Lancashire and South Cumbria clinical policies review May-June 2026

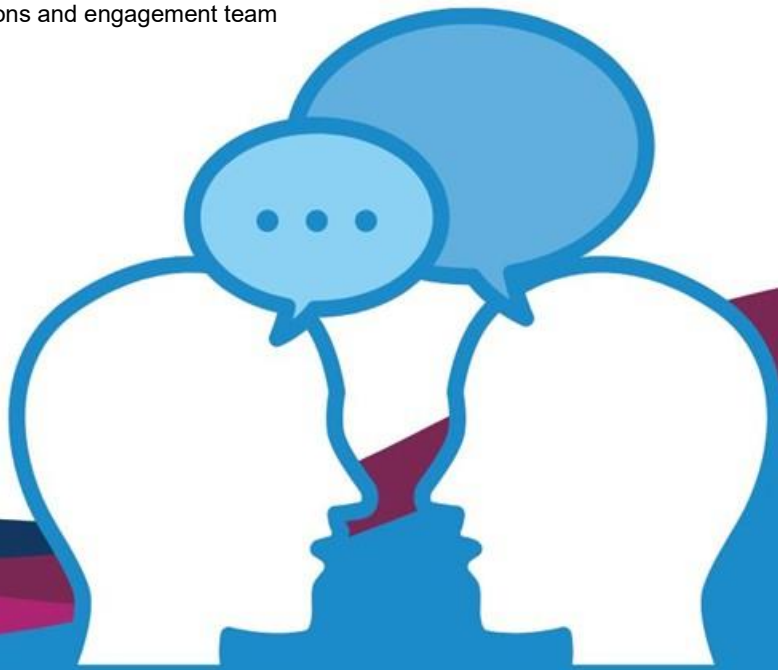
(photorefractive surgery, hip and knee replacement surgery, cataract surgery, surgical removal of bunions)

Listening to communities report

June 2026

NHS Lancashire and South Cumbria ICB communications and engagement team

lscicb.communications@nhs.net



Contents

Acknowledgements

Thank you to the ICB's Influence Network and the VCFSE groups that have taken part in and circulated questionnaires for this engagement.

Introduction

This report outlines the activity and findings of engagement that took place from 11 May 2026 to 12 June 2026 on four clinical policies that the ICB's clinical policy group has been reviewing. Two of the policies being reviewed are new to the ICB. The policies have already been through engagement with clinicians and specialists. To ensure the ICB meets its duty to involve the policies were subject to four weeks of public engagement.

Residents of Lancashire and South Cumbria were encouraged to have their say through a media release and promotion on the ICB's website news, 'Get involved' webpage and social media channels.

Executive summary

The NHS Lancashire and South Cumbria Integrated Care Board regularly reviews its clinical policies to ensure they reflect the latest evidence-based guidance and best practice.

As part of this ongoing process, four clinical policies that determine whether a person can have surgery to treat certain conditions were up for review and the ICB gathered public feedback on the changes.

All the policies are backed by national guidance and scientific evidence.

The first was a policy on surgery for the correction of refractive error, which causes people to have blurred vision. This is commonly known as laser eye surgery and is not normally funded by the ICB at present. The proposed changes would allow the surgery for a very specific group of patients.

The second was a policy on the surgical removal of bunions that currently only applies within one part of Lancashire and South Cumbria (subject to approval), so engagement was undertaken to ensure a policy is implemented consistently across the whole area.

Two new policies are proposed: hip and knee replacement and cataract surgery. These procedures are not currently covered by existing policies; therefore, a new policy has been developed for each. These policies have been adopted from neighbouring ICBs, supporting a reduction in inequity across the North West footprint.

What have we been talking to people about and why?

NHS Lancashire and South Cumbria ICB regularly reviews its clinical policies to ensure they reflect the latest evidence-based guidance and best practice.

As part of this ongoing process, drafts of four clinical policies were prepared for patient and public engagement, feedback and comment: photorefractive surgery for the correction of refractive error, hip and knee replacement, cataract surgery and surgical removal of bunions.

Photorefractive (laser eye) surgery

Visual refractive error is a common eye condition. It causes what people see to become blurred and often become what is known as short-sighted, long-sighted or astigmatism.

