Public Accounts Committee

Submission of written evidence to the inquiry 'Reducing NHS waiting times for elective care'

July 2025

About The Royal College of Ophthalmologists

The Royal College of Ophthalmologists (RCOphth) provides training, professional development and clinical guidance for our more than 4,000 members who include ophthalmologists in training, consultants, SAS doctors and other eye care professionals such as optometrists. We ensure high standards of patient care in the prevention and treatment of eye diseases and other eye conditions. We are the only membership body and representative voice for ophthalmologists in the UK. We champion the ophthalmic profession and advocate on behalf of our members to ensure high standards of patient care and the workforce needed to deliver this.

Summary

- Ophthalmology is the busiest NHS outpatient specialty, with nearly 9 million attendances in England during 2023/24. Almost 600,000 patients are currently waiting for a first appointment with an ophthalmologist. Huge improvements have been made locally to cut waiting times through targeted interventions. In Devon, cataract waiting times reduced from 55 weeks to 2.5 weeks through its One Devon Elective Pilot. More detail on this and other best practice examples is summarised in paragraphs 9-14.
- National support from NHS England and DHSC is needed to ensure these proven cost-effective examples of good practice can be rolled out in ophthalmology units across England, helping to cut waiting times.
- There has been a systematic lack of focus on follow-up appointments which hampers access to care for high-risk patients. This is exacerbated by the fact that this data is not published regularly by NHS England and there are no specific waiting list targets relating to follow-up appointments. A 2023 report by the Re:state thinktank on 'The Hidden Waitlist' found that ophthalmology was the specialty with the most follow-up waits. Follow-ups are crucial for managing long-term, chronic, sight-threatening eye diseases like complex glaucoma and wet age-related macular degeneration (AMD).
- The uncontrolled use and lack of effective oversight of independent sector providers (ISPs) is hampering the ability of ophthalmology services to best match limited resources with patient need. The Centre for Health and the Public Interest (CHPI) found that the NHS spent £700 million on cataract provision in the independent sector between 2018 and 2023. Over the same period, total NHS spending on cataract services roughly doubled. The rapid increase of ISPs delivering NHS cataract surgery since the pandemic has diverted funding and staff there at the expense of comprehensive NHS ophthalmology services which deliver care for higher risk conditions – crucial for preventing irreversible sight loss. RCOphth's 2024 survey found that 67% of ophthalmology clinical leads feel that independent sector provision has had a negative impact on patient care.
- Workforce shortages in most units, coupled with insufficient training numbers to meet future demand are significant challenges to any policies intending to cut waiting lists and provide sustained relief of pressure on hospital eye services.

Progress on targets to increase elective activity and end long waits for treatment

Ophthalmology RTT waiting lists

1. Ophthalmology services represented 8.5% of the NHS total in 2023/24. Like many specialties, waiting lists have risen since the pandemic. Although latest RTT figures show that there were over 586,000 patients waiting for an appointment with an ophthalmologist in March 2025, rising by 6,000 since January, there is welcome improvement for those waiting the longest. Median waiting times for ophthalmology patients dropped from 11.5 to 9.9 weeks in the first four months of the year, with 68.2% of patients treated within the 18-week target. By contrast, in January 2019, 86.3% were seen in that timeframe and the median wait was only 8.1 weeks.
2. It is essential to reduce waiting lists because pressure on hospital eye services will increase over the coming decades as the population continues to grow and live longer, leading to an increase in eye health conditions, especially among older people.
3. Longer waits for diagnosis and treatment increase the risk of otherwise avoidable, irreversible sight loss for patients with more serious conditions such as wet AMD and complex glaucoma.
4. Identifying what is driving progress on reducing waiting lists and targeting funding to cost-effective innovations that are proven to work will deliver large reductions in waiting lists. Paragraphs 9-14 set out policy interventions that have been shown to be effective.
5. RCOphth's 2024 survey of clinical leads found that 70% were more concerned about the impact of outpatient backlogs in their department on patient care than they were 12 months earlier. Clinical leads were most concerned about outpatient backlogs in glaucoma (64%) and medical retina (54%), sub-specialties largely focused on follow-up patients.

