

**Second meeting in 2026 of the Council held in PUBLIC  
on Wednesday 24 June 2026 at 10am via Microsoft Teams**

**AGENDA**

Item no.	Item	Reference	Lead	Page No.	Finish time
1.	<b>Welcome, apologies and Chair's introduction</b>	Oral	Chair	-	10am -10.05am (5 mins)
2.	<b>Declaration of interests</b>	C19(26)	Chair	3 - 6	
3.	<b>Minutes, actions and matters arising</b>		Chair		10.05am- 10.10am (5 mins)
3.1	<b>Minutes – 11 March 2025</b> For approval	C20(26)		7 - 12	
3.2	<b>Updated actions</b> For noting	C21(26)		13 - 14	
3.3	<b>Matters arising</b>				
<b>FOR DECISION</b>					
4.	<b>Consultation on the proposed draft updated statement on the testing of sight</b> For decision	C22(26)	Director of Regulatory Strategy	15 - 77	10.10am- 11.10am (1 hour)
<b>11.10am - 11.20am Break (10 mins)</b>					
5.	<b>External communications strategy</b> For decision	C23(26)	Head of Communications	78 - 93	11.20am – 11.40am (20 mins)
6.	<b>Member code of conduct</b> For decision	C24(26)	Chief of Staff	94 - 121	11.40am – 11.55am (15 mins)
<b>FOR DISCUSSION</b>					
7.	<b>Optical Consumer Complaints Service Annual Report</b> For discussion	C25(26)	Director of Regulatory Operations	122 - 161	11.55am - 12.40pm (45 mins)
<b>12.40pm – 1.25pm Lunch (45 mins)</b>					

8.	<b>Fitness to Practise Unfair Outcomes Research – Analysis and Findings</b> For discussion	C26(26)	EDI Manager	162 - 309	1.25pm – 2.10pm (45 mins)
9.	<b>Financial performance report Q4 2025/26 / Q4 forecast</b> For discussion	C27(26)	Chief Financial Officer	310 - 328	2.10pm – 2.20pm (10 mins)
	<b>Business performance dashboard Q4 2025/26</b> For discussion	C28(26)	Chief of Staff	329 - 331	2.20pm-2.30pm (10 mins)
10.	<b>Business Plan Assurance Report Q4 2025/26</b> For discussion	C29(26)	Chief of Staff	332 - 336	2.30pm-2.40pm (10 mins)

**FOR NOTING**

11.	<b>Advisory Panel Minutes – 22 May 2026</b> (Companies, Education, Registration and Standards Committees) For noting	C30(26)	Committee Chairs	337 - 354	2.40pm – 2.45pm (5 mins)
12.	<b>Chair’s report</b> For noting	C31(26)	Chair	355 - 361	2.45pm – 2.55pm (10 mins)
13.	<b>Chief Executive and Registrar’s report</b> For noting	C32(26)	Chief Executive and Registrar	362 - 381	2.55pm – 3.05pm (10 mins)
14.	<b>Council forward plan</b> For noting	C33(26)	Chair	382 - 383	3.05pm – 3.10pm (5 mins)
15.	<b>Any other business</b> (Items must be notified to the Chair 24 hours before the meeting)	-	Chair	-	3.10pm – 3.15pm (5 mins)

**Meeting Close – 3.15pm**

**Date of next meeting – Wednesday 30 September 2026**

**GOC COUNCIL MEMBER– REGISTER OF INTEREST (UPDATED 16 JUNE 2026)**

	Own interests				Connected Persons interests
	Current interests	Professional memberships	Previous interests	GOC committee memberships	
Raymond <b>CURRAN</b> Registrant member (OO)	<ul style="list-style-type: none"> <li>Head of Ophthalmic Services, Strategic Planning and Performance Group, DoH, Northern Ireland</li> <li>Member, Northern Ireland Ophthalmic Qualifications Committee</li> <li>Task and Finish group member of the Digital Health and Care Policy Directorate of Department of Health NI Artificial Intelligence Steering Group (1. Policy &amp; Governance and 2. Transformation &amp; Innovation).</li> </ul>	<ul style="list-style-type: none"> <li>Honorary Life Fellow, College of Optometrists</li> <li>Member, Association of Optometrists</li> </ul>	<ul style="list-style-type: none"> <li>Council Member and Trustee, College of Optometrists</li> <li>Member of Senate, Ulster University</li> <li>Past-President, Northern Ireland Optometric Society</li> <li>NICE Fellow 2021-23</li> </ul>	<ul style="list-style-type: none"> <li>Council Member</li> <li>Member: Audit, Finance and Risk Committee</li> <li>Member: Registration Committee</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>
Kathryn <b>FOREMAN</b> Lay Member	<ul style="list-style-type: none"> <li>Deputy Chair Assurance &amp; Appointments Committee – General Pharmaceutical Council</li> <li>Investigations Panel Member – Architects Registration Board</li> <li>Lay Member Police Misconduct Panels – NW Police &amp; Crime Commissioners</li> </ul>	<ul style="list-style-type: none"> <li>Law Society (non-practising)</li> </ul>	<ul style="list-style-type: none"> <li>Non-Executive Director- Primary Care 24 (Merseyside) Ltd</li> <li>Lay Member Health &amp; Care Professionals Council (ended December 2023)</li> <li>Associate Midlands and Lancashire Commissioning Support Unit (2022-23)</li> </ul>	<ul style="list-style-type: none"> <li>Lay Council Member</li> <li>Member: Advisory Panel – Registration Committee Member, Audit, Finance and Risk Committee</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>
Lisa <b>GERSON</b> Registrant (OO)	<ul style="list-style-type: none"> <li>Clinic Tutor: Cardiff University</li> <li>Observer status: Regional Optical Committee (ROC) meetings across Wales</li> <li>GOC representative to Optometry Wales</li> </ul>	<ul style="list-style-type: none"> <li>Member of AOP</li> <li>Member of College of Optometry</li> </ul>	<ul style="list-style-type: none"> <li>Chair: Optometry Wales</li> <li>Member: GOC Hearings Panel</li> <li>Member/Acting Chair: GOC Investigation Panel</li> <li>Member: GOC Education Visitor Panel</li> <li>College Counsellor: College of Optometrists</li> <li>Trustee: College of Optometrists</li> <li>Trustee: AOP</li> <li>Employee: Ronald Brown Group</li> <li>Employee: Boots Optician</li> <li>Primary Care Supervisor: Cardiff University</li> </ul>	<ul style="list-style-type: none"> <li>Registration Committee Chair</li> <li>Nominations Committee Chair</li> <li>Council lead for FtP</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>

	Own interests				Connected Persons interests
	Current interests	Professional memberships	Previous interests	GOC committee memberships	
Inderpal <b>GHUMAN</b> Council Associate (OO)	<ul style="list-style-type: none"> <li>Specialist Optometrist, Moorfields Eye Hospital NHS Foundation Trust</li> <li>Association of Optometrists Councillor (Early Career Designate)</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>	<ul style="list-style-type: none"> <li>Johnson and Johnson, Vision Institute</li> </ul>	<ul style="list-style-type: none"> <li>Council Associate, Audit Finance and Risk Committee</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>
Kalwant <b>GREWAL</b> Lay Member	<ul style="list-style-type: none"> <li>Saxon Weald, Member Audit and Risk Committee and Asset Management &amp; Development Committee</li> <li>PHA Homes Chair of the Audit and Risk Committee</li> <li>Sapphire Independent Housing Chair of the Finance, Audit and Risk Committee</li> <li>British Acupuncture Council Chair of the Finance, Risk and Audit Committee</li> <li>Regulatory Advisory Group Independent Chair</li> <li>Democracy Boundary Commission Cymru Deputy Chair of the Governance and Audit Committee</li> <li>General Council of the Bar in England and Wales Vice Chair of the Audit and Risk Committee</li> <li>London Borough of Lewisham Independent Person</li> <li>Royal College of Veterinary Surgeons Independent Member of the Audit and Risk Committee</li> <li>Architects Registration Board, Education Accreditation Panel Member</li> </ul>	<ul style="list-style-type: none"> <li>ACCA</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>	<ul style="list-style-type: none"> <li>Lay Council Member</li> <li>Member: Advisory Panel – Companies Committee</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>
Fahima <b>KIRK</b> Council Associate (DO)	<ul style="list-style-type: none"> <li>Dispensing Optician, Specsavers</li> <li>Local Outreach Coordinator (volunteer), Vision Care Charity</li> <li>Talk and Support Facilitator (volunteer), RNIB charity</li> <li>Student Contact Lens Optician at ABDO College</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>	<ul style="list-style-type: none"> <li>Council Associate, Audit Finance and Risk Committee</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>
Ros <b>LEVENSON</b> Lay member	<ul style="list-style-type: none"> <li>Chair of The Expert Advisory Group for the OSIRIS B project at Queen Mary University of London</li> <li>Chair of The SKILL mix-ED Study Steering Committee at St George's University of London/Kingston University.</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>	<ul style="list-style-type: none"> <li>Chair of the Patient and Lay Committee (APLC) at the Academy of Medical Royal Colleges (AoMRC)</li> </ul>	<ul style="list-style-type: none"> <li>Lay Member: Council</li> <li>Member: Nominations Committee</li> <li>Member: Standards Committee</li> <li>Council lead for Thematic Reviews</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>
Siddhant <b>MAJITHIA</b> Council Associate (OO)	<ul style="list-style-type: none"> <li>Ophthalmic Director and Store Partner, Specsavers, Newark</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>	<ul style="list-style-type: none"> <li>Ophthalmic Director and Store Partner, Specsavers, Towcester</li> <li>Store Manager, SpecSavers, Fosse Park</li> </ul>	<ul style="list-style-type: none"> <li>Council Associate, Audit Finance and Risk Committee</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>
Frank <b>MUNRO</b> Registrant (OO)	<ul style="list-style-type: none"> <li>Chair: Community Low Vision Service Short Life Working Group (CLVSSLWG)</li> <li>Director Munro Eyecare Limited (T/A Munro)</li> </ul>	<ul style="list-style-type: none"> <li>Past President and Honorary Life Fellow, College of Optometrists</li> </ul>	<ul style="list-style-type: none"> <li>Past Chair, NHS Lanarkshire Optometric Advisory Committee</li> </ul>	<ul style="list-style-type: none"> <li>Registrant Member: Council</li> <li>Chair: Education</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>

	Own interests				Connected Persons interests
	Current interests	Professional memberships	Previous interests	GOC committee memberships	
	<ul style="list-style-type: none"> <li>Optometrists)</li> <li>• Founder member, Optometry Scotland</li> <li>• Optometric Advisor, NHS Lanarkshire</li> <li>• Lead Optometrist, Glasgow City Health &amp; Social care Partnership</li> <li>• Visiting Lecturer, Glasgow Caledonian University</li> <li>• Visiting Lecturer, Edinburgh University (MSc Ophthalmology programme)</li> <li>• Member, Greater Glasgow &amp; Clyde Prescribing Review Board</li> </ul>	<ul style="list-style-type: none"> <li>• Member, Association of Optometrists</li> <li>• Member, Optometry Scotland</li> <li>• Hon Fellow, Association of Dispensing Opticians</li> <li>• Member, British Contact Lens Association</li> </ul>	<ul style="list-style-type: none"> <li>• Past President, College of Optometrists</li> <li>• Past Chair, Optometry Scotland</li> <li>• Past Chair, Scottish Committee of Optometrists</li> <li>• Past Chair, NHS Education for Scotland Optometry Advisory Board</li> </ul>	<ul style="list-style-type: none"> <li>Committee</li> <li>• Member: Audit, Finance and Risk Committee</li> <li>• Member: Investment Committee</li> </ul>	
Tim <b>PARKINSON</b> Lay Member	<ul style="list-style-type: none"> <li>• Director: Tim Parkinson Limited (consultancy not to optical sector or organisations linked to optical sector)</li> </ul>	<ul style="list-style-type: none"> <li>• Fellow: Chartered Management Institute</li> <li>• Membership of the Institute of Water</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• Lay member: Senior Council member</li> <li>• Chair: Investment Committee</li> <li>• Chair: Companies Committee</li> <li>• Chair of Remuneration Committee</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>
Prof. Hema <b>RADHAKRISHNAN</b> Registrant (OO)	<ul style="list-style-type: none"> <li>• Professor and Member of Senate and the Board of Governors: University of Manchester</li> <li>• Member of Advisory Board: Zeiss Vision group</li> <li>• Research funding and collaboration with Optegra Eye Hospital group and Zeiss Vision Group</li> <li>• Associate Editor, Translational Vision Science and Technology, an Association for Research in Vision and Ophthalmology Journal.</li> </ul>	<ul style="list-style-type: none"> <li>• Member: College of Optometrists-</li> <li>• Member: Association of Optometrists</li> <li>• Principal Fellow: Higher Education Academy</li> <li>• Member- The Association for Research in Vision and Ophthalmology</li> </ul>	<ul style="list-style-type: none"> <li>• Editorial board member Optometry in Practice, a College of Optometrists journal</li> <li>• External examiner- Aston University Undergraduate and Masters Optometry programmes</li> </ul>	<ul style="list-style-type: none"> <li>• Registrant member: Council</li> <li>• Member: Advisory Panel – Education Committee</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>
Poonam <b>SHARMA</b> Registrant (OO)	<ul style="list-style-type: none"> <li>• Lead Optometry Adviser, NHSE (London); since 01/04/2017</li> <li>• Occasional locum optometrist, various high street optical practices; since 1998</li> <li>• Mentor, Social Mobility Foundation: since 2023</li> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>• Member of AOP</li> <li>• Member of College of Optometrists</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• Member: Council</li> <li>• Companies Committee</li> <li>• Council lead for regulatory reform</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>
William <b>STOCKDALE</b> Registrant (DO)	<ul style="list-style-type: none"> <li>• Own an organisation in the Optical Sector - Optomise Ltd 50% Shareholding.</li> <li>• Own an organisation in the Optical Sector - Telford Opticians 50% Stake.</li> </ul>	<ul style="list-style-type: none"> <li>• Member of ABDO</li> <li>• Member of FODO</li> <li>• Member of ONI</li> </ul>	<ul style="list-style-type: none"> <li>• Chair: Optometry Northern Ireland</li> <li>• Member of a consultative body in the Optical Sector Member</li> </ul>	<ul style="list-style-type: none"> <li>• Member: Council Member</li> <li>• Member: Nominations Committee</li> <li>• Chair: Advisory Panel –</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>

	Own interests				Connected Persons interests
	Current interests	Professional memberships	Previous interests	GOC committee memberships	
			BSO Ophthalmic Committee. • Non-Executive Director FODO	Standards Committee	
Dr Anne <b>WRIGHT</b> CBE Lay Chair	• None	• None	• Committee member: The Shaw Society • Director of Circa management company • Chancellor at the University of Sunderland, which was developing the Northern Ophthalmic Research and Innovation Institute.	• Chair: Council	• None
Catherine (Cathy) <b>YELF</b> Lay Member	<ul style="list-style-type: none"> <li>• Trustee - Action Against AMD</li> <li>• Chair of Planning Committee at Longparish, Hampshire Parish Council</li> <li>• Interim Chair of AAAMD. Foresight Research Ltd is a trading subsidiary of AAAMD. Its aim is to acquire, aggregate and analyse data OCT images from primary care and make those data available for research into AMD.</li> </ul>	• None	<ul style="list-style-type: none"> <li>• CEO of Macular Society</li> <li>• Trustee of the Association of Medical Research Charities.</li> </ul>	<ul style="list-style-type: none"> <li>• Council Member</li> <li>• Member: Advisory Panel - Companies Committee</li> <li>• Member Investment Committee</li> </ul>	• None

**GENERAL OPTICAL COUNCIL  
Minutes of the Public Council  
Meeting held on 11 March 2026 at 10am via Microsoft Teams**

Present:	<p>Dr Anne Wright CBE (Chair), Raymond Curran, Kathryn Foreman, Lisa Gerson, Kalwant Grewal, Ros Levenson, Frank Munro, Tim Parkinson, Hema Radhakrishnan, Poonam Sharma, William Stockdale and Cathy Yelf.</p> <p>Rupa Patel and Desislava Pirkova (Council Associates). John Cappock (Independent Member and Chair of Audit, Finance and Risk Committee).</p>
GOC Attendees:	<p>Helen Alldridge (Legal Administrator), Carole Auchterlonie (Director of Regulatory Operations), Steve Brooker (Director of Regulatory Strategy), Nicola Davis (Operations Manager (Investigations)), Kiran Gill (Chief Legal Officer), Philipsia Greenway (Director of People and Improvement), Nadia Habib (Governance and Compliance Manager) (<i>Minutes</i>), Louise Hall (Investigation Manager), Andy Mackay-Sim (Chief of Staff), Claire Marchant-Williams (Head of Case Progression), Leonie Milliner (Chief Executive and Registrar), Joanna Murphy (EDI Manager), Nadia Patel (Head of Registrations) (<i>attending for item 8 only</i>), Vikram Saklani (Communications Officer), Marc Stoner (Director of Corporate Services), Emma Storer (<i>attending for item 6 only</i>), Charlotte Urwin (Head of Policy, Strategy and Standards) and Manori Wickremasinghe (Chief Financial Officer).</p>
External Attendees:	<p>Siobhan Carson (Senior Scrutiny Officer, Professional Standards Authority (PSA)), Alan Clamp (Chief Executive Officer, PSA), Olivier Deneve (Head of Policy and Public Affairs, College of Optometrists), Selina Powell (Features Editor, Optometry Today) and Alan Tinger (Director of Membership Services, Federation of Ophthalmic and Dispensing Opticians (FODO)).</p>
	<p align="center"><b>Welcome and Apologies</b></p>
1.	<p>The Chair welcomed those in attendance, including Kalwant Grewal who had been appointed on 1 February 2026 as a lay Council member. The Chair congratulated Lisa Gerson and Cathy Yelf on their recent MBE awards. It was noted that this was Rupa and Desislava’s last Council meetings and the Chair thanked them for their contributions. Apologies were received from Siddhant Majithia.</p>
	<p align="center"><b>Declaration of Interests C01(26)</b></p>
2.	<p>The Chief of Staff advised that registrant Council members had an unavoidable conflict for the item on registrant fees (C08(26)), as any changes to fees would have a financial implication for them as individual registrants. All Council members had an unavoidable financial conflict for the item on member fees (C05(26)) as this concerned individual member remuneration. The Chief of Staff outlined the provisions in paragraph 4.7 and 4.8 to manage such conflicts, and</p>

	confirmed that Council had the authority in place. Council was reminded that it had the duty to act in the best interests of the GOC in such circumstances.
3.	It was noted that John Cappock would step away from the meeting during the member appointments item as it was a decision relating to his appointment as the Chair of ARC.
4.	Raymond Curran declared an interest as a Task and Finish group member of the Digital Health and Care Policy Directorate of Department of Health NI Artificial Intelligence Steering Group (1. Policy & Governance and 2. Transformation & Innovation). Cathy Yelf declared an interest as Chair of Planning Committee at Longparish, Hampshire Parish Council.
	<b>Minutes of the meeting held on 16 September 2025 C02(26)</b>
5.	The minutes were approved as an accurate record of the meeting subject to the following amendment: Minute 13 to change from “removing regulatory oversight” to “reducing regulatory oversight.”
	<b>Action points update C03(26)</b>
6.	Council <b>noted</b> updates on previous actions. There were no further comments or updates.
	<b>Matters arising</b>
7.	There were no matters arising.
	<b>Budget and business plan 2026/27 C04(26)</b>
8.	The Chief Executive and Registrar presented the item. It was noted that ARC had scrutinised the budget and the reserves policy, and had tested the 2026/27 budget assumptions against departmental and directorate business plans. It was confirmed that the proposed budget met planned KPIs within the context of the five-year financial forecast to 2030, and that the three proposed projects to be funded from the strategic reserve were necessary and affordable. Council discussed the GOC’s developing position on Artificial Intelligence (AI), noting the government’s request for regulators to publish plans for supporting safe AI innovation. It was highlighted that whilst this request was not applicable to the GOC, the Chief of Staff was developing proposals for SMT on AI governance.
9.	Council was updated on the MyGOC registration website platform redesign, and the work of the project board in progressing and approving process redesign and digital development. It was noted that volatility and inflation risks continue to be monitored closely with the GOC’s investment managers and the bank, and Council confirmed it could convene between meetings if urgent issues arose.
10.	Council: <ul style="list-style-type: none"> <li>• <b>approved</b> the external business plan (annex one)</li> <li>• <b>approved</b> the proposed 2026-27 budget (annex two)</li> <li>• <b>approved</b> three proposed projects to be funded from the strategic reserve at a total proposed cost of £180k, subject to development and approval of business cases and project initiation documentation as described in the paper.</li> </ul>

11.	<b>Action: The Chief of Staff to circulate the government letter on AI to Council.</b>
	<b>Member fees 2026/27 C05(26)</b>
12.	The Chief of Staff presented the item. It was noted that recent recruitment campaigns indicated that the organisation is attracting suitable candidates. Council noted the plans to benchmark Council members' time input.
13.	Council is asked to: <ul style="list-style-type: none"> <li>• <b>noted</b> Remuneration Committee's review of the proposed member fees at its meeting on 10 February 2026 and its recommendation that: <ul style="list-style-type: none"> <li>- there is no general increase in member fees for 2026/27;</li> </ul> </li> <li>• <b>approved</b> the member fee schedule for 2026-27 (annex 1)</li> </ul>
	<b>EDI action plan 2026/2027 C06(26)</b>
14.	The EDI Manager presented the item. Council emphasised the need to demonstrate effective use of data and welcomed plans to strengthen patient engagement within the EDI framework. It acknowledged that the organisation must be prepared to defend this work in a politically volatile climate. It was confirmed that EDI will be integrated into staff objectives and organisational processes, with a clear plan for embedding the approach rather than relying solely on training. Council thanked the EDI manager for their work progressing the action plan at pace.
15.	Council: <ul style="list-style-type: none"> <li>• <b>approved</b> the EDI action plan 2026-27; and</li> <li>• <b>delegated</b> authority to the EDI Manager (in consultation with the Chair of Council) to make any minor amendments prior to publication.</li> </ul>
	<b>Member appointments C07(26) <i>John Cappock exited the meeting for this item.</i></b>
16.	The Chief of Staff presented the item. The Chair thanked Tim Parkinson for his work on both Companies Committee and Investment Committee.
17.	Council: <ul style="list-style-type: none"> <li>• <b>appointed</b> John Cappock, independent lay member, as Chair of Audit, Finance and Risk Committee until 31 March 2030 (with a review after two years);</li> <li>• <b>approved</b> remuneration commensurate with the fee set for the Chair of ARC (£16,462 pro-rata);</li> <li>• <b>appointed</b> Kalwant Grewal to Companies Committee from 11 March 2026;</li> <li>• <b>appointed</b> Poonam Sharma as Chair of Companies Committee from 1st June 2026;</li> <li>• <b>appointed</b> Cathy Yelf as Chair of Investment Committee from 11 November 2026; and</li> <li>• <b>noted</b> Tim Parkinson will step down as Chair of Companies Committee from 31 May 2026 and as Chair of Investment Committee from 10 November 2026.</li> </ul>
18.	Council took a break at 11.20am and returned at 11.30am.

	<b>Registrant fees discussion paper C08(26)</b> <i>John Cappock returned to the meeting.</i>
19.	The Director of Corporate Services introduced the item. The Director of Regulatory Strategy presented the item. Council discussed the complexity of analysing variable fees and the operational impact of any fee changes. Should proposals for change be made, the need for a robust Equality Impact Assessment was highlighted to reduce being exposed to challenge. Council queried evidence on whether specialist qualifications attract higher pay and noted risks, including lack of powers to remove registration following missed payments under instalment options and the potential for businesses to exit regulation by the GOC.
20.	Council: <ul style="list-style-type: none"> <li>• <b>approved</b> the draft discussion paper for the purpose of public consultation; and</li> <li>• <b>delegated</b> final approval to the Chief Executive and Registrar in consultation with the Chair of Council, if Council request minor changes to the document at the meeting.</li> </ul>
	<b>Reserves policy C09(26)</b>
21.	The Director of Corporate Services presented the item. It was noted that ARC endorsed the revised reserves policy. Council highlighted the need to explain the purpose of reserves clearly and ensure the upper and lower reserve levels were consistent with Charity Commission guidance. It noted the policy was intended ensure financial resilience while reducing the risk of holding excessive funds.
22.	Council: <ul style="list-style-type: none"> <li>• <b>approved</b> the proposed changes to the Reserves policy and working capital statement (Annex one); and</li> <li>• <b>delegated</b> any minor revisions to the Chief Executive and Registrar in consultation with the Chair of Audit, Risk and Finance Committee.</li> </ul>
	<b>PSA performance review C10(26)</b>
23.	The Chief Executive and Registrar presented the item. Council discussed mixed stakeholder feedback on engagement and asked how this would be strengthened, including through data sharing with other regulators. Council also noted actions taken with education providers, including refreshed KPIs and the establishment of an education providers' working group. The Chief Executive and Registrar thanked all staff, members and workers for maintaining PSA compliance.
24.	Council <b>noted</b> the PSA's assessment of our performance and our work in engaging with the review process.
	<b>Health and safety report C11(26)</b>
25.	The Director of Corporate Services presented the item. Council requested confirmation on accident and near-miss reporting, clarity on landlord and GOC responsibilities, and an update on high-priority actions. It was confirmed that all high-priority actions, including the fire risk assessment, were complete. Council noted that no accidents or reportable events were recorded. The Chair thanked the Facilities team for their work on the office move.
26.	Council <b>noted</b> the contents of the reports.

27.	<b>Action: Director of Corporate Services to include near-miss data to quarterly reports to ARC.</b>
	<b>Q3 financial performance report / Q3 forecast C12(26)</b>
28.	The Chief Financial Officer presented the item.
29.	Council: <ul style="list-style-type: none"> <li>• <b>noted</b> the financial performance for the nine months ending 31 December 2025 in annex 1.</li> <li>• <b>noted</b> the Q3 forecast for the current 2025-26 financial year in annex 2.</li> </ul>
	<b>Business performance dashboard Q3 2025-26 C12(26) and Business Plan Assurance Report Q3 2025-26 C13(26)</b>
30.	The Chair combined both items to assist with scheduling for the day. The Chief of Staff presented the items. Council noted that a clearer stakeholder communications approach was being developed. Council was assured that performance indicators such as productivity and the median age of active investigations were continuing to improve. The rise in referrals was noted by Council and resourcing discussed. The executive commented that converting fixed-term roles to permanent had strengthened capacity, and most referrals continued to close at triage.
31.	Council took a lunch break at 1.20pm and returned at 2.00pm.
	<b>Advisory Panel minutes – 6 February 2026 C14(26)</b>
32.	The Committee Chair provided an update. It was noted that Raymond Curran had an interest in the mandatory sight testing item and would not participate in the discussion. Council was informed that a protocol on visual acuity for optometrists was being developed, with sector engagement underway and a draft statement to be shared with Council. It noted that most issues raised fell outside the GOC's remit, and guidance had already been reinforced in registrant communications.
33.	Council <b>noted</b> the minutes.
	<b>Chair's report C15(26)</b>
34.	The Chair presented the item. It was noted that an amendment should be made to the report under paragraph 25 to read as "Frank Munro, registrant Council member and Chair of Education Committee."
35.	Council <b>noted</b> the report.
	<b>Chief Executive and Registrar's report C16(26)</b>
36.	The Chief Executive and Registrar presented the item.
	<b>Council forward plan C17(26)</b>
37.	Council <b>noted</b> the Council forward plan. There were no comments or queries.
	<b>Any Other Business</b>
38.	None received.

	<b>Date of the next meeting</b>
39.	Council noted the date of the next public meeting was <b>Wednesday 24 June 2026.</b>
	<b>Close</b>
40.	The meeting ended at 3.08pm.

**COUNCIL**

**Actions arising from strictly confidential Council meetings**

**Meeting Date:** 24 June 2026

**Status:** For noting

**Lead Responsibility and Paper Author:**

Nadia Habib, Governance and Compliance Manager

**Purpose**

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

**Part 1: Action Points from the Council meeting held on 11 March 2026**

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

**Part 2: Action points from previous meetings which remain outstanding**

Reference	By	Description	Deadline	Notes
None				

**Part 3: Action points previously outstanding but now completed**

Reference	By	Description	Deadline	Notes
<b>None</b>				

## Consultation on the proposed draft updated statement on the testing of sight

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**Meeting:** 24 June 2026

**Status:** For decision

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

**Paper author(s):** Marie Bunby (Policy Manager) and Toby Ganley (Policy Manager (Standards))

**Council lead(s):** None

### Purpose

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1. To seek Council approval of our proposed consultation package (including consultation document, proposed draft updated statement, proposed draft revised supervision/delegation standards<sup>1</sup> (annex 1) and equality impact assessment (annex 2)) in connection with the review of our [2013 statement on testing of sight](#) (annex 3).
2. Overall, the objectives of this work are to:
  - provide clarity for registrants by setting out the relevant legislation;
  - support responsible innovation in sight testing formats; and
  - increase public protection by putting appropriate safeguards in place.

### Recommendations

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3. Council is asked to approve:
  - a public consultation on (i) the proposed draft updated statement on the testing of sight and (ii) proposed draft revisions to supervision/delegation standards in our [Standards of Practice for Optometrists and Dispensing Opticians](#) and [Standards for Optical Students](#); and
  - delegate final approval of the consultation documents (annexes 1 and 2) to the Chief Executive and Registrar in consultation with the Chair of Council, if Council requests minor changes to the documents at the meeting.
4. The decision Council is being asked to make is to consult on the proposed draft updated statement and proposed revisions to the supervision/delegation standards, in accordance with our consultation policy. Through the consultation process we will invite stakeholders to provide views and evidence that will inform the executive's recommendation to Council on the final draft of the proposed updated statement and proposed revisions to the supervision/delegation standards.
5. Our [consultation policy](#) states: "*Consultation must take place at a stage when it can have a meaningful effect on the outcome. Consultation needs to influence. It is not a way of rubber-stamping policies which are effectively already in place. Therefore, we*

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<sup>1</sup> [Standard 9](#) of our Standards of Practice for Optometrists and Dispensing Opticians

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*will consult when we are ready to make enough information public for a well-informed debate – the decision will be made by the GOC but guided by the principle that this will be at the stage when it is early enough for stakeholders to be able to input to the proposal but late enough to enable stakeholders to comment on fully formed proposals.”* We are satisfied that our work on the proposed draft updated statement on the testing of sight and standards is at the appropriate point in its development that it is now ready for consultation in accordance with our policy.

### Strategic objective

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6. This work contributes towards the achievement of the following strategic objectives: supporting responsible innovation and protecting the public, and creating fairer and more inclusive eye care services. This work is included in our 2026/27 Business Plan.

### Background

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7. In our [response](#) to our 2022 call for evidence on the Opticians Act and associated GOC policies, we made a commitment to review our 2013 statement on testing of sight in two areas:
  - **pre- and post-screening checks** (paragraph 115): *“We will consider updating our 2013 statement on testing of sight to clarify the position in relation to pre-screening tests and triage checks related to the sight test that may be carried out by persons other than the optometrist or registered medical practitioner. Over time, advances in technology have meant various steps in the patient journey have become automated and safely delegated as part of pre-screening and triage. Use of autorefractors is one example of this and we understand further developments, including in relation to refraction, are on the horizon. If we decide to update our 2013 statement, we will carry out further consultation on this aspect of the testing of sight.”*; and
  - **separation of sight test components** (paragraph 116): *“Our interpretation is that the Act does not specifically prohibit separation of the elements of the sight test by time, place or person. Business models are evolving alongside developments in technology. While relevant to refraction, this issue relates more generally to how the sight test is conducted, rather than which type of optical professional should perform different elements of the sight test. The call for evidence identified a range of views about this and we plan to consider developments in more detail. Depending on the outcome of this work, we may clarify our position in a statement or seek a change in the law.”*
8. The Council, by section 13A of the Opticians Act, has a duty to provide guidance on fitness to practise – the 2013 statement constitutes such guidance. Section 13A(4) requires such guidance to be kept under review and revised as appropriate. Given changes in technology and service delivery since 2013, it is appropriate to review and revise the statement to reflect modern clinical practice.

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9. In June 2023 Council approved our recommendation to carry out further research to understand more about the separation of elements of the sight test by time, person and/or place and whether this separation has adverse impacts on public protection or patient safety. The [research report](#) on a risk-based framework for the testing of sight was published in August 2025 (and discussed with Council in December 2025).
10. On 14 October 2025 we held a stakeholder event at which the researchers presented their research on a risk-based framework for the testing of sight, and at that event we also sought feedback on a set of high-level principles to inform the drafting of a proposed updated statement on testing of sight. On 13 November 2025, we sought feedback on a draft proposed updated statement with the Advisory Panel and discussed our approach to supervision in a joint session of the Standards Committee and Companies Committee. These events have been useful in gauging reaction to the research, understanding the strategic implications of the proposed updated statement, testing our emerging thinking and establishing the likely focus of debate once we reach public consultation.
11. In December 2025 we presented a proposed draft updated statement to Council for discussion, in line with our view that, having considered the information we had gathered to date, we considered it was the right time to consult on proposals. At this meeting, Council requested further information before making a decision to consult, which we presented to the confidential meeting of Council in March 2026.
12. We discussed a draft of the proposed updated statement and our proposals regarding revisions to our supervision/delegation standard at a joint meeting of Companies, Education and Standards Committees on 22 May 2026, prior to finalising proposals. A draft of the proposed updated statement was circulated to the CEOs of the four main UK bodies which represent registrants in May 2026. We have held meetings with all four bodies to discuss the proposed updated statement.
13. Since December 2025, we have continued to research formats of sight testing, considered whether any amendments are required to our standards, and Enventure Research has carried out qualitative research into patient and public views on sight testing using teleoptometry<sup>2</sup>. The report<sup>3</sup> and infographic are published on our [website](#) and the findings are summarised in the consultation document.

## Analysis

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14. The drafting of the proposed updated statement has involved consideration of issues at the intersection of law, regulation and NHS contracting arrangements. Below we

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<sup>2</sup> Teleoptometry involves carrying out a sight test where the optometrist is not physically in the room with the patient, but rather on a virtual screen remote from the patient.

<sup>3</sup> [Enventure Research \(2026\), 'Patient views on teleoptometry: Research report'](#)

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set out our statutory remit relating to this matter and suggest relevant factors to support Council's decision-making.

15. Only the courts can decide how the law applies in each situation, but we can support registrants through publication of position statements setting out the legislation.
16. The GOC's overarching objective is the protection of the public, which is supported by supplementary objectives. However, these should not be seen as standalone objectives – rather, they apply to the way that the GOC carries out its statutory functions of education and training, registration, standards and fitness to practise. In the context of this consultation, we are using our function of maintaining proper standards of professional and business conduct to help us pursue our statutory objectives. We also consider an updated position statement will allow us to put appropriate safeguards in place as formats of sight tests continue to evolve. This responds to feedback received to our 2022 call for evidence which demonstrated that our current statement is inadequate to address contemporary or future risks.
17. We do not have a statutory role to pre-approve formats of sight tests or options for service delivery, although keep ourselves informed of relevant developments. As a statutory regulator we cannot state a preference for a particular format of sight test or method of service delivery. In effect, we can restrict registrants' activities through our standards setting function, but any restrictions on registrants' practise would need to be justified with reference to our statutory objectives and supported by evidence.
18. Approaches to sight testing may be restricted through General Ophthalmic Services (GOS) contracts. NHS Commissioners may apply restrictions when purchasing optical services from private sector contractors and in doing so they will need to consider a range of non-regulatory factors. The GOC has no role in these decisions.
19. The Professional Standards Authority for Health and Social Care's (PSA) standards and guidance are not legally binding, but our performance is assessed against them. The PSA has devised right-touch regulation<sup>4</sup> principles, which Council should have regard to in considering these issues. This is a principles-based approach, which looks at the level of risk of harm and decides on the most effective and proportionate response to that risk, using regulation only where necessary. The principles are that regulation should be proportionate, consistent, targeted, transparent, accountable and agile. We must be able to strike the right balance to the risk of harm by applying the appropriate amount of regulatory force. The principles and regulatory force diagram from the PSA's right-touch regulation guidance are available in annex 4.
20. In assessing public protection risks, Council may also find it helpful to consider the PSA's description of the different types of harm, which extend beyond physical harm. In assessing physical harm (such as an undiagnosed eye condition), in addition to

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<sup>4</sup> Professional Standards Authority for Health and Social Care (2025), Right-touch regulation

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risks due to potential deficiencies in format of sight tests, risks might arise from barriers to accessing timely eye care if certain formats of sight tests were unduly restricted.

### ***Proposed updated statement on testing of sight***

21. An earlier version of the proposed updated statement was shared with Council at the public meeting in December. Changes made since then include:
  - underlining that whatever format of sight test is used, the care, wellbeing and safety of patients must always be the first concern, and registrants must always act in the best interests of the patient;
  - clarifying the different responsibilities of individual and business registrants;
  - making a distinction between delegation and assistance;
  - strengthening the emphasis on patients in vulnerable circumstances;
  - removing the text copying the current version of standard 9 to avoid confusion given we propose changes in the draft consultation; and
  - moving text and minor drafting amendments to improve flow.
  
22. The proposed updated statement sets out, in relation to pre-screening checks, that the Opticians Act and associated regulations allow an optometrist (or registered medical practitioner) to delegate some parts of the sight test to a suitably trained person (such as a dispensing optician or a non-registrant), provided the optometrist remains in overall control of the process and oversees the task(s) being carried out. This represents a change from our 2013 statement, which states that no part of the sight test can be delegated to a dispensing optician or contact lens optician, even under supervision.
  
23. In relation to separation of sight test components, the proposed updated statement sets out that the law permits separation of the components of the sight test by time, person and/or place, and does not restrict the types of equipment, products or technology that registrants may use. This reflects the GOC's longstanding position and therefore we are not asking Council to change its view here.
  
24. Paragraph 9 of the draft updated statement states we are not satisfied that subjective refraction<sup>5</sup> can be safely delegated and therefore no-one else should refract for the purposes of the sight test. Council considered whether dispensing opticians should be permitted to refract for the purposes of the sight test as part of the 2022 call for evidence on the Opticians Act and consultation on GOC associated policies<sup>6</sup>. The Association of British Dispensing Opticians (ABDO) has indicated that it wishes us to revisit this issue given advances in technology. Given Council's decision was recent and followed an extensive evidence collection and stakeholder engagement exercise,

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<sup>5</sup> A technique used to determine the prescription of a lens for correcting a patient's vision based on the patient's personal feedback about the clarity of the successive lenses shown to them.

<sup>6</sup> For further information, see paragraphs 107-116 of our [GOC response to call for evidence on the Opticians Act and consultation on GOC associated policies](#) (2023)

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we do not plan to revisit this issue now. We may wish to review our position in future and any consultation feedback we receive will inform our thinking on this.

25. The Delphi study in the [research report](#) on a risk-based framework for the testing of sight was characterised by lack of consensus around benefits and risks but usefully highlights the range of potential benefits and risks (see annex 5). To help mitigate the main risks identified in this study, the proposed updated statement sets out some key principles which aim to support responsible innovation and protect the public. In summary, these are:
- the burden is on the registrant to demonstrate that the format of sight test they use is safe (including appropriate technology in place to support it) and creates an expectation that it is subject to ongoing audit/evaluation;
  - separation of the sight test by time, person and/or place should be assessed based on risk – it is unlikely to be suitable for all patients;
  - protocols should be in place to determine before the appointment whether the format of sight test is suitable for the patient (risk stratification) and to deal with situations that arise during the appointment where it becomes apparent that the format is no longer appropriate for the patient;
  - ensure that patients are aware of the format of sight test they are being offered prior to the sight test, so that they can exercise choice and appropriately give informed consent (or otherwise);
  - ensure that staff involved in any components of the sight test (including those that are assisting optometrists or those that optometrists delegate to) are appropriately trained and qualified;
  - ensure that all relevant legal and regulatory requirements are complied with including ensuring that a spectacles prescription is not issued until all statutory components of the sight test are complete;
  - ensure patient choice and informed consent; and
  - considerations relating to patients in vulnerable circumstances, including in relation to choice, consent and suitability of sight test formats.
26. Consistent with PSA guidance, we consider that the proposed updated statement aligns with right-touch regulation principles and is using the minimum regulatory force necessary to address a potential emerging risk. The section on separation of sight test components draws on our statement on the use of technology and sight testing frequently asked questions (FAQs) that we produced during the COVID-19 pandemic. We consider that the proposed updated statement strikes the right balance between supporting responsible innovation, protecting the public and maintaining public confidence in the professions and businesses we regulate, as outlined in our [Corporate Strategy 2025-30](#).
27. It is possible to envisage tighter restrictions, for example, prohibiting separation of sight test components for patients within given age ranges or other characteristics. However, such a strict approach carries risks, for example, removing options that

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might benefit certain patient groups, and moves away from an outcomes-focused approach to regulation.

28. Some stakeholders may prefer us to prohibit separation of sight test components altogether. Even though our longstanding view is that the law allows separation, Council could choose to exercise its standards setting function to prohibit separation on public protection grounds. Since the law allows such separation and prohibition would constitute a significant regulatory intervention, the evidence threshold for taking this step would be high. In the executive's view, this evidence threshold has not been met to justify making such a proposal, although it is possible consultation responses may produce evidence that changes our view. Should Council take a different view at today's meeting, and prefer to consult on prohibiting separation, we would return to a future Council meeting with revised proposals for public consultation purposes that would give effect to this position, along with an analysis of risk and impacts of such an approach.
29. Should Council ultimately approve an updated statement following consultation, we intend to review the statement no later than five years after it is approved. We would initiate a review sooner than this should circumstances require.

### ***Proposed revisions to supervision and delegation standards***

30. When undertaking the 2023/24 Standards Review, we left standard 9 on supervision and delegation unchanged pending the outcome of our review of the 2013 statement. Standard 9 relates to everything that registrants do, not just testing of sight.
31. [Standard 9.3](#) says that adequate supervision requires registrants to "*be on the premises, in a position to oversee the work undertaken and ready to intervene if necessary in order to protect patients*". Developments such as teleoptometry open the issue of whether the standard should allow remote models of supervision.
32. Given one apparent driver for this format of service delivery is less availability of optometrists in some geographic locations, it is possible requiring a registrant to be on the premises might stifle innovation or create unnecessary barriers to accessing care. Alternatively, a requirement for a registrant to be on the premises might be considered an essential public protection safeguard, especially in the early stages of teleoptometry adoption.
33. There were mixed views at the Standards/Companies Committee discussion in November 2025. Some members highlighted the geographic access issue arguing that sight test appointments offering teleoptometry, supported by remote oversight and effective referral pathways in case an issue is identified, might protect the public better than not being able to provide an appointment at all. However, others urged caution given the emerging nature of the technology, concern a remote optometrist may not pick up on subtle clues, the benefits of staff interacting in-person to discuss

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patient issues in real time, and the lack of an alternative to abandoning appointments where it emerges that the remote format is not suitable for the patient.

34. The Delphi research touched on this issue only briefly. The public/patient research found mixed views on this question. Many participants were comfortable with the idea of a technician supporting sight tests with the optometrist supervising remotely, while others felt strongly that an optometrist should be physically present. Some questioned why the current requirement in the standard should be relaxed.
35. The draft consultation contains two alternative options for oversight of unregistered colleagues undertaking delegated activities:
  - Option 1 provides for remote oversight of unregistered colleagues undertaking delegated activities if another optometrist or dispensing optician (depending on the activities to be delegated) is on the premises.
  - Option 2 provides for remote oversight of unregistered colleagues undertaking delegated activities with no requirement for a registrant to be on the premises. However, the registrant delegating activities must still be able to oversee the work undertaken and intervene if necessary to protect patients.
36. In terms of practical application of the standards, we consider that while a registrant who delegates activities to appropriately trained and qualified colleagues retains accountability for those activities, they would not typically be required to directly monitor the delivery of the activities being delegated. Standard pre-screening activities (such as intraocular pressure checks or retinal photographs/scans) are examples. However, in the course of the delegated activities being undertaken, there might be occasions where intervention is required, for example, where an intraocular pressure (IOP) assessment has been delegated and there are unexpectedly high or inconsistent results (an optometrist on site may seek to verify the reading).
37. Not all situations where non-registered colleagues are involved in a sight test would constitute delegation. For example, we do not consider an optometrist instructing a technician to operate a slit lamp, where the optometrist is making all the judgements and is conducting the procedure, as meeting this definition. Instead, we view the technician as assisting the optometrist with the procedure. However, when a technician is asked to complete pre-screening activities, albeit with an optometrist remaining in overall control, assessing the results and exercising judgement, we would consider these to be delegated activities.
38. To pursue option 2, we would need to be confident that issues could be identified and responded to satisfactorily with remote oversight only. It also raises the question of whether assessing a patient entirely from imaging on screens, which the person overseeing tasks remotely would be limited to, would be sufficient to identify and/or diagnose conditions requiring intervention. For remote oversight to work effectively, it must rely on patient safety interventions that do not depend on another registrant

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being physically present, for example, referring a patient to an alternative location such as a secondary care facility.

39. As with the draft updated position statement, in considering these issues, Council's decision making should be rooted in its overarching public protection statutory objective, evidence-based and guided by right touch regulation principles.
40. Reflecting the advice of the joint meeting of Companies, Education and Standards Committees on 22 May 2026, the consultation document is neutral on the two options provided, asking respondents for views on the main benefits and risks of each option, as well as any suggestions for alternative wording.

### ***Optical students***

41. Standard 9 applies to the supervision of both a) pre-registration trainees (students) and b) unregistered colleagues undertaking delegated activities. To improve clarity, we consider there is merit in separating out supervision of students from unregistered colleagues in the standards. Our stakeholder engagement and commissioned research has identified strong consensus that remote supervision of optical students should not be permitted. This reflects that students need closer oversight due to their limited clinical experience and to respond adequately where urgent or emergency escalation may be required. Therefore, in the case of optical students, we propose to retain the current requirements for a registrant to be on the premises, in a position to oversee the work undertaken and ready to intervene. This is also consistent with our existing policy on supervision of students which forms part of our approach to quality assurance of education and training qualifications.
42. Pre-registration trainees are subject to our Standards for Optical Students. Standard 8 does not contemplate students delegating activities and we do not see a need to change this. Some minor drafting amendments are proposed to improve clarity.

### ***Latest advice from statutory committees***

43. The Companies, Education and Standards Committees met on 22 May to consider the draft updated statement and draft proposals on revisions to the standards. The draft minute of the discussion is elsewhere on the agenda.

### ***Other factors***

44. The Department for Transport's consultation on mandatory sight tests for older drivers may have implications for future formats of sight tests, in particular, options where unregulated professionals and organisations may be permitted to conduct tests of sight for the purpose of establishing fitness to drive.

## **Finance**

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45. We are within budget for this work (utilising existing resources within the Policy and Standards team) and are not requesting any additional budget for this financial year. Any updates to our statement and/or standards can be managed in-house.

### Risks

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46. The key risk is that we fail to protect the public in a proportionate way by striking the wrong regulatory balance in the drafting of the proposed updated statement and revisions to our standards of practice. A disproportionate approach applying too great a regulatory force could deter innovation and have the effect of restricting registrants' ability to select an appropriate format for sight testing that would deliver benefits for patients and others. Alternatively, retaining the existing 2013 statement, or replacing it with a statement with insufficient safeguards could lead to registrants offering formats of sight tests that might harm patients (e.g. missed diagnosis) and undermine public confidence. The best mitigation is our careful approach to evidence gathering and stakeholder engagement activities, including the planned public consultation. Designing a regulatory approach that is outcomes-focused has the benefit of describing within an updated position statement the broad regulatory parameters within which registrants can innovate responsibly.
47. There may be differing legal interpretations of the Act in relation to delegation, supervision and/or separation of the components of the sight test. One stakeholder has indicated a difference of interpretation of the legislation and their willingness to challenge us in the courts, as necessary. An adverse judgment could have wider implications for long established custom and practice in sight testing which may cause significant disruption in the sector and create an urgent need for legislative change.
48. As with all decisions of Council, the risk of challenge is at each of Council's decision points: the decision to consult, and following consultation, the decision to approve. At this point Council is being asked to decide whether to consult on a proposed updated statement and revisions to our standards of practice. A decision not to consult (i.e. to retain the 2013 statement and the existing standards) is also challengeable, noting the outcome of the policy development phase of the review is that the statement no longer reflects modern clinical practice or developments in case law<sup>7</sup>.
49. In relation to legal risk, a key mitigation here is that all our policy development and decisions of Council are informed by appropriate advice, including advice from Council's committees. Further, our work is aligned to our consultation policy which describes at what point we should consult on proposals.

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<sup>7</sup> An issue in *Mazur v Charles Russell Speechlys LLP [2026] EWCA Civ 369* was whether a judge had been right to hold that unauthorised persons were carrying on the conduct of litigation if they did acts that constituted the conduct of litigation under the supervision of an authorised individual. The Court of Appeal said (paragraph 21) that the words 'conduct of litigation' referred to the tasks undertaken whilst the words 'carry on' referred to direction, control of, and responsibility for, those tasks.

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50. There is concern in the sector that allowing separation of sight test components could unravel a key defining feature of sight tests UK-wide in that they include both eye health and vision checks. We do not wish to undermine this feature of sight testing through our policy choices, and the proposed updated statement reinforces the legal requirement for sight tests to include both eye health and vision checks and sets out that a spectacles prescription cannot be issued until all statutory components of the sight test are complete.
51. There is a risk in relation to pace. June 2026 marks the third anniversary of Council deciding to review the 2013 statement and further delay risks the work being overtaken by events and/or reputational damage. Since we consider the proposed updated statement would enhance public protection by setting out key safeguards around consent, risk stratification and other matters, unnecessary delay risks failure to prevent harm. There is the prospect of both new entrants to the market and existing businesses evolving new formats of service delivery utilising emerging technology to meet patient needs. It is therefore important to proceed carefully but also at reasonable pace.
52. There is also a risk that stakeholders might consider our evidence base insufficient to justify any revisions to the statement or the standards now. To mitigate this risk, there have been regular communications with stakeholders seeking to build understanding and consensus, including the stakeholder roundtable we held on 14 October 2025, the output of which informed the drafting of our proposed updated statement. The consultation exercise seeks views on benefits and risks, and evidence on the safety and efficacy of different formats of sight tests, which will inform the final statement and any changes to the standards. However, this issue is contentious, the future cannot be predicted with certainty, and evidence gaps are inevitable given these are new and evolving formats of service delivery. In this context, the best mitigation is to apply sound regulatory principles, as set out in the PSA's right-touch regulation guidance, in deciding which approach would strike the right balance.

## **Equality Impacts**

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53. We have completed an impact assessment (annex 2) to sit alongside the consultation document. This describes possible impacts on separation of the sight test by time, person and/or place in respect of those with protected characteristics, particularly when considering age (children and older adults) and disability.
54. We know that protected characteristics have an impact on the way in which people access and experience eye care services. Our 2025 public perceptions survey found that those aged 25-34 (5%) and ethnic minorities (6%) are more likely to state they have never had a sight test (vs. 3% overall). The survey also continues to show that those with one or more vulnerability markers are less likely to go for a sight test every two years and are generally less confident in managing their eye health. Sight tests

## **PUBLIC**

using teleoptometry are likely to have greatest positive impacts in rural and coastal communities where workforce pressures are most acute.

### **Devolved nations**

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55. There may be some formats of sight tests (e.g. remote/virtual) that are not permitted within the NHS General Ophthalmic Services (GOS) contracts in one or more of the UK nations by virtue of other guidelines/NHS contract terms. As noted above, we have no role in these decisions, which are informed by non-regulatory factors.

### **Other Impacts**

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56. There may be legislative impacts as outlined above.

### **Communications**

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#### **External communications**

57. We are keeping key stakeholders updated through our two-monthly Optical Sector Policy Forum, meetings with sector body CEOs and our meetings with the UK optometric advisers. As mentioned above, we held a roundtable for stakeholders to discuss our research and principles for a proposed updated statement on 14 October 2025 and held meetings with sector bodies in May and June 2026. We now wish to progress to public consultation on our proposed updated statement. Should Council approve a consultation package, we plan to brief relevant parliamentarians, devolved administrations, Department for Health and Social Care, and NHS bodies. We will continue to keep the PSA informed of developments and they may choose to respond to the consultation.
58. While this Council paper deals with some technical regulatory matters, it goes to the heart of professional practice and may understandably cause anxiety for registrants. Should Council approve the recommendations, we plan to issue a blog aimed at registrants explaining the approach we are taking and encouraging their engagement with the consultation exercise. This will seek to reassure registrants on several points including that: sight tests must continue to include vision and eye health checks; our approach on delegation reflects modern clinical practice; the proposals reinforce the central role of optometrists remaining in overall control of the sight test; and fair allocation of responsibilities between individual and business registrants.
59. Following a request to allow for extra time due to the summer period we intend to consult for 14 (rather than our usual 12) weeks.

#### **Internal communications**

60. We are keeping relevant internal stakeholders updated through our intranet and individual meetings/SMT as appropriate.

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### **Next steps**

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61. We intend to carry out the following next steps:

- public consultation on proposed updated statement and proposed revisions to supervision/delegation standards for 14 weeks from July to October 2026 (following translation of the consultation document into Welsh and uploading to our consultation platform);
- analysis of consultation and preparation of GOC response and updated statement and any revisions to standards in October 2026 to January 2027;
- seek advice from statutory advisory committees on 12 February 2027;
- approval of proposed GOC response to consultation and proposed updated statement and any revisions to standards at public Council in March 2027; and
- publication of revised statement and any revisions to standards in the month following approval at public Council.

### **Attachments**

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Annex 1 – Draft consultation document (including proposed updated testing of sight statement and proposed revisions to supervision and delegation standards)

Annex 2 – Draft impact assessment

Annex 3 – Current 2013 statement on testing of sight

Annex 4 – Right-touch regulation principles, regulatory force diagram and types of harm

Annex 5 – Extract from Delphi study on benefits and risks

## Annex 1

# **Consultation on (i) proposed updated testing of sight statement and (ii) proposed revisions to supervision and delegation standards in our Standards of Practice for Optometrists and Dispensing Opticians and Standards for Optical Students**

**XXXX 2026**

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## Overview

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### What we're doing

1. The General Optical Council (GOC) is the regulator for the optical professions 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 our April 2023 [response](#) to our call for evidence on the Opticians Act 1989 and consultation on associated GOC policies, we said that we would consider updating our [2013 statement on testing of sight](#) to clarify the position in relation to pre-screening tests related to the sight test (referred to as 'eye examination' in Scotland) that may be carried out by persons other than the optometrist or registered medical practitioner. We also said that we were aware of businesses that separated elements of the sight test by time, person and/or place, and that we would consider these developments in more detail.
4. Our approach to this issue is grounded in our overarching statutory objective to protect the public. We aim to support responsible innovation while protecting the public and maintaining public confidence in the professions and businesses we regulate, as outlined in our [Corporate Strategy 2025-30](#). We consider that an updated statement will allow us to put appropriate safeguards in place to protect the public as well as make our expectations for registrants clear.
5. We have produced a proposed updated statement on testing of sight which we would like stakeholders' views on. While producing the proposed updated statement, we considered whether any changes were needed to our [Standards of Practice for Optometrists and Dispensing Opticians](#) and [Standards for Optical Students](#) on supervision and delegation, particularly in relation sight tests where an optometrist is not in the same room as the patient (a 'remote'

type of care known as teleoptometry). We have drafted options for changes to the standards which we would also like stakeholders' views on.

6. This consultation will be open from **XXXX to XXX**. You can respond either using our online consultation platform or by emailing [consultations@optical.org](mailto:consultations@optical.org).

### **What will happen next?**

7. The public consultation will be open for 14 weeks.
8. Once the consultation has closed, we will analyse all the comments we have received and identify how to progress our proposals for updating the statement on testing of sight. We will produce a document summarising the responses we receive to the consultation and, if appropriate, an updated statement and standards. We will ask our Council to approve these prior to publication.

## Section 1: Updated 2013 statement on testing of sight

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9. In 2013 we published a [statement on testing of sight](#) in response to concerns from the sector about who could conduct the sight test and whether refraction for the purpose of issuing a prescription could be conducted outside the sight test.
10. In 2022 we carried out a call for evidence on the Opticians Act and consultation on associated GOC policies. In our March 2023 [response document](#), we made a number of commitments, including:
  - pre- and post-screening checks (paragraph 115): *“We will consider updating our 2013 statement on testing of sight to clarify the position in relation to pre-screening tests and triage checks related to the sight test that may be carried out by persons other than the optometrist or registered medical practitioner. Over time, advances in technology have meant various steps in the patient journey have become automated and safely delegated as part of pre-screening and triage. Use of autorefractors is one example of this and we understand further developments, including in relation to refraction, are on the horizon. If we decide to update our 2013 statement, we will carry out further consultation on this aspect of the testing of sight.”*; and
  - separation of sight test components (paragraph 116): *“Our interpretation is that the Act does not specifically prohibit separation of the elements of the sight test by time, place or person. Business models are evolving alongside developments in technology. While relevant to refraction, this issue relates more generally to how the sight test is conducted, rather than which type of optical professional should perform different elements of the sight test. The call for evidence identified a range of views about this and we plan to consider developments in more detail. Depending on the outcome of this work, we may clarify our position in a statement or seek a change in the law.”*

### Pre- and post-screening checks

11. The Opticians Act 1989 and the Testing of Sight by Persons Training as Optometrists Rules 1993 provide that testing of sight can only be conducted by an optometrist, registered medical practitioner or a student optometrist under supervision. Our 2013 statement includes the wording, *“No part of the sight test can be delegated to a dispensing optician or contact lens optician, even under supervision.”* The statement is silent on delegation to other staff such as optical assistants.

12. Research we commissioned in 2023<sup>1</sup> found that 11 of the 15 participants representing a variety of optical settings (including large corporate bodies, domiciliary, and independent sectors) used support staff (typically optical assistants) for pre- and post-screening tests (described as intraocular pressures, visual fields, retinal photos/scans). We understand this practice has been happening for many years reflecting developments in technology.
13. We know that some stakeholders interpret our 2013 statement on the testing of sight to mean that pre- and post-screening checks cannot be delegated because they consider these to be part of the sight test, whereas others consider that these can be delegated as they are prior to / after the sight test. GOC position statements can help support registrants by setting out how legislation may apply in the current legal, social and technological context.
14. Given developments in technology and service delivery since 2013, we propose to update the statement to reflect the changed environment and provide greater clarity for registrants about our expectations. Specifically, the proposed updated statement says that an optometrist<sup>2</sup> may delegate some parts of the sight test to a suitably trained person (such as a dispensing optician or a non-registrant), provided the optometrist remains in overall control of the process and oversees the task(s) being carried out.
15. A Delphi study as part of research we commissioned in June 2024<sup>3</sup> found consensus that certain sight test components could be safely delegated: *“The delegation of eye test components to appropriately qualified individuals was also considered... Components that were deemed suitable for delegation were presenting vision (low risk only), objective fundus assessment, OCT [optical coherence tomography scan], IOP [intraocular pressures], and visual fields. This is, in part, reflecting current protocols in optometric practice, where appropriately trained individuals, e.g. support staff such as optical assistant, carry out a range of objective and non-invasive tests.”*
16. Since this practice has been commonplace for some time and the Delphi study produced consensus that such procedures can be safely delegated, we have prepared a proposed updated statement (see annex 1). This will support optometrists to discharge their responsibilities by delegating these activities to others (pointing to relevant parts of our [Standards of Practice for Optometrists and Dispensing Opticians](#), such as standard 9 regarding “unregistered colleagues undertaking delegated activities”). The proposed updated statement

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<sup>1</sup> Evans, B., Shah, R., Conway, M. and Chapman, L. (2023), *Clinical research on refraction in the sight test*

<sup>2</sup> Or registered medical practitioner

<sup>3</sup> Jonuscheit, S. et al. (2025), [‘Testing of sight - a risk-based framework: Project report’](#)

also clarifies the responsibilities of business registrants with reference to our [Standards for Optical Businesses](#).

17. This consultation will support us in identifying and determining the likelihood of any risks in relation to the publication of our proposed updated statement materialising, and how to mitigate these risks and/or unintended consequences.
18. We will discuss with the Department of Health and Social Care whether it may be appropriate to update the legislation to provide additional clarity on the delegation of pre- and post-screening checks as part of their programme to reform healthcare regulators' legislation. However, the timetable for legislative change is outside of our control and our understanding is that change to the Opticians Act or associated legislation will not be prioritised within the current parliament.

### **Separation of components of the sight test by time, person and/or place**

19. By separation of the sight test by time, person and/or place, we mean:
  - time: when different components of the sight test are performed across separate appointments (sometimes referred to as asynchronous). For example, pre-test data collection one day, and clinical interpretation or decision-making on another. Future formats of asynchronous care it is possible to foresee could, for example, involve pre-screening assessments in one appointment followed by in-person refraction and eye health checks at a second appointment;
  - person: when multiple individuals (sometimes with different levels of registration or qualification) contribute to different parts of the sight test. In future, sight testing might involve technicians, artificial intelligence-assisted assessments, or clinicians working across distributed systems; and
  - place: when there is physical separation of sight test components by location. For example, data may be collected in a community practice or pre-screening mobile hub, while analysis and decision-making takes place remotely, perhaps in a hospital or diagnostic centre. Some optical businesses are trialling teleoptometry where the patient attends a practice with a technician operating the machinery and the optometrist conducting the examination is in a different location, talking to the technician and patient through a screen, with access to all the results available in real time.
20. As is evident from the examples above, sight tests might evolve in ways that separate one or more elements of time, person or place.
21. While the focus of sector discussions has been on sight testing using teleoptometry, our proposed updated statement would apply to all sight tests that are separated by time, person and/or place. We also need to consider how

sight tests might evolve in future given advances in technology (including the impact of artificial intelligence) and other drivers. This consultation seeks insights on potential future developments in sight testing so that we can consider the regulatory implications of change.

## **QX. How might sight testing continue to evolve in the future?**

### **Understanding the GOC's role and approach**

22. The GOC has a duty to provide guidance on fitness to practise by section 13A of the Act. The 2013 statement constitutes such guidance. Section 13A(4) requires such guidance to be kept under review and revised as appropriate. Given changes in technology and service delivery since 2013, it is appropriate and necessary to review and revise the statement to reflect modern clinical practice.
23. The issues considered in this consultation involve the intersection of law, regulation and NHS contracting arrangements for optical services in the four nations. Overall, the objectives of our review of the 2013 statement and standard 9 are to: provide clarity for registrants by setting out the relevant legislation; support responsible innovation in sight testing formats; and increase public protection by putting appropriate safeguards in place.
24. We do not have any statutory role to pre-approve different formats of sight tests or options for service delivery (although we keep ourselves informed of relevant developments), nor would it be appropriate for us to state a preference for a particular sight testing format or method of service delivery. Optical businesses are free to operate a range of sight testing formats that are consistent with both the relevant legislation and our regulatory arrangements.
25. The design of our legislation is that in exercising our regulatory functions (education and training, registration, standards and fitness to practise) we must pursue our statutory objectives. Our overarching objective is public protection, which in turn involves the pursuit of the following objectives:
  - to protect, promote and maintain the health, safety and wellbeing of the public;
  - to promote and maintain public confidence in the professions we regulate;
  - to promote and maintain proper professional standards and conduct for members of those professions; and
  - to promote and maintain proper standards and conduct for business registrants.

26. In the context of this consultation, we are using our function of maintaining proper standards of professional and business conduct to help us pursue these objectives. While only the courts can decide how the law applies in each situation, we can support registrants through position statements. We also consider an updated statement will allow us to put appropriate safeguards in place as sight testing continues to evolve.
27. In considering these issues we have applied a 'right-touch' approach to regulation in line with guidance from the Professional Standards Authority for Health and Social Care (PSA)<sup>4</sup>, which oversees the UK healthcare regulators. This looks at the level of risk of harm and chooses the most effective and proportionate response, 'doing enough to mitigate the risk to an acceptable level and no more'. The PSA's guidance takes a broad definition of harm to mean 'physical or psychological injury, or other loss or detriment'. Further, we recognise the need for tolerating an appropriate level of risk and that balancing the benefits and risks of change can involve trade-offs.
28. Our proposed updated statement cannot foresee every possible combination of time, person and/or place, or the circumstances in which they might apply, which will change over time. As such, we have deliberately taken an outcomes-focused approach based on key principles. This should help to future-proof the statement although we will review the statement no later than five years after it is approved, or sooner if circumstances require.
29. Approaches to sight testing may be restricted through General Ophthalmic Services (GOS) contracts, but we have no role in such arrangements. NHS commissioners may wish to apply additional restrictions when purchasing optical services from private sector contractors and in doing so they will need to consider a range of non-regulatory factors.

### **Building the evidence base**

30. As service delivery of sight testing evolves, understanding the benefits and risks of separating components of a sight test by time, person and/or place becomes increasingly important.
31. To build our evidence base, we commissioned research with experts and patients, described in paragraphs 32 to 36 below. In addition, we have sought to understand more about changing formats of sight tests in the UK and overseas. This included desk research, observing formats using teleoptometry in practice, and meetings with the Optical Suppliers Association (OSA) and other companies who had developed products/software potentially for use in teleoptometry. In October 2025, we convened a stakeholder roundtable to

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<sup>4</sup> [Right-touch regulation | PSA](#)

discuss the issues. The GOC's statutory advisory committees provided advice to Council at their meetings in November 2025 and May 2026.

32. In 2025, we published independent research on 'Testing of sight: a risk-based framework'<sup>5</sup> which sought to understand the benefits and risks of separating the different components of a sight test by time, person and/or place. It had two main components – a scoping review and a Delphi study (a research method which seeks to build consensus), with differing conclusions from the two parts:
- the scoping review showed a potential for different formats of eye care that involve separation by time, person and/or place to improve eye care delivery through innovation. Benefits included reduction in referrals, reduction in unnecessary hospital eye service (HES) visits, improvements in referral quality and high levels of patient satisfaction. However, it was noted that there were a lack of randomised controlled trials available in the scoping review (seen as the highest-quality study methods) and that careful consideration of economic viability, infrastructure readiness and patient acceptance would be required prior to implementation; and
  - the Delphi panel could not agree on whether there were risks of separating sight test components for patients considered as low risk (a young adult who presents with no complaints, no known risk factors for ocular disease and no previous ocular history), but there was a broad consensus that separation resulted in risk for patients in the higher risk group (e.g. those over 50 presenting with no complaints or previous ocular history but who had additional risk factors for ocular disease).
33. Overall, the study concluded that the separation of sight test components by time, person and/or place may pose some risks for both the NHS and patients. However, in the context of a routine sight test, the likelihood of these risks occurring was considered likely to be low. It also concluded that tailoring eye care to individuals, for example, through considering patients' risk profiles more thoroughly, may offer significant advantages in the prevention, diagnosis and management of ocular conditions. Future studies were recommended to determine if a personalised approach based on patient risk assessment could be considered value for money and cost-effective.
34. We reviewed the studies in the scoping review in the 2025 risk-based framework research related to the theme 'patient satisfaction and acceptability' and considered that further research in this area would be helpful. We therefore commissioned qualitative research into patient and public views into sight testing using teleoptometry, as we consider it important to understand this

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<sup>5</sup> Jonuscheit, S. et al. (2025), ['Testing of sight - a risk-based framework: Project report'](#)

perspective and to gain views on any safeguards that would support public confidence. The research report<sup>6</sup> is published on our website.

35. The research indicated cautious but conditional openness to sight testing using teleoptometry, including the following conclusions:
- teleoptometry was broadly understood once it had been explained and was seen as a logical development to what is happening elsewhere within healthcare and telemedicine;
  - it was viewed as appropriate in specific contexts (including the reason for the appointment) rather than being universally necessary;
  - patient acceptability was conditional based on safeguards (such as qualifications of the technician operating the equipment, suitable technology), communication and giving the patient a choice as to whether or not to participate;
  - patient confidence in teleoptometry depended heavily on trust in regulation, professional standards and clinical oversight; and
  - there was concern from some participants that new approaches could be introduced in ways that reduce quality of care rather than improve it (e.g. the optometrist not being completely focused because they are in a home environment, or the potential for missed pathology or misdiagnosis where an optometrist is not physically present).
36. The research concluded that, *“Many participants recognised the potential benefits of teleoptometry but emphasised that innovation must not come at the expense of quality and patient experience. Overall, teleoptometry was seen as acceptable as an additional option within eye care, when necessary, provided it is introduced carefully, transparently, and with strong safeguards in place.”*

### **Our assessment**

37. In our assessment, changes in service delivery may deliver benefits including improving access for patients in some geographic areas where there are shortages of optometrists, enhancing efficiency for businesses and more flexible working arrangements for registrants. However, it is also possible the changes may introduce new points of vulnerability where clinical oversight, data integrity and accountability are weakened.
38. We consider that updating our position statement and revising our standards on supervision and delegation offers the best approach to mitigating the key risks. In doing so, our aim is to support responsible innovation in sight testing formats

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<sup>6</sup> Enventure Research (2026), ‘Patient views on teleoptometry: Research report’

and increase public protection by putting appropriate safeguards in place. These safeguards aim to address a range of potential harms identified through the evidence collection and stakeholder engagement process, including:

- physical harm, e.g. clinical risks such as missed diagnosis – the proposed updated statement is informed by principles set out in paragraphs 54-56 including the optometrist remaining in overall control of the process, assessing suitability of patients based on risk, the role of clinical audit and evaluation and all staff having appropriate qualifications and training;
- loss of trust and confidence in the profession – as well as safeguards to address risks of physical harm which could impact on trust and confidence the principles emphasise informed patient choice and consent;
- digital exclusion – the principles address patient vulnerability in line with our guidance<sup>7</sup> including specifically where the format of a sight test disadvantages patients who may be less able to engage with remote or technology-enabled approaches and consider alternatives; and
- impacts on professionals and businesses – we foresee some potential for disruption to established ways of working but given the scale of investment required to deliver sight test formats like teleoptometry, this is unlikely to become routine practice at least in the short term.

39. We are aware of stakeholder concerns that separation of sight test components by time, person and/or place could undermine a key feature of UK sight testing in that it combines vision and eye health checks. This feature of UK sight testing delivers significant public health benefits, which we do not wish to undermine through our policy choices. To address this, the proposed updated statement confirms that legislation requires sight tests for the purpose of issuing a prescription to include checks for visual acuity, binocular vision and eye health. It also sets out that a spectacles prescription should not be issued until all statutory components of the sight test are complete.

40. Future developments in sight testing formats cannot be predicted with certainty. Therefore, we will keep the statement under review to respond to new or escalating risks as these emerge. As noted above, should Council ultimately approve an updated statement following consultation, we intend to review the statement no later than five years after it is approved. We would initiate a review sooner than this should circumstances require.

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<sup>7</sup> [Guidance on care of patients in vulnerable circumstances](#)

**QX. What do you see as the main benefits of sight tests involving separation by time, person and/or place?**

**QX. What do you see as the main risks of sight tests involving separation by time, person and/or place?**

**QX. Please provide evidence on the safety and efficacy of sight tests involving separation by time, person and/or place that operate currently.**

### **Proposed updated statement on testing of sight**

41. Having considered the information collected to date, we have produced a draft updated statement (annex 1) for consultation. The proposed updated statement is divided into five sections which we outline below.

#### *Section 1 – Introduction*

42. The introduction clarifies that the scope of the proposed updated statement relates to the testing of sight. We have considered whether the proposed updated statement should apply more widely than sight testing given that other eye care services provided by registrants are capable of being delivered remotely, for example, managing long-term conditions. However, we have restricted the proposed updated statement to sight testing since this has a specific remit within the law, is the focus of stakeholder debate and is where there is most scope for market disruption. In addition, there is already guidance from healthcare regulators<sup>8</sup> and professional/representative bodies on remote consultations and prescribing for registrants to utilise.
43. We recognise that separation of components of the sight test may commonly occur for sound clinical reasons. For example, separating the sight test by time may be necessary for uncooperative children, patients requiring cycloplegic refraction or dilated internal eye examinations, or vulnerable adults who cannot tolerate a full examination in one session. The focus of the proposed updated statement is not on such scenarios but instead where separation is a core design feature of a sight test routinely operated by the business.

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<sup>8</sup> [High level principles for good practice in remote consultations and prescribing](#)

44. Paragraph 2 of the proposed updated statement reaffirms existing legislative requirements that sight tests for the purpose of issuing a prescription must include checks for visual acuity, binocular vision and eye health and why this is important for early identification of eye health conditions.

### *Section 2 – Sight testing legislation*

45. The second section of the proposed updated statement highlights key provisions of the relevant legislation, namely the Opticians Act 1989 and The Sight Testing (Examination and Prescription) (No. 2) Regulations 1989.

### *Section 3 – Delegation of activities for the sight test*

46. Paragraph 6 sets out that an optometrist may delegate some parts of the sight test to a suitably trained person (such as a dispensing optician or a non-registrant), provided the optometrist remains in overall control of the process and oversees the task(s) being carried out.
47. Paragraph 7 gives examples of tasks that can be safely delegated drawing on the evidence of the commissioned research.
48. Paragraphs 8 and 9 relate to refraction (a check for visual acuity sometimes referred to as a vision check or refractive error). We set out that refraction carried out for the purpose of issuing a prescription is a restricted activity, but refraction for other purposes (e.g. verifying a prescription when fitting spectacles) is not restricted. We state that we are not satisfied that subjective refraction can be safely delegated and therefore no-one else should refract for the purposes of the sight test. This refers to a Council decision in March 2023<sup>9</sup>, which followed public consultation and a detailed review of this matter. We are not seeking views on this issue as part of this consultation.
49. Paragraphs 10 and 11 remind registrants of our standards of practice relating to supervision and delegation. These issues are considered further in section 2 of the consultation document.

### *Section 4 – Separation of the sight test by time, person and/or place*

50. Paragraph 13 sets out that the Act permits separation of the components of the sight test by time, person and/or place, and does not restrict the type of equipment, products or technology that can be used by registrants.
51. Paragraph 14 sets out the responsibilities of optometrists when delegating or using technology or equipment, making clear that the care, wellbeing and safety of patients must always be the first concern, and that registrants must always act in the best interests of the patient.

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<sup>9</sup> See page 16 onwards [20230322-public-council-meeting-meeting-papers-mar23.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/114444/20230322-public-council-meeting-meeting-papers-mar23.pdf)

52. Paragraph 15 sets out that where more than one optometrist conducts different components of the sight test, it will be the responsibility of the optometrist conducting the most recent components to assure themselves that previous components were conducted appropriately and, if not, to repeat those components. We consider this is necessary to ensure all components of the sight test have been completed satisfactorily and that the optometrist is able to take a holistic approach assessing all the information that should be available.
53. Paragraphs 16 to 18 outline safeguards which we consider are necessary to support responsible innovation and protect the public. They draw on our statement on the use of technology that we produced during the COVID-19 pandemic.
54. Paragraph 16 sets out the responsibilities of the business registrant to ensure that the sight test format is safe, including to:
- demonstrate that the format of sight test is safe (including appropriate technology in place to support it) and creates an expectation that it is subject to ongoing audit/evaluation, particularly where the sight test is separated by two or more dimensions of time, person and/or place;
  - put in place protocols and service specifications to determine before the appointment whether the format of sight test is suitable for the patient (risk stratification) and to deal with situations that arise during the appointment where it becomes apparent that the format is no longer appropriate for the patient; and
  - ensure that staff involved in any components of the sight test (including those that are assisting optometrists or those that optometrists delegate to) are appropriately trained and qualified.
55. Paragraph 17 sets out responsibilities that apply to both the business registrant and the optometrist, including:
- be able to clinically justify the reasons for any separation of sight test components by a significant period of time;
  - ensure that all relevant legal and regulatory requirements are complied with including ensuring that a spectacles prescription is not issued until all statutory components of the sight test are complete;
  - ensure that patients understand the format of sight test they are being offered prior to the appointment, so that they can exercise choice and appropriately give informed consent (or otherwise);
  - considerations relating to patients in vulnerable circumstances, including in relation to choice, consent and suitability of sight test formats; and

- recognising that that different formats of sight test may affect patient experience as well as clinical safety.
56. Where separation of sight test components takes place, we consider that the strength of governance is key and that formats which separate more than one sight test component should meet higher standards of assurance, audit and oversight (paragraph 16, first bullet). While there is an absence of research evidence on the relative risks, stakeholders have suggested that some aspects of separation of sight test components are riskier than others, especially time. We have therefore added reference to separation by a 'significant period of time' in the proposed updated statement (paragraph 17, first bullet).
57. Paragraph 18 reinforces that individual registrants must make the care of their patients their first and overriding concern. The bullets set out a range of factors that registrants should consider when exercising their professional judgement.
58. Paragraph 19 reminds registrants of the following principle contained in our Standards of Practice for Optometrists and Dispensing Opticians: *"You are professionally accountable and personally responsible for your practice and for what you do or do not do, no matter what direction or guidance you are given by an employer or colleague. This means you must always be able to justify your decisions and actions."*

#### Section 5 – Standards of practice

59. Section 5 of the proposed updated statement lists our relevant [standards of practice](#). Our enforcement approach will recognise that decisions on the design of sight tests and operating protocols will be made by optical businesses whereas other decisions will sit with individual registrants exercising clinical judgement, for example, deciding if the format is suitable for a patient.

**QX. Please comment on the content of the proposed updated statement on testing of sight in relation to delegation of activities for the sight test.**

**QX. Please comment on the content of the proposed updated statement in relation to separation of the sight test by time, person and/or place.**

**QX. If you consider that additional safeguards are needed to protect the public, please provide details here.**

**QX. Please identify any sections of the proposed updated statement that could be made clearer and describe how.**

**QX. Please detail any other comments on the proposed updated statement on testing of sight not covered above.**

## Section 2: Updates to standards on supervision and delegation

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60. When we reviewed our [Standards of Practice for Optometrists and Dispensing Opticians](#) and [Standards for Optical Students](#) in 2024, we considered changes in technology and made updates to ensure that registrants keep updated on developments in digital technologies and apply their professional judgement when utilising the data they generate to inform decision making.
61. In our [response](#) to the consultation on our standards of practice we said that we would review standard 9 on supervision once the review of our 2013 statement on testing of sight had been completed. Since the position statement and standards are interlinked, we wish them to come into effect at the same time. Therefore, we have reviewed our supervision standards – standard 9 of the [Standards of Practice for Optometrists and Dispensing Opticians](#) and standard 8 of the [Standards for Optical Students](#) – and are proposing some changes be made. We consider issues relating to the supervision of students and the oversight of unregistered colleagues undertaking delegated activities in turn.

### *Supervision of pre-registration trainees (students)*

62. The consensus among healthcare regulators seems to be that the supervisor must determine the amount of supervision required by students in each case, according to the trainee's level of skill/experience and the procedure's risk/complexity.
63. We are not aware of any evidence to support remote supervision of students. Students need closer oversight due to limited clinical experience and to respond adequately where urgent or emergency escalation may be required. There was also consensus at our stakeholder roundtable on testing of sight in October 2025 that the risks for supervision of students are higher than when delegating tasks to colleagues.
64. In our 2023 patient and public research to inform the Standards Review, respondents *“became particularly uncomfortable when considering the scenario of a student optometrist being supervised remotely.”*
65. Given the apparent consensus, we consider there is merit in separating out supervision of students from unregistered colleagues in the standards and that the current requirements for a registrant to be on the premises, in a position to oversee the work undertaken and ready to intervene, should remain for the supervision of students. This is consistent with our policy on supervision of students, which forms part of our approach to quality assurance of education and training qualifications<sup>10</sup>.

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<sup>10</sup> Supervision policy [for Education Providers](#)

66. We also think the circumstances in which a student might formally delegate tasks other than routine, low-risk tasks are limited. Standard 8 of the Standards for Optical Students does not contemplate students delegating activities and we do not see a need to amend this. Note that some drafting amendments to standard 8 of the Standards for Optical Students have been proposed to improve clarity.

**QX. What do you see as the main benefits of the proposed amendments to standard 8 of the Standards for Optical Students and why?**

**(Please provide evidence to support your views.)**

**QX. What do you see as the main risks of the proposed amendments to standard 8 of the Standards for Optical Students and why?**

**(Please provide evidence to support your views.)**

**QX. Please provide any suggestions for alternative wording here.**

*Oversight of unregistered colleagues undertaking delegated activities*

67. The draft updated position statement sets out that the Opticians Act and associated regulations allow an optometrist (or registered medical practitioner) to delegate some parts of the sight test to a suitably trained person (such as a dispensing optician or a non-registrant), provided the optometrist remains in overall control of the process and oversees the task(s) being carried out. The Delphi study we commissioned<sup>11</sup> found consensus that certain sight test components could be safely delegated.
68. The key question we seek to resolve in respect of standard 9 is whether the current requirement for a registrant to be on the premises, in a position to oversee the work undertaken and ready to intervene if necessary in order to protect patients, should remain. Considering teleoptometry as an example, given one driver for this format of service delivery is less availability of optometrists in some geographic locations, it is possible that requiring a registrant to be on the premises might stifle innovation or create unnecessary barriers to accessing care. Alternatively, some stakeholders may view a requirement for a registrant to be on the premises as an essential public protection safeguard, especially in the early stages of teleoptometry adoption.

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<sup>11</sup> [Testing-of-sight-a-risk-based-framework-FINAL-20250701.pdf](#)

69. The Delphi research we commissioned on testing of sight<sup>12</sup> touched on supervision but did not come to any conclusions in this area.
70. Our 2023 patient and public research to inform the Standards Review (which did not address teleoptometry specifically)<sup>13</sup> found that, *“Respondents were comfortable with delegation.... However, they have mixed expectations around supervision and were particularly wary of remote supervision.”* The research also highlighted that, *“Respondents had high expectations for supervision – expecting the supervisor to always be in the room or on the premises”* and *“In general, respondents were unable to imagine how remote supervision could be conducted effectively.”*
71. The research published alongside this consultation on patient and public views on sight testing using teleoptometry found mixed views on remote supervision and the requirement to have an optometrist on the premises. Many participants were comfortable with the idea of a technician supporting sight tests conducted by a remote optometrist, while others felt strongly that an optometrist should be physically present. Some questioned why the current requirement in the standard should be relaxed.
72. We consider that while a registrant who delegates activities to appropriately trained and qualified colleagues retains accountability for those activities, they would not typically be required to directly monitor the delivery of the activities being delegated. Standard pre-screening activities (such as intraocular pressure checks or retinal photographs/scans) are examples. However, in the course of the delegated activities being undertaken, there might be occasions where intervention is required, for example, where an intraocular pressure assessment has been delegated and there are unexpectedly high or inconsistent results (an optometrist on site may seek to verify the reading).
73. Not all situations where non-registered colleagues are involved in a sight test would constitute delegation. For example, we do not consider an optometrist instructing a technician to operate a slit lamp, where the optometrist is making all the judgements and is conducting the procedure, as meeting this definition. Instead, we view the technician as assisting the optometrist with the procedure. However, when a technician is asked to complete pre-screening activities, albeit with an optometrist remaining in overall control, assessing the results and exercising judgement, we would consider these to be delegated activities.
74. The two options we propose for oversight of unregistered colleagues undertaking delegated activities are:

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<sup>12</sup> [Testing-of-sight-a-risk-based-framework-FINAL-20250701.pdf](#)

<sup>13</sup> Shift Insight (2023), General Optical Council: [Research on public perceptions of the Standards of Practice for Optometrists and Dispensing Opticians, and the Standards for Optical Students](#)

- Option 1 provides for remote oversight of unregistered colleagues undertaking delegated activities if another optometrist or dispensing optician (depending on the activities to be delegated) is on the premises.
- Option 2 provides for remote oversight of unregistered colleagues undertaking delegated activities with no requirement for a registrant to be on the premises. However, the registrant delegating activities must still be able to oversee the work undertaken and intervene if necessary to protect patients.

75. As a reminder, the standards apply to all situations, not just sight tests separated by time, place or person.

76. Each of these options is described more fully, below.

*Option 1 – provides for remote oversight of unregistered colleagues undertaking delegated activities if another optometrist or dispensing optician (depending on the task to be delegated) is on the premises.*

*Proposed wording: “When delegating activities to an unregistered colleague, you must be able to oversee the work undertaken and ready to intervene if necessary to protect patients. If you are overseeing an unregistered colleague undertaking delegated activities remotely<sup>14</sup>, you must ensure that another registrant, who is qualified and experienced to undertake the delegated activities, is on the premises and ready to intervene if necessary to protect patients.”*

77. This formulation provides for a registrant to remotely oversee an unregistered colleague who is undertaking delegated activities while retaining the requirement for a registrant to be on the premises, in case a situation required hands-on intervention. This option would allow for a registrant in a different location to delegate tasks to a technician, for example. If the registrant overseeing the work undertaken thinks intervention is required, they would be able to exercise their clinical judgement and trigger escalation or referral pathways or seek hands-on intervention from a suitably qualified and experienced registrant on the premises.

**QX. What do you see as the main benefits of option 1 and why?  
(Please provide evidence to support your views.)**

<sup>14</sup> Remote means being in a location that is different to where the patient is receiving treatment, rather than face-to-face in the same location.

**QX. What do you see as the main risks of option 1 and why?  
(Please provide evidence to support your views.)**

**QX. Please provide any suggestions for alternative wording for option 1.**

*Option 2 – provides for remote oversight of unregistered colleagues undertaking delegated activities with no requirement for a registrant to be on the premises. However, the registrant delegating activities must still be able to oversee the work undertaken and intervene if necessary to protect patients.*

*Proposed wording: “When delegating activities to an unregistered colleague, you must be able to oversee the work undertaken and intervene if necessary to protect patients.”*

78. This formulation provides for a registrant to remotely oversee an unregistered colleague who is undertaking delegated activities without retaining the requirement for a registrant to be on the premises. As with option 1, it would allow for a registrant in a different location to delegate activities (to a technician, for example), exercise their clinical judgement and trigger escalation or referral pathways if necessary. This could involve advising the patient to attend a hospital or making arrangements for another registrant to take over their care in-person in a different location or at a different time.
79. Removing the restrictions that prevent remote oversight without requiring a registrant to be on the premises, requires confidence that any potential problems could be identified and responded to satisfactorily with remote oversight only. It also raises the question of whether assessing a patient entirely from imaging on screens, which the person overseeing tasks remotely would be limited to, would be sufficient to identify and/or diagnose conditions requiring intervention. For remote oversight to work effectively, it must rely on patient safety interventions that do not depend on another registrant being physically present, for example, referring a patient to an alternative location such as a secondary care facility.

