33	73	274
Total	**160**	**801**	**987**	**737**	**524**	**1,173**	**4,382**

People & Improvement is a new category of support costs, supporting continuous improvement, and transformation to ensure the organisation operates efficiently and delivers its regulatory objectives.

Governance cost includes fees and expenditure incurred in relation to Council and the committees, external and internal audit fees and staff cost related to supporting the governance activities. Support cost is allocated to different activities on the basis of staff numbers.

The details of the governance cost included under support cost are as follows. Members' fees and expenses include Council (trustees) and committee members costs.

Governance costs	2025/26 £'000	2024/25 £'000
Members' fees and expenses	254	243
Staff cost	462	438
External audit fees	30	28
Internal audit fees	29	28
Other governance cost	41	64
Total	**816**	**801**

8. Net income for the year are stated after charging:	2025/26 £'000	2024/25 £'000
Fees paid to external auditors - haysmacintyre:		
external audit fee	30	28
taxation advice	-	3
Internal audit fees	29	28
Depreciation of fixed assets	209	279

9. Employment costs	Staff Cost £'000	Worker Cost £'000	2025/26 Total £'000	2024/25 Total £'000
Staff employment costs:				
Salaries / Fees	6,133	643	6,776	6,455
Settlements	-	-	-	70
Redundancy	-	-	-	14
National insurance	738	8	746	612
Pension costs	538	9	547	693
Total	**7,409**	**660**	**8,069**	**7,845**

Average number of staff	2025/26	2024/25
Chief Executive's office	1	1
Management team	4	4
Fitness to practise	43	39
Registration	11	11

Strategy	23	23
Governance, compliance, performance reporting	7	8
Corporate services (Facilities, HR, Finance, IT)	24	20
People & Improvement	2	-
Change	-	6
Total	**115**	**112**

People and Improvement is a newly created directorate.

The number of staff whose taxable emoluments fell into higher salary bands was:

	2025/26	**2024/25**
£60,000 but under £70,000	9	7
£70,000 but under £80,000	9	6
£80,000 but under £90,000	2	1
£90,000 but under £100,000	1	0
£100,000 but under £110,000	2	4
£120,000 but under £130,000	0	1
£130,000 but under £140,000	2	1
£140,000 but under £150,000	1	0
£150,000 but under £160,000	0	1
£180,000 but under £190,000	1	0

During the year, Council paid £218,225 for twenty-seven members of staff in this category (2024/25 £178,498 for twenty-one members of staff) to a defined contribution pension scheme. The trustees (Council members) consider the SMT (see page xx, REFERENCE AND ADMINISTRATIVE DETAIL) to be key management personnel.

The trustees are also paid fees and reimbursed expenses for their travel and subsistence. The details are in table ten. No amounts are paid directly to third parties that are not already disclosed in table ten.

Remuneration and benefits received by key management personnel (SMT) are as follows:

Key management personnel	**2025/26 £'000**	**2024/25 £'000**
Gross Pay	693	625
Employer national insurance contributions	86	66
Employer pension contributions	63	62
Benefits	2	3
Total	**844**	**756**

10. Trustees' expenses	Fees £	Expenses £	2025/26 Total £
Lisa Gerson	13,962	-	13,962
Tim Parkinson	16,462	568	17,030
Anne Wright	50,000	-	50,000
Frank Munro	13,962	653	14,615
Ken Gill*	5,487	-	5,487
William Stockdale	13,962	1,208	15,170
Hema Radhakrishnan	13,962	438	14,400
Kathryn Foreman	13,962	161	14,123
Raymond Curran**	13,962	602	14,564
Catherine Yelf**	13,962	-	13,962
Ros Levenson**	13,962	29	13,991
Poonam Sharma**	13,962	-	13,962
Kalwant Grewal**	2,327	-	2,327
Total	**199,934**	**3,659**	**203,593**

Number of trustees	**12**

* Retired during the year
** Appointed during the year.

Comparative figures below.

10. Trustees' expenses	Fees £	Expenses £	2024/25 Total £
Lisa Gerson	13,962	-	13,962
Sinead Burns*	6,981	503	7,484
Claire Minchington	16,462	101	16,563
Roshni Samra	13,962	93	14,055
Josie Forte	13,962	-	13,962
Tim Parkinson	13,962	227	14,189
Anne Wright	50,000	-	50,000
Mike Galvin	13,962	-	13,962
Frank Munro	13,962	628	14,590
Ken Gill	13,962	229	14,191
William Stockdale	13,962	-	13,962
Hema Radhakrishnan	13,962	-	13,962
Kathryn Foreman**	6,981	-	6,981
Total	**206,082**	**1,781**	**207,863**

Number of trustees	**12**

Opticians Act 1989, schedule 1 of the act, paragraph 11 (2) b allows us to pay fees to trustees for attending Council meetings.

11. Tangible fixed assets	Office furniture and equipment £'000	IT hardware £'000	IT software £'000	Capital work-in progress £'000	Total £'000
Cost as at 1 April 2025	7	476	1,750	26	2,260
Add: Cost of additions	-	103		194	296
Less: Disposals	-	-	(29)		(29)
Transfers	-	-	100	(100)	-
Total at 31 March 2025	**7**	**579**	**1,820**	**120**	**2,527**
Less: Depreciation As at 1 April 2025	(5)	(334)	(1,539)	-	(1,878)
Charged in the year	(1)	(94)	(114)	-	(209)
Disposals				-	-
Total at 31 March 2025	**(6)**	**(428)**	**(1,653)**	**-**	**(2,088)**
Net book value 31 March 2026	**1**	**151**	**167**	**120**	**439**
Net Book Value 31 March 2025	*2*	*142*	*211*	*26*	*381*

In 2024/25, the above table included assets relating to refurbishment with a net book value of £nil. This comprised refurbishment costs of £1.025m, offset by an equivalent depreciation provision. These assets have not been excluded from the table this year as they were fully written off in 2024/25 following the office move to a new location that provided fully refurbished premises.

12. Investment	2025/26 £'000	2024/25 £'000
Investments b/f	9,327	9,141
Additions	2,272	2,298
Disposals	(2,306)	(2,305)
Realised gains	323	86
Unrealised gains/ (losses)	613	107
Investments c/f	10,229	9,327
Cash	73	86
Total portfolio	**10,302**	**9,413**

Total portfolio includes cash held with equity managers. During the year £49,238 (2024/25 £47,337) was incurred as investment management fees and has been disclosed on the Statement of Financial Activities as Raising Funds.

	2025/26 £'000	2024/25 £'000
13. Debtors		
Prepayments	361	528
Other debtors	17	19
Accrued income	298	218
Refundable deposit	81	-
Total	**757**	**765**

The refundable deposit paid to the management of the new office premises is receivable at the end of the tenancy period.

	2025/26 £'000	2024/25 £'000
14. Creditors: Amounts falling due within one year		
Trade creditors	8	91
Deferred income (note 14a)	11,976	11,378
Accruals	915	753
Other tax and social security	189	193
Provisions	-	529
Other creditors	38	128
Total	**13,126**	**13,072**

	2025/26 £'000	2024/25 £'000
14a. Deferred income		
At 1 April	11,378	10,931
Amount deferred during the year	12,063	11,484
Amount released to Statement of Financial Activities	(11,465)	(11,037)
Total	**11,976**	**11,378**

Income from registrant renewal fees received in advance is deferred and will be released as income in 2026/27.

	2025/26 £'000	2024/25 £'000
15. Financial Instruments		
Financial assets measured at fair value	10,302	9,414
Financial assets measured at amortised cost	10,679	10,745
Financial liabilities measured at amortised cost	(1,149)	(1,694)
Net financial assets measured at amortised cost	**19,832**	**18,465**

(a) Financial assets measured at fair value include investments.
(b) Financial assets measured at amortised cost include short term deposits and cash in hand, trade debtors, other debtors, and accrued income.
(c) Financial liabilities measured at amortised cost include trade creditors, other creditors, and accruals.

	2025	Income	Expenditure	Transfers / gain / loss	2026
	£'000	£'000	£'000	£'000	£'000
16. Funds					
Unrestricted funds					
Designated funds					
Legal cost reserve	613	-	(30)	117	700
Strategic reserve	3,000	-	(438)	438	3,000
Dererred Projects reserve	-	-	-	11	11
Infrastructure/dilapidations reserve	1,036	-	(408)	(10)	618
Total designated funds	**4,649**	**-**	**(876)**	**556**	**4,329**
General funds					
Income and expenditure reserve	3,345	12,608	(12,008)	380	4,326
Total funds	**7,995**	**12,608**	**(12,884)**	**936**	**8,655**

Comparative figures below.

	2024	Income	Expenditure	Transfers / gain / loss	2025
	£'000	£'000	£'000	£'000	£'000
16. Funds					
Unrestricted funds					
Designated funds					
Legal cost reserve	700	-	(87)	-	613
Strategic reserve	2,596	-	(879)	1,283	3,000

Infrastructure/dilapidations reserve	1,250	-	(214)	-	1,036
Total designated funds	**4,546**	**-**	**(1,179)**	**1,283**	**4,650**
General funds					
Income and expenditure reserve	4,189	12,177	(11,931)	(1,090)	3,345
Total funds	**8,735**	**12,177**	**(13,110)**	**193**	**7,995**

All the reserves are unrestricted. The complex cases legal reserve is to provide for unforeseen and unbudgeted legal costs arising from complex fitness to practise cases. The strategic, research and special projects reserve is held to support the investment in strategic and special projects, research and/or initiatives which facilitate the successful realisation of GOC's strategic plan. Infrastructure/dilapidations reserve is to support the cost of exiting our current premises including dilapidation and reinstatement costs in accordance with the terms of our lease.

During the year, £30k funds from the Complex cases legal reserve was used for complex legal costs related to case progression and hearings. A total of £438k spent on strategic projects were funded through the Strategic, research and special projects reserve. The infrastructure and dilapidation reserve funded a £408k towards the Future office accommodation project. £11k delays in business-as-usual projects were identified to be transferred to the new Deferred expenditure reserve.

At the end of the year, funds from the general reserve were transferred to increase Complex cases legal reserve to £700k, and Strategic, research and special projects reserve to £3,000k, enabling funding for projects in future years, A £10k was transferred to general reserve from the Infrastructure/dilapidations reserve to maintain adequate reserves for future.

17. Analysis of net assets by fund	**Unrestricted funds £'000**	**Total 2025/26 £'000**	**Total 2024/25 £'000**
Tangible fixed assets	439	439	381
Investments	10,302	10,302	9,414
Current assets	11,040	11,040	11,272
Current liabilities	(13,126)	(13,126)	(13,072)
Total net assets	**8,655**	**8,655**	**7,995**

18. Pension commitments

We operate defined contribution auto-enrolment pension schemes on behalf of employees and workers. The assets of these schemes are held separately from those of Council in independently administered funds. The total expense incurred during the year was £546,799 (2024/25 £693,300). There were £11,967 in outstanding contributions in 2025/26, (2024/25 £84,470) included in the balance sheet.

19. Commitments under operating leases

On 31 March 2026, the charity had the following future lease payments under operating leases.

Land and buildings	2025/26 £'000	2024/25 £'000
Within one year	287	237
In two to five years inclusive	937	1,198
Over five years	-	62

Office Equipment lease	2025/26 £'000	2024/25 £'000
Within one year	8	8
In two to five years inclusive	21	29

The total charge of all operating leases to the statement of financial activities as of 31 March 2026 was £220,048 (2024/25 £381,113).

20. Related party transactions

During the year, members of Council receive fees and related expenditure through Council payroll (refer to table ten for details).

There were no related party transactions in the current year.

21. Analysis of changes in net debt	At 1 April 2025 £'000	Cash flows £'000	At 31 March 2026 £'000
Cash and cash equivalents			
Cash	1,557	(674)	883
Cash equivalents	8,950	450	9,400
Total	**10,507**	**(224)**	**10,283**

C37(26) ANNEX TWO

TO BE TYPED ON CLIENT LETTERHEAD

HaysMac LLP
10 Queen Street Place
London
EC4R 1AG

Date:

Dear Sirs

During the course of your audit of our financial statements for the year ended 31 March 2026, the following representations were made to you by management and trustees of the charity, and on behalf of the General Optical Council.

1 We have fulfilled our responsibilities as trustees under the Charities Act 2011 ("the Act") for preparing financial statements, in accordance with FRS102 and the Act, that give a true and fair view and for making accurate representations to you as auditors.

2 We confirm that all accounting records have been made available to you for the purpose of your audit, in accordance with your terms of engagement, and that all the transactions undertaken by the charity have been properly reflected and recorded in the accounting records. All other records and related information, including minutes of all management and trustees' meetings, have been made available to you. We have given you unrestricted access to persons within the charity in order to obtain audit evidence and have provided any additional information that you have requested for the purposes of your audit.

3 We confirm that the methods, significant assumptions and source data used by us in making accounting estimates and their related disclosures are appropriate to ensure compliance with the recognition, measurement and disclosure requirements of FRS102.

4 We confirm that all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to the auditor and accounted for and disclosed in accordance with FRS102 and the Act.

5 We confirm that we have informed you of the details of all correspondence with the charity's regulators during the year and, in particular, the details of all Serious Incident Reports that we have made to the Charity Commission/OSCR.

6 We confirm that there have been no events since the balance sheet date which require disclosing or which would materially affect the amounts in the accounts, other than those already disclosed or included in the accounts.

7 We confirm that we are aware of the definition of a related party set out in FRS102. We confirm that the related party forms have been completed by all trustees and made available to you as part of the audit.

8 We confirm that the related party relationships and transactions set out in the declarations provided to you are a complete list of such relationships and transactions and that we are not aware of any further related parties or transactions and the transactions have been accounted for and disclosed in accordance with FRS102 and the Act.

9 We confirm that the financial statements correctly disclose the Trustees' remuneration and reimbursement of expenses, and are drawn up in accordance with the Statement of Recommended Practice *Accounting and Reporting by Charities*.

10 We confirm that the charity has not contracted for any capital expenditure other than as disclosed in the financial statements.

11 We confirm that we are not aware of any possible or actual instance of non-compliance with those laws and regulations which provide a legal framework within which the charity conducts its business and which are central to the charity's ability to conduct its business.

12 We acknowledge our responsibility for the design and implementation of controls to prevent and detect fraud. We confirm that we have provided you with the latest copy of our risk assessment. We confirm that we have considered the risk of fraud and disclosed to you any actual or suspected instances of fraud involving management or employees who have a significant role in internal control or that could have a material effect on the financial statements. We also confirm that we are not aware of any allegations of fraud by former employees, regulators or others.

13 We confirm that we have reviewed the control procedures governing payments to overseas territories and that the charity has conducted appropriate due diligence procedures to ensure that such payments are used in accordance with the purposes for which they were given.

14 We confirm that, having considered our expectations and intentions for the next twelve months and the availability of working capital, the charity is a going concern.

15 We confirm that in our opinion the effects of unadjusted misstatements as listed in the Audit Findings Report are immaterial, both individually and in aggregate, to the financial statements as a whole.

16 All grants, donations and other incoming resources, receipt of which is subject to specific terms or conditions, have been notified to you. There have been no breaches of terms and conditions in the application of such incoming resources.

17 We confirm that there is no audit information of which you as auditors are unaware, and that each trustee has taken steps to make themselves aware of any relevant information and to establish that you are aware of that information.

We confirm that the above representations are made on the basis of enquiries of management and staff with relevant knowledge and expertise (and, where appropriate, of supporting documentation) sufficient to satisfy ourselves that we can properly make these representations to you and that to the best of our knowledge and belief they accurately reflect the representations made to you by the trustees during the course of your audit.

Yours faithfully
Signed on behalf of the Board of Trustees by:

……..
Dr Anne Wright CBE
Chair of Council

C39(26)

COUNCIL

General Optical Council

Equality, Diversity and Inclusion Annual Report 2025-26 and Equality, Diversity and Inclusion Annual Monitoring Report 2025-26

Meeting: 30 September 2026 **Status:** For decision

Lead responsibility: Andy Mackay Sim (Chief of Staff)
Paper Author(s): Joanna Murphy (EDI Manager)
Council Lead(s): There is no Council lead for this work.

Purpose

1. To enable Council to review and approve the Equality, Diversity and Inclusion (EDI) Annual Report 2025-26 and Equality, Diversity and Inclusion Annual Monitoring Report 2025-26 for publication.

Recommendations

2. Council is asked to:
   - approve the EDI Annual Report 2025-26 (annex one);
   - approve EDI Annual Monitoring Report 2025-26 (annex two);
   - note the progress reported against the General Optical Council's EDI Strategy 2025-2030 and EDI Action Plan during 2025-26; and
   - delegate authority to the Chief Executive and Registrar to approve any minor factual amendments prior to publication.

Strategic objective

3. This work contributes to all three of the GOC's strategic objectives and demonstrates progress against the EDI Strategy 2025-2030 and associated EDI Action Plan.

Background

4. The General Optical Council (GOC), as a public body, is required to comply with the Public Sector Equality Duty under the Equality Act 2010. This includes having due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different groups.

5. The GOC publishes annual equality information to demonstrate transparency, monitor progress and meet its statutory obligations. The attached reports provide an overview of activity undertaken during 2025-26 and analysis of equality monitoring data as of 31 March 2026.

6. The EDI Annual Report outlines progress made during the first year of delivery of the GOC's Equality, Diversity and Inclusion Strategy 2025-2030. The EDI Monitoring

Report provides analysis of diversity data relating to registrants, fitness to practise activity, employees, members and workers.

7. The reports were reviewed by the Senior Management Team in July 2026 and subsequently approved by the Chief Executive and Registrar for submission to Council.

Analysis

8. The EDI Annual Report demonstrates how EDI has continued to be embedded across the organisation's regulatory functions, culture and decision-making processes during 2025-26.

9. Key achievements highlighted within the report include:

- publication and implementation of the GOC EDI Strategy 2025-2030;
- commissioning independent analysis to better understand potential disproportionality within fitness to practise processes;
- continued development of accessibility and inclusive engagement across regulatory services and communications;
- strengthened use of registrant, patient and public insight to inform regulatory policy and practice;
- delivery of targeted EDI learning for decision-makers, leaders and staff;
- continued investment in staff networks, psychological safety and organisational culture.

10. The report also highlights findings from independent analysis of fitness to practise outcomes, which found little evidence of meaningful disproportionality within the most robust analytical models. The analysis also reinforced the importance of continuing to improve data quality, completeness and ongoing monitoring arrangements.

11. The report demonstrates a shift from building organisational awareness of EDI towards embedding EDI more systematically within governance, regulatory activity and organisational processes. It also highlights how EDI supports the delivery of the GOC's wider strategic objectives rather than operating as a standalone programme of work.

12. The accompanying EDI Annual Monitoring Report provides updated analysis across a range of protected and demographic characteristics. The report supports the GOC in understanding the diversity of those who interact with the organisation and identifying areas for further exploration and improvement.

13. Key themes emerging from the monitoring report include:

- continued improvement in the quality and completeness of EDI data, while recognising areas where further improvement is needed;
- analysis of workforce, registrant, employee and fitness to practise datasets to identify trends and patterns over time;
- increased organisational insight to support assurance around fairness, accessibility and inclusion;
- opportunities to strengthen future analysis through improved disclosure and data quality.

14. The reports also support compliance with Professional Standards Authority (PSA) Standard 3, which requires regulators to understand the diversity of those who interact with them and ensure that regulatory processes do not create inappropriate barriers or disadvantage people with protected characteristics.

15. For the fourth consecutive year, the GOC met all 18 PSA Standards of Good Regulation, including standards relating to equality, diversity and inclusion.

16. Together the reports provide assurance that the organisation is continuing to strengthen its approach to equality, diversity and inclusion through evidence, engagement, monitoring and continuous improvement.

Finance

17. EDI activity is factored into the GOC's budget planning and monitoring. The principal investment is the staffing costs for the EDI manager. This ensures subject-matter expertise is available to provide training and advice to the organisation without relying on external consultants. It also means that the EDI budget is a fixed annual cost. Council has chosen to supplement this with investments from reserves, including the commission of the unfair outcomes research in 2025/26.

Risks

18. There are no significant risks associated with approval of the reports. However, failure to continue delivery of the EDI Strategy and associated action plans may:
    - reduce the organisation's ability to demonstrate progress against its equality objectives and Public Sector Equality Duty obligations;
    - weaken assurance against PSA expectations relating to equality, diversity and inclusion;
    - create reputational risk if the organisation is unable to demonstrate how it uses evidence and insight to understand and address potential inequalities and barriers.

19. These risks are mitigated through established governance arrangements, regular reporting to the Senior Management Team and ongoing monitoring of delivery against the EDI Action Plan.

Equality Impacts

20. The report support compliance with the Equality Act 2010 and the Public Sector Equality Duty.

21. No new policy, process or operational change is being introduced through this paper and therefore an Equality Impact Assessment is not required;

22. The reports provide evidence of how equality considerations have been incorporated into both regulatory and organisational activities during the reporting period.

Devolved nations

23. The monitoring report includes analysis across the four nations where data is available.

24. The annual report will be translated into Welsh and published alongside the English version in accordance with the Welsh Language Standards. The report outlines activity undertaken during the year to support compliance with Welsh Language Standards.

Other Impacts

25. The reports support wider organisational objectives relating to fairness, accessibility, transparency, evidence-informed decision-making and public confidence in regulation. No additional impacts have been identified.

Communications

External communications

26. Subject to Council approval:
    - the EDI Annual Report 2025-26 and EDI Annual Monitoring Report 2025-26 will be published on the GOC website;
    - both reports will be available in English and Welsh;
    - publication will be supported through appropriate digital and stakeholder communications channels.

Internal communications

27. Following publication:
    - reports will be shared with colleagues through internal communication channels, including the newly developed quarterly EDI newsletter;
    - key messages and achievements will be highlighted to support awareness of progress and future priorities.

Next steps

28. Following Council approval:

- incorporate any final factual amendments;
- publish both reports on the GOC website in English and Welsh;
- communicate publication internally and externally;
- continue delivery and monitoring of the EDI Action Plan 2026-27;
- report progress through established governance arrangements and future annual reporting cycles.

Attachments

Annex 1: EDI Annual Report 2025-26
Annex 2: EDI Annual Monitoring Report 2025-26

General Optical Council
Equality, Diversity and Inclusion Annual Report 2025–26

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Introduction from the Chief Executive and Registrar

At the General Optical Council (GOC), equality, diversity and inclusion (EDI) are central to how we regulate, how we engage with those who use our services, and how we support our people. As the regulator for eye care services in the UK, the decisions we make, the standards we set and the way people experience our services all contribute to public confidence in our work. Embedding EDI into our regulatory approach supports fairness, consistency and accessibility across our organisation and the services we provide.

This report reflects a year of turning commitment into action. Across our regulatory work and organisational culture, we have continued to strengthen how fairness, accessibility and inclusion are considered in practice, while building the evidence, insight and confidence needed to support lasting change.

Over the past year, we have made encouraging progress. We have strengthened our understanding of fairness and inclusion through improved insight, engagement and assurance, including work to better understand potential unfair outcomes in our fitness to practise processes. We have also taken steps to improve accessibility and engagement, and to embed inclusive thinking more consistently within our policies and decision-making.

Internally, we have continued to focus on building an inclusive and confident culture, including strengthening our approach to psychological safety and speaking up. This includes progress in our Freedom to Speak Up work and the introduction of dedicated leadership to support this agenda. External feedback, including from the Professional Standards Authority, has provided useful assurance and reinforces the importance of continuing this work with care and consistency.

EDI is not a standalone initiative. It is an ongoing organisational responsibility that requires reflection, openness and a willingness to learn. The progress outlined in this report reflects the contribution of colleagues across the organisation, our staff networks, Council and committees, and the registrants and stakeholders who continue to engage with and shape this work.

While we have made encouraging progress, we know there is more to do. As we move forward, we remain committed to strengthening how we use evidence and insight to support fair, proportionate and inclusive regulation, and to building an organisation where people feel able to contribute and be heard.

“*During my time as an Associate, I have observed a genuine commitment from the GOC to fostering equality, diversity and inclusion across the organisation. There is a strong culture of respect and openness, where different perspectives are valued and individuals are encouraged to contribute authentically. I have also seen the organisation continue to*

strengthen its approach to EDI through ongoing conversations, learning opportunities, and a growing focus on ensuring that policies, practices and decision-making are inclusive and accessible. This commitment has helped create an environment where people feel supported, respected and able to thrive.

Former GOC Council Associate

Year at a glance

2025–26 has been a year of building foundations and moving into delivery.

Key developments included:

1. Fairness in fitness to practise
2. Accessibility and engagement
3. Inclusive recruitment review
4. Psychological safety and speaking up
5. EDI data and insight
6. Thomas Pocklington Trust internship partnership

Together these tell a strong story of fairer regulation, accessible services, inclusive people practices, organisational culture, evidence-led improvement and external impact.

Our ambition and direction

In 2025, we launched the GOC Equality, Diversity and Inclusion Strategy 2025–2030. The strategy sets out how we will improve fairness, accessibility, inclusion and confidence across our regulatory work and organisational culture over the next five years.

Our strategy is built around five strategic themes:

1. Data, insight and assurance
2. Learning, culture and confidence
3. Recruitment, progression and representation
4. Policies, guidance and inclusive practice
5. Networks, engagement and community

Through our strategy, we aim to enhance fairness, consistency and confidence in our regulatory processes and decision-making while building an inclusive organisational culture where people feel respected, supported and able to contribute.

This report supports that approach, showing the progress we have made this year and where we are continuing to build, test and learn.

A fair and inclusive experience for our registrants

We are committed to ensuring that registrants can engage with the GOC in a way that is clear, accessible and proportionate.

A focus on accessibility and engagement

Throughout the year, we continued work to improve the accessibility and clarity of our guidance, communications and engagement activity, recognising that people may experience our processes differently and have different needs. This included making changes to help people find and understand information more easily, such as developing a new signposting page and using clearer, more accessible language across our communications. We also took part in We also took part in **The Open University's Witness to Harm, Holding to Account project,** which was supported by engagement across the professional regulation sector, including the Professional Standards Authority. As part of this work, an accessibility review of our website was undertaken. The review identified areas where progress had been made, while also helping us identify further opportunities to improve accessibility.

Alongside this, we have remained focused on how fairness is experienced in practice. This includes ensuring that when registrants engage with our processes, decisions are grounded in evidence, take account of individual context, and are clearly explained. For example, we have strengthened the explanations provided in triage decision letters so that parties have a clearer understanding of how and why decisions have been reached. We have also updated information on our website about our acceptance criteria, using clearer and more accessible language to explain how decisions are made at the triage stage.

Reducing barriers by supporting registrants to take ownership of their learning

We progressed a programme of engagement linked to continuing professional development (CPD) reform and wider regulatory developments. This includes consultation on proposals to move towards a more flexible, outcomes-based approach to CPD, supporting registrants to take greater ownership of their learning while reducing unnecessary administrative burden and potential barriers to participation.

Strengthening fairness and inclusion in our regulatory approach

In March 2026 Council approved a discussion paper on the GOC's approach to setting registration fees. This work forms part of our wider commitment to strengthening fairness and inclusion in how we design and deliver our regulatory approach. The discussion paper focuses on how registration fees are structured and distributed across different

groups of registrants, rather than the overall level of fees. It explores options such as differential fees for particular groups, more flexible payment approaches including instalments, and improving transparency around how fees are set. Consideration of equality, diversity and inclusion has been an important part of this work, recognising that the impact of fees may not be experienced equally by all registrants.

The work has also been informed by insight and feedback from registrants, including survey findings and engagement through our committees, and highlights the importance of understanding how different groups may be affected, including potential cumulative and intersectional impacts where changes are proposed.

Prioritising registrant voices, patient and public voices

Findings from our 2025 Workforce and Perceptions Survey have informed a range of follow-up activity. This has included commissioning further qualitative research to better understand registrants' lived experiences of bullying, harassment, abuse and discrimination in the workplace, and the impact of these experiences on individuals and patient care. The survey found that 36% of respondents had experienced bullying, harassment, abuse or discrimination from patients or service users. Registrants with a disability, women and those from ethnic minority backgrounds were more likely to report these experiences. We continue to take a zero-tolerance approach to these behaviours, as reflected in the joint sector statement we led in 2023, which was signed by key stakeholder organisations.

The survey also highlighted ongoing concerns about commercial pressures. Thirty per cent of respondents said they had felt under pressure to meet commercial targets at the expense of patient care, with registrants from ethnic minority backgrounds, those with a disability and those aged under 35 more likely to report this. These findings have contributed to wider regulatory work, including informing our thematic review into commercial practices and patient safety. Together, this ensures that registrants' experiences are not only heard but actively used to shape how we strengthen our regulatory approach and support safer and more inclusive working environments.

We have continued to prioritise the registrant voice through the launch of our 2026 Workforce and Perceptions Survey, helping to deepen our understanding of experiences in daily clinical practice. We are continuing to track and build our evidence base in relation to commercial pressures and their impact on both the delivery of safe patient care and registrants' health and wellbeing. The survey also includes new questions about how comfortable registrants feel speaking up about concerns in the workplace, as well as questions exploring vision and safe driving to inform the government's consultation on mandatory sight tests for drivers over 70.

Alongside this, we have continued to listen to patients and the public through our annual Public Perceptions Survey and dedicated lived experience research. During the year, we carried out qualitative research to better understand the experiences of people with vulnerabilities when accessing eye care services. The research found that people with vulnerability markers, such as low income, disability or recent difficult life events, were

less likely to have a sight test every two years and were less satisfied with their experiences when they did access care.

The research highlighted a number of barriers to accessing eye care, including low awareness of the importance of eye health and the role of sight tests in identifying wider health conditions such as high blood pressure and diabetes. Participants also identified concerns about cost, including pressure to make purchases, unclear pricing and limited awareness of available support, such as NHS vouchers.

By bringing together insights from registrants, patients and the public, we are building a richer understanding of how different groups experience eye care and optical regulation. These insights continue to inform delivery of our corporate strategy, strengthened standards and supporting guidance, helping us to make eye care fairer, more inclusive and more responsive to the needs of diverse communities.

Training to support fair and proportionate outcomes for registrants

We also delivered equality, diversity and inclusion learning for Advisory Panel members, focused on the difference between equality and equity and their relevance in a regulatory context. The session explored how policies and processes that appear neutral on paper can be experienced differently in practice, depending on individual circumstances and access to support. This included building shared understanding of how advisory challenge can help surface unintended barriers, test assumptions and support fair and proportionate outcomes for registrants.

We delivered targeted learning for Case Examiners, focusing on how fairness and inclusion are reflected in regulatory decision-making. This work built on previous learning on bias, with a focus on improving consistency, clarity and sound judgement in written reasoning.

The sessions explored how to distinguish clearly between evidence and inference, and how to apply structured fairness checks at key points in the decision-making process. This included being explicit about the reasoning behind decisions and ensuring that conclusions are grounded in regulatory risk, rather than assumptions about behaviour, communication style or personal characteristics.

There was also a focus on proportionality in practice. This means considering the seriousness of the concern alongside the wider context, including any mitigating or aggravating factors, and whether the individual has demonstrated insight or taken steps to address what has happened. Taking this balanced view supports decisions that are not only consistent, but also appropriately tailored to the circumstances of each case.

Where cases progress further, this approach continues through to hearings and outcomes. Decision-making is supported by a structured framework, with a range of possible outcomes available. This allows responses to reflect the nature and seriousness of the concern, rather than applying fixed or uniform measures. Careful

consideration is given to context, evidence and impact, so that outcomes are proportionate and clearly reasoned.

At its core, this is about maintaining a careful balance. Decisions must be fair to the individual, while also protecting the public and maintaining confidence in the profession. Embedding equality, diversity and human rights considerations within this process helps ensure that fairness is not treated as abstract but is reflected in how decisions are reached and explained.

"The training was particularly valuable because it was tailored to the Case Examiner role and reflected the way we consider cases on the papers. It gave them the opportunity to build on previous learning about bias and to think more practically about how equality, diversity and inclusion considerations arise in our written decision-making. Being able to discuss the challenges they sometimes face when assessing evidence, drawing inferences and explaining their reasoning helped reinforce the importance of taking a structured, balanced and proportionate approach. It has supported greater confidence in making decisions that are fair, clearly reasoned and grounded in the evidence and regulatory risk in each case."

Claire Marchant-Williams, Head of Case Progression.

Together, this work reflects our focus on ensuring that our regulatory approach not only protects the public, but is also fair, accessible and responsive to the experiences and circumstances of those we regulate

Fair outcomes for the public

Equality, diversity and inclusion play an important role in supporting fair, proportionate and evidence-informed regulatory decision-making.

Understanding fitness to practise outcomes through data

During the year, we continued work to better understand whether there are differences in how aspects of our fitness to practise processes are experienced by registrants, and whether this may point to potential unfair outcomes. This has included building a clearer picture of how different groups engage with and move through these processes, and where further exploration or action may be needed.

Independent analysis has provided an early level of assurance, with little evidence of meaningful disproportionality in outcomes across the most robust models. It also highlighted that case characteristics are often a stronger predictor of outcomes than protected characteristics. However, this should not be seen as a definitive position, given limitations in data completeness and sample sizes, particularly at later stages of the process.

The analysis reinforced the importance of ongoing monitoring, alongside continued improvement in the quality and completeness of our EDI data. It also highlighted the

need to approach findings with care, recognising the limitations of available datasets and avoiding assumptions about causation where the evidence is not yet sufficiently robust.

Continuing to build this evidence base remains an important area of focus. This includes improving the completeness of EDI data, undertaking further exploratory analysis to better understand emerging patterns, and repeating the analysis over time to build a more robust and consistent picture.

Alongside analytical work, we continued to develop assurance and learning activity across regulatory functions, including how fairness, consistency and accessibility are reflected in decision-making. This work is informed by principles set out in our fitness to practise guidance, including the importance of evidence-based decision-making, proportionality and taking account of the individual circumstances of each case.

In practice, this has included strengthening the consistency and transparency of decision-making across regulatory functions. Through assurance activity, guidance and targeted learning, we have supported decision makers to explain more clearly how conclusions have been reached and how relevant factors have been weighed. There is also greater emphasis on applying regulatory principles consistently while taking account of wider context, including indicators of insight, remediation and other relevant factors. Together, these improvements support more transparent and well-reasoned outcomes, helping to ensure that decisions are both proportionate and consistently applied.

This work also contributes to a more coherent and joined-up approach to fairness across our regulatory functions, reinforcing the importance of proportionate decision-making that protects the public while maintaining confidence in the profession.

Embedding Welsh language access

As a public body, we have a statutory obligation to meet the Welsh Language Standards (WLS). Over the past year, we have continued to embed Welsh language access as part of our organisational culture and day-to-day practice, maintaining compliance while also strengthening how we evidence and apply the Standards in practice.

Supporting colleagues to understand their responsibilities remains a core part of this. Welsh language considerations continue to be embedded within our new starter induction, helping ensure that expectations are clear from the outset and that compliance is understood as part of delivering fair and accessible services. This is complemented by ongoing support for colleagues across the organisation.

We have also provided further refresher training for senior leaders, building on earlier activity to strengthen confidence in how the Standards are applied in practice. This has focused on supporting consistent, proportionate decision-making and ensuring that Welsh language considerations are built in early, rather than retrospectively. The sessions have reinforced the importance of being able to clearly explain and evidence decisions, particularly where a proportionate approach is being taken. For example, this has included supporting decision makers to consider whether not translating a document

could create disadvantage for Welsh speakers, and how to balance purpose, audience and impact when deciding on the most appropriate approach.

We also completed and published our annual Welsh Language report in line with our compliance requirements. This provides a structured overview of our activity and progress and supports greater transparency in how we are meeting the Standards. We have also responded to engagement from the Welsh Language Commissioner, including contributing to work aimed at increasing the visibility of Welsh language services across public bodies. This includes input to the Commissioner's platform highlighting the services organisations provide in Welsh, helping to make access routes clearer and more visible to the public.

Through this work, we have strengthened our ability to identify where further focus is needed, particularly in making Welsh language services more visible and ensuring that access routes are clear and consistent. This has included reflecting on where Welsh language provision directly affects participation, such as ensuring that consultations with a likely Welsh speaking audience are available in Welsh at the point of publication, to support fair access and engagement.

Our approach remains practical and proportionate. We continue to focus on providing clear access to Welsh language services where these are needed, supported by transparent and well-reasoned decision-making. Together, this contributes to a more confident, consistent and accessible approach to meeting the Welsh Language Standards in practice.

Working cross-sector to advance equality

We also contributed to wider cross-sector work to advance equality across health and social care. During the year, we participated in a regulators' roundtable on workforce race equality, contributing to the development of shared regulatory principles coordinated through the Health and Social Care Regulators' Forum and NHS Race and Health Observatory. These principles, due to be published in 2026, are intended to support a more consistent and accountable approach across the sector, and we intend to formally endorse them.

At the same time, we engaged with national work to address anti-Muslim hostility and antisemitism, responding to the Department of Health and Social Care and contributing to Lord Mann's independent review. In both cases, we highlighted the regulatory risks these behaviours present for patient safety and public confidence, the need for action across education, professional standards and fitness to practise, while recognising the importance of addressing underlying cultural issues, lived experience, and barriers to speaking up.

Meeting the PSA's standards on equality, diversity and inclusion

For the fourth consecutive year, we met all 18 of the Professional Standards Authority's Standards of Good Regulation, including those relating to equality, diversity and inclusion. Our work has also been reflected in the PSA's 2025 good practice guidance,

which highlights examples of how regulators are embedding EDI across their regulatory functions. This includes our published guidance on caring for patients in vulnerable circumstances, supporting inclusive and person-centred care in practice.

Together, these actions support fair, evidence-informed and consistent regulatory decision-making, ensuring that outcomes are based on evidence and risk, rather than assumption.

This work has informed our ongoing approach and will continue to shape priorities within our EDI Action Plan for 2026/27, as we strengthen our focus on tackling discrimination and supporting fair and inclusive outcomes for registrants and the public.

Building an inclusive and confident culture

We know that inclusive organisational cultures help support better decision-making, stronger collaboration and improved organisational confidence.

Strengthening the foundations of equality and equity

Throughout 2025–26, we focused on strengthening the foundations of equality and equity across the organisation, including building shared understanding of the differences between them and how they show up in practice. This has included activity to support greater awareness and inclusion across areas such as LGBTQIA+ inclusion and disability, alongside a continued focus on how colleagues experience the organisation day to day.

This included a series of lunch and learn sessions focused on disability inclusion and neurodiversity. Delivered in response to colleague feedback and learning requests, the sessions explored how disability and neurodiversity can be experienced in the workplace, the barriers that individuals may encounter, and the practical steps organisations and colleagues can take to create more inclusive environments. The sessions encouraged participants to move beyond assumptions and stereotypes, focusing instead on how workplace systems, communication and ways of working can either enable or hinder participation. They also highlighted the importance of removing barriers, making reasonable adjustments where needed, and recognising that inclusive practices often benefit everyone.

Feedback from colleagues was very positive. Participants reported increased confidence in understanding the difference between equality and equity and highlighted the value of practical discussion and learning on topics such as disability inclusion and neurodiversity. Many also said they would recommend the sessions to colleagues.

The introduction of our Performance Behaviours Framework (PBF) for employees supports both equality and equity. All employees are assessed against a framework of behavioural standards, which provides clear, consistent expectations and reduces subjectivity in performance evaluation. This in turn makes reward and development decisions more transparent. The PBF also recognises that people may have different

circumstances, needs and barriers and may require different support to achieve comparable outcomes by allowing flexibility of approach and reasonable adjustments.

Shining a light on our staff networks

Our employee-led staff networks continued to play an important role in supporting inclusion, awareness, peer support and organisational learning. Over the year, networks have begun to move into a more established phase, with leads developing 12-month action plans and introducing simple governance structures to support sustainability and shared ownership. We also undertook a staff network feedback survey to better understand how to support their development, with findings informing plans to refresh and strengthen their role across the organisation.

Alongside this, networks have led and contributed to a wide range of activity throughout the year, marking key awareness moments, sharing lived experience and creating opportunities for learning and connection. This has included events and initiatives linked to areas such as neurodiversity, race equality, LGBTQIA+ inclusion, disability, social mobility, digital inequality and wellbeing. Activity has taken place consistently across the year, taking a variety of forms, including blogs, webinars, Lunch and Learn sessions, panel discussions and multi-network collaborations, helping to reach colleagues in different ways and support ongoing engagement across the organisation.

This has included activity led by our employee-led Social Mobility Network, which facilitated a session exploring social class and an introduction to the concept of social mobility. The session combined short presentations with open discussion, creating space for colleagues to reflect on how different experiences and backgrounds shape opportunity, progression and access in the workplace. Networks have also collaborated across themes, including work to raise awareness of digital poverty and a joint series led by the Asian Representation Group and EMBRACE focusing on South Asian heritage and lived experiences.

The ABLE network has supported a range of activity focused on disability inclusion, including sessions moving from awareness into action, broader discussions on accessibility in practice, and activity marking the International Day of Persons with Disabilities.

“Since becoming sponsor of the ABLE Network, I’ve been struck by the passion, openness and genuine commitment across colleagues to make the GOC a more inclusive place to work. Hearing directly from people about their lived experiences, particularly where disability is not always visible, has been both powerful and thought-provoking for me personally and has shaped how I think about leadership and inclusion in my own role. It reinforces how important it is that we continue to create safe spaces for honest conversation. As sponsor, I am personally committed to listening, learning and using my role to ensure that the insight and energy from the network lead to meaningful, practical improvements in how we shape our culture, policies and working environment, so that all colleagues feel supported and able to thrive.”

Marc Stoner, Director of Corporate Services and Senior Sponsor of the ABLE Network

Activity across networks has included a session focused on mental health among optometrists, hosted by our Senior Sponsor of the Social Mobility network, Steve Brooker. This provided space to explore wellbeing and share experiences relevant to the profession and wider workforce. Activity marking Black History Month included a session led by social historian Kim Sheldon, exploring themes of resilience, identity and legacy across global Black history, alongside opportunities for colleagues to reflect on how these narratives continue to shape inclusion and belonging today.

The Support and Wellbeing Employee Group (SWEG) has also revitalised its activity under its new Chair, with a programme of informal and engaging sessions designed to support wellbeing and connection. This has included coffee chats exploring topics such as being a female gamer, lunchtime wellbeing sessions, guest speakers and informal sessions such as true crime discussions and reflections on life as an elite rower.

"Being chair of the SWEG Network is something I am incredibly proud of. It gives me the opportunity to create a space where colleagues can step away from their day-to-day roles, focus on their wellbeing, and connect with others across the organisation. I enjoy facilitating a wide range of topics and experiences to staff through initiatives such as coffee mornings, awareness events and discussions, helping to spark conversations that might not otherwise take place. For me, the network is about creating opportunities for people to learn, share, connect and feel supported at work."

Abigail Brown, Chair of SWEG Network

Supporting learning through staff networks

We introduced a pilot mentoring programme for GOC employees, open to all and designed to support development, learning and progression across the organisation. The programme offers a range of mentoring approaches, including traditional one-to-one mentoring, peer support and reverse mentoring, recognising the value of shared learning and different perspectives.

The six-month pilot includes structured onboarding, goal setting and regular check-ins, helping to create meaningful mentoring relationships that support both personal and professional development. The programme was initiated by the Women's Network, which has also led a series of events to mark International Women's Day. Insights from the pilot will be used to inform how we develop and expand this approach in future.

Marking key moments and lived experiences

We continue to value the role that lived experience plays in shaping our organisational culture. This has been reflected in the way we have marked key moments across the year, including National Inclusion Week, Black History Month and International Day of Persons with Disabilities. These activities have focused on creating space for reflection,

amplifying lived experience and encouraging open and constructive conversations about what inclusion looks like in practice.

Through this range of activity, staff networks are playing an increasingly important role in supporting both organisational learning and a more open and inclusive culture, while providing space for colleagues to share experiences, build connections and contribute to positive change.

Accessibility and inclusion in practice

Our partnership with the Thomas Pocklington Trust (TPT) has continued to grow, with 2025–26 marking our fourth year of collaboration. Through this partnership, we have hosted a further intern who has provided valuable support across multiple teams, while also strengthening our understanding of accessibility and inclusion in practice. TPT colleagues also supported internal learning activity, including a Lunch and Learn session to mark World Braille Day, which explored the importance of Braille in supporting access and independence, alongside reflections from interns on how accessibility continues to evolve.

"I am extremely grateful for the ongoing partnership Thomas Pocklington Trust (a charity that supports blind and partially sighted people) has with the General Optical Council. Your continued commitment to employing visually impaired interns through our 'Get Set Progress' internship programme not only aligns with our shared vision of inclusion and opportunity but also sets a powerful example for other organisations to follow. By creating meaningful employment opportunities, the General Optical Council is helping to pave the way for a more inclusive workplace and society for all. We greatly value this collaboration and look forward to continuing and strengthening our relationship in the years ahead."

Charles Colquhoun, Chief Executive, Thomas Pocklington Trust

Investing in EDI learning to support our leaders

We have continued to invest in equality, diversity and inclusion learning across the organisation and targeted development for leaders. This has included creating space for reflection and discussion on how inclusion shows up in practice, and how leaders can support psychological safety within their teams. The focus has been on building confidence to navigate complex or sensitive issues, and on ensuring that inclusion is understood as a shared, organisation-wide responsibility.

We also began introducing the concept of cultural safety through discussions with both the Council and Senior Management Team. This marked an important first step in developing a shared understanding of cultural safety across the organisation and its relevance to both governance and regulatory decision-making. These sessions explored the relationship between psychological safety, cultural competence and cultural safety, encouraging participants to consider how organisational systems, decision-making and behaviours influence whether people feel respected, included and able to contribute. Through facilitated discussion and reflection, Council considered how cultural safety

might apply to its governance and oversight role, including whose perspectives are heard, how challenge is encouraged and how different experiences inform decision-making. Insights from these discussions will help inform the continued development of our EDI Action Plan and wider work to strengthen inclusive leadership and organisational culture.

We have introduced mandatory sexual harassment training for all employees, which reinforces expectations around respectful behaviours and creating safe working environments. Over 90% of colleagues have completed this training to date. All new starters have undertaken EDI induction as part of their onboarding, helping to establish clear expectations from the outset.

We have also begun to commission a programme of cultural safety training, which is currently progressing through procurement and will be rolled out across the organisation during 2026/27.

Embedding organisational frameworks to support EDI

We have also further developed the organisational framework that underpins this work. In developing our new EDI policy, we engaged colleagues from across the organisation through our employee-led policy review group (PRG), which included representatives from different directorates and functions, alongside staff network chairs and leads. Their feedback helped shape a new EDI policy, which was subsequently approved by Council and aligns with the Equality Act 2010, the Public Sector Equality Duty and the Professional Standards Authority's Standards of Good Regulation. The policy reflects a broader and more inclusive understanding of EDI, including explicit reference to neurodiversity, disability inclusion and carers, and is supported by an Equality Impact Assessment which identified positive impacts across all protected characteristics.

Planning is now underway to support the implementation of the policy, including internal and external communication, awareness-raising activity and integration into day-to-day practice. This includes embedding expectations within performance and behaviours frameworks, strengthening understanding of how the policy applies in practice, and supporting colleagues to translate policy into consistent and inclusive decision making.

In practice, this will be reinforced through our PBF, which sets clear expectations for how colleagues demonstrate inclusive behaviours in their roles, supported by structured objective setting, performance conversations and review processes. This helps ensure that equality, diversity and inclusion are not treated as standalone concepts, but are reflected in how performance is assessed, how feedback is given, and how development is supported across the organisation.

Alongside this, we have taken steps to strengthen organisational mechanisms that support openness and trust, including progressing the introduction of a Freedom to Speak Up Guardian role. This will provide an additional route for colleagues to raise concerns and contribute to a culture where people feel safe to speak up and challenge constructively.

Understanding pay equity at the GOC

We continue to monitor our gender pay gap as one indicator of equality and equity within our workforce. While gender pay gap data cannot explain individual pay decisions, it can help us understand broader patterns relating to representation, progression and reward across the organisation. As a relatively small organisation, even modest changes in workforce profile can influence overall results from year to year. This year's analysis is based on full-time employees across Administrator, Officer, Manager, Head of Service and Director roles as of 31 March 2026. To avoid a single role having a disproportionate impact on the findings, the Chief Executive Officer role has been excluded from this analysis. For the purposes of this analysis, sex refers to biological sex as recorded in our workforce data, in line with current UK Government guidance. Employees who have not disclosed their sex are not included in the pay gap calculations.

Although the GOC is not legally required to publish gender pay gap data, we continue to do so as part of our commitment to transparency and fairness. This year, our overall median gender pay gap is **−6.6%**, meaning the median hourly pay for women is **6.6%** higher than that of men. Our mean gender pay gap is **−6.8%**.

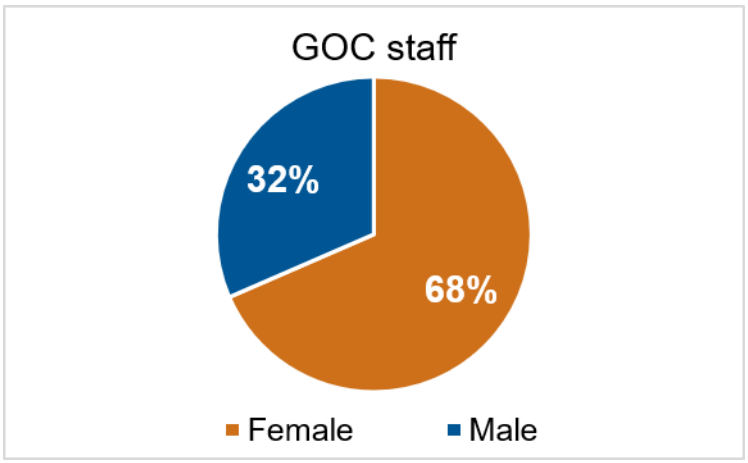
Measure	2025-26
Mean pay gap	-6.8%
Median pay gap	-6.6%

The overall figures provide a useful indication of pay patterns across the organisation. However, they only tell part of the story. Looking beyond the headline result helps us better understand how representation, progression and workforce profile may influence pay outcomes across different role levels.

The charts below provide additional context on workforce representation and pay differences across role levels.

Workforce profile and representation

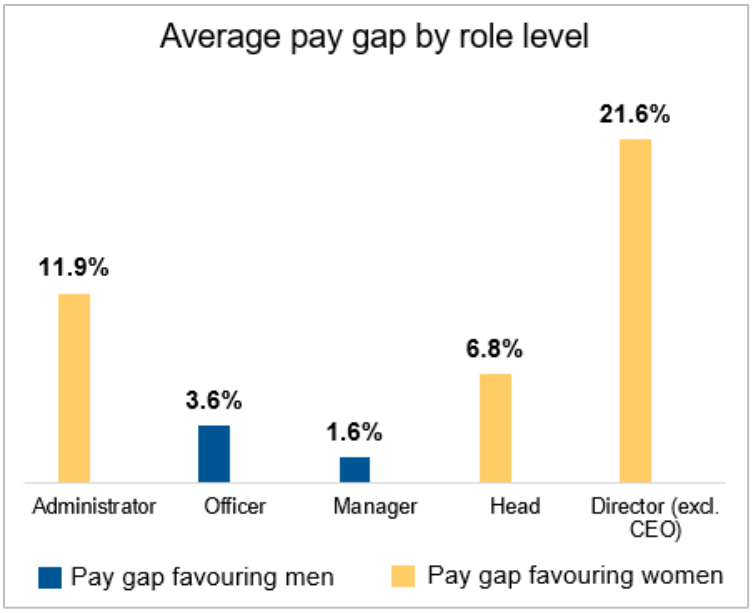
Women are represented across all role levels and make up a larger proportion of employees in all grades. Understanding representation is important when interpreting headline pay gap figures, as workforce composition and pay patterns within roles can both influence overall outcomes.



Pay by role level

Pay differences vary across levels (grades) and do not consistently favour either gender.
The analysis shows:

- **Administrator** average pay is 11.9% higher for women than for men
- **Officer:** pay is broadly comparable, although average pay is 3.6% higher for men
- **Manager:** pay is broadly comparable, with a small difference of 1.6% in favour of men
- **Head of Service:** average pay is 6.8% higher for women than for men
- **Director (excluding CEO):** average pay is 21.6% higher for women than for men, representing the largest difference across role levels



These findings suggest that pay outcomes differ across role levels rather than following a consistent organisation-wide pattern. While men have slightly higher average pay at Officer and Manager level, women have higher average pay at Administrator, Head of Service and Director level.

The analysis also shows that, in several role categories, the highest earners are predominantly female. This may contribute to higher average pay for women overall, particularly where women are represented towards the upper end of pay ranges. However, the data alone cannot determine the reasons for these differences. Factors such as experience, length of service, progression, recruitment decisions and role responsibilities are not reflected in this analysis.

Data completeness

The declared GOC staff sex profile is currently 54.84% female, 25.81% male and 19.35% unknown. Around one fifth of employees have chosen not to disclose their gender.

This limits how fully we can understand pay patterns across the organisation and may affect the completeness of the analysis. Improving disclosure rates will strengthen future insight and help us better understand employee experience and outcomes.

Understanding our results

The overall gender pay gap should be interpreted alongside the role-level analysis. The findings suggest that pay patterns across the organisation are influenced by a range of factors, including progression and representation across different levels of the organisation, rather than by a single underlying trend.

As with all pay analyses, averages can be influenced by a small number of particularly high or low salaries. The data provides an important overview of pay outcomes but cannot, on its own, explain why individual employees are paid differently.

We will continue to build our understanding of pay and progression across the organisation, including improving data completeness and exploring how recruitment, progression and career pathways may influence future outcomes. This forms part of our wider commitment to ensuring that opportunity, development and reward are experienced fairly across the GOC.

EDI Action Plan – delivery and forward look

What we said we would do (2024–25)

In 2024–25, our priorities focused on strengthening our evidence base, improving understanding of registrant and workforce experiences, and embedding equality, diversity and inclusion across our regulatory and organisational practice. This included commitments to develop our approach to analysing potential unfair outcomes, deepen insight into discrimination and workplace experience, strengthen EDI capability across the organisation, and integrate EDI considerations more consistently into policies, processes and decision-making.

What we delivered

During 2025–26, we made meaningful progress against these priorities. This included commissioning independent analysis to better understand potential unfair outcomes in our fitness to practise processes, alongside improving the quality and use of EDI data across the organisation.

We also strengthened our understanding of registrants' lived experiences through our annual Workforce and Perceptions Survey and follow-up qualitative research, helping to build a more detailed picture of the impact of discrimination, harassment and workplace culture on individuals and patient care.

At the same time, we have embedded EDI more consistently across our regulatory functions, including strengthening guidance, supporting decision makers through targeted learning, and improving how fairness, proportionality and evidence are reflected in practice.

Internally, we have invested in building organisational capability and culture, including developing staff networks, delivering organisation-wide learning, strengthening leadership understanding of inclusion and psychological safety, and progressing key policy developments, including the introduction of a new EDI policy.

Overall, this reflects a shift from building awareness to embedding EDI within how we regulate, make decisions and operate as an organisation.

What we are focusing on next (2026–27)

Building on this progress, our 2026–27 EDI Action Plan will focus on deepening our understanding of inequality and strengthening consistency in how EDI is applied in practice. Key priorities include further developing our evidence base, including ongoing

analysis of regulatory outcomes, continued improvement in data quality and the development of an organisational data strategy to strengthen how we collect, use and apply insight to inform decision-making.

We will continue to build on registrant insight through the Workforce and Perceptions Survey and other engagement activity, ensuring that lived experience continues to inform our work. Alongside this, we will strengthen the role of patient and public voices in shaping our regulatory approach. Our research has shown that some of the most vulnerable people in society are less likely to have had a sight test within the last two years and are often less satisfied with their experiences when accessing eye care. Understanding and addressing these inequalities will be an important area of focus, helping to ensure that regulation supports fair access, inclusive experiences and better health outcomes.

We will also strengthen capability across the organisation through the rollout of cultural safety training and continued development for decision-makers, leaders and staff. Alongside this, we will further embed EDI within our policies, frameworks and regulatory processes, supporting consistent, transparent and evidence-informed decision-making.

This forward programme reflects our ongoing commitment to ensuring that equality, diversity and inclusion are integral to how we deliver our role as a regulator, supporting fair outcomes, inclusive experiences and public confidence. We will continue to report on progress annually, ensuring transparency and accountability as we build on the foundations set out in this report and further embed EDI across our regulatory and organisational activity. Our focus will remain on improving insight, building capability and delivering fair, proportionate and inclusive outcomes for registrants, patients and the public.

C39(26) ANNEX TWO

General Optical Council

Equality, Diversity, and Inclusion Annual Monitoring Report

for the year ended 31 March 2026

General Optical Council

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Introduction

Data

The data in this report relates to registrants, registrants going through a fitness to practice (FTP) investigation, GOC employees, and GOC members and workers.

The information in this report is based on our in-house datasets as of 31 March 2026. Our employee data is collected from our internal HR system; data is based on those employees who chose to fill in an EDI form. Member data was collected in April 2026 via our annual member survey.

We are unable to report data involving small cohorts where individuals may be identifiable. Similarly, we may round up or group figures to ensure that individuals cannot be identified within the report. Due to rounding, percentages may not always add up to 100 percent.

Categories

There are additional registers for practitioners with specialist qualifications called specialty registers. There are currently four registerable specialties: for optometrists: Additional supply specialty, Independent prescribing specialty, and Supplementary prescribing specialty, and for dispensing opticians: Contact lens specialty.

While we aim to gather evidence about all protected characteristics, we allow “prefer not to say” responses to many questions and there is a variation in response rates.

Furthermore, where a field is left blank, this data is included in the “prefer not to say” category.

Timeframe

Where possible we have provided three annual instances of data: 31 March 2024, 31 March 2025, and 31 March 2026, to help us identify any trends.

Key

In the ethnicity category, “White EWSNI” means “White English, Welsh, Scottish, or Northern Irish”.

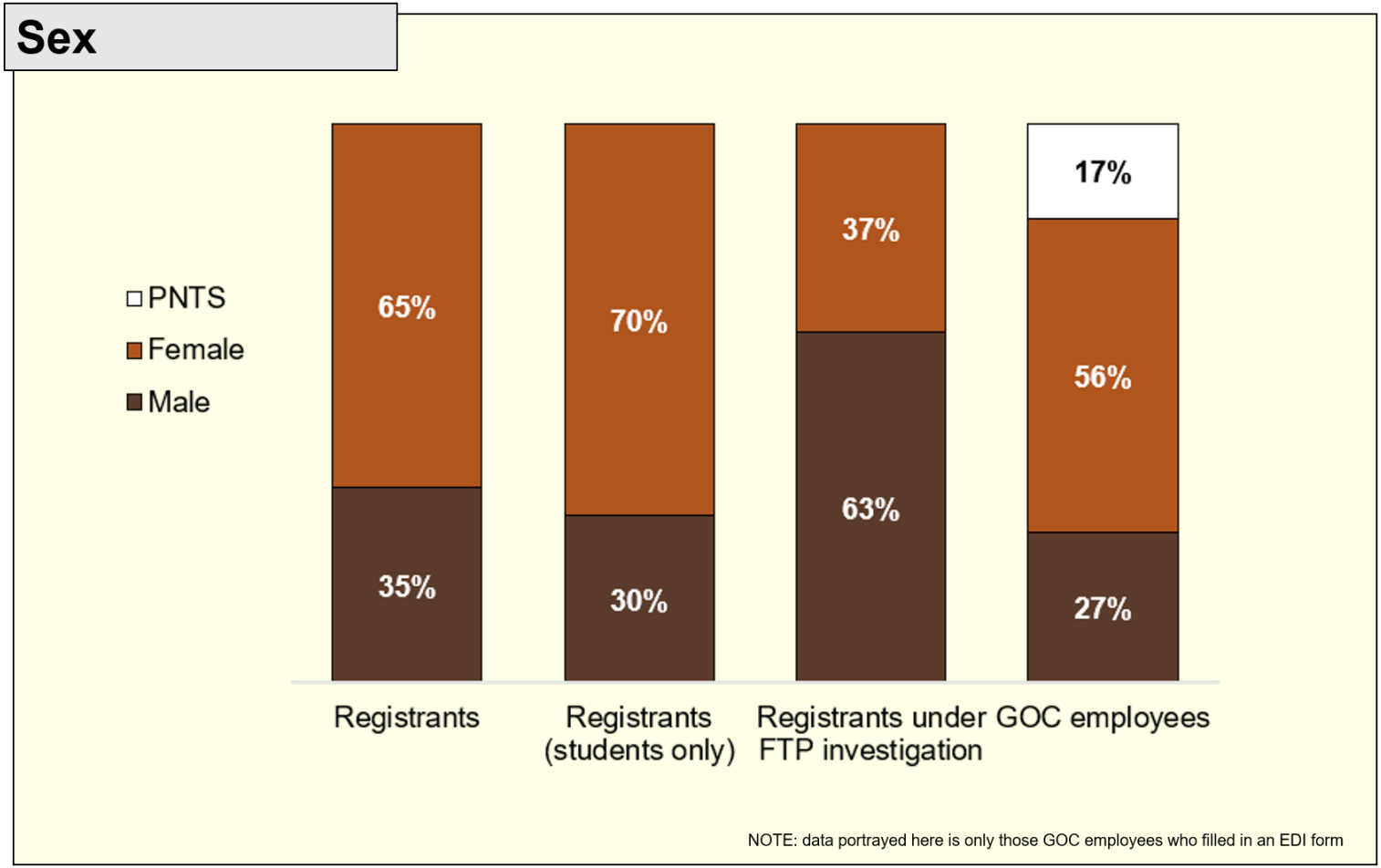
In the religion category, “Christian” includes Catholic, and all other Christian denominations.

“PNTS” means “Prefer not to say”.

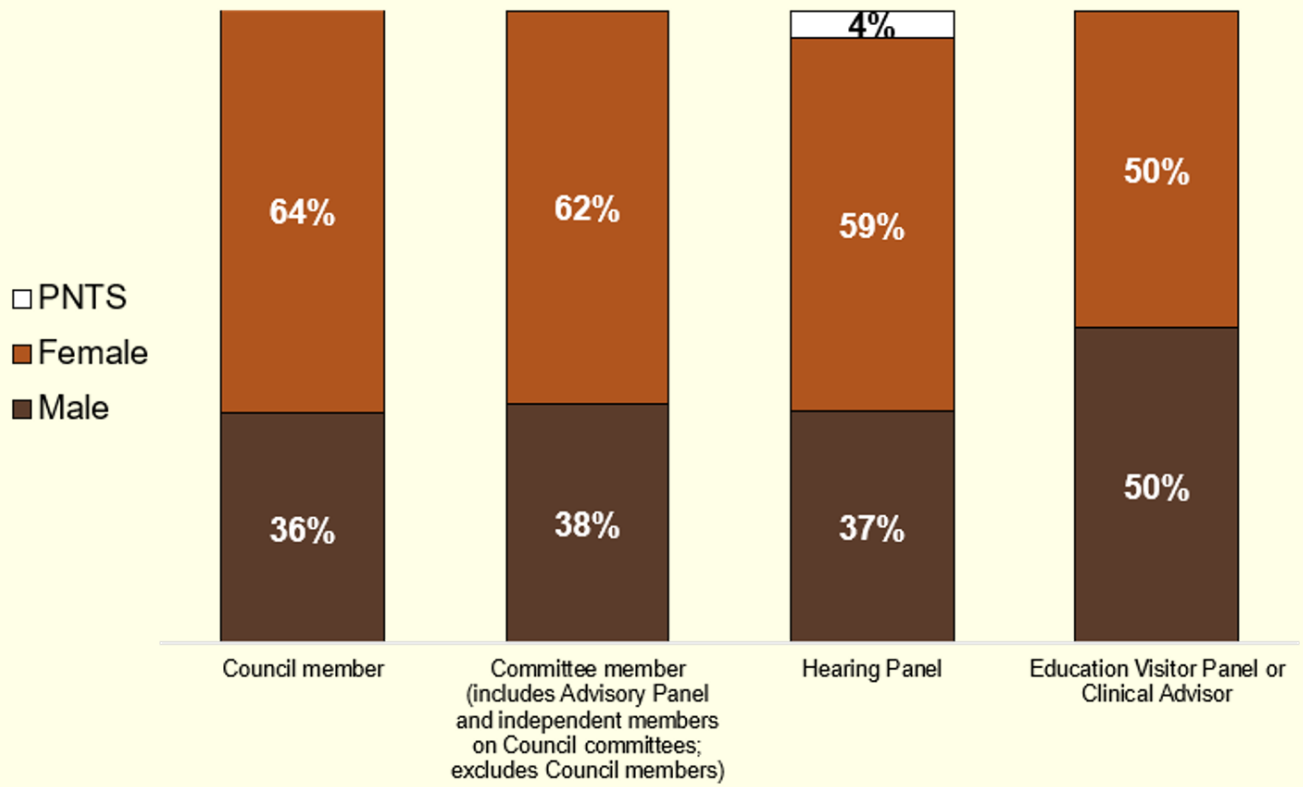
General Optical Council

EDI Data Snapshots

Sex

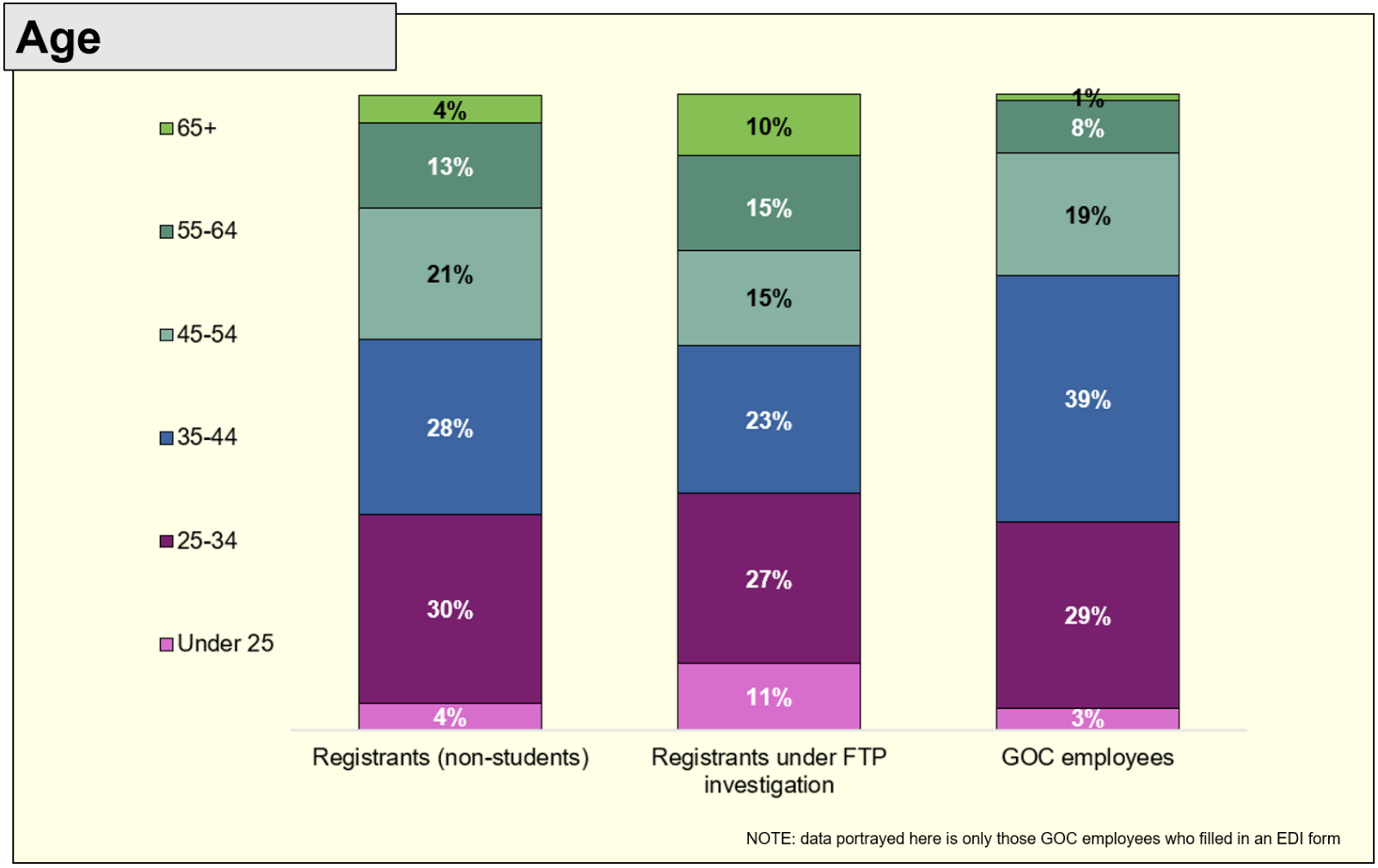


Sex



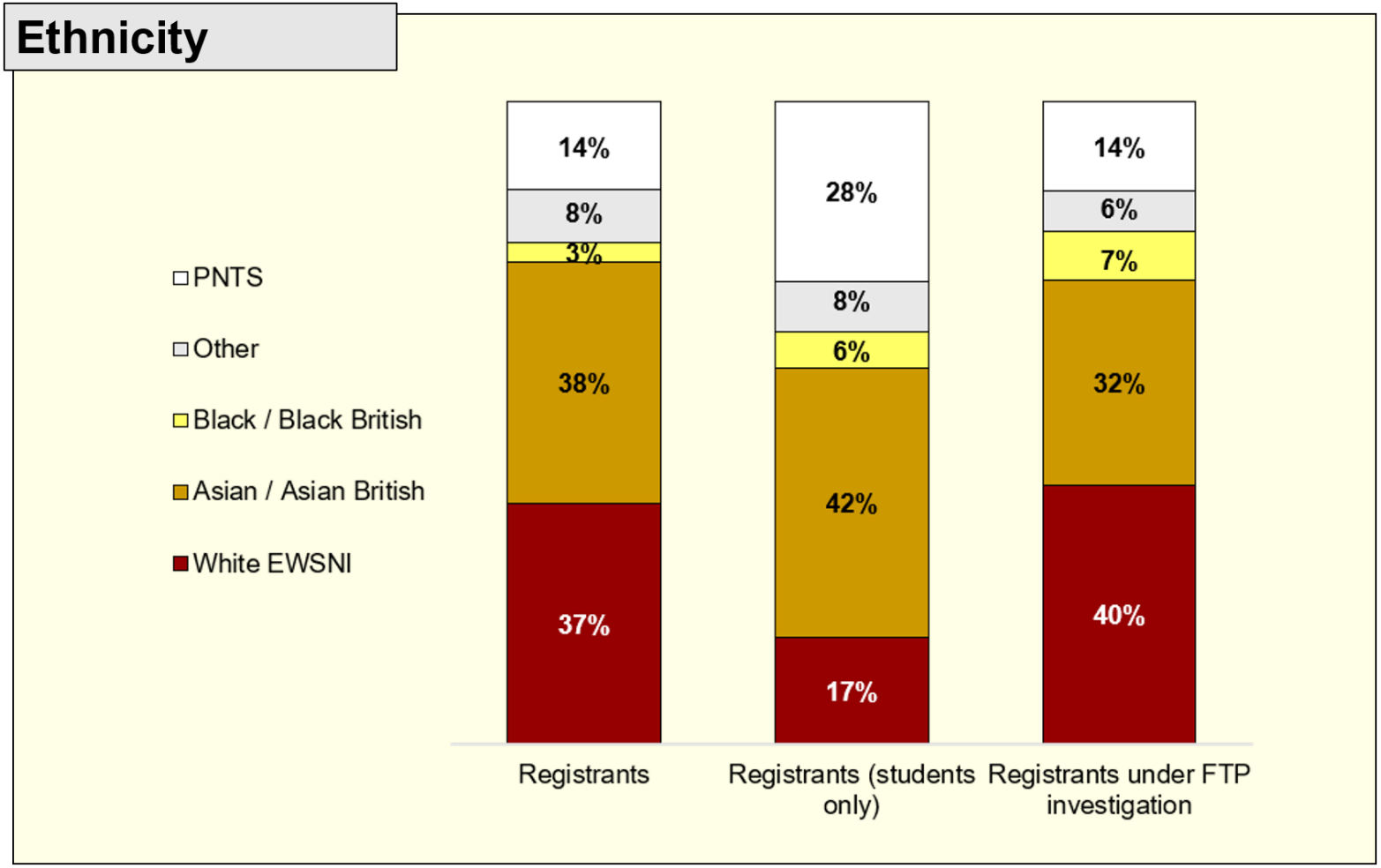
NOTE: data portrayed here is only those members/workers who filled in an EDI form

Age

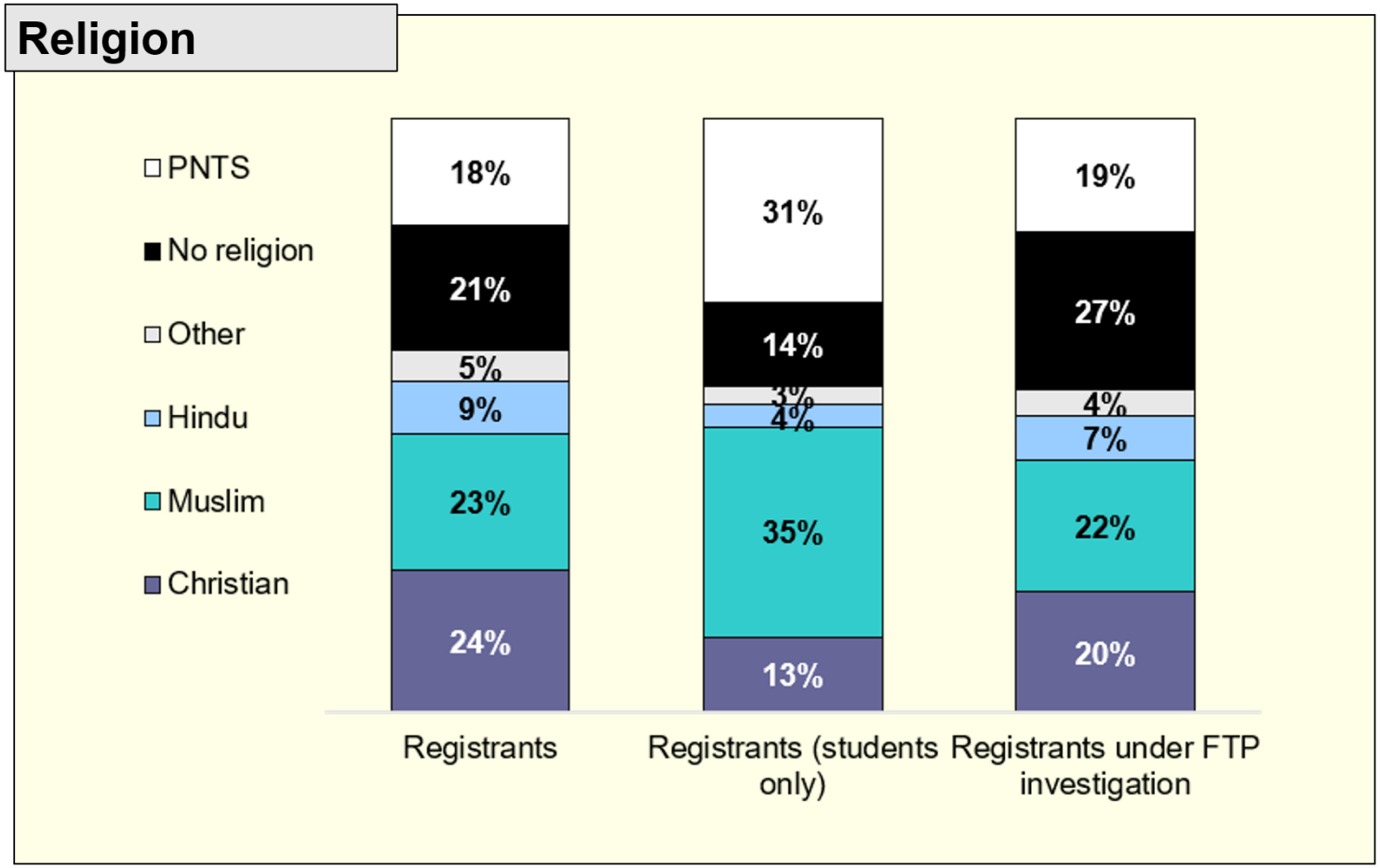


NOTE: data portrayed here is only those GOC employees who filled in an EDI form

Ethnicity


PNTS
Other
Black / Black British
Asian / Asian British
White EWSNI
14%
8%
3%
38%
37%
28%
8%
6%
42%
17%
14%
6%
7%
32%
40%
Registrants
Registrants (students only)
Registrants under FTP investigation

Religion


PNTS
No religion
Other
Hindu
Muslim
Christian
18%
21%
5%
9%
23%
24%
31%
14%
3%
4%
35%
13%
19%
27%
4%
7%
22%
20%
Registrants
Registrants (students only)
Registrants under FTP investigation

EDI Overrepresentation and Underrepresentation

The below data portrays overrepresentation and underrepresentation with regards to the GOC register, registrants under FTP investigation, and the UK public for certain EDI characteristics.

The sources used are:

For sex:

- Population of the UK by sex - Office for National Statistics

For ethnicity:

- Demographics of the United Kingdom - Wikipedia
- England and Wales – Ethnic group - Office for National Statistics – 2021 Census
- Scotland – Scotland's Census 2022 - Ethnic group, national identity, language and religion | Scotland's Census – 2022 Census
- Northern Ireland – Census 2021 main statistics ethnicity tables | Northern Ireland Statistics and Research Agency – 2021 Census

For religion:

- Demographics of the United Kingdom - Wikipedia
- England and Wales – Religion, England and Wales - Office for National Statistics – 2021 Census
- Scotland – SuperWEB2 - Table View – 2022 Census
- Northern Ireland – Census 2021 main statistics religion tables | Northern Ireland Statistics and Research Agency – 2021 Census

The comparator data presented throughout this report has been sourced from recognised national datasets, including census and ONS publications. These sources were selected because they provide the closest available population benchmarks for the characteristics being analysed.

Sex, ethnicity, and religion were selected because they currently, and historically, show the most notable levels of overrepresentation and underrepresentation in the data.

Lastly, in this section, “Asian / Asian British” and “Black / Black British” are referred to as “Asian” and “Black” respectively.

		Register	UK	Difference	Verdict
Sex	Female	65.0%	51.0%	14.0%	Small to moderate overrepresentation
	Male	35.0%	49.0%	-14.0%	Small to moderate underrepresentation
Ethnicity	White EWSNI	37.4%	83.0%	-45.6%	Large underrepresentation
	Asian	37.7%	8.6%	29.1%	Moderate to large overrepresentation
	Black, Asian, Mixed, or Other	48.9%	17.0%	31.9%	Large overrepresentation
Religion	Christian	23.8%	46.5%	-22.7%	Moderate underrepresentation
	Muslim	23.2%	6.0%	17.2%	Moderate overrepresentation
	No religion	21.1%	37.8%	-16.7%	Small to moderate underrepresentation

		Register (students only)	UK	Difference	Verdict
Sex	Female	70.1%	51.0%	19.1%	Moderate overrepresentation
	Male	29.9%	49.0%	-19.1%	Moderate underrepresentation
Ethnicity	White EWSNI	16.7%	83.0%	-66.3%	Large underrepresentation
	Asian	41.8%	8.6%	33.2%	Large overrepresentation
	Black, Asian, Mixed, or Other	55.2%	17.0%	38.2%	Large overrepresentation
Religion	Christian	12.7%	46.5%	-33.8%	Large underrepresentation
	Muslim	35.4%	6.0%	29.4%	Moderate to large overrepresentation
	No religion	14.3%	37.8%	-23.5%	Moderate underrepresentation

Looking at registrants compared with the UK population:

- There is a large underrepresentation of White EWSNI registrants on the GOC register compared to the UK population – the UK population is 83.0% White EWSNI, yet only 37.4% of registrants are White EWSNI.
- There is a moderate-to-large overrepresentation of Asian registrants on the GOC register compared to the UK population – the UK population is only 8.6% Asian, yet 37.7% of registrants are Asian.
- There is a large overrepresentation of Black, Asian, Mixed, and Other registrants on the GOC register compared to the UK population – the UK population is only 17.0% Black, Asian, Mixed, and Other, yet 48.9% of registrants are Black, Asian, Mixed, and Other.

Looking now at students only compared with the UK population:

- There is a large underrepresentation of White EWSNI students on the GOC register compared to the UK population – the UK population is 83.0% White EWSNI, yet only 16.7% of students are White EWSNI.
- There is a large overrepresentation of Asian students on the GOC register compared to the UK population – the UK population is only 8.6% Asian, yet 41.8% of students are Asian.
- There is a large overrepresentation of Black, Asian, Mixed, and Other students on the GOC register compared to the UK population – the UK population is only 17.0% Black, Asian, Mixed, and Other, yet 55.2% of students are Black, Asian, Mixed, and Other.
- There is a large underrepresentation of Christian students on the GOC register compared to the UK population – the UK population is 46.5% Christian, yet only 12.7% of students are Christian.
- There is a moderate-to-large overrepresentation of Muslim students on the GOC register compared to the UK population – the UK population is only 6.0% Muslim, yet 37.8% of students are Muslim.

The demographic profile of student registrants differs more markedly from the UK population than the profile of all registrants compared to the UK population. This suggests that the register demographic profile is on track to become more pronounced than it already is. The register already has an overrepresentation of females, Asians, and Muslims, and this is set to continue further, whilst male, White EWSNI, and Christian representation on the register is set to decrease.

		Registrants under FTP	Register	Difference	Verdict
Sex	Female	37.2%	65.0%	-27.8%	Moderate underrepresentation
	Male	62.8%	35.0%	27.8%	Moderate overrepresentation
Ethnicity	White EWSNI	40.4%	37.4%	3.0%	Negligible
	Asian	31.9%	37.7%	-5.8%	Small underrepresentation
	Black, Asian, Mixed, or Other	45.7%	48.9%	-3.2%	Negligible
Religion	Christian	20.2%	23.8%	-3.6%	Negligible
	Muslim	22.3%	23.2%	-0.9%	Negligible
	No religion	26.6%	21.1%	5.5%	Small overrepresentation

There is a moderate overrepresentation of male registrants under FTP investigation compared to the GOC register – the GOC register is only 35.0% male, yet 62.8% of registrants under FTP investigation are male.

Analysis – Registrants

Appendix: Tables 1-28

As of 31 March 2026, we had 32,638 optometrists, dispensing opticians, student optometrists, and student dispensing opticians on our register.

Numbers

The total number of registrants has increased by 2.1% compared to 2025.

Professional group

The largest annual change occurred with student dispensing opticians – this group has increased by 5.4% compared to 2025.

Sex

65.0% of all registrants are female (64.4% in 2025). As in previous years, the most marked imbalance is found in students – here, females account for 70.6% (69.1% in 2025) and 68.2% (67.3% in 2025) respectively.

Moreover, like previous years, all four specialty categories are 62-64% female and 36-38% male.

Age

Excluding students, like in 2025, age groups with the highest percentage of registrants are aged 25-34 and 35-44 – these are 29.7% (29.3% in 2025) and 27.7% (28.4% in 2025) respectively; regarding this, there has been no significant change over the three-year period. Like the past year, the specialty age profile shows a slightly higher proportion of registrants aged 35-44 (33.2%, compared to 27.7% of all registrants excluding students).

Ethnicity

37.4% of all registrants (38.3% in 2025) are White EWSNI; this has been decreasing over the three-year period. 37.7% of all registrants (37.0% in 2025) are Asian / Asian British; this has been increasing over the three-year period. This is the first year in which White EWSNI registrants are no longer the majority on the register – the number of Asian / Asian British registrants is now greater, though slightly, than the number of White EWSNI registrants.

The percentage of registrants who are either Black / Black British, Asian / Asian British, Mixed, or Other (48.9%) is significantly higher than that of the UK population (17.0%)[1].

Of respondents who provided their ethnicity, 43.3% (44.4% in 2025) are White EWSNI, and 43.7% (42.9% in 2025) are Asian / Asian British.

[1] Demographics of the United Kingdom - Wikipedia

- England and Wales – Ethnic group - Office for National Statistics – 2021 Census
- Scotland – Scotland's Census 2022 - Ethnic group, national identity, language and religion | Scotland's Census – 2022 Census
- Northern Ireland – Census 2021 main statistics ethnicity tables | Northern Ireland Statistics and Research Agency – 2021 Census

Using the above sources, Black, Asian, Mixed, and Other can be summed to 17.0%

There is a proportionately higher rate of White EWSNI specialty registrants (54.5%, compared to 37.4% of all White EWSNI registrants).

Religion

The religion declared most frequently by all registrants was Christian (23.8%), followed by Muslim (23.2%); in 2025, this was 24.6% and 22.2% respectively.

Excluding PNTS, 29.0% (29.9% in 2025) of registrants are Christian, and 28.3% (27.1% in 2025) are Muslim.

The percentage of Muslim registrants is significantly higher than the UK Muslim population (6.0%)[2], and student data shows this will continue.

Disability

1.6% (1.4% in 2025) of registrants declared that they are disabled. Like previous years, there has been no significant change in the percentage of all registrants who have declared a disability. In 2020, 13.0% of working age adults in the UK who are economically active, considered themselves to have a disability[3].

Sexual orientation

Like previous years, there has been no significant change in the percentage of all registrants who have declared a sexual orientation other than heterosexual (less than 3%), as well as those who preferred not to say (roughly 16%). 93.4% of the UK population is heterosexual[4].

Pregnancy and maternity/paternity leave

The percentage of all registrants who have declared that they have been pregnant and/or taken maternity/paternity leave is 6.1% (same as 2025). Over the past three years, each year, between 20% and 22% of respondents selected PNTS.

Country of residence

82.6% (82.3% in 2025) of registrants live in England.

1.9% (2.0% in 2025) of registrants live outside of the UK, in roughly 40 different countries. Of these, more than 27% live in Ireland, just over 20% in Africa, just over 17% in either Crown Dependencies or British Overseas Territories, and just over 12% in Asia.

84.3% of the UK population live in England[5].

[2] Demographics of the United Kingdom - Wikipedia

- England and Wales – Religion, England and Wales - Office for National Statistics – 2021 Census
- Scotland – SuperWEB2 - Table View – 2022 Census
- Northern Ireland – Census 2021 main statistics religion tables | Northern Ireland Statistics and Research Agency – 2021 Census

[3] Disabled People in Employment, House of Commons Briefing Paper – 2024
24.0% of the working age population is disabled; 54.2% are working

[4] Sexual orientation, UK - Office for National Statistics (ons.gov.uk)

[5] Population estimates for the UK, England, Wales, Scotland and Northern Ireland - Office for National Statistics (ons.gov.uk)

Analysis – Fitness to Practice

One of our statutory functions is to investigate allegations where registrants may not be fit to practice as part of our role in protecting the public.

Anyone can initiate a complaint if they have a concern about one of our registrants. If the complaint raises a question about a registrant's fitness to practice (FTP), we will investigate by gathering all the relevant information, for example, optical records, witness statements, or information from the police or NHS organisations. Once the investigation is complete and both the registrant and complainant have had the opportunity to provide comments, all papers are passed to case examiners to decide whether the case should be either closed or referred to the FTP Committee for a hearing.

The data presented in the Appendix shows activity at some of the different stages of our fitness to practice process. They do not track a single cohort of complaints through the system because cases do not necessarily reach outcomes in the same reporting year.

Complainants

Appendix: Tables 29, 30

Sex

Excluding the unknowns, 52.8% of complaints come from females (50.5% in 2025). Unknowns here refer to those who either: do not disclose their gender, or are a company referral. We received 29.4% more complaints this year than the previous.

Location

Regarding UK countries only, 87.5% of complaints came from England.

Registrants Under FTP Investigation

Without Allegation Type

Appendix: Tables 31-43

Numbers

Excluding business registrants, compared with the past year, there have been 21.7% fewer FTP investigations this year.

Professional group

Optometrists make up 59.3% of the register, but account for 71.3% of registrants under FTP investigation. Dispensing opticians make up 20.6% of the register and 16.0% of those under investigation. Student optometrists make up 16.0% of the register and 18.5% of those under investigation.

Over the past three years, there has been no significant change in the proportion of registrants from each professional group under FTP investigation.

Sex

62.8% of registrants under FTP investigation are male (55.0% in 2025). 35.0% of registrants on the register are male (35.7% in 2025).

Ethnicity

This year, compared to the previous two, White EWSNI registrants make up a higher proportion of registrants under FTP investigation compared to their register proportion; conversely, Asian / Asian British registrants make up a smaller proportion. White EWSNI registrants make up 40.4% of registrants under FTP investigation (37.4% of the register is White EWSNI); Asian / Asian British registrants make up 31.9% of registrants under FTP investigation (37.7% of the register is Asian / Asian British).

Excluding PNTS, 46.9% of registrants under FTP investigation are White EWSNI, and 37.0% are Asian / Asian British.

Age

The age group with most registrants under FTP investigation is 25-34 (26.6%), followed by 35-44 (23.4%). Excluding students, age groups with most registrants under FTP investigation is 25-34 (30.5%), followed by 35-44 (27.2%).

Religion

21.1% of registrants on the register are “no religion”, and 26.6% of registrants under FTP investigation are “no religion”. 23.8% of registrants on the register are Christian, and 20.2% of registrants under FTP investigation are Christian. 23.2% of registrants on the register are Muslim, 22.3% of registrants under FTP investigation are Muslim.

The “no religion” category is the only one where the proportion of registrants under FTP investigation is higher than that proportion on the register.

Excluding PNTS, 32.9% of registrants under FTP investigation are “no religion”, 25.0% are Christian, and 27.6% are Muslim.

With Allegation Type

Appendix: Tables 44-49

When we receive a complaint about an individual registrant's fitness to practice or a student registrant's fitness to undertake training, we consider whether the type of allegation should be classified as 'Clinical', 'Conviction/Caution', 'Conduct', 'Health', or 'Mix'. Some allegations are classed as "To be assessed".

These allegation types are distilled further into sub-categories depending on the nature of the complaint, sometimes containing allegations that are a mix in nature (for example clinical and conduct).

Allegation type

The most frequent allegations concern conduct (52.7%), followed by clinical practice (29.0%).

Sex

Like the past year, male conduct cases make up the largest allegation category by sex (36.6%). For both the sexes, the majority of cases are clinical or conduct-related; this has remained unchanged over the past three years.

Age

Conduct cases of 25-34 year-olds, make up the largest allegation category by age (17.2%).

Ethnicity

White EWSNI conduct and Asian / Asian British conduct cases represent the largest allegation category by ethnicity (both 19.4%), followed by White EWSNI clinical cases (14.0%).

Religion

"No religion" conduct cases represent the largest allegation category by religion (15.1%), follow by Muslim conduct cases (14.0%).

Case Examiner Decisions

Appendix: Tables 50-55

Each case is considered by two case examiners (one registrant and one lay person), who decide whether the allegation should be referred to the FTP committee (FTPC) for a full hearing.

Sex

Compared to the past year, a much smaller proportion of male registrants were referred to the FTPC – 28.3% this year versus 57.4% in 2025. 62.8% of registrants under FTP investigation are male.

Age

Like the past three years, the age of registrant cases considered by case examiners is consistent with the register.

Ethnicity

Of the cases referred to the FTPC, 27.1% were White EWSNI (25.0% in 2025), and 52.1% were Asian / Asian British registrants (60.0% in 2025). 40.4% of registrants under FTP investigation are White EWSNI; 31.9% of registrants under FTP investigation are Asian / Asian British.

Religion

Of the cases referred to the FTPC, 25.0% were Christian (22.5% in 2025), and 22.9% were Muslim registrants (22.5% in 2025). 20.2% of registrants under FTP investigation are Christian; 22.3% of registrants under FTP investigation are Muslim.

Analysis – GOC Employees

Appendix: Tables 56-62

At the General Optical Council (GOC) we have a strong commitment to EDI, where our workforce is valued and respected for who they are. We are committed to going beyond meeting our legal obligations under equalities law. For us, EDI is about treating everyone fairly, with empathy and respect. Our values underpin how we work with each other and how we deliver our work. We are committed to being an organisation that has zero tolerance for all forms of unlawful or unfair discrimination, harassment, and victimisation.

All employees are asked to complete an EDI monitoring form upon appointment and to review it for updates annually. This year, 119 out of 136 filled in an EDI form, so data is given based on those 119. Case examiner data is not included in this dataset as they are considered “workers”.

Compared to previous years, levels of non-disclosure increased across many EDI characteristics this year. In particular, the proportion of employees selecting PNTS increased for sex, ethnicity, sexual orientation, and religion. As a result, some apparent changes in workforce demographics are most likely due to changes in disclosure rates. Most employees not disclosing their EDI characteristics this year are new starters.

Sex

56.3% of all employees are female, compared with 69.0% in 2025. We also note that 16.8% selected PNTS, and in 2025 no employee selected PNTS.

Age

29.4% of employees are 25-34 and 38.7% of employees are 35-44. There has been no significant change in the demographic of GOC employees over the past three years.

Ethnicity

Note that employees use the ethnicity “White British” as opposed to “White EWSNI” which is used elsewhere in the report. 36.1% of employees are White British (47.1% in 2025), though 26.1% PNTS compared with 1.1% who selected PNTS in 2025. As of 2021/22, approximately 83.0% of people in UK are White EWSNI[6].

Pregnancy and maternity/paternity leave

Of our 119 employees who filled in an EDI form, fewer than ten were on maternity/paternity leave at the time of accessing the data.

[6] Demographics of the United Kingdom - Wikipedia

- England and Wales – Ethnic group - Office for National Statistics – 2021 Census
- Scotland – Scotland’s Census 2022 - Ethnic group, national identity, language and religion | Scotland's Census – 2022 Census
- Northern Ireland – Census 2021 main statistics ethnicity tables | Northern Ireland Statistics and Research Agency – 2021 Census

Disability

15.1% of employees are disabled (14.9% in 2025).

Religion

In 2025, almost a quarter of employees chose not to say what religion they were; this year, it's just over 40%. Excluding PNTS, 40.8% (42.4% in 2025) said they had no religion, and 43.7% (39.4% in 2025) were Christian.

Sexual orientation

5.0% of employees are not heterosexual (8.0% in 2025), and 36.1% (20.7% in 2025) chose PNTS.

Analysis – GOC Members and Workers

Appendix: Tables 63-79

Our members and workers are the members of Council and our Committees and panels, as well as clinical advisors. Both Council and Committee members scrutinise the GOC, providing checks and balances on the organisation to protect the public. Council also sets the vision and strategy of the GOC.

There are limitations to the data below, in that only information about those who filled in our EDI form is shown. 111 out of 158 members/workers chose to fill in the EDI form, so we only have data for 70.2% (61.4% in 2025) of our members/workers.

Sex

Of the members and workers who filled in our EDI form, 58.6% are female (57.9% in 2025), and 39.6% are male (39.7% in 2025). 1.8% PNTS (2.5% in 2025).

Age

Of the members and workers who filled in our EDI form, like the past year, the most populous age group was 55-64 (36.0%; 40.5% in 2025), followed by 45-54 (21.6%; 24.8% in 2025). 1.8% PNTS (3.3% in 2025).

Ethnicity

Of the members and workers who filled in our EDI form, the largest ethnicity group was White EWSNI (64.9%; 71.9% in 2025), followed by Asian / Asian British (19.8%; 12.4% in 2025); 2.7% PNTS.

Disability

Of the members and workers who filled in our EDI form, 16.2% declared that they are disabled (7.4% in 2025), and 1.8% PNTS (4.1% in 2025).

Sexual orientation

Of the members and workers who filled in our EDI form, 4.5% declared a sexual orientation other than heterosexual (4.1% in 2025), and 6.3% PNTS (7.4% in 2025).

Religion

Of the members and workers who filled in our EDI form, the largest ethnicity group was Christian (36.9%; 38.8% in 2025), followed by “No religion” (27.9%; 32.2% in 2025).

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Registrants

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	31 March 2024		31 March 2025		31 March 2026		2025 to 2026 % change	2024 to 2026 % change
Optometrists	18,010	57.7%	18,725	58.6%	19,361	59.3%	3.4%	7.5%
Dispensing opticians	6,856	22.0%	6,805	21.3%	6,729	20.6%	-1.1%	-1.9%
Student optometrists	5,114	16.4%	5,163	16.2%	5,212	16.0%	0.9%	1.9%
Student dispensing opticians	1,234	4.0%	1,268	4.0%	1,336	4.1%	5.4%	8.3%
Total	**31,214**	**100.0%**	**31,961**	**100.0%**	**32,638**	**100.0%**	**2.1%**	**4.6%**

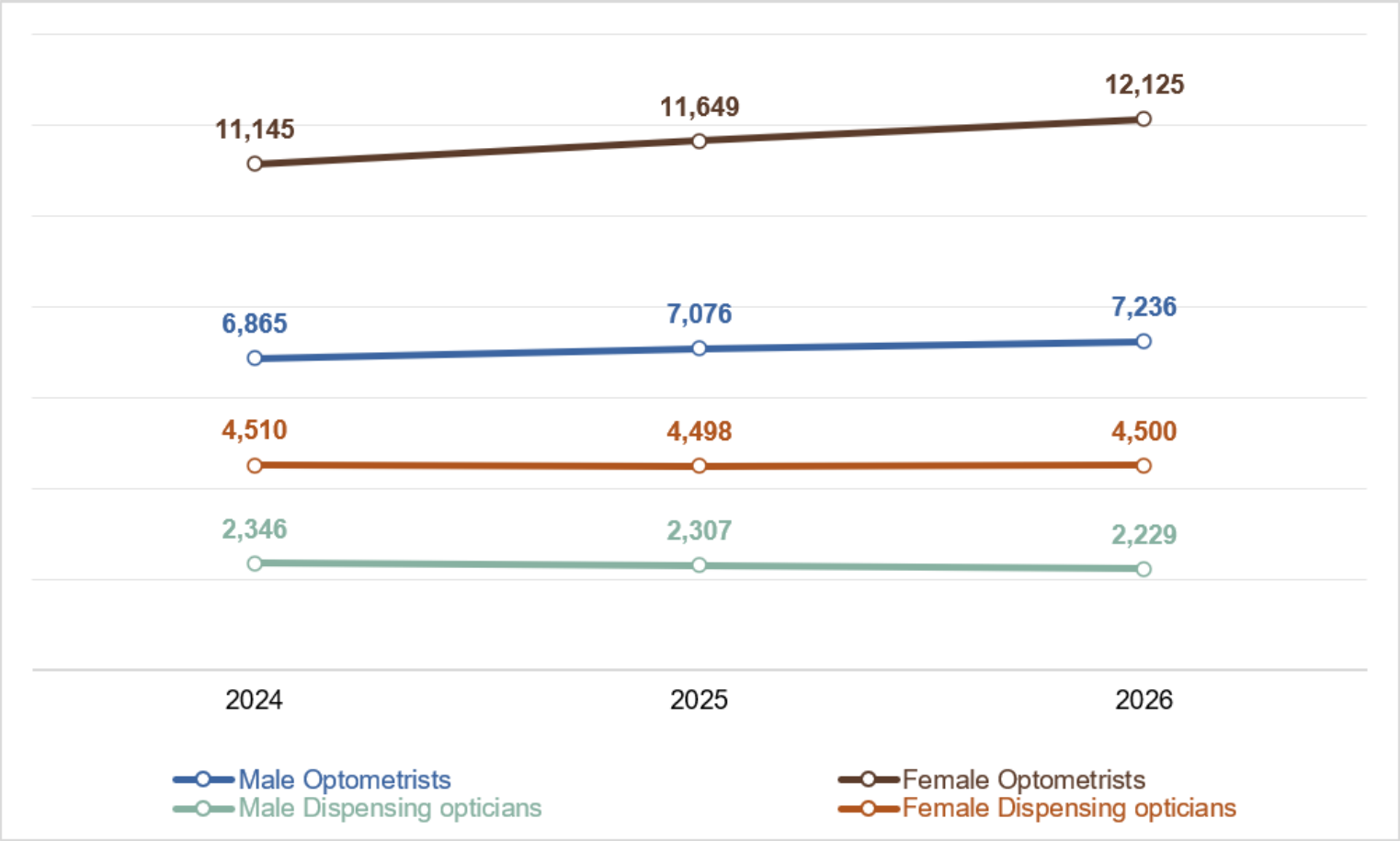
Table 2: Registrants – Sex – 31 March 2026

	Male			Female			Total	
	Total registrants		% of register	Total registrants		% of register	Total registrants	% of registrant type
Optometrists	7,236	22.2%	37.4%	12,125	37.1%	62.6%	19,361	59.3%
Dispensing opticians	2,229	6.8%	33.1%	4,500	13.8%	66.9%	6,729	20.6%
Student optometrists	1,531	4.7%	29.4%	3,681	11.3%	70.6%	5,212	16.0%
Student dispensing opticians	425	1.3%	31.8%	911	2.8%	68.2%	1,336	4.1%
Total	**11,421**	**35.0%**		**21,217**	**65.0%**		**32,638**	**100.0%**

Table 3: Registrants (excluding students) – Sex – 2024 to 2026

		31 March 2024		31 March 2025		31 March 2026		2025 to 2026 % change	2024 to 2026 % change
Male	Optometrists	6,865	27.6%	7,076	27.7%	7,236	27.7%	2.3%	5.4%
	Dispensing opticians	2,346	9.4%	2,307	9.0%	2,229	8.5%	-3.5%	-5.2%
Female	Optometrists	11,145	44.8%	11,649	45.6%	12,125	46.5%	4.1%	8.8%
	Dispensing opticians	4,510	18.1%	4,498	17.6%	4,500	17.2%	<0.1%	-0.2%
Total		**24,866**	**100.0%**	**25,530**	**100.0%**	**26,090**	**100.0%**	**2.2%**	**4.9%**

Graph 1: Registrants (excluding students) – Number of Male vs. Number of Female – 2024 to 2026



Graph 2: Registrants (students only) – Number of Male vs. Number of Female – 2024 to 2026

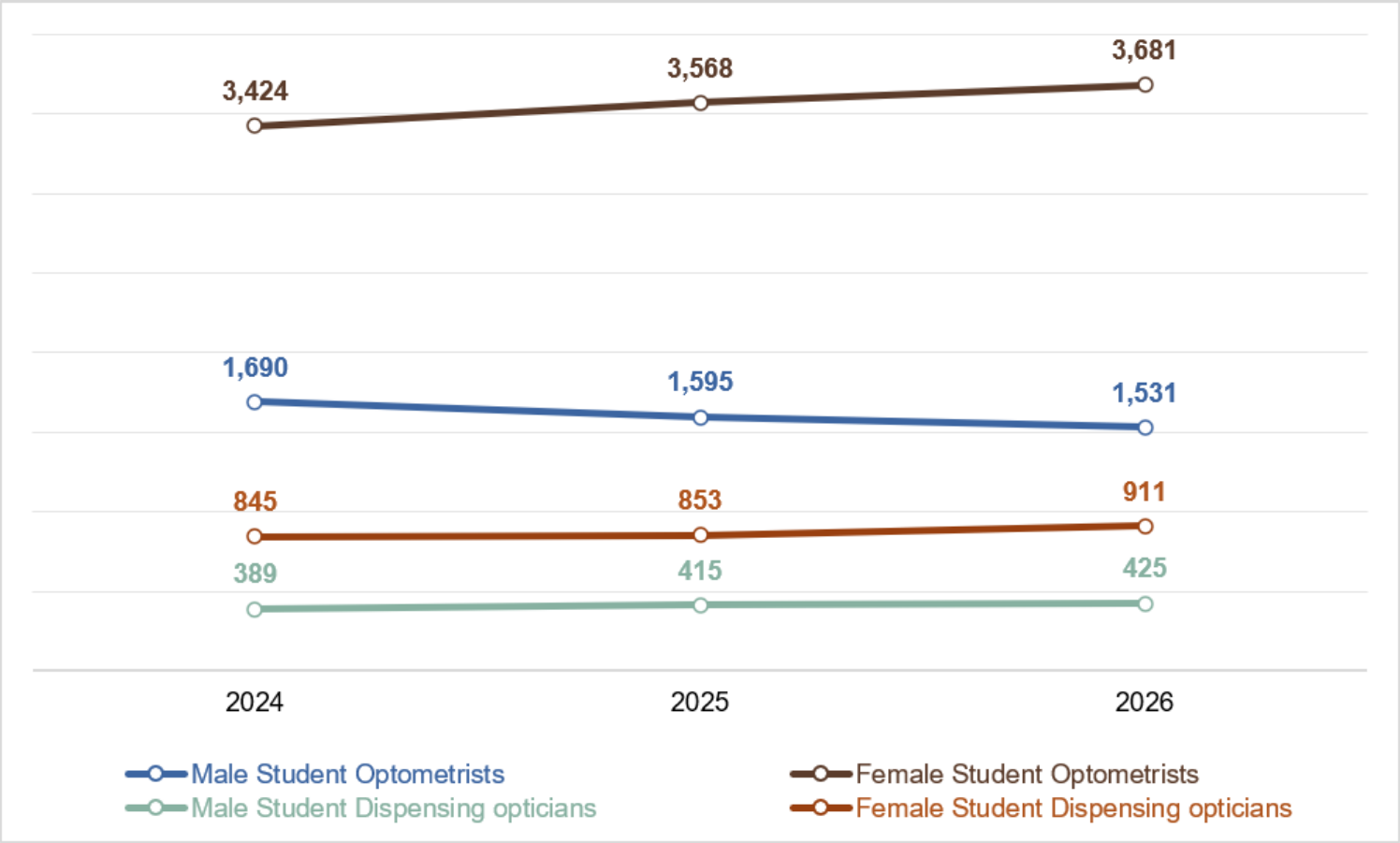


Table 4: Registrants – Specialty – Sex – 31 March 2026

	Contact Lens Specialty		Independent Prescribing Specialty		Additional Supply Specialty		Supplementary Prescribing Specialty		**All specialties**	
Male	431	36.9%	913	36.9%	917	37.0%	911	36.9%	**3,172**	**36.9%**
Female	737	63.1%	1,561	63.1%	1,564	63.0%	1,561	63.1%	**5,423**	**63.1%**
Total	**1,168**	**100.0%**	**2,474**	**100.0%**	**2,481**	**100.0%**	**2,472**	**100.0%**	**8,595**	**100.0%**

Table 5: Registrants (excluding students) – Age – 31 March 2026

	Optometrists		Dispensing opticians		**All non-students**	
Under 25	1,021	5.3%	73	1.1%	**1,094**	**4.2%**
25-34	6,489	33.5%	1,251	18.6%	**7,740**	**29.7%**
35-44	5,233	27.0%	2,004	29.8%	**7,237**	**27.7%**
45-54	3,631	18.8%	1,728	25.7%	**5,359**	**20.5%**
55-64	2,223	11.5%	1,278	19.0%	**3,501**	**13.4%**
65+	764	4.0%	395	5.9%	**1,159**	**4.4%**
Total	**19,361**	**100.0%**	**6,729**	**100.0%**	**26,090**	**100.0%**

Table 6: Registrants (excluding students) – Age – 31 March 2025

	Optometrist		Dispensing optician		**All non-students**	
Under 25	963	5.1%	73	1.1%	**1,036**	**4.1%**
25-34	6,182	33.0%	1,291	19.0%	**7,473**	**29.3%**
35-44	5,225	27.9%	2,030	29.8%	**7,255**	**28.4%**
45-54	3,388	18.1%	1,679	24.7%	**5,067**	**19.9%**
55-64	2,208	11.8%	1,331	19.6%	**3,539**	**13.9%**
65+	759	4.1%	401	5.9%	**1,160**	**4.5%**
Total	**18,725**	**100.0%**	**6,805**	**100.0%**	**25,530**	**100.0%**

Table 7: Registrants (excluding students) – Age – 31 March 2024

	Optometrist		Dispensing optician		**All non-students**	
Under 25	913	5.1%	85	1.2%	**998**	**4.0%**
25-34	5,860	32.5%	1,356	19.8%	**7,216**	**29.0%**
35-44	5,127	28.5%	2,064	30.1%	**7,191**	**28.9%**
45-54	3,218	17.8%	1,644	24.0%	**4,862**	**19.6%**
55-64	2,169	12.0%	1,346	19.6%	**3,515**	**14.1%**
65+	723	4.0%	361	5.3%	**1,084**	**4.4%**
Total	**18,010**	**100.0%**	**6,856**	**100.0%**	**24,866**	**100.0%**

Table 8: Registrants (students only) – Age – 31 March 2026

	Student optometrists		Student dispensing opticians		**All students**	
Under 20	967	18.6%	33	2.5%	**1,000**	**15.3%**
20-24	3,284	63.0%	424	31.7%	**3,708**	**56.6%**
25-30	538	10.3%	427	32.0%	**965**	**14.7%**
31-40	310	6.0%	325	24.3%	**635**	**9.7%**
41+	113	2.2%	127	9.5%	**240**	**3.7%**
Total	**5,212**	**100.0%**	**1,336**	**100.0%**	**6,548**	**100.0%**

Table 9: Registrants (students only) – Age – 31 March 2025

	Student optometrists		Student dispensing opticians		**All students**	
Under 20	872	16.9%	49	3.9%	**921**	**14.3%**
20-24	3,251	63.0%	311	24.5%	**3,562**	**55.4%**
25-30	577	11.2%	440	34.7%	**1,017**	**15.8%**
31-40	352	6.8%	339	26.7%	**691**	**10.7%**
41+	111	2.2%	129	10.2%	**240**	**3.7%**
Total	**5,163**	**100.0%**	**1,268**	**100.0%**	**6,431**	**100.0%**

Table 10: Registrants (students only) – Age – 31 March 2024

	Student optometrists		Student dispensing opticians		**All students**	
Under 20	810	15.8%	52	4.2%	**862**	**13.6%**
20-24	3,268	63.9%	308	25.0%	**3,576**	**56.3%**
25-30	592	11.6%	425	34.4%	**1,017**	**16.0%**
31-40	339	6.6%	318	25.8%	**657**	**10.4%**
41+	105	2.1%	131	10.6%	**236**	**3.7%**
Total	**5,114**	**100.0%**	**1,234**	**100.0%**	**6,348**	**100.0%**

Table 11: Registrants – Specialty – Age – 31 March 2026

	Under 25	25-34	35-44	45-54	55-64	65+	**Total**
Contact Lens Specialty	1	113	282	307	328	137	**1,168**
	0.1%	9.7%	24.1%	26.3%	28.1%	11.7%	**100.0%**
Independent Prescribing Specialty	0	673	859	613	286	43	**2,474**
	0.0%	27.2%	34.7%	24.8%	11.6%	1.7%	**100.0%**
Additional Supply Specialty	0	673	857	614	288	49	**2,481**
	0.0%	27.1%	34.5%	24.7%	11.6%	2.0%	**100.0%**
Supplementary Prescribing Specialty	0	672	858	613	285	44	**2,472**
	0.0%	27.2%	34.7%	24.8%	11.5%	1.8%	**100.0%**
Total	**1**	**2,131**	**2,856**	**2,147**	**1,187**	**273**	**8,595**
	0.0%	**24.8%**	**33.2%**	**25.0%**	**13.8%**	**3.2%**	**100.0%**

Table 12: Registrants – Ethnicity – 31 March 2026

	Optometrists		Dispensing opticians		Student optometrists		Student dispensing opticians		**Total**	
White EWSNI	6,501	33.6%	4,601	68.4%	524	10.1%	569	42.6%	**12,195**	**37.4%**
Asian / Asian British	8,617	44.5%	958	14.2%	2,515	48.3%	225	16.8%	**12,315**	**37.7%**
Black / Black British	562	2.9%	69	1.0%	357	6.8%	14	1.0%	**1,002**	**3.1%**
Mixed/Multiple	228	1.2%	77	1.1%	69	1.3%	21	1.6%	**395**	**1.2%**
Other	1431	7.4%	403	6.0%	320	6.1%	92	6.9%	**2,246**	**6.9%**
PNTS	2,022	10.4%	621	9.2%	1427	27.4%	415	31.1%	**4,485**	**13.7%**
Total	**19,361**	**100.0%**	**6,729**	**100.0%**	**5,212**	**100.0%**	**1,336**	**100.0%**	**32,638**	**100.0%**

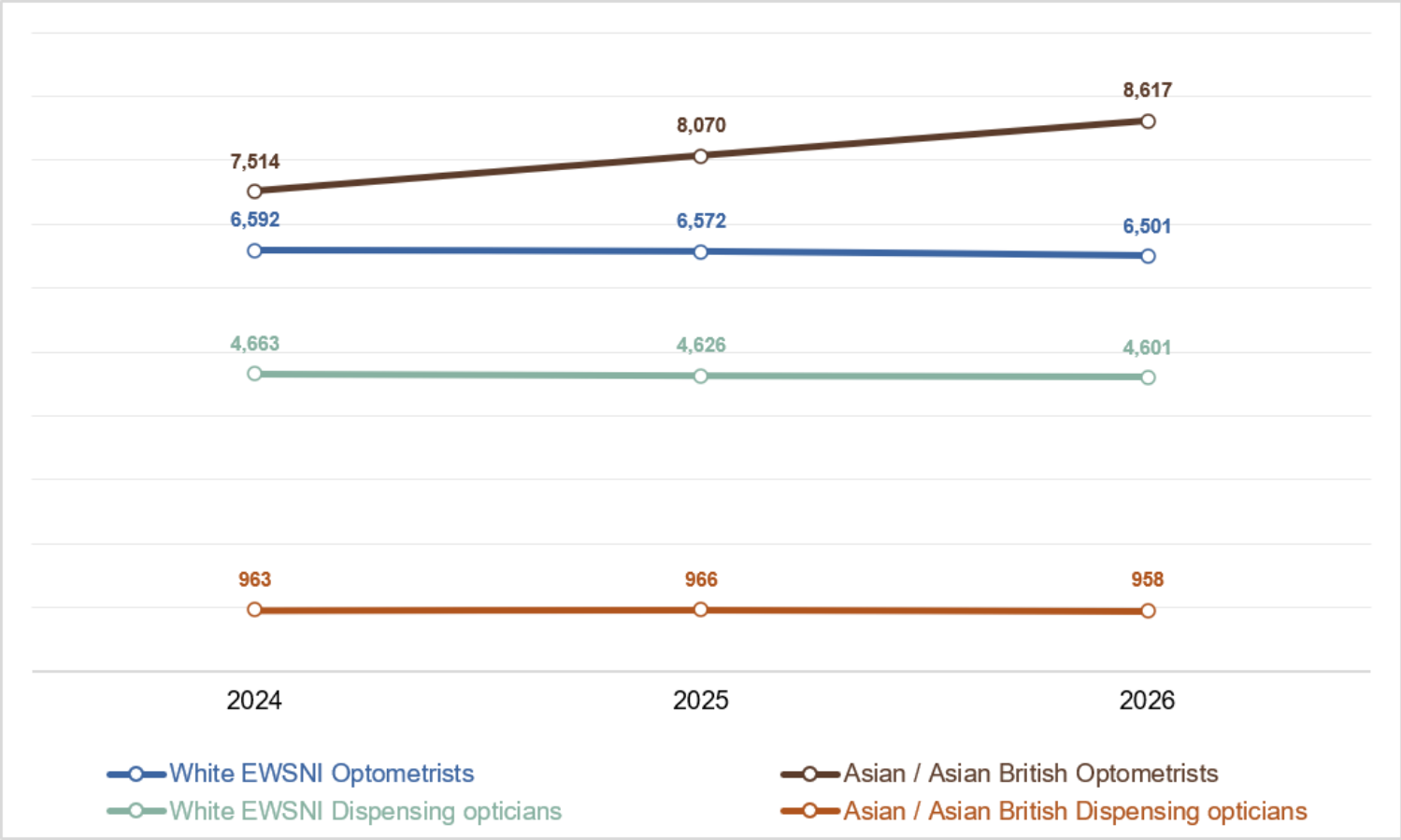
Table 13: Registrants – Ethnicity – 31 March 2025

	Optometrists		Dispensing opticians		Student optometrists		Student dispensing opticians		**Total**	
White EWSNI	6,572	35.1%	4,626	68.0%	497	9.6%	547	43.1%	**12,242**	**38.3%**
Asian / Asian British	8,070	43.1%	966	14.2%	2,556	49.5%	245	19.3%	**11,837**	**37.0%**
Black / Black British	445	2.4%	71	1.0%	356	6.9%	11	0.9%	**883**	**2.8%**
Mixed/Multiple	219	1.2%	74	1.1%	61	1.2%	16	1.3%	**370**	**1.2%**
Other	1427	7.6%	411	6.0%	314	6.1%	91	7.2%	**2,243**	**7.0%**
PNTS	1,992	10.6%	657	9.7%	1379	26.7%	358	28.2%	**4,386**	**13.7%**
Total	**18,725**	**100.0%**	**6,805**	**100.0%**	**5,163**	**100.0%**	**1,268**	**100.0%**	**31,961**	**100.0%**

Table 14: Registrants – Ethnicity – 31 March 2024

	Optometrists		Dispensing opticians		Student optometrists		Student dispensing opticians		**Total**	
White EWSNI	6,592	36.6%	4,663	68.0%	524	10.2%	551	44.7%	**12,330**	**39.5%**
Asian / Asian British	7,514	41.7%	963	14.0%	2,614	51.1%	233	18.9%	**11,324**	**36.3%**
Black / Black British	336	1.9%	71	1.0%	292	5.7%	19	1.5%	**718**	**2.3%**
Mixed/Multiple	213	1.2%	72	1.1%	51	1.0%	13	1.1%	**349**	**1.1%**
Other	1400	7.8%	402	5.9%	275	5.4%	88	7.1%	**2,165**	**6.9%**
PNTS	1,955	10.9%	685	10.0%	1358	26.6%	330	26.7%	**4,328**	**13.9%**
Total	**18,010**	**100.0%**	**6,856**	**100.0%**	**5,114**	**100.0%**	**1,234**	**100.0%**	**31,214**	**100.0%**

Graph 3: Registrants (excluding students) – Number of White EWSNI vs. Number of Asian / Asian British – 2024 to 2026



Graph 4: Registrants (students only) – Number of White EWSNI vs. Number of Asian / Asian British – 2024 to 2026

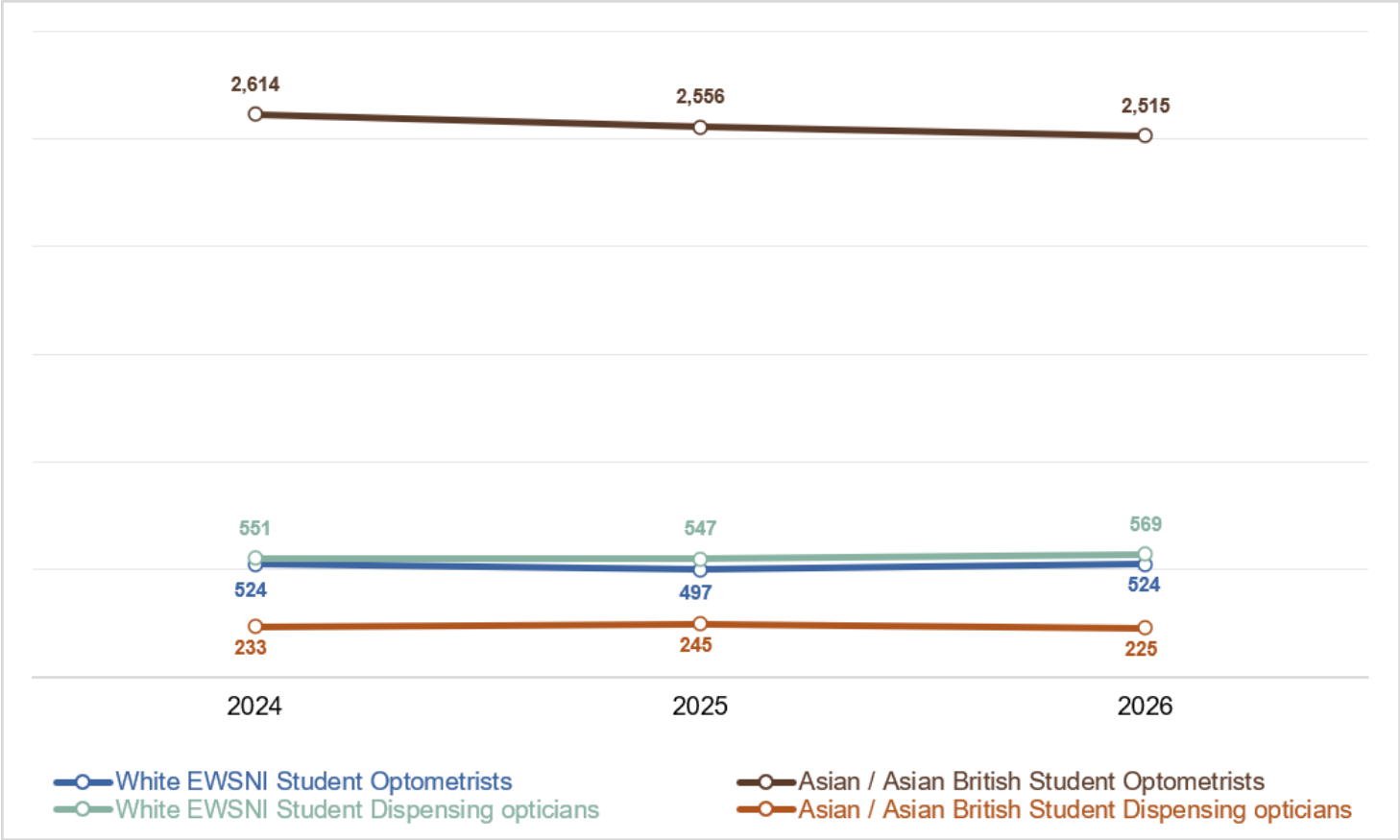


Table 15: Registrants – Specialty – Ethnicity – 31 March 2026

	White EWSNI		Asian / Asian British		Black / Black British		Mixed/ Multiple		Other		PNTS		**Total**	
Contact Lens Specialty	801	68.6%	162	13.9%	7	0.6%	10	0.9%	61	5.2%	127	10.9%	**1,168**	**100.0%**
Independent Prescribing Specialty	1,294	52.3%	693	28.0%	31	1.3%	35	1.4%	201	8.1%	220	8.9%	**2,474**	**100.0%**
Additional Supply Specialty	1,298	52.3%	693	27.9%	31	1.2%	35	1.4%	201	8.1%	223	9.0%	**2,481**	**100.0%**
Supplementary Prescribing Specialty	1,293	52.3%	692	28.0%	31	1.3%	35	1.4%	200	8.1%	221	8.9%	**2,472**	**100.0%**
Total	**4,686**	**54.5%**	**2,240**	**26.1%**	**100**	**1.2%**	**115**	**1.3%**	**663**	**7.7%**	**791**	**9.2%**	**8,595**	**100.0%**

Table 16: Registrants – Specialty – Ethnicity – 31 March 2025

	White EWSNI		Asian / Asian British		Black / Black British		Mixed/ Multiple		Other		PNTS		**Total**	
Contact Lens Specialty	821	68.6%	168	14.0%	7	0.6%	9	0.8%	60	5.0%	131	11.0%	**1,196**	**100.0%**
Independent Prescribing Specialty	1,144	53.9%	556	26.2%	24	1.1%	25	1.2%	173	8.2%	200	9.4%	**2,122**	**100.0%**
Additional Supply Specialty	1,142	54.1%	548	26.0%	24	1.1%	24	1.1%	172	8.1%	201	9.5%	**2,111**	**100.0%**
Supplementary Prescribing Specialty	1,137	54.1%	545	26.0%	24	1.1%	24	1.1%	171	8.1%	199	9.5%	**2,100**	**100.0%**
Total	**4,244**	**56.4%**	**1,817**	**24.1%**	**79**	**1.0%**	**82**	**1.1%**	**576**	**7.7%**	**731**	**9.7%**	**7,529**	**100.0%**

Table 17: Registrants – Specialty – Ethnicity – 31 March 2024

	White EWSNI		Asian / Asian British		Black / Black British		Mixed/ Multiple		Other		PNTS		**Total**	
Contact Lens Specialty	843	68.6%	172	14.0%	9	0.7%	5	0.4%	59	4.8%	140	11.4%	**1,228**	**100.0%**
Independent Prescribing Specialty	946	54.9%	436	25.3%	19	1.1%	18	1.0%	138	8.0%	167	9.7%	**1,724**	**100.0%**
Additional Supply Specialty	950	54.8%	438	25.3%	19	1.1%	18	1.0%	139	8.0%	170	9.8%	**1,734**	**100.0%**
Supplementary Prescribing Specialty	946	54.9%	435	25.2%	19	1.1%	18	1.0%	138	8.0%	168	9.7%	**1,724**	**100.0%**
Total	**3,685**	**57.5%**	**1,481**	**23.1%**	**66**	**1.0%**	**59**	**0.9%**	**474**	**7.4%**	**645**	**10.1%**	**6,410**	**100.0%**

Table 18: Registrants – Disability – 2024 to 2026

	31 March 2024		31 March 2025		31 March 2026	
Has a disability	363	1.2%	433	1.4%	505	1.6%
Does not have a disability	26,703	85.6%	27,307	85.4%	27,812	85.2%
PNTS	4,148	13.3%	4,221	13.2%	4,321	13.2%
Total	**31,214**	**100.0%**	**31,961**	**100.0%**	**32,638**	**100.0%**

Table 19: Registrants – Marital status – 2024 to 2026

	31 March 2024		31 March 2025		31 March 2026	
Married	14,324	45.9%	14,710	46.0%	14,926	45.7%
Single	9,058	29.0%	9,411	29.4%	9,783	30.0%
Civil partnership	121	0.4%	128	0.4%	120	0.4%
Divorced / Legally dissolved	866	2.8%	875	2.8%	886	2.7%
Partner	2,192	7.0%	2,202	6.9%	2,245	6.9%
Separated	274	0.9%	279	0.9%	248	0.8%
Widow/Widower	1,126	3.6%	953	3.0%	1,022	3.1%
PNTS	3,253	10.4%	3,403	10.6%	3,408	10.4%
Total	**31,214**	**100.0%**	**31,961**	**100.0%**	**32,638**	**100.0%**

Table 20: Registrants – Sexual orientation – 2024 to 2026

	31 March 2024		31 March 2025		31 March 2026	
Heterosexual/Straight	25,394	81.4%	26,054	81.5%	26,601	81.5%
Homosexual/Gay/Lesbian	366	1.2%	378	1.2%	408	1.3%
Bisexual	262	0.8%	287	0.9%	301	0.9%
Other	73	0.2%	84	0.3%	86	0.3%
PNTS	5,119	16.4%	5,158	16.1%	5,242	16.1%
Total	**31,214**	**100.0%**	**31,961**	**100.0%**	**32,638**	**100.0%**

Table 21: Registrants – Pregnancy and maternity/paternity – 2024 to 2026

	31 March 2024		31 March 2025		31 March 2026	
Pregnant or on maternity/paternity leave	1,860	6.0%	1,933	6.1%	2,005	6.1%
Neither pregnant nor on maternity/paternity leave	22,680	72.7%	23,267	72.8%	23,772	72.8%
PNTS	6,674	21.4%	6,761	21.2%	6,861	21.0%
Total	**31,214**	**100.0%**	**31,961**	**100.0%**	**32,638**	**100.0%**

Table 22: Registrants – Religion – 2024 to 2026

	31 March 2024		31 March 2025		31 March 2026	
Christian	7,753	24.8%	7,850	24.6%	7,771	23.8%
Muslim	6,586	21.1%	7,107	22.2%	7,561	23.2%
Hindu	2,798	9.0%	2,834	8.9%	2,840	8.7%
Sikh	1,297	4.2%	1,318	4.1%	1,333	4.1%
Jewish	248	0.8%	237	0.7%	228	0.7%
Buddhist	140	0.5%	143	0.5%	140	0.4%
Other	0	0.0%	0	0.0%	0	0.0%
No religion	6,665	21.5%	6,739	21.1%	6,888	21.1%
PNTS	5,727	18.4%	5,733	17.9%	5,877	18.0%
Total	**31,214**	**100.0%**	**31,961**	**100.0%**	**32,638**	**100.0%**

Graph 5: Registrants – Percentage of Christian vs. Percentage of Muslim – 2024 to 2026

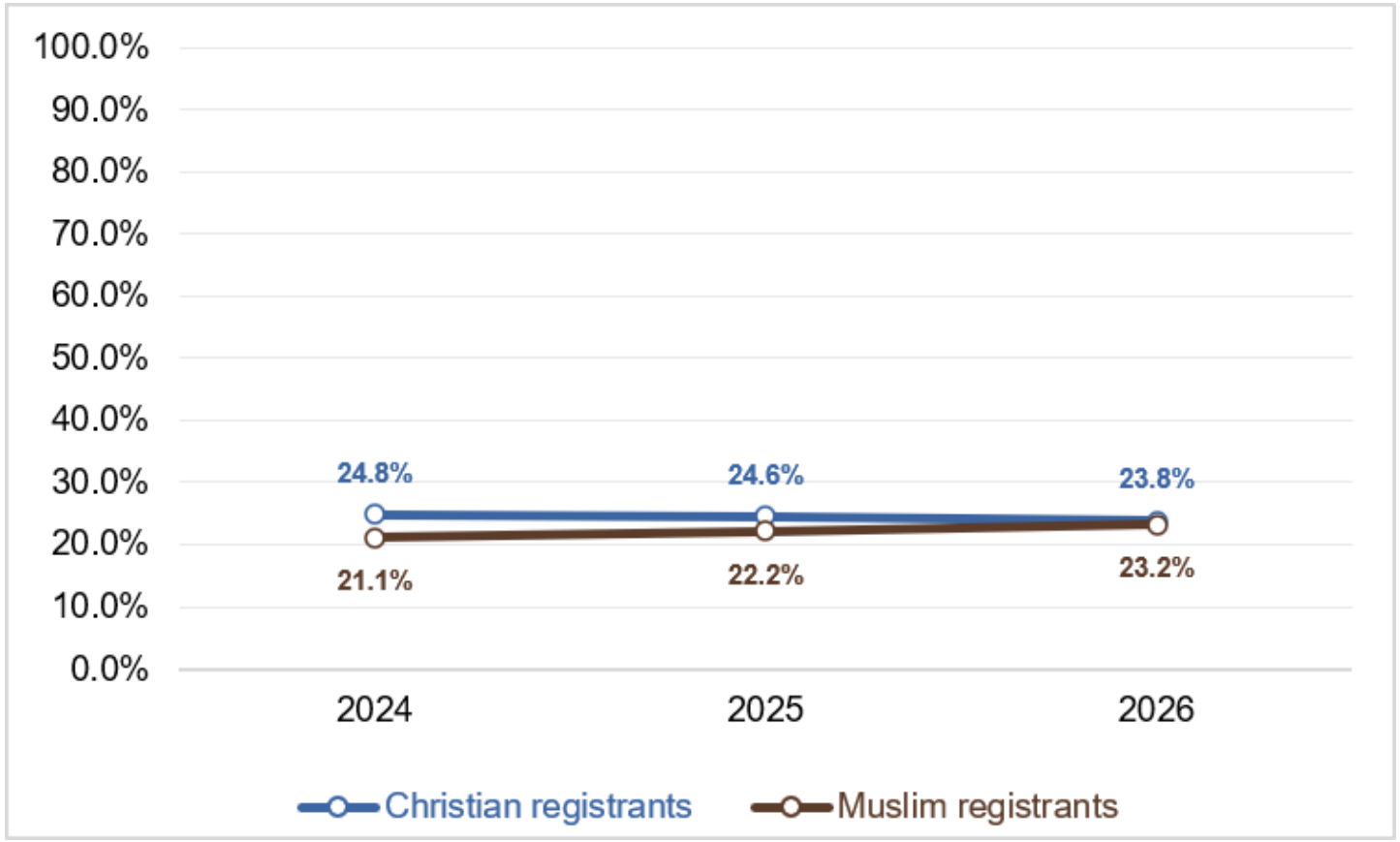


Table 23: Registrants – Religion – 31 March 2026

	Optometrists		Dispensing Opticians		Student Optometrists		Student Dispensing Opticians		**All**	
Christian	4,848	25.0%	2,094	31.1%	665	12.8%	164	12.3%	**7,771**	**23.8%**
Muslim	4,794	24.8%	449	6.7%	2,161	41.5%	157	11.8%	**7,561**	**23.2%**
Hindu	2,257	11.7%	328	4.9%	221	4.2%	34	2.5%	**2,840**	**8.7%**
Sikh	1049	5.4%	130	1.9%	143	2.7%	11	0.8%	**1,333**	**4.1%**
Other	263	1.4%	73	1.1%	27	0.5%	5	0.4%	**368**	**1.1%**
No religion	3,355	17.3%	2,598	38.6%	451	8.7%	484	36.2%	**6,888**	**21.1%**
PNTS	2,795	14.4%	1,057	15.7%	1,544	29.6%	481	36.0%	**5,877**	**18.0%**
Total	**19,361**	**100.0%**	**6,729**	**100.0%**	**5,212**	**100.0%**	**1,336**	**100.0%**	**32,638**	**100.0%**

Table 24: Registrants – Country of residence – 31 March 2026

	Optometrists		Dispensing opticians		Student optometrists		Student dispensing opticians		**Total**	
England	15,790	81.6%	5,844	86.8%	4,185	80.3%	1,154	86.4%	**26,973**	**82.6%**
Scotland	1,737	9.0%	461	6.9%	407	7.8%	68	5.1%	**2,673**	**8.2%**
Wales	815	4.2%	269	4.0%	302	5.8%	48	3.6%	**1,434**	**4.4%**
Northern Ireland	708	3.7%	93	1.4%	122	2.3%	28	2.1%	**951**	**2.9%**
Other	311	1.6%	62	0.9%	196	3.8%	38	2.8%	**607**	**1.9%**
Total	**19,361**	**100.0%**	**6,729**	**100.0%**	**5,212**	**100.0%**	**1,336**	**100.0%**	**32,638**	**100.0%**

Note: These are based on postcode data supplied at registration. Also, this may not reflect where individual registrants work

Table 25: Registrants – Specialty – Country of residence – 31 March 2026

	England		Scotland		Wales		Northern Ireland		Other		**Total**	
Contact Lens Specialty	1,048	89.7%	55	4.7%	53	4.5%	4	0.3%	8	0.7%	**1,168**	**100.0%**
Independent Prescribing Specialty	1,488	60.1%	693	28.0%	175	7.1%	102	4.1%	16	0.6%	**2,474**	**100.0%**
Additional Supply Specialty	1,497	60.3%	688	27.7%	175	7.1%	102	4.1%	19	0.8%	**2,481**	**100.0%**
Supplementary Prescribing Specialty	1,491	60.3%	687	27.8%	175	7.1%	102	4.1%	17	0.7%	**2,472**	**100.0%**
Total	**5,524**	**64.3%**	**2,123**	**24.7%**	**578**	**6.7%**	**310**	**3.6%**	**60**	**0.7%**	**8,595**	**100.0%**

Note: These figures may be double counted due to registrants being active in all more than one prescribing category

Table 26: Registrants – Gender identity – 2024 to 2026

	31 March 2024		31 March 2025		31 March 2026	
Same as birth	27,357	87.6%	28,068	87.8%	28,694	87.9%
Different from birth	23	0.1%	33	0.1%	35	0.1%
PNTS	3,834	12.3%	3,860	12.1%	3,909	12.0%
Total	**31,214**	**100.0%**	**31,961**	**100.0%**	**32,638**	**100.0%**

Table 27: Registrants – Sex and Ethnicity – 31 March 2026

	White EWSNI		Asian / Asian British		Black / Black British		Mixed/Multiple		Other		PNTS		**Total**	
Male	4,045	35.4%	4,188	36.7%	377	3.3%	138	1.2%	752	6.6%	1,921	16.8%	**11,421**	**100.0%**
Female	8,150	38.4%	8,127	23.6%	625	2.9%	257	1.2%	1,494	7.0%	2,564	12.1%	**21,217**	**100.0%**
Total	**12,195**	**37.4%**	**12,315**	**36.3%**	**1,002**	**3.1%**	**395**	**1.2%**	**2,246**	**6.9%**	**4,485**	**13.7%**	**32,638**	**100.0%**

Table 28: Registrants – Age and Ethnicity – 31 March 2026

	White EWSNI		Asian / Asian British		Black / Black British		Mixed/Multiple		Other		PNTS		**Total**	
Under 25	776	13.4%	3,003	51.8%	178	3.1%	76	1.3%	307	5.3%	1,462	25.2%	**5,802**	**100.0%**
25-34	2,606	28.8%	4,551	50.3%	346	3.8%	146	1.6%	544	6.0%	859	9.5%	**9,052**	**100.0%**
35-44	3,079	40.2%	2,668	34.9%	297	3.9%	83	1.1%	629	8.2%	897	11.7%	**7,653**	**100.0%**
45-54	2,793	51.2%	1,448	26.5%	101	1.8%	50	0.9%	428	7.8%	640	11.7%	**5,460**	**100.0%**
55-64	2,225	63.4%	468	13.3%	67	1.9%	34	1.0%	248	7.1%	470	13.4%	**3,512**	**100.0%**
65+	716	61.8%	177	15.3%	13	1.1%	6	0.5%	90	7.8%	157	13.5%	**1,159**	**100.0%**
Total	**12,195**	**37.4%**	**12,315**	**37.7%**	**1,002**	**3.1%**	**395**	**1.2%**	**2,246**	**6.9%**	**4,485**	**13.7%**	**32,638**	**100.0%**

Fitness to Practice

Complainants

Table 29: Complainants – Sex – 2024 to 2026

	31 March 2024		31 March 2025		31 March 2026	
Male	114	28.0%	162	34.5%	180	29.7%
Female	143	35.1%	165	35.1%	201	33.1%
Not known or Anonymous	150	36.9%	142	30.3%	212	34.9%
N/A (e.g. referred by company)	0	0.0%	0	0.0%	14	2.3%
Total	**407**	**100.0%**	**469**	**100.0%**	**607**	**100.0%**

Table 30: Complainants – Location – 2024 to 2026

	31 March 2024		31 March 2025		31 March 2026	
England	335	82.3%	305	65.0%	259	42.7%
Scotland	19	4.7%	22	4.7%	25	4.1%
Wales	13	3.2%	12	2.6%	9	1.5%
Northern Ireland	0	0.0%	4	0.9%	3	0.5%
Not known / Other	40	9.8%	126	26.9%	311	51.2%
Total	**407**	**100.0%**	**469**	**100.0%**	**607**	**100.0%**

Registrants Under FTP Investigation

Without Allegation Type

Table 31: Registrants under FTP investigation – Professional group – 2024 to 2026

	31 March 2024		31 March 2025		31 March 2026	
Optometrists	98	74.8%	89	74.2%	67	60.9%
Dispensing Opticians	19	14.5%	14	11.7%	15	13.6%
Student Optometrists	6	4.6%	14	11.7%	8	7.3%
Student Dispensing Opticians	3	2.3%	3	2.5%	4	3.6%
Subtotal	**126**	**96.2%**	**120**	**96.2%**	**94**	**85.5%**
Business Registrants	5	3.8%	17	14.2%	16	14.5%
Total	**131**	**100.0%**	**137**	**100.0%**	**110**	**100.0%**

Table 32: Registrants under FTP investigation (excluding business registrants) – Professional group – 31 March 2026

	Total investigations		% of investigations against corresponding professional group	Total registrants	% of total registrants
Optometrists	67	71.3%	0.3%	19,361	59.3%
Dispensing Opticians	15	16.0%	0.2%	6,729	20.6%
Student Optometrists	8	8.5%	0.2%	5,212	16.0%
Student Dispensing Opticians	4	4.3%	0.3%	1,336	4.1%
Total	**94**	**100.0%**	**0.3%**	**32,638**	**100.0%**

Table 33: Registrants under FTP investigation (excluding business registrants) – Specialty – 31 March 2026

	Total registrants	% of complaints against specialism	% of complaints against total registrant specialism	Total registrants with specialties	% of total registrants with specialties
Contact lens specialty	30	31.9%	0.1%	1,168	3.6%
Independent prescribing specialty	105	111.7%	0.3%	2,474	7.6%
Additional supply specialty	105	111.7%	0.3%	2,481	7.6%
Supplementary prescribing specialty	105	111.7%	0.3%	2,472	7.6%
Total	**309**		**0.9%**	**8,595**	**26.3%**

Note: These figures may be double counted due to registrants being active in more than one prescribing category

Table 34: Registrants under FTP investigation (excluding business registrants) – Sex – 31 March 2026

	Total	Male			Female		
		Under investigation		Register	Under investigation		Register
Optometrists	**67**	46	48.9%	37.4%	21	22.3%	62.6%
Dispensing Opticians	**15**	7	7.4%	33.1%	8	8.5%	66.9%
Student Optometrists	**8**	3	3.2%	29.4%	5	5.3%	70.6%
Student Dispensing Opticians	**4**	3	3.2%	31.8%	1	1.1%	68.2%
Total	**94**	**59**	**62.8%**	**35.0%**	**35**	**37.2%**	**65.0%**

Table 35: Registrants under FTP investigation (excluding business registrants) – Age – 31 March 2026

	Under 25		25-34		35-44		45-54		55-64		65+		Total	
Optometrists	3	3.2%	17	18.1%	17	18.1%	13	13.8%	8	8.5%	9	9.6%	**67**	**71.3%**
Dispensing Opticians	0	0.0%	4	4.3%	4	4.3%	1	1.1%	6	6.4%	0	0.0%	**15**	**16.0%**
Student Optometrists	6	6.4%	2	2.1%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	**8**	**8.5%**
Student Dispensing Opticians	1	1.1%	2	2.1%	1	1.1%	0	0.0%	0	0.0%	0	0.0%	**4**	**4.3%**
Total	**10**	**10.6%**	**25**	**26.6%**	**22**	**23.4%**	**14**	**14.9%**	**14**	**14.9%**	**9**	**9.6%**	**94**	**100.0%**

Table 36: Registrants under FTP investigation (excluding business registrants) – Ethnicity – 31 March 2026

	White EWSNI		Asian / Asian British		Black / Black British		Mixed/Multiple		Other		PNTS		**Total**	
Optometrists	26	68.4%	23	76.7%	4	57.1%	0	100.0%	4	66.7%	10	76.9%	**67**	**71.3%**
Dispensing Opticians	9	23.7%	2	6.7%	1	14.3%	0	100.0%	0	0.0%	3	23.1%	**15**	**16.0%**
Student Optometrists	1	2.6%	5	16.7%	1	14.3%	0	100.0%	1	16.7%	0	0.0%	**8**	**8.5%**
Student Dispensing Opticians	2	5.3%	0	0.0%	1	14.3%	0	100.0%	1	16.7%	0	0.0%	**4**	**4.3%**
Total	**38**	**100.0%**	**30**	**100.0%**	**7**	**100.0%**	**0**	**100.0%**	**6**	**100.0%**	**13**	**100.0%**	**94**	**100.0%**

Table 37: Registrants under FTP investigation (excluding business registrants) – Ethnicity – 2024 to 2026

		Registrants under FTP investigation	Register
White EWSNI	31 March 2024	24.6%	39.5%
	31 March 2025	28.3%	38.3%
	31 March 2026	40.4%	37.4%
Asian / Asian British	31 March 2024	52.4%	36.3%
	31 March 2025	50.8%	37.0%
	31 March 2026	31.9%	37.7%
Black / Black British	31 March 2024	4.0%	2.3%
	31 March 2025	5.0%	2.8%
	31 March 2026	7.4%	3.1%
Mixed/Multiple	31 March 2024	1.6%	1.1%
	31 March 2025	0.8%	1.2%
	31 March 2026	0.0%	1.2%
Other	31 March 2024	6.3%	6.9%
	31 March 2025	4.2%	7.0%
	31 March 2026	6.4%	6.9%
PNTS	31 March 2024	11.1%	13.9%
	31 March 2025	10.8%	13.7%
	31 March 2026	13.8%	13.7%
Total	**31 March 2024**	**100.0%**	**100.0%**
	31 March 2025	**100.0%**	**100.0%**
	31 March 2026	**100.0%**	**100.0%**

Graph 6: Registrants under FTP investigation (excluding business registrants) compared to the total register – % of White EWSNI vs. % of Asian / Asian British – 2024 to 2026

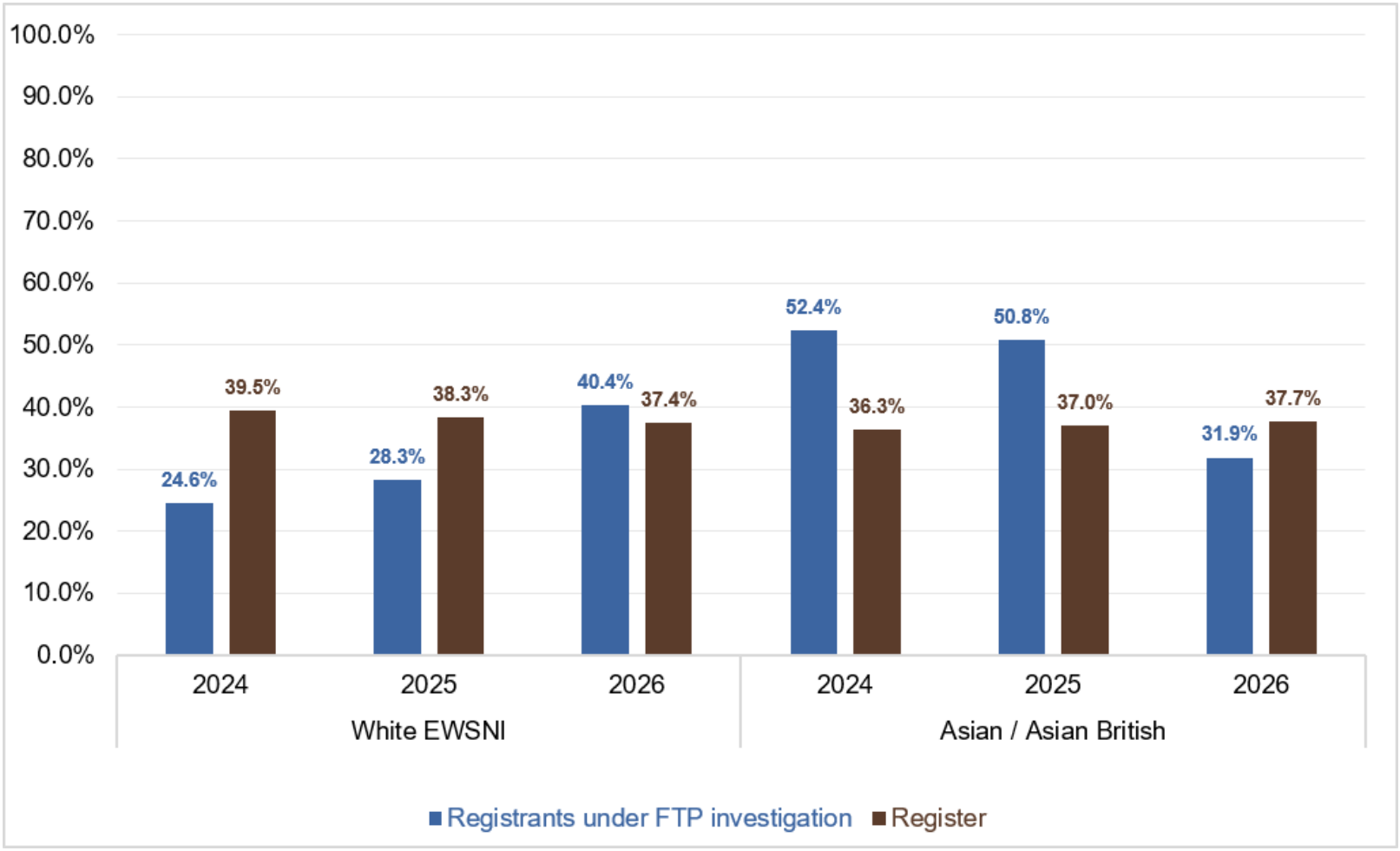


Table 38: Registrants under FTP investigation (excluding business registrants) – Pregnancy and maternity/paternity – 31 March 2026

