

STRUCTURED WEBSITE AUDIT | 2026

Patient Information and Access Across 200 Aesthetic Clinic Websites

A structured audit of patient-facing websites identified through UK aesthetic-clinic listings

THE AUDIT LENS

A deliberately practical question: what could a prospective patient find, understand and do before contacting the clinic?

The study measured the public website journey under consistent, time-limited conditions. It did not assess clinical quality, rank providers or measure what happened after an enquiry.

Website-only audit with no staff-directed enquiries; a limited chatbot test was conducted only where automation was explicit. Findings describe the websites audited, not all aesthetic clinics in the UK.

200

patient-facing websites

Unique canonical domains identified through UK aesthetic-clinic listings.

3 min

per information-finding task

The timer continued through loading, pop-ups, cookie banners and navigation.

120 + 80

non-surgical + surgical/mixed

50 surgical, 30 mixed and 120 non-surgical website journeys.

FINDINGS AT A GLANCE

Four numbers describe the central gap.

Core information = explanation, downtime/recovery, suitability/contraindications and any risk/side-effect wording. Presence was measured; completeness and clinical adequacy were not.

51%

offered a selected-page action without the complete core information set

102/200 websites

48%

showed neither risks nor suitability information for the selected service

96/200 websites

46.5%

helped the visitor move from a tested concern to relevant options

93/200 websites

3%

passed the strict question-first task without requiring identification

6/200 websites

NON-SURGICAL NAVIGATION

Treatment catalogues were common. Concern-led orientation was not.

For a visitor who begins with a concern rather than a treatment name, only one quarter of non-surgical websites connected that concern to relevant options.



Non-surgical websites, n=120. These are related but independent measures, not cumulative funnel stages. Surgical and mixed visitors were more often tested using a procedure they already knew.

SELECTED-SERVICE INFORMATION

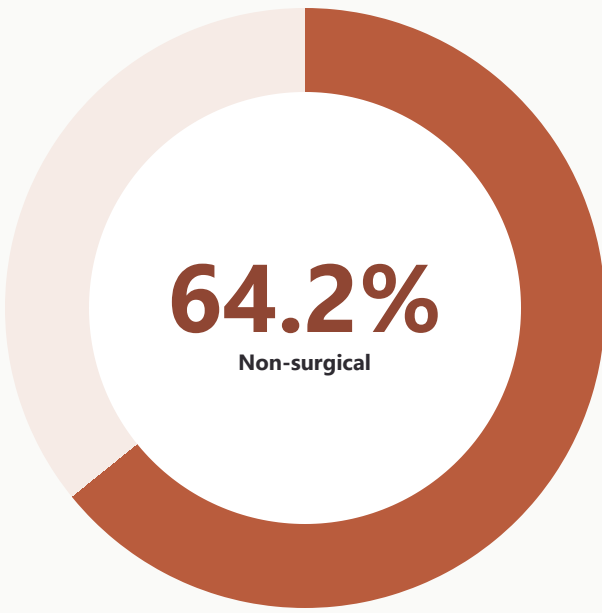
For nearly half, neither risk nor suitability information was found.

48%

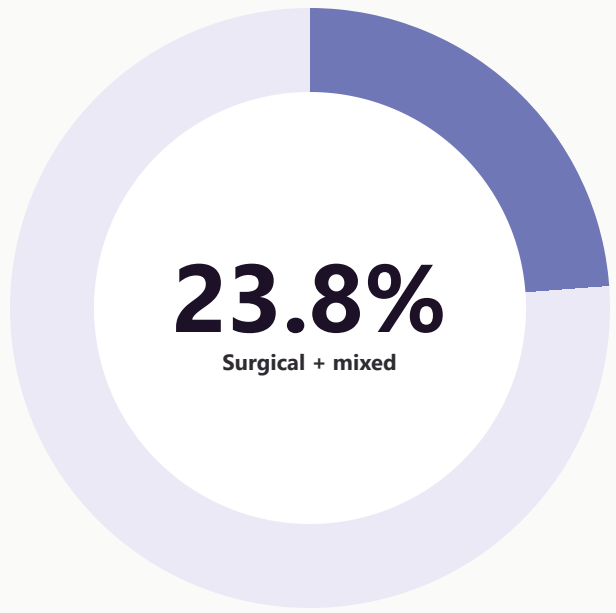
96 of 200 websites

No risk or side-effect wording and no suitability or contraindication information were visible for the selected service within the audit conditions.

Important: “mentioned” was a presence-only field. A yes did not mean that disclosure was complete, balanced, procedure-specific or sufficient for consent.