It is usually treated using glasses or contact lenses.

Photorefractive surgery (PRS), is also known as laser eye surgery. The procedure uses lasers to remove part of the cornea (part of the eye) that then grows back correcting the issue.

The policy aims to manage inappropriate referral and procedure activity in line with evidence-based best practice.

Currently, the NHS Lancashire and South Cumbria ICB do not fund the procedure.

The new policy says the ICB will still not routinely fund the procedure but allows one exception. It will be allowed for people who have a refractive error caused by other eye surgery or after a cornea transplant **if** the problem is not solved by using glasses or contact lenses.

Overall, this should mean that more people are able to have the surgery but still only when it is absolutely necessary.

Hip and knee replacement surgery in the over 16s

Hip and knee replacements are common NHS operations. They replace a worn or damaged hip or knee joint with an artificial joint (a new ‘man-made’ part). This new joint is usually made from metal, plastic, or ceramic.

The operation is done to reduce severe pain and help people move better, often when the smooth covering in the joint has worn away. It is done in hospital, usually with a general anaesthetic. The operation often takes about 1 to 1.5 hours. Many people go home the same day or soon after. Getting fully better can take several months. The new joint is usually made to last about 15 to 25 years.

Doctors usually try other treatments first, especially for hip arthritis. This can include pain relief, advice about the condition, exercises, and staying as active as possible. These can help some people and may delay surgery for a long time. If the joint is badly damaged, a full hip replacement can be one of the best treatments. For most people, the risks from these operations are small.

Some studies have looked at how a high BMI (being very overweight) affects hip or knee replacement. Overall, the evidence suggests a high BMI can increase some risks during or after surgery, especially infection. But the long-term results are usually similar for people with higher and lower BMI.

At the moment, NHS Lancashire and South Cumbria ICB do not have a specific policy just for hip and knee replacement surgery.

Other nearby ICBs - Greater Manchester and Cheshire and Merseyside - already have policies for this surgery. Having a policy for Lancashire and South Cumbria would help us match what other areas do and make decisions more consistent.

The new policy says the operation will be routinely commissioned under certain circumstances. These are:

- The symptoms (e.g. pain) have a substantial impact on quality of life
- Symptoms have lasted at least three months even though other treatments such as special exercises have been tried.
- The need is confirmed with radiography (x-ray)
- Patients must be given advice on lifestyle changes after the operation and the patient and clinician must decide together the operation is the right thing to do

There are some other circumstances too. There are also some exceptions where some people won't have to meet the above criteria. These are mostly people who have already had a hip or knee replacement operation.

Cataract surgery

Cataract surgery is an operation to replace a cloudy lens in the eye with an artificial lens.

Cataract surgery is done to improve a person's vision if they have cataracts. Cataract is a very common condition mostly affecting older people.

Cataract is where the lens in the eye becomes cloudy, which can cause blurry vision and loss of sight. It mainly affects older adults (age-related cataracts) but can also affect children (childhood cataracts).

Surgery is the only way to get rid of cataracts.

There is currently no published clinical policy for cataract surgery within Lancashire and South Cumbria ICB. Neighbouring ICBs, including Greater Manchester and Cheshire and Merseyside, have established policy positions in place. Adopting a cataract policy for the LSC area would support greater alignment with regional ICBs and promote consistency in commissioning practice.

The new policy says that cataract surgery is routinely commissioned for patients that are fit for surgery and consent to it, if some criteria are satisfied. In summary these are:

- An assessment of the patient's eyesight suggests surgery is appropriate

- If there is significant imbalance of vision that is getting worse
- The person has a condition called glaucoma or wet macular degeneration
- The person has with diabetes

The policy follows NICE guidance.

Surgical removal of bunions

Bunions are bony lumps that form on the side of the feet.

The skin may be damaged in the area of the bunion causing pain on walking, difficulty with footwear and concerns about its appearance. In some cases, they may cause people to struggle with their balance.

They can be much worse and lead to additional complications for people with diabetes.

This is a clinical policy being rolled out across the Lancashire and South Cumbria ICB footprint. There was a previous policy that covered the former CCG areas of Greater Preston, and Chorley and South Ribble, however, this was not adopted across the footprint when the previous eight CCGs in Lancashire and South Cumbria were abolished in 2022 and the ICB was formed.

