Minimum waiting times for cataract surgery:
The impact on patients, families and the NHS



SpaMedica

Contents

Section		Page
1.0	Executive summary	03
2.0	Why timely cataract surgery matters	05
3.0	The impact of mandatory minimum waiting times on patients	07
4.0	The impact of mandatory minimum waiting times on carers	13
5.0	The impact of mandatory minimum waiting times on the NHS and wider system	15
6.0	Conclusions and recommendations	17
7.0	Methodology	19

With support and input from:

1 Executive Summary

In April 2025 around half of ICBs across England introduced and subsequently enforced **mandatory minimum waiting times** of up to 16 weeks for elective surgery. For patients referred for cataract surgery this meant **increasing waiting times** which were previously around four weeks. While this approach is intended to help streamline planning and control spend, evidence in this report suggests that the mandatory delay to treatment risks impacting patient health and undermining progress made in reducing waiting lists. Mandatory minimum waiting time policies are intended to control elective spend, but they can displace demand and increase wider system cost rather than reduce it.

As this report shows, delaying cataract surgery by four weeks across England results in an estimated £406.7m loss in wider health and care value annually, driven by increased emergency care, primary care demand and loss of independence[1].

Cataract surgery is one of the most cost-effective procedures in modern healthcare. When delivered promptly, it restores vision, maintains independence and prevents downstream harm. When delayed, patients live longer with impaired sight, increasing their risk of falls, A&E attendances, GP visits, reduced employment and greater reliance on carers.

This report combines new survey research, qualitative insight, NHS data analysis and economic modelling. Findings are based on:

- A survey of 520 patients currently waiting for cataract surgery
- A survey of 300 carers and family members of patients currently waiting for cataract surgery
- Qualitative focus groups with patients and carers
- Analysis of NHS data and published evidence
- Interviews with NHS and charity experts relevant to vision loss and ageing

The patient impact:

By the time patients are referred, cataracts are already materially affecting daily life. Extending waits prolongs avoidable impairment.



85%

report further deterioration in vision while waiting

Many directly attribute multiple impacts to their worsening vision whilst waiting:



92%

change their driving habits, with 29% stopping driving altogether



31%

of working age people with cataracts have to reduce their working hours



69%

report worsening mental health

These impacts affect independence, employment, confidence and quality of life, and worsen over time the longer treatment is delayed. As people live for longer - and in turn work for longer - the prevalence of cataracts and other forms of sight loss in working aged people will also increase, with compounding wider effects.

[1] Veonet and SpaMedica analysis (2025).
NICE cost-effectiveness framework – section 2.1 in methodology



The system impact

Delaying a highly cost-effective planned treatment does not remove demand — it displaces it into areas of the health service that are under significant existing pressure:

19%

of people waiting for cataract surgery report attending A&E or receiving treatment following a trip or fall while waiting

33%

require additional GP appointments

28%

report increased reliance on social care or home support

Based on established cost-effectiveness modelling, every week of delay results in an estimated £164 system loss per patient. At a time when the NHS is under sustained financial and operational pressure, policies designed to control elective activity risk leading to tens of thousands of people needing emergency treatment and reducing overall system efficiency.

Conclusion

This research suggests that timely access to cataract surgery supports wider goals around economic participation, healthy ageing and prevention, with patients reporting a clear negative impact in each of these areas while waiting for treatment. Delaying treatment risks worsening patient outcomes, increasing inequality, and shifting more pressure into the most strained parts of the system.

Senior clinicians and patient organisations contributing to this research warn that minimum waiting times risk prolonging avoidable harm and increasing pressure across the NHS.

Given the scale of potential system impact, further rollout of minimum waiting times for cataract surgery should be paused pending formal clinical, economic and equality assessments are completed.

2 Why timely cataract surgery matters

Cataract surgery is one of the most common and most cost-effective procedures delivered by the NHS. It restores sight, supports independence, reduces risk of falls and helps people continue to work, drive and manage daily life safely.

Cataract surgery is a surgical procedure to replace a cloudy lens (a cataract) in the eye with an artificial intraocular lens (IOL) to restore clear vision. NHS data shows just over 620,000 cataract operations were performed in 2024/25[2], accounting for approximately 7% of all NHS elective surgical activity for that year[3].

The procedure has a high success rate and significantly improves a patient's vision and overall quality of life. Cataract surgery also allows improved identification and monitoring of other more serious conditions, such as glaucoma and Age-related Macular Degeneration (AMD).

The independent sector is a significant contributor to NHS cataract provision. The proportion of NHS-funded cataract surgery delivered by Independent Sector Providers (ISPs) rose from under 20% in January 2016 to 59% in January 2024, supporting higher throughput, shorter waits, and improved access to timely care[4]. Independent sector providers are paid the same rate as NHS Trusts under the NHS Payment Scheme (NHSPS). Independent sector capacity expanded during the post-pandemic recovery period and contributed materially to increase capacity for NHS-funded cataract surgery.

Current regulations and processes

Patients are typically referred for cataract surgery by a GP or optometrist. This is usually based on visual impairment and quality-of-life impacts affecting activities such as reading, driving or working[5].

Alternatively, they may be referred to facilitate management of an ocular comorbidity, such as diabetic retinopathy.

All NHS patients in England have a legal right to start non-urgent, consultant-led treatment within 18 weeks of GP referral. The national target is that 92% of patients should wait no longer than 18 weeks from elective referral to treatment (RTT). The government and NHS England have restated their commitment to restoring performance against this standard as part of a streamlined set of national NHS priorities for this Parliament, with interim milestones set out to support recovery.

This includes improving RTT performance to 65% by March 2026 and 70% by March 2027[6], on the way to further recovery over the course of the Parliament.

The proposed minimum waits

While there has been no official national guidance from NHS England, around half of ICBs have implemented and enforced mandatory minimum waiting times of up to 16 weeks for cataract surgery, compared to previous waits of around four weeks. Appendix 1 sets out the systems that have imposed these rules and length of wait imposed (as of March 2026).

