**Second meeting in 2025 of the Council held in PUBLIC**
**on Wednesday 25 June 2025 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** | C17(25) | Chair | 3-6 | |
| **3.** | **Minutes, actions and matters arising**<br>3.1 **Minutes – 19 March 2025**<br>For approval<br>3.2 **Updated actions**<br>For noting<br>3.3 **Matters arising** | C18(25)<br><br>C19(25) | Chair | 7-10<br><br>11 | 10.05am-10.10am (5 mins) |
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| **FOR DECISION** | | | | | |
| **4.** | **Business regulation**<br>For decision | C20(25) | Director of Regulatory Strategy | 12-149 | 10.10am-10.50am (40mins) |
| **5.** | **Standards guidance and consultation document**<br>For decision | C21(25) | Director of Regulatory Strategy | 150-207 | 10.50am-11.20am (30 mins) |
| **6.** | **Council appointments to committees**<br>For decision | C22(25) | Chief of Staff | 208-210 | 11.20am-11.25am (5 mins) |
| | | | | | |
| **11.25am -11.45am Break (20 mins)** | | | | | |
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| **FOR DISCUSSION** | | | | | |
| **7.** | **Optical Consumer Complaints Service Annual Report**<br>For discussion | C23(25) | Director of Regulatory Operations | 211-258 | 11.45am-12.30pm (45 mins) |
| **8.** | **Lived experience research (patients only) and public perceptions research**<br>For discussion | C24(25) | Director of Regulatory Strategy | 259-427 | 12.30pm – 1:00pm (30 minutes) |
| **9.** | **Continuing Professional Development end of cycle report**<br>For discussion | C25(25) | Director of Regulatory Strategy | 428-448 | 1:00pm – 1.15pm (15 minutes) |

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| **1.15pm – 2:00pm Lunch (45 mins)** | | | | | |
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| **10.** | **Financial performance report Q4 2024/25 / Q4 forecast**<br>For discussion | C26(25) | Chief Financial Officer | 449-463 | 2:00pm-2:10pm (10 mins) |
| **11.** | **Business performance dashboard Q4 2024/25**<br>For discussion | C27(25) | Chief of Staff | 464-466 | 2:10pm-2.20pm (10 mins) |
| **12.** | **Business Plan Assurance Report Q4 2024/25**<br>For discussion | C28(25) | Chief of Staff | 467-471 | 2.20pm-2.30pm (10 mins) |
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| **FOR NOTING** | | | | | |
| **13.** | **Advisory Panel Minutes – 6 June 2025**<br>(Companies, Education, Registration and Standards Committees)<br>For noting | C29(25) | Committee Chairs | 472-483 | 2.30pm-2.35pm (5 mins) |
| **14.** | **Chair's report**<br>For noting | C30(25) | Chair | 484-487 | 2.35pm-2.45pm (10 mins) |
| **15.** | **Chief Executive and Registrar's report**<br>For noting | C31(25) | Chief Executive and Registrar | 488-505 | 2.45pm-2.55pm (10 mins) |
| **16.** | **Council forward plan**<br>For noting | C32(25) | Chief of Staff | 506-507 | 2.55pm-3.00pm (5 mins) |
| **17.** | **Any other business (Items must be notified to the Chair 24 hours before the meeting)** | - | Chair | - | 3.00pm-3.05pm (5 mins) |
| | | | | | |
| **Meeting Close – 3.05pm** | | | | | |
| **Date of next meeting – Tuesday 16 September 2025** | | | | | |

| | Own interests | | | | Connected Persons interests |
|---|---|---|---|---|---|
| | **Current interests** | **Professional memberships** | **Previous interests** | **GOC committee memberships** | |
| Raymond **CURRAN**<br>Registrant member (OO) | • Head of Ophthalmic Services, Strategic Planning and Performance Group, DoH, NI | • Life Fellow, College of Optometrists<br>• Member, AOP | • Council Member (1993-2008) and Trustee (2005-2008), College of Optometrists<br>• Member of Court, Ulster University<br>• Council Member and President, Northern Ireland Optometric Society<br>• NICE Fellow (2022/23)<br>• Clinical Tutor, Ulster University | • Member: Audit Risk & Finance Committee<br>• Member: Registration Committee | • None |
| Kathryn **FOREMAN**<br>Lay Member | • Lay Member Assurance & Appointments Committee – General Pharmaceutical Council<br>• Investigations Panel Member – Architects Registration Board<br>• Non-Executive Director- Primary Care 24 (Merseyside) Ltd<br>• Lay Member Police Misconduct Panels – NW Police & Crime Commissioners | • Law Society (non- practising) | • Lay Member Health & Care Professionals Council ( ended December 2023)<br>• Associate Midlands and Lancashire Commissioning Support Unit ( 2022-23) | • Lay Council Member<br>• Member: Advisory Panel – Registration Committee (from Dec 2024)<br>• Member, Audit, Risk and Finance Committee (from Dec 2024) | • None |
| Lisa **GERSON**<br>Registrant (OO) | • Clinic Tutor: Cardiff University<br>• Observer status: Regional Optical Committee (ROC) meetings across Wales<br>• Observer status: GOC representative to Optometry Wales | • Member of AOP<br>• Member of College of Optometry | • Chair: Optometry Wales<br>• Member: GOC Hearings Panel<br>• Member/Acting Chair: GOC Investigation Panel<br>• Member: GOC Education Visitor Panel<br>• College Counsellor: College of Optometrists<br>• Trustee: College of Optometrists<br>• Trustee: AOP<br>• Employee: Ronald | • Member: Remuneration Committee<br>• Registration Committee Chair<br>• Nominations Committee Chair<br>• Council lead for FtP | • None |

| | Own interests | | | | Connected Persons interests |
|---|---|---|---|---|---|
| | **Current interests** | **Professional memberships** | **Previous interests** | **GOC committee memberships** | |
| | | | Brown Group<br>• Employee: Boots Optician<br>• Primary Care Supervisor: Cardiff University | | |
| Ken **GILL**<br>Lay Member | • Independent Management Board member of the Council of the Inns of Court (until 31 December 2024).<br>• Main Board Non-Executive Member and Chair: Audit and Risk Assurance Committee at the Legal Aid Agency.<br>• Honorary member: Study Portals | • Chartered Accountant Member of the Chartered Institute of Public Finance and Accountancy.<br>• Chartered Member of the Chartered Institute of Personnel and Development<br>• Fellow of the Royal Society of Arts | • Independent member of the Audit and Risk Committee of the General Medical Council<br>• Independent member of the Audit and Risk Committee of the Royal College of Veterinary Surgeons.<br>• Vice Chair of Board and Chair of Audit Committee at the Countess of Chester NHS Foundation Trust.<br>• Client of FTP auditors Weightmans Weightmans and Stewart Duffy (in role with Countess of Chester NHS Foundation Trust).<br>• UK Advisory Board member: Study Portals | • Member: Lay Council member<br>• Chair: Audit, Risk & Finance Committee | • None |
| Ros **LEVENSON**<br>Lay member | • Chair of The Expert Advisory Group for the OSIRIS B project at Queen Mary University of London<br>• Chair of The SKILL mix-ED study 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<br>• Member: Nominations Committee<br>• Member: Standards Committee<br>• Council lead for Thematic Reviews | None |
| Frank **MUNRO**<br>Registrant (OO) | • Director Munro Eyecare Limited (T/A Munro Optometrists) | • Past President and Honorary Life Fellow, College of | • Past President, College of | • Registrant Member: Council | • None |

| | Own interests | | | | Connected Persons interests |
|---|---|---|---|---|---|
| | **Current interests** | **Professional memberships** | **Previous interests** | **GOC committee memberships** | |
| | • Founding member, Optometry Scotland<br>• Optometric Advisor, NHS Lanarkshire<br>• Lead Optometrist, Glasgow City Health & Social care Partnership<br>• Visiting Lecturer, Glasgow Caledonian University<br>• Visiting Lecturer, Edinburgh University (MSc Ophthalmology programme)<br>• Chair, NHS Lanarkshire Optometric Advisory Committee<br>• Member, Greater Glasgow & Clyde Prescribing Review Board | Optometrists<br>• Member, Association of Optometrists<br>• Member, Optometry Scotland<br>• Hon Fellow, Association of Dispensing Opticians<br>• Member, British Contact Lens Association | Optometrists<br>• Past Chair, Optometry Scotland<br>• Past Chair, Scottish Committee of Optometrists<br>• Past Chair, NHS Education for Scotland Optometry Advisory Board | • Member: Education Committee<br>• Member: Audit, Risk & Finance Committee<br>• | |
| Tim **PARKINSON**<br>Lay Member | • Director: Tim Parkinson Limited (consultancy not to optical sector or organisations linked to optical sector) | • Fellow: Chartered Management Institute<br>• Membership of the Institute of Water | • None | • Senior Council member<br>• Chair: Investment Committee<br>• Chair: Companies Committee<br>• Chair: Remuneration Committee | • None |
| Prof. Hema **RADHAKRISHNAN**<br>Registrant (OO) | • Professor and Member of the Board of Governors: University of Manchester-<br>• Member of Advisory Board: Zeiss Vision group<br>• External examiner- Aston University Undergraduate and Masters Optometry programmes<br>• Research funding and collaboration with Optegra Eye Hospital group<br>• Associate Editor, Translational Vision Science and Technology, an Association of Research in Vision and Ophthalmology Journal. | • Member: College of Optometrists- | • Editorial board member Optometry in Practice, a College of Optometrists journal | • Registrant member: Council<br>• Member: Advisory Panel – Education | • None |
| Poonam **SHARMA**<br>Registrant (OO) | • Lead Optometry Adviser, NHSE (London)<br>• Occasional locum optometrist, various high street optical practices<br>• Mentor, Social Mobility Foundation | • Member of AOP<br>• Member of College of Optometrists | • | • Member: Council<br>• Companies Committee<br>• Council lead for regulatory reform | • None |
| William **STOCKDALE**<br>Registrant (DO) | • Own an organisation in the Optical Sector - Optomise Ltd 50% Shareholding.<br>• Own an organisation in the Optical Sector - Telford Opticians 50% Stake. | • Member of ABDO<br>• Member of FODO<br>• Member of ONI | • Chair: Optometry Northern Ireland<br>• Member of a consultative body in the Optical Sector Member BSO Ophthalmic Committee. | • Member: Council Member<br>• Member: Nominations Committee<br>• Member: Advisory Panel – Standards Committee | • None |

| | Own interests | | | | Connected Persons interests |
|---|---|---|---|---|---|
| | **Current interests** | **Professional memberships** | **Previous interests** | **GOC committee memberships** | |
| | | | • Non-Executive Director FODO | | |
| Dr Anne **WRIGHT** CBE<br>Lay Chair | • None | • None | • Committee member: The Shaw Society<br>• Director of Circa management company | • Chair: Council | • None |
| Catherine **YELF**<br>Lay Member | • Trustee, Action Against AMD (Eye research charity) unremunerated | • None | • None | • Lay Member: Council<br>• Member: Companies Commitee<br>• Member: Investment Committee<br>• Council lead - FtP | • None |

# GENERAL OPTICAL COUNCIL
## DRAFT Minutes of the public Council meeting held on Wednesday 19 March 2025 at 10am via Microsoft Teams

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| Present: | Dr Anne Wright CBE (Chair), Kathryn Foreman, Josie Forte, Mike Galvin, Lisa Gerson, Clare Minchington, Frank Munro, Tim Parkinson, Hema Radhakrishnan, Roshni Samra and William Stockdale.<br><br>Deepali Modha, Rupa Patel and Desislava Pirkova (Council Associates). |
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| GOC attendees: | Carole Auchterlonie (Director of Regulatory Operations), Steve Brooker (Director of Regulatory Strategy), Nicole Fitzgerald (Communications Manager), Kiran Gill (Chief Legal Officer), Philipsia Greenway (Director of Change), Vikki Julian (Head of Communications & Engagement), Andy Mackay-Sim (Chief of Staff), Leonie Milliner (Chief Executive and Registrar, Ivon Sergey (Governance and Compliance Manager) (Minutes), Catherine Walker (Communications and Public Affairs Officer) and Manori Wickremasinghe (Chief Financial Officer). |
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| External attendees | Siobhan Carson (Professional Standards Authority (PSA)), Raymond Curran, Olivier Deneve (CoO), Ros Levenson, Selina Powell (Optometry Today), Poonam Sharma and Alan Tinger (FODO). |

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| | **Welcome and apologies** |
| 1. | The Chair welcomed those in attendance, including those observing. This included three newly appointed Council members who would assume office on 1 April 2025: Raymond Curran, Ros Levenson and Poonam Sharma. Apologies were received from Jamie Douglas (Council Associate), Kathryn Foreman (Council member), Ken Gill (Council member) and Desislava Pirkova (Council Associates). |
| | |
| | **Declarations of interests C01(25)** |
| 2. | It was noted Lisa Gerson's entry on GOC representative to Optometry Wales should indicate she holds "observer" status. Declarations for all members were made in relation to C04(25) as detailed below. |
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| | **Minutes of the meeting held on 11 December 2024 C02(25)** |
| 3. | The minutes were approved as an accurate record of the meeting subject, to the following amendments:<br><br>Minute 7 to read " public-centric approach" rather than "patient-centric in approach)<br>Minute 14 to read "cater for ..".<br>Minute 14 to "we are looking to tender for investment manager services". |
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| | **Action points update C03(25)** |
| 4. | Council noted updates on previous actions. |
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| | **Matters arising** |
| 5. | There were no matters arising. |
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| | **Member fees 2025/26 C04(25)** |

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| 6. | The Chief of Staff presented the item. It was noted Council members had a financial interest in this item. The Chief of Staff advised that setting member fees was part of Council's statutory powers, and the conflict was unavoidable. However, to mitigate risk of bias, the recommendation was developed using benchmarking data and input of the independent member on Remuneration Committee. Council noted that there were no general increases to member fees proposed. An additional responsibility allowance had been recommended by the Remuneration Committee for the Chair of Audit, Finance and Risk Committee (ARC). |
| | |
| 7. | Council:<br>**noted** Remuneration Committee's review of benchmark data at its meeting on 10 February 2025 and its recommendation that:<br>o there is no general increase in member fees for 2025/26:<br>o the Chair of Audit, Finance and Risk Committee (ARC) remuneration is increased by £2500 per annum;<br>**approved** the member fee schedule for 2025-26 (annex 2); and<br>**approved** consequential amendments to the member fee policy (annex 1). |
| | |
| | **2025-26 budget and external business plan C05(25)** |
| 8. | The Chief Executive presented the item. The proposed budget included all the costs associated with the establishment of a fourth new permanent directorate, funded from the revenue budget. Council noted the proposed budget had been reviewed by ARC. Council supported the choice of topic for a thematic review, noting that four topics would be considered over the life of the corporate strategy. |
| | |
| 9. | Council<br>**approved** the proposed 2025/26 budget (annex 1) and external business plan (annex 2);<br>**approved** the topic for the first thematic review (commercial practice and patient safety) and the allocation of £40k from strategic reserves to undertake the review, subject to advice from Advisory Panel and approval of the business case by Council. |
| | |
| | **EDI action plan 25/26 C06(25)** |
| 10. | The Chief of Staff presented the item. The EDI Manager, Jem Nash, was thanked for their outstanding contribution in delivery of the EDI action plan. It was noted most actions in the 24/25 plan had been completed. The EDI annual report would be presented to Council at its September 2025 meeting. |
| | |
| 11. | Council:<br>**approved** the 2025-26 EDI action plan (annex one). |
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| | **Safeguarding policy C07(25)** |
| 12. | The Chief of Staff presented the item, noting this policy had been identified as a potential area for improvement in the Council's self-assessment against the Charity Governance Code. Council was supportive of the policy, noting training would be key to ensure clarity of responsibilities. |
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| 13. | Council<br>**approved** the Corporate Safeguarding policy;<br>**noted** the accompanying process note; and<br>**delegated** any minor amendments of the policy to the Chief of Staff. |
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| | **Council appointments to committees C08(25)** |
| 14. | The Chief Executive and Registrar introduced the item. |
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| | Council **appointed**:<br>• Lisa Gerson to Remuneration Committee for a two-year term (1 April 2025 – 31 March 2027);<br>• New Registrant member of Council to Audit Risk & Finance Committee and Registration Committee for a two-year term (1 April 2025 – 31 March 2027);<br>• Ros Levenson to Nominations Committee and Standards Committee for a two-year term (1 April 2025 – 31 March 2027);<br>• New lay member of Council to Investment Committee and Companies Committee for a two-year term (1 April 2025 – 31 March 2027); and<br>• Poonam Sharma to Companies Committee for a two-year term (1 April 2025 – 31 March 2027);<br><br>Council **appointed:**<br>• Poonam Sharma will be the Council lead for regulatory reform for a two-year term (1 April 2025 – 31 March 2027);<br>• Hema Radhakrishnan as the Council lead for Speaking Up for a two-year term (1 April 2025 – 31 March 2027);<br>• Hema Radhakrishnan and Ros Levenson the Council leads for thematic reviews for a two-year term (1 April 2025 – 31 March 2027);<br>• New lay member to Council the Council lead for FtP for a two-year term (1 April 2025 – 31 March 2027), alongside Lisa Gerson, current Council lead for FtP; and<br>• William Stockdale as Council lead for member development for a two-year term (1 April 2025 – 31 March 2027). |
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| | **PSA performance review C09(25)** |
| 15. | The Chief Executive and Registrar introduced the item, noting the GOC had met all 18 PSA Standards of Good Regulation for a third year in a row. All staff were congratulated on this outcome. Council was advised the upcoming PSA consultation sought views on the future standards. |
| | |
| 16. | Council<br>**noted** the PSA's assessment of our performance and our work in engaging with the review process. |
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| | **Financial performance report Q3 2024/25 / Q3 forecast C10(25)** |
| 17. | The Chief Financial Officer presented the item, noting forecast KPIs had been met and reasons for variances. Council commented it had confidence in the executive whilst being aware of the global volatility. |
| | |
| 18. | Council<br>**noted** the financial performance for the nine months ending 31 December 2024 in annex 1; and<br>**noted** the Q1 forecast for the current 2024-25 financial year in annex 2. |
| | |
| | **Business performance dashboard Q3 2024/25 C11(25)** |
| 19. | The Chief of Staff presented the item. Council was advised that the measure of customer satisfaction was being updated for 2025/2026 and would report on the number of corporate complaints reaching a formal stage. |

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| 20. | Council **noted** the report. |
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| | **Business Plan Assurance Report Q3 2024/25 C12(25)** |
| 21. | The Chief of Staff presented the item. It was noted Council had approved the internal business plan for 2025/2026 at its strictly confidential meeting on 18 March 2025.<br><br>Council **noted** the report. |
| | |
| | **Advisory Panel Minutes - 21 February 2025 C13(25)** |
| 22. | The Chairs for each committee of the Advisory Panel provided an update.<br><br>Council **noted** the report. |
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| | **Chair's report C14(25)** |
| 23. | The Chair presented the item. Council warmly welcomed the new Council members and Council Associates. It thanked outgoing members for their significant contribution to the GOC and wished them well for the future.<br><br>Council **noted** the report. |
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| | **Chief Executive and Registrar's report C15(25)** |
| 24. | The Chief Executive and Registrar presented key highlights, thanking retiring Council members on behalf of the executive. The GOC had met all 57 standards in its annual Customer Service Excellence accreditation assessment. |
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| | **Council forward plan C16(25)** |
| 25. | Council **noted** the Council forward plan. |
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| | **Any other business** |
| 26. | There were no other matters. |
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| | **Date of the next meeting** |
| 27. | Council noted the date of the next public meeting as **Wednesday 25 June 2025.** |
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| 28. | The meeting closed at 3.05pm. |
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**PUBLIC**
**C18(25)**

**COUNCIL**

**Actions arising from Public Council meetings**

**Meeting Date:** 25 June 2025 **Status:** For noting

**Lead Responsibility and Paper Author:** Nadia Habib, Governance and Compliance Manager

## Purpose

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

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 19 March 2025

| Reference | By | Description | Deadline | Notes |
|---|---|---|---|---|
| **NONE** | | | | |

### Part 2: Action points from previous meetings which remain outstanding.

| Reference | By | Description | Deadline | Notes |
|---|---|---|---|---|
| **H&S assurance report C56(24)** | The Director of Corporate Services | To ensure Council is provided with four quarters of compliance data, rather than the three on the report. | December 2025 | **Ongoing:** This will be incorporated into the next annual report. |
| **NONE** | | | | |

### Part 3: Action points previously outstanding but now completed.

| Reference | By | Description | Deadline | Notes |
|---|---|---|---|---|
| **NONE** | | | | |

**C20(25)i.**

**COUNCIL**

## Response to business regulation consultation

**Meeting:** 25 June 2025 **Status:** For decision

**Lead responsibility:** Steve Brooker (Director of Regulatory Strategy)
**Paper author(s):** Marie Bunby (Policy Manager) and Angharad Jones (Policy Manager)
**Council lead(s):** Poonam Sharma

### Purpose

1. To enable Council to discuss and approve our draft GOC response to our business regulation consultation prior to publication.

### Recommendations

2. Council is asked to approve:
   - the proposed response to our business regulation consultation (see annex 1); 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: Supporting responsible innovation and protecting the public. This work is included in our 2025/26 Business Plan.

### Background

4. Council approved our business regulation consultation in September 2024 and the consultation was open between 23 October 2024 and 22 January 2025. For further background information about the project, see the 'background to the consultation' section of annex 1. The detail of and reasoning behind the proposals can be found in the annexes to the business regulation consultation document.

### Analysis

5. We received 99 responses to the consultation and have carefully analysed each of the free-text comments, pulling out themes (assisted by the artificial intelligence summarisation tool on our consultation platform) and relevant quotes into a draft GOC response document (annex 1).

6. Anticipating that most consultation responses would come from registrants and the organisations that represent their interests, we also commissioned patient and public

research as part of our consultation activities, the findings of which are incorporated into our draft response. We have provided a summary of the omnibus findings (annex 2) and the report on the qualitative research (annex 3).

7. We have received the draft findings from this year's business registrant survey (yet to be published), which found that 82 per cent of businesses agreed that optical businesses providing specified restricted functions should be regulated by the GOC.

8. In our draft report (annex 1), we have proposed a GOC response setting out our views, having considered the consultation feedback. To help focus discussion we would draw Council's attention to the five areas outlined below where there were mixed views from key stakeholders or we have disagreed with the majority view. Given the late stage of the policymaking process, where Council has previously approved a proposal and the feedback was supportive, we consider there should be no need to discuss these issues. We discussed the five areas with Advisory Panel on 6 June 2025 and have incorporated their feedback below and in our response. The full minutes of the meeting of Advisory Panel are available elsewhere on the agenda. In the Advisory Panel discussion, differences of view were often split between business representatives and others.

**All businesses should have a head of optical practice (paragraphs 76-79)**

9. We welcome broad stakeholder support for the head of optical practice (HOP) role and the key responsibilities that should be enshrined in legislation. There is appetite among sector bodies to work through aspects of the proposals in more detail, which we are committed to doing at the appropriate time. While legislation will set the broad framework, many of the detailed issues will be resolved following legislative reform after further public consultation. Therefore, our focus at this stage is on agreeing the key elements that will need to be captured within primary legislation.

10. We considered carefully whether sole traders could be exempted from the requirement to have a HOP on proportionality grounds. However, Advisory Panel's view was that every business should have a HOP given smaller practices may be more likely to have weaker internal controls and to provide greater clarity and consistency in the regulatory framework. Advisory Panel considered that having a senior clinical voice in a business was important including when it is owned and/or managed by lay persons.

**The head of optical practice does not need to be responsible for training placement arrangements (paragraphs 92-94)**

11. While Advisory Panel agreed that the HOP did not need to be responsible for training placement arrangements directly, it considered they would likely have an oversight of the role in the business that did have that responsibility. As such, we do not consider it necessary to give the HOP a specific responsibility for training placements in legislation but would instead rely on the business standards. We therefore updated

our response to include reference to the head of optical practice having a role to play in taking reasonable steps to ensure that the business complies with the requirement in the Standards for Optical Businesses to ensure that all staff 'have suitable levels of training so as not to have an adverse impact on patient safety' (see standard 3.2). When we review the business standards, we will ensure alignment with the agreed policy position to reinforce legislative reform when it comes.

**Removing the £50,000 financial penalty and replacing this with a power to impose an uncapped fine on a GOC registered business (paragraphs 148-151)**

12. Our proposed response to replace our £50,000 financial penalty with an uncapped fine received mixed feedback from Advisory Panel. Members of the panel representing large businesses were more likely to say that they did not see the patient safety evidence for changing the penalty to an unfixed amount, arguing that the damage to the brand of the businesses far outweighed the actual amount of any fine and that fining joint venture partnerships and franchises could lead to complications. Other members of the committee supported an uncapped penalty, trusting in the regulator to be fair and proportionate in its use. It was also noted that optical businesses are already subject to uncapped penalties in other areas such as employment tribunals, so this would not present novel risk. Although most respondents did not support uncapped fines, both alternatives have flaws, and we are satisfied that our favoured approach best future-proofs the legislation and has the flexibility to reflect the varied size and structure of business registrants.

**Having a power to visit a business in the course of a fitness to practise investigation where a concern has been raised (paragraph 158)**

13. Much of the discussion at Advisory Panel on this topic centred around what is happening in the sector with regard to inspections for the purposes of NHS contracts and we clarified that the consultation had not included a proposal to carry out inspections of all businesses. When the discussion focused on whether the power to visit a business was required in the course of a fitness to practise investigation to ensure just decisions, feedback was mixed, with some feeling that we should have this power for future-proofing purposes given the widening scope of clinical practice and others agreeing that the evidence for it was not there and that it could not therefore be justified.

**Require mandatory participation in the Optical Consumer Complaints Service (OCCS) for all GOC registered businesses but *not* to seek legally binding decisions (paragraphs 167-170 and 178-180)**

14. Advisory Panel feedback in this was again mixed, reflecting the range of views sought during the consultation. The voice of those representing larger businesses exhibited a nervousness around whether it was necessary to make participation in the OCCS mandatory, with concerns around cost and whether it was necessary for patient safety purposes. Other members were in favour of an approach that

promoted consistency and equity for patients that was proportionate and avoided duplication.

15. It is of note that the Competition and Markets Authority (CMA) is currently undertaking an investigation into the vets market[1] due to potential concerns about competition that could be leading to poor outcomes for pet owners. One of the potential remedies that they are considering is regulation of veterinary businesses by a dedicated specialist regulator, complementing regulation imposed on individual veterinary professionals. They are also considering effective complaints and redress mechanisms that require veterinary businesses to participate in mediation via an accredited scheme, with longer term possibilities involving supplementing mediation with a form of binding adjudication and establishment of a veterinary ombudsman. Therefore, our proposed response aligns closely with the CMA's thinking.

## Finance

16. We are within budget for this work (utilising existing resources within the Policy team) and are not requesting any additional budget for this financial year. Any new system of business regulation would be unlikely to come into effect for a number of years and we will budget accordingly when forward planning.

## Risks

17. Any changes to the current system of business regulation will require legislative change, linked to the Department of Health and Social Care's (DHSC) legislative reform programme. We received a letter from the Minister of State for Health and Secondary Care on 2 May 2025 confirming the Government's commitment to reforming the regulation of healthcare professionals across the UK. The timetable for change to our legislation remains unknown, with initial focus on the General Medical Council (GMC), Health and Care Professions Council (HCPC) and Nursing and Midwifery Council (NMC) during the current Parliamentary period. Given the uncertainty, we wrote to DHSC on 7 May 2025 suggesting areas that might be appropriate for fast-track reforms outside the legislative reform programme, which included modernising our business regulation framework.

## Equality Impacts

18. An updated impact assessment has been completed following the consultation (annex 4).

## Devolved nations

19. We are not aware of any particular issues for the devolved nations, although we have been careful to ensure that we understand any differences in business structures. We are in contact with other systems regulators in the nations re our plans to continue the current approach in the Opticians Act 1989 not to regulate restricted

[1] Remedies: vets market investigation working paper

functions that are provided as part of medical/surgical treatment, to ensure that they do not have any objections that we should be aware of.

20. We are keeping the nations updated through our two-monthly Optical Sector Policy Forum and our meetings with the optometric advisers in the nations.

## Other Impacts

21. This project will have legislative impacts – we will need to design a system of business regulation that is compatible with any new legislation designed by the DHSC and will continue to engage with them and other regulators on the programme of legislative reform.

## Communications

### External communications

22. We keep stakeholders updated about this project through our abovementioned meetings under the devolved nations section, as well as updates to public Council, including through the Chief Executive's report.

### Internal communications

23. We have kept staff updated about our consultation progress through our intranet and will continue to do so as the business regulation project progresses.

## Next steps

24. We will aim to publish our response to the consultation by mid-July 2025. Following this, we will formally write to DHSC setting out our proposals and wider progress on legislative reform.

## Attachments

Annex 1: Draft GOC response to business regulation consultation
Annex 2: Public and patient research – internal note summarising omnibus findings
Annex 3: Public and patient research – report on qualitative research
Annex 4: Draft updated impact assessment

Annex 1

# GOC response to business regulation consultation

## C20(25)ii.

## Contents page

## Executive summary

### Background

1. The General Optical Council (GOC) is the regulator for the optical professions in the UK. We currently register around 34,000 optometrists, dispensing opticians, student opticians and optical businesses.

2. Section 9 of the Opticians Act 1989 ('the Act') provides for the GOC to register bodies corporate that meet certain eligibility requirements (including around its directors' registration and the nature of its activities). Our current system results in an inconsistent application of our regulatory powers for businesses and our research estimates that around half of all optical businesses are not required, or able, to register with the GOC.

3. Our response to the 2022 call for evidence on legislative reform established our position that all businesses carrying out specified restricted functions[1] should be registered with the GOC. The current phase of work focuses on how best to modernise our business regulation framework so that it is fit for purpose in the changing landscape of eye care services in all four nations of the UK.

4. We carried out a business regulation consultation which sought views on changes to our framework for regulating businesses – the detail of and reasoning behind all of our proposals can be found in the annexes of the consultation document. The consultation was open from 23 October 2024 to 22 January 2025. We received 99 consultation responses from a range of stakeholders.

### Summary of GOC responses to findings

5. Our responses to each of the sections of the report are summarised in the table below. To see the findings and our full responses with more detail, please refer to the relevant sections of the report.

***Scope of regulation***

- *GP practices and hospitals (NHS and independent) carrying out restricted functions:* We conclude that we should not regulate service providers (including at GP practices or hospitals, clinics, nursing homes or other similar institutions) that are performing restricted functions in the course of providing medical or surgical treatment.
- *Commercial units operating in GP practices and hospitals:* We conclude that we should regulate independent commercial units carrying out specified restricted functions, whether or not they are operating at the same premises as

[1] See paragraph 15 for a definition of the restricted functions.

GP practices and hospitals, *unless* these functions are being carried out as part of the care provided by the GP practice or hospital.

- *Regulation of charities:* When we extend business regulation, any charities providing specified restricted functions should be regulated by the GOC due to the strong public protection rationale.
- *Regulation of university eye clinics:* When we extend business regulation, any university eye clinics providing specified restricted functions should be regulated by the GOC due to the strong public protection rationale.
- *Discretionary power to exempt:* While we recognise the concerns around a discretionary power to exempt certain businesses from registration, we think it would be prudent to have this power as the market is diverse and evolving, and we need to ensure regulation is targeted, proportionate and future-proofed.
- *Majority of registrant directors:* The 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.

***Models of regulatory assurance***

- *Head of optical practice for all businesses:* We have decided that it would be appropriate for all optical businesses to have a head of optical practice.
- *Responsibilities of the head of optical practice:* We welcome the broad support from stakeholders in relation to the proposed responsibilities of a head of optical practice. Setting out these responsibilities in primary legislation will provide clarity on the purpose and limits of the role. This will be supplemented by GOC guidance as required.
- *Responsibilities around training placement arrangements:* Businesses should have the discretion to appoint the most qualified and suitable person to oversee training placements, which may not be the same individual as the head of optical practice.
- *Fully qualified GOC registrant:* We welcome the strong support from stakeholders that a head of optical practice should be a fully qualified GOC registrant and will recommend this to government. The head of optical practice could be an optometrist or dispensing optician; the important issue is their ability to meet all the responsibilities of the role.
- *Employee:* There was broad support that the head of optical practice should be an employee within a business, and we intend to take this proposal forward.
- *Multiple businesses:* Our view is that one individual should not carry out the head of optical practice role for multiple separate and unrelated businesses. However, we are mindful of the different business models in the sector and see that flexibility could be applied in limited circumstances and still meet the needs

of the role, while avoiding situations whereby individuals perform a nominal or consultancy role across multiple unrelated businesses.

- *Power to introduce conduct standards:* We do not consider it necessary to introduce separate standards for this role. However, as the role evolves, we consider it would be prudent for us to have the flexibility to introduce additional standards in future.
- *Characteristics:* We should not prescribe in rules the essential characteristics of the role holder. We will consider the need for any guidance on person characteristics as part of our implementation approach.
- *Business register:* In the interests of public transparency the individual nominated as head of optical practice should be listed on the GOC business register.
- *Annotation on individual register:* If someone is listed as part of the business registrant entry, then it is not necessary to annotate this information to their individual registrant entry.

***Enforcement approach and sanctions***

- *Powers to impose a financial penalty:* Despite uncapped financial penalties not being favoured by stakeholders, we consider this approach would best reflect the diversity of business models and the need to future-proof our legislation.
- *Power to visit:* We have decided not to introduce this power and consider that our existing processes (for example, we can compel a business to provide written information and could visit a business with their consent) are sufficient to address fitness to carry on business concerns.

***Consumer redress***

- *Mandatory participation:* Ultimately, as a patient-focused regulator, we consider that mandatory participation in the OCCS is necessary to deliver public protection and would be a proportionate solution, and we will recommend this model to government.
- *Legally binding decisions:* We have decided to recommend to government that the OCCS should remain a mediation scheme, rather than moving to an adjudication model.
- *Delivery of consumer redress:* We intend to retain the existing model of delivering our consumer redress scheme with a single provider through a competition for the market model.
- *Funding of consumer redress scheme:* We intend to continue with current funding arrangements for the OCCS, sharing the cost among registrants through the registration fee as this is the simplest system to administer, and our

standards are the best lever to address any variability in unfair practices and first-tier complaint handling by businesses.

**Next steps**

6. Although we are leading engagement with stakeholders and the sector through this consultation, responsibility for agreeing changes to the Act does not rest with us but with Parliament, and the pace and outcome of any changes sought to business regulation will be determined by the UK Government.

7. We are committed to working in partnership with stakeholders to refine and further develop our proposals, for example, in relation to the head of optical practice role. We will confirm our plans for taking forward this work once the timetable for reform to the Act is clearer.

8. Should we achieve legislative reform to extend and modernise business regulation, much of the detail will be implemented in secondary legislation and/or guidance. There will be further consultations on any legislation or guidance, giving stakeholders opportunity to input as required.

## Introduction

9. The GOC is one of a number of organisations in the UK known as health and social care regulators. These organisations oversee the health and social care professions by regulating individual professionals and some businesses/premises. We are the regulator for the optical professions in the UK. We currently register around 34,000 optometrists, dispensing opticians, student opticians and optical businesses.

10. We have four primary functions:

    - setting standards for optical education and training, performance and conduct;
    - approving qualifications leading to registration;
    - maintaining a register of those 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 is impaired.

## Background to the consultation

11. This consultation sought views on changes to our framework for regulating businesses. The detail of and reasoning behind all of our proposals can be found in the annexes of the business regulation consultation document.

12. Section 9 of the Opticians Act 1989 ('the Act') provides for the GOC to register bodies corporate that meet certain eligibility requirements (including around its directors' registration and the nature of its activities). Under section 28 of the Act, it is an offence for an unregistered business to use a title, addition or description that falsely implies GOC registration, i.e. GOC registration is mandatory for bodies corporate using a protected title.

13. Our current system results in an inconsistent application of our regulatory powers for businesses and our research estimates that around half of all optical businesses are not required, or able, to register with the GOC. Where we refer to businesses in this response, we are referring to all providers of optical services, including those that may not be considered traditional optical businesses e.g. university eye clinics and charities.

14. Should the Department of Health and Social Care's (DHSC) legislative reform programme proceed, we wish to use this opportunity to update our legislation and the aspects of the Act that apply only to the optical sector. The review of our legislation began in our 2022 call for evidence on the Opticians Act 1989

and associated GOC policies which was a first step in a programme of work to ensure that our legislation and associated policies are fit for the future.

15. As part of the 2022 call for evidence, we addressed the area of business regulation and commissioned research from Europe Economics entitled Mapping of Optical Businesses. The consultation confirmed there was strong stakeholder support for extending business regulation to all businesses carrying out restricted functions. In our 2023 response to the consultation we said that we would develop proposals and consult on an updated framework for business regulation.

16. Restricted functions (referred to as 'specified restricted functions') were defined in the consultation document as:

    - sight testing;
    - contact lens fitting;
    - supply of contact lenses (prescription and zero power cosmetic contact lenses); and
    - spectacle sales to the under 16s and those who are registered sight impaired or severely sight impaired.

**Consultation process**

17. Our business regulation consultation was open for 13 weeks from 23 October 2024 to 22 January 2025.

18. We received 99 consultation responses from a range of stakeholders. These included:

    - one optical patient;
    - 36 optometrists;
    - seven dispensing opticians;
    - five contact lens opticians;
    - three therapeutic prescribing optometrists;
    - two student optometrists;
    - 17 GOC business registrants;
    - 11 optical businesses (not GOC business registrants);
    - four education providers;
    - seven optical professional/representative bodies; and
    - two patient representative charities/organisations.

19. The organisations that were willing to be named were:

    - Association of British Dispensing Opticians (ABDO)
    - Association of Optometrists (AOP)
    - Bexley, Bromley and Greenwich LOC [Local Optical Committee]

- Clyde & Co LLP
- The College of Optometrists
- F.Y. Eye Global Consulting
- FODO (The Association for Eye Care Providers)
- Heyes Opticians Ltd
- MyEyes (Opticians) Limited
- Optometry Scotland
- Optometry Wales
- Pearce & Blackmore Opticians
- The Professional Standards Authority for Health and Social Care (PSA)
- Robinson Optometrists Ltd
- SeeAbility

20. 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**

21. Respondents were encouraged to provide comments throughout the consultation. We reviewed every comment received. We are unable to include individual responses to all of these comments within this report due to the volume that we received.

22. Any comments that have been included are produced verbatim, although we have made minor corrections to spelling and/or grammatical errors where we considered that these were obvious.

23. We have only included comments where the respondent has consented to their response being published (either alongside their 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.

**Patient and public research**

24. As part of our consultation approach, we commissioned research to gather the views of patients on some of our proposals. The research included three online focus groups (24 participants in total), telephone depth interviews with individuals who have experienced dissatisfaction with optical services (three participants) and an omnibus survey of 2,205 members of the UK public.

25. We have summarised the findings of this research in relevant sections of the report below. For further details about the methodology and findings, the report and data tables are available on our website.

## Advisory Panel

26. We also discussed our proposed response 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. We have incorporated their comments where they gave us additional information that had not already been raised during the consultation.

## Next steps

27. Although we are leading engagement with stakeholders and the sector through this consultation, responsibility for agreeing changes to the Act does not rest with us but with Parliament, and the pace and outcome of any changes sought to business regulation will be determined by the UK Government.

28. We are committed to working in partnership with stakeholders to refine and further develop our proposals, for example, in relation to the head of optical practice role. We will confirm our plans for taking forward this work once the timetable for reform to the Act is clearer.

29. Should we achieve legislative reform to extend and modernise business regulation, much of the detail will be implemented in secondary legislation and/or guidance. There will be further consultations on any legislation or guidance, giving stakeholders opportunity to input as required.

## Findings

### Section 1: Scope of regulation

### GP practices and hospitals (NHS and independent) carrying out restricted functions

30. We asked stakeholders to what extent they agreed or disagreed that GP practices and hospitals (NHS and independent) carrying out specific restricted functions should be exempt from GOC business regulation. Of the 92 respondents that answered the question, 39 per cent agreed or strongly agreed, 13 per cent neither agreed nor disagreed, and 48 per cent disagreed or strongly disagreed.

31. The following themes were identified from the comments:

    - regulation should be consistent and apply regardless of the environment, providing a level playing field;
    - regulation should only apply in GP practices / hospital settings where there is commercial activity;
    - there is already regulation of medical practitioners and GP practices and hospitals – duplication of regulation is not appropriate, could lead to additional costs and create confusion and unintended consequences; and
    - we should identify any gaps in existing regulation to ensure fairness and patient safety.

32. Overall, despite recognition of existing regulation by other bodies, the general sentiment was for consistent regulation across providers of specific restricted functions to ensure fairness, patient safety, and to avoid regulatory gaps.

33. The optical professional/representative bodies were generally in agreement that it would be disproportionate to regulate GP practices and hospitals in the course of the provision of medical treatment, as it could duplicate regulation and lead to additional costs and burdens. However, the AOP warned that there could be ambiguity over who has oversight over a business operating in a GP practice or hospital setting due to the current registration requirements in place for the Care Quality Commission (CQC). It argued that since the CQC's requirements give an exemption to primary ophthalmic services (for example, high street optometrists) or ophthalmic services that are of the same kind as those provided by high street optometrists, we would need to be careful of any blanket exemption for GP practices and hospitals.

34. Many of the points made in response to this question were more relevant to our next question on whether commercial units operating in GP practices or hospitals should be regulated.

35. A sample of comments is available in the box below.

*"All practitioners should be subject to a uniform system of regulation."* Optical patient

*"Regulation should be the same for all providers."* Optometrist

*"…if a sight test or restricted function is performed by a Hospital (unlikely a GP practice) as part of the clinical care package, then the Trust or provider should not be subject to be GOC business regulation, as they will have other governance requirements instead e.g. CQC."* Optometrist

*"Providers of restricted functions should have to abide by the regulation for that restricted function regardless of the environment."* Contact lens optician

*"…Provided the services in question are led by a GMC registrant, patient should still receive the highest standards of care and it would be disproportionate for the GOC to provide additional regulation. We support the proposal on the condition that patients receive equivalent levels of protection wherever and whenever they access services involving restricted functions…"* ABDO

*"…these providers are already regulated by the CQC. As optometrists providing restricted functions in these settings will be regulated as individuals (and other healthcare professionals by their regulator) we think it could be disproportionate and unrealistic for the GOC to seek to regulate these settings as well…"* The College of Optometrists

*"Provided the services in question are led by a GMC registrant, such as an OMP/ophthalmologist, then we would support this proposal... any additional regulation by the GOC would be disproportionate…"* FODO – The Association for Eye Care Providers

*"We agree with this statement as long as the referenced services are led by a GMC registrant such as an Ophthalmologist or OMP* [ophthalmic medical practitioner]*. GP practices and hospitals (NHS and independent) are regulated by the relevant organisations."* Optometry Wales

*GOC response – GP practices and hospitals (NHS and independent) carrying out restricted functions*

36. As set out in paragraphs 78-80 of our consultation document, we had not proposed to regulate GP practices and hospitals/clinics providing restricted functions *in the course of medical or surgical treatment*. This is on the basis that these services are already separately regulated and reflects the current

legislative framework. Specifically, the Act and the sight testing regulations[2] are drafted in such a way that the requirements to undertake specific duties while testing sight do not apply when the testing is carried out by a doctor at a hospital or clinic in the course of diagnosing or treating injury or disease of the eye[3].

37. There was a difference of views between representative bodies and individual respondents, possibly reflecting some misunderstanding about a technical set of issues. Having considered the consultation responses, we conclude that we should not regulate service providers (including at GP practices or hospitals, clinics, nursing homes or other similar institutions) that are performing restricted functions in the course of providing medical or surgical treatment. We have heard the concerns about a blanket exemption and will suggest to government that it continue to use similar wording to the current exemption in the Opticians Act to address situations where commercial business is being carried out in the premises of a GP practice, hospital or other similar setting but not in the course of medical or surgical treatment.

**Commercial units operating in GP practices and hospitals**

38. We asked stakeholders whether they thought that commercial units operating in GP practices and hospitals that are providing specific restricted functions should be regulated by the GOC. Of the 70 respondents that answered the question, 86 per cent answered yes, six per cent answered no, and nine per cent were not sure.

39. The following themes were identified from the comments:

- regulation should be applied consistently to all providers including this group to ensure patient safety and care standards;
- if a commercial service is led by a GOC registrant independently of the GP practice / hospital, it should be regulated by the GOC;
- if the primary function of the business is to provide ophthalmology / eye health services, there might be a need for exemption or careful consideration to avoid regulatory complications;
- there could be potential confusion for patients regarding the regulatory body responsible for their care, suggesting that default regulation by the GOC might support public understanding; and
- there is a need for clarity on what constitutes a 'commercial unit' and any exemptions should be carefully designed.

[2] The Sight Testing (Examination and Prescription) (No. 2) Regulations 1989
[3] Regulation 3(2) of the Sight Testing (Examination and Prescription) (No 2) Regulations 1989

40. Overall, most responses favoured consistent regulation by the GOC for optical businesses providing commercial services, including those located within GP practices or hospitals, to ensure uniformity in patient safety and care standards. This view was generally supported by the optical professional/representative bodies, with the caveat that to avoid duplication of regulation, businesses should fall within scope only where they are operating independently of the GP practice / hospital).

41. A sample of comments is available in the box below.

*"Commercial units are similar to high street opticians, and location of this should not matter."* Optical business (not a GOC business registrant)

*"Ensures consistent patient safety and care standards for commercial optical services."* Dispensing optician

*"GP practices are separate from hospitals as some incorporate an optometry practice - if this is the case the optometry practice if carrying out commercial restricted functions should be regulated by the GOC. Optometry practices working in a commercial manner should all fall under GOC regs."* Education provider

*"If this is a standalone commercial operation located within the premises of a GP practice or hospital and thus operates outside the jurisdiction of the GP or hospital regulatory authorities, it should fall under the regulation of the General Optical Council (GOC)."* ABDO

*"Commercial units within GP practices and hospitals should be treated no differently to any other. As they are sub-let spaces, the only distinction to any other commercial unit is their location."* AOP

*"…it would be beneficial - to ensure consistency and uniformity - that units providing commercial functions are regulated, particularly as some independent providers operate out of GP practices. This occurs for example where a room is hired in a GP practice by an optical business, in which restricted functions may be carried out. It would be important that these entities are regulated, as they are most likely not subject to the CQC regulation of the wider practice/hospital. However, we would wish to see a clearer definition of what the GOC considers a 'commercial unit' before commenting further."* The College of Optometrists

*"…If the commercial service is operated/led by a GOC registrant independently of the GP/hospital (i.e. the actual provider organisation of the commercial service does not fall under HIS, HIW, CQC, RQIA, CI or CIW regulation) then it should be regulated by the GOC…"* FODO – The Association for Eye Care Providers

*"…in the case of commercial units operating in GP practices and hospitals it would be useful to understand what other regulatory oversight would apply and therefore the current level of unmanaged risk. We welcome the GOC's position of working*

*with the relevant regulators to better understand the need for regulation for this category of optical business."* PSA

*GOC response – commercial units operating in GP practices and hospitals*

42. We have concluded that we should regulate independent commercial units carrying out specified restricted functions, whether or not they are operating at the same premises as GP practices and hospitals, *unless* these functions are being carried out as part of the care provided by the GP practice or hospital. In this case those functions would be subject to alternative regulatory oversight in the same way as other care provided by the GP practice or hospital. There was strong support for the principle that the location of the business, or who it is being led by, should not matter in this context. We are satisfied this approach will promote consistent public protection without duplicating regulation. We recognise the need for care with definitions provided in any new legislation so that businesses are not inappropriately exempted.

**Regulation of charities**

43. We asked stakeholders to what extent they agreed or disagreed that charities providing specific restricted functions should be regulated by the GOC. Of the 70 respondents that answered the question, 83 per cent agreed or strongly agreed, 11 per cent neither agreed nor disagreed, and six per cent disagreed or strongly disagreed.

44. The following themes were identified from the comments:

- charities providing restricted functions should be regulated to ensure consistent service standards and patient safety;
- regulation should be applied uniformly across all providers regardless of profit status, to maintain public trust and confidence, create a level playing field and avoid creating loopholes that could be exploited;
- while charities should be held to the same standards, the financial burden of regulation could be mitigated through reduced fees or exemptions, given their not-for-profit nature and the valuable services they provide to underserved groups;
- since the Charity Commission does not have a clinical focus, regulation of charities by the GOC would not create duplication of regulation;
- charities often serve vulnerable populations and should potentially face more scrutiny to ensure these groups receive proper care; and

- if individual practitioners are regulated, additional regulation for charities might not be necessary, provided their governance is maintained by an independent regulator.

45. Overall, while there is a clear call for consistent regulation of charities providing restricted functions, there is also a strong recommendation for a fee structure that acknowledges the financial constraints and social contributions of charitable organisations. This sentiment was supported by the optical professional/representative bodies and a charitable organisation.

46. A sample of comments is available in the box below.

*"…The proposal to regulate charities providing restricted functions would therefore appear to be appropriately risk-based. Further, while we do acknowledge the potential downsides of imposing regulation on charities, as a general principle we believe that regulation should be consistent. This includes being consistent between providers. Creating 'loopholes' in terms of which providers are regulated also has the potential to create unintended consequences."* PSA

*"Our responses follow better regulation principles which mean that regulation should be proportionate and based on objective rather than ideological criteria. This means there is no basis on which to make universal assumptions about incentives/behaviour based solely on organisational form..."* FODO – The Association for Eye Care Providers

*"Charities providing restricted functions should be regulated on the same basis as other providers, no organisation should be treated differently to others."* Optometry Wales

Comments referencing fees

*"It could be argued that charities should have more regulation because they are more likely to be dealing with members of the public who are extremely vulnerable e.g. homeless, children with severe disabilities. You may consider reducing the financial burden of GOC registration on charities by reducing or having no cost to register if the business has charitable status."* GOC business registrant

*"In principle we support consistency of application so all those delivering restricted functions are registered, but would argue for financial recognition in the fee structure and application of lower fees for charities… applying the same fee regime to charities will not be sustainable if a charity is already cross subsidising eye care through fundraised income or cannot access contracts that enable full cost recovery, and the pressures of the as yet unidentified fee structure could lead to withdrawal of services."* SeeAbility

*"…While the Charity Commission provides general governance and oversight, it does not enforce clinical standards or patient safety protocols. GOC regulation would ensure that restricted functions are delivered with appropriate professional*

*accountability and oversight… the AOP recommends that the GOC implements a tiered system of fees where the smallest businesses pay less than the larger corporations."* AOP

*"…Feedback from the College's Policy Advisory Panel and Board, strongly recommends that the GOC should consider a fee exemption or a reduced fee model for charities, given that they are not primarily operating a for-profit model. A fee could be a deterrent to new charities emerging to offer vital services to vulnerable groups and could reduce the ability of any charity reaching and benefitting the widest possible cohort of patients."* The College of Optometrists

*"Charities providing restricted functions should be regulated by the GOC to ensure consistent service and patient safety. However, the cost of registration could be a concern, so a reduced fee or exemption should be considered for these charities."* Optometry Scotland

*GOC response – regulation of charities*

47. We conclude that when we extend business regulation, any charities providing specified restricted functions should be regulated by the GOC due to the strong public protection rationale. We are sympathetic in principle to the case for lower registration fees for charities reflecting their status and social contribution. We would expect the legislation to provide us with the flexibility to set reduced fees for groups of registrants, as we do now for individual registrants on low incomes.

**Regulation of university eye clinics**

48. We asked stakeholders to what extent they agreed or disagreed that university eye clinics providing specific restricted functions should be regulated by the GOC. Of the 70 respondents that answered the question, 86 per cent agreed or strongly agreed, seven per cent neither agreed nor disagreed, and seven per cent disagreed or strongly disagreed.

49. The following themes were identified from the comments:

- university eye clinics providing restricted functions should be regulated to ensure consistency, safety and quality of service to patients;
- while these clinics primarily serve as educational facilities for students, they also operate in some capacity as commercial entities, especially when they provide services to the public and generate revenue;
- regulation of university eye clinics would maintain equity with high street optometrists and other providers;

- there are potential unintended consequences of overburdensome regulation, which could impact the ability of universities to provide clinical training and experience for students, suggesting that a light-touch approach or a tiered system of registration might be appropriate; and

- since university eye clinics are already regulated under the GOC's educational standards, additional business regulation may not be necessary.

50. Overall, there was consensus on the need for regulation of university eye clinics that provide services to the public, with considerations for a balanced approach that does not hinder educational objectives or impose excessive financial burdens on educational institutions.

51. The optical professional/representative bodies were all in agreement that university eye clinics should be regulated. The College of Optometrists suggested that consideration should be given to a reduced fee model for university eye clinics.

52. It was notable that of the two university education providers that responded to the consultation, one was in support of the proposal to regulate university eye clinics and the other was not. One of the comments in the 'any other areas' section at the end of the consultation suggested that we should consider parallels with the regulation of other university-based services such as audiology, podiatrists and other allied health clinics.

53. A sample of comments is available in the box below.

*"They are already regulated and the type of regulation would need to be different from business regulation, but they should still be regulated."* Optometrist

*"University clinics will see all categories of patients, albeit that the students will be under supervision, this is no different to a high street practice and requires the same level of governance and oversight."* Optometrist

*"As a student, I respect the need for the GOC to regulate our practices and to ensure we are safe/ready for pre-reg training."* Student optometrist

*"If they have a commercial aspect, perform restricted functions and produce profit they should be regulated."* Education provider

*"Our University eye clinic is not a business, but rather a small part of a charitable organisation. It would be disproportional to have similar business registration fees and administrative burden applied to a single clinic compared to multiples with over 2,000 clinics. Hence the undefined fees is concerning [26] and we do not support the proposal that University clinics are not exempted [74] from the proposed regulations.*

*Hence for organisations such as Universities and Charities, imposing 'business' regulation will impact on staff time and organisational finances, detracting from student education and therefore patient safety, so we are not in support of these proposed changes."* Education provider

*"In a learning environment it is important that from the outset best practice is modelled. They are often seeing vulnerable patients whose care could be compromised."* Patient representative charity/organisation

*"Without regulation of the GOC, there would be a gap in regulation as the risks associated with the entity as opposed to individual practitioners would not be adequately addressed."* ABDO

*"…If university eye clinics are delivering restricted eye care services to the public, they are in effect a commercial entity and are competing with local practices – in this case, they should be required to be registered to avoid fostering inequity. This comes with the caveat they should be subject to our suggested tiered system of registration because any commercial earnings they make are secondary to their main function as education facilities."* AOP

*"…Whilst welcome in principle, university eye clinics exist as part of an educational setting and are not necessarily separate businesses to the University. They exist to support undergraduate teaching courses, while also providing restricted functions to patients, and are already subject to education-related GOC regulation to accredit courses. We would need reassurance that there will be clear distinction between both aspects of regulation e.g. education panel visits and business inspections, and that there wouldn't be over-lap and duplication.*

*We think that to ensure consistency and patient protection and reassurance, and to protect students and staff, regulation of university eye clinics would be positive, and we would be in favour of a light-touch approach…"* The College of Optometrists

*GOC response – regulation of university eye clinics*

54. We have concluded that when we extend business regulation, any university eye clinics providing specified restricted functions should be regulated by the GOC due to the strong public protection rationale.

55. The focus of GOC activity relating to quality assurance of qualifications is to ensure students are well trained; these mechanisms are not designed to ensure university eye clinics provide safe and effective care to patients. Likewise, higher education regulators do not focus on clinical services provided to the public, so there would not be duplication of regulation.

56. We note the comment regarding how other allied health services are regulated in universities e.g. audiology and podiatry. Our understanding is that audiology

and podiatry clinics do not have to be registered with any other organisation regardless of where they are operating, so we consider this is a different starting point to the need to regulate university eye clinics.

57. We note the comments regarding reduced fees for university eye clinics. As with charities where similar considerations apply, we are sympathetic in principle to the case for lower registration fees for university eye clinics and would expect the legislation to provide flexibility in how we set fees.

**Discretionary power to exempt**

58. We asked stakeholders to what extent they agreed or disagreed that the GOC should have a discretionary power to exempt particular businesses from registration. Of the 70 respondents that answered the question, 36 per cent agreed or strongly agreed, 13 per cent neither agreed nor disagreed, and 51 per cent disagreed or strongly disagreed.

59. The following themes were identified from the comments:

- discretionary powers to exempt businesses from registration have the potential to lead to inconsistencies and unfair advantages;
- all businesses interacting with patients should be held to the same standards and exemptions could undermine regulatory uniformity and patient safety;
- there would need to be clear, published guidelines on exemption criteria to ensure fairness and transparency;
- exemptions should only be used in rare or exceptional cases – any discretionary power should not be open to abuse or conflict of interest, with some respondents not being able to envision a situation where exemptions would be necessary if regulations are well-defined from the start;
- the need to be explicit about which entities are exempt and for what reasons, rather than making decisions on a case-by-case basis – there was a lack of confidence by some in the GOC's current regulatory capabilities, questioning its ability to make fair exemption decisions; and
- exemptions could be considered for non-profit organisations or those not directly interacting with the public, such as companies set up for tax purposes for locum optometrists.

60. Overall, there was a desire for consistent regulation across all businesses to ensure patient safety and professional accountability.

61. The optical professional/representative bodies were concerned about the GOC having a discretionary power to exempt, although some suggested safeguards

to ensure any such power would be used appropriately in exceptional circumstances.

62. A sample of comments is available in the box below.

*"…Unless the discretionary power is laid out under very specific conditions which can't be changed or amended (in which case it is not really discretionary), this would be give rise to huge conflicts of interests where it is in someone's interests to either exempt or retain any particular business interest from regulation."* Optometrist

*"Struggle to understand why a business should be exempted."* Contact lens optician

*"There seems to be no rationale for this except that the GOC is trying to future proof the rules to allow for business models to be exempt from registration for models that have not yet been thought of…"* GOC business registrant

*"Agree however it should be considered as to what situations an exemption would be provided, as the default position should be that all businesses should be registered."* Optical business (not a GOC registrant)

*"In principle it is better to have consistency for patients and public in approach but it would seem understandable to have the legislative power for exemptions, as part of future proofing."* SeeAbility

*"The proposal that the GOC should have discretionary powers to exempt providers from having to register may have advantages in terms of future-proofing the legislation. Whilst the consultation sets out a range of provider types that may be exempted, with reference to the relative risks in each case, no overarching criteria for exemption are provided. Were the GOC to move forward with this proposal we would expect to see a clear framework setting out the approach to exemptions and guidance for decision-makers to ensure consistency of approach. Further, the GOC would need to be mindful of how such exemptions would be communicated to the public."* PSA

*"…Introducing exemptions could lead to the potential for inconsistency and perceived inequity in regulatory oversight, leading to varying standards of care and undermining public trust in the regulatory framework. It would also risk creating a precedent where businesses, knowing what type of exemptions are available, vary their operating model to avoid regulatory oversight…"* ABDO

*"…the AOP has concerns about the use of pre-determined exemption criteria and thinks that if the GOC is to have this power, then it should be used only by rare exception and in accordance with clear, published guidance on how and when it would be deployed… allowing unnecessary exemptions would undermine regulatory uniformity, enabling businesses to adapt their operational models in*

*ways that circumvent registration requirements and fees - compromising patient safety and accountability…"* AOP

*"We believe the GOC should establish from the start which entities fall under their regulatory remit, and which don't. However, it may be useful for the GOC to have this option available to them to be used only in exceptional circumstances."* The College of Optometrists

*"Given the case the GOC is making to extend business regulation, there would seem to be no objective case for discretion at an individual business level. Instead, we believe, the GOC should be explicit about exemptions and the reasons for them…"* FODO – The Association for Eye Care Providers

*GOC response – discretionary power to exempt*

63. While we recognise the concerns around a discretionary power to exempt, we think it would be prudent to have this power as the market is diverse and evolving, and we need to ensure regulation is targeted, proportionate and future-proofed. The legislative framework will make it clear which businesses are in scope, and we would expect to use this power in exceptional circumstances only. We recognise the need to build confidence in such a power and would have clear guidance. We could also maintain a published list of exemptions with reasons for our decisions. We would consult on our proposed approach prior to implementation to ensure that stakeholders had a chance to input.

**Majority of registrant directors**

64. We asked stakeholders to what extent they agreed or disagreed with our proposal to remove the requirement for some bodies corporate to have a majority of registrant directors. Of the 69 respondents that answered the question, 48 per cent agreed or strongly agreed, 13 per cent neither agreed nor disagreed, and 39 per cent disagreed or strongly disagreed.

65. The following themes were identified from the comments:

- the current requirement is outdated and overly restrictive, potentially hindering business flexibility and growth;
- it can prevent some businesses from opting into GOC regulation;
- non-registrant directors can play crucial roles in business management without compromising clinical standards;
- if the requirement is removed, there should be adequate measures in place to ensure patient safety and quality of care – in particular, any alternative to

majority registrant directors will need to ensure they understand and comply with optical legislation and GOC regulations; and

- potential negative consequences, such as increased commercial pressures that could compromise patient care, recognising the importance of maintaining a balance between commercial and clinical decision-making.

66. Overall, while there was support for more flexible business structures and recognition of the role non-registrant directors can play, there was also a strong emphasis on the need for businesses to prioritise patient care and adhere to professional standards. The potential risks of removing the majority registrant director requirement were acknowledged, with suggestions for alternative oversight roles and regulatory measures to mitigate these risks.

67. The optical professional/representative bodies were generally supportive of removing the requirement, providing that a head of optical practice (or similar proposal) was adopted.

68. A sample of comments is available in the box below.

Comments in support

*"…To safety proof removal of the majority board rule, you do need to have a registrant HOP* [head of optical practice]*, responsible officer or similar in place. Having a diligent, experienced, accountable registrant in place with not just oversight of the organisation but responsibility for ensuring that the organisation has a robust management system in place is far more effective to ensure patient safety and quality than the majority board rule. Sufficient systems and measures need to be in place to ensure that the individual holds authority and listened to at business ownership level..."* GOC business registrant

*"Our business of* [redacted] *optical practices would like to be registered with the GOC but is currently unable to because of this requirement; it is now an outdated and excessive requirement."* Optical business (not a GOC business registrant)

*"We attempted to register as a corporate body in 2023, as a family run independent practice where the directors include myself (registered optometrist) and my husband who controls account/payroll/practice management and decision making. We were unable to as we had no way round the legislation. We could not reduce to only myself as director as my husband carried out tasks which required business control beyond that of a business secretary, and we did not feel it was right to bring in an outside director who is registered, solely for the purpose of GOC body corporate registration..."* Optical business (not a GOC business registrant)

*"…regulators need to 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. Removing the requirement for a majority of registrant directors should therefore sit alongside other reforms to ensure that patient care is prioritised by optical businesses."* PSA

*"…Registrant directors do not in themselves necessarily add to patient protection and the current requirement creates an unnecessary administrative burden. However where registrant directors are not in place we would expect to see a head of optical practice appointed."* ABDO

*"…While we support this change in principle, it is important that it does not happen in isolation. For example, if the requirement was removed, but mandatory business registration wasn't enacted, then this could increase, rather than decrease the risk of businesses adapting to avoid registration. The proposal also links to the requirement to maintain registrant input into the wider process and as such must be considered alongside the responsibilities of the Head of Optical Practice role."* AOP

*"We agree that if an alternative, such as the Head of Optical Practice serving as a director, were in place, the majority registrant director requirement would not be necessary. However, any alternative should ensure businesses understand optical regulations and maintain compliance."* Optometry Scotland

Comments against

*"…A removal of director requirements can only result in more commercial pressures. The comment in the consultation document around investment and consolidation is very telling. Your proposals are always aimed at easing the commercial approach and reducing the viability of smaller practices to survive…"* Optometrist

*"I think your point about the risk of commercial overtaking clinical provision is sound and this decision would further the potential for this particularly in larger organisations. Keeping a majority (equal to or greater than 50%) I feel is a safer position for organisations which primarily should exist to provide eyecare not to sell products."* Therapeutic prescribing optometrist

*GOC response – majority of registrant directors*

69. We have concluded that the requirement for some bodies corporate to have a majority of registrant directors is no longer justified, anti-competitive, outdated and acts as a barrier to entry to the market. We recognise many stakeholders only felt comfortable removing this requirement if there is another position to ensure that a clinician is involved in the management of the business. Our head of optical practice proposals would deliver such a safeguard, but we do not consider that removal of the majority registrant director requirements should be conditional on this. This reflects the problems that the requirements create and

the availability of alternative regulatory mechanisms to ensure safe and effective patient care, including our Standards for Optical Businesses.

70. We note the PSA's challenge to tackle business practices that do not ensure that patient care is prioritised. Our standards of practice address such matters, supported by supplementary guidance on speaking up. We expect to begin a substantive review of our business standards later in 2025/26. In addition, as part of our corporate strategy for 2025/30, Council decided in March 2025 that commercial practices and patient safety will be the topic of our first thematic review, designed to assess current or emerging risks in the sector.

## Section 2: Models of regulatory assurance

### Head of optical practice for all businesses

*Patient and public research*

71. In the focus groups and interviews, there was widespread support for our proposal to have a nominated person in a business with overall responsibility for meeting the GOC's regulatory standards. Participants felt their confidence and trust would increase with the appointment of a head of optical practice to ensure compliance with our standards. However, some sought clarity on how this would apply in daily practice and reassurance it would not lead to increased costs, especially for small businesses.

*Consultation responses*

72. We asked stakeholders whether all businesses should be required to appoint a head of optical practice. Of the 96 respondents that answered the question, 63 per cent answered yes, 18 per cent answered no, and 20 per cent were not sure.

73. The following themes were identified from the comments:

- the concept and benefits of a head of optical practice were acknowledged, particularly if the registrant director requirement was removed, but any requirement must be implemented proportionately;
- larger businesses with complex structures could benefit from the role;
- concerns about the potential impact on smaller practices and that the requirement might be unnecessary or burdensome for single-practice owners or small businesses, for example, where there may not be any suitable candidates for the role, or the business employs locums; and
- concerns about the clarity of the role and its responsibilities, particularly the need for additional regulation when current systems such as clinical audits and governance leads already exist.

74. Overall, while there was support for the head of optical practice role, particularly in larger businesses, there was concern about its impact on smaller practices. The potential overlap with existing roles and the financial implications were also common concerns. Should the proposal be implemented, the need for clear guidance and proportionate implementation was identified.

75. There was mixed support from the optical professional/representative bodies. In principle they could see the benefits especially for larger businesses. However, there was concern about the impact this would have on smaller or single owner businesses. To mitigate against this, they emphasised the approach must be

flexible and proportionate, considering the range of business structures in the optical sector. The College of Optometrists raised concerns around registrants not wanting to take on the role. Some of these bodies encouraged the GOC to engage with them to further develop and refine the proposals.

76. A sample of comments is available in the box below.

*"Small businesses may struggle to meet this requirement, especially if no registrant is available to take on the role."* Dispensing optician

*"If the requirement for majority registrants as directors is removed, then yes."* Education provider

*"A "Head of Practice" role is a nice idea, but would be costly and the additional registration risk for that individual would make the role unpopular… "* Education provider

*"In practice holding NHS contracts and delivery of NHS services obliges businesses to ensure a clinical audit role is performed and reported upon to the contracting authority, so to all intents and purposes many businesses will have individuals (including practice owners) fulfilling this role but GOC regulation of it would provide greater accountability for business practice to meet professional standards..."* SeeAbility

*"We support the principle of appointing a head of optical practice and for most businesses this would be a proportionate requirement. However, we are concerned that for a small owner-led business with a single practice, the requirement to appoint a head of optical practice might be disproportionate to the level of risk involved…"* ABDO

*"…To illustrate our flexible approach, take the example of a small single-registrant business, where the owner is already responsible for both clinical oversight and operational management. In this common scenario, the HOP role is unnecessary. In such a business the owner/director/registrant already holds liability and accountability in ways that an owner/director of a larger practice does not. Introducing an additional governance role in this context creates unnecessary bureaucracy and adds an unwarranted financial burden that small or independent businesses – already operating under tight margins – are ill-equipped to bear..."* AOP

*"Not against the idea but would depend on the size of the practice."* Bexley Bromley and Greenwich LOC

*"Whilst we are in favour of this proposal in principle (especially to ensure safe and robust systems and processes, transparency and professionalism), the practicalities of appointing a Head of Optical Practice (HOP) could be challenging, and there could be many deterrents to individuals adopting the role. While in large optical practices there are often multiple optometrists and dispensing opticians, in*

*some practices there may be only one optometrist, or a practice may solely rely on locums to provide restricted functions…"* The College of Optometrists

*GOC response – head of optical practice for all businesses*

77. We welcome the broad support for the concept of a head of optical practice and the range of responsibilities envisaged. We think the focus of this role on systems, policies, processes and culture as part of delivering regulatory assurance aligns with a broader policy agenda that aims to strengthen clinical governance. For example, several NHS inquiries have highlighted the failings that poor leadership can have on patient care and the Government has consulted on regulating NHS managers. Strengthening clinical governance will also help instil greater confidence in the regulatory system as government policy seeks to move more hospital eye care services into community settings.

78. We have decided that it would be appropriate for all optical businesses to have a head of optical practice. The optical business sector is complex in terms of the different operating models, and we recognise the need for proportionality, especially for smaller businesses. While we note suggestions that there is no need for a head of optical practice for sole traders, we do not think this would be burdensome in the vast majority of businesses given that by their very nature they are owned by a single individual who has clear responsibility for ensuring the business meets the GOC's regulatory requirements. In addition, our Advisory Panel considered that there should be consistency in the requirement to have a head of optical practice and that risks to patients were often higher in smaller practices, including when owned by lay persons.

79. It should not be necessary for businesses to recruit additional staff to carry out the role, although we note that there may be a small number of businesses that are lay owned and may only contract with locums to carry out restricted functions. In many cases businesses already allocate primary responsibility for compliance to a specified person or role. Even so, we recognise the need to build understanding about the purpose of the role and provide reassurance about where the role holder's responsibilities begin and end. Given the role is new and the sector is diverse, we consider it would be prudent for the GOC to have the power to specify exceptions in rules.

80. There is appetite from sector bodies and businesses to work with the GOC to further develop and refine our proposals, which we would welcome. Much of the detail of the role will be set out in rules to be developed following legislative reform, whereas our focus now is on a small number of key provisions that will need to be enshrined in primary legislation. We will confirm our plans for further engagement with the sector once the timetable for reform to the Act is clearer.

**Responsibilities of the head of optical practice**

81. We asked stakeholders to what extent they agreed or disagreed with the proposed responsibilities for the head of optical practice[4]. Of the 75 respondents that answered the question, 65 per cent agreed or strongly agreed, 24 per cent neither agreed nor disagreed, and 11 per cent disagreed or strongly disagreed.

82. The following themes were identified from the comments:

- whilst the responsibilities outlined seemed largely sensible, as a new development it is important to allow space for the role to evolve;
- there is a need for clarity and flexibility in the role, with concerns about the potential for over-centralisation of responsibility;
- the head of optical practice should not be held solely responsible when something goes wrong; and
- more clarity is needed on how the role will interact and report to other senior management level positions, and particularly any lay ones.

83. Overall, while there was support for the concept of a head of optical practice role, respondents called for clear definitions, practical guidance, and appropriate training to ensure the role is effective and does not place undue burden or unreasonable responsibilities on individuals.

84. The optical professional/representative bodies mainly agreed with the proposals, although the AOP said greater clarity and more detail was needed on the responsibilities, powers and accountability of the role. The importance of training and support for anyone undertaking the role was highlighted.

85. A sample of comments is available in the box below.

> *"Businesses under lay ownership will be encouraged/have to keep to the same standards as other businesses. Having a head of optical practice will help them understand the responsibilities of a GOC registrant."* Optometrist
>
> *"Agree with your principles, however there should be flexibility to allow for the HOP role to evolve and change as this new model beds in and standards of practice evolve and change."* GOC business registrant
>
> *"This would ensure standards as maintained according to the GOC Standards for Optical Businesses."* Optical business (not a GOC business registrant)

[4] These responsibilities were set out in paragraph 98, page 40 of the business regulation consultation document.

*"…We strongly recommend that the GOC clarifies the HOP's responsibilities, powers, and accountability mechanisms through further consultation with sector stakeholders. Ultimately, any new regulatory role must be clear, balanced, and pragmatic, ensuring patient safety while supporting the diverse businesses that make up the optical sector. When/if the HOP role becomes mandatory, we strongly feel that GOC example scenarios must outline such potential complex conflicts of accountability."* AOP

*"…consideration could be given to the training required to enable registrants to confidently and effectively take on an HOP role if they have not previously had any experience of optical business management…"* The College of Optometrists

*"The HOP role should not become an isolated position where businesses rely solely on them without taking ownership themselves. We also support ongoing training for individuals taking on these responsibilities. We welcome the GOC's recognition of the need for clarity in relationships and ensuring the HOP is not unfairly penalised for all issues. The level of authority required should be clearly defined, particularly when the HOP reports to others within the business..."* Optometry Scotland

*GOC response – responsibilities of the head of optical practice*

86. We welcome the broad support from stakeholders in relation to the proposed responsibilities of a head of optical practice. Setting out these responsibilities in primary legislation will provide clarity on the purpose and limits of the role. This will be supplemented by GOC guidance as required.

87. The need to support registrants with training to carry out the role is recognised. We would not anticipate the GOC providing such training as this would not be consistent with our statutory role, but there is an important role for professional leadership here, and we would expect continuing professional development (CPD) providers to develop provision.

**Head of optical practice: responsibilities around training placement arrangements**

88. We asked stakeholders to what extent they agreed or disagreed that the head of optical practice should have responsibilities around the adequacy of arrangements for training placements. Of the 73 respondents that answered the question, 60 per cent agreed or strongly agreed, 19 per cent neither agreed nor disagreed, and 21 per cent disagreed or strongly disagreed.

89. The following themes were identified from the comments:

    - the head of optical practice should have a role in overseeing training, but there should be discretion within a business as to how this is managed

operationally on a day to day basis and overall responsibility should lie with the business itself;

- if the head of optical practice were to manage this aspect it would likely require significant time commitments, especially in larger organisations;
- responsibility for training could be allocated to another registrant or specialist within the organisation depending on its size and structure, and training should be led by the most experienced individual; and
- clarification is needed on the precise responsibilities of the head of optical practice in this area.

90. Overall, while there was consensus on the importance of ensuring the quality of training placements, there were mixed views on whether this should fall within the remit of the head of optical practice. If this is to be the case, there was a clear call for flexibility in assigning responsibility based on the size and structure of the business, with an emphasis on not overburdening the head of optical practice and avoiding conflicts with existing educational structures.

91. There were mixed views from the optical professional/representative bodies on whether training placements should be one of the responsibilities of the role. It was felt that the GOC should avoid being too prescriptive in this area. The head of optical practice could have an oversight role, but it should be possible for them to delegate the more operational day to day running to a colleague with specialist knowledge of this area. The size of the business will also play a part in determining where oversight and operational management for education and training requirements sits. There was also concern about the additional time, responsibility and burden placed on a head of optical practice to fulfil this responsibility, which may deter registrants from taking on the role.

92. A sample of comments is available in the box below.

*"Head of optical practice should work with the business owner to achieve this. They should bear equal responsibility."* Optometrist

*"I believe this HOP position would be a poisoned chalice and is likely to be too great a burden for one individual particularly in a larger organisation."* Therapeutic prescribing optometrist

*"The GOC's Standards for Optical Businesses requires that the business ensures that training placements are adequately operated and people are properly supervised. It can still be the businesses responsibility to ensure high standards for training and that any programmes are operated in accordance with rules laid down by the BCO/ABDO/training institutions. How the business decides to delegate this, either to the HOP or to a Learning & Development (L&D) manager*

*should be left to the business based on the business need."* GOC business registrant

*"…Given that optical businesses come in many different forms, it would make sense for the head of optical service to have oversight of the system of education and training within a business, but not necessarily to have specific responsibility for the adequacy of placements. The GOC should avoid being too prescriptive in this area."* ABDO

*"Education and training in optometry is a complex and technical space, for which we cannot give a full answer here, especially without more specific information on the proposal… There could be a potential role for HOPs to have some responsibility for ensuring commitments to education providers are met and are properly managed, but not necessarily responsibilities around the "adequacy" of arrangements for training placements. In large practices, other colleagues may be better suited to be being responsible for managing the training..."* The College of Optometrists

*"This depends on the type of organisation. For example, in a smaller practice this is most likely to be the same person in any case in some larger organisations, it might be necessary to have more than one HOP and a large team with a different head of department leading training and education in other organisations, it might be that each practice has a HOP, but training and education is organised centrally..."* FODO – The Association for Eye Care Providers

*"The HOP should have a role in ensuring training is conducted, but the overall responsibility must remain with the business. A key unintended consequence of placing this solely on the HOP is the significant time commitment required in larger organisations..."* Optometry Scotland

*"We believe that this should be kept as a decision made by the practice as we feel there could be unintended consequences around recruitment/job descriptions caused if the GOC were to be prescriptive on this point."* Optometry Wales

*GOC response – head of optical practice: responsibilities around training placement arrangements*

93. Although most respondents supported the head of optical practice having responsibilities around training placements, we note the range of concerns expressed and the optical professional/representative bodies had mixed views.

94. We appreciate that education and training is a specialist area and the nature of ensuring compliance with our requirements in this area is somewhat different to the other responsibilities envisaged. Having considered the feedback, and noting that curriculum design and assessment strategy for training placements are the responsibility of education providers under standard 3 of the Requirements for Approved Qualifications in Optometry or Dispensing Optics,

we have concluded that businesses should have the discretion to appoint the most qualified and suitable person to oversee training placements, which may not be the same individual as the head of optical practice. This would avoid being overly prescriptive on the remit of the role and narrowing the pool of potential role holders.

95. Therefore, we will not propose to government that the head of optical practice should have specific responsibilities around the adequacy of arrangements for training placements. However, we would expect the head of optical practice to have an oversight role, through their responsibility to take reasonable steps to ensure that the business complies with the requirement in the Standards for Optical Businesses to ensure that all staff 'have suitable levels of training so as not to have an adverse impact on patient safety' (see standard 3.2).

**Head of optical practice: fully qualified GOC registrant**

96. We asked stakeholders to what extent they agreed or disagreed that the head of optical practice should be a fully qualified GOC individual registrant. Of the 73 respondents that answered the question, 81 per cent agreed or strongly agreed, 11 per cent neither agreed nor disagreed, and eight per cent disagreed or strongly disagreed.

97. The following themes were identified from the comments:

- the head of optical practice should be a GOC registrant, as it is important to have someone with the necessary clinical and regulatory expertise to ensure compliance and maintain clinical standards;
- a registrant would be more trustworthy and have a better understanding of the nuances of optical practice;
- the practicalities of how this requirement would work for smaller practices was highlighted, especially if the head of optical practice must be directly employed and cannot work across multiple businesses;
- there should be exemptions or flexibility in certain circumstances, such as long-term absence of the head of optical practice or for small practices owned by non-registrants; and
- the GOC should engage with sector bodies to further clarify how the role would operate in practice to mitigate risks and costs.

98. Overall, while there was strong support for the head of optical practice to be a GOC registrant due to their understanding of clinical governance and patient care, there was also recognition of the need for flexibility in certain business models or circumstances. It was felt that the role's responsibilities should be

clearly defined, and further discussion with sector bodies was desirable to address potential challenges.

99. The optical professional/representative bodies largely agreed with the proposal but also called for flexibility, for example, taking into account the size of the business and any absence by the head of optical practice. Optometry Wales disagreed as they said there could be unintended consequences in being too prescriptive about the role, such as in relation to recruitment. FODO said this requirement could be difficult for lay business owners or small practices to adhere to, with unintended financial consequences, for example, having to employ an additional employee to fulfil the role or making it difficult to sell a business due to the additional regulatory requirements.

100. A sample of comments is available in the box below.

*"If not the director, definitely need a registrant accountable."* Optometrist

*"Many of the risks are clinically related, and therefore, it should be a registrant appropriate to the functions provided."* Optometrist

*"Ensures the individual responsible for compliance has the necessary clinical and regulatory expertise."* Dispensing optician

*"Provides reassurance that they are trustworthy."* Student optometrist

*"HOP needs to have knowledge of what is required by being regulated."* Optical business (not a GOC business registrant)

*"Whilst we see this role as ideally being registrant-led, we do recognise that the system has to be workable. If the head of optical practice is not a registrant then it should be the business owner (supported ideally by registrant directors) so in the event of any concerns arising the GOC could hold the relevant person to account..."* ABDO

*"The appointment of a GOC registrant with suitable levels of experience to the HOP role will foster greater trust and confidence among employees…"* AOP

*"Should a Head of Optical Practice model be adopted, we believe that they should be a fully qualified GOC individual registrant. However, there may be exceptional circumstances where this is not possible e.g. to cover extended periods of HOP leave in a small practice owned by a non-registrant, and provision may need to be made to account for such circumstances."* The College of Optometrists

*"…while most feedback we received supports that this should always be a GOC registrant, we also received some feedback about challenges the current proposal from the GOC might create for smaller practice owners..."* FODO – The Association for Eye Care Providers

*"The HOP role would need clearly defined responsibilities and a minimum knowledge requirement if both optometrists and dispensing opticians can be*

*eligible. A dispensing optician, for example, should not be held responsible for advice related to procedures within an eye examination."* Optometry Scotland

*"We believe that this should be kept as a decision made by the practice as we feel there could be unintended consequences around recruitment/job descriptions caused if the GOC were to be prescriptive on this point."* Optometry Wales

*GOC response – head of optical practice: fully qualified GOC registrant*

101. We welcome the strong support from stakeholders that a head of optical practice should be a fully qualified GOC registrant and will recommend this to government. A registrant with clinical training who is bound by professional standards will help ensure trust and confidence among both the public and registrants. We note the concerns around unintended consequences and that there may be limited circumstances where some flexibility is needed. We would expect the detailed arrangements to be agreed following change to primary legislation to address how the need for flexibility is best met in those limited circumstances where it is not possible for a registrant to carry out the role.

102. The head of optical practice could be an optometrist or dispensing optician; the important issue is their ability to meet all the responsibilities of the role.

**Head of optical practice: employee**

103. We asked stakeholders to what extent they agreed or disagreed that the head of optical practice should be an individual employed by the business. Of the 73 respondents that answered the question, 68 per cent agreed or strongly agreed, 14 per cent neither agreed nor disagreed, and 18 per cent disagreed or strongly disagreed.

104. The following themes were identified from the comments:

- the head of optical practice should have a direct and significant connection to the business, and first hand experience to understand how the business operates;
- an individual employed by the business would ensure greater accountability;
- there is the potential for conflict of interest or reduced effectiveness if the role is not employed by the business, as an external head of optical practice might not have the same impact or authority as someone within the business;
- there are potential challenges for small practices and the need for flexibility, such as allowing contracted services in certain situations like sick leave, recruitment periods, or when no suitable internal candidate is available;

- contractors or consultants could potentially fill the role where there is no suitable candidate within a business; and
- the GOC should further consult with stakeholders to help refine and clarify the role of the head of optical practice.

105. Overall, while there was consensus on the need for the head of optical practice to have a strong link to the business, there was also a call for flexibility to accommodate various business sizes and situations. It was felt that more stakeholder engagement is needed to refine this aspect of the proposals.

106. The optical professional/representative bodies largely agreed, but again stated that any prescriptive requirements could have unintended consequences and a degree of flexibility was needed, for example, where recruitment to the role is difficult, where services are provided by locums, or the head of optical practice is on long term leave.

107. A sample of comments is available in the box below.

*"Without this if not employed by the business it could lend itself to bribery and corruption. I feel the business needs to be directly accountable…"* Optometrist

*"I think to do this job well you need to have a grasp of the nuances that exist within each business as well as the ability to directly engage with employees. I do not feel an external person would be able to have the same impact."* Optometrist

*"Ensures accountability since the HOP would be directly integrated into the business and its operations."* Dispensing optician

*"Where would liability/responsibility lie otherwise."* Contact lens optician

*"Employment is the preferred and likely model, but a nominated or named registrant is equally viable or preferable. For example, employment may be onerous for small businesses whose resident registrant does not wish to take on the HOP responsibility or where a business has a prolonged period of absence of the incumbent HOP (e.g. sick leave, maternity/paternity leave) or where the HOP leaves the business and the business is in the process of recruitment..."* GOC business registrant

*"It should be someone who has knowledge and access to the business as a whole."* Optical business (not a GOC business registrant)

*"Without this there is a risk of a token figurehead."* Education provider

*"Without a direct line from shareholder/owner to HOP there may be less communication and the possibility of inappropriate behaviours being hidden."* Patient representative charity/organisation

*"…we need to recognise that people change jobs, go onto maternity/paternity leave, have periods of sickness and absence and the business owner would need*

*to have flexibility in providing cover for the HOP role in these circumstances if they couldn't take the role on themselves. There could be a need, therefore, to allow a contractor to take on the HOP role-ideally a registrant."* ABDO

*"The AOP supports the idea that in instances where a HOP is required, they should be employed by the business…"* AOP

*"It would be reasonable that the Head of Optical Practice should be an individual employed by the business. However, there may be circumstances where this may not be possible, such as where no suitable candidate for the HOP is available, where the clinical services are provided by locums, or in circumstances where the HOP is on long-term leave. Provision should be made for this*." The College of Optometrists

*"Whilst most businesses are likely to employ the HOP, there might be sound reasons for also allowing the HOP role to be fulfilled by a contractor, for example:*
*• the need to cover a period of sick leave*
*• the need to cover a period in which a new HOP is being recruited*
*• smaller businesses might struggle to find an employed optometrist who wishes to take on the responsibilities of a HOP and a business owner might need to hire in additional resource to help them manage this..."* FODO – The Association for Eye Care Providers

*GOC response – head of optical practice: employee*

108. There was broad support that the head of optical practice should be an employee within the business, and we intend to take this proposal forward. It is important for there to be clear lines of responsibility and accountability, and we consider this is best ensured if the individual is employed by the business. We recognise practical challenges where flexibility is required in the day-to-day operation of the policy, for example, in situations where the role holder is absent for a long period. We are confident these can be addressed through rules and guidance supported by a proportionate approach to enforcement.

**Head of optical practice: multiple businesses**

109. We asked stakeholders to what extent they agreed or disagreed that an individual should not be a head of optical practice for multiple businesses. Of the 73 respondents that answered the question, 38 per cent agreed or strongly agreed, 26 per cent neither agreed nor disagreed, and 36 per cent disagreed or strongly disagreed.

110. The following themes were identified from the comments:

- restricting individuals to being head of optical practice for a single business would ensure direct and clear accountability a stronger focus on ensuring compliance with regulatory requirements;

- conflicts of interest could arise if a head of optical practice was overseeing multiple separate and unrelated businesses;
- there should be flexibility as business models in optics are complex and in some cases, such as larger multiples or franchises, it may be reasonable for a head of optical practice to oversee multiple related businesses;
- in practical terms there is no reason why a single individual could not fulfil the needs of the role across multiple businesses;
- capping the number of businesses that a single individual could carry out the role for could mitigate risks relating to dilution of focus; and
- it should be up to the business to determine how the role would work and manage the risks.

111. Overall, while there was no consensus, there was a preference for limiting the number of businesses a single individual could undertake the head of optical practice role for to ensure effective management and regulatory compliance, with some flexibility based on the structure and relationship of the business.

112. There were mixed views from the optical professional/representative bodies. Flexibility was a common theme as business structures can vary significantly. Furthermore, these bodies suggested it may be difficult for a business to recruit a head of optical practice, and some flexibility is needed for smaller businesses to be able to fulfil regulatory requirements.

113. A sample of comments is available in the box below.

*"Provided they are directly working in the business, multiple businesses shouldn't be prohibited."* Optometrist

*"It is wholly possible for an individual to ensure that standards and systems are in place across many sites and businesses, especially with current high tech risk management systems..."* GOC business registrant

*"Multiple branches of one company would be fine, not several businesses. Clear conflicts of interest can always happen in similar business models."* Pearce & Blackmore Opticians (GOC business registrant)

*"For individual businesses to assess and manage the risk."* Patient representative charity/organisation

*"While a HOP might ideally be focused on one particular business, there are many different types of optical business and the GOC should therefore allow flexibility about how the role is carried. The overriding need is to focus on the desired outcome of providing the necessary leadership to maintain high standards of care and regulatory compliance in each individual business."* ABDO

*"…Furthermore, a HOP dedicated to one business creates a cohesive work environment for the clinical team, ensuring that professional standards are upheld in a consistent way. This approach fosters a clear and accessible point of contact for clinical teams, helping to avoid potential conflict of commercial interests that could arise if the HOP were overseeing multiple, unlinked businesses. In situations of non-compliance, or a breach of GOC standards, having the HOP operate across multiple organisations would be more challenging to defend..."* AOP

*"…an independent consultant could oversee many practices and be in a position to share best practice frameworks."* Bexley Bromley and Greenwich LOC

*"In most cases, it would be reasonable that for individual practices or small groups of practices, the Head of Optical Practice should be responsible for that one business. However, for some larger multiples, for operational reasons, it would be reasonable that provision is made for the individual to be responsible for several related businesses/franchises. Guidance may be needed on the potential maximum number of practices the HOP should be responsible for, and what structures should be in place for the delegation of responsibilities on a day-to-day basis..."* The College of Optometrists

*"…Further, if a small practice has a single highly valued employed optometrist who can only work part time because they have caring responsibilities and cannot take on the HOP role, then the GOC's proposals to require HOPs to be employed and not to support multiple practices could result in less good patient safety outcomes. Such restrictions on the HOP role could also create complexities with existing employment law, the Equality Act 2010 and put smaller practice owners are risk of having to close – e.g. having to hire an additional GOC registrant to be the HOP which the practice income cannot support…"* FODO – The Association for Eye Care Providers

*GOC response – head of optical practice: multiple businesses*

114. There was no clear consensus in the responses on this issue. It is important to recognise that stakeholders were coming from different perspectives distinguishing between multiple linked businesses (such as joint venture partnerships and franchises) and multiple unlinked businesses. We recognise the challenges for large and small businesses are very different.

115. As the default approach, our view is that one individual should not carry out the head of optical practice role for multiple separate and unlinked businesses. As set out in our consultation, we are concerned this could dilute the individual's ability to carry out the role effectively given their need for access to information, to have the authority to take certain decisions and for there to be proper lines of accountability. We agree with some stakeholders that this situation could lead to potential conflicts of interest that could not be managed satisfactorily.

116. However, we are mindful of the different business models in the sector and see that flexibility could be applied in limited circumstances and still meet the needs of the role, while avoiding situations whereby individuals perform a nominal or consultancy role across multiple unlinked businesses. We will work with stakeholder organisations on the details of implementation to ensure the regulatory framework strikes the right balance. We do not consider this issue needs to be prescribed in primary legislation but instead can be specified in rules and guidance which will be subject to public consultation.

**Head of optical practice: power to introduce conduct standards**

117. We asked stakeholders to what extent they agreed or disagreed that the GOC should have a power to introduce a separate set of conduct standards for the head of optical practice should this be required in the future. Of the 73 respondents that answered the question, 46 per cent agreed or strongly agreed, 21 per cent neither agreed nor disagreed, and 33 per cent disagreed or strongly disagreed.

118. The following themes were identified from the comments:

- if the head of optical practice role encompasses new responsibilities, which our existing standards do not cover, then there could be a case for introducing separate standards for this role to ensure clear expectations;
- separate standards should be introduced if the role is carried out by a non-GOC registrant;
- there is the potential for complexity, over regulation and bureaucracy if separate standards for a head of optical practice role are introduced especially if the role is carried out by GOC registrants who are already subject to GOC standards;
- any additional regulation could be cumbersome and confusing, and the GOC should provide clear guidance rather than creating new standards as the current standards are sufficient and rigorous enough; and
- small businesses may find it difficult to identify a suitable head of optical practice as specific standards could be perceived as onerous.

119. Overall, there was caution against introducing additional regulatory requirements, particularly if those carrying out the role are already regulated by the GOC. Some were not clear on why the GOC would seek to have the power to potentially introduce standards in future but sought assurance that we would engage and consult further with stakeholders if we did so.

120. The optical professional/representative bodies were against introducing additional regulatory standards if the role holder was already a GOC registrant.

It was felt that this could be costly, unnecessary and lead to over regulation, and that any future standards should be subject to further consultation with stakeholders with a clear rationale as to why this is needed.

