

Written Evidence Submitted by Newmedica – 15th June 2026

Newmedica is one of the leading providers of NHS-funded ophthalmology services in England.

Newmedica provides ophthalmology services from 28 locations and last year delivered over 300,000 NHS appointments, including 30,000 for patients with sight-threatening glaucoma and macular degeneration, and over 74,000 cataract procedures. Ophthalmology remains the largest outpatient specialty, representing almost 10% of the total NHS waiting list.

Executive Summary

Part 1 – Strengthening and Protecting Patient Choice

- Clause 5 restates the importance of patient choice but does not currently ensure patients will be offered a genuine choice between all appropriately accredited providers of NHS-funded care.
- Patient choice is meaningful only if patients are clearly shown suitable options and can choose the provider that best meets their needs
- **Ask:** Amend Clause 5 to clarify that patient choice means informed and meaningful choice between suitable NHS-funded and accredited providers.

Part 2 – Effective Collaboration Across a Unified Healthcare System

- Independent-sector providers already form part of NHS-funded elective pathways, but local commissioning preference or activity controls can limit the range of providers patients are offered.
- Where suitable providers with NHS-funded capacity are restricted, patients may have fewer meaningful choices and less ability to choose care that is timely, convenient and clinically appropriate.
- Amend Clauses 10, 16 and 20 to ensure ICBs protect patient choice by using suitable capacity fairly and transparently, with decisions based on patient need, safety, quality, waiting times and all available provider options.

Part 3 – Tackling Health Inequality

- Clause 4 strengthens the duty to reduce inequalities, but it does not explicitly address unequal access to meaningful patient choice or unwarranted local variation in provider options.
- In ophthalmology, patients' ability to choose timely and appropriate care can be critical to preventing avoidable sight loss, particularly for older people, ethnic minority groups, disabled people, people with long-term conditions and underserved communities.
- **Ask:** Amend Clause 4 to clarify that reducing inequalities includes geographical variation in meaningful patient choice, waiting times and provider availability.

Part 4 – Protecting Commissioning Pathways

- Clause 28 would transfer commissioning responsibility for primary ophthalmic services from a national framework to individual ICBs, creating a risk that access to this critical preventative care could vary significantly by area.
- NHS sight tests are a key front door into ophthalmology pathways, helping patients identify sight-threatening conditions and exercise choice about appropriate onward care.

- Amend Clause 28, or add statutory safeguards, to preserve national consistency of General Ophthalmic Services, protect early detection and referral routes, and prevent local financial pressures from restricting access to these services.

Part 1 – Strengthening and Protecting Patient Choice

Newmedica welcomes Clause 5, which places duties on the Secretary of State to promote patient involvement and enable patients to make choices about their care. However, as drafted, new section 1CB refers broadly to choices “with respect to aspects of health services provided to them”. This wording however does not provide a clear definition of which services are included within the definition Patient Choice. This ambiguity risks the current definition of Choice services, as set out in the NHS Choice Framework and Standing Rules, being changed through a new definition of the ‘aspects of health services’ to which Choice would apply.

This matters because a legal right to choose is only meaningful if patient choice still applies to any initial Consultant led outpatient referral.

NHS England data shows that meaningful choice is already a persistent problem. In January 2024, the average number of services shortlisted per referral was 1.1, unchanged from January 2022¹. This indicates that many patients are offered little or no meaningful choice, even where multiple NHS and independent-sector providers may be available. The risk is acute in elective care, including ophthalmology, where patients should be able to consider suitable NHS-funded providers.

The Bill should therefore avoid creating a gap between patient choice on paper and patient choice in practice. Clause 5 should be amended to clarify that patient choice includes informed and meaningful choice between all suitable NHS-funded providers, including NHS trusts, NHS foundation trusts and independent-sector providers, where clinically appropriate and where they meet applicable standards of care. Local commissioning preference should not restrict that choice unless justified by transparent evidence of patient need, quality, safety or effectiveness.

Suggested amendment

Clause 5, page 4, line 4 at end insert—

(2) The choices referred to in subsection (1) include, where clinically appropriate, choice between all appropriately accredited providers of NHS-funded services able to provide the relevant treatment or service.