While this approach is intended to help streamline planning and control spend, evidence in this report suggests that the mandatory delay to treatment risks impacting patient health and undermining progress made in reducing waiting lists.

[2] NHS England. Hospital Admitted Patient Care Activity: 2024-25: Procedures and Interventions – [Accessed January 2026]
[3] NHS England. Hospital Admitted Patient Care Activity: 2024-25: Procedures and Interventions – [Accessed January 2026] 620,000 (cataract surgeries) is 6.9% (rounded to 7%) of 9,016,083 (total procedures)
[4] Maling, S. and Adams, M. (2024) 'Independent Sector Cataract training', Eye, 38(14), pp. 2663–2664. doi:10.1038/s41433-024-03097-y.
[5] NICE (2018). Cataracts in adults: management. [online] Available at: https://www.nice.org.uk/guidance/ng77 [Accessed 28 January 2026].
[6] NHS England. 2025/26 priorities and operational planning guidance. [Accessed January 2026]

Introducing longer waits for cataract surgery is a retrograde step. We have the clinical expertise and facilities to provide timely care — it's disappointing to move backwards without clear clinical reasoning.

– Mr Felipe Dhawahir-Scala - President of the British Eye Emergency Care Society, Vitreoretinal and Cataract Surgeon, Founder and Former Director of the Acute Ophthalmic Services, Manchester Royal Eye Hospital

Referral for cataract surgery is typically made only once visual impairment is already materially affecting daily life, independence or the management of other health conditions.

In practice, this means referral is not an early or precautionary step, but a meaningful threshold of need. Introducing an additional mandatory delay after referral therefore risks extending the period during which patients live with avoidable impairment.

The following sections examine the consequences of delaying surgery for patients, carers and the wider NHS.



3 The impact of mandatory minimum waiting times on patients

To better understand the impact of delayed treatment, we surveyed 520 patients. Respondents were recruited from a large research panel and screened to ensure they were living in England and currently awaiting NHS cataract surgery.

> **By the time people are referred, cataracts are already impacting their quality of life. By extending waits you are making them live with these challenges for longer.**
>
> – A senior NHS consultant ophthalmologist

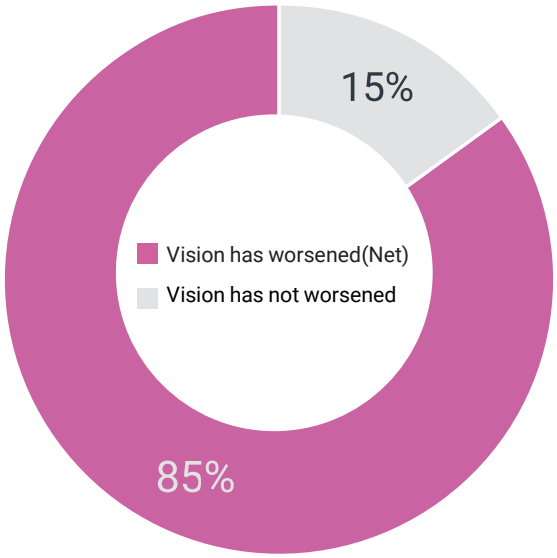
Worsening vision and daily functioning

Of those people responding to our survey, the majority (85%) reported further loss of vision while waiting for surgery.

This visual decline can have immediate consequences for everyday tasks, from reading and driving, to basic household activities. Patient confidence to drive safely is a particularly significant issue for patients with cataracts with many reporting they can no longer travel independently, restricting their mobility and limiting access to work, social activities, and even essential appointments.

This research found that:

Since being referred for cataract surgery, has your vision worsened?



92%

of those waiting for surgery have changed their driving habits – with 63% reporting that they drive less often, and 29% who have stopped driving completely

79%

of patients report feeling less confident leaving the house due to their impaired vision



Employment challenges

The impact on employment is equally profound. Among working-age patients*, a significant proportion reported challenges in continuing their current roles due to worsening vision.

* 68% of the total survey sample were under the age of 65 (354 of 520).



31%

Almost 1 in 3 (31%) of working age people on a cataract surgery waiting list report having to reduce their working hours because of their worsened vision, whilst 1 in 5 (21%) have had to stop working altogether

This has economic consequences for wider society, contributing to avoidable worklessness and lost productivity from those who withdraw from the workforce.

Cataracts are also being seen more frequently in patients in their 50s and early 60s, with 10% of patients in the 55-64 age group showing clinically significant cataracts compared to 5% for this same group just two decades ago[7]. This earlier presentation may reflect wider health trends, such as increasing prevalence of diabetes and obesity; the rise of long-term corticosteroid use; lifestyle and environmental risk factors for cataract development [8],[9],[10],[11]. 1 in 5 working-age people are out of work, with ill-health-related economic inactivity costing an estimated £212 billion per year [12],[13].

Preventing avoidable loss from the workforce is therefore increasingly important, and in line with key government priorities to keep working aged people with treatable health conditions working.

> **People go out less, they become deconditioned, they stop engaging in social activities — their whole quality of life just goes downhill. For older people it is much harder to recover independence once they lose it.**
>
> – Dr Lis Boulton, Health & Care Policy Manager at Age UK

The emotional toll of prolonged waiting for cataract surgery is significant. As patients endure prolonged visual impairment, many experience increased anxiety, stress, and depression. The sense of uncertainty about when or if their condition will be treated can lead to a feeling of being stuck in limbo, further exacerbating psychological distress.



69%

say that their mental health has worsened during the wait for cataract surgery

[7] 20 Statistics About Cataracts You Should Know in 2025, 2025. London Cataract Centre. https://www.londoncataractcentre.co.uk/blog/cataracts-statistics/

[8] The Connection Between Diabetes and Cataracts, December 2025. Verywellhealth [online]. Available at https://www.verywellhealth.com/diabetes-and-cataracts-6753097.