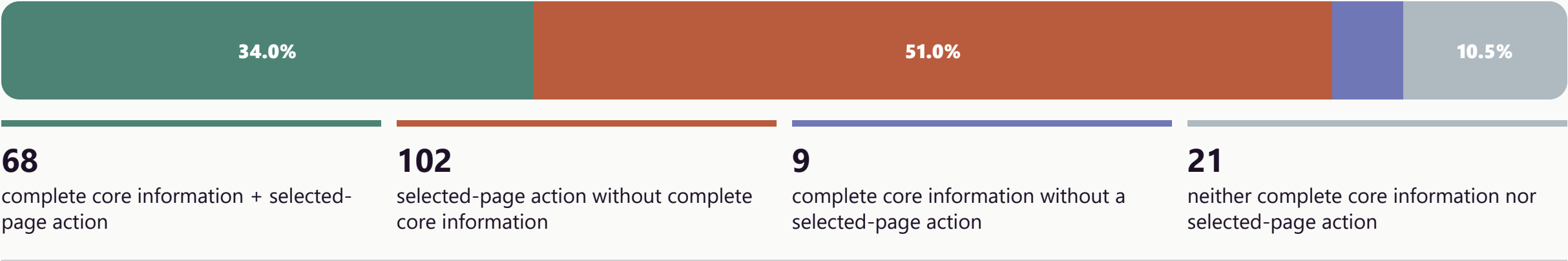
77 of 120 non-surgical websites



19 of 80 surgical or mixed websites

The largest website profile enabled action before completing the audited information journey.

A selected-page action was found on 170/200 websites. Only 68 combined that action with all four core information elements.



All websites, n=200. "Action" includes the audited booking, consultation, callback, form or phone actions found on the selected page.

NON-SURGICAL WEBSITES WITH ONLINE BOOKING

Even when visitors could see a price and book online, important information was often missing.

46.7%

had all four website elements

56/120 non-surgical websites

We isolated non-surgical websites that combined four elements: a treatment page, a treatment price found either on the site or during booking, an online-booking pathway and a clear on-page next step.

75%
lacked the complete core information set
42/56

55.4%
showed neither risks nor suitability
31/56

30.4%
did not identify the exact practitioner
17/56

PRICE VISIBILITY

Half showed a treatment price directly. Another 15% revealed it only inside a booking flow.

The combined 64.5% figure should not be shortened to “showed prices on their websites.” Where the price appeared formed part of the visitor journey.



Consultation prices were audited separately and only on the public website, not inside the booking flow.

SURGICAL AND MIXED WEBSITES

Consultation requests were common. Explaining the consultation was less consistent.

83.8%

offered a consultation-request pathway

67/80 surgical or mixed websites. This was the appropriate next-step measure; immediate treatment booking was not treated as the standard for surgery.

47.5%

of consultation-enabled journeys showed neither a consultation price nor an explanation of the first-consultation process

61 websites that combined a dedicated page, consultation-request pathway and selected-page action

Surgery begins with a consultation. The relevant next step is not “book the operation now,” but explaining what the consultation involves, what it may cost and how to request it. A pathway was counted when visitors could request a consultation from the selected procedure page or elsewhere on the website.

WHO PROVIDES CARE?

On non-surgical websites, practitioner transparency was incomplete.

Only 66 of 120 showed both a named practitioner and a professional registration or qualifying credential.



29/95

websites that named someone did not show a qualifying credential

30.5% of the 95 non-surgical websites with a named practitioner

Important boundary: “not shown” means the visitor could not verify a professional registration or qualifying credential on the website within the audit conditions. It does not mean the practitioner lacked one.

Non-surgical websites, n=120. These three categories are mutually exclusive and use only the audited “practitioner named” and “professional registration or qualifying credential shown” fields.

CONTACT AND AFTER-HOURS ACCESS

Being contactable was not the same as being able to answer the visitor now.

98%

offered at least one phone, email, form,
WhatsApp or chat channel

196/200 websites

VERSUS

3%

passed the strict question-first task
without requiring identifying details

6/200 websites

A form, email or WhatsApp route can accept a message outside opening hours. It does not establish that the visitor receives an immediate answer, how quickly staff respond or whether the response resolves the question.

Visit planning: among the 182 websites where an address or location was found, **93/182 (51.1%)** did not show opening hours.

Most websites fell into the poor mobile loading bands.

