enventure research

General Optical Council

Registrant Workforce and Perceptions Survey 2026

Research Report

May 2026

www.enventure.co.uk

Report prepared by:

Matt Thurman
matt@enventure.co.uk

Report reviewed by:

Andrew Cameron

Kayleigh Pickles

Thornhill Brigg Mill
Thornhill Beck Lane
Brighouse
West Yorkshire
HD6 4AH

01484 404797

www.enventure.co.uk

info@enventure.co.uk

Reg no: 4693096
VAT no: 816927894

Contents

Key findings 4
New insights for 2026 4
Areas of improvement 5
Areas of continuity 6
Areas of concern 8
The Research Programme 10
Introduction 10
Methodology 10
Interpretation of the findings 11
Workforce profile 13
Working status 13
Workplace setting 14
Workforce capacity 15
Additional qualifications and enhanced services 20
Locum working 23
Level of seniority 25
Supervising 27
Job satisfaction 28
Working conditions 32
Experiences of negative working conditions 32
Experiences of time and commercial pressure 37
Harassment, bullying or abuse 50
Discrimination 55
Plans for the future 60
Gaining additional skills 61
Plans to leave the profession 63
Speaking up 64
Continuing Professional Development 68
Artificial intelligence 71
The impact of vision on driving 81

Appendix A – Questionnaire

Appendix B – Respondent demographic profile

Key findings

The survey

The annual Registrant Workforce and Perceptions Survey was conducted between March and April 2026, open to all individual GOC registrants. The survey aims to gain insight into registrants' experiences of working in clinical practice and their perceptions of the GOC.

An 11% response rate was achieved (3,451 responses), providing a robust sample for confident statistical analysis.

New insights for 2026

Many of this year's survey findings represent continuity with recent waves of the survey from 2024 and 2025, and in many cases are in line with survey results dating back even further. Continuity of findings is found in both the overall results and the subgroup analysis, highlighting that the profile, experiences, and attitudes of registrants have changed little in recent years, and that many of the same challenges are still being faced.

This year's survey included two new sections exploring registrants' views and experiences in relation to two areas of current relevance to the optical professions – the use of artificial intelligence (AI) in optical care, and vision and safe driving.

Artificial Intelligence – Cautious optimism, but knowledge, training, and use are limited

New insights gained on the topic of AI indicate that registrants are cautiously positive about the potential role of AI in optical care, but current knowledge, training, and use are limited. Six in ten respondents (60%) rated their knowledge and understanding of AI in relation to optical care as poor, while 40% rated it as good. Just over one in five (22%) had received AI-related CPD or training in the last 12 months, although those who had done so were much more likely to rate their understanding positively.

Use of AI in professional practice is still at an early stage. Six in ten working respondents (60%) said they were not currently using AI for any of the activities listed in the survey. Where AI was being used, this was most commonly to help maintain knowledge and skills (12%), support diagnosis (8%), or write patient correspondence (8%).

Despite limited use, respondents were more likely to think AI will improve (45%) rather than reduce (11%) the quality of eye care. However, over a quarter (27%) did not know what impact AI would have on the quality of eye care, highlighting uncertainty and low levels of understanding. Positive views were more common among those with good AI knowledge and those who had received AI-related CPD/training.

Concerns about AI are also widespread, especially around safety, accountability and transparency. The highest levels of concern related to AI making errors (77%), legal responsibility if something goes wrong (76%), lack of transparency in AI decision-making (68%), data security and patient confidentiality (64%), and the impact on the clinician-patient relationship (63%).

Vision and safe driving – Routine discussions, but direct DVLA/DVA notification remains challenging

The new survey questions on vision and safe driving highlight that discussions about the impact of vision or eye conditions on driving are a routine part of practice for many registrants. Around seven in ten respondents (72%) said they have these conversations with patients at least weekly. These discussions are more common among optometrists, those with additional qualifications, and those involved in enhanced eye care services.

Driving-related discussions are focused mainly on older patients, with respondents most likely to say they commonly raise the issue with patients aged 70–79 (85%), followed by those aged 80+ (73%) and 60–69 (61%). Far fewer commonly raise it with patients aged under 50.

Registrants are generally comfortable advising patients about the implications of not meeting eyesight standards. Almost all were comfortable explaining that this may affect a patient's ability to drive safely (95%), and 89% were comfortable informing patients that they must notify the DVLA/DVA. However, comfort falls significantly when registrants are asked about notifying the DVLA/DVA themselves if the patient cannot or will not do so, with only 37% feeling comfortable and 58% uncomfortable.

The main barrier to direct notification is breaching patient confidentiality (72%), but legal or regulatory concerns (56%) and the risk of aggressive patient reactions (56%) also play a significant role.

In practice, advising patients is much more common than direct notification. Four in five respondents (78%) had advised a patient that they were no longer fit to drive at least once in the last 12 months, while almost all (96%) had never directly notified the DVLA/DVA. This suggests that, although fitness to drive conversations are a regular part of practice, direct notification is rare and likely limited to a small number of more serious or unresolved cases.

Areas of improvement

Confidence in meeting CPD requirements has improved

Overall job satisfaction has improved slightly this year, with 59% of respondents satisfied in their role, up from 55% in 2025. Dissatisfaction has also eased slightly, from 26% to 24%. Although satisfaction remains below the higher levels recorded in 2022 and 2023, this year's results suggest a modest improvement after two years of decline.

Satisfaction continues to vary by workplace setting and experience of delivering care. It is higher among those working in hospitals, education/academia and independent practice, and

lower among those working in multiple/chain opticians. However, as found in previous years, those who find it difficult to provide patients with the level of care they need are significantly more likely to be dissatisfied in their role.

Engagement in enhanced eye care services and additional qualifications has increased

Over half of respondents are now involved in the delivery of enhanced eye care services, increasing to 52% after several years of stability at around 48% to 49%, which may suggest a possible shift towards greater engagement in these services.

Results suggest that registrants holding additional qualifications are becoming increasingly common. The proportion with no additional qualifications has fallen (65%-67% in 2023-2025 to 58% in 2026), while qualifications in areas such as glaucoma, medical retina, and contact lens practice have increased over recent years.

CPD attendance on workplace culture and EDI topics has increased

Although attendance at CPD on workplace culture, speaking up, health inequalities and bias remains relatively modest (ranging from 21% to 30% attendance in the latest CPD cycle), engagement has generally increased across the tracked topics over the last three years. Attendance reached its highest recorded level this year across all four tracked areas, with the largest increase seen for CPD on addressing bullying, harassment, and discrimination in the workplace (+9% pts, from 13% in 2024 to 22% in 2026).

Attendance at CPD is also associated with other positive outcomes. Those who had attended CPD on speaking up were more likely to feel comfortable raising concerns, while those who had attended CPD on bullying, harassment and discrimination were more likely to have personally reported experiences of discrimination.

Areas of continuity

Workforce profile and capacity remain stable

The workforce profile remains broadly stable, with most respondents working or employed (88%), and the distribution of workplace settings changing little over recent years, with most working in multiples (61%) or for an independent practice/as a sole practitioner (41%). Average days worked per week remain similar to previous years at 4.0 days, and scaled-up estimates suggest a broadly stable full-time equivalent workforce (15,054 FTE optometrists and 5,494 FTE dispensing opticians).

Part-time working continues to be more common than full-time working, with 55% working fewer than five days per week. Part-time working is especially common among optometrists, those in independent practice, older respondents, female respondents, those working as locums and those reporting a disability.

The profile of locum workers remains broadly unchanged

Locum working remains a stable feature of the workforce, with 22% of registrants reporting that they work as a locum, broadly unchanged since 2022. The profile of locum workers has also changed little over time, with locum working continuing to be more common among optometrists than dispensing opticians, part-time workers, those working for independent opticians or in domiciliary care, older respondents aged 55+, respondents from ethnic minority groups, and those with additional qualifications.

Workplace setting continues to shape experience

Throughout the survey results, workplace setting remains one of the clearest drivers of attitudes and experiences. Those working in hospitals, education/academia and for independent opticians tend to report higher job satisfaction, while those working in multiples are more likely to report dissatisfaction and certain workplace pressures.

Enhanced services, additional qualifications, locum working, supervision of pre-registration trainees, experiences of workload pressure, and confidence in raising concerns also vary by workplace setting, reinforcing the importance of workplace context in shaping registrants' experiences.

Leadership roles remain concentrated among certain groups

Half of respondents (51%) reported having no managerial responsibility, while fewer occupied senior leadership roles, such as Director/CEO (14%). These leadership roles remain concentrated among certain demographic groups, with Director/CEO roles more common among male respondents, White British/Irish respondents, and those from professional/higher socio-economic backgrounds.

Future career plans remain broadly consistent, with significant continued interest in further development

Immediate career intentions remain broadly consistent with previous survey waves. Gaining additional qualifications or skills remains the most common planned career change, selected by 40% of working respondents, followed by reducing hours (26%), and smaller proportions considering leaving the profession (16%), retiring (9%), switching to locum work (7%) or taking a career break (7%).

Interest in further development continues to vary by career stage and working context, with plans to gain additional qualifications or skills more common among younger respondents, students, full-time workers, those working in multiples or hospitals, those involved in enhanced services, and respondents from ethnic minority groups. The most common areas of interest remain glaucoma, medical retina and independent prescribing.

Plans to leave the profession remain more common among some groups, including dispensing opticians, locums, respondents based in London, those with a disability, and those who report difficulties providing patients with sufficient care.

Areas of concern

Workload pressures remain widespread and are linked to patient care challenges

Negative working conditions remain a significant issue, with two thirds of respondents (66%) reporting working beyond their hours at least sometimes, and six in ten (60%) reporting feeling unable to cope with their workload. Over a third (36%) said they had found it difficult to provide patients with the level of care they need.

The survey results continue to show that these experiences are closely linked. Respondents who reported working beyond their hours, feeling unable to cope with workload, or taking stress-related leave were more likely to report difficulties providing patients with sufficient care. This highlights the relationship between workforce pressures and the ability to deliver safe and effective patient care.

Time and commercial pressures continue to affect patient care

Time and commercial pressures remain common amongst registrants, particularly around insufficient time for sight tests (47% sometimes/frequently experience), pressure to see a high volume of patients (38%), pressure to sell higher-value products (34%), and pressure to meet targets at the expense of patient care (31%). These pressures are more pronounced in some workplace settings, especially multiples, and are always linked with a greater likelihood of reporting difficulties providing sufficient care.

When respondents experienced time or commercial pressures, concerns were most often raised informally with colleagues (32%) or reported to a line manager (20%) rather than through formal processes (2%). However, a large proportion did nothing (31%), suggesting that many registrants may feel unable to challenge these pressures or do not see a clear route for doing so.

Although the majority of respondents (83%) feel confident resisting pressures that could compromise care, the results show that time and commercial pressures remain a challenging part of the working experience for a substantial proportion of registrants.

Free-text suggestions about the most concerning commercial practices reinforce these findings, with the most common concerns relating to short appointment times, sales or conversion targets, upselling, overbooking, and high patient volumes.

> *Reduced testing times. 20 minute clinics are very hard to keep up with, and many tests are omitted to keep up with timing.*
>
> Optometrist

> *Pressure to reduce the time allocated to each patient.*
>
> Optometrist

> *Pressure to dispense and meet targets.*
>
> Dispensing optician

Experiences of harassment, bullying, abuse, and discrimination remain substantial and often unreported

Harassment, bullying, or abuse and discrimination continue to be experienced by a significant minority of registrants. Patients and service users remain the most common source of this behaviour, although experiences from managers and other colleagues are also reported.

These experiences vary by role, workplace setting and demographics, with some groups, including ethnic minority respondents and those with a disability, more likely to report negative experiences.

Reporting remains limited, at 37% for harassment, bullying and abuse, and 28% for discrimination.

Compared with the latest NHS Staff Survey, GOC registrants report higher levels of harassment, bullying or abuse and discrimination, but lower levels of reporting.

Barriers to speaking up are driven by fear of repercussions and doubts about action

Comfort with speaking up about patient safety about both individual GOC registrants and employers remains highest in relation to managers, tutors, employers and professional or representative bodies, and lower in relation to the GOC. For concerns about registrants, respondents are most comfortable speaking up to a manager or tutor, and for concerns about an employer, professional association/representative body routes attract higher levels of comfort than the GOC.

Among those who would not feel comfortable speaking up, the main barriers relate to personal consequences. Respondents were concerned about alienating colleagues (43% GOC registrant, 37% employer), jeopardising their job (41% GOC registrant, 54% employer), being seen as a troublemaker (39% GOC registrant, 38% employer), and whether corrective action would be taken (36% GOC registrant, 39% employer).

Supervisory roles and locum working are associated with greater challenges

Just over a quarter (27%) of working optometrist and dispensing optician respondents had supervised pre-registration trainees in the last 12 months. Supervision is more common in multiples (39%), and those who supervise trainees are more likely than those who do not to report feeling unable to cope with their workload and finding it difficult to provide patients with sufficient care.

Locum working remains an established part of the workforce (22%), but locums continue to report more challenges in some areas. They are more likely than non-locums to report difficulties providing patients with sufficient care and are less comfortable raising patient safety concerns.

The Research Programme

Introduction

The GOC is the regulator for the optical professions of optometry and dispensing optics in the UK, with the overarching statutory purpose to protect, promote and maintain the health and safety of the public. The GOC currently registers almost 32,000 optometrists, dispensing opticians, student optometrists, and student dispensing opticians (the GOC also registers approximately 3,000 optical businesses, but these are not included in this research).

To track registrants' experiences of working in clinical practice and their perceptions of the GOC, a regular survey of the registrant population is carried out. This year's survey focused on the following areas:

- Working status and hours worked
- Job satisfaction and future career plans
- Workplace challenges, including workplace and commercial pressures, bullying, harassment, and discrimination
- Speaking up and raising concerns
- Continuing Professional Development (CPD)
- Artificial intelligence (AI)
- Vision and safe driving

Enventure Research, an independent research agency, was appointed to deliver this survey. This report details the findings of this research.

Methodology

A questionnaire was designed by the GOC and Enventure Research, including a mix of previously used questions to allow for benchmarking and new questions to cover new topics. The questionnaire took approximately 10-12 minutes for registrants to complete. For reference, a copy of the questionnaire can be found in **Appendix A**.

The survey was promoted via personalised email invitation to all GOC registrants with a valid email address. In total, 32,428 registrants were invited to take part. Those who did not respond received up to four reminder emails encouraging them to take part.

The survey was also promoted by the GOC and stakeholder organisations via email newsletters and social media. Respondents who took part via this promotion were required to provide their GOC-registered email address to verify their registration and ensure no duplicate responses were received.

The survey was live between 25 March and 22 April 2026. During this time, 3,451 responses were received, representing an 11% response rate. The table below shows the unweighted response rate for each UK nation.

Figure 1 – Survey response rate by location

Location	Registrant population	Number of responses	Response rate
England	25,772	2,570	10%
Wales	1,444	179	12%
Scotland	2,629	310	12%
Northern Ireland	912	96	11%

Interpretation of the findings

Weighting

As the survey was completed by a sample of GOC registrants, and not the entire population of registered optical professionals, the data has been weighted to ensure that certain subgroups are not over or under-represented and that the data is as close to the GOC registrant profile as possible. Weighting adjusts the proportions of certain groups within a sample to match more closely to the proportions in the target population.

The sample has been weighted by registration type (optometrist, dispensing optician, student optometrist, student dispensing optician), based on an up to date version of the GOC register. All survey results presented within this report are based on the weighted data. This approach to weighting has been taken in previous years of the survey, allowing for comparability.

Sampling confidence interval

As the online survey was completed by a sample of GOC registrants and not the entire registrant population, all results are subject to sampling tolerances. However, as a large number of responses were received, the confidence interval for analysis (also known as the margin of error) is narrow.

Based on a total population of approximately 32,500 registrants and 3,451 survey responses, when interpreting the results to a question which all respondents answered, with a response of 50% there is a 95% chance that this result would not vary by more than +/- 1.6 percentage points (48.5% to 51.5%) had the result been obtained from the entire registrant population.

Subgroup analysis

Subgroup analysis has been undertaken to explore the results provided by different groups of GOC registrants, such as registration type, length of registration, workplace setting, location, and key demographics including gender, age group, ethnicity, and disability status. This analysis has

only been carried out where the sample size is seen to be sufficient for comment. Where sample sizes were not large enough, subgroups have been combined to create larger groups. This analysis is presented in charts, tables, and commentary where statistically significant differences between subgroups have been found.

Interpretation of survey data

This report contains various tables and charts. In some instances, the responses may not add up to 100%. There are several reasons why this might happen:

- The question may have allowed each respondent to give more than one answer
- Only the most common responses may be shown in the table or chart
- Individual percentages are rounded to the nearest whole number so the total may come to 99% or 101%
- A response of between 0% and 0.4% will be shown as 0%

For the analysis of certain questions, response options have been grouped together to provide an overall level. For example, in some instances 'very confident' and 'quite confident' have been grouped and shown as 'total confident'. Where these combined percentages do not equal the overall level reported (being 1% higher or lower), this is due to percentages being rounded to the nearest whole number.

For the analysis of free-text responses, verbatim comments were read in detail and a coding frame was developed for each question based on themes emerging. This then allowed for categorisation of the themes emerging in the comments, which are presented as analysis.

To provide the GOC with insight to inform future workforce planning, certain survey results have been scaled up to the number of optical professionals currently on the GOC's register, converting the results into approximate registrant numbers. Please note that the numbers presented in this report are only approximations, are subject to sampling confidence intervals, and are shown to provide a general idea of the number of GOC registrants who may have answered in a particular way, if everyone on the register had responded to the survey question.

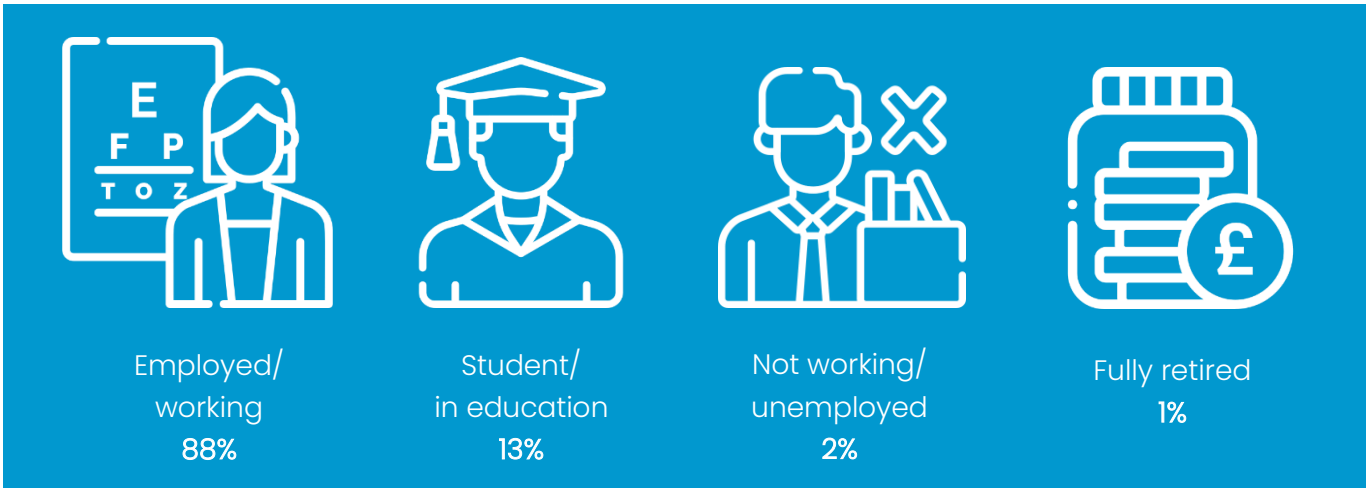
Throughout this report, those who took part in the survey are referred to as 'respondents'.

Workforce profile

Working status

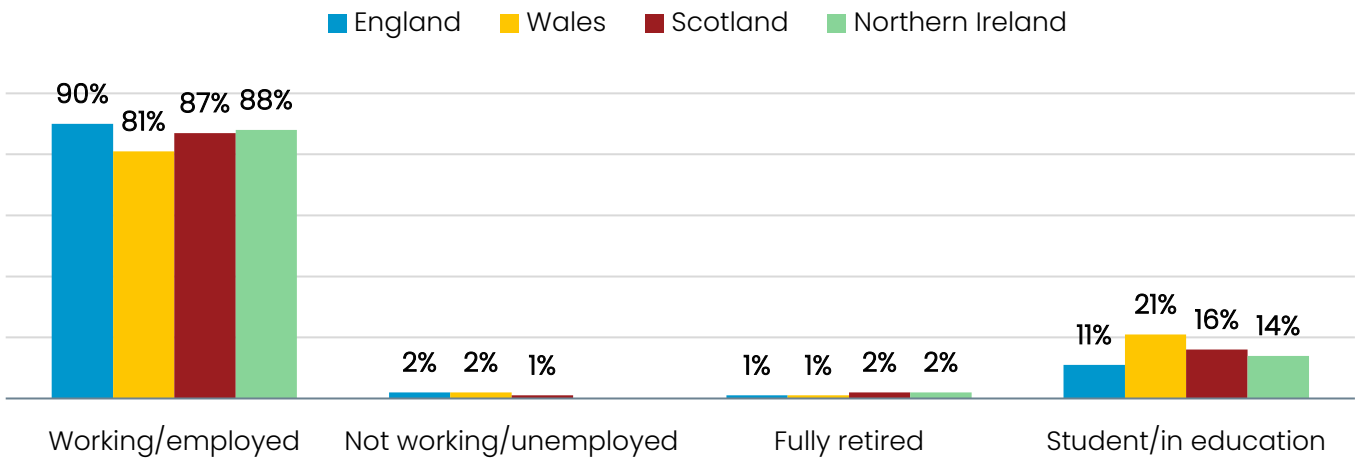
The majority of respondents (88%) were working/in employment. Registrant working status has remained static since 2022.

Figure 2 – Working status
Base: All respondents (3,451)



Working status is broadly consistent across the UK nations, with the exception of a greater proportion of students in Wales (21%) when compared with other UK nations.

Figure 3 – Working status by UK nation
Base: All respondents England (2,770); Wales (186); Scotland (365); Northern Ireland (112)

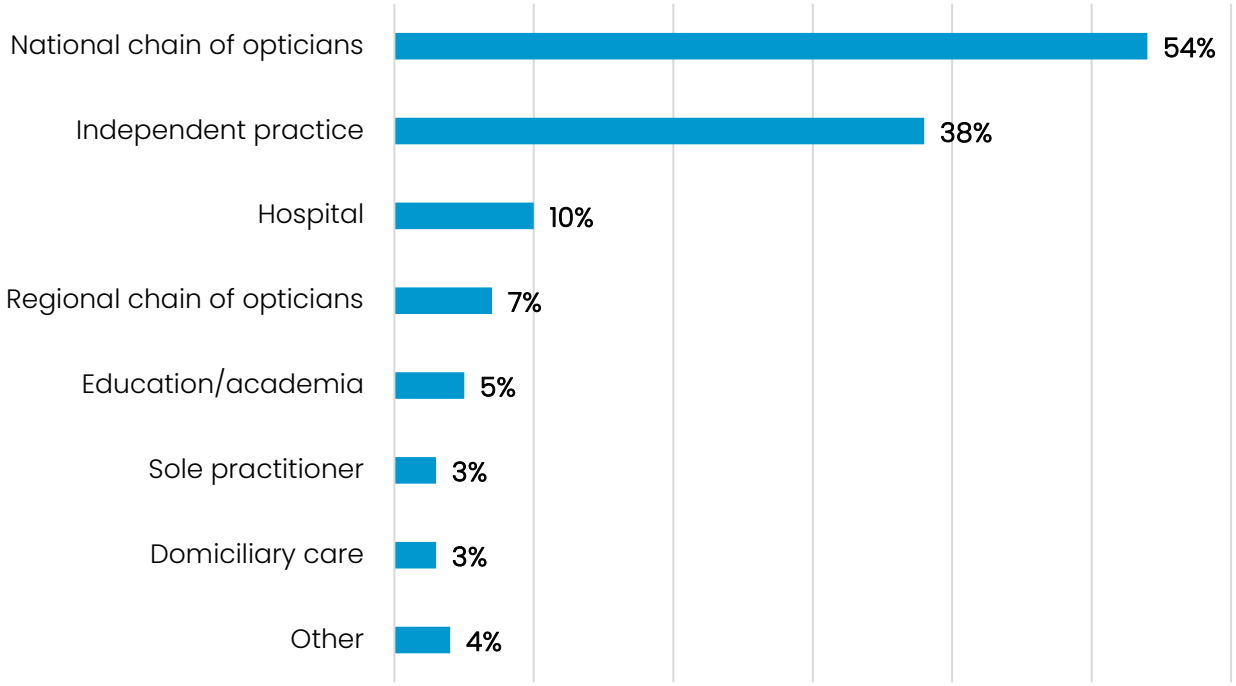


Workplace setting

Workplace profile continues to be broadly stable over time

The overall distribution of registrants by workplace continues to show a consistent pattern. Around three in five (61%) worked for a national or regional chain of opticians (referred to as 'multiple' throughout this report), while just over two in five (41%) worked in independent practice or as a sole practitioner. One in ten (10%) worked in a hospital setting, with smaller proportions based in education/academia (5%) or domiciliary care (3%).

Figure 4 – Workplace setting
Base: Those currently working (3,315)



The free-text 'other' responses were diverse, but most commonly related to respondents working in advisory, regulatory or representative roles (e.g. NHS/ICB, LOC, professional bodies), specialist or community-based services (such as ophthalmology, low vision, special schools, or prisons), charitable organisations, or mixed roles combining multiple settings including locum and consultancy work.

Also mirroring previous years, the majority of working respondents worked in just one workplace setting (83%), with 12% working in two locations, and just 5% across three or more. Working across multiple workplace settings was more common amongst optometrists (23%) when compared with dispensing opticians (7%).

Workforce capacity

Average number of days worked per week

Working respondents provided the number of days per week on average they worked across each location. The table below presents the mean (average) number of days worked, split by registration type (please note that working student optometrists and dispensing opticians have been removed from these calculations), calculated as 4.0 days per week overall – 3.9 days for optometrists and 4.1 days for dispensing opticians.

As seen in previous years, with very small variation in the figures for each location, the overall number of days has remained almost exactly the same as last year (3.9 in 2025).

Figure 5 – Average number of days worked per week across workplace settings by registration type
Base: Those currently working (2,708); Optometrists (2,004); Dispensing opticians (704)

Workplace setting	Number of responses	Total number of days	Optometrists	Dispensing opticians
Independent practice	1,098	3.3	3.1	3.9
Sole practitioner	90	2.0	2.0	2.8
National chain of opticians	1,385	3.6	3.5	4.0
Regional chain of opticians	186	2.8	2.6	3.5
Hospital	280	2.8	2.8	2.5
Domiciliary care	81	2.5	2.3	3.1
Education/academia	161	2.6	2.4	3.4
Other	112	2.6	2.4	3.9
Total/overall	**2,708**	**4.0**	**3.9**	**4.1**

There is some variation in the average number of days worked per week in different settings across the UK nations, but the total number of days is generally similar, ranging from 3.9 in England and Wales to 4.2 in Northern Ireland (although this is based on a significantly smaller base size).

Figure 6 – Average number of days worked per week across workplace settings by UK nation
Base: England (2,015); Wales (138); Scotland (249); Northern Ireland (75)

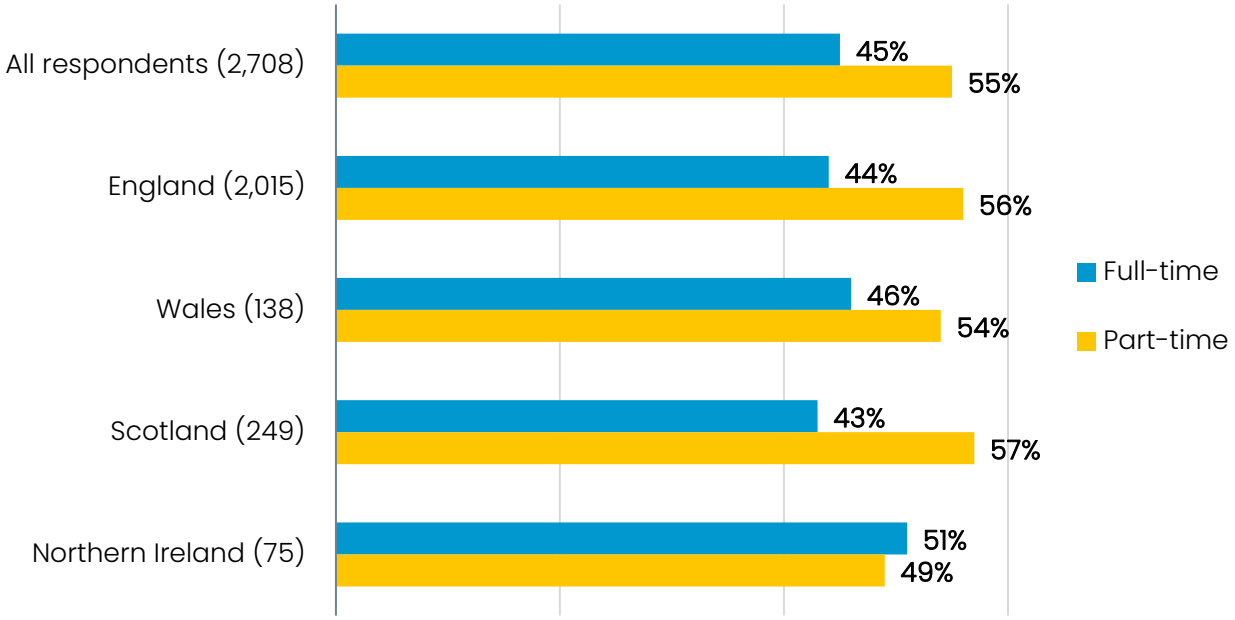
Workplace setting	England	Wales	Scotland	Northern Ireland
Independent practice	3.2	3.1	3.3	4.1
Sole practitioner	1.8	1.8	1.9	3.9
National chain of opticians	3.6	3.9	3.8	3.7
Regional chain of opticians	2.8	3.6	3.0	-
Hospital	2.7	2.6	2.5	3.2

Workplace setting	England	Wales	Scotland	Northern Ireland
Domiciliary care	2.6	2.6	2.2	0.5
Education/academia	2.5	3.5	2.7	3.0
Other	2.6	1.4	2.6	3.0
Total/overall	**3.9**	**4.0**	**4.0**	**4.2**

A small increase in part-time working

Based on full-time work being five days or more per week, **45% of respondents worked full-time and 55% worked part-time**. The split between full and part-time working is fairly consistent across the UK nations, with a more even split amongst those working in Northern Ireland.

Figure 7 – Full-time/part-time working by UK nation
Base: Shown in chart (excluding working students)



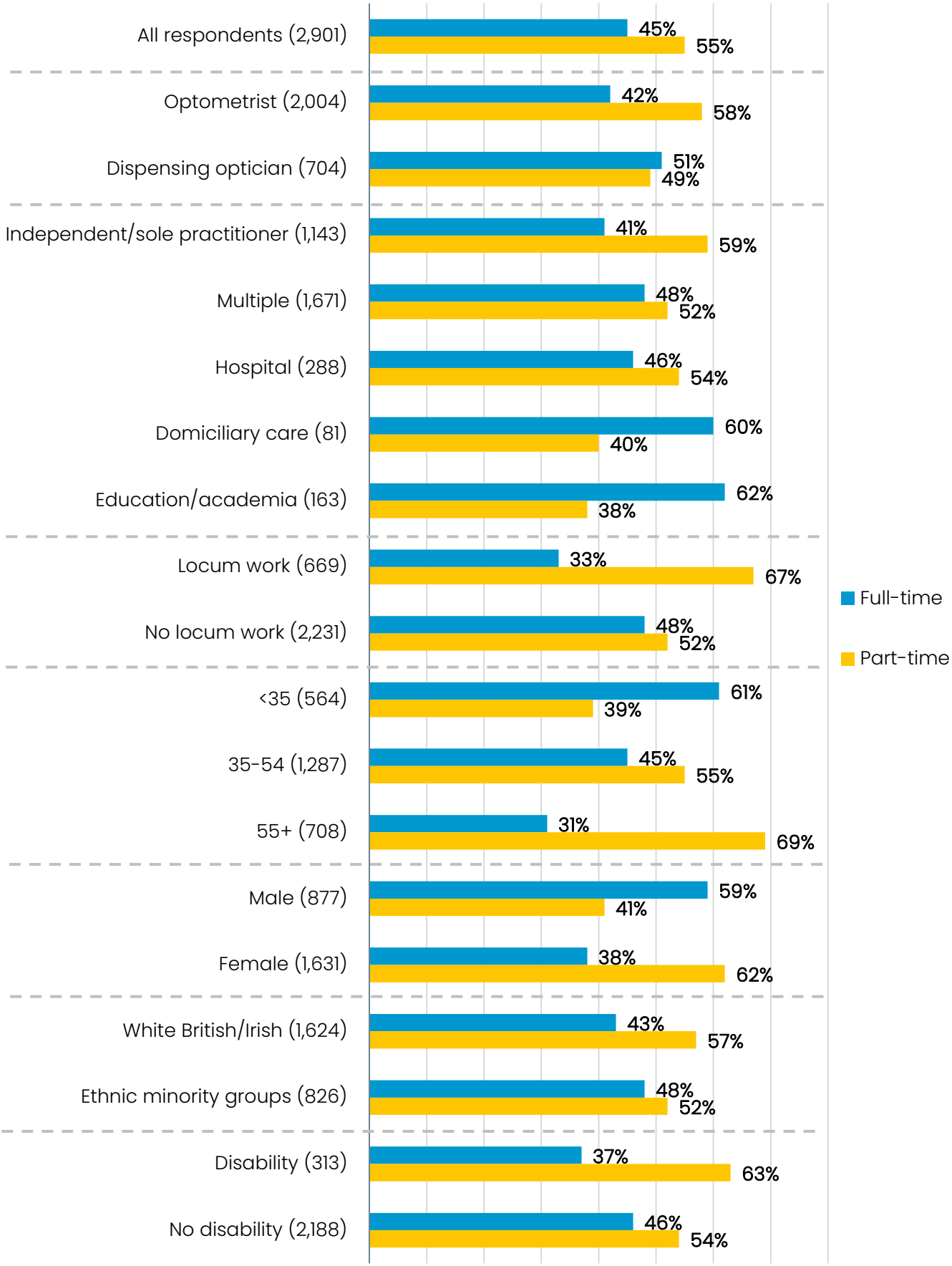
After a small shift towards part-time working between 2024 (53%) and 2025 (56%), this year represents more of a continuation (55%).

The chart overleaf presents the split between full and part-time work by a number of key subgroups, highlighting a range of differences and suggesting working patterns vary by role, workplace setting and respondent demographics.

As seen in previous years, part-time work is more common overall, particularly among optometrists, those working for an independent opticians or as a sole practitioner, females, older professionals, those in locum roles, those of White British/Irish ethnicity, and those who report a disability. In contrast, full-time work is more typical among dispensing opticians, males, those from ethnic minority groups, those working in domiciliary care and education/academia, individuals not doing locum work, and those without a disability. Respondents from ethnic minority groups and those working for multiples show an even split between full-time and part-time working.

Figure 8 – Full-time/part-time working by registration type, workplace setting, locum working, age group, gender, ethnicity, and disability

Base: Shown in chart (excluding working students)



Workforce capacity results scaled up

To help inform workforce planning, the number of working days has been scaled up based on the number of optometrists and dispensing opticians on the current GOC register to provide an informed estimate of the full time equivalent (FTE) number of registrants.

The average number of days and total approximate number of registrants have been multiplied and then divided by five (working days per week) to calculate the approximate workforce size in terms of FTE registrants.

The table below shows that there are approximately 15,054 FTE optometrists and 5,494 FTE dispensing opticians. This represents a continued increase in the total number of FTE optometrists, but a continued decrease in the total number of FTE dispensing opticians, when compared with survey results from 2024 and 2025.

Figure 9 – Scaled up workforce size

Registration type	Average number of days	Total number of registrants	Number of FTE registrants (2026)	*Number of FTE registrants (2025)*	*Number of FTE registrants (2024)*
Optometrist	3.9	19,300	**15,054**	*14,586*	*14,040*
Dispensing optician	4.1	6,700	**5,494**	*5,576*	*5,617*
Total	**4.0**	**26,000**	**20,548**	***20,162***	***19,657***

The following tables show this calculation individually for optometrists and dispensing opticians split across different workplace settings, using the survey results to calculate the approximate number of FTE registrants working in each setting.

Figure 10 – Scaled up workforce size for optometrists by workplace setting

Workplace setting	Average number of days	Total number of registrants	Number of FTE registrants (2026)	*Number of FTE registrants (2025)*	*Number of FTE registrants (2024)*
Independent practice	3.1	8,106	**5,026**	*4,600*	*4,687*
Sole practitioner	2.0	772	**309**	*269*	*270*
National chain of opticians	3.5	9,843	**6,890**	*6,807*	*6,221*
Regional chain of opticians	2.6	1,351	**703**	*838*	*731*
Hospital	2.8	2,509	**1,405**	*1,010*	*1,512*
Domiciliary care	2.3	579	**266**	*236*	*238*
Education/ academia	2.4	1,158	**556**	*468*	*630*

Figure 11 – Scaled up workforce size for dispensing opticians by workplace setting

Workplace setting	Average number of days	Total number of registrants	Number of FTE registrants (2026)	*Number of FTE registrants (2025)*	*Number of FTE registrants (2024)*
Independent practice	3.9	2,546	**1,986**	*2,176*	*2,191*
Sole practitioner	2.8	67	**38**	*36*	*19*
National chain of opticians	4.0	3,484	**2,787**	*2,551*	*2,740*
Regional chain of opticians	3.5	402	**281**	*255*	*296*
Hospital	2.5	134	**67**	*77*	*77*
Domiciliary care	3.1	134	**83**	*53*	*37*
Education/ academia	3.9	335	**261**	*181*	*164*

The following tables show the scaled up approximate workforce size calculation for optometrists and dispensing opticians split by UK nation using the GOC's register to calculate the approximate number of registrants working in each location.

Figure 12 – Scaled up workforce size for optometrists by UK nation

UK nation	Average number of days	Total number of registrants	Number of FTE registrants (2026)	*Number of FTE registrants (2025)*	*Number of FTE registrants (2024)*
England	3.9	15,047	**11,737**	*11,350*	*11,176*
Wales	4.0	796	**637**	*575*	*670*
Scotland	4.0	1,683	**1,346**	*1,289*	*1,397*
Northern Ireland	4.2	680	**571**	*549*	*526*

Figure 13 – Scaled up workforce size for dispensing opticians by UK nation

UK nation	Average number of days	Total number of registrants	Number of FTE registrants (2026)	*Number of FTE registrants (2025)*	*Number of FTE registrants (2024)*
England	4.1	5,486	**4,499**	*4,488*	*4,729*
Wales	4.1	275	**226**	*239*	*265*
Scotland	4.2	445	**374**	*368*	*403*
Northern Ireland	4.0	89	**71**	*68*	*71*

Additional qualifications and enhanced services

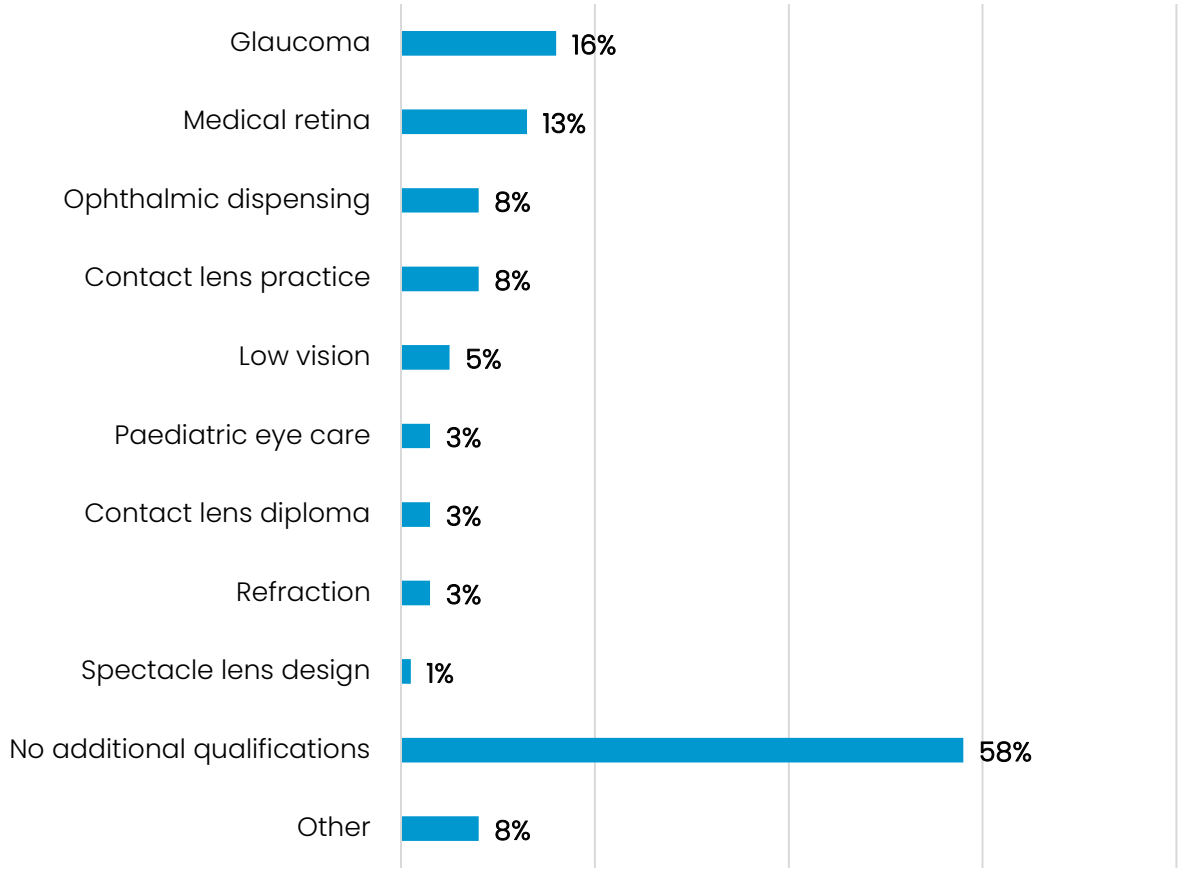
Additional qualifications are common and increasing across the profession

Respondents were asked if they had obtained any additional qualifications, other than the post-registration qualifications approved by the GOC (additional supply speciality, supplementary prescribing speciality, independent prescribing speciality, and contact lens specialty).