121. A sample of comments is available in the box below.

*"More bureaucracy."* Optometrist

*"This could be a step too far in finding such people for small lay owned businesses as registrants may not want to subject themselves to a higher(?) set of standards."* Optometrist

*"GOC rules should apply for everyone, but there could be additional rules for heads to make sure they know they can't get away with misuse of power."* Student optometrist

*"The GOC should have autonomy to introduce new standards (which are helpful) in the same way that the current standards for individual registrants and optical businesses are updated from time to time to allow for change."* GOC business registrant

*"Is this not what is already covered in GOC standards when registered? It sounds like it getting more complex and separated. I feel that if a HOP is required, then their role is to ensure that the business adheres to the GOC standards/code of conduct."* Optical business (not a GOC business registrant)

*"The GOC should clearly outline the responsibilities of a head of optical practice as above and assuming that the person carrying out this role is either a registrant or accountable as a business owner, it should not be necessary to have separate standards for the head of optical practice. The GOC should avoid creating a separate set of standards that is unnecessarily costly and complex to administer."* ABDO

*"…The consultation document suggests that separate standards for HOPs are not required, and there is no rationale provided for their creation. As such, we support the GOC position that additional standards are not required. Further, we do not think it is appropriate for a regulatory body to seek the power to introduce new standards on a speculative basis. Instead, if the GOC identifies a legitimate need for separate standards in future, they should consult again at that time providing full and detailed reasoning."* AOP

*"While the roles and responsibilities of an HOP should be made clear to the post-holder, we do not feel additional regulation is required. However, if the role of a HOP is ever filled by a non-registrant (dependent on acceptance of the related proposal above), the GOC may need to consider additional standards for such individuals."* The College of Optometrists

*GOC response – head of optical practice: power to introduce conduct standards*

122. We do not consider it necessary to introduce separate standards for this role. Since we intend for the role holder to be a GOC registrant who is already subject to our standards, introducing any additional standards could be confusing and disproportionate. However, as the role evolves, we consider it would be prudent for us to have the flexibility to introduce additional standards in future. After further enquiry we consider that our existing legislation enables us to set certain requirements for specific registrant groups. Should we decide to introduce specific standards in the future, as with all changes to our standards, we would consult publicly.

**Head of optical practice: characteristics**

123. We asked stakeholders to what extent they agreed or disagreed that the GOC should specify in rules/guidance essential characteristics of a head of optical practice that businesses should satisfy themselves are met. Of the 71 respondents that answered the question, 73 per cent agreed or strongly agreed, 8 per cent neither agreed nor disagreed, and 18 per cent disagreed or strongly disagreed.

124. The following themes were identified from the comments:

- while there is a need for consistency and clarity in defining the role of a head of optical practice, the GOC should not be overly prescriptive in mandating essential characteristics for the role;
- job descriptions and the appointment of the role should be left to the discretion of business owners, with perhaps the GOC providing guidance or a template for businesses to adapt;
- too much detail in defining essential characteristics could limit suitable candidates or deter potential registrants, and any requirements must be objective and non-discriminatory; and
- being too specific could make it difficult for smaller businesses to recruit and the GOC should not require businesses to recruit additional staff to meet overly stringent criteria.

125. Overall, respondents called for a balanced approach that provides clarity and supports effective leadership, without imposing restrictions that could hinder the recruitment process or the operational flexibility of optical practices.

126. The optical professional/representative bodies were mainly in favour of person characteristics being defined but cautioned against being too prescriptive, as this could deter individuals from taking on the role or there might be no suitable candidates. ABDO thought it should be left to businesses to decide.

127. A sample of comments is available in the box below.

"This would enable consistency across all practices." Optometrist

*"If you do proceed with the HOP proposal I suppose having a set of guidelines would be helpful but it should be left to the organisations to determine who they feel is best suited to the role."* Therapeutic prescribing optometrist

*"Provides clear guidance for businesses on selecting qualified and capable individuals as HOPs."* Dispensing optician

*"It is hard to imagine how the GOC could mandate the characteristics of a HOP candidate as there will be variables across many business models. It may make it difficult to recruit to a mandated model, especially for smaller businesses. It would be helpful if the GOC provided guidance on essential and preferable knowledge, skills and characteristics ie like a job specification."* GOC business registrant

*"As we noted in the responses to previous questions, it is imperative that the HOP role is better defined in order that the postholder is as effective as they can be. This can be achieved using a template "person specification" for businesses to adapt. Detailing the general desirable levels of education and experience that would make someone a good candidate for this role would be hugely beneficial. We would also welcome clarity on how this role may be protected to assure that it can operate as intended."* AOP

*"Specific rules and guidance are essential."* Bexley Bromley and Greenwich LOC

*"If a Head of Optical Practice requirement is introduced, it could be helpful that the GOC specify in rules/guidance, the essential characteristics that it considers necessary for the HOP. However, an unintended consequence is that if no employee or locum meets these characteristics, there would be no Head of Optical Practice. We would need to see the proposed essential characteristics first before commenting further."* The College of Optometrists

*"The FCA and other regulators have such criteria/principles. However, in those sectors, firms are not appointing individuals who are already regulated in their own right in that specific sector/specialism. In the case of a HOP being a GOC registrant, it is therefore difficult to imagine what the GOC would define as "essential characteristics" that are not already covered in existing registrant standards..."* FODO – The Association for Eye Care Providers

*"An unintended consequence is that too much detail on essential characteristics could limit the people who would be suitable for these roles OR put registrants off. The current set up is not an onerous one on registrants and therefore attracts more individuals looking to progress."* Optometry Scotland

*GOC response – head of optical practice: characteristics*

128. Overall stakeholders considered that we should not prescribe in rules the essential characteristics of the role holder, and we agree with this view. Stakeholders did however favour the GOC providing some guidance in this area to help understand our expectations. We will consider the need for any guidance on person characteristics as part of our implementation approach.

**Head of optical practice: business register**

129. We asked stakeholders to what extent they agreed or disagreed with our proposal for the name of the head of optical practice to be listed on the GOC register of businesses. Of the 72 respondents that answered the question, 57 per cent agreed or strongly agreed, 24 per cent neither agreed nor disagreed, and 19 per cent disagreed or strongly disagreed.

130. The following themes were identified from the comments:

- listing the head of optical practice could enhance transparency and accountability, and provide a clear point of contact for the public;
- concerns about the potential shift of focus from organisational accountability to individual responsibility and creating unfair pressure on the head of optical practice, as it may give the impression they are solely accountable for regulatory compliance when it is a shared responsibility;
- practical concerns about keeping the register up to date, especially for businesses with multiple sites and heads of optical practice;
- information on GOC registrants is already publicly available, and additional listings may be redundant and could lead to increased complaints;
- such a measure might deter individuals from taking on the role due to the risk of public scrutiny and potential harassment; and
- the current system is sufficient for raising concerns with the regulator.

131. Overall, while there was recognition of the need for accountability and transparency, there was apprehension about the implications of listing an individual head of optical practice on the GOC business register, with a call for a more balanced approach to responsibility and concerns about practical implementation.

132. There were mixed views from the optical professional/representative bodies. The AOP and Optometry Scotland disagreed and said it could be misleading by giving the impression that the individual was solely responsible for the failings of a business. The College of Optometrists highlighted that it could improve transparency with the public as there would be a clear line of accountability.

133. A sample of comments is available in the box below.

*"Point of contact available to the public and other interested bodies."* Optometrist

*"Risks deterring individuals from taking on the role due to public visibility and scrutiny."* Dispensing optician

*"This may add unnecessary complexity to the register and needs further thought. Where a business has multiple sites listed on the GOC's body corporate register and has multiple HOPs (e.g. they may wish to adopt a regional HOP approach), it would not be easy to identify which HOP is relevant for which site. Further thought is required to understand the benefits to patients, employers and other businesses in listing the nominated HOP on the business register. Any solution needs to take account of the fact that patients/businesses etc need to be able to easily identify the HOP relevant to that particular business site/location."* GOC business registrant

*"I understand the need for accountability to the public, but I think that that's what the GOC exists for. Having a single name listed online for any disgruntled customer to hound has the potential to become very nasty, without much benefit to the safety of the public."* Other

*"Accountability and follows similar lines taken by other regulatory bodies."* Patient representative charity/organisation

*"We do not consider this to be necessary and would query the purpose of such a listing. The necessary information would already be available to the GOC and any member of the public would be able to raise any concerns with the regulator in the usual way without having access to this information."* Clyde & Co LLP

*"…More broadly, our view is that accountability for compliance should be shared proportionately among business owners, directors, senior management, and clinical leads, as they all play a role in operational and clinical governance. Singling out the HOP publicly could place an unfair burden on one individual…"* AOP

*"In order to ensure transparency with the public, and enhance communication between optometry practices and the GOC, this would be a reasonable measure. This would also make it clear to the public and other healthcare professionals who is responsible for ensuring the practice/s meets GOC standards."* The College of Optometrists

*"The FCA has a similar approach. GOC registrants are also already on the register, so there is no significant impact with respect to data in the public domain."* FODO – The Association for Eye Care Providers

*"Putting too much emphasis on a specific person by naming on the GOC list suggests ultimate responsibility which may not be the case and could be misleading to the public or other businesses. The business should remain named*

*only as this keeps the company responsible. Another unintended consequence is that patients may wish to speak directly to the HOP and bypass company complaints procedure which in larger businesses particularly would be problematic and in some cases could cause delay in procedures."* Optometry Scotland

*GOC response – head of optical practice: business register*

134. Whilst we acknowledge the concerns raised by some stakeholders, we have concluded that in the interests of public transparency the individual nominated as head of optical practice should be listed on the GOC business register. It is important that it is clear to the public who is responsible for ensuring a business meets the required regulatory standards. We agree that any annotation must be clearly and correctly communicated, for example, to ensure the head of optical practice is not unduly held to account for the failings of a business, and that we comply with all data protection requirements.

**Head of optical practice: annotation on individual register**

135. We asked stakeholders to what extent they agreed or disagreed with our proposal for individuals acting as a head of optical practice to have an annotation against their entry on the GOC register of individuals. Of the 72 respondents that answered the question, 42 per cent agreed or strongly agreed, 32 per cent neither agreed nor disagreed, and 26 per cent disagreed or strongly disagreed.

136. The following themes were identified from the comments:

- concerns highlighted the potential confusion and unnecessary complexity of any annotation on the GOC register;
- such annotations could be misleading when professionals work across multiple practices but only hold the head of optical practice role in one;
- listing head of optical practice next to business registrant entries would be clearer for the public;
- an annotation could deter qualified individuals from taking on the role due to the increased scrutiny and accountability, and they could be easily contactable by the public;
- the GOC register should focus on clinical qualifications and risks rather than governance roles; and
- questions around the purpose of the annotation and its impact on patient safety or accountability.

137. Overall, respondents were predominantly concerned about the potential for confusion, the deterrent effect on professionals considering the role, and the appropriateness of making such annotations public. Associating the role with business registrant entries rather than individual registrants would be more effective and less confusing.

138. The optical professional/representative bodies disagreed with this proposal. They thought that it could cause confusion with the public, particularly where a registrant works across several practices. It was suggested that it would be better to link this to the registration of the business.

139. A sample of comments is available in the box below.

*"May deter individuals from taking on the role due to public annotation."* Dispensing optician

*"This may add unnecessary complexity to the register, especially as people work in multiple locations…"* GOC business registrant

*"The individual may not want this shared with the public."* Bexley Bromley and Greenwich LOC

*"The register of optical businesses should list the name of the head of optical practice and perhaps indicate whether they are a registrant. It is an excessive burden then to cross reference this onto the registrant list and runs the risk of creating confusion and excessive administration, while adding nothing to patient safety or accountability."* ABDO

*"Annotating the HOP's name implies a greater level of personal accountability compared to other key stakeholders, such as business owners, directors, and senior managers. This undue scrutiny may discourage qualified individuals from applying for the role, undermining the GOC's broader goal of improving regulatory oversight. The GOC individual register exists to verify a professional's qualifications, registration status, and Fitness to Practise history. Adding annotations unrelated to clinical risks or clinical qualifications dilutes the register's primary function and purpose. The HOP role is fundamentally a governance position tied to business compliance, not personal clinical practice…"* AOP

*"There may be occasions whereby a registrant is the HOP of one practice, but also works in several other practices/businesses (e.g. as a locum) where they are not the HOP. This would cause confusion with the public..."* The College of Optometrists

*"This would be unnecessary and could also cause confusion – e.g. where an individual registrant works across multiple practices but has a HOP role at just one practice..."* FODO – The Association for Eye Care Providers

*"Would be confusing in instances where an optometrist works across other practices."* Optometry Scotland

*"We believe that it would be less confusing for the public if heads of optical practices were to* [be] *listed against the practice entry rather than the registrant entry."* Optometry Wales

*GOC response – head of optical practice: annotation on individual register*

140. Based on the feedback we have concluded that if someone is listed as part of the business registrant entry, then it is not necessary to annotate this information to their individual registrant entry. We agree this could cause confusion, particularly if an individual works across multiple businesses and agree with the point that annotations are primarily used to highlight additional clinical skills or risks, not senior levels of management.

## Section 3: Enforcement approach and sanctions

### Powers to impose a financial penalty

*Patient and public research*

141. In the focus groups and interviews, there was widespread support for changing the GOC's powers to an uncapped fining system rather than have a maximum fine, as now. Participants supported stronger enforcement powers, including the ability to issue fines tailored to the size and turnover of an optical business. However, many also wanted the severity of impact on customers to be considered, rather than fines being based solely on business size.

*Consultation responses*

142. We asked stakeholders which option they favoured in relation to the GOC's powers to impose a financial penalty on business registrants. Of the 94 respondents that answered the question, 59 per cent said the financial penalty should be linked to turnover, 28 per cent said that there should be a new maximum amount (replacing the current £50,000 cap) and 14 per cent said that the GOC should have a power to impose an uncapped financial penalty.

143. The following themes were identified from the comments:

- financial penalties should be set in a proportionate and fair way, taking into account, for example, the size and turnover of a business;
- penalties should be impactful enough to act as a deterrent without being so severe as to threaten the viability of businesses, particularly smaller practices;
- appropriate regulation and financial penalties can help improve patient outcomes, however, excessive penalties could harm patient care by forcing practices to close, especially in underserved areas, or preventing practices from making improvements to patient care;
- no evidence was provided as to why the GOC needs a power to impose an uncapped financial penalty – this approach would be disproportionate and potentially damaging to businesses, without clear evidence of benefit to public protection;
- the concept of linking penalties to turnover is complex and potentially unfair, especially for businesses with diverse revenue streams or those that are part of larger and/or global corporations – some businesses might have a high turnover but might not be very profitable or even loss-making; and

- a new maximum penalty could be a viable option, provided it is set in a fair and proportionate manner – clarity is needed on how any new cap would be determined and further consultation would be required.

144. Overall, respondents advocated for proportionate and fair penalties that take into account the size and turnover of businesses, with many opposing uncapped fines and expressing concerns about the potential negative impacts on both businesses and patient care.

145. There were mixed views from the optical professional/representative bodies on whether the maximum fine should be linked to turnover, or a new limit should be set. None of them supported having an uncapped fine, as they said this was disproportionate and no evidence was provided as to why this power was needed to effectively protect the public. However, the PSA favoured an uncapped fine system since it would help to future-proof our legislation.

146. The AOP supported linking the fine to turnover considering this would be the most equitable and proportionate approach. Given the varying sizes of businesses within the UK market, it considered this option would work effectively to penalise companies at the right financial level. However, arguments against this approach were that turnover is not easily calculable. What constitutes turnover can vary between companies and be impacted by, for example, whether the company is operating globally or offers other services such as audiology. A company could have a healthy turnover but be running at a loss, in which case, any fine could damage a business' ability to continue or limit its ability to make improvements to patient care.

147. All of the other optical professional/representative bodies favoured setting a new maximum limit for the fine as the most equitable option, and this could be linked to inflation. The College of Optometrists proposed a hybrid model whereby the penalty is capped but the amount is linked to turnover (or profit).

148. A sample of comments is available in the box below.

*"You have had many chances over recent years to instigate proceedings against business registrants - most notably when organisations were breaching Covid rules and more recently around shortened testing times. With this decision making in mind why should you have the power to raise the fine level. As an organisation you want to increase the power available to you, adding to business costs whilst having completely failed to use your existing powers."* Optometrist

*"Linking the penalty to turnover ensures a relatively equal penalty for all."* Heyes Opticians Ltd (GOC business registrant)

*"The fine should be related to the seriousness of the incident and size of the company. A fine of the same size will have a very different impact on a large*

*multimillion pound company compared to a small independent one."* Optical business (not a GOC business registrant)

*"The ability of the GOC to impose uncapped fines is unjustified (from the evidence they provide) as there is no immediate risk to public protection – this is therefore out of the GOC's remit."* Education provider

*"A fixed maximum will be eroded by inflation and a link to turnover can be manipulated by clever accounting."* Education provider

*"An uncapped penalty would seem to be an extreme scenario as a sanction for businesses not adhering to standards and could lead to variable application and legal disputes. Although we have chosen a new maximum amount it would need to be reflective of the level of risk to patient safety..."* SeeAbility (patient representative charity/organisation)

*"…The possibility of imposing an uncapped fine would ensure that the GOC's legislation remained future-proof. Clearly the details of how the quantum of the fine would be arrived at requires careful consideration; we welcome the GOC's detailed assessment of how this might be done."* PSA

*"Linking financial penalties to a business's turnover ensures fines are proportionate, fair, and impactful across businesses of all sizes…"* AOP

*"…In all cases, the impact of financial penalties on smaller practices must be considered, particularly where a small practice is one of the few (or only) options for patient access to eye care (e.g. rural areas) and a large fine would prevent them from making the required improvements and therefore remaining operational. While there should be a financial penalty as a deterrent, and safeguards in place to protect the public, the sanctions should not risk the provision of safe patient care in areas of greatest need."* The College of Optometrists

*"…if the GOC did have powers to impose a financial penalty based on turnover, it would be difficult to use such a regulatory tool effectively and proportionately in the UK, given the wide range of business models and complex global supply chains. It is therefore not clear under which circumstances a financial penalty based on turnover for primary eye care services would protect the public. For these reasons we think linking a financial penalty to turnover is an unviable option…"* FODO – The Association for Eye Care Providers

*"We do not believe that uncapped financial penalties would be appropriate as we do not see the benefit to the public and runs the risk of discouraging practices from supporting regulating reform. We do not believe that linking the financial penalty to turnover is appropriate - an optical practice may have a healthy turnover and be making a financial loss, and again this runs the risk of discouraging practices from supporting regulatory reform."* Optometry Wales

*GOC response – powers to impose a financial penalty*

149. We have carefully considered the feedback from stakeholders in relation to our approach to setting financial penalties. Despite uncapped financial penalties not being favoured by stakeholders, we consider this approach would best reflect the diversity of business models and the need to future-proof our legislation. As the risk profile of the professions grows and more businesses are brought into regulation, it is important that we can impose appropriate sanctions. In addition, our Advisory Panel noted that businesses are already exposed to unlimited fines (for example, through employment tribunals related to discrimination legislation[5]) so this would not present novel risk.

150. We agree with the arguments that linking fines to turnover alone would be too complex given the business models operating in the market and the limitations of turnover as a metric. We also consider setting a new arbitrary maximum fine limit would pose the same issues that we currently have in not being able to fine proportionately in relation to the market. Also, the cap would need to be reviewed periodically and require legislative reform each time it is changed.

151. Whilst we reiterate that the aim of the financial penalty is not to penalise registrants, any sanction should act to reinforce compliance, and we consider this approach would best help achieve this. Many of the objections to our proposal focused on proportionality and our lack of track record in using fines. To ensure fines are proportionate, we will produce sanctioning guidance to explain how financial penalties should be calculated. Further, the published determination will explain how the fine was calculated in each case. We expect that turnover will often be a key factor in this calculation, but this may not be appropriate in all cases. As with any sanction, the registrant may appeal against the decision, which provides an additional safeguard.

152. To note, in paragraph 154 of our consultation document, we applied the Bank of England's inflationary rate from 1958 (when the Opticians Act was enacted) to estimate what the £50,000 financial penalty would be worth today, which we noted came to nearly £1 million. However, the £50,000 financial penalty was not introduced until The Opticians Act 1989 (Amendment Order) 2005, so the equivalent amount today would be approximately £86,700.

**Power to visit**

*Patient and public research*

153. In the focus groups and interviews, there was widespread support for giving the GOC a power to visit an optical business if we decided to open an investigation

[5] The annual employment tribunal award statistics for the period 2023/24 showed average awards varying between £10,750 and £102,891. (Employment Tribunal Award Stats 2023/24 Published | MFMac)

once a concern had been raised. Some participants spontaneously favoured routine inspections upon registration to identify potential issues early (which we did not propose as part of our business regulation proposals), followed by additional inspections triggered by complaints or self-referral.

*Consultation responses*

154. We asked stakeholders to what extent they agreed or disagreed that introducing a power to visit businesses as part of the fitness to carry on business process could give the GOC greater powers to protect patients and the public. Of the 85 respondents that answered the question, 62 per cent agreed or strongly agreed, 18 per cent neither agreed nor disagreed, and 20 per cent disagreed or strongly disagreed.

155. The following themes were identified from the comments:

- regulatory oversight (by way of visiting or inspecting a business) can help ensure standards are met and increase public safety and confidence in the system;
- as a regulator, the GOC should have a power to oversee the businesses it regulates;
- it was unclear when and how this power would be needed or used and the examples given in the consultation did not clearly demonstrate this – more information is needed to give an informed view;
- concern about the potential duplication with other bodies, as some practices are already subject to NHS inspections;
- if such visits were to occur, there must be clarity on the scope and circumstances under which they would operate; and
- concern that the regulatory costs associated with the proposal would be passed onto registrants.

156. Overall, while there was recognition of the potential benefits of GOC visits for regulatory effectiveness and public confidence, there was also significant concern about duplication, cost, and the need for clear guidelines and justifications for when and how these powers would be used.

157. Although this was not proposed, the optical professional/representative bodies reiterated that they did not support a system of regular or routine inspections. Support for the power to visit was mixed, and some thought the consultation lacked evidence as to why this power was required over and above the investigatory powers the GOC currently has. These bodies also highlighted concerns over costs being passed on to registrants.

158. A sample of comments is available in the box below.

*"Practices already registered have a lot of protocols and governance along with accountable registrants and things like NHS visits, don't see how the GOC should have a right to come to the business, they will already have evidence provided by the practice i.e. records."* Optometrist

*"Important for non NHS practices that have otherwise no oversight."* Optometrist

*"To protect the Optical Practice against any unwarranted allegations from patients or non-patients. For GOC to be aware of the day-to-day running of practices in real life & not be sheltered in their ivory towers in London."* Dispensing optician

*"It is not clear what benefit a site visit adds to FtP cases unless it helps the FtP panel gain a better understanding of what happened in any particular situation (?). Perhaps give the GOC power to utilise this where they have a strong prevailing argument for doing so. It should not be a part of every FtP case or we can see that it may prolong GOC FtP cases even more than currently."* GOC business registrant

*"We agree that there is no evidence to support regular or routine inspections. We consider that the current proposals are disproportionate and unnecessary. Further, it is not clear who would carry out the inspections and what documents or information the GOC would seek to access. We query whether the GOC has staff with the necessary skills and training to appropriately carry out visits which would not prejudice ongoing investigations. We also note that practice visits can be carried out by the College of Optometrists for any issues relating to supervision of pre-registration optometrists…"* Clyde & Co LLP

*"Gives public confidence and follows the approach of other regulatory bodies."* Patient representative charity/organisation

*"…We see potential benefits in the GOC having powers to visit businesses in order to more clearly establish the facts in a particular case. As with all additional regulation however, it would be important to clearly establish the unmanaged risk arising from the current model and whether visiting powers would be the appropriate mechanism to address this. Any proposals to introduce additional regulation, especially where this might impose costs on businesses, would of course need to be carefully considered."* PSA

*"…In relation to whether the GOC requires a power to visit premises as part of a fitness to practise investigation, it is not clear in what circumstances this would be necessary given that the GOC already has powers to request information and gather witness evidence. We would be concerned about the additional costs on registrants of appointing and training a team of inspectors."* ABDO

*"The AOP cannot support the proposed GOC visiting powers without firm assurances for several reasons. Regulatory intervention must be proportionate to*

*business size, risks, and specific non-compliance activity… The AOP understands how in theory this power could assist the GOC to investigate concerns, but believe it should be used only rarely, in a circumscribed way, and only in relation to reported breaches of business regulations. It should not be used opportunistically, to gather evidence against individual registrants."* AOP

*"Having the ability to inspect optical practices could enhance the reputation of the GOC's role as regulator, provide additional confidence to patients and the public, and enable the GOC to fully investigate concerns where they arise – if the inspections are carried out effectively, by suitably qualified 'inspectors' and bring about positive change..."* The College of Optometrists

*"Practices are already inspected by the NHS and therefore we feel this would be duplication of time, cost and effort to both practices and GOC. We don't understand the situations that the GOC may require to visit as part of a fitness to practise and would seek further clarity on this before responding further."* Optometry Scotland

*"We do not understand why the GOC is seeking to introduce this power and on what evidence this is based. We would appreciate further discussion to better understand why this is being proposed."* Optometry Wales

*GOC response – power to visit*

159. We have carefully considered stakeholder feedback in relation to having a power to visit a business as part of the fitness to carry on business process. Whilst we can see the benefits of having such a power, we are mindful that concerns were raised about a lack of evidence, the potential duplication with other regulatory bodies, and the cost and resource implications. We have taken these concerns on board and decided not to introduce this power, as we consider that our existing processes (for example, we can compel a business to provide written information and could visit a business with their consent) are sufficient to address fitness to carry on business. However, we may revisit this issue in the coming years if it becomes apparent that we cannot address any identified regulatory risks within our existing powers.

## Section 4: Consumer redress

### Mandatory participation

*Patient and public research*

160. In the focus groups and interviews, there was widespread support for the proposal that optical businesses should be required to participate in the sector's consumer redress scheme so that all consumers have access to it. Participants felt their trust and confidence would increase knowing that there was such a complaint service, even if it was unlikely they would need to use it.

161. In the omnibus survey, 69 per cent of respondents agreed that if something goes wrong with a service they receive from an optical business, they should have access to an independent organisation to help resolve their complaint.

*Consultation responses*

162. We asked stakeholders to what extent they agreed or disagreed that it should be mandatory for business registrants to participate in the consumer redress scheme. Of the 94 respondents that answered the question, 56 per cent agreed or strongly agreed, 23 per cent neither agreed nor disagreed, and 21 per cent disagreed or strongly disagreed.

163. The following positive or neutral themes were identified from the comments:

- the need for independence and fairness in the complaint resolution process, with some respondents suggesting that the Optical Consumer Complaints Service (OCCS) should remain independent of the GOC;
- consistency and clarity for the public are important factors;
- some support for the idea that a mandated redress scheme could improve trust in optical services and drive higher standards of care; and
- recognition of the potential for a mandated scheme to alleviate regulatory pressure by resolving minor complaints.

164. The following negative themes were identified from the comments.

- while the OCCS is functioning well, making participation mandatory could lead to complications, especially for businesses that already engage with other services like NHS feedback or trading standards;
- a lack of clear justification and evidence for the proposals;
- businesses should have the freedom to choose their consumer redress schemes;

- while there is a need for an independent consumer redress service, there is also a sentiment that many registrants are capable of managing their own affairs without compulsory schemes;
- concerns about the potential for mandatory schemes to over-favour consumers at the expense of businesses; and
- concern that mandatory participation could lead to increased financial burdens (particularly on smaller businesses) and create an unnecessary layer of bureaucracy.

165. Overall, while there was recognition of the benefits of consumer redress schemes like the OCCS, there was apprehension about making such schemes mandatory, with concerns focusing on independence, financial impact and potential over-regulation.

166. The optical professional/representative bodies were not in agreement about whether it should be mandatory for business registrants to participate in the consumer redress scheme. The College of Optometrists, AOP and Optometry Scotland did not think it was necessary or appropriate, with concerns around lack of evidence, potential costs and complications for patients/consumers. However, ABDO, FODO and Optometry Wales were in support citing factors including building public trust, raising standards, saving time for businesses, improving clarity and consistency of approach. Two large business groups and SeeAbility (representing patients) also favoured mandatory participation.

167. A sample of comments is available in the box below.

Comments in support

*"It needs to be a statutory requirement to be fair to all, and at the moment, OCCS does not cover non GOC business registrants."* Optometrist

*"This proposed system is designed to introduce fairness across business registrants, and the current OCCS works well where businesses participate in the service. Any proposal for consumer redress should build on the success of the OCCS model."* GOC business registrant

*"Again for consistency for patients/public so they are clear there is this process and it is mandatory."* SeeAbility (Patient representative charity/organisation)

*"A mandatory consumer redress scheme would ensure that patients have a clear accessible route to seek the resolution of complaints. Public knowledge of such schemes would foster trust even further in optical services whilst at the same time driving higher standards of care in optical businesses who would be aware that they would be accountable for their services. A mandated redress scheme would bring consistency across practices and should support registrants in providing*

*clarity and guidance on how to deal with patient concerns alongside helping promote best practice across healthcare."* ABDO

*"…mandating a business to be part of a consumer redress scheme could help avoid regulatory time being taken up with consumer product type complaints. These are best resolved as quickly as possible at local level or, if not, by referral (currently) to the GOC quality-assured OCCS… if it is possible for the GOC to require use of a quality assured system such as the OCCS and the GOC is confident that its governance arrangements can demonstrably manage any conflicts of interest into the future, we would support this proposal."* FODO – The Association for Eye Care Providers

Comments against

*"I think the OCCS performs well as an independent body. More could be done to publicise their presence to consumers but forcing businesses to sign up to a redress scheme puts them at risk from opportunistic members of the public."* Therapeutic prescribing optometrist

*"We do not consider that there is any evidence that this is necessary. In our experience, the current systems in place work well and businesses engage with them well."* Clyde & Co LLP

*"While we agree that there would be benefits to businesses voluntarily participating in the consumer redress scheme, we are not aware of evidence of public protection risks that would justify making participation mandatory. All additional regulatory burdens should be clearly justified in relation to the GOC's overarching objective of public protection and be proportionate to the risks involved. Further, making participation mandatory risks the process becoming more adversarial and, as the GOC has noted 'arguably goes against the essence of mediation as a process with which parties engage voluntarily and constructively to resolve a dispute.' "* PSA

*"The AOP does not support the implementation of a mandatory scheme due to a lack of clear justification and detail… without clear justification, statutory underpinning, or detailed analysis, the proposal is unsubstantiated, potentially costly, and impractical. The AOP advocates for a proportionate and evidence-based approach that fully considers the financial impact on businesses…"* AOP

*"We do not believe this is required. The industry is regulated enough and businesses are able to resolve issues themselves. We have concerns that this would become an additional layer of bureaucracy that is not necessary and would also become a very expensive service that ultimately the registrants are paying for."* Bexley Bromley and Greenwich LOC

*"The current Optical Consumer Complaints Service (OCCS) works well as a non-mandatory intermediary, and we see no reason to change the system and make*

*this mandatory. The current GOC triage of complaints works well and should continue."* The College of Optometrists

*"We acknowledge that the OCCS are working well in current capacity and would encourage members to access this service however we have concerns that if mandatory, this could cause complications for patients/customers who contact other services first such as the NHS feedback services in Scotland or trading standards. We would suggest making it a recommendation to practices to utilise the service and provide more awareness to optical businesses on how the service operates."* Optometry Scotland

*GOC response – mandatory participation*

168. We recognise that views were divided on this issue, including between the optical professional/representative bodies. As well as support from some of these bodies and the two large businesses who responded, there was strong support for mandatory participation in the patient/public research.

169. The responses, both for and against mandatory participation in the OCCS, largely reflected the arguments advanced in the consultation document with factors relating to public trust, raising standards and consistency, balanced by concerns around changing arrangements that work well and possible negative impacts for business registrants.

170. We are keen to build on a scheme which has operated successfully for more than a decade[6] and are not persuaded that making participation in the scheme mandatory would alter its fundamental nature. For existing business registrants who participate in the scheme voluntarily, nothing would change. However, we are concerned that there may be businesses brought into regulation that are not willing to participate voluntarily. This would widen a power imbalance between consumers and businesses, risk undermining public trust in the regulatory framework and create an unlevel playing field between businesses.

171. Ultimately, as a patient-focused regulator, we consider that mandatory participation in the OCCS is necessary to deliver public protection and would be a proportionate solution, and we will recommend this model to government.

[6] The OCCS 2023-24 annual report records that the service dealt with 1,675 complaints within its remit and 85% of these were resolved or concluded within its process. 51% of all cases were concluded in 0-45 days, and 76% were concluded within 90 days, with an average resolution time of 19 days. Of the 349 complaints that progressed to mediation, 275 (79%) were concluded with a mediation. The average time to mediate a complaint was 58 days.

**Legally binding decisions**

*Patient and public research*

172. In the focus groups and interviews, participants were asked whether optical businesses should be forced to comply with the outcome recommended by the scheme. They were told that if businesses were forced to comply with the outcome, the scheme might become slower, more formal and cost more, but on the other hand, it could mean that consumers are better protected and disputes are kept out of the courts. Most focus group participants favoured a slightly slower yet more formal complaints procedure.

173. In the omnibus survey, 61 per cent of respondents favoured access to a complaints scheme that could make binding decisions, even if this meant a slower and more formal process.

*Consultation responses*

174. We asked stakeholders to what extent they agreed or disagreed that the consumer redress scheme should have powers to make decisions that are legally binding on businesses. Of the 76 respondents that answered the question, 34 per cent agreed or strongly agreed, 24 per cent neither agreed nor disagreed, and 42 per cent disagreed or strongly disagreed.

175. Nearly all of those who provided free-text comments were from those who disagreed with the proposal. The following themes were identified from the comments:

- concerns about the necessity and potential consequences of making decisions from the consumer redress scheme legally binding;
- the belief that the current system, which is largely mediation-based and managed by the OCCS, is effective and efficient;
- concern that legally binding decisions could lead to unnecessary formalisation of simple complaints, increased costs, and possible overlaps with fitness to practise procedures;
- concern about the impact on small and independent practices, as higher operational expenses could be passed on to businesses;
- the potential for increased bureaucracy and red tape without clear benefits;
- a lack of clarity on how legally binding decisions would interact with existing regulatory functions and whether they would trigger further investigations or disciplinary action;

- the industry is low risk and does not require this level of regulation; and
- decisions should remain non-binding, with the courts having final jurisdiction, and businesses should only be answerable to the GOC for investigation.

176. Overall, there is significant resistance to making consumer redress scheme decisions legally binding, with concerns about the necessity, potential increased costs, procedural complications, and the impact on current effective systems. There is a call for more clarity and evidence to support any changes.

177. All of the optical professional/representative bodies were in agreement that the consumer redress scheme should not make legally binding decisions. The PSA considered there was not enough evidence to support such a change. However, the patient representative charity, SeeAbility, did support this option.

178. A sample of comments is available in the box below.

Comments in support

*"By this stage it would seem fair to patients/public that a decision in their favour should be binding, otherwise its potentially a bureaucratic process that could lead to disappointment."* SeeAbility (Patient representative charity/organisation)

Comments against

*"Feels like strong arming businesses, if we have complied with all duties then OCCS should see this and if not then we should be answerable to GOC only for investigation."* Optometrist

*"We are a low risk industry so we should not need this level of regulation at this stage. It should be mandatory for businesses to participate in consumer redress, but not legally binding."* GOC business registrant

*"This would make the OCCS more adversarial as mentioned - businesses follow Consumer Rights so there is no need for the OCCS to provide binding decisions."* Optical business (not a GOC business registrant)

*"We have not seen evidence risk to public protection, which would warrant changing the nature of the consumer redress scheme to make decisions legally binding."* PSA

*"The present process with OCCS does work well without powers to make legally binding decisions and we would not want to see consumer redress become a lengthy, legalistic and more costly process."* ABDO

*"While the AOP is aware that consumer redress exists in many other areas, it cannot support a proposal to render the decisions of any Consumer Redress Scheme for optometry legally binding until there is clarity on a number of significant issues. To ensure that there is not an unnecessary formalising of simple*

*complaints, increased costs, and possible overlaps with Fitness to Practise procedures, we need clarity on the status, identity and processes of any such scheme…*

*… while the AOP is supportive of the general aim to increase consumer protection, we consider the lack of supporting evidence and detail on the proposed redress scheme in this consultation unhelpful, given the risks involved. Therefore, we must strongly oppose the proposal."* AOP

*"The current scheme works well, and we see no reason to change the system. Legally binding decisions - in the absence of any evidence to the contrary - would be an unnecessary step."* The College of Optometrists

*"There is no evidence that this is necessary. The GOC evidence is clear that the current system works very well, it is quick and efficient and adding more duties and red tape for businesses is likely to increase costs for all without benefits for the majority."* FODO – The Association for Eye Care Providers

*"The current system is evidenced to work very well. We have not seen any evidence to suggest that any further processes are required."* Optometry Wales

*GOC response – legally binding decisions*

179. While the patient and public research indicated support for the OCCS making legally binding decisions, this was more finely balanced than whether business participation in the scheme should be mandatory. We recognise the concerns from the consultation feedback around a lack of evidence, the low-risk nature of the industry, and the possible negative impacts for consumers and businesses (particularly around timeliness). Therefore, we have decided to recommend to government that the OCCS should remain a mediation scheme, rather than moving to an adjudication model with legally binding decisions.

180. This model does carry the risk that some consumers may not achieve a fair outcome from their complaint, and if this became a common problem, it could undermine public trust in the regulatory system. However, this needs to be balanced against the benefits to most users who would continue to receive quick, informal and fair redress building on the strengths of the current scheme. We have a range of tools available to incentivise businesses to engage constructively with mediation, including our Standards for Optical Businesses. While we cannot use these standards to insist that businesses comply with a recommended outcome from mediation, a pattern of behaviour across multiple cases could help to complete an overall picture about any business that we have cause to investigate.

181. We also recognise that moving to an adjudication model would fundamentally alter the nature of a scheme that works well. The interaction with our fitness to practise processes is an important consideration here and this dynamic could

change if both the OCCS and the GOC could determine outcomes. We note that mandatory mediation is becoming more common as part of informal resolution techniques prior to court proceedings (e.g. there are plans for compulsory mediation in small civil claims up to a value of £10,000[7]).

**Delivery of consumer redress**

182. We asked stakeholders to what extent they agreed or disagreed with our proposal to continue with our current model of delivering the consumer redress scheme i.e. a single provider through a competition for the market model. Of the 74 respondents that answered the question, 59 per cent agreed or strongly agreed, 26 per cent neither agreed nor disagreed, and 15 per cent disagreed or strongly disagreed.

183. The following themes were identified from the comments:

- the current consumer complaints service works well and should not be significantly altered; and
- the benefits of having a single provider for consistency of decision-making and simplicity, both for businesses and patients.

184. Overall, the consensus among respondents was to maintain the current OCCS model, with some suggesting improvements in communication, oversight and regulation to enhance its effectiveness.

185. The vast majority of optical professional/representative bodies were in favour of keeping the existing system. The AOP cautioned against changes that could lead to fragmentation, inconsistency and confusion, and highlighted the risks of complacency, advocating for evidence-based changes if any are to be made. However, they also highlighted the conflict of interest risks of a scheme funded and contracted by the GOC.

186. A sample of comments is available in the box below.

> *"One provider helps with consistency and ease of access for the public."* Optometrist
>
> *"The current OCCS model works well and is efficient and any new system should be based on this success."* GOC business registrant
>
> *"We agree with the GOC that the OCCS works well for consumer redress and the current arrangements should not be altered."* Education provider
>
> *"It appears at present that the OCCS arrangements work well. Communication for how the business registration scheme and raising issues of meeting GOC*

[7] Increasing the use of mediation in the civil justice system: Government response to consultation - GOV.UK

*standards as opposed to consumer redress could however be made clearer for patients/public. It is better to have a single provider for simplicity and be clear on the roles for the GOC and the roles for the OCCS."* SeeAbility (Patient representative charity/organisation)

*"The present process works well and is understood and supported by the sector and patient feedback is supportive of the scheme."* ABDO

*"The AOP believes the current OCCS model is largely effective, and any changes must be approached with caution to avoid unintended consequences. It is important to acknowledge potential risks that could arise in maintaining or altering its delivery… Any proposed changes must be grounded in clear evidence, provide demonstrable improvements, and avoid creating unnecessary complexity or conflicts. Without such justification, maintaining the existing OCCS model – with ongoing monitoring to ensure quality – is the most pragmatic and proportionate approach."* AOP

*"The current delivery model and process for identifying a single provider appears fair and effective. We see no reason to change the system."* The College of Optometrists

*"We agree with the GOC's analysis. The current scheme is proportionate, popular with patients and works very efficiently."* FODO – The Association for Eye Care Providers

*"Appears to be fair and operating effectively."* Optometry Scotland

*GOC response – delivery of consumer redress*

187. Given the strong support in favour of our existing model and lack of arguments to change the system, we intend to retain the existing model of delivering our consumer redress scheme with a single provider through a competition for the market model. We will continue to periodically tender for the scheme to ensure we are getting best value for money and a high-quality scheme, with fair and consistent outcomes for users.

**Funding of consumer redress scheme**

188. We asked stakeholders how any consumer redress scheme should be funded. Of the 75 respondents that answered the question, 44 per cent thought that every business should contribute through the registration fee (as now), nine per cent thought there should be a pay per use model whereby the business pays for any complaint made against them that is considered by the scheme, 19 per cent thought there should be a combination of the previous two models, three per cent selected 'other', and 25 per cent were not sure.

189. The following themes were identified from the comments:

- support for a shared funding model (as per the existing process which is efficient and effective), where all businesses contribute to the costs, as more equitable and likely to result in lower overall costs which they are able to plan for;
- concerns about the fairness and practicality of funding models for business regulation, particularly in relation to handling complaints – there would be a potential negative impact on businesses, especially smaller ones, if they were required to pay per complaint;
- a pay-per-use model could discourage businesses from seeking mediation services, and could be unfair if complaints are unfounded or vexatious;
- the idea that serial offenders should bear a greater cost was mentioned as an incentive for businesses to improve their practices. However, there was also a call for the system to be fair and equitable across all sizes of business, without discounts for larger market shares; and
- businesses should not be penalised when complaints arise from communication breakdowns rather than actual faults.

190. Overall, the responses highlighted a desire for a fair, simple and equitable funding system that does not disproportionately burden businesses, particularly in cases of unjustified complaints. The optical professional/representative bodies were generally in support of continuing with the existing funding model of a shared fee model.

191. A sample of comments is available in the box below.

*"A pay per use model would potentially make vexatious complaints more costly for a business that has done nothing wrong."* Optometrist

"[A combination of the above two models] *Serial offenders should carry a greater cost - gives an incentive to improve."* Contact lens optician

"[Every business contributing through the registration fee] *As long as the larger providers pay per practice the same as smaller organisations and do not have a discounted fee just because they have a larger market share. The system must be fair and equitable across all sizes of business."* Therapeutic prescribing optometrist

"[A pay per use model] *Would make businesses more wary of causing a patient complaint. As long as if the complaint is dismissed at the early stage (for instance if the complaint is obviously frivolous or unreasonable) that the practice does not have to pay."* Pearce & Blackmore Opticians (GOC business registrant)

*"While it might be superficially attractive to seek to incentivise businesses to avoid complaints by requiring payment per complaint, this would be unfair in a case where a complaint is unwarranted. Furthermore, administering such a system would add an increased amount of administration and cost to the process, and would be likely to prove unworkable. Therefore, we would support continuing with the present funding method."* ABDO

*"We believe that the shared funding model is the most equitable and is likely to deliver the overall lowest cost to all practices."* AOP

*"We agree with paragraph 198 in the consultation document i.e. continue with the current funding arrangements."* The College of Optometrists

*"In the same way as it would be unworkable for individual registrants to fund more of the GOC costs if they get a complaint/concern, it would be impractical and add to bureaucracy for businesses to have a pay per use model. It could also result in less provider support for customers accessing such services (especially from a business struggling to meet expectations).*

*A model where all registrants pay the GOC fee and the GOC procures an efficient service, works cost-efficiently and effectively and ensures there is a level playing field for patients/consumers and registrants with poor providers exiting the market sooner than if there were a pay per use model."* FODO – The Association for Eye Care Providers

*"Cost effective to have all businesses contributing. Would encourage businesses to utilise service better. Could impact small businesses more where they don't have support from peers or additional departments that can specialise in customer service. In many cases it is a breakdown in communication and may not be the practice's "fault" and therefore, why should they be penalised in this instance. There is no cost to the patient in these scenarios so believe it should be the same for practices."* Optometry Scotland

*GOC response – funding of consumer redress scheme*

192. Having considered the responses, we note the concerns around a pay per use model and do not intend to pursue this. We intend to continue with current funding arrangements for the OCCS, sharing the fee among registrants through the registration fee as this is the simplest system to administer, and our standards are the best lever to address any variability in unfair practices and first-tier complaint handling by businesses.

## Section 5: Other areas

### 5.1 Impact assessment

193. We asked stakeholders whether there were any aspects of our proposals that could discriminate against stakeholders with specific characteristics. Of the 93 respondents that answered the question, only nine respondents thought that there were.

194. The following themes were identified from the comments:

- the potential disadvantage to part-time workers for the head of optical practice role, who often have childcare or other caring responsibilities – this could lead to a bias towards full-time employees in the appointment of this role, potentially affecting female registrants more;
- the lack of flexibility in the head of optical practice role to accommodate those on maternity leave or with long-term absences; and
- the cost of the proposals and their impact on individual businesses, especially those serving under-served populations or operating with low income.

195. Overall, respondents were worried about the implications on part-time workers, those with caring responsibilities, and the potential for increased costs affecting service provision to vulnerable groups.

196. A sample of comments is available in the box below.

*"In appointing a HOP* [head of optical practice]*, there is a risk that employers could favour those who are full-time employees, over part-time employees, which could affect those with childcare and other caring responsibilities. This is more likely to disadvantage female registrants – who are less likely to work full-time [GOC Registrant Survey 2024]."* The College of Optometrists

*"The cost of the proposals has not been identified on individual businesses thus there could be an impact on provision of services to under-served populations if provision of services becomes unsustainable due to increased registration fees or additional personnel. This particularly affects people with disabilities, those on a low income and of different ethnicities who research shows often experience barriers to accessing sight testing and other prescribed services."* SeeAbility (Patient representative charity/organisation)

*"The way in which the Head of Optical Practice (HOP) has been specified and restricted might have a negative impact…"* FODO – The Association for Eye Care Providers

*"The HOP role could be assumed to be full time and affect those working part time due to childcare or caring responsibilities. One HOP may limit those who can apply – companies may wish to have multiple HOP to cover in instances of pregnancy or paternity or long term absence."* Optometry Scotland

*"The proposed requirements around Head of Optical Practice e.g. being employed, could negatively impact those who work part time (due to caring or parental responsibilities) and in a locum role."* Optometry Wales

197. We asked stakeholders whether there were any aspects of our proposals that could have a positive impact on stakeholders with specific characteristics. Of the 79 respondents that answered the question, only seven respondents thought that there were.

198. There were no common themes identified from the comments, but the following points were made:

- consistent business regulation would be beneficial for all, potentially leading to improved standards and positive impacts for various groups, especially those who face challenges in accessing eye care services, such as people with disabilities;
- the importance of fairness and non-discrimination in regulations;
- clearer rules or guidance could enable younger optometrists to qualify for roles that they might be excluded from due to age-related experience requirements; and
- the proposals could have positive effects on groups with characteristics relating to age, disability, sex, and race.

199. A sample of comments is available in the box below.

*"Better regulation would be beneficial for all."* Optometrist

*"If business regulation is more consistent and standards are raised, there should be a positive impact across the population and for those who report worse experiences than others in accessing eye care services (such as people with disabilities). It may also help alleviate concerns that individual registrants have that despite the professional standards they must adhere to, there are commercial imperatives they are faced with that can sometimes put them in a difficult position. These are noted by the GOC in the consultation as having an impact on patient and clinical care."* SeeAbility (Patient representative charity/organisation)

*"If the GOC were to specify in rules/guidance, the essential characteristics that it considers necessary for the HOP, this could help enable some younger*

*optometrists to qualify for the role, who otherwise may have been not considered experienced enough solely due to their age."* The College of Optometrists

*"We agree with the GOC's assessment as set out in the accompanying Impact Assessment that the proposals may have positive effects on groups with certain characteristics. The proposals may benefit groups with shared characteristics relating to age, disability, sex, and race."* PSA

*GOC response – impact assessment*

200. We note the concerns around the head of optical practice role potentially negatively impacting women, part-time workers and those on long term absences such as maternity leave, as these people may be less likely to be selected for these roles. These will be considered as we work through the detailed arrangements for implementation.

201. We also note the comment around fees and the impact that it could have if businesses were unable to operate in under-served populations. We would expect the legislation to provide flexibility in fees but this will be considered further following legislative reform.

202. We note that it was felt that there would be positive impacts on persons with protected characteristics if business regulation was consistent and if regulations/guidance promote fairness.

**5.2 Welsh language**

203. 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. Of the 85 respondents that answered the question, only three thought that there would be any effects but did not provide any substantive details in comments.

204. 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. Of the 63 respondents that answered the question, only two thought that there were but did not provide any substantive details in comments.

205. 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. Of the 61 respondents that answered the question, only three

thought that there were but did not provide any substantive details in comments.

*GOC response – Welsh language*

206. We do not believe that our proposals would have any adverse impacts on Welsh language speakers and have detailed this in our updated impact assessment.

**5.3 Any other areas**

207. We asked stakeholders to tell us about any other areas relevant to business regulation that were not covered by the consultation. Thirty-eight respondents provided us with free-text comments in response.

208. The following points were identified from the comments where they had not already been addressed above and we have responded to these after the summary of each point:

- the regulation of online sales, with many highlighting the risks associated with unregistered businesses selling contact lenses and glasses online. There was a call for these businesses to be brought under regulatory control to ensure public safety and to address issues such as incorrect prescriptions and poor-quality materials – *GOC response:* under our new model of business regulation, online sellers based in the UK will be required to register with us if they are providing specified restricted functions. All businesses within the scope of the legislation will be subject to our standards whether they operate physically or online;

- calls for the GOC to address issues with online retailers based outside the UK and for all providers of optical services within the UK to be registered with the GOC – *GOC response:* as outlined on pages 133-134 of our response to the call for evidence on the Opticians Act, "the Opticians Act applies only in the UK and it is difficult to use UK law to prosecute an overseas company even where the purchaser is in the UK. There would be practical problems in presenting a hearing without the power to compel the defendant to attend a UK court. It would also be extremely hard to enforce any conviction or order." We note The College of Optometrists' request for us to raise the issue of overseas sales that do not comply with UK law with the appropriate national regulator/authority and have the powers to end the illegal practice occurring in the UK. It would not be appropriate for us to write to other countries' authorities about sellers based in other jurisdictions, as this is not part of our remit and we must apply registrants' funds towards our statutory purposes. In any event, it is our understanding that other countries' authorities would have no basis for taking action if the businesses are complying with their domestic legislation. We also note the

AOP's calls for us to become a thought leader and innovator in this area. In its 2022 report Safer care for all, the PSA calls on governments to use the current healthcare regulator legislative reform programme "to ensure regulators have the agility to address the challenges brought about by new approaches to funding and delivering care, including the introduction of new technologies", specifically mentioning the difficulties in regulators' ability to act against online providers being "impeded by restrictions on their geographical jurisdictions". We continue to be part of inter-regulatory groups led by government bodies and the PSA that discuss online sales and new technologies;

- the commercial pressure on optometrists to meet sales targets and the potential conflict of interest when optometrists are on bonus schemes could compromise patient care and the GOC should provide clear guidance to prevent such practices and protect employees who raise concerns – *GOC response:* our standards of practice address such matters, including the need for our registrants to use their professional judgement, and we encourage our registrants to speak up (with supporting guidance) where they believe that patient care is being compromised and detail the support that is available to them. In addition, in 2025/26 we will begin a thematic review on commercial practices and patient safety, designed to assess current or emerging risks in the sector;

- a review of the standards of practice to ensure that the balance is right between the responsibilities of individuals and businesses to address the commercial pressures and concerns about speaking up outlined above – *GOC response:* we plan to start our review of our standards for business registrants later in 2025, and will review the balance of the standards between individuals and businesses as part of this;

- the impact of existing regulation (e.g. if they hold an NHS contract) and any extended business regulation on small practices, with concerns about unfair burden and that increased regulation could lead to the closure of small practices, particularly in rural areas where they are vital for patient access to care – *GOC response:* we note the concerns around the impact on small businesses and will take this into account when designing the new system to ensure that our approach is proportionate;

- a more detailed overview of the gaps in regulation, particularly those relating to non-restricted activities such as enhanced schemes for independent prescribing and glaucoma care, many of which are provided under NHS contracts and covered by the CQC – *GOC response:* as outlined in our response to the call for evidence on the Opticians Act, we do not believe the case has been made to change the current list of restricted functions to include enhanced schemes that are effectively part of medical

services regulated by the CQC. However, to future-proof the legislation we proposed a mechanism for the GOC to make recommendations to the Secretary of State to alter the list of restricted functions without the need for primary legislation;

- a call for more robust regulation of domiciliary eye care due to the risks it presents to both practitioners and patients – *GOC response:* as part of our corporate strategy for 2025/30, we will be carrying out several thematic reviews to assess current or emerging risks in the sector – domiciliary care is one of the areas that we will consider for a future thematic review; and

- concerns about the use of locums by businesses – *GOC response:* it is for individual businesses to decide whether it is appropriate to use locums and to ensure that they are appropriately qualified and trained. Our Standards for Optical Businesses refer to locums and we will consider as part of our review of these standards whether any further amendments should be made in this area.

209. A number of comments were made that were outside the scope of this consultation and have therefore not been considered here.

## Findings from the omnibus survey: Business regulation consultation

We commissioned Impact Health to carry out a short survey for us. We asked ten bespoke questions on a national omnibus survey. The survey was administered to a sample of 2,205 individuals, providing a robust, nationally representative view of the UK public segmented by gender, age, social grade (SEG), and region. The fieldwork took place on 22-23 February 2025.

### *Key findings*

78% of respondents said that if a business is carrying out a sight test or eye examination then it should be overseen by an industry regulator.

- Support was higher amongst older respondents (aged 55+).
- Support was also higher amongst those who had been for a sight test / eye examination in the last two years (82%) compared to those who had never been (66%).

60% of respondents said that all optician businesses are regulated, only 32% correctly said some are and 8% said none are regulated.

- Those in the older age group (aged 55+) were more likely to think all optician businesses were regulated compared to younger age groups (16-24%).
- Those who had been for a sight test in the last two years and those who were confident in receiving a high standard of care from an optician business were more likely to think that all businesses were regulated.
- Those in Northern Ireland were more likely to think that all optician businesses are regulated (74%) compared to Scotland (65%), England (59%), and Wales (57%).

69% agreed that all optician businesses should be overseen by an industry regulator.

- Support was higher amongst older respondents (aged 55+).
- Those who had been for a sight test and those who were confident in receiving a high standard of care from an optician business were more likely to think optician businesses should be overseen by an industry regulator.

The main benefits of regulation were seen as:

- Ensuring eye care professionals are well trained (61%).
- Maintaining high standards of performance and conduct (56%).
- Providing accountability for those who fail to meet the required standards (48%).

69% agreed that if something goes wrong with a service they receive from an optician business, they should have access to an independent organisation to help resolve their complaint.

- Support was higher amongst older respondents (aged 55+).
- Those who had been for a sight test in the last two years and those who were confident in receiving a high standard of care from an optician business were more likely to think that they should have access to an independent organisation to help resolve their complaint.
- Those with a physical disability were even more likely to agree (73%).

69% agreed that all optician businesses should be required to take part in an independent consumer complaints scheme.

- Support was higher amongst older respondents (aged 55+).
- Those who had been for a sight test in the last two years and those who were confident in receiving a high standard of care from an optician business were more likely to agree that all optician businesses should be required to take part in an independent consumer complaints scheme.

When asked which consumer redress option respondents preferred:

- 61% favoured a system in which the business had to comply with the outcome, even if this was a slower and more formal process.
- 39% favoured a faster and more informal process, where the business would **not** have to comply with the outcome.

**Reflections**

The findings from this survey show that the current system does not match public expectations about the protections they have when getting a sight test. The vast majority of respondents (78%) expect businesses carrying out sight tests to be subject to industry regulation but only a third (32%) realise the true picture that only some businesses are regulated.

Support for closing this regulatory gap is strong with 7 in 10 respondents (69%) agreeing that all optician businesses should be regulated.

The main benefits of regulation are ensuring eye care professionals are well trained and high standards are in place, as well as the ability to hold those accountable when they fail to meet these standards.

In terms of consumer redress over two-thirds of respondents (69%) think optician businesses should be required to participate in an independent consumer complaints scheme. On balance more respondents favour access to a complaints scheme that can make binding decisions, even if this means a slower and more formal process.

Support for many of the reforms in regulation and introducing a consumer redress scheme are higher amongst older respondents (aged 55+), those who have been for a sight test in the last two years, and those who are confident in receiving a high standard of care from an optician business.

# PUBLIC AND PATIENT RESEARCH INTO REFORMING THE GOC'S SYSTEM OF OPTICAL BUSINESS REGULATION

## Research Report

Prepared for **General Optical Council**
Prepared by **Impact Health**

April 2025
Project No: 5326

General Optical Council

IMPACT

FROM INSIGHT TO INFLUENCE

# REPORTING STANDARDS AND GLOSSARY

- This market research was conducted by Impact Health, an independent market research agency (part of the Impact Research Group)
- All interviews were conducted confidentially, maintaining the anonymity of participants and with strict adherence to the BHBIA, ABPI, EphMRA and MRS guidelines
- All projects are carried out in compliance with the ISO 20252 international standard for market, opinion and social research and GDPR

**Note:** Due to the qualitative nature of this research, all numbers contained in this report are directional only and are not projectable to the overall population.

# CONTENTS

# BACKGROUND TO THE RESEARCH

The General Optical Council (GOC) regulates the optical professions in the UK, ensuring public health and safety. The GOC is reviewing the way it regulates optical businesses. It is seeking to modernise the system of business regulation to help strengthen public protection and remove unnecessary restrictions on businesses.

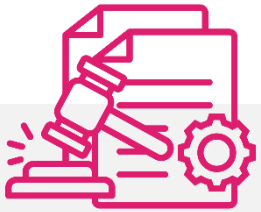
This research was commissioned to gather public and patient views on the GOC's proposed reforms, ensuring they align with public expectations, improve trust, confidence and transparency, and enhance public protection.

# ANSWERING YOUR OBJECTIVES

This study explored public awareness, trust, and expectations regarding optical business regulation. The research sought to understand how people perceived regulation, their experiences with optical services, and their reactions to proposed reforms aimed at improving public protection and confidence.

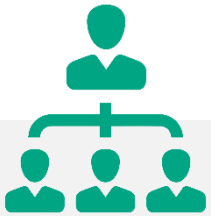
Specifically, our research provided insights across four broad areas of reform:

### Expanding regulation



Bringing all optical businesses under GOC regulation, including those currently unregistered, to close public protection gaps

### Head of optical practice



Introducing a designated person within each business responsible for ensuring compliance with regulatory standards

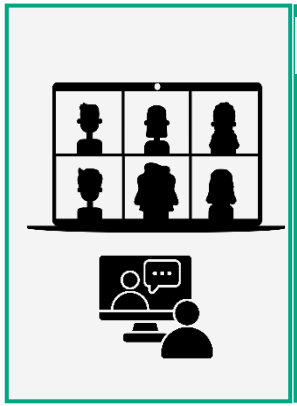
### Consumer redress

Requiring all businesses to participate in an independent consumer redress scheme

### Enforcement and fines

Granting the GOC greater powers to visit businesses and issue higher fines where necessary

# METHODOLOGY AND SAMPLE



**Qualitative methodology**

3x online focus groups (lasting 1.5 hours) each with n=8 members of the public

3x 60 minute web-assisted telephone depth interviews (WATDIs) with individuals who have experienced dissatisfaction with optical services in last two years

**Insights from a total of n=27 respondents**

The sample was broadly representative of the UK population, with some increases to statistically smaller groups, including those experiencing dissatisfaction with optical services, those representing global majorities and devolved nations. Further details on the sample can be found in the appendix.

**Fieldwork dates**

4 - 24 February 2025

Research tools (discussion guide) and materials (stimulus) can be found in the appendix

# EXECUTIVE SUMMARY

FROM INSIGHT TO INFLUENCE

# EXECUTIVE SUMMARY 1

The focus groups and interviews consistently highlighted a **strong consensus** on the need **for reform in the regulation of optical businesses**.

Many respondents were shocked to learn that not all optical businesses are currently regulated, expressing concerns that existing regulation does not adequately address their concerns. Participants emphasised the need for a fairer, clearer, and more supportive regulatory system whilst also being minded not to place too much burden/costs on businesses (especially smaller independents).

# EXECUTIVE SUMMARY 2

There was strong agreement that all optical businesses should be regulated to ensure consistency, accountability, and public safety.  They saw the GOC as an independent body that should hold all optical businesses accountable for the eye care services they provide.

## Head of optical practice

Respondents felt their confidence and trust would increase with the appointment of a head of optical practice to ensure compliance with GOC standards.
However, some sought clarity on how standards would be applied in daily practice and reassurance that this would not lead to increased costs. While there was overall support for this proposal, reassurances were needed.

## Consumer redress

Throughout the research there was widespread support for requiring all optical businesses to participate in a consumer redress scheme, believing trust and confidence would increase if everyone could access it.

The majority were comfortable with a potentially slower but more formal complaints process, prioritising binding decisions over speed.

## Tailoring fines

Respondents supported stronger enforcement powers, including the ability to issue fines tailored to the size and turnover of an optical business.

However, many wanted the severity of impact on customers to be considered, rather than fines being based solely on business size.

## Power to visit

Respondents supported the GOC's ability to visit optical businesses as part of an investigation into a complaint.

However, respondents favoured 'inspections' as a term over 'visits' due to the sentiment of enforcement and accountability.

Some volunteered 'routine inspections' upon registration to identify potential issues early, followed by additional 'inspections' triggered by complaints or self-referral.

# DETAILED FINDINGS

FROM INSIGHT TO INFLUENCE

# LEVELS OF TRUST AND CONFIDENCE IN OPTICAL BUSINESSES

- Since many optical professionals can refer patients to hospitals, respondents felt they are as trustworthy as NHS clinicians
  - However, because people visit optical businesses less frequently than GPs or dentists, it is harder to assess trust
- Optical professionals were perceived as clinically trained and have a very specific role
  - Some felt the retail environment distinguished optical services from those of pharmacists, dentists, and doctors
  - Others compared it to private dentists offering cosmetic treatments (e.g. teeth whitening) or private doctors providing additional services
  - Some intentionally separate their sight test and consultation from the purchase of glasses, choosing to take their prescriptions elsewhere

# VERBATIM - LEVELS OF TRUST AND CONFIDENCE IN OPTICAL BUSINESSES

*I think you just automatically expect it [TRUST] because it's not like going to the shop, it's not like a shopkeeper. You're asking someone who's supposedly done years of training to diagnose things. So it is just like a doctor's really.*

*Andrew*

*Think it's a bit dual sided because although I see the optician at the same level as a dentist or a doctor, the commercial aspect of it where they're selling you a product, it does feel different. A visit to the opticians feels different to me because it is monetary, you are paying for a product and it definitely changes things. And then there's also designers involved with you. So you can get Tommy Hilfiger, you can get your Calvin Klein, you don't go to the dentist or the GP and have that same experience.*

*Krystal*

*Obviously they are qualified. Do you know what I mean? I know they're kind of nestled in a retail operation, but they are qualified to get to that stage. So we're trusting them.*

*Gary*

*I think they all have certificates up on the wall behind the counters, and things like that to say what they've done. So they've done qualifications. It's not like they're just employing someone out of school and letting them be an optician.*

*Dave*

*You were saying that they're different to dentists and doctors, but actually an awful lot of dentists are private now and they can upsell themselves, teeth whitening.*

*Suzie*

*I think it's actually changed now... Because you can now go to an optician and you don't have to buy your glasses from there. You can take the prescription away. Realistically, all you need is the prescription.*

*Andrew*

# PERCEPTION OF IMPORTANCE OF REGULATION OF OPTICAL BUSINESSES

- Most people assumed that all optical businesses were regulated
  - This was due to the understanding that the professionals they employed must be qualified to treat patients and adhere to a code of conduct
  - However, some questioned whether the retail aspect of optical businesses was regulated
- Regulation was seen as essential
  - A poor experience could lead to sight loss or serious health issues
  - None had direct experience with the GOC but assumed they could find complaint procedures online if needed

***However, most realised they were assuming all optical businesses were regulated simply because they knew optical professionals were trained***

*"I would like to think they are [REGULATED] considering what I've said as there's so many of them out there, but your dentist and stuff you hear the British Dental Association, the Association of British Dentists, all that regulation stuff. I haven't heard of anything in all my years of a regulator for opticians, so I could be wrong, but I don't think so"*

*Gary*

*"I don't have any idea, but I would assume based on what they do for a living and what their business is, that I'd be very surprised if they weren't regulated. Are we making the assumption they're regulated because they're trained?"*

*Lucy*

# DIFFERING PERCEPTIONS OF OPTICAL BUSINESSES

- **Most respondents had positive or at least acceptable experiences with optical businesses over the years**
  - Those who were dissatisfied felt their prescribed glasses did not improve their vision or did not experience the level of service they expected

**The importance placed on their relationship with the optical business varied:**

Some, particularly those with long-term eye conditions or past eye trauma, valued trust and confidence in their optical professional highly, and by association the optical business they use

Others took a more practical approach, prioritising ease of booking and appointment availability. They often acknowledged they should visit more regularly, but sight tests remained on their 'to-do' list rather than a priority

Some assigned little value on their relationship with optical businesses, either because they had never required their services or had previously been disappointed by glasses that failed to improve their vision

*"An independent took me right through having glasses, the contact lenses, the laser eye, and I've just stayed there ever since because the service is second to none, they know me well. They know my eyes, they know the whole history … if I have to travel 20 to 30 miles to see them, I'll do it and I'll do it for the reason."* *Lucy*

*"I think it means if you can get an appointment fairly quickly, I can either go online or in the store itself or telephone them up and roughly I would say can get an appointment within at least a week to two weeks."* *Hayley*

# POSITIVE PERCEPTION OF THEIR OPTICAL BUSINESSES

## Convenience vs. personalised care:

- National chains are valued for their accessibility, often located in town centres with easy appointment availability. Non-users feel confident they can access these services when needed
- Independents are preferred by those with complex eye conditions, as they are seen as providing more personalised care, better understanding patient history, and allowing more time for consultations

## Trust in familiarity:

- Some are willing to travel further to receive a more personalised service, including detailed explanations and access to advanced technology not always available at national chains (e.g., prism lenses, which significantly improved one respondent's vision)
- Familiarity also plays a role in trust – optical businesses that are frequently advertised on TV may be perceived as more reliable

## Cost and ease of access:

- Supermarket optical services are popular due to their high appointment availability and acceptance of work vouchers for free sight tests and discounts on glasses. Their pricing is often seen as more competitive
- Some choose to have their sight tests at independent optical business, where they feel more confident in the service, but then purchase glasses from a national chain for better pricing

# CONCERNS WHEN VISITING OPTICAL BUSINESSES - 1

## Lack of personal care:

- Some patients felt they were treated like they were on a "conveyor belt", just another number to staff. National chains, in particular, were perceived as overly busy, rushed, and chaotic, with short appointment times
- There were concerns that conditions or issues might be missed or not explained thoroughly. One respondent felt they should have been referred to a specialist earlier for a chronic eye condition
- Some found they rarely saw the same optical professional year on year and felt some younger professionals lack experience. However, younger customers placed less importance on seeing the same professional every time

*My* [BUSINESS X] *is in [SUPERMARKET X] so I can get my eyes checked and get a chicken at the same time. it's a bit like conveyor belt. The service is not like you get at an independent.*

*Philip*

*I think the thought of them not getting it right and then you go to wait, you get new glasses and then if you get a set of glasses, that glasses don't really work correctly. You could end up with headaches*

*Gary*

## Fear of mistakes:

- There was a risk of optical businesses not dispensing the right glasses for you, trying to 'live with them' and the hassle of having to take them back

# CONCERNS WHEN VISITING OPTICAL BUSINESSES - 2

## Fear of less committed staff:

- While all optical professionals were known to be qualified, some felt that staff (often in larger chains) seemed less committed to patient care. There was a perception that they were using the role as a stepping-stone to another job, which was particularly concerning for those with complex eye conditions

> *"It's not just a conveyor belt of customers, it's a conveyor belt of people that seem to work there as well. Look, I'm pretty sure they read the notes when you walk in, but it'd be nice to see the same person a couple of times at least. Maybe why you see new people all the time is that they might do a year, they might do two, but then they're moving on to an independent or they're setting up their own business."*
>
> *Martin*

## Fear of upselling:

- Some businesses, both large and small, were seen as charging high prices for glasses or trying to "upsell" extras like lens coatings, making customers feel pressured to buy

Despite these concerns, overall trust and confidence in optical businesses remained relatively high. Independent businesses with long-standing reputations were rated slightly higher than national chains.
**Regulation, or the lack of it, was not spontaneously mentioned as a key concern**

# SPECIFIC CASES OF DISSATISFACTION

## Specific incidences of dissatisfaction led to:

- Reluctance to return to same provider
- Increased caution and scepticism
- Greater likelihood to seek second opinions

Since the incidents were considered one-off or infrequent, none of the respondents felt the need to formally complain or escalate the issue – which they believed they could have done by investigating how and who to complain to

## Sources of dissatisfaction due to:

- Poor service and lack of communication
- Long wait times and inefficiency
- Inexperience and inaccurate prescriptions

"Did not say a word to me… not one word. And that was it." Hilary

"It's like they forgot about me." Jon

"I had to go back two or three times… it was just annoying." Faz

# AWARENESS AND PERCEPTION OF GOC

- Most assumed there was a regulator but had no knowledge of who it was or what their specific powers and responsibilities were, beyond enforcing a general 'set of standards'
- Some believed regulations might cover areas such as keeping equipment up to date and setting service level agreements for appointment wait times
- Many assumed the GOC had the authority to remove optical businesses from the register
- There was some uncertainty about whether the GOC could regulate pricing, with little awareness of its actual limitations
- Those previously unaware of the GOC were relieved to learn an optical regulator existed but they:
  - immediately called for greater visibility of the GOC
  - suggested that retailers should prominently display the GOC regulator logo on promotional materials
- Only a small number of respondents had heard of the GOC, typically those in regulatory roles or with a history of complex eye conditions
- Very few had ever noticed the GOC being advertised within an optical business

*"I think they will be able to strike them off the database. So they're no longer able to practise. They lose their license"*

*Andrew*

*"I would assume that they hold them to a certain standard that they have to meet a best practice standard"*

*Krystal*

*"I work for a professional body, so I've come across the General Optical Council before. They're the regulatory body for opticians in the UK. So they set the professional standards and make sure that people adhere to those professional standards"*

*Philip*

# PARTIAL REGULATION OF OPTICAL BUSINESSES

Most respondents were surprised and concerned to learn that only half of optical businesses are registered, as they had assumed all should be regulated, leading to reduced trust and confidence in the system

One participant was **aware of regulatory gaps** due to business structures and had **specifically chosen a GOC-regulated provider** for assurance

Some assumed **online retailers might not be regulated**, particularly those selling **very cheap glasses**, raising concerns about **quality and oversight**

*"That's quite alarming because your eyes are something that shouldn't really be messed with. And it's a bit concerning that you've got doctors and surgeons and stuff and they're all under strict regulations, even pharmacies when you're dispensing medicine. So why your eyes not taken as seriously? Because if you are qualified and you've got a set of standards, you would be able to set the right standards or prescription of your glasses and you can even find out other conditions within an eye test like diabetes or glaucoma or something like that. So yeah, it's a bit alarming"* *Andrew*

*"I think that's shocking. As I know your eyesight is incredibly important and for many, many reasons, including driving a car and being able to see properly not having a crash ….I mean it can lead to blindness"* *Suzie*

*"I am equally shocked with Susie. I would've thought that everyone would be regulated, like she said, it's medical. Why would it not be? You wouldn't find a doctor that is unregulated"* *Hilary*

# REACTIONS TO WHAT THE GOC IS SEEKING TO DO – MAKING REGISTRATION MANDATORY FOR ALL OPTICAL BUSINESSES

Respondents **strongly agreed** that **all optical businesses should be regulated** to maintain consistency, accountability, and public safety. They viewed the GOC as an independent body responsible for ensuring optical businesses are accountable for the eye care services they provide. They also believed that no businesses should be denied the opportunity to register based on flaws in the current system of regulation.

**No respondents identified disadvantages or exemptions to mandatory registration**, expressing full support for its implementation. They also felt that both the GOC and optical businesses should actively promote their registration and the regulations they adhere to in order to increase public trust and awareness.


*Absolutely shocking that you can operate an opticians and fiddle around with our eyes without being set to a certain standard.*

*Martin*

*But you would think across the board they (optical businesses) should all be signed up to this and I would hope that's what they're angling towards.*

*Gerard*

# MAKING REGISTRATION MANDATORY FOR ALL OPTICAL BUSINESSES

## POSITIVES

- Most respondents still felt confident in receiving good care because the optical professionals are required to be well trained even if the business might not be regulated
- Large national chains were perceived to be regulated and therefore trust was higher
- Large national chains could use regulation status as a selling point to reassure customers that standards are set and are high
- Most indicated they would feel more comfortable if all businesses are regulated, as they would be reassured on minimum standards being met and for many this also implied having access to a complaints scheme where penalties could be imposed if standards are not met

## CHALLENGES

- Concern that some optical businesses were deliberately avoiding registration so as not to be regulated
- The fact that some businesses wanted to be registered but couldn't due to business structure seemed 'ridiculous'
- Many felt they might be visiting optical businesses that aren't registered and became worried they would have no access to a complaints procedure
- Many viewed the lack of regulation in some businesses as placing them outside the higher rules and standards that should apply. This was often compared to other industries
- An unregulated optical business was felt to be able to set their own standards, which might be too low
- Concerns were raised that registration fees could increase costs for customers, but many were willing to pay more for a fully regulated and accountable industry

# VERBATIM - REACTIONS TO WHAT GOC IS SEEKING TO DO

*What if something goes wrong and you need to complain? Who do you complain to if that branch isn't registered? Do you have a case even? I dunno.*

Justine

*There must be a hell of a lot of people who don't know that these places are not regulated. In fact, the same problems actually happening with funeral services about regulated*

Andrew

*It would be a bit of a postcode lottery. If you're in a rural area, you might not have much of a choice when it comes to opticians. And the one that you've got close to you might not be the case*

Gary

*(the benefits of all optical businesses being regulated)…that if someone can go wrong, you can go to them and you can complain if you want to complain, but it sets standards and to be honest, it's good for them because they can actually display it that they're actually regulated by GOC.*

Andrew

*It is a bit strange because if they're carrying out the same procedures, tests, whatever and advice as the registered people and they should be able to register. Simple as that. If they're doing the same job, they should be open to the same opportunities*

Dave

# APPOINTING A HEAD OF OPTICAL PRACTICE

Respondents felt their **confidence and trust would improve with the introduction of a head of optical practice** to ensure compliance with the GOC's business standards. However, they sought clarity on how these standards would be applied in daily practice and reassurance that small, independent optical businesses would not face excessive paperwork or administrative burdens.

While there was general support for this proposal, reassurances were needed, such as:

- ensuring the head of optical practice had the required support, training, authority and resources to adequately manage regulation and potentially report failures to meet standards
- this would not mean price increases although many felt they would be happy to pay more for a well-regulated business.

*"If there was someone clearly in charge, maybe you wouldn't feel like just a number"*

*Gerard*

*"…if I knew that I was getting something which was done by a professional who was regulated and has actually got to a certain standard and I can a hundred percent trust them and it's a little bit more expensive, I'd be happy with that."*

*Philip*

# APPOINTING A HEAD OF OPTICAL PRACTICE

## POSITIVES

- Most saw this as a necessary step for accountability which lots of them had in their professional lives already
- Self-referring for potential breaches of standards was considered an effective regulatory approach, drawing comparisons to systems of accountability used by the police or within the teaching profession
- Many felt it would improve consistency in national chains
- The GOC's standards for optical business were well received, but many felt it simply outlined basic expectations that they had assumed all businesses were already following

## CHALLENGES

- Some were concerned that the head of optical practice might be 'marking their own homework' if they were responsible for referring their own optical business to the regulator
- Some thought the concept of the head of optical practice referring their own business was similar to whistleblowing which might be uncomfortable and ineffective. Instead, they preferred compulsory annual visits over self-referral, or an initial visit upon registration to flag any issues, followed by complaint-triggered visits
- There were also concerns on the pressure of small businesses having to pay someone to adopt a potentially new role
- Larger chains were seen as having a high staff turnover, raising concerns about whether maintaining continuity of a head of optical practice was realistic
- There was concern that creating a new role with additional responsibilities could increase costs, potentially impacting prices for customers. However, many were willing to pay more for a better-regulated industry

# VERBATIM - APPOINTING A HEAD OF OPTICAL PRACTICE

*I don't think that will work. I don't see how that can work because in bigger places like [SUPERMARKETS] and [BUSINESS X], you have opticians coming in all the time. The move around, they're like freelance people, a lot of them*

Andrew

*At my work, we've got a compliance manager and she rips everyone into shape. We get weekly updates with what's missing. If there's a spreadsheet, something's wrong or someone might not be pulling their weight as much and she's just as much as a friend in the office to everyone*

Lacey

*Think it's general practice. In every walk of life you've got to have someone who's ultimately responsible for either the health or safety, finance, whatever it is in that whatever workplace you are in, someone who has to be responsible for the management of that place.*

William

*Are they actually going to say something's gone wrong and the onus is on them and they're going to report it? I don't think it should be somebody inside the business. It should be somebody on the outside.*

Justine

*I don't really see it as a concern if it's internal. Where I work, we are regulated very heavily because as pharmaceuticals and medicine we kind of, I guess, mark our own homework but at the same time discuss double check, triple checked again and get signed off. And then we have audits as well. And then we have unexpected visits as well where they just give us a few days in advance where they come to check the work that we're doing, making sure it is compliant.*

Faheema

# STRENGTHENING THE CONSUMER COMPLAINTS AND REDRESS SCHEME

There was **widespread support for requiring all optical businesses to participate in a redress scheme**, ensuring all consumers had access to a formal complaints process. They felt their trust and confidence would increase knowing that there was a complaints and redress service available if required.

All would **appreciate having the option to complain** and seek redress but many thought they would rarely use the service given their general satisfaction, and even those who had issues did not find them severe enough to warrant an official complaint.

The majority were **happy with a potentially slower yet more formal complaints procedure that could make binding decisions**.

> *Yeah, it almost shows that no matter where you go, you're going to get the same treatment and entitlements. The benefits to consumers is they could go anywhere for the same treatment to be treated the same and have the same comeback should they need it and it will open up market competition*
>
> *Dave*

> *I don't think there's anything wrong with a more formal complaint system that's standardised - that sounds like that should happen. And then in terms of the cost, the customer's not paying anything, so I doubt they'll care*
>
> *Joe*

# STRENGTHENING CONSUMER COMPLAINTS AND REDRESS SCHEME

## POSITIVES

- Respondents agreed that all optical businesses should be part of a standard complaints process. They felt that the knock-on effect would be greater adherence to GOC standards and more consistent care across all optical businesses
- All respondents agreed they would be okay with slightly slower resolutions as that is the case for other areas too (28 days to hear back is normal), as they don't expect it to be a quick process
- None had ever needed to access a complaints procedure against an optical business but were pleased to know it might be there in the background if they needed it

## CHALLENGES

- Concern that cases are not always "black and white" and in many cases the redress scheme might favour the business
- Very small minority feel it would not impact on whether they went to the optical business or not

> *"I think the problem with this is until you actually need to use something like this, it doesn't really come up. So, if all swimming along and everything's going fine, you don't really care about this, it's when things go wrong and then you feel like you need somewhere to be able to go to actually sort this out. So again, similar like the financial services ombudsman. It's almost like being a mediator I think between the two, but it only comes into play when you need it."*
>
> *Philip*

# VERBATIM - STRENGTHENING CONSUMER COMPLAINTS AND REDRESS SCHEME

Gerard

*I think most of the time when you make a complaint you get that standardised reply back. It may take us 28 days to fully investigate a complaint. Nobody expects immediate resolutions to complaints these days. And if that's the price, you have to pay a hundred percent time*

*I think it is good. You never know where a situation can arise, where you want to raise a complaint and then you don't have any other option or who's going to listen to you. So it's something nice to have*

Faheema

*It seems to nail everything that we've been talking about to be fair. So yeah, no, I'm very happy. And I know it seems like you can't raise a complaint with the GOC, but you can vicariously through the OCCS, so providing a platform from which you can [complain]*

Martin

*I don't think it's about the quality of the service you get. I think it's more about consumer protection if you've got an issue or a problem*

William

*Not sure it would make much difference though. I didn't complain either way, whether they're regulated or not. So I'm not sure that it'd work that way with me.*

Lacey

*I wouldn't be too fussed if that's not what was to happen if it wouldn't change my decision on going to the opticians either way.*

Lacey

# STRENGTHENING THE GOC'S ENFORCEMENT POWERS - FINES

There was **support for the GOC to have greater ability to fine registered optical businesses** as without the threat of fines, businesses could ignore the regulator.

There was also **support for the GOC to tailor the level of fine to the size and turnover** of the optical business although many wanted severity of impact on customer taken into consideration. However, there was again concern that small independent optical businesses may face high fines as a result of increased GOC powers which might mean they face bankruptcy, so they hoped the GOC would apply fairness in levels of fines.

*"I like the idea to tailor the fines to the size of the business. Is that how they do it in Switzerland with speeding tickets and stuff? They charge it off income because that's what actually stops people doing it."*

*Joe*

*"I mean there's only so many threats you can give somebody before they don't believe the threat anymore. So you need to have that backup to be able to say, look, if this goes any further, you will get a hefty fine"*

*Philip*

# STRENGTHENING THE GOC'S ENFORCEMENT POWERS - FINES

## POSITIVES

- Most participants supported fines being scaled based on business size and turnover, believing this would improve compliance with the GOC's business standards. Larger companies were seen as having greater financial resources, so fines needed to be higher to have a meaningful impact
- There was concern that a standardised fine could disproportionately harm small independent practices, potentially forcing them into bankruptcy

> *"I think it makes perfect sense for them to fine large companies more than your independent retailer because they've got more at their disposal. That's just my opinion"*
>
> *Gerard*

## CHALLENGES

- Some argued that fines should be based on the severity and risk of the breach, rather than just the size of the business
- Others felt that fines should be more severe, with some suggesting harsher penalties or even custodial sentences in extreme cases, based on their professional experiences
- Many believed there should be clear guidance on compensation for patients who suffer physical harm due to negligence
- Some sought clarification on how the GOC would impose fines in cases involving medical negligence and court proceedings

# VERBATIM - STRENGTHENING THE GOC'S ENFORCEMENT POWERS - FINES

*I think it makes perfect sense for them to fine large companies more than your independent retailer because they've got more at their disposal. That's just my opinion*

Gerard

*If I knowingly sent a vehicle out on the road that didn't have an MOT and wasn't serviced, I could face a custodial. If you are going to mess around with my eyes, I also want you under the same caution*

Martin

*I think here what we've got to focus on is that this is a fine for the business, doesn't affect the liability insurance that you have as a patient. Yeah, that's two different things*

William

*...the LA fires and a lot of the private residences were having these private firemen and they were using water and they weren't meant to be using the water, but they were rich enough to pay those fines and so they didn't care. So you'd like to see a scale within that. So those larger businesses such as [BUSINESS X and Y], the fine needs to be an amount that is going to actually impact on them, but it's not also then bad for an independent. So I'd like to see that*

Krystal

*I think it needs to be appropriate to the size of the business. I mean, if you just had a standardised fine across the board, I mean you could wipe a company out so easily, but I think it's important to have these fines because there is no point in giving the GOC these powers unless you give them the stick to beat them in some ways*

Philip

*Think that's just complies with most other businesses. I mean you look at any other business depending on its size, its turnover, etc, it's got to have an impact. So if you are someone like [BUSINESS X or Y], £50,000 is a drop in the ocean*

William

# STRENGTHENING THE GOC'S ENFORCEMENT POWERS - BUSINESS VISITS

There was broad **support for the GOC to visit optical businesses as part of an investigation into a complaint**. However, **some favoured a stricter approach**, suggesting 'routine inspections' upon registration to identify any issues early, followed by additional visits triggered by complaints or self-referral.

Throughout the research, respondents predominantly used the term **'inspections' instead of 'visits'** when discussing regulatory oversight, even though the research materials and moderator framed the topic as business 'visits'. They favoured 'inspections' as it was more familiar (e.g. restaurant inspections) and conveyed a sense of accountability, enforcement and standardisation, whereas 'visits' felt less formal.


"I think there's a danger that if you just go in when there's only a problem that some of these organisations could fly under the radar a little bit and be still acting in maybe the not most professional manner. I think having a routine inspection, even though that sounds a lot more work and a lot more authoritative, it certainly focuses companies' minds, I think, and keeps standards to what they should be. I think if you just say I'm only going to come in when something's wrong, I think standards could slip from there"

*Philip*

# STRENGTHENING THE GOC'S ENFORCEMENT POWERS – BUSINESS VISITS

## POSITIVES

- While business visits were viewed as a positive step by all respondents, many felt that stronger regulation was needed in this area
- Some were happy with proposed changes as customers complaining is a sure sign that an optical business might not be adhering to the GOC standards

> *"If there's a minimum standard and the minimum standard is high enough and it's adhered to, then I would have a lot more confidence in going to* [BUSINESS X] *where I've previously said I don't feel very confident. But if I knew that there was a base level that they had to achieve and they get checked on it and there are penalties that if they miss it before it, I'd like to think that the quality of care was good enough not to get to a complaint. And a set of standards as the GOC clearly want to issue would help that"*
>
> *Martin*

## CHALLENGES

- Most respondents would prefer 'routine inspections' of businesses otherwise it might be too late "after the horse has bolted"
- There were fears that if customers did not complain then a poorly operated optical practice could operate 'under the radar' for many years without the GOC being aware
- Introducing 'routine inspections' would be comparable to food safety checks, but in this case for eye care—where malpractice is seen to carry greater risk
- Some advocated for 'unannounced inspections', arguing that prior warnings allow poorly run businesses to conceal issues and avoid scrutiny

# VERBATIM - STRENGTHENING THE GOC'S ENFORCEMENT POWERS - BUSINESS VISITS

*I think these places that serve you food, they're allowed to be routinely inspected at any point in time and then the hygiene gets rated and then you have to improve. You're dealing with a much more serious issue which is somebody's eyes.*

Gerard

*They're a member of the GOC…a safety measure, isn't it? And it helps maybe the person to feel a bit more secure about them. I don't know, but it's just like a safety net in a way.*

Justine

*Well, to me it sounds a bit contradictory because they're saying that they will go in under certain circumstances if an investigation is open, but we're saying it's going to help better protect the patients. Well, it's not actually if it's just going as and when something happens because it could be multiple things that have*

Andrew

*It could have been that there might have been three or four people who haven't complained, but it's happened before. The same problem happened with schools didn't it? They've got as three-month warning that they were coming in and they actually improved everything brilliantly. They were preparing for it, and I don't think you can't have a prepared investigation like that.*

Andrew

*So that sort of gives them a bit of an out because if there's no complaint then they wouldn't come in. So it makes me feel like the whole system's a little bit on shaky ground. If you don't do it sort of more thoroughly.*

Philip

# CONCLUSIONS

Overall, participants supported the GOC's proposed reforms, particularly in **expanding regulation** to cover all optical businesses, **introducing a head of optical practice** for accountability, and **implementing a universal redress process** to enhance consumer confidence.

Respondents expressed a preference for even greater regulatory oversight than those suggested, advocating for formal inspections rather than business visits, and greater reassurances over the role of head of optical practice.

There was general support for the GOC having stronger powers to fine businesses, though some participants felt the degree of fine should reflect the seriousness of the breach rather than just size and finances of the business.

Participants also highlighted potential challenges, including the regulatory burden on independent (smaller) businesses, the practicality of enforcement, and the need for clearer public communication to ensure consumers are aware of their rights and protections.

# APPENDICES

FROM INSIGHT TO INFLUENCE

# SAMPLE DEMOGRAPHICS

## Overall sample n=27

3 x 1.5 hr Focus Groups = 24

3x 60 min WATDIs = n=3

### Gender

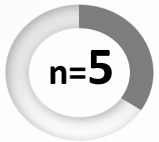
Male n=14 Female n=13

### Age

| | |
|---|---|
| 18-24 | n=4 |
| 25-34 | n=4 |
| 35-44 | n=5 |
| 45-54 | n=5 |
| 55-64 | n=5 |
| 65+ | n=4 |

### Region

| | |
|---|---|
| North England | n=6 |
| Central England | n=6 |
| South England | n=9 |
| Wales | n=2 |
| Scotland | n=2 |
| N. Ireland | n=2 |




**Global majority groups (non-white)**


**Disability and/or health condition**

### Sight test / Eye exam or visited optician/ optometrist in last 2 years

Yes n=22

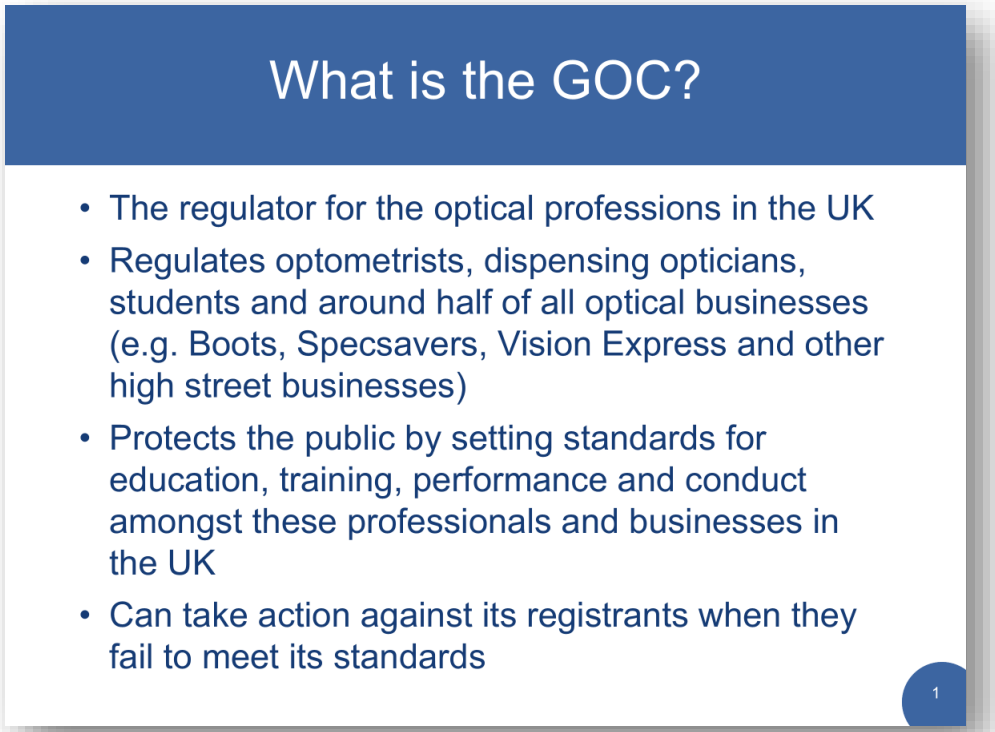
No n=5

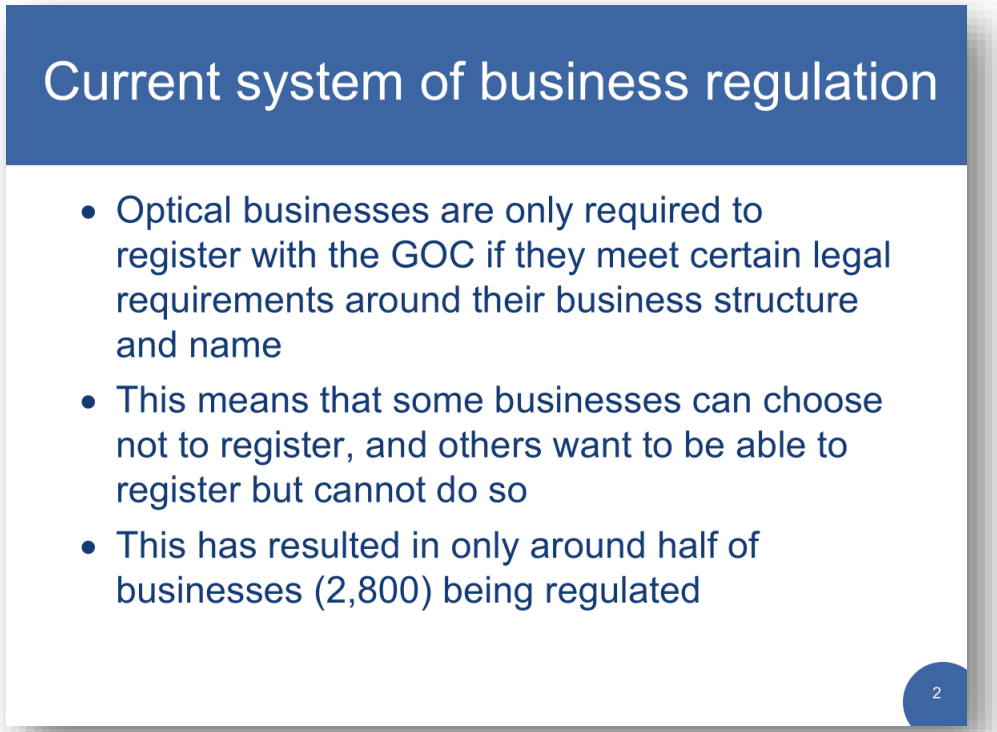
### Household income

| | |
|---|---|
| Low household income (<£25k) | n=10 |
| Mid household income (£25k-£60k) | n=9 |
| High household income (>£60k) | n=8 |

# STIMULUS SLIDES (1+2)

About the stimulus: The following slides were presented as a stimulus during focus groups and in-depth interviews. Their purpose was to ensure that participants were adequately informed about the GOC's proposed reforms, which were the subject of the discussion. The content of the stimulus was agreed upon with the GOC in advance and provided an overview of the main proposed reforms. Please note that, for the purposes of this appendix, the slides have been reduced in size, whereas they were displayed in full-screen mode on PCs and iPads during the research sessions.