	Optometrist		Dispensing optician		Student optometrist		Student dispensing optician		**Total**	
Pregnant or on maternity/paternity leave	3	4.5%	2	13.3%	1	12.5%	0	0.0%	6	6.4%
Neither pregnant nor on maternity/paternity leave	48	71.6%	12	80.0%	7	87.5%	3	75.0%	70	74.5%
PNTS	16	23.9%	1	6.7%	0	0.0%	1	25.0%	18	19.1%
Total	**67**	**100.0%**	**15**	**100.0%**	**8**	**100.0%**	**4**	**100.0%**	**94**	**100.0%**

Table 39: Registrants under FTP investigation (excluding business registrants) – Religion – 31 March 2026

	Christian		Muslim		Hindu		Other		No religion		PNTS		**Total**	
Optometrists	14	73.7%	14	66.7%	5	71.4%	4	100.0%	14	56.0%	16	88.9%	**67**	**71.3%**
Dispensing Opticians	2	10.5%	2	9.5%	1	14.3%	0	0.0%	8	32.0%	2	11.1%	**15**	**16.0%**
Student Optometrists	1	5.3%	5	23.8%	1	14.3%	0	0.0%	1	4.0%	0	0.0%	**8**	**8.5%**
Student Dispensing Opticians	2	10.5%	0	0.0%	0	0.0%	0	0.0%	2	8.0%	0	0.0%	**4**	**4.3%**
Total	**19**	**100.0%**	**21**	**100.0%**	**7**	**100.0%**	**4**	**100.0%**	**25**	**100.0%**	**18**	**100.0%**	**94**	**100.0%**

Table 40: Registrants under FTP investigation (excluding business registrants) – Religion – 2024 to 2026

	31 March 2024		31 March 2025		31 March 2026	
	Registrants under FTP investigation	Register	Registrants under FTP investigation	Register	Registrants under FTP investigation	Register
Christian	19.0%	24.8%	23.3%	24.6%	20.2%	23.8%
Muslim	35.7%	21.1%	25.8%	22.2%	22.3%	23.2%
Hindu	11.9%	9.0%	10.0%	8.9%	7.4%	8.7%
Other	9.5%	5.4%	12.5%	5.3%	4.3%	5.2%
No religion	11.1%	21.4%	16.7%	21.1%	26.6%	21.1%
PNTS	12.7%	18.4%	11.7%	17.9%	19.1%	18.0%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Table 41: Registrants under FTP investigation (excluding business registrants) – Gender Identity – 2024 to 2026

	31 March 2024		31 March 2025		31 March 2026	
	Registrants under FTP investigation	Register	Registrants under FTP investigation	Register	Registrants under FTP investigation	Register
Same as birth	88.9%	87.6%	93.3%	87.8%	86.2%	87.9%
Different from birth	0.0%	0.1%	0.0%	0.1%	0.0%	0.1%
PNTS	11.1%	12.3%	6.7%	12.1%	13.8%	12.1%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Table 42: Registrants under FTP investigation (excluding business registrants) – Sex and Ethnicity – 2024 to 2026

	White EWSNI		All other ethnicities		PNTS		**Total**	
Male	27	45.8%	24	40.7%	8	13.6%	**59**	**100.0%**
Female	11	31.4%	19	54.3%	5	14.3%	**35**	**100.0%**
Total	**38**	**40.4%**	**43**	**45.7%**	**13**	**13.8%**	**94**	**100.0%**

Table 43: Registrants under FTP investigation (excluding business registrants) – Age and Ethnicity – 2024 to 2026

	White EWSNI		All other ethnicities		PNTS		**Total**	
Under 25	1	10.0%	9	90.0%	0	0.0%	**10**	**100.0%**
25-34	8	32.0%	13	52.0%	4	16.0%	**25**	**100.0%**
35-44	6	27.3%	14	63.6%	2	9.1%	**22**	**100.0%**
45-54	7	50.0%	3	21.4%	4	28.6%	**14**	**100.0%**
55-64	9	69.2%	1	7.7%	3	23.1%	**13**	**100.0%**
65+	7	70.0%	3	30.0%	0	0.0%	**10**	**100.0%**
Total	**38**	**40.4%**	**43**	**45.7%**	**13**	**13.8%**	**94**	**100.0%**

With Allegation Type

Note – For tables 44-49, the total is 93, not 94, because 1 registrant's allegation type is "TBA"

Table 44: Registrants under FTP investigation (excluding business registrants) – Allegation type – Professional group – 31 March 2026

	Optometrist		Dispensing Opticians		Student Optometrists		Student Dispensing Opticians		**Total**	
Clinical	24	36.4%	3	20.0%	0	0.0%	0	0.0%	**27**	**29.0%**
Conduct	30	45.5%	10	66.7%	6	75.0%	3	75.0%	**49**	**52.7%**
Conviction/Caution	8	12.1%	1	6.7%	1	12.5%	1	25.0%	**11**	**11.8%**
Health	3	4.5%	1	6.7%	1	12.5%	0	0.0%	**5**	**5.4%**
Mix	1	1.5%	0	0.0%	0	0.0%	0	0.0%	**1**	**1.1%**
Total	**66**	**100.0%**	**15**	**100.0%**	**8**	**100.0%**	**4**	**100.0%**	**93**	**100.0%**

Table 45: Registrants under FTP investigation (excluding business registrants) – Allegation type – Sex – 2024 to 2026

	Male						Female					
	31 March 2024		31 March 2025		31 March 2026		31 March 2024		31 March 2025		31 March 2026	
Clinical	25	19.8%	20	16.7%	16	17.2%	23	18.3%	24	20.0%	11	11.8%
Conduct	31	24.6%	31	25.8%	34	36.6%	18	14.3%	18	15.0%	15	16.1%
Conviction/Caution	13	10.3%	9	7.5%	7	7.5%	6	4.8%	4	3.3%	4	4.3%
Health	1	0.8%	1	0.8%	1	1.1%	5	4.0%	2	1.7%	4	4.3%
Mix	3	2.4%	5	4.2%	0	0.0%	1	0.8%	6	5.0%	1	1.1%
Total	**73**	**57.9%**	**66**	**55.0%**	**58**	**62.4%**	**53**	**42.1%**	**54**	**45.0%**	**35**	**37.6%**

Table 46: Registrants under FTP investigation (excluding business registrants) – Allegation type – Age – 31 March 2026

	Under 25		25-34		35-44		45-54		55-64		65+		**Total**	
Clinical	0	0.0%	3	3.2%	6	6.5%	6	6.5%	5	5.4%	7	7.5%	**27**	**29.0%**
Conduct	8	8.6%	16	17.2%	11	11.8%	6	6.5%	6	6.5%	2	2.2%	**49**	**52.7%**
Conviction/Caution	2	2.2%	2	2.2%	4	4.3%	1	1.1%	2	2.2%	0	0.0%	**11**	**11.8%**
Health	0	0.0%	3	3.2%	1	1.1%	1	1.1%	0	0.0%	0	0.0%	**5**	**5.4%**
Mix	0	0.0%	1	1.1%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	**1**	**1,1%**
Total	**10**	**10.8%**	**25**	**26.9%**	**22**	**23.7%**	**14**	**15.1%**	**13**	**14.0%**	**9**	**9.7%**	**93**	**100.0%**
Total (minus students)	**3**	**3.2%**	**21**	**22.6%**	**21**	**22.6%**	**14**	**15.1%**	**13**	**14.0%**	**9**	**9.7%**	**81**	**87.1%**

Table 47: Registrants under FTP investigation (excluding business registrants) – Allegation type – Ethnicity – 31 March 2026

	Clinical		Conduct		Conviction/Caution		Health		Mix		**Total**	
White EWSNI	13	48.1%	18	36.7%	4	0.0%	2	50.0%	0	0.0%	**37**	**39.8%**
Asian / Asian British	6	22.2%	18	36.7%	4	0.0%	1	25.0%	1	100.0%	**30**	**32.3%**
Black / Black British	1	3.7%	5	10.2%	1	0.0%	0	0.0%	0	0.0%	**7**	**7.5%**
Mixed/Multiple	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	**0**	**0.0%**
Other	2	7.4%	1	2.0%	2	0.0%	1	25.0%	0	0.0%	**6**	**6.5%**
PNTS	5	18.5%	7	14.3%	1	0.0%	0	0.0%	0	0.0%	**13**	**14.0%**
Total	**27**	**100.0%**	**49**	**100.0%**	**12**	**0.0%**	**4**	**100.0%**	**1**	**100.0%**	**93**	**100.0%**

Table 48: Registrants under FTP investigation (excluding business registrants) – Allegation type – Religion – 31 March 2026

	Clinical		Conduct		Conviction/Caution		Health		Mix		**Total**	
Christian	7	25.9%	9	18.4%	2	0.0%	0	0.0%	1	100.0%	**19**	**20.4%**
Muslim	3	11.1%	13	26.5%	3	0.0%	2	40.0%	0	0.0%	**21**	**22.6%**
Hindu	3	11.1%	3	6.1%	1	0.0%	0	0.0%	0	0.0%	**7**	**7.5%**
Other	1	3.7%	3	6.1%	0	0.0%	0	0.0%	0	0.0%	**4**	**4.3%**
No religion	4	14.8%	14	28.6%	5	0.0%	2	40.0%	0	0.0%	**25**	**26.9%**
PNTS	9	33.3%	7	14.3%	0	0.0%	1	20.0%	0	0.0%	**17**	**18.3%**
Total	**27**	**100.0%**	**49**	**100.0%**	**11**	**0.0%**	**5**	**100.0%**	**1**	**100.0%**	**93**	**100.0%**

Table 49: Registrants under FTP investigation (excluding business registrants) – Allegation type – Country of residence – 31 March 2026

	Clinical		Conduct		Conviction/Caution		Health		Mix		**Total**	
England	23	85.2%	40	81.6%	8	0.0%	4	80.0%	1	100.0%	**76**	**81.7%**
Scotland	4	14.8%	4	8.2%	1	0.0%	1	20.0%	0	0.0%	**10**	**10.8%**
Wales	0	0.0%	3	6.1%	1	0.0%	0	0.0%	0	0.0%	**4**	**4.3%**
Northern Ireland	0	0.0%	1	2.0%	1	0.0%	0	0.0%	0	0.0%	**2**	**2.2%**
Other	0	0.0%	1	2.0%	0	0.0%	0	0.0%	0	0.0%	**1**	**1.1%**
Total	**27**	**100.0%**	**49**	**100.0%**	**11**	**0.0%**	**5**	**100.0%**	**1**	**100.0%**	**93**	**100.0%**

Case Examiner Decisions

Table 50: Case Examiner decisions – Sex – 31 March 2026

	Male		Female		**Total**	
No further action (incl. advice/warning issued)	22	23.9%	22	23.9%	**44**	**47.8%**
Referral to Fitness to Practice Committee (FtPC)	26	28.3%	22	23.9%	**48**	**52.2%**
Total	**48**	**52.2%**	**44**	**47.8%**	**92**	**100.0%**

Table 51: Case Examiner decisions – Sex – 2024 to 2026

	Male						Female					
	31 March 2024		31 March 2025		31 March 2026		31 March 2024		31 March 2025		31 March 2026	
No further action (incl. advice/warning issued)	24	51.1%	27	50.0%	22	45.8%	20	64.5%	27	67.5%	22	50.0%
Referral to Fitness to Practice Committee (FTPC)	23	48.9%	27	50.0%	26	54.2%	11	35.5%	13	32.5%	22	50.0%
Total	**47**	**100.0%**	**54**	**100.0%**	**48**	**100.0%**	**31**	**100.0%**	**40**	**100.0%**	**44**	**100.0%**

Table 52: Case Examiner decisions – Age – 31 March 2026

	No further action (incl. advice/warning issued)		Referral to Fitness to Practice Committee (FTPC)		**Total**	
Under 25	1	16.7%	5	83.3%	**6**	**100.0%**
25-34	15	53.6%	13	46.4%	**28**	**100.0%**
35-44	12	44.4%	15	55.6%	**27**	**100.0%**
45-54	9	47.4%	10	52.6%	**19**	**100.0%**
55-64	4	50.0%	4	50.0%	**8**	**100.0%**
65+	3	75.0%	1	25.0%	**4**	**100.0%**
Total	**44**	**47.8%**	**48**	**52.2%**	**92**	**100.0%**

Table 53: Case Examiner decisions – Ethnicity – 31 March 2026

	No further action (incl. advice/warning issued)		Referral to Fitness to Practice Committee (FTPC)		**Total**	
White EWSNI	13	29.5%	13	27.1%	**26**	**28.3%**
Asian / Asian British	19	43.2%	25	52.1%	**44**	**47.8%**
Black / Black British	5	11.4%	3	6.3%	**8**	**8.7%**
Mixed/Multiple	1	2.3%	1	2.1%	**2**	**2.2%**
Other	2	4.5%	2	4.2%	**4**	**4.3%**
PNTS	4	9.1%	4	8.3%	**8**	**8.7%**
Total	**44**	**100.0%**	**48**	**100.0%**	**92**	**100.0%**

Table 54: Case Examiner decisions – Ethnicity – 2024 to 2026

		No further action (incl. advice/warning issued)	Referral to Fitness to Practice Committee (FTPC)	Total
White EWSNI	31 March 2024	18	11	**29**
		62.1%	37.9%	**100.0%**
	31 March 2025	10	10	**20**
		50.0%	50.0%	**100.0%**
	31 March 2026	13	13	**26**
		50.0%	50.0%	**100.0%**
Asian / Asian British	31 March 2024	21	16	**37**
		56.8%	43.2%	**100.0%**
	31 March 2025	31	24	**55**
		56.4%	43.6%	**100.0%**
	31 March 2026	19	25	**44**
		43.2%	56.8%	**100.0%**
Black / Black British	31 March 2024	0	1	**1**
		0.0%	100.0%	**100.0%**
	31 March 2025	3	1	**4**
		75.0%	25.0%	**100.0%**
	31 March 2026	5	3	**8**
		62.5%	37.5%	**100.0%**
Mixed/Multiple	31 March 2024	1	0	**0**
		0.0%	0.0%	**100.0%**
	31 March 2025	1	1	**2**
		50.0%	50.0%	**100.0%**
	31 March 2026	1	1	**2**
		50.0%	50.0%	**100.0%**
Other	31 March 2024	0	1	**1**
		0.0%	100.0%	**100.0%**
	31 March 2025	1	1	**2**

		50.0%	50.0%	**100.0%**
	31 March 2026	2	2	**4**
		50.0%	50.0%	**100.0%**
PNTS	31 March 2024	4	5	**9**
		44.4%	55.6%	**100.0%**
	31 March 2025	8	3	**11**
		72.7%	27.3%	**100.0%**
	31 March 2026	4	4	**8**
		50.0%	50.0%	**100.0%**
Total	**31 March 2024**	**44**	**34**	**78**
		56.4%	**43.6%**	**100.0%**
	31 March 2025	**54**	**40**	**94**
		57.4%	**42.6%**	**100.0%**
	31 March 2026	**44**	**48**	**92**
		47.8%	**52.2%**	**100.0%**

Table 55: Case Examiner decisions – Religion – 31 March 2026

	Christian		Muslim		Hindu		Other		No religion		PNTS		**Total**	
No further action (incl. advice/ warning issued)	15	16.3%	10	10.9%	2	2.2%	3	3.3%	8	8.7%	6	6.5%	**44**	**47.8%**
Referral to Fitness to Practice Committee (FTPC)	12	13.0%	11	12.0%	5	5.4%	6	6.5%	7	7.6%	7	7.6%	**48**	**52.2%**
Total	**27**	**29.3%**	**21**	**22.8%**	**7**	**7.6%**	**9**	**9.8%**	**15**	**16.3%**	**13**	**14.1%**	**92**	**100.0%**

GOC Employees

Table 56: GOC Employees – Sex – 2024 to 2026

	31 March 2024		31 March 2025		31 March 2026	
Female	54	69.2%	60	69.0%	67	56.3%
Male	24	30.8%	27	31.0%	32	26.9%
PNTS	0	0%	0	0%	20	16.8%
Total responses received	**78**	**100.0%**	**87**	**100.0%**	**119**	**100.0%**

Table 57: GOC Employees – Age – 2024 to 2026

	31 March 2024		31 March 2025		31 March 2026	
Under 25	1	1.3%	3	3.4%	4	3.4%
25-34	23	29.5%	23	26.4%	35	29.4%
35-44	30	38.5%	34	39.1%	46	38.7%
45-54	14	17.9%	16	18.4%	23	19.3%
55-64	11	14.1%	11	12.6%	10	8.4%
65+	0	0.0%	0	0.0%	1	0.8%
Total responses received	**78**	**100.0%**	**87**	**100.0%**	**119**	**100.0%**

Table 58: GOC Employees – Ethnicity – 2024 to 2026

	31 March 2024		31 March 2025		31 March 2026	
White British	35	44.9%	41	47.1%	43	36.1%
Asian / Asian British	15	19.2%	15	17.2%	14	11.8%
Black / Black British	15	19.2%	19	21.8%	18	15.1%
Mixed/Multiple	3	3.8%	6	6.9%	3	2.5%
Other	9	11.5%	9	10.3%	10	8.4%
PNTS	1	1.3%	1	1.1%	31	26.1%
Total responses received	**78**	**100.0%**	**87**	**100.0%**	**119**	**100.0%**

Table 59: GOC Employees – Disability – 2024 to 2026

	31 March 2024		31 March 2025		31 March 2026	
Disabled	10	12.8%	13	14.9%	18	15.1%
Not disabled	68	87.2%	74	85.1%	101	84.9%
Total responses received	**78**	**100.0%**	**87**	**100.0%**	**119**	**100.0%**

Table 60: GOC Employees – Sexual orientation – 2024 to 2026

	31 March 2024		31 March 2025		31 March 2026	
Heterosexual	55	70.5%	55	63.2%	70	58.8%
Gay/Lesbian	1	1.3%	2	2.2%	4	3.4%
Bisexual	4	5.1%	5	5.7%	2	1.7%
Other	0	0.0%	0	0.0%	0	0.0%
PNTS	18	23.1%	18	20.7%	43	36.1%
Total responses received	**78**	**100.0%**	**87**	**100.0%**	**119**	**100.0%**

Table 61: GOC Employees – Religion – 2024 to 2026

	31 March 2024		31 March 2025		31 March 2026	
Christian	18	23.1%	26	29.9%	31	26.1%
Muslim	8	10.3%	7	8.0%	7	5.9%
Hindu	4	5.1%	4	4.6%	3	2.5%
Buddhist; Sikh	2	2.6%	1	1.1%	1	0.8%
No religion	24	30.8%	28	32.2%	29	24.4%
PNTS	22	28.2%	21	24.2%	48	40.3%
Total responses received	**78**	**100.0%**	**87**	**100.0%**	**119**	**100.0%**

Table 62: GOC Employees – Gender Identity – 2024 to 2026

	31 March 2024		31 March 2025		31 March 2026	
Same as birth	59	75.6%	68	78.2%	76	63.9%
Different from birth	1	1.3%	1	1.1%	0	0.0%
PNTS	18	23.1%	18	20.7%	43	36.1%
Total responses received	**78**	**100.0%**	**87**	**100.0%**	**119**	**100.0%**

GOC Members and Workers

Table 63: Members and Workers – Committee – 31 March 2026

	Lay	Registrant	**Total**
Council member	5	6	**11**
Committee member (includes Advisory Panel and independent members on Council committees; excludes Council members)	12	17	**29**
Hearing Panel	27	22	**49**
Education Visitor Panel or Clinical Advisor	4	18	**22**
Total responses received	**48**	**63**	**111**

Table 64: Members and Workers – Sex – 31 March 2026

	Male		Female		PNTS		Total	
Council member	4	36.4%	7	63.6%	0	0.0%	**11**	**100.0%**
Committee member (includes Advisory Panel and independent members on Council committees; excludes Council members)	11	37.9%	18	62.1%	0	0.0%	**29**	**100.0%**
Hearing Panel	18	36.7%	29	59.2%	2	4.1%	**49**	**100.0%**
Education Visitor Panel or Clinical Advisor	11	50.0%	11	50.0%	0	0.0%	**22**	**100.0%**
Total responses received	**44**	**39.6%**	**65**	**58.6%**	**2**	**1.8%**	**111**	**100.0%**

Table 65: Members and Workers – Age – 31 March 2026

	Under 25		25-34		35-44		45-54		55-64		65+		PNTS		**Total**	
Council member	0	0.0%	0	0.0%	0	0.0%	2	18.2%	5	45.5%	4	36.4%	0	0.0%	**11**	**100.0%**
Committee member (includes Advisory Panel and independent members on Council committees; excludes Council members)	1	3.4%	4	13.8%	5	17.2%	10	34.5%	5	17.2%	4	13.8%	0	0.0%	**29**	**100.0%**
Hearing Panel	0	0.0%	0	0.0%	9	18.4%	7	14.3%	26	53.1%	6	12.2%	1	2.0%	**49**	**100.0%**
Education Visitor Panel or Clinical Advisor	0	0.0%	1	4.5%	6	27.3%	5	22.7%	8	36.4%	1	4.5%	1	4.5%	**22**	**100.0%**
Total responses received	**1**	**0.9%**	**5**	**4.5%**	**20**	**18.0%**	**24**	**21.6%**	**44**	**39.6%**	**15**	**13.5%**	**2**	**1.8%**	**111**	**100.0%**

Table 66: Members and Workers – Ethnicity – 31 March 2026

	White EWSNI		Asian / Asian British		Black / Black British		Mixed/Multiple		Other		PNTS		**Total**	
Council member	8	72.7%	2	18.2%	0	0.0%	0	0.0%	1	9.1%	0	0.0%	**11**	**100.0%**
Committee member (includes Advisory Panel and independent members on Council committees; excludes Council members)	15	51.7%	12	41.4%	0	0.0%	1	3.4%	1	3.4%	0	0.0%	**29**	**100.0%**
Hearing Panel	33	67.3%	7	14.3%	0	0.0%	0	0.0%	6	12.2%	3	6.1%	**49**	**100.0%**
Education Visitor Panel or Clinical Advisor	16	72.3%	1	4.5%	0	0.0%	0	0.0%	5	22.7%	0	0.0%	**22**	**100.0%**
Total responses received	**72**	**64.9%**	**22**	**19.8%**	**0**	**0.0%**	**1**	**0.9%**	**13**	**11.7%**	**3**	**2.7%**	**111**	**100.0%**

Table 67: Members and Workers – Religion – 31 March 2026

	Christian		Muslim		Hindu		Buddhist; Jewish; Sikh; Other		No religion		PNTS		**Total**	
Council member	5	45.5%	0	0.0%	2	18.2%	2	18.2%	2	18.2%	0	0.0%	**11**	**100.0%**
Committee member (includes Advisory Panel and independent members on Council committees; excludes Council members)	8	27.6%	4	13.8%	4	13.8%	2	6.9%	8	25.9%	3	10.3%	**29**	**100.0%**
Hearing Panel	19	38.8%	3	6.1%	2	4.1%	9	18.4%	11	22.4%	5	10.2%	**49**	**100.0%**
Education Visitor Panel or Clinical Advisor	9	40.9%	0	0.0%	0	0.0%	1	4.5%	10	45.5%	2	9.1%	**22**	**100.0%**
Total responses received	**41**	**36.9%**	**7**	**6.3%**	**8**	**7.2%**	**14**	**12.6%**	**31**	**27.9%**	**10**	**9.0%**	**111**	**100.0%**

Table 68: Members and Workers – Gender identity – 31 March 2026

	Male		Female		PNTS		Total	
Council member	4	36.4%	7	63.6%	0	0.0%	**11**	**100.0%**
Committee member (includes Advisory Panel and independent members on Council committees; excludes Council members)	11	37.9%	18	62.1%	0	0.0%	**29**	**100.0%**
Hearing Panel	18	36.7%	29	59.2%	2	4.1%	**49**	**100.0%**
Education Visitor Panel or Clinical Advisor	11	50.0%	11	50.0%	0	0.0%	**22**	**100.0%**
Total responses received	**44**	**39.6%**	**65**	**58.6%**	**2**	**1.8%**	**111**	**100.0%**

Table 69: Members and Workers – Intersex and/or variation of sex characteristics (VSC) – 31 March 2026

	Yes		No		PNTS		Total	
Council member	0	0.0%	10	90.9%	1	9.1%	**11**	**100.0%**
Committee member (includes Advisory Panel and independent members on Council committees; excludes Council members)	1	3.4%	28	96.6%	0	0.0%	**29**	**100.0%**
Hearing Panel	0	0.0%	45	91.8%	4	8.2%	**49**	**100.0%**
Education Visitor Panel or Clinical Advisor	0	0.0%	20	90.9%	2	9.1%	**22**	**100.0%**
Total responses received	**1**	**0.9%**	**103**	**92.8%**	**7**	**6.3%**	**111**	**100.0%**

Table 70: Members and Workers – Disability – 31 March 2026

	Yes		No		PNTS		Total	
Total responses received	**18**	**16.2%**	**91**	**82.0%**	**2**	**1.8%**	**111**	**100.0%**

Note: Disability here is defined as any physical or mental health conditions or illnesses that reduces one's ability to carry out day-to-day activities, which have lasted or are expected to last 12 months or more

Table 71: Members and Workers – Type of disability – 31 March 2026

	Neurodivergent condition (e.g. ADHD, autism, dyslexia)		Mental health condition (e.g. depression, anxiety)		Neurodivergent condition (e.g. ADHD, autism, dyslexia)		Physical impairment (e.g. mobility, sensory, chronic pain)		Long-term health condition (e.g. diabetes, heart disease)		Hidden or invisible condition (e.g. chronic fatigue, fibromyalgia)		Other		PNTS		**Total**	
Total responses received	**1**	**0.9%**	**2**	**1.8%**	**1**	**0.9%**	**9**	**7.9%**	**3**	**2.6%**	**3**	**2.6%**	**2**	**1.8%**	**93**	**81.6%**	**114**	**100.0%**

Note: The total exceeds 111 because an individual can select more than one disability.

Table 72: Members and Workers – Marital status – 31 March 2026

	Married or in a registered civil partnership		Never married and never registered a civil partnership		Separated, divorced or civil partnership dissolved		Widowed or a surviving partner from a civil partnership		Co-habiting or living with a partner		PNTS		**Total**	
Council member	11	100.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	**11**	**100.0%**
Committee member (includes Advisory Panel and independent members on Council committees; excludes Council members)	21	72.4%	4	13.8%	2	6.9%	0	0.0%	2	6.9%	0	0.0%	**29**	**100.0%**
Hearing Panel	38	77.6%	6	12.2%	1	2.0%	1	2.0%	2	4.1%	1	2.0%	**49**	**100.0%**
Education Visitor Panel or Clinical Advisor	20	90.9%	1	4.5%	1	4.5%	0	0.0%	0	0.0%	0	0.0%	**22**	**100.0%**
Total responses received	**90**	**81.1%**	**11**	**9.9%**	**4**	**3.6%**	**1**	**0.9%**	**4**	**3.6%**	**1**	**0.9%**	**111**	**100.0%**

Table 73: Members and Workers – Sexual orientation – 31 March 2026

	Heterosexual		Gay/Lesbian		Bisexual		Other		PNTS		**Total**	
Council member	11	100.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	**11**	**100.0%**
Committee member (includes Advisory Panel and independent members on Council committees; excludes Council members)	27	93.1%	1	3.4%	0	0.0%	0	0.0%	1	3.4%	**29**	**100.0%**
Hearing Panel	42	85.7%	2	4.1%	1	2.0%	0	0.0%	4	8.2%	**49**	**100.0%**
Education Visitor Panel or Clinical Advisor	19	86.4%	1	4.5%	0	0.0%	0	0.0%	2	9.1%	**22**	**100.0%**
Total responses received	**99**	**89.2%**	**4**	**3.6%**	**1**	**0.9%**	**0**	**0.0%**	**7**	**6.3%**	**111**	**100.0%**

Table 74: Members and Workers – Main spoken language – 31 March 2026

	English		Other (including sign language)		PNTS		**Total**	
Council member	10	90.9%	0	0.0%	1	9.1%	**11**	**100.0%**
Committee member (includes Advisory Panel and independent members on Council committees; excludes Council members)	29	100.0%	0	0.0%	0	0.0%	**29**	**100.0%**
Hearing Panel	47	95.9%	1	2.0%	1	2.0%	**49**	**100.0%**
Education Visitor Panel or Clinical Advisor	21	95.5%	1	4.5%	0	0.0%	**22**	**100.0%**
Total responses received	**107**	**96.4%**	**2**	**1.8%**	**2**	**1.8%**	**111**	**100.0%**

Table 75: Members and Workers – Additional languages spoken fluently – 31 March 2026

	Yes		No		PNTS		Total	
Council member	2	18.2%	9	81.8%	0	0.0%	**11**	**100.0%**
Committee member (includes Advisory Panel and independent members on Council committees; excludes Council members)	10	34.5%	19	65.5%	0	0.0%	**29**	**100.0%**
Hearing Panel	7	14.3%	40	81.6%	2	4.1%	**49**	**100.0%**
Education Visitor Panel or Clinical Advisor	5	22.7%	17	77.3%	0	0.0%	**22**	**100.0%**
Total responses received	**24**	**21.6%**	**85**	**76.6%**	**2**	**1.8%**	**111**	**100.0%**

Table 76: Members and Workers – Occupation of main household earner when you were aged 14 – 31 March 2026

	Clerical and intermediate occupations such as secretary, personal assistant, call centre agent, clerical worker, nursery nurse		Modern professional and traditional professional occupations such as teacher, nurse, physiotherapist, social worker, musician, police officer (sergeant or above), software designer, accountant, solicitor, medical practitioner, scientist, civil engineer or mechanical engineer		Routine, semi-routine manual and service occupations such as postal worker, machine operative, security guard, caretaker, farm worker, catering assistant, sales assistant, HGV driver, cleaner, porter, packer, labourer, waiter or waitress, bar staff		Senior, middle or junior managers or administrators such as finance manager, chief executive, large business owner, office manager, retail manager, bank manager, restaurant manager, warehouse manager		Small business owners who employed fewer than 20 people such as corner shop owners, small plumbing companies, retail shop owner, single restaurant or cafe owner, taxi owner, garage owner		Technical and craft occupations such as motor mechanic, plumber, printer, electrician, gardener, train driver		Long-term unemployed (claimed Jobseeker's Allowance or earlier unemployment benefit for more than a year)		Other		PNTS		**Total**	
Council member	0	0.0%	5	45.5%	1	9.1%	1	9.1%	1	9.1%	2	18.2%	0	0.0%	1	9.1%	0	0.0%	**11**	**100.0%**
Committee member (includes Advisory Panel and independent members on Council committees; excludes Council members)	1	3.4%	5	17.2%	5	17.2%	7	24.1%	6	20.7%	3	10.3%	0	0.0%	0	0.0%	2	6.9%	**29**	**100.0%**
Hearing Panel	3	6.1%	20	40.8%	7	14.3%	8	16.3%	5	10.2%	3	6.1%	1	2.0%	0	0.0%	2	4.1%	**49**	**100.0%**
Education Visitor Panel or Clinical Advisor	2	9.1%	6	27.3%	3	13.6%	6	27.3%	0	0.0%	2	9.1%	0	0.0%	1	4.5%	2	9.1%	**22**	**100.0%**
Total responses received	**6**	**5.4%**	**36**	**32.4%**	**16**	**14.4%**	**22**	**19.8%**	**12**	**10.8%**	**10**	**9.0%**	**1**	**0.9%**	**2**	**1.8%**	**6**	**5.4%**	**111**	**100.0%**

Table 77: Members and Workers – Type of school attended most of the time between the ages of 11 and 16 – 31 March 2026

	State-run or state-funded school		Independent or fee-paying school		Independent or fee-paying school, where I received a means-tested bursary covering 90% or more of the overall cost of attending throughout my time there		Attended school outside the UK		PNTS		**Total**	
Council member	9	81.8%	1	9.1%	0	0.0%	1	9.1%	0	0.0%	**11**	**100.0%**
Committee member (includes Advisory Panel and independent members on Council committees; excludes Council members)	22	75.9%	2	6.9%	1	3.4%	2	6.9%	2	6.9%	**29**	**100.0%**
Hearing Panel	40	81.6%	4	8.2%	3	6.1%	1	2.0%	1	2.0%	**49**	**100.0%**
Education Visitor Panel or Clinical Advisor	17	77.3%	3	13.6%	0	0.0%	2	9.1%	0	0.0%	**22**	**100.0%**
Total responses received	**88**	**79.3%**	**10**	**9.0%**	**4**	**3.6%**	**6**	**5.4%**	**3**	**2.7%**	**111**	**100.0%**

Table 78: Members and Workers – Free school meal eligibility during school years (if finished school after 1980) – 31 March 2026

	Yes		No		I don't know		PNTS or N/A		**Total**	
Council member	0	0.0%	7	63.6%	0	0.0%	4	36.4%	**11**	**100.0%**
Committee member (includes Advisory Panel and independent members on Council committees; excludes Council members)	2	6.9%	21	72.4%	1	3.4%	5	17.2%	**29**	**100.0%**
Hearing Panel	9	18.4%	22	44.9%	2	4.1%	16	32.7%	**49**	**100.0%**
Education Visitor Panel or Clinical Advisor	2	9.1%	16	72.3%	0	0.0%	4	18.2%	**22**	**100.0%**
Total responses received	**13**	**11.7%**	**66**	**59.5%**	**3**	**2.7%**	**29**	**26.1%**	**111**	**100.0%**

Table 79: Members and Workers – Country of residence – 31 March 2026

	England		Scotland		Wales		Northern Ireland		Other		PNTS		**Total**	
Council member	7	63.6%	1	9.1%	1	9.1%	2	18.2%	0	0.0%	0	0.0%	**11**	**100.0%**
Committee member (includes Advisory Panel and independent members on Council committees; excludes Council members)	28	96.6%	0	0.0%	0	0.0%	1	3.4%	0	0.0%	0	0.0%	**29**	**100.0%**
Hearing Panel	41	83.7%	2	4.1%	2	4.1%	2	4.1%	0	0.0%	2	4.1%	**49**	**100.0%**
Education Visitor Panel or Clinical Advisor	17	77.3%	3	13.6%	0	0.0%	2	9.1%	0	0.0%	0	0.0%	**22**	**100.0%**
Total responses received	**93**	**83.8%**	**6**	**5.4%**	**3**	**2.7%**	**7**	**6.3%**	**0**	**0.0%**	**2**	**1.8%**	**111**	**100.0%**

Student Academic Year

In previous years, this report included student academic year data provided by GOC-approved education providers. We have removed this section from the Equality, Diversity and Inclusion Annual Monitoring Report because the information is reported separately through our annual UK Optical Education report. This helps ensure there is a single source of information for education provider data and avoids duplication across our publications.

As this data is collected from education providers rather than from the GOC's internal systems, readers should refer to the latest UK Optical Education report:

UK Optical Education 2025 Report

Access the report here

C40(26)

COUNCIL

General Optical Council

Lord Mann review of antisemitism and other forms of racism in the NHS and healthcare regulatory system

Meeting: 30 September 2026 **Status:** For decision

Lead responsibility: Andy-Mackay-Sim (Chief of Staff)
Paper Author(s): Andy Mackay-Sim (Chief of Staff); Joanna Murphy (EDI Manager)
Council Lead(s): There is no Council lead for this work

Purpose

1. To enable Council to consider the GOC's response to the Lord Mann review of antisemitism and other forms of racism and decide whether to use the proposed definitions of antisemitism and anti-Muslim hostility across the organisation.

Recommendations

2. Council is asked to:
   - note the proposed response and implementation plan set out in Annex 1;
   - note that the following recognised definitions will be used to support our organisational understanding of the terms “antisemitism” and “anti-Muslin hostility”:
     - the International Holocaust Remembrance Alliance (IHRA) working definition of antisemitism (Annex 4);
     - the UK Government's non-statutory definition of anti-Muslim hostility (Annex 5);
   - delegate authority to the Chief Executive and Registrar to oversee implementation of the actions identified in Annex 3 and make any minor consequential amendments as required.

Strategic objective

3. This work contributes towards the achievement the achievement of all three of our strategic objectives and is included within the 2026/2027 EDI action plan.

Background

4. The Lord Mann review of antisemitism and other forms of racism in the NHS and healthcare regulatory system was published on 4 June 2026. The review was commissioned by the Secretary of State for Health and Social Care and the Prime Minister in October 2025 to examine how the NHS and healthcare regulatory system recognises, reports and responds to antisemitism and other forms of racism.

5. The GOC contributed evidence to the review through a written submission in December 2025. Following publication of the review, the EDI Manager completed an initial assessment of the recommendations and worked with relevant operational, and policy leads to identify actions required to support implementation.

6. This work builds on our established commitment to advancing equality, diversity and inclusion across our regulatory functions. This includes signing up to the NHS Race and Health Observatory Seven Anti-Racism Principles (Annex 1). We are also a signatory of the Observatory's Workforce Race Equity in Health and Social Care Shared Principles for Regulators (Annex 2).

Analysis

7. The GOC has a clear commitment to identifying and addressing racism, discrimination, harassment and abuse. Creating a fair, inclusive and respectful regulatory environment is fundamental to maintaining public confidence and supporting safe and effective eye care for all.

8. We have an established track record of advancing equality, diversity and inclusion. This includes embedding equality considerations within regulatory decision-making, undertaking research into registrants' and patients' lived experiences, and strengthening organisational understanding of inequalities and discrimination.

9. Evidence gathered through our registrant survey and lived experience work demonstrates that discrimination remains a significant issue within the professions we regulate. In the 2026 registrant survey, almost one third of respondents reported experiencing discrimination in the workplace or during their studies in the previous 12 months. Among those who had experienced discrimination, race was the most commonly reported factor, followed by age and sex. Almost one in five linked their experience to religion or belief.

10. We continue to perform strongly against the Professional Standards Authority's Standard of Good Regulation in relation to Standard 3, Equality, Diversity and Inclusion, including commendations for our work in recent reviews. However, the Mann Review provides a valuable opportunity to strengthen existing arrangements and ensure alignment with emerging expectations across the healthcare regulatory sector.

11. The implementation analysis set out in Annex 3 identifies actions relating to organisational learning, workforce development, data and insight, policy review and cultural safety. Delivery of these actions will build on existing work rather than create a separate programme.

Using definitions to support understanding

12. One of the Lord Mann review recommendations is that the Department of Health and Social Care (DHCS) should work with health and care regulators to develop a consistent approach to definitions relating to racism and religious hatred.

13. Consistent definitions support shared understanding, improve organisational learning and help ensure clarity and consistency in our use of language. It fulfils the first of shared principles for regulators: “We demonstrate leadership by naming racism explicitly and consistently to advance race equity and commit to work actively to address racism.”

14. To align with this recommendation and the principles, it is proposed that we use the following definitions:
    - the International Holocaust Remembrance Alliance (IHRA) non-legally binding working definition of antisemitism; and
    - the UK Government's non-statutory definition of anti-Muslim hostility.

15. The use of these definitions will provide a recognised framework to support understanding and the identification of antisemitism and anti-Muslim hostility across the organisation. They would complement, rather than replace, our existing equality, diversity and inclusion policy and our wider commitment to addressing all forms of discrimination and racism.

16. Use of the definitions will also support training, policy development, organisational learning and internal operations. Both definitions are non-statutory and their use of would not create new legal duties or alter our statutory responsibilities. We are commissioning training for our decision-makers to assist them in understanding how existing legal obligations and case law should be accounted for in their decision-making.

17. Use of the definitions would also demonstrate our commitment to responding constructively to Lord Mann’s review and to working alongside other regulators to improve consistency in understanding and the identification of antisemitism and anti-Muslim hostility across the sector.

Finance

18. There are no direct financial impacts in connection with this paper. Council allocated £80k of reserves for 2026-27 to support training on antisemitism and other forms of racism. Providers have been identified for the first tranche of this work, and the EDI manager is in the process of arranging this training to take place across the organisation.

Risks

19. We are already well aligned with many of the recommendations within Lord Mann’s review. However, there are risks associated with not responding to the review and

maintaining alignment with emerging expectations across the health and care regulatory system.

20. Failure to respond appropriately to the Mann Review recommendations could create reputational risk and be perceived as a lack of commitment to tackling racism, antisemitism and anti-Muslim hostility.
    - **Mitigation:** We have completed an assessment of the recommendations and developed a proportionate implementation plan. Progress will be monitored through existing governance arrangements and reported as appropriate.

21. There is a risk that implementation actions are not delivered within the intended timescales.
    - **Mitigation**: Delivery will be coordinated through a cross-organisational task and finish group, with oversight from the Chief Executive and Registrar and regular engagement with relevant operational leads.

22. There is a risk that the use of the proposed definitions may attract external scrutiny or challenge.
    - **Mitigation:** We will be clear and transparent about the purpose of the definitions, communicate how they support existing commitments to tackling discrimination, and maintain appropriate records of decision making and implementation.

23. There is also a risk that the definitions are viewed as a standalone intervention rather than part of our broader work to address discrimination and promote inclusion.
    - **Mitigation:** Communications, policies and learning activity will continue to emphasise that we take all forms of discrimination seriously and that the definitions are intended to support understanding and consistency rather than create a hierarchy of discrimination.

Equality Impacts

24. The proposed response is expected to have a positive impact on equality, diversity and inclusion by supporting a clearer and more consistent approach to understanding and addressing antisemitism, anti-Muslim hostility and other forms of racism.

25. The use of recognised definitions will support organisational learning, policy development and decision-making, while reinforcing the GOC's commitment to tackling discrimination and promoting equality of opportunity

26. An integrated Equality Impact Assessment has not been undertaken at this stage, as this paper does not propose any changes to policy, process or decision-making. Should future work arising from the review result in substantive policy or process changes, the need for a proportionate equality impact assessment will be considered as part of the development process.

Devolved nations

27. No specific implications for the devolved nations have been identified.

Other Impacts

28. No significant llegislative, privacy or sustainability impacts have been identified. Any future changes arising from implementation of the recommendations will be considered through our established governance and impact assessment processes.

Communications

External communications

29. Subject to Council approval, we will;
    - publish a statement outlining its response to the Lord Mann review and confirm use of the proposed definitions;
    - communicate how this work builds on existing equality, diversity and inclusion commitments;
    - continue engagement with the Professional Standards Authority, Department of Health and Social Care and partner regulators as sector-wide activity develops.

Internal communications

30. Subject to Council approval, we will;
    - communicate Council's decision and the rationale for using the definitions to staff, Council and committee members;
    - promote awareness and understanding of the review's recommendations;
    - support implementation through targeted learning and communications activity.

Next steps

31. Following Council’s decision;
    - we will implement the actions identified within Annex 3;
    - where relevant, and in line with usual processes on internal and external engagement, the IHRA working definition of antisemitism and the UK Government definition of anti-Muslim hostility will be incorporated into organisational learning and guidance activities;
    - cross-organisational task and finish group will coordinate implementation across teams;
    - we will continue engagement with sector partners and regulators to support alignment with emerging approaches;
    - progress will be monitored through existing governance arrangements, and a six-month update will be developed in line with the expectations outlined within the Mann Review.

Attachments

Annex 1: NHS Race and Health Observatory Seven Anti-Racism Principles
Annex 2: NHS Race and Health Observatory Workforce Race Equity in Health and Social Care Shared Principles for Regulators
Annex 3: Mann Review Initial Assessment and Alignment
Annex 4: International Holocaust Remembrance Alliance (IHRA) Working Definition of Antisemitism
Annex 5: UK Government Non-Statutory Definition of Anti-Muslim Hostility

RHO's '7 Principes of Anti-Racism for Staff in the NHS'

Anti-racism is about more than just pledges and good intentions. To meaningfully combat racism in healthcare, we need to think about tangible actions. A simple, evidence-based model of anti-racism is a good start for NHS organisations and healthcare systems to think about the practical steps needed to make significant and sustained improvements on tackling racial inequalities in the workplace.

To help address the challenges associated with racial and ethnic inequalities, the NHS Race and Health Observatory has developed an evidence-based model that presents seven fundamental principles of anti-racism for the workplace. The model is designed to guide the NHS in building equitable and inclusive workplaces.

1. **Name Racism**
   - Name racism explicitly and consistently to advance race equity across all staff and at all levels of the organisation
   - Actively commit to sustained and multi-level work to address racism and its root causes establishing commitment on the agenda from all leaders and staff
   - Articulate the evidence-base for the "why" and the "how" when it comes to tackling race inequality and promoting inclusion

2. **Demonstrate Leadership**
   - Embed equity into organisational governance, performance management, strategy, and decision-making – review policies through an anti-racism lens
   - Model the behaviours and actions that we expect from others, and have clear leadership accountability for developing work to tackle racism and advance equity
   - Inspire a clear, equity-focused vision for equity across the workforce – reinforce innovation, reward progress and celebrate success

3. **Focus on Data and Evidence**
   - Strengthen the collection and use of data to generate insights and strategies to drive targeted, evidence-based action
   - Enable assessment of the extent and impact of racism, and the effectiveness of work to address racism
   - Focus on evaluation for continuous learning and development of interventions to tackle inequality

4. **Value Lived Experience Insight**
   - Listen to staff who experience racism and act upon what is heard
   - Co-design and co-produce work with staff and centre focus on their experiences
   - Balance technology and innovation with human insight and cultural context

5. **Use Evidence-Based Interventions**
   - Foster evidence-based strategic and operational approaches to tackle racism – share replicable good practice within and beyond the organisation

- Consider how racism intersects with other inequalities, and with health inequalities, throughout work to address racism
- Support continuous improvement, and adopt an anti-racism approach to Quality Improvement (QI)

6. Foster Transparency and Accountability

- Set specific, measurable and timely indicators for work on addressing racism
- Evaluate and report on the impact of work to hold individual staff, and the organisation, to account for achieving measurable progress
- Develop emotionally resonant communication strategies that support structural understanding of racism and discrimination

7. Promote Well-Being and Cultural Safety

- Empower staff to achieve and maintain working environments where "everyone counts" – supporting line managers to lead with compassion and civility
- Understand structural, institutional and inter-personal racism and other forms of discrimination through impactful education and learning approaches
- Promote culturally sensitive and psychologically safe approaches to staff health and well-being within the workplace

Advancing Workforce Race Equity in Health and Social Care: Shared principles across regulators

INTRODUCTION

On behalf of our organisations, we pledge our commitment to the advancement of race equity and inclusive working environments across the health and care sector and beyond. Based on the NHS Race and Health Observatory anti-racism principles and building on a roundtable in June 2025, we sign up to these nine regulatory principles.

The anti-racism principles have been framed using a strengths-based positioning that promotes organisational awareness, efficacy, and resourcefulness thus making us more resilient and capable of achieving the goals of these principles.

Our focus on anti-racism is in response to the compelling evidence base across the NHS, CQC research and other professional bodies' reviews which demonstrate a strong correlation between people's experience of discrimination and their ethnicity. Our intention is that, by drawing attention to and driving action on racism in the workplace, we also improve equity for the other dimensions of discrimination to ensure that our workplaces are inclusive, compassionate, and valuing everyone's contributions.

1. **Naming racism:** We demonstrate leadership by naming racism explicitly and consistently to advance race equity and commit to work actively to address racism.

2. **Valuing lived experience:** We listen to people working in health and care who experience racism, we co-produce our work with them, centring our agenda on their experiences and ensuring psychological safety. We consider how racism intersects with other inequalities and with health inequalities throughout our work to address racism.

3. **Showing leadership:** We raise our ambition on race equity and inclusion for the workforce at every level of the health and care system, through modelling the behaviours and actions that we expect from others and having clear leadership accountability for developing our work to tackle racism and advance equity.

4. **Collaborative working:** We act positively as a group of health and social care regulators, collectively influencing and promoting workforce race equity. We do this through a shared understanding of how racism and other forms of discrimination operate, co-creation of strategies, clear and aligned goals and communications and sharing good practice.

5. **Data and insight development:** We strengthen the collection and use of data to generate insights that drive action, enabling assessment of the extent and impacts of racism and the effectiveness of work to address racism.

6. **Empowering approaches:** We empower health and care leaders, providers, and the workforce, to achieve and maintain working environments - and a health and care system - where "everyone counts". This involves understanding structural, institutional and inter-personal racism and other forms of discrimination through impactful education and learning approaches, supporting continuous improvement in performance and sharing good practice.

7. **Using our powers effectively:** We embed the advancement of workforce race equality and inclusion in regulatory strategy, policy and standards within the health and care sector and in our day-to-day business. We set standards and expectations of those we regulate in a way that explicitly embeds a focus on equality on the regulatory decisions that we make; and more broadly use our role and functions to tackle racism and help deliver positive change.

8. **Influencing progress together:** We use our collective voice to influence national policy on workforce race equity and wider health inequalities and equity issues, based on our regulatory insights.

9. **Transparency and Accountability:** We set ourselves specific, measurable and timely indicators for our work on addressing racism and promoting workforce race equity. We then evaluate and report on the impact of our work as regulators to hold ourselves and others to account for achieving measurable progress.

EXPLANATORY NOTES

- We use the word "equity" throughout the principles as this encompasses the widest range of approaches and actions, including legal obligations around equality in the Equality Act 2010.
- The focus of this work is on race and ethnicity. This is data and evidence driven – stark inequalities by race (and ethnicity) are widening, and with the diversity of the health and care workforce increasing, there is an even more urgency to tackle these inequalities. When considering what we mean by race equity, we include all forms of racism and associated discrimination in this work, including on the basis of religion, faith or belief, for example Antisemitism and Islamophobia. However, using these principles will move forward equity for staff with other equality characteristics too.
- Having shared principles is an important step forward. We recognise that the principles alone will not deliver change. Each regulator will need to work through the changes required to deliver them in practice, considering their role and size. We will also need to work together as regulators to maximise our positive impact on workforce race equity and inclusion.

SIGNED BY



General Medical Council







General Optical Council

General Osteopathic Council

General Pharmaceutical Council

General Chiropractic Council

C40(26) ANNEX TWO

Lord Mann's review of antisemitism and other forms of racism in the NHS and healthcare regulatory system – Initial Assessment and Alignment

Executive Summary

This document provides an initial assessment of the General Optical Council's (GOC) alignment with the recommendations set out in Lord Mann's Review on antisemitism and other forms of racism in the NHS and healthcare regulatory system.

It uses the **explicit wording of relevant recommendations** to set out:

- the expectation established by the review
- the GOC's current position
- and proposed next steps

While a number of the recommendations are directed at the wider health system, NHS bodies, or government, this assessment considers which are directly applicable to professional regulators, as well as those that represent emerging best practice and may be adopted proportionately by the GOC. Where recommendations are not directly applicable to the GOC, they have been reflected through proportionate actions or consideration as emerging best practice within relevant sections.

Overall, the GOC is well aligned with the direction of the review and is already delivering against a number of the relevant recommendations, with further work focused on consistency, clarity and application in practice.

- adoption and application of agreed definitions
- strengthening consistency in regulatory decision-making
- enhancing training and capability
- and contributing to greater alignment across regulators and engaging with expected system-wide follow-up activity through PSA and cross-regulator forums

The approach set out here focuses on building on existing frameworks, with activity aimed at improving clarity, consistency and confidence, rather than significant structural change.

A detailed cross-check against relevant recommendations is set out in the sections below.

Each section below sets out the relevant recommendations in full, followed by a structured assessment of the GOC's current position and proposed next steps.

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Strategy, Principles and Leadership 3

Regulatory Functions and Standards 5

People and Culture 7

Data and Insights 8

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Strategy, Principles and Leadership

Recommendation 1: adoption of NHS Race and Health Observatory principles

Recommendation 7: embedding measurable EDI objectives in leadership performance

Recommendation 10: *the Department of Health and Social Care should work across the health and care regulators, including the Care Quality Commission, to secure an agreed approach on definitions of racism and religious hatred.*

Recommendation 16: *health and care system and professional regulators should establish a taskforce to clarify and reinforce the appropriate mechanisms, including the emerging concerns protocol, for sharing information about local areas of concern, racist incidents, thematic issues related to antisemitism and other forms of racism, and best practice for employers and regulators to address them. Health and care system and professional regulators should co-ordinate actions where more than one regulator has a role to play in responding to issues or incidents and the Department of Health and Social Care should work closely with the devolved nations.*

Recommendation 22: *regulators to report on embedding antiracism principles*

Area	Expectation	Current Position	Next Steps
Adoption of definitions	Use IHRA definition of antisemitism and government definition of anti-Muslim hostility (Rec 10)	Planned – target Council Sept approval	Develop SMT paper and Council timeline; early engagement with Council
Anti-racism principles	Adopt and embed antiracism principles across regulatory practice (Rec 1, Rec 22)	GOC has formally signed up to Workforce Race Equity Shared Principles, aligned to national anti-racism framework	Ensure this commitment is clearly referenced in Mann Review response and linked to definitions work
Leadership accountability	Embed measurable EDI objectives in leadership performance (Rec 7)	Strong PBF framework in place embedding EDI expectations across all leadership levels, with clear performance indicators for	Ensure explicit alignment with new definitions (antisemitism, anti-Muslim hostility strengthen visibility and reporting, and

		all staff. Accountability for Council and Committee members is in place but less explicitly articulated in relation to EDI.	consider how EDI expectations can be more clearly embedded for Council and Committee members.
Cross-regulator coordination	Share information on areas of concern, racist incidents and best practice, and support coordinated responses across regulators (Rec 16)	Established engagement through JHRF and NHS Alliance quarterly meetings, supporting discussion and alignment across regulators; emerging concerns protocol discussed through Health and Social Care Regulators Forum, though current visibility and application are variable and primarily England-focused	Continue structured engagement; ensure learning from incidents and thematic issues is shared including through existing mechanisms such as the Health and Social Care Regulators Forum, and through ongoing consideration of the emerging concerns protocol, and consider alignment with any formal cross-regulator mechanisms arising from this recommendation

The GOC has already made a public commitment to shared anti-racism principles across regulators, providing a strong foundation for alignment with the Mann Review. The focus will be on ensuring these commitments are clearly connected to the proposed adoption of definitions and reflected in practice.

Regulatory Functions and Standards

Recommendation 13: *a single national set of policy frameworks should be developed and clearly signposted to support more effective handling and investigation of racial harassment and discrimination. Work should be undertaken to develop the skills and cultural capability to deal with these issues better in trusts, including how they are investigated and staff supported.*

Recommendation 16*: Regulators should strengthen coordination and information sharing on racist incidents, areas of concern and best practice, including through agreed mechanisms.*

Recommendation 18: *the Department of Health and Social Care, NHS England and the Care Quality Commission should work with health and care professional regulators to develop a clear, single set of national guidance for employers (in England), clearly defining employers' responsibilities in tackling discrimination incidents and providing guidance and examples of the types of incidents that may require a regulatory referral, alongside coordinated communications for patients and the public and clear, accessible materials to support navigation of the system.* While this recommendation spans guidance, communications and patient-facing materials, this section focuses on implications for regulatory standards, guidance and case handling

Area	Expectation	Current Position	Next Steps
Standards alignment	Ensure standards support effective handling and investigation of racial harassment and discrimination (Rec 13)	Likely largely compliant, aligned with existing professional standards and fitness to practise framework (see: How we investigate a concern) and supporting guidance for raising concerns and speaking up	Undertake targeted review with policy and standards and FtP colleagues, including how existing guidance (such as speaking up) supports consistent handling of discrimination concerns and align with emerging cross-regulator expectations where appropriate; draw on upcoming review of the Standards for Optical Businesses to consider how expectations on businesses

			in this area can be strengthened
Use in FtP	Ensure clarity and consistency in how incidents are assessed and referred within regulatory processes (Rec 18)	Partially embedded; updated guidance for case examiners (2025) reflects consideration of discriminatory behaviours, with further updates to case handling SOPs in progress. Discrimination-related cases are identified and monitored at triage, though consistency in application and alignment with emerging cross-regulator approaches is still developing	Undertake targeted review of implications for guidance, panels and case handling, and consider alignment with emerging cross-regulator approaches, including how clearer expectations for employers on when concerns should be escalated to regulators can be reflected in guidance and case handling practice
Cross Regulator Coordination	Share appropriate and proportionate information on areas of concern, thematic issues and best practice, through agreed mechanisms, and support coordinated responses across regulators (Rec 16)	Established engagement through JHRF and NHS Alliance quarterly meetings, supporting discussion and alignment across regulators	Continue structured engagement; ensure learning from incidents and thematic issues is shared, including through existing mechanisms such as the Health and Social Care Regulators Forum and through ongoing consideration of the emerging concerns protocol and consider how best to align with any formal cross-regulator mechanisms arising from this recommendation

The GOC has an established fitness to practise framework, supported by structured investigation processes, case examiner decision-making, and hearings and sanctions guidance. This provides a clear and proportionate framework for assessing concerns and protecting the public, with further work focused on alignment with definitions.

People and Culture

Recommendation 32: *the NHS mandatory training module on equality, diversity and human rights requires urgent updating and the specific inclusion of quality assured content on antisemitism and anti-Muslim hostility.*

Recommendation 35: *the leaders of the UK health and care system and professional regulators should ensure they undertake similar training, if they have not already done so.*

Area	Expectation	Current Position	Next Steps
Internal policy alignment	Ensure policies and practice support understanding and application of racism and discrimination (Rec 32)	Strong EDI policy framework in place setting clear expectations on behaviour, inclusion and non-discrimination across the organisation	Ensure alignment with adopted definitions and reinforce through communication and training rather than policy change
Training and engagement	Provide quality assured training on antisemitism, anti-Muslim hostility and wider racism (Rec 32, Rec 35)	Targeted training identified. Conversations held with specialist suppliers on antisemitism and anti-Muslim hostility; proposals received and assessed as fit for purpose, including recommendation from another regulator	Progress to commissioning and onboarding; align delivery with definitions and ensure training is embedded through ongoing engagement and reflection on learning

The EDI policy, alongside the performance and behavioural framework, provides clear expectations for behaviour and accountability across the organisation. This establishes a strong internal foundation, with the focus on ensuring alignment with new definitions and reinforcing expectations through communication and training rather than policy change.

Data and Insights

Recommendation 2: *The Secretary of State for Health and Social Care should consider including Jewish and Sikh as ethnicities in data collection. This could include consulting on this question for the health service as part of a wider update and equalisation of data capture across the NHS, as part of the update of the Unified Information Standard for Protected Characteristics (UISPC).*

Recommendation 5*: Recommendation 5: there should be board-level oversight of all investigations related to racism through annual reporting on volume, themes, outcomes and timelines, deep-dives into hotspots or repeated patterns, and assurance that recommendations are implemented and monitored. Existing governance systems can also be strengthened.*

Recommendation 7: *all NHS board members and senior leaders should have explicit, measurable equality, diversity and inclusion objectives embedded within their performance goals, supported by robust data and monitoring.*

Recommendation 11:
As the NHS staff standards and their associated accountability processes continue to develop, the staff experience questions in the annual NHS Staff Survey should be reviewed. This review should involve a broad range of staff representatives and networks, ensuring the questions remain relevant and effective in capturing the experiences of ethnic minority staff of racism and discrimination, including the experiences of Jewish NHS staff.

Area	Expectation	Current Position	Next Steps
Understanding racism trends	Strengthen the use of data to identify patterns, monitor inequalities and inform action (Rec 7)	Range of data sources in place including, public, workforce and perceptions survey, registrant surveys, FtP data (including differential outcomes), staff survey, Freedom to Speak Up, exit interviews, and ER case	Develop a more structured approach to triangulation across data sources to identify trends and inform decision-making; including improving visibility of emerging concerns data to support earlier identification of

		data. Survey design particularly on workplace behaviours, is informed by the NHS staff survey to support benchmarking; any changes arising from recommendation 11 will be reflected in future surveys	issues, aligned with the development of the organisational data strategy
Ethnicity data collection	Ensure data collection reflects appropriate and inclusive ethnic categories (Rec 2; emerging best practice)	GOC uses ethnicity classifications aligned to ONS Census standards and NHS data collections. These do not include Jewish or Sikh as ethnic categories.	Keep this under review as national standards develop, including through cross-system work on ethnicity data, and consider any changes where there is an agreed approach across health and care.

This provides a strong evidence base across both workforce and public experience. Recent survey findings highlight variation in experience across different groups, including differences in satisfaction and reported discrimination. The key opportunity is to strengthen how these data sources are triangulated and used collectively to identify trends and inform action. There is also an opportunity to strengthen Board and Council visibility of trends and themes relating to discrimination within fitness to practise and wider organisational data, including through more structured and regular reporting drawing together volume, themes, outcomes and learning. (Rec 5)

Complaints and Case Handling

Recommendation 16: *health and care system and professional regulators should establish a taskforce to clarify and reinforce mechanisms for sharing information about racist incidents, thematic issues and best practice, and to co-ordinate actions where more than one regulator is involved.*

Recommendation 18: *regulators should support clearer guidance on handling discrimination incidents and improve consistency in when matters are referred to regulators.*

Area	Expectation	Current Position	Next Steps
Capability	Ensure staff can recognise and respond appropriately to racism and discrimination in case handling (Rec 16)	Strong foundations in place with general EDI training; specialist suppliers identified to deliver targeted training on antisemitism and anti-muslim hostility	Proceed with commissioning and onboarding; deliver targeted training for case handlers and decision-makers, drawing on emerging good practice across regulators Plan for engagement with PSA activity under Rec 23, including supporting any insight-gathering with FtP staff and aligning with internal learning and development activity
Consistency	Strengthen consistency in handling cases and clarity of escalation and referral (Rec 18)	Established frameworks, but practice may vary in application	Use adoption of definitions and supplier input to strengthen consistency; review and update case handling guidance; draw on good practice across regulators and contribute to

shared learning

The GOC's fitness to practise framework already includes structured decision-making guidance intended to support consistency and fairness. Planned training and a light-touch review of guidance will build on this existing foundation, supported by learning from other regulators. The review's recommendation on access to expert advice in FtP decision-making is noted and likely to be taken forward at a system level, potentially led by the PSA. The GOC should engage with the process of developing any such cross-regulator approach.

External Positioning and System Role

Recommendation 16: *regulators should co-ordinate actions and share information on racist incidents and areas of concern across the system.*

Recommendation 17: *inter-regulatory EDI working should be strengthened to support sharing of good practice and alignment of approaches.*

Recommendation 18: *the Department of Health and Social Care, NHS England and the Care Quality Commission should work with the health and care professional regulators to develop a clear, single set of national guidance for employers, clearly defining employers' responsibilities in tackling discrimination incidents and providing guidance and examples of the types of incidents that may require a regulatory referral.*

Area	Expectation	Current Position	Next Steps
Clarity of role	Ensure clear articulation of expectations on employers and the regulator's role in addressing discrimination (Rec 18).	Internally, responsibilities are well defined through EDI policy and PBF framework. Supporting guidance for employers provides a basis for escalation (see: FtP guidance for employers), though expectations on employers, particularly in relation to when	Review external guidance and communications to ensure clearer expectations for employers on handling discrimination and when escalation to the regulator is appropriate, alongside clear

		issues should be escalated to the regulator, could be more clearly articulated externally	explanation of the GOC's role
Cross-regulator working	Strengthen collaboration and sharing of good practice across regulators (Rec 16, Rec 17)	Established engagement through JHRF and NHS Alliance quarterly meetings, supporting shared discussion and alignment of approaches	Continue structured engagement post publication; use forums to share learning, test approaches and identify good practice to adopt proportionately, including contributing to cross-regulator work to develop and strengthen public-facing communications and accessible materials for patients and the public on raising concerns and navigating the system, working with patient representative groups where appropriate (Rec 18)

The GOC already participates in established cross-regulator forums, providing a strong basis for alignment with Recommendations 16 and 17. The key focus will be on strengthening clarity of role externally and contributing to more coordinated system-wide approaches, aligned with any lead role the Department of Health and Social Care takes in convening cross-regulator activity

Priority Next Steps (Aligned to SMT Direction)

The review includes an expectation that regulators report on progress within six months; this has been reflected in the proposed delivery plan, with a draft update scheduled for late 2026.

Immediate (pre-publication)

Action	Lead owner	Supporting roles	Timeline
Prepare initial analysis and engagement approach, mapping against existing frameworks (EDI policy, PBF, FtP)	EDI Manager	Policy and Standards, FtP, HR	June
Begin planning Council paper and governance route through SMT	EDI Manager	CEO Office / Governance	June
Identify key internal stakeholders and establish working group (Policy, FtP, HR, Comms)	EDI Manager	Directors / Heads of Service	June
Initial review of external guidance, including clarity of regulator vs employer role	Policy Lead	FtP, EDI	June–July

Short term (to September Council)

Action	Lead owner	Supporting roles	Timeline
Develop SMT paper recommending use of IHRA and anti-Muslim hostility definitions (awaiting steer from DHSC)	EDI Manager	Policy and Standards, Legal, P&C	August
Early engagement with Council	CEO / Chair / EDI Manager	Governance	July–August
Targeted assurance review of standards, FtP policy and process and other	Reg Ops	FtP, Legal, EDI	July–August

related policies			
Finalise training approach and commission specialist suppliers	EDI Manager	HR / L&D	July–August
Develop structured approach to triangulation of data (surveys, FtP, ER, FTSU and exit interviews), including potential for thematic reporting, through a cross-organisational working group and aligned with the organisational data strategy.	Insight / Data Lead (with cross-organisational input)	EDI, Policy and Standards, P&C, FtP	September onwards

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Around Council decision (September)

Action	Lead owner	Supporting roles	Timeline
Prepare Council paper	CEO / Council	EDI Manager, SMT	September
Agree organisational position and key messaging (internal and external)	Comms Lead	EDI, CEO Office	September
Confirm proportionate implementation approach	SMT	EDI, Policy and Standards, P&C	September

Post-September (implementation phase)

Action	Lead owner	Supporting roles	Timeline

Reference definitions across guidance, training and communications	EDI Manager	Policy and Standards, Comms, HR	Oct–Dec
Deliver targeted training (case handlers, decision-makers, leadership)	HR / L&D Lead	EDI, external suppliers	Oct–Dec
Review and update case handling guidance (with supplier input)	FtP Lead	Policy and Standards, EDI	Oct–Feb
Strengthen consistency of practice through updated guidance and training	FtP Lead	EDI, P&C	Oct–Dec
Strengthen data triangulation and introduce more systematic thematic insight to inform decision-making and organisational learning	Insight / Data Lead	EDI, HR, FtP	Oct–Jan
Continue cross-regulator engagement (JHRF, NHS Alliance) to align approaches and share good practice	EDI Manager	SMT, FtP, Policy	Ongoing
Build on HSRF discussion (July) to clarify approach to Recommendation 16, including how the emerging concerns protocol is used and understood; explore opportunities with CQC to strengthen awareness and practical application where helpful	EDI Manager	Policy and Standards, FtP, SMT	Oct-Dec
Prepare a six-month progress update on embedding antiracism principles (Mann review Rec 22) including proposed route for submission (PSA or Mann Review team)	EDI Manager	SMT, Policy and standards, FtP, P&C	Dec (council)

GOV•UK

Guidance

A Definition of Anti-Muslim Hostility

An overview of the government's new non-statutory definition of anti-Muslim hostility, what it seeks to address and its intended application.

From: **Ministry of Housing, Communities and Local Government (/government/organisations/ministry-of-housing-communities-local-government)**

Published: 9 March 2026

Applies to England

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— 1. Introduction
— 2. Why we must tackle anti-Muslim hostility
— 3. The case for a definition
— 4. Development of the government's new definition
— 5. The definition
— 6. Definition of anti-Muslim hostility
— 7. Related definitions and clarifications
— 8. Notes on use
— 9. Next steps

1. Introduction

The United Kingdom is built on values of freedom, fairness, tolerance, and respect. It is a country where people of all backgrounds living under and within our laws should feel safe. We are proud of and celebrate the contributions made by our diverse communities, which form an integral part of our national life, strengthening the country's social, cultural and economic fabric, and enriching our heritage.

Yet, in recent years, our Muslim communities have faced growing hostility, discrimination, and hate. Home Office statistics show that hate crimes targeting Muslims are now at record levels: 4,478 crimes were recorded in the run up to March 2025 – up a fifth on 2024 – and representing almost half of all religious hate crimes. This is not an isolated year – they have been far too high for too long. We also know there is significant underreporting.

This is not just about numbers: such hostility has a significant impact on the lives of people who live in this country. We have witnessed mosques, schools and Muslim-owned property and businesses attacked and vandalised. Women who wear a headscarf have been harassed. Muslims also face widespread online abuse, where even positive or supportive sentiment about Muslims is often met with an avalanche of abuse.

Anti-Muslim hostility not only affects Muslims but also other people who are perceived to be Muslim – including Sikhs, Hindus or those who have left Islam. This can mean that people are targeted simply because they look Muslim. Assumptions are made about people from diverse ethnic, racial and cultural backgrounds and they are treated as a collective group and negatively stereotyped, irrespective of their actual opinions, beliefs or actions as individuals – a process sometimes described as racialisation.

2. Why we must tackle anti-Muslim hostility

The impact on British Muslim communities is profound. Many Muslims now fear using public services, including transport and healthcare, and are wary of reporting crimes against them. Some feel forced to isolate themselves for their own safety. This drives communities further apart and entrenches the very problems that need to be overcome to build social cohesion.

The government is taking sustained action to keep Muslims safe. We have boosted security for places of worship and funding for organisations focused on reporting and tackling anti-Muslim hate. Our Protective Security for Mosques scheme enables Muslim places of worship and schools to upgrade their CCTV, alarm systems and fencing.

Alongside this, the government funds the British Muslim Trust to operate a national helpline for victims of anti-Muslim hate to report incidents safely, online or in person. The service, launched as part of the government's

Combatting Hate Against Muslims Fund, encourages cultural understanding and reporting by affected communities.

Yet, against the alarming backdrop of increasing hate crime, we all need to do more to get to the root of the prejudice and hostility that many Muslims face, while crucially ensuring everyone's rights to freedom of expression are protected.

3. The case for a definition

If you are unable to define an issue, you are far less able to tackle it. As with the International Holocaust Remembrance Alliance's working definition of antisemitism, which the UK government adopted in 2016, a clear definition of anti-Muslim hostility is an important step towards combatting the unacceptable hostility that Muslims face. Previous attempts to define anti-Muslim hatred have fallen short, leaving the concept ambiguous and highly contested.

A definition – focused on protecting individuals rather than religion or belief – can provide clarity and consistency in understanding anti-Muslim hostility. A definition must not and will not prohibit free speech nor stop issues being raised in the public interest. Rather, it should, through setting out clearer parameters, allow the development of a framework for understanding when legitimate debate crosses into unacceptable hatred, prejudice and discrimination of individuals.

For communities, a clear definition can help to provide a shared language to describe the distinct forms of hostility many Muslims face. It can increase understanding in wider society of what anti-Muslim hostility is, its impact on fellow citizens and give victims the confidence that what they are experiencing will be recognised and taken seriously.

Practically, a definition can also serve as a tool for government and organisations to better understand, measure, prevent and address anti-Muslim hostility – whether empowering people to report incidents, informing staff training and guidance, enhancing education, or facilitating more effective and consistent policy responses and support.

Creating a new definition of anti-Muslim hostility is not about granting special privileges, giving preferential treatment to particular communities, or protecting the religion of Islam. It is about protecting people from unacceptable hostile behaviour that seeks to intimidate and divide. It is about upholding the principle that everybody should expect and enjoy equal dignity, justice, security and opportunity.

While existing law provides important protections to everyone in the UK, legislation alone is not enough: law can address offences, but a definition

can be the foundations of the wider cultural, educational and preventative work needed to stop hatred from taking root.

4. Development of the government's new definition

For those reasons, the government established an independent expert Working Group to provide advice to government on appropriate and sensitive language to describe, understand and define unacceptable treatment, prejudice, discrimination and hate targeting Muslims or anyone who is perceived to be Muslim. The Working Group undertook a significant evidence gathering exercise, including a Call for Evidence which informed their private advice, and forms the basis of the definition that the government is now adopting.

The government is deeply grateful to the Working Group for their insights and work throughout this process.

5. The definition

This is a working definition and, as with all working definitions, it may need to evolve over time as understanding of the issues develops.

The definition uses the terminology "anti-Muslim hostility", which reflects the wider prejudice and discrimination Muslims face, and squarely focuses on Muslims as individuals rather than Islam as a religion. "Hostility" focuses on actions and conduct rather than simply the holding of beliefs. As the definition and notes make clear, the right to express hostility to others is part of our right to freedom of expression under law. But hostility with the intention of encouraging hatred against others because they are Muslim or perceived to be Muslim is conduct government is committed to challenging.

The definition covers the different aspects of hostility Muslims face: criminal acts, discrimination on the basis of being Muslim or perceived to be Muslim, and also the way in which Muslims can be treated as a collective group defined by fixed and negative characteristics with the intention to encourage hatred against them.

For many, anti-Muslim hostility can be articulated as a form of racism. However, Muslims come from diverse ethnic, racial and cultural backgrounds, and UK law treats race and religion as distinct protected characteristics. In practice, hostility against Muslims often relies on assumptions about dress, appearance, names, or other perceived markers that the perpetrator associates with being Muslim. These assumptions treat individuals as if they belong to a collective group with fixed negative traits - a process sometimes described as racialisation. Importantly, this definition makes clear that prejudicial stereotyping or racialisation constitute anti-

Muslim hostility when combined with an intention to encourage hatred against Muslims.

6. Definition of anti-Muslim hostility

The UK government's non-statutory definition of anti-Muslim hostility is the following:

> Anti-Muslim hostility is intentionally engaging in, assisting or encouraging criminal acts – including acts of violence, vandalism, harassment, or intimidation, whether physical, verbal, written or electronically communicated – that are directed at Muslims because of their religion or at those who are perceived to be Muslim, including where that perception is based on assumptions about ethnicity, race or appearance.
>
> It is also the prejudicial stereotyping of Muslims, or people perceived to be Muslim including because of their ethnic or racial backgrounds or their appearance, and treating them as a collective group defined by fixed and negative characteristics, with the intention of encouraging hatred against them, irrespective of their actual opinions, beliefs or actions as individuals.
>
> It is engaging in unlawful discrimination where the relevant conduct – including the creation or use of practices and biases within institutions – is intended to disadvantage Muslims in public and economic life.

The purpose of the definition is to protect Muslims from hostility. **It must be read alongside the accompanying text set out below,** which makes clear that open debate in the public interest is important and must be fully safeguarded. Context must also always be taken into account when interpreting and applying the definition.

Everyone should feel able to contribute to the exchange of ideas that supports a free and thriving society, participate in academic and political discussion and feel able to raise concerns. This accompanying text is intended to make clear that these principles are essential and must be upheld.

It is important to bear in mind the fundamental right of every person in the United Kingdom to exercise freedom of speech and expression within the law. Examples of expression that are protected include:

- criticisms of a religion or belief, including Islam, or of its practices, or critical analyses of its historical development

- ridiculing or insulting a religion or belief, including Islam, or portraying it in a manner that some of its adherents might find disrespectful or scandalous
- criticism of the belief systems or practices of individual adherents of a religion or belief, including Islam
- raising concerns in the public interest
- contributing to debates in the public interest, including academic and political debate

7. Related definitions and clarifications

Discrimination: Under the Equality Act 2010, discrimination may be direct or indirect. Direct discrimination occurs when someone is treated less favourably by another person or people because of an actual, perceived, or associated protected characteristic.

Indirect discrimination occurs when a policy which applies in the same way for everybody has an effect which particularly disadvantages people with a protected characteristic, unless the person applying the policy can show it is a proportionate means of achieving a legitimate aim.

Ethnicity, race and appearance: The definition refers to the way that people are perceived to be Muslim based on assumptions about their ethnicity, race, or appearance. The Working Group identified that people are often perceived to be Muslim based on these differences that may have little to do with religious belief. The definition should not be interpreted as excluding other reasons why people may be perceived to be Muslim.

Freedom of expression: Article 10 of the European Convention on Human Rights protects the right to hold opinions and express them freely without interference from public authorities, including the right to express views publicly. This right may be restricted only where it is lawful, necessary and proportionate to do so in order to:

- protect national security
- protect territorial integrity
- protect public safety
- prevent disorder or crime
- protect health or morals
- protect the reputation or rights of others
- prevent the disclosure of information received in confidence
- maintain the authority or impartiality of the judiciary

8. Notes on use

The government is adopting this definition of anti-Muslim hostility and will refer to it when developing and revising relevant policy. We encourage relevant organisations, employers and sectors to do the same – with the definition designed for organisations to use in ways that they consider to be useful and lawful.

The definition is non-statutory and must not be confused with legislation. It does not override, and must not be used in any way that is inconsistent with, any part of the law or statutory functions, guidance, or codes of practice etc.

Specifically, the definition is not intended to be an authoritative or exhaustive statement or summary of criminal law or a guide to particular criminal offences. **The definition does not change what is or is not a crime,** nor does it equate anti-Muslim hostility with crime. Some actions set out in the definition would constitute criminal acts as well as being examples of anti-Muslim hostility, but the definition also sets out non-criminal conduct or behaviour which would constitute anti-Muslim hostility.

The definition is also not intended to be an exhaustive statement or summary of equalities legislation or of how that legislation applies. It refers to unlawful discrimination, which is the subject matter of the Equality Act 2010. The definition only covers a subset of such unlawful discrimination – that is, unlawful discrimination deliberately targeted at Muslims. **The definition does not change what is or is not unlawful under the Equality Act 2010.** Similarly, some actions set out in the definition would be unlawful under the Equality Act 2010 as well as being examples of anti-Muslim hostility, but the definition also includes some actions which would not fall within the scope of, or breach, the Equality Act. For instance, the second paragraph of the definition covers prejudicial stereotyping where the intention is to encourage hatred, no matter whether this behaviour would be capable of being a criminal offence or would be unlawful under the Equality Act 2010. Therefore, the second paragraph is intended to encompass behaviour that is not necessarily unlawful, but which is reprehensible in this context, because it extends beyond the bounds of protected free speech.

The definition does not alter the legal position under the Equality Act 2010 and other legislation that race and religion are distinct. It does not reclassify Muslims as a racial group in law and does not modify the scope or content of existing statutory protections. While cases of anti-Muslim hostility may be the product of racism or may be combined with racism, the distinction between hostility related to race and hostility related religion is often important under the law. For example, race and religion are separate protected characteristics under equalities legislation. With cases of hostility,

it can sometimes be difficult to discern whether the hostility is related to race, to religion or to both. References to race (and ethnicity) in the definition of anti-Muslim hostility are not intended to conflate the two, or to suggest that there is no distinction between race and religion. It is an essential element of the definition that there is hostility directed against people or communities because of their religious identity or perceived religious identity.

Use of the definition must always take into account the context. Context matters because of the various ways and settings that anti-Muslim hostility can manifest, from subtle forms of prejudice and discrimination to overtly criminal acts. Alternatively, the context may demonstrate that the behaviour should not be regarded as anti-Muslim hostility, for example, because it is a legitimate expression of free speech. In addition, there is no right to always be protected from offence and indeed people may express views that others find uncomfortable or disagreeable. However, offensive views – including those spread electronically – are sometimes used for intimidation or harassment of others. Those behaviours are not acceptable, and everyone has the right to their own opinions and beliefs without being subjected to such hostility.

The definition and accompanying text must be read together. The accompanying text is intended to inform the interpretation of the definition. The accompanying text recognises that it is essential in a free, democratic and tolerant society that everyone is able to robustly exchange views and exercise protected free speech, even when these may cause offence. At the same time, it is essential to the proper functioning of a democratic society that all communities are able to participate fully in it. Tolerance and respect for the equal dignity of all human beings constitute the foundations of a respectful and inclusive democratic, pluralistic society.

This is a working definition. The definition, its implementation, and measuring its success will be subject to ongoing monitoring and regular review. Adjustments may be made as the context of the issue evolves, in response to feedback and emerging evidence to ensure clarity, effectiveness, and useful application of the definition.

9. Next steps

Defining a problem is a crucial first step towards addressing it, but we recognise that there is much more we need to do to combat religious hatred and ensure that every individual and community in the UK feels safe, respected and included.

That includes making sure that Muslim communities feel safe and protected at their place of worship or community centre, in the workplace, on public transport or accessing public services.

The government encourages the adoption of the definition across the public, private and third sectors, and them to consider how this definition applies in their contexts.

Reporting helplines and services should also consider how the definition can inform their processes, ensuring that incidents of anti-Muslim hostility are accurately identified, recorded, and addressed.

As part of our next steps, we will work with sectors to consider practical guidance and the best approaches to provide sector-specific guidance and support effective implementation.

While the definition is non-statutory, it should serve as a valuable guidance tool, enabling the government and other relevant bodies to better understand and respond to anti-Muslim hostility, supporting further action on tackling religiously motivated hate.

Published 9 March 2026

OGL

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INTERNATIONAL HOLOCAUST REMEMBRANCE ALLIANCE

26 May 2016

IHRA non-legally binding working definition of antisemitism

Adopted by the IHRA Plenary in Bucharest

In the spirit of the Stockholm Declaration that states: "With humanity still scarred by …antisemitism and xenophobia the international community shares a solemn responsibility to fight those evils" the committee on Antisemitism and Holocaust Denial called the IHRA Plenary in Budapest 2015 to adopt the following working definition of antisemitism.

On 26 May 2016, the Plenary in Bucharest decided to:

Adopt the following non-legally binding working definition of antisemitism:

"Antisemitism is a certain perception of Jews, which may be expressed as hatred toward Jews. Rhetorical and physical manifestations of antisemitism are directed toward Jewish or non-Jewish individuals and/or their property, toward Jewish community institutions and religious facilities."

To guide IHRA in its work, the following examples may serve as illustrations:

Manifestations might include the targeting of the state of Israel, conceived as a Jewish collectivity. However, criticism of Israel similar to that leveled against any other country cannot be regarded as antisemitic. Antisemitism frequently charges Jews with conspiring to harm humanity, and it is often used to blame Jews for "why things go wrong." It is expressed in speech, writing, visual forms and action, and employs sinister stereotypes and negative character traits.

Contemporary examples of antisemitism in public life, the media, schools, the workplace, and in the religious sphere could, taking into account the overall context, include, but are not limited to:

- Calling for, aiding, or justifying the killing or harming of Jews in the name of a radical ideology or an extremist view of religion.
- Making mendacious, dehumanizing, demonizing, or stereotypical allegations about Jews as such or the power of Jews as collective — such as, especially but not exclusively, the myth about a world Jewish conspiracy or of Jews controlling the media, economy, government or other societal institutions.
- Accusing Jews as a people of being responsible for real or imagined wrongdoing committed by a single Jewish person or group, or even for acts committed by non-Jews.
- Denying the fact, scope, mechanisms (e.g. gas chambers) or intentionality of the genocide of the Jewish people at the hands of National Socialist Germany and its supporters and accomplices during World War II (the Holocaust).
- Accusing the Jews as a people, or Israel as a state, of inventing or exaggerating the Holocaust.
- Accusing Jewish citizens of being more loyal to Israel, or to the alleged priorities of Jews worldwide, than to the interests of their own nations.
- Denying the Jewish people their right to self-determination, e.g., by claiming that the existence of a State of Israel is a racist endeavor.
- Applying double standards by requiring of it a behavior not expected or demanded of any other democratic nation.
- Using the symbols and images associated with classic antisemitism (e.g., claims of Jews killing Jesus or blood libel) to characterize Israel or Israelis.
- Drawing comparisons of contemporary Israeli policy to that of the Nazis.
- Holding Jews collectively responsible for actions of the state of Israel.

Antisemitic acts are criminal when they are so defined by law (for example, denial of the Holocaust or distribution of antisemitic materials in some countries).

Criminal acts are antisemitic when the targets of attacks, whether they are people or property – such as buildings, schools, places of worship and cemeteries – are selected because they are, or are perceived to be, Jewish or linked to Jews.

Antisemitic discrimination is the denial to Jews of opportunities or services available to others and is illegal in many countries.

C41(26)

COUNCIL

General Optical Council

Social Media Policy

Meeting: 30 September 2026 **Status:** For decision

Lead responsibility: Vikki Julian, Head of Communications, Andy Mackay-Sim, Chief of Staff
Paper Author(s): Vikki Julian, Head of Communications
Council Lead(s): There is no Council lead for this work

Purpose

1. To enable Council to approve a new social media policy.

Recommendations

2. Council is asked to:
   - approve the policy, which will apply to members, workers and staff.

Strategic objective

3. This work contributes towards the achievement of all strategic objectives. It is included in the Governance business plan as part of the review of the Member Code of Conduct.

Background

4. The review of the Member Code of Conduct identified social media use amongst employees, members and workers as an emerging issue for organisations. The GOC's lack of policy in this respect is a potential reputational risk.

5. This policy is designed to mitigate the risk by setting clear expectations for staff, members and workers around acceptable social media use.

6. SMT has the authority to approve the policy in respect to employees. The principles set out in the member code of conduct mean that the policy, if it is to apply to members and workers, should be approved by Council.

7. SMT endorsed this policy at its meeting of 25 of June and recommended it should be considered by Council.

Analysis

8. The policy has been designed to balance colleagues' right to freedom of expression with our role as a public regulator and our duty to maintain public confidence in our ability to regulate.

9. It does not seek to curtail social media use or the right to freedom of expression. It explicitly references the benefits of social media use in both professional and personal contexts; recognises the right of colleagues to share opinions on social, political and equality issues; and notes that this can be an important contribution to public and professional dialogue.

10. It seeks to protect the integrity of the GOC's corporate communications channels by restricting their use to authorised individuals, namely the Communications team.

11. It recognises that employees, members and workers may use social media in both their personal and professional lives and that the interplay between these may merge and can be complex. It makes considerations around both types of use.

12. In a professional context it sets out that posting content that is unlawful; amounts to harassment, discrimination or bullying; discloses confidential information; or could reasonable undermine the GOC's ability to act impartially as a regulator is not acceptable. It also states that online bullying or harassment and sharing confidential information is prohibited. It recommends making clear that all opinions are individual and not the view of the GOC, as a way of mitigating risk around commenting on potentially contentious topics.

13. Similarly, in a personal use context, the policy sets out that posting content that is unlawful; amounts to harassment, discrimination or bullying; discloses confidential information; or could reasonable undermine the GOC's ability to act impartially as a regulator is not acceptable. Online bullying or harassment and sharing confidential information is prohibited.

14. In both a personal and professional context, we ask that colleagues be mindful when commenting on potentially contentious issues, but do not explicitly prohibit this.

15. We consider this is the appropriate balance between freedom of expression and reputational protection, whilst giving appropriate leeway to act if any of the explicitly prohibited behaviours (which would represent the most egregious reputational damage) are breached.

16. The policy also ties risks around data and IT security.

17. The policy makes a recommendation around consideration of privacy settings. This is prudent not only in terms of reputational protection, but also in terms of staff wellbeing, as there have been instances of registrants trying to engage with colleagues via their personal social media.

Finance

18. There are no costs associated with this policy.

Risks

19. This section deals explicitly with risks around implementing the policy, rather than social media use in general.

20. There is a risk that colleagues may feel the policy goes too far in restricting freedom of expression. The mitigation for this is the balance in the policy between positive use and negative behaviours. Training around the policy will also need to be clear on this point.

21. There is a risk that the policy may not catch all negative reputational consequences of social media use due to its stance on allowing engagement around potentially contentious issues. We believe the right to freedom of expression is appropriately balanced and that the policy captures and explicitly prohibits the behaviours which would be most damaging reputationally.

Equality Impacts

22. This policy has been reviewed by our internal staff-led Policy Review Group (PRG) to collect feedback from staff. It suggested some additions around EDI inclusions. It does not require a specific impact assessment.

Devolved nations

23. There are no specific impacts for the devolved nations.

Communications

External communications

24. This policy will be published on our website.

Internal communications

25.

- Training for staff will be provided in an all-staff meeting and via Iris.
- Training for Council will be provided in a catch-up.
- Specific comms plans will be developed to ensure members and workers are aware of the policy, following its approval at Council.
- The policy should be included in GOC inductions for staff, members and workers going forward.

Next steps

26. Should Council approve the policy, we will implement as set out above.

Attachments

Annex 1: Social Media Policy

Social media policy

Status of document: Draft
Version: v3.0
Date of approval:
Effective from:
Owner: Vikki Julian, Head of Communications
Author: Vikki Julian, Head of Communications
Planned next review date: Two years from publication date
Linked policies: IT policy Disciplinary policy Bullying and harassment policy EDI policy Member code of conduct

1. About this policy

1.1 The General Optical Council (GOC) recognises the importance of social media as a tool for communications and engagement in both professional and personal capacities.

1.2 We recognise that colleagues have the right to freedom of expression in their personal lives, including the right to hold and share opinions on social, political and equality issues. This can be an important contribution to public and professional dialogue, including on equality, diversity and inclusion, when shared respectfully.

1.3 This policy is intended to support colleagues to exercise that right responsibly, balancing it with our role as a public regulator and our duty to maintain public confidence.

1.4 At the GOC we have a strong commitment to equality, diversity and inclusion, where our workforce is valued and respected for who they are. We will apply this policy with care and proportionality, taking into account context, lived experience and potential impacts on different groups, to avoid unintended disadvantage.

1.5 In some circumstances, the GOC may take action against staff, members or workers for their social media use, even if this is in private messages, per the Bullying and Harassment and Disciplinary policies for staff, and the Code of Conduct for members.

2. Who does this policy apply to?

2.1 This policy applies to all GOC staff, members and workers.

3. Who is responsible for this policy?

3.1 The Senior Management Team (SMT) has overall responsibility for the effective operation of this policy. SMT has delegated responsibility for its implementation to the Communications team.

3.2 The Communications team is responsible for managing the GOC's social media channels and for advising staff, members and workers on social media use.

3.3 Staff members who manage/support members and workers are responsible for ensuring they are aware of this policy.

3.4 All staff, members and workers are responsible for complying with this policy.

4. GOC social media channels

4.1 The GOC's corporate social media channels (LinkedIn, X, Instagram, YouTube) may only be accessed and used by authorised individuals.

4.2 Any requests to post on corporate social media channels must be made through the GOC's Communications team.

4.3 You must not set up any of your own corporate social media channels without prior authorisation from the Head of Communications.

5. Use of personal social media in a professional context

5.1 You may wish to use social media channels to communicate about your work at the GOC and engage with other professionals. The GOC welcomes staff, members and workers, engaging with its corporate content for the purposes of raising awareness, engagement, and amplification.

5.2 The GOC recognises the value of colleagues contributing to public and professional conversations, including around equality, diversity and inclusion, where this is done in a respectful and responsible way.

5.3 Where a channel is linked with your role at the GOC (e.g. LinkedIn), you must make clear that you are posting on your own behalf, not as an authorised GOC representative. For example, you may choose to include a line such as "all opinions my own" in any biographical information.

5.4 The GOC asks those who use social media to be mindful when commenting on sensitive or strongly held issues, including equality-related topics. You should be respectful of others and consider how your role may influence how your views are perceived.

5.5 You must not post content that:

- is unlawful

- amounts to harassment, discrimination or bullying
- discloses confidential information
- or could reasonable undermine the GOC's ability to act impartially as a regulator.

5.6 You must not engage in any online behaviour (for example, online bullying and harassment) that could damage the GOC's interests or reputation, whether directly or indirectly.

5.7 You must never share any confidential or sensitive information about the GOC on social media.

5.8 These examples are intended as guidance only and should not be interpreted as a complete list of prohibited conduct. You are expected to exercise good judgement and ensure social media activity is consistent with your duties, and the GOC's policies and values.

6. Use of personal social media in a personal context

6.1 There is unlikely to be a need for you to say you work at the GOC on most personal social networking sites. However, if you chose to do so, you must make clear that you are posting on your own behalf, not as an authorised GOC representative.

6.2 Be mindful when using social media, particularly when commenting on sensitive or strongly held issues, including equality-related topics. When engaging in discussions on sensitive issues, you should be respectful, avoid causing harm, and consider how your views may be perceived by others.

6.3 You must not post content that:

- is unlawful
- amounts to harassment, discrimination or bullying
- discloses confidential information
- or could reasonable undermine the GOC's ability to act impartially as a regulator.

6.4 You must not engage in any online behaviour (for example, online bullying and harassment) that could damage the GOC's interests or reputation, whether directly or indirectly.

6.5 Never share any confidential or sensitive information about the GOC.

6.6 These examples are not exhaustive. You are expected to exercise good judgement and ensure your social media activity is consistent with the GOC's policies and values.

7. Data and IT security

7.1 You are reminded that use of social media in both personal and professional contexts can carry data and IT security risks. You must take reasonable steps to mitigate these, for example, by having secure passwords and being mindful that hackers use social media as part of social engineering schemes.

7.2 For your wellbeing and privacy, you may wish to consider using privacy settings on social media accounts, particularly personal accounts. Remember that accounts with no privacy settings are publicly available and searchable by any internet user and any content posted is into the public domain.

7.3 If using social media on a GOC device, you must follow the IT policy.

8. Support

8.1 If you need further support or guidance on using social media, please contact the Communications team.

8.2 If you are concerned about a social media post, please contact the Communications team.

C42(26)

Council

Audit, Finance and Risk Committee (ARC) annual report 2025-26

Meeting: 30 September 2026 **Status:** For noting

Lead responsibility: John Cappcock, Chair of ARC
Paper Author(s): Andy Mackay-Sim, Chief of Staff

Purpose

1. To present the ARC annual report 2025-26 for Council's information.

Recommendations

Council is asked to:

- **note** the ARC annual report 2025-26

Strategic objective

2. The work of ARC contributes to all three of the organisation's strategic objectives by providing Council with assurance in respect to finance, risk and internal controls.

Background

3. As part of its terms of reference, ARC has a key role in providing assurance to the Council on matters pertaining to finance, risk and internal control. Its annual report to Council is attached as annex one.

4. As part of developing its annual report, ARC Committee members were asked to complete a self-assessment form, using the National Audit Office (NAO) Audit and Risk Assurance Committee Effectives self-assessment tool. The anonymised outcome of this self-assessment is included in the report.

5. The annual report has been drafted by the Chief of Staff and Chair of ARC. It was approved by ARC at its meeting on 7 September 2026.

Analysis

6. An annual report to Council increases the visibility of this assurance role to Council members, the public and registrants. It also supports good governance practice by ensuring that there is a clear mechanism for ARC to report on its activities and findings on a regular basis.

Finance

7. There are no financial implications associated with preparing the Committee's annual report.

Risks

8. There are no risks associated with preparing an annual report from ARC to Council, and it reflects good governance practice for the Committee to do so.

Equality Impacts

9. There are no likely impacts in respect to equalities, diversity and inclusion (EDI) in preparing this report.

Devolved nations

10. There are no specific impacts for the devolved nations.

Other Impacts

11. There are no significant impacts identified.

Communications

External communications

12. The ARC Annual Report 2025/26 is included in the Council papers for the public meeting and therefore will be available on the GOC website.

Internal communications

13. The report will be shared with Leadership Team via email by the Chief of Staff, as a way of showcasing the Committee's work and role in decision-making, risk management and internal controls.

Next steps

14. None.

Attachments

Annex 1: Audit, Finance and Risk Committee (ARC) annual report 2025/26

General Optical Council
Audit, Finance and Risk Committee
Annual Report
Year Ended 31 March 2026

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Message from the Chair

This is the fifth annual report to Council by the Audit, Finance and Risk Committee (ARC). It complements the regular reporting to Council by the Committee throughout the year in respect to finance, risks, governance and internal controls. It also provides a self-assessment that will inform the activities the Committee undertakes in the year ahead.

I was appointed as Chair of ARC on 25 June 2025. I also serve as the independent member of the Committee and was present at all meetings of the Committee covered by the period of this report. I am satisfied that the Committee has discharged its responsibilities as detailed within its terms of reference.

This year has seen several substantial pieces of work, this included:

- the procurement of an internal auditor;
- how projects transitioned from the 2020-25 strategic period into the new GOC strategy for 2025-30; and
- the updating of the corporate risk registers to reflect the GOC strategy for 2025-30.

I would like to express my sincere thanks to the ARC Committee members who discharge their duties and responsibilities with exceptional diligence and dedication. I am also grateful to the Council Associates who have taken the time to join our meetings and have made valuable contributions to our discussions.

I am also very grateful to both internal and external audit representatives from TIAA and HaysMac respectively, who attend our meetings on a regular basis and provide helpful challenge, assurance and external perspective.

Finally, I would like to thank the members of the governance and finance teams who support the Committee so ably and attentively throughout the year.

John Cappock

Chair of Audit, Finance and Risk Committee

August 2026

Membership

The Committee membership for 2025/26 was:

- John Cappock (independent Committee member 1 April 2025 – 31 March 2026; appointed as Chair 25 June 2025)
- Raymond Curran (registrant Committee member 1 April 2025 – 31 March 2026
- Kathryn Foreman (lay Committee member 1 April 2025 – 31 March 2026)
- Ken Gill (lay Committee member 1 April 2025 – 31 July 2025: Chair 1 April 2025 – 24 June 2025)
- Frank Munro (registrant Committee member – 1 April 2025 – 31 March 2026)

Ken Gill resigned as Council member with effect from 31 July 2025. Council appointed John Cappock as Chair of the Committee on 25 June 2025.

ARC is attended by the Chief Executive and Registrar, Senior Management Team (SMT) as required, Chief of Staff, Chief Legal Officer and Chief Financial Officer. Secretariat support is provided by the Governance team. In addition, the Chair of Council regularly attends as an observer. The Council Associates have observed ARC meetings and made valuable contributions, and an invitation to observe ARC will be extended to the newly appointed Council Associates for 2026/27.

Introduction

This report presents the activity of the ARC for 2025/26, alongside its assessment of the GOC position in respect to its areas of responsibility. The aim is to produce an annual report to model best practice in respect to governance and assist Council with the necessary assurances regarding the organisation.

Purpose

The ARC terms of reference are available online. Its primary duties are:

- To provide Council with assurances relating to:
    - management of GOC finances;
    - management of risk;
    - the internal control environment; and
    - corporate and charity governance.
- To appoint, reappoint and remove the external supplier of internal audit services and associated fees
- To approve the internal audit plan;
- To approve policies relating to the following:
    - financial regulations;
    - working capital;
    - risk management;
    - contracts and procurement;
    - information governance;

    - anti-financial crime;
    - working capital; and
    - credit cards.
- To advise Council on:
    - the annual report, accounts and financial statements of the organisation;
    - the suitability of the proposed annual budget
    - matters of note in the financial performance reports;
    - the appointment, reappointment and removal of the external auditors;
    - the external audit fee and other fees for audit and non-audit services;
    - the Reserves Policy;
    - the Risk Appetite statement.
- To approve the external audit terms of engagement;
- To approve the external audit annual plan;
- To approve the statements to be included in the annual report concerning internal controls and risk management; and
- To ensure that all policies and work within the committee's remit take account of and promote the GOC values and commitment to equality, diversity and inclusion.

ARC does this through a combination of regular reporting, deep dives, and specific work throughout the year.

The annual report provides Council with:

- An account of how ARC has fulfilled its responsibilities in 2025/26.
- A self-assessment of the strength and capacity of the ARC membership regarding the required skills and expertise to adequately fulfil its functions.
- An evaluation of the organisation's performance in respect to internal and external audit, and the corporate control environment.
- Areas for future consideration both by Council and its committees.

Our activity in 2025/26

ARC met six times in 2025/26. A list of agenda items is attached as **annex 1.** The Committee divided its meetings, so the agenda for each meeting alternated between either a focus on risk or financial performance throughout the year. The Committee was able to be flexible when required and the Chair exercised discretion to ensure time-critical matters were not unduly delayed.

The key areas of focus for the Committee in 25/26 were:

Scrutinising plans to respond to PSA performance review feedback

In November 2025, the Committee reviewed action plans for education quality assurance and regulatory operations. This was following PSA feedback in the performance review process that had suggested these areas needed additional focus to ensure improvements. The Committee provided assurance to Council that the plans were adequate, and it will continue to monitor the progress in implementing these plans in 2026/27.

Updating the corporate risk register

The Committee supported the executive in revising the corporate risk register to take account of the GOC strategy for 2025-26. This included regular discussions about identified and emerging risks, reviewing the drafted contents and scrutiny of the existing and proposed controls. The Committee provided assurance to Council that the activity to update the register took account of feedback and captured the key risks for the current strategic period.

Internal audit procurement

Internal audit services went out to procurement in 2025-26. Following a competitive process, the contract was awarded to the incumbent provider, TIAA, for a further five years. The Committee was involved in the early stages of the procurement, including reviewing the proposed tender. The Chair of the Committee, alongside the Director of Corporate Services and the Chief of Staff, was part of the selection panel.

Projects in transition

The GOC had invested in several critical transformational projects as part of its 2020-25 ‘fit for the future’ strategy. Some of these projects were due for completion outside of the lifecycle of the former strategy. To support the transition, the Committee received reports of the bridging arrangements for the following:

- MyGOC (registrant online platform);
- Employee Performance Behaviour Framework (PBF); and
- Future Office Accommodation (FOA)

The Committee continues to monitor benefits realisation for these projects, and how the new directorate, People and Improvement, has set its agenda for project work in the years ahead.

Financial management

ARC conducted regular and detailed reviews of the organisation’s financial performance and five-year forecast, including an interrogation of forecasting assumptions throughout the year. It continues to work closely with the Investment Committee to ensure that the risks associated with financial volatility are managed and mitigated.

In January 2026, ARC reviewed the internal and external business plans and proposed budget for 2026/27 prior to approval by Council in March 2025.

Internal audit

The internal audit plan for 25/26 was delivered within the year, including audit of the following areas: Human Resources Management; Integrity of the Register; Never Event Framework; and ICT Cyber Security. An audit into Core Finance Operations was planned but reporting was delayed until 2026-27 due to operational capacity.

All audits received a substantial or reasonable assurance audit opinion.

TIAA is satisfied that, for the areas reviewed during the year, General Optical Council has reasonable and effective risk management, control and governance processes in place.

ARC maintained a review of audit findings and tracked the management response to any recommendations arising through to completion.

Risk management

The Committee reviewed the corporate risk register on a regular basis, prior to it being considered by Council at its strictly confidential meetings. It undertook deep dives into the following areas: the Legal department (September 2025) and Cyber-security (January 2026).

Chair's opinion to Council

It is my assessment that ARC discharged its responsibilities over the past year. The Committee covered a broad range of issues relating to finance, risk, governance, and internal control. This work supported the Council and executive by providing assurance on the internal control environment, including financial and risk management.

Committee self-assessment

ARC members were asked to complete the National Audit Office 'Audit and Risk Assurance Committee Effectiveness Tool' (May 2022). Members were asked to score 179 questions, distributed across six sections, ranking in the following way –

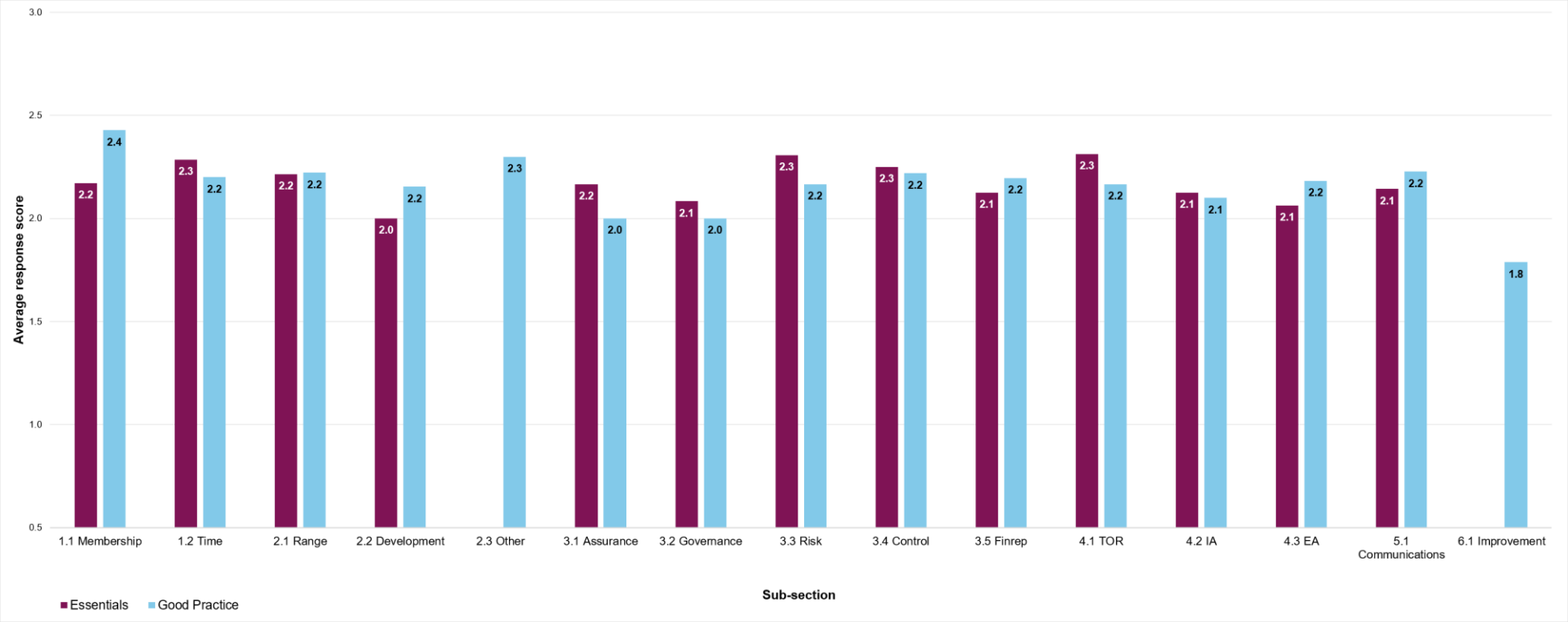
1 = Room for improvement, 2 = Meeting standards, 3 = Excelling

The tool is intended for government bodies, so some questions were disapplied by the Committee as not relevant.

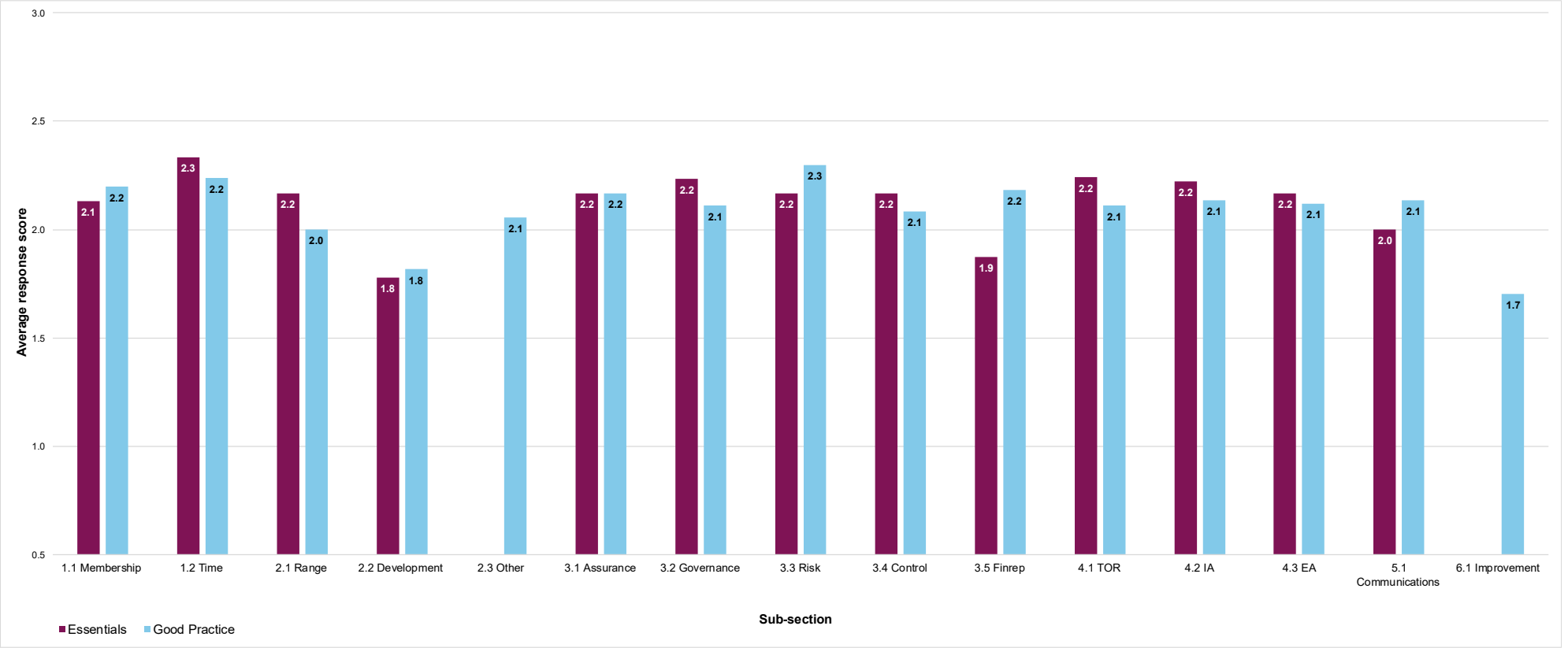
The self-assessment was carried out in August 2026, so does not reflect the views of Committee members who demitted prior to this date. However, it does give an indication of the current membership's experiences and will assist with identifying future areas for improvement and development.

The results are summarised in the charts below, and the results for 2025-26 are included for the purposes of comparison. The questions were split into 'essential' (which "reflect guidance set out in the HM Treasury Audit and Risk Assurance Committee Handbook") and 'good practice' (which "go beyond basic requirements and set a standard for audit and risk assurance committees to demonstrate leading behaviours").

2025-26 response



2024-25 response:



The Chief of Staff has reviewed the self-assessments and provided the following summary feedback:

- The Committee self-assessment results have not deviated significantly from 2024-25. There remains a consistent understanding of the role of the Committee, with both the essentials and good practice factors scoring above average.
- There appears to be minor changes in several scores across all categories. The small survey size and restrictive scoring system can account for some of this variance, though the Chair and Chief of Staff will review individual responses to help identify areas of focus for 2026-27.
- In terms of areas for improvement, the following were highlighted:
    - limited evidence of assurance mapping or using the three lines of defence model to understand how risk was being managed;
    - the Committee's scope of work, and whether having finance and risk combined in one committee was creating confusion or drawing focus away from key issues;
    - the Committee's learning and development – this included induction and ensuring there was a positive culture of learning and development in the Committee;
    - the Committee's role in relation to external audit, including how it reviews the approach to external audit and reporting; and
    - the lack of clarity about how the Committee pursues its own continual improvement, including how feedback is collected and acted upon.
- These areas are similar to those identified in the previous year.
- The Committee Chair will review the responses with the Chief of Staff and will raise actions where necessary to address emerging themes.
- In addition, the feedback will be included as part of the data captured for the board effectiveness review.

The Committee will continue to monitor this in future years and report back to Council to inform policies, procedures and practices as required.

Forward look

The Committee will use 2026-27 to deep-dive into the operational risk registers following the update of the corporate risk register in 2025-26. It will continue to provide assurance to Council that the risk management processes within the organisation remain robust, and that internal controls are adequate and planned improvements identified. This will include ongoing review of the organisation's fraud maturity, following an advisory audit in 2024-25.

The Committee will participate in the Council's board effectiveness review, which includes consideration of how Council organises its non-statutory committees to reflect its changing dynamics. The Committee looks forward to seeing the outcomes

of the effectiveness review and will incorporate agreed findings into its forward work plan.

The Committee will also continue its compliance monitoring through the year. The significant and serious incident management policy gives ARC a role in tracking lessons learnt from significant and serious incidents as may arise.

The Committee will ensure a long-term form of forward planning, setting its forward plan for three years. This enables a more strategic view of recurring items, and greater visibility of when key compliance and governance reviews are occurring in the committee life-cycle.

The Council's financial position remains strong, as borne out by its annual accounts and external audit. ARC will monitor financial performance closely in light of the economic instability and will continue to provide robust challenge where the executive anticipates over or underspends in its future budgetary forecasts.

Appendix 1 - Substantive items considered by ARC: April 2025 to March 2026

7 May 2025

Internal audit annual report 24/25 and internal audit recommendations progress report	ARC20(25)
Strategic Change Board: assurance report Q4 24-25	ARC23(25)
Exceptions and serious incidents report Q4 24-25	ARC24(25)
Compliance report Q4 24-25	ARC25(25)
Corporate risk register	ARC26(25)
Policy and Standards department risk register deep-dive	ARC27(25)

8 July 2025

GOC financial statements and annual report (including private discussion with external audit)	ARC21(25)
Bridging projects reports 2025/26	ARC24(25)
Financial performance, forecast and budget update Q4 24/25	ARC25(25)
Exceptions and serious incidents Q1 25/26	ARC26(25)
Annual self-assessment and report to Council: verbal update	Oral

2 September 2025

Procurement plicy	ARC31(25)
ARC Annual Report 2024-25	ARC32(25)
Corporate risk register	ARC33(25)
Legal department risk register deep dive	ARC34(25)
Q1 2025/26+ five-year forecast report	ARC35(25)
Financial performance report (June 2025/26)	ARC36(25)
Compliance report Q1 update 2025/26	ARC37(25)
Director's report	ARC38(25)
Progress against internal audit workplan and internal audit findings reports	ARC39(25)

25 November 2025

Internal audit tender	ARC44(25)
Updated corporate risk register	ARC45(25)
Project assurance board update	ARC46(25)
2026/27 registration fees rules	ARC47(25)
Financial performance report (September 2025/26)	ARC48(25)
Q2 2025/26+ five-year forecast Report	ARC49(25)
Registers of Interests and gifts and hospitality annual review	ARC50(25)
Weightman's audit update	ARC51(25)
PSA performance reviews: FtP and Education	ARC52(25)
Exceptions and serious incidents Q2 2025/26	ARC53(25)
Compliance report Q2 update 2025/26	ARC54(25)
Contracts – tenders and exceptions	ARC55(25)

29 January 2025

Update on response to the fraud maturity audit + Fraud policy and prevention plan	ARC04(26)
Corporate risk register	ARC05(26)
Deep dive into risk ID 7 – Cyber-security	ARC06(26)
Exceptions and serious incidents Q3 25/26	ARC07(26)
Director's report	ARC08(26)
Progress against internal audit workplan + internal audit findings report + internal audit recommendations progress report	ARC09(26)
Brief on the audit selection process	Oral

24 February 2026

Financial performance report (December 2025/26)	ARC14(26)
Q3 2025/26+ five-year forecast report	ARC15(26)
Proposed budget and internal business plan 2026/27	ARC16(26)
Director's report	ARC17(26)
Review of reserves policy	ARC18(26)
External audit plan 2025/26	ARC19(26)
Compliance report Q3 update 2025/26	ARC20(26)

C43(26)

COUNCIL

General Optical Council

CPD reform

Meeting: 30 September 2026 **Status:** For decision

Lead responsibility: Steve Brooker (Director of Regulatory Strategy)
Paper author(s): Steve Brooker (Director of Regulatory Strategy)
Council lead(s): none

Purpose

1. To ask Council to approve our response to the consultation on CPD reform.

Recommendations

2. Council is asked to:
   - **approve** the draft consultation response document and draft updated impact assessment in Annexes 1 and 2; and
   - **delegate** final approval to the Chief Executive and Registrar in consultation with the Chair of Council, if Council request minor changes to the documents at the meeting.

Strategic objective

3. This work contributes towards the achievement of the following strategic objective: Preventing harm through agile regulation. CPD reform is highlighted as a priority in the corporate strategy, and this work is included in our 2025/26 Business Plan.

Background

4. Our 2025-30 corporate strategy includes a commitment to "*Reforming our CPD system so that it focuses on the quality rather than quantity of professional development and supports the expanded clinical roles registrants will perform within service redesign*".

5. Council approved consultation documents at its meeting in December 2025. This followed an internal appraisal of the GOC's CPD system, a review of CPD systems among other healthcare and professional services regulators, an evaluation of the 2022-24 cycle and registrant feedback through the 2025 registrant survey.

6. The strategic drivers of change included maturation of the current CPD system, including identifying weaknesses, supporting Government policy to shift care from hospitals to communities and its expectation in the 10 Year Plan for the NHS in England that all healthcare regulators 'renew' their CPD systems.

7. The vision for reform set out in the consultation is to modernise and scale back our CPD requirements towards a more flexible, less prescriptive system. Our proposals fell into three broad groups including:

    - maximising opportunities for registrants to design their CPD approach;
    - leveraging the role of business registrants; and
    - ending CPD provider approval and audit.

8. The more significant proposals in consultation, such as ending the points system and CPD provider approval, require changes to the CPD Rules 2021. Other proposals consistent with the overall direction of travel do not require legislative change and could be introduced for the start of the 2028-30 cycle.

9. The consultation ran from January to April 2026 and received 165 written responses. In addition, we ran several stakeholder events during the consultation period.

Analysis

Consultation feedback

10. The consultation presented significant proposals for reform so as expected we received a range of perspectives with some respondents favouring a more liberalised system and others preferring to retain a prescriptive system. The four UK sector bodies submitted a joint response on areas where they agreed, but their individual responses highlighted several areas where they disagreed. Often the views of organisations differed from those of individual respondents. Therefore, a challenge for the executive in drafting the consultation response has been to find a way forward that can command broad stakeholder support.

11. Council's approach should follow our published consultation policy, which includes:

    "*We will remain guided by our governing principles, in particular the principle of protecting the public. We focus on the evidence and reasoning given in the consultation, making primarily qualitative analysis of the responses. Decisions will not be made on numbers alone. Rather, our decisions are made on the basis of the strength of the arguments put to us and our assessment of the evidence of the impact of our proposals. Consultation is not a vote and we do not devise any artificial weighting of responses from optometrists, dispensing opticians, patients or any other stakeholder group. Where appropriate, we are likely to give more weight to feedback from optical sector bodies representing significant numbers of our registrants than individuals.*"

12. Below, we summarise our proposed response to stakeholder feedback under the three groups of proposals.

Maximising opportunities for registrants to design their CPD approach

13. The headline proposal was to end the points system. Overall views were finely balanced with organisations tending to be in favour and individuals against. Notably, three of the four UK sector bodies (as well as Optometry Scotland and Optometry Wales) were in favour. The College of Optometrists was against, but its main objection was that culture change in the profession was needed first – it did not rule out ending the points system once this had taken place.

14. Support for ending the points system was conditional on second order issues like the content of guidance and assurance mechanisms. The draft response says that we are committed to working with the profession to co-create the necessary guidance and assurance mechanisms and that more detailed plans will be subject to public consultation at the appropriate stage.

15. There was good support for other proposed building blocks including the need for registrants to make a compliance declaration at registration renewal, ongoing CPD record review and the Registrar being able to remove registrants from the register where their CPD records are assessed as inadequate and they have failed to remediate, subject to appeal.

16. There was broad consensus behind introducing these changes following the end of the 2028-30 cycle, which would allow time for culture change and detailed planning and is a more realistic timetable for legislative change.

17. In terms of changes possible for the start of the 2028-30 cycle, there was interest in recalibrating points, changing the mandatory learning domains and removing barriers to self-directed CPD. We propose setting up a stakeholder task and finish group to review options and forge consensus.

Leveraging the role of business registrants

18. The proposals in this section received the most pushback from both individuals and organisations. Overall, the sentiment was that while businesses have an important role in supporting registrants with their learning and development, they should not shape the CPD registrants do or help GOC police the system. The commercial influence of businesses on learning plans was highlighted. Also, some businesses have more scope to support CPD than others and concerns about additional burdens and costs for businesses were raised.

19. We propose to withdraw the specific proposal for businesses to ensure that individual registrants have an up-to-date Personal Development Plan (PDP).

20. Responses from businesses considered that our existing Standards for Optical Businesses were sufficient, but we also received some suggestions about how they might be strengthened. We plan to consider the need for any changes in the upcoming review of these standards and may also include a new section on the role

of employers in our CPD guidance materials. The focus will be on creating an environment to support learning rather than specific requirements.

21. There was good support for incorporating patient feedback within CPD, so we plan to add a new section to our CPD guidance about this.

Ending CPD provider approval and audit

22. Responses to this question were quite evenly distributed, with more organisations tending to favour ending CPD provider approval but more individuals preferring to keep it. Many responses took neutral positions. Some respondents sought a middle ground where alternative assurance mechanisms such as standards and audit could replace CPD provider approval. However, unless GOC approves (and can remove) CPD providers, standards would not be binding and there would be no basis for us to conduct audits. Therefore, on this issue, we need to make a clear choice.

23. Some responses argued that the commercial nature of the sector justified GOC (uniquely among professional services regulators) needing to maintain CPD provider approval and audit. However, the risk this factor presents, as well as GOC's ability to mitigate that risk, are perhaps both exaggerated.

24. Generally, responses on this issue were more cautious than anticipated. Reflecting PSA guidance, we should adopt a 'right touch' regulatory approach based on our assessment of risk. The recommendation to Council is that we should seek to end CPD provider approval on the following grounds: market forces and registrant choice should ensure quality in the absence of GOC approval; lowering barriers to entry and improving diversity of CPD provision; and being unable to justify our position as the sole remaining professional services regulator within or outside of healthcare to still approve CPD providers.

25. Finally, in terms of changes possible without legislative change, there was support for making it easier for provisional CPD providers to qualify as fully approved CPD providers and for gradually reducing audits over the cycle. There were also calls from CPD providers to simplify our internal processes. We plan to engage with small CPD providers and the task and finish group on these points. Finally, stakeholders want us to keep our Standards for CPD Providers, which we are content to do until CPD provider approval ends.

Finance

26. There are no financial costs associated with the policy development phase of work.

27. The proposed system would be cheaper to operate than the current one, but most savings would materialise only if the points system was ended. Our income from CPD providers is exceeded by the costs of CPD provider regulation, but we cannot increase income since the £45 annual fee is prescribed in the CPD Rules 2021.

28. We propose changes to points requirements for the start of the 2028-30 cycle, but the specification will not be known until the task and finish group completes its work. However, viewed in isolation, resulting IT development costs should be modest and met from BAU funds within the 2025-30 financial forecast envelope.

29. The contract with the current IT supplier for MyCPD ends in December 2027. A decision by Council today will support early planning for the 2028-30 cycle as we will need to draw up a specification of changes for the selected supplier to implement.

Risks

30. There is a risk to patient safety if registrants do not undertake sufficient and relevant CPD that maintains their existing skills and develops new capabilities. Equally, there are risks if weaknesses in the current system are not addressed, such as unnecessary costs of regulation and insufficient time available to learn new skills that will support the shift in eye care from hospitals to communities.

31. If we confirm our preference to end the points system this could undermine compliance with these requirements in the current cycle. To a degree this is unavoidable, but we have a communications plan to support compliance, and the statutory notice reminder is an important safeguard. At the current stage of the cycle, points tallies are where we expect them to be based on previous experience.

32. It will remain challenging to secure wide stakeholder support for the proposals. The creation of a task and finish group will help forge consensus about changes for the 2028-30 cycle and there is a clear commitment to co-create with stakeholders more detailed plans for changes requiring amendments to the CPD Rules 2021.

33. Government may be unwilling to amend the CPD Rules 2021 even for a 2031 start despite its 10-Year Plan for the NHS in England asking regulators to renew their CPD systems. If Council agrees the response documents, it will enable us to give officials plenty of notice of our plans but ultimately this is outside of our control.

Equality Impacts

34. The equality impact assessment has been updated following stakeholder feedback, at Annex 2. The feedback did not substantially alter our assessment of the impacts.

Devolved nations

35. The CPD requirements apply equally to all nations. The paper references the systems of CPD grants and allowances available in each nation.

Communications

External communications

36. Subject to Council approval, finalised documents will be published in October. Communications with registrants will emphasise continuity for the remainder of the current cycle and plans for a managed transition thereafter.

37. There is already a communications plan for the current cycle. The draft response document identifies opportunities to support culture change and address specific issues like clarifying what activities count as legitimate self-directed CPD.

Internal communications

38. The team is primed to support the changes planned for the 2028-30 cycle.

Next steps

39. Subject to Council approval, we will translate the documents in Annexes 1 and 2 into Welsh ahead of publication in October 2026.

40. The draft response document includes an outline timetable for changes that we plan to introduce for the 2028-30 cycle. We should not need to consult publicly on these changes, since these are based on the outcome of a previous consultation, although we will engage with sector bodies via the task and finish group.

41. Once the response document is finalised, we will write to the Minister, explaining how we have met expectations to ‘renew’ our CPD system and to seek support for legislative change in time for the end of the 2028-30 CPD cycle.

Attachments

Annex 1 – Draft consultation response paper
Annex 2 – Updated impact assessment

GOC response to our consultation on reforms to Continuing Professional Development

October 2026

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1. Executive summary

Background

1. The General Optical Council (GOC) regulates eye care services in the UK. We currently register around 35,000 optometrists, dispensing opticians, student optometrists, student dispensing opticians and optical businesses.

2. Continuing professional development (CPD) is a legal requirement for all fully qualified optometrists and dispensing opticians registered with the GOC, and one of our responsibilities is to administer the CPD scheme. CPD ensures that registrants maintain and develop their knowledge and skills to help ensure the safety and quality of care that their patients receive.

3. Our 2025-30 corporate strategy includes a commitment to "*Reforming our CPD system so that it focuses on the quality rather than quantity of professional development and supports the expanded clinical roles registrants will perform within service redesign*". The consultation document set out the drivers for change, including the expectation in the 10-year NHS Plan for England that professional regulators 'renew' their CPD systems.[1] The policy thinking that underpins the GOC's current system dates to 2018, so a review was timely to ensure that our approach meets government expectations, supports service redesign and aligns with good practice across professional services regulation.

4. Our vision for reform, which we set out in the consultation, is to modernise and scale back our CPD requirements towards a more flexible, less prescriptive system. Our proposals fell into three broad groups including:
   - Maximising opportunities for registrants to design their CPD approach
   - Giving business registrants a greater role to support registrants with CPD
   - Ending CPD provider approval and audit.

5. Some of the most significant proposals, such as ending the points system, would require changes to the CPD Rules 2021, which require parliamentary time. Other proposals could be implemented without changes to legislation and can be introduced for the beginning of the 2028-30 CPD cycle.

6. We consulted publicly for 12 weeks from 19 January 2026 to 19 April 2026. 165 written consultation responses were received from CPD providers, registrants, employers, the education sector, representative bodies and other stakeholders.

7. We also held several stakeholder events during the consultation period. Feedback received at these events is summarised at the start of each chapter.

[1] UK Government and NHS England, Fit for the Future: The 10 Year Health Plan for England, July 2025.

Summary of GOC response to consultation feedback

Changes requiring amendment to the CPD Rules 2021 – target January 2031

Maximising freedom for registrants to design their CPD approach

- End the points system and three-year cycles
- GOC indicative guidance on the amount, learning areas and types of activity with clarity on our approach to CPD record review and registration removal
- Registrants required to maintain a personal development plan
- Registrants to make a compliance declaration as part of registration renewal
- Registrants to maintain learning records for review purposes with approach to record keeping on GOC or personal IT systems to be determined later
- Independent assessors to review a sample of records against the guidance
- Registration could ultimately be removed if CPD records are assessed as inadequate with the final decision made by the Registrar, appealable to the Registration Appeals Committee:

Giving business registrants a greater role to support registrants with CPD

- None required

CPD providers

- End CPD provider approval to coincide with end of the points system

Changes for 2028-30 cycle – all possible within the CPD Rules 2021

Maximising freedom for registrants to design their CPD approach

- Consider reallocation of points for different activities focused on the overall burden of activity and incentives to support key sector priorities, such as increasing the pool of supervisors, teaching, post-registration qualifications
- Change from four to two mandatory learning domains focused on clinical practice and professional behaviours.
- Remove requirements that may be holding back use of self-directed CPD including the minimum amount of provider-led CPD and the need to write a reflective statement for each self-directed CPD event

Giving business registrants a greater role to support registrants with CPD

- Review the Standards for Optical Businesses
- Incorporate patient feedback within CPD guidance
- Proposal to give business registrants specific responsibility to ensure individual registrants have an up-to-date personal development plan is withdrawn

CPD providers

- Reduce the number of CPD events requiring approval before CPD providers can convert from provisionally approved to fully approved status
- Maintain standards for CPD providers
- Reduce number of CPD provider audits over 2028-30 cycle

Next steps

8. While we can make some changes to the CPD system before the 2028-30 cycle begins, major changes would require changes to the CPD Rules 2021 – this is secondary legislation. Although we are leading engagement with the sector through this consultation, responsibility for agreeing changes to legislation does not rest with us but with Parliament, and the pace and outcome of any changes will be determined by the UK Government. There will be further consultations on any changes to legislation, led either by the GOC and/or the UK Government.

9. Professional bodies, employers, CPD providers and others are key partners in the delivery of the CPD system, and it is important for our changes to command sector confidence. We are committed to working in partnership to refine and further develop our proposals, and more widely to support the process of culture change and a managed transition. We will set up a task and finish group, which will focus initially on changes that need to be introduced in January 2028.

10. Below is an outline timetable for work ahead of the 2028-30 CPD cycle.

Task	**Timetable**
Task and Finish Group	November 2026 to March 2027
Publish updated guidance	October 2027
2025-27 CPD cycle ends	31 December 2027
Council to consider evaluation of 2025-27 CPD cycle	June 2028

2. Introduction

Background to policy

11. This consultation sought views on modernising and scaling back our continuing professional development (CPD) requirements towards a more flexible and less prescriptive system. The detail and reasoning behind our proposals can be found in the Reforms to CPD consultation paper.

12. Our proposals fell into three groups (text reproduced from consultation paper):
    - **Maximising opportunities for registrants to design their CPD approach.** Moving away from a minimum points-based system and prescribed learning formats towards an outcomes-based approach that sets broad expectations for registrants. GOC would issue guidance on the amount, learning areas and types of CPD activity, but registrants would decide what activities to undertake. Registrants would still complete a Personal Development Plan and reflect on progress. They would keep records of their CPD, and we would review a sample of registrant CPD records annually against our guidance. Registration could be removed if CPD records are assessed as inadequate with opportunity for remediation and appeal. All registrants would make an annual compliance declaration during registration renewal to help underpin this system.
    - **Leveraging the role of business registrants.** Employers have a closer relationship with registrants than GOC, so are better placed to support them to identify and progress their learning and development needs. We would review the GOC's Standards for Optical Businesses to underpin this role. Businesses could have specific responsibilities in relation to certain key features of a revised scheme, such as checking Personal Development Plans are in place. Businesses would be encouraged to incorporate patient feedback as part of appraisals and similar systems.
    - **Ending CPD provider approval and audit.** GOC is the only healthcare regulator to approve and audit CPD providers and we consider this function is no longer necessary for public protection reasons. Registrant satisfaction with CPD provision is high and we consider market forces should be sufficient to ensure quality in the absence of GOC oversight.

13. Some aspects of the CPD system are prescribed in secondary legislation – the CPD Rules 2021. The consultation included proposals that would require amendments to these Rules, and we sought views on the timetable for such changes. We explained that we had alerted government to a possible need for legislative change but were working on the basis that parliamentary time will not be available before the 2028-30 cycle begins. However, we explained that there is scope to make improvements consistent with our vision for reform within the CPD Rules 2021 ahead of the 2028-30 cycle without legislative change.

Consultation process

14. Our consultation was open for 12 weeks from 19 January to 19 April 2026.

15. We received 165 written consultation responses from a range of stakeholders. These were made up of:

- 41 dispensing opticians
- 1 student dispensing optician
- 68 optometrists
- 9 contact lens dispensing opticians
- 16 therapeutic prescribing optometrists
- 8 professional bodies
- 11 CPD providers
- 2 education providers
- 2 GOC business registrants, and
- 4 “other” individuals.

16. The organisations who were willing to be identified were:

- Association of British Dispensing Opticians (ABDO)
- Association of Optometrists (AOP)
- Bexley, Bromley and Greenwich Local Optical Committee
- College of Optometrists
- FODO – the Association for Eye Care Providers
- Optometry Scotland
- Optometry Wales

17. ABDO, the AOP, the College of Optometrists and FODO also submitted a joint response highlighting areas where they agreed.

18. We are grateful for all the feedback we received and have taken this into account in deciding our next steps.

Approach to producing this response

19. Responses were analysed in line with our consultation policy, which includes the following paragraph:

> “*We will remain guided by our governing principles, in particular the principle of protecting the public. We focus on the evidence and reasoning given in the consultation, making primarily qualitative analysis of the responses. Decisions will not be made on numbers alone. Rather, our decisions are made on the basis of the strength of the arguments put to us and our assessment of the evidence of the impact of our proposals. Consultation is not a vote and we do not devise any artificial weighting of responses from optometrists, dispensing opticians, patients or any other stakeholder group. Where appropriate, we are*

likely to give more weight to feedback from optical sector bodies representing significant numbers of our registrants than individuals."

20. Respondents were encouraged to provide comments throughout the consultation, and we reviewed every comment received. Any comments that have been included are produced verbatim, although we have made minor corrections to spelling and/or grammatical errors where obvious.

21. We have only included comments where the respondent has consented to their response being published (either alongside their organisation name or anonymously). It is our practice not to include the names of individual respondents, even where they have given their consent for us to publish their response.

Stakeholder engagement

22. As part of our consultation approach, we held events with stakeholders during the 12-week consultation period. Feedback from these events is included in relevant sections of the report below. We also held discussions with patient representative groups.

Advisory Panel

23. We discussed the proposals with our Advisory Panel, which is made up of four statutory committees: Companies Committee, Education Committee, Registration Committee and Standards Committee. Their role is to give advice and assistance to our Council.

3. Findings relating to maximising opportunities for registrants to design their CPD approach

Summary of feedback from stakeholder consultation events

24. Across the consultation events, participants broadly supported the intention to move away from a points-based CPD model, seeing potential benefits in a more flexible and reflective approach to professional learning. Many felt the current system can encourage a “tick-box” mentality, where registrants focus on accumulating points rather than identifying and meeting genuine learning needs. At the same time, there was a strong message that flexibility should not come at the expense of clarity. Stakeholders stressed that registrants need clear expectations, guidance and a visible framework so that requirements remain understandable and consistent across different roles and settings.

25. A recurring concern was that removing points altogether could weaken accountability and reduce engagement, particularly for registrants who are less confident in planning their own development or who may otherwise leave learning until the end of the cycle. Many stakeholders therefore favoured retaining some form of minimum requirement or baseline expectation, whether expressed through hours, annual activity expectations or another measurable threshold. Participants also highlighted that any future model should still ensure fairness and consistency, with clear ways to evidence learning, support audit processes and maintain confidence that all registrants are meeting appropriate professional standards.

26. Stakeholders emphasised that CPD should be driven by individual learning objectives and tailored to scope of practice, recognising that meaningful development will differ across professional settings. However, they noted practical challenges in making this work, including the availability of suitable learning opportunities, uncertainty about what could count as self-directed learning, and concerns that the proposed changes could simply replace one form of administrative recording with another. Overall, the feedback suggested cautious support for reform, but with a clear expectation that any transition should be gradual, well-communicated and accompanied by strong guidance to help registrants adapt to a new system confidently and effectively.

Summary of consultation feedback

27. A summary of written feedback received from respondents to the consultation in respect of each question asked in relation to maximising opportunities for registrants to design their CPD approach follows.

Changes requiring legislative reform

28. Questions 1 to 9 asked for views on proposals that would require amendments to the CPD Rules 2021 and therefore would not be possible to implement before the start of the 2028-20 CPD cycle.

Agreement with our objectives for the review (Question 1)

Q1 Do you agree with our objectives for the review?	Overall	Individuals	Organisations
Yes	51.2%	45.2%	84.0%
No	20.0%	20.7%	16.0%
Not sure	28.8%	34.1%	0.0%

29. Responses were broadly supportive of the GOC's direction of travel to modernise CPD and move the emphasis away from the quantity of CPD required towards quality, relevance, and outcomes. However, some respondents cautioned that reforms must retain sufficient structure and assurance to protect patients, maintain consistent standards, and avoid unintended consequences such as inequities or cost-shifting. In its response, the College of Optometrists called for an evolution of the current framework rather than a wholesale restructuring.

30. In a joint response, the four UK sector bodies suggested the following principles should be embedded in the proposed new system of CPD: maintain public protection; provide a framework that gives sufficient clarity for registrants; be evidence-based; be based on a full assessment of the impacts; and be capable of consistent application across the sector. While understanding and supporting the ambition to move towards a more outcome-focused approach to CPD that empowers registrants, they highlighted that successfully navigating this transition will involve substantial change over a significant period, including major cultural change. Therefore, they encourage GOC to work closely with them, as the main sector bodies, during this period of change and to establish effective mechanisms to support this collaboration.

31. There was concern that the proposed reforms were too vague, with insufficient detail about what would replace the points system. Some respondents felt the reforms seemed more focused on reducing costs and regulatory burden than on improving professional standards or public protection.

32. Stakeholders indicated support for:

- More flexible and less prescriptive CPD that supports learning tailored to the development needs and scope of practice of optical professionals
- Outcomes-focused learning to reduce compliance and "tick-box" behaviour and encourage more meaningful learning and development
- Recognition of diverse career pathways, including non-clinical roles (for example, in education, leadership, research, industry/manufacturing etc.)
- Support for workforce transformation and evolving models of care across the four nations, including enhanced clinical skills for expanding community eye care, urgent eye care pathways, integrated pathways, digital/remote care, and emerging AI-supported tools

- Reducing unnecessary regulation cost and burden, although cautioned this should explicitly include business registrants and CPD providers.

33. A recurring theme was conditional support for the proposals. Concerns raised by stakeholders included:

- Public protection needs to be explicit – some considered the consultation objectives insufficiently clear on how the proposed reforms will continue to protect the public and maintain high standards as clinical roles expand
- Loss of structure and reduced engagement – moving too far towards open-ended, self-determined learning could reduce attendance at structured CPD courses, weaken collaboration, and erode shared standards underpinning safe care
- Loss of focus on core competence – while recognising that supporting diverse career trajectories was important, CPD should focus on maintaining and enhancing competence as a registrant
- Equity impacts – a less structured system may widen inequalities which could affect practitioners in rural and remote settings and small practices with limited infrastructure. Respondents called for design for inclusivity and fairness, ensuring the framework works across different employment models and settings
- Risk of cost and responsibility transfer – oversight costs could transfer from the GOC to employers, with clarity requested on who bears new responsibilities in a reformed system
- Evidence base and impact assessment – there were calls for a more comprehensive and transparent impact assessment
- Change fatigue and implementation practicality – some respondents noted substantial recent changes with limited time for systems to bed in, potential disruption and that reforms to the CPD system should remain practical, straightforward and better in operation than the current approach.

34. A sample of the comments we received are in the box below.

"We agree with the proposed shift of focus from the quantity to the quality of CPD undertaken by registrants. We also agree that the system should be less prescriptive and more flexible in line with other health professions." (AOP)

"We welcome the focus on the responsibility of registrants for their own CPD, which will be relevant to their scope of practice and learning and development needs. We have long argued that the GOC's existing approach is out of keeping with the approaches of other professional regulators and risks infantilising the professions through over prescription. As regulated, autonomous and accountable health professionals, optometrists and dispensing opticians are best placed to make decisions about the CPD which meets their needs and an updated CPD system should support this." (FODO)

"We need to know what the costs of compliance are – there could be far better, more economical ways of doing this than restructuring the whole system. We believe that these current proposals will lead to an increase in fitness to

practice cases and so would just transfer costs rather than save money." (The College of Optometrists)

"We agree that CPD requirements should fit with diverse career pathways. However, there is a need to define boundaries where registrants' careers cross over into different professions or areas not under the regulation of the GOC. For example, a GOC registrant who has chosen to undertake a career in education will still need to complete CPD to fulfil the GOC requirements to be considered safe to remain on the register." (ABDO)

"We support the GOC's intention to modernise CPD and reduce unnecessary administrative burden. However, a complete shift towards open ended self-determined learning risks reducing engagement in structured education. Clear expectations are needed to ensure the profession continues to benefit from consistent, high-quality learning." (CPD Provider)

"We consider that the stated objectives would benefit from a clearer and more explicit emphasis on public protection. As registrants take on increasingly complex clinical responsibilities, CPD remains a core regulatory mechanism to ensure that professionals are safe to practise. Any reforms must therefore be grounded in maintaining consistent standards of care and public confidence in the profession." (Optometry Scotland)

GOC response - Agreement with our objectives for the review

35. We welcome broad support for our objectives for the review to create a more flexible, outcomes-focused system that recognises diverse career pathways and supports workforce transformation aligned to service redesign.

36. In line with our legislation, we can reassure stakeholders that our review is rooted in our overarching public protection statutory objective. We agree with the four main UK sector bodies that any new system should also give sufficient clarity for registrants, be evidence-based, be based on a full assessment of the impacts, and be capable of consistent application across the sector.

37. We appreciate why some stakeholders wanted more detail on how a future scheme would work but this consultation was based on a first principles review of the CPD system focusing on key design principles and high-level system architecture. When we have clarity from government on timetable for changes to the CPD Rules 2021, detailed planning can begin. We do not underestimate the culture change required and are committed to working collaboratively with the four main UK sector bodies and others to co-create proposals and support a managed transition. We intend to create a task and finish group as the main mechanism for this purpose, which will focus initially on changes for the 2028-30 cycle. Changes to the CPD Rules 2021 will require public consultation.

38. We agree the CPD system needs to ensure registrants maintain the core requirements for remaining safe to practise. It should be possible to deliver this while supporting diverse career pathways and expanding scopes of practice.

39. We welcome feedback about more strongly reflecting design for inclusivity and fairness within the review objectives. Responses throughout the consultation highlight the advantages and disadvantages of the various options for registrants depending on their specific needs and operating environment. The responses have informed an updated impact assessment but overall, we consider a more flexible approach to CPD to be fairer and more inclusive because it can adapt to the diverse needs and circumstances of registrants.

40. Some stakeholders used this section of the consultation to comment on the merits of specific proposals for change. These comments reflect choices that occur across our proposals where stakeholders had differing views, such as balancing flexibility and prescription. A recurring theme was the conditional nature of support for our proposals. Therefore, rather than respond to these specific points here, we consider them under the relevant questions below.

Moving away from a points system (Question 2)

Q2 Do you agree that we should move away from a points system?	Overall	Individuals	Organisations
Yes	37.7%	35.3%	50.0%
No	44.0%	47.4%	26.9%
Not sure	18.2%	17.3%	23.1%

41. The data indicates split views with organisations more supportive of moving away from a points system than individual responses.

42. Our consultation policy states that "*where appropriate, we are likely to give more weight to feedback from optical sector bodies representing significant numbers of our registrants than individuals".* Of the UK-wide sector bodies, ABDO, AOP and FODO supported moving away from a points system. Optometry Scotland and Optometry Wales also took this position. The AOP's position was informed by a member survey which received 752 responses.

43. The College of Optometrists was the only sector body which answered 'no' to this question, on the basis that "*a structured, objective, and accountable CPD framework must remain in place until a profession-wide cultural shift has been achieved*". On its estimate, such a shift could take five to seven years.

44. Those supporting moving away from a points system supported a more outcomes-focused and needs-led approach that reduces "tick-box" behaviour. This support was conditional on being accompanied with clear guidance and

benchmarks with safeguards to maintain consistency, interactive learning, and assurance of competence. Without these, many foresaw reduced engagement and increased variability, with potential consequences for public protection.

45. Respondents supporting retaining the points system cited its clarity, structure, and ease of understanding. Many felt it provides a clear and measurable framework for tracking progress and ensuring all registrants meet a minimum standard of professional development. A recurring concern was that removing the points system would lead to inconsistency, reduced accountability, and a risk that some registrants would do little or no CPD unless compelled.

46. Concerns highlighted about moving away from a points system included:

- Removing points without an alternative benchmark creates uncertainty about what “sufficient CPD” means for registrants, employers, providers, and auditors.
- An over-reliance on self-directed learning could result in less interactive learning, fewer peer-to-peer opportunities (e.g. peer review, case-based discussion), and more inconsistent portfolios.
- Risk of reduced engagement and lower quality CPD – the consultation feedback cited experience in other professions where loosening requirements reduced attendance at formal CPD, peer learning, and professional networking.
- Readiness and culture change – a recurring view was that the profession is not yet uniformly prepared for a less prescriptive model; some argued a multi-year transition (with investment and guidance) is required.
- An administrative burden shift for organisations embedding CPD into appraisal and governance may disproportionately affect smaller practices.

47. Several conditions to support moving away from a points system were cited in the responses and included:

- Publishing clear guidance on the expected volume of CPD, acceptable types of activities, and recording requirements to support consistency in audits and reviews.
- Retaining a quantitative indicator if points are removed to preserve a baseline benchmark.
- Setting minimum expectations for interactive learning (e.g. peer review, workshops, case-based learning) to protect against overly solitary/self-directed portfolios.
- A diversity and balance across learning types (structured and self-directed), linked to scope of practice and PDP objectives.
- Introducing proportionate assurance mechanisms to maintain standards and public confidence.
- Phasing implementation with transitional support, recognising this is a significant system and culture change.

48. A sample of the comments we received are in the box below.

"We agree that a points system creates an unnecessary culture of box-ticking which goes against the purpose of continuing professional development for healthcare professionals, and stifles expansion of scope of practice and the development of clinical expertise. Moving away from the points system will enable registrants' lifelong learning to become outcomes-focused, which is in line with best practice CPD for healthcare professionals. Additionally, this will help registrants to develop and undertake meaningful professional development plans.

However, we believe that it will take some time for the sector as a whole to make the cultural shift necessary for the majority of registrants to be able to autonomously fulfil their necessary CPD requirements, thus enabling them to be safe and developing healthcare practitioners, outside of the familiarity of the points-based system." (ABDO)

"We agree that the points system should be abolished. Doing so would be consistent with supporting a culture in which individual registrants, as regulated health professionals, are personally accountable for undertaking professional development which meets their own needs.

The consultation document correctly identifies the challenges of a points system, including the somewhat arbitrary nature of points totals, the risk of a tick-box approach to compliance and perverse incentives to complete CPD which might not be appropriate to an individual's needs and career aspirations. These factors provide an ample rationale for moving to a more outcomes-based approach." (FODO)

"The points system can create perverse incentives, where registrants prioritise activities that maximise point value rather than those most relevant to their PDP, scope of practice or service needs. For example, activities that attract higher points often generate stronger demand regardless of their practical relevance, while more in depth or longer term learning – such as post registration qualifications or specialist development – may be comparatively undervalued despite delivering greater benefit to competence and patient care...