While a majority of respondents (58%) report having none, a substantial proportion of the workforce (42%) hold at least one additional qualification, indicating that they are a common feature of the profession. Where held, these were most often in clinical areas such as glaucoma (16%) and medical retina (13%).

Figure 14 – Additional qualifications

Base: All respondents excluding students (3,128)



The proportion of respondents with no additional qualifications has declined notably in recent years (from 65%-67% in 2023-2025 to 58% in 2026), indicating a gradual increase in qualification levels across the workforce.

This has been driven by steady growth in glaucoma and medical retina (+3% pts and +4% pts since 2023), alongside a recent increase in contact lens practice qualifications (+4% pts since 2025).

Additional qualifications concentrated among optometrists, hospital settings and Wales-based registrants

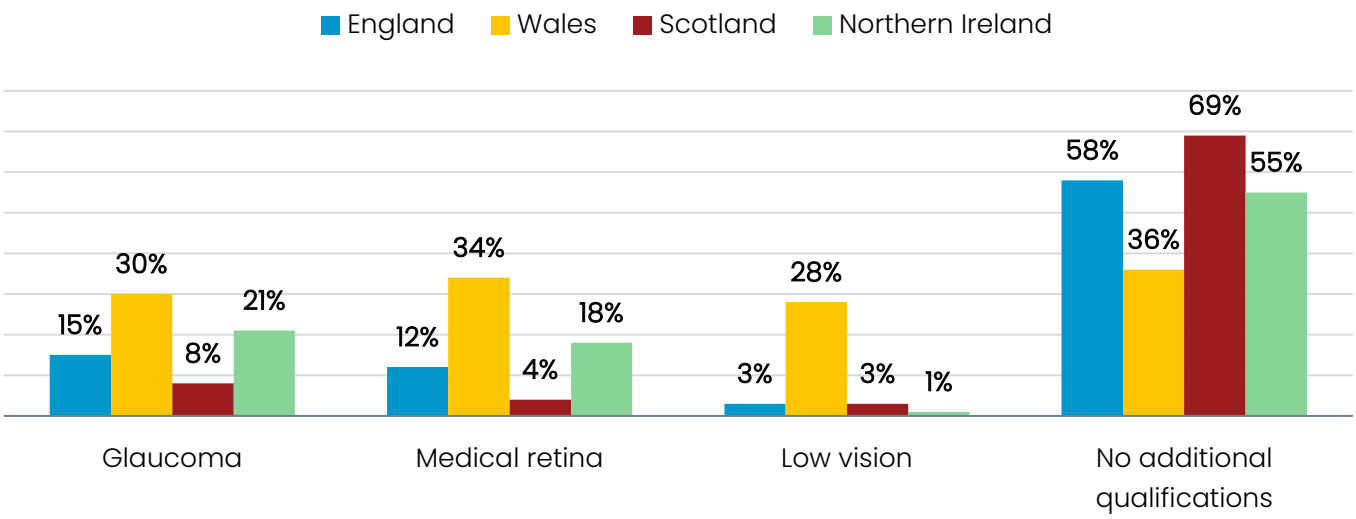
Additional qualifications are more prevalent among optometrists than dispensing opticians, with optometrists far more likely to report having at least one (49% vs 40%).

By workplace setting, holding at least one additional qualification is particularly concentrated amongst those working in hospitals (73%) or in education/academia (72%), particularly when compared with those working in multiples (38%), in an independent/as a sole practitioner (45%), or in domiciliary care (40%).

As found in previous years, registrants based in Wales were significantly more likely to report holding additional qualifications when compared with other UK nations, particularly in the fields of glaucoma, medical retina, and low vision. As also seen in previous waves of the survey, having no additional qualifications was more common amongst those living in Scotland.

Figure 15 – Additional qualifications by UK nation

Base: All respondents excluding students England (2,317); Wales (162); Scotland (283); Northern Ireland (94)



Engagement in enhanced services has increased after period of stability

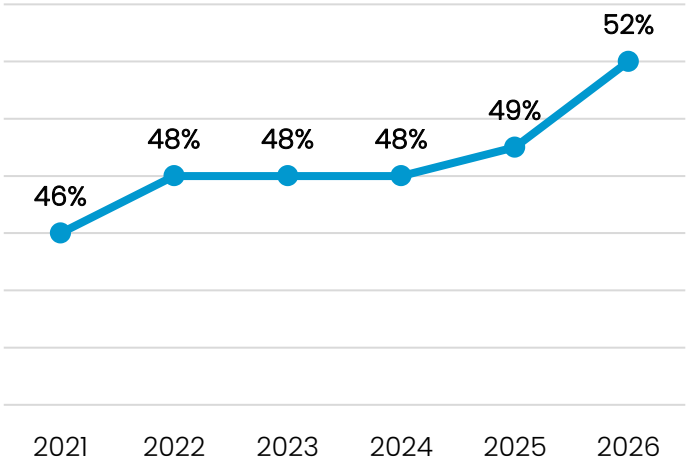
Over half of respondents (52%) are involved in the delivery of enhanced eye care services.

This marks a notable increase compared with recent years, following a sustained period of stability at around 48–49% since 2022.

The uplift in this year suggests a potential shift towards greater engagement in enhanced services across the profession, although it will be important to monitor whether this represents the start of a longer-term trend.

Figure 16 – Involvement in enhanced eye care service delivery 2021 to 2026

Base: Working respondents 2021 (4,880); 2022 (3,647); 2023 (3,468); 2024 (4,049); 2025 (3,315); 2026 (3,022)



Optometrists are significantly more likely than dispensing opticians to be involved (60% vs 34%). There is also a clear link with additional qualifications, with 60% of those holding at least one qualification involved, compared with 46% of those without.

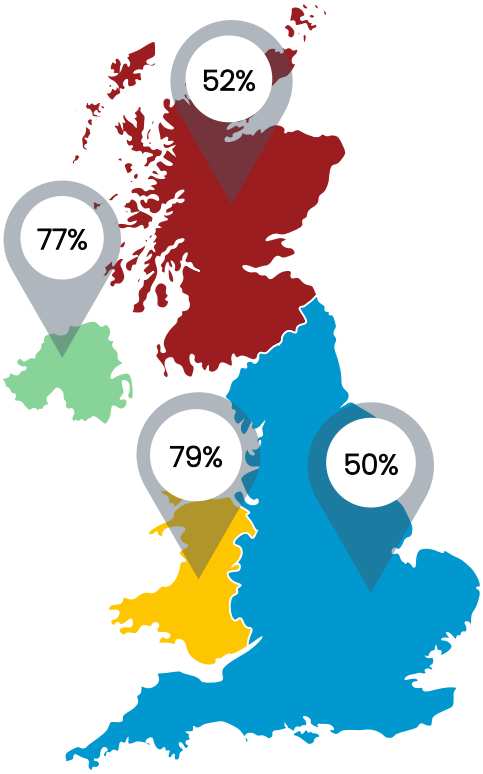
By workplace setting, involvement in enhanced services is highest among those working in independent practices and multiples (both 55%), and slightly lower among those in hospital settings (52%), domiciliary care (43%), and education/academia (46%). There is also some variation by age, with those aged 35–54 most likely to be involved (56%), compared with 52% of those aged under 35, and 46% of those aged 55 and over.

Delivery of enhanced eye care services continues to be far more common in Wales and Northern Ireland

As found in previous years, respondents in Wales and Northern Ireland were far more likely to be involved in the delivery of enhanced eye care services when compared with those in England and Scotland.

Figure 17 – Involved in the delivery of enhanced services by UK nation

Base: England (2,252); Wales (156); Scotland (276); Northern Ireland (92)



Locum working

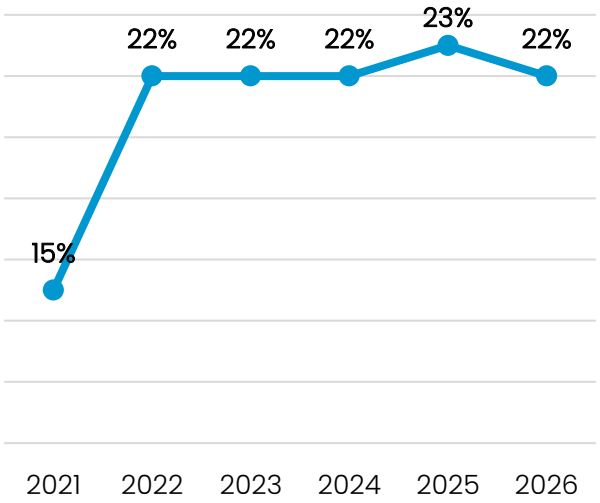
The proportion and profile of locum workers remains consistent

Around one in five registrants (22%) report working as a locum. This remains consistent with recent years, with the proportion stable at around 22–23% since 2022, following an increase from 15% in 2021. Overall, this may suggest that locum working has become an established and steady feature of the workforce.

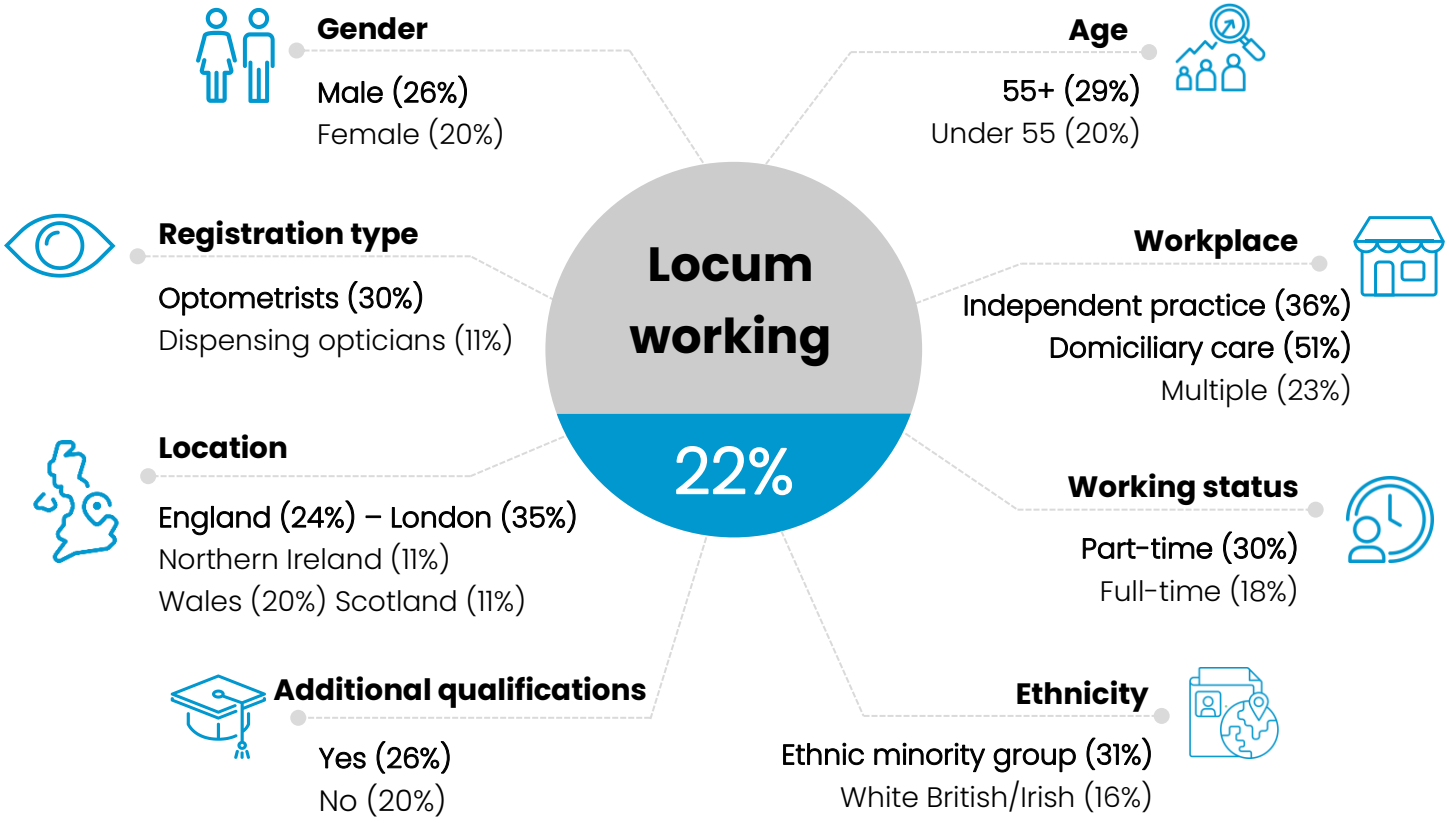
Reinforcing this consistency, the profile of locum workers has also changed little in recent years, with certain groups more likely to work as locums. It is more common among optometrists than dispensing opticians, and tends to be associated with more flexible working patterns, particularly among those working part-time. It is also more prevalent in community-based settings, especially independent practice and domiciliary care, and among more experienced, older registrants.

Figure 18 – Locum working 2021 to 2026

Base: Working respondents 2021 (4,880); 2022 (3,647); 2023 (3,468); 2024 (4,049); 2025 (3,022)



The diagram below highlights which groups are more likely to undertake locum work.

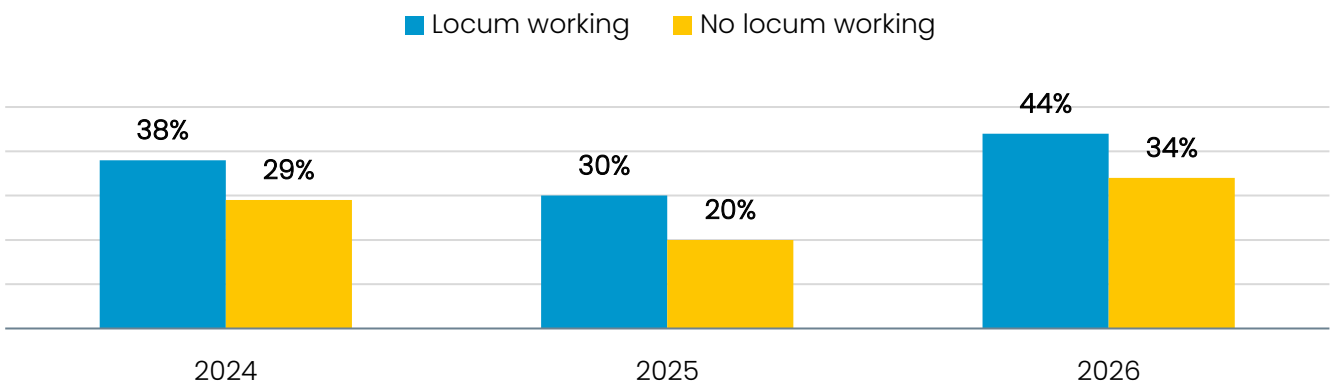


Locum workers remain more likely to report challenges in delivering sufficient patient care, with concerns increasing this year

As in previous years, those who work as locums are more likely than non-locums to report finding it difficult to provide patients with the sufficient level of care they need (44% vs 34% sometimes or frequently).

Following a dip in 2025 (30% vs 20%), the proportion has increased again in 2026, rising above 2024 levels for both groups (38% vs 29%).

Figure 19 – Difficulties providing sufficient patient care by locum working 2024-2026
Base: 2024 (3,315); 2025 (4,049); 2026 (3,022)

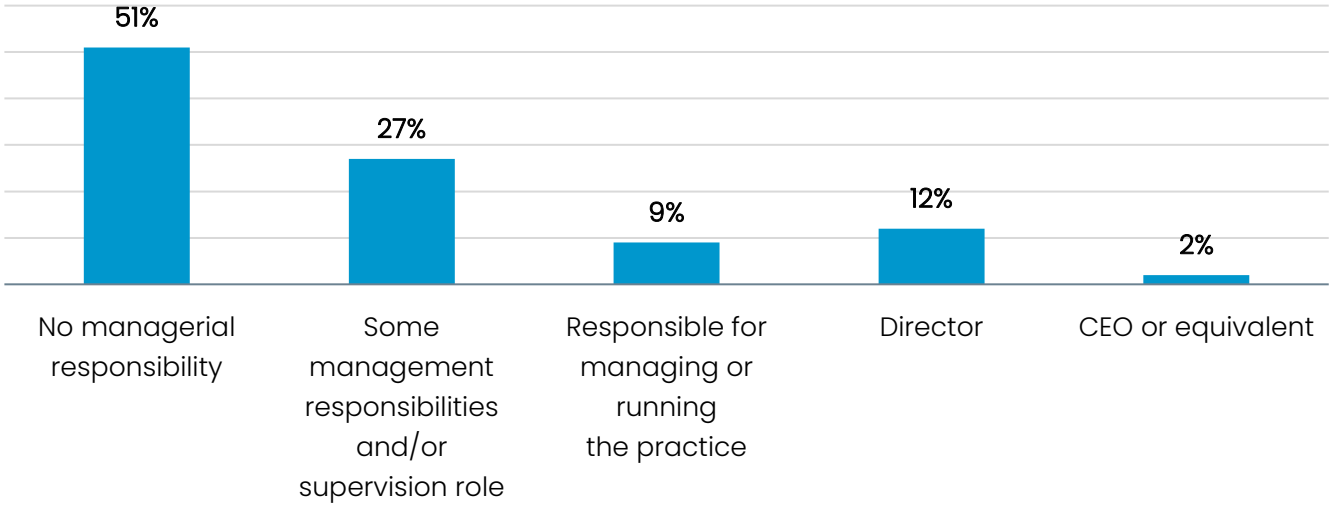


Level of seniority

Workforce continues to be concentrated in non-managerial positions

Half of respondents (51%) report having no managerial responsibility, with a further 27% holding some level of management or supervisory role. Fewer registrants occupy more senior positions, with 9% responsible for managing or running a practice, 12% at director level, and 2% at CEO level or equivalent.

Figure 20 – Level of seniority in current role
Base: All working respondents (3,022)



As expected, younger respondents aged under 35, those with fewer years registered with the GOC, and students were more likely to have no managerial responsibility when compared with those aged 35+ and with a greater number of years of GOC registration.

Those who worked as locums were also more likely to have no managerial responsibility (67%) when compared with those who did no locum work (47%).

Leadership roles remain more concentrated among certain demographic groups

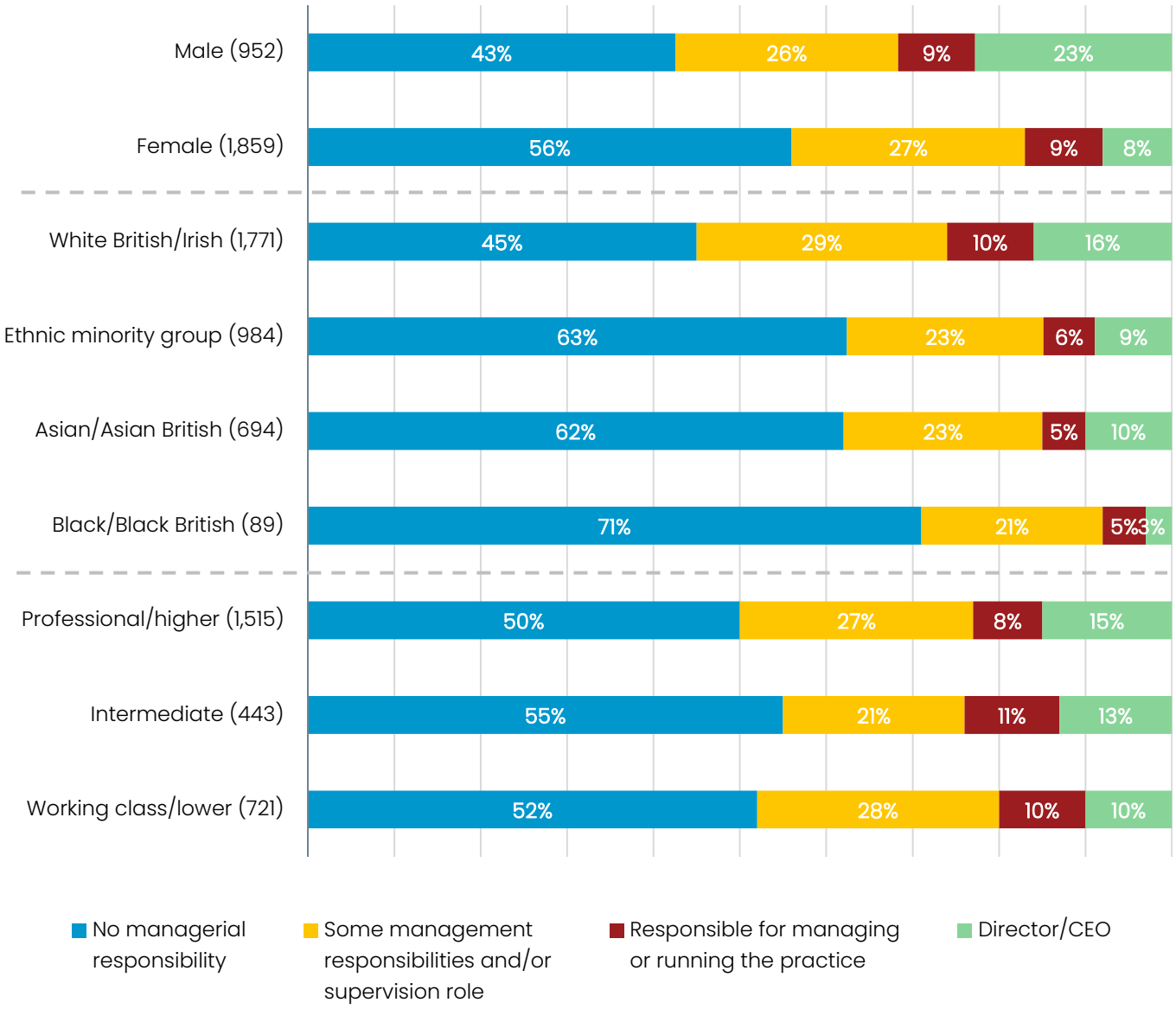
Showing little change from previous years, leadership roles (Director/CEO level) are not evenly distributed across demographic groups, with the clearest differences seen by gender and ethnicity.

Male respondents are more likely than female respondents to be in a Director/CEO role, while female respondents are more likely to report having no managerial responsibility. A similar pattern is evident by ethnicity, with White British/Irish respondents more likely than those from minority ethnic groups to be in senior leadership roles, while minority ethnic respondents are more likely to have no managerial responsibility.

Differences are also present by socio-economic background, with respondents from professional/higher backgrounds more likely to be in Director/CEO roles than those from working class/lower backgrounds.

Figure 21 – Level of seniority in current role by ethnicity

Base: Shown in chart



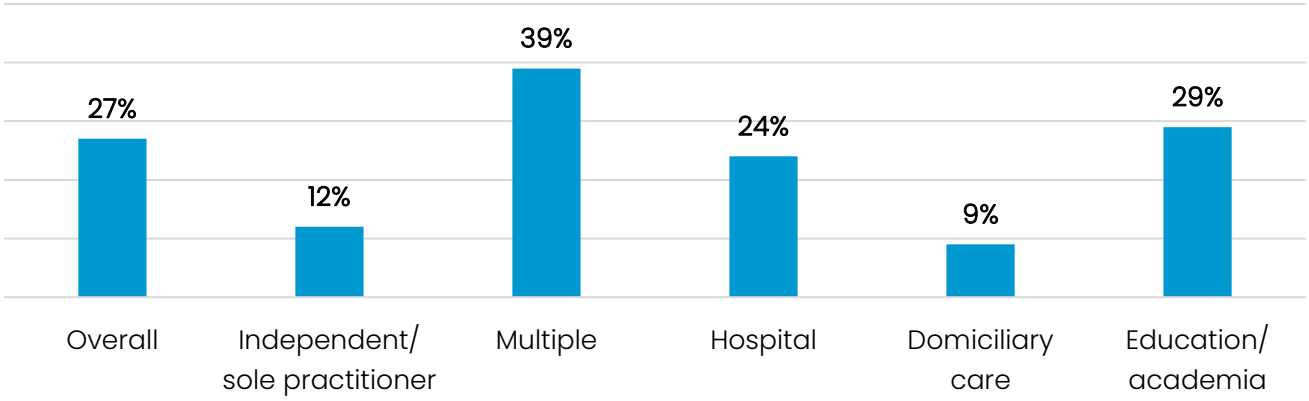
Supervising

Just over a quarter (27%) of working optometrist and dispensing optician respondents had worked in a role supervising pre-registration trainees in the last 12 months.

Supervision is more commonplace in multiple/chain opticians, and can negatively impact workload

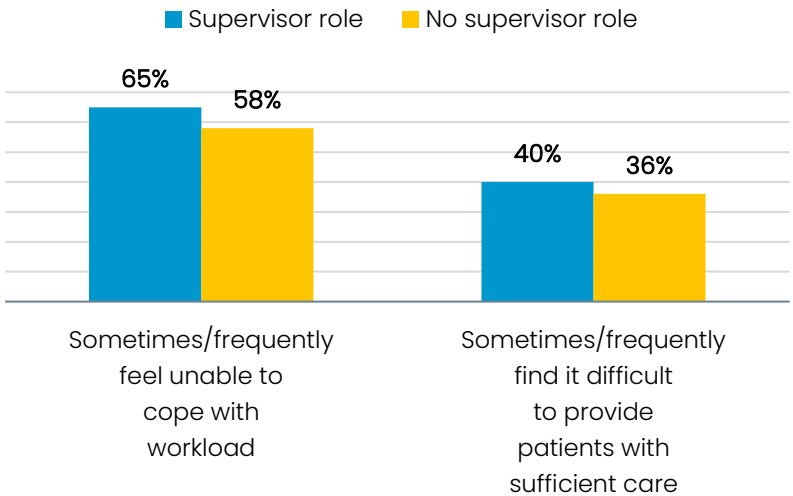
Continuing trends found in previous years, working as a supervisor was more common amongst those who worked for a multiple when compared with other workplace settings, particularly those working in independent opticians.

Figure 22 – Working as a supervisor for pre-registration trainee optometrists by workplace setting
Base: Working optometrists and dispensing opticians (2,708); Independent/sole practitioner (1,124); Multiple (1,513); Hospital (280); Domiciliary care (81); Education/academia (161)



Those who work as supervisors also continue to be more likely to feel unable to cope with their workload and find it difficult to provide patients with the level of care they need when compared with those who do no supervising. Again, this highlights the potential negative impact of taking on this responsibility for optometrists and dispensing opticians on their workload and ability to deliver safe patient care.

Figure 23 – Workplace challenges by working as a pre-registration trainee supervisor
Base: Sometimes/frequently feel unable to cope with workload (1,619); Sometimes/frequently finding it difficult to provide patients with sufficient care (999)



Job satisfaction

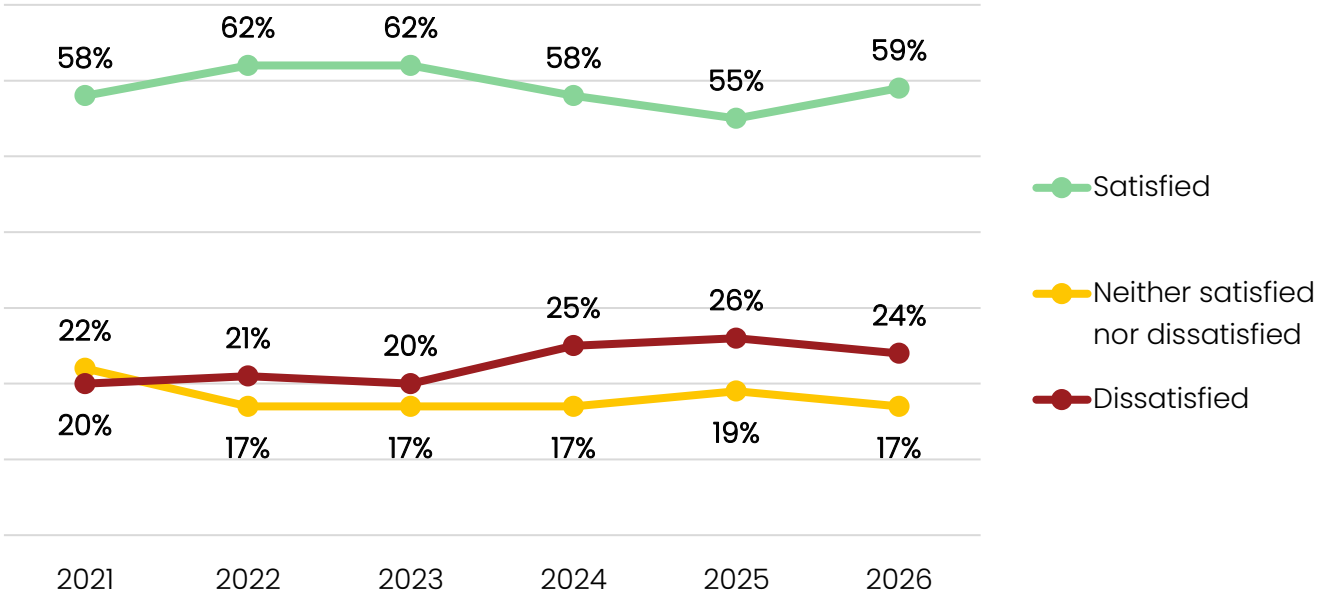
Job satisfaction shows modest improvement

Three in five respondents (59%) report being satisfied in their job/role over the last 12 months, with satisfaction increasing compared with 2025 (55%).

At the same time, dissatisfaction has eased slightly from its recent peak (26% to 24%), suggesting a modest improvement in overall sentiment. While satisfaction remains below the higher levels seen in 2022 and 2023 (62%), these results may suggest a potential stabilisation and early signs of recovery in job satisfaction.

Figure 24 – Job/role satisfaction 2021 to 2026

Base: Working respondents excluding 'not applicable' 2021 (4,378); 2022 (3,628); 2023 (3,468); 2024 (4,043); 2025 (3,306); 2026 (3,015)



Exploring job satisfaction

Although the majority of registrants report being satisfied in their role over the last 12 months (59%), with a quarter (24%) dissatisfied, this a significant minority of the workforce who are experiencing challenges in their role.

Analysis of this result highlights meaningful differences across the workforce, with satisfaction shaped by workplace context, career stage, and day-to-day experience of delivering care.

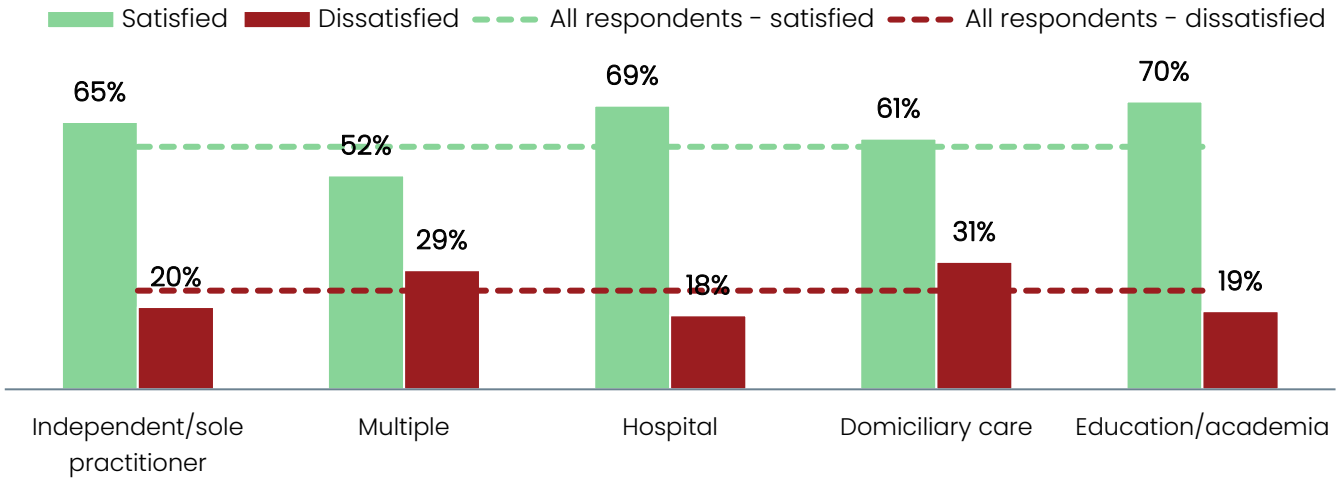
Workplace setting is a key driver of job satisfaction

Satisfaction varies considerably by workplace setting, suggesting that this one of the clearest drivers of experience. Satisfaction is especially high in hospitals, education and academia, and amongst those working in independent practices or as sole practitioners. In contrast, satisfaction is low amongst those working in multiples, who make up a significant proportion of the overall sample (61%).

This may suggest that greater autonomy or variety are associated with higher satisfaction, whereas those in more commercial or high-volume environments such as multiples are more likely to report dissatisfaction.

Figure 25 – Job/role satisfaction by workplace setting

Base: Independent/sole practitioner (1,170); Multiple (1,757); Hospital (288); Domiciliary care (81); Education/ academia (162)

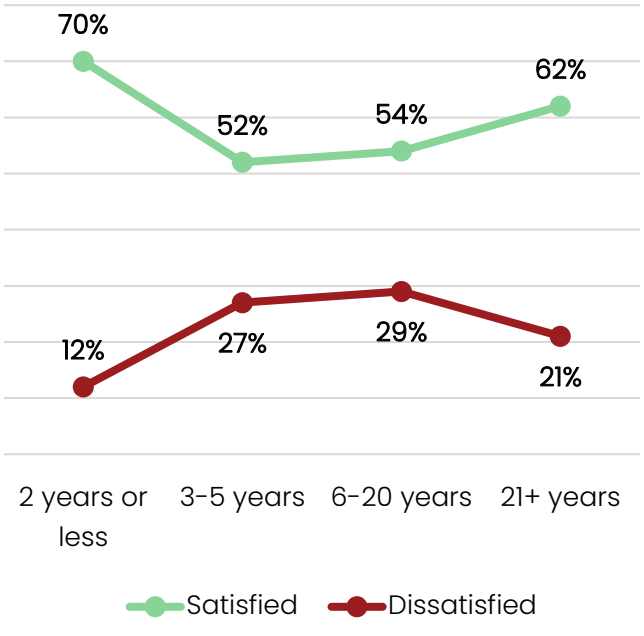


A mid-career dip in satisfaction is evident

There is a clear relationship between experience and job satisfaction, with a notable dip among mid-career registrants. Satisfaction is highest among those at the very start of their careers and those with the most experience, while those in the middle stages report comparatively lower satisfaction and higher dissatisfaction. This may suggest a mid-career pressure point that may impact job satisfaction.

Figure 26 – Job/role satisfaction by length of registration

Base: 2 years or less (348); 3-5 years (379); 6-20 years (985); 21+ years (1,292)

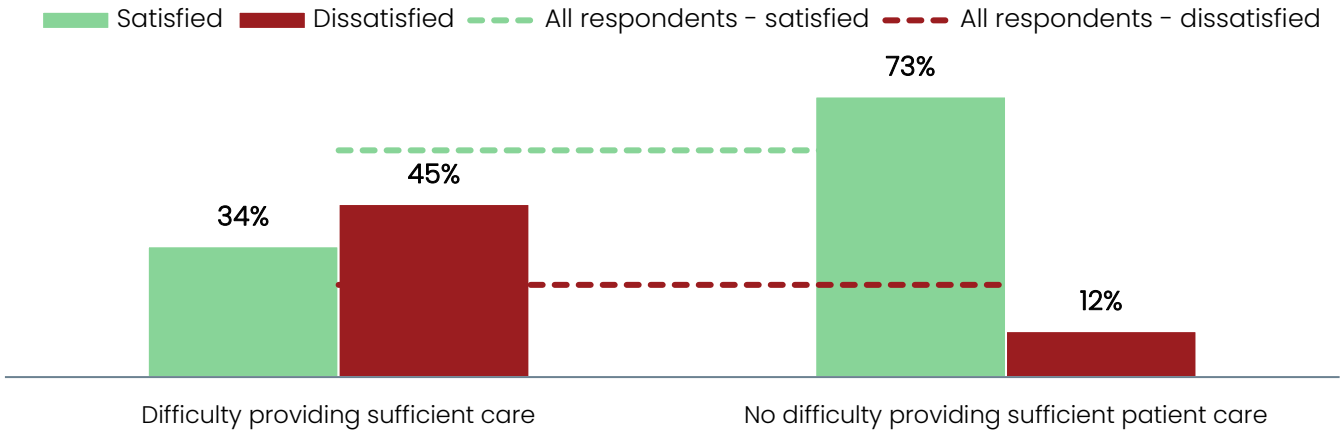


Ability to deliver sufficient patient care is the strongest predictor of satisfaction

The most striking difference in job satisfaction relates to whether registrants feel able to provide patients with the sufficient level of care they need. Those who report difficulties in delivering appropriate care are significantly less likely to feel satisfied and considerably more likely to feel dissatisfied with their role, highlighting the impact of professional fulfilment and frustration on job satisfaction.

Figure 27 – Job/role satisfaction by workplace setting

Base: Difficulty providing sufficient care (1,083); No difficulty providing sufficient care (1,932)

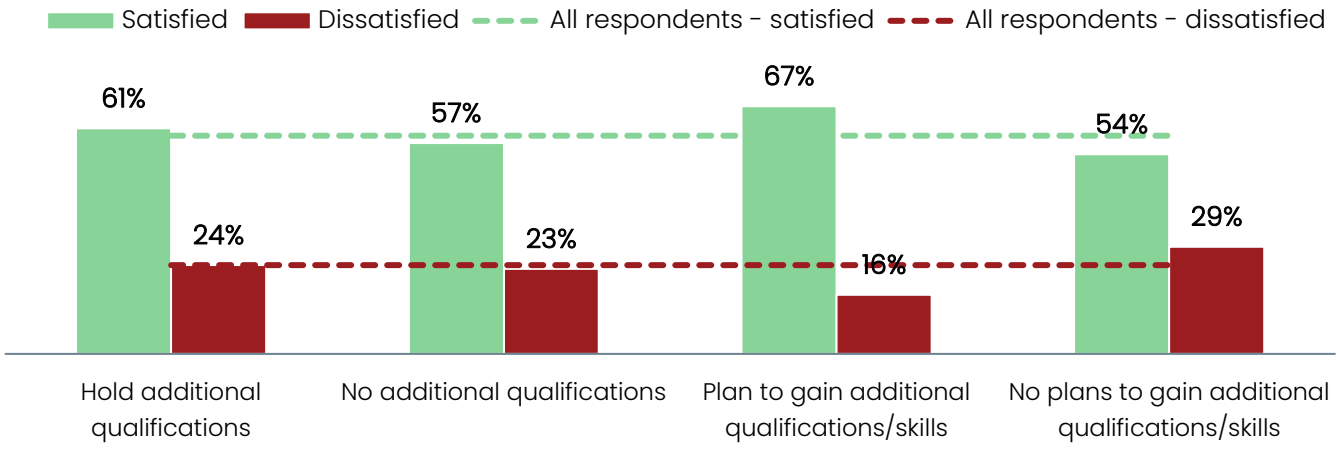


Professional development linked to higher job satisfaction

Registrants who already hold additional qualifications tend to report slightly higher levels of satisfaction than those who do not, but the more pronounced difference is seen among those who are planning to gain further qualifications or skills. Those with plans to undertake additional qualifications report notably higher satisfaction and lower dissatisfaction, while those with no plans to develop further are less satisfied and more likely to feel dissatisfied, suggesting that engagement in professional development, whether through existing qualifications or a forward-looking intention to upskill, is associated with more positive job experiences.

Figure 28 – Job/role satisfaction by existing additional qualifications and plans to gain additional qualifications/kills in the next 12 months

Base: Hold additional qualifiactions (1,282); No additional qualifications (1,732); Plan to gain additional qualifications/skills (1,218); No plans to gain additional qualifications/skills (1,732)

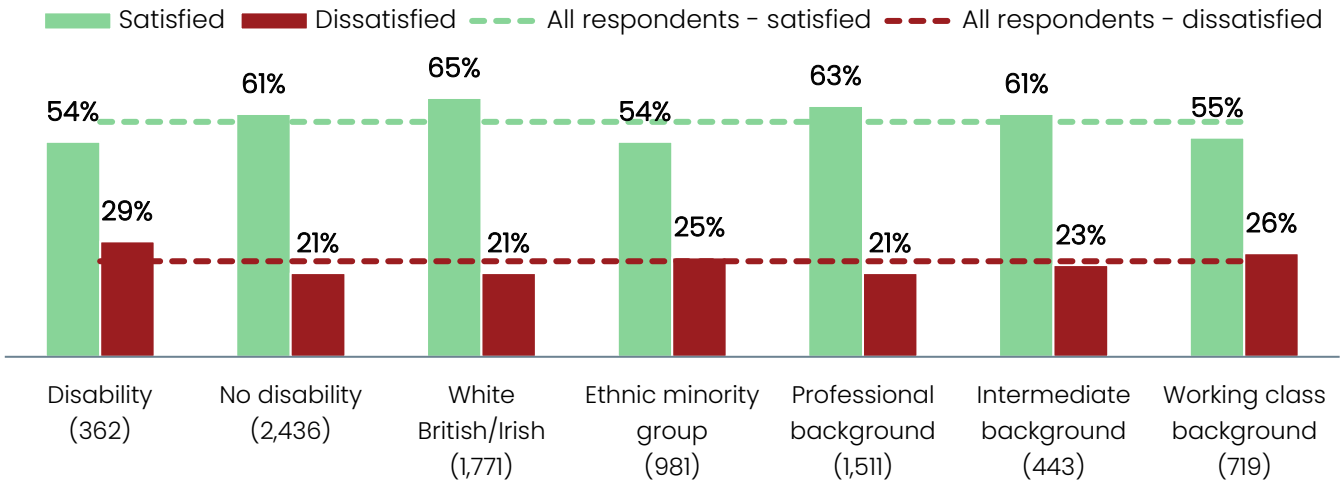


Some variation in satisfaction by demographic characteristics

There are also some differences in job satisfaction across demographic groups. Registrants with a disability are less likely to feel satisfied and more likely to feel dissatisfied with their role compared with those without a disability.

Differences by ethnicity are less pronounced overall, although there is some variation between White British/Irish and ethnic minority groups in levels of satisfaction and dissatisfaction. A similar pattern is seen by socio-economic background, where those from working class backgrounds tend to report slightly lower satisfaction and higher dissatisfaction than those from professional or intermediate backgrounds.