(3) Appropriately accredited providers under subsection (2) include—

(a) NHS trusts,

(b) NHS foundation trusts, and

(c) independent sector providers delivering NHS-funded services, provided that they meet applicable quality, safety, regulatory and contractual requirements.

(4) The Secretary of State must exercise their functions under this section with a view to ensuring that patient choice is meaningful, clearly presented to patients, and not restricted by local commissioning preference except where justified by transparent evidence of patient need, quality, safety or effectiveness.”

¹ NHS England (2024). *Statistics» Supplementary Information*. [online] [www.england.nhs.uk](https://www.england.nhs.uk/statistics/statistical-work-areas/supplementary-information/). Available at: <https://www.england.nhs.uk/statistics/statistical-work-areas/supplementary-information/>.

Clause 5 Explanatory Note: This amendment clarifies that patient choice should include the ability to choose between all appropriately accredited providers of NHS-funded care, including NHS trusts, foundation trusts and independent-sector providers.

Part 2 – Effective Collaboration Across a Unified Healthcare System

Newmedica supports the creation of a more unified healthcare system in which NHS organisations and independent NHS providers work together in the interests of patients. The objective should be to employ NHS-funded capacity to deliver the best patient outcomes and enable true choice, without favour to provider type. Where providers can deliver high-quality NHS-funded care safely, effectively and at the nationally set tariff, they should be regarded as part of the capacity available to patients.

Patients should be able to choose from the full range of suitable providers able to deliver their care safely and effectively, by local commissioning decisions or rigid activity controls.

Clause 10 should be clarified so that it cannot be applied in a way that restricts patient choice, or that permits commissioners to vary at their discretion public-private proportions in terms of providers, a power which the Secretary of State is denied in the bill. Recent local examples show why stronger safeguards are needed. In Leicester, Leicestershire and Rutland, the ICB set an Indicative Activity Plan (IAP) that reduced commissioned independent ophthalmology activity by 54% relative to 2024/25 and introduced a minimum referral-to-treatment wait of 14 weeks. For Newmedica’s services alone, this led to ten highly skilled redundancies, reduced clinic time, and 100 patients being moved to surgery dates at or beyond 18 weeks. In Greater Manchester, an IAP has led to three redundancies, further planned losses, and 416 hours of healthcare provision being lost in Manchester alone. This has occurred despite some NHS trusts in the area seeing only 42.2% of patients within the 18-week target.

These examples show how local activity controls can narrow the provider options available to patients, reduce capacity and undermine national commitments on patient choice and timely care. Local commissioning decisions should not frustrate the Secretary of State’s duty under this clause to remain agnostic to provider type. In ophthalmology, we’ve seen how such decisions inadvertently create longer waits, avoidable deterioration in sight, greater pressure on NHS trusts and higher downstream costs.

Clauses 16 and 20 should therefore be strengthened. Clause 16 should require ICBs not only to have regard to waiting times and patient choice, but to ensure patients are offered suitable provider options in the interests of patient need and compliance with waiting-time standards. Where an ICB restricts provider participation, limits activity or declines to commission from a suitable accredited provider, it should publish the evidence base for that decision, including the expected impact on patient choice, waiting times, equality, available capacity and value for money. Clause 20 should require annual ICB performance assessments to evaluate their decision-making processes against key performance metrics.

Suggested amendments

Clause 10, page 6, line 21, at end insert—

“(2) For the purposes of subsection (1), action may be in the interests of the health service where it is justified by one or more of the following—

- (a) patient need;*
- (b) timely access to treatment or services;*
- (c) quality or safety of care;*

- (d) clinical effectiveness;*
- (f) reduction of waiting times;*
- (g) the availability of suitable provider capacity; or*
- (h) the need to protect or promote patient choice.”*

Clause 10 Explanatory Note: This amendment clarifies that decisions affecting the balance of public and private sector provision may be justified where they are in the interests of patients and the health service, including by improving access, quality, safety, effectiveness or waiting times.

Clause 16, page 12, line 4, leave out “may” and insert “must”

Clause 16, page 12, line 7, leave out lines 7 to 10 and insert—

“(2) The regulations must include provision as to arrangements that integrated care boards must make to address cases in which a specified treatment or other specified service is not provided, or is unlikely to be provided, within a specified period.

