Lancashire and
South Cumbria
Integrated Care Board

Lancashire and South Cumbria Clinical policies review: April 2026 (Carpal tunnel syndrome, Sacral neuromodulation and Trigger finger)

Listening to communities report

April 2026

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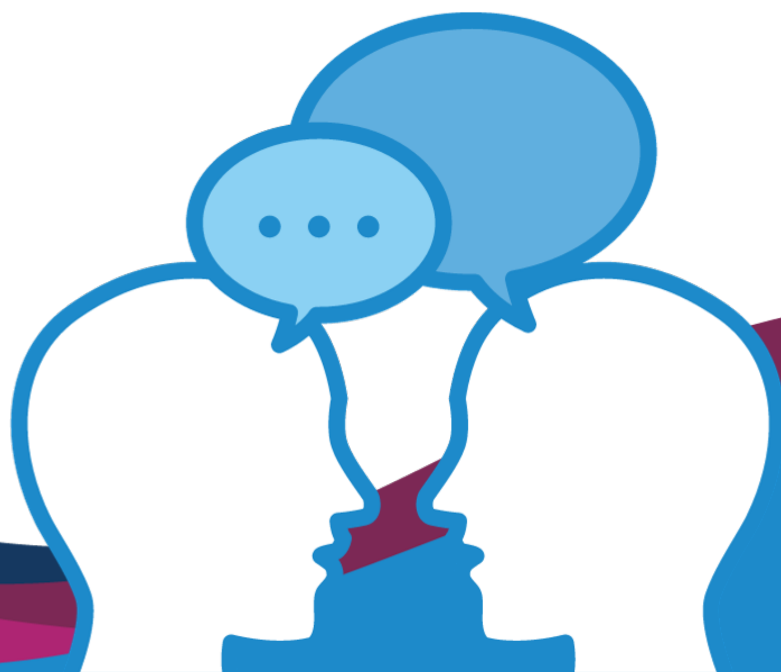

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Acknowledgements

Thank you to the ICBs citizens panel 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 throughout March 2026.

The engagement related to three policies that the ICB's clinical policy group has been reviewing. The policies have already been through some engagement with clinicians and specialists. To ensure the ICB meets its duty to involve the policies were subject to four weeks of public engagement.

Executive summary

This report sets out what we heard during public engagement on three draft clinical policies reviewed by NHS Lancashire and South Cumbria ICB: Carpal tunnel syndrome surgery, Sacral neuromodulation and the surgical release of trigger finger. Engagement took place over four weeks in March 2026 to support the ICB's duty to involve.

We gathered views through an online questionnaire for each policy and a discussion with the Citizens Health Reference Group (CHRG). In total, we received 77 questionnaire responses about Carpal tunnel syndrome surgery, 68 about Sacral neuromodulation and 92 about trigger finger, alongside discussion with 11 CHRG members.

Overall, respondents showed a good spread across Lancashire and South Cumbria and reported high levels of understanding of the proposed changes (95–97% across the three surveys). Support for the Carpal tunnel syndrome surgery and Sacral neuromodulation policies was very strong, with no respondents disagreeing with either proposal. For trigger finger, the majority agreed, with a minority (12%) disagreeing or strongly disagreeing.

- **Carpal tunnel syndrome surgery:** 92% agreed/strongly agreed and nobody disagreed. Comments focused on reassurance that the policy is clinically led, clarity on subjective criteria (for example, what counts as symptoms that 'significantly impact' sleep or function), and potential impact on waiting times.
- **Sacral neuromodulation:** no respondents disagreed. Feedback supported alignment with NICE and improved access, alongside requests for clearer explanations of the trial phase and follow-up, and consideration of travel to specialist centres and consistent decision-making through MDT assessment.
- **Trigger finger:** most respondents agreed, but concerns were raised about perceived restrictions and whether changes could delay effective treatment. Key themes included the need for flexibility for individual circumstances, clarity on terms such as 'interfere with activities', and diabetes-related considerations (including steroid injection risks and informed consent).