[9] Becker et al., 2018. Cataract in patients with diabetes mellitus-incidence rates in the UK and risk factors. Available at https://pubmed.ncbi.nlm.nih.gov/29386666/

[10] Tirakunwichcha et al, 2026. Impact of Metabolic Syndrome on Cataracts: A Systematic Review and Meta-Analysis. Metabolic Syndrome and Related Disorders. Available at https://journals.sagepub.com/doi/10.1177/15578518251407586

[11] Reverse the trend report, 2024. Diabetes UK. Available at https://www.diabetes.org.uk/about-us/our-impact/how-we-influence-change/our-work-in-parliament/reverse-the-trend-report

[12] Keep Britain Working: Final report, 2025. Department for Work and Pensions, and Department for Business and Trade. https://www.gov.uk/government/publications/keep-britain-working-review-final-report/keep-britain-working-final-report

[13] Employment in the UK: January 2026, 2026. Office for National Statistics. https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/employmentintheuk/january2026

> **It's almost like my life has been put on hold while I'm waiting. It makes me very on edge because I don't know what's happening and I can't plan anything.**
>
> – Tina, patient

Many patients also face social isolation, finding that their visual impairment makes it more difficult to participate in social gatherings or engage in hobbies that they once enjoyed.

75%

of patients say they have become more withdrawn or less socially engaged whilst waiting for cataract surgery

Extended periods of withdrawal can have lasting effects. Prolonged withdrawal can make it harder for patients to re-engage socially, even after surgery.



Exacerbation of pre-existing health conditions and inequalities

Delayed cataract surgery can also complicate the management of other conditions.

Conditions such as arthritis, diabetes, and mobility impairments are often exacerbated by the visual impairment caused by cataracts. Difficulties managing medication or attending appointments mean their health conditions can worsen, further impacting their ability to live independently and safely.

54%

say that their worsening vision makes it harder to attend their medical appointments

48%

say it makes it harder to take their medication – citing occasions where they have misread their prescription multiple times, so no longer feel confident doing it

For older patients and those with complex health needs, this can be particularly pronounced. Visual impairment increases the risks of falls, and many patients report feeling unsteady on their feet, compounding their vulnerability and additionally resulting in cost to the wider healthcare system.

64%

worry more about tripping or falling

35%

say they have stumbled, tripped, or felt more unsteady on their feet

> **I've got arthritis all over. I walk with a stick, so I find it hard to walk and I need a double hip replacement so I'm not just waiting for my eyes… It's not good, because I keep walking into things.**
>
> – Julia, patient



Each additional week on the waiting list prolongs the period during which patients must cope with avoidable visual impairment. Where capacity is available, additional non-clinical delay risks prolonging avoidable impairment.

Extending waits for cataract surgery risks worsening existing health inequalities, particularly for patients from deprived areas, who are already less likely to receive timely treatment. New analysis of NHS waiting lists shows that ophthalmology patients from the most deprived areas are least likely to be seen within 18 weeks (67.7%, vs 71.7% in the least deprived areas)[14].

Whilst this difference in headline percentages may appear modest, at scale this represents thousands more patients in deprived communities experiencing longer waits for treatment and reflects the persistent postcode lottery in access to care. Evidence also suggests that elective waiting lists tend to grow more quickly in more deprived areas, meaning delays are likely to compound over time[15].

In this context, extending minimum waiting times risks entrenching regional variation in access to cataract surgery and exacerbating existing inequalities, with patients in areas of higher need facing prolonged visual impairment and greater risks to health and independence.

Why additional delay matters

Forcing patients to wait longer extends the significant negative impact of cataracts. Even where clinical measures of vision may not significantly worsen over a short additional period, patients are still required to live longer with compromised sight. Extending the waiting period prolongs the knock-on effects on people's wider health, responsibilities,

> **He has had to have surgery cancelled in the past because of his own anxiety because his blood pressure hasn't been at the right level. Not knowing when it's going to be keeps triggering his anxiety and then his blood pressure.**
>
> – Poonam, carer

These impacts do not affect patients alone. They also shift burden onto families and informal carers.

[14] Waiting List Minimum Data Set (WLMDS), November 2025. NHS England.
[15] Kings Fund, 2021 [online]. Available at https://www.kingsfund.org.uk/insight-and-analysis/press-releases/poorest-areas-waiting-longer-hospital-treatment

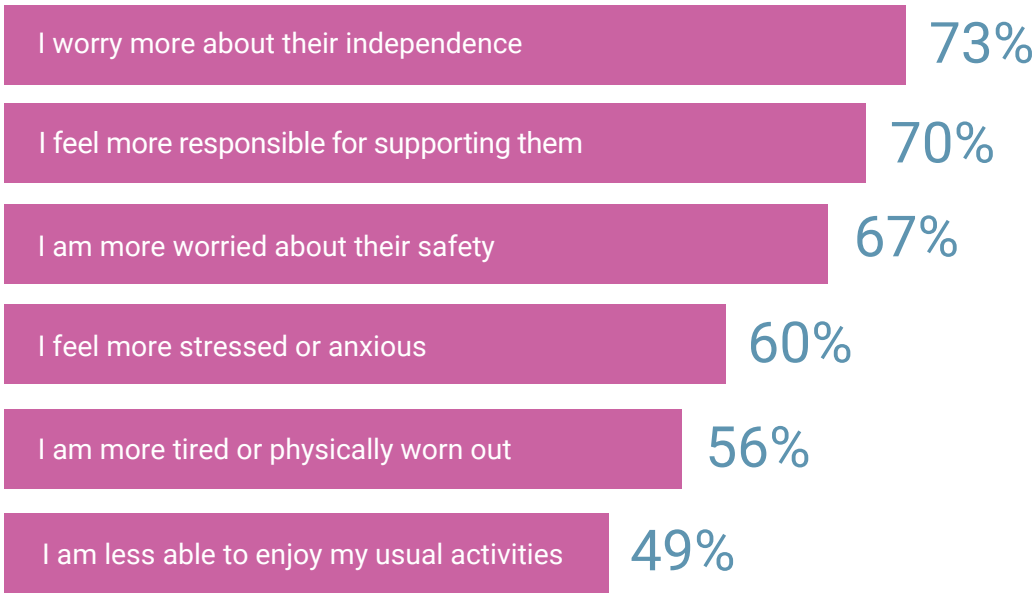
4 The impact of mandatory minimum waiting times on carers

77% of patients we surveyed told us they have needed more support from others since their referral. To better understand this, we surveyed 300 people who provide care for someone on a waiting list. 86% of respondents said the patient's declining health and/or independence had required them to provide additional support or care.