(3) The arrangements referred to in subsection (2) must include a duty to offer patients access to an alternative appropriately accredited provider where such a provider has available capacity and can provide the treatment or service safely, effectively and within the applicable waiting-time standard.”

Clause 16 Explanatory Note: This amendment strengthens the duties on Integrated Care Boards by requiring them to use available capacity across all appropriately accredited providers where this is needed to meet patient need, protect choice and reduce waiting times.

Clause 16, page 12, line 17, leave out lines 17 to 22 and insert—

“(2) The arrangements required under subsection (1) must secure that patients are offered a genuine choice between all appropriately accredited providers of NHS-funded services able to provide the relevant treatment or service, including NHS trusts, NHS foundation trusts and independent-sector providers.

(3) Regulations must require integrated care boards to present choices clearly to eligible patients, including information on waiting times, location, quality, accessibility and the nature of the service offered.

(4) Regulations must require integrated care boards to commission services across all suitable providers where this is necessary to meet patient need, protect patient choice, reduce waiting times or comply with applicable waiting-time standards.

(5) Where an integrated care board decides to restrict provider participation, limit available activity, or decline to commission from an appropriately accredited provider, it must publish—

- (a) the evidence base for the decision;*
- (b) the population-needs assessment relied upon;*
- (c) the equality impact of the decision;*
- (d) the impact on waiting times and patient choice;*
- (e) the available provider capacity considered; and*
- (f) the reasons why the restriction is justified by patient need, quality, safety, effectiveness or value for money.*

(6) The Secretary of State must exercise oversight of integrated care board compliance with this section and must publish guidance on the discharge of duties under this section.”

Clause 16 Explanatory Note: This amendment requires ICBs to present choices clearly to patients and publish evidence where they restrict provider participation, so that decisions are transparent and based on need rather than system preference.

Clause 20, page 15, line 25, at end insert—

“(2A) An annual performance assessment of an integrated care board must include an assessment of how effectively the board has—

- (a) protected and promoted patient choice;*
- (b) complied with waiting-time standards;*
- (c) used available capacity across all appropriately accredited providers;*
- (d) avoided unwarranted variation in access to services;*
- (e) published evidence for decisions restricting provider participation or activity;*
- (f) secured timely access to primary ophthalmic, community ophthalmology and elective ophthalmology services; and*
- (g) addressed inequalities in access and outcomes.”*

Clause 20 Explanatory Note: This amendment ensures that annual ICB performance assessments consider how effectively boards have protected patient choice, met waiting-time standards, used available provider capacity and avoided unwarranted variation in access.

Part 3 – Tackling Health Inequality

Newmedica welcomes Clause 4’s duty on the Secretary of State to have regard to reducing inequalities in access to health services and outcomes. However, the duty should be strengthened to cover meaningful patient choice, timely access and unwarranted local variation. Without this clarification, the Bill risks leaving in place the practical mechanisms through which inequality is created for patients: longer waits, fewer provider options, restricted capacity and postcode variation.

This is particularly important in ophthalmology, where delays can cause irreversible harm and disproportionately affect older people, ethnic minority groups, disabled people, people with long-term conditions and deprived, rural, coastal or post-industrial communities. Wet AMD and glaucoma illustrate the point. Wet AMD requires urgent medical attention, normally within two weeks of referral, and can cause irreversible damage to central vision. Around 600,000 people in the UK live with sight loss because of AMD, and an estimated 39,800 develop AMD each year². Glaucoma is similarly time-sensitive: more than one million people in the UK are estimated to have the condition, rising to more than 1.6 million by 2060³, and as many as half a million may be undiagnosed. Because glaucoma can progress without

² Owen, C.G., Jarrar, Z., Wormald, R., Cook, D.G., Fletcher, A.E. and Rudnicka, A.R. (2012). The estimated prevalence and incidence of late stage age related macular degeneration in the UK. *British Journal of Ophthalmology*, 96(5), pp.752–756. doi:<https://doi.org/10.1136/bjophthalmol-2011-301109>.