Across the engagement, people asked for policies and supporting information to be written in plain English and for decision-making to be consistent and transparent. These findings will be shared with the ICB's clinical policy group to inform final policy wording, any supporting clinician guidance, and patient-facing summaries.

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 three clinical policies were prepared for patient and public engagement, feedback and comment: Carpal tunnel Syndrome surgery, Sacral Neuromodulation and the surgical release of Trigger finger.

We want to make sure local people...

...Are aware and informed about proposals...

... Know how they can get involved...

... Understand why decisions are made...

...Feel enthusiastic about what is possible...

...Have trust in the process.

Carpal tunnel syndrome surgery

Carpal tunnel syndrome happens when a nerve in the wrist (the median nerve) becomes compressed. This can cause:

- Pain, tingling or numbness in the thumb, index and middle fingers
- Symptoms that are worse at night
- In severe cases, muscle weakness or wasting at the base of the thumb

Some people get better on their own or with basic treatment such as splints or a steroid injection.

The surgery is a common, often outpatient, procedure that cuts the transverse carpal ligament to relieve pressure on the median nerve. Between August 2024 and July 2025 there were 1,877 surgeries undertaken in Lancashire and South Cumbria.

The policy aims to avoid unnecessary surgery because many people improve without an operation.

Under the new policy there is a more flexible 6–12 week non-surgical period. The criteria for immediate surgery have been broadened to include allowance for people who have recurring cases which wasn't covered before.

We have also updated guidance around pregnancy-related carpal tunnel saying surgery should be avoided if possible. This is because it is usually only temporary during pregnancy and we want to avoid unnecessary surgery, but there is no longer a restriction of waiting 12 weeks after birth because this was not supported by any evidence.

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

Sacral neuromodulation

Sacral neuromodulation (SNM) is a treatment where a small device sends gentle electrical signals to nerves in the lower back (sacral nerves). This can help people with certain bladder problems when other treatments haven't worked. The treatment starts with a short "trial phase." If the trial helps, a permanent device may be implanted.

The proposed policy expands access, so it aligns with NICE recommendations. If approved the new policy will allow SNM for:

- Chronic non-obstructive urinary retention (men & women) – same criteria as now
- Overactive bladder in men – when conservative treatments have failed
- Overactive bladder in women, if:
  - Reviewed by a local/regional multi-disciplinary team (specialists from different fields working together to make joint decisions)
  - Non-surgical treatments and medicines have not worked
  - Botulinum toxin A (a medicine) has not worked or is not acceptable to the patient

There are conditions that patients must have had a good response to the trial phase and have a clear understanding of risks, long-term commitment, and possible need for revision surgery.

Conditions such as constipation and faecal incontinence are not offered SNM which is the same as the current policy and Faecal incontinence is actually covered by an NHS England policy.

Overall, this will improve access to the treatment for more people.

Surgical release of trigger finger

Trigger finger happens when a tendon in the finger becomes swollen or irritated and struggles to glide smoothly. This makes the finger:

- Painful
- Stiff
- “Catch” or “lock” when bent or straightened

It is common and often improves with simple treatments. If it doesn’t improve then a surgical release may be necessary. The surgery is an outpatient procedure usually performed under local anaesthesia.

In order to bring the policy in line with new evidenced based guidance we are proposing some changes as follows:

- The new policy adds additional criteria including that symptoms must interfere with daily activities or cause pain.
- Additional clarity has been added by changing the wording of the steroid injection criteria to “one or two” injections.
- The required splinting period changes from 3–12 weeks to “at least 3 weeks”, making it more flexible.
- Diabetes is removed as an automatic reason for surgery
  - The previous policy worked on the basis that diabetes could make the non-surgical treatments less effective and so people with diabetes could effectively go straight to surgery. Newer evidence shows diabetes alone does not make conservative treatment less effective and so this clause has been removed.
- Addition of 'multiple trigger digits'
  - People with several fingers affected may qualify for surgery sooner because this increases the chance that non-surgical treatments won’t work.