> **I've been going for counselling, so I have someone to sort of unload on because obviously I've got my own things going on as well.**
>
> - Rukhsar, patient

Disruption to lives

Carers told us they worry more about their loved one's independence, creating an ongoing sense of concern about autonomy slipping away while surgery is delayed. Stress and anxiety are often the result of a shift from offering help, to feeling fundamentally responsible for the wellbeing of the person they support. Some describe seeking mental health support to help them cope with this situation.

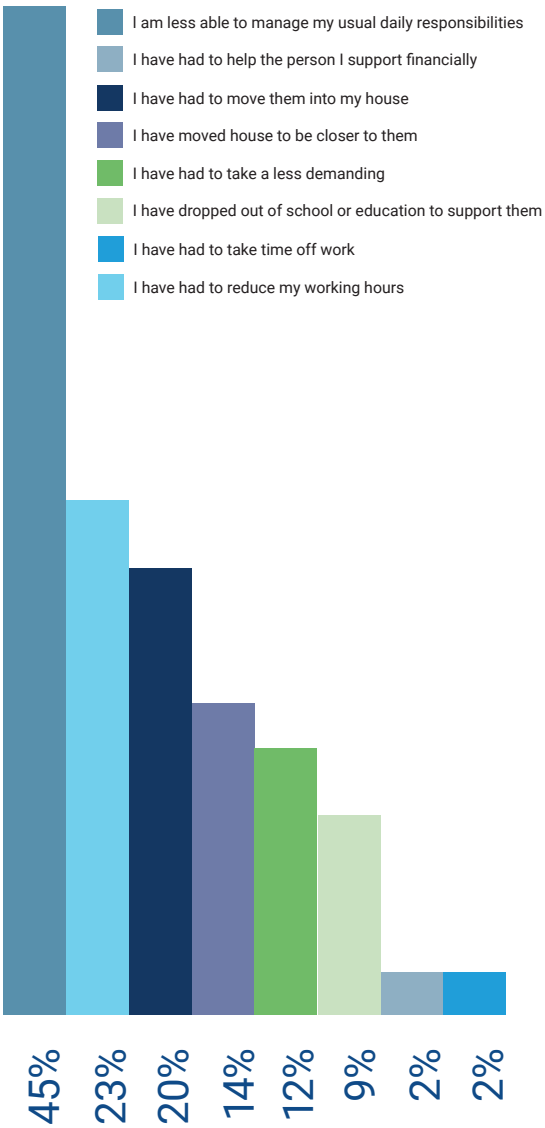


Impact on livelihood

Almost half of the carers surveyed are now unable to manage their usual daily responsibilities, as a result of caring for people waiting for cataract surgery. Caring duties often mean individuals take time off work or reduce their working hours for appointments, transport or emergencies.

This aligns with a recent Carers UK report which found that 35% of carers who remain in work while caring for people waiting for cataract surgery have reduced their working hours and a fifth (21%) have taken on a lower paid or more junior role[16].

One carer, a teacher, told us they had to switch to supply teaching so that they could manage the demands of caring, impacting their security and income.



> **I've sort of had to go on to do supply teaching so I can pick the days I work and don't work according to when she might or might not need me.... Definitely fewer hours overall, so that is impacting financially.**
>
> – Carer

These impacts are significant not only for carers themselves, but because they represent a transfer of burden from planned care into unpaid care, lost working time and wider family strain.

This transfer of burden does not stop at families. It also creates additional demand across the health system.



[16]Carers UK ([2025]) 'State of Caring [2025]: The cost of caring - the impact of caring across carers' lives', Carers UK , [21] October. Available at: https://www.carersuk.org/media/upzd[0]h[2]y/state-of-caring-[2025]-cost-of-caring-report_v[2].pdf (Accessed: [10] February [2026]).



5 The impact of mandatory minimum waiting times on the system

How pressure in one part of the NHS creates cost elsewhere.

The NHS is an interconnected system. Decisions taken in one area of care inevitably affect demand and performance elsewhere. When access to timely treatment is constrained in one pathway, the resulting unmet need does not disappear and often re-emerges in other parts of the system, frequently in less efficient and more costly forms of care.

When access to cataract surgery is delayed, patients are required to live for longer with impaired vision, leading to difficulties that affect their ability to live and manage their health safely and independently. As a result, demand is displaced into other NHS services, increasing pressure across the system.

This displacement also has a measurable wider economic impact. New analysis, based on the NICE cost-effectiveness model for cataract surgery and the costs associated with trips, falls and loss of independence, estimates a total system loss of £164 for every week that treatment is delayed[17].

With approximately 620,000 cataract procedures carried out in England in 2024/25[18], delaying cataract surgery by just four weeks would result in an estimated £406.7 million annual loss in wider health and societal value associated with delayed surgery. This is before accounting for longer-term social care and productivity impacts.