**QX. What do you see as the main benefits of option 2 and why?  
(Please provide evidence to support your views.)**

**QX. What do you see as the main risks of option 2 and why?  
(Please provide evidence to support your views.)**

**QX. Please provide any suggestions for alternative wording for option 2.**

## Section 3: Impact assessment and Welsh language

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### *Impact assessment*

80. We have produced a draft impact assessment. We are interested in stakeholder views on our assessment. We will provide a more detailed impact assessment once we have considered views received during the consultation.
81. It is possible that testing of sight separated by time, person and/or place (e.g. virtual sight testing using teleoptometry) may have positive impacts for people based in rural or remote areas where we understand recruitment of optometrists can be challenging. By making eye care more accessible, this could lead to earlier detection of sight-threatening conditions.
82. Separation of sight test components may be less suitable for patients in older age groups, children, those with multiple or pre-existing eye conditions, or those who may rely more heavily on continuity of care or in-person interaction. Ensuring that patients are clearly informed about the format of care being offered so they can make a meaningful choice (including opting for an alternative where appropriate), will be an important safeguard in supporting equitable access and experience.
83. There is also a potential risk of digital exclusion where sight tests rely on technology or remote interaction. This may disproportionately affect some groups, including older people, those on lower incomes or those with limited digital confidence. Mitigations should ensure that alternative, accessible options remain available. More complex or varied formats of care may be harder for some patients to understand or navigate. Clear communication and consistent standards will be important to support equitable experience and confidence.
84. Inequalities could widen if the market evolved so there were fewer practices with on-site optometrists, which would mean further to travel for such patients. However, this risk should be mitigated if we decide to maintain the requirement in standard 9 for an optometrist to be on the premises for supervision purposes.

**QX. 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

**If yes, please explain your reasoning.**

**QX. Are 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

**If yes, please explain your reasoning.**

*Welsh language*

85. 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.
86. The proposals in this document relate to a proposed updated statement on testing of sight that will apply to optical businesses providing sight testing across the UK, including in Wales. We have assessed that these proposals are unlikely to have any effects on opportunities to use the Welsh language or affect the treatment of the Welsh language. However, as service delivery evolves, it will be important to ensure that language needs continue to be considered within patient communication and access arrangements.

**QX. 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
- b) No
- c) Not sure

**If yes, please explain your reasoning.**

**QX. 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
- b) No
- c) Not sure

**If yes, please explain how.**

**QX. Could the proposed changes be revised so that they would not have negative effects, or so that they would have decreased negative 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
- b) No
- c) Not sure

**If yes, please explain your reasoning.**

## Section 4: How to respond to the consultation

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87. This consultation will be open from XXX to XXXX 2026.
88. 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.
89. However, if that is not possible, you can respond to the consultation by emailing [consultations@optical.org](mailto:consultations@optical.org)

# Annex 1: Proposed updated statement on testing of sight

## Section 1 – Introduction

1. This statement relates to the testing of sight for the purposes of the Opticians Act 1989 ('the Act') and The Sight Testing (Examination and Prescription) (No. 2) Regulations 1989. The sight test within the meaning of the Act is often referred to as an eye test or eye examination across the UK nations.
2. A sight test consists of checks for visual acuity (sometimes referred to as a vision check, refraction or refractive error), binocular vision<sup>15</sup> and eye health<sup>16</sup>, for the purposes of issuing a prescription and/or making a referral. While there is flexibility in the way that a sight test can be carried out, registrants should ensure that sight tests include checks for visual acuity, binocular vision and eye health. This supports early identification of eye health conditions.

## Section 2 – Sight testing legislation

3. Section 36(2) of the Act defines "testing sight" as "testing sight with the object of determining whether there is any and, if so, what defect of sight and of correcting, remedying or relieving any such defect of an anatomical or physiological nature by means of an optical appliance prescribed on the basis of the determination".
4. Sections 26(1) and 26(2) of the Act set out that when a sight test is performed, it shall be the duty of the person testing sight to:
  - perform examinations of the eye that are required for the purpose of detecting injury, disease or abnormality in the eye;
  - immediately following the test, issue a written statement that the above examinations have been carried out, that the patient is / is not being referred to a medical practitioner and the reason for the referral (in practice, this is usually combined with the prescription mentioned below); and
  - provide a signed, written prescription for an optical appliance or a signed, written statement confirming that no optical appliance is necessary.
5. Article 3 of The Sight Testing (Examination and Prescription) (No. 2) Regulations 1989 provides that the person testing sight must conduct:

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<sup>15</sup> Vision using two eyes with overlapping fields of view, allowing good perception of depth.

<sup>16</sup> Examinations of the eye for the purpose of detecting injury, disease or abnormality in the eye (see article 3 of The Sight Testing (Examination and Prescription) (No. 2) Regulations 1989 for further information).

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

### **Section 3 – Delegation of activities for the sight test**

6. An optometrist (or registered medical practitioner) may delegate some parts of the sight test to a suitably trained person (such as a dispensing optician or a non-registrant), provided the optometrist remains in overall control of the process and oversees the task(s) being carried out.
7. Advances in technology mean that an optometrist can safely delegate some parts of the sight test in this way. Examples of tasks that can be safely delegated include intraocular pressure checks, visual field tests, autorefractometry and retinal photographs/scans<sup>17</sup>.
8. The legislation places specific restrictions on who may carry out refraction<sup>18</sup>, depending on its purpose. Refraction<sup>19</sup> for the purpose of issuing a prescription<sup>20</sup> is restricted<sup>21</sup> to a registered optometrist, a registered medical practitioner or a student optometrist / medical practitioner under supervision. However, refraction carried out for other purposes (for example, to verify a prescription issued by an optometrist or registered medical practitioner when fitting a patient's spectacles), is not restricted by legislation and can therefore be undertaken by anyone.
9. We are not satisfied that subjective refraction<sup>22</sup> can be safely delegated and therefore no-one else should refract for the purposes of the sight test<sup>23</sup>.
10. In circumstances where tasks are delegated, the optometrist must comply with our [Standards of Practice for Optometrists and Dispensing Opticians](#), including standard 9 on supervision and delegation.

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<sup>17</sup> Evans, B., Shah, R., Conway, M. and Chapman, L. (2023), *Clinical research on refraction in the sight test*

<sup>18</sup> Refraction is the assessment of a patient's vision to determine the patient's visual acuity i.e. how well they can see.

<sup>19</sup> Refraction as part of the sight test refers to a check of the patient's visual acuity i.e. how well they can see, and whether any corrective measures such as spectacles or contact lenses are required.

<sup>20</sup> Under section 26 of the Opticians Act 1989 and the Sight Testing (Examination and Prescription) (No. 2) Regulations 1989.

<sup>21</sup> By section 24 of the Opticians Act and rule 3 of the Testing of Sight by Persons Training as Optometrists Rules 1993.

<sup>22</sup> A technique used to determine the prescription of a lens for correcting a patient's vision based on the patient's personal feedback about the clarity of the successive lenses shown to them.

<sup>23</sup> For further information, see paragraphs 107-116 of our [GOC response to call for evidence on the Opticians Act and consultation on GOC associated policies](#) (2023)

11. Business registrants permitting delegation by the optometrist must satisfy themselves that, as required by the [Standards for Optical Businesses](#), their staff are:
  - able to exercise their professional judgement (standard 3.1);
  - suitably trained, qualified and registered (standard 3.2); and
  - adequately supervised and supported (standard 3.3).

#### **Section 4 – Separation of the sight test by time, person and/or place**

12. Service delivery of eye care is evolving alongside developments in technology and formats have developed where some components of the sight test are carried out at different times, by different persons and/or in different places, whether that be remotely or in person.
13. The Act permits separation of the components of the sight test by time, person and/or place, and does not restrict the type of equipment, products or technology that can be used by registrants.
14. Whatever format of sight test is used, the care, wellbeing and safety of patients must always be the first concern, and registrants must always act in the best interests of the patient. Clinical responsibility for the patient and all patient care remains the responsibility of the optometrist(s) conducting the sight test. Components of the sight test should only be delegated to others and technology or equipment should only be used where the optometrist is satisfied that these can be performed/used safely and accurately<sup>24</sup>.
15. Where more than one optometrist conducts different components of the sight test, it will be the responsibility of the optometrist conducting the most recent components to assure themselves that previous components were conducted appropriately and, if not, to repeat those components.
16. If a **business registrant** introduces a sight test format involving separation of components by time, person and/or place, it is their responsibility to:
  - have satisfied themselves, and be able to demonstrate, the format is safe (including appropriate technology in place to support it) and keep it subject to ongoing audit/evaluation. This is particularly important for formats that

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<sup>24</sup> In this statement we use the terms 'delegation' and 'assisting'. In the former, a person is responsible for conducting the task and the optometrist delegating it may not be present (e.g. an optical assistant/technician conducting an OCT scan) but they remain in overall control of the sight test and responsible for overseeing the task(s) being carried out. In the latter, an optometrist may ask others to assist them in a task but is not delegating it to them (e.g. in a teleoptometry format of sight testing where an optical assistant/technician is operating equipment at the direction of the optometrist who can see the patient and live results of the equipment being used through a screen).

separate sight test components by two or more dimensions of time, person and/or place;

- have documented protocols and service specifications for how the format should be operated, including:
  - i. how to assess whether any patients would not be suitable for the format due to their clinical risk, vulnerability or other factors; and
  - ii. how to manage situations when it becomes evident during the appointment that the format is unsuitable for the patient; and
- ensure that staff involved in any components of the sight test (including those that are assisting optometrists or those that optometrists delegate to) are appropriately trained and qualified.

17. Both the **business registrant** and the **optometrist** have a responsibility to:

- be able to clinically justify the reasons for any separation of sight test components by a significant period of time (e.g. where it was not possible to complete the test in a single appointment);
- ensure that all relevant legal and regulatory requirements are complied with including ensuring that a spectacles prescription is not issued until all statutory components of the sight test are complete;
- communicate with patients to ensure that they understand the format of sight test they are being offered prior to the appointment or before beginning the sight test so that they can exercise choice and appropriately give informed consent (or otherwise);
- consider the needs of patients in vulnerable circumstances, including:
  - i. some patients may need additional support in understanding what is being offered to them, or require information in different formats;
  - ii. some patients may experience overlapping factors (for example, age, disability or socio-economic circumstances) which could affect their suitability for different formats of sight test;
  - iii. recognise where the format of sight tests disadvantages patients who may be less able to engage with remote or technology-enabled approaches and consider alternatives for these patients; and
- recognise that different formats of sight test may affect patient experience as well as clinical safety, and that both should be considered when determining whether a format is appropriate.

18. An **individual registrant** must make the care of their patients their first and overriding concern. An individual registrant must exercise professional judgement as to what equipment, products and technology to use to help them to assess each patient's needs, and the most appropriate way in which to conduct a sight test, particularly when separating components by time, person and/or place. In exercising their professional judgement, individual registrants should take account of:
- the nature of any specific clinical risks (for example, the patient's age, family history, pre-existing medical conditions and any current symptoms);
  - patient vulnerability<sup>25</sup>;
  - relevant clinical advice;
  - advice from the optical professional bodies;
  - advice from other relevant regulators, such as the Medicines and Healthcare products Regulatory Agency (MHRA);
  - current good practice in the use of technology to inform the care provided;
  - their ability to use the format of sight test in line with our standards of practice;
  - joint regulatory guidance on remote consultation and prescribing: <https://standards.optical.org/supporting-guidance/remote-consultations-and-prescribing/>; and
  - public health advice at the time in question.
19. We recognise that not all optical businesses are registered with us and therefore cannot be held to account through our processes. However, the introduction to our [Standards of Practice for Optometrists and Dispensing Opticians](#) sets out: "You are professionally accountable and personally responsible for your practice and for what you do or do not do, no matter what direction or guidance you are given by an employer or colleague. This means you must always be able to justify your decisions and actions." This applies to all registrants, irrespective of where they are working.

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<sup>25</sup> Patients in vulnerable circumstances are patients who, due to their personal circumstances are in need of particular care, support or protection or at risk of abuse and neglect. See page 3 and standard 7.1 of our [Standards of Practice for Optometrists and Dispensing Opticians](#) and supplementary [guidance on care of patients in vulnerable circumstances](#) for further information.

## Section 5 – Standards of practice

20. Our standards set out the key principles that registrants must follow to keep themselves, those they lead or manage, and those they care for, safe. The standards are as follows:

- [Standards of Practice for Optometrists and Dispensing Opticians](#) – standards particularly relevant are:
  - standard 2 (communicate effectively with your patients);
  - standard 3 (obtain valid consent);
  - standard 5 (keep your knowledge and skills up to date – see 5.1 and 5.3);
  - standard 7 (conduct appropriate assessments, examinations, treatments and referrals);
  - standard 9 (supervision and delegation);
  - standard 12 (ensure a safe environment for your patients); and
- [Standards for Optical Students](#) – standards particularly relevant are:
  - standard 2 (communicate effectively with your patients);
  - standard 3 (obtain valid consent);
  - standard 6 (conduct appropriate assessments, examinations, treatments and referrals under supervision);
  - standard 8 (supervision and delegation);
  - standard 11 (ensure a safe environment for your patients); and
- [Standards for Optical Businesses](#) – standards particularly relevant are:
  - standard 1.1.6: ensure that when introducing technological interventions, including artificial intelligence (AI) and machine learning, they do not compromise patient care, and that professional standards continue to be met;
  - standard 1.2.4: only provides, promotes and utilises equipment, medications and medical devices (including software and other technologies) that are fit for their intended use, hygienic and in a good state of repair;

- standard 1.2.5: ensures that staff utilising equipment, medications and medical devices (including software and other technologies) have undergone appropriate training in their use;
- standard 1.2.11: ensures that unauthorised access to equipment, medications and medical devices (including software and other technologies) and restricted areas of the premises is prevented;
- standard 1.3.5: provides patients or carers with the information they need to be able to safely use, administer or look after medications or medical devices (including software and other technologies) that they have been prescribed or directed to use in order to manage their eye conditions;
- standard 1.4: patients can give valid consent to treatment;
- standard 3.1: your staff are able to exercise their professional judgement;
- standard 3.2: staff are suitably trained, qualified and registered; and
- standard 3.3: staff are adequately supervised and supported.

[NB This statement replaces our 2013 statement on testing of sight, which has now been withdrawn.]

## **Annex 2: Draft revisions to supervision and delegation standards**

### **Draft proposed Standards of Practice for Optometrists and Dispensing Opticians**

#### **9. Ensure that supervision and delegation are undertaken appropriately**

This standard applies to supervision of optical students and oversight of unregistered colleagues undertaking delegated activities.

When supervising, there is a shared responsibility to ensure that patient care and safety is not compromised. When activities are delegated to unregistered colleagues the registrant retains responsibility for the delegated activities.

**9.1** When supervising a student or overseeing an unregistered colleague undertaking delegated activities, you must:

**9.1.1** Take all reasonable steps to prevent harm to patients.

**9.1.2** Comply with all legal requirements governing the activity.

**9.1.3** Ensure that details of those being supervised or undertaking delegated activities are recorded on the patient record.

**9.1.4** Be sufficiently qualified and experienced to undertake the functions you are supervising or delegating.

**9.1.5** Ensure that the students or unregistered colleagues have appropriate qualifications, knowledge and/or skills to undertake the activities.

**9.2** Adequate supervision of student optometrists and student dispensing opticians requires you to:

**9.2.1** Retain clinical responsibility for the patient.

**9.2.2** Be on the premises, able to oversee the work undertaken and ready to intervene if necessary to protect patients.

**9.3** When delegating activities to an unregistered colleague, you must:

**9.3.1** Retain responsibility for the delegated activities and for ensuring that they have been performed to the appropriate standard.

**Option 1 – remote oversight of delegated activities allowed, if another optometrist or dispensing optician (depending on the activities to be delegated) is on the premises.**

**9.3.2** Be able to oversee the work undertaken and ready to intervene if necessary to protect patients. If you are overseeing an unregistered colleague undertaking delegated activities remotely<sup>26</sup>, you must ensure that another registrant, who is qualified and experienced to undertake the delegated activities, is on the premises and ready to intervene if necessary to protect patients.

**Option 2 – remote oversight of delegated activities with no requirement for a registrant to be on the premises**

**9.3.2** Be able to oversee the work undertaken and intervene if necessary to protect patients.

## **Draft proposed Standards for Optical Students**

### **8. Ensure that supervision is undertaken appropriately**

The responsibility to ensure that supervision does not compromise patient care and safety is shared between the supervisor and the trainee. When being supervised:

**8.1** You may undertake supervised activities only if your supervisor is approved by your employer or training provider.

**8.2** You may undertake supervised activities only if your supervisor is on the premises, able to oversee the work you undertake and is ready to intervene if necessary to protect patients.

**8.3** Your supervisor retains clinical responsibility for the patient.

**8.4** You must comply with all legal requirements governing the activity.

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<sup>26</sup> Remote means being in a location that is different to where the patient is receiving treatment, rather than face-to-face in the same location.

## Annex 2

### Impact Assessment Screening Tool

<b>Name of policy or process</b>	Statement on testing of sight
<b>Purpose of policy or process</b>	To set out the GOC's position on testing of sight
<b>Team/Department</b>	Policy and Standards
<b>Date</b>	22 December 2025; updated 13 April and 7 May 2026
<b>Screen undertaken by</b>	Marie Bunby and Toby Ganley
<b>Approved by</b>	Charlotte Urwin
<b>Date approved</b>	15 May 2026
<b>Instructions:</b>	<ul style="list-style-type: none"> <li>• Circle or colour in the current status of the project or policy for each row.</li> <li>• <b>Do not miss out any rows.</b> If it is not applicable – put N/A, if you do not know put a question mark in that column.</li> <li>• This is a live tool, you will be able to update it further as you have completed more actions.</li> <li>• Make sure your selections are accurate at the time of completion.</li> <li>• Decide whether you think a <b>full</b> impact assessment is required to list the risks and the mitigating/strengthening actions.</li> <li>• If you think that a full impact assessment is <b>not</b> required, put your reasoning in the blank spaces under each section.</li> <li>• You can include comments in the boxes or in the space below.</li> <li>• Submit the completed form to the Compliance Manager for approval.</li> </ul>

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:

5: The topic of technology related to sight testing has had some media interest in the last 12 months and we expect this to continue as methods of service delivery evolve alongside developments in technology. We are mitigating this risk through ongoing discussion and engagement with stakeholders so that they are aware of our plans and have an opportunity to comment through the public consultation process.

8: We have prepared a full communications plan to support consultation engagement which will be completed when we are able to determine timescales. The consultation document and annexes will be translated into Welsh. The proposals in this document relate to an updated version of our existing 2013 statement on testing of sight to reflect the current position in relation to pre-/post-screening activities and separation of the sight test by time, person and/or place. It will apply to any formats of sight tests that fall within UK regulation. 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.

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	N/A
2. Will the data be anonymised?	No	Sometimes, in shared documents	Yes, immediately, and the original retained	Yes, immediately, and the original deleted	N/A
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 <b>all</b> 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	N/A
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	N/A
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 <b>and</b> the relevant employees are aware	N/A
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	N/A
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 <b>and</b> approved by Gov. dept.	N/A
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	N/A
11. Will data be handled by anyone outside the EU?	Yes	-	-	No	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	N/A

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	N/A

Please put commentary below about reasons for information governance ratings:

1-13: This proposal does not involve the collection or processing of personal data as part of its core function. The consultation proposals do not involve us collecting data – it is not a policy or process that involves applications – rather it is a proposed updated position statement and proposed revised standards for our registrants, therefore much of this section is not applicable.

Responses to the consultation itself will be unlikely to provide personal data about individuals but they may provide information about businesses and their 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 \(optical.org\)](#)).

Consultation respondents can provide their personal information (name, contact details and EDI information) when submitting a consultation response, but it is not mandatory. Where gathered, all such information is used solely for the purposes of analysing responses and we do not identify or publish the names of any individuals who have responded to the consultation.

Our consultation platform includes a privacy statement, setting out how we will use respondents' data ([Privacy Policy | General Optical Council](#)).

Most risks are low or medium and have been mitigated.

Full impact assessment not required.

<b>C) Human rights, equality and inclusion</b>	<b>High risk</b>	<b>Medium risk</b>		<b>Low risk</b>	<b>? or N/A</b>
1. Main audience/policy user	Public			Registrants, employees or members	
2. Participation in a process (right to be treated fairly, right for freedom of expression)	Yes, the policy, process or activity restricts an individual's inclusion, interaction or participation in a process			No, the policy, process or activity does not restrict an individual's inclusion, interaction or participation in a process	
3. The policy, process or activity includes decision-making which gives outcomes for individuals (right to a fair trial, right to be treated fairly)	Yes, the decision is made by one person, who may or may not review all cases	Yes, the decision is made by one person, who reviews all cases	Yes, the decision is made by an panel which is randomly selected; which may or may not review all cases	Yes, the decision is made by a representative panel (specifically selected) OR No, no decisions are required	N/A
	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	N/A
	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	N/A
	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	N/A

<b>C) Human rights, equality and inclusion</b>	<b>High risk</b>	<b>Medium risk</b>		<b>Low risk</b>	<b>? or N/A</b>
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	N/A
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	N/A
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	N/A
	Change in arrangements is very often	Change in arrangements is quite often		Change in arrangements is rare	N/A
	Only can attend in person	Mostly required to attend in person		Able to attend remotely	N/A
	Unequal attendance / involvement of attendees	Unequal attendance/ involvement of attendees, but this is monitored and managed		Attendance/involvement is equal, and monitored per attendee	N/A
	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)	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	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:

3-9: The proposed updated statement and proposed revised standards do not include decision-making which gives outcomes for individuals, therefore much of this section is not applicable. Any direct impact at this stage will therefore be limited. Potential future impact will depend on how care is implemented in practice by businesses.

The consultation approach is designed to support inclusive participation through availability of documents in alternative formats on request, open access through our website, and multiple response routes. Any decisions on the content of the final statement 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.

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 safeguards being put in place by optical businesses operating sight tests that are separated by time, person and/or place. It includes guidance on having documented protocols and service specifications for how the format should be operated,

Protected characteristic	Type of potential impact: positive, neutral, negative?	Explanations (including examples or evidence/data used) and actions to address negative impact
		including how to assess whether any patients would not be suitable for the format of sight test due to their clinical risk. This is likely to protect patients in the older age group, as our research <sup>1</sup> shows that they fall into the category of a higher risk patient and are therefore a) less likely to be suitable for such a sight test format by virtue of their age and b) more likely to have pre-existing eye conditions.
Disability	Positive	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. Having documented protocols and service specifications for how a sight test separated by time, person and/or place should be operated is likely to have a positive impact on those with a disability, as it will ensure that the format is suitable for patients being offered it, as well as ensuring that the patient is aware of the format prior to the appointment so that they can exercise choice and informed consent (or otherwise).
Sex	Neutral	No specific differential impacts have been identified at this stage, although this will be kept under review as formats of sight test evolve.
Gender reassignment (trans and non-binary)	Neutral	No specific differential impacts have been identified at this stage, although this will be kept under review as formats of sight test evolve.
Marriage and civil partnership	Neutral	No specific differential impacts have been identified at this stage, although this will be kept under review as formats of sight test evolve.

<sup>1</sup> Jonuscheit, S. et al. (2025), [‘Testing of sight - a risk-based framework: Project report’](#)

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	No specific differential impacts have been identified at this stage, although this will be kept under review as formats of sight test evolve.
Race	Neutral	No specific differential impacts have been identified at this stage, although this will be kept under review as formats of sight test evolve.
Religion/belief	Neutral	No specific differential impacts have been identified at this stage, although this will be kept under review as formats of sight test evolve.
Sexual orientation	Neutral	No specific differential impacts have been identified at this stage, although this will be kept under review as formats of sight test evolve.
Other groups (e.g. carers, people from different socio-economic groups)	Positive	Testing of sight separated by time, person and/or place (e.g. remote sight testing using teleoptometry) and providing for remote supervision, are likely to be positive for people based in rural or remote areas where recruitment of optometrists can be challenging. This may improve accessibility of care and therefore earlier detection of sight-threatening conditions. It should also be noted that some individuals may experience overlapping impacts (for example, older people with disabilities or those experiencing socio-economic disadvantage), which may not be fully captured when considering characteristics individually.

### **Annex 3 – Current 2013 statement on testing of sight**

The General Optical Council statement on refraction for the purpose of sight testing.

#### **Detail**

##### **Statement on testing of sight**

Refraction for the purpose of issuing a prescription is an essential part of the sight test[1]. As such, refraction for the purpose of sight testing is restricted[2] and can only be conducted by a registered optometrist, a registered medical practitioner or a student optometrist under supervision. No part of the sight test can be delegated to a dispensing optician or contact lens optician, even under supervision.

Refraction for purposes not associated with the testing of sight, for example to verify a prescription issued by an optometrist or registered medical practitioner, is not restricted. This can therefore be undertaken by dispensing opticians and contact lens opticians.

#### **Footnotes**

[1] under Section 26 of the Opticians Act 1989 (as amended by the Opticians Act 1989 Amendment Order 2005) and the Sight Testing (Examination and Prescription) (No. 2) Regulations 1989.

[2] by Section 24 of the Opticians Act and Rule 3 of the Testing of Sight by Persons Training as Optometrists Rules 1993.

#### **Published**

2013

## Annex 4 – Right-touch regulation principles, regulatory force diagram and types of harm

Extracts from the PSA's [Right-touch regulation](#) are provided below.

“The principles are that regulation should be:

**Proportionate:** regulators should only intervene when necessary. Remedies should be appropriate to the risk posed, and costs identified and minimised.

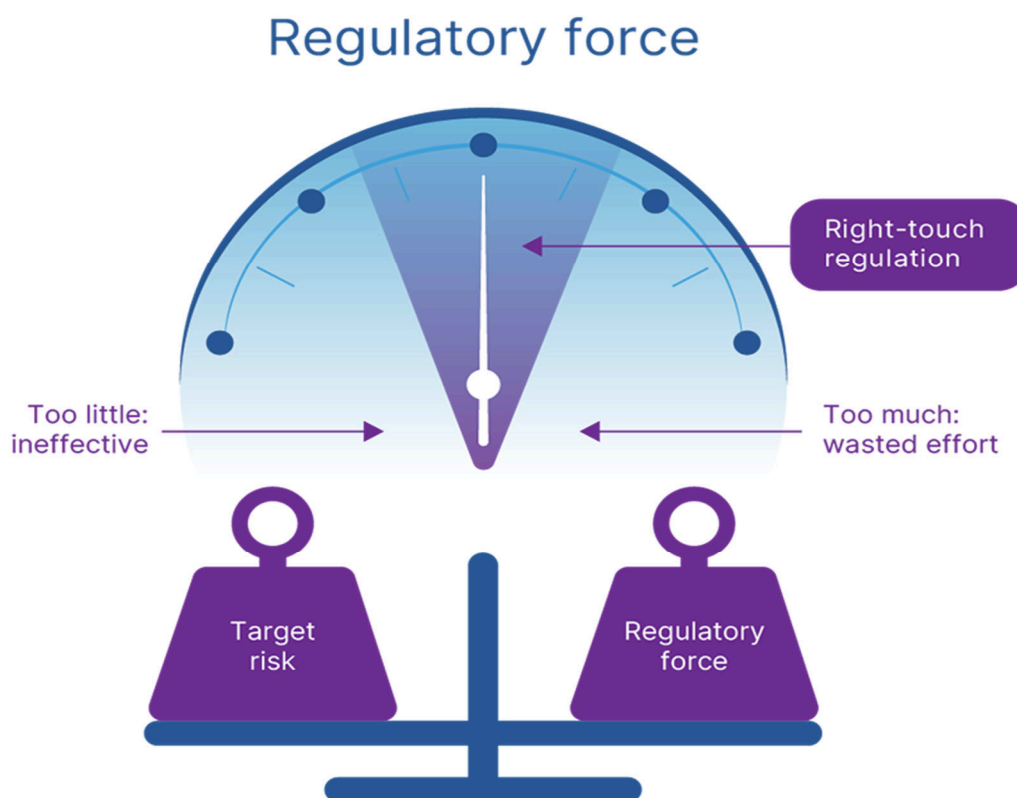
**Consistent:** rules and standards should be joined up and implemented fairly. Regulators should work for consistent outcomes with disparity only where this can be justified.

**Targeted:** regulation should be focused on the problem it is seeking to solve, and minimise unwanted side effects.

**Transparent:** regulators should work openly, be accessible to scrutiny, and keep regulations simple and user-friendly

**Accountable:** regulators must work transparently, and be open and accessible to scrutiny.

**Agile:** regulators must look forward, anticipating and adapting to change.”



## **Types of harm (Page 12)**

### 3. What is harm?

Regulation has an important part to play in protecting the public against risk of harm.

By harm we mean physical or psychological injury, or other loss or detriment. For example, this may include:

- harm to the physical, psychological and emotional health and wellbeing of members of the public
- financial and other kinds of loss, such as digital exclusion, loss of control of personal data, and damage to earnings, career and/or career progression
- harm to the reputation of an organisation delivering services – and resulting damage to public trust, both to specific organisations and to institutions more generally
- disruption to the work of teams, and to the availability and quality of services in the future
- damage to the trust and perceived legitimacy of the regulator by those regulated, which may result in disengagement
- in consequence of the above, damage to trust and confidence in services and professions.

In whichever sector they operate, regulators need to understand the range of possible physical, psychological, financial, and other harms that may result to the public from the entities they oversee, and what factors increase and decrease the risk of harm occurring.

**Annex 5 – Extract from Delphi study on benefits and risks**

	<b>Risk</b>	<b>Low risk patient Consensus (Yes/No)</b>	<b>Higher risk patient Consensus (Yes/No)</b>
<b>NHS risks</b>	Risk of increase in the number of referrals	Red	Red
	Risk of cost increases for the NHS	Red	Red
	Risk of missing key clinical information	Red	Green
	Risk of difficulties seeing diagnostic patterns	Green	Green
	Risk of insufficient continuity of care	Green	Green
	Risk of increase in health inequalities	Red	Green
<b>Patient risks</b>	Risk of delaying diagnosis	Red	Green
	Risk of missing ocular conditions	Red	Green
	Risk of delaying treatment	Red	Green
	Risk of experiencing irreversible visual impairment	Red	Green
	Risk of reduction in convenience in relation to accessing care	Red	Green
	Risk of reduction in continuity of care	Green	Green
	Risk of increasing barriers to accessing care	Red	Green

	<b>Benefit</b>		
<b>NHS benefits</b>	Better use of clinical resources and personnel	Red	Red
<b>Patient benefits</b>	Reduced waiting times	Red	Red
	More convenient locations	Red	Red
	Easier or less travel	Red	Red

## External Communications Strategy

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**Meeting:** 24 June 2026

**Status:** For decision

**Lead responsibility:** Vikki Julian (Head of Communications)

**Paper Author(s):** Vikki Julian (Head of Communications)

### Purpose

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1. Council is asked to approve the proposed external communications strategy.

### Recommendations

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2. Council is asked to delegate any minor amendments to the approval of the Chief Executive and Registrar.

### Strategic objective

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3. This work contributes towards the achievement of all objectives and is in our Business Plan.

### Background

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4. The first GOC external communications strategy was developed in 2023, with the purpose of developing key building blocks for effective communications and engagement. That strategy has successfully delivered its proposed activities, and driven awareness of, and engagement with, communications across the organisation.
5. Following the launch of the 2025-30 corporate strategy, a new communications strategy for external audiences is required to ensure alignment. This new communications strategy outlines the core communications principles that will drive forward our work; explains how communications will support the strategic priorities of the 2025-30 corporate plan; and identifies activities necessary to support the GOC to achieve its revised mission and vision.
6. This strategy deals specifically with external facing communications. There is a separate internal strategy for internal communications, and these work in conjunction with each other.

### Analysis

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7. This strategy does not represent a radical departure from the previous external communications strategy; rather, it builds on what has been successful and suggests some elevations which will further strengthen our external communications

and ensure they are representative of, and aligned to, some of the key drivers of the corporate strategy 2025-30. These include supporting the corporate strategy's focus on data and user/patient voice; enhancing our reputation as modern and agile regulator, particularly through use of new channels such as MyGOC, social media and brand; and a focus on accessibility of our communications to support developing fairer and more inclusive eyecare services.

8. The strategy defines the team capacity, roles and functions needed to deliver the activities identified and sets out our core external communications channels and their appropriate uses.
9. It considers key external audiences and stakeholders in detail and makes recommendations for how and when we should communicate with them, based on their communications needs.
10. It provides an evaluation of available data, which has been used to make key decisions about the effectiveness of activities, including what we should continue to do as part of communications business as usual.
11. The strategy is driven by a set of refined overarching communications principles which are in sync with the corporate strategy 2025-30 and will guide the direction of communications activity. These are:
  - Communications first: taking a strategic approach and making sure communications, particularly messaging, are considered as part of all our work at an early stage
  - Targeted: making sure we get messages to the right people and in the right way and at the right time
  - Accessible and inclusive: using methods and language that meet the needs of the audience and supports our commitment to equality, diversity and inclusion
  - Integrated: using a multi-channel approach for maximum impact
  - Collaborative: co-creating with our internal and external audiences where relevant, listening and responding accordingly.
12. Communications activities have been divided into five strategic pillars, three of which match with the corporate strategy, to ensure strategic alignment. They are:
  - Effective business as usual – a focus on activities which have been identified as working well for our external audiences, or which are statutorily required.
  - Preventing harm through agile regulation – a focus on data, patient/user voice and representing the GOC as a modern regulator.
  - Fairer, more inclusive eye services – activities planned around enhanced accessibility as well as a focus on EDI.

- Supporting responsible innovation and protecting the public – making sure the innovations in the new MyGOC platform can enhance our communications with registrants to provide the most effective support.
- Communications as a strategic function – continuing to build on earlier work, so that the whole organisation can be supported with their communications needs. Bringing communications in at an early point in decision making so messaging and impact can be the most effective possible.

**Finance**

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13. The work identified in this strategy is accounted for in the annual communications budget.

**Risks**

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14. The SWOT analysis at Section 6 of the strategy sets out specific communications risks and their mitigations.

**Equality Impacts**

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15. Specific consideration has been given to how the strategy supports our EDI work, and this is identified in the activities at section 8.

**Devolved nations**

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16. There are no specific impacts for the devolved nations.
17. Communications will continue to meet statutory obligations under the Welsh Language Scheme.
18. The Parliaments of devolved nations are treated as separate stakeholders, with specific communications needs.

**Communications**

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**External communications**

19. We do not expect any other particular external communications requests related to the strategy itself.

**Internal communications**

20. The strategy will be published on Iris and presented to colleagues as part of embedding it.

**Next steps**

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21. If approved, the work plan set out in the strategy will be implemented.

**Attachments**

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Annex 1: External Communications Strategy

## **External communications strategy for 2025-30 corporate strategy**

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### **1. Mission and vision**

The General Optical Council (GOC) is the regulator for optical professions in the UK. Our vision is “safe and effective eye care for all” and our mission is to “protect the public by upholding high standards in eye care services”.

Our corporate strategy for 2025-30 supports this vision and mission with three strategic objectives:

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

High quality communications are crucial to helping us achieve these objectives and critical in maintaining public confidence in the GOC.

### **2. Purpose and key themes**

This strategy sets out a comprehensive approach to delivering communications in line with our corporate strategy. It outlines the core communications principles that will drive forward our work; explains how communications will support strategic priorities; and identifies the activities necessary to support the GOC to achieve its mission and vision.

This plan focuses on communications with our external audiences and should be read in conjunction with our internal communications strategy which sets out our approach for communicating with staff, members and workers.

The main communications activity in the strategy is divided into five key themes:

- Effective business as usual – a continuation of what is working well based on data and analysis
- Preventing harm through Agile regulation – a focus on using data and insight, including patient and user voice, to communicate our role as a modern, evidence-based regulator
- Creating fairer and more inclusive eye care services – with emphasis on improving the accessibility and reach of our communications
- Supporting responsible innovation and protecting the public – making best use of the innovations offered by the upgraded MyGOC to support registrants
- Communications as a strategic function – making sure colleagues continued to be well supported and ensuring communications is considered as part of decision-making.

### **3. Context**

This is the second GOC external communications strategy. The first strategy was designed in 2023, with the purpose of developing key building blocks for effective communications and engagement. Key achievements from that strategic period include:

- redevelopment of core channels including the intranet and a new website
- brand refresh
- a new internal communications strategy
- new processes including around strategic planning e.g. introduction of a “comms grid”
- upskilling of the communications team and GOC staff more widely
- development of a crisis communications approach
- developing a public affairs function, building our intelligence gathering capacity and building key relations across Westminster.

These achievements have put the foundations in place to run effective communications so we can move to a place where the GOC’s communications are truly strategic.

### ***Capacity***

The Communications team is now a team of five, comprising of the Head of Communications, Communications Manager, Communications Officer, Communications and Public Affairs Officer and Internal Communications Officer.

The team are well-established and experienced, with defined roles and skills, but are also able to cover all areas of the communications mix. The Communications team is lean for the size of the organisation and provides value for money by delivering much of the communications output (including video and design) in house.

### ***The purpose of our communications***

In line with our vision, mission and strategic priorities, the key purpose of our communications is to maintain confidence in the organisation’s ability to protect the public by upholding high standards. We do this by:

- projecting our authority through our unified voice, brand, messaging, and engagement
- building and maintaining our reputation with registrants and the public
- ensuring our stakeholders are aware of our role and our aims
- clearly communicating the relevance of our functions and work in relation to public protection and upholding high standards in the profession
- precisely communicating what is required and expected in terms of our statutory obligations
- working in partnership with stakeholders, including involving people in our decision making, and ensuring individual and collective feedback on our work.

To achieve this, our Communications team undertakes the following functions:

- ensures planning and strategic oversight to ensure the GOC's communications needs are being met
- provides communications support and expertise to the GOC to ensure our voice, brand and messaging are appropriate and that our communications are in line with our strategic priorities, mission and vision
- produces key corporate communications such as the annual report and business plan
- manages and develops content for our external facing channels to ensure stakeholders are aware of our mission and the work we do
- reputation monitoring and crisis communications so that confidence in the GOC is maintained and enhanced
- proactively communicates our purpose and work in line with our strategic priorities, including media relations and wider engagement with stakeholders, including in Parliament and the devolved administrations
- gathers intelligence so we can broaden our engagement with stakeholders and the sector and improve our effectiveness as a regulator.

#### 4. Data and evaluation

Understanding who we are talking to and what our audiences want to hear from us is key to the effectiveness of our communications. It is also important that, particularly where it comes to our statutory obligations and our expectations of registrants, we communicate clearly and precisely.

The last time we specifically surveyed registrants about our communications was in the 2022 Registrants and Public Perceptions surveys. The Registrant survey showed that most registrants (88%) preferred to hear from us via email bulletins. Far fewer used the website (33%) or interacted via social media (5% use LinkedIn and 4% use Twitter). Most felt the frequency of the bulletins was about right and in terms of content, most (81%) found it informative. The survey also covered the FtP specific bulletin, which 85% found useful. One of the areas for improvement outlined in the Stakeholder Perceptions survey was developing and demonstrating our knowledge of the optical sector. As a result, in 2023 we launched our optical practice familiarisation programme, which we have regularly communicated about since.

Our Public Perceptions surveys continue to demonstrate that the public have a high level of trust in the optical sector and high levels of satisfaction.

Analysis of social media channel metrics over the last five years shows LinkedIn to be our most successful account, with followers almost doubling in five years. Popular content on linked includes our consultations and policy work.

Start of year	Followers
2021	10,050
2022	11,820
2023	14,179
2024	16,103
2025	17,993
2026	20,113

We continue to maintain a presence on X (Twitter) but operate it as a broadcast channel (i.e. we do not engage in debate). Followers and engagement have slightly declined, but this is in line with many other companies as the channel has fallen out of favour with users. Given the number of followers, we consider that it is still worth using at this time but are keeping under review.

Start of year	Followers
2021	7,537
2022	7,952
2023	8,088
2024	8,072
2025	7,985
2026	7,857

Our ebulletins continue to be successful. Over the past three years, they have had a click-through-rate of 2.42% and an open rate of 58.98%.<sup>1</sup> The 58.98% open rate is positive, especially as the current UK email open rate is 35.9%, rising to around 51-60% for membership/professional body-related organisations. Our email click-through-rate is also good, with the average unique click rate in the UK approximately 2.3%, while for the healthcare industry it is between around 2.07% and 2.69%.

The top 10 pages on our site over the past two years show strong interest in our FtP work, as well as standards and CPD.

	2025-26	2024-25
1.	Past hearings and outcomes	Past hearings
2.	Apply to join the student register	Reflective exercise
3.	Apply to join the register as a fully qualified individual	Future Hearings
4.	Future Hearings	International Optometrists
5.	Hearings	Standards of practice for optometrists and dispensing opticians
6.	Search resources and publications	Hearings
7.	Standards of practice for optometrists and dispensing opticians	Reflective exercise guidance template
8.	International optometrists	Apply to join the student register
9.	CPD	Apply to join the register as a fully qualified individual
10.	Apply to renew your independent prescribing specialty	Site search

## 5. Audience

Our identified audiences are as follows:

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<sup>1</sup> Open rate = the number of recipients opening the email. Click through = the number of recipients that click on a link (e.g. interact with the newsletter).

<b>External</b>	
<p>Registrants</p> <ol style="list-style-type: none"> <li>1. Student dispensing opticians and optometrists</li> <li>2. Fully qualified dispensing opticians and optometrists</li> <li>3. Businesses and body corporates</li> </ol>	<p>Core – we need to communicate regularly</p> <p>Important to acknowledge the differing needs of fully qualified dispensing opticians and optometrists – for example, newly qualified vs someone more established in their career</p>
<p>Optical representative and membership bodies across all nations</p>	<p>Core</p>
<p>Public</p> <ul style="list-style-type: none"> <li>• “The general public”</li> <li>• Members of the public who need to use our (GOC) services</li> <li>• Patients (e.g. those who regularly use optical services)</li> </ul>	<p>People who need to use our (GOC) services and patients are a core audience who are generally more engaged, and we will need to communicate with them frequently</p> <p>In terms of the wider public, we would want them to know the optical sector is regulated</p> <p>Planned work around user and patient voice will give us further insights and more specific opportunities</p>
<p>Patient representative groups and third sector organisations</p>	<p>In line with the focus in the corporate strategy, we should routinely with these organisations and align this to planned work on user and patient voice. As well as representatives, they can act as a conduit for us to engage directly with their members</p>
<p>Professional Standards Authority</p>	<p>Core – it is crucial we regularly demonstrate our good practice and compliance with PSA standards</p>
<p>Other health and social care regulators, including MHRA and CQC</p> <p>Regulators outside of healthcare where relevant</p>	<p>We should engage with where relevant to our work particularly where there are broader public protection aims.</p> <p>e.g. education regulators</p>

<p>Education</p> <ul style="list-style-type: none"> <li>• CPD providers</li> <li>• Providers of GOC approved qualifications</li> <li>• FE &amp; HE statutory education, training, regulatory, quality assurance, research and funding bodies in each of the four nations</li> <li>• Prospective providers of GOC approved qualifications</li> </ul>	<p>Core – we need to communicate regularly</p>
<p>NHS and healthcare commissioners</p> <ul style="list-style-type: none"> <li>• Regional areas for NHS England</li> <li>• The devolved nations</li> </ul>	<p>We should engage with where relevant to our work</p>
<p>Government/Westminster/devolved administrations</p> <ul style="list-style-type: none"> <li>• MPs/MSPs/MS/Lords with specific interest in eye health/optical sector</li> <li>• DHSC</li> <li>• Government bodies in all nations of UK</li> <li>• Welsh Language Commissioner</li> </ul>	<p>We should engage reactively where relevant to our work but also proactively seek opportunities to influence policy in line with our strategic aims</p> <p>We have built strong relationships with MPs that have a specific interest in the optical sector and relevant APPGs</p>
<p>Media</p> <ul style="list-style-type: none"> <li>• Optical sector</li> <li>• National/local</li> <li>• Member/ governance sector</li> </ul>	<p>We should engage where relevant to our work but also proactively seek opportunities to build our reputation.</p>

**Communications channels**

The existing channels we use to deliver our communications are as follows:

<p><b>External (owned)</b></p>
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Website	
My GOC/My CPD	
Social media	Twitter, LinkedIn, YouTube
E-bulletins	Registrant bulletins
FtP focus	email format
Brand	
Events	Roadshows, launches
Reports	Annual report, external business plan, policy reports
<b>External (not GOC)</b>	
Media	sector, local, national
Events	Sector events

## 6. Risk

The Communications team runs a specific departmental risk register and a number of key communications risks are carried as part of the corporate risk register.

Effective communications are also an important part of supporting the organisation to manage risk and maintain the confidence of the public and registrants. There are also specific strengths, weaknesses, opportunities, and threats related to our current communications capacity which are shown in the SWOT analysis below.

<b>Strengths</b>	<b>Weaknesses</b>
<ul style="list-style-type: none"> <li>• Clearly defined audiences</li> <li>• Capacity and skill to deliver comms projects in-house</li> <li>• A clear set of strategic priorities to inform our approach to communications and engagement</li> <li>• Recognised authority on optical regulation</li> </ul>	<ul style="list-style-type: none"> <li>• Communications across the organisation are not always planned in good time or coordinated</li> <li>• We need to communicate complicated concepts</li> <li>• Lack of joined up working with the sector bodies</li> <li>• Variable engagement across organisation with communications</li> </ul>

<ul style="list-style-type: none"> <li>• Most of the public have high levels of trust in the optical professions</li> <li>• Refreshed brand</li> <li>• New channels with more opportunities for communications</li> <li>• PSA recognition of our approach to stakeholder engagement</li> </ul>	<ul style="list-style-type: none"> <li>• Need to develop a more strategic approach</li> <li>• Accessibility of our communications outputs</li> <li>• Varied registrant understanding of our role</li> </ul>
<p><b>Opportunities</b></p> <ul style="list-style-type: none"> <li>• Engaged stakeholders</li> <li>• Interesting projects with broad scope which give the opportunity to communicate proactively</li> <li>• MyGOC project offers an opportunity to communicate and interact with our registrants in a dynamic way</li> <li>• Remote environment offers more tools and opportunities to engage (Microsoft Teams, webinars, surveys, polls)</li> <li>• Getting staff and Council actively involved in communications</li> <li>• Collaborating with the professional bodies strategically to best serve our registrants</li> <li>• To be truly UK-wide by working with the devolved nations</li> <li>• New data and user voice strategies which will support communications approaches</li> </ul>	<p><b>Threats</b></p> <ul style="list-style-type: none"> <li>• Resource and capacity in the team between meeting short-term needs, including crises, and long-term strategic needs is difficult to balance</li> <li>• Reputational risk of not being able to control the behaviour of our audiences on social media</li> <li>• Not meeting our registrants' needs and losing their confidence</li> <li>• The public not understanding our role leading to a lack of public confidence</li> <li>• Being considered ineffective by some stakeholders</li> <li>• Delayed legislative reform could affect perceptions of our effectiveness</li> </ul>

## 7. Broad communications principles

This strategy is underpinned by the following communications principles:

- Communications first: taking a strategic approach and making sure communications, particularly messaging, are considered as part of all our work at an early stage

- Targeted: making sure we get messages to the right people and in the right way and at the right time
- Accessible and inclusive: using methods and language that meet the needs of the audience and supports our commitment to equality, diversity and inclusion
- Integrated: using a multi-channel approach for maximum impact
- Collaborative: co-creating with our internal and external audiences where relevant, listening and responding accordingly

It will also be delivered in accordance our overarching values:

- We act with integrity
- We pursue excellence
- We respect other people and ideas
- We show empathy
- We behave fairly
- We are agile and responsive to change.

## 8. Key activities

Activities for the life of this strategy are listed below. They have been categorised into the strategic pillars of the corporate strategy to demonstrate how communications will align with this work. There are two further strands, focused on delivering our core business as usual and developing communications as a strategic function.

### ***Effective business as usual***

Our core communications tactics are now well developed, having been refined over the life of our previous strategy. We will continue to deliver these to a high standard, elevating where possible.

<b>Area of work</b>	<b>Success measures</b>
Social media and e-bulletins	Deliver 6 registrant e-newsletters annually Deliver 2 FtP bulletins annually Grow LinkedIn following by 10% Maintain presence on Twitter
Ensure all planned activities which have critical communications activity are captured in the Communications business plan and engage with relevant teams to ensure comms-first approach	By each business plan sign-off
Website	Continue to embed new website, increase visits by 10% annually
Political monitoring	Monthly horizon scanning briefing Briefings on key issues
Media	Daily news monitoring

	Increased positive/neutral coverage in sector press plus aim for national coverage
Maintain crisis comms approach	All reputation-impacting incidents handled effectively Comms attendance on all TCGs
Corporate communications	Deliver annual report, business plan (annually) plus other required communications

### ***Preventing harm through Agile regulation***

- As our regulatory approach develops to meet evolving challenges our focus will be on using data and insight to communicate a modern, evidence-based approach. Our communications will need to pivot to reflect this, with a focus on data and technology through brand (particularly imagery) and messaging, which will include more data and evidence where appropriate.
- User voice is an important element of this, and our communications will focus on representing how we use the views of patients and others in the sector to inform our work. The Optical Sector Familiarisation Programme is an important element here, allowing us to demonstrate our knowledge of, and engagement with the sector.
- Where appropriate, we should focus on our role as a convenor, bringing together the sector and others to focus on emerging regulatory issues

<b>Area of work</b>	<b>Success measures</b>
Brand	Our language and imagery should be modern and technology-forward  Continue to add appropriate imagery to brand library  Where appropriate, ensure messaging includes evidence/data as a key element  Recognition from stakeholders of an evidence/data-based approach
Patient voice and data strategies	Once these are published, consider how these can support our communications approach
User voice	Where appropriate, include the voices of patients and service users in our communications  Stakeholder and PSA recognition of our focus on user voice

Convening role	Wherever possible, look for opportunities to bring together stakeholders  Recognition of this approach by stakeholders and the PSA
Optical Sector Familiarisation Programme	Continue to run and communicate about  At least 3 sessions annually

### ***Creating fairer and more inclusive eye care services***

- Given our role in the eye care sector, we should aim to deliver communications to a “gold standard” of accessibility, ensuring that everyone is able to access our services in the way that is best for them.
- We should ensure that we are using the most appropriate channels for our communications. As younger registrants join the register, and Twitter use declines, we will trial an Instagram account to ensure we are reaching registrants in the places we most interact.
- We should also ensure that our brand and messaging continue to showcase underrepresented groups, in line with our EDI commitments.

<b>Area of work</b>	<b>Success measures</b>
Undertake audit of channel accessibility	Implement identified improvements Increased followers and engagement on website and social channels
Develop “easy read” versions of core publications	Easy read versions of annual report and business plan annually. Consider any flagship reports for easy read
Trial Instagram account	Look to gain 1000 followers in six months
Brand/messaging	Ensure appropriate representation in imagery and messaging

### ***Supporting responsible innovation and protecting the public***

- The launch of the new MyGOC platform offers an innovative opportunity to streamline our communications with registrants and will function as a new direct channel to communicate with them. This will support registrants in their practice by streamlining the administrative tasks they need to undertake.

<b>Area of work</b>	<b>Success measures</b>
MyGOC	Successful launch where all registrants are able to access

	Increased engagement with surveys and research requiring registrant input
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### Communications as a strategic function

- In continuing to develop communications as a strategic function for the organisation, we will continue to work with colleagues to develop their knowledge and understanding of the importance of communications, including by delivering training.
- We will also ensure that the communications continues to be engaged in decision making through Leadership team and SMT to ensure a joined up and timely approach.

Area of work	Success measures
Supporting colleagues to be effective communicators	<p>Effective management of the comms inbox to deal with communications queries</p> <p>Ensure all major projects have a communications lead and appropriate comms plan</p> <p>Provide team communications training for education and CPD and other teams – look to see improved communications and improved joint working</p> <p>Look for opportunities to share communications skills with colleagues</p>
Ensure a joined-up approach	<p>Communications strategy training with SMT</p> <p>Continue to run and effective comms grid</p> <p>Comms presence at Leadership team and SMT (where appropriate)</p>

### 9. Evaluation

This strategy will be evaluated by regular reporting on outcomes and the KPIs identified above to SMT through the monthly business plan reporting and via business plan objectives.

**Council****Member code of conduct review**

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**Meeting: 24 June 2026****Status:** For decision.**Lead responsibility:** Leonie Milliner, Chief Executive and Registrar**Paper Author(s):** Andy Mackay-Sim, Chief of Staff**Purpose**

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1. To present a revised member code of conduct for Council to approve.

**Recommendations**

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Council is asked to:

- **approve** the revised member code of conduct;
- **delegate any** minor amendments to the code for approval by the Chief of Staff (in consultation with the Chair of Council); and
- **approve** a revision of the Council scheme of delegation to remove the reference to 'investigations policy'.

**Strategic objective**

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2. This work is a core governance document and indirectly contributes towards all three strategic objectives. It is included in the internal business plan for Governance for 2025/26 and 2026/27.

**Background**

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3. The Charity Governance Code recommends that all charities have a code of conduct for trustees to support good governance practice. This document assists trustees in understanding their obligations, and the expectations placed on them in respect to leadership, ethics and culture.
4. As consequence, the GOC has adopted a member code of conduct which covers all individuals engaged as members of Council, its committees or panels (except for Education Visitor Panel members, who will be covered under a similar code developed by the executive). This defines the standards of conduct expected by all those engaged in this context. The document was last revised in 2021. The current code is attached as **annex 1**.
5. The Chief of Staff has significantly revised the code of conduct to take account of best practice, feedback and themes that have emerged from governance failures in the wider charity and public sector. This revised version is attached **annex 2**.
6. Council was provided with a provisional draft at its strictly confidential meeting on 10 March 2026. It reviewed the updates, the engagement undertaken to date and the planned engagement activity.

7. Following the discussion, the Chief of Staff issued the proposed code and a survey to all Council, committee and panel members (including independent committee members and Council Associates). Individuals were asked to complete a short questionnaire with the following questions:
  - To what extent does the proposed code support you in understanding the obligations of members? (1-5 rating)
  - How confident would you feel in using the code to identify and speak up about poor conduct? (1-5 rating)
  - What, if anything, do you feel the code does well? (free text box)
  - What, if anything, do you think the code is missing? (free text box)
8. The results of this survey, including the executive response to the free text questions are attached in **annex 3**.

## Analysis

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7. The member code of conduct has been revised as follows:
  - additions to clarify specific responsibilities for Council members (both in terms of the relevant legislation and in the context of being charity trustees);
  - additions to clarify the general obligations that apply to all members and remove ambiguities in the previous wording;
  - explicit provisions regarding the statutory obligation to not undermine public confidence in the regulation of registrants;
  - explicit provisions about what is likely to constitute a breach of the code;
  - additional guidance on working together with the executive, including a section on personal relationships;
  - greater emphasis on equality, diversity and inclusion, which is concomitant with the Council's obligations and commitments under the EDI strategy;
  - additions to reference anti-fraud, sexual harassment, bullying and other forms of harassment;
  - additions to outline how the GOC recognises and preserves the independence of its members, and the parallel responsibility for the executive to provide professional candour and advice in order to support the GOC's statutory role;
  - a set of core principles to support the Chief of Staff and others in determining how to resolve any ambiguities that arise in relation to decision-making about member or staffing matters.
8. The Chief of Staff engaged with the following key stakeholders:
  - a meeting with the Chief Executive and Registrar, Chair of Council and Senior Council Member;
  - a meeting of the Governance documents working group (comprised of Kathryn Foreman, Tim Parkinson and Hema Radhakrishnan) session to review the proposed code alongside the codes of conduct from other health and social care regulators;
  - an open invite focus group with Hearing Panel members and chairs to share their feedback on the proposed code (eight members attended, two provided written feedback);
  - a meeting with the Hearings team to review the new elements of the code and how these might relate to their work; and

- desktop reviews with SMT, the Chief Legal Officer, Head of Communications and Head of People and Culture.
9. Feedback has been positive, with all parties endorsing the overall tone and style of the code. Several amendments have been made to reduce ambiguity and strengthen the GOC's expectations of members in key areas. One area of potential risk identified in several discussions was the use of social media. A social media policy is being developed by the Head of Communications to support the GOC and its people (employees, Council members and workers) to understand their obligations in this regard. This will also reflect the guidance issued by the Charity Commission on social media usage by trustees. It is anticipated that this policy will be finalised in the summer with a decision by Council in September 2026.
  10. The government is proposing additional legal responsibilities for public officials under the Public Office (Accountability) Bill. This is yet to be passed into law. As an interim arrangement, the code has been amended to make it explicit that Council members are public office holders and subject to any legal duties that arise from holding office. Briefings and training will be provided to Council members when their duties change.
  11. Nominations Committee will support the Chief of Staff to develop processes and procedures to support the use of the code, including how alleged breaches of the code will be considered. A Council decision regarding the process is planned for later in 2026/27.
  12. Council's feedback on the proposed revisions will be incorporated into the code before it is finalised. A time-limited delegation is being proposed to assist with this final approval.
  13. The current Council scheme of delegation gives Council the authority to approve an investigations policy. This policy is an amalgamation of several functions, including the process for workplace investigations in relation to employees. The Head of People and Culture and Chief of Staff have agreed that Council should have a separate policy for member issues, and the workplace investigation policy would be better delegated to Senior Management Team (SMT) as an operational policy for employees. A recommendation is included to enact this change.
  14. The Chief of Staff will develop a light touch investigations policy for member conduct concerns, and present this to Nominations Committee for review. This will then be considered by Council.

## **Finance**

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15. There is no financial impact attached to the code of conduct. All activities are delivered within the current budgets set by Council. Any new activities would be assessed for financial implications as they were developed.

## **Risks**

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16. The code is a key mitigation for risks around poor governance practice and organisational culture. Having an explicit, transparent code of conduct ensures that members are supported to demonstrate high standards of ethics and probity.

## **Equality Impacts**

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17. The proposed code of conduct is anticipated to have a positive impact in terms of the GOC's approach to EDI. It includes several explicit provisions about the responsibility of members to reflect EDI in all aspects of their work, including setting the organisational tone and culture for the organisation.

## **Devolved nations**

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18. There are no explicit impacts for devolved nations.

## **Other Impacts**

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16. There are no significant impacts identified.

## **Communications**

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### **External communications**

17. No external communications are planned. A copy will be shared with the PSA for information.

### **Internal communications**

18. Once confirmed by Council, the self-assessment will be circulated to Leadership Team for information.

## **Next steps**

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19. None.

## **Attachments**

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- Annex 1 – GOC code of conduct for members – current version
- Annex 2 – GOC code of conduct for members – revised version
- Annex 3 - Member code of conduct survey response
- Annex 4 - Member code of conduct survey summary

## **THE GENERAL OPTICAL COUNCIL**

### **Code of Conduct for Members**

#### **Introduction**

The General Optical Council's main objective is to protect, promote and maintain the health and safety of the public. It follows that public protection is at the heart of the role of Council members, Committee members and Hearings Panel members and must at all times underpin their conduct and behaviour.

This Code provides guidance for members to assist them in undertaking their duties in accordance with currently accepted standards of public service.

The Council endorses the Seven Principles of Public Life set out by the Nolan Committee (1996):

#### **Selflessness**

Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.

#### **Integrity**

Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

#### **Objectivity**

In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

#### **Accountability**

Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

#### **Openness**

Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

#### **Honesty**

Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

#### **Leadership**

Holders of public office should promote and support these principles by leadership and example.

## **Ways of working**

Our mission, vision and values are set out below:

### **Our mission**

Our mission is to protect the public by upholding high standards in the optical professions.

### **Our vision**

Our vision is to be recognised for delivering world-class regulation and excellent customer service.

### **Our values**

Our values underpin the way we work with each other, with the public, registrants and partner organisations:

We act with integrity

We pursue excellence

We respect other people and ideas

We show empathy

We behave fairly

We are agile and responsive to change

## **Corporate responsibilities**

Members of Council together take corporate responsibility for the governance of the organisation and its decisions.

As trustees of a charity employing staff, they have a duty to ensure that the GOC complies with relevant employment, equalities, human rights, health and safety, data protection and freedom of information legislation.

More generally, members of Council have corporate responsibility for ensuring that Council complies with any statutory or administrative requirements for the use of its funds. This includes compliance with charity law and the requirements of the Charity Commission.

Council is accountable to the public through Parliament and the Privy Council.

The key functions of the Council are:

- ③ Policy and Strategic Direction
- ③ Performance Monitoring
- ③ Financial Stewardship
- ③ Accountability, Communication, and Stakeholder Engagement

**Duties of individuals**

Members of Council have a duty to ensure that they have a clear understanding of their responsibilities as trustees of a registered charity and that they meet the legal requirements for eligibility to serve as a charity trustee.

Members have a duty to make themselves available for service on the Council and those of its Boards, Committees and Panels to which they may be appointed.

Individual members should follow the Seven Principles of Public Life and comply with this Code of Conduct as follows:

**Attendance**

Members are expected to attend Council, Council committees, working groups and seminars regularly, to prepare and contribute effectively and to conduct themselves at all times in accordance with the public interest.

**Confidentiality**

Members are expected to respect the confidentiality of privileged information and only to share documents on public agendas.

**Equality and Diversity**

Members must at all times demonstrate respect and dignity for others; a commitment to diversity and equal opportunities; and conduct themselves in a non-discriminatory manner.

**Expression of views**

Members are expected to distinguish clearly, when speaking or writing, between personal views and those of the GOC. Any communication with the media either of a general nature which may not be specifically related to Council work or policy or more particularly which is about the Council's work or policy, including publication of views via the Internet, should be discussed with the Communications Manager, Chair or Registrar before a statement is made.

**Collective responsibility**

Members accept collective responsibility for enabling Council to achieve its objectives and for decisions taken by Council. Members are expected to contribute to discussion and debate freely to enable a robust decision to be made. Once Council has taken a decision, members must support the communication and implementation of that decision.

**Speaking up**

Notwithstanding collective responsibility, members have a duty to raise any concerns about possible wrongdoing within the GOC, as set out in our Speaking Up Policy, with the Chief Executive if it concerns a member of staff, with the Chair of Council if it concerns the Chief Executive or another member, or with the Chair of the Finance, Audit and Risk Committee if it concerns the Chair of Council.

### Conflicts of Interest

Members have a duty to complete and maintain their entry in the Members' Register of Interests, declaring any professional, business, or personal interests which may, or might be perceived to, conflict with their responsibilities as members in accordance with Council's guidance.

Members have a duty to avoid placing themselves under obligation to any individual or organisation which might affect their ability to act impartially and objectively in relation to their GOC responsibilities. This includes observing our guidance on management of interests and making any declarations as required by this guidance.

Members are free to engage in political activities or to maintain associations with professional organisations provided that such activity does not conflict with the public protection role of the GOC or compromise their position as a member.. Such outside activities must always be openly declared when a related matter is under discussion.

If a member or a body corporate for which a member is a responsible officer, is the subject matter of an investigation or proceedings undertaken by the GOC regarding their fitness to practise (or in the case of a body corporate, fitness to undertake business as an optometrist or dispensing optician, or both) the member must contact the Registrar and declare this. The member must make such a declaration immediately they are aware that the GOC has received a complaint or information to initiate an investigation or proceedings. The presumption will be that the member will withdraw from all activities related to Council business until the conclusion of the investigation or proceedings. This is an essential step to protect the GOC from any perception that a conflict of interest may exist which might impact upon the decisions that the GOC takes during the investigation or proceedings. The member must under no circumstances discuss the subject matter of the investigation or proceedings with any other member or employee.

Members may be approached to act as a witness on behalf of a registrant who is to appear before the Fitness to Practise Committee or whose case is to be considered by the Investigation Committee. It is inappropriate for a member to act as an expert witness for any party appearing before the Fitness to Practise Committee, or whose case is to be considered by the Investigation Committee. Members must refuse to accept any such instructions, or resign their position. Should a member be approached to act as a lay (i.e. nonexpert) or *character* witness on behalf of a registrant who is to appear before the Fitness to Practise Committee, this must be immediately declared to the Registrar. Again, the presumption will be that the member will withdraw from all activities related to Council business until the conclusion of the investigation or proceedings. This is also to protect the GOC from any suggestion that the Investigation Committee for Fitness to Practise Committee might be unduly influenced by hearing evidence from an active member or any perception that the Investigation Committee or Fitness to Practise Committee may be biased as a result.

**Gifts and hospitality**

Members must not accept gifts, hospitality or benefits offered as a consequence of GOC business, other than reasonable refreshments. If gifts cannot be refused without causing offence, they should be reported to the Registrar within 15 working days, who will discuss with the member what action should be taken.

**Anti-Fraud**

Members are expected to adopt the highest standards of propriety and accountability and to promote an anti-fraud culture. This includes ensuring compliance with the law on bribery and taking steps to avoid any situation where there is an expectation of a gift or payment in return for an advantage of any kind.

**Personal behaviour**

Members' behaviour must demonstrate the standards expected of holders of public office. Where a member has been charged with, or has been convicted of, a criminal offence, or has been the subject of a disciplinary procedure by any licensing body (including the GOC), the member must inform the Registrar at the earliest opportunity. The presumption will be that the member will withdraw from all activities related to Council business until the conclusion of the investigation or proceedings.

17 July 2006

Amended April 2009

Amended November 2020

## Code of conduct for members

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Status of document: Draft			
Version: v2.0			
Date of approval: TBC			
Effective from: TBC			
Owner: Council			
Author: Chief of Staff			
Planned next review date: Approval + 5 years			
Version	Author	Date	Changes
2	Chief of Staff	TBC	Substantial revision to v1

## 1. Purpose

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- 1.1 The purpose of this policy is to set out the standards of conduct required of our Council and committee members. The policy is structured as follows:
- Scope: who this policy applies to;
  - Legal obligations: the statutory powers and duties conferred to members, and the relevant legislation for different GOC roles
  - General obligations: those obligations that apply to all members, regardless of role.
  - Specific obligations: where the obligations include a more explicit or different requirement because of the role.
  -
- 1.2 This code of conduct will assist our members in understanding the ethical and cultural principles we embody as an organisation, and the behaviours we expect when they work on our behalf. It will also assist the public, registrants, employees and workers to know what they can expect from our members. Setting ourselves a high standard for ethical conduct in public life is a critical part of how we discharge our responsibilities as a regulator and charity with confidence.

## 2. Scope

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- 2.1 This policy applies to anyone who has been appointed by the GOC to undertake a role as a member of a committee or panel, and to those who have been appointed by the Privy Council as a member of Council.
- 2.2 This policy does not extend to others working on behalf of the GOC (for example, employees). A separate group of policies apply in such circumstances, though the GOC will align such documents to reflect our organisational values and shared principles where appropriate.
- 2.3 Individuals will be advised of which policies apply at the time they are appointed by the GOC. Members are expected to be familiar with both the general responsibilities outlined in the code, and those that apply to their specific role.
- 2.4 A principle of proportionality will be applied when assessing potential breaches of the code of conduct. The broad aim of the proportionality principle in the context of the code of conduct is to ensure that the code does not have a greater effect on the personal lives of members than is reasonably necessary to protect the interests and reputation of GOC.
- 2.5 To that end, the GOC expects members to avoid taking any action that would be liable to undermine public confidence in the regulation of registrants. This code of conduct therefore applies to all professional and personal conduct, where such conduct would be liable to undermine public confidence in the regulation of registrants. This applies regardless of whether the member was actively undertaking work on behalf of the GOC at the time.

2.6 This code of conduct should not be considered an exhaustive statement of the kinds of conduct which may result in the Council considering a breach of this code of conduct.

### 3. Legal obligations

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3.1 There are several provisions within legislation by which a member might be disqualified, suspended or removed from office. The GOC expects members to familiarise themselves with these conditions and take all reasonable steps to inform the Chief of Staff without delay if they believe these conditions apply or are likely to apply.

3.2 The statutory obligations apply as follows to the following groups:

Role	Statutory provisions regarding disqualification, suspension or removal
Council member	The General Optical Council (Constitution) Order 2009
Statutory Committee member (members appointed to Advisory Panel and one of its statutory committees)	The General Optical Council Committee Constitution Rules 2005 (Part 1A)
Hearings Panel member	The General Optical Council Committee Constitution Rules 2005 (Rule 28)

3.3 The legislation that is specific to the GOC is published on its website [here](#). In addition, the GOC is registered as a charity in England and Wales, and must comply with charity law.

3.4 As trustees of the charity, Council members have specific legal duties, including under the Charities Act 2011 and the Trustee Act 2000. Charity Commission guidance describes the six main duties of charity trustees as follows:

- Ensure your charity is carrying out its purposes for the public benefit;
- Comply with your charity’s governing document and the law;
- Act in your charity’s best interests;
- Ensure your charity is accountable;
- Act with reasonable care and skill; and
- Manage your charity’s resources responsibly.

3.5 The Professional Standards Authority for Health and Social Care (PSA) is the independent regulatory oversight body for regulators of health and care practitioners. It fulfils this role by reviewing and monitoring performance, producing guidance, sharing knowledge and expertise. All GOC members are expected to comply with the guidance issued by the PSA relevant to their respective roles. The executive will support members by providing education

and training on this guidance and how it is reinforced by GOC policies and processes.

- 3.6 Registrant members are defined as those registered with the GOC in one of the professions we regulate. All registrants are expected to uphold the standards required of them by the GOC. The statutory provisions provide further detail in relation to fitness to practise matters and how these could be considered grounds for disqualification, suspension or removal as a member.
- 3.7 In addition, if an individual (either a registrant or lay member) works in a regulated profession, there is an expectation that they will act in accordance with the standards and regulations that apply to their profession. They must fulfil any legal duty as required under the terms of their registration with a regulated body. Failure to do so could be considered grounds for disqualification, suspension or removal as a member.
- 3.8 If the individual has been recruited for a role which includes a specific requirement to hold a professional or regulated status, then this must be maintained for the duration of their term of office.

## 4. General responsibilities

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### Principles of public life and GOC values

- 4.1 All members of the GOC are expected to maintain high standards of integrity, probity and ethical conduct in their professional and personal lives. Members must act in accordance with the seven principles of public life:

**Selflessness:** Holders of public office should act solely in terms of the public interest.

**Integrity:** Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

**Objectivity:** Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

**Accountability:** Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

**Openness:** Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.

**Honesty:** Holders of public office should be truthful.

**Leadership:** Holders of public office should exhibit these principles in their own behaviour and treat others with respect. They should actively promote and robustly support the principles and challenge poor behaviour wherever it occurs.

4.2 In addition to this, members are also required to act in accordance with the values of the GOC, namely:

- We act with integrity
- We pursue excellence
- We respect other people and ideas
- We show empathy
- We behave fairly
- We are agile and responsive to change.

4.3 The GOC will produce policies and procedures that support members in meeting these obligations. Key relevant policies include, but are not limited to:

- Anti-fraud policy
- Expenses policy
- Financial regulations and scheme of delegation
- Freedom to speak up policy for members, employees and workers
- Gifts and hospitality policy
- Information Governance framework
- Management of interests policy
- Member appointment policy
- Member fee policy
- Member review policy
- Safeguarding policy
- Social media policy (to follow)

4.4 The relevant policies will be published on the GOC website and shared with members regularly, including at the appointment stage.

4.5 Evidence of a failure to comply with these policies will constitute a breach of the code of conduct. Failure to reflect the GOC values or the principles of public life will constitute a breach of the code of conduct, where such conduct would be liable to undermine public confidence in the regulation of registrants.

## **Equality, Diversity and Inclusion (EDI)**

- 4.6 The GOC has published an equality, diversity and inclusion (EDI) strategy for 2025-30 which summarises our key commitments, and describes the following objectives:
- Be active in addressing inequality and preventing discrimination
  - Promote and reflect diversity
  - Foster inclusivity and accessibility
  - Build a culture of confidence in EDI
- 4.7 Promoting equality, reducing inequalities and addressing discrimination are essential components of who we are as an organisation. Throughout the development of this policy and the processes that support it, we have:
- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
  - Given regard to the need to reduce inequalities, bias and unfair outcomes.
- 4.8 All members have an obligation to promote equality, reduce inequalities and address discrimination. There is an expectation that members will support the commitments set out in the GOC EDI strategy and take personal responsibility for promoting it in their roles.
- 4.9 The GOC expects all members to meet this obligation by:
- familiarising themselves with the EDI strategy, EDI policy and the GOC's anti-racism statement;
  - attending education and training, and having due regard for any advice and guidance provided to assist members in fulfilling their responsibilities;
  - engaging with the GOC's support to ensure members can consider inclusive behaviours, reducing bias and upholding dignity in discussions and decision-making;
  - actively supporting the GOC in its work to remove barriers to EDI, including making reasonable adjustments where recommended; and
  - speaking up when you feel we have not met our EDI commitments as an organisation
- 4.10 Evidence that a member has failed to meet their obligations in respect to EDI, or interfered in the GOC's duties in this respect, will be considered a breach of the code of conduct.

### **Attendance and participation at meetings**

- 4.11 All members have an obligation to engage fully in respect to their specific roles; this includes taking the time to prepare for and attend meetings. This is to ensure that the GOC can effectively discharge its statutory functions as a charity and regulator. The GOC will consider any necessary reasonable

adjustments for members with disabilities or long-term conditions to support attendance and participation.

- 4.12 Repeated failure to attend meetings is likely to be considered a conduct issue, unless the individual has given reasonable grounds for non-attendance.
- 4.13 Where necessary, the Chief of Staff can agree a temporary leave of absence for up to twelve months. Longer leaves of absence will require a decision by Council (for Council members) or Nominations Committee (for all other members). Council members who fail to attend three consecutive sessions of Council (which means a consecutive absence from three strictly confidential meetings and three public meetings in total) without reasonable explanation will be considered a breach of the code of conduct. Statutory committee members who fail to attend three scheduled meetings of the statutory committee they are appointed to without reasonable explanation will not be subject to annual reappointment. Independent Committee members who fail to attend three scheduled meetings of the relevant committee without reasonable explanation will be subject to automatic removal by Nominations Committee. In every circumstance, the Chief of Staff will write to the member providing advance notice of the intention to remove the member, in case the member wishes to offer an explanation or alternative course of action for the relevant decision-maker to consider.

### **Confidentiality**

- 4.14 Members must respect the confidentiality of the information shared with them in the context of their duties with the GOC. They must not distribute it to others outside the GOC. It is only permitted to share documents that are already in the public domain. If members wish to use information that is not in the public domain, then they should contact the relevant author to obtain the necessary permission. If they are uncertain of the document's provenance, then they should contact the Chief of Staff. Any deliberate sharing of sensitive information with third parties without express written permission will be considered a breach of the code.
- 4.15 Members are required to comply with the GOC's information governance framework, including any instructions provided by the Information Governance team about the secure storage and disposal of confidential information.

### **Expression of views and communication**

- 4.16 Members are required to distinguish clearly, when speaking, writing or otherwise acting, between their personal or professional views (including those of their employers or other organisations they work for) and those of the GOC. It is important that any communication or actions, regardless of whether they are personal or not, do not undermine public confidence in the GOC's ability to

regulate, and do not interfere with the GOC's charitable purpose. This extends to social media used in a personal or professional capacity. Any misrepresentation of the GOC's views or reputational harm that arises from a member's communications are likely to be considered a breach of the code.

4.17 Members should not take any action or make any commitment which might be construed as being done on behalf of the GOC, unless authorised by the GOC to do so.

4.18 In relation to queries or correspondence on policy matters, Council members should seek the advice and views of the executive. Council members should uphold collective responsibility in responding to queries, as set out in the GOC's standing orders.

4.19 Any queries or correspondence about operational decisions involving cases of individual registrants are to be referred to the executive for any response. In some circumstances members may wish to respond directly to the individual or organisation that has written to them. The Chief of Staff can provide a draft form of words for members to use.

4.29 Any communication with the media that carries reputational impact for the GOC should be discussed with the Head of Communications and Engagement, Chair of Council and Chief of Staff before a statement is made. This includes statements of a general nature (which may not be specifically related to Council work or policy but could impact the perception of the GOC) or more particularly which is about the Council's work or policy. Communication includes publication of views via the internet, social media or other public platforms.

### **Member review and personal development**

4.30 The member review policy describes the purpose and process for member reviews. Council members are required to engage in the review process, and failure to do so without reasonable grounds will be considered a breach of the code.

4.31 All members are required to commit to personal and professional development, including briefings and development offered by the GOC. The mandatory training required of members will be determined by the Chief of Staff in consultation with the Nominations Committee.

### **Management of interests**

4.32 All members are required to disclose and manage any conflicts of interests relevant to their duties at the GOC, including those that might relate to a connected person.

- 4.33 The management of interests policy provides explicit guidance for members on the management of interests, and any failure to disclose any relevant conflict in a timely fashion is likely to be considered a breach of the code of conduct.
- 4.34 If something within this policy brings an individual into conflict with their obligations outside of the GOC, then they should seek advice from the Chief of Staff as a priority.

### **Working with the executive**

- 4.35 Effective working relationships between members and others working on behalf of the GOC are essential for the discharge of the GOC's regulatory duties. It is acknowledged that good working partnerships are critical to the governance and culture of the organisation, regardless of seniority, responsibilities or other relevant factors.
- 4.36 There is an expectation that members and employees will show each other mutual respect and courtesy when working together. This expectation extends to anyone undertaking work on behalf of the GOC, including contractors, workers and others.
- 4.37 The GOC recognises that the independence of its members is a critical part of how the organisation discharges its regulatory obligations. Parallel to this independence is the expectation that those working on behalf of the GOC can speak with candour in pursuit of the GOC's statutory purpose, and that members will give due regard to any advice or views provided for that aim.
- 4.38 While members can rely on appropriate advice and support from the executive when performing their duties, both the executive and its members will seek to preserve that independence and not knowingly place each other in a position where the principles of public life could be comprised. Any deliberate attempt to do so by a GOC employee is likely to be considered a disciplinary matter. Any deliberate attempt to do so by a member is likely to be considered a breach of this code.
- 4.39 The GOC maintains this independence through its organisational structure, committee terms of reference, schemes of delegation, reporting lines, policies and protocols. Underpinning this are the following general principles:
- Decisions about members, whether these be matters of policy or in respect to individual members, will be taken by members, except where certain administrative functions are explicitly delegated by Council (such as the payment of expenses);
  - Where policies apply to members and others working on behalf of the GOC, the presumption will be that the approval rests with Council unless explicitly delegated;
  - Decisions about members will be taken with consideration of the views of the executive, where necessary or appropriate;

- Decisions about members will not be subject to undue influence by the executive;
- Decisions about individual staffing matters will not be made by members, except in the limited circumstances as set out in the Council scheme of delegation (such as the appointment of the Chief Executive and Registrar); and
- Decisions about individual staffing matters will not be subject to undue influence by members.

4.40 If circumstances arise where there is uncertainty in respect to where the necessary authority lies, and policies or procedures are silent on how these principles should be applied, then the Chief of Staff will determine the necessary procedures to ensure the GOC's compliance with its governance framework and these principles.

### **Bullying and harassment**

4.41 The GOC does not tolerate bullying or harassment and will consider such behaviour a breach of the code of conduct.

4.42 The Advisory, Conciliation and Arbitration Service (ACAS) describes bullying as unwanted behaviour from a person or group that is either:

- offensive, intimidating, malicious or insulting; or
- an abuse or misuse of power that undermines, humiliates, or causes physical or emotional harm to someone.

4.43 Bullying might:

- be a regular pattern of behaviour or a one-off incident;
- happen face-to-face, on social media, in emails or calls;
- happen at work or in other work-related situations; and
- not always be obvious or noticed by others.

4.44 It is possible someone might not know their behaviour is bullying. It can still be bullying even if they do not realise it or do not intend to bully someone.

4.45 In addition to the above, under the Equality Act 2010, unwanted conduct behaviour can be harassment if it relates to any of the below listed 'protected characteristics' and has the purpose or effect of either (a) violating the other person's dignity or (b) creating an intimidating, hostile, degrading, humiliating or offensive environment for the other person. The relevant characteristics are:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race

- religion or belief
- sex
- sexual orientation

4.46 Members can also have confidence that the GOC will take any concerns about bullying and harassment by others seriously. This will include investigation where necessary.

4.47 Where members witness bullying or harassment, they have a responsibility to speak up under the GOC's freedom to speak up policy.

### **Personal relationships in the workplace**

4.48 It is rarely appropriate for members and the executive to have personal relationships that extend beyond the workplace and what would be expected in a professional setting. While circumstances may arise from time to time that could be considered manageable, it is critical that any personal or family relationships are disclosed to the Chief of Staff and appropriately considered under the management of interests policy.

### **Sexual harassment**

4.49 Sexual harassment, or victimisation connected to it, is unlawful and will not be tolerated. We will take active steps to help prevent the sexual harassment and victimisation of anyone working on behalf of the GOC. Anyone who is a victim of, or witness to, sexual harassment is encouraged to report it in accordance with the organisation's commitments and legal duties. This will enable us to take appropriate action and provide support.

4.50 Sexual harassment and victimisation will be considered a serious breach of the code of conduct in respect to members.

## **5. Specific responsibilities: Council**

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### **Trustee duties**

5.1 The GOC is a charity registered in England and Wales, and is subject to charity law. Council members are charitable trustees as defined within the Charities Act 2011 and are required to act in accordance with charity law and guidance. Failure to comply with the duties and responsibilities of a charitable trustee will be considered a breach of the code of conduct.

5.2 The Council is collectively responsible for decision-making, and individual Council members are bound by the provisions within the standing orders of the Council. Failure to comply with the standing orders is likely to be considered a breach of this code of conduct.

5.3 Council members accept collective responsibility for the pursuit of the Council's objectives and for decisions taken by Council. Council members are expected to contribute to discussion and debate freely to enable a robust decision to be

made. Once Council has taken a decision, individual Council members must support the communication and implementation of that decision.

## **Public office duties**

- 5.4 Although not publicly funded, the GOC is a public body for some purposes including judicial review and freedom of information requests. Accordingly, members may be classified as holders of public office, and thus may be subject to the common law offence of misconduct in public office (and any offences that are introduced by the Public Office (Accountability) Bill) as well as the tort of misfeasance in public office. Any such adverse finding will be considered a breach of this code.

## **6. Specific responsibilities: Council Associates**

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- 6.1 Council has opted to establish a Council Associate scheme. This is open to registrants, and the purpose of scheme is to:
- enrich debate and ensure a greater diversity of lived experiences to inform our decision making.
  - offer talented candidates the experience and skills needed to go on to have a rewarding boardroom career.
- 6.2 Council Associates will take part in all our Council meetings and associated activity. They will also get involved in our Audit, Finance and Risk Committee to maximise their transferable experience of governance.
- 6.3 Due to our governing laws, the legal obligations outlined in section four above do not apply to Council Associates. Council Associates cannot be voting members when decisions are taken. However, they will be expected to maintain a high level of professional integrity, confidentiality and conduct, including those responsibilities outlined in section five. As registrants, Council Associates are required to uphold the standards required of them by the GOC.

## **7. Allegations relating to conduct**

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- 7.1 The public can refer concerns about a member's conduct via the corporate complaints policy. The policy includes a section about how the GOC will consider complaints about members.
- 7.2 Those working on behalf of the GOC can refer their concerns under the GOC's freedom to speak up policy. This should be referred to the Chief of Staff unless there is a conflict of interest, in which case the issue should be raised with another named person in the policy (for example, the Chair of Council, Senior Council Member or Chief Executive and Registrar).
- 7.3 The Chief of Staff will ensure that the Chair of Council, or another appropriate member, is engaged at the point the concern is received. The Chief of Staff will consult with the appropriate member on whether the member subject to referral

is invited to temporarily withdraw from duties. It is expected that any member invited to withdraw from duties will comply with the request until such time as the matter is resolved.

## **8. Sanctions relating to conduct**

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- 8.1 The grounds for disqualification are matters that would be established by another authority, such as a court of competent jurisdiction, a regulator (including the GOC's fitness to practise committee) or other statutory authority. Matters of disqualification are therefore not covered by the code of conduct. Where circumstances have arisen where a member has been disqualified from office by virtue of a condition within the relevant legislation, the Chief of Staff will take the necessary steps to remove them from office without delay.
- 8.2 The legislation described in section four of this code sets out the grounds for possible suspension and removal from office. Council has determined that the following are potential actions available when matters do not result in a suspension or removal from office:
- a breach of code of conduct letter will be sent to the member;
  - an action Council requires the member to undertake;
  - written commitment from the member to abide by specific conditions;  
or
  - a requirement to undertake further education and education and training.
- 8.3 Council will determine the process by which issues relating to member conduct, sanctions and the possible removal or suspension from office are considered.