³ UCL (2026). *Over 1 million estimated to have glaucoma in UK*. [online] UCL News. Available at: <https://www.ucl.ac.uk/news/2026/jan/over-1-million-estimated-have-glaucoma-uk>.

symptoms, late diagnosis and delayed follow-up are major causes of avoidable sight loss, with older people and people of African or African Caribbean origin at higher risk.⁴

In ophthalmology, delay does not affect all patients equally. It has the greatest impact on those already at higher clinical risk or less able to navigate barriers such as transport, distance, digital exclusion or limited local service availability. Patients in one ICB area should not benefit from a broad range of NHS-funded providers while patients elsewhere face a narrower list, longer waits or reduced activity. Such variation creates a postcode lottery in both choice and outcomes, with consequences for patient groups already at higher risk of avoidable sight loss.

Failure to use available independent-sector capacity risks creating avoidable inequality in three ways. First, it increases waiting times where suitable capacity exists but is not commissioned or offered to patients. Second, it entrenches unwarranted variation between ICB areas in the provider options available to patients. Third, it weakens meaningful patient choice: for vulnerable patients, the best option may not be the nearest hospital, but the provider with the shortest wait, the most accessible location, suitable transport support or the capacity to provide regular follow-up. Commissioning from a broader base of clinics can also support the Government's objective of shifting more care into community settings, particularly for older, disabled, rural, coastal or deprived patients who may struggle to attend repeated hospital appointments.

Clause 4 should therefore be strengthened so that the duty to reduce inequalities includes timely access, unwarranted variation, meaningful patient choice and effective use of suitable NHS-funded capacity where clinically appropriate. ICBs should be expected to protect meaningful patient choice, use suitable capacity where appropriate, and assess decisions to restrict provider participation or activity for their impact on inequalities, waiting times and patient outcomes. Clear national service specifications, aligned with NICE guidance, would also support consistency in specialist assessment, treatment initiation and follow-up, irrespective of provider type or local commissioning preference.

Suggested amendment

Clause 4, page 3, line 26, after "services" insert "including timely access to appropriate treatment and care"

Clause 4, page 3, line 29, at end insert—

"and

(c) reduce unwarranted variation in access to services, waiting times, and the availability of meaningful patient choice, including by ensuring that available NHS-funded capacity is used effectively where clinically appropriate."

Clause 4 Explanatory Note: This amendment clarifies that the Secretary of State's duty to reduce inequalities includes reducing inequalities in timely access to treatment, unwarranted variation between areas, and the availability of meaningful patient choice.

Part 4 – Protecting Commissioning Pathways

⁴ Meliante, L.A., Stuart, K.V., Luben, R.N., Nolan, W.P., Khawaja, A.P. and Foster, P.J. (2026). Current burden and future projections of glaucoma in the United Kingdom. *British Journal of Ophthalmology*. [online] doi:<https://doi.org/10.1136/bjo-2025-328373>.

Clause 28 (page 55, Line 18) risks disrupting established ophthalmology referral pathways by transferring commissioning responsibility for primary ophthalmic services from a national framework to individual Integrated Care Boards. The current General Ophthalmic Services model provides a consistent national route for NHS sight tests, early detection and onward referral. NHS sight tests are not simply routine optical services: they are a key prevention and referral route for glaucoma, macular degeneration, cataracts and other sight-threatening conditions. If timely access varies by ICB area, patients may enter the pathway later, have fewer onward choices and face greater risk of avoidable deterioration.

Variation is already visible in community eye health services outside the GOS contract. Some ICBs continue to commission community urgent eye care and glaucoma services, while others have reduced, withdrawn or moved services back into hospitals. Coventry and Warwickshire ICB withdrew a community urgent eye care service that had diverted at least 13,000 A&E attendances per year; Surrey and Sussex ICB cancelled its Sussex urgent and minor eye care service in 2024; and in Leeds, referral into community urgent and minor eye care has been restricted through a call-centre model, with many patients directed to A&E instead. These examples show how local variation can weaken community pathways, reduce practical patient choice and displace patients into GP practices, A&E departments and already pressured hospital services.

Clause 28 should therefore be amended, or accompanied by clear statutory safeguards, to ensure that any transfer of commissioning responsibility preserves the national consistency of General Ophthalmic Services, protects early detection and onward referral routes, and prevents local financial pressures from narrowing patient choice or restricting access to primary ophthalmic services. Primary optometry, community ophthalmology, independent-sector ophthalmology providers and NHS hospital eye services should function as a connected pathway, with patients referred to the right setting at the right time.