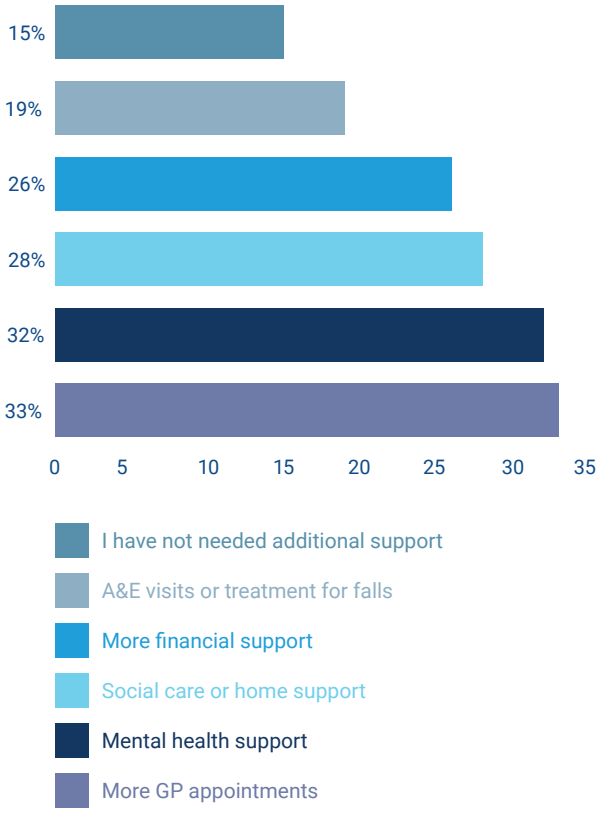
Increased demand on emergency care

Emergency departments are one of the most pressured parts of the NHS. Data shows persistently high levels of A&E attendance and emergency admissions throughout 2025, alongside large numbers of patients experiencing prolonged waits for admission[19].

In this context, even relatively modest increases in avoidable emergency demand can have a disproportionate impact. Impaired vision associated with cataracts is a well-established risk factor for trips, falls, and accidents and while cataracts may progress gradually from a clinical perspective, making patients live longer with these challenges can have a significant cost impact.

Our research shows that nearly one in five people waiting for cataract surgery (19% - equivalent to approximately 58,900 people) needed A&E visits or treatment following a trip or fall while on the waiting list. These presentations are consistent with the known risks associated with prolonged visual impairment.

Additional Support Needed



[17]Veonet and SpaMedica analysis (2025). NICE cost-effectiveness framework – section 2.1 in methodology
[18]Vision Profile Statistical Commentary, July 2025 (UK Government)
[19]NHS England: A&E Attendances & Emergency Admission statistics, NHS and independent sector organisations in England
(Accessed January 2026 here: https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/)

When people are made to wait longer, they become more dependent. That dependency doesn't disappear — it shows up elsewhere in the system, often in emergency and acute care.

– Mr Felipe Dhawahir-Scala - President of the British Eye Emergency Care Society, Vitreoretinal and Cataract Surgeon, Founder and Former Director of the Acute Ophthalmic Services, Manchester Royal Eye Hospital

Based on survey data and established treatment costs, we estimate that long waits for cataract surgery cost the NHS £21.67 million per year in A&E attendances alone[20]. This is a conservative estimate and does not include additional downstream care costs.



I had to take her to the GP because her balance and perception had declined. The day after, we ended up going to A&E. It was a really harrowing experience — she was terrified she was going to go completely blind.

– Carer of a person waiting for cataract surgery

Commissioning decisions that contribute to avoidable A&E demand risk worsening pressure in already stretched urgent care settings. Pressure on primary and community care settings.

[20] See 'Cost of increased A&E usage' in the report methodology

Pressure on primary and community care

Patients facing mandatory minimum waiting times for cataract surgery are generating significant additional demand in primary care.

33% of patients on waiting lists report that they require additional GP appointments while waiting, this equates to approximately 204,600 patients needing at least one extra consultation each year. The King's Fund estimates that the average 10-minute face-to-face GP consultation cost the NHS £37 in 2023/24[21]. On this basis, the additional primary care activity associated with delayed cataract treatment represents a minimum cost pressure of £7.6 million annually. This figure is conservative as many patients will need multiple appointments and it does not include wider admin or onward referral costs.

These statistics must be considered in the context of pressures on primary care. According to the 2025 GP Patient Survey, around 22% of patients reported they could not contact their GP practice or did not know what the next step would be after trying to make contact. Of those patients, 6.6% subsequently attended A&E because they were unable to reach their GP.[22] Making decisions which lead to hundreds of thousands of people needing additional GP appointments will exacerbate these issues.

This matters not only because delay shifts pressure elsewhere in the system, but because it risks undermining progress already made in reducing ophthalmology waits. NHS RTT data show that ophthalmology waiting times have begun to rise again, and clinicians warn that policies which deliberately defer treatment risk accelerating this trend.

> **Whilst we appreciate the pressure on hospital eye services in managing limited resources, ensuring equity of access, and balancing capacity, any delay to patient treatment increases the risk of trips and falls and may have significant negative impact on a person's ability to manage their daily life.**
>
> – Eamonn Dunne, Partnerships & Projects Development Manager, Thomas Pocklington Trust

Progress at risk

> **Introducing longer waits for cataract surgery is a retrograde step. We have the clinical expertise and facilities to provide timely care — it's disappointing to move backwards without clear clinical reasoning.**
>
> – Mr Felipe Dhawahir-Scala - President of the British Eye Emergency Care Society, Vitreoretinal and Cataract Surgeon, Founder and Former Director of the Acute Ophthalmic Services, Manchester Royal Eye Hospital

[21] https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/key-facts-figures-nhs

[22] Care Quality Commission (CQC): The state of health care and adult social care in England 2024/25 (Accessed January 2025 here: https://www.cqc.org.uk/publications/major-report/state-care/2024-2025)

NHS-funded ophthalmology services have made meaningful progress in reducing cataract waiting times, despite sustained pressure on elective care. Through expanded capacity and focused efforts to address post-pandemic backlogs, including the contribution of the independent sector in the post-COVID period, waiting lists have moved in the right direction.

However, this progress is now at risk. As figure 1 shows, we are in the midst of the longest sustained rise in the length of wait for treatment since the COVID-19 pandemic, with a 31% increase in the average number of weeks that patients have waited for ophthalmology treatment since March 2025. Clinicians warn that policies which deliberately delay access to treatment risk accelerating this trend.

From an NHS perspective, an important question is not whether cataract surgery can be deferred, but where the resulting demand will surface. The evidence suggests it is likely to reappear in some of the most pressured and costly parts of the system. In this context, minimum waiting times function as a system-level intervention with system-wide consequences.