**Annex 3: Member code of conduct – Update 2026**

**Survey responses to the question: What, if anything, do you think the code is missing?**

Feedback raised	Executive response
<p>Not something missing but perhaps an error - under 8.2 there is a reference to the Council potentially requiring a member to issue an apology. It is my understanding that generally under UK law (and policy) you cannot legally or procedurally compel anyone to issue an apology against their will. For self-evident reasons an apology has to be made freely, otherwise it is insincere and meaningless.</p>	<p>The reference to requiring an apology has been removed from the final document.</p>
<p><b>A point of clarification: 4.17 Members should not take any action or make any commitment which might indicate their acceptance of the individual or organisation’s position on behalf of the GOC. The GOC sits on Advisory Groups - which are associated with different projects etc - which (I assume) indicates their acceptance and support of an organisations position (e.g. College of Optometrists UK Eye Care data hub - <a href="https://www.college-optometrists.org/policy-and-influencing/uk-eye-care-data-hub#advisorygroup-f3d40de7">https://www.college-optometrists.org/policy-and-influencing/uk-eye-care-data-hub#advisorygroup-f3d40de7</a>) I wanted clarify that 'not take any action' does NOT mean that GOC members etc are not to sit on these groups? I hope that makes sense - I wanted to clarify what 'take any action' really means? Thanks</b></p>	<p>The cited example is not relevant, as an employee is the GOC representative on the advisory panel for the UK Eye Care Data Hub.</p> <p>Appointment of members to outside bodies, including advisory bodies, should be made by the GOC. Typically, this is agreed by the Chair of Council and reported to the next Council meeting.</p> <p>The wording has been altered to clarify that members can act or make a commitment where they have the necessary authority to do so.</p> <p>The GOC schemes of delegation also specify some circumstances where authority is delegated to a single member (for example, where the Chair of Council is a required signatory for contracts above a certain value).</p>
<p>The obligations for the distinct individuals e.g. Council members, panel members etc. are scattered throughout and I wonder whether a summary under headings for specific groups would make the document simpler to navigate</p>	<p>The code has been structured to begin with the legal framework, before moving to general responsibilities and then specific responsibilities. A short sentence has been included to explain that structure from the outset.</p>

**Annex 3: Member code of conduct – Update 2026**

**Survey responses to the question: What, if anything, do you think the code is missing?**

<p>and make sure the groups appreciate their specific roles and requirements within it in a far simpler fashion? The phrase, 'then they should seek advice from the Chief of Staff as a priority.' comes in many places and relates to all individuals. However, a panel member, for example, has no link/contact/connection to the Chief of Staff and with so many individuals, is this the most effective process for escalation? There is no safeguarding element - vulnerable adults, children witnesses etc. I wonder if this is an area you may wish to consider? There is no element relating to modern technology and disappearing media, WattsApp groups etc.? There is nothing relating to photography, recording etc.?</p>	<p>The Chief of Staff is the individual with delegated responsibility for coordination of member and governance issues. All members receive an induction and introductory session with the Chief of Staff following appointment.</p> <p>The Chief of Staff is also working with the Head of Hearings to ensure there is a greater visibility of the role for panel members.</p> <p>The GOC has a safeguarding policy and a safeguarding group responsible for considering related issues and advising members. The code already includes requirements to abide with this policy.</p> <p>The retention of information is covered in the Information Governance policies, which are mandated in the code for all members. This would extend to any Whatsapp messages or groups.</p> <p>The recording of meetings and photography has not presented itself as an issue in the past and is more likely to relate to the conduct of witnesses or other meeting attendees. Provisions are already set out in the remote hearings protocol. This will be considered as a future revision to Council, committee and other panel procedures.</p>
<p>Not very clear on who 'members' are - this is crucial to establishing who important aspects of the policy apply to. Some parts apply only to council members. Suggest adding a definition of 'members' (to include ftp hearing panel members) to s2.1.</p>	<p>Amended 2.1 to clarify that a member is anyone <u>appointed</u> to a panel or committee by the GOC or appointed by the Privy Council to Council. This is the simple definition of a 'member' in the context of the work of the GOC. Where responsibilities differ, this is set out in sections 5 and 6.</p>
<p>Clarity that the Nolan principles relate to public life, e.g. pure selflessness etc. isn't expected in private life too</p>	<p>There are circumstances where a member's actions in their private life could impact the public's perception of their ability to reflect the Nolan principles in their public role (for example, a conviction for a significant offence).</p> <p>The code cannot cover every foreseeable scenario, so it is recommended that the</p>

**Annex 3: Member code of conduct – Update 2026**

**Survey responses to the question: What, if anything, do you think the code is missing?**

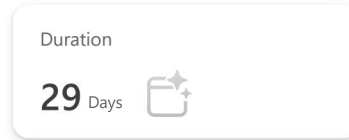
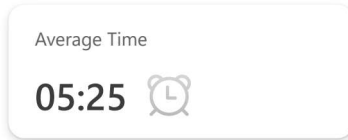
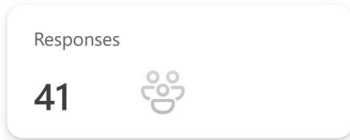
	flexible wording is retained. Where issues about a breach of principles are considered, one factor will be whether the GOC could have reasonably expected the individual to apply the principles to a personal matter or not. The Corporate Complaints policy sets out a triage process to assess conduct complaints, including the need to consider whether the complaint relates to matters outside the GOC’s responsibilities.
<p><b>What is the position for the GOC providing references for members of Council/Committees/Panels (who are not GOC employees) in respect of their contribution to GOC work? An observation: while I think this is an excellent document, it is only as good as all playing their respective roles in it, so the right training has to be available at the right time, the register of interests must be seen to be updated promptly and regularly if members are taking the time to provide updates etc - the GOC must play its part as much as the members.</b></p>	<p>The GOC will confirm terms of office. It does not provide personal character references.</p> <p>Considerations about training will be taken forward as part of revising our member learning and development offer in 2026/27.</p>
<p><b>4.12 Would be good to have guidance on what repeated absence is defined as</b></p>	<p>Paragraph 4.13 sets this out for Council and committee members. The issue of absence is not relevant to Panel members as individuals have flexibility in working arrangements.</p>
<p><b>The language is possibly not quite precise enough eg "Members are expected..." when, in some cases, this might be better as "Members are required..."</b></p>	<p>Amendments have been made where appropriate.</p>
<p><b>Speaking up / whistleblowing link</b></p>	<p>There is now a dedicated page for speaking up for members, workers and employees at the GOC: <a href="https://optical.org/about-us/how-we-work/freedom-to-speak-up.html">https://optical.org/about-us/how-we-work/freedom-to-speak-up.html</a></p> <p>The code does not include links as these rapidly become out of date. Instead we will ensure that members receive an annual reminder of the ‘reading list’ of relevant</p>

**Annex 3: Member code of conduct – Update 2026**

**Survey responses to the question: What, if anything, do you think the code is missing?**

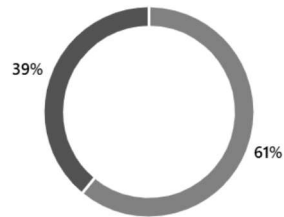
	policies and procedures, with hyperlinks included.
<b>We just need to close the circle in terms of linking to the member review/reappointment processes for Hearing Panel Chairs and Members which may shortly be revised</b>	The review process for Hearing Panel chairs and members is being revised. The likely outcome is that member reviews will only apply for Council members, so the requirement has been removed for other members.
<b>Nothing. I noticed a typo I think in paragraph 4.9 - the last line in the final bullet point should say “have not” and is missing the word “have”</b>	This has been amended.

## Responses Overview Active



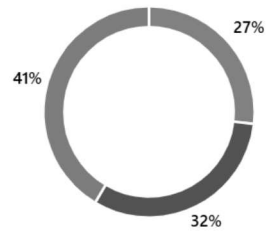
1. I am...

- a registrant member 25
- a lay member 16

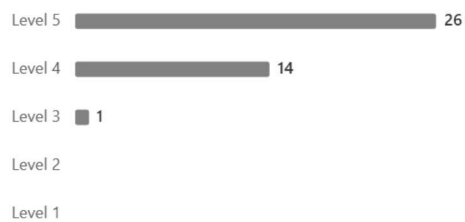


2. I am...

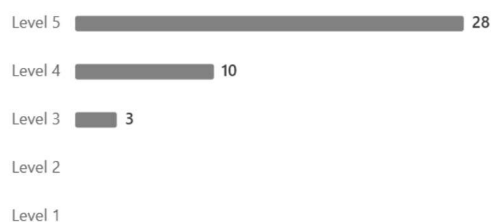
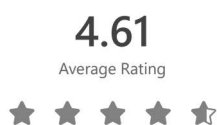
- a Council member 11
- a committee member (excluding hearing panel or investigation committee) 13
- a hearing panel member or investigation committee member 17



3. To what extent does the proposed code support you in understanding the obligations of members? (1-5 rating)



4. How confident would you feel in using the code to identify and speak up about poor conduct? (1-5 rating)



5. What, if anything, do you feel the code does well? (free text box)

24  
Responses

Latest Responses  
"Think it's good to have the clarity"  
...

9 respondents (39%) answered clear for this question.

[Update](#)

document - very clear member and staff clear protocol responsibilities and duties  
effectively covers Good members clear issues breach of the code  
changes are clear GOC Nolan work Code easy  
clear statement code is clear Clear expectations Sets out clearly  
easy

6. What, if anything, do you think the code is missing? (free text box)

23  
Responses

Latest Responses  
...

7 respondents (30%) answered member for this question.

Advisory Groups right time references for members acceptance of the individual  
WattsApp groups UK policy Chairs and Members  
link Groups member panel members Committees/Panels  
specific groups individual Council members document simpler  
organisations position GOC members contribution to GOC



# Optical Consumer Complaints Service

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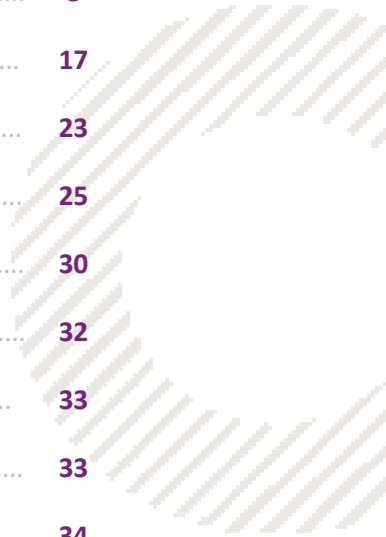
## Resolving with Confidence

Annual Report 2025-26



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# Introduction

The 2025-26 reporting year has been one of significant growth, strengthened collaboration, and continued evolution for the Optical Consumer Complaints Service (OCCS). Complaint volumes increased from 1,679 to 2,201 cases, being a 31% rise reflecting both heightened consumer awareness of the OCCS and growing confidence among practices in the value of independent mediation. Despite this increase, the nature and tone of complaints remained broadly consistent, with clinical care, communication, aftercare, and cost-related concerns continuing to dominate.



The OCCS maintained strong performance across all key indicators. Overall, 143 enquiries were redirected from the GOC, representing 23.6% of all enquiries received by the regulator. This was not only the highest number of referrals the OCCS has ever received from the GOC, but it also reflected a significant change in how referrals are now made.

The GOC has adopted a more proactive and agile direct referral pathway, enabling consumer concerns to be identified earlier and creating the best opportunity for them to be addressed at the earliest possible stage. This direct referral pathway now accounts for over 55% of the 143 referrals received by the OCCS, an increase of 15% compared with last year.

The remaining cases continue to be discussed at biweekly meetings between the GOC and the OCCS. In addition to improving the overall consumer journey, this approach has helped to ensure that regulatory resources are focused more effectively and proportionately.



The year also saw a substantial increase in mediated cases, rising from 296 to 450, representing a 52% increase. This growth was driven by clearer consumer expectations alongside increasingly complex case presentations.

Despite this increase in both volume and complexity, additional staffing capacity enabled the OCCS to improve overall performance, reducing average resolution times from 19.2 to 15.5 days. Resolution times for mediated cases also fell significantly, from 70.6 to 60.7 days, demonstrating improved efficiency while maintaining service standards.

Insights from complaints continued to highlight the importance of clear communication, expectation setting, and robust record-keeping across the patient journey. Complaints about costs and charges rose from 4% to 7%, reflecting broader economic pressures and heightened consumer sensitivity to value.

Cases involving online suppliers increased by 47% during the year. While the vast majority of these cases related to UK-based companies, most did not have a GOC registrant linked to the business.

Sector-specific trends included an increase in concerns relating to laser and clear lens extraction outcomes, with around 30% of these cases requiring mediation. This rise is likely to reflect, at least in part, the strong





and trusted relationship the OCCS has developed with the sector.

Prevention and education remained central to the OCCS’s mission. The service delivered 45 CPD sessions, reaching registrants across multiple, independent LOCs and locum networks. CPD focused on communication, record keeping, and insights drawn directly from OCCS casework. New upstream initiatives included developing a student webinar for launch in the 2026-27 academic year and new resources for front-of-house teams, recognising their critical role in early complaint management.

**45**   
CPD SESSIONS

Operationally, the OCCS continued to strengthen its infrastructure, invest in new systems, and refine internal processes to support efficiency and responsiveness. Collaboration with the GOC, professional bodies, and sector partners remained a defining feature of the year, underpinning improvements in signposting, insight sharing, and the culture of complaint handling across the profession.

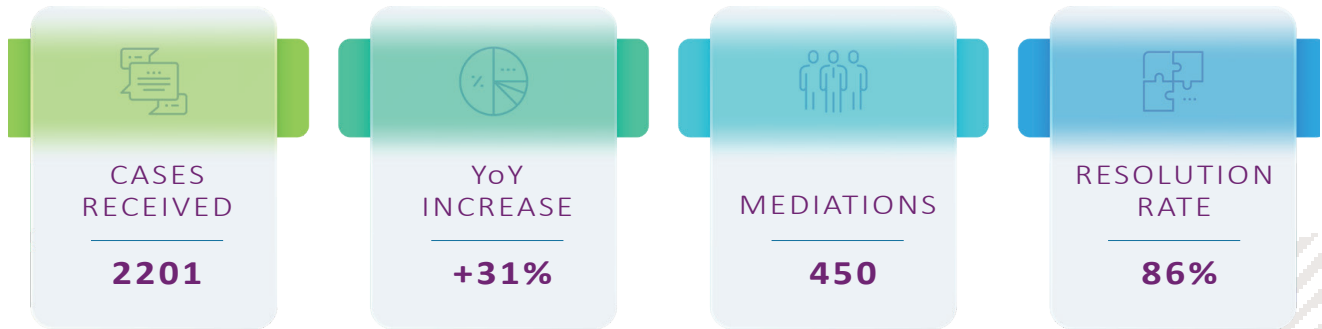
Looking ahead, the OCCS will focus on enhancing accessibility, expanding educational outreach, deepening collaboration with the GOC, and continuing to provide high-quality, timely mediation. The service remains committed to supporting both consumers and practitioners, promoting early resolution, and contributing to a more transparent, communicative, and patient-centred optical sector.





# Executive Summary

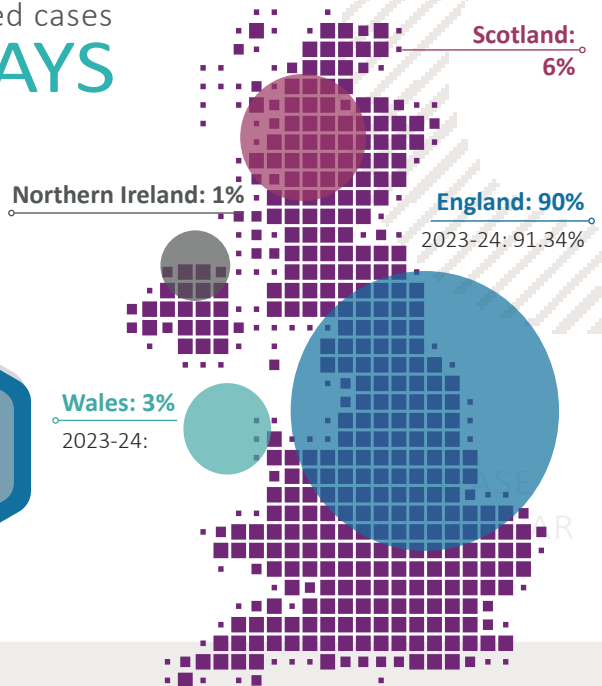
AN OVERVIEW OF THE OCCS ACTIVITY AND INSIGHT FROM 1 APRIL 2025 TO 31 MARCH 2026



Average resolution time | Average mediated cases  
**15.5 DAYS** | **60.7 DAYS**

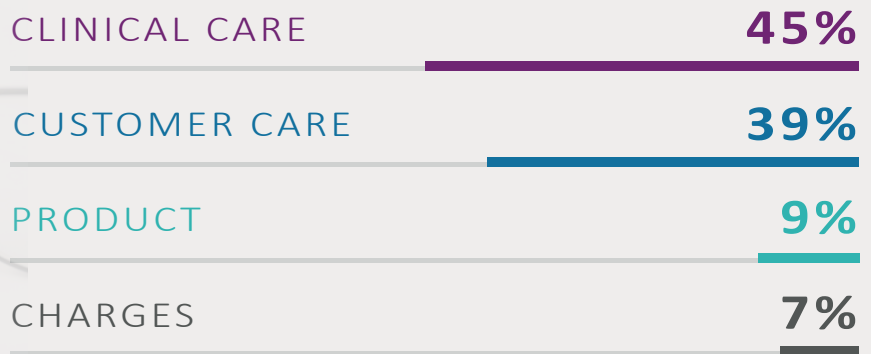
## RESOLUTION PERFORMANCE

- 19%** Reduction in overall resolution time
- 22%** Reduction in mediation duration
- 3%** Cases ended without resolution



## NATURE OF COMPLAINT

Clinical concerns remained the largest category, typically related to the examination process, perceived diagnostic issues, the communication of clinical findings, and situations in which no prescription was issued.





# 1. 31% INCREASE IN ACTIVITY

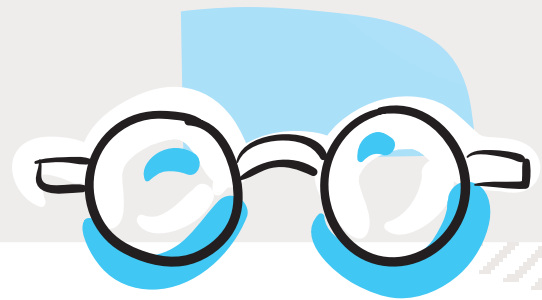
2025-26 was the busiest OCCS year to date, with much of the increase seen in full mediation support, where complaints had exhausted the local complaints process. The OCCS concluded 69% more mediations in the last 12 months than in 2024-25, whilst maintaining a resolution rate of 86%. This is consistent with complaint activity in other sectors. Mediation by the OCCS continues to be effective in resolving the concerns raised, making the insight captured even more valuable in supporting the consumer relationship between patients and optical teams.

# 2. INCREASE IN CUSTOMER CARE (+67%) AND COST RELATED COMPLAINTS (+210%)

The increase in complaints directly linked to the customer experience (appropriate selling, delays in supply, and after care) contributed to the overall increase inactivity during 2025-26. This increase has been attributed to changing consumer expectations around how complaints are resolved and the use of AI to facilitate raising complaints and in deciding whether to accept a resolution proposed by the optical business.

# 3. LENS REPLACEMENT & CATARACTS

Complaints relating to lens replacement surgery and cataract issues accounted for the greater increase in clinical/goods & services-related issues referred to the OCCS, rising from 116 to 273, being a 135% increase).



## FEEDBACK



**High levels of consumer satisfaction** during 2025-26 **reflect confidence** in OCCS support and resolution.

Feedback gathered during 2025-26 indicates that consumers continue to value the OCCS as a supportive, accessible and independent route to resolving disputes.



A recurring theme is that the OCCS is sometimes the only route consumers feel is available to make progress, particularly where provider responses are slow.





# Economic Climate and Its Impact on Consumers

The economic environment throughout 2025 and into 2026 continued to present significant challenges for consumers across the UK. Although inflationary pressures eased compared with earlier periods, overall consumer confidence remained subdued. Rising living costs, ongoing concerns around household finances, and uncertainty about future economic conditions continued to influence consumer behaviour and decision-making.

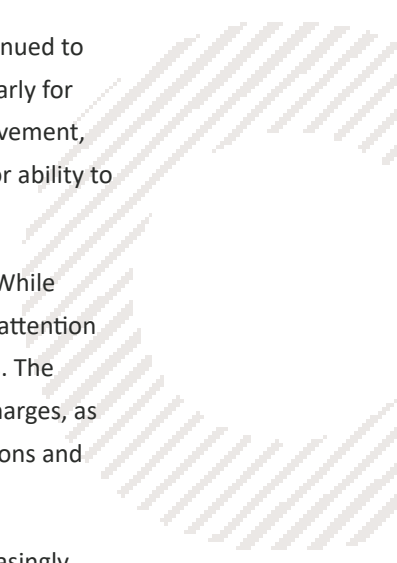
For many households, essential expenditure such as housing, energy, food, and transport continued to squeeze disposable income. As a result, discretionary spending remained constrained, particularly for lower and middle-income consumers. Even where economic indicators showed modest improvement, this was not consistently reflected in consumers' perceptions of their own financial resilience or ability to absorb unexpected costs.

In this context, affordability remained a key consideration for consumers seeking optical care. While eye examinations and clinical services are widely regarded as essential, consumers paid closer attention to the associated costs of spectacles, lenses, contact lenses, and optional or enhanced services. The OCCS observed increased sensitivity regarding pricing, value for money, and transparency of charges, as reflected in a rise in complaints about costs, fees, and perceived gaps between initial expectations and final prices.

At the same time, expectations of service quality remained consistently high. Consumers increasingly expect clear communication, transparent pricing, and reliable standards of care throughout the entire optical journey, from clinical assessment and dispensing through to aftercare and follow up. In a context of financial pressure, service dissatisfaction appeared to have a heightened impact; where outcomes fell short of expectations or communication was perceived as unclear, consumers were more likely to escalate their concerns.

This economic backdrop also contributed to a shift in how consumers articulate complaints. The OCCS observed more defined, specific expectations regarding resolution, including clearer views on remedies, refunds, and corrective action. While digital tools and increased access to information have supported consumer awareness of rights and redress options, they have also, at times, contributed to unrealistic expectations around outcomes, particularly in more complex or clinically nuanced cases.

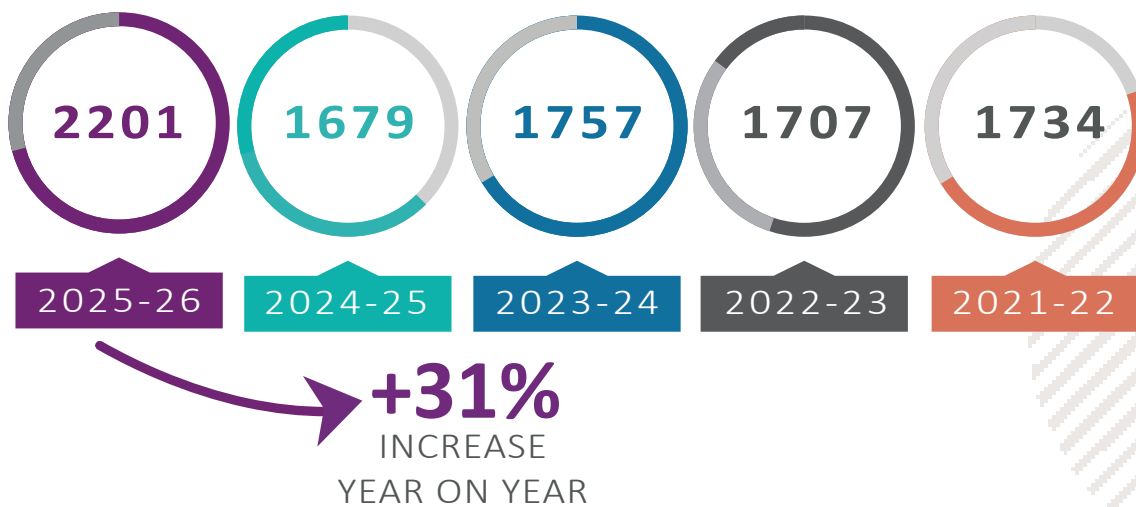
Overall, the economic climate during 2025-26 shaped not only the volume of complaints received by the OCCS but also their content and complexity. Affordability pressures, combined with high expectations of service quality and value, reinforced the importance of early communication, transparent pricing, and effective local complaint handling within optical practices. Against this backdrop, the OCCS continued to play a critical role in providing proportionate, independent support to both consumers and practices, helping to navigate disputes constructively and maintain confidence in the optical sector.



# OCCS Activity 2025-26

## OVERALL DEMAND

During 2025-26, the Optical Consumers Complaints Service experienced a significant increase in demand, with 2,201 cases received, compared with 1,679 cases in 2024-25. This represents a 31% year on year increase in overall case volumes.



The sustained growth in demand reflects both increased consumer awareness of the service and rising levels of engagement across the optical sector, underscoring the continued importance of proportionate case handling, targeted resolution, and effective referral pathways.

Analysis also suggests that the use of AI is assisting consumers to raise complaints when they may previously not felt able or have time to do so. The overwhelming majority of patients in the optical sector receive high class eye healthcare and are optical professionals are amongst the most trusted professionals. Research indicates that across healthcare, only a minority of dissatisfied patients will raise a complaint<sup>1</sup>. While optical eye healthcare is unique in being a well established healthcare/retail sector, it is likely that not all consumers have felt able or willing to raise complaints with the optical business.

Early indications, both in optics and other sectors, suggest that AI is facilitating consumers to articulate their complaints. The OCCS is monitoring and analysing the impact in terms of volumes, how complaints are presented and resolution. At this stage, there are some impacts that need to be explored further such as disproportionate escalation, complaints becoming more legalistic and supporting consumers to enter more meaningful and relevant prompts to produce more accurate and proportionate content and responses. The OCCS, as part of Nockolds Resolution is undertaking further analysis in this area and hosting a roundtable event in 2026 to explore the impacts of AI and solutions to improve the positive outputs of its use.

<sup>1</sup> Healthwatch yougov poll 2025 <https://www.healthwatch.co.uk/report/2025-01-27/pain-complain-why-its-time-fix-nhs-complaints-process>



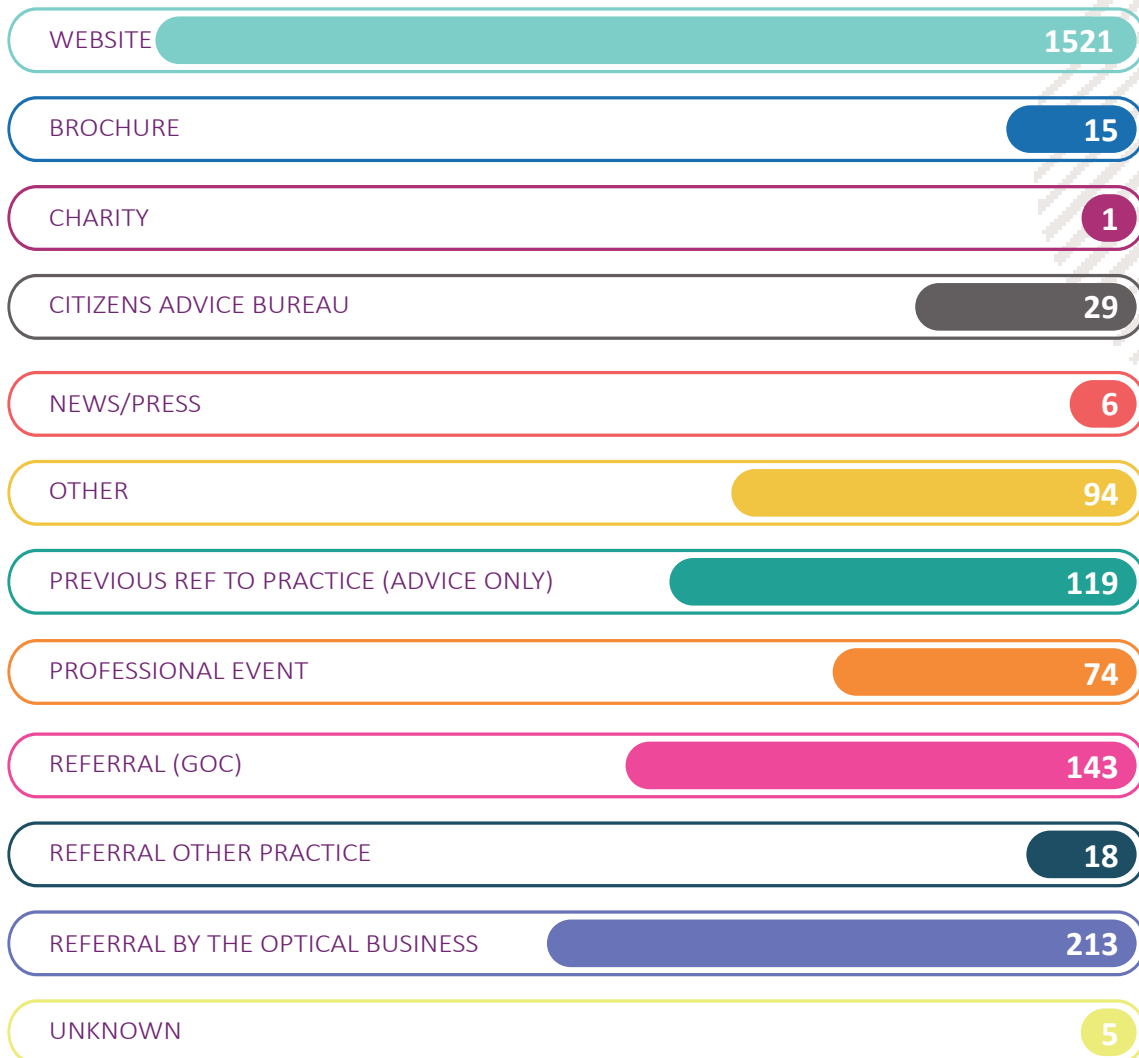
## CASE PROGRESSION AND OUTCOMES

Alongside the increase in cases received, there was a material rise in cases progressing beyond initial assessment:

- Mediated cases increased from 296 to 450, representing a 52% year on year increase
- Full complaint mediation is provided in a fifth of all cases. This is consistent with previous years (18% in 2024-25, and 20% this year)
- Average time to resolution across all cases fell from 19.2 days to 15.5 days (a 19% reduction)
- Average time to conclude mediated cases reduced from 70.6 days to 60.7 days (a 22% reduction)

At year's end, 132 cases remained open, which will inevitably affect completion time measures in the next reporting period.

## SOURCE OF ENQUIRIES TO OCCS





This analysis is based on the information provided by consumers when they contact the OCCS initially. Further analysis confirms that within those who state 'website' as their link to the OCCS, many have been given details of the OCCS by the optical business (within the complaint policy or independently) or via GOC (directly or self-triage via the GOC website).

## ACCESS ROUTES AND CONTACT METHODS

Consumers continued to access the OCCS through multiple channels:



- Overall online engagement increased, with online originated cases rising by approximately 47% year on year

The availability of multiple contact methods continues to support accessibility and reduce barriers to engagement for consumers with differing needs and preferences.

## KEY DEMAND TRENDS

The overall increase in complaint activity and mediations was accompanied by notable shifts in case characteristics, including:

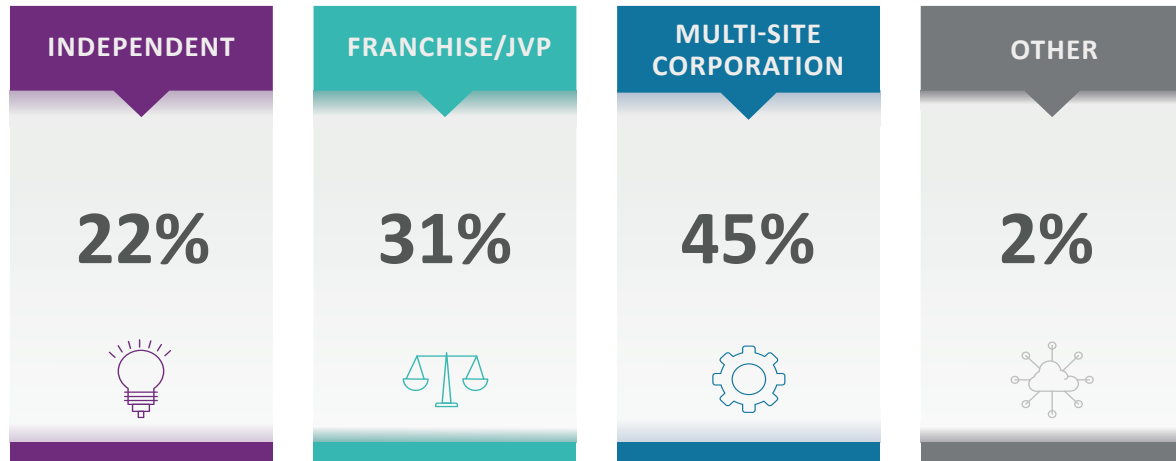
- An increase in cases relating to clinical concerns, including complaints relating to diagnosis.
- An increase in consumers proceeding with the mediation process following initial conversations and interactions with the OCCS. In recent years, the OCCS had seen an increase in cases where consumers did not continue to engage (10% of consumers in 2024-25). During 2025-26 the OCCS has seen this reverse, with an increase in engagement. There has been a 28% improvement in consumer engagement with 2024-25. The OCCS team have focused on providing consumers with reassurance around the mediation process, the effectiveness and supportive approach of OCCS mediations. This has contributed to the increase and has occurred in the context of a more adversarial complaint landscape with higher consumer expectations.
- There was a small increase in domiciliary-related complaints in absolute terms, although these represented a slightly smaller proportion of total cases compared with the previous year. This may be linked to the ongoing growth in the optical domiciliary sector. The most noticeable change was the nature of complaints, with a marked increase in customer care-related complaints, particularly post-examination. We continue to stress to domiciliary providers the importance of clear transparent prices and communication to help manage expectations and reduce consumer anxiety.





## SECTOR ANALYSIS

In 2025-26, complaints referred to the OCCS largely reflected estimated market share in terms of business ownership:



## ANALYSIS OF MEDIATION, CASE COMPLEXITY AND DISPUTE INTENSITY

### Mediation Rates and Patterns

In 2025-26, the OCCS saw a marked increase in cases progressing to mediation, outstripping the overall increase in OCCS activity.

- 450 cases entered mediation, compared with 296 in 2024–25, representing a 52% year on year increase
- Mediation accounted for 20% of all cases received, up from around 18% in the previous year

The growth in mediation volumes indicates not only higher overall demand, but also a greater proportion of cases requiring structured intervention to support resolution. This points to growing complexity in complaint issues, driven by heightened consumer expectations and greater readiness among parties to pursue formal resolution pathways rather than early informal ones.

Despite higher mediation volumes, the OCCS achieved improvements in timeliness:





This reduction points to improved process efficiency and triage, which will require increased OCCS resource should the level of activity continue in 2026-27. The OCCS is investing in technology to ensure resources can be focused on the de-escalation and resolution work of the team, which is highly skilled and requires 1-1 contact.

### Volume Versus Complexity

The 31% increase in cases received was not evenly distributed across case types or outcomes, suggesting that demand growth was accompanied by a shift in complexity rather than a simple scaling of previous patterns.

Key indicators include:

- Increase in mediations

A higher proportion of the complaints referred to the OCCS had reached the stage where the consumer felt local resolution had been exhausted and the matter needed to be escalated. While some could still be de-escalated and local resolution supported, many required impartial resolution support as the relationship or communication channels had broken down, or the consumer was unwilling to continue direct discussions with the practice as their initial requests had been declined.

- Increase in the more complex complaints linked to clinical themes, including perceived missed diagnosis and examination concerns

Analysis indicated that these complaints are predominantly related to the way the Optometrist communicates to the consumer, with both the diagnosis and management of conditions such as cataracts and discussing changes in prescription. This highlights the importance and challenges when advising consumers about the outcomes of their sight test. The OCCS has up streamed this insight by focusing on communication, ensuring consumer understanding and documenting outcomes within all of our CPD sessions, to support registrants in optimising consumer trust and engagement through the consumer journey and interactions with their practice teams.

An increase in multi-issue and medically material (Myopia Management) cases, rising from 4 to 16. Whilst numerically low, the increase is noticeable. Analysis of these complaints indicates that the consumer concerns are related to the consumer and contractual aspects rather than the effectiveness of the products supplied. For example, not being aware that lost or damaged spectacles would not be replaced, and that the aftercare provision is the practice's commitment to provide additional lenses when prescription changes meet the defined criteria. The OCCS is seeking to work with the sector and providers to make practices aware of the complaint trends we are seeing, and the importance of communication and education.

At the same time, the OCCS recorded:

- Increased consumer engagement in mediation (being a noticeable fall of 28% in cases where the consumer chose not to proceed with mediation)
- Increased use of targeted resolution and signposting, supported by more proactive triage and referral decisions within the wider complaints system

Taken together, this suggests that while a greater number of cases are being assessed and filtered at an earlier stage, those that proceed further are increasingly complex and resource intensive.






## Indicators of Dispute Intensity

Several measurable indicators point to higher dispute intensity within a subset of the caseload:

- The absolute number of cases requiring mediation increased sharply, particularly among larger providers
- Resolution rates remained high, and only 3% of complaints concluded their interaction with the OCCS without a resolution. Resolution Managers have shared that complaints appear to escalate at an earlier stage and consumers are less inclined to remain in dialogue with a practice when their requested resolution is not provided. More intensive mediation input is required to achieve a resolution which both parties can agree. The use of AI may also be having an impact as complainants are increasingly referring a complaint response from a business to an open AI model, and the prompts entered will determine the response or analysis provided by the AI. This can then influence the consumer's view and assessment on whether a complaint response is reasonable or acceptable. There have been examples of this unnecessarily escalating a complaint when a reasonable and appropriate response and proposal has been put forward by the practice. In the alternative, there are also examples of where the consumer has been able to articulate the basis of their complaint with more detail and reference to their consumer rights, which the business have then had to take on board. The maintained resolution rates in this climate reflect the OCCS mediation team's ability to manage consumer expectations at the outset and also the continued trust and support we receive from practices to work with the consumers to find a mutually satisfactory resolution.
- Certain complaint themes (notably diagnostic and clinical concerns) showed stronger growth than product or service-related issues

In addition, the data shows:

- 
- Increased escalation among disputes involving clinical judgment or patient outcomes
  - Greater sensitivity around complaints where trust, confidence or perceived harm were involved, which are more likely to resist early closure


However, there are also counterbalancing indicators of containment:

- Reductions in average resolution times across both mediated and non-mediated cases
- Increased use of soft referrals and early signposting, reducing unnecessary escalation
- Stable mediation outcomes among some high-volume providers, suggesting improved complaint handling maturity in parts of the sector

## Overall Assessment

The 2025-26 data indicate that the OCCS is managing a higher-volume, higher-complexity caseload, with mediation increasingly used as a proportionate response to more challenging disputes. While efficiency gains have been achieved, particularly in resolution times, sustained increases in mediation volumes and open cases indicate ongoing pressure on capacity, especially when disputes involve clinical or professionally sensitive matters.

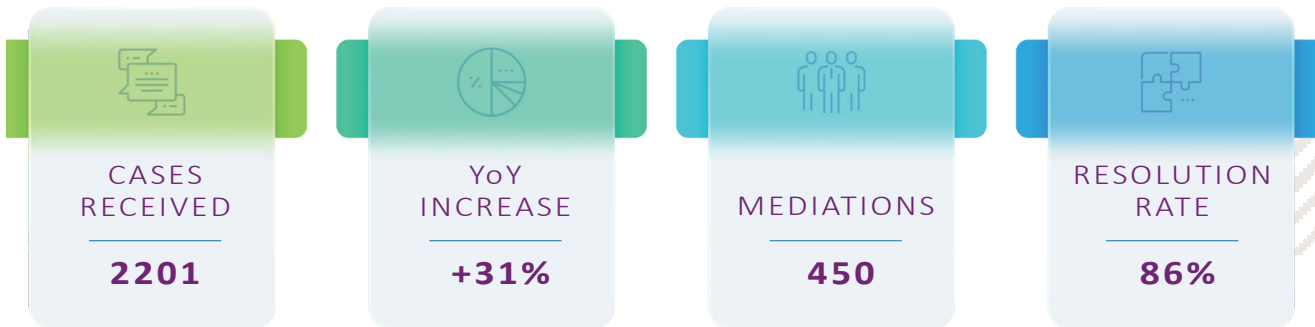
This profile reinforces the importance of:

- Continued investment in early triage and assessment
  - Strong collaboration across referral pathways
  - Ongoing monitoring of dispute intensity indicators to ensure that mediation resources remain targeted, proportionate and effective
- 

## RESOLUTION PERFORMANCE

### Overview

During 2025-26, the OCCS maintained a strong focus on timely, proportionate and effective resolution, while responding to a significantly increased caseload. Despite a 31% rise in cases received, the service achieved notable improvements in resolution times, expanded targeted-resolution activity, and sustained effective mediation outcomes.



### Resolution Timelines

Overall resolution performance improved when compared with the previous reporting year:

- The average time to resolve all cases reduced from 19.2 days to 15.5 days, representing a 19% improvement. This has been achieved through early triage and redeploying resources within the team to adapt the complaint resolution process for complaints that escalate at an earlier stage.
- Mediation resolution times also shortened across most case categories, reflecting improved triage, earlier decision-making and more efficient progression through the complaints process

For cases progressing to mediation:

- The average time to conclude mediated cases reduced from 70.6 days to 60.7 days, an improvement of approximately 22%
- These gains were achieved despite a substantial increase in both the number and complexity of mediated cases

As highlighted, additional resources and investment will be required to maintain reasonable timelines, effectiveness and satisfaction ratings if the increased activity continues throughout 2026-27.

### Resolution Outcomes

The distribution of outcomes demonstrates a balanced and proportionate approach to handling complaints:

- The volume of mediated resolutions also rose, increasing from 296 to 450 complaints. This reflects both higher demand and a greater share of disputes requiring structured intervention, and
- The proportion of cases resolved through advice, signposting, or referral remained stable, indicating efficient filtering and appropriate use of OCCS resources.

### Targeted Resolution Performance

Targeted resolution remains a key approach to managing demand, increased volumes and escalation. This



has involved:

- Earlier triage and case assessment
  - » Clearer referral and signposting pathways
  - » More effective engagement with providers at an earlier stage of the mediation process to define the information needed, key issues and focus on swift resolution. Examples include not requesting the full clinical history and records for complaints purely relating to consumer terms and rights.

The increased use of targeted resolution has contributed to improved overall timeliness and reduced unnecessary progression to mediation.

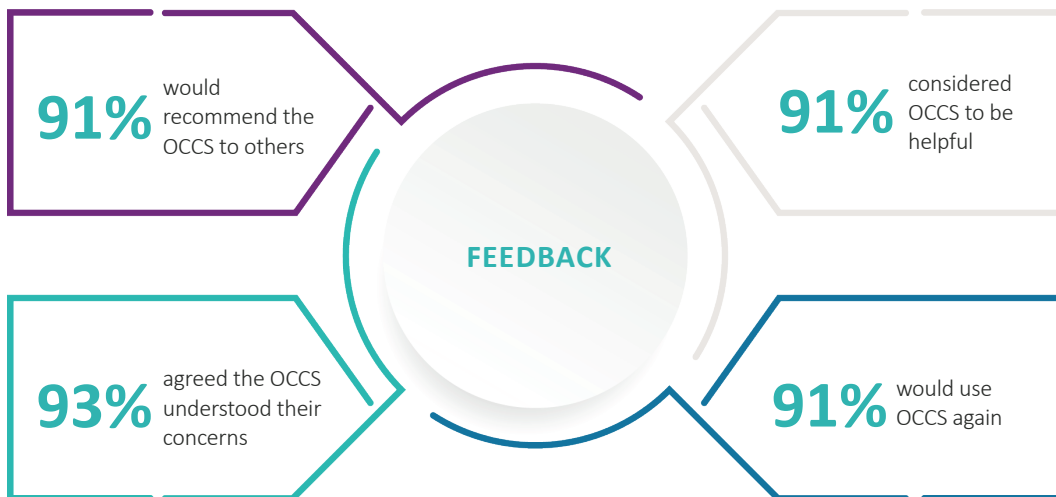
The OCCS continues to monitor unsuccessful mediation cases closely, recognising that such cases often involve higher-intensity disputes, including clinical judgement, trust, or perceived harm, where consensual resolution may be more difficult to achieve.

### Service User Feedback

High levels of consumer satisfaction during 2025-26 reflect confidence in OCCS support and resolution.

Feedback response rate is currently 10% of mediations, gathered during 2025-26, which indicates that consumers continue to value the OCCS as a supportive, accessible and independent route to resolving disputes.

Overall sentiment remained strongly positive across the core service measures. In 2025-26, around nine in ten respondents said they would use the OCCS again (90.9%), and similarly high proportions felt the OCCS understood their concerns (90.9%) and was helpful (88.6%). Respondents also reported high levels of satisfaction with ease of contact (84.1%), process satisfaction (79.5%), and outcome satisfaction (79.5%), as well as strong ratings for productivity (81.8%), efficiency (79.5%), and willingness to recommend OCCS to others (86.4%).



Where feedback is less positive, comments most often relate to timeliness and updates, especially where progress depends on delayed practice engagement (including references to long-running cases and requests for clearer timeframes), and in a small number of cases, dissatisfaction with outcomes or clarity of final explanations. These insights align with the OCCS's continued focus on expectation setting, proactive





communication, and supporting providers to respond promptly and constructively.

Practice feedback is obtained through a range of channels:

- Feedback surveys
- Regular interactions and annual feedback & insight sessions with multiples and optical stakeholders

"Mediation should always be the first step in resolving a complaint and your service certainly achieved this for me."

"The service and support that I received enabled me to receive a refund that I was sure I was due."

"I found the OCCS to be an extremely useful mediator, especially when I could find nowhere else to help me."

"I felt supported and listened to, and was pleased I received a positive outcome"

OCCS is a supportive, accessible and independent route to resolving disputes.

Qualitative comments help explain what drives these ratings. Many respondents highlight reassurance, professionalism and the value of having someone “listen” and translate the process clearly, often naming individual Resolution Managers and praising their efforts

**"very efficient"      "reassuring"      "helpful and understanding"**

A recurring theme is that the OCCS is sometimes the only route consumers feel they have to make progress, particularly when provider responses are slow.

### OVERALL ASSESSMENT

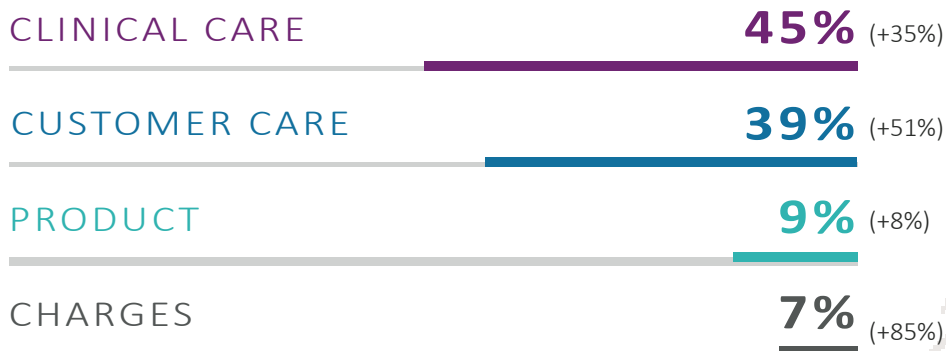
The 2025-26 performance data demonstrate that the OCCS has maintained effective resolution outcomes and improved timeliness despite operating in a markedly higher-volume, higher-complexity environment. The combination of faster resolution, stronger early intervention, and sustained mediation effectiveness ensures that resolution processes remain proportionate, fair, and responsive, while highlighting the need for ongoing capacity and demand management.





# Complaint Themes and Insights

## NATURE OF COMPLAINT



The complaints received by the Optical Consumer Complaints Service (OCCS) during 2025-26 highlight several consistent and emerging themes across clinical care, customer experience, cost and charging practices, and product-related issues. These patterns reflect both the pressures facing consumers in a challenging economic climate and the evolving expectations placed on optical practices.

### CLINICAL CARE

45%

Clinical concerns remained the largest category, accounting for approximately 45% of all complaints. These cases are typically related to the examination process, perceived diagnostic issues, the communication of clinical findings, and situations in which no prescription was issued.

Around 23% of all complaints were directly linked to interactions with the optometrist, including concerns about the thoroughness of the examination, clarity of explanations, and the level of care provided.

We also saw continued issues when consumers obtained a prescription from one practice and sought spectacles elsewhere, accounting for 2.5% of all complaints. The OCCS supported resolution in over 90% of these cases.

Myopia management enquiries increased significantly, rising from 4 to 16 cases, with enquiries largely centred on consent, communication, and expectation setting rather than clinical outcomes.

### CUSTOMER EXPERIENCE AND AFTERCARE

39%

Customer service and aftercare accounted for approximately 40% of complaints, reflecting the importance of communication, expectation management, and continuity of care throughout the consumer journey.

Common themes included delays in aftercare, dissatisfaction with the dispensing process, and concerns about how issues were handled once raised.





The proportion of complaints concerning customer care and service requiring full OCCS mediation input has increased compared with 2024-25. Some of this change in approach appears to be linked to consumers' ability to research and draft comprehensive complaint letters online. This means consumers contact the OCCS with clearer, more firmly defined expectations of the outcomes they seek, often requiring more active facilitation to resolve them.

## PRODUCT-RELATED ISSUES



Product-related complaints decreased slightly from 11% to 9%, reflecting improvements in dispensing accuracy and product quality, as well as more effective local resolution within practices.

Where product issues did arise, they commonly concerned varifocal adaptation, lens performance, frame durability, or expectations regarding product guarantees.

Complaints involving online suppliers increased by 47% (from 36 to 53), with the majority involving UK-registered companies without an associated GOC registrant. These cases often centred on product quality, fulfilment issues, and difficulties accessing aftercare.

## COST, CHARGES, AND COMMERCIAL TRANSPARENCY



Complaints relating to costs and charges rose significantly, increasing from 4% to 7% of all cases (from 73 to 158). This trend aligns with wider economic pressures and heightened consumer sensitivity to value, transparency, and perceived fairness. This is consistent with complaint activity in other sectors.

Concerns typically relate to unclear pricing structures, unexpected charges, refund policies, and the perceived value of products or services. The OCCS continues to play a key role in helping consumers understand the basis of charges and supporting practices to communicate more clearly and consistently.

## SECTOR-SPECIFIC TRENDS

### LASER AND CATARACT

Laser and Cataract issues saw a significant increase in concerns relating to both laser eye surgery and optical care associated with cataract diagnosis and treatment, with the doubling year on year. These cases are complex, with around 30% requiring mediation, substantially higher than the sector wide (20%). These complaints are more likely to involve communication explanation and consumer expectations than clinical concerns. Last year, the OCCS saw a 135% increase in complaint relating to laser and cataract. In 2024-5, any one time OCCS had 2.5 cases relating to laser eye surgery being mediated throughout the year, in 2025-26, this increased to 20. This increase is likely to be linked to greater awareness of the OCCS, practices having greater confidence in the OCCS to support complaints of this nature, and increases in procedures and more complex treatment types.

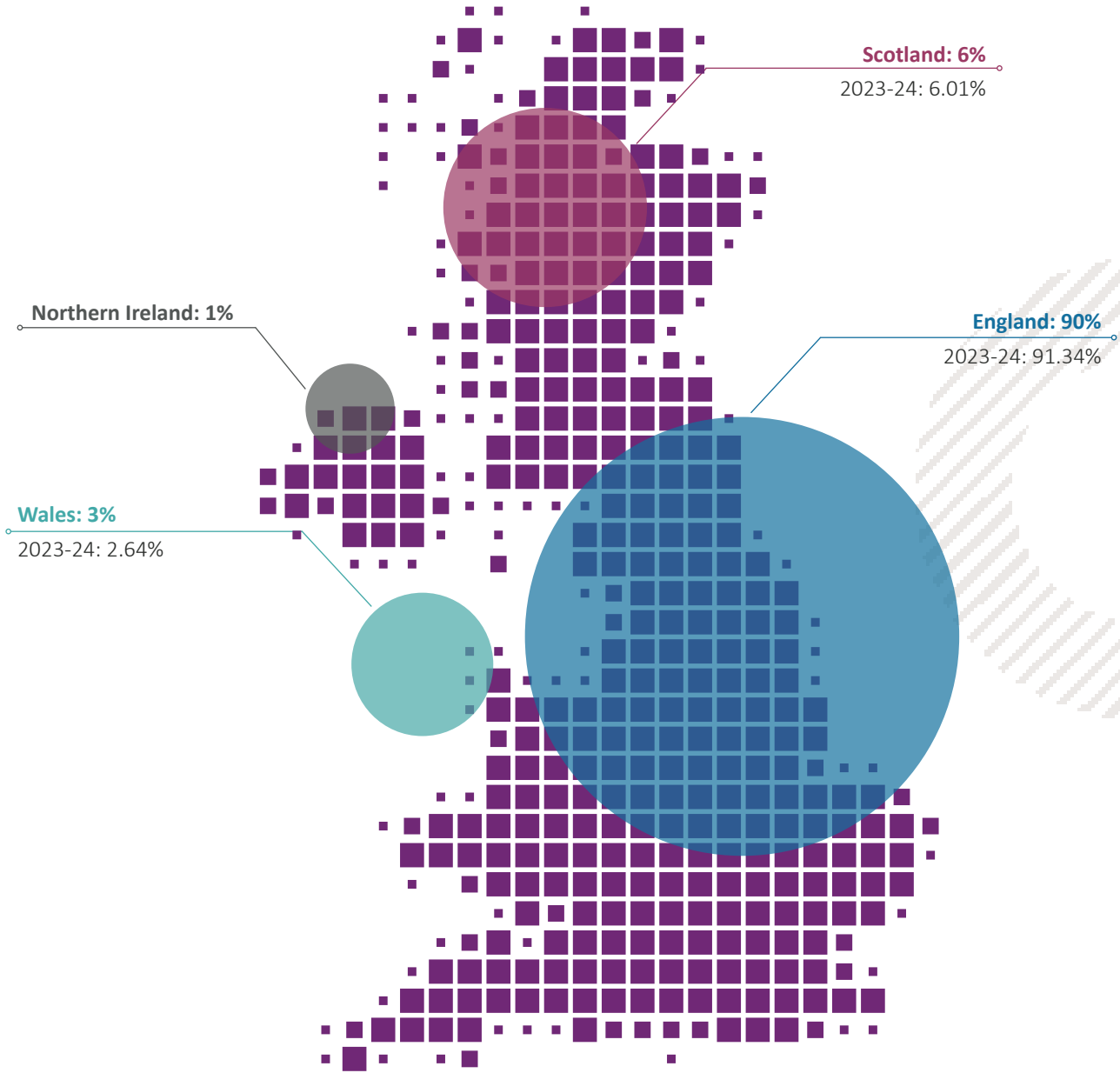
### DOMICILIARY

Domiciliary complaints increased from 80 to 93 cases, though they fell proportionally from 4.8% to 4.2% of total complaints, remaining broadly aligned with the sector's size.





## REGIONAL ACTIVITY





## REFLECTIONS FROM THE OCCS TEAM

### Paul Chapman Hatchett

Clinical Advisor



Having completed my first full year with the OCCS, it is clear that while the volume of complaints has increased, the tone and nature of the concerns raised have remained broadly consistent. What has changed, however, is patients' level of awareness of their ability to seek support through the OCCS. Consumers appear increasingly confident in raising concerns, and practices are more frequently recognising when they have reached the limits of their internal processes and would benefit from independent mediation.

This shift reflects the growing trust and value placed in the OCCS by both optical consumers and providers. The feedback received during CPD sessions reinforces this—registrants consistently express appreciation for the clarity, balance, and support the OCCS brings to complaint resolution.

From an optometric standpoint, a key insight this year has been the ongoing need to remind registrants of the importance of documenting clinical reasoning, clearly recording how advice was communicated, and ensuring that patients have genuinely understood the information provided. Thorough, contemporaneous records not only support registrants should a concern be raised—whether with the OCCS or the GOC—but also enable all members of the practice team to provide patients with consistent information. This continuity is essential for building and maintaining trust throughout the patient journey.

The year has also highlighted the value of broad and inclusive CPD engagement, to help ensure that we reach as wide a cross-section of registrants as possible. We have endeavoured to include locums, early-career practitioners, and those working in diverse practice settings, with the goal of driving improvement of standards across the profession. By sharing insights from complaints and emphasising the roles of communication, expectation setting, and record-keeping, CPD continues to play a central role in preventing complaints and supporting high-quality patient care.

### Rachael Brennan

Complaints Resolution Manager



Reflecting on the past year with the OCCS, it is clear that the foundations of effective complaint prevention continue to lie in clear communication, early expectation setting, and transparency throughout the patient journey. Consumer feedback consistently highlights the importance of practices explaining, from the outset, what patients can expect in terms of processes, costs, aftercare, and what to do if something goes wrong. When patients understand how a practice will support them and feel confident they can return with concerns, trust is strengthened, satisfaction improves, and unnecessary escalation is avoided.





A notable development this year has been the increasing use of AI tools by consumers when raising complaints or seeking to understand their rights under consumer law. For many, this has lowered the barrier to expressing concerns, giving voice to individuals who may have previously struggled to articulate their issues. While this can be empowering, it also brings challenges. AI generated content is not always accurate, and it is essential that both consumers and practitioners treat such information as a starting point rather than definitive guidance. Ensuring that advice is verified and grounded in the realities of optical regulation and consumer law remains crucial.

Another continuing theme is the growing emphasis consumers place on value for money. Patients increasingly want to understand not only what they are paying for, but how the products and services they receive reflect that value. Expectations around what constitutes a reasonable offer to resolve a complaint have risen, and practices are under greater pressure to demonstrate fairness, transparency, and responsiveness.

In this context, maintaining high standards of customer care is more important than ever. Consumers expect attentive service, clear explanations, and timely responses when concerns arise. Practices that invest in communication and relationship building are better positioned to maintain trust and resolve issues quickly and constructively.

As complaint volumes continue to rise, these insights reinforce the importance of the OCCS's role in supporting both consumers and practices. By promoting clarity, empathy, and early engagement, we can help ensure that concerns are addressed promptly and that the patient–practice relationship remains strong.



### **Dawn Slocombe**

Complaints Resolution Manager

2025-2026 has proved to be a busier year for the OCCS, with an increase in overall enquiries and in mediations assigned to the Resolution Managers, which has been challenging. Our days are extremely busy.

References to Consumer Law and its relation to bespoke products are becoming more frequent, with consumers often relying on information provided online about the product. These necessitate further discussions with the OCCS, for both consumers and practices given the bespoke nature of products supplied by practices.

It is a pleasure engaging with consumers and practices this year, and I have noticed an increase in practices contacting the OCCS to seek advice on resolving consumer issues before the mediation process. We have received very positive feedback from all sectors.





## Kayleigh Turnbull

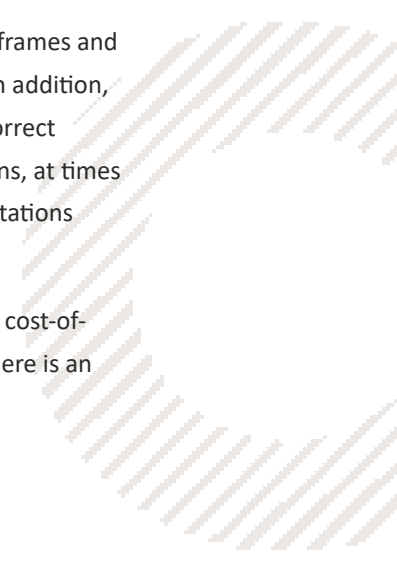
Complaints Resolution Manager

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Over the past year, the OCCS has seen a noticeable increase in the need for direct intervention to support resolution between patients and practices. More consumers are returning to OCCS following initial advice, suggesting a shift away from issues being resolved at a local level. There has also been a rise in concerns relating to myopia management, particularly around informed consent, terms and conditions, and the consistency of communication at the front-of-house stage.

Customer expectations continue to evolve, with greater focus on the quality and longevity of frames and lenses, leading to more disputes around warranties, replacements, and multifocal products. In addition, complaints linked to external prescriptions have increased, often involving perceptions of incorrect outcomes. The growing use of AI-assisted complaint submissions is also influencing interactions, at times complicating communication, obscuring the root cause of issues, and raising unrealistic expectations regarding entitlement and outcomes.

These trends sit alongside wider cultural and economic pressures, including the impact of the cost-of-living crisis, which is placing additional strain on both consumers and providers. As a result, there is an increasing demand for support in complaint handling and resolution across both sides.






# Working with the General Optical Council

The relationship between the OCCS and the General Optical Council (GOC) continues to strengthen, with 2025-26 marking a year of more proactive collaboration, earlier signposting, and improved alignment in triage and consumer guidance. This partnership remains central to directing consumers to the most appropriate route for their concern and to supporting the GOC in focusing its regulatory resources on matters relating to Fitness to Practise.

**143**  
GOC Referrals to OCCS



## REFERRAL ACTIVITY AND EARLY SIGNPOSTING



During the reporting period, the GOC referred 143 enquiries to the OCCS, a 6% increase from 135 the previous year. Although the GOC's overall enquiry volume rose from 464 to 607, the proportion directed to the OCCS remained significant at 23.6%, representing almost a quarter of all enquiries received by the regulator.

A notable development has been the shift toward earlier signposting. Historically, around two-thirds of referrals were passed to the OCCS during the fortnightly joint review meeting. This year, 55% of referrals were redirected at the earliest stage of GOC triage, enabling consumers to access mediation support more quickly and reducing unnecessary progression through regulatory pathways. This change reflects the GOC's growing confidence in the OCCS's ability to resolve consumer service issues efficiently and constructively.

## IMPROVING CONSUMER UNDERSTANDING AND EXPECTATIONS

The OCCS has worked closely with the GOC triage team to ensure that consumers receive clear, consistent explanations of the respective roles of the OCCS and the regulator. This has been particularly important in cases where consumers initially approach the GOC with service-related concerns rather than regulatory ones.

Joint efforts have focused on:

- Clarifying the distinction between Fitness to Practise issues and consumer service concerns
- Ensuring consumers understand the scope and limitations of mediation
- Aligning messaging to prevent unrealistic expectations about compensation or regulatory outcomes



This collaborative approach has contributed to smoother consumer journeys and reduced frustration for individuals who may otherwise have been directed through inappropriate channels.

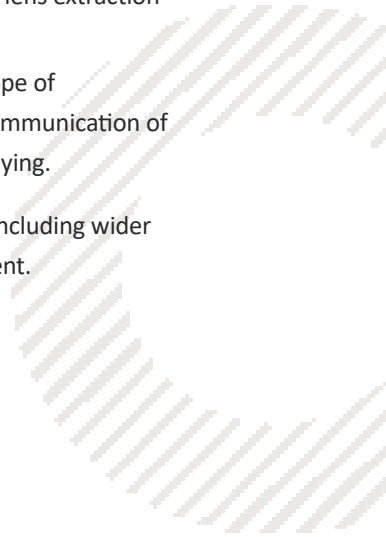
## **SUPPORTING THE GOC THROUGH INSIGHT AND FEEDBACK**

Beyond case referrals, the OCCS continues to provide the GOC with valuable insights into emerging trends, consumer expectations, and areas where communication or practice behaviours may contribute to complaints.

This includes:

- Feedback on recurring themes such as cost transparency, aftercare, and communication
- Early identification of issues arising from online providers without GOC registrants
- Insight into sector specific challenges, including the rise in concerns relating to laser and lens extraction providers
- An insight-based session for GOC Triage & Investigation teams around the increasing scope of Optometric practice and insights we are seeing at the OCCS, particularly around clear communication of expectations and ensuring valid consent for treatments, which are predominately fee paying.

These insights support the GOC's strategic focus on prevention, and wider regulatory functions, including wider regulatory functions, including policy development, standards review, and stakeholder engagement.





# Engagement and Upstreaming

## CONTINUING PROFESSIONAL DEVELOPMENT (CPD) – EXPANDING REACH AND ENGAGEMENT

During the year, the Optical Consumer Complaints Service delivered a significant programme of CPD activity across the optical sector, reaching a large and diverse audience through both OCCS-led and partner-hosted events. In total, OCCS delivered 45 CPD sessions across a wide range of settings, including national conferences, Local Optical Committee (LOC) events and national webinars. A key priority throughout the year was to ensure that CPD activity reached as broad a cohort of registrants as possible.

**45**   
CPD SESSIONS

In addition to issuing over 1,100 CPD certificates directly, it is estimated that a further 700 or more certificates were issued by event partners for OCCS CPD sessions. Targeted sessions were delivered for locum optometrists and dispensing opticians, recognising the particular challenges they face when working across different practice environments with varying systems, cultures and communication approaches.

As part of the 2025-26 CPD programme, OCCS introduced structured participant feedback, asking attendees to rate the usefulness of each session and to suggest future topics. Despite feedback being optional, response rates to date have been exceptionally high at 93%, with strong, consistently positive results from both optometrists and dispensing opticians, reflecting the content's sector-wide relevance. CPD themes increasingly focused on complaint prevention and targeted resolution, emphasising practice-wide responsibility for complaint handling, proactive communication, and the role of all staff, particularly front-of-house teams, in creating a positive patient experience.

 **93%**  
POSITIVE FEEDBACK

## STRENGTHENING OPERATIONAL COLLABORATION

Regular engagement between OCCS and GOC teams, including triage, investigations, policy, and new Council members, has helped ensure a consistent understanding of the OCCS's role and the value of alternative dispute resolution (ADR) within the optical sector.

Training and briefing sessions delivered by the OCCS have supported GOC staff in:

- Recognising case studies for mediation
- Ensuring regulatory resources are focused
- Understanding consumer behaviour and expectations
- Improving the accuracy of signposting

This operational alignment has contributed to more efficient case handling and improved outcomes for consumers and registrants.



## STAKEHOLDER ENGAGEMENT – CONSUMERS

### Consumer Access to the OCCS

The OCCS is committed to ensuring that its arrangements for consumer access are clear, proportionate, and inclusive and consistent with principles of good administration. Access routes are designed to support transparency, fairness, and public confidence, while recognising the varied circumstances in which consumers may seek to engage with the OCCS.

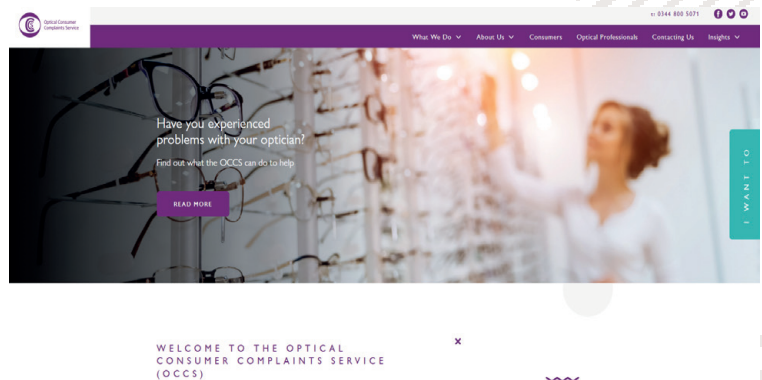
### ACCESS CHANNELS

Consumers can access the OCCS through a combination of digital and non-digital channels, enabling them to engage with the service in ways that best meet their needs.

### DIGITAL SERVICES

The OCCS website serves as the primary public interface and provides authoritative information on OCCS's role, remit, and processes. Digital access arrangements support:

- Clarity about the circumstances in which the OCCS can consider a complaint or concern
- Online submission of enquiries and complaints to enable timely and consistent handling
- Information to assist consumers in understanding complaint handling expectations and outcomes



Digital services are designed to support consistency, transparency and efficiency, while ensuring that content is presented in accessible, plain language.

### TELEPHONE AND DIRECT CONTACT

The OCCS recognises that digital access may not be appropriate or sufficient for all consumers. Telephone support is therefore available to ensure equitable access and to provide additional assistance where required.

Telephone contact enables consumers to:

- Seek clarification on the OCCS's role and remit
- Receive guidance on complaint procedures and next steps

Staff handling telephone enquiries act in accordance with principles of fairness, courtesy and clarity, taking account of individual circumstances and any indicators of vulnerability.

### ACCESSIBILITY AND REASONABLE ADJUSTMENTS

The OCCS is committed to meeting its obligations in relation to equality, accessibility and non-discrimination. Access arrangements are designed to minimise barriers to engagement and to support consumers with diverse needs.





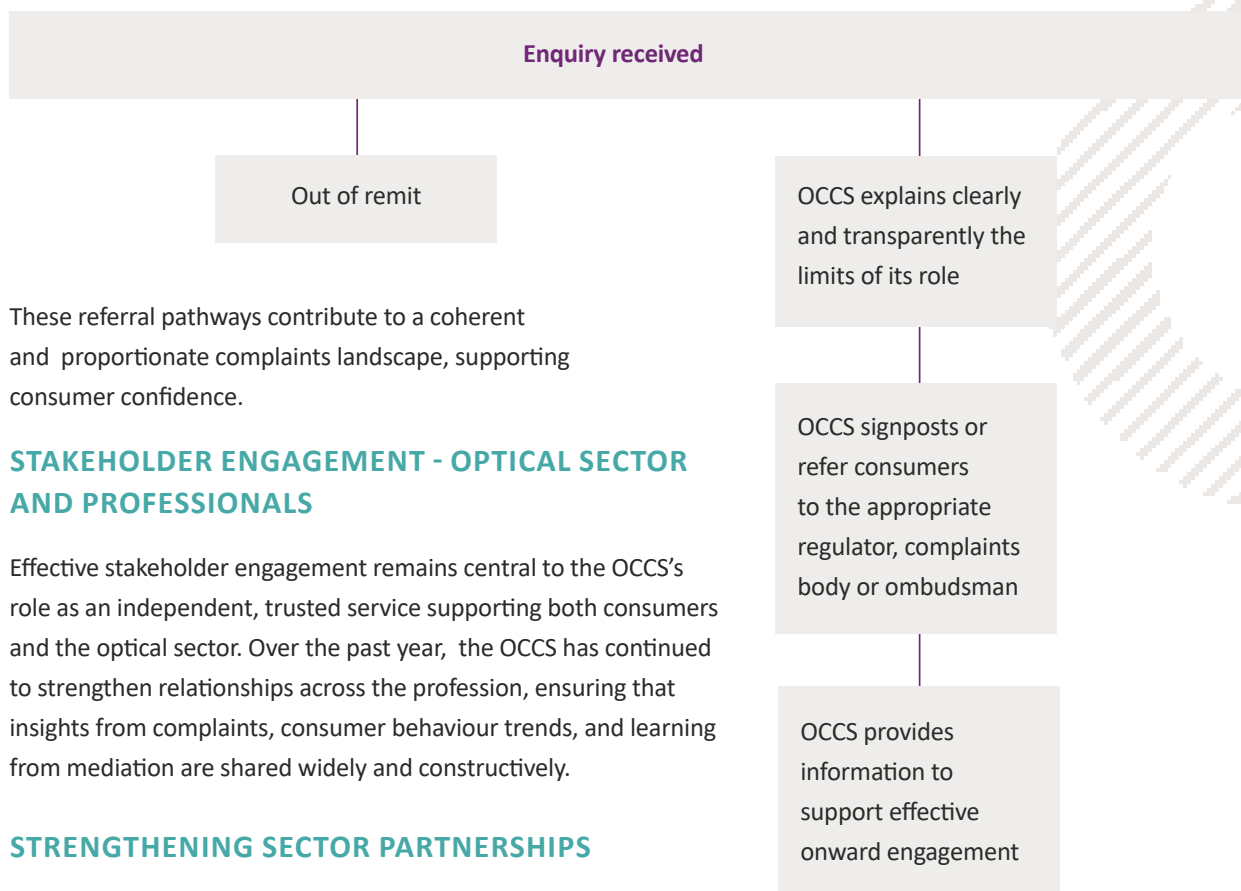
This includes:

- Use of clear and proportionate language in communications
- Offering multiple access routes to avoid digital exclusion
- Making reasonable adjustments where requested, consistent with relevant equality legislation and guidance

The OCCS reviews accessibility considerations to ensure that arrangements remain appropriate and responsive.

## REFERRAL AND SIGNPOSTING ARRANGEMENTS

The OCCS receives enquiries at varying stages of the complaints process, including matters that fall outside its remit.



These referral pathways contribute to a coherent and proportionate complaints landscape, supporting consumer confidence.

## STAKEHOLDER ENGAGEMENT - OPTICAL SECTOR AND PROFESSIONALS

Effective stakeholder engagement remains central to the OCCS’s role as an independent, trusted service supporting both consumers and the optical sector. Over the past year, the OCCS has continued to strengthen relationships across the profession, ensuring that insights from complaints, consumer behaviour trends, and learning from mediation are shared widely and constructively.

## STRENGTHENING SECTOR PARTNERSHIPS

The OCCS has maintained strong and collaborative relationships with key sector bodies, including LOCSU, AOP, FODO, ABDO, and other professional organisations. Regular dialogue with these partners has supported shared understanding of emerging issues, helped align messaging on consumer expectations, and ensured that learning from OCCS casework is reflected in sector guidance and professional development.

Engagement with Local Optical Committees (LOCs) across England has continued to grow, with OCCS participation in regional events, CPD sessions, and discussions on complaint handling culture. These interactions have helped reinforce the importance of targeted resolution, clear communication, and consistent patient support across diverse practice settings.





## COLLABORATION WITH SECTOR MEDIA

The OCCS has also maintained a strong presence in optical media, working closely with leading publications and digital platforms to share insights, highlight trends, and promote best practices. Media engagement has played an important role in raising awareness of the OCCS's work, supporting registrants' understanding of common complaint themes, and encouraging practices to adopt proactive approaches to communication and aftercare.

Through articles, interviews, and commentary, the OCCS has contributed to sector wide conversations on topics such as cost transparency, myopia management, and the impact of economic pressures on consumer expectations.

## ENGAGEMENT WITH PROVIDERS ACROSS THE SECTOR

The OCCS continues to work closely with multiple independent practices, domiciliary providers, and laser providers, ensuring that all parts of the sector have access to support, insights, and mediation expertise. This year saw increased engagement with senior leadership teams within specialist providers, reflecting the rise in complex cases requiring mediation and the shared commitment to improving communication and patient experience.

Regular contact with practice teams, both clinical and non clinical, has helped reinforce the value of early engagement with the OCCS and the benefits of constructive, open dialogue when concerns arise.

## BUILDING A SHARED CULTURE OF LEARNING

Across all stakeholder groups, the OCCS has continued to champion a culture of openness, learning, and continuous improvement. By sharing data, insights, and case trends, the OCCS helps stakeholders identify areas for development, strengthen communication practices, and improve the overall consumer journey.

This collaborative approach ensures that the OCCS remains not only a mediation service but a partner in raising standards, supporting registrants, and promoting trust between patients and the optical sector.

## USING COMPLAINT INSIGHTS TO DRIVE LEARNING

The core focus of OCCS CPD continued to be the translation of real-world complaint insights into practical learning for registrants. Sessions explored:

- How clear, consistent communication with patients and colleagues can prevent misunderstandings
- The importance of setting and checking expectations throughout the patient journey
- Strategies for managing difficult conversations and resolving concerns early
- The role of transparent explanations in reducing perceived clinical or service failings

Record keeping remained a prominent theme. CPD emphasised the importance of clear, comprehensive, and contemporaneous records, both to protect registrants and to support continuity of care. Good documentation was highlighted as a key factor in reducing disputes and improving patient experience.

## SUPPORTING THE NEXT GENERATION OF REGISTRANTS

To strengthen upstream education, the OCCS has developed a webinar for undergraduate students, scheduled for release at the start of the 2026-27 academic year. This resource introduces students to the OCCS, the principles of mediation, and the importance of communication in preventing complaints. It also includes common scenarios encountered in practice, with guidance on:





- Recognising when concerns require escalation
- Understanding the limits of one's competence
- Navigating challenging interactions with confidence and professionalism

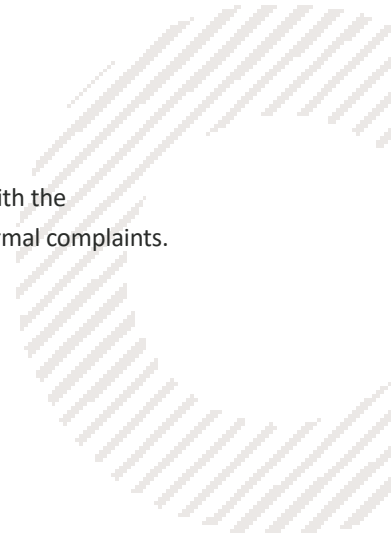
This initiative aims to embed good communication habits early in a registrant's career, supporting long term improvements in complaint prevention.

## **DEVELOPING RESOURCES FOR FRONT OF HOUSE TEAMS**

Recognising the pivotal role of non clinical staff in shaping the patient experience, the OCCS is also developing new educational content for front of house teams. These resources will focus on:

- Identifying early signs that a patient has concerns
- Responding empathetically and constructively
- Using proactive communication to prevent escalation
- Understanding when and how to involve clinical colleagues

Front-of-house staff are often the first point of contact when issues arise, and equipping them with the confidence and skills to manage concerns effectively can significantly reduce the likelihood of formal complaints.





# Looking Ahead: Priorities and Planned Developments

As the OCCS moves into 2026-27, our focus remains on strengthening the quality, accessibility, and impact of the service while supporting the wider optical sector to prevent complaints and enhance the consumer experience. Building on the insights and trends observed over the past year, several key priorities will shape our work in the year ahead.

1	Enhancing Accessibility and Customer Support
2	Deepening Collaboration with the GOC
3	Strengthening CPD and Upstream Education
4	Improving Insight Sharing and Sector Learning
5	Investing in Service Infrastructure and Efficiency

## ENHANCING ACCESSIBILITY AND CONSUMER SUPPORT

We will continue to improve the accessibility of the OCCS for all consumers, with particular emphasis on supporting individuals with additional needs, including neurodiverse patients and those requiring tailored communication approaches. Planned developments include:

- Refining online pathways to make it easier for consumers to understand how the OCCS can help
- Reviewing our communication materials to ensure they are inclusive, clear, and accessible
- Strengthening guidance for practices on supporting vulnerable patients and carers

These improvements aim to ensure that every consumer can access fair, timely, and appropriate support.

## DEEPENING COLLABORATION WITH THE GOC

Our partnership with the GOC will remain central to improving the consumer journey. Building on the success of earlier signposting and closer triage alignment, we will:

- Continue joint work to clarify the boundaries between regulatory and consumer service issues
- Share insights to support policy development and standards review
- Expand and enhance training and briefing sessions with GOC teams with a focus on providing a greater insight into the function and decision-making processes of the GOC triage team, while also ensuring a consistent and shared understanding of the role of the OCCS.
- This collaboration will help ensure that consumers are directed to the right place at the right time, reducing unnecessary escalation and improving outcomes.





## STRENGTHENING CPD AND UPSTREAM EDUCATION

CPD and early career education will continue to be a major focus for the OCCS. Priorities for the coming year include:

- Launching the new student webinar at the start of the 2026–27 academic year
- Expanding CPD delivery to reach more registrants, including locums and those in independent practice
- Developing additional content on communication, expectation setting, and record keeping
- Creating new resources for front of house teams, recognising their vital role in early complaint prevention

By supporting registrants at all stages of their careers, we aim to embed strong communication practices and reduce avoidable complaints across the sector.

## IMPROVING INSIGHT SHARING AND SECTOR LEARNING

The OCCS will continue to use complaint data to identify emerging trends and share learning with the sector. Planned developments include:

- Producing more regular thematic insights for practices and professional bodies
- Supporting sector wide discussions on issues such as cost transparency, and myopia management
- Working with providers of laser and lens extraction services to improve communication and reduce the complexity of mediated cases

These insights will help practices anticipate challenges and strengthen their approach to patient care.

## INVESTING IN SERVICE INFRASTRUCTURE AND EFFICIENCY

With complaint volumes continuing to rise, the OCCS will focus on maintaining high quality, timely mediation. Key developments include:

- Further embedding the new IT system to improve case management and reporting
- Refining internal processes to support faster resolution times
- Ensuring staffing levels remain aligned with demand and case complexity

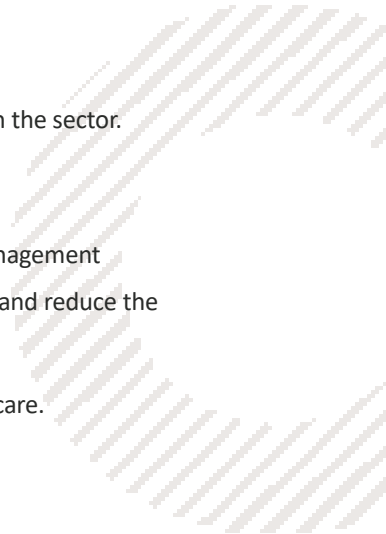
These improvements will help us maintain the high standards expected by consumers, practices, and the GOC.

## SUPPORTING A POSITIVE COMPLAINT HANDLING CULTURE

Finally, the OCCS will continue to champion a culture of openness, early resolution, and constructive communication across the optical sector. We will:

- Encourage practices to view complaints as opportunities for learning
- Promote proactive engagement with consumers at the earliest stage
- Support teams in developing confidence and consistency in handling concerns

By strengthening the complaint-handling culture, we aim to reduce escalation, improve patient trust, and support the sector's long-term resilience.





# Acknowledgements and Closing Remarks

As we conclude this year's Annual Report, the OCCS would like to extend sincere thanks to the many individuals and organisations who have contributed to another year of constructive, collaborative, and impactful work on behalf of optical consumers.

Our continued progress is only possible through the strong partnerships we maintain across the sector. We are grateful to the General Optical Council (GOC) for their ongoing engagement, early signposting, and shared commitment to ensuring that consumers are directed to the most appropriate route for their concerns. The strengthened relationship between our teams has played a vital role in improving the consumer journey and ensuring that regulatory and mediation pathways remain clear and effective.

We also thank the professional bodies, including the AOP, FODO, ABDO, and LOCs across the UK, for their willingness to share insight, participate in CPD activity, and support the wider culture of openness and learning that underpins effective complaint resolution. Their collaboration helps ensure that the lessons emerging from OCCS casework translate into meaningful improvements in practice.

Our appreciation extends to the optical practices, multiples, independents, and domiciliary providers who have engaged with the OCCS throughout the year. Their willingness to work constructively with us, often in challenging circumstances, demonstrates a shared commitment to maintaining trust, transparency, and high standards of care for patients. The growing number of practices proactively directing consumers to the OCCS reflects confidence in our service and the value of independent mediation.

We also acknowledge the contributions of registrants and front-of-house teams who have participated in CPD sessions, shared feedback, and embraced opportunities to strengthen communication and complaint-handling skills. Their engagement is essential to upstream work that helps prevent complaints and supports a more positive patient experience.

As the OCCS looks ahead, we remain committed to evolving in step with the sector, strengthening our role as a trusted, independent resource, and ensuring that every consumer has access to fair, timely, and constructive support. The insights gained this year will continue to shape our priorities, inform our educational work, and guide our contribution to improving the optical landscape for both patients and practitioners.

The OCCS thanks all who have supported, engaged with, and contributed to our work over the past year. We look forward to continuing this shared journey of learning, improvement, and collaboration.





# Appendix 1: Outcomes

## Outcomes (All)

	2025-26	2024-25	+/-
Out of Remit	119	86	28%
Supporting Local Resolution	1308	1023	22%
Referred To Practice	728	550	24%
Advice Only	580	473	18%
Consumer Not to Pursue	107	167	-56%
Resolved on Mediation	387	241	38%
Mediation Unsuccessful	73	49	33%
Practice Advice	92	91	1%
Concluded	2086	1657	21%





# Appendix 2: Complaint Nature

## Nature of Complaint

	2025-26	2024-25	+/-
Clinical Care	980	813	21%
Customer Care	874	608	44%
Product	189	185	2%
Charges	158	73	116%



# Appendix 3: Business Types

## Business Types

	% of OCCS Enquiries
Independent	22%
Franchise/JVP	31%
Multi-Site Corporation	45%
Other	2%

## Business Types - Nature of Received Complaint

	Independent	Franchise/JVP	Multi-Site Corporation
Clinical Care	41%	50%	45%
Customer Care	48%	35%	35%
Product	6%	10%	9%
Charges	6%	5%	10%

## Business Types - Outcome

	Independent	Franchise/JVP	Multi-Site Corporation
Practice Advice	10%	4%	2%
Out Of Remit	10%	3%	2%
Supporting local resolution	55%	58%	60%
Consumer not pursue	5%	7%	6%
Resolved on mediation	15%	24%	26%
Mediation concluded without a resolution	4%	4%	4%

# Appendix 4: EDI Data

## Age Range

	OCCS 2025-26	OCCS 2024-25	Comparison with National Data
16-24	4%	4%	11.7%
25-34	10%	11%	13.5%
35-44	15%	11%	13%
45-55	24%	22%	13.3%
55-64	23%	23%	12.6%
65 or over	23%	28%	18.5%
Under 16	0%	1%	20.8%

## Gender

	OCCS 2025-26	OCCS 2024-25	Comparison with National Data
Female	50%	61%	50.4%
Male	48%	37%	49.2%
Other	2%	1%	0.4%

## Disability

	OCCS 2025-26	OCCS 2024-25	Comparison with National Data
No	71%	76%	82.2%
Yes	29%	24%	17.8%

## Ethnicity

	OCCS 2025-26	OCCS 2024-25	Comparison with National Data
Asian	10%	9%	9.3%
Black	7%	3%	4.0%
Mixed	2%	3%	2.9%
Other	4%	5%	2.1%
White	77%	81%	81.7%



### Sexual Orientation

	OCCS 2025-26	OCCS 2024-25	Comparison with National Data
Bisexual	2%	1%	2%
Gay	2%	3%	2.7%
Heterosexual	91%	90%	93.6%
Other	5%	6%	1.7%
Prefer not to say	0%	0%	Not a category in ONS Census

### Marital Status

	OCCS 2025-26	OCCS 2024-25	Comparison with National Data
Married	48%	46%	40.7%
Single	29%	32%	47.5%
Divorced	8%	6%	6.6%
Widowed	5%	7%	0.1%
Civil Partnership	3%	3%	4.9%
Separated	1%	1%	Not a category in the ONS Census
Prefer not to say	7%	5%	Not a category in the ONS Census

### Religion

	OCCS 2025-26	OCCS 2024-25	Comparison with National Data
Buddhist	1%	2%	0.5%
Christian	44%	48%	46.2%
Hindu	3%	2%	1.7%
Muslim	6%	6%	6.5%
None	30%	24%	37.2%
Other	3%	4%	0.6%
Prefer not to Say	10%	12%	6.0%
Sikh	1%	1%	0.9%
Jewish	1%	1%	0.5%





### Region

	OCCS 2025-26	OCCS 2024-25	Comparison with National Data
Wales	3%	4%	5%
Scotland	7%	7%	8%
England	89%	88%	84%
Northern Ireland	1%	1%	3%





# Appendix 5: Feedback

	Service User Feedback
<b>Client would use OCCS again</b>	
Strongly agree/agree	91%
Strongly disagree	9%
<b>The client would use ADR again</b>	
Strongly agree/agree	86%
Strongly disagree	14%
<b>Client is satisfied with the outcome</b>	
Strongly agree/agree	80%
Strongly disagree	20%
<b>The client is satisfied with the process</b>	
Strongly agree/agree	83%
Strongly disagree	19%
<b>Easy to contact OCCS</b>	
Strongly agree/agree	86%
Strongly disagree	14%
<b>The OCCS understood my concerns</b>	
Strongly agree/agree	93%
Strongly disagree	7%
<b>The OCCS were fair</b>	
Strongly agree/agree	79%
Strongly disagree	21%
<b>The OCCS were productive</b>	
Strongly agree/agree	86%
Strongly disagree	14%
<b>The OCCS were efficient</b>	
Strongly agree/agree	83%
Strongly disagree	17%





The OCCS were helpful	
Strongly agree/agree	91%
Strongly disagree	9%
The client would recommend OCCS to others	
Strongly agree/agree	90%
Strongly disagree	10%



## **FtP unfair outcomes - analysis and findings**

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**Meeting:** 24 June 2026

**Status:** For advice

**Lead responsibility:** Carole Auchterlonie (Director of Regulatory Operations)

**Paper Author(s):** Joanna Murphy (EDI Manager)

**Council Lead(s):** There is no Council lead for this work

### **Purpose**

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1. To present the findings of the independent analysis of unfair outcomes in Fitness to Practise (FtP), and to support Council in considering the level of assurance this provides and the proposed next steps.