The removal of the diabetes criteria is not expected to affect many people however the addition of the criteria around pain or interfering with daily activities may mean fewer people are eligible for the treatment. On the other hand, the addition of the criteria around multiple fingers affected may mean some people can access surgery sooner.

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.

Since Carpal tunnel syndrome surgery and Sacral neuromodulation policies both represent an increase in provision it was decided that these required only comments and no specific engagement was required.

The surgical release of trigger finger represents an increase in provision for some but, on face value, could represent a reduction in provision or a restriction in provision for others. It is also common in people with diabetes and so a more targeted approach was taken.

How did we gather views?

The same basic approach was taken for all three policies. Additional targeting was carried out for the trigger finger policy.

Focus groups

The ICB has a cohort of people who meet regularly to discuss the work of the ICB. The Citizens Health Reference Group (CHRG) were presented with the policies with an explanation of what was changing. An open discussion was then held and views about the policies captured.

Particular attention was made to the trigger finger policy but all three were discussed.

Questionnaire

A standardised questionnaire was prepared asking seven 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. Have you read the policy change details and understood them?
4. Overall do you agree or disagree with the policy change?
   i. Strongly agree
   ii. Agree
   iii. Neither agree nor disagree
   iv. Disagree
   v. Strongly disagree
5. If you disagree, please tell us why (Comment box)
6. Is there any specific part of the new policy you feel is unclear? (Comment box)
7. Do you have any other comments (comment box)

Promotion of the survey

The questionnaire was available on a dedicated page on the [ICB website's "get involved" section].

The web page 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 ICBs citizens panel with links to each of the surveys.

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

The trigger finger policy was also sent directly to VCFSE groups that had a special interest such as diabetes UK and Age UK covering Lancashire and South Cumbria. They were sent links to the questionnaires with a request to share with their members.

How many people got involved?

The table below shows how many people provided feedback on each of the policies. The CHRG discussed all three policies.

Engagement opportunity	Number of responses
Carpal tunnel syndrome surgery questionnaire	77
Sacral neuromodulation questionnaire	68
Surgical release of trigger finger questionnaire	92
CHRG discussion	11

What did we hear?

The CHRG did discuss the individual policies but also had some general feelings towards the process of engagement that applied to all policies going forward.

This was about how easy the policies are for the public to understand. They appreciated that these were clinical policies and therefore would only normally be reviewed by clinicians but commented that on occasions the public may want to check the policy to understand why they may be rejected for certain procedures.

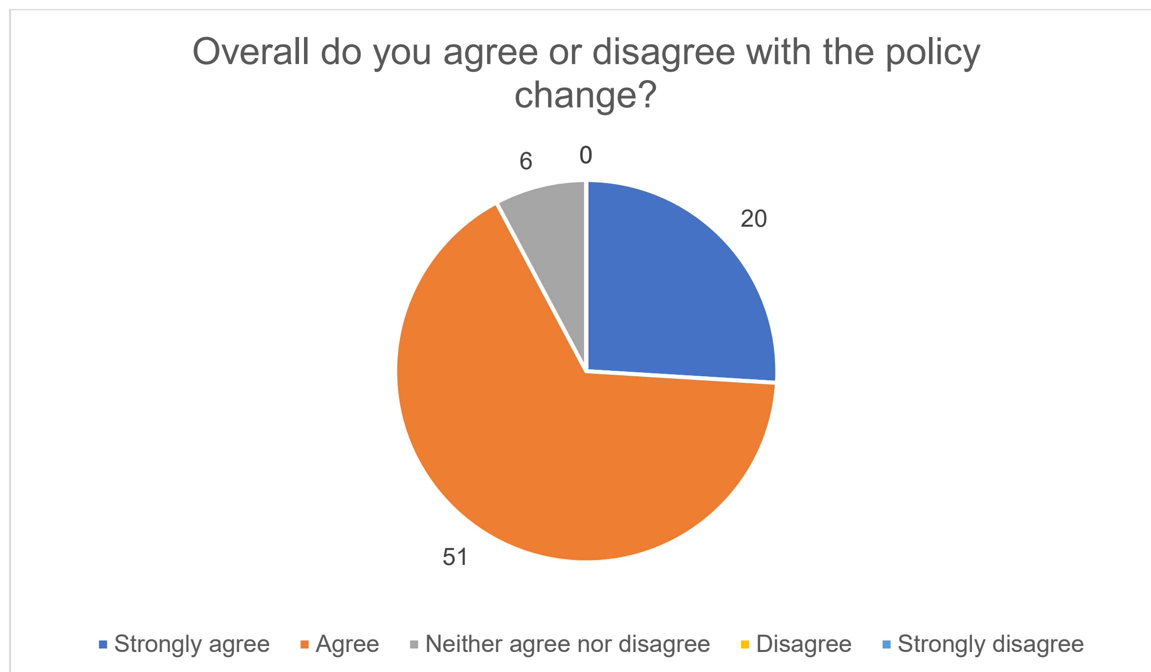
They suggested that it might be useful to have policies broken down into what is relevant to the clinician (such as what tests must be carried out or diagnosis criteria) and then a section that is relevant to the patient. They acknowledged that this may not always be possible but then stressed the need for the policies to be worded in a plain English way – reminding policy makers that the average reading age in Lancashire and South Cumbria is 11 years.