We therefore support the consultation's conclusion that a points system is a poor proxy for competence and does not reliably demonstrate whether registrants are maintaining and developing their skills in a way that benefits patients or services." (CPD Provider)

"While an outcomes focused approach is welcomed, the points system currently provides a clear, consistent benchmark for the expected volume of CPD. Removing it entirely risks creating variability and uncertainty around what constitutes sufficient learning. If a move away from a points system was considered then it is likely a different measure would need to be used, e.g.

hours of learning. Whatever measure is used to quantify CPD there are inherent limitations." (Education provider)

"I do not agree that the points system should be removed. While it may not be perfect, it provides a clear and measurable framework that ensures registrants undertake a minimum level of professional development. Removing it risks creating inconsistency in how much CPD registrants complete and may reduce accountability." (Therapeutic Prescribing Optometrist)

"The current evidence base tells a clear story: a significant proportion of registrants complete the majority of their CPD activity in the weeks immediately before the deadline. This is not a failure of the points system, it is a signal that the profession has not yet developed the self-assessment skills, professional confidence, or cultural relationship with CPD that a less structured framework would require.

Removing the framework before that foundation is in place risks a measurable decline in CPD quality and engagement, with foreseeable consequences for patient safety and fitness to practise." (The College of Optometrists)

GOC response – Moving away from a points system

49. The responses to this question rehearsed many of the arguments for and against points systems highlighted in the consultation paper. Those supporting moving away from points pointed to it promoting a box-ticking culture which is fundamentally at odds with being a trusted healthcare professional, creation of perverse incentives, and the benefits of an outcomes-focused approach given the diversity of professional careers and expanding scopes of practice. Alternatively, those wishing to retain a points system stressed the benefits of clarity and guaranteeing a minimum level of CPD is undertaken by all.

50. While responses across respondents were quite evenly split, five of the six sector bodies answering this question representing dispensing opticians, optometrists and businesses indicated conditional support for moving away from a points system. While the College of Optometrists disagreed, this was partly based on its view that a culture shift was first needed, which it estimated could take five to seven years. The sentiment that the sector is not ready now, but it is a desirable ambition for the future, was a theme in several responses.

51. Government has indicated that change to the GOC's legislation will not happen in the current parliament. Given the timing of the three-year CPD cycles, it will be 2031 at the earliest before the points system could be ended. We agree that culture change, greater confidence and skills development in self-directed learning is needed. By 2031, the current CPD system will have operated for nearly a decade, and we are optimistic that with focused effort and sector-wide collaboration, the required culture shift can be achieved by then.

52. We recognise that support for moving away from a points system is conditional upon guidance and assurance mechanisms being co-created with sector bodies. We do not see removal of a points system as requiring a binary choice between a free-for-all and a tightly prescribed system. Equally, we are mindful of not replacing the current system with a different prescriptive model that could repeat existing flaws and be less transparent.

53. The challenge is to strike the right balance which maximises opportunities for registrants to design their CPD approach while maintaining the minimum requirements necessary for public protection. The following sections of this document consider consultation feedback on individual elements of the CPD system covered in later questions and our position on each.

Issuing guidance on the amount, areas and types of learning rather than setting specific requirements (Question 3)

Q3 Do you agree that we should issue guidance on the amount, areas and types of learning rather than set specific requirements?	Overall	Individuals	Organisations
Yes	59.2%	55.3%	80.0%
No	26.7%	29.5%	12.0%
Not sure	14.0%	15.1%	8.0%

54. There was broad support for moving away from setting specific requirements towards issuing guidance on the amount, areas and types of learning. Respondents stressed guidance must be clear and structured, and that some baseline minimum expectations (like interactive and peer learning) should be retained to protect consistency, patient safety, and public confidence.

55. Key themes raised include:

- Clarity and specificity are essential – guidance must not be vague and should include practical examples, measurable criteria, and a clear description of what “sufficient CPD” looks like in practice.
- Auditability and evidence expectations – there were calls for explicit guidance on what evidence will be required for audit/record review, how submissions will be assessed, and how to record informal/workplace learning and reflective practice.
- Flexibility, but within a framework – a guidance-led approach is seen as better able to reflect different scopes of practice, roles (clinical, leadership, education) and evolving services, while still requiring a coherent framework to avoid wide variation in quality.
- Maintain alignment to standards and/or domains – some responses value learning domains and/or continued alignment to the GOC Standards of Practice to keep core competence in view and prevent over-specialisation.

- Minimum expectations may still be needed – guidance alone may not sustain engagement or consistency; some advocate minimum standards, especially for interactive learning and planned learning via a PDP.

56. A concern about the guidance addressing the amount of CPD was that any indicative hours/volume could become a de-facto minimum and recreate a compliance or "tick-box" culture. In its response, FODO noted that replacing the points system with guidance about the amount of CPD risks undermining the GOC's intention to implement a more outcomes-based model. Others argued that registrants need clearer expectations about minimum activity over a cycle to support consistent engagement across different working patterns.

57. Some practical suggestions and conditions raised in the responses include:

- Providing examples of acceptable activities and evidence (including informal and workplace-based learning), plus practical advice on reflection and portfolio recording.
- Piloting guidance and enabling peer/self-assessment in a "safe to fail" environment to reduce anxiety about "getting it wrong".
- Keeping peer review as a core or mandated element.
- Recognising a wider range of valuable activities which may include educating others, participation in projects and committees, leadership learning (including relevant non-clinical leadership experience) and service improvement.
- Explicitly recognising different individual circumstances with tailored guidance for registrants taking breaks (e.g. maternity, childcare, illness, sabbaticals), new registrants joining mid-cycle, part-time workers, locums, and portfolio careers).

58. There was appetite for GOC to develop and refine guidance in partnership with professional bodies, employers, and CPD providers.

59. A sample of the comments we received are in the box below:

"We believe that including some specific requirements will enable a more robust CPD scheme that is fit for purpose and supports the role of the GOC in the protection of patients. There is still a need to provide a framework for the scheme to ensure that registrants are fit to practise in their professions, whatever their current working circumstances. A specific-requirement structure is seen across the majority of other UK healthcare regulators to varying degrees.

The current alignment of CPD learning outcomes with the GOC Standards of Practice for Optometrists and Dispensing Opticians ('the Standards of Practice') and the Learning Domains, provides a reasoned framework which supports registrants in understanding if the learning they are undertaking, or looking to undertake, is relevant to their professional registration with the GOC. We suggest keeping an alignment of 'learning areas' with the Standards of

Practice to enable registrants to focus their learning, even if redesign of the learning domains takes place." (ABDO)

"The GOC has set out its rationale for moving away from a points-based approach which sets requirements based on the volume and type of learning that must be completed. Replacing this with guidance about the amount of CPD risks undermining the GOC's intention to implement a more outcomes-based model. Even expressed in guidance and not as a compulsory requirement, such guidance on the amount of CPD is likely to become the default minimum, undermining the culture change that the GOC rightly wishes to support." (FODO)

"Guidance needs to be specific and measurable, itemising / describing fully clear criteria against which registrants will be assessed and what constitutes adequacy / inadequacy. This requires transparent piloting to enable the maximum number of registrants to engage in peer- and self-assessment in an environment providing safety to fail. Current barriers to self-directed learning stem not from GOC restrictions but from fear of "getting it wrong"" (College of Optometrists)

GOC response – Issuing guidance on the amount, areas and types of learning rather than setting specific requirements

60. We welcome broad support for issuing guidance on the amount, areas and types of learning rather than setting specific requirements.

61. A theme from the consultation events, which recurred in written responses, was that flexibility should not come at the expense of clarity, and that registrants need clear expectations, guidance and a visible framework. Therefore, in the absence of a points system, guidance will be very important. One purpose of such guidance will be to explain what GOC will look for when reviewing CPD records and the circumstances that could lead to removal from the register. Guidance can also support registrants by suggesting norms, detailing good practice and providing practical resources like templates.

62. We understand why some stakeholders would prefer us to retain specific requirements such as peer review. We see peer review as important and wish to encourage continued use of this and other types of learning. However, the reality of mandating specific requirements is the serious consequences for the registrant if they are not met. Under the current system, if registrants achieve their required points but do not meet a single mandatory requirement like peer review, they face removal from the register. We wish to shift from a punitive to a supportive CPD culture. Moving away from a points system yet removing registration for failure to do specific types of learning would seem contradictory, disproportionate and not outcomes focused.

63. The purpose of this consultation is to resolve first order questions such as whether to retain the points system and replace this with guidance. As stated under Question 2, we plan to co-create guidance with sector bodies. Sector bodies also have an important role in supporting registrants directly by developing their own resources, as they do successfully now.

Guidance specifying that registrants carry out sufficient CPD (or words to that effect) or provide a notional minimum amount of activity that would apply to most registrants, e.g. number of hours (Question 4)

Q4 [Should guidance specify that registrants carry out sufficient CPD (or words to that effect) or provide a notional minimum amount of activity that would apply to most registrants, e.g. number of hours?]	Overall	Individuals	Organisations
Sufficient CPD	34.6%	34.3%	36.0%
Notional minimum amount	27.2%	28.5%	20.0%
Both	25.9%	24.1%	36.0%
Neither	6.2%	6.6%	4.0%
Not sure	6.2%	6.6%	4.0%

64. Once again, the responses revealed a tension between wanting flexibility to avoid a box-ticking culture and providing clarity, assurance and consistency. Some respondents were concerned that the concept of “sufficient CPD” is too vague and open to interpretation, potentially leading to inconsistency and unfairness. Some others criticised the use of time-based measures arguing that people learn at different rates, and that hours do not necessarily reflect learning or competence. Responses highlighted concerns about the impact of minimum hours on those with caring responsibilities, part-time workers, or those on leave. Some highlighted the practical difficulties with regulating or recording hours, especially for self-organised activities.

65. Those supporting “sufficient CPD” want strong, practical guidance describing how to demonstrate sufficiency alongside clear criteria, with examples of acceptable portfolios, expectations for regular engagement across the cycle, and explicit links to scope of practice, PDP, reflection, and outcomes/impact. They viewed volume-based measures as a poor proxy for competence.

66. Those supporting a “notional minimum” (hours/benchmark) want a baseline to ensure everyone does some CPD, to support fairness and reduce subjectivity in reviews; often suggesting indicative hours aligned to current point values, plus minimum expectations for interactive learning and ongoing planning/reflection.

67. Those supporting a hybrid approach (i.e. “Both”) want an overarching outcomes-based principle plus indicative benchmarking or ranges used for guidance. This

would help registrant to self-assess and support employers and reviewers, while avoiding rigidity. For example, the Association of Optometrists favoured guidance that sets out a clear, indicative range or level of activity for most registrants, alongside expectations around reflection.

68. Across responses there was appetite for guidance that is practical, example-led and audit-ready. If an indicative benchmark is used, respondents emphasised careful wording (e.g., range or illustrative examples rather than a single figure) to prevent a compliance target culture while still supporting consistency, fairness and public assurance.

69. A sample of the comments we received are in the box below:

"We do not think it is adequate for guidance to state only that registrants should undertake "sufficient" CPD, as this is likely to increase anxiety about potential audits as well as be interpreted inconsistently across the sector. Cross-sector discussion about these proposals highlighted that, while there is support for moving away from a points-based system, there remains a need for some shared understanding of the expected level of engagement with CPD.

Rather than specifying a fixed minimum number of hours, we would favour guidance that sets out a clear, indicative range or level of activity for most registrants, alongside expectations around reflection, relevance to scope of practice and the impact of learning; this would provide greater clarity and consistency without recreating a rigid, points-based approach." (Association of Optometrists)

"The concept of "sufficient CPD" is too vague and open to interpretation. Without a defined minimum expectation, registrants may interpret the requirement very differently, leading to wide variation in professional development. A notional minimum amount of CPD would provide clarity and consistency while still allowing flexibility for registrants to choose activities relevant to their practice." (Therapeutic Prescribing Optometrist)

"We strongly feel that the GOC should require a notional minimum amount of CPD activity to be carried out by registrants within a specified timeframe (e.g. annually). We believe this should be specified either in a minimum number of hours or through setting expectations of regular activity, and include a minimum requirement for learning with others/interactive CPD. This should also continue to include a mandatory peer review as well as include a requirement for a PDP to be maintained and reflection to be conducted." (ABDO)

"We are concerned that introducing a notional minimum amount for all CPD activity, even if described as indicative, would be counterproductive. As highlighted in the consultation, such benchmarks are likely to be interpreted

as a de facto minimum, recreating a compliance driven culture and undermining the shift towards professional judgement and accountability that the GOC is seeking to promote. This risks registrants focusing once again on meeting a numerical target rather than undertaking learning that is most relevant to their role, scope and development needs." (CPD Provider)

GOC Response - Guidance specifying that registrants carry out sufficient CPD (or words to that effect) or provide a notional minimum amount of activity that would apply to most registrants, e.g. number of hours

70. Responses to this question revealed the same tension as in earlier questions between the balance between flexibility and prescription. As such, our response is consistent with our position on earlier questions.

71. We see no value in replacing a system based on required minimum points with one based on required minimum hours. As stakeholders highlight, this would replicate the issues with the existing system and hours-based systems could introduce additional equality, diversity and inclusion risks.

72. As stated previously, guidance can support registrants by suggesting norms, detailing good practice and providing practical resources like templates. We see potential merit in the AOP's suggestion that guidance contains an indicative range or level of activity for most registrants to provide greater clarity and consistency without recreating a rigid, points-based approach. However, indicative ranges would, by definition, be a guide, not minimum requirements. The guidance will also explain what GOC will look for when reviewing CPD records and the circumstances that could lead to removal from the register.

Requiring registrants to make a personal development plan (PDP) and reflect on progress as part of appraisals and similar mechanisms (Question 5)

Q5 Should registrants be required to make a personal development plan and reflect on progress as part of appraisals and similar mechanisms?	Overall	Individuals	Organisations
Yes	31.9%	27.7%	53.8%
No	52.8%	58.4%	23.1%
Not sure	15.3%	13.9%	23.1%

73. The data indicates the differing responses of individuals and organisations so our consultation policy giving more weight to sector bodies is relevant here.

74. Where some respondents answered no to this question, they supported the need for PDPs and reflection in principle but were concerned about linking this to appraisals due to wider concerns about the role of employers. These wider

concerns are detailed under Questions 14 to 17, but in brief, included lack of access to appraisals for some registrants and risks around introducing undue commercial influence into registrants' learning and development.

75. Many respondents suggested that PDPs are inflexible, time-consuming, and often become a "tick box" or "box-filling" exercise with little practical value. Instead, they considered professionals should be trusted to manage their own learning without mandatory PDPs. There was concern that PDPs and reflection statements are not inclusive for all learning styles and may disadvantage those who struggle with written reflection or self-appraisal, including neurodivergent registrants. Some felt that PDPs are more useful for early-career professionals but should be optional for experienced practitioners.

76. Those respondents who saw value in PDPs and reflective practice argued they encourage purposeful, relevant CPD and critical thinking. Some suggested improvements, such as clearer guidance, templates, or making the process easier on the GOC's MyCPD platform.

77. Overall, common themes were a desire for greater flexibility, simplicity, and trust in professionals' ability to direct their own learning, with many questioning the effectiveness and practicality of mandatory PDPs in their current form.

78. A sample of the comments we received are in the box below:

"We agree with the principle that individual registrants should, through a Personal Development Plan (PDP) or a similar mechanism, identify their learning needs, how they will seek to meet their learning needs and review those periodically.

However, the wording of this question confuses the individual responsibility of a regulated professional to undertake CPD which meets their needs, with the role of employers in overseeing performance and supporting the development of those they employ, through mechanisms such as appraisal.

It is important that the CPD system supports the ability of individual registrants to go beyond the PDP or equivalent agreed with their employer, recognising that some of their CPD will be part of their own personal and professional development – for example, supporting their future career aspirations outside of their employer.

Locums and sole practice owners will also not have access to an employment-based PDP or appraisal. It is important that the GOC's approach is inclusive of all registrants, including those in locum roles and those with portfolio careers." (FODO)

"We agree that personal development planning and reflection on progress should form an important part of an outcomes-based CPD system. Cross-

sector discussion strongly supported reflective practice as essential to meaningful learning and to linking CPD with improvements in practice.

We also consider that requiring registrants to maintain a personal development plan and reflect on progress could be valuable." (Association of Optometrists)

"Expecting all registrants to independently produce high quality PDPs risks creating wide variation in the quality, rigour and usefulness of these documents.

Therefore, we recommend that if PDPs are to remain mandatory, the GOC should:
• Provide a standardised PDP template, guidance and exemplars accessible to all registrants.
• Offer clear direction for registrants without an employer, ensuring they are not disadvantaged compared to those supported by corporate governance teams.
• Consider a "best practice" rather than "mandatory" approach for employers, recognising the differing capacities of multiples, independents and provider organisations." (CPD Provider)

"A requirement that is too closely tied to employer-led appraisal systems risks creating inconsistency and may disadvantage parts of the workforce.

We therefore support an approach where:
• registrants are required to undertake development planning and reflection
• this can be achieved through a range of mechanisms, not limited to formal appraisals
• the emphasis is on meaningful engagement rather than a prescribed format

It is also important that expectations remain proportionate and do not introduce unnecessary administrative burden. Development planning and reflection should support professional practice rather than becoming a compliance exercise." (Optometry Scotland)

GOC response – Requiring registrants to make a personal development plan (PDP) and reflect on progress as part of appraisals and similar mechanisms

79. Planning and reflection are critical features of the current system, which we see as vital steps to maintaining standards. If the points system ends, retaining mechanisms for planning and reflection would provide important assurance that registrants are engaging meaningfully with CPD. Therefore, we will retain the requirement for registrants to make a PDP.

80. A standardised PDP template was introduced at the start of the 2025-27 cycle. We plan to build on this approach supported by practical guidance.

81. We recognise that not all registrants can access appraisals so the guidance will cover various ways that reflection could be demonstrated, for example through a section on the PDP template. We agree there is scope to develop a best practice rather than mandatory approach for employers, recognising the differing capacities of multiples, independents, and provider organisations.

Requiring registrants to make an annual declaration as part of registration renewal that they have carried out sufficient learning to maintain their competence and kept adequate records for review purposes (Question 6)

Q6 Should registrants be required to make an annual declaration as part of registration renewal that they have carried out sufficient learning to maintain their competence and kept adequate records for review purposes?	Overall	Individuals	Organisations
Yes	68.5%	64.7%	88.5%
No	21.0%	22.8%	11.5%
Not sure	10.5%	12.5%	0.0%

82. Some viewed the declaration as a proportionate mechanism that would reinforce professional accountability provided it is underpinned by clear guidance and credible audit systems. Cited benefits included promoting continuous learning via a regular prompt to reflect on learning, reinforcing personal responsibility and professionalism, keeping competencies current and evidencing them, supporting a lighter-touch approach by avoiding overly prescriptive requirements, and aligning with approaches used by some other regulators.

83. A recurring concern was a lack of clarity around what constitutes "sufficient learning" or competence, with calls for clearer definitions and guidance to avoid inconsistent interpretation. Some suggested providing templates or specific methods for record-keeping.

84. The minority of responses against this proposal said it risked becoming a meaningless "tick box" exercise or formality, especially without objective criteria or oversight. Some advocated for continued or increased auditing and oversight to ensure honesty and compliance.

85. Some responses noted the risk of registrants inadvertently making false declarations if requirements are unclear. Suggested mitigations included explicitly referencing relevant professional standards and the seriousness of dishonest declarations to strengthen deterrence and understanding.

86. A sample of the comments we received are in the box below:

"The proposal reinforces the responsibility of individual registrants to undertake CPD to maintain and develop their competence and be able to evidence this if they are invited to participate in CPD record review.

The proposal is consistent with the approach of other regulators who require all registrants to make a declaration and then audit a random sample of registrants at fixed intervals to demonstrate their compliance." (FODO)

"This approach promotes professional responsibility and reduces administrative burden. However, it must be supported by clear definitions, and robust guidance to avoid inconsistency. Additionally, as previously discussed, without a benchmark, there is a risk of significant variation in engagement and quality." (Education Provider)

"The proposed requirement for registrants to maintain their own learning records which should be available for review upon request is a positive move to reduce administrative burden. Annual declaration at time of registration renewal maintains compliance whilst signaling trust.

Although the proposals suggest an annual declaration model supported by sample audits, it does not clarify whether businesses would share any compliance obligations or consequences in such cases. This lack of clarity risks creating uncertainty for employers about their responsibilities and potential liabilities under the proposed reforms." (Optometry Wales)

"It is insufficient to make a declaration when optometrists are already saying they comply with the standards in making their application. Focus should be in keeping the system honest and robust – sampling audits is inadequate for this.

We feel that focused audits should be implemented based on outcomes from (anonymous) peer reviews.

The GOC needs to be very clear of what constitutes "sufficient learning" to those registrants who say they meet the expectations and to define what those expectations are. A mechanism will also need to be in place for those who report that they comply and do not meet the requirements as they could be viewed as lying which is a very serious FtP situation." (The College of Optometrists)

GOC response – Requiring registrants to make an annual declaration as part of registration renewal that they have carried out sufficient learning to maintain their competence and kept adequate records for review purposes

87. We were pleased to see strong support for this proposal and will proceed on this basis. The declaration will sit alongside other assurance mechanisms including CPD record review. The wording of the declaration will reflect other decisions about the CPD scheme and will be developed at a later stage.

88. In answer to the query by Optometry Wales, the declaration is the individual registrant's responsibility and would not have implications for businesses.

Requiring registrants to maintain records of CPD activity on GOC IT systems or keep their own records (Question 7)

Q7 Should registrants be required to maintain records of CPD activity on GOC IT systems or be able to keep their own records?	Overall	Individuals	Organisations
GOC systems	52.2%	55.5%	33.3%
Choose GOC systems or own records	38.5%	34.3%	62.5%
Own records only	9.3%	10.2%	4.2%

89. Many respondents favoured a centralised system for recording CPD using the GOC's own platform, citing consistency, transparency, ease of audit, and regulatory oversight as key benefits. Some respondents mentioned that a centralised approach is simpler, reduces the risk of lost records, and ensures everyone is following the same process. However, some noted that the GOC's current system is not user-friendly and could be improved, and there were calls for templates or improvements to make the process easier.

90. There was also support for an approach where registrants can choose to record CPD using the GOC system, an employer/professional body platform, or their own records, provided records are robust enough for audit. Avoiding unnecessary duplication was another theme raised where registrants already use established systems (e.g. workplace learning platforms) and to reduce administrative burden that could undermine engagement.

91. A sample of the comments we received are in the box below:

The key requirement should be that records are sufficiently robust to support audit and demonstrate reflection and learning outcomes, rather than prescribing the system in which they are held." (Association of Optometrists)

"Allowing registrants to select their preferred system for recording CPD supports flexibility and, for some registrants, may reduce administrative burden. However,

where registrants do not have access to alternative approved software or platforms, for example locums or those working within small businesses, the GOC IT system should be retained to ensure equitable access. This will help ensure that increased flexibility does not inadvertently disadvantage certain groups of registrants." (Optometry Wales)

"Maintaining records within a centralised GOC system would ensure consistency, transparency, and ease of review. Allowing registrants to keep their own records may create variation in record quality and make the review process more complex and less reliable. A centralised system also supports regulatory oversight and helps ensure that records are maintained in a consistent format." (Therapeutic Prescribing Optometrist)

"We feel registrants should maintain their own CPD records rather than being required to record their CPD activity on GOC systems. This sits better with the move towards encouraging registrants to plan, reflect and evidence their CPD as a regulated healthcare professional.

Some registrants already use employer learning systems, and in particular those who hold additional qualifications will be accustomed to maintaining their own records. Requiring parallel or duplicate record keeping solely for GOC purposes would add unnecessary complexity and increase the burden on registrants." (CPD Provider)

"We consider that registrants should be able to choose whether to use GOC systems, third-party systems (e.g. professional body platforms) or maintain their own CPD records; this would provide appropriate flexibility within an outcomes-based CPD model and reflect the diversity of working arrangements across the sector, including those who already use employer or professional body systems.

A GOC system could play an important role as a default or optional platform, particularly for registrants who do not have access to alternative tools. However, requiring all registrants to use a single system risks creating unnecessary administrative burden and duplication and may reduce engagement. (Association of Optometrists)

GOC response – Requiring registrants to maintain records of CPD activity on GOC IT systems or keep their own records

92. Much of the complexity and burden for registrants in the current system is created by the need to log CPD activity to obtain their required point totals. Ending the points system will mean a simpler set of IT requirements with the main remaining purpose for GOC being to facilitate CPD record review.

93. There was no clear consensus on this issue, and the responses articulated the pros and cons of the different options well. Using a GOC system reduces burden

for those registrants selected for record review since this is based on their logged records and does not require them to do anything. There are also advantages around consistency and reinforcing engagement with CPD. Alternatively, we recognise the benefits of a more flexible approach where registrants need only share their CPD records when selected for record review.

94. In the medium term, we anticipate moving toward a single integrated IT platform that will meet all registration and CPD requirements. The optimal IT approach will depend on the final CPD scheme requirements, so we will return to this issue once these are known and implementation plans are more advanced.

GOC reviewing a sample of CPD records following annual registration renewal (Question 8)

Q8 Should GOC review a sample of CPD records following annual registration renewal?	Overall	Individuals	Organisations
Yes	60.1%	56.9%	76.9%
No	23.3%	26.3%	7.7%
Not sure	16.6%	16.8%	15.3%

95. Many respondents emphasised the importance of some form of review or audit of CPD records to ensure compliance and maintain professional standards. Several suggested that reviews should be regular but not necessarily annual or universal; instead, a sample or risk-based approach was preferred to avoid excessive administrative burden.

96. A recurring theme was the need for clear, upfront guidance on what is expected from CPD to avoid retrospective criticism and ensure fairness. Many stressed that the process should be designed to promote learning and improvement rather than feel punitive. There was also some support for combining random sampling with targeted review where there are known risks or previous non-compliance concerns.

97. A sample of the comments we received are in the box below:

"We think this should be mandatory for auditing any quality system. The GOC needs to evidence the quality of their systems so that targeted improvements can be made on solid data.

Whilst we recognise that audit can only ever be conducted on a sampling basis, accountability can be very variable as a consequence, with some overdoing through fear of lack of compliance and others hoping they will "get away with it". (The College of Optometrists)

"We feel that to ensure registrants are complying with the requirements of registered healthcare professionals to complete appropriate and effective lifelong learning, as administers of the scheme the GOC should review a random sample of CPD records following annual registration renewal. Additionally, it may be appropriate to have some targeted reviews based on previous non-compliance or concerns of completing the scheme appropriately. Clear guidance should be provided to registrants in relation to the CPD scheme to ensure they are able to comply with the expectations of the GOC record reviews.

Broad learning from these reviews should be clearly communicated to all registrants to enable better practice to be adopted by all. Currently, information regarding registrant record reviews have been published deep within Council papers, which is not a readily accessible communication form for registrants to enable reflection and learning". (ABDO)

"We support a balanced approach that combines random sampling with targeted review, where there are known risks or previous concerns. This approach mirrors the direction taken by other outcomes based CPD systems and helps to ensure that review remains proportionate, fair and educational rather than punitive. Record review should primarily function as a quality assurance and learning tool, supporting the vast majority of registrants who are committed to maintaining and developing their competence for the benefit of patients." (CPD Provider)

"We agree but sampling must be risk-based, transparent, and supportive. The GOC must ensure that reviews are context-sensitive, accounting for the varied nature of practice. For example, the professional development opportunities and clinical focus for a hospital optometrist or academic researcher differ significantly from those of a community-based locum. A supportive review process should recognise these different professional constraints and avoid a 'one-size-fits-all' approach to auditing." (Anonymous respondent)

GOC response – GOC reviewing a sample of CPD records following annual registration renewal

98. We welcome strong support for this proposal. As set out in the consultation, CPD record review is an established feature of the current system and will assume even greater importance in the absence of a points system.

99. As now, the emphasis will be on supporting improvement, not to punish. Further, there will continue to be transparency about how the CPD record review system works through published materials. We anticipate building on the current approach which includes a mixture of random and targeted reviews.

100. We accept that we can do more to share the broad learnings from CPD record reviews with registrants collectively to support continuous improvement within the sector and will action this within the current CPD cycle.

Registrar able to remove registrants from the register where their CPD records are assessed as inadequate and they have failed to remediate, subject to appeal (Question 9)

Q9 Should the Registrar be able to remove registrants from the register where their CPD records are assessed as inadequate and they have failed to remediate, subject to appeal?	Overall	Individuals	Organisations
Yes	53.7%	50.7%	70.8%
No	23.8%	27.2%	4.2%
Not sure	22.5%	22.1%	25.0%

101. Many respondents emphasised that removal from the register for not meeting CPD requirements should be a last resort, and only after registrants have been given clear guidance, feedback, and meaningful opportunities for remediation or support. There was a strong call for individual circumstances (such as illness or personal issues) to be considered before any action is taken.

102. Some respondents highlighted the need for clear, specific, and transparent standards and expectations regarding what constitutes ‘adequate’ (and ‘inadequate’) CPD, as ambiguity could lead to unfairness or inconsistent enforcement. Some described removal as “harsh” or “punitive” and suggested alternatives such as suspension with time to remedy, mentoring, additional training, or mandatory CPD catch-up sessions. A robust right to repeal was regarded as essential. Some questioned the direct link between CPD records and actual professional competence, suggesting that poor CPD records do not necessarily mean a practitioner is unfit to practise.

103. Support for the power to remove registrants from the register was justified by some on patient safety grounds and sustaining confidence in professional standards. Some feedback asked for clearer alignment between CPD non-compliance processes and fitness to practise processes.

104. Separately, the idea of voluntary removal from the register outside annual renewal was suggested where the registrant requests it and is not subject to fitness to practise proceedings, aligning with other regulators and reducing unnecessary burden.

105. A sample of the comments we received are in the box below:

"We agree that, as now, the Registrar should be able to remove registrants from the Register where they have been assessed as not meeting the GOC's requirements and have failed to remediate, subject to the ability to appeal.

In keeping with national and international regulatory practice, the GOC's approach should provide individual registrants with the support, time and information necessary to help them meet the GOC's requirements, avoiding registrants being removed from the Register unless absolutely necessary.

We would also like to see separate changes to the GOC's registration rules to permit the Registrar to remove a registrant's name from the Register outside of registration renewal where they have requested voluntary removal and are not the subject of fitness to practise proceedings (paragraph 60 refers). This would be consistent with similar powers held by other professional regulators." (FODO)

"We consider the completion of appropriate and sufficient CPD to be a fundamental requirement of remaining on the Register as a competent eye care professional capable of delivering safe patient care. As such, removal from the Register is a necessary regulatory safeguard of last resort where a registrant has persistently failed to meet CPD expectations, as outlined in the consultation's discussion of non compliance and public protection.

However, consistent with national and international regulatory practice, we strongly support an approach that is supportive, proportionate and improvement focused. As the consultation makes clear, CPD record review is intended to be educational rather than punitive, and removal should occur only after registrants have been provided with:
• clear feedback on identified deficiencies;
• accessible and unambiguous guidance on what remediation is required;
• reasonable timeframes to address concerns; and
• appropriate consideration of individual circumstances, supported by a robust exceptional circumstances policy." (CPD Provider)

"Where a registrant repeatedly fails to engage with CPD requirements or remediation, this may indicate a broader concern around professionalism, insight, or commitment to maintaining competence. In such cases, it could be argued that the matter may be more appropriately considered within an established fitness to practise (FtP) process, which:
- allows for investigation of underlying causes,
- provides registrants with procedural safeguards,
- sets proportionate outcomes by assessing public risk instead of relying solely on administrative criteria." (CPD Provider)

"Yes, with appropriate systems and safeguards. We agree with this, but the requirements and processes must be transparent and there must be a procedure, with time for remediation and opportunity to appeal. It will be very

important for registrants to have a clear process to remediate, especially during the first cycle, but probably permanently." (Association of Optometrists)

GOC response – Registrar able to remove registrants from the register where their CPD records are assessed as inadequate and they have failed to remediate, subject to appeal

106. Given the consensus supporting our proposals we will proceed on this basis.

107. As set out in the consultation, this is intended as a measure of last resort, would follow opportunity for remediation, and be subject to appeal. The ethos of our proposals is to move from a punitive to a supportive system but there needs to be a backstop should a minority of registrants abuse the system. Exceptional circumstances will be considered, as is currently the case. Guidance will explain what GOC will look for when reviewing CPD records and the circumstances that could lead to removal from the register.

108. We support the call for changes to our registration rules to permit the Registrar to remove a registrant's name from the Register outside of registration renewal where they have requested voluntary removal and are not the subject of fitness to practise proceedings. However, this would require legislative reform and although we have written to Ministers asking for this change to be fast-tracked, we have been advised that reform to our legislation will not be prioritised.

109. We do not agree with the suggestion that cases should be considered through our fitness to practise processes. The purpose of these processes is to consider allegations of serious misconduct. This would be a disproportionate mechanism and would risk creating a backlog in our fitness to practise caseload.

Changes possible within the CPD Rules 2021

110. Questions 10 to 13 asked for views on proposals that would not require amendments to the CPD Rules 2021 and therefore would be possible to implement before the start of the 2028-20 CPD cycle.

Changing the competencies (the four domains) which CPD events must relate to (Question 10)

Q10 Should we change the competencies (the four domains) which CPD events must relate to?	Overall	Individuals	Organisations
Yes	38.5%	34.6%	60.0%
No	36.0%	40.4%	12.0%
Not sure	25.5%	25.0%	28.0%

111. Many respondents felt the current CPD competency domains are generally adequate, broad, and flexible enough to cover the range of professional

practice. However, a significant number of respondents felt the domains are too restrictive or not always relevant to all registrants, especially those in non-traditional roles or not in continual practice.

112. A recurring theme was criticism of a “tick box” mentality, with some saying the domains encourage collecting points rather than meaningful learning. A few advocated removing domains entirely or allowing professionals to focus CPD on their own interests and needs.

113. Some respondents felt the domains should be expanded or updated to reflect changes in practice, such as new technology, digital care, or evolving NHS contracts. There are also calls for greater emphasis on areas like law, professionalism, and leadership, though some questioned the relevance of “leadership” as a domain. There is support in the feedback for a revised model to remain grounded in the Standards of Practice.

114. General areas for reform highlighted in the responses included: updating the domain descriptors to reflect modern practice; reducing mandatory domain “coverage” requirements that drive compliance behaviours; and considering a simplified standards aligned structure with clear expectations for both clinical and professional behaviour learning.

115. A sample of the comments we received are in the box below:

“We believe that there is a need within the CPD scheme to ensure that registrants continue to undertake education which reinforces GOC professional, leadership and accountability expectations as outlined in the Standards of Practice for Optometrists and Dispensing Opticians. One reform potential may be to redesign the learning domains into two groups of standards e.g. those which fall into ‘clinical practice’ and those covering ‘professional behaviours’, with a requirement to evidence some CPD completed from both groups.” (ABDO)

“The GOC needs to significantly expand the types of activities that contribute to the (especially non-clinical) domains. This will increase the likelihood of registrant compliance by making development more enjoyable and easier to achieve. Forcing people to do a very limited list of activities does not make the process attractive for those who prefer to learn in different ways.

GOC must include studying for higher qualifications and teaching / developing others as acceptable activities for CPD.

Routine activities and those that do not cost registrants their own money must be prioritised – especially in self-directed learning.” (The College of Optometrists)

"The four existing domains remain sufficient at present and do not need to increase in number. However, the GOC should adopt an agile approach which aligns to the changing requirements across the workforce.

We commend the inclusion "to develop enhanced clinical skills supporting the shift in eye care delivery from hospitals to communities" as this aligns to the changing role of an optometrist. The GOC should consider how the domains align with the wider requirements of the workforce and service redesign priorities across the four nations." (CPD Provider)

GOC response – Changing the competencies (the four domains) which CPD events must relate to

116. Any changes we make to the CPD system ahead of the 2028-30 cycle should be consistent with the broad direction of travel decided on the earlier questions as this will support a phased transition to longer-term reforms. As such, we are keen to create greater flexibility that gives registrants more control of their own learning while ensuring that all registrants maintain core competencies.

117. We see merit in ABDO's suggestion of moving to two domains focused on clinical practice and professional behaviours. This will ensure core clinical competencies are maintained as well as embrace wider issues that support safe and effective eye care. Our fitness to practise caseload trends reflect an increased focus on professional conduct as well as clinical competence, while our registrant survey highlights challenges in areas like commercial practices and workplace behaviours. Such a twin approach should encourage CPD across a broad sweep of issues, including equality, diversity and inclusion, leadership, professional ethics, developments in technology and many more.

118. Studying for post-registration qualifications counts as acceptable activity under the current system and this will continue to be the case. We accept a role for us in conjunction with sector bodies and CPD providers to educate registrants about the wide range of activities that legitimately count towards CPD points. This could help address strategic sector challenges such as encouraging more registrants to support future generations by teaching and acting as supervisors.

Adjusting the points allocated to different activities to make it easier to reach the total points required under the CPD Rules 2021 (Question 11)

Q11 Should we adjust the points allocated to different activities to make it easier to reach the total points required under the CPD Rules 2021?	Overall	Individuals	Organisations
Yes	55.5%	54.3%	62.5%
No	28.4%	30.4%	16.7%

Not sure	16.0%	15.2%	20.8%

119. Respondents generally supported reweighting CPD points if it better reflects learning quality, rewards interactive and substantive development (including post registration qualifications), and reduces administrative burden while avoiding unintended incentives and being underpinned by clear guidance.

120. Areas of support in the responses include weightings being proportionate to learning value so that longer, more in-depth or advanced development (e.g., postgraduate/specialist clinical training, independent prescribing pathways, leadership programmes) should attract higher points than short sessions. There was also some support for interactive learning (e.g. peer-based, case-based workshops and discussion-based learning) counting for more, along with self-directed learning which involves meaningful engagement with others.

121. There were also warnings against adding complexity or inconsistency across CPD formats; clear, unambiguous guidance was seen as essential to ensure fairness. A suggestion included simplifying how learning is evidenced and recorded (including via the GOC CPD platform) and defining what counts as "interactive" for self-directed CPD submissions.

122. A sample of the comments we received are in the box below:

"We recognise that the existing points framework can create unintended incentives, where shorter or less in-depth activities may attract a similar or greater number of points than more substantive learning, including post-registration qualifications. This does not always reflect the time commitment or value of the learning undertaken.

Rebalancing the allocation of points would help to:
• better reflect the depth, complexity and relevance of different types of CPD
• reduce the need for registrants to undertake multiple smaller activities to meet requirements
• support engagement with more meaningful and developmental learning

In particular, greater recognition should be given to structured and longer-term learning, such as post-registration qualifications. This is especially important as registrants develop advanced clinical skills, including progression towards Independent Prescribing and delivery of enhanced services. The CPD system should actively support, rather than inadvertently discourage, this type of professional development." (Optometry Scotland)

"For healthcare professionals learning with others is shown to support behaviour change and reflection on current practice. Therefore, we would recommend this practice is favoured over and above seeking to reward post-registration qualifications. It is already possible for course designers of post-registration

qualifications to consider how they can support interactivity as a beneficial form of learning in their course design." (ABDO)

"The current weighting does not always reflect the value of learning. Interactive, peer-based, and case-based learning should carry greater weight than passive activities on the basis that evidence shows these are amongst the most effective CPD. Clear guidance will be needed to ensure consistency." (Education Provider)

"The current CPD framework was introduced to shift focus away from points towards reflective learning. Adjusting point allocations specifically to make it "easier" to reach the total risks re introducing a compliance driven, point chasing culture, which appears to contradict the stated aims of CPD reforms.

Before any adjustment is considered, it would be helpful to see:
- clear data showing widespread difficulty in meeting CPD requirements,
- analysis of whether any challenges relate to access, clarity, engagement, or relevance, rather than point values themselves,
- and evidence that changing point weightings would improve learning quality or public protection." (CPD Provider)

GOC response – Adjusting the points allocated to different activities to make it easier to reach the total points required under the CPD Rules 2021

123. There was broad support for adjusting points allocated to different activities.

124. The total number of points required is specified by legislation so we cannot change this. We could choose to make it easier for registrants to achieve their points totals by increasing points for all types of activity, thus reducing the total amount of CPD required. However, in our 2025 registrant survey, 72% of respondents considered the points required 'about right' and reducing the overall volume of activity was not a strong theme in consultation responses. Instead, the consultation feedback centred on reweighting points based on value of learning, complexity and supporting professional advancement.

125. We are open to adjusting the system on this basis but are mindful of risks around creating confusion and disengagement from CPD activities that would attract fewer points. Therefore, we will discuss options with the task and finish group before confirming plans for the next cycle.

Removing the limit on the minimum number of CPD points that must be obtained from provider-led activity (Question 12)

Q12 Should we remove the limit on the minimum number of CPD points that must be obtained from provider-led activity?	Overall	Individuals	Organisations
Yes	52.5%	51.1%	60.0%
No	37.7%	38.7%	32.0%
Not sure	9.9%	10.2%	8.0%

126. Those supporting removing the limit emphasised flexibility and an outcomes focused approach. They argued registrants should be able to choose learning that best matches their scope of practice and PDP, including workplace based learning and other structured development that may not fit traditional provider led formats. Several responses framed removal as a proportionate, transitional step ahead of broader legislative reform, intended to strengthen professional autonomy and ownership of lifelong learning, and to reduce format driven “box ticking”. Supporters also noted that much learning occurs informally through day-to-day practice and peer interaction at work and asked for clearer expectations and practical guidance on how non provider led learning should be recorded, evidenced and used effectively.

127. Those opposing removal, or supporting it with safeguards, focused on quality assurance, consistency and the wider professional learning culture. They described provider led CPD as important for interactive and peer-based learning (debate, challenge, case-based discussion, peer review), exposure to shared standards and emerging practice, and maintaining clinical consistency, linking this to patient safety and service quality. A recurring concern was that without a minimum expectation some registrants could default to mostly self-directed CPD, reducing engagement with structured learning and weakening the benefits of multi professional perspectives. Some CPD providers also highlighted the investment required to meet GOC standards (governance, audits, quality assurance) and warned that removing the minimum number could devalue assured provision and create variability in the robustness of CPD evidence.

128. Some suggestions to mitigate risks while increasing flexibility included:

- Retain a baseline requirement for provider led and/or interactive CPD, potentially at a lower minimum.
- Publish clear guidance encouraging a balanced mix of learning types and explaining the distinct value of provider led versus self-directed learning.
- Strengthen support for registrants to plan, reflect on and evidence outcomes (with professional bodies, employers and providers supplying exemplars and tools).
- Maintain appropriate oversight through record review and engagement with commissioners/governments to avoid unintended consequences.

129. A sample of the comments we received are in the box below:

"We believe removal of this limit would enable registrants to take greater ownership of their professional development planning, make more informed choices about the most appropriate learning activities, and pursue a wider range of development opportunities – including scope of practice expansion – without being constrained by how learning is delivered. This is particularly relevant for registrants undertaking substantial post registration qualifications, workplace based learning or other structured development that may not always be delivered through traditional provider led formats." (CPD Provider)

"Provider-led CPD plays an important role in ensuring that learning activities are structured, evidence-based, and delivered by individuals with appropriate expertise. Removing the requirement for a minimum amount of provider-led CPD could lead to a greater reliance on informal or self-directed learning that may not be subject to the same level of quality assurance. Maintaining a minimum requirement helps ensure that registrants engage with structured learning opportunities and external professional input." (Therapeutic Prescribing Optometrist)

"Removal of this limit now will enable registrants to develop greater ownership and responsibility of their life-long learning plans and outcomes over the next few years before legislation reform is possible. This will support more registrants being able to be fully confident with autonomous professional development planning and execution before the current limits on the scheme are potentially removed.

However, as previously stated, we believe current registrants will require significant support and guidance to enable them to develop the necessary skills to be independent and effective life-long learning healthcare professionals. We feel that the sector professional representative bodies would be a suitable resource to provide this guidance to their respective memberships and support them to appropriately identify, undertake, reflect on and document their learning activities to enable them to make satisfactory declarations to the GOC in relation to CPD." (ABDO)

"In Wales, where a significant proportion of registrants hold higher qualifications and deliver enhanced WGOS services, the current CPD system provides assurance to the Welsh Government and Health Boards that competence is being maintained. An overly flexible approach to CPD may risk undermining this assurance and could result in Health Boards introducing their own, potentially variable, CPD requirements, thereby creating inconsistency within Wales and across the home nations." (Optometry Wales)

GOC response – Removing the limit on the minimum number of CPD points that must be obtained from provider-led activity

130. There was broad support for removing the limit on the minimum number of CPD points that must be obtained from provider-led activity across individuals and organisations. As with other questions in this section, we are keen to explore opportunities to make changes ahead of the 2028-30 cycle that are consistent with the broad direction of travel decided on the earlier questions.

131. We do not see self-directed CPD as inherently less valuable than provider-led CPD, so a minimum threshold seems an artificial constraint in this context. Over the 2022-24 cycle, less than 4% of points were from self-directed CPD. Given these figures, while self-directed CPD may increase, we expect most registrants to continue to rely on provider-led activity, so the impact on CPD providers of removing the limit during the 2028-30 cycle is likely to be limited.

132. Over the 2028-30 cycle, mandatory elements like interactive learning and peer review will remain, supported by assurance mechanisms like CPD record review, which should ensure positive registrant engagement with CPD.

133. Therefore, we will remove the limit on the minimum number of CPD points that must be obtained from provider-led activity for the 2028-30 CPD cycle.

Removing the need for a reflection statement to be provided for each self-directed CPD activity (Question 13)

Q13 Should we remove the need for a reflection statement to be provided for each self-directed CPD activity?	Overall	Individuals	Organisations
Yes	71.9%	75.4%	50.0%
No	18.1%	15.9%	31.8%
Not sure	10.0%	8.7%	18.2%

134. Across responses a key theme was not whether reflection matters, but whether requiring a separate reflection statement for every self-directed CPD activity is proportionate and whether it unintentionally suppresses engagement with self-directed learning.

135. Some felt requiring a written reflection statement for every self-directed CPD activity is overly burdensome, time-consuming, and can lead to meaningless or insincere responses simply to fulfil a requirement. Other respondents thought that reflection should be incorporated into broader learning reviews or personal development plans rather than required after each CPD event.

136. Concerns were raised about the lack of consistency between self-directed and provider-led CPD, querying why reflection is only required for the former. Others

highlighted the need for clear guidelines on evidence and learning outcomes to ensure quality and relevance. Low self-directed uptake some argued, stems from uncertainty about what counts, what level of reflection is acceptable, and how record review will judge submissions, not from reflection itself.

137. A sample of the comments we received are in the box below:

"We are supportive of the principle of providing as much flexibility as possible, pending implementation of changes to the CPD Rules. The consultation describes how requirements for reflection statements, which apply to 'self-directed' activities only, have limited registrant uptake of self-directed rather than 'provider-led' activities.

In that context, removing the need for a reflection statement for each self-directed CPD activity is consistent with a move towards an outcomes-based approach.

However, we would note the important role that reflection plays in helping a registrant to identify what they have learnt from a CPD activity and its impact on their practice. The GOC should consider how reflection is built-in to its new approach to CPD – for example via content in guidance or in evidence requirements for CPD audit." (FODO)

"To remove reflection statements would be to lower the standard of CPD at precisely the moment the profession should be raising it, and a move away from a robust pedagogical approach." (The College of Optometrists)

"We are strongly against the removal of the need for a reflection statement to be provided for each self-directed activity. The GOC has not provided any evidence that the reflection statement is a current barrier to registrants undertaking self-directed learning. We believe that the low uptake of self-directed learning has potentially arisen owing to a lack of confidence from registrants in what is required from them to submit this, and in particular what will be accepted by the GOC in a possible record review. Additionally, we do not feel the current guidance or resources provided by the GOC offer enough support to registrants inexperienced in uploading self-directed learning to consider doing so." (ABDO)

"Rather than removing reflection entirely, we believe the GOC should focus on redesigning how reflection on self directed learning is captured and evidenced, in line with the outcomes focused intent of the reformed system. A more proportionate and flexible approach could include:
• allowing consolidated or thematic reflection across multiple related learning activities;
• capturing reflection within a PDP or periodic learning review, rather than requiring a standalone statement for each activity; and

• using reflective prompts aligned to record review criteria, rather than mandating a uniform reflective statement for every instance of learning." (CPD Provider)

GOC response – Removing the need for a reflection statement to be provided for each self-directed CPD activity

138. There was broad support for removing the need for a reflection statement to be provided for each self-directed CPD activity across individuals and organisations. However, the UK sector bodies were split on this point (FODO supported; ABDO, College of Optometrists opposed; AOP did not answer).

139. The limited take-up of self-directed CPD so far is likely due to a combination of factors including the ease of obtaining provider-led CPD, lack of awareness and lack of confidence about what GOC will accept, as well as the burden of providing a reflection statement for each activity. We wish to work with sector bodies and others to help educate registrants about self-directed CPD.

140. As noted in our response to the previous question, we do not see self-directed CPD as inherently less valuable than provider-led CPD. Therefore, it would be inconsistent to require reflection statements for one type of activity and not the other. This is different to requiring registrants to demonstrate that claimed CPD activity was undertaken where there are differences with provider-led CPD. However, we address this challenge via guidance and CPD record review.

141. Reflection will continue to remain a key design feature of the CPD system in the 2028-30 cycle and our longer-term reform plans. However, reflecting a key theme in the feedback, our concern is that a separate reflection statement for every self-directed CPD activity is disproportionate and might unintentionally suppress engagement with self-directed learning. We also agree there is scope to improve the quality of reflection in broader learning reviews and PDPs.

142. Therefore, we will remove the need for a reflection statement to be provided for each self-directed CPD activity in the 2028-30 cycle. We will consider ways to strengthen reflection more broadly in our preparations for the beginning of the 2028-30 cycle, for example making this a focus of CPD record reviews. Further, we will work with others to address communication and confidence barriers that might also limit the uptake of self-directed CPD.

4. Findings relating to business registrants

Summary of feedback from stakeholder consultation events

144. Stakeholder feedback on the proposals relating to business registrants at the consultation events showed broad support for businesses more actively supporting CPD, particularly where employers already provide conferences, training programmes and online learning. Participants saw value in businesses helping to identify learning needs through team discussions, one-to-one meetings and feedback mechanisms, and they noted that interactive CPD can be especially helpful in reducing isolation for single-practitioner settings. However, they stressed that this role would need to be clearly defined, especially in settings such as small practices, hospitals, education and industry, where existing appraisal arrangements do not always align neatly with professional development responsibilities.

145. At the same time, respondents raised significant concerns about whether businesses should have a stronger role in overseeing or shaping registrants' CPD. Many were uneasy about giving employers additional influence over professional requirements, particularly given existing commercial pressures in some parts of the sector. There was concern that CPD could be used inappropriately to reinforce sales targets or create unrealistic expectations. Participants also highlighted that locums and those working outside traditional optical business settings may not have the same access to structured employer support, making a business-led model harder to apply consistently and fairly.

146. Concerns were also raised about quality, fairness and commercial bias if businesses or manufacturers play a larger part in delivering CPD. While some participants acknowledged that larger providers often already deliver high-quality learning, others warned that loosening requirements could blur the line between education and promotion. Stakeholders felt that clearer GOC guidance would be needed on what businesses are expected to do, what evidence would be required, and how to ensure consistency across different practice types. Overall, feedback suggested cautious support for businesses playing a supportive role, but strong resistance to any approach that would allow commercial interests or employer priorities to undermine registrants' professional autonomy or the integrity of CPD.

Summary of consultation feedback

147. A summary of feedback received from respondents to the consultation in respect of each question asked in relation to leveraging the role of business registrants now follows. None of the proposed changes require reform to the CPD Rules 2021 or the Opticians Act 1989.

Leveraging the role of businesses within the CPD system to support a less prescriptive system for individual registrants (Question 14)

148. Respondents were not asked to select answer options for Question 14 so there is no quantitative analysis in this section of the response document.

149. Many respondents expressed reservations about increasing the role of businesses in the CPD system with concerns relating to commercial bias, inconsistencies in CPD provision, and a loss of professional autonomy, especially for locums and those in non-traditional roles. Some respondents cautioned against creating a new prescriptive compliance regime for employers.

150. Respondents highlighted major differences between large organisations (multiples) often with structured governance, appraisal and training infrastructure, and small independent practices, often with limited capacity, time, backfill and administrative support.

151. Some respondents favoured business involvement in providing guidance and exemplars (e.g. supportive learning culture, informal appraisal, peer discussion, case-based learning) rather than mandated systems, particularly for small practices where formality could add red tape and cost. Some asked for clear guidance on what is expected of employers and what, if any, consequences or obligations would follow if a registrant's CPD is judged inadequate. Lack of clarity was viewed as creating uncertainty and potential risk for employers.

152. Organisations recommended that the GOC prioritise clear communication and partnership working (with employers, professional bodies and CPD providers), avoid transferring regulatory oversight to businesses, and ensure expectations are flexible, proportionate and workable across diverse practice settings.

153. Meanwhile, a significant number of respondents argued that CPD should remain primarily the responsibility of the individual and the regulator, not the employer. Some expressed a preference for maintaining a prescriptive system, with some stating that prescription ensures engagement and learning. There was a desire to avoid commercial influence, maintain professional autonomy, and ensure fairness for registrants regardless of employment status.

154. A sample of the comments we received are in the box below:

"The GOC's Standards for Optical Businesses already include appropriate standards about the role of businesses in supporting their staff to learn and develop in their roles and to practise in accordance with the GOC's standards. Our members already meet these requirements by supporting their staff to identify their learning needs and providing opportunities for learning and development appropriate to their and business needs. The consultation document does not outline a persuasive rationale as to why any substantive changes are required to these standards. These standards were also updated recently, and the Government has asked all regulators to review 'red tape' as

part of avoiding avoidable further costs on businesses. This would seem to be working in the opposite direction without supporting evidence." (FODO)

"We do not support a model that relies on businesses to deliver core regulatory functions or assumes a consistent level of infrastructure across all settings.

The optical sector includes:
• independent practices with limited capacity
• larger organisations with established training structures
• a significant locum workforce
• registrants working across multiple employers

Given this variation, a system that depends on business-led oversight cannot be applied consistently or equitably across the profession.

We therefore support a balanced approach where businesses are encouraged to support CPD, but responsibility remains clearly with the individual registrant." (Optometry Scotland)

"Businesses can play a valuable role in supporting CPD, but their contribution must be framed as best practice, not a mandatory requirement, due to the significant variation we have across the sector.
We can contribute meaningfully by:
• offering structured PDP review within existing governance frameworks,
• facilitating case-based support discussions,
• providing remote case audit and learning from escalation pathways,
• enabling peer review opportunities
• delivering feedback driven CPD based on patient experience, incidents, and quality data." (CPD Provider)

GOC response – Leveraging the role of businesses within the CPD system to support a less prescriptive system for individual registrants

155. The responses highlighted the range of ways in which businesses currently make a positive contribution toward CPD, which we are grateful for.

156. The sentiment in responses was consistent that businesses have an important role in supporting registrants with their learning and development but should not shape the CPD registrants do. Our proposals were framed in similar vein, i.e. '*to support registrants to identify and pursue their learning development needs*'. While recognising concerns about commercial influence over learning plans, we consider a supportive employer will take an active interest in each registrant's learning and development – our guidance will be framed accordingly and reinforce the importance of professional autonomy in developing PDPs.

157. The consultation document acknowledged the diverse practice settings in the sector, so we recognise that some businesses have more scope to support CPD than others. Again, we will reflect this in our guidance, ensuring our expectations are flexible, proportionate and workable across diverse practice settings.

158. Ultimately, CPD is the individual's responsibility, and we do not foresee any consequences for businesses if a registrant's CPD is judged inadequate. However, as reflected in the current Standards for Optical Businesses, it is appropriate for regulators to set minimum expectations for business registrants relating to supporting CPD. Question 16 was about any changes needed to the Standards for Optical Businesses, so we comment further there. As a matter of factual accuracy, the Standards Review in 2024 was focused on individual registrants with only consequential amendments made to the Standards for Optical Businesses. The Standards for Optical Businesses date back to 2019, and we remain committed to a substantive review of these.

Business registrants having specific responsibility to ensure individual registrants have an up-to-date personal development plan (Question 15)

Q15 Should business registrants have specific responsibility to ensure individual registrants have an up-to-date personal development plan?	Overall	Individuals	Organisations
Yes	23.7%	24.3%	20.8%
No	56.3%	58.8%	41.7%
Not sure	20.0%	16.9%	37.5%

159. The majority of respondents believed that responsibility for maintaining a PDP should rest with individual registrants, not businesses. Many argued that professional development is a personal responsibility and that businesses should only be required to ensure their employees are registered.

160. A significant concern was that placing responsibility on businesses would create an unreasonable burden, especially for small practices and locums, who may lack the resources or infrastructure to support or monitor PDPs. There was also concern about the impracticality for businesses to monitor PDPs for registrants who work across multiple employers or as locums.

161. Some respondents worried that increased business involvement could lead to commercial bias or put business interests ahead of registrants' professional development. Others mentioned that businesses already have significant administrative demands and that duplicating appraisal or CPD monitoring would be inefficient.

162. A sample of the comments we received are in the box below:

"We consider that the existing GOC Standards for Optical Businesses are already sufficient by requiring businesses to support the learning and development of their staff, to have a system for monitoring staff objectives and training needs and to support staff to meet the GOC's standards and requirements.

Additional prescription in this area is unnecessary and would be contrary to the GOC's policy objectives. If implemented, in the short term this could act as a disincentive to more businesses registering with the GOC." (FODO)

"The PDP is a personal development plan and so needs to be personal. If businesses gain too much responsibility for registrants' PDPs then they will influence them to align with the business requirements, not the individual optometrist (who might be developing their skills to leave that employer). This will tie registrants into particular businesses and will reduce workforce mobility, which drives down the quality of patient care." (The College of Optometrists)

"Optometrists and dispensing opticians are autonomous, accountable healthcare professionals, and responsibility for identifying learning needs, maintaining a PDP and meeting CPD requirements should sit firmly with the individual registrant. The CPD framework must continue to allow registrants to go beyond any PDP agreed with an employer, recognising that some learning will support future career aspirations or roles outside their current employment. Transferring formal responsibility for PDP ownership to businesses risks undermining this professional accountability." (CPD Provider)

"Responsibility for CPD, including development planning, should remain with the individual registrant as part of their professional obligations. Introducing a formal requirement on businesses risks blurring accountability and creating inconsistency in how responsibilities are applied and enforced.

The structure of the optical workforce means that many registrants:
• work across multiple employers
• operate as locums
• work in settings where formal appraisal systems are not in place

In these circumstances, it would not be practical or equitable to place responsibility on a business to ensure that a PDP is in place and maintained." (Optometry Scotland)

GOC response – Business registrants having specific responsibility to ensure individual registrants have an up-to-date personal development plan / How the Standards for Optical Businesses be strengthened to help achieve this outcome

163. Feedback on this question was consistent with responses to Question 15 highlighting concerns about professional autonomy, commercial bias, the role of businesses in the CPD system and increasing burdens on businesses.

164. Our proposals were limited to businesses checking whether PDPs had been completed and would not have permitted businesses to determine the CPD registrants do. Even so, we recognise concerns that businesses should not be expected to police our CPD system, so we will not proceed with this proposal. As set out in our response to the previous question, our guidance will reinforce the importance of professional autonomy in developing PDPs.

165. In our response to Question 5, we confirmed that PDPs will remain an integral part of the CPD system. In the absence of businesses checking if PDPs have been completed, we need an alternative mechanism to assure ourselves that individual registrants are creating and maintaining PDPs. As set out previously, a standardised PDP template was introduced at the start of the 2025-27 cycle, and we plan to build on this approach supported by practical guidance.

Strengthening the Standards for Optical Businesses (Question 16)

166. Respondents were not asked to select answer options for Question 16 so there is no quantitative analysis in this section of the response document.

167. A significant theme was concern about increasing the regulatory burden on businesses, especially smaller practices. Several respondents argued that businesses already do enough to support CPD and that further requirements could be impractical or unfair. There was also concern that shifting responsibility to businesses could undermine professional autonomy and create inequities for those in non-traditional roles.

168. However, many respondents supported strengthening standards by holding businesses more accountable for supporting registrants' CPD. Suggestions included requiring businesses to provide time, resources, and support for CPD activities. Some called for clearer guidance, monitoring, and accountability mechanisms, such as audits, sanctions, or reporting pathways for registrants.

169. In summary, responses were divided between those who want stronger business accountability for supporting CPD and those who fear increased burdens or loss of professional autonomy. Many called for clearer guidance, proportionality, and practical support, while a significant minority questioned the need for further change or business involvement at all.

170. A sample of the comments we received are in the box below:

"Optometry Scotland considers that any changes to the Standards for Optical Businesses should focus on reinforcing good practice in supporting professional development, rather than introducing prescriptive or enforceable requirements linked to individual registrants' CPD compliance.

The current standards already recognise the importance of creating an environment in which staff are supported to learn and develop. We would support building on this by providing greater clarity and emphasis within guidance, rather than through additional regulatory obligations." (Optometry Scotland)

"There is a meaningful and important distinction between an employer supporting a registrant's development and an employer directing or controlling it. Extending business standards into the governance of individual CPD risks conflating those two things. Employers are not independent arbiters of professional competence; they have commercial interests that may not always align with the registrant's broader developmental needs or with the public interest. Oversight of CPD must remain with the GOC and the profession, not be delegated to the business environment." (The College of Optometrists)

"The proposal to amend the Standards for Optical Businesses to give employers a greater role in supporting CPD acknowledges that businesses often work closely with registrants and can identify development needs.

However, as mentioned above, this change could create significant challenges for small and independent practices who may have limited administrative capacity and fewer resources compared to large corporate providers.

Expanding business responsibilities in this area risks placing disproportionate pressure on these smaller organisations, potentially creating a gap between independents and large corporate providers. Without funding support or guidance for businesses the proposed changes may unintentionally disadvantage small providers." (Optometry Wales)

GOC response – How the Standards for Optical Businesses be strengthened

171. We are grateful for the suggestions received, which will help us to identify whether any changes are needed to the Standards for Optical Businesses. This will be considered further when we begin our review of the standards and any proposed changes will be subject to public consultation.

172. We appreciate the distinction between an employer supporting a registrant's development and directing or controlling it. The focus of the existing standards is on the former and this will remain the case. Further, if opportunities to improve our approach are identified, we will consider carefully whether this is best achieved through standards or the CPD guidance documentation.

Incorporating patient feedback within the CPD system (Question 17)

173. Respondents were not asked to select answer options for Question 17 so there is no quantitative analysis in this section of the response document.

174. There was support for using patient feedback as a potentially valuable input to CPD, but not as a mandatory or prescriptive requirement with respondents citing concerns about its relevance, reliability, and practicality. Many argued that patients lack understanding of professional roles and clinical competence, making their feedback potentially subjective, biased, or unhelpful. Some highlighted the difficulty of collecting meaningful patient feedback, with low response rates and a tendency for only dissatisfied patients to participate.

175. A repeated concern was that not all registrants can obtain patient feedback (locums, small/independent practices with limited infrastructure, self-employed clinicians, and non-patient facing registrants), and that mandating it would create unfairness and inconsistent expectations.

176. A sample of the comments we received are in the box below:

"We would welcome registrants to be encouraged to obtain and reflect on service-user feedback to support their professional development planning. However, it should be recognised that not all GOC registrants undertake clinical practice with patients and not all who do may be able to obtain feedback. For example, it may be more difficult for a locum to obtain patient feedback and not relevant to a GOC registrant only working in academia or manufacturing. Therefore, though this feedback is desirable and should be encouraged, we do not believe it should be made a mandatory aspect of the scheme." (ABDO)

"Patient feedback should inform CPD where available, but it must not be mandatory due to inequitable access. It should be incorporated as a valuable source of learning, used flexibly and proportionately rather than as a compulsory requirement for all registrants." (CPD Provider)

"It shouldn't be included. Patients generally give feedback based on customer service rather than professional practice." (Bexley, Bromley and Greenwich Local Optical Committee)

"Patient feedback should inform CPD where available. For example, patient complaints could be used as a driver for targeted CPD. It could be incorporated as a valuable source of learning, used flexibly and proportionately rather than as a compulsory requirement for all registrants. Many locums and small practices lack formal mechanisms for collecting feedback. A mandatory requirement would create unfairness." (Anonymous respondent)

GOC response – Incorporating patient feedback within the CPD system

177. We welcome support for incorporating patient feedback within CPD, which we consider is a missing element of the current system.

178. The consultation document stated: "*we are not proposing to be prescriptive about engagement approaches but would use guidance to encourage businesses to use patient feedback as one tool to support registrants to continuously improve the care they provide.*"

179. Therefore, our proposal is consistent with consultation feedback to view patient feedback as a good practice tool rather than a mandatory requirement. We will build this into our guidance ahead of the start of the 2028-30 CPD cycle.

5. Findings relating to ending CPD provider approval and audit

Summary of feedback from stakeholder consultation events

180. Across the stakeholder events, many felt that some form of regulation or oversight of CPD providers remains important for maintaining quality, consistency and confidence in the system. Participants were concerned that removing provider regulation entirely could create a “free-for-all”, making it harder to compare quality, prevent poor practice and guard against inappropriate commercial influence. This was seen as particularly important in the optical sector, where the commercial environment creates a risk that CPD could become more promotional than educational if safeguards are weakened.

181. Others favoured a lighter-touch or more proportionate system rather than full deregulation, arguing that approval still has value but could be made simpler, less repetitive and less burdensome. Suggestions included relying more on participant feedback, adopting annual rather than repeated applications, creating different levels of provider status, and giving providers more flexibility in how and when they are assessed. Participants also noted that feedback from approvers can help improve provision, although some described the process as stressful, overly focused on wording, and more difficult for smaller organisations or local groups than for larger providers.

182. While some participants were wary of employers or manufacturers having too much influence over CPD content, others acknowledged that larger commercial providers often deliver high-quality learning and that manufacturers are already an important part of the current system. There was also recognition that reform could widen the market and increase flexibility, potentially enabling more practitioners or small groups to offer CPD, but only if suitable safeguards remain in place. Overall, the feedback suggested cautious openness to reform, if quality assurance, transparency and public confidence are preserved through some form of continued oversight.

Summary of consultation feedback

183. A summary of feedback received from respondents to the consultation in respect of each question asked in relation to ending CPD provider approval and audit now follows.

184. The proposal relating to Question 18 (ending CPD provider approval) would require change to the CPD Rules 2021. Questions 19 to 21 cover changes that could be made within the CPD Rules 2021 and thus could be introduced at any time. Unlike the questions in section 1, there is no requirement for any changes to coincide with the start of the 2028-30 CPD cycle, although there may be advantages to coordinating changes to minimise risk of stakeholder confusion.

Seeking to end CPD provider approval (Question 18)

Q18 [Should we seek to end CPD provider approval?]	Overall	Individuals	Organisations
Yes	32.5%	30.6%	42.3%
No	42.5%	44.0%	34.6%
Not sure	25.0%	25.4%	23.1%

185. Many respondents emphasised the importance of maintaining CPD provider approval as a mechanism for ensuring the quality, consistency, and relevance of CPD activities. Many felt that removing provider approval could lead to a proliferation of low-quality, commercially biased, or inconsistent CPD, and that some form of oversight or minimum standards is necessary to maintain trust and protect registrants from substandard learning.

186. A significant number of respondents, however, criticised the current approval process as overly complex, bureaucratic, and a barrier to entry for smaller or new providers. Several suggested that the process should be simplified or made less onerous, with some proposing a lighter-touch system or a focus on outcomes rather than provider status.

187. Some respondents argued that market forces and registrant choice could ensure quality in the absence of formal approval, especially given high current satisfaction rates. However, others countered that registrant satisfaction does not necessarily equate to educational quality, as choices may be driven by convenience rather than standards.

188. Overall, the message from respondents is to not simply ‘end’ or ‘keep’ approval but maintain confidence in CPD quality. If provider approval is removed, respondents want the regulator to replace it with clear standards, strong guidance, transparency about commercial influence, and proportionate monitoring/feedback mechanisms, implemented with adequate transition time. If approval is retained, many still support streamlining and reducing duplication while strengthening quality assurance.

189. A sample of the comments we received are in the box below:

“We are not persuaded that CPD provider approval should be ended without a clearly defined alternative approach to quality assurance.

The current system provides a level of assurance to registrants that CPD activity meets an expected standard. Removing this entirely risks creating variability in the quality and relevance of CPD provision, particularly in a more flexible system where registrants have greater autonomy in selecting learning activities.” (Optometry Scotland)

"The consultation notes that the GOC is currently the only UK health regulator undertaking CPD provider audits. This does not suggest any inadequacy, rather it reflects a higher level of regulatory oversight, with the GOC setting a potential benchmark for best practice among regulators. This is further reinforced by the GOC's own findings that there are high levels of registrant satisfaction with current CPD provision." (Optometry Wales)

"We support the intention to move away from CPD provider approval as part of a more flexible, outcomes-based CPD model. This approach has the potential to better reflect modern professional learning, enable a wider range of educational activities and align with approaches taken in other healthcare professions.

However, we do not believe that sufficient alternative quality assurance mechanisms have yet been defined to support the safe removal of provider approval. Feedback across the sector highlights clear concerns about how CPD quality will be assured in practice, particularly in the absence of clear standards, consistent guidance and defined audit expectations. As part of its public-protection responsibilities, any regulator must assure itself that high-quality CPD is taking place. The GOC must assure itself that these changes do not create circumstances for an increase in poor-quality CPD." (Association of Optometrists)

"The current CPD provider approval framework offers an important baseline level of quality assurance for registrants, employers and the public. Approved provider status gives confidence that CPD provision meets defined standards relating to educational quality, relevance to professional practice, appropriate learning design, balance and management of commercial influence. As employers, we see clear value in a system that provides upfront assurance and reduces the burden on individual registrants to judge the quality and independence of CPD provision without support.

We are particularly concerned that removing provider approval may make it more difficult for registrants to distinguish between high quality educational content and material that is promotional, narrowly focused or misaligned with the GOC Standards of Practice. This risk is heightened in an optical sector where a significant proportion of CPD is delivered by commercial organisations, including manufacturers, and where registrants may already experience commercial pressures within retail environments. Without an approval framework, registrants – particularly those earlier in their careers or less confident in self-directed CPD planning – may struggle to consistently identify learning that meets regulatory expectations." (CPD Provider)

GOC response – Seeking to end CPD provider approval

190. Overall, responses to this question were quite evenly distributed, with more organisations tending to favour ending CPD provider approval but more individuals preferring to keep it. Many responses took neutral positions.

191. Some respondents sought a middle ground where alternative assurance mechanisms such as standards and audit could replace CPD provider approval. However, unless GOC approves (and can remove) CPD providers, standards would not be binding and there would be no basis for us to conduct audits. Therefore, on this issue, we need to make a clear choice.

192. The need for CPD provider approval is partly linked to the current points system since more CPD points are available for GOC approved provider-led CPD. This argument falls away in the absence of a points system and where provider-led CPD takes its place alongside a wide range of activities that support learning.

193. We are persuaded by the argument that market forces and registrant choice should ensure quality in the absence of GOC approval. The registrant community is highly networked, and employers will continue to exert influence as large expert purchasers of CPD. CPD providers that gain a reputation for delivering poor quality CPD should not expect to survive in this environment. Further, deregulation should lower barriers to entry for smaller CPD providers and thus improve the diversity of CPD provision available to registrants.

194. GOC is an outlier among healthcare and other professional services regulators in approving CPD providers. We understand that poor quality CPD is not viewed as an issue in other sectors in the absence of regulatory approval and we are not aware of other regulators seeking to introduce or restore such systems. Given our thematic review on commercial practices and patient safety, we are aware of concerns about inappropriate commercial influence on CPD. However, commercial actors provide CPD in many healthcare environments, so this issue is not unique to eye care. GOC mitigates risks of inappropriate commercial influence by approving the content of the CPD provider's first ten events, but once approved, CPD providers can deliver any CPD activity they choose. Therefore, the extent to which CPD provider approval mitigates risks around commercial influence should not be overestimated and addressing issues relating to commercial practices in eye care stretch well beyond CPD provision.

195. We are grateful for feedback on the current approval process. Reducing the number of CPD events requiring approval before CPD providers can convert from provisionally approved to fully approved status would help reduce barriers to entry for smaller providers (see Question 19 below). In the meantime, we will carry out an internal review to identify opportunities to simplify processes.

Reducing the number of CPD events requiring approval before CPD providers can convert from provisionally approved to fully approved status (Question 19)

Q19 [Should we reduce the number of CPD events requiring approval before CPD providers can convert from provisionally approved to fully approved status?]	Overall	Individuals	Organisations
Yes	46.2%	44.0%	58.3%
No	22.1%	20.1%	33.3%
Not sure	31.6%	35.8%	8.3%

196. There was a clear split between those who believe the current requirements are necessary for maintaining standards and quality, and those who feel the process is too onerous, particularly for small or new providers. Several suggested lowering the threshold for approval to support innovation and smaller providers.

197. Among those in favour of a reduction of the threshold, points raised included: helping smaller or specialist providers enter the market; reducing administrative burden; moving away from a fixed number of events and judging progression on the quality and consistency of submissions; and streamlining provider approval because events are approved anyway.

198. For those against a reduction, points raised included: requiring multiple approved events helps demonstrate a provider can deliver high quality CPD consistently; reducing the number of events could allow providers to gain full approval before reliability is proven; and that clearer standards, guidance and feedback to address any misalignment with expectations are needed.

199. Overall, there was conditional openness to reducing the numeric requirement where this removes unnecessary barriers, but only alongside stronger clarity, support and/or alternative safeguards to protect educational quality. Where respondents opposed change, the central message was that assurance should be strengthened first, using clearer standards and better feedback before lowering any approval threshold.

200. A sample of the comments we received are in the box below:

"If provider approval continues we would be open to a reduction in the number of approved CPD events required for a provider to move from provisional to full approval, if this is supported by GOC's operational experience and does not alter the underlying approval standard. A reduction from 10 successful submissions to a lower figure would be a prudent step as long as approvers can reasonably determine that a provisional provider is consistently meeting the required standard." (Association of Optometrists)

"While we recognise and broadly support the GOC's stated long term direction towards an outcomes focused CPD model with greater emphasis on registrant autonomy and self directed learning, the evidence presented in the consultation indicates that quality assurance at the provisional provider stage remains necessary and relevant at this point in the system's evolution. Reducing the number of events required for progression risks weakening an important quality control gateway before alternative safeguards are fully established." (CPD Provider)

"The existing threshold may act as a barrier to entry, particularly for smaller or more specialised providers. Reducing this requirement could broaden the range of CPD provision available and improve accessibility.

However, it remains important that an appropriate level of quality assurance is maintained. Any reduction should still ensure that providers:
• demonstrate an understanding of GOC expectations
• are capable of delivering relevant and appropriate CPD
• meet a consistent standard before full approval is granted

We therefore support a calibrated approach that lowers barriers while retaining sufficient oversight to maintain confidence in the quality of provision." (Optometry Scotland)

GOC response – Reducing the number of CPD events requiring approval before CPD providers can convert from provisionally approved to fully approved status

201. There was support among both individuals and organisations on this point. Should CPD provider approval end, reducing the number of CPD events requiring approval before CPD providers can convert from provisionally approved to fully approved status would support the transition. Changes here should support smaller CPD providers and encourage innovation.

202. Feedback was clear that the approval standard by which we assess the quality of CPD must not be lowered, which we can confirm. Overall, in line with feedback from Optometry Scotland, we will lower barriers while retaining sufficient oversight to maintain confidence in the quality of provision.

203. In the current system, we must approve ten different CPD events before CPD providers can convert from provisionally approved to fully approved status. This creates a barrier to entry for smaller CPD providers or charities focused on specific learning outcomes, so we intend to move away from this approach.

Phasing out CPD provider audits over the 2028-30 cycle (Question 20)

Q20 [Should we phase out CPD provider audits over the 2028-30 cycle?]	Overall	Individuals	Organisations
Yes	36.7%	36.4%	38.5%
No	36.1%	36.4%	34.6%
Not sure	27.2%	27.3%	26.9%

204. Overall, responses to this question were mixed with a trend towards conditional support rather than full endorsement. While some stakeholders agreed with the direction of reducing regulatory burden, most emphasised that robust alternative safeguards must be in place before audits are removed.

205. There are concerns that removing audits prematurely could reduce oversight of CPD quality, increase variability in provision, and risk commercially biased or low quality CPD to enter the system. It was suggested that audits could only be phased out if replaced by clear, effective safeguards including mechanisms (feedback systems) for reporting concerns (from registrants, employers or practices) and monitoring of underperforming providers.

206. The overall trend was strong support for retaining some form of audit or oversight to ensure CPD quality and protect the public, with some openness to reducing the frequency or administrative burden of audits.

207. A sample of the comments we received are in the box below:

"CPD provider audits are an important mechanism for maintaining quality assurance within the CPD system. Phasing out audits would significantly reduce oversight of CPD provision and may allow standards to decline over time without detection. Audits also provide an opportunity for the regulator to identify areas where CPD provision can be improved and to ensure providers are adhering to the required standards. Given the central role that CPD plays in maintaining professional competence and protecting patients, removing this form of oversight appears premature and potentially risky." (Therapeutic Prescribing Optometrist)

"We support phasing out CPD provider audits over 2028–30 in principle, but only if alternative safeguards are in place first. Removing audits without a clear replacement framework would risk inconsistent CPD quality, greater commercial bias and reduced confidence in the system." (Association of Optometrists)

"We cannot support phasing out CPD provider audits over the 2028–30 cycle. The removal of audits introduces the risk that some providers may deliver poor quality, commercially biased or promotional CPD.

However, we would support a change in this direction this change if processes were put in place to address CPD that is:

• educationally poor,
• commercially driven rather than clinically relevant, or
• inconsistent with GOC learning expectations.

This process may be facilitated by obtaining feedback from registrants and employers with reporting to the GOC via a designated feedback mechanism that enables registrants to submit concerns directly to the GOC. This could act as a safety net, ensuring the GOC retains visibility of emerging issues in the CPD marketplace without reinstating full audits." (CPD Provider)

GOC response – Phasing out CPD provider audits over the 2028-30 cycle

208. Reducing the number of CPD provider audits would support a phased transition towards our plans ultimately to remove CPD provider approval. Respondents asked for systems to be introduced to deal with poor provision before audits are reduced including targeted reviews following event feedback and mechanisms for registrants to raise concerns about CPD providers. Both are current features of our approach to CPD provider regulation, which we plan to maintain.

209. Feedback about a provider following each event is different from raising concern about a provider to GOC and we have established systems in place for this. Concerns would be for issues beyond the general content, delivery and usefulness of the CPD session, and relate to concerns that our standards are potentially not being met. Further information about how to raise concerns about GOC approved CPD providers can be found on our website here.

Withdrawing the GOC's Standards for CPD Providers (Question 21)

Q21 [Should we withdraw GOC's Standards for CPD Providers?]	Overall	Individuals	Organisations
Yes	17.2%	15.3%	26.9%
No	66.2%	67.2%	61.5%
Not sure	16.6%	17.6%	11.5%

210. Many respondents emphasised the importance of having standards for CPD providers, seeing them as essential for maintaining quality, consistency, and professional relevance in CPD activities. Many noted that standards provide clear expectations for providers and reassurance for registrants that CPD meets appropriate professional standards. Several respondents highlighted that, without standards, there is a risk of declining quality or a "race to the bottom".

211. There were some calls for greater flexibility in the standards, with some suggesting that they are currently too rigid or restrictive and may limit creativity and the scope of CPD. A few respondents proposed that standards could be

more of a recommendation, with random auditing, not a strict requirement. There were also suggestions that the standards need updating, particularly to better address non-clinical domains such as leadership and communication.

212. A sample of the comments we received are in the box below:

"We would be open to withdrawing GOC's Standards for CPD Providers, but only where they are replaced by clear, published quality principles and practical safeguards that give providers, registrants and auditors a shared understanding of what good CPD looks like. In the absence of such a replacement, withdrawing the standards would risk increasing inconsistency and reducing confidence in CPD quality across the sector." (Association of Optometrists)

"Removing these standards without a clearly defined alternative risks creating variability in CPD quality and making it more difficult to identify and address poor provision." (Optometry Scotland)

"As a CPD provider, we do not support withdrawing the GOC's Standards for CPD Providers. The Standards provide clarity on expectations, support consistency across providers, and underpin quality assurance within provider led CPD. They have guided significant investment by providers in governance, learning design, evaluation, and audit readiness, and form a key part of the assurance that registrants and the public place in provider led activity.

Removing the Standards without a clear and robust alternative risks increasing variability in quality and undermining the confidence built into the current system. If reform is needed, this would be better achieved through reviewing and refining the Standards to ensure they remain proportionate, clear, and fit for purpose, rather than withdrawing them altogether." (CPD Provider)

GOC response – Withdrawing the GOC's Standards for CPD Providers

213. There was a clear preference for retaining the GOC's Standards for CPD Providers, so we are content to keep them in place. The Standards will continue to form the basis for our audit activity and investigating concerns raised with us.

214. Ultimately, should CPD provider approval end following reform to the CPD Rules 2021, GOC would have no means to enforce the standards. At this point, we will need to consider if standards would be useful as a self-regulatory tool for CPD providers or in supporting registrants to search for suitable CPD provision.

6. Other areas

When we should introduce changes requiring amendment to the CPD Rules 2021 (Question 22)

Q22 [When should we aim to introduce changes requiring amendment to the CPD Rules 2021?]	Overall	Individuals	Organisations
January 2028	53.3%	58.3%	26.1%
January 2031	23.3%	15.7%	65.2%
January 2034	12.7%	14.2%	4.3%
Another date	10.7%	11.2%	4.3%

215. Although more individual respondents selected January 2028, most considered January 2031 as a more realistic and proportionate date, allowing adequate development, testing and communication. Some noted that reforms are unlikely before the end of the 2028–2030 cycle due to uncertainty over legislative time.

216. Other themes raised include a phased and/or parallel implementation approach (running old and new arrangements in tandem for a period) to reduce compliance risk and allow behavioural and cultural change to embed safely. Some recommended early evaluation of initial changes during the 2028–2030 cycle (e.g., after two years) to inform decisions on whether, and how, to proceed with more significant reforms requiring legislative amendment.

217. A sample of the comments we received are in the box below:

"Changes that require amendment to the CPD rules 2021 should not be made until at least January 2031. However, an evaluation of any initial changes made to the scheme should be undertaken after the first two years of the 2028-2030 cycle, to enable an informed decision on whether or not to implement more significant changes that require legislative change." (ABDO)

"We consider January 2028 too early for changes requiring amendment to the CPD Rules 2021. Cross-sector feedback supports the overall direction of reform but indicates that substantial further work is needed on the detail of the framework, including guidance, quality assurance, audit expectations and practical support for registrants and providers. A January 2031 implementation date would allow sufficient time for these elements to be developed, tested and communicated, helping to support a safer and more consistent transition across the sector." (Association of Optometrists)

"The sector needs long run-in times for changes that require a change in the culture as this is always a slow process which will require sustained support. Procedural changes can be implemented quickly with sufficient training.

There needs to be clarity and transparency from the GOC regarding the status and milestones of the change project." (The College of Optometrists)

GOC response – When we introduce changes requiring amendment to the CPD Rules 2021

218. We agree with feedback that 2028 is too soon to introduce changes of this scale considering the amount of preparatory activity needed. This is not just for GOC but for professional bodies, CPD providers, employers and other stakeholders. Mindful of comments in relation to the points system (Question 2), there is a need to embed culture change before such a significant change can be safely introduced. The measures we outlined in responses to previous questions will support this culture change to take place as part of a managed transition. Moreover, our reading of the political environment is that reform to the CPD Rules 2021 would not be prioritised in time for January 2028 implementation.

219. We understand the call for clarity on the status and milestones for change and have included an outline timetable in the executive summary. In broad terms, we will seek reforms requiring changes to the CPD Rules 2021 for implementation following the end of the 2028-30 cycle. This includes the most significant planned changes like ending the points system and CPD provider approval. Changes possible within the CPD Rules 2021 like recalibrating points and simplification of CPD provider approval, will be introduced from the start of the 2028-30 cycle. Both sets of changes will require detailed planning, and we will establish a task and finish group to assist us with this work, focused initially on changes that need to be in place for January 2028.

220. Where changes to the CPD Rules 2021 are required, ultimately, the timetable is not within GOC's control, but we foresee two scenarios. The first scenario is that government amends the CPD Rules 2021 before making wider planned reforms to the Opticians Act. The second scenario is that changes to the Opticians Act happen first. If the current proposals for amendments to the General Medical Council's legislation are mirrored in a reformed Opticians Act (as is intended), GOC would have powers to make changes to its rules, subject to consultation, without the need for Privy Council approval. In this situation, the GOC would then have control over the timetable for CPD reform. In either scenario, public consultation on proposed revisions to CPD rules will be required.

221. It would be regrettable if we were unable to make changes until 2034 or later. We do not underestimate the extent of the change programme required, but consider it is achievable to make the technical, practical and cultural changes necessary ready for introduction following the end of the 2028-30 cycle.

Impact assessment

Q26 [Are there any aspects of our proposals that could discriminate against stakeholders with specific characteristics?]	Overall	Individuals	Organisations
Yes	13.6%	12.1%	21.7%
No	46.9%	46.0%	52.2%
Not sure	39.4%	41.9%	26.1%

222. The feedback included concerns that the proposed reforms could unintentionally disadvantage certain groups, particularly if employer-based requirements become mandatory or if the system becomes less structured and more reliant on self-direction. At risk-groups cited in the feedback include: locums, sole practitioners, portfolio workers, those on maternity leave or career breaks, part-time registrants, and those with disabilities or neurodiversity (such as autism, ADHD, dyslexia).

223. One identified theme was that increased business involvement in CPD (e.g., through appraisals or monitoring) risks creating inequity for those without consistent employer support, such as locums or those working outside GOC-registered businesses. Some responses highlighted that the removal of familiar, structured mechanisms (like points and provider approval) could disadvantage newly qualified, internationally trained, or under-represented registrants who rely on clear frameworks.

224. The need for clear guidance, inclusive design, and proportionate assurance mechanisms to avoid these risks was noted. Some respondents emphasised the importance of flexibility to accommodate different working patterns and personal circumstances (e.g. those on maternity leave, with caring responsibilities or disabilities), and the need for ongoing equality impact monitoring.

225. A sample of the comments we received are in the box below:

"Some aspects of the proposed reforms could have unintended negative impacts on certain groups of registrants. In particular, the removal of structured CPD requirements and greater reliance on self-directed learning and employer support may disadvantage registrants who have less access to workplace training opportunities. For example, locum practitioners, part-time workers, and those working across multiple practices may not have the same level of organisational support for CPD as those employed in larger organisations. This could create inequalities in access to structured learning opportunities and professional development.

Registrants with caring responsibilities, those returning from parental leave, and individuals with disabilities or long-term health conditions may also face

challenges if CPD expectations become less structured and more dependent on employer support or informal learning arrangements.

Additionally, registrants working in smaller practices or rural settings may have fewer opportunities to access high-quality CPD if regulatory oversight of CPD providers is reduced. These factors could unintentionally widen disparities in professional development opportunities across the profession." (Therapeutic Prescribing Optometrist)

"The consultation document and accompanying impact assessment do not provide a detailed analysis to demonstrate the extent to which the consultation proposals will increase or decrease costs on businesses, nor do they provide evidence that the costs and benefits of different options have been considered." (FODO – The Association for Eye Care Providers)

"Proposals that seek to strengthen the role of businesses – for example through appraisals, monitoring or PDP oversight – risk creating inequity for registrants who are locums, sole practitioners, business owners, or portfolio workers, or those whose employers are not GOC registered. These groups may not have access to consistent workplace systems or support, potentially leading to uneven application of requirements and perceptions of unfairness." (CPD Provider)

"A more flexible and less prescriptive CPD system may disadvantage registrants who have less access to support, structured development opportunities or consistent workplace infrastructure. This risk is closely linked to the structure of the workforce and variation in working arrangements." (Optometry Scotland)

Q27 [Are there any aspects of our proposals that could have a positive impact on stakeholders with specific characteristics?]	Overall	Individuals	Organisations
Yes	17.8%	11.4%	52.2%
No	31.5%	35.0%	13.0%
Not sure	50.7%	53.7%	34.8%

226. Benefits noted in the feedback included increased flexibility in CPD requirements, particularly for those who face barriers to attending traditional, provider-led or structured sessions. This includes individuals with caring responsibilities, disabilities, those on maternity or parental leave, and those with variable work patterns or who struggle to participate outside of normal working hours.

227. Some responses noted that a less prescriptive, more self-directed approach could widen participation and improve the impact of CPD. There was also mention

of the potential for positive effects related to age, and for those returning from career breaks.

228. A sample of the comments we received are in the box below:

"It could be a fantastic opportunity to develop the optical workforce and encourage self-directed development and registrants taking far more responsibility for their own development.

The GOC needs to significantly expand its guidance and resources to registrants surrounding CPD – to inspire and encourage more activity and reduce narrow prescription of suitable activities, whilst maintaining focus on professional development that increases the safety and effectiveness of protected activities of self or others." (The College of Optometrists)

"The consultation proposals, if implemented, would provide more flexibility for registrants to choose the CPD that best meets their needs and circumstances, without a bias towards formal courses. This is likely to have a positive impact overall, including for those in lower socio-economic groups, for those who work part time, or for those who have caring responsibilities." (FODO – The Association for Eye Care Providers)

"Increased emphasis on professional judgement, reflective practice and personal development planning may benefit registrants whose learning styles or cultural backgrounds align less well with formalised, classroom based education. Supporting multiple pathways to competence encourages diversity in learning approaches and recognises different strengths and experiences.

However, the extent to which these positive impacts are realised will depend on clear guidance, proportionate assurance mechanisms and appropriate support, particularly for registrants who may require additional confidence or structure when navigating a less prescriptive system." (CPD Provider)

GOC response – impact assessment

229. We are grateful for the feedback, and we have chosen to combine our responses to Questions 26 and 27 given the similarity in the issues raised.

230. We agree with the final comment in the box above that the changes should have positive impacts overall, but success will depend on the quality of guidance and support, as well as our approach to assurance mechanisms. At its heart, our proposals seek to introduce greater flexibility and less prescription in a sector that is characterised by a wide diversity of roles and practice settings. Greater flexibility should reasonably be expected to benefit registrants working outside of traditional high-street eye care delivery patterns. Examples include practitioners

who are older, working part-time or those with caring responsibilities. A greater emphasis on self-directed CPD should also support less affluent registrants, including those not eligible for NHS grants or not working for large employers where there is ready access to CPD activities charged at no cost to registrants.

231. We recognise concerns that a more flexible approach does not benefit everyone and that some specific groups may be at a disadvantage if the system becomes less structured and more reliant on self-direction. Our expectation is that most registrants will continue to access provider led CPD via employers and events with self-directed CPD growing in influence over time. The new system would present greater choice, allowing registrants to continue with a highly structured approach if that is what suits them best. Guidance by GOC and others can support registrants by suggesting norms, detailing good practice and providing practical resources like templates. A minimum requirement for GOC guidance will be to explain what GOC will look for when reviewing CPD records and the circumstances that could lead to removal from the register.

232. An advantage of the current three-year cycle supported by our approach to exceptional circumstances is that it supports ‘CPD breaks’ due to pregnancy, caring responsibilities and other life events. This is because the total points needed can be spread over the course of each cycle. If our proposals are implemented, the concept of a three-year CPD cycle will end. Our guidance on CPD record review will explain how we will treat such situations in future.

233. Some concerns raised in Question 26 related to our specific proposals for business registrants to play a greater role in supporting CPD. However, we have stepped back from these proposals following stakeholder feedback.

234. An updated impact assessment has been published alongside this response.

Welsh language

235. We asked stakeholders if the proposed changes would have effects, whether positive or negative, on: (i) opportunities for persons to use the Welsh language, and (ii) treating the Welsh language no less favourably than the English language. Nine respondents indicated that the proposed changes would have effects on opportunities for people to use the Welsh language, and 10 respondents indicated they would have effects on treating the Welsh language no less favourably than the English language. In the feedback, most respondents did not identify any direct impact of the proposed CPD reforms on the Welsh language or its treatment relative to English.

236. We asked stakeholders whether the proposed changes could be revised so that they would have positive effects, or increased positive effects, on: (i) opportunities for persons to use the Welsh language, and (ii) treating the Welsh language no less favourably than the English language. 15 respondents indicated that the proposed changes could be revised so that they would have

positive effects, or increased positive effects, on opportunities for people to use the Welsh language, and 12 respondents indicated they could be revised to treat the Welsh language no less favourably than the English language. In the feedback, there was support expressed for documentation and resources to be made accessible in Welsh, in line with regulatory expectations.

237. We asked stakeholders whether the proposed changes could be revised so that they would not have negative effects, or so that they would have decreased negative effects, on: (a) opportunities for persons to use the Welsh language, and (b) treating the Welsh language no less favourably than the English language. 10 respondents indicated that the proposed changes could be revised so that they would not have negative effects or decreased negative effects on opportunities for people to use the Welsh language. Eight respondents indicated they could be revised so that they would not have negative effects or decreased negative effects on treating the Welsh language no less favourably than the English language. As with previous questions, language accessibility was noted as an important consideration. Overall, feedback was not as extensive for questions relating to Welsh language compared with other questions asked.

GOC response – Welsh language

238. We are grateful for responses to this question. Few responses included specifics on changes we might make with feedback focused on translation of documents.

239. Overall, we remain of the view that our proposals would have a neutral impact on the Welsh language. We translate our CPD materials into Welsh now, and this will continue to be the case.

C43(26) ANNEX TWO

Impact Assessment Screening Tool

Name of policy or process	CPD reform
Purpose of policy or process	To reform GOC's CPD requirements
Team/Department	Education and CPD
Date	3 August 2026
Screen undertaken by	Steve Brooker
Approved by	L Milliner
Date approved	17 Sept 2026
Instructions:	• Circle or colour in the current status of the project or policy for each row. • **Do not miss out any rows**. If it is not applicable – put N/A, if you do not know put a question mark in that column. • This is a live tool, you will be able to update it further as you have completed more actions. • Make sure your selections are accurate at the time of completion. • Decide whether you think a **full** impact assessment is required to list the risks and the mitigating/strengthening actions. • If you think that a full impact assessment is **not** required, put your reasoning in the blank spaces under each section. • You can include comments in the boxes or in the space below. • Submit the completed form to the Compliance Manager for approval.

A) Impacts	High risk	Medium risk		Low risk	? or N/A
1. Reserves	It is likely that reserves may be required	It is possible that reserves may be required		No impact on the reserves / not used	
2. Budget	No budget has been allocated or agreed, but will be required	Budget has not been allocated, but is agreed to be transferred shortly	Budget has been allocated, but more may be required (including in future years)	No budget is required OR budget has been allocated and it is unlikely more will be required	
3. Legislation, Guidelines or Regulations	Not sure of the relevant legislation	Aware of all the legislation but not yet included within project/process	Aware of the legislation, it is included in the process/project, but we are not yet compliant	Aware of all the legislation, it is included in the project/process, and we are compliant	
4. Future legislation changes	Legislation is due to be changed within the next 12 months	Legislation is due to be changed within the next 24 months	Legislation may be changed at some point in the near future	There are no plans for legislation to be changed	
5. Reputation and media	This topic has high media focus at present or in last 12 months	This topic has growing focus in the media in the last 12 months	This topic has little focus in the media in the last 12 months	This topic has very little or no focus in the media in the last 12 months	
6. Resources (people and equipment)	Requires new resource	Likely to complete with current resource, or by sharing resource	Likely to complete with current resource	Able to complete with current resource	
7. Sustainability	Less than 5 people are aware of the process/project, and it is not recorded centrally nor fully	Less than 5 people are aware of the project/process, but it is recorded centrally and fully	More than 5 people are aware of the process/project, but it is not fully recorded and/or centrally	More than 5 people are aware of the process/ project and it is clearly recorded centrally	
	No plans are in place for training, and/or no date set for completion of training	Training material not created, but training plan and owner identified and completion dates set	Training material and plan created, owner identified and completion dates set	Training completed and recorded with HR	N/A
8. Communication (Comms) / raising awareness	No comms plan is in place, and no owner or timeline identified	External comms plan is in place (including all relevant stakeholders) but not completed, an owner and completion dates are identified	Internal comms plan is in place (for all relevant levels and departments) but not completed, and owner and completion dates are identified	Both internal and external comms plan is in place and completed, owner and completion dates are identified	
	Not sure if needs to be published in Welsh	Must be published in Welsh; Comms Team aware		Does not need to be published in Welsh	

Please put commentary below about your impacts ratings above:
1, 2 and 3: No funds are required during the policy development phase of the project, but implementation of short-term reforms (e.g. recalibration of points) may require IT costs in the 2027/28 financial year that exceed the development budget in the contract for the MyCPD platform. Long-term reforms like ending the points system would result in savings for GOC and reduced compliance costs for registrants. The £45 annual CPD provider fee is prescribed in the CPD Rules 2021 and is outweighed by the costs of regulation. The timetable for delivery of long-term reform is not within the GOC's control and will be determined by the UK Government. We recognise that our proposals may have adverse economic consequences for CPD providers. However, we should not assume that registrants will undertake less CPD because of the changes. We consider that a viable market for CPD provision that would enable registrants to fulfil the revised requirements will continue to exist if our proposals are implemented. 3 and 4: The CPD Rules 2021 are secondary legislation. Our working assumption is that government will not prioritise reform to the CPD Rules 2021 during the current parliament. Proposals labelled as short-term are possible within the CPD Rules 2021. 8: A communications plan supported consultation engagement. The consultation document and annexes were translated into Welsh. The proposals in this document relate to a framework of CPD regulation that will apply to all registrants across the UK, including in Wales. Consultation feedback confirmed our assessment that these proposals will not have any effects on opportunities to use the Welsh language or affect the treatment of the Welsh language. Full impact assessment not required.

B) Information governance	High risk	Medium risk		Low risk	? or N/A
1. What data is involved?	Sensitive personal data	Personal data	Private / closed business data	Confidential / open business data	
2. Will the data be anonymised?	No	Sometimes, in shared documents	Yes, immediately, and the original retained	Yes, immediately, and the original deleted	
3. Will someone be identifiable from the data?	Yes	Yes, but their name is already in the public domain(SMT/Council)	Not from this data alone, but possibly when data is merged with other source	No – all anonymised and cannot be merged with other information	N/A
4. Is **all** of the data collected going to be used?	No, maybe in future	Yes, but this is the first time we collect and use it	Yes, but it hasn't previously been used in full before	Yes, already being used in full	
5. What is the volume of data handled per year?	Large – over 4,000 records	Medium – between 1,000-3,999 records		Less than 1,000 records	
6. Do you have consent from data subjects?	No	Possibly, it is explained on our website (About Us)	Yes, explicitly obtained, not always recorded	Yes, explicitly obtained and recorded/or part of statutory duty/contractual	N/A
7. Do you know how long the data will be held?	No – it is not yet on retention schedule	Yes – it is on retention schedule	Yes – but it is not on the retention schedule	On retention schedule **and** the relevant employees are aware	
8. Where and in what format would the data be held? (delete as appropriate)	Paper; at home/off site; new IT system or provider; Survey Monkey; personal laptop	Paper; archive room; office storage (locked)	GOC shared drive; personal drive	other IT system (in use); online portal; CRM; Scanned in & held on H: drive team/dept folder	
9. Is it on the information asset register?	No	Not yet, I've submitted to Information Asset Owner (IAO)	Yes, but it has not been reviewed by IAO	Yes, and has been reviewed by IAO **and** approved by Gov. dept.	
10. Will data be shared or disclosed with third parties?	Yes, but no agreements are in place	Yes, agreement in place	Possibly under Freedom of Information Act	No, all internal use	
11. Will data be handled by anyone outside the EU?	Yes	-	-	No	
12. Will personal or identifiable data be published?	Yes – not yet approved by Compliance	Yes- been agreed with Compliance	No, personal and identifiable data will be redacted	No - no personal or identifiable data will be published	

B) Information governance	High risk	Medium risk		Low risk	? or N/A
13. Individuals handling the data have been appropriately trained	Some people have never trained by GOC in IG	All trained in IG but over 12 months ago		Yes, all trained in IG in the last 12 months	

Please put commentary below about reasons for information governance ratings:
1-13: We do not anticipate that respondents to the consultation will provide personal data about individuals, but they may provide information about commercial practices. In line with our consultation policy, we will redact information which we consider to be offensive, vexatious, libellous or contain rhetoric that promotes discriminatory behaviour/views against anyone with protected characteristics under the Equality Act 2010, or are irrelevant (consultation-policy-final-july-2024.pdf). Consultation respondents can provide their personal information (name, contact details and EDI information) when submitting a consultation response, but it is not mandatory. Where gathered, all such information is used solely for the purposes of analysing responses, and we do not identify or publish the names of any individuals who have responded to the consultation. Our existing governance controls around EDI monitoring data will be applied as part of our wider data assurance approach. Our consultation platform includes a privacy statement, setting out how we will use respondents' data (Privacy Policy | General Optical Council). Most risks are low or medium and have been mitigated. Full impact assessment not required.

C) Human rights, equality and inclusion	High risk	Medium risk		Low risk	? or N/A
1. Main audience/policy user	Public			Registrants, employees or members	
2. Participation in a process (right to be treated fairly, right for freedom of expression)	Yes, the policy, process or activity restricts an individual's inclusion, interaction or participation in a process			No, the policy, process or activity does not restrict an individual's inclusion, interaction or participation in a process	
3. The policy, process or activity includes decision-making which gives outcomes for individuals (right to a fair trial, right to be treated fairly)	Yes, the decision is made by one person, who may or may not review all cases	Yes, the decision is made by one person, who reviews all cases	Yes, the decision is made by an panel which is randomly selected; which may or may not review all cases	Yes, the decision is made by a representative panel (specifically selected) OR No, no decisions are required	
	There is limited decision criteria; decisions are made on personal view	There is some set decision criteria; decisions are made on 'case-by-case' consideration	There is clear decision criteria, but no form to record the decision	There is clear decision criteria and a form to record the decision	
	There is no internal review or independent appeal process	There is a way to appeal independently, but there is no internal review process	There is an internal review process, but there is no way to appeal independently	There is a clear process to appeal or submit a grievance to have the outcome internally reviewed and independently reviewed	
	The decision-makers have not received EDI and unconscious bias training, and there are no plans for this in the next 3 months	The decision-makers are due to receive EDI and unconscious bias training in the next 3 months, which is booked	The decision-makers are not involved before receiving EDI and unconscious bias training	The decision-makers have received EDI and unconscious bias training within the last 12 months, which is recorded	

C) Human rights, equality and inclusion	High risk	Medium risk		Low risk	? or N/A
4. Training for all involved	Less than 50% of those involved have received EDI training in the last 12 months; and there is no further training planned	Over 50% of those involved have received EDI training, and the training are booked in for all others involved in the next 3 months.		Over 80% of those involved have received EDI training in the last 12 months, which is recorded	
5. Alternative forms – electronic / written available?	No alternative formats available – just one option	Yes, primarily internet/computer-based but paper versions can be used		Alternative formats available and users can discuss and complete with the team	
6. Venue where activity takes place	Building accessibility not considered	Building accessibility sometimes considered		Building accessibility always considered	N/A
	Non-accessible building;	Partially accessible buildings;	Accessible buildings, although not all sites have been surveyed	All accessible buildings and sites have been surveyed	N/A
7. Attendance	Short notice of dates/places to attend	Medium notice (5-14 days) of dates/places to attend		Planned well in advance	
	Change in arrangements is very often	Change in arrangements is quite often		Change in arrangements is rare	
	Only can attend in person	Mostly required to attend in person		Able to attend remotely	
	Unequal attendance / involvement of attendees	Unequal attendance/ involvement of attendees, but this is monitored and managed		Attendance/involvement is equal, and monitored per attendee	
	No religious holidays considered; only Christian holidays considered	Main UK religious holidays considered	Main UK religious holidays considered, and advice sought from affected individuals if there are no alternative dates	Religious holidays considered, and ability to be flexible (on dates, or flexible expectations if no alternative dates)	
8. Associated costs	Potential expenses are not included in our expenses policy	Certain people, evidencing their need, can claim for potential expenses, case by case decisions		Most users can claim for potential expenses, and this is included in our	N/A

C) Human rights, equality and inclusion	High risk	Medium risk		Low risk	? or N/A
				expenses policy; freepost available	
9. Fair for individual's needs	Contact not listed to discuss reasonable adjustments, employees not aware of reasonable adjustment advisors	Most employees know who to contact with queries about reasonable adjustments		Contact listed for reasonable adjustment discussion	N/A
10. Consultation and Inclusion	No consultation; consultation with internal employees only	Consultation with employees and members	Consultation with employees, members, and wider groups	Consultation with policy users, employees, members and wider groups	

Please put commentary below for human rights, equalities and inclusion ratings above:
3: Decisions on the CPD system will be made by our Council following public consultation, which will affect individuals and business owners. There is no right of appeal for Council decisions, except judicial review. During implementation, participation and outcomes across protected groups will be monitored through the points system (short-term reforms) and audit system (long-term reforms), so any emerging disparities can be identified and addressed. 5: The consultation was available to all on our website. Documents are available in alternative formats on request, and our website meets accessibility guidelines. Any decisions on the CPD system covered in the consultation will be made at a public Council meeting which takes place online and is open to all to attend. We publish Council papers a week in advance of meetings. Operational matters relating to implementation may be taken by the executive working within schemes of delegation. 6-9: Council meetings take place online. As above, relevant decisions would be made at the public Council meeting, which is open to the public. Papers for the meeting are published a week in advance and are available in alternative formats on request. Full impact assessment not required.

Protected characteristic	Type of potential impact: positive, neutral, negative?	Explanations (including examples or evidence/data used) and actions to address negative impact
Age	Positive	Under the current model registrants must obtain the same points requirements regardless of age, which may be disproportionate for experienced professionals. The need to obtain CPD points regardless of intentions to retire may disadvantage older professionals. Therefore, it is possible that older professionals will benefit from a less prescriptive CPD system. Consultation feedback highlighted that greater flexibility should reasonably be expected to benefit registrants working outside of traditional high-street eye care delivery patterns. Examples given included practitioners who are older.
Disability	Positive	Registrants with a disability may find it harder to attend events such as conferences which attract high numbers of points meaning the total points requirement can be harder to reach. The need to accumulate sufficient points by a fixed deadline to remain on the register can cause anxiety towards the end of the cycle, especially for registrants who are neurodiverse. Therefore, registrants with a disability may benefit from a less prescriptive CPD system. Some consultation feedback confirmed these benefits. Conversely, some consultation feedback also highlighted that a less structured CPD system could cause difficulties for registrants who are neurodiverse. In response, our expectation is that most registrants will continue to access provider led CPD via employers and events with self-directed CPD growing in influence over time. The new system would present greater choice, allowing registrants to continue with a highly structured approach if that is what suits them best. Guidance by GOC and others can support registrants by suggesting norms, detailing good practice and providing practical resources like templates. A minimum requirement for GOC guidance will be to explain what GOC will look for when reviewing CPD records and the circumstances that could lead to removal from the register.
Sex	Neutral	We have no evidence that the current CPD system creates different impacts for men or women. However, we will monitor participation and outcomes through implementation to identify any emerging disparities.

Protected characteristic	Type of potential impact: positive, neutral, negative?	Explanations (including examples or evidence/data used) and actions to address negative impact
Gender reassignment (trans and non-binary)	Neutral	No specific impacts identified at this stage. We do not hold evidence showing barriers linked to the CPD points model. We will ensure the consultation and supporting materials are inclusive and that any system changes (e.g., CPD system updates) support name changes and correct identity information.
Marriage and civil partnership	Neutral	We do not have evidence that registrants in this group are disproportionately affected by the current CPD requirements. No differential impact is expected under the proposed reforms.
Pregnancy/ maternity	Positive	Our research does not indicate that registrants in this category find the current system too onerous. Even so, it is reasonable to infer that a less prescriptive system would benefit registrants who find it difficult to meet the points requirements due to lack of time. An advantage of the current three-year cycle supported by our approach to exceptional circumstances is that it supports ‘CPD breaks’ due to pregnancy, caring responsibilities and other life events. This is because the total points needed can be spread over the course of each cycle. If our proposals are implemented, the concept of a three-year CPD cycle will end. Our guidance on CPD record review will explain how we will treat such situations.
Race	Neutral	We do not currently hold evidence showing differential impact by ethnicity. Access to CPD events can vary depending on employment setting, but this is not necessarily linked to race. We will continue to monitor participation data to identify any patterns.
Religion/belief	Neutral	No specific impacts identified. CPD cycles do not require attendance at events tied to particular dates, and a less event-driven system may reduce any risk of clashes with religious observance.
Sexual orientation	Neutral	We have no evidence that the current CPD model impacts registrants differently based on sexual orientation, and the proposed reforms are not expected to create any new barriers.

Protected characteristic	Type of potential impact: positive, neutral, negative?	Explanations (including examples or evidence/data used) and actions to address negative impact
Other groups (e.g. carers, people from different socio-economic groups)	Positive	Our research indicates that subgroups more likely to think that the number of points required under the current system is too high, includes dispensing opticians, those working full-time, and those who work as locums. Those with caring responsibilities may find it harder to attend events such as conferences which attract high numbers of points meaning the total points requirement can be harder to reach. Participation and outcomes across protected groups will be monitored through the points system (short-term reforms) and audit system (long-term reforms), so any emerging disparities can be identified and addressed. Consultation feedback highlighted potential disadvantages if the system becomes less structured and more reliant on self-direction. At risk-groups cited included: locums, sole practitioners, portfolio workers, those on maternity leave or career breaks, part-time registrants, and those with disabilities or neurodiversity (such as autism, ADHD, dyslexia). However, others highlighted that greater flexibility should reasonably be expected to benefit registrants working outside of traditional high-street eye care delivery patterns. Examples include practitioners who are older, working part-time or those with caring responsibilities. Further, a greater emphasis on self-directed CPD should also support less affluent registrants, including those not eligible for NHS grants or not working for large employers where there is ready access to CPD activities charged at no cost to registrants. As highlighted in the section on disability above, the new system would present greater choice, allowing registrants to continue with a highly structured approach if that is what suits them best. GOC guidance will provide clarity about our minimum expectations, as well as materials like templates, thus supporting those who prefer greater structure. Consultation feedback highlighted concerns about impacts of specific proposals for business registrants to play a greater role in supporting CPD. However, we have stepped back from these proposals following stakeholder feedback.

PUBLIC
C44(26)

General Optical Council

Council

Significant preventable events framework and significant incident policy

Meeting: 7 September 2026 **Status:** For decision
Lead responsibility: Andy Mackay-Sim (Chief of Staff)
Paper Author(s): Andy Mackay-Sim (Chief of Staff)

Purpose

1. To present the new significant preventable events framework and the revised serious and significant incident policy to Council for approval.

Recommendations

2. Council is asked to**;**
   - **approve** the new significant preventable events framework (annex 3); and
   - **approve** the revised serious and significant incident policy (annex 4).

Strategic objective

3. Plans to produce these policies was included in the 2026/27 business plan. They represent important internal controls to help support our strategic objectives for 2025-30.

Background

4. Council approved a never-event framework in 2021 (annex 1), and a serious and significant incident management policy in March 2023 (annex 2). Both documents were scheduled for a review in the 2026-27 business plan. Delays reviewing the never-event framework arose due to unexpected staffing changes in 2025-26.

5. A review of the never-event framework was undertaken with the relevant operational leads in Regulatory Operations and Registration. The serious incident and significant incident policy was reviewed by the Chief of Staff. Both documents were presented to the Senior Management Team (SMT) for review via email. Following this, SMT recommended approval to ARC and Council. The revised policies are attached as annexes 3 and 4.

6. The ARC terms of reference require it provide Council with assurances regarding the management of risk and the internal control environment. ARC considered

the papers on 7 September 2026 and recommended approval of the two proposed documents.

Analysis

7. The review of the never-event framework resulted in the following changes:

   - The framework has been retitled to avoid using the term ‘never-event’ as this refers to a very explicit set of criteria in NHS settings. Recent public consultations on the NHS England approach to the never-event framework identified that the language of the ‘never-event’ could lead to under reporting or issues in the control environment. The GOC is anticipating the NHS is replacing its own ‘never-event framework’ with a more explicit set of criteria.
   - There have been limited changes to the former never-event descriptors, though the context and information contained in the policy has been altered to fit the new approach.
   - Two of the descriptors were amalgamated to reduce repetition.

8. The serious and significant incident policy has been revised, with changes focussed on improving clarity and reducing unnecessary additional reporting requirements. Learning from previous incidents has been incorporated and the criteria between the different types of incidents has been made more explicit.

Finance

9. There are no direct financial implications because of this report.

Risks

10. The two policies are intended to enable the effective identification and treatment of risk in business critical areas. There is a risk that the documentation does not cover every scenario, and this is mitigated in part by using broad definitions for what qualifies as significant and serious incidents. The policy is intended to be used flexibly to ensure that incidents can be properly identified, assessed, reported and managed.

11. There is a risk of low visibility of the policy and framework across the organisation. This is mitigated in part by communications and targeted induction for the relevant teams.

Equality Impacts

12. There are no implications identified in respect to EDI.

Devolved nations

13. This report contains no implications in respect to the devolved nations. The GOC is regulated by the Charity Commission, as a charity based and registered in England. It has no requirement to report serious incidents to other charity regulators in the devolved nations.

Other Impacts

14. There are no implications identified in respect of legislation, resources, or sustainability.

Communications

Internal communications

15. The policies will be uploaded for IRIS and incorporated into the relevant induction processes.

External communications

16. The policies will be uploaded on the GOC webpage to ensure that there is visibility for all stakeholders.

Next steps

17. Assuming the Council approves the polices, they will be uploaded and circulated as set out.

Attachments

Annex 1 – current Never-Event Framework
Annex 2 – current Serious and Significant Incident Policy
Annex 3 – proposed Significant Preventable Events Framework
Annex 4 – proposed Serious and Significant Incident Policy

GOC Never Events Framework

1. Introduction

1.1 The General Optical Council (GOC) defines a Never Event as an incident of the utmost criticality, which GOC internal controls should prevent from happening. Never Events require enhanced investigation and reporting using the incident review template (annex three).

1.2 The GOC recognises the importance of effectively managing its risks and learning from incidents. An important element in ensuring objectives are met is promoting a culture in which Never Events are reported at the earliest opportunity. Timely notification of incidents provides the organisation with an opportunity to address contributory factors and prevent a recurrence.

1.3 Developing a culture where staff feel confident to report incidents will contribute to and uphold GOC values. The Chief Executive and Senior Management Team (SMT) are committed to encouraging open and fair reporting and reporting of incidents. All staff can be confident that this approach will be adhered to at all times except where malicious, criminal, gross or repeated misconduct is involved.

1.4 The purpose of this document is to explain how the GOC will respond when they occur.

2. GOC Never Events

2.1 The GOC has described five Never Events. They are:

1) No registrant whether student or fully qualified individual or body corporate without the correct qualifications / identity or other documentary evidence, or fitness to practise suitability will be registered or restored to the register.

2) No registrant whether student or fully qualified individual or body a corporate will be suspended or removed from the register without approval and appropriate double checking by an appropriate manager.

3) No registrant whether student or fully qualified individual or body corporate who is non-compliant with our requirements relating to renewal or CET/CPD requirements to remain on the register (past expiry date);

4) No Fitness to Practise Committee order (substantive or interim) should lapse; expire; or fail to be reviewed without an authorised decision being

made that it is no longer necessary and/or that a review is not required; and

5) All registration status changes following a substantive or interim hearing, to be updated within three working days of the hearing concluding.

2.2 The Never Events list will be reviewed by the Director of Resources/Corporate Services (DoR) (with input from key staff) and the SMT on a regular basis to ensure that the incidents continue to reflect the definition of a Never Event and that prevention and control measures are up to date, adequate and are operating effectively. This also provides the opportunity for new Never Events to be added, as and when appropriate.

2.3 The types of incidents defined as Never Events have been identified using the following criteria:

a. Significant / serious patient safety implications

b. High level of reputational risk

c. Scored 5 on the risk impact scale (annex one)

3. Responsibilities

3.1 SMT will determine which incidents are included on the list of Never Events.

3.2 To ensure that there is a robust control environment supporting the management of the risks to which Never Events relate, the DoR is responsible for working with relevant Heads of Function on the effective design and operation of mitigating actions.

3.3 Heads of Functions are responsible for ensuring that there are documented processes/procedures which describe how tasks are to be undertaken so that Never Events do not occur.

What to do if a Never Event occurs

3.4 The person who identifies that a Never Event has occurred is responsible for immediately reporting the incident to their Head of Function or Director, and to the DoR, who will notify the SMT group without delay. For the purposes of reporting, suspected Never Events must be clearly identified as such, even if the status is uncertain at the time of report.

3.5 Due to the risk implications associated with Never Events, the director with responsibility for the area in which the incident occurred will assume the role of the risk owner. In the event the incident relates to areas in which more than one director has responsibility, the risk owner responsibility will be shared.

3.6 The DoR will agree with the relevant director(s) on who will investigate and report on the Never Event.

4. Investigations

4.1 It is important that if a Never Event occurs the problems in the case are identified and analysed through full investigation using a systems-based investigation method (see root cause analysis guidance – annex two) to understand how and why they occurred (from a systems perspective). This will mean effective and targeted action can be taken to prevent recurrence.

4.2 The incident reporting template (annex three) may be used as a starting point for communicating the result of the investigation. However, the investigation final report for a Never Event likely will require considerable detail and the Investigating Officer should determine the most effective format for presenting their findings and recommendations.

4.3 The DoR will assist the Investigating Officer ensure consistency in reports.

5. Reporting

Routine Reporting

5.1 All routine reporting related to Never Events is the responsibility of the Head of Secretariat, with support from the DoR.

5.2 Quarterly reports will be prepared for SMT on Never Events (by way of inclusion in the Significant Incidents Report). These will both support the operation of effective risk mitigation by providing control assurance and reinforce learning of lessons through progress updates on agreed actions from any previous Never Event.

5.3 As part of end-of-year reporting, a summary of Never Events investigations and key learning will be provided to Audit and Risk Committee.

Never Event Investigation Reports

5.4 Due to the serious nature of Never Events, it is important that they are responded to promptly. A draft report, agreed by the risk owner(s), should be circulated to SMT within 14 days of the incident being reported. SMT should sign off the final report within 28 days of the incident being reported.

Failure to report a Never Event

5.5 This framework is designed to provide staff with clarity on their responsibilities and what to do if a Never Event happens. It is important that we all work in a culture where openness, transparency and learning from the incident are key.

5.6 A failure to report a Never Event is unacceptable and can signal regulatory, cultural and safety failings in an organisation. In some circumstances, it may not be apparent that an incident is a Never Event until there has been some degree of investigation. In these circumstances, the possibility that a Never Event has occurred should still be reported as soon as it is identified.

5.7 Failure to report a Never Event should be thoroughly investigated by the Governance team, with support from the DoR, to understand what prevented the recognition and/or reporting of the incident. This may lead to efforts to develop knowledge/awareness about incident reporting and Never Events more specifically. It may also lead to broader initiatives to measure and improve reporting culture as part of a wider culture in the organisation. If the failure to report was a deliberate act, this is likely to constitute a serious failing by the staff members involved under the Disciplinary Policy, which refers to “Failure to follow GOC policy/procedure resulting in significant disruption or effect to the GOC”.

Annex one– risk impact scale

Impact					
DESCRIPTOR	**1 INSIGNIFICANT**	**2 MINOR**	**3 MODERATE**	**4 MAJOR**	**5 CATASTROPHIC**
Financial (damage/loss)	Organisational / financial loss (£< 1k).	Organisational / financial loss (£1,000-£10,000).	Organisational / financial loss (£10,000 - 100,000).	Organisational / financial loss (£100,000 - £1m).	Organisational / financial loss (£>1m).
Reputation & publicity	Limited negative local public exposure with negligible impact on stakeholder confidence.	Negative local public exposure with low impact on stakeholder confidence. Local media coverage <1day.	Negative local and limited national public exposure with moderate impact on stakeholder confidence and PSA	Negative national public exposure with significant impact on stakeholder confidence. Loss of public confidence.	Full public inquiry. MP concerns/ questions in parliament. Severe loss of confidence in the organisation.
Information Governance	**Potential** breach of confidentiality risk assessed as low, e.g. files/data was encrypted.	Serious **potential** breach of confidentiality e.g. unencrypted records/data lost.	Serious breach of confidentiality from inadequately protected PC(s), laptop(s) and remote device(s).	Serious breach of confidentiality with particularly sensitivity data.	Serious breach of confidentiality with potential for ID theft.
Information Technology	An event which leads to loss of critical business processes but can be managed under normal circumstances and resolved quickly and easily.	An event which leads to loss of critical business processes but can be managed under normal circumstances and resolved in around 1 day.	A significant event, which leads to loss of critical business processes but can be managed under normal circumstances and resolved in 1 or 2 days.	A critical event, which leads to loss of critical business processes, but can be resolved with proper management within a few days.	An extreme event, which leads to loss of critical business processes which takes significant management time and resources to resolve.

Legislative	Minor internal breach.	Significant internal breach.	Reportable incident to regulator, no follow up.	Report of breach to regulator with immediate correction to be implemented.	Report to regulator, prosecution or fines requiring major corrective action.

Impact					
DESCRIPTOR	**1 INSIGNIFICANT**	**2 MINOR**	**3 MODERATE**	**4 MAJOR**	**5 CATASTROPHIC**
Security	Very minor incidents/ damage to assets, property or personnel.	Localised incidents/ damage to assets, property or personnel with no effect on service delivery.	Organisational wide incidents/ damage to assets, property or personnel with some effect on service delivery.	Organisation wide incidents/ damage to assets, property or personnel with significant impact on service delivery.	Extreme incident with major effects on the organisation's ability to deliver core services.
Health & Safety	On-site exposure immediately contained. Trivial injury	On-site exposure, contained after prolonged effect. Minor injury	On-site exposure, contained with outside assistance. Major injury.	Prolonged/Major incident with serious casualties. Major injuries.	Major incident with fatalities.
Staffing and Competence	Short term low staffing level temporarily reduces service quality (< 1 day).	Ongoing low staffing level reduces service quality. **Minor error** due to ineffective training.	Late delivery of key objectives/service due to lack of staff. **Moderate error** due to ineffective training.	Uncertain delivery of key objectives / service due to lack of staff. **Major error** due to ineffective training.	Non-delivery of key objectives / service due to lack of staff. Loss of key staff **Critical error** due to ineffective training, systems, or process design.
Projects	Minimal impact on project.	Delay/ minor issues with project, but within tolerance.	Delay or issues with project outside of tolerances.	Uncertain delivery of project.	Non-delivery of project.

Annex two – Root Cause Analysis Guidance (The 5 Steps)

1. Gather as much data as possible – this will yield causes and supporting evidence
2. Data can be time sensitive – gather it as soon as possible after the incident
3. Not all evidence is equal – high-quality evidence tends to be objective (documents, emails, computer logs) – the more subjective the evidence is (personal recollections, uncorroborated statements, etc) the lower its quality and less it should be relied upon
4. All data/evidence collected must be stored securely so that it is not tampered with, destroyed or damaged

7. The Problem Statement describes clearly the gap between what happened and what should have been achieved. It should include:

   - the Focal Point (a one sentence description of the problem being investigated) / the date and time of incident / where the incident happened, and the system and process involved / what was the actual impact of the incident / what could the potential impact have been

8. A high quality Problem Statement contains a good level of detail and does not stray into mentioning any solutions (those come later!)

9. Root Cause Analysis uses a Causes & Effect chart to visually present causes and their logical relationships - this helps demonstrate the interaction of causes, effects and evidence, and help find solutions

10. There is no set methodology in RCA for ascertaining cause and effect, though a common technique is to use the ‘5 Whys’ (repeatedly asking the question “why” until reaching a point where all of the issues are fully understood)

11. It is perfectly acceptable to have more than one root cause!

12. There will likely be a number of options available to address the identified root cause(s) - in considering which to recommend, think about the effectiveness, ease of implementation, cost/benefit, and any potential negative consequences of the possible solutions

13. Recommendations should address all root causes identified by the process and concentrate specifically on eliminating or reducing the likelihood of recurrence

14. Solutions should be SMART – Specific, Measurable, Achievable, Realistic and Timebound

15. Clearly show how the proposed solution will eliminate the problem, and why this is the best course of action for the organisation to follow

16. Ensure there is a plan to monitor the implementation of the solution and the effect it is having – *without checking, how can the organisation be confident it has fixed the problem?*

Annex three – Incident review (read Root Cause Analysis Guidance first)

NOTE: This form has been designed to include future use as part of a wider incident management approach (not just for Never Events)*.*

Click here to enter text.

Incident number (to be provided by Secretariat team): Click here to enter text.

Related risks: Click here to enter text.

Incident Impact: Choose an item.

Incident Category: Choose an item.

Introduction

Click here to enter text.

Findings from the incident review

Click here to enter text.

The issues

Click here to enter text.

Recommendations

1. Click here to enter text.

Actions

Action	Due date	By	Date completed
1.	**Click here to enter a date.**		**Click here to enter a date.**
2.	**Click here to enter a date.**		**Click here to enter a date.**
3.	**Click here to enter a date.**		**Click here to enter a date.**
4.	**Click here to enter a date.**		**Click here to enter a date.**

5.	**Click here to enter a date.**		**Click here to enter a date.**

Click here to enter text.

Click here to enter a date.

Serious and significant incidents policy

Status of document:	ACTIVE
Version:	1
Date of approval:	Interim policy approved by SMT 18 Jan 2023 Final policy approved by Council - 22 March 2023
Effective from:	19 January 2023 – interim policy 22 March 2023 – final policy
Owner:	Head of Governance
Author:	Head of Governance
Planned next review date:	March 2026

1. Policy statement

1.1 The General Optical Council (GOC) recognises the importance of effectively managing its risks and learning from incidents. An important element in ensuring objectives are met is promoting a culture in which incidents (including serious incidents, Never Events, accidents and near misses) are reported at the earliest opportunity. Timely notification of incidents provides the organisation with an opportunity to address contributory factors and prevent a recurrence. Developing a culture where staff feel confident to report incidents will support the GOC in becoming a learning organisation.

1.1.1 The Chair of Council, Chief Executive and Senior Management Team (SMT) are committed to encouraging open and fair reporting of incidents.

2. Purpose

2.1 The purpose of this policy is:

- to provide a consistent definition of a serious incident, a significant incident, near miss, and never event;
- to clarify roles and responsibilities;
- to provide information on notification, management and reporting requirements and timescales;
- to signpost tools and resources that support good practice; and
- to provide guidelines to ensure that all incidents are reported appropriately, and that lessons learned from analysis of the event are shared across the organisation.

-

3. Scope

3.1 This policy applies to:

- employees (whether permanent or temporary) and workers; [1]
- members;[2] and
- contractors working with, or on behalf of, the GOC.

3.2 Compliance with this policy is mandatory. Non-compliance for employees and workers may be considered a disciplinary matter. Non-compliance for members is a breach of the terms of appointment and could result in a code of conduct investigation.

3.3 If you require further advice and guidance, you should contact the Head of Governance at speakingup@optical.org. All requests for advice will be treated in confidence.

[1] Workers are appointed under a contract of employment by the Executive. This will commonly apply where work is ad-hoc and semi-regular.

[2] Members are appointed by the Privy Council (in the case of Council Members) or via the Council's appointment processes for committee members. This will commonly apply where individuals are a member of a committee or Council.

4. Definitions

4.3. **Serious incident:** As a charity, the GOC has a responsibility to manage and report serious incidents in accordance with guidance issued by the Charity Commission. The definition provided by the Charity Commission is:

'A serious incident is an adverse event, whether actual or alleged, which results in or risks significant:

- *harm to your charity's beneficiaries, staff, volunteers or others who come into contact with your charity through its work (who are collectively referred to throughout this guidance as people who come into contact with your charity through its work)*
- *loss of your charity's money or assets*
- *damage to your charity's property*
- *harm to your charity's work or reputation.[3]'*

Annex 1 sets out examples of what the Charity Commissions considers reportable serious incidents. However, it is not intended as an exhaustive list.

4.4. **Significant incident:** For the purposes of this policy, a significant incident may not meet the threshold for reporting as a serious incident to the Charity Commission. However, any incident which is significant (i.e. below the threshold of a serious incident) must be identified, assessed and any decision taken by SMT about whether it meets that threshold reported to the Audit, Finance and Risk Committee (ARC). Examples of significant incidents are enclosed in annex 5. However, it is not intended as an exhaustive list.

4.5. **Near miss:** an event (such as a significant or serious event) which does not have (but could have had) similar consequences to those of a significant or serious event. Examples of near misses are likely to be similar to those listed under significant incidents.

4.5. **Never event:** an incident of the utmost criticality, which GOC internal controls should prevent from happening. These are described within the GOC Never Events Framework

5. Review of this policy

5.1 Governance will be responsible for reviewing this policy every three years, considering new or changes to legislation and regulations as well as best practice before presenting it for consideration by SMT and approval by Council.

6. Responsibilities

6.1 Chair of Council and Council Members

6.1.1. As trustees, the Council has a duty to report any serious incidents to the Charity Commission. It has delegated the management and reporting of serious and significant incidents to the Executive via the Chief Executive and Registrar. Reporting and receiving assurance following a serious or significant incident has been delegated

[3] https://www.gov.uk/guidance/how-to-report-a-serious-incident-in-your-charity

to ARC with a clear line of escalation to Council where concerns are substantial enough to warrant it.

6.2 Chief Executive and Registrar

6.2.1. The Chief Executive and Registrar has overall responsibility for ensuring that the GOC has in place a robust incident management and reporting framework, ensuring that:

- there is a fair incident reporting culture;
- staff are encouraged to report incidents; and
- lessons learned are shared across the organisation.

6.2.2. The Chief Executive and Registrar is accountable to the Council in respect to the management and reporting of significant incidents.

6.2.3. The Chief Executive and Registrar will be responsible for activating the incident management procedure and convening the first meeting of the Strategic Command Group (SCG). This can be done by another member of SMT in an emergency.

6.3 Senior Management Team

6.3.1. As the executive board, the SMT is responsible for ensuring that management and accountability structures and culture in the organisation are appropriate to promote management, reporting and learning from incidents. It also provides leadership as a SCG in the event an incident requires active management.

6.4 Strategic Command Group (SCG)

6.4.1. The SCG is comprised of the members of SMT and supported by the Head of Governance. The name applies only when the incident management procedure is in place and refers to meetings explicitly convened as part of this procedure. The purpose of SCG is to provide the corporate and strategic direction when responding to significant incidents. The SCG will delegate operational oversight of the incident management to the Tactical Coordination Group (TCG).

6.4.2. The SCG convenes when the incident management procedure is activated, sets the frequency of meetings and reporting requirements, and agrees the step down of the procedure when the incident has been successfully managed.

6.4.3. The SCG will be responsible for assessing whether a significant event meets the threshold for a serious event and is therefore reportable to the Charity Commission. If the SCG is unable to consider the matter, due to the nature of the event (e.g., an ongoing criminal investigation where confidentiality is critical), this decision will be made by the Chief Executive based on advice from the Head of Governance. If there a conflict of interests for the Chief Executive, then the matter will be referred to the Chair of Council for decision.

6.5 Tactical Coordination Group (TCG)

6.5.1. The Tactical Coordination Group will be comprised of heads of service with the relevant corporate remits to manage a developing incident. The type of incident and associated risks will define the membership of the TCG and will be subject to approval by SCG. This will include, but not be limited to:

- Head of Communications
- Head of Governance
- Facilities Manager (if required)
- Head of People and Culture (if required)

- Head of Legal (if required)
- Head of Finance (if required)
- Head of IT (if required)
- Risk owner
- Other heads of department as judged appropriate

6.5.2. The TCG will be convened by SMT/SCG and expected to provide SMT and risk owner with any necessary operational capacity, corporate coordination and support. The TCG will disband at the direction of SCG once the incident has been managed and the process has been stepped down to the review phase. TCG members may participate at the review stage as required.

6.6 Directors

6.6.1. Individual directors are responsible for ensuring:

- that the content of this policy is followed in their area of responsibility;
- that learning from incident reporting is shared appropriately to encourage learning in their area of responsibility; and
- that staff training needs identified in the application of this policy are met to ensure improvement.

6.7 Head of Governance

6.7.1. The Head of Governance will ensure that there is an appropriate and effective incident management framework, including but not limited to:

- arrangements for record keeping and reporting;
- documented policies, procedures and guidance;
- appropriate training and support made available and delivered; and
- adequate resources are made available for the operation of this policy.

6.8 All persons in scope of this policy

6.8.1. All persons listed in the scope of this policy are responsible for:

- familiarising themselves with its contents; and
- highlighting to their line manager any training they feel they require related to it.

6.9 Person identifying the incident

6.9.1. At all times, the safety of the public, members, workers and employees is of primary importance. As a first step, the person identifying the incident should take immediate action to ensure that they and others remain safe.

6.9.2. The incident should be reported as soon as is possible so you can seek the appropriate advice. Reporting should be directed to the Head of Governance and Director of Corporate Services (aspragg@optical.org and ygearty@optical.org). You should also inform your line manager, relevant risk owner and your director.

6.10 Risk owners

6.10.1. An incident can be thought of as a risk that has actualised. The priority for the owner of the risk to which the incident relates is ensuring the appropriate steps are taken to manage the incident in line with the policy and then completion of any necessary recovery work.

6.10.2. The expectation is that the risk owner will fully participate in the incident management and reporting processes, and seek the necessary advice, guidance and support from

the TCG and Head of Governance. The risk owner will be accountable to SCG in terms of regular reporting and keeping the necessary parties informed during the incident management procedure.

6.10.3. The risk owner should also ensure that any required updates are undertaken following the incident and investigation findings.

6.11 Investigating officers

6.11.1 Upon being asked by the Director of Corporate Services to undertake a review, the investigating officer will coordinate an investigation to identify the factors that were likely to have led to the incident. The investigating officer should liaise with the risk owner to ascertain what, if any, corrective actions are required to prevent the incident from recurring.

6.11.2 Findings are remedial actions should be recorded using the Incident Review template, which is attached at Appendix 3.

7. Policy

7.1 Incident Management

Step-up of the incident management procedure

7.1.1. Upon notification of an incident, the Head of Governance and risk owner will use the risk scoring in the corporate and departmental risk registers as a means of assessing the severity of the risk. The risk scoring should inform the decision to implement the incident management procedure, alongside the professional judgement of the risk owner and Head of Governance.

7.1.2 The extent to which this procedure is followed will determined by the following:

- The likelihood of an extended disruption due to an incident
- The risk to the public, member, workers and employees
- The extent to which the GOC is exposed to reputational, financial or legal risk.

7.1.3 The SCG will be responsible for determining the regularity by which both the SCG and TCG will convene and the necessary reporting requirements. This will be proportionate to how the situation is developing. Examples might include:

- a weekly SMT meeting with TCG meeting daily;
- both SMT and TCG meeting daily; or
- alternate days for SCG and TCG meetings.

7.1.4 This will be kept under review throughout the incident management process and can be altered as best suited to assist workflow and developments.

7.1.5 The Chair of Council, Chair of ARC and Senior Council Member will be kept apprised of when the incident management procedure has been activated by the Head of Governance. The Head of Communications will establish what member, worker and employee communications are required throughout the course of the incident.

Step-down of the incident management procedure

7.1.6 SCG will be responsible for approving the stepping down of the incident management procedure. The TCG will disband once this procedure is stepped down.

7.2 Investigation

7.2.1. The Director of Corporate Services will appoint an investigating officer to lead a review to ascertain both the cause of the incident and any lessons which can be learned. If specialist technical knowledge is not required to decide the course of the investigation (e.g for IT, health and safety or information governance incidents), a member of the Governance team should normally be chosen as the investigating officer.

7.2.2. The review should be undertaken and completed in a timely manner; normally within 10 working days of the incident, though complex investigations may take longer.

7.2.3. The risk owner is responsible for signing off the draft incident review report, including any identified corrective actions. The completed report should be sent to SMT.

7.2.4. On occasions there may be other considerations, such as potential management action, where the commissioning of the review and consideration of the subsequent report may be limited to the Chief Executive (or Chair of Council in exceptional circumstances). In such cases the investigation report would be on limited circulation until the outcome of any recommendations were agreed.

7.2.5. Risk owners and the investigating officer should assess the impact of the incident so that the investigation can be both appropriate and proportionate. The rating of the incident should be consistent with the risk matrix contained in the GOC Risk Management Policy[4]. The Head of Governance can assist with risk owners with assessing whether an incident's impact (level of harm) is:

Insignificant	Minor	Moderate	Major	Catastrophic/ Never Event

7.2.6. A complex investigation and lengthy report will not likely be required for incidents rated as either '**Insignificant'** or '**Minor'**. It remains important, however, for learning points to be highlighted and corrective action agreed with the risk owner. Reflective practice is a useful method to use when identifying learning from low-level incidents. More information on this model can be found at Appendix 2.

7.2.7. Incident scored as either '**Moderate'** or '**Major'** have consequences which are outside of GOC risk tolerances and warrant a Serious Incident Review. For these incidents, a Root Cause Analysis (RCA) should be completed. Guidance on how to complete a RCA can be found at Appendix 3, and the Head of Governance will assist the investigating officer as required. To ensure effective learning, a RCA report should be completed (including sign off from the Risk Owner) within 12 weeks of incident notification.

7.2.8 It is not anticipated that many incidents will be rated as '**Never Events'**, as the internal control environment should be sufficiently robust to prevent their occurrence. Due to the severity of this type of incident, a separate framework exists which both describes them and explains how the organisation will respond if they happen.

7.3 Incident Categories

7.3.1. Grouping incidents into categories assists with incident management and facilitates reporting, analysis and learning. The 7 incident categories used by the GOC are set out in Appendix 5.

[4]

7.4. Communication and Data Protection

7.4.1. In the event of a serious incident Council and the appropriate relevant agencies must be informed either prior to, or at the same time as filing the Charity Commission online form. Depending on the nature of incident, appropriate relevant agencies may include the Professional Standards Authority and Department of Health and Social Care. Any decisions regarding the requirement to inform other agencies will be taken by the Chief Executive in consultation with the Chair of Council. For serious data breaches requiring reporting to the Information Commissioner's Officer, reporting must be made within 72 hours of being first alerted to the incident. Please refer to the Information Governance Handbook for further details about the process and paperwork.

7.4.2. Serious or significant incidents may lead to a high level of media attention, and not only in the immediate aftermath. Communications are a vital element in supporting and delivering effective management of incidents. Therefore, any media requests must be directed to the Communications Team.

7.4.3 The GOC must comply with data protection requirements at all times. Incident reports should not normally refer to individuals by name or other using other identifiable personal information. Records of communication with individuals about the incident should be kept separately. In some circumstances it may be necessary to identify individuals, for example when reporting incidents in the public interest or if there are mandatory external reporting requirements. In such circumstances, full and unredacted access to incident reports will only be granted on a need-to-know basis.

7.5 Openness and Transparency

7.5.1. Information relating to incidents including internal reports and root cause analysis are subject to requests under the Freedom of Information (FOI) Act. All requests for information regarding incidents will be handled and responded to as per statutory FOI requirements.

7.5.2 This policy requires that all incidents are assessed and if it is believed that the incident is likely to result in a high risk of adversely affecting the individuals' rights and freedoms the individual must be informed without undue delay.

7.6 Reporting

7.6.1 Incidents assessed 'Insignificant' or 'Minor' will be reported to ARC as part of its regular incident and exceptions report on a quarterly basis, as per its terms of reference. Where a significant incident occurs is assessed as 'Moderate' or 'Major', Council and the ARC will be kept informed. A report will be provided to the next scheduled meeting of ARC. Serious incidents must be reported to Council.

7.6.2 In order to ensure lessons are shared across the organisation, the Head of Governance will:

- review the draft report and assess any immediate cross-organisational implications;
- monitor the completion of agreed actions arising out of incidents; and
- update the incident log with findings, corrective actions and completion dates.

The Head of Governance will assist risk owners in identifying lessons that can be learned from incidents. The Head of Governance is also responsible for analysis of incidents across the organisation, drawing out themes or patterns. Findings from analytic work will be provided to the SMT and Leadership Team on a quarterly basis.

This report will also include, by exception, details of any actions from previous incidents which have not been completed within timescales.

7.7 Sharing of Lessons Learned

7.7.1. It is the responsibility of heads of departments to ensure that there are systems in place to deliver local learning from incidents, either through information being cascaded or relayed across teams.

7.7.2 The Head of Governance will engage with all staff to deliver cross-organisational learning through channels such as IRIS/SharePoint.

Training requirements

8.1. New staff, members and workers will be made aware of their responsibilities for incident reporting as part of the corporate induction.

8.2. The policy does not have a specific, required training component.

Monitoring and compliance

9.1 The Head of Governance is responsible for monitoring and reporting on compliance with this policy.

9.2 Breaches of this policy will be reported to SMT and ARC. A breach where a serious incident is not appropriately reported to the Charity Commission or other relevant authorities is a significant incident and should be subject to investigation.

9.6. The Director of Corporate Services will meet with the Head of Governance every six months to review the management and response to incidents and near misses.

Associated documentation

10.1. While not an exclusive list, this policy should be read in conjunction with:

- Business continuity plan;
- Anti-bribery statement;
- Risk management policy;
- Never Events Framework
- Speaking Up (Whistleblowing);
- Information governance handbook;
- Information security policy;
- Health and Safety policy; and
- Code of Conduct.

Appendices

Appendix 1 – Charity Commission serious incidents examples table

Appendix 2 – Incident review template

Appendix 3 – Reflective Practice Guidance

Appendix 4 – Root Cause Analysis Guidance

Appendix 5 – GOC Incident Categories

Appendix 1

Charity Commission serious incidents examples table

Appendix 2

Incident review

Click here to enter text.

Incident number: Click here to enter text.

Related risks: Click here to enter text.

Incident Impact: Choose an item.

Incident Category: Choose an item.

Introduction

Click here to enter text.

Findings from the incident review

Click here to enter text.

The issues

Click here to enter text.

Recommendations

1. Click here to enter text.

Actions

Action	Due date	By	Date completed
1.	Click here to enter a date.		Click here to enter a date.
2.	Click here to enter a date.		Click here to enter a date.
3.	Click here to enter a date.		Click here to enter a date.
4.	Click here to enter a date.		Click here to enter a date.
5.	Click here to enter a date.		Click here to enter a date.

Signed

Click here to enter text.

Click here to enter a date.

Appendix 3 - Reflective Practice Guidance

1. Introduction

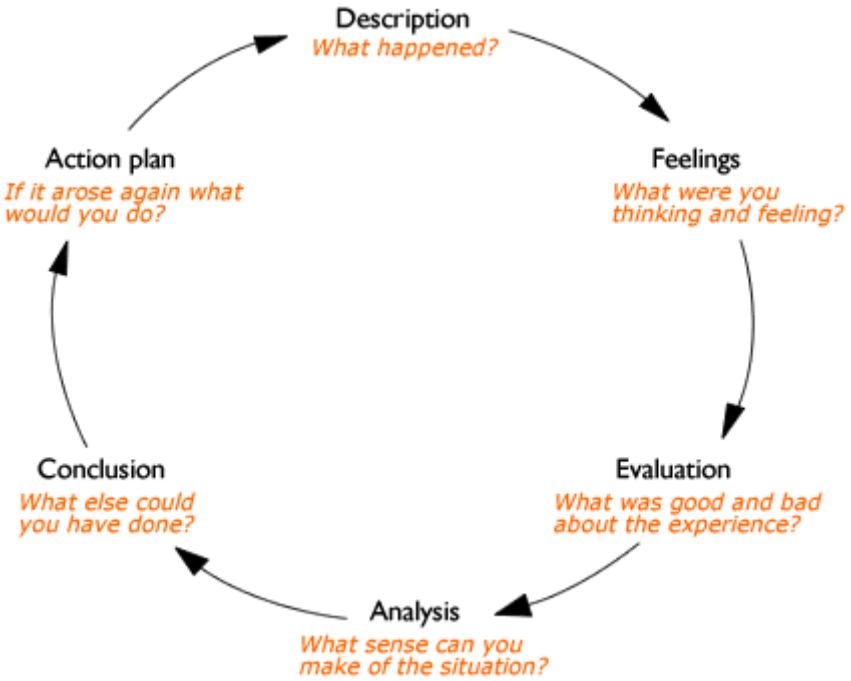
1.1 Personal reflection can help staff consider the difference between what they were thinking at the time of the incident and what has been learned looking back after the event to help them think differently if something similar happens in the future.

1.2 It is important to remember that this type of review is only appropriate for the least serious incidents – i.e. those with an impact rated Insignificant or Minor.

2. The Reflective Cycle

2.1 The reflective model adopted by the GOC for learning from incidents is based on a cycle, in which experience directly contributes to shaping a person's future actions. This is outlined below.

2.2 Also provided here is a template for capturing both the learning and the benefit to be gained from it. There is no obligation to use this document, though managers may wish to encourage their staff to do as part of the Performance Development process.



Name:	Date:
Job Title:	Department:
Brief Description of the Incident:	
1. What were you thinking and feeling at the time the incident happened?	
2. What was positive and negative about the experience?	
3. Can you make sense of the incident, and would other people agree with your analysis?	
4. What alternative actions could you have taken?	
5. If the situation happened again, what would you do?	

Appendix 4 - Root Cause Analysis Guidance (The 5 Steps)

Create the Problem Statement

The Problem Statement describes clearly the gap between what happened and what should have been achieved. It should include:

- the Focal Point (a one sentence description of the problem being investigated) / the date and time of incident / where the incident happened, and the system and process involved / what was the actual impact of the incident / what could the potential impact have been

A high quality Problem Statement contains a good level of detail and does not stray into mentioning any solutions (those come later)

Gather and Manage Data

Gather as much data as possible – this will yield causes and supporting evidence
Data can be time sensitive – gather it as soon as possible after the incident
Not all evidence is equal – high-quality evidence tends to be objective (documents, emails, computer logs) – the more subjective the evidence is (personal recollections, uncorroborated statements, etc) the lower its quality and less it should be relied upon.
All data/evidence collected must be stored securely so that it is not tampered with, destroyed or damaged
Good data storage should enable easy access for those who need it
Remember – there may be legal reasons for retaining evidence.