# STIMULUS SLIDES (3+4)

## What is the GOC seeking to do?

- Review its system of business regulation
- Bring all businesses into regulation
- All businesses will then have to comply with GOC standards
- Every time patients access an optical business they know it will be regulated by the GOC
- Improve the quality of care patients receive when they visit an optical business

3

## List of proposed changes

These are some of the changes the GOC wants to make:

- Introduce a new position within a business called a head of optical practice
- Change the system of consumer complaints
- Increase the amount it can fine a business when it fails to meet its standards
- A new power to visit a business if an investigation is opened when a concern is raised

4

# STIMULUS SLIDES (5+6)

## Head of optical practice

- The GOC is proposing that every business should have a head of optical practice
- This would be an employee within a business
- Their main responsibility would be to ensure the business meets the GOC's regulatory standards
- They would also tell the GOC when the business fails to meet any of the standards

5

## What are the GOC's standards for optical businesses?

Example standards include:

- Patients can expect to be safe
- Patient care is delivered in a suitable environment
- Patients can give valid consent to treatment
- Services provided are open and transparent
- Provides clear information to patients about costs of products and professional services
- Confidentiality is respected
- Staff are able to exercise their professional judgement
- Staff are suitably trained, qualified and registered
- Staff are adequately supervised and supported

6

# STIMULUS SLIDES (7+8)

## Consumer complaints

- The GOC deals with concerns about whether an individual or business is fit to provide a service (this is called 'fitness to practise')
- The GOC cannot deal with consumer complaints (e.g. if you have an issue with your glasses or contact lenses or the service you receive)

7

## Consumer complaints

- The GOC funds the Optical Consumer Complaints Service (OCCS) who can consider consumer complaints
- They will listen to the complaint, gather information and work with the consumer and the practitioner/business to reach a fair resolution
- The OCCS can provide a mediation service where complaints are difficult to resolve

8

# STIMULUS SLIDES (9+10)

## Consumer complaints

- But currently not all businesses are required to register with the GOC, so not all consumers are able to use the scheme
- The current consumer complaints service has no powers to force a business to:
  - participate in the scheme
  - agree to an outcome

9

## Consumer complaints

- The GOC would make it a requirement for all businesses to participate in the consumer complaints scheme
- This would mean *all* consumers would be able to use the scheme
- The GOC is considering whether businesses must comply with the outcome recommended by the OCCS

10

# STIMULUS SLIDES (11+12)

## Changes to how the GOC will fine a business

- Currently the GOC can fine businesses that fail to meet its standards up to a maximum of £50,000, but it would like the ability to impose an unlimited fine or set a new maximum limit
- The GOC would like to have the ability to tailor the fine to the size and finances of the business

11

## A new GOC power to visit

- The GOC would like a ***new*** power that would mean they could (in certain circumstances) visit a business if an investigation is opened following a concern raised about the business
- The GOC is not proposing to routinely inspect businesses
- This new power would help the GOC better protect patients and the public as they could go into a business to assess a concern in person

12

# DISCUSSION GUIDE

Below is the summarised topic guide utilised in this research, which aligns with the stimulus material. Please note that certain adaptations were made as necessary, depending on the format (interview or focus group). The guide embedded (.pdf) is the final version that was agreed upon with the GOC before the research commenced.

### 1. Research Introduction (5 mins)
- Welcome participants and set expectations
- Explain GDPR compliance, confidentiality, and research purpose
- Assure participants that findings will be anonymised

### 2. Participant Introductions (10 mins)
- Name, location, household details
- Hobbies and interests
- Description of the last visit to an optical business

### 3. Current Perceptions of Optical Businesses (15 mins)
- Experiences with optical businesses (positives and negatives)
- Satisfaction levels and areas for improvement
- Trust and concerns regarding optical businesses
- Comparisons with other healthcare services (GPs, dentists, etc.)
- Impact of negative experiences and how they were handled

### 4. Perceptions of Regulation of Optical Businesses (10 mins)
- Awareness of optical business regulation
- Views on whether businesses should be regulated
- Perceptions of unregulated vs. regulated businesses
- Awareness of the General Optical Council (GOC) and its role

### 5. What is GOC Seeking to Do? (10 mins)
- Explanation of proposed regulatory changes
- Participants' understanding of the reasons for reform
- Whether these changes would improve trust and confidence

### 6. Head of Optical Practice (10 mins)
- Reactions to the proposal of having a Head of Optical Practice in every business
- Perceived benefits or drawbacks of this role
- Whether it would improve consumer protection and governance

### 7. Consumer Complaints (10 mins)
- Awareness of how to complain about optical businesses
- Perceptions of current complaints processes
- Support for an independent redress scheme for consumers

### 8. Approach to Fines and Business Visits (10 mins)
- Views on GOC's power to issue fines for non-compliance
- Thoughts on allowing GOC to visit businesses
- Whether these measures would increase public confidence

### 9. Summary of Key Points (10 mins)
- Final thoughts on optical business regulation
- Key recommendations or concerns from participants
- Any areas needing further clarification

GOC Reform Discussion Guide

# THANK YOU

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All projects are carried out in compliance with the ISO 20252 international standard for market, opinion and social research and GDPR.

IMPACT
FROM INSIGHT TO INFLUENCE

# Impact Assessment Screening Tool

| | |
|---|---|
| **Name of policy or process** | Regulation of optical businesses |
| **Purpose of policy or process** | To regulate all optical businesses within the UK |
| **Team/Department** | Policy and Standards |
| **Date** | 31 July 2024; updated 19 March 2025 |
| **Screen undertaken by** | Charlotte Urwin; updated by Marie Bunby |
| **Approved by** | Steve Brooker |
| **Date approved** | 6 August 2024; updated 1 May 2025 |
| **Instructions:** | • Circle or colour in the current status of the project or policy for each row.<br>• **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.<br>• This is a live tool, you will be able to update it further as you have completed more actions.<br>• Make sure your selections are accurate at the time of completion.<br>• Decide whether you think a **full** impact assessment is required to list the risks and the mitigating/strengthening actions.<br>• If you think that a full impact assessment is **not** required, put your reasoning in the blank spaces under each section.<br>• You can include comments in the boxes or in the space below.<br>• Submit the completed form to the Compliance Manager for approval. |

**Annex 4**

| 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 6: The purpose of this project is to identify the changes we need to make to the framework that we use to regulate optical businesses, so that we can bring all businesses that carry out certain restricted functions (see consultation document) within scope of our regulation. The timetable for delivery of this project is not within the GOC's control and will be determined by the UK Government.<br><br>The project therefore focusses on the policy decisions that need to be made and at this time can be delivered using existing policy and standards resources and budgets. We may need to commission additional consultancy to inform policy decisions, which may require access to the reserves in future.<br><br>As we already regulate some optical businesses and therefore have systems and processes to manage that regulation, we will be able to use those systems to regulate those businesses. For example, we already have systems and processes to enable us to hold a register of optical businesses and those will be updated to reflect these changes.<br><br>However, our proposals will require resources (both financial and people) to implement and maintain. Our research by Europe Economics estimates that we would need three additional registration officers for a six-month period and half a full time equivalent (FTE) lawyer's time to draft the rule and legislative changes. The one-off administrative costs are estimated to be just over £90,000 (including overheads, recruitment and training costs where relevant). We would also incur on-going costs for maintaining our enlarged business register, including the renewals process. We estimate that this would require two full time registration officers per year at an estimated total cost of almost £90,000 per year. It is also likely that an increased business register would lead to increased fitness to practise costs. As noted in the paper on enforcement and sanctions, levels of complaints about optical businesses are relatively low. The research estimates those costs at being about £80,000 per year. We propose that all businesses should be part of the Optical Consumer Complaints Service (OCCS). We propose that the OCCS will continue to be funded by registrant fees, but there may be additional costs related to increasing the number of businesses which can engage with the OCCS.<br><br>The costs to the GOC will be offset by increased income from business registrant fees. The cost of regulation per business should reduce due to economies of scale. At this stage we have identified potential costs where appropriate in each proposal, as set out in the annexes.<br><br>We also recognise that our proposals may have resource implications for optical businesses, particularly those which we do not currently regulate. Our research from Europe Economics gives some details of the costings to businesses, but the cost will vary depending on the eventual model chosen and other factors, such as the extent of changes the business will need to make to bring it in line with the proposals. |

We recognise that once our proposals are finalised we will need to undertake further work to assess the impact of each proposal and will seek views on costings during the consultation.

3 and 4: Any changes to our framework of business regulation will require change to our legislation. As such, legislation will change in the future, subject to agreement by the UK Government.

8: We will prepare a full communications plan to support consultation engagement. The consultation document and annexes will be translated into Welsh.

The proposals in this document relate to a framework of business regulation that will apply to all optical businesses across the UK, including in Wales. We have assessed that these proposals will not have any effects on opportunities to use the Welsh language or affect the treatment of the Welsh language. 19/3/25: Respondents to the consultation did not provide any details of adverse impacts in this area.

The risks identified in this section are low and medium risks. They have been addressed as far as possible and a full impact assessment is not necessary.

| 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 | None - 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: The consultation proposals themselves are about the regulation of businesses, not individuals. We do not anticipate therefore that respondents to the consultation would 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 (optical.org)).<br><br>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.<br><br>Our consultation platform includes a privacy statement, setting out how we will use respondents' data (Privacy Policy \| General Optical Council).<br><br>Most risks are low or medium and have been mitigated.<br><br>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<br>(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<br>(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)<br>OR<br>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 model of business regulation will be made by our Council following public consultation. These decisions do not directly give outcomes for individuals, though if the proposals were implemented by the UK Government then business owners providing specified restricted functions would be required to register with the GOC. There is no right of appeal for Council decisions. However, it will then be for the UK Government to decide whether to implement these changes.<br><br>5: The consultation is available to all on our website. Documents are available in alternative formats on request. Any decisions on the model of business regulation will be made at a public Council meeting which take place online and are open to all to attend. We publish Council papers a week in advance of meetings.<br><br>6-9: Council meetings take place online. Any decisions on business regulation 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.<br><br>10: Our 2022 consultation on the call for evidence on the Opticians Act 1989 and associated GOC policies confirmed there was strong stakeholder support for extending business regulation to all businesses carrying out restricted functions.<br><br>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 | These proposals will result in all optical businesses carrying out certain functions being regulated by the GOC. Our public perceptions research shows that young people are more likely to experience something going wrong during a visit to the opticians/optometrist practice. Extending business regulation to all optical businesses providing specified restricted functions will mean that all businesses will be required to comply with our standards and there will be improved access to consumer redress should something go wrong.<br><br>The consistent application of GOC business standards would also benefit employees as it would provide a more standardised and safer working environment. Our research shows that younger registrants are more likely to experience harassment, bullying, abuse or discrimination at work. We are strengthening our standards to ensure businesses provide more support to staff who experience bullying, harassment, abuse and discrimination at work. Extending business regulation would mean an extension of support for all staff.<br><br>19/3/25: Some respondents to the consultation felt clearer rules or guidance could enable younger optometrists to qualify for roles that they might be excluded from due to age-related experience requirements.<br><br>Some respondents to the consultation felt that the proposals could have positive effects on groups with characteristics relating to age. |
| Disability | Positive | These proposals will result in all optical businesses carrying out certain functions being regulated by the GOC. Our public perceptions research shows that people with a disability are more likely to experience something going wrong during a visit to the opticians/optometrist practice. Extending business regulation to all optical businesses providing specified restricted functions will mean that all businesses will be required to comply with our standards and there will be improved access to consumer redress should something go wrong. |

| Protected characteristic | Type of potential impact: positive, neutral, negative? | Explanations (including examples or evidence/data used) and actions to address negative impact |
|---|---|---|
| | | The consistent application of GOC business standards would also benefit employees as it would provide a more standardised and safer working environment. Our research shows that registrants with a disability are more likely to experience harassment, bullying, abuse or discrimination at work. We are strengthening our standards to ensure businesses provide more support to staff who experience bullying, harassment, abuse and discrimination at work. Extending business regulation would mean an extension of support for all staff.<br><br>19/3/25: Some respondents to the consultation felt that consistent business regulation would be beneficial for all, potentially leading to improved standards and positive impacts for various groups, especially those who face challenges in accessing eye care services, such as people with disabilities. |
| Sex | Positive | The consistent application of GOC business standards would also benefit employees as it would provide a more standardised and safer working environment. Our research shows that female registrants are more likely to experience harassment, bullying, abuse or discrimination at work. We are strengthening our standards to ensure businesses provide more support to staff who experience bullying, harassment, abuse and discrimination at work. Extending business regulation would mean an extension of support for all staff.<br><br>19/3/25: Some respondents to the consultation were concerned about the proposal to have a head of optical practice as they felt it could disadvantage part-time workers who often have childcare or other caring responsibilities – this could lead to a bias towards full-time employees in the appointment of this role, potentially affecting female registrants more. These concerns will be considered as we work through the detailed arrangements for implementation.<br><br>Some respondents to the consultation felt that the proposals could have positive effects on groups with characteristics relating to sex. |

| 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 | |
| Marriage and civil partnership | Neutral | |
| Pregnancy/ maternity | Neutral | 19/3/25: Some respondents to the consultation were concerned about the proposal to have a head of optical practice as it was felt there was a lack of flexibility in the role to accommodate those on maternity leave (or other long-term absences). These concerns will be considered as we work through the detailed arrangements for implementation. |
| Race | Positive | The consistent application of GOC business standards would also benefit employees as it would provide a more standardised and safer working environment. Our research shows that registrants from ethnic minority backgrounds are more likely to experience harassment, bullying, abuse or discrimination at work. We are strengthening our standards to ensure businesses provide more support to staff who experience bullying, harassment, abuse and discrimination at work. Extending business regulation would mean an extension of support for all staff.<br>19/3/25: Some respondents to the consultation felt that the proposals could have positive effects on groups with characteristics relating to sex. |
| Religion/belief | Neutral | |
| Sexual orientation | Neutral | |

| 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) | | These proposals will result in all optical businesses carrying out certain functions being regulated by the GOC. Our public perceptions research shows that carers and those going through difficult life circumstances are more likely to experience something going wrong during a visit to the opticians/optometrist practice. Extending business regulation to all optical businesses providing specified restricted functions will mean that all businesses will be required to comply with our standards and there will be improved access to consumer redress should something go wrong.<br><br>19/3/25: Some respondents to the consultation were concerned about the cost of the proposals and their impact on individual businesses, especially those serving under-served populations or operating with low income. These concerns will be considered as we work through the detailed arrangements for implementation. We would expect the legislation to provide flexibility in fees but this will be considered further following legislative reform. |

**Public**

**C21(25)i.**

**Council**

## Consultation on new guidance for GOC registrants

**Meeting:** 25 June 2025 **Status:** For decision

**Lead responsibility:** Steve Brooker (Director of Regulatory Strategy)

**Paper Authors:** Steve Brooker (Director of Regulatory Strategy) and Charlotte Urwin (Interim Director of Corporate Services)

**Council Lead:** None

### Purpose

1. To enable Council to consider the proposed consultation document, impact assessment and proposed guidance on maintaining appropriate sexual boundaries and care of patients in vulnerable circumstances, for the purpose of public consultation.

### Recommendations

2. Council is asked to:

- **approve** the proposal to consult on the draft guidance on maintaining appropriate sexual boundaries and care of patients in vulnerable circumstances and the draft equality impact assessment
- **delegate approval** of the consultation document, equality impact assessment and draft guidance to the Chief Executive and Registrar in consultation with the Chair of Council and the Chair of Standards Committee, 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: Creating fairer and more inclusive eye care services.

### Background

4. In January 2025, we launched three updated sets of standards, produced following an extensive period of stakeholder engagement. These are the Standards of Practice for Optometrists and Dispensing Opticians, Standards for Optical Students and Standards for Optical Businesses.

5. We made changes to the standards in several key areas, including clarifying our requirements on maintaining appropriate sexual boundaries with patients and colleagues, as well as highlighting the importance of identifying and responding to the needs of patients in vulnerable circumstances. As part of our response to the consultation we committed to producing guidance for registrants on these two areas.

6. We previously expected to consult on the Speaking up guidance as well. However, closer review of that guidance suggests substantial changes are not required. Instead, minor amendments have been approved by the Registrar, as happened with other minor guidance updates before we launched the new standards. These changes are being translated into Welsh and the document be published shortly.

## Analysis

*Purpose of guidance*

7. Section 13A of Opticians Act 1989 gives GOC a duty to "*provide, in such manner as the Council considers appropriate, guidance for registered optometrists, registered dispensing opticians and student registrants, on matters relating to fitness to practise or, in the case of a student registrant, fitness to undertake training, and in particular on the standards of conduct and performance expected of them*". A similarly worded duty exists for business registrants. This section of the legislation also creates duties on GOC to consult before issuing or revising guidance, and to keep existing guidance under review and to revise it, as appropriate.

8. We produce guidance to help registrants meet our standards. Whilst it is non-binding, registrants will refer to the guidance as part of making reasoned and informed decisions and to support their professional judgement. It is important therefore that the guidance is as clear and easily understood as possible and reflects the circumstances in which registrants practice or learn. Consulting on the guidance helps us to test whether this is the case.

*Guidance on Care of Patients in Vulnerable Circumstances*

9. The guidance expands on the following new text in the introduction and an addition to an existing standard:

   *(Introduction) "Consider and respond to the needs of patients who, due to their personal circumstances, are in need of particular care, support or protection or at risk of abuse and neglect. Patients may be vulnerable for a range of reasons, including physical or mental health conditions, capability in managing their health, or handling a difficult set of life events. Levels of vulnerability may vary between contexts, and change over time, so consider a patient's vulnerabilities as part of each consultation"*

   *Standard 13.7 (12.7). "Consider and respond to the needs of patients with a*

*disability, and patients in vulnerable circumstances, and make reasonable adjustments to your practice to accommodate these and improve access to optical care"*

10. The development of the guidance has been informed by the latest understanding of concepts of vulnerability in regulation, the Professional Standards Authority's Safer Care for All report and its standards of good regulation (especially Standard 3), GOC's public perceptions survey and our new lived experience research, which considers both inequalities of access and inequalities of patient experience.

11. The guidance moves away from outdated notions of vulnerability that automatically label people belonging to certain groups in society as vulnerable. Instead, it starts on the basis that a series of factors combine to shape vulnerability including an individual's personal characteristics (e.g. health conditions, capability) and life circumstances (e.g. finances, where they live), inherent features of eye care (e.g. knowledge imbalance, stressful situations) as well as the actions of eye care professionals and businesses (e.g. empathy, communication, adaptations).

12. The draft incorporates advice from the Standards Committee discussion on 6 June, including making explicit reference to legislation on mental capacity; encouraging practices to make prospective patients aware of services issues that might create access barriers (e.g. stairs); and the role of businesses in alerting patients to their eligibility for financial support (e.g. free tests, vouchers).

*Guidance on maintaining appropriate sexual boundaries*

13. The guidance expands on the following new standards:

*"15.3 (14.3) You must not engage in unwanted conduct of a sexual nature with students, colleagues or others with whom you have a professional relationship. You must not create an intimidating, degrading, humiliating or offensive environment, whether intended or not. Maintaining sexual boundaries applies to your behaviours, actions and communications.*

*15.4 (14.4) You must not engage in conduct of a sexual nature with patients or violate their dignity. Maintaining sexual boundaries applies to your behaviours, actions and communications."*

14. The draft guidance incorporates advice from Standards Committee, which discussed it at their meetings on 21 February and 6 June 2025. For example, we have used this feedback to provide further clarity on why registrants must not treat patients with whom they are in a sexual relationship. There were different views among members on whether registrants should be able to treat spouses and partners and if the expectations should be different for optometrists and dispensing opticians. We anticipate there will be a range of views on these matters during public consultation.

## Finance

15. We have funds allocated in the 2025-26 budget to cover the costs of translating the guidance consultation documents into Welsh to ensure our compliance with the Welsh Language Standards.

## Risks

16. The consultation feedback indicated registrants' appetite for guidance in these two areas. The risks are around either misalignment of views between GOC and the sector or the guidance suggesting we have misunderstood how the sector works.

17. The first element of this risk is particularly relevant with the guidance on maintaining appropriate sexual boundaries, where we may see some stakeholder feedback about whether it is appropriate to suggest that registrants should not treat a person with whom they are in a sexual relationship. Whilst not all healthcare regulators produce guidance on maintaining appropriate sexual boundaries, our guidance on this point is consistent with that from some other regulators, including the General Medical Council and the Health and Care Professions Council.

18. These risks are mitigated by ongoing press monitoring, maintaining links with key stakeholder bodies, and our plans to engage stakeholders throughout the consultation period, to get their insights on the proposed changes.

## Equality Impacts

19. We have prepared a draft equality impact assessment for the guidance.

## Devolved nations

20. We are a UK wide regulator. As set out above, we will translate the consultation documents into Welsh and will also provide Welsh language versions of the final pieces of guidance.

## Communications

### External communications

21. We will work with the Communications team to finalise the stakeholder engagement plan for the consultation. Prior to launching the consultation, we will send out targeted communications to key stakeholders via e-mails and newsletters, and we will publicise the consultation through our social media channels. We will develop a communications plan to support the launch of a consultation on the draft guidance.

### Internal communications

22. No internal communications are planned at this time.

## Next steps

23. Subject to Council agreement that we can consult on the draft guidance, we will run a public consultation likely to start in July.

**Attachments**

Annex one: Draft consultation document
Annex two: Draft guidance on maintaining appropriate sexual boundaries
Annex three: Draft guidance on care of patients in vulnerable circumstances
Annex four: Draft impact assessment

# Guidance on maintaining appropriate sexual boundaries

## Contents

## About this guidance and how it applies to you

1. We have developed this guidance to help our registrants to understand the importance of maintaining appropriate sexual boundaries with patients and colleagues. Maintaining appropriate boundaries applies to your behaviours, actions and communications.

2. It is crucial that appropriate sexual boundaries are maintained. Patients must know that you will ensure their care and safety and behave appropriately towards them, not engage in sexual conduct with them or violate their dignity. Students, colleagues and others with whom you have a professional relationship must know that you will not engage in unwanted sexual conduct with them or create an intimidating, degrading, humiliating or offensive environment.

3. In this document, when we use the term ‘sexual misconduct’ we mean unwelcome or uninvited behaviour of a sexual nature, or which can reasonably be interpreted as sexual, that offends, embarrasses, harms, humiliates or intimidates an individual or group. It also includes any sexual activity that takes places without consent. Sexual misconduct encompasses elements of harassment, violence and abuse and can be physical, verbal or visual.

4. This guidance should be read alongside the *Standards of Practice for Optometrists & Dispensing Opticians* which all optometrists and dispensing opticians must apply to their practice and the *Standards for Optical Students* which all student optometrists and dispensing opticians must apply to their practice. Where we refer to both sets of standards, these will be referred to as “standards” for ease of reading. Where we refer to specific standards, we will put the number of the Standards for Optical Students in brackets after the number for the Standards of Practice, where applicable (e.g. 11(10)).

5. Standard 15(14) outlines the importance of maintaining appropriate boundaries with others and never abusing your professional position. In this context, ‘others’ can include patients, students, colleagues and people with whom you have a professional relationship. Standards 15.3 and 15.4 (14.3 and 14.4) focus on the importance of maintaining appropriate sexual boundaries with colleagues and patients (annex 1).

6. Standard 17(16) outlines the importance of ensuring your conduct does not damage public confidence in you or your profession, whilst standard 11(10) makes clear that you must protect and safeguard patients, colleagues and others from harm.

7. If you are an optical business registered with the GOC, you should read this guidance alongside the *Standards for Optical Businesses,* which all registered businesses must apply to the conduct of their business. Where we refer to these standards, we will always provide the number and refer to these standards explicitly.

8. The most relevant standard in the Standards for Optical Businesses is standard 1.1, which outlines the importance of protecting patients in your care from abuse and standard 3.3 which ensures that staff who experience bullying, discrimination or harassment in the workplace are supported.

9. The word 'must' indicates a mandatory requirement, for example, registrants must comply with the law and must meet the GOC's standards.

10. You should use your professional judgement to apply this guidance to your own practice and the variety of settings in which you might work.

11. There are two parts to this guidance:

    - **Part 1** which focuses on guidance for individual registrants (optometrists, dispensing opticians and optical students), and
    - **Part 2** which focuses on guidance for businesses

    *Whether you are reading the guidance from an individual or business perspective, it is important to read both parts.*

## Part 1 – Guidance for Individuals

12. In this section 'you' refers to the individual registrant.

### The importance of maintaining appropriate sexual boundaries with patients and colleagues

13. The Professional Standards Authority (PSA) outline the importance of maintaining clear and appropriate sexual boundaries with patients.[1] Maintaining appropriate boundaries with patients is an important aspect of being a registered professional, upholding the trust between you and your patient. When those boundaries are breached it can have a detrimental and lasting impact on patients and carers and fundamentally damage their trust and confidence in health professionals.

14. It is also important to maintain appropriate boundaries with students, colleagues and others with whom you have a professional relationship. Appropriate professional relationships are important for ensuring effective collaborative working in the best interests of patient. When boundaries are breached in the workplace, it can contribute to a negative or hostile working environment, with a detrimental impact on both those who work there and the patients who receive care there.

15. Maintaining appropriate sexual boundaries with patients and colleagues is also important to manage the power imbalances within healthcare. There is a power imbalance between health professionals and their patients and there may also be one between more junior and senior colleagues, or between students and supervisors. You should recognise that power imbalance and ensure that you do not take advantage of it to unduly influence or exploit patients or colleagues.

16. Inappropriate sexual behaviour isn't limited to criminal acts such as sexual assault or rape, but can include a range of behaviours, for example use of sexual humour, sharing sexual images, or making inappropriate comments. All acts of inappropriate sexual behaviour have the potential to cause significant emotional or physical harm to a patient or a colleague.

### What is considered inappropriate sexual behaviour?

17. Inappropriate sexual behaviour (including actions and communications) of any kind, including all forms of sexual harassment and abuse, is unacceptable.

[1] Professional Standards Authority: Clear sexual boundaries between healthcare professionals and patients (information for patients and carers)

18. In their guidance on Identifying and tackling sexual misconduct, the General Medical Council provide a helpful list of inappropriate and unacceptable sexual behaviours[2]. The examples provided can include, but are not limited to:

- “sexual or sexist comments, jokes, innuendo and ‘banter’
- suggestive looks or leering
- groping or repeated unwelcome touching
- sexual gestures
- a person discussing their own sex life
- intrusive questions about a person’s private or sex life
- sending sexually explicit emails, text messages or posts on social media
- displaying sexually graphic pictures, posters or photos
- spreading sexual rumours about a person
- propositions and sexual advances
- making promises in return for sexual favours
- excessive or unwanted compliments on a person’s appearance”

19. You must not display sexual behaviour or make inappropriate sexual advances towards a patient. Inappropriate sexual behaviour can include any of the examples provided above in paragraph 31.

20. If you experience unwanted sexual behaviour from a patient, you should tell them that the behaviour(s) are inappropriate, where it is safe to do so. If you feel unsafe and the patient does not stop the behaviour, you should remove yourself from the situation and seek help.

**Serious sexual misconduct**

21. If you become aware that a colleague or patient has committed sexual assault, rape or other criminal behaviour, this must be reported in line with your workplace policy to an individual who is able to act (e.g., senior leader/colleague). Please refer to our section on speaking up below.

**Relationships with Patients**

Relationships with current patients

22. As an eye care professional, you will see some patients only once whilst you may see other patients regularly. We recognise that the nature of your interactions with patients you see regularly may become more familiar over time. However, you must always maintain appropriate boundaries with patients, irrespective of how frequently you see them and how well you get to know them.

[2] Identifying and tackling sexual misconduct - ethical topic - GMC

23. You may find yourself in a situation where you are attracted to a patient you are treating. You must take steps to ensure you maintain appropriate boundaries for example, you could hand care of the patient over to another professional.

24. You must not engage in conduct of a sexual nature with patients or violate their dignity. This means that you should not engage in a sexual relationship with a current patient, nor should you treat someone you are in a sexual relationship with. Doing this would blur the boundaries between health professional and patient.

25. You must make reasoned and informed decisions in the best interests of your patient. Treating a patient with whom you are in a relationship could lead to a lack of objectivity about the treatment they should receive, result in you missing a potential issue or interfering with treatment provided by other health professionals. The patient might feel less comfortable discussing sensitive matters about their health or circumstances with someone they are also in a sexual relationship with.

26. If you are in a sexual relationship with an individual who becomes a patient of a business that you work for, you must ensure that you do not treat them directly and always maintain appropriate boundaries. You should declare your relationship and ensure that a colleague/another member of the team treats the patient.

27. You must not use your professional relationship with your patient to pursue a relationship with a patient's relative or carer.

28. If you are in a situation where a patient is attempting to engage in or pursue a relationship with you, you must ensure you establish/re-establish an appropriate professional boundary.

<u>Relationships with former patients</u>

29. Pursuing a relationship with a former patient is potentially inappropriate depending on individual circumstances which may include:

    - The circumstances and nature of the previous professional relationship
    - Whether you are likely to care for other individuals that the patient is close to (e.g., family members)
    - If there is a possibility that the individual may require treatment from you again at some stage in the future

- The length of time between interaction with the individual as a patient and the present
- If the patient was vulnerable at that time that they were under your care, and if they are still vulnerable
- If the previous professional relationship is a factor in the patient's current decisions
- Whether there could be a perceived power imbalance and therefore an abuse of your professional position.

30. There is not a specific time period for when it is appropriate to start a personal relationship with a patient after ending a professional relationship. However, the closer the time period between the professional relationship ending and the personal relationship beginning the more likely it is that it could be perceived as a failure to maintain appropriate boundaries.

Vulnerable patients

31. Children and young people under the age of 18 years must be considered vulnerable. You must not pursue personal relationships with anyone under the age of 18.

32. In your professional practice you will work with a variety of individuals who may be in vulnerable circumstances. Some vulnerabilities include physical and mental illness, frailty, disability or current circumstances (e.g., work or financial issues, family issues, etc.) It is important to note that a patient's vulnerabilities can either be permanent or temporary.

33. You must not pursue personal relationships with vulnerable patients. A personal relationship with a vulnerable patient will be considered a breach of professional boundaries and more likely to be deemed as inappropriate.

**Professional Relationships (relationships with colleagues and students)**

34. Relationships that are of a consensual and reciprocated nature are considered to be private between those individuals. It is important that appropriate professional boundaries are still maintained. Care should be taken to ensure that the relationship (either during or once it ends) does not impact clinical practice or the working environment.

35. You must not engage in unwanted conduct of a sexual nature with students, colleagues or others with whom you have a professional relationship. You must not create an intimidating, degrading, humiliating or offensive environment,

whether intended or not. This can include verbal or written comments, sharing or displaying sexual images, as well as unwelcome physical contact.

36. We expect registrants to be mindful of situations where relationships may be at risk of being seen as non-consensual, for example where there are power imbalances (e.g., between educators and students, or senior/junior colleagues). Relationships must not impact on clinical practice, the working or learning environments, and must not hinder career progression.

## Speaking up and reporting incidents

37. If a patient breaches boundaries with yourself or a member of staff, you should highlight this to the patient if safe to do so. Where required, you should remove yourself from the situation and report the incident to a senior member of staff.

38. If you are made aware that a colleague or member of staff has behaved inappropriately towards a patient, you must speak up and report this as soon as possible and offer support to the patient where possible.

39. When reporting an incident to a senior colleague or organisation, you should ensure you respect patient confidentiality. Any issues relating to patient safety must be prioritised. If patient identity needs to be disclosed as part of an investigation, ensure that the patient is made aware of this. Where possible, patient consent must be obtained.

40. In circumstances where consent on identity disclosure cannot be obtained, you must inform the patient. Please view our guidance documents on consent, disclosing confidential information and speaking up for further information.

41. If you have been in a situation where you have experienced inappropriate sexual behaviours, you should report this to your line manager if able to do so, or another appropriate individual in your workplace who will be able to investigate.

42. You have a responsibility to speak up and take action if you become aware of inappropriate sexual behaviour(s) within your workplace. This could include challenging the behaviour with the perpetrator, reporting it to a line manager, or offering support to the individual who experienced the behaviour.

43. Registrants who are in leadership positions must take steps to ensure that the workplace environment is a safe place for reporting concerns. It is important that leaders demonstrate and model the behaviours of challenging inappropriate behaviour, speaking up and reporting where appropriate.

C21(25)ii.

44. Report any incidents in line with your workplace policies, and access support if required.

45. You may also want to refer to our separate guidance on speaking up.

## Part 2 – Guidance for Businesses

46. In this section 'you' refers to the body corporate or the director or responsible officer of an optical business (whether or not you are a registered optometrist or a registered dispensing optician).

### Ensuring appropriate processes are in place

47. As a healthcare provider, you must ensure that you are upholding professional standards, ensuring that patients are safe in your care. You have a responsibility to ensure that both patients and those who work for you are supported and protected.

48. You must understand your legal and professional responsibilities to safeguard patients from abuse and ensure that you and your staff are prepared and supported to do so.

49. You must ensure that staff are adequately supervised and supported (standard 3.3). This includes providing support to staff who have experienced harassment, such as sexual harassment, in the workplace.

50. Employers now have a legal duty to take reasonable steps to prevent sexual harassment and create a safe working environment. They also have a duty to anticipate when sexual harassment may occur and take reasonable steps to prevent it. [3]

51. You must ensure that you develop appropriate workplace policies (Standard 2.2) that outline procedures and actions in regard to sexual boundary violations/incidents, including reporting procedures. Incidents should be addressed quickly and appropriately. Policies should support staff in managing situations that they have experienced with colleagues, as well as understanding how to support patients.

52. You must ensure that you provide an open and transparent environment where speaking up is encouraged. You should also ensure that you and your staff are familiar with our speaking up guidance and process.

### Supporting patients

53. Patient care and safety should be at the heart of your organisation, and it is therefore crucial that any incidents that affect the care of a patient are dealt with quickly.

[3] New protections from sexual harassment come into force - GOV.UK

54. You should provide an open and transparent environment around reporting any complaints from your patients and support them if they wish to report any inappropriate behaviour or incidents to a higher authority.

55. You should ensure there are policies and procedures in place that outline management and escalation of incidents, and that patients are able to find a safe place to talk through or report incidents.

56. You should ensure that patient confidentiality is respected and maintained where appropriate, only disclosing information where there is consent to do so, or where not disclosing the information will significantly harm the patient/others. See guidance on consent.

**Supporting members of staff**

57. Where staff have experienced a boundary violation/an incident has taken place, whether from another member of staff/health professional, or from a patient, they should be supported by you as the organisation. Support will include ensuring that the incident is appropriately reported, and that any escalation is acted on quickly.

58. Where appropriate, policies and procedures should outline how staff/health professionals that work within the context of your business will be supported on a long-term basis, and you should be open and transparent about any changes that are put in place following an incident. This can include, for example, offering time off, or referral to an appropriate support service if required.

59. Workplace policies should ensure that staff, students and other professionals who work within the context of your business are provided support to return to work/maintain a working relationship at the business.

## Annex 1: Relevant Standards

Note that we have only provided the relevant standards below and have not replicated the entire standard unless necessary.

**Standards of Practice for Optometrists and Dispensing Opticians**

**Standard 11: Protect and safeguard patients, colleagues and others from harm**

**11.1** You must be aware of and comply with your legal obligations in relation to safeguarding of children, young people and vulnerable adults.

**11.2** Protect and safeguard children, young people and vulnerable adults from abuse. You must:

- 11.2.1 Be alert to signs of abuse and denial of rights.
- 11.2.2 Consider the needs and welfare of your patients.
- 11.2.3 Report concerns to an appropriate person or organisation.
- 11.2.4 Act quickly in order to prevent further risk of harm.
- 11.2.5 Keep adequate notes on what has happened and what actions you took.

**Standard 15: Maintain appropriate professional boundaries**

15.1 Maintain appropriate boundaries with your patients, students, colleagues and others with whom you have a professional relationship. Maintaining appropriate boundaries applies to your behaviours, actions, and communications.

15.2 Never abuse your professional position to exploit or unduly influence your patients or the public, whether politically, financially, sexually or by other means which serve your own interest.

15.3 You must not engage in unwanted conduct of a sexual nature with students, colleagues or others with whom you have a professional relationship. You must not create an intimidating, degrading, humiliating or offensive environment, whether intended or not. Maintaining sexual boundaries applies to your behaviours, actions and communications.

15.4 You must not engage in conduct of a sexual nature with patients or violate their dignity. Maintaining sexual boundaries applies to your behaviours, actions and communications.

**Standard 17. Do not damage the reputation of your profession through your conduct**

17.1 Ensure your conduct, whether or not connected to your professional practice, does not damage public confidence in you or your profession.

17.2 Ensure your conduct in the online environment, particularly in relation to social media, whether or not connected to your professional practice, does not damage public confidence in you or your profession.

17.3 Be aware of and comply with the law and regulations that affect your practice, and all the requirements of the General Optical Council.

**Standards for Optical Students**

**Standard 10. Protect and safeguard patients, colleagues and others from harm**

10.1 Protect and safeguard children, young people and vulnerable adults from abuse. You must:

- 10.1.1 Be alert to signs of abuse and denial of rights.
- 10.1.2 Consider the needs and welfare of your patients.
- 10.1.3 Report concerns to an appropriate person or organisation, whether this is your tutor, supervisor or training provider.
- 10.1.4 Act quickly in order to prevent further risk of harm. Seek advice immediately if you are unsure of how to proceed.
- 10.1.5 Keep adequate notes on what has happened and what actions you took.

**Standard 14: Maintain appropriate professional boundaries**

14.1 Maintain appropriate boundaries with your patients, students, colleagues and others with whom you have a professional relationship. Maintaining appropriate boundaries applies to your behaviours, actions, and communications.

14.2 Never abuse your professional position to exploit or unduly influence your patients or the public, whether politically, financially, sexually or by other means which serve your own interest.

14.3 You must not engage in unwanted conduct of a sexual nature with students, colleagues or others with whom you have a professional relationship. You must not create an intimidating, degrading, humiliating or offensive environment, whether

intended or not. Maintaining sexual boundaries applies to your behaviours, actions and communications.

14.4 You must not engage in conduct of a sexual nature with patients or violate their dignity. Maintaining sexual boundaries applies to your behaviours, actions and communications.

**16. Do not damage the reputation of your profession through your conduct**

16.1 Ensure that your conduct, whether or not connected to your professional study does not damage public confidence in you or your profession.

16.2 Ensure your conduct in the online environment particularly in relation to social media, whether or not connected to your professional study, does not damage public confidence in you or your profession.

16.3 Be aware of and comply with the law and all the requirements of the General Optical Council.

**Standards for optical businesses**

**Standard 1.1 Patients can expect to be safe in your care**

Promoting patient safety is at the heart of all healthcare. A patient should be able to trust their healthcare provider to prioritise their safety so that they can receive the best possible care. An important aspect of this is that optical businesses must not inhibit the healthcare professionals they employ or contract with from meeting their own professional standards. To achieve this, your business must:

1.1.1 Understand its legal and professional responsibilities to safeguard patients from abuse and ensures that it and its staff are prepared and supported to do so.

1.1.2 Have a process for staff to report any safeguarding concerns and encourages them to do so.

**Standard 2.2 You ensure compliance with relevant regulations**

As part of its responsibilities to the GOC, your business has a duty to ensure it is compliant with all regulations affecting the running of the business.
Failure to comply puts at stake the reputation of the business and its ability to continue operating. The personal and professional conduct of directors
also has the potential to affect the ability of the business to continue operating (for example, if a criminal offence is committed). The information

listed below is not exhaustive and other statutory or regulatory duties may apply depending on the structure of your business or the environment in which it operates. To achieve this, your business

(..) 2.2.2 Acts on any instruction from a statutory authority requiring measures to be implemented to safeguard the welfare of patients and staff.

2.2.6 Provides staff with clear information in relation to all legislation relevant to their roles

# Guidance on Care of Patients in Vulnerable Circumstances

## Contents

## About this guidance and how it applies to you

1. We have developed this guidance to help our registrants to consider and respond to the needs of patients in vulnerable circumstances. That could include patients with underlying health conditions, children, or those experiencing a difficult life event which could affect their ability to access eye care or make informed decisions about their care.

2. The care, well-being and safety of patients must always be your first concern. This is at the heart of being a healthcare professional. Even if you do not have direct contact with patients, your decisions or behaviour can still affect their care and safety.

3. You will likely come across vulnerable patients throughout your career. Being able to recognise and respond to vulnerability will help to make sure that you provide safe and effective eye care and improve access to care.

4. This guidance provides an overview of the importance of understanding vulnerabilities, advice on how to support individuals in vulnerable circumstances, and guidance for businesses on how to support staff to identify vulnerabilities and adjust their practice accordingly.

5. This guidance should be read alongside the Standards of Practice for Optometrists and Dispensing Opticians ('Standards of Practice') which all optometrists and dispensing opticians must meet, the Standards for Optical Students which all optical students must meet and the Standards for Optical Businesses. Where we refer to both sets of standards for individual registrants these will be referred to as "standards" for ease of reading. Where we refer to specific standards, we will put the number of the Standards for Optical Students in brackets after the number for the Standards of Practice, where applicable (e.g., 11 (10)). Annex 1 of this guidance highlights relevant standards.

6. Standard 1(1) outlines the importance of treating patients as individuals and where possible modifying your care and treatment based on their needs. Standard 7 (6) focusses on the need to conduct an adequate assessment, which may include capturing any current symptoms, personal beliefs, cultural factors and vulnerabilities, whilst standard 8 (7) covers record keeping. Standard 11 (10) covers legal obligations in relation to safeguarding of children, young people and vulnerable adults. Standard 13 (12) includes the need to consider and respond to the needs of people in vulnerable circumstances and make reasonable adjustments to your practice.

7. If you are an optical business registered with the GOC, you should read this guidance alongside the Standards for Optical Businesses, which all registered

businesses must apply to the conduct of their business. Where we refer to these standards, we will always provide the number and refer to these standards explicitly.

8. Standard 1.1 of the Standards for Optical Businesses covers patients' expectations that they can be safe in the care of the business, including in relation to safeguarding. Standard 1.2 highlights the need to provide a suitable environment and Standard 1.3 sets out the importance of clear communication with patients. Standard 3.1 identifies the importance of staff being able to exercise their professional judgement to meet the needs of patients, including those in vulnerable circumstances.

9. The word 'must' indicates a mandatory requirement, for example, registrants must comply with the law and must meet the GOC's standards.

10. You should use your professional judgement to apply this guidance to your own practice and the variety of settings in which you might work.

11. There are two parts to this guidance: part 1 which focuses on guidance for individual registrants (optometrists, dispensing opticians and optical students) and part 2 which focuses on guidance for businesses. Whether you are reading the guidance from an individual or business perspective, it is important to read both parts.

## What do we mean by 'vulnerable circumstances'?

12. The concept of vulnerability is an important one within healthcare, recognising that there is a power and knowledge imbalance between health professionals and their patients. This vulnerability is amplified due to the anxiety that many people will naturally feel in any healthcare interaction. We cover the need to maintain appropriate boundaries because of that power imbalance in standard 15 (14) and in separate guidance on that topic. Vulnerability also features in legislation, often in relation to children or vulnerable adults, where there are legal duties to protect them from harm or abuse. This is covered under standard 11 (10) and also in standard 1.1.1 of the Standards for Optical Businesses but legal duties on safeguarding are not covered in detail within this guidance.

13. In the introduction to the standards and in standard 13.7 (12.7) we refer to 'patients in vulnerable circumstances'. These are patients who, due to their personal circumstances are in need of particular care, support or protection or at risk of abuse and neglect.

14. Patients may be vulnerable for a range of reasons, including physical or mental health conditions, capability in managing their health, or handling a difficult set of

life events. Vulnerabilities can often be invisible and therefore difficult to identify. Some examples of vulnerable circumstances include:

- Mental health conditions;
- Learning difficulties such as dyslexia;
- Past trauma, including within the healthcare system;
- Difficult life events, such as a recent bereavement;
- Severe financial difficulties;
- Language barriers that may prevent individuals seeking the care they need and understanding what is being communicated; and
- Domestic abuse.

15. Vulnerable circumstances can also include the situation in which the patient meets with the eye care professional. For example, patients in domiciliary care may be considered vulnerable because the eye care professional has come into the patient's home to deliver their care. The patient may feel more pressure to purchase an optical appliance because they find it more difficult to say no in their own home.

16. Levels of vulnerability may vary between contexts and change over time. Everyone can be vulnerable at some point in their lives, even if only for short periods.

17. Therefore, a series of factors combine to shape vulnerability including an individual's personal characteristics (e.g. health conditions, capability) and life circumstances (e.g. finances, where they live), inherent features of eye care (e.g. knowledge imbalance, stressful situations) as well as the actions of eye care professionals and businesses (e.g. empathy, communication, adaptations).

## Why supporting patients in vulnerable circumstances matters

18. There are inequalities in eye health outcomes, for example around 60% of people living with sight loss are women, and people from certain ethnic minority groups are at greater risk of some leading causes of sight loss, such as glaucoma and diabetic retinopathy. Addressing inequalities is a challenge in all healthcare environments, and some causes of these inequalities reflect structural features in society that are beyond the influence of registrants. However, there is evidence of healthcare inequalities in eye care in relation to both access and patient experience, which registrants can help to improve through their professional practice.

19. Our research shows that the most vulnerable patients experience significantly worse outcomes. Individuals in vulnerable circumstances are less likely to be

satisfied with their care or may not access care at all.[1] Patients in vulnerable circumstances who have poor experiences, or who feel that registrants haven't supported them appropriately, may be less likely to seek eye care in future. You play a vital role in supporting those individuals to access eye care and manage their eye health.

20. Our 2025 public perceptions survey highlights the following:[2]
    - Patients from a global majority background are less likely to be satisfied with the overall experience of visiting an opticians/optometrists (82% vs 88%). They are also more likely never to have had a sight test (6% vs 3%)
    - Patients with a disability are also less likely to be satisfied with the overall experience (83% vs 88%).
    - Only 68% of patients who are confident in managing their own eye health are satisfied with the overall experience (versus 87% on average).
    - Those who do not speak English as a first language are less likely to be satisfied compared to the average (77% versus 89%).

21. Vulnerabilities may present in different ways and may also affect different patients in different ways. Patients who are vulnerable may be significantly less able to advocate for themselves and represent their own interests. They may require adjustments due to having more specific support needs. They may be less able to make informed decisions about their care or feel less comfortable declining treatment or choosing options they believe are best for them. They may also find it more difficult to take on board information being shared with them.

22. However, you should not make assumptions about a patient's vulnerabilities or how best to respond to them. It is therefore important that you use your professional judgement to support your patients and identify any additional needs they may have.

[1] Public perceptions research 2024 | GeneralOpticalCouncil
[2] Research not yet published at time of drafting

## Part 1: Guidance for Individuals

23. In this section ‘you’ refers to the individual registrant.

### Identifying and assessing patients in vulnerable circumstances

24. The first step in any episode of care is to carry out an assessment of the patient. You should conduct an adequate assessment for the purposes of the optical consultation or treatment. This includes where necessary any relevant medical, family and social history of the patient. This may include current symptoms, personal beliefs, cultural factors and vulnerabilities (standard 7 (6)).

25. In some cases, a patient’s vulnerability may not be obvious. Patients may provide you with information about their vulnerabilities, but there may be occasions where patients do not disclose sensitive information about their circumstances.

26. At the beginning of an assessment, you should ask patients if there is anything you need to know about their circumstances or anything else which you should know to help you to meet their needs.

27. We do not expect you to probe for information that is not necessary to conducting an adequate assessment, but you should be alert to signs which might indicate a vulnerability. Listening to patients, giving them your full attention, responding with sensitivity and compassion and treating patients as individuals are all ways in which you can identify potential vulnerabilities (standard 1).

28. If you are seeing a patient you have seen before, or has been seen in the practice before, there may already be a record of information which suggests the patient may be in vulnerable circumstances. As part of checking whether there have been any changes in the patient’s history or circumstances, you should check whether there have been any changes in their vulnerabilities.

29. We acknowledge that registrants work in a variety of different settings and that many businesses may have their own processes for assessing patients. But as a professional you are still responsible for the adequacy of the assessment you carry out, ensuring that you capture enough information to make an appropriate assessment.

30. You should make sure you record the details and findings of the assessment you carry out, including information on any vulnerabilities (standard 8.2.4 (7.2.4)) as part of the record of the patient’s treatment.

C21(25)iii.

31. If you have concerns that a patient's safety or wellbeing is at risk, including if they are at risk of abuse, you must follow reporting procedures in line with your workplace policies and any legal requirements.

**Making reasonable adjustments to your practice**

32. Once you have identified that a patient is in vulnerable circumstances, you should consider and respond to their needs (standard 13.7(12.7)). In doing so, you may find it helpful to speak to the patient sensitively to understand if there are any adjustments they have found beneficial in the past. This may be particularly helpful in situations where the patient has been managing these vulnerable circumstances for a long time.

33. You should make reasonable adjustments to your practice to accommodate these vulnerable circumstances and improve access to care. The adjustments will vary depending on the individual and there is no 'one size fits all approach'. Reasonable adjustments could include but are not limited to:
    - Giving the patient more time to complete their consultation or any aftercare, or pausing the consultation or aftercare to give the patient time to consider their options
    - Providing written information on next steps or treatment plans
    - Adjusting the treatment or shop floor environment to be more conducive to the patient (for example, reducing distractions or noise)
    - Using an interpreter or a chaperone for the patient
    - Adapting your communication style, by explaining technical terms or using visual aids

34. Patients, including those in vulnerable circumstances, may experience some anxiety about the consultation or treatment. Whilst some patients may be familiar with the sight test, or process of purchasing glasses or contact lenses, for others this may be the first time visiting an optical business. Clear introductions and expectation setting, combined with being verbally reassuring throughout your interaction with them, can help to reduce levels of anxiety and make sure that patients understand what is happening throughout their visit.

35. You should not make assumptions about the patient's level of knowledge or understanding and you should give them the opportunity to ask questions and take account of and respond to any concerns or expectations they may have expressed.

36. Vulnerable circumstances may also affect a patient's capacity to consent (standard 3(3)). The existence of these circumstances should not lead to an automatic assumption that the patient does not have the capacity to consent.

Instead, you should use your professional judgement to make a decision based on all the circumstances and the information reasonably available to you. You should also refer to our separate guidance on consent.

37. If you are unsure about a how to adjust your practice, you should get advice from your employer, other senior colleagues, health and social care professionals or people involved in their care. If you are still unsure you may need to consult your professional or representative body or obtain legal advice.

38. If you need to develop your skills in assessing vulnerable circumstances and adjusting your practice you should undertake further training as appropriate.

## Part 2: Guidance for Businesses

39. In this section ‘you’ refers to the body corporate or the director or responsible officer of an optical business (whether or not you are a registered optometrist or a registered dispensing optician).

### Workplace policies and procedures

40. Businesses will already have in place policies and procedures relevant to patients in vulnerable circumstances. For example, they will have procedures to meet their legal and professional obligations to safeguard patients from abuse or to provide an accessible patient care environment in line with equalities legislation and the law on mental capacity. You should make prospective patients aware of potential access barriers in advance of appointments, such as stairs.

41. You should consider whether your business needs any additional policies or procedures to support patients in vulnerable circumstances. This could include making changes to any assessment processes to support staff to identify these patients, such as providing examples of questions that staff could ask to draw out this information or making changes to written assessment forms.

42. You should make sure that any record keeping system allows your staff to capture information about a patient’s vulnerable circumstances and hold it safely and securely (Standards for Optical Businesses 2.4.1).

### Supporting staff to make reasonable adjustments

43. It is important for staff to be able to exercise their professional judgement in fulfilling their duties to patients, and to meet the expectations of their professional regulator. Empowered staff can take into consideration what is best for patients, including those in vulnerable circumstances, and act in their best interests.

44. You should support staff to have the confidence to make decisions in their role, including decisions on how to adjust their practice to respond to the needs of patients in vulnerable circumstances (Standards for Optical Businesses 3.1.2-6). Making decisions on how to support these patients may sometimes be difficult for staff, particularly for those who may not have supported patients in similar circumstances before. So, encourage staff to seek appropriate advice if needed.

45. To help staff to communicate effectively with patients in vulnerable circumstances, you should provide information that is accessible to patients in a way they understand, taking into consideration individual needs and requirements (Standards for Optical Businesses 3.1). Conversations about vulnerability may touch on sensitive or personal matters for a patient. So, supporting staff to

develop their communication skills and to treat patients with care and compassion is vital.

46. Patients in vulnerable circumstances may need more time to process information they have been given or make decisions (which could include changing their mind). So, you should ensure, so far as possible, that operational or commercial pressures do not inhibit staff from allowing patients the time they need. (Standards for Optical Businesses 3.2). You should also allow staff sufficient time, as far as possible, to accommodate patients' needs within the provision of care.

47. You should also provide clear information to patients about the costs of products and professional services (Standards for Optical Businesses 2.1.8). Transparency in pricing is important so that all patients can make informed decisions. Vulnerability could make it more likely for patients to feel confused or pressured to buy services. For example, patients who feel less confident managing their own health may feel less confident in seeking information on pricing. Equally, those who have experienced a serious life event may feel less able to make an informed decision at the point of purchase.

48. You should support patients to understand their eligibility for financial support, such as free sight tests and which products are available to patients who are using eye care vouchers. Training staff on how to handle conversations about pricing will further support patients in vulnerable circumstances.

## Annex 1 - Relevant standards

Note that we have only provided the relevant standards below and have not replicated the entire standard unless necessary.

**Standards of Practice for Optometrists and Dispensing Opticians**

**Standard 1. Listen to patients and ensure they are at the heart of the decisions made about their care**

1.1 Give patients your full attention and allow sufficient time to deal properly with their needs.

1.2 Listen to patients and take account of their views, preferences and concerns, responding honestly and appropriately to their questions.

1.3 Assist patients in exercising their rights and making informed decisions about their care. Respect the choices they make.

1.4 Treat patients as individuals and respect their dignity and privacy. This includes a patient's right to confidentiality.

1.5 Where possible, modify your care and treatment based on your patient's needs and preferences without compromising their safety.

**Standard 7: Conduct appropriate assessments, examinations, treatments and referrals**

7.1 Conduct an adequate assessment for the purposes of the optical consultation, including where necessary any relevant medical, family and social history of the patient. This may include current symptoms, personal beliefs, cultural factors and vulnerabilities.

**Standard 8. Maintain adequate patient records**

8.1 Maintain clear, legible and contemporaneous patient records which are accessible for all those involved in the patient's care.

8.2 As a minimum, record the following information:
8.2.1 The date of the consultation.
8.2.2 Your patient's personal details.
8.2.3 The reason for the consultation and any presenting condition.
8.2.4 The details and findings of any assessment or examination conducted.
8.2.5 Details of any treatment, referral or advice you provided, including any drugs or appliance prescribed or a copy of a referral letter.
8.2.6 Consent obtained for any examination or treatment.

8.2.7 Details of all those involved in the optical consultation, including name and signature, or other identification of the author

**Standard 11. Protect and safeguard patients, colleagues and others from harm**

11.1 You must be aware of and comply with your legal obligations in relation to safeguarding of children, young people and vulnerable adults.

11.2 Protect and safeguard children, young people and vulnerable adults from abuse. You must:
11.2.1 Be alert to signs of abuse and denial of rights.
11.2.2 Consider the needs and welfare of your patients.
11.2.3 Report concerns to an appropriate person or organisation.
11.2.4 Act quickly in order to prevent further risk of harm.
11.2.5 Keep adequate notes on what has happened and what actions you took.

11.3 Promptly raise concerns about your patients, colleagues, employer or other organisation if patient or public safety might be at risk and encourage others to do the same. Concerns should be raised with your employing, contracting, professional or regulatory organisation as appropriate. This is sometimes referred to as 'whistle-blowing' and certain aspects of this are protected by law

**Standard 13. Show respect for fairness to others and do not discriminate**

13.7 Consider and respond to the needs of patients with a disability, and patients in vulnerable circumstances, and make reasonable adjustments to your practice to accommodate these and improve access to optical care.

**Standards for Optical Students**

**Standard 1. Listen to patients and ensure they are at the heart of the decisions made about their care**
1.1 Give patients your full attention and allow sufficient time to deal properly with their needs.

1.2 Listen to patients and take account of their views, preferences and concerns, responding honestly and appropriately to their questions.

1.3 Assist patients in exercising their rights and making informed decisions about their care. Respect the choices they make.

1.4 Treat patients as individuals and respect their dignity and privacy. This includes a patient's right to confidentiality.

1.5 Where possible, modify your care and treatment based on your patient's needs and preferences without compromising their safety.

**Standard 6: Conduct appropriate assessments, examinations, treatments and referrals under supervision**

You will develop your clinical skills over the course of your training, becoming more proficient as you near the end of your studies. As part of your training, you will apply these clinical skills in a real-life setting under the direction of your tutor or supervisor gradually taking more responsibility for patients as your skills develop. In conjunction with your tutor or supervisor:

6.1 Conduct an adequate assessment for the purposes of the optical consultation, including where necessary any relevant medical, family, and social history of the patient. This may include current symptoms, personal beliefs, cultural factors, or vulnerabilities.

6.7 When in doubt, consult with your tutor or supervisor appropriately for advice on assessment, examination, treatment and other aspects of patient care, bearing in mind the need for patient confidentiality.

**Standard 7. Maintain adequate patient records**

7.1 Maintain clear, legible and contemporaneous patient records which are accessible for all those involved in the patient's care.

7.2 As a minimum, record the following information:
7.2.1 The date of the consultation.
7.2.2 Your patient's personal details.
7.2.3 The reason for the consultation and any presenting condition.
7.2.4 The details and findings of any assessment or examination conducted.
7.2.5 Details of any treatment, referral or advice you provided, including any drugs or appliance prescribed or a copy of a referral letter.
7.2.6 Consent obtained for any examination or treatment.
7.2.7 Details of all those involved in the optical consultation, including name and signature, or other identification of the author

**Standard 10. Protect and safeguard patients, colleagues and others from harm**

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10.1.1 Be alert to signs of abuse and denial of rights.
10.1.2 Consider the needs and welfare of your patients.
10.1.3 Report concerns to an appropriate person or organisation.
10.1.4 Act quickly in order to prevent further risk of harm.
10.1.5 Keep adequate notes on what has happened and what actions you took.

10.2 Promptly raise concerns about your patients, colleagues, employer or other organisation if patient or public safety might be at risk and encourage others to do the same. Concerns should be raised with your employing, contracting, professional or regulatory organisation as appropriate. This is sometimes referred to as 'whistle-blowing' and certain aspects of this are protected by law

**Standard 12. Show respect for fairness to others and do not discriminate**

12.7 Consider and respond to the needs of patients with a disability, and patients in vulnerable circumstances, and make reasonable adjustments to your practice to accommodate these and improve access to optical care.

**Standards for Optical Businesses**

**Standard 1.1 Patients can expect to be safe in your care**

Promoting patient safety is at the heart of all healthcare. A patient should be able to trust their healthcare provider to prioritise their safety so that they can receive the best possible care. An important aspect of this is that optical businesses must not inhibit the healthcare professionals they employ or contract with from meeting their own professional standards. To achieve this, your business must:

1.1.1 Understand its legal and professional responsibilities to safeguard patients from abuse and ensures that it and its staff are prepared and supported to do so.
1.1.2 Have a process for staff to report any safeguarding concerns and encourages them to do so.

**Standard 1.2 Patient care is delivered in a suitable environment**

It is crucial that the environment in which patients receive treatment and care is fit for purpose, so that patients are protected and that accurate information can be obtained about a patient's eye health. This applies no matter where the care is being delivered, including online. To achieve this, your business:
(…)

1.2.2 Provides an accessible patient care environment in line with current equalities legislation

**Standard 1.3 Communication is clear and effective**
Clear communication with patients is vital to be able to provide suitable care to them and ensure that they are involved in making decisions about their own healthcare. It is also important that they know what they can expect from their optical care and have a realistic understanding of what can be provided so that their expectations can be managed. To achieve this, your business:
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.
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.

**Standard 2.1 The services you provide are open and transparent**
The Mid-Staffs Hospital Public Inquiry identified a need for openness and transparency within healthcare. In order to be able to promote the public's trust in you as a business and in the optical professions, you need to ensure that the services you provide to patients and the public are transparent; that complaints are handles fairly; and that staff are able to be candid. To achieve this, your business:
(…)
2.1.3 Ensures that staff have roles appropriately assigned, with clear lines of accountability and, where staff interact with patients and the public, they identify themselves and their role(s) clearly.
(…)
2.1.8 Provides clear information to patients about costs of products and professional services

**Standard 3.1 Your staff are able to exercise their professional judgement**
It is important for staff to be able to exercise their professional judgement in fulfilling their duties to patients, and to meet the expectations of their professional regulator. This relies on staff being empowered to take into consideration what is best for patients and doing so with their interests and circumstances in mind. They should be in a position to do so without being subject to unreasonable external influence or pressure. To achieve this, your business:
3.1.1 Promotes awareness and understanding of the Standards of Practice for Optometrists and Dispensing Opticians, Standards for Optical Students and Standards for Optical Businesses to staff.

3.1.2 Supports its staff to have the confidence to make decisions appropriate to their role.
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.
3.1.5 Encourages staff to seek advice on making difficult decisions if they need to, and lets them know with whom they can do this.
3.1.6 Ensures that any changes to prescribed products are clinically justified, and staff are able to apply professional judgement when deciding if a change to the prescribed product is right for individual patients.

# Consultation on new guidance for GOC registrants

**[insert date]**

## Contents page

## Overview

**What we're doing**

1. The General Optical Council (GOC) is the regulator for the optical professions and businesses in the UK. We currently register around 35,000 optometrists, dispensing opticians, student optometrists, student dispensing opticians and optical businesses. The groups on our register are called registrants. For more information, please visit our website: https://www.optical.org/

2. 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 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; and
   - investigating and acting where registrants' fitness to practise, train or carry on business may be impaired.

3. In January 2025, we launched three updated sets of standards, produced following an extensive period of stakeholder engagement. These are the Standards of Practice for Optometrists and Dispensing Opticians, Standards for Optical Students and Standards for Optical Businesses. You can read more about our standards consultation and outcomes here. A short animation outlining the key changes can be viewed here.

4. We developed new guidance to help registrants to understand some changes we had made to the standards.

5. This consultation is seeking views on newly developed guidance. We are consulting on the following pieces of guidance:
   - New guidance on Care of Patients in Vulnerable Circumstances
   - New guidance on Maintaining Appropriate Sexual Boundaries

6. This consultation will be open from [insert date] to [insert date], and you can respond either using our online consultation platform: Public participation platform of General Optical Council | CitizenLab or by emailing consultations@optical.org

**Why we're consulting on our guidance**

7. The purpose of this consultation is to obtain feedback from stakeholders on our guidance. We are keen to hear views on whether the guidance is easy to read and understand and supports registrants to interpret the standards. This will help us to make sure the guidance is as helpful to our registrants as possible.

8. We are not consulting on the standards themselves, as they have already been subject to full public consultation.

**What will happen next?**

9. The public consultation will be open for 12 weeks.

10. Once the consultation has closed, we will analyse all the comments we have received and identify whether we need to make further changes to our guidance.

11. We expect to publish our revised guidance in late 2025.

## Section 1: Developing and updating guidance

12. Our standards define the behaviour and performance expected of all registered optometrists and dispensing opticians, optical students and optical businesses. Registrants are professionally accountable and personally responsible for their practice and must comply with the standards.

13. We produce guidance in specific areas to help registrants to meet our standards. For example, we have existing guidance on consent and on disclosing confidential information. You can find our existing guidance on our website. Guidance supports registrants to meet our standards, but is not binding nor does it limit a registrant's ability to use their professional judgement to make decisions.

14. Our guidance explores the standards in more detail or provides information on how the standards can be applied in practice. As standards should be read as a whole, guidance will often bring together several relevant standards rather than focus on one specific standard. Guidance can also signpost registrants to other sources of support and information provided by organisations external to the GOC.

15. In 2025 we launched three new sets of standards. We made changes to the standards in several key areas, including clarifying our requirements on maintaining appropriate sexual boundaries with patients and colleagues, as well as highlighting the importance of identifying and responding to the needs of patients in vulnerable circumstances. We have produced guidance on these topics to help registrants to meet these new standards.

16. We also reviewed all our existing guidance to make sure that it aligned with the new standards. Where we made minor changes to the guidance, to address formatting issues or update the references to standards, these changes were approved by the GOC registrar and published alongside the revised standards.[1]

17. To help us to draft the guidance, we looked at fitness to practise cases against GOC registrants, enquiries we have received about our standards and guidance from other regulators. We also looked at the responses we received to the consultation on our standards, which highlighted areas of concern for registrants or points on which registrants wanted clarity.

**Referencing standards in the guidance**

18. Throughout this document and within the guidance documents we will refer to specific standards that have been revised using the standard number, for example, standard 6.1. We recognise that the numbering in the Standards of

[1] This was the guidance on consent, on disclosing confidential information and on the duty of candour.

Practice for Optometrists and Dispensing Opticians differs from the numbering within the Standards for Optical Students.

19. To address this, we refer to the number within the Standards of Practice for Optometrists and Dispensing Opticians first, and then the number within the Standards for Optical Students in brackets afterwards. For example, standard 6.1 (5.1).
20. When referring to the Standards for Optical Businesses we will simply refer to the relevant standard, for example, standard 1.1.4.

**Summary of new guidance**

Guidance on Care of Patients in vulnerable circumstances

21. The guidance expands on the following new text in the introduction and addition to an existing standard:

    (Introduction) “Consider and respond to the needs of patients who, due to their personal circumstances, are in need of particular care, support or protection or at risk of abuse and neglect. Patients may be vulnerable for a range of reasons, including physical or mental health conditions, capability in managing their health, or handling a difficult set of life events. Levels of vulnerability may vary between contexts, and change over time, so consider a patient’s vulnerabilities as part of each consultation”

    Standard 13.7 (12.7). “Consider and respond to the needs of patients with a disability, and patients in vulnerable circumstances, and make reasonable adjustments to your practice to accommodate these and improve access to optical care”

22. The guidance is presented in two parts - Part 1 for individuals and Part 2 for businesses. It covers a number of areas including:
    - What we mean by vulnerable circumstances and why supporting patients in vulnerable circumstances matters
    - How to identify and assess patients in vulnerable circumstances
    - Making reasonable adjustments to practice
    - Expectations for businesses, including workplace policies and procedures and how to support staff

Guidance on Maintaining Appropriate Sexual Boundaries

23. The guidance expands on the following new standards:

“15.3 (14.3) You must not engage in unwanted conduct of a sexual nature with students, colleagues or others with whom you have a professional relationship. You must not create an intimidating, degrading, humiliating or offensive environment, whether intended or not. Maintaining sexual boundaries applies to your behaviours, actions and communications.
15.4 (14.4) You must not engage in conduct of a sexual nature with patients or violate their dignity. Maintaining sexual boundaries applies to your behaviours, actions and communications.”

24. The guidance is presented in two parts - Part 1 for individuals and Part 2 for businesses. It covers a number of areas including:
    - The importance of maintaining appropriate sexual boundaries;
    - What is considered inappropriate sexual behaviour;
    - Expectations around relationships with patients, including former and vulnerable patients;
    - Expectations for businesses, including ensuring appropriate processes are in place and providing support;
    - Speaking up and reporting incidents.

## Section 2: Seeking your views

25. Below we have set out a series of questions on our revised and newly developed guidance. We invite stakeholders to comment if they think we can make the guidance clearer, if anything is missing or if there is anything else we should consider about the guidance.

**Consultation questions**

Guidance on Care of Patients in Vulnerable Circumstances

**Q1. How can we make the guidance clearer?**

Please provide details

**Q2: Is anything missing from the guidance or is there anything else we should consider?**

If so, please provide details

Guidance on Maintaining Appropriate Sexual Boundaries

**Q3. How can we make the guidance clearer?**

Please provide details

**Q4: Is anything missing from the guidance or is there anything else we should consider?**

If so, please provide details

*Welsh language*

26. Under the Welsh language standards, we are required to consider what effects, if any (whether positive or adverse), the policy decision would have on opportunities for persons to use the Welsh language and treating the Welsh language no less favourably than the English language, whether those effects are positive or adverse.

27. The guidance on patients in vulnerable circumstances includes examples of reasonable adjustments that registrants can apply to their practice to support patients, which does include support to help patients engage with registrants if English is not their first language. However, the provision of Welsh Language

services in healthcare in Wales is already required by legislation and therefore would not be affected by this guidance.

28. We have assessed that these proposals will not have any effects on opportunities to use the Welsh language or affect the treatment of the Welsh language and there is more information on our assessment in the impact assessment.

**Q5: Will the proposed changes 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?**

a) Yes re (i)
b) Yes re (ii)
c) No re (i)
d) No re (ii)
e) Not sure re (i)
f) Not sure re (ii)

Please provide additional details.

**Q6. Could the proposed changes 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?**

a) Yes re (i)
b) Yes re (ii)
c) No re (i)
d) No re (ii)
e) Not sure re (i)
f) Not sure re (ii)

Please provide additional details.

**Q7. Could the proposed changes 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?**

a) Yes re (i)
b) Yes re (ii)
c) No re (i)
d) No re (ii)
e) Not sure re (i)
f) Not sure re (ii)

Please provide additional details.

*Impact assessment*

29. We have produced a draft impact assessment which we will update following views received during the consultation.

**Q8. Are there any aspects of our proposals that could discriminate against stakeholders with specific characteristics?** (Please consider age, sex, race, religion or belief, disability, sexual orientation, gender reassignment, gender identity, gender expression, pregnancy or maternity, caring responsibilities or any other characteristics.)
a) Yes
b) No
c) Not sure

Please provide additional details.

**Q9Are there any aspects of our proposals that could have a positive impact on stakeholders with specific characteristics?** (Please consider age, sex, race, religion or belief, disability, sexual orientation, gender reassignment, gender identity, gender expression, pregnancy or maternity, caring responsibilities or any other characteristics.)
a) Yes
b) No
c) Not sure

Please provide additional details.

## Section 3: How to respond to the consultation

29. This consultation will be open from [insert date] to [insert date].

30. We would be grateful if you could input your responses into our consultation hub so that we can collect information about you or your organisation and whether your response can be published.

31. However, if that is not possible, you can respond to the consultation by emailing consultations@optical.org. Please ensure you provide us with information on whether you are responding on behalf of yourself or an organisation, which organisation you are responding for, and whether we have permission to publish your response and name yourself or your organisation.

C21(25)iiiii.

## Impact Assessment Screening Tool

| | |
|---|---|
| **Name of policy or process** | Guidance development |
| **Purpose of policy or process** | To produce new guidance to support the new standards |
| **Team/Department** | Policy & Standards |
| **Date** | 01 May 2025 |
| **Screen undertaken by** | Charlotte Urwin |
| **Approved by** | Steve Brooker |
| **Date approved** | 6 June 2025 |

| | |
|---|---|
| **Instructions:** | • Circle or colour in the current status of the project or policy for each row.<br>• **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.<br>• This is a live tool, you will be able to update it further as you have completed more actions.<br>• Make sure your selections are accurate at the time of completion.<br>• Decide whether you think a **full** impact assessment is required to list the risks and the mitigating/strengthening actions.<br>• If you think that a full impact assessment is **not** required, put your reasoning in the blank spaces under each section.<br>• You can include comments in the boxes or in the space below.<br>• 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 | **NA** |
| 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;** | | Does not need to be published in Welsh | |

| Please put commentary below about your impacts ratings above: |
| --- |
| **Point 5** There is some media interest in the topic of sexual harassment and failing to maintain appropriate sexual boundaries in healthcare (see for example Surviving in Scrubs campaign). There is also some interest in the topic of vulnerability in a range of services. Our annual registrant and public surveys (which cover issues relevant to both pieces of guidance) are covered in the professional press. Our ongoing media monitoring identifies relevant coverage.<br><br>**Point 8** The consultation documents will be translated into Welsh before consultation.<br><br>The risks identified in this section are mainly low. A full impact assessment is 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 | **NA** |
| 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 | **NA** |
| 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** | |

| B) Information governance | High risk | Medium risk | | Low risk | ? or N/A |
|---|---|---|---|---|---|
| 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 | **None - no personal or identifiable data will be published** | |
| 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: |
|---|
| **Point 1**: The draft guidance may be considered private/closed business data, until such time as the documents are shared for public consultation, when they would become open business data.<br><br>**Point 2:** The draft guidance does not relate to specific individuals so there is no requirement to anonymise the data.<br><br>**Point 4**: All the feedback received on the draft guidance will be used to inform any changes.<br><br>**Point 7**: Retention schedule requires consultation documents to be retained for 6 years after the date created – the consultation document will contain copies of the draft guidance<br><br>**Point 9**: All documents relating to the guidance project will be on the asset register.<br><br>**Point 10**: The draft guidance will be shared with stakeholders for review as part of the consultation.<br><br>**Point 13**: All project staff have received information governance training.<br><br>The risks identified in this section are low or medium, and the medium risks have been addressed as far as possible, therefore a full impact assessment is not necessary. |

| 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<br>(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<br>(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<br>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 | 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** | |

| C) Human rights, equality and inclusion | High risk | Medium risk | | Low risk | ? or N/A |
|---|---|---|---|---|---|
| | | next 3 months, which is booked | | **12 months, which is recorded** | |
| 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 | **NA** |
| | Non-accessible building; | Partially accessible buildings; | Accessible buildings, although not all sites have been surveyed | All accessible buildings and sites have been surveyed | **NA** |
| 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)** | |

| C) Human rights, equality and inclusion | High risk | Medium risk | | Low risk | ? or N/A |
|---|---|---|---|---|---|
| 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 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 | **See EDI section** |
| 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: |
|---|
| **Point 3**: The draft guidance for consultation will be reviewed by Council. As this is guidance rather than standards, it is intended to inform practice but does not limit registrant's practice in any way. There is no internal GOC appeals process – Council's decision is final. Council members undergo annual EDI training.<br><br>**Point 5**: The draft guidance will be shared as part of the public consultation document. We will follow the 'Making our consultations accessible' guidance within the GOC Consultation Policy.<br><br>**Point 7**: The consultation will be live for 12 weeks, expected to be from July to October.<br><br>**Point 10**: Evidence suggests that accessing an online consultation may be more challenging for some groups, e.g., those from lower socio-economic backgrounds, or those over 65 years of age. The guidance on patients in vulnerable circumstances has been informed by research undertaken with those groups to make sure it reflects their experiences. We will also contact patient groups and ask them to share details of the consultation with the individuals they represent.<br><br>The risks identified in this section are mainly low, therefore a full impact assessment is not necessary. |

| Protected characteristic | Type of potential impact: positive, neutral, negative? | Explanations (including examples or evidence/data used) and actions to address negative impact |
|---|---|---|
| Age | Positive | Our 2025 patient and public research highlights that those in younger age groups (aged 16-34) are less likely than those in older age groups (aged 55 and over) to be satisfied with the overall experience of the opticians/optometrists practice (79% vs. 92%). Older people may also be more vulnerable, either because of co-morbidities or because they may feel less confident in managing their own health. Our guidance on patients in vulnerable circumstances may support registrants to adapt their practice to support both younger and older patients. |
| Disability | Positive | Our 2025 patient and public research highlights that those with a disability are less likely than those without one to be satisfied with the overall experience of the opticians/optometrists practice (83% vs 88%). As above, the guidance on patients in vulnerable circumstances may support registrants to adapt their practice to support patients with a disability. |
| Sex | Positive | Our 2024 registrant survey shows that female registrants are more likely to experience harassment, bullying or abuse than male registrants. That may include sexual harassment. The guidance on maintaining appropriate sexual boundaries may support female registrants who experience this inappropriate sexual behaviour. It will also highlight to all registrants the negative impact that inappropriate behaviour can have. |
| Gender reassignment (trans and non-binary) | Neutral | Neither piece of draft guidance should have any impact on people who are trans or non-binary. |
| Marriage and civil partnership | Neutral | Neither piece of draft guidance should have any impact on people who are married or in a civil partnership. |

| Protected characteristic | Type of potential impact: positive, neutral, negative? | Explanations (including examples or evidence/data used) and actions to address negative impact |
|---|---|---|
| Pregnancy/ maternity | Neutral | Neither piece of draft guidance should have any impact on those who are pregnant or on maternity leave. |
| Race | Positive | Our 2025 patient and public research highlights that those from a white background are more satisfied than those from an ethnic minority background with the overall experience of the opticians/optometrists practice (88% vs. 82%). Many patients from an ethnic minority background are not in vulnerable circumstances. However, some patients, for example those for whom English is not their main language, maybe more vulnerable. As above, the guidance on patients in vulnerable circumstances may support registrants to adapt their practice to support these patients. |
| Religion/belief | Neutral | Neither piece of draft guidance should have any impact on people someone based on their religion or beliefs, including the absence of either. |
| Sexual orientation | Neutral | Neither piece of draft guidance should have any impact on people based on their sexual orientation. |
| Other groups (e.g. carers, people from different socio-economic groups) | Neutral | **Different socio-economic groups**<br>Our 2025 patient and public research highlights that those with an income of £25,001 – 35,000 are less likely to be satisfied with value for money when visiting an opticians/optometrists practice (67%), as are those who say they are struggling financially (71%). In contrast, those with a household income of £50,001 or more are more inclined to be satisfied with value for money (78%). In addition, those with at least one marker of vulnerability (which includes a household income of less than £25,000) are less likely to be satisfied with the overall experience. As above, the guidance on patients in vulnerable circumstances may support registrants to adapt their practice to support patients whose financial circumstances may make them more vulnerable. |
| | Neutral | **Welsh language users** |

| Protected characteristic | Type of potential impact: positive, neutral, negative? | Explanations (including examples or evidence/data used) and actions to address negative impact |
|---|---|---|
| | | Under the Welsh language standards, we are required to consider what effects, if any (whether positive or adverse), the policy decision would have on opportunities for persons to use the Welsh language and treating the Welsh language no less favourably than the English language, whether those effects are positive or adverse.<br><br>Our policy proposals are to produce guidance to support our standards. We did not identify any Welsh language impacts arising from the new standards. As this is guidance, it is intended to support compliance with our standards but does not restrict a registrant's professional judgement, nor does it place any restrictions on opportunities to use Welsh nor lead to unfavourable treatment.<br><br>The guidance on maintaining appropriate sexual boundaries would not prevent patients from using the Welsh language when engaging with registrants, nor lead to any less favourable treatment of the Welsh than English language.<br><br>The guidance on patients in vulnerable circumstances includes examples of reasonable adjustments that registrants can apply to their practice to support patients, which does include support to help patients engage with registrants if English is not their first language. However, the provision of Welsh Language services in healthcare in Wales is already required by legislation and therefore would not be affected by this guidance. |
| | Positive | **Patients in vulnerable circumstances**<br><br>Our public and patient research shows that patients with at least one marker of vulnerability are likely to be less satisfied by their experience at the opticians/optometrists practice. The guidance on patients in vulnerable circumstances should have a positive impact on the care they receive. |

**Public**
**C22(25)**

**Council**

## Appointment of Council members to committees

**Meeting: 25 June 2025** **Status:** For decision.

**Lead responsibility:** Dr Anne Wright CBE, Chair of Council
**Paper Author(s):** Andy Mackay-Sim, Chief of Staff

### Purpose

1. To confirm the appointment of new Council members to committees.

### Recommendations

Council is asked to **appoint**:

- John Cappock, independent lay member, as Chair of Audit, Finance and Risk Committee until 31 March 2026;
- approve remuneration commensurate with the fee set for the Chair of ARC (£16,462 pro-rata)

### Strategic objective

2. This work contributes towards all three strategic objectives as it concerns the core governance functions of the Council. It is included in the business plan under 'member support' – managing Council and committee member appointments, reappointments, appraisals and development and evaluation of performance.

### Background

Appointment to Audit, Finance and Risk Committee (ARC)

3. Ken Gill, lay Council member, has indicated that he will be resigning with effect from 31 July 2025. Plans to recruit to the vacancy are underway with an appointment planned towards the end of the current financial year.

4. In the interim, this has created a vacancy for the Chair of ARC, which had been occupied by Ken Gill since 1 October 2024. The terms of reference for ARC specify that Council will appoint a Chair of the Committee.

### Analysis

8. The Chief Executive and Registrar, Chief of Staff and Chair of Council have discussed options, based on the current committee membership and the skills profile across Council.

9. Council membership does not currently include a qualified financial professional, a gap that will be remedied by the planned recruitment. There has also been a

significant turnover of Council and ARC membership. The Council members on ARC have all been appointed to the Committee in the last 12 months.

10. As an interim measure, the Committee could elect its own Chair on a meeting-by-meeting basis. However, it is preferable to ensure continuity arrangements are in place so that the various duties and responsibilities associated with ARC are adequately covered while Council undertakes a recruitment process.

11. The Committee independent member, John Cappock, was appointed to ARC on 1 April 2022. He brings a wealth of experience as a finance professional, having held significant management positions in higher education institutions. He is a non-executive board member for an NHS integrated care board and a non-executive director for an NHS Foundation Trust. He is chair for two audit committees. It is therefore recommended that John Cappock assumes the role of Chair of ARC for the remainder of the financial year (until 31 March 2026). Council will then consider

12. In order to ensure that John Cappock is fairly remunerated, it is proposed that he receives a fee commensurate with the Chair of ARC, as described in the fee schedule approved by Council in March 2025. This equates to approximately three to four days a month, and would cover Committee meetings, liaison with the executive, planning and preparation and other duties consistent with the role. It will be expected that John Cappock will attend Council meetings in order to provide assurances on behalf of the Committee and report on its activities.

## Finance

13. There is a small financial impact for the appointment, which is offset in part against the fees being saved because of the Council member vacancy.

## Risks

14. If Council does not appoint a Chair of ARC, there is a risk that the effectiveness of the Committee will diminish, including its ability to provide assurance to Council. Appointing an experienced and competent interim Chair of ARC will remove this risk.

## Equality Impacts

15. There are no explicit impacts for equality, diversity or inclusion.

## Devolved nations

16. There are no explicit impacts for devolved nations.

## Other Impacts

19. There are no significant impacts identified.

## Communications

### External communications

20. No external communications are planned.

### Internal communications

21. No internal communications are planned.

## Next steps

22. None.

## Attachments

None.

**PUBLIC**
**C23(25)i.**

**COUNCIL**

**Optical Consumer Complaints Service (OCCS) Annual Report 2024-2025 'Resolving complaints in a changing consumer landscape'**
**Meeting: 25 June 2025** **Status:** For noting

**Lead responsibility:** Carole Auchterlonie (Director of Regulatory Operations)
**Paper Author(s):** Claire Marchant-Williams (Head of Case Progression)
**Council Lead(s):** Lisa Gerson and Cathy Yelf

## Purpose

1. For Council to receive and discuss the 2024-2025 Optical Consumer Complaints Service (OCCS) annual report.

## Recommendations

2. Council is asked to note the OCCS annual report

## Strategic objective

3. This work contributes towards the achievement of the following of last year's strategic objective: excellence in customer service. This work is included in our 2024/25 Business Plan.

## Background

4. The GOC commissions and funds the OCCS as an impartial mediation service for consumers and optical practices. Following an external procurement exercise in 2024, Nockolds Resolution were reappointed as our contractor to provide the OCCS, and the current contract runs until 31 March 2027, with a contract value of approximately £840,000 over three years.

5. Nockolds Resolution has provided the OCCS since 2014. Each year, they are invited to present their annual report to Council. The attached report provides a summary of OCCS activity for 2024-25.

## Analysis

6. The OCCS report demonstrates that 27% of our 2024-25 referrals have been successfully diverted to the OCCS for a mediated resolution. This is an increase from 16% last year.

7. There was a decrease of 4.33% in the volume of complaints received by the OCCS this year (1679 received in 2024-25 compared to 1755 received in 2023-24), and like last year 95% of those were within remit for the OCCS to assist and resolve through effective mediation.

8. The OCCS has maintained a strong resolution rate – with only 49 unsuccessful mediations in 2024-25 (3% of all complaints) which is a decrease from 73 (21% of all complaints) in 2023-24.

9. Last year, it was highlighted that complaints about domiciliary care had doubled in number (from 42 in 2022-23 to 98 in 2023-24). This year's report demonstrates that this trend has not continued, with complaints about this area reducing to 53.

10. The report highlights that there has been a year-on-year increase in the number of consumers citing prescription errors rising from 183 in 2023-24 to 230 in 2024-25. The report details how this can be seen as a positive increase with consumers becoming more confident to speak up about issues that impact their vision and quality of life.

11. The report notes that there has been a significant increase in successful mediations with regards to complaints involving refractive surgery. These have historically taken longer to resolve due to the nature of the issues involved. 2024-25 has seen successful mediations rise from 56% in 2022-23 to 89%.

## Finance

12. There are no costs associated with this paper

## Risks

13. There are no identified risks associated with the completion of this report.

## Equality Impacts

14. No equality impact assessment was necessary for the report.

## Devolved nations

15. There are no direct implications for the devolved nations, and the report shows a proportionate spread consistent with population data.

## Communications

16. The report will be uploaded to the OCCS and GOC websites and communicated via the social media platforms for each organisation.

## Next steps

17. This report is for noting only.

## Attachments

Annex 1: OCCS Annual Report 2024-2025 -” Resolving complaints in a changing consumer landscape”

# Optical Consumer Complaints Service

2024-2025

## Resolving complaints in a changing consumer landscape

# Contents

# Introduction

The ongoing cost-of-living crisis and consumer confidence in the UK continues to shape consumer behaviour, with heightened expectations and reduced tolerance for what were once considered reasonable outcomes. Within this challenging landscape, the OCCS has seen increased pressure from consumers expecting greater value and durability from optical products like eyewear. Despite these economic tensions, the OCCS has delivered a strong resolution rate of 89%, up from 85% the previous year. This report outlines how the service has adapted, maintaining fairness and trust while supporting both consumers and optical professionals through an increasingly complex and demanding complaints landscape.


The financial pressures facing UK households have intensified over the past 12 months, with inflationary pressures, rising energy costs, and limited wage growth continuing to squeeze incomes. For many consumers, this strain has triggered heightened scrutiny over their discretionary spend, including those relating to healthcare and optical services. As a result, the OCCS has observed a growing reluctance among consumers to accept outcomes that are considered 'reasonable' within industry standards. Expectations have remained high throughout the year, with many individuals seeking more than just satisfactory service. Indeed, they now expect long-lasting value, especially when making investments in products such as eyewear.

This shift in consumer mindset has created new complexities in complaint resolution. In particular, there is now greater sensitivity around the durability and perceived longevity of eyewear products. Similarly, complaints are increasingly driven by consumer assumptions that spectacles and lenses should endure for longer periods, even in cases where usage, wear, or changes in prescription might naturally impact performance. Naturally, these expectations can lead to friction when industry norms and consumer sentiment diverge, placing further importance on transparent communication and effective complaint management.

The increase in resolution rates this year is a testament to the service's commitment to constructive dialogue, fair mediation, experience of the team and collaborative engagement with all parties involved. What's more, we have strengthened our processes to ensure that every complaint is approached with empathy, clarity, and a solution-focused mindset, all essential qualities in a period where public trust and consumer confidence are under pressure.

It is also important to acknowledge the broader context in which optical practices are operating. The cost-of-living crisis has not only affected consumer attitudes but has also increased operational costs for many practices, impacting their capacity to offer flexibility in complaint settlements. The Primary Care Network paper – The Future of Primary Care (February 2025) has highlighted the pressures on healthcare business this year. The report comments that the sector is reporting flat sales and rising expenses, while increases in National Insurance and minimum wage have impacted many practices. The OCCS continues to play a crucial role in bridging the gap between these competing pressures, promoting balanced outcomes that reflect both the financial limitations of providers and the needs of consumers.

As we move forward, the OCCS remains focused on maintaining high standards of service while remaining responsive to the economic realities faced by both consumers and practitioners. In an increasingly challenging environment, our ability to facilitate fair resolutions and support the optical sector's reputation for professionalism and care has never been more vital.

This report sets out the trends, insights, and outcomes that have defined our work over the last year, and outlines our continued commitment to building trust, promoting fairness, and adapting to a landscape that demands resilience, innovation, and compassion.

# The role of the OCCS

The OCCS is a consumer complaint resolution service funded by the General Optical Council. The service uses mediation techniques to support consumers and optical businesses to resolve complaints which have exhausted the practice's own complaint process. The OCCS is an independent service which is funded by the General Optical Council (GOC) and delivered by Nockolds Solicitors. The OCCS is also audited by the Chartered Trading Standards Institute, as an Alternative Dispute Resolution (ADR) approved body under the ADR Regulations.

An overview of the OCCS process is at Appendix 1.

There are many ways in which the OCCS supports consumer complaint resolution:

- local resolution - providing consumers with advice and constructive guidance so they can return to the practice for the complaint to be resolved. This work is invaluable in helping to resolve complaints swiftly and as locally as possible. The team de-escalate and where appropriate, give guidance to help consumers raise their complaint effectively in a focused way which increases the likelihood of local resolution at the first stage;
- signpost consumers to trusted organisations with advice where the complaint falls outside the remit of the OCCS;
- provide advice to aid and improve consumer understanding in terms of the role of the regulator and consumer rights and signpost when necessary;
- through complaint mediation, interacting with consumers and practices to resolve consumer issues;
- gather insight to then be shared with optical professionals and businesses to drive improvements in standards of practice, communication, and customer care.

The OCCS also plays a strategic role in supporting the GOC and the sector to deliver proportionate complaint resolution of complaints. This is achieved by the OCCS resolving complaints which do not amount to fitness to practise (FTP) allegations, allowing the GOC to focus on timely case progression of FTP investigations. Where concerns involving potential FTP allegations are received by the OCCS, these are flagged under a risk-based protocol to ensure serious concerns are referred to the GOC.

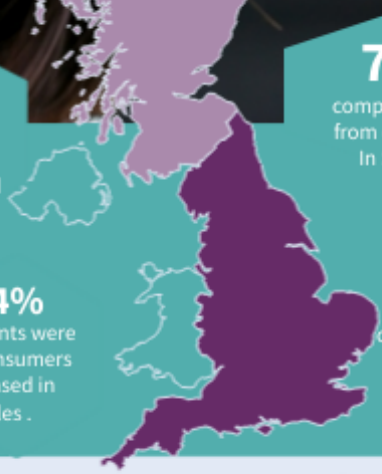
As detailed in this report, the OCCS also prioritises upstreaming and insight sharing work to ensure trends and analysis support improved standards of practice, effective consumer communication and confidence in optical professionals to meet and even exceed, the evolving needs of consumers accessing eye healthcare in the UK.

The activities of the OCCS also seek to strengthen consumer trust and confidence in optical professionals, and greater understanding of the regulatory role of the GOC and complaint redress landscape by GOC registrants.