Figure 29 – Job/role satisfaction by disability, ethnicity, and socio-economic background
Base: Shown in chart



Working conditions

Experiences of negative working conditions

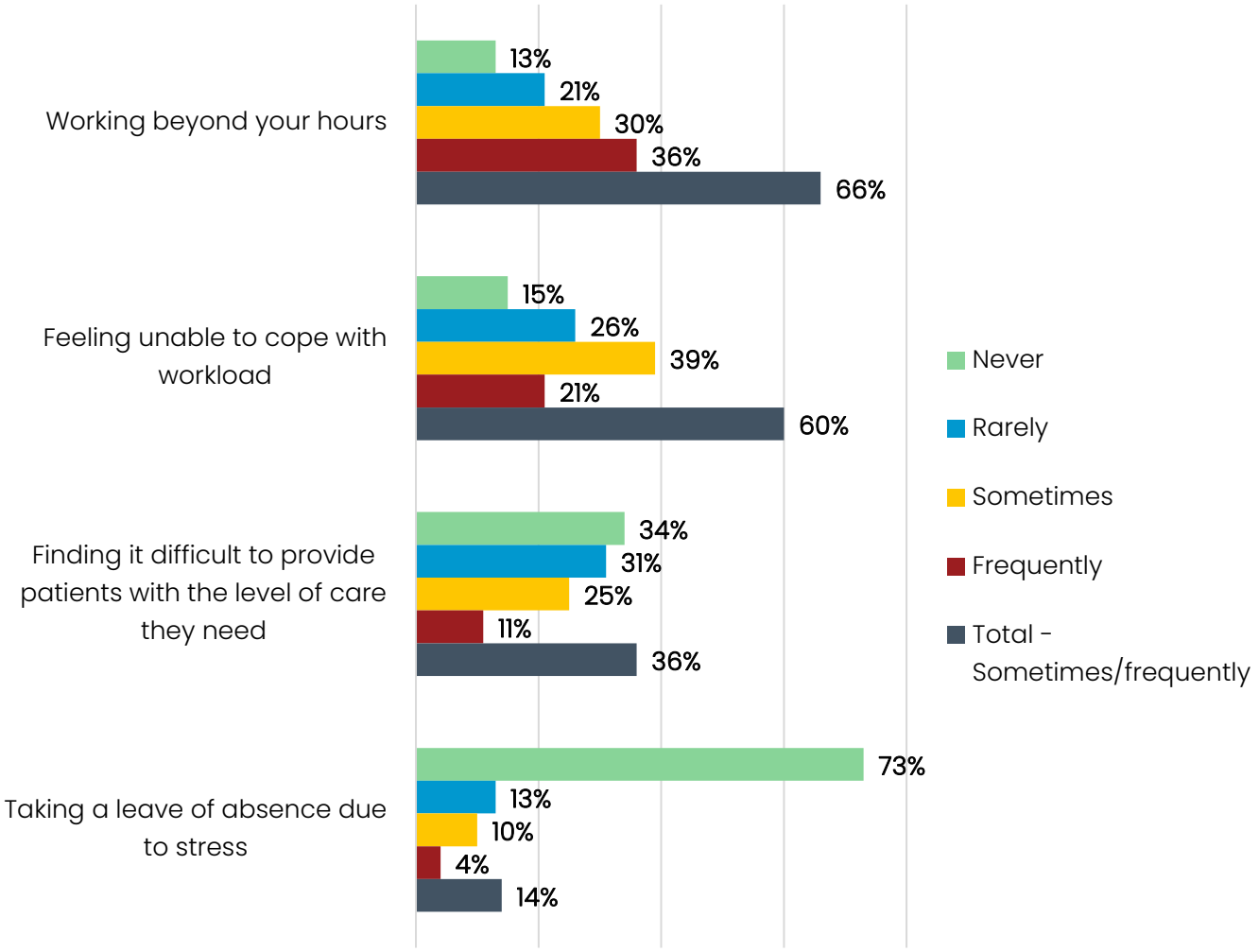
Workload pressures remain the most widespread challenge

Working beyond contracted hours continues to be the most commonly reported negative working condition, with two-thirds (66%) of respondents indicating this occurs at least sometimes. A similarly high proportion (60%) report struggling to cope with their workload, highlighting the ongoing pressure many registrants face in their day-to-day roles.

While a smaller proportion (36%) report difficulties in delivering the level of care they would like, this still affects a notable minority, and may be linked with other workload pressures.

In contrast, taking time off due to stress remains relatively uncommon (14%), indicating that while pressures are widespread, they do not always translate into absence.

Figure 30 – Experience of negative working conditions in the last 12 months
Base: Those currently working/employed (3,022)

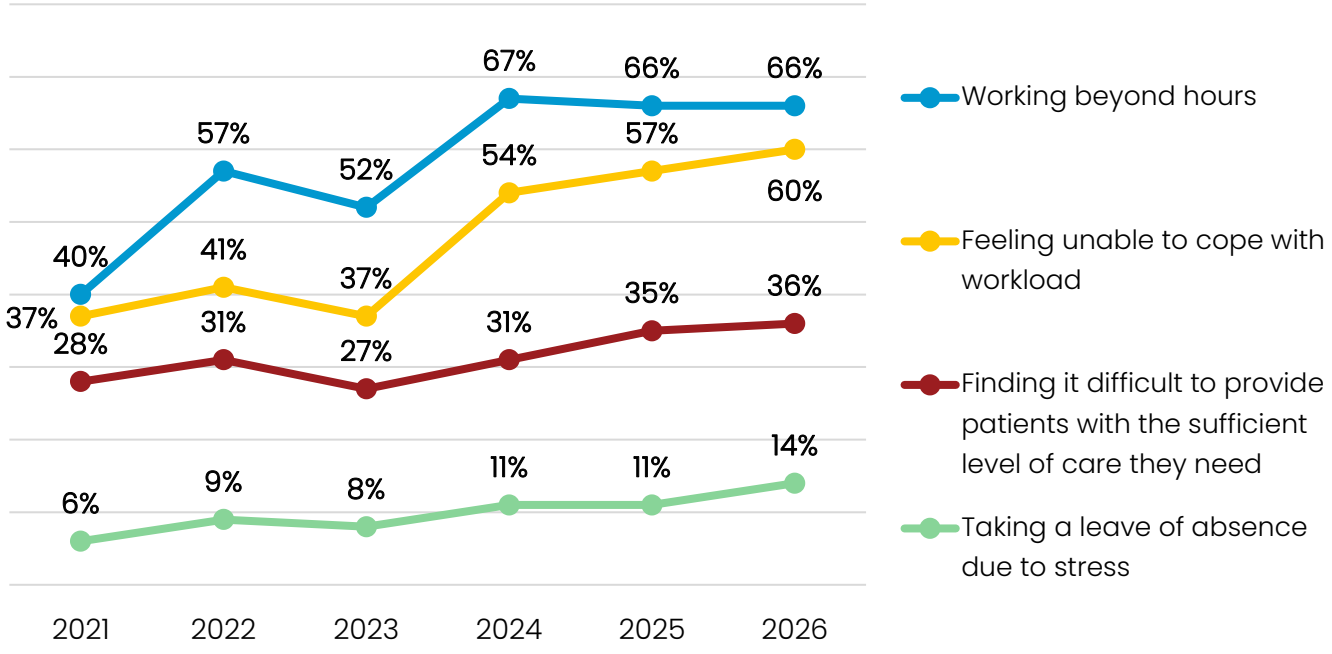


Some aspects of negative working conditions are increasing over time

Although caution is required when comparing over time due to changes in question format since 2024, the available trend data suggests that negative working conditions have become more prevalent in recent years. In particular, there has been a noticeable increase in the proportion of respondents reporting that they feel unable to cope with their workload, as well as those finding it difficult to provide patients with the level of care they need. Both measures have risen steadily since 2023, indicating growing strain within the workforce.

Working beyond contracted hours has remained consistently high over the last three years. Meanwhile, reports of stress-related absence, while still comparatively low, have shown a gradual upward trend.

Figure 31 – Experience of negative working conditions 2021 to 2025 (sometimes/frequently)
Base: Those currently working/employed 2021 (4,479); 2022 (3,647); 2023 (3,486); 2024 (4,049); 2025 (3,315); 2026 (3,022)

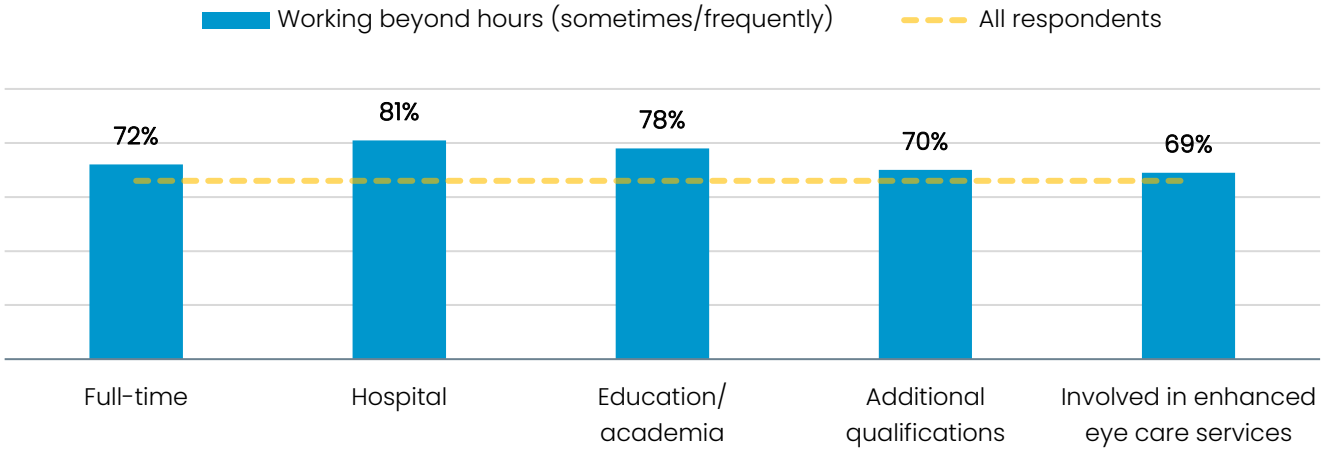


Working beyond hours is more prevalent among those in demanding and extended roles

Working beyond hours is widespread, but is more common among some groups than others. Respondents working full-time were more likely than those working part-time to say they had done so at least sometimes, while those working in hospital and education/academia settings also stood out as more likely to report working beyond their hours. This was also more common among registrants with additional qualifications and those involved in enhanced eye care services.

Figure 32 – Impact of working status, workplace setting, additional qualifications, and involvement in enhanced eye care services on working beyond hours

Base: Full-time (1,209); Hospital (288); Education/academia (163); Additional qualifications (1,287); Involveed in enhanced eye care services (1,574)



Workload strain varies by role, setting, working pattern and region

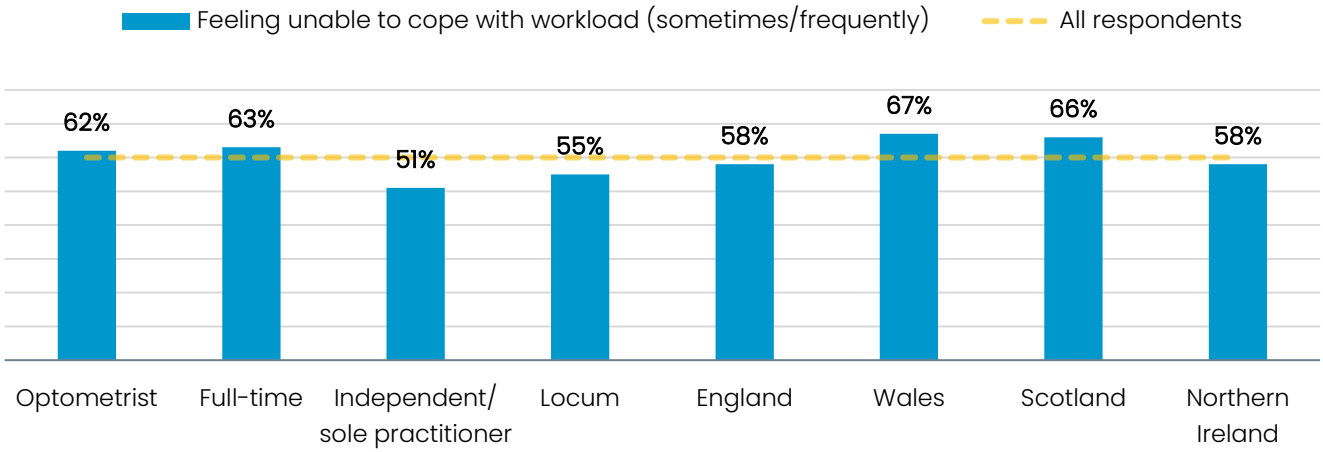
Feeling unable to cope with workload is more common among optometrists and those working full-time when compared with dispensing opticians and those working part-time.

Analysis by workplace setting shows that those working as independent or sole practitioners are less likely to report struggling with workload when compared with all other settings. Locum workers are also less likely to report this issue.

Regional analysis highlights that respondents in Wales and Scotland are more likely to report feeling unable to cope with workload compared with those in England and Northern Ireland.

Figure 33 – Impact of role working status, workplace setting, locum working, and region on feeling unable to cope with workload

Base: Optometrist (2,004); Full-time (1,209); Independent/sole practitioner (1,174); Locum (669); England (2,252); Wales (156); Scotland (276); Northern Ireland (92)



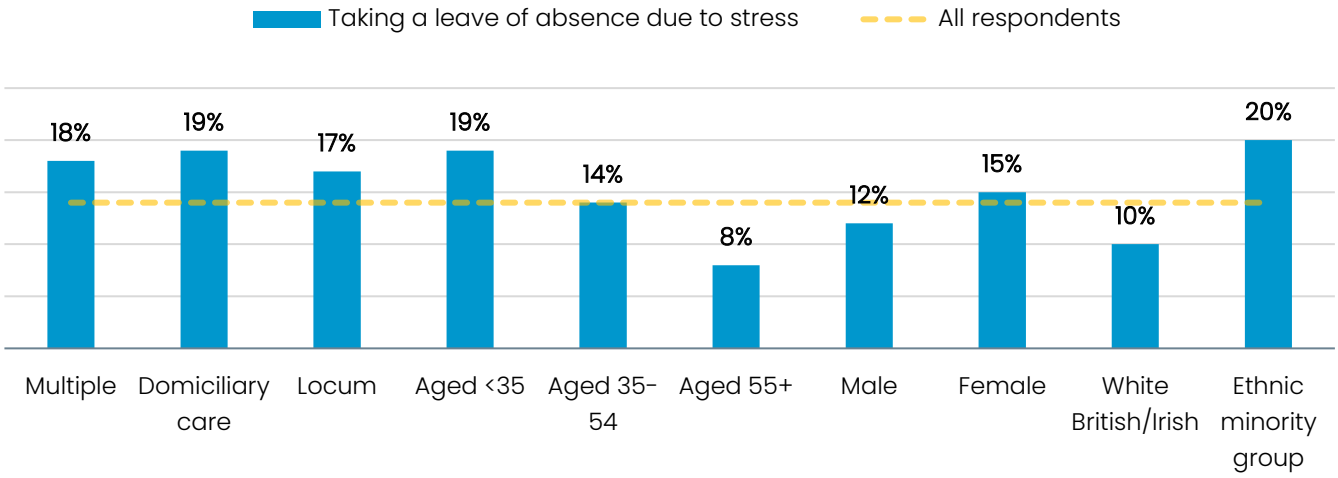
Clear demographic differences in experiences of stress-related absence

Taking a leave of absence due to stress remains less common overall, but there are clear differences across registrant groups. It is more likely to be reported by those working in multiples and domiciliary care when compared with other settings, and also by locum workers.

Younger respondents aged under 35 are more likely to report taking time off due to stress, with likelihood declining steadily with age. Differences are also evident by gender and ethnicity, with female respondents more likely than male respondents to report taking a leave of absence, and those from ethnic minority groups notably more likely to do so compared with White respondents.

Figure 34 – Impact of role working status, workplace setting, locum working, and region on feeling unable to cope with workload

Base: Multiple (1,760); Domiciliary care (81); Locum (669); Aged <35 (826); Aged 35-54 (1,338); Aged 55+ (709); Male (952), Female (1,859); White British/Irish (1,771); Ethnic minority group (984)



Consistently more negative experiences among those with a disability

Across all measures, disability status has a clear and consistent impact on experiences of negative working conditions. Respondents who report having a disability are more likely to say they have worked beyond their hours (71% vs 65% of those without a disability), felt unable to cope with their workload (65% vs 58%), found it difficult to provide patients with the sufficient level of care they need (41% vs 35%), and taken a leave of absence due to stress (27% vs 11%).

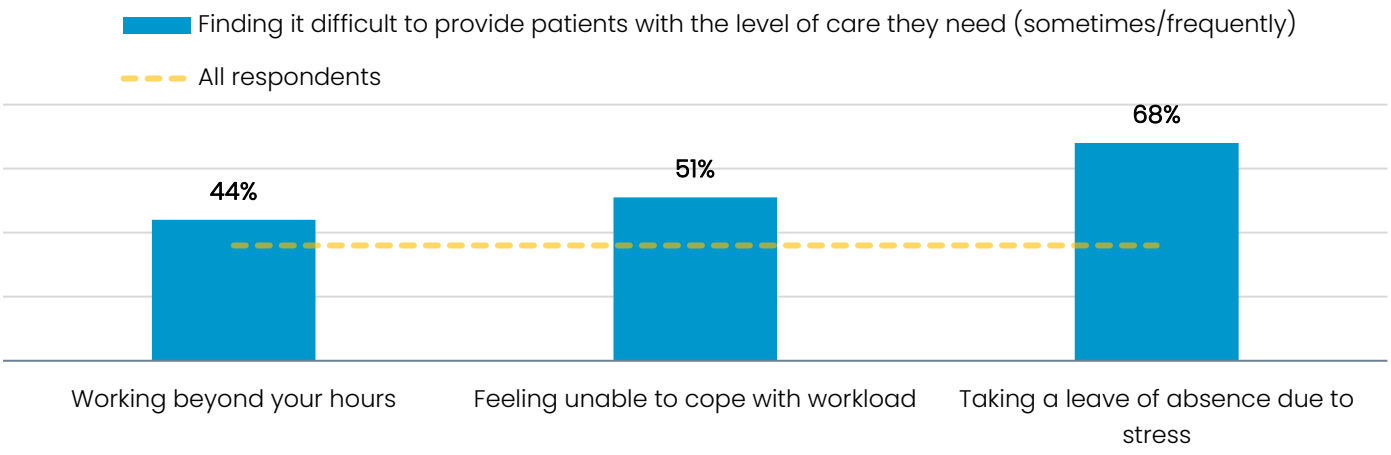
Negative working conditions correlate with difficulties providing patients with sufficient care

As found in previous years, respondents with experience of working beyond their hours, feeling unable to cope with their workload, or taking a leave of absence due to stress were also more likely to report difficulties providing patients with the level of care they need.

This result continues to confirm the correlation between workplace challenges and the ability to deliver safe care for patients.

Figure 35 – Impact of negative working conditions on providing sufficient patient care

Base: Working beyond hours (2,002); Feeling unable to cope with workload (1,802); Taking a leave of absence due to stress (427)



Experiences of time and commercial pressure

Widespread time and commercial pressures are impacting patient care

A substantial proportion of respondents report experiencing time and commercial pressures that may impact patient care.

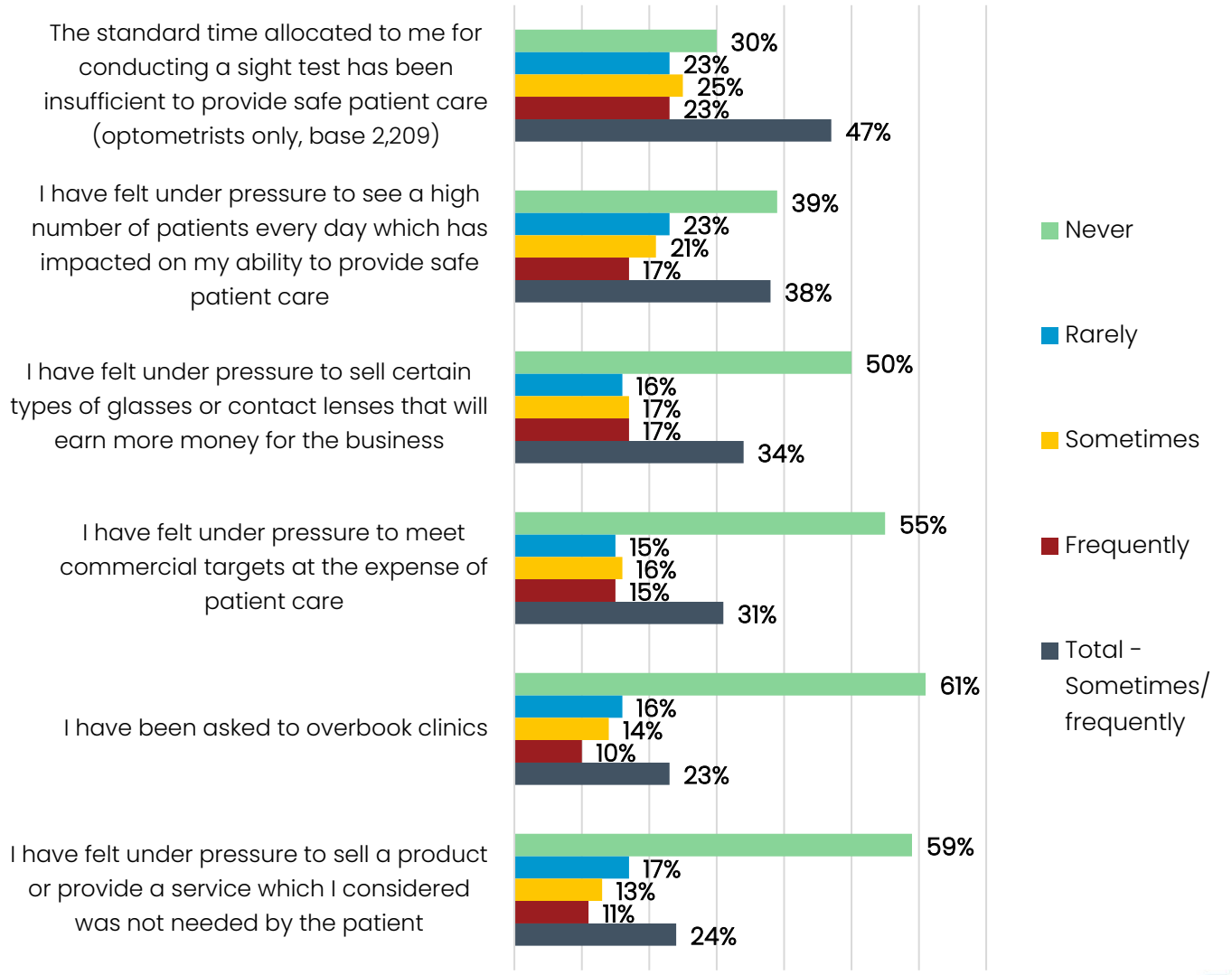
The most commonly cited issue relates to insufficient time for sight tests, with nearly half of optometrists (47%) indicating that the time allocated has been inadequate to provide safe care. Alongside this, over a third (38%) report pressure to see a high volume of patients every day.

Commercial pressures are also evident, with around a third reporting pressure to sell higher-value products (34%) or meet targets at the expense of patient care (31%). Around a quarter indicated they have felt pressured to sell products or services they did not consider needed (24%), or asked to overbook clinics (23%).

This year's results are almost identical to those seen in 2025, showing little change over the last 12 months.

Figure 36 – Experience of time and commercial pressure in the last 12 months

Base: Respondents currently working/employed (3,022)



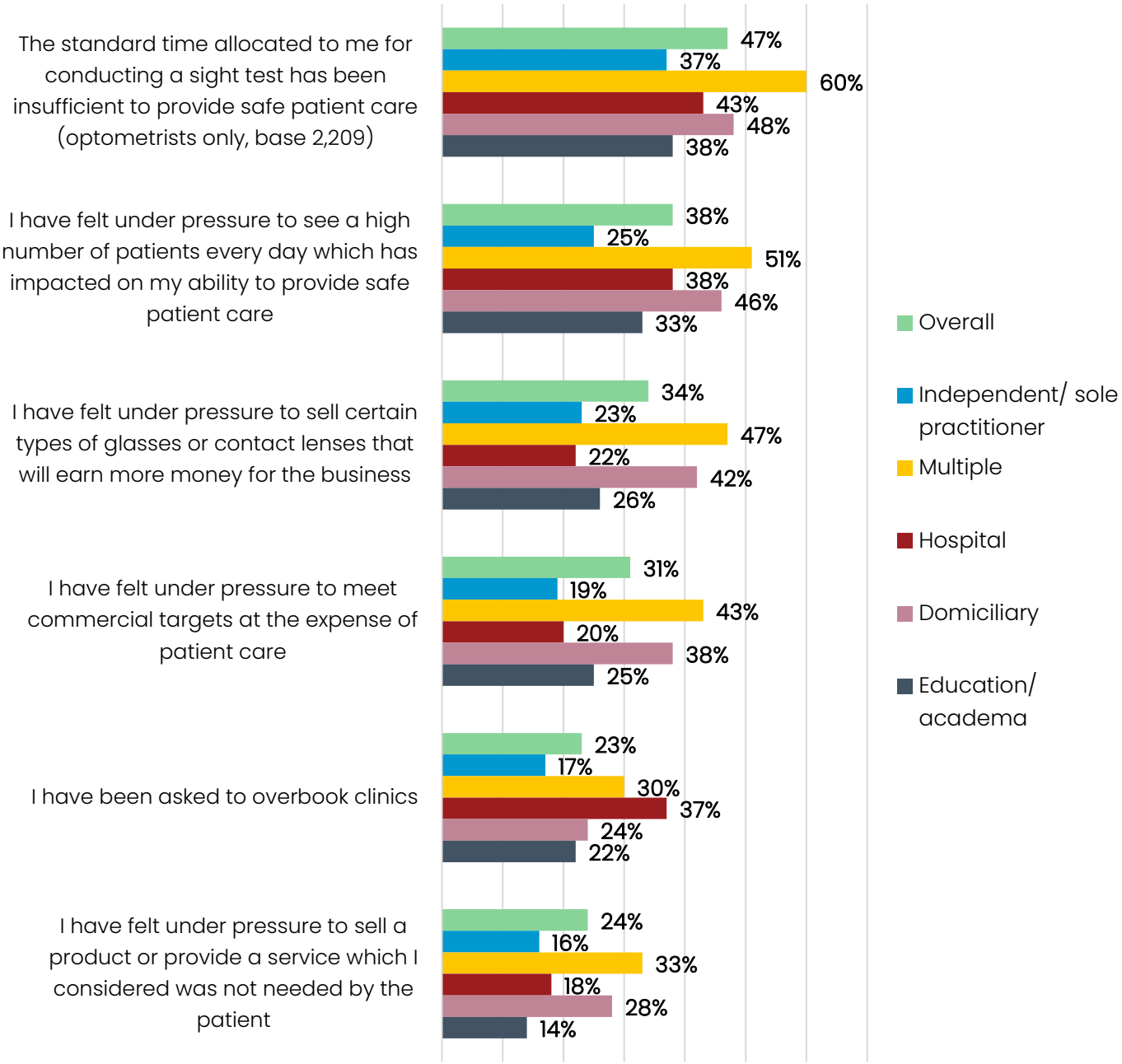
A consistent pressure gap between multiples and independent practice

As found in 2025, workplace setting is strongly associated with experiences of pressure, with those working in multiples consistently more likely to report negative working conditions than those in independent or sole practitioner settings. Across all measures, respondents in multiples are markedly more likely to report pressures relating to time, workload and commercial expectations, while those in independent settings are consistently less likely to do so.

Those working in a hospital setting are less likely to report commercial pressures, such as being asked to sell products or meet targets, but are more likely than average to report being asked to overbook clinics.

Figure 37 – Experience of time and commercial pressure in the last 12 months (sometimes/frequently) by workplace setting

Base: Overall (3,022); Independent/sole practitioner (1,174); Multiple (1,760); Hospital (288); Domiciliary care (81); Education/academia (163)

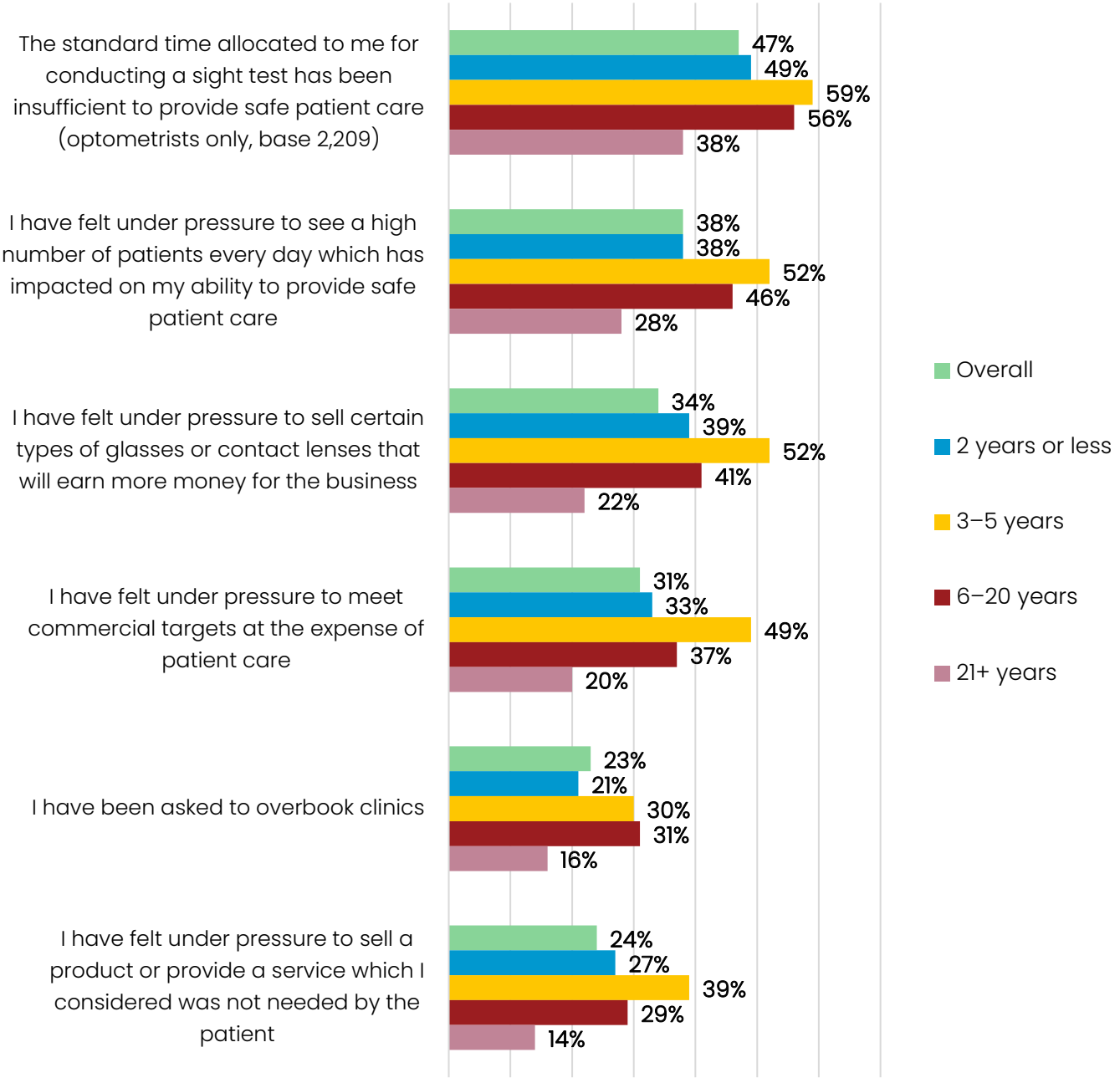


Commercial pressures peak among those with 3–5 years' experience

Respondents registered for 3–5 years are consistently the most likely to report commercial and time pressures across most measures, including insufficient sight test time, pressure to see a high number of patients, pressure to sell higher-value products, pressure to meet commercial targets, and pressure to sell/provide something they felt was not needed. Those registered for 6–20 years also report above-average pressure across most areas, but usually to a lesser extent than the 3–5 year group. In contrast, those registered for 21+ years are consistently least likely to report these pressures.

Figure 38 – Experience of time and commercial pressure in the last 12 months (sometimes/frequently) by workplace setting

Base: Overall (3,022); 2 years or less (348); 3-5 years (379); 6-20 years (988); 21+ years (1,296)

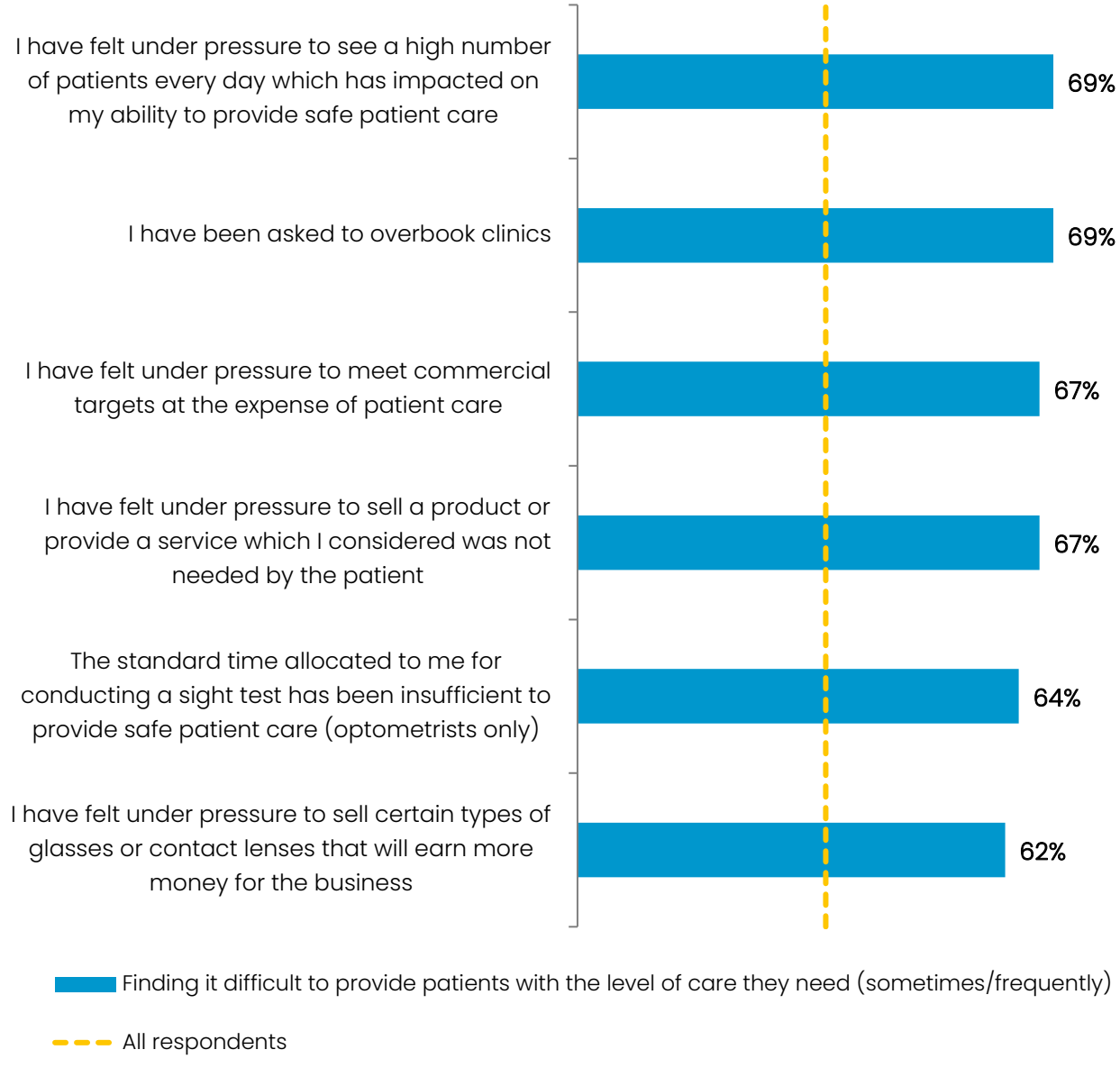


Ongoing relationship between time/commercial pressures and patient care challenges

As with negative working conditions, a clear relationship between commercial pressures and the ability to provide sufficient patient care is evident again this year, reinforcing the pattern seen previously.

Overall, over a third of respondents (36%) report that they sometimes or frequently struggle to provide patients with the level of care they need. However, this nearly doubles for those who report being asked to see a high number of patients each day (69%), to overbook clinics (69%), or feeling under pressure to meet commercial targets (67%) or to sell products or services they consider unnecessary (67%).

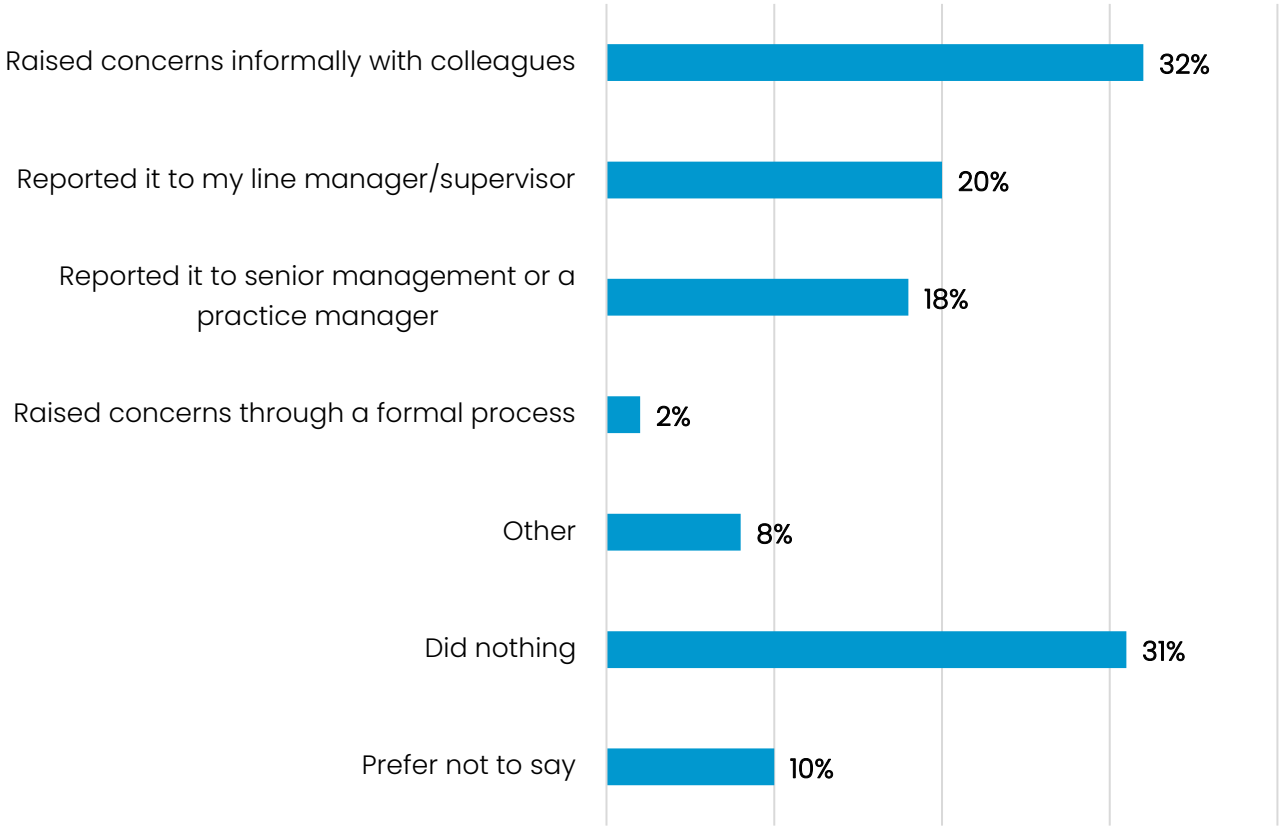
Figure 39 – Impact of time and commercial pressure on providing sufficient patient care
Base: Respondents currently working/employed (3,022)



Concerns are most often raised informally, with many taking no action

Most respondents who experienced time or commercial pressures tend to raise concerns informally rather than through formal channels. A third (32%) say they discussed issues with colleagues, while one in five (20%) reported concerns to a line manager or supervisor, and slightly fewer escalated to senior management (18%). In contrast, very few respondents report using formal processes (2%). However, a large proportion (31%) say they did nothing, similar to the level who raised concerns informally with colleagues.

Figure 40 – Actions taken when experiencing time/commercial pressures
Base: Those who reported any experience of time/commercial pressure (2,293)



Most 'other' free-text responses described managing the situation themselves, typically by prioritising patient care (e.g. overrunning or refusing to compromise), or by removing themselves from the situation (e.g. leaving or avoiding certain workplaces), with some also highlighting informal discussions.