Analyse Cause and Effect

RCA uses a Causes & Effect chart to visually present causes and their logical relationships - this helps demonstrate the interaction of causes, effects and evidence, and help find solutions

There is no set methodology in RCA for ascertaining cause and effect, though a common technique is to use the '5 Whys' (repeatedly asking the question "why" until reaching a point where all of the issues are fully understood)

Generate Solutions

Clearly show how the proposed solution will eliminate the problem, and why this is the best course of action for the organisation to follow
Ensure there is a plan to monitor the implementation of the solution and the effect it is having – *without checking, how can the organisation be confident it has fixed the problem?*

Produce the Final Report

There will likely be a number of options available to address the identified root cause(s) - in considering which to recommend, think about the effectiveness, ease of implementation, cost/benefit, and any potential negative consequences of the possible solutions

Recommendations should address all root causes identified by the process and concentrate specifically on eliminating or reducing the likelihood of recurrence

Solutions should be SMART – Specific, Measurable, Achievable, Realistic and Timebound

Appendix 5 – Incident Categories

1. Health and Safety (including accidents and fire)

Examples of the sort of incidents that would be reported under this type are:

- Accidental injury
- Contact with or exposure to hazards
- Fires including false alarms
- Moving and handling
- Slips, trips and falls by service users, staff members and visitors

2. Security incidents

Security incidents include any incident that involved theft, loss or damage to organisation or personal property, such as:

- Deliberate damage to equipment, property and vehicles
- Loss or theft of equipment, property and vehicles
- Intruder alarms including false alarms
- Breaches of security

3. Violence and aggression incidents

Examples of incidents falling within this type of incident would include:

- Aggressive behaviour, physical assaults, verbal abuse.
- Harassment/inappropriate behaviour including sexual and racial

4. Information governance: confidentiality breaches, records management

Examples of these incidents are:

- Unauthorised or inappropriate disclosure of confidential service user information, (accidental or deliberate).
- Unavailability of records, missing or destroyed records
- Inaccurate information
- Breach of computer password security
- Loss or damage to Human Resources records
- Disclosure of staff information, accidental or deliberate

5. Information Technology (IT) incidents

Examples of reportable IT incidents are:

- IT system failures
- Network / system security
- Malware
- Loss of electronic data
- Unauthorised access or misuse of IT systems
- Inappropriate use of IT and Internet facilities, e.g. accessing pornographic/obscene material

6. Regulatory delivery

These incidents include:

- Breach of organisational policy
- Integrity of the register

- Illegal acts including legal challenge to GOC.

7. Other incidents

Wherever possible, incidents should be included as one of the above types. However these lists are not exhaustive and sometimes an incident will occur that does not apply to these types and included as ‘other’. Examples of might include:

- Financial loss
- A number of staff becoming unwell during working hours
- Non-violent / inappropriate behaviour of service user
- Use of illegal substances/drugs on GOC premises.

Significant preventable events framework

Status of document: Draft
Version: v2.0
Date of approval: TBC
Effective from: TBC
Owner: Audit, Finance and Risk Committee
Author: Chief of Staff
Planned next review date: Approval + three years

1. Purpose

1.1 This framework describes the events that the GOC has defined as being outside its risk tolerances in relation to public protection or impact to public confidence in our ability to regulate. It outlines the related policies that inform the identification, reporting and response to significant preventable events.

2. Scope

2.1 This framework applies to all who work on behalf of the GOC. The following teams will incorporated the framework into the induction of their new staff:

- Case Progression
- Governance (Chief of Staff and managers only)
- Investigations
- Hearings
- Fitness to Pracise (FTP) Legal
- Legal
- Registration
- Senior Management Team (SMT)

2.2 This framework should be read in conjunction with the following policies and procedures:

- Freedom to speak up policy for employees, member and workers
- Risk management strategy and policy
- Significant incident policy

3. Background

3.1 This framework was previously named the 'GOC never-event framework'. However, a review of the national policy environment in relation to never-events has led to the framework being retitled. This is to avoid confusion with NHS never-events or any subsequent reform of the NHS never-event framework. It also has been amended to increase an emphasis on the GOC's duty of candour, and to ensure that staff speak up when events occur.

3.2 In revising the framework we have moved away from describing a set of operational events to a framework that emphasises reducing risk to public protection. The framework is constructed to outline the events we consider outside our tolerance of risk. These events are likely to have a significant impact on public confidence in respect to our ability to regulate.

4. Definition

4.1 We define a significant preventable event as a public protection issue that was entirely in our control to prevent. This is an event that impacts public protection which effective management controls should prevent from happening. It does

not cover all public protection events. This is particularly the case where we had no control over events or limited chance to intervene from a regulatory perspective prior to harm occurring.

4.2 The types of incidents defined as significant preventable events have been identified using the following criteria:

a. significant / serious patient safety implications;

b. high level of reputational risk;

c. scored 5 on the risk impact scale (annex one); and

d. within the GOC's operational control to prevent.

4.3 In practical terms, the significant preventable events we describe will be a consequence of something we have failed to do or has not done within a required timescale.

4.4 We have identified four significant preventable events:

a. No student registrant, qualified registrant or body corporate will be registered, renewed or restored unless all required qualifications, CPD, identity checks, documentary evidence and fitness to practise suitability checks have been completed and verified.
b. No registrant whether student or fully qualified individual or body a corporate will be suspended or removed from the register without approval and appropriate checks by an appropriate manager
c. No Fitness to Practise Committee order (substantive or interim) should lapse; expire; or fail to be reviewed due to a scheduling issue without an authorised decision being made that it is no longer necessary and/or that a review is not required; and
d. All registration status changes following a substantive or interim hearing, including any appeal outcome that results in a change to registration status to be updated within three working days of the hearing concluding, or the appeal outcome being determined.

4.5 These events are ones that are entirely in our control as a regulator. Our internal control environment should be designed to prevent them from happening. We have excluded events where the GOC had the opportunity to influence events to reduce public protection risk, as these are covered by our wider risk assessment processes. The policy will be regularly reviewed to ensure it accurately captures the events we consider preventable. The GOC is also at risk of significant events, which may be preventable or unpreventable, but would require an immediate emergency response from the organisation. For example, these could include (but are not limited to):

a. Severe data loss as result of a cyber-attack or other unforeseen circumstances;

b. Serious misconduct by a senior leader in the organisation, leading to an arrest;
c. High profile incident or incidents that impact public confidence in the GOC's ability to adequately protect the public;
d. Anything identified as a serious incident by Charity Commission guidance and therefore requiring a report to the regulator
e. A Fitness to Practise Committee does not extend a substantive order within the required timeframes due to procedural issues (which are not scheduling related)

4.5 The GOC operates a significant incident policy which sets out its organisational response to any issue that might qualify as significant, regardless of whether it is preventable or not.

5. Responsibilities

All employees

5.1 Employees should be familiar with the significant incident policy and the freedom to speak up policy for employees, members and workers. All employees in the named departments in paragraph 2.1 must ensure that they are familiar with the significant preventable events framework.

5.2 Employees should comply with any management direction, internal control or standard operating procedure intended to stop a significant preventable event from occurring.

5.3 Employees have a duty to identify and report any suspected significant preventable events or significant events. Failure to knowingly do so or to attempt to conceal an issue is likely to be considered a disciplinary matter.

Managers/heads of department

5.4 Managers and heads of department are responsible for ensuring the internal control environment in their department is designed to stop significant preventable events from occurring.

5.5 Managers and heads of department have a responsibility to regularly review the management checks and ensure they are fit for purpose. The regularity of these reviews will be determined by the relevant director.

5.6 Managers and heads of department are responsible for establishing a culture of trust and encourage reporting from all staff. This includes an understanding of their specific responsibilities under the freedom to speak up policy for employees, members and workers.

Chief of Staff

5.7 The Chief of Staff is responsible for working with colleagues to develop the framework for review by Senior Management Team (SMT) and Audit, Finance Committee (ARC), prior to approval by Council.

5.8 The Chief of Staff is responsible for developing a significant incident policy, for review by Senior Management Team (SMT) and Audit, Finance Committee (ARC), prior to approval by Council.

5.9 The Chief of Staff is responsible for coordinating departments to ensure reporting is timely and accurate to the relevant external stakeholders (including the Professional Standards Authority (PSA), Charity Commission and Information Commissioner's Office where appropriate).

Directors

5.10 Directors will be responsible for overseeing the internal control environment created by managers and heads of department to stop significant preventable events from occurring.

5.11 Directors are responsible for promoting a culture consistent with the freedom to speak up policy for employees, members and workers. This includes ensuring that there is a consistent emphasis on the duty of care and the duty of candour within their directorates.

5.12 Directors will set 'the tone at the top' by ensuring that there is a clear focus on stopping significant preventable events from occurring, and reducing the risk of other significant events taking place.

5.13 Directors will be responsible for ensuring that any lessons learnt from a significant preventable event are implemented.

5.14 Directors will be accountable to the Chief Executive and Registrar for any significant preventable events that occur in their areas of responsibility.

5.15 Directors with no direct responsibility for areas identified at risk of significant preventable events have a duty to cooperate and coordinate with their peers to ensure that the corporate environment stops preventable events from occurring. This includes playing an enabling role through the appropriate corporate services and mechanisms, such as IT, Finance or People and Culture.

Chief Executive and Registrar

5.16 The Chief Executive and Registrar is accountable to Council in respect to the significant preventable event framework. The Chief Executive and Registrar is also responsible for promoting a culture of candour and enabling staff to have the freedom to speak up.

6. Identification and reporting of a significant preventable event

6.1 The person who identifies that a significant preventable event has occurred is responsible for immediately reporting the incident to their head of department and director. For the purposes of reporting, suspected significant preventable events must be clearly identified as such, even if the status is uncertain at rthe time of report.

6.2 Due to the risk implications associated with significant preventable events, the director with responsibility for the area in which the incident occurred will assume the role of the risk owner. In the event the incident relates to areas in which more than one director has responsibility, the risk of owner responsibility will be shared.

6.3 The process for assessing and responding to a suspected significant preventable event is set out in the significant incident policy.

6.4 Council and ARC will be informed by the Chief of Staff if a significant preventable event has occurred. A detailed report will also be included in the quarterly significant incidents and exceptions report to ARC. Communication with stakeholders will be determined as part of the operational response. The GOC will uphold its duty of candour and ensure that all preventable significant events are reported to the PSA. A summary of significant events (preventable or otherwise) will be included in the annual report along with a summary of any remedial action and lessons learned.

7. Failure to report a significant event

7.1 This framework is designed to provide employees with clarity on their responsibilities and what to do if a significant preventable event happens. It is important that we all work in a culture where openness, transparency and learning from the incident are key.

7.2 A failure to report a significant event (preventable or otherwise) can signal regulatory, cultural and safety failings in an organisation. In some circumstances, it may not be apparent that an incident is a significant preventable event until there has been some degree of investigation. In these circumstances, the possibility that a significant preventable event has occurred should still be reported as soon as it is identified.

7.3 Failure to report a significant event should be thoroughly investigated to understand what prevented the recognition and reporting of the incident.

7.4 If the failure to report was a deliberate act, this is likely to constitute a serious failing by employees involved. Such matters will be considered under the GOC's disciplinary policy.

Serious and significant incidents policy

Status of document:	Draft
Version:	2
Date of approval:	TBC
Effective from:	TBC
Owner:	Council
Author:	Chief of Staff
Planned next review date:	Approval date + five years

1. Purpose

1.1 This policy describes how the GOC will identify and manage significant and serious incidents. The policy:

- provides a consistent definition of a serious incident, a significant incident, near miss, and significant preventable event;
- describes the relevant roles and responsibilities;
- sets out the process for notification, management, reporting requirements and timescales;
- provides direction to ensure that all incidents are reported appropriately, and that lessons learned from analysis of the event are shared with relevant departments, stakeholders and individuals.

2. Scope

2.1 This policy applies to:

- employees (whether permanent or temporary);
- members;[1]
- workers; and
- contractors working with, or on behalf of, the GOC.

2.2 Compliance with this policy is mandatory. Non-compliance for employees and workers may be considered a disciplinary matter. Non-compliance for members is a breach of the code of conduct.

2.3 If you require further advice and guidance, you should contact the Chief of Staff at amackaysim@optical.org. All requests for advice will be treated in confidence.

3. Definitions

3.1 **Serious incident:** As a charity, the GOC has a responsibility to manage and report serious incidents in accordance with guidance issued by the Charity Commission. The definition provided by the Charity Commission is:

'A serious incident is an adverse event, whether actual or alleged, which results in or risks significant:

- *harm to your charity's beneficiaries, staff, volunteers or others who come into contact with your charity through its work (who are collectively referred to throughout this guidance as people who come into contact with your charity through its work)*
- *loss of your charity's money or assets*
- *damage to your charity's property*
- *harm to your charity's work or reputation.[2]'*

[1] Members are appointed by the Privy Council (in the case of Council Members) or via the Council's appointment processes for committee members. This term commonly applies where individuals are a member of a committee or Council, regardless of employment status.

[2] https://www.gov.uk/guidance/how-to-report-a-serious-incident-in-your-charity

Appendix 1 sets out examples of what the Charity Commissions considers reportable serious incidents. However, it is not intended as an exhaustive list.

3.2 **Significant incident:** For the purposes of this policy, a significant incident does not meet the threshold for reporting as a serious incident to the Charity Commission. However, it is an incident that is either outside the organisation's risk tolerance, or close to breaching that tolerance. This is likely to be any event where the impact is considered 'major' or 'catastrophic' within the GOC risk management strategy and policy. Some categories relating to significant incidents are enclosed in appendix 2. However, it is not intended as an exhaustive list.

3.3 **Near miss:** a high-risk event, where it appeared initially to be a significant or serious incident, though the risk did not materialise into an issue.

3.4 **Significant preventable event:** a public protection issue that was in our control to prevent. This is an event that impacts public protection which effective management controls should prevent from happening. The significant preventable event framework provides definitions and should be read in conjunction with this policy.

4. Responsibilities

4.1 Chair of Council and Council Members

4.2 As trustees, the Council has a duty to report any serious incidents to the Charity Commission. It has delegated the management of significant and serious incidents to the executive via the Chief Executive and Registrar. It has delegated reporting to the Chief of Staff. Reporting and receiving assurance following a serious or significant incident has been delegated to Audit, Finance and Risk Committee (ARC) with a clear line of escalation to Council where concerns are substantial enough to warrant it.

4.3 Chief Executive and Registrar

4.4 The Chief Executive and Registrar has overall responsibility for ensuring that the GOC has in place a robust incident reporting and management framework, ensuring that:

- there is an emphasis on a duty of candour and a freedom to speak up culture;
- internal controls are focussed on preventing risks becoming issues;
- resources are prioritised to respond to issues; and
- lessons learned are shared across the organisation.

4.5 The Chief Executive and Registrar is accountable to the Council in respect to the prevention and management of significant incidents.

4.6 The Chief Executive and Registrar will be responsible for activating the incident management procedure and convening the first meeting of the Strategic Command Group (SCG). This can be done by another member of SMT or the Chief of Staff in an emergency.

4.7 Senior Management Team

4.8 As the executive board, the SMT is responsible for ensuring that the structures and culture in the organisation are appropriate to promote management, reporting and

learning from incidents. It also provides leadership as a SCG in the event an incident requires active management.

4.9 Strategic Command Group (SCG)

4.10 The SCG is comprised of the members of SMT and supported by the Chief of Staff. The name applies when the incident management procedure is in place and refers to meetings explicitly convened as part of this procedure and decisions made as part of the significant incident response. The purpose of SCG is to provide the corporate and strategic direction when responding to significant incidents. The SCG will delegate operational oversight of the incident management to the Tactical Coordination Group (TCG).

4.11 The SCG convenes when the incident management procedure is activated. It determines the scope of the TCG, the frequency of SCG meetings and any reporting requirements. The SCG approves the step-down of the procedure when the incident has been successfully managed.

4.12 Tactical Coordination Group (TCG)

4.13 The Tactical Coordination Group will be comprised of heads of service with the relevant corporate remits to manage a developing incident. The type of incident and associated risks will define the membership of the TCG and will be subject to approval by SCG. This will include, but not be limited to:

- Chief Financial Officer (if required)
- Chief Legal Officer (if required)
- Chief of Staff
- Head of Communications
- Facilities Manager (if required)
- Head of People and Culture (if required)
- Head of IT (if required)
- Risk owner
- Other heads of department as judged appropriate

4.14 The TCG will be convened by SMT/SCG and expected to provide SMT and the risk owner with additional operational capacity, corporate coordination and support. The TCG will disband at the direction of SCG once the incident has been managed and the process has been stepped down to the review phase. TCG members may participate at the review stage as required.

4.15 Directors

4.16 Individual directors are responsible for ensuring:

- that the content of this policy is followed in their area of responsibility;
- that their directorates have established adequate internal controls to reduce the risk of significant or serious incidents;
- that learning from incident reporting is shared appropriately to encourage learning in their area of responsibility; and

- that staff training needs identified in the application of this policy are met to ensure improvement.

4.17 Chief of Staff

4.18 The Chief of Staff will ensure that there is an appropriate and effective incident management framework, including but not limited to:

- assessment of whether an issue meets the relevant criteria for a serious or significant incident;
- arrangements for record keeping and reporting;
- documented policies, procedures and guidance;
- appropriate training and support made available and delivered; and
- adequate resources are made available for the operation of this policy.

4.19 All persons in scope of this policy

4.20 All persons listed in the scope of this policy are responsible for:

- familiarising themselves with its contents;
- complying with all reasonable instructions issued by the SCG or TCG: and
- highlighting to their line manager any training they feel they require.

4.21 Person identifying the incident

4.22 At all times, the safety of the public, employees, members and workers is of primary importance. As a first step, the person identifying the incident should take immediate action to ensure that they and others remain safe.

4.23 The incident should be reported as soon as is possible so appropriate advice can be sought. Reporting should be directed to the Chief of Staff (amackaysim@optical.org). The person reporting should also inform their line manager, relevant risk owner and director.

4.24 Risk owners

4.25 An incident is a risk that has actualised. The priority for the owner of the risk to which the incident relates is ensuring the appropriate steps are taken to manage the incident in line with the policy and then completion of any necessary recovery work.

4.26 The expectation is that the risk owner will fully participate in the incident management and reporting processes, and seek the necessary advice, guidance and support from the TCG and Chief of Staff. The risk owner will be accountable to the TCG in terms of regular reporting and keeping the necessary parties informed during the incident management procedure.

4.27 The risk owner should also ensure that any required updates are undertaken following the incident and investigation findings.

5. Process

5.1 Incident Management

Step-up of the incident management process

5.2 Upon notification of an incident, the Chief of Staff and risk owner will use the risk scoring in the corporate and departmental risk registers as a means of assessing the severity of the risk. The rating of the incident should be consistent with the risk matrix and appetite contained in the GOC risk management policy. The risk scoring should inform the Chief Executive and Registrar's decision to implement the incident management process, alongside the professional judgement of the risk owner and Chief of Staff

5.3 The extent to which this procedure is followed will determined by the following:

- the likelihood of an extended disruption due to an incident;
- the risk to the public, member, workers and employees; and/or
- the extent to which the GOC is exposed to reputational, financial or legal risk.

5.4 The SCG will be responsible for determining the terms of reference for the TCG, the regularity by which both the SCG and TCG will convene and the necessary reporting requirements. This will be proportionate to how the situation is developing. Examples might include:

- a weekly SMT meeting with TCG meeting daily;
- both SMT and TCG meeting daily; or
- alternate days for SCG and TCG meetings.

5.5 This will be kept under review throughout the incident management process and can be altered as best suited to assist workflow and developments.

5.6 The Chair of Council, Chair of ARC and Senior Council Member will be kept apprised of when the incident management procedure has been activated by the Chief of Staff. The Head of Communications will establish what member, worker and employee communications are required throughout the course of the incident.

Step-down of the incident management procedure

5.7 SCG will be responsible for approving the stepping down of the incident management procedure. The TCG will disband once this procedure is stepped down.

5.8 Investigation

5.9 Investigations will be commissioned by the Chief of Staff on behalf of the Chief Executive and Registrar. The nature and extent of the issue will determine the investigation methodology and reporting arrangements. Upon being asked by the Chief of Staff to undertake a review, the investigating officer will coordinate an investigation to identify the factors that were likely to have led to the incident. The investigating officer should liaise with the risk owner to ascertain what, if any, corrective actions are required to prevent the incident from recurring.

5.10 Findings, lessons learnt and remedial actions should be reported to the SMT. SMT is responsible for tracking the implementation of any recommendations. An outcome summary will also be provided to ARC following the conclusion of any investigation or review.

5.11 On occasions there may be other considerations, such as potential management action, where the commissioning of the review and consideration of the subsequent

report may be limited to the Chief Executive and Registrar (or Chair of Council in exceptional circumstances). In such cases the investigation report would be on limited circulation. The Chief of Staff will coordinate communication in such instances.

5.12 Communication and Data Protection

5.13 In the event of a serious incident, Council and the appropriate relevant agencies must be informed either prior to, or at the same time as filing the Charity Commission online form. Depending on the nature of incident, appropriate relevant agencies may include the Professional Standards Authority and Department of Health and Social Care. Any decisions regarding the requirement to inform other agencies will be taken by the Chief Executive and Registrar in consultation with the Chair of Council. For serious data breaches requiring reporting to the Information Commissioner's Officer, reporting must be made within 72 hours of being first alerted to the incident. The GOC's information governance policies contain further details about the process and paperwork.

5.14 Serious or significant incidents may lead to a high level of media attention, and not only in the immediate aftermath. Communications are a vital element in supporting and delivering effective management of incidents. Therefore, any media requests must be directed to the Communications Team.

5.15 Duty of Candour

5.16 The GOC has a duty of candour in how it identifies, manages and reports on significant incidents. It is committed to improving standards in public administration, particularly where it has the opportunity to learn from unforeseen issues and risks. This duty must be upheld by anyone named within this policy, or working with the GOC.

6. Training requirements

6.1 New staff, members and workers will be made aware of their responsibilities for incident reporting as part of the corporate induction.

6.2 All lessons learnt reviews will identify learning points which will be accommodated into training for the teams and individuals likely to benefit from the information.

7. Monitoring and compliance

7.1 The Chief of Staff is responsible for monitoring and reporting on compliance with this policy.

7.2 Breaches of this policy will be reported to SMT and ARC. A breach where a serious incident is not appropriately reported to the Charity Commission or other relevant authorities is a significant failure of internal controls and should be subject to investigation.

8. Associated documentation

8.1 While not an exclusive list, this policy should be read in conjunction with:

- Business continuity plan;
- Anti-fraud policy and response plan;

- Risk management policy;
- Significant preventable events framework;
- Freedom to speak up policy for employees, members and workers;
- Information governance handbook;
- IT policy;
- Health and Safety policy; and
- GOC member code of conduct.

9. Review of this policy

9.1 Governance will be responsible for reviewing this policy every three years, considering new or changes to legislation and regulations as well as best practice before presenting it for consideration by SMT and ARC and approval by Council.

Appendices

Appendix 1 – Charity Commission serious incidents examples table

Appendix 2 – Incident categories

Appendix 1

Charity Commission serious incidents examples table

Appendix 2 – Incident Categories

1. Health and Safety (including accidents and fire)

Examples of the sort of incidents that would be reported under this type are:

- Accidental injury
- Contact with or exposure to hazards
- Fires including false alarms
- Moving and handling
- Slips, trips and falls by service users, staff members and visitors

2. Security incidents

Security incidents include any incident that involved theft, loss or damage to organisation or personal property, such as:

- Deliberate damage to equipment, property and vehicles
- Loss or theft of equipment, property and vehicles
- Intruder alarms including false alarms
- Breaches of security

3. Violence and aggression incidents

Examples of incidents falling within this type of incident would include:

- Aggressive behaviour, physical assaults, verbal abuse.
- Harassment/inappropriate behaviour including sexual and racial

4. Information governance: confidentiality breaches, records management

Examples of these incidents are:

- Unauthorised or inappropriate disclosure of confidential service user information, (accidental or deliberate).
- Unavailability of records, missing or destroyed records
- Inaccurate information
- Breach of computer password security
- Loss or damage to Human Resources records
- Disclosure of staff information, accidental or deliberate

5. Information Technology (IT) incidents

Examples of reportable IT incidents are:

- IT system failures
- Network / system security
- Malware
- Loss of electronic data
- Unauthorised access or misuse of IT systems
- Inappropriate use of IT and Internet facilities, e.g. accessing pornographic/obscene material

6. Regulatory delivery

These incidents include:

- Breach of organisational policy
- Integrity of the register
- Illegal acts including legal challenge to GOC.

7. Other incidents

Wherever possible, incidents should be included as one of the above types. However these lists are not exhaustive and sometimes an incident will occur that does not apply to these types and included as ‘other’. Examples of might include:

- Financial loss
- A number of staff becoming unwell during working hours
- Non-violent / inappropriate behaviour of service user
- Use of illegal substances/drugs on GOC premises.

C45(26)

COUNCIL

General Optical Council

Education: Annual monitoring & reporting 2026: UK optical education report

Meeting: 30 September 2026 **Status:** For noting

Lead responsibility: Steve Brooker (Director of Regulatory Strategy)
Paper Author(s): Ben Pearson (Education Policy Manager)

Purpose

1. This paper presents the annual monitoring & reporting (AMR) 2026: UK optical education report for the academic year 2024/25, which forms a key public output of the Approval and Quality Assurance (A&QA) cycle undertaken by the Education department.

Recommendations

2. Council is asked to:
   - Note the update and consider the report (annex one).

Strategic objective

3. This work contributes towards the achievement of the following strategic objective: Preventing harm through agile regulation.

Background

4. Annual monitoring & reporting (AMR) is one of our quality assurance (QA) activities, alongside our quality assurance visits, notification of reportable events and changes to qualifications, and conditions management.

5. The AMR enables us to carry out sector-wide analysis of GOC approved qualifications and routes to registration, to identify key themes, trends and risks. Whilst we already require providers to notify us about key events and changes throughout the year, AMR is a mechanism that enables these notifications to be verified and considered against the broader context. The AMR 2026 UK optical education report contextualises information provided by providers of GOC approved qualifications in their annual monitoring return forms with external policy developments and findings from GOC surveys.

6. The information in the AMR report is organised into five broad sections, aligned to our desired high-level outcomes, which are:
   - Outcome 1 – Sufficient students to meet patient needs
   - Outcome 2 – Qualifications equip registrants to deliver safe and effective eye care for all

- Outcome 3 – High levels of student satisfaction and welfare
- Outcome 4 – A strong, innovative and resilient sector
- Outcome 5 – Post-registration qualifications support registrants to deliver a wide range of eye care services in communities.

7. Following Council, and prior to publication, we will send copies of the AMR report to all providers for a factual check. Any significant changes will be reported to Council.

8. The publication of the AMR sector report and distribution of qualification reports to providers will close the 2024/25 AMR cycle.

Analysis

9. The key findings from this year's AMR include:

Student applications and recruitment

10. Student applications and recruitment remain strong, with evidence of continued demand and expanding capacity across optical education. Optometry admissions increased by 16.3% for 2025/26 compared with 2024/25 admissions data, while dispensing optics admissions rose by 46.6%. Optometry remains competitive, with providers admitting an average of 18.8% of applicants and median academic offers remaining broadly equivalent to AAB at A-level. Planned new qualifications, including two new optometry Masters' degrees and a dispensing optics apprenticeship, should support further growth, although this will need to be balanced against placement, supervision and academic staffing capacity. The number of trainees on independent prescribing (IP) qualifications rose from 415 in 2023/24 to 580 in 2024/2025. The number of trainees on contact lens optics (CLO) qualifications decreased by 26.8% to 41 trainees in 2025/26 (a 114.6% drop over the last three years).

Attainment

11. Attainment is generally positive, with an average of 96.7% of optometry students receiving a 2:2 degree, whilst for DO's an average of 83.3% of students exiting with a degree were awarded a 2:2 or above. However, there are differences in attainment by gender, age and ethnicity, with statistical testing suggesting that some differences are unlikely to be due to random variation alone.

Progression

12. The average proportion of Year 1 optometry students progressing to Year 2 has increased by 4 percentage points to 82.8% (78.8% in 2023/24). For DOs, 97.3% of students with the largest DO provider (comprising approximately 87% of DO students in the first-year cohort) progressed to second year. Attrition also appears to be reducing, with the proportion of optometry students not completing within a single cohort (i.e. leaving between the start and end of the expected qualification duration or

retaking final year assessment(s)) falling to 20.4% (24.5% in 2023/24) with Year 1 exit rates falling to 4.7% (6.4% in 2023/24). DO student progression is strong at the largest provider, though qualifications with significantly smaller cohorts show more variation.

Student satisfaction

13. Student satisfaction in optometry is broadly strong, with 2025 National Student Survey (NSS) scores above subjects allied to medicine in all categories, except learning resources (-1.2%pt). Scores in all categories except teaching (-1.3%pt) are higher than last year. For DO qualifications, participation in the NSS was limited to one of the smaller GOC approved providers in terms of student numbers and so for this reason we are not presenting NSS data this year.

Resourcing and investment

14. The sector is investing significantly in expansion and innovation, including new qualifications and apprenticeship routes and upgrades to clinical facilities including modernised teaching environments and installation of new technology. Providers are expanding relationships with NHS bodies, hospitals, community practices, high-street providers, local authorities, charities and professional bodies to secure placements and diversify student experience with patients.

Finance

15. There are no budget recommendations to approve with this item.

AMR Development

16. The AMR process is in continuous development, and each year we make refinements and improvements of the AMR process.

17. The findings, analysis, and outcomes of this year's AMR process will inform the education team's approval and quality assurance activities and used to develop policy and to inform implementation processes.

18. We continue to consider all feedback received from stakeholders regarding this year's AMR process and will use this to refine the AMR process for next year.

Equality Impacts

19. Providers were asked to submit EDI data and widening participation information used to inform the development of access and participation plans and initiatives in operation.

20. We have continued to request EDI data for admissions, progression and attainment relating to gender, age, ethnicity, and disability. Some providers consider this

burdensome, so we are reviewing our approach to ensure we collect information in a proportionate way. Where possible, we will use data from providers and student registrants collected in our registration processes.

21. Changes in data collection and our new data science capability have enabled a UK-wide EDI analysis for the first time. Overall, statistical testing in respect of gender, age, and ethnicity suggests that some differences identified in progression and attainment are unlikely to be due to random variation alone and are therefore likely to represent genuine differences in outcomes. However, we will wish to review next year's data before confirming any pattern and further analysis is required to understand reasons for those differences. Not all providers were able to provide the full data requested. The main reason given for this is low numbers where there is a risk individuals could be identified and internal threshold reporting policies are in place.

22. On average, like previous years, most optometry students are Asian, female, and aged 20 and under. Most DO students are white, female, and aged 30 and over. Over the past four years, for both optometry and DO qualifications, there has been a gradual increase in the percentage of female students.

23. Providers were asked to submit widening participation information used to understand progression and attainment patterns across different student groups and inform the development and enhancement of access and participation plans, EDI monitoring, and targeted support. Interventions such as reasonable adjustments, mentoring and financial support have been put in place to ensure students from different backgrounds can progress towards meeting the outcomes for registration.

Devolved nations

24. There are no specific impacts of the AMR on devolved nations.

Communications

25. We intend to discuss the strategic implications of the report's findings at the next EdCom meeting.

Next steps

26. The next steps are as follows:

October 2026	Finalise & publish sector report for 2024/25 academic year
October 2026	Refine and finalise 2025/26 AMR process & documentation
October 2026	Start the procurement process for the longitudinal research to measure the effectiveness of the GOC's education and training requirements
November 2026	2025/26 AMR form and guidance sent to providers
January 2027	Deadline for 2025/26 AMR form returns

Attachments

Annex one: Annual monitoring & reporting 2026: UK optical education report (for the 2024/25 academic year)

General Optical Council

Annual monitoring & reporting 2026: UK optical education report

Published November 2026

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Overview: the sector at a glance

GOC approved qualifications and qualifications approved as 'approved training establishments' (stage 4 applications for approval)

Qualification type	Number of providers	Number of approved qualifications which meet the 'old' QA handbooks	Number of approved qualifications which meet the ETR*
Optometry (OP)	18	22	17**
Independent prescribing (IP)	6	3	3***
Dispensing optics (DO)	7	2	5
Contact lens optician (CLO)	1	0	1

*Includes providers with full GOC approval already adapted to the Education and Training Requirements (ETR) or at stage 4 of the staged application process who have been granted GOC approval to recruit to the qualification.
**Includes two qualifications combining Optom with IP
*** Standalone IP qualifications only, not including combined Optom with IP

Student Numbers

Total students	2022/23	2023/24	2024/25	2025/26
OP*	3,296	3,466	3,448	3,421
IP	521	415	580	N/A**
DO	783	952	1,088	1,054
CLO	59	88	56	41

*excludes those on College of Optometrist's Scheme for Registration due to different term period.
**complete total trainee numbers for IP are unavailable for 2025/26. This figure will be reported in next year's report.

Admissions to year 1	2022/23	2023/24	2024/25	2025/26**
OP	1,039	1,114	1,187	1,381
DO	346	338	305	447

**Student registration data substitutes admissions data which will be supplied to the GOC later in 2026.

2025 National Student Survey (NSS): Average scores by category in optometry and subjects allied to medicine*

* For DO qualifications, participation in the NSS was limited to one of the smaller GOC approved providers in terms of student numbers and so for this reason we are not presenting NSS data for DO qualifications this year.

	Optometry 2024	Optometry 2025	Subjects allied to medicine
Teaching	91.5%	90.2%	86.9%
Learning Opportunities	88.0%	88.2%	84.8%
Assessment and Feedback	80.4%	83.2%	80.5%
Academic Support	89.1%	92.3%	84.8%
Organisation and Management	85.2%	87.1%	69.7%
Learning Resources	86.3%	87.3%	88.5%
Student Voice	79.9%	80.9%	76.9%
Student Union	77.6%	81.9%	79.8%

Average academic offer

UCAS Points	2021/22	2022/23	2023/24	2024/25
OP	134	136	134	134
DO	47	61.3	5 GCSEs (Grade 4-9/ C+)	5 GCSEs (Grade 4-9/ C+)

Average percentage of students exiting the qualification

Students exiting without graduating	2023/24			2024/25		
	Year 1	Year 2	Year 3	Year 1	Year 2	Year 3
OP	6.3%	4.4%	1.4%	4.7%	2.3%	1.0%
DO	4.5%*	1.3%	2.2%	8.6%	0.5%	0.0%

* Largest DO qualification

Strengths, weaknesses, opportunities and threats

SWOT analysis: optical education sector	
Strengths	Weaknesses
Admissions are expanding strongly, with 2025/26 optometry and dispensing optics entrants increasing by 16.3% and 46.6% respectively compared with the closest comparable 2024/25 data. Optometry remains academically competitive, with median offers equivalent to AAB at A-level and application-to-admission ratios indicating continued demand. Student satisfaction is generally strong, with 2025 NSS scores for optometry above subjects allied to medicine in most categories. Progression and attrition indicators for optometry have improved, including higher progression across all three measures and a lower proportion not completing within a single cohort. Attainment remains high, with most optometry students gaining a 2:2 degree or above and a strong Scheme for Registration pass rate of 93.4%. Dispensing optics provides a flexible route into the profession with the new degree level apprenticeship. Sector collaboration remains a key asset, including SPOKE activity, shared work on clinical learning, and supporting ETR implementation. Number of registered independent prescribing optometrists increases by 19.7% to 2,474 (2,066 in 2025).	Statistical testing suggests differences in progression and attainment by gender, age, and ethnicity, but further work is needed to understand the reasons for these differences. Enhanced EDI data is incomplete for some providers, with internal reporting thresholds for small numbers limiting sector-level interpretation Some NSS categories remain comparatively weaker, including assessment and feedback, student voice and students' union. Student welfare and culture remain areas requiring attention, including stress-related absence, harassment, discrimination and confidence in reporting concerns.

Opportunities	Threats
New optometry qualifications at the University of Leicester and De Montfort University, and the dispensing optics apprenticeship at Anglia Ruskin University, provide opportunities to expand capacity and geographical reach. The first integrated optometry and independent prescribing qualifications in Scotland create scope to increase prescribing capability and support enhanced community services. AI and digital health developments provide opportunities to modernise curricula, assessment, AI literacy and preparation for technology-enabled practice. The UK Eye Care Data Hub and streamlined international registration routes can support workforce planning, service design and workforce capacity. Strong interest in new optometry and dispensing optics qualifications could expand capacity further, increase geographical reach and support widening participation.	Financial pressures across higher education could affect the viability, investment capacity or risk appetite of innovation. New and expanding provision may intensify competition for students, placements, supervisors and clinically experienced academic staff. Clinical placement availability remains a key dependency as ETR cohorts progress and more students require supervised patient-facing experience. If differential progression and attainment outcomes are not understood and addressed, inequalities could persist or widen. If welfare, culture, harassment and discrimination concerns are not addressed effectively, confidence in optical education and interest in optical careers could be affected. AI and digital health developments may create risks for academic integrity, assessment security, fairness and safe practice if not managed proportionately.

Key themes: Optical education advances in 2026

1. Optical education is moving forward at pace, with significant progress implementing the Education and Training Requirements (ETR) especially regarding clinical training where the transition to integrated Master's qualifications is now a reality. The College of Optometrist's first Clinical Learning in Practice (CLiP) placements launched in 2025 and 2026, marking a major scaling-up of placement provision, with more than 500 students across multiple UK universities undertaking CLiP placements that embed supervised patient-facing clinical experience within optometry degree qualifications. Optical education is also benefitting from increased capacity with the University of Leicester and De Montfort University (also in Leicester) launching new optometry qualifications in 2026 (following stage 3 approval from the GOC of their respective qualifications), as well as a new dispensing optics apprenticeship launching this year.

2. Artificial Intelligence (AI) is increasingly shaping healthcare and education, and regulators are actively considering how best to respond. We joined five other health and care regulators in publishing a joint statement on the use of AI in professional education and training. The statement emphasises key principles that education providers should consider in the delivery of their qualifications which include accountability, academic integrity, AI literacy, and preparation for practice on the appropriate use of AI. Meanwhile, Ofqual has continued to develop its approach to regulating the use of AI in qualifications, focusing on ensuring fairness for students, maintaining the validity of qualifications, protecting the security of assessments, and maintaining public confidence, while recognising the opportunities that AI presents for innovation, particularly regarding assessments. More broadly, alongside other regulators, we are considering recommendations by the National Commission into the Regulation of AI in Healthcare, which are aimed at creating a coherent, consistent and proportionate approach to AI regulation.

3. We have also started the process of streamlining our international registration routes, following an analysis of potential equivalent non-UK optometry qualifications and qualification systems. The qualification systems in Canada and the USA were assessed as matching or exceeding the ETR, enabling direct entry to the GOC register. Professionals from these countries are already benefiting from the direct access route supporting workforce capacity. In many other cases, applicants will need to complete a short GOC approved qualification designed for graduates/professionals with non-UK optometry qualification(s) prior to joining the GOC register, except for Australia, New Zealand and Ireland, where sufficient clinical experience may be evidenced for direct entry to the register on top of their acquired qualification(s).

4. While progress is evident across many areas, challenges remain. One area of particular concern is the continued prevalence of sexual misconduct in higher

education. The Office for Students (OfS) has published evidence demonstrating the scale of the issue in English higher education and has introduced strengthened regulatory requirements designed to ensure that universities take effective action to prevent and address harassment and sexual misconduct.

5. Taken together, the expansion of CLiP placements, regulatory developments on AI, and the modernisation of our international registration routes, demonstrate a sector that is evolving purposefully.

Our Approach

6. Like last year, the data and analysis presented in this report are organised around five high-level outcomes that we wish to achieve.

7. The five high-level outcomes are:
   - Outcome 1 – Sufficient students to meet patient needs
   - Outcome 2 – Qualifications equip registrants to deliver safe and effective eye care for all
   - Outcome 3 – High levels of student satisfaction and welfare
   - Outcome 4 – A strong, innovative and resilient sector
   - Outcome 5 – Post-registration qualifications support registrants to deliver a wide range of eye care services in communities.

8. Each outcome contains a series of metrics (such as numbers of applications and admissions etc). Data generally reflects the 2024/25 reporting year, however, where available and appropriate to use, more recent data for 2026 has been included, such as recent registration data. These metrics are supported by qualitative assessment as appropriate. Our basket of indicators is summarised in the graphic on page 9.

9. The report uses information from a range of sources, including information submitted by providers of GOC approved qualifications as well as GOC surveys, internal data and news about developments in healthcare and education from external organisations such as the UK Government and Office for Students.

10. Like last year, the data and analysis presented in this report are organised around five high-level outcomes that we wish to achieve.

Basket of indicators	
High-level Outcomes	**Indicators**
Sufficient students to meet patient needs	• Applications numbers • Admissions numbers • Applications/admissions ratio • Average UCAS points offer • New GOC registrations • Attrition – % Year 1 students not progressing to Year 2 • Attrition – % students not completing qualification within single cohort • Attrition - % students exiting qualification in Year 1 • EDI – figures on admissions, progression and attainment for gender, age, ethnicity and disability
Qualifications equip registrants to deliver safe and effective eye care for all	• Attainment – % students getting a pass grade (required by the GOC) • % registrants being pre-registration supervisors
High levels of student satisfaction and welfare	• National Student Survey scores • Negative culture - % students experienced harassment, abuse or bullying in last 12 months • Negative culture - % students experienced discrimination in last 12 months • Negative culture - % students reporting these behaviours • Negative culture - % students taking leave of absence due to stress in last 12 months
A strong, innovative and resilient sector	• Numbers of GOC approved qualifications • Quality assurance and enhancement activity - % ETR requirements assessed as met • Quality assurance and enhancement activity – number of conditions and serious concerns • Financial sustainability – commentary • Innovation – commentary • Risk analysis - commentary
Post-registration qualifications support registrants to deliver a wide range of eye care services	• % registrants interested in obtaining post-registration qualifications • % registrants holding post-registration qualifications • GOC registration numbers for contact lens opticians and independent prescribers • Numbers of IP and CLO trainees • Admissions numbers for IP and CLO • Attainment - % students achieving pass or higher • EDI – cohort data by gender, age, ethnicity, disability • EDI – progression from entry-level qualifications

Outcome 1: Sufficient students to meet patient needs

Applications and admissions

11. The optical education and workforce landscape is continuing to evolve. As noted in the key themes section, new and revised qualifications are coming through the approval pipeline, and degree-level apprenticeships are creating additional routes into the profession. At the same time, the expansion of community-based eye care and the growing clinical role of optical professionals mean that workforce supply needs to be considered in the context of service redesign and changing patient needs across the UK.

12. A sufficient supply of appropriately qualified optical professionals will be critical if enhanced eye care is to be delivered safely and effectively in community settings, helping to manage demand on GPs and hospital eye services. This will require not only overall workforce growth, but also the right mix of skills, qualifications and supervision arrangements to support new models of care, with attention to geographical distribution, including remote, rural and underserved areas. The launch of the UK Eye Care Data Hub in 2025 developed by The College of Optometrists has an important role modelling the eye care workforce and the prevalence and incidence of eye diseases to support planning, service design, and workforce optimisation.

13. It remains the case that our role is not to determine workforce capacity requirements. However, we can support informed planning by making registration and education data available where appropriate, and by ensuring that regulatory requirements do not create unnecessary barriers to supply. The ETR has removed regulatory caps on student numbers, and the development of new qualifications and routes into the professions provides further opportunity for the sector to respond to future demand.

14. Enhancing the attractiveness of careers in optics is a sector priority. Application numbers remain strong[1] and there is interest in setting up new qualifications in optometry and dispensing optics. At the end of July 2026, across all qualification types, 12 applications for new qualifications were in progress. There will be three additional qualifications beginning in September 2026: two optometry Masters' Degrees at the University of Leicester, and De Montfort University, as well as a dispensing optics apprenticeship qualification at Anglia Ruskin University. Meanwhile, the Sector Partnership for Optical Knowledge and Education (SPOKE) has secured additional funding to deliver training and resources for local careers outreach activities to attract interest in the optical professions.

[1] Whilst there were 7,419 applications to optometry qualifications in 2024-25, and 357 applications for Dispensing optics it's important to note these are not unique applications with many individuals applying to multiple providers. The number of unique individual applicants is not available.

15. A comparison between admissions data from 2024/25 and student registration data from 2025/26[2] (the closest comparable data) shows an increase of 16.3% in new entrants for optometry, and an increase of 46.6% for dispensing optics. These both represent significant expansion in student numbers.

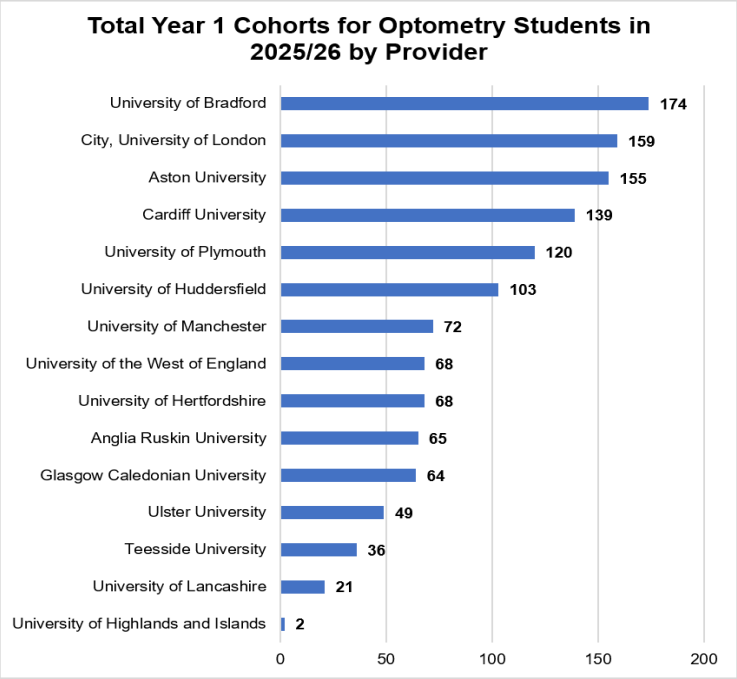
Optometry

16. Although total optometry (OP) figures have decreased slightly by 1.3% since 2023/24 with 3,421 total numbers of students in 2025/26 compared with 3,466 students in 2023/24, there has been a significant increase of 16.3% in Year 1 admissions from 1,114 in 2023/24 to 2,381 in 2025/26. This reflects the impact of two new qualification as well as increased admissions at some existing education providers. Given the planned expansion in OP qualifications reported in paragraph 13, we may see further growth in admissions next year. There remains a considerable range of small, medium, and large cohort sizes (see Chart 1). Meanwhile, the College of Optometrists' Scheme for Registration cohort comprised 994 students (968 in 2023/24).

17. Across all OP qualifications, 35 international students were admitted (2.9% of all admissions) compared with 36 students in the previous reporting year.

18. Entry to OP qualifications has become very slightly less competitive this year. Education providers admitted an average of 18.8% (17.9% in 2023/24; 21.7% in 2022/23) of all applicants with a range of 7.0% to 37.1%.

Table 1 – Year 1 optometry cohort by provider in 2025/26



[2] Provider admissions data for the next academic year (2025/26) is not available and GOC student registration data for the 2025/26 year 1 cohort is used instead as the closest comparable data. The provider data for 2025/26 will be available in next year's report.

Table 2 – Optometry cohort and admissions

	2023/24	2024/25	2025/26
Total OP students	3,466	3,448	3,421
Year 1 admissions[3]	1,114	1,187	1,381*

* Registration data

Dispensing optics

19. Although total DO student figures fell this year, they have increased by 9.8% since 2023/24. After admissions fell slightly last year, there has been a steep rise this year from 305 to 447, representing a 46.6% increase. Given the planned expansion in DO qualifications reported in paragraph 13, including the apprenticeship route, we may see further growth in admissions next year.

20. The 2025/26 Year 1 dispensing optics cohort sizes by provider is provided in table 3 below.

Table 3 – Year 1 dispensing optics cohort by provider in 2025/26

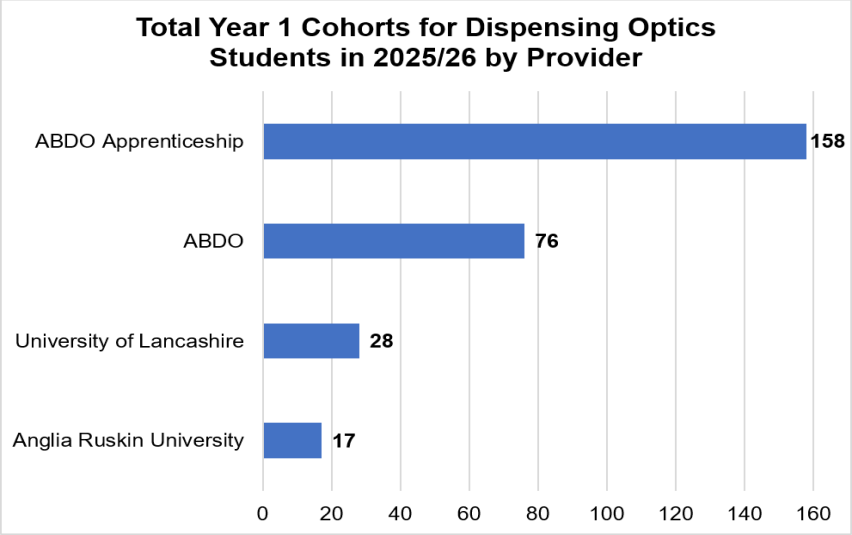


Table 4 – Dispensing optics cohort and admissions

	2023/24	2024/25	2025/26
Total DO students	960	1,139	1,054
Year 1 admissions	338	305	447*

* Registration data

[3] The admissions ratio for optometry of 18.8% (mean) or 18.3% (median) does not infer the overall volume of individual applicants who were unable to secure a place as each may have applied for more than one optical qualification and we do not hold this information. Dispensing optics information is not available given the disparate size of providers and that the dominant provider is not routed via UCAS.

Average UCAS points offer

21. UCAS tariff points provide a common metric of standardising applicants with different qualifications (for example, ‘A’ Levels, ‘AS’ Levels, ‘BTEC’s etc). In general, UCAS points can indicate the competitiveness of qualifications in attracting high tariff (or quality) students.

22. The median academic offer made by OP qualifications to prospective students was 136.0 UCAS tariff points which approximately equates to AAB grades at A-Level in England (same as the past three years).

23. For dispensing optics, student admissions are not routed via UCAS applications, so this information is unavailable. However, for providers teaching dispensing optics qualifications, the average academic offer is five GCSEs at grade 4-9 /C+ (inc. mathematics, English and science).

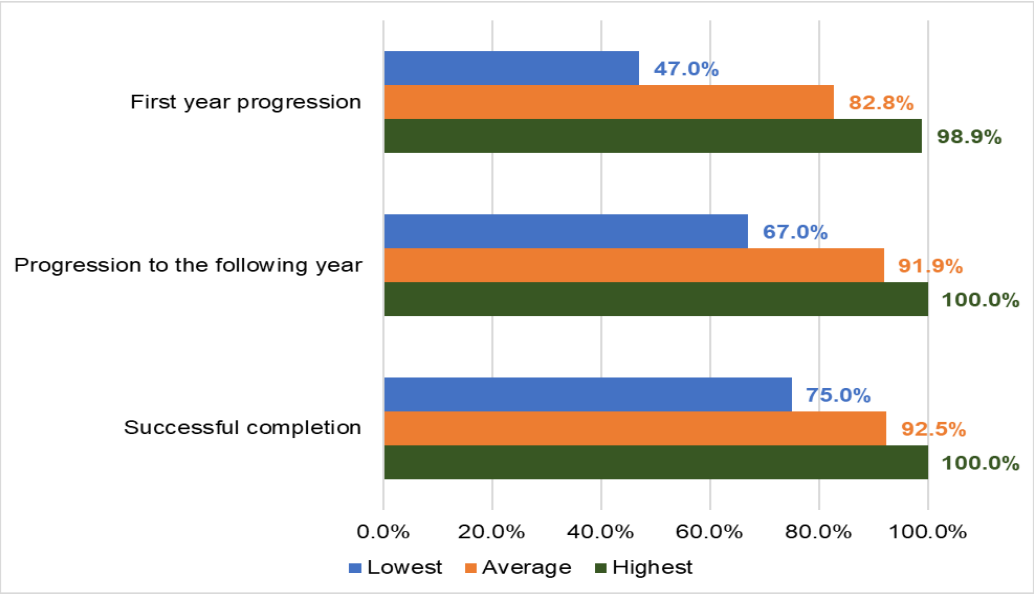
Progression and attrition

Progression rates

24. Progression rates reflect how well students are developing in their journey to becoming a fully qualified GOC registrant. For optometry, an average of 82.8% (78.8% in 2023/24; 81.7% in 2022/23) students progressed to the second year, an average of 91.9% (86.6% in 2023/24; 84.8% in 2022/23) progressed to the following year of the qualification, and an average of 92.5% (90.5% in 2023/24; 90.2% in 2022/23) of final year students successfully completed the qualification. Therefore, there is evidence of improved progression rates across all three measures. Standard deviation is higher for first year progression at 13.5%, and so rates vary, and the provider with the lowest rate of 47% cited a year-on-year fall coinciding with the replacement of a BSc with an MOptom qualification.

25. Meanwhile, for dispensing optics, an average of 97.3% of students with the largest DO provider progressed to the second year, and 88.5% (85.1% in 2023/24; 83.2% in 2022/23) final year students completed the course. For the two qualifications with smaller cohorts, an average of 62.5% of students progressed to the second year (SD: 2.5%), and an average of 86% of students progressed to the third year (SD: 9.5%).

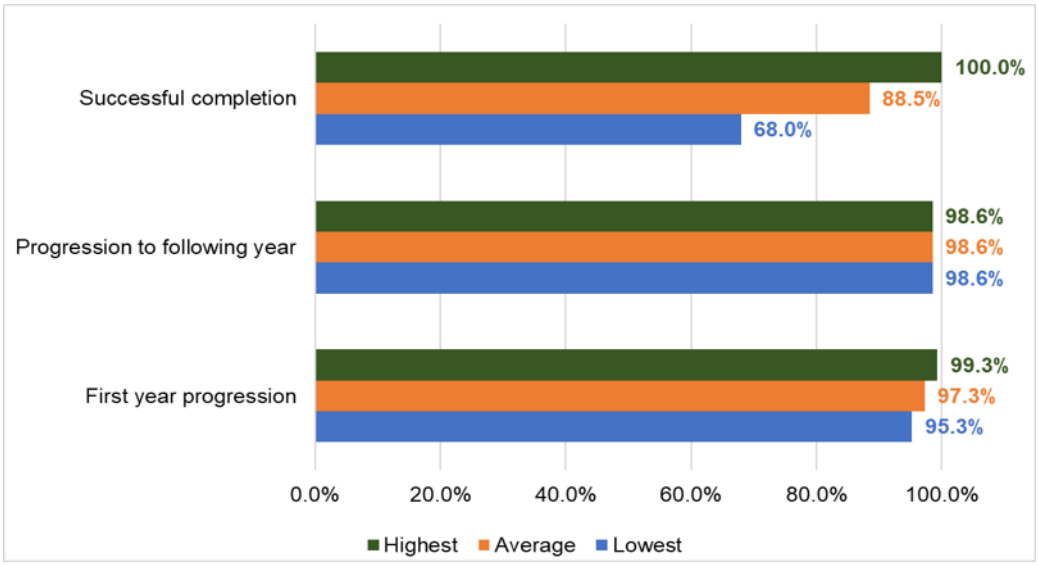
Table 5 – Optometry progression



Standard deviation:
First year progression σ = 13.5%
Progression to following year σ = 8.0%
Successful completion σ = 7.7%

26. Meanwhile, for dispensing optics, an average of 97.3% of students with the largest DO provider progressed to the second year, and 88.5% (85.1% in 2023/24; 83.2% in 2022/23) final year students completed the course[4]. For the two qualifications with smaller cohorts, an average of 62.5% of students progressed to the second year (SD: 2.5%), and an average of 86% of students progressed to the third year (SD: 9.5%).

Table 6 – DO student progression



Note: First and second year progression data relates to the ETR cohort where data reflects the largest provider.

[4] Based on attainment/progression data for all relevant providers with graduating cohorts.

Standard deviation:
First year progression σ = 2.0%
Progression to following year σ = 0.0%
Successful completion σ = 13.7%

Attrition

27. The overall percentage of OP students not completing a qualification within a single cohort (i.e. leaving between the start and end of the expected qualification duration or retaking final year assessment(s)) was 20.4%[5] (24.5% in 2023/24; 21.8% in 2022/23). The percentage figure for dispensing optics is not comparable due to different assessment timeframes compared with optometry under the handbook requirements.

28. The average rate of students exiting a qualification for year one was 4.7% (6.3% in 2023/24) of optometry students and for DO students the rate was 3.6% (4.5% in 2023/24) and 0.7%[6] for the largest provider's two approved qualifications (the Diploma and Apprenticeship respectively).[7]

29. Therefore, there are good signs of attrition reducing on both measures.

Equality, diversity and inclusion

30. Providers were asked to submit EDI data, and widening participation information used to inform the development of access and participation plans and initiatives in operation.

31. As noted in previous reports, the Professional Standards Authority (PSA) has strengthened its Standards of Good Regulation relating to EDI – the criteria it uses to assess performance of the healthcare regulators. The evidence matrix developed to support its strengthened Standard 3 includes expectations relating to taking appropriate account of diverse student needs, improving the diversity of student admissions and progression, and identifying unfair differential attainment in training.

32. We asked providers to supply enhanced EDI information for admissions, progression and attainment relating to gender, age group, ethnicity, and disability and this information is featured below. We are reviewing our approach to collecting enhanced EDI information ahead of issuing the next annual monitoring return (AMR) forms to ensure we collect information in a proportionate way. We already request some information from providers and student registrants as part of our registration processes, and we intend to use

[5] These percentage figures take account of the percentage share of students for each provider to arrive at a total weighted percentage.
[6] This is the first reporting year for the dispensing optics apprenticeship, therefore data for previous years is not available.
[7] The average percentage exit rate for optometry drops slightly in later years (2.3% for year 2 and 1.1% for year 3). It is important to note that for optometry these are average sector rates with variance across the sector for each year.

that to ascertain enhanced EDI data to reduce the current reporting burden on providers.

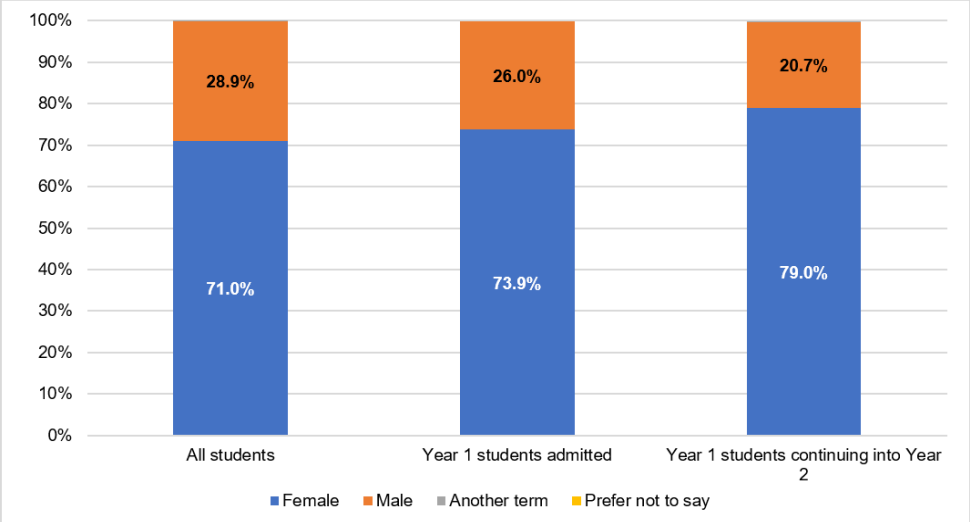
33. Overall, statistical testing in respect of gender, age groups, and ethnicity suggests that some differences identified in progression and attainment are unlikely to be due to random variation alone and are therefore likely to represent genuine differences in outcomes. However, further analysis would be required to understand reasons for those differences. Not all providers were able to provide the full data requested and the main reason for this is low numbers where there is a risk individuals could be identified and internal threshold reporting policies are in place.

34. On average, like previous years, most OP students are Asian, female, and aged 20 and under. Most DO students are White, female, and aged 30 and over. Longer-term trends suggest that over the past four years, for both OP and DO qualifications, there has been a gradual increase in the percentage[8] of female students.

Gender

35. As in previous years, over seven in ten OP students are female. The average range of female students between providers is 51.0% to 84.4%. There is a 9.9%pt difference between females (83.2%) and males (73.3%) continuing into Year 2. Meanwhile for attainment, there is a 6%pt difference between females (96.4%) and males (90.4%) achieving a grade required by the GOC. Statistical testing suggests that both the progression and attainment differences are unlikely to be due to random variation alone and are therefore likely to represent genuine differences in outcomes between male and female students. However, further analysis would be required to understand the reasons for these differences.

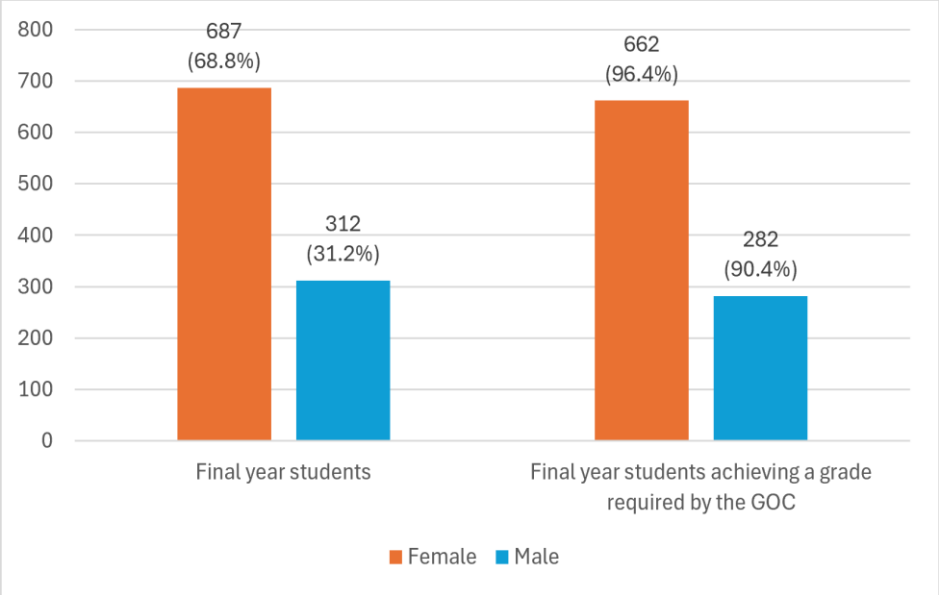
Table 7 – Admissions and progression* by gender (OP)



[8] Average (mean) figures across providers are used.

Year 1 students continuing into Year 2 – Gender data			
	Continuing	Not continuing	Standard deviation σ
Females	83.2%	16.8%	12.7%
Males	73.3%	26.6%	21.0%

Table 8 – Attainment by gender (OP)

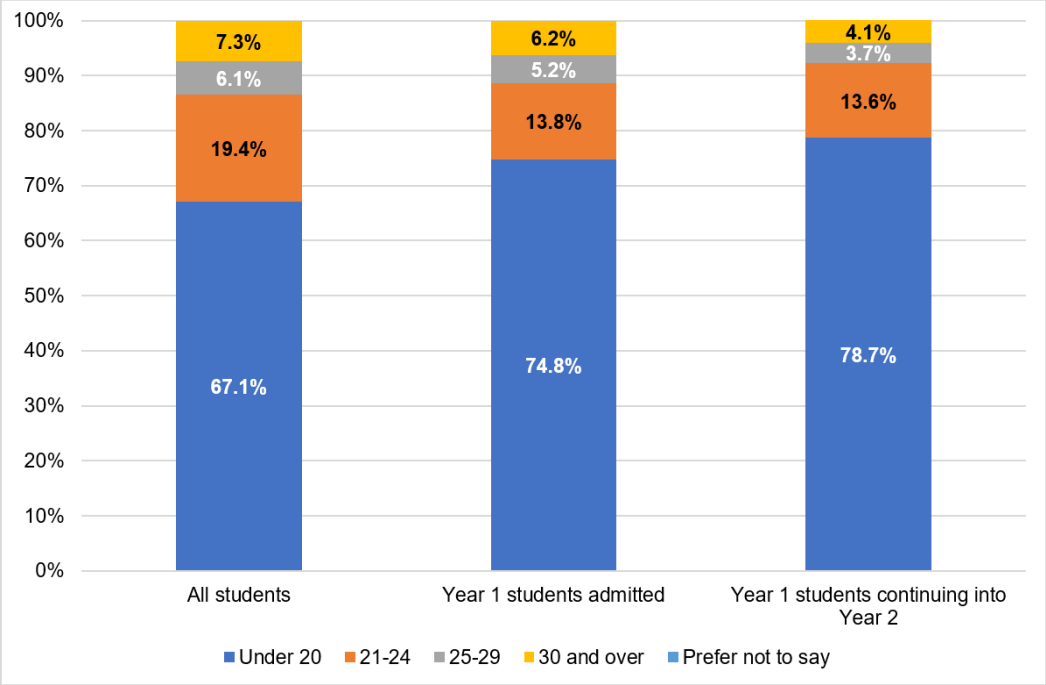


Standard deviation – Final year students achieving a grade required by the GOC (2.2+):
Female σ = 9.5%
Male σ = 9.4%

Age

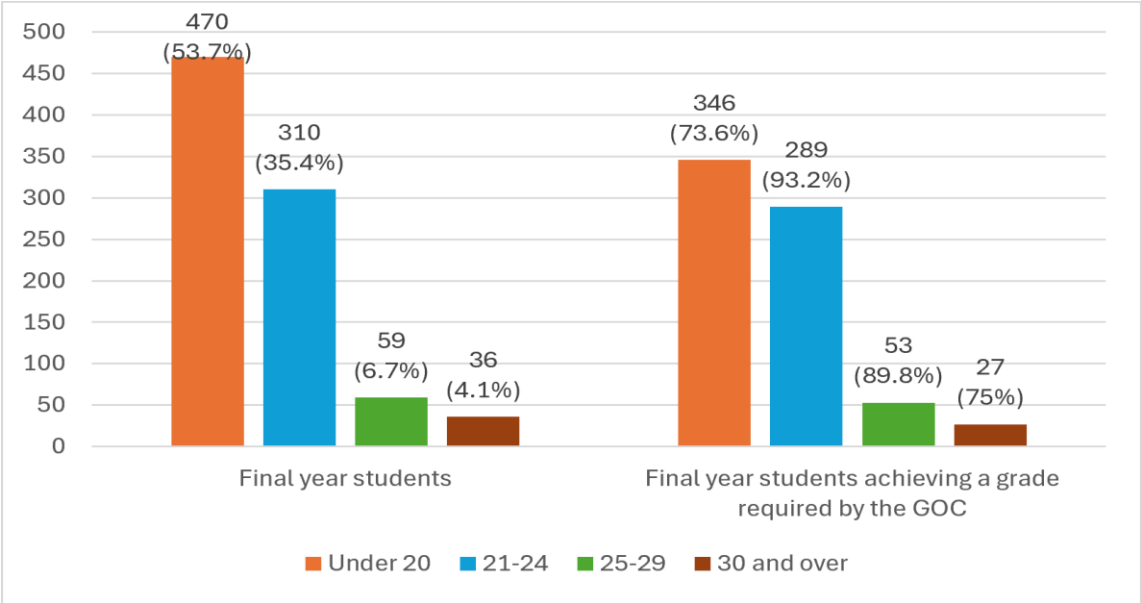
36. 67.1% (61.5% in 2023/24) of OP students are aged 20 or under, and 86.5% (83.3% in 2023/24) are 24 or under. 7.3% of OP students are aged 30 or over. There is a 15.7%pt difference between those aged under 20 (83.4%) and those aged 30 and over (67.7%) continuing into Year 2. Meanwhile, the difference between those under 20 and 21-24-year-olds is 7.2%pt and for 25–29-year-olds is 8.4%pt. Attainment rates are highest for 21-24-year-olds (93.2%) and lowest for the under 20s (73.6%). A statistical assessment suggests that the differences in attainment between age groups are unlikely to be explained by random variation alone, with the strongest contrasts observed between students aged 21-24 and both the youngest and oldest age groups. There is also some evidence that progression rates vary by age, although this relationship appears less pronounced than for attainment and should be interpreted with caution given the relatively small numbers in some age categories.

Table 9 – Admissions and progression by age* (OP)



Year 1 students continuing into Year 2 – Age data			
	Continuing	Not continuing	Standard deviation σ
Under 20	83.4%	16.6%	15.8%
21-24	76.2%	23.7%	19.2%
25-29	75.0%	25.0%	33.2%
30 and over	67.7%	32.3%	27.0%

Table 10 – Attainment by age (OP)

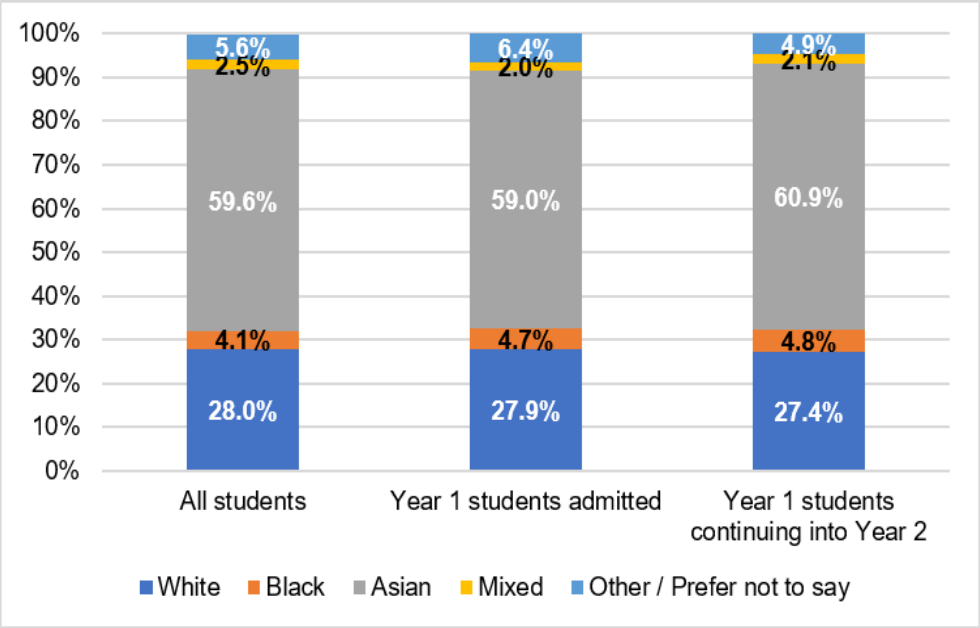


Standard deviation – Final year students achieving a grade required by the GOC (2.2+):
Under 20 σ = 6.1%
21-24 σ = 30.1%
25-29 σ = 11.7%
30 and over σ = 36.9%

Ethnicity

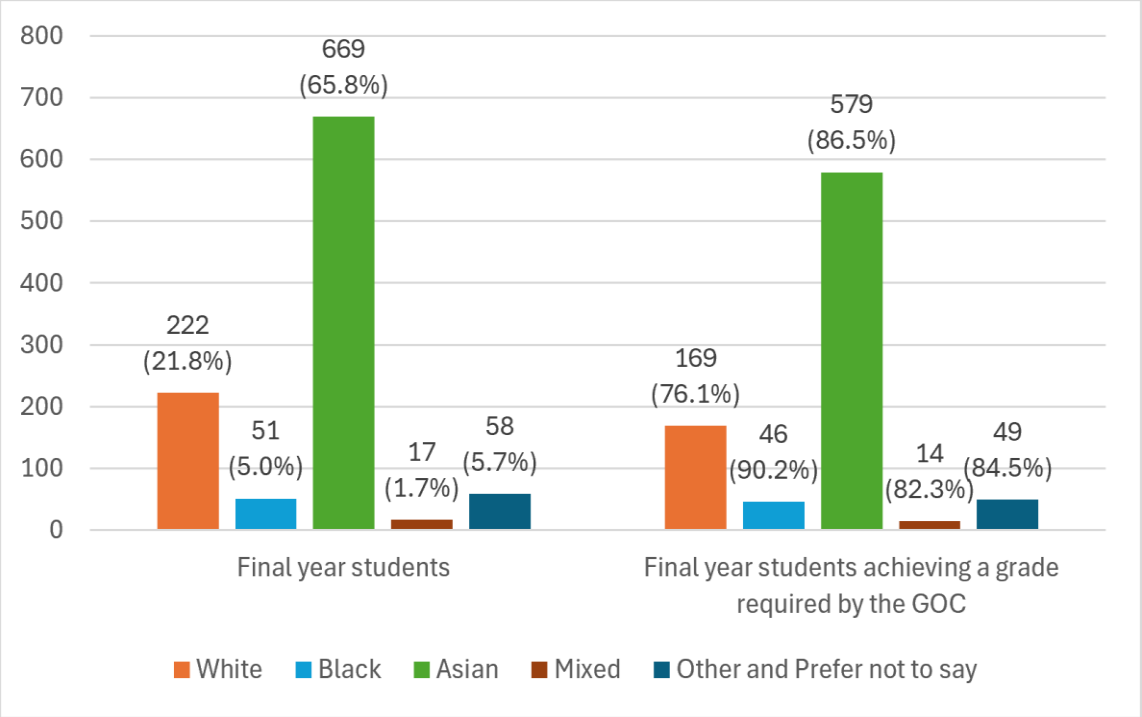
37. Ethnicity data for total student cohort by proportion is similar to previous years. There is a 9.3%pt difference between Asian students (84.2%) and white students (74.9%) continuing into Year 2, whilst progression rates were highest among black students (92.8%). Attainment rates are highest for black students (90.2%) and lowest for white students (76.1%). Statistical testing suggests that both progression and attainment rates vary across ethnic groups, and that the differences observed are unlikely to be explained by random variation alone. Some ethnic categories (black and mixed) contain relatively small numbers of students and therefore the results should be interpreted with caution.

38. Table 11 – Admissions and progression by ethnicity* (OP)



Year 1 students continuing into Year 2 – Ethnicity data			
	Continuing	Not continuing	Standard deviation σ
White	74.9%	25.1%	15.5%
Black	92.8%	7.1%	18.2%
Asian	84.2%	15.8%	16.2%
Mixed	86.9%	13.0%	21.6%
Other / Prefer not to say	74.6%	25.3%	42.5%

Table 12 – Attainment by ethnicity (OP)

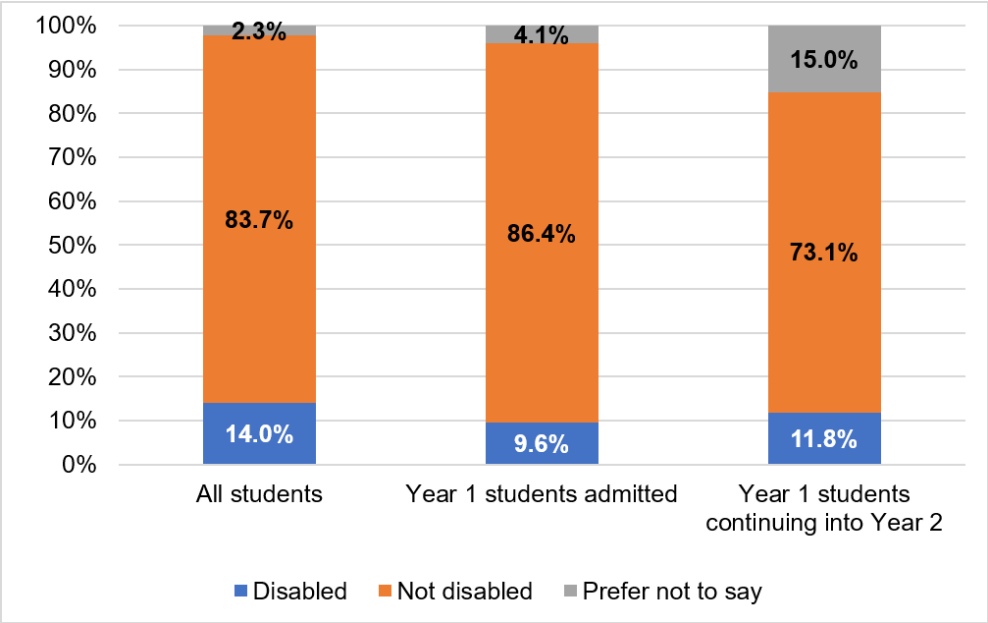


Standard deviation – Final year students achieving a grade required by the GOC (2.2+):
White σ = 3.8%
Black σ = 10.0%
Asian σ = 5.7%
Mixed σ = 17.5%
Undisclosed σ = 9.2%

Disability

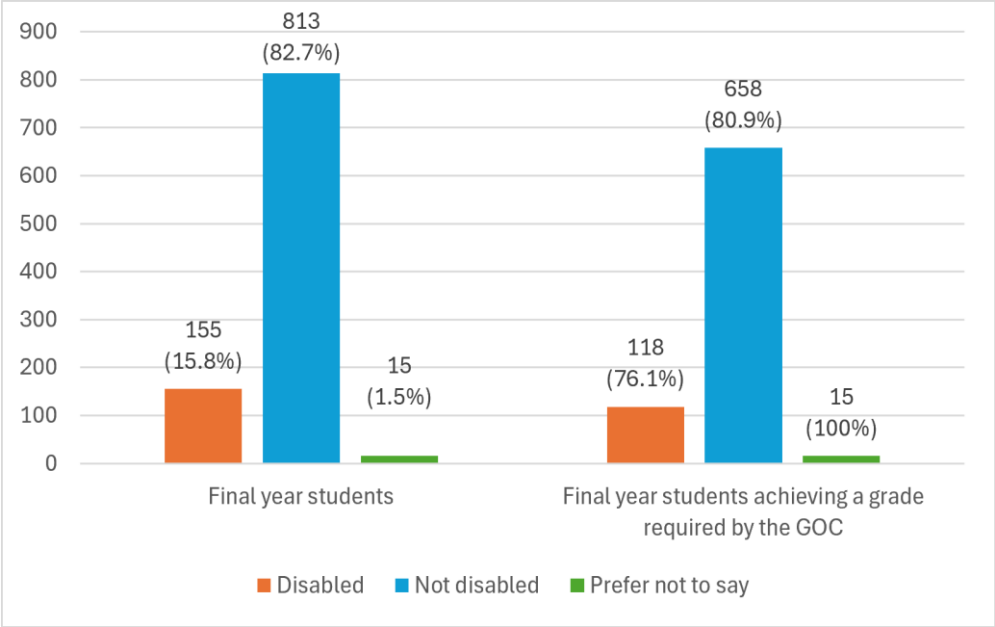
39. The proportion of students declaring a disability increased year-on-year from 6% in 2020/21 to 14.9% in 2023/24, with a slight decrease to 14.0% in 2024/25. There is an 18.1%pt difference between students with a disability (90.3%) and students without a disability (72.2%) continuing into Year 2. For attainment, there is a 4.8%pt difference between students without a disability (80.9%) and students with a disability (76.1%) achieving a grade required by the GOC. Statistical testing suggests that the difference in progression rates between students with and without a declared disability is unlikely to be due to random variation alone. By contrast, the difference in attainment rates is not statistically significant and should therefore be interpreted with caution.

Table 13 – Admissions and progression by disability status* (OP)



Year 1 students continuing into Year 2 – Disability status data			
	Continuing	Not continuing	Standard deviation σ
Disabled	90.3%	9.7%	18.2%
Not disabled	72.2%	27.8%	18.2%

Table 14: Attainment by disability status (OP)

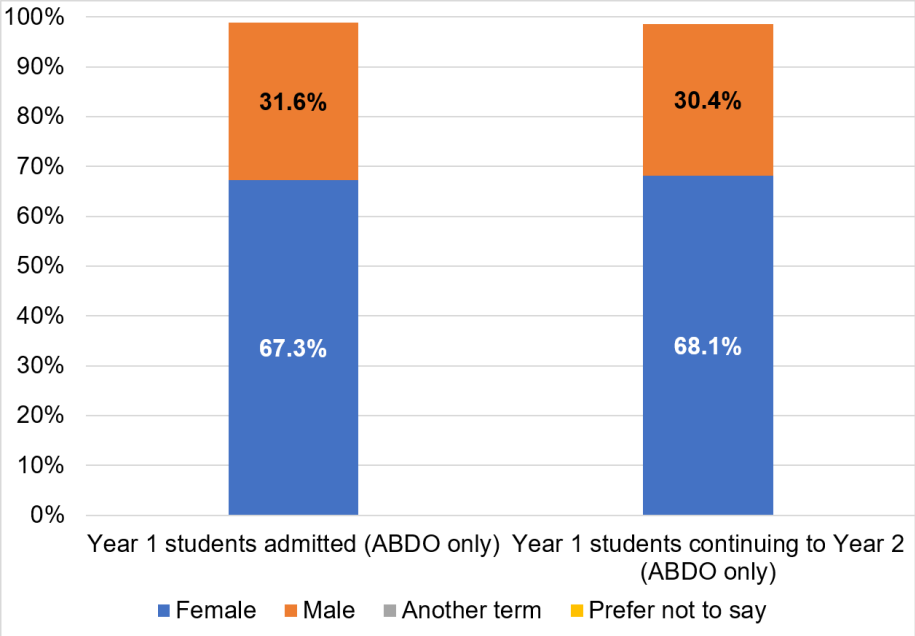


Standard deviation – Final year students achieving a grade required by the GOC (2.2+):
Disabled σ = 18.2%
Not disabled σ = 9.3%

Dispensing optics

40. Average data[9] relates to the two dispensing optics approved qualifications run by the largest ETR provider accounting for over 90% of students in the Year 1 2024/25 cohort. EDI data for other providers was incomplete with high levels of variance in some areas. There is insufficient data relating to EDI attainment for statistical significance testing purposes. Meanwhile, general attainment data for dispensing optics is provided in the next chapter.

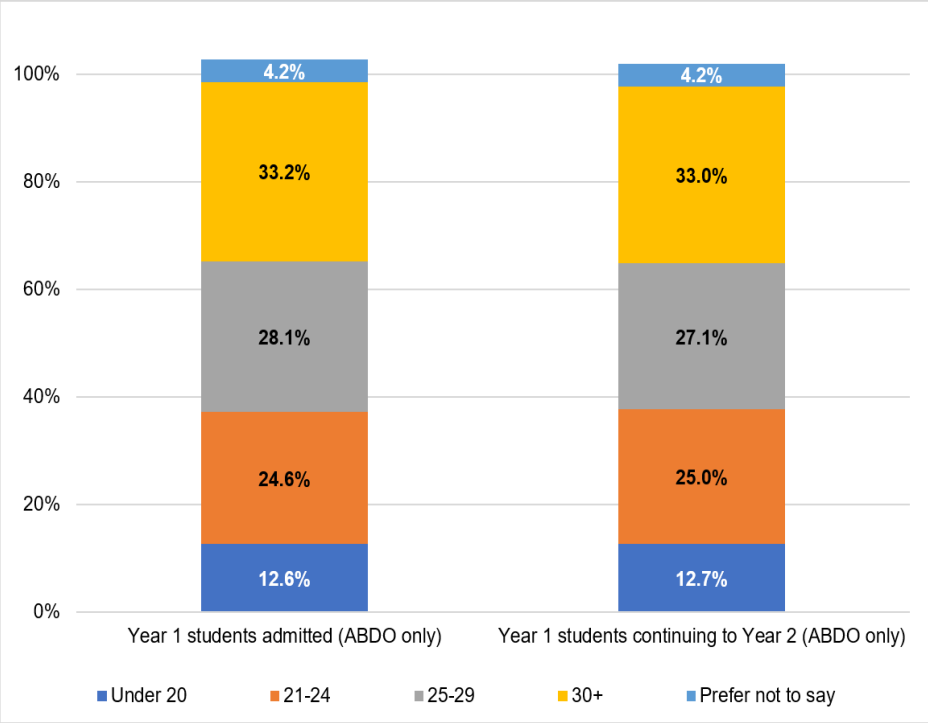
Table 15 – Admissions and progression by gender (DO)



Year 1 students continuing into Year 2 – Gender data (ABDO only)			
	Continuing	Not continuing	Standard deviation σ
Females	97.3%	2.7%	1.8%
Males	93.1%	6.9%	7.0%

[9] Where data is withheld for an indicator relating to one of the two dispensing optics qualifications, alternative data is provided in respect of the other qualification, rather than not at all, if this is available. This occurs twice within the age group category (“20 and under”, and “Prefer not to say”).

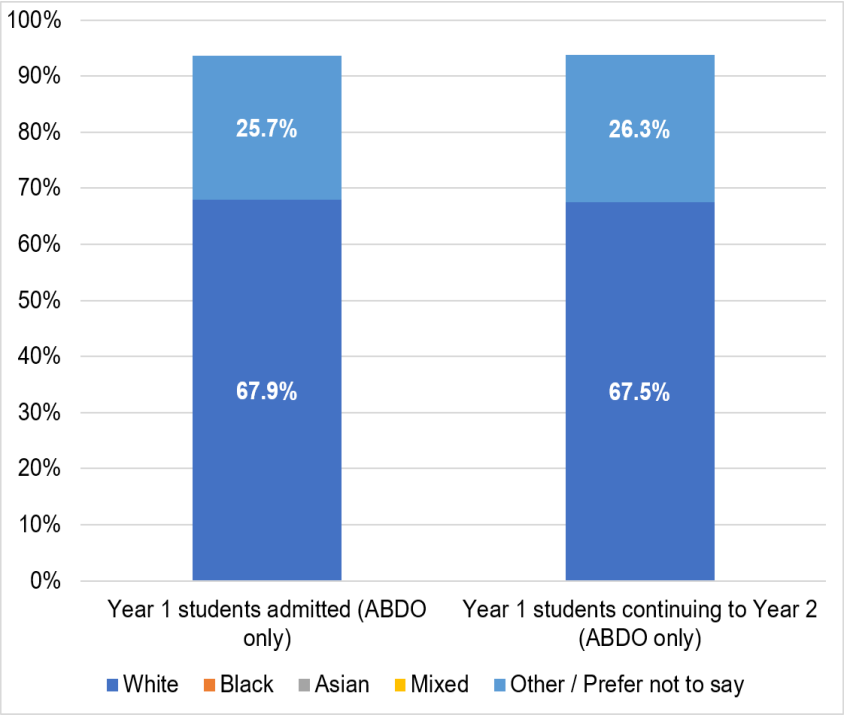
Table 16 – Admissions and progression by age (DO)



Note: Numbers in the above chart may total >100% due to withheld data being excluded and, as a result, averages being slightly higher than the true number.

Year 1 students continuing into Year 2 – Age data			
	Continuing	Not continuing	Standard deviation σ
Under 20	100.0%	0.0%	N/A
21-24	98.5%	1.5%	1.8%
25-29	93.5%	6.5%	6.25%
30 and over	95.6%	4.4%	1.8%

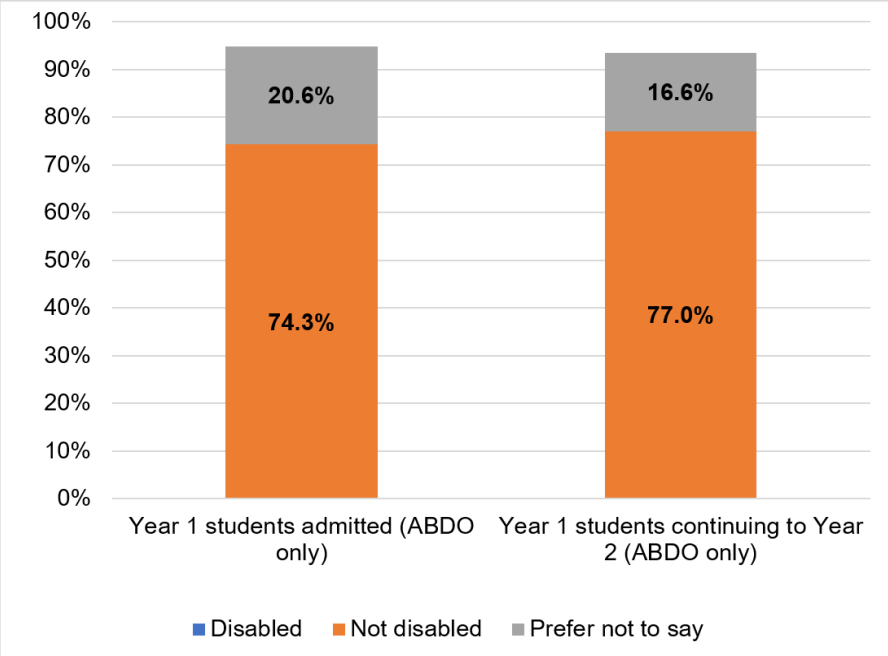
Table 17 – Admissions and progression by ethnicity (DO)



Due to some data being withheld, totals for the “ABDO only” bar charts do not sum to 100%.

Year 1 students continuing into Year 2 – Ethnicity data			
	Continuing	Not continuing	Standard deviation σ
White	92.2%	8.0%	4.0%
Black	Data withheld	Data withheld	-
Asian	Data withheld	Data withheld	-
Mixed	Data withheld	Data withheld	-
Other / Prefer not to say	98.6%	1.4%	1.3%

Table 18 – Admissions and progression by disability status (DO)



Year 1 students continuing into Year 2 – Disability status data			
	Continuing	Not continuing	Standard deviation σ
Disabled	Data withheld	Data withheld	-
Not disabled	100%	0.0%	0.0%

Widening Participation

40. Providers collect and review admissions, enrolment, attainment, award, continuation, completion and progression data, often disaggregated by protected characteristics and widening participation (WP) indicators. WP information may include a student's declared disability, ethnicity, gender, age group, socio-economic background, religion or belief, sexual orientation, first generation university student (or not), and refugee status.

41. Most data are collected centrally by universities through admissions, enrolment, student record systems, equality monitoring returns, disability services, business intelligence teams and institutional dashboards with various external and regulatory sources of information including HESA.

42. Providers use institutional quality processes to identify and respond to differential attainment, including annual monitoring, programme boards, enhancement planning, course reports, module improvement plans, EDI committees, Access and Participation Plan monitoring, school action plans and award gap action plans. Where gaps are identified or suspected, actions include deeper analysis at module and assessment level and continuing monitoring over multiple cohorts, amongst others.

43. Targeted support includes but isn't limited to early intervention where students show signs of difficulty, study skills provision, mentoring, coaching and leadership programmes, access to wellbeing and disability services, and tailored academic guidance. Providers also address structural barriers through bursaries, hardship funds, Chromebook loans, food vouchers, discounted bus fares, free digital textbooks, etc. Several providers are acting on religious, cultural and timetable barriers, including provision of prayer rooms, adjusting timetables to avoid Eid or Friday worship, offering choice of assessment timings during religious festivals, and avoiding unnecessary clustering of deadlines and assessments.

44. Reasonable adjustments are generally assessed individually by central disability, wellbeing, occupational health or student support services, often resulting in a formal support plan. Qualification teams then implement the recommendations while ensuring professional competence and patient safety requirements are maintained.

45. Some examples of reasonable adjustments in the returns include: common assessment adjustments including additional time, rest breaks, use of a computer, flexible deadlines; teaching and learning adjustments including lecture recordings, electronic or accessible formats, advance access to slides and materials, seating or room adjustments; timetabling and attendance adjustments including considerate spreading of assessments, allowances for absences, adjustments to accommodate caring responsibilities, religious observance etc.

46. Following sector discussions concerning how all students, regardless of their background can progress towards meeting the outcomes for registration without compromising patient safety, a recently published SPOKE report considered the importance of supporting those with disabilities and championing diversity whilst considering where the borderlines lie regarding patient safety. The report summarises the themes identified during SPOKE network discussions which include: robust systems and entry requirements, mental health and undeclared issues, assessing new and chronic health conditions, fitness to practise timelines, confidentiality and data protection, academic misconduct, reasonable adjustments, and assessment of communication outcomes.

47. Most data are collected centrally by universities through admissions, enrolment, student record systems, equality monitoring returns, disability services, business intelligence teams and institutional dashboards with various external and regulatory sources of information including HESA.

Outcome 2: Qualifications equip registrants to deliver safe and effective eye care for all

48. Providers of approved qualifications continue to use the GOC's handbook requirements whilst using the ETR for their more recent cohorts. A longitudinal research impact study is planned to measure the effectiveness of the new outcomes and standards for GOC approved qualifications on registrants' competence, confidence and capability (measuring the change we want to see). Preparation for the impact study is expected to commence in late 2026 and will provide valuable input concerning newly qualified registrants in:
    - feeling prepared for safe clinical practice,
    - feeling confident within their scope of practice, and
    - perceiving gaps in their knowledge, skills and behaviours.

Attainment rate

Optometry

49. To measure attainment, we consider the percentage of degree classifications which are a 2:2 or above and fails.

50. Student attainment on this measure is high but has fallen slightly. Across the providers, an average of 96.7% of optometry students who completed their qualification obtained a 2.2 or higher (98.9% in 2023/24; 99.4% in 2022/23).

51. An average of 1.7% (0.4% in 2023/24; 0.2% in 2022/23) of students failed the qualification. The range of first-class degrees is from 0.0% to 43.1% (0.0% to 33.3% in 2023/24; 10.6% to 63.0% in 2022/23).

52. The pass rate for the College of Optometrists' Scheme for Registration (stage two) was 93.4% (93.6% in 2023/24; 96.3% in 2022/23).

Table 19 – Attainment (OP)

Metric	Lowest	Average	Highest
Degree – First	0.0%	23.3%	43.1%
Degree – 2:2 or higher	83.3%	96.7%	100.0%

Standard deviation:
Degree – First σ = 13.0%
Degree – 2:2 or higher σ = 4.6%

Dispensing optics

53. Analysis of student attainment is difficult for DO qualifications because not all awards are classified in the same way (some use 'pass', 'merit', and 'distinction' grades), some are not classified at all, and some do not follow the traditional academic year structure and are therefore not comparable with optometry. For those qualifications awarding degrees, attainment has fallen this year with an average of 85.5% (91.9% in 2023/24; 93.3% in 2022/23) of students obtaining either a 2:2 or higher (for honours degrees), or a pass or higher (for non-honours qualifications).

Table 20 – Attainment (DO)

Metric	Lowest	Average	Highest
Degree – First	7.7%	17.3%	35.3%
Degree – 2:2 or higher	73.0%	83.3%	100.0%
Degree – Distinction	28.0%	44.0%	56.0%
Degree – Pass, Merit, or Distinction	68.0%	87.6%	100.0%

Standard deviation data not provided due to range of attainment classifications

54. Data from the dispensing optics awarding body focuses on initial attempts of the final assessment. The pass rate for the reporting year is 29.1%, with final completion taking place on an individual basis. The first dispensing optics cohorts graduating from ETR compliant qualifications will be covered in next year's report.

Placements and supervision

55. Progress has been achieved with the development of Clinical Learning in Practice (CLiP) placements as well as other placement schemes operating in Manchester and in Scotland, and work continues across the sector to facilitate placements in sufficient numbers. In last year's GOC 2025 business registrant survey, a quarter of respondents had arrangements with universities or the College of Optometrists to offer placements with this being more common amongst multiples (44%) than independent practices (11%).[10]

56. In the GOC's 2026 registrant survey, just over a quarter (26%) of working optometrist respondents had worked as a supervisor for pre-registration trainees in the last 12 months, a six-percentage point increase on the previous year, whilst for dispensing opticians 29% had. Working as a supervisor was more common amongst those who worked for a multiple (39%) compared with independents (12%). There was variation between nations ranging from 18% in

[10] Business Registrant Survey 2025, Impact for the GOC, p24, April 2025. Note: The findings are based on completes from 192 registered businesses, representing 7% of the overall registered business population

Northern Ireland to 32% in Wales. Those supervising trainees are more likely to report feeling unable to cope with their workload (65%) and finding it more difficult to provide patients with sufficient care (40%), than those who do not supervise trainees (57% and 36% respectively).[11] SPOKE is currently updating its supervision guidance which is expected to be published later this year.

Table 21 – Working as a supervisor

Metric	2025	2026
Percentage of working optometrists who worked as a pre-registration supervisor in last 12mths	20%	26%
Percentage of working dispensing opticians who worked as a pre-registration supervisor in last 12mths	Not collected	29%

[11] Registrant Workforce and Perceptions Survey 2026, Enventure Research for the GOC, May 2026, p27

Outcome 3: High levels of student satisfaction and welfare

57. Student feedback from annual monitoring returns suggests that overall, students have a positive view towards their qualification and value their qualification teams for being approachable, and supportive. Students generally appear to recognise teaching quality and the value of clinical placements where their knowledge and skills can be applied in preparation for future practice. They also appreciate support received during assessment periods and are positive about receiving clear explanations of assessment processes. Main concerns raised in the returns relate to timeliness and clarity of communication, the availability of practical learning, and access to resources. Actions raised to address these concerns include enhanced communication plans, earlier release of resources, and expanding practical learning opportunities.

58. Average National Student Survey (NSS) scores for OP qualifications are higher than the 'subjects allied to medicine' (SATM) for all categories except Learning Resources (-1.2%pt). Scores in all categories except Teaching (-1.3%pt) are higher than last year.

59. For DO qualifications, participation in the NSS was limited to one of the smaller GOC approved providers in terms of student numbers and so for this reason we are not presenting NSS data this year. ABDO qualifications are not participating in the NSS and instead collect alternative feedback.

60. With regard to supervision, 86.4% of ophthalmic[12] students said they had received appropriate supervision on their placement, an increase of three percentage points on the previous year.[13]

61. In the GOC's 2026 registrant survey, 11% of optometry student respondents had experienced harassment, abuse, or bullying *from tutors, lecturers or supervisors* in the last 12 months, whilst DO student respondents had not experienced any. In terms of overall experience of harassment, abuse, or bullying (i.e. in addition to that experienced above), for 32% of optometry students and 43% of DO students the last incident was reported (either by themselves or a colleague), which is slightly higher than for fully qualified registrants in respect of both professions.

62. 8% of optometry student respondents had experienced discrimination from tutors, lecturers or supervisors in the last 12 months (a two-percentage point increase on the previous year), compared with 2% of DO student respondents (up two percentage points from zero last year).

[12] Under the HECoS (Higher Education Classification of Subjects) ophthalmics as an aggregate grouping includes optometry, ophthalmic dispensing, orthoptics, and ophthalmology.
[13] NSS data, July 2026

63. 20% of optometry student respondents reported taking a leave of absence due to stress in the last 12 months compared to 15% of fully qualified optometry respondents. The figure for DO student respondents was 14% compared to 11% of fully qualified DO respondents.[14]

64. 42% of student optometrists and 29% of student dispensing opticians reported feeing under pressure to meet commercial targets at the expense of patient care, compared to 33% of fully qualified optometrist and 22% of fully qualified dispensing opticians. 69% of optometry student respondents were confident in their ability to resist commercial pressures that they believed could compromise patient care, compared with 89% of DO student respondents. In contrast, 69% of optometrists surveyed did not believe their education and training equipped them to manage commercial pressures well while maintaining safe patient care, compared with 40% of dispensing opticians.

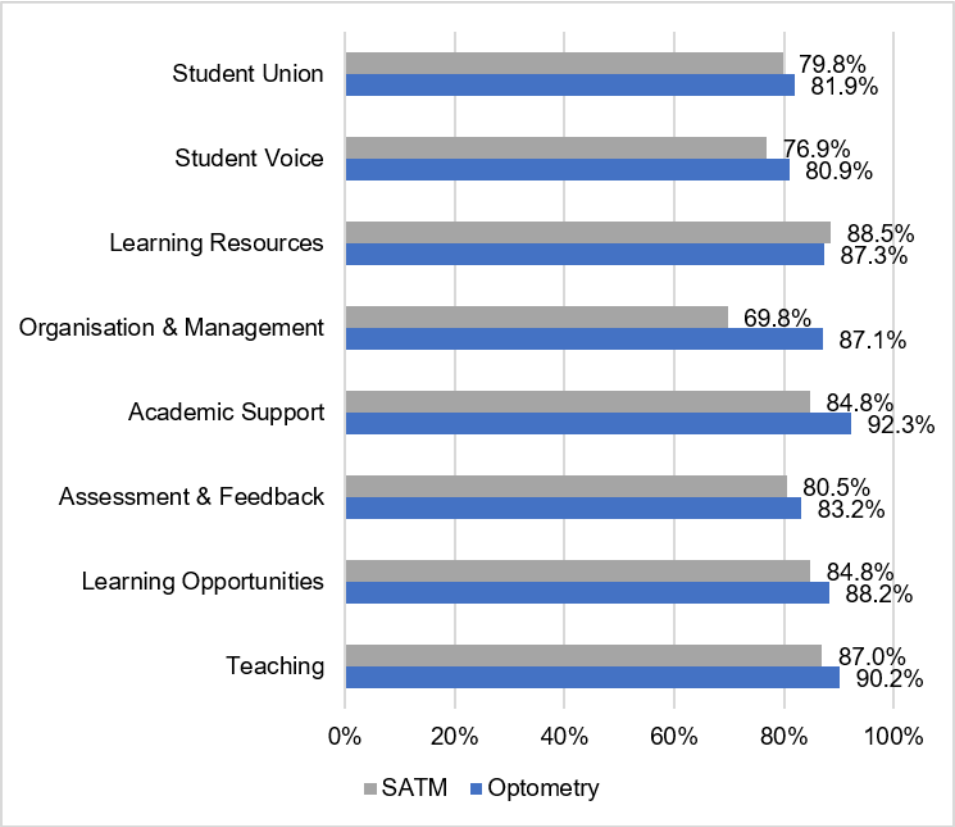
65. The GOC's 2026 thematic review on commercial practices and patient safety notes that a greater focus on supporting students and early career professionals is needed given the importance of education and training to prepare future registrants to identify and manage conflicts of interest, behave ethically when encountering commercial pressures and maintain professional autonomy.

Optometry

66. By category[15], the averages for student satisfaction are illustrated in in the chart below. The range of the average of OP NSS scores is between 80.9% and 92.3% for all categories. The average score for OP qualifications in the NSS is above the average for SATM for 7 of the 8 categories.

[14] GOC Workforce and Perceptions Survey 2026
[15] The figures refer to the proportion (%) of students expressing satisfaction in each category of their university experience. An explanation of the category groupings is provided at Appendix 3.

Table 22 – NSS category scores (OP)



Outcome 4: A strong, innovative and resilient sector

Number of GOC approved qualifications

67. The number of qualifications across the GOC's regulated professions is increasing with two new optometry qualifications and a new dispensing optics apprenticeship launching in 2026. Some providers of dispensing optics qualifications against the handbook have become ABDO teaching centres under the Education and Training Requirements, and there is potential for new qualifications in both dispensing optics and optometry.

Table 23 – Number of qualifications

Qualification type	Number of providers	Number of qualifications under handbook	Number of qualifications under ETR*
Optometry (OP)	18	22	17**
Independent prescribing (IP)	6	3	3***
Dispensing optics (DO)	7	2	5
Contact lens optician (CLO)	1	0	1

*Includes providers with full GOC approval already adapted to the ETR or at stage 4 of the staged application process who have been granted GOC approval to recruit to the qualification.
**Includes two quals combined Optom with IP
*** Standalone IP qualifications only, not including combined Optom with IP

Quality Assurance and Enhancement activities

68. We are continuing to quality assure against both the handbook and ETR until all handbook qualifications are taught out. Our quality assurance activities consist of visits to providers, processing adaptations for existing qualifications moving from the handbooks to the ETR, reviewing applications for GOC approval against the ETR, and setting and monitoring conditions for qualifications.

69. Our quality assurance and enhancement method helps us to identify whether there are any repeated areas of concerns for particular qualifications. For example, if we identify that a qualification is consistently not meeting a particular requirement we are able to set conditions to continue to monitor and then trigger further quality assurance, like a risk-based review, if required. Under our new quality assurance and enhancement methodology (QAEM) we will be able to monitor areas of repeated concern and non-assurance both within qualifications and across the sector.

70. A summary of QA activity for the 2024/25 academic year is provided below:

Table 24: Summary of QA activity for the 2024/25 academic year.

Activity	Statistics
Handbook Quality Assurance (QA) visits	• 3 QA visits in the 2024/25 academic year.
ETR Adaptation outcomes *(this only includes adaptations where the adaptation outcome report had been issued in that academic year)*	• 9 adaptations completed in the 2024/25 academic year. • 174/194* standards were deemed met. ○ This equates to 90%. **The number of standards met (194) counts the same standard multiple times if it was reviewed for different qualifications.*
Applications	• Application submissions in the 2024/25 academic year: ○ Stage 1: x3 ○ Stage 2 (including Stages 1-2 combined): x1 ○ Stage 3 (including Stages 1-3 combined) x2 ○ Stage 4: x1
Conditions	• 45 conditions were set across all processes (including QA visits, adaptation outcomes and applications). 32 conditions have been met and 13 remain open. 12 relate to one qualification going through the application process where the conditions remained open after stage 4a. ○ For QA visits, 12 conditions were set.
Change notifications	• 46 notifications were submitted and one remains open due to the provider awaiting information from a third party.
Serious Concerns review (SCRs)	• No SCRs were issued or conducted.

Financial Sustainability

71. The funding of higher education is a devolved matter, and different funding methods exist in each nation of the UK. The sufficiency and sustainability of funding for optical education remains a key risk for the sector with the Office for Students (OfS) reporting 35.8% of higher education providers in England with a deficit for 2024/25 (an improvement on the previous year's 44.2%), whilst

expected to rise to 42.7% in 2025/26 based on provider forecasts[16]. Meanwhile the Institute of Fiscal Studies (IFS) estimates that funding for teaching resources per-student in England has fallen by 22% in real terms since 2012/13, however, the government's commitment to increase the fee cap with inflation this year to £9,535 will, according to the IFS, arrest the decline in real terms.[17]

72. As reported last year, the former Secretary of State for Education Bridget Phillipson MP, announced that funding will be refocussed away from Level 7 (masters-level) apprenticeships from January 2026. Meanwhile, the Secretary of State wrote to the OfS in July 2026 setting out funding priorities for the 2026/27 financial year. Whilst funding will be cut in a number of areas, the Secretary of State has requested that funding for high-cost courses in Price Groups A and B is protected, and alongside that, funding supplements for nursing, midwifery and allied health courses (which includes optometry and ophthalmic dispensing) are also protected "recognising their importance to the government's 10 Year Health Plan".[18]

73. In England, following the completion of the our Education Strategic Review, with qualifications integrating at least 1600 hours / 48 weeks of patient-facing learning and experience in practice, Ministers have agreed that support will continue to be provided for the supervision of optometry trainees to any contractor who holds a GOS contract and is providing placements as part of an ETR qualification. Contractors will have been able to claim up to £4,010 per eligible student for training completed between 1 April 2025 and 31 March 2026 for a placement period between 44-48 weeks.[19]

74. In Scotland, the amount paid to supervisors claiming a grant for taking on a pre-registration trainee optometrist on or after 1 April 2025 increased by 4% to £4,644.[20]

75. In the annual returns, financial sustainability is a significant concern with providers noting that that implementation of the ETR has increased operational complexity and in some cases, the direct cost of qualification delivery with cited factors including enhanced clinical experience, supervision, specialist equipment and staffing requirements. A broad concern noted in the returns is the challenging financial climate in higher education with potential consequences for staffing, resources, student experience and sustainability, with some providers noting their department has been affected directly. As reported in last year's UK Education Report there is ongoing concern that the

[16] Financial sustainability of higher education providers in England, OFS, 14 May 2026, p39
[17] Annual Report on education spending in England: 2025-26, Institute for Fiscal Studies (ifs.org.uk), January 2026, p12
[18] Public letter from the Secretary of State for Education, 6 July 2026
[19] Letter setting out general ophthalmic services fees and payments from 1 April 2025, DHSC, 8 December 2025
[20] Letter setting out GOS remuneration increases in Scotland, Scottish Government, 19 August 2025

funding climate will put staff:student ratios (SSR) under pressure; and in this context, we asked SPOKE to produce guidance on SSRs.[21]

76. Providers of GOC approved qualifications have reported significant resourcing and investment decisions in three broad areas. First, for **clinical facilities, equipment and simulation-based learning,** examples cited in the returns include refurbished or expanded eye clinics, new OCT units, slit-lamp simulators, VR/simulation suites, upgraded laboratories, and modernised clinical teaching environments amongst others. Second, for **staffing, teaching capacity and academic infrastructure,** providers have referred to recruiting or increasing clinical tutors, using visiting lecturers, external experts, practice-based educators, PhD students, part-time supervisors and specialist clinicians to support delivery, notwithstanding resource pressures as noted above which include difficulty recruiting GOC-registered academic staff, long-term staff absence, and the challenge of running legacy and new programmes simultaneously, amongst others. Third, for **placement capacity, partnerships and flexible delivery models,** providers are expanding relationships with NHS bodies, hospitals, community practices, high-street providers, employers, local authorities, charities and professional bodies to secure placements and diversify experience with patients. Alongside this, several are adapting programme models through blended learning, online assessment, e-portfolios, digital resources and apprenticeship routes, amongst others.

Innovation

77. 80% of optometry ETR qualifications utilised the method for delivering professional and clinical learning and experience established by the College of Optometrists in partnership with providers and employers (CLiP). Alternatives to the CLiP model include the University of Manchester which includes the integration of patient facing experience throughout the duration of the qualification, as well as qualifications in Scotland developed in partnership with Public Services Delivery Scotland (PSD Scotland). Meanwhile, Glasgow Caledonian University (GCU) launched the UK's first integrated optometry and independent prescribing MOptom (IP) qualification in 2024 in partnership with PSD Scotland, followed by the University of the Highlands and Islands in 2025.

78. The returns provide substantial evidence of innovation and good practice. Common strengths include blended and flexible delivery, investment in clinical and simulation facilities (virtual learning environments), multi-disciplinary (MDT) learning, expanded placement networks, strong student support and feedback cultures, providing a wide range of career options beyond traditional routes, and closer partnerships with NHS, community, charitable and commercial organisations.

[21] Not published at the time of writing

79. Several providers emphasised MDT learning across the school or faculty sharing teaching with orthoptics, dispensing, pharmacy, medicine and other health qualifications. Many providers are strengthening external and in-house clinical opportunities in specialist areas such as myopia management, medical retina and glaucoma. Providers have modernised their curriculum to align with the ETR, advanced clinical skills and evolving professional roles in optics. Some providers discussed integrating the responsible use of AI into teaching. A SPOKE project mapping the use of AI in teaching and identifying gaps and understanding sector perspectives about the impact of AI launched in February 2026.

80. Other notable innovations reported by providers include initiatives to support widening participation and access to GOC approved qualifications. They include: flexible study routes, apprenticeship models in dispensing optics, initial year programmes, support for non-standard entrants, earn-while-learning approaches, targeted academic support, disability/neurodiversity support and efforts to reach students outside traditional recruitment areas.

Risk

81. Across the returns, the most consistent strategic risks cited are financial pressure, shortages of suitably qualified academic clinicians, competition for staff, and the need to secure high-quality placements at scale.

82. Many providers are continuing to manage the complexity of teaching out legacy handbook qualifications whilst running adapted or new ETR qualifications. A recurring risk over the last two years is a shortage of academically trained, GOC-registered clinicians, with providers reporting limited selection particularly at senior levels, staff absences, and continuity of provision when staff may retire. Some concerns about placement capacity were raised in the returns both in relation to optometry and independent prescribing. The legacy of the pandemic was noted by some providers with ongoing impacts including mental wellbeing of students, and difficulties for a small number of DO students gaining the required case records needed to complete their qualification.

83. Whilst independent prescribing and advanced clinical services have been cited as growth areas by some providers, the enhancement of other health professionals' scope of practice in the long-term could, it was noted, reduce the need for optical staff in some areas. Meanwhile, whilst AI is viewed by some providers as an opportunity, risks have also been identified in relation to the integrity of student assessment and future workforce demand.

Outcome 5: Post-registration qualifications support registrants to deliver a wide range of eye care services

84. The GOC's post-registration qualifications in independent prescribing and contact lens optics as well as a growing number of specialist qualifications are helping to prepare optical professionals to deliver enhanced eye care in community settings with an increasing ageing population, whilst helping to relieve pressure on GPs and hospital eye care services.

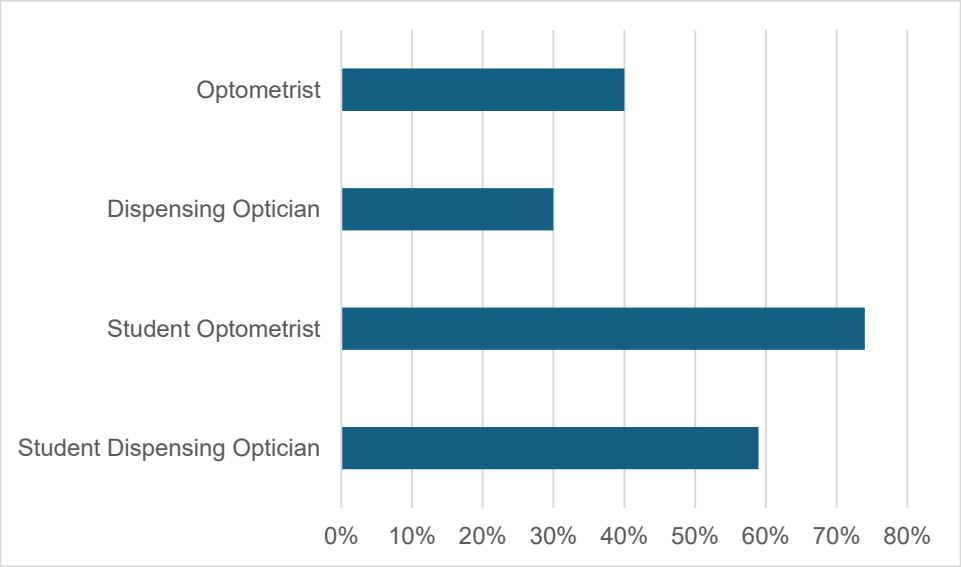
Interest in post-registration qualifications

85. Well over a third of respondents (42%) to the GOC's 2026 registrant survey had at least one additional qualification, including 16% who had a glaucoma qualification and 13% who had a medical retina qualification. Additional qualifications are more prevalent among optometrists than dispensing opticians, with optometrists more likely to report having at least one (49% vs 40%).

86. 40% of respondents were considering obtaining additional qualifications in the next 12-24 months. There is significantly greater interest in gaining additional qualifications/skills amongst younger respondents and optical students when compared with older respondents and fully qualified registrants.

87. The top three additional qualifications of interest were glaucoma (40%), medical retina (39%), and independent prescribing (38%).[22] Amongst dispensing optician respondents, interest in moving to optometry has fallen over the last three years by 6% pts (22% in 2024, 16% in 2026).

Table 25 – Plans to gain additional qualifications by registration type



[22] Ibid, p20, 21 & 62

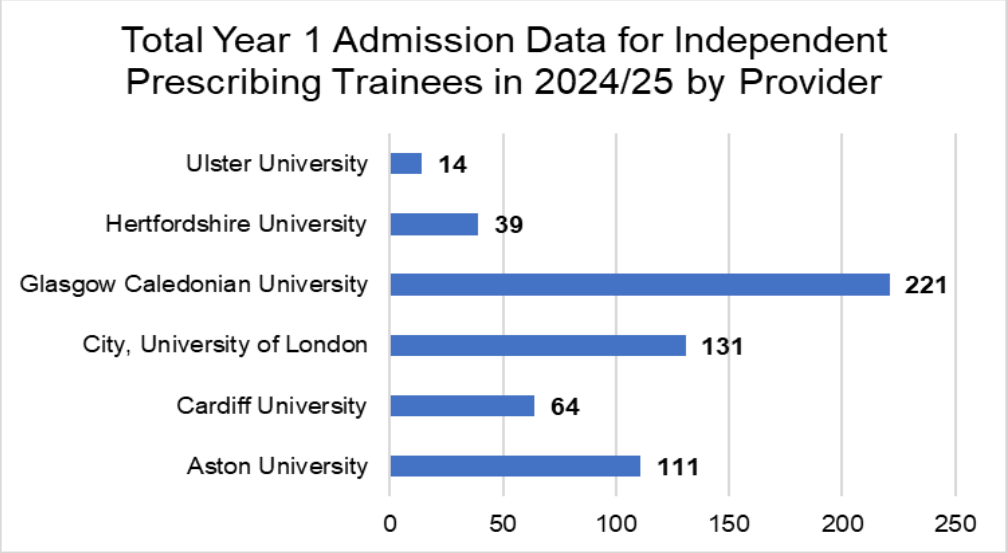
Independent prescribing

88. Unless otherwise indicated, the comments here relate to all independent prescribing and therapeutic prescribing (IP) qualifications, excluding the IP approved qualification offered by the College of Optometrists.

89. As of March 2026, 2,474 (2,066 in 2025) GOC registrants are registered as independent prescribing optometrists, an increase of 19.7% from 2025.

90. The number of IP trainees increased substantially from 415 in 2023/24 to 580 in 2024/2025 – a 39.8% increase.

Table 26 – Number of IP trainees by provider



91. Whilst nearly all education and training providers have adapted to the ETR for entry-level qualifications, three providers are still delivering the handbook IP qualification (see *ETR Adaptations status in Annex 2*).

92. As reported last year, the recent 2025 SPOKE report on enhancing the scope of practice in optical professionals questioned the sustainability of IP qualifications as a result of lower numbers of potential supervisor practitioners (compared with contact lens optics) and recommended increased recognition and status of supervision across the sector and mentoring of others as a core expectation for all registrants.[23]

[23] Enhancing the scope of practice in optical professionals, SPOKE Project 3, p6. January 2025

Key data – IP qualifications

Table 27 – Number of IP trainees

Total students	2022/23	2023/24	2024/25
Total IP trainees	521	415	580

Table 28 – Admissions and attainment (IP)

Metric	Lowest	Average	Highest
Applicants admitted	53.3%	68.2%	89.5%
Attainment – pass or higher	91.2%	96.8%	100.0%

93. The number of applications to IP qualifications jumped by 71.5% from 460 in 2023/24 to 789 in 2024/25 indicating increased competition for places. IP qualifications admitted an average of 68.2% of applicants (83.8% in 2023/24; 91.4% in 2022/23).

94. IP qualification admission sizes ranged from 14 to 221 with an average of 97. In 2023/24, this was 13 to 114 with an average of 69; in 2022/23, this was 15 to 215 with an average of 80.

95. An average of 96.8% (95.6% in 2023/24; 98.3% in 2022/23) of students passed the IP qualification, with three of the six qualifications having a pass rate of 100%. Meanwhile, the pass rate for the College of Optometrists' Therapeutic Final Common Assessment was 76% (78% in 2023-24; 76% in 2022/23).

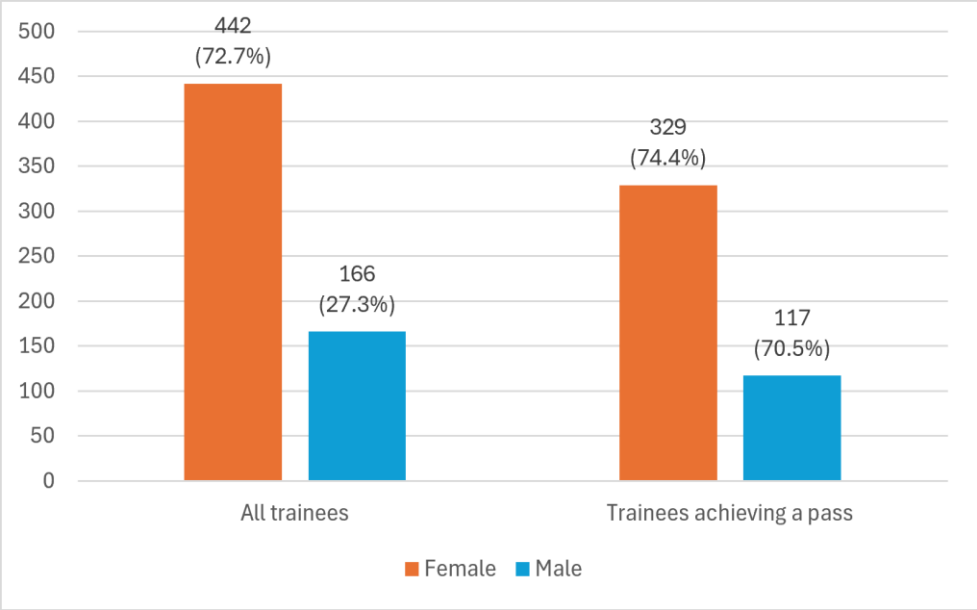
96. In terms of EDI cohort data, on average, 60.9% of IP students are aged 30 or over; 53.1% are White and 35.8% are Asian; 74.0% are female.

Progression from entry-level qualifications

97. We compare registrants with a specialist qualification on the GOC register and optical professionals training to acquire a specialist qualification as an indication of progression from entry level qualifications. The percentage of black IP trainees and black IP registrants are similar (2.6% and 1.2% respectively). There are a higher percentage of Asian trainees than Asian IP registrants (35.8% and 28.2%). There are a lower percentage of white trainees than white IP registrants (53.1% and 59.1%). There are a lower percentage of male trainees to male IP registrants (25.6% and 36.9%). Meanwhile the percentage of white CLO trainees and white CLO registrants are similar (76.7% and 72.7%). There are a higher percentage of male trainees to male CLO registrants (43.3% and 36.2%).

Independent prescribing EDI data

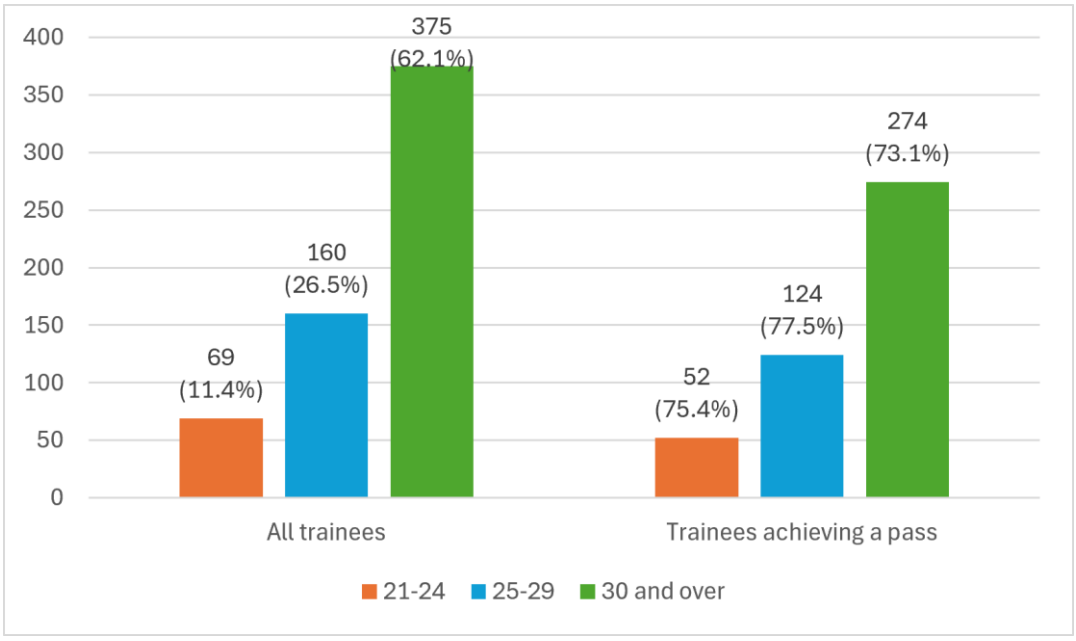
Table 29 – IP attainment by gender



Standard deviation – Trainees achieving a pass
Female σ = 21.8%
Male σ = 14.1%

98. Of IP trainees, 74.0% were female and 26.0% were male. Attainment rates were slightly higher for female trainees (74.4%) than male trainees (70.5%), a difference of 3.9 percentage points. Statistical testing did not identify a statistically significant difference in attainment between female and male trainees.

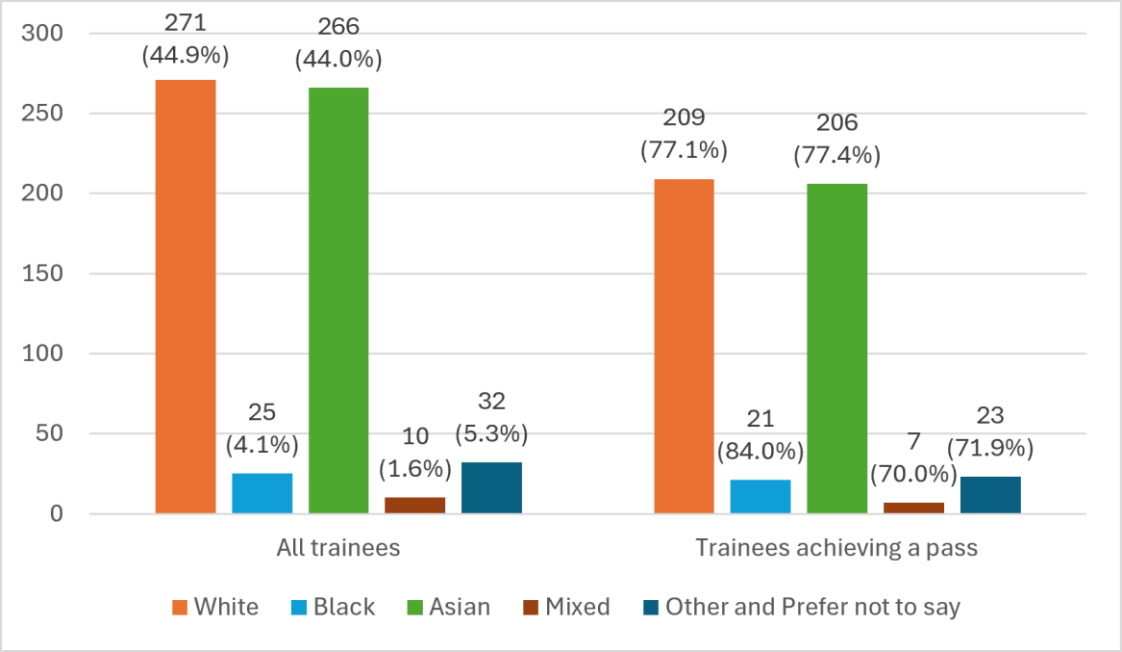
Table 30 – IP attainment by age group



Standard deviation – Trainees achieving a pass
21-24 σ = 13.0%
25-29 σ = 19.7%
30 and over σ = 17.3%

99. Nearly two-thirds of IP trainees (60.9%) were aged 30 or over. Attainment rates were broadly similar across age groups, ranging from 73.1% among trainees aged 30 and over to 77.5% among those aged 25-29. The largest difference observed was 4.4 percentage points between trainees aged 25-29 and those aged 30 and over. Statistical testing did not identify a statistically significant difference in attainment between age groups.

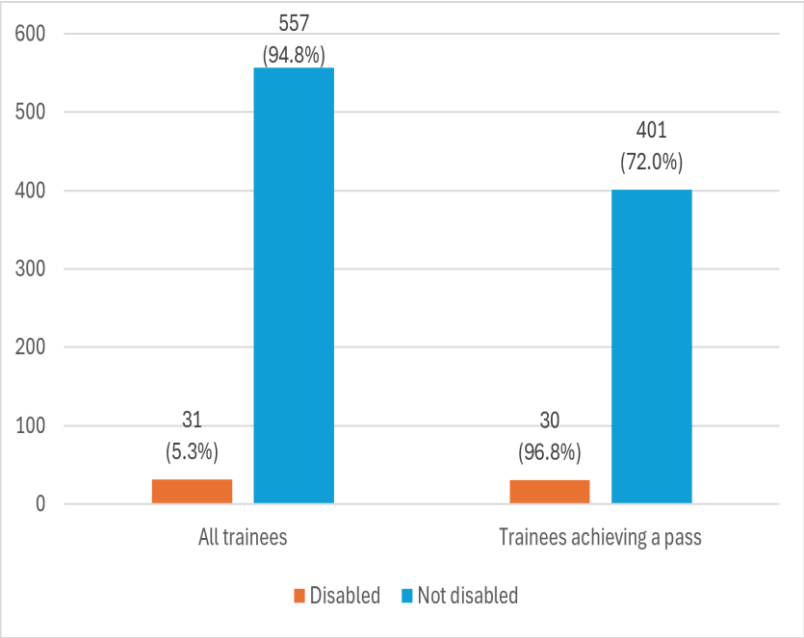
Table 31 – IP attainment by ethnicity



Standard deviation – Trainees achieving a pass
White σ = 18.0%
Black σ = 31.3%
Asian σ = 18.9%
Mixed σ = 23.6%
Other and Prefer not to say σ = 19.8%

100. The largest ethnic groups among IP trainees were white (44.6%) and Asian (43.8%). Attainment rates were similar for white trainees (77.1%) and Asian trainees (77.4%). Black trainees achieved the highest attainment rate (84.0%), although the cohort size was relatively small (25 trainees). Mixed ethnicity trainees had the lowest attainment rate (70.0%), though numbers were also small. Statistical testing did not identify a statistically significant difference in attainment by ethnicity.

Table 32 – IP attainment by disability



Standard deviation – Trainees achieving a pass
Disabled σ = 20.0%
Not disabled σ = 17.4%

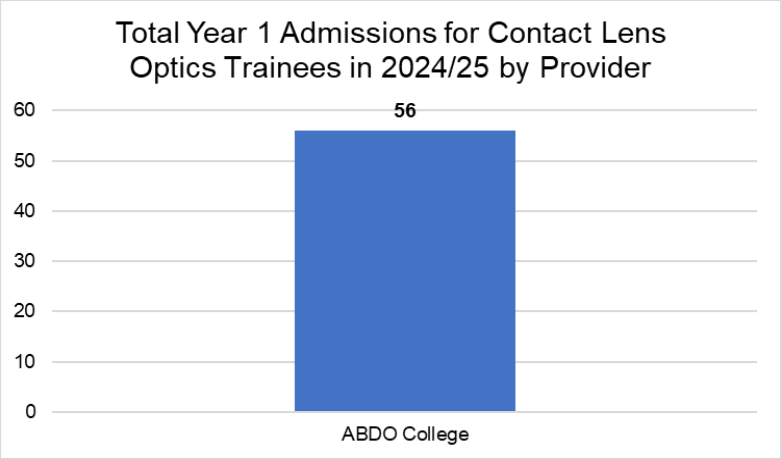
101. A relatively small proportion of IP trainees (5.3%) declared a disability. Attainment rates were 96.8% among trainees declaring a disability compared with 72.0% among trainees not declaring a disability, a difference of 24.8 percentage points. Statistical testing identified a statistically significant difference in attainment by disability status. However, given the relatively small number of trainees declaring a disability (31), this finding should be interpreted with caution.

Contact lens opticians

102. As of March 2026, 1,168 (1,045 in 2025) GOC registrants are registered as contact lens opticians, an increase of 11.8% from 2025.

103. The number of trainees on contact lens optics (CLO) qualifications has fallen over the last three years by 114.6% (41 in 2025/26, 56 in 2024/25 and 88 in 2023/24). The GOC has been informed that work is being undertaken with employers to understand why they have been reluctant to support CLO trainees.

Table 33 – Number of CLO trainees by provider



Key data – CLO qualifications

Table 34 – Total students (CLO)

Total students	2023/24	2024/25	2025/26
Total students in year 1 cohort	88	56	41

Table 35 – Admissions and attainment (CLO)

Metric	Lowest	Average	Highest
Applicants admitted	100.0%	100.0%	100.0%
Attainment – pass or higher	N/A	N/A	N/A

* At the time of submitting the form no students had completed all six units of the Diploma in Contact Lens Practice.

Observations

104. ABDO College admitted 100.0% of their applicants (over 92% in 2023/24; 83% in 2022/23).

105. EDI data shows that, like previous years, most CLO students are females: 53.3% (65.2% in 2023/24; 80.2% in 2022/23). Also, EDI data shows that 63.3% are aged 30 years or above (65.7% in 2023/24), which is unsurprising for a qualification taken after initial qualification. 76.7% of students on CLO qualifications are White.

Annex 1: Background information

Annual monitoring return requirements

A1.1 The GOC is required to "keep informed of the nature of the instruction given by any approved training establishment to persons training as optometrists or dispensing opticians and of the assessments on the results of which approved qualifications are granted", under s.13(1) Opticians Act 1989. Qualifications leading to a registrable therapeutic / independent prescribing (IP) or contact lens optician (CLO) specialism are also included within the GOC's regulatory scope.

A1.2 In executing this duty, we approve and quality assure qualifications leading to GOC registration or speciality registration, which includes all elements of training, learning and assessment that a provider must deliver for its students to be awarded a GOC approved qualification that meets the GOC's requirements and to enable students to be eligible to register with the GOC as an optometrist (OP) or dispensing optician (DO), or with an IP or CLO specialty, upon successful completion of their training and assessment.

A1.3 As part of our quality assurance and enhancement method of qualifications, all providers are required to demonstrate how their approved qualification(s) meet our requirements, as set out in the ETR. We seek assurance from these providers in several ways, including quality assurance visits, notification of reportable events and changes, conditions management, and the compulsory AMR submission. We also scrutinise and note proposed adaptations to qualifications to ensure they meet the ETR requirements.

Annual monitoring returns process

A1.4 Providers were required to report information for the period 1 September 2024 – 31 August 2025.

A1.5 Providers of GOC approved qualifications(s) were required to submit information relating to qualification risks to delivery, lessons learned, and good practice.

A1.6 We issued the AMR forms to providers on 1 November 2025. Providers were required to submit a completed form by 30 January 2026. Compliance with this year's AMR process was good, with all returns submitted by 6 February 2026. Responses to additional queries were generally prompt. No compliance breaches occurred.

A1.7 Every AMR must be signed by a 'responsible officer'. The responsible officer is a staff member with sufficient authority to represent the provider and bears ultimate responsibility for the information submitted in the return. The

responsible officer must only sign off the form when they are satisfied that the information gives a true and fair account of the qualification.

A1.8 We analysed the information to identify:

- current risks and issues relating to individual approved qualifications(s);
- themes, strengths, and risks within the optical education sector;
- the diversity of students within the optical sector;
- examples of good practice and lessons learnt; and
- ways the GOC's quality assurance activities could be developed.

A1.9 The analysis and outcomes are based upon the information and data as calculated and submitted by providers of GOC approved qualifications. We have not sought to externally verify the information submitted.

A1.10 We consider all feedback from stakeholders regarding the 2024/25 AMR process and use this to help refine the AMR process.

A1.11 The publication of this report closes the 2024/25 AMR process.

Caveats to the GOC Approved Qualifications Report

A1.12 The AMR process is in continuous development and we will make refinements and improvements for each year of the process.

A4.13 The findings, analysis, and outcomes of this year's AMR process will be fed into the GOC Education Operations team's approval and quality assurance activities and used by the GOC Education Development team to develop policy and to inform processes.

A4.14 Please note that the findings from providers outlined in this report are indicative and do not represent a formal position or policy of the GOC. The findings in this report should not be relied upon for advice or used for any other purpose and may not be representative.

A4.15 The analysis and outcomes contained within this report are based solely upon the information and data as calculated and submitted by the qualifications. We have not sought to externally verify the information and data submitted. The responsible officer for each qualification has attested that the information submitted in the AMR gives a true and fair view of that qualification.

A4.16 The information provided by each professional association qualification in relation to student attainment (assessment pass rates) has been calculated on different bases (i.e., the basis for each calculation has been different) from the other professional association qualifications and the academic qualifications.

Annex 2: ETR adaptations / application status

Qualification type	Qualification provider	Adaptation/application status	Start date
Optometry	Anglia Ruskin University	Adapted	Sep 23
	Aston University	Adapted	Sep 23
	University of Bradford	Adapted	Sep 24
	University of Bradford – accelerated route	Not yet adapted	TBC
	Cardiff University	Adapted	Sep 23
	De Montfort University	Stage 4 application	Sep 26
	City St George's, University of London	Adapted	Sep 23
	University of Lancashire	Adapted	Sep 23
	University of Leicester	Stage 4 application	Sep 26
	Glasgow Caledonian University (with IP)	Adapted	Sep 24
	University of Hertfordshire	Adapted	Sep 23
	University of Huddersfield	Adapted	Sep 24
	University of Manchester	Adapted	Sep 24
	University of Plymouth	Adapted	Sep 23
	Teesside University	Adapted	Sep 24
	University of the Highlands and Islands (with IP)*	Stage 4 application *UHI's submission is being managed as an application (UHI-OP-IP1-APP) due to the inclusion of IP which does not have GOC approval currently	Sep 25
	University of the West of England, Bristol	Adapted	Sep 24
	Ulster University	Adapted	Sep 23
Dispensing optics	ABDO	Adapted incorporating: ABDO College, Bradford College and Capital City College (formerly City and Islington College) which are now ABDO teaching centres	Sep 23
	ABDO - Apprenticeship	Stage 4 application	Sep 24
	Anglia Ruskin University	Adapted	Sep 23
	Anglia Ruskin University Apprenticeship	Stage 4 application	Sep 26
	University of Lancashire	Adapted	Sep 23
	Glasgow Caledonian University	Adapted	Sep 26
Independent prescribing	Aston University	Adapted	Oct 23
	Cardiff University	Adapted	Sep 24
	City St George's, University of London	Adapted	Sep 26
	Glasgow Caledonian University	Adapted	Jan 26
	University of Hertfordshire	Not yet adapted	TBC
	Ulster University	Adapted	Sep 27
Contact lens optics	ABDO	Adapted incorporating: Bradford College and ABDO College which are now ABDO teaching centres	Sep 24

Annex 3: Data tables

A2.1 Unless otherwise specified, the data reported below relates to the period 1 September 2024 – 31 August 2025.

A2.2 Unless otherwise specified, the data reported below relates to 'academic' (non-professional association) qualifications.

A. Application data*

	Admissions Ratio (Applications:Admissions)		UCAS Points Offer (equivalent)	
	Average	**Median**	**Average**	**Median**
All Qualifications	35.3%	20.2%	133.7	136.0
Optometry	18.9%	18.3%	133.7	136.0
Dispensing optics	Dispensing optics information is not available given the disparate size of providers and that the dominant provider is not routed via UCAS			
Independent prescribing	68.2%	68.2%	N/A	N/A
Contact lens opticians	100.0%	100.0%	N/A	N/A

* The admissions ratio does not infer the overall volume of individual applicants who were unable to secure a place as each may have applied for more than one optical qualification.

B. Average cohort data: The reporting year (2024/25)

	Year 1	Year 2	Year 3	Year 4
Optometry	75	69	61	23
Dispensing optics	112	63	47	N/A
Independent prescribing	71	55	N/A	N/A
Contact lens opticians	56*	N/A	N/A	N/A

* one provider only

C. Average cohort data: Next reporting year (2025/26)

	Year 1	Year 2	Year 3	Year 4
Optometry	86	66	66	22
Dispensing optics	279	482	293	N/A
Independent prescribing	46	51	N/A	N/A
Contact lens opticians	41*	N/A	N/A	N/A

* one provider only

D. Student average progression

	Progression from first year	Progression to the following year	Students completing the qualification
Optometry	82.8%	91.9%	92.5%
Dispensing optics	79.9%	91.9%	100.0%

E. Student average attainment: optometry, dispensing optics, and both qualifications

	Pass grade*	Fail
Both qualifications	89.3%	4.1%
Optometry	96.7%	1.9%
Dispensing optics	98.6%	7.9%

*a pass grade for optometry is a 2:2 degree or higher whilst for dispensing optics it may include a “pass” or other grade such as a 2:2 degree or higher.

F. Student average attainment: Independent Prescribing and Contact lens opticians

	Pass	Fail
Independent prescribing	96.7%	3.2%
Contact lens opticians	N/A*	N/A*

* No students had completed the 6 units of the Diploma in Contact Lens Practice at the time of submitting the AMR return.

G. Student average attainment: Professional Associations*

	Pass	Fail	Resits (as a % of total number of students examined)
Professional Association (dispensing opticians)**	29.11%	70.89%	20.37%
Professional Association (independent prescribing & optometry)	93.4%	24.0%	16.0%
Contact lens optics is now a fully integrated ETR qualification	N/A	N/A	N/A

* This table will be removed once all approved qualification cohorts have been assessed under the ETR.
**Relates to first attempts of the final assessments

H. National Student Survey – average satisfaction score by category

	Optometry	Subjects allied to medicine
Teaching	90.2%	87.0%
Learning Opportunities	88.2%	84.8%
Assessment & Feedback	83.2%	80.5%
Academic Support	92.3%	84.8%
Organisation & Management	87.1%	69.8%
Learning Resources	87.3%	88.5%

Student Voice	80.9%	76.9%
Student Union	81.9%	79.8%

I. EDI – Average gender data

	Female	Male
All qualifications	70.0%	29.7%
Optometry	71.0%	28.9%
Dispensing optics	65.3%	34.3%
Independent prescribing	74.0%	25.6%
Contact lens opticians*	53.3%	43.3%

* one provider only

J. EDI – Average age data

	20 & under	21-24	25-29	30 and over	Unknown / Prefer not to say
All qualifications	46.1%	15.9%	13.8%	24.2%	0.2%
Optometry	67.1%	19.4%	6.1%	7.3%	0.0%
Dispensing optics	55.2%	16.0%	11.0%	16.5%	1.4%
Independent prescribing	0.0%	7.7%	31.2%	60.9%	0.0%
Contact lens opticians*	0.0%	Withheld	26.7%	63.3%	Withheld

* one provider only, and some data withheld so percentage does not add up to 100

K. EDI – average disability data

	Known disability	No known disability	Unspecified / Prefer not to say
All qualifications	11.0%	85.9%	2.7%
Optometry	14.0%	83.7%	2.3%
Dispensing optics	8.5%	82.2%	7.1%
Independent prescribing	6.5%	93.3%	0.3%
Contact lens opticians*	0.0%	100.0%	0.0%

* one provider only

L. EDI – Average ethnicity data

	White	Black	Asian	Mixed	Other / Not known
All qualifications	38.7%	3.0%	50.0%	1.9%	7.1%
Optometry	28.0%	4.1%	59.6%	2.5%	5.6%
Dispensing optics	46.0%	0.4%	38.4%	1.0%	11.8%
Independent prescribing	53.1%	2.6%	35.8%	1.4%	6.9%
Contact lens opticians*	76.7%	Withheld	Withheld	Withheld	Withheld

* one provider only, and some data withheld so percentage does not add up to 100

M. EDI – Average refugee status data

	All students/trainees	Year 1 students/trainees
All qualifications	<0.1%	<0.1%
Optometry	0.2%	0.2%
Dispensing optics	0.0%	0.0%
Independent prescribing	0.0%	N/A
Contact lens opticians	0.0%	N/A

Annex 4 – 2025 National Student Survey categories

#	Question	Category
1	How good are teaching staff at explaining things?	**Teaching**
2	How often do teaching staff make the subject engaging?	
3	How often is the course intellectually stimulating?	
4	How often does your course challenge you to achieve your best work?	
5	To what extent have you had the chance to explore ideas and concepts in depth?	**Learning Opportunities**
6	How well does your course introduce subjects and skills in a way that builds on what you have already learned?	
7	To what extent have you had the chance to bring together information and ideas from different topics?	
8	To what extent does your course have the right balance of directed and independent study?	
9	How well has your course developed your knowledge and skills that you think you will need for your future?	
10	How clear were the marking criteria used to assess your work?	**Assessment & Feedback**
11	How fair has the marking and assessment been on your course?	
12	How well have assessments allowed you to demonstrate what you have learned?	
13	How often have you received assessment feedback on time?	
14	How often does feedback help you to improve your work?	
15	How easy was it to contact teaching staff when you needed to?	**Academic Support**
16	How well have teaching staff supported your learning?	
17	How well organised is your course?	**Organisation & Management**
18	How well were any changes to teaching on your course communicated?	
19	How well have the IT resources and facilities supported your learning?	**Learning Resources**
20	How well have the library resources (e.g. books, online services and learning spaces) supported your learning?	
21	How easy is it to access subject specific resources (e.g. equipment, facilities, software) when you need them?	
22	To what extent do you get the right opportunities to give feedback on your course?	**Student Voice**

23	To what extent are students' opinions about the course valued by staff?	
24	How clear is it that students' feedback on the course is acted on?	
25	How well does the students' union (association or guild) represent students' academic interests?	**Student Union**
26	How well communicated was information about your university/college's mental wellbeing support services?	**Mental Wellbeing Services**

C46(26)

COUNCIL

Public perceptions survey 2026 and Registrant survey 2026

Meeting: 30 September 2026 **Status:** For noting

Lead responsibility: Steve Brooker (Director of Regulatory Strategy)
Paper author: Angharad Jones (Policy Manager)

Purpose

1. To enable Council to discuss the key findings from our public perceptions survey 2026 (annex 1) and registrant survey 2026 (annex 2).

Recommendations

2. Council is asked to note the findings from the surveys.

Strategic objective

3. This work contributes towards the achievement of the following strategic objective: Creating fairer and more inclusive eye care services. This work is included in our 2026/27 Business Plan.

Background

4. As the regulator, it is important that we maintain a robust understanding of the views and experiences of patients, the public and registrants. Our annual public perceptions survey and registrant survey provide an important evidence base for identifying emerging trends, monitoring changes in confidence and experience over time, and highlighting issues where we, or the wider sector, may need to take action. They also provide assurance that we are actively listening to those affected by optical regulation, supporting transparency and accountability.

5. We have carried out an annual public perceptions survey since 2015 (except in 2018) to track patient and public views, perceptions and experiences of eye care. We commissioned DJS to carry out the last three surveys. The 2026 survey is based on a UK representative sample of 2,014 participants, who completed the online survey between 9 February and 2 March 2026. All previous reports are available on the policy and research pages of our website.

6. We have commissioned Enventure Research to carry out our annual registrant survey since 2021. It is an online survey of all our individual registrants including students. The aim is to help us better understand registrants' experiences of working in clinical practice including any challenges they face and their future plans. Over the years, we have engaged with stakeholders such as The College of Optometrists and

ABDO in developing and refining the questions on areas such as workforce capacity to help inform sector work. The online survey was sent out between 25 March and 22 April 2026. We received 3,451 responses, representing a 11% response rate. The research is highly robust with a 90% confidence interval at +/- 1.5% (this compares to +/- 5% in many public opinion surveys). The previous reports are available on the policy and research pages of our website.

Analysis

7. In this section we have provided an overview of the new questions from the registrant survey on AI, and an analysis of the key findings from both surveys.

New questions from the registrant survey 2026

Artificial intelligence

8. This year, we included new questions on registrants' use, perceptions and views of artificial intelligence to strengthen our evidence base on an evolving area of practice. Registrants are cautiously optimistic about the potential of AI in optical care, but the survey findings suggest that understanding, training and practical use remain at an early stage. While many respondents see opportunities for AI to improve care, uncertainty is still high and concerns about safety, accountability and transparency are widespread.
    - 60% rated their knowledge and understanding of AI in optical care as poor, compared with 40% who rated it as good.
    - 22% had received AI-related CPD or training in the last 12 months.
    - 60% of working respondents were not currently using AI for any of the activities listed in the survey.
    - Where AI was being used, it was most often to maintain knowledge and skills (12%), support diagnosis (8%) or write patient correspondence (8%).
    - 45% thought AI would improve the quality of eye care, while 11% thought it would reduce quality and 27% were unsure.
    - Key concerns included AI making errors (77%), legal responsibility if something goes wrong (76%), lack of transparency (68%), data security and patient confidentiality (64%), and the clinician-patient relationship (63%).

9. AI is now a growing focus for healthcare regulation. The National Commission into the Regulation of AI in Healthcare is an advisory body launched by the Medicines and Healthcare products Regulatory Agency (MHRA) in 2025 with the purpose of developing a new regulatory framework in AI and healthcare. The Commission have reviewed the UK landscape and made recommendations aimed at creating a coherent, consistent and proportionate approach to AI regulation. In response to the Commission's recommendations, healthcare regulators including GOC have agreed to develop a set of high-level principles to guide how they regulate the use of AI by health and care professionals across the UK by January 2027.