### **Recommendations**

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2. Council is asked to:
  - note the findings of the independent analysis across triage, investigations and hearings;
  - take assurance that there is currently little evidence of meaningful disproportionality in FtP outcomes, while recognising the limitations of the available data; and
  - agree the proposed next steps to strengthen data quality, deepen analysis and maintain ongoing assurance.

### **Strategic objective**

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3. This work contributes to the achievement of being a fair, evidence-led and proportionate regulator and is included within the EDI Action Plan and Business Plan.

### **Background**

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4. In March 2024, Council approved the commissioning of independent research to explore whether outcomes within the GOC's FtP processes differ for registrants with protected characteristics.
5. The purpose of this work was to strengthen the evidence base, improve transparency, and support assurance in line with the Public Sector Equality Duty and Professional Standards Authority expectations. Following a procurement process, the research was commissioned to Dr Gareth Davies (Medistat Limited), an independent statistician with experience supporting UK health regulators.
6. The analysis covers outcomes between 2020 and 2024 across three stages of the FtP process:

## **PUBLIC**

- triage;
- investigations; and
- hearings.

## **Analysis**

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### Overview of approach

7. The analysis used statistical modelling to assess whether protected characteristics were associated with different outcomes at each stage of the FtP process, both individually and when considered alongside case characteristics.
8. Statistical differences do not in themselves demonstrate unfairness. Rather, they highlight areas where further exploration may be required.

### Key findings

9. The key findings from the analysis were:  
There is little evidence of meaningful disproportionality in FtP outcomes across the most robust models; where statistically significant differences were identified, these were primarily associated with “prefer not to say” responses rather than specific protected characteristic groups;
  - Case characteristics are stronger predictors of outcomes than protected characteristics;
  - Sample sizes are relatively small at later stages of the process, which limits the strength of conclusions;
  - There is very limited evidence of intersectionality effects, and none once case characteristics are taken into account.

### Interpretation and assurance

10. Taken together the findings provide a level of assurance that there is no strong evidence of systemic disproportionality in FtP outcomes at this stage. However, this should be viewed as an early evidence base rather than a definitive position, particularly given limitations in data completeness and sample size. Continued monitoring and improvement will be important to maintain confidence and strengthen assurance over time.

### Strengths and limitations

11. Strengths of this work includes;
  - independent delivery and transparent methodology;
  - alignment with approaches used by other regulators; and
  - establishment of a baseline for future analysis.

## **PUBLIC**

12. Limitations of this work includes;
- incomplete data, including relatively high levels of “prefer not to say” responses; small sample sizes, particularly at hearings stage; and
  - findings reflecting the current dataset only and likely to evolve as more data becomes available.

## **Finance**

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13. The cost of commissioning the independent research was met from strategic reserves, as previously approved by Council. The work was completed within the agreed budget and followed appropriate procurement processes.
14. The approach represents value for money by providing an independent evidence base to support regulatory assurance and future decision-making.

## **Risks**

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15. The key risks associated with the recommendations are:
- risk of misinterpretation, where findings are taken as definitive evidence that no unfairness exists; **mitigation:** ensure clear communication that this is part of an ongoing evidence-building approach;
  - risk of false reassurance, as findings may change as more data becomes available; **mitigation:** commit to repeating the analysis and strengthening data quality; and
  - data quality risk, where incomplete data may mask potential patterns; **mitigation:** implement actions to improve completeness of EDI data.

## **Equality Impacts**

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16. An Equality Impact Assessment is not required for this paper as it presents analysis only and does not propose changes to policy or process. The work itself supports the GOC’s equality objectives by improving understanding of potential differential outcomes and informing future action.

## **Devolved nations**

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17. There are no specific implications for devolved nations. The analysis relates to UK-wide FtP processes.

## **Other Impacts**

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18. The following other impacts have been identified:
- privacy: all data used in the analysis was anonymised;
  - sustainability and futureproofing: the work supports a more evidence-led and consistent approach to regulatory assurance over time.

## **Communications**

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## **PUBLIC**

### **External communications**

19. A copy of the report has been shared with the PSA. No immediate external publication is proposed. Any future publication will be carefully framed and agreed with Council.

### **Internal communications**

20. Findings will be shared with staff in a proportionate and accessible way, with a focus on learning, assurance and next steps.

### **Next steps**

21. Subject to Council's views, the following next steps are proposed:
- improve the quality and completeness of EDI data, including reducing "prefer not to say" responses;
  - undertake further exploratory analysis to better understand identified patterns;
  - expand the range of case characteristics included in future modelling; and
  - repeat the analysis when additional data is available.

### **Attachments**

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Annex 1: Summary report of findings

Annex 2: Triage outcomes report

Annex 3: Investigation outcomes report

Annex 4: Hearing outcomes report

Annex 5: Supplier presentation

<b>Unfair Outcomes research</b>	
<b>Phase:</b>	5 – Amendments and final sign off
<b>Activity:</b>	Report 4 Summary of findings
<b>Date:</b>	11 Jan 2026
<b>Ref:</b>	5.1.260111

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## Introduction

The overall aim of the GOC unfair outcomes research project was to investigate whether disproportionality had been apparent in GOC FTP process outcomes.

This report summarises the findings relating to EDI characteristics as reported in the GOC Unfair Outcomes Research reports 1:Triage, 2:Investigations, and 3:Hearings. For the methods and the full results please refer to those reports.

## Results

Results are summarised here for the three separate analyses that were conducted for each FTP process. In all analyses the baseline category was the largest in terms of the number of registrants with that particular characteristic.

## **Unadjusted**

These are the effect of the EDI characteristic on its own, without taking into account any other variable. This often accords with what people observe but it may differ from the result obtained once other variables are taken into account. As an illustration, in the unadjusted triage analysis every five year increase in age statistically significantly increases the chance of a case being open. This effect, “older registrants are higher risk”, may be apparent to those working in FTP and certainly has been reported by other regulators. However, if there are reasons why risk increases with age, for example if older registrants are more likely to develop a disability, which in turn makes them more likely to report a health concern, then looking at age alone may be misleading. In the language of intersectionality, the unadjusted analysis does not consider intersections between EDI characteristics.

## **Adjusted for EDI only**

These are the effect of an EDI characteristic after taking into account all the other EDI variables, but not taking into account case characteristics. Returning to the illustration above, the fact that increases in age remained statistically significant in the triage analysis after adjusting for the other EDI variables indicated that the age effect persisted across the other EDI characteristics.

In these adjusted analyses intersectionality between selected EDI characteristics was tested. Only three statistically significant intersectionalities were identified, two of which disappeared when case characteristics were adjusted for. The one remaining intersectionality included a Prefer not to say so had limited value. As such the findings in the reports which are summarised here are based on the main effects only, not interactions.

## **Adjusted for EDI and case characteristics**

These are the effect of an EDI characteristic after taking into account all the other EDI variables and the supplied case characteristics. These are the most definitive of the three analyses, though it should be noted that only a limited range of case characteristics were supplied. Returning again to the illustration above, the fact that increases in age were no longer statistically significant in the triage analysis after adjusting for the other EDI variables and the case variables must be taken into account when considering any possible effect of age.

In these adjusted analyses intersectionality between selected EDI characteristics was tested in the presence of case characteristics. Only one statistically significant intersectionality was identified, which included a Prefer not to say so had limited value. As such the findings in the reports which are summarised here are based on the main effects only, not interactions.

### Summary table key

The following tables simplify the statistical analysis findings into four groups.

For the seven categorical EDI variables these groups indicate:

↑	This level of this variable was <u>statistically significantly more likely</u> to have the outcome than the baseline level.
	This level of this variable was <u>more likely</u> to have the outcome than the baseline level but not statistically significantly so.
	This level of this variable was <u>less likely</u> to have the outcome than the baseline level but not statistically significantly so.
↓	This level of this variable was <u>statistically significantly less likely</u> to have the outcome than the baseline level.

For the one continuous EDI variable (age) these groups indicate:

↑	Each 5 year increase in age <u>statistically significantly increased</u> the chance of the outcome.
	Each 5 year increase in age <u>increased</u> the chance of the outcome, but not statistically significantly so.
	Each 5 year increase in age <u>decreased</u> the chance of the outcome, but not statistically significantly so.
↓	Each 5 year increase in age <u>statistically significantly decreased</u> the chance of the outcome.
-	For any variable this indicates that no result was available, either because the category have insufficient data or it was out of scope.

## Age

Age was the only continuous EDI variable and was analysed on the basis of the effect of a five year increase in age. Age was not included in any interaction terms where intersectionality was investigated.

Increases in age were a statistically significant predictor of a case opening in the unadjusted and adjusted for EDI only triage analyses. When case characteristics were also adjusted for the effect became not statistically significant (Table 1).

Increases in age were not a statistically significant predictor in any of the investigations or hearing analyses (Table 1).

**Table 1: Statistical analysis summary: Age**

	Triage			Investigations						Hearings		
	Case opened vs Closure			Advice/warning vs NFA			Referred to FTPC vs NFA			Sanction vs No sanction		
	Unadjusted	Adjusted		Unadjusted	Adjusted		Unadjusted	Adjusted		Unadjusted	Adjusted	
		EDI only	EDI & case		EDI only	EDI & case		EDI only	EDI & case		EDI only	EDI & case
Effect of increase in registrant age of:												
Five years	↑	↑										

In summary, there was no indication of statistically significant disproportionality in any of the FTP outcomes considered with regards to the age of the registrant once all EDI and available case characteristics had been adjusted for.

## Gender

Gender was a categorical variable and was analysed on the basis of a comparison of females to the baseline gender value of male. Gender was included in two interaction terms where intersectionality was investigated: ethnicity and gender; disability and gender.

Female registrants were statistically significantly less likely to be referred to the FTPC than to have NFA in the unadjusted investigations analysis. When EDI and case characteristics were adjusted for the effect became not statistically significant (Table 2).

Female registrants were not statistically significantly more or less likely to receive the outcomes of interest in any of the triage or hearing analyses (Table 2).

None of the interaction terms involving gender indicated any statistically significant intersectionality between gender and ethnicity or gender and disability.

**Table 2: Statistical analysis summary: Gender**

	Triage		Investigations			Hearings		
	Case opened vs Closure		Advice/warning vs NFA		Referred to FTPC vs NFA		Sanction vs No sanction	
		Adjusted		Adjusted		Adjusted		Adjusted
Baseline comparison is to: Male	Unadjusted	EDI only EDI & case	Unadjusted	EDI only EDI & case	Unadjusted	EDI only EDI & case	Unadjusted	EDI only EDI & case
Female					↓			

In summary, there was no indication of statistically significant disproportionality in any of the FTP outcomes considered with regards to the gender of the registrant once all EDI and available case characteristics had been adjusted for.

## Ethnicity

Ethnicity was a categorical variable and was analysed on the basis of a comparison of a number of ethnicities to the baseline ethnicity value of white. Ethnicity was included in one interaction term where intersectionality was investigated: ethnicity and gender.

No ethnicities were statistically significantly more or less likely to receive the outcomes of interest in any of the FTP stages considered in these analyses (Table 2).

The interaction term involving ethnicity did not indicate any statistically significant intersectionality between ethnicity and gender.

**Table 3: Statistical analysis summary: Ethnicity**

Baseline comparison is to: White	Triage			Investigations						Hearings		
	Case opened vs Closure			Advice/warning vs NFA			Referred to FTPC vs NFA			Sanction vs No sanction		
	Unadjusted	Adjusted		Unadjusted	Adjusted		Unadjusted	Adjusted		Unadjusted	Adjusted	
		EDI only	EDI & case		EDI only	EDI & case		EDI only	EDI & case		EDI only	EDI & case
Indian												
Pakistani												
Other Asian												
Black												
Other global majority												
Prefer not to say												

In summary, there was no indication of statistically significant disproportionality in any of the FTP outcomes considered with regards to the ethnicity of the registrants.

## Disability

Disability was a categorical variable and was analysed on the basis of a comparison of a yes (have a disability), or prefer not to say, to the baseline disability value of no (do not have a disability). Disability was included in three interaction terms where intersectionality was investigated: disability and gender; disability and sexual orientation; disability and religion.

Registrants with a disability were statistically significantly less likely to have a case opened in the unadjusted triage analysis. When EDI and case characteristics were adjusted for the effect became not statistically significant (Table 4).

Registrants who answered prefer not to say to the disability question were statistically significantly more likely to have a case opened in the adjusted for EDI and case triage analysis (Table 4).

No disability statuses were statistically significantly more or less likely to receive the outcomes of interest in any of the investigations or hearings analyses (Table 2).

All three interaction term involving disability indicated statistically significant intersectionality, though in all instances for the no disability group. Only one remained significant after adjusting for EDI and case characteristics though that was for the combination of no disability and prefer not to say for religion.

**Table 4: Statistical analysis summary: Disability**

	Triage			Investigations						Hearings		
	Case opened vs Closure			Advice/warning vs NFA			Referred to FTPC vs NFA			Sanction vs No sanction		
	Unadjusted	Adjusted		Unadjusted	Adjusted		Unadjusted	Adjusted		Unadjusted	Adjusted	
EDI only		EDI & case	EDI only		EDI & case	EDI only		EDI & case	EDI only		EDI & case	
Baseline comparison is to: No (disability)												
Yes (disability)	↓			-	-	-						
Prefer not to say			↑									

In summary, there was some indication of statistically significant disproportionality in relation to disability status though this was generally disadvantageous to those with no disability or prefer not to say, either for disability or for its interactions. As such it has limited utility in terms of understanding any meaningful imbalance.

## Religion

Religion was a categorical variable and was analysed on the basis of a comparison of a number of religions to the baseline religion value of Muslim. Religion was included in one interaction term where intersectionality was investigated: religion and disability.

Hindu registrants were statistically significantly more likely to have a case opened in the unadjusted triage analysis. Jewish registrants were statistically significantly less likely to have a case opened in the unadjusted triage analysis. In both instances, when EDI and case characteristics were adjusted for these effects became not statistically significant (Table 5).

Registrants who responded with prefer not to say to the religion question were statistically significantly more likely to be referred to the FTPC after adjusting for EDI and case characteristics (Table 5).

The interaction term involving religion did indicate three statistically significant intersectionalities between religion and disability, though only one persisted after adjusting for EDI and case and that one related to prefer not to say as the response to the religion question.

**Table 5: Statistical analysis summary: Religion**

Baseline comparison is to: Muslim	Triage Case opened vs Closure			Investigations Advice/warning vs NFA						Hearings Sanction vs No sanction		
	Unadjusted	Adjusted		Unadjusted	Adjusted		Unadjusted	Adjusted		Unadjusted	Adjusted	
		EDI only	EDI & case		EDI only	EDI & case		EDI only	EDI & case		EDI only	EDI & case
Christian												
No religion or belief												
Hindu	↑											
Sikh												
Jewish	↓	↓		-	-	-				-	-	-
Buddhist				-	-	-				-	-	-
Prefer not to say								↑	↑			

In summary, there was some indication of statistically significant disproportionality in relation to religion, though being for those who said prefer not to say means it has little utility in terms of understanding any meaningful imbalance.

## Sexual orientation

Sexual orientation was a categorical variable and was analysed on the basis of a comparison of three categories to the baseline sexual orientation value of heterosexual. Sexual orientation was included in one interaction term where intersectionality was investigated: sexual orientation and disability.

No sexual orientations were statistically significantly more or less likely to receive the outcomes of interest in any of the FTP stages considered in these analyses (Table 6).

The interaction term involving sexual orientation did not indicate any statistically significant intersectionality between sexual orientation and disability.

**Table 6: Statistical analysis summary: Sexual orientation**

Baseline comparison is to: Heterosexual	Triage			Investigations						Hearings		
	Case opened vs Closure			Advice/warning vs NFA			Referred to FTPC vs NFA			Sanction vs No sanction		
	Unadjusted	Adjusted		Unadjusted	Adjusted		Unadjusted	Adjusted		Unadjusted	Adjusted	
		EDI only	EDI & case		EDI only	EDI & case		EDI only	EDI & case		EDI only	EDI & case
Gay/Lesbian/Homosexual	Green			Yellow			Yellow			-	-	-
Bisexual	Green			-	-	-	Yellow	Green		-	-	-
Prefer not to say	Green			Green			Green			Green	Yellow	Green

In summary, there was no indication of statistically significant disproportionality in any of the FTP outcomes considered with regards to the sexual orientation of the registrants.

## Pregnancy & maternity

Pregnancy and maternity was a categorical variable and was analysed on the basis of a comparison of two categories to the baseline pregnancy and maternity value of no (not pregnant or in the state of maternity). Pregnancy and maternity was not included in any interaction terms where intersectionality was investigated.

No categories of pregnancy and maternity were statistically significantly more or less likely to receive the outcomes of interest in any of the FTP stages considered in these analyses (Table 7).

**Table 7: Statistical analysis summary: Pregnancy and maternity**

Baseline comparison is to: No (not pregnant and not in state of maternity)	Triage		Investigations						Hearings		
	Case opened vs Closure		Advice/warning vs NFA			Referred to FTPC vs NFA			Sanction vs No sanction		
	Unadjusted	Adjusted	Unadjusted	Adjusted		Unadjusted	Adjusted		Unadjusted	Adjusted	
EDI only		EDI & case		EDI only	EDI & case		EDI only	EDI & case		EDI only	EDI & case
Yes	Yellow		Green			Green			-	-	-
Prefer not to say	Green	Yellow	Green			Yellow			Green		

In summary, there was no indication of statistically significant disproportionality in any of the FTP outcomes considered with regards to the pregnancy and maternity status of the registrants.

## Marital status

Marital status was a categorical variable and was analysed on the basis of a comparison of a number of categories to the baseline marital status value of married. Due to the high levels of missing values for the EDI characteristic, marital status was not included in any of the adjusted analyses so could not be included in any interaction terms where intersectionality was investigated.

Registrants who were single were statistically significantly less likely to have a case opened in the triage analysis (Table 8).

Registrants who were a partner or who were a widow/widower were statistically significantly more likely to be referred to the FTPC than received NFA in the investigations analysis (Table 8).

Registrants who were a divorced or a from a legally dissolved civil partnership were statistically significantly more likely to receive advice/warning than to have NFA in the investigations analysis (Table 8).

**Table 8: Statistical analysis summary: Marital status**

Baseline comparison is to: Married	Triage			Investigations						Hearings		
	Case opened vs Closure			Advice/ warning vs NFA			Referred to FTPC vs NFA			Sanction vs No sanction		
	Unadjusted	Adjusted		Unadjusted	Adjusted		Unadjusted	Adjusted		Unadjusted	Adjusted	
EDI only		EDI & case	EDI only		EDI & case	EDI only		EDI & case	EDI only		EDI & case	
Single	↓	-	-		-	-		-	-		-	-
Partner		-	-		-	-					-	-
Divorced/legally dissolved		-	-		↑	-					-	-
Widow/widower		-	-		-	-					-	-
Separated		-	-		-	-					-	-
Civil partnership		-	-		-	-					-	-
Prefer not to say												

In summary, there was some indication of statistically significant disproportionality in some of the FTP outcomes considered with regards to the marital status of the registrants though this must be viewed with caution as adjustment for other EDI and case characteristics was not possible.

## Discussion

Based on the data provided for these analyses there was very little evidence of any disproportionality in GOC FTP outcomes in the periods studied. Effects apparent in the unadjusted analysis tended to disappear in the adjusted analyses.

Very few interactions indicated intersectionality, and only one persisted in the adjusted analyses. In that instance it involved an uninformative response, prefer not to say, so had limited utility in terms of understanding any meaningful imbalance. There was so little evidence of intersectionality it was not worth including it in the main analyses.

However, there are a good reasons to be cautious with the interpretation of these analyses. The number of records available for analysis was small. Whilst this is good news in terms of public protection, it is bad news in terms of the certainty of findings. Many of the small number of statistically significant findings were based on very small counts and had very wide confidence intervals. The possibility of some or all of these being by chance rather than representing true effects cannot be entirely ruled out.

It may also be the case that lurking in these non-significant findings are some true effects that will only become apparent in future analyses when greater numbers of records available for analysis enable them to appear. Similarly the fact that any one effect may not exist now does not mean that it may not develop anew in the future.

The high levels of missing data for some variables, and high levels of uninformative responses (PNTS) for others, may mask important effects that will never be discovered without improvements in data quality.

The recommended next steps therefore are:

- 1) Take some reassurance that based on these analyses, there is little meaningful evidence of disproportionality in GOC FTP outcomes to date.
- 2) Plan and implement a programme to improve EDI data quality and data completeness, including reducing the levels of uninformative (PNTS) responses.
- 3) Plan to repeat this type of analysis when at least two more years of data are available.
- 4) Determine and include a wider range of case characteristics in those future analyses to try to get as useful as possible model of FTP outcome factors.

<b>Unfair Outcomes research</b>	
<b>Phase:</b>	4 – Analysis & report drafting
<b>Activity:</b>	Report 1 Triage
<b>Date:</b>	11 Jan 2026
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## Introduction

### Background

The GOC is, like all UK health and care regulators, keen to understand the impact of its regulatory functions, and how this impact varies across different groups who share protected characteristics. Through analysing the characteristics of the professionals about whom fitness to practise complaints and concerns are raised, and the subsequent actions taken by the regulator, it is possible to build a picture of who was more or less likely to progress through the triage process.

It is important to understand that this analysis does not determine if fitness to practise triage decisions were fair or unfair. A statistically significant result alone cannot be taken to mean that there was something wrong, but it should trigger a separate, in-depth piece of work to understand why there was a difference. Therefore, this analysis is the important first step towards being able to address that core question of whether or not the GOC's fitness to practise functions were fair.

The triage decision is the first decision point for any concern referred to the GOC – either by members of the public, employers or other sources (such as police). The descriptive analysis of these concerns provides a picture of the cases that 'land' at the GOC, before any decision was made. The logistic regression models then assess the first significant decision taken by the regulator: 'is this a concern we should investigate?' In doing so the models make explicit how those triage decisions impact on registrants with different protected characteristics.

### UK healthcare regulators literature review

Most UK healthcare regulators investigations into fitness to practise (FTP) and protected characteristics have focussed on disproportionality in referrals rather than disproportionality in FTP decision point outcomes. And they have focussed on a small subset of protected characteristics, likely reflecting the narrower equality, diversity and inclusion (EDI) data set collected by UK regulators until relatively recently.

Where other UK regulators have assessed disproportionality in FTP decision point outcomes it has been reported that concerns relating to older registrants (GMC, 2025, SWE, 2023, SWE, 2024), male registrants (GMC, 2025, SWE, 2023, SWE, 2024, GPhC, 2023), internationally qualified registrants (GMC, 2025, West et al., 2017) and

black and minority ethnic (BME) registrants (West et al., 2017, SWE, 2023, SWE, 2024) were more likely to progress to an investigation or equivalent FTP stage.

Whilst disproportionality in referrals is not the focus of this GOC unfair outcomes research, it is nevertheless instructive to consider such referral patterns across UK health profession regulators. Older registrants (GMC, 2025, West et al., 2017, HCPC, 2024, SWE, 2023, SWE, 2024, GDC, 2025), male registrants (GMC, 2025, GCC, 2023, GDC, 2025, HCPC, 2024, SWE, 2023, SWE, 2024, West et al., 2017, GPhC, 2023), internationally qualified registrants (GMC, 2025), and BME registrants (West et al., 2017, GDC, 2025, SWE, 2023, SWE, 2024, GPhC, 2023) have been reported as being more likely to be complained about.

White registrants have been reported as being more likely to be referred by the public (West et al., 2017) and BME registrants have been reported as being more likely to be referred by employers (Atewologun et al., 2019, West et al., 2017). However a later report indicated that the BME employer referral effect for doctors had subsequently disappeared (GMC, 2022).

### **Research question**

The overall aim of the GOC unfair outcomes research project is to investigate whether disproportionality has been apparent in GOC FTP process outcomes. This first report investigates outcomes at the first stage of the GOC FTP process, triage.

The principal research question for this report is therefore:

- Is there statistical evidence of disproportionality in GOC FTP triage outcomes with regards to the protected characteristics of the registrants involved in that process?

## Methods

### Study design

This is an observational retrospective cross-sectional study of all GOC FTP concerns meeting the inclusion criteria.

### Participants

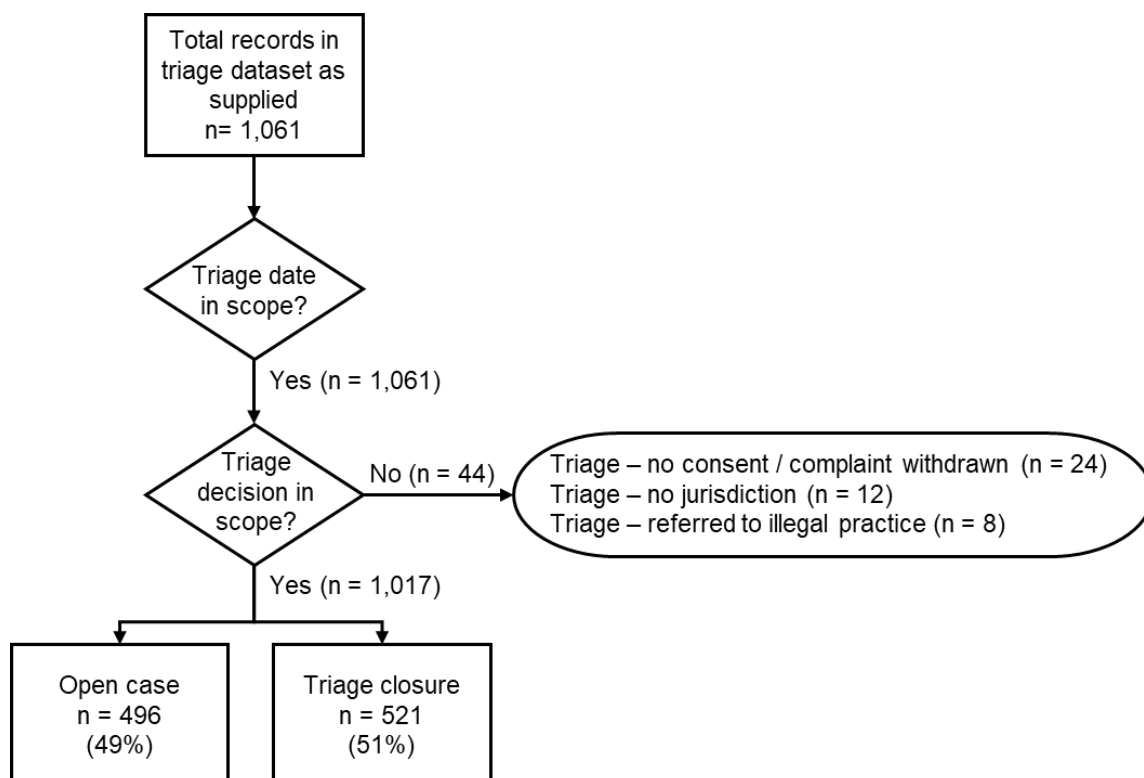
The study data set consisted of all GOC FTP concerns received where:

- A triage decision of either closure or open case was made between 01 Jan 2020 and 31 Dec 2024 inclusive.
- The concern related to a GOC registrant only and not a GOC regulated business or any other entity, with no differentiation between professional groups.

### Data collection

The data were supplied by GOC. Of the 1,061 records supplied, 44 did not meet the inclusion criteria, leaving 1,017 records for the analysis (Figure 1).

**Figure 1: Data collection flow chart**



## Variables

The binary outcome variable was the triage decision, coded to make the analyses focus on the likelihood of a case being opened.

There were eight explanatory variables related to protected characteristics and three explanatory variables relating to the case characteristics.

The original specification had included two non-protected characteristic explanatory variables, years on the register and referral source, but neither were included in the data as supplied. Inspection of the data as supplied identified three case characteristic variables that had strong effects and these were included instead of the two original ones. All three case characteristic explanatory variables were categorical and all used the largest category as the baseline value (Table 1a). The baseline value is the category against which the other categories are compared.

**Table 1a: Categorical explanatory variables, case characteristics**

Case characteristic	Category	Notes
Interim order status	No	Baseline value
	Yes	
Risk Level	Low	Baseline value
	Medium	
	High	
Allegation group	Conduct	Baseline value, ASA   Complaint handling (Business)   Failure to Declare   Personal Conduct   Procedures (Business)
		Clinical
	Conviction	Conviction/Caution
	Health	Health
	Clinical/conduct	Multiple (Clinical/Conduct)
Conviction/conduct	Multiple (Conviction or Caution/Failure to Declare)	
To be assessed	To be assessed	

The only continuous protected characteristic explanatory variable was age in years at the time of concern receipt. Age was included in the models as age/5 meaning a unit increase in age in the models was the effect of a five-year increase in age.

The other seven explanatory variables relating to protected characteristics were categorical and all used the largest category as the baseline value (Table 1b). In some instances categories were combined into groups with the agreement of GOC.

**Table 1b: Categorical explanatory variables, protected characteristics**

<b>Protected characteristic</b>	<b>Category</b>	<b>Notes</b>
Gender	Male	Baseline value
	Female	
Ethnicity	White	Baseline value
	Indian	
	Pakistani	Any other Asian   Bangladeshi   Chinese
	Other Asian	
	Black	
	Other global majority	
Prefer not to say	Mixed   Other	
Disability	No	Baseline value
	Yes	
	Prefer not to say	
Marital status	Married	Baseline value
	Single	
	Partner	
	Divorced/legally dissolved	
	Widowed/widower	
	Separated	
	Civil partnership	
	Prefer not to say	
	Religion	
No religion		
Christian		Christian   Catholic
Hindu		
Sikh		
Jewish		
Buddhist		
Prefer not to say		
Sexual orientation		
	Gay/Lesbian/Homosexual	
	Bisexual	
	Prefer not to say	
Pregnancy & maternity	No	Baseline value
	Yes	
	Prefer not to say	

## Data Analysis

The analytical objectives of this report were to produce:

1. Descriptive analyses of each of the study variables (EDI characteristics and other) to characterise this registrant population.
2. Univariate (on their own) assessments of each of the specified variables of interest by means of binary logistic regression. These indicated the risk of the outcome for each level of each variable without adjusting for other variables and intersectionality.
3. Multivariate (all together) assessment of all the specified variables of interest at the same time by means of binary logistic regression. This indicated the risk of the outcome for each variable having adjusted for other variables and intersectionality. Multivariable models were produced for all EDI variables together and for all EDI and case characteristic variables together.

The purpose of the multivariable models here was to explicitly demonstrate the effect of each of the protected characteristics in the presence of the others rather than to develop the best fitting and most parsimonious model to predict the outcome. As such there was no variable selection process and only the saturated (all variables together) model is presented. Intersectionality was assessed by means of interaction terms for ethnicity and gender, disability and gender, disability and sexual orientation, and disability and religion.

Model assurance was based on the Area under the ROC Curve for model discrimination, Pearson Chi-Square test and Hosmer and Lemeshow test for goodness of fit, and visual inspection of a range of residuals for regression diagnostics including signs of outliers.

Probabilities (p-values) of less than 0.05 were considered statistically significant. All analyses were conducted using Stata 19.5 SE (StataCorp, 2025).

To ensure like for like comparisons across the univariate and multivariable models, these analyses were based on the records that were complete for all the variables. The exception to this was Marital status, which was only included in the univariate analysis due to the relatively high levels of missing data.

## **Ethical Considerations**

The data supplied by GOC for this research were anonymous at the point of supply and therefore they were not considered to be personal data, meaning data protection legislation did not apply. Research using anonymised data cannot, by definition, require informed consent from participants as it is not possible to identify them to obtain consent. The proposal for this research was reviewed by and agreed to by the GOC. No other scientific or ethical review was needed or obtained.

## **Limitations**

Some of the categories within some of the explanatory variables were small. Where it could be reasonably justified some grouping of categories has taken place. These groups may be harder to reliably interpret as they could contain mixed effects. The decision to group them was a pragmatic attempt to retain as many records as possible for the analysis.

As described earlier, this was not an exercise to find the best fitting model to predict triage outcomes. That would likely be based on a wider range of data than those made available for this analysis, particularly additional data concerning case characteristics. Therefore poor performance in the model assurance analyses would reasonably be expected if the protected characteristics did not predict triage outcomes. Indeed, in such a situation it would reinforce the finding that protected characteristics were poor predictors.

## Results

### Univariate analysis summary

Analysis of each EDI variable individually identified a small number of statistically significant effects before other variables were taken into account. Each variable is discussed in more detail in its own section but the univariate results are summarised below. The full table of univariate logistic regression model outputs can be found in Annex A.

The odds ratio for age suggested a 6% increase in the likelihood of a case being opened for each increase in age of 5 years. The odds ratios for religion suggested a 63% increase in the likelihood of a case being opened for registrants who reported their religion as Hindu, compared to the baseline category of Muslim.

The odds ratios for disability suggested a 43% decrease in the likelihood of a case being opened for registrants who replied yes to this question, compared to the baseline category of no. The odds ratios for religion suggested an 88% decrease in the likelihood of a case being opened for registrants who reported their religion as Jewish, compared to the baseline category of Muslim. The odds ratios for marital status suggested an 28% decrease in the likelihood of a case being opened for registrants who reported their marital status as single, compared to the baseline category of married.

All three case characteristic variables showed statistically significant effects. The odds ratios for risk suggested a 128% increase in the likelihood of a case being opened when it was classified as medium risk and a 758% increase in the likelihood of a case being opened when it was classified as high risk, compared to the baseline category of low risk. The odds ratios for interim order status suggested an 823% increase in the likelihood of a case being opened when the interim order status was yes, compared to the baseline category of no. The odds ratios for allegation group suggested a 72% decrease in the likelihood of a case being opened when it was classified as conviction, a 54% decrease when it was classified as health, and an 84% decrease when it was classified as to be assessed, compared to the baseline category of conduct.

### **Multivariable analysis summary – EDI characteristics only**

Analysis of each EDI variable adjusted for all other EDI variables identified a small number of statistically significant effects. Each variable is discussed in more detail in its own section but the multivariable EDI only model results are summarised below. The full table of multivariable EDI only logistic regression model output can be found in Annex B.

Of the statistically significant effects identified in the univariate analysis for EDI characteristics, only two persisted after adjustment for other EDI variables and one new effect emerged. Only one of the 52 intersectionality interaction terms was statistically significant. A pragmatic decision was taken to remove the interaction terms as there was very little evidence of intersectionality, including them substantially increased the complexity of interpretation, and including them reduced the number of records in the analysis. The results reported for this analysis are therefore for the main effects only. The one significant interaction term is described in the disability section.

The EDI adjusted odds ratio for age suggested a 9% increase in the likelihood of a case being opened for each increase in age of 5 years. The univariate effect for registrants who reported their religion as Hindu disappeared once other EDI variables were taken into account.

The EDI adjusted odds ratios for religion suggested a 91% decrease in the likelihood of a case being opened for registrants who reported their religion as Jewish, compared to the baseline category of Muslim. The univariate effect for registrants who replied yes to the disability question disappeared once other EDI variables were taken into account. Marital status was not included in the multivariable analysis due to the high levels of missing data.

The EDI adjusted odds ratios for sexual orientation suggested a 48% decrease in the likelihood of a case being opened for registrants who replied prefer not to say to this question, compared to the baseline category of heterosexual/straight. It was noted that whilst none of the other categories for sexual orientation were statistically significant, they were all around a 50% decrease in the likelihood of a case being opened compared to the baseline.

The technical evaluation of the model indicated no issues with the goodness of fit (Pearson Chi-Square  $p = 0.18$ , Hosmer-Lemeshow  $p = 0.59$ ) but with little accuracy in

outcome prediction illustrated by the area under the ROC curve (0.60) being in the poor discrimination range (Annex C). The poor discrimination is visible in the scatterplot and histogram of the predicted probabilities (Annex C). Regression diagnostics analysis of the residuals indicated no serious issues (Annex D). The persistent outlier in the top left was the one case opened for a Jewish registrant.

### **Multivariable analysis summary – EDI and case characteristics**

Analysis of each EDI and case variable adjusted for all other EDI and case variables identified only one statistically significant effect for EDI variables and a number of statistically significant effects for case characteristic variables. Each variable is discussed in more detail in its own section, but the multivariable EDI and case characteristic model results are summarised below. The full table of multivariable EDI and case characteristic logistic regression model output can be found in Annex C.

None of the statistically significant effects identified in the univariate analysis or multivariable adjusted for EDI only analysis persisted after adjustment for other EDI variables and case characteristics, and one new effect emerged. None of the 52 intersectionality interaction terms were statistically significant, including the one that had been significant in the adjusted for EDI only model. A pragmatic decision was taken to remove the interaction terms as there was no evidence of intersectionality, including them substantially increased the complexity of interpretation, and including them reduced the number of records in the analysis. The results reported for this analysis are therefore for the main effects only.

The EDI and case characteristic adjusted odds ratio for disability suggested a 105% increase in the likelihood of a case being opened for registrants who reported prefer not to say to the disability question, compared to the baseline category of no.

The univariate effects reported for all three case characteristic variables persisted when adjusted for EDI and case characteristics. The EDI and case characteristic adjusted odds ratios for risk suggested a 150% increase in the likelihood of a case being opened when it was classified as medium risk and a 633% increase in the likelihood of a case being opened when it was classified as high risk, compared to the baseline category of low risk. The EDI and case characteristic adjusted odds ratios for interim order status suggested an 528% increase in the likelihood of a case being

opened when the interim order status was yes, compared to the baseline category of no. The EDI and case characteristic adjusted odds ratios for allegation group suggested a 64% decrease in the likelihood of a case being opened when it was classified as conviction, a 72% decrease when it was classified as health, and an 87% decrease when it was classified as to be assessed, compared to the baseline category of conduct.

The technical evaluation of the model detected an issue with the goodness of fit (Pearson Chi-Square  $p = 0.42$ , Hosmer-Lemeshow  $p = 0.02$ ). Inspection of the Hosmer-Lemeshow deciles isolated the issue to the ninth decile, where the predicted probability of a case opening is high. Inspection of the residuals further narrowed the source down to three covariate patterns, all of which had only one registrant in them though in one instance there were three separate records for the same registrant. In all instances they had a high predicted probability, largely due to being in the high-risk group, but had been closed at triage. A decision was made to leave all outlying cases in the analysis set. There was an improvement in the accuracy of the outcome prediction, the area under the ROC curve of 0.73 being in the adequate discrimination range (Annex F). The slightly better discrimination is visible in the scatterplot and histogram of the predicted probabilities (Annex F). The regression diagnostics analysis of the residuals used to investigate the poor goodness of fit are shown in Annex G.

## Age

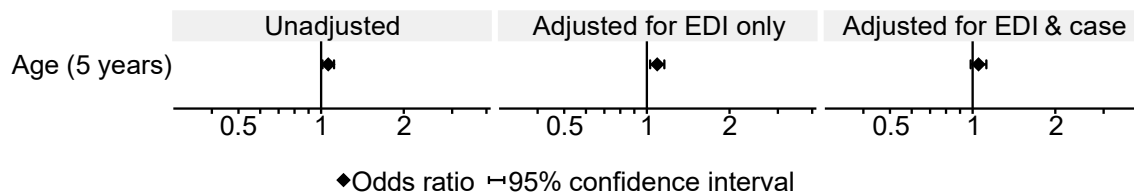
The median age in years of the registrants at the time the complaint was received was three years higher for concerns resulting in a case opening than for concerns which were closed at triage (Table 2).

Age was modelled as the effect of a five-year increase in age to make the results easier to interpret. Age was statistically significant in the unadjusted and adjusted for EDI only analyses but was not statistically significant (Odds ratio (OR) 1.05, 95% confidence interval (CI) 0.98 to 1.12,  $p = 0.14$ ) once case variables were added into the model (Figure 2 & Annexes A, B and E).

**Table 2: Descriptive statistics: age (years)**

Triage outcome	n	Mean	SD	Median	IQR	Min	Max
Closure	517	37.4	13.0	35	27 to 44	18	85
Case opened	491	39.4	12.8	38	28 to 47	21	76
Total	1,008	38.4	12.9	36	28 to 45.5	18	85

**Figure 2: Odds ratios: age (five years)**



## Gender

The concerns received were split just over 60:40 males to females though an almost identical percentage within each gender had a case opened (Table 3).

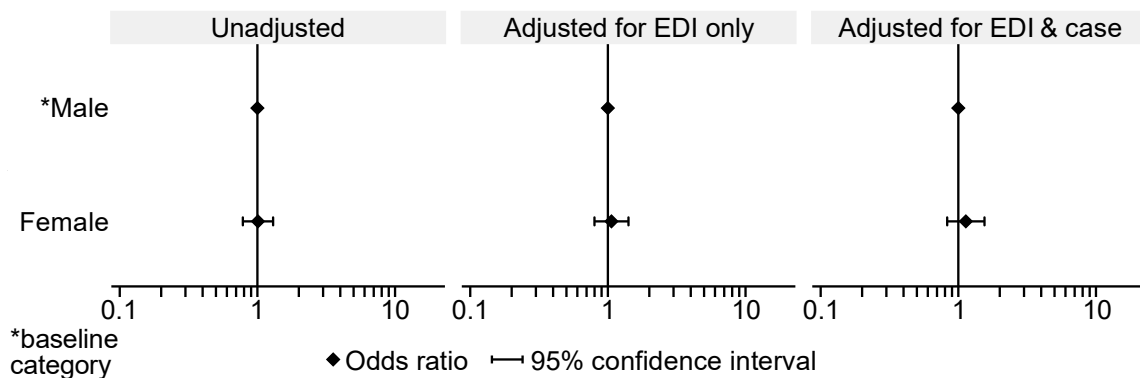
Gender was not statistically significant in the unadjusted, adjusted for EDI only, or adjusted for EDI and case characteristic analyses (Figure 3 & Annexes A, B and E).

While not statistically significant, the EDI and case characteristic adjusted odds ratios for gender suggested a 13% increase (OR 1.13, 95% CI 0.83 to 1.55,  $p = 0.43$ ) in the likelihood of a case being opened for registrants who were female, compared to the baseline category of male.

**Table 3: Descriptive statistics: gender**

Gender	All cases		Triage outcome			
	n	%	Closure		Case opened	
	n	%	n	%	n	%
Male	615	61.0	316	51.4	299	48.6
Female	393	39.0	201	51.2	192	48.9
Total	1,008	100.0	517	51.3	491	48.7

**Figure 3: Odds ratios: gender**



## Ethnicity

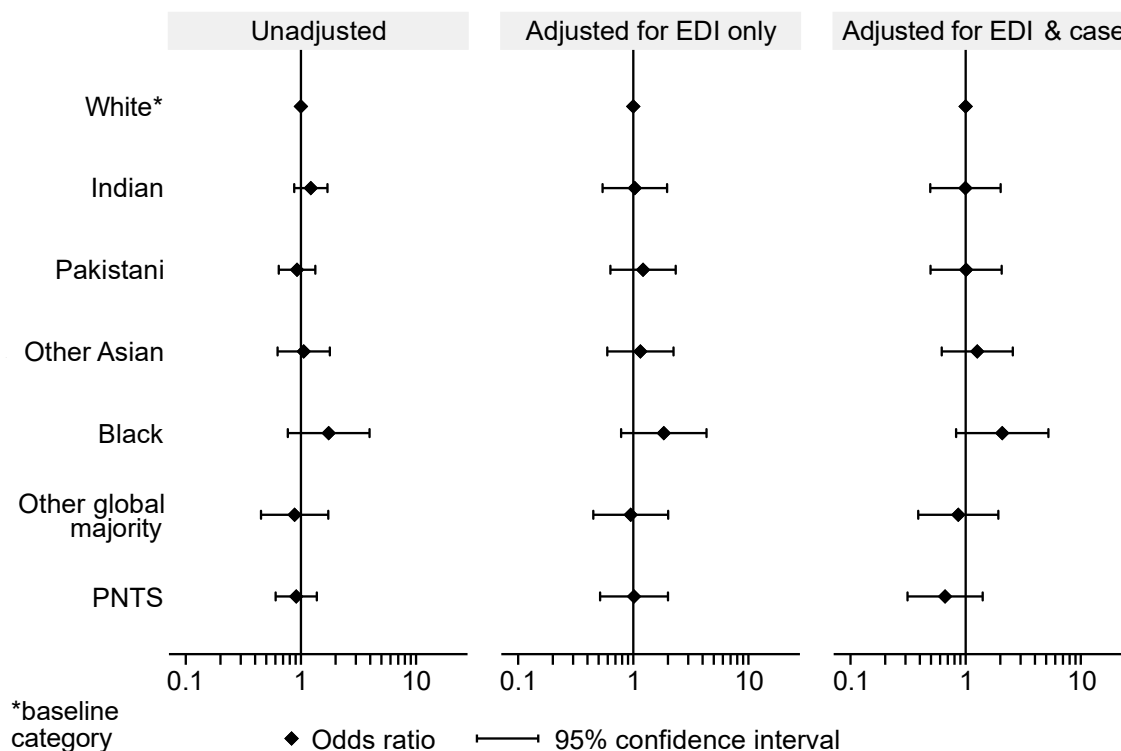
Three quarters of the concerns received were for one of white, Indian or Pakistani ethnicities (Table 4). Two ethnicities, Indian and Black, had somewhat higher percentages of cases opened. However, no ethnicity was statistically significant in any of the logistic regression analyses (Figure 4 & Annexes A, B and E).

While not statistically significant, the EDI and case characteristic adjusted odds ratios for Black registrants suggested a 108% increase (OR 2.08, 95% CI 0.83 to 2.53,  $p = 0.12$ ) in the likelihood of a case being opened for registrants who were black, compared to the baseline category of white.

**Table 4: Descriptive statistics: gender**

Ethnicity	All cases		Triage outcome			
	n	%	Closure		Case opened	
			n	%	n	%
White	351	34.8	183	52.1	168	47.9
Indian	231	22.9	109	47.2	122	52.8
Pakistani	172	17.1	93	54.1	79	45.9
Other Asian	67	6.7	34	50.8	33	49.3
Black	26	2.6	10	38.5	16	61.5
Other global majority	38	3.8	21	55.3	17	44.7
PNTS	123	12.2	67	54.5	56	45.5
Total	1,008	100.0	517	51.3	491	48.7

**Figure 4: Odds ratios: ethnicity**



## Disability

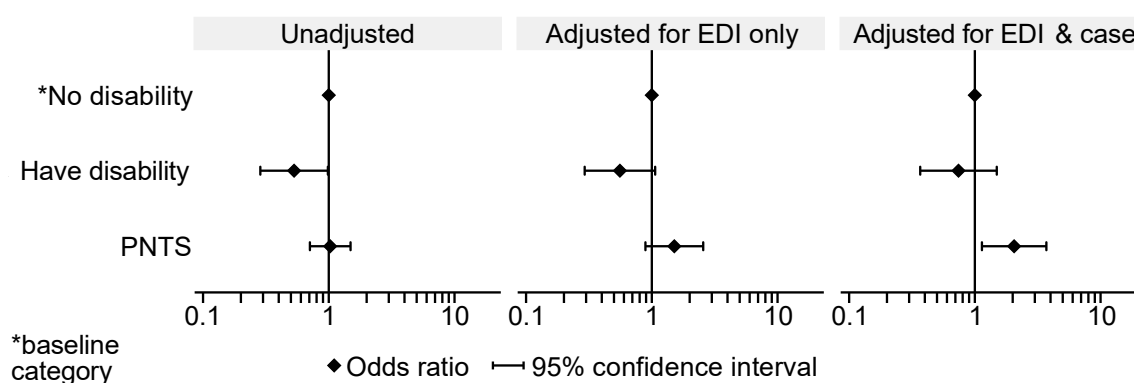
Almost three times as many registrants answered prefer not to say to this question as answered yes (Table 5). The percentage of cases opened (34%) was notably lower for those that answered yes, than no (49%) and prefer not to say (50%). The lower level of cases being opened for those answering yes was statistically significant in the univariate analysis but was not statistically significant in either of the multivariable analyses (Figure 5 & Annexes A, B and E).

While not statistically significant in the univariate or adjusted for EDI only analyses, the EDI and case characteristic adjusted odds ratios for registrants answering prefer not to say to this question was statistically significant and suggested a 105% increase (OR 2.05, 95% CI 1.14 to 3.70,  $p = 0.02$ ) in the likelihood of a case being opened for registrants answered prefer not to say, compared to the baseline category of no.

**Table 5: Descriptive statistics: disability**

Disability	All cases		Triage outcome			
	n	%	Closure		Case opened	
	n	%	n	%	n	%
No	833	82.6	422	50.7	411	49.3
Yes	47	4.7	31	66.0	16	34.0
PNTS	128	12.7	65	50.0	64	50.0
Total	1,008	100.0	517	51.3	491	48.7

**Figure 5: Odds ratios: disability**



The one statistically significant intersectionality occurred between disability and religion with the interaction term for non-disabled Jewish registrants indicating a lower chance of a case being opened (OR 0.10, 95% CI 0.01 to 0.86,  $p = 0.04$ ). Only nine registrants had this combination of characteristics and the effect disappeared when the case characteristics were also adjusted for.

## Religion

Three quarters of the concerns received were for one of Muslim, Christian, no religion, or Hindu religion (Table 6). Hindu registrants had a higher percentage (57%) of cases opened and Jewish registrants had a very low percent (9%) of cases opened. In the univariate analysis the both the Hindu and Jewish rates were statistically significant though neither Hindu (OR 1.79, 95% CI 0.93 to 3.42,  $p = 0.08$ ) or Jewish (OR 0.12, 95% CI 0.01 to 1.07,  $p = 0.06$ ) were statistically significant after adjusting for EDI and case characteristics, albeit marginally so (Figure 6 & Annexes A, B and E).

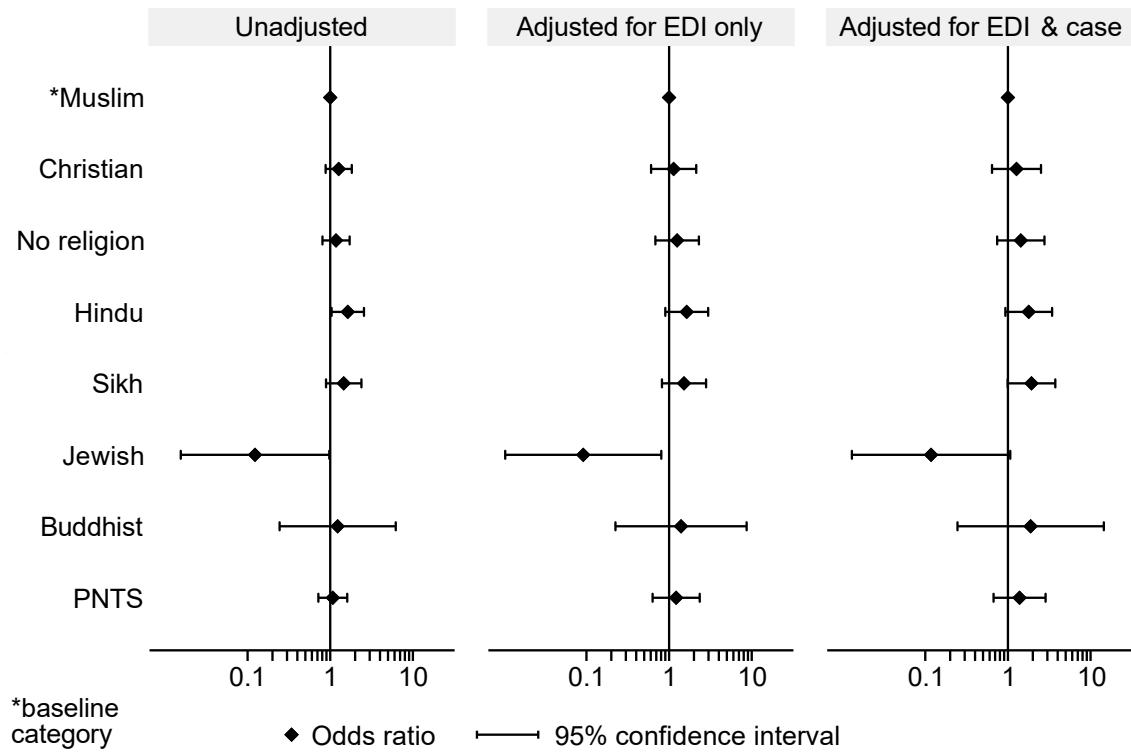
While not statistically significant, the EDI and case characteristic adjusted odds ratios suggested a 93% increase (OR 1.93, 95% CI 0.99 to 3.75,  $p = 0.05$ ) in the likelihood of a case being opened for Sikh registrants, compared to the Muslim baseline category.

**Table 6: Descriptive statistics: religion**

Religion	All cases		Triage outcome			
	n	%	Closure		Case opened	
	n	%	n	%	n	%
Muslim	272	27.0	150	55.2	122	44.9
Christian	203	20.1	100	49.3	103	50.7
No religion	178	17.7	91	51.1	87	48.9
Hindu	107	10.6	46	43.0	61	57.0
Sikh	83	8.2	38	45.8	45	52.2
Jewish	11	1.1	10	90.9	1	9.1
Buddhist	6	0.6	3	50.0	3	50.0
PNTS	148	14.7	79	53.4	69	46.6
Total	1,008	100.0	517	51.3	491	48.7

The one statistically significant intersectionality interaction term occurred in t, the EDI and case characteristic adjusted odds ratios suggested a 93% increase (OR 1.93, 95% CI 0.99 to 3.75,  $p = 0.05$ ) in the likelihood of a case being opened for Sikh registrants, compared to the Muslim baseline category.

Figure 6: Odds ratios: religion



### Sexual orientation

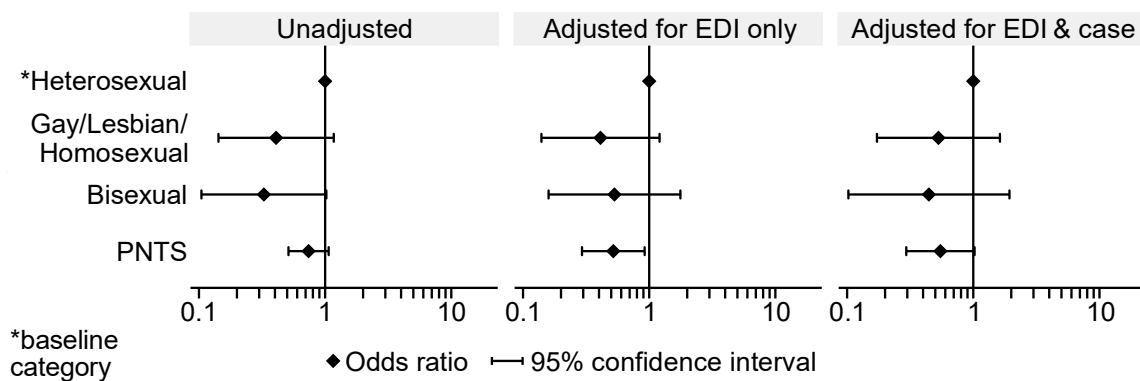
Four times as many registrants answered prefer not to say to this question as answered Gay/Lesbian/Homosexual, or Bisexual (Table 7). The percentage of cases opened (34%) was notably lower for those that answered Gay/Lesbian/Homosexual (29%), or Bisexual (25%), than prefer not to say (43%) and Heterosexual/straight (51%).

No sexual orientation category was statistically significant in the univariate analysis but prefer not to say was statistically significant in the adjusted for EDI only model (OR 0.52, 95% CI 0.29 to 0.92,  $p = 0.03$ ) but not in the adjusted for EDI only model (OR 0.55, 95% CI 0.29 to 1.02,  $p = 0.06$ ), albeit only marginally so (Figure 5 & Annexes A, B and E).

**Table 7: Descriptive statistics: sexual orientation**

Sexual orientation	All cases		Triage outcome			
	n	%	Closure		Case opened	
			n	%	n	%
Heterosexual/straight	840	83.3	416	49.5	424	50.5
Gay/Lesbian/Homosexual	17	1.7	12	70.6	5	29.4
Bisexual	16	1.6	12	75.0	4	25.0
PNTS	135	13.4	77	57.0	58	43.0
Total	1,008	100.0	517	51.3	491	48.7

**Figure 7: Odds ratios: sexual orientation**



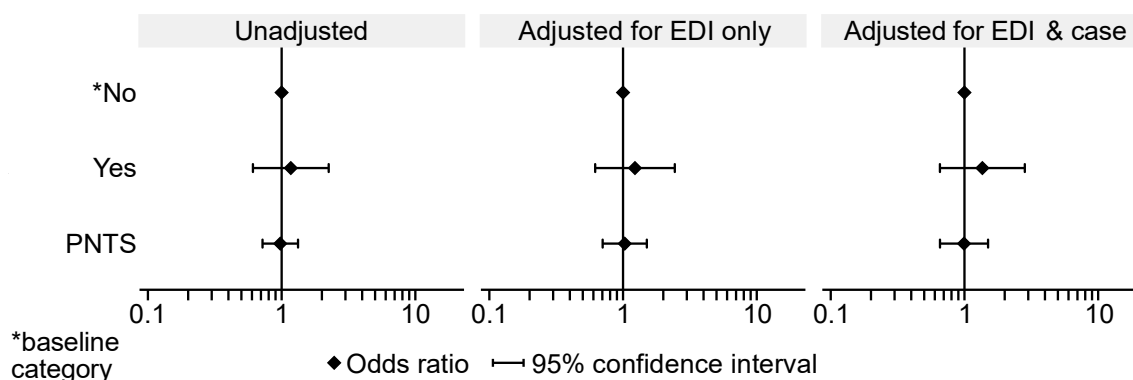
### Pregnancy & maternity

This question had the highest level of prefer not to say, with one in five registrants choosing that response. Over five times as many registrants answered prefer not to say to this question as answered yes (Table 8). There was very little difference between the response groups and none of these were statistically significant in any of the univariate or multivariable analyses (Figure 8 & Annexes A, B and E).

**Table 8: Descriptive statistics: pregnancy & maternity**

Pregnancy & maternity	All cases		Triage outcome			
	n	%	Closure		Case opened	
	n	%	n	%	n	%
No	760	75.4	390	51.3	370	48.7
Yes	38	3.8	18	47.4	20	52.6
PNTS	210	20.8	109	51.9	101	48.1
Total	1,008	100.0	517	51.3	491	48.7

**Figure 8: Odds ratios: pregnancy & maternity**



### Marital status

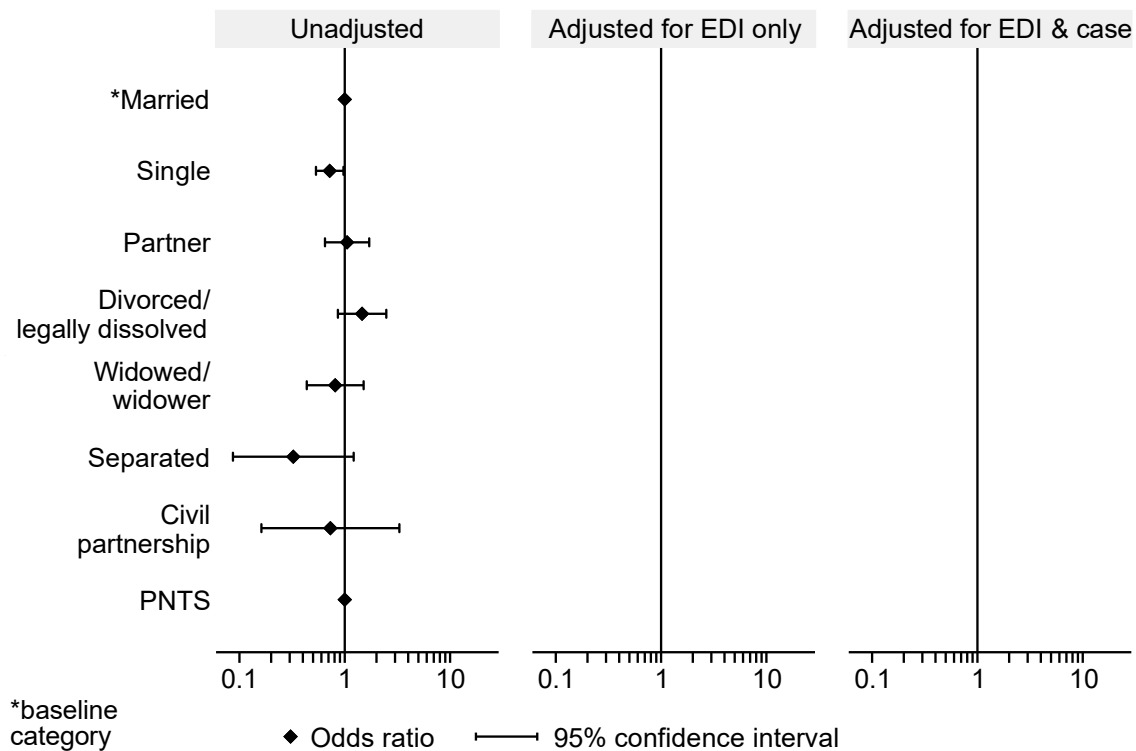
Due to the high levels of missing data, marital status was only included in the univariate analysis. Almost eighty percent of the concerns were one of the top two categories (married or single) and as a result there were some small counts and wide confidence intervals for some of the other categories (Table 9 & Figure 9).

The univariate analysis indicated a 28% decrease (OR 0.72, 95% CI 0.53 to 0.97,  $p = 0.03$ ) in the likelihood of a case being opened for registrants who were single, compared to the baseline category of married (Figure 9 & Annex A).

**Table 9: Descriptive statistics: marital status**

Marital status	All cases		Triage outcome			
	n	%	Closure		Case opened	
			n	%	n	%
Married	450	48.1	222	49.3	228	50.7
Single	280	29.9	161	57.5	119	42.5
Partner	77	8.2	37	48.1	40	52.0
Divorced/legally dissolved	65	6.9	26	40.0	39	60.0
Widowed/widower	44	4.7	24	54.6	20	45.5
Separated	12	1.3	9	75.0	3	25.0
Civil partnership	7	0.8	4	57.1	3	42.9
PNTS	1	0.1	1	100.0	0	0.0
Total	936	100.0	484	51.7	452	48.3

**Figure 9: Odds ratios: marital status**



### Interim order status

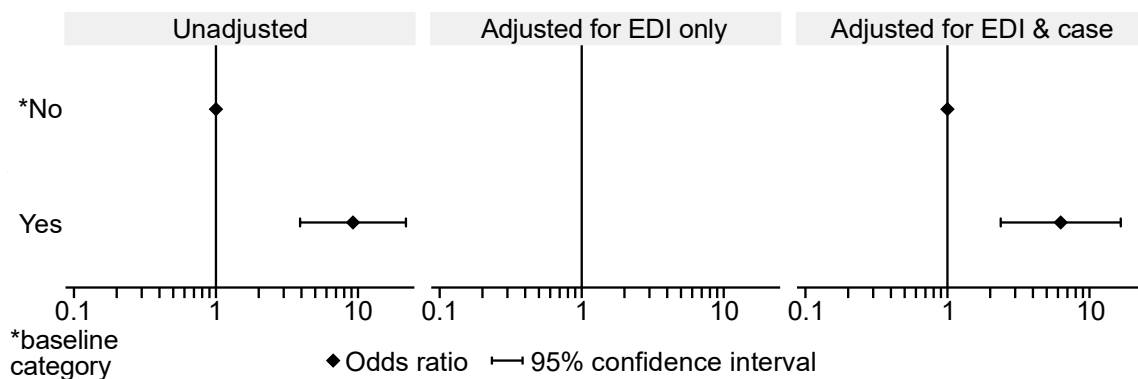
Case characteristics were evaluated univariately and with all EDI and case characteristic variables. Only a small fraction of concerns had an interim order but there was a very clear difference in the percentage of cases opened where there was an interim order (89%) compared to the cases where the wasn't such an order (46%) in place (Table 10).

The univariate analysis suggested an 823% increase (OR 9.23, 95% CI 3.91 to 21.8,  $p < 0.01$ ) in the likelihood of a case being opened when an interim order was in place, compared to the when it wasn't (Figure 10 & Annexes A and E). Adjusting for EDI and other case characteristics only very slightly lessened this effect and it was still highly significant (OR 6.28, 95% CI 2.37 to 16.6,  $p < 0.01$ ).

**Table 10: Descriptive statistics: interim order status**

Interim order status	All cases		Triage outcome			
	n	%	Closure		Case opened	
			n	%	n	%
No	954	94.6	511	53.6	443	46.4
Yes	54	5.4	6	11.1	48	88.9
Total	1,008	100.0	517	51.3	491	48.7

**Figure 10: Odds ratios: interim order status**



## Risk

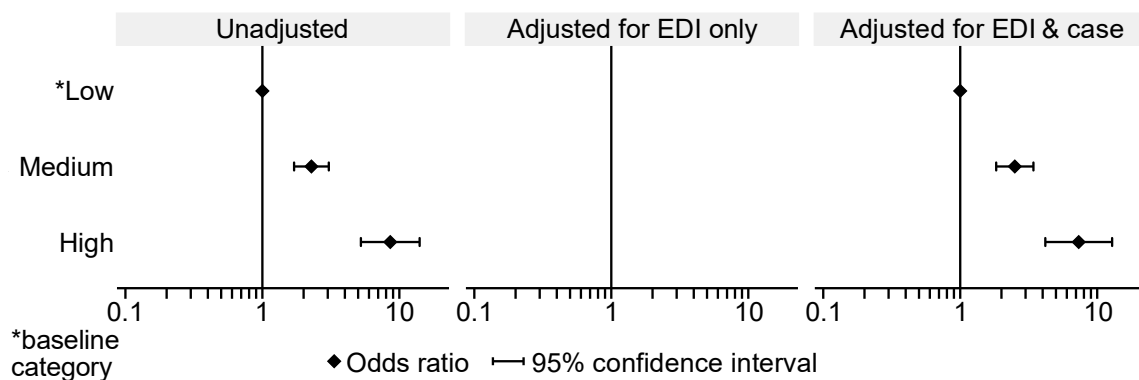
Over half of the concerns were medium risk and there was a very clear gradient in the percentage of cases opened from low risk (31%), through medium risk (51%) to 80% of those classed as high risk (Table 11).

The univariate analysis suggested a 128% increase (OR 2.28, 95% CI 1.70 to 3.05,  $p < 0.01$ ) in the likelihood of a case being opened for medium risk cases, and a 758% increase (OR 8.58, 95% CI 5.24 to 14.1,  $p < 0.01$ ) in the likelihood of a case being opened for high risk cases compared to low risk cases (Figure 11 & Annexes A and E). Adjusting for EDI and other case characteristics only very slightly changed these effects and both medium risk (OR 2.50, 95% CI 1.83 to 3.42,  $p < 0.01$ ) and high risk concerns (OR 7.33, 95% CI 4.18 to 12.9,  $p < 0.01$ ) were still highly significant.

**Table 11: Descriptive statistics: risk**

Risk	All cases		Triage outcome			
	n	%	Closure		Case opened	
	n	%	n	%	n	%
Low	306	30.7	210	68.6	96	31.4
Medium	574	56.9	281	49.0	293	51.0
High	128	12.7	26	20.3	102	79.7
Total	1,008	100.0	517	51.3	491	48.7

**Figure 11: Odds ratios: risk**



## Allegation group

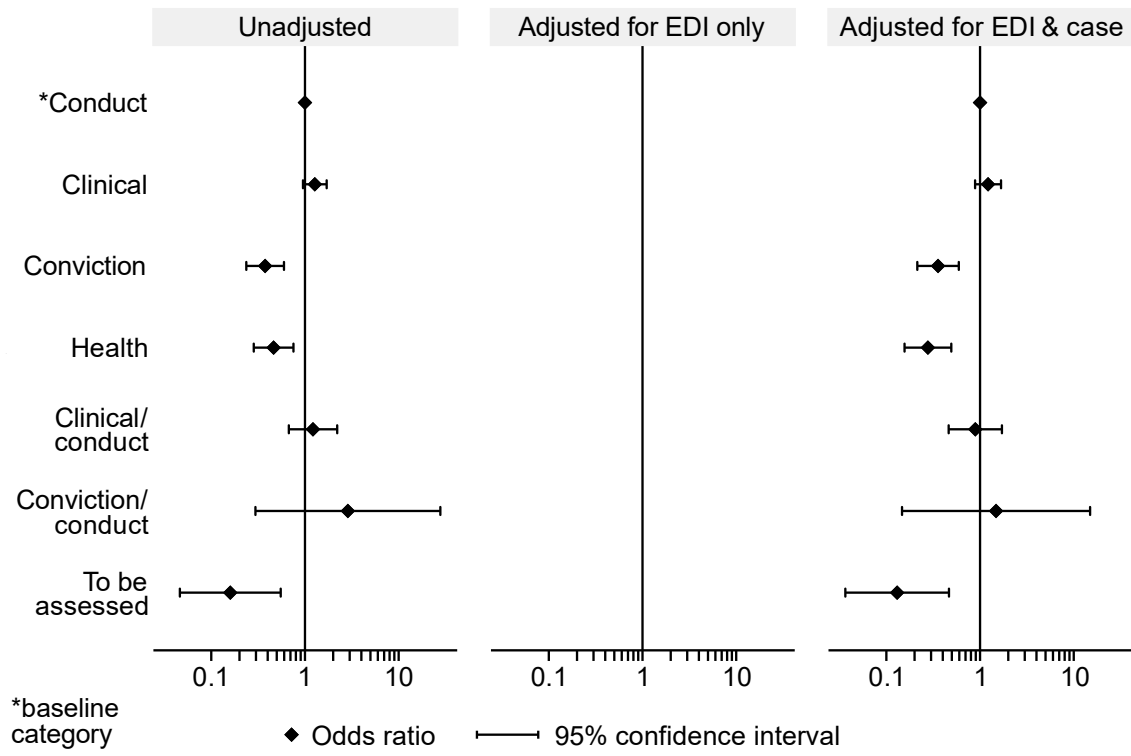
Almost three quarters of concern were one of the top three categories: conduct, clinical or conviction. There appeared to be two fairly distinct groups of categories in terms of the percent resulting in a case opening. For those involving conduct and/or clinical over half of concerns resulted in a case opening. For those involving conviction (on its own), health or to be assessed the percentage with a case opening were very much lower, from 14 to 32% (Table 12).

The univariate analysis suggested a 62% decrease (OR 0.38, 95% CI 0.24 to 0.60,  $p < 0.01$ ) in the likelihood of a case being opened for conviction cases, a 54% decrease (OR 0.46, 95% CI 0.28 to 0.75,  $p < 0.01$ ) in the likelihood of a case being opened for health cases, and an 84% decrease (OR 0.16, 95% CI 0.05 to 0.55,  $p < 0.01$ ) in the likelihood of a case being opened for to be assessed cases compared to conduct cases (Figure 12 & Annexes A and E). Adjusting for EDI and other case characteristics only very slightly changed these effects with conviction (OR 0.36, 95% CI 0.21 to 0.59,  $p < 0.01$ ), health (OR 0.28, 95% CI 0.16 to 0.49,  $p < 0.01$ ), and to be assessed (OR 0.13, 95% CI 0.04 to 0.47,  $p < 0.01$ ) all remaining still highly significant.

**Table 12: Descriptive statistics: allegation group**

Allegation group	All cases		Triage outcome			
	n	%	Closure		Case opened	
			n	%	n	%
Conduct	368	36.5	180	48.9	188	51.1
Clinical	366	36.3	157	42.9	209	57.1
Conviction	110	10.9	79	71.8	31	28.2
Health	89	8.8	60	67.4	29	32.6
Clinical/conduct	50	5.0	22	44.0	28	56.0
Conviction/conduct	4	0.4	1	25.0	3	75.0
To be assessed	21	2.1	18	85.7	3	14.3
Total	1,008	100.0	517	51.3	491	48.7

Figure 12: Odds ratios: allegation group



## Discussion

These analyses highlight two important analytical issues. First, effects seen in univariate analysis often disappear once other variables are adjusted for. Second, variables with no univariate effect can have a significant effect once other variables are adjusted for.

With regards to the research question, the results of this analysis suggest:

- 1) There is very little statistical evidence of disproportionality in GOC FTP triage outcomes with regards to the protected characteristics of the registrants involved in that process, after adjusting for all EDI variables and all available case characteristics. The one statistically significant finding was a higher level of case opening for prefer not to say for disability.
- 2) There are two protected characteristics where certain levels are on the borderline of statistical significance, namely those of Sikh, Jewish or Hindu religions and those who answered prefer not to say to the sexual orientation question.
- 3) There was very little evidence of intersectionality between the variables analysed with interaction terms, and no evidence once case characteristics were adjusted for.
- 4) Overall, EDI characteristics are very poor predictors of triage outcome whereas case characteristics are very good predictors of triage outcome. This makes it essential to adjust for case characteristics when considering effects of EDI characteristics.

Some of the univariate effects reported here somewhat align with those reported by other UK regulators, in particular an age effect, though this disappeared in the multivariable analysis presented here. No gender or ethnicity effects were observed here, and referral source was not supplied for analysis.

The impact of adjusting for case characteristics raises an important consideration for the validity of these results. It is almost certain that there were other case characteristics that would have strong predictive power, possibly including referral source and registration route (UK or international). To be certain of the effect/non-effect of EDI variables it would be prudent to model triage outcomes in the presence of all plausible case characteristic variables.

Although the focus has been on statistically significant effects, there are some possibly interesting patterns in the results in general. One potential explanation for any very low percentage of concerns having a case open is that that have been over-referred. Are the low case rates for all non-heterosexual sexual orientation categories the result of over referral? Likewise with the extraordinarily low rate of cases being opened where the registrant was Jewish. Further and more detailed in-house assessment of those cases would be needed to try to understand the reasons for those effects.

Whilst the dataset used for these analyses represented the total relevant case load over a five-year period, it was not huge and some of the categories within some of the characteristics had very small counts. This in turn led to some uncertainty in the analyses, apparent in the sometimes wide confidence intervals. If there has been no substantive change in the triage procedures, it would be prudent to repeat the exercise when more years of data are available.