The proposed policy is currently in force within Cheshire and Merseyside ICB.

Under this policy, a patient can be referred for a surgical opinion (which may lead to the surgery being undertaken) if other treatments have not worked when tried for at least three months **and** they have pain or the bunion is causing a disability.

What have we talked about before?

Clinical policy harmonisation

In 2019, all previous CCGs carried out a harmonisation programme to bring policies in line with each other across Lancashire and South Cumbria. These policies were then adopted by the ICB.

As part of the harmonisation an extensive period of engagement on each policy took place where the views of the public were gathered on the policies.

Who have we heard from and how?

Deciding who to talk to

Under an agreed process for engagement on clinical policies, the policies were categorised based on their level of change, impact on patients with protected characteristics under the equality act 2010 and the number of clinical conditions the policy covers.

How did we gather views?

The same basic approach was taken for all four policies.

Questionnaire

A standardised questionnaire was prepared asking eight questions plus a selection of demographic monitoring questions. These were:

1. What is the first part of your postcode?
2. Do you or someone you are responding for have a condition / require treatment that is covered by the policy?
3. Do you think the reasons for the policy change are reasonable?
    i. Yes
    ii. No
    iii. Unsure
    iv. Please explain
4. Do you think the criteria for access are clear and understandable?
    i. Yes
    ii. No
    iii. If No, please explain
5. Do you think the policy disadvantages any individuals or groups? Please explain.
6. Does the policy provide enough information to allow a clinician to discuss a patient's eligibility for treatment?
    i. Yes
    ii. No
    iii. Unsure
    iv. If No, what is missing?
7. Do you agree or disagree with the policy change?
    i. Yes
    ii. No
8. Is there anything else you would like to tell us about the policy or the proposed policy change?

As the policy for photorefractive (laser eye) surgery is already in place and is being changed with a possible increase in provision, four further questions were added:

1. The proposed policy will mean potentially more people would be able to get laser eye treatment because of the added exclusion criteria. Do you consider this to be an appropriate use of NHS resources?
    i. Yes
    ii. No
    iii. Unsure
    iv. Please explain your answer
2. Are the exclusion criteria clear about which patients are included in the policy and which are not?
    i. Yes
    ii. No
    iii. Unsure
3. To what extent do you agree with the clinical circumstances identified within the exclusion criteria as justifying NHS-funded photorefractive treatment?
    i. Strongly agree
    ii. Agree
    iii. Neither agree nor disagree
    iv. Disagree

v. Strongly disagree

4. Are there any potential risks, unintended consequences, or equity issues commissioners should consider as a result of expanding access through the addition of the exclusion criteria? [text box]

Promotion of the survey

The questionnaire was available on a dedicated webpage on the ICB website's 'Get involved' section.

The webpage and engagement opportunity, including brief summaries of the policies, were promoted through a press release that was issued to all Lancashire and South Cumbria press outlets.

A newsletter was issued to the ICB's Influence Network with links to each of the surveys.

A similar update was issued to ICB stakeholders including elected members and VCFSE representatives.

How many people got involved?

The table below shows how many people provided feedback on each of the four policies.

Engagement opportunity	Number of responses
Photorefractive (laser eye) surgery	4
Hip and knee replacement surgery	6
Cataract surgery	1
Surgical removal of bunions	3

What did we hear?