10. In terms of our approach, through the Standards Review in 2024, we explored AI, digital literacy and wider technological change. Our revised standards now require registrants to remain informed about digital technologies and to exercise professional judgement when using data generated by those technologies to support decision making. We have also participated in sector body initiatives including a study by The College of Optometrists. We will revisit AI again when we undertake our substantive review of the business standards which will commence in late 2026 and once the joint high-level principles referred to in the previous paragraph have been agreed.

11. Other regulators are increasingly examining how AI can support healthcare professionals in practice. The General Medical Council recently published a report showing that doctors are using technology, including artificial intelligence (AI), to reduce administrative burdens, improve efficiency and create more time for patients. The GDC has undertaken rapid evidence assessment to better understand the impact and potential implications of AI, while the General Osteopathic Council has issued guidance and the General Pharmaceutical Council has released a position statement setting out its approach to AI use.

High patient satisfaction levels but challenging working conditions persist

12. The 2026 surveys present a clear paradox. Public confidence in optical care remains very high and has strengthened: 94% of respondents said they were confident they would receive a high standard of care from an optician or optometrist practice, up from 93% in 2025, while satisfaction with the overall experience increased from 87% to 89%. More people are also accessing routine eye care, with 84% reporting a sight test or eye examination in the last two years, compared with 80% in 2025.

13. Positively, job satisfaction has increased since last year (from 55% to 59%), but in general, these positive public-facing indicators sit alongside worrying evidence about the conditions in which registrants are delivering care. Two-thirds of registrants' report working beyond their hours at least sometimes, 60% report feeling unable to cope with their workload, and more than a third (36%) say they have found it difficult to provide patients with the level of care they need. This suggests that high patient satisfaction may be being sustained despite, rather than because of, the working environment experienced by parts of the optical workforce.

14. Commercial pressures provide a further indication of strain within the system. Registrants continue to report pressure to see a high volume of patients (38%), sell higher-value products (34%) and meet targets at the expense of patient care (31%), with these pressures more commonly reported by those working in multiples and by those more early on in their career.

15. The registrant survey also highlights persistent cultural and workplace risks. In the last 12 months, 38% of registrants experienced harassment, bullying or abuse from patients or service users, 19% from managers and 18% from colleagues. Almost a third (31%) experienced some form of discrimination. Ethnic minority registrants and

registrants with a disability remain more likely to report these behaviours, while reporting levels continue to be limited, at 37% for harassment, bullying and abuse and 28% for discrimination.

16. Taken together, the findings point to a sector that continues to command strong public trust while relying on a workforce experiencing significant pressure, unequal treatment and limited confidence in local reporting mechanisms. We have undertaken a thematic review into commercial practices and patient safety, which Council are also discussing at this meeting, where we have outlined what we, and the wider sector, can do to help address some of these issues.

17. The wider policy environment is placing greater emphasis on accountability for workplace culture and professional behaviours. The Department of Health and Social Care's new NHS staff standards will make NHS employers in England formally accountable for workforce treatment, including tackling racism and supporting health and wellbeing. The Lord Mann review on antisemitism and other forms of racism in the NHS further reinforces the need for a clear, system-wide zero-tolerance approach. Developments beyond healthcare also indicate a broader regulatory shift towards greater accountability, for example, the Financial Conduct Authority will require regulated firms to notify future employers about any serious cases of racism, bullying and harassment against former employees. A progress update on our response to the Mann review is the subject of another paper on today's agenda.

Finance

18. The policy and standards budget includes the costs of commissioning the public perceptions survey and registrant survey.

Risks

Public perceptions survey

19. There is a risk that we do not understand the public's views and experiences of eye care, which could have weaken our ability to protect the public.

20. There is also a risk that we do not address the risks and issues raised by the public via our research. We have mitigated these risks by carrying out an annual survey since 2015, and we use the research to, for example, inform the policies and standards we set to fulfil our statutory role in protecting the public.

Registrant survey

21. There is a risk that we do not understand registrant views of the GOC or working in clinical practice, which could weaken our ability to protect the public. There is also a potential reputational risk if we do not act upon the findings of the survey. We mitigate these risks by ensuring that we capture and track registrant data via our annual survey, and we demonstrate publicly, how we are acting on these findings.

Equality Impacts

22. We have not carried out an equality impact assessment as the surveys are not a new or amended policy. However, the research findings highlight concerning experiences for registrants and patients from groups with protected characteristics.

Devolved nations

23. For the public perceptions survey, Scotland, Wales and Northern Ireland were over-sampled to ensure that confident statistical analysis could be undertaken by nation.

24. The registrant survey was sent to all individual registrants across the UK. In England 10% of registrants responded to the survey (2,570 out of 25,772 registrants); in Scotland 12% (310 out of 2,629 registrants); in Wales 12% (179 out of 1,444); and Northern Ireland 11% (96 out of 912 registrants).

25. Any significant differences between nations are highlighted in the reports. Infographics, highlighting the key findings, are available for each nation for both surveys. The data tables also give the findings by nation.

Communications

External communications

26. The surveys are published on the GOC's website and continue to get good coverage in the sector press and sometimes beyond, which shows how the surveys can stimulate conversations in the wider sector.

27. Both reports have been presented and well received by several external stakeholders including The College of Optometrists and national optometric advisors in Wales, Scotland and Northern Ireland. We are aware that the findings and tracking of data on an annual basis continue to be of interest for a wide range of organisations and are used to help inform policy development.

28. This year we asked questions on vision and driving to help inform the Department for Transport public consultation on introducing mandatory eyesight testing for older drivers. We await the government's response document.

Internal communications

29. We have disseminated the findings to relevant internal teams to help inform their work and the findings have been used to, for example, inform our thinking into the thematic review on commercial practices and patient safety.

Next steps

30. We have published the public perceptions survey and registrant survey on our website.

31. The contracts for both surveys have now come to an end, providing an opportunity to review our approach to commissioning and delivering this research. This review will form part of a broader assessment of our research activities, including the development of a public and patient engagement strategy, with the aim of ensuring that future work remains strategically relevant, engaging for stakeholders, and proportionate in terms of cost and value for money. The outcome will help inform how we prioritise, design and procure future research so that it continues to support evidence-based policy and regulatory decision-making.

Attachments

Annex 1: Public perceptions survey 2026
Annex 2: Registrant survey 2026

General Optical Council

Public Perceptions Research

March 2026

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djs research

JN9485

02 Summary of findings

Summary of findings (1)

Satisfaction with the **overall experience** of an opticians/optometrist practice has increased this year (89% vs. 87% 2025). Patient satisfaction has also increased when it comes to the **time the optometrist gave to address needs properly** (89% vs 87% 2025). A new question for this wave shows that 89% of patients are satisfied with how long they had to wait for an appointment.

Just over three quarters (76%) are satisfied with overall **value for money**. Satisfaction has also remained stable when it comes to **the experience of buying glasses or contact lenses** (72%).

The youngest age groups (16-24), ethnic minorities, and those with at least one vulnerability marker are **less likely than average to be satisfied across almost all satisfaction metrics**.

Summary of findings (2)

More this year say they would go to **an opticians/optometrist practice** in the event of an eye problem (41% vs. 36% 2025) – this remains ahead of a GP practice/surgery, which has seen year-on-year decline (23% vs. 27% 2025). Those in **England** remain less likely to turn to an opticians/optometrist practice first (38%), while those in Wales (60%) and Scotland (50%) are more likely to do so. Those in Northern Ireland are no more or less likely than average (47%).





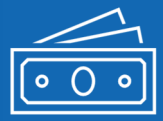
Confidence in a high standard of care from an opticians/optometrist practice sees a small but significant increase (94% vs. 93% 2025), as have comparators: pharmacy (89% vs. 86% 2025), dental practice/surgery (84% vs. 80% 2025) and a GP practice/surgery (82% vs. 78% 2025).

More this year say they are **confident in managing their own eye health** (90% vs. 85% 2025), which is driven by more who say they are very confident (38% vs. 34% 2025).



Summary of findings (3)

Not being able to be seen on the same day is still the most common reason why some would not visit an opticians/optometrist practice first in the event of an eye problem (30%).



More this year say they have not felt uncomfortable about visiting an opticians/optometrist practice (53% vs. 49% 2025). For those that have felt uncomfortable, the cost of glasses/contact lenses (21%) and sight test/eye examinations (15%) continue to be the main reasons why. The most common reasons for not having a sight test/eye examination in the last two years are because they didn't experience any issues with their eyes (41%) and just didn't think about it (36%). Cost of glasses/contact lenses (24%) and of the sight test/eye examination (19%) are also barriers for some.

More participants this year say they have had a sight test/eye examination **in the past two years** (84% vs. 80% 2025). Just 3% say they have never had one.



Summary of findings (4)

One third (33%) have shopped around while more than three in five (64%) knew the price before attending their appointment – both remain in line with previous waves.







More this year say they bought either their glasses or contact lenses from the same opticians/optometrist practice where they had their sight test/eye examination (83% vs. 79% 2025). Encouragingly, fewer this wave agree when asked if they **felt pressured** to purchase specific brands or types of glasses or contact lenses (20% vs. 24% 2025) and more strongly agree that pricing was **clear and transparent** when they last purchased glasses or contact lenses (36% vs. 32% 2025). Just under three quarters (73%) feel that the price they expected to pay **matched** the price they ended up paying.

New to this wave, just under two in five (38%) say they spent up to £100 in the last 12 months on eye care services. Just under half (47%) spent between £101-500, while one in ten (10%) spent between £501-2,000.



Summary of findings (5)

Of those who were dissatisfied with their overall experience, more than four in five (81%) say they **did not complain**, while 35% **considered complaining** but decided not to. 15% say they **complained**.



Participants were asked **who they think is responsible** for notifying the Driver and Vehicle Licensing Agency (DVLA) or Driver and Vehicle Agency (DVA for Northern Ireland) if a patient's sight test falls below the standard required to drive safely. More than half (51%) think responsibility lies **with the patient**, while just over two in five (41%) say it lies **with the optometrist**.

Participants were asked if they would be **put off** going for a sight test/eye examination if the optometrist was required to automatically notify the DVLA or DVA of patients who fall below the standard required to drive safely. 15% say they would definitely be put off (compared to 13% in 2017).



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04 Advanced statistical analysis

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01 Background and methodology

Background and methodology

Since 2015, the regulator for the optical professions in the UK, the General Optical Council (GOC), has carried out an annual representative public perceptions survey to explore areas such as satisfaction levels with sight tests/eye examinations, confidence and trust in the optical professions, shopping habits and complaints.

Making decisions based on evidence is a strategic priority for the GOC. The findings of the annual survey are used to inform the policy work conducted both at the GOC and with stakeholder bodies across the optical sector. The GOC commissioned DJS research in 2024 to continue the long-standing annual survey.

The 2026 survey was redesigned by DJS Research in conjunction with the GOC. A copy of the questionnaire is published separately.

Fieldwork was conducted online and distributed to a sample using our UK consumer partner panel provider, Dynata. Fieldwork took place between **9 February – 2 March 2026**.

A total of **2,014 completes** were achieved. A full breakdown of the sample profile can be found in chapter 4.

Replicating the approach in previous waves, interlocking quotas were set on gender and age within UK nations in order to achieve a representative sample of the UK. Scotland, Wales, and Northern Ireland were over-sampled so that confident statistical analysis could be undertaken by nation.

As in the previous wave, data in this wave has been weighted to reflect a nationally representative sample of the UK population in terms of age, gender, and nation. It is important to take into consideration that waves before 2024 had been weighted to the 'boosted' profiles of Scotland, Wales, and Northern Ireland, rather than the actual representative proportions of those nations. While comparisons to previous waves have been made throughout this report, it is important to consider the different weighting schemes applied, although the difference is small (approximately 1% or less between weight schemes).

Throughout this report, the commentary provided on sub-groups is based on statistically significant differences, unless otherwise stated. The most relevant statistically significant differences are reported on in each question, meaning, there may be instances where some statistically significant differences are not discussed as they are not as relevant.

Note on statistics and confidence intervals

Participants in the research are only samples of the total population, so we cannot be certain that the figures obtained are exactly those we would have found if every single person in the United Kingdom aged 16 and older had been surveyed. However, we can predict the variation between the sample results and the true values from knowing the size of the samples on which the results are based and the number of times that a particular answer is given.

It is important to note that margins of error relate only to samples that have been selected using strict random probability sampling methods. However, in practice it is reasonable to assume that these calculations provide a good indication of the confidence intervals relating to this survey and the sampling approach used.

Size of sample on which the survey results are based	Approx. sampling tolerances applicable to percentages at or near these levels (at the 95% confidence level)		
	10% or 90% ±	30% or 70% ±	50% ±
2,014 (all participants)	1.3%	2.0%	2.2%
1,676 (all participants who have had a sight test/eye examination in the last two years)	1.4%	2.2%	2.4%
1,238 (all participants who have purchases glasses OR contact lenses)	1.7%	2.6%	2.8%

For example, with a sample of 2,014 where 50% give a particular answer, the chances are 19 in 20 (95%) that the true value (which would have been obtained if the whole population had been surveyed) will fall within the range of plus or minus 2.2 percentage points from the sample result, i.e. between 47.8% and 52.2%.

Notes on reporting

Where a 'patient' is mentioned in this report, it is defined as those who have had a sight test/eye examination in the last two years.

The General Optical Council wished to explore differences in access and experience within the sample. To enable this, analysis was conducted using 'vulnerability markers' throughout the report.

Where 'vulnerability markers' are mentioned in this report, these include those:

- With a disability
- Who have less than £25,000 of household income
- Not confident in managing their own eye health
- Going through a difficult life circumstance
- Consider themselves to be struggling financially
- Say they cannot afford essentials

Vulnerability markers have been grouped into four different categories:

- None
- One
- Two to three
- Four or more

Additional analysis has been conducted to explore whether access to, and experience of, optical services differs by area deprivation. Summary findings are included on slides 56–59, with a full report available separately.

Trend data has been significance tested. Statistically significant changes between 2025 and 2026 are indicated throughout with these arrows depending on the direction change:

denotes significantly higher than the previous wave

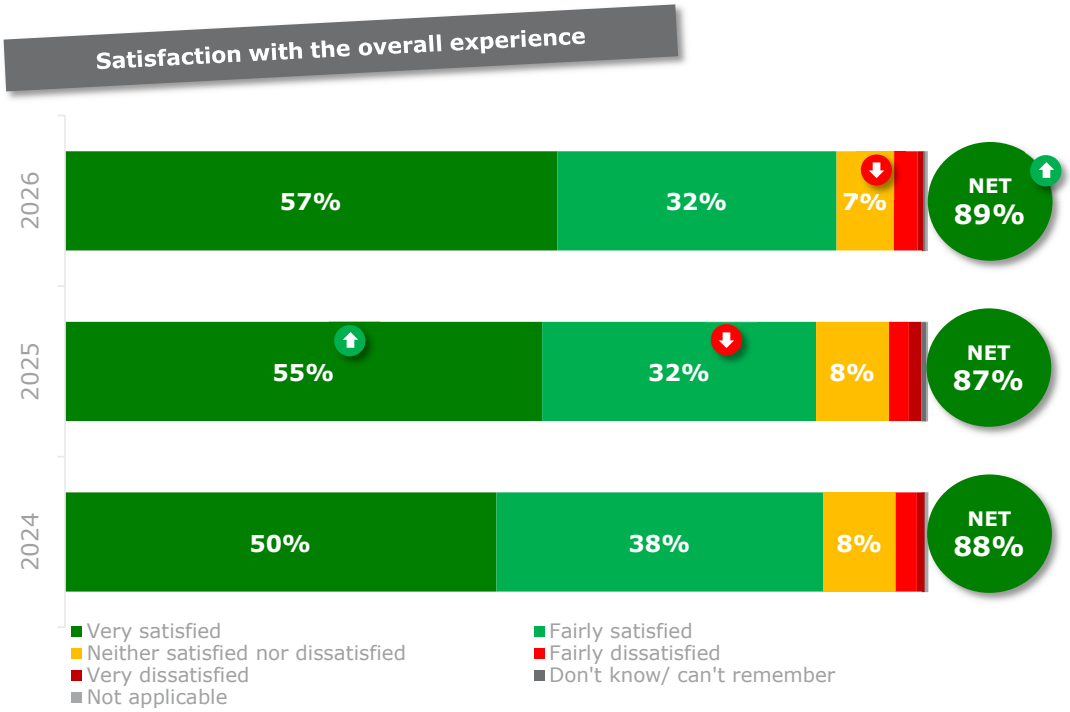
denotes significantly lower than the previous wave

03 Main findings

Satisfaction levels

Satisfaction with the overall experience

Satisfaction with the overall experience of the opticians/optometrist practice has increased this year with 89% satisfied overall (an increase from 87% in 2025), while fewer say they are neither satisfied nor dissatisfied (7% vs. 8% in 2025). Just 4% say they are dissatisfied.



Those aged 65 and older are more likely than those aged 16-34 to be satisfied with their overall experience (95% vs. 83%). A similar story can be found for those from a white background compared to ethnic minorities (90% vs. 86%).

Those in ABC1 social grades are more likely than average to be satisfied with their overall experience (90%).

Other groups more likely than average to be satisfied with their overall experience include those who:

- Had their sight test/eye examination within the last 6 months (93%)
- Are confident in both receiving care from an opticians/optometrist and in managing their own eye health (91% respectively)
- Those who spent up to £100 on eye care services in the last 12 months (93%)

In terms of groups who are more likely than average to be dissatisfied with their overall experience, these include those who:

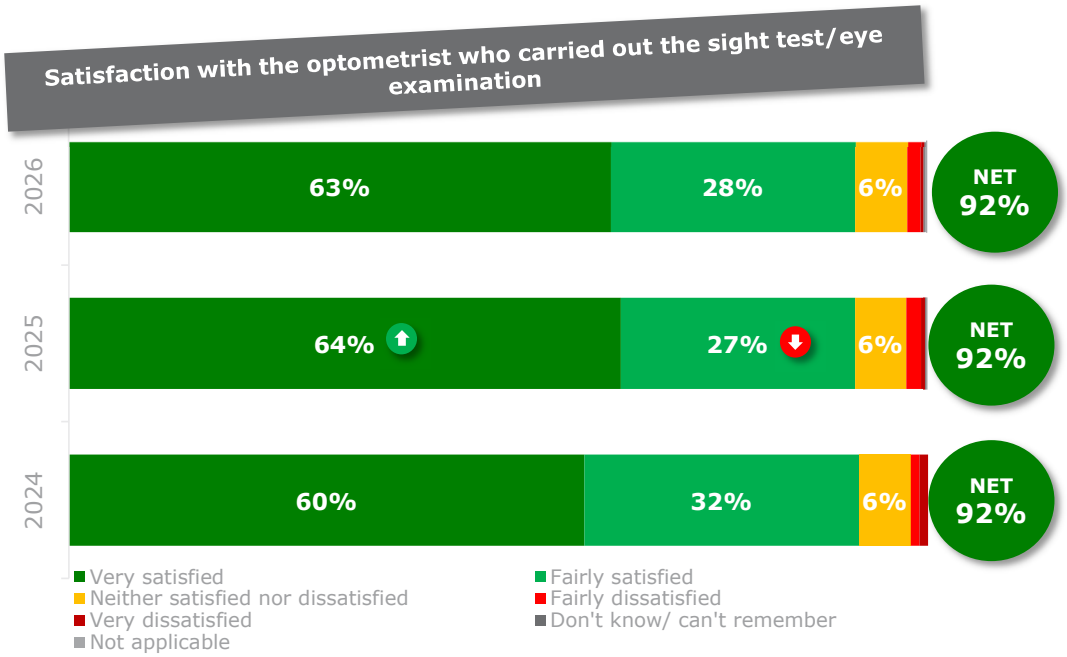
- Have at least one vulnerability marker (5%)
- Have felt uncomfortable about visiting an opticians/ optometrist practice (5%)
- Are not confident in both receiving care from an opticians/optometrist (33%) and in managing their own eye health (15%)

Q018. Thinking of the last time you had a sight test/eye examination, how satisfied or dissatisfied were you with the following? **Base:** All participants who have had a sight test/eye examination in the last two years (1,676), 2025 participants (1,616), 2024 participants (1,599).

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Satisfaction with the optometrist who carried out the sight test/eye examination

Satisfaction with the optometrist who carried with the sight test/eye examination remains stable this year (92%). Just 2% are dissatisfied, which is also comparable to previous waves.



Those aged 16-34 are less likely to be satisfied with the optometrist compared to those 65 and over (86% vs 98%). The same can be said for those from a white background compared to ethnic minorities (93% vs. 88%).

Those who are those confident in both receiving care from an opticians/optometrist and in managing their own eye health are more likely to be satisfied with the optometrist (93% respectively).

Groups who are more likely than average to be dissatisfied with their optometrist include those who:

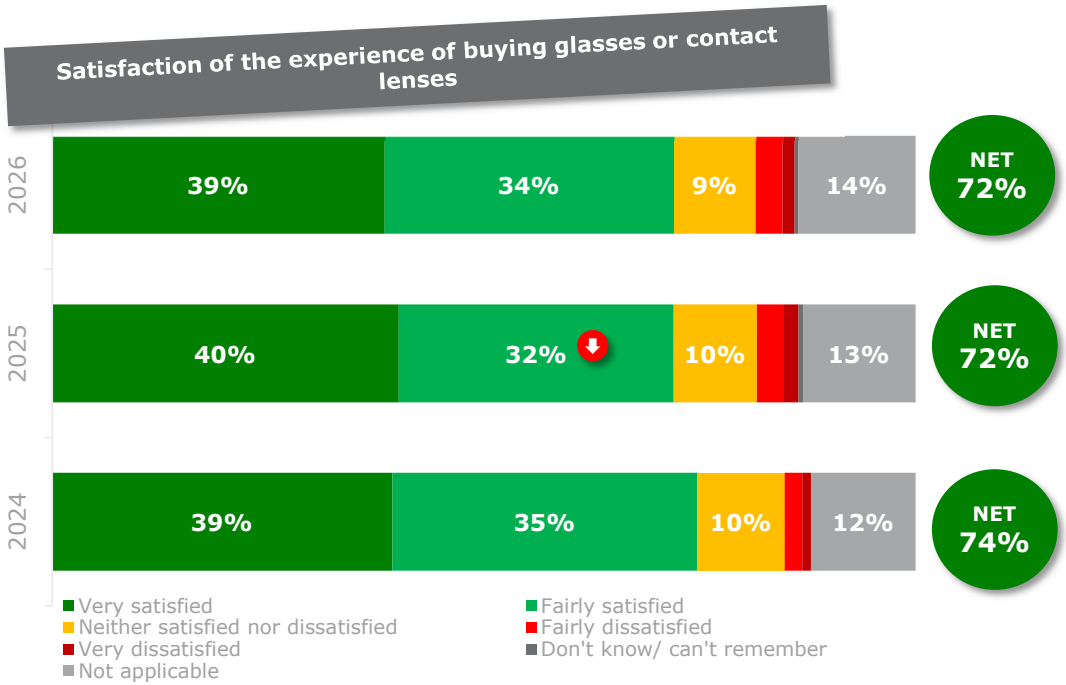
- Have 2-3 vulnerability markers (4%)
- Are not confident in managing their own eye health (8%)
- Have felt uncomfortable about visiting an opticians/ optometrist practice (3%)

Q018. Thinking of the last time you had a sight test/eye examination, how satisfied or dissatisfied were you with the following? **Base:** All participants who have had a sight test/eye examination in the last two years (1,676), 2025 participants (1,616), 2024 participants (1,599).

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Satisfaction with the experience of buying glasses or contact lenses

Over seven in ten (72%) are satisfied with their experience of buying glasses or contact lenses, consistent with previous waves. The proportion who are dissatisfied remains low (4%).



Groups who are more likely to be dissatisfied include those who:

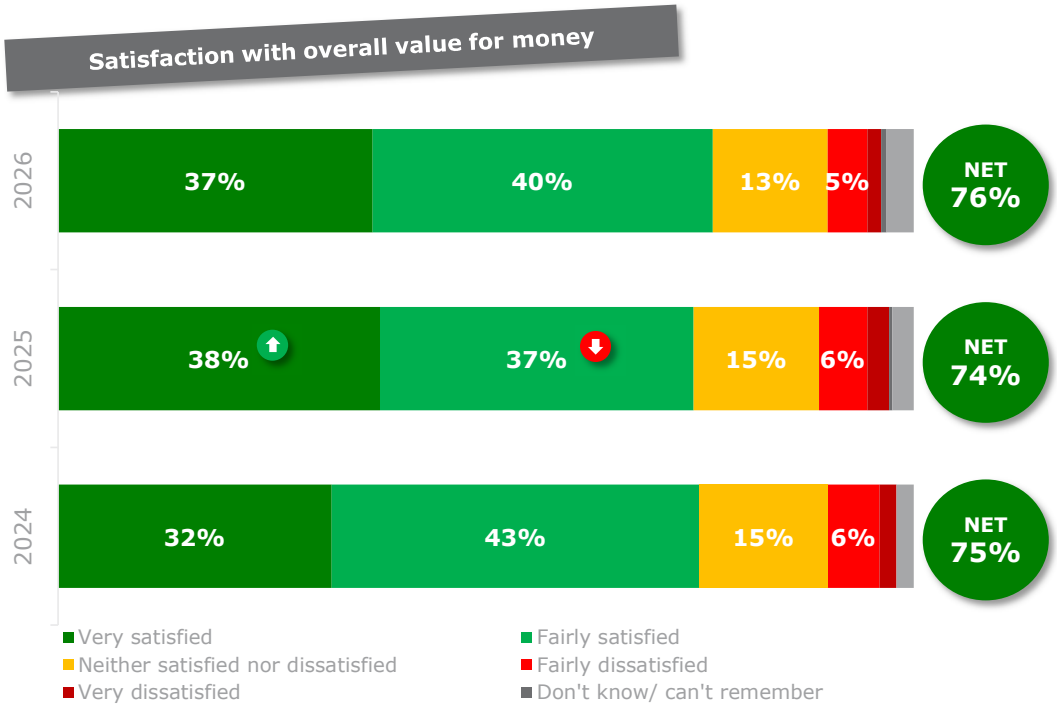
- Have at least one vulnerability marker (5%)
- Are not in work (10%)
- Are not confident in receiving a high standard of care from an opticians/optometrist practice (29%) or managing their eye health (17%)
- Spent between £101-500 in eye care in the last 12 months (6%).

Q018. Thinking of the last time you had a sight test/eye examination, how satisfied or dissatisfied were you with the following? **Base:** All participants who have had a sight test/eye examination in the last two years (1,676), 2025 participants (1,616), 2024 participants (1,599).

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Satisfaction with value for money

Just over three quarters (76%) are satisfied with the overall value for money. A similar proportion remain dissatisfied (7% vs. 8% 2025).



Those aged 16-24, likely with less disposable income, are less likely than average to be satisfied with the overall value for money (70%). This is also evident when we look at income, with those on a lower income (£25k-£35k) also more dissatisfied with value for money (10%).

Those living in Scotland are less likely than average to be dissatisfied (2%).

Those with at least one vulnerability marker are more likely than average to be dissatisfied with value for money (9%), especially those with 4 or more (17%).

Participants who are not confident in receiving a high standard of care from an opticians/optometrist practice (40%) or managing their own eye health (23%) are more likely to be dissatisfied with the overall value for money.

Those who have had a recent sight test/eye examination in the last six months are more likely than average to be satisfied with the value for money (82%). The same can be said for those who knew the price before attending (78%).

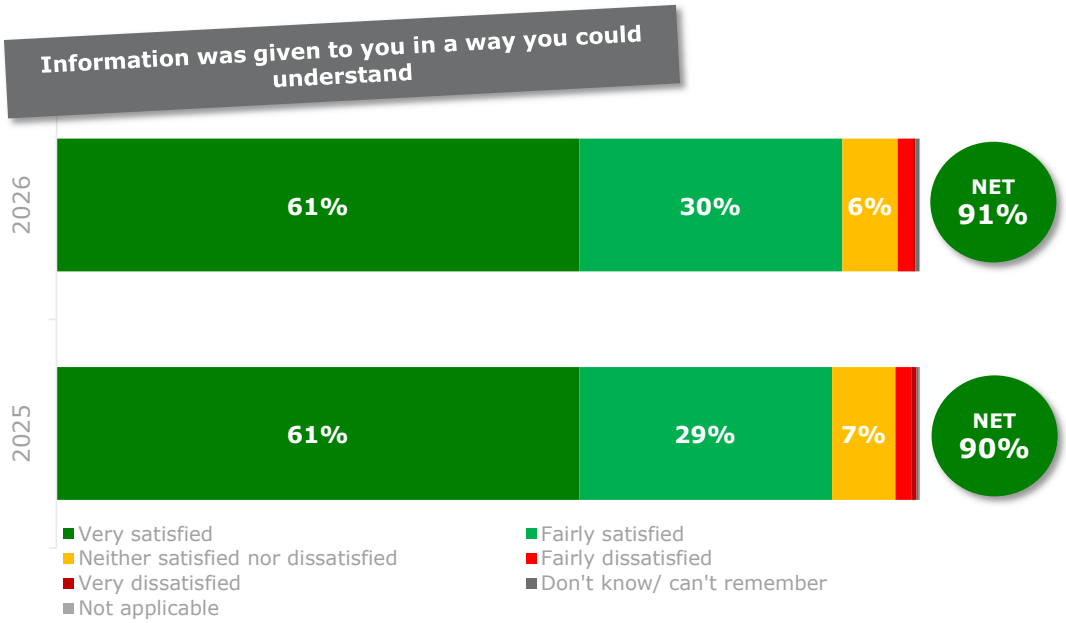
Q018. Thinking of the last time you had a sight test/eye examination, how satisfied or dissatisfied were you with the following? **Base:** All participants who have had a sight test/eye examination in the last two years (1,676), 2025 participants (1,616), 2024 participants (1,599).

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Satisfaction with delivery of information

Just over nine in ten (91%) say that at their last sight test/eye examination, information was given to them in a way which they could understand, in line with the previous year. Just 2% were dissatisfied.



Older participants (65+) are more likely to be satisfied compared to younger participants (16-34) (95% vs. 86%).

There are differences by ethnicity as well, with White participants more likely to be content that they understood the information given to them compared to those from an ethnic minority background (92% vs. 88%).

Other groups more likely than average to be satisfied include those who:

- Are of a higher social grade (ABC1) (92%)
- Have no vulnerability markers (93%)
- Had their last sight test/eye examination in the last 6 months (93%)
- Had their last sight test/eye examination at a high street opticians/optometrist practice (92%)
- Had an NHS funded sight test/eye examination (94%)

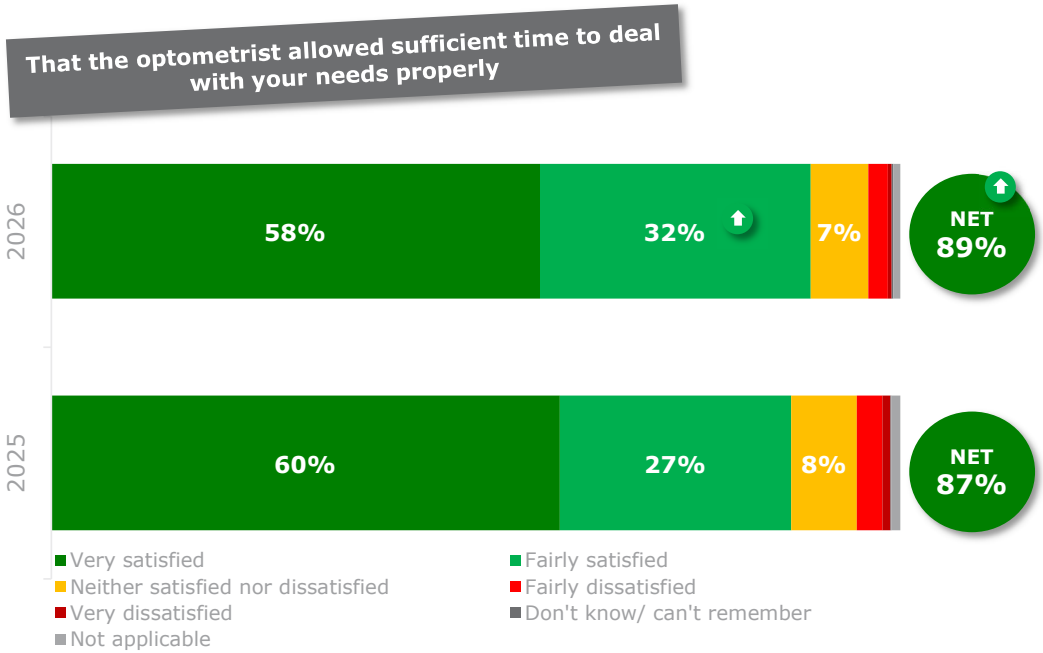
Q018. Thinking of the last time you had a sight test/eye examination, how satisfied or dissatisfied were you with the following? **Base:** All participants who have had a sight test/eye examination in the last two years (1,676), 2025 participants (1,616). Please note this statement was added in the 2025 survey wave so 2024 data is not available.

19

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Satisfaction with time given to address needs

Nine in ten (89%) are satisfied that their optometrist allowed sufficient time to deal with their needs properly, which has increased since the previous wave. This is primarily driven by more participants being *fairly satisfied* (32% vs. 27% in 2025). Just 3% are dissatisfied.



Those aged 16-34 are less likely than all other age groups to be satisfied (82% vs. 91% 35-64 and 96% 65 and older).

White participants are more likely than those from an ethnic minority background to be satisfied (91% vs. 84%).

Those not confident in receiving a high standard of care from their opticians/optometrist practice (19%), or managing their own eye health (6%), are more likely than average to be dissatisfied with time given to address their needs.

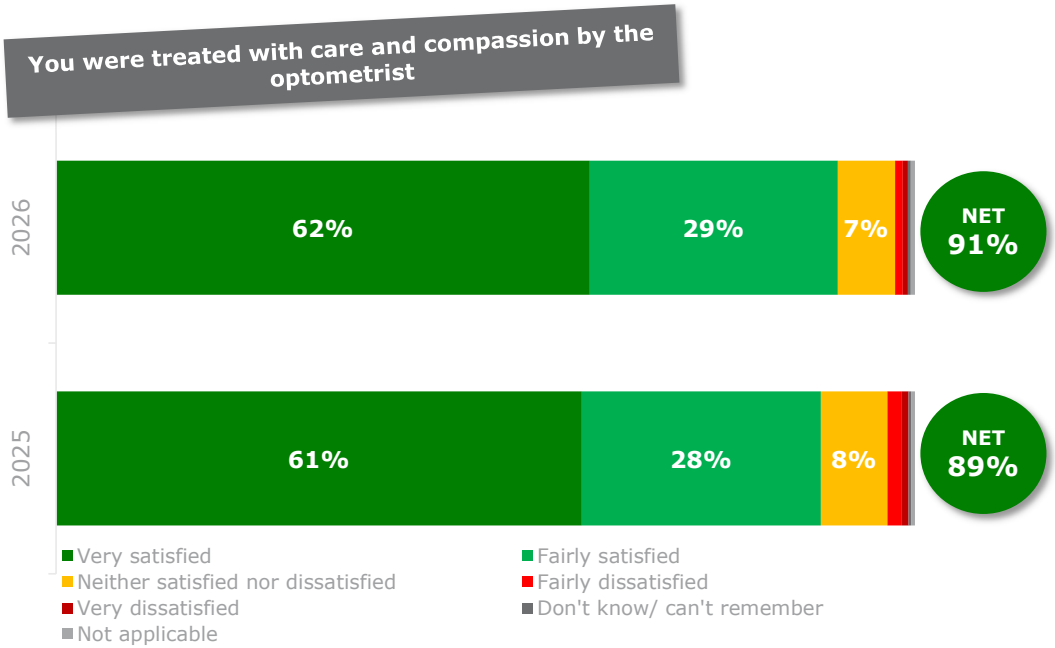
Those who had their last sight test/eye examination at a high street opticians/optometrist practice are more likely than average to be satisfied (91%), as are those who went in the last 6 months (92%).

Q018. Thinking of the last time you had a sight test/eye examination, how satisfied or dissatisfied were you with the following? **Base:** All participants who have had a sight test/eye examination in the last two years (1,676), 2025 participants (1,616). Please note this statement was added in the 2025 survey wave so 2024 data is not available.

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Satisfaction with care and compassion

More than nine in ten (91%) are satisfied that they were treated with care and compassion by their optometrist, which has had a slight but not statistically significant increase this year (vs. 89% in 2025). Just 1% are dissatisfied.



There are few demographic differences, the main being that older participants (65+) are more likely than younger people (16–34) to be satisfied (96% vs. 86%).

Those with at least one vulnerability marker are less likely than average to be satisfied compared to those with none (88% vs. 94%).

Participants that are less confident in receiving a high standard of care from their opticians/optometrist practice or managing their own eye health are more likely than average to be dissatisfied with the levels of care and compassion they received (12% and 6% respectively).

Those who had their sight test/eye examination conducted at a high street opticians/optometrist practice are more likely to be satisfied (92%).

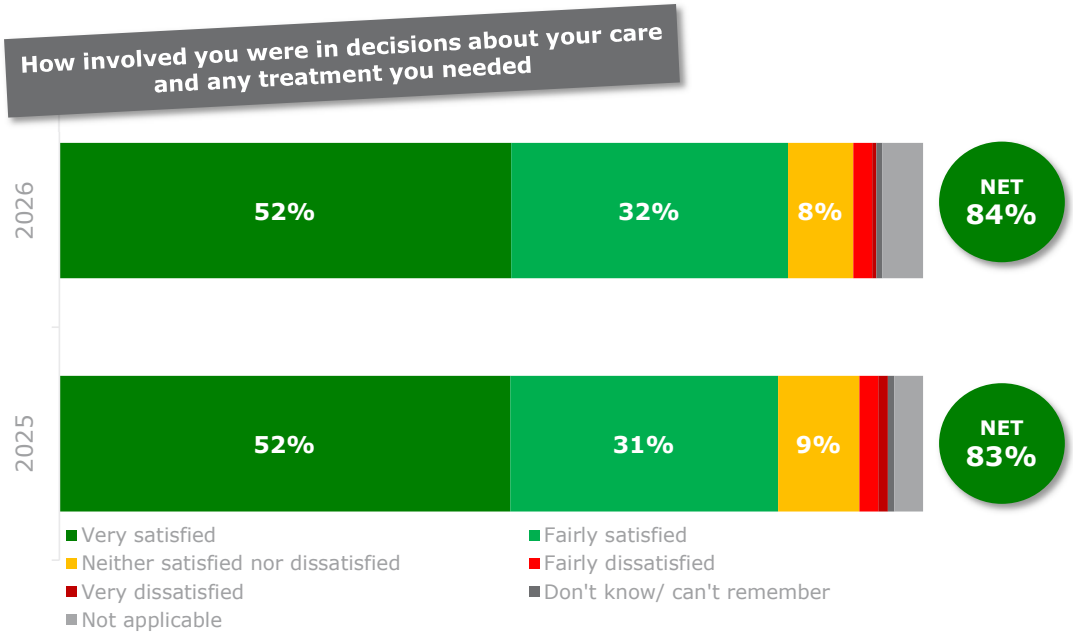
Q018. Thinking of the last time you had a sight test/eye examination, how satisfied or dissatisfied were you with the following? **Base:** All participants who have had a sight test/eye examination in the last two years (1,676), 2025 participants (1,616). Please note this statement was added in the 2025 survey wave so 2024 data is not available.

21

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Satisfaction with involvement in care and treatment decisions

The majority (84%) of participants are satisfied with the level of involvement they had in decisions about their care and treatment, which is in line with the previous year. Only 3% are dissatisfied.



In terms of demographic differences:

- Older participants (65+) are more likely than younger people (16-34) to be satisfied (87% vs. 80% 16-34)
- As with previous metrics, ethnic minorities tend to be more dissatisfied (5% vs. only 2% of those from a white background), albeit the majority remain satisfied overall

Participants with at least one vulnerability marker are more likely than average to be dissatisfied (4%), as are those in work (4%), those less confident in receiving a high standard of care from their opticians/optometrist practice (15%), or managing their own eye health (10%).

Participants who had their sight test/eye examination in the last 6 months are more likely than average to be satisfied (89%), as are those with an eye condition (87%).

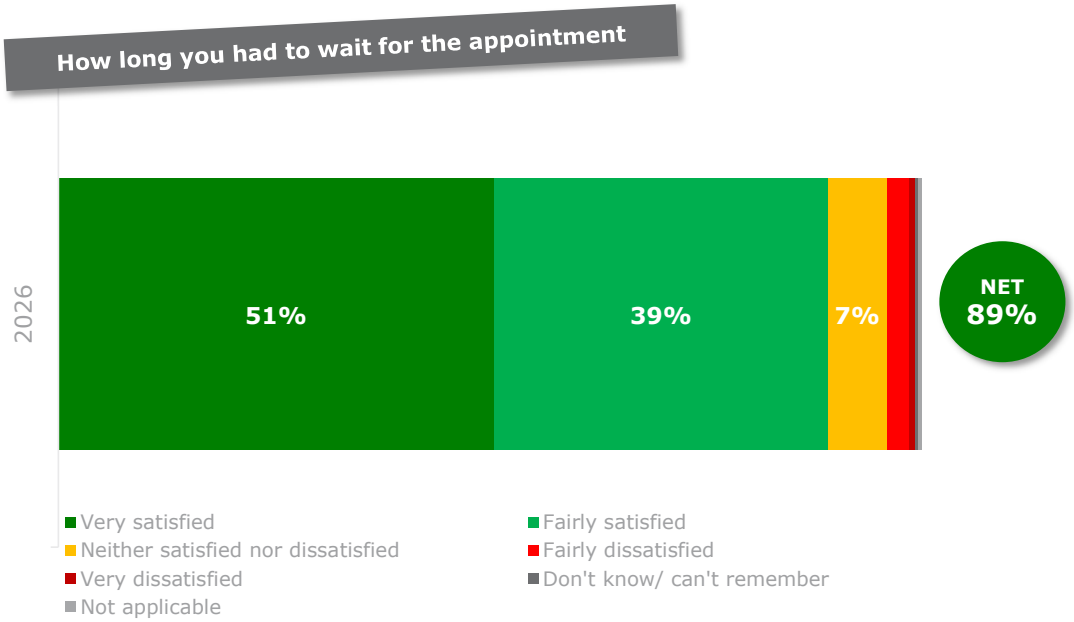
Q018. Thinking of the last time you had a sight test/eye examination, how satisfied or dissatisfied were you with the following? **Base:** All participants who have had a sight test/eye examination in the last two years (1,676), 2025 participants (1,616). Please note this statement was added in the 2025 survey wave so 2024 data is not available.

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Satisfaction with wait time for the appointment

For the first time participants were asked how satisfied or dissatisfied they were with the length of time they had to wait for their sight test/eye examination appointment, with almost nine in ten (89%) being satisfied. Only 3% say they are dissatisfied.



In terms of demographic differences:

- Older participants (65+) are generally more satisfied than younger people (16-34) (96% vs. 82% 16-34)
- Once again, there are significantly greater satisfaction levels amongst white participants compared to those from an ethnic minority background (92% vs. 80%)

Groups who are more likely than average to be satisfied include those who:

- Are retired (97%)
- Are confident in receiving a high standard of care from their opticians/optometrist practice (91%)
- Are confident in managing their own eye health (90%)
- Wear glasses (91%)
- Had their last sight test/eye examination at a high street opticians/ optometrist practice (91%)
- Had an NHS funded sight test/eye examination (93%)

Groups who are more likely than average to be dissatisfied include those who have at least one vulnerability marker (4%), and those in work (4%), especially those part-time (8%).

Q018. Thinking of the last time you had a sight test/eye examination, how satisfied or dissatisfied were you with the following? **Base:** All participants who have had a sight test/eye examination in the last two years (1,676). Please note this statement was added in the 2026 survey wave so no trend data is not available.

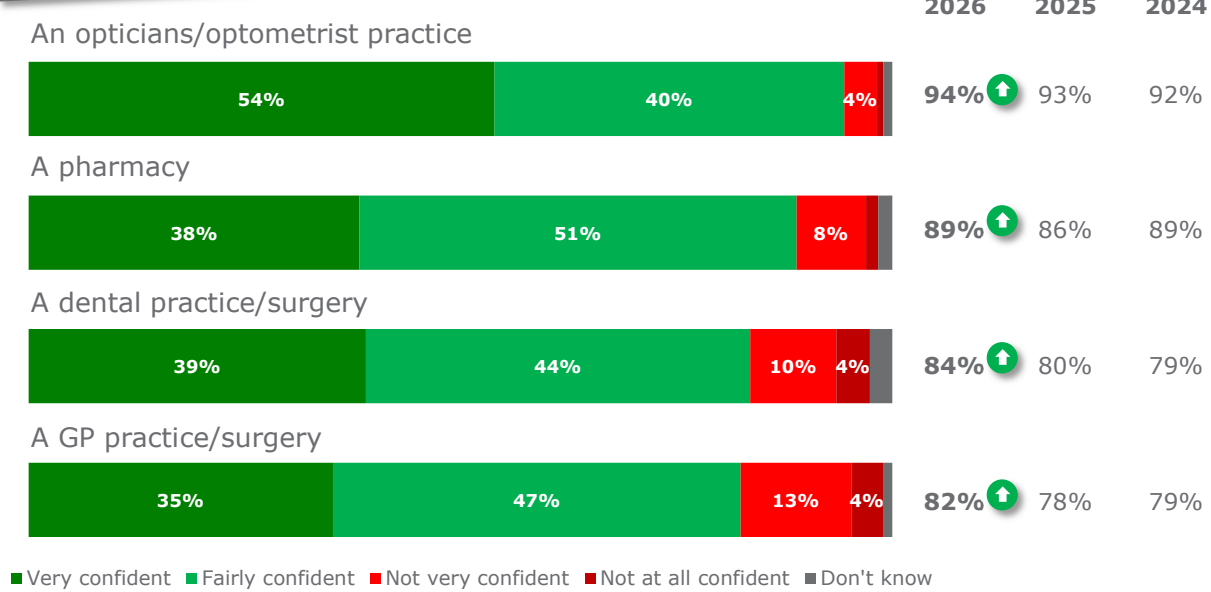
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Confidence levels

Confidence in receiving care

Confidence in receiving a high standard of care from an opticians/optometrist practice sees a small but significant increase this year (94% vs. 93% in 2025) and remains ahead of other services in comparison. This is primarily driven by an increase in those saying they are very confident (54% vs. 50% in 2025). All other comparators also see a significant increase.

Confidence in receiving high standard of care



Confidence in receiving a high standard of care from an opticians/optometrist practice remains varied by age as young people (16-34) are less likely to be confident than older people (65+) (93% vs. 97%).

Those who speak English as a first language are also more likely than average to be confident (95%).

Those who have at least one vulnerability marker are less likely than average to be confident in receiving a high standard of care from an opticians/optometrist practice (92%), as are those who do not wear glasses or contacts (88%).

Those who had a sight test/eye examination in the last two years (96%) are more likely to be confident than those who haven't (89%). Confidence is particularly low amongst those who have never had one (74%).

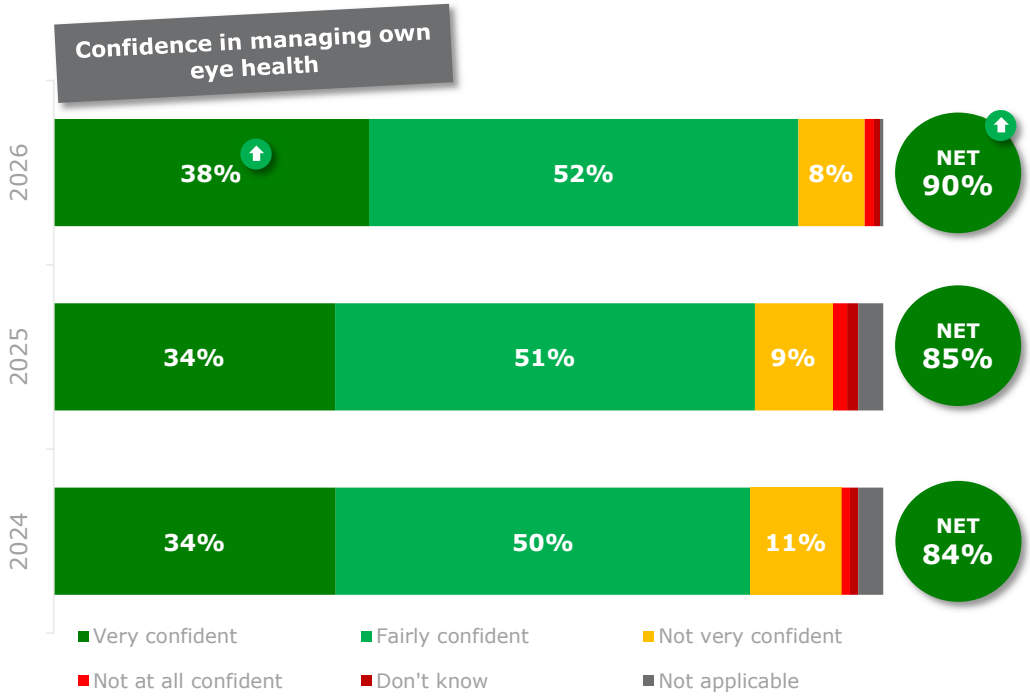
Those who had their sight test at a high street optician are more likely than average to be confident (95%). This is also the case for those who have an eye condition (96%).

S01a. To what extent are you confident or not in receiving a high standard of care from each of the following healthcare services? **Base:** All participants (2,014), 2025 participants (2,012), 2024 participants (2,035).

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Confidence in managing eye health

The public's confidence in managing their own eye health sees an increase this year (90% vs. 85% in 2025). This is driven by more who say they are very confident (38% vs. 34% in 2025).



Similar to the previous question, confidence in managing their own eye health has differences by age groups – young people (16-34) are less likely than older people (65+) to say they are confident (87% vs. 95%).

Confidence also differs by those who speak English as a first language, as those who do are more confident than those who don't (90% vs. 74% English not first language).

Those who have at least one vulnerability marker are less likely than average to say they are confident in managing their own eye health (82%). Similarly, those who are not confident in receiving a high standard of care from an opticians/optometrist practice are less likely to be confident (54%).

Those who had a sight test/eye examination in the last two years are more likely to be confident than those who had one more than two years ago (93% vs. 75%).

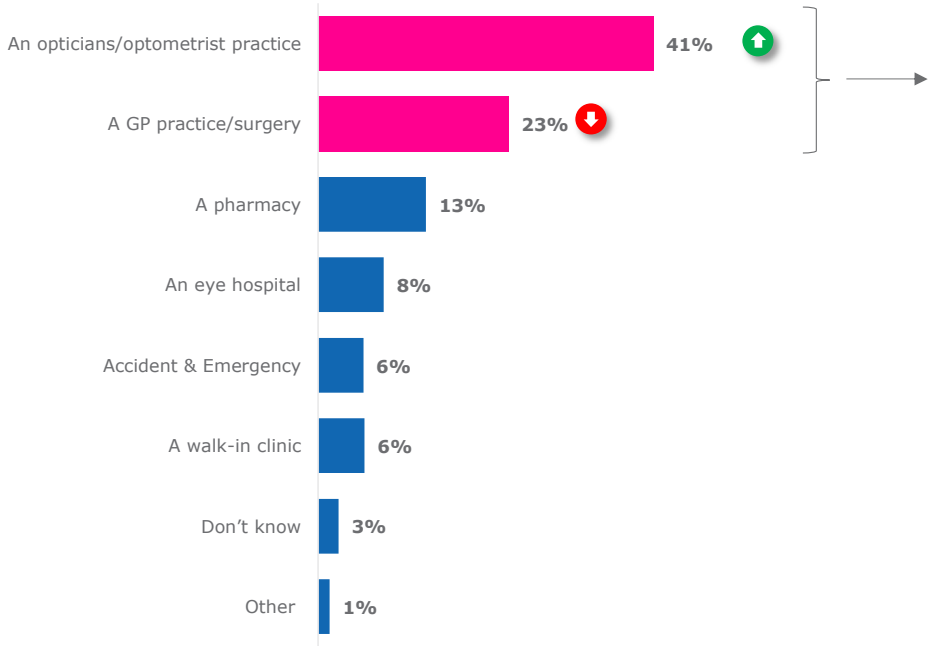
S01b. To what extent are you confident or not in managing your eye health? **Base:** All participants (2,014), 2025 participants (2,012), 2024 participants (2,035).

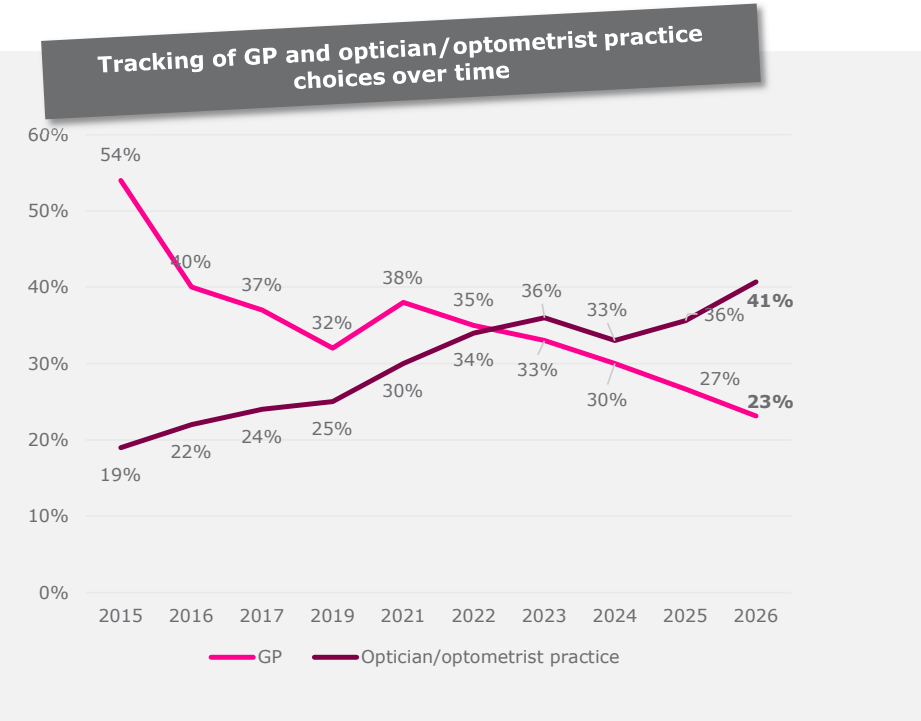
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Perceptions of urgent care

First ‘port of call’ for an eye problem

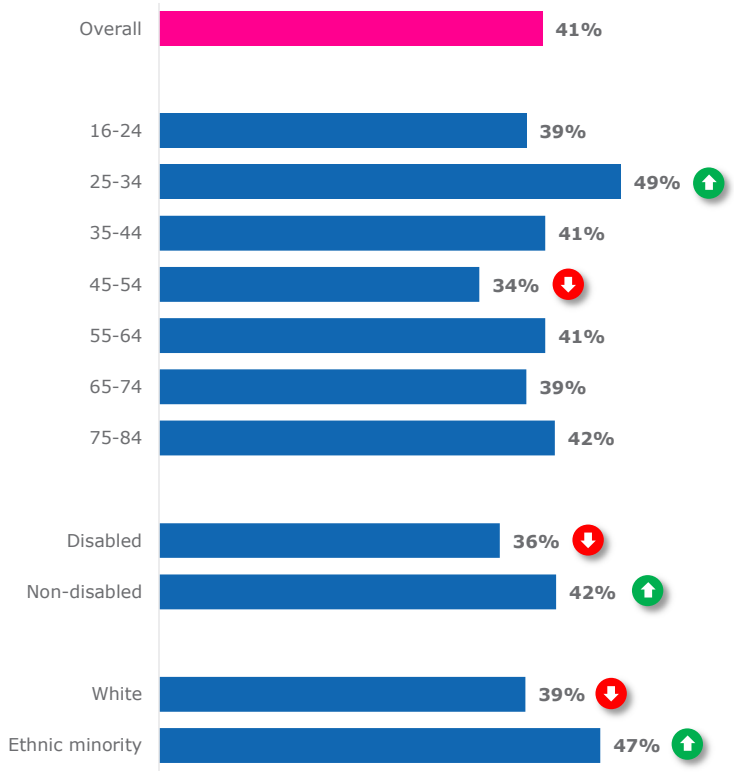
In this wave, a higher proportion say they would first turn to an opticians/optometrist practice in the event of an eye problem (41% vs. 36% 2025). Significantly fewer say they would turn to a GP compared to the previous wave (23% vs. 27% 2025).





Q01. If you woke up tomorrow with an eye problem, such as something in your eye, a red eye or blurred vision, where would you go or who would you speak to first? **Base:** All participants (2,014), 2025 participants (2,012), 2024 participants (2,035).

First ‘port of call’ for an eye problem cont’d.



Those aged 25–34 are more likely to turn to an opticians/optometrist practice (49%). Those aged 35-44 are more likely than average to say they would go to an eye hospital (12%), while 45–54-year-olds are more inclined to go to a walk-in clinic (10%).

Those from a white background are less likely than ethnic minorities to choose an opticians/optometrist practice (39% vs. 47%). Those with a disability are more likely than average say they would turn to GP practice/surgery as the first port of call (29%).

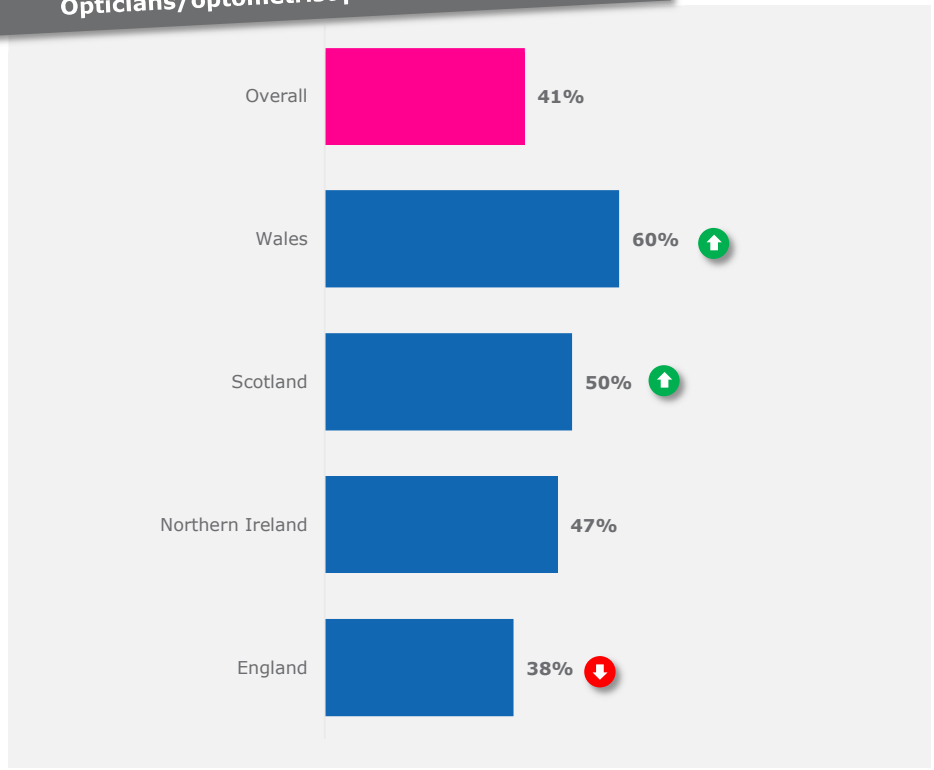
Those with at least one vulnerability marker are less likely than average to say they would go to an opticians/optometrist practice in the first place for an eye problem (36%). Instead, they are more likely than average to go to a GP practice/surgery (26%) or a pharmacy (15%). Intuitively, those less confident in managing their own eye health (28%) are less likely than average to turn to an opticians/optometrist practice first.

Those who had a sight test/eye examination in the last two years are more likely than those who had one more than two years ago to go to an opticians/optometrist practice first in the event of an eye problem (45% vs 21%). Those who had their sight test/eye examination more than two years ago are more likely to go to a GP practice (38%) or pharmacy (19%).

Q01. If you woke up tomorrow with an eye problem, such as something in your eye, a red eye or blurred vision, where would you go or who would you speak to first? **Base:** All participants (2,014), 2025 participants (2,012), 2024 participants (2,035).

First ‘port of call’ for an eye problem cont’d.

Opticians/optometrist practice by nation



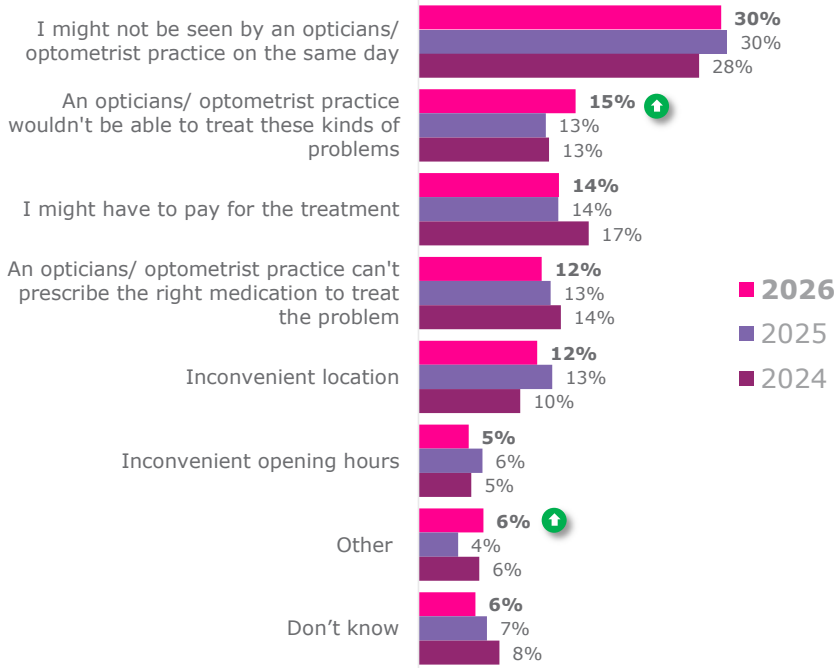
By region, those in England are less likely than those in Wales or Scotland to say they would visit an opticians/optometrist in the first instance (38% vs. 60% and 50% respectively).

Those living in England are more likely than average to say that they would turn to a GP surgery/practice (24%), an eye hospital (9%), or a walk-in clinic (6%) instead.

Q01. If you woke up tomorrow with an eye problem, such as something in your eye, a red eye or blurred vision, where would you go or who would you speak to first? **Base:** All participants (2,014).

Reasons for not choosing an opticians/optometrist practice as first port of call

Among those who did not say they would go to an opticians/optometrist practice first in the event of an eye problem, the worry of not getting a same day appointment remains the most common reason for doing so (30%). More this wave say that an opticians/ optometrist practice wouldn't be able to treat the kinds of problems they have as a reason (15% vs. 13% 2025).



Women are more likely than men to mention not being seen on the same day as a barrier to seeing an opticians/optometrist practice (33% vs. 27%). Paying for treatment (19% vs. 9%) and inconvenient opening hours (9% vs. 1%) are bigger barriers for young people (16-34) compared to those aged 65 and older.

Those from lower social grades (C2DE) are more likely to mention paying for treatment as a barrier (18% vs. 12% of ABC1s). The same can be found for those with at least one vulnerability marker (16%), and those not confident in receiving a high standard of care from an opticians/optometrist practice (24%).

Those in work are more likely than average to mention inconvenient opening hours as a barrier (6%), whereas those not in work are more likely than average to mention the possibility of not being seen same day (39%).

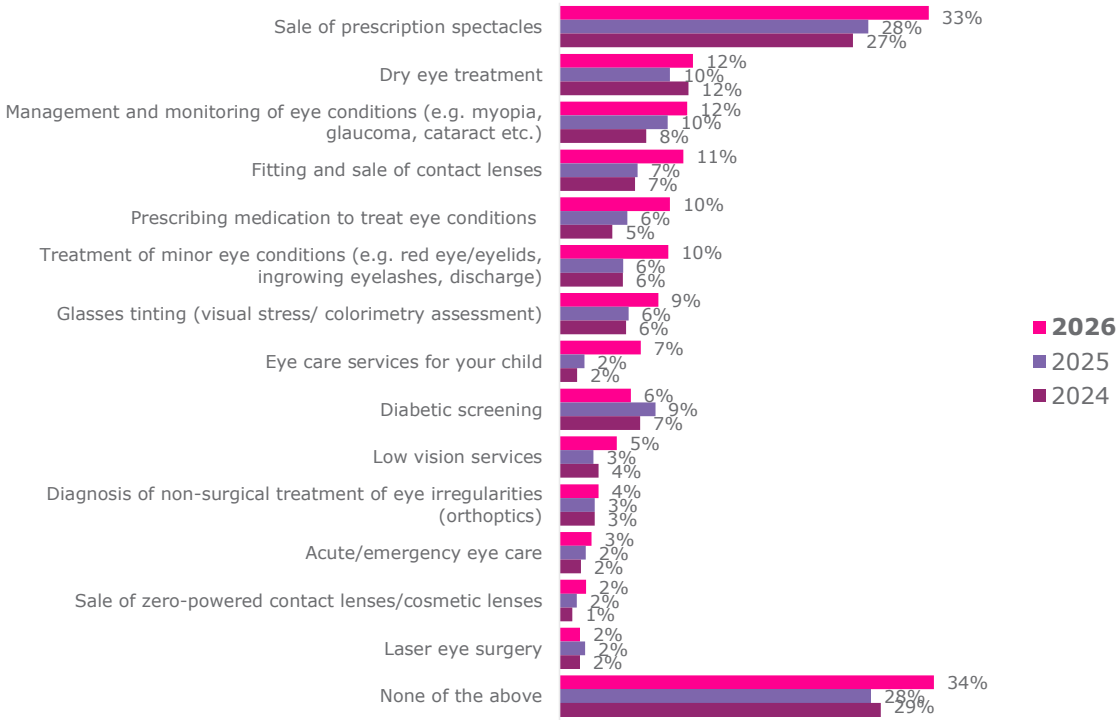
Those who last had a sight test/eye examination more than two years ago are more likely to cite potential payment for treatment as a reason not to choose an opticians/optometrist practice first (20%). Those who have had a sight test/eye examination in the last two years are more likely than average to mention not being seen on the same day (31%).

Q02. Why would you choose not to go to an opticians/optometrist practice first in this situation? **Base:** All participants not choosing to visit an opticians/optometrist practice (1,131), 2025 (1,225), 2024 (1,309).

Use of optical services

Use of optical services*

Participants were asked if they had used any of the listed optical services in the past two years. Sale of prescription spectacles is the most popular service (33%), followed by dry eye treatment (12%), and management and monitoring of eye conditions (12%). Over a third (34%) say they have used none of the listed services in the past two years.



Q04d. In the last 2 years, have you used any of the following services? **Base:** All participants (2,014), 2025 (2,012), 2024 (2,035).

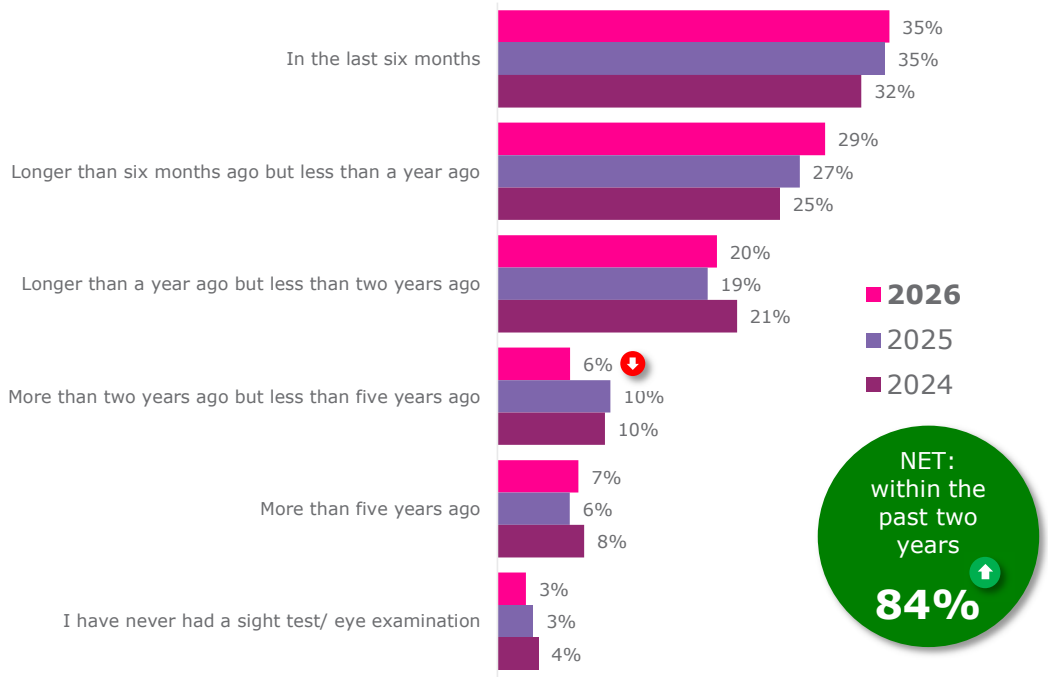
Those aged 65 and older are more likely than average to say they have bought spectacles (45%), had an eye condition managed/monitored (16%), undergone diabetic screening (12%) and/or had laser eye surgery (3% vs. 2% overall). In contrast, those aged 16-24 are more likely than average to have had fitting and sale of contact lenses (15%) and/or bought zero-powered contact lenses/cosmetic lenses (5% vs. 2% overall). Two in five young people (16-24) have not used any of the services (41%).

Those who are less confident in managing their eye health are more likely to say they have used none of the different services (46%), as are those with low incomes of under £20,000 (46%), C2DEs (41%), and those not in work (51%).

* This wave of the survey sees the option of sight testing/eye examinations and domiciliary services removed as potential options for participants to select. Other codes have also been amended. Therefore, comparisons to previous waves of the survey are only indicative and statistical significance compared to the previous wave has been omitted.

Last reported visit for sight test/eye examination

More participants say they have had a sight test/eye examination in the past two years compared to last year (84% vs. 80% 2025). In this wave fewer say they had a sight test/eye examination more than two years ago (14% vs. 17% 2025). Just 3% say that they have never had one.



Those aged 65 and older are more likely than average to have had a sight test/eye examination in the last two years (90%).

Unsurprisingly, those who wear glasses (92%) or contact lenses (97%) are more likely than average to have had a sight test/eye examination in the past two years compared to those who do not wear any (46%). Those with an existing eye condition are also more likely than average to have had their sight test/eye examination in the past two years (95%).

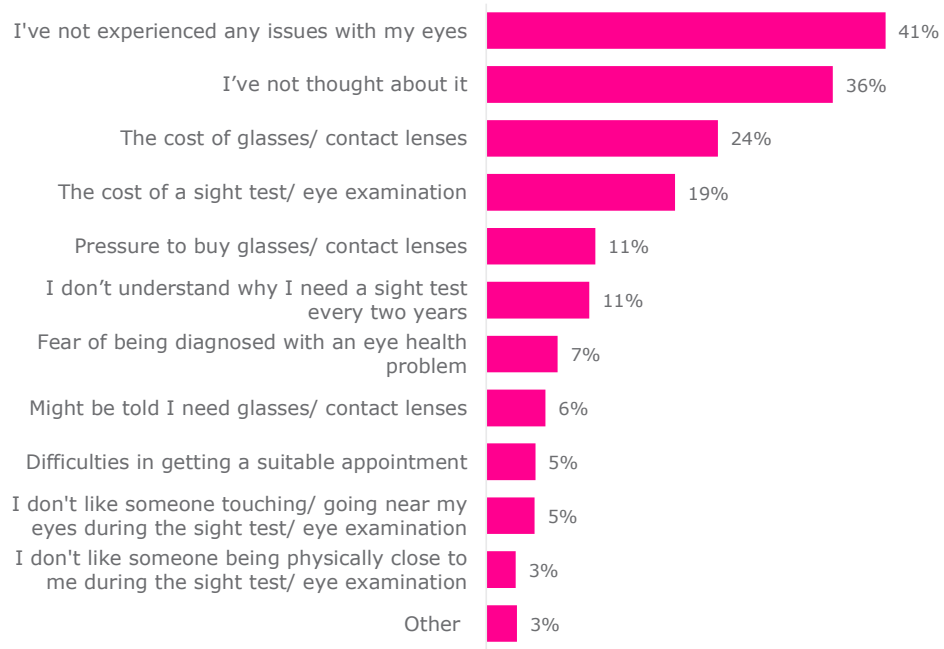
Those with no vulnerability markers (89%) are more likely than those with at least one marker (79%) to have had a sight test/eye examination in the past two years. Those with four or more vulnerability markers are more likely to say their last eye test was over five years ago (14%).

Those who have low confidence in managing their eye health are more likely to say their last sight test/eye examination was two or more years ago (33%), or never (8%).

Q04a. When was the last time you had a sight test/eye examination? **Base:** All participants (2,014), 2025 (2,012), 2024 participants (2,035).

Reasons for not having a sight test / eye examination in the last two years

Participants who have not been for a sight test/eye examination in the last two years were asked why. The most common reason is not experiencing any issues with their eyes (41%), which suggests that routine check ups are not common behaviour for some. Just over a third (36%) say they haven't thought about it, followed by reasons around cost (24% cost of glasses/contacts; 19% cost of a sight test/eye examination).



Those aged 16-34 are more likely than average to say they have not thought about having a sight test/eye examination (43%), whereas 35–64-year-olds are more likely to cite the perceived cost of glasses/contact lenses (31%) as a reason to not go for a test/examination.

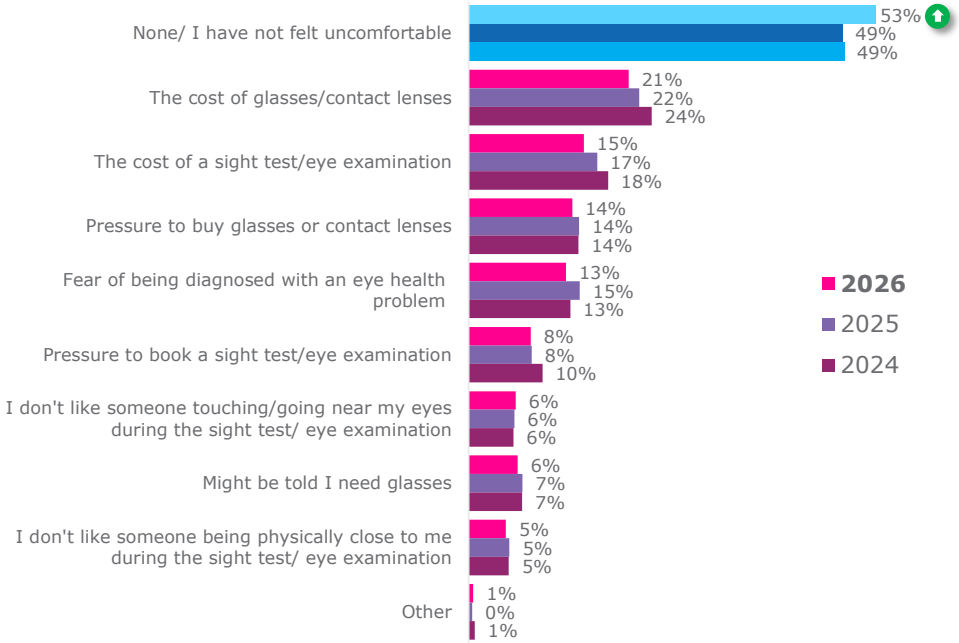
Those with at least one vulnerability marker are more likely than average to cite the cost of the sight test/eye examination (23%). Those struggling financially are more likely to cite both the cost of glasses/contact lenses (31%) and of a sight test/eye examination (26%).

Sub-group analysis is limited due to small base sizes.

Q04AI. Why have you not been for a sight test / eye examination in the last two years? **Base:** All respondents who have not had a sight test in the last two years (338).

Discomfort around visiting an opticians/optometrist practice

Consistent with previous waves, the most common reasons for discomfort around visiting an opticians/optometrist practice continue to be about money. The cost of glasses continues to be the most common reason (21%), followed by the cost of a sight test/eye examination (15%). More this wave say they have not felt uncomfortable about visiting an opticians/optometrist practice (53% vs. 49% in 2025).



Those more likely to mention the cost of glasses or contact lenses as a reason for feeling uncomfortable about visiting an opticians/optometrist practice include:

- Females (23%)
- Those from an Asian background (31%)
- Those with at least one vulnerability marker (24%), especially those with four or more (40%)
- Those who say they cannot afford essentials (30%), and
- Those who are struggling financially (28%)

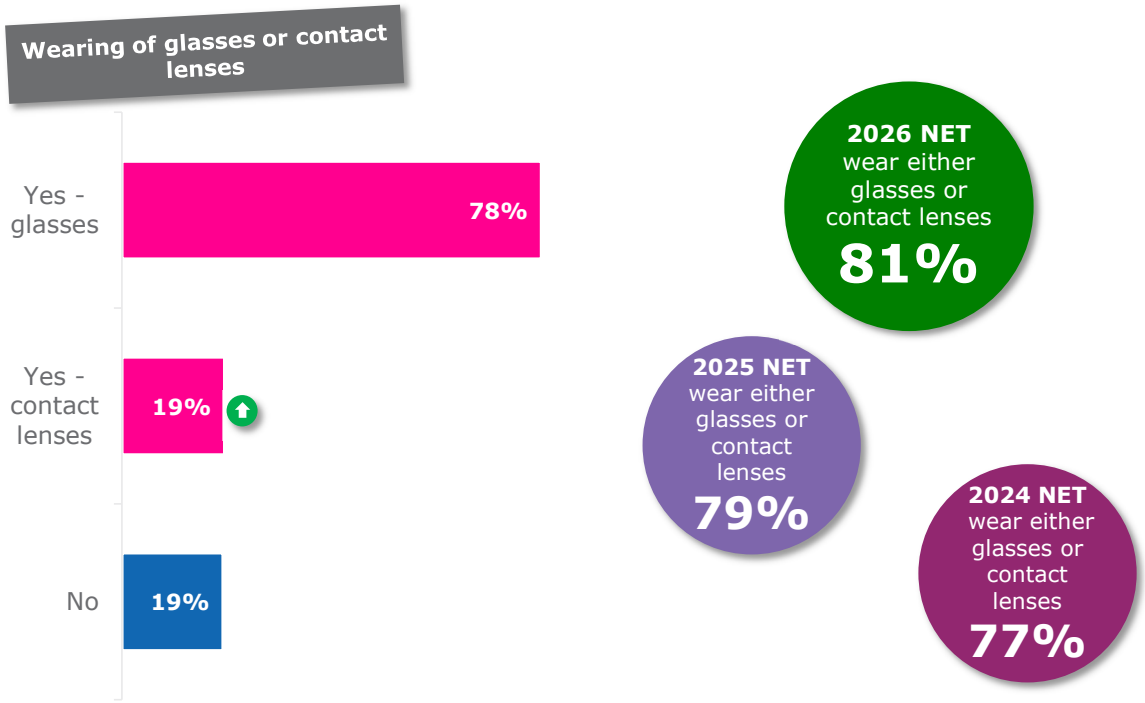
Those aged 16-34 are more likely than average to mention almost all reasons, except pressure to buy glasses or contact lenses. Those aged 65 and older are more likely than all other age groups to say they have not felt uncomfortable (77%), especially those aged 75-84 (83%).

White participants are more likely than ethnic minorities to say that they have not felt uncomfortable (58% vs. 39%). Ethnic minority participants are more likely to mention most of the reasons listed, although they are in line with the overall data when it comes to the cost of glasses/contact lenses and someone touching their eyes or being physically close during a sight test/eye examination.

Q03. Have you ever felt uncomfortable about visiting an opticians/optometrist practice for any of the following reasons? **Base:** All participants (2,014), 2025 (2,012), 2024 participants (2,035).

Wearing glasses or contact lenses

Just over four in five (81%) say that they wear glasses, contact lenses, or both. Just under four in five (78%) say they wear glasses. This year, more say they wear contact lenses (19% vs. 14% 2025). Just under one in five (19%) say they do not wear glasses or contact lenses.



Those aged 55 and over are more likely than average to wear either glasses or contact lenses (91%). Those aged 25-44 are more likely to wear contact lenses (30%), although they are also more likely to say they wear neither glasses nor contact lenses (24%). Those aged 16-24 are also more likely to say they wear neither (33%).

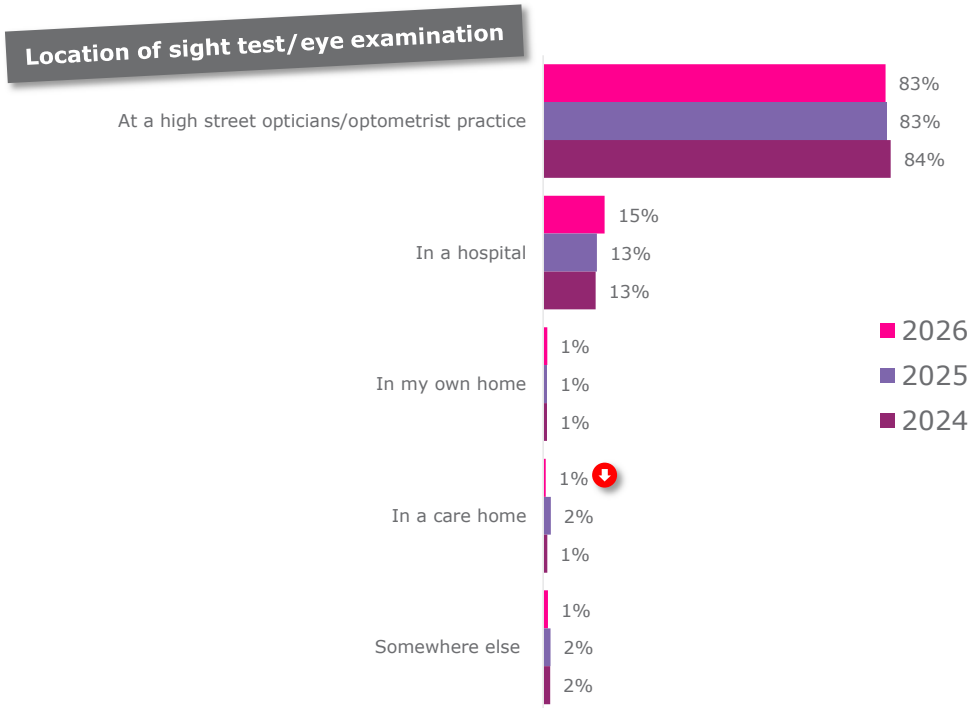
Females are more likely than males to say they wear contact lenses (21% vs. 17%). The same can be found for ethnic minorities compared to those from a white background (29% vs. 16%).

Those who has their last sight test/eye examination more than two years ago (57%), have at least one vulnerability marker (21%), are not confident in managing in receiving care from an opticians/optometrist (31%), and those not confident in managing their own eye health (34%) are more likely to wear neither glasses nor contact lenses.

S01c. Do you wear glasses or contact lenses? **Base:** All participants (2,014), 2025 (2,012), 2024 participants (2,035).

Location of test

Consistent with the previous waves, 83% of those who have had a sight test/eye examination did so at a high street opticians/optometrist practice.



Women are more likely than men to have had their sight test/eye examination at a high street opticians/optometrist practice (85% vs. 80%) whereas men are more likely than women to say their sight test/eye examination took place in a hospital (17% vs. 13%).

Those aged 45-74 are all more likely than average to say their sight test/eye examination took place at a high street opticians/optometrist practice (93%). In contrast, those aged 16-34 are less likely than average to say their sight test/eye examination took place at a high street opticians/optometrist practice (66%), but rather at an hospital (30%).

Those who live in Wales are more likely than average to say their test was at a high street opticians/optometrist practice (91%). Those in England are more likely to say it took place in a hospital (16%).

Participants with an existing eye condition are more likely to have had their last sight test/eye examination at a hospital (26%), whereas those without a condition are more likely to do so at a high street opticians/optometrist (89%).

Those with an NHS funded sight test/eye examination are more likely to have done theirs at a high street opticians/optometrist practice (87%).

Q04b. Thinking of the last time you had a sight test/eye examination, where was this? **Base:** All participants who have had a sight test/eye examination (1,958), 2025 participants (1,953), 2024 participants (1,963).

Choosing the opticians/optometrist practice

One third (33%) say that they shopped around before picking which opticians/optometrist practice to visit. Just under seven in ten (67%) did not shop around.



… shopped around before picking which opticians/ optometrist practice to go to…

Those more likely than average to say they shopped around before selecting an optician/optometrist include those:

- Aged 16-44 (49%)
- From an ethnic minority background (53%)
- From ABC1 social grades (34%)
- With household income of more than £50,001 (36%)
- In work (40%)
- Who are not confident in receiving a high standard of care from an opticians/optometrist (45%)
- Who paid themselves for their last sight test/eye examination (39%)
- Who knew the price before their sight test/eye examination (36%)
- Who spend £501 or more on their eye care (60%).

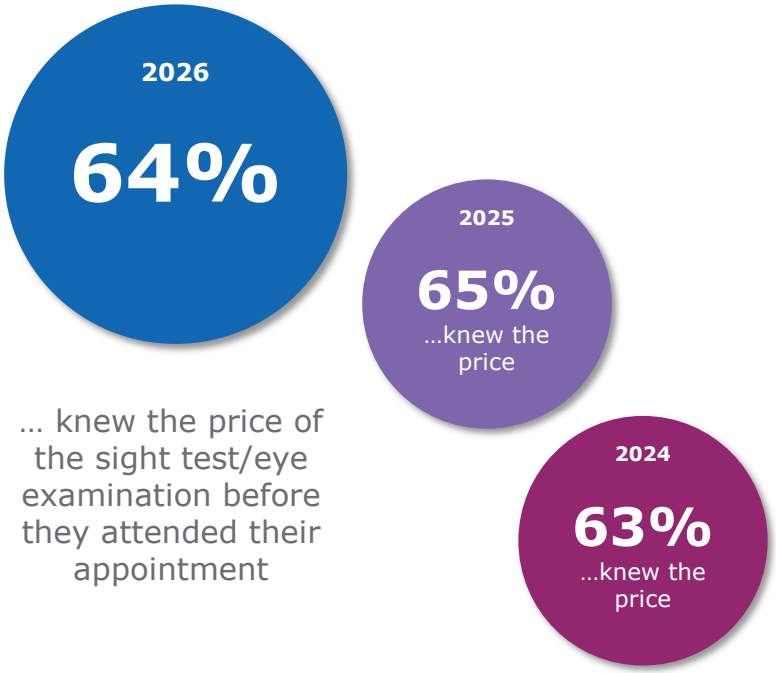
Those more likely to say they did not shop around include those:

- Aged 55 and older (83%)
- From a white background (73%)
- From Wales (79%) or Northern Ireland (81%)
- With a disability (72%)
- With less than £20,000 household income (75%)
- Not in work (74%)
- Who did not know the price before their sight test/eye examination (72%)
- Who had an NHS funded sight test/eye examination (78%).

Q05. Did you shop around (i.e., compare different opticians/ optometrist practices) before picking which one to go to? **Base:** All participants who have had an eye sight test/eye examination in the past two years (1,676), 2025 participants (1,616), 2024 participants (1,599).

Knowledge of prices before attending appointment

More than three in five (64%) say that they knew the price of the sight test/eye examination before their appointment, in line with the previous waves. Less than two in five (36%) say they did not.



… knew the price of the sight test/eye examination before they attended their appointment

Those aged 65 and over are more likely than average to say they knew the price before their sight test/eye examination (76%). In contrast, those aged 16-34 are more likely to say they did not (43%).

Those in full time work (39%), full time education (55%), and those who do not wear glasses or contact lenses (53%) are more likely to say they did not know the price of the sight test/eye examination.

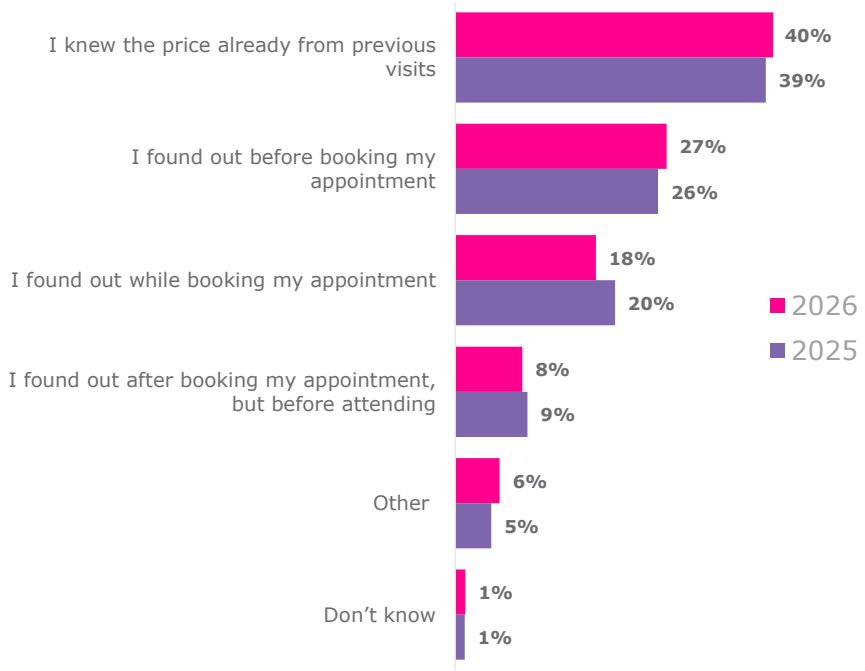
As expected, those who say that they shopped around before their appointment are more likely to say that they knew the price compared with those who did not (70% vs 61% respectively).

Interestingly, those who said they paid for their own sight test/eye examination are more likely than average to say they did not know the price (41%).

Q07. Did you know the price of the sight test/eye examination before you attended your appointment? **Base:** All participants who have had a sight test/eye examination in the past two years (1,676), 2025 participants (1,616), 2024 participants (1,599).

Source of price information

There are no changes this wave when it comes to how participants first found out about the price of their sight test/eye examination. All sources remain in line with the previous wave - 40% say that they knew this from previous visits, 27% before booking their appointment, 18% while booking the appointment, and 8% after booking their appointment but before attending.



Those aged 16-34 are more likely than average to say they either found out before booking their appointment (33%), while booking their appointment (24%), or after booking their appointment but before attending (18%). In contrast, those aged 65 and older are more likely to know the price from previous visits (60%).

Those not confident in receiving a high standard of care from an opticians/optometrist practice are more likely to have found out after booking their appointment, but before attending (18%).

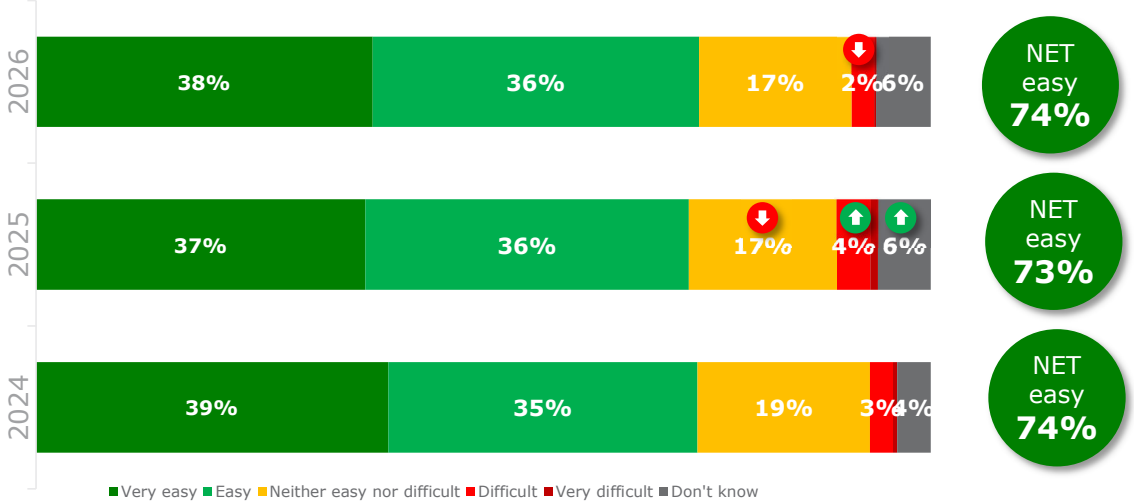
Those who shopped around are more likely to have found out the price before booking their appointment (35%) or after booking their appointment but before attending (13%). Those who did not shop around are more likely than average to know the price from previous visits (47%).

Those who paid for their last sight test/eye examination are more likely than average to have either found out the price before booking their appointment (31%), while booking their appointment (24%), or after booking their appointment but before attending (13%). Those whose employers paid are more likely to have found out while booking their appointment (32%), while those with NHS funding are more likely to know the price from previous visits (53%).

Q08. How did you first find out what the price of the sight test/eye examination would be? **Base:** All respondents who knew the price of the sight test/ eye examination before they attended their appointment (1,068), 2025 participants (1,041).

Ease of sourcing price information

In line with previous years, 74% say they found sourcing the price of their sight test/eye examination easy. There are fewer this year who found getting the price was difficult (3% vs. 5% 2025).



Those aged 65 or over are more likely to say they found it very easy (60%) to find out the price of their last test/examination, whereas those aged 16-34 are more likely to say they found it difficult (4%).

Those who are confident in receiving care from an opticians/optometrist practice (75%) and confident in managing their eye care (76%) are more likely than average to have found it easy to find out the price.

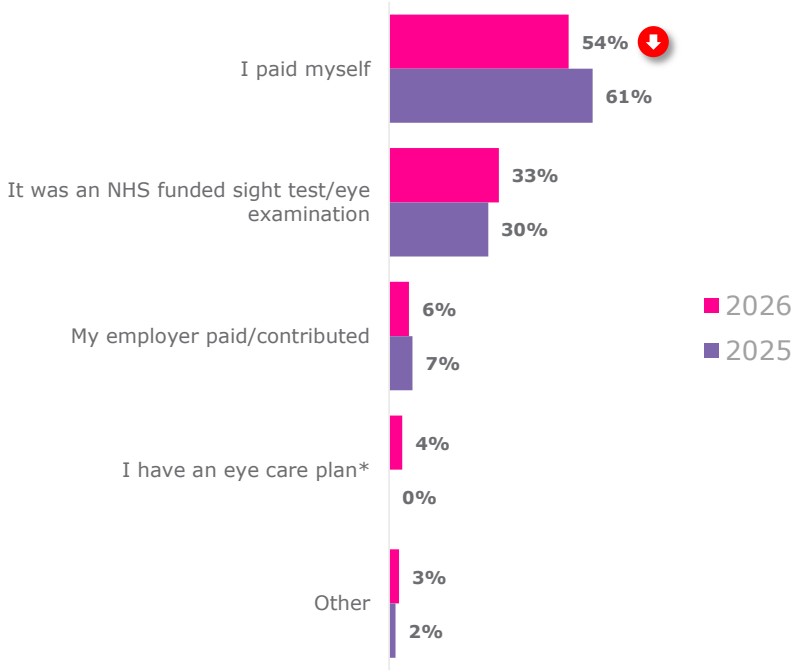
Those who had their last sight test/eye examination at a high street optician/optometrist practice are more likely to say they found it very easy to find out the price (40%).

Q09. Overall, how easy, or difficult was it to find out the price of your last sight test/eye examination? **Base:** All participants who have had a sight test/eye examination in the last two years (1,958), 2025 participants (1,953), 2024 participants (1,599).

Chart is missing figures due to small proportions and spacing

Source of sight test/eye examination funding

This year, fewer participants say their last sight test/eye examination was paid for by themselves (54% vs. 61% 2025), and one third say it was funded by the NHS (33%). Relatively few (6%) still say their employer paid or contributed towards their sight test/eye examination. New to this wave, 4% say their sight test/eye examination was covered under their eye care plan.



Those aged 16-54 are more likely than average to have paid themselves (68%), whereas those aged 65 and older are more likely to have had their sight test/eye examination funded by the NHS (67%).

By region, those in England are more likely than average to have paid themselves (56%).

Those with a disability are more likely than average to say their sight test/eye examination was funded by the NHS (49%). The same can be found for those with at least one vulnerability marker (38%).

Those who last had their sight test/eye examination at a high street optician/optometrist practice are more likely than average to say it was funded by the NHS (34%), whereas those who paid themselves are more likely to have had their last sight test/eye examination at a hospital (64%).

Intuitively, those in work are more likely than average to say they either paid themselves (68%) or their employer paid or contributed (9%).

Those who shopped around are more likely than average to have paid themselves (65%), whereas those who did not shop around are more likely to have received NHS funding (38%).

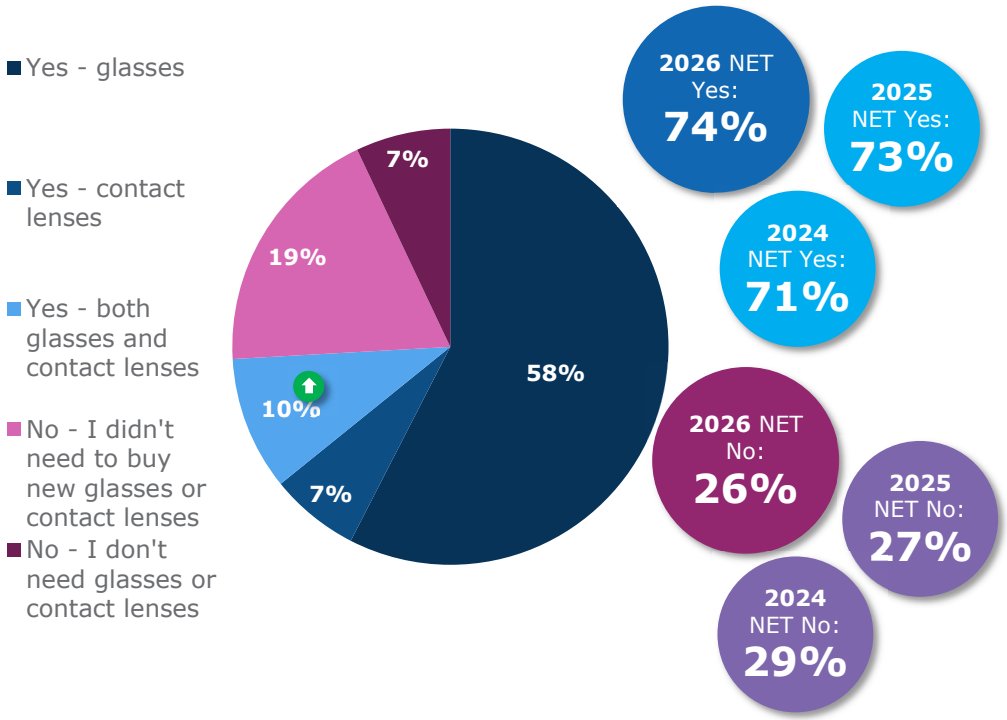
C00. How was your last sight test paid for? **Base:** All participants who have had a sight test/eye examination in the past two years (1,676), 2025 participants (1,616).

* New code added this wave

Purchasing eyewear

Purchase of glasses or contact lenses

Almost three quarters (74%) purchased glasses or contact lenses following their sight test/eye examination. The largest proportion (58%) bought glasses only, but 7% bought contact lenses only. The proportion who bought both glasses and contact lenses has increased significantly since 2025 (10% vs. 6%). Just under one in five (19%) did not need to purchase new glasses or contact lenses.



In terms of demographic differences:

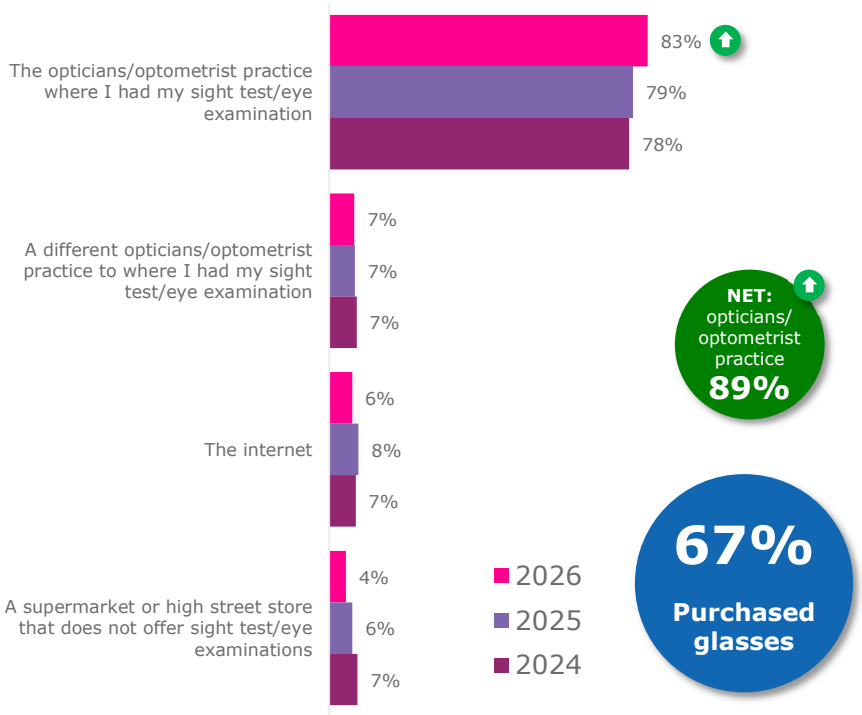
- Under 65s are more likely to have purchased glasses, contacts or both as a result of their visit (78% vs. 61% of those aged 65 and older).
- However, when it comes to buying *glasses specifically*, it is those aged 35 and over who were more likely to have made a purchase compared with those aged 16-34 (61% vs. 49%).
- White participants are less likely to have made a purchase as a result of their sight test/eye examination than ethnic minority participants (72% vs. 80%).

Consistent with previous waves, those who had their sight test/eye examination at a high street opticians/optometrist practice are more likely to have purchased glasses only as a result of their sight test/eye examination (61%). Alternatively, those whose sight test/eye examination was performed at a hospital facility are significantly more likely to have purchased contact lenses only (14% vs. 7% overall), or both glasses and contacts (15%).

Q010. Did you purchase glasses or contact lenses as a result of your sight test/eye examination? **Base:** All participants who have had a sight test/eye examination in the past two years (1,676), 2025 participants (1,616), 2024 participants (1,599).

Source of glasses purchase

Of those who purchased glasses as a result of their sight test/eye examination, over eight in ten (83%) purchased them from the same opticians/optometrist practice where they had their sight test/eye examination; this represents a significant increase on 2025 (79%).



Those more likely than average to have purchased their glasses from the same opticians/optometrist practice where they had their sight test/eye examination include:

- Those aged 65 and over (90% vs. 77% of 16-34s)
- White participants (85% vs. 76% of ethnic minority participants)
- Those who say they are not financially struggling (86% vs. 78% of those who say they are struggling).

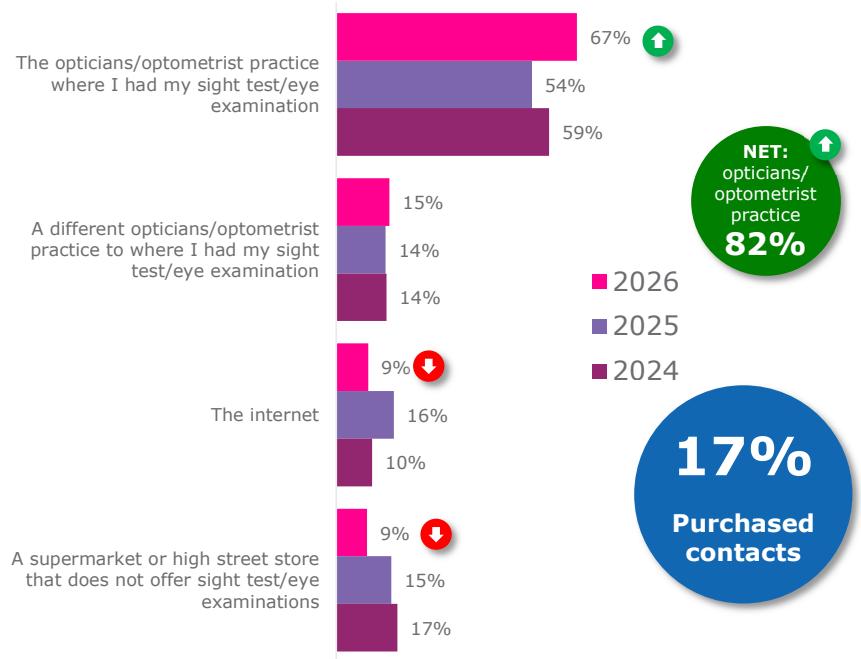
Those in social grades C2DE (9%), those with 4 or more vulnerability markers (12%) and those who say they cannot afford essentials (12%) are all more likely to purchase their glasses from the internet (vs. 6% overall).

Those who had their sight test/eye examination in a hospital facility (12%), those aged 16-24 (11%) and ethnic minorities (11%) are all more likely to have purchased their glasses from a *different* opticians/optometrist practice to where they had their sight test/eye examination (vs. 6% overall).

Q012. Where did you purchase your glasses from? **Base:** All participants who purchased glasses (1,135), 2025 participants (1,070), 2024 participants (1,013).

Source of contact lenses purchase

Of those who bought contact lenses as a result of their sight test/eye examination, over two thirds (67%) purchased them from the same opticians/optometrist practice where they had their sight test/eye examination, a significant increase compared to 2025 (54%). As seen in previous waves, those who purchased contact lenses are more likely report using other sources than the opticians/optometrist practice, compared with those who purchased glasses.



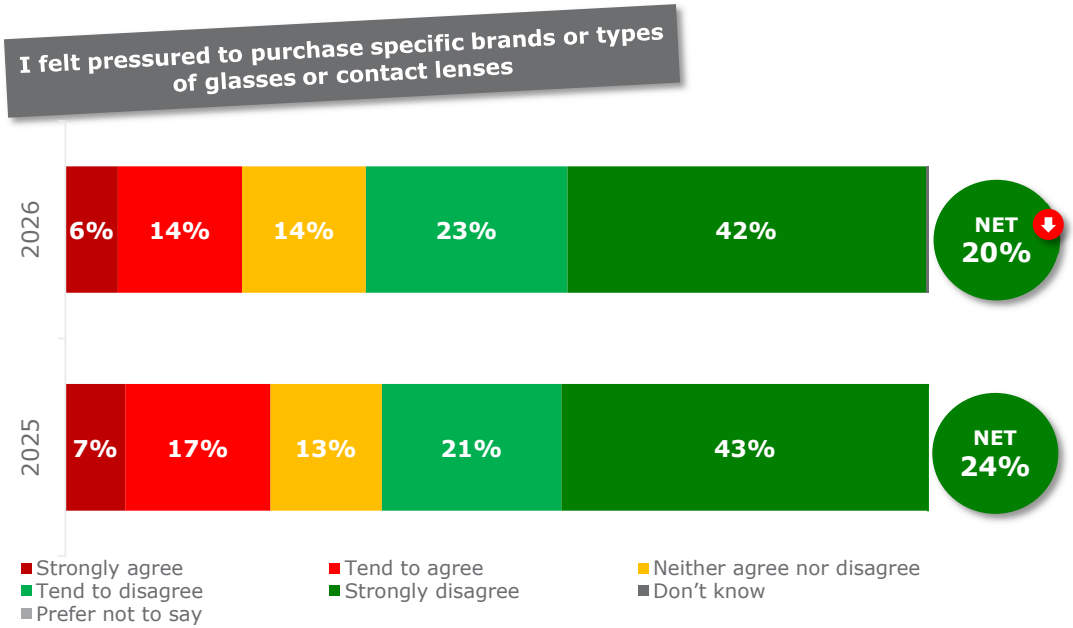
Those aged 45-54 are more likely to have purchased their contact lenses from the opticians/optometrist practice where they had their sight test/eye examination (87%), while those aged 16-34 are more likely to have purchased their contact lenses at a *different* opticians/ optometrist practice to where they had their sight test/eye examination (19% vs. 15% overall).

White participants are more likely to have purchased contact lenses from the opticians/optometrist practice where they had their sight test/eye examination (77% vs. 54% of ethnic minorities), whereas ethnic minority participants are more likely have bought them from a *different* opticians/optometrist practice (23% vs. 8% of white participants).

Q013. Where did you purchase your contact lenses from? **Base:** All participants who purchased contact lenses (255), 2025 participants (205), 2024 participants (196).

Experience of purchase

Of those who purchased either glasses or contact lenses, one in five (20%) agree that they felt pressure to purchase specific brands or types of glasses or contact lenses, though this has fallen since 2025 (24%). Around two thirds (65%) disagree that they felt this pressure.



Groups who are more likely to **agree** that they felt pressure to purchase specific brands or types of glasses or contact lenses include (vs. 19% overall):

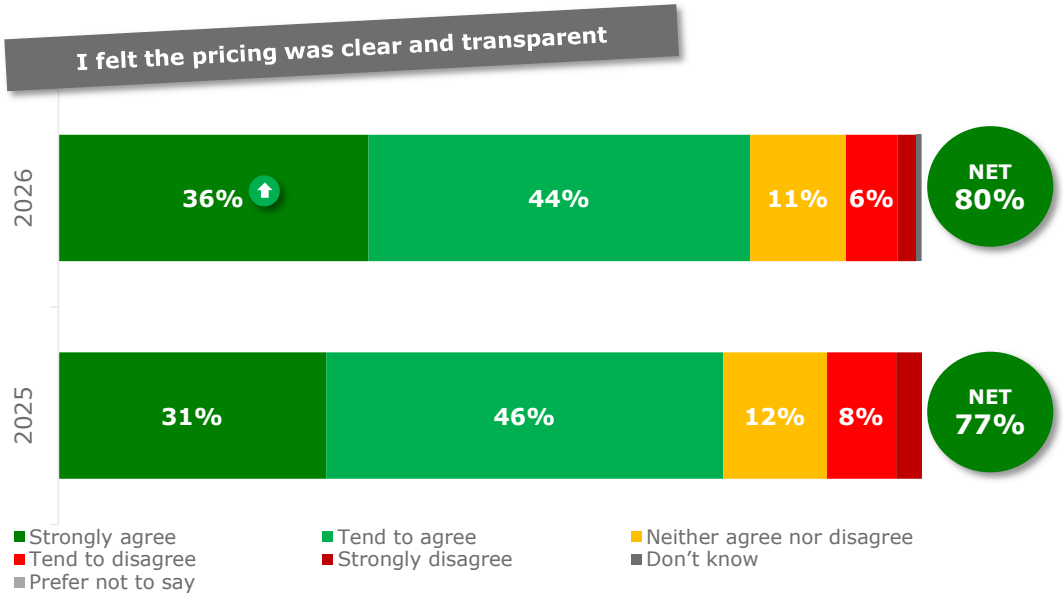
- Those aged 25-44 (33%)
- Ethnic minorities (31%)
- Those living in England (22%)
- Those who are working (24%)
- Those who had their sight test/eye examination at a hospital facility (38%)
- Those who say they are struggling financially (25%)
- Those with an eye condition (27%)

Q013A. Thinking about when you last purchased glasses or contact lenses, to what extent do you agree or disagree with the following statements? **Base:** All participants who have purchases glasses OR contact lenses (1,238), 2025 participants (1,177).

Chart is missing figures due to small proportions and spacing

Experience of purchase

Eight in ten (80%) agree that the pricing was clear when they last purchased glasses or contact lenses, with more than one third (36%) reporting that they *strongly agree,* a significant increase on 2025 (31%). Less than one in ten (8%) disagree with the statement.



Groups who are more likely to **agree** that the pricing was clear and transparent include (vs. 80% overall):

- ABC1 social grades (82% vs. 76% of C2DEs)
- Those with an income of over £50,001 (86%)
- Those with no vulnerability markers (83%)

Groups who are comparatively more likely to **disagree** with the statement include (vs. 8% overall):

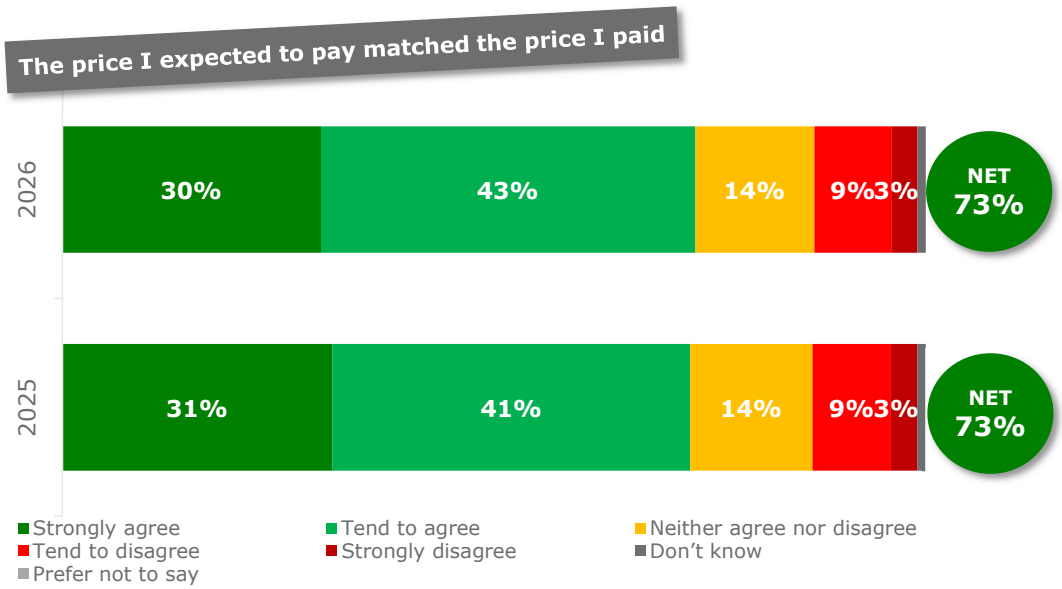
- Those aged 35-64 (10%)
- Those earning £25,001-£35,000 (14%)
- Those who say they are struggling financially (11%)

Q013A. Thinking about when you last purchased glasses or contact lenses, to what extent do you agree or disagree with the following statements? **Base:** All participants who have purchases glasses OR contact lenses (1,238), 2025 participants (1,177).

Chart is missing figures due to small proportions and spacing

Experience of purchase

Amongst those who purchased glasses or contact lenses as a result of their sight test/eye examination, three quarters (73%) agree that they paid the price that they had expected, while only 12% disagree. These findings are in line with 2025.



Groups who are more likely to **agree** that the price they paid matched what they expecting include:

- Males (76% vs. 71% of females)
- ABC1 social grades (75%)
- Those with an income of over £50,001 (77%)
- Those with no vulnerability markers (76%)
- Those who say that they knew the price before their appointment (76%)

Groups who are more likely to **disagree** with the statement include:

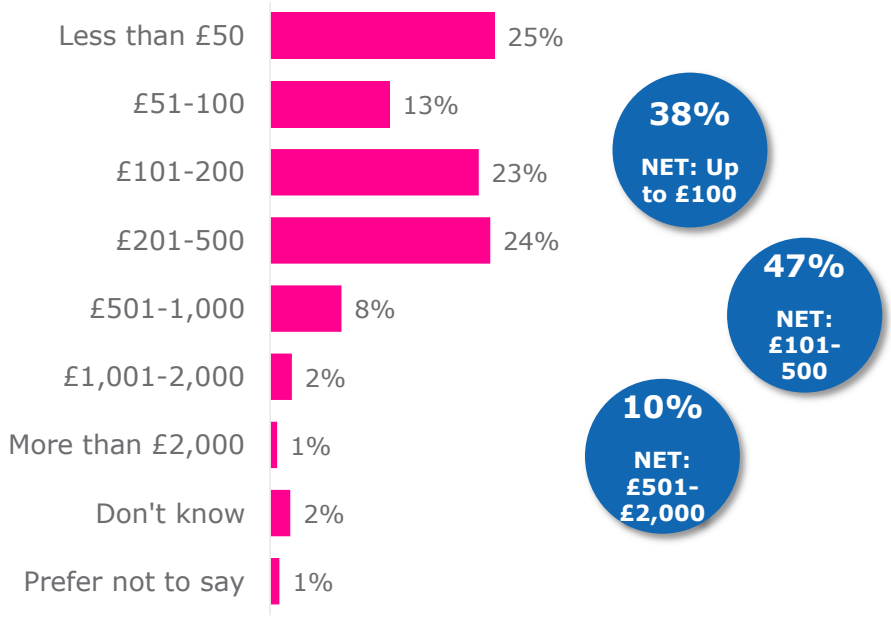
- Females (14% vs. 9% of males)
- Those with at least one vulnerability marker (14%) – and higher amongst those with 4 or more markers (24%)
- Those who say they are struggling financially (15%)
- Those who did not know the price beforehand (17%)

Q013A. Thinking about when you last purchased glasses or contact lenses, to what extent do you agree or disagree with the following statements? **Base:** All participants who have purchases glasses OR contact lenses (1,238), 2025 participants (1,177).

Chart is missing figures due to small proportions and spacing

Total spent on eye care service in the past 12 months

For the first time participants were asked how much they had spent in total on eye care services in the last 12 months. One quarter (25%) say they spent less than £50 – similar proportions spent either £101-200 (23%) or £201-500 (24%). Fewer participants spent £51-100 (13%), and even fewer spent larger amounts of £501-1,000 (8%), £1,001-2000 (2%), or more than £2,000 (1%).



By demographics, those aged 16-34 are more likely than average to have spent between £501-£2,000 on eye care services in the last 12 months (15% vs. 10% overall). Those aged 35-64 are more likely to have spent between £101-500 (52% vs. 47% overall), while those aged 65 and older are more likely to have spent up to £100 (52%).

By region, those in England are more likely than average to have spent between £501-2,000 (11%).

Those with a disability are more likely to have spent up to £100 (46%), as are those in C2DE social grades (44%), those with less than £20,000 income (58%), who have at least one vulnerability marker (44%), and those not in work (50%).

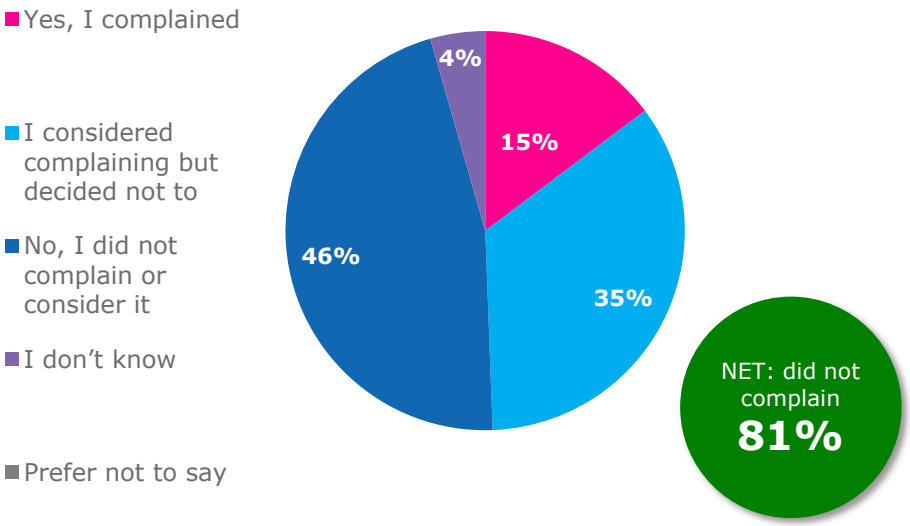
Q014A_0. In the last 12 months, how much have you spent in total on eye care services (e.g. the sight test/ eye examination, glasses, contact lenses, eye care plans and other services)? **Base:** All respondents who have had an eye test in the past two years (1,676).

Poor experiences and complaints

Complaints about the experience

New to this year, those who were dissatisfied with their overall experience of the opticians/optometrist practice were asked if they complained or considered complaining about the experience*. Less than half (46%) said they did not complain or consider it, while 35% considered complaining but decided not to. 15% say they complained.

Sub-group analysis is not possible due to very small base sizes.

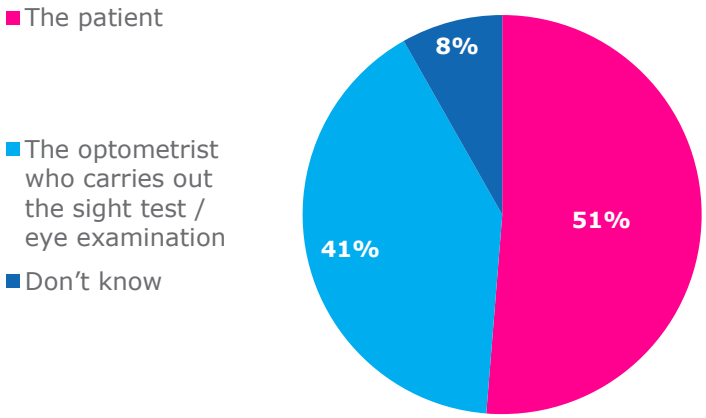


Q019. Thinking about your most recent experience at the opticians/ optometrist practice, did you complain or consider complaining about the experience**? Base:** All respondents who were dissatisfied with their overall experience of the opticians/optometrist practice (52).

* Very small base

Responsibility for notifying the DVLA if sight falls below driving standard

In this wave*, all participants were asked who they think should be responsible for notifying the Driver and Vehicle Licensing Agency (DVLA) or Driver and Vehicle Agency (DVA for Northern Ireland) if a patient's sight test falls below the standard required to drive safely. Just over half (51%) think the patient should be responsible, while just over two in five (41%) think the optometrist should be responsible. Less than one in ten (8%) say they don't know.



Those aged 45-54 are more likely than average to think the patient should be responsible (57%), those aged 35-44 are more likely to think it should be the optometrists responsibly.

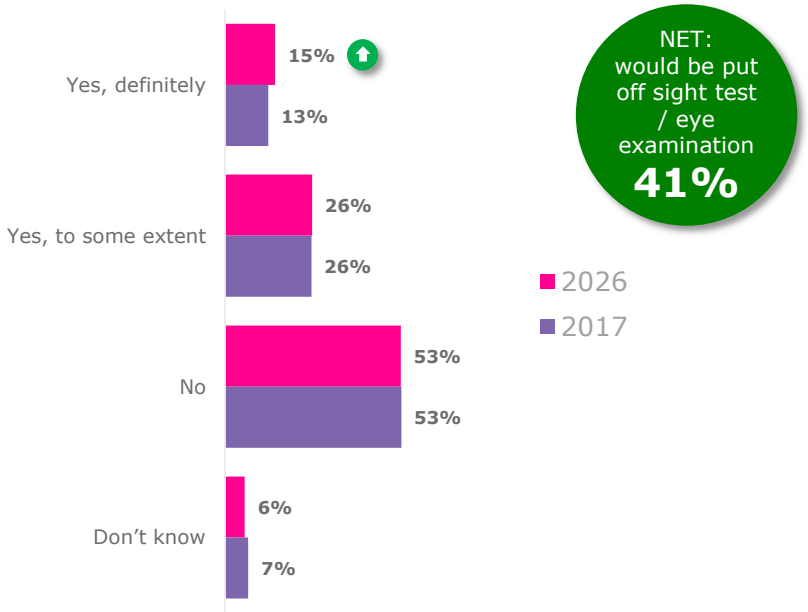
Those who had their last sight test/eye examination at a high street opticians/optometrist practice are more likely than average to think it should be the patient's responsibility (53%).

Q020. If a patient visits an opticians/optometrist practice, and after getting their sight tested they fall below the standard required to drive safely, who do you think should be responsible for notifying the Driver and Vehicle Licensing Agency (DVLA) or Driver and Vehicle Agency (DVA for Northern Ireland)? **Base:** All participants (2,014).

* Question was originally asked in 2017, but the code 'Both the patient and the optician' was removed from this wave due to it not being a viable policy option. This change in question means figures are not comparable.

Feelings towards sight test / eye examination if DVLA notification was required

Returning from the 2017 survey, all participants were asked if they would be put off going for a sight test/eye examination if the optometrist who carried out their test was required to automatically notify the DVLA or DVA of patients who fall below the standard required to drive safely. This year sees a small but significant increase in those who say yes, definitely compared to 2017 (15% vs. 13% 2017). All other proportions remain in line with 2017.



Those aged 16-34 are more likely than average to say automatic notification would put them off going for a sight test/eye examination (56% vs. 41% overall), whereas those aged 65 and older are more likely to say no (73% vs. 53% overall).

Those with a disability are more likely than average to say they would not be put off going for a sight test/eye examination (59%).

Those in work are more likely than average to say they would be put off going for a sight test/eye examination compared to those not in work (49% vs. 32%).

Q021. If the optometrist who carried out your sight test was required to automatically notify the DVLA or DVA of patients who fall below the standard required to drive safely, and you were concerned about your vision, would this put you off going for a sight test / eye examination**? Base:** All participants (2,014), 2017 participants (3,025).

04 Advanced statistical analysis

IMD deprivation analysis: overview

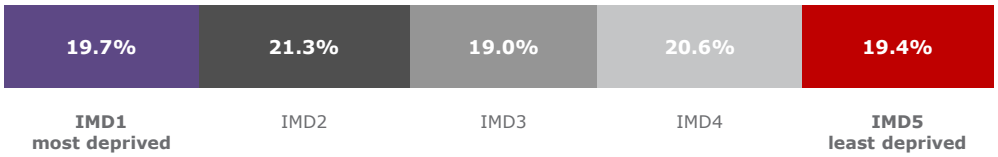
In this wave, GOC wanted to explore whether respondents' experiences and access to eye care services differed by levels of area deprivation, to help understand whether there are any patterns that could inform future work on health inequalities. This was done by matching respondents' postcodes, where provided, to published Index of Multiple Deprivation (IMD) data. This enabled the survey data to be segmented by IMD quintile, from the most deprived 20% of areas to the least deprived 20%.

The analysis focused on measures such as confidence in eye care services, latest sight tests/eye examinations, satisfaction with experiences, and barriers to accessing sight tests/eye examinations. As postcode data was also available in wave 1 of the survey, analysis was also conducted on this wave for indicative comparison.

A note on interpretation: postcode provision was optional, so not all respondents could be classified. However, around 94% of all wave 3 respondents were matched to an IMD quintile, and the wave 3 sample is broadly even across IMD quintiles.

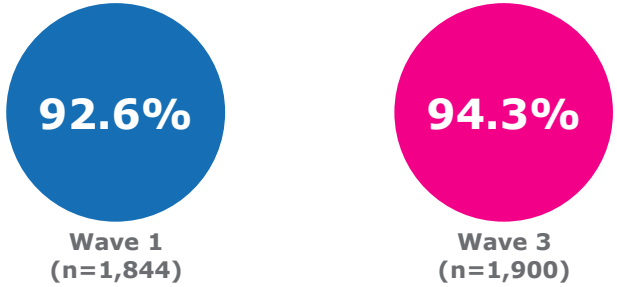
IMD is an area-level lens. It should complement, rather than replace, individual-level vulnerability markers in the main report.

Wave 3 spread by IMD quintile



No quotas were set on IMD, yet each quintile is close to the expected 20% share. Analysis focuses on quintiles rather than deciles to protect base sizes for subgroup comparisons.

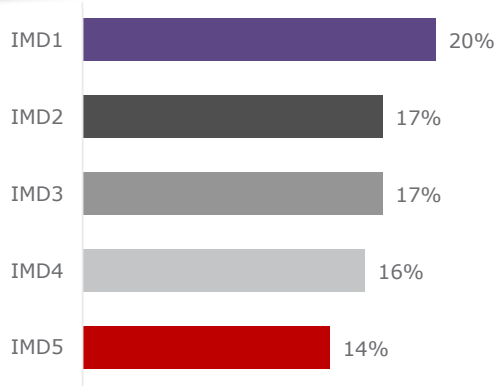
Coverage of postcode classification



IMD deprivation analysis: access

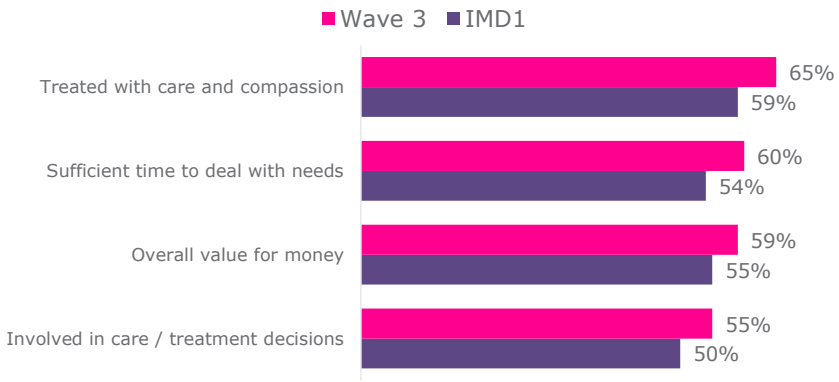
Confidence and overall satisfaction vary only modestly by IMD. The clearest differences are seen in whether people have had a recent sight test, and in the proportion saying they were 'very satisfied' with aspects of their experience.

Not had a sight test in the last two years



IMD1 is significantly higher than the total; IMD5 is significantly lower.

Very satisfied by aspect: IMD1 vs Wave 3



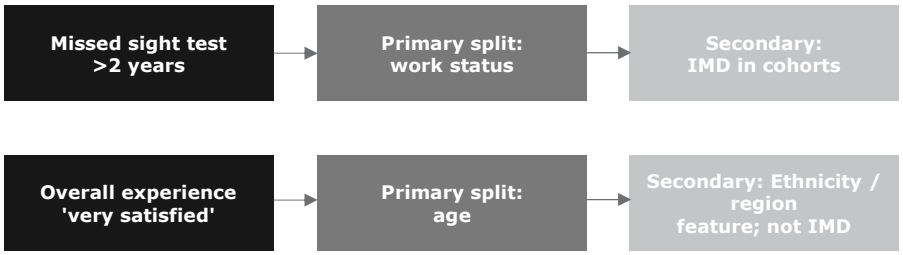
Net satisfaction remains high: overall experience is 90%-92% across IMD quintiles. IMD1 is significantly lower when compared to the total sample,

Overall satisfaction is very similar across IMD groups, but people in the most deprived areas (IMD1) are more likely to be overdue a sight test and less likely to say they were 'very satisfied' with aspects of their experience.

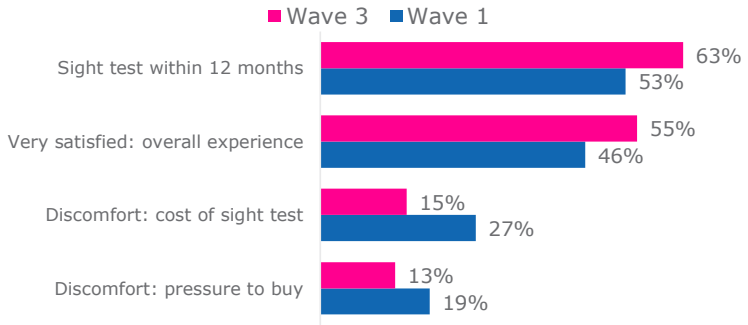
IMD deprivation analysis: CHAID analysis

CHAID analysis was used to test whether IMD was one of the strongest predictors of access and satisfaction when considered alongside other profile characteristics. It works by splitting respondents into groups based on the factors that best explain differences in outcomes.

Which factors best explain access and satisfaction?



Positive movement among IMD1 since Wave 1



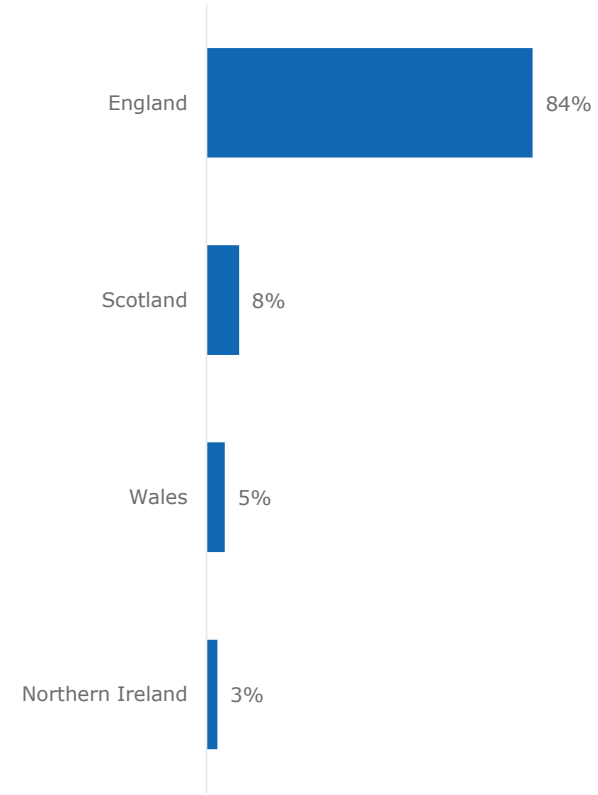
Among IMD1, access and experience look better in Wave 3 than Wave 1 (more recent sight tests and higher 'very satisfied' overall). Discomfort linked to cost and pressure to buy is lower (lower is better).

Work status is the strongest differentiator for missing sight tests, though IMD is secondary factor behind this. Age is the strongest differentiator for being very satisfied with the overall experience. IMD therefore helps explain some access differences, but it is not the dominant driver of access or satisfaction.

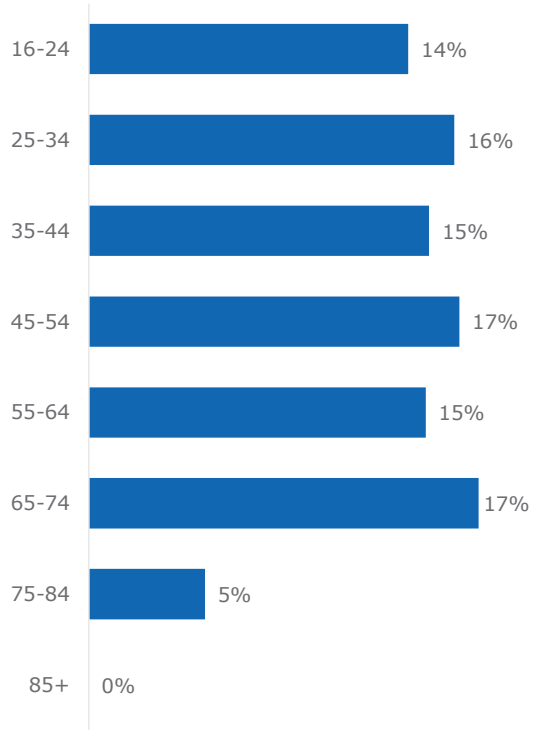
05 Audience profile

Weighted profile of participants (1)

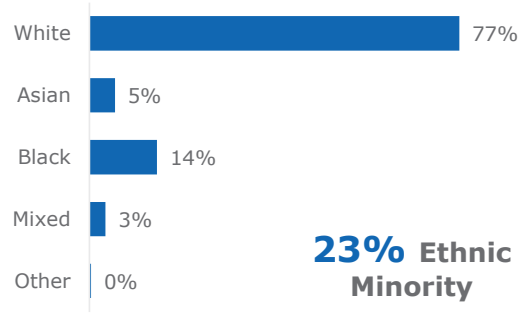
Nation



Age group

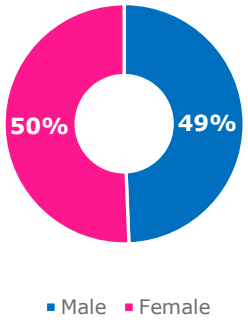


Ethnicity



23% **Ethnic Minority**

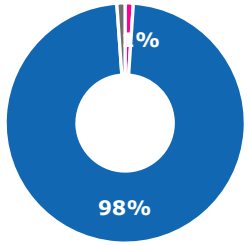
Gender



Source: S02, S03, S05, S06 **Base:** All participants (2,014)

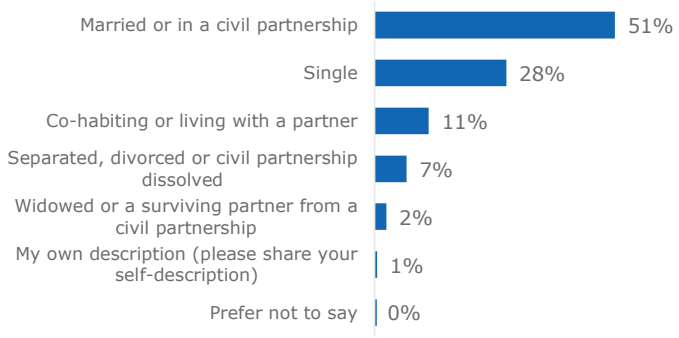
Weighted profile of participants (2)

Trans history

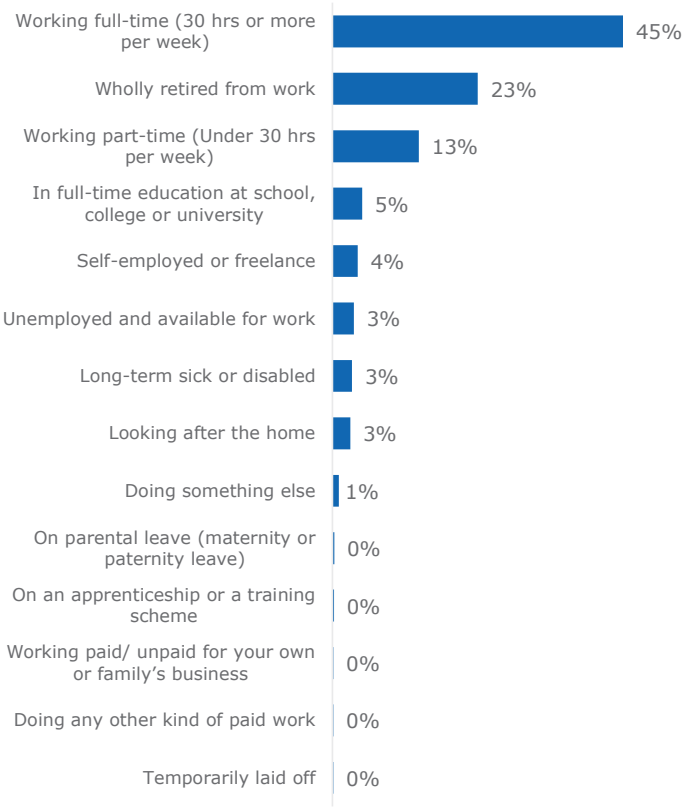


Yes No Prefer not to say

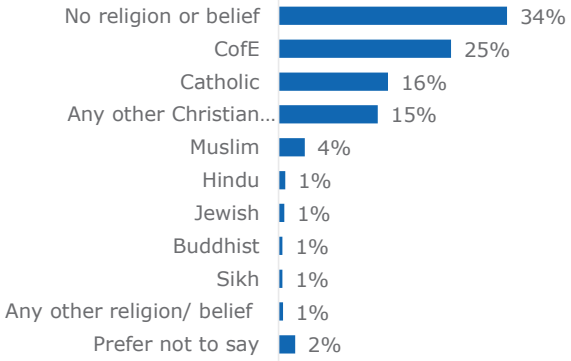
Marital status



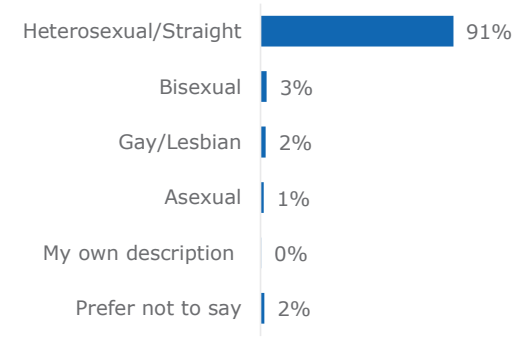
Working status



Religion



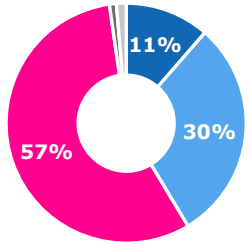
Sexual orientation



Source: C02, C02a, C05, C07, C08 **Base:** All participants (2,014).

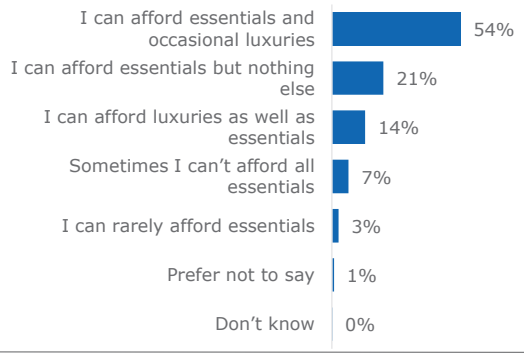
Weighted profile of participants (3)

Financially struggling

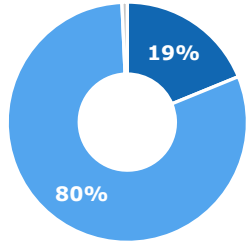


Yes Slightly No Don't know Prefer not to say

Ability to pay for luxuries or essentials

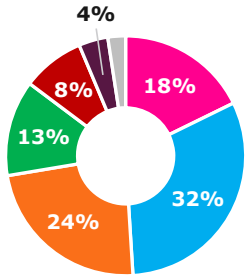


Unpaid caring responsibilities



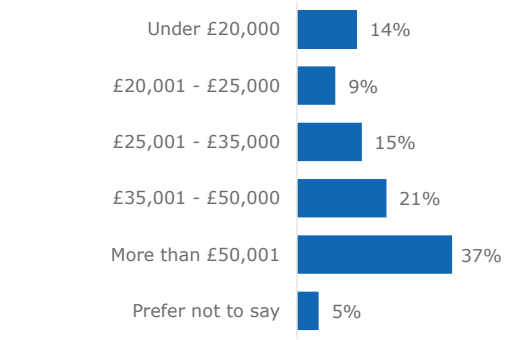
Yes No Prefer not to say

SEG



A B C1 C2 D E I'd prefer not to say

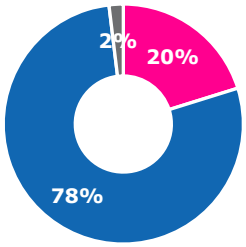
Annual income



Source:, C06a, C09, C10, C011, C014, C15 **Base:** All participants (2,014)

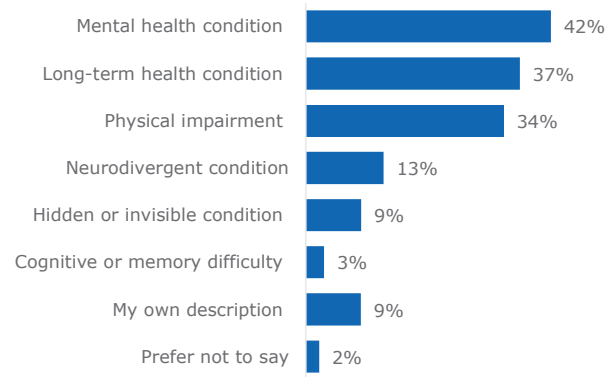
Weighted profile of participants (4)

Disability

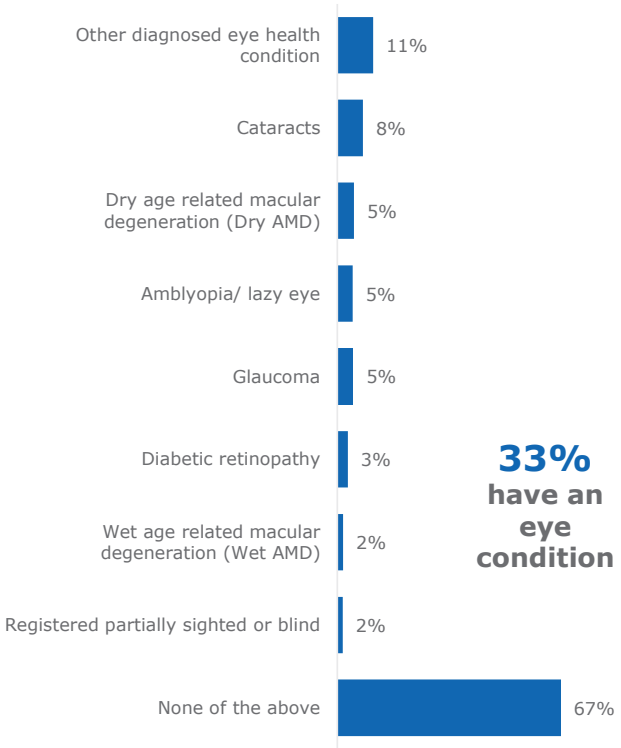


Yes ■ No ■ Prefer not to say

Disability category

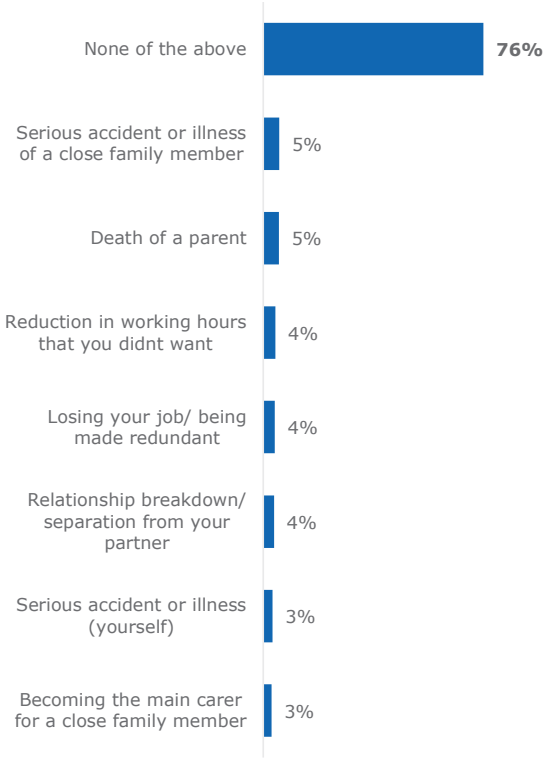


Eye conditions



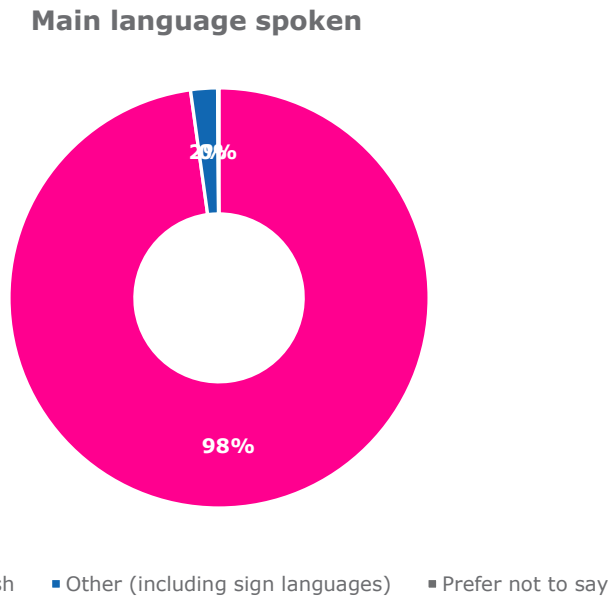
33% have an eye condition

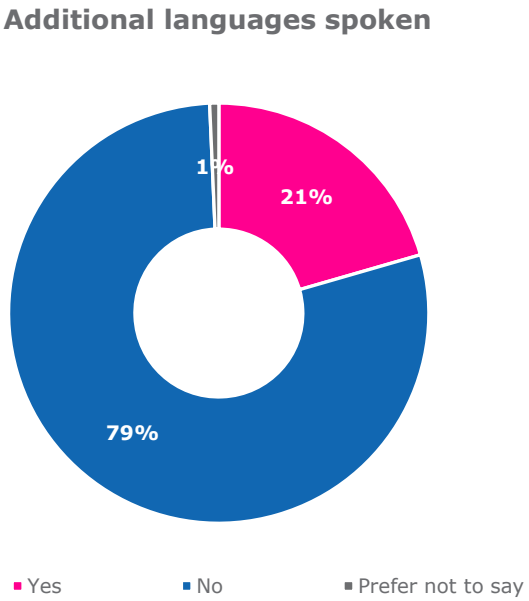
Events experienced in last 12 months (>1%)



Source: C01, C03, C03A, C12 **Base:** All participants (2,014)

Language





Source: S07. What is your main language? **Base:** All participants (2,014). **S08A.** Do you speak any additional languages fluently (including sign languages)? **Base:** All participants (2,014).