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**Annex A: Univariate (unadjusted) logistic regression models outputs**

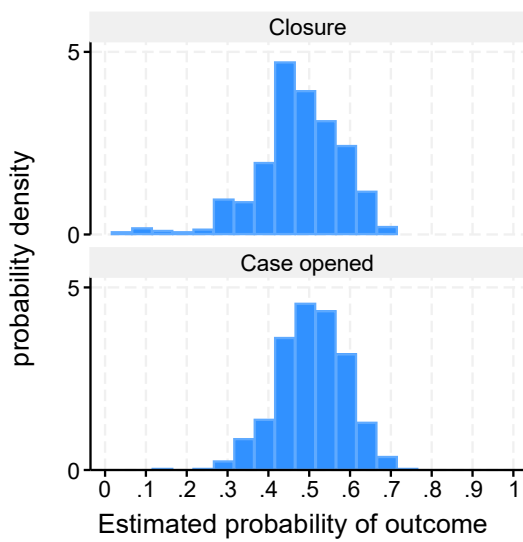
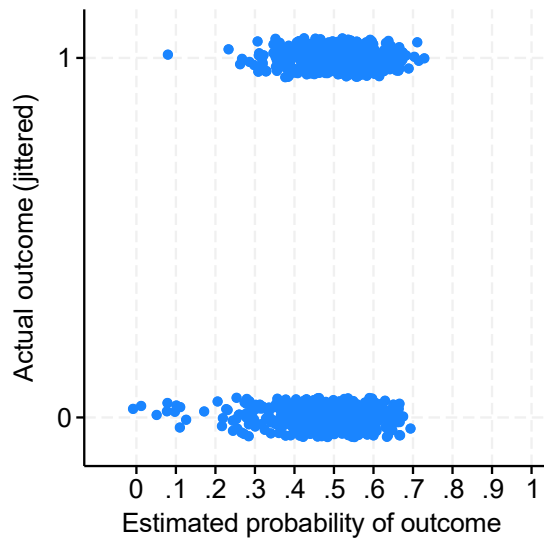
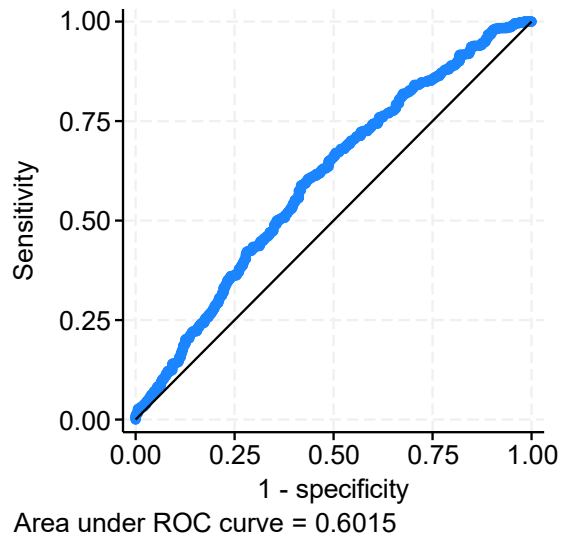
<b>Variable</b>	<b>Coefficient (<math>\beta</math>)</b>	<b>SE</b>	<b>Wald <math>\chi^2</math></b>	<b>p value</b>	<b>Odds Ratio</b>	<b>95% CI</b>
<b>Age (5 years)</b>	0.060	0.025	2.4	0.015	1.06	1.01 to 1.11
<b>Gender</b>						
*Male					1.00	
Female	0.009	0.129	0.1	0.941	1.01	0.78 to 1.30
<b>Disability</b>						
*No					1.00	
Yes	-0.635	0.316	-2.0	0.044	0.53	0.29 to 0.98
PNTS	0.026	0.190	0.1	0.889	1.03	0.71 to 1.49
<b>Ethnicity</b>						
*White					1.00	
Indian	0.198	0.170	1.2	0.243	1.22	0.87 to 1.70
Pakistani	-0.078	0.187	-0.4	0.677	0.93	0.64 to 1.33
Other Asian	0.056	0.267	0.2	0.835	1.06	0.63 to 1.78
Black	0.556	0.417	1.3	0.183	1.74	0.77 to 3.95
Other global majority	-0.126	0.343	-0.4	0.714	0.88	0.45 to 1.73
PNTS	-0.094	0.210	-0.4	0.655	0.91	0.60 to 1.37
<b>Religion</b>						
*Muslim					1.00	
Christian	0.236	0.186	1.3	0.204	1.27	0.88 to 1.82
No religion	0.162	0.193	0.8	0.403	1.18	0.80 to 1.72
Hindu	0.489	0.230	2.1	0.034	1.63	1.04 to 2.56
Sikh	0.376	0.252	1.5	0.136	1.46	0.89 to 2.39
Jewish	-2.096	1.056	-2.0	0.047	0.12	0.02 to 0.97
Buddhist	0.207	0.826	0.3	0.802	1.23	0.24 to 6.20
PNTS	0.071	0.205	0.3	0.728	1.07	0.72 to 1.60
<b>Sexual orientation</b>						
*Heterosexual					1.00	
Gay/Lesbian/ Homosexual	-0.895	0.537	-1.7	0.096	0.41	0.14 to 1.17
Bisexual	-1.118	0.581	-1.9	0.055	0.33	0.10 to 1.02
PNTS	-0.302	0.187	-1.6	0.106	0.74	0.51 to 1.07
<b>Pregnancy &amp; maternity</b>						
*No					1.00	
Yes	0.158	0.333	0.5	0.635	1.17	0.61 to 2.25
PNTS	-0.024	0.156	-0.2	0.880	0.98	0.72 to 1.33
<b>Marital status</b>						
*Married					1.00	
Single	-0.329	0.153	-2.1	0.032	0.72	0.53 to 0.97
Partner	0.051	0.247	0.2	0.835	1.05	0.65 to 1.71
Divorced/legally dissolved	0.379	0.270	1.4	0.161	1.46	0.86 to 2.48
Widowed/widower	-0.209	0.317	-0.7	0.510	0.81	0.44 to 1.51
Separated	-1.125	0.673	-1.7	0.095	0.32	0.09 to 1.21
Civil partnership	-0.314	0.770	-0.4	0.683	0.73	0.16 to 3.30
PNTS					1.00	

	Variable	Coefficient ( $\beta$ )	SE	Wald $\chi^2$	p value	Odds Ratio	95% CI
<b>Risk</b>							
	*Low					1.00	
	Medium	0.825	0.149	5.5	0.000	2.28	1.70 to 3.05
	High	2.150	0.252	8.5	0.000	8.58	5.24 to 14.1
<b>Interim order status</b>							
	*No					1.00	
	Yes	2.222	0.438	5.1	0.000	9.23	3.91 to 21.8
<b>Allegation group</b>							
	*Conduct					1.00	
	Clinical	0.243	0.148	1.6	0.102	1.27	0.95 to 1.70
	Conviction	-0.979	0.236	-4.1	0.000	0.38	0.24 to 0.60
	Health	-0.771	0.249	-3.1	0.002	0.46	0.28 to 0.75
	Clinical/conduct	0.198	0.303	0.7	0.515	1.22	0.67 to 2.21
	Conviction/conduct	1.055	1.159	0.9	0.363	2.87	0.30 to 27.9
	To be assessed	-1.835	0.632	-2.9	0.004	0.16	0.05 to 0.55

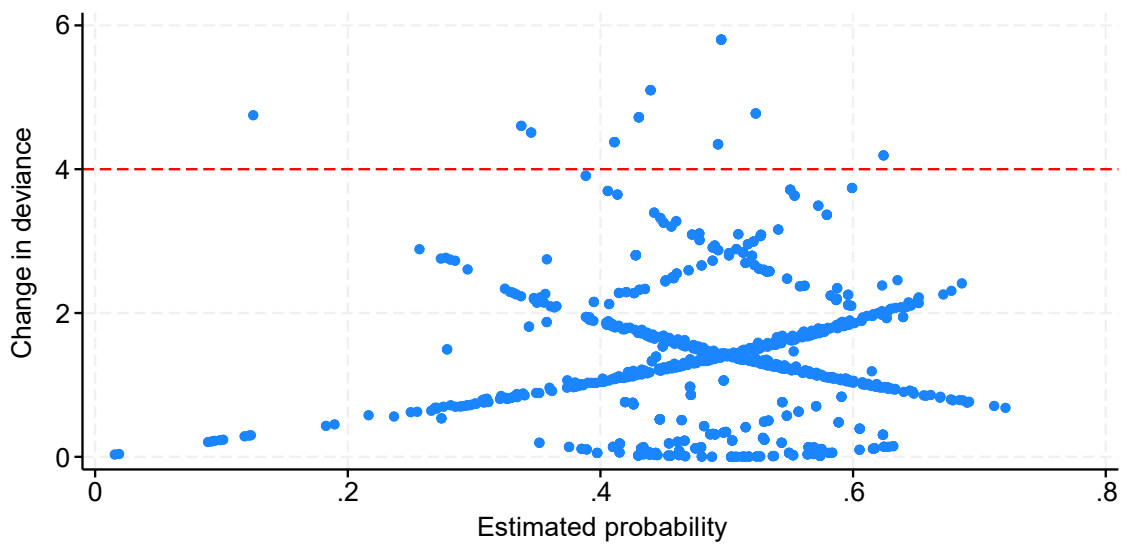
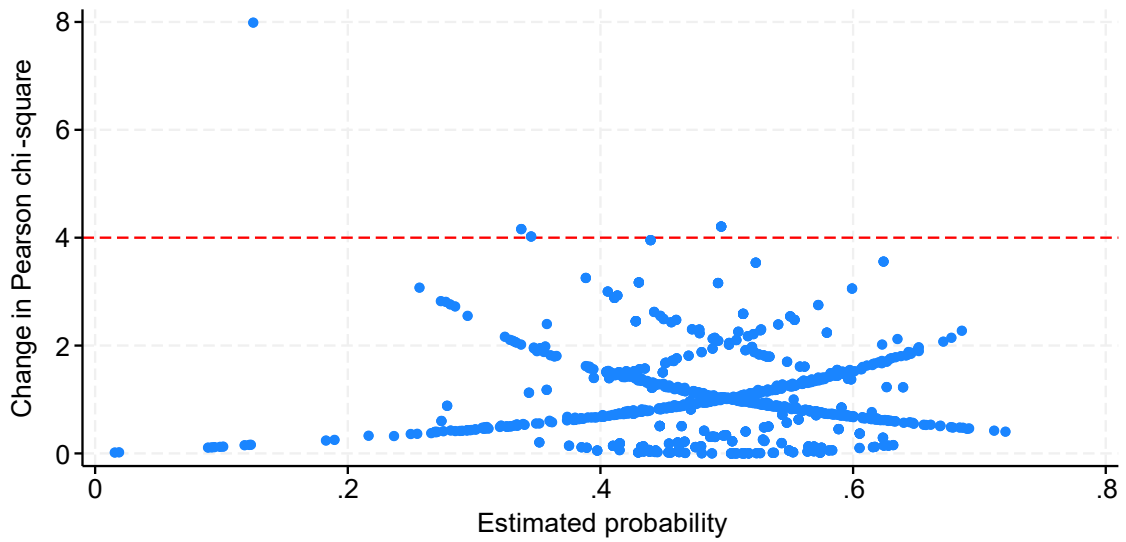
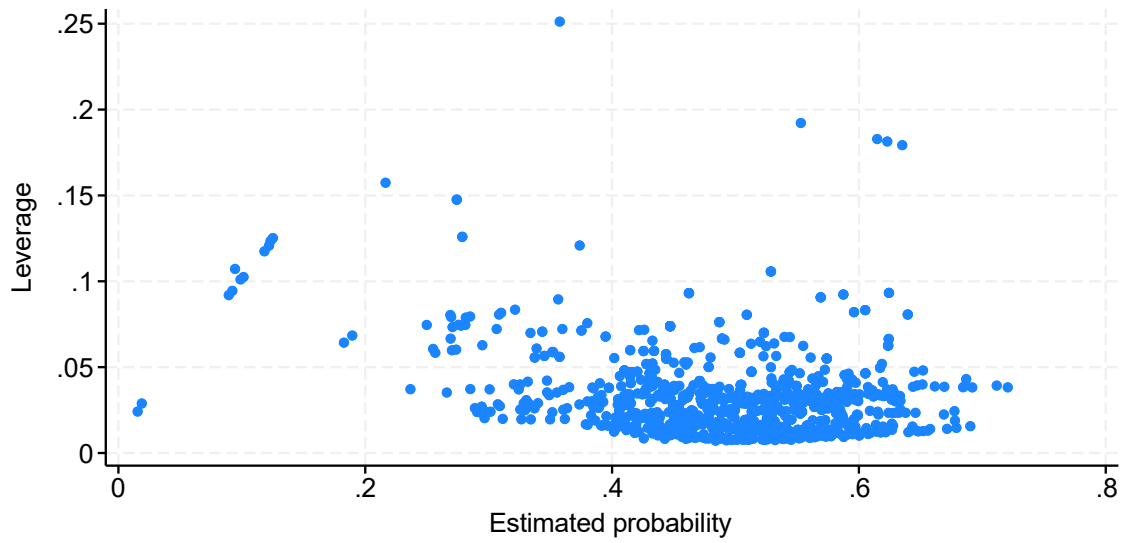
**Annex B: Multivariable (adjusted for EDI) logistic regression model output**

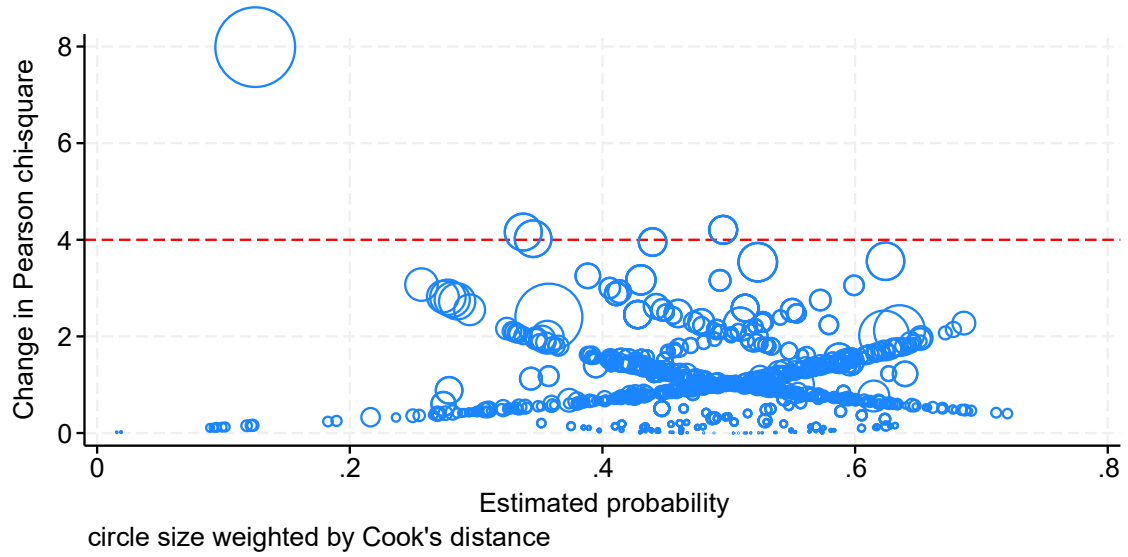
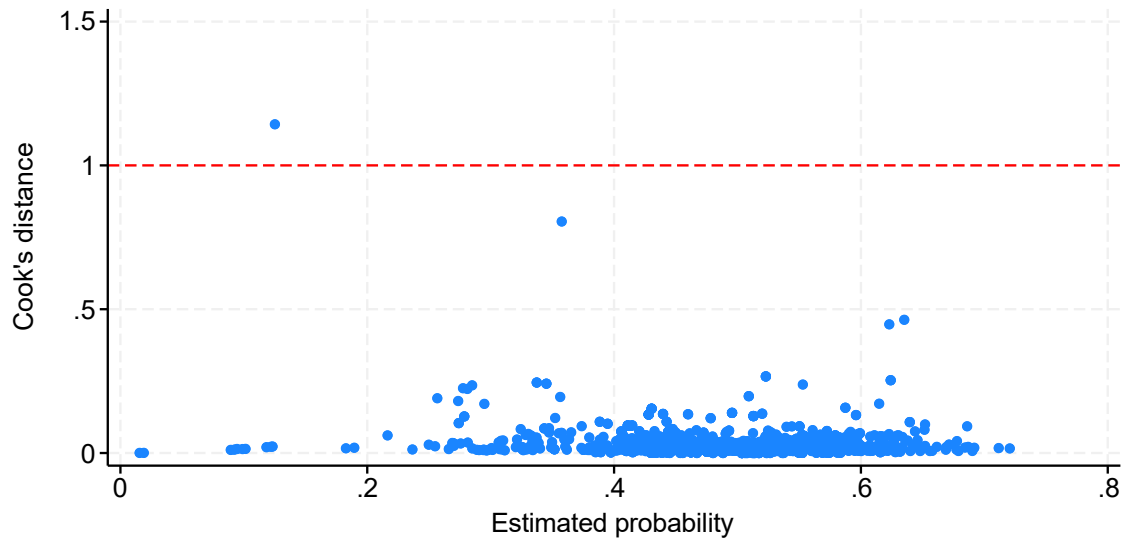
<b>Variable</b>	<b>Coefficient (<math>\beta</math>)</b>	<b>SE</b>	<b>Wald <math>\chi^2</math></b>	<b>p value</b>	<b>Odds Ratio</b>	<b>95% CI</b>
<b>Age (5 years)</b>	0.087	0.030	2.9	0.004	1.09	1.03 to 1.16
<b>Gender</b>						
*Male					1.00	
Female	0.060	0.145	0.4	0.679	1.06	0.80 to 1.41
<b>Disability</b>						
*No					1.00	
Yes	-0.584	0.329	-1.8	0.076	0.56	0.29 to 1.06
PNTS	0.412	0.270	1.5	0.127	1.51	0.89 to 2.56
<b>Ethnicity</b>						
*White					1.00	
Indian	0.031	0.329	0.1	0.925	1.03	0.54 to 1.97
Pakistani	0.195	0.333	0.6	0.558	1.22	0.63 to 2.34
Other Asian	0.142	0.338	0.4	0.674	1.15	0.59 to 2.24
Black	0.611	0.436	1.4	0.161	1.84	0.78 to 4.33
Other global majority	-0.051	0.382	-0.1	0.893	0.95	0.45 to 2.01
PNTS	0.015	0.346	0.0	0.965	1.02	0.52 to 2.00
<b>Religion</b>						
*Muslim					1.00	
Christian	0.128	0.321	0.4	0.691	1.14	0.61 to 2.13
No religion	0.224	0.309	0.7	0.468	1.25	0.68 to 2.29
Hindu	0.491	0.305	1.6	0.107	1.63	0.90 to 2.97
Sikh	0.416	0.314	1.3	0.185	1.52	0.82 to 2.80
Jewish	-2.391	1.109	-2.2	0.031	0.09	0.01 to 0.81
Buddhist	0.333	0.932	0.4	0.721	1.40	0.22 to 8.68
PNTS	0.197	0.335	0.6	0.556	1.22	0.63 to 2.35
<b>Sexual orientation</b>						
*Heterosexual					1.00	
Gay/Lesbian/ Homosexual	-0.889	0.550	-1.6	0.106	0.41	0.14 to 1.21
Bisexual	-0.634	0.614	-1.0	0.302	0.53	0.16 to 1.77
PNTS	-0.654	0.292	-2.2	0.025	0.52	0.29 to 0.92
<b>Pregnancy &amp; maternity</b>						
*No					1.00	
Yes	0.206	0.350	0.6	0.556	1.23	0.62 to 2.44
PNTS	0.029	0.194	0.2	0.881	1.03	0.70 to 1.51
<b>Constant</b>	-0.902	0.397				

Annex C: Multivariable (adjusted for EDI) model goodness of fit



Annex D: Multivariable (adjusted for EDI) model regression diagnostics



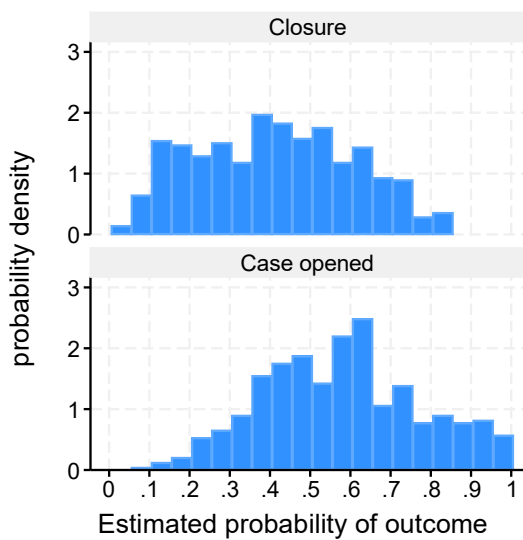
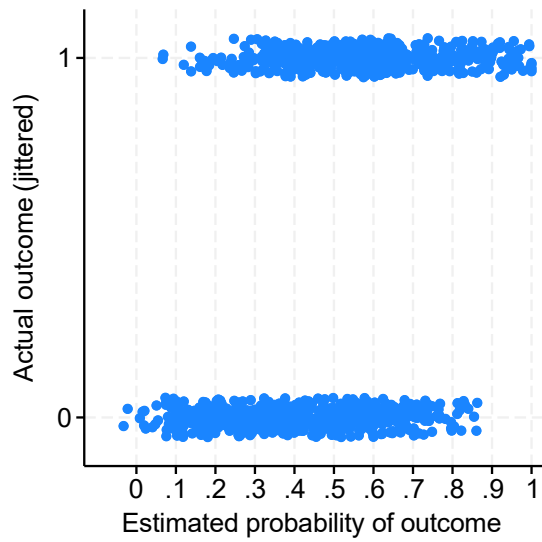
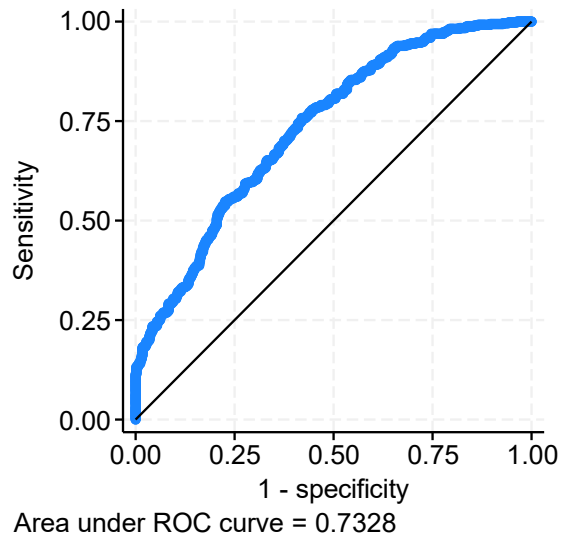


**Annex E: Multivariable (adjusted for EDI & case) logistic regression model output**

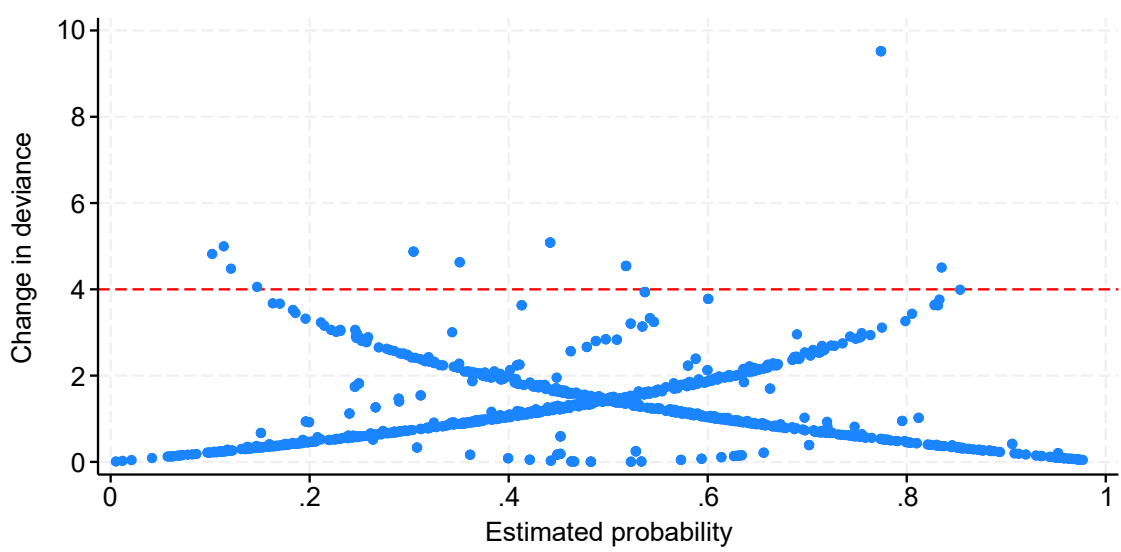
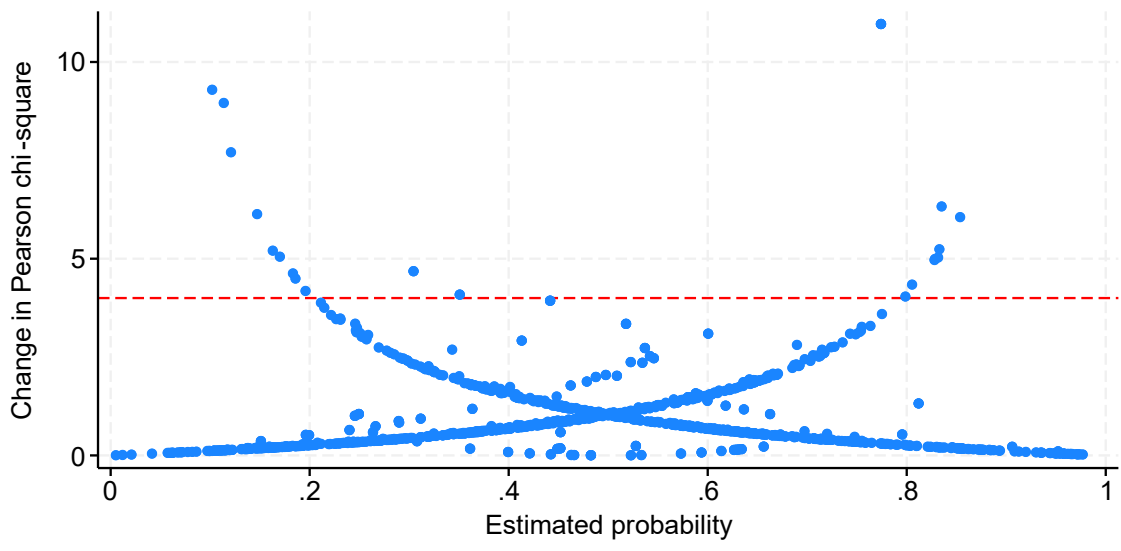
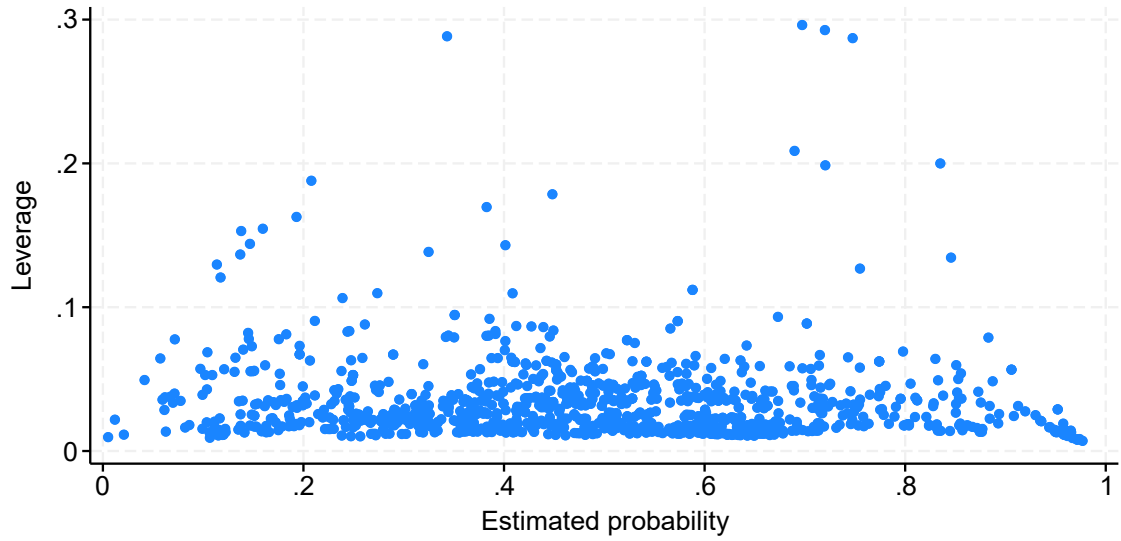
<b>Variable</b>	<b>Coefficient (<math>\beta</math>)</b>	<b>SE</b>	<b>Wald <math>\chi^2</math></b>	<b>p value</b>	<b>Odds Ratio</b>	<b>95% CI</b>
<b>Age (5 years)</b>	0.050	0.034	1.5	0.139	1.05	0.98 to 1.12
<b>Gender</b>						
*Male					1.00	
Female	0.125	0.159	0.8	0.431	1.13	0.83 to 1.55
<b>Disability</b>						
*No					1.00	
Yes	-0.299	0.358	-0.8	0.403	0.74	0.37 to 1.49
PNTS	0.719	0.301	2.4	0.017	2.05	1.14 to 3.70
<b>Ethnicity</b>						
*White					1.00	
Indian	-0.004	0.359	0.0	0.990	1.00	0.49 to 2.01
Pakistani	0.009	0.363	0.0	0.980	1.01	0.50 to 2.06
Other Asian	0.232	0.363	0.6	0.522	1.26	0.62 to 2.57
Black	0.732	0.471	1.6	0.120	2.08	0.83 to 5.23
Other global majority	-0.147	0.409	-0.4	0.719	0.86	0.39 to 1.92
PNTS	-0.411	0.383	-1.1	0.284	0.66	0.31 to 1.41
<b>Religion</b>						
*Muslim					1.00	
Christian	0.239	0.348	0.7	0.492	1.27	0.64 to 2.51
No religion	0.359	0.336	1.1	0.286	1.43	0.74 to 2.77
Hindu	0.580	0.332	1.7	0.081	1.79	0.93 to 3.42
Sikh	0.657	0.339	1.9	0.052	1.93	0.99 to 3.75
Jewish	-2.141	1.126	-1.9	0.057	0.12	0.01 to 1.07
Buddhist	0.633	1.040	0.6	0.543	1.88	0.25 to 14.5
PNTS	0.324	0.370	0.9	0.380	1.38	0.67 to 2.85
<b>Sexual orientation</b>						
*Heterosexual					1.00	
Gay/Lesbian/ Homosexual	-0.635	0.573	-1.1	0.267	0.53	0.17 to 1.63
Bisexual	-0.809	0.750	-1.1	0.280	0.45	0.10 to 1.94
PNTS	-0.599	0.318	-1.9	0.059	0.55	0.29 to 1.02
<b>Pregnancy &amp; maternity</b>						
*No					1.00	
Yes	0.308	0.373	0.8	0.408	1.36	0.66 to 2.83
PNTS	-0.007	0.211	0.0	0.972	0.99	0.66 to 1.50
<b>Risk</b>						
*Low					1.00	
Medium	0.918	0.160	5.7	0.000	2.50	1.83 to 3.42
High	1.992	0.287	7.0	0.000	7.33	4.18 to 12.9
<b>Interim order status</b>						
*No					1.00	
Yes	1.837	0.496	3.7	0.000	6.28	2.37 to 16.6

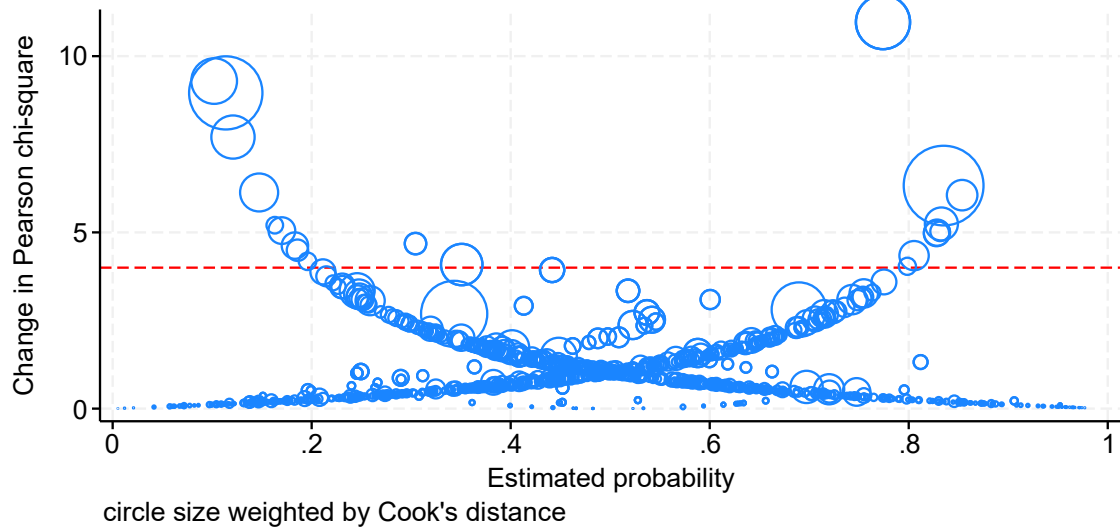
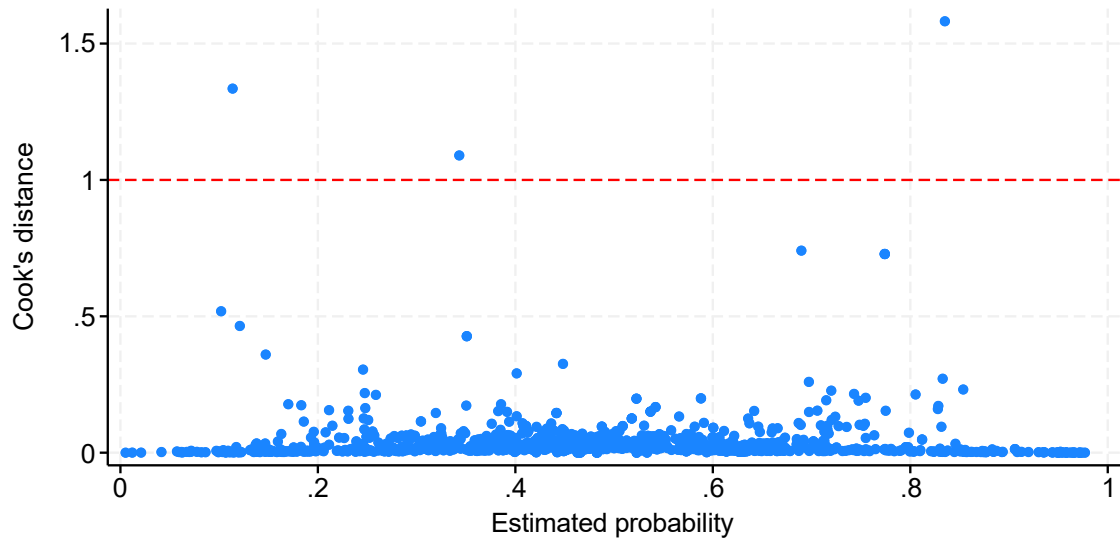
Variable	Coefficient ( $\beta$ )	SE	Wald $\chi^2$	p value	Odds Ratio	95% CI
<b>Allegation group</b>						
*Conduct					1.00	
Clinical	0.197	0.163	1.2	0.225	1.22	0.89 to 1.68
Conviction	-1.032	0.260	-4.0	0.000	0.36	0.21 to 0.59
Health	-1.281	0.293	-4.4	0.000	0.28	0.16 to 0.49
Clinical/conduct	-0.116	0.334	-0.3	0.727	0.89	0.46 to 1.71
Conviction/conduct	0.394	1.179	0.3	0.739	1.48	0.15 to 15.0
To be assessed	-2.037	0.650	-3.1	0.002	0.13	0.04 to 0.47
<b>Constant</b>	-1.370	0.459				

Annex F: Multivariable (adjusted for EDI & case) model goodness of fit



Annex G: Multivariable (adjusted for EDI & case) model regression diagnostics





<b>Unfair Outcomes research</b>	
<b>Phase:</b>	4 – Analysis & report drafting
<b>Activity:</b>	Report 2 Investigations
<b>Date:</b>	11 Jan 2026
<b>Ref:</b>	4.2.260111

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## Introduction

### Background

The GOC is, like all UK health and care regulators, keen to understand the impact of its regulatory functions, and how this impact varies across different groups who share protected characteristics. Through analysing the characteristics of the professionals about whom fitness to practise complaints and concerns are raised, and the subsequent decisions taken by case examiners, it is possible to build a picture of who was more or less likely to receive any particular outcome when case examiners made their decisions.

The decisions available to case examiners are:

- take no further action
- take no further action but issue the registrant with advice on his/her future conduct or practise
- give a warning to the registrant
- refer the complaint to the independent Fitness to Practise Committee
- refer the case to the Investigation Committee for a health or performance assessment

It is important to understand that this analysis does not determine if individual case examiners, or their decisions, were fair or unfair. A statistically significant result alone cannot be taken to mean that there was something wrong, but it should trigger a separate, in-depth piece of work to understand why there was a difference. Therefore, after looking at the results of the GOC's triage decisions in the first report of this project, this second report is the next step towards being able to address that core question of whether or not the GOC's fitness to practise functions are fair.

The case examiners' decision is a significant decision point for any concern that the GOC has identified as warranting investigation. The descriptive analysis of these cases provides a picture of the decisions taken by case examiners about cases that the GOC had investigated after deciding that they met the threshold for investigation after receiving details from complainants or referrers. The model assessed the outcome of the case examiners' decision of 'what should happen next?' after that investigation, and how the impact of that decision differs on registrants with different protected characteristics.

## UK healthcare regulators literature review

Most UK healthcare regulators investigations into fitness to practise (FTP) and protected characteristics have focussed on disproportionality in referrals rather than disproportionality in FTP decision point outcomes. And they have focussed on a small subset of protected characteristics, likely reflecting the narrower equality, diversity and inclusion (EDI) data set collected by UK regulators until relatively recently.

Where other UK regulators have assessed disproportionality in FTP investigations or equivalent it has been reported that investigations concerning male registrants (HCPC, 2024, SWE, 2023, SWE, 2024, GPhC, 2023), older registrants (GMC, 2016, SWE, 2023, SWE, 2024), or black registrants (SWE, 2023, SWE, 2024) were more likely to result in a referral to a fitness to practice panel or committee. Older registrants have also been found to be more likely to receive a warning (GMC, 2016).

Analyses from UK regulators focussing on the likelihood of a case being closed at this stage have found closure to be less likely for white registrants and for disabled registrants (NMC, 2020).

It is important to recognise that any effect may be transient, and indeed the GMC reported that some of the effects in its earlier reports no longer existed (GMC, 2022).

## Research question

The overall aim of the GOC unfair outcomes research project is to investigate whether disproportionality has been apparent in GOC FTP process outcomes. This second report investigates outcomes at the second stage of the GOC FTP process, investigations.

The principal research question for this report is therefore:

- Is there statistical evidence of disproportionality in GOC FTP investigations outcomes with regards to the protected characteristics of the registrants involved in that process?

## Methods

### Study design

This is an observational retrospective cross-sectional study of all GOC FTP concerns meeting the inclusion criteria.

### Participants

The study data set consisted of all GOC FTP investigations where:

- An investigation decision of either referral to the FTPC, no further action (NFA) with or without advice, or a warning was made between 01 Jan 2020 and 31 Dec 2024 inclusive.
- The concern related to a GOC registrant only and not a GOC regulated business or any other entity, with no differentiation between professional groups.

### Data collection

The data were supplied by GOC. Of the 676 records supplied, 44 did not meet the inclusion criteria, and a further 51 were disregarded following a later duplicate identification process leaving 483 records for the analysis (Figure 1).

### Variables

The outcome variable was the investigation decision, coded at three levels: NFA, Referred to the FTPC, Advice/warning (a combination of NFA(advice) and Warning). The largest group, NFA, was coded as the baseline outcome meaning the analyses focus on the likelihood of a investigation resulting in a referral or advice/warning.

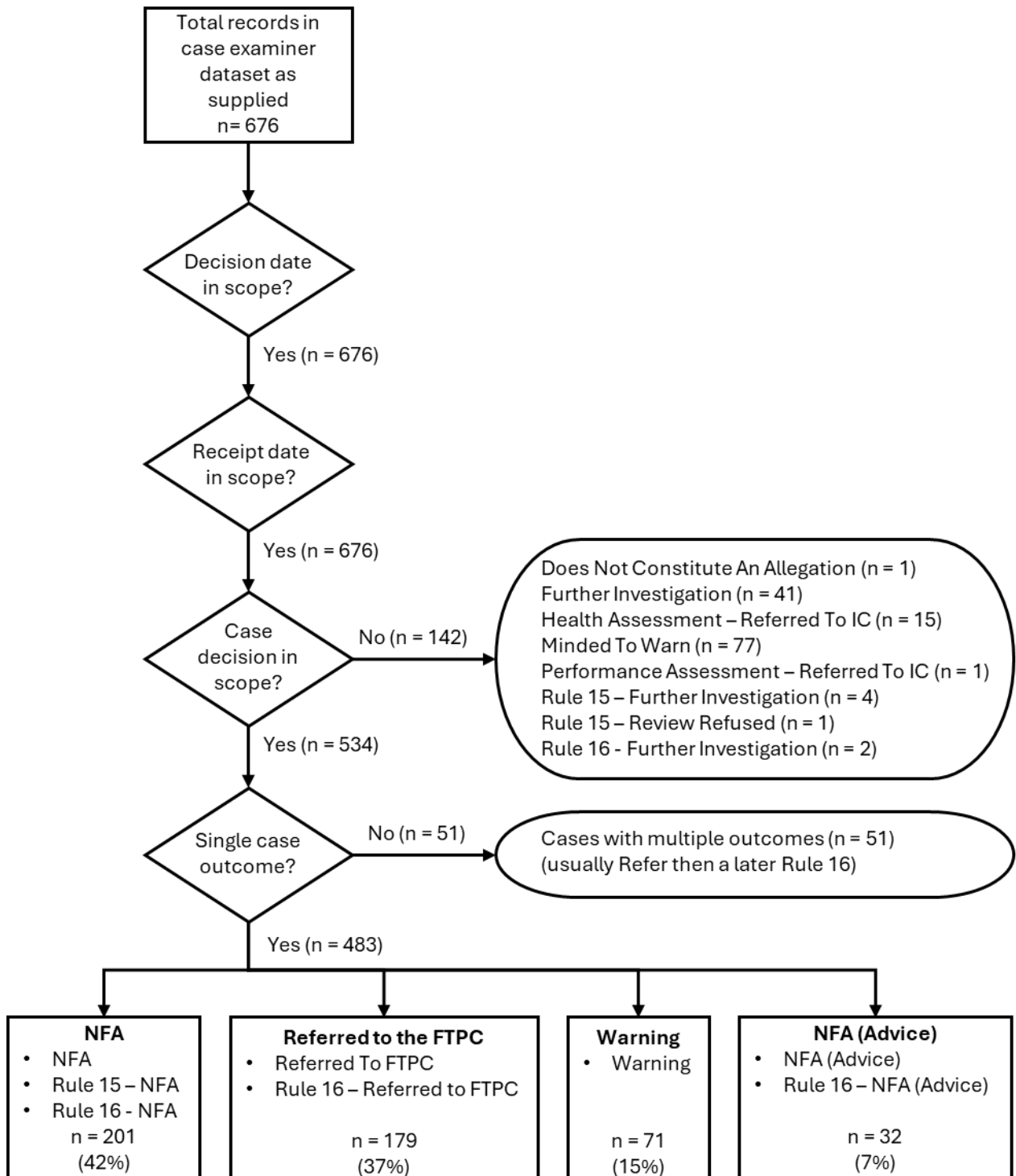
There were eight explanatory variables related to protected characteristics and one subsequently supplied explanatory variable relating to the case characteristics. Gender is included in the analyses here under protected characteristics as while not a protected characteristic itself, it was supplied by GOC rather than sex.

The original specification had included two non-protected characteristic explanatory variables, years on the register and referral source, but neither were included in the data as supplied. The one case characteristic explanatory variable, allegations, was

categorical and used the largest category as the baseline value (Table 1a). The baseline value is the category against which the other categories are compared.

The only continuous protected characteristic explanatory variable was age in years at the time of concern receipt. Age was included in the models as age/5 meaning a unit increase in age in the models was the effect of a five-year increase in age.

**Figure 1: Data collection flow chart**



**Table 1a: Categorical explanatory variable, case characteristics**

Characteristic	Category	Notes
Allegation group	Clinical Conduct Multiple Health Conviction/caution	Baseline value  Clinical/Conduct, Conviction or Caution/Failure to Declare

The other seven explanatory variables relating to protected characteristics were categorical and all used the largest category as the baseline value (Table 1b). In some instances categories were combined into groups with the agreement of GOC.

### Data Analysis

The analytical objectives of this report were to produce:

1. Descriptive analyses of each of the study variables (EDI characteristics and other) to characterise this registrant population.
2. Univariate (on their own) assessments of each of the specified variables of interest by means of binary logistic regression. These indicated the risk of the outcome for each level of each variable without adjusting for other variables and intersectionality.
3. Multivariable (all together) assessment of all the specified variables of interest at the same time by means of multinomial logistic regression. This indicated the risk of the outcome for each variable having adjusted for other variables and intersectionality. As the outcome had three levels, there were two multinomial models, the first contrasting NFA with Advice/warning and the second contrasting NFA with Referred to FTPC. Multinomial models were produced for all EDI variables together and for all EDI and case characteristic variables together

The purpose of the multivariable models here was to explicitly demonstrate the effect of each of the protected characteristics in the presence of the others rather than to develop the best fitting and most parsimonious model to predict the outcome. As such there was no variable selection process and only the saturated (all variables together) model is presented. Intersectionality was assessed by means of interaction terms for

ethnicity and gender, disability and gender, disability and sexual orientation, and disability and religion.

**Table 1b: Categorical explanatory variables, protected characteristics**

<b>Characteristic</b>	<b>Category</b>	<b>Notes</b>
Gender	Male	Baseline value
	Female	
Ethnicity	White	Baseline value
	Indian	
	Pakistani	Any other Asian   Bangladeshi   Chinese
	Other Asian	
	Black	
	Other global majority	
Prefer not to say	Mixed   Other	
Disability	No	Baseline value
	Yes	
	Prefer not to say	
Marital status	Married	Baseline value
	Single	
	Partner	
	Divorced/legally dissolved	
	Widowed/widower	
	Separated	
	Civil partnership	
	Prefer not to say	
Religion	Muslim	Baseline value
	Christian	Christian   Catholic
	No religion	
	Hindu	
	Sikh	
	Jewish	
	Buddhist	
	Prefer not to say	
	Sexual orientation	Heterosexual/ straight
Gay/Lesbian/Homosexual		
Bisexual		
Prefer not to say		
Pregnancy & maternity	No	Baseline value
	Yes	
	Prefer not to say	

As the multinomial model in effect two models, the standard model assurance methods based on the Area under the ROC Curve for model discrimination, Pearson Chi-Square test and, and visual inspection of a range of residuals for regression diagnostics including signs of outliers are not available. A multinomial variant of the

Hosmer and Lemeshow test for goodness of fit was used and in addition, as a proxy, the models have been refitted as binomial logistic regression models for the purposes of estimating goodness of fit via the ROC curve and inspection of predicted values.

Probabilities ( $p$ -values) of less than 0.05 were considered statistically significant. All analyses were conducted using Stata 19.5 SE (StataCorp, 2025).

To ensure like for like comparisons across the univariate and multivariable models, these analyses were based on the records that were complete for all the variables. The exception to this was Marital status, which was only included in the univariate analysis due to the relatively high levels of missing data.

### **Ethical Considerations**

The data supplied by GOC for this research were anonymous at the point of supply and therefore they were not considered to be personal data, meaning data protection legislation did not apply. Research using anonymised data cannot, by definition, require informed consent from participants as it is not possible to identify them to obtain consent. The proposal for this research was reviewed by and agreed to by the GOC. No other scientific or ethical review was needed or obtained.

### **Limitations**

Some of the categories within some of the explanatory variables were small. Where it could be reasonably justified some grouping of categories has taken place. These groups may be harder to reliably interpret as they could contain mixed effects. The decision to group them was a pragmatic attempt to retain as many records as possible for the analysis.

As described earlier, this was not an exercise to find the best fitting model to predict investigations outcomes. That would likely be based on a wider range of data than those made available for this analysis, particularly additional data concerning case characteristics. Therefore poor performance in the model assurance analyses would reasonably be expected if the protected characteristics did not predict investigations outcomes. Indeed, in such a situation it would reinforce the finding that protected characteristics were poor predictors.

## Results

The added complexity of there being two outcome comparisons within the multinomial model, namely advice/warning vs NFA and referral to FTFC vs NFA, means that the results of one model really need to be borne in mind when viewing the other model. Here each model is presented separately, with the combined interpretation being in the discussion.

### Univariate analysis summary: Advice/warning v NFA

In this univariate analysis for advice/warning vs NFA, each EDI variable was assessed on its own, i.e. without taking the other variables into account. Each variable is discussed in more detail in its own section but the statistically significant univariate results, along with those on the margins of statistical significance are summarised below. The full table of univariate multinomial regression model outputs can be found in Annex A.

In marital status, divorced/legally dissolved registrants were statistically significantly more likely (RRR 2.46, 95% CI 1.03 to 5.86,  $p = 0.043$ ) to receive advice/warning than to receive NFA when compared to the baseline category married.

In allegation group, registrants with health allegations were statistically significantly less likely (RRR 0.12, 95% CI 0.02 to 0.96,  $p = 0.046$ ) to receive advice/warning than to receive NFA when compared to the baseline category clinical.

Whilst not quite statistically significant, females were more likely than males to receive advice/warning than NFA, and registrants in the multiple allegation group were much less likely than registrants in the clinical allegation group to receive advice/warning than NFA.

### **Univariate analysis summary: Referral to FTPC v NFA**

In this univariate analysis for referral to FTPC vs NFA, each EDI variable was assessed on its own, i.e. without taking the other variables into account. Each variable is discussed in more detail in its own section but the statistically significant univariate results, along with those on the margins of statistical significance are summarised below. The full table of univariate multinomial regression model outputs can be found in Annex B.

In gender, female registrants were statistically significantly less likely (RRR 0.59, 95% CI 0.39 to 0.92,  $p = 0.019$ ) to receive referral to FTPC than to receive NFA when compared to the baseline category male.

In marital status, registrants who said they had a partner (RRR 2.41, 95% CI 1.08 to 5.36,  $p = 0.031$ ) or who said they were widowed/widower (RRR 4.65, 95% CI 1.24 to 17.5,  $p = 0.023$ ) were statistically significantly more likely to receive referral to FTPC than to receive NFA when compared to the baseline category married.

In allegation group, registrants with conduct allegations (RRR 3.62, 95% CI 2.24 to 5.87,  $p < 0.001$ ), multiple allegations (RRR 3.76, 95% CI 1.80 to 7.84,  $p < 0.001$ ), or health allegations (RRR 2.36, 95% CI 1.04 to 5.38,  $p = 0.041$ ) were statistically significantly more likely to receive referral to FTPC than to receive NFA when compared to the baseline category clinical.

Whilst not quite statistically significant, registrants saying yes to pregnancy and maternity were less likely than those saying yes to receive referral to FTPC than to receive NFA, and registrants in the divorced/legally dissolved marital status group were much more likely than registrants in the married group to receive referral to FTPC than NFA.

### **Multinomial analysis summary: Advice/warning v NFA, EDI only**

Analysis of each EDI variable adjusted for all other EDI variables in the comparison of advice/warning vs NFA found no statistically significant effects. None of those reported in the corresponding univariate analysis persisted once other variables were adjusted for. Females remained at higher risk than males but this was not statistically significant.

None of the 52 intersectionality interaction terms were statistically significant. A pragmatic decision was taken to remove the interaction terms as there was no evidence of intersectionality, including them substantially increased the complexity of interpretation, and including them reduced the number of records in the analysis. The results reported for this analysis are therefore for the main effects only.

Each variable is discussed in more detail in its own section. The full table of multinomial model outputs for advice/warning v NFA adjusted for EDI variables only can be found in Annex C1.

The technical evaluation of the multinomial logistic regression model indicated no issues with the goodness of fit (modified Hosmer-Lemeshow  $p = 0.46$ ). The technical evaluation of the proxy logistic regression model indicated little accuracy in outcome prediction illustrated by the area under the ROC curve (0.61) being in the poor discrimination range (Annex C2). The poor discrimination is also visible in the scatterplot and histogram of the predicted probabilities (Annex C2). In other words, as the variables included in the model were poor predictors of the outcome, there was no evidence of EDI characteristics being associated with either of these outcomes.

### **Multinomial analysis summary: Referral to FTPC v NFA, EDI only**

Analysis of each EDI variable adjusted for all other EDI variables in the comparison of referral to FTPC vs NFA found one statistically significant effect. None of those reported in the corresponding univariate analysis persisted once other variables were adjusted for. Females remained at lower risk than males and those who said yes to pregnancy and maternity remained at lower risk than those that said no but neither was statistically significant. The one statistically significant result was for PNTS for religion (RRR 2.99, 95% CI 1.01 to 8.86,  $p = 0.048$ ) who were more likely to receive referral to FTPC than to receive NFA when compared to the baseline category Muslim. The confidence interval is wide and only just excludes 1 so this finding should be viewed with some caution.

Only one of the 52 intersectionality interaction terms was statistically significant. A pragmatic decision was taken to remove the interaction terms as there was very little evidence of intersectionality, including them substantially increased the complexity of interpretation, and including them reduced the number of records in the analysis. The results reported for this analysis are therefore for the main effects only. The one significant interaction term is described in the disability section.

Each variable is discussed in more detail in its own section. The full table of multinomial model outputs for referral to FTPC v NFA adjusted for EDI variables only can be found in Annex D1.

The technical evaluation of the multinomial logistic regression model indicated no issues with the goodness of fit (modified Hosmer-Lemeshow  $p = 0.46$ ). The technical evaluation of the proxy logistic regression model indicated little accuracy in outcome prediction illustrated by the area under the ROC curve (0.64) being in the poor discrimination range (Annex D2). The poor discrimination is also visible in the scatterplot and histogram of the predicted probabilities (Annex D2). In other words, as the variables included in the model were poor predictors of the outcome in all but one instance, there was little evidence of EDI characteristics being associated with either of these outcomes.

### **Multinomial analysis summary: Advice/warning v NFA, EDI & case**

Analysis of each EDI variable adjusted for all other EDI variables and case variables in the comparison of advice/warning vs NFA found one statistically significant effect and a couple of marginal ones. The one statistically significant result was for health allegations (RRR 0.10, 95% CI 0.01 to 0.81,  $p = 0.031$ ) who were less likely to receive advice/warning than to receive NFA when compared to the baseline category clinical. Marginally non-significant effects were observed for those with multiple allegations being less likely to receive advice/warning than NFA when compared to those with clinical allegations, and females who were more likely than males to receive advice/warning than NFA.

None of the 52 intersectionality interaction terms were statistically significant. A pragmatic decision was taken to remove the interaction terms as there was no evidence of intersectionality, including them substantially increased the complexity of interpretation, and including them reduced the number of records in the analysis. The results reported for this analysis are therefore for the main effects only.

Each variable is discussed in more detail in its own section. The full table of multinomial model outputs for referral to FTPC v NFA adjusted for EDI variables only can be found in Annex E1.

The technical evaluation of the multinomial logistic regression model indicated no issues with the goodness of fit (modified Hosmer-Lemeshow  $p = 0.30$ ). The technical evaluation of the proxy logistic regression model indicated little accuracy in outcome prediction illustrated by the area under the ROC curve (0.67) being in the poor discrimination range (Annex E2). The poor discrimination is also visible in the scatterplot and histogram of the predicted probabilities (Annex E2). In other words, as the variables included in the model were poor predictors of the outcome in all but one instance, there was little evidence of EDI characteristics being associated with either of these outcomes.

### **Multinomial analysis summary: Referral to FTPC v NFA, EDI & case**

Analysis of each EDI variable adjusted for all other EDI variables and case variables in the comparison of referral to FTPC vs NFA found four statistically significant effects and a couple of marginal ones.

In religion, the one statistically significant result was for PNTS (RRR 3.58, 95% CI 1.13 to 11.4,  $p = 0.031$ ) who were more likely to receive referral to FTPC than to receive NFA when compared to the baseline category Muslim. There was also a marginally non-significant result in religion with Sikhs also being more likely than Muslims to receive referral to FTPC than to receive NFA. In both instances the confidence intervals were wide so these results should be viewed with some caution.

In allegation group, registrants with conduct allegations (RRR 4.25, 95% CI 2.53 to 7.13,  $p < 0.001$ ), multiple allegations (RRR 3.92, 95% CI 1.80 to 8.56,  $p = 0.001$ ), or health allegations (RRR 3.83, 95% CI 1.51 to 9.71,  $p = 0.005$ ) were statistically significantly more likely to receive referral to FTPC than to receive NFA when compared to the baseline category clinical. There was also a marginally non-significant result here with those with conviction/caution allegations also being more likely to receive referral to FTPC than to receive NFA when compared to the baseline category clinical.

Each variable is discussed in more detail in its own section. The full table of multinomial model outputs for referral to FTPC v NFA adjusted for EDI variables only can be found in Annex E1.

The technical evaluation of the multinomial logistic regression model indicated no issues with the goodness of fit (modified Hosmer-Lemeshow  $p = 0.30$ ). The technical evaluation of the proxy logistic regression model indicated slightly improved accuracy in outcome prediction illustrated by the area under the ROC curve (0.72) just being in the acceptable discrimination range (Annex F2). The improved discrimination is also visible in the scatterplot and histogram of the predicted probabilities (Annex F2). In other words, there was some evidence of this model being predictive of outcomes, however this was driven by addition of the highly predictive case characteristics, with the same model without those being a poor predictor (see D1).

## Age

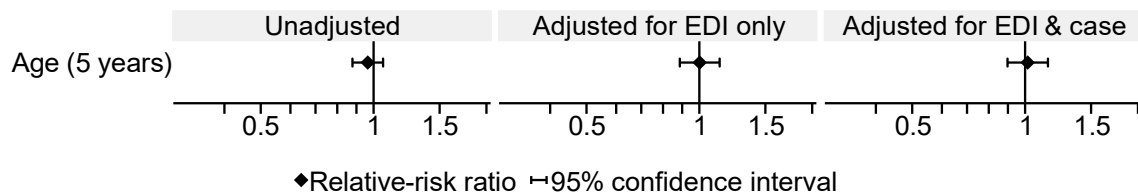
Both the mean and median ages in years of the registrants at the time the complaint was received were virtually the same for all investigations outcomes (Table 2).

Age was modelled as the effect of a five-year increase in age to make the results easier to interpret. Age was not statistically significant in any of the analyses (Figure 2a, Figure 2b, & Annexes A, B, C1, D1, E1, and F1).

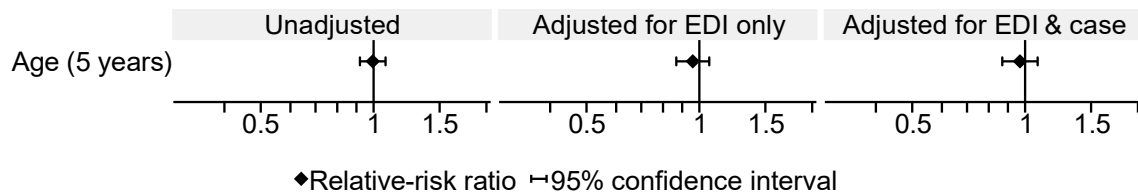
**Table 2: Descriptive statistics: age (years)**

Investigation outcome	n	Mean	SD	Median	IQR	Min	Max
NFA	195	40.5	12.6	38	31 to 50	20	76
Advice/warning	102	39.3	12.4	37.5	28 to 50	22	65
Referred to FTPC	177	40.3	13.6	39	29 to 51	21	74
Total	474	40.2	12.9	38	29 to 50	20	76

**Figure 2a: Relative-risk ratios: age (five years), Advice/warning vs NFA**



**Figure 2b: Relative-risk ratios: age (five years), Referral to FTPC vs NFA**



## Gender

Registrants involved in investigations were split just over 60:40 males to females. While the percentages receiving an outcome of NFA were fairly similar, a much larger proportion of females received advice/warning and accordingly a much larger proportion of males were referred to the FTPC (Table 3).

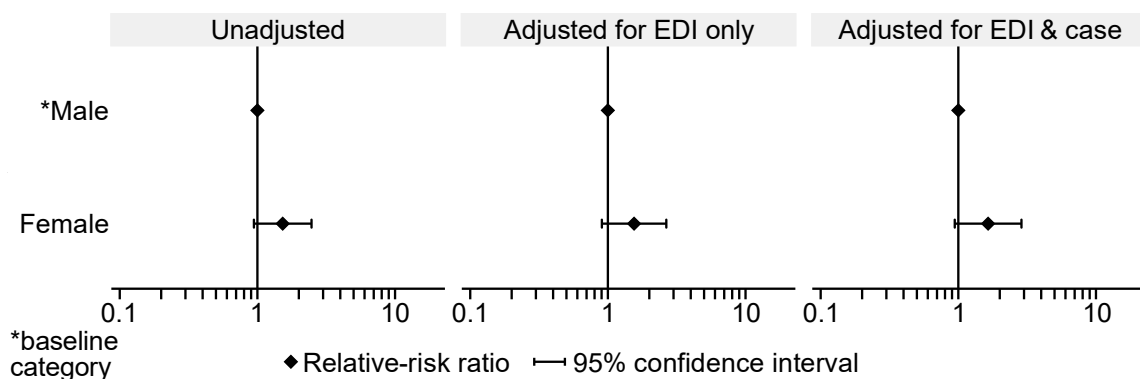
These differences are clearly evident in relative risk ratios (RRR) which are higher for females when comparing advice/warning to NFA (Figure 3a) and lower for females when comparing referral to FTPC to NFA (Figure 3b).

The only statistically significant finding was the unadjusted RRR for referral to FTPC (RRR 0.59, 95% CI 0.39 to 0.92,  $p = 0.02$ ). In other words, females were only 59% as likely as males to be referred to the FTPC. After adjustment for EDI and for EDI and case, the effect remained but was no longer statistically significant. The full model outputs for gender can be found in Annexes A, B, C1, D1, E1, and F1.

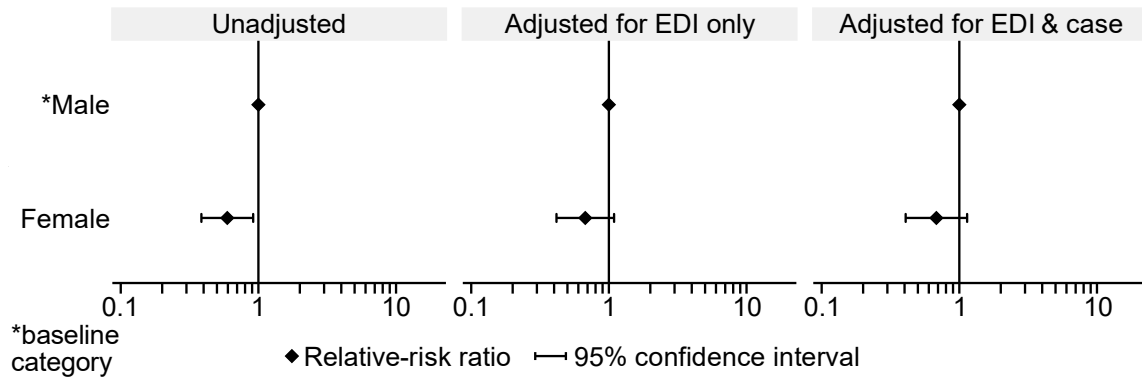
**Table 3: Descriptive statistics: gender**

Gender	All cases		Investigations outcome					
	n	%	NFA		Advice/warning		Referred to FTPC	
			n	%	n	%	n	%
Male	292	61.6	116	39.7	50	17.1	126	43.2
Female	182	38.4	79	43.4	52	28.6	51	28.0
Total	474	100	195	41.1	102	21.5	177	37.3

**Figure 3a: Relative-risk ratios: gender, Advice/warning vs NFA**



**Figure 3b: Relative-risk ratios: gender, Referral to FTPC vs NFA**



## Ethnicity

Three quarters of investigations were for one of white, Indian or Pakistani ethnicities (Table 4). There was very little variation between all the ethnicities in terms of the unadjusted percents receiving each outcome. The most notable variation was in the smaller categories, due in part to the large effect an individual case could have on the percentages and as such none of these were statistically significant (Figure 4a and Figure 4b).

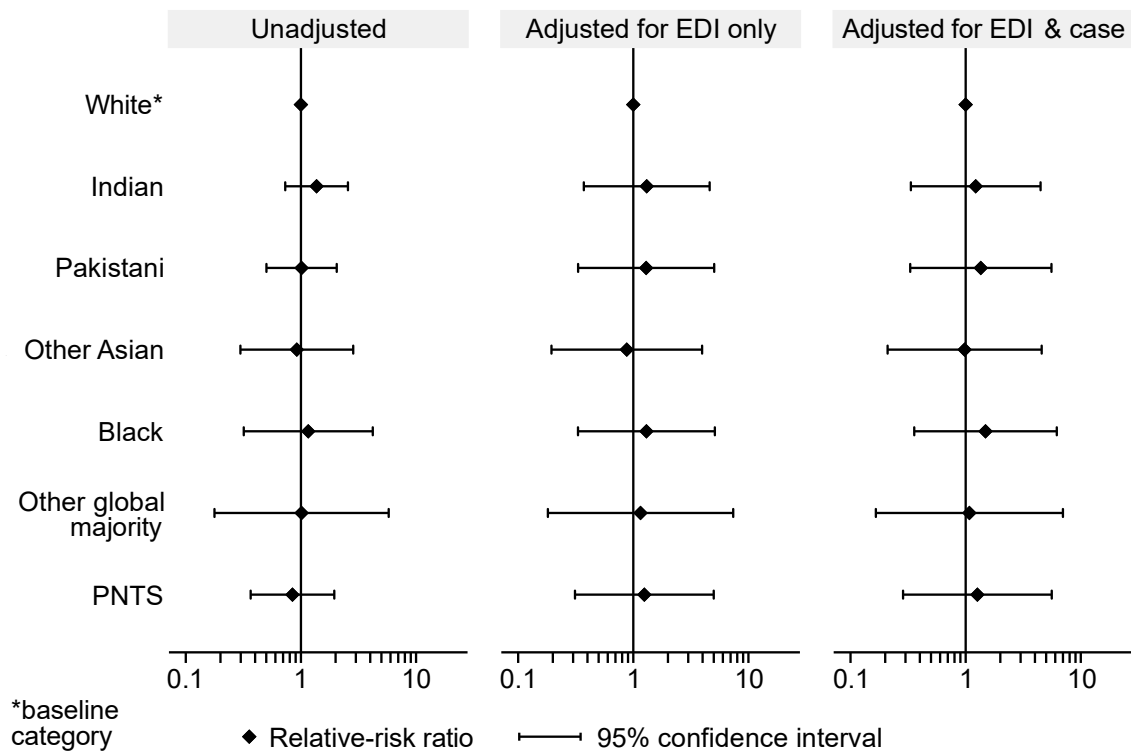
It was noted that variation between ethnicities was greater in the referral to FTPC vs NFA comparison than in the advice/warning vs NFA comparison. This was especially so after adjustment with three ethnicities moving away from lower than or parity with white to higher than white RRR (Figure 4b)

The full model outputs for ethnicity can be found in Annexes A, B, C1, D1, E1, and F1.

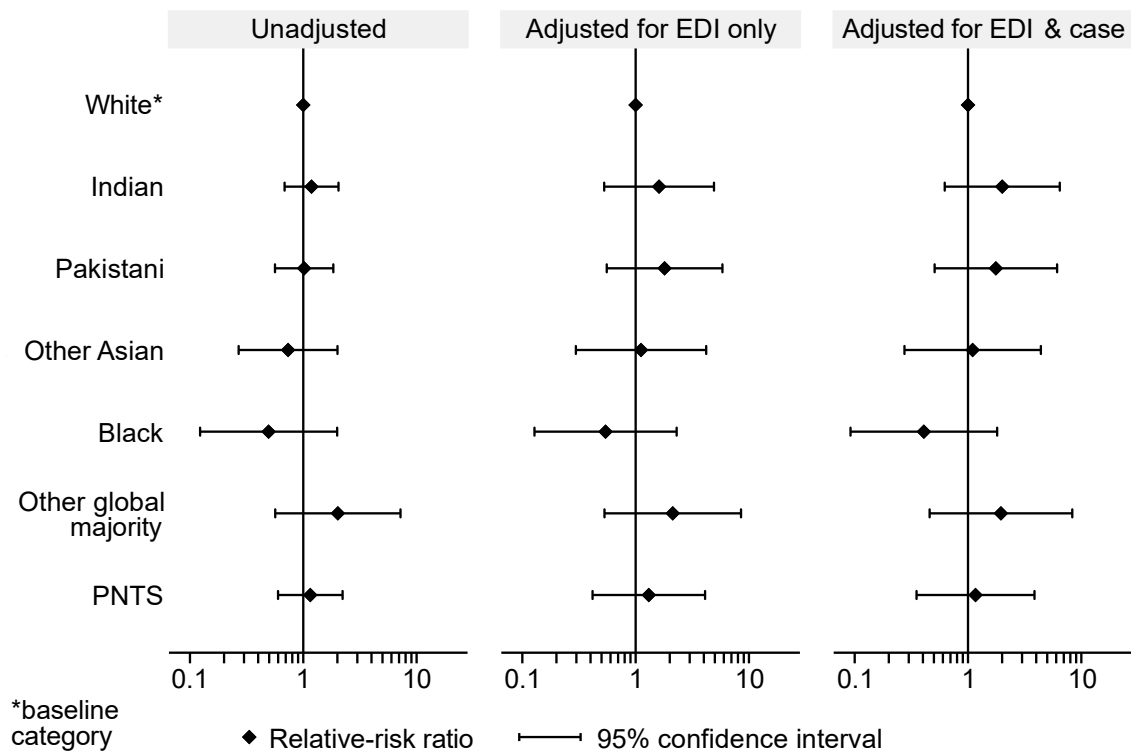
**Table 4: Descriptive statistics: ethnicity**

Ethnicity	All cases		Investigations outcome					
	n	%	NFA		Advice/ warning		Referred to FTPC	
	n	%	n	%	n	%	n	%
White	177	37.3	75	42.4	37	20.9	65	36.7
Indian	108	22.8	40	37.0	27	25.0	41	38.0
Pakistani	81	17.1	34	42.0	17	21.0	30	37.0
Other Asian	23	4.9	11	47.8	5	21.7	7	30.4
Black	14	3.0	7	50.0	4	28.6	3	21.4
Other global majority	13	2.7	4	30.8	2	15.4	7	53.8
PNTS	58	12.2	24	41.4	10	17.2	24	41.4
Total	474	100	195	41.1	102	21.5	177	37.3

**Figure 4a: Relative-risk ratios: ethnicity, Advice/warning vs NFA**



**Figure 4b: Relative-risk ratios: ethnicity, Referral to FTPC vs NFA**



## Disability

Over six times as many registrants answered prefer not to say to this question as answered yes (Table 5). Only 10 registrants had answered yes to this question and none of those were in the advice/warning outcome group meaning no RRR calculations were possible for the comparison of advice/warning to NFA (Figure 5a).

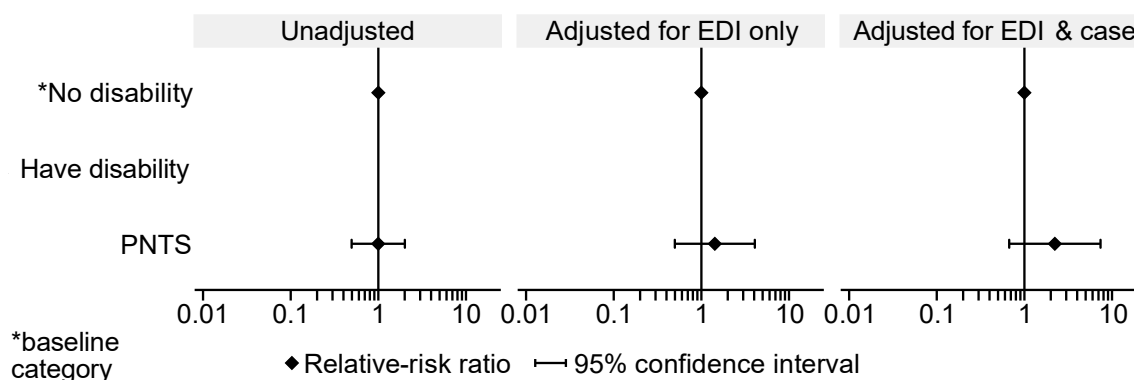
There were no statistically significant differences between PNTS and no disability in the analyses comparing advice/warning to NFA but it was noted that the RRR moved away from parity with no disability when adjusted for EDI only and moved further away when adjusted for case (Figure 5a). This may indicate that PNTS would have a statistically significantly higher RRR in a model with more case characteristics, though the only way to test that would be to build such a model.

The same pattern in reverse was present in the analyses comparing referral to FTFC and NFA, but with both have disability and PNTS moving away from parity with no disability, potential towards a statistically significantly lower RRR if a fuller explanatory model could be built (Figure 5b). The full model outputs for disability can be found in Annexes A, B, C1, D1, E1, and F1.

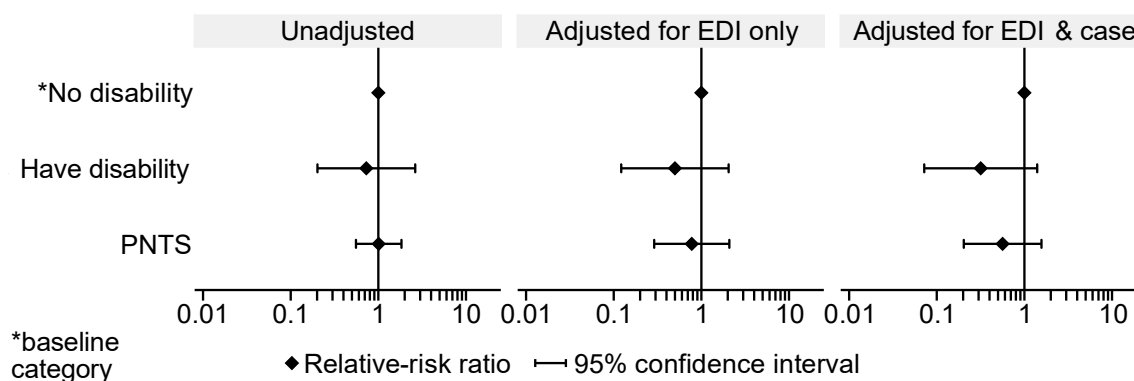
**Table 5: Descriptive statistics: disability**

Disability	All cases		Investigations outcome					
	n	%	NFA		Advice/warning		Referred to FTFC	
	n	%	n	%	n	%	n	%
No	400	84.4	163	40.8	88	22.0	149	37.3
Yes	10	2.1	6	60.0	0	0	4	40.0
PNTS	64	13.5	26	40.6	14	21.9	24	37.5
<b>Disability</b>	<b>474</b>	<b>100</b>	<b>195</b>	<b>41.1</b>	<b>102</b>	<b>21.5</b>	<b>177</b>	<b>37.3</b>

**Figure 5a: Relative-risk ratios: disability, Advice/warning vs NFA**



**Figure 5b: Relative-risk ratios: disability, Referral to FTPC vs NFA**



The one statistically significant intersectionality occurred between disability and religion with the interaction term for non-disabled registrants who answered Prefer not to say to the religion question indicating a lower chance of a case resulting in advice/warning before adjustment for case characteristics (OR 6.35, 95% CI 1.37 to 29.5,  $p = 0.02$ ) and after adjustment for case characteristics (OR 6.66, 95% CI 1.37 to 32.3,  $p = 0.02$ ). Of the 19 registrants with this combination of characteristics, 12 (63%) were referred to the FTPC, a much higher percentage than for other groups, typically 33 to 37%. As the vast majority (84%) of cases were for registrants who said they were not disabled, as Prefer not to say is not a religion, and as the confidence intervals for this interaction term are very wide, it did not appear to justify the inclusion of interaction terms in the model.

## Religion

Almost eighty percent of the investigations were for registrants who were of Muslim, Christian, no religion, or Hindu religion (Table 6). There were very few Jewish or Buddhist registrants in this analysis and none of those were in the advice/warning outcome group meaning no RRR calculations were possible for the comparison of advice/warning to NFA for Jewish or Buddhist registrants (Figure 6a).

The only statistically significant findings were for PNTS compared to the baseline Muslim in the referral to FTFC vs NFA analysis after adjustment for EDI only (RRR 2.99, 95% CI 1.01 to 8.86,  $p = 0.048$ ) and EDI and case variables (RRR 3.58, 95% CI 1.13 to 11.4,  $p = 0.031$ ). The adjusted RRRs for Christian, no religion and Sikh were all also higher than the baseline but none were statistically significant. It's possible that if the actual religions for those who said PNTS were for any of those higher groups then the "true" finding would be statistically significant. However this is impossible to prove or disprove. The full model outputs for religion can be found in Annexes A, B, C1, D1, E1, and F1.

**Table 6: Descriptive statistics: religion**

Religion	All cases		Investigations outcome					
	n	%	NFA		Advice/warning		Referred to FTFC	
	n	%	n	%	n	%	n	%
Muslim	117	24.7	53	45.3	25	21.4	39	33.3
Christian	109	23.0	48	44.0	20	18.3	41	37.6
No religion	86	18.1	33	38.4	22	25.6	31	36.0
Hindu	62	13.1	25	40.3	17	27.4	20	32.3
Sikh	29	6.1	9	31.0	6	20.7	14	48.3
Jewish	3	0.6	2	66.7	0	0	1	33.3
Buddhist	3	0.6	1	33.3	0	0	2	66.7
PNTS	65	13.7	24	36.9	12	18.5	29	44.6
Total	474	100	195	41.1	102	21.5	177	37.3

Figure 6a: Relative-risk ratios: religion, Advice/warning vs NFA

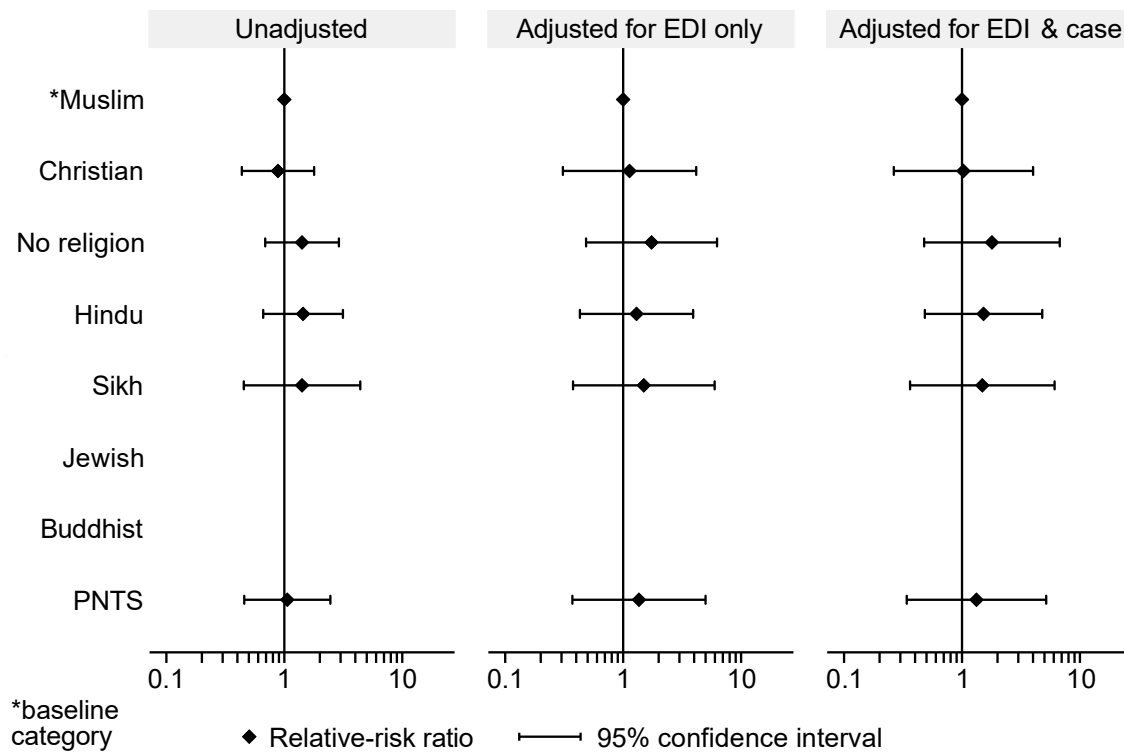
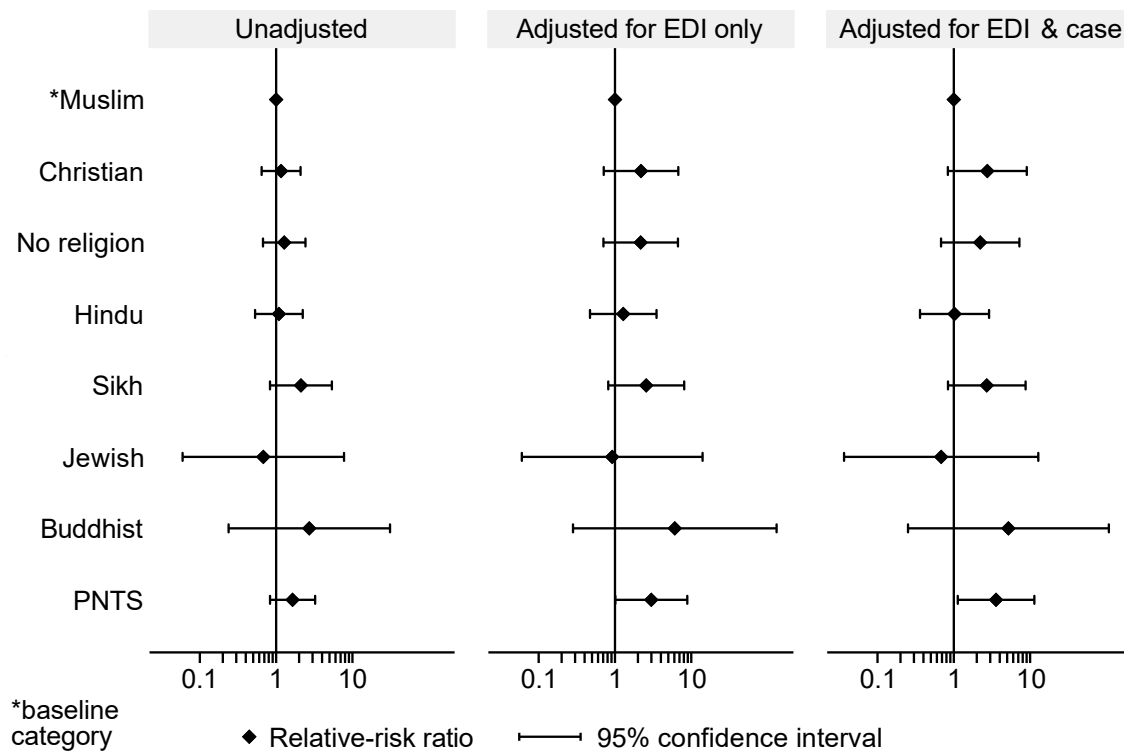


Figure 6b: Relative-risk ratios: religion, Referral to FTPC vs NFA



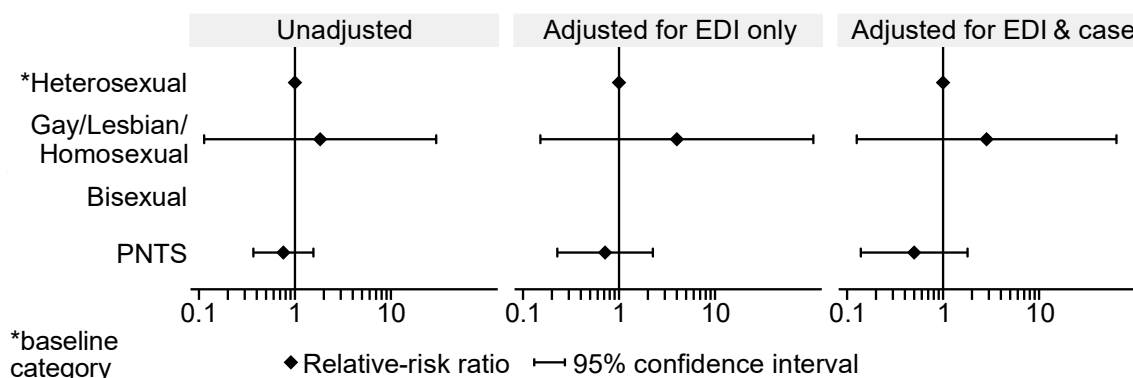
### Sexual orientation

Very few registrants in investigations had stated Gay/Lesbian/Homosexual or Bisexual for their sexual orientation with over 98% of registrants in investigations stating straight/heterosexual or PNTS (Table 7). As such where it was possible to produce an RRR for Gay/Lesbian/Homosexual or Bisexual the confidence intervals were huge and none of the differences were statistically significant (Figure 7a and Figure 7b). The full model outputs for sexual orientation can be found in Annexes A, B, C1, D1, E1, and F1.

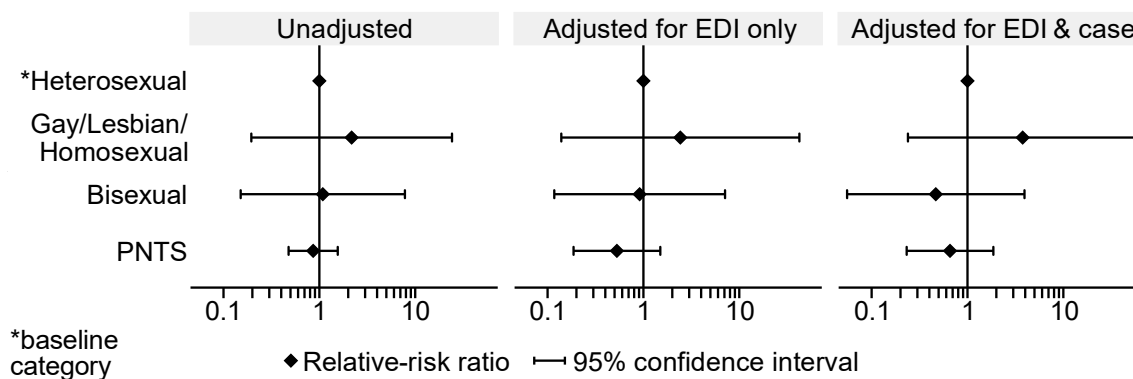
**Table 7: Descriptive statistics: sexual orientation**

Sexual orientation	All cases		Investigations outcome					
	n	%	NFA		Advice/warning		Referred to FTPC	
			n	%	n	%	n	%
Heterosexual/straight	402	84.8	163	40.5	89	22.1	150	37.3
Gay/Lesbian/Homosexual	4	0.8	1	25.0	1	25.0	2	50.0
Bisexual	4	0.8	2	50.0	0	0	2	50.0
PNTS	64	13.5	29	45.3	12	18.8	23	35.9
Total	474	100	195	41.1	102	21.5	177	37.3

**Figure 7a: Relative-risk ratios: sexual orientation, Advice/warning vs NFA**



**Figure 7b: Relative-risk ratios: sexual orientation, Referral to FTPC vs NFA**



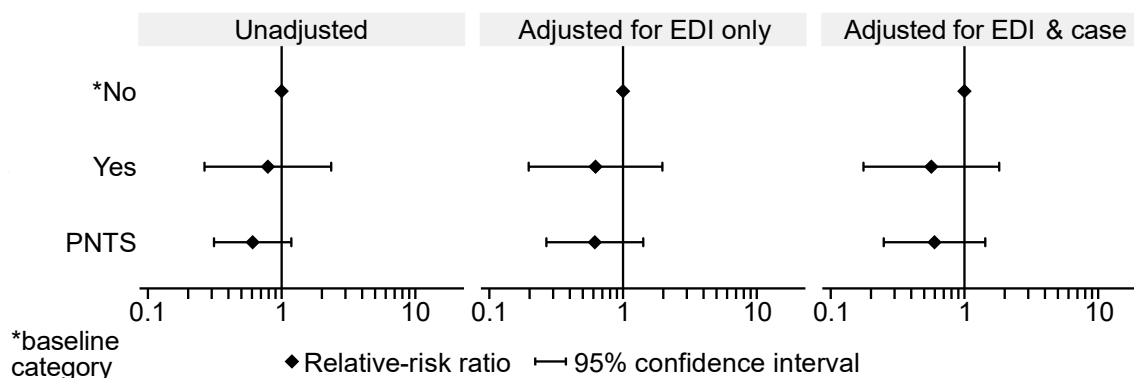
### Pregnancy & maternity

This question had the highest level of prefer not to say, with one in five registrants choosing that response. Over five times as many registrants answered prefer not to say to this question as answered yes (Table 8). Registrants answering yes were less likely to receive advice/warning and less likely to be referred to FTPC, in other words were more likely to be NFA but not statistically significantly. The full model outputs for pregnancy and maternity can be found in Annexes A, B, C1, D1, E1, and F1.

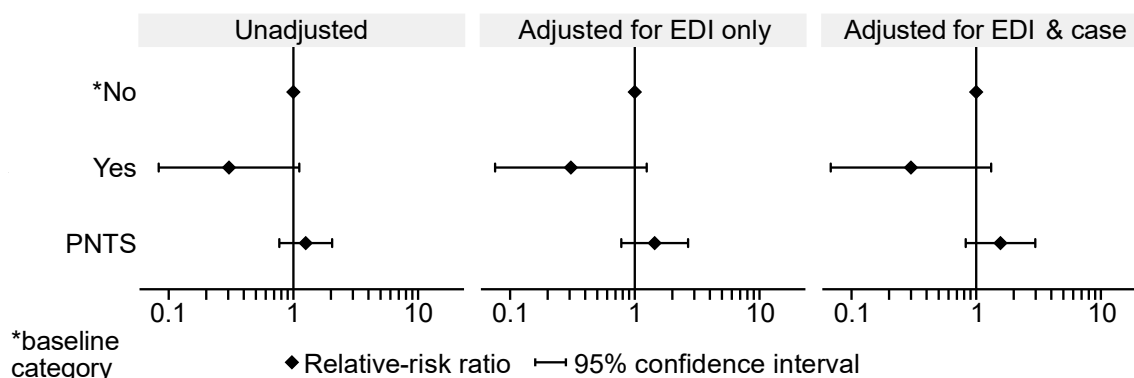
**Table 8: Descriptive statistics: pregnancy & maternity**

Disability	All cases		Investigations outcome					
	n	%	NFA		Advice/warning		Referred to FTPC	
	n	%	n	%	n	%	n	%
No	356	75.1	144	40.4	83	23.3	129	36.2
Yes	19	4.0	11	57.9	5	26.3	3	15.8
PNTS	99	20.9	40	40.4	14	14.1	45	45.5
<b>Disability</b>	<b>474</b>	<b>100</b>	<b>195</b>	<b>41.1</b>	<b>102</b>	<b>21.5</b>	<b>177</b>	<b>37.3</b>

**Figure 8a: Relative-risk ratios: pregnancy & maternity, Advice/warning vs NFA**



**Figure 8b: Relative-risk ratios: pregnancy & maternity, Referral to FTPC vs NFA**



## Marital status

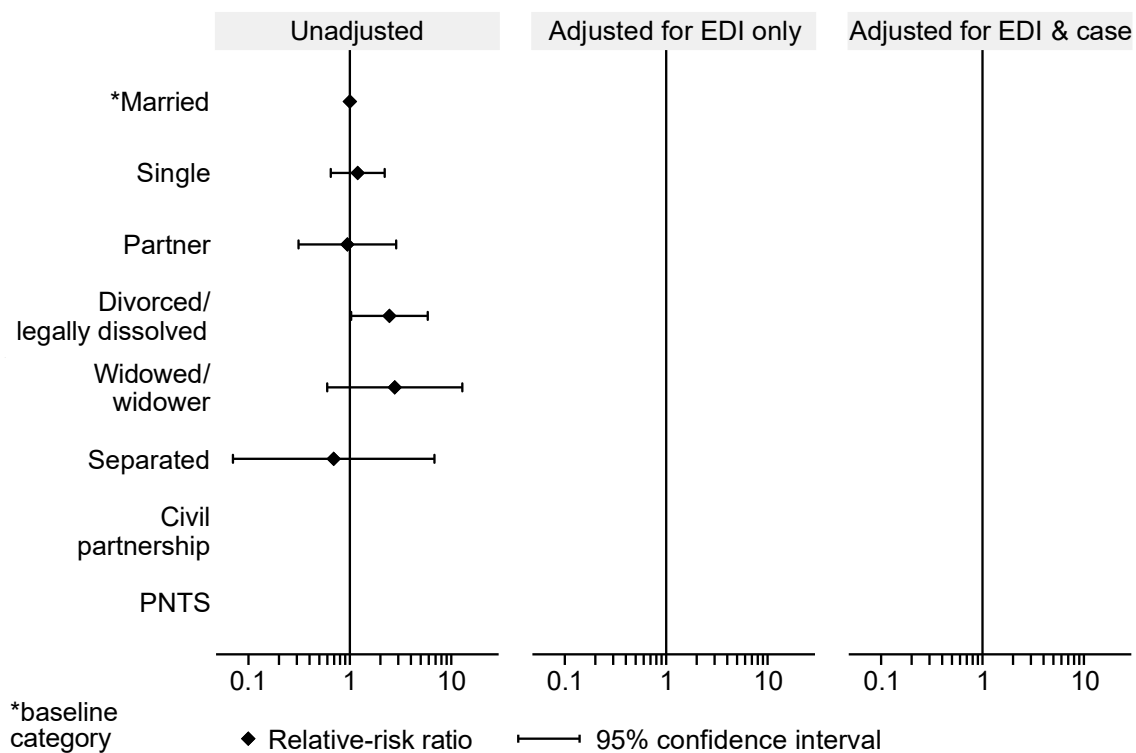
Due to the high levels of missing data, marital status was only included in the univariate analysis. Almost seventy percent of the concerns were one of the top two categories (married or single) and as a result there were some small counts and wide confidence intervals for some of the other categories and it was not possible to estimate some RRR as there were zero counts for some outcomes for some categories.

The univariate analysis indicated a statistically significantly higher risk (RRR 2.46, 95% CI 1.03 to 5.86,  $p = 0.043$ ) for divorced/legally dissolved registrants for the receipt of advice/warning compared to NFA (Figure 9a). For the comparison of referral to FTPC vs NFA registrants who stated partner (RRR 2.41, 95% CI 1.08 to 5.36,  $p = 0.031$ ) or widowed/widower (RRR 4.65, 95% CI 1.24 to 17.5  $p = 0.023$ ) had statistically significantly higher risks of the receipt of referral to FTPC compared to NFA (Figure 9b). The full model outputs for marital status can be found in Annexes A and B.