For further details about the OCCS visit opticalcomplaints.co.uk and follow our social media channels

# Executive Summary

Overview of the OCCS activity and insight from 1 April 2024 to 31 March 2025



**1%** complaints were from consumers based in Northern Ireland

**7%** complaints were from consumers In Scotland

**88%** complaints were from consumers in England

**4%** complaints were from consumers are based in Wales .

The number of complaints received in 2024-25

**1679**

-4.4%

**95%** complaints were consumer related & in remit

**86%**

Complaints resolved within the OCCS process

**GOC - OCCS interaction**

- GOC referrals to OCCS: 135 (27% enquiries)
- GOC investigations opened: 137 (27% enquiries)
- OCCS referrals to GOC: 7 (0.4% OCCS activity)

- Local Resolution 65%
- Practice Advice 6%
- Mediation 18%
- + Consumer not pursuing matters 11%

**93%** considered the OCCS to be helpful and efficient (+3% YoY)

**88%** were satisfied with the OCCS process (+8% YoY)

**8.7/10** overall satisfaction (-% YoY)

**83%** were satisfied with the outcome (+7% YoY)

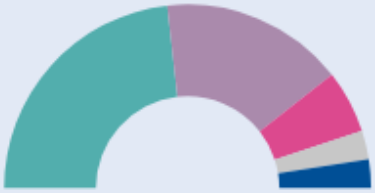
## Insight sharing & upstreaming

75 CPD events hosted across the UK

## Feedback

**More than 9-in-10** consumers would recommend the OCCS

## Nature of complaint

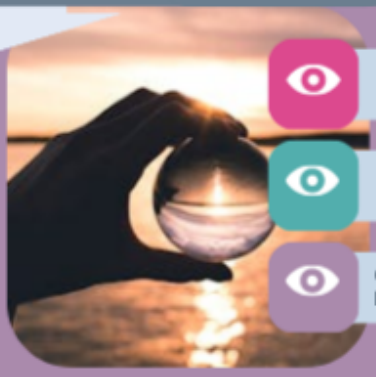


- Goods & services (46.46%)
- Customer care (32.32%)
- Product (11.11%)
- Other (5.05%)
- Charges (5.05%)

## Complaints relating to:

- Independent practices (22%)
- Franchise or JVP (41%)
- Multiples (34%)
- Other & NHS (3%)

## Most common complaints referred to the OCCS



- Prescription issues
- Frame related
- Dispensing
- Customer care on dispensing
- Complaint handling

### 1 Complaints regarding expectations of an eye examination have doubled this year

On analysis, some of the increase appears to be driven by greater consumer awareness and higher expectations of the eye examination appointment, particularly in relation to the time available to discuss concerns or worries, and the inclusion of OCT and other elements.

### 2 Improved resolution rate in refractive surgery complaints

A higher proportion of these complaints are coming through to mediation, however along side this is an improvement in resolution rates so overall more consumers are benefiting from using the OCCS and achieving an acceptable outcome.

### 3 Increase in complaints relating to domiciliary eye healthcare fall

53 complaints relating to domiciliary were received by the OCCS, representing a fall from the significant increase (98) seen last year and a return to similar levels received in 2023 (42). Activity in this area remains higher than in pre-pandemic years.

## The OCCS team

As announced earlier in the year, Richard Edwards retired from his role as Clinical and Strategic Advisor to the OCCS after 10 years with the service. Richard made a huge contribution to the work of the OCCS and in particular, the upstreaming and insight sharing work of the service, and we wish him a wonderful retirement!

The OCCS is delighted to welcome Paul Chapman-Hatchett to the team, and following a transitional period alongside Richard, Paul is now supporting the OCCS, sector and consumers as our Clinical Advisor

For more details about the team visit: opticalcomplaints.co.uk/meet-the-team

# OCCS objectives 2024-25

## Progress overview

Leverage OCCS data and trends to drive continuous improvement across the optical sector, providing clear, evidence-based insight that informs best practice and enhances complaint resolution strategies.

Continue to support the GOC in embedding and evolving efficient, fair, and proportionate case-handling processes, ensuring alignment with PSA performance standards and strengthening public confidence in regulatory outcomes.

Enhance the accessibility and inclusivity of OCCS services for all users, with a specific focus on those who are neurodiverse, disabled, or made vulnerable by their circumstances, to ensure equitable access to mediation and fair complaint outcomes.

Contribute to the continued development and practical implementation of business regulation in optics, engaging with the GOC's reviews of both individual and business standards to support clarity, compliance, and the role of regulation in complaint redress.

# OCCS Activity

Between 1st April 2024 and 31st March 2025, the OCCS received a total of 1,679 complaints, with 1,594 falling within remit. This reflects a slight but meaningful reduction compared to the same period in the previous year, when 1,755 complaints were received, with 1,631 falling within the OCCS remit. The 4.33% decrease in overall complaint volume may attributed to a range of factors:

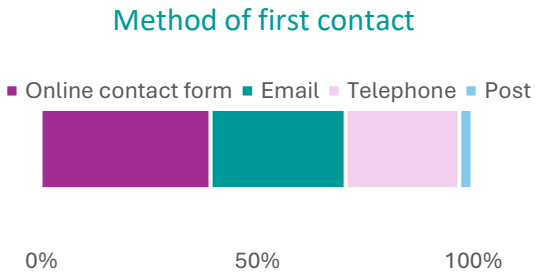
- indicators from practice suggest activity in the sector has been level year on year[1]
- be perceived as a positive indicator, suggesting that improvements across the optical sector, whether it's in communication, customer care, product quality, or expectations management, are beginning to make a tangible difference.

While complaint numbers can fluctuate for a variety of reasons, this trend is particularly encouraging given the ongoing pressures on household finances, which have continued to heighten consumer expectations and scrutiny. It may also indicate that practices are adopting more proactive approaches to handling concerns before they escalate, supported in part by OCCS guidance, resources, and sector engagement.

Importantly, this reduction does not signal a drop in accessibility or visibility of the OCCS—awareness and use of the service remain strong. Instead, it reflects a sector gradually embedding more effective, preventative practices, with the OCCS continuing to play a key role in promoting resolution-focused thinking and upholding high standards across the profession.

### Accessing the OCCS

In 2024–2025, the OCCS continued to provide an accessible, approachable, and flexible service to all users, with multiple channels to ensure people could raise concerns in a way that suited their individual needs and preferences. While the total number of initial contact submissions decreased compared to 2023–2024, this change reflects a broader trend of more targeted and appropriate use of the service, rather than a decline in accessibility or awareness.




Notably, contact via the OCCS website remained the most popular access point, with 345 users choosing this channel, demonstrating that our digital presence continues to provide a convenient and user-friendly route for those seeking help. Although email and phone enquiries decreased, these reductions may indicate that improved clarity on the website and in

[1] Primary Care Network – Future of primary care report

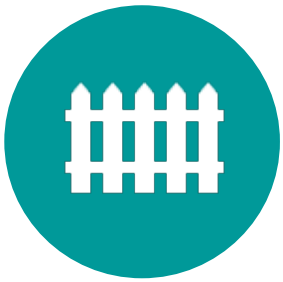
public-facing guidance is successfully helping users navigate the service more efficiently and with greater confidence.

The drop in contact via letter also reflects the growing preference for digital communication, aligning with broader trends in consumer engagement. Throughout the year, the OCCS remained committed to ensuring accessibility for all, including those less confident online. We continue to ensure that, regardless of method, all consumers and professionals feel supported, listened to, and empowered to seek fair outcomes through our service.

## OUTCOMES

The OCCS provides a range of support to facilitate the proportionate resolution of consumer optical complaints. Wherever possible, the OCCS will enable consumers to bring their complaints to the service. There are occasions when the OCCS is unable to assist because no GOC registrant is involved (either individual or business). We are seeing an increase in complaints regarding online providers including those where we cannot identify a registrant.

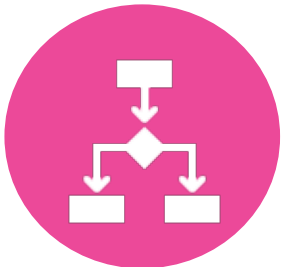
Where a complaint is in remit, the OCCS will encourage and support local resolution by providing initial mediation-based input to help consumers to work with the practice to find an agreeable resolution. If this has been exhausted, the OCCS will provide highly effective resolution support, enabling the consumer and practice to understand the reasons for the complaint and the barriers to resolution to date. Overall, this means that 86% of referrals in remit are resolved within the OCCS process which demonstrates the value of the service for both consumers and optical practices.



**Out of remit, 86 (5% of all enquiries)**

**Practice enquiries, 91 (5% of all enquiries)**

**Supporting local resolution: Advice 473 (29%) Returned to practice 550 (33%)**



**Consumer not to pursue, 167 (10% of all enquiries)**

**Resolved on mediation, 241 (15% of all enquiries)**

**Concluded without a resolution, 49 (3% of all enquiries)**

## Remit

The 2024–2025 reporting reveals continued progress in how the OCCS supports and engages with both consumers and optical professionals. Notably, 95% of all enquiries received fell within remit. This indicates that greater awareness and understanding of the OCCS's role is helping to ensure that those reaching out to the service are doing so at the right time and for the right reasons, enabling more effective and timely resolutions.

| Fig 2. | 2024-25 |
|---|---|
| Out of remit (5% of all enquiries) | 86 |
| Civil claim for compensation | 8 |
| Referred to GOC by OCCS | 7 |
| No GOC registrant involvement | 40 |
| Not a UK practice | 9 |
| Other complaints: | 22 |
| Not an optical complaint | 4 |
| Complaint circumstances or final complaint response over 12 months ago | 8 |
| Other | 10 |

Seven concerns were referred to the General Optical Council, which less than 0.5% of enquiries received by the OCCS. This is consistent with last year, when six concerns were referred by the OCCS. The concerns referred this year included complaints where the consumer felt their concerns should be investigated by the regulator, however it was likely that they circumstances would not amount to an allegation of impaired fitness to practise. In this scenario, the OCCS will explain the role of the GOC and how the acceptance criteria are applied, to help consumer make an informed decision on whether to refer their concern to the GOC.

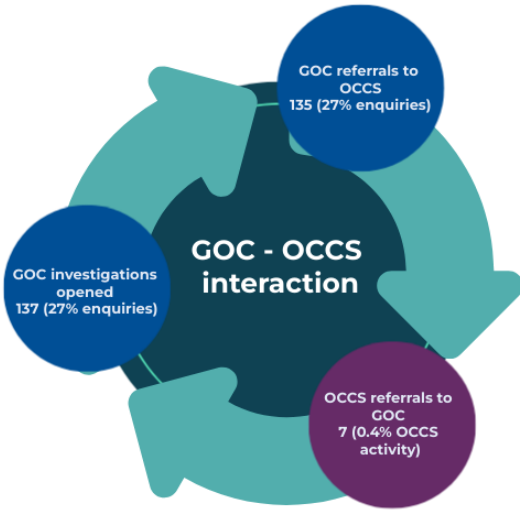
We have also been monitoring referrals which are out of remit and note we have received 75 referrals relating to online providers over the last two years, which fall outside of remit as no registrant can be identified. The OCCS will continue to capture data and insight on this to feed into the business regulation review.

### Collaborating with the GOC Triage Team

The OCCS provides highly effective support to the fitness to practise process within the General Optical Council in that concerns which do not amount to potential FtP allegations are referred or self-triage to the OCCS.

This allows the GOC Regulation team to focus resources on FtP concerns and provides complainants with a resolution-focused pathway to resolve their concerns with the practice.

This year 135 complaints (up from 81 Last year) were referred to OCCS by the GOC Triage team, from a total of 506 concerns received by the GOC, which equates to 27% of all enquiries. This represents a 40% increase in the number of referrals to the OCCS by the GOC between 2023-24 and 2024-25. Earlier referral of these concerns to the OCCS increases the likelihood of the complaint being resolved through the OCCS mediation process and heightens consumer satisfaction.




There will also be referrals which will have reviewed the GOC website and self-triaged to the OCCS, or where the complainant was signposted to the OCCS as part of an early enquiry to the GOC.

The OCCS and GOC Triage teams continue to work collaboratively to support effective triage and ensuring that concerns are handled in the most proportionate forum. This collaboration aims to increase registrant awareness and understanding of the role of the GOC and the impact of the OCCS thereby enhancing consumer confidence and trust in both optical professionals and practices. This also provides reassurance to registrants regarding the GOC's strategic aim to deliver compassionate and agile regulation.

## IN REMIT REFERRALS[2]

### Practice advice

Additionally, 6% of contacts were from optical practices seeking advice, an encouraging 4% increase from the previous year. This modest but meaningful growth demonstrates the OCCS's ongoing success in promoting its advisory function to professionals, encouraging early intervention and equipping practices with the tools to manage and resolve issues locally. This proactive approach not only empowers professionals but also helps to de-escalate concerns before they escalate into formal complaints.

[2] Hereafter percentages refer to the proportion of complaints in remit, rather than all enquiries received.

## Supporting local and early resolution

Notably, 35% of enquiries were identified as matters that were, or should have been, within the practice's own complaint process. These were supported through the local resolution phase, reflecting our commitment to collaboration, early guidance, and reinforcing the importance of local resolution as a first step. This combined effort continues to strengthen complaint handling across the optical sector.

The OCCS team plays a pivotal role at the early stages of complaint handling, working to calm tensions, de-escalate situations wherever possible, and to guide complaints toward constructive resolution. Often, consumers reach out after submitting a complaint with a practice, but they feel dissatisfied with the outcome or the pace. In other instances, they contact the OCCS before raising the issue directly with the practice, seeking clarity and advice on how to proceed. Complaints at this stage, where the matter is still at practice level, remain the most common type of enquiry, consistent with last year's data.

A further 30% of referrals were assisted by the OCCS providing "Advice Only" support, offering insight and direction to assist consumers in their understanding. This advisory function is valuable for both consumers and practitioners as early engagement and clarification help to prevent escalation.

In 2023–24, 11% of enquiries within OCCS remit were categorised as "consumer not to pursue," where individuals chose not to proceed with mediation even after local resolution had been exhausted. This marked a significant improvement, representing a numerical 24% decrease from 2022-23 and a 13% decrease year on year which indicates greater consumer engagement and trust in mediation as a constructive route for resolving complaints. We continue to monitor this as it has been noted that the proportion of consumers with a domiciliary care complaint who do not progress into mediation is slightly higher. This will be monitored and evaluated.

There are several reasons why consumers may ultimately decide not to proceed. Some are seeking an investigative or adjudicative process and may consider alternative routes such as legal proceedings. Others may disengage during the process, choosing not to return the Agreement to Mediate form or respond to further communication. In some cases, initial contact with the OCCS may offer the reassurance or clarity the consumer needed to reach closure independently, without continuing the formal process.

The reduction in non-pursuit cases reflects growing confidence in the mediation pathway highlighting the OCCS's success in providing timely, balanced, and accessible guidance. As the service continues to evolve, ensuring that consumers are well-informed and supported at every step remains central to encouraging full engagement in the complaint resolution journey.

## Mediations

When local resolution has been exhausted or proves ineffective, the OCCS plays a crucial role in facilitating impartial, constructive mediation between consumers and optical practices. This stage of the process is activated once it becomes clear that a complaint cannot be resolved solely between the parties involved. At this point, the OCCS steps in to provide a structured, neutral space where both the consumer's concerns and the practice's position can be discussed openly and fairly, to reach a mutually acceptable outcome.

Between April 2024 and March 2025, 18% of all OCCS enquiries progressed to formal mediation. This figure remains consistent with the data from 2023–24, indicating a steady demand for this deeper level of intervention. The consistency also suggests that while local resolution remains the primary focus and is often successful, a reliable proportion of complaints benefit from further, structured mediation support. These cases usually involve more complex concerns or instances where communication between the parties has broken down.

The outcomes achieved through OCCS mediation are varied and tailored to the specific circumstances of each case. Common resolutions include supporting consumers to return to the practice for a further consultation or assessment, which often leads to adjustments, repairs, or even a replacement product being offered. In some cases, partial or full refunds are agreed upon as a goodwill gesture or in recognition of a service shortfall. Other forms of resolution include the provision of supplementary or complementary products, reinstatement of NHS vouchers, and formal apologies where appropriate.

A particularly valuable aspect of the mediation process is its emphasis on restoring relationships and trust. Rather than focusing on blame, the OCCS encourages open dialogue and realistic expectations, which can lead to outcomes that are satisfactory to all parties involved. This not only resolves the immediate complaint but also supports ongoing consumer confidence in the optical profession.

Mediation through the OCCS is not a one-size-fits-all approach. The process is highly adaptable, informed by the unique needs of the consumer and the professional, and delivered by a team skilled in both the optical sector and mediation techniques. Every resolution is the result of careful negotiation, empathy, and a commitment to fairness.

The fact that over 80% of complaints progressing to mediation are resolved demonstrates the OCCS's readiness to step in when needed and to provide a robust mechanism for addressing more entrenched complaints. As pressures on both consumers and practices continue, whether due to economic conditions or evolving expectations, this impartial and supportive service remains vital.

Overall, the mediation service offered by the OCCS remains an essential part of the complaint resolution pathway, ensuring that even the more complex or unresolved matters are given the time, care, and structure necessary to achieve fair and practical outcomes.

By combining deep knowledge of the optical sector with professional mediation techniques, the OCCS team can offer practical and impartial support from the very first point of contact. Where local resolution proves ineffective or breaks down, the OCCS can step in more formally, progressing the matter to full mediation and helping both consumers and practices work toward a fair and balanced outcome. The day-to-day contact with practice teams underpins the CPD and session work we do to prepare and equip optical professions, and in turn assist practices to deliver high standards of customer and patient care. Emphasising that only 2% of the cases that come to the OCCS conclude the process without a resolution, the sessions highlight to optical professionals that the mediation team are highly effective, and also if registrants take on board some of the complaint management skills (Using AERO framework to manage complaints), they will be able to resolve these lived experiences issues themselves and they will never reach the OCCS.

## OCCS IMPACT

### Resolutions

Many consumers who contacted the OCCS expressed a strong desire for an apology from the optical practice as a key part of resolving their complaint. For many, the call for an apology stemmed not only from dissatisfaction with the product or service received but also from the emotional impact of how they were treated, often citing poor communication, feeling dismissed or disrespected, or being accused of dishonesty. Apologies were seen to acknowledge distress, rebuild trust, and restore dignity, particularly for long-standing or vulnerable patients who felt let down by the practice.

Others sought an apology for administrative failings, missed appointments, delays, or receiving incorrect or misleading information, especially when these issues had tangible consequences such as affecting vision, causing financial loss, or leading to unnecessary stress. In many cases, people also requested apologies from specific staff members, reflecting the personal nature of their grievances.

Ultimately, the desire for an apology often reflected a broader wish for accountability, empathy, and recognition of the inconvenience, upset, or harm caused. While the OCCS cannot compel practices to apologise, many consumers saw it as a vital gesture of goodwill and a necessary first step toward resolution and closure.

Overall, the similarities with last year's data indicate that resolution rates have remained relatively stable, even amidst a growingly challenging economic environment. This consistency makes the close rate all the more meaningful, highlighting the OCCS's ability to deliver successful outcomes despite external pressures. Sustaining such performance in the face of economic uncertainty is a testament to the service's resilience and continued effectiveness.

## Timescales


Average number of days – ALL receipt to conclusion


Average number of days – Mediated complaints


Average number of days – Mediated refractive eye surgery complaints

OCCS's ability to resolve matters swiftly, despite the growing complexity of cases and ongoing societal and financial pressures on consumers and practices alike.

Looking specifically at mediated cases, the average resolution time has also improved slightly, now standing at 69 days, down from 71 from last year. This subtle reduction suggests greater effectiveness in managing more intricate disputes without sacrificing the quality or fairness of outcomes.

For refractive surgery-related complaints, which often involve clinical details and higher emotional stakes, the data shows strong consistency: the average resolution time is 97 days, up 2 days on 2023-24. These timelines are linked to the refined mediation process used in refractive surgery related complaints, more complex nature of the issues involved, and the level of information shared by consumers and practices.

Overall, this refined dataset confirms the OCCS's continued dedication to swift, balanced, and consumer-focused complaint resolution.

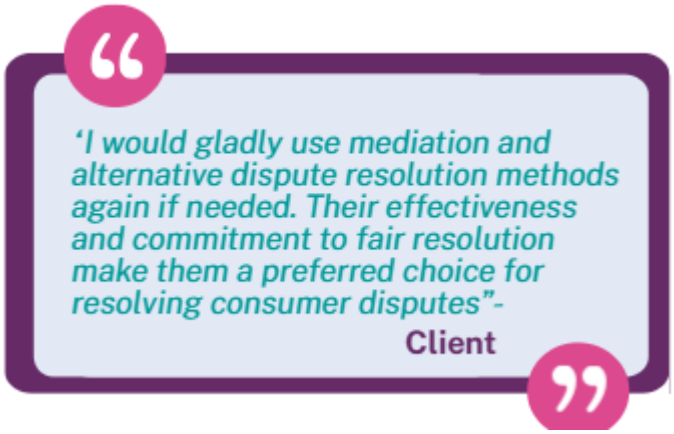
## OCCS Feedback

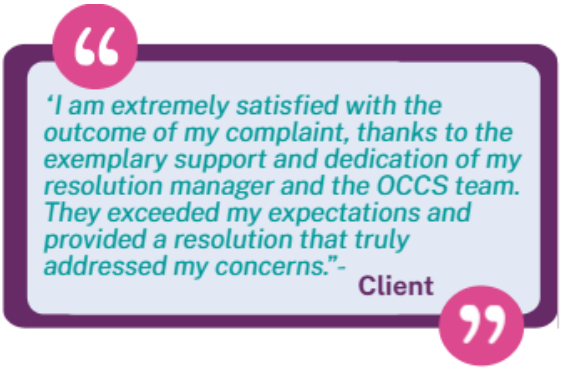
The OCCS uses a range of methods to request feedback on the service experience.

- Short, accessible surveys to all service users which consumer mainly utilise to provide feedback. Response rates were 12% in 2023-24, a decrease of by 2%. The OCCS continues to refresh the survey content and style to seek to improve the response rate; however, for a non-incentivised feedback method, 5% is the lower end of the response rates.


- Stakeholder meetings including with Defence Bodies such as AOP and FODO;
- Regular meetings with businesses operating multiple practices.

Service users also contact us via email to share feedback. Here are some examples:



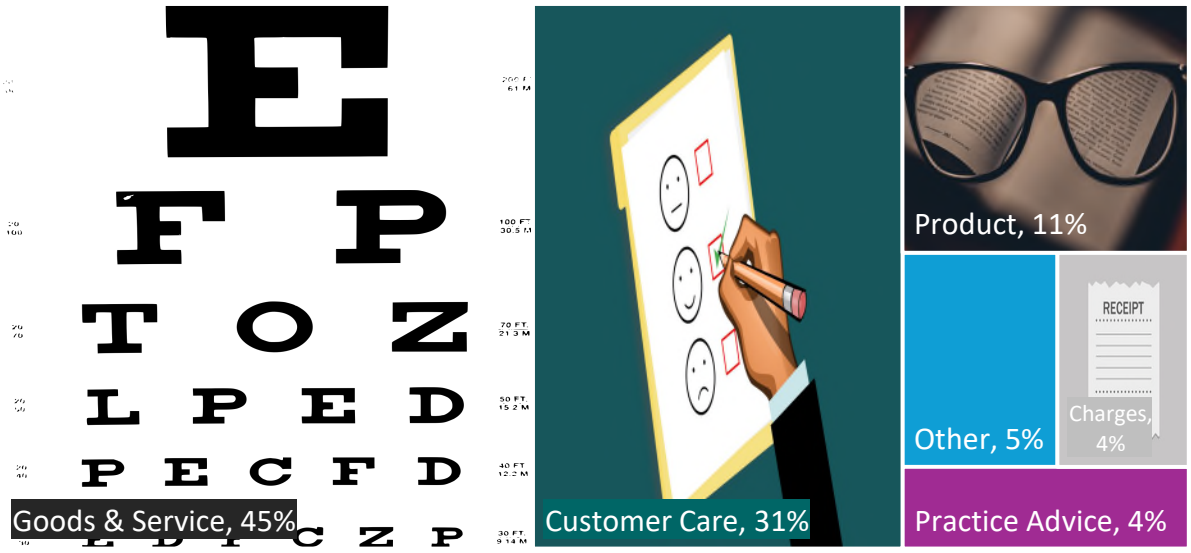



# Complaint insight

Of the complaints that were resolved through mediation between 2024 – 25, the largest share was attributed to the category of Goods & Services. In total, complaints of this nature represented 46% of the total number of complaints received. Similar to last year, this datapoint suggests the ongoing effects of the cost-of-living crisis. More specifically, a greater number of people complaining over goods and services suggests that there is a lower tolerance for imperfections and a higher expectation than there was before.

## OCCS MEDIATION INSIGHT

### NATURE OF COMPLAINT




When considering the concerns raised in the different complaint categories:

- 23% of complaints relate to the consumer perception of the service delivery (up from 19% in 2023-24)
- 21% of complaints relate to concerns about the eye examination itself (18% in 2023-24)
- 25% of complaints relate to the dispense stage of the consumer interaction (26% in 2023-24)

The five most common scenarios referred to the OCCS in 2024-25 were:

1. Consumer considers there to be an error with the prescription (207)
2. Practice not dealing with the complaint (182)
3. Dispensing (145)
4. Complaint regarding the spectacle frame (96)
5. Dispensing optician customer care (77)

## Analysis – clinical and optometric concerns

During 2024-25, the OCCS has seen an increase in complaints regarding:

- Cataract related complaints have increased by 70% (from 7 to 23, which is a statistically significant increase). This may be as a result of an increase in ophthalmology NHS departments and also private providers. These complaints are often linked to communication and, in particular, the treatment threshold variances in NHS criteria and where private providers may apply different thresholds, so are surgically treating cataracts at an earlier stage.

- Concerns regarding the eye examination, including expectations of the sight test and time available, have nearly doubled in the last year. This increase has been seen across all parts of the sector. On analysis, some of the increase appears to be driven by greater consumer awareness and higher expectations of the eye examination appointment, particularly in relation to the time available to discuss concerns or worries.

- Complaints relating to the perceived or actual accuracy of the prescription provided accounted for around 12% of the complaints referred to the OCCS. Analysis indicates these complaints involve situations where a returning consumer is advised to persevere, however research [3]suggests that in 80% of situations, there is an underlying prescription issue, rather than a matter of non-tolerance or adjustment. The OCCS intends to focus on this in forthcoming insight-led CPD sessions.

- Diagnosis related complaints have also increased statistically in 2024-25 (from 25 to 48) which represents a return to levels seen in 2022-23. This is still 25% lower than the peak in 2021-22 when we saw 63 diagnosis related complaints. These relate to referral pathways, categorisation (urgent or routine referrals) and referrals made where the ophthalmology subsequently reassured the consumer that all was well.

  Misdiagnosis, while rare, is one of the more serious concerns brought to the OCCS, as it can relate directly to a consumer's eye health and long-term well-being. Consumer satisfaction in this type of complaint highlights the value in enhancing communication focus in clinical training, better use of diagnostic technology, or more robust internal procedures for escalation and referral within practices. It may also indicate a greater emphasis on patient education, ensuring that consumers have a clearer understanding of their condition and the limitations or scope of an optometrist's role.

  The increase in diagnosis concerns is driven by more glaucoma and retinal detachment concerns and an increase in miscellaneous issues. Only two complaints related to macular degeneration, and this included a situation where the consumer was reassured, they did not have AMD. The 'Macular

[3] Beesley J, Davey CJ, Elliott DB. What are the causes of non-tolerance to new spectacles and how can they be avoided? Ophthalmic and Physiological Optics. 2022;42(3):619–32.

Spectacular' initiative, informed by OCCS insight, is now in its third year, and it is pleasing to see the impact continue.

The analysis suggests a positive trend: consumers are becoming more confident in identifying and raising issues that directly impact their vision and quality of life. This increased reporting may also reflect heightened awareness of their rights, as well as greater trust in the OCCS as a safe and impartial space to raise concerns. They also underscore the importance of effective communication, clear expectation setting and patient-centred care in optical services. While these complaints can be complex, they offer valuable opportunities for learning and service improvement across the sector.

While the OCCS does not assess the clinical accuracy of care, its role in facilitating open dialogue helps to rebuild trust and clarify expectations where misunderstandings occur. This decline in misdiagnosis complaints is a welcome trend and reflects the optical sector's commitment to maintaining high clinical standards and patient-focused care.

The OCCS continues to use its sector insight to support both consumers and practices in navigating these sensitive issues, ensuring that concerns are addressed through careful mediation and, where possible, resolved at a local level.

We continue to address the majority of these complaints through referral to practice with preliminary mediation, advice and local resolution support. Insight from discussions with consumers who refer their diagnosis concerns to the OCCS indicates that consumers reach out to the OCCS as they are seeking external reassurance and support to obtain clarification or an acknowledgement from the practice that there was an issue with the diagnosis or the pathway. For many consumers, they are anxious about their health and sight, and the situation is exacerbated when the communication and explanations do not meet their expectations or needs.  All the mediations involving complaints

Complaints in this group which fall outside of remit were a combination of consumers wanting to refer the matter to the GOC or where there are allegations of negligence and resulting harm, which gives rise to a legal claim. These were signposted and provided information to help the consumer to obtain independent legal advice in their local area.

### Analysis – complaints involving refractive surgery see a significant increase in successful mediations

The number of complaints relating to refractive eye surgery has remained consistent with last year. Historically, these complaints taken longer to resolve and had a lower resolution rate due to the nature of the issues involved. Where the complaint involves allegations of harm or impaired vision, the complainant is sign posted as the OCCS does not mediate complaints involving clinical negligence allegation and harm. The service does mediate consumer related issue and concerns regarding a refractive surgery provider who is a GOC business registrant. This year has seen a significant increase in the success rate of mediations up from 56% in 22/23 to 89% in 2024-25.  This is a testament to the input of all parties involved and a commitment to finding an agreeable solution for complainants.

## Analysis – complaints involving contact lenses

In 2024-25, the OCCS saw a statistical increase in complaints involving contact lenses, up to 24 from 6 in the previous year. % in 22/23 to 89% in 2024-25. On reviewing, the increase was attributable to a change in supplier by a multiple provider in early 2025. This came to the OCCS team's attention, and the OCCS sought to provide information and guidance to consumers and liaised with the provider to ensure consumers were informed and remedial action in hand.

## Analysis – dispensing related complaints

While complaints regarding dispensing overall are largely level, year on year, complaints involving the dispense of varifocal lenses fell by 81% year on year. OCCS CPD has historically focused on how to minimise complaints in this area. Ongoing insight sharing will include further insight on effective communication and in particular helping eye healthcare professionals to approach conversations with consumers where the complainant is seeking a refund or lens change.

## Analysis – customer care and lived experience complaints

The way in which eye healthcare is delivered and the consumer perception of that service sits at the heart of customer care related complaints referred to the OCCS. In recent years all sectors have reported an increase in attitudinal and service complaints. In 2024-25, the OCCS received fewer complaint regarding after care, general attitudes, complaint handling and optometrist customer care. There was an increase in customer care by dispensing opticians, but it should be noted that this was a new category added in 2023-24 so year on year comparison must been seen in that context.

## Analysis – complaint insight by business types

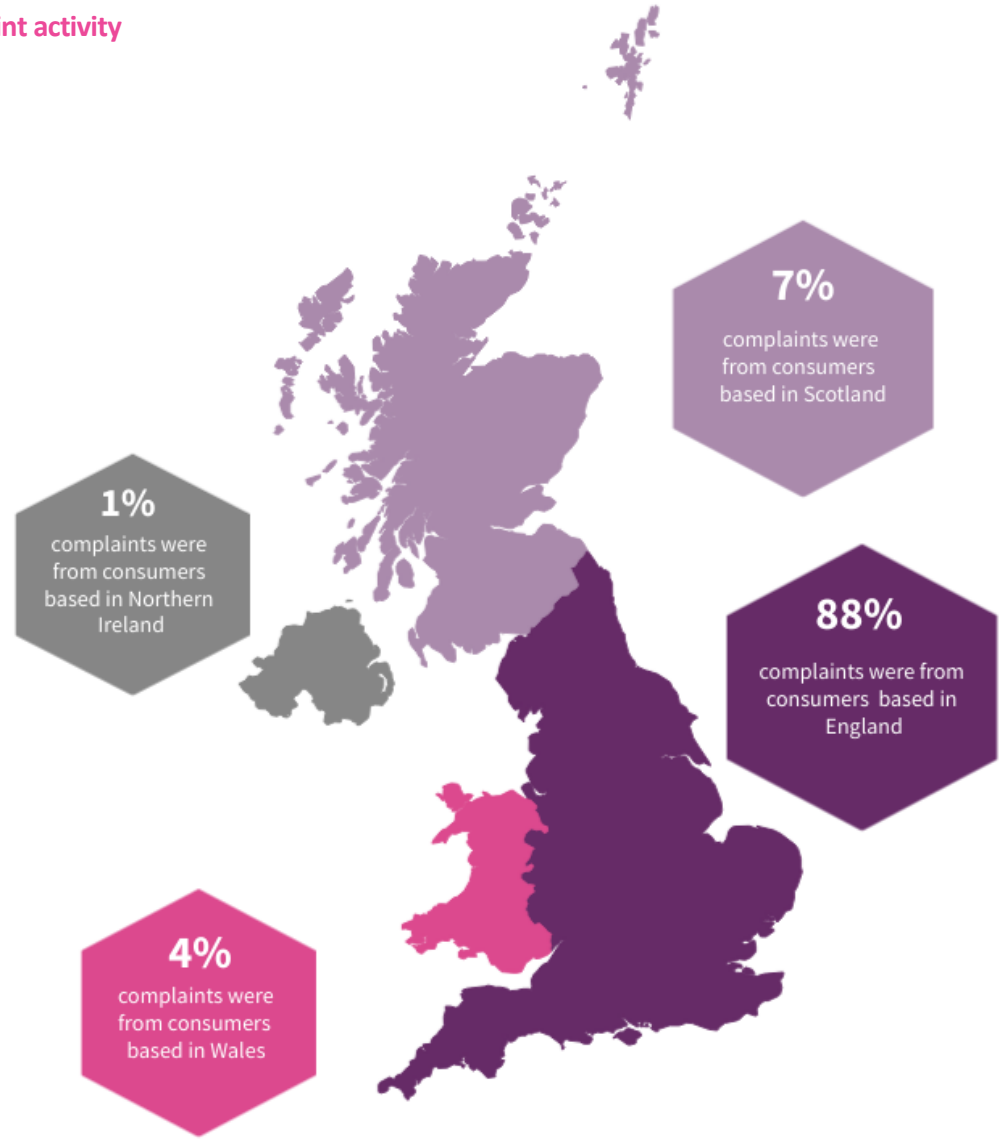
The nature of complaints referred to the OCCS based on business type is generally aligned with market share and overall complaint circumstances. Over 50% of the Practice enquiries were received from practices in the independent sector, which is to be expected given the support available central office and professional standards in large multiple practices.

Outcomes by business type do show some variations in how complaints invoking practices from different areas of the sector interact with the OCCS: This year we saw a higher proportion of complaints from multiple practices supported with preliminary mediation and resolved through advice at that stage than in previous years. This is also a higher proportion when compared with independent practice complaint outcomes.

The resolution rates in the final mediation phase of the OCCS process are also higher for practices in larger, multiple groups than in complaints involving independent practices.

Please appendix 4 for full details.

## Regional complaint activity




The OCCS provides complaint resolution for optical complaints arising across the UK. The service has handled complaints from all four nations during 2024-25 which is closer to the national population distribution compared with previous years.

The service continues to engage with stakeholders across the UK to ensure national awareness and to enable the OCCS team to remain fully informed of UK variations in pathways and NHS interactions.

## OVERALL INSIGHTS

### Price Sensitivity

In the context of an ongoing cost-of-living crisis, price sensitivity has become an overarching theme that ties together the trends and data we've observed across the OCCS. When household budgets are squeezed or consumer confidence more fragile, every purchase, especially healthcare-adjacent products like eyewear, comes under intense scrutiny. Consumers are less inclined to accept "reasonable" industry outcomes and more likely to challenge any expense they perceive as unjustified.

This heightened focus on value is reflected in several key metrics: overall complaint volumes fell by 4.33% year-on-year as consumers seem to reserve formal complaints for issues they deem truly significant; prescription-error concerns rose from 183 to 230, suggesting that even minor perceived inaccuracies in a paid-for service prompt formal challenge; meanwhile, misdiagnosis complaints have almost halved over two years, indicating both improved clinical standards and perhaps greater consumer selectivity about when to engage the complaints process, along with improved communication in practice.

Price sensitivity also influences how consumers access the OCCS. Digital channels saw robust usage, yet email and phone inquiries dropped markedly, an indicator that consumers are using the website's self-service guidance to resolve questions quickly, without incurring further costs (time or potentially paid-for legal advice). The sharp reduction in "consumer not to pursue" cases—from 10% to 9%—underscores that those who do engage expect tangible value: an apology, a refund, or service adjustment.

Behind the scenes, the OCCS's 86% resolution rate and a steady median resolution time with the 14-day timeline, demonstrate a commitment to cost-efficient, high-quality outcomes. By combining data-driven insight with flexible mediation techniques, the service supports both consumers and practices under pressure to control costs while maintaining satisfaction. Ultimately, as price sensitivity continues to shape consumer behaviour, the OCCS's role in delivering swift, fair, and transparent resolutions has never been more critical to sustaining trust and value in optical care.

### Complaints involving online suppliers

In the last two years, the OCCS has received 75 complaints relating to online suppliers. The OCCS has been unable to assist in 55% of those complaints, as the businesses were not regulated and we could not trace a GOC registrant's involvement. In around one third of complaints, the OCCS did assist with advice and helped the consumer to raise their complaint with the provider. 5% of consumers did not proceed further, and we were able to mediate 9% of complaints (with 5 successfully resolved and 1 concluding without resolution).

The OCCS has analysed the status of the online providers as it is likely that online sales will continue to increase. Key points to note are:

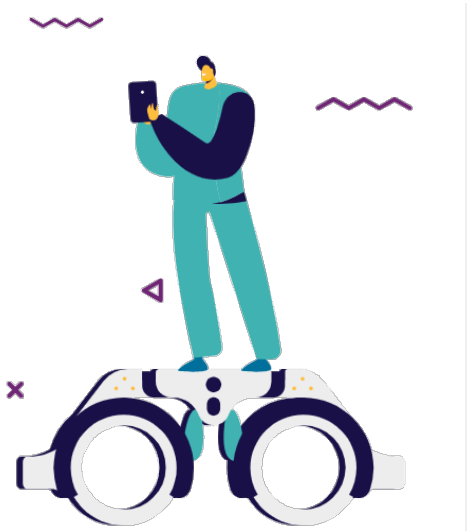
- 24 businesses (which were linked to 51 of the complaints) are registered in the UK. In 19 complaints, the OCCS were unable to identify a GOC registrant.
- There is no GOC registrant involvement in 6 of the UK businesses. These 6 businesses account for 19 complaints.
- 3 businesses were based outside the UK (Germany, India and Australia) and represented 4 complaints.

The OCCS will continue to share insight on this area of activity with the GOC to feed into the consultation and review of business regulation. It is noted that regulation of businesses registered outside the UK may not be possible, subject to the details and requirements for businesses to be regulated by the GOC based on activity rather than business title.

Some providers are owned or linked to optical business that already interact with the OCCS. The OCCS is seeking to develop channels of communication with online providers to gain a greater understanding of their structure and willingness or ability to engage with the OCCS. The OCCS will continue developing these relationships and encourage the streamlining of complaint resolution in line with in-store best practice pending the updates to business regulation.

Consumer awareness of the redress and regulation could be a subject covered by OCCS insight sharing and consumer facing activity to assist consumers in making informed choice when selecting a provider.

## Communication in Clinical Complaints



The root cause and primary issue in clinical-related complaints has consistently been communication and misaligned understanding of the risk, need for treatment or referral and counselling consumers to aid understanding and the clinical progression of the condition. This once again demonstrates the need and benefits of developing professional confidence and expertise in this area, which minimises unnecessary patient anxiety and professional resilience, a cornerstone of OCCS CPD provision.

For over two years, the OCCS has worked closely with the sector to deliver many CPD session around the criticality of effective communication in the emerging field of myopia management. It is to the great credit of those eye healthcare professionals working in this area that we have seen almost no complaints relating to myopia management. Indeed, in the low number of complaints referred to the OCCS, the concern related to

the myopia being reversed. The concerns appeared to be linked to an overminused prescription at an earlier point. This may be something for ECPs (Eye Care Professionals) to be wary of at initial prescribing. That said new research published in The American Journal of Ophthalmology (Vol 269 P60-68) has identified the best time to treat myopia is before the child becomes myopic and, as such, the issues of overminused prescriptions becomes somewhat moot.

## OCT and tech interpretation

One area to note is the continuing trend of complaints relating to the interpretation of OCT scans. It is essential that registrants maintain their skills in this area of clinical practice. This is particularly important for mobile or locum practitioners who may use different models of OCT on a regular basis. It is a registrant's responsibility to make sure they are familiar with the equipment, and competent in the analysis of their OCT scans.

The OCCS is considering whether there is an opportunity to use the OCCS platform to highlight consumer expectations and complaint insight to inform discussions the scope of the NHS eye examination and sight test.

## Domiciliary

As highlighted in previous annual reports, the OCCS continues to monitor complaints involving in domiciliary eye health care.

The complaints involving domiciliary eye healthcare received by the OCCS dropped from 98 in 2023-24 to 53 this year. This returns activity in this area to a level more consistent with 2022-23 (42) after a significant increase last year (98). Activity does remain around 40% higher than the average between 2021-2023, 32 per year).

It is noted that consumers in these complaints are more likely not to pursue their complaint through to mediation (13% compared with 10% overall). This will be an area of analysis and focus for the OCCS in the coming year as it is essential that consumers accessing care in this way are supported to raise concerns and seek resolution when necessary. Analysis suggests this data may be impacted by circumstances where residential care home managers raise concerns on behalf of residents and may not then continue for various reasons including staff turnover. The OCCS has liaised with care home providers as part of outreach and awareness activities, as well as in individual complaints to improve and maintain access and engagement.

We continue to develop relationships and raise awareness of the service in this sector and with consumer representatives/support organisations to reduce barriers to complaining through improved awareness and access to the OCCS. Consumer accessing eye healthcare in their homes may be vulnerable, and both the

OCCS and the sector more widely need to be vigilant in all areas of practice and conduct. We welcome the significant reduction in complaints in this area but continue to monitor and share intelligence with the General Optical Council and the NHS where we identify potential concerns about conduct or professionalism. This is important to ensure there is a feedback loop and cross-organisational awareness of what can appear to be isolated, low-level issues when not seen in the wider context.

### Commercial Pressure & Workplace Culture

There has been considerable interest in workplace culture, as well as commercial pressure this year. Data from the extensive OCCS database shows a reduction in complaints where the substantive issue is an allegation of overselling from 18 to 14. This now represents less than 1% of OCCS workload.

We continue to see very challenging impact due to the financial pressures on household incomes and practice operating costs, which result in both parties to a complaint being more financially aware and focused on this time. We will support the GOC's work in this area through ongoing insight sharing and analysis of qualitative responses.

## CONSUMER INSIGHT

The OCCS has prioritised efforts to enhance accessibility for individuals who may require adjustments or tailored support to engage fully with the service. Further information on these initiatives can be found in the appendix.

As part of its impartial mediation process, the OCCS does not collect Equality, Diversity, and Inclusion (EDI) data relating to individual optical professionals. This is because complaints are typically handled at a practice level, rather than focusing on one-to-one interactions with specific staff members. Mediation is framed around the relationship between the consumer and the optical practice as a whole, ensuring a fair and balanced approach to resolving concerns.

This year, the OCCS has been developing further relationships with consumer stakeholders and representative groups. Public-facing initiatives are planned for 2025-26 and beyond, which will seek to raise the awareness of the OCCS. The aim is for consumers to feel empowered to raise dissatisfaction and to escalate their concerns to the OCCS if matters are not resolved to their satisfaction. It is noted that consumers deciding not to progress into mediation is slightly higher amongst consumers raising concerns about domiciliary care. This will be closely monitored by the OCCS, and steps will be taken to improve access and engagement.

Evaluating and improving accessibility for all consumers and optical professionals is a strategic objective for the OCCS. Over the past 12 months, the OCCS has been developing relationships with key contacts in consumer stakeholder groups and with groups who can support consumers who may be less inclined to

raise a concern or to contact the OCCS. Plans for activity during 2025-26 are developing with some focused collaborations with national charities to also assist with 4 nations variations in terms of NHS care and availability of care.

## REFLECTIONS OF THE OCCS TEAM

*We have seen complaints relating to the diagnosis of cataracts increase this year, with consumers expressing concerns about the condition's impact on their ocular health and lifestyle. In these complaints, it appears that there is often a misinterpretation or misunderstanding of what a cataract is, its current stage, and its progression. This seems to lead to increased anxiety and the consumer seeking a second opinion, often incurring additional consultation fees. Recognising that a consumer may be unfamiliar with these conditions is important. There should be an opportunity to ask questions and be reassured during their visit. It is vital that the consumer feels confident and comfortable returning to the practice should they have any concerns.*

*We do continue to see Domiciliary complaints and inquiries from vulnerable people, the elderly or disabled, living alone or in care homes, although fewer than in the previous year. They often describe feeling isolated and unheard and seek more effective and prompt communication from the practice. Frequently, we hear that consumers think something hasn't been explained clearly to them or their own needs or vulnerabilities had not been taken into account. Domiciliary visits can be challenging, and consumer feedback suggests that allowing extra time to process information, providing clear written information, and offering supportive aftercare will enhance consumer satisfaction and understanding.*

*A consistent trend over the last few years shows that the cost-of-living situation continues to impact consumers and their expectations of a reasonable offer to resolve the complaint."*

**Rachael Brennan, Resolution Manager**

*"I, personally, had just not fully understood the incredible value OCCS brings to consumers as well as registrants, how amazing and effective the mediators are and the potential that OCCS CPD has to enhance consumer journeys through their optical experiences.*

*I am also now aware of the importance of continuing to strengthen the relationship with GOC, it is clear that by taking 27% of GOC queries away from them, is beneficial all round, ensuring the GOC fulfils its responsibilities more effectively and registrants know that only appropriate investigations remain in the GOC process, maintaining and nurturing the trust of this relationship is very important"*

**Paul Chapman Hatchett, Clinical Advisor**

# Stakeholders and Engagement

## KEY STAKEHOLDERS

### Professional bodies and NHS

We continue to host annual review meetings with key sector stakeholders, including the NHS and large employers, to share insights and facilitate action to improve consumer outcomes. Building on this established and valued series of meetings, we have developed this to ensure up-to-date knowledge of NHS pathways and engage with four nations stakeholders so as to ensure the OCCS is tuned in to the diverging agendas impacting practices across the UK. This has enabled us to understand local variance better and shape our interventions accordingly.

### Consumer organisations

During 2024-25 the OCCS has been building and strengthening relationships with a range of consumer bodies and representative groups in order to raise the profile of the service and to obtain their input to our process and insight sharing to benefit the consumer groups they represent. This has focused on organisations that represent consumers more likely to be vulnerable either for situational or characteristic reasons.

This activity has included contact and information sharing with care home providers and representatives to support our wider work and individual resolutions in domiciliary eye health care complaints.

These activities will continue in 2025-26 and beyond, where discussions and plan, this year will lead to more public-facing activity.

### Insight sharing – Developing a learning culture & driving improvement

We delivered a record 75 CPD sessions in 2024-25 to thousands of registrants with consistently high feedback (range from 96 to 100%). We are delighted to see a post-pandemic movement by many of our CPD partners away from online delivery to increasingly in person events.

We continue to deliver CPD content at national industry conferences such as 100% Optical, National Optometric Conference & Association of Optometrists events as well as large corporate sector events to sustain our profile and carry the message of FTP change & improvement to educate and engagingly reassure registrants, receiving overwhelmingly positive feedback. The reassurance we can give registrants that the sword of Damocles is not an ever-present threat to them, and this is always well received (unsurprisingly!). This helps registrants to understand the GOC's work to deliver compassionate regulation.

We continue to work in partnership with many and varied organisations to create & deliver new CPD content. This year, we have stepped up our work co-creating and delivering CPD content with FtP team to disseminate insights, themes, and trends from historical FtP cases to frontline practitioners. We have also broadened the CPD proposition this year into IP and tele-optometry sectors and continued our contribution to post reg Paediatric optometry programme.

Last year we reported on our creation of a Year Two customer care/complaint management/ communication skills module with a UK Optometry Undergraduate Programme and our willingness to make this available to UK undergraduate programmes. Disappointingly, only the original University who initiated this work have used this module. The OCCS is looking to build bigger relationships with UK academic institutions in the future.

The above project also aligns with an initiative to work collaboratively with the GOC FtP team in delivering awareness and insight sessions to students. There are currently plans to launch these in 2025/26 academic year so more information on the sessions and their impact will be shared next year.

## DIGITAL ACTIVITY

### Website – opticalcomplaints.co.uk

- Number of visits: 27,510
- Number of new visits: 27,284
- Most popular pages:
    - ‘The right to a refund’ blog
    - Home
    - Contact us
    - FAQs
    - Returns and spectacles blog
- Time spent: Average engagement time 1m 09s

### Social Media

Using platforms like LinkedIn, Facebook, and X (formerly Twitter) offered the Optical Consumer Complaints Service (OCCS) a range of strategic benefits in reaching and engaging its diverse audience.

LinkedIn provides a professional environment ideal for connecting with optical professionals, practice managers, and industry stakeholders. Through LinkedIn, the OCCS continues to share thought leadership articles, insights from annual reports, and updates on complaint resolution strategies as well as CPD events. This helped reinforce the OCCS's role as a trusted authority in the optical sector, fostering both professional engagement and collaboration.

We are looking to build our profile on LinkedIn. We will be having our first CPD promotion on Insta & TikTok. We are also encouraging registrants to spread the word of our CPD events through the various WhatsApp groups they are part of.

We are also looking to see if we can develop more trust of the OCCS (& GOC) though direct contact with registrants, as well continuing to use current offerings through multiples, small chains, and LOC's

Facebook serves as a valuable platform for directly reaching the public and consumers directly. Its broad user base and community-focused nature make it ideal for promoting eye health awareness, sharing consumer-friendly advice (e.g. spotting signs of eye conditions), and encouraging dialogue around complaint processes. Features such as comments, shares, and events allow OCCS to foster trust and accessibility among service users.

X (Twitter) is especially useful for real-time updates, raising awareness around national campaigns (such as World Cancer Day), and highlighting key developments like report releases or partnerships. Its brevity and fast pace make it ideal for bite-sized content and sharing links to deeper resources on the OCCS website.

By actively using all three platforms, the OCCS ensures it maintains a strong presence across both professional and public spheres, supporting education, transparency, and dialogue while enhancing its visibility and impact across the optical sector.

# AND FINALLY….

The OCCS cannot provide an update on 2024-25 without recognising the huge contribution made over the last 10 years by our clinical advisor, Richard Edwards.

Richard joined the OCCS team in 2014, when Nockolds was appointed to deliver the OCCS by the General Optical Council after a strategic introduction at Optrafair in London. Richard has been instrumental in developing the OCCS into the effective and successful service that it is today. In helping consumers and practices to resolve some of our most complex and protracted complaints, Richard had deployed his vast experience in optics to improve the outcomes for so many individual complainants and practice teams. In addition to this, Richard has worked extensively with OCCS colleagues, the GOC team, and stakeholders to evolve a more proportionate and continuous improvement-based approach to complaints and concerns, which has had, and will continue to have a positive impact on the lives of optical professionals and patients for many years to come. Richard's work with the GOC around acceptance criteria, the remodelling of FtP triage and identifying early trends and potential communication 'hot spots' such as in myopia management has contributed to optics regulation being seen as forward looking and agile. The CPD outreach work Richard has delivered over the last 10 years means the OCCS insight has been shared with thousands of optical professionals. This has enabled the OCCS to share the AERO © complaint framework and improve the understanding and confidence in effective complaint resolution as well as the role of the GOC as a regulator.

Jennie Jones, Head of the OCCS shares her reflections on working with Richard:

*"Working with Richard and witnessing first-hand the impact he has had on the sector is one of the highlights of my professional career so far. Richard is indeed a 'special one' in that he combines humour, warmth with strategic intellect that always keeps the end in mind and people at the centre. I will miss working alongside Richard's wisdom, his football analogies as well as the focus and drive that are part of Richard's DNA. Thank you, Richard, from all of us at the OCCS, all the consumers and practice colleagues that you have interacted with and stakeholder colleagues. We have all benefited hugely from your work in optics not only over the last decade, but across a long and successful career. Thank you for the parting gift of helping us to introduce Paul Chapman-Hatchett to the OCCS Clinical Advisor Role. Enjoy some well-deserved fun!"*

The OCCS would like to wish Richard a long, happy and fun filled retirement.

# Conclusion

*Altogether, the OCCS's current strategy effectively addresses the informational needs of both consumers and optical professionals. By focusing on eye health education, complaint resolution, professional development, and sector innovation, the OCCS reinforces its role as a pivotal resource in the optical industry. The service continues to look to the future, evolving and developing to provide effective complaint resolution and upstreaming, as required for the delivery of eye healthcare and regulation of optical professionals over the next five to ten years and beyond.*

## OCCS objectives 2025-26

1. Leverage OCCS data and trends to drive continuous improvement across the optical sector, providing clear, evidence-based insight that informs best practice and enhances complaint resolution strategies.

2. Continue to support the GOC in embedding and evolving efficient, fair, and proportionate case-handling processes, ensuring alignment with PSA performance standards and strengthening public confidence in regulatory outcomes.

3. Enhance the accessibility and inclusivity of OCCS services for all users, with a specific focus on those who are neurodiverse, have disabilities, or made vulnerable due to their circumstances, to ensure equitable access to mediation and fair complaint outcomes.

4. Contribute to the continued development and practical implementation of business regulation in optics, engaging with the GOC's strategic aims and to support clarity, compliance, and the role of regulation in complaint management.

5. To increase CPD training and upstreaming work across the sector, to include complaint handling, key themes and trends and improving registrant understanding of the role of the regulator and the optical complaints landscape.

   This will include an analysis of the impact of the outreach work to raise the OCCS profile.

# Appendices

**APPENDIX 1**

# OCCS process

The OCCS uses mediation techniques to help consumers and optical practices to resolve consumer complaints

Further details are available online at opticalcomplaints.co.uk or by contacting a member of the OCCS team

1

**Remit**
The complaint circumstances are reviewed to ensure the matter falls within the OCCS remit. If outside remit, the consumer is signposted with advice. FtP allegations are referred to the GOC.

2

**Supporting local resolution**
If the practice's complaint procedure has not been exhausted, the OCCS will assist with preliminary mediation and de-escalation. The complaint may be resolved with advice or referred back to the practice for resolution.

3

**Consumer**
If the practice complaint process is exhausted, the consumer confirms they wish to proceed and signs Agreement to Mediate (consent and GDPR)

4

**Mediation**
Matter assigned to a resolution manager for shuttle mediation. Practice contacted and provides relevant information including records and payment details

5

**Resolution**
Agreement is reached and confirmed in Mediation Agreement if appropriate.

6

**Feedback**
All service users are asked to share feedback on their experience and the outcome

7

## APPENDIX 2 - OUTCOMES

| All | 2024- 25 | 2023-24 | 2024-25 % (all) | 2045-25 % in remit |
|---|---|---|---|---|
| **Out of remit** | **86** | **125** | **5%** | **-** |
| **Phase A- Supporting Local Resolution** | **1023** | **1067** | **62%** | **65%** |
| Referred to practice | 550 | 485 | 33% | 35% |
| Concluded with advice | 473 | 582 | 29% | 30% |
| **Client not to pursue** | **167** | **190** | **10%** | **11%** |
| **Resolved on mediation** | **241** | **275** | **15%** | **15%** |
| **Concluded without a resolution** | **49** | **73** | **2%** | **3%** |
| **Practice Advice** | **91** | **70** | **6%** | **6%** |
| **Grand total closed complaints** | **1657** | **1800** | **100%** | **1571** |

### Outcomes of GOC Referrals

| | Outcome |
|---|---|
| **Phase A: Supporting Local Resolution** | **53.8%** |
| Refer to practice | 36.6% |
| Advice Only | 17.2% |
| **Client not to pursue** | **25.8%** |
| **Resolved on mediation** | **18.3%** |
| **Concluded without a resolution** | **2.2%** |
| **Grand total** | **100%** |

## APPENDIX 3- NATURE OF COMPLAINT

| | 2024-25 | 2024-25% |
|---|---|---|
| Charges | 73 | 4.3% |
| Customer Care | 522 | 31.1% |
| Goods and Services | 752 | 44.8% |
| Other | 86 | 5.1% |
| Practice Advice | 61 | 3.6% |
| Product | 185 | 11.0% |
| Grand total of received complaints | 1679 | 100% |

### SUB-CATEGORY OF COMPLAINT

| | 2024- 25 | 2023-24 | 2022-23 |
|---|---|---|---|
| **Goods and service** | 752 | **706** | **658** |
| Cataract | 23 | 7 | 2 |
| Concerns with the examination | 70 | 45 | 42 |
| Dispense of Varifocal | 57 | 76 | 112 |
| Dispensing | 145 | 142 | 118 |
| Error with prescription | 207 | 213 | 184 |
| Eye Test | 37 | 6 | 7 |
| Missed diagnosis | 48 | 34 | 44 |
| Outcome of laser eye surgery | 44 | 42 | 40 |
| Outcome of lens replacement surgery | 39 | 37 | 25 |
| Prescription prescribed in one practice and dispensed in another | 53 | 73 | 44 |
| Reglaze- issues with consumers own frame | 12 | 8 | 13 |
| Unknown | 17 | 23 | 27 |
| **Customer Care** | **522** | **532** | **468** |
| After care | 13 | 23 | 20 |
| Alleged inappropriate selling | 20 | 21 | 19 |
| Attitude | 51 | 60 | 68 |

| | | | |
|---|---|---|---|
| Complaint Handling | 75 | 59 | 58 |
| Consumer Change of mind | 28 | 22 | 23 |
| Delay in supply | 52 | 94 | 53 |
| Dispensing Optician Customer Care | 77 | 4 | 2 |
| Excluded from store | 2 | 2 | 6 |
| Failure to deal with concerns/complaint | 107 | 137 | 92 |
| Laser surgery- complaint handling | 12 | 8 | 9 |
| NHS Voucher Query | 7 | 15 | 26 |
| No prescription Provided | 7 | 18 | 17 |
| Non-qualified staff issues | 1 | 3 | 4 |
| Optometrist customer care | 58 | 48 | 52 |
| Pupillary Distance- entitlement | 3 | 2 | 2 |
| Unknown | 8 | 16 | 17 |
| **Product** | **185** | **147** | **104** |
| Contact lenses | 25 | 8 | 5 |
| Product- frames | 96 | 97 | 68 |
| Product- lens coating | 12 | 19 | 19 |
| Product- lenses | 37 | 20 | 8 |
| Unknown | 12 | 1 | 1 |
| Varifocals- quality | 3 | 2 | 3 |
| **Other** | **86** | **81** | **98** |
| Miscellaneous | 68 | 74 | 92 |
| Practitioner Query | 2 | 1 | 1 |
| Prescription- content | 3 | 1 | - |
| Unknown- | 13 | 5 | 5 |
| **Charges** | **73** | **76** | **97** |
| Charges and offers | 73 | 74 | 94 |
| Unknown | - | 2 | 3 |
| **Practice Advice** | **61** | **54** | **55** |
| **Unknown** | **-** | **160** | **148** |
| **Grand total** | **1679** | **1755** | **1628** |

## APPENDIX 4- BUSINESS TYPES

| Complaint Nature | Independent | Multiple/Franchise/JVP |
|---|---|---|
| Goods & Service | 22% | 78% |
| Customer Care | 21% | 79% |
| Product | 26% | 74% |
| Other | 17% | 83% |
| Charges | 19% | 81% |
| Practice Advice | 52% | 48% |

| Outcomes (all) | Independent | Multiples (inc Franchises and JVPs) | Outcome |
|---|---|---|---|
| Out Of Remit | 4% | 3% | 3% |
| Practice Advice | 6% | 3% | 3% |
| Supporting local resolution (total) | 54% | 64% | 64% |
| - with advice | 19% | 27% | 37% |
| - with guidance and referral to practice | 35% | 37% | 27% |
| Consumer not to Pursue | 10% | 9% | 9% |
| Resolved on mediation | 19% | 18% | 19% |
| Mediation concluded without a resolution | 7% | 3% | 3% |
| **Grand Total** | **100%** | **100%** | |

## APPENDIX 5 – CONSUMER EDI DATA

| AGE | OCCS 2024-25 | OCCS 2023-24 | Comparison with National Data |
|---|---|---|---|
| 16-24 | 4% | 2% | 11.7% |
| 25-34 | 11% | 7% | 13.5% |
| 35-44 | 11% | 13% | 13% |
| 45-55 | 22% | 20% | 13.3% |
| 55-64 | 23% | 28% | 12.6% |
| 65 or over | 28% | 29% | 18.5% |
| Under 16 | 1% | 1% | 20.8% |

| GENDER | OCCS 2024-25 | OCCS 2023-24 | Comparison with National Data |
|---|---|---|---|
| Female | 61% | 60% | 50.4% |
| Male | 37% | 40% | 49.2% |
| Non-Binary | 1% | 0% | 0.4% |

| DISABILITY | OCCS 2024-25 | OCCS 2023-24 | Comparison with National Data |
|---|---|---|---|
| No | 72% | 76% | 82.2% |
| Yes | 28% | 24% | 17.8% |

| ETHNICITY | OCCS 2024-25 | OCCS 2023-24 | Comparison with National Data |
|---|---|---|---|
| Asian | 9% | 14% | 9.3% |
| Black | 3% | 4% | 4.0% |
| Mixed | 3% | 3% | 2.9% |
| Other | 5% | 4% | 2.1% |
| White | 81% | 75% | 81.7% |

| SEXUAL ORIENTATION | OCCS 2024- 25 | OCCS 2023-24 | Comparison with National Data |
|---|---|---|---|
| Bisexual | 1% | 2% | 2% |
| Gay | 3% | 2% | 2.7% |
| Heterosexual | 90% | 94% | 93.6% |
| Other | 6% | 2% | 1.7% |
| Prefer not to say | 0% | 0% | Not a category in ONS Census |

| MARITAL STATUS | OCCS 2024- 25 | OCCS 2023-24 | Comparison with National Data |
|---|---|---|---|
| Married | 46% | 51% | 40.7% |
| Single | 32% | 26% | 47.5% |
| Divorced | 6% | 9% | 6.6% |
| Widowed | 7% | 6% | 0.1% |
| Civil Partnership | 3% | 2% | 4.9% |
| Separated | 1% | 2% | Not a category in ONS Census |
| Prefer not to say | 5% | 4% | Not a category in ONS Census |

| RELIGION | OCCS 2024-25 | OCCS 2023-24 | Comparison with National Data |
|---|---|---|---|
| Buddhist | 2% | 0% | 0.5% |
| Christian | 48% | 48% | 46.2% |
| Hindu | 2% | 4% | 1.7% |
| Muslim | 6% | 8% | 6.5% |
| None | 24% | 29% | 37.2% |
| Other | 4% | 4% | 0.6% |
| Prefer not to Say | 12% | 6% | 6.0% |
| Sikh | 1% | 1% | 0.9% |
| Jewish | 1% | 0% | 0.5% |

| REGION | OCCS 2024-25 | OCCS 2023-24 | Comparison with National Data |
|---|---|---|---|
| Wales | 4% | 3% | 5% |
| Scotland | 7% | 6% | 8% |
| England | 88% | 91% | 84% |
| Northern Ireland | 1% | 0% | 3% |

## APPENDIX 6 – SERVICE USER FEEDBACK

| | 2024-25 | 2023- 24 |
|---|---|---|
| Response Rate % | 12% | 14% |
| /10 | | |
| How well did we understand your concerns | 8.8/10 | 8.8/10 |
| How satisfied were you with the outcome | 8.3/10 | 7.6/10 |
| How satisfied were you with the process | 8.8/10 | 7.6/10 |
| Easy to contact OCCS | 9.1/10 | 9.4/10 |
| How would you rate your overall experience | 8.7/10 | 8.7/10 |
| % | | |
| Would you recommend OCCS to others | 91% | 87% |
| Would use OCCS again | 94% | 86% |
| Would use ADR again | 91% | 86% |
| Consider OCCS to be: | | |
| Fair | 80% | 67% |
| Helpful & Efficient | 93% | 90% |
| Productive | 85% | 76% |

**C24(25)i.**

**COUNCIL**

## Public perceptions survey and qualitative lived experience research

**Meeting:** 25 June 2025 **Status:** For noting

**Lead responsibility:** Steve Brooker (Director of Regulatory Strategy)
**Paper Author:** Angharad Jones (Policy Manager)
**Council Lead(s):** There is no Council lead for this work.

### Purpose

1. To enable Council to discuss the key findings from our public perceptions survey and the qualitative research exploring the lived experiences of patients and non-patients accessing and using eye care services.

### 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 2025/26 Business Plan.

### Background

4. As a regulator it is important that we understand the views and experiences of patients and members of the public when accessing and using eye care services. This helps highlight and address any potential issues or risks that may impact on patient and public health and safety, including inequalities of access and experience.

5. Over the past ten years, we have carried out an annual public perceptions survey. This year we commissioned DJS to carry out an online survey of a UK wide representative sample of approximately 2,000 people. The aim is to track trends in areas such as patient/public satisfaction levels, perceptions of opticians/optometrist practices, where to go with an urgent eye care issue, trust and confidence in the professions, and complaints. Since last year we have also focused the survey on collecting data ('vulnerability markers') to identify more vulnerable groups of respondents such as those with financial difficulties, those going through a difficult life event (e.g. bereavement), those with a disability, or those with low confidence in managing their eye health. This has enabled us to drill down further into the experiences of different patient groups.

6. Since we launched the survey back in 2015, the research findings have generally been positive. However, when we look at different segments of the population the data suggests that some groups have less positive experiences. For example, those with a disability or from an ethnic minority background have lower satisfaction levels, and those with one or more vulnerability markers are less likely to have had a sight test/eye examination in the last two years, are less confident in managing their eye health and are also less satisfied when they do access eye care services.

7. These findings prompted us to carry out new qualitative research exploring in greater depth the lived experiences of more vulnerable groups. We commissioned Explain Research to carry out 38 in-depth interviews with individuals who had at least one or more vulnerability markers. We wanted the research to build on the findings from the public perceptions survey. This is the first time we have carried out a qualitative research project like this, and it has helped bring to life the experiences of more vulnerable individuals which will help deepen our understanding of their experiences.

8. Both reports, including executive summaries are annexed to this paper.

## Analysis

9. In this section we have focused on the key findings from the public perceptions survey and qualitative research on lived experiences in relation to barriers those with vulnerability markers face when accessing and using eye care services.

### *Low priority of eye health and low awareness of the benefits of regular testing can act as a barrier for those with vulnerabilities*

10. The public perceptions survey continues to show that those with one or more vulnerability markers are less likely to go for a sight test/eye examination every two years, and are generally less confident in managing their eye health. Participants in the lived experience research also didn't view eye health as a priority particularly compared to other routine appointments such as dental care. There was a lack of awareness about the recommended period for routine sight tests/eye examinations, as well as a general lack of knowledge about the benefits of regular testing including that the test checked eye health as well as vision and even broader conditions such as diabetes and high blood pressure. Many participants had a high tolerance for deteriorating vision and self-managed by buying off the shelf ready readers rather than going for a sight test/eye examination.

### *Cost and pressure to buy can deter those with vulnerabilities from accessing eye care services*

11. The public perceptions survey shows that those with at least one vulnerability marker said that the cost of glasses, contact lenses, and the sight test/eye examination were the main reasons why they felt uncomfortable visiting an opticians/optometrist practice. This was followed by pressure to buy glasses or contact lenses. New to this wave, those with four or more vulnerability markers were: more likely to say they felt pressure to buy specific brands or types of glasses or contact lenses; less likely to

think pricing was transparent and clear; and less likely to say the price they expected to pay matched the price they paid.

12. These concerns were reinforced in the lived experience research, where cost was a significant barrier in deterring participants from going for a sight test/eye examination. Participants were also concerned about: the cost of glasses and contact lenses; the lack of transparency around costs; and pressure to buy.

13. Many participants in the lived experience research were unaware or didn't know if they were eligible for any financial help, for example via the NHS for their sight test or purchase of eyewear. The public perceptions survey found that those who said they were struggling financially and those who said they were not, were equally as likely to have paid for the sight test/eye examination themselves.

***Previous poor experiences can act as barrier to accessing eye care services***

14. The public perceptions survey shows that those with vulnerability markers are more likely to have had a poor experience when visiting an opticians/optometrist practice and complained about this. New to this wave, the public perceptions survey also found that one in eight respondents who had had a sight test/eye examination, felt they were treated less favourably due to a range of personal characteristics, including age, gender, weight, race, or disability. Those with one or more vulnerability markers also said they were treated less favourably.

15. The lived experience research shows that previous poor experiences can deter those with vulnerabilities from accessing eye care services. Participants in the lived experience research said that they avoided going to have a sight test/eye examination either because they have had a negative experience previously that has put them off returning, or they were anticipating a negative experience before attending.

***Psychological barriers can deter those with vulnerabilities from accessing eye care services***

16. There are some psychological barriers, identified in the lived experience research, that may deter some with more hidden vulnerabilities such as mental health conditions from accessing eye care. For example, some participants found the idea of being in a retail environment off putting or intimidating because of a feeling that it was 'too open' and of 'being watched' which differed from other more traditional healthcare environments such as GP practices or hospitals. Other concerns included: sitting next to strangers; long waits with a lack of communication; and feeling uncomfortable trying on glasses in front of others.

**Reflections**

17. This year we have continued to build on our understanding of how different sections of the population access and experience eye care services through our annual public perceptions survey and our new lived experience research. In relation to

access, these findings are particularly concerning as any barriers that prevent people from using eye care services will result in poorer health outcomes, particularly for segments of the population that are already experiencing some level of vulnerability.

18. It is important that we use these findings to help improve the experiences of more vulnerable groups. One of our three new strategic objectives under our corporate strategy 2025-30 is to create fairer and more inclusive eye care services. We also have a legal obligation under the Public Sector Equality Duty to promote equality in our decision making and regulatory functions. The Professional Standards Authority (PSA) also monitor and expect regulators (under standard 3 of their performance review criteria) to understand the diversity of its service users and ensure there are not inappropriate barriers that disadvantage those with protected characteristics.

19. We have already deployed our regulatory levers to enhance our standards of practice for individual registrants to help ensure they are better able to identify, support and treat more vulnerable patients. Draft guidance on care of patients in vulnerable circumstances is being considered by Council elsewhere on the agenda. This standard is reflected in our Continuing Professional Development (CPD) scheme, so will be embedded in the lifelong learning we require registrants to undertake. It also forms part of our education and training requirements, ensuring that students are taught how to manage more vulnerable patients from the outset. It is reasonable to expect that change may take time, and it is therefore important for us to continue to carry out regular research to help track trends in this area.

20. Alongside this we must also look at how businesses can improve the patient experience, and internal scoping on a substantive review of our business standards is due to begin towards the end of 2025/26. This will help us decide what regulatory levers we could exert to facilitate access and address some of the issues highlighted in the research. For example, we could enhance requirements for businesses around price transparency, pressure to sell, and making reasonable adjustments that are effective in supporting more vulnerable patients to access both sight tests/eye examinations and the retail environment. In addition, we are just beginning our first thematic review on commercial practices and patient safety which will help deepen our understanding of issues such as pressure to buy acting as a barrier to accessing care, and will help us identify possible interventions.

21. The wider sector such as employers, professional and representative bodies, commissioners and governments also have a role to play and should consider what they can do to address access barriers and help improve health outcomes for some of the most vulnerable groups in society. For example, targeted public health messages could help raise awareness of the benefits of regular sight tests/eye examinations, and businesses could of their own volition consider staff training and adapting their processes to better support those with vulnerabilities. A key priority of the Labour government is to move more services into the community, but it is

important that these are accessible and inclusive if we are to see a reduction in health inequalities.

## Finance

22. The policy and standards budget includes the costs of commissioning the annual public perceptions survey.

## Risks

23. There is a risk that we do not understand the public's views and experiences of eye care, which could have negative implications for our role of protecting and promoting the public's health and safety.

24. There is also a risk that we do not address the risks and issues raised by the public via our research, which could have negative implications for our role of protecting and promoting the public's health and safety. We have mitigated these risks by carrying out an annual survey since 2015 and new qualitative research to support this, and we use the research to, for example, inform the policies and standards we set to fulfil our statutory role in protecting the public.

25. Another risk is that we overstep our remit as a statutory regulator on access issues since the boundaries can be blurred. It would be helpful for Council to discuss where our role on access issues appropriately begins and ends in this respect.

## Equality Impacts

26. We have not carried out an equality impact assessment as the public perceptions survey and lived experience research is not a new or amended policy. However, the research findings highlight concerning experiences for patients from groups with protected characteristics or more vulnerable groups.

## Devolved nations

27. For the public perceptions survey, Scotland, Wales and Northern Ireland were over-sampled to ensure that confident statistical analysis could be undertaken by nation.

## Communications

### External communications

28. Both reports will be published on the GOC website in July. We will continue to disseminate the findings to stakeholders including the national optometric advisors in Wales, Scotland and Northern Ireland, and professional and representative bodies. 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. As in previous years, we expect good coverage in the trade press which helps stimulate conversations in the sector.

## Internal communications

29. We will present the findings of the research to relevant staff.

## Next steps

30. We will be publishing both reports in July, along with the data tables and infographics.

## Attachments

Annex one: Public perceptions survey 2025
Annex two: Qualitative research exploring the lived experiences of patients and non-patients accessing and using eye care services

General Optical Council

# Public Perceptions Research

March 2025

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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 remains high (87%), with an increase in those saying they are ***very satisfied*** (55% vs. 50% 2024). New questions for this wave show that satisfaction varies when it comes to **delivery of information** (90%), **time taken to properly address needs** (87%), being **treated with care and compassion** (89%), and **involvement in care and treatment decisions** (83%).

Around three quarters (74%) remain satisfied with the overall **value for money**, with an increase in the proportion saying they are ***very satisfied*** (38% vs. 32% 2024). Satisfaction also remains stable when it comes to **the experience of buying glasses or contact lenses** (72%).

Younger people aged 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**. This is in line with the previous wave.

# Summary of findings (2)

**An opticians/optometrist practice** remains the most likely place that the public would go to in the event of an eye problem (36%) – ahead of a GP practice/surgery, which has seen a drop this year (27% vs. 30% 2024). Those in **England** remain less likely to turn to an opticians/optometrist practice first (33%), while those in Scotland (53%) and Wales (53%) are more likely to do so. Those in Northern Ireland are in line with the average. Those aged 16-24 remain more inclined to visit a GP practice/surgery than an opticians/optometrist practice.

**Confidence in a high standard of care** from an opticians/optometrist practice remains high (93%), compared to a pharmacy (86%), dental practice/surgery (80%) and a GP practice/surgery (78%).

As in 2024, most (85%) are **confident in managing their own eye health,** with relatively few saying they have little or no confidence (11%).

# 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%). However, in 2025, more identify the inconvenience of the location as a factor (13% vs. 10% 2024), while fewer cite the possibility of needing to pay (14% vs. 17% 2024).

The cost of glasses/contact lenses (22%) and sight test/eye examinations (17%) continue to be the main reasons why some feel uncomfortable **visiting an opticians/optometrist practice,** although half do not feel uncomfortable at all (49%). Those who feel particularly uncomfortable due to a range of factors include those aged 16-34, ethnic minorities, those with at least one vulnerability marker, those who are struggling financially, and those not confident in managing their own eye health.

A stable four in five (80%) say they have **had a sight test/eye examination in the last two years,** with only 3% saying they have **never had a sight test/eye examination**. Those aged 25-34 (5%) and ethnic minorities (6%) are more likely to state they have never had a sight test/eye examination.

# Summary of findings (4)

**A high street opticians/optometrist practice** continues to be the most popular location for a sight test/eye examination (83%). The proportions of those who shop around (31%) and know the price before attending their appointment (65%) also remain stable with 2024.

The location where the public purchase their glasses and contact lenses is consistent with 2024. However, new questions for this wave show that almost a quarter (24%) say they **felt pressured** to purchase a specific brand or type of glasses or contact lenses. Over three quarters (77%) feel that the pricing was **clear and transparent** when they last purchased glasses or contact lenses, while slightly fewer (73%) feel that the price they expected to pay **matched** the price they ended up paying.

Amongst those who knew the price of their sight test/eye examination before attending, around two in five (39%) say they knew this information from previous visits. Just over a quarter (26%) found out before booking, while one in five (20%) found out during the booking process. Around one in ten (9%) found out after booking, but before attending.

# Summary of findings (5)

Just over one in ten (12%) say they **complained or considered complaining about an experience** at their opticians/optometrist practice. New questions for this wave show that the most common outcome to complaints include receiving a suitable repair or replacement (33%), an apology (32%) or a full or partial refund (28%). Almost three quarters (73%) say they are **satisfied with the outcome of their complaint**, with more being *very satisfied* (45%) than *fairly satisfied* (28%). Less than one in five (16%) are dissatisfied with the outcome.

New to this wave, 12% say they felt they were treated **less favourably due to a range of personal characteristics**, including age, gender, weight, race, or disability. This is particularly prevalent among younger people aged 16-34.

# Contents

# 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. This research helps to identify improvements in the service provided to patients. 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 2025 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 **17 – 24 February 2025**.

A total of **2,012 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 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+ 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% ± |
| 2,012 (all participants) | 1.3% | 2.0% | 2.2% |
| 1,616 (all participants who have had a sight test/eye examination in the last two years) | 1.5% | 2.2% | 2.4% |
| 1,177 (all participants who have purchases glasses OR contact lenses) | 1.7% | 2.6% | 2.9% |

For example, with a sample of 2,012 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

Trend data has been significance tested. Statistically significant changes between 2024 and 2025 are indicated throughout with these arrows depending on the direction change:

denotes significantly higher than the previous wave

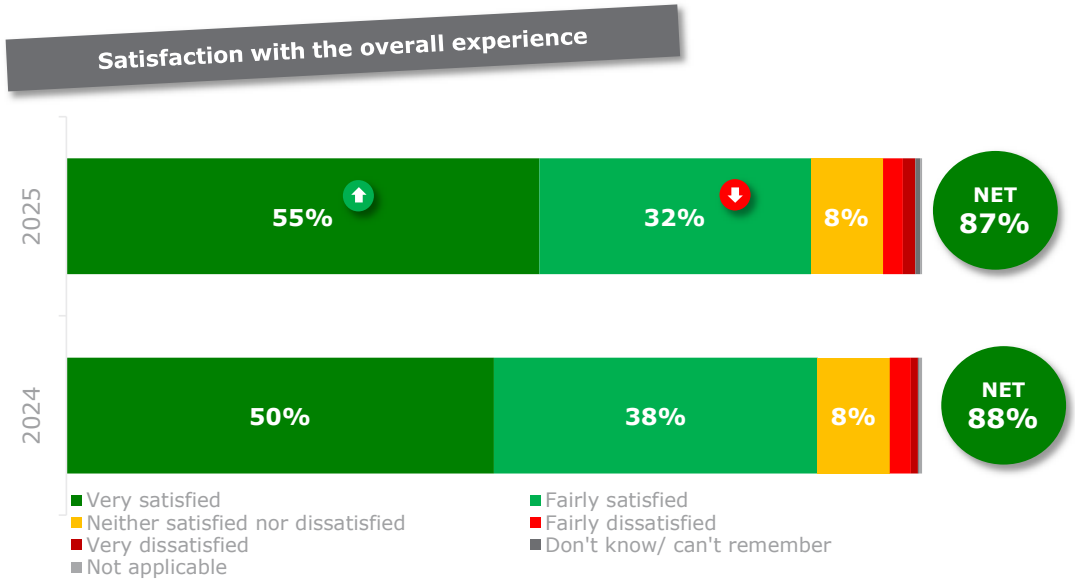
denotes significantly lower than the previous wave

# 03 Main report findings

# Satisfaction levels

# Satisfaction with the overall experience

Satisfaction with the overall experience of the opticians/optometrist practice remains stable overall at 87%, although more this year say they are *very satisfied* (55% vs. 50% 2024) than *fairly satisfied* (32% vs. 38%). Levels of dissatisfaction remain low (4%).




Consistent with the previous year, there are a number of demographic differences in relation to overall satisfaction:

- Those in younger age groups (aged 16-34) are less likely than those in older age groups (aged 55 and over) to be satisfied with the overall experience (79% vs. 92%)
- Those from a white background are more satisfied than those from an ethnic minority background (88% vs. 82%)
- Those with a disability are less likely than those without one to be satisfied with the overall experience (83% vs 88%)

Additionally, women are more likely than men to say they were satisfied with the overall experience (89% vs 85%).

Other groups less likely to be satisfied include carers (79%), those with at least one vulnerability marker (84%), those not confident in receiving a high standard of care from an opticians/optometrist practice (46%) or managing their own eye health (68%), those with an eye condition (84%), and those who felt they were treated less favourably due to a personal characteristic (62%).

Results vary based on the location of the sight test/eye examination; those having their sight test/eye examination at a high street opticians/optometrist practice are more likely to be satisfied with the overall experience (89%) compared to those in a hospital (77%).

**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 (1,616), 2024 participants (1,599).



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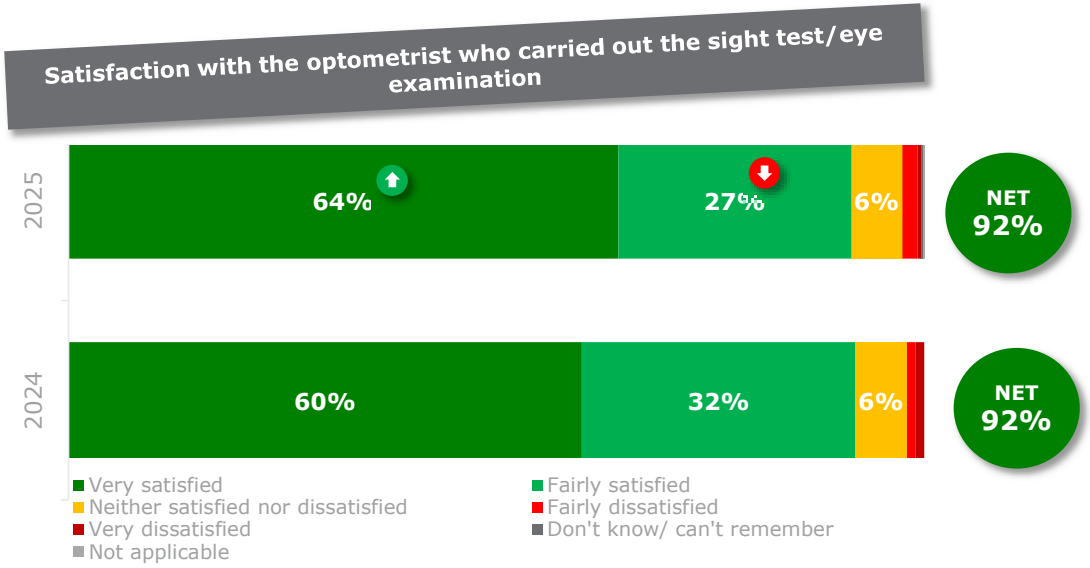
# Satisfaction with the optometrist who carried out the sight test/eye examination

As with satisfaction with the overall experience, satisfaction with the optometrist who carried with the sight test/eye examination remains stable (92%), and more say they are *very satisfied* (64% vs. 60% 2024) than *fairly satisfied* (27% vs. 32%). Just 2% are dissatisfied.




Consistent with the previous year, those in younger age groups 16-34 are less likely to be satisfied with the optometrist when compared to older participants aged 55 and over (87% vs 96%). White participants also continue to be more satisfied than ethnic minorities (93% vs. 86%).

Carers are less satisfied than non-carers with their optometrist (86% vs. 93%). Satisfaction is also lower among those with at least one vulnerability marker (90%), those in work (89%), those not confident in receiving a high standard of care from an opticians/optometrist practice (54%) or managing their eye health (75%), and those who felt they were treated less favourably due to a personal characteristic (78%).

Higher levels of satisfaction with optometrists continue to be present among those who had their sight test/eye examination at a high street opticians/optometrist practice (93%) compared to those in a hospital (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 (1,616), 2024 participants (1,599).



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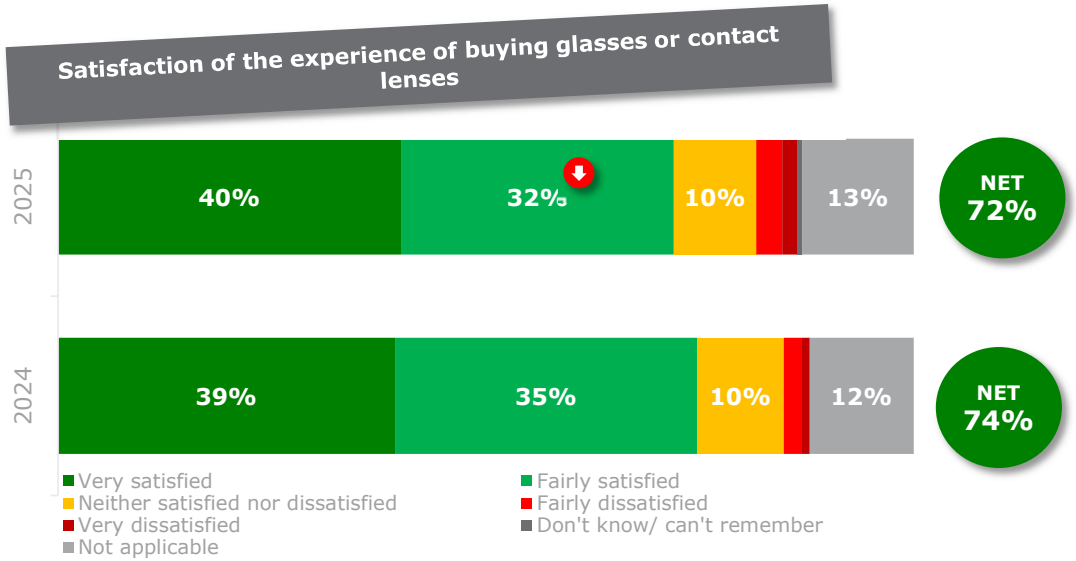
# Satisfaction with the experience of buying glasses or contact lenses

Over seven in ten (72%) are satisfied with their experience of buying glasses or contact lenses. This year, fewer say they are *fairly satisfied* with their experience (32% vs. 35%) and dissatisfaction is higher (5% vs 3% 2024), although the proportion who are dissatisfied remains fairly low.




Women are more likely than men to say they were satisfied with the experience of buying glasses or contact lenses (76% vs. 68%). Ethnic minorities are also more likely than white participants to be satisfied with their experience (77% vs. 71%).

Those who had their sight test/eye examination conducted at a high street opticians/optometrist practice are more likely to be satisfied (74%) compared to a hospital (64%).

Dissatisfaction is comparatively higher among those:

- Who do not speak English as a first language (12%)
- With a disability (10%)
- Who are carers (9%)
- With at least one vulnerability marker (7%)
- Who are not confident in receiving a high standard of care from an opticians/optometrist practice (25%)
- Who are not confident in managing their eye health (12%)
- Who felt they were treated less favourably due to a personal characteristic (17%).

**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 (1,616), 2024 participants (1,599).



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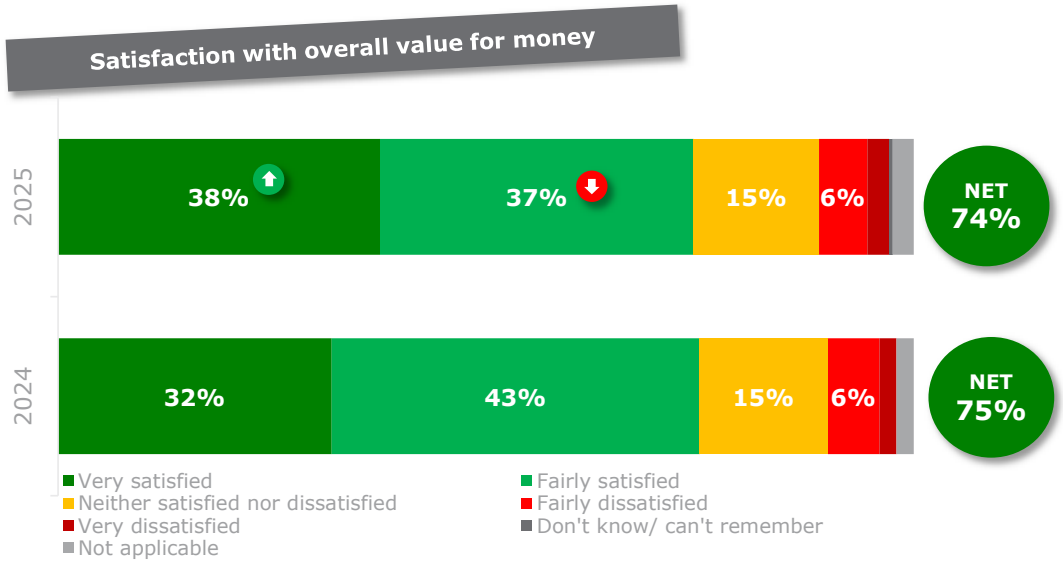
# Satisfaction with value for money

Just under three quarters (74%) are satisfied with the overall value for money. This year, the proportion of those who are *very satisfied* (38% vs. 32% 2024) is now in line with those who say they are *fairly satisfied* (37% vs. 43% 2024). There is no change in the proportion who are dissatisfied with value for money (8%).




Those aged 16-24 continue to be less likely than any other age group to be satisfied with the overall value for money (67%). Those with an income of £25,001 – 35,000 are also less likely to be satisfied with value for money (67%), as are those who say they are struggling financially (71%). In contrast, those with a household income of £50,001 or more are more inclined to be satisfied with value for money (78%).

Those not confident in receiving a high standard of care from an opticians/optometrist practice (44%) or managing their own eye health (51%) are less likely be satisfied with the overall value for money. The same can be found for those who felt they were treated less favourably due to a personal characteristic (65%).

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 (77%). Participants who paid for their own eye test are more likely than those who had employer contributions to be satisfied with value for money (78% vs. 62%).

**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 (1,616), 2024 participants (1,599).



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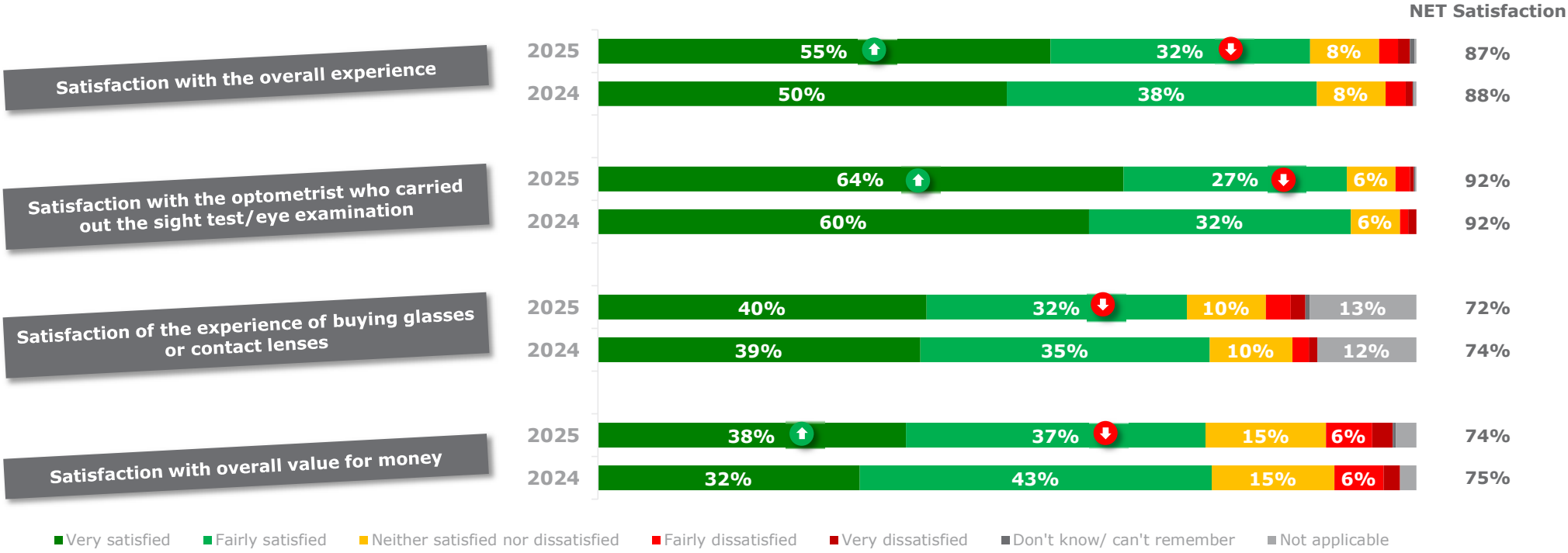
# Satisfaction trends

While the proportion of net satisfaction remains stable this year, the proportion of those who are very satisfied is significantly higher across almost all metrics, with the exception of the buying glasses or contact lenses experience.