Carpal tunnel syndrome surgery

The survey responses showed that the respondents were from a good spread of Lancashire and South Cumbria. The majority (65 per cent) were over 65 years of age.

26 per cent of respondents reported to having Carpal tunnel syndrome.

97 per cent said they fully understood the new policy, those who didn't understand said this was based on the wording and not really being sure what the change to the policy actually is. Based on the wording only really reflecting a change from eight weeks to six to 12 weeks it is easy to see where the ambiguity lies.



Nobody disagreed with the policy change and 92 per cent agreed or strongly agreed.

Comments made ranged from people expressing their own lived experience or seeking reassurance that the policy had been clinically verified before being implemented. This will be fed back.

A selection of other comments that may be of interest to the policy group are listed below.

- We say it will increase provision of the surgery but how will it affect the waiting list for the surgery. Will people be waiting longer?
- We need to ensure this doesn't negatively impact people waiting for the operation
- Addition of Rheumatoid Disease as waiting for surgery impacts hugely on ability to be independent.
- The use of clinical terms such as paraesthesia while clinically accurate are difficult to understand for many but if presented as pins and needles it becomes comprehensible to the majority.
- I felt that conservative treatment recommendations V surgical intervention recommendations may need to be more specific.
- How is and who defines: "Symptoms significantly impact sleep or function"? This is subjective, if the GP feels it's significant and the surgeon doesn't how is this resolved. This element of the change leaves the new policy unclear.
- Cautionary anecdote: many years ago as a consultant I saw a patient whose surgeon was proposing repeat surgery for recurrent carpal tunnel syndrome - but whose symptoms were due to cervical spine problems that were rendering her tetraplegic. Should objective confirmation e.g. by nerve conduction studies., be advised before repeat surgery?
- Suggest ways to measure how symptoms affect daily activities and sleep, so surgery is prioritised.
- Specify guidance on when to consider surgery within the 6 to12 week conservative therapy window, particularly for patients whose symptoms are rapidly worsening.

