

**BEFORE THE FITNESS TO PRACTISE
COMMITTEE OF THE GENERAL OPTICAL
COUNCIL**

GENERAL OPTICAL COUNCIL

F(25)11

AND

JAMIL NANDA (01-23061)

**DETERMINATION OF A SUBSTANTIVE
REVIEW 25 SEPTEMBER 2026**

Committee Members: Louise Fox (Chair/Lay)
Miriam Karp (Lay)
Jackie Alexander (Lay)
Louise Gow (Optometrist)
Peena Govind (Optometrist)

Legal adviser: Helen Gower

GOC Presenting Officer: Leonie Hinds

Registrant: Present and represented

Registrant representative: Wendy Hewitt

Hearings Officer: Arjeta Shabani

Outcome: Not impaired and no further order.

DETERMINATION

Background

1. At the time of the events in question the Registrant was one of the Directors of [redacted] Visionplus Ltd, a branch of Specsavers. On 17 July 2023, the General Optical Council (“the Council”) received a referral regarding the Registrant from Specsavers Optical Group Limited. An internal investigation had been conducted by Specsavers’ Financial Risk Support (“FRS”) team, which had identified concerns regarding the Registrant’s practice, including the Registrant’s supervision of pre-registration Optometrists and the volume of clinical interactions performed by the Registrant.
2. The FRS team initially completed a preliminary remote analysis of the Practice to understand why there was a disparity between the Practice’s profits when compared with the Specsavers’ group average. As part of the investigation, the FRS team arranged for 10 mystery shopper visits to be undertaken within the Practice between 3 and 15 February 2023.
3. The mystery shopper visits were covertly recorded and the footage was reviewed by Mr A, Specsavers Professional Services Consultant. Mr A identified concerns that the two pre-registration Optometrists, for whom the Registrant was responsible for supervising, had both failed to obtain valid consent of their patients for their examination to be conducted by a pre-registration Optometrist, which was contrary to what the patient records indicated. Additionally, the two pre-registration Optometrists and the Registrant, all recorded examinations in the patient records which had not been performed or had recorded different results to those found.
4. Subsequently, the FRS investigation carried out a full internal investigation, which identified multiple concerns, as outlined in the FRS Investigation Report, dated 4 May 2023.
5. At the Final Hearing held on 13-16 October 2025 the Registrant made full admissions to the entirety of the allegation. The allegations involved:
 - The Registrant’s failure to provide adequate supervision to the pre-registrant Optometrists by providing insufficient supervision on days where he had more than 3 pre-registration Optometrists to supervised.
 - The Registrant’s failure to ensure that his operator code was accurately used for category dispenses and collections. Other employees had access to and used the Registrant’s code, undermining the intended safeguards and integrity of the records.
 - Patients were given misleading information regarding the cost of the sight test and there was a lack of transparency regarding the OCT scan being optional.
 - The Registrant failed to adhere to established procedures in clinical practice. When recording test results for unaided vision and best corrected visual acuity, he calculated estimations instead of recording the accurate

measurements and made inconsistent manual adjustments.