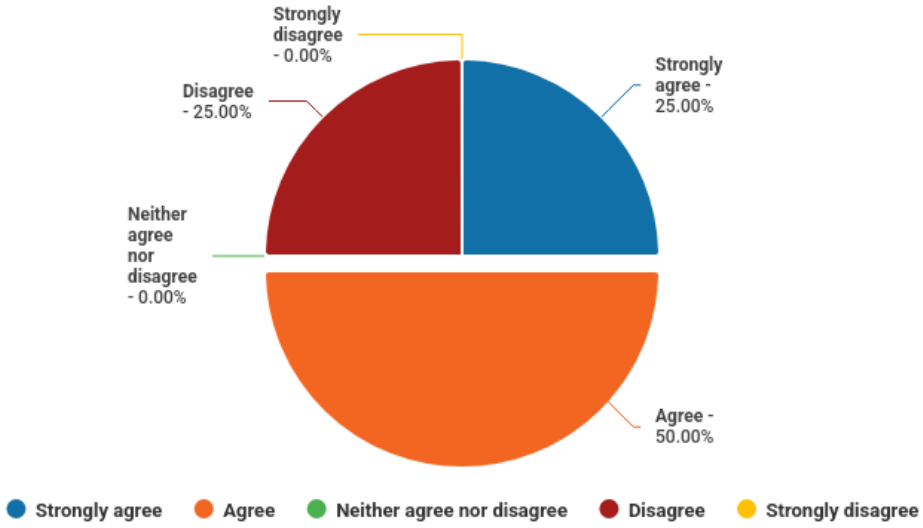
Photorefractive (laser eye) surgery for the correction of refractive error

The four survey responses showed that the respondents were from Fylde Coast (1), Central Lancashire (2) and Wigan (1). They were all White British and between 35 and 74 years of age. Three were female and one was male.

75 per cent of respondents reported to being affected in some way by refractive error.

100 per cent said the reasons for the policy were reasonable and 75 per cent thought it was a good use of NHS resources.

When asked if they agreed with the clinical circumstances identified within the exclusion criteria as justifying NHS funded photorefractive treatment, the pie chart below shows the mixed responses.



Two out of the four respondents felt that the exclusion criteria included in the policy was clear about which patients are eligible and which are not.

75 per cent said there was enough information for a clinician to explain the policy to a patient. The one person who disagreed stated that:

"The policy provides some information about routine refractive error and the proposed exclusion, but it does not provide enough information for clinicians to discuss eligibility where visual impairment is complex, neurological or neuro-ophthalmic.

It should specify what pathway applies where the patient has functional visual impairment but does not fit the proposed exclusion. It should also state whether clinicians should consider ophthalmology, neuro-ophthalmology, orthoptics, specialist optometry, neurology or an Individual Funding Request route.

The policy should also define 'cannot be corrected by glasses or contact lenses' more clearly. For example, it should explain whether this includes patients who cannot achieve functional vision despite standard spectacles, patients needing specialist prisms or lenses, patients whose symptoms are worsened by standard correction or patients whose visual disability requires neuro-ophthalmic assessment."

All four respondents thought the reasons for the policy change were reasonable, but one person said that the rationale should be broadened to make clear that the key principle is functional visual impairment which cannot be adequately corrected by conventional means.

"If the policy is limited only to non-refractive ophthalmic surgery and corneal transplantation, it may fail to address other patients with complex visual disability who may have an equally significant functional need."

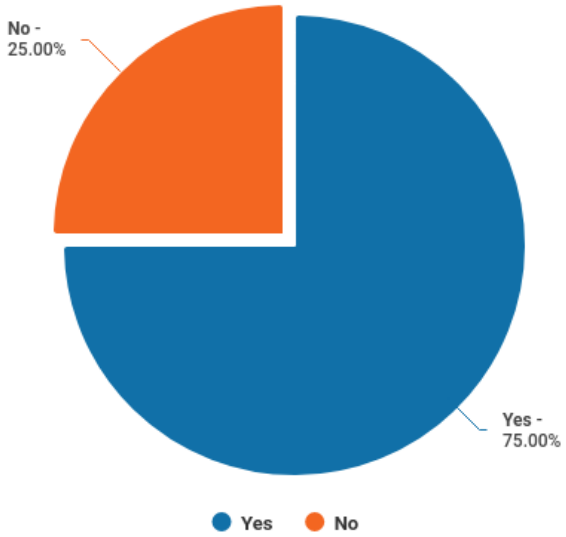
The suggestion was to add wording along the following lines:

"Patients with complex neuro-ophthalmic visual impairment, including but not limited to diplopia, acquired ocular misalignment, palinopsia, visual processing disturbance or post-neurological illness visual impairment, should not be excluded solely because the proposed intervention relates to vision correction.