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enventure research

General Optical Council

Registrant Workforce and Perceptions Survey 2026

Research Report

May 2026

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Appendix A – Questionnaire

Appendix B – Respondent demographic profile

Key findings

The survey

The annual Registrant Workforce and Perceptions Survey was conducted between March and April 2026, open to all individual GOC registrants. The survey aims to gain insight into registrants' experiences of working in clinical practice and their perceptions of the GOC.

An 11% response rate was achieved (3,451 responses), providing a robust sample for confident statistical analysis.

New insights for 2026

Many of this year's survey findings represent continuity with recent waves of the survey from 2024 and 2025, and in many cases are in line with survey results dating back even further. Continuity of findings is found in both the overall results and the subgroup analysis, highlighting that the profile, experiences, and attitudes of registrants have changed little in recent years, and that many of the same challenges are still being faced.

This year's survey included two new sections exploring registrants' views and experiences in relation to two areas of current relevance to the optical professions – the use of artificial intelligence (AI) in optical care, and vision and safe driving.

Artificial Intelligence – Cautious optimism, but knowledge, training, and use are limited

New insights gained on the topic of AI indicate that registrants are cautiously positive about the potential role of AI in optical care, but current knowledge, training, and use are limited. Six in ten respondents (60%) rated their knowledge and understanding of AI in relation to optical care as poor, while 40% rated it as good. Just over one in five (22%) had received AI-related CPD or training in the last 12 months, although those who had done so were much more likely to rate their understanding positively.

Use of AI in professional practice is still at an early stage. Six in ten working respondents (60%) said they were not currently using AI for any of the activities listed in the survey. Where AI was being used, this was most commonly to help maintain knowledge and skills (12%), support diagnosis (8%), or write patient correspondence (8%).

Despite limited use, respondents were more likely to think AI will improve (45%) rather than reduce (11%) the quality of eye care. However, over a quarter (27%) did not know what impact AI would have on the quality of eye care, highlighting uncertainty and low levels of understanding. Positive views were more common among those with good AI knowledge and those who had received AI-related CPD/training.

Concerns about AI are also widespread, especially around safety, accountability and transparency. The highest levels of concern related to AI making errors (77%), legal responsibility if something goes wrong (76%), lack of transparency in AI decision-making (68%), data security and patient confidentiality (64%), and the impact on the clinician-patient relationship (63%).

Vision and safe driving – Routine discussions, but direct DVLA/DVA notification remains challenging

The new survey questions on vision and safe driving highlight that discussions about the impact of vision or eye conditions on driving are a routine part of practice for many registrants. Around seven in ten respondents (72%) said they have these conversations with patients at least weekly. These discussions are more common among optometrists, those with additional qualifications, and those involved in enhanced eye care services.

Driving-related discussions are focused mainly on older patients, with respondents most likely to say they commonly raise the issue with patients aged 70–79 (85%), followed by those aged 80+ (73%) and 60–69 (61%). Far fewer commonly raise it with patients aged under 50.

Registrants are generally comfortable advising patients about the implications of not meeting eyesight standards. Almost all were comfortable explaining that this may affect a patient's ability to drive safely (95%), and 89% were comfortable informing patients that they must notify the DVLA/DVA. However, comfort falls significantly when registrants are asked about notifying the DVLA/DVA themselves if the patient cannot or will not do so, with only 37% feeling comfortable and 58% uncomfortable.

The main barrier to direct notification is breaching patient confidentiality (72%), but legal or regulatory concerns (56%) and the risk of aggressive patient reactions (56%) also play a significant role.

In practice, advising patients is much more common than direct notification. Four in five respondents (78%) had advised a patient that they were no longer fit to drive at least once in the last 12 months, while almost all (96%) had never directly notified the DVLA/DVA. This suggests that, although fitness to drive conversations are a regular part of practice, direct notification is rare and likely limited to a small number of more serious or unresolved cases.

Areas of improvement

Confidence in meeting CPD requirements has improved

Overall job satisfaction has improved slightly this year, with 59% of respondents satisfied in their role, up from 55% in 2025. Dissatisfaction has also eased slightly, from 26% to 24%. Although satisfaction remains below the higher levels recorded in 2022 and 2023, this year's results suggest a modest improvement after two years of decline.

Satisfaction continues to vary by workplace setting and experience of delivering care. It is higher among those working in hospitals, education/academia and independent practice, and

lower among those working in multiple/chain opticians. However, as found in previous years, those who find it difficult to provide patients with the level of care they need are significantly more likely to be dissatisfied in their role.

Engagement in enhanced eye care services and additional qualifications has increased

Over half of respondents are now involved in the delivery of enhanced eye care services, increasing to 52% after several years of stability at around 48% to 49%, which may suggest a possible shift towards greater engagement in these services.

Results suggest that registrants holding additional qualifications are becoming increasingly common. The proportion with no additional qualifications has fallen (65%-67% in 2023-2025 to 58% in 2026), while qualifications in areas such as glaucoma, medical retina, and contact lens practice have increased over recent years.

CPD attendance on workplace culture and EDI topics has increased

Although attendance at CPD on workplace culture, speaking up, health inequalities and bias remains relatively modest (ranging from 21% to 30% attendance in the latest CPD cycle), engagement has generally increased across the tracked topics over the last three years. Attendance reached its highest recorded level this year across all four tracked areas, with the largest increase seen for CPD on addressing bullying, harassment, and discrimination in the workplace (+9% pts, from 13% in 2024 to 22% in 2026).

Attendance at CPD is also associated with other positive outcomes. Those who had attended CPD on speaking up were more likely to feel comfortable raising concerns, while those who had attended CPD on bullying, harassment and discrimination were more likely to have personally reported experiences of discrimination.

Areas of continuity

Workforce profile and capacity remain stable

The workforce profile remains broadly stable, with most respondents working or employed (88%), and the distribution of workplace settings changing little over recent years, with most working in multiples (61%) or for an independent practice/as a sole practitioner (41%). Average days worked per week remain similar to previous years at 4.0 days, and scaled-up estimates suggest a broadly stable full-time equivalent workforce (15,054 FTE optometrists and 5,494 FTE dispensing opticians).

Part-time working continues to be more common than full-time working, with 55% working fewer than five days per week. Part-time working is especially common among optometrists, those in independent practice, older respondents, female respondents, those working as locums and those reporting a disability.

The profile of locum workers remains broadly unchanged

Locum working remains a stable feature of the workforce, with 22% of registrants reporting that they work as a locum, broadly unchanged since 2022. The profile of locum workers has also changed little over time, with locum working continuing to be more common among optometrists than dispensing opticians, part-time workers, those working for independent opticians or in domiciliary care, older respondents aged 55+, respondents from ethnic minority groups, and those with additional qualifications.

Workplace setting continues to shape experience

Throughout the survey results, workplace setting remains one of the clearest drivers of attitudes and experiences. Those working in hospitals, education/academia and for independent opticians tend to report higher job satisfaction, while those working in multiples are more likely to report dissatisfaction and certain workplace pressures.

Enhanced services, additional qualifications, locum working, supervision of pre-registration trainees, experiences of workload pressure, and confidence in raising concerns also vary by workplace setting, reinforcing the importance of workplace context in shaping registrants' experiences.

Leadership roles remain concentrated among certain groups

Half of respondents (51%) reported having no managerial responsibility, while fewer occupied senior leadership roles, such as Director/CEO (14%). These leadership roles remain concentrated among certain demographic groups, with Director/CEO roles more common among male respondents, White British/Irish respondents, and those from professional/higher socio-economic backgrounds.

Future career plans remain broadly consistent, with significant continued interest in further development

Immediate career intentions remain broadly consistent with previous survey waves. Gaining additional qualifications or skills remains the most common planned career change, selected by 40% of working respondents, followed by reducing hours (26%), and smaller proportions considering leaving the profession (16%), retiring (9%), switching to locum work (7%) or taking a career break (7%).

Interest in further development continues to vary by career stage and working context, with plans to gain additional qualifications or skills more common among younger respondents, students, full-time workers, those working in multiples or hospitals, those involved in enhanced services, and respondents from ethnic minority groups. The most common areas of interest remain glaucoma, medical retina and independent prescribing.

Plans to leave the profession remain more common among some groups, including dispensing opticians, locums, respondents based in London, those with a disability, and those who report difficulties providing patients with sufficient care.

Areas of concern

Workload pressures remain widespread and are linked to patient care challenges

Negative working conditions remain a significant issue, with two thirds of respondents (66%) reporting working beyond their hours at least sometimes, and six in ten (60%) reporting feeling unable to cope with their workload. Over a third (36%) said they had found it difficult to provide patients with the level of care they need.

The survey results continue to show that these experiences are closely linked. Respondents who reported working beyond their hours, feeling unable to cope with workload, or taking stress-related leave were more likely to report difficulties providing patients with sufficient care. This highlights the relationship between workforce pressures and the ability to deliver safe and effective patient care.

Time and commercial pressures continue to affect patient care

Time and commercial pressures remain common amongst registrants, particularly around insufficient time for sight tests (47% sometimes/frequently experience), pressure to see a high volume of patients (38%), pressure to sell higher-value products (34%), and pressure to meet targets at the expense of patient care (31%). These pressures are more pronounced in some workplace settings, especially multiples, and are always linked with a greater likelihood of reporting difficulties providing sufficient care.

When respondents experienced time or commercial pressures, concerns were most often raised informally with colleagues (32%) or reported to a line manager (20%) rather than through formal processes (2%). However, a large proportion did nothing (31%), suggesting that many registrants may feel unable to challenge these pressures or do not see a clear route for doing so.

Although the majority of respondents (83%) feel confident resisting pressures that could compromise care, the results show that time and commercial pressures remain a challenging part of the working experience for a substantial proportion of registrants.

Free-text suggestions about the most concerning commercial practices reinforce these findings, with the most common concerns relating to short appointment times, sales or conversion targets, upselling, overbooking, and high patient volumes.

> *Reduced testing times. 20 minute clinics are very hard to keep up with, and many tests are omitted to keep up with timing.*
>
> Optometrist

> *Pressure to reduce the time allocated to each patient.*
>
> Optometrist

> *Pressure to dispense and meet targets.*
>
> Dispensing optician

Experiences of harassment, bullying, abuse, and discrimination remain substantial and often unreported

Harassment, bullying, or abuse and discrimination continue to be experienced by a significant minority of registrants. Patients and service users remain the most common source of this behaviour, although experiences from managers and other colleagues are also reported.

These experiences vary by role, workplace setting and demographics, with some groups, including ethnic minority respondents and those with a disability, more likely to report negative experiences.

Reporting remains limited, at 37% for harassment, bullying and abuse, and 28% for discrimination.

Compared with the latest NHS Staff Survey, GOC registrants report higher levels of harassment, bullying or abuse and discrimination, but lower levels of reporting.

Barriers to speaking up are driven by fear of repercussions and doubts about action

Comfort with speaking up about patient safety about both individual GOC registrants and employers remains highest in relation to managers, tutors, employers and professional or representative bodies, and lower in relation to the GOC. For concerns about registrants, respondents are most comfortable speaking up to a manager or tutor, and for concerns about an employer, professional association/representative body routes attract higher levels of comfort than the GOC.

Among those who would not feel comfortable speaking up, the main barriers relate to personal consequences. Respondents were concerned about alienating colleagues (43% GOC registrant, 37% employer), jeopardising their job (41% GOC registrant, 54% employer), being seen as a troublemaker (39% GOC registrant, 38% employer), and whether corrective action would be taken (36% GOC registrant, 39% employer).

Supervisory roles and locum working are associated with greater challenges

Just over a quarter (27%) of working optometrist and dispensing optician respondents had supervised pre-registration trainees in the last 12 months. Supervision is more common in multiples (39%), and those who supervise trainees are more likely than those who do not to report feeling unable to cope with their workload and finding it difficult to provide patients with sufficient care.

Locum working remains an established part of the workforce (22%), but locums continue to report more challenges in some areas. They are more likely than non-locums to report difficulties providing patients with sufficient care and are less comfortable raising patient safety concerns.

The Research Programme

Introduction

The GOC is the regulator for the optical professions of optometry and dispensing optics in the UK, with the overarching statutory purpose to protect, promote and maintain the health and safety of the public. The GOC currently registers almost 32,000 optometrists, dispensing opticians, student optometrists, and student dispensing opticians (the GOC also registers approximately 3,000 optical businesses, but these are not included in this research).

To track registrants' experiences of working in clinical practice and their perceptions of the GOC, a regular survey of the registrant population is carried out. This year's survey focused on the following areas:

- Working status and hours worked
- Job satisfaction and future career plans
- Workplace challenges, including workplace and commercial pressures, bullying, harassment, and discrimination
- Speaking up and raising concerns
- Continuing Professional Development (CPD)
- Artificial intelligence (AI)
- Vision and safe driving

Enventure Research, an independent research agency, was appointed to deliver this survey. This report details the findings of this research.

Methodology

A questionnaire was designed by the GOC and Enventure Research, including a mix of previously used questions to allow for benchmarking and new questions to cover new topics. The questionnaire took approximately 10-12 minutes for registrants to complete. For reference, a copy of the questionnaire can be found in **Appendix A**.

The survey was promoted via personalised email invitation to all GOC registrants with a valid email address. In total, 32,428 registrants were invited to take part. Those who did not respond received up to four reminder emails encouraging them to take part.

The survey was also promoted by the GOC and stakeholder organisations via email newsletters and social media. Respondents who took part via this promotion were required to provide their GOC-registered email address to verify their registration and ensure no duplicate responses were received.

The survey was live between 25 March and 22 April 2026. During this time, 3,451 responses were received, representing an 11% response rate. The table below shows the unweighted response rate for each UK nation.

Figure 1 – Survey response rate by location

Location	Registrant population	Number of responses	Response rate
England	25,772	2,570	10%
Wales	1,444	179	12%
Scotland	2,629	310	12%
Northern Ireland	912	96	11%

Interpretation of the findings

Weighting

As the survey was completed by a sample of GOC registrants, and not the entire population of registered optical professionals, the data has been weighted to ensure that certain subgroups are not over or under-represented and that the data is as close to the GOC registrant profile as possible. Weighting adjusts the proportions of certain groups within a sample to match more closely to the proportions in the target population.

The sample has been weighted by registration type (optometrist, dispensing optician, student optometrist, student dispensing optician), based on an up to date version of the GOC register. All survey results presented within this report are based on the weighted data. This approach to weighting has been taken in previous years of the survey, allowing for comparability.

Sampling confidence interval

As the online survey was completed by a sample of GOC registrants and not the entire registrant population, all results are subject to sampling tolerances. However, as a large number of responses were received, the confidence interval for analysis (also known as the margin of error) is narrow.

Based on a total population of approximately 32,500 registrants and 3,451 survey responses, when interpreting the results to a question which all respondents answered, with a response of 50% there is a 95% chance that this result would not vary by more than +/- 1.6 percentage points (48.5% to 51.5%) had the result been obtained from the entire registrant population.

Subgroup analysis

Subgroup analysis has been undertaken to explore the results provided by different groups of GOC registrants, such as registration type, length of registration, workplace setting, location, and key demographics including gender, age group, ethnicity, and disability status. This analysis has

only been carried out where the sample size is seen to be sufficient for comment. Where sample sizes were not large enough, subgroups have been combined to create larger groups. This analysis is presented in charts, tables, and commentary where statistically significant differences between subgroups have been found.

Interpretation of survey data

This report contains various tables and charts. In some instances, the responses may not add up to 100%. There are several reasons why this might happen:

- The question may have allowed each respondent to give more than one answer
- Only the most common responses may be shown in the table or chart
- Individual percentages are rounded to the nearest whole number so the total may come to 99% or 101%
- A response of between 0% and 0.4% will be shown as 0%

For the analysis of certain questions, response options have been grouped together to provide an overall level. For example, in some instances 'very confident' and 'quite confident' have been grouped and shown as 'total confident'. Where these combined percentages do not equal the overall level reported (being 1% higher or lower), this is due to percentages being rounded to the nearest whole number.

For the analysis of free-text responses, verbatim comments were read in detail and a coding frame was developed for each question based on themes emerging. This then allowed for categorisation of the themes emerging in the comments, which are presented as analysis.

To provide the GOC with insight to inform future workforce planning, certain survey results have been scaled up to the number of optical professionals currently on the GOC's register, converting the results into approximate registrant numbers. Please note that the numbers presented in this report are only approximations, are subject to sampling confidence intervals, and are shown to provide a general idea of the number of GOC registrants who may have answered in a particular way, if everyone on the register had responded to the survey question.

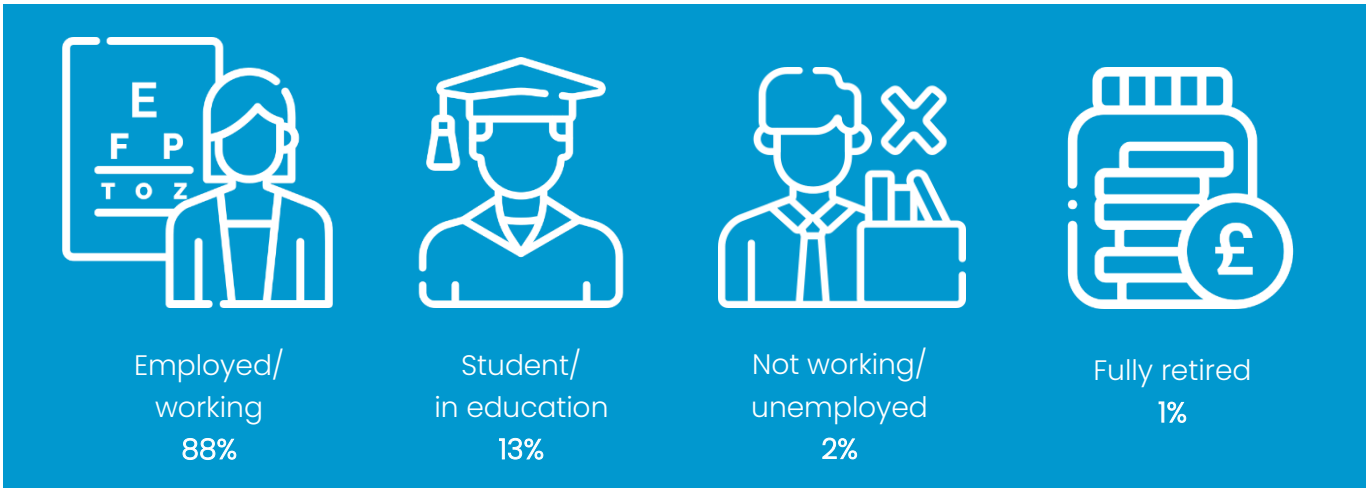
Throughout this report, those who took part in the survey are referred to as 'respondents'.

Workforce profile

Working status

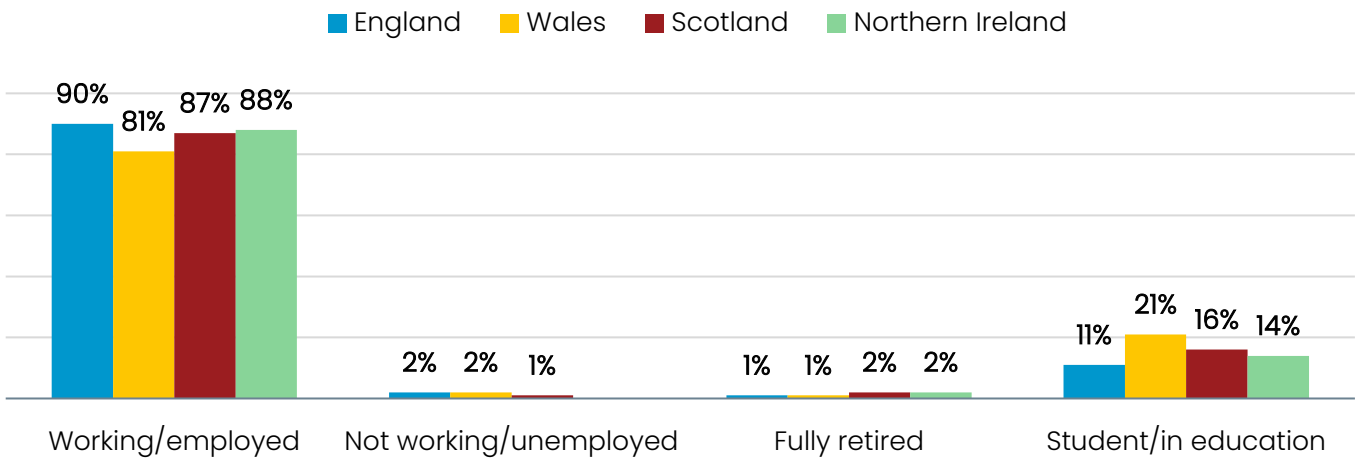
The majority of respondents (88%) were working/in employment. Registrant working status has remained static since 2022.

Figure 2 – Working status
Base: All respondents (3,451)



Working status is broadly consistent across the UK nations, with the exception of a greater proportion of students in Wales (21%) when compared with other UK nations.

Figure 3 – Working status by UK nation
Base: All respondents England (2,770); Wales (186); Scotland (365); Northern Ireland (112)

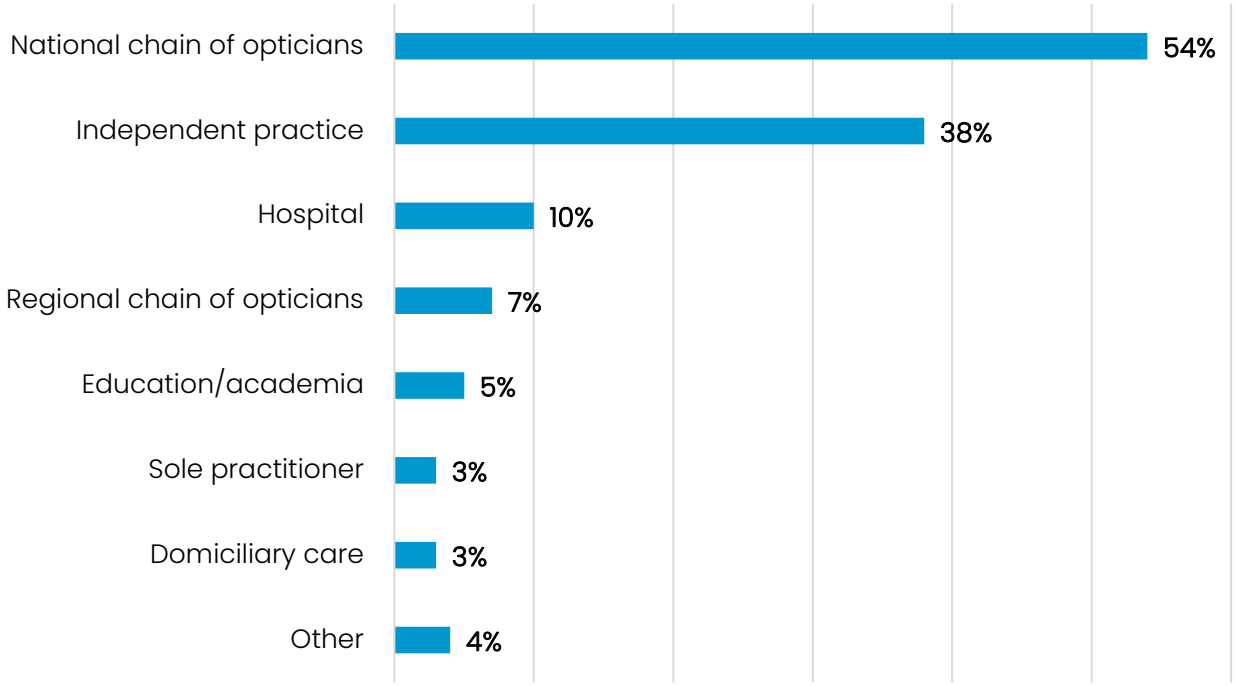


Workplace setting

Workplace profile continues to be broadly stable over time

The overall distribution of registrants by workplace continues to show a consistent pattern. Around three in five (61%) worked for a national or regional chain of opticians (referred to as 'multiple' throughout this report), while just over two in five (41%) worked in independent practice or as a sole practitioner. One in ten (10%) worked in a hospital setting, with smaller proportions based in education/academia (5%) or domiciliary care (3%).

Figure 4 – Workplace setting
Base: Those currently working (3,315)



The free-text 'other' responses were diverse, but most commonly related to respondents working in advisory, regulatory or representative roles (e.g. NHS/ICB, LOC, professional bodies), specialist or community-based services (such as ophthalmology, low vision, special schools, or prisons), charitable organisations, or mixed roles combining multiple settings including locum and consultancy work.

Also mirroring previous years, the majority of working respondents worked in just one workplace setting (83%), with 12% working in two locations, and just 5% across three or more. Working across multiple workplace settings was more common amongst optometrists (23%) when compared with dispensing opticians (7%).

Workforce capacity

Average number of days worked per week

Working respondents provided the number of days per week on average they worked across each location. The table below presents the mean (average) number of days worked, split by registration type (please note that working student optometrists and dispensing opticians have been removed from these calculations), calculated as 4.0 days per week overall – 3.9 days for optometrists and 4.1 days for dispensing opticians.

As seen in previous years, with very small variation in the figures for each location, the overall number of days has remained almost exactly the same as last year (3.9 in 2025).

Figure 5 – Average number of days worked per week across workplace settings by registration type
Base: Those currently working (2,708); Optometrists (2,004); Dispensing opticians (704)

Workplace setting	Number of responses	Total number of days	Optometrists	Dispensing opticians
Independent practice	1,098	3.3	3.1	3.9
Sole practitioner	90	2.0	2.0	2.8
National chain of opticians	1,385	3.6	3.5	4.0
Regional chain of opticians	186	2.8	2.6	3.5
Hospital	280	2.8	2.8	2.5
Domiciliary care	81	2.5	2.3	3.1
Education/academia	161	2.6	2.4	3.4
Other	112	2.6	2.4	3.9
Total/overall	**2,708**	**4.0**	**3.9**	**4.1**

There is some variation in the average number of days worked per week in different settings across the UK nations, but the total number of days is generally similar, ranging from 3.9 in England and Wales to 4.2 in Northern Ireland (although this is based on a significantly smaller base size).

Figure 6 – Average number of days worked per week across workplace settings by UK nation
Base: England (2,015); Wales (138); Scotland (249); Northern Ireland (75)

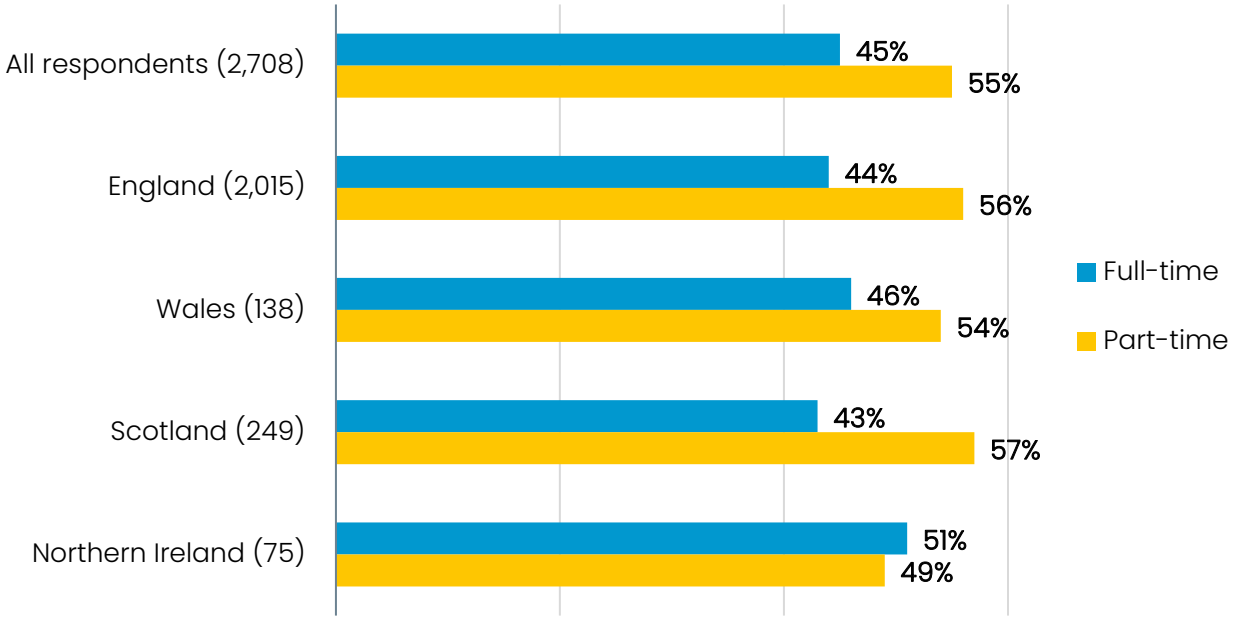
Workplace setting	England	Wales	Scotland	Northern Ireland
Independent practice	3.2	3.1	3.3	4.1
Sole practitioner	1.8	1.8	1.9	3.9
National chain of opticians	3.6	3.9	3.8	3.7
Regional chain of opticians	2.8	3.6	3.0	-
Hospital	2.7	2.6	2.5	3.2

Workplace setting	England	Wales	Scotland	Northern Ireland
Domiciliary care	2.6	2.6	2.2	0.5
Education/academia	2.5	3.5	2.7	3.0
Other	2.6	1.4	2.6	3.0
Total/overall	**3.9**	**4.0**	**4.0**	**4.2**

A small increase in part-time working

Based on full-time work being five days or more per week, **45% of respondents worked full-time and 55% worked part-time**. The split between full and part-time working is fairly consistent across the UK nations, with a more even split amongst those working in Northern Ireland.

Figure 7 – Full-time/part-time working by UK nation
Base: Shown in chart (excluding working students)



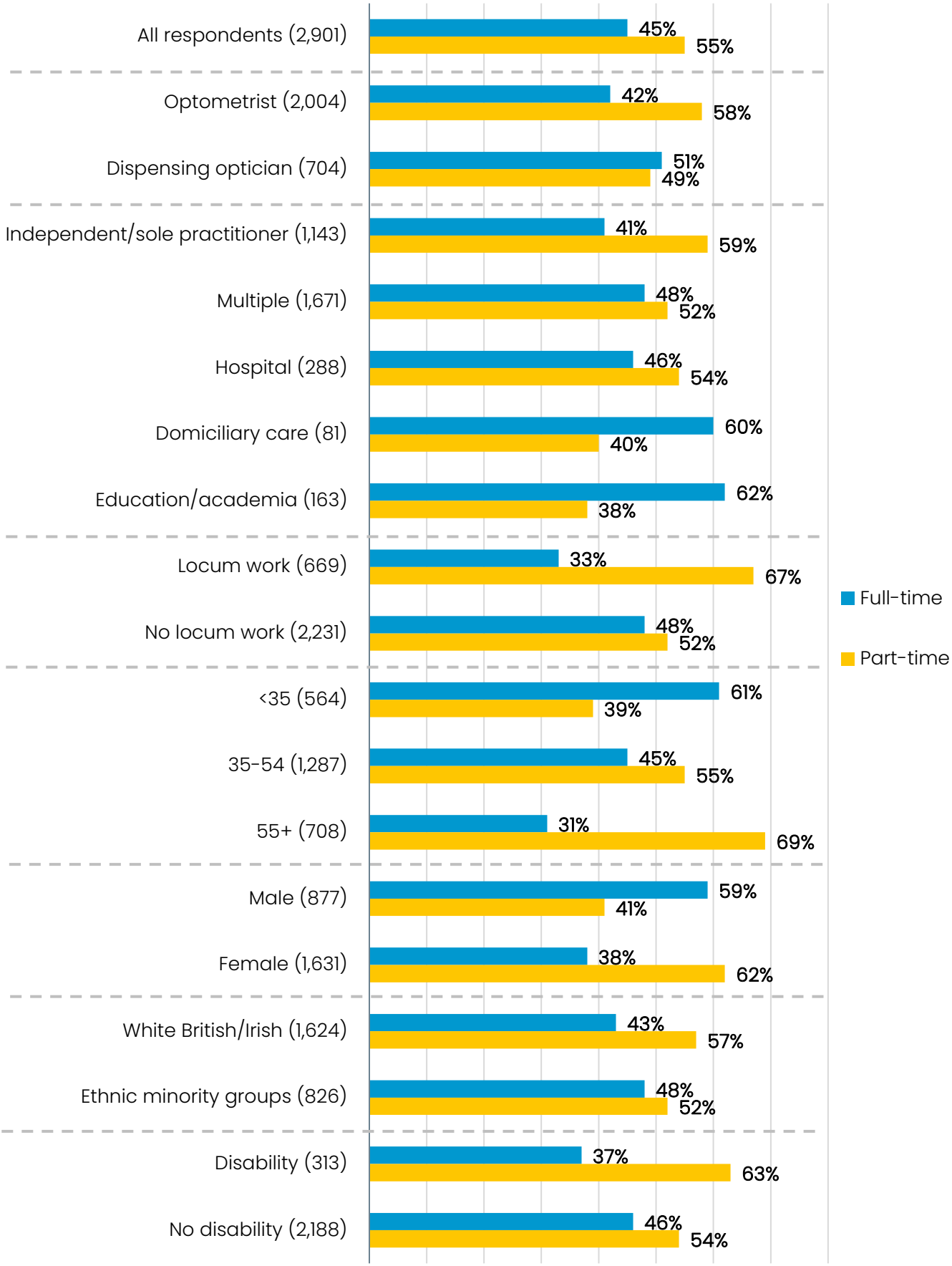
After a small shift towards part-time working between 2024 (53%) and 2025 (56%), this year represents more of a continuation (55%).

The chart overleaf presents the split between full and part-time work by a number of key subgroups, highlighting a range of differences and suggesting working patterns vary by role, workplace setting and respondent demographics.

As seen in previous years, part-time work is more common overall, particularly among optometrists, those working for an independent opticians or as a sole practitioner, females, older professionals, those in locum roles, those of White British/Irish ethnicity, and those who report a disability. In contrast, full-time work is more typical among dispensing opticians, males, those from ethnic minority groups, those working in domiciliary care and education/academia, individuals not doing locum work, and those without a disability. Respondents from ethnic minority groups and those working for multiples show an even split between full-time and part-time working.

Figure 8 – Full-time/part-time working by registration type, workplace setting, locum working, age group, gender, ethnicity, and disability

Base: Shown in chart (excluding working students)



Workforce capacity results scaled up

To help inform workforce planning, the number of working days has been scaled up based on the number of optometrists and dispensing opticians on the current GOC register to provide an informed estimate of the full time equivalent (FTE) number of registrants.

The average number of days and total approximate number of registrants have been multiplied and then divided by five (working days per week) to calculate the approximate workforce size in terms of FTE registrants.

The table below shows that there are approximately 15,054 FTE optometrists and 5,494 FTE dispensing opticians. This represents a continued increase in the total number of FTE optometrists, but a continued decrease in the total number of FTE dispensing opticians, when compared with survey results from 2024 and 2025.

Figure 9 – Scaled up workforce size

Registration type	Average number of days	Total number of registrants	Number of FTE registrants (2026)	*Number of FTE registrants (2025)*	*Number of FTE registrants (2024)*
Optometrist	3.9	19,300	**15,054**	*14,586*	*14,040*
Dispensing optician	4.1	6,700	**5,494**	*5,576*	*5,617*
Total	**4.0**	**26,000**	**20,548**	***20,162***	***19,657***

The following tables show this calculation individually for optometrists and dispensing opticians split across different workplace settings, using the survey results to calculate the approximate number of FTE registrants working in each setting.

Figure 10 – Scaled up workforce size for optometrists by workplace setting

Workplace setting	Average number of days	Total number of registrants	Number of FTE registrants (2026)	*Number of FTE registrants (2025)*	*Number of FTE registrants (2024)*
Independent practice	3.1	8,106	**5,026**	*4,600*	*4,687*
Sole practitioner	2.0	772	**309**	*269*	*270*
National chain of opticians	3.5	9,843	**6,890**	*6,807*	*6,221*
Regional chain of opticians	2.6	1,351	**703**	*838*	*731*
Hospital	2.8	2,509	**1,405**	*1,010*	*1,512*
Domiciliary care	2.3	579	**266**	*236*	*238*
Education/ academia	2.4	1,158	**556**	*468*	*630*

Figure 11 – Scaled up workforce size for dispensing opticians by workplace setting

Workplace setting	Average number of days	Total number of registrants	Number of FTE registrants (2026)	*Number of FTE registrants (2025)*	*Number of FTE registrants (2024)*
Independent practice	3.9	2,546	**1,986**	*2,176*	*2,191*
Sole practitioner	2.8	67	**38**	*36*	*19*
National chain of opticians	4.0	3,484	**2,787**	*2,551*	*2,740*
Regional chain of opticians	3.5	402	**281**	*255*	*296*
Hospital	2.5	134	**67**	*77*	*77*
Domiciliary care	3.1	134	**83**	*53*	*37*
Education/ academia	3.9	335	**261**	*181*	*164*

The following tables show the scaled up approximate workforce size calculation for optometrists and dispensing opticians split by UK nation using the GOC's register to calculate the approximate number of registrants working in each location.

Figure 12 – Scaled up workforce size for optometrists by UK nation

UK nation	Average number of days	Total number of registrants	Number of FTE registrants (2026)	*Number of FTE registrants (2025)*	*Number of FTE registrants (2024)*
England	3.9	15,047	**11,737**	*11,350*	*11,176*
Wales	4.0	796	**637**	*575*	*670*
Scotland	4.0	1,683	**1,346**	*1,289*	*1,397*
Northern Ireland	4.2	680	**571**	*549*	*526*

Figure 13 – Scaled up workforce size for dispensing opticians by UK nation

UK nation	Average number of days	Total number of registrants	Number of FTE registrants (2026)	*Number of FTE registrants (2025)*	*Number of FTE registrants (2024)*
England	4.1	5,486	**4,499**	*4,488*	*4,729*
Wales	4.1	275	**226**	*239*	*265*
Scotland	4.2	445	**374**	*368*	*403*
Northern Ireland	4.0	89	**71**	*68*	*71*

Additional qualifications and enhanced services

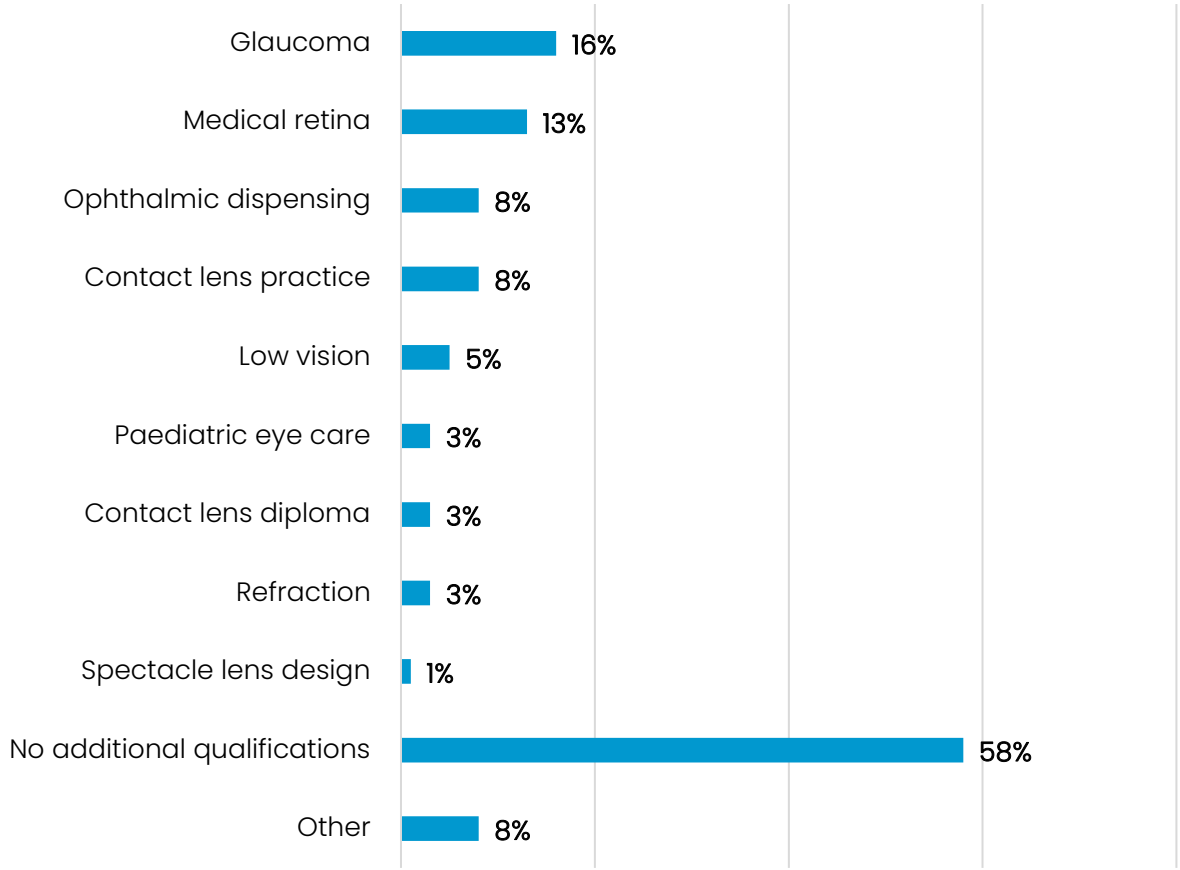
Additional qualifications are common and increasing across the profession

Respondents were asked if they had obtained any additional qualifications, other than the post-registration qualifications approved by the GOC (additional supply speciality, supplementary prescribing speciality, independent prescribing speciality, and contact lens specialty).

While a majority of respondents (58%) report having none, a substantial proportion of the workforce (42%) hold at least one additional qualification, indicating that they are a common feature of the profession. Where held, these were most often in clinical areas such as glaucoma (16%) and medical retina (13%).

Figure 14 – Additional qualifications

Base: All respondents excluding students (3,128)



The proportion of respondents with no additional qualifications has declined notably in recent years (from 65%-67% in 2023-2025 to 58% in 2026), indicating a gradual increase in qualification levels across the workforce.

This has been driven by steady growth in glaucoma and medical retina (+3% pts and +4% pts since 2023), alongside a recent increase in contact lens practice qualifications (+4% pts since 2025).

Additional qualifications concentrated among optometrists, hospital settings and Wales-based registrants

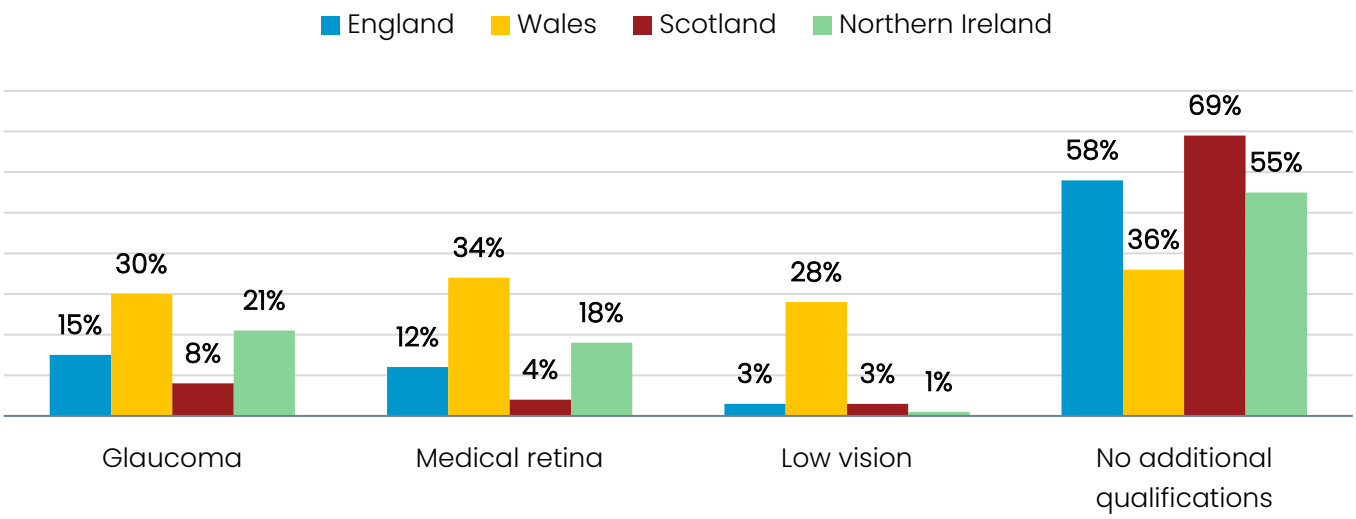
Additional qualifications are more prevalent among optometrists than dispensing opticians, with optometrists far more likely to report having at least one (49% vs 40%).

By workplace setting, holding at least one additional qualification is particularly concentrated amongst those working in hospitals (73%) or in education/academia (72%), particularly when compared with those working in multiples (38%), in an independent/as a sole practitioner (45%), or in domiciliary care (40%).

As found in previous years, registrants based in Wales were significantly more likely to report holding additional qualifications when compared with other UK nations, particularly in the fields of glaucoma, medical retina, and low vision. As also seen in previous waves of the survey, having no additional qualifications was more common amongst those living in Scotland.

Figure 15 – Additional qualifications by UK nation

Base: All respondents excluding students England (2,317); Wales (162); Scotland (283); Northern Ireland (94)



Engagement in enhanced services has increased after period of stability

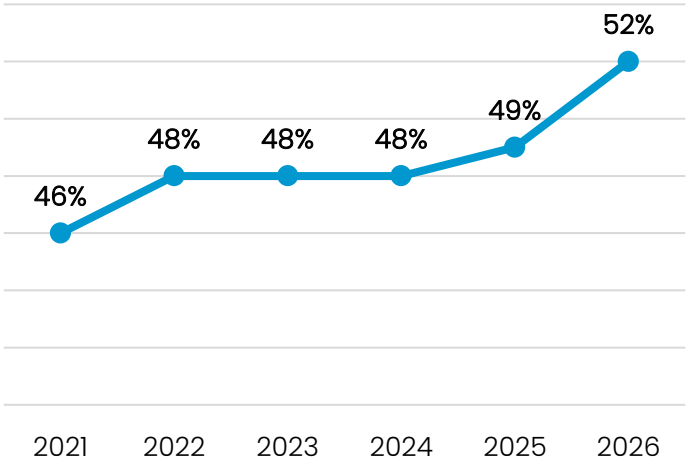
Over half of respondents (52%) are involved in the delivery of enhanced eye care services.

This marks a notable increase compared with recent years, following a sustained period of stability at around 48–49% since 2022.

The uplift in this year suggests a potential shift towards greater engagement in enhanced services across the profession, although it will be important to monitor whether this represents the start of a longer-term trend.

Figure 16 – Involvement in enhanced eye care service delivery 2021 to 2026

Base: Working respondents 2021 (4,880); 2022 (3,647); 2023 (3,468); 2024 (4,049); 2025 (3,315); 2026 (3,022)



Optometrists are significantly more likely than dispensing opticians to be involved (60% vs 34%). There is also a clear link with additional qualifications, with 60% of those holding at least one qualification involved, compared with 46% of those without.

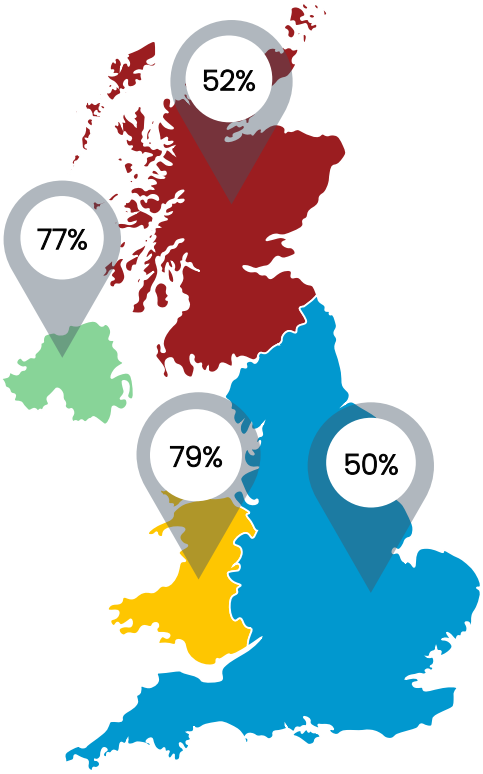
By workplace setting, involvement in enhanced services is highest among those working in independent practices and multiples (both 55%), and slightly lower among those in hospital settings (52%), domiciliary care (43%), and education/academia (46%). There is also some variation by age, with those aged 35–54 most likely to be involved (56%), compared with 52% of those aged under 35, and 46% of those aged 55 and over.

Delivery of enhanced eye care services continues to be far more common in Wales and Northern Ireland

As found in previous years, respondents in Wales and Northern Ireland were far more likely to be involved in the delivery of enhanced eye care services when compared with those in England and Scotland.

Figure 17 – Involved in the delivery of enhanced services by UK nation

Base: England (2,252); Wales (156); Scotland (276); Northern Ireland (92)



Locum working

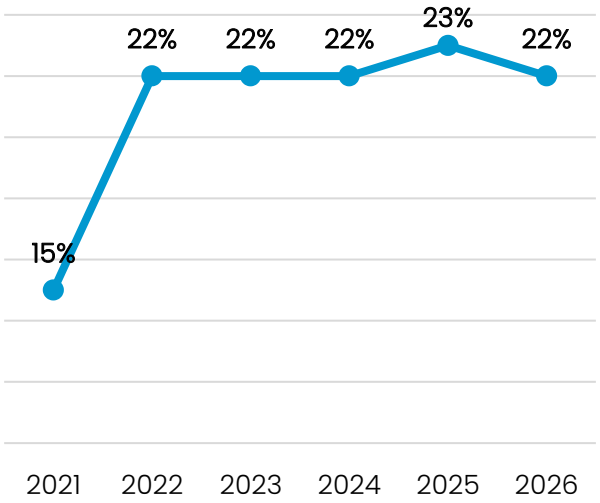
The proportion and profile of locum workers remains consistent

Around one in five registrants (22%) report working as a locum. This remains consistent with recent years, with the proportion stable at around 22–23% since 2022, following an increase from 15% in 2021. Overall, this may suggest that locum working has become an established and steady feature of the workforce.

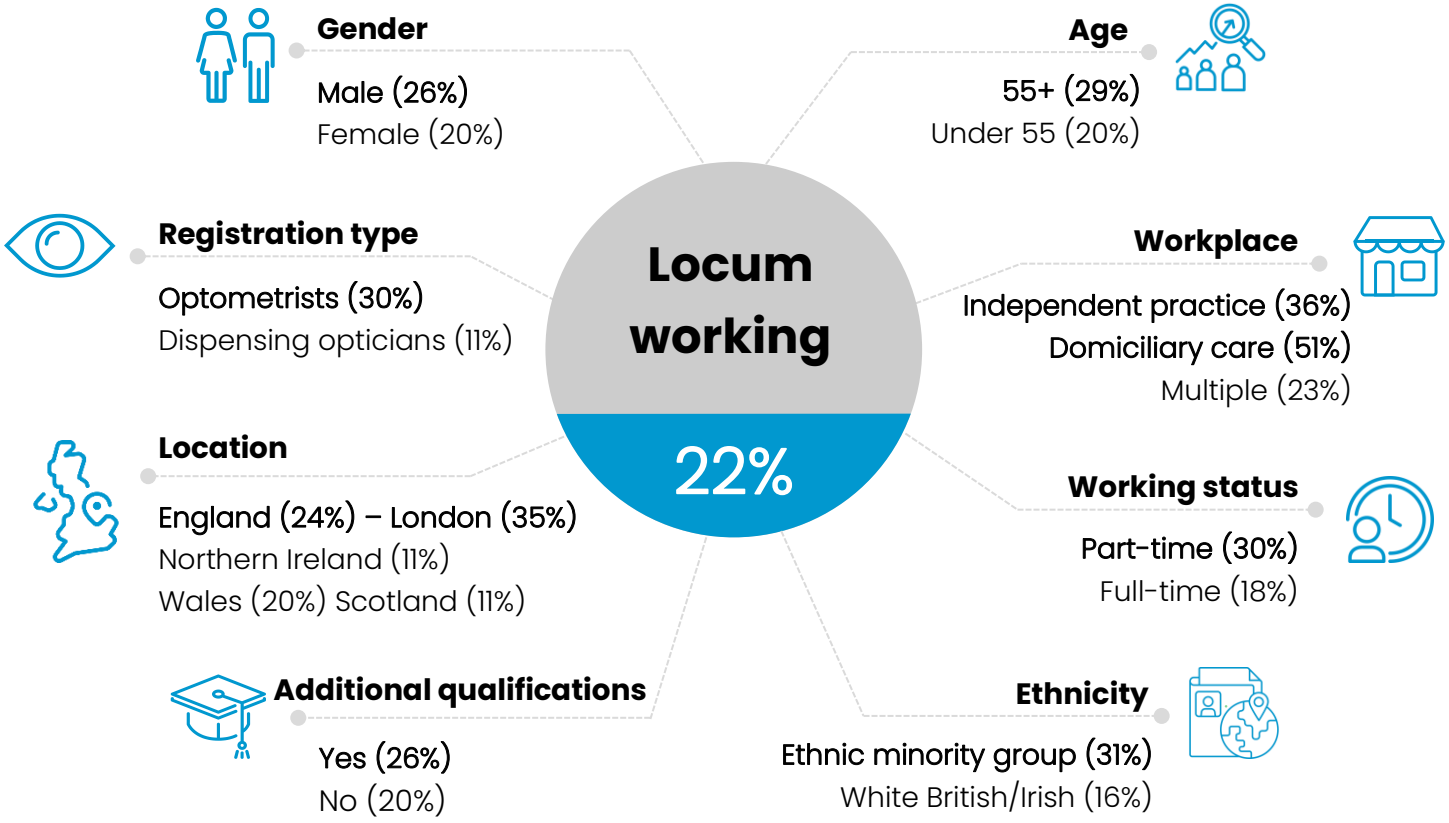
Reinforcing this consistency, the profile of locum workers has also changed little in recent years, with certain groups more likely to work as locums. It is more common among optometrists than dispensing opticians, and tends to be associated with more flexible working patterns, particularly among those working part-time. It is also more prevalent in community-based settings, especially independent practice and domiciliary care, and among more experienced, older registrants.

Figure 18 – Locum working 2021 to 2026

Base: Working respondents 2021 (4,880); 2022 (3,647); 2023 (3,468); 2024 (4,049); 2025 (3,022)



The diagram below highlights which groups are more likely to undertake locum work.

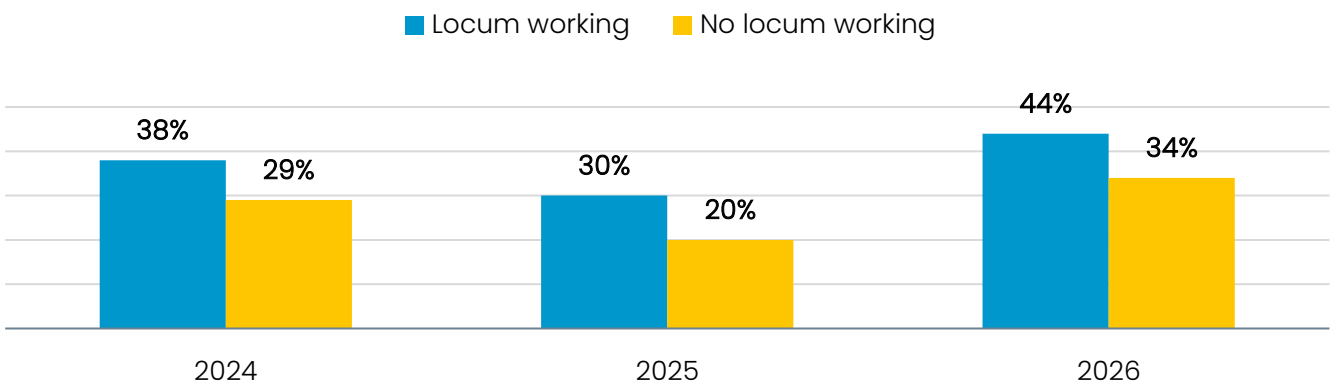


Locum workers remain more likely to report challenges in delivering sufficient patient care, with concerns increasing this year

As in previous years, those who work as locums are more likely than non-locums to report finding it difficult to provide patients with the sufficient level of care they need (44% vs 34% sometimes or frequently).

Following a dip in 2025 (30% vs 20%), the proportion has increased again in 2026, rising above 2024 levels for both groups (38% vs 29%).

Figure 19 – Difficulties providing sufficient patient care by locum working 2024-2026
Base: 2024 (3,315); 2025 (4,049); 2026 (3,022)

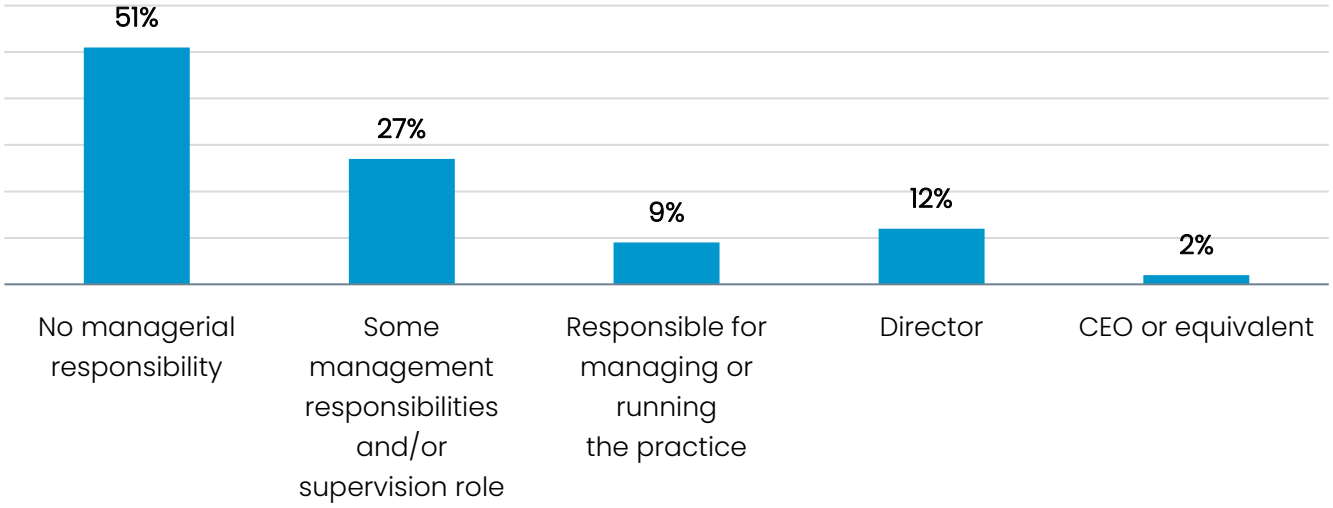


Level of seniority

Workforce continues to be concentrated in non-managerial positions

Half of respondents (51%) report having no managerial responsibility, with a further 27% holding some level of management or supervisory role. Fewer registrants occupy more senior positions, with 9% responsible for managing or running a practice, 12% at director level, and 2% at CEO level or equivalent.

Figure 20 – Level of seniority in current role
Base: All working respondents (3,022)



As expected, younger respondents aged under 35, those with fewer years registered with the GOC, and students were more likely to have no managerial responsibility when compared with those aged 35+ and with a greater number of years of GOC registration.

Those who worked as locums were also more likely to have no managerial responsibility (67%) when compared with those who did no locum work (47%).

Leadership roles remain more concentrated among certain demographic groups

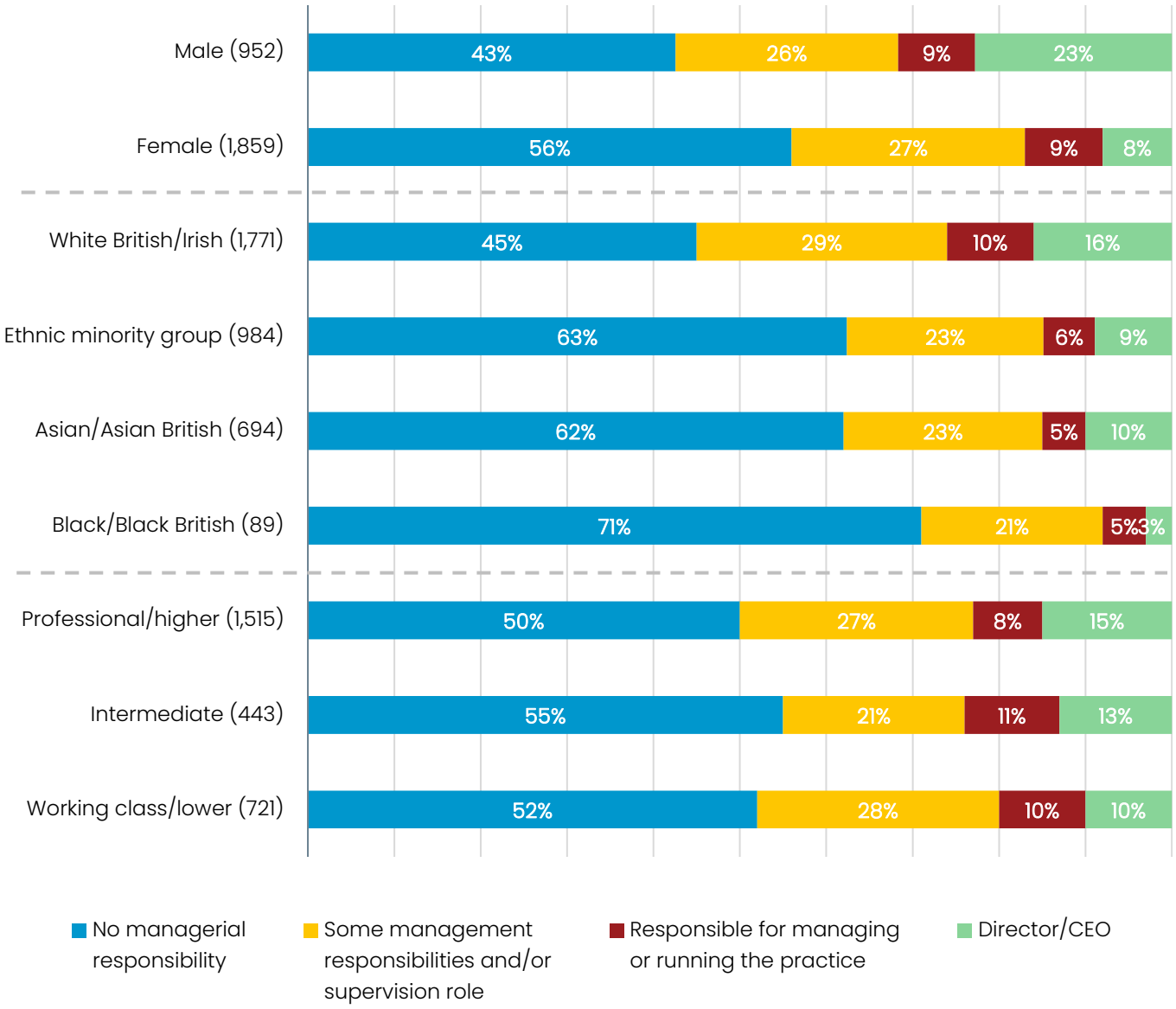
Showing little change from previous years, leadership roles (Director/CEO level) are not evenly distributed across demographic groups, with the clearest differences seen by gender and ethnicity.

Male respondents are more likely than female respondents to be in a Director/CEO role, while female respondents are more likely to report having no managerial responsibility. A similar pattern is evident by ethnicity, with White British/Irish respondents more likely than those from minority ethnic groups to be in senior leadership roles, while minority ethnic respondents are more likely to have no managerial responsibility.

Differences are also present by socio-economic background, with respondents from professional/higher backgrounds more likely to be in Director/CEO roles than those from working class/lower backgrounds.

Figure 21 – Level of seniority in current role by ethnicity

Base: Shown in chart



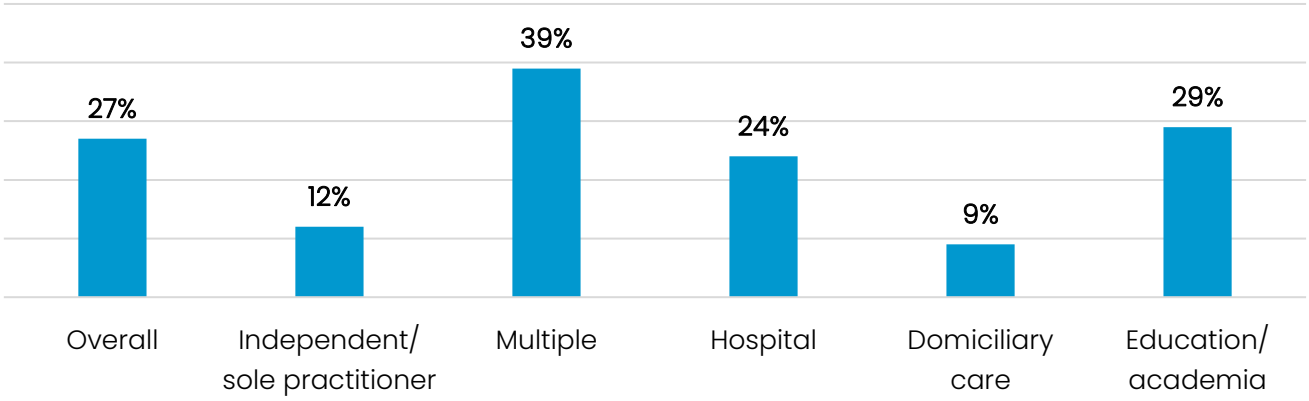
Supervising

Just over a quarter (27%) of working optometrist and dispensing optician respondents had worked in a role supervising pre-registration trainees in the last 12 months.

Supervision is more commonplace in multiple/chain opticians, and can negatively impact workload

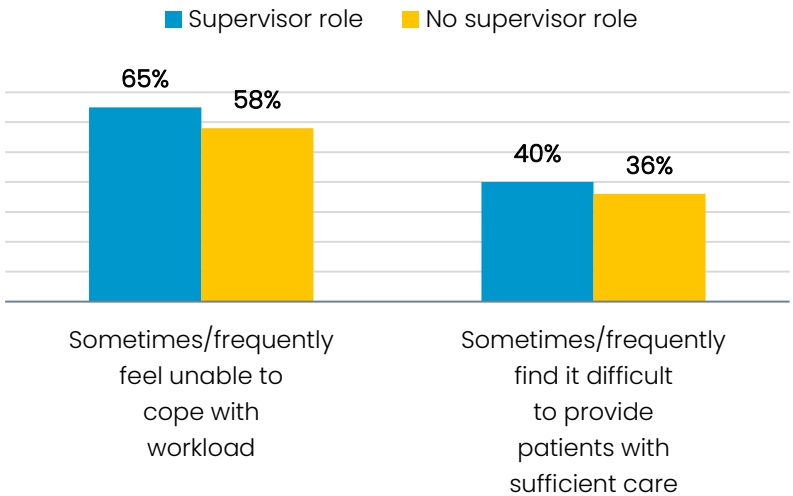
Continuing trends found in previous years, working as a supervisor was more common amongst those who worked for a multiple when compared with other workplace settings, particularly those working in independent opticians.

Figure 22 – Working as a supervisor for pre-registration trainee optometrists by workplace setting
Base: Working optometrists and dispensing opticians (2,708); Independent/sole practitioner (1,124); Multiple (1,513); Hospital (280); Domiciliary care (81); Education/academia (161)



Those who work as supervisors also continue to be more likely to feel unable to cope with their workload and find it difficult to provide patients with the level of care they need when compared with those who do no supervising. Again, this highlights the potential negative impact of taking on this responsibility for optometrists and dispensing opticians on their workload and ability to deliver safe patient care.

Figure 23 – Workplace challenges by working as a pre-registration trainee supervisor
Base: Sometimes/frequently feel unable to cope with workload (1,619); Sometimes/frequently finding it difficult to provide patients with sufficient care (999)



Job satisfaction

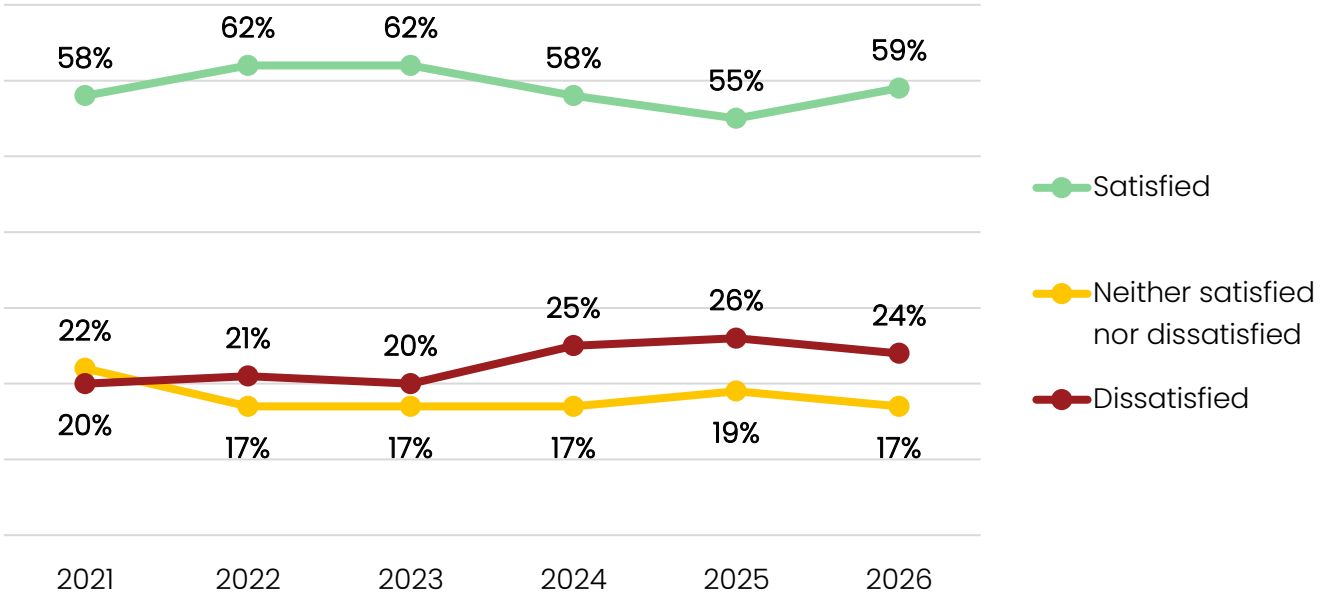
Job satisfaction shows modest improvement

Three in five respondents (59%) report being satisfied in their job/role over the last 12 months, with satisfaction increasing compared with 2025 (55%).

At the same time, dissatisfaction has eased slightly from its recent peak (26% to 24%), suggesting a modest improvement in overall sentiment. While satisfaction remains below the higher levels seen in 2022 and 2023 (62%), these results may suggest a potential stabilisation and early signs of recovery in job satisfaction.

Figure 24 – Job/role satisfaction 2021 to 2026

Base: Working respondents excluding 'not applicable' 2021 (4,378); 2022 (3,628); 2023 (3,468); 2024 (4,043); 2025 (3,306); 2026 (3,015)



Exploring job satisfaction

Although the majority of registrants report being satisfied in their role over the last 12 months (59%), with a quarter (24%) dissatisfied, this a significant minority of the workforce who are experiencing challenges in their role.

Analysis of this result highlights meaningful differences across the workforce, with satisfaction shaped by workplace context, career stage, and day-to-day experience of delivering care.

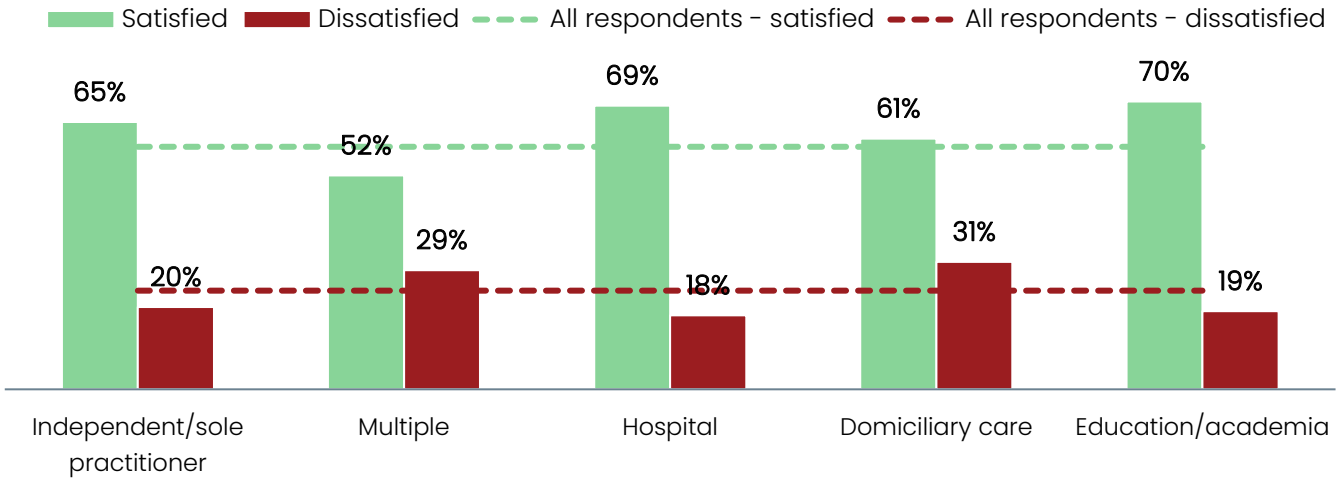
Workplace setting is a key driver of job satisfaction

Satisfaction varies considerably by workplace setting, suggesting that this one of the clearest drivers of experience. Satisfaction is especially high in hospitals, education and academia, and amongst those working in independent practices or as sole practitioners. In contrast, satisfaction is low amongst those working in multiples, who make up a significant proportion of the overall sample (61%).

This may suggest that greater autonomy or variety are associated with higher satisfaction, whereas those in more commercial or high-volume environments such as multiples are more likely to report dissatisfaction.

Figure 25 – Job/role satisfaction by workplace setting

Base: Independent/sole practitioner (1,170); Multiple (1,757); Hospital (288); Domiciliary care (81); Education/ academia (162)

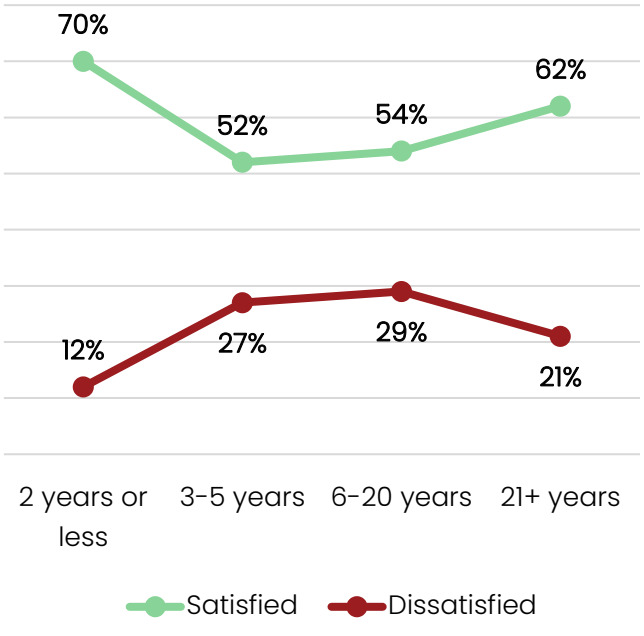


A mid-career dip in satisfaction is evident

There is a clear relationship between experience and job satisfaction, with a notable dip among mid-career registrants. Satisfaction is highest among those at the very start of their careers and those with the most experience, while those in the middle stages report comparatively lower satisfaction and higher dissatisfaction. This may suggest a mid-career pressure point that may impact job satisfaction.

Figure 26 – Job/role satisfaction by length of registration

Base: 2 years or less (348); 3-5 years (379); 6-20 years (985); 21+ years (1,292)

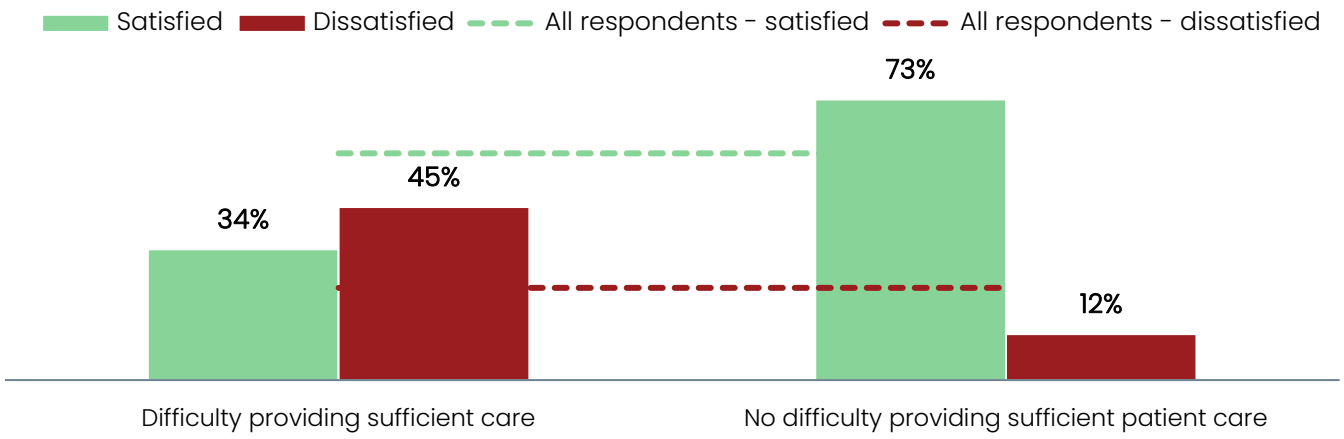


Ability to deliver sufficient patient care is the strongest predictor of satisfaction

The most striking difference in job satisfaction relates to whether registrants feel able to provide patients with the sufficient level of care they need. Those who report difficulties in delivering appropriate care are significantly less likely to feel satisfied and considerably more likely to feel dissatisfied with their role, highlighting the impact of professional fulfilment and frustration on job satisfaction.

Figure 27 – Job/role satisfaction by workplace setting

Base: Difficulty providing sufficient care (1,083); No difficulty providing sufficient care (1,932)

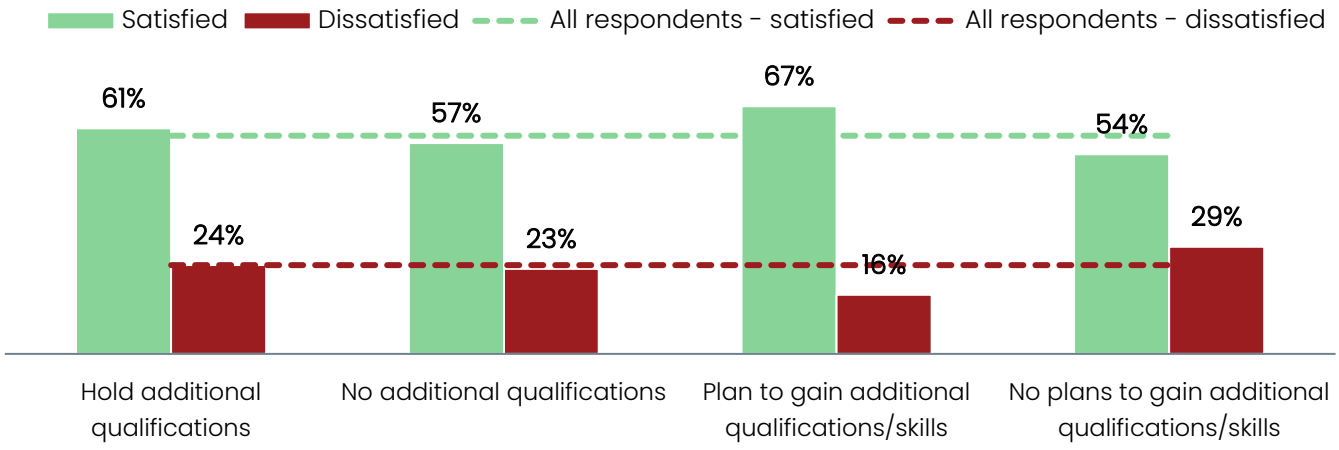


Professional development linked to higher job satisfaction

Registrants who already hold additional qualifications tend to report slightly higher levels of satisfaction than those who do not, but the more pronounced difference is seen among those who are planning to gain further qualifications or skills. Those with plans to undertake additional qualifications report notably higher satisfaction and lower dissatisfaction, while those with no plans to develop further are less satisfied and more likely to feel dissatisfied, suggesting that engagement in professional development, whether through existing qualifications or a forward-looking intention to upskill, is associated with more positive job experiences.

Figure 28 – Job/role satisfaction by existing additional qualifications and plans to gain additional qualifications/kills in the next 12 months

Base: Hold additional qualifiactions (1,282); No additional qualifications (1,732); Plan to gain additional qualifications/skills (1,218); No plans to gain additional qualifications/skills (1,732)

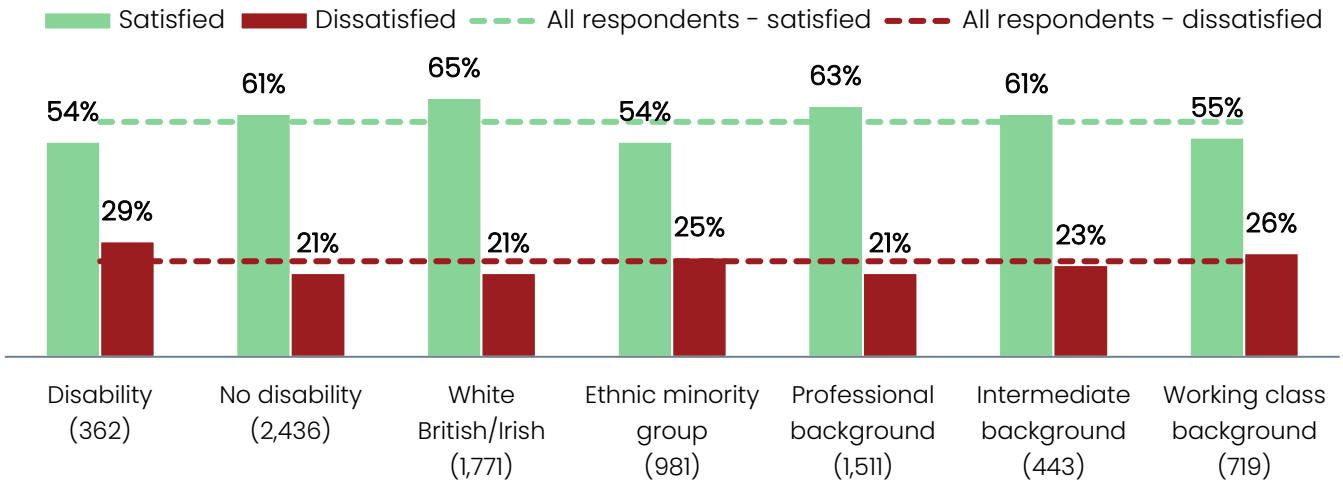


Some variation in satisfaction by demographic characteristics

There are also some differences in job satisfaction across demographic groups. Registrants with a disability are less likely to feel satisfied and more likely to feel dissatisfied with their role compared with those without a disability.

Differences by ethnicity are less pronounced overall, although there is some variation between White British/Irish and ethnic minority groups in levels of satisfaction and dissatisfaction. A similar pattern is seen by socio-economic background, where those from working class backgrounds tend to report slightly lower satisfaction and higher dissatisfaction than those from professional or intermediate backgrounds.

Figure 29 – Job/role satisfaction by disability, ethnicity, and socio-economic background
Base: Shown in chart



Working conditions

Experiences of negative working conditions

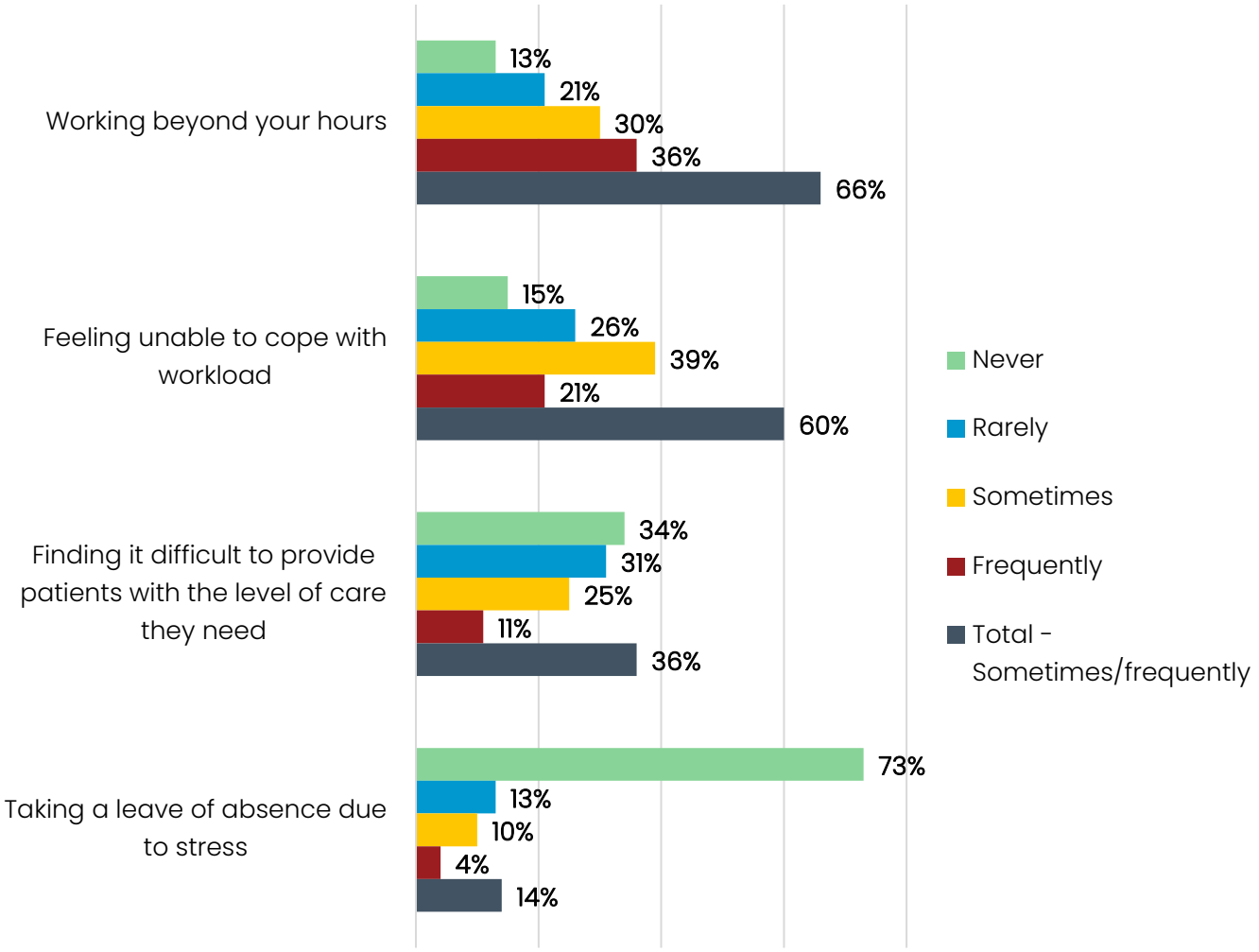
Workload pressures remain the most widespread challenge

Working beyond contracted hours continues to be the most commonly reported negative working condition, with two-thirds (66%) of respondents indicating this occurs at least sometimes. A similarly high proportion (60%) report struggling to cope with their workload, highlighting the ongoing pressure many registrants face in their day-to-day roles.

While a smaller proportion (36%) report difficulties in delivering the level of care they would like, this still affects a notable minority, and may be linked with other workload pressures.

In contrast, taking time off due to stress remains relatively uncommon (14%), indicating that while pressures are widespread, they do not always translate into absence.

Figure 30 – Experience of negative working conditions in the last 12 months
Base: Those currently working/employed (3,022)

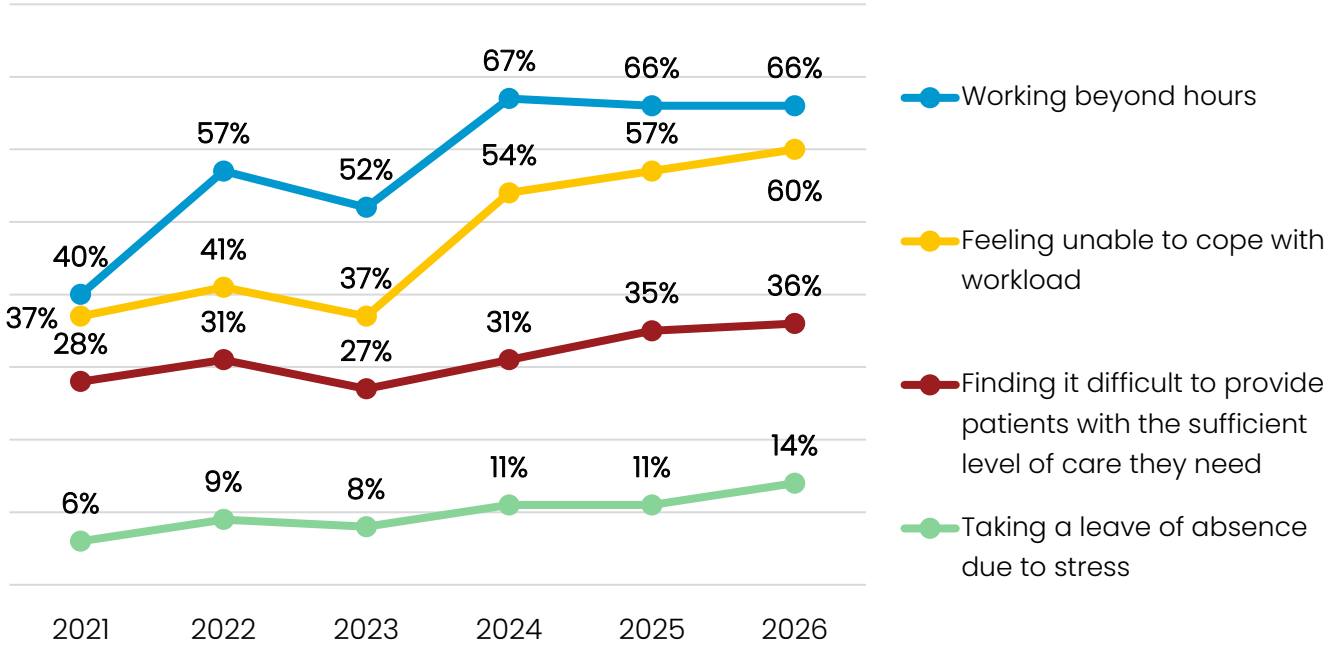


Some aspects of negative working conditions are increasing over time

Although caution is required when comparing over time due to changes in question format since 2024, the available trend data suggests that negative working conditions have become more prevalent in recent years. In particular, there has been a noticeable increase in the proportion of respondents reporting that they feel unable to cope with their workload, as well as those finding it difficult to provide patients with the level of care they need. Both measures have risen steadily since 2023, indicating growing strain within the workforce.

Working beyond contracted hours has remained consistently high over the last three years. Meanwhile, reports of stress-related absence, while still comparatively low, have shown a gradual upward trend.

Figure 31 – Experience of negative working conditions 2021 to 2025 (sometimes/frequently)
Base: Those currently working/employed 2021 (4,479); 2022 (3,647); 2023 (3,486); 2024 (4,049); 2025 (3,315); 2026 (3,022)

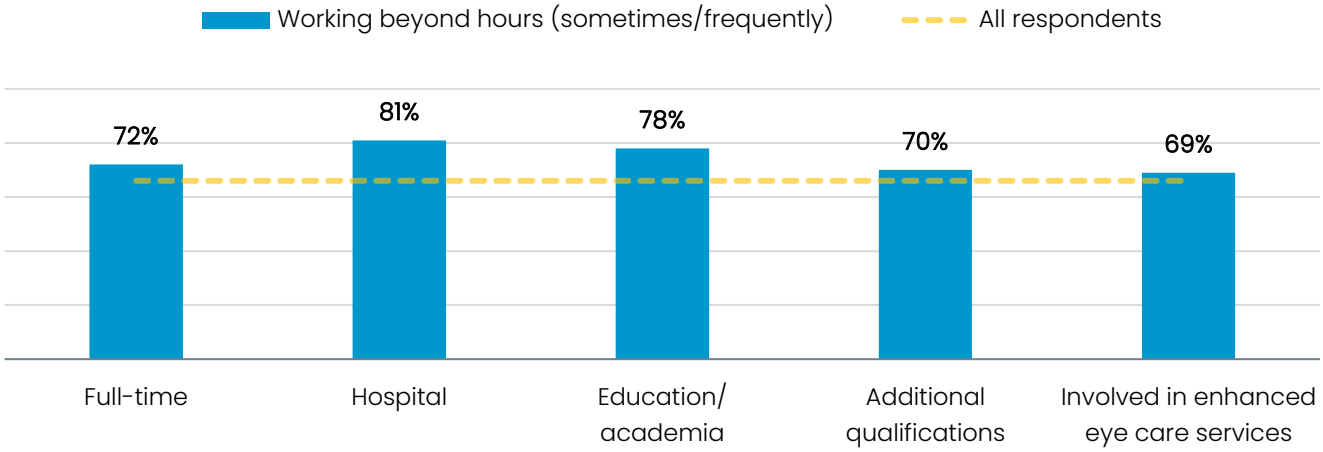


Working beyond hours is more prevalent among those in demanding and extended roles

Working beyond hours is widespread, but is more common among some groups than others. Respondents working full-time were more likely than those working part-time to say they had done so at least sometimes, while those working in hospital and education/academia settings also stood out as more likely to report working beyond their hours. This was also more common among registrants with additional qualifications and those involved in enhanced eye care services.

Figure 32 – Impact of working status, workplace setting, additional qualifications, and involvement in enhanced eye care services on working beyond hours

Base: Full-time (1,209); Hospital (288); Education/academia (163); Additional qualifications (1,287); Involveed in enhanced eye care services (1,574)



Workload strain varies by role, setting, working pattern and region

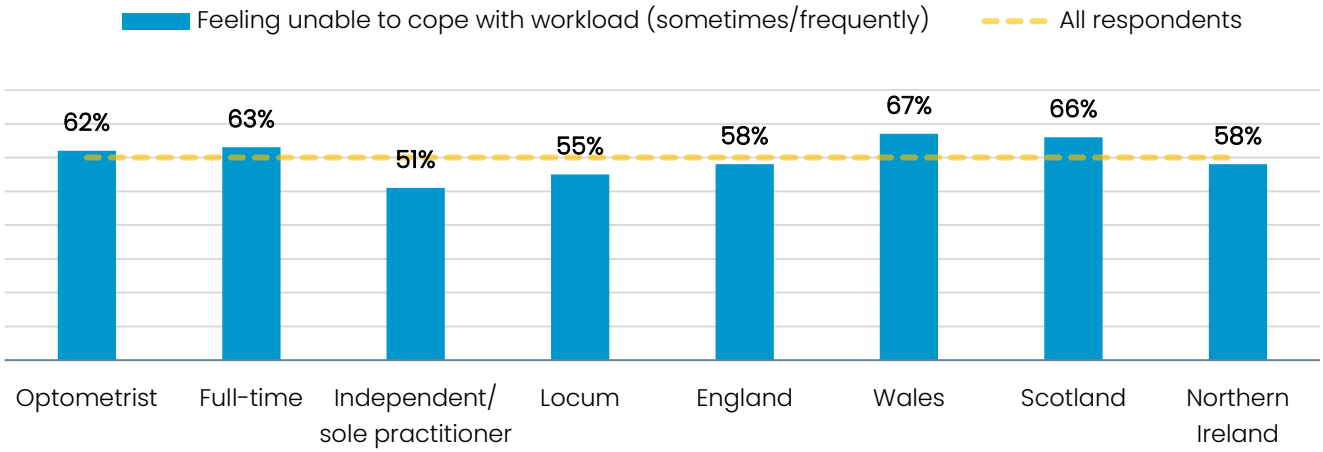
Feeling unable to cope with workload is more common among optometrists and those working full-time when compared with dispensing opticians and those working part-time.

Analysis by workplace setting shows that those working as independent or sole practitioners are less likely to report struggling with workload when compared with all other settings. Locum workers are also less likely to report this issue.

Regional analysis highlights that respondents in Wales and Scotland are more likely to report feeling unable to cope with workload compared with those in England and Northern Ireland.

Figure 33 – Impact of role working status, workplace setting, locum working, and region on feeling unable to cope with workload

Base: Optometrist (2,004); Full-time (1,209); Independent/sole practitioner (1,174); Locum (669); England (2,252); Wales (156); Scotland (276); Northern Ireland (92)



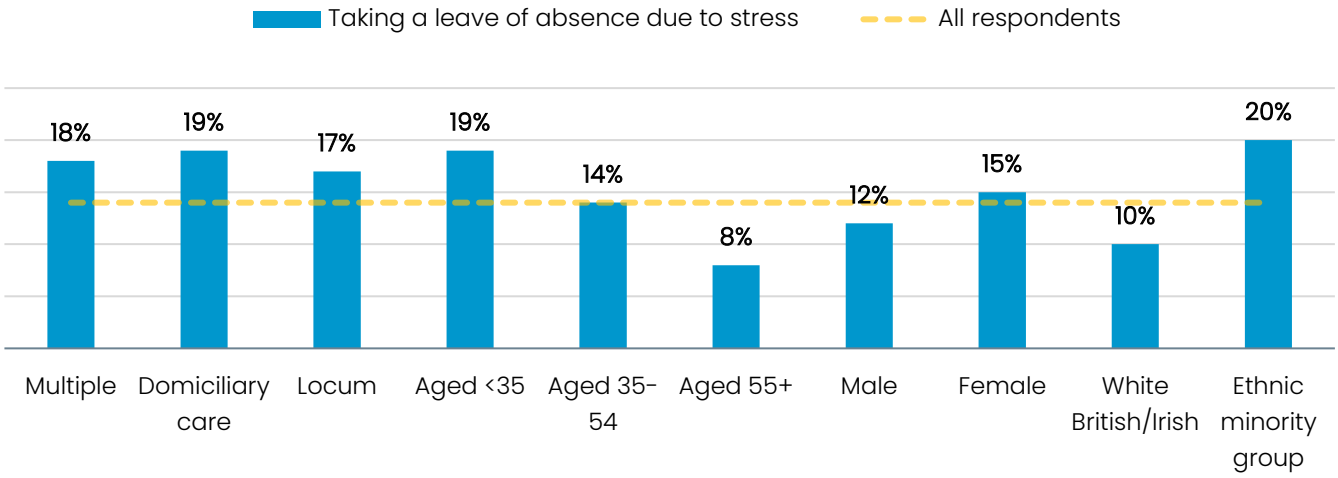
Clear demographic differences in experiences of stress-related absence

Taking a leave of absence due to stress remains less common overall, but there are clear differences across registrant groups. It is more likely to be reported by those working in multiples and domiciliary care when compared with other settings, and also by locum workers.

Younger respondents aged under 35 are more likely to report taking time off due to stress, with likelihood declining steadily with age. Differences are also evident by gender and ethnicity, with female respondents more likely than male respondents to report taking a leave of absence, and those from ethnic minority groups notably more likely to do so compared with White respondents.

Figure 34 – Impact of role working status, workplace setting, locum working, and region on feeling unable to cope with workload

Base: Multiple (1,760); Domiciliary care (81); Locum (669); Aged <35 (826); Aged 35-54 (1,338); Aged 55+ (709); Male (952), Female (1,859); White British/Irish (1,771); Ethnic minority group (984)



Consistently more negative experiences among those with a disability

Across all measures, disability status has a clear and consistent impact on experiences of negative working conditions. Respondents who report having a disability are more likely to say they have worked beyond their hours (71% vs 65% of those without a disability), felt unable to cope with their workload (65% vs 58%), found it difficult to provide patients with the sufficient level of care they need (41% vs 35%), and taken a leave of absence due to stress (27% vs 11%).

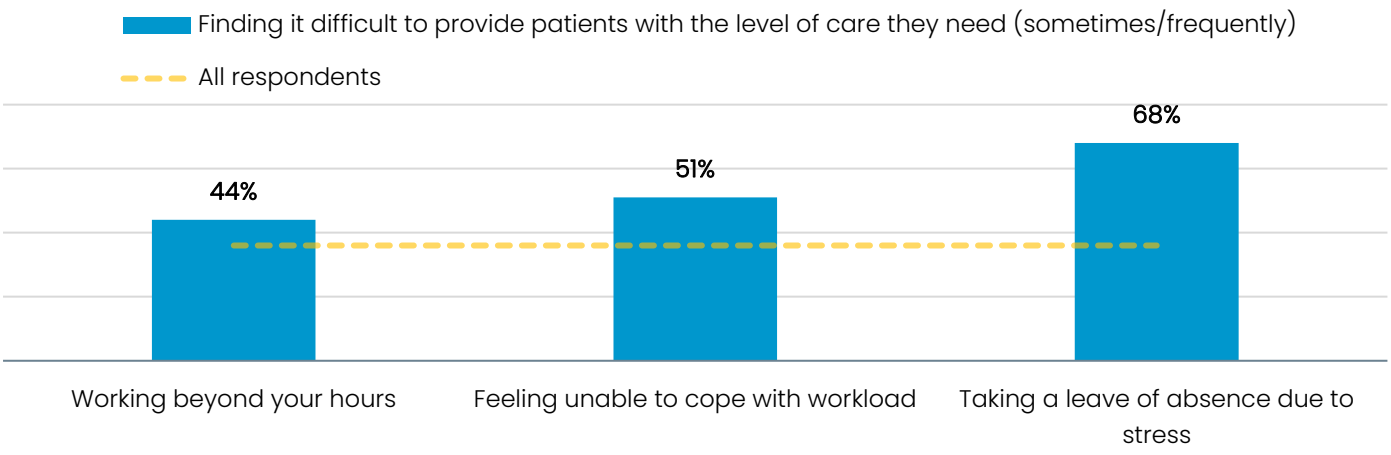
Negative working conditions correlate with difficulties providing patients with sufficient care

As found in previous years, respondents with experience of working beyond their hours, feeling unable to cope with their workload, or taking a leave of absence due to stress were also more likely to report difficulties providing patients with the level of care they need.

This result continues to confirm the correlation between workplace challenges and the ability to deliver safe care for patients.

Figure 35 – Impact of negative working conditions on providing sufficient patient care

Base: Working beyond hours (2,002); Feeling unable to cope with workload (1,802); Taking a leave of absence due to stress (427)



Experiences of time and commercial pressure

Widespread time and commercial pressures are impacting patient care

A substantial proportion of respondents report experiencing time and commercial pressures that may impact patient care.

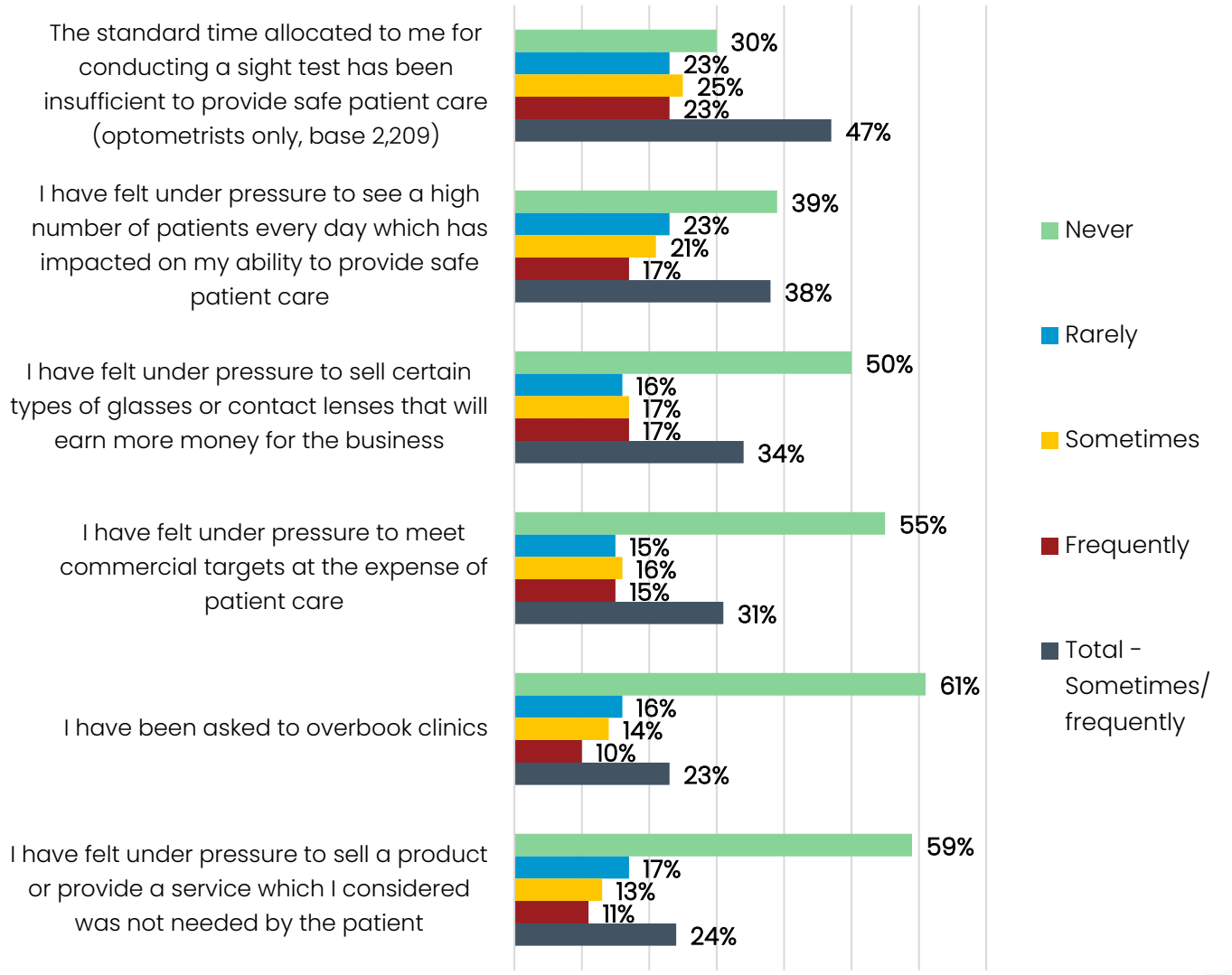
The most commonly cited issue relates to insufficient time for sight tests, with nearly half of optometrists (47%) indicating that the time allocated has been inadequate to provide safe care. Alongside this, over a third (38%) report pressure to see a high volume of patients every day.

Commercial pressures are also evident, with around a third reporting pressure to sell higher-value products (34%) or meet targets at the expense of patient care (31%). Around a quarter indicated they have felt pressured to sell products or services they did not consider needed (24%), or asked to overbook clinics (23%).

This year's results are almost identical to those seen in 2025, showing little change over the last 12 months.

Figure 36 – Experience of time and commercial pressure in the last 12 months

Base: Respondents currently working/employed (3,022)



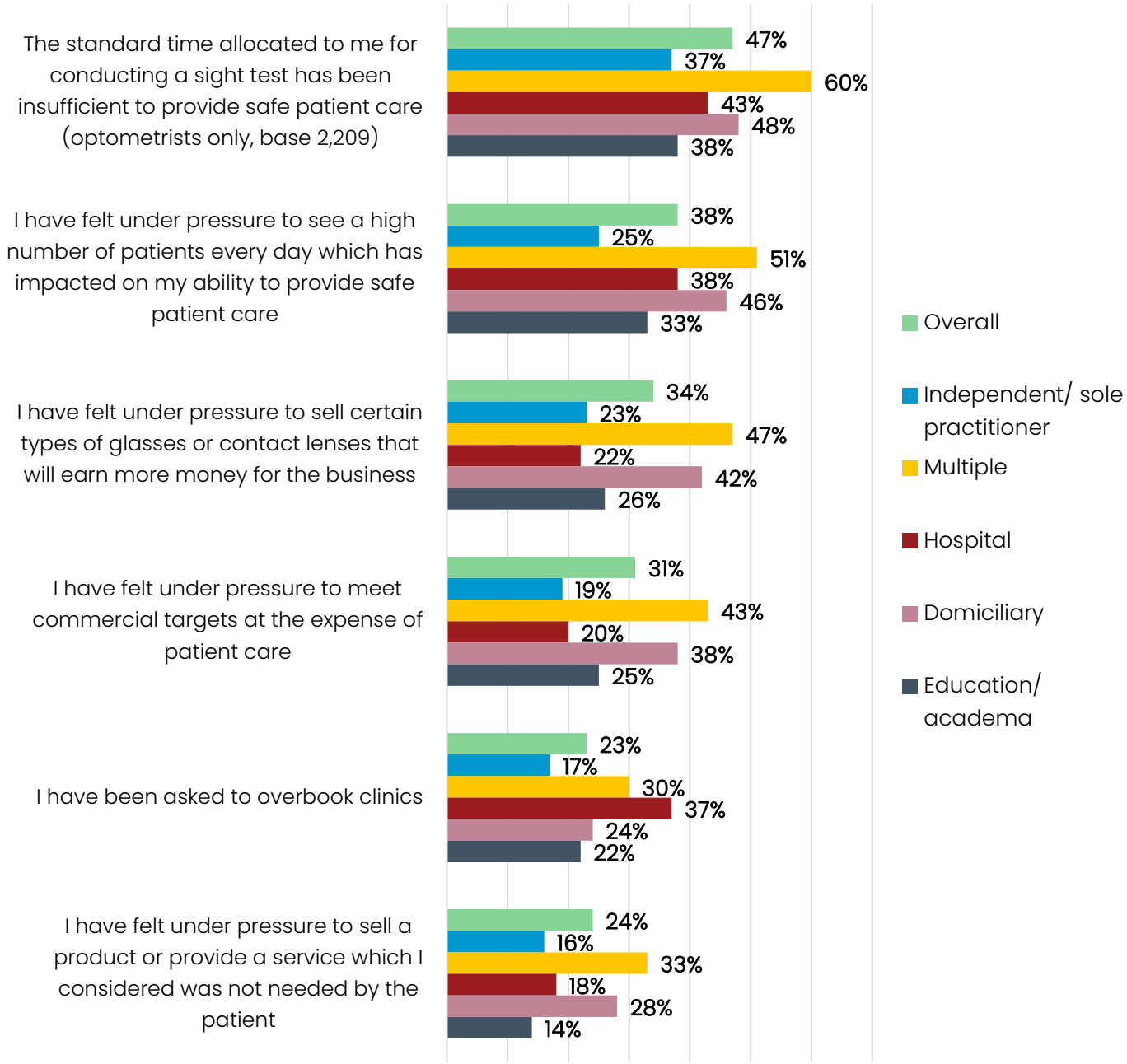
A consistent pressure gap between multiples and independent practice

As found in 2025, workplace setting is strongly associated with experiences of pressure, with those working in multiples consistently more likely to report negative working conditions than those in independent or sole practitioner settings. Across all measures, respondents in multiples are markedly more likely to report pressures relating to time, workload and commercial expectations, while those in independent settings are consistently less likely to do so.

Those working in a hospital setting are less likely to report commercial pressures, such as being asked to sell products or meet targets, but are more likely than average to report being asked to overbook clinics.

Figure 37 – Experience of time and commercial pressure in the last 12 months (sometimes/frequently) by workplace setting

Base: Overall (3,022); Independent/sole practitioner (1,174); Multiple (1,760); Hospital (288); Domiciliary care (81); Education/academia (163)

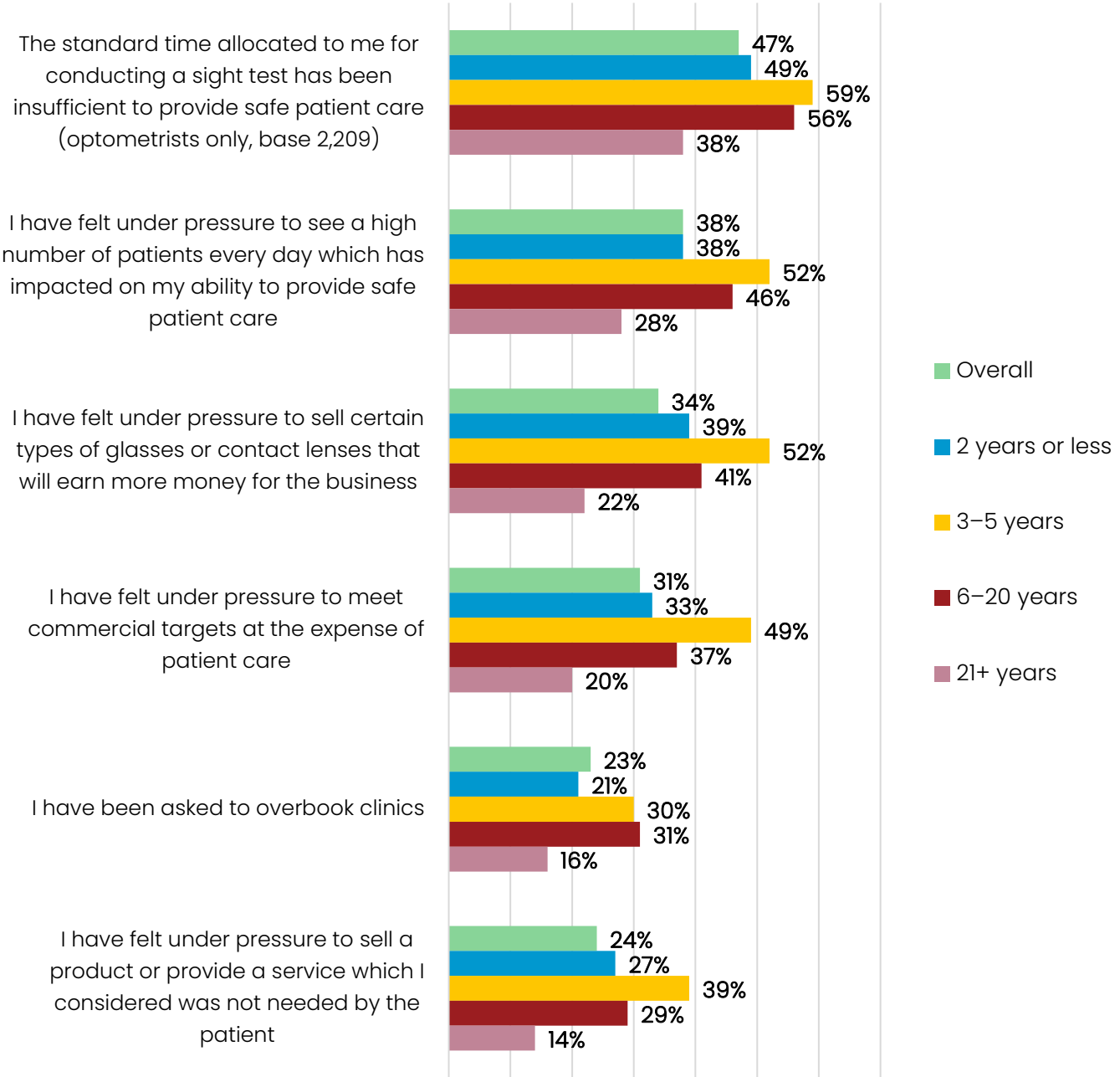


Commercial pressures peak among those with 3–5 years' experience

Respondents registered for 3–5 years are consistently the most likely to report commercial and time pressures across most measures, including insufficient sight test time, pressure to see a high number of patients, pressure to sell higher-value products, pressure to meet commercial targets, and pressure to sell/provide something they felt was not needed. Those registered for 6–20 years also report above-average pressure across most areas, but usually to a lesser extent than the 3–5 year group. In contrast, those registered for 21+ years are consistently least likely to report these pressures.

Figure 38 – Experience of time and commercial pressure in the last 12 months (sometimes/frequently) by workplace setting

Base: Overall (3,022); 2 years or less (348); 3-5 years (379); 6-20 years (988); 21+ years (1,296)

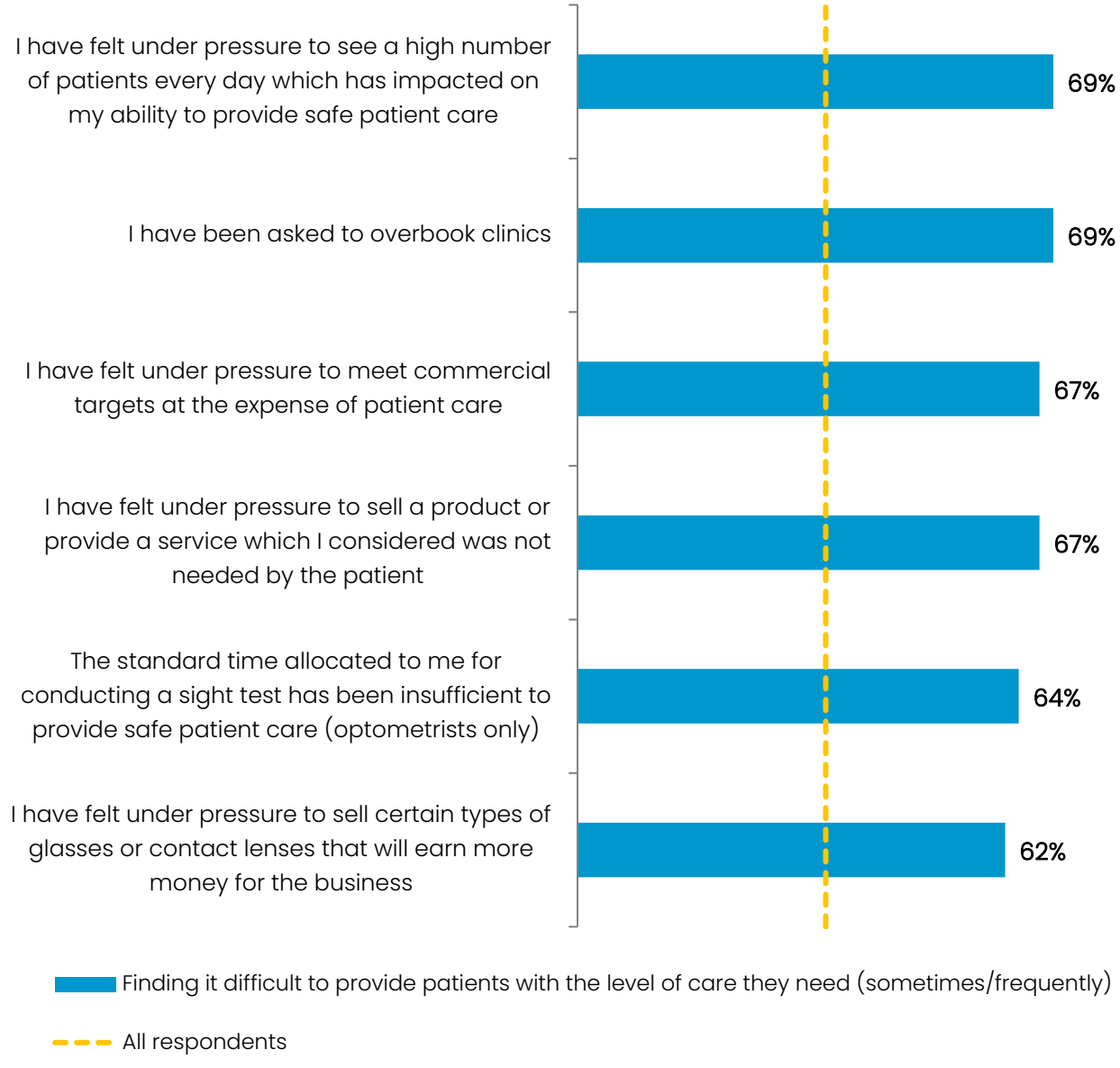


Ongoing relationship between time/commercial pressures and patient care challenges

As with negative working conditions, a clear relationship between commercial pressures and the ability to provide sufficient patient care is evident again this year, reinforcing the pattern seen previously.

Overall, over a third of respondents (36%) report that they sometimes or frequently struggle to provide patients with the level of care they need. However, this nearly doubles for those who report being asked to see a high number of patients each day (69%), to overbook clinics (69%), or feeling under pressure to meet commercial targets (67%) or to sell products or services they consider unnecessary (67%).

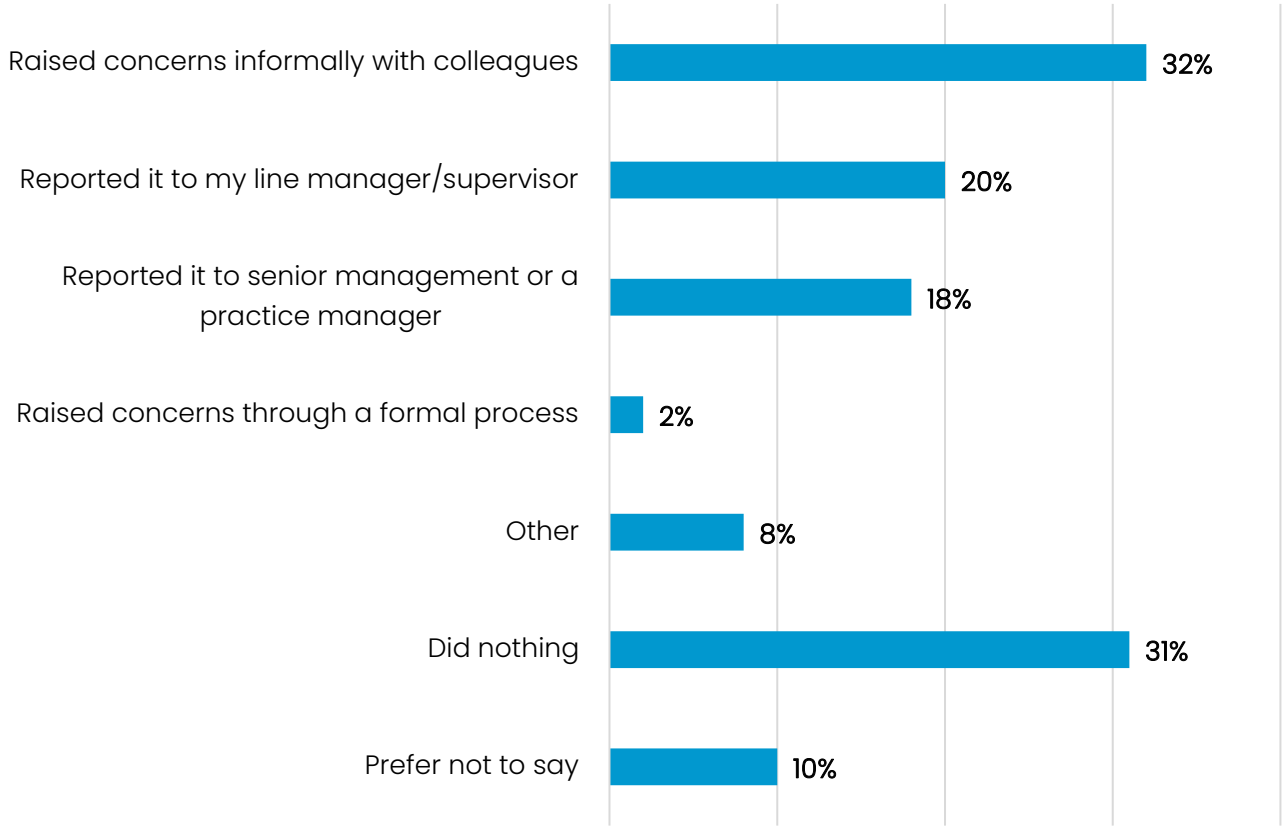
Figure 39 – Impact of time and commercial pressure on providing sufficient patient care
Base: Respondents currently working/employed (3,022)



Concerns are most often raised informally, with many taking no action

Most respondents who experienced time or commercial pressures tend to raise concerns informally rather than through formal channels. A third (32%) say they discussed issues with colleagues, while one in five (20%) reported concerns to a line manager or supervisor, and slightly fewer escalated to senior management (18%). In contrast, very few respondents report using formal processes (2%). However, a large proportion (31%) say they did nothing, similar to the level who raised concerns informally with colleagues.

Figure 40 – Actions taken when experiencing time/commercial pressures
Base: Those who reported any experience of time/commercial pressure (2,293)



Most 'other' free-text responses described managing the situation themselves, typically by prioritising patient care (e.g. overrunning or refusing to compromise), or by removing themselves from the situation (e.g. leaving or avoiding certain workplaces), with some also highlighting informal discussions.

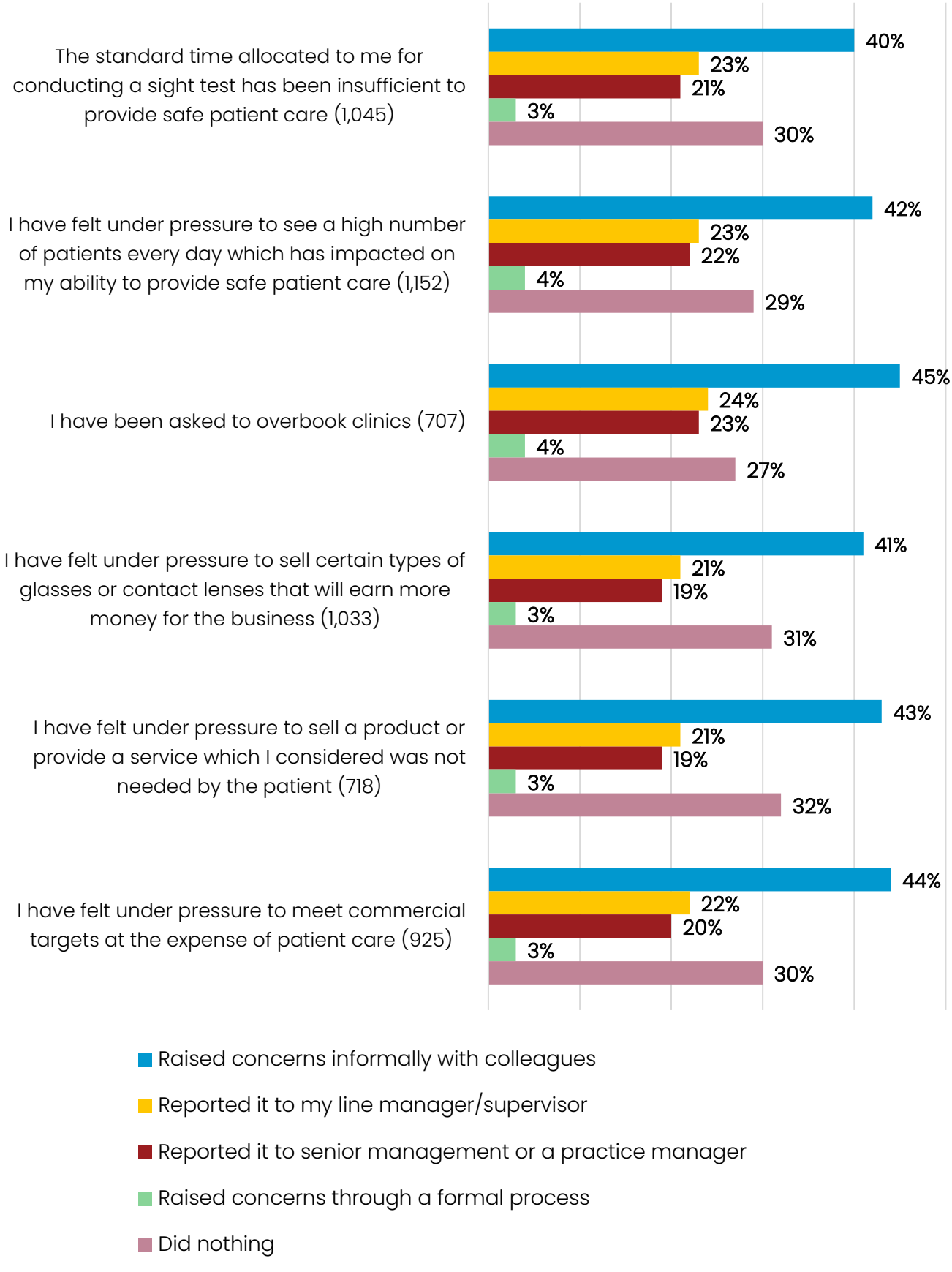
Approach to raising concerns is similar across all types of pressure

Actions follow a very consistent pattern across all types of time and commercial pressure experienced. The chart overleaf shows the actions taken by each type of time/commercial pressure experienced sometimes or frequently, highlighting that informal discussion with colleagues is the most common action taken, followed by those who said they did nothing.

The only small difference in results is found when being asked to overbook clinics, where respondents were slightly more likely to report taking informal action.

Figure 41 – Actions taken when experiencing time/commercial pressures by type of pressure

Base: Those who reported sometimes/frequently experiencing time/commercial pressure (shown in chart)



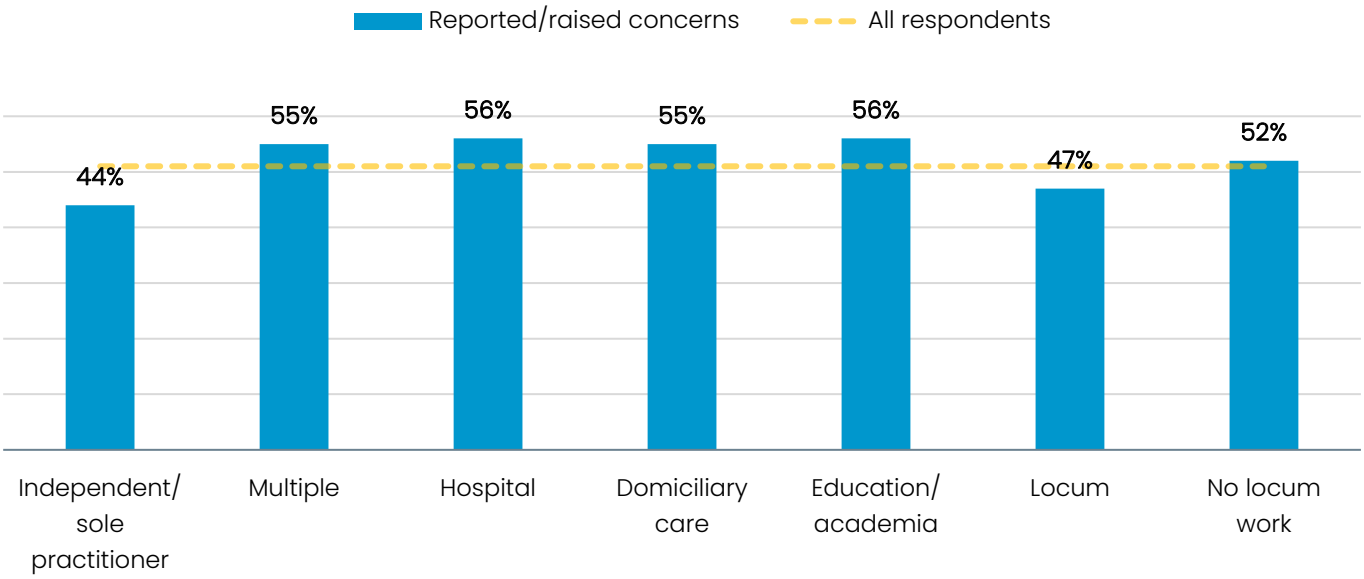
Likelihood of raising concerns varies by workplace setting and working pattern

In total, just over half (51%) reported or raised a concern about time or commercial pressure in some way. Those working in multiples, hospitals, domiciliary care, and education or academia were more likely to have done so compared with those working in an independent opticians or as a sole practitioner.

It is interesting to note that those who undertake locum are also less likely to raise concerns, while those who do no locum work are slightly more likely to take action.

Figure 42 – Impact of workplace setting and locum working on reporting/raising concerns

Base: Independent/sole practitioner (762); Multiple (1,516); Hosptial (241); Domiciliary care (60); Education/academia (108); Locum (549); No locum work (1,744)

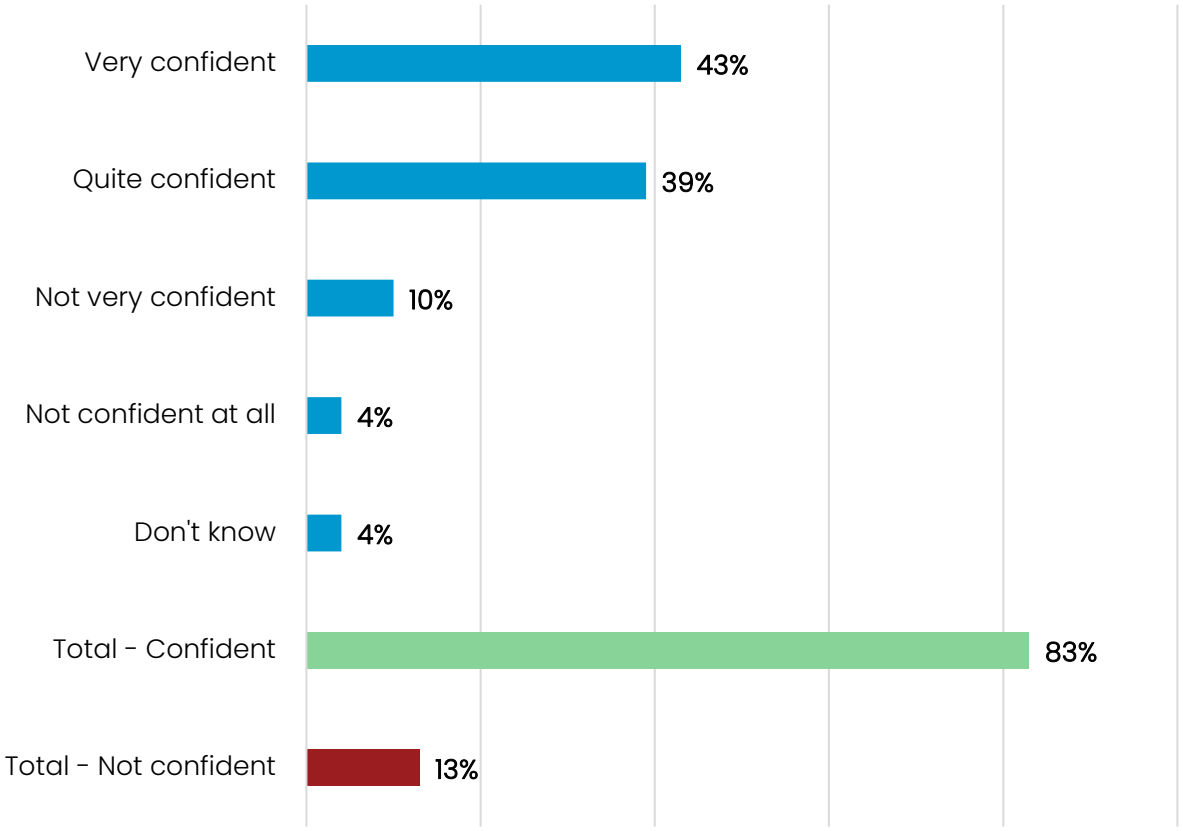


Most feel confident to resist commercial pressures that could compromise care

Overall, confidence in the ability to resist commercial pressures is high, with over eight in ten working respondents (83%) reporting that they feel confident. Around four in ten (43%) say they are very confident, indicating a strong level of assurance among a substantial proportion of the workforce.

However, a notable minority express lower confidence, with around one in eight (13%) saying they are not confident.

Figure 43 – Confidence in ability to resist commercial pressures that could compromise patient care
Base: All respondents excluding fully retired (3,414)



Confidence varies by experience, setting and background

There is some variation in confidence in the ability to resist commercial pressures. Dispensing opticians report higher levels of confidence than optometrists, while confidence is notably lower among working student optometrists.

By workplace setting, those working in an independent opticians or as a sole practitioner report the highest confidence when compared with all other settings. Confidence also increases with age, with respondents aged 55+ more likely to feel confident than those under 35.

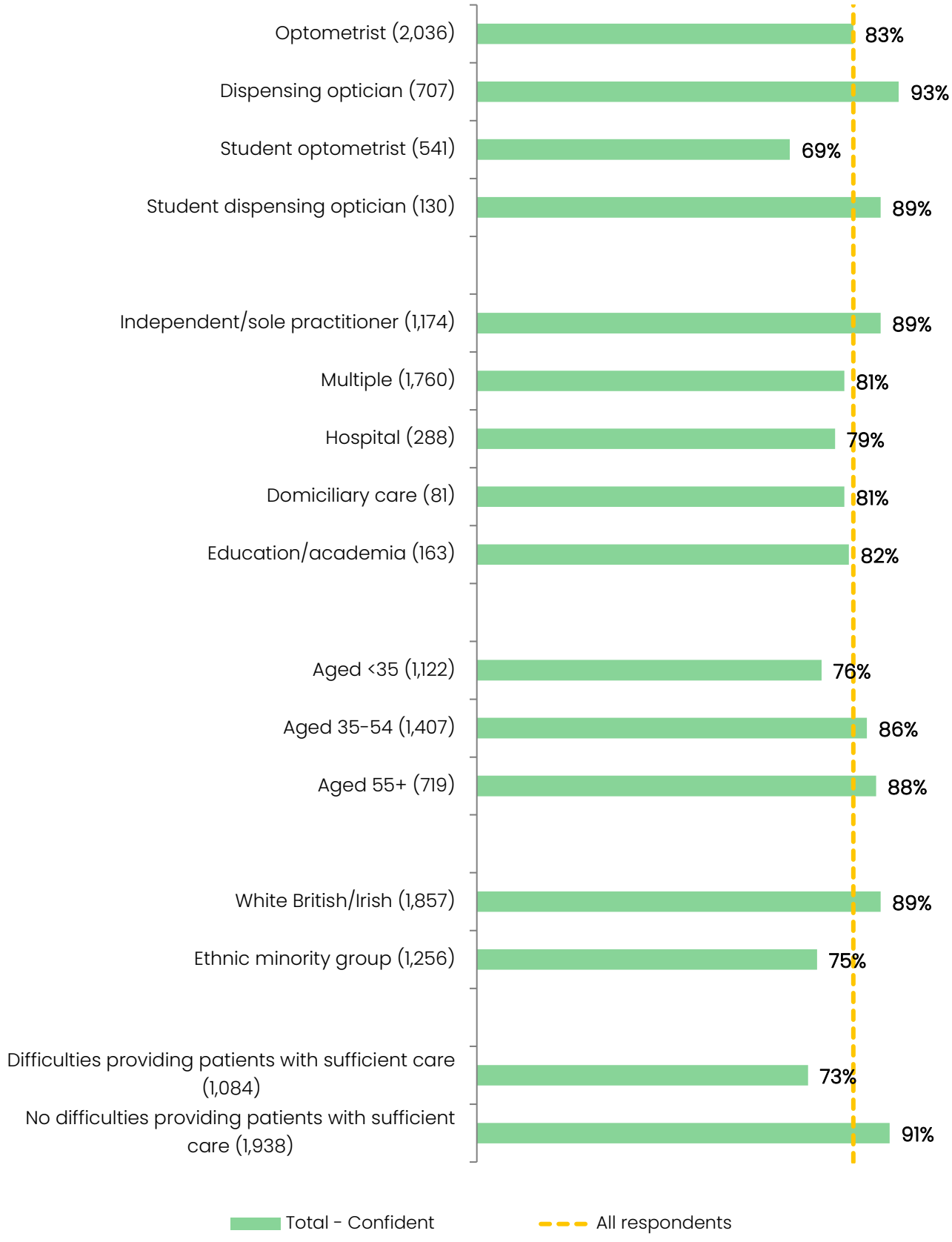
There are also differences by ethnicity, with respondents from ethnic minority groups less likely to report confidence compared with those who are White British/Irish.

Confidence is lower among those experiencing difficulties providing sufficient care

Confidence in resisting commercial pressures is notably lower among those who report difficulties providing patients with sufficient care in the last 12 months. While a strong majority of those not experiencing such difficulties feel confident, this drops among those who do, which may suggest that challenges in delivering adequate care may be linked to reduced confidence in resisting commercial pressures.

Figure 44 – Confidence in ability to resist commercial pressures by registrant type, workplace setting, age group, ethnicity, and experience of difficulties providing patients with sufficient level of care

Base: Shown in chart

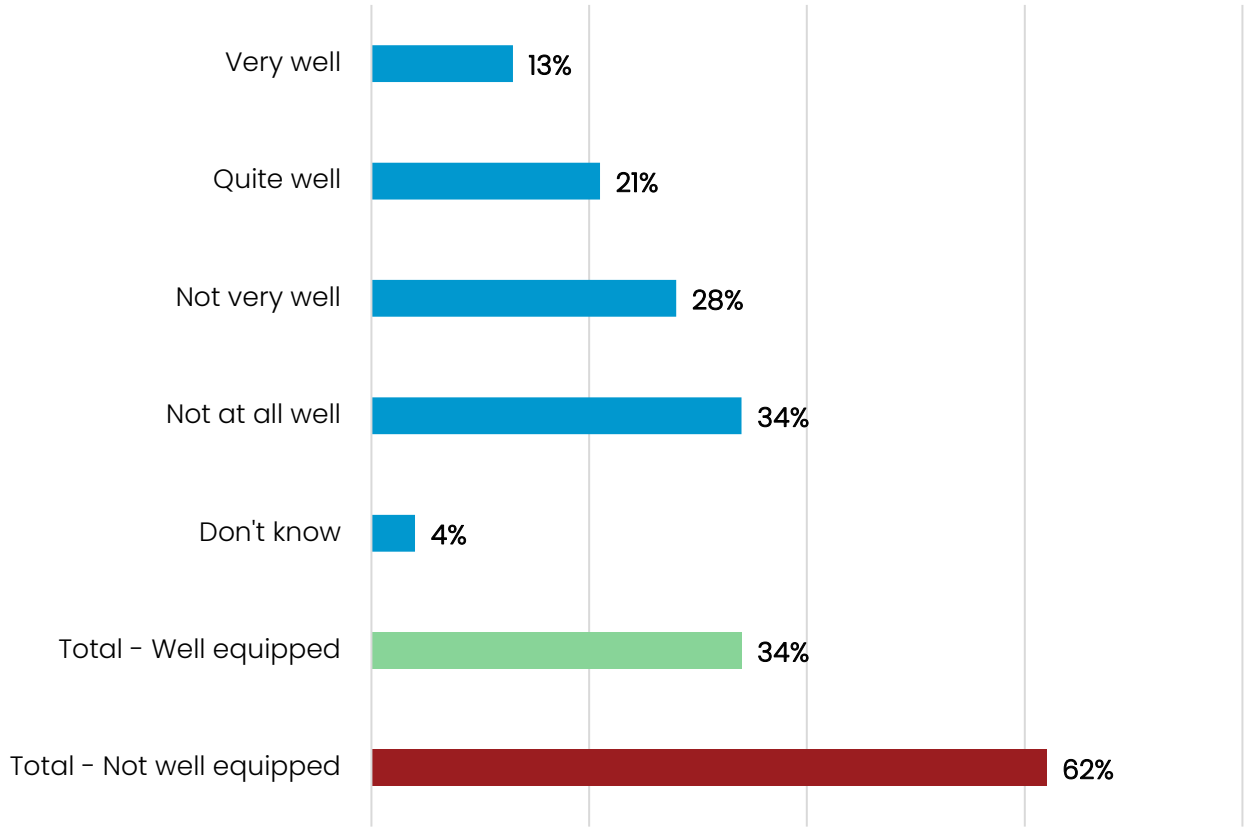


Most feel their education and training did not equip them to manage commmpercial pressures while maintaining safe patient care

Overall, respondents are more likely to feel that their education and training did not equip them well to manage commercial pressures while maintaining safe patient care. Almost two thirds (62%) report that they were not well equipped, including 34% who felt not at all well equipped. In contrast, only 34% feel their training equipped them well.