**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 (1,616), 2024 participants (1,599).



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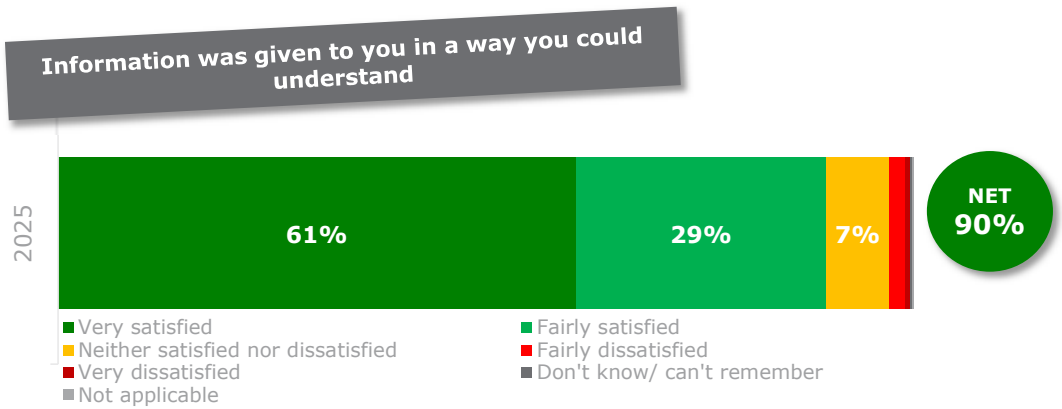
# Satisfaction with delivery of information

Nine in ten (90%) say that at their last sight test/eye examination, information was given to them in a way which they could understand. More say they were *very satisfied* (61%) than *fairly satisfied* (29%). Just 2% say they were dissatisfied.




In terms of demographic differences:

- Women are more likely than men to be satisfied with the delivery of information (92% vs. 88%)
- Those aged 55 and over are more likely to be satisfied compared to younger age groups (95% vs. 83% of those aged 16-34)
- White participants are more likely than those from an ethnic minority background to be satisfied (91% vs. 84%)
- Those in work are less likely to be satisfied (87%) compared to those who are retired (97%).
- Those who state English is their first language are more likely to be satisfied (90%) compared to those where English is not their first language (83%).

Satisfaction is higher among those who had their sight test/eye examination at a high street opticians/optometrist practice (91%) compared to a hospital (83%) setting.

**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 (1,616). Please note this statement was added in the 2025 survey wave so 2024 data is not available.

20

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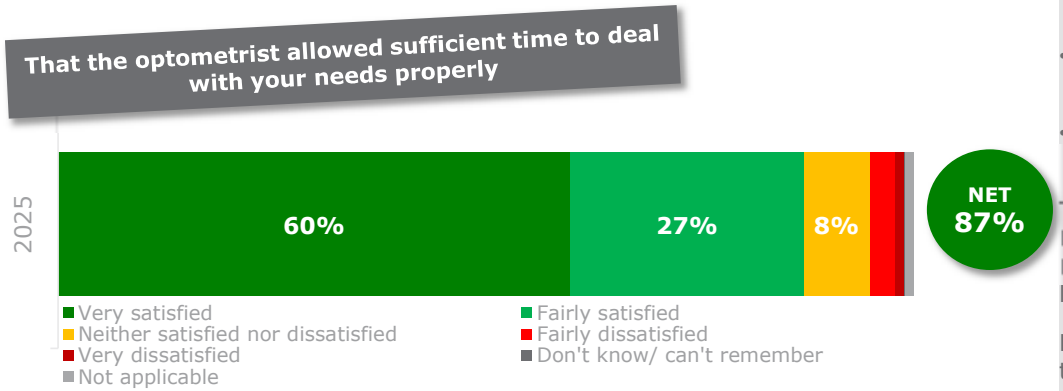
# Satisfaction with time given to address needs

Almost nine in ten (87%) are satisfied that their optometrist allowed sufficient time to deal with their needs properly, more of which are *very satisfied* (60%) than *fairly satisfied* (27%). Only 4% are dissatisfied.




In terms of demographic differences:

- Women are more likely than men to be satisfied with the time that was given to address their needs (89% vs. 85%)
- Those aged 55 and over are more likely than younger age groups to be to satisfied (94% vs. 77% 16-34)
- White participants are more likely than those from an ethnic minority background to be satisfied (89% vs. 80%)

Those with a lower income of under £20,000 are more likely than average to be satisfied with the time given to address their needs (91%), as are those with a household income of £50,001 or more (90%). Those with at least one vulnerability marker are also less inclined to be satisfied (85%).

Participants who are less confident in receiving a high standard of care from their opticians/optometrist practice (42%) or managing their own eye health (60%) are also less likely than average to be satisfied when it comes to sufficient time being given to address their needs.

**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 (1,616). Please note this statement was added in the 2025 survey wave so 2024 data is not available.



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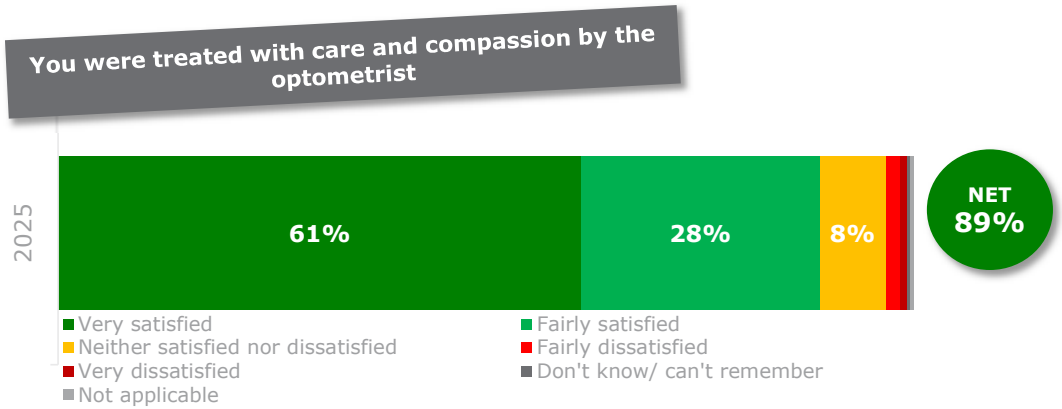
# Satisfaction with care and compassion

Just under nine in ten (89%) are satisfied that they were treated with care and compassion by their optometrist – more are *very satisfied* (61%) than *fairly satisfied* (28%). Just 2% are dissatisfied.




In terms of demographic differences:

- Those aged 55 and over are more likely than younger age groups to be to satisfied (94% vs. 81% 16-34)
- White participants are more likely than those from an ethnic minority background to be satisfied (91% vs. 83%)

Those who do not speak English as a first language are less likely to be satisfied compared to the average (77%). The same can be said for carers (82%) and those in work (86%).

Those with at least one vulnerability marker are less likely than average to be satisfied (87%).

Participants who are less confident in receiving a high standard of care from their opticians/optometrist practice (56%) or managing their own eye health (73%) are also less likely than average to be satisfied with the levels of care and compassion.

Those who had their sight test/eye examination conducted at a high street opticians/optometrist practice are more likely to be satisfied (92%) compared to those done in a hospital (77%).

**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 (1,616). Please note this statement was added in the 2025 survey wave so 2024 data is not available.

22

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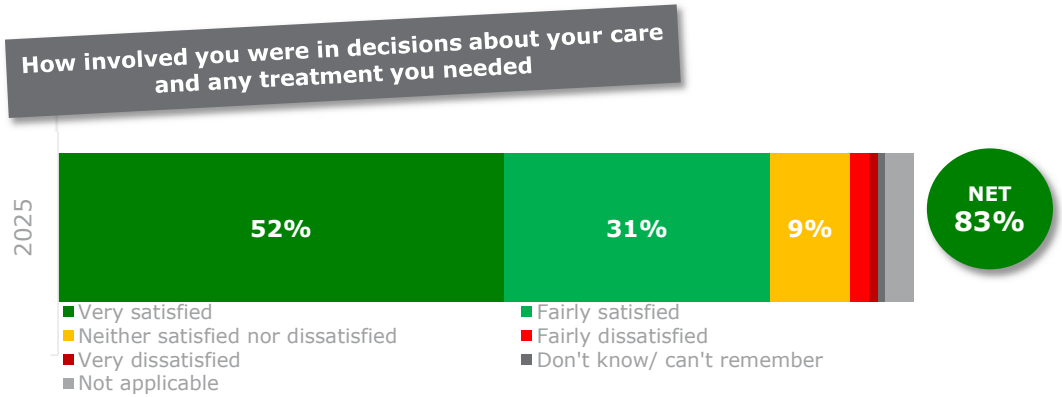
# Satisfaction with involvement in care and treatment decisions

More than four in five (83%) are satisfied with the level of involvement they had in decisions about their care and treatment. Most are very satisfied (52%) rather than fairly satisfied (31%). Only 3% say they are dissatisfied with their involvement. Just 1% say they don't know while 3% say it is not applicable to them.




In terms of demographic differences:

- Women are more likely than men to be satisfied with their involvement (86% vs. 81%)
- Those aged 55 and over are more likely than younger age groups to be to satisfied (87% vs. 77% 16-34)
- White participants are more likely than those from an ethnic minority background to be satisfied (84% vs. 79%)

Those with a lower income of under £20,000 are more likely than average to be satisfied with their involvement in care and decision making (89%), as are those with a household income of £50,001 or more (87%). Those with at least one vulnerability marker are also less likely than average to be satisfied (81%).

Those less confident in receiving a high standard of care from their opticians/optometrist practice (49%) or managing their own eye health (58%) are less likely than average to be satisfied with their involvement.

Participants who had their sight test/eye examination at a high street opticians/optometrist (85%) practice are more likely to be satisfied compared to those who had it at a hospital (77%).

**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 (1,616). Please note this statement was added in the 2025 survey wave so 2024 data is not available.



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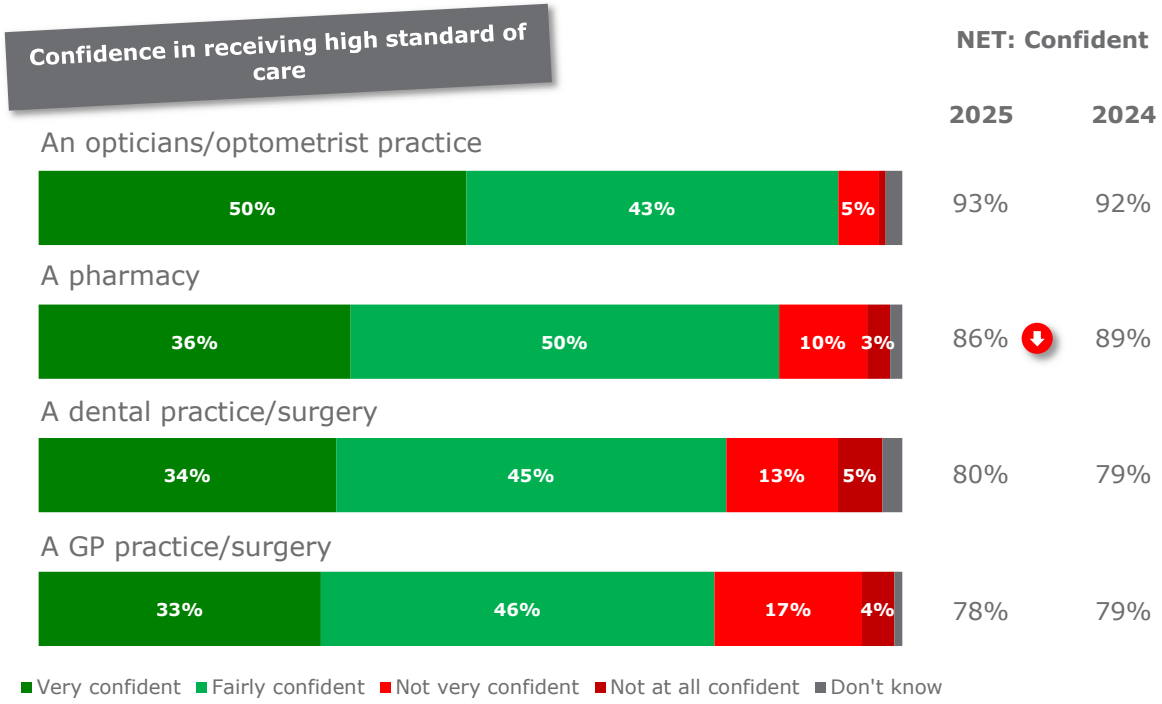
# Confidence levels

# Confidence in receiving care

Confidence in receiving a high standard of care from an opticians/optometrist practice remains stable this year (93% confident) and remains ahead of other services in comparison. By way of context, confidence in receiving a high standard of care from a pharmacy has fallen this year (86% vs 89% 2024).




Confidence in receiving a high standard of care from an opticians/optometrist practice remains varied when it comes to age - those aged 16-24 are less likely than those aged 65 and over to say they are confident (88% vs. 97%). Similarly, those from a white background are more likely to be confident compared to those from an ethnic minority background (94% vs. 88%), as are those with English as a first language (93% vs 84% of those who do not speak English as a first language).

Those who have at least one vulnerability marker are less likely than average to be confident in their opticians/optometrist practice overall (90%), as are those who are not confident in managing their own eye health (70%).

Those who have had a sight test/eye examination in the last two years (95%) are more likely to be confident than those who had one more than two years ago (86%), with even lower levels of confidence amongst those who have never had a sight test/eye examination (60%).

**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 (2,012), 2024 participants (2,035).

25

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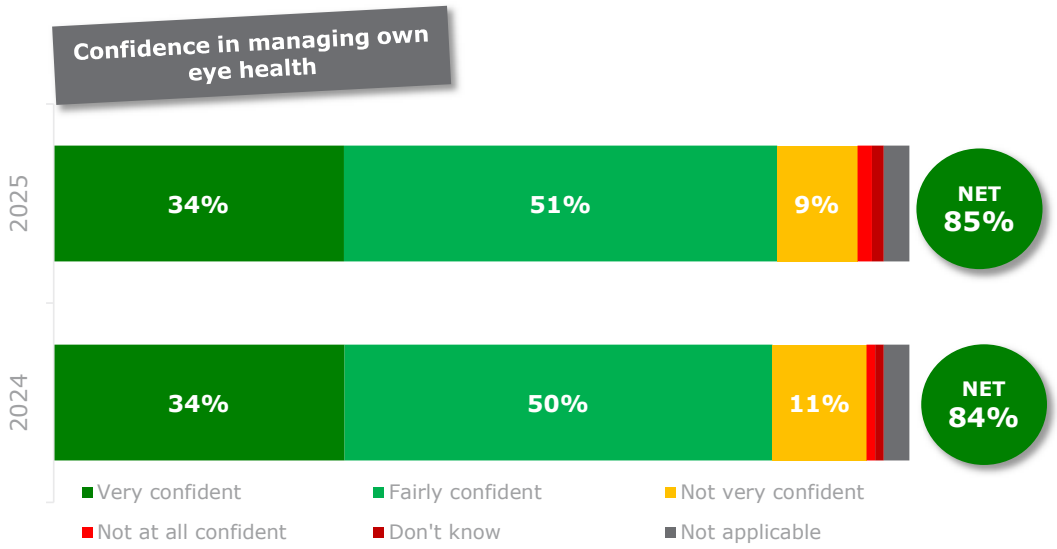
# Confidence in managing eye health

The public's confidence in managing own their own eye health remains stable this year (85%).




As with confidence in receiving a high standard of care from an opticians/optometrist practice, there is a clear difference in confidence by age group as those aged 16-24 are less likely than those aged 65 and over to say they are confident (77% vs. 90%). Similar differences in confidence can also be found by ethnicity (86% white vs. 80% ethnic minority) and speaking English as a first language (85% vs 73% who do not speak English as a first language).

Those who have at least one vulnerability marker are less likely to say they are confident in managing their own eye health (76%), as are those not confident in receiving a high standard of care from an opticians/optometrist practice (43%).

Those who do not wear glasses or contact lenses are less likely to be confident in managing their own eye health (72%), as are those who have last had an eye test over two years ago (66%).

**S01b.** To what extent are you confident or not in managing your eye health? **Base:** All participants (2,012), 2024 participants (2,035).

26

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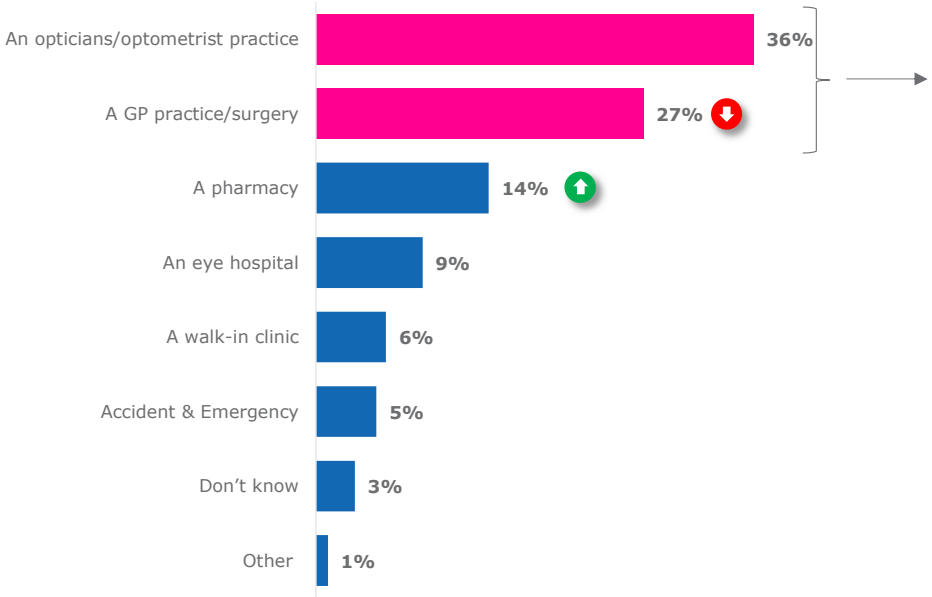
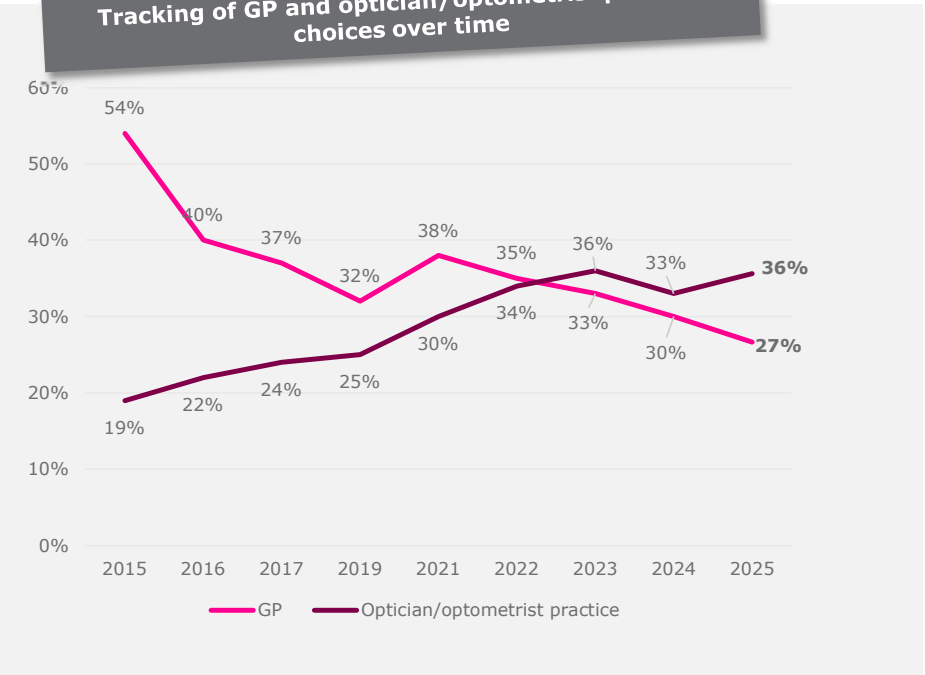
# Perceptions of urgent care

# First ‘port of call’ for an eye problem

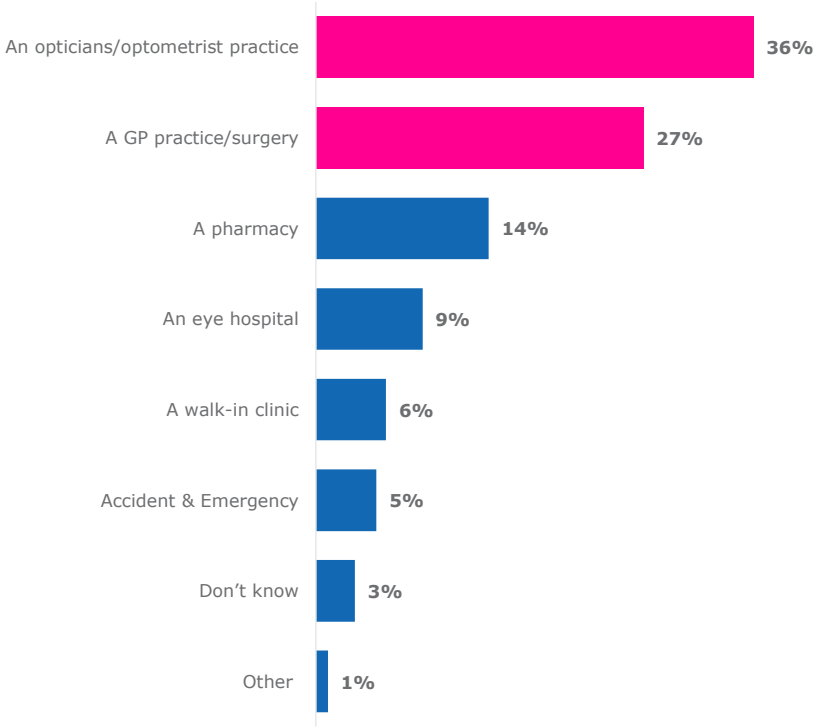
While not a statistically significant shift, a slightly higher proportion say they would turn to an opticians/optometrist practice first in the event of an eye problem (36% vs. 33% 2024). Significantly fewer say they would turn to a GP this year (27% vs. 30% 2024), while more would turn to a pharmacy (14% vs. 12% 2024).




**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 (2,012), 2024 participants (2,035).

# First ‘port of call’ for an eye problem cont’d.




Younger people aged 16-24 are less inclined to say they would visit an opticians/optometrist practice (28% vs. 36% overall) and more likely to turn to a GP practice/surgery (35% vs. 27% overall) or walk-in clinic (9% vs. 6% overall) instead.

Those with a disability are less likely than average to say they would turn to an opticians/optometrist practice as their first port of call for an eye problem (29%) – instead, they are more likely than average to say they would go to a walk-in clinic (9% vs 6%).

Those with a lower household income of less than £20,000 are less likely to say they would turn to an opticians/optometrist practice first (30%). They are more likely than average to say they don’t know who they would go to first (8% vs. 3% overall). The opposite is found for those who have a higher household income of £50,001 or more, where 41% would go to an opticians/optometrist practice (vs. 36% overall).

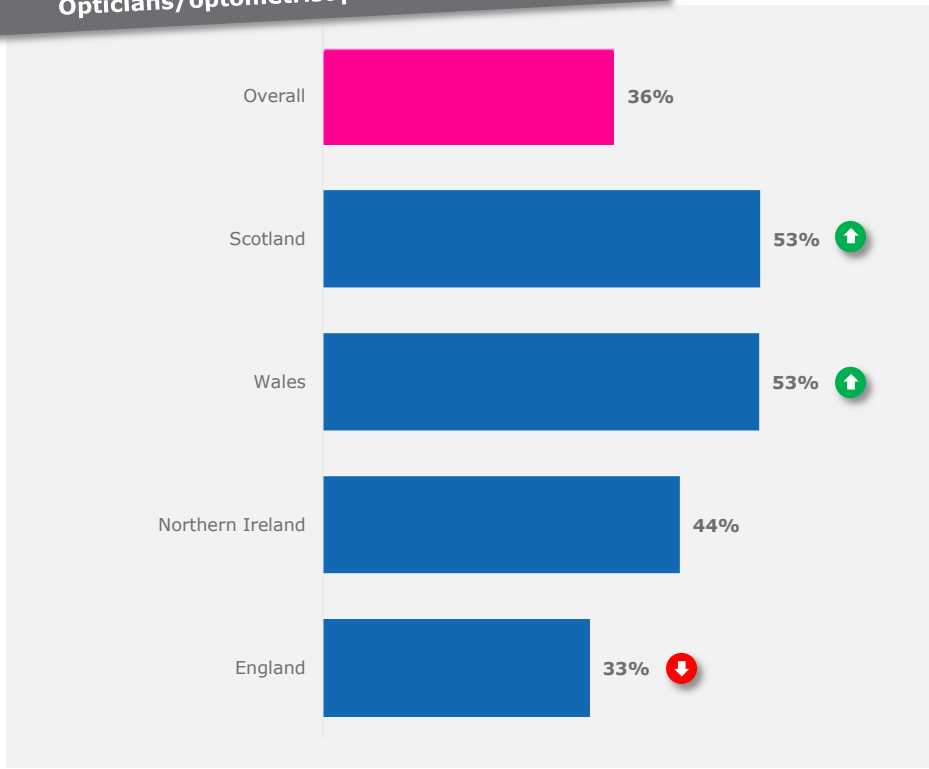
Those with at least one vulnerability marker are less likely to say they would go to an opticians/optometrist practice in the first place for an eye problem (33%) and are more likely than average to go to a GP practice/surgery (29%). Participants who are less confident in receiving a high standard of care from their opticians/optometrist practice (27%) or in managing their own eye health (23%) are also less likely than average to turn to an opticians/optometrist practice first.

Participants who have had their sight test/eye examination within the last two years are more likely to say they would speak to their opticians/optometrist practice first in the event of an eye problem (39%). The opposite can be found for those who last had their sight test/eye examination more than two years ago (22%); they are instead more likely to speak to their GP practice/surgery (38%).

**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 (2,012), 2024 participants (2,035).

# First ‘port of call’ for an eye problem cont’d.

**Opticians/optometrist practice by nation**



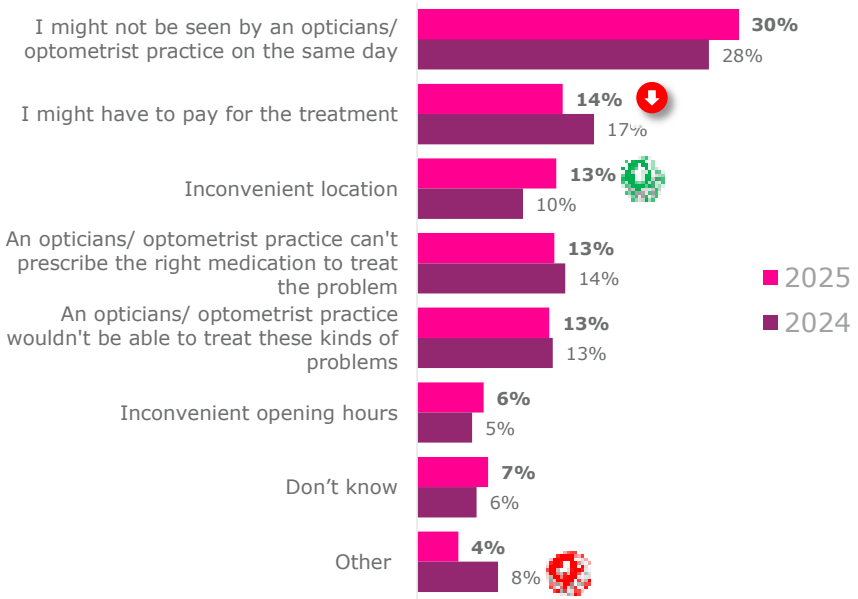

When looking at the results by nation, those living in England (33%) are less likely than those living in Wales (53%) and Scotland (53%) to say they would turn to an opticians/optometrist practice first. Those in Northern Ireland are in line with the average (44%). This is consistent with the previous year, where those in Wales (43%) and Scotland (44%) were more likely than those in England (31%). In 2024, those in Northern Ireland also remained statistically in line with the average (41% vs. 33% overall).

Those living in England are more likely than those in other nations to say that they would turn to a GP surgery/practice (28%) 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 (2,012).

# 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, fear of not getting a same day appointment continues to be the most common reason for doing so (30%). Fewer this year say they are worried about paying for treatment (14% vs. 17% 2024), while more cite the opticians/optometrist practice being in an inconvenient location.




Amongst those who would not go to an opticians/optometrist practice first in the event of an eye problem, women are more likely than men to cite the possibility of not being seen on the same day as a barrier (34% vs. 27%). Those aged 55 and over are also more likely than average to say this (35%), while the possibility of paying for treatment is a bigger worry, comparatively speaking, for those aged 16-34 (18%).

Those who have a disability are more likely than average to say they are worried about not getting a same day appointment (36%). Carers, on the other hand, are more likely to cite inconvenient opening hours as a factor (10%).

Those with at least one vulnerability marker are more inclined to mention the possibility of paying for treatment as a reason for not choosing to visit an opticians/optometrist practice first (17%). Those not confident in receiving a high standard of care from an opticians/optometrist practice (28%) or managing their own eye health (24%) are also more likely to mention this reason.

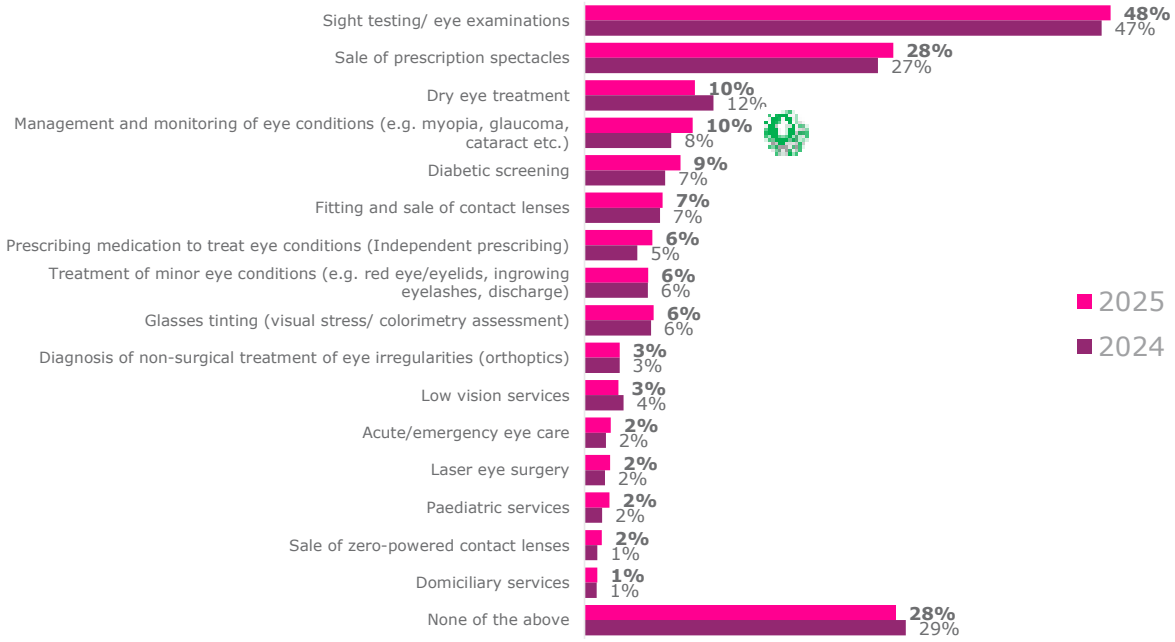
Those who last had a sight test/eye examination two or more years ago are more likely to cite potential payment for treatment as a reason not to choose an opticians/optometrist practice first (19%). In contrast, those who have been seen in the last two years are more likely to mention opticians/optometrist practices not being able to prescribe the right medication as a barrier (15%).

**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 (1,225), 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. Similarly to 2024, having a sight test/eye examination is the most common service used (48%), followed by sale of prescription glasses (28%) and dry eye treatment (10%). Participants in this wave are more likely to have used management and monitoring of eye conditions than those in 2024 (10% vs. 8%). A similar proportion have not used any optical service in the past two years (28% vs. 29%).




Those aged 55 and over are more likely than others to have had a sight test/eye examination (60% vs. 48% overall) and to buy prescription glasses (43% vs. 28% overall). For those aged 65 and over specifically, they are also more likely to have made use of management and monitoring of eye condition services (18% vs. 10% overall) and diabetic screening services (16% vs. 9% overall).

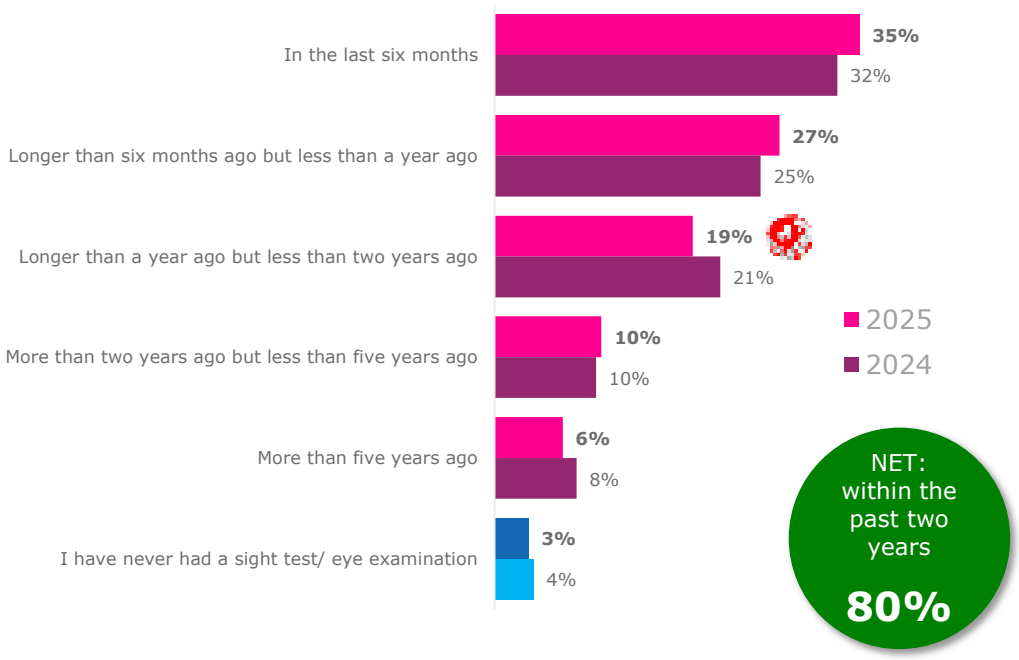
Those aged 16-34 are more likely to have used fitting and sale of contact lenses (11% vs.7% overall) or to have not used any of the listed services in the past 2 years (32% vs. 28% overall).

As seen in the previous wave, those who are less confident in managing their eye health are more likely to say they have used none of the different services (41% vs. 28% overall), as are those with low incomes of under £20,000 (35%).

**Q04d.** In the last 2 years, have you used any of the following services? **Base:** All participants (2,012), 2024 (2,035).

# Last reported visit for sight test/eye examination

Four in five (80%) state that they have had a sight test/eye examination in the past two years, in line with the previous wave (79%). Just under one in five (17%) had a sight test/eye examination more than two years ago, while only 3% say that they have never had one.




Those aged 55 and over are more likely to have had a sight test/eye examination in the last two years (87% vs. 80% overall), while those aged 16-34 are more likely to state it has been over two years since their last sight test/eye examination (20% vs. 17%). Those aged 65 and over specifically are more likely to state they had had a sight test/eye examination in the past six months (41% vs. 35%). Those aged 25-34 (5%) and ethnic minorities (6%) are more likely to state they have never had a sight test/eye examination (vs. 3% overall). These differences are consistent with the previous wave.

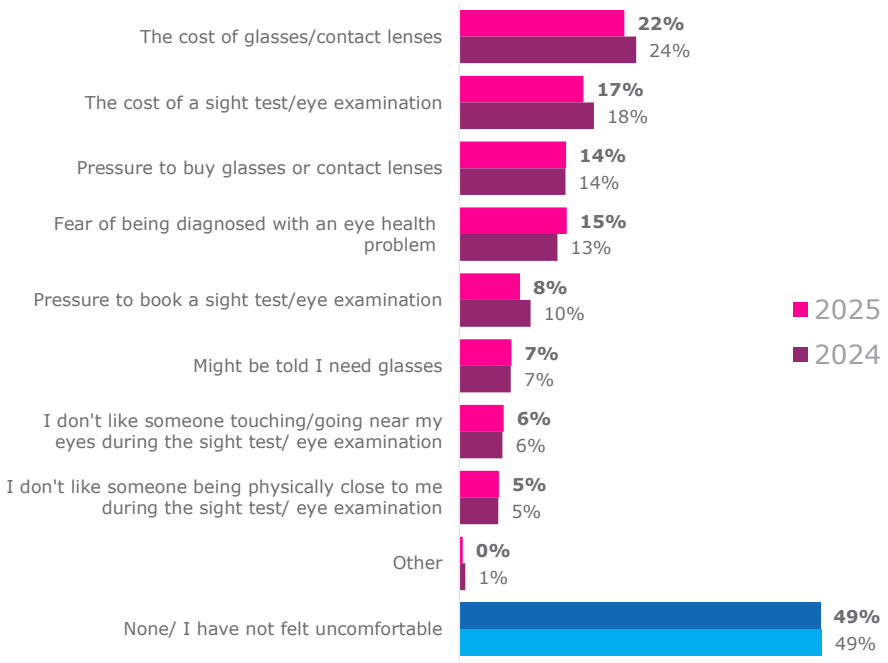
Sub-group differences that are also consistent with 2024 include:

- Those who wear glasses (89%) or contact lenses (91%) are more likely to have had a sight test/eye examination in the past two years (vs. 80% overall), in addition to those with an existing eye condition (90%).
- Those with no vulnerability markers (84%) are more likely than those with at least one marker (77%) to have had a sight test/eye examination in the past two years.
- 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 (38% vs. 17% overall), or that they have never had one (9% vs. 3% overall).

**Q04a.** When was the last time you had a sight test/eye examination? **Base:** All participants (2,012), 2024 participants (2,035).

# Discomfort around visiting an opticians/optometrist practice

The most commonly cited reasons for discomfort around visiting an opticians/optometrist practice are associated with money, consistent with 2024. The cost of glasses is the most cited reason for discomfort (22%), followed by the cost of a sight test/eye examination (17%) and the pressure to buy glasses or contact lenses (14%).




Groups more likely to cite the **cost of glasses or contact lenses** as a reason for feeling uncomfortable about visiting an opticians/optometrist practice include:

- Those aged 16-34 (29% vs. 22% overall)
- Females (24%)
- Those with at least one vulnerability marker (27%), especially those with four or more (36%)
- Those who state that their last eye test was over two years ago (30%)
- Participants who say they are struggling financially (32%) and those who state they cannot afford essentials (33%).

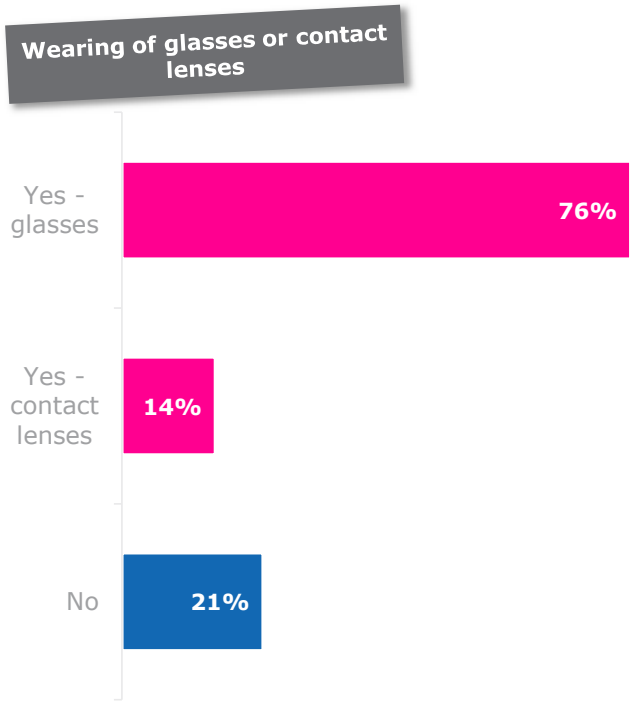
As seen in the previous wave, those living in Scotland are less likely than average to cite the cost of sight test/eye examinations as a reason (10% vs. 17% overall); this is most likely due to the availability of free sight tests/eye examinations.

White participants are more likely than ethnic minorities to say that they have not felt uncomfortable (53% vs. 34%). Ethnic minority participants are more likely to mention the following as reasons for discomfort: the cost of sight tests/eye examinations (26% vs. 17% overall), fear of being diagnosed with an eye health problem (25% vs. 15% overall), pressure to book a sight test/eye examination (13% vs. 8% overall) and being told they need glasses (10% vs. 7%).

**Q03.** Have you ever felt uncomfortable about visiting an opticians/optometrist practice for any of the following reasons? **Base:** All participants (2,012), 2024 participants (2,035).

# Wearing glasses or contact lenses

Just under four in five (79%) say that they wear glasses, contact lenses, or both, which is consistent with the previous wave (77%). Three quarters (76%) say they wear glasses and one in seven (14%) say they wear contact lenses.




**2025 NET** wear either glasses or contact lenses **79%**

**2024 NET** wear either glasses or contact lenses **77%**

Those aged 55 and over are more likely than average to wear glasses (90% vs.76% overall). Those aged 16-34 and 35-54 are more likely to wear contact lenses (21% and 16% vs. 14% overall). Those aged 16-34 are also more likely to wear neither glasses nor contact lenses (34% vs. 21% overall).

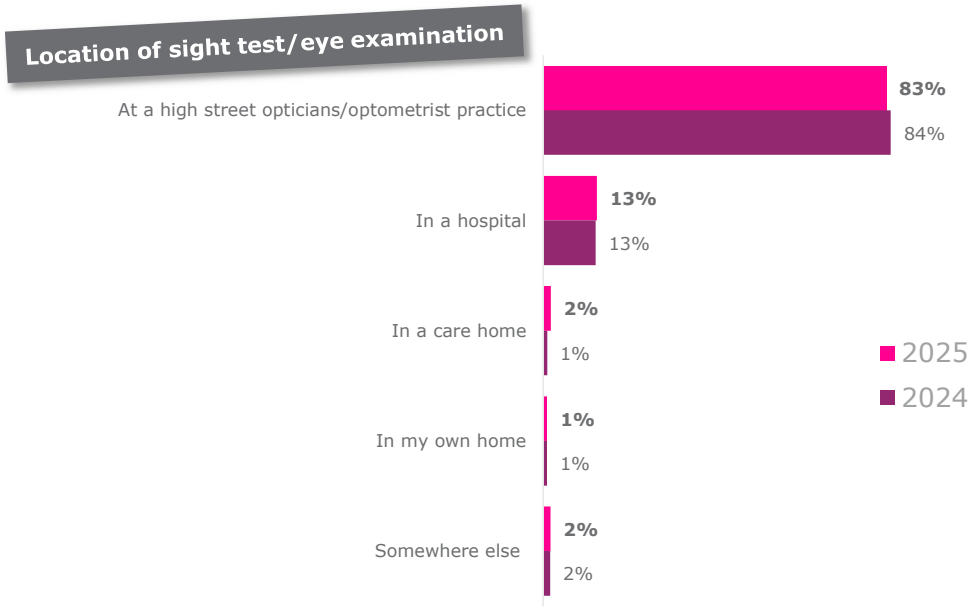
Females (16% vs. 14% overall), ethnic minorities (23%), those who work, either part time or full time (18%), and those on a high income (21%) are more likely to wear contact lenses than average.

Participants who state their last sight test/eye examination was over two years ago (47%), those who cannot afford essentials (28%) and those with at least one vulnerability marker (23%) are more likely to wear neither glasses nor contact lenses (vs. 21% overall).

**S01c.** Do you wear glasses or contact lenses? **Base:** All participants (2,012), 2024 participants (2,035).

# Location of test

Over eight in ten (83%) of those who have had a sight test/eye examination did so at a high street opticians/optometrist practice. The locations of sight tests/eye examinations continue the pattern that was seen in the previous wave.




Women are more likely than men to say their sight test/eye examination took place at a high street opticians/optometrist practice (86% vs. 79%).

Those aged 55 and over are also more likely to say their sight test/eye examination took place at a high street opticians/optometrist practice (90% vs. 71% of those aged 16-34).

Young people are more likely to state that their last sight test/eye examination took place at a hospital (23% vs. 13%). This may suggest that young people are less likely to attend regular sight tests/eye examinations and appointments but rather wait until they experience potential issues with their eye health. Participants with an existing eye condition are also more likely to have had their last sight test/eye examination at a hospital (24%).

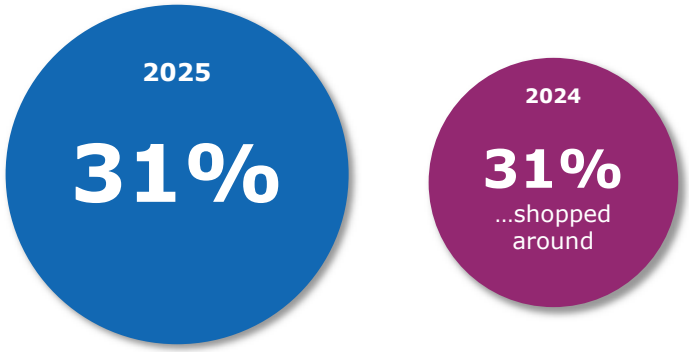
Those who state that their sight test/eye examination was funded by the NHS are more likely to have visited a high street opticians/optometrist practice (88% vs. 83% overall).



**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 (1,953), 2024 participants (1,963).
*Green text denotes sub-group statistic being significantly more likely than overall. Red text denotes sub-group statistic being significantly less likely than overall.*

# Choosing the opticians/optometrist practice

Similar to last year, three in ten (31%) say that they shopped around before picking which optician/optometrist practice to visit. This continues to be significantly higher than the proportion that shopped around in 2023 (21%).




… shopped around before picking which opticians/ optometrist practice to go to…

Shopping around before selecting an optician/optometrist practice is more likely amongst younger participants aged 16-34 (48% vs. 31% overall), while those aged 55 and over are more likely to say they did not shop around (81% vs. 67% overall).

The likelihood to shop around is higher amongst:

- Those who have an eye condition (41% vs. 31% overall)
- Participants who have previously felt uncomfortable at an optician/optometrist practice (43%)
- Those who paid for their sight tests/eye examinations (36%)
- Those with at least two vulnerability markers (38%)
- Participants who have had a sight test/eye examination in the past 6 months (35%).

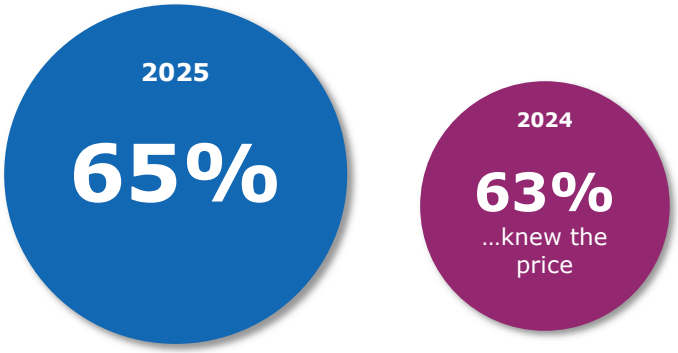
Perhaps unsurprisingly, those who knew the price of their sight test/eye examination prior to visiting are more likely to have shopped around (35%), compared to those who did not know the price beforehand (24%).

Other groups who are less likely to say that they shopped around include those who are not struggling financially (26%).

**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 (1,616), 2024 participants (1,599).

# Knowledge of prices before attending appointment

Two thirds (65%) say that they knew the price of the sight test/eye examination before their appointment, in line with the proportion in 2024 (63%).







… knew the price of the sight test/eye examination before they attended their appointment

Those aged 65 and over are significantly more likely to say they knew the price before their sight test/eye examination (71% vs. 58% of those aged 16-34).

When looking at financial circumstances, perhaps counter-intuitively, those who say that they are *not* struggling financially are more likely to have known the price of their sight test/eye examination prior to their visit than those who *are* struggling financially (67% vs. 62% respectively).

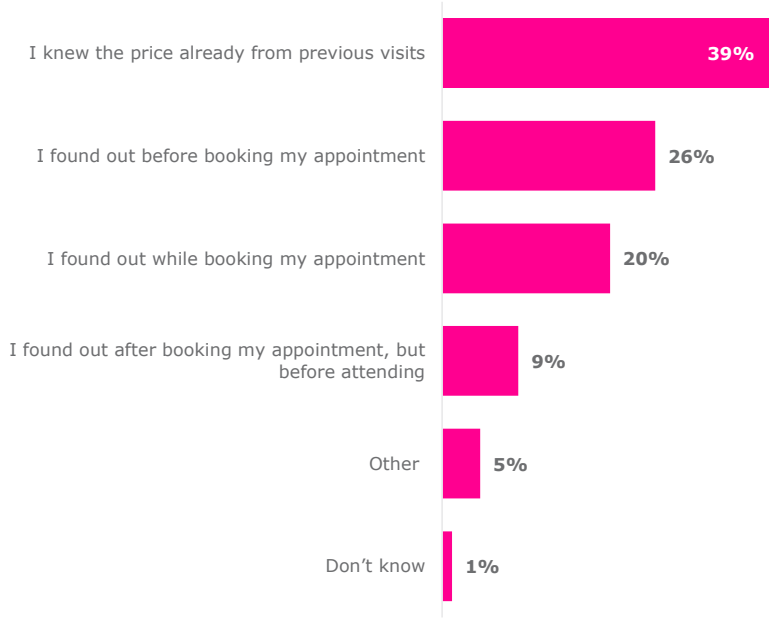
As expected, those who say that they shopped around before their appointment are more likely to say that they knew the price compared with those who did not (73% vs 61% respectively).

There are no significant differences by means of payment.

**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 (1,616), 2024 participants (1,599).

# Source of price information

When asked how they first found out about the price of their sight test/eye examination, around four in ten (39%) say that they knew this from previous visits . This is followed by a quarter (26%) who report finding out the price before booking their appointment and two in ten (20%) who found out while booking the appointment.




In terms of demographic differences:

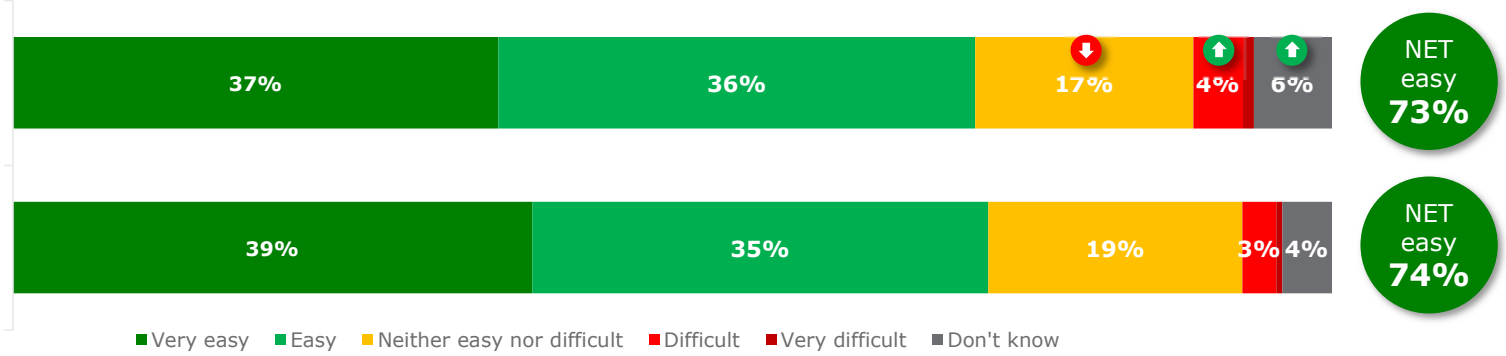
- Those aged 55 or over are more likely to know the price from a previous visit (50% vs. 39% overall), while those aged 34-54 were more likely to find out whilst booking (28% vs. 20%) and those aged 16-34 after booking but before attending (17% vs. 9% overall).
- Participants in England are more likely than average to find out the price while booking (21%).
- White participants are more likely to know the price from previous visits compared to ethnic minorities (42% vs. 27% respectively), who are more likely to have found out the price while booking the appointment (28% vs. 19%).

Participants who had their last sight test/eye examination at a high street opticians/optometrist practice are more likely to know the price from previous visits (41%) than average.

**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 (1,041). Please note that statements and routing have changed in the 2025 wave, therefore data is no longer comparable with previous waves.

# Ease of sourcing price information

Just under three quarters (73%) say they found sourcing the price of their sight test/eye examination *very easy* or *easy*, in line with last year at 74%. However, there has been a slight fall in the proportion who say they found it *neither easy nor difficult* (17% vs. 19%) and a slight increase in those who found it *difficult* (5% vs. 3%), compared to 2024.




Those aged 55 or over are more likely to say they found it *very easy* or *easy* to find out the price of their sight test/eye examination (77% vs. 70% of those aged 16-34 and 71% of those aged 35-54). Younger participants aged 16-34 are more likely to say they found the process of discovering the price *difficult* or *very difficult* (7% vs. 5% overall).

Participants who are confident in receiving care from an opticians/optometrist practice (75%) and confident in managing their eye care (77%) are both significantly more likely to have found it *very easy* or *easy* to find out the price, compared with those who are not confident (44% and 50% respectively).

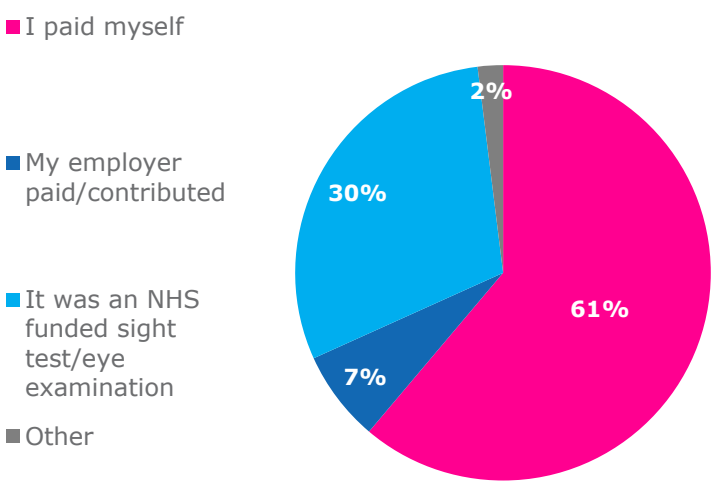
**Q09.** Overall, how easy, or difficult was it to find out the price of your last sight test/eye examination? **Base:** All participants who have had a sight test/eye examination in the last two years (1,953), 2024 participants (1,599). Please note that question routing has changed in the 2025 wave, therefore comparisons to previous waves are indicative only.



*Chart is missing figures due to small proportions and spacing*

# Source of sight test/eye examination funding

Over six in ten (61%) of those who had a sight test/eye examination in the past two years say they paid for it themselves, whereas three in ten (30%) say it was funded by the NHS. Less than one in ten (7%) say their employer paid or contributed towards their sight test/eye examination. A small proportion (2%) paid in another way.




In terms of demographic differences:

- Those aged 16-54 are more likely than those aged 55 and over to have paid themselves (72% vs. 46%).
- Those aged 25-44 are more likely than those aged 55 and over to have had their sight test/eye examination paid for (or at least contributed to) by their employers (11% vs. 2%).
- In contrast, those aged 65 and over are more likely than younger age groups to have an NHS funded sight test/eye examination (59% vs. 17% 16-54).
- Those with a disability are more likely to say their sight test/eye examination was funded by the NHS (40% vs. 27% of those without a disability).

Those who last had their sight test/eye examination at a high street optician/optometrist practice are slightly more likely to say it was funded by the NHS (32% vs. 30% overall). In contrast, those who had their last sight test/eye examination at a hospital are more likely to say they paid themselves (70% vs. 61% overall).

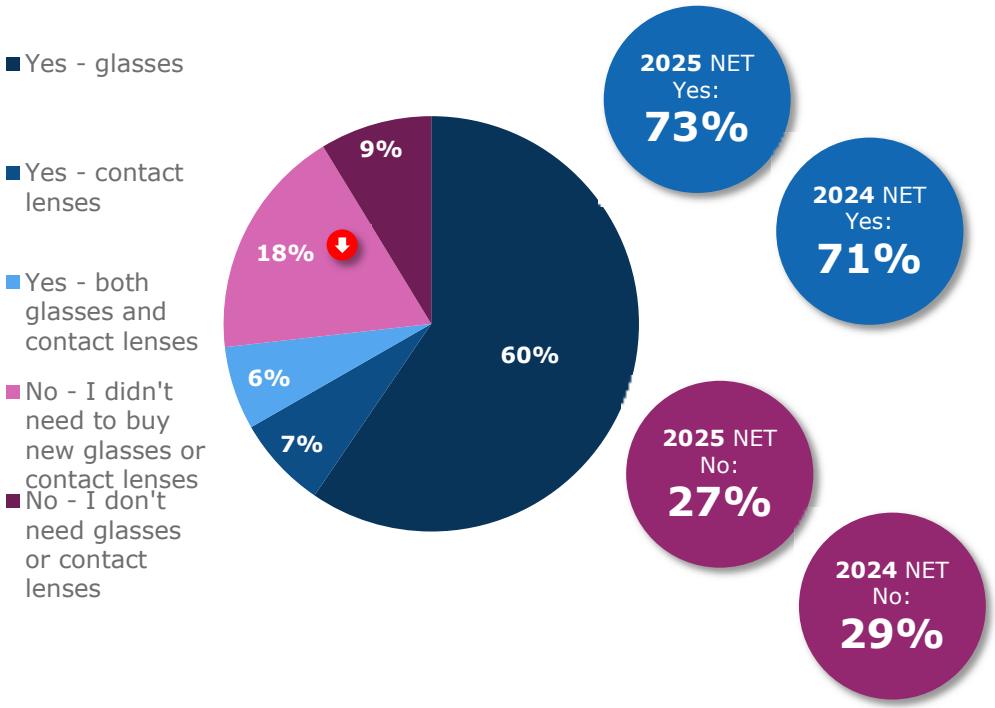
Intuitively those who shopped around are more likely than average to have paid themselves (71%), whilst those who did not shop around are more likely to have received NHS funding (34%).

**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 (1,616).

# Purchasing eyewear

# Purchase of glasses or contact lenses

Almost three quarters (73%) purchased glasses or contact lenses following their sight test/eye examination. The largest proportion (60%) bought glasses only, but 7% bought contact lenses only, and 6% bought both. Just under one in five (18%) did not need to purchase new glasses or contact lenses, which is significantly lower than the proportion in 2024 (22%).




In terms of demographic differences:

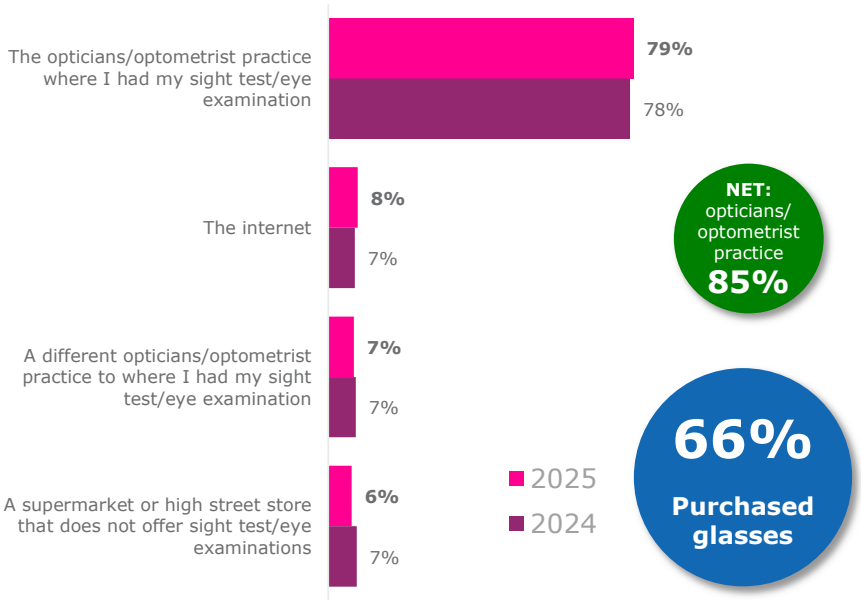
- Women are more likely to purchase glasses, contacts or both as a result of their visit (78% vs. 68% of men).
- Those aged 16-24 are more likely to have made some form of purchase than those aged 55 and over (77% vs. 69% respectively). However, those aged 55 and over were more likely to have purchased glasses specifically (66% vs. 60% overall).
- 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 2024, 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 (64% vs. 60% overall). Alternatively, those whose sight test/eye examination was performed at a hospital facility are significantly more likely to have purchased contact lenses only (17% vs. 7% overall), or both glasses and contacts (13% vs. 6% overall).

**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 (1,616), 2024 participants (1,599).

# Source of glasses purchase

Of those who purchased glasses as a result of their sight test/eye examination, eight in ten (79%) purchased them from the same opticians/optometrist practice where they had their sight test/eye examination, consistent with 2024. Other sources of glasses purchase are less commonly used.




Those more likely than average to have purchased their glasses from the same opticians/optometrist practice where they had their sight test/eye examination are:

- Women (82% vs. 75% of men)
- Those aged 55 and over (86% vs. 65% of 16-34s and 81% of 35-54s)
- White participants (80% vs. 73% of ethnic minority participants)
- Those whose sight test/eye examination was funded by the NHS (85%), compared to those who paid themselves (77%) or their employer paid/contributed to the purchase of glasses (70%)
- Those with no vulnerability markers (83%) and those who state they are not financially struggling (83%).

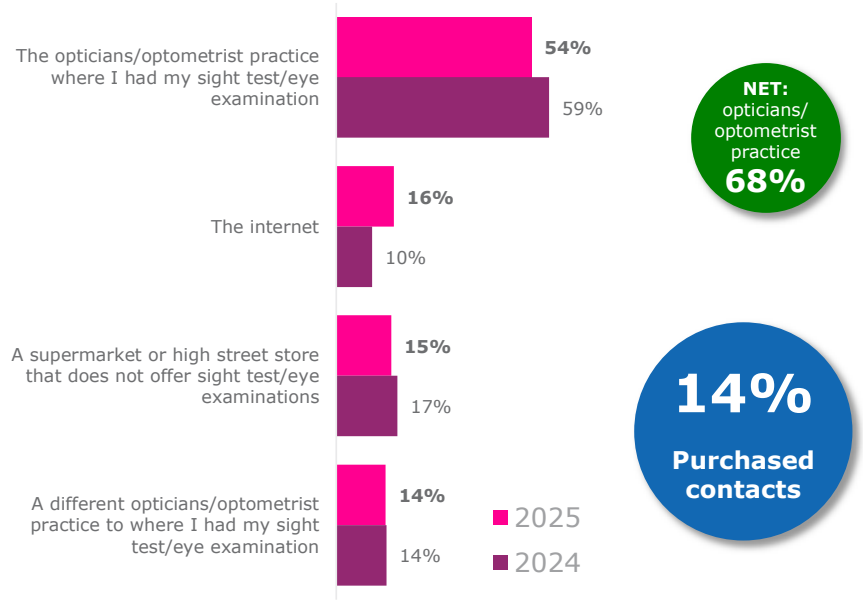
Those who had their sight test/eye examination in a hospital facility (13%) and those who shopped around before their visit (14%) are more likely to purchase their glasses from the internet (vs. 8% overall).

Those with an eye condition (11%) and those with a low income (13%) are more likely to have purchased their glasses from a different opticians/optometrist practice to where they had their sight test/eye examination (vs. 7% overall).

**Q012.** Where did you purchase your glasses from? **Base:** All participants who purchased glasses (1,070), 2024 participants (1,013).

# Source of contact lenses purchase

Of those who purchased contact lenses as a result of their sight test/eye examination, over half (54%) purchased them from the same opticians/optometrist practice where they had their sight test/eye examination. As seen in 2024, those who purchased contact lenses are more likely to use other sources than the opticians/optometrist practice where they had their sight test/eye examination, compared with those who purchased glasses.



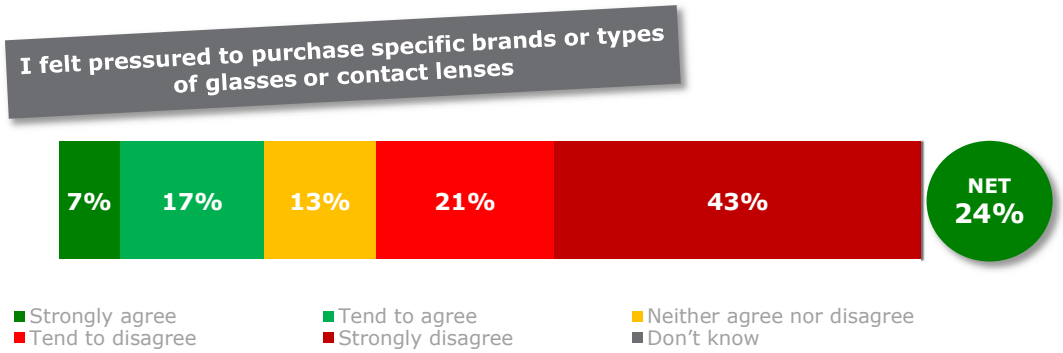

Women are more likely to purchase their contact lenses from the opticians/optometrist practice where they had their sight test/eye examination (61% vs. 46% of men). Conversely, men are more likely to source them from a supermarket or high street store that does not offer sight test/eye examinations (21% vs. 11% of women).

There are very few significant differences by age group in terms of where contact lenses are purchased, however those aged 35-44 are more likely to make their purchases on the internet (28% vs. 16% overall).

**Q013.** Where did you purchase your contact lenses from? **Base:** All participants who purchased contact lenses (205), 2024 participants (196).

# Experience of purchase

Of those who purchased either glasses or contact lenses, a quarter (24%) agree that they felt pressure to purchase specific brands or types of glasses or contact lenses. However, just under two thirds (63%) 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. 24% overall):

- Those aged 16-34 (38%)
- Ethnic minorities (37%)
- Those who had their sight test/eye examination at a hospital facility (47%).

Other groups more likely to have felt pressure include those with at least one vulnerability marker (27%), those with an income of £20,001-£25,000 (32%) and those with an eye condition (30%). This is in addition to those who are not confident in managing their eye health or receiving care (35% and 41% respectively). This may be a potential concern, as those with financial and care needs are potentially experiencing pressure to purchase specific brands or types of glasses or contact lenses.

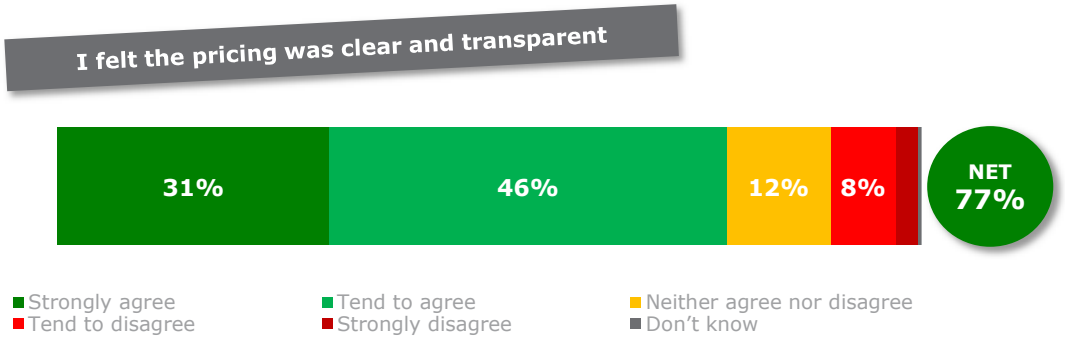
**Q013A.** Thinking about when you last purchased glasses or contact lenses, to what extent do you agree or disagree with the following statements? **Base:** All participants who have purchases glasses OR contact lenses (1,177)



*Chart is missing figures due to small proportions and spacing*

# Experience of purchase

Over three quarters (77%) agree that the pricing was clear when they last purchased glasses or contact lenses, with three in ten reporting that they *strongly agree*. Only one in ten (10%) disagree with the statement.




In terms of demographic differences:

- Those aged 55 and over are more likely to agree the pricing was clear and transparent (81% vs. 73% of those aged 16-34).
- White participants are more likely than those from an ethnic minority background to disagree that the pricing was clear (11% vs. 7% overall).

Those with an income of £20,001-£25,000 (16%), those with at least one vulnerability marker (13%), and those with a disability (14%) are all significantly more likely to disagree that the pricing was clear.

Those that have low confidence both in receiving care from their opticians/optometrist practice and managing their eye health are also more likely to disagree with the transparency of the pricing (22% and 23% respectively).

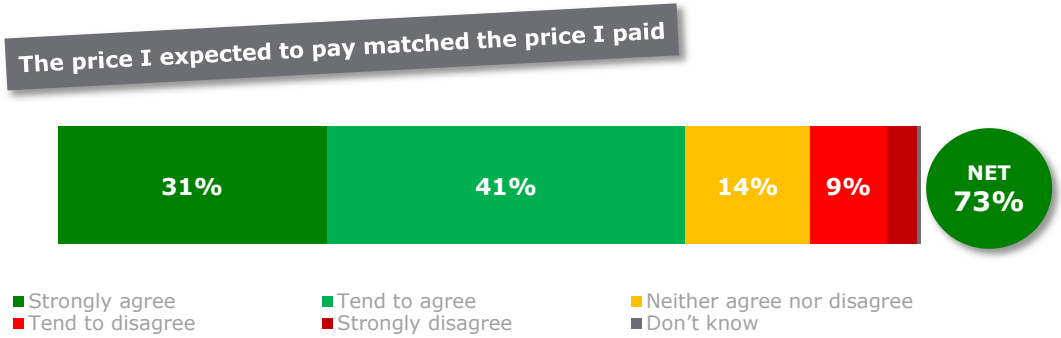
**Q013A.** Thinking about when you last purchased glasses or contact lenses, to what extent do you agree or disagree with the following statements? **Base:** All participants who have purchases glasses OR contact lenses (1,177)



*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, over seven in ten (73%) agree that they paid the price that they had expected, while only 12% disagree. More say they *tend to agree* with this statement than *strongly agree* (41% vs. 31%).




In terms of demographic differences, those aged 35-54 are more likely to agree that the price of the glasses or contact lenses matched what they were expecting (76% vs. 65% of those aged 16-34).

Those who say that they knew the price before their appointment are more likely to agree that the price matched their expectations (77%).

Groups who are less likely to agree that the price matched their expectations include those who state they are struggling financially (67%) and those who have at least one vulnerability marker (70%).

**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 (1,177)

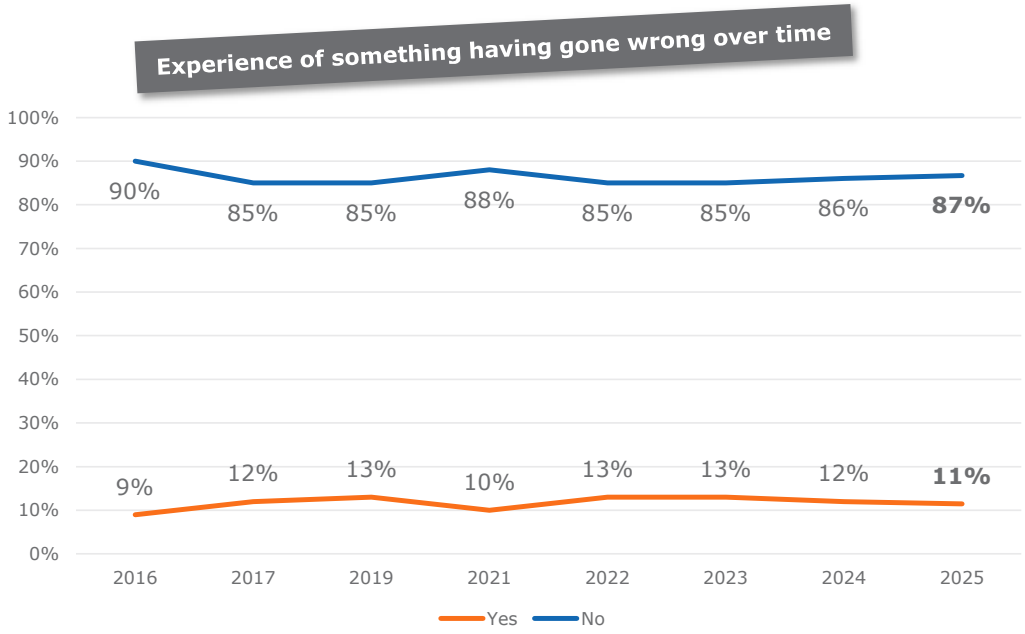


*Chart is missing figures due to small proportions and spacing*

# Poor experiences and complaints

# Poor experiences

The proportion of those who say they have experienced something go wrong when visiting an opticians/optometrist practice remains stable this year (87% no; 11% yes).




Those in older age groups are more likely to say they have not experienced anything go wrong with the care or service they received (89%). While those in younger age groups are no more or less likely to say something did go wrong (11% of 16-34s), they are more likely to say they 'don't know' if something went wrong (4% vs. 2% overall).

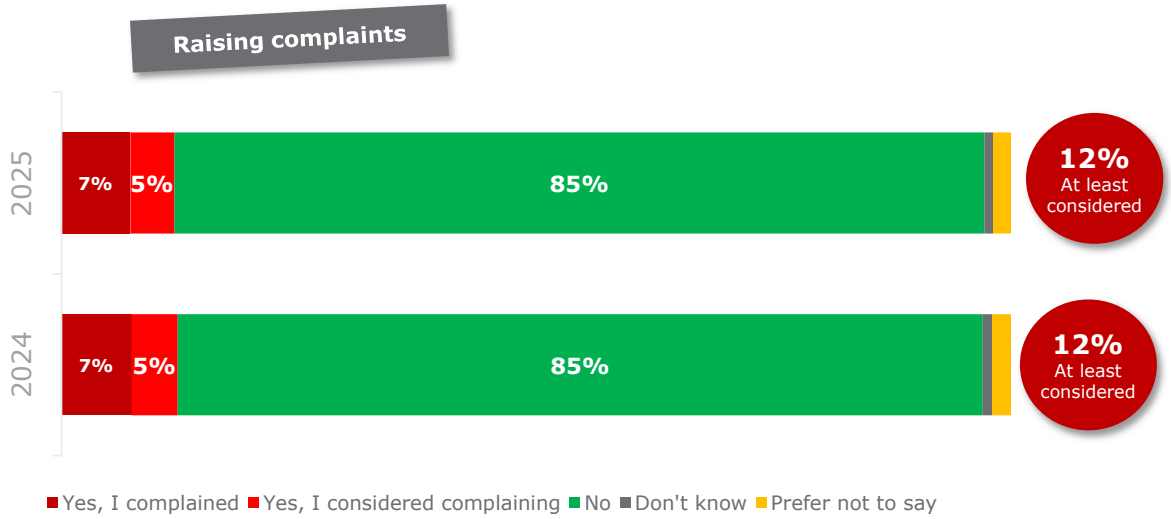
Those with a disability are more likely than average to say that something went wrong with their service or care (19%), as are carers (23%), those with a household income of less than £20,000 (19%), and those not in work (16%).

Those with at least one vulnerability marker are more likely than average to say that something went wrong with the care or service when visiting an opticians/optometrist practice (15%), as are those who are less confident in receiving a high standard of care from their opticians/optometrist practice (20%) or in managing their own eye health (18%).

**Q015.** Have you ever experienced a situation where something has gone wrong with the care/service you received when visiting an opticians/ optometrist practice? **Base:** All participants who visited an opticians/ optometrists practice on their last sight test/eye examination (1,634), 2024 participants (1,667).

# Raising complaints

The proportion of those who made a complaint remains stable this year, with 7% saying they complained and a further 5% considered complaining.




In terms of demographic differences:

- Women are more likely than men to say they complained (9% vs. 6%)
- Younger age groups aged 16-34 are more likely than older people aged 55 and over to say they *considered* complaining (8% vs. 2%)
- Those from a white background are less likely than ethnic minorities to say they *considered* complaining (4% vs. 9%)

Carers are more likely to say they have complained about an experience before (15%), as are those with a household income of £20,001 - £25,000 (13%).

Those with at least one vulnerability marker are more likely than average to say they have complained before about an experience at an opticians/optometrist practice (8%), as are those who say they have been treated less favourably due to a personal characteristic (21%). Those less confident in receiving a high standard of care from their opticians/optometrist practice or managing their own eye health are more likely to say they *considered* complaining (14% and 11% respectively).

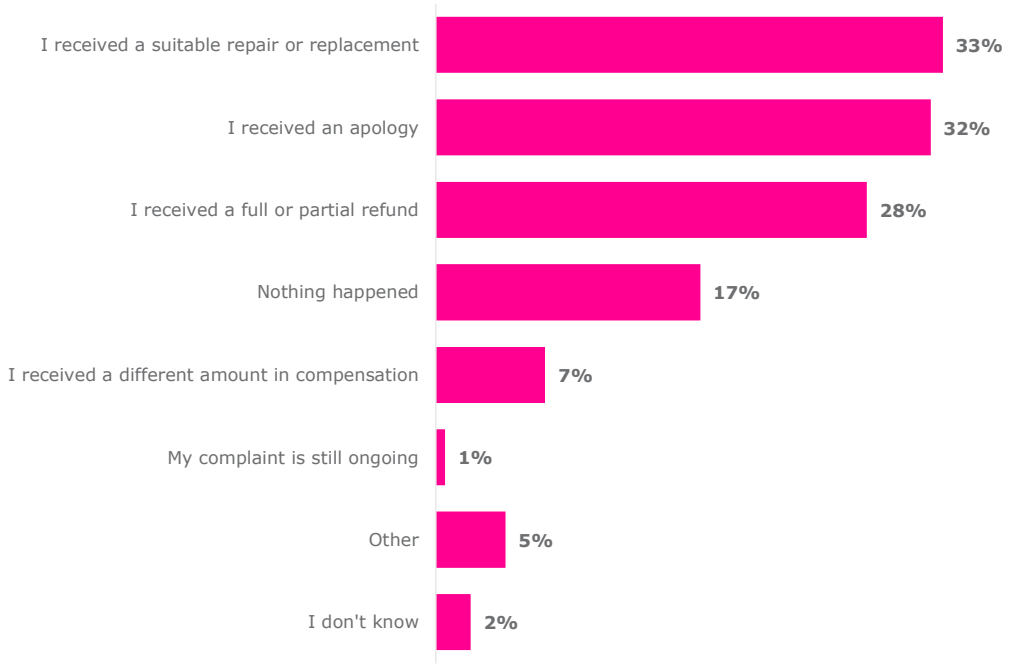
**Q016.** Have you ever complained or considered complaining about an experience when visiting an opticians/ optometrist practice? **Base:** All participants who visited an opticians/ optometrist practice on their last sight test/eye examination (1,634), 2024 participants (1,667).



*Chart is missing figures due to small proportions and spacing*

# Outcome of complaint

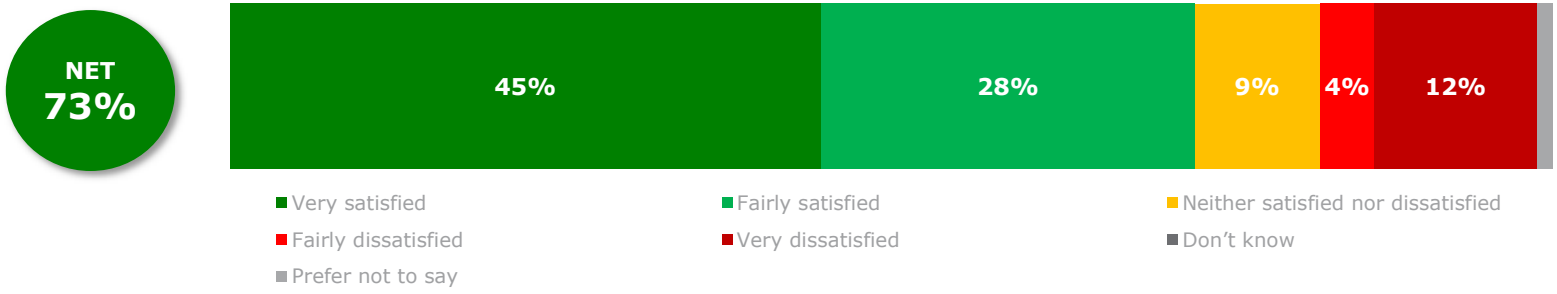
New to the survey this year, those who complained were asked what the outcome of their complaint was. The most common outcomes include receiving a suitable repair or replacement (33%), an apology (32%), or receiving a refund, either in full or partial (28%). Sub-group analysis is not possible for this question due to small sub-group sizes.




**Q016A.** What was the outcome of your complaint? **Base:** All participants who complained (113)

# Satisfaction with the outcome of the complaint

Also a new question to the survey this year, those who complained and reached some form of resolution were asked about the extent to which they were satisfied or dissatisfied with the outcome. Almost three quarters (73%) say they were satisfied with the outcome, with more of these being *very satisfied* (45%) than *fairly satisfied* (28%). Fewer than one in five (16%) were dissatisfied, with more being *very dissatisfied* (12%) than *fairly dissatisfied* (4%). Just under one in ten (9%) say they were neither satisfied nor dissatisfied with the outcome. Again, sub-group analysis is not possible for this question due to the small base size (109).



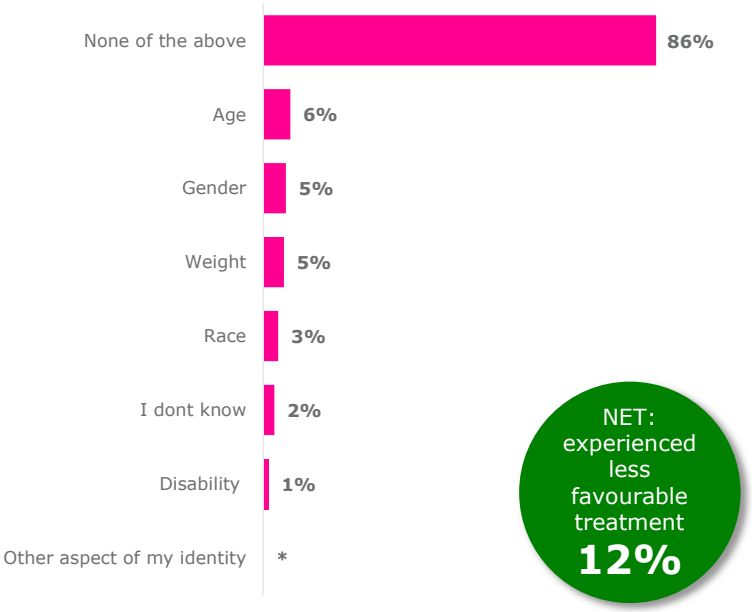

**Q016B.** Were you satisfied or dissatisfied with the outcome of your complaint? **Base:** All participants who complained and their complaint is not ongoing (109).



*Chart is missing figures due to small proportions and spacing*

# Treatment during sight test/eye examination

Finally, another new question to the survey this year involved asking those who had a sight test/eye examination in the past two years if they felt they were treated less favourably due to their personal characteristics. Overall, one in eight (12%) feel they were treated less favourably due to at least one of the factors covered in the survey. This was most often due to their age (6%), followed by their gender (5%), weight (5%), race (3%), or disability (1%). However, just under nine in ten (86%) feel they were not treated any less favourably due to any of the listed personal characteristics.




Young people aged 16-34 are more likely than average to say they felt that they were treated less favourably due to age (11%), gender (11%), weight (9%) or race (7%). In contrast, those aged 55 and over were more likely than average to say they were not treated any less favourably due to the factors listed (94% vs. 86% of overall).

In terms of other demographic differences, men are more likely than women to say they were treated less favourably due to race (4% vs. 2%). Those from an ethnic minority background are more likely than average to say they were treated less favourably due to their race (7%).

Those with a disability and carers are more likely to say they were treated less favourably due a personal characteristic (23% and 27% respectively). The same can be found for those with at least one vulnerability marker (16%).

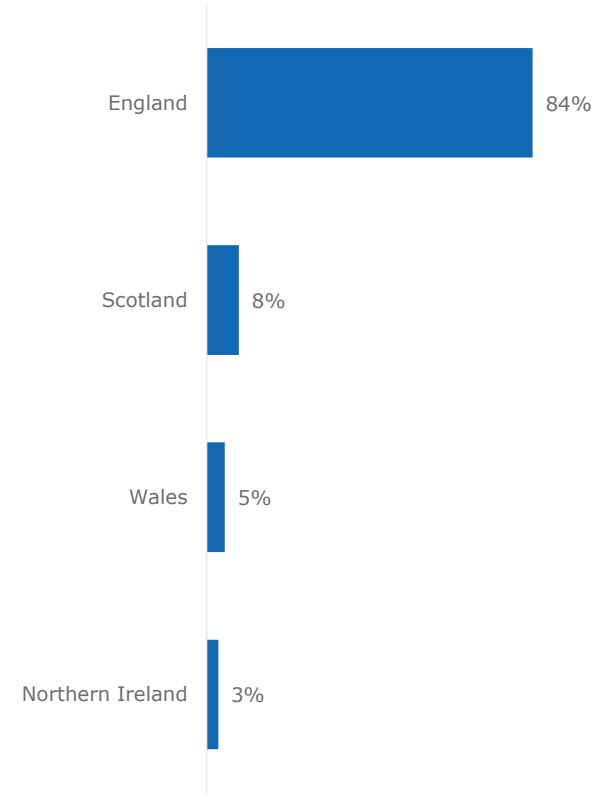
Those with a household income of less than £20,000 or more than £50,001 are more likely to say they were not treated less favourably (92% and 89% respectively vs. 86% overall).

**Q016C**. Thinking of your last visit to an opticians/ optometrist practice, did you feel you were treated less favourably due to any of the following factors? **Base:** All participants who have had a sight test/eye examination in the past two years (1,616).