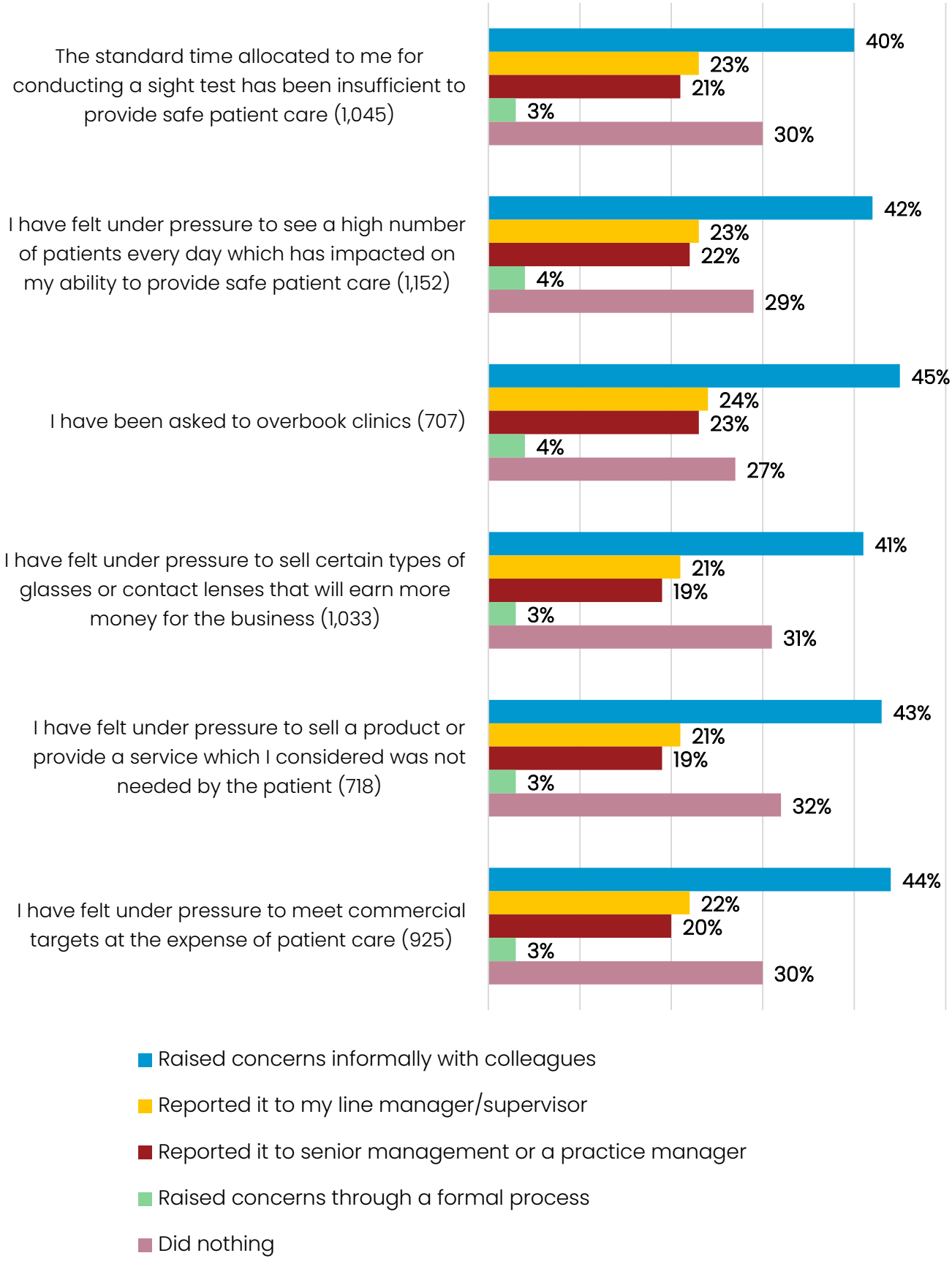
Approach to raising concerns is similar across all types of pressure

Actions follow a very consistent pattern across all types of time and commercial pressure experienced. The chart overleaf shows the actions taken by each type of time/commercial pressure experienced sometimes or frequently, highlighting that informal discussion with colleagues is the most common action taken, followed by those who said they did nothing.

The only small difference in results is found when being asked to overbook clinics, where respondents were slightly more likely to report taking informal action.

Figure 41 – Actions taken when experiencing time/commercial pressures by type of pressure

Base: Those who reported sometimes/frequently experiencing time/commercial pressure (shown in chart)



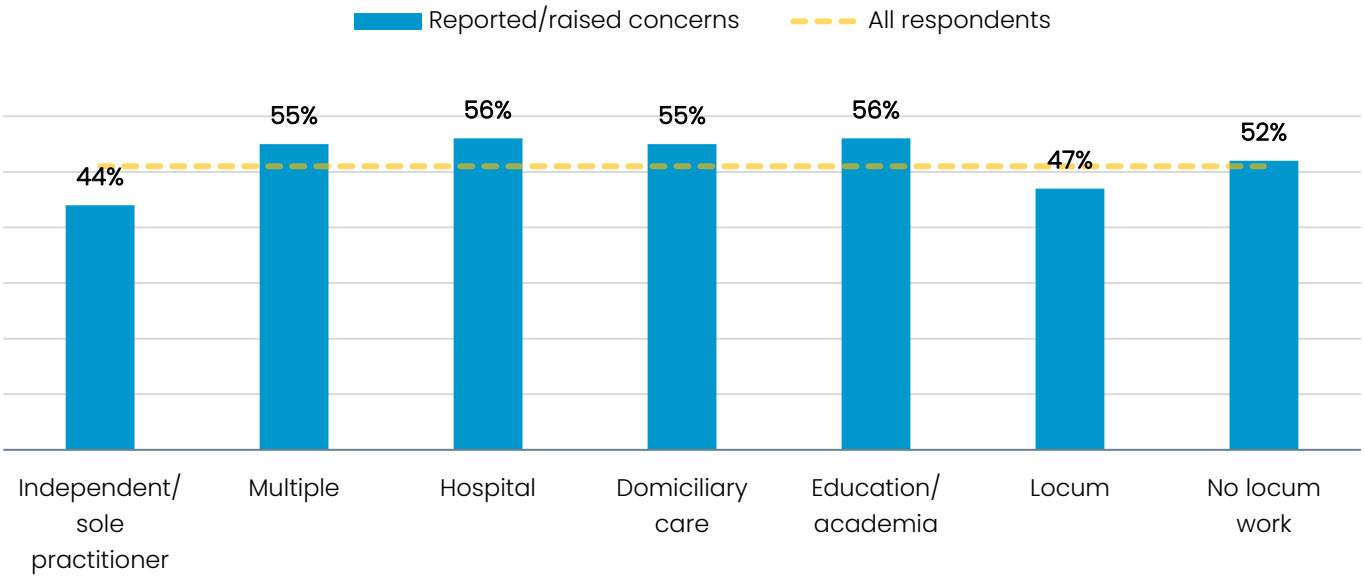
Likelihood of raising concerns varies by workplace setting and working pattern

In total, just over half (51%) reported or raised a concern about time or commercial pressure in some way. Those working in multiples, hospitals, domiciliary care, and education or academia were more likely to have done so compared with those working in an independent opticians or as a sole practitioner.

It is interesting to note that those who undertake locum are also less likely to raise concerns, while those who do no locum work are slightly more likely to take action.

Figure 42 – Impact of workplace setting and locum working on reporting/raising concerns

Base: Independent/sole practitioner (762); Multiple (1,516); Hosptial (241); Domiciliary care (60); Education/academia (108); Locum (549); No locum work (1,744)

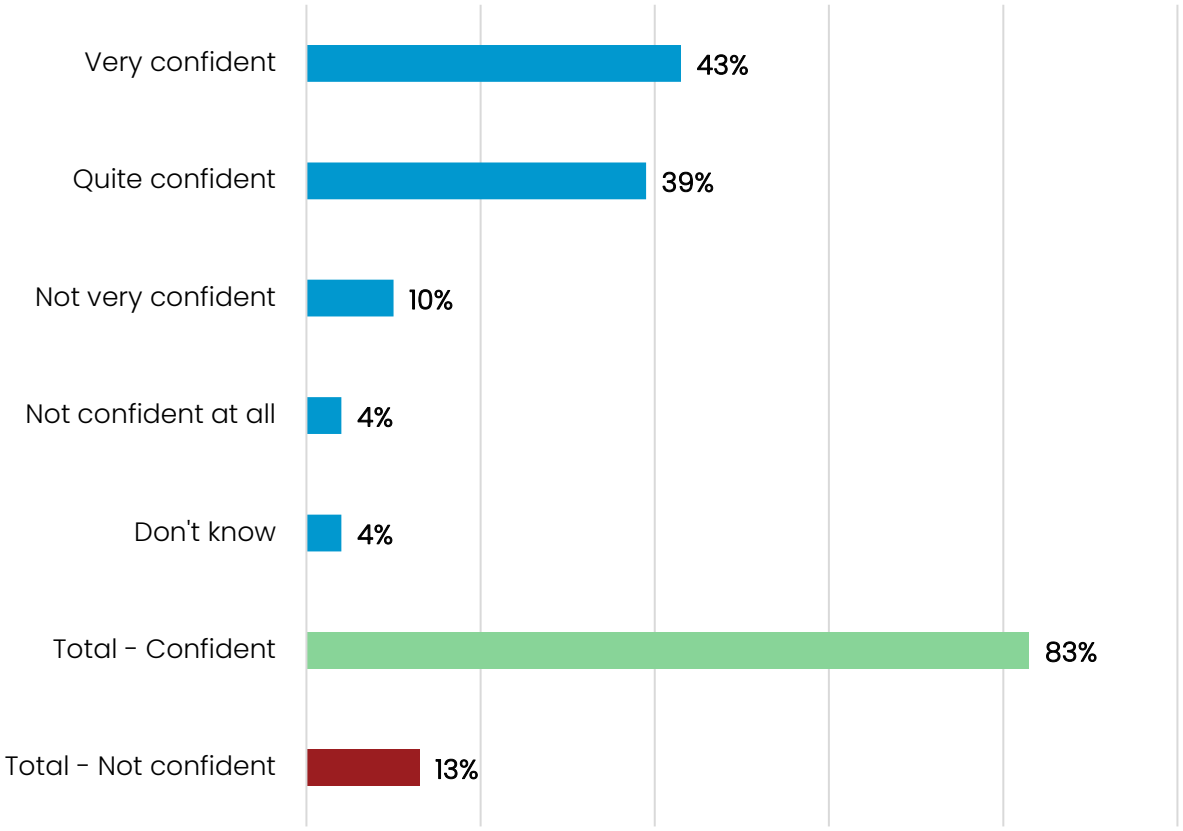


Most feel confident to resist commercial pressures that could compromise care

Overall, confidence in the ability to resist commercial pressures is high, with over eight in ten working respondents (83%) reporting that they feel confident. Around four in ten (43%) say they are very confident, indicating a strong level of assurance among a substantial proportion of the workforce.

However, a notable minority express lower confidence, with around one in eight (13%) saying they are not confident.

Figure 43 – Confidence in ability to resist commercial pressures that could compromise patient care
Base: All respondents excluding fully retired (3,414)



Confidence varies by experience, setting and background

There is some variation in confidence in the ability to resist commercial pressures. Dispensing opticians report higher levels of confidence than optometrists, while confidence is notably lower among working student optometrists.

By workplace setting, those working in an independent opticians or as a sole practitioner report the highest confidence when compared with all other settings. Confidence also increases with age, with respondents aged 55+ more likely to feel confident than those under 35.

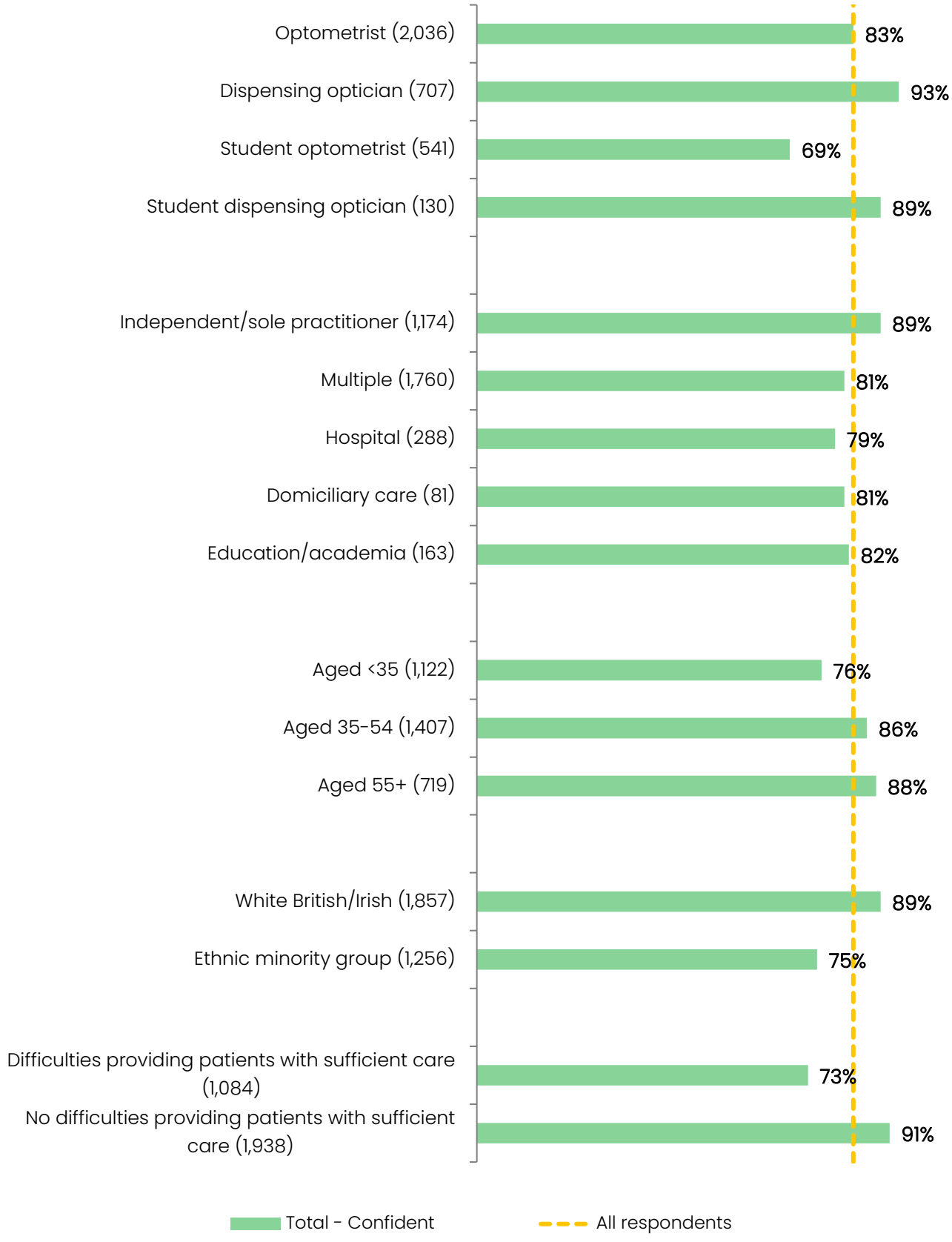
There are also differences by ethnicity, with respondents from ethnic minority groups less likely to report confidence compared with those who are White British/Irish.

Confidence is lower among those experiencing difficulties providing sufficient care

Confidence in resisting commercial pressures is notably lower among those who report difficulties providing patients with sufficient care in the last 12 months. While a strong majority of those not experiencing such difficulties feel confident, this drops among those who do, which may suggest that challenges in delivering adequate care may be linked to reduced confidence in resisting commercial pressures.

Figure 44 – Confidence in ability to resist commercial pressures by registrant type, workplace setting, age group, ethnicity, and experience of difficulties providing patients with sufficient level of care

Base: Shown in chart

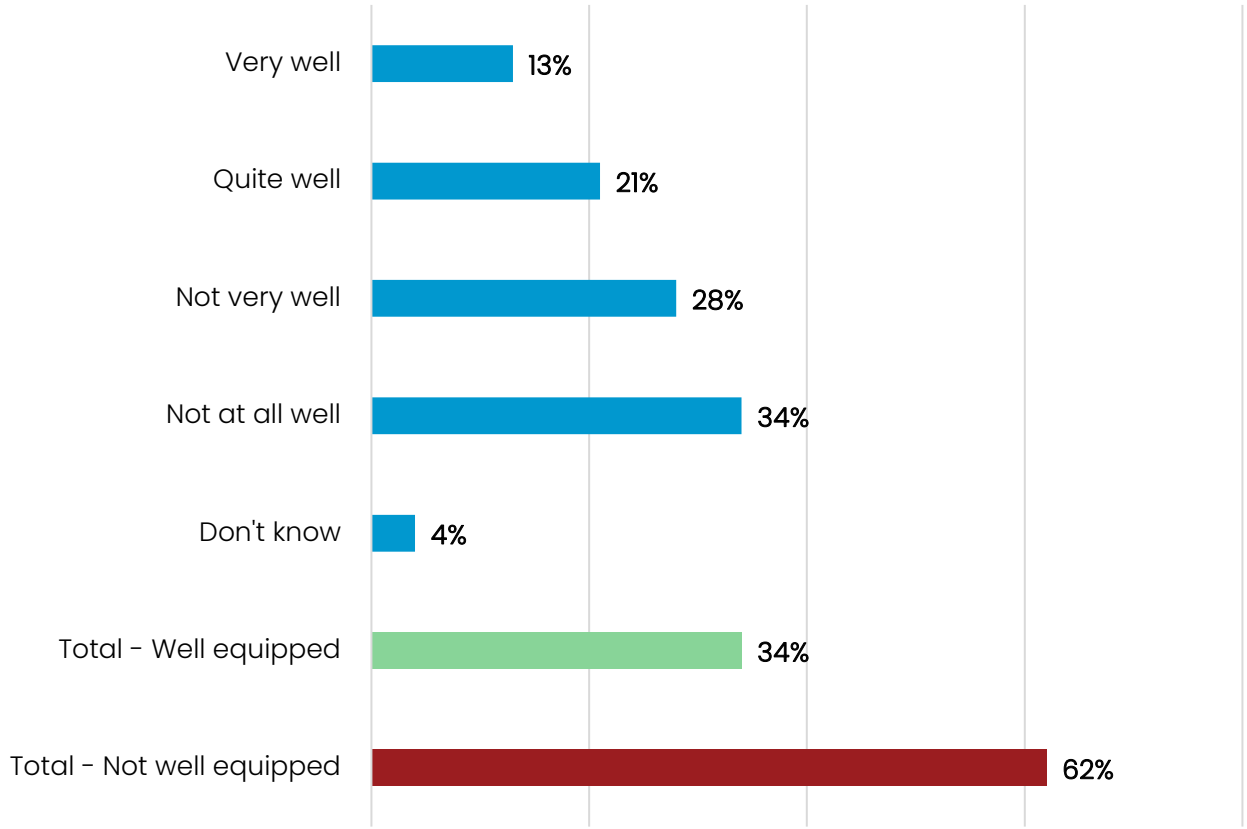


Most feel their education and training did not equip them to manage commpercial pressures while maintaining safe patient care

Overall, respondents are more likely to feel that their education and training did not equip them well to manage commercial pressures while maintaining safe patient care. Almost two thirds (62%) report that they were not well equipped, including 34% who felt not at all well equipped. In contrast, only 34% feel their training equipped them well.

Figure 45 – How well education and training equipped registrants to manage commercial pressures while maintaining safe patient care

Base: Those currently working exclusing students (2,743)



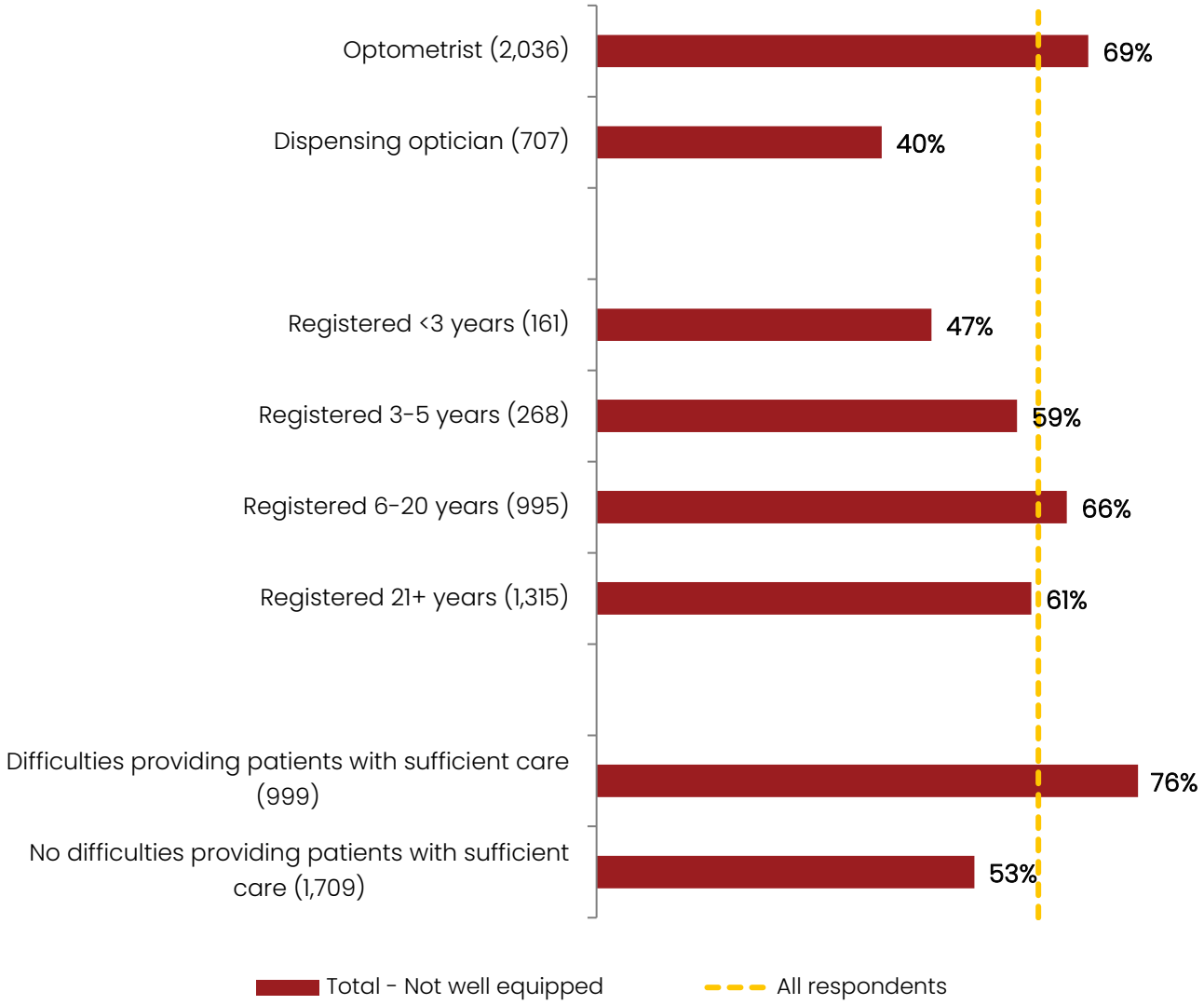
Variations in perceived preparedness by role, experience, and ability to provide sufficient patient care

Optometrists are notably more likely than dispensing opticians to say they are not well equipped, suggesting greater perceived gaps in preparation among this registrant group. By experience, those registered for 6+ years are more likely to feel underprepared than those earlier in their careers, particularly those registered for less than 3 years.

As with confidence in resisting commercial pressures, the most pronounced difference is linked to experience of difficulties providing patients with sufficient care, with those experiencing difficulties far more likely to feel not well equipped compared with those no experience of such difficulties.

Figure 46 – Feeling not well equipped to manage commercial pressures while maintaining safe patient care by registrant type, length of registration, and experience of difficulties providing patients with sufficient level of care

Base: Shown in chart



Time pressures and sales targets dominate concerns about patient care

Respondents were asked what one commercial practice they were most concerned about in terms of its potential impact on patient care. The thematic analysis of 2,097 free-text comments to show the frequency of mentions is presented in the table overleaf.

The most common concerns raised by respondents centre on the interaction between time pressures and commercial expectations, and how these may compromise the quality of patient care. The single most frequently cited issue relates to appointment times and reduced testing time (21%), with respondents highlighting concerns that standard sight test durations are insufficient to carry out thorough assessments, particularly as clinical expectations and technology have evolved. Closely linked to this, many also pointed to overbooking, ghost clinics, and high patient volumes (16%), reinforcing the sense that time constraints are being driven not only by short appointment slots, but also by pressure to see more patients overall.

A substantial proportion of responses focus on sales-driven practices. Around one in five respondents mentioned conversion or sales targets (20%), while a similar proportion highlighted overselling or upselling products and services (19%).

The most common themes point to a consistent overall concern about environments where time constraints and commercial incentives intersect, creating conditions that may negatively impact on safe patient care.

Figure 47 – Most concerning commercial practices in terms of potential impact on patient care (coded free-text, 20+ mentions)

Top themes in free-text responses	Frequency	%
Appointment times/reduced testing time	450	21%
Conversion/sales targets	425	20%
Overselling/upselling products and services	404	19%
Overbooking/ghost clinics/patient volumes	332	16%
Multiple/specific business practice	166	8%
Workload/time pressures	161	8%
NHS underfunding/GOS	102	5%
Business costs/increasing prices/staying profitable	93	4%
Understaffing/underqualified staff/over-reliance on OAs	55	3%
Online sales/purchasing	54	3%
Increasing number of tests/scans/services	48	2%
No additional time for complex patients	46	2%
Accommodating late patient arrivals/walk-ins/emergencies	45	2%
Financial impact on patients/feeling pressured to buy	35	2%
Myopia management/cost of myopia management	35	2%
Performance reviews linked to sales	34	2%
Lack of honesty to patients/damaging patient trust	31	1%
Charging for OCT/additional scans/extra services	29	1%
Lack of support or action from GOC/professional bodies	25	1%
Contact lens selling/care	24	1%
AI/AI glasses	23	1%
Insufficient/lack of training	22	1%
Managing referrals	20	1%

Top themes in free-text responses	Frequency	%
Sales-related bonuses/earning commission	20	1%
No concerns/none regarding current practice/NA to workplace	192	9%

Appointment times/reduced testing time

> *Reduced testing times. 20 minute clinics are very hard to keep up with and many tests are omitted to keep up with timing.*
> Optometrist

> *Allotted time for the exam, when there are more clinical things to check than ever.*
> Optometrist

> *Testing times*
> Dispensing optician

> *Pressure to reduce the time allocated to each patient*
> Optometrist

Conversion/sales targets

> *Conversion is more important that patient care where I work.*
> Optometrist

> *Sales and conversion rates*
> Optometrist

> *Pressure to meet sales targets, as it may influence clinical decisions and affect patient-centred care.*
> Student optometrist

> *Pressure to dispense and meet targets*
> Dispensing optician

Overselling/upselling products and services

> *Overselling or selling to no change prescriptions*
> Optometrist

> *Upselling of scans to well patients with no clinical indication*
> Optometrist

> *In high street patients may be encouraged to buy more expensive options than needed*
> Student optometrist

> *Dispensing clinically insignificant prescriptions especially to children*
> Optometrist

Overbooking/ghost clinics/patient volumes

> *Ghost clinics and overbooking patients on already small testing times.*
> Dispensing optician/student optometrist

> *Extra diary alongside fully booked diaries*
> Optometrist

> *Squeezing in patients to already busy diaries*
> Optometrist

> *Too many patients booked in one day, 20 including MECS CUES post cats is too much*
> Optometrist

Harassment, bullying or abuse

In total, almost half of respondents (46%) had personally experienced some form of harassment, bullying, or abuse at work (or study for those in education) in the last 12 months. After a fall of 6% pts from 2024 (50%) to 2025 (44%), this represents a small increase (+2% pts).

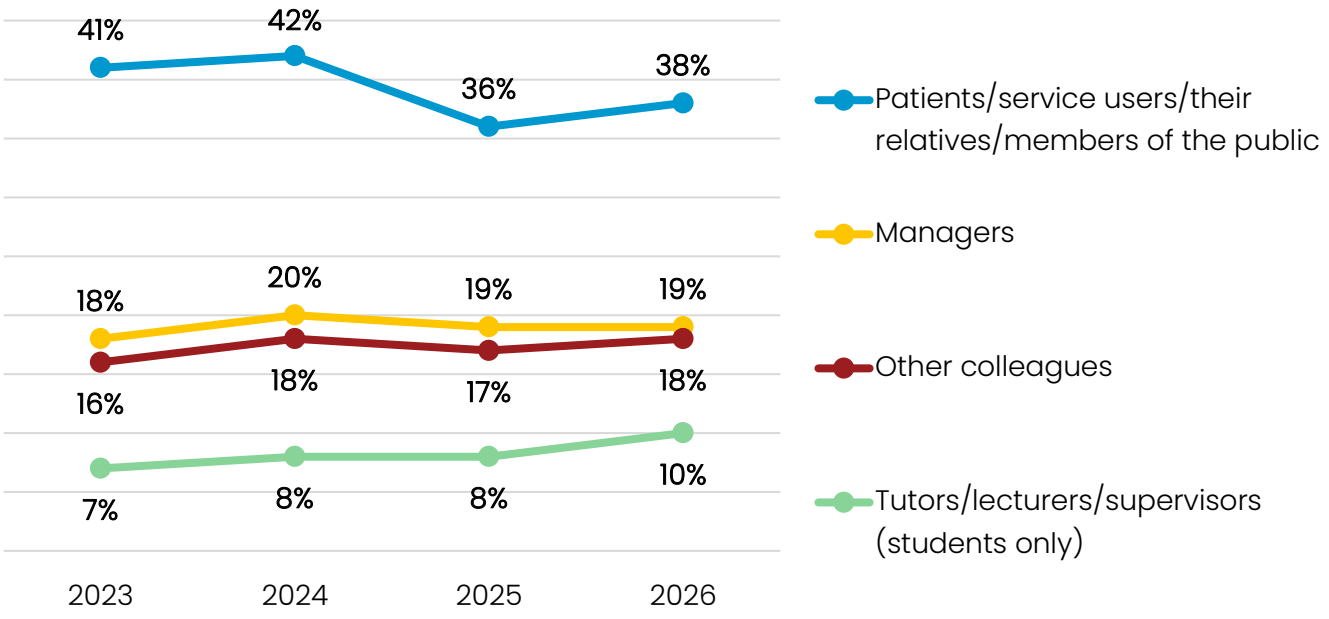
Patients/service users continue to be the main source of harassment, bullying or abuse at work

As found every year, the primary source of harassment, bullying or abuse is patients and service users, their relatives or other members of the public, with 38% of respondents having at least one experience of this in the last 12 months. Mirroring the combined result, after a drop in reporting of this type of harassment, bullying or abuse between 2024 and 2025, this year's result shows a small increase (+2% pts from 36% to 38%).

Reports in relation to managers and other colleagues have remained similar over the last four years, but reports in relation to tutors/lecturers/supervisors have increased slowly from 7% in 2023 to 10% in 2026 (+2% pts).

Figure 48 – Personal experience of harassment, bullying, or abuse at work (or study) 2023 to 2026 (% at least one experience in the last 12 months)

Base: All respondents excluding full-time students and retired 2023 (3,557); 2024 (4,521); 2025 (3,774); 2026 (3,414); Students 2023 (469); Students 2024 (509); Students 2025 (454); Students 2026 (435)



GOC registrants are still more likely to experience this behaviour from patients or the public and managers when compared with the national NHS average

This question is asked in the annual NHS Staff Survey. As found in previous waves of the survey, experience of harassment, bullying or abuse from patients/service users, their relatives, or other members of the public is much more common amongst GOC registrants (38% for GOC registrants, 25% for the NHS Staff Survey).

GOC registrants are also more likely have experience of this behaviour from managers (19% vs 9%), but are in line with the national NHS average in relation to harassment, bullying or abuse from other colleagues, reflecting previous years' results.

Figure 49 – Experience of harassment, bullying or abuse in the last 12 months – Comparison with NHS Staff Survey 2025

Base: GOC survey respondents (3,774), NHS Staff Survey 2025 (c.751k)

Source of harassment, bullying or abuse	This survey	NHS Staff Survey 2025
Patients/service users/relatives, other members of the public	38%	25%
Managers	19%	9%
Other colleagues	18%	17%

Ethnic minority respondents are more likely to report harassment from managers and colleagues

As seen in previous waves, respondents from ethnic minority backgrounds are more likely than White British/Irish respondents to report experiencing harassment, bullying or abuse from managers (21% vs 16%) and from other colleagues (20% vs 16%). However, this pattern was not evident for harassment from patients or service users (36% vs 38%).

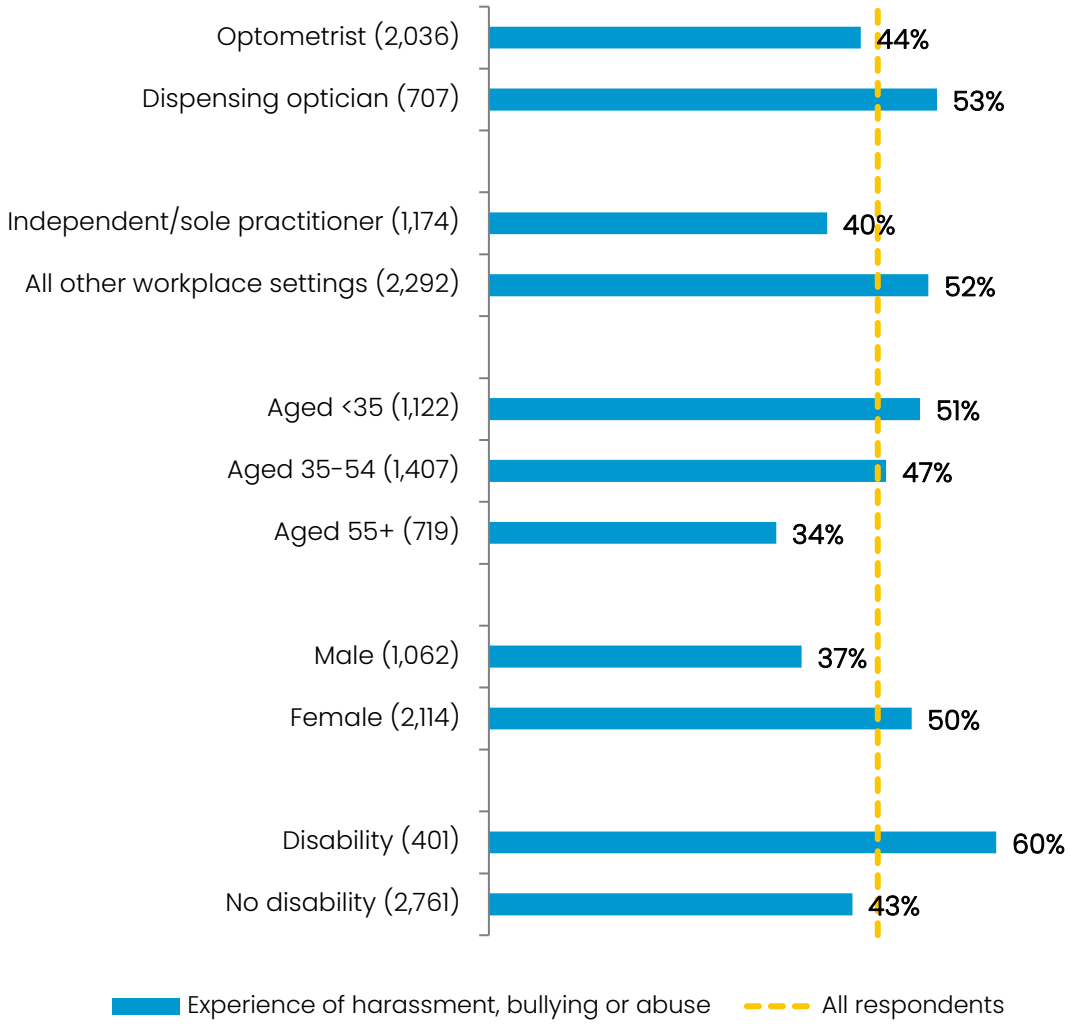
Unlike 2024 and 2025, ethnic minority group respondents were not more likely than White British/Irish respondents to report experiences involving tutors, lecturers or supervisors (8% vs 13%).

Experiences of harassment, bullying or abuse varies by role, workplace setting, and demographics

Experiences of harassment, bullying or abuse are more commonly reported by dispensing opticians than optometrists, and by those working outside independent or sole practitioner settings. Younger respondents are more likely to report these experiences than older age groups, and women report them more often than men. Respondents with a disability are also more likely to report experiencing harassment compared with those without a disability.

Figure 50 – Experience of harassment, bullying, or abuse at work by registration type, workplace setting, age group, gender, and disability

Base: Shown in chart

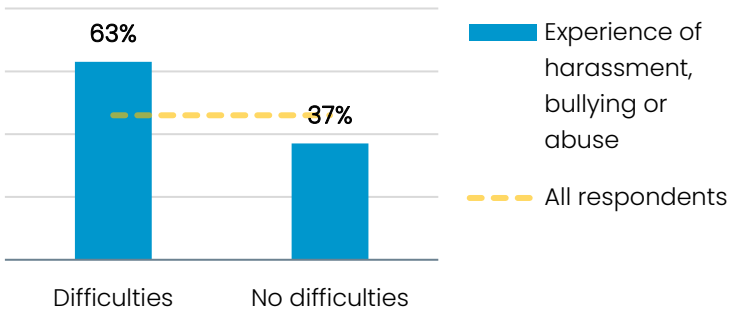


Consistent link between harassment, bullying or abuse and challenges in delivering patient care

Consistent with findings from 2024 and 2025, respondents who report difficulties providing patients with a sufficient level of care are significantly more likely to have experienced harassment, bullying or abuse at work (63% vs 37% of those reporting no such difficulties). This ongoing pattern highlights a clear association between negative workplace experiences and challenges in delivering safe and sufficient patient care.

Figure 51 – Experience of harassment, bullying, or abuse at work by experience of difficulties providing sufficient patient care

Base: Difficulties (1,084); No difficulties (1,013)



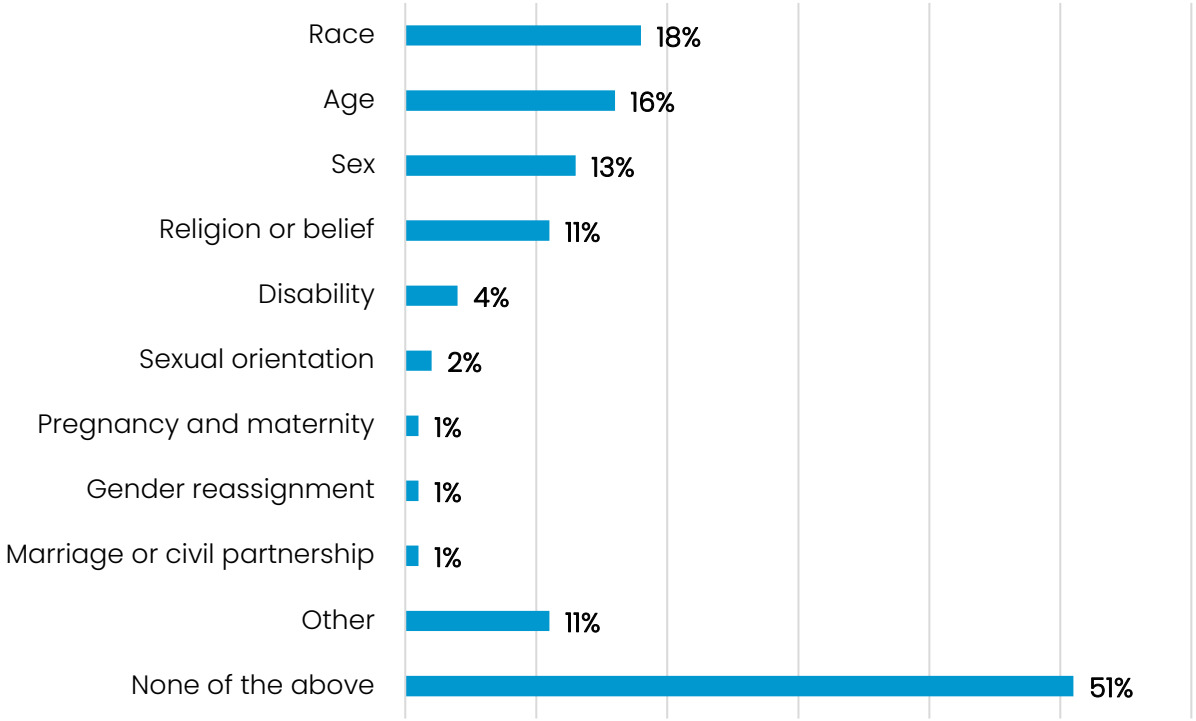
Harassment is more often general in nature, with some links to protected characteristics

Around half of those who had experienced harassment, bullying or abuse said it was not related to any of the listed protected characteristics (51%), suggesting that much of this behaviour is perceived as more general in nature rather than linked to specific personal attributes.

Among those who did identify a perceived reason, race (18%) and age (16%) are the most commonly cited factors, followed by sex (13%) and religion or belief (11%).

Figure 52 – Types of harassment, bullying or abuse experienced

Base: Those who had experienced harassment, bullying or abuse in the last 12 months (1,555)



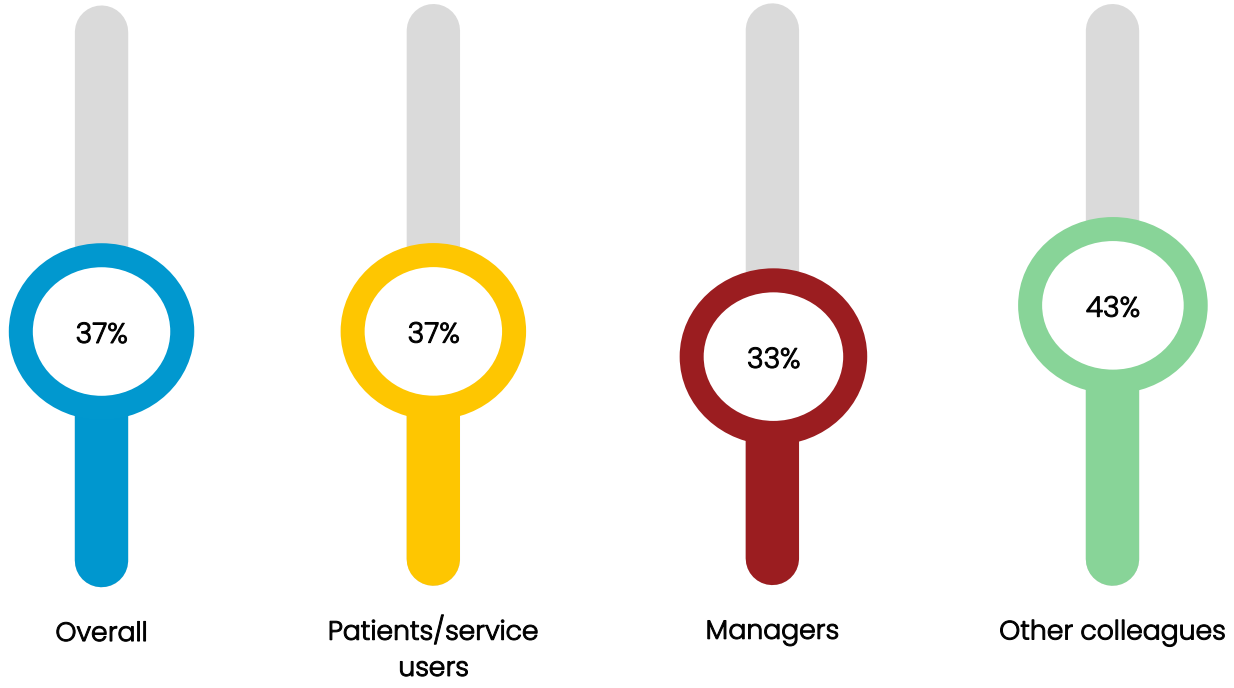
The 'other' responses most commonly centred around general verbal abuse or aggression from patients/the public, alongside pressure or conflict linked to workload, targets or workplace practices, and negative behaviours from colleagues or management (e.g. bullying, undermining or poor management practices), with some additional mentions of personal characteristics such as language, accent, nationality or appearance.