Where a Consultant Ophthalmologist, Consultant Neuro-Ophthalmologist, Consultant Neurologist, Orthoptist or suitably qualified specialist optometrist confirms material functional

visual impairment and confirms that conventional correction has failed, is unsuitable or requires specialist intervention, the ICB should consider clinically indicated assessment and treatment.

This may include specialist refraction, prism correction, tinted or filtered lenses, contact lenses, pharmacological treatment, orthoptic management, strabismus or ocular alignment surgery, or exceptional refractive surgical intervention where clinically justified."



The pie chart above shows that one person disagreed with the policy change.

50 per cent felt that the criteria for access were clear and understandable. The only comment left in relation to this was:

"The criteria are understandable in relation to the proposed new exclusion, but they do not clearly explain how clinicians should manage patients with complex neuro-ophthalmic visual impairment.

The policy should clarify whether the following are inside or outside the policy:

1. specialist refraction where ordinary spectacles are inadequate

2. prism correction for diplopia

3. tinted or filtered lenses for neurological visual disturbance

4. contact lenses where clinically required rather than cosmetic

5. orthoptic intervention

6. neuro-ophthalmology assessment

7. pharmacological treatment for visual processing disturbance where clinically indicated

8. strabismus or ocular alignment surgery

9. exceptional refractive surgery where a refractive component contributes to functional visual impairment."

When asked about potential risks, unintended consequences, or equity issues commissioners should consider one person said:

“The main unintended consequence is that the policy may create inequity by recognising only certain structural ophthalmic causes of functional refractive difficulty, such as post-surgical or post-corneal transplant refractive error, while excluding patients whose visual impairment arises from complex neuro-ophthalmic conditions.

For example, patients with diplopia, acquired ocular misalignment, palinopsia, neurological visual processing disturbance or post-neurological illness visual impairment may experience substantial functional disability, including difficulty reading, using screens, travelling safely, driving, working or managing daily activities. These patients may require specialist refraction, prisms, tinted or filtered lenses, contact lenses, medication, orthoptic care or surgical assessment.

The equity risk is that patients with neurological or neuro-ophthalmic visual disability may be treated as if they are seeking routine elective refractive correction, when their need is functional and disability-related. This could particularly disadvantage disabled people, people with acquired brain injury, people with post-infectious neurological conditions, migraine-related visual disturbance or other complex visual processing disorders.

The policy should therefore include a clear functional visual impairment pathway or exception clause. This would not open access to routine cosmetic or lifestyle laser surgery. It would simply ensure that patients with clinically evidenced complex visual disability are considered fairly where conventional correction has failed or is unsuitable.”

The same respondent felt the policy may disadvantage disabled people and patients with complex neuro-ophthalmic conditions if it defines eligibility only by the origin of the refractive error rather than by functional visual impairment and clinical need. This was explained as:

“Patients with palinopsia, diplopia, acquired brain injury-related visual disturbance, migraine-associated visual disturbance or other neurological visual processing disorders may have severe functional impairment despite not fitting neatly into the categories of post-surgical refractive error or corneal transplantation.

A patient whose functional vision is impaired following corneal transplantation may be considered under the proposed exclusion, while a patient whose functional vision is impaired following neurological illness or acquired brain injury may be excluded, even where both experience substantial impact on daily life, work, reading, mobility and safety.”

As such, the recommendation is that the policy should include a disability-sensitive exception for complex neuro-ophthalmic visual impairment, subject to specialist clinical assessment.

A different respondent felt there is a disadvantage for patients who would not qualify for this through the NHS but would still need the surgery:

“You’re ensuring the worst people in this category obtain treatment but at that point their functional daily living will have reduced significantly which would then require more of a burden on social services care benefits support and ESA for unemployed individuals.”

Hip and knee replacement surgery for the over 16s

The survey responses showed that the respondents were from the Preston area (3), the Fylde Coast (1), Wigan (1) and the Lancaster area (1). All respondents were aged between 35 and 74 years of age, female and White British.

One out of the six respondents reported that they or someone they were responding for had a condition/require treatment that is covered by this policy.