- In respect of a number of patient examinations the records of examinations carried out by the Registrant did not provide a true reflection of the examination he performed. For example, he recorded information in patient's histories that he had not elicited, failed to record information that his patient gave him, and documented test results when he had not performed the relevant examination.
 - The Registrant's conduct was dishonest in that he knowingly created false patient records, by, for example, recording results for eye examinations that had not been performed.
 - The Registrant breached patient confidentiality and data protection by failing to ensure that his screen was not visible to Patient 7.
6. The Final Hearing Committee was satisfied that the Registrant's conduct was serious and would be considered wholly unacceptable and deplorable by fellow practitioners. It determined that the facts admitted by the Registrant amounted to misconduct, with the exception of the breach of patient confidentiality and data protection which the Committee found was limited and not serious enough to amount to misconduct.
 7. The Final Hearing Committee heard evidence from the Registrant on steps he had taken to restructure the systems in the Practice, and the Registrant had also reflected and retrained. That Committee considered that the Registrant had only demonstrated limited insight into why his misconduct had occurred and therefore how to avoid it in the future. That Committee considered that there was evidence that the Registrant's misconduct appeared to be longstanding and ingrained, and that he had yet to fully acknowledge his pattern of behaviour. That Committee also considered that the Registrant lacked insight into the impact of his inadequate supervision upon the pre-registration Optometrists and the profession. The Committee found that the Registrant had not yet fully remediated and that the risk of the Registrant repeating the misconduct remained.
 8. The Final Hearing Committee decided that the Registrant's fitness to practise was impaired on public protection grounds and on public interest grounds.
 9. The Final Hearing Committee determined that the appropriate and proportionate sanction was a Suspension Order for a period of 12 months to address the public interest concerns that it had identified. The Committee noted that imposing a suspension, rather than erasure, had been a finely balanced decision and one of the factors favouring suspension was to give the Registrant the opportunity to develop his insight further. The Final Hearing Panel considered that a Review Committee may be assisted by:
 - An in-depth reflective statement demonstrating wider reflections and insight into the motivations and/or causes that led to the misconduct occurring;
 - Any further evidence of remediation, such as further CPD, self-directed learning or peer review training, shadowing or mentoring.
 10. This Committee was provided with a 185 page Registrant's bundle which included: a reflective statement; reflections on mentoring sessions; an

independent monitoring report; CPD certificates and reflections on CPD; a development and restoration plan; reflections on peer review; testimonials; reflections on [redacted], and an “*unconscious motivators psychological report*”.

11. On behalf of the GOC, Ms Hinds invited the Committee to assess the evidence provided by the Registrant. She acknowledged that the evidence provided went further than the evidence at the substantive hearing and that it was capable of showing that the risk has reduced significantly. It was a matter for the Committee to assess whether the risk has reduced sufficiently and whether public confidence would be maintained if the Registrant was permitted to return to unrestricted practice. Ms Hinds confirmed that, following receipt of the Registrant's bundle, the GOC's position was neutral in respect of whether the Registrant's fitness to practise remained impaired.
12. The Registrant gave evidence to the Committee. His evidence was consistent with the written material in the bundle and addressed the concerns about his insight which were described by the Final Hearing Committee. The Registrant spoke about his understanding of the reasons he acted as he did. He acknowledged that at the time of the Final Hearing he was trying to justify what had happened rather than looking at the deeper reasons for his behaviour. He had a tendency to want to prove himself, his vulnerability is his desire to please, and he was susceptible to commercial pressures. He had, over a period of time, rationalised decisions that were wrong.
13. The Registrant spoke about the impact of his behaviour on his patients. He deeply regretted that patients, some of whom had been loyal to him for twenty years, were not given the full information to enable them to make decisions. The Registrant said that he had no right not to give them the information and that his behaviour undermined public confidence in the profession.
14. In respect of his dishonesty, the Registrant said that his behaviour had become normalised. This was a serious breach of trust and undermined his integrity. The Registrant said that one of the biggest challenges for him during his suspension has been to address the reasons for his dishonesty. He now understands the warning signs for any challenge to his ethical standards, and he would seek guidance and support from his peers or his external mentor.
15. During the year of his suspension the Registrant has been working as a retail director for the Practice. His focus has been on ensuring that the business follows the GOC standards, that consent from patients is obtained and that procedures are in accordance with guidelines.
16. The Registrant said that in future if he were subject to commercial pressures he would stop, think, seek advice from colleagues and devise a plan. He would advise those who might place pressure on him of the best that could be achieved while maintaining professional standards. He gave an example of where he had said “no” while working during his suspension as the Retail Director. He had said that the volume of patients could not be further increased.
17. In relation to challenges within his personal life, the Registrant said that if things became difficult he would take himself out of work, talk to people, and address matters through [redacted]. He would not keep things to himself.
18. The Registrant frankly told the Committee that it had been hard for him to undertake [redacted] and mentoring during his suspension, but that he had fully

engaged with his mentor and his [redacted], and the process of remedial work had become easier.