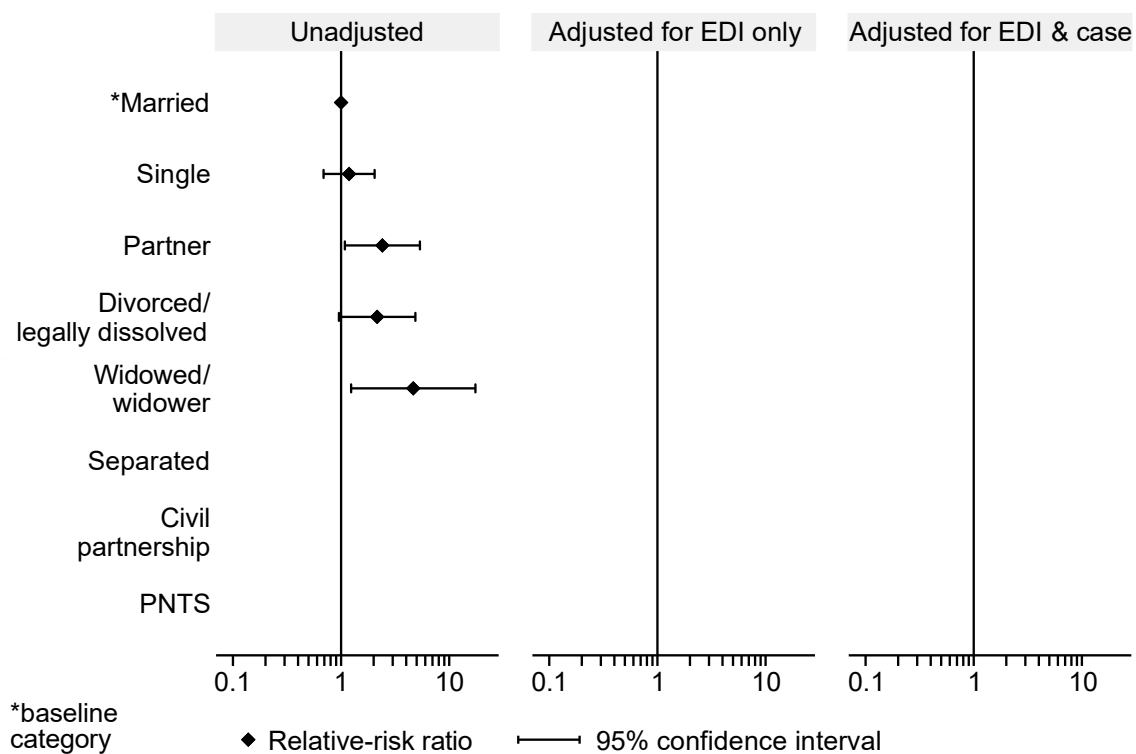
**Table 9: Descriptive statistics: marital status**

Marital status	All cases		Investigations outcome					
	n	%	NFA		Advice/warning		Referred to FTPC	
	n	%	n	%	n	%	n	%
Married	233	49.2	106	45.5	51	21.9	76	32.6
Single	97	20.5	40	41.2	23	23.7	34	35.1
Partner	35	7.4	11	31.4	5	14.3	19	54.3
Divorced/legally dissolved	41	8.6	11	26.8	13	31.7	17	41.5
Widowed/widower	17	3.6	3	17.6	4	23.5	10	58.8
Separated	4	0.8	3	75.0	1	25.0	0	0
Civil partnership	2	0.4	0	0	0	0	2	100
PNTS	2	0.4	0	0	0	0	2	100
Total	474	100	195	41.1	102	21.5	177	37.3

**Figure 9a: Relative-risk ratios: marital status, Advice/warning vs NFA**



**Figure 9b: Relative-risk ratios: marital status, Referral to FTPC vs NFA**



### Allegation group

Over eight percent of investigations were for just two allegation groups, conduct or clinical (Table 10). Investigations for conduct, multiple or health allegations were less likely to result in advice/warning than in NFA when compared to the baseline of clinical allegations (Figure 10a). This was statistically significant for health allegations before and after adjustment for EDI characteristics (RRR 0.10, 95% CI 0.01 to 0.81,  $p = 0.031$ ).

Investigations for conduct, multiple or health allegations were more likely to result in referral to FTPC than in NFA when compared to the baseline of clinical allegations (Figure 10b). This was statistically significant in all instances after adjustment for EDI characteristics: conduct (RRR 3.62, 95% CI 2.24 to 5.87,  $p < 0.001$ ), multiple (RRR 3.76, 95% CI 1.80 to 7.85,  $p < 0.001$ ), and health (RRR 2.36, 95% CI 1.04 to 5.38,  $p = 0.041$ ). The full model outputs for allegation groups can be found in Annexes A, B, C1, D1, E1, and F1.

**Table 10: Descriptive statistics: allegation group**

Marital status	All cases		Investigations outcome					
	n	%	NFA		Advice/warning		Referred to FTPC	
	n	%	n	%	n	%	n	%
Clinical	237	50.0	114	48.1	71	30.0	52	21.9
Conduct	150	31.6	49	32.7	20	13.3	81	54.0
Multiple	40	8.4	14	35.0	2	5.0	24	60.0
Health	28	5.9	13	46.4	1	3.6	14	50.0
Conviction/caution	19	4.0	5	26.3	8	42.1	6	31.6
Total	474	100	195	41.1	102	21.5	177	37.3

**Figure 10a: Relative-risk ratios: allegation group, Advice/warning vs NFA**

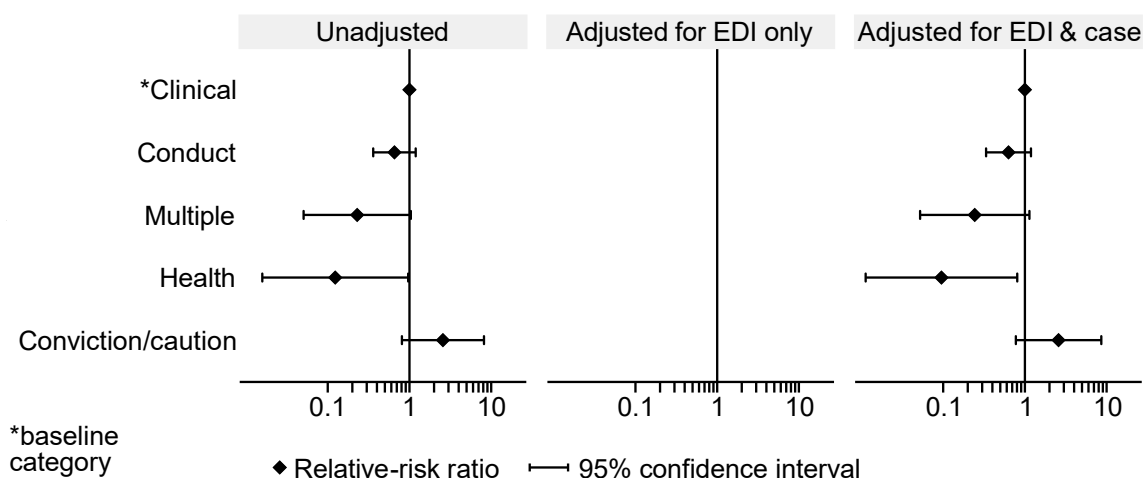
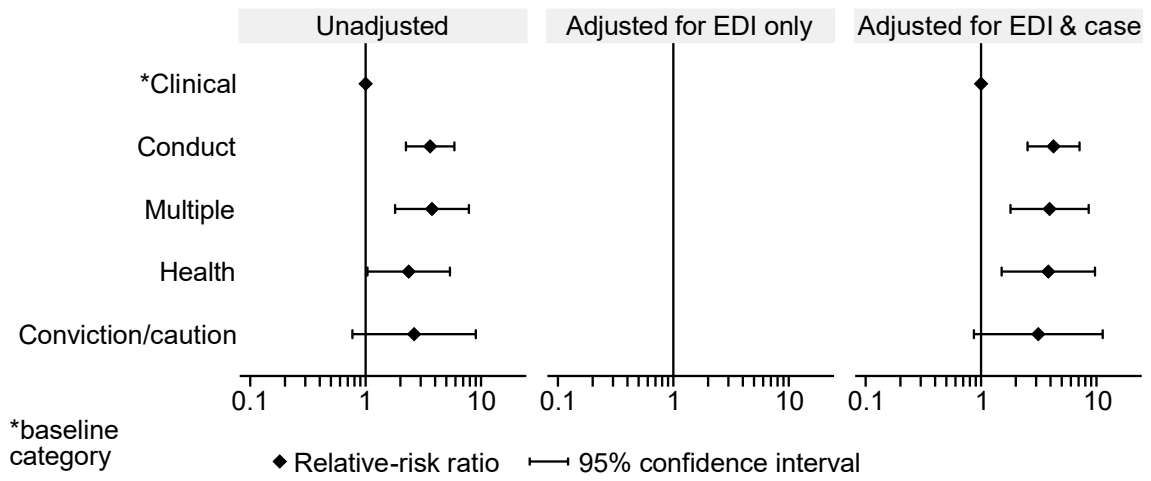


Figure 10b: Relative-risk ratios: allegation group, Referral to FTPC vs NFA



## Discussion

These analyses highlight two important analytical issues. First, effects seen in univariate analysis often disappear once other variables are adjusted for. Second, variables with no univariate effect can have a significant effect once other variables are adjusted for.

With regards to the research question, the results of this analysis suggest:

- 1) There was very little statistical evidence of disproportionality in GOC FTP investigation outcomes with regards to the protected characteristics of the registrants involved in that process, after adjusting for all EDI variables and all available case characteristics. The one statistically significant EDI finding was an increased risk of referral to FTPC rather than NFA for those answering PNTS for religion.
- 2) There were two protected characteristics where certain levels were on the borderline of statistical significance, namely females (at higher risk of advice/warning than NFA and lower risk of referral to FTPC than NFA) when compared to males, and those of Sikh religion at higher risk of referral to FTPC than NFA when compared to Muslims.
- 3) There was very little evidence of intersectionality between the variables analysed with interaction terms, with only one combination being statistically significant after case characteristics were adjusted for. And that combination included a prefer not to say category.
- 4) Overall, EDI characteristics were very poor predictors of investigations outcomes whereas case characteristics were very good predictors of investigations outcome. This makes it essential to adjust for case characteristics when considering effects of EDI characteristics.

Only one of the effects reported by other regulators was apparent in the analyses here. Age had no effect on the likelihood of any of the outcomes. There were signs of a similar gender effect, with females being less likely to be referred to a FTPC though this was not statistically significant when adjusted for EDI and case characteristics. Black registrants were less likely to be referred to FTPC rather than more likely as suggested by other UK regulators. Similarly disabled registrants here were less likely to be referred to FTPC rather than more likely as suggested by other UK regulators.

The impact of adjusting for case characteristics raises an important consideration for the validity of these results. It is almost certain that there were other case characteristics that would have strong predictive power, possibly including referral source, registrant engagement with the process, legal representation, and registration route (UK or international). To be certain of the effect/non-effect of EDI variables it would be prudent to model investigations outcomes in the presence of all plausible case characteristic variables.

Although the focus has been on statistically significant effects, there are some possibly interesting patterns in the results in general. This is made more complicated to consider due to the dual nature of the multinomial approach. For example, females were more likely than males to receive advice/warning than NFA and less likely to receive referral to FTFC than NFA. What this in effect says is females were more likely to have NFA and less likely to be referred to FTFC than males, as shown in the respective table. For other characteristics the relationship between the two comparisons is harder to see, especially when there are many levels within a characteristic.

Looking at the most predictive model, referral to FPC vs NFA for EDI and case characteristics, it was noted that for both ethnicity and religion almost all data RRR values are above 1, i.e. higher than the baseline of white and Muslim respectively. Whether these are by chance or systemic cannot be determined from the data and analysis here but may warrant more detailed investigation.

Whilst the dataset used for these analyses represented the total relevant case load over a five-year period, it was not huge and some of the categories within some of the characteristics had very small counts. This in turn led to some uncertainty in the analyses, apparent in the sometimes wide confidence intervals. If there has been no substantive change in the investigations procedures, it would be prudent to repeat the exercise when more years of data are available.

Given that the one intersectionality found involved prefer not to say, it would also be prudent to try to reduce the levels of prefer not to say to all EDI questions which currently account for around 1 in 8 responses and may be masking important effects.

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**Annex A: Univariate models outputs: Advice/warning vs NFA**

<b>Variable</b>	<b>Coefficient (β)</b>	<b>SE</b>	<b>Wald χ<sup>2</sup></b>	<b>p value</b>	<b>RRR</b>	<b>95% CI</b>
<b>Age (5 years)</b>	-0.036	0.048	-0.8	0.455	0.96	0.88 to 1.06
<b>Gender</b>						
*Male					1.00	
Female	0.423	0.246	1.7	0.085	1.53	0.94 to 2.47
<b>Disability</b>						
*No					1.00	
Yes	-	-	-	-	-	-
PNTS	-0.003	0.357	0.0	0.994	1.00	0.50 to 2.01
<b>Ethnicity</b>						
*White					1.00	
Indian	0.314	0.320	1.0	0.327	1.37	0.73 to 2.56
Pakistani	0.013	0.359	0.0	0.970	1.01	0.50 to 2.05
Other Asian	-0.082	0.576	-0.1	0.887	0.92	0.30 to 2.85
Black	0.147	0.658	0.2	0.823	1.16	0.32 to 4.21
Other global majority	0.013	0.889	0.0	0.988	1.01	0.18 to 5.79
PNTS	-0.169	0.427	-0.4	0.692	0.84	0.37 to 1.95
<b>Religion</b>						
*Muslim					1.00	
Christian	-0.124	0.360	-0.3	0.731	0.88	0.44 to 1.79
No religion	0.346	0.367	0.9	0.346	1.41	0.69 to 2.90
Hindu	0.366	0.397	0.9	0.357	1.44	0.66 to 3.14
Sikh	0.346	0.580	0.6	0.551	1.41	0.45 to 4.41
Jewish	-	-	-	-	-	-
Buddhist	-	-	-	-	-	-
PNTS	0.058	0.429	0.1	0.892	1.06	0.46 to 2.46
<b>Sexual orientation</b>						
*Heterosexual					1.00	
Gay/Lesbian/ Homosexual	0.605	1.420	0.4	0.670	1.83	0.11 to 29.6
Bisexual	-	-	-	-	-	-
PNTS	-0.277	0.368	-0.8	0.451	0.76	0.37 to 1.56
<b>Pregnancy &amp; maternity</b>						
*No					1.00	
Yes	-0.237	0.557	-0.4	0.670	0.79	0.26 to 2.35
PNTS	-0.499	0.340	-1.5	0.142	0.61	0.31 to 1.18
<b>Marital status</b>						
*Married					1.00	
Single	0.178	0.312	0.570	0.568	1.20	0.65 to 2.20
Partner	-0.057	0.566	-0.100	0.920	0.95	0.31 to 2.86
Divorced/legally dissolved	0.899	0.444	2.030	0.043	2.46	1.03 to 5.86
Widowed/widower	1.019	0.783	1.300	0.193	2.77	0.60 to 12.8
Separated	-0.367	1.167	-0.310	0.753	0.69	0.07 to 6.82
Civil partnership	-	-	-	-	-	-
PNTS	-	-	-	-	-	-

Variable	Coefficient ( $\beta$ )	SE	Wald $\chi^2$	p value	RRR	95% CI
<b>Allegation group</b>						
*Clinical					1.00	
Conduct	-0.423	0.305	-1.4	0.166	0.66	0.36 to 1.19
Multiple	-1.472	0.771	-1.9	0.056	0.23	0.05 to 1.04
Health	-2.091	1.049	-2.0	0.046	0.12	0.02 to 0.96
Conviction/caution	0.944	0.590	1.6	0.11	2.57	0.81 to 8.16

## Annex B: Univariate models outputs: Referral to FTPC vs NFA

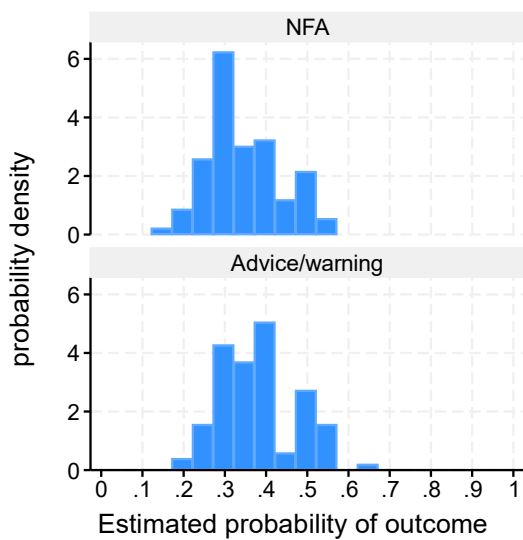
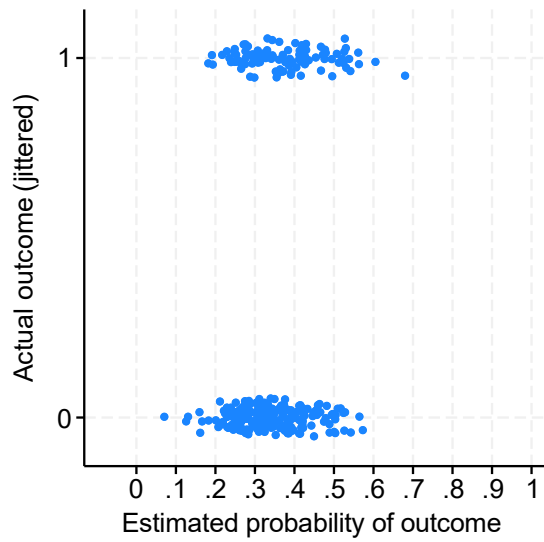
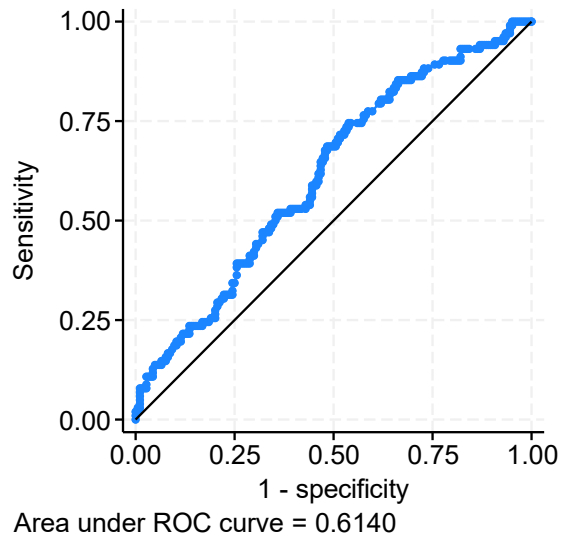
Variable	Coefficient ( $\beta$ )	SE	Wald $\chi^2$	p value	RRR	95% CI
<b>Age (5 years)</b>	-0.005	0.040	-0.1	0.895	0.99	0.92 to 1.08
<b>Gender</b>						
*Male					1.00	
Female	-0.520	0.221	-2.4	0.019	0.59	0.39 to 0.92
<b>Disability</b>						
*No					1.00	
Yes	-0.315	0.655	-0.5	0.631	0.73	0.20 to 2.64
PNTS	0.010	0.305	0.0	0.974	1.01	0.56 to 1.84
<b>Ethnicity</b>						
*White					1.00	
Indian	0.168	0.279	0.6	0.548	1.18	0.68 to 2.05
Pakistani	0.018	0.302	0.1	0.953	1.02	0.56 to 1.84
Other Asian	-0.309	0.512	-0.6	0.547	0.73	0.27 to 2.00
Black	-0.704	0.711	-1.0	0.322	0.49	0.12 to 1.99
Other global majority	0.703	0.649	1.1	0.279	2.02	0.57 to 7.21
PNTS	0.143	0.335	0.4	0.669	1.15	0.60 to 2.22
<b>Religion</b>						
*Muslim					1.00	
Christian	0.149	0.300	0.5	0.619	1.16	0.65 to 2.09
No religion	0.244	0.327	0.8	0.456	1.28	0.67 to 2.42
Hindu	0.084	0.367	0.2	0.820	1.09	0.53 to 2.23
Sikh	0.749	0.476	1.6	0.116	2.11	0.83 to 5.38
Jewish	-0.387	1.243	-0.3	0.755	0.68	0.06 to 7.76
Buddhist	1.001	1.243	0.8	0.421	2.72	0.24 to 31.1
PNTS	0.496	0.347	1.4	0.153	1.64	0.83 to 3.24
<b>Sexual orientation</b>						
*Heterosexual					1.00	
Gay/Lesbian/ Homosexual	0.776	1.230	0.6	0.528	2.17	0.19 to 24.19
Bisexual	0.083	1.006	0.1	0.934	1.09	0.15 to 7.81
PNTS	-0.148	0.301	-0.5	0.622	0.86	0.48 to 1.56
<b>Pregnancy &amp; maternity</b>						
*No					1.00	
Yes	-1.189	0.663	-1.8	0.073	0.30	0.08 to 1.12
PNTS	0.228	0.249	0.9	0.360	1.26	0.77 to 2.05
<b>Marital status</b>						
*Married					1	
Single	0.170	0.277	0.6	0.540	1.19	0.69 to 2.04
Partner	0.879	0.408	2.2	0.031	2.41	1.08 to 5.36
Divorced/legally dissolved	0.768	0.415	1.9	0.064	2.16	0.96 to 4.86
Widowed/widower	1.537	0.675	2.3	0.023	4.65	1.24 to 17.5
Separated	-	-	-	-	-	-
Civil partnership	-	-	-	-	-	-
PNTS	-	-	-	-	-	-

Variable	Coefficient ( $\beta$ )	SE	Wald $\chi^2$	p value	RRR	95% CI
<b>Allegation group</b>						
*Clinical					1.00	
Conduct	1.288	0.246	5.2	0.000	3.62	2.24 to 5.87
Multiple	1.324	0.376	3.5	0.000	3.76	1.80 to 7.85
Health	0.859	0.420	2.1	0.041	2.36	1.04 to 5.38
Conviction/caution	0.967	0.628	1.5	0.124	2.63	0.77 to 9.01

**Annex C1: Multinomial model output: Advice/warning vs NFA, EDI only**

<b>Variable</b>	<b>Coefficient (<math>\beta</math>)</b>	<b>SE</b>	<b>Wald <math>\chi^2</math></b>	<b>p value</b>	<b>RRR</b>	<b>95% CI</b>
<b>Age (5 years)</b>	0.002	0.062	0.0	0.970	1.00	0.89 to 1.13
<b>Gender</b>						
*Male					1.00	
Female	0.439	0.275	1.6	0.111	1.55	0.90 to 2.66
<b>Disability</b>						
*No					1.00	
Yes	-	-	-	-	-	-
PNTS	0.354	0.536	0.7	0.510	1.42	0.50 to 4.07
<b>Ethnicity</b>						
*White					1.00	
Indian	0.268	0.642	0.4	0.676	1.31	0.37 to 4.60
Pakistani	0.257	0.694	0.4	0.711	1.29	0.33 to 5.04
Other Asian	-0.130	0.769	-0.2	0.866	0.88	0.19 to 3.96
Black	0.263	0.698	0.4	0.707	1.30	0.33 to 5.11
Other global majority	0.145	0.946	0.2	0.878	1.16	0.18 to 7.38
PNTS	0.221	0.708	0.3	0.755	1.25	0.31 to 5.00
<b>Religion</b>						
*Muslim					1.00	
Christian	0.125	0.664	0.2	0.851	1.13	0.31 to 4.17
No religion	0.554	0.652	0.9	0.396	1.74	0.48 to 6.25
Hindu	0.261	0.564	0.5	0.644	1.30	0.43 to 3.92
Sikh	0.404	0.705	0.6	0.567	1.50	0.38 to 5.96
Jewish	-	-	-	-	-	-
Buddhist	-	-	-	-	-	-
PNTS	0.309	0.663	0.5	0.642	1.36	0.37 to 4.99
<b>Sexual orientation</b>						
*Heterosexual					1.00	
Gay/Lesbian/ Homosexual	1.388	1.670	0.8	0.406	4.01	0.15 to 105
Bisexual	-	-	-	-	-	-
PNTS	-0.334	0.585	-0.6	0.568	0.72	0.23 to 2.25
<b>Pregnancy &amp; maternity</b>						
*No					1.00	
Yes	-0.474	0.587	-0.8	0.420	0.62	0.20 to 1.97
PNTS	-0.486	0.426	-1.1	0.254	0.62	0.27 to 1.42
<b>Constant</b>	-0.040	0.052				

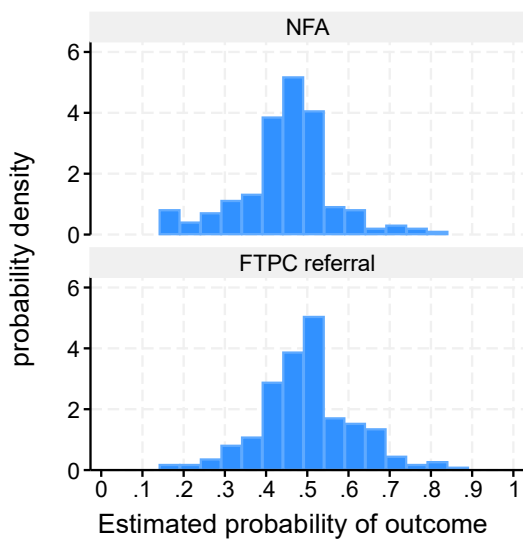
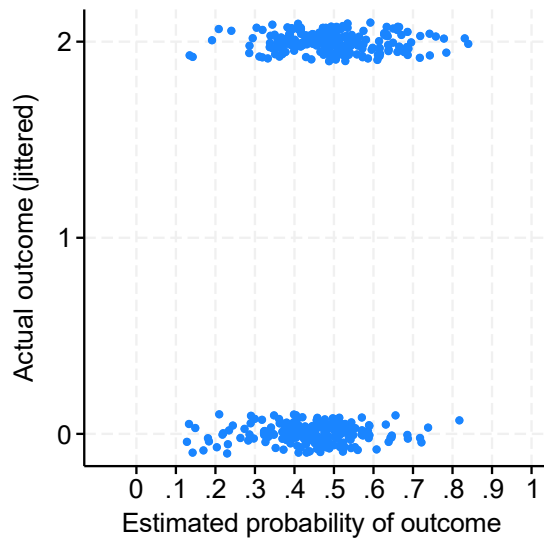
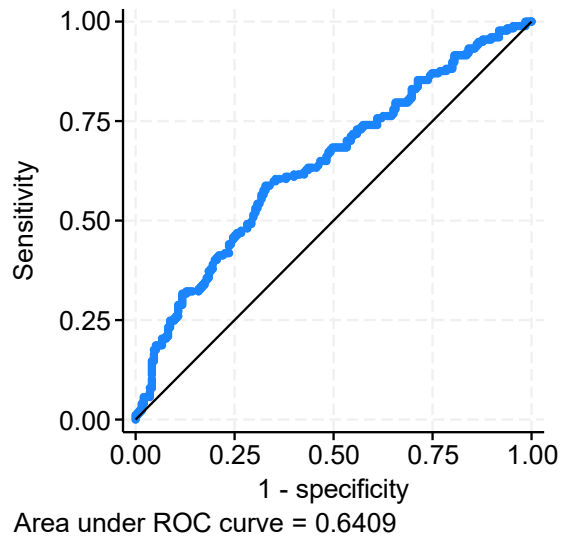
Annex C2: Multinomial model: Advice/warning vs NFA, EDI only - goodness of fit



## Annex D1: Multinomial model output: Referral to FTPC vs NFA, EDI only

	Variable	Coefficient ( $\beta$ )	SE	Wald $\chi^2$	p value	RRR	95% CI
<b>Age (5 years)</b>		-0.040	0.052	-0.8	0.436	0.96	0.87 to 1.06
<b>Gender</b>						1.00	
	*Male					1.00	
	Female	-0.394	0.246	-1.6	0.109	0.67	0.42 to 1.09
<b>Disability</b>						1.00	
	*No					1.00	
	Yes	-0.694	0.720	-1.0	0.335	0.50	0.12 to 2.05
	PNTS	-0.252	0.504	-0.5	0.617	0.78	0.29 to 2.09
<b>Ethnicity</b>						1.00	
	*White					1.00	
	Indian	0.476	0.569	0.8	0.403	1.61	0.53 to 4.91
	Pakistani	0.588	0.600	1.0	0.327	1.80	0.56 to 5.83
	Other Asian	0.110	0.675	0.2	0.871	1.12	0.30 to 4.19
	Black	-0.611	0.737	-0.8	0.407	0.54	0.13 to 2.30
	Other global majority	0.754	0.708	1.1	0.287	2.13	0.53 to 8.51
	PNTS	0.268	0.583	0.5	0.646	1.31	0.42 to 4.10
<b>Religion</b>						1.00	
	*Muslim					1.00	
	Christian	0.786	0.574	1.4	0.171	2.19	0.71 to 6.76
	No religion	0.776	0.574	1.4	0.176	2.17	0.71 to 6.69
	Hindu	0.250	0.512	0.5	0.626	1.28	0.47 to 3.50
	Sikh	0.943	0.585	1.6	0.107	2.57	0.82 to 8.07
	Jewish	-0.084	1.392	-0.1	0.952	0.92	0.06 to 14.1
	Buddhist	1.805	1.567	1.2	0.249	6.08	0.28 to 131
	PNTS	1.096	0.554	2.0	0.048	2.99	1.01 to 8.86
<b>Sexual orientation</b>						1.00	
	*Heterosexual					1.00	
	Gay/Lesbian/ Homosexual	0.886	1.459	0.6	0.543	2.43	0.14 to 42.4
	Bisexual	-0.091	1.046	-0.1	0.931	0.91	0.12 to 7.10
	PNTS	-0.637	0.532	-1.2	0.231	0.53	0.19 to 1.50
<b>Pregnancy &amp; maternity</b>						1.00	
	*No					1.00	
	Yes	-1.180	0.714	-1.7	0.099	0.31	0.08 to 1.25
	PNTS	0.367	0.315	1.2	0.243	1.44	0.78 to 2.67
<b>Constant</b>		-0.378	0.701				

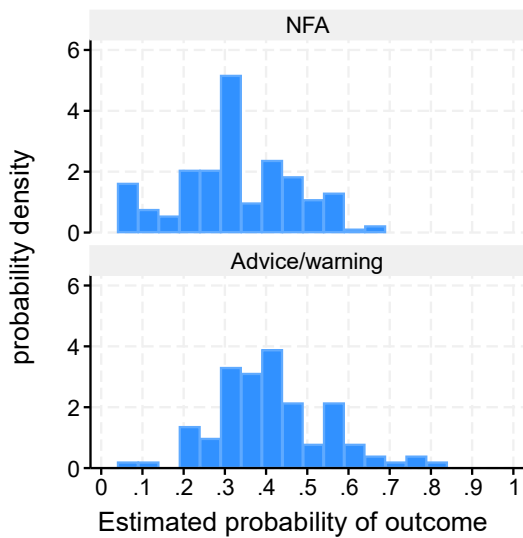
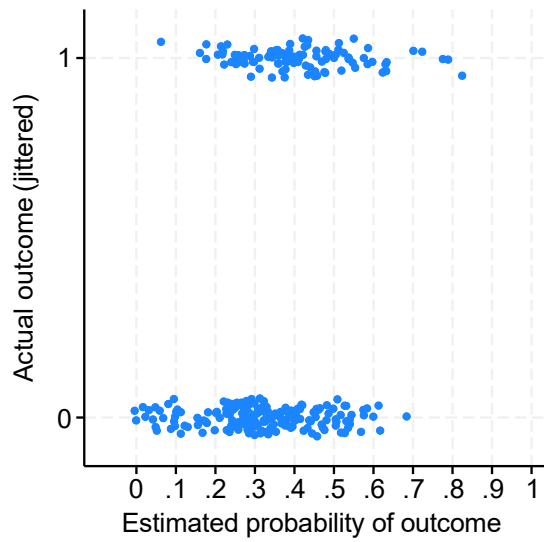
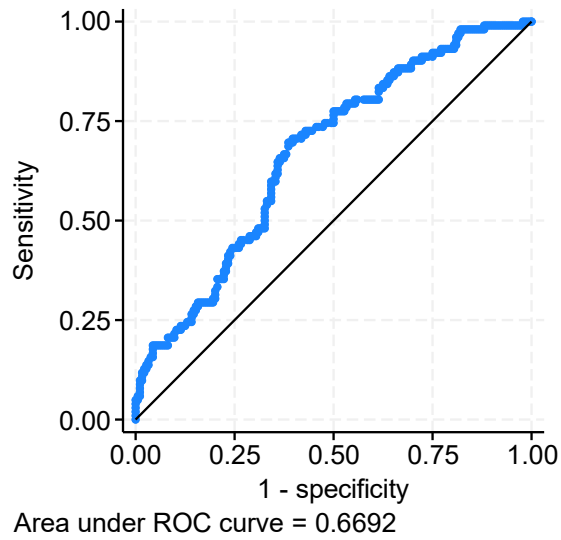
Annex D2: Multinomial model: Referral to FTPC vs NFA, EDI only - goodness of fit



**Annex E1: Multinomial model output: Advice/warning vs NFA, EDI & case**

<b>Variable</b>	<b>Coefficient (β)</b>	<b>SE</b>	<b>Wald χ<sup>2</sup></b>	<b>p value</b>	<b>RRR</b>	<b>95% CI</b>
<b>Age (5 years)</b>	0.016	0.063	0.3	0.798	1.02	0.90 to 1.15
<b>Gender</b>						
*Male					1.00	
Female	0.498	0.285	1.8	0.080	1.65	0.94 to 2.88
<b>Disability</b>						
*No					1.00	
Yes	-	-	-	-	-	-
PNTS	0.801	0.612	1.3	0.191	2.23	0.67 to 7.39
<b>Ethnicity</b>						
*White					1.00	
Indian	0.201	0.662	0.3	0.761	1.22	0.33 to 4.47
Pakistani	0.303	0.721	0.4	0.674	1.35	0.33 to 5.56
Other Asian	-0.020	0.786	0.0	0.980	0.98	0.21 to 4.58
Black	0.397	0.727	0.6	0.585	1.49	0.36 to 6.19
Other global majority	0.075	0.955	0.1	0.938	1.08	0.17 to 7.00
PNTS	0.235	0.759	0.3	0.757	1.26	0.29 to 5.59
<b>Religion</b>						
*Muslim					1.00	
Christian	0.028	0.694	0.0	0.968	1.03	0.26 to 4.01
No religion	0.585	0.675	0.9	0.387	1.79	0.48 to 6.74
Hindu	0.421	0.585	0.7	0.472	1.52	0.48 to 4.79
Sikh	0.397	0.720	0.6	0.581	1.49	0.36 to 6.10
Jewish	-	-	-	-	-	-
Buddhist	-	-	-	-	-	-
PNTS	0.282	0.695	0.4	0.685	1.33	0.34 to 5.18
<b>Sexual orientation</b>						
*Heterosexual					1.00	
Gay/Lesbian/ Homosexual	1.044	1.589	0.7	0.511	2.84	0.13 to 64.0
Bisexual	-	-	-	-	-	-
PNTS	-0.693	0.653	-1.1	0.289	0.50	0.14 to 1.80
<b>Pregnancy &amp; maternity</b>						
*No					1.00	
Yes	-0.570	0.596	-1.0	0.339	0.57	0.18 to 1.82
PNTS	-0.516	0.446	-1.2	0.248	0.60	0.25 to 1.43
<b>Allegation group</b>						
*Clinical					1.00	
Conduct	-0.461	0.323	-1.4	0.154	0.63	0.34 to 1.19
Multiple	-1.412	0.786	-1.8	0.072	0.24	0.05 to 1.14
Health	-2.351	1.090	-2.2	0.031	0.10	0.01 to 0.81
Conviction/caution	0.949	0.614	1.6	0.122	2.58	0.78 to 8.61
<b>Constant</b>	-0.031	0.055				

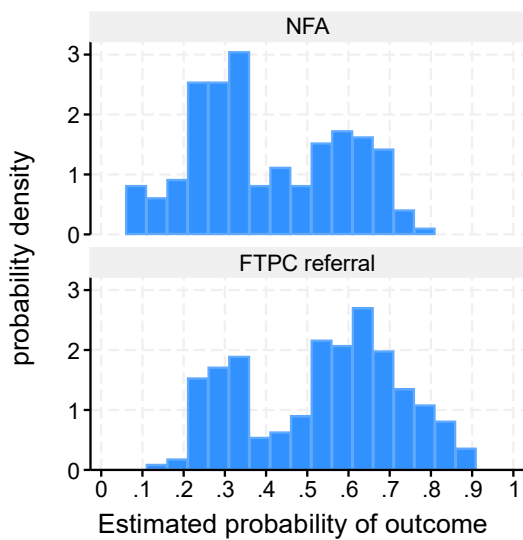
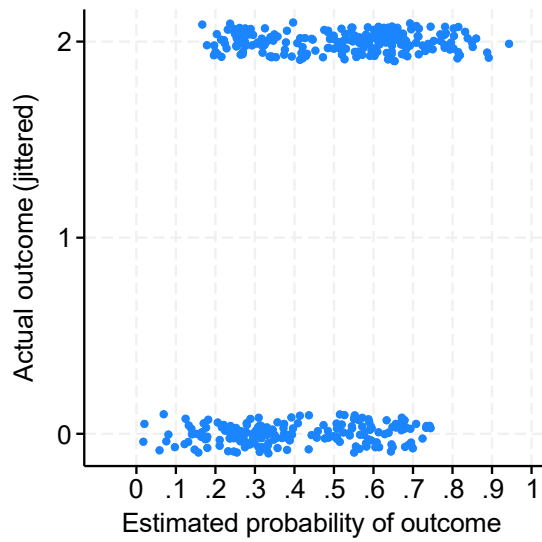
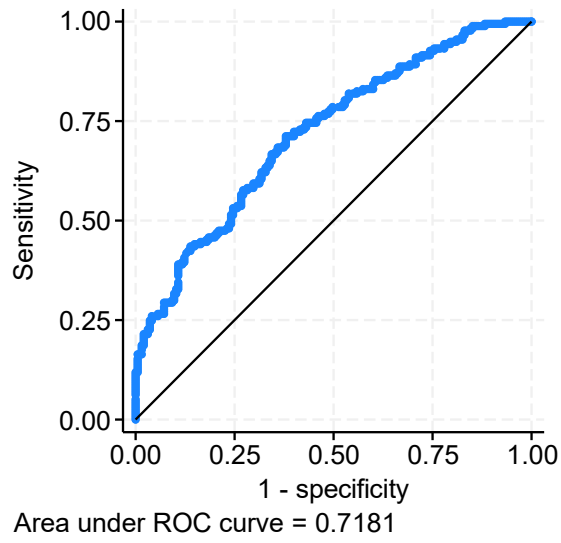
Annex E2: Multinomial model: Advice/warning vs NFA, EDI & case - goodness of fit



**Annex F1: Multinomial model output: Referral to FTFC vs NFA, EDI & case**

<b>Variable</b>	<b>Coefficient (<math>\beta</math>)</b>	<b>SE</b>	<b>Wald <math>\chi^2</math></b>	<b>p value</b>	<b>RRR</b>	<b>95% CI</b>
<b>Age (5 years)</b>	-0.031	0.055	-0.6	0.570	0.97	0.87 to 1.08
<b>Gender</b>						
*Male					1.00	
Female	-0.384	0.262	-1.5	0.143	0.68	0.41 to 1.14
<b>Disability</b>						
*No					1.00	
Yes	-1.148	0.757	-1.5	0.130	0.32	0.07 to 1.40
PNTS	-0.572	0.521	-1.1	0.272	0.56	0.20 to 1.57
<b>Ethnicity</b>						
*White					1.00	
Indian	0.696	0.596	1.2	0.243	2.00	0.62 to 6.45
Pakistani	0.566	0.635	0.9	0.373	1.76	0.51 to 6.11
Other Asian	0.094	0.707	0.1	0.894	1.10	0.27 to 4.39
Black	-0.898	0.760	-1.2	0.238	0.41	0.09 to 1.81
Other global majority	0.669	0.739	0.9	0.366	1.95	0.46 to 8.32
PNTS	0.153	0.611	0.3	0.803	1.16	0.35 to 3.86
<b>Religion</b>						
*Muslim					1.00	
Christian	1.011	0.608	1.7	0.096	2.75	0.84 to 9.04
No religion	0.797	0.603	1.3	0.187	2.22	0.68 to 7.24
Hindu	0.022	0.532	0.0	0.968	1.02	0.36 to 2.90
Sikh	0.995	0.598	1.7	0.096	2.70	0.84 to 8.73
Jewish	-0.381	1.495	-0.3	0.799	0.68	0.04 to 12.8
Buddhist	1.648	1.546	1.1	0.286	5.20	0.25 to 107
PNTS	1.274	0.590	2.2	0.031	3.58	1.13 to 11.4
<b>Sexual orientation</b>						
*Heterosexual					1.00	
Gay/Lesbian/ Homosexual	1.325	1.406	0.9	0.346	3.76	0.24 to 59.3
Bisexual	-0.762	1.087	-0.7	0.484	0.47	0.06 to 3.93
PNTS	-0.419	0.531	-0.8	0.430	0.66	0.23 to 1.86
<b>Pregnancy &amp; maternity</b>						
*No					1.00	
Yes	-1.205	0.756	-1.6	0.111	0.30	0.07 to 1.32
PNTS	0.449	0.328	1.4	0.171	1.57	0.82 to 2.98
<b>Allegation group</b>						
*Clinical					1.00	
Conduct	1.446	0.265	5.5	0.000	4.25	2.53 to 7.13
Multiple	1.367	0.398	3.4	0.001	3.92	1.80 to 8.56
Health	1.342	0.475	2.8	0.005	3.83	1.51 to 9.71
Conviction/caution	1.142	0.656	1.7	0.082	3.13	0.87 to 11.3
<b>Constant</b>	-1.306	0.764				

Annex F2: Multinomial model: Referral to FTPC vs NFA, EDI & case - goodness of fit



<b>Unfair Outcomes research</b>	
<b>Phase:</b>	4 – Analysis & report drafting
<b>Activity:</b>	Report 3 Hearings
<b>Date:</b>	11 Jan 2026
<b>Ref:</b>	4.3.260111

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## Introduction

### Background

The GOC is, like all UK health and care regulators, keen to understand the impact of its regulatory functions, and how this impact varies across different groups who share protected characteristics. Through analysing the characteristics of the professionals about whom fitness to practise complaints and concerns are raised, and the subsequent actions taken by the Fitness to Practise Committees, it is possible to build a picture of who was more or less likely to receive any particular outcome when committees make their decisions.

The GOC Fitness to Practise Committees (GOC, 2020) decide whether or not a registrant is fit to practise; if they believe a registrant's fitness to practise is impaired, they can decide on:

- conditional registration – the registrant can stay on the register as long as they keep to certain conditions, such as doing extra training or being supervised while they work
- suspension from the register – the registrant's name is temporarily taken off the register, and they cannot work for a fixed period of time
- removal from the register – sometimes referred to as 'erasure' or 'striking off'. The registrant's name is taken off the register, which means that they cannot work as an optometrist or dispensing optician (or train, or run a GOC registered business) in the UK. If they want their name to be put back on the register in future there is a separate process that they have to go through, which includes considering the original reason for their removal
- financial penalty – the registrant must pay a fine up to a maximum of £50,000.

If the Fitness to Practise Committee decides that a registrant is fit to practise, they can still warn them about their future behaviour or performance.

It is important to understand that this analysis does not determine if individual committees and committee members, or their decisions, were fair or unfair. A statistically significant result alone cannot be taken to mean that there was something wrong, but it should trigger a separate, in-depth piece of work to understand why there was a difference. Therefore, after looking at the results of the GOC's triage decisions in the first report of this project, the decisions taken by case examiners in the second

report of this project, this third report is the next step towards being able to address that core question of whether or not the GOC's fitness to practise functions are fair.

The Fitness to Practise Committee's decision is the point at which a registrant may be found unfit to practise, and may ultimately be prevented from practising. The descriptive analysis of these cases shows what happens at the conclusion of the investigative process. The model assessed the outcome of the Committee's decision of 'is this registrant fit to practise?' after that investigation, what sanction (if any) should be applied to the registrant, and how the impact of those decisions differs on registrants with different protected characteristics.

### **UK healthcare regulators literature review**

Healthcare regulators in the UK have engaged extensively, but variedly, with analysis of hearing outcomes. And where they have, the findings have varied between regulators, and sometimes varied from year to year with a regulator. The picture is further complicated by the lack of consistency in the way regulators present such analyses, making comparisons difficult. For example some have grouped decisions into binary classifications, such as impairment or no impairment, while others have incorporated narratives about eventual severity of any sanction that may be applied.

Where other UK regulators have assessed disproportionality in FTP hearing outcomes it has been reported that hearings involving male registrants (GMC, 2016, NMC, 2020, GPhC, 2025), black and minority ethnic (BME) registrants (GMC, 2018), or disabled registrants (NMC, 2020) were more likely to result in a sanction.

Analyses from UK regulators have also reported the opposite effects with FTP hearings involving male registrants (HCPC, 2024) or BME registrants (NMC, 2020) being less likely to result in a sanction. One of those reports also found lower sanction rates in both the very youngest and oldest age groups (HCPC, 2024).

It is important to recognise that any effect may be transient, and indeed the GMC reported that some of the effects in its earlier reports no longer existed (GMC, 2022).

## Research question

The overall aim of the GOC unfair outcomes research project is to investigate whether disproportionality has been apparent in GOC FTP process outcomes. This third report investigates outcomes at the final stage of the GOC FTP process, hearings.

The principal research question for this report is therefore:

- Is there statistical evidence of disproportionality in GOC FTP hearing outcomes with regards to the protected characteristics of the registrants involved in that process?

## Methods

### Study design

This is an observational retrospective cross-sectional study of all GOC FTP substantive hearings meeting the inclusion criteria.

### Participants

The study data set consisted of all GOC FTP substantive hearing where:

- A decision of either no sanction or sanction was made between 01 Jan 2020 and 31 Dec 2024 inclusive.
- The hearing related to a GOC registrant only and not a GOC regulated business or any other entity, with no differentiation between professional groups.

### Data collection

The data were supplied by GOC. Of the 233 records supplied, 54 did not meet the inclusion criteria, leaving 179 records for the analysis (Figure 1).

### Variables

The binary outcome variable was based on the hearing decision, coded as sanction or no sanction with the analyses focusing on the likelihood of a sanction being received. The range of decisions within the two groups can be found in Figure 1.

There were eight explanatory variables related to protected characteristics and two explanatory variables relating to the case characteristics. Gender is included in the analyses here under protected characteristics as while not a protected characteristic itself, the data supplied by GOC were labelled 'gender' rather than 'sex'.

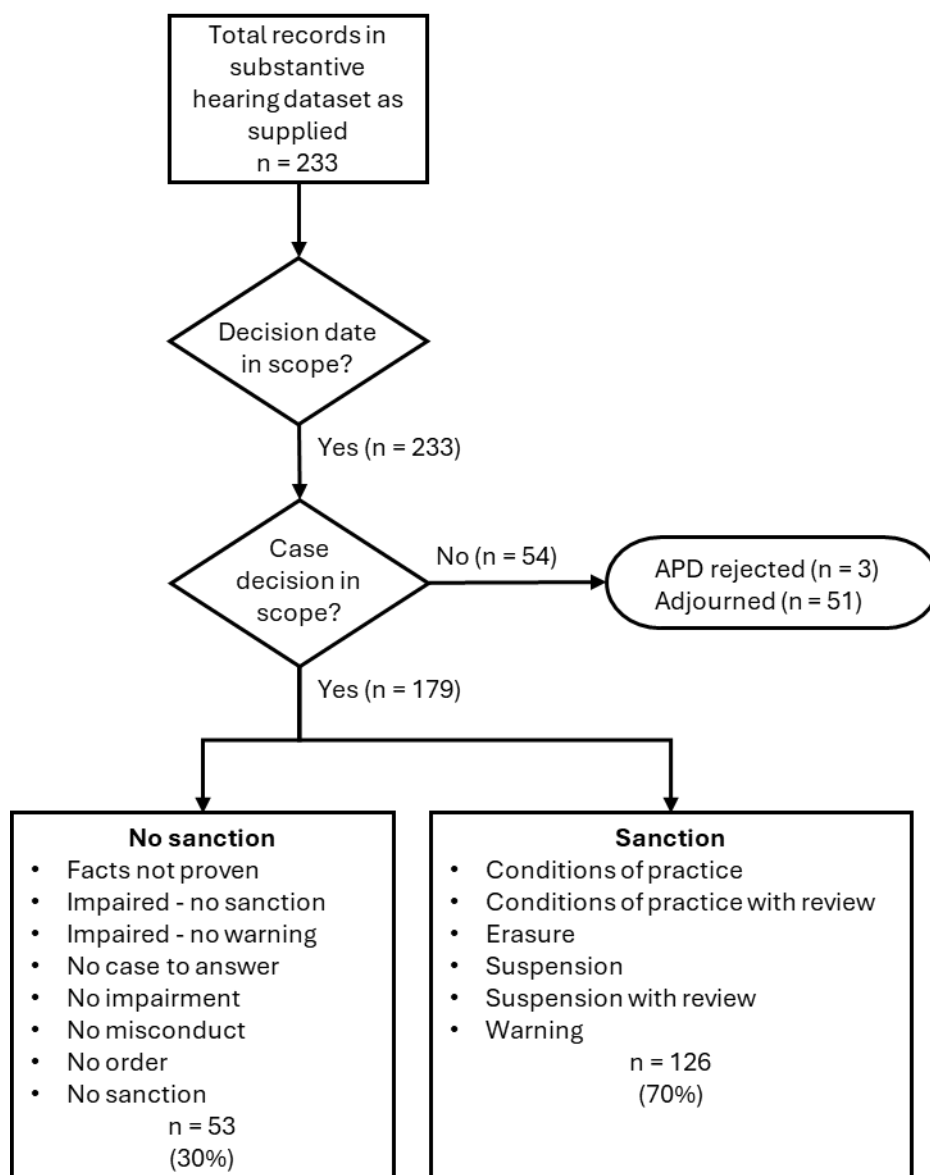
The original specification had included two non-protected characteristic explanatory variables, years on the register and referral source, but neither were included in the data as supplied. Inspection of the data as supplied identified one case characteristic variable that had a strong effect and this was included instead of the two original ones. In addition, and based on the observed effect of allegations in the triage analysis, allegations were added to the original dataset by GOC. Both case characteristic

explanatory variables were categorical and both used the largest category as the baseline value (Table 1a). The baseline value is the category against which the other categories are compared.

The only continuous protected characteristic explanatory variable was age in years at the time the hearing started. Age was included in the models as age/5 meaning a unit increase in age in the models was the effect of a five-year increase in age.

The other seven explanatory variables relating to protected characteristics were categorical and all used the largest category as the baseline value (Table 1b). In some instances categories were combined into groups with the agreement of GOC.

**Figure 1: Data collection flow chart**



**Table 1a: Categorical explanatory variables, case characteristics**

<b>Characteristic</b>	<b>Category</b>	<b>Notes</b>
Occupation	Optometrist	Baseline value
	Dispensing Optician	
	Student Optometrist	
	Student Dispensing Optician	
Allegation group	Conduct	Baseline value
	Clinical	
	Conviction/Caution	
	Multiple Health	

**Table 1b: Categorical explanatory variables, protected characteristics**

<b>Characteristic</b>	<b>Category</b>	<b>Notes</b>
Gender	Male	Baseline value
	Female	
Ethnicity	White	Baseline value
	Indian	
	Pakistani	Any other Asian   Bangladeshi   African   Other
	Other global majority Prefer not to say	
Disability	No	Baseline value
	Yes	
	Prefer not to say	
Marital status	Married	Baseline value
	Single	
	Partner	
	Divorced/legally dissolved	
	Widowed/widower	
	Civil partnership	
	Prefer not to say	
Religion	Muslim	Baseline value
	Christian	
	No religion	Christian   Catholic
	Hindu	
	Sikh	
	Jewish	
	Buddhist	
	Prefer not to say	
Sexual orientation	Heterosexual/ straight	Baseline value
	Gay/Lesbian/Homosexual	
	Prefer not to say	
Pregnancy & maternity	No	Baseline value
	Yes	
	Prefer not to say	

## Data Analysis

The analytical objectives of this report were to produce:

1. Descriptive analyses of each of the study variables (EDI characteristics and other) to characterise this registrant population.
2. Univariate (on their own) assessments of each of the specified variables of interest by means of binary logistic regression. These indicated the risk of the outcome for each level of each variable without adjusting for other variables and intersectionality.
3. Multivariate (all together) assessment of all the specified variables of interest at the same time by means of binary logistic regression. This indicated the risk of the outcome for each variable having adjusted for other variables and intersectionality. Multivariable models were produced for all EDI variables together and for all EDI and case characteristic variables together

The purpose of the multivariable models here was to explicitly demonstrate the effect of each of the protected characteristics in the presence of the others rather than to develop the best fitting and most parsimonious model to predict the outcome. As such there was no variable selection process and only the saturated (all variables together) model is presented. Intersectionality was assessed by means of interaction terms for ethnicity and gender, disability and gender, disability and sexual orientation, and disability and religion.

Model assurance was based on the Area under the ROC Curve for model discrimination, Pearson Chi-Square test and Hosmer and Lemeshow test for goodness of fit, and visual inspection of a range of residuals for regression diagnostics including signs of outliers.

Probabilities (p-values) of less than 0.05 were considered statistically significant. All analyses were conducted using Stata 19.5 SE (StataCorp, 2025).

To ensure like for like comparisons across the univariate and multivariable models, these analyses were based on the records that were complete for all the variables. The exception to this was Marital status, which was only included in the univariate analysis due to the relatively high levels of missing data.

## **Ethical Considerations**

The data supplied by GOC for this research were anonymous at the point of supply and therefore they were not considered to be personal data, meaning data protection legislation did not apply. Research using anonymised data cannot, by definition, require informed consent from participants as it is not possible to identify them to obtain consent. The proposal for this research was reviewed by and agreed to by the GOC. No other scientific or ethical review was needed or obtained.

## **Limitations**

Some of the categories within some of the explanatory variables were small. Where it could be reasonably justified some grouping of categories has taken place. These groups may be harder to reliably interpret as they could contain mixed effects. The decision to group them was a pragmatic attempt to retain as many records as possible for the analysis.

As described earlier, this was not an exercise to find the best fitting model to predict hearing outcomes. That would likely be based on a wider range of data than those made available for this analysis, particularly additional data concerning case characteristics. Therefore poor performance in the model assurance analyses would reasonably be expected if the protected characteristics did not predict hearing outcomes. Indeed, in such a situation it would reinforce the finding that protected characteristics were poor predictors.

Records with missing data were necessarily excluded from the logistic regression analyses, and for consistency reasons, from all other analyses. In total 15 hearings had to be excluded, 13 of these for missing EDI data and two for missing case characteristic data. These 13 did not appear to be missing at random, with all being for hearings starting in 2020 or 2021, and all resulting in a sanction. This seems to be a consequence of systematic EDI data collection commencing near to the beginning of the study period. The effect of this then seems to have been that registrants whose case was already advanced at that point did not encounter the EDI data collection before receiving the sanction, and then left the register without having had EDI data collected. It is undeterminable as to whether these excluded records would have affected the findings.

## Results

### Univariate analysis summary

Analysis of each EDI variable individually identified no statistically significant effects before other variables were taken into account. This was in part due to the very small counts in many characteristic categories leading to considerable uncertainty and accordingly very large confidence intervals. The one variable with a marginal result is discussed in more detail below and all univariate results are discussed in more detail in their respective EDI results sections. The full table of univariate logistic regression model outputs can be found in Annex A.

The one marginal result was the odds ratio for Other global majority which suggested a 69% decrease in the likelihood of a hearing resulting in a sanction, compared to the baseline category of white. It was not statistically significant ( $p=0.06$ ) and being based on just 13 cases must be viewed with some uncertainty.

The profession variable showed one statistically significant effect. The odds ratio for Dispensing Optician suggested a 184% increase ( $p=0.03$ ) in the likelihood of a hearing resulting in a sanction to the baseline category of Optometrist. In addition, but on the margins of statistical significance ( $p = 0.05$ ) in part as it was based on just 13 cases, the odds ratio for Student Optometrist suggested a 694% increase in the likelihood of a hearing resulting in a sanction compared to the baseline category of Optometrist.

The odds ratios for allegation group suggested a 55% decrease in the likelihood of a case being opened when it was classified as clinical compared to the baseline category of conduct. This was a statistically significant finding ( $p = 0.04$ ).

### Multivariable analysis summary – EDI characteristics only

Analysis of each EDI variable adjusted for all other EDI variables identified no statistically significant effects. In general the uncertainty increased as the fairly small dataset became very sparse when spread across the multivariable strata. The one marginal effect observed in the univariate analysis moved away from statistical significance. Only one of the 45 intersectionality interaction terms was statistically significant. A pragmatic decision was taken to remove the interaction terms as there was very little evidence of intersectionality, including them substantially increased the

complexity of interpretation, and including them reduced the number of records in the analysis. The results reported for this analysis are therefore for the main effects only. The one significant interaction term is described in the disability section.

Each variable is discussed in more detail in its own section and the full table of multivariable EDI only logistic regression model output can be found in Annex B.

The technical evaluation of the model indicated no issues with the goodness of fit (Pearson Chi-Square  $p = 0.09$ , Hosmer-Lemeshow  $p = 0.83$ ) but with little accuracy in outcome prediction illustrated by the area under the ROC curve (0.69) being in the poor discrimination range (Annex C). The poor discrimination is visible in the scatterplot and histogram of the predicted probabilities (Annex C). Regression diagnostics analysis of the residuals indicated no serious issues (Annex D). No clear pattern was established for the five outlying cases other than the fact that none of them had received a sanction.

### **Multivariable analysis summary – EDI and case characteristics**

Analysis of each EDI and case variable adjusted for all other EDI and case variables identified no statistically significant effects for any EDI variables or case characteristic variables. Each variable is discussed in more detail in its own section and the full table of multivariable EDI and case characteristic logistic regression model output can be found in Annex C.

None of the statistically significant or marginally significant effects identified in the univariate analysis persisted after adjustment for other EDI variables and case characteristics, and no new effects emerged. None of the 45 intersectionality interaction terms were statistically significant, including the one that had been significant in the adjusted for EDI only model. A pragmatic decision was taken to remove the interaction terms as there was no evidence of intersectionality, including them substantially increased the complexity of interpretation, and including them reduced the number of records in the analysis. The results reported for this analysis are therefore for the main effects only.

The technical evaluation of the model detected an issue with the goodness of fit (Pearson Chi-Square  $p < 0.01$ , Hosmer-Lemeshow  $p = 0.05$ ). Inspection of the Hosmer-Lemeshow deciles only identified some small expected counts in the upper deciles, where the expected probability of receiving a sanction is high. Inspection of the residuals revealed that the issue was being caused by a number of outliers who had not received sanction when they had a high probability of receiving one. These were all cases where there was a higher risk professional group and/or a higher risk allegation. As none of these combinations were implausible a decision was made to leave all outlying cases in the analysis set. There was an improvement in the accuracy of the outcome prediction when compared to the model without case characteristics, the area under the ROC curve of 0.75 being in the adequate discrimination range (Annex F). The slightly better discrimination is visible in the scatterplot and histogram of the predicted probabilities (Annex F). The regression diagnostics analysis of the residuals used to investigate the poor goodness of fit are shown in Annex G.

## Age

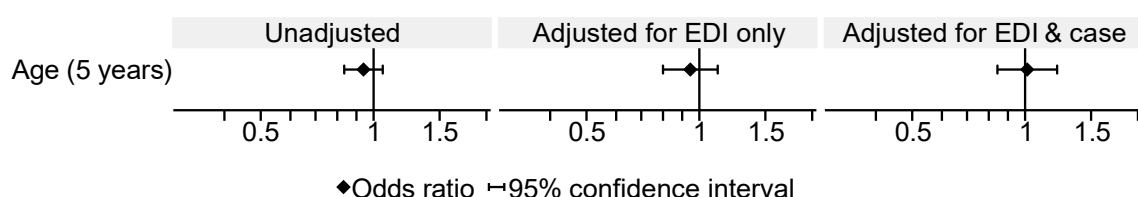
There was very little difference in the median ages in years of the registrants at the time the hearing started between those that did and didn't receive a sanction (Table 2).

Age was modelled as the effect of a five-year increase in age to make the results easier to interpret. Age was not statistically significant in any of the models (Figure 2 & Annexes A, B and E).

**Table 2: Descriptive statistics: age (years)**

Hearing outcome	n	Mean	SD	Median	IQR	Min	Max
No sanction	52	44.8	14.0	42	33 to 56	25	77
Sanction	112	42.5	13.7	41.5	32 to 50	22	76
Total	164	43.2	13.8	42	32 to 51	22	77

**Figure 2: Odds ratios: age (five years)**



## Gender

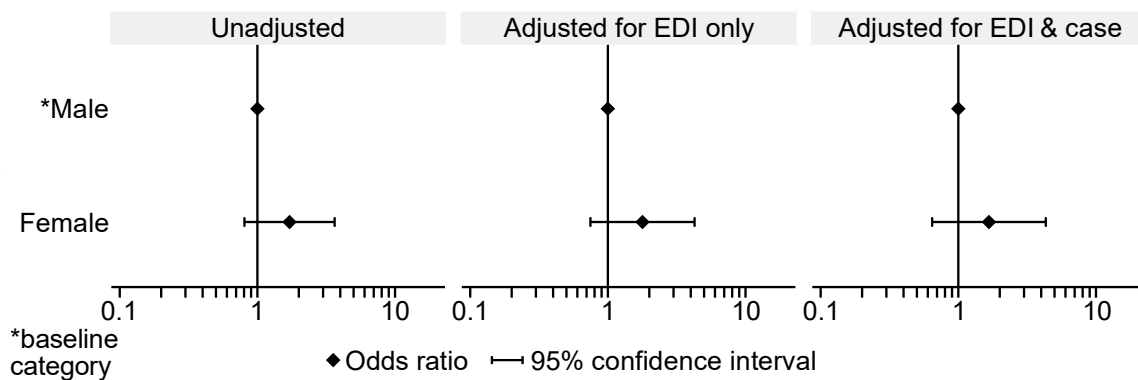
The hearings were split just under 70:30 males to females. Female registrants had a higher percentage of hearing resulting in a sanction (Table 3) though this was not statistically significant in the unadjusted, adjusted for EDI only, or adjusted for EDI and case characteristic analyses (Figure 3 & Annexes A, B and E).

While not statistically significant, it is noted that there was a 67% increase (OR 1.67, 95% CI 0.65 to 4.32,  $p = 0.29$ ) in the likelihood of a hearing resulting in a sanction for registrants who were female, compared to the baseline category of male, after adjusting for EDI and case characteristics.

**Table 3: Descriptive statistics: gender**

Gender	All cases		Hearing outcome			
	n	%	No sanction		Sanction	
	n	%	n	%	n	%
Male	114	69.5	40	35.1	74	64.9
Female	50	30.5	12	24.0	38	76.0
Total	164	100.0	52	31.7	112	68.3

**Figure 3: Odds ratios: gender**



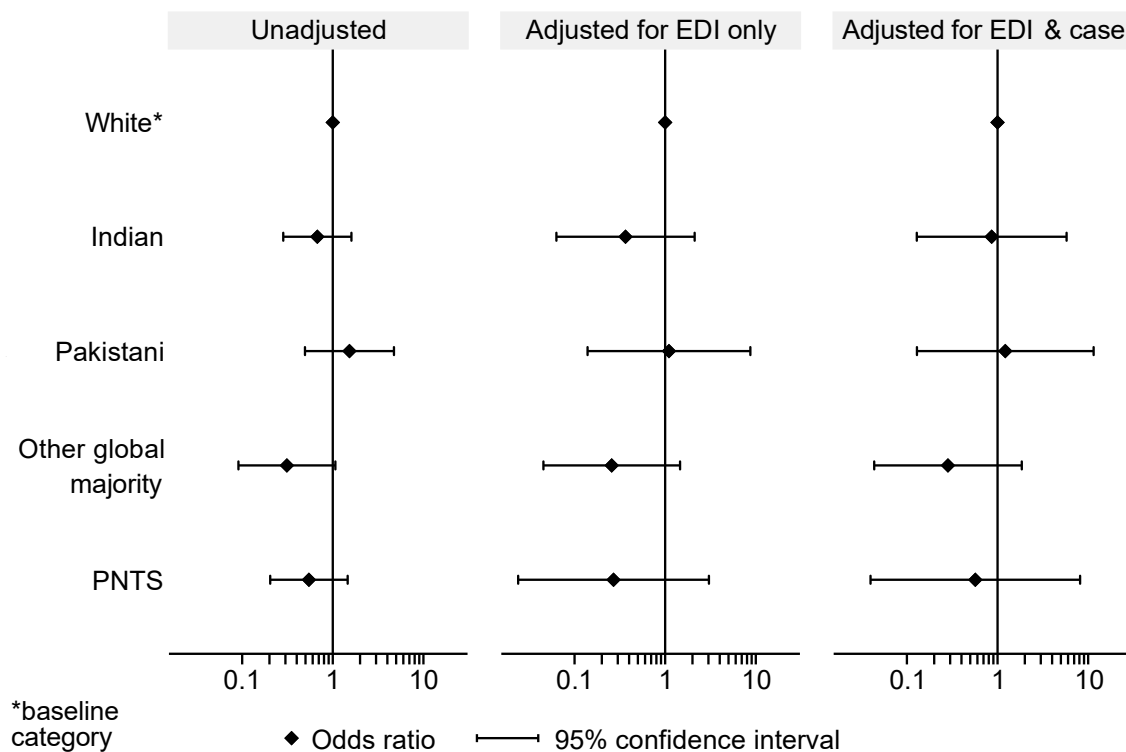
### Ethnicity

Three quarters of the hearings were for one of white, Indian or Pakistani ethnicities (Table 4). While there was some degree of variation between the ethnicities in terms of the percent of hearings resulting in a sanction, caution is urged due to the small numbers involved and no ethnicity was statistically significant in any of the logistic regression analyses (Figure 4 & Annexes A, B and E).

**Table 4: Descriptive statistics: ethnicity**

Ethnicity	All cases		Hearing outcome			
	n	%	No sanction		Sanction	
	n	%	n	%	n	%
White	60	36.6	16	26.7	44	73.3
Indian	40	24.4	14	35.0	26	65.0
Pakistani	26	15.9	5	19.2	21	80.8
Other global majority	13	7.9	7	53.8	6	46.2
PNTS	25	15.2	10	40.0	15	60.0
Total	164	100.0	52	31.7	112	68.3

**Figure 4: Odds ratios: ethnicity**



## Disability

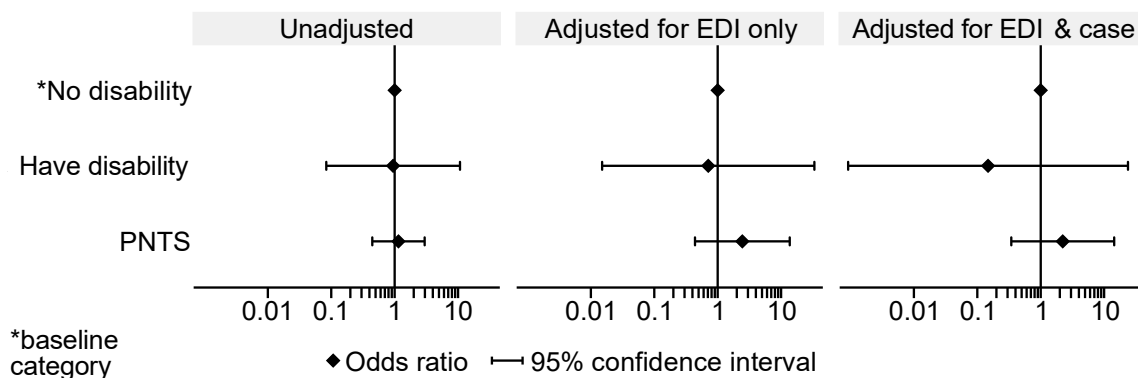
Eight times as many registrants answered prefer not to say to this question as answered yes (Table 5). There was very little difference between the groups in terms of the unadjusted percentages of hearings resulting in a sanction.

There were no statistically significant effects in any of the logistic regression models (Figure 5 & Annexes A, B and E). However it is noted that the odds ratio for registrants answering prefer not to say to this question were higher after adjusting for EDI and case characteristics than before adjustment (OR 2.23, 95% CI 0.34 to 14.4,  $p = 0.40$ ).

**Table 5: Descriptive statistics: disability**

Disability	All cases		Hearing outcome			
	n	%	No sanction		Sanction	
			n	%	n	%
No	137	83.5	44	32.1	93	67.9
Yes	3	1.8	1	33.3	2	66.7
PNTS	24	14.6	7	29.2	17	70.8
Total	164	100.0	52	31.7	112	68.3

**Figure 5: Odds ratios: disability**



The one statistically significant intersectionality occurred between disability and religion with the interaction term for non-disabled Hindu registrants indicating a lower chance of a case being opened (OR 7.62, 95% CI 1.06 to 54.6,  $p = 0.04$ ). Only 16 registrants had this combination of characteristics, the confidence interval was extremely wide, and the effect disappeared when the case characteristics were also adjusted for.

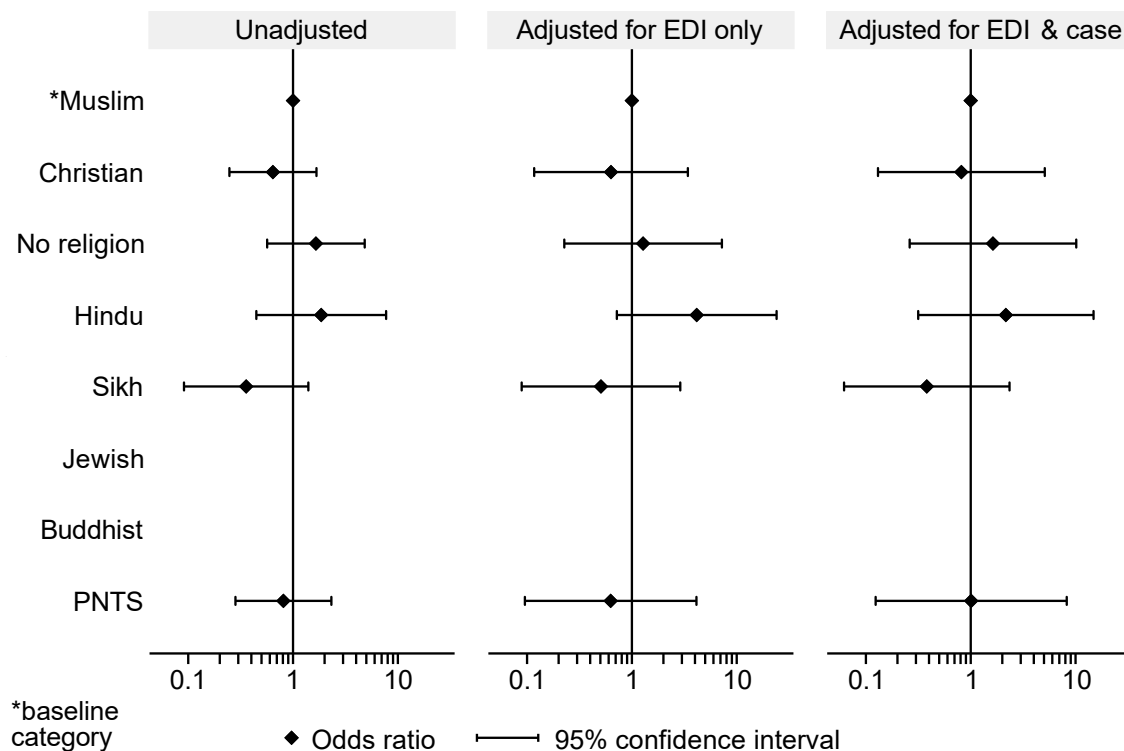
## Religion

Three quarters of the concerns received were for one of Muslim, Christian, no religion, or Hindu religion (Table 6). While there was some degree of variation between the religions in terms of the percent of hearings resulting in a sanction, caution is urged due to the small numbers involved and no religion was statistically significant in any of the logistic regression analyses (Figure 6 & Annexes A, B and E).

**Table 6: Descriptive statistics: religion**

Religion	All cases		Hearing outcome			
	n	%	No sanction		Sanction	
	n	%	n	%	n	%
Muslim	40	24.4	12	30	28	70.0
Christian	35	21.3	14	40	21	60.0
No religion	34	20.7	7	20.6	27	79.4
Hindu	16	9.8	3	18.8	13	81.3
Sikh	11	6.7	6	54.5	5	45.5
Jewish	1	0.6	1	100	0	0
Buddhist	1	0.6	0	0	1	100
PNTS	26	15.9	9	34.6	17	65.4
Total	164	100	52	31.7	112	68.3

**Figure 6: Odds ratios: religion**



### Sexual orientation

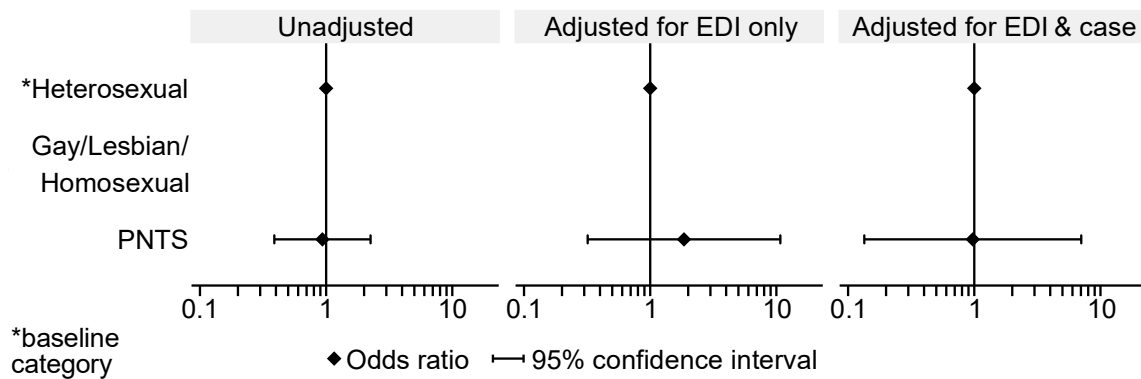
Only two hearings involved registrants who reported their sexual orientation as Gay/Lesbian/Homosexual, and in both instances a sanction was received (Table 7). Because all the outcomes were the same for this group it could not be included in the logistic regression models.

There were no statistically significant differences between the two groups that could be modelled, Prefer not to say and Heterosexual/straight (Figure 7 & Annexes A, B and E).

**Table 7: Descriptive statistics: sexual orientation**

Sexual orientation	All cases		Hearing outcome			
	n	%	No sanction		Sanction	
			n	%	n	%
Heterosexual/straight	135	82.3	43	31.9	92	68.1
Gay/Lesbian/Homosexual	2	1.2	0	0	2	100
PNTS	27	16.5	9	33.3	18	66.7
Total	164	100	52	31.7	112	68.3

**Figure 7: Odds ratios: sexual orientation**



### Pregnancy & maternity

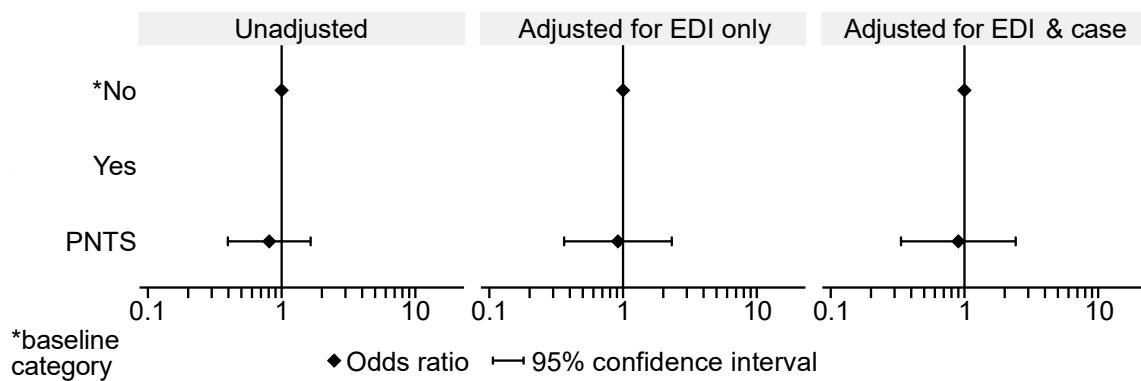
This question had the highest level of prefer not to say, with almost one in three registrants in hearings choosing that response (Table 8). Only two hearings involved registrants who reported their pregnancy and maternity status as yes, and in both instances a sanction was received. Because all the outcomes were the same for this group it could not be included in the logistic regression models.

There were no statistically significant differences between the two groups that could modelled, Prefer not to say and no (Figure 8 & Annexes A, B and E).

**Table 8: Descriptive statistics: pregnancy & maternity**

Pregnancy & maternity	All cases		Hearing outcome			
	n	%	No sanction		Sanction	
	n	%	n	%	n	%
No	114	69.5	35	30.7	79	69.3
Yes	2	1.2	0	0	2	100
PNTS	48	29.3	17	35.4	31	64.6
Total	164	100	52	31.7	112	68.3

**Figure 8: Odds ratios: pregnancy & maternity**



### Marital status

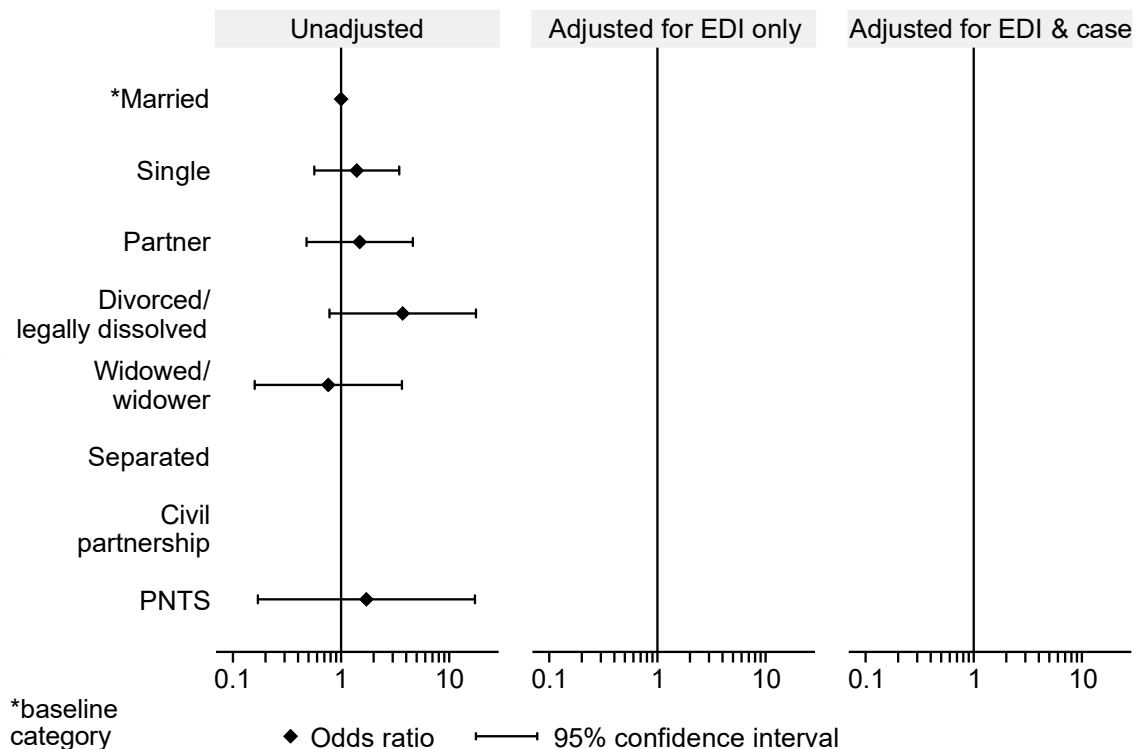
Due to the high levels of missing data, marital status was only included in the univariate analysis. Almost three quarters of registrants in hearings were in one of the top three categories (married, single, partner) and as a result there were some small counts and wide confidence intervals for some of the other categories (Table 9). Civil partnership had to be excluded from the model as there was only one such registrant in a hearing.

There were no statistically significant differences between the two groups that could be modelled, Prefer not to say and no (Figure 9 & Annexes A, B and E).

**Table 9: Descriptive statistics: marital status**

Marital status	All cases		Hearing outcome			
	n	%	No sanction		Sanction	
			n	%	n	%
Married	75	45.7	28	37.3	47	62.7
Single	30	18.3	8	26.7	22	73.3
Partner	18	11.0	5	27.8	13	72.2
Divorced/legally dissolved	15	9.1	2	13.3	13	86.7
Widowed/widower	7	4.3	3	42.9	4	57.1
Separated	0	0	-	-	-	-
Civil partnership	1	0.6	0	0	1	100
PNTS	4	2.4	1	25.0	3	75.0
Missing	14	8.5	5	35.7	9	64.3
Total	164	100	52	31.7	112	68.3

**Figure 9: Odds ratios: marital status**



### Professional group

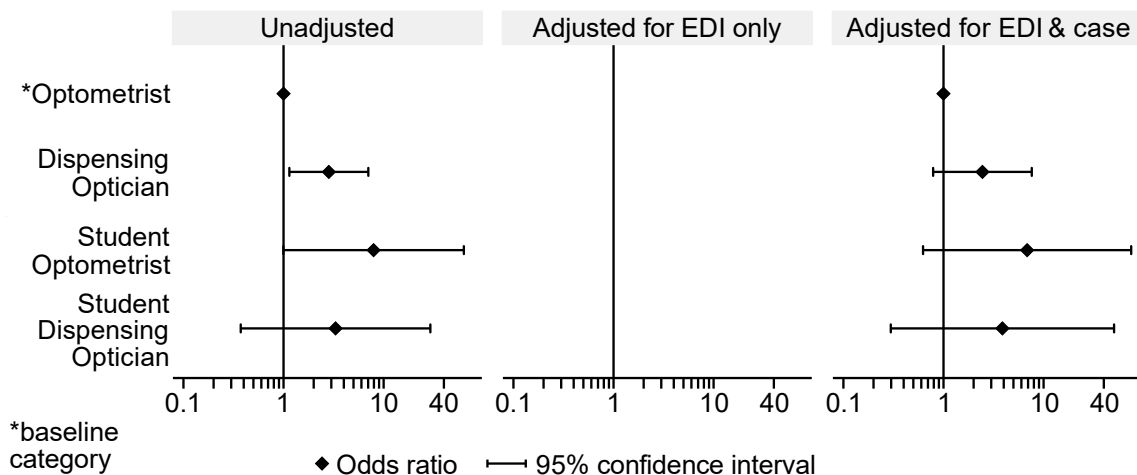
Case characteristics were evaluated univariately and with all EDI and case characteristic variables. Two third of hearings were for Optometrists, and as a result there were some small counts for some of the other categories (Table 10).

The univariate analysis suggested an 184% increase (OR 2.84, 95% CI 1.14 to 7.03,  $p=0.03$ ) in the likelihood of a sanction for hearings involving a Dispensing Optician and a 794% increase (OR 7.94, 95% CI 1.00 to 63.3,  $p=0.05$ ) in the likelihood of a sanction for hearings involving a Student Optometrist compared to the baseline profession Optometrist(Figure 10 & Annexes A and E). After adjusting for EDI and other case characteristics both of these remained much higher than the baseline profession but neither were statistically significant. The very large confidence intervals for all bar the baseline group indicate the degree of uncertainty caused by the small numbers.

**Table 10: Descriptive statistics: professional group**

Profession	All cases		Hearing outcome			
	n	%	No sanction		Sanction	
			n	%	n	%
Optometrist	108	65.9	43	39.8	65	60.2
Dispensing Optician	37	22.6	7	18.9	30	81.1
Student Optometrist	13	7.9	1	7.7	12	92.3
Student Dispensing Optician	6	3.7	1	16.7	5	83.3
Total	164	100	52	31.7	112	68.3

**Figure 10: Odds ratios: professional group**



### Allegation group

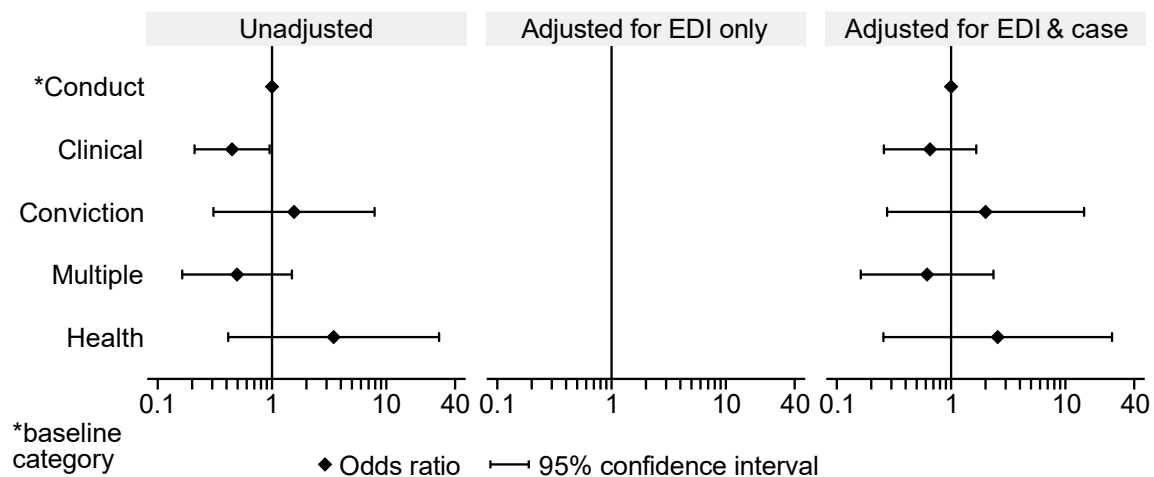
Almost three quarters of concern were one of the top two categories: conduct, and clinical with small counts in the other categories (Table 11).

The univariate analysis suggested a 55% decrease (OR 0.45, 95% CI 0.21 to 0.95, p 0.4) in the likelihood of a hearing resulting in a sanction for clinical cases when compared to the baseline category of conduct (Figure 11 & Annexes A and E). Adjusting for EDI and other case characteristics this difference reduced slightly and was no longer statistically significant.

**Table 11: Descriptive statistics: allegation group**

Allegation group	All cases		Hearing outcome			
	n	%	No sanction		Sanction	
			N	%	n	%
Conduct	70	42.7	18	25.7	52	74.3
Clinical	55	33.5	24	43.6	31	56.4
Conviction	11	6.7	2	18.2	9	81.8
Multiple	17	10.4	7	41.2	10	58.8
Health	11	6.7	1	9.1	10	90.9
Total	164	100	52	31.7	112	68.3

**Figure 11: Odds ratios: allegation group**



## Discussion

These analyses highlight an important analytical issue. Effects seen in univariate analysis often change once other variables are adjusted for.

With regards to the research question, the results of this analysis suggest:

- 1) There was no statistical evidence of disproportionality in GOC FTP hearing outcomes with regards to the protected characteristics of the registrants involved in that process, after adjusting for all EDI variables and all supplied case characteristics.
- 2) There was very little evidence of intersectionality between the variables analysed with interaction terms, and no evidence once case characteristics were adjusted for.
- 3) Overall, EDI characteristics are very poor predictors of hearing outcomes whereas case characteristics improve prediction of hearing outcome. This makes it essential to adjust for case characteristics when considering effects of EDI characteristics.