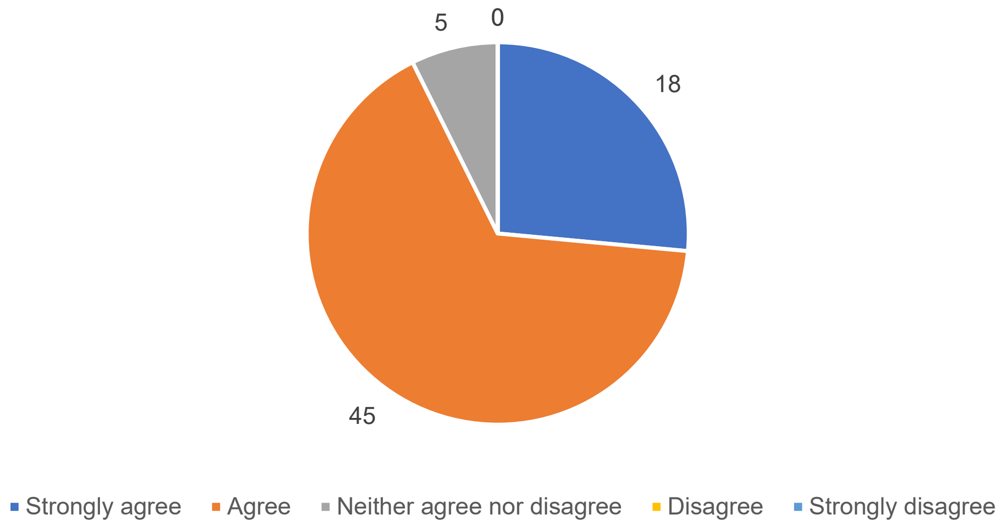
Sacral neuromodulation

Again, the responses were from a good spread of the population across Lancashire and South Cumbria.

The median age was 65 and over.

17 per cent of respondents were people with experience of sacral neuromodulation.

95 per cent fully understood the policy change and those who did not understand said it was because they were not fully familiar with the condition or were unsure as to whether it allowed them to access treatment or not.



No respondents disagreed with the policy.

Some of the comments focussed on ensuring adequate explanation of what the temporary device means and what it does. One respondent was expressing concern that they felt they would benefit and qualify for sacral neuromodulation but that his clinicians had not yet offered it to him – perhaps some additional awareness may be required.

Comments about the policy that may be of use are as follows:

- Question over why it has to be done in a specialist unit and will this require some people to travel further? Can it not be done in a local hospital?
- "As someone with a diagnosis of Detrusor Bladder Overactivity caused by spinal nerve damage, I have been lucky enough to have treatment of PTNs, this treatment every 4 weeks has made a huge difference. however none of the hospitals near me do this treatment so I make a 92 mile round trip every 4 weeks to access the treatment on the NHS.
  The treatment makes a huge different to the lives of people with severe incontinence where all other treatments have failed.
  I feel that more hospitals in Lancashire need to be able to offer the stimulation treatments for patients where other treatments have failed
- Specify how MDT assessment should document suitability for SNM, to ensure consistent decision-making.
- Patients should have a clearly defined follow-up plan to monitor device performance, complications, and symptom improvement.