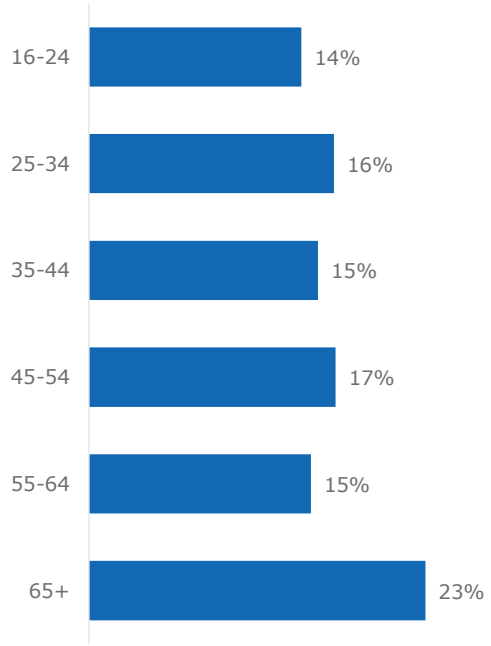
# 04 Audience profile

# Weighted profile of participants (1)

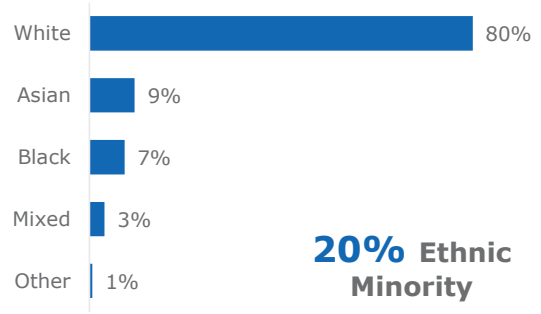
## Nation




## Age group

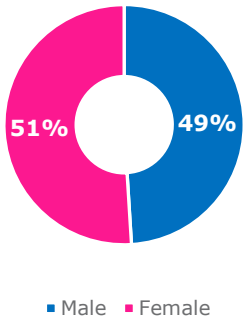



## Ethnicity




**20% Ethnic Minority**

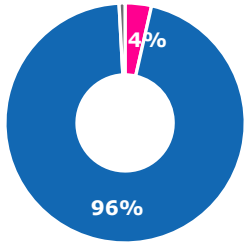
## Gender




**Source:** S02, S03, S05, S06 **Base:** All participants (2,012)

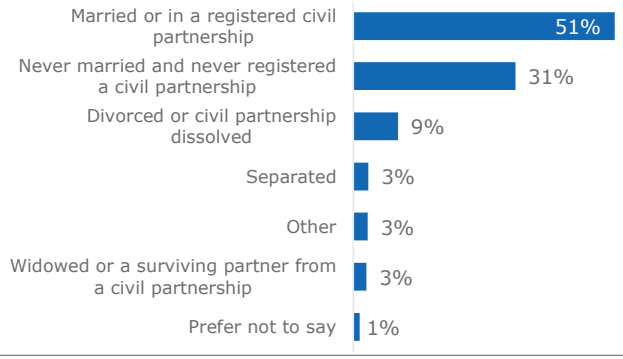
# Weighted profile of participants (2)

## Trans history

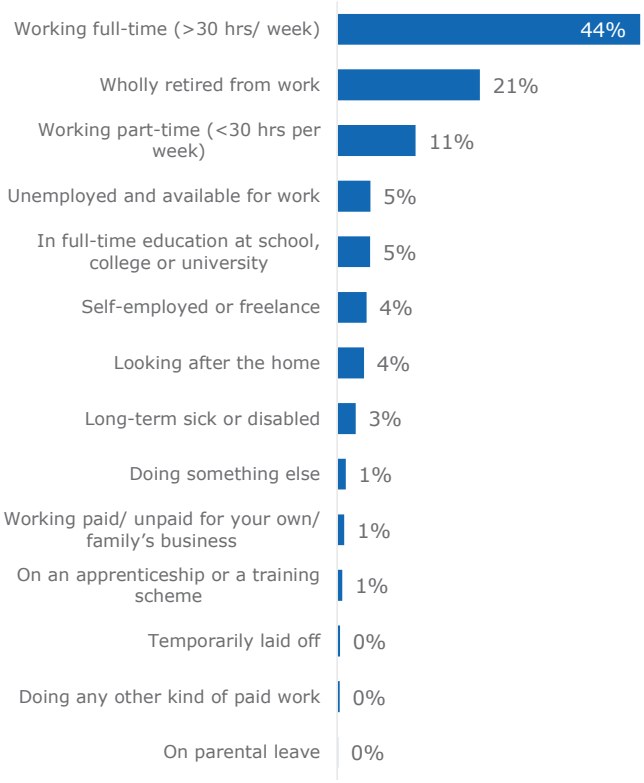



Yes No Prefer not to say

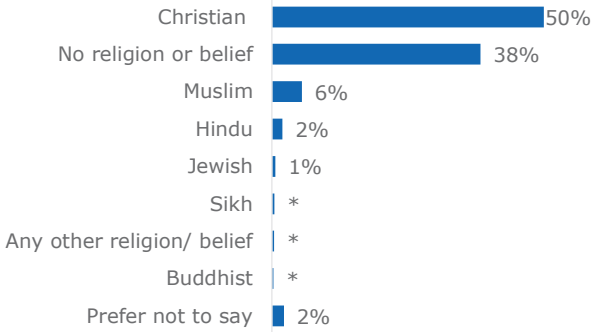
## Marital status



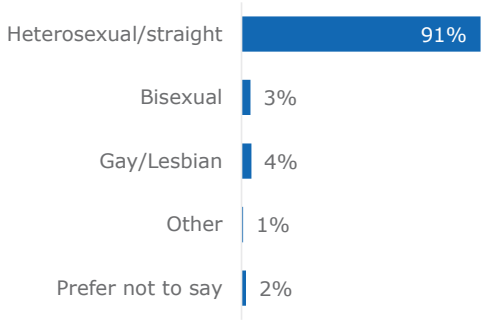

## Working status




## Religion




## Sexual orientation

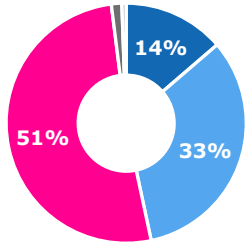





**Source:** C02, C02a, C05, C07, C08 **Base:** All participants (2,012).

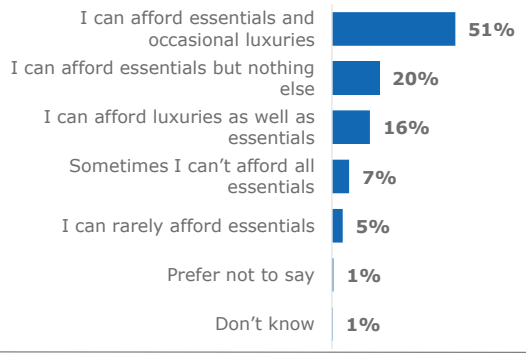
# Weighted profile of participants (3)

## Financially struggling

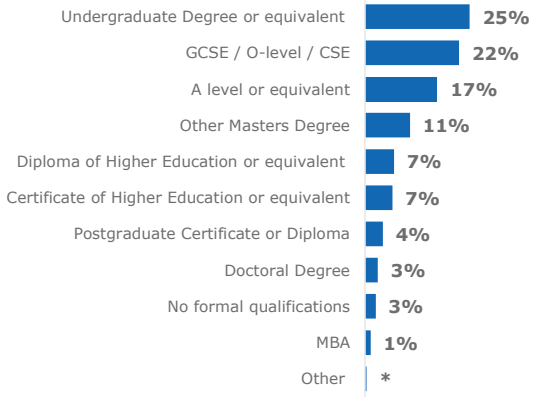



Yes Slightly No Don't know Prefer not to say

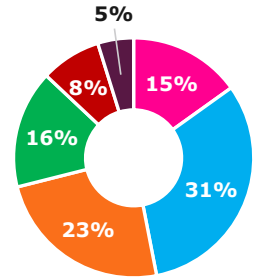
## Ability to pay for luxuries or essentials




## Highest level of education

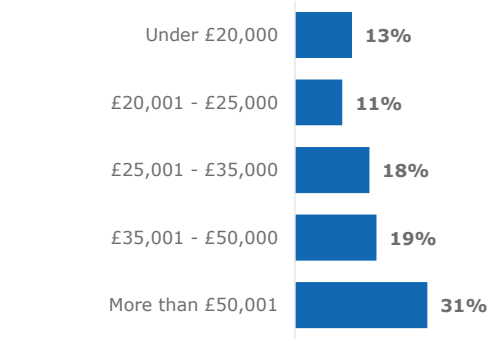



## SEG

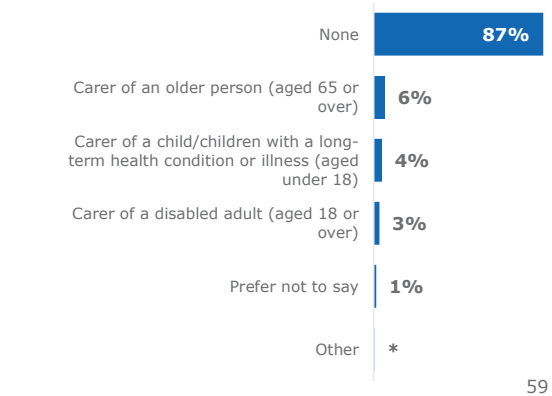



A B C1 C2 D E

## Annual income



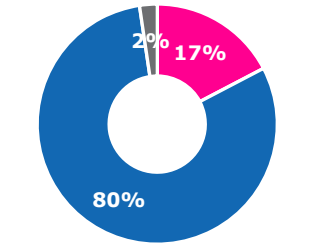

## Unpaid caring responsibilities




**Source:**, C06, C09, C10, C011, C014, C15 **Base:** All participants (2,012)

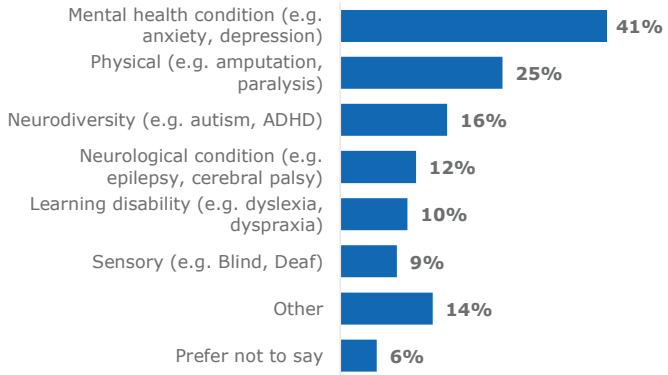
# Weighted profile of participants (4)

## Disability

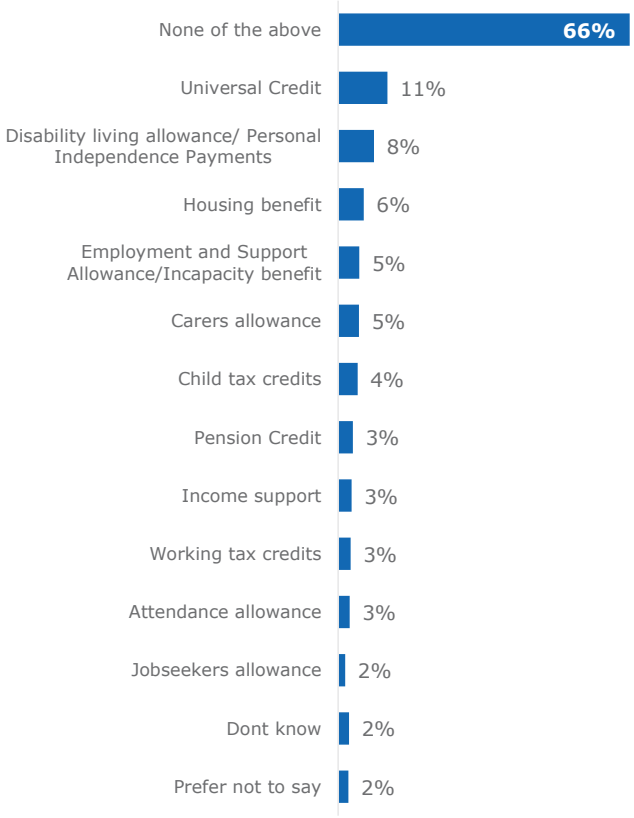



Yes No Prefer not to say

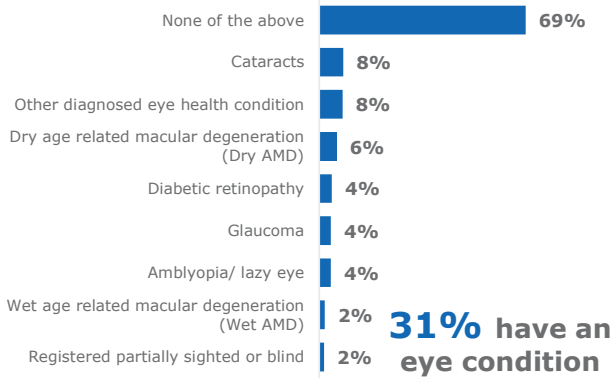
## Disability category




## Benefits received

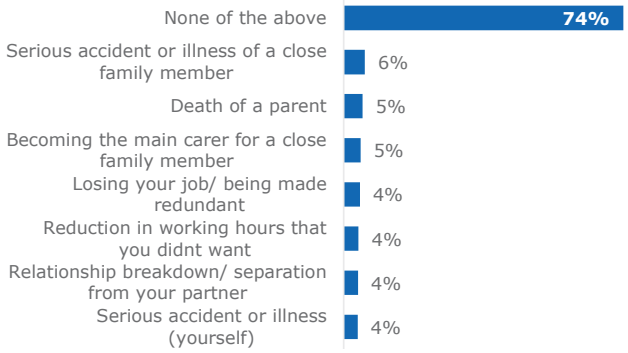



## Eye conditions




**31%** have an eye condition

## Events experienced in last 12 months (>1%)

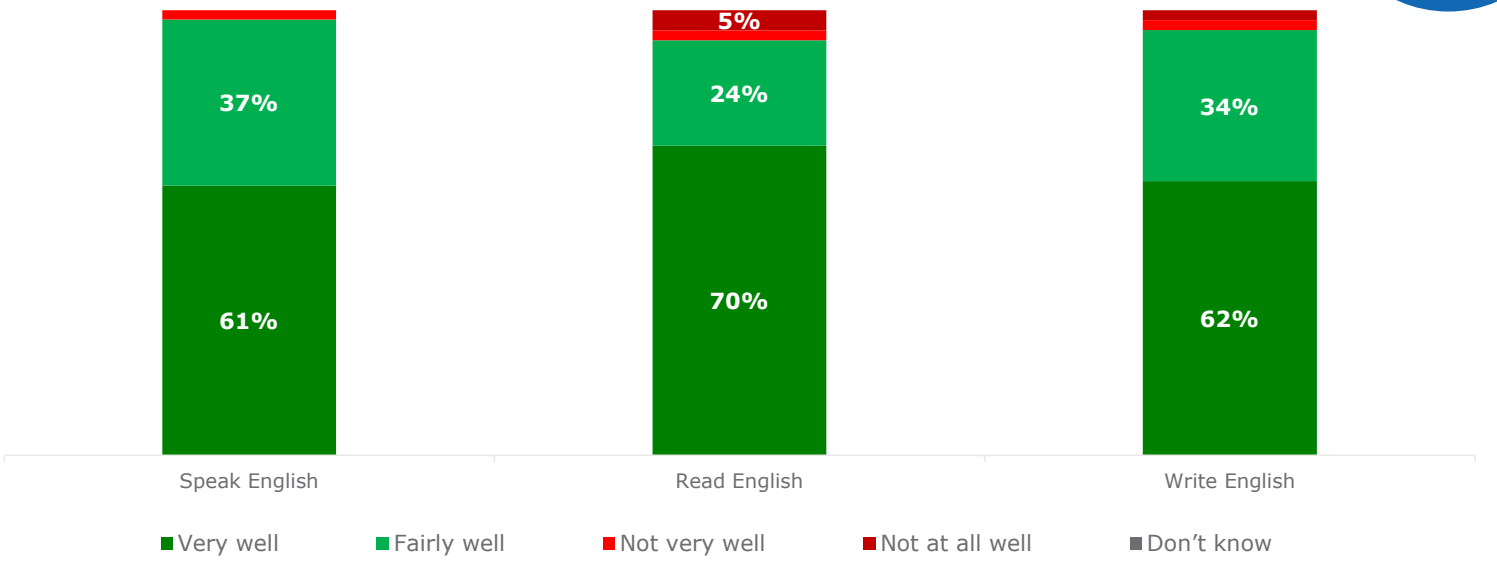



**Source:** C01, C03, C03A, C12, C13 **Base:** All participants (2,012)

# Language

**Ability to speak and read English**

**3%** said that English was not their first language




**Source:** S07. Is English your first language, or not? **Base:** All participants (2,012). **S08.** Overall, how well, or not, would you say you speak English? **Base:** All participants who do not speak English as their first language (62).

# For more information

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# General Optical Council

## Qualitative research exploring the lived experience of patients and non-patients accessing and using eye care services

Final report

June 2025

# Contents

# Key findings

This research was commissioned by the General Optical Council (GOC) to:

1. Explore the lived experiences of patients/non-patients with specific 'vulnerabilities' and how this relates to their access to, and experience of, eye care delivered by optometrists and dispensing opticians in the UK.

2. Identify ways that the GOC can better support patients and non-patients, including effective interventions which could support them when accessing or using eye care services.

To achieve these objectives, Explain Market Research carried out 38 in-depth interviews among patients and non-patients (who had not had a sight test / eye examination in the past two years). All had a defined vulnerability marker.

The findings identified both barriers to accessing a sight test / eye examination (inequalities of access) and defined a set of patient needs within these eye care services (inequalities of experience).

## Inequalities of access: barriers to accessing a sight test / eye examination

A range of barriers influencing people's decision to seek a sight test / eye examination were revealed in the research. These are listed below and then discussed in more detail within the body of the report.

**Low importance of maintaining eye health**

Within this research there was a general low importance placed on maintaining eye health and sometimes an assumption that deteriorating vision was just a normal part of ageing. Participants were often unaware of the recommended frequency of sight tests / eye examinations. They were equally unaware of the role of sight tests / eye examinations in maintaining good vision and eye health, often stating that they did not need one as they hadn't noticed any changes in vision. Importantly, people associated opticians / optometrist practices with testing their vision rather than diagnosing and treating eye health conditions.

**High tolerance for, and self-management of, symptoms related to sight or eye health**

Aligned to the low importance of maintaining eye health described above, participants also discussed a high tolerance for symptoms related to worsening vision (i.e. headaches, blurry vision and eye strain). These symptoms were often viewed as a normal part of ageing. Further, vision was often self-assessed, i.e. checking themselves to see if car number plates can still be seen, and self-managed, i.e. through purchasing off-the-shelf glasses.

**Psychological barriers**

Amongst participants, particularly those with mental health difficulties, the self-management techniques described above were sometimes underpinned by several psychological barriers to visiting an opticians / optometrist practice. These include the 'open' nature of the physical environment, having to sit next to strangers in

waiting rooms, concerns over the length of the wait and feeling uncomfortable trying on glasses in front of others.

**Cost-related barriers**

The majority of participants had an annual household income of less than £25,000. Within this context, narratives revealed perceptions that of the costs involved in a sight test / eye examination were inhibiting. Importantly, these costs were mostly associated with price of eye wear (frames, lenses and contact lenses) and not necessarily with the cost of the sight test / eye examination. The latter was often unknown for those that were required to pay or overridden by the costs of eye wear for those eligible for a free test.

## Inequalities of experience: Patient satisfaction in their experiences of sight tests / eye examinations

Alongside discussions of the barriers to accessing care, participants also discussed having specific needs that influenced their sense of satisfaction with their experiences of having a sight test / eye examination.

**The need to recognise and cater for hidden vulnerabilities and concerns**

A key finding of this research is the differentiation of the experiences of patients with vulnerabilities more visible to others, i.e. some physical disabilities, and those with hidden vulnerabilities, i.e. some mental health problems and learning disabilities.

In general, participants with those more visible forms of physical disabilities discussed care that was more accommodating to their needs. In contrast, patients with more hidden vulnerabilities discussed more complex and problematic interactions with eye care services. Importantly, when these needs were addressed, satisfaction was greatly improved.

**The need to feel a 'thorough job' has been done**

For many, a sense of dissatisfaction was rooted in feeling that they had been 'rushed through' their sight test / eye examination. This led to a sense of being poorly cared for, not listened to and, in some cases, concern that their test had not been performed thoroughly.

**The need for an empathetic approach**

Further to the need to feel listened to, mentioned above, patients were notably appreciative when an optometrist and/or dispensing optician took their time with them, and showed they were empathetic to their needs. As part of this, the ability to support people with vulnerabilities and quickly identify their needs was viewed as an important skill amongst optometrists / dispensing opticians.

**The need for continuity of care**

Dissatisfaction could also be generated by a lack of continuity in care. Some wished to be able to develop a sense of connection to their optometrist. Others were concerned that there was a lack of communication between hospitals and different optometrists involved in their care. For some, there was a belief that this had led to delays in diagnosis.

**The need for transparency on costs**

Participants wished for more clarity and a better upfront understanding of the financial implications of the options available during a sight test / eye examination. For most, this desire for clarity related to the cost of eye wear.

## Participants' suggested interventions

Within participant discussions of inequalities of access and experience, they suggested interventions for improvement. These are listed below.

### Greater awareness and knowledge of eye health and the benefits of routine sight tests / eye examinations

Interventions suggested by participants were as follows:

- ➔ Education among those with vulnerability markers / their carers regarding the importance of maintaining good eye health, clarity of the role of optometrists within this and the subsequent need to get a sight test / eye examination within recommended timeframes. This should include raising awareness about the importance of getting a test even when they cannot identify 'something wrong' with their eyes and the role of optometrists beyond testing sight and eye health, such as treating emergency minor conditions.
- ➔ Establishing an understanding of the link between certain symptoms and eye health may benefit a wide range of people including those with lower health literacy and understanding.
- ➔ Accessible information should be universally available in opticians / optometrist practices, such as easy-read documentation, or written materials translated into other languages.

## Greater transparency around costs

Greater transparency may play an important role in helping people become more comfortable about going to visit an opticians / optometrist practice.

- ➔ Participants wanted greater clarity on costs involved in getting a test, getting glasses or contacts (and the long-term expected costs of this), as well as clarity about the financial help people can get with their health costs, for those in a range of different circumstances. Upfront communication about this could help improve transparency.
- ➔ Opportunities to have flexible payment options for people on a low income to pay for glasses, for example in instalments, should be considered.
- ➔ All staff involved in the selection of eye wear should consider their approach to reduce any sense of feeling pressured to buy, for example in giving people space to look through options in their own time.

## Opticians / optometrist practices should better cater for patients with both visible and hidden vulnerabilities

Participants felt that opticians / optometrist practices should enquire early on whether patients require reasonable adjustments.

Reasonable adjustments included:

- ➔ The opticians / optometrist practice should offer the right care in the right place for patients, i.e. offering appointments at home or any other environment that meets specific needs (for example, a known community centre). This should be provided more widely to include those that aren't / don't believe they are covered by the criteria for domiciliary care, such as those that have certain mental health conditions.
- ➔ The length of the appointment should be considered, as should reducing waiting times.
- ➔ The way tests are performed should be considered where possible, for example, using the right specialist techniques for those unable to do a traditional test (such as those with a learning disability).
- ➔ Effective follow-up should be provided to support people that have additional needs (for example, checking they are wearing glasses and/or symptoms are resolving).
- ➔ Staff training and raising awareness were viewed as important – for instance, mental health first aid and helping staff support those with a learning disability or other markers of vulnerability, such as being on a low income.

## Greater continuity of care

Patients pointed out that improving care continuity would build their confidence in the care they are receiving. Suggestions put forward included:

- ➔ Several participants spoke about wishing to be able to select their optometrist, see the same person the following time, or find out information about them and their qualifications.
- ➔ Improving the communication between the hospital and the opticians / optometrist practice to avoid any duplication of appointments and improve care for those with known eye health conditions.

# Introduction

# Introduction

## Background

The GOC regulates eye care services in the UK and protects the public by regulating optometrists, dispensing opticians, optical students and some eye care businesses.

The GOC carries out a patient survey annually, the latest published wave of which was in 2024[1]. Within this, 88 per cent of respondents reported satisfaction with accessing eye care services, with 50 per cent stating that they were very satisfied[2]. Despite this, there are some groups that are more likely to report poorer experiences. Those with certain 'vulnerability markers' reported lower satisfaction across many domains of their experience. This included: satisfaction with their overall experience; satisfaction with the optometrist who carried out the sight test / eye examination; their experience of buying contact lenses or glasses; and their satisfaction with value for money. Those with several vulnerability markers were also significantly less likely to go for a sight test / eye examination every two years.

The GOC's corporate strategy for 2025-2030[3] outlines its mission, vision and strategic objectives. One of these objectives is to create 'fairer and more inclusive eye care services', therefore addressing inequalities or barriers to access care, especially for those with vulnerabilities.

In this context, research was commissioned to provide insights to the GOC and wider sector about the patient and non-patient experience, particularly among groups that are more likely to report poorer experiences or challenges accessing care, to bring their views, experiences and needs to life. The findings could also help identify interventions that may help improve access to, and experience of, eye care services for more vulnerable patients.

[1] GOC (2024) Public perceptions reports | GeneralOpticalCouncil
[2] GOC Public Perceptions Research 2024.pdf
[3] GOC Corporate Strategy 2025-2030

Explain Research, an independent market research company, was commissioned to carry out a programme of qualitative research to investigate the lived experience of patients and non-patients accessing and using eye care services delivered by optometrists and dispensing opticians in the UK.

## Research objectives

The specific research objectives for this project were as follows:

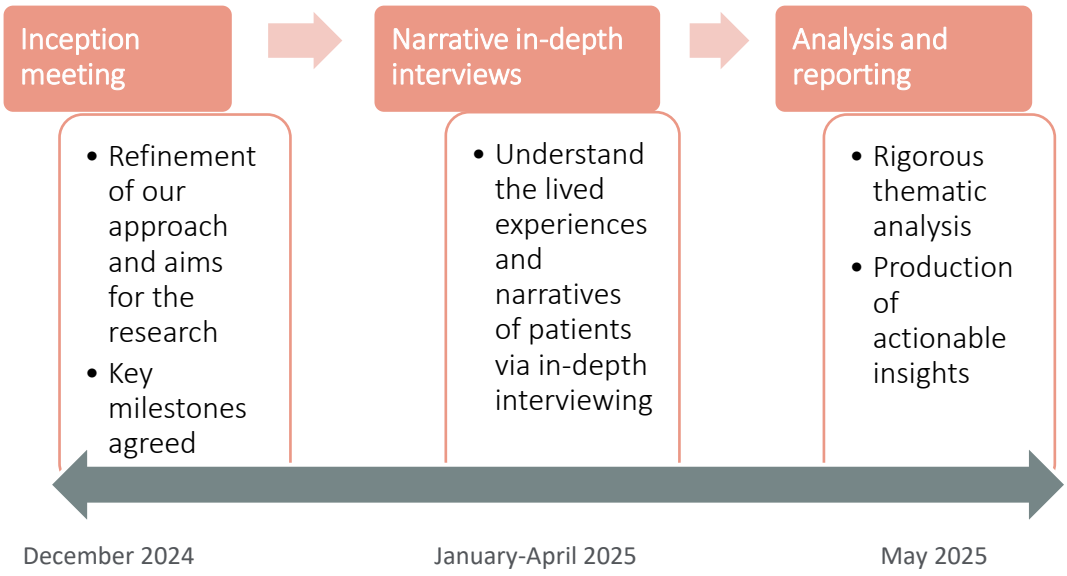
**To explore the lived experiences of patients / non-patients with specific 'vulnerabilities' and how this relates to their access to, and experience of, eye care delivered by registered optometrists and dispensing opticians in the UK.**

**To identify ways that the GOC can better support patients and non-patients, including effective interventions which have / could have supported them when accessing or using eye care services.**

# Methodology and participant profile summary

# Methodology and participant profile summary

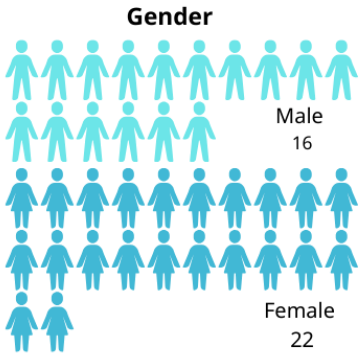
Our approach to this research comprised the following key elements:




More methodological information can be found in Appendix A of this report, including the approach that was taken to participant sampling and how vulnerability markers were defined. A copy of the discussion guide is provided in Appendix B.

We carried out 38 in-depth interviews among patients and non-patients. Interviews were conducted both face to face (n=24) and online (n=14). Of these 38 interviews, 23 were with patients and 15 with non-patients. 37 considered themselves to have one or more of the defined vulnerabilities[4]. The key sociodemographic details of the participant sample are summarised in the infographic overleaf.

[4] Please note: one person taking part did not fall into the vulnerability criteria but was permitted into the research given they were from an ethnic minority background and had previously complained about their care, both relevant criteria for inclusion to explore in this study based on previous research.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Female
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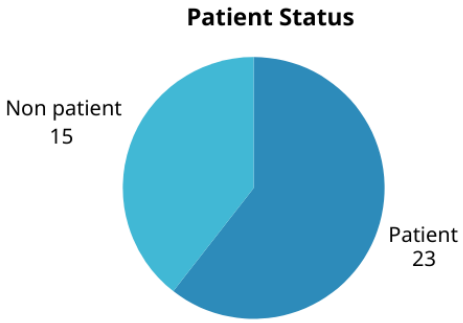
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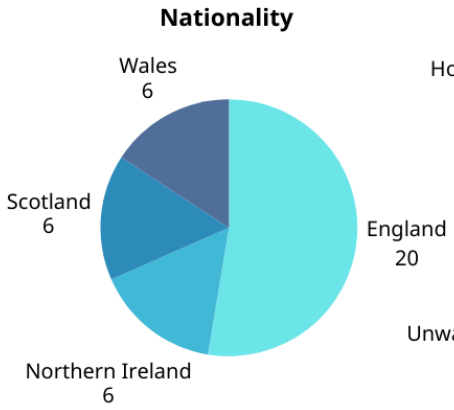
15
Patient
23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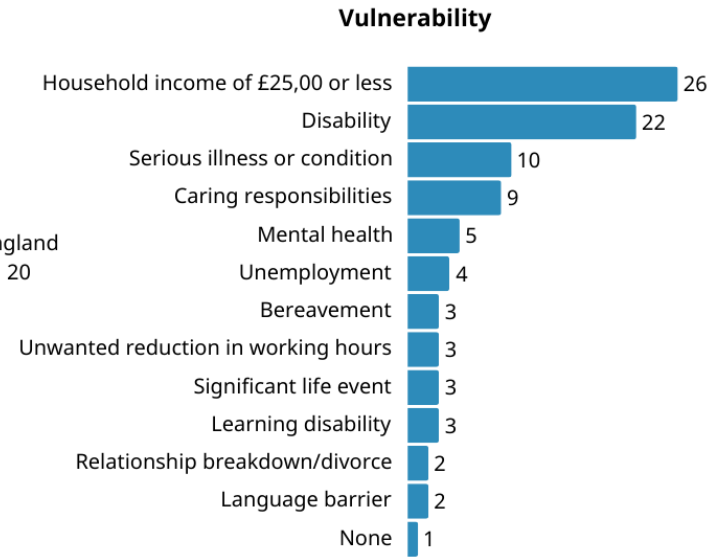
Scotland
6
England
20
Northern Ireland
6


Vulnerability
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Disability
22
Serious illness or condition
10
Caring responsibilities
9
Mental health
5
Unemployment
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Bereavement
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Unwanted reduction in working hours
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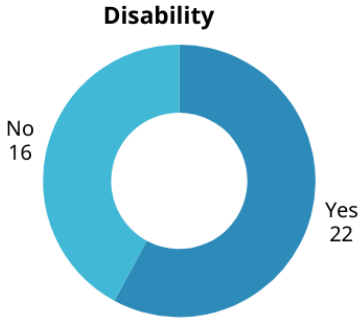
Significant life event
3
Learning disability
3
Relationship breakdown/divorce
2
Language barrier
2
None
1


Disability
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Yes
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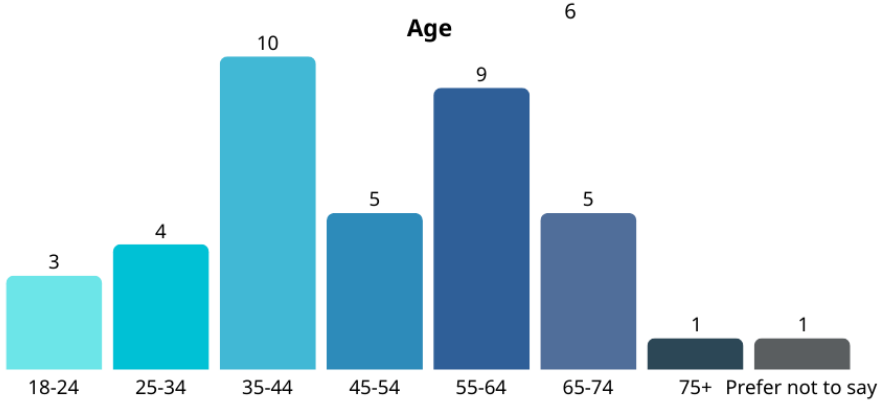
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5
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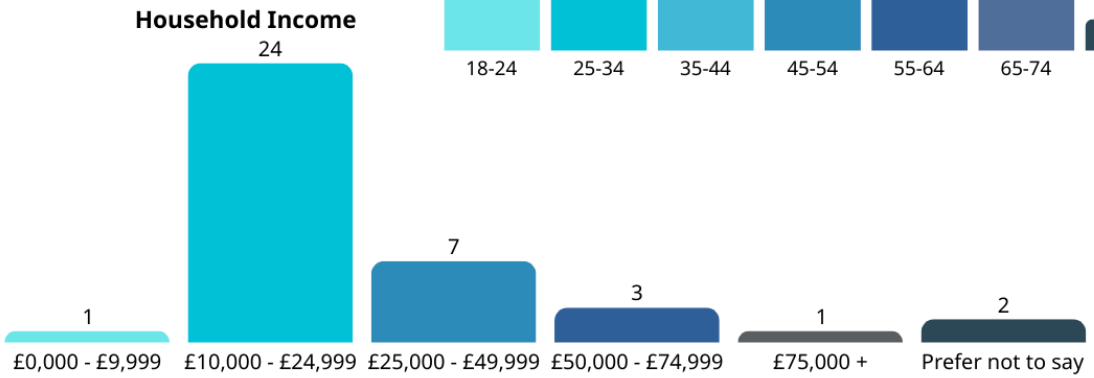
25-34
35-44
45-54
55-64
65-74
75+
Prefer not to say


Household Income
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24
7
3
1
2
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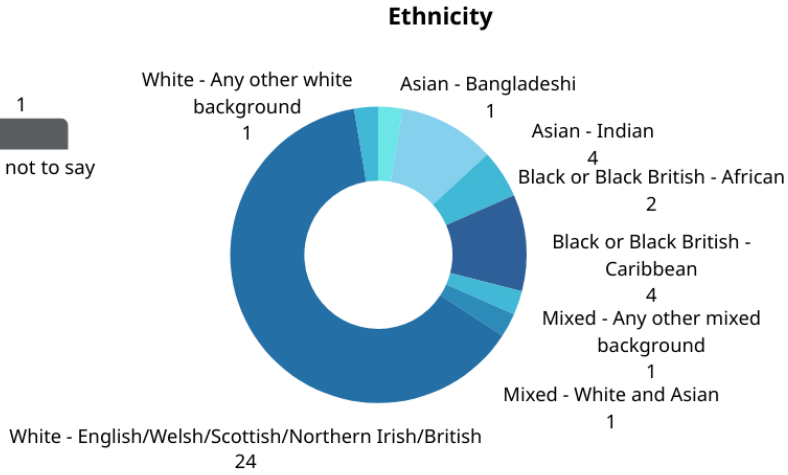
£10,000 - £24,999
£25,000 - £49,999
£50,000 - £74,999
£75,000 +
Prefer not to say


Ethnicity
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Asian - Bangladeshi
1
Asian - Indian
4
Black or Black British - African
2
Black or Black British - Caribbean
4
Mixed - Any other mixed background
1
Mixed - White and Asian
1
White - English/Welsh/Scottish/Northern Irish/British
24

# Research findings

# Research findings

For ease, the findings of this research have been divided into two broad categories:

| |
|---|
| **Inequalities of access: Patient barriers to accessing a sight test / eye examination** |
| **Inequalities of experience: Patient satisfaction with their experiences of sight tests / eye examinations** |

Each will now be described in turn. Findings will be interwoven with verbatim and relevant case studies to bring views and experience to life.

# Inequalities of access: Patient barriers to accessing a sight test / eye examination

A key goal for this research was to identify challenges or barriers that patients and non-patients with vulnerability markers experience when accessing or having a sight test / eye examination.

A range of barriers influencing people's decision to seek a sight test / eye examination were revealed in the research. These are listed below and then discussed in more detail.

Please note, barriers are not ordered by their relative level of importance or impact. Indeed, they are often interlinked. Additionally, many of these factors were relevant for patients and non-patients alike and could often be the reason for previous patients' check-ups lapsing (i.e. going beyond the recommended two-year period between sight tests / eye examination).

## Low importance of maintaining eye health

Participants were asked to discuss attitudes towards eye health in the context of their general health. This provided useful context regarding how people view their eyes in relation to other health priorities.

The level of knowledge that people had about eye health was significantly greater among those that had diagnosed issues and conditions. These had prompted them to learn more about the issues affecting their eyes, especially if serious issues such as a risk of sight loss was one of the side effects of their condition. They had learned to be their own advocate in navigating health systems, as the following quote from a patient with glaucoma illustrates:

- *"I know, sort of the annual calendar of what I need to do, or if I don't get contact to get in touch, and that's why I went into the opticians in January, just to find out why I hadn't had a glaucoma checkup. And that revealed that something had gone wrong with the recording system."*

Conversely, this also meant that participants without a diagnosed health condition could be naïve to the need for sight tests / eye examinations every two years.

- *"I'll get new glasses only if I need to. You're not forced to do it like, if my sight, if my vision has changed, then I think they recommend that you do"* (Patient, England, Female, 25-34)

Sight tests / eye examinations were viewed as a low priority unless 'serious' issues with vision were perceived. This was particularly the case when there were other health concerns or personal difficulties at play. Some patients using glasses described going for a sight test / eye examination if they perceived a change in their vision and were well enough to go to a check-up, even those going through major life events, such as cancer. However, some who had not been for a sight test / eye examination

recently or ever deprioritised their eyes in light of serious life events or other pressures which took precedence. This included those who prioritised the health needs of others before their own, and so issues could be left to fester.

- *"I'm a private family carer and paid carer... [I] look after three of them…. [now I'm] also sort of roped in to look after their sister, and one of their cousins, so back and forth to them as well… running around appointments, that sort of thing. There's so much running around with three of them with medical appointments... I neglect myself and look after everybody else." (Non-patient, Wales, Female, 55-64)*

Many non-patients said they didn't visit because they thought 'nothing was wrong' with their vision. They asserted that 'as long as they are able to see', their 'eyes must be fine'. This was very unlike their attitude towards, for instance, visiting the dentist, where regular check-ups to make sure things are on track with their oral health seemed much more normalised.

- *"I do, like, for example, every year, twice, like cleaning for my teeth. So because, you know, I smoke as well sometimes, so I, I want to do it, you know, for my hygiene thing." (Non-patient, Wales, Male, 25-34)*
- *"I've never had my eyes tested in 40 years. I don't know… off the top, there's nothing preventing me going but I'd never really had a problem where I thought I can't see or I got to squint at anything" (Non-patient, Wales, Male, 35-44)*

Aligned with this, there was inconsistent knowledge of the recommended frequency for sight tests / eye examinations. Previous research[5] showed that those with vulnerability markers are more likely to say that their test was over two years ago. Consistent with this, we have found that knowledge of the recommended testing frequency seemed to be built through experience as a patient first, such as via appointment reminders when a test was due, or verbal advice given following a test. There was also greater knowledge of the recommended interval among those that

[5] GOC Public Perceptions Research 2024.pdf

had been specifically advised about increased testing frequency (such as those with diabetes or at risk of glaucoma). However, there was low awareness among non-patients that people are generally recommended to get a sight test every two years even if they considered themselves to have no sight issues. It was also not recognised that regular visits were helpful not just to address changes in vision but also to address eye health.

- *"I didn't realise that you should go every two years. It doesn't tell you that on any adverts, does it?" (Non-patient, Scotland, Female, 35-44)*
- *"[I'm] surprised its two-yearly checkups, I gotta be honest. But that wouldn't worry me, I mean, I don't know much about the eyes" (Non-patient, Wales, Female, 55-64)*
- *"This probably sounds ridiculous, but like...unless there's something wrong... do you like, get your eye tested?" (Non-patient, England, Female, 18-24)*
- *"Is it every four years? No, it's not? [Interviewer – 'two years'] Two years. Oh! I never knew that, I thought it was four because they sent the letter out [recently]… I know that you get all these adverts on the TV for the all the good ones… the glasses and stuff, but it's not really talked about" (Non-patient, Northern Ireland, Female, 35-44)*

Even among those aware of the recommended two-year timeframe, there was evidence of scepticism of the rationale for this. One patient felt the reasoning for this was commercial, so instead they waited until they felt their eyes failing further before returning:

- *"I believe the optician says two pair and two pair every two years, but that's money making. [So] I go with failing now" (Non-patient, England, Female, 55-64)*

## People associated opticians / optometrist practices with testing their vision rather than diagnosing and treating eye health conditions

Where symptomatic eye problems had been experienced, such as an eye infection or headaches, the GP was often the first port of call who sometimes signposted them on to their opticians / optometrist practice. It was not commonly known that an optometrist could treat eye health conditions such as dry eyes.

- *“Oh, yeah I've got dry eyes, yeah, but no, just buy some drops. I just buy some drops. I think everybody gets dry eyes at some point… [I’ve not had] additional tests at the opticians… any treatment, just, just, just the sight test.” (Patient, England, Female, 65-74)*
- *"They get a machine thing or whatever they look in your eye?" (Non-patient, Wales, Male, 35-44)*
- *"… I noticed when I'm looking at the numbers, I thought they're not as clear as they used to be. I still see them, but they're not as clear …. So I know I should get tested, but I don't feel I've got any problem other than general loss, because distance is fine." (Non-patient, Wales, Female, 55-64)*

Another barrier to getting a test was dismissal of symptoms they were experiencing as being caused by other known health conditions. Several participants spoke about having had headaches all their life, but associated this more with their long-term health conditions, such as epilepsy, neurological injury or bipolar disorder. A few of these non-patients had worn glasses as a child or at some point in their childhood they stopped wearing glasses as they moved into teenage years and adulthood. Some had not had an eye test for decades.

- *“…I still get them, now and again [sore heads] but I don’t think it’s to do with my eyes. I think because I never really had many problems that I thought were associated with my eyes.” (Non-patient, Scotland, Female, 35-44)*

- *"I think I went to the optician when I was younger... I can't even remember what, like, what they were for. I don't think I needed them for very long." (Non-patient, England, Female, 18-24)*

This is elaborated on further in the case study example overleaf.

**Case study: A person with multiple health conditions talks about their eye strain and migraines being linked to other conditions**

'Lee' is in his 40s and lives with his dog in a high rise flat in the centre of a city in South Wales. He loves fishing, being out on the water and an outdoor lifestyle. His flat is full of fishing paraphernalia. Lee used to work in kitchens but suffering with multiple health conditions has prevented him from working. He is on disability benefits and Universal Credit. Lee has dealt with a lot of stress in recent years and has some long term mental and physical health conditions. In recent times he has found himself homeless, before he was supported to find the flat he is currently living in. He experienced bereavement a few years ago when he lost his mother and thinks that played into his breakdown too. He has low trust in the NHS because he initially had trouble with getting himself classified as disabled due to the types of conditions he has. Everyone in his family wears glasses except him. He recalls his mother wearing glasses from a supermarket. She never went for a test when she was alive.

Lee talked about his lived experience of multiple long-term conditions, where the symptoms of these conditions cross over themselves. This led him to assume that his eye strain and migraines are due to his current health conditions and had not really considered the fact that he may need to have an eye test to check that the cause of these headaches isn't related to his vision. He thought about getting an eye test but as he believes he can 'still see', doesn't think this is necessary.

- *"I think there's a crossover between a lot of illnesses. So, whether you've got Fibro, you can have lupus. There are several different things that relate to the same thing. You can see with my hands, I've got arthritis as well, then something [else] is pain, my shoulders are always hurting, and, like, even in my spine here as well, yes, yeah. And like, [I have] headaches. Migraines…[but] my eyes have always been very good. I mean, I can see quite far, and I can probably see quite well?... [But] I think the thing is, now, more often than not, that when you are on your phone, on Facebook, or, oh, yeah, you know, but you can sort of feel your eye [strain] because you watch your TV or something. That's the only thing. I've thought about [getting a test] but I've never really put it into [practice]"*

Some of those taking part in the research admitted they put up with symptoms for longer than they should do – in some cases years – because they weren't necessarily sure of the link between these symptoms and their vision, as shown in the below case studies of two patients with learning disabilities. Indeed, we know that people with a learning disability have worse physical and mental health than those without a learning disability[6].

**Case study: A person with a learning disability discusses not associating their symptoms with vision deficits**

'Paul' has a learning disability. Now in midlife, he originally had his eyes tested when he was a boy. He had a lazy eye and had an operation for this, though never wore glasses throughout childhood. Later in life he had persistent headaches, especially when at his computer, but did not associate these with needing glasses. He had these headaches for a long time. He contacted a charity called SeeAbility that supported him to get a test where it was found he needed strong prescription glasses. He is still having headaches but has stopped wearing his glasses because he worries they are now giving him headaches. Every year Paul has his annual health check with his GP but he was only asked whether he had been to see an optician, and if he wore glasses. He was not referred to a specialist service because of his headaches, or told about services he could go to in his area to have a test. Paul wished he had a test as part of his annual check.

- *"I didn't know a lot about getting your eyes tested and why it is important for people with learning disability to have their eyes tested and stuff like that"*
- *"…every year… you have an annual health check, and you talk to the doctor, you talk to the nurse, you get your blood done, your blood pressure, talk about health. But eye care is not included"*

[6] Learning Disability - Health Inequalities Research | Mencap

**Case study: An advocate of a person with a severe learning disability discusses symptoms being incorrectly attributed, which prevented access to testing**

'Shane' has a severe learning disability, cerebral palsy, and visual and other sensory impairment and lives in England. His advocate spoke with us about their experiences as a family accessing an eye test. The first problem that they faced was accessing care because issues with vision were incorrectly attributed to their diagnosed learning disability. He had his first eye test in his 50s (six years ago) where he was found to have had cerebral vision impairment and needed specialist glasses and interventions.

- *"And as a family, we kind of noticed very early on, once he was started, he was late walking. But we noticed he wasn't seeing things, you know, he wouldn't see curves and, you know, wouldn't he trip over things? And we kept raising that, and we were just told, 'oh, it's just part of his very severe learning disability'. And we've had that through his life, really… Lower field vision was a problem for him, and as he was getting older, we thought things were changing… he had his first eye test in his 50s…"*

## High tolerance for, and self-management of, symptoms related to sight or eye health

Some participants did recognise that symptoms they were having may be linked to worsening vision. For instance:

- headaches;
- blurry vision; and
- occasional eye strain.

Yet, they admitted a high tolerance for these symptoms. Some accepted these while also waiting for more significant things to 'go wrong' with their vision before consulting an optometrist, such as further vision loss, weeping eyes, or pain. People sometimes said they expected their eyesight to get worse as they age, and therefore such symptoms – especially 'milder' ones such as blurred or strained vision or problems reading – was something they would put up with.

- *"I just feel like I don't want to pay for glasses when I don't really need them. Well, I don't think I need them, particularly. It's blurred sometimes, but…" (Non-patient, Northern Ireland, Female, 25-34)*
- *"Aye, I just wouldn't even go because I'd think, 'oh… I can see?'... I'm not falling over things? Do you know what I mean? … I just felt it wasn't needed. I didn't know you were supposed to get your eyes tested. My eyesight's pretty good. Well …probably not quite as good as what it was when I was really young, but it's still pretty good. I can see quite a distance" (Non-patient, Scotland, Female, 35-44)*
- *"Yeah, okay, obviously, you know, in the day, sometimes my eyes feel tired because I'm all day … on the PC, you know, in work, like eight hours and a half. And, you know, sometimes you feel like tired, but yeah… I don't feel like I have any 'issues' with my eyes?" (Non-patient, Wales, Male, 25-34)*

Self-management, through 'testing' and 'treating' themselves, gave people a sense of reassurance that there is no need for professional input. Commonly, this 'testing' was by checking they can still read the licence plate of the car in front of them. To illustrate, one person said that they had a sight test / eye examination through work fifteen years ago and because they had received a clean bill of health at that time and could still read the licence plate of cars in front of them today, there was no need to get re-tested. People did not know that they would be unable to perceive small changes to their vision over time, or that a test would pick up additional health problems beyond those relating to vision.

- *"I mean, I use my eyesight all day, every day, I am driving trucks. So, when you drive a truck, you see… when I drive a car you just focus on what is in front, the car in front. So, when you drive a truck, believe it or not, you are miles ahead of that. It is just kind of anticipation. So, I think, my eyes are okay?" (Non-patient, Scotland, Male, 35-44)*
- *"I mean, I can see quite far, and I can probably see quite well… [you know] the thing in the police where they say, can you still read the number plate at whatever distance? And yeah, I can still see a number plate…" (Non-patient, Wales, Male, 35-44)*

Several non-patients with 'mild' vision problems purchased off-the-shelf reading glasses which 'treated' the problem instead of visiting an opticians / optometrist practice. To illustrate:

- *"So, I've never really had a pair of glasses that were actually tailormade. I just relied on Poundland … because they worked okay" (Non-patient, Northern Ireland, Male, 65-74)*

These were viewed as cheap, easily replaceable and a 'low-risk' purchase in comparison with prescription frames which they worried about breaking. This is illustrated in the case study overleaf.

**Case study: A person self-managing their deteriorating vision without going for a test (Non-patient, Wales, Female, 55-64)**

As a non-patient, 'Joanne' relies almost solely on her own judgement about her eyes. As a carer and lone parent, she has numerous priorities that come before her own well-being. This self-sacrificing approach is further exacerbated when costs are involved. With a tight monthly budget, unexpected or 'unnecessary' costs are unworkable. She doesn't know that she would be eligible for help with her health costs. Unaware that you should have an eye test every two years, eye health simply isn't on her radar. She justifies this by saying she has not noticed any 'significant' issues with her eyes such as 'pain' or 'throbbing' in her eyes. Although she admits her vision is declining, she views this as 'a normal sign of ageing' and not one she requires professional assistance with. To self-manage her deteriorating vision, she relies on a collection of unprescribed reading glasses. These provide her with a quick and inexpensive solution, that suit her needs as she doesn't worry about losing or breaking an expensive pair of glasses. She also keeps several pairs in different locations for easy access e.g. bathroom, kitchen, car.

- *"I noticed my sight, my age, and anyway, most people, their sight starts deteriorating. But I every now and then, on a rare occasion, I go to Mecca bingo…and I noticed when I'm looking at the numbers, I thought; they're not as clear as they used to [be]… I should really have one done... I know I should get tested, but I don't feel I've got any problem other than general loss, because distance is fine? I guess, or mild blurred vision, that's not something that you think 'I need to go with the opticians for'. But if you had, like a serious- if I had any pain or throbbing or sometimes your eyeball can increase in size, or any weeping, if there was something like that?"*
- *"I just bought some cheapies... these do the job for me… I'm a single mum, not really working, and lot of stuff going on. I bought these [her glasses from B&M] because they used to be a pound, two pound now, £1.99… if you go to the opticians and pay a fortune, well, then you drop them, scratch them...So I'm always looking for a last minute just pick-up pair of glasses"*

## Psychological barriers

Beyond the rationale offered by participants of cost/replaceability, there was a sense that these self-management behaviours were sometimes also rooted in psychological reasons.

Some we spoke to with vulnerability markers felt intimidated by the physical environment of the opticians / optometrist practice, including:

- the 'open' aspect of the environment;
- the prospect of sitting next to strangers in a waiting area;
- how long they would have to wait to be seen; and
- feeling uncomfortable about trying glasses on in front of others.

These concerns were commonly, though not exclusively, voiced by those that had a mental health condition, or struggled with their mental health. For example, some mentioned a lack of motivation to leave the house, or that due to mood changes they were less likely to make an appointment or miss or cancel it. Some participants said that their anxiety extended to not feeling able to ring to make an appointment.

- *"…the more I think about it, the longer I put it off. The longer I put it off, the more I can't do it. Do you know what I mean?" (Non-patient, Female, Scotland, 35-44)*
- *"I leave things too late, too long, sometimes because I always say, God, it'll pass. It'll pass. You know? Yeah, I am one of those that I know I am, but with my sight, yes, my sight is starting to go downhill, but only in reading. And it's not major it's just yeah, I struggle a bit more to read" (Non-patient Female, Wales, 45-54)*
- *"…It can be scary…because obviously you don't know what to expect when you get there. Do you see the same person? This one does that test. Then there's the someone else does that. And then there's the puffing things in your eyes. Then it's just, it's horrendous, isn't it, when you're doing all these things, and then*

*someone's having to look for glasses. I mean, you see two or three people. There's two machines, I think used to be, and then you're sent back out, and then the optician will come, and then there's the head gear. It's…it's scary. I think it can be overwhelming, really. Because sometimes you think…, I just want to get out."* (Patient, England, Female, 65-74)

Aspects of the environment within opticians / optometrist practices could also be triggering, as shown in the following case study.

**Case study: Person who finds the optician environment triggering (Non-patient, Scotland, Male, 35-44)**

'Rob' has been going for eye tests regularly for 17 years; he is short-sighted, has astigmatism and wears glasses. Despite being a regular patient, he has not had an eye test in over three years since developing post-traumatic stress disorder after being involved in a serious accident. Since the accident, Rob said he finds medical environments particularly stressful. Three years ago, he attended his first eye test since receiving his diagnosis. From the moment he entered the waiting room, he felt overwhelmed and anxious. During the test itself, he described feeling extremely distressed and vulnerable, particularly while positioned in the machine which flashed lights into his eyes. The experience became so intense that he suffered a panic attack, finding it nearly impossible to calm down in what he perceived as a high-pressure setting. After the test, still feeling exposed and shaken, he quickly chose the first pair of glasses he saw to avoid the discomfort of browsing in an open space. Although the staff were friendly, none of them were aware of his diagnosis. Rob later shared that he struggles to disclose his condition. These encounters were particularly difficult when interacting with male professionals, as feelings of vulnerability often prevent him from opening up, yet he felt like he couldn't ask for a female optometrist to see him.

- *"If it's a lady I'm fine. If it's a guy then I'm not keen. I don't know why. That won't open me up as much, if that makes sense? But you can't say that because you look like a… I don't know... I'd feel rude and I'd feel a bit wrong asking that and explaining why I wanted that"*

A few struggling with psychological barriers also said they were worried about coming into an opticians / optometrist practice and finding out things about their eyes (or brain) that they did not want to know. This was especially salient for those who were going through multiple health challenges in their life, where they worried about the

next thing that was ‘going to go wrong’. This could feed into their avoidance behaviour and inclination to put off going for a test.

- *“... it's almost kind of just as every room looks the same nearly as next, just so you always expect last room, it's gonna be 'that type' of conversation, face to face, serious conversation” (Non patient, England, Female, 18-24)*

## Cost-related barriers

The majority of those taking part in this research had a household income of less than £25,000 annually, and of those, many considered themselves to be struggling financially. Participants spoke about their circumstances and the effect this had on them in detail. These included: a sudden loss or a change in hours at work and the significant impact of this; the challenges of budgeting in the context of infrequent or casual work; unemployment; being on long-term benefits / new to benefits; not being able to work because of caring responsibilities; working longer and avoiding retirement for financial reasons; being in a single-income household; and the challenge of having no savings to manage unexpected purchases – or indeed pay for things upfront without any forward-planning or saving. Often, dependents such as children were the first recipients when it came to spending on the 'non-essentials'. However, the challenge of being in a single person household was noted too, as there are no other income streams to fall back on if finances are tight.

In this context, participants often discussed costs as a barrier to having a sight test / eye examination. These narratives focussed predominantly on the prospect of spending money on eyewear itself, i.e. the cost of frames, lenses and contact lenses. These were viewed grudgingly, because it would mean needing to go without other things they would rather – or need to – spend that money on. This could act as a barrier to accessing care because people would put off going, always finding other things that money is needed for.

- *"I just never really went because I always thought, if I had to go, I would have had to pay for glasses. It's put me off a bit." (Non-patient, Northern Ireland, Female, 25-34)*
- *"Like, rent has got up... 100 pounds so then obviously bills are going up, like heating, and the water's went up, our phone bills, trying to pay for driving lessons… [but] even though we're getting help, it doesn't, we'll still save up money to try and do things for ourselves, or try and like, get little things for*

*ourselves, … and obviously for [child] yeah? Like...new shoes, clothes, or a haircut...” (Non-patient, England, Female, 25-34)*

- *“Bills. The cost of things. You can’t get a packet of crisps for less than one-pound-thirty-five. My wages haven’t changed, nowhere near the way inflation has, and obviously I live alone, so you do get single person discount on the council tax, but …it is always easier when there are two people in the household” (Non-patient, Scotland, Male, 25-34)*

Importantly, within discussions of costs, most participants either did not discuss the cost of the sight test / eye examination itself or were unsure what those costs would be. It was perceptions of the costs of the eyewear itself that was the true barrier.

- *“Yeah. And, I mean, I'm a single mum, not really working … and it is the cost, because I don't actually know how much it is to have a general eye test…I would imagine about 60 pounds. Is that right?” (Non-patient, Wales, Female, 54-64)*
- *“I think it is a cost. I wouldn't know how much a sight test would cost, probably about 30 or 40, quid. I would have thought.” (Non-patient, Wales, Male, 35-44)*

This was also true of Scottish participants, who were aware that their actual sight test / eye examination was free, but still reflected negatively on the cost of glasses.

- *“But then you have to pay. You have to pay for your glasses then, but your eye test is free. It's like free prescriptions. But [the glasses] costs a fortune” (Patient, Scotland, Male, 75+)*

Perceptions of high costs amongst non-patients were frequently shaped by advertising or friends and family who told them about their latest purchases, and how much they had spent. This often related to product features such as ‘fading’ (reactor light), which they lacked understanding about, but knew cost more, and led to a perception that getting ‘specialist’ glasses through an opticians / optometrist practice would be expensive. One or two worried about becoming ‘trapped’ in a reliance on glasses, then having to get their sight re-tested and potentially replace the glasses which all has cost implications.

- *“A couple of hundred, I think, maybe. My friend, she was actually saying about that, last night. Two hundred pounds for a pair of glasses, she paid…. I think it’s extra money you didn't have to spend, that there’s no need to spend. If you know what I mean?” (Non-patient, Scotland, Male, 25-34)*
- *"…how much things cost you like to have... glasses, lenses, and, you know, the fading, or whatever you call it, whether it's reading glasses or varifocals, you know, the different places ... all I know in my head is... expensive!" (Non-patient, Northern Ireland, Female, 35-44)*
- *“Well, I know some of my friends have bought glasses, they say they’re just over a hundred pounds, for a pair of glasses!” (Non-patient, Northern Ireland, Female, 25-34)*

Cost concerns could influence the length of time in which previous patients return for a sight test / eye examination. Participants might, for example, delay having a test, or not go for another one at all, especially if they felt like they paid too much the last time. This is illustrated in the below case study examples.

**Case study: Negative experiences relating to cost led to a delayed return (Non-patient, Northern Ireland, Female, 35-44)**

'Layla' is recently married and lives in a house she has just moved into with her new husband and two of her three children that are still at home. She cares for her mother who lives just one street away from her on the outskirts of Belfast. She 'can't see a thing' without her glasses. She originally got tested ten years ago and got told to wear them but never did. Experiencing migraines and finding she 'couldn't see properly' she returned for an eye test and was found to require a strong prescription.

Layla said that part of the reason she didn't return was that she had never received a reminder and didn't know the recommended testing frequency was every two years. But on deeper reflection she said that the cost was a barrier to her returning too. She faced a really difficult situation when at the payment desk, learning for the first time at that stage how much this was all going to cost her. She really couldn't afford the glasses, was shocked at the actual cost of it all, but social embarrassment took over and she ended up asking her partner to put it on a credit card for her. She felt that once she was at the till and the order had been 'put through' there was no 'way back' to change her mind. She can't recall being told some of the glasses could have been free for her.

- *"…when he put the nice ones on, I really liked them and I love them, even now, but when he said one-hundred-and-eighty pounds, we were at the counter and [I] thought ****, we are going to have to go through with this now…when you take it to the till … you feel like, well I have to pay it now because I am at the till. That is what I felt like, yes… so, I guess, well I have ordered it now, so I can't go back on my word and say that I don't want them anymore…"*
- *"…. it does put you off, and going back, knowing what the cost is going to be next time… because we… we don't have that kind of money just sitting about"*

**Case study: A person that avoided going for a test because of lack of affordability (Patient, Northern Ireland, Female, 35-44)**

'Stacey' lives with her children in Northern Ireland in a house that was originally adapted for her husband's mobility problems. He died seven years ago and she struggles greatly with depression. Some days she doesn't want to get out of bed. Leaving the house can be hard. One of her sons has a learning disability and she cares for him. She's worn prescription glasses for years. Her last eye test was five months ago but she dreads going and had a three-year gap between tests. One of the reasons for this was complex changes to her Universal Credit.

- *"… it takes twelve weeks to come back. So it does really take a long time for it to come back, to see if you're approved for a pair of glasses. It's really mad… It really is and, by the time you go back, you have to wait for an appointment. It's just a long process, just to get a pair of glasses"*

As someone who is in receipt of benefits, she could get "the free glasses", or help with more expensive ones, but hated the thought of having to downgrade her choice to the 'free ones'. It made her feel embarrassed and ashamed. On her last visit she worried, because the time before that she felt pressure to purchase a second pair when she had struggled financially to pay for just one. Consequently, she didn't want to know if she needed a new pair and was waiting for benefits changes to come through. In the meantime, she had broken her one pair of glasses and so was doing without any, leading to headaches.

- *"I feel as if they're pressuring you to buy something you don't want to buy. The last time, I just wanted the one pair and they were: 'I know, but what if you lost these? You need the second pair'. I do get where they're coming from because the last time I had a pair, I sellotaped them… because they fell and broke, but I was afraid to go near the opticians, for the simple fact, because I was afraid to live without glasses because I always needed the glasses [but couldn't afford them]. Since I have stopped wearing them, because they had broke, I have been having headaches and stuff and yeah, I'm sure my vision's worse. That was my biggest fear. It came true"*

In both above cases, participants explained they had felt a sense of shame at not being able to afford glasses, or to pay the difference to allow them to get a nicer pair of frames they would feel confident in. More broadly across the sample too, there was variable knowledge about whether people would be eligible for help with their health costs, and specifically what that would be. While some were aware that the test should be free for them, those who had never had a sight test / eye examination (or who had a significant gap in the time since their last test whereby they couldn't recall costs), were sometimes unaware if they were eligible to receive a free test or an optical voucher to reduce the cost of glasses or contact lenses.

- *"I think they told me in the eye test place years ago, when I was on a low benefit, and I was working, I was on a low income, and they told me then, so you could claim for your glasses then, and then, when I went on Universal Credit, they told me then" (Patient, Scotland, Female, 55-64)*
- *"If they are coming out and telling you to come and get your eyes tested, if you really need them, don't be worried, because we can give you a free pair or give you help with it, they don't do that" (Patient, Northern Ireland, Female, 35-44)*
- *"I think you'd get your prescription [the test] for free and … with the frames or you can get NHS maybe, but they'd just be basic?" (Patient, Scotland, Female, 35-44)*

One participant spoke about a feeling they had that even if a test is free, they would feel obligated to buy glasses:

- *"Oh, you're saying free eye test, but you have to actually pay your way, like… to get your ears pierced [you have to] buy the earrings. Yeah. So if it was actually a free eye test, and like there was no hidden terms and conditions, I probably would go, I would say, yeah, yeah. But then I would feel a bit obliged to get glasses…" (Patient, Northern Ireland, Female, 25-35)*

A further issue related to cost was paying in full upfront for glasses. For example, one patient highlighted there's no point in going to the opticians / optometrist practice unless she saves up beforehand. Another participant mentioned being able to pay in instalments previously, but recently her practice had withdrawn that option from customers.

- *"The new thing they're doing, they're looking for an upfront payment for your glasses, which, before, you could have said, right, I get paid on a certain date, I'll go in and pay for them but now, it's not like that, anymore and they can't do your new glasses, until they have your payment up front" (Non-patient, Northern Ireland, Female, 35-44)*

The following case study further illustrates this challenge.

**Case study: The challenge of managing large upfront payments on a low income (Patient, Scotland, Female, 55-64)**

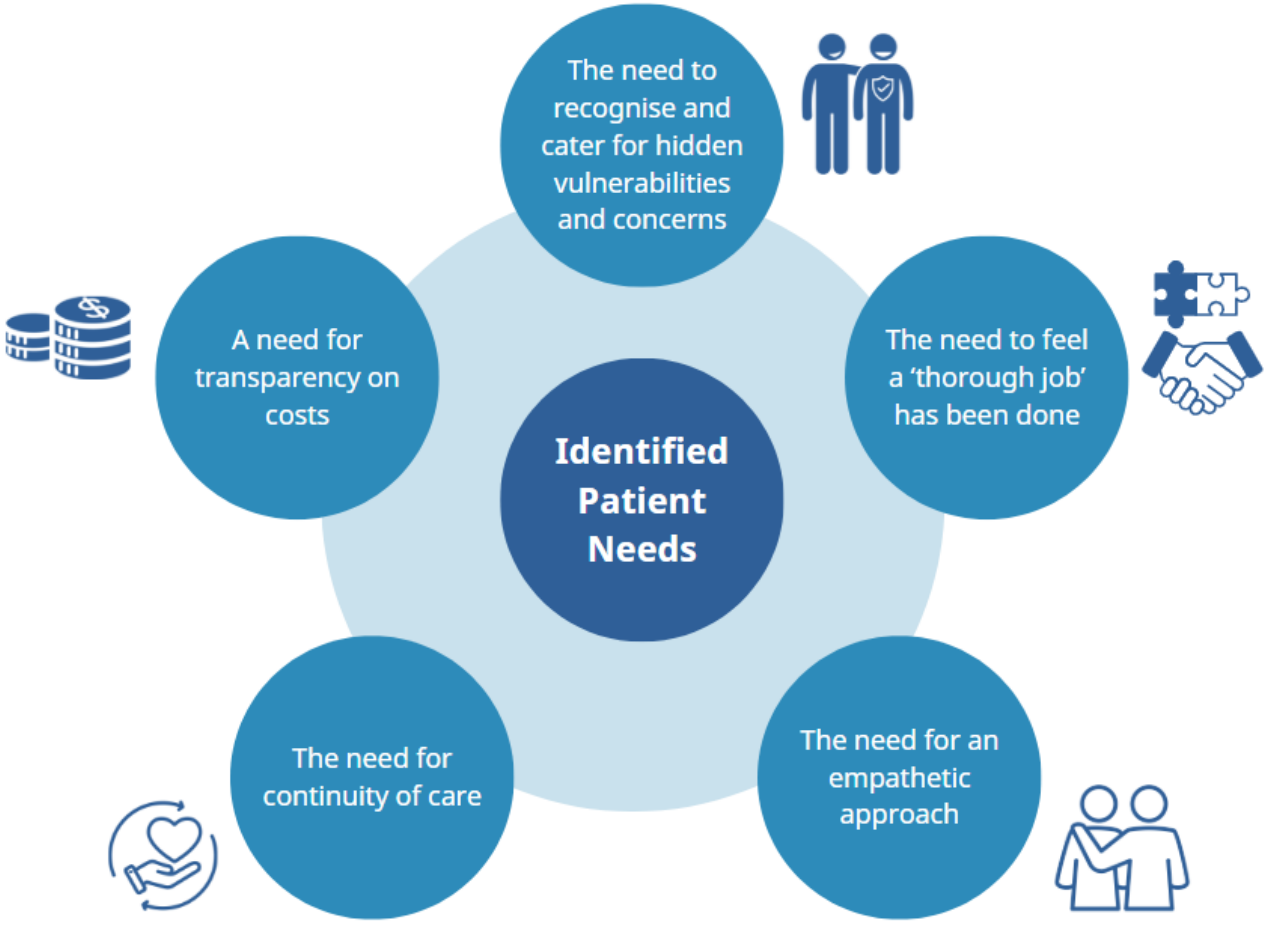
'Barbara' is in her 60s. She lives with her mum in an upper floor flat in a town in the central lowlands of Scotland. She doesn't work, being a full-time carer for her mum, and having a physical disability herself that affects mobility. Both her and her mother wear glasses, and they both have glaucoma. She keeps herself busy by volunteering at a local food bank and has a good friendship group that come to socialise at her flat for bingo nights. She doesn't drive and relies on her partner for transportation. The main reason she chose her optician / optometrist practice was the proximity from her home. Financially, she is struggling – Barbara talks about her bills being very high because she needs to keep the heating on owing to her mother's health. This was particularly difficult after the end of their Winter Fuel Payments.

Barbara is in receipt of benefit payments and doesn't pay for frames. However, her mum is required to pay. The required cost, over £200, is difficult for them to manage as they, as a collective, have no savings. She wishes that she could pay this in instalments.

- *"It's a lot to find just out of nowhere. If they offered you to pay in instalments...not just myself or my mum, but it would help a lot of people that are struggling, because in this day and age, a lot of people haven't got a lot of money. Who really has got savings? We've not got savings because who can save up nowadays?"*

# Inequalities of experience: Patient satisfaction with their experiences of sight tests / eye examinations

Throughout this research, patients detailed the experiences before, during or after a sight test / eye examination. Through these narratives a series of key needs were identified, that if met, would serve to increase their overall satisfaction in, or ability to engage with, high street opticians / optometrist practices. These key needs are:




These key needs will now be explained in more detail, again using illustrative quotes and case studies.

## The need to recognise and cater for hidden vulnerabilities and concerns

A key finding of this research is the differentiation of the experiences of patients with vulnerabilities more visible to others, i.e. some physical disabilities, and those with hidden vulnerabilities, i.e. some mental health problems and learning disabilities.

In general, participants with those more visible forms of physical disabilities discussed care that was more accommodating to their needs. For example, they said that they had been able to find places to have their eye care that were adapted to their mobility needs. One patient mentioned that she welcomed her opticians / optometrist practice asking at the point of booking if they had any mobility needs and if they would like to be seen downstairs in the branch.

- *"There is disabled access into the premises. The doors are quite wide, so somebody who's got a physical disability can get into the premises without any great difficulty"* (Patient, England, Male, 64-75)

This contrasts with the experiences of patients with hidden vulnerabilities. For instance, as discussed earlier in this report, people with a learning disability can experience delays to getting a test because symptoms were linked to pre-existing diagnosed health conditions, or patients themselves not linking their symptoms to their eyes. Another participant mentioned earlier, 'Rob', also spoke about his hidden vulnerability – 'holding in a panic attack' because his attendance was exceptionally triggering for his PTSD: being contained within a small room; the lights going off; and flashes in his eyes. All were distressing for him, but he did not feel this was picked up on or asked about in a way which would have really transformed his experience. He ended up rushing though the test, not returning to have another sight test / eye examination for a few years, and even today as it stands his test is overdue and he is not sure when he thinks he will be able to feel well enough to have another because he cannot face it.

- *"It was just me putting my head back and then a flash that checks the back of my eye. It was that... I was in the middle of a panic attack… [after the test]… I just grabbed the first pair I saw... I didn't care, didn't honestly care is what I did... Aye, I just wanted to get out of the door"* (Non-patient, Scotland, Male, 35-44)

Another mentioned a silent panic that they tried to mask during the test as the results would mean the difference between them being able to drive or not, so the stakes were high for them. Another talked about their deep anxiety relating to having the intraocular pressure test. The thought of having the 'puffer' go in her eye gave her serious fear and apprehension beforehand. When this was acknowledged, she felt able to go ahead with the test. Another person with a hearing impairment mentioned she finds it difficult to communicate with healthcare professionals sometimes due to her hearing issues. She doesn't like doing one-to-one appointments and worries about having someone that talks too quietly. Another pointed out that due to a family history of eye conditions, she associates sight tests / eye examinations with 'being scary', in anticipation of bad news.

- *"What line will I get down to? Will I get down sufficiently to be able to keep my driving licence or not?"* (Patient, England, Male, 64-75)
- *"You know, I can't explain it, but I do get a fear when I'm sitting there"* (Patient, Scotland Female, 64-75)
- *"I can't say… it's the machines. I just think the I don't know, I don't know, you get anxious, don't you? You don't know these people, and I don't think I've ever seen the same person twice"* (Patient, England, Female, 65-74)

Throughout discussions with inexperienced patients, it was common to hear about concerns relating to gaps in knowledge. This could be exacerbated by vulnerability markers. For instance**,** people that spoke English as a second language or had other communication needs said that they were unclear about what would happen at their test before attending, or during the appointment. To illustrate, one patient really valued when the optometrist used a translator for him to ensure he

understood what was being asked of him during the test. We spoke to two people who were originally refugees to the UK. This had led to them not knowing that you could just go to the high street for a test – they didn't realise that you did not need to be invited by letter in the way that other healthcare services they had engaged with operated. One mentioned that she wished that there had been written materials in her language to just explain how the optical part of the health system works, and what she was entitled to financially.

- *"No, usually, I think they bring translator. They bring translator. That time, because I don't speak English well. Until now, I don't speak English well"* (Patient, Northern Ireland, Male, 54-65)

The complexities which people with these more hidden vulnerabilities face when interacting with eye care services are illustrated well in the below case study.

**Case study: An advocate of a person with a severe learning disability discusses the challenge of getting him seen as an adult**

'Delilah' lives in the south east of England. She is a mother of four and took part in the research to tell us about her youngest son's experiences of getting a sight test / eye examination. He has global developmental delay and autism. He went to a school for special educational needs, is non-verbal and does not walk. The whole family wears glasses and when he was younger, she carried him to the opticians / optometrist practice to try to get his eyes tested. In every practice, they tried to get him familiar with the surroundings but it was too much for him and *"within five seconds he would have a meltdown"*.

They were referred to a hospital by the GP but there too the unfamiliar environment and their inability to see him at a prompt time meant that by the time his test came around he couldn't participate. A turning point came when he was able to be seen in the community at his special school in familiar surroundings. He was found to be short-sighted and prescribed the correct lenses which was *"life changing"* for him.

However, as he has now left school they find themselves in the same position they were in before – nowhere suitable to take him they are aware of locally – and so it has been six years since his last test. She thinks being seen at home would be ideal for her son but associated this service as being for elderly people. He has an annual health check, but she can't recall being contacted about his eyes.

- *"We have an annual check, annual checkup with the GP, they do his blood pressure. You know, it's called an MOT… he also has epilepsy. So obviously, he goes for his regular, you know, appointments. But no one contacted us with regards [to eyes]?... because we transition to the adult sector, we were sort of, we've been sort of like left on our own."*
- *"Most opticians didn't have a quiet room, a waiting room… when we did get him into the room the test was too much for him… The memories of the waiting room… we went into this small room with an unfamiliar… he used to end up pulling people. I was so embarrassed, I just picked him up quickly and ran out. Because by the time he got into the room… they have to come quite close to him… asking a lot of questions, and I think it's too much for him"*

Despite these issues, it is important to acknowledge that when their individual fears and concerns were addressed, the experience of patients with hidden vulnerabilities was greatly improved. For instance, one patient talked about her anxiety relating to the intraocular pressure test, and the positive impact acknowledging this had on her experience.

- *"…when it is the puffer and the camera, I just get a fear. I don't know, can't explain it, but I do get a fear when I'm sitting there and I feel like I'm so nervous and feeling sick and I'm sitting and she is going, right, just a minute. But they take that long in doing it and you're sitting with your eye like that. I sometimes, when she does it, my eyes shut and then she has got to do it again and that gets me agitated…. [Name] makes me try to feel more at ease, she says, come on, just get it done. She tells me I will be fine. She says, calm down and she talks to me when I am getting it done."* (Patient, Scotland, Female, 55-64)

The following case study describes perfectly how the care of a specialist team – the right care, in the right place – had been transformational.

**Case study: Patient-centred care for a person with a learning disability**

'Shane', who we met earlier in the report, had an advocate that was very knowledgeable about the sector. On thinking that he needed a sight test / eye examination, Shane's advocate contacted a learning disability nurse who had an initial check using accessible vision tests that were meaningful to the patient. Armed with this information they approached an optometrist who was able to work with a dispensing optician to find the right glasses for Shane.

- *"So for example, he doesn't understand pictures, but he likes people's faces. So there are some sort of very accessible vision tests that they use with very young children … where it's just sort of different sizes of faces. So we quickly discovered that there were clear parts of his vision, that he just saw nothing, and … once you crossed that line, suddenly he could see. …so armed with that kind of information, I then did a wider search, to find someone who did accessible eye tests, and found someone I think, I think they were about sort of 20 miles from where he lives, but who was prepared to come and do a home visit, which was a big plus, and the optometrist actually came out with the optician and did an assessment at home, and used a lot of that functional assessment to of help narrow…they were able to work out that he needed some glasses to be able to see his meals and things like that… so that helped immediately. Suddenly, he was able to see the world again"*

## The need to feel a ‘thorough job’ has been done

Negative patient experiences often revolved around a sense of feeling rushed through a test. This led to a general sense of being poorly cared for, which could lead to distress and/or frustration and a consequent lack of satisfaction with the experience.

- *“I thought she was nice, but I thought she was...in a hurry, and I was trying to explain the situation and everything, and let's put this on, put that on in the eye chart and everything, and I felt very hurried”* (Patient, England, Female, 55-64)
- *“...It seems it's a very rushed system, especially for someone like me and what I found is they're rushing, and because I can't do it in their time scale, they're huffing, they're puffing, they get they're getting frustrated, which then makes me more frustrated. And when I'm frustrated, my vision is worse... because I'm not then concentrating properly, which then has an impact on my mental health, because I feel that I'm not able to do it properly”* (Patient, England, Female, 45-54)

The feeling of being rushed also led some participants to doubt that they were receiving genuine and adequate care in their sight test / eye examination.

- *“... how much genuine advice, or how much health advice about your eyes are they giving you, whenever they're waiting for the next person to come in? Because the more they sell, the more glasses they sell and frames they sell, then obviously, the more money [they] earns”* (Patient, Northern Ireland, Male, 65-74)
- *"It was his general demeanour, his lack of engagement with me. I think he had a sense of importance… I didn't think he measured that the actual focus of my left eye as well as he could have, so I was out of pocket by about 400 quid, because I’ve never worn these glasses”* (Patient, Wales, Male, 55-64)

Accordingly, people told us they were appreciative when they had a sense that the optometrist had been ‘thorough’ in their treatment of them. Part of this was

provided by giving the impression that they were being listened to. Where this was the case, satisfaction was positively impacted.

- *"I can't remember ever having a negative experience. They've always been very accommodating, very polite, very professional when I've been there" (Patient, Wales, Female, 35-44)*
- *"Because if [they] speak to you, talk to you when you're doing the test… sometimes it's okay, yes, so yeah, so not being really quiet and just getting on?"* (Patient, Scotland, Female, 55-64)
- *"Aye, [I felt listened to] they were interested in, especially when they asked the medication that you're on. And they're quite upfront in saying, is your tablet still the same? Has there been any changes in your mental health?... But even them asking, that's kind of an assurance"* (Patient, Scotland, Female, 35-44)

## The need for an empathetic approach

Patients liked it when their optometrist / dispensing optician took their time with them, and showed they were empathetic to their needs. Being verbally reassuring and putting people at ease was really important to patients during or after their test. For instance, some worried about what sorts of 'diagnoses' they may be given, especially those that had received bad news recently about their health who worried about what else could have 'gone wrong' with their eyes. Others mentioned concern about what the results of a test might mean for them in their lives. For example, one person with suspected deteriorating vision mentioned that the outcome of a test would mean they may not be able to drive any more, and this led to a great degree of anxiety for them. Another lamented that more care should have been given to the way that bad news was communicated.

- *"Even the guy that picked up on the glaucoma, the way I was told that he thought I had glaucoma, was so brash, that I was stunned... it was very blunt delivery. There was no care behind it"* (Patient, England, Female, 45-54)

Conversely, one participant spoke about how he really valued the optometrist showing him images of his eyes and talking him through the rationale to send him on to the hospital. Here, he felt included and involved in decisions being made about his care and it made a huge difference to how he felt afterwards.

- *"He tells me about it. He shows you the pictures, and you see all the little veins are all like curled up. He says, 'The tighter the curl, the worse it's getting.' He says, 'Them little blood vessels should be more straight,' he says. He says, 'That's how I knew you had something wrong with you' … he's great – honest, fantastic!"* (Patient, Scotland, Male, 75+)

As part of this, emotional intelligence – being able to support people with vulnerabilities and being able to figure out needs quickly – was viewed as important. For example, one participant valued being shown by the dispensing optician which frames he could have aligned to the voucher value he had, and that put him at ease

because the main concern worrying him was cost. Another pointed out how they valued kindness and stopping to show they care. For instance, one patient highlighted that as soon as they walked in, they were greeted and their glasses were cleaned for them – just showing a sense of professionalism and customer care was strongly valued.

- *"I can go in, and she'll just fix them there and then. That's great. They're welcoming, and they're quite capable"* (Patient, Scotland, Female, 35-44)
- *"I usually get [person's name], because she's the main one. She owns the shop. She'll tell you if you put glasses on, if you suit them or not?"* (Patient, Scotland, Female, 55-64)
- *"Well, she knows, I'm petrified, and she tries to calm me down and then she says, 'come on you will be alright, it's me that is doing this, it will be just a second'. I say, 'well hurry up'. She says that she is going as fast as she can. So, she does all right."* (Patient, Scotland, Female, 55-64)
- *"He's great. I've even walked in and he's just taken off and cleaned [my glasses] for me…. The staff are everything – they tell you, 'Anytime you come… anything wrong with your glasses, just come in'"* (Patient, Scotland, Male, 75+)

## The need for continuity of care

Dissatisfaction could be generated by a lack of continuity in patient care. To illustrate, some talked about their frustration at not being able to see the same optometrist twice or being unable to request a specific optometrist. This would have provided a sense of connection to their optometrist and a confidence in the continuation of their care. This theme also emerged when patients voiced concerns that the hospital and optometrist do not seem to speak to each other, leading to duplication of appointments for diabetic eye screening. One of the participants was attending both appointments without realising this wasn't required; another said that, since they see a different person every time, they weren't sure if information had been passed on.

- *"[Asking for optometrist] 'No, he's left'... 'He's gone somewhere else'. And then you know when you go back the next time you're not seeing the person that you saw before, then it's somebody else, like locums kind of thing. Okay, that's how it's been for the last I'd say, good, five, six years…I get my eyes tested every year, and I have to say, well, you know, my records do indicate I'm diabetic, right? … I just feel like I'm prompting them all the time…."* (Patient, England, Female, 55-64)
- *"If you consider if I drive my car. I would have driven my car to Scotland. Police in Scotland can tell me if I've got an MOT, yet, if I go to a hospital, the hospital in [where they live] they can't tell me whether I've been [to the opticians] or not?"* (Patient, England, Female, 45-54)

One said that they had a sense that there was a lot of temporary staff where they were seen and this gave the impression that they aren't invested in the place or their care. Someone with multiple eye conditions talked about dissatisfaction stemming from a 'siloed' approach to her eye care, with different professionals only looking at different aspects, which was frustrating.

- *“Obviously I've got multiple eye conditions. So what I found is, if I was going to [eye hospital] for my squint to have Botox, they only ever looked at the squint? Yeah, when I was going to the glaucoma clinic, they only were looking for glaucoma. When I then ended up in A and E, despite me having glaucoma, they looked beyond it and actually saw that I had inflammation. And their first question then was, have you got an autoimmune disease?”* (Patient, England, Female, 45-54)

Patients welcomed a sense of continuity in their aftercare too. They appreciated being able to return to the practice to have issues resolved.

- *“I've had instances where, like, sort of the screws come out, and I've had to go back, and they've repaired them. I've had them cleaned. I had one experience, this was for our staff, where I said, it just doesn't seem right. They don't feel like they fit properly, and they've adjusted them. I've had one where the lens came out and they’ve sent them away, and it's been replaced.”* (Patient, England, 55-64)

Another issue identified related to a lack of continuity leading to poor care or a delayed diagnosis. For instance, some had more serious adverse experiences, including two that had a late diagnosis of glaucoma. They raised several issues that they felt led to delayed diagnosis. These included being seen by locums who did not pass on the correct information leading to deterioration being overlooked.

- *“I was maybe for two or three years, seen by the same optician, but the last two times I went, it was by locums. And the locums, they didn't pass on the information. I don't think they properly looked back over the records. You know, when they called me to come and do the visual field test again, I don't think the locum bothered to look at the retest results. I don't think all the dots were joined up”* (Patient, England, 35-44)
- *“And the previous occasion I've been to see an optician in mid-2020, right? And so basically the previous optician, he's now retired, and he'd retired when I saw*

*the one in 2020, he should have been referring me on to the on ophthalmology people. I mean, he didn't, for some reason, and the optician in 2020 was astonished that I hadn't been referred earlier. So, so that was a bit of a surprise on two counts. Firstly, that hadn't been referred before, yeah. And secondly, that having been referred, I'm suddenly told that I've got glaucoma"* (Patient, Male, England, Prefer not to say)

## The need for transparency on costs

Related to costs as a barrier to access, participants wished for more clarity and a better upfront understanding of the financial implications of the options available during a sight test / eye examination.

- *"It's about being upfront. For glasses, for lenses, the fading, or whatever you call it. Whether it's reading glasses or bifocals, all I know is expensive" (Non-patient, Wales, Female, 55-64)*
- *"The only thing that I get miffed about is when you get the ones, yeah, they're nice. And then then they add this anti-glare, anti-scratch, anti this, anti that. Next thing you know, the glasses were £120 but are now £230. So that's a bit naughty, yeah? So, the sort of add-ons. Clearer at pricing them." (Non-patient, England, Male, 55-64)*
- *"… there are adds-ons when you are wanting to buy glasses e.g. anti-scratch, anti-glare. This is pushed on you." (Patient, England, Male, 55-64)*

When discussing the costs of eye wear, patients also discussed a sense of pressure to buy glasses after their sight test / eye examination.

- *"Once that was done, then if you go downstairs now, one of the ladies there will help me. I used to feel a bit pressured about buying glasses because, well, we'd just be thinking, are these girls on commission?"* (Patient, Wales, Male, 55-64*)*
- *"They pushed selling frames really hard, yeah, to the point where I felt I couldn't use my current frames, but it was only because I insisted, as in, I bought these frames not that long ago, and for me, they were really expensive, and what I find is, all I'm doing is choosing another very similar frame. So why are you pushing a new frame so hard?"* (Patient, England, Male, no age given)

As previously mentioned in this report, for most participants, concerns focussed on the cost of eye wear. However, costs associated with the sight test / eye

examination were also mentioned by some, particularly the extra cost required for additional options within the examination itself.

- *"And the other thing to mention was, during the eyesight test, they would keep giving me options that they were saying things like, you can have this test, but for an extra 15 pounds, you could have that. And for me, it was unsettling, because I'm in a chair, it's a dark room, and you're expecting me to make a decision immediately, and it comes across as and if I don't have this test, you weren't going to do a full test and things could be missed, so you start to panic"* (Non-patient, England, Female, no age given)
- *"I don't know actually how much it is to have a general eye test … Then if they want to improve the test, I remember someone saying you can have a glaucoma test, but that costs extra." (Non-patient, Wales, Female, 55-64)*

# Implications of the research: improving the patient experience

# Implications of the research: improving the patient experience

Building on the analysis presented within this research, interventions suggested by participants that have been or may be able to better support access for patients and non-patients with vulnerability markers are detailed below.

## Improve awareness of eye health and the benefits of routine sight tests / eye examinations

This research has revealed an opportunity to improve awareness and knowledge of eye health and when to get a test among those who have never had a test, as well as those who have not visited in a while. This may include raising awareness that it is recommended they get a test even when they cannot identify 'something wrong' with their eyes at present. 'Push' communication was suggested by a few in the sample to encourage those who lack intrinsic motivation to get a test to come and have one. For example, an automated 'screening' letter was suggested when you reach a certain age to stimulate people to think about their need to attend.

- *"For me... an invite would take me over the barrier. Do you see what I mean? ... 'it's about time', you know, 'you're getting to this age, go and get them checked'. I think it just gives you a bit more of a push if you get a letter"* (Non-patient, Female, 54-55)

Further education may also be useful in relation to addressing the lack of detailed knowledge about the professions of optometrist and dispensing optician to support trust in them as qualified and registered professionals.

Establishing a clear link between certain symptoms and the need to get a sight test / eye examination may benefit a wide range of people consulted in this research. In addition, while doing so is a personal choice, better public health information may be needed about why it is not recommended to rely on non-prescription reading

glasses without ever having a sight test / eye examination. For example, that by doing so means they are missing out on the opportunity to pick up on issues with their eye health, or wider health, they may not be aware of currently. This is particularly the case given the high tolerance for deteriorating eye health that was evident among a proportion of those in our sample.

Better communication during consultations was also mentioned by some in order to build their own knowledge and awareness.

- *"They did a scan of the back of the eye…but I feel like they're not really informative. They don't really tell you what's going on unless you ask them. So I have to ask them, like, what's it like? What is this red part of my eye? Like? I have to ask them… they're not really informative"* (Patient, England, 18-25, Male)

Accessible information universally available in local opticians / optometrist practices, such as easy-read documentation, or written materials translated into other languages (there will be others beyond those covered in our sample) were desired by those with these communication needs.

## Demystify costs and reduce pressure to buy

Without financial security, individuals can feel vulnerable before, during, or after a test as they worry about what they will have to pay as a result of findings about their eyes.

Across the research it was clear that people wanted greater clarity on the costs involved in getting glasses or contact lenses if required. When discussing the cost of the sight test / eye examination itself, patients discussed a similar desire for clarity on the costs of the additional options that could be offered.

There was also a need for clarity about the help people can get with these costs, if any. There was also a sense that repayment options that offer opportunities for people on a low income to pay for glasses in instalments would be welcomed.

- *"Prices should be outlined and made clear in advertisements"* (Non-patient, Wales, Male, 35-44)

There was also concern amongst participants regarding feeling pressured to buy. There is a clear call for all those that help patients in this specific aspect of their care to consider their approach. This could be both by overtly stating that there was no pressure to buy after a test. It could also be managed by considering the ways that the process of choosing and purchasing is managed, i.e. by allowing patients to freely browse selections on their own.

- *"…And you shouldn't be made to feel that way [when choosing glasses]. You should be able to go there and freely choose without somebody breathing down your neck, if you like"* (Patient, England, Female, 25-34)

# Offer reasonable adjustments to cater for both visible and hidden vulnerabilities

A number of interventions were discussed relating to people's visible and hidden vulnerabilities and needs. This list is not exhaustive but provides some initial starting ideas for what patients believe would be helpful.

## Increase staff awareness of hidden vulnerabilities

This research revealed several psychological barriers to visiting an opticians / optometrist practice, particularly for those with a mental health condition or learning disability including: the 'open' aspect of the retail environment; the prospect of sitting next to strangers in a waiting area; long waiting times; not being able to start appointments promptly; and trying on glasses in front of other people (being 'watched').

It was desired that staff be more 'tuned into' patient anxiety and putting them at ease, looking for 'hidden' as well as more visible vulnerabilities, and, as mentioned throughout the report, an empathetic approach is strongly welcomed. To facilitate this, raising staff awareness and training in mental health first aid was mentioned by one of our participants. They said this might allow them to better identify and meet the needs of people struggling with anxiety during their attendance.

- *"What I'm saying is, you know, they're not, nurses, they're not meant to be social workers. But sometimes understand that people can feel very anxious about the results and put them maybe a little bit at ease would be nice"* (Patient, England, Female, 55-64)

## Adjusting/tailoring appointment times

For those unable to wait due to building anxiety or for other reasons, they would benefit from being seen straight away. Other interventions such as transparency about running times would be welcomed (for example, have the time on the wall for

how late they are running like a GP practice). It may be useful if businesses allow patients the opportunity to provide a reason for cancelling an appointment, so they have the chance to explain if it is for mental health reasons (and know they won't be fined for cancelling, which was a perception/concern). Beyond this, some asked for more same-day appointments to provide better access for those who need to have appointments on mental health 'good days'.

## Increase the range of appointment types available

Adjusting the types of appointments offered to maximise accessibility was suggested, such as providing longer appointments for people with specific needs, more weekend slots / late night appointments to allow greater flexibility for working people. Longer appointments were raised as an idea for those with information processing delay or other vulnerabilities, if these do not already exist. Making spaces more family friendly so that people can attend with children where they do not have informal childcare to rely on was also noted. Greater thought being put into the impact of the retail environment for more vulnerable customers was also mentioned. For instance, having an early discussion before attendance about reasonable adjustments, the need for privacy when trying on glasses if needed (a 'changing room' area), and attending during quieter times. As part of this, one person reflected that it would be useful for them to ask at a pre-appointment booking questionnaire about additional needs.

- *"Like a changing room, like a fitting room, yeah, that would be good.... that would be a brilliant idea..."* (Patient, England, Female, 45-54)
- *"I think, if they're all running behind, I think it would be nice if they said, unfortunately, staff were running half an hour late today"* (Patient, England, Female, 45-54)
- *"Longer appointments…yeah for somebody who might have information overload, it might take them half an hour to come to reframe information and it's just… speak slowly and stuff like that… somebody might have ADHD and to get*

*hyper whilst doing an appointment, or somebody might we have a friend who is autistic, and he ends up running just to like, you know, and end up running like that"* (Patient, England, Male, 45-54)

Greater provision was also discussed so that people who struggle to leave their house can get a test, including those that aren't / don't believe they are covered by the criteria for domiciliary care. Indeed, there was low awareness of the opportunity to be seen at home among those consulted, potentially reflecting the opportunity for creating greater awareness of these services among groups with relevant vulnerability markers. As shown in the case study examples, when an individualised approach is taken, such as a person with a learning disability that cannot complete a sight test / eye examination in the traditional way, this can end up with a life-changing diagnosis for people that historically have been unable to engage with services.

- *"If they could come to my house, it would be ideal…Because they could just come and test my eyes at my house, and then, even on my bad days, I could say, they're going to come, open the door, it will be fine. I'm in the comfort of my home. If you know what I mean?"* (Patient, Scotland, Female, 35-44)

Patient transport for those who want to attend appointments in person, but struggle with getting there because they don't have access to transport was also mentioned. Another floated the idea of a mobile screening unit in areas of higher deprivation to help people who struggle to attend appointments (for example, due to lack of access to transport). Having more accessible toilets for people who have physical disabilities, or for instance require the use of a walking aid or scooter, was also cited.

- *"Some people can't afford to get themselves a bus into town, or they're physically incapable of getting into town, because they've got other conditions like alcohol and drug abuse"* (Patient, Wales, Male, 55-64)

## Ensure a personalised approach to care

Another common theme mentioned throughout this research is that people wanted a sense that their care is more individualised and personal. They don't want to feel as though they are on a 'conveyor belt' or feeling rushed during the sight test / eye examination by their optometrist.

- *"If I was tasking my staff to carry out these tests, I would say to them to be as personable as possible with the client, to not make them feel that they're part of the conveyor belt process, where the next one's in, the next one's out, next one's in, next one's out. That they're special, that they're really focused on just your eyes at that moment"* (Non-patient, Northern Ireland, Male, 65-74)

## Provide continuity of care

Patients pointed out that improving care continuity would build their confidence in the care they are receiving. Several spoke about wishing to be able to select their optometrist, see the same person the next time, or find out information about them and their qualifications. Improving the communication between the opticians / optometrist practice and hospital to avoid the duplication of appointments was also mentioned as important. It was also felt that continuity of care would minimise the risk of missed diagnoses.

As raised in this research there were several missed opportunities for people with a learning disability to be signposted to accessible services that meet their needs. Assistance from the wider healthcare sector (for example, spotting this early at the GP or at other touch points they have with healthcare services) was raised as a valuable way to ensure earlier and effective intervention.

Continuity was important for follow-up care, for example knowing who to contact in the case of unresolved issues.

- *"[maybe they could say] do you mind if we contacted you by text or by email to follow up, and then you can address any concern that you have back to us directly"* (Non-patient, Northern Ireland, Male 65-74)

# Summary of findings and ideas for interventions

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## Summary of findings

The primary goal of this research was to explore the lived experiences of patients and non-patients with specific 'vulnerabilities' and how this relates to their access to, and experience of, eye care delivered by optometrists and dispensing opticians in the UK. The research also sought to identify ways that the GOC and wider sector can better support patients and non-patients, including effective interventions which could support them when accessing or experiencing care. These objectives sought to provide insight for the GOC relating to their objective for fairer and more inclusive eye care services.

This research has, first of all, validated previous research carried out by the GOC highlighting that certain vulnerability markers do have relevance for patients and non-patients in terms of accessing and experiencing eye care services. Further, within participant discussions of these inequalities of access and experience, they suggested interventions for improvement. These are listed below.

There is, however, a note of caution in the interpretation of the participants' suggested interventions. As the first piece of exploratory qualitative research carried out on this subject by the GOC, and due to the necessary diversity of the sample in order to achieve a wide variety of views, more work is likely needed with specific groups of interest to find out how some of the ideas for improved access to care can play out in practice in the wider sector. For instance, there is much more to learn in terms of the practical application of catering to the hidden vulnerabilities revealed in the research.

# Inequalities of access/experience and participants' suggested interventions

## Greater awareness and knowledge of eye health and the benefits of routine sight tests / eye examinations

**The research revealed that eye health was a low priority amongst participants. There was also a high tolerance for, and self-management of, symptoms related to vision / eye health.**

**There was a poor understanding that the sight test / eye examination included a check of the health of the eye alongside the vision check. There was also a lack of awareness of the full scope of the services opticians / optometrist practices offer.**

Interventions suggested by participants were as follows:

- ➔ Education among those with vulnerability markers / their carers regarding the importance of maintaining good eye health, clarity of the role of optometrists within this and the subsequent need to get a sight test / eye examination within recommended timeframes. This should include raising awareness about the importance of getting a test even when they cannot identify 'something wrong' with their eyes and the role of optometrists beyond testing sight and eye health, such as treating emergency minor conditions.
- ➔ Establishing an understanding of the link between certain symptoms and eye health may benefit a wide range of people including those with lower health literacy and understanding.
- ➔ Accessible information should be universally available in opticians / optometrist practices, such as easy-read documentation, or written materials translated into other languages.