The absence of any statistically significant effects here is not entirely at odds with the findings of other UK regulators. There is no compelling evidence from them of any particular effect or of any effects sustained over time. The small numbers involved here and likely elsewhere will contribute to the difficulties in establishing the meaning of any observed effect in terms of statistical significance.

The impact of adjusting for case characteristics raises an important consideration for the validity of these results. It is almost certain that there were other case characteristics that would have strong predictive power, possibly including referral source, registrant engagement with the process, legal representation, and registration route (UK or international). To be certain of the effect/non-effect of EDI variables it would be prudent to model hearing outcomes in the presence of all plausible case characteristic variables.

Although the focus has been on statistically significant effects, there are some possibly interesting patterns in the non-significant results. The higher sanction rate for females could be the sign of some bias or could be the side effect of an excess of undue cases for males going forward to hearings. The higher sanction rates in some professional groups may be caused by known or expected factors. Further and more detailed in-

house assessment of those cases would be needed to try to understand the reasons for those and any other effects.

Whilst the dataset used for these analyses represented the total relevant case load over a five-year period, it was not huge and some of the categories within some of the characteristics had very small counts. This in turn led to some uncertainty in the analyses, apparent in the sometimes wide confidence intervals. If there has been no substantive change in the hearing procedures, it would be prudent to repeat the exercise when more years of data are available.

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**Annex A: Univariate (unadjusted) logistic regression models outputs**

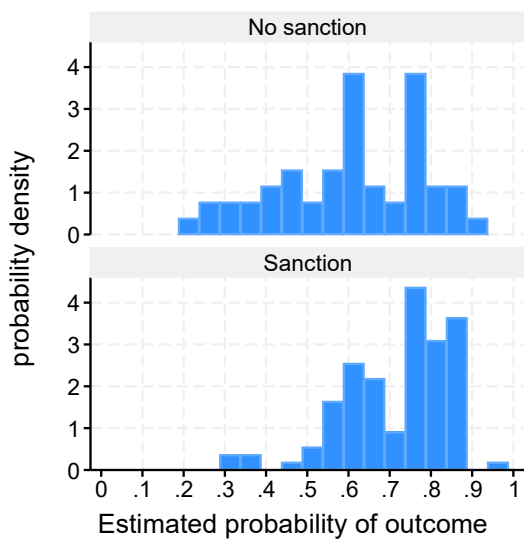
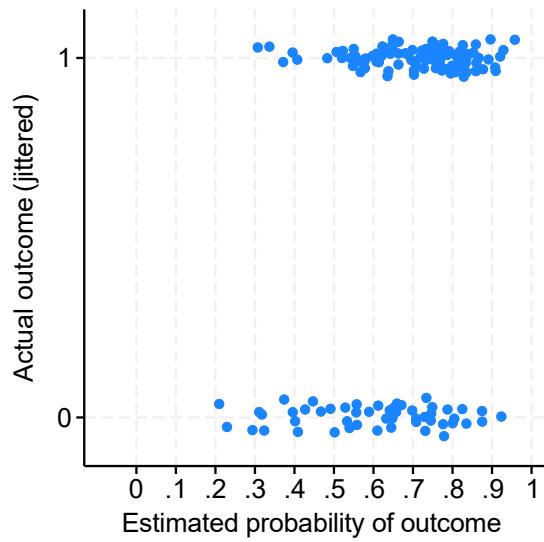
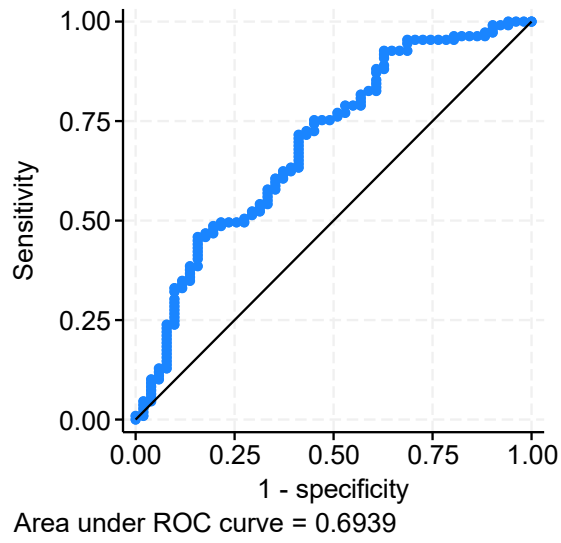
<b>Variable</b>	<b>Coefficient (<math>\beta</math>)</b>	<b>SE</b>	<b>Wald <math>\chi^2</math></b>	<b>p value</b>	<b>Odds Ratio</b>	<b>95% CI</b>
<b>Age (5 years)</b>	-0.062	0.060	-1.0	0.304	0.94	0.84 to 1.06
<b>Gender</b>						
*Male					1.00	
Female	0.537	0.385	1.4	0.163	1.71	0.80 to 3.64
<b>Disability</b>						
*No					1.00	
Yes	-0.055	1.238	0.0	0.964	0.95	0.08 to 10.7
PNTS	0.139	0.485	0.3	0.775	1.15	0.44 to 2.97
<b>Ethnicity</b>						
*White					1.00	
Indian	-0.393	0.442	-0.9	0.374	0.68	0.28 to 1.61
Pakistani	0.423	0.577	0.7	0.463	1.53	0.49 to 4.73
Other global majority	-1.166	0.628	-1.9	0.064	0.31	0.09 to 1.07
PNTS	-0.606	0.502	-1.2	0.227	0.55	0.20 to 1.46
<b>Religion</b>						
*Muslim					1.00	
Christian	-0.442	0.488	-0.9	0.365	0.64	0.25 to 1.67
No religion	0.503	0.547	0.9	0.358	1.65	0.57 to 4.83
Hindu	0.619	0.728	0.9	0.395	1.86	0.45 to 7.73
Sikh	-1.030	0.697	-1.5	0.140	0.36	0.09 to 1.40
Jewish	.	.	.	.	.	.
Buddhist	.	.	.	.	.	.
PNTS	-0.211	0.538	-0.4	0.694	0.81	0.28 to 2.32
<b>Sexual orientation</b>						
*Heterosexual					1.00	
Gay/Lesbian/ Homosexual	.	.	.	.	.	.
PNTS	-0.067	0.448	-0.2	0.880	0.93	0.39 to 2.25
<b>Pregnancy &amp; maternity</b>						
*No					1.00	
Yes	.	.	.	.	.	.
PNTS	-0.213	0.364	-0.6	0.558	0.81	0.40 to 1.65
<b>Marital status</b>						
*Married					1.00	
Single	0.334	0.461	0.7	0.469	1.40	0.57 to 3.45
Partner	0.396	0.577	0.7	0.493	1.49	0.48 to 4.60
Divorced/legally dissolved	1.312	0.796	1.6	0.099	3.71	0.78 to 17.7
Widowed/widower	-0.272	0.800	-0.3	0.734	0.76	0.16 to 3.65
Civil partnership	.	.	.	.	.	.
PNTS	0.539	1.179	0.5	0.647	1.71	0.17 to 17.3
<b>Profession</b>						
* Optometrist					1.00	
Dispensing Optician	1.042	0.463	2.2	0.025	2.84	1.14 to 7.03
Student Optometrist	2.072	1.059	2.0	0.050	7.94	1.00 to 63.3
Student Dispensing Optician	1.196	1.113	1.1	0.282	3.31	0.37 to 29.3

	Variable	Coefficient ( $\beta$ )	SE	Wald $\chi^2$	p value	Odds Ratio	95% CI
<b>Allegation group</b>							
	*Conduct					1.00	
	Clinical	-0.805	0.386	-2.1	0.037	0.45	0.21 to 0.95
	Conviction/caution	0.443	0.828	0.5	0.593	1.56	0.31 to 7.90
	Multiple	-0.704	0.564	-1.2	0.211	0.49	0.16 to 1.49
	Health	1.242	1.084	1.1	0.252	3.46	0.41 to 29.0

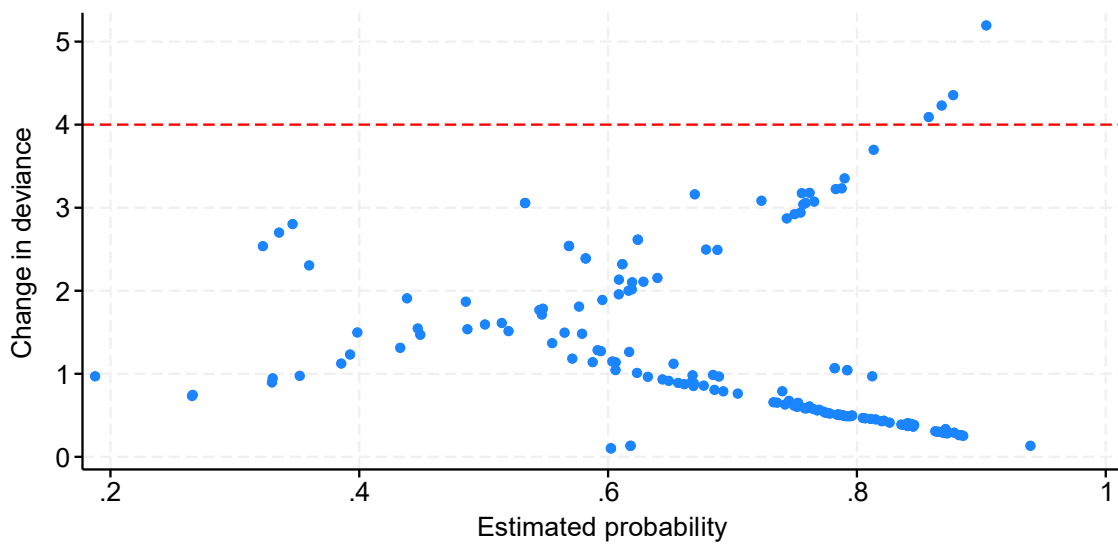
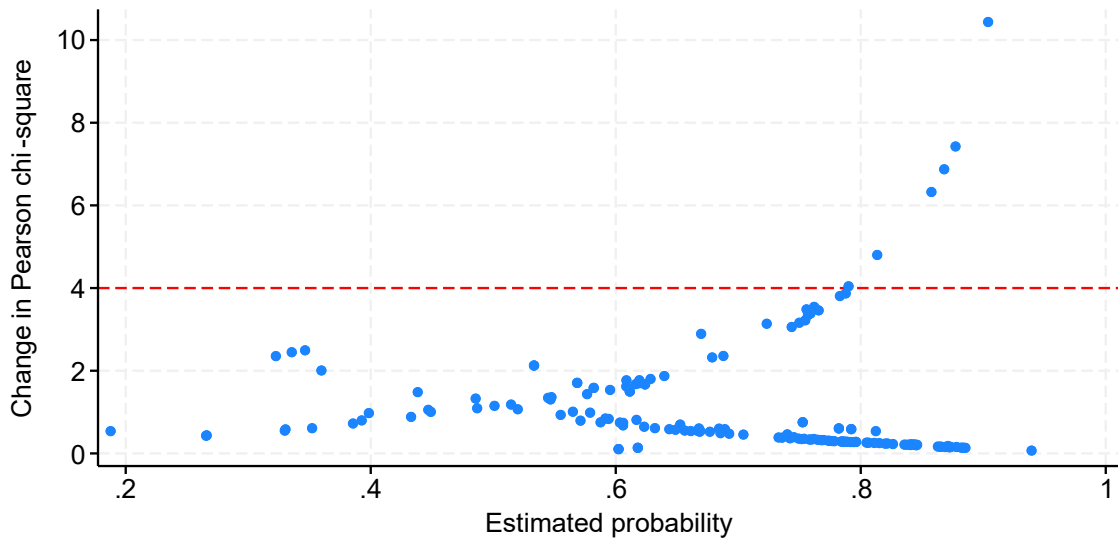
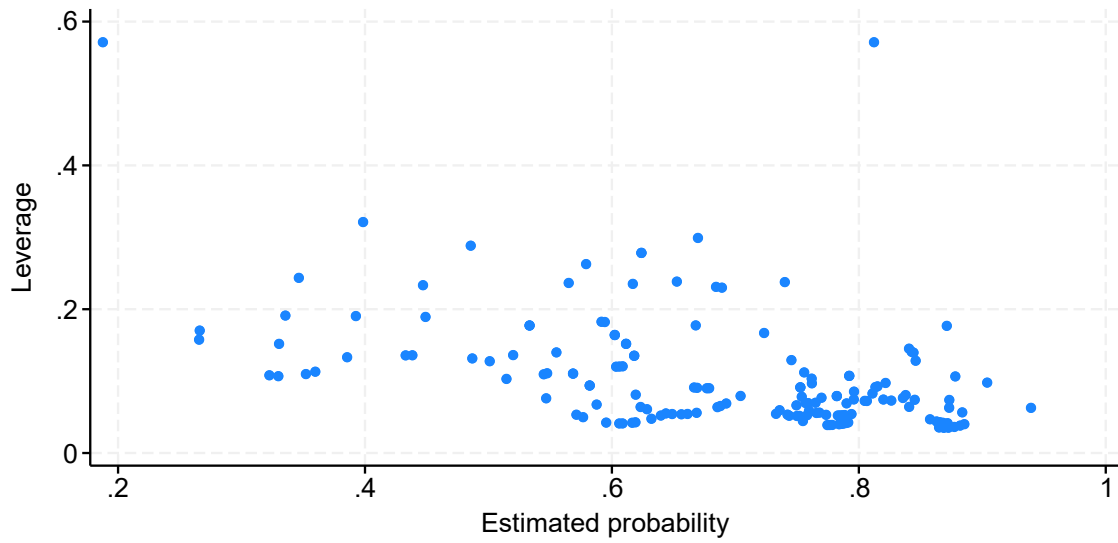
**Annex B: Multivariable (adjusted for EDI) logistic regression model output**

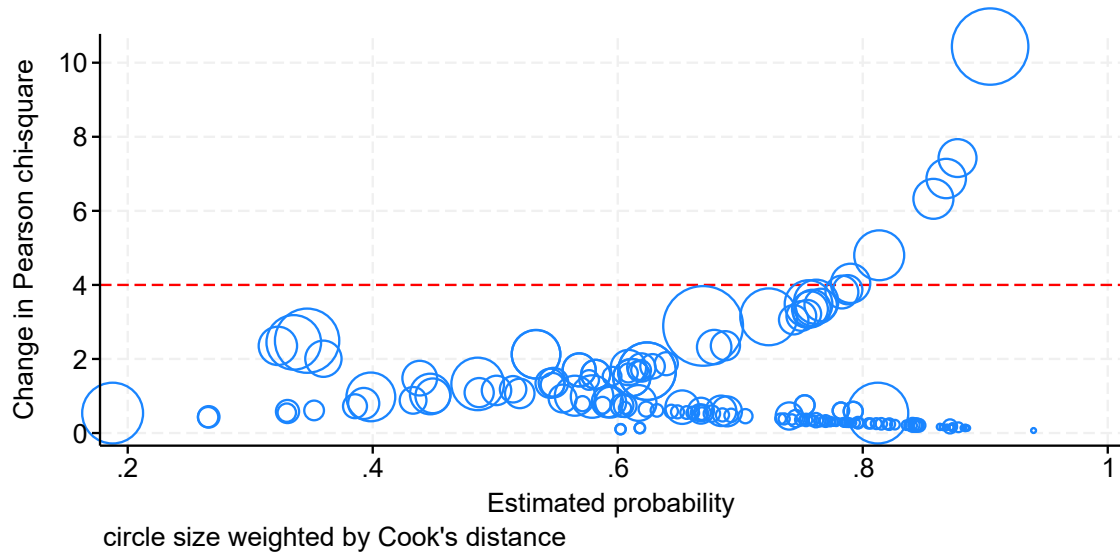
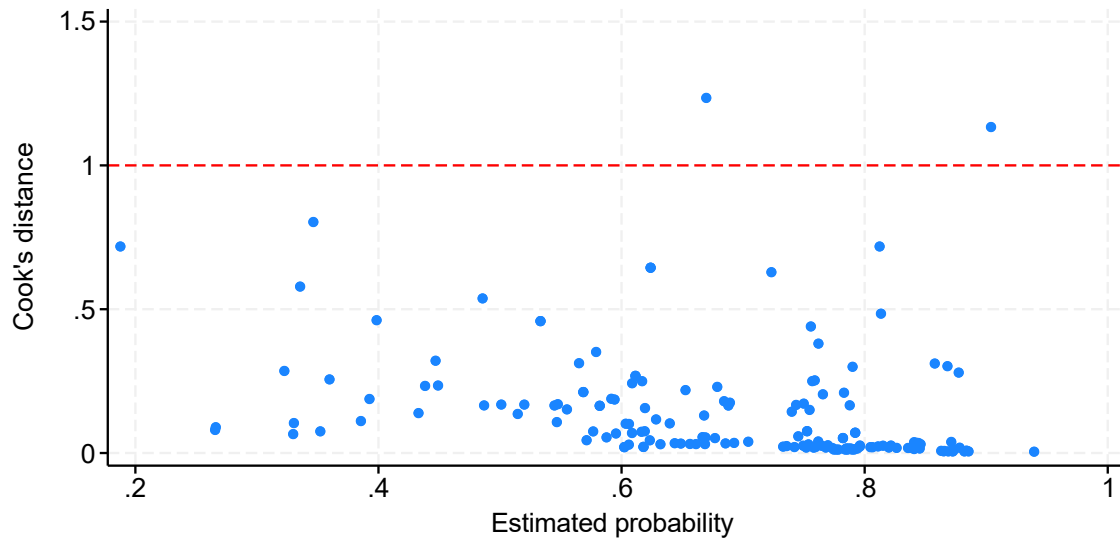
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<b>Age (5 years)</b>	-0.055	0.086	-0.6	0.520	0.95	0.80 to 1.12
<b>Gender</b>						
*Male					1.00	
Female	0.579	0.444	1.3	0.192	1.78	0.75 to 4.26
<b>Disability</b>						
*No					1.00	
Yes	-0.342	1.966	-0.2	0.862	0.71	0.02 to 33.5
PNTS	0.895	0.878	1.0	0.308	2.45	0.44 to 13.7
<b>Ethnicity</b>						
*White					1.00	
Indian	-1.007	0.896	-1.1	0.261	0.37	0.06 to 2.12
Pakistani	0.096	1.055	0.1	0.927	1.10	0.14 to 8.71
Other global majority	-1.357	0.886	-1.5	0.125	0.26	0.05 to 1.46
PNTS	-1.311	1.236	-1.1	0.289	0.27	0.02 to 3.04
<b>Religion</b>						
*Muslim	0.000	.	.	.	1.00	
Christian	-0.458	0.861	-0.5	0.595	0.63	0.12 to 3.42
No religion	0.246	0.883	0.3	0.781	1.28	0.23 to 7.22
Hindu	1.424	0.895	1.6	0.112	4.15	0.72 to 24.0
Sikh	-0.679	0.889	-0.8	0.445	0.51	0.09 to 2.90
Jewish	.	.	.	.	.	.
Buddhist	.	.	.	.	.	.
PNTS	-0.466	0.962	-0.5	0.628	0.63	0.10 to 4.13
<b>Sexual orientation</b>						
*Heterosexual	0.000	.	.	.	1.00	
Gay/Lesbian/ Homosexual	.	.	.	.	.	.
PNTS	0.617	0.897	0.7	0.492	1.85	0.32 to 10.8
<b>Pregnancy &amp; maternity</b>						
*No	0.000	.	.	.	1.00	
Yes	.	.	.	.	.	.
PNTS	-0.087	0.473	-0.2	0.854	0.92	0.36 to 2.32
<b>Constant</b>	1.496	1.272				

Annex C: Multivariable (adjusted for EDI) model goodness of fit



Annex D: Multivariable (adjusted for EDI) model regression diagnostics

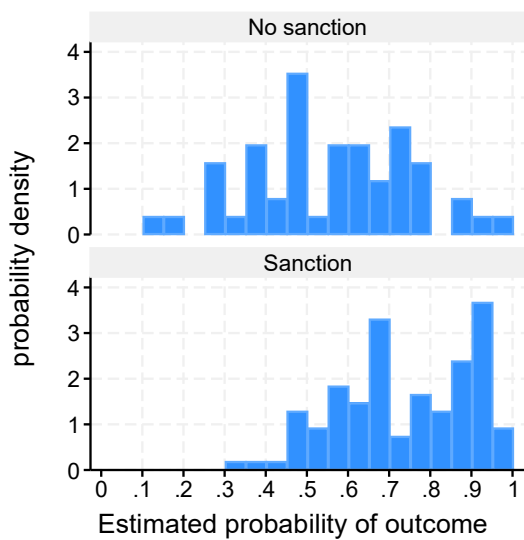
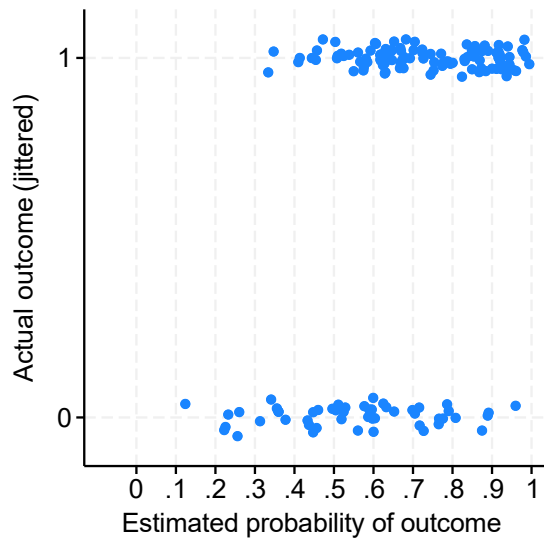
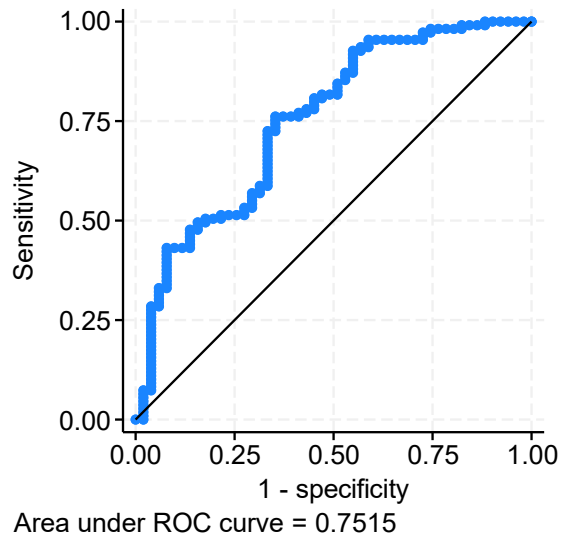




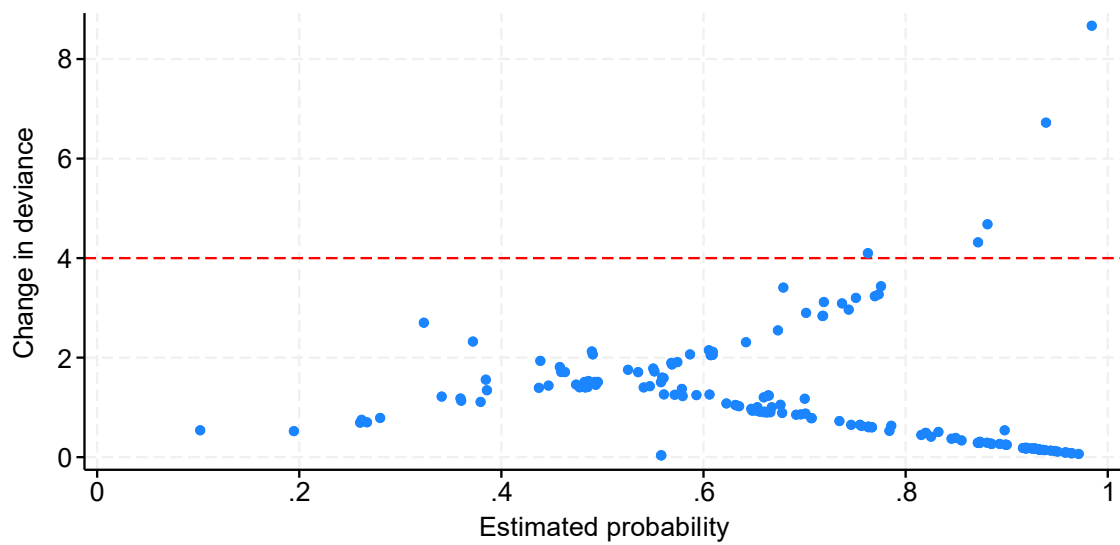
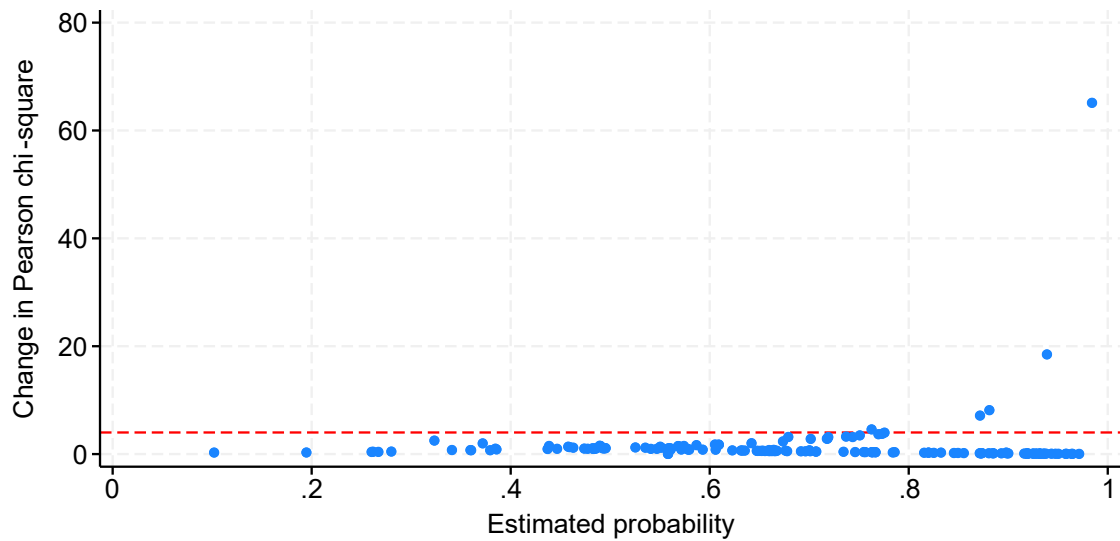
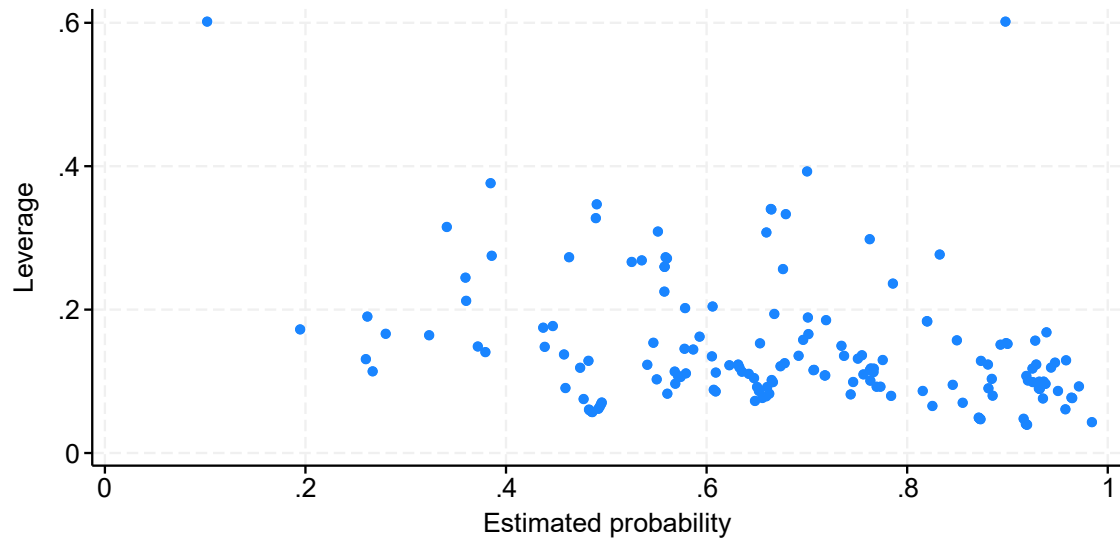
**Annex E: Multivariable (adjusted for EDI & case) logistic regression model output**

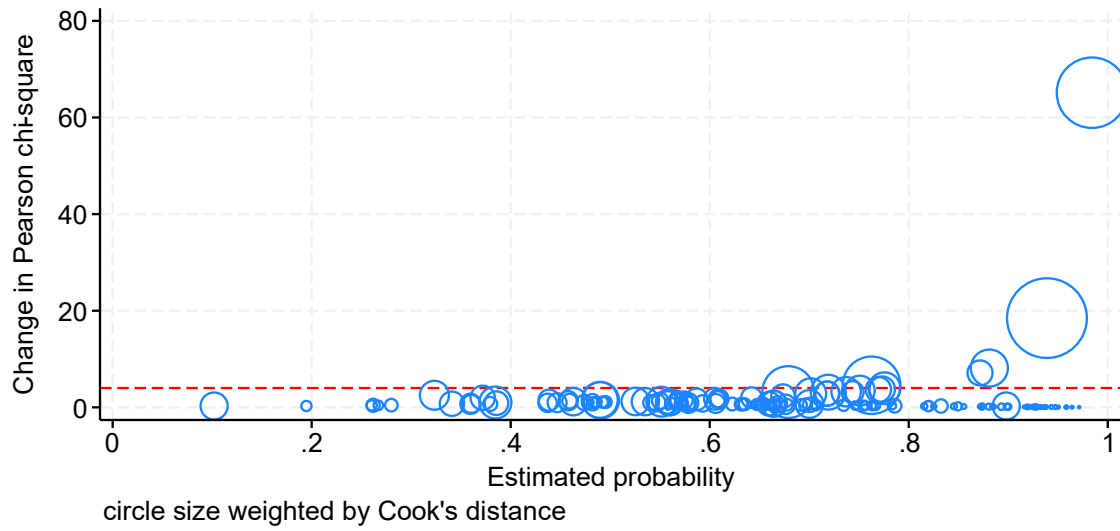
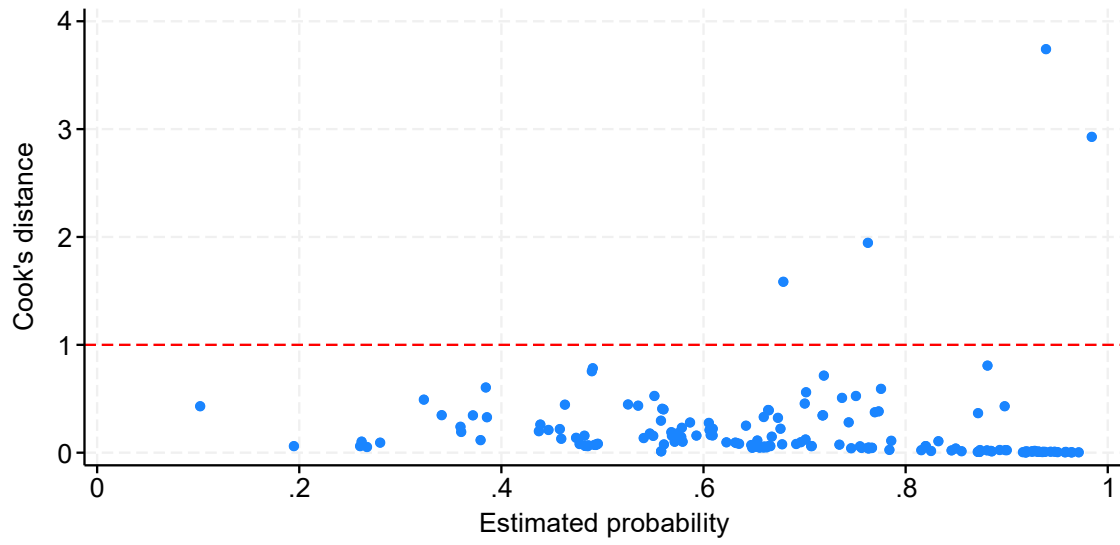
<b>Variable</b>	<b>Coefficient (β)</b>	<b>SE</b>	<b>Wald χ<sup>2</sup></b>	<b>p value</b>	<b>Odds Ratio</b>	<b>95% CI</b>
<b>Age (5 years)</b>	0.013	0.094	0.1	0.886	1.01	0.84 to 1.22
<b>Gender</b>						
*Male					1.00	
Female	0.512	0.485	1.1	0.291	1.67	0.65 to 4.32
<b>Disability</b>						
*No					1.00	
Yes	-1.912	2.593	-0.7	0.461	0.15	0.00 to 23.8
PNTS	0.800	0.953	0.8	0.401	2.23	0.34 to 14.4
<b>Ethnicity</b>						
*White					1.00	
Indian	-0.149	0.971	-0.2	0.878	0.86	0.13 to 5.78
Pakistani	0.197	1.145	0.2	0.863	1.22	0.13 to 11.5
Other global majority	-1.259	0.956	-1.3	0.188	0.28	0.04 to 1.85
PNTS	-0.564	1.358	-0.4	0.678	0.57	0.04 to 8.15
<b>Religion</b>						
*Muslim	0.000	.	.	.	1.00	
Christian	-0.206	0.935	-0.2	0.826	0.81	0.13 to 5.09
No religion	0.488	0.934	0.5	0.601	1.63	0.26 to 10.2
Hindu	0.772	0.983	0.8	0.432	2.16	0.32 to 14.9
Sikh	-0.965	0.927	-1.0	0.298	0.38	0.06 to 2.34
Jewish	0.000	.	.	.	.	.
Buddhist	0.000	.	.	.	.	.
PNTS	0.010	1.071	0.0	0.993	1.01	0.12 to 8.24
<b>Sexual orientation</b>						
*Heterosexual	0.000	.	.	.	1.00	
Gay/Lesbian/ Homosexual	0.000	.	.	.	.	.
PNTS	-0.027	1.010	0.0	0.978	0.97	0.13 to 7.05
<b>Pregnancy &amp; maternity</b>						
*No	0.000	.	.	.	1.00	
Yes	0.000	.	.	.	.	.
PNTS	-0.105	0.504	-0.2	0.835	0.90	0.34 to 2.42
<b>Profession</b>						
* Optometrist					1.00	
Dispensing Optician	0.896	0.579	1.5	0.121	2.45	0.79 to 7.62
Student Optometrist	1.924	1.222	1.6	0.115	6.85	0.62 to 75.1
Student Dispensing Optician	1.356	1.310	1.0	0.301	3.88	0.30 to 50.6
<b>Allegation group</b>						
*Conduct	0.000				1.00	
Clinical	-0.424	0.475	-0.9	0.372	0.65	0.26 to 1.66
Conviction/caution	0.695	1.013	0.7	0.493	2.00	0.28 to 14.6
Multiple	-0.484	0.682	-0.7	0.478	0.62	0.16 to 2.35
Health	0.939	1.175	0.8	0.424	2.56	0.26 to 25.6
<b>Constant</b>	0.427	1.394				

Annex F: Multivariable (adjusted for EDI & case) model goodness of fit



Annex G: Multivariable (adjusted for EDI & case) model regression diagnostics





# General Optical Council: Unfair Outcomes Research

Dr Gareth R Davies, Medistat Limited

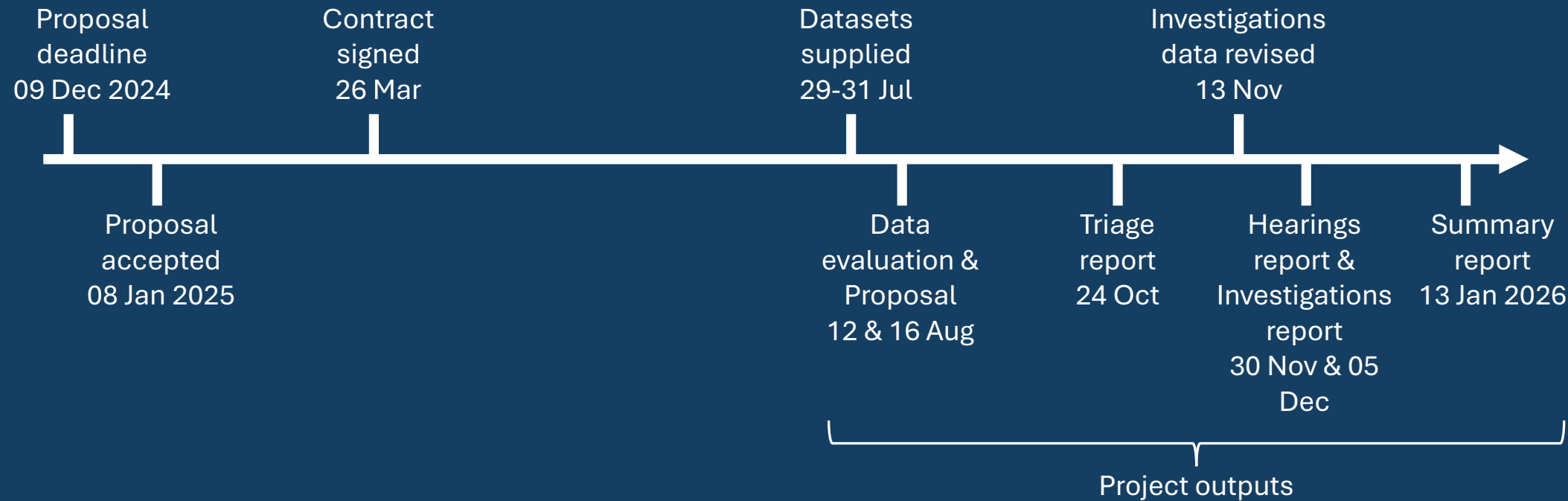
## Two questions

- 1) Would you expect disproportionality in healthcare regulators FTP outcomes?
- 2) Did you suspect disproportionality in GOC FTP outcomes?

# Background

## Unfair Outcomes Research Briefing

1. We are looking for a provider to undertake additional analysis of our data to understand if certain demographic groups are more likely to experience unfair differential outcomes in our fitness to practise process.



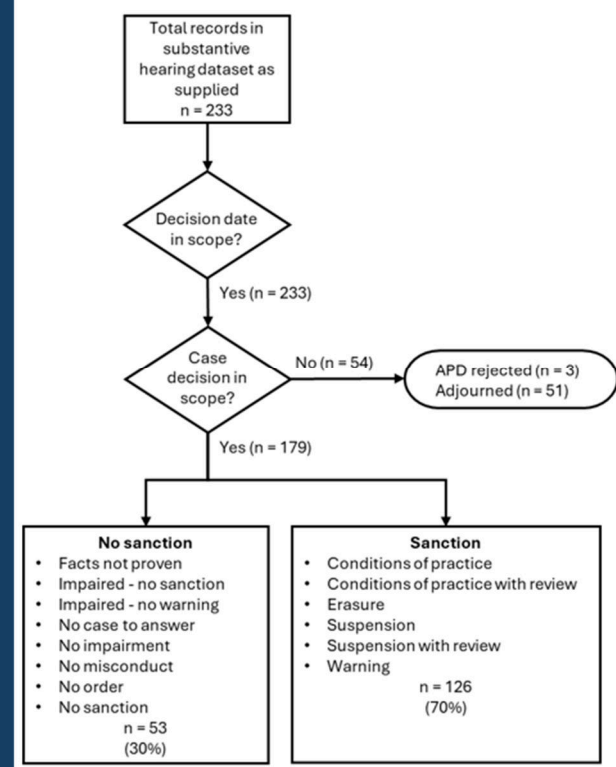
# Sample sizes (outcomes in 2020-24)

Triage outcomes	n	%
Open case	496	49
Triage closure	521	51
	<b>1,017</b>	

Investigations outcomes	n	%
No further action	201	42
No further action (advice)	32	7
Warning	71	15
Referred to the FTPC	179	37
	<b>483</b>	

Outcome	n	%
No sanction	53	30
Sanction	126	70
	<b>179</b>	

Figure 1: Data collection flow chart



# Variables

Variable type	Variable	Triage	Investigations	Hearings
<b>EDI: Continuous</b>	Age	✓	✓	✓
<b>EDI: Categorical</b>	Gender	✓	✓	✓
	Ethnicity	✓	✓	✓
	Disability	✓	✓	✓
	Religion	✓	✓	✓
	Sexual orientation	✓	✓	✓
	Pregnancy & maternity	✓	✓	✓
	Marital status*	✓	✓	✓
<b>Case: Categorical</b>	Interim order status	✓		
	Risk	✓		
	Allegation group	✓	✓	✓
	Professional group			✓

## Methods: Logistic regression

Logistic regression is a way of testing whether variables predict an outcome.

In the reports:

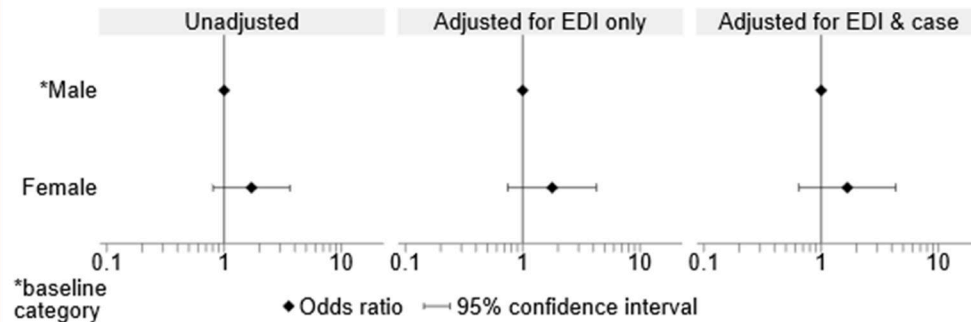
- each variable was tested on its own (univariate) and in the presence of other variables (multivariable).
- Intersectionality between selected characteristics was tested using interaction terms.

# Results: Odds ratio interpretation

Table 3: Descriptive statistics: gender

Gender	All cases		Hearing outcome			
	n	%	No sanction		Sanction	
			n	%	n	%
Male	114	69.5	40	35.1	74	64.9
Female	50	30.5	12	24.0	38	76.0
Total	164	100.0	52	31.7	112	68.3

Figure 3: Odds ratios: gender



OR > 1 means more likely to have the outcome than the baseline group.

Not statistically significant if the confidence interval crosses the vertical line.

Annex E: Multivariable (adjusted for EDI & case) logistic regression model output

Variable	Coefficient (β)	SE	Wald χ <sup>2</sup>	p value	Odds Ratio	95% CI
*Male					1.00	
Female	0.512	0.485	1.1	0.291	1.67	0.65 to 4.32

Table 2: Statistical analysis summary: Gender

Baseline comparison is to: Male	Triage			Investigations			Hearings					
	Case opened vs Closure			Advice/warning vs NFA			Referred to FTPC vs NFA			Sanction vs No sanction		
	Unadjusted	Adjusted		Unadjusted	Adjusted		Unadjusted	Adjusted		Unadjusted	Adjusted	
		EDI only	EDI & case		EDI only	EDI & case		EDI only	EDI & case		EDI only	EDI & case
Female												

## Key findings: EDI

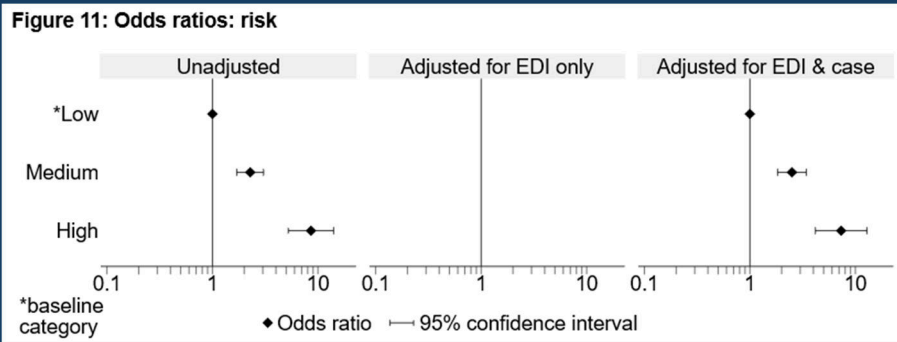
In the most important analyses (multivariable models adjusted for EDI and case characteristics) the only statistically significant effects were:

- Disability (Triage): Prefer not to say
  - OR 2.05 (1.14 to 3.70)
  - 64/128 = 50%
- Religion (Investigations referred to FTPC vs NFA): Prefer not to say
  - OR 3.58 (1.13 to 11.4)
  - 29/65 = 45%
- Interaction (intersectionality) between Prefer not to say for Religion or belief and No for Disability.

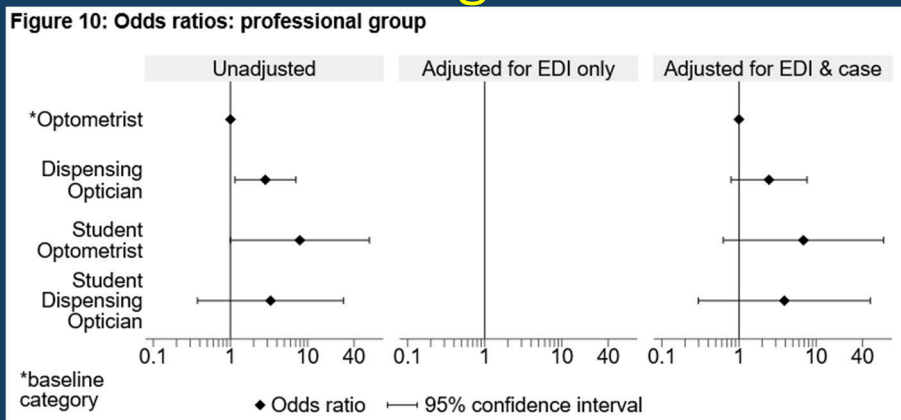
# Key findings: Case characteristics

Unlike EDI, case characteristics are very good predictors of outcomes.

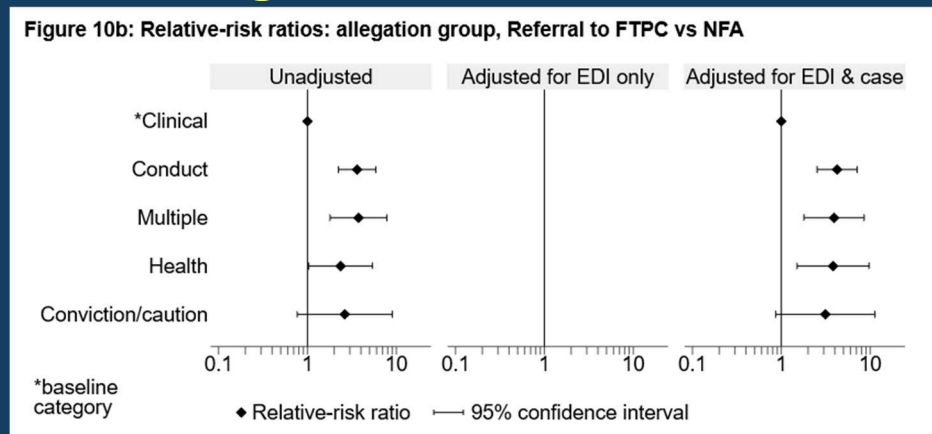
## At Triage



## Almost at hearings



## At Investigations



## Cautions

Sample sizes were small, and some counts within groups were so small they could not be analysed.

These results represent the current data set. They do not hold for previous or future cases.

Repeating these analyses in the future on more data will change the results, which could include identifying disproportionality, or ruling it out more strongly.

High levels of missing data or uninformative responses (prefer not to say) will have impacted on the utility of these analyses.

## Recommendations

- 1) Take some reassurance that based on these analyses, there is little meaningful evidence of disproportionality in GOC FTP outcomes to date.
- 2) Plan and implement a programme to improve EDI data quality and data completeness, including reducing the levels of uninformative (PNTS) responses.
- 3) Plan to repeat this type of analysis when at least two more years of data are available.
- 4) Determine and include a wider range of case characteristics in those future analyses to try to get as useful as possible model of FTP outcome factors.

# The end

For more information see:

Report 1: Triage outcomes

Report 2: Investigations outcomes

Report 3: Hearing outcomes

Report 4: Summary of findings

**Council**

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**Financial performance report for the year ending 31 March 2026**

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**Meeting:** 24 June 2026

**Status:** for noting

**Lead responsibility:** Marc Stoner  
(Director of Corporate Services)

**Paper author:** Manori Wickremasinghe  
(Chief Financial Officer)

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**Purpose**

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1. To provide a summary of the financial position for the year ending 31 March 2026. The detailed report will be presented to the Audit and Risk Committee at its meeting on 7 July 2026.

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**Recommendations**

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2. Council is asked to:
  - **note** the financial performance for the year ending 31 March 2026, as set out in annex one.

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**Strategic objective**

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3. This report is relevant to delivery of all our strategic objectives.

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**Background**

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4. The financial performance report to 31 March 2026 relates to year one of the corporate strategic plan and is consistent with delivery of that year's business plan.

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**Analysis**

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5. The financial performance report for the year ending 31 March 2026 is included at annex one. The report shows a business-as-usual surplus of £689k and an overall deficit of £184k before unrealised portfolio gains and losses. This position is favourable to both budget and the Q3 forecast, mainly due to higher income and lower business-as-usual expenditure, partly offset by higher project expenditure.
6. The KPI, at 6%, remains within the accepted +/-5% tolerance of the forecast target, but varies by 7% from the budgeted KPI. KPIs are balanced over a five-year horizon.
7. The final reported surplus was £61k lower than the Q3 forecast, mainly because unrealised investment gains were lower than forecast by year end.

## **PUBLIC**

This reflects market movement in the investment portfolio during quarter four, although market values recovered shortly after the year end.

8. Some business-as-usual expenditure has moved into 2026/27. Where this expenditure remains committed or is still expected to be required, it has been identified for release from the new deferred expenditure reserve, subject to the usual governance and budgetary controls.
9. The report also highlights the continuing challenge of forecasting expenditure in areas where activity levels are affected by external factors. Additional controls have been introduced to strengthen purchase order review and to identify required write-offs before quarterly forecasts are prepared.
10. Growth in the market value of the investment portfolio during the first three quarters contributed to strong unrealised investment gains. This supported the reported surplus and increased reserve levels. Market values reduced briefly during the fourth quarter but recovered shortly after the year end.
11. Overall, the report shows a stronger-than-budgeted year-end position, while also identifying areas where forecasting and expenditure controls will continue to be strengthened during 2026/27.
12. Further analysis is included in the report at annex one.

## **Finance**

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13. There are no additional financial implications of this work.

## **Risks**

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14. The following risks are associated with finance, as identified in the finance risk register:
  - We are unable to deliver our strategic plans, programme of change, and business as usual sufficiently quickly or effectively.
  - We fail to deliver value for money.
  - Capability and resilience: small teams and reliance on particular individuals may cause burnout, errors, or impacts on organisational delivery if those individuals are absent or leave the organisation.
15. Reporting and monitoring financial performance against budgets and forecasts are a fundamental part of managing and mitigating these risks.

## **Equality Impacts**

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16. No equality impact assessment has been undertaken.

## **Devolved nations**

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## **PUBLIC**

17. There are no implications for the devolved nations.

### **Communications**

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#### **External communications**

18. None planned.

#### **Internal communications**

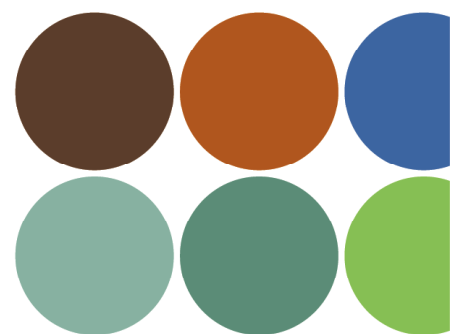
19. The financial report and forecast are shared with the Leadership Team and SMT as part of the regular financial reporting process.

### **Attachments**

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Annex one: Financial performance report for the year ending 31 March 2026.

# Financial Performance Report for the Year ending 31 March 2026



<b>Contents</b>	<b>Page</b>
Highlights	3
Key Performances	3-4
Risks and Future Impacts	4-5
Graphs and Tables	6-10
Income and Expenditure Accounts (Table A)	11-12
Income and Expenditure Accounts incl. Project Expenditure (Table B)	13
Multi Year Project spend analysis (quarterly reporting)	14
Balance Sheet	15
Fixed deposits	16

**C27(26)ii.**G O C :- Summary P & L to 31 March 2026

	Actual £000's	Budget £000's	Variance £000's	Q3 Forecast £000's	Variance £000's
Registrant Income	12,119	11,928	191	12,101	19
Other Income	484	343	141	406	76
Expenses - BAU	(11,914)	(12,414)	500	(12,216)	302
<b>Surplus / (Deficit) -BAU</b>	<b>689</b>	<b>(143)</b>	<b>832</b>	<b>291</b>	<b>397</b>
Project expenditure	(872)	(477)	(395)	(897)	25
Surplus / (Deficit) -before portfolio Gains/Losses	(184)	(620)	436	(606)	423
KPI to date +/-5%	6%	-1%	7%	2%	3%
Approved KPI for 2025-26		-0.11%		2.35%	
Approved KPI for five years 2025-30		1%		0.85%	

**Highlights**

The year-end position before unrealised portfolio gains and losses was a deficit of £184k. This was £436k favourable to budget and £423k favourable to the Q3 forecast. The improved position was mainly driven by higher income and lower business-as-usual expenditure, partly offset by higher project expenditure.

Business-as-usual performance before project expenditure was a surplus of £689k, compared with a budgeted deficit of £143k and a Q3 forecast surplus of £291k. Total income was £12.603m, which was £333k above budget and £96k above forecast. Total expenditure including projects was £12.786m, which was £104k favourable to budget and £327k favourable to forecast.

**Key drivers of the improved financial performance**

The KPI increased by 7% compared with budget and remains within the forecast tolerance of +/-5% (see table above). The overall variance against forecast was driven primarily by movements in business-as-usual (BAU) expenditure.

The main drivers of the favourable year-end position were higher interest income, lower BAU expenditure and the release of expenditure no longer required at year end. Bank and deposit interest was £119k above budget and £76k above forecast, reflecting the level of fixed deposits placed and the higher interest rate environment.

BAU expenditure was £500k favourable to budget and £302k favourable to forecast. This reflected a combination of genuine savings, reduced use of contingency provisions, lower than expected expenditure in some directorates, and a smaller level of delayed expenditure than in previous periods.

## **Financial Performance Report for the 12 months ending 31 March 2026**

Some expenditure has moved into 2026/27. Where the expenditure remains committed or is still expected to be required, it has been identified for release from the relevant reserve in the following year, subject to the normal governance and budgetary controls.

Project expenditure was £395k higher than budget but £25k favourable to forecast. This was mainly due to the timing of approved strategic and accommodation-related projects.

No new complex legal cases were identified during the period that met the agreed criteria. The staff vacancy rate was 4.1%, compared with a budget assumption of 4.0% ref. (table 5, page 11).

The financial impact was limited because a number of vacancies were covered by agency staff and because quarterly forecasts had already absorbed earlier vacancy savings.

The year-end review also identified purchase order and coding issues, including late closure of completed FTP case purchase orders. Additional controls have been introduced to strengthen monthly purchase order review and to identify required write-offs before quarterly forecasts are prepared.

Overall, the report shows a stronger than budgeted financial position at year end. The main points requiring correction before circulation are the numerical and cross-reference inconsistencies summarised below.

More details on variances are under tables 2-3, pages 9-10.

### **Future Impacts (So what?)**

A few delays, although small in value, will affect the next financial year. While some departments will be able to repurpose their 2026/27 budgets to absorb the impact, others may require additional expenditure. The use of the new reserve to carry forward certain BAU costs is expected to reduce the impact compared with previous years.

We have introduced two additional controls to mitigate the impact of aged purchase orders not being written off on a timely basis, particularly within Investigations. Firstly, Finance will provide a monthly open purchase order report to the Head of Investigations for review and agreement. Secondly, Finance will amend the timing of the quarterly purchase order exception report, which forms part of the contract exceptions report, to ensure that any required purchase order write-offs are identified before quarterly forecasts are prepared. This second control will apply to all departments.

We continue to work with IT to minimise forecast variances where practicable.

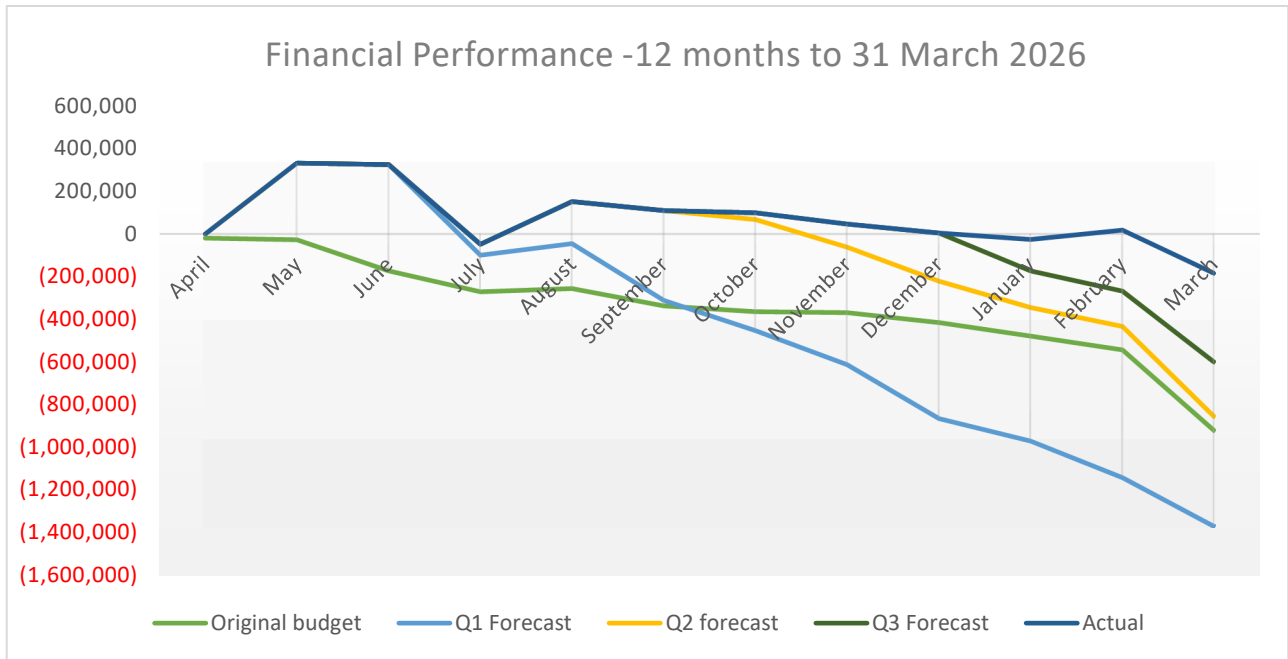
Work is underway to assess the application of the complex legal costs reserve to judicial review and appeal cases where GOC is liable for the insurance excess. If approved, this treatment is expected to reduce the variance in BAU expenditure.

The new workforce planning initiative is now at the approval stage and is ready to be incorporated into next year's budget. The new Performance and Behaviours Framework (PBF) is expected to support improved staff retention over time and will inform performance-related pay progression increases from 2026/27.

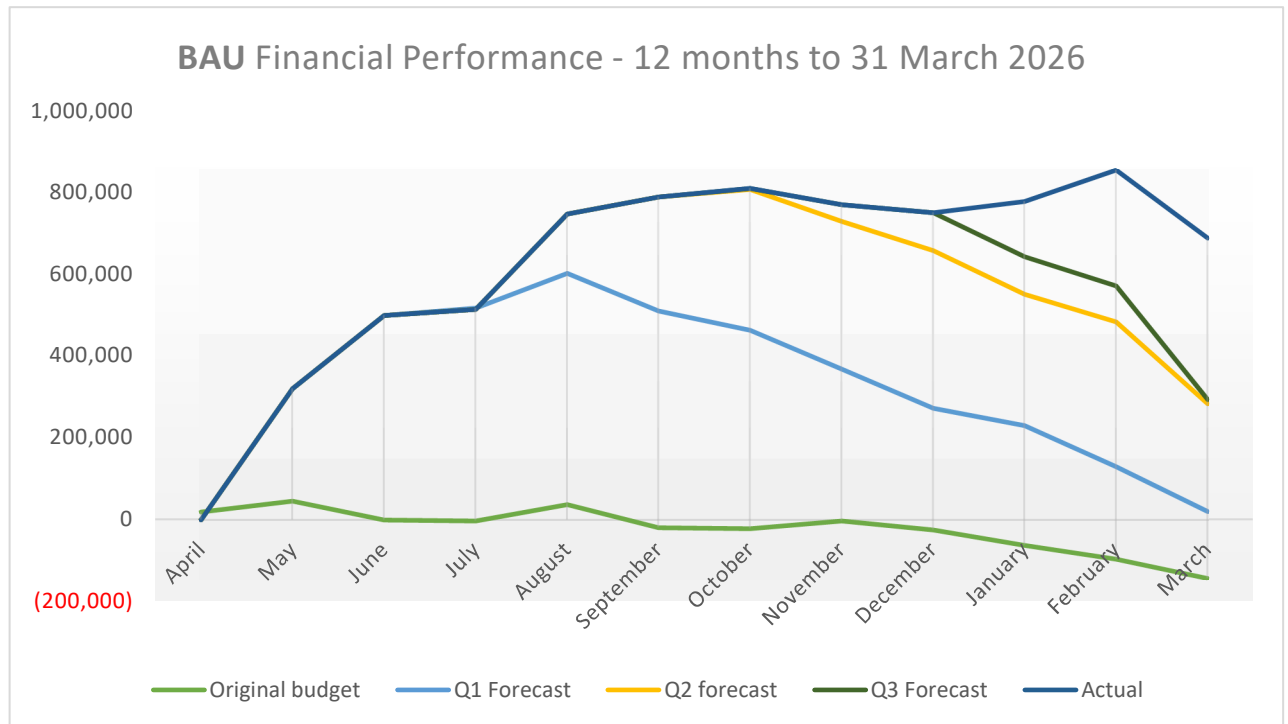
All new business cases with financial implications continue to be assessed for affordability before submission for SMT approval.

Fixed deposits funded from renewal income have now been placed as planned. The prevailing higher interest rate environment has resulted in interest income exceeding budget.

**Graphical analysis on Financial Performance and Variance**



Graph 1



Graph 2

### Analysis of Expenditure

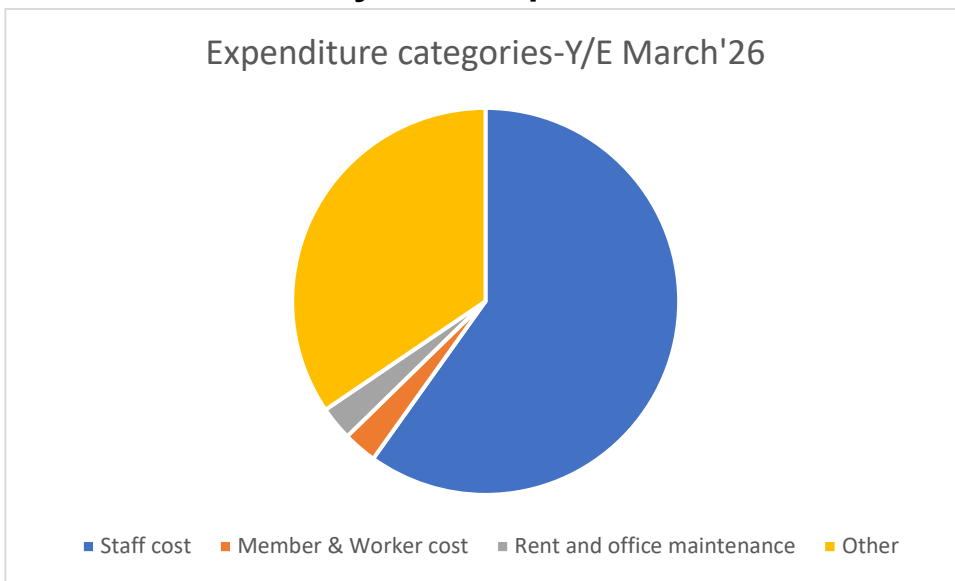


Chart 1

Chart 1 highlights the fixed cost against the variable (Other) costs.

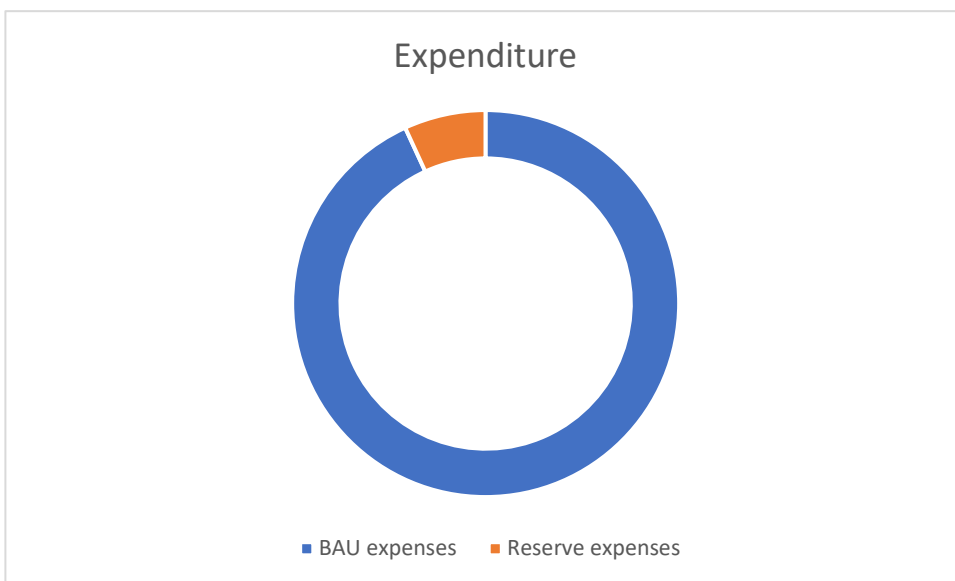
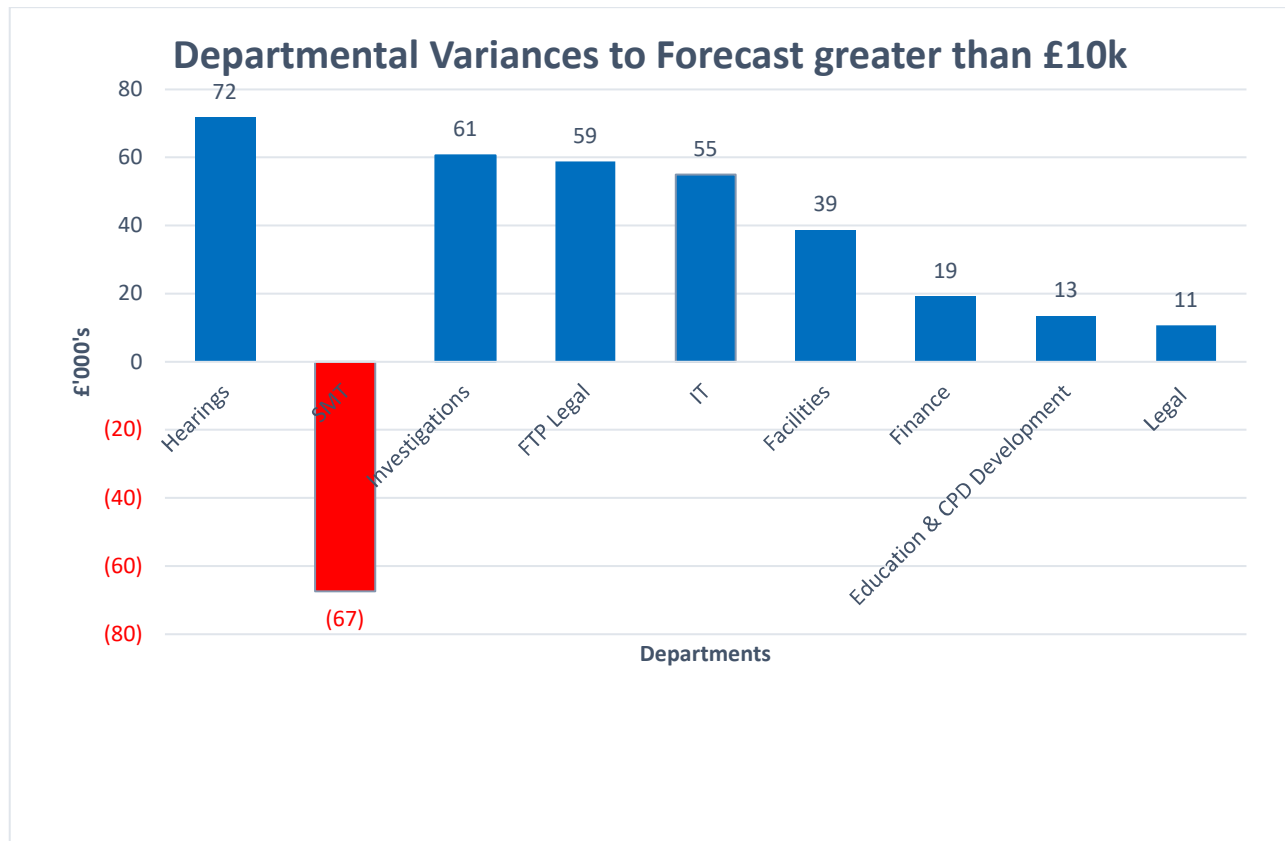


Chart 2



Graph 3

Cash and Cash Equivalent Summary - 31 March 2026

	Actual £'000	BUDGET £'000	Variance £'000	Q3 Forecast £'000	Variance £'000
Cash at Bank	884	497	387	413	471
Short term Investments	9,400	8,900	500	9,400	0
<b>Working Capital</b>	<b>10,284</b>	<b>9,397</b>	<b>887</b>	<b>9,813</b>	<b>471</b>
Investments	10,297	8,536	1,761	10,565	(268)
<b>Total</b>	<b>20,581</b>	<b>17,933</b>	<b>2,648</b>	<b>20,378</b>	<b>203</b>

Table 1

**C27(26)ii.**

<b>Analysis of BAU expense variance March</b>	
<b>Savings</b>	<b>£'000</b>
Savings	327
Delays to 2026/27	34
Accounting, PO, coding errors	40
Others	5
<b>Additional expenses</b>	<b>406</b>
Additions	(41)
Staff vacancy gaps (excluding efficiency measures)	(63)
<b>Total Expense Variance</b>	<b>302</b>

Table 2

Table 3

<b>Analysis of net savings over past quarter (BAU exp.)</b>	
Savings	Q4
	£'000
Savings	327
Staff vacancy gaps	(63)
Additions	(41)
<b>Net savings/(overspent) from forecast</b>	<b>223</b>

Last year trend	143
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Table 3

**C27(26)ii.**

**Headcount Mar 26 (non- FTE)**

	Actual FTC* Mar-26	Actual Perm. Mar-26	Actual Total Mar-26	Q3 Forecast Mar-26	Budget Mar-26
Governance & CEO's Office	1.0	8.0	<b>9.0</b>	9.0	9.0
Regulatory Strategy	2.0	24.0	<b>26.0</b>	28.0	26.0
Regulatory Operations	8.0	36.0	<b>44.0</b>	46.0	40.0
Corporate Services*	4.0	25.0	<b>29.0</b>	29.0	26.0
People & Improvement	6.0	6.0	<b>12.0</b>	12.0	10.0
<b>Total Headcount</b>	<b>21.0</b>	<b>99.0</b>	<b>120.0</b>	<b>124.0</b>	<b>111.0</b>

\* including Agency temp staff

Table 4

**Staff Vacancy rate - reasonability test compared to approved budget**

No. of staff vacancies during the period	16
Staff vacancy rate today	4.1%
Staff vacancy rate budgeted	4.0%
BAU NC 1000 budget annual budget	6,151
Impact if no future staff vacancies	3.6%

Table 5

**Table A**  
**Income and Expenditure Accounts**

	April - March			April - March		
	Actual £'000	Budget £'000	Variance £'000	Actual £'000	Forecast £'000	Variance £'000
<b>Income</b>						
Registration	12,119	11,928	192	12,119	12,101	18
Dividend Income	249	234	15	249	255	(7)
Bank & Deposit Interest	217	98	119	217	141	76
Other Income	18	11	7	18	10	9
<b>Total Income</b>	<b>12,603</b>	<b>12,270</b>	<b>333</b>	<b>12,603</b>	<b>12,507</b>	<b>96</b>
<b>Expenditure</b>						
<b>Governance &amp; CEO's Office</b>						
CEO's Office	261	87	(174)	261	188	(73)
Governance & Member Fees	739	739	1	739	745	6
<b>Total Governance &amp; CEO's Office</b>	<b>1,000</b>	<b>827</b>	<b>(173)</b>	<b>1,000</b>	<b>933</b>	<b>(67)</b>
<b>Regulatory Strategy</b>						
Director of Regulatory Strategy	168	245	77	168	168	1
Policy	388	426	38	388	395	8
Communications	340	365	25	340	343	3
Education & CPD Operations	601	710	110	601	609	8
Education & CPD Development	446	527	81	446	460	13
<b>Total Regulatory Strategy</b>	<b>1,942</b>	<b>2,273</b>	<b>331</b>	<b>1,942</b>	<b>1,975</b>	<b>33</b>
<b>Regulatory Operations</b>						
Director of Regulatory Operations	176	180	4	176	177	1
Investigation	1,319	1,334	15	1,319	1,380	61
Case Progression	1,043	1,030	(13)	1,043	1,051	8
FTP Legal	252	292	40	252	311	59
Legal	243	256	13	243	253	11
Hearings	1,468	1,389	(79)	1,468	1,540	72
<b>Total Regulatory Operations</b>	<b>4,502</b>	<b>4,481</b>	<b>(20)</b>	<b>4,502</b>	<b>4,713</b>	<b>211</b>
<b>Corporate Services</b>						
Director of Corporate Services	127	169	43	127	128	1
Facilities	694	757	64	694	732	39
Finance	601	653	52	601	620	19
Registration	743	758	14	743	750	7
IT	1,178	1,279	101	1,178	1,233	55
<b>Total Corporate Services</b>	<b>3,342</b>	<b>3,615</b>	<b>273</b>	<b>3,342</b>	<b>3,463</b>	<b>121</b>

**Table A (Contd.)**

	April - March			April - March		
	Actual £'000	Budget £'000	Variance £'000	Actual £'000	Forecast £'000	Variance £'000
<b>People &amp; Improvement</b>						
Director of P&I	159	169	10	159	163	3
Project Delivery & Continual Improvement	197	237	40	197	203	6
People & Culture	698	748	50	698	695	(3)
	<b>1,054</b>	<b>1,155</b>	<b>101</b>	<b>1,054</b>	<b>1,060</b>	<b>6</b>
Depreciation	75	63	(12)	75	72	(2)
<b>Total Expenditure</b>	<b>11,914</b>	<b>12,414</b>	<b>499</b>	<b>11,914</b>	<b>12,216</b>	<b>302</b>
<b>Surplus / (Deficit) before project expenditure</b>	<b>688</b>	<b>(143)</b>	<b>832</b>	<b>688</b>	<b>291</b>	<b>397</b>
<b>Project Expenditure</b>						
Education Strategic Review project	64	17	(47)	64	64	0
Complex Legal Cases	30	146	116	30	33	4
PBF	4	0	(4)	4	4	0
Employment Status	91	74	(17)	91	100	9
Thematic Review	40	40	0	40	40	0
Unfair Outcomes EDI Research	15	20	5	15	15	0
Project Depreciation & Amortisation	139	160	22	139	141	2
Arrears on Pay	82	0	(82)	82	82	0
Future Office Accommodation	408	19	(389)	408	418	10
<b>Total Project expenditure</b>	<b>872</b>	<b>477</b>	<b>(395)</b>	<b>872</b>	<b>897</b>	<b>25</b>
<b>Surplus / (Deficit) after project expenditure</b>	<b>(184)</b>	<b>(620)</b>	<b>436</b>	<b>(184)</b>	<b>(606)</b>	<b>423</b>
Unrealised Investment gains	936	468	468	936	1,419	(483)
<b>Surplus / Deficit</b>	<b>752</b>	<b>(152)</b>	<b>904</b>	<b>752</b>	<b>813</b>	<b>(61)</b>

**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
<b>Income</b>						
Registration	12,119	11,928	192	12,119	12,101	18
Dividend Income	249	234	15	249	255	(7)
Bank & Deposit Interest	217	98	119	217	141	76
Other Income	18	11	7	18	10	9
<b>Total Income</b>	<b>12,603</b>	<b>12,270</b>	<b>333</b>	<b>12,603</b>	<b>12,507</b>	<b>96</b>
<b>Expenditure</b>						
Staff Salaries Costs	7,091	7,063	(28)	7,091	7,053	(38)
Other Staff Costs	417	301	(116)	417	436	19
Staff Benefits	149	171	22	149	170	21
Member & Worker Costs	359	291	(69)	359	362	2
Professional Fees	738	742	4	738	749	11
Finance Costs	149	137	(12)	149	144	(5)
Case Progression	849	1,048	199	849	961	112
Hearings	1,023	963	(60)	1,023	1,101	79
CPD & Standards	249	417	168	249	269	20
IT Costs	698	761	62	698	755	56
Office Services	808	596	(211)	808	850	42
Other Costs	42	177	135	42	49	8
Depreciation & Amortisation	213	223	10	213	213	(0)
<b>Total Expenditure</b>	<b>12,786</b>	<b>12,890</b>	<b>104</b>	<b>12,786</b>	<b>13,113</b>	<b>327</b>
<b>Surplus / Deficit</b>	<b>(184)</b>	<b>(620)</b>	<b>436</b>	<b>(184)</b>	<b>(606)</b>	<b>423</b>
Unrealised Investment gains	936	468	468	936	1,419	(483)
<b>Surplus / (Deficit)</b>	<b>752</b>	<b>(152)</b>	<b>904</b>	<b>752</b>	<b>813</b>	<b>(61)</b>
<b>Staff cost to total expenditure ratio</b>	60%	58%		60%	58%	

**C27(26)ii.**

**Analysis of Multi-Year Strategic Project - as at 31 March 2026 Q3 Forecast**

Project Expenditure		Approved by the Council	Prior Year Spend	Current Year to date Spend	Actual Spend To Date	Forecasted Future Spend	Total Spend	Variance	Remarks
Dec-25		£'000	£'000	£'000	£'000	£'000	£'000	£'000	
P34	Future Office Accommodation	764	313	408	721	0	721	43	Council approved £764k which included £68k depreciation - this cost was wrote off the BAU at the end of 2024-25. Q3 forecast includes £30k contingency for 2026-27 future spend.
P38	PBF	150	137	4	141	9	150	0	Project is closed, BAU funds to support on-going consultancy and training.
P39	Employment Status	108	8	91	99	0	99	9	£18k additional funds approved for expected legal fees, as at now £9k spent.
P40	Thematic Review	40	0	40	40		40	0	Project is paid in full but work is on going, as at now completion date is expected to be in October 2026.
P41	Unfair Outcomes EDI Report	20	0	15	15	5	20	0	Project is complete.
P42	Worker Project - Backdated Pay	646	529	82	611	0	611	35	Total payroll costs including pension and NI 0.6%
P37	My GOC (capital)	322	0	114	114	208	322	0	Council approved a further £48k. As at now, project is scheduled for completion in July26 - September26.

## Balance Sheet as at 31 March 2026

	2025-26 31 March 2026 £'000	2024-25 31-Mar-25 £'000	Variance £'000
<b>Fixed Assets</b>			
Refurbishment	(0)	2	(2)
Furniture & Equipment	1	0	1
IT Hardware	140	142	(2)
IT software	168	211	(43)
Capital Work in Progress	164	26	138
<b>Total Tangible Fixed Assets</b>	<b>472</b>	<b>381</b>	<b>91</b>
Investment	10,297	9,413	884
Refundable deposit	81	0	81
<b>Total Fixed Assets</b>	<b>10,851</b>	<b>9,794</b>	<b>1,057</b>
<b>Current Assets</b>			
Debtors, Prepayments & Other Receivable	658	765	(107)
Short term deposits	9,400	8,950	450
Cash and monies at Bank	884	1,557	(673)
<b>Total Current assets</b>	<b>10,943</b>	<b>11,256</b>	<b>(313)</b>
<b>Current Liabilities</b>			
Creditors & Accruals	2,666	1,694	972
Income received in advance	10,380	11,378	(998)
<b>Total Current Liabilities</b>	<b>13,046</b>	<b>11,272</b>	<b>1,774</b>
<b>Current Assets less Current Liabilities</b>	<b>(2,103)</b>	<b>(1,800)</b>	<b>(303)</b>
<b>Total Assets less Current Liabilities</b>	<b>8,748</b>	<b>7,994</b>	<b>754</b>
Long Term Liabilities	0	0	0
<b>Total Assets less Total Liabilities</b>	<b>8,748</b>	<b>7,994</b>	<b>754</b>
<b>Reserves</b>			
Complex cases legal	613	613	(0)
Strategic, research and special projects	3,000	3,000	0
Infrastructure/dilapidations	1,036	1,036	0
General income & expenditure	4,098	3,345	753
<b>Total</b>	<b>8,748</b>	<b>7,994</b>	<b>754</b>

Financial Performance Report for the 12 months ending 31 March 2026

Fixed deposit plan 2025/26-2026/27 updated with FDs placed as at 31/3/26

Budget			Actual			
Month planned	Month to mature	Amount	Date Placed	Amount	Interest Rate	Total Interest Due
Feb-26	32 day call deposit	750,000	2/19/2026	750,000.00	0.50%	
Mar-26	Apr-26	1,000,000	3/12/2026	1,000,000.00	1.05%	1,121.92
Mar-26	May-26	1,000,000	3/12/2026	1,000,000.00	1.05%	1,984.93
Mar-26	Jun-26	900,000	3/3/2026	900,000.00	3.51%	9,606.82
Mar-26	Jul-26	1,000,000	3/12/2026	1,000,000.00	3.63%	12,928.77
Mar-26	Aug-26	1,000,000	2/25/2026	1,000,000.00	3.52%	16,973.15
Mar-26	Sep-26	1,300,000	3/24/2026	1,300,000.00	4.26%	27,462.41
Mar-26	Oct-26	1,100,000	3/3/2026	1,100,000.00	3.55%	24,713.84
Mar-26	Nov-26	1,100,000	3/3/2026	1,100,000.00	3.54%	27,951.45
Apr-26	Dec-26	250,000	3/24/2026	250,000.00	4.39%	8,178.63
<b>TOTAL</b>		<b>9,400,000</b>		<b>9,400,000</b>		<b>130,922</b>

Budget	98,000.00
Variance (Gain)	32,921.92

# Business performance quarterly dashboard

On track
At risk
Off track

For the year 1 April 2025 – 31 March 2026

Q4 report (1 January 2026 – 31 March 2026)		Q1	Q2	Q3	Q4	Measure	Q4 (24/25)	
<b>Finance</b>								
1.1	BAU budget; operate within budget /forecast	16.0%	4.0%	1.0%	3.0%	Tolerance is ±5% p.a. for 2025-30, balancing over the five years. Tolerance for year 1 as per budget is -1%. (24/25 ±10%)	7.7%	
1.2	Reserves; operate within reserves policy	0.0%	0.0%	0.0%	0.0%	Tolerance is ±10%	0.0%	
<b>People</b>								
2.1	Planned L&D events realised	100%*	100%*	90%*	100%	Target is ≥90%	100%	
2.2	Annual voluntary staff turnover (12-month rolling)	11.8%	8.1%	6.3%	5.3%	Target is <17%***	13.7%	
2.3	Staff engagement – pulse survey	% response	55.0%	48.7%	43.0%	40%	N/A	51.0%
	Employee Net Promoter Score (ENPS)	ENPS	19.7	18.2	21.5	0	ENPS: Target is 0-30, which is rated as good (the higher the better)	13.7
<b>Customer</b>								
3.1	FOI requests resolved	100%	100%	100%	100%	Target is 100% in ≤20 working days	100%	
3.2	Corporate complaints (stage 1 or stage 2): received	0	0	0	0	N/A	0	
	Corporate complaints (stage 2): resolved	N/A**	N/A**	N/A**	N/A**	Target is ≥90% in ≤20 working days	100%	
<b>Regulatory functions</b>								
4.1	Registration applications completed	98%	99%	99%	98%	Target is ≥95% forms completed	98%	
4.2	Registration accuracy	97%	98%	99%	99%	Target is ≥95%	99%	
4.3	Approved qualifications meeting new ETR	86%	88%	88%	88%	Target is 100% by July 2026 ex. CoO	84%	
4.4	Quality of GOC approved providers' CPD	97%	96%	98%	95%	Target is ≥85% good or excellent	96%	
4.5	Customers receiving an FtP update	83%	82%	85%	85%	Target is ≥90% every 12 weeks	82%	
4.6	FtP cases resolved (rolling median)	41%	52%	46%	47%	Target is ≥60% within 78 weeks	58%	
4.7	Hearings concluded first time	83%	92%	89%	91%	Target is ≥90%	93%	
4.8	Hearings dates utilised	92%	97%	89%	82%	Target is ≥90%	92%	
4.9	New investigations at representations	50%	44%	43%	41%	≥80% of investigations at reps within 35 weeks from DIO (for the period)	N/A	

\* We would have like to deliver Safeguarding Training to a new Safeguarding panel member but there has been poor customer service from Safeguarding Alliance. We are following this up and looking at alternative providers.

\*\* No stage 2 complaints received

\*\*\* Target is public sector turnover which includes voluntary and involuntary turnover. Our equivalent performance (voluntary and involuntary turnover) is 15.4%.