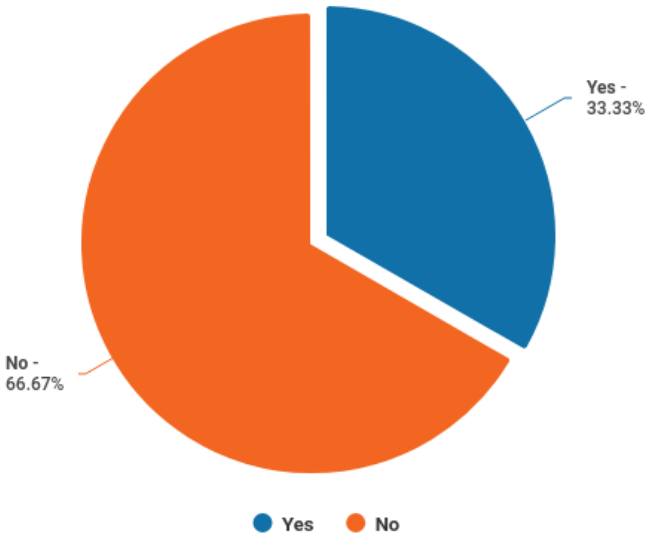


Chart: Do you or someone you are responding for have a condition / require treatment that is covered by the policy?

50 per cent said the reasons for the policy were reasonable and of those who did not think it was, they pointed out the following:

- There is no exclusion based on BMI.
- The reasons for excluding patients with previous joint replacements were not clear.
- If people are in pain or require corrective surgery or replacement it should be available without a policy.

The majority of respondents (nearly 67 per cent) said the criteria for access was not clear and understandable because the reasons for excluding patients with previous joint replacements was not clear and the wording for the measure of whether someone qualifies for a joint replacement was too subjective/ambiguous, needing outcome measures adding to ensure standardisation.

The same respondents (over 67 per cent) said there was not enough information for a clinician to explain the policy to a patient and suggested more clarity was needed around age, stating, *"a lot of surgeons will not replace joints in under 40s"*. Another respondent felt patients should be under the remit of a specialist physiotherapist who would then refer to an orthopaedic surgeon, rather than going via a GP.

Nobody disagreed with the policy.

The only other comment made was: *"It should be acknowledged that some individuals may have a high pain threshold and not feel a lot of pain but their quality of life is impacted (eg unable to walk a reasonable distance)."*

Cataract surgery

There was only one respondent to this survey who was female, White British, from the Preston area and between 65 and 74 years of age.

The respondent indicated either they or someone they were responding for had a condition/required treatment that is covered by the policy.

They agreed that the reasons for the policy were reasonable and that the criteria for access listed in the policy were clear and understandable, and the policy provided enough information for a clinician to explain the policy to a patient.

They didn't feel any individuals or groups would be disadvantaged by the policy and they agreed with the new policy.

No further comments were made.

Surgical removal of bunions

There were three respondents to this survey. They were all female and White British. One was between 35-44 years of age and two were 65-74 years of age. Two were from the Preston area and one was from the Fylde Coast.

Two respondents indicated either they or someone they were responding for had a condition/required treatment that is covered by the policy and one respondent was not.

One out of the three respondents (33 per cent) disagreed that the reasons for the policy were reasonable and also that the criteria for access listed in the policy were clear and understandable. The same respondent didn't agree that the policy provided enough information for a clinician to explain the policy to a patient.

The main reasons provided for disagreeing with the three questions above were concerns that if people wait too long for surgery their bunions become more advanced and surgery then rarely works. There were also worries about people with wide feet, osteoarthritis in the feet and other foot issues who should be considered ahead of the three months and a need to consider of co-morbidities should be taken into account, so that those with a greater need can be seen first. In summary, the respondent stated that the policy oversimplifies the condition and leaves no room for other factors to be considered.

The feedback also stated that the policy unfairly disadvantages:

- all groups of people who are not diabetic, as anyone who is diabetic will get faster treatment
- older people, ultimately increasing pain, creating balance issues and limiting the activities they can do, causing isolation and loneliness
- people with osteoarthritis in their feet and other joints as mobility and pain are significant factors.

What we have learned

Key themes

Several important themes emerged from the responses to these surveys.