## Greater transparency around costs

**The research has shown that those who struggle financially can feel vulnerable before, during, or after a sight test / eye examination as they worry about what they will have to pay for any required glasses frames, lenses or contact lenses. There was also, to a lesser extent, concern about the costs of additional options during a sight test / eye examination itself.**

**Greater transparency may play an important role in helping people become more comfortable about going to visit an opticians / optometrist practice.**

- ➔ Participants wanted greater clarity on costs involved in getting a test, and getting glasses or contact lenses (and the long-term expected costs of this). They also desired greater clarity about the financial help available for those in a range of different circumstances. Upfront communication about this could help improve transparency.
- ➔ Opportunities to have flexible payment options for people on a low income to pay for glasses, for example in instalments, should be considered.
- ➔ All staff involved in the selection of eyewear should consider their approach to reduce any sense of feeling pressured to buy, for example in giving people space to look through options in their own time.

## Opticians / optometrist practices should better cater for patients with both visible and hidden vulnerabilities

**A key finding of this research is differentiation between the experiences of patients with vulnerabilities more visible to others, i.e. some physical disabilities, and those with hidden vulnerabilities, i.e. some mental health problems and learning disabilities.**

Participants felt that opticians / optometrist practices should enquire early on whether patients require reasonable adjustments.

Reasonable adjustments included:

- ➔ The opticians / optometrist practice should offer the right care in the right place for patients, i.e. offering appointments at home or any other environment that meets specific needs (for example, a known community centre). This should be provided more widely to include those that aren't / don't believe they are covered by the criteria for domiciliary care, such as those that have certain mental health conditions.
- ➔ The length of the appointment should be considered, as should reducing waiting times.
- ➔ The way tests are performed should be considered where possible, for example, using the right specialist techniques for those unable to do a traditional test (such as those with a learning disability).
- ➔ Effective follow-up should be provided to support people that have additional needs (for example, checking they are wearing glasses and/or symptoms are resolving).
- ➔ Staff training and raising awareness were viewed as important – for instance, mental health first aid and helping staff support those with a learning disability or other markers of vulnerability, such as being on a low income.

## Greater continuity of care

**Patients pointed out that improving care continuity would build their confidence in the care they are receiving.** Suggestions put forward included:

- ➔ Several participants spoke about wishing to be able to select their optometrist, see the same person next time, or find out information about them and their qualifications.
- ➔ Improving the communication between the hospital and the opticians / optometrist practice to avoid any duplication of appointments and improve the care for those with known eye health conditions.

# Appendices

# Appendix A: Research methodology

Each interview lasted up to 90 minutes, with some conducted in person and some online.

The online interviews allowed us to gain a geographic spread of participants, and to ensure people could take part flexibly at a time convenient to them. In-person interviews were conducted among both patients and non-patients at home to optimise patient comfort and convenience while benefitting rapport-building and the depth of interactions, particularly among those who had multiple markers of vulnerability. All fieldwork was carried out between February and April 2025. A copy of the discussion guide is provided in Appendix B.

Given the sensitive nature of discussions involving lived experiences of barriers, challenges or difficult life events or personal circumstances, interviews were carried out using a trauma-informed approach. This included ensuring that participants felt safe speaking to us and were not retraumatised by the telling or re-telling of difficult narratives. Space was given to allow interviews to be participant-led, and opportunities to pause the interview given as needed. In line with the Market Research Society Code of Conduct (2023), all participants were reminded of their right to refuse to answer any questions they felt uncomfortable with or stop the interview at any time. They were also reminded of their right to anonymity and confidentiality in taking part. All participants left interviews reassuring us of their wellbeing and we experienced no concerns about this throughout the study.

All interviews were audio/audio-visually recorded for data collection purposes and transcribed to allow us to draw from data accurately. Qualitative analysis was iterative and carried out throughout the project to allow emerging insights and themes to be fed back into discussions for the purposes of triangulation. Regular analysis/debrief sessions were also carried out among the fieldwork team to reflect

on the credibility of findings as they emerged, and to further develop insights across the fieldwork period.

## Sampling criteria

Sampling was primarily undertaken to reach a maximal variation of the following criteria:

1. **Defined vulnerability markers (and criteria linked to lower satisfaction)**
2. **Service use history (whether they were a current or non-patient)**

## Defined vulnerability markers

Within our recruitment, we adopted the same vulnerability markers as utilised within the GOC's Public perceptions survey[7]. These were defined via a range of profiling characteristics (shown below)[8].


- **Living on low incomes / consider themselves to be struggling financially**. 25 out of the 38 people interviewed reported household annual income of £24,999 a

[7] Public perceptions research 2024 | GeneralOpticalCouncil

[8] Please note: one person taking part did not fall into the vulnerability criteria but was permitted into the research given they were from an ethnic minority background and had previously complained about their care, both relevant criteria for inclusion based on previous research.

year or less and of those many said as part of the screening process that they considered themselves to be struggling financially[9].

- **Have a disability.** Participants were asked whether they considered themselves to have a disability[10], and 22 of the 38 participants interviewed stated that they did.
- **Experiencing significant life events.** Across the sample, we interviewed people experiencing a wide range of recent life events or personal circumstances including recent experience of job loss, bereavement, relationship breakdowns, becoming a carer, homelessness, serious health conditions, or hospitalisation. Nine had caring responsibilities, the majority of whom cared for adults[11].
- **Confidence in managing eye health.** The spread of this has fallen out naturally (not asked about directly on the screener) but discussions revealed a range of confidence levels.

## Service use history

Alongside these established vulnerability markers, a range of service use histories were captured in the sample. These are listed below:

- **Patients:** defined as those that have had a sight test / eye examination within the last two years.
- **Non-patients:** comprising lapsed patients (current non-patients that have not had a sight test / eye examination in the last two years – sometimes for

[9] Q: *'What is your household income'*; follow up Q: *'Sometimes people find that their income does not quite cover their living costs, or they find it difficult to live on their total household income. In the last 12 months, has this happened to you?'*

[10] Disability was defined as*: anyone with a physical or mental impairment that has substantial adverse effects over the long term that impacts their day-to-day activities.*

[11] Q: *'In the last 12 months have you experienced any of the following life circumstances? Including serious illness or condition; disability; serious accident; severe financial hardship / being made bankrupt; serious illness or condition; bereavement of a close family member; divorce or relationship breakdown; becoming the main carer for a close family member; moved house; unemployment; unwanted reduction in working hours; mental health condition; something else which has affected your well-being'*.

many years), as well as those that have never had a sight test/eye examination.

As the research progressed it was necessary to slightly skew recruitment towards patients. This enabled us to fully explore recent eye care experiences across the broad sample variables of interest. These included 'heavier' service users such as those with known eye conditions, and those that had negative experiences, or felt they had cause to complain. This enabled a deeper exploration of people's experiences with optometrists and dispensing opticians. Further, the subject of barriers and challenges to access or use care were explored fully with all participants because many issues were pertinent for patients and non-patients alike.

A significant range of additional criteria were captured across the sample, as shown below.

- A spread of sociodemographic variables (e.g. age, gender, and ethnicity).
- Representation of those living in different locations across the UK, including those living in more rural/suburban versus urban areas.
- A mix of different types of places visited to have their sight test, e.g. different retailers.
- Those with known eye conditions took part (such as astigmatism, glaucoma, dry eye, low vision, macular oedema, diabetic retinopathy, blepharospasm and blepharitis, cataracts, etc) some of whom used hospital services for their eye care as well as using high street opticians / optometrist practices.
- As noted above, there was also inclusion in the sample of a few people that had had particularly negative experiences with either cause to complain, or had complained, to explore their experiences.

Please note that where a carer or advocate has spoken on behalf of an individual with a learning disability not able to verbalise their experiences, it is the patient/non-patient's profile that has been incorporated into our results and not the profile information of the carer. This happened on two occasions in the sample.

## Recruitment

All patients and non-patients taking part opted-in voluntarily.

The face-to-face element was carried out by Explain in conjunction with our recruitment partners to facilitate on-street and snowballing[12] methods to find the participants of interest across the four nations within the timeframe.

Online recruitment was carried out via stakeholder engagement – publicising the research on our behalf among groups of interest and inviting interested people to sign-up via an online open link. Explain wishes to thank the General Optical Council and all stakeholders that helped promote this study.

Alongside this, we carried out additional recruitment utilising our recruitment partners to find people that fit more specific criteria, such as those that have previously been dissatisfied or made a complaint (as the incidence of this in the general population is low).

All participants were screened at the point of recruitment to ensure that they met the recruitment criteria. To encourage participation and to thank participants for their time, all those completing an interview with us were paid a cash incentive or vouchers to the value of £60. Carers of those with a learning disability unable to speak on behalf of themselves were paid £90 to ensure that both they and the patient they were speaking on behalf of were thanked for sharing their views and experiences.

[12] On-street recruitment involved a trained recruiter approaching people in person to determine if they were interested in taking part in the research. Snowballing refers to a technique in which research participants are asked to identify known people that may be interested in taking part in the research.

## Interpreting the findings in this report

It is important to note that while insights provided here fully represent the views of those taking part, these cannot be extrapolated as representative of all in each of these groups of interest.

People that have taken part will be referred to as ‘participants’, ‘patients’, or ‘non-patients’.

# Appendix B: Discussion guide

## Discussion guide: In-depth interviews with patients and non-patients

| Timings | Section |
|---|---|
| **3 mins** | Introduction<br><br>*Thank you for agreeing to take part in this discussion today. My name is X and I work for Explain Research – we're an independent research agency and have been asked to speak with a range of people that need to use eye care services in the UK to find out about their experiences – as well as those that haven't visited in a while. This will involve us talking about what happened during the last time you had an eye examination / sight test, eye care treatment, or, for instance, buying some glasses or contact lenses after your sight test or eye examination. If you haven't visited an opticians or optometrist practice in a while, we'd like to find out more about why that might be and what, if anything, could be done to make things easier for you in terms of getting the service you need, and a good experience when visiting.*<br><br>*There are no right or wrong answers in your response today, I'm just hoping to understand your thoughts and opinions and find out a bit more about you as well – does that sound ok? I just want to confirm that this is Market Research and that means I won't be asking you in detail about any sensitive medical or specific health information today, just your general views on using opticians and optometrist practices. If we touch on anything in discussions that are too sensitive or upsetting for you to talk about we will be guided by you and what you feel comfortable with. You have the right to refuse to answer any of the questions we ask you today.*<br><br>**Interviewer to state:**<br><br>○ Information about the research and end use.<br><br>○ MRS Guidelines: Right to refuse / anonymity.<br><br>○ Recording: We will be audio / audio-visually recording this discussion in line with MRS Code of Conduct. The recording will be stored on our secure servers and no one outside of the research team will have access to this. Can I confirm that you are happy for me to record this discussion? |

| | |
|---|---|
| | **Start recording, record consent.**<br><br>○ Any questions? Okay to begin? |
| **30 minutes** | My life, health and eye health<br><br>**<u>Patient narratives of lived experience of any identified 'vulnerabilities'</u> (e.g. going through a significant life event, experiencing financial difficulties, living with a disability) – 15 mins**<br><br>*This section will briefly explore the specific vulnerabilities of interest and attitudes towards their eye care in the context of their general life and health.*<br><br>**NOTE: Interviewer to use / omit lines of questioning depending on participant relevance / known vulnerability markers and time permitting.**<br><br>***I thought we could start by finding out a little more about you, if that's ok?***<br><br>○ **Can you tell me a bit about yourself? …**<br><br>○ **<u>Environment:</u> Where do you live (e.g. rural/urban/house/flat/rented/owner)?** How do you find this?<br><br>○ **<u>Social support:</u> Who do you live with?** PROBE: 'vulnerability marker' - any difficulties or recent changes relating to <u>relationships, family or living situations</u> and the impact on them. Quick read of living situation and social support.<br><br>○ **<u>Take me though your daily routines:</u> How do you spend your days / nights?** Note to interviewer – get a sense of their daily activities and sense of coping.<br><br>○ **<u>Caring responsibilities:</u> Do you have caring responsibilities?** PROBE: dependents / formal carer responsibilities.<br><br>○ **<u>Check for isolation:</u> What places do you go to often in the community – how do you get there?** PROBE: any difficulties and where relevant their solutions.<br><br>○ **<u>Work status:</u>** *[If in work]* **what do you do for work?** *[If not in work]* **can you tell me about your current situation if that's ok? Are you looking for work at the moment?** PROBE: 'vulnerability marker' – recent life events relating to changes in work or financial situation and the impact on them.<br><br>○ **<u>Financial situation:</u> If you don't mind me asking, how do you feel you're coping financially at the moment?** PROBE: 'vulnerability marker' – |

people that feel they're struggling financially – what with and the impact on them both practically and emotionally.

- **Disability: Do you identify as having a disability**? If so, could you tell me more about that? **Note I am not wanting to explore any confidential medical information with you.** PROBE: 'vulnerability marker' – living with a disability: In what ways, if at all, does your disability influence the way you live your life?

**Eye health in the context of general health – 15 mins**

- **General health and wellbeing: How would you describe your general/physical health at the moment?** In what ways are you healthy? In what ways less so?
    - **Can you tell me a little about the sorts of healthcare services you've accessed lately and the healthcare professionals you've seen?** Do you visit the doctors or dentists often, for example? PROBE: touch points with health services / interactions with other HCPs to build up a picture of support needs.
    - **Is there anything in your life going on at the moment that's impacted the way you access health care services?**
    - **How confident, if at all, would you say you are in managing your general health?** On a scale of 1-10. Why do you say this? What, if anything, could increase that number / make you more feel more confident?
- **Mental health and wellbeing: Do you feel healthy mentally?** Why/why not? PROBE: recent life events relating to significant changes and the impact on them. **What's important to you in your life**? Has anything changed? If so, what's becoming more important? What's becoming less important?

***Let's talk about your eyes and vision.***

**CHECK FOR EYE CONDITIONS OR CONDITIONS THAT CAN IMPACT VISION:**

- **Just to check, do you have any eye conditions/conditions that affect eyes?** If so, could you tell me about this / these? How long have you lived with this? Again, note we don't want details of private medical histories here, a general discussion is ok.
- **What actions, generally, do you take in your life to manage your eye health?** (e.g. getting sight tests / eye examinations / treatments)
- **How often do you think about your eye health? Why do you say this?**

| | |
|---|---|
| | ○ **Overall, how important is looking after your eye health to you?** What would you say is the impact of your eye condition/s on your everyday life? Why do you say this?<br><br>**FOR THOSE THAT SAY THEY <u>DO NOT</u> HAVE A KNOWN EYE CONDITION:**<br><br>○ **How do you know you don't have an eye condition? Have you had a recent test? Why? Why not?** (NOTE: detailed probes around barriers to using services for current non-patients are below, can explore here if fits better)<br><br>**FOR ALL:**<br><br>○ **How confident, if at all, would you say you are in managing your <u>*eye health*</u>?** On a scale of 1-10. Why do you say this? What, if anything, could increase that number / make you more feel more confident?<br><br>○ **If you had to compare your eye health to your general health, how would you describe the relationship?**<br><br>**FOR CARERS ONLY:**<br><br>○ **Are you a carer or do you have responsibility for someone else's eye health?** Can you tell me about that and how it works for you? What has gone well / less well with this in the past in terms of using or accessing eye care services? |
| **50 minutes** | Journey-mapping patient experiences with eyecare services<br><br>**<u>Exploring patient and public experiences of accessing and using high street opticians / optometrist practices / barriers to use – 35 mins</u>**<br><br>*This section will explore patient experiences of using high street opticians and optometrist practices in the UK. It will also explore barriers to care and challenges to accessing or using these services.*<br><br>**<u>FOR CURRENT PATIENTS - HAVE HAD AN EYE TEST WITHIN THE LAST 2 YEARS</u>**<br><br>○ **Tell me all the places you've been to over the last 2 years to have your eyes tested or treated.** INTERVIEWER TO LIST / MAKE NOTE OF<br><br>***For this research project, we want to focus the discussion on your experiences of high street / opticians and optometrist practices, rather than any experiences you have had of receiving eye care in other settings such as hospitals. Let's think about some recent experiences you have had using high street opticians or optometrist practices*** *(NOTE: experiences for carers will be skewed towards their experiences of managing someone else's eye care* |

*although they can talk about themselves too especially if it helps them draw useful contrasts).*

- **How regularly do you get your eyes tested there?** Why is that? What prompted you into this pattern of testing?
- **What words/pictures/phrases do you associate with an 'opticians/optometrist practice'?** What is your awareness of the services they provide? PROBE: healthcare service vs retail. Why do you say this?
- [IF USING] **What words/pictures/phrases do you associate with an 'opticians/optometrist practice'?** What is your awareness of the services they provide? PROBE: healthcare service vs retail. Why do you say this?
- **Where do you buy / are administered your prescription glasses or contact lenses – is this in the place you were tested?** Why/ why not? Check for differences in where they buy lenses/frames.

***Let's go into a bit more detail about your experience of using high street opticians and optometrist practices. I want you to cast your mind back and tell me about your experience of using this right from the start to the end. Its ok if you have to think for a little bit to help you recall the specifics – take your time.***

**BEFORE AN APPOINTMENT:**

- **Take me back to before your sight test /eye examination – <u>how did you know</u> it was time to go?** PROBE: Triggers for treatment.
- **<u>How do you feel</u> when you know a sight test / eye examination appointment is coming up?** Why do you say this? PROBE: Probe any positive or negative associations/barriers.
- **How do you <u>select</u> the opticians / optometrist practice that you use?** What's important to you in your decision-making process? Is this somewhere you've started going recently / been going for years? If you recently changed – why was this?
- **Take me though the <u>appointment booking</u> process** – what was good / bad about this aspect for you? Are there any changes or improvements that could be made to this that would make your experience better?
- **What did the appointment <u>cost</u>**? Were you aware of this cost beforehand? Check – did they pay / an employer pay / NHS funded? What are your feelings towards this? Was it a barrier to going?

**DURING SERVICE INTERACTIONS**

- **Thinking about your sight test / eye examination, tell me what happened in a step-by-step process**. Take me through it.
    - **Were there any strong 'pain' points for you**? Times when you felt frustrated or upset by something during your use of the service?
    - **What about any strong 'joy' points** – things that went well and you felt pleased about?
- **Who helped you during your sight test / eye examination? Thinking about them specifically, how helpful, if at all, did you think they were?** Why do you say this? What could have been done to improve your experience?
- **And then thinking about any help you got after your test, how helpful, if at all, did you think they were?** Why do you say this? What could have been done to improve your experience?

  (Note to interviewer: where possible tease out from what they're saying whether they're talking about optometrist or DO – e.g. can ask if it was the person that tested their eyes or helped with their glasses choice – however bear in mind in some practices this wouldn't necessarily be a dispensing optician.)
    - **What was the outcome of your appointment - what did they recommend**? Was this as you expected or were there any surprises?
    - **If your practitioner recommended a product, talk me through selecting / purchasing this**? What were the positives/negatives about this experience. Did you feel any pressure to buy?
- **How accessible, if at all, was this service in terms of meeting your needs?** Did you need any adjustments made and was this request granted?
- **Overall, how did you feel during this interaction**? Did you experience any emotions during your use of this service? If so, what and when specifically?
    - **PROBE: gently probe around anything 'unacceptable' in their narrative (e.g. being spoken to in a certain way, being singled out or 'othered' for any reason such as for their age or race or gender, etc.** If any participants said they wanted to or did make a complaint about something, explore this here.

- Overall:
    - **How satisfied were you with the eye examination or sight test that was provided? And in terms of purchasing your glasses or CLs? Can talk about either now or previously.**

**TIME PERMITTING LINK TO AS MANY STANDARDS OF CARE AS POSSIBLE/AS RELEVANT:**

- **Did you feel…**
    - Listened to?
    - Communicated with effectively?
    - Treated with care and compassion?
    - Involved in any decisions about your care?
    - Safeguarded / have your privacy respected?
    - Responded to in the event of a complaint?
- **Did your experience meet your expectations?** Why/why not?
- **Thinking about the different steps of your journey, what, if anything, would you do to improve the service that you received?** In which areas do you feel the service could be improved the most?

**POST-SERVICE INTERACTIONS**

- **After your interaction with this service, was there any follow up with you (either regarding their sight test / eye examination or for retail purposes?)** Can you tell me about what happened? Were you happy with the outcomes of this or could there be improvements made?

**CURRENT NON-PATIENTS – PEOPLE THAT HAVE NOT HAD AN EYE TEST WITHIN THE LAST 2 YEARS**

- **Have you had a sight test / eye examination before?** Why/Why not? If so, why the 2 year+ gap?
- **How often do you think you're supposed to go?** Did you know you are supposed to get your sight tested every two years? Is that surprising?
- **What is your understanding of what happens at an appointment?** PROBE: Do they know the sight test also includes an eye health check not just a vision check.

- **Do you have an eye condition, but you avoid sight tests / eye examinations for any reason, or one is overdue?** Why is this?

**IMPORTANT: Probe any barriers below to accessing eye care for people that have not had an eye test in the last 2 years**

- **KEY QUESTION: Can I ask, what are the reasons you've not used eye care services up to now/within the last 2 years?**
    - Spontaneous views [INTERVIEWER TO LIST AND PROBE IN DETAIL]

THEN PROBE….

- Cost
- Pressure to buy
- Fear of being diagnosed with an eye health problem
- Feeling uncomfortable / someone too close
- Any others

- **For each, why does this prevent you from going? What could be done to tackle this issue?**
- **If you don't have sight tests / eye examinations but know you need one, what could be done to better support your access?**

**FOR ALL**

**Exploring the role that 'vulnerabilities' may play in people's access to, or use of, eye care services (15 minutes – may be more for those experiencing barriers to access)**

***At the beginning of this discussion we talked a bit about your life and some of the things that are important to you now, including things that you may be going though that might influence your health and eye health.***

***I'd like to reflect now for the last part of our discussion today on whether some of the things you're going through impact you being able to get the eye care that you need, specifically in relation to visiting an opticians or optometrist practice, and if that's the case, what could make things easier for you in your opinion.***

*Interviewer to adapt as relevant and focus on the most salient in discussions (if not already discussed during the above) – this is an indicative list, please be guided by individual patient stories. For each mentioned discuss the relationship*

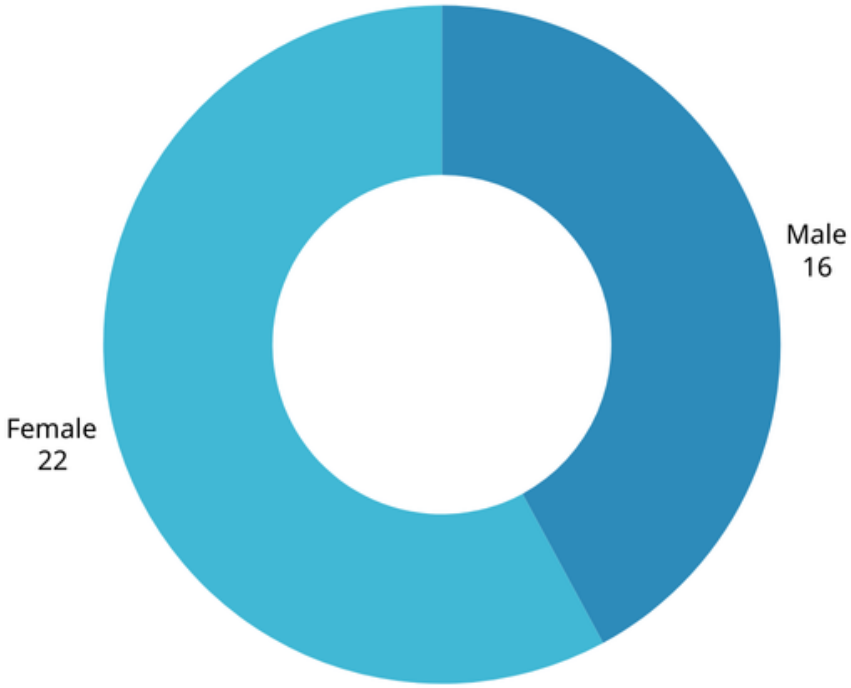
| | |
|---|---|
| | *between the vulnerability and access to / use of services, and what they feel could be done to improve their experience as a patient in the context of this.*<br><br>○ How, if at all, would you say aspects of your…[insert as appropriate] makes it difficult to access or use any of the eye care services we've talked about today? E.g.<br><br>○ …Disability<br><br>○ Low vision itself<br><br>○ Financial situation (if not mentioned already probe awareness of free sight tests / NHS low-income scheme)<br><br>○ Personal difficulties or challenges<br><br>○ Confidence relating to managing eye health<br><br>○ Current health conditions<br><br>○ Language / communication<br><br>○ The way that you've been treated … etc<br><br>○ Specifically in what ways can these things impact your access or use to eye care?<br><br>**PROBE:**<br><br>○ Spontaneous views<br><br>○ Motivation to seek help<br><br>○ Affording treatment<br><br>○ Visiting an opticians, etc.<br><br>○ **Based on your experiences, what should or could be done in order to improve your experiences thinking about the eye care services you access / increasing access to eye care services for you?**<br><br>○ I**f you were in charge of improving the experience for people like you when visiting or using an opticians / optometrist practice – what would you do?** Why do you say this? |
| **2 minutes** | Thanks and close<br><br>***Thank you for all of your time today, we hope you have enjoyed this discussion and we really appreciate your time. As I said earlier Explain work to Market Research Society Codes of Practice, this means that the things you have said*** |

| | |
|---|---|
| | ***today will be anonymised within our report. That means that we will never attach your name to anything that you have said, and we will never pass your details on to any third party including the General Optical Council who have asked us to come and speak to you today on their behalf.***<br><br>**Parting question:**<br><br>○ **Before we go, is there anything that I've forgotten to ask you about today that you would like to say in relation to your experiences of eye care services?**<br><br>***Thank you again for your time.***<br><br>**Stop recording.**<br><br>○ Arrangements for incentive payments.<br><br>**Close.** |

# Appendix C: Sample profile

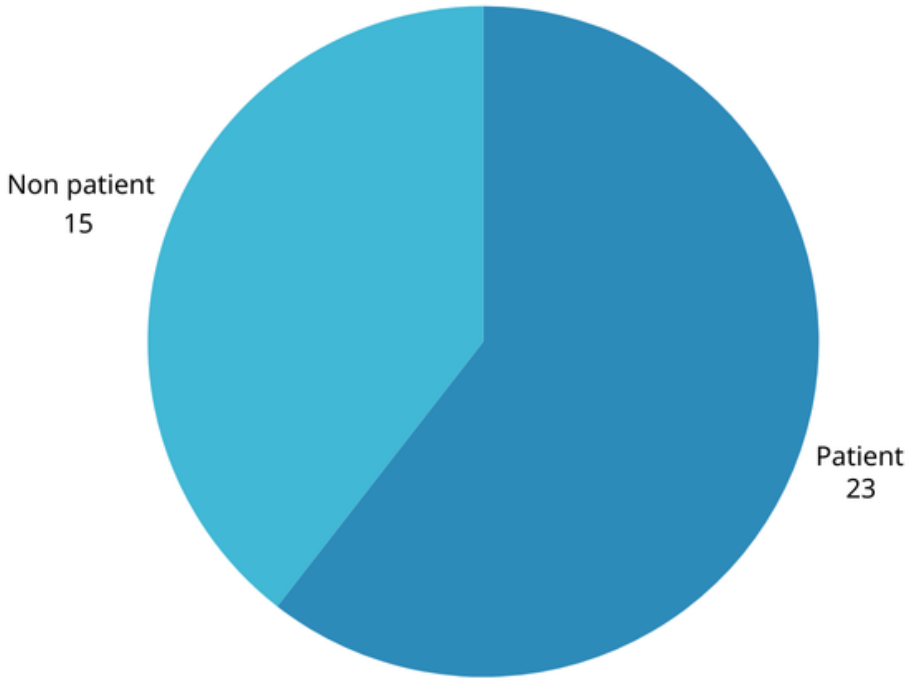
## Gender

The sample split in relation to gender is as follows.




| Gender | Frequency |
|---|---|
| **Male** | 16 |
| **Female** | 22 |
| **Total** | **38** |

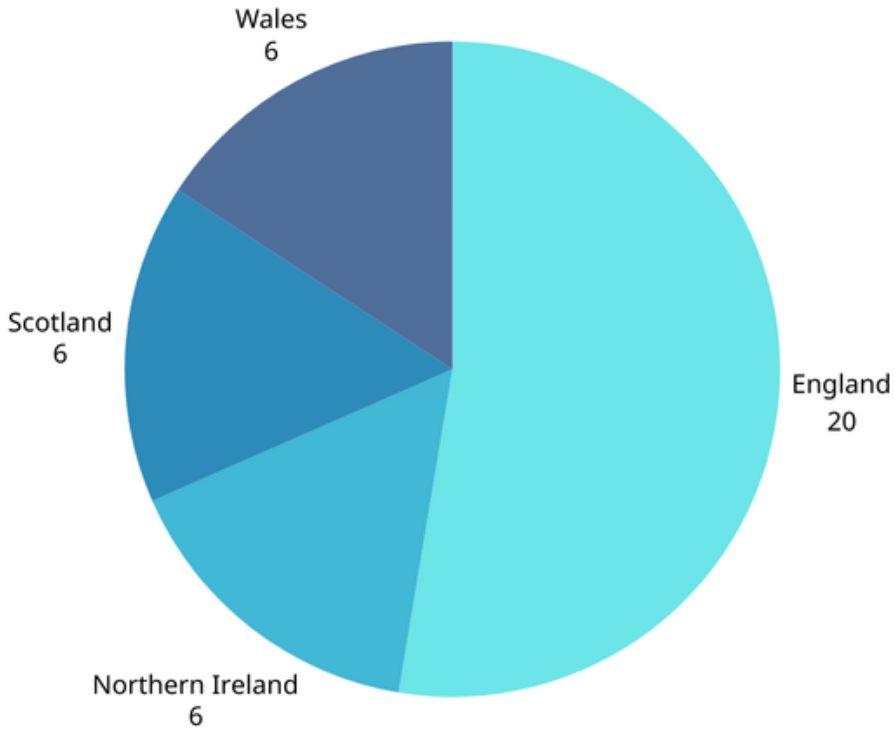
# Patient Status




| Patient Status | Frequency |
|---|---|
| Patient | 23 |
| Non-patient | 15 |
| **Total** | **38** |

# Nationality

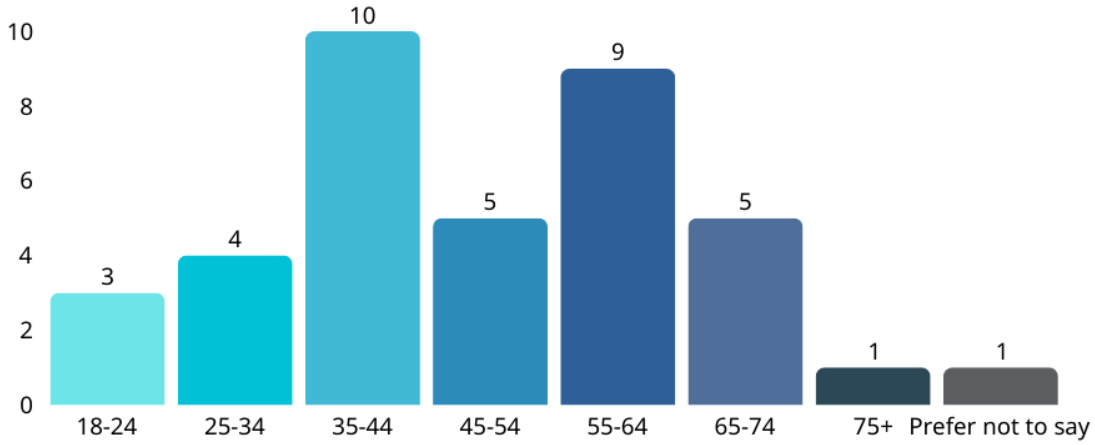
A spread across the four nations was achieved. Participants in England were spread across the country comprising the South, South East, North East, North West and the West Midlands.




| Nationality | Count |
|---|---|
| England | 20 |
| Northern Ireland | 6 |
| Scotland | 6 |
| Wales | 6 |
| **Total** | **38** |

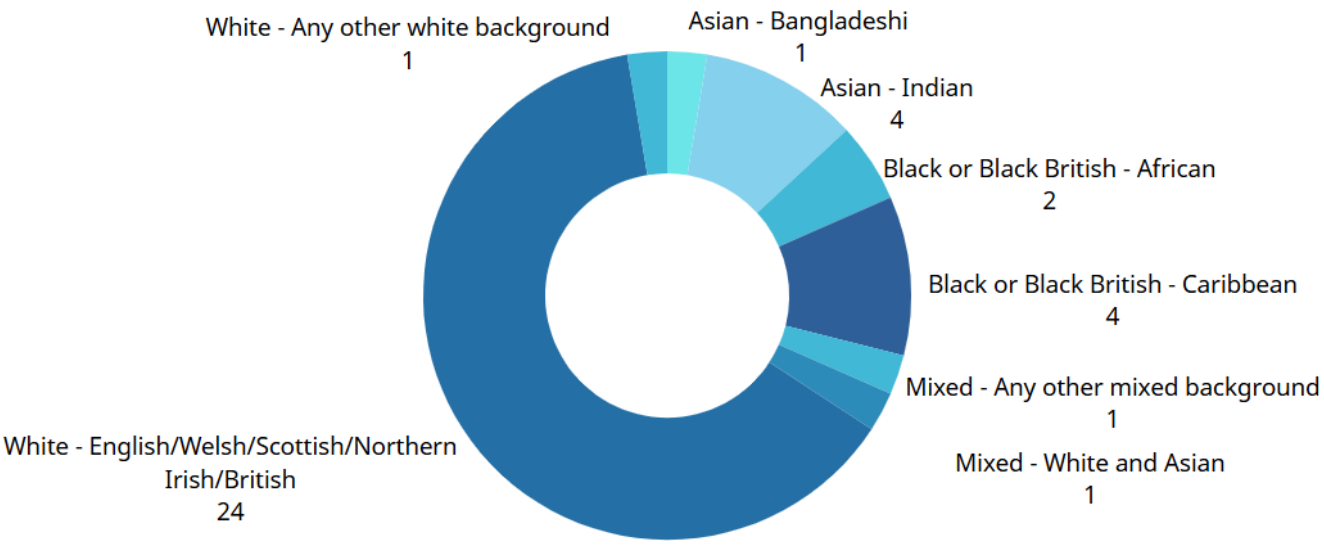
# Age

A spread of ages was achieved across the sample.




| Age | Frequency |
|---|---|
| 18 - 25 | 3 |
| 25 - 34 | 4 |
| 35 - 44 | 10 |
| 45 - 54 | 5 |
| 55 - 64 | 9 |
| 65 - 74 | 5 |
| 75+ | 1 |
| Prefer not to say | 1 |
| **Total** | **38** |

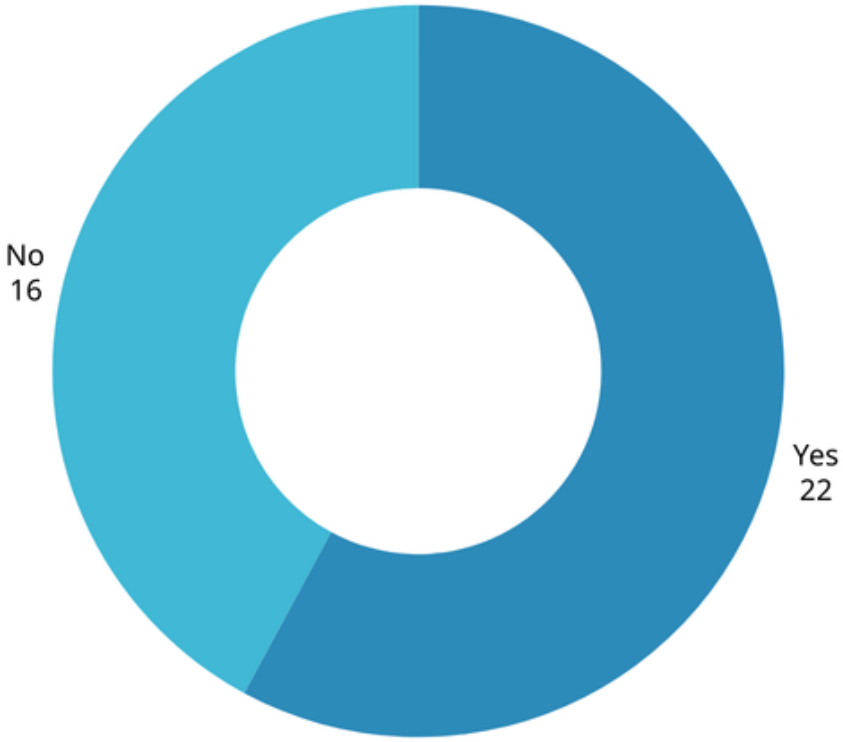
# Ethnicity




| Ethnicity | Count |
|---|---|
| Asian - Bangladeshi | 1 |
| Asian - Indian | 4 |
| Black or Black British - African | 2 |
| Black or Black British - Caribbean | 4 |
| Mixed – Any other mixed background | 1 |
| Mixed - White and Asian | 1 |
| White - English/Welsh/Scottish/Northern Irish/British | 24 |
| White - Any other white background | 1 |
| **Total** | **38** |

## Disability

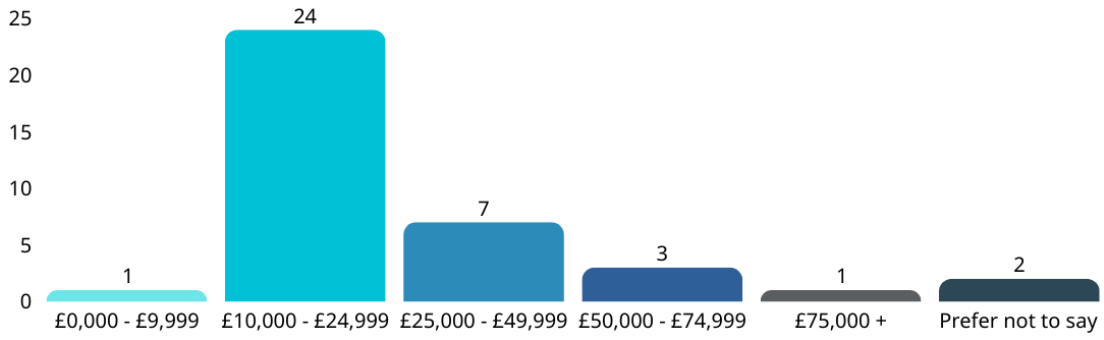
On screening those that said that they considered themselves to have a disability was as follows:




| Disability | Count |
|---|---|
| Yes | 22 |
| No | 16 |
| Prefer not to say | 0 |
| **Total** | **38** |

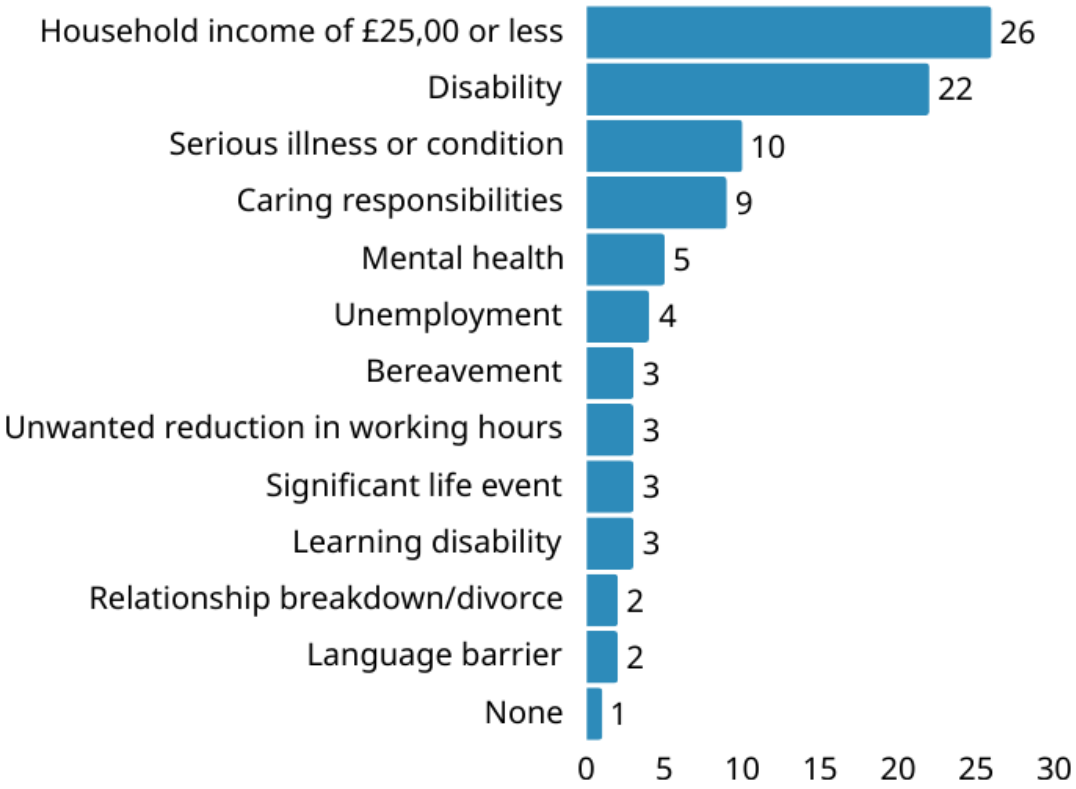
# Income

25 out of the 38 interviewed said that they had a household income of £24,999 or less and many of those considered themselves to be struggling financially.




| Income | Count |
|---|---|
| £0,000 - £9,999 | 1 |
| £10,000 - £25,000 | 24 |
| £25,000–£49,999 | 7 |
| £50,000 - £74,000 | 3 |
| £75,000+ | 1 |
| Prefer not to say | 2 |
| **Total** | **38** |

## Vulnerabilities




| Vulnerabilities | Count |
|---|---|
| Household income of £25,000 or less | 26 |
| Disability | 22 |
| Serious illness or condition | 10 |
| Caring responsibilities | 9 |
| Mental health | 5 |
| Unemployment | 4 |
| Bereavement | 3 |
| Unwanted reduction in working hours | 3 |
| Significant life event | 3 |
| Learning disability | 3 |
| Relationship breakdown/divorce | 2 |
| Language barrier | 2 |
| None | 1 |


Authors: Claire Cook, Kirsty Laing, Scarlet Morgan

Report check: Kirsty Laing

Final sign off: Kirsty Laing

**Public**
**C25(25)i.**

**Council**

## Evaluation of Continuing Professional Development (CPD) cycle 2022-24

**Meeting:** 25 June 2025 **Status:** For noting

**Lead responsibility:** Steve Brooker (Director of Regulatory Strategy)
**Paper author:** Steve Brooker (Director of Regulatory Strategy)
**Council lead(s):** There is no Council lead for this work.

### Purpose

1. To enable Council to discuss a high-level evaluation of the three-year CPD cycle (from 1 January 2022 to 31 December 2024.)

### Recommendations

2. Council is asked to note the evaluation.

### Strategic objective

3. This is a continuous improvement project. This work is included in our 2025/26 Business Plan.

### Background

4. A series of factors make an evaluation of the 2022-2024 CPD cycle important. It was the first cycle following significant reforms to the previous Continuing Education and Training (CET) scheme, and introduced new, more flexible CPD requirements for registrants. The end-of-cycle arrangements in previous cycles had been problematic so it is important to know whether the lessons were learned. The evaluation will also inform policy options for possible changes ahead of 2028-30 CPD cycle.

5. The evaluation was informed by evidence from sources including data collected during the cycle, end-of-cycle processes, EDI analysis and GOC surveys.

6. The evaluation seeks to provide a high-level overview of the three-year CPD cycle at a level suitable for Council and public consumption. The project team has completed a separate review of the end-of-cycle processes to support operational planning ahead of the close of the 2025-27 cycle. CPD appeals may also provide learning for the next cycle.

7. Education Committee considered the paper on 6 June – the minutes of this meeting are elsewhere on the agenda.

### Analysis

8. Overall, the cycle should be judged as successful based on fewer registrants failing to meet their requirements compared to the previous cycle, especially in the context of registrants needing to adapt to significant new requirements. Having a dedicated communications plan was a key factor in this success. There were fewer disputes and exceptional circumstances applications than in the previous cycle. The end-of-cycle processes largely went smoothly due to factors including automation, simplified processes and improved internal collaboration.

9. We are grateful to sector bodies and the media for raising awareness of the new CPD scheme, and for supporting registrants to comply with the requirements.

10. Areas for future focus emerging from the analysis include:

- Similar to previous cycles, whilst most registrants met their CPD requirements by the end of the cycle, many left it very late to either complete their CPD activities and/or upload evidence to MyCPD;.
- The intention is that the Professional Development Plan (PDP) should be completed at the beginning of each cycle, to provide registrants with an opportunity to plan their learning and professional development at the outset of the three-year cycle, and to use the PDP as a tool to reflect upon progress with a peer during and at the end of the cycle. Despite active communications from both GOC and professional bodies regarding the utility and purpose of a PDP, many registrants did not upload a PDP until the end of the last cycle. To assist registrants to reflect upon and plan their CPD at the start of this current cycle, a mandatory PDP form has been introduced. However, by the end of March 2025, only 27% had completed their online PDP form.
- Self-directed CPD was an important new addition to the 2022-24 CPD cycle, with registrants able to gain up to 50% of points using self-directed CPD. However, this opportunity been significantly underutilised, accounting for less than 4% of points recorded on MyCPD.
- Most registrants consider the number of CPD points required is about right. However, a significant minority consider them excessive, and only half of businesses consider the compliance costs are reasonable.
- One theme which emerged from our review of exceptional circumstances applications was that some registrants were unclear on their CPD requirements, particularly new registrants joining the register at the end of the cycle. We plan to tailor communications to this group in the 2025-27 cycle.
- As part of a focus on the quality of CPD, we can do more to extract the learning from CPD record reviews and give feedback to all registrants.

## Finance

11. No costs were incurred in producing the evaluation.

## Risks

12. The CPD requirements are our key tool for ensuring registrants keep their skills up-to-date and develop their capability to practise safely to meet changing patient and commissioner requirements. This evaluation provides assurance that the last cycle operated successfully, albeit with improvements identified in annex 1.

## Equality Impacts

13. An EDI analysis was conducted considering the age, sex, race and disability of all registrants failing their requirements, those making disputes and exceptional circumstances applications and GOC decisions on these applications.

14. The analysis suggests males and white registrants are slightly overrepresented among those who failed to meet their points requirements compared to the overall composition of the register. Older registrants were also overrepresented, but this is likely to reflect many in this group planning to retire at the end of the cycle.

15. The small numbers limit analysis of post-cycle decisions but does not suggest any significant disproportionality of outcomes.

## Devolved nations

16. N/A

## Communications

### External communications

17. None planned beyond publication of the Council papers. A communications plan to support the new cycle is in development.

### Internal communications

18. The evaluation will be used by the CPD project team to inform future planning. It will also inform development of policy options for the next cycle.

## Next steps

19. Work on potential reforms for the next cycle will begin in the autumn. We have notified DHSC of the possible need for a s60 order. We are also exploring prospects for amending our legislation ahead of full-scale reform of the Opticians Act to allow voluntary retirement/withdrawals from the register.

## Attachments

Annex 1: Evaluation

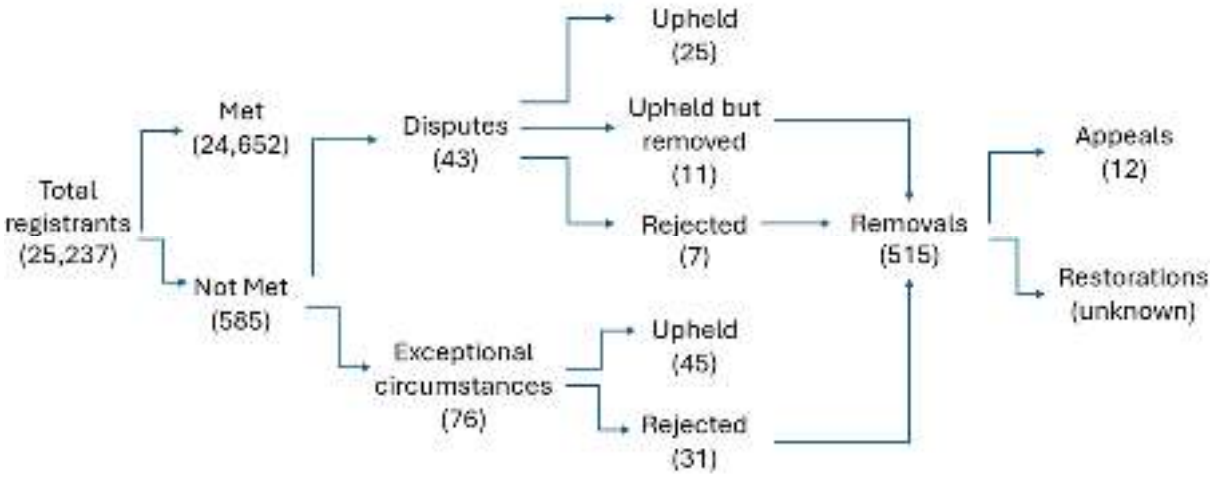
# Annex one – Evaluation of CPD 2022-24 cycle

## Summary

1. The 2022-24 cycle introduced significant reforms to GOC's CPD requirements designed to allow registrants to tailor learning and development to their own needs. Key changes included the need for a reflective statement based on a personal development plan, enabling self-directed CPD and placing responsibility on registrants to upload their points to an upgraded IT portal. Advance approval of CPD events was withdrawn replaced by a framework of reviews of registrant CPD records and audits of CPD providers.

2. Recognising that culture change takes time was a maxim of our implementation approach. There was also a significant investment in communications activities.

3. Fewer registrants failed their CPD requirements compared to the previous cycle despite growth in the register over the period. Ultimately, subject to appeals and restorations yet to be concluded, 515 registrants (2.0%) were removed from the register due to CPD failures. The final figures can be broken down as follows:




4. There were fewer disputes compared to the previous cycle and a higher uphold rate. There were fewer exceptional circumstances applications compared to the previous cycle and a lower uphold rate due to the absence of COVID-19 factors.

5. EDI analysis suggests males and White registrants are slightly overrepresented among those who failed to meet their points requirements compared to the overall make-up of the register. Older registrants were also overrepresented in these figures, but this is likely to reflect many in this group planning to retire at the end of the cycle. The small numbers limit analysis of post-cycle decisions but does not suggest any significant disproportionality of outcomes.

6. Areas for future focus emerging from the analysis include:
    - Following the pattern of previous cycles, although most registrants met their requirements in the end, many left it late to either complete their CPD activities and/or upload evidence of them to MyCPD.
    - The PDP should be completed at the beginning of the cycle, but many documents were not uploaded until the end of the cycle. Even though we have introduced a mandatory PDP form within MyCPD for the 2025-27 cycle, by the end of March 2025 only 27% had completed it.
    - Self-directed CPD was underutilised, accounting for less than 4% of points despite half of the points requirement being available via this method.
    - Most registrants consider the number of CPD points required is about right. However, a significant minority consider them excessive, and only half of businesses consider the compliance costs are reasonable.
    - A theme of exceptional circumstances applications was that some new registrants were unclear on their CPD requirements, so we need to tailor communications to this group.
    - As part of a focus on the quality of CPD, we can do more to extract the learning from CPD record reviews and give feedback to all registrants.

7. Positives to highlight include a rapid review carried out midway through the cycle which led to relaxation of scheme requirements and the largely smooth running of the end-of-cycle processes. There were few serious concerns findings in reviews of registrant records and audits of CPD providers. Survey evidence indicates that registrant confidence in completing the CPD requirements grew over the cycle.

8. The 2025-30 corporate strategy includes as a priority “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”. Work on potential reforms for the next cycle will begin in the autumn and we have notified DHSC of the possible need for a s60 order.

**Background**

9. The 2022-24 CPD cycle was the first following significant reforms to our requirements. Key changes included:
    - Allowing registrants more control over their learning and development and the ability to tailor CPD activities to their own needs
    - Replacing a system based on competencies with one linked to the standards of practice (the domains)
    - Placing responsibility on registrants rather than CPD providers to upload points to an upgraded portal run by Perceptive (MyCPD)

- Introducing the concept of self-directed CPD: registrants may obtain up to 50% of their points requirements via this route
- Introducing a requirement on registrants to undertake a reflective exercise towards the end of the cycle based on their Personal Development Plan
- GOC no longer giving advance approval to CPD events but reviewing a sample of registrant CPD records and auditing a sample of CPD providers

10. Given the wide-ranging nature of the reforms our implementation approach was guided by the principle that culture change takes time. This manifested in taking a proportionate and supportive approach to compliance, lots of communication with registrants and keeping changes for the 2025-27 cycle to a minimum.

**Implementation**

*Key milestones*

11. Key milestones included:
    - January 2022 – new MyCPD platform went live
    - June 2022 – main guidance for registrants published
    - December 2022 – lessons learned review of previous cycle completed
    - June 2023 – first wave of audits and reviews
    - September 2023 – dedicated communications plan finalised
    - December 2023 – completion of ‘rapid review’
    - May 2024 – exceptions policy published
    - July 2024 – reflective exercise system launched
    - September 2024 – SMT agreed end-of-cycle process document
    - November 2024 – statutory warning notices issued to those with shortfalls
    - January 2025 – failure notices issued
    - January and February 2025 – exceptional circumstances and disputes windows open
    - End of February 2025 – removal notices issued
    - March 2025 – appeals window

12. Due to the difficult end to the previous cycle, staffing changes and other issues, operational implementation of the reforms was behind schedule until summer 2023. For example, the main guidance for registrants should have been available to coincide with the launch of the cycle and the first wave of audits and reviews did not begin until midway through the cycle. However, by the midpoint of the cycle, everything that registrants needed to complete their requirements was in place. The reflective exercise and the statutory notice warning about points shortfalls were launched on time. Further, SMT agreed the end-of-cycle process document in September 2024 clarifying who would do what and when, enabling sufficient time to prepare for implementing the agreed plan.

*'Rapid Review'*

13. Halfway through the cycle a review was conducted to see how the new CPD scheme had been received and if it was meeting its objectives, and whether there was an opportunity to provide further guidance or make changes. We relaxed requirements in two areas increasing flexibility for registrants:
    - Allowing registrants with a specialty to obtain points in the specialty domain through self-directed CPD
    - Clarifying that contact lens opticians could participate in peer review with optometrists

14. There was an ongoing programme of refinement to MyCPD throughout the cycle.

*Communications Plan*

15. In September 2023 a dedicated Communications Plan was finalised to raise awareness and support registrants to comply with the scheme requirements.

16. The objectives of the Communications Plan were to:
    - Ensure registrants who are yet to do so understand why completing a PDP is important and fill it in as soon as possible
    - Ensure registrants obtain their relevant points totals
    - Explain clearly self-directed CPD and its benefits so it is used more
    - Ensure all registrants are aware of their end of cycle reflective exercise, understand what they are required to do, and complete it on time
    - Effectively communicate the latest developments in the CPD scheme – for instance, learnings arising from different waves of CPD audits and reviews, results of the CPD rapid review etc. - so that registrants / providers gain a good understanding of them
    - Keep CPD providers informed about the latest developments in the CPD scheme and what they can do to support registrants

17. As well as the November 2024 statutory notice and general updates about CPD in the monthly registrant bulletins, direct emails to registrants yet to complete their PDP, reflective exercise and requirements / recommendations around total points were issued at regular intervals during 2023 and 2024, as follows:

    PDP emails:

    - November 2023 – Reminder to all registrants still to complete a PDP, featuring link to relevant PDP resources (model templates, blog, new PDP webpage)
    - December 2023 and then every two months until end of scheme – follow-up emails to registrants still to complete a PDP

    Points reminder emails:

- October to December 2023 – Monthly reminder to all registrants still to obtain six points reminding them of our points recommendations
- September to December 2024 – Monthly reminders to all registrants still to hit their points recommendations

Reflective exercise emails:

- July 2024 – To all fully qualified registrants informing them of launch
- September to December 2024 – Monthly reminders to all registrants still to complete the reflective exercise

18. There was significant communications activity throughout the cycle, which contributed to the favourable end-of-cycle position. CPD was a testbed for new approaches to communications for GOC, including an animation and video interview on self-directed CPD and a blog series on different aspects of CPD.

19. It is important to acknowledge the significant support provided by membership bodies and the trade press in supporting registrants to meet their requirements. We proactively shared our proposed end-of-cycle communications to registrants with membership bodies, which supported a collaborative approach.

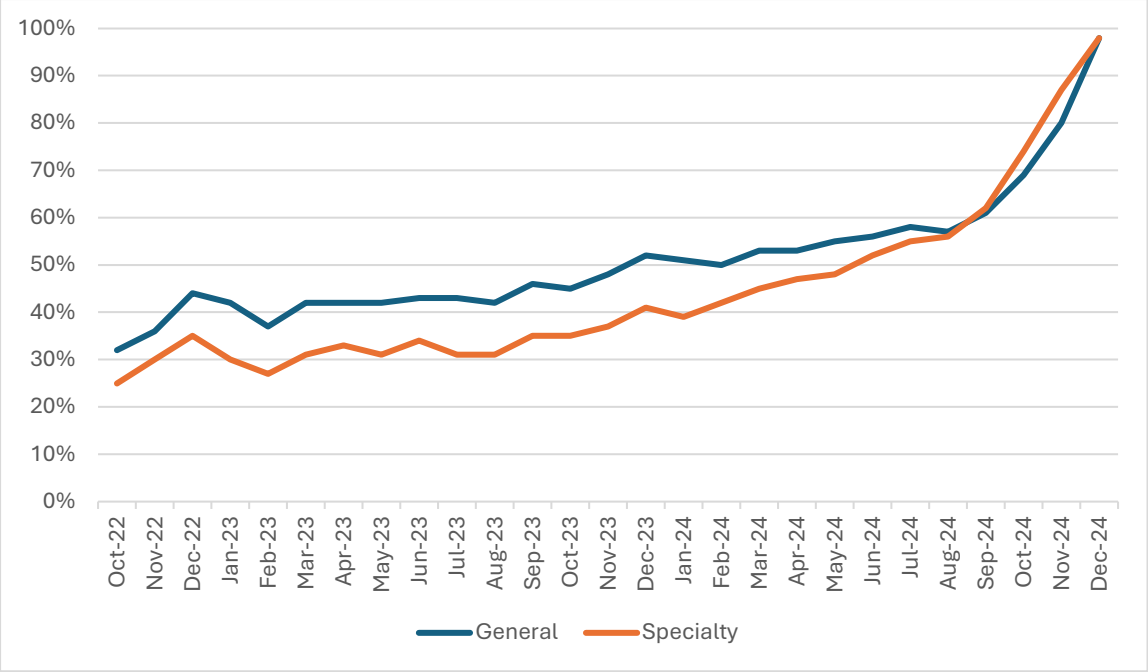
**Compliance with CPD points requirements**

*Progress towards meeting points requirements*

20. We encourage registrants to carry out CPD regularly and maintain up to date records on the MyGOC platform. To track progress, we monitor the proportion of registrants logging at least one point per month (reflecting that most registrants must obtain 36 points over the 3yr cycle (Chart 1)). Our data indicates that most registrants were below target in the first two years of the cycle, the rate of progress then gradually increased until August 2024 and there was a rapid acceleration in the final months. Of note, progress for the speciality registers consistently lagged those for the general register until August 2024.

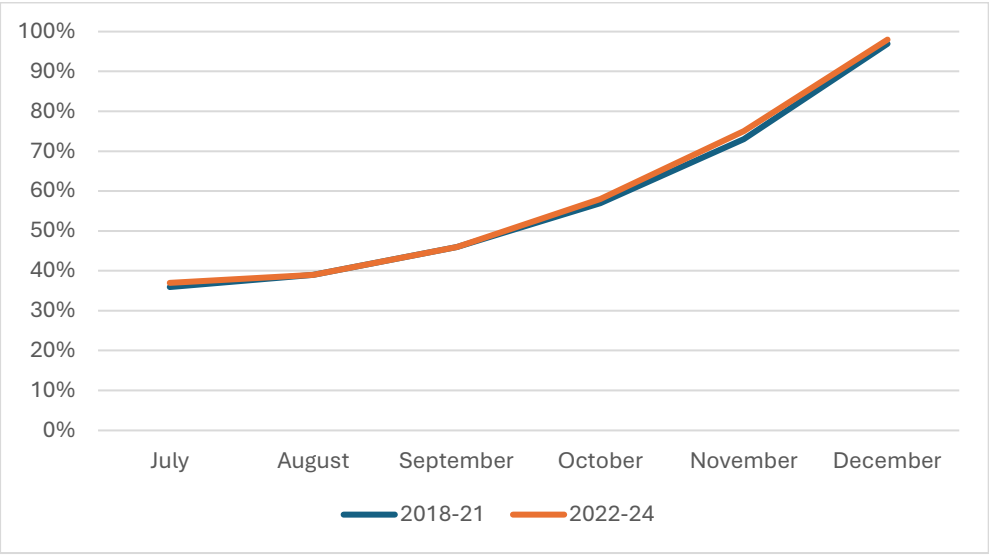
21. A key change in this cycle was the requirement for registrants rather than CPD providers to log points on MyGOC. Some registrants preferred to upload their points in bulk at certain times, including at the very end of the cycle, so this does not fully reflect when CPD activity takes place. In the context of a major change to our scheme, this created a situation where GOC did not know until the end of the cycle how many registrants would have a points shortfall and ultimately would be removed from the register(s).

Chart 1 – % registrants achieving at least 1 point per month




22. Comparison with the previous cycle shows an almost identical trajectory in registrants meeting all their CPD points requirements in the final six months of the cycle (Chart 2). At the end of October 2024, 58% of registrants had met all their requirements. In line with a new statutory requirement for this cycle, all other registrants (10,595) received a statutory notice warning them of a possible points shortfall and the implications. Where the registrant's communication preferences are to receive statutory notices by post this was sent by recorded delivery by a mailing house. At £5 per letter this represents a significant administrative cost.

Chart 2 – % registrants met all points requirements, 2018-21 and 2022-24




*End-of-cycle outturn*

23. By the end of the cycle, 1,051,610 points were logged on MyCPD – an indication of the large volume of CPD activity that took place over the three-year period.

24. At the end of the cycle, prior to disputes and exceptional circumstances applications being considered, 585 registrants (2.3%) did not meet their points requirements. This compares to 719 registrants (3.1%) at the same point in the previous cycle. The smaller number is encouraging given growth in the size of the register by more than 2000 registrants between 2021 and 2024.

25. Out of the 585 registrants who did not meet their points requirements, 260 had notified us of their intention to retire or withdraw from the register. The Registration Rules 2005 prevent registrants voluntarily withdrawing from the register. The DHSC's 2021 consultation on legislative reform proposed giving voluntary removal powers to all healthcare regulators, with a duty on the regulators to set out in rules their approach to dealing with voluntary removal requests during a fitness to practise investigation. Therefore, we have asked DHSC to consider a s60 order to remove this restriction as part of a wider package of reforms ahead of full-scale change to the Opticians Act.

26. The data shows that progress towards points requirements by optometrists and dispensing opticians matches almost exactly until the final month of the cycle. However, at the end of the cycle, 99% of optometrists met their final requirements compared to 97% of dispensing opticians.

27. Our analysis suggests that males and White registrants were slightly overrepresented among those who failed to meet their points requirements compared to the make-up of the register overall. Older registrants were also overrepresented, but this is likely to reflect higher numbers in this group planning to retire at the end of the cycle.

Table 1 – EDI analysis of registrants who failed to meet their points requirements by 31 December 2024

| | Number | % failed requirements | % on register in March 2024 |
|---|---|---|---|
| **Sex** | | | |
| Female | 332 | 56.8% | 63.8% |
| Male | 253 | 43.2% | 56.2% |
| | | | |
| **Age** | | | |
| Under 25 | 10 | 1.7% | 4.0% |
| 25-34 | 114 | 19.5% | 29.0% |
| 35-44 | 121 | 20.7% | 28.9% |
| 45-54 | 92 | 15.7% | 19.6% |
| 55-64 | 116 | 19.8% | 14.1% |
| 65+ | 132 | 22.6% | 4.4% |
| | | | |

| | | | |
|---|---|---|---|
| **Ethnicity** | | | |
| White/EWSNI/Irish | 290 | 55.7% | 50.4% |
| Asian/Asian British | 163 | 27.9% | 31.6% |
| Black/Black British | 7 | 1.2% | 1.3% |
| Mixed/Multiple | 6 | 1.1% | 1.0% |
| Other | 12 | 2.0% | 4.7% |
| Prefer not to say | 71 | 12.1% | 11.0% |
| | | | |
| **Disability** | | | |
| Has a disability | 8 | 1.4% | 1.2% |
| Does not have a disability | 505 | 86.3% | 85.6% |
| Prefer not to say | 72 | 12.3% | 13.3% |

28. As Table 2, below, illustrates, there were high levels of compliance with all points-related elements of the CPD requirements.

Table 2 – Compliance with points-related elements

| General points | % |
|---|---|
| Specialist points | 98% |
| Provider-led requirements | 99% |
| Interactive points | 98% |
| Core domains | 99% |
| Peer review requirement | 99% |
| Overall cycle points requirements | 98% |

29. Following the conclusion of disputes and exceptional circumstances processes, 524 registrants were sent removal notices compared to 589 in the previous cycle. This number reduced to 515 following determinations of some late exceptional circumstances applications that were received after removal notices were issued.

30. Overall, given the extent of change in our CPD requirements and the number of planned retirements, this is a positive outcome.

**Compliance with other scheme elements**

*Personal Development Plan*

31. The PDP was not a new feature of the scheme in this cycle but had more prominence than in previous cycles. This was not least due to the requirement for the reflective exercise towards the end of the cycle to be based on the PDP.

32. We encourage registrants to complete the PDP as early in the cycle as possible, as this will help them make sure they complete CPD that is meaningful to their current and future practice. By the end of the cycle, only 278 registrants had not logged a PDP on MyCPD, ultimately reflecting high levels of engagement.

However, only 46% of registrants had uploaded their PDP in the first six months of the cycle and approximately 1500 uploaded the document in December 2024.

33. A possible reason for this is ambiguity in the CPD Rules 2021 about whether GOC can require registrants to upload a PDP. The Rules state the reflective exercise must be based on the PDP but there is no standalone PDP requirement. Another reason is that the MyCPD platform did not enable registrants to update their PDP once uploaded whereas good practice is to treat it as a live document. For the 2025-27 cycle we have introduced a mandatory online PDP form that can be updated over time (see final section below).

*Self-directed CPD*

34. Self-directed CPD is learning from sources other than GOC approved CPD providers. Any type of learning relevant to someone's professional development can count. Examples could include reading an article, working towards an academic or vocational qualification, lecturing, webinars from outside the optical sector, or volunteering in wider healthcare. What matters is that registrants learn useful things from it which they can apply to their professional practice.

35. The end-of-cycle data suggests that self-directed CPD was underutilised. Only 3.9% of points were from self-directed CPD even though up to 50% of points may be obtained via this route. As noted above, GOC proactively promoted self-directed CPD. One potential reason why it was underutilised is that employers arrange sufficient provider-led activity. Another is the additional effort required to evidence that self-directed CPD was undertaken, especially the requirement to write a brief reflective statement. Lack of familiarity is another possible reason with our registrant survey indicating less than half of respondents were confident about completing self-directed CPD in the first two years of the cycle.

*Reflective Exercise*

36. Registrants must carry out and document a reflective exercise towards the end of the CPD cycle by reflecting on their professional development through discussion with a peer. The reflective exercise allows registrants to gain insights about their practice to improve the way they work and/or the care they give to their patients, as well as to prepare in advance for the next CPD cycle.

37. The reflective exercise functionality was launched on time in July 2024. Under the exceptions policy we clarified that failure to complete the reflective exercise (or a PDP) would not on its own be grounds for removal from the register for the 2022-24 cycle, however, completion or non-completion would be considered as mitigating or aggravating factors within the exceptions assessment process. By the end of the cycle, 97% of registrants had uploaded their reflective exercise to MyCPD. More than half of these statements were uploaded to MyCPD in

December. Given the reflective exercise was a new feature of the scheme this represents a good rate of compliance.

**Disputes and exceptional circumstances**

38. Following the end of cycle, those registrants identified as failing the requirements had a time-limited opportunity to dispute the accuracy of our records or make an exceptional circumstances application.

*Disputes*

39. Table 3 indicates there were fewer disputes compared to the previous cycle and a higher uphold rate. This was anticipated since in this cycle registrants rather than CPD providers had responsibility for logging their CPD activity on MyCPD. Decisions on disputes were made by the departmental team reflecting these were factual in nature. We upheld disputes in cases where the registrant could demonstrate they had completed the CPD activity during the 2022-24 cycle but failed to log this on MyCPD before 31 December 2024.

40. Of the 43 disputes, 31 were from optometrists and 12 from dispensing opticians, broadly reflecting the ratio of optometrists to dispensing opticians on the register.

41. Of the 36 upheld disputes, 11 registrants were still removed from the register since there was a points shortfall once the disputed points had been accepted.

42. On an EDI analysis, 62% of disputes made by females were upheld compared to 50% for males. The small numbers do not allow analysis in other categories.

Table 3 – Summary of disputes

| | 2025 | 2022 |
|---|---|---|
| Applications | 43 | 81 |
| Upheld | 36 | 45 |
| Rejected | 7 | 36 |
| Success rate | 84% | 56% |

*Exceptional circumstances*

43. Table 4 indicates fewer exceptional circumstances applications compared to the previous cycle and a lower uphold rate. Applications were considered against the criteria in our exceptions policy, which was published well in advance of the cycle ending to ensure transparency. Since decisions on these applications involved qualitative judgement and a level of discretion, in all cases the Registrar made the decision after considering a recommendation from the departmental team.

44. The reason for the lower success rate in 2025 will to some extent reflect the absence of COVID-19 factors which were prominent in 2022.

45. Of the 76 applications, 33 were from optometrists and 41 from dispensing opticians, suggesting dispensing opticians were overrepresented in the figures relative to both numbers on the GOC register and numbers failing to meet their points requirements. However, the success rate was similar between the two professional groups.

Table 4 – Summary of exceptional circumstances applications

| | 2025 | 2022 |
|---|---|---|
| Applications | 76 | 122 |
| Upheld | 45 | 79 |
| Rejected | 31 | 43 |
| Success rate | 59% | 65% |

46. On an EDI analysis, 57% of applications from females were upheld compared to 50% from males. Further, 62% of applications from Asian registrants were upheld compared to 54% from White registrants. The numbers are too small to allow analysis in other ethnic categories, or for age or disability.

47. Table 5 (based on a snapshot before late applications) shows the main reasons given in applications mostly related to physical and mental health conditions, caring responsibilities and challenging life circumstances like bereavement and separation. In some applications multiple reasons were given.

48. Eight applications claimed confusion about the scheme requirements. In some cases, these involved individuals who joined the register at the end of the cycle. Although new registrants received bespoke correspondence clarifying their requirements, we will review how best to support this group ahead of the end of the 2028-30 cycle.

Table 5 – Reasons given in exceptional circumstances applications

| **Reason** | **Number** |
|---|---|
| Physical health | 15 |
| Carer – disabled dependant | 14 |
| Physical health – pregnancy related | 10 |
| Mental health | 10 |
| Bereavement | 10 |
| Confusion about scheme requirements | 8 |
| Maternity | 7 |
| Left/not in practice | 6 |
| Separation | 5 |
| Stress | 4 |
| Sickness of dependant | 3 |
| Studying | 3 |
| Remote working | 2 |

| | |
|---|---|
| Limited scope of practice | 1 |
| Court action/litigation (not FtP related) | 1 |
| Domestic abuse | 1 |
| FtP undertakings | 1 |

**Appeals**

49. Following conclusion of the disputes and exceptional circumstances processes, we send registrants a statutory notice of our intention to remove them from the register(s). Registrants have a statutory one-month period to appeal this decision.

50. We received a total of 12 appeals: one was withdrawn, six were extinguished following approval of their late exceptional circumstances application, and the remaining six are being prepared for hearing. This compares with 21 appeals and three hearings in the last cycle.

**CPD record reviews**

51. The purpose of record review is to ensure that registrants are undertaking CPD which aligns with their scope of practice and professional development needs, and that they are keeping good-quality records of CPD they complete. CPD reviewers are optometrists and dispensing opticians who have been appointed and trained by the GOC.

52. Up to 10% of registrants have their CPD records reviewed each CPD cycle with reviews scheduled every April, June and October. The process should not be burdensome for registrants since reviewers base their reviews using records on the MyCPD platform.

53. If a registrant is undertaking CPD relevant to their professional needs and keeping good quality records, they will receive a ‘pass.’ If improvement is required on a registrant’s record keeping or their learning is not believed to be appropriate or on track, they will receive a ‘requires improvement’ outcome. Alongside this, registrants will be given recommendations and specific actions which we expect them to complete. In these circumstances, registrants may be subject to a targeted review in the following 12 months, where the reviewer will look at a selection of their CPD records and consider if the registrant has acted in accordance with the recommendations reported in the previous review.

54. The first wave of reviews took place in June 2023, which was later than planned and represented a missed opportunity to address any early issues. However, by the end of the cycle, 2273 reviews had been completed (9.3% of registrants).

55. The outcome of record reviews shows an improvement in the pass rate over time and a small proportion of serious concerns (Table 6). A serious concerns

outcome means there are significant issues with a registrant's record-keeping and/or there is evidence that their learning does not align with their needs or with the GOC's *Standards of practice*.

56. In October 2024, the Chair of CPD Reviewers wrote a guest article[1] summarising common learning from the reviews; we will look to do more of this activity in the 2025-27 cycle.

Table 6 – CPD Record Review Outcomes

| | Number of reviews | Pass | Requires improvement | Serious concerns |
|---|---|---|---|---|
| Jun 23 | 380 | 67.6% | 29.7% | 2.6% |
| Oct 23 | 439 | 72.2% | 25.5% | 2.3% |
| Apr 24 | 480 | 69.0% | 27.5% | 3.5% |
| Jun 24 | 413 | 74.6% | 23.5% | 1.9% |
| Oct 24 | 561 | 75.0% | 22.3% | 2.7% |

**End-of-cycle arrangements**

*Benefits of changes to end-of-cycle operational arrangements*

57. There was significant focus on learning from the end-of-cycle arrangements in 2022. Improvements and benefits from the changes made included:

- A cross-departmental project team was established to co-design the approach, improving collaboration and mutual understanding of processes
- SMT approved the end-of-cycle process document providing senior collective responsibility for the plans and clarity to teams on who does what and when
- Registrants who did not meet their requirements were issued a single template letter in January directing them to tailored information on MyCPD as required. This replaced the 30 letter templates used previously, thereby simplifying processes and improving accuracy and speed
- Integration with CRM to support data management and document generation and automation reduced the scope for manual error and improved efficiencies
- The CPD operations team was temporarily over-resourced for three months with a staff member seconded from registration. This bolstered resilience and improved coordination between departments

58. The process revealed some learning points including areas where we need to tighten guidance and improve clarity, and some errors in correspondence. Overall, the end-of-cycle largely ran smoothly with all key milestones met on time.

[1] The GOC's Record review explained

## CPD providers

*Number of full and provisionally qualified providers*

59. GOC is the only regulator to approve CPD providers and audit provision. There are two types of CPD provider: provisionally approved providers and fully approved providers. We review and approve at least ten unique and self-authored CPD submissions from provisionally approved providers before we consider giving them fully approved status.

60. Table 7 shows the total number of CPD providers shrank by 51 between December 2022 (the first available record) and December 2024, from 382 to 331. Over the full cycle 233 new applications were submitted for provisional provider status with 112 approved. 1221 CPD events by provisionally approved providers were submitted to the GOC and 634 were approved. Overall, ten provisionally approved providers achieved fully approved provider status over the cycle. This small number reflects a combination of the minimum ten CPD submissions requirement not being met and the quality of these events.

61. We will consider the proportionality of the ten submissions requirement ahead of the 2028-30 cycle. Further, we will consider what further support we can provide to provisionally approved CPD providers to supplement existing activities like our annual workshop.

Table 7 – Number of CPD providers

| | December 2022 | December 2024 |
|---|---|---|
| Provisionally approved | 260 | 204 |
| Fully approved | 122 | 127 |
| Total | 382 | 331 |

Registrant feedback

62. We collect feedback from registrants following events they attended, on the quality of both providers and the event and track the average monthly ratings (Table 8). The average monthly feedback rated at either good or excellent was 96% for providers and 93% for events suggesting consistently high registrant satisfaction across the cycle.

Table 8 – Quality of CPD provision

| | Provider | Event |
|---|---|---|
| Excellent | 24% | 30% |
| Good | 72% | 63% |
| Poor | 4% | 6% |
| Very poor | 0% | 1% |

*CPD provider audits*

63. Approximately 10% of CPD providers were audited annually including a mixture of randomly selected and targeted audits. As with CPD reviews, these took place in April, June and October and this process started midway through the cycle. The outcomes are summarised in Table 9.

64. Considering the small numbers of audits there is no obvious pattern in the outcomes, and there were only two serious concern outcomes across the cycle.

Table 9 – Audit outcomes

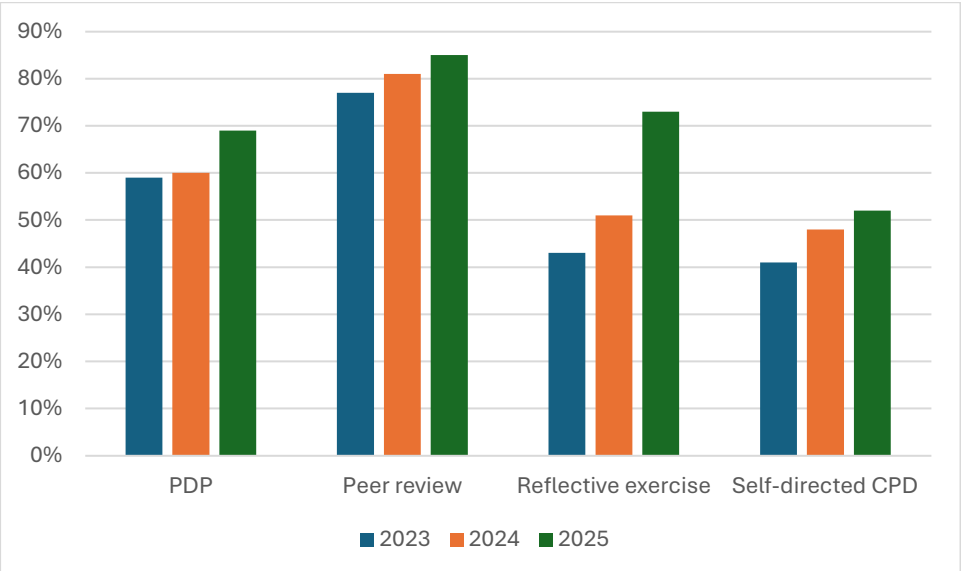
| | Number | Pass | Requires improvement | Serious concerns |
|---|---|---|---|---|
| Jun 23 | 8 | 5 | 2 | 1 |
| Oct 23 | 8 | 3 | 5 | 0 |
| Apr 24 | 9 | 8 | 0 | 1 |
| Jun 24 | 5 | 2 | 3 | 0 |
| Oct 24 | 13 | 8 | 5 | 0 |

**Registrant feedback**

*Confidence in completing specific requirements*

65. Between 2023-25 we included questions in our annual registrant surveys to test confidence in specific elements of the CPD scheme. Confidence in each of the elements increased over time, although there is less confidence in self-directed CPD, which likely reflects fewer registrants having direct experience of utilising this option.

Chart 3 – Confidence in CPD requirements

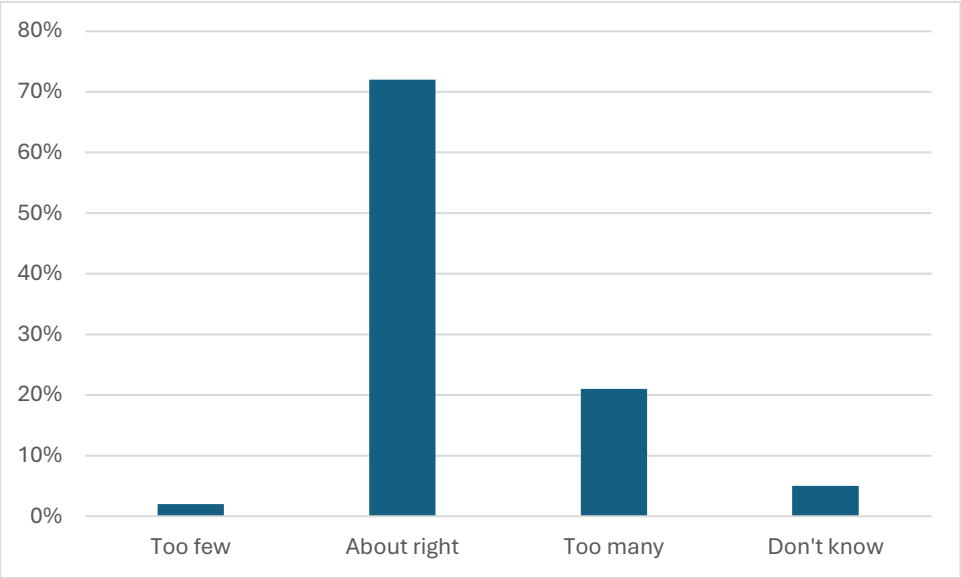


*Views on points requirements*

66. In the 2025 Registrant Survey we asked respondents to provide views on whether the number of CPD points required was too few, about right or too many.

67. Over seven in ten respondents (72%) considered the number of points was about right although a significant minority considered there were too many (21%). Dispensing opticians were more likely than optometrists to consider too many CPD points were required (29% v 18%).

Chart 4 – Views on number of CPD points




*Business registrants*

68. In the 2025 Business Registrant Survey we included questions on how employers support individual registrants to meet the CPD requirements. The small sample size means the results have indicative value.

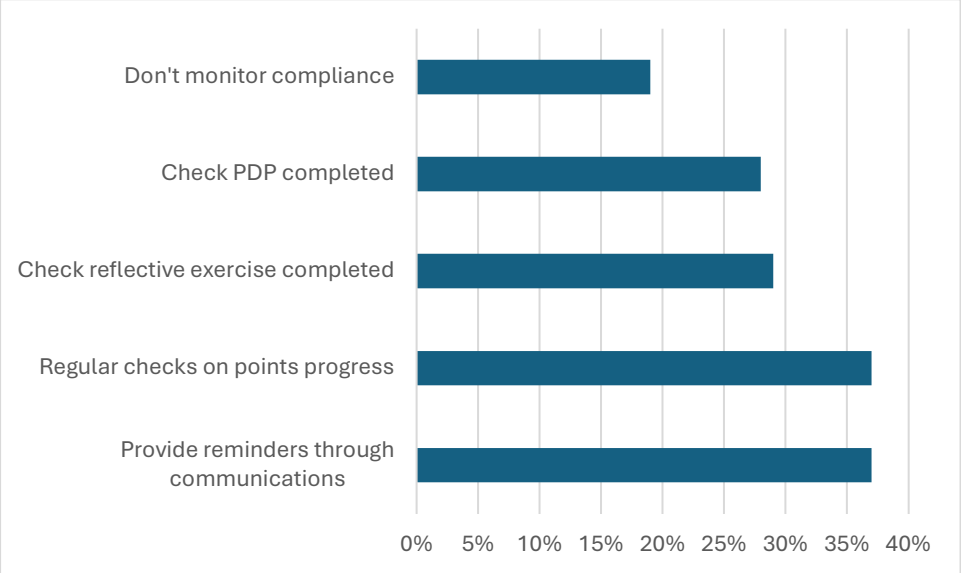
69. The most common form of support was the free-of-charge provision of CPD through third party providers (42%), followed by providing time off for CPD (37%) and providing their own CPD free of charge (33%). Around a quarter (24%) provided funding for employees to complete CPD, while very few provided their own CPD at a cost (1%). Almost a quarter of respondents (22%) indicated that they provided no support for CPD to their employees.

70. Businesses were asked how they monitor whether their registrant employees are complying with their CPD requirements. Chart 5 indicates a significant minority of businesses monitor compliance, most often through regular communications and

checking progress against points requirements. Nearly three in ten respondents checked whether the PDP or reflective exercise had been completed. Smaller businesses were significantly less likely to monitor compliance.

71. In the 2025 edition of the survey, only 50% of respondents agreed that the costs to them of complying with CPD requirements were reasonable.

Chart 5 – How businesses monitor compliance with CPD requirements.




**Looking ahead**

*Changes made in advance of 2025-27 cycle*

72. To support culture change we kept changes to the 2025-27 cycle to a minimum.

73. Given low initial uptake of the PDP in the 2022-24 cycle, we introduced a mandatory online PDP form in MyCPD. This change was made following consultation with sector bodies and was designed to improve compliance. However, at the end of March 2025, 27% of registrants had uploaded their PDP suggesting this change has had limited impact.

74. To ease the transition to the new cycle for CPD providers, we stopped CPD sessions automatically expiring on the IT platform and allowed providers to submit new sessions for 2025 ahead of the end of the 2022-24 cycle.

*Areas for longer-term change*

75. The 2025-30 corporate strategy includes as a priority "*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*". We expect to begin work on policy options in autumn 2025.

76. We are testing appetite for reform with DHSC officials since most substantive changes to the scheme requirements will require amendments to the CPD Rules 2021. However, while the current legislation is prescriptive, we will also identify changes to the scheme possible within the boundaries of the CPD Rules 2021.

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**C26(25)i.**

**Council**

## Financial performance report for the year ending 31 March 2025

**Meeting:** 25 June 2025
**Lead responsibility:** Charlotte Urwin (Acting Director of Corporate Services)
**Status:** for noting
**Paper author:** Manori Wickremasinghe (Chief Financial Officer)

## Purpose

1. To provide a summary of the financial reports for the year ending 31 March 2025. The detailed report will be presented to Audit and Risk Committee at its meeting on 8 July 2025.

## Recommendations

2. Council is asked to:
   - **note** the financial performance for the year ending 31 March 2025 in annex one

## Strategic objective

3. This report is relevant to delivery of all our strategic objectives.

## Background

4. The financial performance report of 31 March 2025 relates to year five (the final year) of the 'Fit for the Future' strategic plan (which covered the period 1 April 2020 to March 2025) and is consistent with delivery of that year's business plan.

## Analysis

5. The 31 March 2025 financial performance report (FPR) (Annex one) shows a surplus of £636k for business as usual (BAU) operations and a deficit of £545k for total operations before the unrealised portfolio. The results continue to show positive variance for both BAU and reserve expenditure for the budget and the Q3 forecast. The report includes highlights, key performance indicators, risks, and future impacts in detail.

6. The financial performance for the year has achieved the KPI levels set by the Council. The KPI for 2024-25 is the net profit margin +/-10% compared to the budget and forecast. The KPI of +3.36% KPI against the budget and +7.65% against the Q3 forecast are both within the acceptable range of +/-10%. The report produced an additional KPI before the Future Office Accommodation

project (FOA), showing the KPI levels before FOA variance of £571k due to the project completion delaying to 2025/26.

7. The results increased the reserves by £143k compared to the Q3 forecast predictions due to net savings and efficiency. Operations delayed to 2025/26 will have a £81k impact on the current year's budget. We will re-assess and include these costs as part of the Q1 forecast for 2025/26. The report highlights the ongoing challenges in predicting expenditure for business areas affected by external factors (such as in hearings and education QA) whilst assuring other areas are managed within smaller variances.

8. The high market volatility impacted the Q4 of 2024-25, reducing the expected reserves by £362k. We expect short to medium volatility in the market and impact on our investment portfolio and reserve levels but are confident in the maintenance of long-term growth.

9. Further analysis is included in the report (annexe one).

## Finance

10. There are no additional financial implications of this work.

## Risks

11. The following risks are associated with finance, as identified in the finance risk register:
    - The GOC fails to deliver value for money
    - The GOC is unable to deliver its strategic plans, programme of change, and business as usual either sufficiently quickly or effectively
    - Capability and resilience: Small teams lead to over-reliance on particular individuals, causing burnout, errors and/or impacting organisational delivery if absent or on departure.

12. Reporting and monitoring financial performance against budgets and forecasts are a fundamental part of managing and mitigating these risks.

## Equality Impacts

13. No equality impact has been undertaken.

## Devolved nations

14. There are no implications for the devolved nations.

## Communications

### External communications

15. None planned.

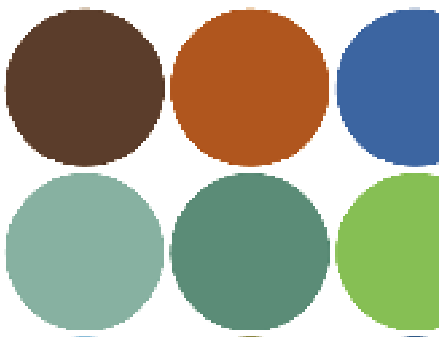
## Internal communications

16. The financial report and the forecast are shared with the Leadership Team and SMT as part of the regular financial reporting process.

## Attachments

Annex one: Financial performance report for the year ending 31 March 2025.

# Financial Performance Report for the Year ending 31 March 2025



# Financial Performance Report for the 12 months ending 31 March 2025

## Contents

# Financial Performance Report for the 12 months ending 31 March 2025

## G O C :- Summary P & L to 31 March 2025

| | Actual £000's | Budget £000's | Variance £000's | Q3 Forecast £000's | Variance £000's |
|---|---|---|---|---|---|
| Registrant Income | 11,672 | 11,980 | (308) | 11,654 | 18 |
| Other Income | 519 | 361 | 158 | 508 | 11 |
| Expenses - BAU | (11,554) | (12,326) | 772 | (11,718) | 163 |
| **Surplus / (Deficit) -BAU** | **636** | **15** | **623** | **445** | **193** |
| Project expenditure | (1,181) | (981) | (200) | (1,919) | 738 |
| Surplus / (Deficit) -before portfolio Gains/Losses | (545) | (966) | 421 | (1,474) | 929 |

| KPI | Actual | Budget | Variance* | | Forecast | Variance* |
|---|---|---|---|---|---|---|
| Net Profit Margin | -4.47% | -7.83% | 3.36% | | -12.12% | 7.65% |
| ** acceptable KPI = +/-10%* | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| KPI before Future Office Accommodation Project | -2.72% | -7.46% | 4.75% | | -5.67% | 2.95% |

## Highlights

The results before unrealised portfolio gains/losses for the year ending 31 March 2025 show a positive variance of £421k against the budget and £929k against the Q3 forecast. The business as usual (BAU) results before reserve expenses including strategic projects show a positive variance of £623k against the budget and £193k against the Q3 forecast.

The total registrant income of £11,672k is £308k less than the budget, but £18k above the Q3 forecast. The total expenditure (including projects) of £12,735k is £572k favourable to the budget and £901k against the Q3 forecast.

### Key drivers of the improved financial performance

The key drivers for the positive variance are mainly due to reduced expense levels. There is a large impact due to the delay in the Future Office Accommodation (FOA) project which had originally been expected to complete in 2024/25 and will now complete in 2025/26, due to the delays in delivering our final office premises. Although it is only a couple of months, the delay to the next financial year resulted in £571k variance (to the Q3 forecast) in 2024/25. The above table restates the KPI with results before FOA project for a clearer perspective. Some variances in IT expenditure were also linked to the office move delay.

Other main reasons are a combination of savings, efficiency, staff vacancy gaps and additional costs. (ref. Tables 3-4 for BAU variances– page 8).

33% of Business as Usual (BAU) variances were due to IT. The majority of the other costs were expenses that cannot be predicted accurately and are prone to variances. These include early completions of hearings, central contingency, staff being on long-term sick leave, and some HR-related expenses. In addition, there were fewer adaptations than

forecasted in the Education area due to the activity being new. Efficiencies were made by finding free venues for hearings in March. Some plans were delayed to next year. We anticipate that these costs will have a £54k impact in 2025/26 and £26k in 2025/26.

The above positive variances were partly netted off by some additional expenditures related to payroll and HR-related legal costs.

Large savings were realised in complex legal cases now completed due to the closing of purchase orders for those cases. This is funded through the Complex Cases Legal Reserve.

£56k of fixed assets related to refurbishments; furniture, fixtures, and some IT costs were written off at the end of the year as the result of the office move. Although writing off of the refurbishment asset balance was initially forecasted under FOA, we wrote off fixed asset balances to BAU, utilising the high level of BAU surplus. FOA will use the original forecast value to absorb additional costs and will remain within the approved budget.

We have been reviewing the staff vacancy gap percentage for the year (actual vs. approved budget) to ensure that our 4% vacancy gap for 2025/26 is reasonable. For the year ending 2024/25, the staff vacancy rate is 4.6%. This gives confidence in the 2025/26 budget approach on the vacancy gap.

**Risks for achieving the budget.**

We have completed the year with high variances. The impact is analysed below.

**Future impacts (So what?)**

Results for 2024/25 have ended with surpluses similar to previous years, improving reserve levels from those planned. This will help fund future strategic projects and contingencies. e.g. the additional costs for the member review liabilities.

We plan to review the IT budget to understand and reduce the high variances in this area, and help match the capacity, capability, and planning.