**NOTE** – CPD stats have been temporarily removed as the data is not meaningful at this stage in the cycle; these will return towards the end of the 2025-27 cycle

	KPI	Current RAG status (why it is amber/red; when/how we will get it to green)	Budget implications	Risks
4.3	<p>Approved qualifications meeting new ETR - <b>88%</b></p> <p>Target is 100% by July 2026</p>	<p><b>Why amber/red:</b> Providers are permitted to adapt their approved qualifications to the ETR at their own pace. Three qualifications remain outstanding, two of which are currently not recruiting students. The target (not deadline) for 100% of providers to adapt will be updated as we work with each qualification provider to support them as they work through their plans to either adapt to the ETR or seek an alternative solution.</p>	<p>All adaptations have been budgeted for.</p>	<p>There is a risk that three providers still delivering qualifications that meet the 'old' handbooks, with outdated requirements and core competencies.</p> <p>Risk that providers are adapting significantly later than expected following implementation of new Education and Training Requirements in 2021 (optom/DO and IP) and 2022 (CLO).</p> <p>This is mitigated through careful planning with providers to support adaptation timing based on last student intake and handbook visits, to avoid setting a hard deadline.</p> <p>Providers who choose not to adapt their remaining qualifications, and no longer hold a GOC approved qualification, will need to apply afresh and go through the staged application process should they then wish to offer an approved qualification.</p>
4.5	<p>Customers receiving an FtP update – <b>85%</b></p> <p>Target is ≥90%</p>	<p><b>Why amber/red:</b> There was a slight dip over the festive period, balancing resource and case progression. This remains a priority for Investigation and Triage teams. Additionally, this is a cumulative rolling measure, so improvements in monthly performance take time to be reflected in the overall figure.</p> <p><b>How we will get back to green:</b> Additional training will take place in Q4 alongside more robust oversight at case reviews. As a result, we expect to see improvements in this KPI as we enter the new reporting year.</p>	<p>None.</p>	<p>May undermine stakeholder confidence and perceptions of transparency. This carries reputational risk and could impact trust and engagement in our regulatory processes.</p>

4.6	<p>FtP cases resolved (rolling median) – <b>47%</b></p> <p>Target is ≥60% within 78 weeks</p>	<p><b>Why amber/red:</b> This reflects the current focus on progressing our oldest and most complex cases through the system.</p> <p><b>How we will get back to green:</b> Performance has improved since the start of the year; however, we anticipate some fluctuation as we continue to move legacy cases through to conclusion. We expect to see continued positive shifts in related indicators, including timeliness at earlier stages, demonstrating that cases are advancing more efficiently through the process.</p>	<p>Forecasts support increased expenditure on legal charges and hearings to support the progression of these cases.</p>	<p>Older and more complex cases typically present greater challenges at hearing, requiring additional time and resource. This creates operational pressure and affects overall resolution performance.</p>
4.8	<p>Hearing dates utilised – <b>83%</b></p> <p>Target is ≥90%</p>	<p><b>Why amber/red:</b> 73% of substantive hearings concluded early, and there was insufficient alternative work for committees to complete.</p> <p><b>How we will get back to green:</b></p> <ul style="list-style-type: none"> <li>• Ongoing project to integrate substantive reviews into the “Hearings on papers” process, increasing the work available for committees that finish early.</li> <li>• Improved use of information to more accurately forecast hearing lengths, and use of case management meetings to reduce hearing duration where appropriate.</li> </ul>	<p>When hearings finish early, we pay committee members in line with our cancellation policy</p>	<p>Wasted fees is not efficient and should always aim to be reduced to zero to ensure every £ of registrant fees is spent to ensure value for money.</p>
4.9	<p>New investigations at representations – <b>41%</b></p> <p>Target is ≥80%</p>	<p><b>Why amber/red:</b> A significant proportion of cases currently at this stage are older, more complex matters, which are taking longer to progress through the earlier stages of the process.</p> <p><b>How we will get back to green:</b> Improved productivity levels across the year are now supporting increased case movement. The median age of both the overall stage 2 caseload and the active caseload within Investigations have fallen and we expect this momentum to translate into improved performance against this indicator as we enter the new financial year.</p>	<p>Forecasts support increased expenditure on legal charges and hearings to support the progression of these cases.</p>	<p>As with other legacy matters, these cases can require greater time and resource at hearing, increasing operational demand and impacting overall performance.</p>



**GOC Internal Business Plan – 2025/26**  
Exceptions Report – Q4 update

All CRITICAL and ESSENTIAL Q1-Q4 activities are ON TRACK or COMPLETE for the following business areas:

**Hearings, Legal,  
Communications, Education  
Facilities, Finance, IT, Registration  
Continuous Improvement, People & Culture**

The following slides describe, with commentary, all CRITICAL and ESSENTIAL Q1-Q4 activities that are either OFF TRACK (amber) or DEADLINE MISSED (red)

### Case Progression

Activity	BAU/Project	Timing	Priority	Success Measures	RAG	Comments
Annual review of FtP Guidance	BAU	Q1-Q4	<ul style="list-style-type: none"> <li>• Critical</li> </ul>	<ul style="list-style-type: none"> <li>• Relevant changes and updates of published policies, internal processes, and guidance have been made where necessary.</li> <li>• Priorities will include:               <ul style="list-style-type: none"> <li>• Investigation processes</li> <li>• Stage three processes including direct referral.</li> </ul> </li> <li>• Work will also commence to review the Acceptance Criteria.</li> <li>• Any process changes by virtue of the new CMS are updated</li> </ul>		<p><b>Why amber/red:</b> Additional time is required to update Triage guidance in line with wider FTP improvement activity and operational changes currently underway following recent process and audit reviews</p> <p><b>How we will get back to green:</b> Updated guidance will be delivered over the summer period to ensure alignment with FTP improvement actions and support clear, consistent implementation.</p>

**CPD**

Activity	BAU/Project	Timing	Priority	Success Measures	RAG	Comments
<p>Deliver a platform to record CPD and ensure our standards and requirements are met</p>	<p>BAU</p>	<p>Q1-Q4</p>	<p>● Essential</p>	<p>CPD system has &lt;1% unplanned outage (i.e. 3.5 days outage per year).</p>	<p style="background-color: red;"></p>	<p><b>Why amber/red:</b> The MyCPD system had an unplanned outage between 24 and 29 December due to limits on system storage capacity</p> <p><b>How we will get back to green:</b> The unplanned outage was picked up by our contractor for the MyCPD platform when their offices opened on 29 Dec and was escalated to GOC IT team. We will consider who carries responsibility for monitoring of CPD emails and systems over the Christmas period and increasing IT storage capacity to avoid this type of outage in the future.</p>

## Policy and Standards

Activity	BAU/Project	Timing	Priority	Success Measures	RAG	Comments
Changes to the standard on supervision in response to findings of the research into the risk-based model on the testing of sight	Strategic project	Q1-Q4	<p style="text-align: center;">●</p> Essential	SMT and Council satisfaction that there has been high quality engagement with a range of stakeholders. Any changes to the standards are proportionate, focussed on protecting the public whilst supporting responsible innovation		<p><b>Why amber/red:</b> Rephased to bring draft consultation package to June 2026 Council to allow time to gather additional evidence following discussion at December 2025 Council</p> <p><b>How we will get back to green:</b> Included on the agenda for June 2026 Council</p>

# Governance

Activity	BAU/Project	Timing	Priority	Success Measures	RAG	Comments
Member appointment process	Continuous Improvement Project	Q3-Q4	<div style="text-align: center;"> <span style="color: red;">●</span>                      Essential                 </div>	<ul style="list-style-type: none"> <li>• Q1 - review of internal processes</li> <li>• Q2 - review of guidance to panels and applicants</li> <li>• Nominations Committee - December 2025 - revised guidance and processes approved</li> </ul>		<p><b>Why amber/red:</b>                      Unplanned member recruitment and staff turnover has contributed to delays.</p> <p><b>How we will get back to green:</b>                      Review will be deferred to 26/27</p>

**Minutes of the meeting of the Advisory Panel held on  
Friday 22 May 2026 at 9.15am via MS Teams**

**Present:** Frank Munro (Education Committee) (Advisory Panel Chair), Zabir Ali, (Companies Committee), Sana Asif (Standards Committee), Kay Bagshaw (Standards Committee), Jutinder Basi (Companies Committee), Geraldine Birks (Registration Committee), Gavin Cooper (Registration Committee), Dr. Helen Court (Education Committee), Khalid Dalil (Registration Committee), Dean Dunning (Education Committee), Kathryn Foreman (Registration Committee), Sally Gosling (Education Committee), Dan Green (Education Committee), Kalwant Grewal Companies Committee), Imran Hakim (Companies Committee), Sarah Joyce (Companies Committee), Dimple Kumar (Standards Committee), Ros Levenson (Standards Committee), Julia Lewis (Standards Committee), Haseena Lockhat (Standards Committee), Hana Patel (Education Committee), Tim Parkinson (Companies Committee), Aoife Prendergast (Registration Committee), Prof. Hema Radhakrishnan (Education Committee), Reena Rani (Registration Committee), Chloe Robson (Standards Committee), Parth Shah (Companies Committee), Amit Sharma (Companies Committee), Poonam Sharma (Companies Committee), William Stockdale (Standards Committee), Dr. Ahalya Subramanian (Education Committee), Nilla Varsani (Standards Committee) and Cathy Yelf (Companies Committee).

**Apologies:** Jacqui Adams (Education Committee), Gordon Dingwall (Companies Committee), Lisa Gerson (Registration Committee Chair) and Dan McGhee (Companies Committee).

**GOC Attendees:** Carole Auchterlonie (Director of Regulatory Operations), Steve Brooker (Director of Regulatory Strategy), Marie Bunby (Policy Manager), Nadia Denton (Governance Officer) (*minutes*), Toby Ganley (Policy Manager (Standards)), Kiran Gill (Chief Legal Officer), Philipsia Greenway (Director of People and Improvement), Terry Koranteng (Information Governance Officer), Andrew Mackay-Sim (Chief of Staff), Marc Stoner (Director of Corporate Services), Charlotte Urwin (Head of Strategy, Policy and Standards) and Dr. Anne Wright CBE (Council Chair).

<b>Welcome and Apologies</b>	
1.	The Chair welcomed everyone to the meeting. The Advisory Panel noted that; <ul style="list-style-type: none"> <li>• apologies had been received from Jacqui Adams, Dan McGhee, Gordon Dingwall and Lisa Gerson; and</li> <li>• new members Zabir Ali, Jutinder Basi and Kalwant Grewal were joining the meeting for the first time.</li> </ul>
<b>Declaration of Interests and confidentiality AP00(26)</b>	
2.	The Panel noted the register of interests.

	<b>Minutes of the meeting held on 6 February 2026 AP04(26)</b>
3.	The minutes of 6 February 2026 were approved as an accurate record of the meeting subject to the following correction: <ul style="list-style-type: none"> <li>to note that Raymond Curran <u>had</u> attended the meeting.</li> </ul>
	<b>Actions point updates AP05(26)</b>
4.	The actions were noted.
	<b>Matters Arising</b>
5.	There were no matters arising.
	<b>Commercial practices and patient safety thematic review: key findings AP06(26)</b>
6.	<p>The Head of Strategy, Policy and Standards &amp; Policy Manager introduced the item. Specific points raised in discussion included:</p> <p><u>Practices which were a cause for concern</u></p> <ul style="list-style-type: none"> <li>ghost clinics could affect patient safety - optometrists (especially those new in practice) would be put under enormous pressure, potentially risking burnout if they had to see more patients per time slot;</li> <li>there were variations in how long it could take an optometrist to undertake an eye test and rolling clinics could allow for flexibility;</li> <li>individuals with additional needs might need a longer appointment for their sight test;</li> <li>some practices may decide not to book in patients who need more time to undertake a sight test (leading to an inequality of service);</li> <li>there could be a demographic difference in terms of testing times i.e. a younger person may not need as much time as an older one – shorter sight tests are not always unsafe;</li> <li>double booking patients could lead to patient dissatisfaction and a drop in sales for practices having an impact on the whole business;</li> <li>short appointment times and time pressures did not just relate to commercial practice in community optometry but also in hospitals;</li> <li>the difference between ghost clinics and rolling clinics needed to be made clearer in the report;</li> <li>practices needed to consider more effective methods of reminding patients of their appointments and analysing no-shows, such as the integration and use of AI;</li> <li>some concerns that commercially related KPIs might impact patient care;</li> <li>the need for the profession to recognise that the eyecare landscape was changing and that practices need to be considering this going forward;</li> <li>that changing demographics and evolving technology should be informing development / delivery of emerging care models;</li> </ul> <p><u>the extent to which the GOC's existing system of regulation (e.g. education, standards, fitness to practise) can sufficiently address the issues identified</u></p> <ul style="list-style-type: none"> <li>it was discussed whether the GOC should indicate the minimum time for an eye test especially as other regulators did not adopt similar approaches;</li> <li>how would the GOC ensure the compliance of a minimum testing time and what would be the penalty for non-compliance;</li> <li>was there a need for the GOC to develop guidance on minimum testing times;</li> </ul>

- the guidance about reporting concerns and speaking up was clear in the Standards of Practice for Optometrists and Dispensing Opticians but the same emphasis did not appear to be applied to the Standards for Optical Businesses;
- consideration should be made for how, aside from the speaking up policy, registrants could report concerns about feeling under pressure in practice and how to make existing guidance more visible;
- though the Standards for Optical Businesses were clear about the safety and responsibilities of business, not all businesses were regulated or had to adhere to the standards;
- concern that not all optical businesses were registered with the GOC;
- it was evident that registrants were not feeling empowered and it would be necessary to empower them to understand and know how to respond when things went wrong;
- students would not always have an awareness of what the workload might be and responsibilities expected of them in practice;
- an education piece should be considered for students, so that students could be introduced to business practices while studying rather than waiting until they become clinicians;
- the GOC could learn from other regulators such as the RCGP who had already considered this matter;
- the GOC could consider working with optical colleges to determine how these aspects could be integrated into course learning during the student's final year;
- was there a case for integrated commercial ethics models in Education and CPD frameworks;
- whether the development of cross collaborative joint guidance with other bodies such as the AOP and FODO could be effective;

How the GOC and the wider sector might best address the gaps

- the GOC should seek to have a push for better funding models within the sector and if possible negotiate with the NHS about funding;
- notwithstanding the complex considerations around charging for eyecare services that careful consideration be given as a minimum, to the cost of eye examinations and what this would include e.g. OCT;
- despite the Public Perception Survey indicating that the Public seemed well informed of charges that practices encourage better price transparency by suggesting practices display their prices online;
- to consider if there could be value in using the research outcomes as a basis for a more collaborative discussion across the sector which could include reviewing the appropriate language used to assess different patient flows and working arrangements for clinical teams;
- the use of the term '**Sight Test**' was not helpful in the current climate with the expansion and complexity of evolving community eyecare delivery; and
- that there was a lack of understanding relating to the concept of cross subsidy of product sales to meet the clinical needs of practices.

7.	The Advisory Panel <b>discussed</b> the evidence presented in the annexes and addressed the questions in paragraph 30.
	<b>Register Retention Analysis AP07(26)</b>
8.	The Director of Regulatory Strategy introduced the item. Specific points raised in discussion included:

	<ul style="list-style-type: none"> <li>• many dispensing opticians were leaving the sector due to pay, which was in and around the minimum wage and deemed too low for the level of responsibility and risks faced daily;</li> <li>• for dispensing opticians seeking to develop their careers and progress up the salary scale they would need to study and obtain extra qualifications;</li> <li>• the fact that most dispensing opticians were restricted in terms of flexible working (such as being unable to work from home) acted as a disincentive;</li> <li>• dispensing opticians feel that the registrant fee is disproportionate and that dispensing opticians do not receive the CPD funding awarded to optometrists;</li> <li>• that the GOC should re-consider dispensing optician registration fees;</li> <li>• the cost of various sector body fees such as those of the GOC, ABDO and FODO added up for dispensing opticians;</li> <li>• that the GOC should consider collaborating with other sector stakeholders to investigate morale and retention and even consider how the working benefits for dispensing opticians could be enhanced;</li> <li>• that the GOC should consider an exit review with those leaving the professions to help understand the rationale for leaving, as happens with other regulators;</li> <li>• To use the exit review to gain better intelligence and data around leavers</li> <li>• that the data should make a distinction between people leaving the register entirely and those going into other clinical sector roles;</li> <li>• the retention of people who were mid-career would seem particularly important; and</li> <li>• further research should look at EDI factors such as socio-economic and caring responsibilities especially as a disproportionate number of women were leaving.</li> </ul>
9.	The Advisory Committee <b>discussed</b> the paper.
	<b>Date of Next Meeting</b>
10.	The date of the next meeting was noted as <b>16 October 2026</b> .
	<b>Any Other Business</b>
11.	There was none.
12.	<b>The meeting closed at 10:59am.</b>

**GENERAL OPTICAL COUNCIL****Minutes of the meeting of the Companies Committee  
held on Friday 22 May 2026 at 11.15am via MS Teams**

Present: Tim Parkinson (*Chair*), Zabir Ali, Jutinder Basi, Kalwant Grewal, Sarah Elizabeth Joyce, Parth Shah, Amit Sharma, Poonam Sharma and Cathy Yelf.

Apologies: Gordan Dingwall, Imran Hakim and Dan Maghee.

GOC Attendees: Steve Brooker (Director of Regulatory Strategy), Marie Bunby (Policy Manager) and Nazia Khanom (Governance and Compliance Officer) (*minutes*).

	<b>Proposed updated statement on testing of sight and supervision standards - COM01(26)</b>
1.	<p>The Companies Committee joined the Education and Standards Committee for the discussion of this item only.</p> <p><b>Companies Committee Members Present:</b> Tim Parkinson (Chair), Sarah Elizabeth Joyce, Parth Shah, Amit Sharma, Poonam Sharma, Kalwant Grewal, Amit Sharma, Jutinder Basi and Cathy Yelf.</p> <p><b>Education Committee Members Present:</b> Frank Munro (Chair), Helen Court, Dean Dunning, Sally Gosling, Dan Green, Professor Hema Radhakrishnan and Ahalya Subramanian.</p> <p><b>Apologies:</b> Jacqui Adams, Gordon Dingwall and Dan McGhee.</p> <p><b>GOC Attendees:</b> Carole Auchterlonie (Director of Regulatory Operations), Steve Brooker (Director of Regulatory Strategy), Marie Bunby (Policy Manager), Nadia Denton (Governance and Compliance Officer) (<i>minutes</i>), Toby Ganley (Policy Manager, Standards), Kiran Gill (Head of Legal), Terry Koranteng (Information Governance Officer) (<i>minutes</i>), Samara Morgan (Head of Education and CPD), Charlotte Urwin (Head of Strategy, Policy and Standards) and Dr Anne Wright (Chair of Council)</p>
2.	<p>The Committee considered proposed updates to the GOC's Statement on the Testing of Sight (last issued in 2013) and proposed amendments to the Standards on Supervision and Delegation (last reviewed in 2016).</p> <p><b>Key points discussed</b> <b>Testing of Sight Statement</b></p>

- Members noted the need to update the statement to reflect developments in technology, changes in service delivery and evolving patient expectations.
- The revised statement seeks to clarify the responsibilities of individual registrants and business registrants, including where responsibilities are shared.
- Additional emphasis has been placed on protecting patients in vulnerable circumstances and ensuring accessibility of information.
- The distinction between delegation of tasks and assistance with tasks was welcomed as providing greater clarity.
- The discussion focused on the use of digital imaging, remote care models and emerging technologies.
- Members noted reference to intra-ocular examination in the statement and highlighted the importance of maintaining appropriate clinical examination skills and ensuring technology supports rather than replaces professional judgement.
- Concerns were raised about potential deskilling if reliance on technology becomes excessive.

### **Supervision and Delegation**

- The Committee advised that the consultation should be neutral on the two options.
- Members generally recognised the need for flexibility to support innovation while maintaining patient safety.
- Members felt a higher level of direct oversight may continue to be necessary when supervising students.
- Some members suggested clearer definitions of terms such as supervision, delegation, oversight and intervention might be helpful.
- The importance of ensuring accountability remains clear when activities are delegated was emphasised.

### **Communication with Patients**

- There was discussion about the importance of ensuring patients understand who is involved in their care, how services are delivered and who is responsible for communicating findings.
- Clear communication of findings, responsibilities and care pathways was identified as an important patient safety consideration.

### **Overall Themes**

- Patient safety must remain the primary consideration.
- Regulation should support responsible innovation without creating unnecessary barriers, while maintaining patient safety.
- Future guidance should be sufficiently flexible to accommodate continued technological developments and kept under regular review.

The Committee supported continued consultation and stakeholder engagement before final proposals are presented to Council.

3.	The Companies Committee and Education Committee left the meeting.
	<b>Welcome and apologies</b>
4.	The Chair proceeded to welcome those in attendance including new Advisory Panel members Jutinder Basi and Zabir Ali along with Council Member Kalwant Grewal. Apologies were received from Gordon Dingwall, Imran Hakim and Dan McGhee.
	<b>Minutes from meeting held on Friday 13 November 2025 - COM02(26)</b>
5.	The minutes were approved as an accurate record.
	<b>Update since last meeting COM03(26)</b>
6.	The Chair provided a verbal update on the Council's discussions relevant to optical businesses.
7.	The Companies Committee <b>noted</b> the paper.
	<b>Commercial practices and patient safety thematic review: key findings - AP06(26)</b>
8.	The Policy Manager introduced the item. The Committee discussed how business pressures may affect patient safety and what should be reflected in the final GOC report on commercial practices and patient safety. The Committee supported improved training, guidance and support to help clinicians manage business pressures, make safe decisions and build confidence in practice. It was also noted that the report should distinguish between inappropriate sales pressure and properly supporting informed choice. Members noted that it remained unclear whether the current evidence showed direct patient harm or primarily highlighted stress and pressure on staff and suggested that further evidence may be needed.
9.	The Director of Regulatory Strategy suggested that company websites should include the price of an eye test to support greater price transparency. The Committee broadly supported making the cost of a basic sight test and any chargeable add-ons clearer in advance, particularly for online booking, whilst recognising that too much detail could cause confusion. The Committee also noted that, although prices could be listed in advance, they may change once the patient attends their appointment. This is because additional, unplanned tests may be required following the initial assessment. It was also suggested that businesses should make patients' eligibility for NHS-funded sight tests clearer.
10.	Discussion of sales targets and incentives was limited, as the Committee agreed that additional information is needed before any conclusions can be reached or recommendations made.
11.	The Companies Committee <b>noted</b> the paper.
	<b>Any Other Business</b>
12.	The Committee noted that this was Tim Parkinson's final meeting as Chair. The Chair thanked members for their contributions and congratulated Poonam Sharma, who would become the new Chair.
	<b>Meeting Close</b>
	The meeting closed at 1pm.

**Minutes of the Education Committee held on  
Thursday 22 May 2026 at 11.15am via MS Teams**

**Present:** Frank Munro (*Chair*), Dr. Helen Court, Dean Dunning, Sally Gosling, Dan Green, Prof. Hema Radhakrishnan and Dr. Ahalya Subramanian.

**Apologies:** Jacqui Adams

**Absent:** Hana Patel

**GOC Attendees:** Nadia Denton (Governance Officer) (*Minutes*), Samara Morgan (Head of Education and Continuing Professional Development (CPD)) and Dr. Anne Wright CBE (Chair of Council).

	<b>Proposed updated statement on testing of sight and supervision standards EDU01(26)</b>
1.	<p>The Education Committee joined the Standards Committee and Companies Committee for discussion of this item.</p> <p><b>Companies Committee Members Present:</b> Tim Parkinson (Chair), Jutinder Basi, Kalwant Grewal, Sarah Elizabeth Joyce, Parth Shah, Amit Sharma, Poonam Sharma, and Cathy Yelf.</p> <p><b>Education Committee Member Present:</b> Frank Munro (Chair), Helen Court, Dean Dunning, Sally Gosling, Dan Green, Professor Hema Radhakrishnan and Ahalya Subramanian.</p> <p><b>Apologies:</b> Jacqui Adams, Gordon Dingwall and Dan McGhee.</p> <p><b>GOC Attendees:</b> Carole Auchterlonie (Director of Regulatory Operations), Steve Brooker (Director of Regulatory Strategy), Marie Bunby (Policy Manager), Nadia Denton (Governance and Compliance Officer) (<i>minutes</i>), Toby Ganley (Policy Manager, Standards), Kiran Gill (Head of Legal), Terry Koranteng (Information Governance Officer) (<i>minutes</i>), Samara Morgan (Head of Education and CPD), Charlotte Urwin (Head of Strategy, Policy and Standards) and Dr Anne Wright (Chair of Council)</p>
2.	<p>The Committee considered proposed updates to the GOC's Statement on the Testing of Sight (last issued in 2013) and proposed amendments to the Standards on Supervision and Delegation (last reviewed in 2016).</p> <p><b>Key points discussed</b> <b>Testing of Sight Statement</b></p>

- Members noted the need to update the statement to reflect developments in technology, changes in service delivery and evolving patient expectations.
- The revised statement seeks to clarify the responsibilities of individual registrants and business registrants, including where responsibilities are shared.
- Additional emphasis has been placed on protecting patients in vulnerable circumstances and ensuring accessibility of information.
- The distinction between delegation of tasks and assistance with tasks was welcomed as providing greater clarity.
- The discussion focused on the use of digital imaging, remote care models and emerging technologies.
- Members noted reference to intra-ocular examination in the statement and highlighted the importance of maintaining appropriate clinical examination skills and ensuring technology supports rather than replaces professional judgement.
- Concerns were raised about potential deskilling if reliance on technology becomes excessive.

#### **Supervision and Delegation**

- The Committee advised that the consultation should be neutral on the two options.
- Members generally recognised the need for flexibility to support innovation while maintaining patient safety.
- Members felt a higher level of direct oversight may continue to be necessary when supervising students.
- Some members suggested clearer definitions of terms such as supervision, delegation, oversight and intervention might be helpful.
- The importance of ensuring accountability remains clear when activities are delegated was emphasised.

#### **Communication with Patients**

- There was discussion about the importance of ensuring patients understand who is involved in their care, how services are delivered and who is responsible for communicating findings.
- Clear communication of findings, responsibilities and care pathways was identified as an important patient safety consideration.

#### **Overall Themes**

- Patient safety must remain the primary consideration.
- Regulation should support responsible innovation without creating unnecessary barriers, while maintaining patient safety.
- Future guidance should be sufficiently flexible to accommodate continued technological developments and kept under regular review.

	The Committee supported continued consultation and stakeholder engagement before final proposals are presented to Council.
3.	The Education Committee left the Standards Committee meeting.
	<b>Welcome and Apologies</b>
4.	The Chair opened the meeting and welcomed everyone present. It was noted that Jacqui Adams had sent her apologies.
	<b>Declarations of interests and confidentiality</b>
5.	There were no new declarations of interest.
	<b>Minutes from break out session held on 13 November 2025 EDU02(26)</b>
6.	The minutes of the meeting held on 13 November were approved as an accurate record.
	<b>Committee Engagement (Oral)</b>
7.	<p>The Chair introduced the item and invited committee members to share their experiences of committee engagement and suggest ways to improve engagement with the GOC. It was noted that the members;</p> <ul style="list-style-type: none"> <li>• left Education Committee meetings feeling informed and positive about engagement;</li> <li>• found that it could be challenging to make contributions during the main Advisory Panel meeting;</li> <li>• would welcome the opportunity to play a more overt role in terms of GOC education and CPD strategy;</li> <li>• would welcome the opportunity for earlier input on strategic developments within GOC;</li> <li>• would welcome status updates on strategic developments within GOC;</li> <li>• would welcome the opportunity to share key learnings with other the other statutory advisory committees;</li> <li>• would welcome more specific guidance on areas of discussion for the various agenda items;</li> <li>• would welcome the opportunity to contribute items to committee meeting agendas;</li> <li>• would welcome committee papers being issues slightly earlier;</li> <li>• would welcome an update on how far the Education Strategic Review was achieving the intended changes;</li> <li>• would welcome re-engagement and/or more regular updates in between meetings;</li> <li>• thought it was worth considering a WhatsApp group or equivalent network where information could be circulated;</li> <li>• suggested it might be useful to meet in person occasionally;</li> <li>• suggested that a half day away day could be useful to gather more insights from members;</li> <li>• suggested that lay members should be kept in the loop as much as GOC registrant members were through newsletters;</li> <li>• suggested that it would be useful for Dispensing Optician related items to be discussed more frequently;</li> </ul>

	<ul style="list-style-type: none"> <li>• suggested that it would be useful to create an opportunity where members could piece together year on year trends that related to the education sector;</li> <li>• it might be helpful to invite the council members of Optometry schools to contribute items to the Education Committee agenda; and</li> <li>• would welcome a review of the Education Committee terms of service – to revisit the purpose of the groups in advising and assisting Council</li> </ul>
8.	The Head of Education and CPD indicated that they would consider methods to feedback key takeaways from Optical Schools Council (OSC) and Opticians Academic Schools Council (OASC) meetings; and present feedback given by the Education Committee as advice to Education team. The Chair of Council suggested that cultural change might be needed within the GOC and that the forthcoming Board Effectiveness Review could impact this.
	<b>Any Other Business</b>
9.	There was none.
	<b>The meeting closed at 12.53pm.</b>

**GENERAL OPTICAL COUNCIL**  
**Minutes of the Registration Committee Meeting held on**  
**Friday 22 May 2026, 11.15 am – 11:53pm via MS Teams**

Present: Geraldine Birks (Chair), Gavin Cooper, Khalid Dalil, Kathryn Foreman, Reena Rani and Aoife Prendergast.

GOC Attendees: Oliver George (Registration Officer), Nadia Patel (Head of Registration), Diana Smith (Administrator) (*Minutes*), Shareen Shah (Registration Operation Manager) (*item 6 only*), and Marc Stoner (Director of Corporate Services).

Apologies: Lisa Gerson and Raymond Curran.

	<b>Welcome and Apologies</b>
1.	The Chair opened the meeting and welcomed all attendees. It was noted that: <ul style="list-style-type: none"> <li>• Lisa Gerson and Raymond Curran had sent their apologies; and</li> <li>• Geraldine Birks would chair the meeting.</li> </ul>
	<b>Minutes from the Registration Committee meeting held on 13 November 2025</b>
2.	The Committee approved the minutes as an accurate record of the last meeting.
	<b>Fee update</b>
3.	The Director of Corporate Services advised the committee that the fees discussion paper was now live on the GOC website and was open for comments until 20 July 2026.
	<b>Renewal update and report</b>
4.	The Head of Registration introduced the item and the Committee were provided with an update on the financial income explaining it was broadly in line with the budget. There were no concerns regarding the finances. The Committee noted that consideration could be given in future to collecting data on registrants who choose to leave the register. It also remarked that the use of personal emails was a positive development.
	<b>MyGOC update including a demonstration</b>
5.	The Head of Registration introduced the item. The Committee was provided with an update about the development of the My GOC platform. The Head of Registration then invited the Registration Officer to demonstrate the new platform, with an overview of the new features and functions. It was noted that data would automatically sync to CRM when registrants input their personal data, which would save the Registration team from doing manual logging. The Committee heard that end to end testing would continue until the platform was ready to launch in September 2026. The Committee commended the Registration team work on the project and remarked that it looked well-designed and easy to use.
	<b>Non-UK update</b>
6.	The Registration Operations Manager presented an update on the Education and Training Requirements (ETR) to the Committee, outlining how the framework is being introduced to create a more consistent and transparent approach to assessing non-UK optometry qualifications, replacing the previous case-by-case model.

	<p>The Committee then heard that implementation is being overseen by a project board, with a focus on embedding the framework into operational practice and ensuring consistency, quality assurance, and effective risk management as the approach develops.</p> <p>The Committee thanked the Registration Operations Manager for the informative presentation and welcomed the progress being made. It also noted the anticipated next phase of the programme, including further development of exception criteria, continued refinement of processes, and the planned transition towards full implementation of the ETR framework, with ongoing updates to be provided as work progresses.</p>
	<b>Any Other Business</b>
7.	There was no other business.
	<b>Meeting Close</b>
8.	The meeting closed at 11.53am.

**Minutes of the meeting of the Standards Committee held on  
Friday 22 May 2026 at 11.15am via MS Teams**

**Present:** Zabir Ali, Sana Asif, Kay Bagshaw, Helen Court, Dean Dunning, Sally Gosling, Dan Green, Dimple Kumar, Ros Levenson, Julia Lewis, Haseena Lockhat, Frank Munro, Hana Patel, Hema Radhakrishnan, Chloe Robson, William Stockdale (Chair), Ahalya Subramanian, and Nilla Varsani.

**GOC Attendees:** Marie Bunby (Policy Manager), Toby Ganley (Policy Manager (Standards)), Terry Koranteng (Information Governance Officer (Governance)) (*minutes*), Charlotte Urwin (Head of Strategy, Policy and Standards).

	<b>Proposed updated statement on testing of sight and supervision standards - STD01(26)</b>
1.	<p>The Standards Committee were joined by the Education Committee and Companies Committee for discussion of this item.</p> <p><b>Companies Committee Members Present:</b> Tim Parkinson (Chair), Sarah Elizabeth Joyce, Parth Shah, Amit Sharma, Poonam Sharma, Kalwant Grewal, Jutinder Basi and Cathy Yelf.</p> <p><b>Education Committee Member Present:</b> Frank Munro (Chair), Helen Court, Dean Dunning, Sally Gosling, Dan Green, Professor Hema Radhakrishnan and Ahalya Subramanian.</p> <p><b>Apologies:</b> Jacqui Adams, Gordon Dingwall and Dan McGhee.</p> <p><b>GOC Attendees:</b> Carole Auchterlonie (Director of Regulatory Operations), Steve Brooker (Director of Regulatory Strategy), Marie Bunby (Policy Manager), Nadia Denton (Governance and Compliance Officer) (<i>minutes</i>), Toby Ganley (Policy Manager, Standards), Kiran Gill (Head of Legal), Terry Koranteng (Information Governance Officer) (<i>minutes</i>), Samara Morgan (Head of Education and CPD), Charlotte Urwin (Head of Strategy, Policy and Standards) and Dr Anne Wright (Chair of Council)</p>
2.	<p>The Committee considered proposed updates to the GOC's Statement on the Testing of Sight (last issued in 2013) and proposed amendments to the Standards on Supervision and Delegation (last reviewed in 2016).</p> <p><b>Key points discussed</b> <b>Testing of Sight Statement</b></p>

- Members noted the need to update the statement to reflect developments in technology, changes in service delivery and evolving patient expectations.
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- There was discussion about the importance of ensuring patients understand who is involved in their care, how services are delivered and who is responsible for communicating findings.
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#### **Overall Themes**

- Patient safety must remain the primary consideration.
- Regulation should support responsible innovation without creating unnecessary barriers, while maintaining patient safety.
- Future guidance should be sufficiently flexible to accommodate continued technological developments and kept under regular review.

	The Committee supported continued consultation and stakeholder engagement before final proposals are presented to Council.
3.	The Companies Committee and Education Committee left the meeting.
	<b>Welcome</b>
4.	The Chair welcomed those in attendance. No apologies were noted.
	<b>Minutes from meeting held on Friday 13 November 2025 - STD02(26)</b>
5.	The minutes from the meeting held on 13 November 2025 were approved as a true record of the meeting.
	<b>Artificial Intelligence Update Presentation - Oral</b>
6.	<p>The Committee received an update on artificial intelligence (AI), including recent internal GOC activity, external regulatory developments, developments in the optical sector, and emerging themes for future standards and guidance.</p> <p><b>Key points from the presentation</b></p> <p>The Committee was reminded that AI had previously been discussed, and of the definition of AI adopted by the NHS, as technology that enables computers to complete tasks that would previously have required human intelligence.</p> <p>It was noted that eye care is close to the forefront of AI adoption in healthcare because many eye conditions rely heavily on imaging, and AI is particularly effective at analysing images.</p> <p>Recent GOC activity included:</p> <ul style="list-style-type: none"> <li>• exploring internal organisational uses of AI;</li> <li>• updating IT policy to address AI-related considerations;</li> <li>• being a joint signatory to a statement on principles relating to AI in education and training;</li> <li>• responding to an MHRA consultation;</li> <li>• participating in a PSA workshop on AI in health and social care regulation;</li> <li>• engaging with the National Commission into the Regulation of AI in Healthcare.</li> </ul> <p>External developments discussed included:</p> <ul style="list-style-type: none"> <li>• PSA work on how regulators should guide professionals using AI;</li> <li>• the Patient Safety Commissioner's interest in AI regulation;</li> <li>• expected recommendations from the National Commission into the Regulation of AI in Healthcare;</li> <li>• the Health Foundation's survey on public attitudes to technology and AI in healthcare;</li> </ul>

- activity by other healthcare regulators, including the General Osteopathic Council (GOsC), General Medical Council (GMC) and General Pharmaceutical Council (GPhC);
- sector developments including the AOP AI resource hub and the Specsavers/CASCADER partnership.

### **Emerging themes**

The main theme identified was the need for a “human in the loop” approach. AI may support clinical and business practice, but professional accountability remained with people and organisations.

The Committee noted that AI should not dilute professional responsibility. Registrants would continue to apply professional judgement, meet GOC standards, and remain accountable for decisions supported by AI.

There was also discussion about the need for regulation to be coordinated rather than fragmented, particularly where responsibilities may sit across individual regulated professionals, business registrants, manufacturers, software developers and medical device regulators.

### **Committee discussion**

Members recognised that AI may have significant potential in both clinical practice and practice management. AI could support more efficient clinic management and improve processes for both patients and practitioners.

However, members also raised several risks and considerations, including:

- the need for registrants to understand the limitations of AI tools;
- the importance of maintaining critical professional judgement;
- the risk that less experienced clinicians may place too much reliance on AI outputs;
- the need to audit AI-generated information for accuracy;
- the risk of AI hallucinations or apparently confident but incorrect outputs;
- the need to consider bias in datasets, particularly from an equality, diversity and inclusion perspective, including whether datasets are representative of different ethnic groups and patient populations;
- the need to consider patient perceptions and confidence in the use of AI, and when and how consent is given;
- the possibility that patients may be concerned if practitioners appear to rely too heavily on AI or automated tools;
- the need to maintain public confidence and ensure patients understand the appropriate role of AI in care delivery;
- the balance of responsibility between individual registrants, business registrants, manufacturers/developers and other regulators.

Members also discussed whether AI systems have embedded values or priorities. It was noted that AI tools may reflect the values, assumptions or biases of developers, datasets or system design. This could be relevant in both clinical and business

	<p>contexts, for example where tools prioritise efficiency, profitability, access or other outcomes.</p> <p>The Committee noted that future guidance should be clear that AI is a tool and does not replace professional judgement.</p> <p><b>Standards considerations</b></p> <p>The Committee considered whether existing standards were sufficient to cover AI or whether specific guidance may be needed.</p> <p>Key points included:</p> <ul style="list-style-type: none"> <li>• professional judgement should remain central;</li> <li>• registrants should be able to justify their use of AI tools;</li> <li>• businesses and individual registrants should consider whether AI tools are appropriate, safe and effective;</li> <li>• the GOC should avoid approving specific products or platforms;</li> <li>• guidance should help registrants understand how existing professional standards apply to AI;</li> <li>• the need for clarity regarding responsibilities of individuals, business registrants, manufacturers and system developers;</li> <li>• patient safety, accountability, transparency and fairness should be central themes.</li> </ul> <p>It was noted that a draft guidance document may be brought back to a future Committee meeting.</p>
	<p><b>Any Other Business</b></p>
<p>7.</p>	<p>There was no other business.</p>
	<p><b>The meeting closed at 12.45pm.</b></p>

**COUNCIL**

**Report from the Chair of Council**

**Meeting:** 24 June 2026

**Status:** For noting

**Lead responsibility & paper author:** Dr Anne Wright CBE (Chair of Council)

**Introduction**

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1. This report covers my principal activities since the last Public Council meeting on 11 March 2026.
2. In the beginning of April 2026, we announced the appointments of Fahima Kirk and Inderpal Ghuman as the new Council Associates.
3. Fahima is a student contact lens optician and dispensing optician based in Leicester. She works as a Dispensing Consultant for the East region at Specsavers. She is a Cert 4 Facilitator, where she teaches the next generation of dispensing opticians. Fahima is also an Outreach Coordinator for Vision Care and a Talk and Support Facilitator for RNIB. In 2025, she was the winner of the Doug Perkins Dispensing Optician Award for Clinical Excellence. Fahima holds a degree in English Language and Literature attained from the University of Leicester in 2021, during which she worked part-time in optics. This experience ignited a passion to delve further, and she enrolled onto the Dispensing Optician Diploma and qualified in 2024. She is currently studying for her Contact Lens Diploma and Diploma in Paediatric Eyecare.
4. Inderpal (Indy) is a specialist optometrist at Moorfields Eye Hospital in London, where he works across a range of services including consultant glaucoma, medical retina, external disease, urgent care, and specialist contact lenses. He graduated from Aston University with a first-class degree in Optometry and has since developed extended clinical experience within multidisciplinary hospital settings. He has completed further qualifications in glaucoma and medical retina and is currently undertaking an MSc in Advanced Clinical

Practice in Ophthalmology at University College London (UCL). Indy has a particular interest in advanced clinical practice and the evolving role of optometrists. Alongside his clinical work, Indy has been actively involved in professional and regulatory engagement, including serving two terms as a national councillor for the Association of Optometrists and contributing to education reform initiatives linked to the GOC Education Strategic Review.

5. Liam Parsons (Lay) and Nasr Khan (Registered Medical Practitioner) were appointed as the new Investigation Committee members and both their terms commenced on 9 March 2026 for a period of four years until 8 March 2030.
6. Liam works as a psychologist and undertakes regulatory work as a Partner for the Health and Care Professions Council (HCPC). Liam strongly believes in the role of professional regulation in maintaining public trust, and in the importance of fair and evidence-informed decision-making. Liam looks forward to supporting the GOC's work in upholding professional standards and maintaining confidence in the optical professions.
7. Nasr has been a GP since 2012. For the last 8 years Nasr has worked as a salaried GP at the Junction Health Centre in Battersea. Nasr concurrently works as a Medical Examiner at 3 hospitals across Southwest London and Surrey (Epsom and St Helier, East Surrey Hospital - Redhill, Royal Surrey County Hospital - Guildford). This work involves independent scrutiny of the causes of deaths that do not fall under the jurisdiction of the coroner. Nasr is a Judicial Office Holder and sits in the First-Tier Tribunal (Social Entitlement Chamber). This role involves deciding appeals against benefit decisions made by the Department of Work and Pensions. Lastly, Nasr is currently onboarding but has not yet commenced a role with the Care Quality Commission (CQC), where he will assist in the inspection of GP Practices.
8. Jutinder Basi (Registrant - DO) and Zabir Ali (Registrant - OO) were appointed as the new Advisory Panel (Companies Committee) Members and both their

terms commenced on 25 February 2026 for a period of four years until 24 February 2030.

9. Jutinder has worked in optics for most of his life. Jutinder started at the age of 13, undertaking work experience in his mother's optical practice. From there, he progressed through various roles, including Optical Assistant, Dispensing Optician, and Store Manager within the multiple sectors. Just over two years ago, Jutinder became a Director of Welbourne Opticians in Lancaster. This transition has given Jutinder invaluable experience of independent practice ownership and exposed Jutinder to a completely different business model, along with the opportunities and challenges that come with it. Jutinder's career has allowed him to gain experience across many areas of optics, and Jutinder remains passionate about delivering excellent patient care while continuing to develop both professionally and personally within the industry.
10. Zahir is a qualified optometrist, having graduated from Aston University in 2008. He gained his Independent Prescribing qualification in 2023 and has a keen interest in the provision of enhanced services through community optometry practices. He is a Boots Opticians franchise partner and leads Wessex Optical, a multi-site optometry business operating across Dorset, Hampshire and Staffordshire. His work focuses on delivering accessible, high-quality eye care in community settings, alongside developing sustainable practice teams and services. Zahir is also actively involved in the wider optical sector, business community and local civic life. He is Vice Chair of the Hampshire and Isle of Wight Local Optical Committee, a Director of Wimborne BID, and a member of the BCP Holocaust Memorial Committee.

## Management

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11. I have held weekly catch-up meetings with Leonie Milliner, Chief Executive and Registrar (CE&R) and with Andy Mackay-Sim, Chief of Staff.

12. As well as other meetings on specific priorities and issues, I have held quarterly 1:1 meetings with individual Senior Management Team (SMT) members.
13. I completed the CE&R end of year business performance review meeting on 9 June 2026. This review was conducted within the Performance Behaviours Framework (PBF).
14. To celebrate International Women's Day the Registration Officer on behalf of the Women's Network, organised a quiz session on 12 March 2026.
15. As part of Neurodiversity Awareness Week, I joined the lunch and learn session on 17 March 2026, organised and hosted by the Equality, Diversity, and Inclusion (EDI) Manager. The session looked at neurodiversity in a broad sense rather than focusing on specific conditions.
16. To celebrate Women's History Month (WHM) I joined the CE&R's inspiring presentation on 20 March 2026, entitled WHM spotlight session; 'Elsie Widdowson's fight to feed a nation.'
17. I watched the recording of the Women's Network lunch and learn smashing the glass ceiling session that was held on 31 March 2026.
18. I watched the recording of the Staff Wellbeing and Engagement Group (SWEG) coffee break, 'Solving the great stink' where Rob Harris, Visitor Experience Manager at Crossness Pumping Station (and also Claire Marchant-Williams' husband), led a talk on 9 April 2026 about how London transformed from unregulated chaos into a clean, ordered modern city.
19. On 8 May 2026, I joined the SWEG coffee break, Charles Bonnet Syndrome session hosted by Cathy Yelf, Council member who discussed the Charles Bonnet Syndrome.
20. I watched the recording of the designing for dignity (creating safe spaces for the unhoused) Social Mobility Network session held on 12 May 2026, hosted by Arjun

(Kiran Gill's son) who is a junior Interior designer with experience in residential and commercial hospitality projects.

21. On 19 May 2026, I attended the ABLE session celebrating Global Accessibility Day in partnership with Thomas Pocklington Trust (TPT) which focused on digital accessibility.
22. On 9 June 2026, I joined the social mobility webinar organised by the EDI Manager, which was a geography focussed session.
23. To mark Pride Month, the SWEG and Rainbow Committee hosted a special coffee break on 10 June 2026, exploring the history and significance of Pride. An engaging session led by the EDI Manager, who shared the history of Pride and explored how Pride Month has helped to drive progress for LGBTQIA+ rights and equality. The session also reflected on why Pride remains an important opportunity to celebrate diversity, raise awareness and promote inclusion.
24. As part of our Pride Month celebrations, the Rainbow Committee held a fun and engaging Pride/LGBTQIA+ themed quiz session on 18 June 2026 to test knowledge, learn something new, and celebrate diversity and inclusion with colleagues in a 3-round quiz challenge.

### **Council and Committees**

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25. I have continued to join fortnightly meetings with Tim Parkinson, Senior Council Member (SCM).
26. I have also held catch-ups with Council Members and Associates and participated in induction sessions for incoming members.
27. During 21 April 2026 to 21 May 2026, I conducted Council Member and Associate end-of-year review meetings. On 15 June 2026, I completed my Council Chair end of year review meeting with Tim Parkinson, SCM as the reviewer.

28. On 18 May 2026 and on 22 May 2026, I hosted individual Council Associate introductory meetings with Fahima Adam and with Inderpal Ghuman.
29. On 2 June 2026, I chaired the Council virtual coffee morning session where all Council Members and Associates were welcomed to join. In addition, I chaired the Council catch-up sessions on 14 April 2026 and on 19 May 2026.
30. I attended the Remuneration Committee meeting on 7 April 2026; the Investment Committee meeting on 6 May 2026; the Audit, Finance and Risk Committee (ARC) meeting on 12 May 2026; the Nomination Committee meeting on 19 May 2026; and the Advisory Panel meeting and Education Committee meeting on 22 May 2026.

### **Stakeholders**

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31. 17 March 2026: GOC and General Osteopathic Council (GOsC) Chair catch-up meeting with Jo Clift, GOsC Chair.
32. 19 March 2026: GOC and Health and Care Professions Council (HCPC) Chair catch-up meeting with Christine Elliott, HCPC Chair.
33. 24 March 2026: GOC and General Medical Council (GMC) Chair's catch-up meeting with Professor Dame Carrie MacEwen, GMC Chair.
34. 14 May 2026: Professional Standards Authority (PSA) for Health and Social Care Chairs' Roundtable organised by Caroline Corby, PSA Chair.
35. 12 June 2026: GOC - General Pharmaceutical Council (GPhC) joint Chair and CE&R meeting with the CE&R and Gisela Abbam, GPhC Chair and Kathie Cashell, GPhC CE&R.

**Council Member meetings with stakeholders**

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36. In the absence of the provider forum, Frank Munro, Council Member observed the Optometry Schools Council (OSC)/Opticians Academic School Council (OASC) meeting in April 2026.
  
37. A Specsavers visit was held on 29 April 2026 in Norwich. Attendees included Tim Parkinson, SCM, and Ros Levenson, Council Member, supported by Toby Ganley, Policy Manager (Standards).
  
38. Lisa Gerson, our Council Member attended the Optometry Wales AGM, Conference and dinner on 29 April 2026 and on 30 April 2026 on behalf of GOC. Lisa talked about the work of the GOC and stimulated interest from both dispensing and optometry registrants in future opportunities that the GOC offers. Lisa also provided a presentation on the GOC Strategy 2025 - 2030 which prompted comments on the registrant fee review discussion paper.
  
39. On 8 June 2026, William Stockdale, our Council Member took part in a roundtable discussion with Bradford University which focused on domiciliary eye care, with Paul Chapman-Hatchett as one of the other participants.

**COUNCIL****Chief Executive and Registrar's Report**

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**Meeting:** 24 June 2026**Status:** For noting**Lead responsibility and paper author:** Leonie Milliner, Chief Executive and Registrar**Council Lead(s):** Dr Anne Wright CBE, Council Chair**Purpose**

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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**

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2. Council is asked to note the Chief Executive and Registrar's report.

**Strategic objective**

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3. This work contributes towards the achievement of all parts of our Strategic Plan and our 2026-2027 Business Plan.

**Background**

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4. The last report to Council was provided for its public meeting on 11 March 2026.

**Analysis**

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5. Since Council last met, we have welcomed five new members of staff: Tom Eustice, Operations Manager (Triage); Terry Koranteng, Information Governance Officer; Lisa Caryer, Registration Officer; Adiam Weldensae, Lawyer; and Hosaam Safdar, Finance Officer. I meet all new members of staff for an informal introduction to the GOC as part of their induction programme.
6. Since Council last met James Risk, Finance Officer; James Whitton, Education Operations Manager, and Nassaka Kagwa, People and Culture Administrator have left the GOC. We are very grateful for their contributions and wish them both well for the future.

**Internal engagement**

7. I continue to hold weekly meetings and pre-brief meetings with the Chair of

Council, the Chief of Staff, with each Director of the Senior Management Team (SMT) and other members of the executive as required. I meet our Head of People and Culture at least monthly for people and culture partner meetings.

8. I continue to chair our SMT's fortnightly meetings and our monthly All-Staff Meetings (ASM). I also attend SMT's monthly corporate Risk Register meetings chaired by the Director of Corporate Services. On 13 April 2026 and on 8 June 2026, I attended the Leadership Team (LT) meetings (which has a rotational chair). I meet our Head of People and Culture at least monthly for people and culture partner meetings.
9. From 24 March 2026 to 7 May 2026, I held and completed the SMT's and the Chief of Staff's end of year business performance reviews. On 9 June 2026, I attended my end of year business performance review meeting with the Chair of Council. In preparation for this year's performance reviews, I attended two workshops held for all employees on 12 March 2026 and on 2 April 2026 on the Performance and Behaviours Framework (PBF) performance review process and setting objectives for the next performance year.

#### Council and Committee engagement

10. I attended the Remuneration Committee meeting on 7 April 2026; the Council catch-up session on 14 April 2026; the Investment Committee meeting on 6 May 2026; and the Audit, Finance and Risk Committee (ARC) meeting on 12 May 2026.
11. On 23 March 2026, I hosted an Advisory Panel (Companies Committee) member induction with newly appointed members Jutinder Basi and Zabir Ali.
12. On 26 March 2026, I attended the GOC Fitness to Practise (FtP) Chairs briefing. The day's agenda included sessions on equality vs equity, learning from best practice, and recognising and mitigating bias in decision-making. The day also included an opportunity for committee chairs to reflect on member reviews and leading fair and effective hearings.
13. On 27 March 2026 we held our FtP Committee members annual briefing. I was delighted to provide an overview of progress made in delivering year one of our new strategy plan and provide an update on key policy initiatives. Other topics included updates on review hearings, recent case law, and key learning points from decision audits, and reflections on actions following the outcome of our recent PSA annual performance review.

#### Staff wellbeing and engagement

14. Our volunteer internal staff networks continue to work hard to mark important cultural events and religious festivals, and I would like to express my thanks to the network chairs and committees for their impactful leadership which helps secure employee wellbeing and belonging, as well as promote a culture of psychological safety.
15. To celebrate International Women's Day, our Women's Network organised a quiz on 12 March 2026 and a lunch and learn session on 31 March 2026 called 'Smashing the glass ceiling,' where there was an opportunity to hear from a panel of GOC staff about their career in regulation, recognising the power of shared experiences, mutual support, and collective growth in advancing women's careers. In addition, there was an optional and relaxed Curriculum Vitae (CV) sharing session at the end of the panel session.
16. To support Women's History Month (WHM), I gave a presentation on 20 March 2026 which explored the remarkable life and legacy of the pioneering scientist Elsie Widdowson, whose groundbreaking work helped shape modern nutritional science and played a vital role in supporting the nation during wartime Britain.
17. As part of Neurodiversity Awareness Week, our EDI Manager hosted a lunch and learn session on 17 March 2026 looking at neurodiversity in a broad sense, exploring what neurodiversity is and why it matters in the workplace.
18. To celebrate World Health Day and to promote employee wellbeing, Elena Consoli, an online external Yoga Instructor, offered an online beginner-friendly, fully accessible lunchtime yoga class to all staff on 7 April 2026. Elena also offers weekly online evening yoga sessions, organised by Staff Wellbeing and Engagement Group (SWEG).
19. Ahead of World Autism Acceptance Day, our ABLE Network and the Parent and Carer Network hosted a lived experience coffee and learn, autism and parenting session on 26 March 2026. This session offered an opportunity to hear directly from lived experience, deepen understanding of neurodiversity, and reflect on how greater awareness can help create more inclusive environments for everyone.
20. Our Social Mobility Network have hosted two sessions this quarter. The first was on 12 May 2026 called 'designing for dignity' which explored the creation of safe spaces for the unhoused and how design can counter the isolation of vulnerable young people and foster dignity and connection. On 9 June 2026, the network organised a webinar focusing on the geography of social mobility, exploring the intersection of education, housing and location with social mobility.

21. On 16 April 2026 we held our alcohol-free Spring lunch (which replaced for the first time our staff Christmas lunch). In the morning colleagues were invited to take part in a range of skill and cultural based activities, including a tour of Canary Wharf's public art led by our Governance officer and a staff-quiz in the office. I hosted a confidence-building presentation workshop and subsequently offered a 1:1 coaching session for participants if required.
22. Our SWEG continues to organise short online coffee break talks on topics of interest to staff and members. On 9 April 2026, we heard from Rob Harris, Visitor Experience Manager at Crossness Pumping Station called 'The great stink' about how London transformed from unregulated chaos into a clean, ordered modern city. I am also very grateful to Cathy Yelf who hosted a SWEG coffee break on 8 May 2026 to raise awareness of Charles Bonnet Syndrome.
23. We celebrated Global Accessibility Day in partnership with Thomas Pocklington Trust (TPT) on 19 May 2026, with a session that explored the impact of accessibility in technology. The panel consisted of interns from the Get Set Progress Internship Programme, who shared their personal experiences with digital accessibility and discussed its importance both in their day-to-day roles and in their personal lives. Their perspectives provided valuable insight into how accessibility shapes user experiences, workplace inclusion, and everyday interactions with technology.
24. To mark Pride Month, the SWEG and Rainbow Committee hosted a coffee break on 10 June 2026, exploring the history and significance of Pride and explored how Pride Month has helped to drive progress for LGBTQIA+ rights and equality. The session also reflected on why Pride remains an important opportunity to celebrate diversity, raise awareness and promote inclusion. All staff were welcomed.
25. As part of our Pride Month celebrations, the Rainbow Committee held a Pride/LGBTQIA+ themed quiz on 18 June 2026 to celebrate diversity and inclusion with colleagues in friendly a 3-round quiz challenge.

## **People and Improvement**

### People and Culture

26. During the last quarter, People and Culture has made strong progress in strengthening workforce management, governance, and organisational capability, aligned to the our strategic priorities. A key milestone has been the implementation of the Performance and Behaviour Framework (PBF). All employees have completed with their line manager a performance review in Q1 aligned to the PBF. I am delighted to report that all completed PBF

performance review forms were returned on time, which provided a firm foundation for moderation, which we have introduced to ensure consistency and fairness, supporting a more robust and transparent performance culture. Building on a successful pilot, the organisation-wide moderation process was completed by early June, the output of which will be considered by the Senior Management Team (SMT) on 26 June and Remuneration Committee on 2 July.

27. The people policy review programme is underway to ensure our people policies are compliant with new legislation and reflect current best practice. Workforce planning capability has been enhanced through agreement for quarterly workforce planning meetings with finance, improving alignment between staffing, service demand, and budget planning. This represents an important step toward more integrated and forward-looking decision-making.
28. Our employee benefits offer has been renewed, and we have introduced a new health cash plan provider, enhancing the range and accessibility of health and wellbeing support available to employees. In addition, procurement activity has been undertaken to strengthen key enablers, including the tender of an employment resources platform to support managers with consistent advice, and the tender of a survey provision solution to enhance employee voice and engagement insight.
29. Investment in systems and insight has progressed, with improved HR analytics capability enabling better workforce data, reporting, and trend analysis to support evidence-based decision-making. Overall, these developments reflect a continued focus on building a more consistent, data-driven, and strategically aligned People and Culture function, supporting both organisational performance and employee experience.

#### Project Delivery

30. The first AI Governance Board met on 11 June 2026. It considered a new assessment tool to support teams who want to introduce AI functionality into their work. It also reviewed proposals regarding the use of AI in making redactions.
31. MyGOC is planned to launch in September, after the student registration period has closed. The project board continues to meet to discuss and agree engagement activity and monitor financial output. In preparation, the primary focus has been test and development completion, and readiness/migration activity. Testing end-to-end continued throughout May, with change requests (CR's) being assessed and prioritised whilst data integration is developed and tested

32. The project team continue launch and readiness activities, with the first issue of communications to fully qualified registrants in May.
33. Continuous Improvement (CI) work continues with the team's discussions across the business. A record of activities proposed activities are being held centrally for discussion at the first CI Board.

## **Corporate Services**

### Registration

34. The annual renewal for fully qualified (FQ) and body corporate (BC) registrants closed on 31 March. Removals took place on 9 April 2026, the renewal rates remained consistent with expected numbers compared to the previous cycle as shown below.
35. The annual renewal for fully qualified (FQ) and body corporate (BC) registrants closed on 31 March. Removals took place on 9 April 2026, the renewal rates remained consistent with expected numbers compared to the previous cycle as shown below.
36. We will be conducting an audit of all BC's 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.
37. We are currently preparing for the annual renewal for student registrants which will open at the end of May. The students will have an initial deadline of 15 July with a final deadline of 31 August.
38. The team are currently preparing to begin the end-to-end testing for the MyGOC platform. We have also developed a clear launch and onboarding strategy, including sending tailored emails for different registrant groups to help them get ready for the new system.

### Information Technology (IT)

39. The GOC was awarded Cyber Essentials recertification in March 2026 and has subsequently achieved recertification for Cyber Essentials Plus, demonstrating its continued commitment to maintaining robust cyber security standards

### Finance

40. The 2025/26 financial year ended on 31 March 2026 and the end of year

accounts have been produced. Our external auditors are currently carrying out the field work on their testing of the figures and are due to report to the executive in July on any findings. To date, the executive, have not been made aware of any material concerns by the auditors.

### Facilities

41. An internal audit is scheduled to take place in relation to health, safety and wellbeing. The field work is expected to be carried out in June and a report issued to the executive in July.

### **Regulatory Operations**

42. Case progression activity has focused on strengthening delivery while managing a higher volume of concerns. We received 607 referrals in 2025/26, 31% more than in 2024/25. More triage decisions were completed in Q4 than in the previous quarters, reflecting a focus on throughput and timeliness alongside maintaining quality. Dip sampling by department Heads, focusing on triage closure decisions, has provided early assurance of improvements in both the quality of decision-making and how those decisions are evidenced and recorded.
43. The investigations team undertook trauma-informed investigations training and started embedding this approach into operational practice. This has included reviewing stakeholder communications, accessibility and website content to support clearer and more inclusive engagement.
44. We have also strengthened our approach to stakeholder communication, including introducing clearer expectations around the timeliness and quality of updates provided throughout investigations.
45. By the end of Q4, the hearings team had delivered 339 hearing days for 2025/26, including 22 in-person days, and concluded 37 substantive cases against a business plan target of 40. While slightly below target, this was offset by a further 12 cases that were listed but concluded earlier than anticipated, reflecting improved case progression. This strong operational performance was underpinned by a 92% utilisation rate, demonstrating effective management of scheduled versus actual hearing days.
46. As part of our commitment to continuous improvement, we launched a new hearings feedback survey for substantive cases, linked to an AI-enabled reporting tool. This is providing more systematic insight into stakeholder feedback, and we are developing an action plan to drive further improvements

into the next year.

47. We have also recruited and appointed six new clinical advisers to strengthen support to Fitness to Practise Committees in health cases, with training scheduled for July 2026.
48. We completed our annual training programme for hearing panel members in Q4, including a dedicated session for chairs and a wider programme for all hearing panel members. This covered key areas such as trauma-informed practice, case law updates, and sexual misconduct cases, supporting consistency and quality in decision-making.

## **Regulatory Strategy**

### New Standards from the Professional Standards Authority

49. The Professional Standards Authority for Health and Social Care (PSA) published its updated Standards for Regulators and Accredited Registers in March 2026. The overall number of standards have been reduced from 18 to 16. The PSA has explained that its changes include:
  - A single, consistent set of standards for both regulators and accredited registers
  - Clearer expectations around transparency and accountability
  - Stronger emphasis on governance, leadership and organisational culture
  - Reinforced risk-based and evidence-informed approaches to professional suitability and safeguarding
  - Clear expectations around collaboration and information sharing across the regulatory system
  - Measures to support earlier, local resolution of concerns about registrants
50. We will be reviewing the new standards to ensure that we can continue to meet them. This will include reviewing the evidence framework for the types of examples of evidence that the PSA will be expecting to receive. While the new standards come into effect on 1 July 2026, we will not be assessed against the new standards until our January-December 2027 performance review year.

### Thematic review

51. We are continuing to collect and analyse evidence to support the thematic review. Since Council last met, our appointed agency, Shift Insight, completed qualitative research into commercial practices and patient safety and we completed our second LinkedIn conversation and survey on the topic of sales

targets and incentives. We discussed some of our key analysis and findings so far with our Advisory Panel on 22 May 2026.

52. The evidence gathering phase is nearing conclusion and over the next period the project team will focus on analysis and report writing. However, as we are still awaiting some datasets and information from commissioners to support analysis of sight tests for young children, we have decided to change our timetable for this work to present to Council in September 2026.

### Research

53. The annual 2026 registrant survey has now concluded. In addition to collecting data for the thematic review on commercial practices and patient safety, new questions were included this year to gather registrants' views and experiences relating to the use of AI, as well as vision and safe driving. The annual public perceptions survey has also been completed, and we have continued to monitor trends in relation to patient satisfaction and the use of eye care services. Both reports will be presented to Council in September.
54. As the three-year contracts for both research projects have now come to an end, a review and evaluation of research activity over the past three years will be undertaken to identify clear lessons learned and to strengthen future research planning and delivery ahead of commissioning any future surveys.

### Driving vision standards

55. Following the publication of the Government's road safety strategy early this year, the Department for Transport consulted on proposals to introduce mandatory eyesight testing for drivers over 70 years old. Our [submission](#) was informed by our existing guidance on reporting drivers to the DVLA where the patient may not be safe to drive, will not or cannot inform the DVLA themselves and there are safety concerns, as well as a number of conversations with stakeholders and several pieces of commissioned research.
56. We focused our submission on questions relevant to our regulatory remit. We noted evidence from our research shows mixed views on where responsibility for reporting to the DVLA should lie. We also noted that alignment of any new requirements with existing sight testing regimes might help avoid confusion and reduce unintended public health consequences. We pointed to the risk that introducing a separate, narrower driving test, could discourage full eye examinations and lead to undiagnosed conditions or unmet vision needs, which could impact quality of life and increase costs to the NHS. We indicated that using optometrists to conduct tests, would allow for any necessary corrective measures to be prescribed without adding friction to the system.

57. We will continue to engage with colleagues at the Department for Transport and DVLA as they develop these proposals and will share with them relevant findings from our recent public perception and registrant surveys.

#### Approach to setting registrant fees

58. We launched our consultation on our discussion paper on setting registrant fees on 27 April. The consultation will run for 12 weeks, until 20 July. We expect to bring a response document to Council no earlier than December 2026.

#### National Commission into the Regulation of AI in Healthcare

59. We continue to engage with the Commission as it continues its evidence gathering. On 28 May, alongside other healthcare regulators, we attended a workshop on professional liability and the use of AI in healthcare hosted by the MHRA and PSA on behalf of the Commission. The workshop was part of the Commission's broader work to review and advise on the regulatory framework and its applicability in the AI era.

#### Communications

60. We have promoted our discussion paper on setting registrant fees through our website and social media channels. We press released the appointment of our two new council associates, Fahima Adam and Indy Ghuman. Drafting has commenced on this year's Annual Report and EDI Annual Report.

#### Education and Continuing Professional Development (CPD)

61. CPD audits and provider reviews commenced in April. In preparation, in March we undertook our annual CPD auditor and reviewer workshop. In this review and audit period we reviewed 525 registrant records and audited 11 CPD providers records.
62. Our consultation on CPD reform closed in April. We are reviewing the responses and preparing the consultation response.
63. Following register renewals, 48 registrants have sought restoration to the register, requiring checks on the CPD restoration requirements. I can report that 45 registrants have met the CPD requirements, with three requiring additional information.
64. The annual Sector Strategic Implementation Steering Group meeting took place

on 22 April where we heard updates relating to clinical placements funding across the four nations, apprenticeships, placements for IP trainees, and updates from the Sector Partnership for Optical Knowledge and Education (SPOKE).

65. We held our quarterly contract meeting with SPOKE in April where we discussed current knowledge hub projects including supervision guidance and student staff ratios, mapping AI in education, and lifelong learning for a great workforce.
66. We attended meetings held by the Optometry Schools Council (OSC) in April and Opticians Academic Schools Council (OASC) in June and provided updates on education quality assurance related matters and sought feedback on our work in this area.
67. As part of our Quality Assurance and Enhancement Method (QAEM) outlined in our Education and Training Requirements (ETR), we are commencing the rollout of provider-focused periodic reviews this year. We plan a phased approach for all providers of GOC approved qualifications periodic reviews over the next four years. The order of the rollout is based on time since quality assurance visits under the 'old' handbooks and when we reviewed providers plans to adapt their qualification/s to the ETR. We have established a 'Periodic Review Focus Group' comprised of provider representatives which will enable providers to share feedback in real time and to enable the team to make adjustments to the periodic review method to ensure proportionality.
68. There are currently 12 new qualifications progressing through our staged application process to gain GOC-qualification approval. As part of this process, on 26 May I granted stage 3 approval to Anglia Ruskin University to recruit students to its BSc (Hons) DO apprenticeship qualification from September 2026. This is the second DO apprenticeship granted approval to recruit, and we continue to quality assure these qualifications through the staged application process as they progress towards a stage 5 outcome (full GOC qualification approval).
69. Since the beginning of this year, the education team have been reviewing the 35 annual monitoring returns from GOC approved education providers for qualifications delivered against both the handbook and ETR in the 2024/25 academic year. This year we committed to responding to all providers before the end of June 2026, with either additional information requests or an outcome of our reviews and are on track to do this. Alongside this, all responses continue to be analysed to form the basis of our annual UK optical education report due to be considered by Council in September and published later this year.

70. Following publication of the evaluation of non-UK optometry guidance in November 2025 to ensure alignment to the ETR, the education and registration teams continue to work together to review and redesign our registration processes for international applicants to the GOC's register.

### **Governance**

71. We have published a reasonable adjustments process note for member recruitment. This provides clearer guidance on how reasonable adjustments can be requested, considered and implemented throughout member recruitment processes, supporting a consistent, fair and inclusive approach for candidates.
72. We have welcomed two new Council Associates, Fahima Kirk and Indy Ghuman. Their appointments support our succession planning and broaden the range of skills and perspectives available to Council, while providing structured opportunities to develop understanding of the GOC's governance arrangements and regulatory work.
73. The member database project for CRM is progressing, with work continuing to improve how we hold, manage and use member information. The project is intended to strengthen governance administration, support more efficient engagement with Council, committees and associates, and provide a more reliable source of information for planning, reporting and assurance activity.
74. The Chief of Staff has been working with the Chair of Council and others to scope a board effectiveness review. It is intended that this work will commence in September, once a partner has been selected.

### **Equality, Diversity, and Inclusion (EDI)**

75. Following Council approval, the EDI 2026–27 action plan is now in place, structured around five priority themes and 28 deliverables. Progress is underway, with early delivery focused on building the foundations needed for sustainable change. Alongside this, updated Equality Impact Assessment (EqIA) guidance and templates have been developed, with a pilot phase planned to test and refine the approach before wider implementation.
76. On 3 June we signed the Workforce Race Equity in Health and Social Care: Shared Principles for Regulators, aligned to help tackle longstanding racism experienced by health and social care staff. The shared principles, based on the independent NHS Race and Health Observatory's Seven Principles of Anti-Racism, bring regulators together around a common commitment to addressing

racial inequalities across the health and social care workforce. The shared principles focus on strengthening leadership, improving the quality and use of data, and taking evidence-informed action to tackle disparities experienced by ethnic minority professionals.

77. We are one of nine regulators who have committed to ensuring improved collective accountability, with signatories including the Health and Care Professions Council, Social Work England, General Optical Council, General Pharmaceutical Council, General Chiropractic Council and the General Osteopathic Council.
78. Work to strengthen our approach to inclusive recruitment has progressed, with Phase 1 insights and recommendations shared with SMT. Discussions are now underway to shape Phase 2, which will move into designing and implementing practical changes.
79. We have also made progress in improving how we understand and use diversity data. Monitoring forms have been updated to provide clearer explanations and encourage accurate disclosure, supported by the development of a new internal EDI data page to improve transparency and understanding for colleagues. This will be shared imminently.
80. Preparatory work is progressing on a number of key programmes, including the commissioning of a cultural safety programme and engagement with specialist organisations to support work on antisemitism and anti-Muslim hostility. We have also begun early work to consider and respond to the Mann Review, including scoping implications for our regulatory approach (see section below).
81. We have also submitted our TIDE (Talent Inclusion and Diversity Evaluation) accreditation application, with outcomes expected later in the year. TIDE is a self-assessment and benchmarking tool from Onvero that helps us measure our progress and strengthen our approach to equality, diversity and inclusion. Together, these areas of work are helping to build a more consistent and informed approach to inclusion across the organisation.

#### Lord Mann Review – implications for regulators

82. [The Mann Review](#) into antisemitism and other forms of racism in the NHS and healthcare regulatory system, and the Government's response, was published on 4 June 2026. The review sets out expectations that health and care regulators take a more active and coordinated role in addressing racism, including antisemitism and anti-Muslim hostility. It highlights the need for greater consistency across the regulatory landscape, particularly in how discrimination is defined, identified and addressed, alongside stronger

collaboration between regulators.

83. Several recommendations are directly relevant to regulators. These include establishing a more consistent approach to definitions of racism and religious hatred; strengthening joint working through the Professional Standards Authority (PSA) and existing inter-regulatory groups; and improving the sharing of information, data and learning on discrimination and good practice. The review also calls for clearer guidance for employers on when concerns should be referred to regulators, and for more accessible communication for patients and the public.
84. The review further emphasises the importance of capability and culture within regulatory organisations. This includes embedding equality, diversity and inclusion within leadership accountability, strengthening approaches to fitness to practise cases involving racism, and improving access to training and expert input to support decision making. Overall, the recommendations point to a more consistent, joined up and proactive approach across the sector.
85. We have undertaken an initial structured assessment, mapping relevant recommendations to current activity, policies and practices, and identified priority next steps with further work focused on consistency, clarity and application in practice. Overall, we consider we are well aligned and already delivering against a number of the relevant recommendations. This includes identifying opportunities for greater alignment with other regulators, reviewing relevant policies and processes, and identifying where further development may be required.
86. We have responded to the PSA's request for a nominated senior lead for ongoing liaison and have been asked to share our initial reflections at the planned Chief Executive's Steering Group (CESG) across on 22 July. This sits alongside planned work with specialist organisations to strengthen our approach to antisemitism and anti-Muslim hostility, and the commissioning of training for all staff and members, as well as a wider cultural safety programme.

#### External Stakeholder Engagement

87. Since the last public Council meeting on 11 March 2026, I have attended the following external meetings and engagements:
  - 13 March 2026: Meeting with Optometry Schools Council (OSC), Opticians Academic School Council (OASC) and College of Optometrists (COO) with the Director of Regulatory Strategy and the Head of Education and CPD. Joined by Ian Humphreys, COO Chief Executive; Lizzy Ostler, COO Director

of Education; Professor Joy Myint, OSC Head of School and Professor of Optometry at Cardiff University; with OSC representatives, Rupal Lovell-Patel, University of Lancashire, Lyle Gray, Glasgow Caledonian University (GCU), Godwin Oveneri, University of the Highlands and Islands (UHI), Gurvinder Chattha, University of Hertfordshire, Claire Gorman, University of Plymouth; Dr Catriona MacLennan, OASC Lecturer in Vision Science at Glasgow Caledonian University and Nina McDermott, OASC Principal at ABDO College; Miranda Richardson, ABDO Head of Professional Qualifications and Education Dean Dunning, ABDO Head of qualifications.

- 13 March 2026: Meeting with Dr Vijay Anand, Head of Optometry at Moorfields Eye Hospital NHS Foundation Trust, Hussain Khambhati and Hannah Dunbar, Policy Leads/Optometrists at Moorfields Eye Hospital, accompanied by the GOC's Head of Strategy, Policy and Standards and the Head of Education and CPD.
- 24-25 March 2026: Attendance at the Institute of Regulation (IoR) 2026 annual conference with the theme of 'advancing regulation together' and pre-conference dinner, jointly organised by Marcial Boo, IoR Chair, Sinéad Whelan, General Manager and Kirsty Mills, Global VP Regulatory Solutions at Objective Corporation. Conference speakers included Lord Willetts, Chair of the Regulatory Innovation Office, Professor Dame Julia Black, Nuffield College, Oxford and Paul Rees MBE, CEO of the Nursing and Midwifery Council (NMC) and David Lunn, Director of Regulation Directorate from the Department of Business and Trade.
- 30 31 March 2026: I attended a two-day training session at Royal Academy of Dramatic Art (RADA) Course, focusing on effective TV and radio interviews.
- 27 April 2026: I chaired the Optical sector CEO meeting accompanied by the Chief of Staff with the relevant sector body Chief Executive's in attendance, including Adam Sampson, Chief Executive, Association of Optometrists (AOP), Harjit Sandhu, Group Managing Director, Federation of Ophthalmic and Dispensing Opticians (FODO), Alistair Bridge, Chief Executive, Association of British Dispensing Opticians (ABDO) and Ian Humphreys, Chief Executive College of Optometrists (COO).
- 13 May 2026: meeting with GOC Adam Sampson, Association of Optometrists (AOP) Chief Executive and Ella Franci, AOP Director of Legal and Regulatory accompanied by the Director of Regulatory Strategy, the Chief Legal Officer and the Chief of Staff.
- 15 May 2026: introductory meeting with Kathie Cashell, the General Pharmaceutical Council (GPhC)'s newly appointed Chief Executive.

- 15 May 2026: a training session to learn more about Colligo, a recently installed internal IT application, hosted by Tim Brady, Chief Executive Officer at Colligo.
- 17-22 May 2026: six-day course at London Business School, 'Executing strategy for results.'
- 2 June 2026: meeting with Harjit Sandhu, Group Managing Director, Federation of Ophthalmic and Dispensing Opticians (FODO), David Hewlett, FODO Director of Policy and Strategy, Michael Guthrie, FODO Director of Policy and Regulation accompanied by the Director of Regulatory Strategy and Chief of Staff.
- 3 June 2026: Chief Executives of Regulatory Bodies (CEORB) meeting organised by Nick Jones, (CEORB Chair), Chief Executive and Registrar at the GCC with the relevant regulatory bodies in attendance.
- 4 June 2026: 2026 Association for Nutrition (AfN) annual discourse hosted by Leeds Beckett University.
- 10 June 2026: National advancing practice professional and regulatory bodies engagement group meeting organised by NHS England workforce.
- 12 June 2026: joint Chair and CE&R meeting with General Pharmaceutical Council (GPhC) Chair of Council Gisela Abbam, and Kathie Cashell, GPhC CE&R.
- 12 June 2026: meeting with Ian Humphreys, Chief Executive College of Optometrists (COO), Sarah Cant, COO Director of Policy and Strategy, accompanied by Director of Regulatory Strategy and Chief of Staff.
- 15 June 2026: meeting to with Alistair Bridge, Chief Executive, Association of British Dispensing Opticians (ABDO), Max Halford, ABDO Clinical Lead, accompanied by Director of Regulatory Strategy and Chief of Staff.
- 17 June 2026: Institute of Regulation (IoR) webinar 'Rewiring Regulation from Rulebook to Operating System', organised by Robyn Ingham, Events and Projects Officer.
- 19 June 2026: GOC defence stakeholder group meeting organised by the Director of Regulatory Operations.

88. A range of other engagements by Directors are listed in Annex 1.

**Finance**

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89. This paper requires no decisions and so has no financial implications.

**Risks**

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90. The corporate risk register has been reviewed in the past quarter and discussed with ARC.

**Equality Impacts**

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91. No impact assessment has been completed as this paper does not propose any new policy or process.

**Devolved nations**

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92. We continue to engage with all four nations across a wide range of issues.

**Other impacts**

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93. No other impacts have been identified.

**Communications**

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**External communications**

94. This report will be made available on our website, but there are no further communication plans.

**Internal communications**

95. An update to staff normally follows each Council meeting, which will pull out relevant highlights.

**Next steps**

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96. There are no further steps required.

**Attachments**

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Annex 1 - Directors' stakeholder and other meetings.

<b>Philipsia Greenway</b> Director of People and Improvement	<b>Steve Brooker</b> Director of Regulatory Strategy	<b>Carole Auchterlonie</b> Director of Regulatory Operations	<b>Marc Stoner</b> Director of Corporate Services
Meetings with EB partnership – scheduled monthly	Meetings with national optometric advisers – scheduled fortnightly	20.3.26 - Defence Stakeholder Group	27.3.26 - Meeting with EB Partnership.
15.4.26 Gallio restaurant meeting – preparations for staff lunch	12.3.26 – Thomas Pocklington Trust – CPD reform consultation meeting	26.3.26 Annual FtP Chairs' training	30.4.26 - meeting Pixl8 senior board.
30.4.2026 - meeting Pixl8 senior board	13.3.26 – OSC, OASC, College of Optometrists – education quality assurance	27.3.26 Annual FtP panel members' training	22.4.26 - Brewin Dolphin – Charities update.
30.4.26 - Browne Jacobson	13.3.26 – Chaired Optical Sector Policy Forum	1.4.26 Cross-regulators Directors of FtP	30.4.26 - TIAA internal audit planning
04.6.26 - Worknest	16.3.26 – Michael Guthrie, FODO – introductory meeting	2.4.26 AOP legal and regulatory team	30.4.26 - Institute of Regulation – Risk group
08.6.26 - The Survey Initiative	16.3.26 – Chaired CPD reform consultation event	10.4.26 Annie Hudson, independent reviewer of social work regulation	11.05-26 – Brewin Dolphin – Financial resilience in investments
	23.3.26 – ABDO – CPD consultation meeting	24.4.26 Chief Executives of Regulatory Bodies (CEORB) - deputising for CEO	27.05.26 - Optometric Advisory Board.
	26.3.26 – Chief Executives Steering Group – deputising for CEO	15.6.26 Cross-regulators Directors of FtP	29.05.26 - Meeting with EB Partnership

<b>Philipsia Greenway</b> Director of People and Improvement	<b>Steve Brooker</b> Director of Regulatory Strategy	<b>Carole Auchterlonie</b> Director of Regulatory Operations	<b>Marc Stoner</b> Director of Corporate Services
	30.3.26 – Chaired CPD reform consultation event		
	1.4.26 – OSC – digitising AMR forms		
	10.4.26 – Teesside and Aston Universities – sight testing of young children		
	22.4.26 – Chaired SSISG – implementation of education and training requirements		
	23.4.26 – PSA Regulatory Data and AI Working Group		
	23.4.26 – College of Optometrists President's annual dinner		
	27.4.26 – Presented to Scottish Government meeting, Glasgow – clinical governance and regulation		
	30.4.26 – DHSC, NHS England, Capita – sight testing of young children		
	1.5.26 – Optometry Standards and Registrants Alliance – introductory meeting		
	7.5.26 – Mel Venables, PSA – routine catch-up meeting		

<b>Philipsia Greenway</b> Director of People and Improvement	<b>Steve Brooker</b> Director of Regulatory Strategy	<b>Carole Auchterlonie</b> Director of Regulatory Operations	<b>Marc Stoner</b> Director of Corporate Services
	8.5.26 – Chaired Optical Sector Policy Forum		
	12.5.26 – ABDO graduation ceremony, Canterbury Cathedral		
	13.5.26 – Association of Optometrists – sight testing		
	14.5.26 & 22.6.26 – Teesside and Aston Universities – sight testing of young children		
	2.6.26 – FODO – sight testing		
	10.6.26 – HSCNI – sight testing of young children in Northern Ireland		
	12.6.26 – College of Optometrists – sight testing		
	15.6.26 – ABDO – sight testing		
	15.6.26 – HEIW – CPD		
	17.6.26 – Institute of Regulation webinar – Rewiring regulation		

<b>Council Catch-up 7 July 2026</b>
<b>Council Meeting (Strictly Confidential) 29 September 2026</b>
<p><b>For decision</b></p> <ul style="list-style-type: none"> <li>-</li> </ul> <p><b>For discussion</b></p> <ul style="list-style-type: none"> <li>- Corporate risk register</li> </ul> <p><b>For noting</b></p> <ul style="list-style-type: none"> <li>- ARC 7 July and 7 September 2026 update</li> <li>- Nominations Committee 22 September 2026 update (verbal)</li> <li>- Council papers for the public session</li> </ul>
<b>Council Meeting (Public) 30 September 2026</b>
<p><b>For decision</b></p> <ul style="list-style-type: none"> <li>- Annual report and financial statements 2025/26</li> <li>- ARC annual report 2025/26</li> <li>- Equality, Diversity and Inclusion annual report 2025/26</li> <li>- Thematic review on commercial practices and patient safety</li> <li>- Continuing Professional Development consultation response</li> <li>- UK optical education report</li> </ul> <p><b>For discussion</b></p> <ul style="list-style-type: none"> <li>- Registrant and public perception survey</li> <li>- Q1 2026/27 Financial performance report</li> <li>- Business performance dashboard Q1 2026/27</li> <li>- Business Plan Assurance Report Q1 2026/27</li> </ul> <p><b>For noting</b></p> <ul style="list-style-type: none"> <li>- Chair's report</li> <li>- Chief Executive's Report</li> </ul>
<b>Council Catch-up 13 October 2026</b>
<b>Council Strategy Day 18 November 2026 (In person)</b>
<b>Council Meeting (Strictly Confidential) 8 December 2026</b>
<p><b>For decision</b></p> <ul style="list-style-type: none"> <li>- External audit provider: contract decision</li> </ul> <p><b>For discussion</b></p> <ul style="list-style-type: none"> <li>- Corporate risk register</li> </ul> <p><b>For noting</b></p> <ul style="list-style-type: none"> <li>- ARC 24 November 2026 update (verbal)</li> <li>- Investment Committee 10 November 2026 update</li> <li>- Nominations Committee 25 November 2026 update (verbal)</li> <li>- Council papers for the public session</li> </ul>
<b>Council Meeting (Public) 9 December 2026</b>
<p><b>For decision</b></p> <ul style="list-style-type: none"> <li>- Gifts and hospitality policy</li> <li>- Management of interests policy</li> <li>- Registrant fees 2027/2028</li> <li>- Annual reappointment of Council members to committees</li> <li>- Fees discussion paper consultation response</li> </ul>

**For discussion**

- H&S assurance report
- Council's self-assessment against the Charity Governance Code
- Q2 2026/27 Financial performance report/Q2 2026/27 forecast
- Business performance dashboard Q2 2026/27
- Business Plan Assurance Report Q2 2026/27

**For noting**

- Advisory Panel 16 October 2026 update
- Chair's report
- Chief Executive's Report

**Council Catch-up 19 January 2027****Council Catch-up 2 March 2027****Council Meeting (Strictly Confidential) 16 March 2027****For decision**

- 5-year forecast and internal business plan 2027/28

**For discussion**

- Corporate risk register

**For noting**

- ARC 26 January and 23 February 2027 update
- Nominations Committee 12 January 2027 update
- Remuneration Committee 9 February 2027 update
- Council papers for the public session

**Council Meeting (Public) 17 March 2027****For decision**

- 2027-28 Budget, external business plan and five year forecast
- Member fees 27/28
- EDI action plan 27/28

**For discussion**

- Q3 2026/27 Financial performance report
- Business performance dashboard Q3 2026/27
- Business Plan Assurance Report Q3 2026/27
- PSA performance review

**For noting**

- Advisory Panel 12 February 2027 update
- Chair's report
- Chief Executive's Report