The **photorefractive (laser eye) surgery policy** feedback noted that limiting surgery access could lead to increased reliance on social services and benefits, as those most in need may only receive treatment once their functional daily living is significantly impaired. Half of respondents felt the criteria for access were clear, but there was ambiguity around management of patients with complex neuro-ophthalmic visual impairment and what treatments are covered. Concerns were raised about insufficient detail for complex cases, particularly neuro-ophthalmic and neurological visual impairments, and about possible inequity, with the policy potentially disadvantaging disabled people and those with complex neurological visual disabilities. The risk of treating functional needs as routine elective correction was highlighted.

Concerns were raised about the **surgical removal of bunions policy**'s lack of flexibility, with respondents highlighting that the criteria for access do not sufficiently account for individual differences, such as co-morbidities, severity of the condition, or other foot issues. Secondly, there was a perception that the policy disproportionately disadvantages certain groups, notably non-diabetic individuals, older people, and those suffering from osteoarthritis, potentially leading to increased pain, mobility problems, and social isolation.

Additionally, the clarity and adequacy of information provided by two of these two policies (**photorefractive (laser eye) surgery and the surgical removal of bunions**) were questioned, particularly regarding whether clinicians would be able to explain it effectively to patients and whether certain groups of patients could be disadvantaged by the exclusion criteria.

For the **hip and knee replacement surgery policy**, half of the respondents considered the reasons for the policy reasonable, while others questioned the lack of exclusions based on BMI and unclear rationale for excluding patients with previous joint replacements. Nearly two-thirds felt the criteria for access were unclear, noting ambiguous wording regarding eligibility for joint replacement and calling for standardised outcome measures to improve clarity. Over two-thirds thought there was insufficient information for clinicians to explain the policy to patients, particularly needing more clarity around age-related eligibility and referral pathways. Some respondents preferred that patients be managed initially by specialist physiotherapists who would refer to orthopaedic surgeons, rather than referral via GPs. No respondents disagreed with the proposed policy, suggesting general support despite concerns about clarity and exclusions. One comment emphasised that individuals with high pain thresholds may not report much pain but still suffer significant reductions in quality of life, such as being unable to walk reasonable distances.

There was only one respondent for the **cataract surgery policy** and they had no objections or concerns to anything in the policy.

Conclusion and recommendations

It must be noted that all the surveys received very low numbers in terms of responses, and all the respondents were White British, and the majority were either 35-44 or 65-74 years of age. The only geographical representation in all the feedback came from the areas of: Preston, Fylde Coast, Lancaster and Wigan.

Photorefractive (laser eye) surgery recommendations:

- Prevent inequity by including exceptions for neuro-ophthalmic disabilities - for cases involving complex visual impairment and neurological issues, clearer pathways and guidance for such cases is needed.
- Better define 'cannot be corrected by glasses or contact lenses', to include patients with complex needs such as those requiring specialist prisms, lenses, or neuro-ophthalmic assessment.
- Broaden the policy to address functional impairment, not just structural causes. Add a disability-sensitive exception for complex cases.
- Define which treatments are covered, including specialist lenses, orthoptic intervention, and exceptional surgery.

Hip and knee replacement surgery recommendations:

- Clarify the exclusion of patients with previous joint replacements by providing explicit reasoning.
- Make access criteria for joint replacement surgery more objective, using standardised assessment tools.
- Review BMI's role in eligibility and explain its inclusion or exclusion.
- Ensure clinicians have sufficient information, including age restrictions and referral pathways.
- Allow specialist physiotherapists to refer patients directly to orthopaedic surgeons.
- Recognise quality of life factors, such as functional impairment, alongside pain levels.

Cataract surgery recommendations:

- None

Surgical removal of bunions recommendations:

- Revise the policy to allow greater flexibility, ensuring that individual patient factors such as co-morbidities, severity, and specific foot conditions (e.g., osteoarthritis, wide feet) are considered alongside standard access criteria.
- Review prioritisation to avoid disadvantaging non-diabetic patients, older adults, and those with osteoarthritis, so that treatment is based on overall need, not just diabetic status.
- Shorten waiting periods for those at risk of condition progression, as prolonged delays may reduce surgical effectiveness and increase complications.
- Enhance policy clarity and detail, providing clinicians with comprehensive information to explain eligibility and access criteria to patients.