19. The Registrant was asked about the CPD he had completed on probity and ethics, maintaining professional ethics, and ethics and ethical standards. The Registrant described his learning from each course. For example, the course on maintaining professional ethics in March 2026 was a one-to-one course. This allowed the Registrant to understand that he is a “people pleaser” and that through small lapses he had slowly normalised behaviour that was wrong.
20. In relation to his development and restoration plan, the Registrant had listed the CPD courses he would carry out and he had also made a pledge that he would be honest and caring in his professional responsibilities.
21. The Registrant said that his peer review with Mr B is ongoing. If an issue came up the Registrant would speak with Mr B. The Registrant also has contact every two weeks with a College of Optometrists Assessor, who ensures that the pre-registration trainees in the Practice are appropriately supervised.
22. The Registrant told the Committee that safeguards are now in place for pre-registration trainees. There are four supervisors within the Practice, and clinics are structured to ensure that students only see the recommended number of patients and no more, and there is time set aside for discussions and weekly meetings.
23. The Registrant said that the Committee can be reassured that there would be no repetition of dishonesty because he has deeply reflected and now understands the reasons he behaved as he did. He no longer feels the need to prove himself. He has looked at the person shown in the video evidence of the mystery shoppers, which is himself, and he does not want to be the person in that video.
24. On behalf of the Registrant, Ms Hewitt submitted that the Registrant has provided impressive and compelling evidence and she invited the Committee to conclude that the Registrant’s fitness to practise is no longer impaired. She submitted that the Registrant’s insight is fully embedded and that he has fully remediated his misconduct. She submitted that an informed member of the public should not have concerns or loss of confidence, given that the regulatory process has required the Registrant to demonstrate that he is no longer a risk to members of the public.

Findings regarding impairment

25. The Committee has accepted the advice of the Legal Adviser. The Committee was advised that at a Review hearing, there is in effect a persuasive burden upon a registrant to demonstrate that they are fit to resume unrestricted practice. The context of the Committee’s decision is the overarching objective of protecting the public, upholding and maintaining public confidence in the profession, and upholding professional standards. The Committee should exercise its own judgment in assessing the Registrant’s current level of insight in light of the information provided.
26. The Legal Adviser advised that its powers were set out at section 13F of the Opticians Act 1989 should the Committee find current impairment. In considering

sanction the Committee should bear in mind the requirement of proportionality. Any sanction must be sufficient to protect the public and the public interest and the minimum that is sufficient for that purpose.

