Introducing mandatory eyesight testing for older drivers

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a healthcare organisation for eyesight

Final comments

Q23. Any other comments?

The Royal College of Ophthalmologists recognises the importance of good vision for safe driving, and the need to identify drivers who do not meet legal driving vision standards. The current system relies heavily on self-declaration, which is inadequate where drivers are not aware of, or do not report, their visual impairment. This consultation process should be used as an opportunity to improve the guidance on driving vision standards.

The College supports, in principle, reform of driving vision standards, including the introduction of mandatory eyesight testing for older drivers at the point of licence renewal, while not endorsing a specific testing model at this stage.

To ensure reforms are effective, the issues of poor evidence base, likelihood of increase in referrals and the potential for age discrimination need to be addressed. These issues currently qualify the College's support for the proposals. If these matters are satisfactorily addressed, the College could reconsider the strength of its support.

Evidence base for policy change

The College is concerned that the precise levels of visual acuity and visual field loss associated with collision risk is poorly evidenced. Routine post-collision data collection rarely includes formal assessment of drivers' vision, and the coding of collision causes is weak. This limits the evidence base needed to develop effective policy.

Further research may help to identify the standards that should be consistently applied to drivers' eyesight tests. But international evidence shows little consensus on the minimum visual acuity or visual field thresholds required for safe driving. This highlights the difficulty of defining a universal standard. In the absence of compelling supporting evidence, policy development should include a commitment to improve data capture and evaluation and to revise guidance in light of further information. Without reliable data, it is difficult to determine whether the proposals for mandatory eyesight tests for older drivers will improve road safety.

At this stage, the College does not take a position on specific test modalities, thresholds, or delivery models. However, it would support efforts to strengthen the evidence base alongside implementation, including improved data collection and post-implementation evaluation.

Proportionality of policy change

Any change to driving vision standards that relies on age thresholds should be clearly justified by robust evidence, proportionate to the risk identified and compliant with existing equality legislation. It should consider the potential impact on older drivers.

Likelihood of increase in referrals to hospital eye services

A key concern is the potential impact on NHS capacity. This may arise through the unintended consequences of increasing eyesight testing for older drivers, which could significantly increase referrals to hospital eye services.

Even among healthy older individuals, up to 20% may perform poorly on visual field tests, creating false positives that require specialist assessment. This could increase demand on already overstretched NHS ophthalmology services.

A similar increase in NHS burden is seen in false-positive glaucoma referrals from optometry, which accounts for up to 50% of referrals for the condition. The presence of glaucoma rises steeply with age. Greater testing of older drivers will increase unnecessary referrals for a range of suspected eye conditions, leading to an increased burden on hospital appointments, exacerbating capacity pressures and the need for additional funding.

To mitigate this, the government should take steps to ensure that the accuracy of ophthalmology referrals from primary care is improved. One approach is appropriately commissioned repeat measures, where optometrists are funded by ICBs to repeat certain tests to confirm abnormal findings before referring patients. This reduces referrals based on a single abnormal result, lowering unnecessary referrals and increasing the likelihood that referred patients have genuine disease.

Another approach is enhanced case finding, where optometrists identify potential disease earlier or more systematically, for example through targeted testing of higher-risk groups. Together, these interventions strengthen pathways between optometry and hospital eye services by reducing avoidable referrals and ensuring patients with the most complex or high-risk conditions are seen and treated sooner, helping protect hospital capacity.

Regional disparities would increase owing to the variable availability of Esterman/field-testing equipment (often used in testing fitness to drive) within community optometry settings. The Esterman test assesses a person's peripheral (side) vision. It presents lights at set locations across the visual field and records

Q23. Any other comments?

which points are seen or missed; helping to identify retained and lost field of vision.

The costs of any mandatory eyesight testing, if incurred by the driver, should not be structured in a way that deters compliance or creates inequitable barriers to access, particularly for older people and those from disadvantaged groups.

Behavioural changes and driver compliance

The College notes the potential for unintended behavioural consequences arising from changes to driving vision standards. There is a risk that some individuals may continue to drive despite no longer meeting the required standards. This may occur because they do not understand the requirement, dispute the outcome of a test, or are reluctant to stop driving given the significant impact on their independence, employment or daily life. This underlines the importance of ensuring that any revised guidance is clear, evidence-based and proportionate, and is supported by effective patient communication, appropriate clinical guidance and realistic consideration of driver compliance.

Role of ophthalmologists in driving vision standards

Revisions to guidance should recognise that ophthalmologists should not be responsible for enforcing existing standards or for referring older drivers for eyesight tests. Ophthalmologists' primary duty is to diagnose and treat eye disease. Requiring ophthalmologists to assess or report drivers' fitness to meet legal eyesight standards could compromise the doctor–patient relationship and undermine trust if confidentiality concerns are not carefully addressed.

Conclusion

The College supports reform of driving vision standards in principle, including the introduction of mandatory eyesight testing for older drivers at the point of licence renewal. However, the current evidence base is insufficient for the College to support a specific eyesight testing model for older drivers. Policymakers should prioritise improving collision data, strengthening the evidence base, and carefully assessing the health system impacts of any proposed changes to strengthen the impact of policy change.

Road safety in older drivers depends on many health factors, not just eyesight, and policy responses should reflect this broader context. Good visual acuity alone does not guarantee safe driving, especially when many older drivers experience comorbidities. Conditions such as dementia, cognitive decline and medication side-effects can all impair attention, reaction time and judgment. Policies focused on vision testing should be complementary to wider medical and health considerations in order to have a positive impact in reducing collision risk and increasing road safety.