Follow-up waits

6. The neglect of follow-up waiting lists and the lack of scrutiny is hugely concerning. A 2023 report by the Re:state thinktank found that ophthalmology has the most follow-up waits, at 10,000 per NHS trust. Because of the lack of specialised knowledge and equipment needed to manage chronic eye conditions in primary care, hospital outpatient follow-up appointments make up a significant proportion of the ophthalmology workload.
7. Data on follow-up cases and risk rating is not effectively integrated into the decision-making process of commissioners and NHS trusts. A stronger focus is needed on clinical risk when managing waiting lists. One solution would be for NHS trusts in England to report risk ratings alongside Latest Clinically Appropriate Date (LCAD) data, as in Wales. Regular publication of this data would help prioritise patients at risk of irreversible sight loss and encourage timely access to ophthalmic care.

Workforce shortages

8. Long waits for treatment are compounded by workforce shortages. RCOphth's 2022 Census Report found that more than three quarters (76%) of NHS eye units did not have enough consultants to meet current patient demand and over half (52%) found it more difficult to recruit consultants over the last 12 months. Based on the minimum recommended three full time equivalent (FTE) consultant to 100,000 population ratio, an additional 285 ophthalmology training places need to be phased in by 2031 to meet demand for services.

Progress across the three areas of diagnosis, surgery, and outpatients

Innovation

9. There are examples of how NHS England's Targeted Investment Funding has been used to improve ophthalmology services in different parts of the country. RCOphth published a case study on the One Devon Elective Pilot, which was supported by Getting it Right First Time (GIRFT). The clinician-led approach aims to reduce unwarranted variation between NHS surgical services across settings. The NHS Nightingale Hospital Exeter's Centre of Excellence for Eyes surgical hub opened in February 2022. It runs a high-volume, low-complexity (HVLC) cataract theatre alongside diagnostic lanes for medical retina and glaucoma. The pilot increased elective activity and ended long waits for treatment by introducing three new treatment pathways for cataracts, medical retina and glaucoma. The result was to clear waiting lists of 4,000 patients for both glaucoma and medical retina, and 1,500 for cataracts.
10. For medical retina, consultant time is concentrated on patients with the most urgent treatment needs. Virtual pods reduce face-to-face appointments and enable the consultant to provide clinical opinions and practitioners to oversee treatment decisions. They typically involve a team of three to four practitioners and one consultant. The practitioners are assembled from band six nurses (5 full time equivalents (FTE)), band seven nurses (1.5 FTE), a band seven orthoptist (1 FTE), optometrists (two band sevens (2 FTE) and one band eight (1 FTE)) and a band six ophthalmic photographer (1 FTE). Resident doctors attend on an ad-hoc basis to enhance their learning or do their virtual reviews supported by a consultant. Up to 58 virtual reviews are conducted in a four-hour session.
11. For routine glaucoma patients, only those requiring further tests or a face-to-face examination need to visit the hospital. Patients are prioritised by need through better use of digital technology, such as the Zeiss Forum ophthalmic data management platform that improves diagnostic accuracy and provides clinicians with a detailed patient medical record. This is an example of the investment in IT and digital infrastructure that is necessary to achieve the government's target of shifting the NHS from an analogue to digital service.
12. Other hospitals, such as Ninewells in Dundee (NHS Tayside), have trialled a high-volume Immediate Sequential Bilateral Cataract Surgery (ISBCS) model. Performing cataract surgeries in both eyes during the same hospital visit has proven to be an effective and innovative surgical pathway that significantly reduces backlogs and improves efficiency.
13. The single point of access (SPoA) model has successfully reduced waiting times by streamlining referrals for specific eye diseases. Accelerator funding in North Central London has enabled the handling of over 25,000 referrals from optometry since July 2023. The referral triage system significantly reduces inappropriate and duplicate referrals. This is essential to reducing the pressure on ophthalmology services. The SPoA model can be expanded to other ophthalmology units and specialties.
14. These selected examples of best practice in ophthalmology units throughout the country show that the specialty has successfully modernised and innovated over the last five years. Targeted support is needed to sustain established work and expand it beyond pilots. This will ensure that all areas of the workforce benefit from development and all patients have the same access to timely care.

Governance and oversight of the transformation programmes

15. RCOphth is concerned that the current commissioning framework does not enable local systems to allocate resources most effectively according to patient need. This is most evident in the rapid and uncontrolled expansion of NHS cataract surgery delivered by

independent sector providers. Limited commissioner oversight of this investment threatens the stability and sustainability of comprehensive NHS ophthalmic services.