Overall reporting unchanged, with notable growth in colleague-related reporting

Almost two in five (37%) who had experienced harassment, bullying or abuse in the last 12 months said they or a colleague had reported it. This result represents a general continuation with previous waves of the survey, which have varied between 33% (2023) and 38% (2024).

However, unlike previous years, reporting in the case of harassment, bullying or abuse from other colleagues has increased by 7% pts (36% in 2025 to 43% in 2026).

Figure 53 – Reporting harassment, bullying or abuse at work (they or a colleague reported)
Base: Those who had experience of harassment, bullying or abuse at work in the last 12 months excluding 'don't know' and 'not applicable' responses (1,375)



Persistent gap in harassment, bullying or abuse reporting compared with NHS staff

The proportion of GOC registrants reporting bullying, harassment or abuse is significantly lower than the national average found in the 2025 NHS Staff Survey, as found in previous survey waves. It is again evident that GOC registrants are both more likely to experience harassment, bullying or abuse, and less likely to report it when compared with the national average.

Figure 54 – Experience of harassment, bullying or abuse in the last 12 months – Comparison with NHS Staff Survey 2024
Base: GOC survey respondents (1,375), NHS Staff Survey 2025 (c.270k)

Harassment, bullying or abuse reported	This survey	NHS Staff Survey 2024
Yes (they or a colleague reported)	37%	55%

Discrimination

In total, three in ten respondents (31%) had personally experienced some form of discrimination at work (or study for those in education) in the last 12 months. This is broadly similar to the results found in 2024 (31%) and 2025 (29%).

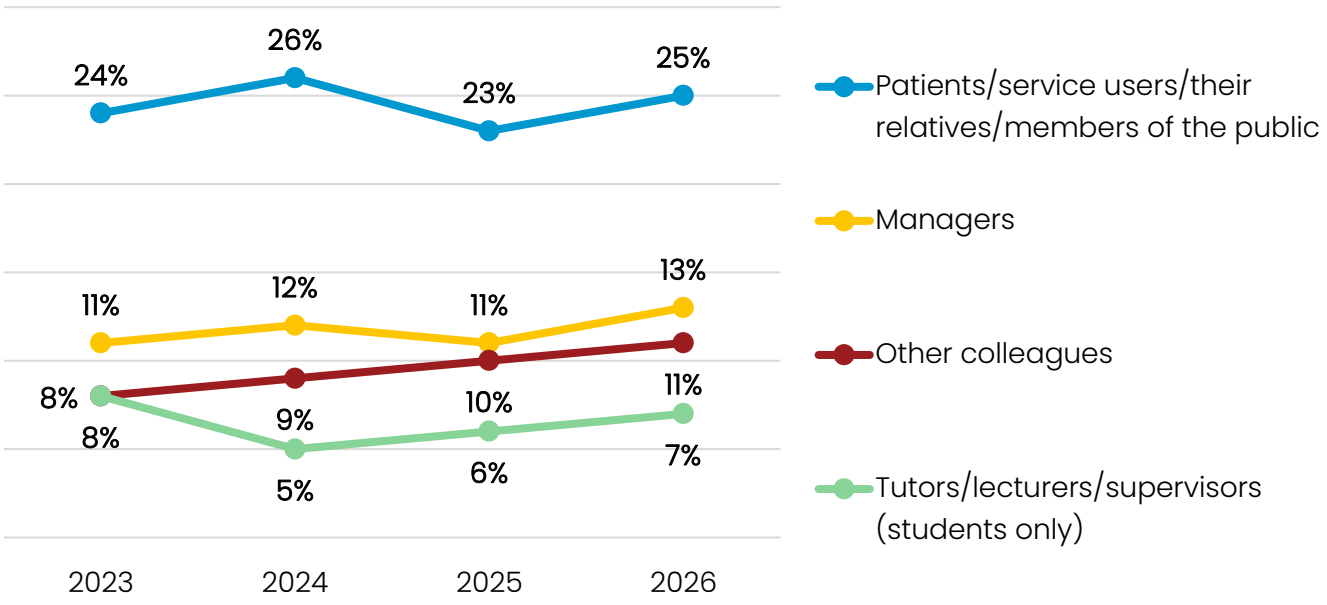
Discrimination continues to be more likely to come from patients/service users, but incidence from other sources is slowly increasing

As found with harassment, bullying and abuse, discrimination towards registrants is more likely to come from patients and service users, their relatives or other members of the public, although to a lesser degree. A quarter (25%) of respondents said they had at least one experience of this in the last 12 months. Experiences of discrimination from managers, other colleagues, and tutors/lecturers/supervisors were less frequent.

Looking across all four years of survey results, experiences of discrimination from managers, other colleagues, and tutors/lecturers are slowly increasing.

Figure 55 – Personal experience of discrimination at work (or study) 2023 to 2026 (% at least one experience in the last 12 months)

Base: All respondents excluding full-time students and retired 2023 (3,557); 2024 (4,521); 2025 (3,774); 2026 (3,414) Students 2023 (469); Students 2024 (509); Students 2025 (454); Students 2026 (435)



Elevated discrimination persists for GOC registrants compared with NHS staff

Comparison with the latest NHS Staff Survey continues to show that GOC registrants report higher levels of discrimination than the national benchmark. Experiences of discrimination from patients, service users, their relatives or other members of the public remain substantially more common among GOC registrants, and discrimination from managers or other colleagues is also reported more frequently.

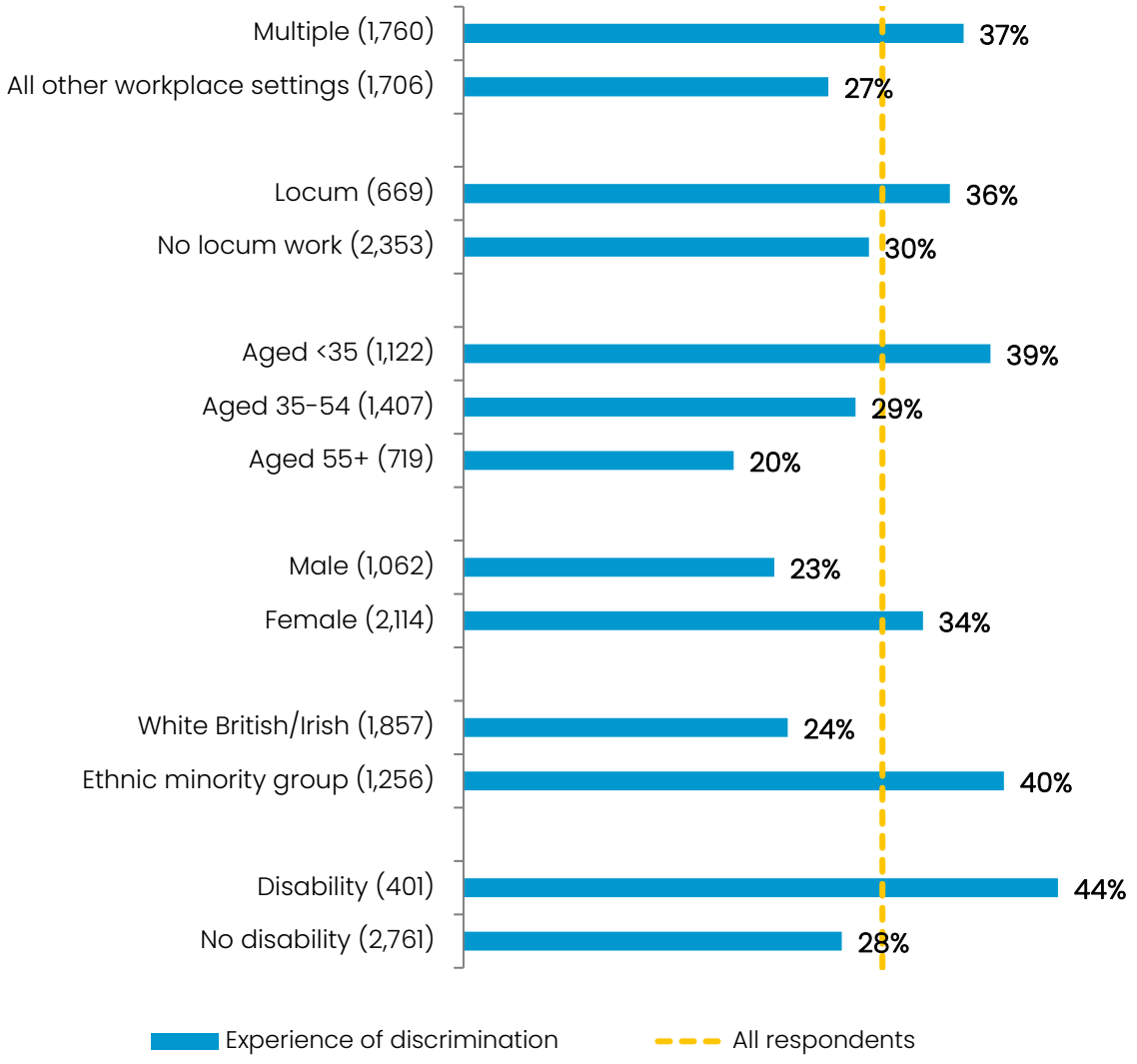
Figure 56 – Experience of discrimination in the last 12 months – Comparison with NHS Staff Survey 2025
Base: GOC survey respondents (3,414), NHS Staff Survey 2024 (c.751k)

Source of discrimination	This survey	NHS Staff Survey 2025
Patients/service users/relatives, other members of the public	25%	9%
Managers **or** other colleagues	16%	9%

Variation in reported discrimination by demographic and workplace characteristics

Experience of discrimination is notably higher among younger respondents, females, ethnic minority groups, those with a disability, and those working as locums or for multiple opticians. Whilst many of these groups have been more likely to report discrimination over recent waves of the survey, it is interesting to note that there is no difference between optometrists and dispensing opticians, as seen in previous years.

Figure 57 – Experience of discrimination at work by workplace setting, locum working, age group, gender, ethnicity, and disability
Base: Shown in chart

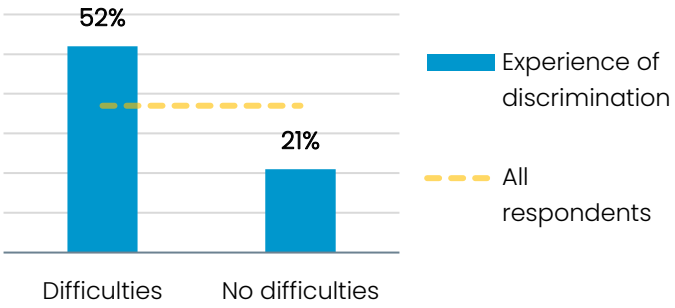


Continued link between discrimination and the ability to deliver sufficient care for patients

As with experiences of harassment, bullying or abuse, finding it difficult to provide patients with the sufficient level of care continues to influence experiences of discrimination at work. As found in 2024 and 2025, this could indicate correlation between the negative experience of discrimination and registrants' ability to deliver safe patient care.

Figure 58 – Experience of discrimination at work by experience of difficulties providing sufficient patient care

Base: Difficulties (1,084); No difficulties (1,031)



Racial, sexual, and age-related discrimination are most frequently reported

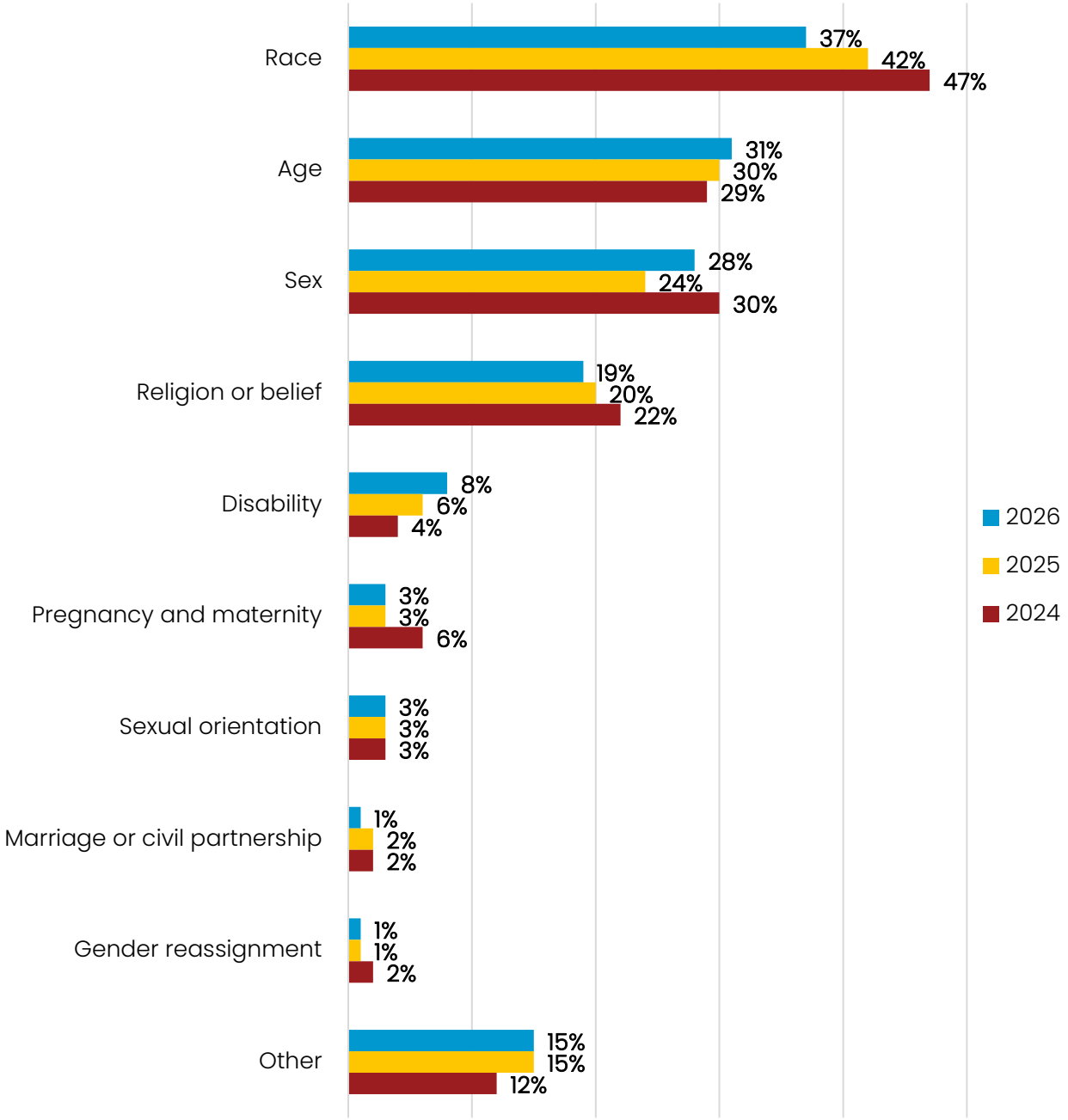
Race remains the most commonly cited form of discrimination in 2026 (37%), followed by age (31%) and sex (28%). One in five link their experience to religion or belief (19%), while fewer attribute it to disability (8%) or other characteristics such as pregnancy and maternity, sexual orientation, marriage or civil partnership, and gender reassignment (each 3% or lower).

'Other' types of discrimination mentioned mainly related general bullying, rudeness, and interpersonal conflict, alongside perceived favouritism and unfair treatment by managers or colleagues (e.g. workload distribution, promotions, or opportunities). There are also frequent references to personal characteristics not explicitly listed (gender, nationality, accent, appearance, family or caring responsibilities), as well as issues linked to professional status, experience or role (e.g. being a locum, trainee, or dispensing optician).

Over time, reports of race-related discrimination have declined (from 47% in 2024 to 37% in 2026), while age-related discrimination has remained broadly stable. Sex-related discrimination has fluctuated but is slightly lower than in 2024. In contrast, disability-related discrimination has increased gradually.

Figure 59 – Types of discrimination experienced 2024 to 2026

Base: Those who had experienced discrimination in the last 12 months 2024 (1,409); 2025 (1,088); 2026 (1,050)



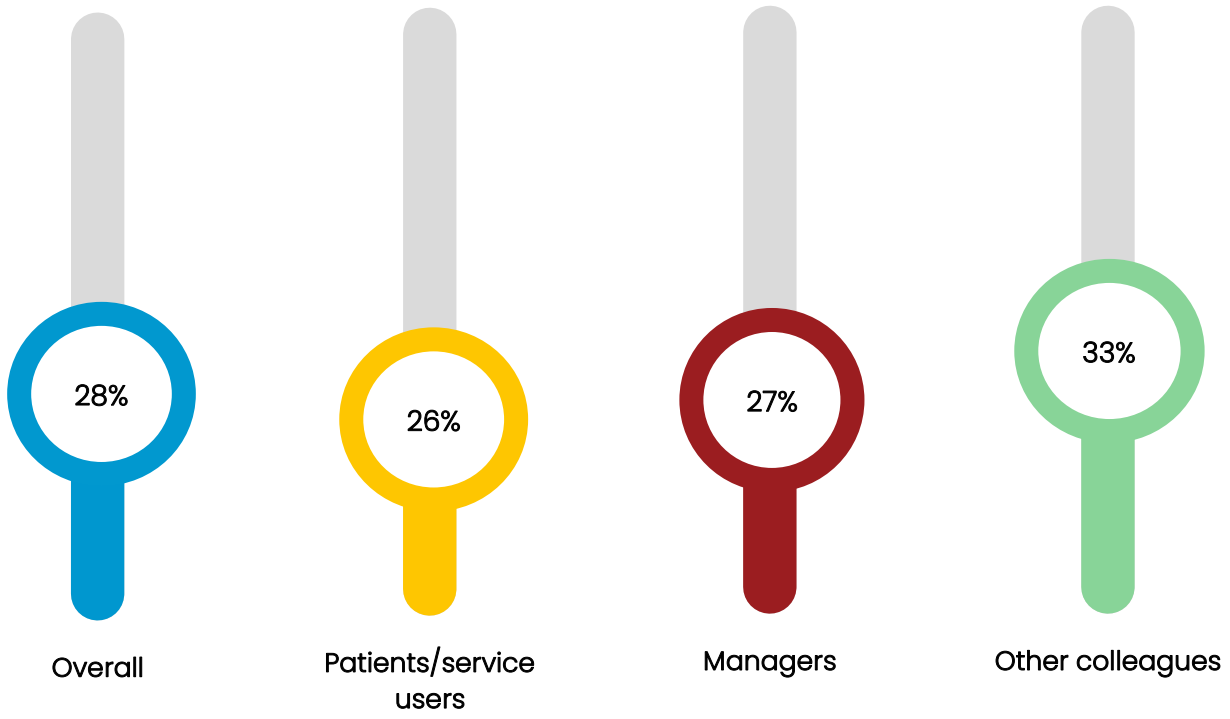
Only a quarter of registrants reported experiences of discrimination

Almost three in five respondents (28%) who had experienced discrimination at work in the last 12 months said they or a colleague had reported it, representing a small increase from 2024 (24%) and 2025 (25%).

As with harassment, bullying and abuse, reporting was slightly more likely in the case of discrimination from other colleagues.

Figure 60 – Reporting discrimination at work

Base: Those who had experience of discrimination at work in the last 12 months excluding 'don't know' and 'not applicable' responses (970)



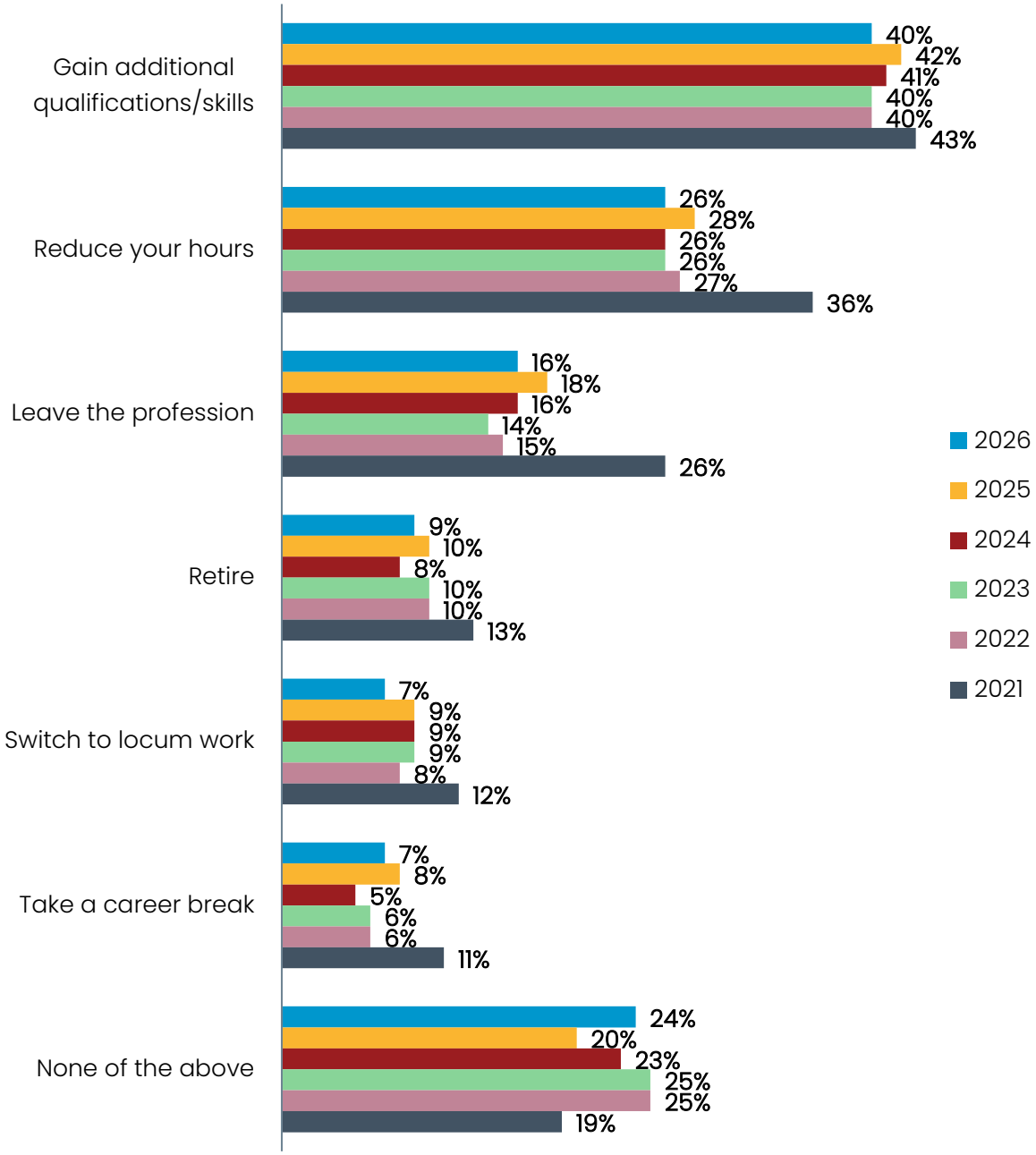
Plans for the future

Immediate career intentions remain broadly consistent over time

As in previous years, gaining additional qualifications or skills remains the most commonly cited immediate career intention among those currently working, selected by 40% of respondents. Around a quarter plan to reduce their hours (26%), while smaller proportions are considering leaving the profession (16%), retiring (9%), switching to locum work (7%), or taking a career break (7%). Overall, the pattern of responses remains broadly consistent with previous survey waves since 2022, with only relatively minor movement across the different career intentions shown.

Figure 61 – Are you considering making any of the following changes to your career over the next 12-24 months?

Base: Those currently working 2026; (3,022); 2025 (3,315); 2024 (4,049); 2023 (3,486); 2022 (3,647); 2021 (4,479)



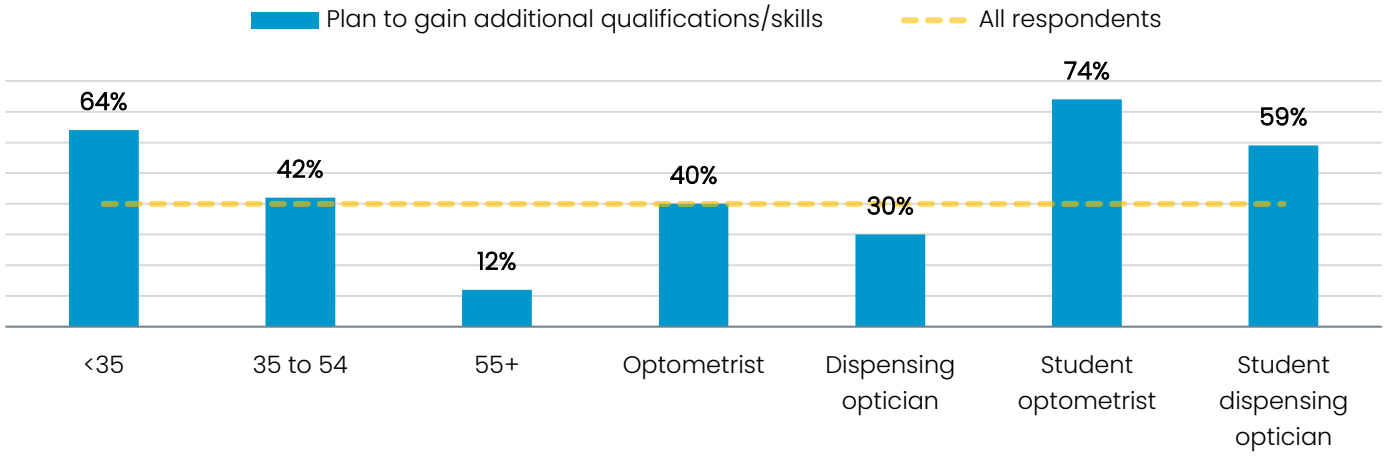
Gaining additional skills

Interest in gaining additional qualifications continues to vary by career stage, working pattern, and workplace setting

Cementing the results from previous years, younger respondents and optical students are significantly more likely to be considering gaining additional qualifications/skills in the next 12 months when compared with older respondents and fully qualified registrants, particularly dispensing opticians.

Figure 62 – Plan to gain additional qualifications/skills by age and registration type

Base: Aged <35 (862); 35-54 (1,338); 55+ (709); Optometrist (2,004); Dispensing optician (704); Student optometrist (193); Student dispensing optician (122)



Plans to gain additional qualifications/skills was more common amongst:

- Those working for a multiple (46%) or in a hospital (45%) (vs 33% independent/sole practitioner, 27% domiciliary care, 37% education/academia)
- Those involved in delivering enhanced services (45%, vs 35% for those not involved)
- Those working full-time (46%, vs 30% part-time)
- Those from ethnic minority groups (53%, vs 35% for White British/Irish)

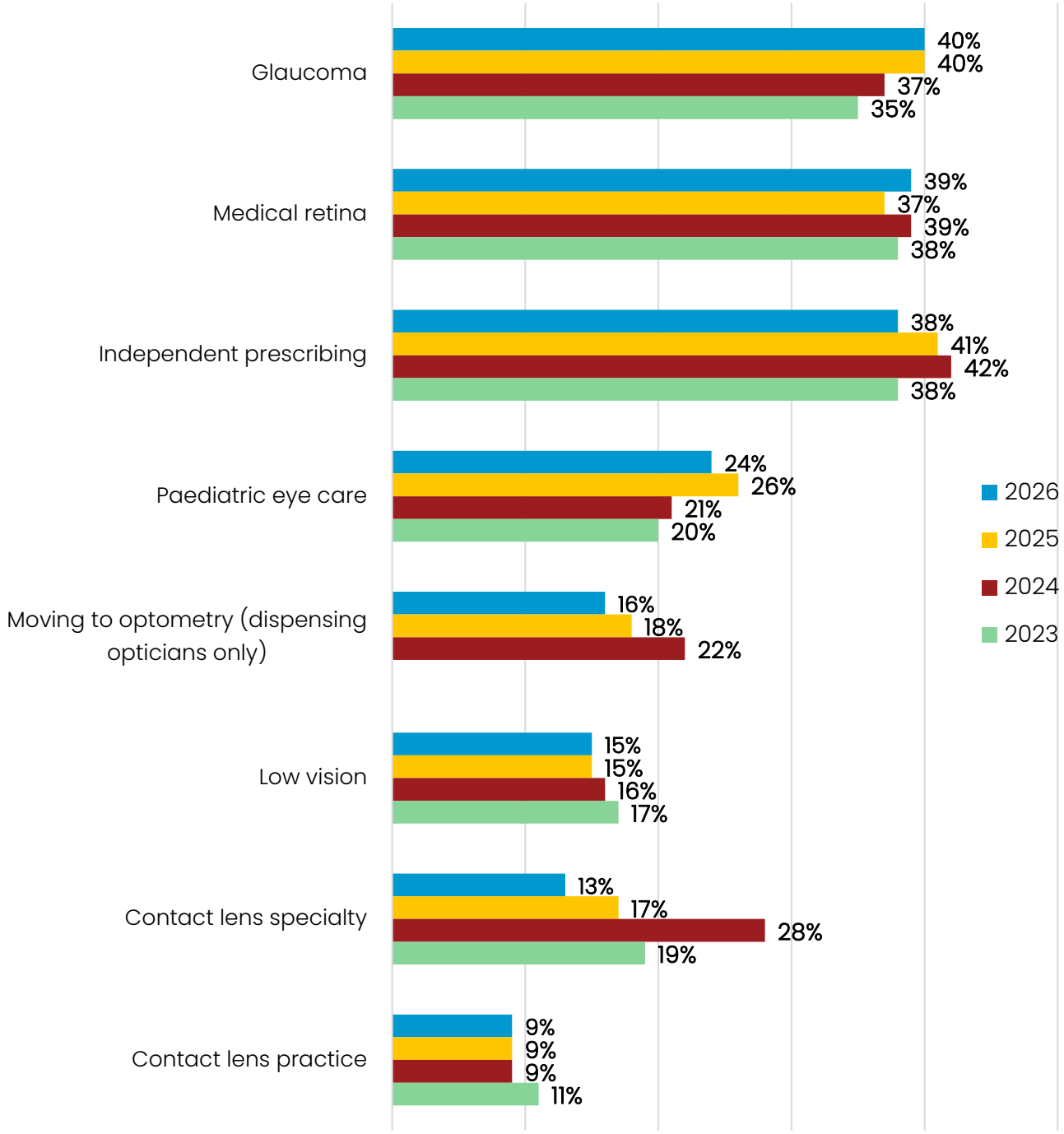
Glaucoma, medical retina, and independent prescribing continue to be the most popular areas of interest for development

Three areas stand out as being most popular for gaining additional qualifications/skills – glaucoma (40%), medical retina (39%), and independent prescribing (38%) – which have remained at similar levels over the last few survey waves.

Amongst dispensing optician respondents, interest in moving to optometry has fallen over the last three years by 6% pts (22% in 2024, 16% in 2026).

Figure 63 – Areas of interest in gaining additional qualifications/skills

Base: Those who plan to gain additional qualifications/skills in the next 12-24 months 2026 (1,219); 2025 (1,408); 2024 (1,653); 2023 (1,377)



Plans to leave the profession

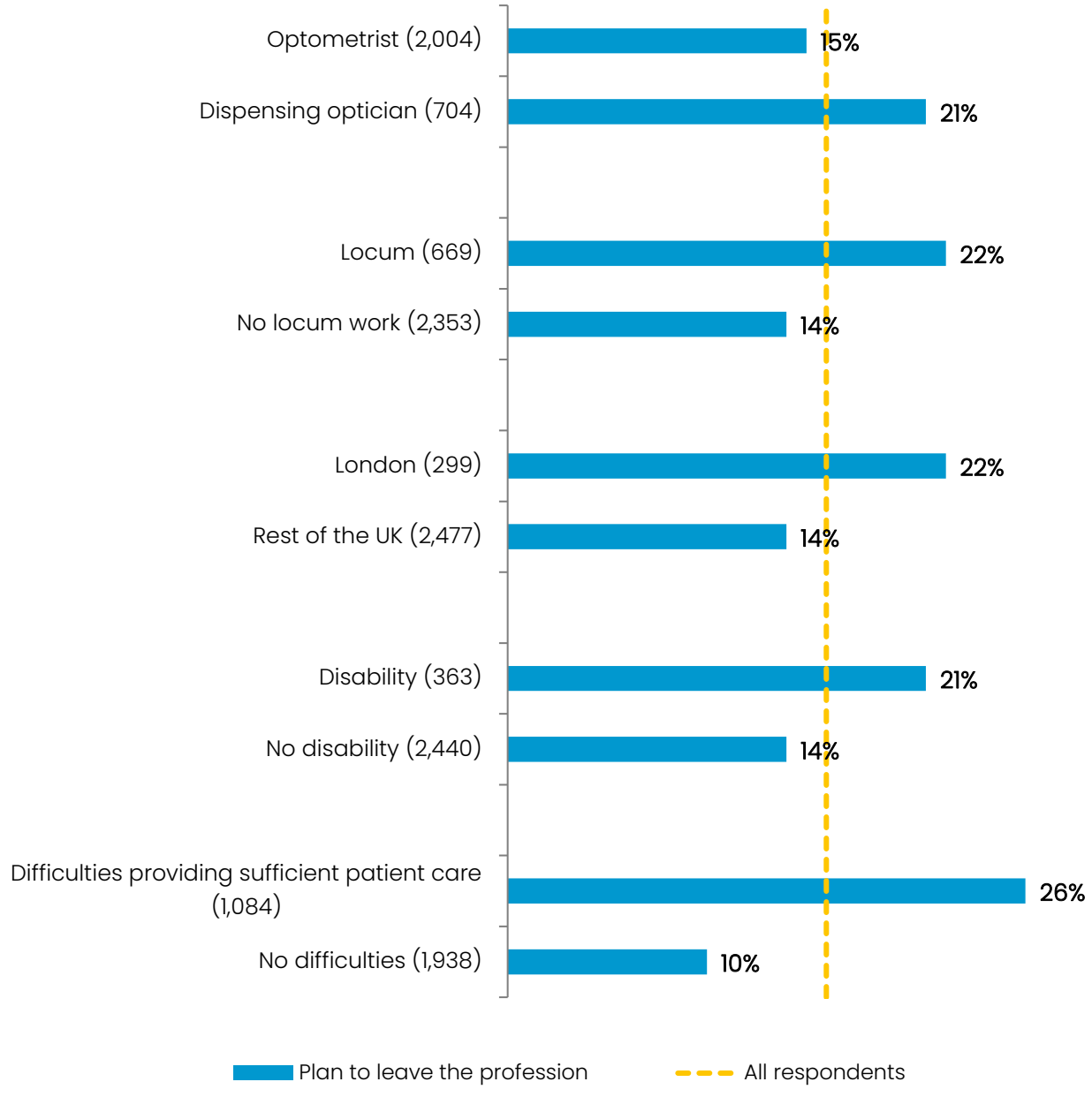
Intentions to leave are highest among those facing workplace pressures

Plans to leave the profession are more common among dispensing opticians, locums, respondents based in London, those with a disability, and those who report difficulties providing patients with the sufficient level of care they need.

In particular, respondents who reported experiencing difficulties providing sufficient patient care are considerably more likely to be considering leaving the profession than those not reporting these difficulties.

Figure 64 – Plans to leave the profession in the next 12 months by registration type, locum working, location, disability, and difficulty providing patients with sufficient care

Base: Shown in chart



Speaking up

Managers and employers remain the preferred routes for raising patient safety concerns

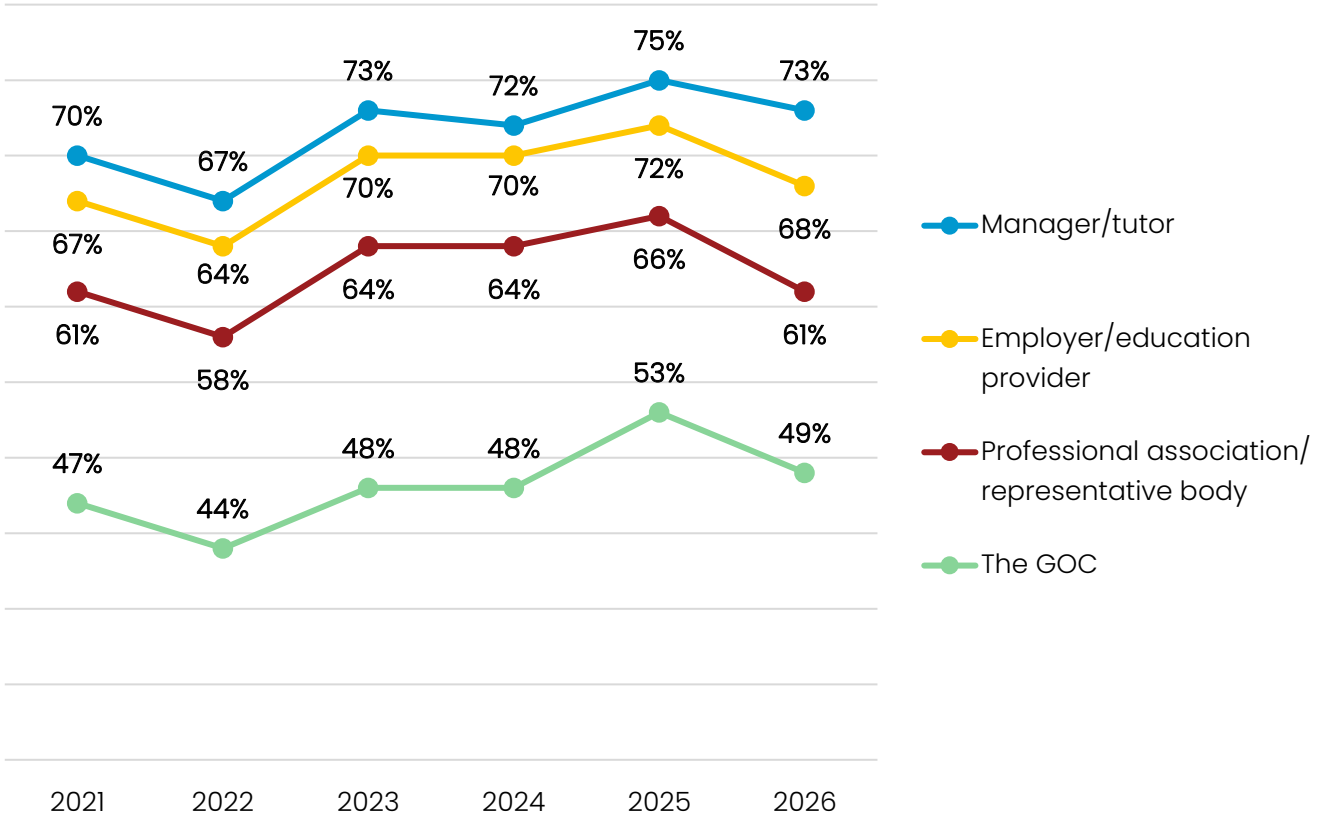
Comfort speaking up about patient safety concerns regarding an individual GOC registrant remains highest in relation to managers/tutors and employers/education providers. This year, almost three quarters of respondents said they would feel comfortable speaking up to a manager or tutor (73%), while just over two thirds would feel comfortable doing so to an employer or education provider (68%), and a further 61% to a professional association or representative body.

Comfort speaking up to the GOC was lower at 49%. This continues the pattern seen across previous years, where respondents are consistently more comfortable raising concerns with those closer to their workplace or training environment than with the GOC.

Results over time also show a slight decrease in comfort across all four audiences between 2025 and 2026. However, 2026 results remain broadly in line with earlier years, and in most cases are higher than the levels recorded in 2021 and 2022.

Figure 65 – Feeling comfortable speaking up about patient safety concerning an individual GOC registrant

Base: All respondents excluding 'not appliable' 2021 (4,880); 2022 (4,102); 2023 (3,932); 2024 (4,575); 2025 (3,798); 2026 (3,174)



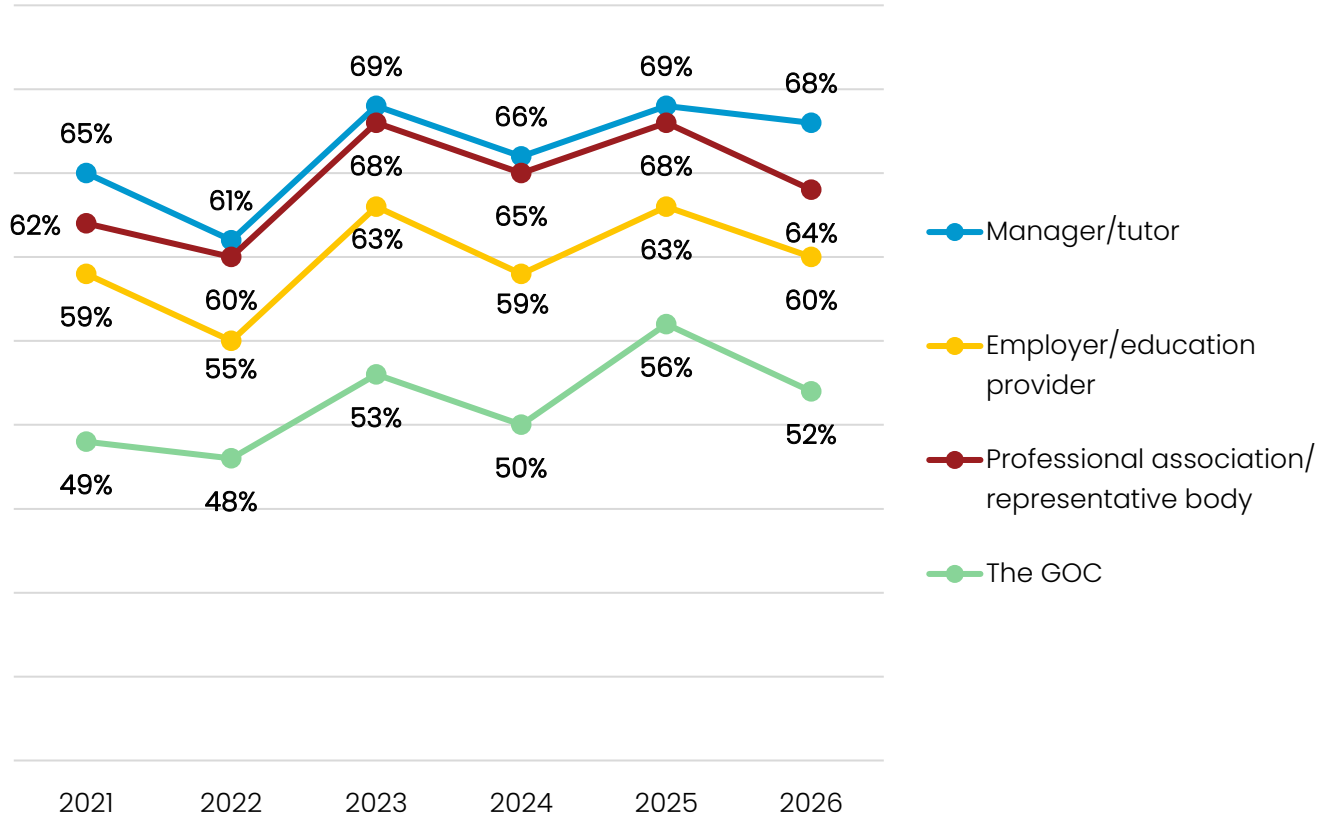
Workplace and representative routes attract higher comfort for employer-related concerns

Reflecting concerns relating to individual registrants, comfort speaking up about patient safety concerns relating to an employer is also highest in relation to managers/tutors and professional associations or representative bodies. Around two thirds of respondents said they would feel comfortable speaking up to a manager or tutor (68%), and a similar proportion would feel comfortable speaking up to a professional association or representative body (64%).