27. The Committee carefully reviewed the documents provided by the Registrant and the Registrant's oral evidence. In respect of the documents the Committee noted that there was independent evidence which confirmed the Registrant's full participation and engagement with reflection, [redacted], peer review discussions, and relevant and targeted CPD. For example, the independent mentoring report from Mr C dated 18 May 2026 confirmed the dates when the Registrant met with Mr C and a summary of the topics discussed.
28. The Committee considered that the Registrant's reflective statement was impressive and persuasive evidence. The Registrant had addressed each of the areas within the admitted allegations, and had considered the impact of his behaviour on patients, pre- registration trainees, colleagues, his employer, and public confidence in the profession. The Registrant had also reflected on and addressed the concerns identified by the Final Hearing Committee relating to his level of insight. He had thought about the underlying reasons for his conduct, and he acknowledged that over a period of time his conduct had become deeply embedded. The statement also incorporated the Registrant's learning from the CPD he had completed. The Committee was satisfied that the CPD completed by the Registrant was not simply a box ticking or an academic exercise. The Registrant had applied himself, had been willing to be challenged within the training, and had provided detailed written reflections on his learning. The Committee was also satisfied that the Registrant has a professional support network and that he now understands the importance of checking and engaging in discussion about his judgments and key decisions with his support network.
29. The Registrant also provided impressive testimonials from his peers, colleagues and former trainees. The individuals who provided the testimonials were aware of the allegations admitted by the Registrant and the purpose of their testimonial. The testimonials demonstrated that the Registrant has openly discussed the findings of the Final Hearing Committee with his peers and the importance of placing professional standards and the needs of patients first, ahead of commercial considerations. The Registrant's peers describe that the Registrant has an understanding of what went wrong and that there have been changes in the Registrant's confidence and communication skills.
30. Having carefully reviewed the evidence, the Committee did not identify any further steps that the Registrant might take to reflect on or to remediate his misconduct. The Committee's assessment was that the Registrant had demonstrated a good level of insight. Although dishonesty is very difficult to remediate, the Committee was of the view that the Registrant had taken remedial steps to reduce, as far as possible, the risk that he might repeat similar conduct. The Registrant works in a senior position in a commercial environment, and it is highly likely that in the future he will be placed in a situation that tests his integrity. The Registrant is now aware of his vulnerabilities, and the Committee's assessment was that it was highly unlikely that he would repeat dishonest conduct, or any of the other conduct found proved by the Final Hearing Committee.
31. Having decided that the risk of repetition is very low the Committee concluded that there is no ongoing risk to public safety, and that the Registrant's fitness to

practise is not impaired on the basis of the personal component of impairment.

32. The Committee also considered the need to uphold and maintain public confidence in the profession and to uphold professional standards. The purpose of a review hearing is to monitor the Registrant's progress and is not to make a reassessment of the gravity of the misconduct. The Committee considered that an informed member of the public would be reassured that there has been a significant change in the level of the Registrant's insight, that the risk of repetition of misconduct is very low, and that there is no ongoing risk to public safety. The Committee concluded that public confidence in the profession and the regulatory process would not be undermined if the Committee permitted the Registrant to practise without restriction.
33. The Committee therefore concluded that the Registrant's fitness to practise is not impaired on the basis of the public component.
34. The Committee found that the fitness of Jamil Nanda to practise as an optometrist is not impaired. The current Suspension Order will expire on 12 November 2026 and the Registrant will remain subject to that order until that date.
35. The Committee makes a formal declaration that the Registrant's fitness to practise is no longer impaired for the reasons above.

Chairman of the Committee: Louise Fox



Signature

Date: 25 September 2026

Registrant: Jamil Nanda

Signature ...present via video conference

Date: 25 September 2026

FURTHER INFORMATION
Transcript
A full transcript of the hearing will be made available for purchase in due course.
Appeal
Any appeal against an order of the Committee must be lodged with the relevant court within 28 days of the service of this notification. If no appeal is lodged, the order will take effect at the end of that period. The relevant court is shown at section 23G(4)(a)-(c) of the Opticians Act 1989 (as amended).
Professional Standards Authority
This decision will be reported to the Professional Standards Authority (PSA) under the provisions of section 29 of the NHS Reform and Healthcare Professions Act 2002. PSA may refer this case to the High Court of Justice in England and Wales, the Court of Session in Scotland or the High Court of Justice in Northern Ireland as appropriate if they decide that a decision has been insufficient to protect the public and/or should not have been made, and if they consider that referral is desirable for the protection of the public. Where a registrant can appeal against a decision, the Authority has 40 days beginning with the day which is the last day in which you can appeal. Where a registrant cannot appeal against the outcome of a hearing, the Authority's appeal period is 56 days beginning with the day in which notification of the decision was served on you. PSA will notify you promptly of a decision to refer. A letter will be sent by recorded delivery to your registered address (unless PSA has been notified by the GOC of a change of address). Further information about the PSA can be obtained from its website at www.professionalstandards.org.uk or by telephone on 020 7389 8030.
Contact
If you require any further information, please contact the Council's Hearings Manager at Level 29, One Canada Square, London, E14 5AA or by telephone, on 020 7580 3898.