Imposing minimum waits is driving increased emergency activity, worsening patient flow, and reduced overall efficiency at a time when the NHS can least afford it.

RTT Ophthalmology Waiting Times, England

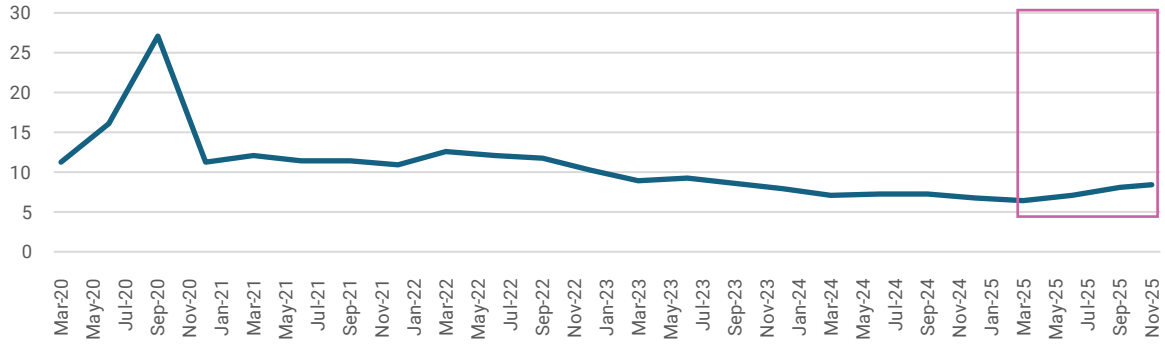


Figure 1

6 Conclusions and recommendations

Mandatory minimum waiting times may appear to control elective spend in the short term, but this analysis suggests they risk increasing overall system cost by delaying one of the NHS's most cost-effective interventions.

Clinicians and charities we spoke to agree that minimum waiting times for cataract surgery are not a clinically-led response to system pressure. As the evidence in this report shows, the wider impacts of delaying treatment are:



85%

report further deterioration in vision while waiting

Many directly attribute multiple impacts to their worsening vision whilst waiting:



92%

change their driving habits, with 29% stopping driving altogether



31%

of working age people with cataracts have to reduce their working hours



69%

report worsening mental health



19%

of people waiting for cataract surgery report attending A&E or receiving treatment following a trip or fall while waiting



33%

require additional GP appointments



28%

report increased reliance on social care or home support

Senior clinicians and patient organisations contributing to this report consistently warned that minimum waiting times are not a clinically led response to system pressure, and that their unintended consequences are likely to fall most heavily on patients, carers and already pressured services.

In light of this evidence, we recommend the following:

1. Pause further rollout of minimum waiting times: ICBs should pause the introduction or expansion of minimum waiting times for cataract surgery while the full downstream impact is properly assessed. Commissioning decisions of this scale should be informed by a comprehensive understanding of their clinical, economic and equality impact.

2. Engage with patient organisations: Commissioners should work with patients and representative organisations to better understand the lived experience of extended waits. This report demonstrates that the effects of delay are not confined to visual acuity alone, but extend to independence, mental health, employment, and carer burden. These impacts should form part of any formal impact assessment.

3. Assess value with clinician support: Clinical leaders and professional bodies should be engaged to review the evidence on timing, outcomes and prevention impacts. Cataract surgery is widely regarded as one of the most cost-effective interventions in modern healthcare. Decisions to delay access should be considered alongside clinical evidence regarding outcomes, risk of deterioration, and long-term value.

4. Reassess policy once full impact is understood: Only once patient impact, system consequences and economic implications are fully evaluated should decisions be taken about the future role — if any — of minimum waiting times in cataract commissioning. Policy should be grounded in evidence, aligned with patient need, and consistent with wider NHS objectives on prevention, productivity and reducing inequality.



7 Methodology

This report combined quantitative and qualitative research approaches to understand the experiences and attitudes of people waiting for cataract surgery, and their families or people who care for them, across England. This included:

1. A survey of people on a cataract waiting list
2. A survey of those caring for someone on a waiting list
3. A focus group with people on a cataract waiting list
4. A focus group with those caring for someone on a waiting list
5. Analysis of NHS England data
6. Economic modelling based on established costs for cataract surgery

Quantitative survey

The quantitative research was conducted independently by Censuswide. Censuswide abides by and employs members of the Market Research Society (MRS), follows the MRS Code of Conduct and ESOMAR principles, and is a member of the British Polling Council.

Patients:

Our sample consisted of 520 Adults in England living with cataracts who are currently waiting to have cataract surgery (at least 60% who have been waiting for over 15 weeks), and who are not planning to pay the full cost of treatment themselves (i.e. not fully self-funded private treatment). The data was collected between 12.12.25 - 09.01.26.

Family members / carers:

Our sample consisted of 300 Family members/ close friends of individuals living with cataracts (at least 60% who have been waiting for over 15 weeks), and who are not planning to pay the full cost of treatment themselves (i.e. not fully self-funded private treatment). The data was collected between 12.12.25 - 19.12.25.

Qualitative focus groups

The research was conducted by Censuswide using online qualitative focus groups among 10 participants in England. Two 90-minute focus groups were conducted: four participants who are currently waiting for cataract surgery on 15th January 2026 and six participants who care for somebody waiting for cataract surgery on 19th January 2026.

Participants were recruited from England via a structured screening process to reflect a mix of relevant demographics and experiences aligned with the study criteria.

The sessions were conducted online via video conferencing, moderated by ZPB Associates, and recorded with participant consent for research and analysis purposes.

Censuswide abides by and employs members of the Market Research Society, follows the MRS Code of Conduct and ESOMAR principles, and is a member of the British Polling Council.

Please note: As a qualitative study, the results reflect the views, feelings, and language of the participants involved in the research and are intended to provide insight into the range of perspectives that exist within the target audience. Findings should be interpreted as exploratory and illustrative rather than definitive or quantifiable across the wider population.

Anonymity and Ethics

All research was conducted in line with recognised market research standards. Participants were informed of the purpose of the research and provided consent to take part. All responses were treated confidentially and analysed in aggregate. No personally identifiable information is included in this report.