Comfort is slightly lower in relation to employers or education providers themselves (60%). Again, comfort speaking up to the GOC remains lower than for other audiences, although just over half of respondents said they would feel comfortable doing so in 2026 (52%).

Levels of comfort decreased slightly between 2025 and 2026 across all four audiences, but remain broadly in line with the pattern seen over previous years.

Figure 66 – Feeling comfortable speaking up about patient safety concerning an employer
Base: All respondents excluding 'not applicable' 2021 (4,880); 2022 (4,102); 2023 (3,932); 2024 (4,575); 2025 (3,798); 2026 (3,083)



Training on speaking up can increase confidence

As found in 2025, respondents who had attended Continuing Professional Development (CPD) on the topic of speaking up were more likely to indicate that they would feel comfortable speaking up about an individual GOC registrant or an employer to each different authority (e.g. manager,

tutor, employer etc.) when compared with those who had not attended this type of CPD. The analysis of this result can be found in the CPD chapter of this report.

Job security and workplace relationships are key barriers to speaking up

Among those who would not feel comfortable speaking up, the main barriers relate to concerns about the personal consequences of raising concerns.

For concerns about an individual GOC registrant, the most common reason was that respondents might alienate themselves from colleagues (43%). Similar proportions said they might jeopardise their job (41%) or would not want to be seen as a troublemaker by management (39%).

For concerns about an employer, concern about jeopardising their job was the most prominent barrier, mentioned by over half of respondents (54%). This was notably higher than for concerns about an individual registrant, suggesting that raising concerns about an employer may be seen as carrying greater personal or employment-related risk.

There is also evidence of scepticism about whether speaking up would lead to change. Around four in ten said they did not believe corrective action would be taken, both in relation to concerns about an employer (39%) and an individual registrant (36%).

By comparison, practical uncertainty appears to be a less common barrier. Fewer than one in five said they would not know who to contact, while very few said they would assume others already knew about the issue or that it was none of their business, suggesting that discomfort is driven less by a lack of awareness of routes for raising concerns, and more by fears of repercussions and doubts about whether action would be taken.

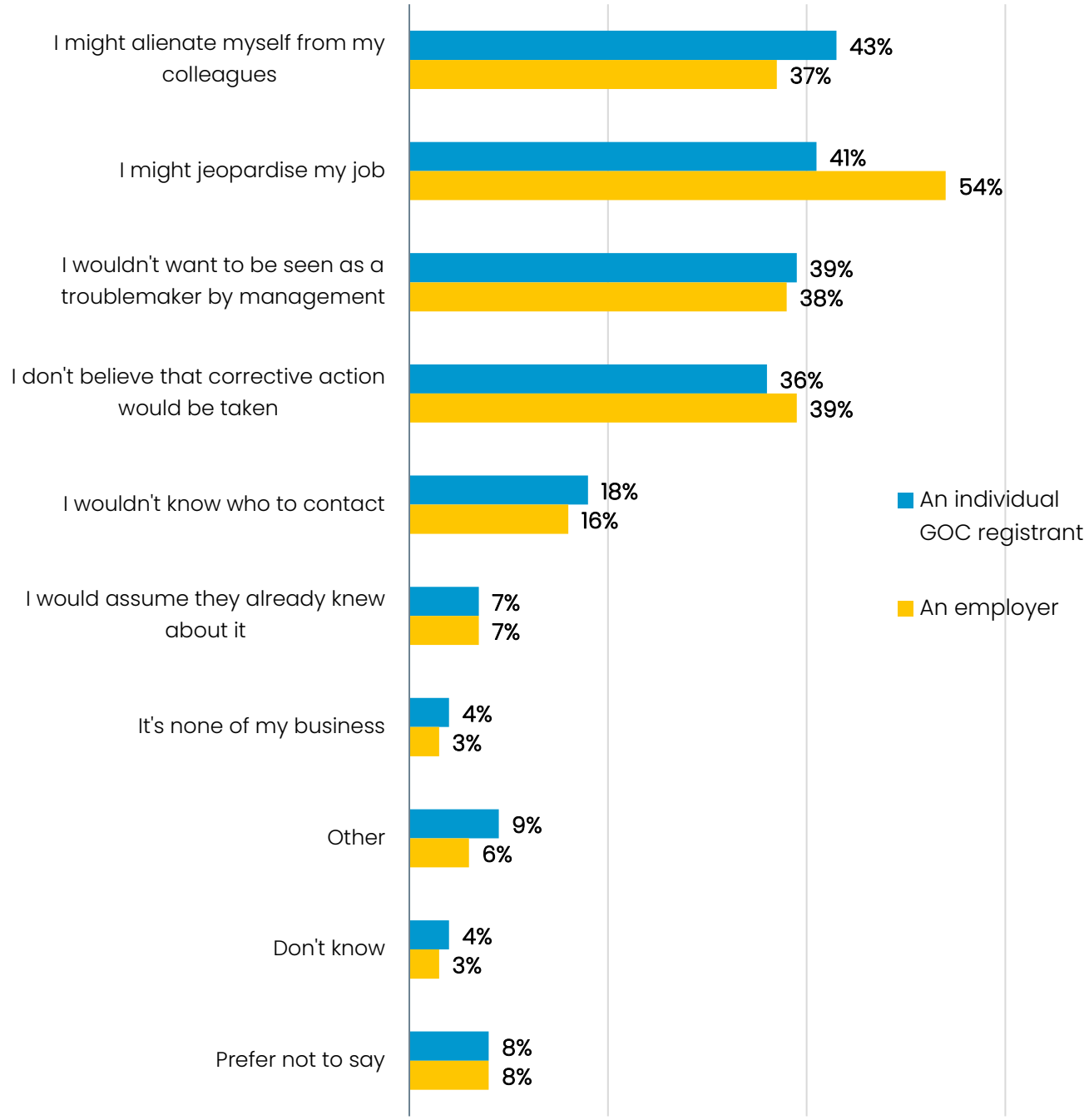
The most common “other” responses reinforce that discomfort is often linked to the perceived seriousness and consequences of speaking up. Many respondents said they would prefer to resolve concerns locally first, by speaking directly to the individual, manager, employer or professional body, and would only involve the GOC as a last resort if the concern was very serious or remained unresolved.

A second recurring theme in “other” responses was lack of confidence in the process, particularly in relation to the GOC. Respondents raised concerns about the process being stressful, punitive, heavy-handed, slow or unlikely to lead to meaningful action, alongside fears of retaliation, damage to working relationships, being blacklisted within a small profession, or jeopardising someone’s career or livelihood.

This question’s response options were changed for this year’s survey, meaning direct comparison is not possible, but the results are broadly similar to those collected in 2025.

Figure 67 – Reasons for not feeling comfortable speaking up about patient safety concerning an individual GOC registrant/an employer

Base: Those who did not feel comfortable speaking up about: a registrant (1,749); an employer (1,688)



Continuing Professional Development

Attendance at CPD relating to workplace issues remains low, but new interest in EDI and AI

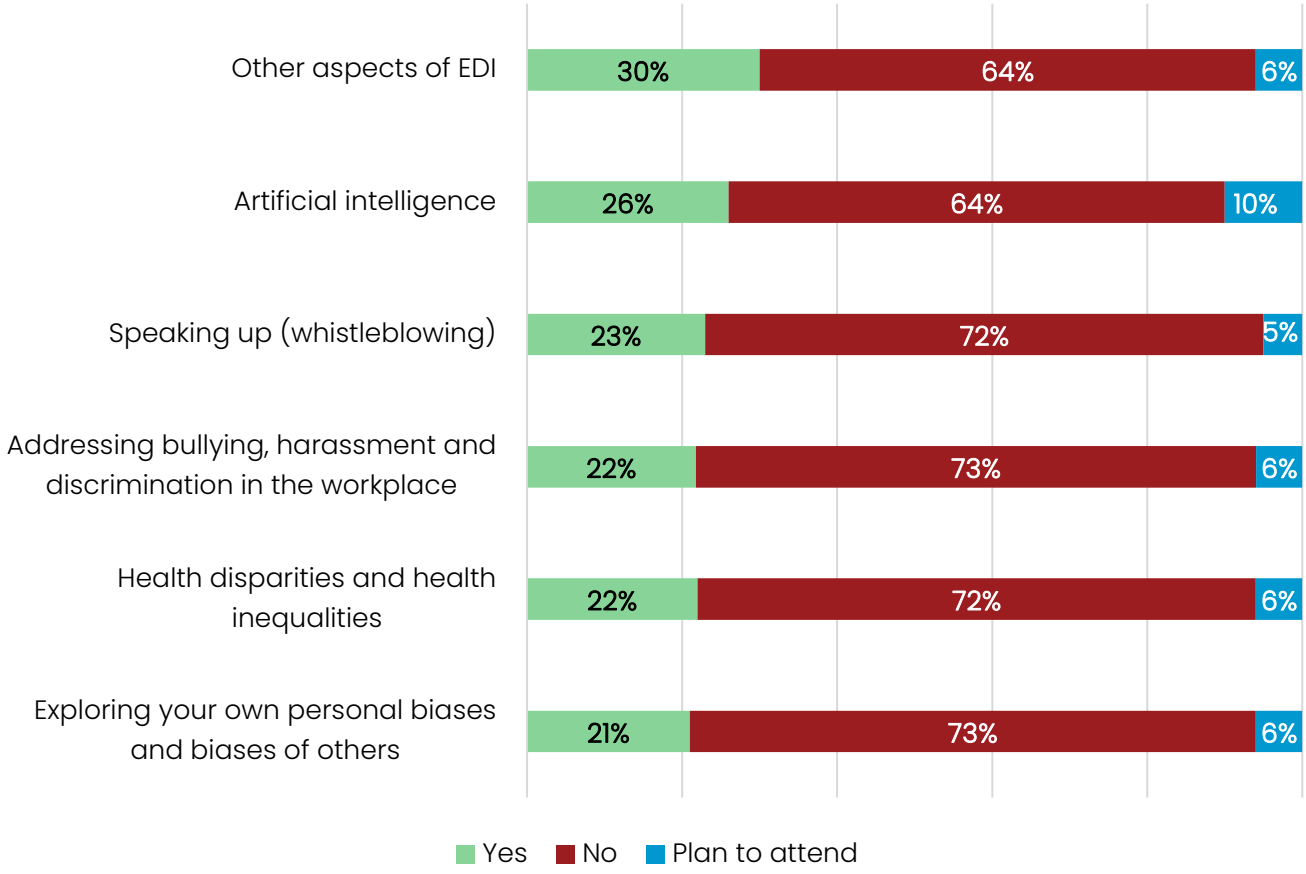
As seen in previous years, attendance at CPD (provider-led or self-directed) to learn about various topics listed was limited. Attendance was highest for other aspects of EDI (30%), followed by artificial intelligence (26%) – both of which were new options for this year's survey.

Around one in five had attended CPD on the remaining topics, including speaking up/whistleblowing (23%), addressing bullying, harassment and discrimination in the workplace (22%), health disparities and health inequalities (22%), and exploring personal biases and the biases of others (21%).

Across all topics, the majority of respondents said they had not attended relevant CPD, ranging from 64% for other aspects of EDI and artificial intelligence to 73% for addressing bullying, harassment and discrimination and exploring biases.

Artificial intelligence stands out as the topic with the highest proportion planning to attend CPD in future, at 10%, compared with 5% to 6% for the other topics.

Figure 68 – Attendance at CPD on specific topics within the latest CPD cycle
Base: All respondents excluding students (2,780)

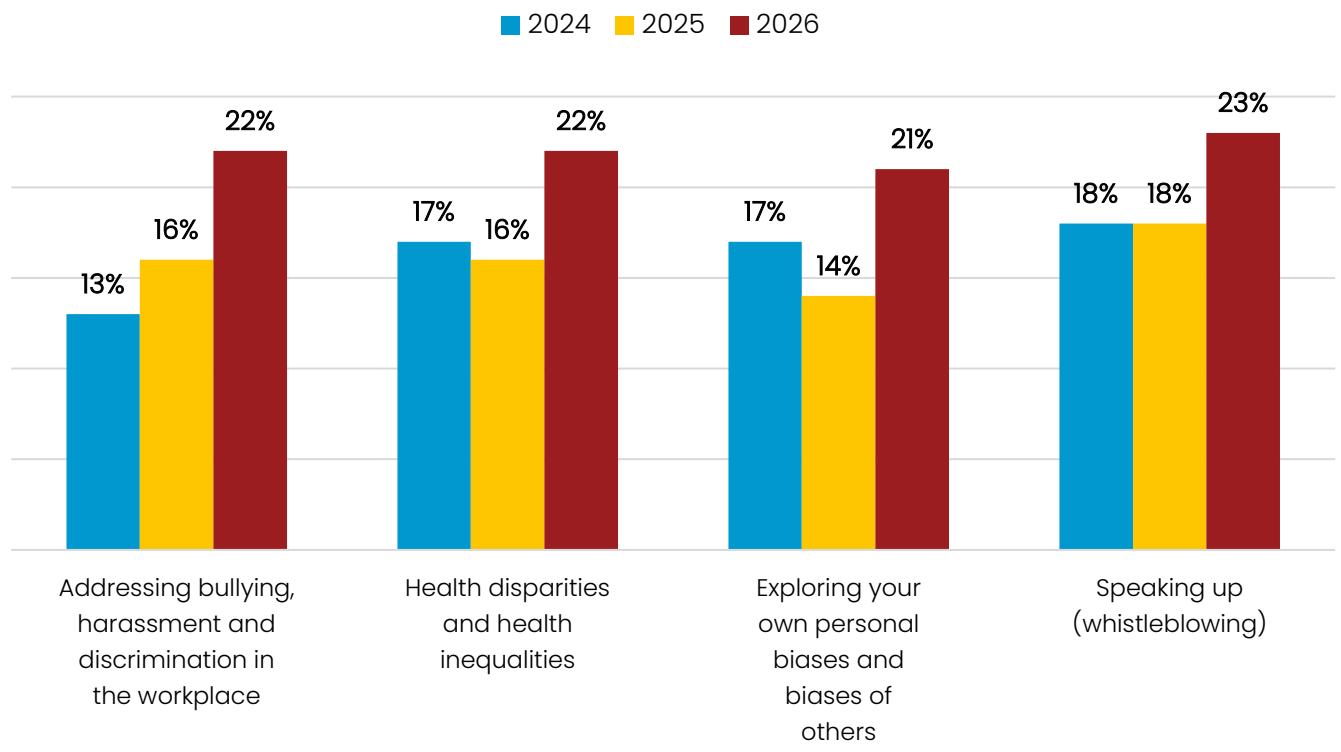


CPD attendance has increased across workplace culture and EDI topics

Although overall attendance at CPD on these topics remains relatively modest, results over the last three years suggest growing engagement with CPD focused on workplace culture, speaking up, health inequalities and bias.

Attendance has generally increased for all four areas, reaching their highest recorded level this year. The largest increase is seen for addressing bullying, harassment and discrimination in the workplace, rising by 9% pts between 2024 and 2026.

Figure 69 – Attendance at CPD on specific topics within the latest CPD cycle – 2024 to 2025
Base: All respondents 2024 (3,686); 2025 (3,063); 2026 (2,780)

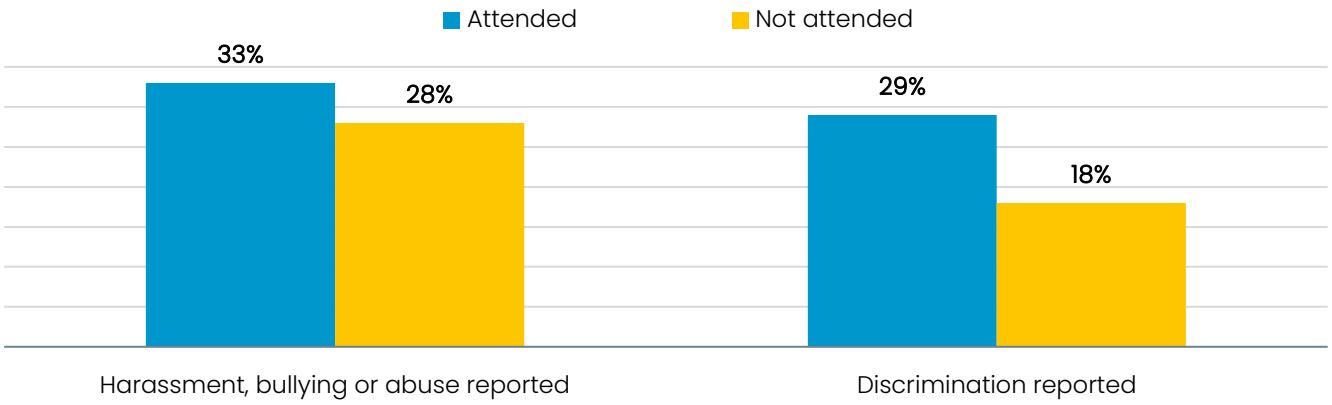


CPD attendance is associated with reporting discrimination and feeling able to speak up

As found in 2025, attendance at CPD has a direct impact on other behaviours related to the workplace, emphasising the positive impact that attending CPD can have.

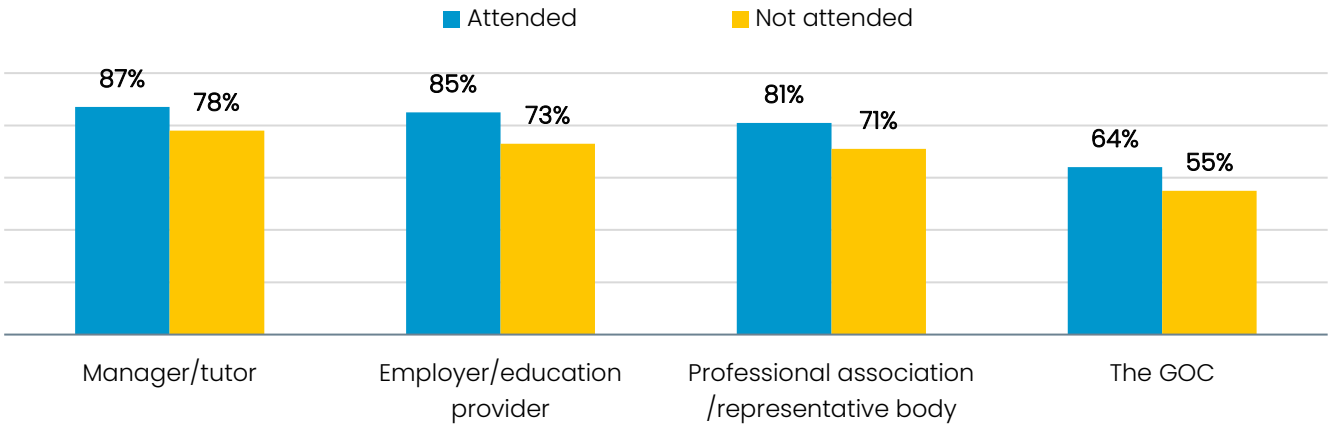
Respondents who had attended CPD on the topic of addressing bullying, harassment and discrimination in the workplace were significantly more likely to have personally reported their experiences of discrimination when compared with those who had not attended this type of CPD. However, again the difference seen for those who personally reported their experiences of harassment, bullying or abuse is less pronounced.

Figure 70 – Personally reporting harassment, bullying or abuse/discrimination by attendance at CPD on the topic of addressing bullying, harassment and discrimination in the workplace
Base: Attended (284); Not attended (925)



Those who had attended CPD on the topic of speaking up were again more likely to indicate that they would feel comfortable speaking up about an individual GOC registrant or an employer to each different authority (e.g. manager, tutor, employer etc.) when compared with those who had not attended this type of CPD.

Figure 71 – Feeling comfortable speaking up about an individual GOC registrant or employer by attendance at CPD on the topic of speaking up (% comfortable)
Base: Attended (560); Not attended (1,824)



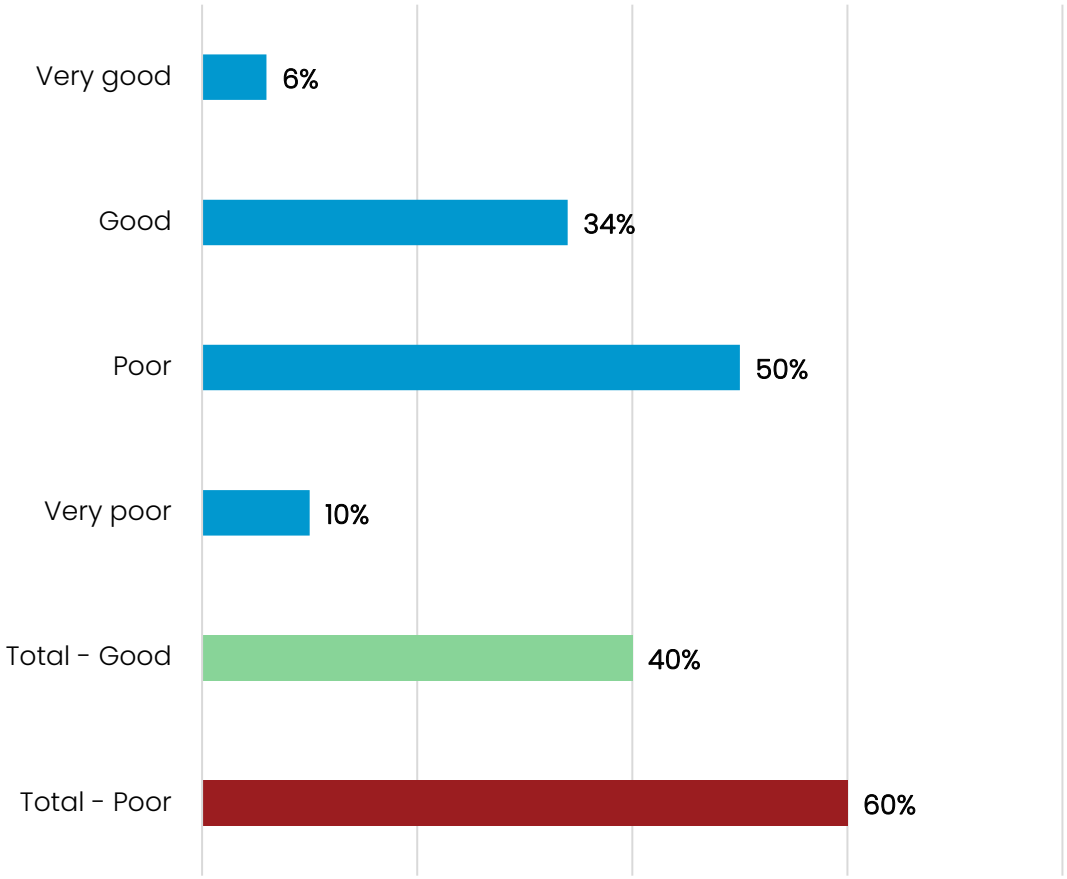
Artificial intelligence

Limited knowledge and understanding of AI in relation to optical care

Overall, respondents were more likely to describe their knowledge and understanding of AI in relation to optical care and professional practice negatively rather than positively. Six in ten (60%) rated their understanding as poor or very poor, while four in ten (40%) considered it good or very good.

Figure 72 – Self-described knowledge and understanding of AI in relation to optical care and professional practice

Base: All respondents (3,451)

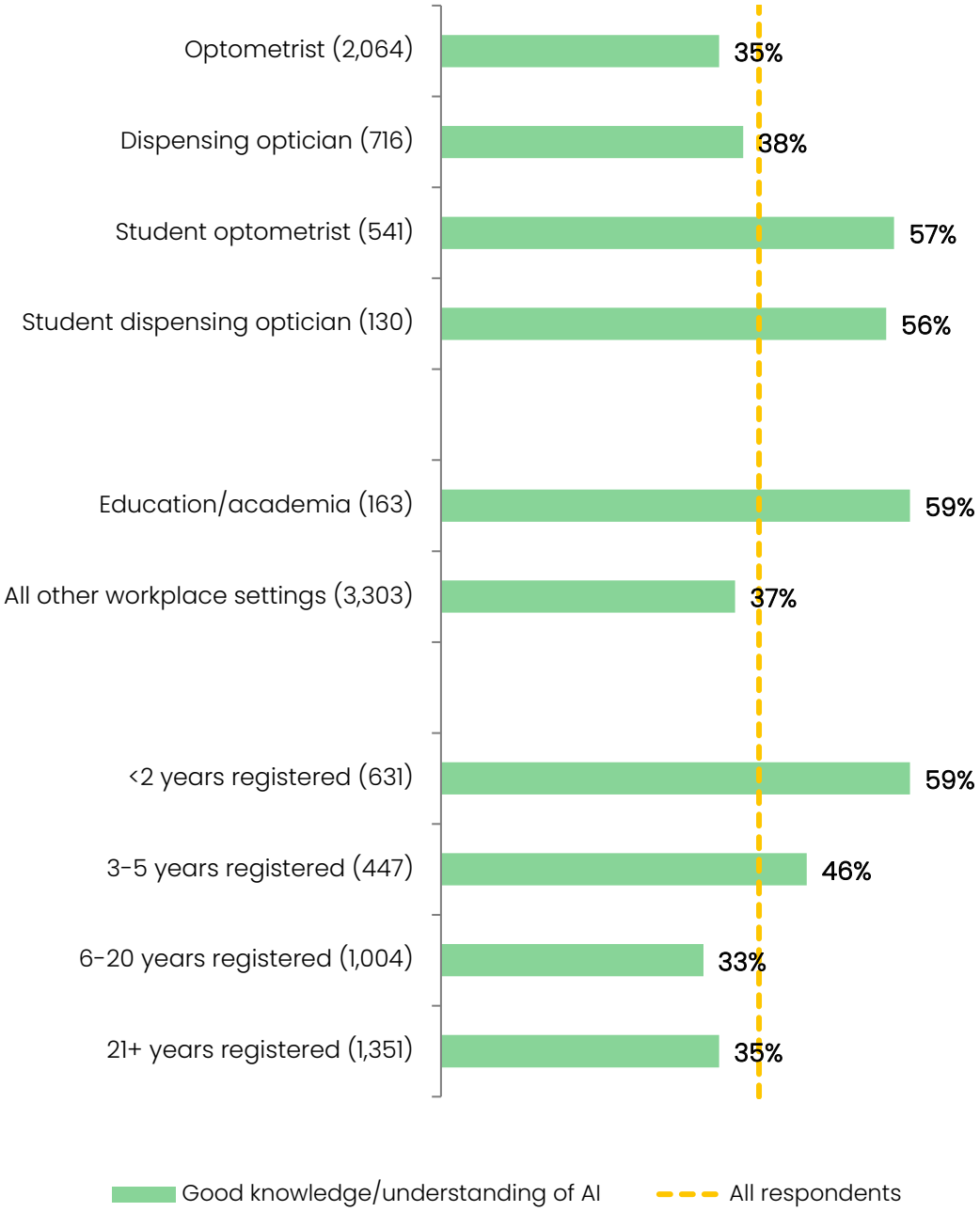


Understanding of AI is strongest amongst students and recently registered respondents

Younger and more recently registered respondents were more likely to report good knowledge and understanding of AI, with particularly high confidence amongst students (both optometrist and dispensing optician) and those registered for fewer than two years. Respondents working in education or academia were also more likely to feel confident in their understanding of AI when compared with those working in other settings.

Figure 73 – Good knowledge/understanding of AI by registration type, workplace setting, and length of registration

Base: Shown in chart

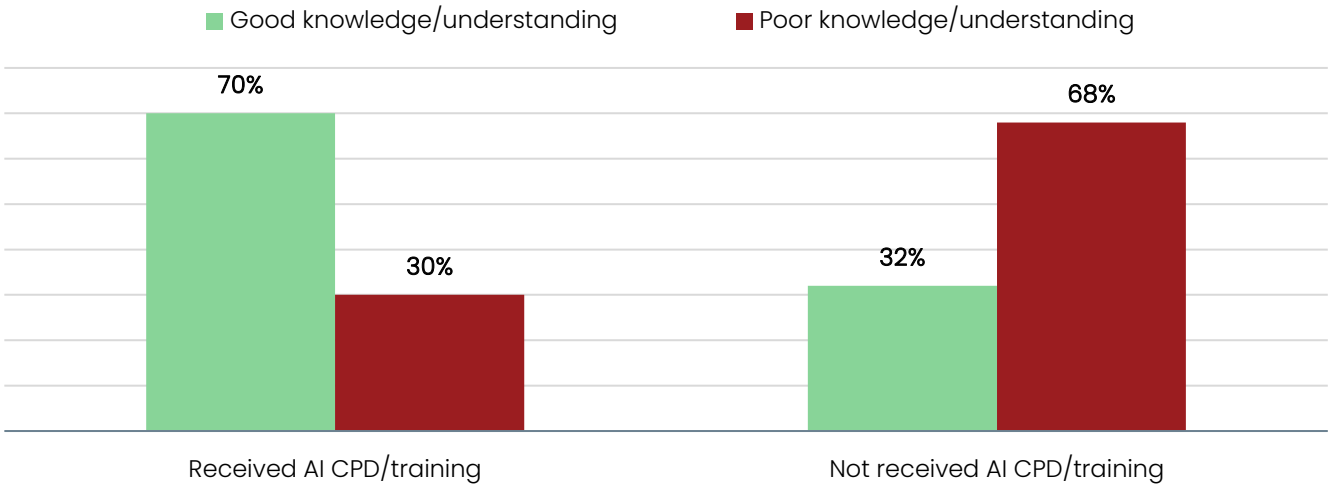


Formal AI training is more common amongst experienced registrants despite lower confidence levels

Just over one in five respondents (22%) reported having received CPD or training relating to AI within the last 12 months.

Those who had undertaken training were significantly more likely to describe their knowledge and understanding of AI positively, suggesting that training may play an important role in improving confidence in this area.

Figure 74 – Self-described knowledge and understanding of AI in relation to optical care and professional practice by receipt of CPD or training about AI over the last 12 months
Base: Received AI CPD/training (748); Not received AI CPD/training (2,703)

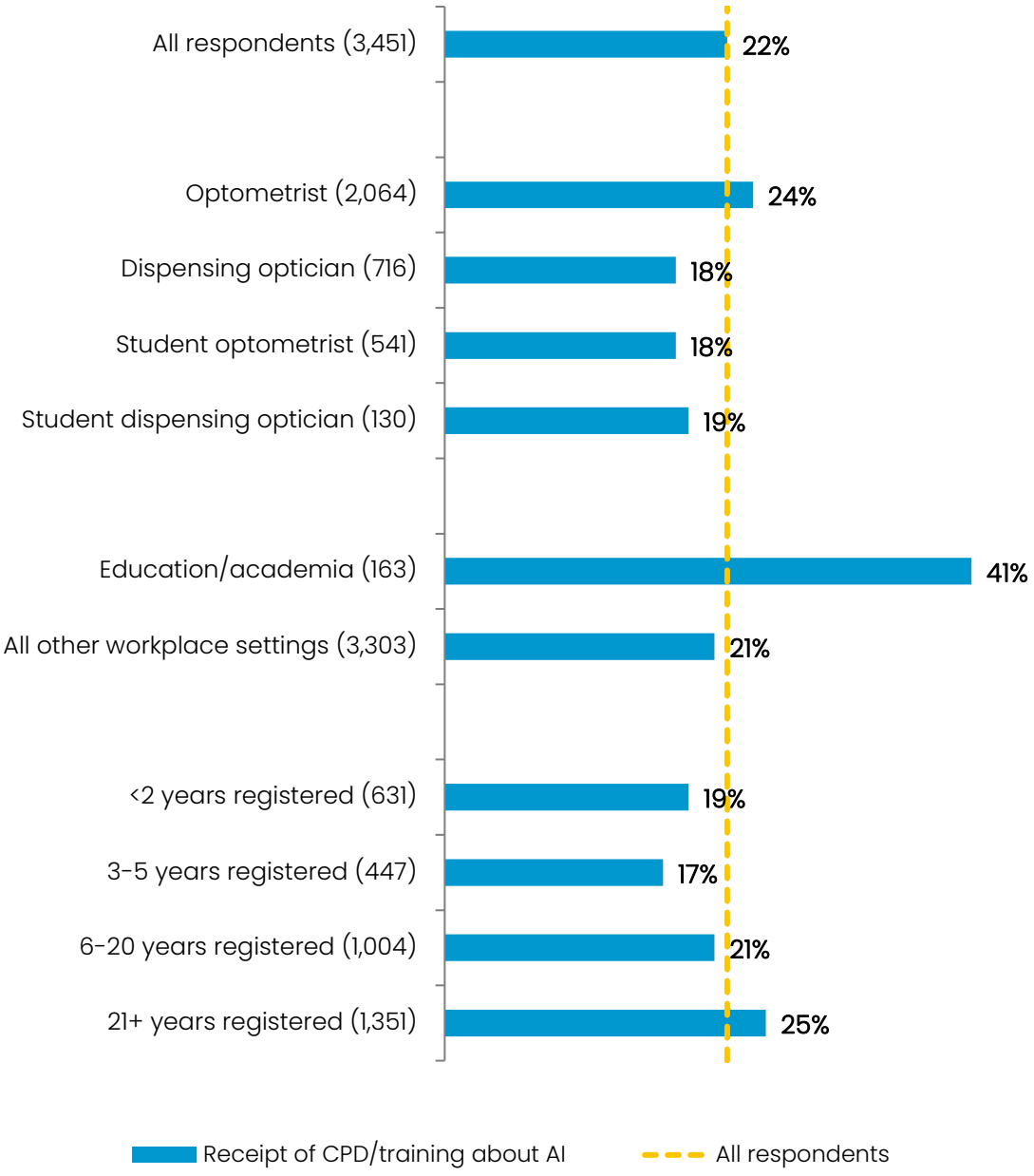


However, as shown in the chart overleaf, the profile of those receiving training does not fully mirror the groups reporting the highest levels of knowledge in AI. Students and more recently registered respondents were most likely to report good knowledge and understanding of AI, despite being less likely to have received formal training or CPD in this area. Conversely, optometrists and longer-registered professionals were more likely to have undertaken training, despite reporting lower levels of confidence overall.

This may suggest that familiarity with AI amongst younger respondents is shaped through wider exposure during education and everyday technology use, while more established professionals may increasingly be using formal CPD and training to develop knowledge and confidence in this area.

Figure 75 – Receiving CPD or training about AI over the last 12 months by registration type, workplace setting, and length of registration

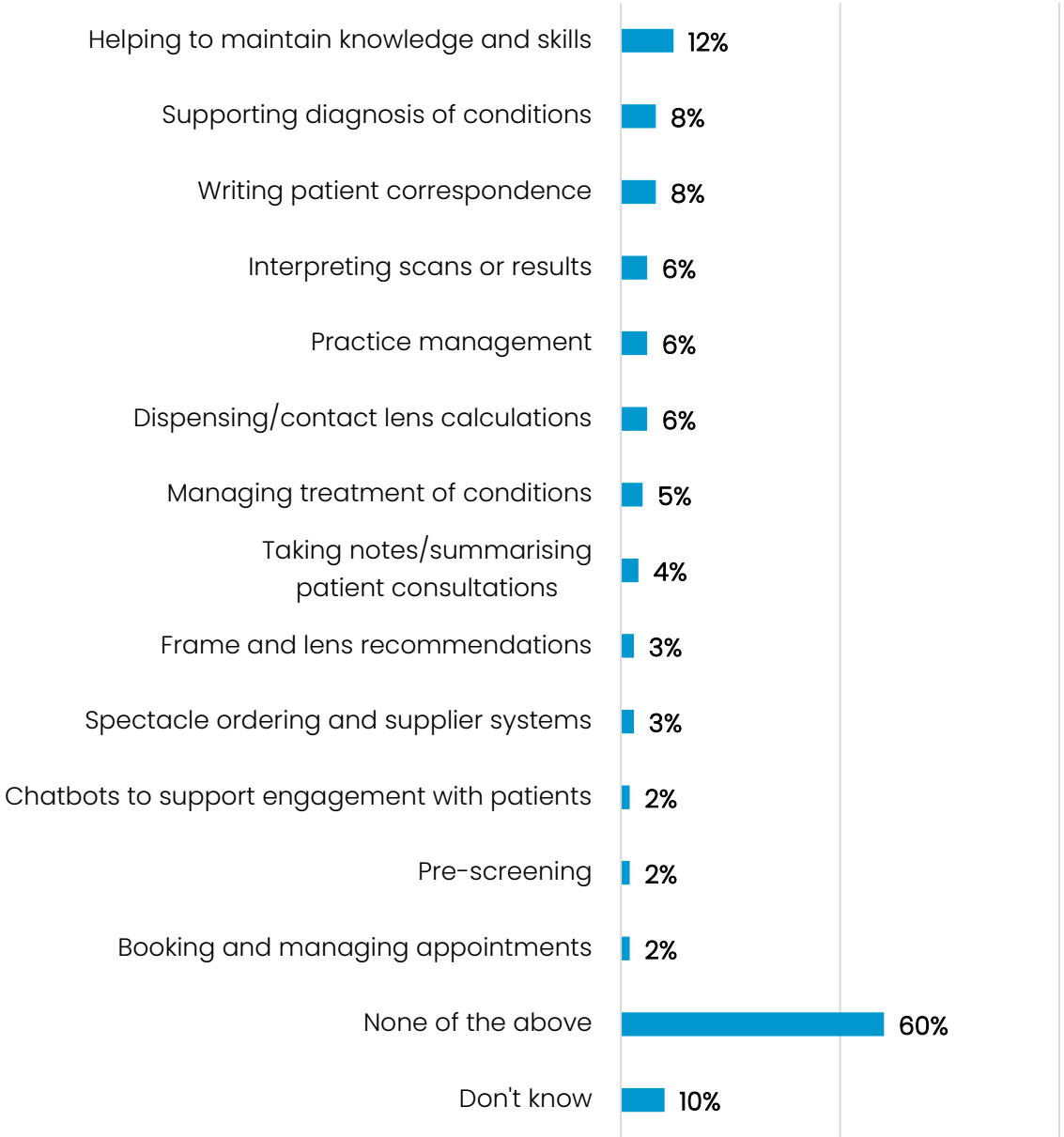
Base: Shown in chat



Current use of AI in professional practice remains limited

Current use of AI in professional practice remains relatively limited, with six in ten working respondents (60%) indicating that they are not currently using AI for any of the activities listed. Where AI is being used, it is most commonly to support maintaining knowledge and skills (12%), diagnosis of conditions (8%), and writing patient correspondence (8%). Use of AI for more operational or patient-facing activities, such as appointment management (2%), pre-screening (2%), or chatbot support (2%), was less common.

Figure 76 – Current use of AI in professional practice
Base: Respondents currently working (3,022)



Respondents working in hospital (52%) and education/academia (55%) were less likely to indicate that they were not currently using AI for any of the activities listed, suggesting greater use of AI within these settings. Those involved in enhanced eye care services (58% vs. 61% not involved) and respondents registered for fewer than two years (55% vs. 61% of those registered 6–20 years) were also less likely to select 'none of the above'.

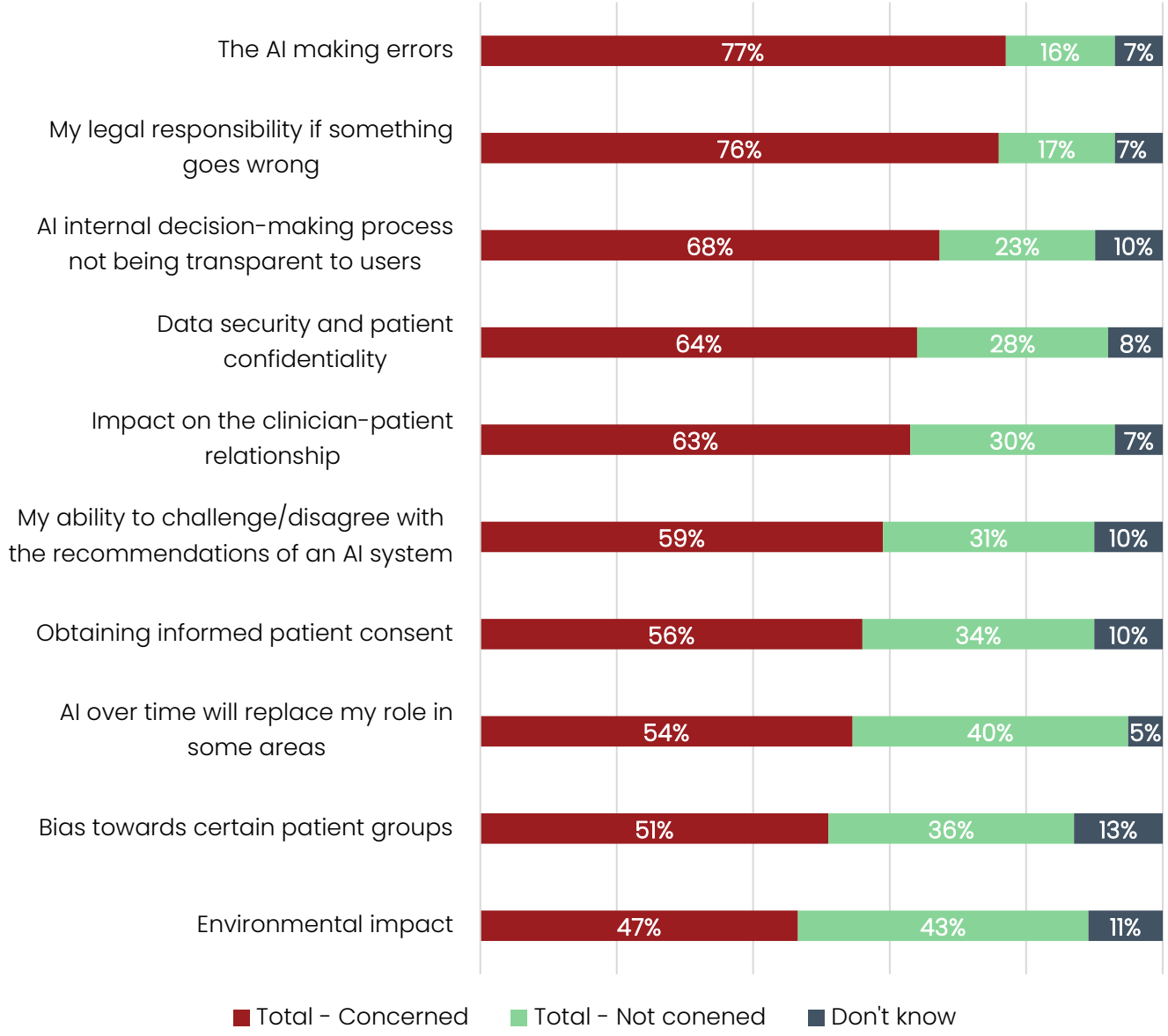
Concerns about AI are centred on safety, accountability, and transparency

Overall, respondents expressed relatively high levels of concern about the use of AI within eye care, particularly in relation to patient safety, accountability, and professional responsibility. The highest levels of concern related to AI making errors (77% concerned) and legal responsibility if something goes wrong (76% concerned), while concerns around transparency of AI decision-making (68% concerned), data security (64% concerned), and the impact on the clinician-patient relationship (63% concerned) were also widespread.