16. Between 2018/19 and 2022/23, annual spending on NHS-funded cataract operations in the independent sector rose by 458%, resulting in a 57% increase in the total number of cataract procedures performed.
17. A recent Sunday Times investigation highlighted issues of patient safety and value for money arising from apparent inducements for referrals and unnecessary follow-up appointments. The article said that ISPs delivering NHS cataract surgery face claims they have artificially inflated costs for the taxpayer.
18. RCOphth wrote to the National Audit Office in November 2024 to suggest the watchdog examines the impact of independent sector provision of NHS services as part of its report on NHS England's management of elective care transformation programmes.
19. The CHPI report 'Out of sight: the hidden profits and conflicts of interest behind the outsourcing of NHS cataract care' looks at the issue in depth. Since 2017, there has been an increase of 31% (equivalent to £2.7bn) on independent sector provision of NHS services. The number of NHS cataract procedures performed by ISPs increased by 344% over the same period. The proportion of NHS cataract operations undertaken by ISPs increased from 24% to 55%. Annual spend on NHS cataract procedures undertaken by ISPs and the NHS increased by 109% and the proportion of the NHS ophthalmology budget spent on cataracts increased from 27% to 36%.
20. CHPI researchers determined that, "*the expenditure records of 42 ICBs for 2023/24 found that £536 million was spent on five private companies which generate most of their annual income from delivering NHS funded eye care services*." They raise the concern that, "*The NHS patient choice regulations, in effect, allow private companies to demand a contract from their local NHS ICB even if there is no identified need for them, and ICBs are unable to refuse to them because of these rules as long as they are able to deliver a healthcare service in the way specified by the NHS*." There is a knock-on effect on patient safety: "*The ability of companies to provide thousands of cataract operations on a non-contract basis also poses a potential risk to patient safety as it limits the ability of the ICB to have control and oversight of the care that is being delivered*."
21. CHPI's research indicates that in 2021/2022 14% of ISP-delivered cataract surgery was on a non-contracted basis – rising to 25% in seven integrated care boards. This question of value for money and making the best use of scarce resources is paramount.
22. RCOphth suggests a review should look into non-contracted activity, potential upcoding practices, and payments in referral pathways. Patient safety must be paramount, especially in relation to the management of post-operative complications. A rebalancing is necessary to ensure best use of limited resources to meet patient need, where prioritisation by urgency prevents unnecessary irreversible sight loss. Without such interventions, there is a significant threat to the long-term sustainability of NHS ophthalmology services. These areas would be strong contenders for areas that the Committee should investigate when determining what is good value for money in reducing waiting times for elective treatment.
23. Our 2024 survey found that 67% of ophthalmology clinical leads feel that independent sector provision has had a negative impact on patient care. Uncontrolled cataract surgeries in ISPs are provided by diverting funding, workforce and infrastructure away from NHS patients with more serious conditions requiring more urgent and intensive treatment such as complex glaucoma and wet AMD to generally non-urgent cataract surgeries.
24. RCOphth supported NHS England's proposal to require commissioners to set payment limits for elective activity, set out in its 2025/26 NHS Payment Scheme consultation. NHS England

has instead confirmed changes it will make to the NHS Standard Contract "*to assist commissioners in the management of variable activity to deliver elective performance targets and balanced financial plans… the proposed changes give commissioners greater control in the management of activity based on a Contract Indicative Activity Plan*". ICBs must have more control over spending on the activities that they commission so they are better able to control the allocation of scarce resources and meet patient need. Integral to this is how independent sector provision of services for NHS patients is managed, particularly in maintaining value for money and sustainability of services. One solution, which has been discussed with the Minister of State for Care, is to consider reducing the cataract tariff by 20-30% in 2026/27, alongside appropriate increases in tariffs for more complex ophthalmic services such as retinal surgery and corneal transplants. Another is to apply differential rates to NHS and IS providers.

25. The experience of using ISPs in ophthalmology has taught us that they are not the solution to the problems in ophthalmology. This response gives examples of how the traditional NHS model can reduce waiting times when adequately funded and staffed. Clinical need, not profit, should be driving the allocation of scarce resources, prioritising patients needing the swiftest access to care. Currently, the draining of limited workforce and resources from the NHS to ISPs is significantly hampering the ability of the NHS to recover.