Findings are reported anonymously to protect participants' privacy and to ensure individuals could share their experiences openly and honestly.

Estimating the system cost of minimum waiting times for cataract surgery (£406.7 million)

1. Overview

This analysis estimates the annual system value lost in England as a result of introducing a four-week minimum waiting time for cataract surgery.

The methodology builds on:

- The Social Return on Investment (SROI) model developed for Veonet by Value for Good (June 2025)
- The England-specific monetisation model for SpaMedica (United Kingdom summary, p.11–13)
- The wider Cataract Value Proposition documentation

The calculation deliberately adopts conservative assumptions at each stage in order to ensure the resulting estimate represents a lower-bound system impact.

2. Underlying economic model

2.1 NICE cost-effectiveness framework

NICE evaluates cataract surgery using cost per QALY gained. Cataract surgery is widely recognised as highly cost-effective, generating approximately:

- 1.25 QALYs (first eye)
- 0.68 QALYs (second eye)
- Over a 12-year horizon with a 3.5% discount rate

However, NICE's ICER framework does not fully monetise wider downstream impacts s uch as productivity impacts, reduced falls and trauma, depression, institutionalisation, need for informal and formal care, and transport dependency.

2.2 Social return on investment (SROI) model.

To capture these broader impacts, Value for Good developed a structured SROI model for Veonet using an anchor peer-reviewed study (Brown et al.), 60 scientific sources, ~20 official datasets, internal clinical and cost data, and conservative parameter assumptions.

The England base-case results (most conservative scenario) show that per first-eye surgery (Year 1 only):

- Surgery cost: £1,054
- Total first-year benefit: £9,587
- Net first-year benefit: £8,533

The model applies:

- 12-year benefit horizon
- 3.5% healthcare discount rate
- Lowest-bound caregiving hours
- Minimum wage proxies for unpaid care
- Conservative employment probabilities

Importantly, the base case is explicitly described as conservative in multiple categories, particularly unpaid care and indirect costs (p.12–13).

3. Translating annual benefit into weekly value

To estimate the cost of delay, we focused only on Year 1 net benefit, not lifetime value. From the England base case, the net benefit (Year 1, first-eye surgery) was equal to £8,533

To estimate the value realised per week:
£8,533 ÷ 52 weeks = £164 per week

This assumes benefits accrue evenly over the first year.

Rationale for even distribution assumption

Many benefits (e.g. reduced falls risk, transport dependency, informal care) begin immediately after visual restoration. The SROI model quantifies annualised cost differences between visually impaired and non-impaired individuals. Spreading benefit evenly across 52 weeks represents a neutral, conservative simplification.

This produces a weekly lost value of £164 per patient per week of delay.

4. Estimating the cost of a four-week minimum wait

Several Integrated Care Boards have moved from ~4-week treatment windows to minimum waits of up to 8–14 weeks.

To ensure conservatism:

- We modelled only a 4-week delay
- Even where real-world increases are longer
- Using the smallest policy shift observed

Per-patient four-week loss = £164 × 4 weeks = £656. This represents the minimum lost first-year societal value per patient due to delayed surgery.

5. Scaling to national impact

According to NHS England data, approximately 620,000 cataract procedures (SpaMedica data) were performed in England in 2024/25. All of these patients experienced a waiting period prior to treatment.

Applying the conservative 4-week delay assumption to this annual activity:

620,000 × £656 = £406,720,000

Rounded to a £406.7 million annual system loss

6. Why this estimate is conservative

This figure likely understates the true economic impact for several reasons:

6.1 Only year 1 benefits included

The SROI model demonstrates lifetime net benefit per first eye of £80,454 (12-year horizon). Our delay estimate includes only the first year, not discounted future effects.

6.2 Shortest possible delay modelled

Many ICBs have introduced waits longer than 4 weeks. We selected the minimum increase for prudence.

6.3 Conservative cost inputs

The underlying SROI base case:

- Uses minimum national wage for unpaid care valuation
- Uses lowest identified excess care hours
- Uses conservative employment probabilities
- Excludes additional harder-to-quantify wellbeing impacts

6.4 Excluded wider economic effects

The model does not include:

- Broader productivity spillovers
- Informal carer economic participation beyond minimum wage proxy
- Reduced mental health prescribing
- Wider public health impacts
- Road traffic accidents avoided
- Secondary care utilisation shifts

7. Interpretation

Minimum waiting time policies do not remove the cost of surgery. The intervention cost is still incurred. However, delay reduces the period over which first-year benefits can be realised, resulting in:

- Lost NHS savings
- Increased social care exposure
- Increased unpaid carer burden
- Increased fall risk
- Reduced independence
- Reduced wellbeing

At national scale, even modest weekly value loss becomes material. A four-week delay equates to approximately £406.7 million in lost annual societal value. This represents a transfer of cost from short-term commissioning control to wider system and societal burden.

Referral-to-treatment (RTT) waiting times

We report Median Waiting Time in weeks for Completed Pathways for the Ophthalmology specialty at 3-monthly intervals. These figures were extracted from the 'Referral to Treatment (RTT) Waiting Times' dataset. (https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/)

Admitted pathways are waiting times for cases where patients completed their RTT pathway during the month with an inpatient/day case admission for treatment. Until September 2015 adjustments were made to admitted pathways for clock pauses, where a patient had declined reasonable offers of admission and chose to wait longer.

The 31% increase figure is based on the difference between the median waiting time in March 2025 (6.4 weeks) and September 2025 8.1 weeks)

The cost of increased A&E usage.

This analysis estimates the annual additional cost to the NHS associated with A&E visits linked to patients waiting for cataract surgery. focuses only on direct A&E attendance costs. It does not include ambulance call-outs, hospital admissions, fracture treatment, outpatient follow-up, rehabilitation, social care costs, or long-term complications.

1. Number of cataract patients in England

According to the latest NHS statistics, 620,000 admissions for cataract surgery were recorded in 2024 (Vision Profile Statistical Commentary, July 2025 (UK Government)).