Respondents were comparatively less concerned about the longer-term impact of AI replacing aspects of their role, although over half (54%) still expressed concern about this. Environmental impact generated the lowest level of concern overall (47%) and also one of the highest proportions of uncertainty (11%), alongside bias towards certain patient groups and transparency of AI systems (13%).

Figure 77 – Concern about the use of AI in eye care

Base: All respondents (3,451)



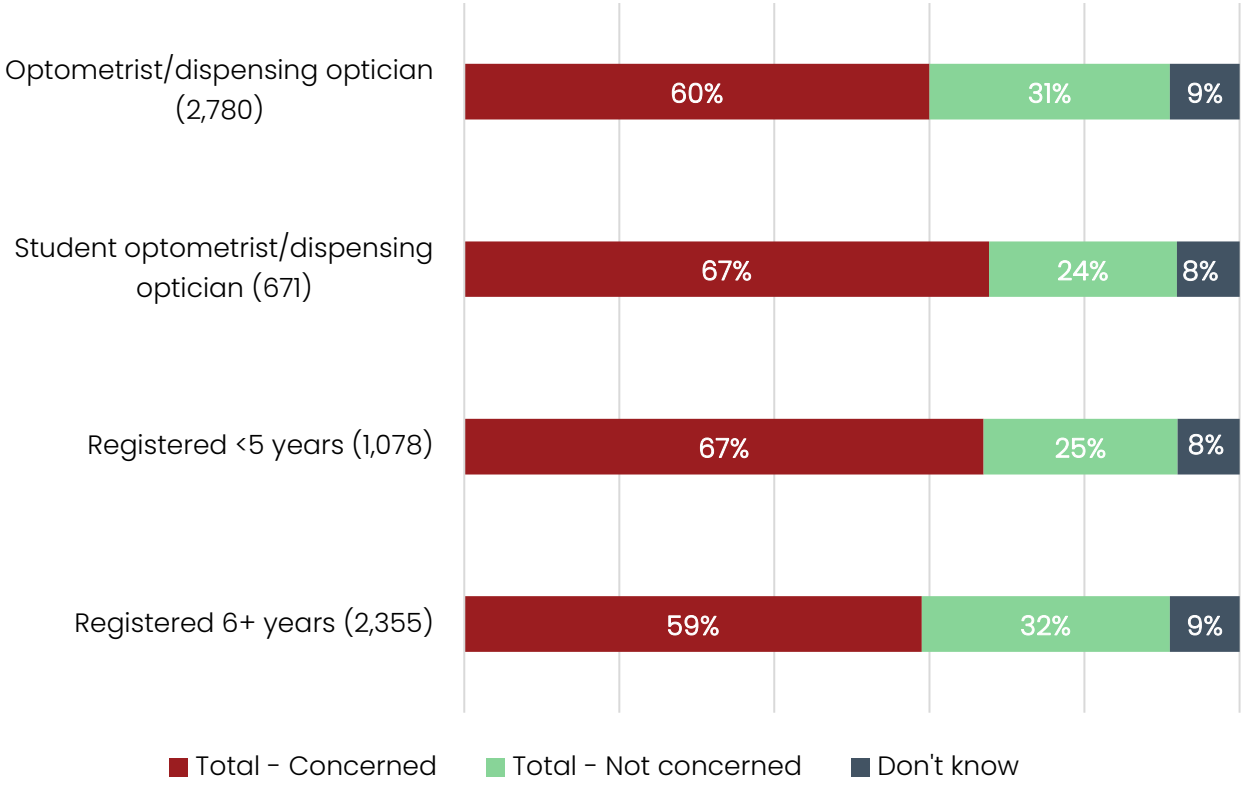
Greater AI understanding does not reduce concern among students and newer registrants

To summarise the pattern across the ten AI concern statements, a combined measure has been created showing the average level of concern across all AI-related issues.

This shows that concern is higher amongst students and those registered for fewer than five years when compared with qualified optometrists and dispensing opticians, and those registered for 6+ years.. This is interesting because these same groups were more likely to report good knowledge/ understanding of AI, suggesting that greater familiarity does not necessarily mean lower concern.

Figure 78 – Concern about the use of AI in eye care by registration type and length of registration

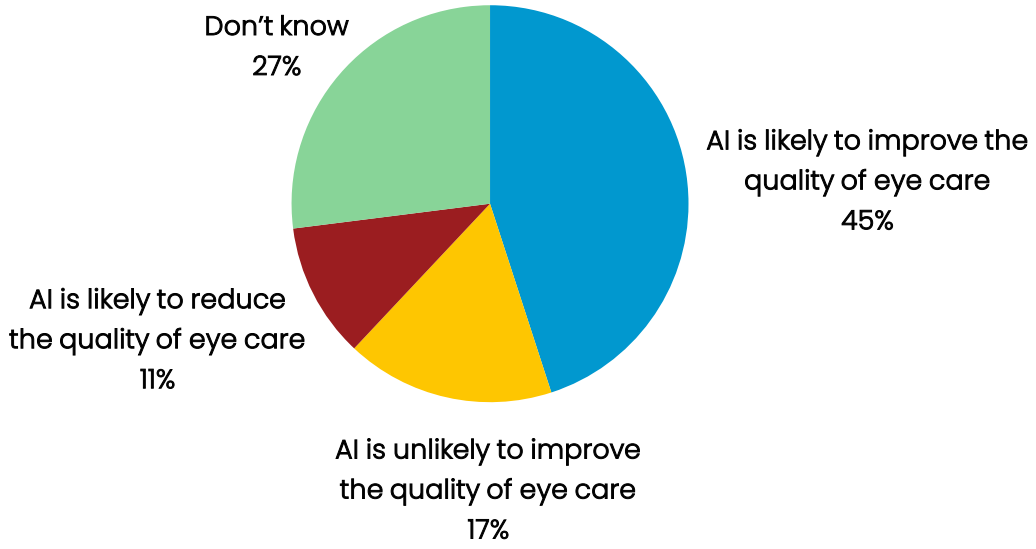
Base: Shown in chart



Mixed but cautiously positive views on AI's impact on eye care

Overall, respondents were more likely to feel that AI will improve the quality of eye care than reduce it. Almost half (45%) felt AI is likely to improve quality, compared with around one in ten (11%) who felt it is likely to reduce quality. However, views were not universally positive, with a notable minority saying AI is unlikely to improve care (17%). More than a quarter (27%) were unsure, highlighting that a large proportion feel unable to comment.

Figure 79 – Predicted impact of AI on the quality of eye care by registration type and workplace setting
Base: All respondents (3,451)

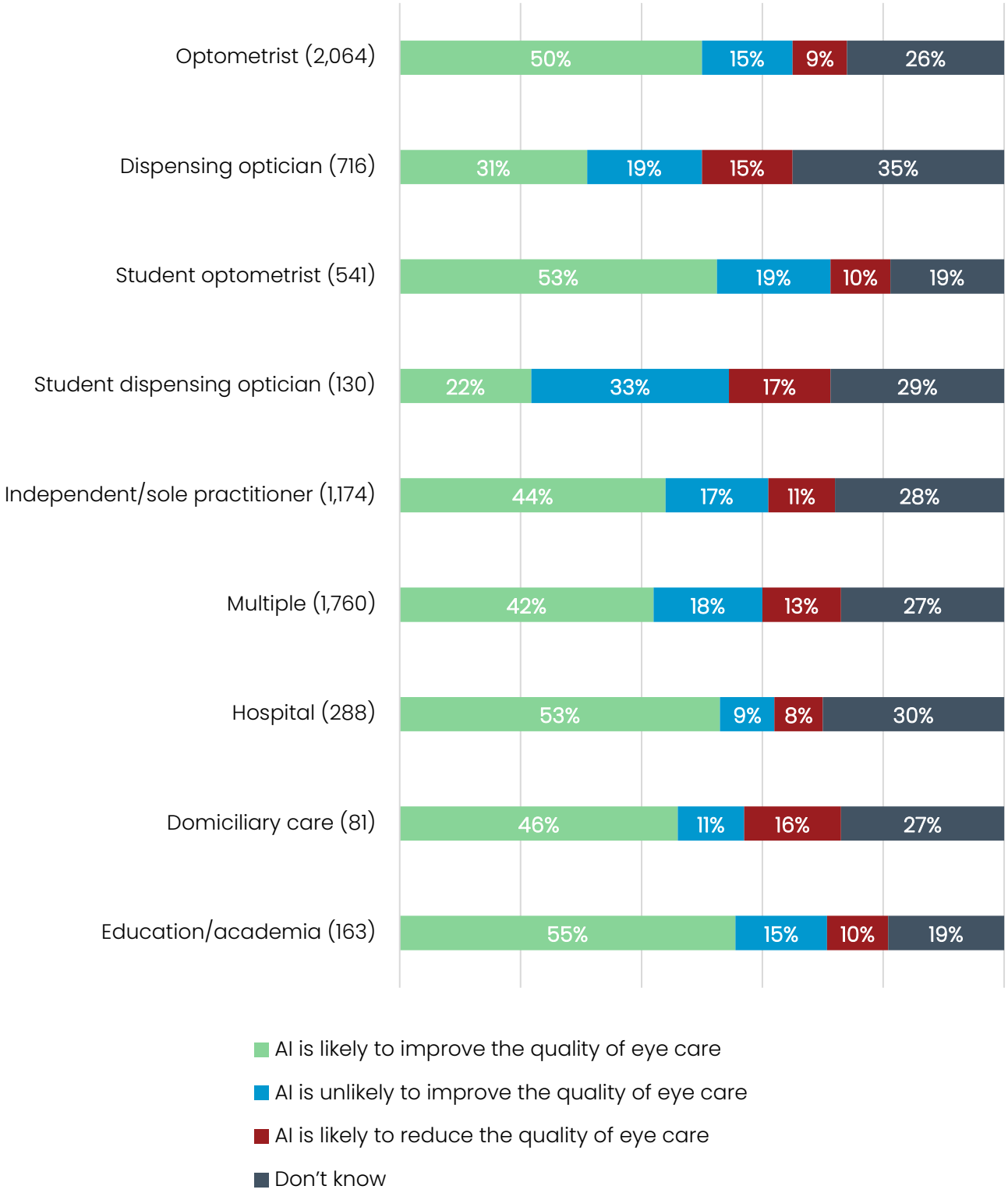


Optimism about AI is strongest among optometrists, hospitals and education settings

Views on the potential impact of AI were more positive among optometrists and student optometrists, around half of whom felt AI is likely to improve the quality of eye care. By contrast, dispensing opticians and student dispensing opticians were less positive, with higher proportions saying AI is unlikely to improve care, likely to reduce care quality, or that they did not know.

By workplace setting, respondents working in hospitals and education/academia were the most likely to feel AI will improve eye care, while those working in multiples and independents/as sole practitioners were closer to the overall average.

Figure 80 – Predicted impact of AI on the quality of eye care by registration type and workplace setting
Base: Shown in chat

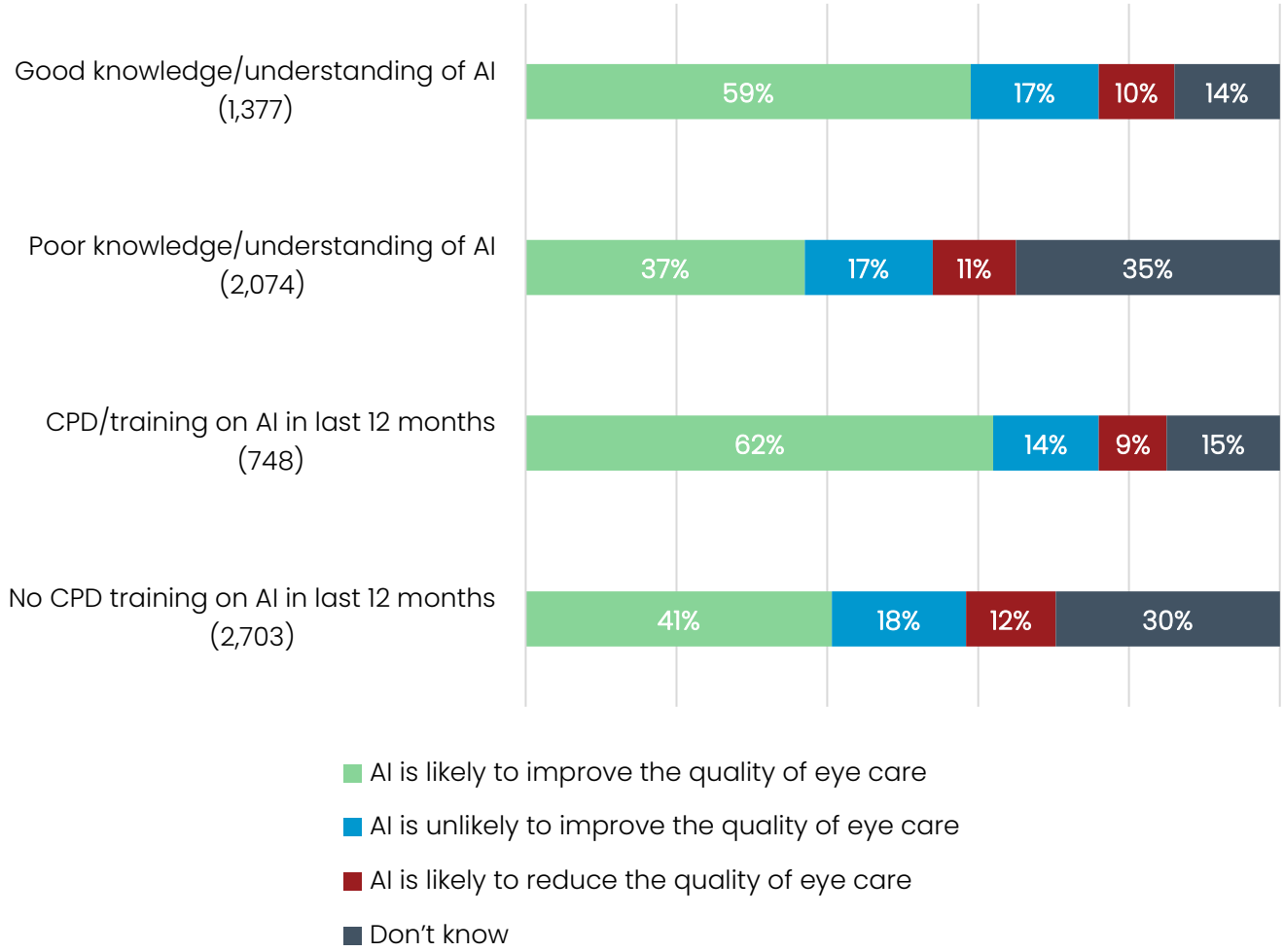


Understanding and training drive positive perceptions of AI's potential impact on eye care

Respondents with good knowledge or understanding of AI, and those who had received AI-related CPD or training in the last 12 months, were more likely to feel that AI will improve the quality of eye care. In contrast, those with poorer understanding or no recent training were much more likely to say they did not know. This suggests that greater exposure to AI is associated with more positive views about its potential impact, although levels of concern about AI reducing care quality remain relatively similar across groups.

Figure 81 – Predicted impact of AI on the quality of eye care level of knowledge/understanding of AI and experience of CPD/training on AI in last 12 months

Base: Shown in chat



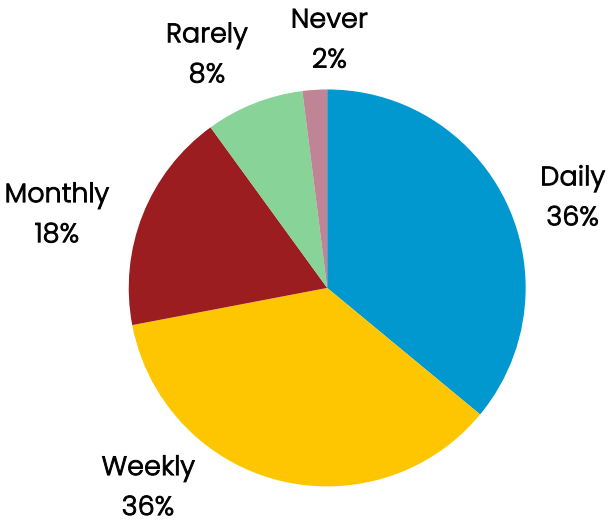
The impact of vision on driving

Discussions about driving implications are a routine part of practice for many registrants

Discussions about the impact of a patient's vision or eye condition on their ability to drive appear to be a routine part of practice for many registrants, with 72% having these conversations at least weekly (36% daily, 36% weekly), while only 10% report doing so rarely or never.

Figure 82 – Frequency of discussing the impact of a patient's vision or eye condition on their ability to drive in the last 12 months

Base: All respondents excluding those who answered 'not applicable' (3,151)



Optometrists were significantly more likely than dispensing opticians to report discussing this daily (44% vs 22%). Dispensing opticians were more likely than optometrists to say these conversations took place monthly or less often (41% vs 20%).

Daily discussions were also more common among those with additional qualifications (40% vs 36% without) and among those involved in enhanced eye care services (44% vs 31% not involved), suggesting these conversations are more frequent among registrants working in more clinically extended roles.

There was some variation across the UK nations, with respondents in England more likely than those in Scotland and Northern Ireland to say they had these discussions daily (37% vs 27% and 22% respectively), while Wales was more in line with England (35%). Instead, weekly discussions were more common in Scotland (44%) and Northern Ireland (42%).

Within England, respondents in London were less likely than the England average to report daily discussions (29% vs 37%), and more likely to say these took place monthly (26% vs 18%).

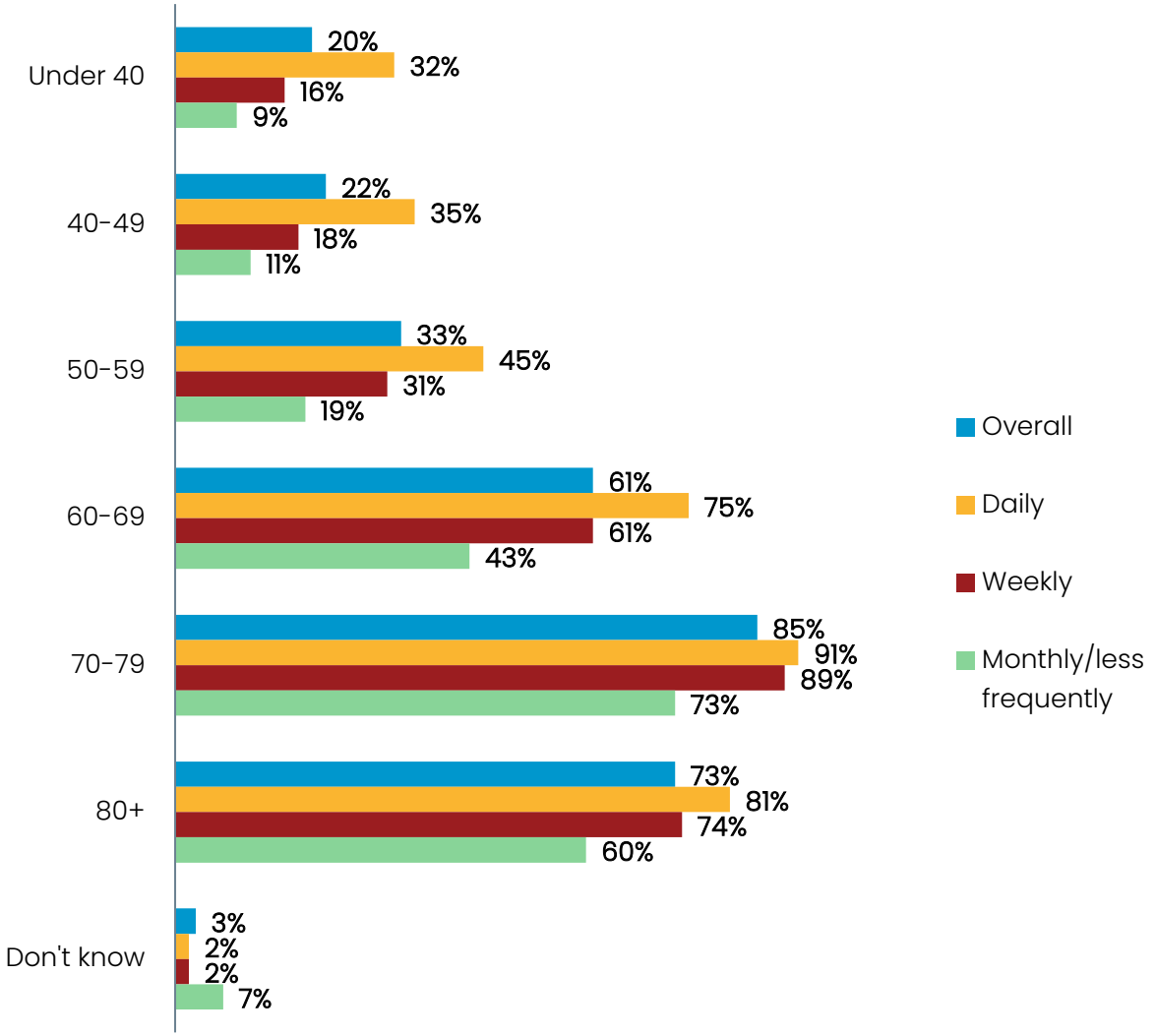
Driving-related discussions are focused primarily on older patients

When discussing the impact of vision or eye conditions on driving, registrants were most likely to say they commonly raise this with patients aged 70-79 (85%), followed by those aged 80+ (73%) and 60-69 (61%). Far fewer said they commonly raise this with patients under 50 (20%-22%).

Those who discuss driving implications with patients on a daily basis were significantly more likely than those doing so monthly or less often to raise the topic across every age group, including patients aged under 40 (32% vs 9%), 40-49 (35% vs 11%) and 50-59 (45% vs 19%). This suggests those who have these discussions frequently may take a broader, risk-based approach, instead of focusing mainly on older age groups.

Figure 83 – Age groups where discussions about the impact of vision or eye conditions on driving are most commonly raised by frequency of discussions

Base: Those who have discussed the impact of a patient's vision or eye condition on their ability to drive in the last 12 months (3,098)



Optometrists were generally more likely than dispensing opticians to report raising driving implications with older patients, particularly those aged 80+ (79% vs 65%) and 60-69 (64% vs 57%).

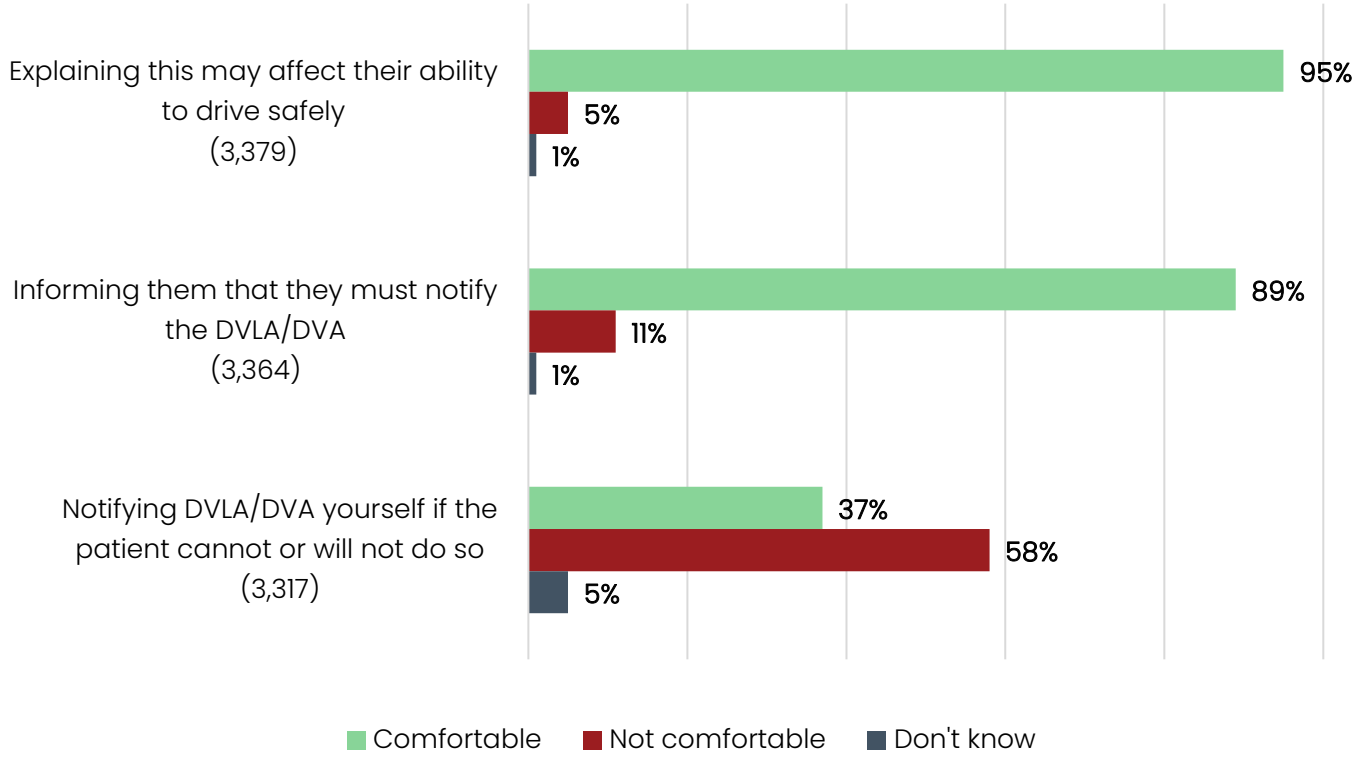
Driving-related discussions are focused primarily on older patients

Registrants are generally comfortable with conversations that involve explaining the implications of not meeting the eyesight standards and informing patients of their responsibility to notify the DVLA/DVA. Almost all respondents were comfortable explaining that this may affect a patient's ability to drive safely (95%), and nearly nine in ten were comfortable informing patients that they must notify the DVLA/DVA (89%).

By contrast, registrants were much less comfortable with notifying the DVLA/DVA themselves. Only 37% said they would feel comfortable doing this, while 58% said they would feel uncomfortable. This suggests confidence is high where the discussion centres on advising the patient, but falls significantly where the registrant may need to take direct action themselves.

Figure 84 – Comfort taking action if a patient does not meet the eyesight standards outlined in DVLA/DVA guidance

Base: All respondents excluding those who answered 'not applicable' (shown in chart)



Experience increases comfort with patient conversations, but not direct notification

Across all registration types and experience levels, most felt comfortable explaining that a patient's eyesight may affect their ability to drive safely and informing them that they must notify the DVLA/DVA.

By registration type, optometrists and dispensing opticians were generally more comfortable than student registrants with these two advisory actions. For example, 97% of optometrists and 95% of dispensing opticians felt comfortable explaining the implications for driving safety, compared with 88% of student optometrists and 89% of student dispensing opticians, likely reflecting the greater practical experience of qualified registrants in handling sensitive patient conversations.

However, the pattern reversed for notifying the DVLA/DVA directly if a patient could not or would not do so, with both student optometrists and student dispensing opticians more likely than qualified optometrists and dispensing opticians to feel comfortable with this action (55% and 45% vs (32% and 40%). Potentially this could indicate a more theoretical or rules-based perspective amongst students, while experienced registrants may be more aware of the practical and professional complexities involved.

This pattern was also seen by length of registration, where comfort with the two advisory actions rose slightly with experience, while comfort with notifying the DVLA/DVA directly was highest among those registered for two years or less (52%) and lower among those registered for longer.

Figure 85 – Comfort taking action if a patient does not meet the eyesight standards outlined in DVLA/DVA guidance by registration type

Base: Optometrist (2,024-2,057); Dispensing optician (682-702); Student optometrist (493-495); Student dispensing optician (118-125)

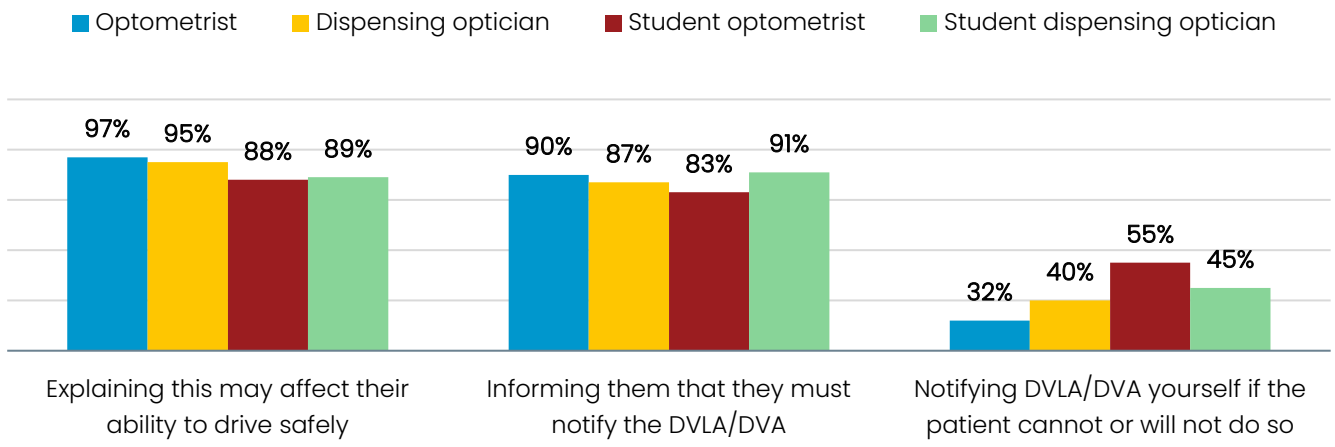
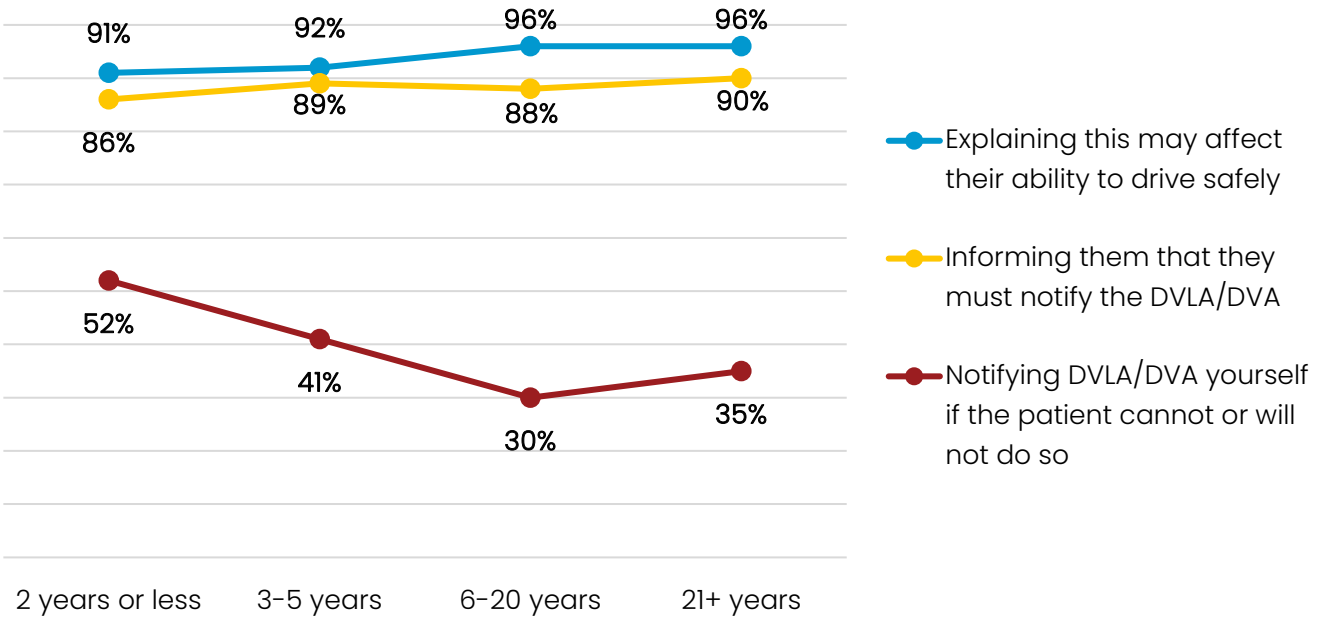


Figure 86 – Comfort taking action if a patient does not meet the eyesight standards outlined in DVLA/DVA guidance by length of registration

Base: <2 years (567-586); 3-5 years (440-443); 6-20 years (984-996); 21+ years (1,308-1,340)

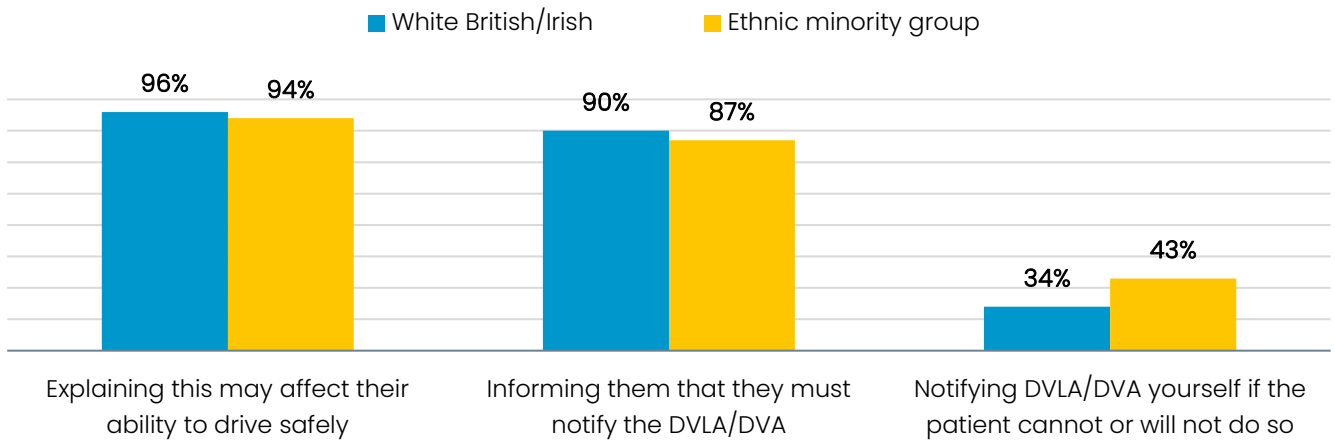


Some differences in comfort levels are evident by ethnicity

There were some differences by ethnicity. White British/Irish respondents were slightly more likely than those from minority ethnic backgrounds to feel comfortable explaining that a patient's eyesight may affect their ability to drive safely (96% vs 94%) and informing patients that they must notify the DVLA/DVA (90% vs 87%). However, the pattern reversed for notifying the DVLA/DVA directly if a patient could not or would not do so, where respondents from minority ethnic backgrounds were more likely to feel comfortable (43% vs 34%). This may partly reflect differences in the profile of respondents within each group, length of registration, role or workplace setting.

Figure 87 – Comfort taking action if a patient does not meet the eyesight standards outlined in DVLA/DVA guidance by ethnicity

Base: White British/Irish (1,827-1,856); Ethnic minoriry group (1,209-1,232)



Confidentiality, conflict, and unclear cases are the main barriers to notifying the DVLA/DVA

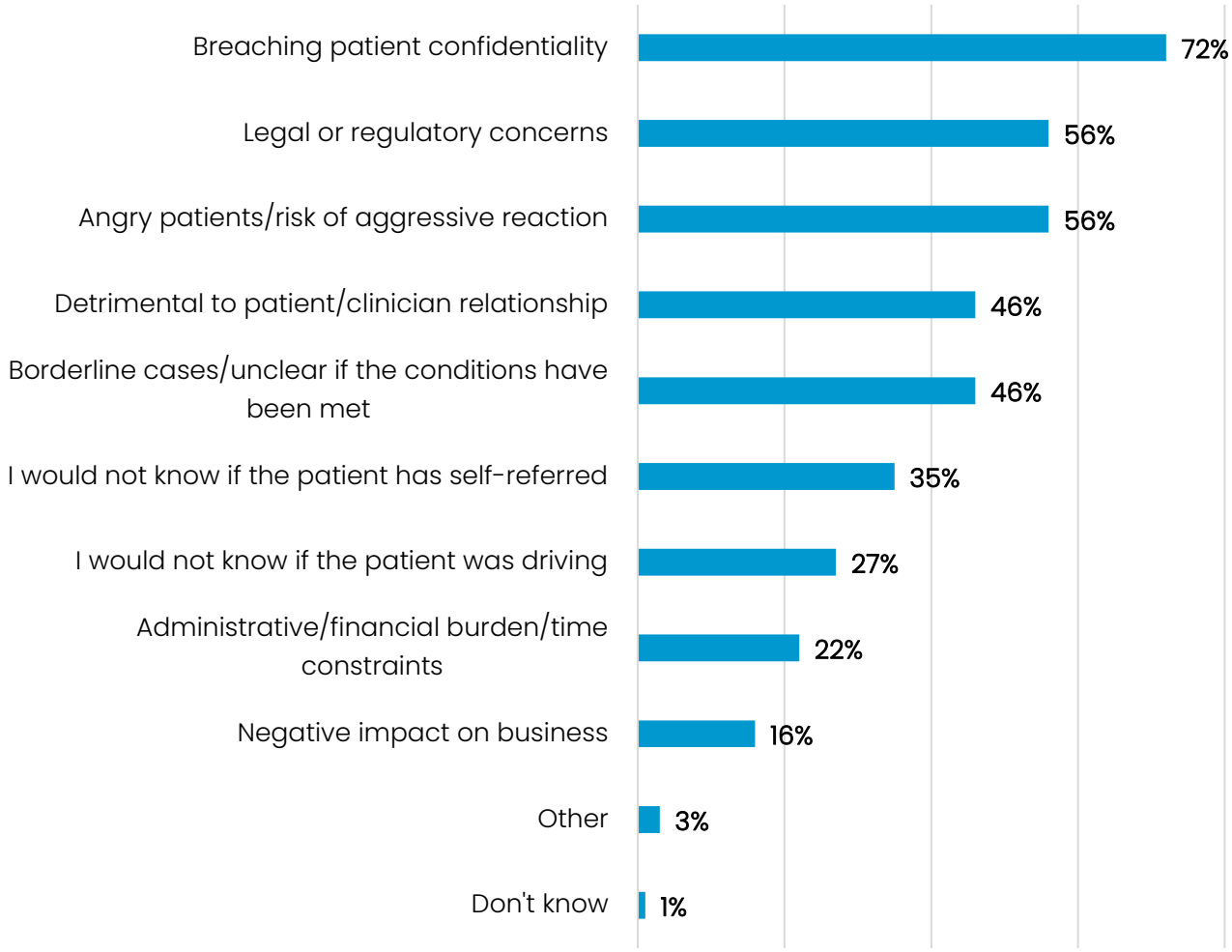
Among respondents who said they would feel uncomfortable notifying the DVLA/DVA directly, concerns were most commonly related to professional judgement, confidentiality and the potential consequences of taking action.

The most frequently cited reasons were breaching patient confidentiality (72%), legal or regulatory concerns (56%), angry patients or the risk of an aggressive reaction (56%), and damage to the patient/clinician relationship (46%). A similar proportion (46%) pointed to borderline cases where it may be unclear whether the relevant conditions had been met.

Practical uncertainties were also noted by some, including not knowing whether the patient had self-referred (35%) or was driving (27%), while fewer cited administrative burden (22%) or negative business impact (16%).

Figure 88 – Reasons for feeling uncomfortable notifying the DVLA/DVA if a patient does not meet the eyesight standards

Base: Those who felt uncomfortable notiying the DVLA/DVA (1,925)



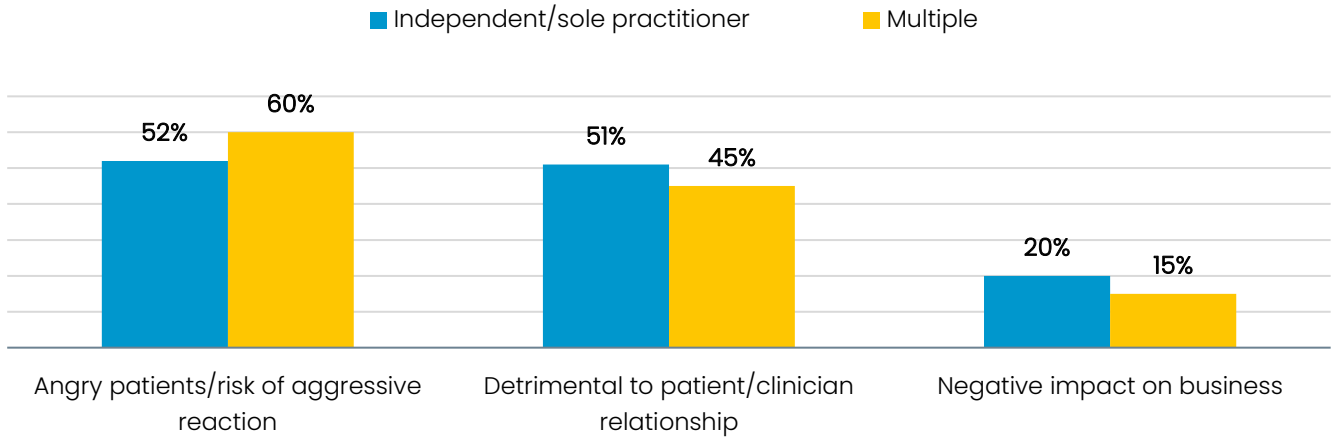
Free-text 'other' responses (3%) most commonly related to uncertainty about the reporting process or professional responsibility, alongside concerns about confidentiality, patient wellbeing, and the lack of clear guidance or feedback from the DVLA/DVA.