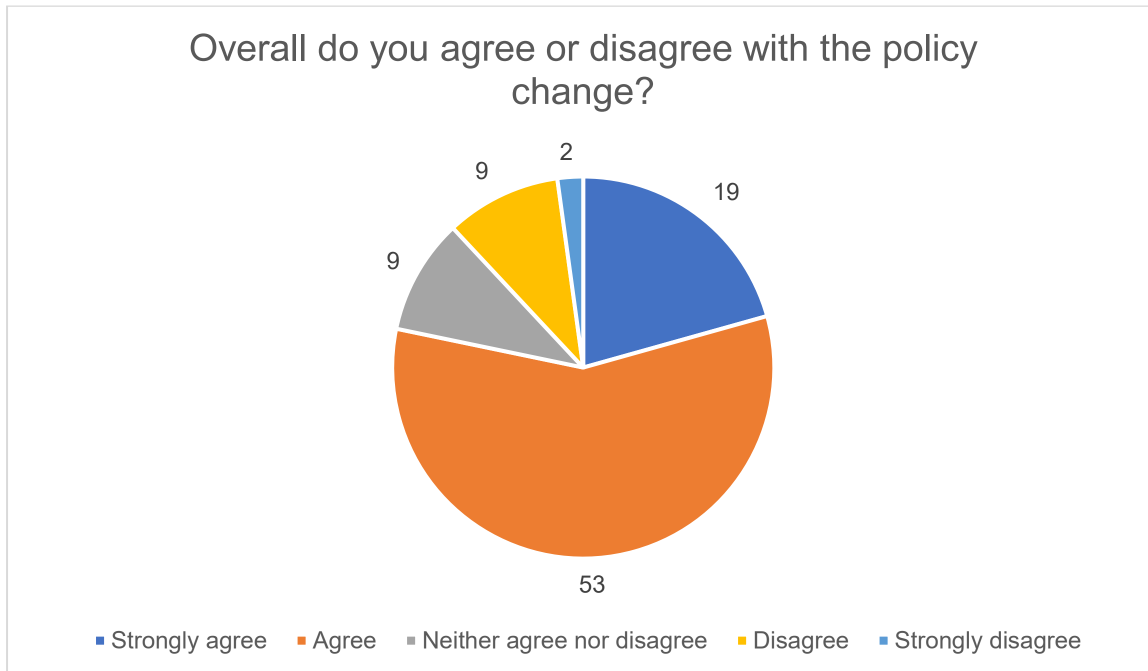
Surgical release of trigger finger

In respect to location the responses represent a good spread of the population across Lancashire and South Cumbria.

The median age was 65 and over.

27 per cent of respondents were people with experience of trigger finger.

97 per cent fully understood the policy change and those who did not understand were unsure of the timescales for the conservative methods to take effect. This is however included in the three week timescale given in the case of splinting.



The vast majority of respondents agreed with the policy however 11 people (12 per cent) disagreed or strongly disagreed.

Those who disagreed were asked to state why. There were 15 responses to this question which can be provided however in summary:

- Concern that the policy is cost-driven / delays effective treatment: Several commenters interpret reduced access to surgery (or later surgical thresholds) as cost cutting and 'fobbing people off', potentially leaving people to cope with a treatable condition for longer.
- Value of surgery as an effective intervention: People with lived experience report surgery resolved symptoms and prevented the condition becoming debilitating; some argue surgery should be available when it is clinically best, and accessible to all.
- Need for individualised decision-making and flexibility: Multiple comments stress that impact on daily life and pain is subjective; they want 'leeway' for clinicians to consider personal circumstances (work, caring responsibilities) rather than a blanket rule.
- Debate over steroid injection thresholds and informed consent: Some support conservative/alternative treatments first but want clarity on what the alternatives achieve. Others argue the threshold should remain at two steroid injections before moving on and note that failed injections can worsen symptoms.
- Diabetes-specific concerns: Commenters highlight that steroid injections can raise blood glucose and that diabetes-related reduced pain sensation may mask severity—so risks and options should be clearly explained, and earlier/preventative intervention considered for some.
- Minority/contrasting view: A small number of responses indicate the current system is working or that they would support alternatives if evidence shows they are effective and can avoid surgery.

In the general comments about the policy the key outstanding theme was around the ambiguity in the term “interfere with activities.” They suggest clarity around which activities and the extent at which trigger finger should interfere. A suggestion was to change the wording to “prevents day-to-day living activities.”

What we have learned

Key themes across comments were the need for clear, plain-English wording; reassurance that decisions will remain clinically led; and clarity where terms could be interpreted differently (for example, what is meant by symptoms that ‘significantly impact’ sleep or function, and what it means for trigger finger to ‘interfere with activities’). People also highlighted the importance of considering the impact on waiting times and ensuring consistent decision-making across services.

Conclusion and recommendations

Overall, feedback indicates strong public support for the proposed changes to the Carpal tunnel syndrome surgery and Sacral neuromodulation policies, with respondents recognising the intention to align with best evidence and improve access where clinically appropriate. For the surgical release of trigger finger policy, most people agreed with the proposed changes; however, a minority raised concerns about eligibility and how the policy may be applied in practice.

Based on what we heard, we recommend that the final policies are accompanied by a brief patient-facing summary for each procedure, including clear explanations of key criteria and what patients can expect from conservative treatment options. We also recommend reviewing and, where necessary, tightening any subjective wording and providing supporting guidance to clinicians to help ensure equitable, consistent application of the policies across Lancashire and South Cumbria.