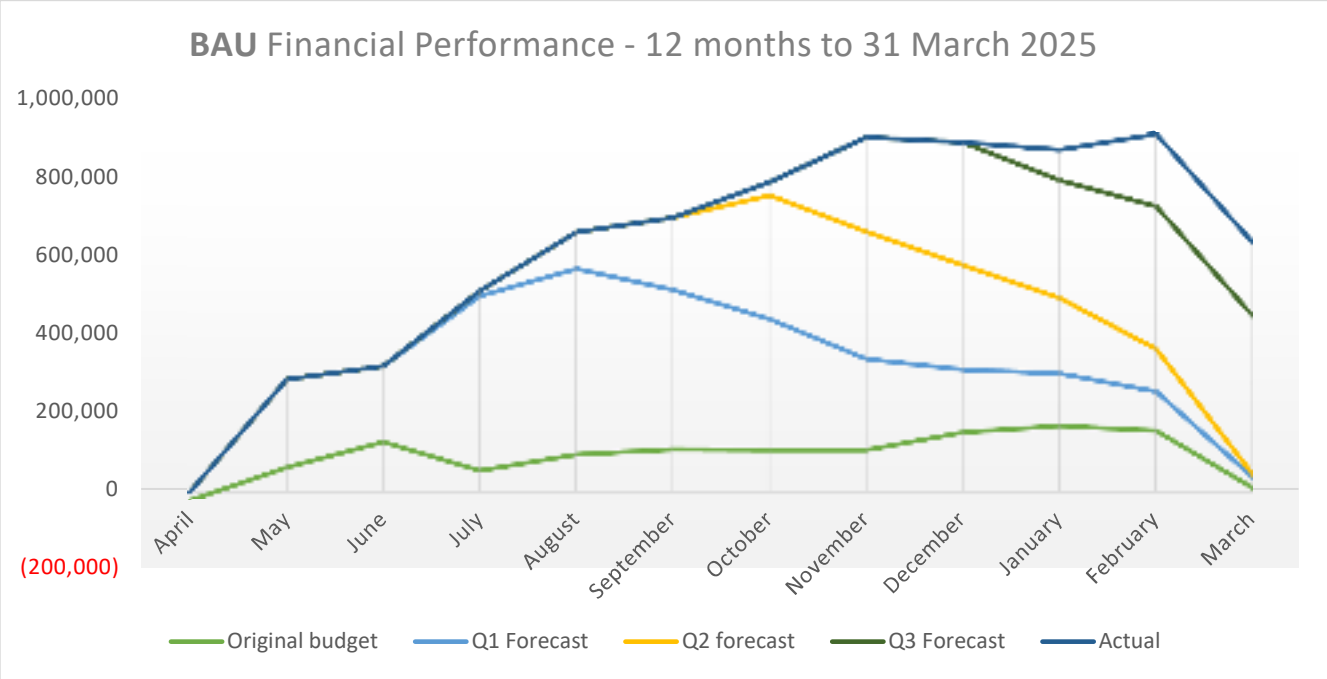
The hearings budget has already adopted methods of reducing variances by making provisions for early completion of hearings in 2025/26. With the new legal support model now well embedded, the investigations department will review their purchase orders more frequently and close them when cases are completed.

Some unexpected and difficult-to-plan costs and new activities will continue to give rise to variances in the future. Some operations are external facing and will have impacts due to external events. Our agile approach continues to increase positive variances. These need to be recognised as active savings and efficiencies.

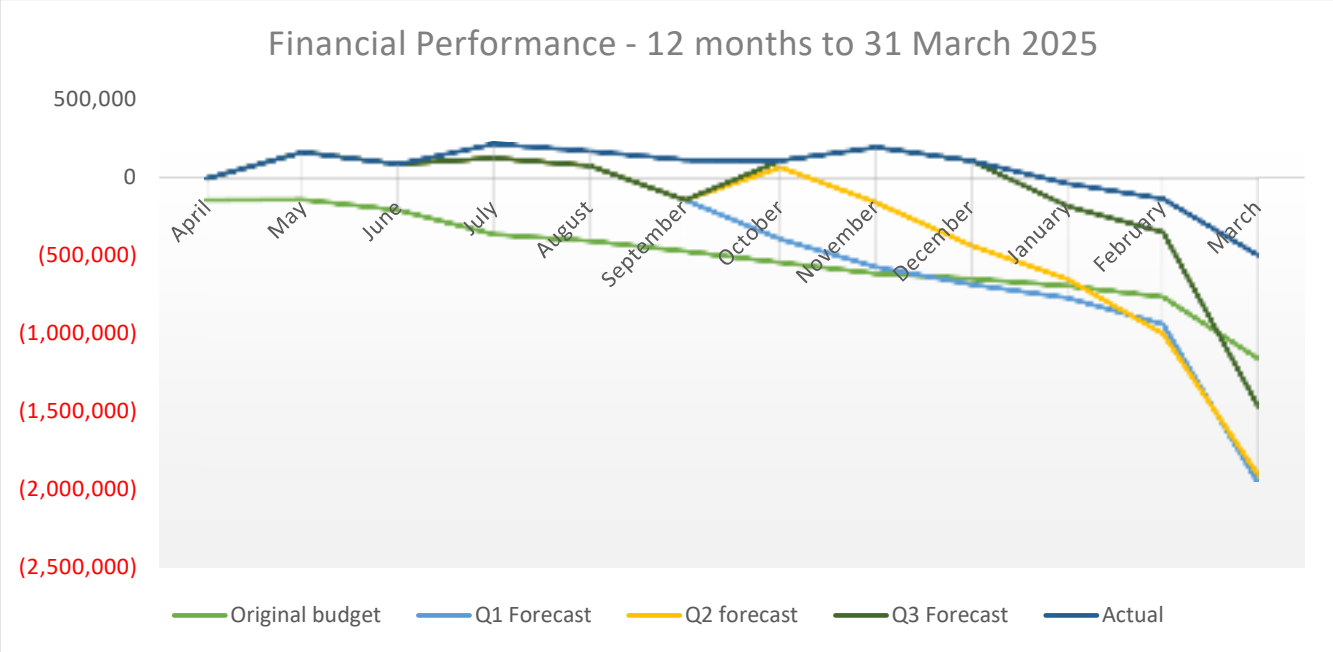
The market volatility will affect our investments negatively in the short to medium term. Our investment market value may reduce more than budgeted during 2025/26 as the market is

very volatile to the current global/US political changes. However, we expect to achieve our planned long-term benefits as forecasted.

**Graphical analysis on Financial Performance and Variance**




*Graph 1*




*Graph 2*

## Analysis of Expenditure

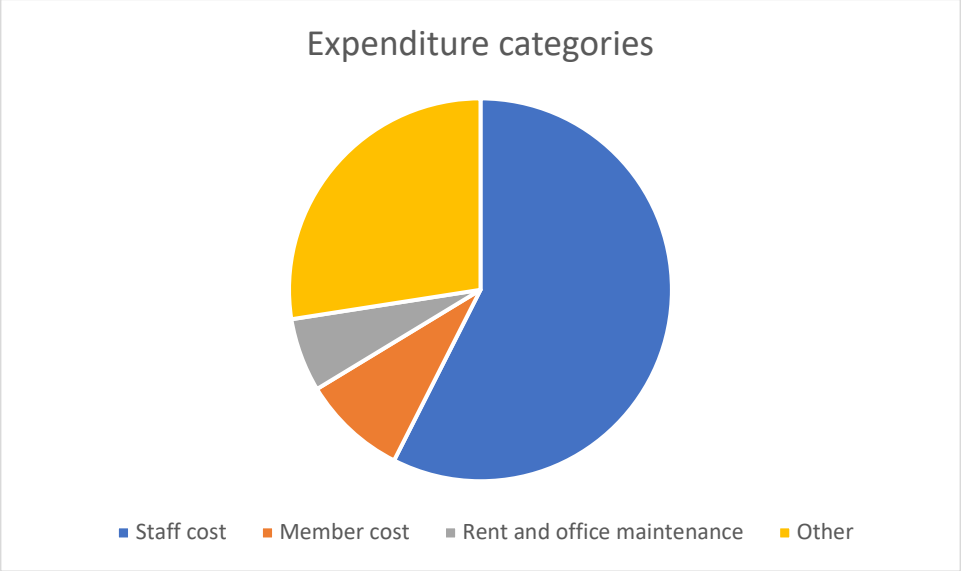



*Chart 1*

*Note: Categories under "Other" are detailed in Table B in page 11*

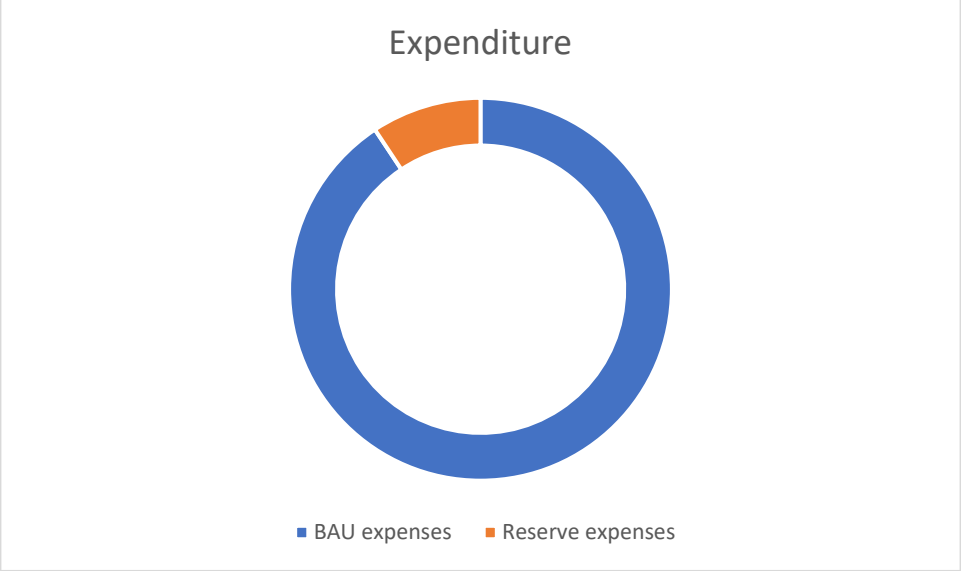
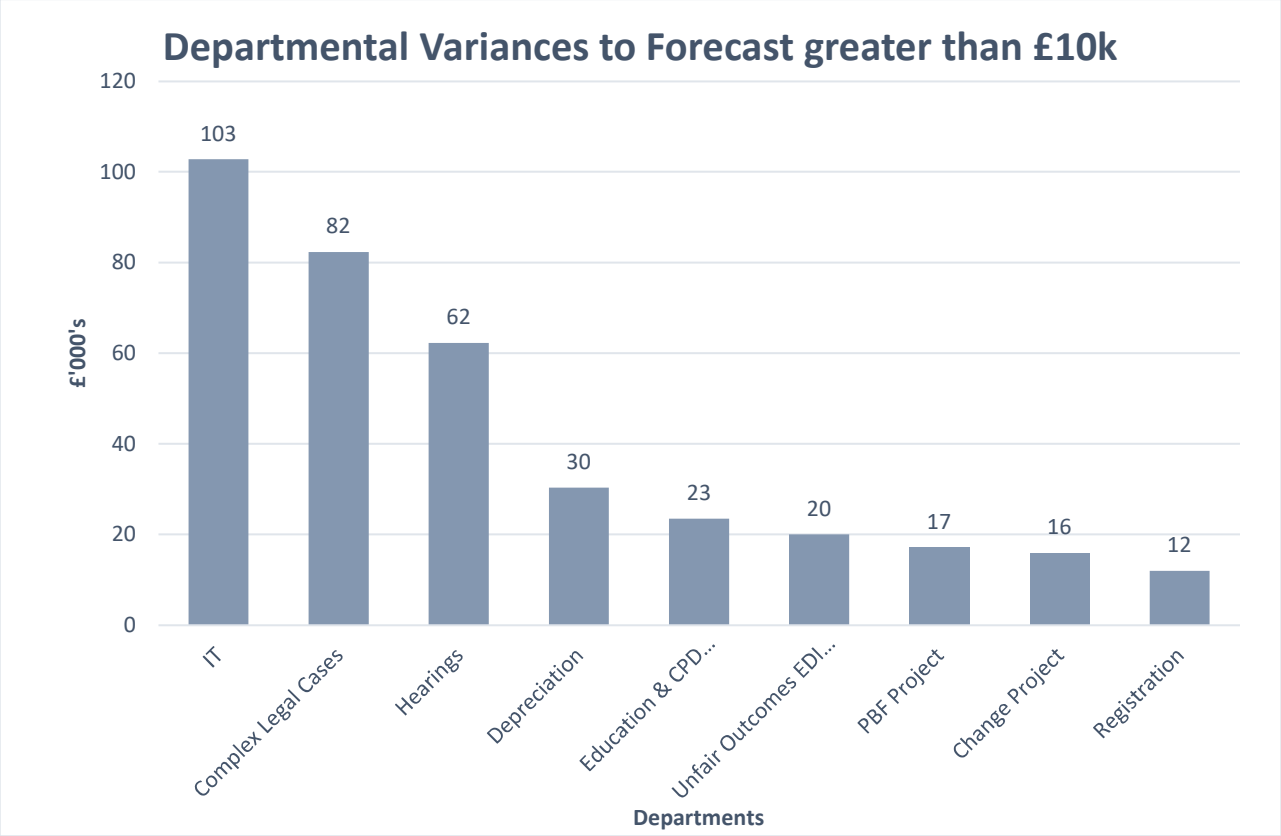



*Chart 2*




*Graph 3*

*Note: FoA not included as graph visuals will be less clear. FoA variance £571k as project completion changed to 25/26.*

Cash and Cash Equivalent Summary - 31 March 2025

| | Actual £'000 | BUDGET £'000 | Variance £'000 | Q3 Forecast £'000 | Variance £'000 |
|---|---|---|---|---|---|
| Cash at Bank | 1,558 | 554 | 1,004 | 745 | 813 |
| Short term Investments | 8,950 | 8,600 | 350 | 8,750 | 200 |
| **Working Capital** | **10,508** | **9,154** | **1,354** | **9,495** | **1,013** |
| Investments | 9,398 | 9,171 | 227 | 9,760 | (362) |
| **Total** | **19,906** | **18,325** | **1,581** | **19,255** | **651** |

*Table 1*

**Headcount March 25 (non- FTE)**

| | Actual FTC* Mar-25 | Actual Perm. Mar-25 | **Actual Total** Mar-25 | Q3 Forecast Mar-25 | Budget Mar-25 |
|---|---|---|---|---|---|
| Chief Executive Office | - | 8.0 | **8.0** | 9.0 | 9.0 |
| Regulatory Strategy | - | 23.0 | **23.0** | 24.0 | 24.0 |
| Regulatory Operations | 6.0 | 38.0 | **44.0** | 45.0 | 41.0 |
| Corporate Services | 9.0 | 20.0 | **29.0** | 30.0 | 22.0 |
| Change | 3.0 | 6.0 | **9.0** | 10.0 | 10.0 |
| **Total Headcount** | **18.0** | **95.0** | **113.0** | **118.0** | **106.0** |

** including Agency temp staff*

*Table 2*

# Financial Performance Report for the 12 months ending 31 March 2025

| | |
|---|---|
| Staff Vacancy Rate to date | 4.6% |
| Impact if no future staff vacancies (24/25) | 4.6% |

| Analysis of BAU expense variance March | | |
|---|---|---|
| **Savings** | **£'000** | |
| Efficiency | 21 | |
| Savings | 189 | |
| Staff vacancy gaps (excluding efficiency measures) | 16 | |
| Delays | 6 | |
| Delayed to Next Year- Not budgeted in next year | 81 | |
| Revised plans and timing(uncertain) | 0 | |
| Accounting, PO, coding errors | 10 | |
| Additional expenses | 323 | |
| Additions | (83) | |
| Others | (21) | |
| Total Expense Variance | 219 | |

*Table 3*

| Analysis of net savings over past quarters (BAU exp.) | | | | | |
|---|---|---|---|---|---|
| Savings | Q1 | Q2 | Q3 | Q4 | Total |
| | £'000 | £'000 | £'000 | £'000 | £'000 |
| Efficiency | - | 16 | - | 21 | 37 |
| Savings | 42 | 97 | 243 | 189 | 571 |
| Staff vacancy gaps | 143 | 27 | 4 | 16 | 190 |
| Additions | (71) | (144) | (61) | (83) | (359) |
| **Net savings/(overspent) from approved budget/forecast** | **114** | **(4)** | **186** | **143** | **439** |
| Last year trend | 54 | 38 | 194 | 246 | 532 |

*Table 4*

# Financial Performance Report for the 12 months ending 31 March 2025

## Table A
### Income and Expenditure Accounts

| | April - March | | | April - March | | |
|---|---|---|---|---|---|---|
| | Actual £'000 | Budget £'000 | Variance £'000 | Actual £'000 | Forecast £'000 | Varianc £'000 |
| **Income** | | | | | | |
| Registration | 11,672 | 11,980 | (308) | 11,672 | 11,654 | 1 |
| Dividend Income | 238 | 265 | (27) | 238 | 250 | (12 |
| Bank & Deposit Interest | 252 | 86 | 166 | 252 | 244 | |
| Other Income | 29 | 10 | 19 | 29 | 14 | 1 |
| **Total Income** | **12,191** | **12,341** | **(151)** | **12,191** | **12,163** | **2** |
| **Expenditure** | | | | | | |
| **Executive Office** | | | | | | |
| CEO's Office | 201 | 282 | 80 | 201 | 220 | 1 |
| Governance | 705 | 729 | 23 | 705 | 717 | 1 |
| **Total Executive** | **906** | **1,010** | **104** | **906** | **937** | **3** |
| **Regulatory Strategy** | | | | | | |
| Director of Regulatory Strategy | 129 | 129 | (0) | 129 | 130 | |
| Policy | 485 | 499 | 14 | 485 | 488 | |
| Communications | 294 | 309 | 16 | 294 | 291 | (2 |
| Education & CPD Operations | 712 | 810 | 98 | 712 | 706 | (6 |
| Education & CPD Development | 464 | 556 | 91 | 464 | 488 | 2 |
| **Total Regulatory Strategy** | **2,083** | **2,302** | **219** | **2,083** | **2,103** | **2** |
| **Regulatory Operations** | | | | | | |
| Director of Regulatory Operations | 167 | 144 | (23) | 167 | 168 | |
| Investigation | 1,270 | 1,370 | 99 | 1,270 | 1,268 | (2 |
| Case Progression | 925 | 924 | (1) | 925 | 924 | (1 |
| FTP Legal | 273 | 301 | 28 | 273 | 280 | |
| Legal | 222 | 239 | 16 | 222 | 219 | (4 |
| Hearings | 1,184 | 1,341 | 157 | 1,184 | 1,246 | 6 |
| **Total Regulatory Operations** | **4,041** | **4,318** | **277** | **4,041** | **4,106** | **6** |
| **Corporate Services** | | | | | | |
| Director of Corporate Services | 180 | 153 | (27) | 180 | 156 | (24 |
| Facilities | 1,192 | 1,144 | (48) | 1,192 | 1,190 | (2 |
| People & Culture | 604 | 623 | 19 | 604 | 609 | |
| Finance | 592 | 629 | 37 | 592 | 600 | |
| Registration | 754 | 705 | (48) | 754 | 766 | 1 |
| **Total Corporate Services** | **3,323** | **3,255** | **(68)** | **3,323** | **3,321** | **(2** |

# Financial Performance Report for the 12 months ending 31 March 2025

**Table A (Contd.)**

| | April - March | | | April - March | | |
|---|---|---|---|---|---|---|
| | Actual £'000 | Budget £'000 | Variance £'000 | Actual £'000 | Forecast £'000 | Variance £'000 |
| IT (BAU) | 984 | 1,268 | 285 | 984 | 1,086 | 103 |
| Depreciation | 161 | 172 | 11 | 161 | 165 | 4 |
| Disposal of Fixed Assets | 56 | 0 | (56) | 56 | 0 | (56) |
| **Total Expenditure** | **11,554** | **12,326** | **772** | **11,554** | **11,718** | **163** |
| **Surplus / (Deficit) before project expenditure** | **636** | **15** | **621** | **636** | **445** | **191** |
| **Project Expenditure** | | | | | | |
| Education Strategic Review project | 82 | 62 | (20) | 82 | 81 | (0) |
| Change | 397 | 399 | 2 | 397 | 413 | 16 |
| Complex Legal Cases | 87 | 232 | 145 | 87 | 169 | 82 |
| Testing of Sight | 50 | 0 | (50) | 50 | 50 | (0) |
| PSB Framework | 133 | 0 | (133) | 133 | 150 | 17 |
| Employment Status | 8 | 1 | (7) | 8 | 16 | 8 |
| Unfair Outcomes EDI Research | 0 | 0 | 0 | 0 | 20 | 20 |
| Potential Projects | 0 | 0 | 0 | 0 | 0 | 0 |
| Project Depreciation & Amortisation | 118 | 136 | 17 | 118 | 145 | 26 |
| Case Management Project | 93 | 107 | 13 | 93 | 89 | (4) |
| Future Office Accommodation | 214 | 45 | (169) | 214 | 785 | 571 |
| **Total Project expenditure** | **1,181** | **981** | **(200)** | **1,181** | **1,919** | **738** |
| **Surplus / (Deficit) after project expenditure** | **(545)** | **(966)** | **421** | **(545)** | **(1,474)** | **929** |
| Investment gains | 179 | 221 | (42) | 179 | 540 | (362) |
| **Surplus / Deficit** | **(366)** | **(745)** | **379** | **(366)** | **(933)** | **567** |

# Financial Performance Report for the 12 months ending 31 March 2025

## Table B

### Income and Expenditure Accounts Including Project Expenditure

| | April - March | | | April - March | | |
|---|---|---|---|---|---|---|
| | Actual £'000 | Budget £'000 | Variance £'000 | Actual £'000 | Forecast £'000 | Variance £'000 |
| **Income** | | | | | | |
| Registration | 11,672 | 11,980 | (308) | 11,672 | 11,654 | 18 |
| Dividend Income | 238 | 265 | (27) | 238 | 250 | (12) |
| Bank & Deposit Interest | 252 | 86 | 166 | 252 | 244 | 8 |
| Other Income | 29 | 10 | 19 | 29 | 14 | 14 |
| **Total Income** | **12,191** | **12,341** | **(151)** | **12,191** | **12,163** | **28** |
| **Expenditure** | | | | | | |
| Staff Salaries Costs | 6,611 | 6,760 | 149 | 6,611 | 6,633 | 22 |
| Other Staff Costs | 519 | 311 | (208) | 519 | 545 | 26 |
| Staff Benefits | 157 | 164 | 7 | 157 | 163 | 6 |
| Members Costs | 1,120 | 1,405 | 285 | 1,120 | 1,177 | 57 |
| Professional Fees | 781 | 697 | (84) | 781 | 894 | 113 |
| Finance Costs | 127 | 119 | (8) | 127 | 128 | 1 |
| Case Progression | 984 | 1,154 | 170 | 984 | 1,066 | 82 |
| Hearings | 241 | 293 | 53 | 241 | 247 | 7 |
| CPD & Standards | 131 | 79 | (52) | 131 | 120 | (11) |
| Communication | 55 | 74 | 18 | 55 | 58 | 3 |
| Registration | 14 | 13 | (1) | 14 | 12 | (2) |
| IT Costs | 617 | 784 | 167 | 617 | 729 | 112 |
| Office Services | 1,035 | 1,056 | 22 | 1,035 | 1,523 | 488 |
| Other Costs | 8 | 91 | 83 | 8 | 31 | 24 |
| Disposal of Fixed Assets | 56 | 0 | (56) | 56 | 0 | (56) |
| Depreciation & Amortisation | 279 | 308 | 29 | 279 | 309 | 30 |
| **Total Expenditure** | **12,735** | **13,309** | **574** | **12,735** | **13,636** | **902** |
| **Surplus / Deficit** | **(544)** | **(966)** | **424** | **(544)** | **(1,474)** | **930** |
| Unrealised Investment gains | 179 | 221 | (42) | 179 | 540 | (362) |
| **Surplus / (Deficit)** | **(366)** | **(745)** | **381** | **(366)** | **(933)** | **568** |
| **Staff cost to total expenditure ratio** | 57% | 54% | | 57% | 54% | |

# Financial Performance Report for the 12 months ending 31 March 2025

## Balance Sheet as at 31 March 2025

| | 2024-25 31 March 2025 £'000 | 2023-24 31-Mar-24 £'000 | Variance £'000 |
|---|---|---|---|
| **Fixed Assets** | | | |
| Refurbishment | 0 | 105 | (105) |
| Furniture & Equipment | 2 | 57 | (55) |
| IT hardware | 145 | 131 | 14 |
| IT software | 182 | 18 | 164 |
| Capital Work in Progress | 55 | 33 | 22 |
| **Total Tangible Fixed Assets** | **384** | **344** | **40** |
| Investment | 9,398 | 9,266 | 132 |
| **Total Fixed Assets** | **9,782** | **9,610** | **172** |
| | | | |
| **Current Assets** | | | |
| Debtors, Prepayments & Other Receivable | 568 | 675 | (107) |
| Short term deposits | 8,950 | 7,450 | 1,500 |
| Cash and monies at Bank | 1,558 | 3,131 | (1,573) |
| **Total Current assets** | **11,075** | **11,256** | **(181)** |
| | | | |
| **Current Liabilities** | | | |
| Creditors & Accruals | 1,303 | 1,200 | 103 |
| Income received in advance | 11,184 | 10,931 | 253 |
| **Total Current Liabilities** | **12,487** | **12,131** | **356** |
| | | | |
| **Current Assets less Current Liabilities** | **(1,412)** | **(875)** | **(537)** |
| | | | |
| **Total Assets less Current Liabilities** | **8,370** | **8,735** | **(365)** |
| | | | |
| Long Term Liabilities | 0 | 0 | 0 |
| | | | |
| **Total Assets less Total Liabilities** | **8,370** | **8,735** | **(365)** |
| | | | |
| **Reserves** | | | |
| Legal Costs Reserve | 700 | 700 | (0) |
| Strategic Reserve | 2,596 | 2,596 | (0) |
| Infrastructure / dilapidations | 1,250 | 1,250 | 0 |
| Income & Expenditure | 3,824 | 4,189 | (365) |
| **Total** | **8,370** | **8,735** | **(365)** |

# Business performance quarterly dashboard

On track
At risk
Off track

For the year 1 April 2024 – 31 March 2025

| Q4 report (31 January 2025 – 31 March 2025) | | Q1 | Q2 | Q3 | Q4 | Measure | *Q4 (23/24)* |
|---|---|---|---|---|---|---|---|
| **Finance** | | | | | | | |
| 1.1 | BAU budget; operate within budget | +7.3% | +3.3% | +8.0% | +7.7% | Tolerance is ±10% | +4.5% |
| 1.2 | Reserves; operate within reserves policy | 0.0% | 0.0% | 0.0% | 0.0% | Tolerance is ±10% | 0.0% |
| 1.3 | Change team; operate within budget | +0.2% | +0.5% | +7.0% | +0.4% | Tolerance is ±10% | -0.5% |
| **People** | | | | | | | |
| 2.1 | Planned L&D events realised | 100% | 100% | 100% | 100% | Target is ≥90% | 100% |
| 2.2 | Staff turnover (excluding end of FTCs) | 13.8% | 17.3% | 16.8% | 16.3% | Target is ≤17% | 11.4% |
| 2.3 | Staff engagement/ pulse survey: % response | 71.5%* | 73.0% | ** | 51% | N/A | ** |
| | Staff engagement/pulse survey: engagement score | 3.08 | 9.41 | ** | 21.67 | Employee Net Promoter Score (eNPS) – Target is 50<br>Good=0, Excellent=50, Outstanding=70 (rare) | ** |
| **Customer** | | | | | | | |
| 3.1 | FOI requests resolved | 94.7% | 100% | 100% | 100% | Target is 100% in ≤20 working days | 100% |
| 3.2 | Corporate complaints (stage 2 in 2024/stage 1 or stage 2 in 2025****): received | 2 | 1 | 0 | 2 | N/A | 5 |
| | Corporate complaints (stage 2): resolved | 100% | 100% | N/A | 100% | Target is ≥90% in ≤20 working days | 100% |
| **Regulatory functions** | | | | | | | |
| 4.1 | Registration applications completed | 99% | 99% | 99% | 98% | Target is ≥95% forms completed | 98% |
| 4.2 | Registration accuracy | 99% | 99% | 99% | 99% | Target is ≥95% | 98% |
| 4.3 | Approved qualifications meeting new ETR | 43% | 84% | 84% | 84% | Target is 100% by Sep 2025 *ex. CoO* | 32% |
| 4.4 | Quality of GOC approved providers' CPD | 96% | 96% | 97% | 96% | Target is ≥85% good or excellent | 96% |
| 4.5 | Customers receiving an FtP update | 82% | 80% | 81% | 82% | Target is ≥90% every 12 weeks | 86% |
| 4.6 | FtP cases resolved (rolling median) | 59% | 65% | 60% | 58% | Target is ≥60% within 78 weeks | 52% |
| .4.7 | Hearings concluded first time | 92% | 93% | 96% | 93% | Target is ≥90% | 88% |
| 4.8 | Hearings dates utilised | 93% | 79% | 81% | 92% | Target is ≥90% | 78% |
| 4.9 | New investigations at representations | 74% | 59% | 53% | 46% | Target is 80% within 40 weeks | 69% |

* The pulse survey ran until July
** No pulse survey ran
*** Policy changed in December 2024, and stage 1 is now considered the first formal stage for appeal.

| Q4 report (31 January 2025 – 31 March 2025) | | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|
| **Regulatory functions** | | | | | |
| | **Registrant engagement with CPD** | | | | |
| 4.10 | Number of fully-qualified registrants | Previous cycle | Previous cycle | Previous cycle | 25,531 |
| 4.11 | Number yet to log a PDP – OO/IP | Previous cycle | Previous cycle | Previous cycle | 13,698 |
| 4.12 | Number yet to log a PDP – DO/CLO | Previous cycle | Previous cycle | Previous cycle | 4,774 |
| 4.13 | Number of registrants yet to complete their SOP | Previous cycle | Previous cycle | Previous cycle | 15,547 |
| 4.14 | Number yet to access the platform at all | Previous cycle | Previous cycle | Previous cycle | 11,150 |
| 4.15 | General total points on or above target – OO/IP | Previous cycle | Previous cycle | Previous cycle | 21% |
| 4.16 | General total points on or above target – DO/CLO | Previous cycle | Previous cycle | Previous cycle | 21% |
| 4.17 | Specialist total points on or above target – IP | Previous cycle | Previous cycle | Previous cycle | 18% |
| 4.18 | Specialist total points on or above target – CLO | Previous cycle | Previous cycle | Previous cycle | 19% |
| | **Registrant progress against final CPD requirements – % of registrants who have achieved their:** | | | | |
| 4.19 | entire general points requirement | Previous cycle | Previous cycle | Previous cycle | 0% |
| 4.20 | entire specialist points requirement | Previous cycle | Previous cycle | Previous cycle | 0% |
| 4.21 | provider-led requirement | Previous cycle | Previous cycle | Previous cycle | 2% |
| 4.22 | interactive points requirement | Previous cycle | Previous cycle | Previous cycle | 0% |
| 4.23 | core domains requirement | Previous cycle | Previous cycle | Previous cycle | 1% |
| 4.24 | peer review requirement | Previous cycle | Previous cycle | Previous cycle | 3% |
| 4.25 | overall cycle requirements | Previous cycle | Previous cycle | Previous cycle | 0% |

| KPI | Current RAG status (why it is amber/red; when/how we will get it to green) | Budget implications | Risks |
|---|---|---|---|
| Customers receiving an FtP update – **82%**<br><br>Target is ≥90% every 12 weeks | We are being proactive in our reporting to ensure we remain on top of updates, using data to drive this approach. In recent months, we have seen consistent performance nearer the target. In addition to this improvement, we have received positive feedback from stakeholders noting a marked enhancement in the quality of updates provided. | N/A | This will have an impact on customer satisfaction. |
| FtP cases resolved (rolling median) – **58%**<br><br>Target is ≥60% within 78 weeks | We remain focused on our strategy to progress older cases, which is expected to have a positive impact over the next two quarters. We have designated time each month, with oversight from the Head of Investigations, to actively manage our legacy caseload. | N/A | This will have an impact on end-to-end timeliness. |
| New investigations at representations – **46%**<br><br>Target is ≥80% within 40 weeks | As this is a rolling KPI, improvements take time to become evident. We remain focused on our strategy to progress older cases, which is expected to have a positive impact over the next two quarters. | N/A | This will have an impact on end-to-end timeliness. |

C28(25)

**GOC Internal Business Plan – 2024/25**
Exceptions Report – Q4 update

All CRITICAL and ESSENTIAL Q4 activities are ON TRACK or COMPLETE for the following business areas: **Hearings, Legal, Comms, CPD, Education, Legislative Reform, Policy & Standards, Facilities, Finance, People & Culture, Registration,** and **IT**

The following slides describe, with commentary, CRITICAL and ESSENTIAL Q1-Q4 activities that are either OFF TRACK (amber) or DEADLINE MISSED (red)

## Case Progression

C28(25)

| Activity | BAU/Project | Timing | Priority | Success Measures | RAG | Comments |
|---|---|---|---|---|---|---|
| Timeliness in fitness to practise (Triage, Investigations) | BAU | Q4 | • Critical | Improved timeliness in FTP:<br><br>≥60% of all concerns will have been resolved (by case examiner or FtPC) within 78 weeks of receipt<br><br>≥80% of triage decisions will be made within six weeks<br><br>≥50% of new investigations will be at representation stage within 30 weeks<br><br>≥85% of new investigations will be at representation stage within 40 weeks<br><br>≥40% reduction in cases open for longer than three years<br><br>≥20% reduction in cases open for longer than two years | | **Why amber/red:** The KPI remains amber as we continue to make steady progress across several key areas. Notably, we've seen improvements in both our triage and end to end KPIs, as well as some reduction in the number of older cases, which reflects the effectiveness of our recent efforts. However, there is still work to be done in the middle stages of the process.<br><br>**How we will get back to green:** Manager led interventions to drive accountability and momentum, and the implementation of more robust escalation processes for cases that are not progressing as expected (from April '25). These measures are designed to improve consistency and accelerate case progression in the middle stages of the process. |

## People & Culture

C28(25)

| Activity | BAU/ Project | Timing | Priority | Success Measures | RAG | Comments |
|---|---|---|---|---|---|---|
| Review of HR Policies to ensure legal compliance and fit for a world class regulator | Continuous improvement project | Q4 | ● Critical | • Complete and launch revised policies at (2) by 31 March 2025 | | **Why amber/red**:<br>• Legacy action<br>• Capacity of People and Culture, alongside 2 significant projects and BAU<br>• Head of P&C had to balance need for new policy for legislative compliance v volume of outdated policies<br><br>**How we will get back to green**: Worknest has completed the legislative review of all HR policies. Head of P&C is developing a plan for review and implementation of the changes and introduction of two new policies. |
| Implementing and assessing new ways of working | BAU | Q1-Q4 | ● Essential | • Review our agile working guidelines - 31 March 2025<br>• Review our guidelines for working abroad - 31 March 2025<br>• Modernise and updating our flexible working policy - TBC 2024<br>• Create a culture of self service to support efficient use of resources - 30 July 2024<br>• Review our premises and working environment - 31 December 2024 | | **Why amber/red**:<br>• Capacity of People and Culture, alongside 2 significant projects and BAU<br>• Head of P&C had to balance need for new policy for legislative compliance v volume of outdated policies<br>• Future Office Accommodation project delayed<br><br>**How we will get back to green**: Worknest has completed the legislative review of all HR policies. Head of P&C is developing a plan for review and implementation of the changes and introduction of two new policies. |

## Change Management Office

C28(25)

| Activity | BAU/Project | Timing | Priority | Success Measures | RAG | Comments |
|---|---|---|---|---|---|---|
| 2023/24 Digital Portfolio:<br><br>- Case Management System (CMS)<br>- MyGOC platform (pending outcome of ITT)<br>- HR & Payroll system<br>- Telephony | Strategic Project | Q1-Q4 | ● Essential | Digital transformation projects delivered to time, cost and quality measures agreed by SCB: | | **Updates and current position:**<br>-CMS Phase 1: went live 01 May<br>-CMS Phase 2: went live mid-April. Now handed over to the business area<br>- MyGOC Discovery phase: completed and 1st sprint of development in testing. Project go live est Nov/Dec 2025<br>- HR Payroll: work underway to bridge variances in scope between HR and Payroll teams. In parallel, assessing supplier solutions (CiPHR, Sage & Microsoft) against GOC needs. Handed over to business area<br>- Telephony: new telephone system functional with continuous improvements planned over the next few months. Complete<br><br>**Why amber/red**: 2023-24 Initial procurement process did not identify a preferred supplier. Alternate procurement route followed which concluded in September 2024.<br><br>**How will we get back to green?**<br>MyGOC is now in development phase with an estimated Go Live date. Now being managed as part of new People and Improvement directorate. |

## Governance

C28(25)

| Activity | BAU/Project | Timing | Priority | Success Measures | RAG | Comments |
|---|---|---|---|---|---|---|
| Compliance with GDPR requirements | BAU | Q1-Q4 | ● Critical | All GDPR processes are managed in line with the policies and required timeframes<br><br>- Performance is consistently measured and reported to SIRO; no major data breaches require a report to the ICO<br>- Data destruction register finalised Q2 2024/25<br>- Data Protection Impact Assessment process reviewed Q3 2024/25 | | **Why amber/red**: Referral to ICO for medium risk breach.<br><br>**How we will get back to green**: Head of Registrations will be preparing a lessons learned review report for SMT. |

# DRAFT minutes of the meeting of the Advisory Panel held on Friday 6 June 2025 at 9.15am via MS Teams

**Present:** Lisa Gerson (Registration Committee Chair) (Advisory Panel Chair), Jacqui Adams (Education Committee), Sana Asif (Standards Committee), Kay Bagshaw (Standards Committee), Dr. Helen Court (Education Committee), Raymond Curran Registration Committee, Khalid Dalil (Registration Committee), Gordon Dingwall (Companies Committee), Dean Dunning (Education Committee), Lynn Emslie (Registration Committee), Kathryn Foreman (Registration Committee), Sally Gosling (Education Committee), Gordon Ilett (Companies Committee), Sarah Joyce (Companies Committee), Dimple Kumar (Standards Committee), Ros Levenson (Standards Committee), Wayne Lewis (Companies Committee), Julia Lewis (Standards Committee), Dan McGhee (Companies Committee), Frank Munro (Education Committee), Tim Parkinson (Companies Committee), Dr. Hema Radhakrishnan (Education Committee), Reena Rani (Registration Committee), Alison Sansome (Registration Committee), Amit Sharma (Companies Committee), Poonam Sharma (Companies Committee), William Stockdale (Standards Committee), Dr. Ahalya Subramanian (Education Committee), Dr. Alica Thompson (Education Committee), Nilla Varsani (Standards Committee), Dr. Anne Wright CBE (Council Chair) and Cathy Yelf (Companies Committee).

**Apologies:** Geraldine Birks (Registration Committee), Imran Hakim (Companies Committee), Haseena Lockhat (Standards Committee) and Chloe Robson (Standards Committee).

**GOC Attendees:** Carole Auchterlonie (Director of Regulatory Operations), Steve Brooker (Director of Regulatory Strategy), Nadia Denton (Governance Officer) (*minutes)*, Marie Bunby (Policy Manager), Kiran Gill (Chief Legal Officer), Andrew Mackay-Sim (Head of Governance), Leonie Milliner (Chief Executive and Registrar), Charlotte Urwin (Acting Director of Corporate Services).

| | **Welcome and Apologies** |
|---|---|
| 1. | The Chair welcomed everyone to the meeting. The advisory Panel noted that:<br>• the new members included Raymond Curran, Ros Levenson, Poonam Sharma, Cathy Yelf; and<br>• apologies had been received from Geraldine Birks, Imran Hakim, Haseena Lockhat and Chloe Robson. |
| | |
| | **Declaration of Interests and confidentiality AP00(25)** |
| 2. | The Panel noted the register of interests and that the following members had the following changes to their interests: |

| | |
|---|---|
| | • Kathryn Foreman was now the deputy chair of the GPhC Assurance and Appointments Committee; and<br>• Dan McGhee was now a Body Corporate Director of Abbeyfield V.E. Ltd. |
| | |
| | **Minutes of the meeting held on 21 February 2025 AP04(25)** |
| 3. | The minutes were approved as an accurate record of the meeting subject to correction the spelling of Alicia Thompson's name. |
| | |
| | **Actions point updates AP05(25)** |
| 4. | The actions were noted. |
| | |
| | **Matters Arising** |
| 5. | There were no matters arising. |
| | |
| | **Business regulation consultation response and research AP06(25)** |
| 6. | The item was introduced by the Director of Regulatory Strategy and the Policy Manager. The Advisory Panel noted that:<br><br>• the executive had received a letter from the government indicating that they would proceed with legislative reform within the current parliamentary period;<br>• significant legislative reform in relation to the GOC was still several years away; and<br>• the Chief Executive and Registrar had reached out to specific government officials to request a fast track of aspects of legislation reform. |
| | |
| 7. | In discussion the Advisory Panel made the following suggestions about the consultation response and research:<br><br><u>All businesses except sole traders should have a head of optical practice</u><br>• all businesses should have a head of optical practice, even sole traders, who will be the head of optical practice by the nature of their role;<br>• some lay sole traders were also business owners and so would need to have clinical oversight;<br>• lay business owners should have it made clear to them that from a public safety perspective they needed to have a person responsible for clinical practice working within the business;<br>• the role of the head of optical practice should be made visible not just within the sector but more broadly; and<br>• the executive should consider the terminology, perhaps adopting the term 'responsible clinician' instead of 'head of optical practice' which would be more relatable to registrants. |
| | |
| 8. | <u>The head of optical practice does not need to be responsible for training placement arrangements:</u><br><br>• the head of optical practice should be responsible for ensuring that all staff were adequately trained to deliver a service; and |

| | |
|---|---|
| | • the head of optical practice should have oversight of training even if not directly involved to ensure that trainees were not exposing the public to risk. |
| | |
| 9. | <u>Removing the £50,000 financial penalty and replacing this with a power to impose an uncapped fine on a GOC registered business</u><br><br>• due consideration should be taken for the penalty application based on the size of the business and the impact that the penalty would have in changing behaviour;<br>• the brand damage and reputational loss from a fine should also be taken into consideration;<br>• there should not be inequity in terms of how the fines were applied across different businesses; and<br>• some members supported an uncapped penalty and others thought that penalties should be capped but at a higher amount than currently. |
| | |
| 10. | <u>Having a power to visit a business in the course of a fitness to practise investigation where a concern has been raised</u><br><br>• the power to visit a business in the course of a fitness to practise investigation may not be required at present, but would be a useful regulatory tool to 'future-proof' proposal;<br>• the possibility of an unannounced visit in the course of a fitness to practise investigation could have a positive impact;<br>• visits were a governance tool that the GOC could deploy if required as part of an investigation, but should not be used as 'fishing expeditions';<br>• the power to visit may encourage compliance in terms of standards;<br>• not having this power would mean that the GOC would have no power to visit in the course of a fitness to practise investigation;<br>• business non-compliance was low risk compared to within a hospital environment;<br>• there was nothing in the consultation data to suggest that registrants were concerned about the power to visit;<br>if the proposal was extended to regular or ah-hoc inspections, this could create a resource issue for the GOC and duplicate current NHS commissioner visits; and<br>• the GOC could consider encouraging businesses to display a certificate indicating that they are a GOC registered business – this could be a service for which the GOC could charge and earn extra income. |
| | |
| 11. | <u>Require mandatory participation in the OCCS for all GOC registered businesses but *not* to seek legally binding decisions</u><br><br>• the use of the OCCS as a mediation service is very beneficial;<br>• mandatory participation by businesses in the OCCS may give reassurance to the public;<br>• there would be financial implications for businesses as well as the OCCS;<br>• smaller businesses might be disproportionately affected; and<br>• businesses could be encouraged to promote the fact that they are signed up to a GOC supported redress scheme. |
| | |

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| 12. | Advisory Panel **considered** the draft GOC response to the business regulation consultation prior to decision at Council. |
| | |
| | **Thematic review paper AP07(25)** |
| 13. | The item was introduced by the Director of Regulatory Strategy. The Advisory Panel suggested:<br><br>• it would be useful to gather wider data first before honing in on a specific area;<br>• sample size of any commissioned research would be important, particularly as smaller sample sizes were more difficult to base evidence on;<br>• there should be a more nuanced consideration of the needs of the over 55s;<br>• the executive should consider the elements that need to be looked at to ensure that the public are safe and protected;<br>• very young children and children with learning difficulties and/or special needs were a target audience that needed to be considered; and<br>• the GOC should be explicit about what is safe practice for the patient versus judgements about how a practice may be run. |
| | |
| 14. | The Advisory Panel:<br><br>• **reviewed** the existing evidence;<br>• **identified** gaps in evidence;<br>• **made suggestions** about how best to fill those gaps; and<br>• **advised** on proposed scope and methodology. |
| | |
| | **Date of Next meeting** |
| 15. | The date of the next meeting was noted as **13 November 2025**. |
| | |
| | **Any Other Business** |
| 16. | There was none. |
| | |
| | **The meeting closed at 11:18am.** |

General Optical Council

# GENERAL OPTICAL COUNCIL

## DRAFT Minutes of the meeting of the Companies Committee held on Friday 6 June 2025 at 11:20 hours via Microsoft Teams.

Present: Tim Parkinson (Chair), Gordon Dingwall, Gordon Ilett, Sarah Elizabeth Joyce, Wayne Lewis, Dan McGhee, Amit Sharma, Poonam Sharma and Cathy Yelf

Apologies: Imran Hakim,

GOC Attendees: Carole Auchterlonie (Director of Regulatory Operations), Marie Bunby (Policy Manager), Kiran Gill (Chief Legal Officer), Andy Mackay-Sim (Chief of Staff) (Minutes) and Dr Anne Wright CBE (Chair of Council).

| | |
|---|---|
| | **Welcome and apologies** |
| 1. | The Chair welcomed those in attendance, including new Council members Poonam Sharma and Cathy Yelf. Apologies were received from Imran Hakim. |
| | |
| | **Minutes from meeting held on Friday 18 October 2024 COM01(25)** |
| 2. | The minutes from the breakout session held on 18 October 2024 were approved as an accurate record. |
| | |
| | **Council discussions on topics relevant to optical businesses COM02(25)** |
| 3. | The Chair provided a verbal summary of the report and recent Council discussions on matters relevant to optical businesses. There were no additional comments or questions.<br><br>The Committee **noted** the paper. |
| | |
| | **Business registrant survey COM03(25)** |
| 4. | The Policy Manager introduced the item. It was noted the response rate was lower than the GOC had hoped. Discussions were ongoing about whether to repeat the exercise for a third year or direct resources to other research activity regarding business registrants. The Committee was supportive of not repeating the survey for a third year. |
| | |
| 5. | The Committee discussed the results related to the use of locums. It suggested that there was a significant challenge for business registrants in ensuring that locums were appropriately integrated into the organisation's practice, and that patient safety risks were kept at a minimum. It was suggested that this could be an area for further research and exploration by the GOC. |
| | |
| 6. | The Committee discussed the challenge of communicating the GOC's remit to business registrants, and how this could have impacted the response regarding the GOC providing benefit to the registrant. It was noted that the regulator provided a benefit in maintaining high standards across the professions. |
| | |

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|---|---|
| 7. | The Committee urged caution in how the GOC interpreted the response to the question about innovation. Reference was made back to the updated GOC standards for registrants, which encouraged responsible innovation.<br><br>The Committee **noted** the paper. |
| | |
| | **Business regulation consultation response** |
| 8. | The Committee reflected on the feedback gathered during the Advisory Panel meeting. Concerns remained that the head of optical practice role should have sufficient authority to influence and direct board level decision-making within large organisations, and that the title of the role should better reflect the seniority required within the business (suggestions included responsible or superintendent officer). |
| | |
| 9. | The Committee discussed the timescale for regulatory reform, and whether there was scope to influence government policy and implement changes before the next parliament. It was noted that through its consultation, the GOC was building the evidence base to make the case for business regulation. |
| | |
| | **Any Other Business** |
| 10. | The next meeting of the Committee would take place on 13 November 2025. |
| | |
| | **Meeting Close** |
| 11. | The meeting closed at 12.37pm |

General Optical Council

**DRAFT minutes of the Education Committee held on Friday 6 June 2025 at 11.30am via MS Teams**

**Present:** Frank Munro (Chair), Jacqui Adams, Dr. Helen Court, Dean Dunning Sally Gosling, Dr Hema Radhakrishnan and Dr. Ahalya Subramanian and Dr. Alicia Thompson.

**GOC Attendees:** Nadia Denton (Governance Officer – *Minutes*), Kate Furniss (Operations Manager - Education and CPD) and Leonie Milliner (Chief Executive and Registrar).

| | |
|---|---|
| | **Welcome and Apologies** |
| 1. | The Chair opened the meeting and welcomed everyone. It was noted that the Chief Executive and Registrar would be present as an observer. |
| | |
| | **Declarations of interests and confidentiality** |
| 2. | There were no new declarations of interest. |
| | |
| 3. | **Minutes from break out session held on 21 February 2025 ED03(25)** |
| | The minutes of the last meeting were approved as a true record subject to a correction to add Dr. Alicia Thompson's appellation. |
| | |
| | **Evaluation of CPD cycle ED04(25)** |
| 4. | The Operations Manager (Education and CPD) introduced the item. The Education Committee noted that the uptake of self-directed learning by registrants was only 4% and suggested that:<br><br>• some registrants were unclear about which aspects of self-directed CPD they should record on MyGOC, and discussed how registrants could more easily evidence self-directed CPD activity (such as reading research articles, watching an educational webinar or information gleaned from a WhatsApp group) to meet the requirements of the scheme;<br>• more needed to be done to support the registrants in undertaking their Professional Development Plans (PDP) at the beginning of the CPD cycle, or there was a risk the scheme could be seen as more focused on points rather than learning outcomes;<br>• it was noted that the executive planned to increase communication with new registrants joining the register in the final three months of the CPD cycle, so that they understood the scheme's requirements and reduced the risk of being removed from the register for non-compliance;<br>• communication activity could include video vignettes with registrants who had a positive interaction with the CPD process;<br>• the tone of the communication should be along the lines of 'you can do it' to make it an exciting prospect for registrants; and<br>• the GOC could consider hosting a session with a CPD assessor allowing them to give examples of the types of CPD they have accepted and rejected, with an explanation of the rationale. |

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| | |
| 5. | The Education Committee noted that:<br><br>• the executive would check to see if there were any barriers in place in terms of registrants uploading information onto the CPD portal; and<br>• future regulatory reform could allow for a much broader, mature approach to registrant professional development. |
| | |
| 6. | The Education Committee **noted** and **considered** the report. |
| | |
| | **Any Other Business** |
| 7. | There was none. |
| | |
| | **The meeting closed at 12.10pm** |

**GENERAL OPTICAL COUNCIL**
**DRAFT Minutes of the Registration Committee Meeting held on Friday 6 June 2025, 11.20am – 12:04pm via MS Teams**

Present: Lisa Gerson (Chair), Reena Rani Anand, Khalid Dalil, Lynn Emslie, Kathryn Foreman, Ali Sansome, Raymond Curran

GOC Attendees: Vineeta Desai (Minutes); Daniel Hall (Registration Manager) and Charlotte Urwin (Acting Director of Corporate Services)

Apologies: Geraldine Birks, Nadia Patel (Head of Registration).

| | |
|---|---|
| | **Welcome and Apologies** |
| 1. | The Chair opened the meeting and welcomed all attendees. The Committee noted the following:<br>• Raymond Curran was welcomed as a new Council member.<br>• This may be the last meeting for Lynn Emslie and Ali Sansome – the committee expressed its sincere thanks for their valuable contributions over their two terms of office.<br>• Apologies had been received from Geraldine Birks and Nadia Patel.<br>• The Committee acknowledged it was Eid today and extended warm wishes to all those celebrating. |
| | |
| | **Minutes from break out session held on 21 February 2025** |
| 2. | It was noted that there was a typo in Khalid's name in the minutes of the last meeting, which will be corrected. The Committee otherwise approved the minutes as an accurate record of the last meeting. |
| | |
| | **Renewal Report** |
| 3. | The Acting Director of Corporate Strategy introduced the paper and highlighted several key points:<br>• Renewal rates were higher than at the end of the previous CPD cycle, which is a positive development.<br>• The team continued to seek improvements, recognising renewal as a key point of engagement with registrants<br>• Workforce data showed higher withdrawal rates among female registrants aged 25–39, and amongst dispensing opticians. Recent registrant surveys had also highlighted that dispensing opticians were more likely to say that they were considering leaving the profession. |
| | |
| 4. | The Committee was provided with an overview of the renewal process. It queried what steps were in place to mitigate people not receiving email reminders and was informed that the Registration team followed up with phone calls where needed. |
| | |

| | |
|---|---|
| | **Body Corporate 92a audit** |
| 5. | The Registration Manager introduced the item and provided an overview of the compliance process for body corporates. The Committee noted that here are approximately 5500 optical businesses in the UK, of which only 2,500–2,800 are registered. It was informed that there were a number of reasons why businesses were not registered, some might choose not to be registered whilst others were unable to because of their structure. |
| | |
| | **Any Other Business** |
| 6. | The Committee thanked the executive for the papers and the work they described. The Chair noted that this would be the final meeting for Lynn Emslie and Ali Sansome and extended warm thanks for their valuable contributions to the Committee over the past two years. |
| | |
| | **Meeting Close** |
| 7. | The meeting concluded at 12:04pm |
| | |

General Optical Council

**Minutes of the meeting of the Standards Committee held on Friday 6 June 2025 at 11:20am via MS Teams**

**Present:** William Stockdale (chair), Sana Asif, Kay Bagshaw, Dimple Kumar, Nilla Varsani, Ros Levenson.

**Apologies:** Chloe Robson.

**GOC Attendees:** Steve Brooker (Director of Regulatory Strategy), Andrea Moss (Operations Manager Investigations - minute taker).

| | |
|---|---|
| 1. | **Welcome and Apologies** |
| | The Chair opened the meeting and welcomed everyone, including Ros Levenson who was attending her first meeting.<br><br>The Chair invited attendees to introduce themselves. |
| | |
| 2. | **Minutes from break out session held on Friday 21 February 2025** |
| | Minutes from meeting held on 21 February 2025 were approved as a true record. |
| | |
| 3. | **Draft guidance** |
| | **Draft guidance on maintaining sexual boundaries:**<br>• The Committee revisited its discussion in February on whether registrants should be able to treat their partners. Some members felt this section of the guidance could be clearer, but others felt it covered what it needed to. Overall, the Committee considered that this issue would attract a range of views during consultation.<br>• The Committee discussed how this would work in remote areas where choice of optometrist was limited. The executive clarified that guidance works on a comply or explain basis and registrants can deviate where reasonable and justified, however the guidance needed to reflect the most common situations.<br>• The different risk profile between dispensing opticians and optometrists was discussed, since the need for objectivity when checking eye health was higher than fitting eyewear. The Committee also discussed the meaning of the word 'treatment' in this context and agreed that it was unnecessary to define this term.<br>• The wording on duties on businesses relating to sexual harassment was discussed and it was explained that it mirrored the wording of legislation and as such, the guidance should not deviate from the language used in law. |

| | |
|---|---|
| | **Draft Guidance on care of patients in vulnerable circumstances:**<br><br>• The Committee welcomed the guidance since it can be difficult for registrants to know if a patient is vulnerable and to deal with sensitive conversations.<br>• Public concerns about the cost of eyewear, the sight test and pressure selling revealed by GOC's research were discussed. A Healthwatch England report had shown one of the barriers to access was people not understanding they could get financial support. The Committee also considered a lack of price transparency and whether businesses were alerting patients to eligibility for financial support.<br>• The Committee discussed if registrants were sufficiently aware of their duty to make reasonable adjustments and whether the guidance should encourage businesses to alert prospective patients to accessibility considerations both online and in store windows, for example if it was necessary to use stairs. |
| | |
| | **Any Other Business** |
| 4. | The Director of Regulatory Strategy raised the role of optometrists notifying the DVLA without a patient's consent when they are not fit to drive. This was a live issue in context of the Senior Coroner for Lancashire's Prevention of Future Deaths report.<br><br>The panel agreed the current regime was inadequate, including the 20m vision check, but were concerned about introducing mandatory reporting without mandatory sight tests due to the risk of patients choosing not to get tested due to fear of having their driver's licence withdrawn, whereas they would meet the standard with a prescription. |
| | |
| 5. | **The meeting closed at 12:36** |

**COUNCIL**

**Report from the Chair of Council**

**Meeting:** 25 June 2025 **Status:** For noting

**Lead responsibility & paper author:** Dr Anne Wright (Chair of Council)

## Introduction

1. This report covers my principal activities since the last Public Council meeting on 19 March 2025.

2. On 1 April 2025, we were delighted to welcome four new Council Members: lay members Ros Levenson and Catherine Yelf, and registrant members Raymond Curran and Poonam Sharma. Raymond Curran is Head of Ophthalmic Services within the Strategic Planning and Performance Group of the Department of Health Northern Ireland. Poonam Sharma is Regional Lead Optometry Adviser NHSE - London region. Ros Levenson has undertaken and published extensive independent research on health and social care issues, and her many lay appointments have included NHS organisations, regulatory bodies, and committees of medical royal colleges. Cathy Yelf is a former CEO at the Macular Society, and a trustee of the charity Action Against Age-related Macular Degeneration.

3. Today we also welcome Siddhant Majithia, an independent prescribing optometrist, chartered manager and ophthalmic director working in community practice and professional education, as our new Council Associate, to their first public Council meeting. Siddhant's appointment commenced on 10 April 2025.

4. I am also delighted to see recognition of the optical sector in his Majesty the King's 2025 Birthday Honours List with two awards. On behalf of Council, I send warmest congratulations to Cathy Yelf, Lay Council Member, who is awarded the MBE (Member of the Order of the British Empire) and Doug Perkins, co-founder of Specsavers on the award of the CBE (Commander of the British Empire).

## Management

5. I have held weekly catch-up meetings with Leonie Milliner, our Chief Executive and Registrar (CE&R) and our Chief of Staff, including pre-brief meetings when required. On 25 April 2025, I completed with Leonie Milliner, CE&R, her 2024-2025 end-of-year business performance appraisal.

6. I have held quarterly 1:1 meetings with individual SMT members including our new Acting Director of Corporate Services Charlotte Urwin, as well as other meetings on specific priorities and issues. I also joined in the all-staff meeting on 26 March 2025.

## Council and Committees

7. From 24 March 2025, I have held fortnightly meetings with Tim Parkinson, new Senior Council Member (SCM); and my last fortnightly 1:1 meeting with Clare Minchington, (former SCM) was on 31 March 2025 with Tim also in attendance.

8. I have also held catch-ups with Council Members and Associates and participated in induction sessions for incoming Council Members and Council Associate.

9. On 25 March 2025, I participated in the Council Knowledge Transfer session organised by our Governance team with Council and the relevant staff in attendance. The session was designed to promote continuity of the knowledge base as between retiring and incoming Council members, prior to induction for new members. I am grateful to everyone who participated and those who contributed to this valuable learning and development opportunity.

10. I attended Remuneration Committee meetings on 24 March 2025 and on 29 April 2025; the Audit, Finance and Risk Committee (ARC) meeting on 7 May 2025; Investment Committee meeting on 13 May 2025; Nominations Committee meeting on 20 May 2025 and Advisory Panel meeting on 6 June 2025. I chaired

the Council Catch-up session on 15 April 2025 and held a Council virtual coffee morning session on 5 June 2025.

11. I attended the Council Teach-in Day on 30 April 2025 for Council members organised by our Governance team. This was an opportunity for all Council members, new and established, to learn in more detail about the GOC, including how it delivers its regulatory functions and strategic objectives. Once again, this proved to be a valuable learning opportunity shared by both new and existing members, and I am grateful to everyone from teams across the GOC who contributed to the excellent presentations and discussions.

12. On 3 June 2025 I joined the Finance Chairs group meeting with Council and the relevant staff in attendance.

13. During the period 15 May 2025 - 12 June 2025, I have conducted Council Members' end of year review meetings. Tim Parkinson as Senior Council Member conducted my own end-of-year review meeting on 16 June 2025.

**Stakeholders**

14. 16 April 2025: I joined the national Optometric Professional Advisors' meeting along with our Senior Council Member (SCM) and CE&R, with David O'Sullivan, Chief Optometric Advisor to the Welsh Government, Raymond Curran, Head of Ophthalmic Services, Strategic Planning and Performance Group, at the Department of Health Northern Ireland and Janet Pooley, Chief Optometric Adviser at the Scottish Government, and Daniel Hardiman-McCartney, Clinical Adviser for the College of Optometrists representing England.

15. 6 May 2025: Introductory meeting with Ron Barclay-Smith, Chair of the Nursing and Midwifery Council (NMC).

16. 13 May 2025: Meeting with the New Zealand Optometrists and Dispensing Opticians Board (ODOB) Joint Chair/Deputy Chair (SCM)/CEO introductory meeting along with SCM, Tim Parkinson and CE&R, Leonie Milliner. We met with

Annette Morgan, Optometrist (ODOB Chair), Sophie Woodburn, Optometrist (ODOB Deputy Chair), Suzanne Halpin, CE&R at ODOB.

17. 14 May 2025: Professional Health Regulator Chairs' Roundtable, held by Caroline Corby, Chair of the Professional Standards Authority.

## Council Member meetings with stakeholders

18. On 28 March 2025, William Stockdale, our Council Member represented the GOC at the PSA and Patient and Client Council (PCC) joint event, entitled "Professionals and the Public: In Partnership for Patient Safety".

**PUBLIC**
**C31(25)**

**COUNCIL**

## Chief Executive and Registrar's Report

**Meeting:** 25 June 2025 **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 2025/2026 Business Plan.

## Background

4. The last report to Council was provided for its public meeting on 19 March 2025.

## Analysis

5. To align our internal capabilities with the delivery of our new corporate strategy on 1 April 2025 we launched our new operating model, which consists of four permanent directorates; People and Improvement; Corporate Services; Regulatory Strategy; and Regulatory Operations; alongside the Governance team, which reports directly to me as Chief Executive and Registrar.
6. The new permanent People and Improvement directorate launched on 1 April 2025 and I am delighted to welcome Philipsia Greenway, our former Director of Change, as our new Director of People and Improvement to her first Council meeting in her new role. Philipsia will combine her role as Director of People and Improvement with her role as our Senior Information Risk Owner (SIRO).

7. I am also delighted to announce that Andy Mackay-Sim's role title has changed from Head of Governance to Chief of Staff, to reflect his responsibility for advising the Chair of Council, members and SMT on all governance and compliance matters.

8. I am also very pleased to announce that following a departmental structure review within Regulatory Strategy, Sam Morgan has been appointed as Head of Education and Continuing Professional Development (CPD), with responsibility for both Education and CPD operations and development.

9. Likewise, I am also pleased to announce that after a successful recruitment process, Nadia Habib has been appointed Acting Governance and Compliance Manager for six months from 2 June 2025. Nadia's substantive role as Information Governance Officer has been advertised.

10. Following a competitive internal selection process, Charlotte Urwin was appointed Acting Director of Corporate Services on an interim basis whilst we recruit for a permanent Director of Corporate Services. Charlotte commenced her role on 20 May 2025. The recruitment campaign for the permanent Director of Corporate Services is underway with the interviews on 20 June 2025 and 26 June 2025. I look forward to continuing to work with our directors to deliver the GOC's new corporate strategy over the next five years.

11. Since Council last met, we have welcomed five new members of staff: Emma Pitt, Performance Management Implementation Lead (People and Culture); Bria Mason, Administrator (People and Culture); James Risk, Project Finance Officer (Corporate Services); Joanna Murphy, Equality, Diversity and Inclusion Manager (Governance) and Ania Feranska-Iqbal, Dynamics 365 Support Analyst (Corporate Services).

12. I would like to thank Ivon Sergey (Governance and Compliance Manager), Jem Nash (EDI Manager), Pauline Whitelaw (Policy Manager (Standards)), Kaylee Mitchell (Investigation Officer) and Christopher Antoine (Archiving Assistant), all of whom have left since the last report. We wish them well for the future.

<u>Internal engagement</u>

13. I continue to hold weekly meetings with our Chair of Council, the Chief of Staff and with each member of our Senior Management Team (SMT). In addition, I held regular catch-up meetings with our Head of People and Culture, and other members of the executive as required.

14. I continue to chair our monthly All-Staff Meetings (ASM) organised by our Communications team, with all staff invited. Our Chair of Council attended our

ASM on 26 March 2025. I also chaired SMT fortnightly meetings and joined our Leadership Team (LT) meeting (which has a rotational chair) on 12 May 2025. I also attended our monthly corporate Risk Register meetings chaired by our Acting Director of Corporate Services.

15. During April 2025, I undertook end of year reviews for SMT and the Chief of Staff.

Staff wellbeing and engagement

16. On 20 March 2025, all staff were welcomed to join our happiness hour session, which was a celebration of positivity and connection, organised by our EDI group. The GOC is committed to fostering staff wellbeing and promoting a positive workplace culture. In celebration of the 'International Day of Happiness' (20 March 2025), our Administrative Assistant held a virtual wellbeing initiative aimed at improving mental health, strengthening connections among staff, and promoting awareness of happiness as a driver of productivity and satisfaction.

17. I engaged in the staff running group session, organised by our Registration Manager on 09 April 2025, in support of the Brain Tumour Charity.

18. On 30 May 2025, I participated in our Anti-Racism Group (ARG) Committee meeting, organised by our ARG group with the relevant staff in attendance.

Council and Committee engagement

19. On 19 March 2025, I attended the in-person Fitness to Practise (FtP) Committee Chairs annual training session, held at the HCPC's offices, organised by our Head of Hearings. The event provided an opportunity for the Chairs to meet, share best practice, discuss challenges, and engage in chair-specific training. Several of our Chairs completed their full term in December 2024, and a new cohort began in January 2025. I presented the introductory session. The training day included an overview of the member review process, and a session led by Nick Yeo, Independent Member of Nominations Committee, on the 'Seven Rules for (Public) Life: The Nolan Principles.'

20. On 20 March 2025, I attended the in-person Fitness to Practise (FtP) Committee annual training day, also organised by our Head of Hearings. I presented the introductory session; other sessions were led by members of the executive and by external legal advisors.

21. We held our Council knowledge transfer session on 25 March 2025, organised by the Governance team with Council, newly appointed Council members and the relevant staff in attendance. I participated in two Council catch-up sessions

on 15 April and 22 May 2025. Alan Clamp, Chief Executive from the Professional Standards Authority for Health and Social Care (PSA), joined one of our sessions to discuss the recent PSA consultations on their standards.

22. On 30 April 2025, we held our Council teach-in day for Council members, organised by our Governance team. This was an opportunity for all Council members, new and established, to learn about the GOC, including how it delivers its regulatory functions and strategic objectives. We received positive feedback from Council members about both the knowledge transfer day and teach-in day, and I extend my thanks to everyone, including staff, who led or prepared the various sessions and workshops.

23. I attended our Remuneration Committee meeting on 29 April 2025; Audit, Finance and Risk Committee (ARC) meeting on 7 May 2025; Investment Committee meeting on 13 May 2025; Nominations Committee meeting on 20 May 2025; and our Advisory Panel meeting on 6 June 2025.

24. I hosted an introductory meeting on 2 May 2025 for our newly appointed Council Associate, Siddhant Majithia, followed by a further introductory meeting on 3 June 2025 with Raymond Curran and Cathy Yelf, our new Council Members. In addition, we held our finance Chairs group meeting, later that day, with Council and the relevant staff in attendance.

Office move

25. Since the last meeting we have progressed our move from 10 Old Bailey to One Canada Square. An internal team, which includes the IT department, facilities, the future office accommodation project manager and others worked hard to move us out of 10 Old Bailey in line with our plan. We have closed all the accounts and services with our old landlord and suppliers and the interim move to our interim office on Level 10, One Canada Square was completed successfully. Our interim office is very pleasant and fully operational and is being utilised by staff whilst contractors complete the fitout of our new permanent office on Level 29.

26. Our new office on level 29 of One Canada Square is looking terrific. Since the middle of April, we have held weekly on-site visits at our new permanent office on Level 29, giving us a chance to meet the fitout contractors to discuss the fitout as it progresses. Good progress is being made on the building, electrical and cabling work. The views are smashing, and the fit out is bright, modern, and utilises our corporate branding and values as manifestations and wall art to create a professional and comfortable working environment. After tendering, a new desk booking system was selected and is in final configuration & testing, ready to support our move into our permanent office. The facilities team have

also had their Fire Marshal training with the Canary Wharf group.

27. We expect to move from our interim office accommodation into L29 at the beginning of July and we are planning three staff- orientated launch days focusing on staff familiarisation, health and safety, and getting to know the Canary Wharf estate. A schedule for each of these days is currently under development. In due course, we will schedule an autumn strategy/ training day for Council in the new office, so that Council members can familiarise themselves with our new office environment.

**People and Improvement**

Project Delivery

28. Our temporary Change Directorate closed on 31 March, and the three strategic projects bridging into the new strategy with end dates in 2025 have been transferred into the People & Improvement Directorate (MyGOC; Future office and Performance Behaviour Framework (PBF)).

29. As part of the end of the Fit for the Future program, a closure report was discussed at ARC on 7 May. The report outlines the accomplishments of the directorate, including the Change Management Office (CMO) programme of work during the directorate's 3-year tenure, alongside a reflection on lessons learned.

30. The report also notes the bridging projects (MyGOC, Performance Behaviour Framework and Future Office Accommodation) which are being brought into 2025 /26 and proposed a streamlined governance process to provide continued assurance to ARC. The proposal was designed through discussion with John Cappock (Independent Observer), Mike Galvin (outgoing Council Lead) and SMT. ARC approved the revised governance arrangements at its 7 May meeting.

31. Phase 1 of MyGOC development has completed and the project board has approved progression to Phase 2 whilst Pixl8 continues to work through identified fixes to phase 1 products. There are currently no live key issues.

People and Culture

32. The Performance Behaviours Framework (PBF) has been finalised following consultation with staff, which ended in March. The framework agreed by SMT in June and published on IRIS, along with a 'you said we did'. The Pay and Reward policy has also been updated to support the implementation framework.

33. Pilot groups have been identified across the business to provide additional assurance alongside the training elements over the next few months. The appraisal moderation process is under development, and the aim is to test the proposed process using the pilot groups, alongside training and engagement. This project will have continued oversight through ARC until its completion.

34. Alongside this, end of year performance reviews have been completed for all eligible staff and objectives to support the delivery of 2025/26 business plans are now in place.

35. Following engagement with employees, we have updated and published our Redundancy Policy and published a new Sexual Harassment Policy, along with 'You Said, We Did' communication, on Iris. Employees must complete the first phase of mandatory training by end July 2025, which involves an e-learning module 'Recognising Sexual Harassment'.

36. The March pulse survey results showed an increase in employee Net Promoter Score (eNPS) to 21.67 and a reflection of ‘good’ employee engagement across GOC. In May the Leadership Team discussed its response to employee feedback provided in the free text element of the pulse survey, which asked staff for feedback on what we could do better this year. Several meaningful areas of action are now in progress. These include upskilling/L&D; updating our family friendly and recruitment policies; respecting people's time and managing workload; communication and connection; and fair application of pay and reward processes.

37. Learning and development has remained a key priority. Since the last Council meeting we have delivered time management and freedom to speak up staff training. In addition, 19 of our female employees attended a bespoke ‘Speaking up with Confidence & Impact’ programme delivered by RADA business, in line with our ongoing commitment to inclusion. This workshop was specifically designed to address the unique challenges women can face in the workplace, particularly around self-esteem, self-promotion, visibility and stepping up into leadership roles with confidence. While these challenges are not exclusive to any one group, research highlights that women can face additional barriers in these areas. By offering this workshop, we aimed to provide women working for us with practical tools to navigate these challenges, boost their confidence, and ensure their voices are heard.

38. Several activities took place to support employee wellbeing and raise awareness of key diversity events; Mental Health Awareness Week, Women in the Workforce and Gender Parity, the Brain Tumour Charity Twilight Walk and Happiness Hour – In celebration of the International Day of Happiness.

39. We have reintroduced the People and Culture update into the monthly All Staff Meetings, where a key focus for everyone is the monthly CEO Achievement Awards. In this period, we welcomed EM Partnership who spoke to employees about the GOC benefits package and the one-to-one meeting employees can now have with a benefits adviser to discuss GOC benefits in more detail.

**Corporate Services**

Information Technology (IT)

40. The primary focus for the IT department this quarter has been the office move, covered above.

41. IT completed the rollout of ThreatLocker in Q4, which has locked down our environment, aiming to ensure malicious software cannot be installed. This aims to mitigate the impact of any potentially successful future cyber-attack against the GOC.

Registration

42. The annual renewal for fully qualified and body corporate registrants closed on 31 March. This year's process was more complex due to the conclusion of the CPD cycle. However, the renewal rates remained consistent with expected numbers compared to the previous cycle.

43. We are currently conducting an audit of all body corporate registrants registered under 92(a) of the Opticians Act. As part of this process, directorships are verified with Companies House and any issues identified are raised with the relevant body corporate to resolve within the deadline.

44. Annual renewal for student registrants opened on 30 May with an initial deadline of 15 July with a final deadline of 31 August. Although it is still very early in the process, the numbers of students renewing so far are in line with trends from previous years.

Finance

45. We have now completed the financial year-end, with SMT reviewing the year-end report on 16 May. The year ended with a slightly higher surplus than both budget and forecast. The Financial Performance Report is presented to the meeting as a separate paper.

46. As identified in the budget for 2025-26 discussed at the previous Council

meeting, we anticipate some cash drawdowns from our investments in this year. This will be to cover the costs of the office move and strategic expenditure. Our potential drawdown requirements are subject to ongoing review and we are in regular contact with our investment managers, Brewin Dolphin.

47. We continue to see volatility in the financial markets and are monitoring that impact on our investment portfolio. The Chief Financial Officer met our investment manager on two occasions this quarter to discuss both market volatility and drawdowns. These meetings gave us assurance on our reserve levels, business plans, and cash flow availability for 2025-26.

48. Haysmac, our external auditors have started the external audit for the year-end 2024-25 and we held the completion meeting on the 18 June. The fieldwork comprised sample checking, analysis as well as assurance testing and the outcomes will be presented to ARC in July.

Facilities

49. The main priority for the Facilities team is the office move, covered above. The archive project is now complete.

Regulatory Operations

50. The training days for Fitness to Practise panel chairs and members on 20 and 21 March received excellent feedback. The hearings team has also been supporting the latest recruitment campaign for registrant and lay panel members.

51. The new in-house advocacy team completed a bespoke induction and training programme and the number and type of cases being presented in-house is gradually increasing. Case progression is also benefiting from greater in-house support and case direction at an earlier stage in the process.

52. We have implemented a quality assurance framework across investigations, designed to support both individual development and collective improvement across the team. This has been in development during the year and is now being rolled out.

53. CMS Phase Two successfully went live on 6 April 2025, delivering all planned functionality. This phase introduced new capabilities including finance functionality, integration with MS Teams, enhanced search for knowledge articles, and a series of major improvements to the Phase One build. We will be monitoring user adoption of Phase Two features and gathering feedback to

ensure the system is meeting operational needs.

54. About half the metrics used for management reporting are now validated for use in CMS. Once all the metrics are validated, this will automate what was previously an entirely manual reporting exercise, representing the single largest efficiency gain for Regulatory Operations.

55. The PSA is carrying out an audit of fitness to practise cases as part of this year's performance review and the team have been assisting the PSA with the process.

**Regulatory Strategy**

Driving vision standards

56. Council will have noted media coverage of the tragic deaths caused by drivers who were not fit to drive highlighted by HM Senior Coroner for Lancashire in his Prevention of Future Deaths report. The Secretary of State for Transport responded to the report on 12 June, which includes a commitment to "*work with healthcare professionals and their regulatory bodies to identify and aim to address any concerns and issues that may be preventing them from notifying the DVLA when it is in the public interest to do so*".

57. The Director of Regulatory Strategy discussed the issues with sector bodies at the Optical Sector Policy Forum and the policy team engaged with officials preparing the government's response to the report. Standards Committee had an initial discussion at its 6 June meeting. We used social media to remind registrants of our existing guidance on when they should report patients who are unfit to drive to the authorities. The AOP and College of Optometrists have written a joint letter to the Secretary of State calling for legislative change. We will continue to engage with officials as they explore policy options.

Legislative Reform

58. We received a letter from the Minister of State for Health and Secondary Care on 2 May 2025 confirming the Government's commitment to reforming the regulation of healthcare professionals across the UK. The timetable for change to our legislation remains unknown with initial focus on the General Medical Council (GMC), Health and Care Professions Council (HCPC) and Nursing and Midwifery Council (NMC) during the currently Parliamentary period. We wrote to DHSC on 7 May 2025 suggesting areas that might be appropriate for fast-track reforms outside the legislative reform programme, which included modernising our business regulation framework.

Sight testing research

59. The academic consortium led by Glasgow Caledonian University continues to work on research on the separation of the sight test by time, person and place, to inform our project to update our 2013 statement on the testing of sight. We have received the first draft of the report and expect delivery of the final research report, accompanied by a lay summary, by the end of June.

Orthoptists

60. As part of our call for evidence on the Opticians Act 1989 and consultation on associated GOC policies, we commissioned research into refraction in the sight test[1]. The research found that orthoptists were capable of refracting young children during their work in the hospital eye service and argued for them to be able to issue prescriptions and optical vouchers. In our response to the call for evidence we said that we would discuss the issues connected with orthoptists refracting for the purposes of sight testing with the Health and Care Professions Council (HCPC – the regulator for orthoptists) and the British and Irish Orthoptic Society (BIOS).

61. We had several discussions with the HCPC and BIOS between late 2023 and early 2025. BIOS published a report on 8 April 2025 entitled 'A review of evidence by the British and Irish Orthoptic Society to support the legislative change to allow orthoptists to prescribe glasses in the hospital setting in accordance with the Opticians Act 1989'. BIOS is asking for a review of GOC legislation regarding sight testing that would allow orthoptists to be able to conduct refractions and prescribe glasses within the hospital/NHS setting.

62. We were given the opportunity to comment on the report before it was published. Our feedback included a suggestion to carry out a mapping exercise to compare the orthoptist competencies against the GOC's outcomes for registration for optometrists (as set out in our 2021 Requirements for Approved Qualifications in Optometry or Dispensing Optics) to identify any gaps. We understand that BIOS intends to carry out this mapping exercise in the coming months. We will take a view on next steps once we have considered the results of the mapping.

PSA consultation on standards review

63. We responded to the PSA's consultation on reviewing its standards of good regulation. We outlined our view that the current standards are heavily weighted towards operational delivery of key regulatory functions and tend to

[1] Evans, B., Shah, R., Conway, M. and Chapman, L. (2023), *Clinical research on refraction in the sight test*

focus on quantitative key performance indicator driven activity (particularly in areas such as fitness to practise). As well as being silent on governance, leadership and culture, they do not consider regulatory approach and effectiveness, i.e. how regulation is delivered and whether it is effective in achieving/improving public protection.

Research Update

64. Our survey of business registrants closed in March 2025 and we have received the report. We discussed the findings with Companies Committee on 6 June 2025 and will update Council further at its meeting in September 2025.

65. The annual individual registrant survey fieldwork is complete, and the report will be presented at the Council meeting in September 2025. The lived experience research with the registrant sample will also be presented at this meeting.

Communications

66. The new look website launched on Tuesday 10 June. This has a fresh modern look, along with improved accessibility and functionality.

Education and Continuing Professional Development (CPD)

67. Ulster University's adaptation to the Education and Training Requirements (ETRs) for its independent prescribing qualification (IP) was noted. The last intake for its Postgraduate Certificate in the Theory of Independent Prescribing qualification will be September 2026. The Postgraduate Certificate in Independent Prescribing for Optometrists qualification under the ETR will admit trainees from September 2027.

68. We have confirmed planned adaptation dates for all outstanding qualifications. We are also seeing increased interest in new qualifications.

Governance

69. The Governance team has been supporting several member recruitment campaigns. This has included roles on Advisory Panel, Hearing Panels and Council Associates. There has been a significant interest in these campaigns, including over 400 applications for the Hearing Panel vacancies.

70. The team has been focussed on maintaining continuity while several changes to staffing have taken place. It will be resuming the governance documents review in the summer. The focus for review in 2025/26 will be the Council's standing orders, member code of conduct and the scheme of delegation.

Equality, Diversity and Inclusion (EDI)

71. The EDI manager, Head of People and Culture and Chief of Staff have begun to plan to review the GOC employee recruitment practices, to ensure that the guidance and support for recruiting managers reflects best practice in respect to EDI.

72. We marked mental health awareness week with a mental wellbeing session organised by our Administrative Assistant, who is our Thomas Pocklington Trust intern. The Chief of Staff used a blog post to reflect on the theme of community and how this can support good mental health.

73. The GOC marked Pride month by publishing information on the intranet (Iris), resharing links to the staff LGBTQIAP+ network and previous articles, as well as posting details of Pride events including at Canary Wharf.

74. The GOC's new staff network for social mobility ran an event on 11 June to help encourage GOC staff to think about the importance of social mobility.

External Stakeholder Engagement

75. Since the last public Council meeting on 19 March 2025, I have attended the following external meetings and engagements:

- 21 March 2025: 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 other regulatory bodies in attendance.

- 25 March 2025: Association of British Dispensing Opticians (ABDO) webinar scheduled with Alistair Bridge, Chief Executive of ABDO, to encourage applicants for Dispensing Optician roles for our Hearing Panel and Advisory Panel recruitment campaign. Lisa Gerson, joined as Council lead for FTP to talk about preparing for the application process and interview and the role of a registrant Fitness to Practice (FtP) Panel Member. Our Director of Regulatory Operations and our Head of Hearings discussed the Regulatory Operations element.

- 26 March 2025: Institute of Regulation (IoR) pre-conference dinner with Marcial Boo, IoR Chair, Matt Graves, Objective Corporation, Regional Director and regulatory Chief Executives.

- 1 April 2025: meeting with Karen Homles, Health and Safety Executive, regarding fitness to practise arrangements in the new building safety regulator.

- 3 April 2025: Optical Sector CEO meeting with the relevant sector bodies.

- 4 April 2025: Intellectual Property Regulation Board (IPReg) meeting with Sally Gosling, Head of Education Review.

- 10 April 2025: RBC Brewin Dolphin Perspective on ‘Understanding Trump's Trade Offensive’ webinar. Speakers included Guy Foster, RBC Brewin Dolphin Chief Strategist who also leads the Investment Solutions business and Lord Kim Darroch, retired UK civil servant and life peer in the House of Lords.

- 10 April 2025: Catch-up meeting with Adrian Barrowdale. Equality, Diversity and Inclusion Strategic Lead at the Health and Care Professions Council (HCPC).

- 16 April 2025: Accompanied our Council Chair and Senior Council Member (SCM) at the National Optometric Professional Advisors meeting with David O’Sullivan, Chief Optometric Advisor to the Welsh Government, Raymond Curran, Head of Ophthalmic Services, Strategic Planning and Performance Group, at the Department of Health Northern Ireland and Janet Pooley, Chief Optometric Adviser at the Scottish Government, and Daniel Hardiman-McCartney, Clinical Adviser for the College of Optometrists representing England.

- 24 April 2025: Chief Executives of Regulatory Bodies (CEORB) meeting organised by the General Chiropractic Council (GCC) with other regulatory bodies in attendance.

- 28 April 2025: Accompanied by our Communications and Public Affairs Officer, I attended a meeting with Shockat Adam MP, optometrist, and independent politician who has served as the Member of Parliament for Leicester South since 2024.

- 13 May 2025: Browne Jacobson LLP meeting with Raymond Silverstein, Partner at Browne Jacobson LLP. Accompanied by our Council Chair and our Head of People and Culture.

- 13 May 2025: New Zealan Optometrists and Dispensing Opticians Board Joint Chair/Deputy Chair (SCM)/CEO introductory meeting.

- 20 May 2025: Association of British Dispensing Opticians (ABDO) 2025 graduation and prize giving ceremony, organised by Alistair Bridge, Chief Executive of ABDO.

- 20 May 2025: Royal Academy of Dramatic Art (RADA) Business summer reception with David Harewood, RADA President and Marcus Ryder, Chair of RADA Council.

- 30 May 2025: CEORB meeting organised by the GCC with other regulatory bodies in attendance.

- 2 June 2025: Sustainability Roundtable follow-up meeting organised by Louisa Wickham, National Clinical Director for Eye Care and Medical Director at Moorfields Eye Hospital NHS Foundation Trust.

- 10 June 2025: Optometric Advisory Board meeting organised by Olivia Crolla, Deputy Manager, Optometry at NHS Education for Scotland.

- 11 June 2025: National Advancing Practice Professional Bodies meeting organised by Jamie Morgan, Project Manager at NHS England, Centre for Advancing Practice.

- 16 June 2025: RBC Brewin Dolphin trustee webinar, ‘What's on the horizon for charities in 2025?’, organised by Phillip Payne, Director, Wealth Manager at RBC Brewin Dolphin Charities and accompanied by our Acting Director of Corporate Services.

- 16 June 2025: ‘Preventative Sight Loss Roundtable’, organised by Chair and Co-Chair of the All-Party Parliamentary Group (APPG) on Eye Health and Visual Impairment, Marsha de Cordova, Member of Parliament for Battersea and Shockat Adam, Member of Parliament for Leicester South.

- 19 June 2025: GOC defence stakeholder group meeting organised by our Director of Regulatory Operations with the relevant stakeholders and staff in attendance.

- 19 June 2025: Health and Social Care Regulators Forum organised by Charles Rendell, Strategy Manager at Care Quality Commission (CQC).

76. A range of other engagements by Directors are listed in Annex 1.

**Finance**

77. This paper requires no decisions and so has no financial implications.

## Risks

78. The corporate Risk Register has been reviewed in the past quarter and discussed with ARC.

## Equality Impacts

79. No impact assessment has been completed as this paper does not propose any new policy or process.

## Devolved nations

80. We continue to engage with all four nations across a wide range of issues.

## Other impacts

81. No other impacts have been identified.

## Communications

### External communications

82. This report will be made available on our website, but there are no further communication plans.

### Internal communications

83. An update to staff normally follows each Council meeting, which will pull out relevant highlights.

## Next steps

84. There are no further steps required.

## Attachments

Annex 1 - Directors' stakeholder and other meetings.

## Annex 1 – Directors' meetings/visits since last Council meeting

| **Philipsia Greenway**<br>Director of People and Improvement | **Steve Brooker**<br>Director of Regulatory Strategy | **Carole Auchterlonie**<br>Director of Regulatory Operations | **Charlotte Urwin**<br>Acting Director of Corporate Services (started 20 May 2025) |
|---|---|---|---|
| 20/3/25 - participation in Objective Corporation's Digital Change in UK Regulation webinar | 21/3/25 OCCS – handover from Richard Edwards to Paul Chapman-Hatchett | 20/3/25 - Fitness to Practise Chairs' training day | 16/06/2025 - RBC Brewin Dolphin Trustees Training |
| 28/3/25- EB Partnership monthly meeting re GOC benefits | 26/3/25 - Janet Pooley, Scottish Government – education funding | 21/3/25 - Fitness to Practise panel members' training day | |
| 16/3/25 – Thirdway onsite meeting at One Canada Square L29 | 1/4/25 - staff and students at Ulster University, Coleraine | 25/3/25 - ABDO webinar about DO recruitment to Hearing Panel and Advisory Panel | |
| 25/3/25 – CiPHR meeting | 1/4/25 - Brian McKeown, Optometry Northern Ireland, Coleraine | 27/3/25 - Institute of Regulation annual conference | |
| 03/6/25 – Finance Chairs Group Meeting | 2/4/25 - Optimise, Newtownards – shadowing domiciliary care | 7/4/25 - PSA FtP audit team | |
| 05/6/25 – Addecco webinar for Men's Health | 3/4/25 - Raymond Curran, visit to two Belfast hospitals | 15/4/25 - Joy Myint – student engagement and FtP | |
| 13/06/25 – Thirdway final L29 walkaround | 10/4/25 - Explain Research – lived experience project | 29/5/25 - OCCS - annual report planning | |

| **Philipsia Greenway**<br>Director of People and Improvement | **Steve Brooker**<br>Director of Regulatory Strategy | **Carole Auchterlonie**<br>Director of Regulatory Operations | **Charlotte Urwin**<br>Acting Director of Corporate Services (started 20 May 2025) |
|---|---|---|---|
| | 16/4/25 - National Optometric Advisers, joined by GOC Chair of Council and CEO | 19/6/25 - Defence Stakeholder Group | |
| | 8/5/25 - DHSC, Eye Health Forum | | |
| | 8/5/25 - DBT, Regulated Professions Advisory Forum – trade matters | | |
| | 9/5/25 - Chaired Optical Sector Policy Forum | | |
| | 16/5/25 - Melanie Venables, PSA – routine catch-up | | |
| | 20/5/25 - Janet Pooley, Scottish Government – Human Medicines Regs | | |
| | 28/5/25 - Competition and Markets Authority – veterinary services market investigation | | |
| | 29/5/25 - Glasgow Caledonian University led research team on separation of sight test project – progress review | | |
| | 29/5/25 - SPOKE – quarterly catch-up meeting | | |

| **Philipsia Greenway**<br>Director of People and Improvement | **Steve Brooker**<br>Director of Regulatory Strategy | **Carole Auchterlonie**<br>Director of Regulatory Operations | **Charlotte Urwin**<br>Acting Director of Corporate Services (started 20 May 2025) |
|---|---|---|---|
| | 6/6/25 - Royal College of Veterinary Surgeons – business regulation | | |
| | 9/6/25 - DVLA – Response to Prevention of Future Deaths report | | |
| | 9/6/25 - College of Optometrists – quarterly catch-up meeting | | |
| | 11/6/25 – Interviewed by PhD student at University of Huddersfield for study on AI | | |
| | 18/6/25 – Interviewed candidates for Director of Corporate Services role | | |
| | 19/6/25 - SeeAbility – regular catch-up meeting | | |

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| **Council Catch-up 15 July 2025** |
| - **MyGOC update**<br>- **One Canada Square office move**<br>- **PBF update**<br>- **NHSE commissioning? (Poonam?)** |
| **Council Catch-up 3 September 2025** |
| - |
| **Council Meeting (Strictly Confidential) 15 September 2025** |
| **For decision**<br>-<br>**For discussion**<br>- **Strategic risk discussion/ revised CRR**<br>- **Public perceptions survey**<br>- **Registrant survey**<br>**For noting**<br>- **Committee updates**<br>- **Council papers for the public session** |
| **Council Meeting (Public) 16 September 2025** |
| **For decision**<br>- **Standing orders and scheme of delegation**<br>- **Annual report and financial statements 2023/24**<br>- **ARC annual report 2023/24**<br>- **Equality, Diversity and Inclusion annual report 2023/24**<br>**For discussion**<br>- **Registrant and public perception survey**<br>- **Q1 Financial performance report**<br>- **Business performance dashboard Q1**<br>- **Business Plan Assurance Report Q1**<br>**For noting**<br>- **Chair / Chief Executive Report**<br>- **Committee updates** |
| **Council Catch-up 08 October 2025** |
| - |
| **Council Catch-up 18 November 2025** |
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| **Council Meeting (Strictly Confidential) 16 December 2025** |
| **For discussion**<br>- **Strategic risk discussion**<br>**For noting**<br>- **Committee updates**<br>- **Council papers for the public session** |
| **Council Meeting (Public) 17 December 2025** |
| **For discussion**<br>- **Q3 Financial performance report**<br>**For decision** |

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| - **Registrant fees 2026/27**<br>**For noting**<br>**- Business performance dashboard Q2**<br>**- Business Plan Assurance Report Q2**<br>- **Chair / Chief Executive Report**<br>- **Committee updates** |
| **Council Catch-up 13 January 2026** |
| **Council Catch-up 17 February 2026** |
| **Council Meeting (Strictly Confidential) 10 March 2026** |
| **For discussion**<br>- **Strategic risk discussion**<br>**For noting**<br>- **5-year forecast**<br>- **Committee updates**<br>- **Council papers for the public session** |
| **Council Meeting (Public) 11 March 2026** |
| **For discussion**<br>- **Q3 Financial performance report**<br>**For decision**<br>- **Budget and business plan 2026/27**<br>**For noting**<br>- **Business performance dashboard Q3**<br>- **Business Plan Assurance Report Q3**<br>- **Chair / Chief Executive Report**<br>- **Committee updates** |