Because some patients undergo surgery in both eyes, admissions do not equal individual patients. To avoid overstating impact, we apply a conservative assumption.

We assume that in the absence of patient-level national data on bilateral surgery, we apply a conservative assumption that 50% of admissions represent unique patients.

620,000 ÷ 2 = 310,000 patients

This produces an estimated 310,000 individual patients awaiting cataract surgery. This assumption is conservative, as not all patients undergo bilateral surgery within the same year.

2. Percentage of patients attending A&E due to falls

Survey data collected indicates that 19% of patients reported visiting A&E due to a trip or fall while waiting for cataract surgery.

Applying this proportion to the estimated patient population:

310,000 × 19% = 58,900 patients annually may attend A&E due to falls while waiting for surgery.

3. Cost per A&E attendance

According to analysis by The King's Fund:

- The cost of an A&E attendance ranges between £173 and £563 (The King's Fund – Key Facts and Figures on the NHS)
- For this estimate, we apply the midpoint average of £368 per visit. Using the midpoint avoids overstating costs while reflecting realistic NHS unit costs.

4. Total estimated cost

Multiplying the estimated number of A&E attendances by the average cost per visit:

58,900 × £368 = £21,675,200 per year

The estimated annual cost to the NHS of A&E visits linked to cataract surgery waiting times is therefore £21.67 million.

Conservative assumptions and limitations

This estimate is likely to understate the true system cost because:

- It assumes only one A&E visit per affected patient.
- It excludes ambulance transport costs.
- It excludes hospital admissions following A&E.
- It excludes fracture treatment and surgery.
- It excludes rehabilitation costs.
- It excludes GP follow-up and outpatient care.
- It excludes social care impacts.
- It excludes long-term morbidity.
- It does not model mortality from falls.
- It does not include productivity loss or informal care burden.
- It also assumes that half of admissions represent unique patients, which reduces the estimated population base.

Integrated Care Board	Imposed minimum waiting times
NHS North West London Integrated Care Board	8
NHS Cheshire And Merseyside Integrated Care Board	10
NHS Humber And North Yorkshire Integrated Care Board	10
NHS Greater Manchester Integrated Care Board	12
NHS Hertfordshire And West Essex Integrated Care Board	14
NHS North East And North Cumbria Integrated Care Board	12
NHS South Yorkshire Integrated Care Board	13
NHS Birmingham And Solihull Integrated Care Board	14
NHS Black Country Integrated Care Board	14
NHS Devon Integrated Care Board	14
NHS Dorset Integrated Care Board	14
NHS Frimley Integrated Care Board	14
NHS Herefordshire And Worcestershire Integrated Care Board	14
NHS Leicester, Leicestershire and Rutland Integrated Care Board	14
NHS Mid and South Essex Integrated Care Board	14
NHS Somerset Integrated Care Board	15
NHS Lincolnshire Integrated Care Board	16
NHS Shropshire, Telford and Wrekin Integrated Care Board	16
NHS South East London Integrated Care Board	16
NHS West Yorkshire Integrated Care Board	16
NHS Coventry And Warwickshire Integrated Care Board	14 weeks for first appointment (Pre-Assessment Consultation), 17 weeks for treatment.
NHS Bath And North East Somerset, Swindon and Wiltshire Integrated Care Board	None
NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board	None
NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board	None
NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board	None
NHS Cambridgeshire And Peterborough Integrated Care Board	None
NHS Cornwall And the Isles of Scilly Integrated Care Board	None
NHS Derby And Derbyshire Integrated Care Board	Additional local arrangements agreed*
NHS Gloucestershire Integrated Care Board	None
NHS Hampshire And Isle of Wight Integrated Care Board	Additional local arrangements agreed*
NHS Kent And Medway Integrated Care Board	None
NHS Lancashire And South Cumbria Integrated Care Board (Ophthalmology)	None
NHS Norfolk And Waveney Integrated Care Board	None
NHS North Central London Integrated Care Board	None
NHS North East London Integrated Care Board	None
NHS Northamptonshire Integrated Care Board	None
NHS Nottingham And Nottinghamshire Integrated Care Board	None
NHS South West London Integrated Care Board	None
NHS Staffordshire And Stoke-On-Trent Integrated Care Board	Additional local arrangements agreed*
NHS Suffolk And North East Essex Integrated Care Board	None
NHS Surrey Heartlands Integrated Care Board	Additional local arrangements agreed*
NHS Sussex Integrated Care Board	None

* SpaMedica operate in partnership with ICBs. In some areas ICBs have engaged with SpaMedica to agree processes to slow down activity even where a mandatory minimum wait time hasn't been included in the contract. In these areas SpaMedica have agreed local arrangements, which can include introduction of minimum waiting times, but they are not likely to be applied to all providers equally. Mandatory schemes should apply to all providers, local arrangements are unlikely to.

We would like to thank the following individuals and organisations for their contributions:

Dr Lis Boulton
Health and Care Policy Manager, Age UK

Alex Day
Consultant Ophthalmic Surgeon, Moorfields Eye Hospital & Private Care; Chair of The Royal College of Ophthalmologists Cataract Surgery Standards Group

Mr Felipe Dhawahir-Scala
President of the British Eye Emergency Care Society, Vitreoretinal and Cataract Surgeon, Founder and Former Director of the Acute Ophthalmic Services, Manchester Royal Eye Hospital

Eamonn Dunne
Partnerships & Projects Development Manager, Thomas Pocklington Trust

Richard Newsom
Ophthalmic Consultant Surgeon, SpaMedica

Ellie Southwood MBE
Director of Impact and External Affairs, Fight for Sight

This report has been written by ZPB Associates, a London-based strategy and data-led healthcare consultancy. ZPB works with health and care providers, digital health innovators, and pharmaceutical companies to deliver services including data and research, stakeholder engagement, brand strategy, marketing and public relations. With forensic knowledge of health landscapes, the ZPB team are the healthcare communications experts with the networks and channels for brands to succeed.

SpaMedica