84%

recorded poor mobile LCP

168 of 200 websites

Only

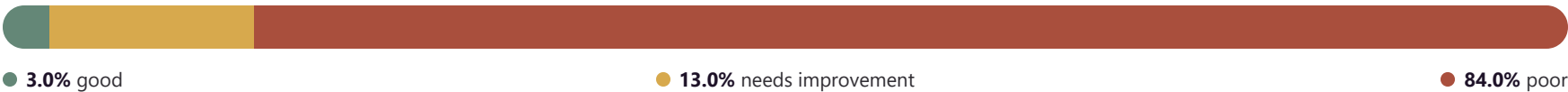
6%

achieved a green overall mobile performance score

12 of 200 websites

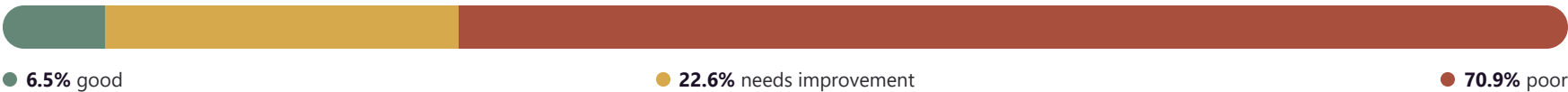
Mobile LCP

Largest content element: ≤2.5s / 2.5–4s / >4s



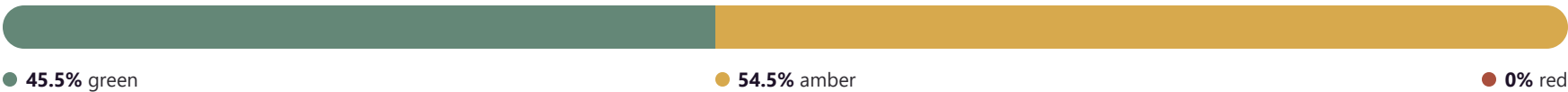
Mobile FCP

First content: ≤1.8s / 1.8–3s / >3s



Automated accessibility

Scores: 90–100 / 50–89 / 0–49



Single-run Google PageSpeed/Lighthouse mobile lab results. Loading indicators are not exact patient waiting times, and automated accessibility scores are not complete accessibility assessments. Valid n=200 except FCP, n=199.

IMPROVEMENT PRIORITIES

Two website models require different next steps.

Non-surgical websites

- Build genuine concern-to-option routes instead of relying on treatment and brand lists.
- Use a consistent page structure covering explanation, recovery, suitability and risk wording.
- Make prices visible before the visitor has to enter a booking flow where possible.
- Connect every service to the exact practitioner who provides it.

Surgical and mixed websites

- Keep consultation request as the appropriate next step rather than pushing immediate treatment booking.
- Explain the first consultation, its likely price and what happens after the request.
- Keep provider, credential, recovery and risk-related information close to the selected procedure.
- Use page-level actions that follow, rather than interrupt, the information journey.

The audit allowed three minutes per task - already a generous amount of attention for a real visitor. Essential information should be findable substantially faster.

Designed for careful interpretation and reproducible calculations.

Audit method

- Google Maps listings collected through Apify, filtered for relevance and checked for a live website URL.
- The audit unit was the patient-facing website/domain; 200 unique canonical domains were included.
- Passive, website-only assessment outside normal clinic hours; no forms, bookings or messages were submitted.
- Each information-finding task had a three-minute limit, including loading and navigation friction.
- Fixed concern/procedure scenarios and documented Y/N/N/A coding rules were used.
- Results are reported for all websites and, where relevant, for non-surgical versus surgical/mixed websites.

Interpretation boundaries

- The sample is not claimed to represent every aesthetic clinic in the UK.
- “Not found” means not visible within the audit conditions; it does not prove absence outside the website.
- Risk, suitability and credential measures recorded visibility, not clinical adequacy or actual qualifications.
- The audit did not measure clinical quality, response speed, conversion, revenue or causation.

Declaration of interest. iGlowly develops patient-information software for aesthetic-clinic websites. The published codebook, de-identified data and calculation workbook allow the aggregate findings to be checked independently.

[ACCESS THE FULL RESEARCH](#)

Read the study, check the codebook, reproduce the calculations.

Everything behind these findings is published so the aggregate results can be checked independently.

Dataset DOI: [10.5281/zenodo.21764680](https://doi.org/10.5281/zenodo.21764680)

CSV

De-identified dataset

The full de-identified audit data for all 200 websites.

ZIP

Audit codebook

The documented coding rules and field definitions used across all 200 websites.

XLSX

Published calculations

The workbook reproducing every percentage and combined measure, with QA checks.

[READ THE FULL STUDY](#)

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www.iglowly.com/en/research/uk-aesthetic-clinic-website-audit-2026

Report DOI: [10.5281/zenodo.21764660](https://doi.org/10.5281/zenodo.21764660)

Findings describe the websites audited, not all aesthetic clinics in the UK. Presence-only measures record website visibility, not clinical adequacy.