Figure 45 – How well education and training equipped registrants to manage commercial pressures while maintaining safe patient care

Base: Those currently working exclusing students (2,743)



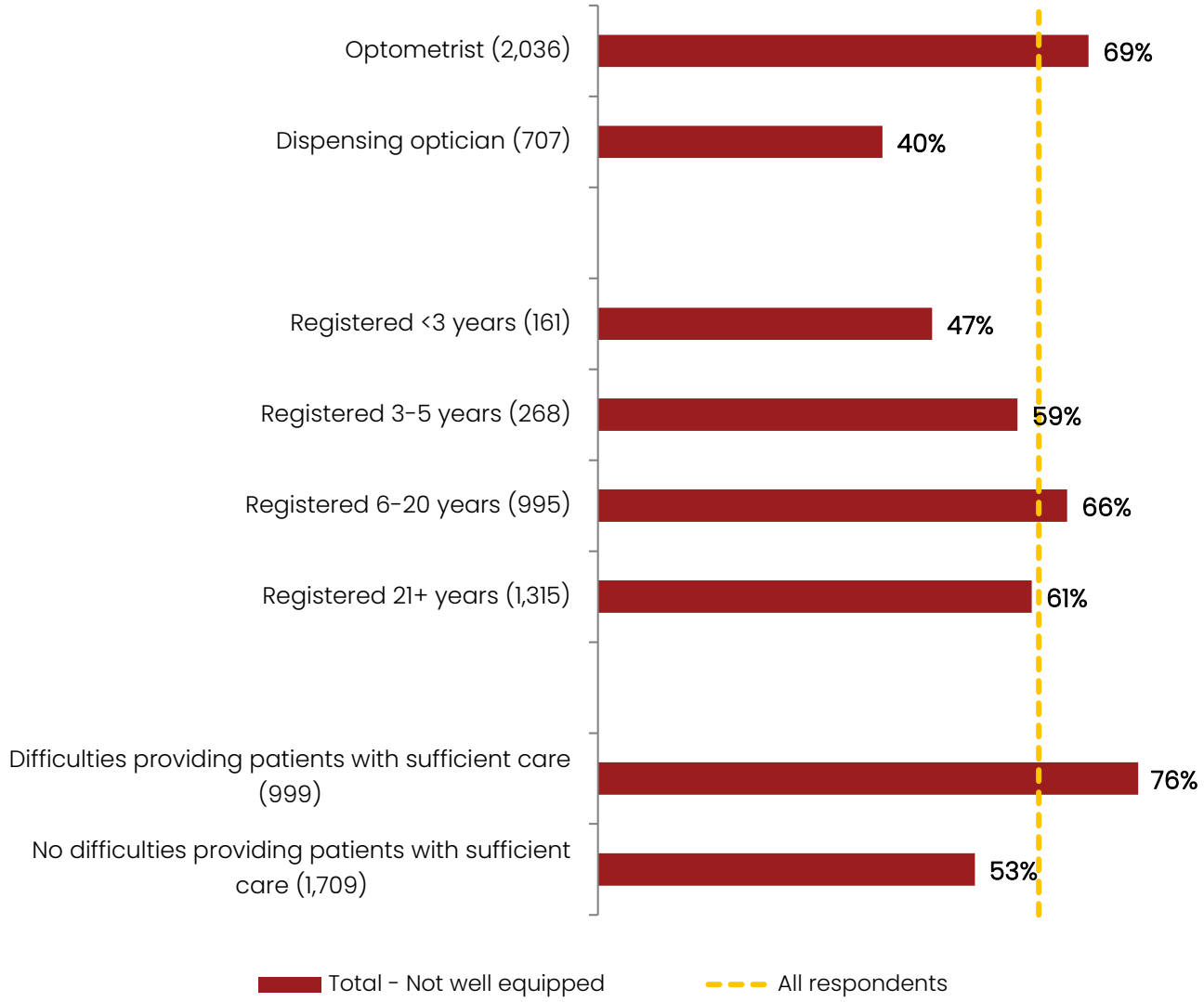
Variations in perceived preparedness by role, experience, and ability to provide sufficient patient care

Optometrists are notably more likely than dispensing opticians to say they are not well equipped, suggesting greater perceived gaps in preparation among this registrant group. By experience, those registered for 6+ years are more likely to feel underprepared than those earlier in their careers, particularly those registered for less than 3 years.

As with confidence in resisting commercial pressures, the most pronounced difference is linked to experience of difficulties providing patients with sufficient care, with those experiencing difficulties far more likely to feel not well equipped compared with those no experience of such difficulties.

Figure 46 – Feeling not well equipped to manage commercial pressures while maintaining safe patient care by registrant type, length of registration, and experience of difficulties providing patients with sufficient level of care

Base: Shown in chart



Time pressures and sales targets dominate concerns about patient care

Respondents were asked what one commercial practice they were most concerned about in terms of its potential impact on patient care. The thematic analysis of 2,097 free-text comments to show the frequency of mentions is presented in the table overleaf.

The most common concerns raised by respondents centre on the interaction between time pressures and commercial expectations, and how these may compromise the quality of patient care. The single most frequently cited issue relates to appointment times and reduced testing time (21%), with respondents highlighting concerns that standard sight test durations are insufficient to carry out thorough assessments, particularly as clinical expectations and technology have evolved. Closely linked to this, many also pointed to overbooking, ghost clinics, and high patient volumes (16%), reinforcing the sense that time constraints are being driven not only by short appointment slots, but also by pressure to see more patients overall.

A substantial proportion of responses focus on sales-driven practices. Around one in five respondents mentioned conversion or sales targets (20%), while a similar proportion highlighted overselling or upselling products and services (19%).

The most common themes point to a consistent overall concern about environments where time constraints and commercial incentives intersect, creating conditions that may negatively impact on safe patient care.

Figure 47 – Most concerning commercial practices in terms of potential impact on patient care (coded free-text, 20+ mentions)

Top themes in free-text responses	Frequency	%
Appointment times/reduced testing time	450	21%
Conversion/sales targets	425	20%
Overselling/upselling products and services	404	19%
Overbooking/ghost clinics/patient volumes	332	16%
Multiple/specific business practice	166	8%
Workload/time pressures	161	8%
NHS underfunding/GOS	102	5%
Business costs/increasing prices/staying profitable	93	4%
Understaffing/underqualified staff/over-reliance on OAs	55	3%
Online sales/purchasing	54	3%
Increasing number of tests/scans/services	48	2%
No additional time for complex patients	46	2%
Accommodating late patient arrivals/walk-ins/emergencies	45	2%
Financial impact on patients/feeling pressured to buy	35	2%
Myopia management/cost of myopia management	35	2%
Performance reviews linked to sales	34	2%
Lack of honesty to patients/damaging patient trust	31	1%
Charging for OCT/additional scans/extra services	29	1%
Lack of support or action from GOC/professional bodies	25	1%
Contact lens selling/care	24	1%
AI/AI glasses	23	1%
Insufficient/lack of training	22	1%
Managing referrals	20	1%

Top themes in free-text responses	Frequency	%
Sales-related bonuses/earning commission	20	1%
No concerns/none regarding current practice/NA to workplace	192	9%

Appointment times/reduced testing time

> *Reduced testing times. 20 minute clinics are very hard to keep up with and many tests are omitted to keep up with timing.*
> Optometrist

> *Allotted time for the exam, when there are more clinical things to check than ever.*
> Optometrist

> *Testing times*
> Dispensing optician

> *Pressure to reduce the time allocated to each patient*
> Optometrist

Conversion/sales targets

> *Conversion is more important that patient care where I work.*
> Optometrist

> *Sales and conversion rates*
> Optometrist

> *Pressure to meet sales targets, as it may influence clinical decisions and affect patient-centred care.*
> Student optometrist

> *Pressure to dispense and meet targets*
> Dispensing optician

Overselling/upselling products and services

> *Overselling or selling to no change prescriptions*
> Optometrist

> *Upselling of scans to well patients with no clinical indication*
> Optometrist

> *In high street patients may be encouraged to buy more expensive options than needed*
> Student optometrist

> *Dispensing clinically insignificant prescriptions especially to children*
> Optometrist

Overbooking/ghost clinics/patient volumes

> *Ghost clinics and overbooking patients on already small testing times.*
> Dispensing optician/student optometrist

> *Extra diary alongside fully booked diaries*
> Optometrist

> *Squeezing in patients to already busy diaries*
> Optometrist

> *Too many patients booked in one day, 20 including MECS CUES post cats is too much*
> Optometrist

Harassment, bullying or abuse

In total, almost half of respondents (46%) had personally experienced some form of harassment, bullying, or abuse at work (or study for those in education) in the last 12 months. After a fall of 6% pts from 2024 (50%) to 2025 (44%), this represents a small increase (+2% pts).

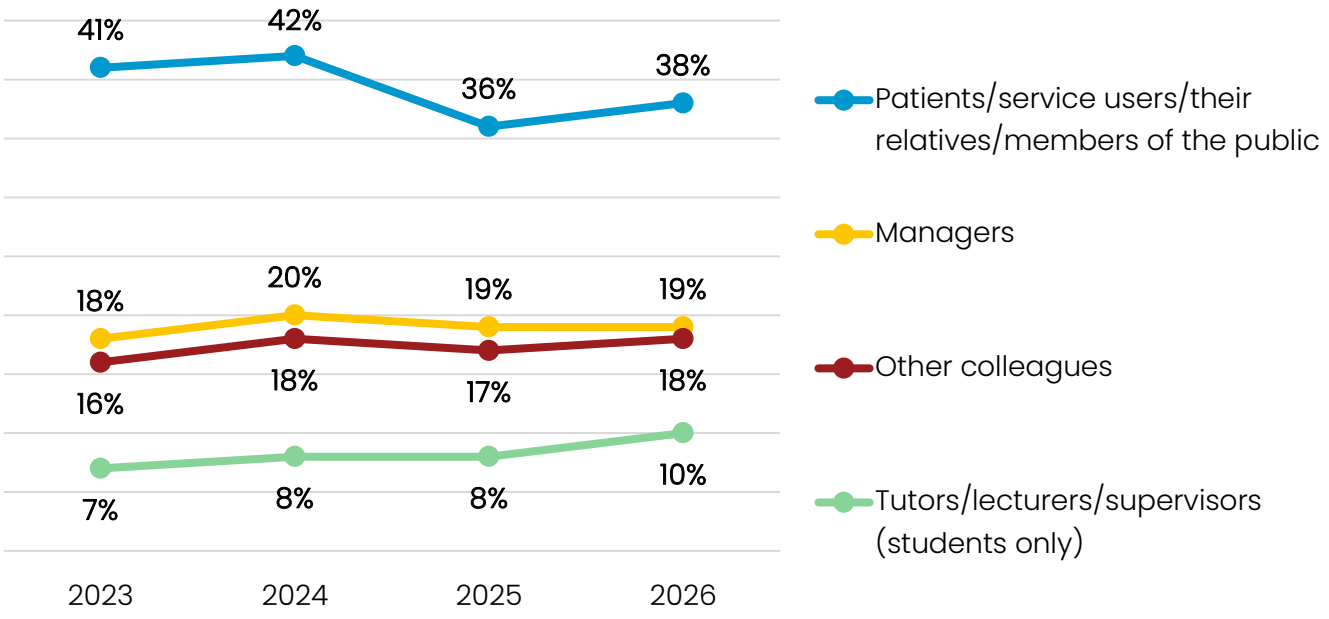
Patients/service users continue to be the main source of harassment, bullying or abuse at work

As found every year, the primary source of harassment, bullying or abuse is patients and service users, their relatives or other members of the public, with 38% of respondents having at least one experience of this in the last 12 months. Mirroring the combined result, after a drop in reporting of this type of harassment, bullying or abuse between 2024 and 2025, this year's result shows a small increase (+2% pts from 36% to 38%).

Reports in relation to managers and other colleagues have remained similar over the last four years, but reports in relation to tutors/lecturers/supervisors have increased slowly from 7% in 2023 to 10% in 2026 (+2% pts).

Figure 48 – Personal experience of harassment, bullying, or abuse at work (or study) 2023 to 2026 (% at least one experience in the last 12 months)

Base: All respondents excluding full-time students and retired 2023 (3,557); 2024 (4,521); 2025 (3,774); 2026 (3,414); Students 2023 (469); Students 2024 (509); Students 2025 (454); Students 2026 (435)



GOC registrants are still more likely to experience this behaviour from patients or the public and managers when compared with the national NHS average

This question is asked in the annual NHS Staff Survey. As found in previous waves of the survey, experience of harassment, bullying or abuse from patients/service users, their relatives, or other members of the public is much more common amongst GOC registrants (38% for GOC registrants, 25% for the NHS Staff Survey).

GOC registrants are also more likely have experience of this behaviour from managers (19% vs 9%), but are in line with the national NHS average in relation to harassment, bullying or abuse from other colleagues, reflecting previous years' results.

Figure 49 – Experience of harassment, bullying or abuse in the last 12 months – Comparison with NHS Staff Survey 2025

Base: GOC survey respondents (3,774), NHS Staff Survey 2025 (c.751k)

Source of harassment, bullying or abuse	This survey	NHS Staff Survey 2025
Patients/service users/relatives, other members of the public	38%	25%
Managers	19%	9%
Other colleagues	18%	17%

Ethnic minority respondents are more likely to report harassment from managers and colleagues

As seen in previous waves, respondents from ethnic minority backgrounds are more likely than White British/Irish respondents to report experiencing harassment, bullying or abuse from managers (21% vs 16%) and from other colleagues (20% vs 16%). However, this pattern was not evident for harassment from patients or service users (36% vs 38%).

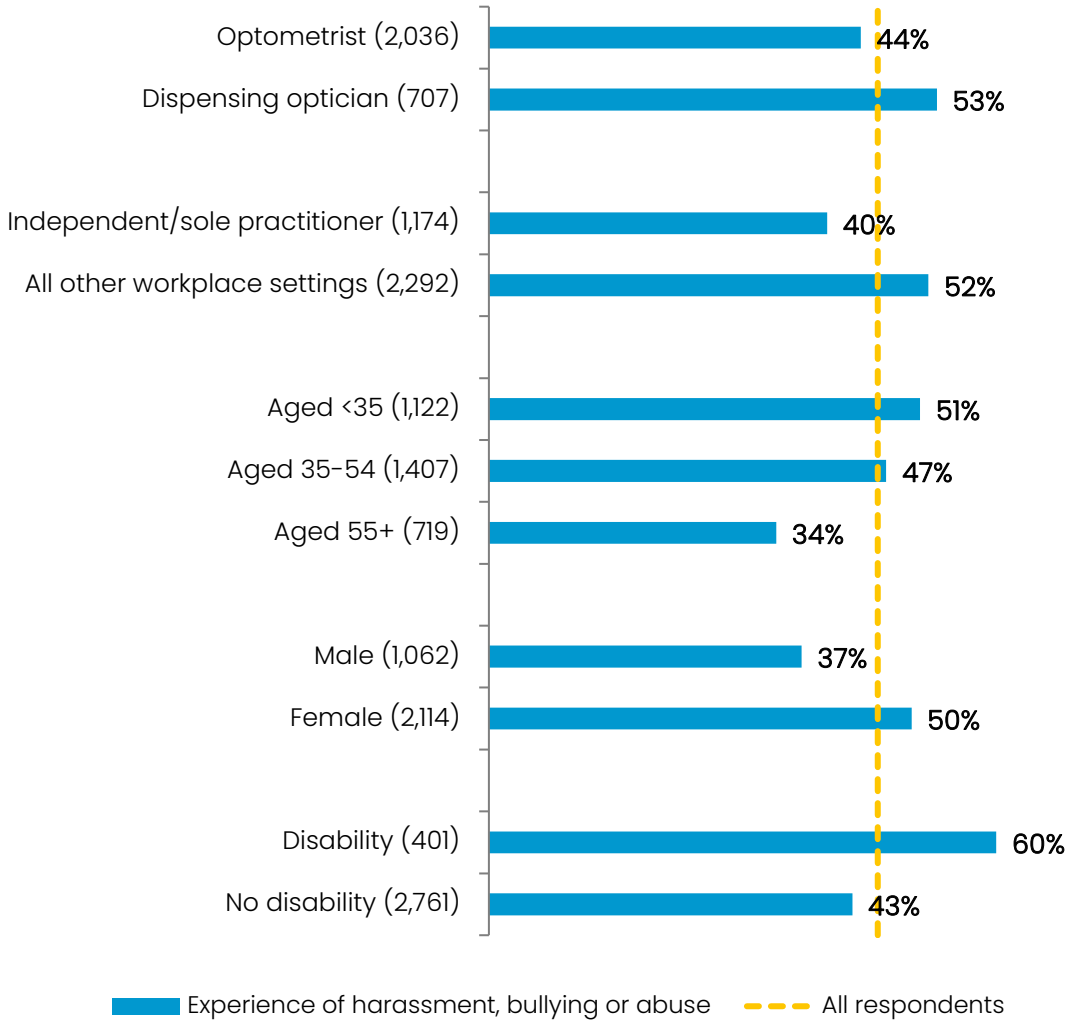
Unlike 2024 and 2025, ethnic minority group respondents were not more likely than White British/Irish respondents to report experiences involving tutors, lecturers or supervisors (8% vs 13%).

Experiences of harassment, bullying or abuse varies by role, workplace setting, and demographics

Experiences of harassment, bullying or abuse are more commonly reported by dispensing opticians than optometrists, and by those working outside independent or sole practitioner settings. Younger respondents are more likely to report these experiences than older age groups, and women report them more often than men. Respondents with a disability are also more likely to report experiencing harassment compared with those without a disability.

Figure 50 – Experience of harassment, bullying, or abuse at work by registration type, workplace setting, age group, gender, and disability

Base: Shown in chart

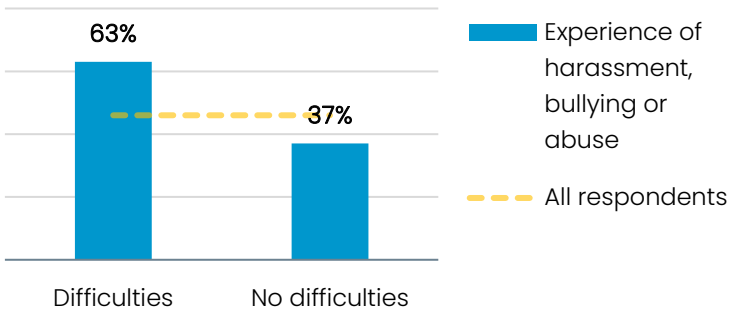


Consistent link between harassment, bullying or abuse and challenges in delivering patient care

Consistent with findings from 2024 and 2025, respondents who report difficulties providing patients with a sufficient level of care are significantly more likely to have experienced harassment, bullying or abuse at work (63% vs 37% of those reporting no such difficulties). This ongoing pattern highlights a clear association between negative workplace experiences and challenges in delivering safe and sufficient patient care.

Figure 51 – Experience of harassment, bullying, or abuse at work by experience of difficulties providing sufficient patient care

Base: Difficulties (1,084); No difficulties (1,013)



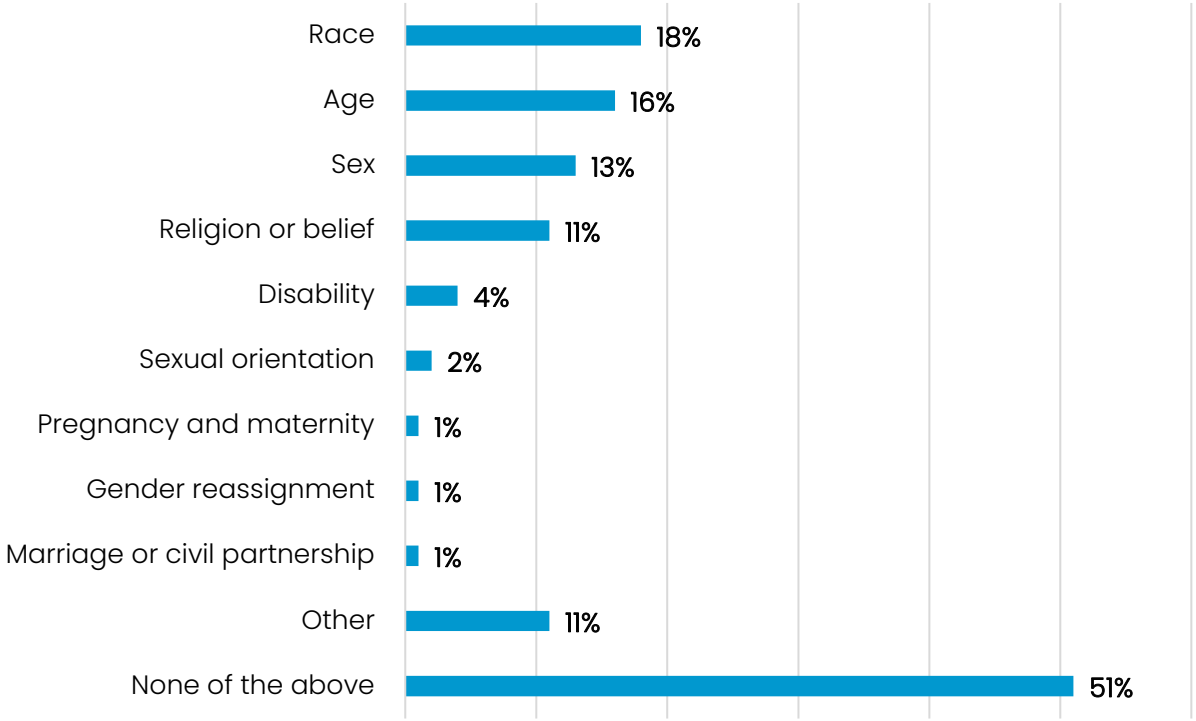
Harassment is more often general in nature, with some links to protected characteristics

Around half of those who had experienced harassment, bullying or abuse said it was not related to any of the listed protected characteristics (51%), suggesting that much of this behaviour is perceived as more general in nature rather than linked to specific personal attributes.

Among those who did identify a perceived reason, race (18%) and age (16%) are the most commonly cited factors, followed by sex (13%) and religion or belief (11%).

Figure 52 – Types of harassment, bullying or abuse experienced

Base: Those who had experienced harassment, bullying or abuse in the last 12 months (1,555)



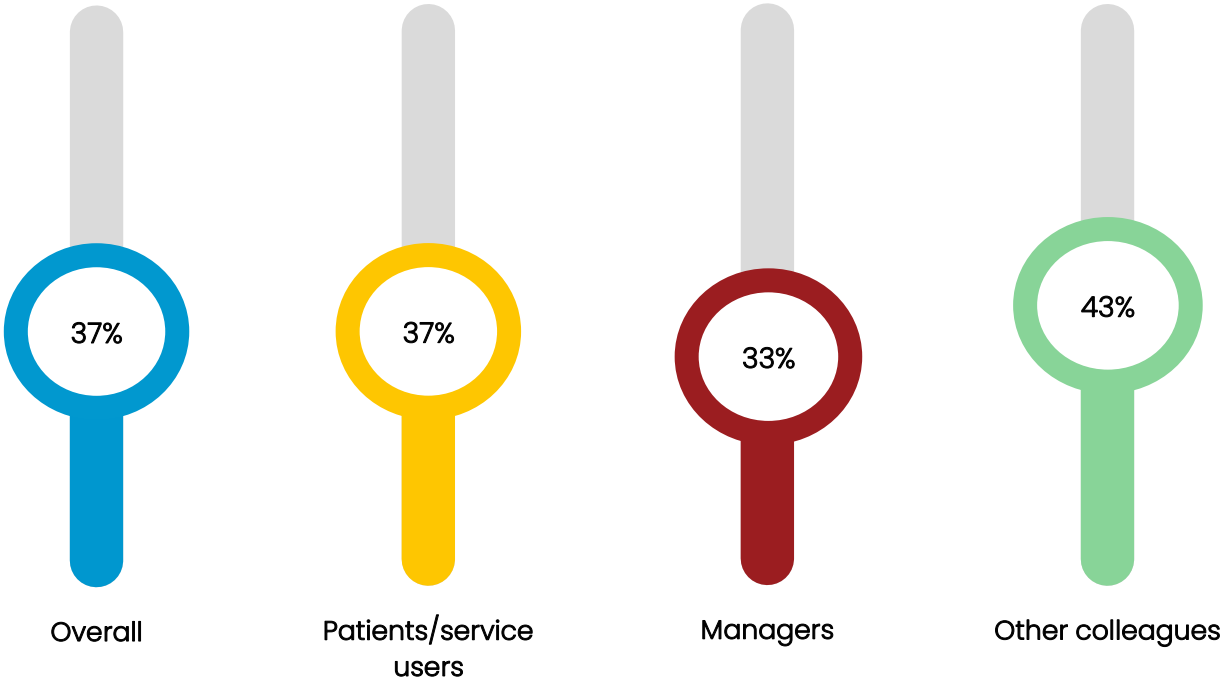
The 'other' responses most commonly centred around general verbal abuse or aggression from patients/the public, alongside pressure or conflict linked to workload, targets or workplace practices, and negative behaviours from colleagues or management (e.g. bullying, undermining or poor management practices), with some additional mentions of personal characteristics such as language, accent, nationality or appearance.

Overall reporting unchanged, with notable growth in colleague-related reporting

Almost two in five (37%) who had experienced harassment, bullying or abuse in the last 12 months said they or a colleague had reported it. This result represents a general continuation with previous waves of the survey, which have varied between 33% (2023) and 38% (2024).

However, unlike previous years, reporting in the case of harassment, bullying or abuse from other colleagues has increased by 7% pts (36% in 2025 to 43% in 2026).

Figure 53 – Reporting harassment, bullying or abuse at work (they or a colleague reported)
Base: Those who had experience of harassment, bullying or abuse at work in the last 12 months excluding 'don't know' and 'not applicable' responses (1,375)



Persistent gap in harassment, bullying or abuse reporting compared with NHS staff

The proportion of GOC registrants reporting bullying, harassment or abuse is significantly lower than the national average found in the 2025 NHS Staff Survey, as found in previous survey waves. It is again evident that GOC registrants are both more likely to experience harassment, bullying or abuse, and less likely to report it when compared with the national average.

Figure 54 – Experience of harassment, bullying or abuse in the last 12 months – Comparison with NHS Staff Survey 2024
Base: GOC survey respondents (1,375), NHS Staff Survey 2025 (c.270k)

Harassment, bullying or abuse reported	This survey	NHS Staff Survey 2024
Yes (they or a colleague reported)	37%	55%

Discrimination

In total, three in ten respondents (31%) had personally experienced some form of discrimination at work (or study for those in education) in the last 12 months. This is broadly similar to the results found in 2024 (31%) and 2025 (29%).

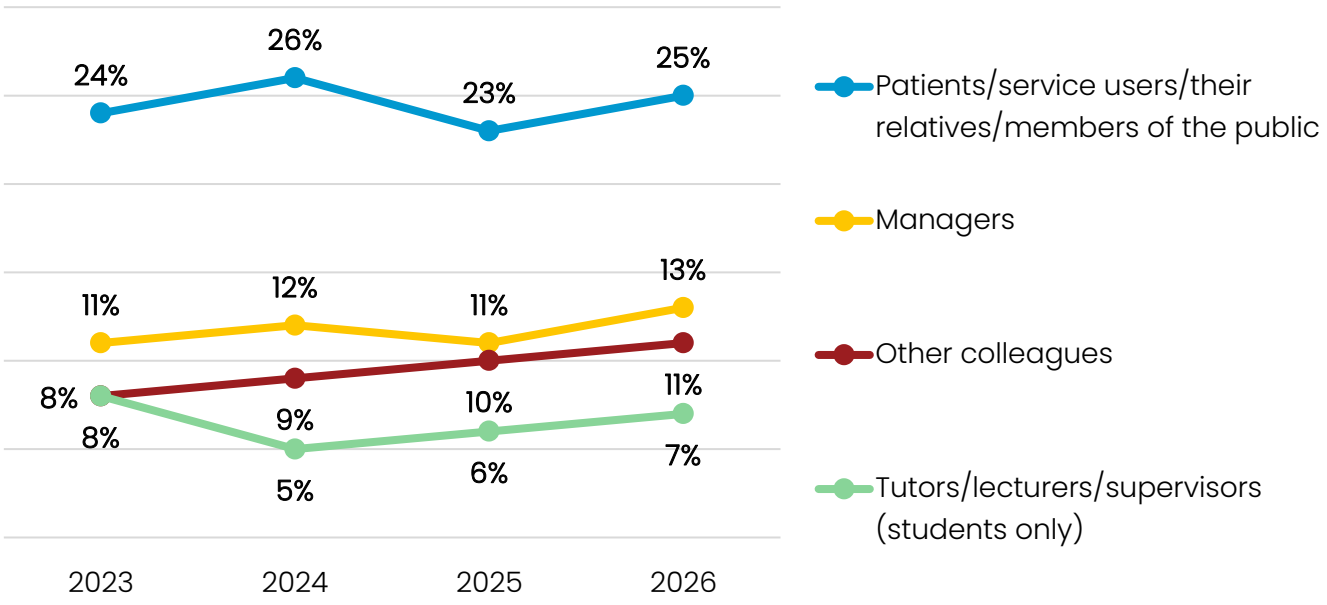
Discrimination continues to be more likely to come from patients/service users, but incidence from other sources is slowly increasing

As found with harassment, bullying and abuse, discrimination towards registrants is more likely to come from patients and service users, their relatives or other members of the public, although to a lesser degree. A quarter (25%) of respondents said they had at least one experience of this in the last 12 months. Experiences of discrimination from managers, other colleagues, and tutors/lecturers/supervisors were less frequent.

Looking across all four years of survey results, experiences of discrimination from managers, other colleagues, and tutors/lecturers are slowly increasing.

Figure 55 – Personal experience of discrimination at work (or study) 2023 to 2026 (% at least one experience in the last 12 months)

Base: All respondents excluding full-time students and retired 2023 (3,557); 2024 (4,521); 2025 (3,774); 2026 (3,414) Students 2023 (469); Students 2024 (509); Students 2025 (454); Students 2026 (435)



Elevated discrimination persists for GOC registrants compared with NHS staff

Comparison with the latest NHS Staff Survey continues to show that GOC registrants report higher levels of discrimination than the national benchmark. Experiences of discrimination from patients, service users, their relatives or other members of the public remain substantially more common among GOC registrants, and discrimination from managers or other colleagues is also reported more frequently.

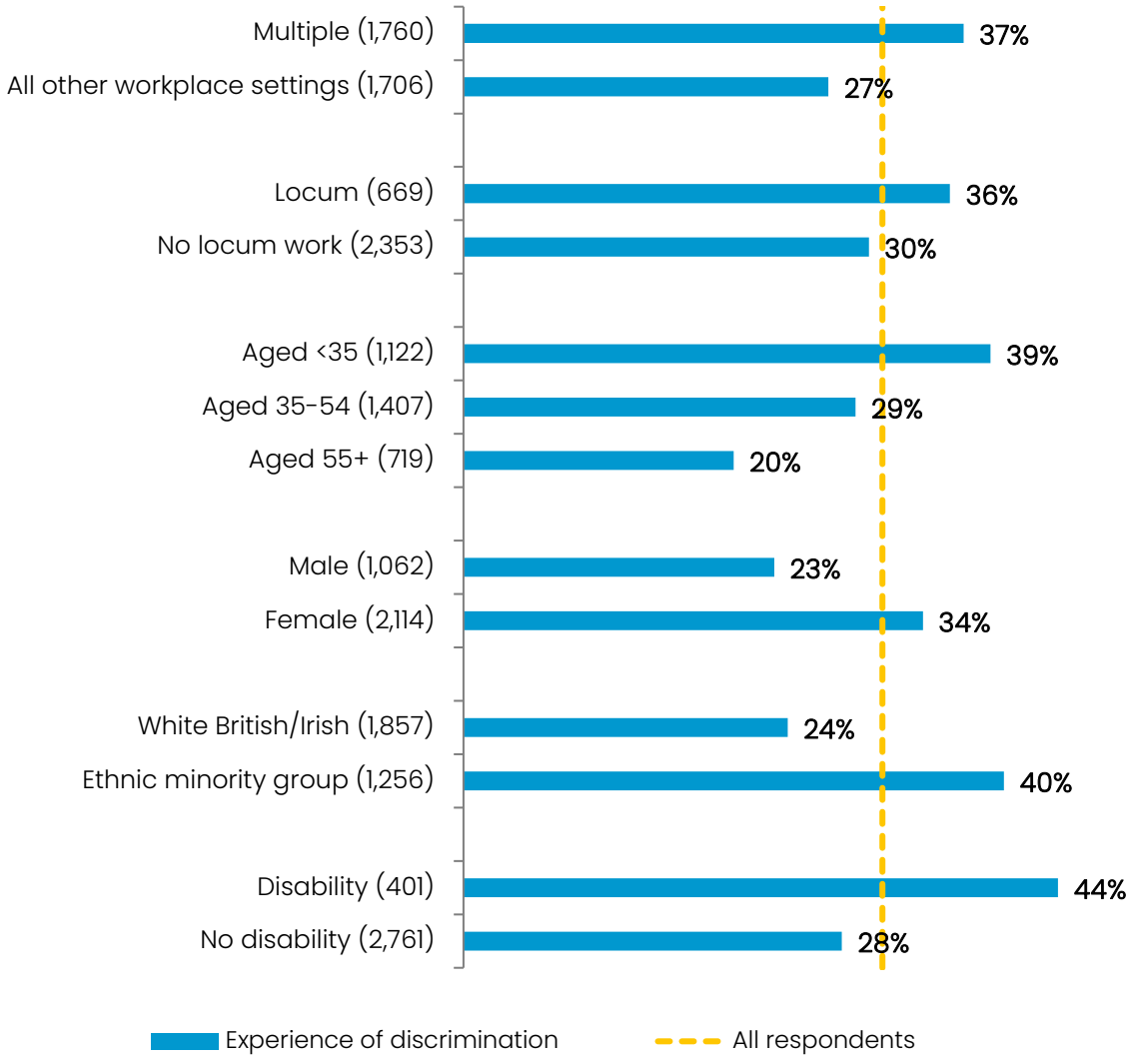
Figure 56 – Experience of discrimination in the last 12 months – Comparison with NHS Staff Survey 2025
Base: GOC survey respondents (3,414), NHS Staff Survey 2024 (c.751k)

Source of discrimination	This survey	NHS Staff Survey 2025
Patients/service users/relatives, other members of the public	25%	9%
Managers **or** other colleagues	16%	9%

Variation in reported discrimination by demographic and workplace characteristics

Experience of discrimination is notably higher among younger respondents, females, ethnic minority groups, those with a disability, and those working as locums or for multiple opticians. Whilst many of these groups have been more likely to report discrimination over recent waves of the survey, it is interesting to note that there is no difference between optometrists and dispensing opticians, as seen in previous years.

Figure 57 – Experience of discrimination at work by workplace setting, locum working, age group, gender, ethnicity, and disability
Base: Shown in chart

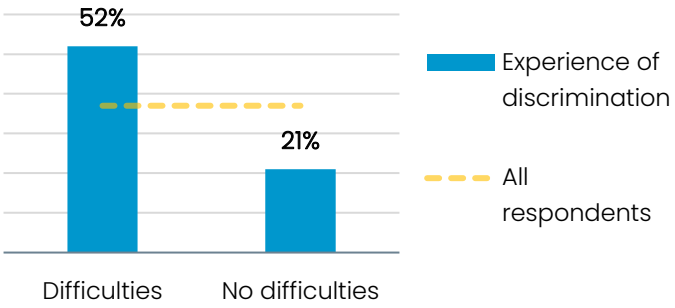


Continued link between discrimination and the ability to deliver sufficient care for patients

As with experiences of harassment, bullying or abuse, finding it difficult to provide patients with the sufficient level of care continues to influence experiences of discrimination at work. As found in 2024 and 2025, this could indicate correlation between the negative experience of discrimination and registrants' ability to deliver safe patient care.

Figure 58 – Experience of discrimination at work by experience of difficulties providing sufficient patient care

Base: Difficulties (1,084); No difficulties (1,031)



Racial, sexual, and age-related discrimination are most frequently reported

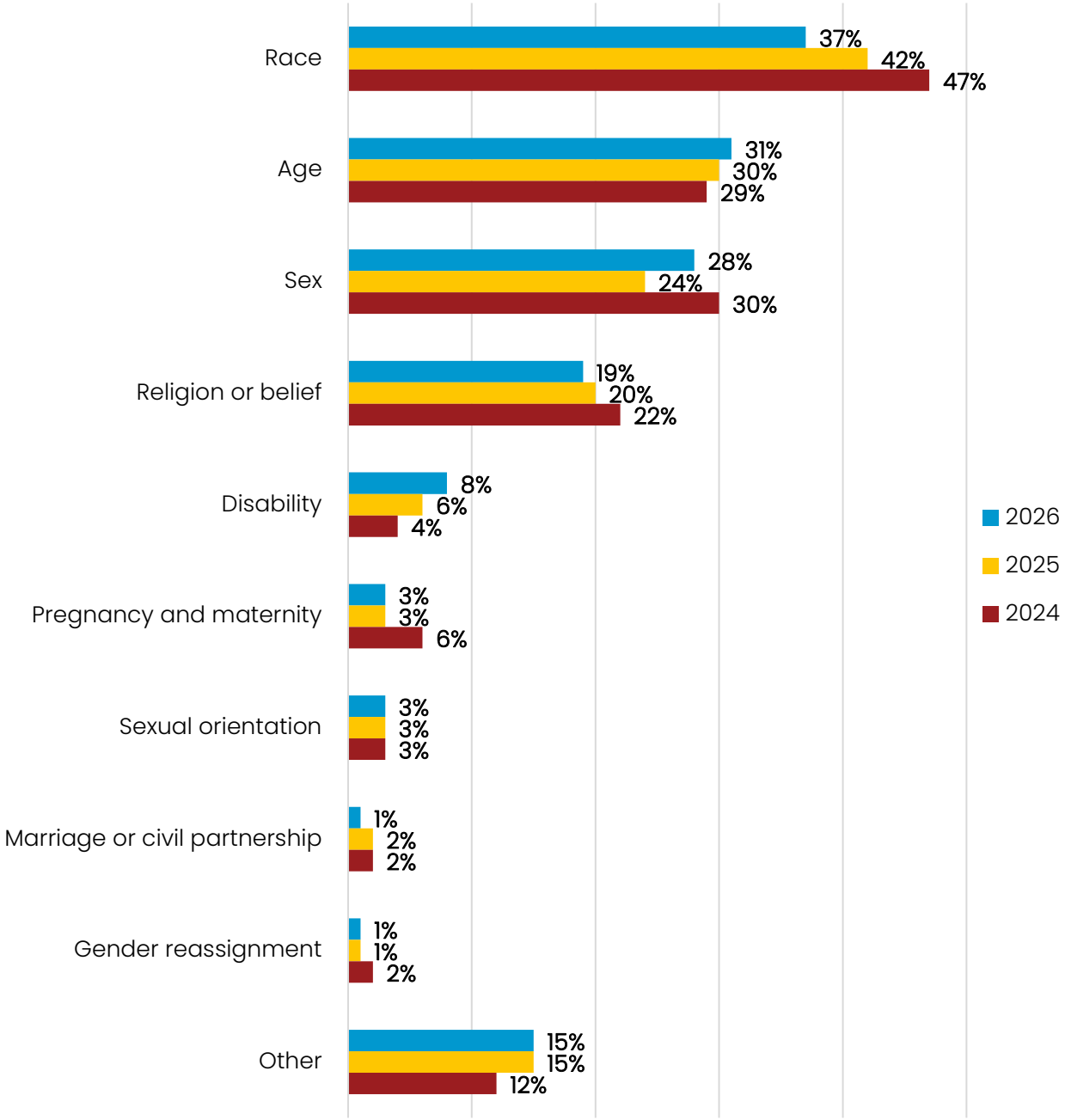
Race remains the most commonly cited form of discrimination in 2026 (37%), followed by age (31%) and sex (28%). One in five link their experience to religion or belief (19%), while fewer attribute it to disability (8%) or other characteristics such as pregnancy and maternity, sexual orientation, marriage or civil partnership, and gender reassignment (each 3% or lower).

'Other' types of discrimination mentioned mainly related general bullying, rudeness, and interpersonal conflict, alongside perceived favouritism and unfair treatment by managers or colleagues (e.g. workload distribution, promotions, or opportunities). There are also frequent references to personal characteristics not explicitly listed (gender, nationality, accent, appearance, family or caring responsibilities), as well as issues linked to professional status, experience or role (e.g. being a locum, trainee, or dispensing optician).

Over time, reports of race-related discrimination have declined (from 47% in 2024 to 37% in 2026), while age-related discrimination has remained broadly stable. Sex-related discrimination has fluctuated but is slightly lower than in 2024. In contrast, disability-related discrimination has increased gradually.

Figure 59 – Types of discrimination experienced 2024 to 2026

Base: Those who had experienced discrimination in the last 12 months 2024 (1,409); 2025 (1,088); 2026 (1,050)



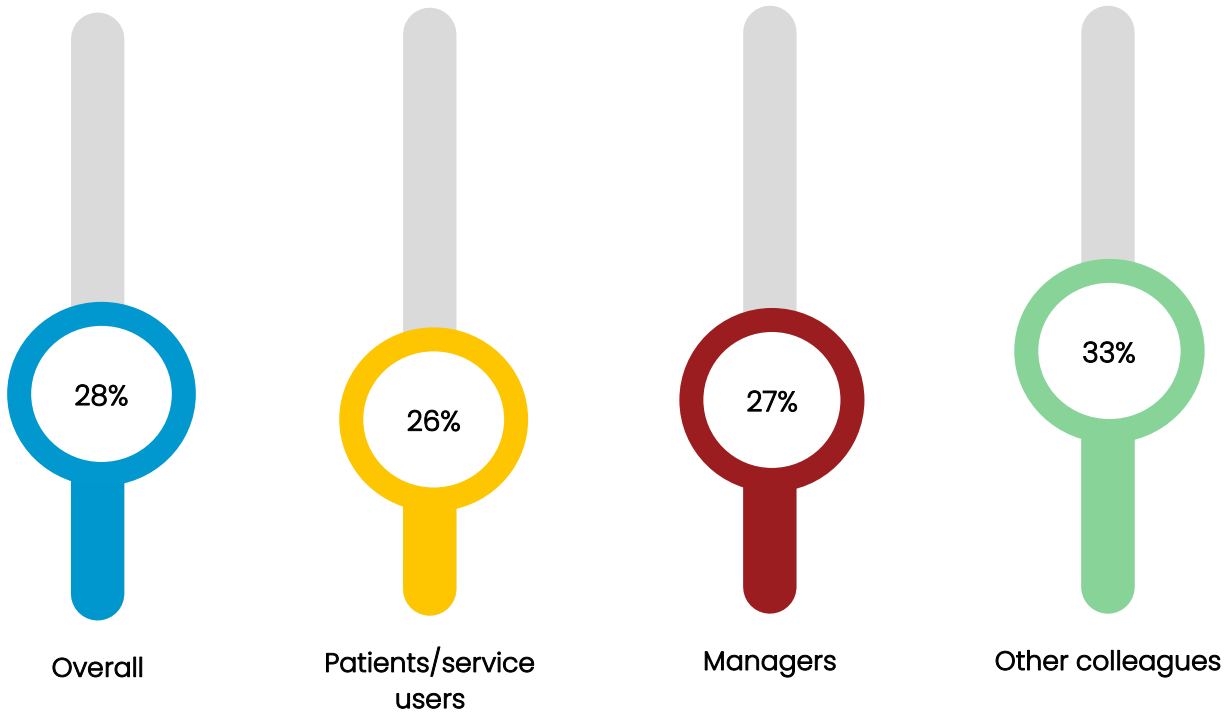
Only a quarter of registrants reported experiences of discrimination

Almost three in five respondents (28%) who had experienced discrimination at work in the last 12 months said they or a colleague had reported it, representing a small increase from 2024 (24%) and 2025 (25%).

As with harassment, bullying and abuse, reporting was slightly more likely in the case of discrimination from other colleagues.

Figure 60 – Reporting discrimination at work

Base: Those who had experience of discrimination at work in the last 12 months excluding 'don't know' and 'not applicable' responses (970)



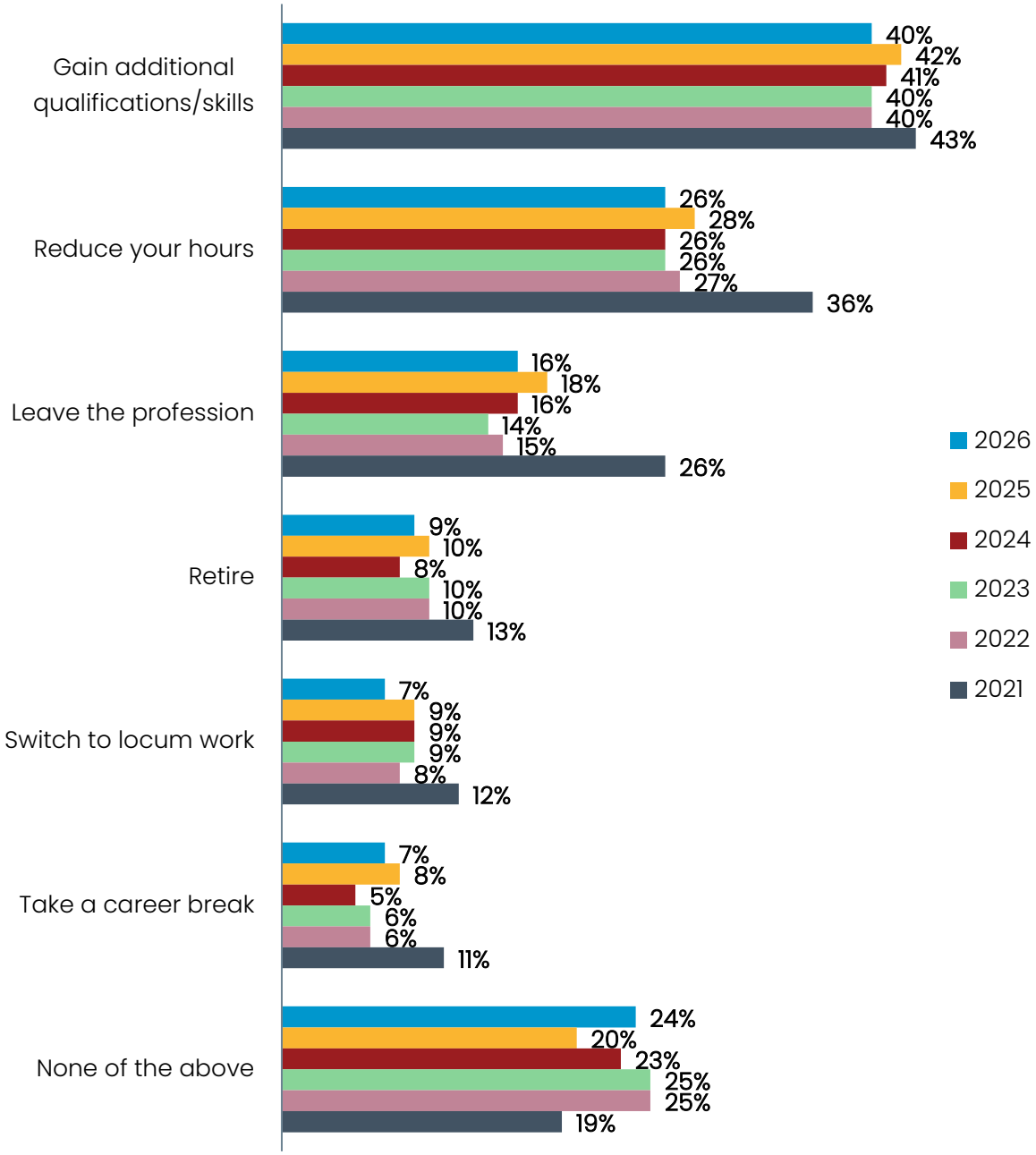
Plans for the future

Immediate career intentions remain broadly consistent over time

As in previous years, gaining additional qualifications or skills remains the most commonly cited immediate career intention among those currently working, selected by 40% of respondents. Around a quarter plan to reduce their hours (26%), while smaller proportions are considering leaving the profession (16%), retiring (9%), switching to locum work (7%), or taking a career break (7%). Overall, the pattern of responses remains broadly consistent with previous survey waves since 2022, with only relatively minor movement across the different career intentions shown.

Figure 61 – Are you considering making any of the following changes to your career over the next 12-24 months?

Base: Those currently working 2026; (3,022); 2025 (3,315); 2024 (4,049); 2023 (3,486); 2022 (3,647); 2021 (4,479)



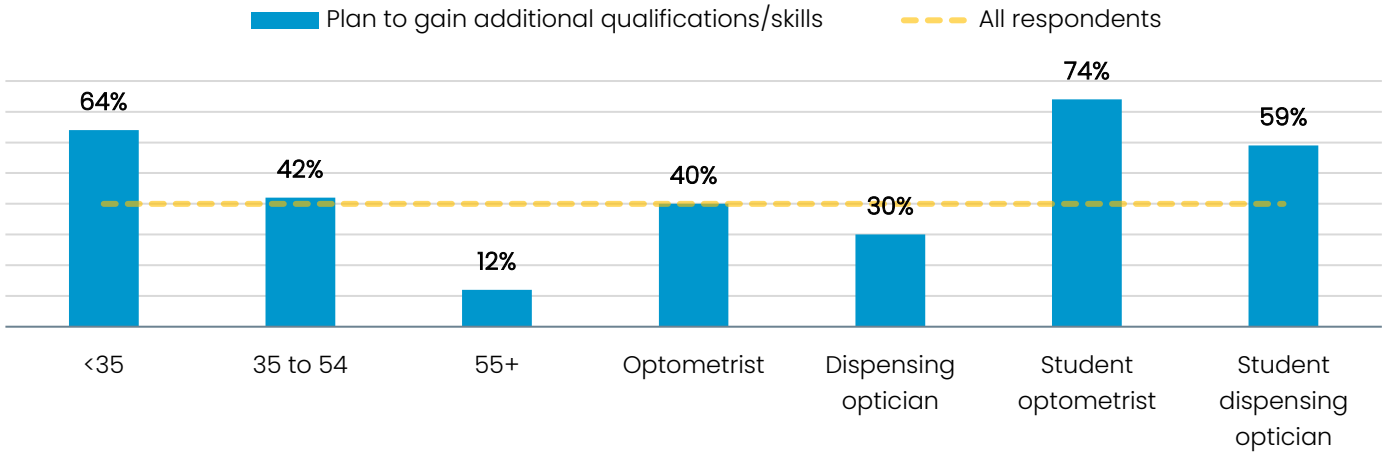
Gaining additional skills

Interest in gaining additional qualifications continues to vary by career stage, working pattern, and workplace setting

Cementing the results from previous years, younger respondents and optical students are significantly more likely to be considering gaining additional qualifications/skills in the next 12 months when compared with older respondents and fully qualified registrants, particularly dispensing opticians.

Figure 62 – Plan to gain additional qualifications/skills by age and registration type

Base: Aged <35 (862); 35-54 (1,338); 55+ (709); Optometrist (2,004); Dispensing optician (704); Student optometrist (193); Student dispensing optician (122)



Plans to gain additional qualifications/skills was more common amongst:

- Those working for a multiple (46%) or in a hospital (45%) (vs 33% independent/sole practitioner, 27% domiciliary care, 37% education/academia)
- Those involved in delivering enhanced services (45%, vs 35% for those not involved)
- Those working full-time (46%, vs 30% part-time)
- Those from ethnic minority groups (53%, vs 35% for White British/Irish)

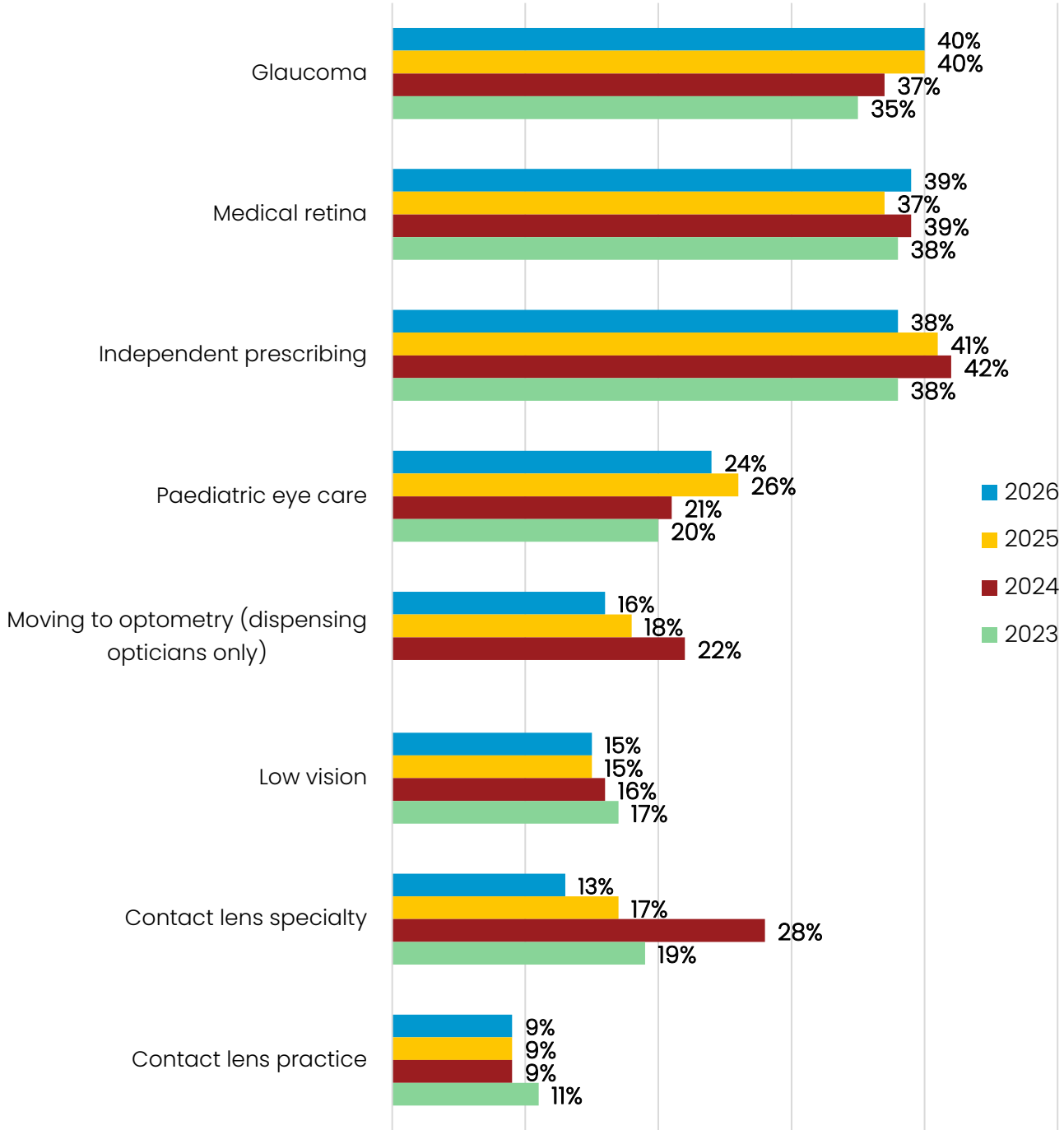
Glaucoma, medical retina, and independent prescribing continue to be the most popular areas of interest for development

Three areas stand out as being most popular for gaining additional qualifications/skills – glaucoma (40%), medical retina (39%), and independent prescribing (38%) – which have remained at similar levels over the last few survey waves.

Amongst dispensing optician respondents, interest in moving to optometry has fallen over the last three years by 6% pts (22% in 2024, 16% in 2026).

Figure 63 – Areas of interest in gaining additional qualifications/skills

Base: Those who plan to gain additional qualifications/skills in the next 12-24 months 2026 (1,219); 2025 (1,408); 2024 (1,653); 2023 (1,377)



Plans to leave the profession

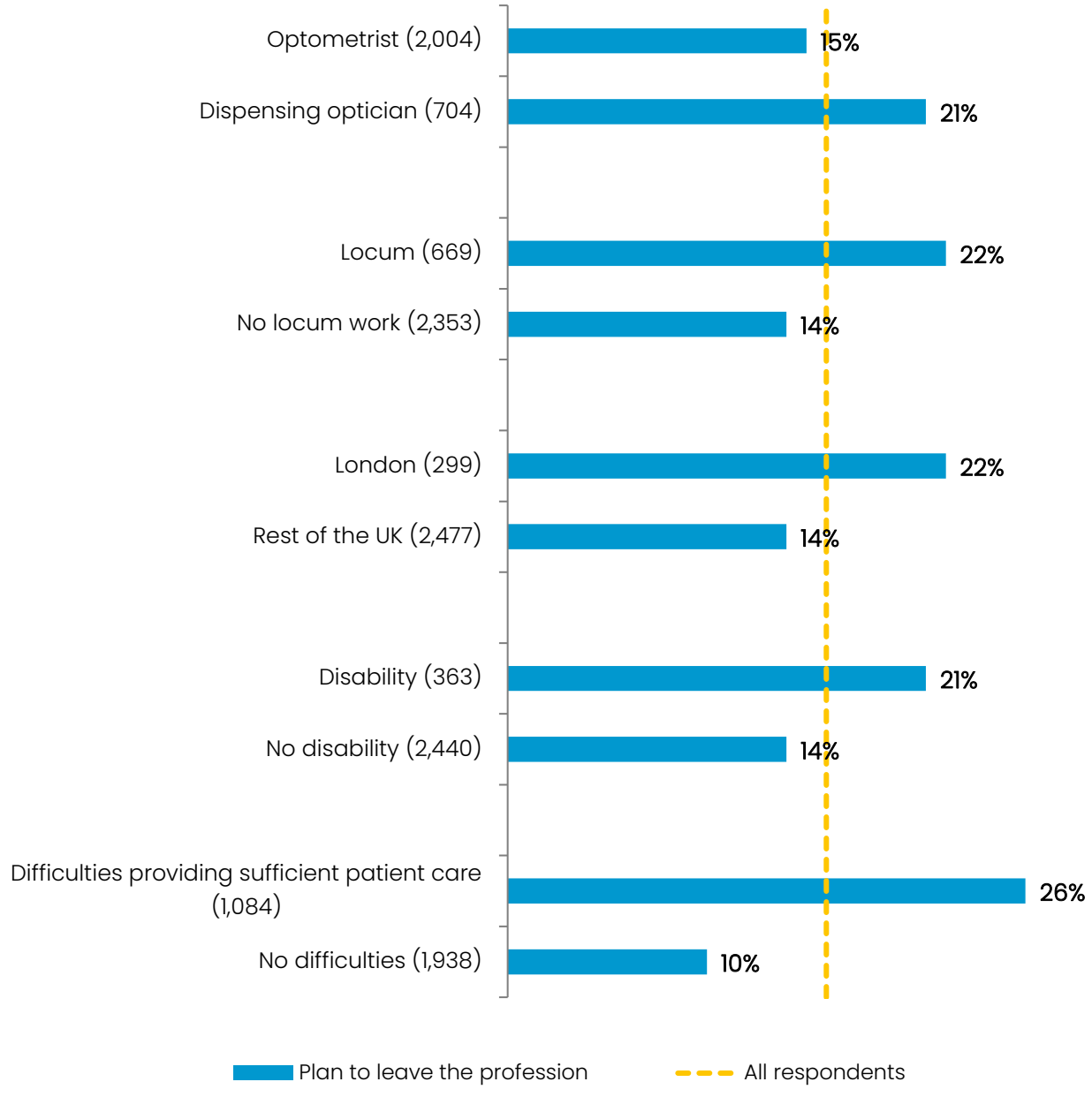
Intentions to leave are highest among those facing workplace pressures

Plans to leave the profession are more common among dispensing opticians, locums, respondents based in London, those with a disability, and those who report difficulties providing patients with the sufficient level of care they need.

In particular, respondents who reported experiencing difficulties providing sufficient patient care are considerably more likely to be considering leaving the profession than those not reporting these difficulties.

Figure 64 – Plans to leave the profession in the next 12 months by registration type, locum working, location, disability, and difficulty providing patients with sufficient care

Base: Shown in chart



Speaking up

Managers and employers remain the preferred routes for raising patient safety concerns

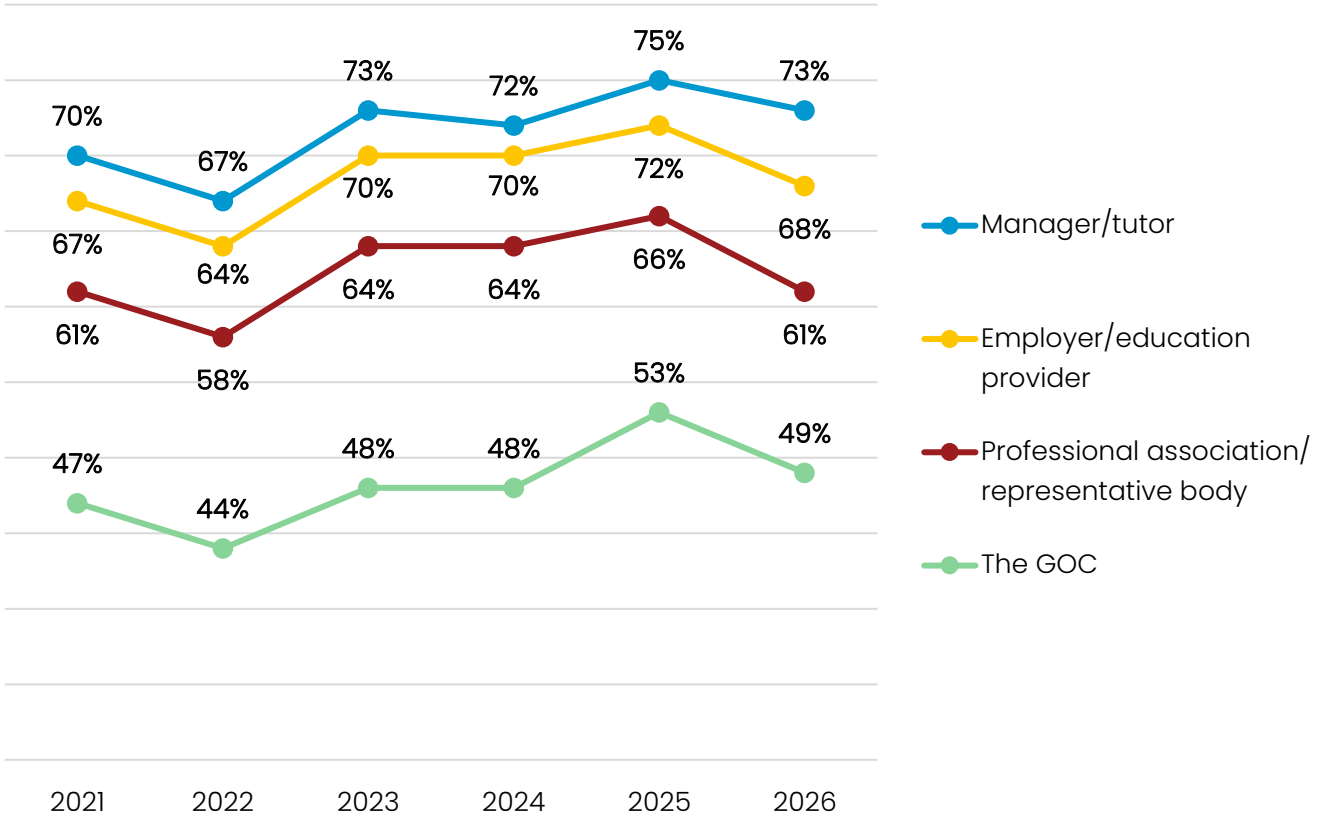
Comfort speaking up about patient safety concerns regarding an individual GOC registrant remains highest in relation to managers/tutors and employers/education providers. This year, almost three quarters of respondents said they would feel comfortable speaking up to a manager or tutor (73%), while just over two thirds would feel comfortable doing so to an employer or education provider (68%), and a further 61% to a professional association or representative body.

Comfort speaking up to the GOC was lower at 49%. This continues the pattern seen across previous years, where respondents are consistently more comfortable raising concerns with those closer to their workplace or training environment than with the GOC.

Results over time also show a slight decrease in comfort across all four audiences between 2025 and 2026. However, 2026 results remain broadly in line with earlier years, and in most cases are higher than the levels recorded in 2021 and 2022.

Figure 65 – Feeling comfortable speaking up about patient safety concerning an individual GOC registrant

Base: All respondents excluding 'not appliable' 2021 (4,880); 2022 (4,102); 2023 (3,932); 2024 (4,575); 2025 (3,798); 2026 (3,174)



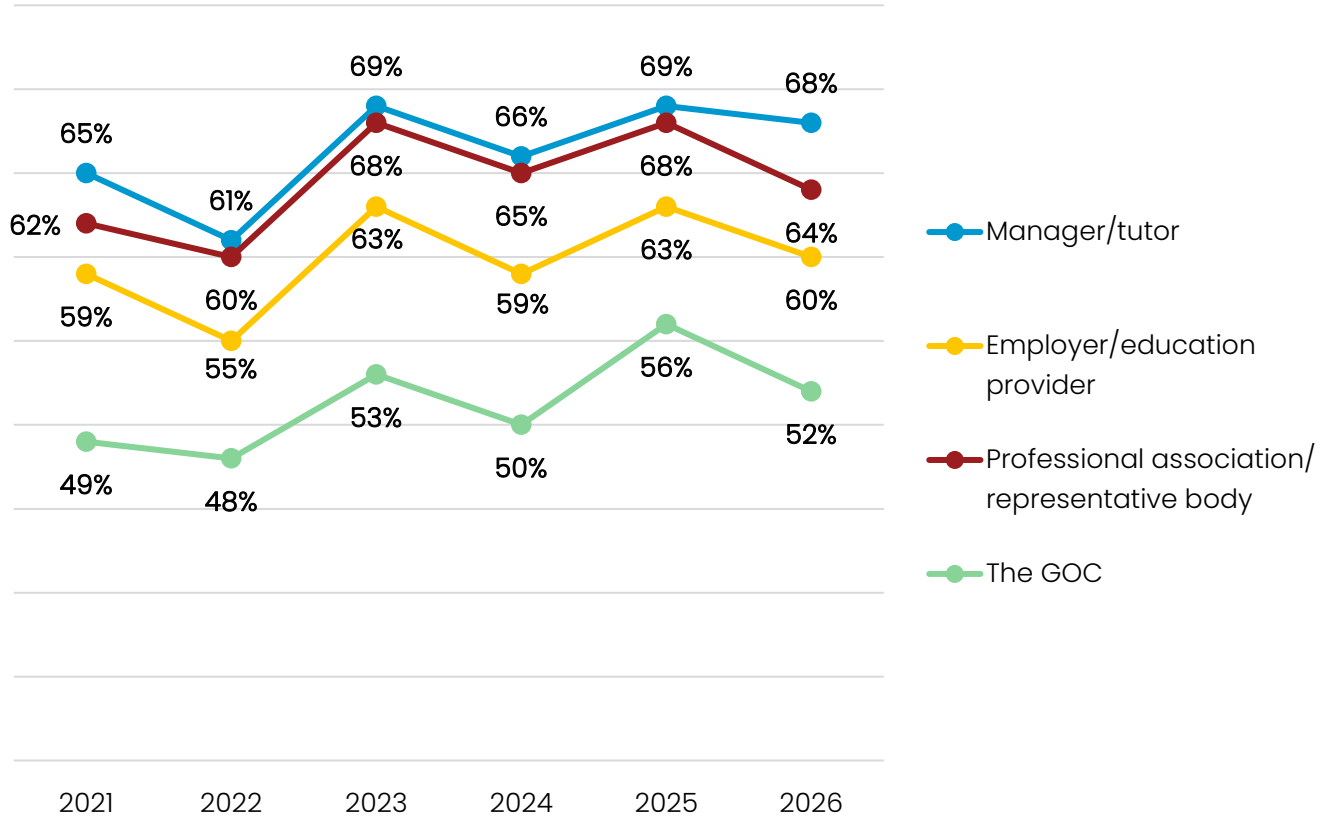
Workplace and representative routes attract higher comfort for employer-related concerns

Reflecting concerns relating to individual registrants, comfort speaking up about patient safety concerns relating to an employer is also highest in relation to managers/tutors and professional associations or representative bodies. Around two thirds of respondents said they would feel comfortable speaking up to a manager or tutor (68%), and a similar proportion would feel comfortable speaking up to a professional association or representative body (64%).

Comfort is slightly lower in relation to employers or education providers themselves (60%). Again, comfort speaking up to the GOC remains lower than for other audiences, although just over half of respondents said they would feel comfortable doing so in 2026 (52%).

Levels of comfort decreased slightly between 2025 and 2026 across all four audiences, but remain broadly in line with the pattern seen over previous years.

Figure 66 – Feeling comfortable speaking up about patient safety concerning an employer
Base: All respondents excluding 'not applicable' 2021 (4,880); 2022 (4,102); 2023 (3,932); 2024 (4,575); 2025 (3,798); 2026 (3,083)



Training on speaking up can increase confidence

As found in 2025, respondents who had attended Continuing Professional Development (CPD) on the topic of speaking up were more likely to indicate that they would feel comfortable speaking up about an individual GOC registrant or an employer to each different authority (e.g. manager,

tutor, employer etc.) when compared with those who had not attended this type of CPD. The analysis of this result can be found in the CPD chapter of this report.

Job security and workplace relationships are key barriers to speaking up

Among those who would not feel comfortable speaking up, the main barriers relate to concerns about the personal consequences of raising concerns.

For concerns about an individual GOC registrant, the most common reason was that respondents might alienate themselves from colleagues (43%). Similar proportions said they might jeopardise their job (41%) or would not want to be seen as a troublemaker by management (39%).

For concerns about an employer, concern about jeopardising their job was the most prominent barrier, mentioned by over half of respondents (54%). This was notably higher than for concerns about an individual registrant, suggesting that raising concerns about an employer may be seen as carrying greater personal or employment-related risk.

There is also evidence of scepticism about whether speaking up would lead to change. Around four in ten said they did not believe corrective action would be taken, both in relation to concerns about an employer (39%) and an individual registrant (36%).

By comparison, practical uncertainty appears to be a less common barrier. Fewer than one in five said they would not know who to contact, while very few said they would assume others already knew about the issue or that it was none of their business, suggesting that discomfort is driven less by a lack of awareness of routes for raising concerns, and more by fears of repercussions and doubts about whether action would be taken.

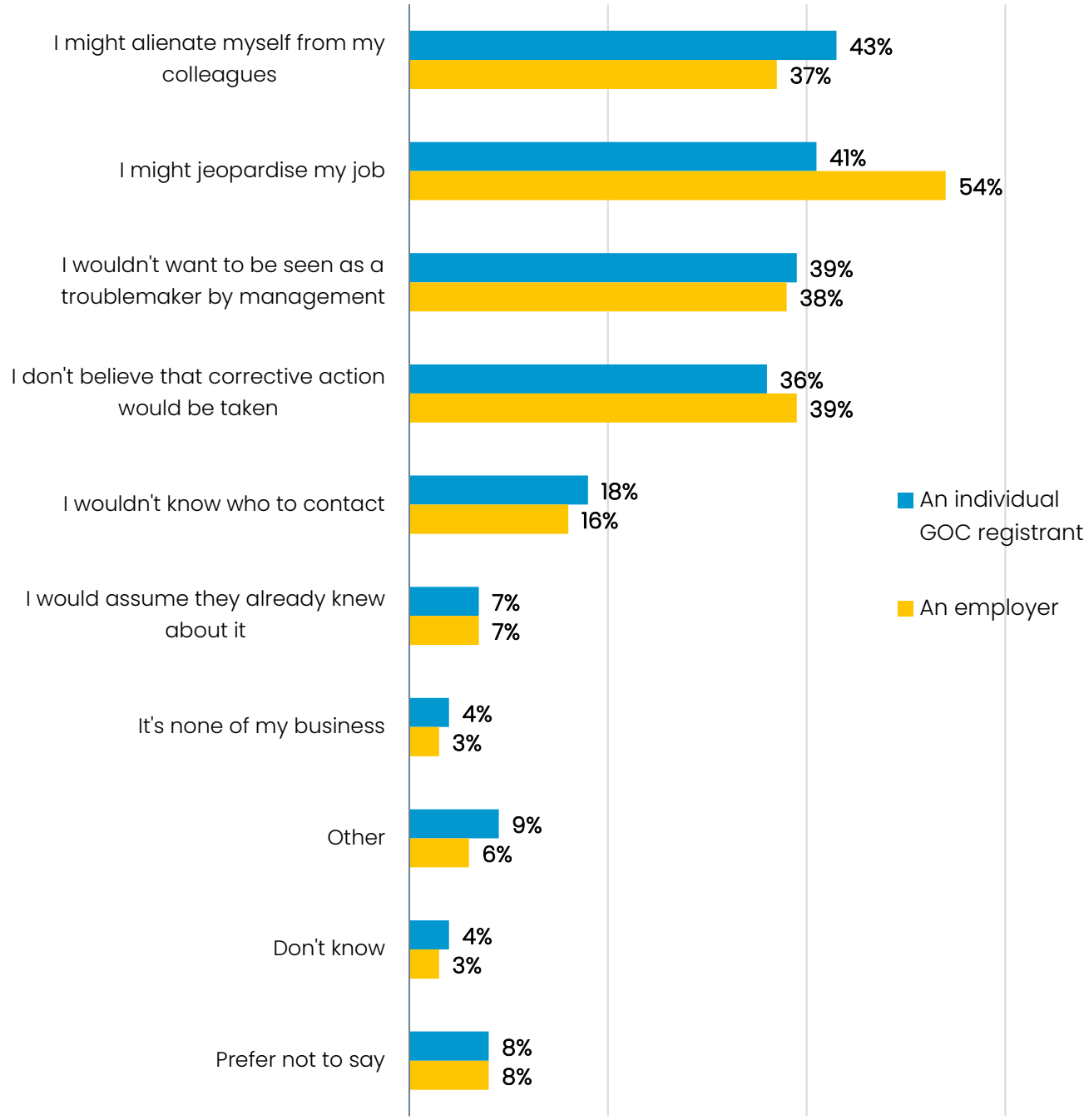
The most common “other” responses reinforce that discomfort is often linked to the perceived seriousness and consequences of speaking up. Many respondents said they would prefer to resolve concerns locally first, by speaking directly to the individual, manager, employer or professional body, and would only involve the GOC as a last resort if the concern was very serious or remained unresolved.

A second recurring theme in “other” responses was lack of confidence in the process, particularly in relation to the GOC. Respondents raised concerns about the process being stressful, punitive, heavy-handed, slow or unlikely to lead to meaningful action, alongside fears of retaliation, damage to working relationships, being blacklisted within a small profession, or jeopardising someone’s career or livelihood.

This question’s response options were changed for this year’s survey, meaning direct comparison is not possible, but the results are broadly similar to those collected in 2025.

Figure 67 – Reasons for not feeling comfortable speaking up about patient safety concerning an individual GOC registrant/an employer

Base: Those who did not feel comfortable speaking up about: a registrant (1,749); an employer (1,688)



Continuing Professional Development

Attendance at CPD relating to workplace issues remains low, but new interest in EDI and AI

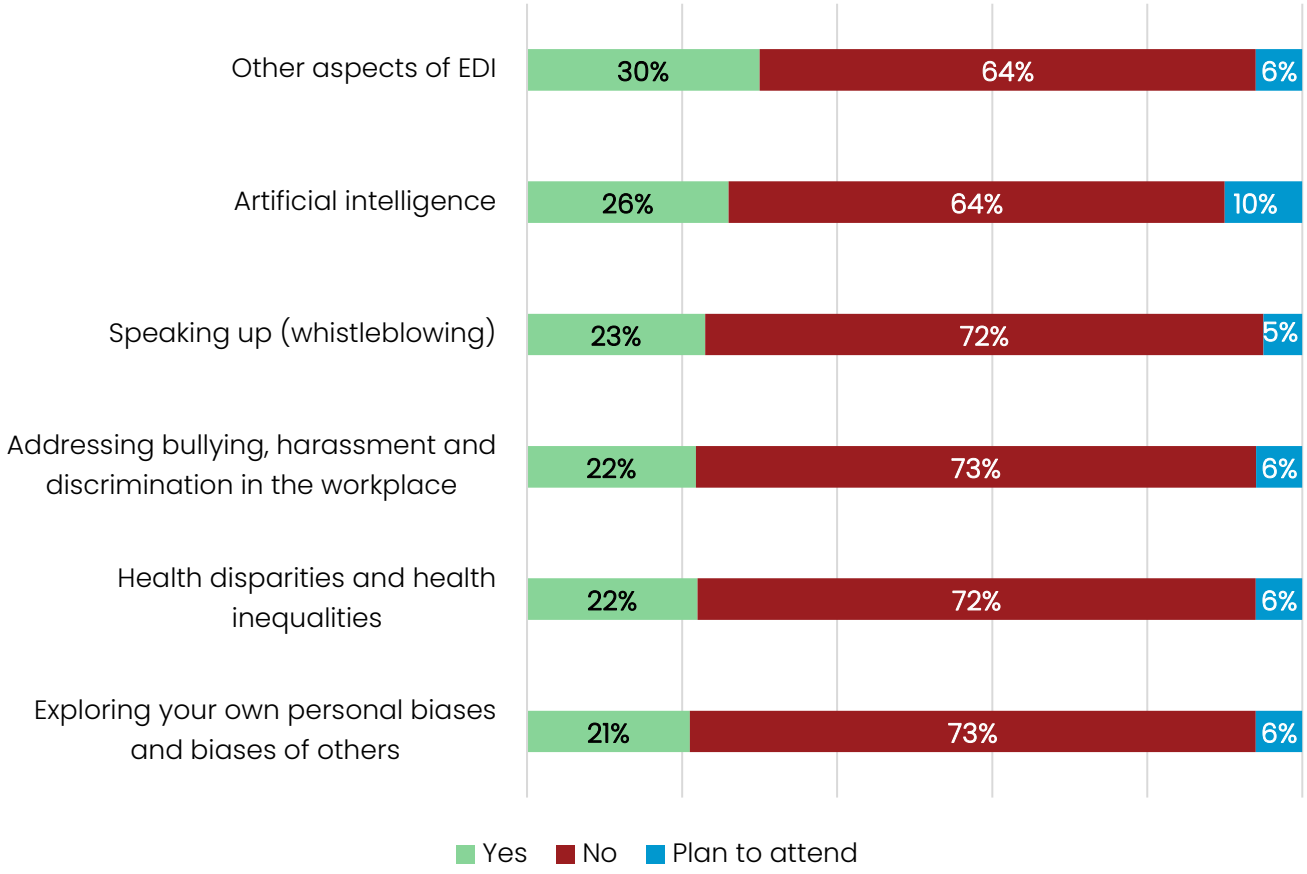
As seen in previous years, attendance at CPD (provider-led or self-directed) to learn about various topics listed was limited. Attendance was highest for other aspects of EDI (30%), followed by artificial intelligence (26%) – both of which were new options for this year's survey.

Around one in five had attended CPD on the remaining topics, including speaking up/whistleblowing (23%), addressing bullying, harassment and discrimination in the workplace (22%), health disparities and health inequalities (22%), and exploring personal biases and the biases of others (21%).

Across all topics, the majority of respondents said they had not attended relevant CPD, ranging from 64% for other aspects of EDI and artificial intelligence to 73% for addressing bullying, harassment and discrimination and exploring biases.

Artificial intelligence stands out as the topic with the highest proportion planning to attend CPD in future, at 10%, compared with 5% to 6% for the other topics.

Figure 68 – Attendance at CPD on specific topics within the latest CPD cycle
Base: All respondents excluding students (2,780)

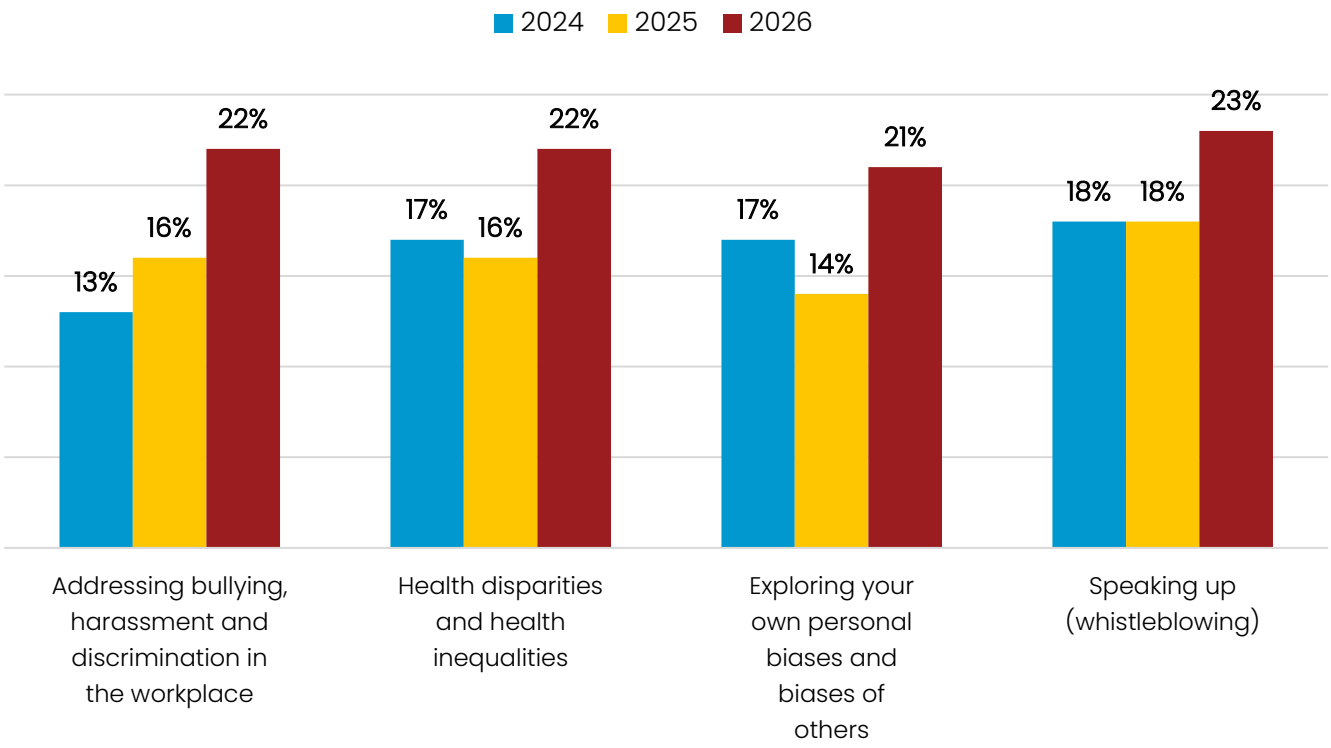


CPD attendance has increased across workplace culture and EDI topics

Although overall attendance at CPD on these topics remains relatively modest, results over the last three years suggest growing engagement with CPD focused on workplace culture, speaking up, health inequalities and bias.

Attendance has generally increased for all four areas, reaching their highest recorded level this year. The largest increase is seen for addressing bullying, harassment and discrimination in the workplace, rising by 9% pts between 2024 and 2026.

Figure 69 – Attendance at CPD on specific topics within the latest CPD cycle – 2024 to 2025
Base: All respondents 2024 (3,686); 2025 (3,063); 2026 (2,780)

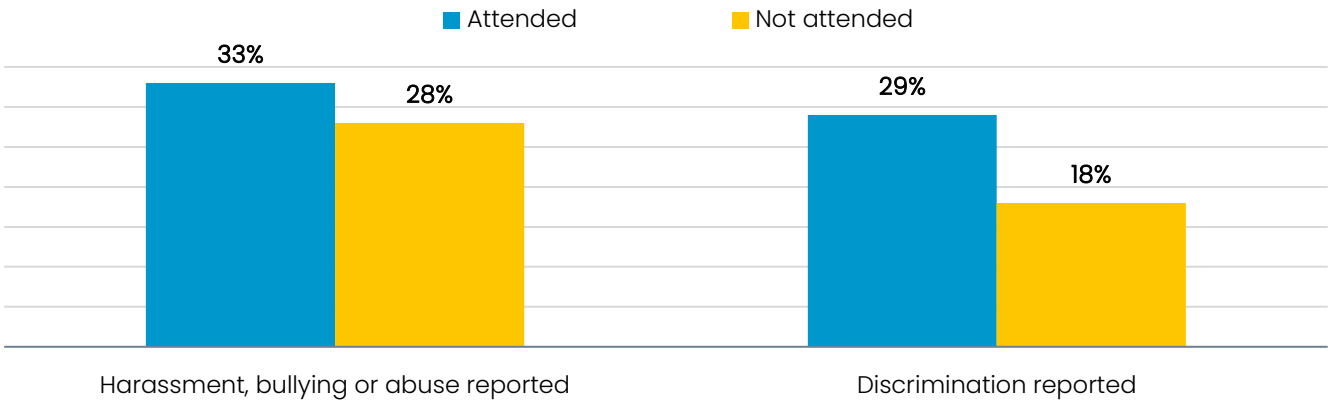


CPD attendance is associated with reporting discrimination and feeling able to speak up

As found in 2025, attendance at CPD has a direct impact on other behaviours related to the workplace, emphasising the positive impact that attending CPD can have.

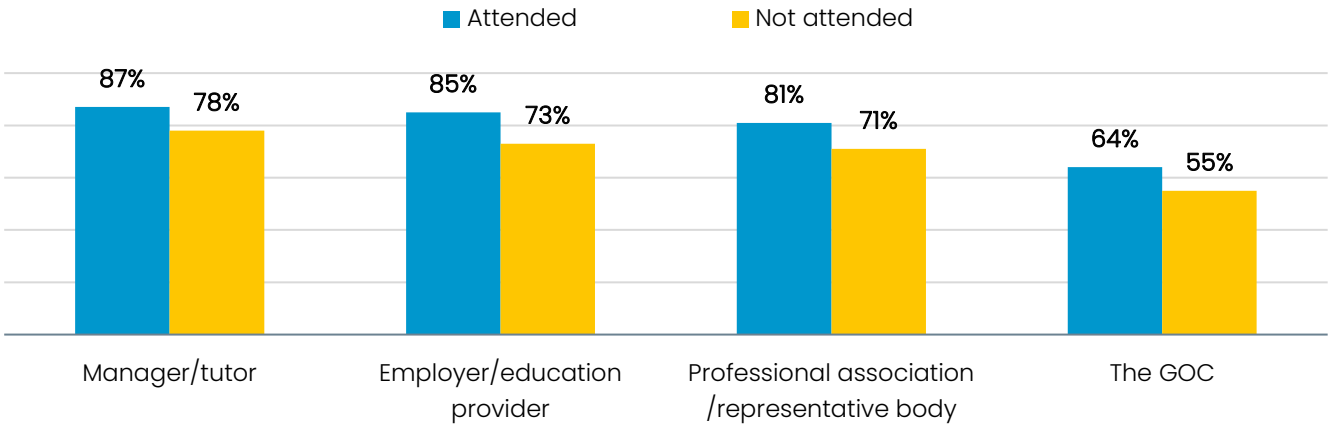
Respondents who had attended CPD on the topic of addressing bullying, harassment and discrimination in the workplace were significantly more likely to have personally reported their experiences of discrimination when compared with those who had not attended this type of CPD. However, again the difference seen for those who personally reported their experiences of harassment, bullying or abuse is less pronounced.

Figure 70 – Personally reporting harassment, bullying or abuse/discrimination by attendance at CPD on the topic of addressing bullying, harassment and discrimination in the workplace
Base: Attended (284); Not attended (925)



Those who had attended CPD on the topic of speaking up were again more likely to indicate that they would feel comfortable speaking up about an individual GOC registrant or an employer to each different authority (e.g. manager, tutor, employer etc.) when compared with those who had not attended this type of CPD.

Figure 71 – Feeling comfortable speaking up about an individual GOC registrant or employer by attendance at CPD on the topic of speaking up (% comfortable)
Base: Attended (560); Not attended (1,824)



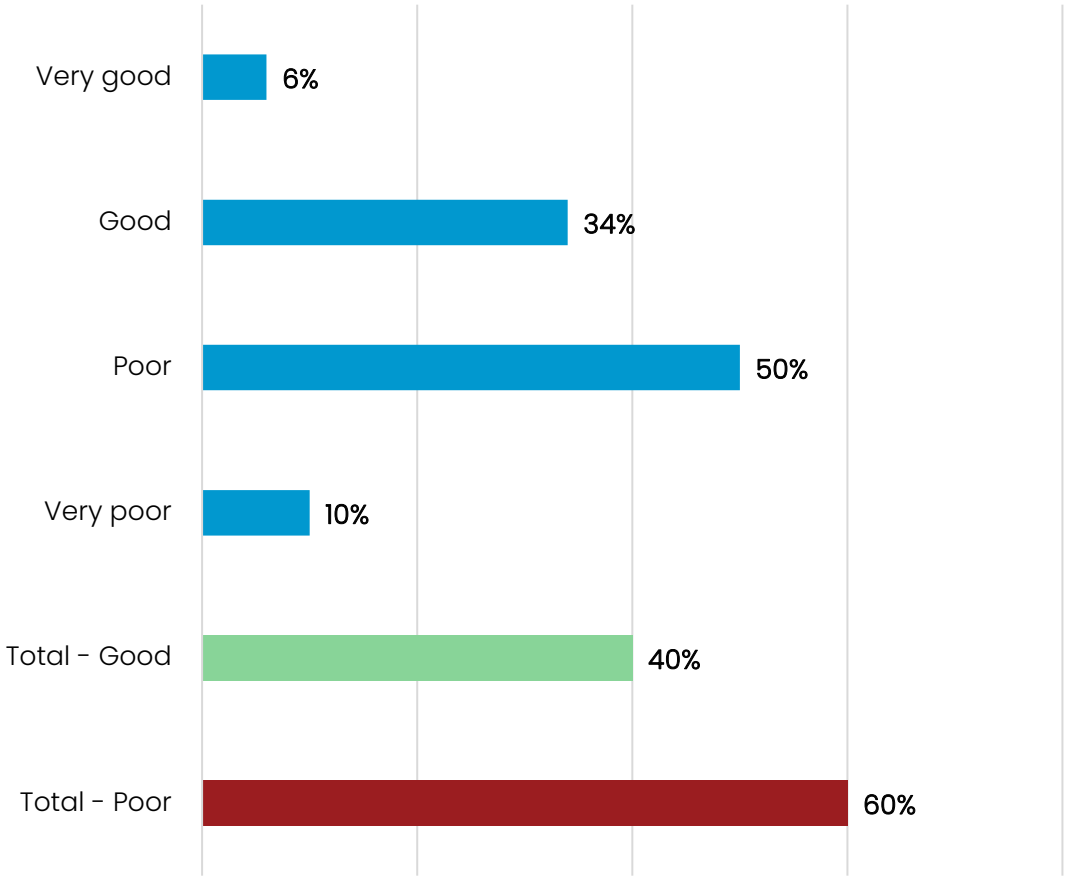
Artificial intelligence

Limited knowledge and understanding of AI in relation to optical care

Overall, respondents were more likely to describe their knowledge and understanding of AI in relation to optical care and professional practice negatively rather than positively. Six in ten (60%) rated their understanding as poor or very poor, while four in ten (40%) considered it good or very good.

Figure 72 – Self-described knowledge and understanding of AI in relation to optical care and professional practice

Base: All respondents (3,451)

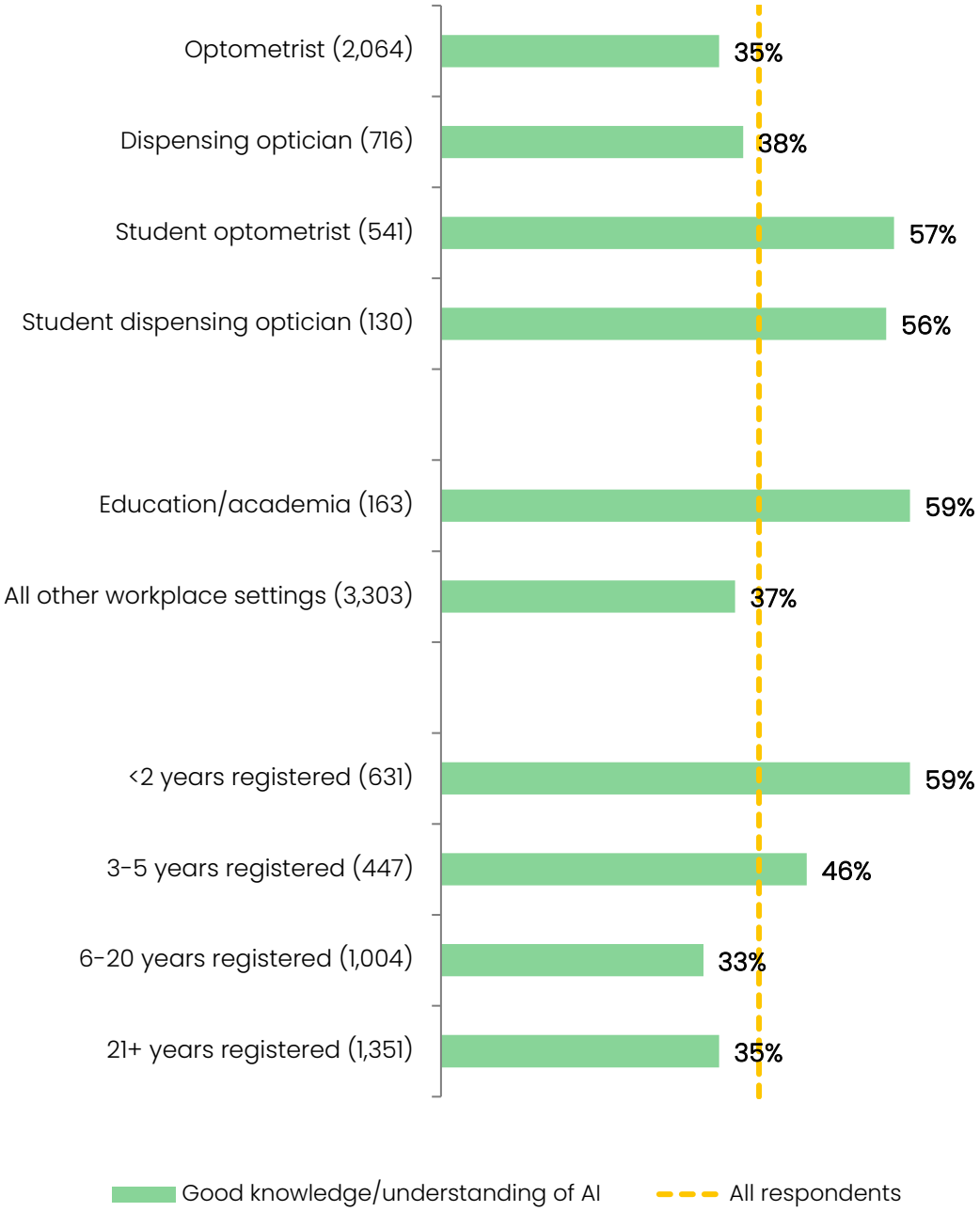


Understanding of AI is strongest amongst students and recently registered respondents

Younger and more recently registered respondents were more likely to report good knowledge and understanding of AI, with particularly high confidence amongst students (both optometrist and dispensing optician) and those registered for fewer than two years. Respondents working in education or academia were also more likely to feel confident in their understanding of AI when compared with those working in other settings.

Figure 73 – Good knowledge/understanding of AI by registration type, workplace setting, and length of registration

Base: Shown in chart

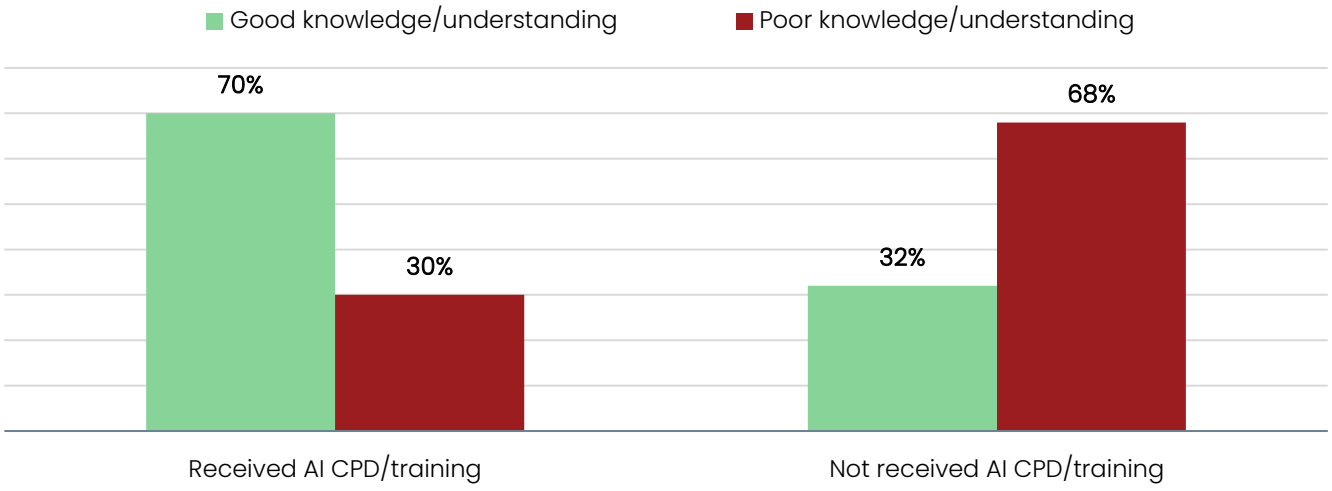


Formal AI training is more common amongst experienced registrants despite lower confidence levels

Just over one in five respondents (22%) reported having received CPD or training relating to AI within the last 12 months.

Those who had undertaken training were significantly more likely to describe their knowledge and understanding of AI positively, suggesting that training may play an important role in improving confidence in this area.

Figure 74 – Self-described knowledge and understanding of AI in relation to optical care and professional practice by receipt of CPD or training about AI over the last 12 months
Base: Received AI CPD/training (748); Not received AI CPD/training (2,703)

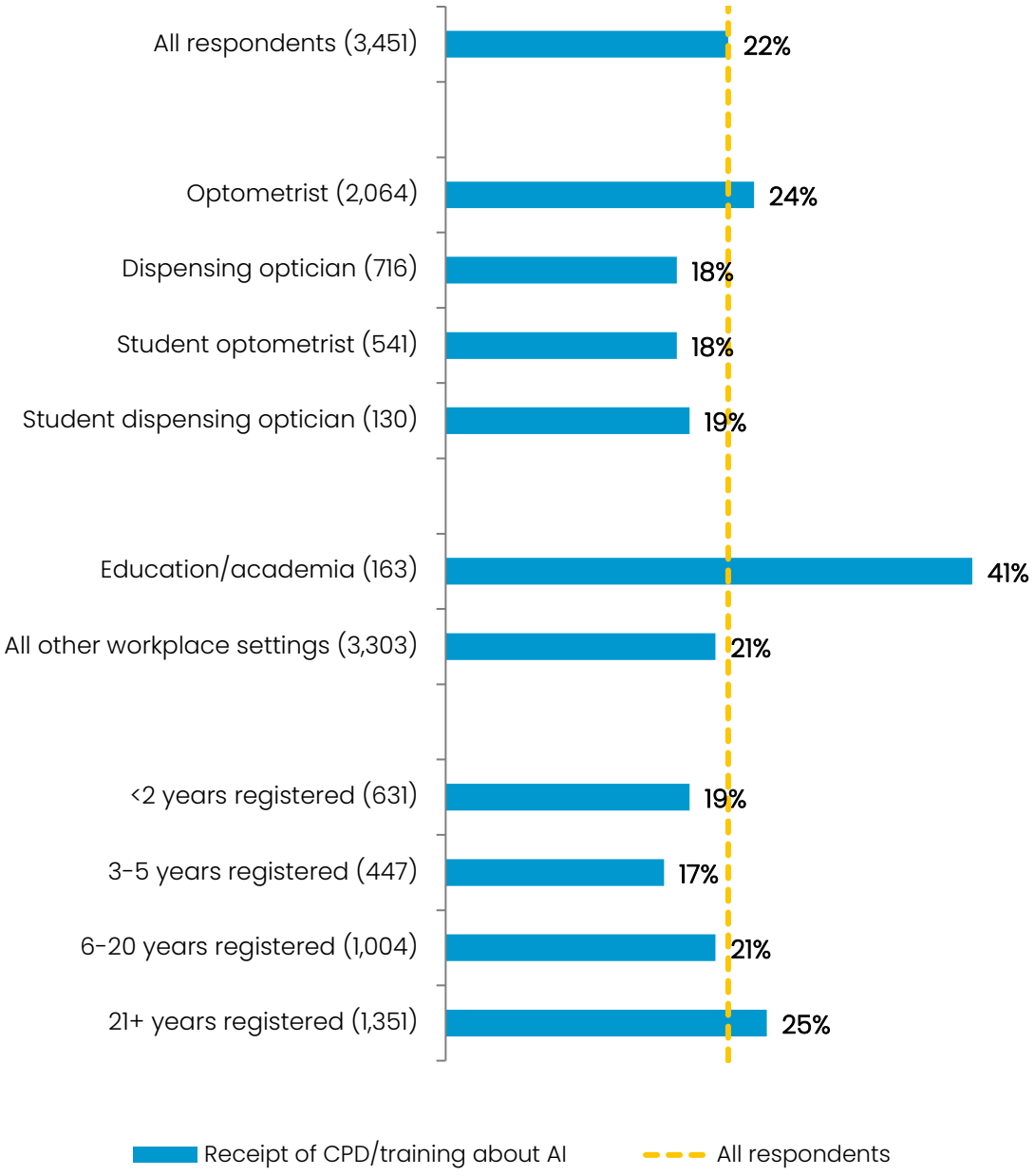


However, as shown in the chart overleaf, the profile of those receiving training does not fully mirror the groups reporting the highest levels of knowledge in AI. Students and more recently registered respondents were most likely to report good knowledge and understanding of AI, despite being less likely to have received formal training or CPD in this area. Conversely, optometrists and longer-registered professionals were more likely to have undertaken training, despite reporting lower levels of confidence overall.

This may suggest that familiarity with AI amongst younger respondents is shaped through wider exposure during education and everyday technology use, while more established professionals may increasingly be using formal CPD and training to develop knowledge and confidence in this area.

Figure 75 – Receiving CPD or training about AI over the last 12 months by registration type, workplace setting, and length of registration

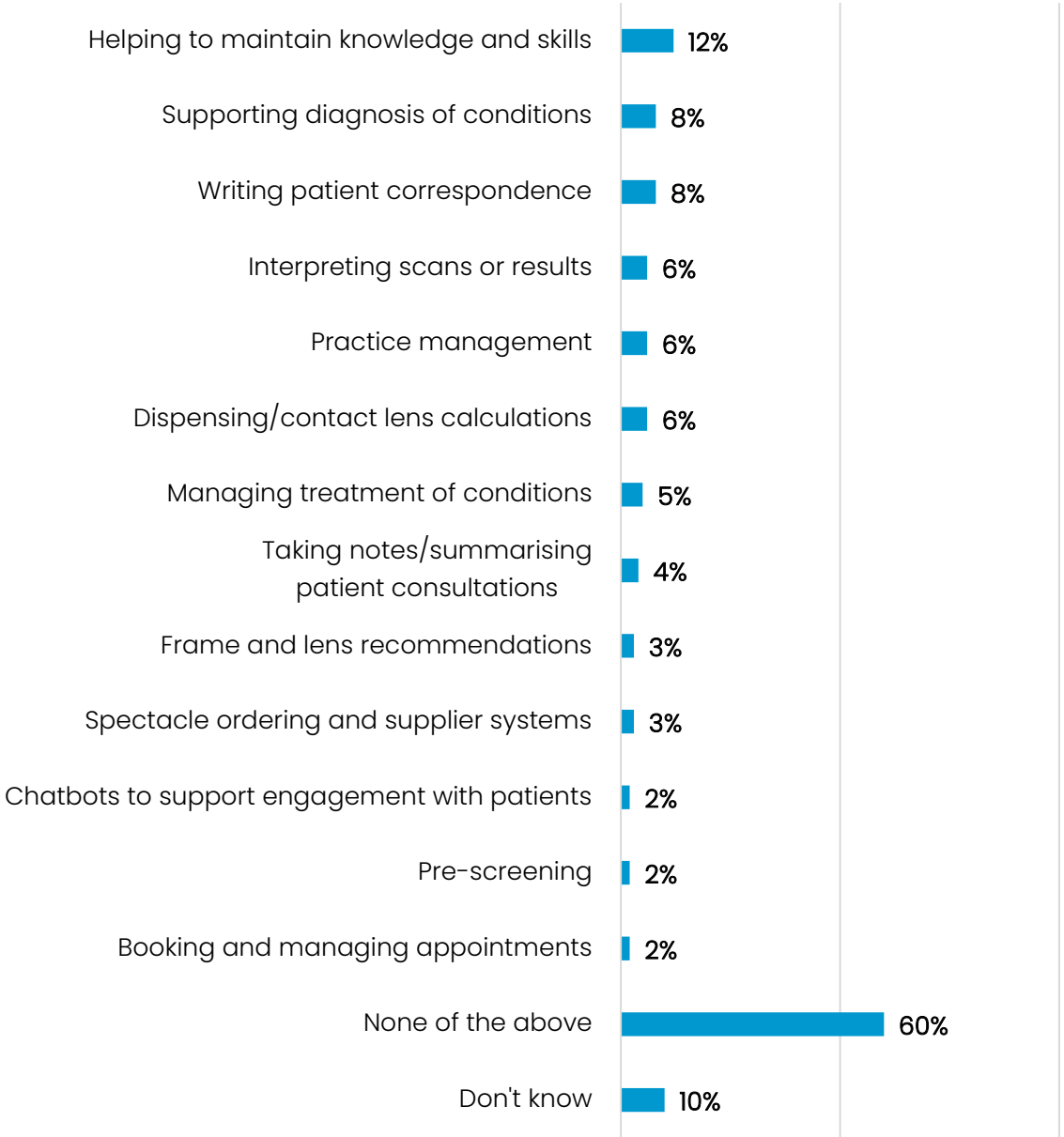
Base: Shown in chat



Current use of AI in professional practice remains limited

Current use of AI in professional practice remains relatively limited, with six in ten working respondents (60%) indicating that they are not currently using AI for any of the activities listed. Where AI is being used, it is most commonly to support maintaining knowledge and skills (12%), diagnosis of conditions (8%), and writing patient correspondence (8%). Use of AI for more operational or patient-facing activities, such as appointment management (2%), pre-screening (2%), or chatbot support (2%), was less common.

Figure 76 – Current use of AI in professional practice
Base: Respondents currently working (3,022)



Respondents working in hospital (52%) and education/academia (55%) were less likely to indicate that they were not currently using AI for any of the activities listed, suggesting greater use of AI within these settings. Those involved in enhanced eye care services (58% vs. 61% not involved) and respondents registered for fewer than two years (55% vs. 61% of those registered 6–20 years) were also less likely to select 'none of the above'.

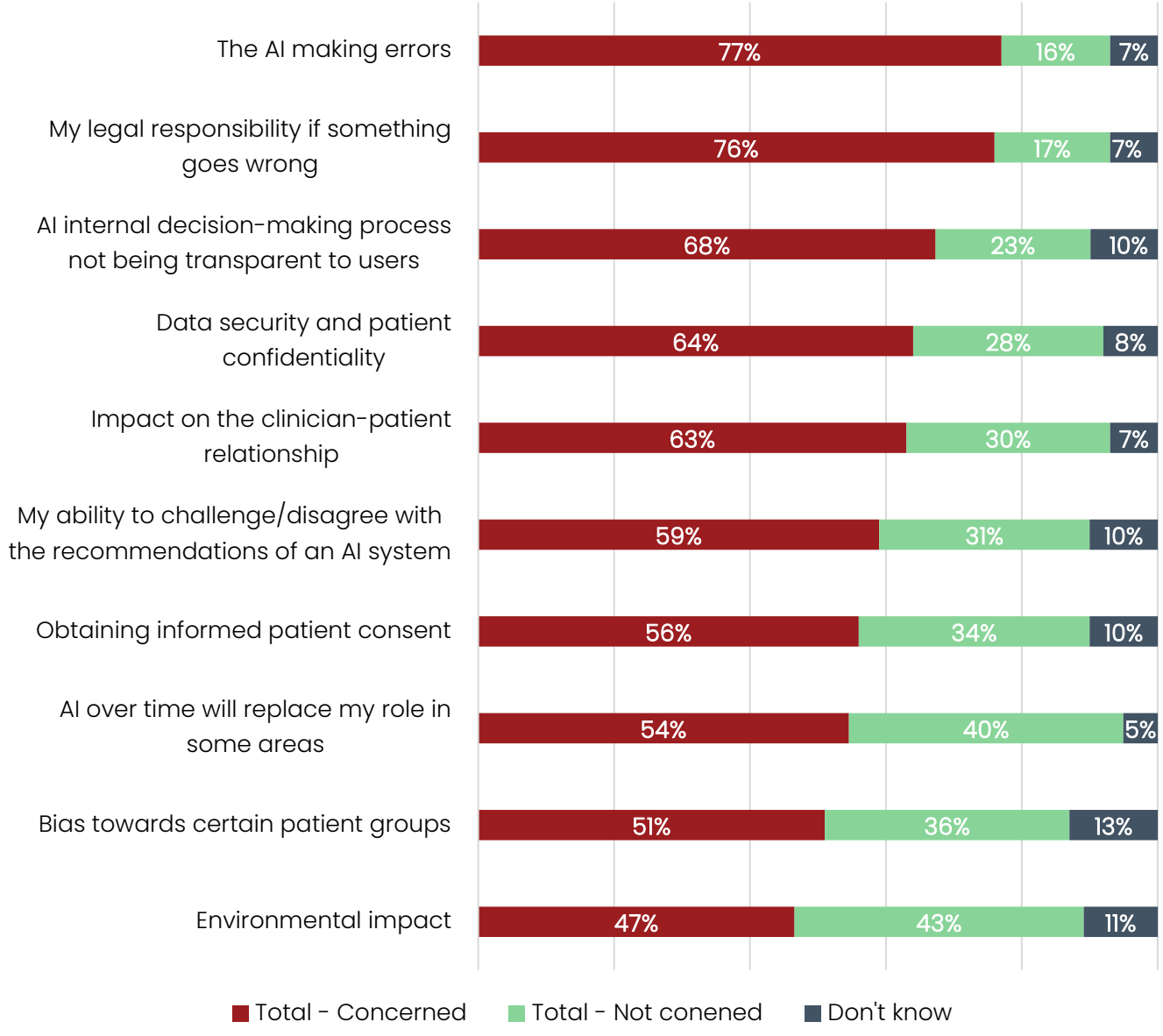
Concerns about AI are centred on safety, accountability, and transparency

Overall, respondents expressed relatively high levels of concern about the use of AI within eye care, particularly in relation to patient safety, accountability, and professional responsibility. The highest levels of concern related to AI making errors (77% concerned) and legal responsibility if something goes wrong (76% concerned), while concerns around transparency of AI decision-making (68% concerned), data security (64% concerned), and the impact on the clinician-patient relationship (63% concerned) were also widespread.

Respondents were comparatively less concerned about the longer-term impact of AI replacing aspects of their role, although over half (54%) still expressed concern about this. Environmental impact generated the lowest level of concern overall (47%) and also one of the highest proportions of uncertainty (11%), alongside bias towards certain patient groups and transparency of AI systems (13%).

Figure 77 – Concern about the use of AI in eye care

Base: All respondents (3,451)



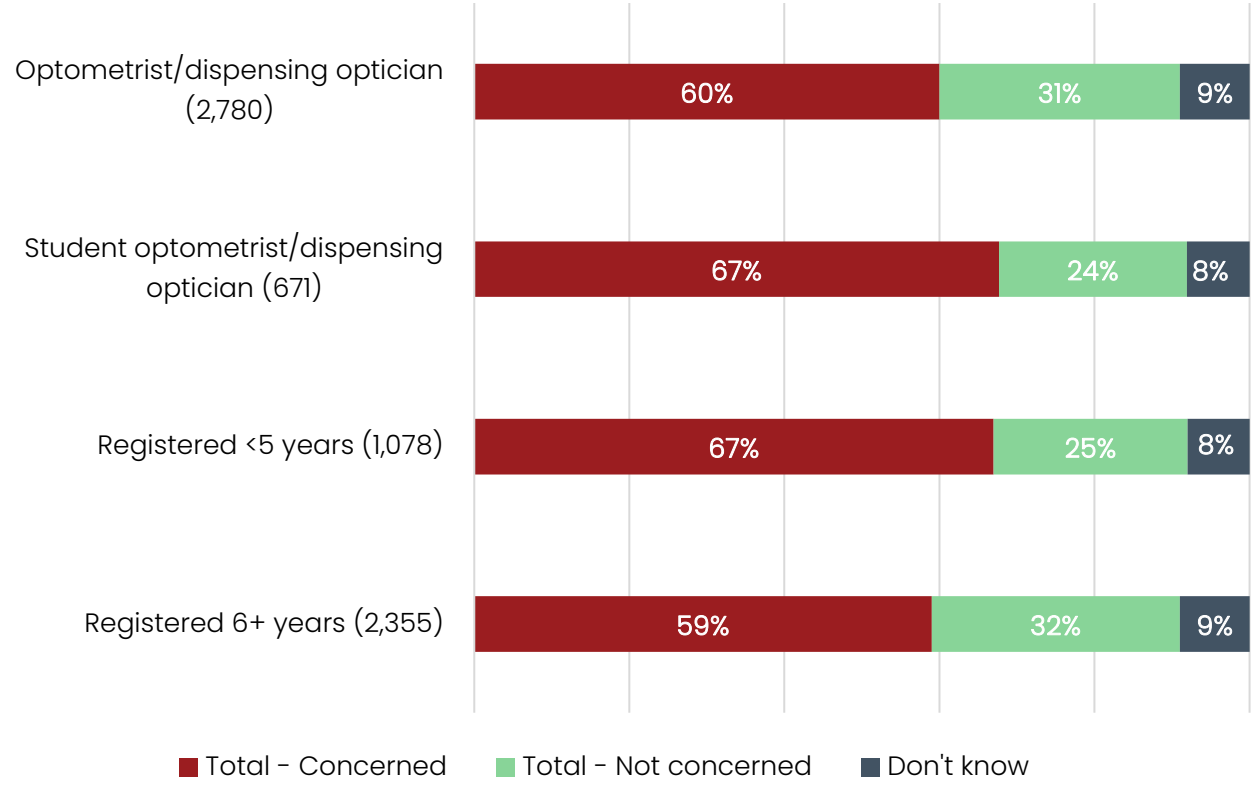
Greater AI understanding does not reduce concern among students and newer registrants

To summarise the pattern across the ten AI concern statements, a combined measure has been created showing the average level of concern across all AI-related issues.

This shows that concern is higher amongst students and those registered for fewer than five years when compared with qualified optometrists and dispensing opticians, and those registered for 6+ years.. This is interesting because these same groups were more likely to report good knowledge/ understanding of AI, suggesting that greater familiarity does not necessarily mean lower concern.

Figure 78 – Concern about the use of AI in eye care by registration type and length of registration

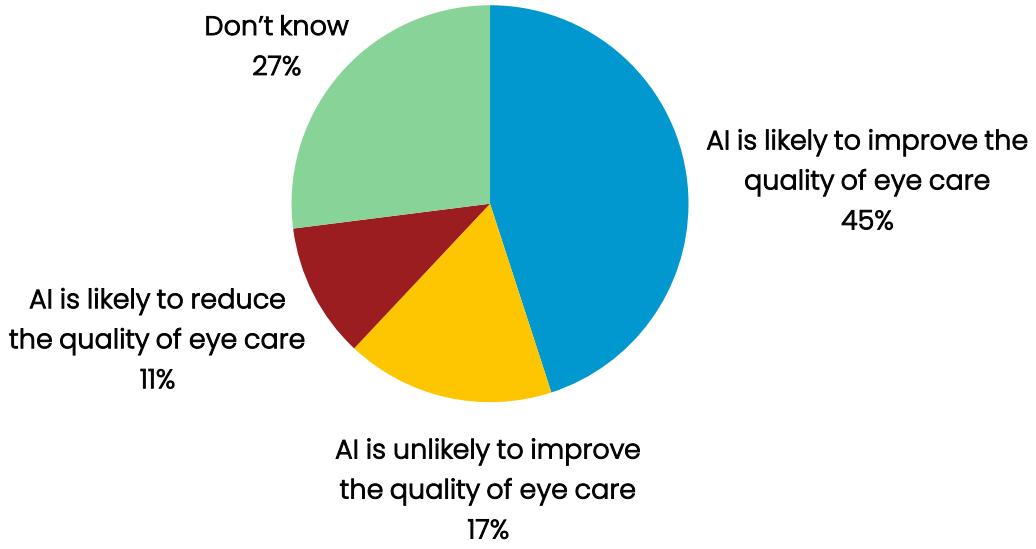
Base: Shown in chart



Mixed but cautiously positive views on AI's impact on eye care

Overall, respondents were more likely to feel that AI will improve the quality of eye care than reduce it. Almost half (45%) felt AI is likely to improve quality, compared with around one in ten (11%) who felt it is likely to reduce quality. However, views were not universally positive, with a notable minority saying AI is unlikely to improve care (17%). More than a quarter (27%) were unsure, highlighting that a large proportion feel unable to comment.

Figure 79 – Predicted impact of AI on the quality of eye care by registration type and workplace setting
Base: All respondents (3,451)

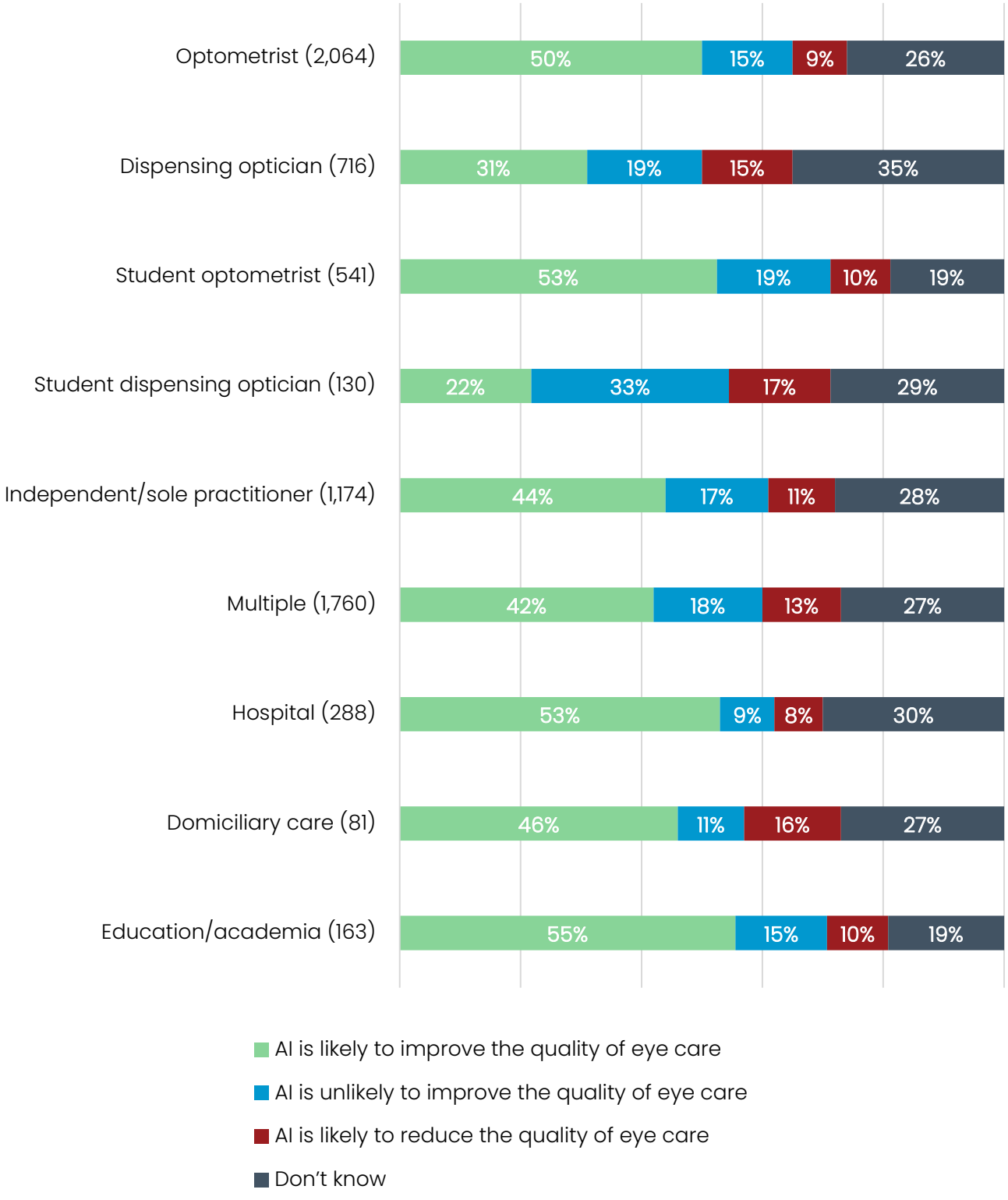


Optimism about AI is strongest among optometrists, hospitals and education settings

Views on the potential impact of AI were more positive among optometrists and student optometrists, around half of whom felt AI is likely to improve the quality of eye care. By contrast, dispensing opticians and student dispensing opticians were less positive, with higher proportions saying AI is unlikely to improve care, likely to reduce care quality, or that they did not know.

By workplace setting, respondents working in hospitals and education/academia were the most likely to feel AI will improve eye care, while those working in multiples and independents/as sole practitioners were closer to the overall average.

Figure 80 – Predicted impact of AI on the quality of eye care by registration type and workplace setting
Base: Shown in chat

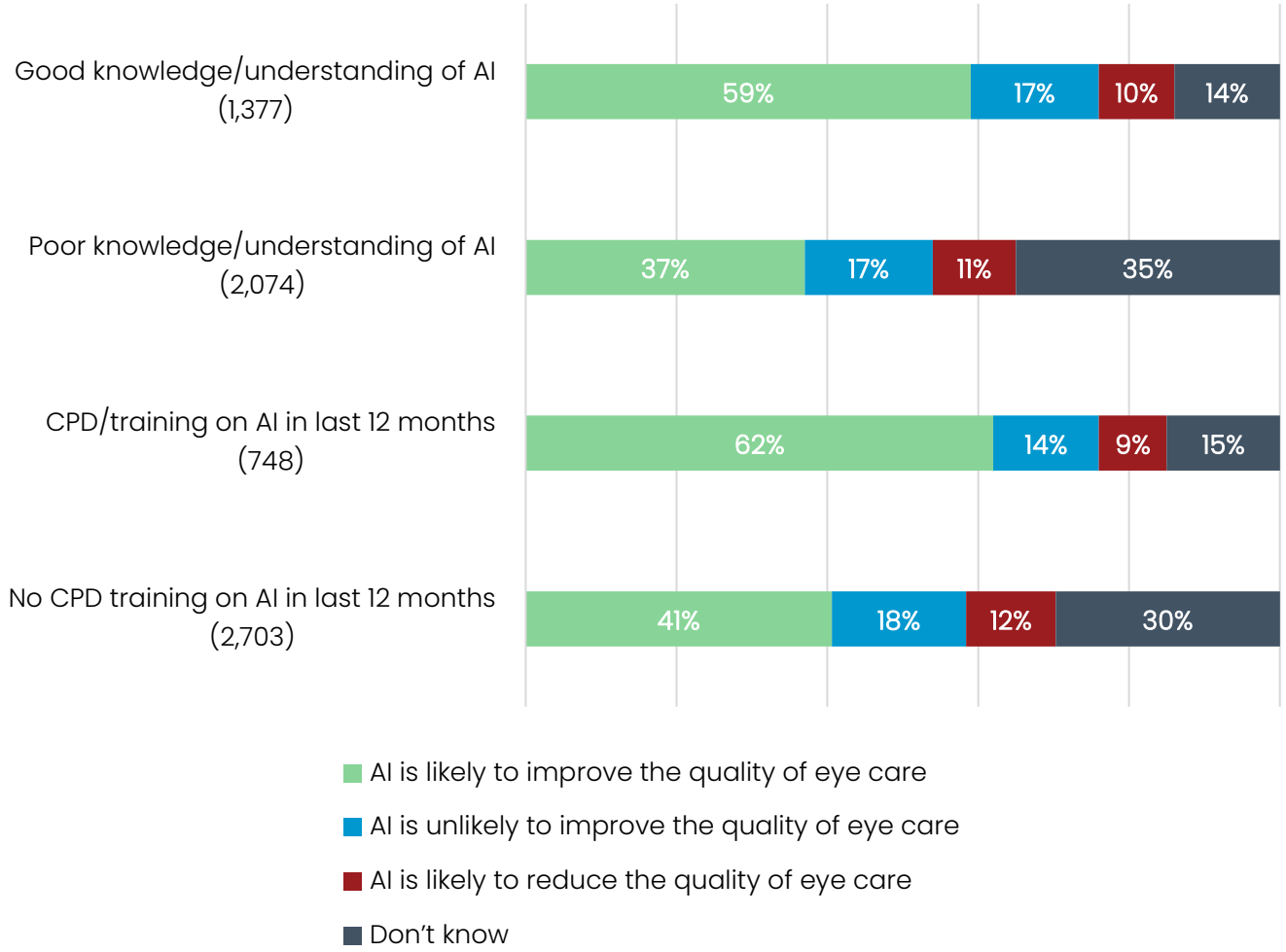


Understanding and training drive positive perceptions of AI's potential impact on eye care

Respondents with good knowledge or understanding of AI, and those who had received AI-related CPD or training in the last 12 months, were more likely to feel that AI will improve the quality of eye care. In contrast, those with poorer understanding or no recent training were much more likely to say they did not know. This suggests that greater exposure to AI is associated with more positive views about its potential impact, although levels of concern about AI reducing care quality remain relatively similar across groups.

Figure 81 – Predicted impact of AI on the quality of eye care level of knowledge/understanding of AI and experience of CPD/training on AI in last 12 months

Base: Shown in chat



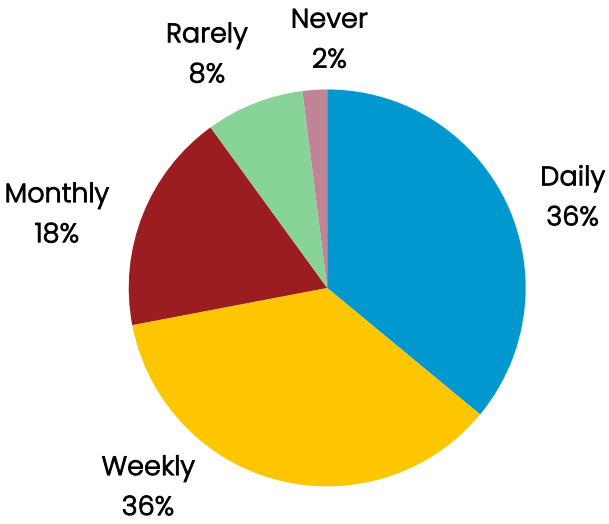
The impact of vision on driving

Discussions about driving implications are a routine part of practice for many registrants

Discussions about the impact of a patient's vision or eye condition on their ability to drive appear to be a routine part of practice for many registrants, with 72% having these conversations at least weekly (36% daily, 36% weekly), while only 10% report doing so rarely or never.

Figure 82 – Frequency of discussing the impact of a patient's vision or eye condition on their ability to drive in the last 12 months

Base: All respondents excluding those who answered 'not applicable' (3,151)



Optometrists were significantly more likely than dispensing opticians to report discussing this daily (44% vs 22%). Dispensing opticians were more likely than optometrists to say these conversations took place monthly or less often (41% vs 20%).

Daily discussions were also more common among those with additional qualifications (40% vs 36% without) and among those involved in enhanced eye care services (44% vs 31% not involved), suggesting these conversations are more frequent among registrants working in more clinically extended roles.

There was some variation across the UK nations, with respondents in England more likely than those in Scotland and Northern Ireland to say they had these discussions daily (37% vs 27% and 22% respectively), while Wales was more in line with England (35%). Instead, weekly discussions were more common in Scotland (44%) and Northern Ireland (42%).

Within England, respondents in London were less likely than the England average to report daily discussions (29% vs 37%), and more likely to say these took place monthly (26% vs 18%).

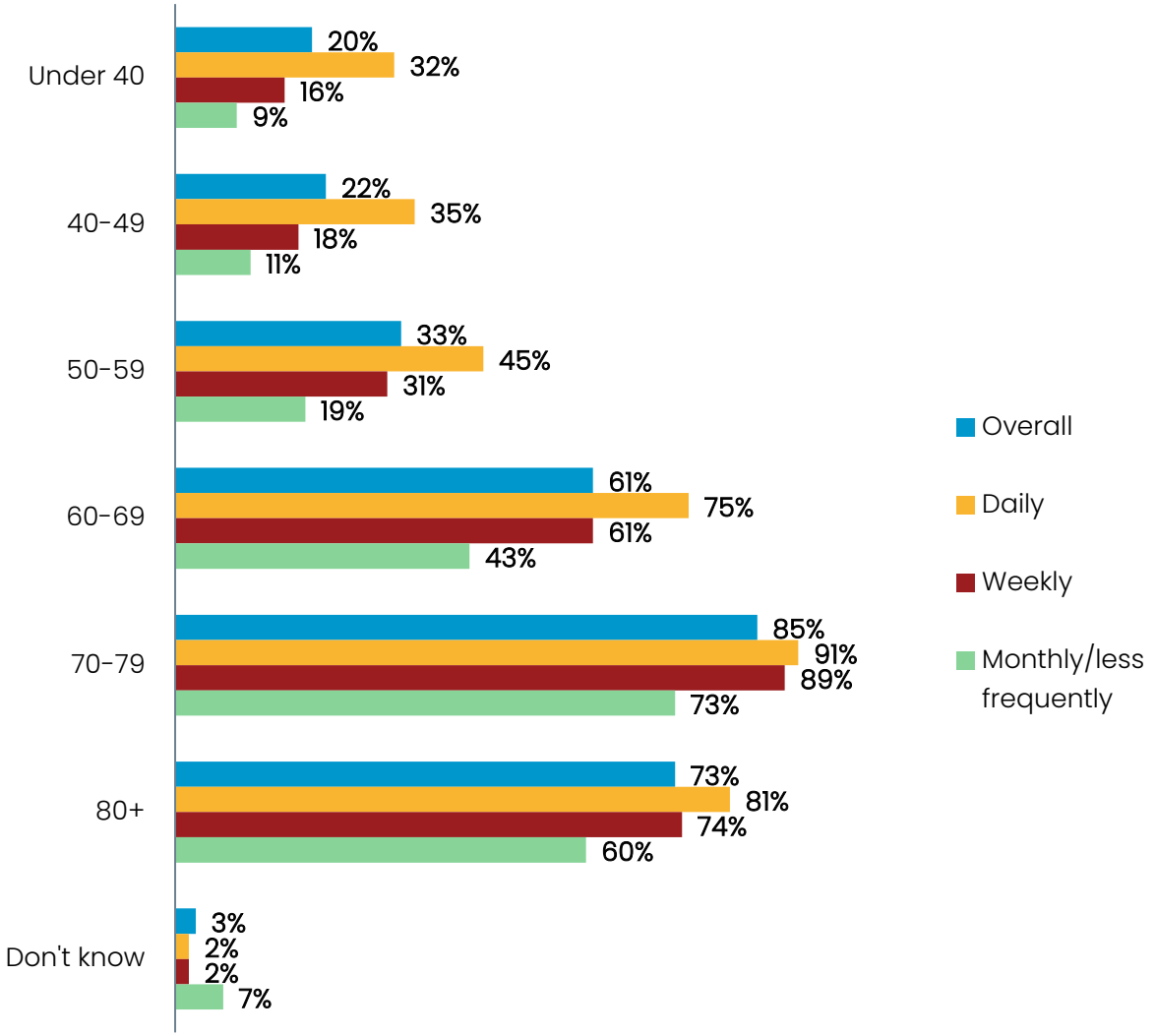
Driving-related discussions are focused primarily on older patients

When discussing the impact of vision or eye conditions on driving, registrants were most likely to say they commonly raise this with patients aged 70-79 (85%), followed by those aged 80+ (73%) and 60-69 (61%). Far fewer said they commonly raise this with patients under 50 (20%-22%).

Those who discuss driving implications with patients on a daily basis were significantly more likely than those doing so monthly or less often to raise the topic across every age group, including patients aged under 40 (32% vs 9%), 40-49 (35% vs 11%) and 50-59 (45% vs 19%). This suggests those who have these discussions frequently may take a broader, risk-based approach, instead of focusing mainly on older age groups.

Figure 83 – Age groups where discussions about the impact of vision or eye conditions on driving are most commonly raised by frequency of discussions

Base: Those who have discussed the impact of a patient's vision or eye condition on their ability to drive in the last 12 months (3,098)



Optometrists were generally more likely than dispensing opticians to report raising driving implications with older patients, particularly those aged 80+ (79% vs 65%) and 60-69 (64% vs 57%).

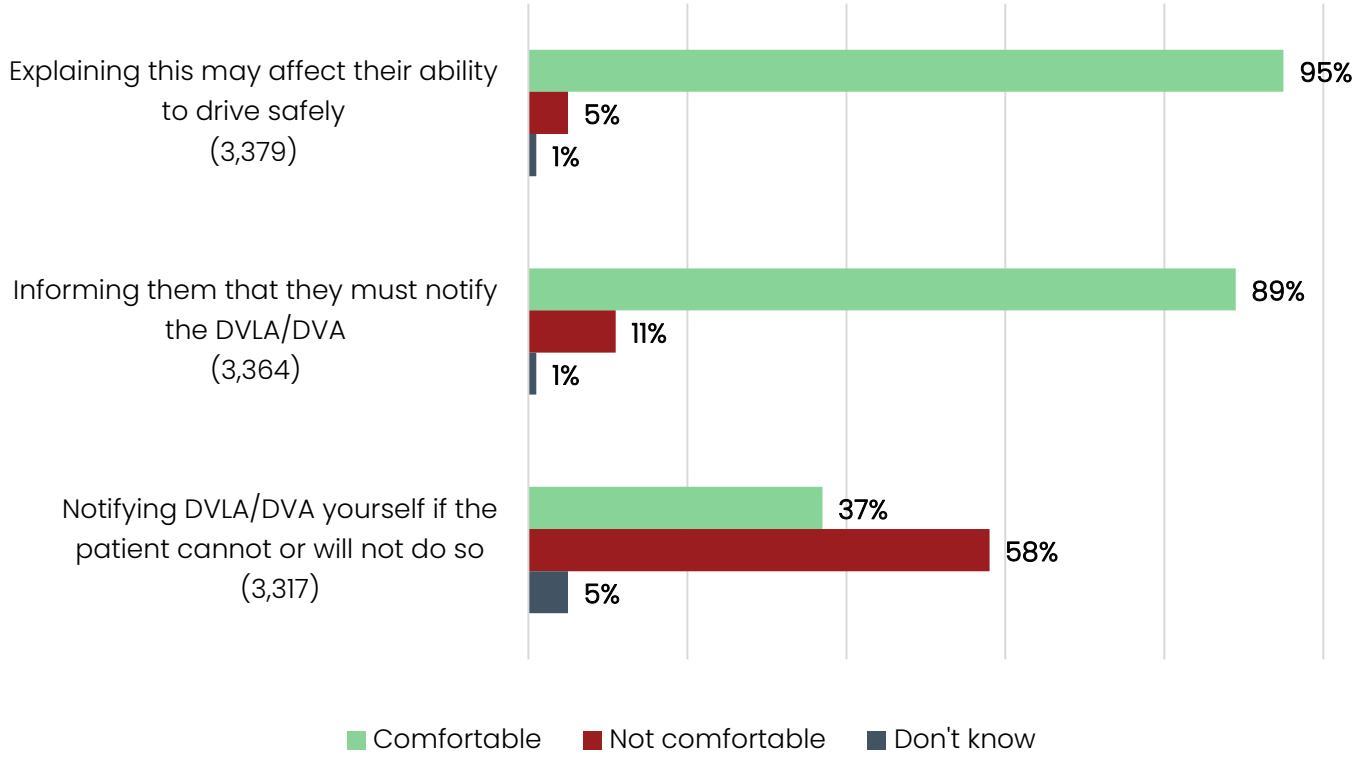
Driving-related discussions are focused primarily on older patients

Registrants are generally comfortable with conversations that involve explaining the implications of not meeting the eyesight standards and informing patients of their responsibility to notify the DVLA/DVA. Almost all respondents were comfortable explaining that this may affect a patient's ability to drive safely (95%), and nearly nine in ten were comfortable informing patients that they must notify the DVLA/DVA (89%).

By contrast, registrants were much less comfortable with notifying the DVLA/DVA themselves. Only 37% said they would feel comfortable doing this, while 58% said they would feel uncomfortable. This suggests confidence is high where the discussion centres on advising the patient, but falls significantly where the registrant may need to take direct action themselves.

Figure 84 – Comfort taking action if a patient does not meet the eyesight standards outlined in DVLA/DVA guidance

Base: All respondents excluding those who answered 'not applicable' (shown in chart)



Experience increases comfort with patient conversations, but not direct notification

Across all registration types and experience levels, most felt comfortable explaining that a patient's eyesight may affect their ability to drive safely and informing them that they must notify the DVLA/DVA.

By registration type, optometrists and dispensing opticians were generally more comfortable than student registrants with these two advisory actions. For example, 97% of optometrists and 95% of dispensing opticians felt comfortable explaining the implications for driving safety, compared with 88% of student optometrists and 89% of student dispensing opticians, likely reflecting the greater practical experience of qualified registrants in handling sensitive patient conversations.

However, the pattern reversed for notifying the DVLA/DVA directly if a patient could not or would not do so, with both student optometrists and student dispensing opticians more likely than qualified optometrists and dispensing opticians to feel comfortable with this action (55% and 45% vs (32% and 40%). Potentially this could indicate a more theoretical or rules-based perspective amongst students, while experienced registrants may be more aware of the practical and professional complexities involved.

This pattern was also seen by length of registration, where comfort with the two advisory actions rose slightly with experience, while comfort with notifying the DVLA/DVA directly was highest among those registered for two years or less (52%) and lower among those registered for longer.

Figure 85 – Comfort taking action if a patient does not meet the eyesight standards outlined in DVLA/DVA guidance by registration type

Base: Optometrist (2,024-2,057); Dispensing optician (682-702); Student optometrist (493-495); Student dispensing optician (118-125)

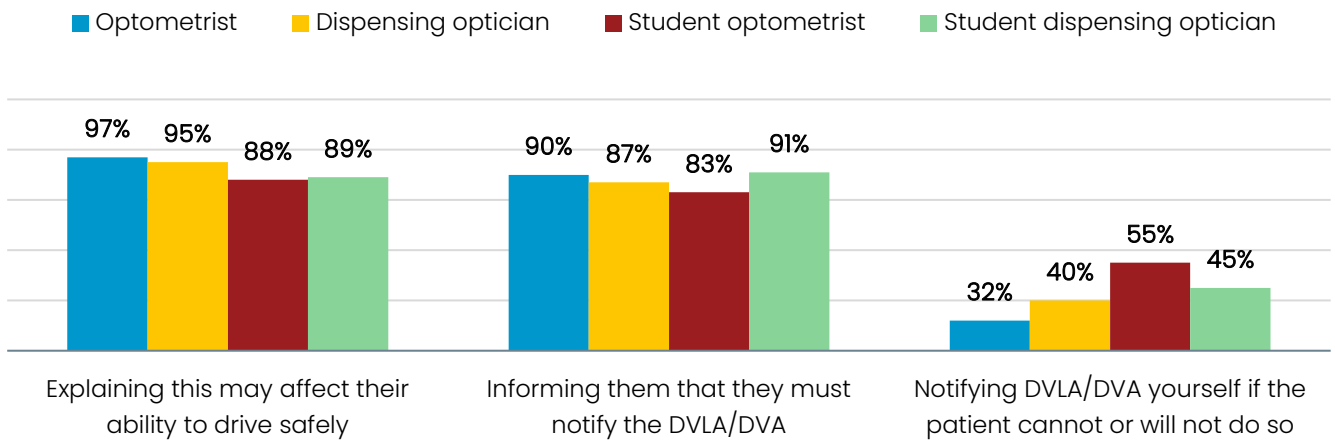
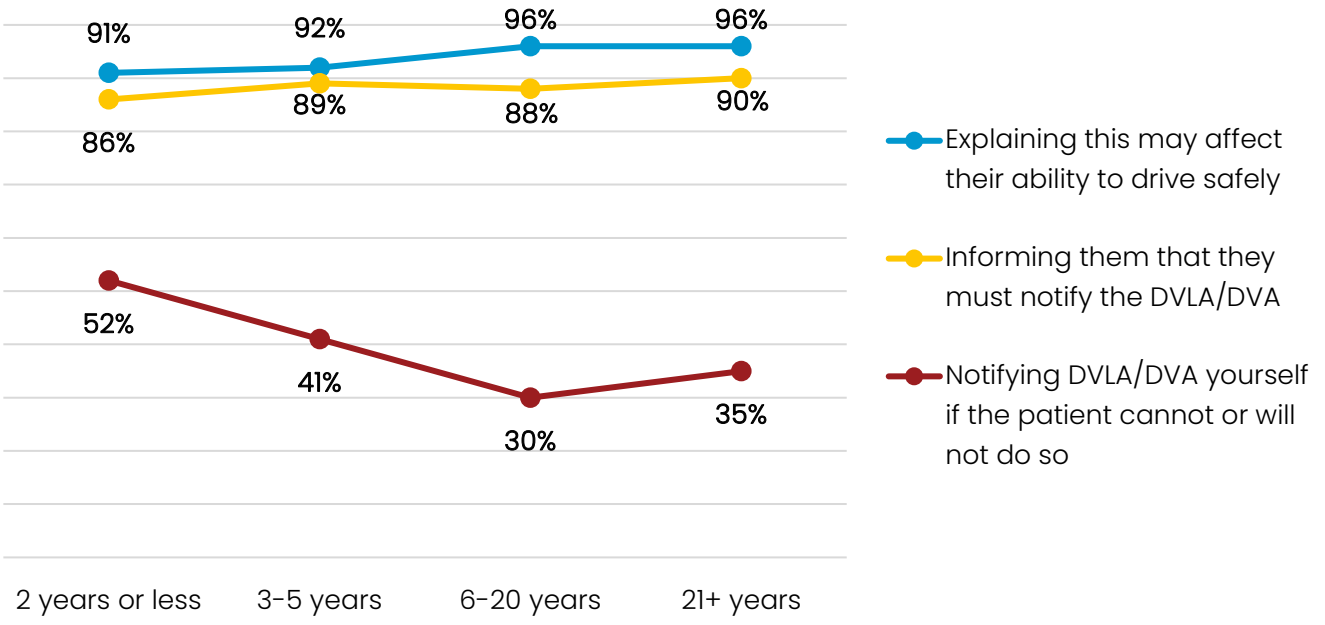


Figure 86 – Comfort taking action if a patient does not meet the eyesight standards outlined in DVLA/DVA guidance by length of registration

Base: <2 years (567-586); 3-5 years (440-443); 6-20 years (984-996); 21+ years (1,308-1,340)

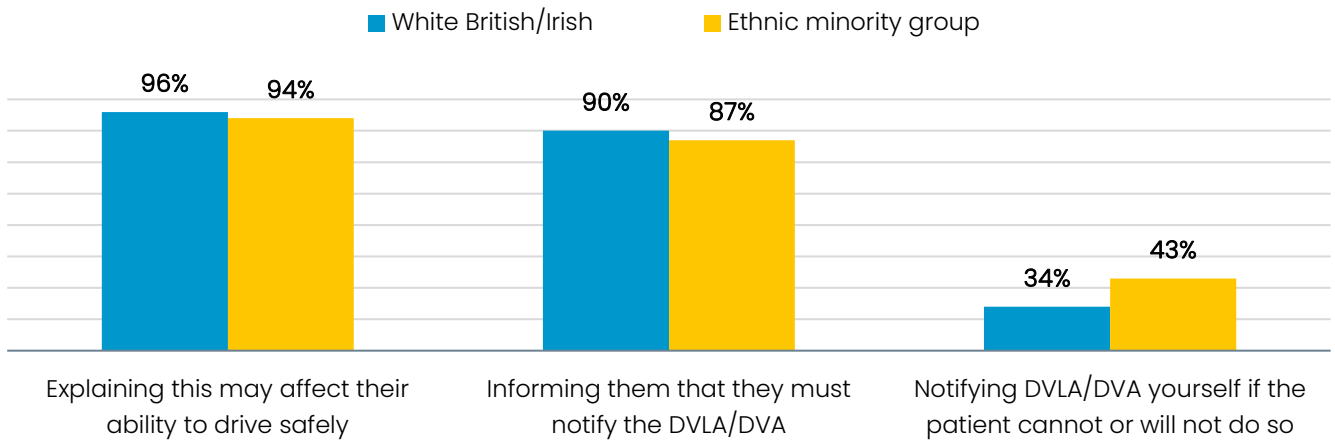


Some differences in comfort levels are evident by ethnicity

There were some differences by ethnicity. White British/Irish respondents were slightly more likely than those from minority ethnic backgrounds to feel comfortable explaining that a patient's eyesight may affect their ability to drive safely (96% vs 94%) and informing patients that they must notify the DVLA/DVA (90% vs 87%). However, the pattern reversed for notifying the DVLA/DVA directly if a patient could not or would not do so, where respondents from minority ethnic backgrounds were more likely to feel comfortable (43% vs 34%). This may partly reflect differences in the profile of respondents within each group, length of registration, role or workplace setting.

Figure 87 – Comfort taking action if a patient does not meet the eyesight standards outlined in DVLA/DVA guidance by ethnicity

Base: White British/Irish (1,827-1,856); Ethnic minoriry group (1,209-1,232)



Confidentiality, conflict, and unclear cases are the main barriers to notifying the DVLA/DVA

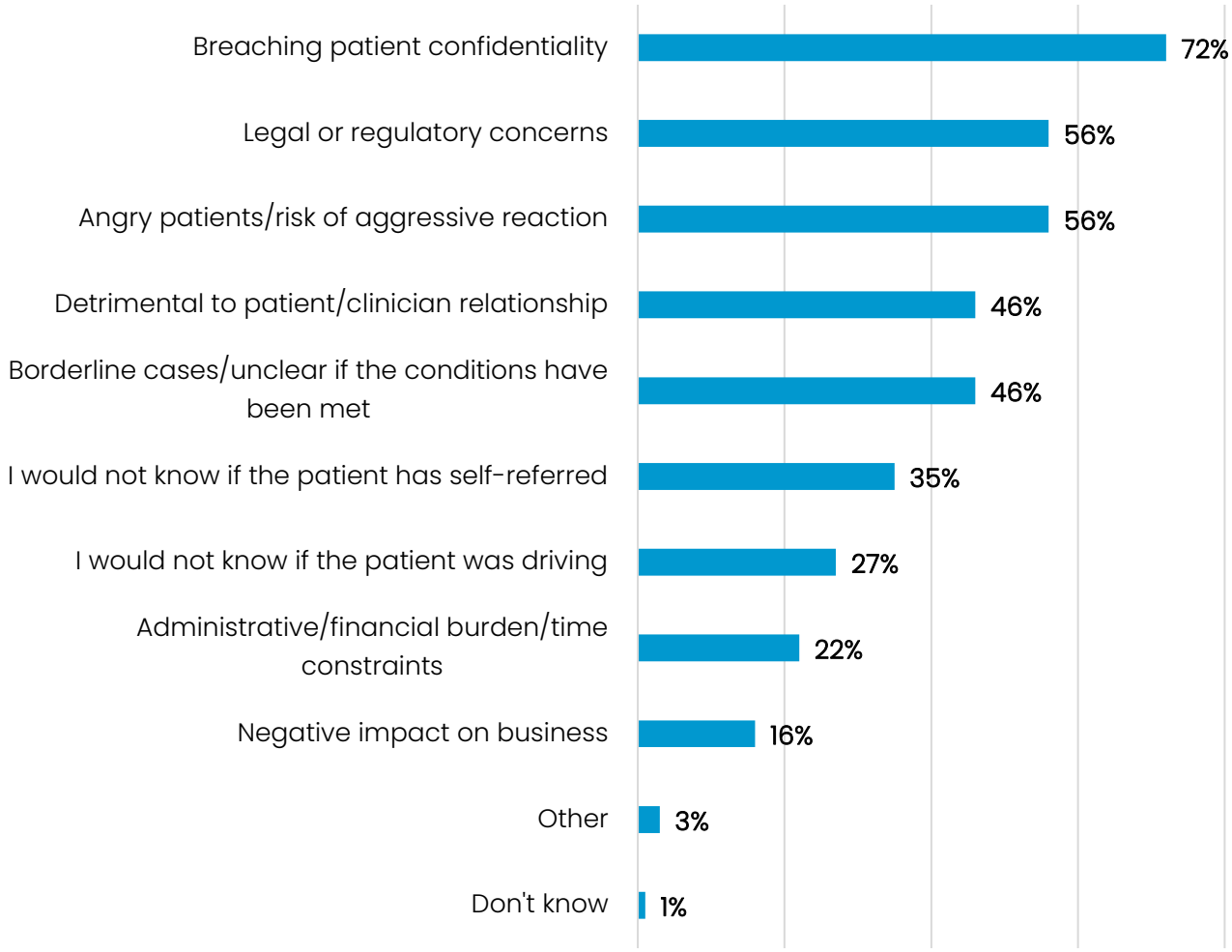
Among respondents who said they would feel uncomfortable notifying the DVLA/DVA directly, concerns were most commonly related to professional judgement, confidentiality and the potential consequences of taking action.