Concerns about notifying the DVLA/DVA differ between multiples and independent practices

Respondents working in multiple/chain opticians were more likely to cite angry patients or the risk of an aggressive reaction as a source of discomfort when notifying the DVLA/DVA when compared to those working in independent opticians (60% vs 52%). In contrast, those working in independent settings were more likely to mention a detrimental impact on the patient/clinician relationship (51% vs 45%) and a negative impact on the business (20% vs 15%). These results may reflect differences in patient relationships and commercial context between the two settings.

Figure 89 – Reasons for feeling uncomfortable notifying the DVLA/DVA if a patient does not meet the eyesight standards by workplace setting

Base: Independent/sole practitioner (715); Multiple (1,027)



Experience changes the nature of concerns about notifying the DVLA/DVA

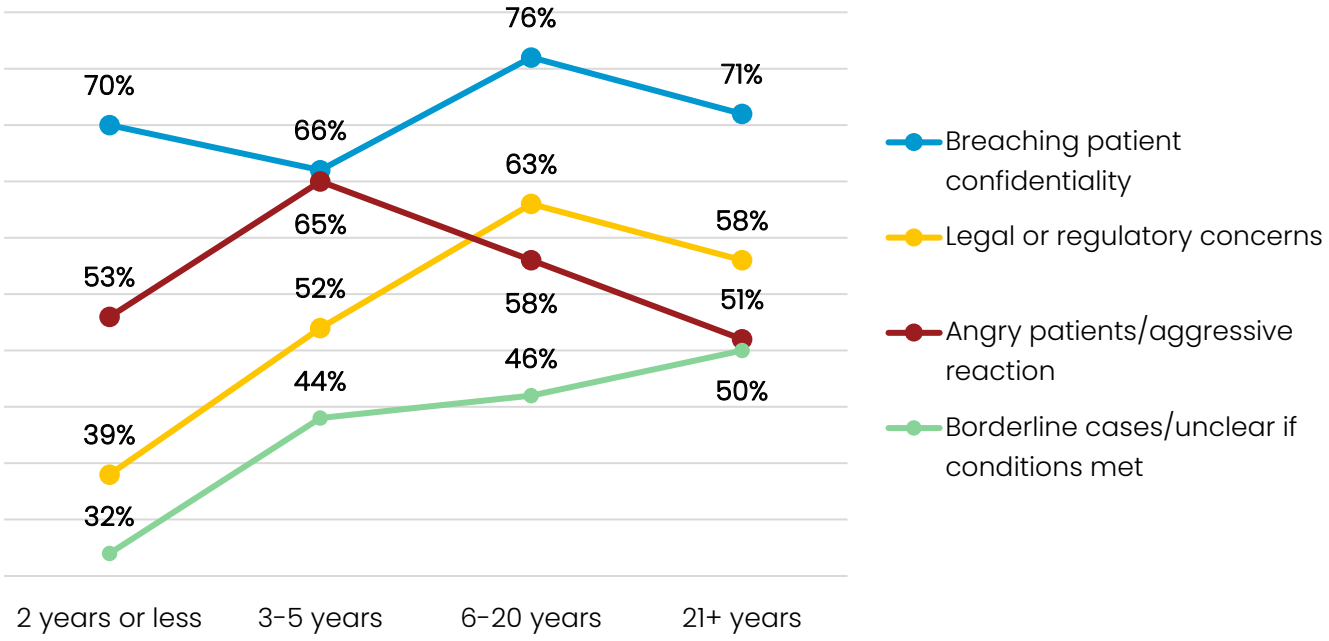
Legal or regulatory concerns are more common among longer-registered respondents, rising from 39% among those registered for two years or less to 63% among those registered for 6–20 years, suggesting greater awareness of the professional complexities involved. Concerns about borderline or unclear cases also increased steadily with experience (32% to 50%), indicating that more experienced registrants may be more conscious of the challenges involved in making finely balanced judgements.

By contrast, concern about angry patients or aggressive reactions was highest among those registered for 3–5 years (65%) and lower among both the least and most experienced groups (53% and 51% respectively).

Concerns about breaching patient confidentiality were consistently high across all experience levels, ranging from 66% to 76%.

Figure 90 – Reasons for feeling uncomfortable notifying the DVLA/DVA if a patient does not meet the eyesight standards by length of registration

Base: <2 years (226); 3-5 years (232); 6-20 years (646); 21+ years (807)



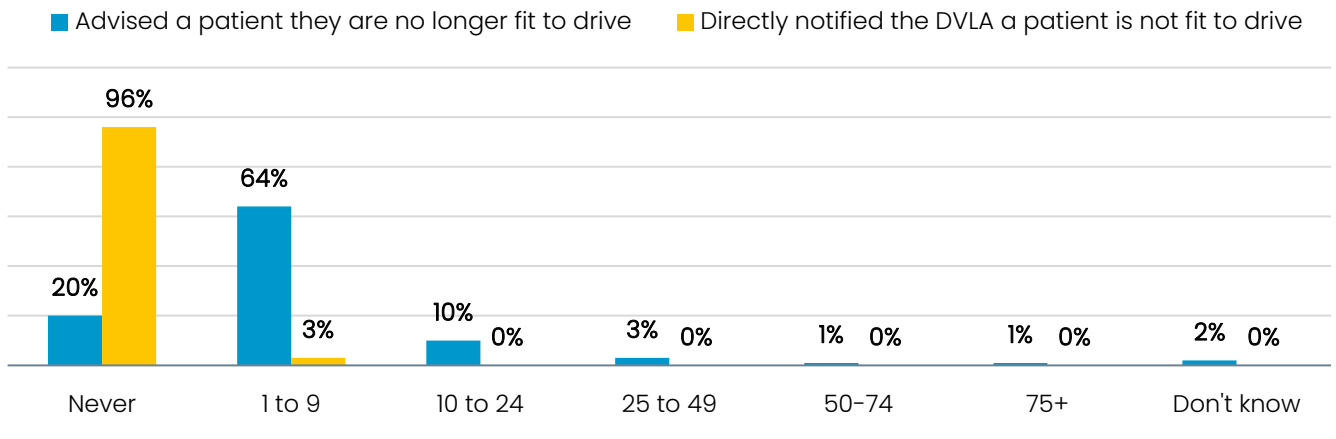
Advising patients Is common, direct DVLA/DVA notification is rare

Advising patients that they are no longer fit to drive was a relatively common experience for many respondents over the last 12 months. Four in five (78%) had done this at least once, with most doing so between one and nine times (64%) and 14% who had done so 10 or more times. In contrast, directly notifying the DVLA/DVA was rare, with almost all respondents (96%) never having done so. Only 3% had done so between one and nine times.

This suggests that discussing fitness to drive with patients forms a routine part of practice for many registrants, whereas direct notification to the DVLA/DVA is uncommon and likely limited to a small number of more serious cases.

Figure 91 – Frequency of advising a patient they are no longer fit to drive / directly notifying the DVLA a patient is not fit to drive over the last 12 months

Base: All respondents excluding those who answered 'not applicable' (3,137 / 3,110)



Role, experience, and setting shape exposure to advising patients

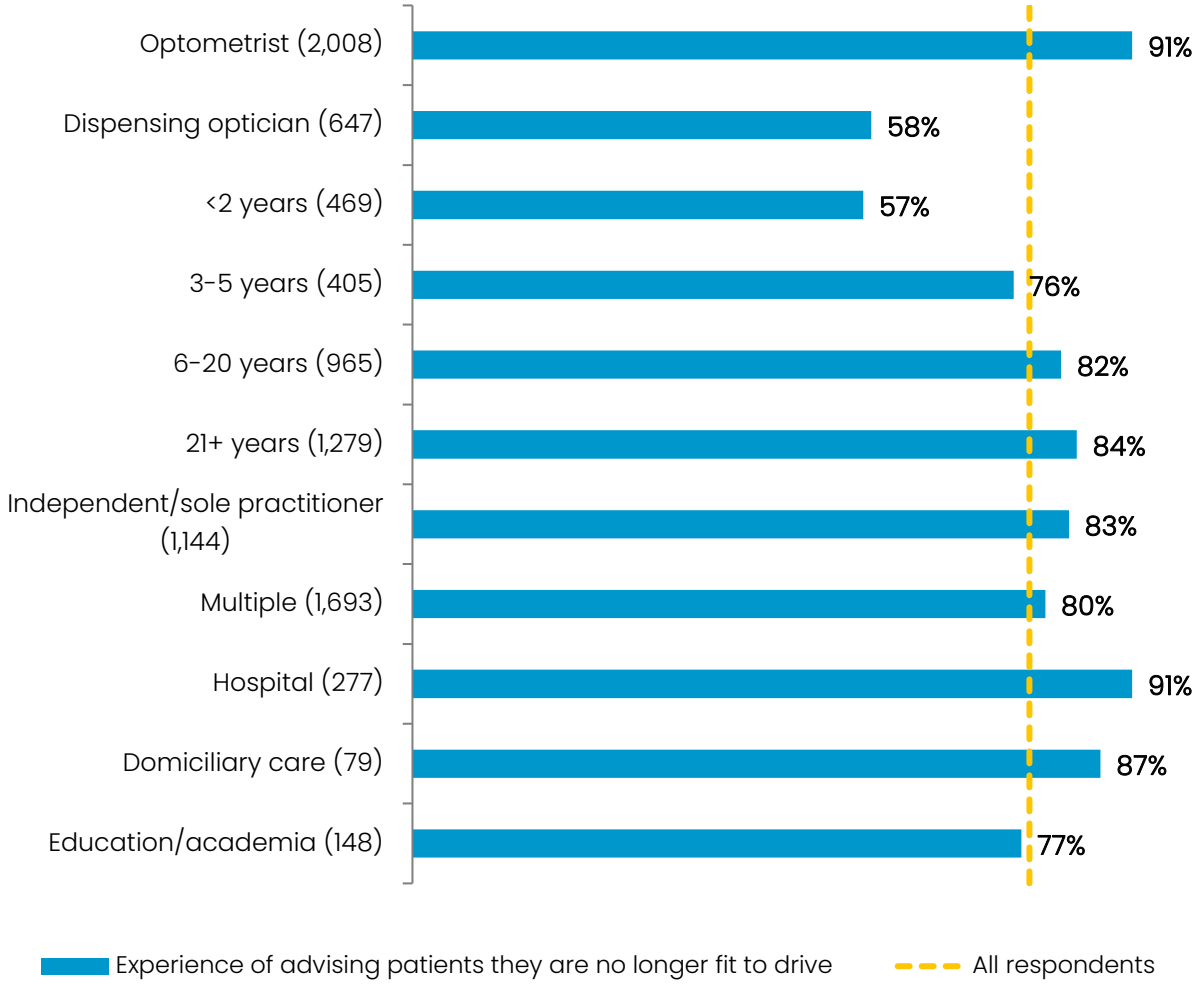
Experience of advising patients they are no longer fit to drive varied notably by role, experience, and workplace setting. Optometrists were substantially more likely than dispensing opticians to have done so in the last 12 months (91% vs 58%), reflecting differences in clinical responsibilities and patient contact.

There was also a clear relationship with time on the register, with just over half of those registered for less than two years (57%) having advised a patient at least once, rising to 76% among those registered for 3–5 years, 82% for those registered for 6–20 years and 84% for those registered for 21+ years.

By workplace setting, respondents working in hospitals (91%) and domiciliary care (87%) were most likely to have had these discussions, followed by independent/sole practitioners (83%) and those working in multiples (80%). Those in education/academia were least likely among the settings shown (77%), likely reflecting less frequent direct patient contact.

Figure 92 – Experience of advising patients they are no longer fit to drive by registration type and workplace setting

Base: All respondents excluding those who answered 'not applicable' (shown in chart)



In contrast, experience of direct reporting to the DVLA/DVA is exceptional across the profession, not concentrated in one segment.

Appendix A – Questionnaire

Workforce & Perceptions Survey 2026

Welcome to the General Optical Council (GOC)'s Workforce and Perceptions Survey 2026.

The survey should take around 10 minutes to complete, and by taking part you can be entered into a prize draw to win a **£250 online gift card**.

Completing the survey

To navigate through this questionnaire, use the arrow buttons at the bottom of each page. DO NOT use the back/forward options in your browser. To remove your answers to a question, click the reset button.

If you do not have time to complete the survey in one sitting, your progress will be automatically saved and you can return to where you left off at any point by clicking on the survey link again in your email invitation, or the 'save' button at the bottom of the page.

The GOC has appointed Enventure Research to conduct this survey so that your responses remain confidential. For more information about this survey, please visit the Enventure Research website.

If you have any questions about this survey, please call the Enventure Research survey helpline on 0800 0092 117 or email helpline@enventure.co.uk

Your role

The first set of questions are about your role and where you work.

Q1 **Please tell us which of the following roles apply to you (if you are retired, please select the most appropriate role before you retired)** *Please select as many as apply*

- ❑ Optometrist
- ❑ Optometrist with an independent prescribing specialty (including additional supply and supplementary prescribing)
- ❑ Dispensing optician
- ❑ Dispensing optician with a contact lens specialty
- ❑ Student optometrist
- ❑ Student optometrist undertaking the pre-registration scheme
- ❑ Student dispensing optician

Q2 **Which of these best describes your current working status?** *Please select as many as apply*

- ❑ Working / employed (including full/part-time and locum work, and temporarily away from work e.g. parental leave/extended sick leave etc.)
- ❑ Not working / unemployed
- ❑ Fully retired
- ❑ Student / in education

Q3 **Please select which of these best describes your current role** Asked if Q1=Optom/DO and Q2=Working/employed

- ❑ No managerial responsibility
- ❑ Some management responsibilities and/or supervision role
- ❑ Responsible for managing or running the practice
- ❑ Director
- ❑ CEO or equivalent

Q4 **Do you work as a locum?** Asked if Q2=Working/employed

- ❑ Yes
- ❑ No

Q5 **Where do you currently work?** *Please select all that apply* Asked if Q2=Working/employed

- ❑ Independent practice
- ❑ Sole practitioner
- ❑ National chain of opticians (e.g. UK-wide chain of opticians)
- ❑ Regional chain of opticians (e.g. chain of opticians working within one region in the UK)
- ❑ Hospital
- ❑ Domiciliary care
- ❑ Education/academia
- ❑ Other

Other *Please specify*

_____

_____

Q6 **For each location selected, please state how many days on average per week you work there** *Please type in the boxes below - please use whole or half days only e.g. 1, 1.5*
Each row asked based on answer at Q5

Independent practice _____

Sole practitioner _____

National chain of opticians _____

Regional chain of opticians _____

Hospital _____

Domiciliary care _____

Education/academia _____

Other _____

Q7 **In the last 12 months, have you worked in a role supervising pre-registration trainees?** Asked if Q1=Optometrist/DO and Q2=Working/employed

- ❑ Yes
- ❑ No

Q8 **Are you currently involved in delivering enhanced eye care services (e.g. providing patients with care beyond the remit of a routine sight test, such as Minor Eye Conditions Service (MECS), NHS Community Glaucoma Service or Anterior Eye Service (Scotland), Low Vision Service Wales, or NI PEARS (Northern Ireland))?**
Asked if Q2=Working/employed

- ❑ Yes
- ❑ No
- ❑ I am not aware of these services
- ❑ Don't know

Q9 **Do you have any of the following additional qualifications?** *Please select all that apply*
Not asked to those who are students only

- ❑ No additional qualifications
- ❑ Glaucoma
- ❑ Medical retina

- ❑ Paediatric eye care
- ❑ Low vision
- ❑ Contact lens practice
- ❑ Contact lens diploma
- ❑ Spectacle lens design
- ❑ Refraction
- ❑ Ophthalmic dispensing
- ❑ Other

Other *Please specify*

_____

_____

Q10 **Approximately how long have you been on the GOC register?**

- ❑ Less than 1 year
- ❑ 1 to 2 years
- ❑ 3 to 5 years
- ❑ 6 to 10 years
- ❑ 11 to 15 years
- ❑ 16 to 20 years
- ❑ 21 years and over
- ❑ Don't know

Your career

The GOC would like to find out a bit more about satisfaction levels and career prospects in the professions. All questions in this section only asked if Q2=Working/employed

Q11 **Thinking about the last 12 months, to what extent are you satisfied or dissatisfied with your role/job?**

- ❑ Very satisfied
- ❑ Quite satisfied
- ❑ Neither satisfied or dissatisfied
- ❑ Quite dissatisfied
- ❑ Very dissatisfied
- ❑ Not applicable

Q12 **Are you considering making any of the following changes to your career over the next 12-24 months?** *Please select all that apply*

- ❑ Gain additional qualifications/skills
- ❑ Switch to locum work
- ❑ Reduce your hours
- ❑ Leave the profession
- ❑ Take a career break
- ❑ Retire
- ❑ Other
- ❑ None of the above

Other *Please specify*

_____

_____

Q13 **In what areas are you interested in gaining additional qualifications/skills?** *Please select all that apply* Asked if Q12=Gain additional qualifications/skills

- ❑ Independent prescribing (including additional supply and supplementary prescribing)
- ❑ Contact lens specialty
- ❑ Contact lens practice
- ❑ Moving to optometry

- ❑ Glaucoma
- ❑ Medical retina
- ❑ Paediatric eye care
- ❑ Low vision
- ❑ Spectacle lens design
- ❑ Refraction
- ❑ Ophthalmic dispensing
- ❑ Other
- ❑ Don't know

Other *Please specify*

_____

_____

Workplace pressure

Q14 **In the last 12 months, have you experienced any of the following?** Asked if Q2=Working/employed

	Never	Rarely	Sometimes	Frequently
Working beyond your hours	❑	❑	❑	❑
Feeling unable to cope with workload	❑	❑	❑	❑
Taking leave of absence due to stress	❑	❑	❑	❑
Finding it difficult to provide patients with the sufficient level of care they need	❑	❑	❑	❑

Q15 **In the last 12 months, have you experienced any of the following?** Asked if Q2=Working/employed

	Never	Rarely	Sometimes	Frequently
The standard time allocated to me for conducting a sight test has been insufficient to provide safe patient care Shown for optoms/student optoms only	❑	❑	❑	❑
I have felt under pressure to see a high number of patients every day which has impacted on my ability to provide safe patient care	❑	❑	❑	❑
I have been asked to overbook clinics	❑	❑	❑	❑
I have felt under pressure to sell certain types of glasses or contact lenses that will earn more money for the business	❑	❑	❑	❑
I have felt under pressure to sell a product or provide a service which I considered was not needed by the patient	❑	❑	❑	❑
I have felt under pressure to meet commercial targets at the expense of patient care	❑	❑	❑	❑

Q16 **When you experienced pressure of this kind, what did you do?** *Please select all that apply* Asked if rarely/sometimes/frequently for any at Q15

- ❑ Reported it to my line manager / supervisor
- ❑ Reported it to senior management or a practice manager
- ❑ Raised concerns informally with colleagues

- ❑ Raised concerns through a formal process (e.g. whistleblowing, HR, regulatory body)
- ❑ Did nothing
- ❑ Other
- ❑ Prefer not to say

Other *Please specify*

_____

_____

Q17 **How confident are you in your ability to resist commercial pressures that you believe could compromise patient care?** Asked to all except retired

- ❑ Very confident
- ❑ Quite confident
- ❑ Not very confident
- ❑ Not confident at all
- ❑ Don't know

Q18 **How well did your education and training equip you to manage commercial pressures while maintaining safe patient care?** Asked to fully qualified optoms/DOs excluding retired

- ❑ Very well
- ❑ Quite well
- ❑ Not very well
- ❑ Not at all well
- ❑ Don't know

Q19 **What one commercial practice are you most concerned about in terms of its potential impact on patient care?** Asked to all except retired
Please summarise your one suggestion in the box below

_____

_____

_____

Speaking up

Questions in this section asked to all but those who are fully retired

Q20 **How comfortable would you feel speaking up about patient safety concerning <u>an individual GOC registrant</u> with the following...**

	Very comfortable	Quite comfortable	Not very comfortable	Not comfortable at all	Don't know	Not applicable
Your manager / tutor?	❑	❑	❑	❑	❑	❑
Your employer / education provider?	❑	❑	❑	❑	❑	❑
Your professional association / representative body?	❑	❑	❑	❑	❑	❑
The GOC?	❑	❑	❑	❑	❑	❑

Q21 **Why wouldn't you feel comfortable speaking up?** *Please select all that apply* Asked if Q20=Not very comfortable/Not comfortable at all

- ❑ I might jeopardise my job
- ❑ I don't believe that corrective action would be taken
- ❑ I might alienate myself from my colleagues
- ❑ It's none of my business

- ❑ I wouldn't want to be seen as a troublemaker by management
- ❑ I would assume they already knew about it
- ❑ I wouldn't know who to contact
- ❑ Other
- ❑ Prefer not to say
- ❑ Don't know

Other *Please specify*

_____

_____

Q22 **How comfortable would you feel speaking up about patient safety concerning <u>your employer</u> with the following...**

	Very comfortable	Quite comfortable	Not very comfortable	Not comfortable at all	Don't know	Not applicable
Your manager / tutor?	❑	❑	❑	❑	❑	❑
Your employer / education provider?	❑	❑	❑	❑	❑	❑
Your professional association / representative body?	❑	❑	❑	❑	❑	❑
The GOC?	❑	❑	❑	❑	❑	❑

Q23 **Why wouldn't you feel comfortable speaking up?** *Please select all that apply* Asked if Q22=Not very comfortable/Not comfortable at all

- ❑ I might jeopardise my job
- ❑ I don't believe that corrective action would be taken
- ❑ I might alienate myself from my colleagues
- ❑ It's none of my business
- ❑ I wouldn't want to be seen as a troublemaker by management
- ❑ I would assume they already knew about it
- ❑ I wouldn't know who to contact
- ❑ Other
- ❑ Prefer not to say
- ❑ Don't know

Other *Please specify*

_____

_____

Harassment, bullying or abuse

Questions in this section exclude fully retired

Q24 **In the last 12 months, how many times have you personally experienced harassment, bullying or abuse at work (or study) from...?**

	Never	1 to 2	3 to 5	6 to 10	More than 10
Patients / service users, their relatives or other members of the public	❑	❑	❑	❑	❑
Managers	❑	❑	❑	❑	❑
Other colleagues	❑	❑	❑	❑	❑
Tutors / lecturers / supervisors (option displays for students only)	❑	❑	❑	❑	❑

Q25 **Was the harassment, bullying or abuse you experienced ever related to any of the following?** *Please select all that apply* Asked if Q24=1 or more for any option

- ❑ Age
- ❑ Disability
- ❑ Gender reassignment
- ❑ Marriage or civil partnership
- ❑ Pregnancy and maternity
- ❑ Race
- ❑ Religion or belief
- ❑ Sex
- ❑ Sexual orientation
- ❑ Other
- ❑ None of the above

Other *Please specify*

Q26 **The last time you experienced harassment, bullying or abuse at work (or study), did you or a colleague report it?** Asked if Q24=1 or more for any option

- ❑ Yes, I reported it
- ❑ Yes, a colleague reported it
- ❑ No
- ❑ Don't know
- ❑ Not applicable

Discrimination

Questions in this section exclude fully retired

Q27 **In the last 12 months, how many times have you personally experienced any discrimination in your role at work (or study) from...?**

	Never	1 to 2	3 to 5	6 to 10	More than 10
Patients / service users, their relatives or other members of the public	❑	❑	❑	❑	❑
Managers	❑	❑	❑	❑	❑
Other colleagues	❑	❑	❑	❑	❑
Tutors / lecturers / supervisors (option displays for students only)	❑	❑	❑	❑	❑

Q28 **What type of discrimination have you experienced?** *Please select all that apply* Asked if Q27=1 or more for any option

- ❑ Age
- ❑ Disability
- ❑ Gender reassignment
- ❑ Marriage or civil partnership
- ❑ Pregnancy and maternity
- ❑ Race
- ❑ Religion or belief
- ❑ Sex
- ❑ Sexual orientation
- ❑ Other

Other *Please specify*

Q29 **The last time you experienced discrimination at work (or study), did you or a colleague report it?** Asked if Q27 =1 or more for any option

- ❑ Yes, I reported it
- ❑ Yes, a colleague reported it
- ❑ No
- ❑ Don't know
- ❑ Not applicable

Continuing Professional Development (CPD)

Q30 **Within this CPD cycle (1 January 2025 to 31 December 2027), have you attended any CPD (provider-led or self-directed) to learn about any of the following topics?** Asked to all except students

	Yes	No	Plan to attend
Addressing bullying, harassment and discrimination in the workplace	❑	❑	❑
Health disparities and health inequalities	❑	❑	❑
Exploring your own personal biases and biases of others	❑	❑	❑
Speaking up (whistleblowing)	❑	❑	❑
Artificial intelligence	❑	❑	❑
Other aspects of equality, diversity, and inclusion (EDI)	❑	❑	❑

Artificial intelligence (AI)

Q31 **How would you describe your knowledge and understanding of artificial intelligence (AI) in relation to optical care and professional practice?**

- ❑ Very good
- ❑ Good
- ❑ Poor
- ❑ Very poor

Q32 **Over the last 12 months, either in your professional practice or studies, have you received CPD or training about AI?**

- ❑ Yes
- ❑ No

Q33 **During your professional practice, are you currently using AI to assist with any of the following activities?** *Please select all that apply* Asked to those currently working/employed

- ❑ Booking and managing appointments
- ❑ Chatbots to support engagement with patients
- ❑ Taking notes/summarising patient consultations
- ❑ Helping to maintain knowledge and skills
- ❑ Interpreting scans or results
- ❑ Supporting diagnosis of conditions
- ❑ Managing treatment of conditions
- ❑ Writing patient correspondence
- ❑ Spectacle ordering and supplier systems
- ❑ Frame and lens recommendations
- ❑ Dispensing/contact lens calculations
- ❑ Pre-screening, e.g. to analyse questionnaires completed by patients before attending their sight test appointment
- ❑ Practice management, e.g. business analytics, workforce planning
- ❑ None of the above
- ❑ Don’t know

Q34 **How concerned, if at all, are you about the following aspects of AI use in eye care?**

	Very concerned	Fairly concerned	Not very concerned	Not at all concerned	Don't know
My ability to challenge/disagree with the recommendations of an AI system	❑	❑	❑	❑	❑
Bias towards certain patient groups	❑	❑	❑	❑	❑
The AI making errors	❑	❑	❑	❑	❑
Lack of transparency in how AI systems make decisions	❑	❑	❑	❑	❑
Data security and patient confidentiality	❑	❑	❑	❑	❑
Impact on the clinician-patient relationship	❑	❑	❑	❑	❑
My legal responsibility if something goes wrong	❑	❑	❑	❑	❑
Obtaining informed patient consent	❑	❑	❑	❑	❑
AI over time will replace my role in some areas	❑	❑	❑	❑	❑
Environmental impact	❑	❑	❑	❑	❑

Q35 **On balance, which of the following statements best describes how you feel about the impact of AI on the quality of eye care?**

- ❑ AI is likely to improve the quality of eye care
- ❑ AI is unlikely to improve the quality of eye care
- ❑ AI is likely to reduce the quality of eye care
- ❑ Don’t know

Driving vision

Q36 **In the last 12 months, how often have you discussed the impact of a patient’s vision or eye condition on their ability to drive?**

- ❑ Daily
- ❑ Weekly
- ❑ Monthly
- ❑ Rarely
- ❑ Never
- ❑ Not applicable

Q37 **When discussing the impact of vision or eye conditions on driving, which age groups do you commonly raise this with?** *Please select all that apply* Asked if Q36=Rarely to daily

- ❑ Under 40
- ❑ 40-49
- ❑ 50-59
- ❑ 60-69
- ❑ 70-79
- ❑ 80+
- ❑ Don't know

Q38 **If a patient does not meet the eyesight standards outlined in DVLA/DVA guidance, how comfortable would you feel about the following?**

	Very comfortable	Quite comfortable	Not very comfortable	Not comfortable at all	Don't know	Not applicable
Explaining this may affect their ability to drive safely	❑	❑	❑	❑	❑	❑
Informing them that they must notify DVLA/DVA	❑	❑	❑	❑	❑	❑
Notifying DVLA/DVA yourself if the patient cannot or will not do so	❑	❑	❑	❑	❑	❑

Q39 **What would make you feel uncomfortable about notifying the DVLA/DVA in this situation?** *Please select all that apply* Asked if Q382c=Not very comfortable/not at all comfortable

- ❑ Breaching patient confidentiality
- ❑ Legal or regulatory concerns
- ❑ Detrimental to patient/clinician relationship
- ❑ Angry patients/risk of aggressive reaction
- ❑ I would not know if the patient was driving
- ❑ I would not know if the patient has self-referred
- ❑ Negative impact on business
- ❑ Administrative/financial burden/time constraints
- ❑ Borderline cases/unclear if the conditions have been met
- ❑ Other
- ❑ Don't know

Q40 **Over the last 12 months, approximately how many times have you:**

	Never	1-9	10-24	25-49	50-74	75-99	100+	Don't know	Not applicable
Advised a patient they are no longer fit to drive	❑	❑	❑	❑	❑	❑	❑	❑	❑
Directly notified the DVLA a patient is not fit to drive	❑	❑	❑	❑	❑	❑	❑	❑	❑

About you

The GOC is deeply committed to promoting equality, valuing diversity and being inclusive in all its work as a health professions regulator, and to making sure we meet our equality duties. The following questions relate to our equality and diversity work and add to our understanding of the diversity of the optical profession, so that we can make sure our services and events reflect this diversity. They will also allow any differences in results between different groups to be highlighted.

Please remember you will not be individually identified in your survey response, and **you can answer prefer not to say if you wish to each question**.

Sex, gender and orientation

Q41 **What is your sex, as recorded at birth?**

- ❑ Female
- ❑ Male
- ❑ My own description
- ❑ Prefer not to say

Please share your self-description

_____

_____

Q42 **Which of these best describes your Gender Identity?**

- ❑ Man/Male
- ❑ Woman/Female
- ❑ Non-Binary
- ❑ Gender Fluid
- ❑ Questioning
- ❑ My own description
- ❑ Prefer not to say

Please share your self-description

_____

_____

Q43 **Are you intersex and/or have a variation of sex characteristics (VSC)?**

- ❑ Yes
- ❑ No
- ❑ Prefer not to say

Q44 **Are you trans, or do you have a trans history?**

- ❑ Yes
- ❑ No
- ❑ Prefer not to say

Q45 **Which of the following best describes your sexuality?**

- ❑ Asexual
- ❑ Bisexual
- ❑ Gay/Lesbian
- ❑ Heterosexual/Straight
- ❑ My own description
- ❑ Prefer not to say

Please share your self-description

_____

_____

Age and relationship status

Q46 **What is your age?**

- ❑ Under 25
- ❑ 25 - 34
- ❑ 35 - 44
- ❑ 45 - 54
- ❑ 55 - 64
- ❑ 65 +
- ❑ Prefer not to say

Q47 **Are you currently:**

- ❑ Co-habiting or living with a partner
- ❑ Married or in a civil partnership
- ❑ Separated, divorced or civil partnership dissolved
- ❑ Single
- ❑ Widowed or a surviving partner from a civil partnership

- ❑ My own description
- ❑ Prefer not to say

Please share your self-description

_____

_____

Ethnic background

Q48 **What is your ethnicity?**

- ❑ Asian/Asian British - Bangladeshi / Bangladeshi British
- ❑ Asian/Asian British - Chinese / Chinese British
- ❑ Asian/Asian British - Indian / Indian British
- ❑ Asian/Asian British - Pakistani / Pakistani British
- ❑ Asian/Asian British - Any other Asian background
- ❑ Black/Black British - African / African British
- ❑ Black/Black British - Caribbean / Caribbean British
- ❑ Black/Black British - Any other Black background
- ❑ Mixed/Multiple Ethnic Group - White and Asian
- ❑ Mixed/Multiple Ethnic Group - White and Black African
- ❑ Mixed/Multiple Ethnic Group - White and Black Caribbean
- ❑ Mixed/Multiple Ethnic Group - Any other mixed / multiple ethnic background
- ❑ Other ethnic group - Arab / Arab British
- ❑ Other ethnic group - Any other ethnic group
- ❑ White - English / Welsh / Scottish / Northern Irish / British
- ❑ White - Irish
- ❑ White - Gypsy or Irish Traveller
- ❑ White - Roma
- ❑ White - Any other white background
- ❑ Prefer not to say

Please share your self-description

_____

_____

Disability, health and neurodiversity

Q49 **Do you have any physical or mental health conditions or illnesses lasting or expected to last 12 months or more?**

- ❑ Yes
- ❑ No
- ❑ Prefer not to say

Q50 **Do any of your conditions or illnesses reduce your ability to carry out day-to-day activities?** Asked if Q49=Yes

- ❑ Yes, a lot
- ❑ Yes, a little
- ❑ Not at all

Q51 **How would you categorise your disability/disabilities?** *Please select all that apply* Asked if Q49=Yes

- ❑ Physical impairment (e.g. mobility, sensory, chronic pain)
- ❑ Long-term health condition (e.g. diabetes, heart disease)
- ❑ Neurodivergent condition (e.g. ADHD, autism, dyslexia)
- ❑ Mental health condition (e.g. depression, anxiety)
- ❑ Cognitive or memory difficulty (e.g. dementia, brain injury)
- ❑ Hidden or invisible condition (e.g. chronic fatigue, fibromyalgia)

- ❑ My own description
- ❑ Prefer not to say

Please share your self-description

_____

_____

Religion or belief

Q52 **What is your religion or belief?**

- ❑ No religion or belief
- ❑ Buddhist
- ❑ Christian (including Church of England, Catholic, Protestant and all other Christian denominations)
- ❑ Hindu
- ❑ Jewish
- ❑ Muslim
- ❑ Sikh
- ❑ Any other religion
- ❑ Prefer not to say

Please share your self-description

_____

_____

Caring and family responsibilities

Q53 **Do you have any unpaid caring responsibilities for a child/children and/or another adult(s)?**

- ❑ Yes
- ❑ No
- ❑ Prefer not to say

Q54 **If yes, please select all that apply** Asked if Q53=Yes

- ❑ For a child/children
- ❑ For an adult
- ❑ Prefer not to say

Q55 **Are you pregnant, on parental leave, or recently returned from parental leave?**

- ❑ Yes
- ❑ No
- ❑ Prefer not to say

Language and communication

Q56 **What is your main language?**

- ❑ English
- ❑ Other (including sign languages)
- ❑ Prefer not to say

Please share your other language

_____

_____

Q57 **Do you speak any additional languages fluently (including sign languages)?**

- ❑ Yes
- ❑ No
- ❑ Prefer not to say

Socio-economic background

Q58 **What was the occupation of your main household earner when you were aged about 14?**

- ❑ **Modern professional and traditional professional occupations** such as teacher, nurse, physiotherapist, social worker, musician, police officer (sergeant or above), software designer, accountant, solicitor, medical practitioner, scientist, civil engineer or mechanical engineer
- ❑ **Senior, middle or junior managers or administrators** such as finance manager, chief executive, large business owner, office manager, retail manager, bank manager, restaurant manager, warehouse manager
- ❑ **Clerical and intermediate occupations** such as secretary, personal assistant, call centre agent, clerical worker, nursery nurse
- ❑ **Technical and craft occupations** such as motor mechanic, plumber, printer, electrician, gardener, train driver
- ❑ **Routine, semi-routine manual and service occupations** such as postal worker, machine operative, security guard, caretaker, farm worker, catering assistant, sales assistant, HGV driver, cleaner, porter, packer, labourer, waiter or waitress, bar staff
- ❑ **Long-term unemployed** (claimed Jobseeker's Allowance or earlier unemployment benefit for more than a year)
- ❑ **Small business owners** who employed fewer than 20 people such as corner shop owners, small plumbing companies, retail shop owner, single restaurant or cafe owner, taxi owner, garage owner
- ❑ **Other** such as retired, this question does not apply to me, I don't know
- ❑ Prefer not to say

Q59 **Which type of school did you attend for the most time between the ages of 11 and 16?**

- ❑ State-run or state-funded school
- ❑ Independent or fee-paying school
- ❑ Independent or fee-paying school, where I received a means-tested bursary covering 90% or more of the overall cost of attending throughout my time there
- ❑ Attended school outside the UK
- ❑ Don't know
- ❑ Prefer not to say

Q60 **If you finished school after 1980, were you eligible for free school meals at any point during your school years?**

- ❑ Yes
- ❑ No
- ❑ Not applicable (finished school before 1980 or went to school overseas)
- ❑ Don't know
- ❑ Prefer not to say

Q61 **Which region does your main residence fall within?**

- ❑ North East
- ❑ North West
- ❑ Yorkshire and Humber
- ❑ East Midlands
- ❑ West Midlands
- ❑ East of England
- ❑ London
- ❑ South East
- ❑ South West
- ❑ Wales
- ❑ Scotland
- ❑ Northern Ireland
- ❑ Other
- ❑ Prefer not to say

Please share your other

_____

_____

Prize draw

As a thank you for your time today, we are offering you the opportunity to enter our prize draw to win a £250 gift card that can be used at a range of outlets or donated to charity. The winner will be randomly selected when the survey closes. Full terms and conditions of the prize draw can be found here.

Q62 **Do you want to be entered into our prize draw?**
By answering yes you are agreeing to be contacted by Enventure Research via your GOC-registered email address if you are selected as the winner.

- ❑ Yes
- ❑ No

Thank you for taking the time to take part in this survey. Your views are greatly appreciated.

Please click the tick button below to send your response.

Appendix B – Demographic profile

Demographic profile of survey respondents
Base: All respondents (3,451)

Demographic	Number	Percentage
What is your sex, as recorded at birth?		
Female	2,153	62%
Male	1,090	32%
My own description	3	0%
Prefer not to say	206	6%
Which of these best describes your Gender Identity?		
Man/Male	1,080	31%
Woman/Female	2,131	62%
Non-Binary	11	0%
Gender Fluid	2	0%
Questioning	1	0%
My own description	4	0%
Prefer not to say	223	6%
Are you intersex and/or have a variation of sex characteristics (VSC)?		
Yes	11	0%
No	3,160	92%
Prefer not to say	280	8%
Are you trans, or do you have a trans history?		
Yes	18	1%
No	3,188	92%
Prefer not to say	245	7%
Which of the following best describes your sexuality?		
Asexual	50	1%
Bisexual	95	3%
Gay/Lesbian	68	2%
Heterosexual/Straight	2,852	83%
My own description	10	0%
Prefer not to say	375	11%
What is your age?		
Under 25	450	13%
25 - 34	672	19%
35 - 44	742	22%
45 - 54	665	19%
55 - 64	571	17%
65 +	183	5%
Prefer not to say	168	5%
Are you currently:		
Co-habiting or living with a partner	413	12%
Married or in a civil partnership	1,809	52%

Demographic	Number	Percentage
Separated, divorced or civil partnership dissolved	134	4%
Single	755	22%
Widowed or a surviving partner from a civil partnership	21	1%
My own description	20	1%
Prefer not to say	299	9%
What is your ethnicity?		
Asian/Asian British	884	26%
Black/Black British	156	5%
Mixed/Multiple	44	1%
White	2,019	58%
Other	44	1%
Prefer not to say	304	9%
Do you have any physical or mental health conditions or illnesses lasting or expected to last 12 months or more?		
Yes	409	12%
No	2,787	81%
Prefer not to say	256	7%
Do any of your conditions or illnesses reduce your ability to carry out day-to-day activities?		
Yes, a lot	46	1%
Yes, a little	177	5%
Not at all	163	5%
Prefer not to say	24	1%
How would you categorise your disability/disabilities?		
Physical impairment (e.g. mobility, sensory, chronic pain)	107	3%
Long-term health condition (e.g. diabetes, heart disease)	141	4%
Neurodivergent condition (e.g. ADHD, autism, dyslexia)	92	3%
Mental health condition (e.g. depression, anxiety)	137	4%
Cognitive or memory difficulty (e.g. dementia, brain injury)	2	0%
Hidden or invisible condition (e.g. chronic fatigue, fibromyalgia)	79	2%
My own description	28	1%
Prefer not to say	18	1%
What is your religion or belief?		
No religion or belief	1,074	31%
Buddhist	20	1%
Christian	1,135	33%
Hindu	210	6%
Jewish	38	1%
Muslim	434	13%
Sikh	95	3%
Other	45	1%
Prefer not to say	400	12%
Do you have unpaid caring responsibilities for a child/children and/or another adult(s)?		
Yes	958	28%
No	2,241	65%
Prefer not to say	252	7%
If yes, please select all that apply		

Demographic	Number	Percentage
For a child/children	714	21%
For an adult	306	9%
Prefer not to say	8	0%
Are you pregnant, on parental leave, or recently returned from parental leave?		
Yes	124	4%
No	3,130	91%
Prefer not to say	197	6%
What is your main language?		
English	3,208	93%
Other (including sign languages)	92	3%
Prefer not to say	150	4%
Do you speak any additional languages fluently (including sign languages)?		
Yes	1,030	30%
No	2,231	65%
Prefer not to say	190	5%
What was the occupation of your main household earner when you were aged about 14?		
Modern professional & traditional professional occupations	1,197	35%
Senior, middle or junior managers or administrators	485	14%
Clerical and intermediate occupations	161	5%
Technical and craft occupations	304	9%
Routine, semi-routine manual and service occupations	435	13%
Long-term unemployed	69	2%
Small business owners who employed less than 25 people	373	11%
Other / retired / / NA / don't know	80	2%
Prefer not to say	347	10%
Which type of school did you attend for the most time between the ages of 11 and 16?		
State-run or state-funded school	2,517	73%
Independent or fee-paying school	342	10%
Independent or fee-paying school (means-tested bursary for 90% of cost)	49	1%
Attended school outside the UK	315	9%
Don't know	14	0%
Prefer not to say	214	6%
If you finished school after 1980, were you eligible for free school meals at any point during your school years?		
Yes	533	15%
No	1,976	57%
Not applicable (finished school before 1980 or went to school overseas)	445	13%
Don't know	260	8%
Prefer not to say	237	7%
Which region does your main residence fall within?		
North East	114	3%
North West	329	10%
Yorkshire and Humber	272	8%
East Midlands	208	6%

Demographic	Number	Percentage
West Midlands	278	8%
East of England	181	5%
London	341	10%
South East	389	11%
South West	403	12%
Wales	192	6%
Scotland	318	9%
Northern Ireland	105	3%
Outside the UK	89	3%
Prefer not to say	231	7%