The most frequently cited reasons were breaching patient confidentiality (72%), legal or regulatory concerns (56%), angry patients or the risk of an aggressive reaction (56%), and damage to the patient/clinician relationship (46%). A similar proportion (46%) pointed to borderline cases where it may be unclear whether the relevant conditions had been met.

Practical uncertainties were also noted by some, including not knowing whether the patient had self-referred (35%) or was driving (27%), while fewer cited administrative burden (22%) or negative business impact (16%).

Figure 88 – Reasons for feeling uncomfortable notifying the DVLA/DVA if a patient does not meet the eyesight standards

Base: Those who felt uncomfortable notiying the DVLA/DVA (1,925)



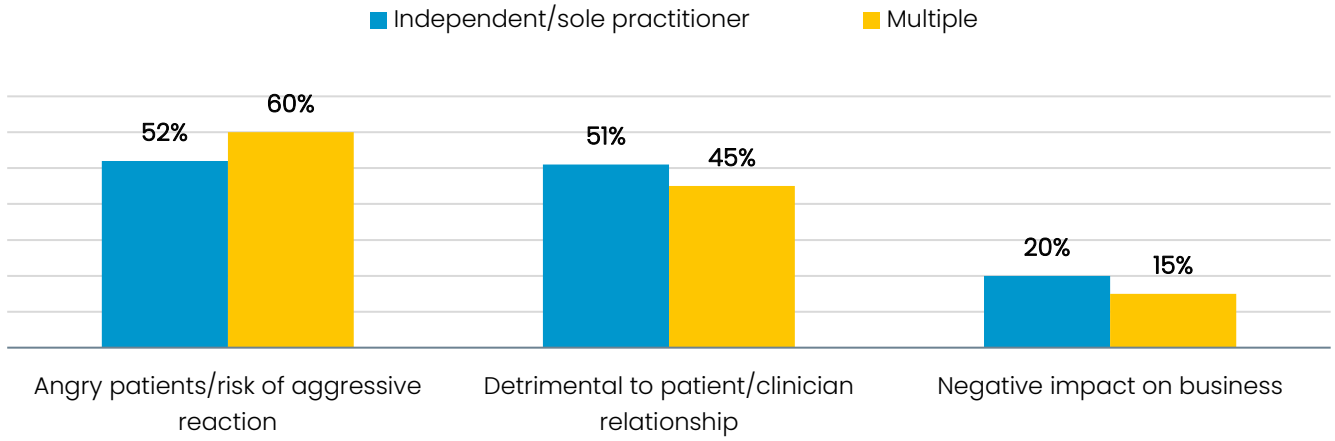
Free-text 'other' responses (3%) most commonly related to uncertainty about the reporting process or professional responsibility, alongside concerns about confidentiality, patient wellbeing, and the lack of clear guidance or feedback from the DVLA/DVA.

Concerns about notifying the DVLA/DVA differ between multiples and independent practices

Respondents working in multiple/chain opticians were more likely to cite angry patients or the risk of an aggressive reaction as a source of discomfort when notifying the DVLA/DVA when compared to those working in independent opticians (60% vs 52%). In contrast, those working in independent settings were more likely to mention a detrimental impact on the patient/clinician relationship (51% vs 45%) and a negative impact on the business (20% vs 15%). These results may reflect differences in patient relationships and commercial context between the two settings.

Figure 89 – Reasons for feeling uncomfortable notifying the DVLA/DVA if a patient does not meet the eyesight standards by workplace setting

Base: Independent/sole practitioner (715); Multiple (1,027)



Experience changes the nature of concerns about notifying the DVLA/DVA

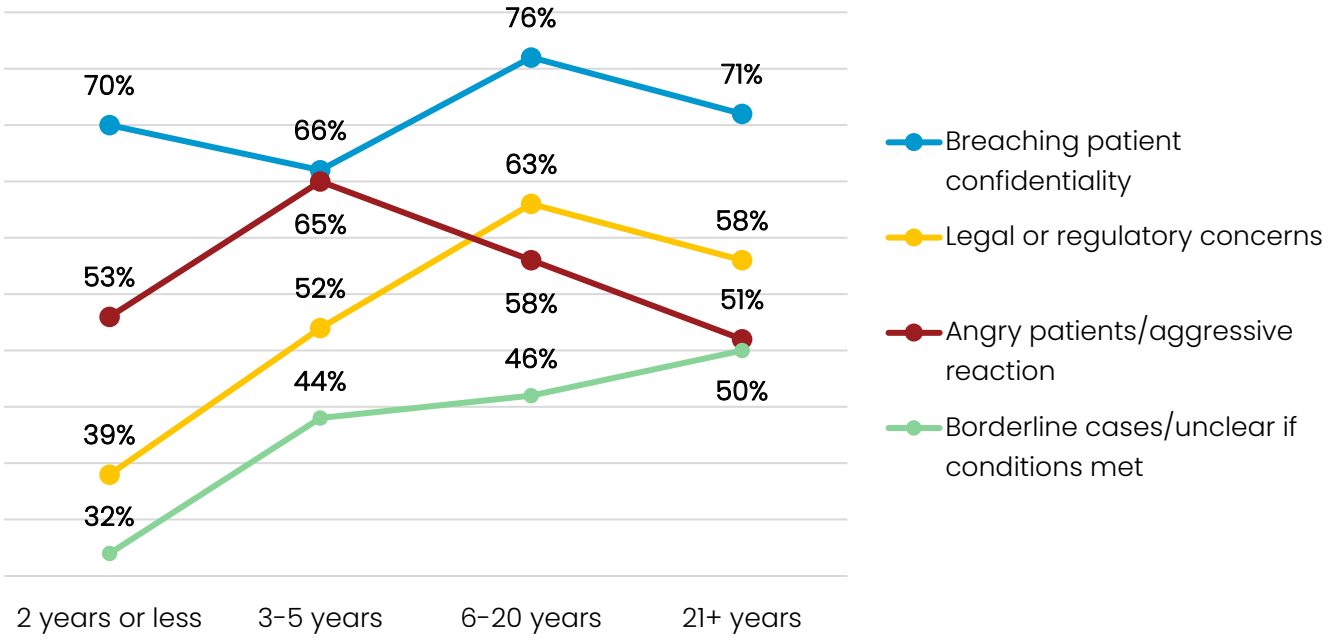
Legal or regulatory concerns are more common among longer-registered respondents, rising from 39% among those registered for two years or less to 63% among those registered for 6–20 years, suggesting greater awareness of the professional complexities involved. Concerns about borderline or unclear cases also increased steadily with experience (32% to 50%), indicating that more experienced registrants may be more conscious of the challenges involved in making finely balanced judgements.

By contrast, concern about angry patients or aggressive reactions was highest among those registered for 3–5 years (65%) and lower among both the least and most experienced groups (53% and 51% respectively).

Concerns about breaching patient confidentiality were consistently high across all experience levels, ranging from 66% to 76%.

Figure 90 – Reasons for feeling uncomfortable notifying the DVLA/DVA if a patient does not meet the eyesight standards by length of registration

Base: <2 years (226); 3-5 years (232); 6-20 years (646); 21+ years (807)



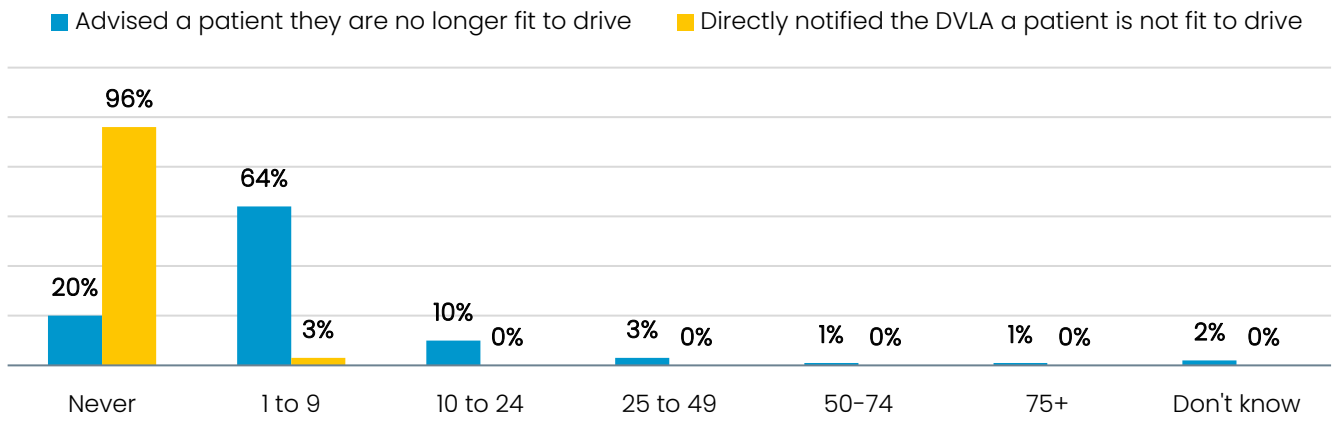
Advising patients Is common, direct DVLA/DVA notification is rare

Advising patients that they are no longer fit to drive was a relatively common experience for many respondents over the last 12 months. Four in five (78%) had done this at least once, with most doing so between one and nine times (64%) and 14% who had done so 10 or more times. In contrast, directly notifying the DVLA/DVA was rare, with almost all respondents (96%) never having done so. Only 3% had done so between one and nine times.

This suggests that discussing fitness to drive with patients forms a routine part of practice for many registrants, whereas direct notification to the DVLA/DVA is uncommon and likely limited to a small number of more serious cases.

Figure 91 – Frequency of advising a patient they are no longer fit to drive / directly notifying the DVLA a patient is not fit to drive over the last 12 months

Base: All respondents excluding those who answered 'not applicable' (3,137 / 3,110)



Role, experience, and setting shape exposure to advising patients

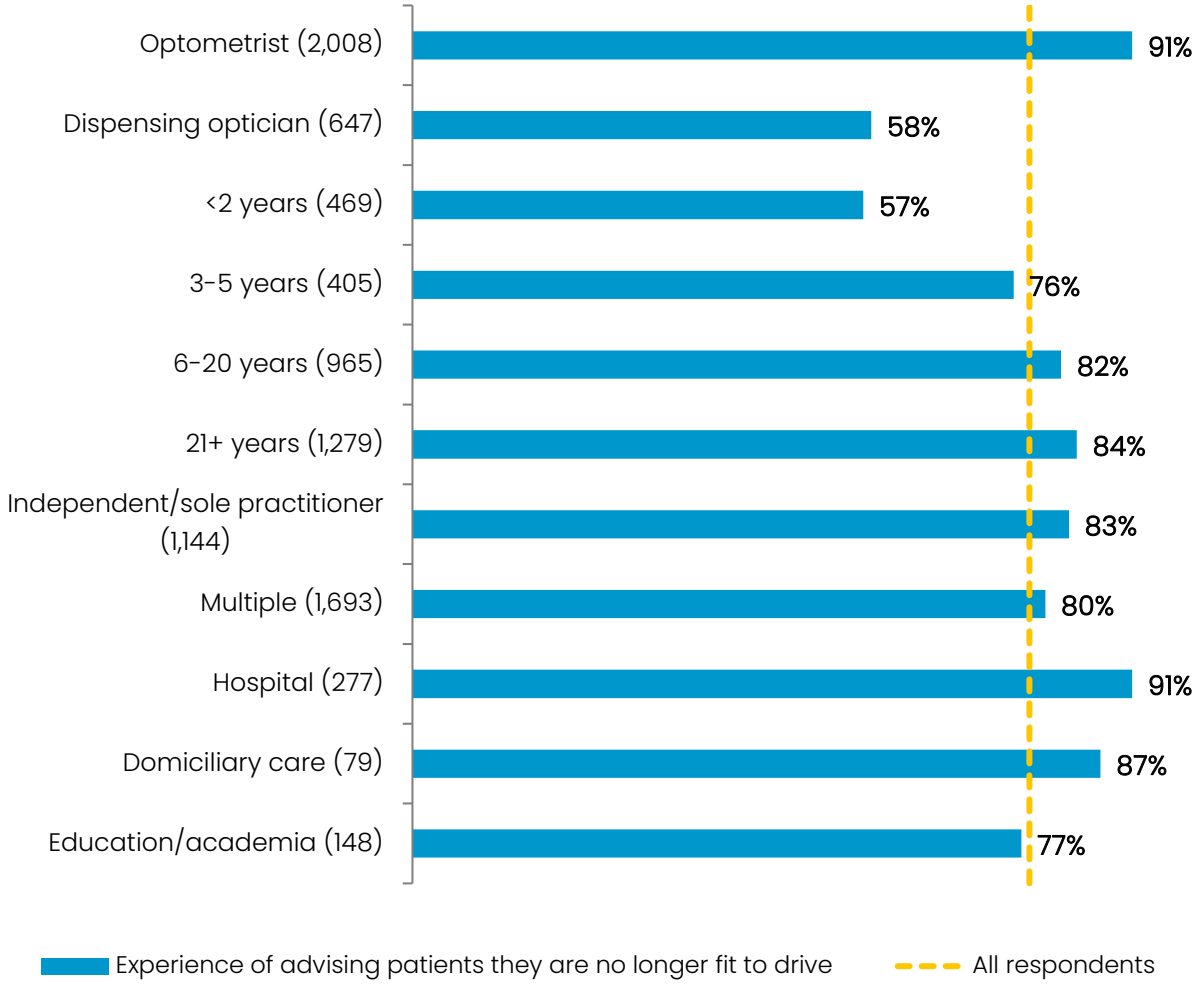
Experience of advising patients they are no longer fit to drive varied notably by role, experience, and workplace setting. Optometrists were substantially more likely than dispensing opticians to have done so in the last 12 months (91% vs 58%), reflecting differences in clinical responsibilities and patient contact.

There was also a clear relationship with time on the register, with just over half of those registered for less than two years (57%) having advised a patient at least once, rising to 76% among those registered for 3–5 years, 82% for those registered for 6–20 years and 84% for those registered for 21+ years.

By workplace setting, respondents working in hospitals (91%) and domiciliary care (87%) were most likely to have had these discussions, followed by independent/sole practitioners (83%) and those working in multiples (80%). Those in education/academia were least likely among the settings shown (77%), likely reflecting less frequent direct patient contact.

Figure 92 – Experience of advising patients they are no longer fit to drive by registration type and workplace setting

Base: All respondents excluding those who answered 'not applicable' (shown in chart)



In contrast, experience of direct reporting to the DVLA/DVA is exceptional across the profession, not concentrated in one segment.

Appendix A – Questionnaire

Workforce & Perceptions Survey 2026

Welcome to the General Optical Council (GOC)'s Workforce and Perceptions Survey 2026.

The survey should take around 10 minutes to complete, and by taking part you can be entered into a prize draw to win a **£250 online gift card**.

Completing the survey

To navigate through this questionnaire, use the arrow buttons at the bottom of each page. DO NOT use the back/forward options in your browser. To remove your answers to a question, click the reset button.

If you do not have time to complete the survey in one sitting, your progress will be automatically saved and you can return to where you left off at any point by clicking on the survey link again in your email invitation, or the 'save' button at the bottom of the page.

The GOC has appointed Enventure Research to conduct this survey so that your responses remain confidential. For more information about this survey, please visit the Enventure Research website.

If you have any questions about this survey, please call the Enventure Research survey helpline on 0800 0092 117 or email helpline@enventure.co.uk

Your role

The first set of questions are about your role and where you work.

Q1 **Please tell us which of the following roles apply to you (if you are retired, please select the most appropriate role before you retired)** *Please select as many as apply*

- ❑ Optometrist
- ❑ Optometrist with an independent prescribing specialty (including additional supply and supplementary prescribing)
- ❑ Dispensing optician
- ❑ Dispensing optician with a contact lens specialty
- ❑ Student optometrist
- ❑ Student optometrist undertaking the pre-registration scheme
- ❑ Student dispensing optician

Q2 **Which of these best describes your current working status?** *Please select as many as apply*

- ❑ Working / employed (including full/part-time and locum work, and temporarily away from work e.g. parental leave/extended sick leave etc.)
- ❑ Not working / unemployed
- ❑ Fully retired
- ❑ Student / in education

Q3 **Please select which of these best describes your current role** Asked if Q1=Optom/DO and Q2=Working/employed

- ❑ No managerial responsibility
- ❑ Some management responsibilities and/or supervision role
- ❑ Responsible for managing or running the practice
- ❑ Director
- ❑ CEO or equivalent

Q4 **Do you work as a locum?** Asked if Q2=Working/employed

- ❑ Yes
- ❑ No

Q5 **Where do you currently work?** *Please select all that apply* Asked if Q2=Working/employed

- ❑ Independent practice
- ❑ Sole practitioner
- ❑ National chain of opticians (e.g. UK-wide chain of opticians)
- ❑ Regional chain of opticians (e.g. chain of opticians working within one region in the UK)
- ❑ Hospital
- ❑ Domiciliary care
- ❑ Education/academia
- ❑ Other

Other *Please specify*

_____

_____

Q6 **For each location selected, please state how many days on average per week you work there** *Please type in the boxes below - please use whole or half days only e.g. 1, 1.5* Each row asked based on answer at Q5

Independent practice _____

Sole practitioner _____

National chain of opticians _____

Regional chain of opticians _____

Hospital _____

Domiciliary care _____

Education/academia _____

Other _____

Q7 **In the last 12 months, have you worked in a role supervising pre-registration trainees?** Asked if Q1=Optometrist/DO and Q2=Working/employed

- ❑ Yes
- ❑ No

Q8 **Are you currently involved in delivering enhanced eye care services (e.g. providing patients with care beyond the remit of a routine sight test, such as Minor Eye Conditions Service (MECS), NHS Community Glaucoma Service or Anterior Eye Service (Scotland), Low Vision Service Wales, or NI PEARS (Northern Ireland))?** Asked if Q2=Working/employed

- ❑ Yes
- ❑ No
- ❑ I am not aware of these services
- ❑ Don't know

Q9 **Do you have any of the following additional qualifications?** *Please select all that apply* Not asked to those who are students only

- ❑ No additional qualifications
- ❑ Glaucoma
- ❑ Medical retina

- ❑ Paediatric eye care
- ❑ Low vision
- ❑ Contact lens practice
- ❑ Contact lens diploma
- ❑ Spectacle lens design
- ❑ Refraction
- ❑ Ophthalmic dispensing
- ❑ Other

Other *Please specify*

_____

_____

Q10 **Approximately how long have you been on the GOC register?**

- ❑ Less than 1 year
- ❑ 1 to 2 years
- ❑ 3 to 5 years
- ❑ 6 to 10 years
- ❑ 11 to 15 years
- ❑ 16 to 20 years
- ❑ 21 years and over
- ❑ Don't know

Your career

The GOC would like to find out a bit more about satisfaction levels and career prospects in the professions. All questions in this section only asked if Q2=Working/employed

Q11 **Thinking about the last 12 months, to what extent are you satisfied or dissatisfied with your role/job?**

- ❑ Very satisfied
- ❑ Quite satisfied
- ❑ Neither satisfied or dissatisfied
- ❑ Quite dissatisfied
- ❑ Very dissatisfied
- ❑ Not applicable

Q12 **Are you considering making any of the following changes to your career over the next 12-24 months?** *Please select all that apply*

- ❑ Gain additional qualifications/skills
- ❑ Switch to locum work
- ❑ Reduce your hours
- ❑ Leave the profession
- ❑ Take a career break
- ❑ Retire
- ❑ Other
- ❑ None of the above

Other *Please specify*

_____

_____

Q13 **In what areas are you interested in gaining additional qualifications/skills?** *Please select all that apply* Asked if Q12=Gain additional qualifications/skills

- ❑ Independent prescribing (including additional supply and supplementary prescribing)
- ❑ Contact lens specialty
- ❑ Contact lens practice
- ❑ Moving to optometry

- ❑ Glaucoma
- ❑ Medical retina
- ❑ Paediatric eye care
- ❑ Low vision
- ❑ Spectacle lens design
- ❑ Refraction
- ❑ Ophthalmic dispensing
- ❑ Other
- ❑ Don't know

Other *Please specify*

_____

_____

Workplace pressure

Q14 **In the last 12 months, have you experienced any of the following?** Asked if Q2=Working/employed

	Never	Rarely	Sometimes	Frequently
Working beyond your hours	❑	❑	❑	❑
Feeling unable to cope with workload	❑	❑	❑	❑
Taking leave of absence due to stress	❑	❑	❑	❑
Finding it difficult to provide patients with the sufficient level of care they need	❑	❑	❑	❑

Q15 **In the last 12 months, have you experienced any of the following?** Asked if Q2=Working/employed

	Never	Rarely	Sometimes	Frequently
The standard time allocated to me for conducting a sight test has been insufficient to provide safe patient care Shown for optoms/student optoms only	❑	❑	❑	❑
I have felt under pressure to see a high number of patients every day which has impacted on my ability to provide safe patient care	❑	❑	❑	❑
I have been asked to overbook clinics	❑	❑	❑	❑
I have felt under pressure to sell certain types of glasses or contact lenses that will earn more money for the business	❑	❑	❑	❑
I have felt under pressure to sell a product or provide a service which I considered was not needed by the patient	❑	❑	❑	❑
I have felt under pressure to meet commercial targets at the expense of patient care	❑	❑	❑	❑

Q16 **When you experienced pressure of this kind, what did you do?** *Please select all that apply* Asked if rarely/sometimes/frequently for any at Q15

- ❑ Reported it to my line manager / supervisor
- ❑ Reported it to senior management or a practice manager
- ❑ Raised concerns informally with colleagues

- ❑ Raised concerns through a formal process (e.g. whistleblowing, HR, regulatory body)
- ❑ Did nothing
- ❑ Other
- ❑ Prefer not to say

Other *Please specify*

_____

_____

Q17 **How confident are you in your ability to resist commercial pressures that you believe could compromise patient care?** Asked to all except retired

- ❑ Very confident
- ❑ Quite confident
- ❑ Not very confident
- ❑ Not confident at all
- ❑ Don't know

Q18 **How well did your education and training equip you to manage commercial pressures while maintaining safe patient care?** Asked to fully qualified optoms/DOs excluding retired

- ❑ Very well
- ❑ Quite well
- ❑ Not very well
- ❑ Not at all well
- ❑ Don't know

Q19 **What one commercial practice are you most concerned about in terms of its potential impact on patient care?** Asked to all except retired

Please summarise your one suggestion in the box below

_____

_____

_____

Speaking up

Questions in this section asked to all but those who are fully retired

Q20 **How comfortable would you feel speaking up about patient safety concerning <u>an individual GOC registrant</u> with the following...**

	Very comfortable	Quite comfortable	Not very comfortable	Not comfortable at all	Don't know	Not applicable
Your manager / tutor?	❑	❑	❑	❑	❑	❑
Your employer / education provider?	❑	❑	❑	❑	❑	❑
Your professional association / representative body?	❑	❑	❑	❑	❑	❑
The GOC?	❑	❑	❑	❑	❑	❑

Q21 **Why wouldn't you feel comfortable speaking up?** *Please select all that apply* Asked if Q20=Not very comfortable/Not comfortable at all

- ❑ I might jeopardise my job
- ❑ I don't believe that corrective action would be taken
- ❑ I might alienate myself from my colleagues
- ❑ It's none of my business

- ❑ I wouldn't want to be seen as a troublemaker by management
- ❑ I would assume they already knew about it
- ❑ I wouldn't know who to contact
- ❑ Other
- ❑ Prefer not to say
- ❑ Don't know

Other *Please specify*

_____

_____

Q22 **How comfortable would you feel speaking up about patient safety concerning <u>your employer</u> with the following...**

	Very comfortable	Quite comfortable	Not very comfortable	Not comfortable at all	Don't know	Not applicable
Your manager / tutor?	❑	❑	❑	❑	❑	❑
Your employer / education provider?	❑	❑	❑	❑	❑	❑
Your professional association / representative body?	❑	❑	❑	❑	❑	❑
The GOC?	❑	❑	❑	❑	❑	❑

Q23 **Why wouldn't you feel comfortable speaking up?** *Please select all that apply* Asked if Q22=Not very comfortable/Not comfortable at all

- ❑ I might jeopardise my job
- ❑ I don't believe that corrective action would be taken
- ❑ I might alienate myself from my colleagues
- ❑ It's none of my business
- ❑ I wouldn't want to be seen as a troublemaker by management
- ❑ I would assume they already knew about it
- ❑ I wouldn't know who to contact
- ❑ Other
- ❑ Prefer not to say
- ❑ Don't know

Other *Please specify*

_____

_____

Harassment, bullying or abuse

Questions in this section exclude fully retired

Q24 **In the last 12 months, how many times have you personally experienced harassment, bullying or abuse at work (or study) from...?**

	Never	1 to 2	3 to 5	6 to 10	More than 10
Patients / service users, their relatives or other members of the public	❑	❑	❑	❑	❑
Managers	❑	❑	❑	❑	❑
Other colleagues	❑	❑	❑	❑	❑
Tutors / lecturers / supervisors (option displays for students only)	❑	❑	❑	❑	❑

Q25 **Was the harassment, bullying or abuse you experienced ever related to any of the following?** *Please select all that apply* Asked if Q24=1 or more for any option

- ❑ Age
- ❑ Disability
- ❑ Gender reassignment
- ❑ Marriage or civil partnership
- ❑ Pregnancy and maternity
- ❑ Race
- ❑ Religion or belief
- ❑ Sex
- ❑ Sexual orientation
- ❑ Other
- ❑ None of the above

Other *Please specify*

Q26 **The last time you experienced harassment, bullying or abuse at work (or study), did you or a colleague report it?** Asked if Q24=1 or more for any option

- ❑ Yes, I reported it
- ❑ Yes, a colleague reported it
- ❑ No
- ❑ Don't know
- ❑ Not applicable

Discrimination

Questions in this section exclude fully retired

Q27 **In the last 12 months, how many times have you personally experienced any discrimination in your role at work (or study) from...?**

	Never	1 to 2	3 to 5	6 to 10	More than 10
Patients / service users, their relatives or other members of the public	❑	❑	❑	❑	❑
Managers	❑	❑	❑	❑	❑
Other colleagues	❑	❑	❑	❑	❑
Tutors / lecturers / supervisors (option displays for students only)	❑	❑	❑	❑	❑

Q28 **What type of discrimination have you experienced?** *Please select all that apply* Asked if Q27=1 or more for any option

- ❑ Age
- ❑ Disability
- ❑ Gender reassignment
- ❑ Marriage or civil partnership
- ❑ Pregnancy and maternity
- ❑ Race
- ❑ Religion or belief
- ❑ Sex
- ❑ Sexual orientation
- ❑ Other

Other *Please specify*

Q29 **The last time you experienced discrimination at work (or study), did you or a colleague report it?** Asked if Q27 =1 or more for any option

- ❑ Yes, I reported it
- ❑ Yes, a colleague reported it
- ❑ No
- ❑ Don't know
- ❑ Not applicable

Continuing Professional Development (CPD)

Q30 **Within this CPD cycle (1 January 2025 to 31 December 2027), have you attended any CPD (provider-led or self-directed) to learn about any of the following topics?** Asked to all except students

	Yes	No	Plan to attend
Addressing bullying, harassment and discrimination in the workplace	❑	❑	❑
Health disparities and health inequalities	❑	❑	❑
Exploring your own personal biases and biases of others	❑	❑	❑
Speaking up (whistleblowing)	❑	❑	❑
Artificial intelligence	❑	❑	❑
Other aspects of equality, diversity, and inclusion (EDI)	❑	❑	❑

Artificial intelligence (AI)

Q31 **How would you describe your knowledge and understanding of artificial intelligence (AI) in relation to optical care and professional practice?**

- ❑ Very good
- ❑ Good
- ❑ Poor
- ❑ Very poor

Q32 **Over the last 12 months, either in your professional practice or studies, have you received CPD or training about AI?**

- ❑ Yes
- ❑ No

Q33 **During your professional practice, are you currently using AI to assist with any of the following activities?** *Please select all that apply* Asked to those currently working/employed

- ❑ Booking and managing appointments
- ❑ Chatbots to support engagement with patients
- ❑ Taking notes/summarising patient consultations
- ❑ Helping to maintain knowledge and skills
- ❑ Interpreting scans or results
- ❑ Supporting diagnosis of conditions
- ❑ Managing treatment of conditions
- ❑ Writing patient correspondence
- ❑ Spectacle ordering and supplier systems
- ❑ Frame and lens recommendations
- ❑ Dispensing/contact lens calculations
- ❑ Pre-screening, e.g. to analyse questionnaires completed by patients before attending their sight test appointment
- ❑ Practice management, e.g. business analytics, workforce planning
- ❑ None of the above
- ❑ Don’t know

Q34 **How concerned, if at all, are you about the following aspects of AI use in eye care?**

	Very concerned	Fairly concerned	Not very concerned	Not at all concerned	Don't know
My ability to challenge/disagree with the recommendations of an AI system	❑	❑	❑	❑	❑
Bias towards certain patient groups	❑	❑	❑	❑	❑
The AI making errors	❑	❑	❑	❑	❑
Lack of transparency in how AI systems make decisions	❑	❑	❑	❑	❑
Data security and patient confidentiality	❑	❑	❑	❑	❑
Impact on the clinician-patient relationship	❑	❑	❑	❑	❑
My legal responsibility if something goes wrong	❑	❑	❑	❑	❑
Obtaining informed patient consent	❑	❑	❑	❑	❑
AI over time will replace my role in some areas	❑	❑	❑	❑	❑
Environmental impact	❑	❑	❑	❑	❑

Q35 **On balance, which of the following statements best describes how you feel about the impact of AI on the quality of eye care?**

- ❑ AI is likely to improve the quality of eye care
- ❑ AI is unlikely to improve the quality of eye care
- ❑ AI is likely to reduce the quality of eye care
- ❑ Don’t know

Driving vision

Q36 **In the last 12 months, how often have you discussed the impact of a patient’s vision or eye condition on their ability to drive?**

- ❑ Daily
- ❑ Weekly
- ❑ Monthly
- ❑ Rarely
- ❑ Never
- ❑ Not applicable

Q37 **When discussing the impact of vision or eye conditions on driving, which age groups do you commonly raise this with?** *Please select all that apply* Asked if Q36=Rarely to daily

- ❑ Under 40
- ❑ 40-49
- ❑ 50-59
- ❑ 60-69
- ❑ 70-79
- ❑ 80+
- ❑ Don't know

Q38 **If a patient does not meet the eyesight standards outlined in DVLA/DVA guidance, how comfortable would you feel about the following?**

	Very comfortable	Quite comfortable	Not very comfortable	Not comfortable at all	Don't know	Not applicable
Explaining this may affect their ability to drive safely	❑	❑	❑	❑	❑	❑
Informing them that they must notify DVLA/DVA	❑	❑	❑	❑	❑	❑
Notifying DVLA/DVA yourself if the patient cannot or will not do so	❑	❑	❑	❑	❑	❑

Q39 **What would make you feel uncomfortable about notifying the DVLA/DVA in this situation?** *Please select all that apply* Asked if Q382c=Not very comfortable/not at all comfortable

- ❑ Breaching patient confidentiality
- ❑ Legal or regulatory concerns
- ❑ Detrimental to patient/clinician relationship
- ❑ Angry patients/risk of aggressive reaction
- ❑ I would not know if the patient was driving
- ❑ I would not know if the patient has self-referred
- ❑ Negative impact on business
- ❑ Administrative/financial burden/time constraints
- ❑ Borderline cases/unclear if the conditions have been met
- ❑ Other
- ❑ Don't know

Q40 **Over the last 12 months, approximately how many times have you:**

	Never	1-9	10-24	25-49	50-74	75-99	100+	Don't know	Not applicable
Advised a patient they are no longer fit to drive	❑	❑	❑	❑	❑	❑	❑	❑	❑
Directly notified the DVLA a patient is not fit to drive	❑	❑	❑	❑	❑	❑	❑	❑	❑

About you

The GOC is deeply committed to promoting equality, valuing diversity and being inclusive in all its work as a health professions regulator, and to making sure we meet our equality duties. The following questions relate to our equality and diversity work and add to our understanding of the diversity of the optical profession, so that we can make sure our services and events reflect this diversity. They will also allow any differences in results between different groups to be highlighted.

Please remember you will not be individually identified in your survey response, and **you can answer prefer not to say if you wish to each question**.

Sex, gender and orientation

Q41 **What is your sex, as recorded at birth?**

- ❑ Female
- ❑ Male
- ❑ My own description
- ❑ Prefer not to say

Please share your self-description

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Q42 **Which of these best describes your Gender Identity?**

- ❑ Man/Male
- ❑ Woman/Female
- ❑ Non-Binary
- ❑ Gender Fluid
- ❑ Questioning
- ❑ My own description
- ❑ Prefer not to say

Please share your self-description

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Q43 **Are you intersex and/or have a variation of sex characteristics (VSC)?**

- ❑ Yes
- ❑ No
- ❑ Prefer not to say

Q44 **Are you trans, or do you have a trans history?**

- ❑ Yes
- ❑ No
- ❑ Prefer not to say

Q45 **Which of the following best describes your sexuality?**

- ❑ Asexual
- ❑ Bisexual
- ❑ Gay/Lesbian
- ❑ Heterosexual/Straight
- ❑ My own description
- ❑ Prefer not to say

Please share your self-description

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Age and relationship status

Q46 **What is your age?**

- ❑ Under 25
- ❑ 25 - 34
- ❑ 35 - 44
- ❑ 45 - 54
- ❑ 55 - 64
- ❑ 65 +
- ❑ Prefer not to say

Q47 **Are you currently:**

- ❑ Co-habiting or living with a partner
- ❑ Married or in a civil partnership
- ❑ Separated, divorced or civil partnership dissolved
- ❑ Single
- ❑ Widowed or a surviving partner from a civil partnership

- ❑ My own description
- ❑ Prefer not to say

Please share your self-description

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Ethnic background

Q48 **What is your ethnicity?**

- ❑ Asian/Asian British - Bangladeshi / Bangladeshi British
- ❑ Asian/Asian British - Chinese / Chinese British
- ❑ Asian/Asian British - Indian / Indian British
- ❑ Asian/Asian British - Pakistani / Pakistani British
- ❑ Asian/Asian British - Any other Asian background
- ❑ Black/Black British - African / African British
- ❑ Black/Black British - Caribbean / Caribbean British
- ❑ Black/Black British - Any other Black background
- ❑ Mixed/Multiple Ethnic Group - White and Asian
- ❑ Mixed/Multiple Ethnic Group - White and Black African
- ❑ Mixed/Multiple Ethnic Group - White and Black Caribbean
- ❑ Mixed/Multiple Ethnic Group - Any other mixed / multiple ethnic background
- ❑ Other ethnic group - Arab / Arab British
- ❑ Other ethnic group - Any other ethnic group
- ❑ White - English / Welsh / Scottish / Northern Irish / British
- ❑ White - Irish
- ❑ White - Gypsy or Irish Traveller
- ❑ White - Roma
- ❑ White - Any other white background
- ❑ Prefer not to say

Please share your self-description

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Disability, health and neurodiversity

Q49 **Do you have any physical or mental health conditions or illnesses lasting or expected to last 12 months or more?**

- ❑ Yes
- ❑ No
- ❑ Prefer not to say

Q50 **Do any of your conditions or illnesses reduce your ability to carry out day-to-day activities?** Asked if Q49=Yes

- ❑ Yes, a lot
- ❑ Yes, a little
- ❑ Not at all

Q51 **How would you categorise your disability/disabilities?** *Please select all that apply* Asked if Q49=Yes

- ❑ Physical impairment (e.g. mobility, sensory, chronic pain)
- ❑ Long-term health condition (e.g. diabetes, heart disease)
- ❑ Neurodivergent condition (e.g. ADHD, autism, dyslexia)
- ❑ Mental health condition (e.g. depression, anxiety)
- ❑ Cognitive or memory difficulty (e.g. dementia, brain injury)
- ❑ Hidden or invisible condition (e.g. chronic fatigue, fibromyalgia)

- ❑ My own description
- ❑ Prefer not to say

Please share your self-description

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Religion or belief

Q52 **What is your religion or belief?**

- ❑ No religion or belief
- ❑ Buddhist
- ❑ Christian (including Church of England, Catholic, Protestant and all other Christian denominations)
- ❑ Hindu
- ❑ Jewish
- ❑ Muslim
- ❑ Sikh
- ❑ Any other religion
- ❑ Prefer not to say

Please share your self-description

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Caring and family responsibilities

Q53 **Do you have any unpaid caring responsibilities for a child/children and/or another adult(s)?**

- ❑ Yes
- ❑ No
- ❑ Prefer not to say

Q54 **If yes, please select all that apply** Asked if Q53=Yes

- ❑ For a child/children
- ❑ For an adult
- ❑ Prefer not to say

Q55 **Are you pregnant, on parental leave, or recently returned from parental leave?**

- ❑ Yes
- ❑ No
- ❑ Prefer not to say

Language and communication

Q56 **What is your main language?**

- ❑ English
- ❑ Other (including sign languages)
- ❑ Prefer not to say

Please share your other language

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Q57 **Do you speak any additional languages fluently (including sign languages)?**

- ❑ Yes
- ❑ No
- ❑ Prefer not to say

Socio-economic background

Q58 **What was the occupation of your main household earner when you were aged about 14?**

- ❑ **Modern professional and traditional professional occupations** such as teacher, nurse, physiotherapist, social worker, musician, police officer (sergeant or above), software designer, accountant, solicitor, medical practitioner, scientist, civil engineer or mechanical engineer
- ❑ **Senior, middle or junior managers or administrators** such as finance manager, chief executive, large business owner, office manager, retail manager, bank manager, restaurant manager, warehouse manager
- ❑ **Clerical and intermediate occupations** such as secretary, personal assistant, call centre agent, clerical worker, nursery nurse
- ❑ **Technical and craft occupations** such as motor mechanic, plumber, printer, electrician, gardener, train driver
- ❑ **Routine, semi-routine manual and service occupations** such as postal worker, machine operative, security guard, caretaker, farm worker, catering assistant, sales assistant, HGV driver, cleaner, porter, packer, labourer, waiter or waitress, bar staff
- ❑ **Long-term unemployed** (claimed Jobseeker's Allowance or earlier unemployment benefit for more than a year)
- ❑ **Small business owners** who employed fewer than 20 people such as corner shop owners, small plumbing companies, retail shop owner, single restaurant or cafe owner, taxi owner, garage owner
- ❑ **Other** such as retired, this question does not apply to me, I don't know
- ❑ Prefer not to say

Q59 **Which type of school did you attend for the most time between the ages of 11 and 16?**

- ❑ State-run or state-funded school
- ❑ Independent or fee-paying school
- ❑ Independent or fee-paying school, where I received a means-tested bursary covering 90% or more of the overall cost of attending throughout my time there
- ❑ Attended school outside the UK
- ❑ Don't know
- ❑ Prefer not to say

Q60 **If you finished school after 1980, were you eligible for free school meals at any point during your school years?**

- ❑ Yes
- ❑ No
- ❑ Not applicable (finished school before 1980 or went to school overseas)
- ❑ Don't know
- ❑ Prefer not to say

Q61 **Which region does your main residence fall within?**

- ❑ North East
- ❑ North West
- ❑ Yorkshire and Humber
- ❑ East Midlands
- ❑ West Midlands
- ❑ East of England
- ❑ London
- ❑ South East
- ❑ South West
- ❑ Wales
- ❑ Scotland
- ❑ Northern Ireland
- ❑ Other
- ❑ Prefer not to say

Please share your other

_____

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Prize draw

As a thank you for your time today, we are offering you the opportunity to enter our prize draw to win a £250 gift card that can be used at a range of outlets or donated to charity. The winner will be randomly selected when the survey closes. Full terms and conditions of the prize draw can be found here.

Q62 **Do you want to be entered into our prize draw?**
By answering yes you are agreeing to be contacted by Enventure Research via your GOC-registered email address if you are selected as the winner.

- ❑ Yes
- ❑ No

Thank you for taking the time to take part in this survey. Your views are greatly appreciated.

Please click the tick button below to send your response.

Appendix B – Demographic profile

Demographic profile of survey respondents
Base: All respondents (3,451)

Demographic	Number	Percentage
What is your sex, as recorded at birth?		
Female	2,153	62%
Male	1,090	32%
My own description	3	0%
Prefer not to say	206	6%
Which of these best describes your Gender Identity?		
Man/Male	1,080	31%
Woman/Female	2,131	62%
Non-Binary	11	0%
Gender Fluid	2	0%
Questioning	1	0%
My own description	4	0%
Prefer not to say	223	6%
Are you intersex and/or have a variation of sex characteristics (VSC)?		
Yes	11	0%
No	3,160	92%
Prefer not to say	280	8%
Are you trans, or do you have a trans history?		
Yes	18	1%
No	3,188	92%
Prefer not to say	245	7%
Which of the following best describes your sexuality?		
Asexual	50	1%
Bisexual	95	3%
Gay/Lesbian	68	2%
Heterosexual/Straight	2,852	83%
My own description	10	0%
Prefer not to say	375	11%
What is your age?		
Under 25	450	13%
25 - 34	672	19%
35 - 44	742	22%
45 - 54	665	19%
55 - 64	571	17%
65 +	183	5%
Prefer not to say	168	5%
Are you currently:		
Co-habiting or living with a partner	413	12%
Married or in a civil partnership	1,809	52%

Demographic	Number	Percentage
Separated, divorced or civil partnership dissolved	134	4%
Single	755	22%
Widowed or a surviving partner from a civil partnership	21	1%
My own description	20	1%
Prefer not to say	299	9%
What is your ethnicity?		
Asian/Asian British	884	26%
Black/Black British	156	5%
Mixed/Multiple	44	1%
White	2,019	58%
Other	44	1%
Prefer not to say	304	9%
Do you have any physical or mental health conditions or illnesses lasting or expected to last 12 months or more?		
Yes	409	12%
No	2,787	81%
Prefer not to say	256	7%
Do any of your conditions or illnesses reduce your ability to carry out day-to-day activities?		
Yes, a lot	46	1%
Yes, a little	177	5%
Not at all	163	5%
Prefer not to say	24	1%
How would you categorise your disability/disabilities?		
Physical impairment (e.g. mobility, sensory, chronic pain)	107	3%
Long-term health condition (e.g. diabetes, heart disease)	141	4%
Neurodivergent condition (e.g. ADHD, autism, dyslexia)	92	3%
Mental health condition (e.g. depression, anxiety)	137	4%
Cognitive or memory difficulty (e.g. dementia, brain injury)	2	0%
Hidden or invisible condition (e.g. chronic fatigue, fibromyalgia)	79	2%
My own description	28	1%
Prefer not to say	18	1%
What is your religion or belief?		
No religion or belief	1,074	31%
Buddhist	20	1%
Christian	1,135	33%
Hindu	210	6%
Jewish	38	1%
Muslim	434	13%
Sikh	95	3%
Other	45	1%
Prefer not to say	400	12%
Do you have unpaid caring responsibilities for a child/children and/or another adult(s)?		
Yes	958	28%
No	2,241	65%
Prefer not to say	252	7%
If yes, please select all that apply		

Demographic	Number	Percentage
For a child/children	714	21%
For an adult	306	9%
Prefer not to say	8	0%
Are you pregnant, on parental leave, or recently returned from parental leave?		
Yes	124	4%
No	3,130	91%
Prefer not to say	197	6%
What is your main language?		
English	3,208	93%
Other (including sign languages)	92	3%
Prefer not to say	150	4%
Do you speak any additional languages fluently (including sign languages)?		
Yes	1,030	30%
No	2,231	65%
Prefer not to say	190	5%
What was the occupation of your main household earner when you were aged about 14?		
Modern professional & traditional professional occupations	1,197	35%
Senior, middle or junior managers or administrators	485	14%
Clerical and intermediate occupations	161	5%
Technical and craft occupations	304	9%
Routine, semi-routine manual and service occupations	435	13%
Long-term unemployed	69	2%
Small business owners who employed less than 25 people	373	11%
Other / retired / / NA / don't know	80	2%
Prefer not to say	347	10%
Which type of school did you attend for the most time between the ages of 11 and 16?		
State-run or state-funded school	2,517	73%
Independent or fee-paying school	342	10%
Independent or fee-paying school (means-tested bursary for 90% of cost)	49	1%
Attended school outside the UK	315	9%
Don't know	14	0%
Prefer not to say	214	6%
If you finished school after 1980, were you eligible for free school meals at any point during your school years?		
Yes	533	15%
No	1,976	57%
Not applicable (finished school before 1980 or went to school overseas)	445	13%
Don't know	260	8%
Prefer not to say	237	7%
Which region does your main residence fall within?		
North East	114	3%
North West	329	10%
Yorkshire and Humber	272	8%
East Midlands	208	6%

Demographic	Number	Percentage
West Midlands	278	8%
East of England	181	5%
London	341	10%
South East	389	11%
South West	403	12%
Wales	192	6%
Scotland	318	9%
Northern Ireland	105	3%
Outside the UK	89	3%
Prefer not to say	231	7%

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C47(26)

COUNCIL

Financial performance to 30 June 2026 and Q1 forecast

Meeting: 30 September 2026	**Status:** for noting
Lead responsibility: Marc Stoner, Director of Corporate Services	**Paper author:** Manori Wickremasinghe, Chief Financial Officer

Purpose

1. To provide Council with a summary of financial performance for the three months to 30 June 2026 and the Q1 forecast for the 2026-27 financial year. Both reports were reviewed by the Audit, Finance and Risk Committee on 7 September 2026.

Recommendations

2. Council is asked to:
   - **note** the financial performance for the three months ending 30 June 2026 in annex 1.
   - **note** the Q1 forecast for the current 2026-27 financial year in annex 2.

Strategic objective

3. This report is relevant to delivery of all our strategic objectives.

Background

4. This report covers the financial performance in the three months to 30 June 2026 and the forecast to 31 March 2027.

5. There are two financial reports for review at this meeting as listed below.
   - actual financial performance to 30 June 2026 (annex 1).
   - Q1 forecast for 2026-27 (annex 2).

6. 2026/27 is the second year of the GOC's five-year corporate strategy.

Analysis

7. In summary, the GOC recorded a positive variance for the three months to 30 June 2026 and the Q1 forecast indicates an improved full-year position compared with the budget approved in February 2026. The favourable position is driven mainly by lower business-as-usual expenditure and strong investment

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performance, although investment volatility and increased fitness to practise demand remain areas for continued monitoring.

Actual financial performance to 30 June 2026

8. In the three-month period to 30 June 2026, we continued to deliver strong financial performance, resulting in a positive variance of £226k before unrealised investment gains. Business-as-usual results, excluding reserve expenditure, show a £214k positive variance to budget.

8. The key performance indicator is outside the approved tolerance of +/-5%. Performance against the KPI is managed over the five-year horizon of the strategic plan.

9. Business-as-usual expenditure was £193k below budget. The Q1 reforecasting exercise enabled the resulting surplus to be redeployed in support of the business and strategic plans, while keeping business-as-usual expenditure at an acceptable level for the full year.

10. The variance was largely attributable to differences in business-as-usual (BAU) expenditure, arising from a combination of planned savings, timing delays and additional costs. Key drivers included the timing of PBF-related payroll increases, efficiencies secured through Microsoft charity status, and contingency provisions included in the budget.

11. Future forecasts will be more robust, evidence-based and actively managed to deliver sustainable savings and address emerging cost pressures.

12. The investment portfolio remains volatile, which may affect future financial performance and reserve levels. This risk is monitored regularly.

13. All known risks are reviewed regularly and mitigated. Quarterly forecasts incorporate all known variances, new trends, and known external changes.

14. The prime reasons for variances are highlighted under the key drivers in Annex One, along with potential risks and potential future impacts of the financial performance.

Q1 2026/27 forecast

15. The 2026-27 Q1 forecast indicates an improvement in financial performance compared with the budget approved in February 2026. The forecast deficit of £326k represents a favourable variance of £342k against budget.

16. Lower business-as-usual (BAU) expenditure and strong investment portfolio performance are the principal drivers of the favourable variance. The forecasting process has enabled surpluses generated in Q1 to be redeployed in support of the business plan, while maintaining BAU expenditure at acceptable levels for the full year.

17. Annual income, primarily from registration fees, funds business-as-usual operations. The Q1 forecast shows income £55k below budget, while BAU expenditure is forecast to be £146k below budget.

18. The forecast reflects the increase in new concerns entering triage and includes funding for two fixed-term roles to help manage the higher volume. This emerging risk will be closely monitored and incorporated into future forecasts as appropriate.

19. Reserve expenditure comprises Council-approved spending funded from designated reserves for strategic initiatives, complex legal matters, infrastructure dilapidations and deferred projects.

20. The Q1 forecast reflects all known operational changes since the budget was approved, including external impacts, appropriate contingencies and demand-led activity such as fitness to practise. Newly identified risks and external impacts will be monitored throughout the forecast period and incorporated into future forecasts as appropriate.

21. More details, including key drivers, risks and impacts, are provided in the narrative in Annex 2.

22. Regular quarterly reforecasting improves forecasting accuracy and ensures that the risks associated with delivering the budget remain visible to Council, ARC and SMT.

Finance

23. There are no additional financial implications arising from this paper.

Risks

24. The following risks are associated with finance, as identified in the corporate risk register:
    - We are unable to deliver our strategic plans, programme of change and business-as-usual activity sufficiently quickly or effectively.
    - We fail to deliver value for money;
    - Capability and resilience: small teams and reliance on particular individuals may cause burnout and errors and may affect organisational delivery if individuals are absent or leave the organisation.

25. Reporting and monitoring financial performance against budgets and forecasts is a fundamental part of managing and mitigating these risks.

Equality Impacts

26. No equality impact assessment has been undertaken as this paper is for reporting purposes only.

Devolved nations

27. There are no implications for the devolved nations.

Communications

External communications

28. None planned.

Internal communications

29. The financial report is shared with the Leadership Team and SMT as part of the regular financial reporting process.

Next steps

30. Financial performance will continue to be monitored through the regular reporting cycle, with future forecasts updated to reflect known variances, emerging risks and external changes.

Attachments

Annex 1: Financial performance report – period ending 30 June 2026.
Annex 2: Q1 forecast for 2026-27

Financial Performance Report for the Period ending 30 June 2026

General Optical Council
Financial Performance Report for the 03 months ending 30 June 2026

Contents

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C47(26) ANNEX ONE

GOC :- Summary P & L to 30 June 2026

	Actual £000's	Budget £000's	Variance £000's
Income	3,338	3,317	21
Expenditure (BAU)	3,177	3,370	193
Operating Surplus / (Deficit) (BAU)	**161**	**(53)**	**214**
Strategic Projects Expenditure	64	84	20
Complex Legal cost Expenditure	8	0	(8)
Deferred Expenditure	0	0	0
Infrastructure cost Expenditure	0	0	0
Surplus / (Deficit) before movement in reserves	**89**	**(137)**	**226**
Funded by reserves:			
General income and expenditure	161	(53)	214
Strategic, research and special projects	(64)	(84)	20
Complex case legal costs	(8)	0	(8)
Deferred Expenditure	0	0	0
Infrastructure/dilapidations	0	0	0
	89	**(137)**	**226**

KPI to date +/-5%	5%	-1%	6%

Approved KPI for 2026-27	-3.40%
Approved KPI for five years 2025-30	0.85%

Table 1

Highlights

The results before unrealised portfolio gains and losses for the period ending 30 June 2026 show a surplus of £89k against a budgeted deficit of £137k. This represents a favourable variance of £226k. The business as usual position before reserve-funded expenditure shows a surplus of £161k against a budgeted deficit of £53k.

Income includes registrant income of £3,187k, which represents 95% of total income. Total income is £21k above budget. Total expenditure, including reserve-funded expenditure, is £3,249k, which is £205k favourable to budget.

Key drivers of the improved financial performance

This report covers the second year of the strategic period. The year-to-date financial performance is 5%, compared with a budgeted deficit of 1%, resulting in a favourable variance of 6 percentage points. This is outside the approved tolerance of plus or minus 5%.

The overall movement was driven primarily by expenditure variances, with smaller favourable movements in investment and other income.

Registration income was £13k, or 0.4%, below budget, mainly due to the timing of individual registration fee income. This variance is expected to unwind over the coming months. Higher dividend and interest income offset the reduction, resulting in total income being £21k above budget at the end of quarter one.

Expenditure variances were more significant and reflected a combination of planned savings, timing delays and additional expenditure.

Planned variances included the timing of PBF related payroll increases, which takes effect from July and had a total impact of £64k. Additional efficiencies were also achieved through securing Microsoft charity status, despite the complexity created by GOC not being a registered company, generating savings of £19k to date. Contingency built into two maternity cover posts contributed a further £33k.

Timing delays also contributed to the reported variance. In particular, delays across two projects resulted in savings of £18k to-date, under IT budget.

Other savings and delays were less predictable. The earlier than planned conclusion of hearing days, together with a shift from planned in-person to remote hearings, contributed £43k. External contract legal advice, which is a contingent budget, was not required during the quarter. A further £33k of activity has been classified as timing uncertain, including staff training within People and Culture.

A small number of items require further investigation. In particular, the high variance in external legal costs within Investigations needs additional analysis to understand the underlying cause and identify any appropriate mitigating action.

Investment performance was also favourable during the quarter, with the market value of investments increasing from £10.3m to £11.1m. This level of short-term growth is above long-term expectations and volatility is expected to continue. Excluding unrealised investment gains, the underlying operating position remains a surplus of £89k against a budgeted deficit of £137k.

The new deferred expenditure reserve includes £11k carried forward from 2025/26, which has not yet been utilised.

There were 10 staff vacancies during the quarter. The current staff vacancy rate is 3.6%, compared with the budgeted assumption of 4% (see tables 6 and 7 on page 13). Each quarterly forecast takes account of payroll savings identified in the previous quarter.

Strategic projects and the future office accommodation programme are expected to be completed within Council approved limits. The multi-year projects table, updated quarterly, is provided on page 15.

Further detail on the main variances is provided on pages 10 to 15.

Future Impacts and management response

The Q1 variance is above the approved plus or minus 5% KPI threshold, although not all drivers were within management control. In recent years, BAU expenditure has consistently underspent against budget. Where savings are confirmed as recurring or deliverable, management will consider whether they can be redeployed to support delivery of the business plan and strategic plan while keeping the full-year BAU variance within approved tolerance.

The Q1 and Q2 forecasting process therefore needs to be robust, evidence-based and actively managed, so that genuine savings are captured, timing differences are understood, and emerging cost pressures are addressed early.

The favourable investment performance has strengthened the reported year to date position; however, investment gains remain subject to market volatility and should not be relied upon to support recurring expenditure decisions.

We will use the Q1 and Q2 forecasting process to distinguish between recurring savings, one-off savings and timing differences. Where savings are considered sustainable, consideration will be given to redeploying resources to support delivery of the business plan and strategic plan, while maintaining financial performance within the approved KPI tolerance.

General Optical Council
Financial Performance Report for the 03 months ending 30 June 2026

Income and Expenditure Accounts

	April - June			2026-27
	Actual £'000	Budget £'000	Variance £'000	Budget £'000
Income				
Registration	3,187	3,200	(13)	12,730
Dividend Income	73	64	8	257
Bank & Deposit Interest	72	50	22	98
Other Income	6	2	4	10
Total Income	**3,338**	**3,317**	**21**	**13,095**
Expenditure				
Executive Office				
CEO's Office	79	90	10	358
Governance	194	201	6	806
Total Executive	**274**	**290**	**17**	**1,164**
Regulatory Strategy				
Director of Regulatory Strategy	44	57	14	231
Policy	128	130	2	576
Communications	85	88	3	397
Education & CPD	285	309	24	1,210
Total Regulatory Strategy	**542**	**584**	**42**	**2,414**
Regulatory Operations				
Director of Regulatory Operations	45	44	(1)	178
Investigation	337	361	24	1,455
Case Progression	289	267	(21)	1,121
FTP Legal	72	78	6	335
Legal	70	66	(4)	272
Hearings	316	361	46	1,552
Total Regulatory Operations	**1,129**	**1,178**	**49**	**4,914**
Corporate Services				
Director of Corporate Services	36	37	1	148
Facilities	227	205	(22)	837
Finance	131	154	23	669
Registration	253	281	28	746
IT	277	322	46	1,405
Total Corporate Services	**924**	**999**	**75**	**3,806**

General Optical Council
Financial Performance Report for the 03 months ending 30 June 2026

Income and Expenditure Accounts (Contd.)

	April - June			2026-27
	Actual £'000	Budget £'000	Variance £'000	Budget £'000
People & Improvement				
Director of P&I	41	43	2	173
Project Delivery & Continual Improvement	60	55	(4)	222
People & Culture	185	198	13	768
	286	**297**	**11**	**1,164**
Depreciation	22	21	(1)	79
Total Expenditure	**3,177**	**3,370**	**194**	**13,541**
Surplus / (Deficit) before project expenditure	**161**	**(54)**	**215**	**(446)**
Project Expenditure				
Education Strategic Review project	28	28	(0)	70
Complex Legal Cases	8	0	(8)	110
Thematic Review	0	0	0	40
Project Depreciation & Amortisation	37	56	19	237
Future Office Accommodation	0	0	0	30
Board effectiveness review Project	0	0	0	50
EDI training Project	0	0	0	80
Deferred Expenditure	0	0	0	0
Finance/HR /Payroll systems Project	0	0	0	50
Potential Projects	0	0	0	70
Total Project expenditure	**72**	**84**	**12**	**737**
Surplus / (Deficit) after project expenditure	**89**	**(137)**	**227**	**(1,184)**
Unrealised Investment gains	827	130	696	514
Surplus / Deficit	**916**	**(7)**	**923**	**(669)**

Table 2

General Optical Council
Financial Performance Report for the 03 months ending 30 June 2026

Income and Expenditure Accounts Including Project Expenditure

	April - June			2026-27
	Actual £'000	Budget £'000	Variance £'000	Budget £'000
Income				
Registration	3,187	3,200	(13)	12,730
Dividend Income	73	64	8	257
Bank & Deposit Interest	72	50	22	98
Other Income	6	2	4	10
Total Income	**3,338**	**3,317**	**21**	**13,095**
Expenditure				
Staff Salaries Costs	1,891	1,928	36	7,553
Other Staff Costs	76	77	0	433
Staff Benefits	47	44	(3)	177
Member & Worker Costs	69	72	3	403
Professional Fees	111	141	30	788
Finance Costs	111	115	4	156
Case Progression	238	246	8	1,160
Hearings	199	231	33	967
CPD & Standards	94	92	(3)	332
IT Costs	145	186	40	887
Office Services	186	164	(21)	679
Other Costs	22	82	59	428
Depreciation & Amortisation	58	77	19	316
Total Expenditure	**3,249**	**3,454**	**205**	**14,278**
Surplus / Deficit	**89**	**(137)**	**227**	**(1,183)**
Unrealised Investment gains	827	130	696	514
Surplus / (Deficit)	**916**	**(7)**	**923**	**(669)**
Staff cost to total expenditure ratio	62%	59%		57%

Table 3

General Optical Council
Financial Performance Report for the 03 months ending 30 June 2026

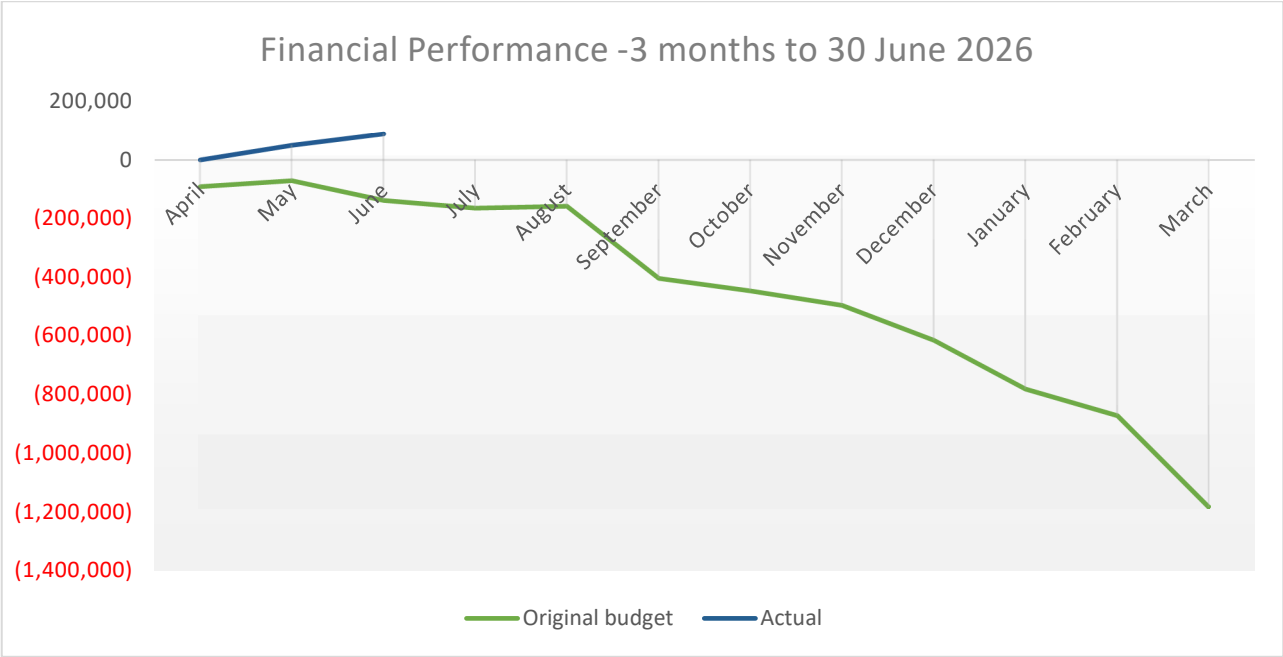
Balance Sheet as at 30/06/2026

	2026-27 30 June 2026 £'000	2025-26 31-Mar-26 £'000	Variance £'000
Fixed Assets			
Furniture & Equipment	1	1	(0)
IT Hardware	124	151	(27)
IT software	139	168	(29)
Capital Work in Progress	271	120	151
Total Tangible Fixed Assets	**535**	**439**	**95**
Investment	11,115	10,302	813
Total Fixed Assets	**11,650**	**10,740**	**910**
Current Assets			
Debtors, Prepayments & Other Receivable	651	757	(106)
Short term deposits	6,500	9,400	(2,900)
Cash and monies at Bank	891	883	8
Total Current assets	**8,042**	**11,040**	**(2,998)**
Current Liabilities			
Creditors & Accruals	1,096	1,149	53
Income received in advance	9,026	11,976	2,950
Total Current Liabilities	**10,122**	**13,125**	**3,003**
Current Assets less Current Liabilities	**(2,080)**	**(2,086)**	**6**
Total Assets less Current Liabilities	**9,571**	**8,655**	**916**
Long Term Liabilities	0	0	0
Total Assets less Total Liabilities	**9,571**	**8,655**	**916**
Reserves			
Complex cases legal costs	700	700	(0)
Strategic, research and special projects	3,001	3,000	1
Deferred expenditure reserve	11	11	0
Infrastructure/dilapidations	618	618	(0)
General income & expenditure	5,241	4,326	915
Total	**9,571**	**8,655**	**916**

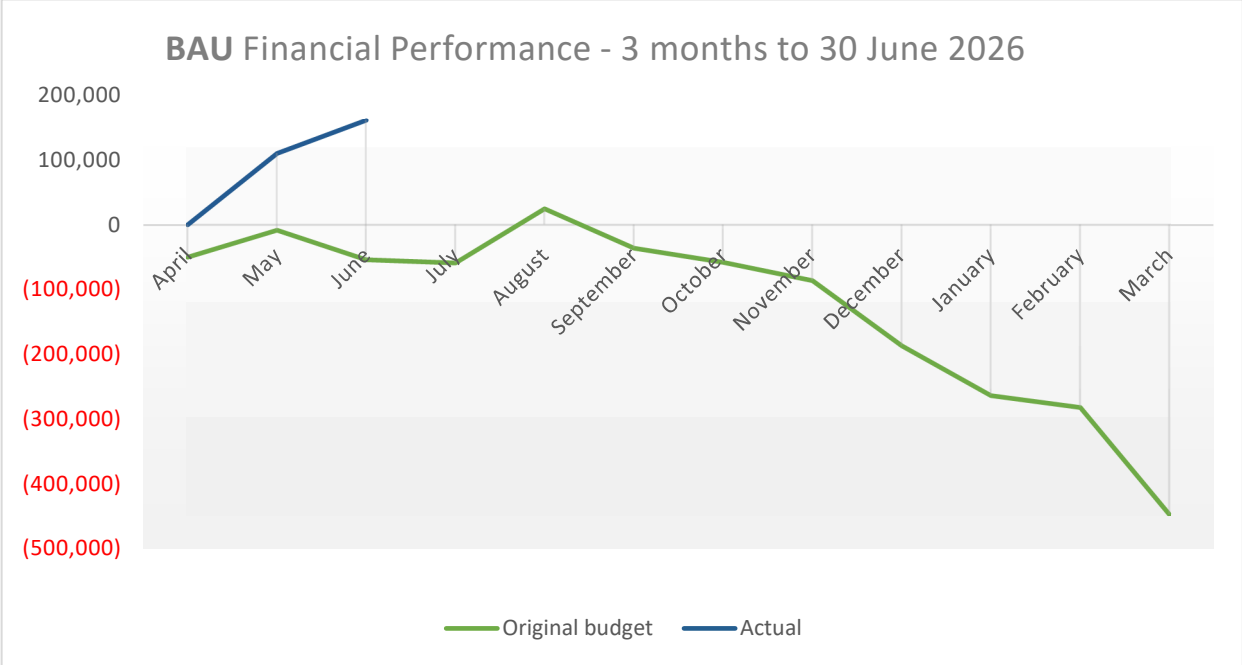
Table 4

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Analysis on Financial Performance and Variance



Graph 1



Graph 2

General Optical Council
Financial Performance Report for the 03 months ending 30 June 2026

Analysis of Expenditure

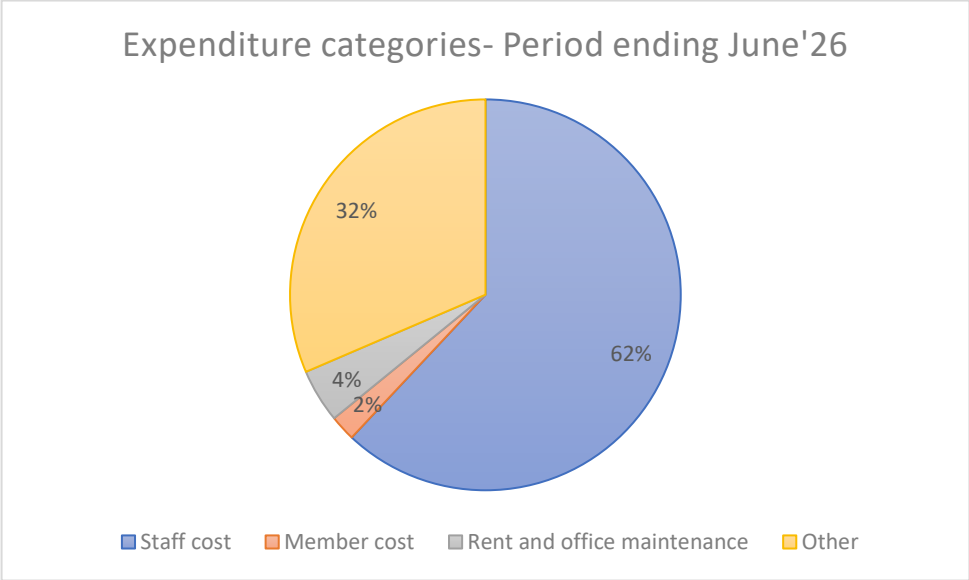


Chart 1

Note: highlights the fixed cost against the variable (Other) costs. Other costs are variable costs in professional fees, finance costs, case progression, Hearings, Education CPD, IT, Office services, and depreciation.

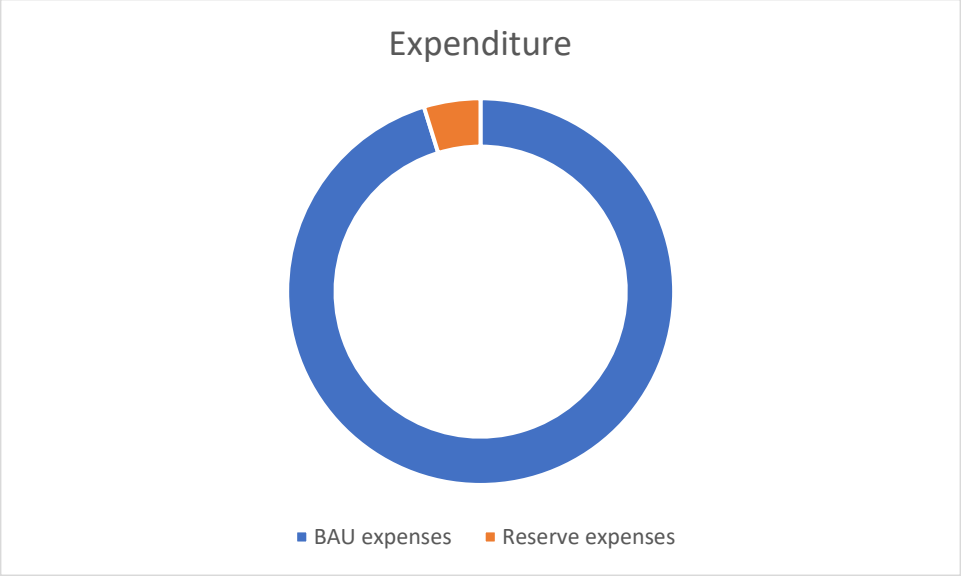
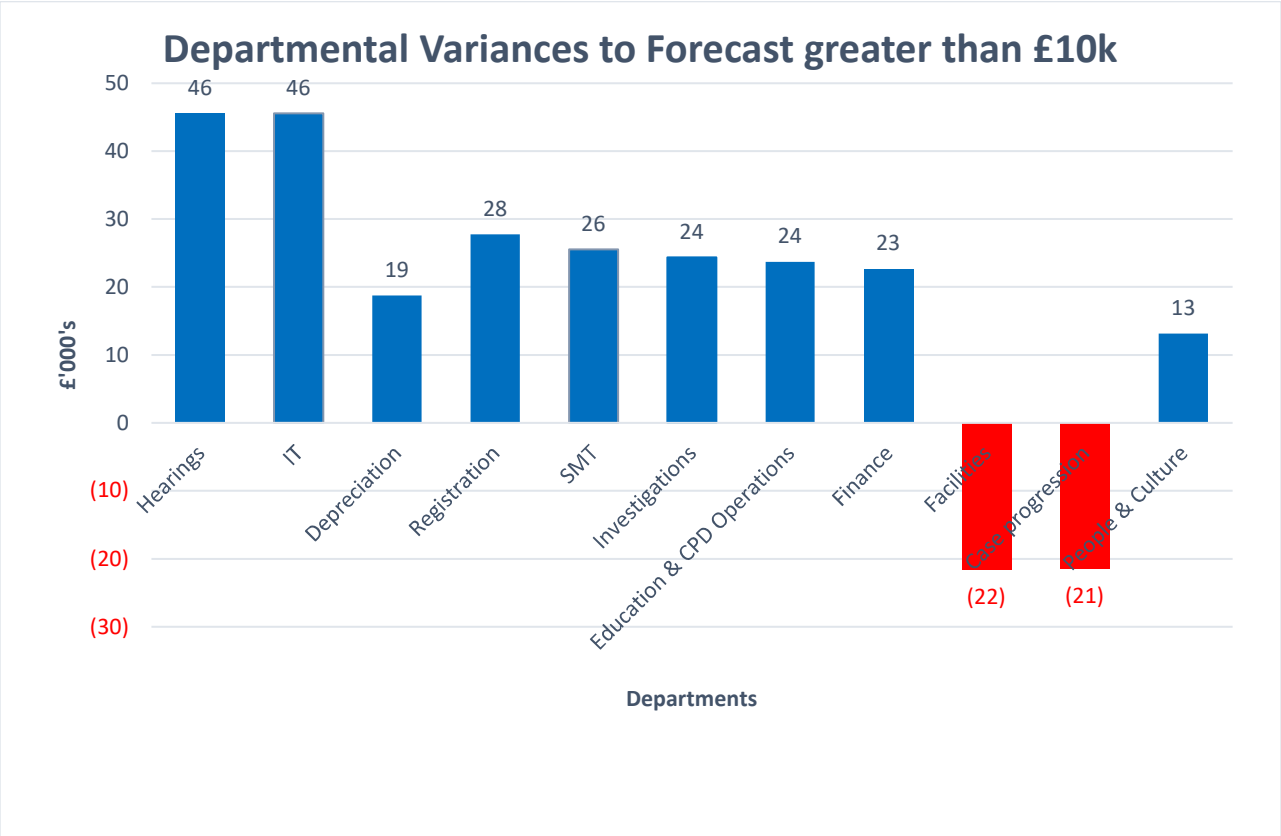


Chart 2

General Optical Council
Financial Performance Report for the 03 months ending 30 June 2026



Graph 3

Cash and Cash Equivalent Summary - 30 June 2026

	Actual £'000	BUDGET £'000	Variance £'000
Cash at Bank	891	294	597
Short term Investments	6,500	6,500	0
Working Capital	**7,391**	**6,794**	**597**
Investments	11,115	10,681	434
Total	**18,506**	**17,475**	**1,031**

Table 5

General Optical Council
Financial Performance Report for the 03 months ending 30 June 2026

Headcount June 26 (non- FTE)

	Actual FTC* Jun-26	Actual Perm. Jun-26	**Actual Total Jun-26**	Budget Jun-26
Governance & CEO's Office	-	9.0	**9.0**	11.0
Regulatory Strategy	2.0	24.0	**26.0**	29.0
Regulatory Operations	6.0	38.0	**44.0**	42.0
Corporate Services*	4.0	24.0	**28.0**	29.0
People & Improvement	5.0	6.0	**11.0**	10.0
Total Headcount	**17.0**	**101.0**	**118.0**	**121.0**

** including Agency temp staff*

Table 6

Staff Vacancy rate - reasonability test compared to approved budget	
No. of staff vacancies during the period	10
Staff Vacancy Rate to date	3.6%
Staff vacancy rate budgeted	4.0%
BAU NC 1000 budget annual budget	6,436
Impact if no future staff vacancies	0.9%

Table 7

Detailed analysis of 03 months results against the Budget

Investment Income:

	Actual *£'000*	Budget *£'000*	Variance *£'000*	Q1 Forecast *£'000*	Variance *£'000*
Dividend income received	249	234	15	255	(6)
Unrealised investment gains/(losses)	936	468	468	1,419	(483)
Total Income from Investment	**1,185**	**702**	**483**	**1,674**	**(489)**
Total Investment Portfolio	**10,297**	**8,536**	**1,761**	**10,565**	**(268)**

Table 8

General Optical Council
Financial Performance Report for the 03 months ending 30 June 2026

Variance Analysis of BAU Expenditure

Analysis of BAU expense variance June	
Savings	**£'000**
Savings	138
Delays	81
Revised plans and timing (uncertain)	63
Additional expenses	
Additions	(77)
Staff vacancy gaps (excluding efficiency measures)	(10)
Total Expense Variance	195

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Analysis of Multi-Year Strategic Project - as at 30 June 2026 Approved Budget

Project Expenditure		Approved by the Council	Prior Year Spend	Current Year to date Spend	Actual Spend To Date	Forecasted Future Spend	Total Spend	Variance	Remarks
Jun-26		£'000	£'000	£'000	£'000	£'000	£'000	£'000	
P34	Future Office Accommodation	764	313	408	721	30	751	13	Council approved £764k which included £68k depreciation - this cost was wrote off the BAU at the end of 2024-25. Q3 forecast includes £30k contingency for 2026-27 future spend.
P40	Thematic Review	40	0	0	0	40	40	0	This is part pf a £200k multi year approved project. SB confirmed £40k likely to be spent in next financial year
P37	My GOC (capital)	322	0	114	114	208	322	0	Council approved a further £48k. As at now, project is scheduled for completion in July26 - September26.
P44	Board effectiveness review Project	50	0	0	0	50	50	0	Planned for later in the financial year
P45	EDI training Project	80	0	0	0	80	80	0	Planned for later in the financial year
P46	Finance/HR /Payroll systems Project	50	0	0	0	50	50	0	Planned spend for Jan27
P43	Potential Projects	70	0	0	0	70	70	0	Remaining project budget

Table 10

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Q1 Forecast 2026-27

Forecast Report

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Key drivers 3-4

Risks and plans to mitigate 4 -5

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Q1 Forecast 2026/27

	Budget £'000	Q1 forecast £'000	Variance to Budget £'000
Income	13,095	13,040	(55)
Expenditure (BAU)	13,541	13,395	146
Surplus / (Deficit) before reserve expenditure	**(446)**	**(355)**	**90**
Reserve Expenditure	737	697	40
Surplus / (Deficit) after project expenditure	**(1,183)**	**(1,052)**	**130**
Unrealised Investment gains	514	726	212
Surplus / (Deficit)	**(669)**	**(326)**	**342**

Table 1

Highlights

Overall, the Q1 forecast shows a more favourable position than the approved budget, mainly due to lower BAU expenditure and higher fixed deposit interest, partly offset by reduced income from non-UK applicant assessments. The main delivery risks relate to case volumes, legal expenditure, workforce capacity and short-term investment market volatility.

The above table compares the 2026/27 Q1 forecast with the original Council-approved budget agreed in February 2026. This is the second year of the 2025-30 strategic plan.

The 2026/27 Q1 forecast shows an improved position before reserve expenditure when compared with the approved budget. Annual income, mainly from registration fees, funds BAU operations. Reserve expenditure is strategic or contingent in nature and is described on page 13.

The reserve expenditure includes multi-year strategic projects (ref. Table 5, Page 13) all of which are within the council-approved limits.

Key drivers of the change in performance- 2026/27 Q1 forecast

The overall movement from budget is mainly driven by changes in BAU expenditure.

Changes to non-UK applicant assessment reduced income, but this was partly offset by lower expenditure. Fixed deposit interest income increased because of higher fixed deposit rates in late February 2026, which also helped offset the reduction in registration income.

Net movement in business as usual (BAU) expenditure is £146k; within that, the highlights are as follows.

- Two maternity cover contingencies built to the budget were released to fund two forthcoming maternity covers.
- PBF performance central contingency of £276k was utilised across departments, releasing £21k to the surplus.
- Central employee savings of 4% were underutilised by £22k in Q1, with the remainder retained over the rest of the year.
- Provision made for insurance excesses for appeals and judicial reviews, amounting to £50k, was removed from BAU, and £75k is forecast through the complex legal reserve.
- Registration panel member fee cost was reduced by 28% to accommodate the expected low volumes in non-UK assessments.
- Hearing days were reduced from 370 to 350 due to cancelled and early finishes in Q1. The associated cost in legal advisors reduced in line with fewer hearing days.
- Optical advisor costs increased due to high number of concerns. This is linked to the high number of new cases coming through (ref. Risks paragraph below).
- CW (Canary Wharf) awarded more rent-free months to the contract and the cost of rent per month over the five years reduced.
- IT reduced external consultancy costs, with plans to use more in-house expertise.
- The Opus Phase 2, a telephone and internet texting message add-on option was delayed to next year.
- £40k savings have been included following confirmation of charity status for Microsoft products.

Other highlights of the year that helped build the forecast accurately are:

- EVP fees costs are now better managed with more assured plans rather than estimates used previously.
- All hearing days in 2026-27 are expected to be BAU. All complex cases marked for hearings have now concluded, and no further cases have been identified.
- Tower Hamlets Council awarded charity status, exempting 80% of business rates costs, in line with the budget.
- Complex legal case criteria was updated to include insurance excesses of appeal and judicial review cases.
- The Future Office accommodation project is at the final stage, with £30k forecast for final improvements.
- MyGOC project is estimated to be completed at the end of Q2 this year.
- The People and Improvement department continues to support the organisation with project management.

Risks of not achieving 2026/27 Q1 Forecast.

The key risks are related mainly to expenditure. Revenue is relatively low risk, as most of the income is received or agreed (e.g., renewal income, fixed deposit income).

- New concerns into triage increased by 31% during 2025-26 and by 12% during Q1 compared to Q1 in 2025-26. The Case Examiner/IC referral rate increased from 52% in 2025/26 to 58% in Q1 and reached 62% by the end of July. The increased proportion of cases progressing from Case Examiners to a hearing requires investigations support and is expected to drive higher legal and staff costs. Current volumes remain manageable, however if new investigation openings consistently exceed 10 cases per month and the CE referral rate remains above 50%, the resource model will need to be reviewed.
- An emerging trend across regulators is that patients may be using AI tools when deciding whether to complain to health regulators and when adding clinical concerns.
- The reduced in-house advocate headcount is expected to increase reliance on external legal providers and create greater volatility in legal expenditure. Additional resource is planned to mitigate the risk, provide experienced support during a period of sustained pressure and help maintain operational performance.
- Hearing days could change at short notice, either increasing or decreasing, depending on case scheduling requirements, cancellations or postponements.
- Any increase in staff vacancies may affect the achievement of business plans, as most work is carried out internally by staff.
- The unrealised gains/losses on investments' market values are expected to fluctuate in the short term. However, high short-term volatility could affect year-end reserve levels.

Plans to mitigate risks

The Case Progression department and the Regulatory Operations directorate are closely monitoring the number and complexity of new cases to assess whether this is a sustained trend or a one-off increase. Depending on the outcome, the directorate will prepare proposals for additional resources to mitigate the risk and maintain KPIs. Fixed-term resources have already been secured to manage the high volume of work in triage.

The forecast provides additional funds for legal support for investigations until the required number of in-house lawyers get recruited and stabilised.

Quarterly workforce planning is carried out alongside the forecast process, enabling SMT to assess available funding, work priorities and proposed roles. After reviewing the July five-year forecast, SMT approved three roles essential to delivery of the current business plan. In addition, SMT confirmed the provisional approval given in February 2026 for two further roles.

Our low-risk appetite can sometimes lead to cautious budgeting and forecasting assumptions. We are continuing to address this by refining forecast assumptions, for example by assuming that 10% of hearing dates may be cancelled in the future. We have also embedded a 4% staff vacancy assumption, reducing forecast costs by 4% of payroll expenditure. This will require careful management of the business plan to avoid delivery delays. A central contingency fund is also available to meet unplanned expenditure.

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Short-term market volatility may reduce our reserves at any point. We receive regular advice from the investment manager that helps us better understand market conditions. We also plan to be agile in the use of strategic projects and cash drawdowns, maintaining strong investment levels and benefiting from their long-term growth, as in the past.

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Income and Expenditure Accounts – Q1 Forecast

	Strategic Yr 1	Strategic Yr 2		
	2025/26	2026/27		
		Budget	Q1 Forecast	Variance
	£'000	£'000	£'000	£'000
Income				
Registration	12113	12,730	12,640	(90)
Dividend Income	263	257	279	22
Bank & Deposit Interest	217	98	111	13
Other Income	16	10	10	0
Total Income	**12,609**	**13,095**	**13,040**	**(55)**
Expenditure				
Governance & CEO's Office				
CEO[1]	255	358	103	255
Governance & Member Fees	739	806	823	(17)
Total Governance & CEO's Office	**994**	**1,164**	**926**	**238**
Regulatory Strategy				
Director of Regulatory Strategy	172	231	204	26
Policy & Standards	388	576	571	5
Communications	342	397	401	(5)
Education & CPD	1051	1,210	1,227	(17)
Total Regulatory Strategy	**1,953**	**2,414**	**2,404**	**10**
Regulatory Operations				
Director of Regulatory Operation	176	178	192	(14)
Investigation	1368	1,455	1,571	(116)
Case Progression	1044	1,121	1,189	(68)
FTP Legal	255	335	270	65
Legal	244	272	299	(26)
Hearings	1469	1,552	1,536	16
Total Regulatory Operations	**4,556**	**4,914**	**5,057**	**(143)**
Corporate Services				
Director of Corporate Services	130	148	150	(1)
Facilities	692	837	866	(29)
Finance	603	669	664	5
IT	1227	1,405	1,357	48
Registration	752	746	749	(3)
Total Corporate Services	**3,404**	**3,806**	**3,786**	**20**
People & Improvement				
Director of People and Improvement	163	173	177	(3)
Project Delivery & Continual Improvement	200	222	230	(7)
People and Culture	666	768	809	(40)
Total People & Improvement	**1,029**	**1,164**	**1,215**	**(51)**

Income and Expenditure Accounts Q1 Forecast (Contd.)

	Strategic Yr 1	Strategic Yr 2		
	2025/26	2026/27		
		Budget	Q1 Forecast	Variance
	£'000	£'000	£'000	£'000
Depreciation & Amortisation	74	79	80	(1)
Total Expenditure	**12,011**	**13,541**	**13,467**	**73**
Surplus / (Deficit) before reserve expenditure	**598**	**(446)**	**(427)**	**18**
Reserve Expenditure				
Education Strategic Review project	64	70	70	0
Thematic Review	40	40	0	40
Board Effectiveness Review	0	0	50	(50)
Systems Project	0	0	50	(50)
Cultural sensitivity training - Hearing Panel	0	0	80	(80)
Case Examiner project[3]	0	0	60	(60)
Potential Projects[4]	0	250	10	240
Completed projects	197			
Project Depreciation & Amortisation	134	237	203	34
Total Strategic Reserve Expenditure	**435**	**597**	**523**	**74**
Legal Reserve Expenditure				
Complex Legal Cases	30	110	133	(23)
Infrastructure/delap reserve expenditure				
Future Office Project	408	30	30	0
Deferred Projects Reserve		0	11	(11)
Total Reserve expenditure	**873**	**737**	**697**	**40**
Surplus / (Deficit) after reserve expenditure	**(275)**	**(1,183)**	**(1,124)**	**58**
Unrealised Investment gains	936	514	726	212
Surplus / (Deficit)	**661**	**(669)**	**(398)**	**270**

1. *CEO budget includes 4% recruitment vacancy rate*
3 *Allocated £60k for initial consultancy costs for a new strategic project, pending Council approval. The project cost will be at much higher value and will be known after the consultancy work ends.*
4 *Any unknown potential projects for future.*

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Income & Expenditure Forecast - by Category

	2026-27 Year 1 Strategic Yr 2		
	BUDGET 2026-27	Q1 Forecast	Variance
	£'000	£'000	£'000
Income			
Registration	12,730	12,640	(90)
Dividend Income	257	279	22
Bank & Deposit Interest	98	111	13
Other Income	10	10	0
Total Income	**13,095**	**13,040**	**(55)**
Expenditure			
Staff Salaries Costs	7,553	7,750	(125)
Other Staff Costs	433	581	(148)
Staff Benefits	177	174	3
Members Costs	323	333	(10)
Professional Fees	738	757	(19)
Finance Costs	156	147	9
Case Progression	1,160	1,213	(54)
Hearings	967	904	63
Education and CPD	332	332	(1)
IT Costs	837	845	(8)
Office Services	679	706	(27)
Other Costs	358	129	229
Depreciation & Amortisation	316	283	33
Potential Projects	250	10	240
Unplanned BAU expenses	-	-	-
Total Expenditure	**14,278**	**14,164**	**185**
Surplus / Deficit	**(1,183)**	**(1,124)**	**130**
Unrealised Investment gains	514	726	212
Surplus / (Deficit)	**(669)**	**(398)**	**270**
Staff cost to total expenditure ratio	57%	60%	

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Analysis of Multi-Year Strategic Project - as at 30 June 2026 Q1 Forecast

	Project Expenditure	Approved by the Council	Prior Year Spend	Current Year to date Spend	Actual Spend To Date	Forecasted Future Spend	Total Spend	Variance	Remarks
	Jun-26	£'000	£'000	£'000	£'000	£'000	£'000	£'000	
P34	Future Office Accommodation	764	313	408	721	30	751	13	Council approved £764k which included £68k depreciation - this cost was wrote off the BAU at the end of 2024-25. Q3 forecast includes £30k contingency for 2026-27 future spend.
P40	Thematic Review	40	0	0	0	40	40	0	This is part pf a £200k multi year approved project. SB confirmed £40k likely to be spent in next financial year
P37	My GOC (capital)	322	114	155	269	53	322	0	Council approved a further £48k. As at now, project is scheduled for completion in July26 - September26.
P44	Board effectiveness review Project	50	0	0	0	50	50	0	Planned for later in the financial year
P45	EDI training Project	80	0	0	0	80	80	0	Planned for later in the financial year
P46	inance/HR /Payroll systems Proje	50	0	0	0	50	50	0	Planned spend for Jan27
P43	Potential Projects	70	0	0	0	70	70	0	Remaining project budget

Table 3

Assumptions

Income

- Low-income thresholds will not change.
- There will be no impact on annual fee collection and direct debit plan from the future fee strategy.
- No change to ancillary fees.
- Non-UK assessment work reduced by 80%.
- New registration numbers for OOs will increase by 5% in 26/27, DO numbers will increase by 9% in 26/27
- Student numbers increase by 3%.
- Body corporate numbers will not increase. There was a 25% increase in 2025 and decrease in 2023 (15%) and 2024 (25%).
- 80% of new registrants would be transfers and 20% would be direct.
- There will be no unusual shift due to retirement. Age analysis reports show that 4% of the registrants are over 65 years of age and this is stable over the past 4 years.
- Total investment average returns (dividend income + unrealised gains) will be 7.4%,
- There is a risk of volatility of 9.5% of investment valuation.
- We have assumed that the portfolio will stay within the parameters, grow during the 5yr period at similar levels to long-term growth. But the short-term volatility could be very high, as experienced in 2020 and 2022.
- FD interest will gradually reduce with inflationary rate.
- Dividend income will stay as projected by Brewin Dolphin.

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Expenditure - assumptions

- IT developments will be carried out as planned.
- There will be no new strategic projects costing more than the potential earmarked project levels.
- There will be no high-value fixed asset purchases over the forecast values.
- There will be a 4% vacancy rate p.a.
- The central contingency provided for two maternity leave covers will be adequate.
- Flexible working will continue for staff, members, and panels.
- Governance
    - Council and committee meetings and number of members will remain same.
- Policy and Standards
    - Research programme (BAU surveys and one-off pieces of research) to continue but surveys retendered and likely changed in scope/size
    - That we will hold a stakeholder event on a topic of interest
- Education and CPD
    - EVP training days will be held in person as online events were not as effective.
    - assumption on stage 3 apps as expressions of interest wouldn't have been received this far in advance, based on numbers for previous years and that these will gradually decrease, decreasing the EVP member costs.
    - Assume the CPD Programme management work will be done through unified registrant portal
- Case Progression
    - 150 decisions by case examinations for future years based on 2526 volume – 20% reduction applied based on previous 5-year trend
    - CE decision numbers will remain the same. Monies have been agreed to be released from potential strategic projects, £60k initially to support a review.
    - Referrals into triage increased by 30% last year and have continued to increase this year. This is likely to increase demand for optometric adviser input, with a related increase in costs if the number of hours needs to rise. The model for optical adviser use is expected to be reviewed in Q3-Q4.
- Investigations
    - Yr 1 – The reduced in-house advocate headcount is expected to increase reliance on external legal providers and create greater month-to-month volatility in legal expenditure. This has been forecast as accurately as possible based on current information.
    - Yr 1- Investigation operating costs - Core investigation costs, including day-to-day operational expenditure, are assumed to remain broadly stable throughout the financial year with no significant unforeseen cost pressures.
    - Yr 1 - Expert witness expenditure - Expert witness costs are assumed to remain within budget but will require regular monitoring due to the complexity and variability of cases. Forecasts should be reviewed throughout the year to identify any emerging pressures
    - Yr 1 - Caseload and external legal instruction - The budget assumes current caseload volumes and complexity remain broadly in line with forecast. Any sustained increase in high-complexity cases requiring external legal support

or specialist expertise is likely to place additional pressure on the budget and may require reprioritisation or additional funding.

- Hearings
    - Initially assumed 372 hearing days for the year.
    - The investigation team has updated its forecast for disclosures expected in 2026-27, increasing from 4 disclosures a month to 7 disclosures a month. Based on this, I have forecast realistically we will receive 5 or 6 disclosures/month rather than all 7. Following 10 disclosures in June, with an average hearing day of 5 days, we can assume we will run 350 hearing days
    - Assume around 7% of hearings will be in person
- Finance
    - No. of external contract legal advice work will reduce as planned.
    - There will not be high numbers of unplanned member travel to the office, that could increase the tax costs.
    - Annual growth (capital and dividend income) of investment portfolio will be 7.4%.
    - The investment management fee calculation method by Brewin Dolphin will not change over the period.
- Registration
    - Non-UK assessor cost will reduce by 80%.
    - Retention costs - Retention postage and letter costs have been reduced due to the use of the e-service. However, when emails bounce back, a letter is issued instead
    - Bank charges will remain high. There is a possibility that new MyGOC suppliers or another new option may offer lower rates, but this was not forecasted as not yet finalised.
    - The renewal cycle will remain annual.
    - Renewals will be on annual basis with one upfront payment.
    - Reminder letters have 80% reduction due to e-service correspondence option.
- Facilities
    - Insurance cost will stay high.
    - Staff hybrid levels will stay at similar levels to present.
    - Office utility and other admin costs will stay as forecasted for the new premises.
- IT
    - IT maintenance contract will largely remain the same, inflation applied to outer years
    - Finance/HR/Payroll systems consultancy to start in 26/27,
    - AI sensitivity labelling project to begin in 2026-27
    - Any approved IT strategic projects will have their own budgets. IT projects will be added as and when identified and approved.
- Project Delivery & Continual Improvement
    - The cost forecasted will be adequate as this is a new department.
- P&C
    - Benefit costs remain as previously forecast

    - Consultancy includes pay benchmarking (QCG Regulatory Salary Planning Survey) to meet our 2/3 year commitment, and 3 job evaluations identified through financial and workforce planning
    - Training expenditure is subject to an agreed plan and will be phased throughout the year. Training identified to date includes Holding difficult conversations (for Registration), ACAS workplace investigation training and Safeguarding training.
- Potential Projects
    - This includes potential IT projects.
- MyGOC Project
    - It is a capital project. Assume MyGOC will not be delayed any further as that will impact operations and finance projections.

Risks not covered in Q1 Forecast

- There will be no additional costs on PMI project.
- The Case examiner referral rates will not develop to investigations and hearings.
- The case examiner referral rates will be a one-off increase.

Cash Drawdown Plan

In the event of us exhausting the annual renewal income before the next renewal cycle, we will be drawing down cash from investments. These will happen if and when there is a large expenditure planned during Q3 and early Q4 in a financial year, before the renewal cycles bring the next batch of funds.

Low cash drawdowns from long-term investments are required for 2026/27, as the forecast operating surplus is expected to fund the £300k drawdown previously forecast.

	Q1 2026/27-Cashflow												
Month ending	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27	Year 1 2026-27 (Strategic Yr 2)
	Actual	Actual	Actual	Q1 forecast	Q1 forecast	Q1 forecast	Q1 forecast	Q1 forecast	Q1 forecast	Q1 forecast	Q1 forecast	Q1 forecast	Q1 forecast
	£'000's	£'000's	£'000's	£'000's	£'000's	£'000's	£'000's	£'000's	£'000's	£'000's	£'000's	£'000's	£'000's
Opening Balance	875	975	987	752	757	840	817	910	943	703	262	414	875
Income													
Registration	313	2	65	99	68	61	55	55	55	654	2,800	9,240	13,467
Dividend income	33	24	14	23	23	23	23	23	23	23	23	24	279
FD interest income	4	5	12	13	17	28	25	28	11	1	2	2	148
Other	0	0	0	1	1	1	1	1	1	1	1	1	8
Transfers from Deposit Account	1,000	1,000	900	1,000	1,000	1,300	1,100	1,100	800	0		0	9,200
Transfers from Investment									0	0			0
Total Cash Inflow	1,350	1,031	991	1,137	1,110	1,413	1,204	1,207	890	678	2,826	9,267	23,102
Expenditure													
Staff payroll	369	365	377	430	390	393	394	395	391	395	394	391	4,683
Council/Worker payroll	60	53	57	65	62	58	60	103	52	76	83	110	838
HMRC	193	221	219	238	218	218	219	241	214	227	230	242	2,680
Pension Contributions	95	98	95	100	91	91	91	94	90	92	92	93	1,122
Rent and Service Charge	0	0	112	0	0	81	0	0	81	0	0	81	356
Corporate credit cards	4	8	1	12	12	12	12	12	12	12	12	12	121
Supplier payments	422	175	347	267	235	547	313	310	267	297	243	578	4,001
Direct Debits	21	30	18	20	20	20	20	20	20	20	20	20	249
Fixed assets	86	69	0	0	0	17	0	0	0	0	0	0	172
Transfers to Deposit Account	0										1,600	7,800	9,400
Total Cash outflow	1,250	1,019	1,226	1,131	1,027	1,437	1,110	1,175	1,129	1,120	2,674	9,327	23,623
Net Cash in / (outflow)	100	12	(235)	5	83	(24)	94	32	(239)	(442)	152	(60)	(521)
Closing Balance	975	987	752	757	840	817	910	943	703	262	414	353	353
On Deposit													
Opening balance	9,400	8,400	7,400	6,500	5,500	4,500	3,200	2,100	1,000	200	200	1,800	9,400
Deposited	0	0	0	0	0	0	0	0	0	0	1,600	7,800	9,400
Withdrawn	(1,000)	(1,000)	(900)	(1,000)	(1,000)	(1,300)	(1,100)	(1,100)	(800)	0	0	0	(9,200)
Closing Balance	8,400	7,400	6,500	5,500	4,500	3,200	2,100	1,000	200	200	1,800	9,600	9,600
Brewin Dolphin Investment													
Opening balance	10,300	10,300	10,300	11,115	11,115	11,115	11,239	11,239	11,239	11,365	11,365	11,365	10,300
Investment Gains	0	0	827	0	0	137	0	0	139	0	0	137	1,240
BD charges	0		(12)			(13)			(13)			(13)	(51)
Deposited	0	0	0	0	0	0	0	0	0	0	0	0	0
Withdrawn	0	0	0	0	0	0	0	0	0	0	0	0	0
Closing Balance	10,300	10,300	11,115	11,115	11,115	11,239	11,239	11,239	11,365	11,365	11,365	11,489	11,489

Business Performance Quarterly Dashboard

On track
At risk
Off track

For the year 1 April 2026 – 31 March 2027

Q1 report (1 April 2026 – 30 June 2026)			Q1	Q2	Q3	Q4	Measure	Q4 (25/26)
Finance								
1.1	BAU budget; operate within budget/forecast		6%				Tolerance is ±5% p.a. for 2025-30, balancing over the five years	3.0%
1.2	Reserves		0				Operating within the range (£3.9m - £9.25m) as per reserve policy	N/A
People								
2.1	Annual staff turnover		9.6%				Target is <15%	N/A
2.2	Voluntary turnover rate		4.4%				Target is <12%	N/A
2.3	Staff engagement – pulse survey	% response	54%				N/A	40%
	Employee Net Promoter Score (eNPS)	eNPS	-1.59				eNPS: Target is 0-30, which is rated as good Note: the higher, the better	0
Customer								
3.1	FOI requests resolved		100%				Target is 100% in ≤20 working days	100%
3.2	Corporate complaints (stage 1 or 2): received		2				N/A	0
	Corporate complaints (stage 2): resolved		100%				Target is ≥90% in ≤20 working days	N/A
Regulatory functions								
4.1	Registration applications completed		99%				Target is ≥95% forms completed	98%
4.2	Registration accuracy		99%				Target is ≥95%	99%
4.3	Approved qualifications meeting new ETR		88%				Target is 100% by July 2028 *ex. CoO*	88%
4.4	Quality of GOC approved providers' CPD		100%				Target is ≥85% good or excellent	95%
4.5	Customers receiving an FtP update		93%				Target is ≥90% every 12 weeks	85%
4.6	FtP cases resolved (rolling median)		43%				Target is ≥60% within 78 weeks	47%
4.7	Hearings concluded first time		100%				Target is ≥90%	91%
4.8	Hearings dates utilised		99%				Target is ≥90%	82%
4.9	New investigations at representations		56%				Target is ≥80% of investigations at reps within 35 weeks from date investigation opened (for the period)	41%

Note: CPD stats have been temporarily removed as the data is not meaningful at this stage in the cycle; these will return towards the end of the 2025-27 cycle

KPI (and RAG)		Current RAG status (why it is amber/red; recovery plan to get to green)	Budget implications and other risks
1.1	BAU budget; operate within budget/forecast – **6%** Tolerance is ±5% p.a. for 2025-30, balancing over the five years	**Why amber/red:** Q1 expenditure is currently 6% below forecast, marginally outside the agreed tolerance of ±5%. This position is primarily driven by: • Delayed implementation of PBF-related payroll increases from June to July. This was due to the introduction of the new PBF process • Additional savings in IT budget achieved through Microsoft's recognition of GOC's charity status. • Contingency built into two maternity cover posts • Delays in projects resulting in savings in IT budget. More details are in June FPR which was presented to SMT on 23rd July. **Recovery plan to get back to green:** The new Q1 forecast has re-purposed the savings and phased the delays, ensuring the KPIs for the 2025-30 strategic period is met.	Savings have arisen from process changes, contingencies and efficiencies. Regular reforecasting will ensure resources are optimally allocated and expenditure remains aligned to strategic financial targets.
2.3	Staff engagement – pulse survey Employee Net Promoter Score (eNPS) – **−1.59** eNPS: Target is 0-30, which is rated as good Note: the higher the better	**Why amber/red:** Employee Net Promoter Score reduced to −1.59, below the target range of 0-30. The decline appears to be driven by a shift in sentiment in relation to a single question, with more colleagues selecting neutral responses and a small reduction in those who would actively recommend the GOC as a place to work to friends and family. At this stage, the survey does not provide sufficient evidence to draw firm conclusions about the factors behind this change, although informal engagement with some teams has suggested the inclusion of 'friends and family' in the question prompts a negative response, as individuals do not want 'friends and family' in their workplace, rather than not recommending the GOC as a great place to work. The question has been amended to remove reference to 'friends and family' in future surveys. **Recovery plan to get back to green:** Further qualitative feedback will be gathered through directorate and team discussions during August and September. Findings will be used to identify actions to improve communication, engagement, and employee experience.	Increased employee dissatisfaction can lead to higher staff turnover, recruitment and onboarding costs, reduced productivity and greater absenteeism. This can consequently place addition pressure on the budget and service quality, employee morale and organisational performance.

4.6	FtP cases resolved (rolling median) – **47%** Target is ≥60% within 78 weeks	**Why amber/red:** Performance remains below target due to the progression of older, more complex cases progressing to a hearing. This should be considered alongside the continued reduction in the median age of the caseload, demonstrating that legacy cases are progressing through the system. **Recovery plan to get back to green:** We will continue to focus on progressing legacy cases whilst maintaining performance across earlier stages of the process. As the median age of the caseload continues to reduce, we expect this to translate into more sustained improvement in the end-to-end KPI.	Forecasts support increased expenditure on legal charges and hearings to support the progression of these cases. Progressing older and more complex cases requires additional legal and hearing resources, creating cost pressures and impacting overall case resolution performance.
4.9	New investigations at representations – **56%** Target is ≥80%	**Why amber/red:** This reflects some cases taking longer to progress through the early stages of investigation, including where additional evidence, expert input or external information has been required before representations can appropriately be sought. The current position is being actively monitored to ensure delays are identified and addressed at an early stage **Recovery plan to get back to green:** We are maintaining a clear focus on the progression of new investigations, with increased oversight of cases approaching the KPI timeframe and early identification of barriers to progression. Investigation planning and regular case review will continue to be used to ensure necessary evidence is obtained promptly and that cases move to representations at the earliest appropriate point. We expect this focus to improve performance towards the 80% KPI over the coming reporting periods.	Same as above

Overall Assessment

Organisational performance remains strong in Q1. Most KPIs are meeting or exceeding target and key regulatory performance measures continue to perform well. Areas requiring management attention relate primarily to employee engagement, financial phasing, and a of Fitness to Practise timeliness measures. Current recovery plans and forecasts indicate these issues are being actively managed, and no significant strategic risks have been identified at this stage.

GOC Internal Business Plan – 2026/27
Council Exceptions Report – Q1 update

All CRITICAL and ESSENTIAL Q1 activities are either ON TRACK or COMPLETE for the following business areas:

Case Progression, Hearings, Legal
Communications, CPD, Policy and Standards
Facilities, Finance, Registration
People & Culture
Governance

The following slides describe, with commentary, CRITICAL and ESSENTIAL Q1 activities that are either OFF TRACK (amber) or DEADLINE MISSED (red)

Regulatory Strategy – Education

Activity	BAU/Project	Timing	Priority	Success Measures	RAG	Comments
Continue to develop CRM within the Education team	Departmental Project (minor scale)	Q2-Q4	● Essential	• Development work is concluded enabling CRM to be used for the different QA activities • 100% providers and qualifications are accurately added on to the CRM, and a bi-annual quality check is completed • 100% of conditions are added post visit, within the agreed post-visit timelines • New performance reports are designed and used which improve our oversight of operational performance		**Why amber/red:** Delays due to sickness absence, competing priorities, and forthcoming Dynamics 365 Support Analyst vacancy. **How we will get back to green:** IT manager and Head of Education and CPD have met to discuss how the CPD Project Manager could support with progressing developments until a new Dynamics 365 Support Analyst is in place. IT Manager to take forward with CRM Project Manager.

Corporate Services – IT

Activity	BAU/Project	Timing	Priority	Success Measures	RAG	Comments
Replace existing 'Search the Register' (StR) with Pixl8 version on new website	Continuous Improvement Project	Q1-Q3	● Essential	Fortesium StR replaced with Pixl8 StR.		**Why amber/red:** The main MyGOC replacement project is delayed which has consequently meant the original target for StR is at risk. **How we will get back to green:** Proposals are being documented which may allow the target deadline to be met, but if the MyGOC project is delayed then StR will have to be replaced in 2027.

Change – Continuous Improvement

Activity	BAU/Project	Timing	Priority	Success Measures	RAG	Comments
Project Delivery/Support - PBF solution development (support)	Strategic Project	Q1-Q4	Essential	• Support with pilot solution selection and development • SME/Advisory and other support • Support with agreed solution development and implementation to agreed timelines		**Why amber/red:** Work paused pending a general review of the PBF process and feedback. Outcome may require change the scope of the project and the proposed system/solution **How we will get back to green:** Re assessment of the initiative following the outcomes of the review

COUNCIL

Report from the Chair of Council

Meeting: 30 September 2026 **Status:** For noting

Lead responsibility & paper author: Dr Anne Wright CBE (Chair of Council)

Introduction

1. This report covers my principal activities since the last Public Council meeting on 24 June 2026.

2. We announced the appointment of two new members of the Advisory Panel; Dhillon Memhi (Registrant Ophthalmic Optometrist, Standards Committee) and Helen Marriott (Lay, Education Committee). Their terms of office commenced on 28 September 2026 for a period of four years until 27 September 2030.

Management

3. I have held weekly catch-up meetings with Leonie Milliner, Chief Executive and Registrar (CE&R) and with Andy Mackay-Sim, Chief of Staff.

4. As well as other meetings on specific priorities and issues, I have held quarterly 1:1 meetings with individual Senior Management Team (SMT) members.

5. On 30 June 2026, I joined the open invite Rainbow and Able partnered session which explored the intersection of LGBTQIA+ and neurodivergent identities, and what that meant for inclusion in practice.

6. The SWEG coffee break presented a World Chocolate Day open invite session on 7 July 2026, which I joined and organised by Joanna Murphy, EDI Manager. To celebrate, Jayne Brown, mother of Abigail Brown, Internal Communications Officer, kindly shared insights into her role as a chocolate taster for Nestlé.

7. For South Asian Heritage Month, the Embrace and Women's Networks organised a session on 20 July 2026. The session explored this year's theme, understanding unity and diversity and was hosted by Kiran Gill, Chief Legal Officer, Rekha Randhawa, Head of FTP (Legal) and Roma Malik, Optometrist Clinical Advisor.

8. On 21 July 2026, I joined the July All-Staff Meeting (ASM) and contributed a brief introduction item around my role as Chair of Council.

9. I watched the Staff Wellbeing and Engagement Group (SWEG) coffee break recording from the 4 August 2026, where Council Members, Lisa Gerson and Cathy Yelf spoke about their experiences of receiving their awards of an MBE (Member of the Order of the British Empire) at Windsor Castle.

10. As part of this year's theme for South Asian Heritage Month, (unity and diversity), I attended the Embrace and ABLE Network session on 19 August 2026 with external Speaker, Bhavini Makwana. Bhavini spoke about how she was diagnosed with Retinitis Pigmentosa (RP) and how she has adapted well whilst living with a deteriorating eye condition, including her achievement in founding BAME Vision.

11. On 3 September 2026, Council Members Lisa Gerson and Ros Levenson presented a joint EDI session entitled, 'Understanding the Jewish High Holy Days'.

12. I watched the Together in Care Network and Rainbow Network recording from 9 September 2026 where staff members were invited to join a conversation which explored different paths to parenthood and the experiences of LGBTQ+ parents and carers.

13. During the 14 September 2026 - 20 September 2026, National Inclusion Week 2026 activities for staff members were held.

14. On 14 September 2026, I attended the opening event session for National Inclusion Week (NIW). The theme for the week recognised the importance of continuing to create inclusive workplaces where people feel valued, heard and

supported, even during times of change. The opening webinar set the scene for the activities planned.

15. In a further session, ‘Build Trust. Navigate Change’ hosted by external speaker, Rebecca Renshaw, we celebrated Welsh culture.

16. On 15 September 2026, I joined a NIW lunch and learn session, celebrating Raksha Bandhan, a festival that honours the bond between siblings and the importance of love, care and protection within families and communities. Ram Kundnani, Senior Digital Transformation Lead and Kiran Gill, Chief Legal Officer, offered personal stories and reflections and shared the significance of Raksha Bandhan, how it is celebrated, and what the festival meant to them.

Council and Committees

17. I have continued to join fortnightly meetings with Tim Parkinson, Senior Council Member (SCM).

18. I have also held catch-ups with Council Members and Associates and participated in induction sessions for incoming members.

19. On 24 June 2026, I attended a Lord Mann Review briefing meeting with Leonie Milliner, CE&R, Lisa Gerson and Ros Levenson, Council Members and Andy Mackay-Sim, Chief of Staff and Joanna Murphy, EDI Manager.

20. I attended a meeting on 17 August 2026 with Tim Parkinson, SCM, Lisa Gerson, Council Member, John Cappock, Audit, Finance, and Risk Committee (ARC) Chair. Joined by Leonie Milliner, CE&R, Marc Stoner, Director of Corporate Services, Manori Wickremasinghe, Chief Financial Officer and Andy Mackay-Sim, Chief of Staff.

21. On 17 September 2026, I met with Kalwant Grewal, Council Member for a review discussion.

22. I attended the Remuneration Committee meeting on 2 July 2026; the Audit, Risk and Finance Committee (finance view) meeting on 7 July 2026; the Audit, Risk and Finance Committee (risk view) meeting on 7 September 2026; the Nomination Committee meeting on 22 September 2026; and the Council catch-up sessions on 7 July 2026 and on 8 September 2026.

Stakeholders

23. 30 June 2026: GOC and Professional Standards Authority for Health and Social Care (PSA) joint Chair and CE&R meeting accompanied by Leonie Milliner, CE&R, with Caroline Corby, PSA Chair and Alan Clamp, PSA Chief Executive.

24. 10 September 2026: Department of Health and Social Care (DHSC) quarterly catch-up meeting accompanied by Leonie Milliner, CE&R and Steve Brooker, Director of Regulatory Strategy, with Phil Harper, DHSC Deputy Director Professional Standards, and International Workforce.

Council Member meetings with stakeholders

25. N/A

COUNCIL

Chief Executive and Registrar's Report

Meeting: 30 September 2026 **Status:** For noting

Lead responsibility and paper author: Leonie Milliner, Chief Executive and Registrar

Council Lead(s): Dr Anne Wright CBE, Council Chair

Purpose

1. To provide Council with an update on stakeholder and other meetings attended by the Chief Executive and Registrar and activities not reported elsewhere on the agenda.

Recommendations

2. Council is asked to note the Chief Executive and Registrar's report.

Strategic objective

3. This work contributes towards the achievement of all parts of our Strategic Plan and our 2026-2027 Business Plan.

Background

4. The last report to Council was provided for its public meeting on 24 June 2026.

Analysis

5. I will start my report by paying tribute to Nicola McNally, a member of our investigations team, who sadly passed away on 20 August 2026, having been unwell for a while. Nicola was a highly experienced investigator with a wealth of experience in health regulation, having joined us from the General Dental Council in 2018. Nicola had a wonderful sense of humour, warmth and positivity, and she is much missed by everyone at the GOC, most especially by her colleagues in the Regulatory Operations team.
6. We opened an online book of condolence, which contained many moving tributes and personal memories from those who worked closely with Nicola. She is fondly remembered by all, and we have sent our deepest condolences to Nicola's family, with whom we remain in close contact.
7. Since Council last met, we have welcomed four new members of staff, Janice McCrudden, Head of Optometric Advice; Nicola Bibbey, Education Operations

Manager; Naseer Shan, Registration Officer; Nouara Adamou, Hearings and Scheduling Officer. I meet monthly with all new members of staff for an informal introduction to the GOC as part of their induction programme.

8. Rekha Randhawa, Head of FTP (Legal) commenced her role as an interim Head of Investigations on 1 September 2026 and completed a handover with Rebecca Bryan, Head of Investigations.

9. I would like to thank Ania Feranska-Iqbal, Dynamics 365 Support Analyst; Emma Pitt, Performance and Implementation Lead and Sandeep Kaur Dulku, People and Culture Manager who have all left the GOC since our last report. We are very grateful for their contributions and wish them well for the future.

Internal engagement

10. I have weekly meetings with Dr Anne Wright, Chair of Council, Andy Mackay-Sim, Chief of Staff, with each Director of the Senior Management Team (SMT) and other members of the executive as required. I met with Emma Storer, Head of People and Culture at least monthly for people and culture partner meetings.

11. I continue to chair our SMT's fortnightly meetings, and I attended SMT's monthly corporate Risk Register meetings chaired by the Director of Corporate Services. I also chaired the SMT strategy, planning and preparation day on 11 August 2026.

12. On 10 August 2026, I attended the Leadership Team (LT) meeting chaired by Charlotte Urwin, Head of Strategy, Policy and Standards.

13. I chaired the monthly All-Staff Meetings (ASM) with all staff members invited. Hema Radhakrishnan, Council Member, joined our ASM in June, and Dr Anne Wright, Chair of Council, kindly contributed to the July ASM. I also reviewed all reward and recognition letters prepared by the people and culture team.

14. As part of our National Inclusion Week (NIW) skills development programme, I led a presentation skills workshop in the office on 16 September 2026 aligned with this year's theme, 'Build Trust. Navigate Change' for six members of staff.

Council and Committee engagement

15. I attended the pre-Council catch-up meeting on 24 June 2026 with Kalwant Grewal, Council Member and Andy Mackay-Sim, Chief of Staff.

16. On 24 June 2026, I contributed to the Lord Mann's Review on antisemitism and

other forms of racism in the NHS briefing meeting with Dr Anne Wright, Chair of Council, Lisa Gerson and Ros Levenson, Council Members, Andy Mackay-Sim, Chief of Staff and Joanna Murphy, EDI Manager.

17. I attended a bilateral meeting on 1 July 2026 with Tim Parkinson, Senior Council Member (SCM).

18. I attended the Remuneration Committee meeting on 2 July 2026; the Audit, Risk and Finance Committee (ARC) meetings on 7 July 2026 and on 7 September 2026; the Council catch-up sessions on 7 July 2026 and on 8 September 2026; and the Nomination Committee meeting on 22 September 2026.

19. On 17 August 2026, I joined a meeting with Dr Anne Wright, Chair of Council, Tim Parkinson, SCM, Lisa Gerson, Chai of Nominations Committee and John Cappock, ARC Chair. In attendance were Marc Stoner, Director of Corporate Services, Manori Wickremasinghe, Chief Financial Officer and Andy Mackay-Sim, Chief of Staff.

<u>Staff wellbeing and engagement</u>

20. The volunteer internal staff networks continue to work hard to mark important cultural events and religious festivals, and I would like to express my thanks to the network chairs and committees for their impactful leadership which helps secure employee wellbeing and belonging, as well as promote a culture of psychological safety.

21. On 30 June 2026, I attended the Rainbow and Able network sessions exploring the intersection of LGBTQIA+ and neurodivergent identities, and what that meant for inclusion in practice. We looked at lived experiences, common barriers, and simple ways we could create more inclusive environments for colleagues and patients.

22. On 1 July 2026 I participated in the Staff Wellbeing and Engagement Group (SWEG) session, where staff members had an opportunity to create rainbow-themed bracelets to wear and show their support at the Pride Picnic event.

23. On 7 July 2026 our SWEG coffee break celebrated World Chocolate Day when Jayne Brown, our Internal Communications Officer's mother, kindly shared insights into her role as a chocolate taster for Nestlé.

24. For South Asian Heritage Month, our Embrace and Women's Network organised a session on 20 July 2026 to explore this year's theme,

understanding unity and diversity, hosted by Kiran Gill, Chief Legal Officer, Rekha Randhawa, Head of FTP (Legal) and Roma Malik, Optometrist Clinical Advisor. On 29 July 2026, the Embrace Network organised and hosted a short quiz in celebration of South Asian Heritage, which I participated. In support this year's theme (unity and diversity) on 19 August 2026the Embrace and ABLE Networks were honoured to host an external Speaker, Bhavini Makwana, founder of BAME Vision. Bhavini led an inspiring and thought-provoking conversation about how she was diagnosed with Retinitis Pigmentosa; what it has been like growing up as a South Asian female, and the barriers she faced due to ignorance, lack of awareness or understanding. Staff members had the opportunity to ask questions and learn from Bhavini's experiences.

25. I was thrilled to be invited to our SWEG coffee break on 4 August 2026 to hear Council Members Lisa Gerson and Cathy Yelf inspiring talk about their experiences of being awarded an MBE (Member of the Order of the British Empire). Cathy and Lisa shared the stories behind their awards, the contributions that led to this recognition, and what it was like to attend the ceremony at Windsor Castle to receive their honours. This was a fantastic opportunity for staff members to learn more about their experiences and celebrate their achievements.

26. On 3 September 2026, Council Members Lisa Gerson and Ros Levenson presented a joint EDI session entitled, 'Understanding the Jewish High Holy Days'. Lisa provided an introduction to the Yomin Noryium, the Days of Awe, the period encompassing Rosh Hashanah, the Jewish New Year, and Yom Kippur, the Day of Atonement, which this year fell between 11 September 2026 and 21 September 2026. Lisa discussed her own practices and explored the themes of celebration, reflection, repentance, forgiveness, atonement, and renewal. Ros reflected briefly on the diversity of Jewish life and shared some memories of the High Holy Days from her childhood in the Jewish East End of London. Together, they offered staff members an opportunity to learn more about the significance of this important period in the Jewish calendar and to ask questions in an open and respectful environment.

27. The Together in Care Network and Rainbow Network were delighted to invite staff members to a conversation on 9 September 2026 exploring different paths to parenthood and the experiences of LGBTQ+ parents and carers. We were pleased to welcome Melinka Berridge, a Partner and the Head of the Regulatory Team at Kingsley Napley LLP, who shared their personal journey to parenthood and discussed a range of topics with staff members whether a parent, considering parenthood, or supporting parents.

28. During the 14 September 2026 to the 20 September 2026, we marked National

Inclusion Week (NIW) 2026 with a series of activities and skill-building workshops for staff. The theme recognised the importance of continuing to create inclusive workplaces where people feel valued, heard and supported, and provided an opportunity to connect with colleagues from across the organisation. A workshop held on 14 September 2026 celebrated Welsh culture and traditions hosted by external speaker, Rebecca Renshaw, including learning few Welsh words and phrases, leaning about traditional Welsh cakes and an opportunity to sing the Welsh national anthem

29. As part of National Blood Week, I joined the SWEG coffee break blood donation awareness session on 22 September 2026 which highlighted the importance of blood donation and the life-changing impact it could have on patients across the UK.

30. To celebrate National Fitness Day, Joanna Murphy, EDI Manager, hosted a lunchtime bootcamp session on 24 September 2026 with all-staff members welcomed.

People and Improvement

<u>People and Culture</u>

31. Following the successful implementation of the Performance and Behaviour Framework (PBF), we have now completed our first full annual performance cycle for all employees, including the introduction of moderation arrangements to support consistency, fairness, and transparency in performance assessment. The outcomes of the moderation process will inform future workforce and talent discussions, helping to embed a stronger performance culture and providing valuable insight to support succession planning, development priorities, and organisational capability.

32. Workforce planning arrangements have become embedded through quarterly meetings between People and Culture, Finance, and budget holders. This has strengthened our ability to forecast future workforce requirements, identify capacity risks, and ensure workforce decisions are aligned with operational priorities and financial planning.

33. The people policy review programme has continued at pace, with a number of key policies, including our family leave and flexible working policies, reviewed and updated to ensure compliance with evolving employment legislation and alignment with best practice. Alongside this, further work has been undertaken to strengthen colleague understanding of the policies through the development of supporting frequently asked questions, published on our employee intranet,

Iris.

34. Employee wellbeing and engagement remain key areas of focus. During the quarter, work commenced on the development of a people and culture wellbeing strategy, intended to provide a clear framework for promoting positive wellbeing, supporting employee resilience, and enhancing the overall employee experience. In parallel, the Social, Wellbeing and Engagement Group (SWEG) has continued to coordinate a range of wellbeing, networking, and engagement activities, contributing to a positive organisational culture and supporting opportunities for colleagues to connect, collaborate, and share experiences across teams.

35. Preparatory work is underway to support the organisation's readiness for anticipated employment law reforms. The first step has includes reviewing existing people policies and identifying areas where changes to policy or processes may be required. This work will continue over the coming months to implement necessary changes, ensuring the organisation remains compliant with legislative developments whilst maintaining a positive employee experience and supporting effective workforce management.

Project Delivery

36. We are continuing prepare for the launch of MyGOC with front-end product development nearing completion, and most issues and requirements addressed, with the remainder pending testing. Data migration, initial testing, and follow-up work are ongoing. Following UAT testing sign off, the integration will be moved across to live where further testing will continue. Internal and external teams still driving towards end October date to complete the product.

37. The priority remains achieving a fully tested and stable product as quickly as possible. The launch date will be determined separately through operational planning and overall readiness.

38. As part of the onboarding strategy for the MyGOC project, the Registration team has contacted all body corporates and a targeted group of fully qualified registrants to confirm that their contact details are current and to support a smooth onboarding process.

39. With MyGOC nearing its implementation, work has begun in designing the governance structure for the execution of the projects & continuous improvement (CI) function within the organisation. This includes ensuring there is clear oversight of all project and CI work with clear delegation of duties across the governance infrastructure. Plans will be shared with Council at its

November in person strategy session at the GOC offices.

Corporate Services

Fraud and risk

40. At the end of July 2026, we held our first quarterly fraud meeting. This meeting was a brainstorm session to identify possible areas of fraud risk. The fraud leads have developed a fraud risk register with an initial focus on human resource and workforce fraud, expenses and benefits fraud, procurement, supplier and contract fraud, financial management and reporting fraud, information security and cyber enabled fraud and governance, conduct and ethics fraud. The executive proposes to discuss the findings with the Audit, Finance and Risk Committee at its November 2026 meeting.

Registration

41. Student renewals closed on 31 August 2026. The register has been updated to remove students who did not renew their registration. The monthly amendments published on the website have also been updated to reflect these removals.

42. The new student intake opened on 1 September 2026 and will close on 31 October 2026. During this period, approximately 1,500 new students are expected to be registered across all education providers.

Information Technology (IT)

43. The rollout of laptops and GOC email accounts for Council members is underway. This investment will strengthen data security, improve information governance, reduce cyber security risks and provide Council members with secure access to GOC systems and information. Training and implementation support are being provided as part of the rollout.

Finance

44. Internal Audit has completed its review of the GOC's core finance operations and provided a substantial assurance opinion, confirming that key financial controls are operating effectively. The review found strong evidence of appropriate segregation of duties, oversight and governance arrangements, with no evidence of inappropriate payments, control override, systemic weaknesses or high-risk anomalies identified through sample testing and full population data analytics. One low-priority recommendation was made to

strengthen the timeliness of control account reconciliations, which has been accepted and implemented by management.

Facilities

45. Internal audit has completed its review of the GOC's health, safety and wellbeing arrangements and provided a reasonable assurance opinion. The review concluded that the GOC has effective and proportionate arrangements in place to manage health, safety and wellbeing risks, supported by clear policies, risk assessments, training and wellbeing initiatives. As part of the audit, management sought internal audit input on the draft wellbeing strategy. The recommendations made, comprising one medium and two low-priority actions, relate primarily to strengthening the governance and performance monitoring arrangements for the draft strategy and completing planned policy updates. All recommendations have been accepted and are being implemented.

Regulatory Operations

46. Triage has completed implementation of key changes in response to the PSA audit last year. The focus this quarter has moved to embedding improvements to ensure they are consistently applied and sustained across the service. Quality assurance activity indicates positive improvements in the quality and recording of risk assessments and decision-making, demonstrating increased consistency and confidence in the application of policy and guidance.

47. Alongside driving quality improvements, the triage team has continued to respond to increasing volumes of concerns. Over and above the 31% increase in concerns received in 2025-26, we received 12% more concerns in Q1 than in the same period in 2025-26. Additional temporary resource has been secured to strengthen resilience while we maintain timeliness and effective caseload management. In parallel, a programme of SOP reviews and communication improvements has been undertaken across the triage and FTP Orders teams to support effective and efficient service delivery.

48. The focus for the investigations team has been on strengthening the quality and consistency of investigations and the experience of those engaging with our processes. In May 2026, we reinforced our stakeholder support guidance, building on the areas of positive practice recognised by the PSA and internal audit, while responding to opportunities for further improvement. This work supports a more consistent and person-centred approach to engagement throughout the investigation process.

49. In June 2026, we delivered revised allegations drafting guidance and supporting training, providing a clearer and more consistent framework for the identification and formulation of allegations. This strengthens the quality of investigations at an early stage and supports effective decision-making as cases progress.

50. Following a stakeholder consultation, we published revised Hearings and Indicative Sanctions Guidance in July. The guidance improves clarity for Fitness to Practise Committees (FtPCs) when considering applying sanctions as part of fitness to practise proceedings. Improvements include: a clear definition of hearsay, with examples to support FtPCs when applications rely on hearsay evidence; an explanation of factors such as situational vulnerability and special measures that might support vulnerable witnesses in providing best evidence; and clear definitions to distinguish between sexual harassment and sexual motivation.

51. Hearings operational performance remains strong and on track to meet or exceed business objectives for the year. Alongside this, we have strengthened our hearing resources to support continuous improvement in decision-making quality and consistency. This includes successfully recruiting and onboarding seven new Clinical Advisers, increasing the breadth of clinical expertise available to support fitness to practise proceedings.

52. In addition, we have established dedicated resource provision for our pool of Legal Advisers to further enhance the consistency and quality of legal support for committees. This investment includes new guidance and training materials for Legal Advisers to support the drafting of clear, consistent and legally robust decisions for the Fitness to Practise Committee. Complementing this, a bespoke training video explores key aspects of the GOC's legislative framework and provides practical advice on managing hearings and drafting determinations.

53. Elsewhere, the GOC has maintained public protection by stopping illegal sales of non-prescription (fashion) contact lenses by an online seller. We contacted the seller on being informed that a young person had developed an eye infection from using their lenses; the seller immediately suspended sales of the relevant brand and issued a product recall, and they have now ceased sales of all non-prescription contact lenses in the UK. Legally, such lenses can be sold only by or under the clinical supervision of a registered optometrist, dispensing optician or medical practitioner, and the GOC can take action where the risks justify our involvement. The GOC is grateful to the Government agency that brought this matter to our attention.

Regulatory Strategy

Sight testing consultation

54. GOC's consultation on (i) proposed updated testing of sight statement and (ii) proposed revisions to supervision and delegation standards in our Standards of Practice for Optometrists and Dispensing Opticians and Standards for Optical Students opened on 15 July and will close on 21 October.

Approach to setting registrant fees

55. The discussion paper on our approach to setting registrant fees ran from 27 April to 20 July 2026 and received 306 responses. We expect to bring back the draft response document to the Council's December meeting for decision.

Driving vision standards

56. Questions on driving vision were included in the GOC's annual registrant survey, which is covered elsewhere on the agenda. The findings were shared with the Department for Transport and DVLA to inform the government's consultation. As yet, government has not issued its consultation response.

National Commission into the Regulation of AI in Healthcare

57. The National Commission into the Regulation of AI in Healthcare published its report on 10 September.[1] The commission calls for continuous, real-world monitoring throughout a device's lifecycle, public access to safety information on AI, and tougher enforcement powers for the MHRA to protect patients. The report includes the following recommendation (recommendation 32) aimed at the professional regulators:

    "DHSC and the devolved health departments, working with professional regulators, those responsible for setting and delivering education and training for the healthcare professions (including the medical Royal Colleges), and healthcare education providers, should establish a coordinated approach to building professional capability in the safe and effective use of AI in healthcare. This should span initial education, postgraduate training (where relevant) and continuing professional development, and should complement setting-specific training on technologies. Expectations should be expressed as defined

[1] National Commission into the Regulation of AI in Healthcare: Recommendations for a future regulatory framework - GOV.UK

capabilities so that they remain applicable across the four nations and adaptable to the differing needs of professional groups and providers."

58. At our request, SPOKE (Sector Partnership for Optical Knowledge and Education) launched a project in February 2026 to review the current state of AI education across qualifications, identifying gaps, and understanding sector perspectives about AI's impact. The project aims to audit how AI content is covered and explore sector experiences with AI-related challenges such as academic integrity and ethical considerations.

59. The PSA have welcomed the Commission's report and highlighted the need for coordination across the regulatory landscape to develop effective regulation.[2] The Director of Regulatory Strategy is representing GOC on the PSA and MHRA's AI Principles Task and Finish Group, which has been established to develop a shared set of high-level principles for regulators to support them in developing guidance, standards and policy for AI use for their registered health and care professionals. The Group issued a joint statement of intent and is working towards developing the principles by January 2027.

60. Questions on AI were included in the GOC's annual registrant survey for the first time, which is covered elsewhere on the agenda.

Communications

61. New Prime Minister Andy Burnham has announced a new cabinet, including a new Secretary of State for Health, Yvette Cooper, and new junior ministers. Karin Smith retains the portfolio for regulatory reform and responsibility for eye health transfers to James Frith, Parliamentary Under-Secretary of State. I have written to him with an introduction on our key areas of work, and offering a meeting.

62. We launched the GOC's Instagram (@generalopticalcouncil) with a video featuring the Head of Optometric Advice encouraging registrants to contribute to our consultation on proposed updates to the testing of sight statement.

63. We published the joint whistleblowing disclosures report, highlighting the healthcare professional regulators coordinated effort in working together to address the serious issues raised to them. The purpose of this report is to set out how the healthcare professional regulators handle disclosures, highlight the action taken about these issues, and to improve collaboration across the health sector.

[2] PSA welcomes National AI Commission report | PSA

64. We sent a monthly registrant email newsletter, and an edition of FtP Focus, our in-depth newsletter demystifying FtP, which discussed the different kinds of declarations registrants need to make, the triage process, and included case studies.

Education and Continuing Professional Development (CPD)

65. I granted permission to both De Montfort University and University of Leicester to recruit students to their new Master of Optometry qualifications. Both universities began to take on students to these qualifications in September.

66. City St George's, University of London's adaptation to the Education and Training Requirements (ETR) for its independent prescribing qualification was noted. Its Postgraduate Certificate in Therapeutic Prescribing qualification under the ETR will begin to take on students from September 2026.

67. To mark the halfway point in the 2025-27 CPD cycle, we issued a press release highlighting overall progress on points tallies. Analysis of CPD data from the end of June 2026 showed that 43% of registrants – just over 10,900 – were 'on track' with their general points total at this stage of the cycle, meaning they had achieved at least half of their general points requirement. The data also showed that nearly four in five registrants had completed a personal development plan. The theme of the press release was 'slow and steady wins the race'. With 18 months remaining in the cycle, we encouraged registrants to review their progress and take steps now to ensure they remain on track to complete their CPD requirements by the end of 2027.

Governance

68. Following a competitive procurement process, we have commissioned a board effectiveness review. This will be delivered by Campbell Tickell through Q3 – Q4 2026/27. A final report including recommendations and a proposed response to Council will be considered in summer 2027.

69. The Chief of Staff has been working closely with Director of People and Improvement to develop the GOC's AI Governance Board. The Board has been reviewing, approving and monitoring projects that use AI in the GOC. It has established a risk assessment tool that has begun to define our risk appetite in relation to the use of AI. The most visible output of these recent discussions will be the use of AI to help produce the minutes from this public Council meeting.

70. The member database project has made significant progress and is nearing a

key milestone, with the project due to enter the testing phase and a go-live launch date now established. This work will deliver an enhanced system for managing member information and supporting operational efficiency across the department.

71. The team has also navigated a period of transition in committee management responsibilities. The change has provided valuable opportunities to strengthen team resilience, broaden governance expertise, and build greater flexibility and capability across the function. The team has been working collaboratively to maintain effective governance support throughout the transition.

Equality, Diversity, and Inclusion (EDI)

72. Following Council approval of the EDI Action Plan 2026-27, progress continues across all five priority themes. Activity has increasingly focused on implementation, with several key projects moving from design into delivery

73. The Equality Impact Assessment (EqIA) review has reached a significant milestone. The pilot phase has now been completed, feedback has been incorporated into the guidance and templates, and the revised approach has been reviewed by senior colleagues. Final documentation is currently progressing through SMT approval ahead of organisation-wide implementation.

74. Progress has continued on our inclusive recruitment programme. Phase 1 is now approximately 80% complete, with the remaining activity focused on refreshing the recruitment and selection policy, which is currently progressing through review and approval processes. Phase 2 has now commenced in partnership with our HR Business Partner and will focus on developing practical tools and resources, including a refreshed recruitment toolkit, a shortlisted candidate information pack, and a detailed review of the Hireful recruitment system to better understand opportunities to support inclusive recruitment practices.

75. Work to strengthen our diversity data collection and engagement has continued. Our new internal EDI data and insight page is now live, helping colleagues better understand organisational diversity data and trends. We have also updated the corporate complaints webpage, related forms and administration emails to improve diversity data declarations and encourage greater transparency. The next phase of work will focus on strengthening diversity data messaging and collection opportunities through our external website and MyGOC.

76. We have made further progress in strengthening our approach to cultural safety

and anti-racism. Suppliers have now been identified for our cultural safety programme, antisemitism training and anti-Muslim hostility training, with onboarding and contract approval processes underway. An update will be provided to all colleagues at an upcoming All Staff Meeting, including an overview of our wider anti-racism programme and opportunities to register for forthcoming learning and development activities.

Lord Mann Review – implications for regulators

77. Since the publication of the Lord Mann Review into antisemitism and other forms of racism in the NHS and healthcare regulatory system, we have continued to assess the recommendations and their implications for the GOC. A detailed review has been undertaken, including mapping recommendations against current activity, policies and practices, identifying areas of strong alignment and opportunities for further development.

78. To maintain focus and accountability for this work, we have established a cross-organisational task and finish group to oversee delivery of actions arising from the review and our wider anti-racism programme. The group will coordinate activity across teams, monitor progress and support implementation through existing governance arrangements.

79. We have also continued engagement with sector partners, including the Professional Standards Authority and other health and care regulators, to support greater consistency in approaches to discrimination, racism, antisemitism and anti-Muslim hostility across the regulatory landscape.

80. Alongside this, suppliers have been secured for antisemitism training, anti-Muslim hostility training and our wider cultural safety programme, with onboarding and contract approval processes underway. Colleagues will receive an update through a forthcoming All Staff Meeting, including opportunities to participate in learning activities and understand how this work contributes to our wider anti-racism commitments.

81. To maintain focus and accountability, we have established an internal task and finish group to oversee delivery of actions arising from both the Mann Review and our broader anti-racism programme.

82. A separate paper elsewhere on this agenda sets out the findings of our assessment, proposed implementation approach and recommendations for Council consideration.

External Stakeholder Engagement

83. Since the last public Council meeting on 24 June 2026, I have attended the following external meetings and engagements:

- 25 June 2026: Chief Executives of Health and Social Care Regulators Steering Group (CESG) meeting organised by Nick Jones (CESG Chair), Chief Executive and Registrar (CE&R) at the General Chiropractic Council (GCC) with the relevant regulatory bodies in attendance.

- 30 June 2026: GOC and Professional Standards Authority for Health and Social Care (PSA) joint Chair and CE&R meeting accompanied by Dr Anne Wright, Chair of Council, with Caroline Corby, PSA Chair and Alan Clamp, PSA Chief Executive.

- 30 June 2026: General Medical Council (GMC) Reception, Supporting the UK's Medical Workforce, sponsored by Lord Hunt of Kings Heath and organised by Professor Dame Carrie MacEwen, GMC Chair, with other health sector leaders in attendance.

- 3 July 2026: Thomas Pocklington Trust (TPT) Get Set Progress Internship Celebration Event 2026, organised by the TPT team and accompanied by Joanna Murphy, EDI Manager.

- 28 July 2026: Institute of Regulation (IoR) pilot meeting for small regulators (with fewer than approximately 50 staff), organised by Sinéad Whelan, IoR Chief Operating Officer (Acting Director).

- 29 July 2026: Intellectual Property Regulation Board (IPReg) introductory meeting with Jay Parmar, Chief Executive and Sally Gosling, Head of Education Review.

- 30 July 2026: Chief Executives of Regulatory Bodies (CEORB) meeting organised by Nick Jones, CEORB Chair and GCC CE&R with the relevant regulatory bodies in attendance.

- 3 August 2026: Public sector leadership research confidential interview conducted by Heather Connery from the Henley Business School. Organised by Dr Filipe Morais, Lecturer in Governance and Professor Kevin Money, Professor of Reputation and Responsible Leadership.

- 4 August 2026: De Montfort University's (DEM) Master of Optometry stage 3 application meeting accompanied by Steve Brooker, Director of Regulatory

Strategy, Georgina Carter, Education Operations Manager and Georgia Smith, Education Officer (Development), with Simon Oldroyd, DEM Pro Vice Chancellor, Dr Kim Stuart, DEM Head of School, David Bryan, DEM Director of Faculty Operations, and Nat Potiwat, DEM Subject Group Lead in attendance.

- 19 August 2026: I chaired the Optical sector CEO meeting accompanied by Andy Mackay-Sim, Chief of Staff. With the relevant sector bodies, including Adam Sampson, Association of Optometrists (AOP) Chief Executive, Harjit Sandhu, Federation of Ophthalmic and Dispensing Opticians (FODO) Group Managing Director, Alistair Bridge, Association of British Dispensing Opticians (ABDO) Chief Executive, and Ian Humphreys, College of Optometrists (COO) Chief Executive in attendance.

- 3 September 2026: Anti-Muslim hostility training supplier meeting accompanied by Joanna Murphy, EDI manager with Professional Speaker, Sal Naseem.

- 9 September 2026: National Health Service (NHS) England professional regulators forum, organised by Professor Sheona MacLeod, National Director of Education and Training at NHS England (People Group).

- 10 September 2026: Department of Health and Social Care (DHSC) quarterly catch-up meeting accompanied by Dr Anne Wright, Chair of Council and Steve Brooker, Director of Regulatory Strategy, with Phil Harper, DHSC Deputy Director.

- 14 September 2026: Antisemitism training briefing meeting accompanied by Joanna Murphy, EDI manager with Mark Rusling, Head of Training at the Antisemitism Policy Trust.

- 16 September 2026: Fieldfisher regulators workshop, ‘How can regulators effectively prepare for, and manage, crises?’, organised by Tom Crawford, Fieldfisher Practice Development Director and the Fieldfisher Regulatory Team, which involved Sarah Ellson, Partner, Olivia Rogers, Senior Associate and Charlie Smith, Associate.

- 18 September 2026: GOC defence stakeholder group meeting organised by Carole Auchterlonie, Director of Regulatory Operations with the relevant staff and stakeholders in attendance.

- 21 September 2026: GOC and Australian Health Practitioner Regulation

Agency (Ahpra) meeting accompanied by Steve Brooker, Director of Regulatory Strategy and Charlotte Urwin, Head of Strategy, Policy and Standards with Justin Untersteiner, Ahpra CEO, Stuart Aamodt, Optometry Board of Australia Chair, Lynda Pham, Optometry Board of Australia Executive Officer.

- 25 September 2026: CESG meeting organised by Nick Jones (CESG Chair), GCC CE&R, with the relevant regulatory bodies in attendance.

84. A range of other engagements by Directors are listed in Annex 1.

Finance

85. This paper requires no decisions and so has no financial implications.

Risks

86. The corporate risk register has been reviewed in the past quarter and discussed with ARC.

Equality Impacts

87. No impact assessment has been completed as this paper does not propose any new policy or process.

Devolved nations

88. We continue to engage with all four nations across a wide range of issues.

Other impacts

89. No other impacts have been identified.

Communications

External communications

90. This report will be made available on our website, but there are no further communication plans.

Internal communications

91. An update to staff normally follows each Council meeting, which will pull out relevant highlights.

Next steps

92. There are no further steps required.

Attachments

Annex 1 - Directors' stakeholder and other meetings.

Philipsia Greenway Director of People and Improvement	**Steve Brooker** Director of Regulatory Strategy	**Carole Auchterlonie** Director of Regulatory Operations	**Marc Stoner** Director of Corporate Services
26.6.26 – EB Partnership monthly meeting	Meetings with national optometric advisers – scheduled fortnightly		26.6.26 – GOC and EB partnership catch up.
30.6.26 – SIRO training with Data Privacy Advisory (DPAS)	2.7.26 – PSA – regular catch-up		2.6.26 – IoR workforce SIG
29.7.26 – GOC Project Board with suppliers	15.7.26 – Teesside and Aston Universities – sight testing of young children		7-7-26 – Audit planning meeting with TIAA.
18.8.26 – Survey Initiative re pulse survey	21.7.26 – PSA/MHRA - AI Task and Finish Group		29.7.26 – MyGOC project Board
24.9.26 – Addecco webinar on Employment Law changes	22.7.26 – Chief Executives Steering Group		8.8.26 – External audit completing meeting with HaysMac.
25.7.26 – EB Partnership monthly meeting	28.7.26 – NHS Scotland – workforce planning		13.8.26 – Meeting with GOC insurers
	4.8.26 – ABDO – sight testing consultation		19.8.26 – Meeting with TIAA on risk development session for Council
	4.8.26 – De Montfort University – Stage 3 application		

Philipsia Greenway Director of People and Improvement	**Steve Brooker** Director of Regulatory Strategy	**Carole Auchterlonie** Director of Regulatory Operations	**Marc Stoner** Director of Corporate Services
	10.8.26 – Teesside and Aston Universities – sight testing of young children		
	18.8.26 – PSA/MHRA - AI Task and Finish Group		
	24.8.26 – NHS England – sight testing of young children		
	25.8.26 – Public Health Scotland – sight testing of young children		
	26.8.26 – Welsh Government – sight testing consultation		
	27.8.26 – Chief Executives Of Regulatory Bodies (CEORB)		
	9.9.26 – Public Health Scotland – sight testing of young children		
	10.9.26 – DHSC – regular catch-up		

ANNEX ONE - Directors' meetings/visits since last Council meeting

Philipsia Greenway Director of People and Improvement	**Steve Brooker** Director of Regulatory Strategy	**Carole Auchterlonie** Director of Regulatory Operations	**Marc Stoner** Director of Corporate Services
	11.9.26 – chaired Optical Sector Policy Forum		
	15.9.26 – PSA/MHRA - AI Task and Finish Group		
	21.9.26 – Australian Health Practitioner Regulatory Agency – thematic review		
	22.9.26 – PSA/MHRA - AI Task and Finish Group		
	25.9.26 – Teesside and Aston Universities – sight testing of young children		
	25.9.26 – PSA – regular catch-up		
	28.9.26 – Hosted visit by Malaysian Optical Council		

Council Meeting (Strictly Confidential) 8 December 2026

For decision

- External audit provider: contract decision
  [Reason for inclusion: 3.15.2]

For discussion

- Corporate risk register
  [Reason for inclusion: 3.15.4]

For noting

- ARC 24 November 2026 update (verbal)
  [Reason for inclusion: 3.15.5]
- Investment Committee 10 November 2026 update
  [Reason for inclusion: 3.15.5]
- Nominations Committee 25 November 2026 update (verbal)
  [Reason for inclusion: 3.15.1]

Training Session

- Anti-Muslim hostility awareness training

Council Meeting (Public) 9 December 2026

For decision

- Gifts and hospitality policy
- Management of interests policy
- Registrant fees 2027/2028
- Annual reappointment of Council members to committees
- Fees discussion paper consultation response
- Data Strategy

For discussion

- H&S assurance report
- Council's self-assessment against the Charity Governance Code
- Q2 2026/27 Financial performance report/Q2 2026/27 forecast
- Business performance dashboard Q2 2026/27
- Business Plan Assurance Report Q2 2026/27

For noting

- Advisory Panel 16 October 2026 update
- Chair's report
- Chief Executive's Report

Council Catch-up 19 January 2027

Council Catch-up 2 March 2027

Council Meeting (Strictly Confidential) 16 March 2027

For decision

- 5-year forecast and internal business plan 2027/28
  [Reason for inclusion: 3.15.5]

For discussion

- Corporate risk register
  [Reason for inclusion: 3.15.4]

For noting

- ARC 26 January and 23 February 2027 update
  [Reason for inclusion: 3.15.5]
- Nominations Committee 12 January 2027 update
  [Reason for inclusion: 3.15.1]

- Remuneration Committee 9 February 2027 update
  [Reason for inclusion: 3.15.1]

Council Meeting (Public) 17 March 2027

For decision

- 2027-28 Budget, external business plan and five year forecast
- Member fees 27/28
- EDI action plan 27/28
- Outcome of consultation on the statement testing of sight and changes to the standards on supervision
- Public and patient involvement strategy
- Decision on topic for second thematic review *(only if not already included in budget paper)*

For discussion

- Q3 2026/27 Financial performance report
- Business performance dashboard Q3 2026/27
- Business Plan Assurance Report Q3 2026/27
- PSA performance review

For noting

- Advisory Panel 12 February 2027 update
- Chair's report
- Chief Executive's Report