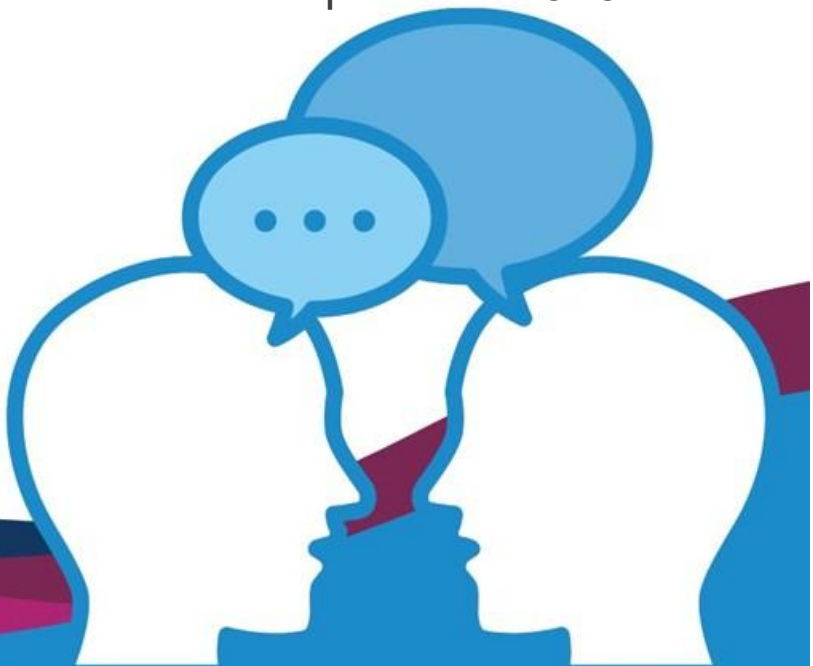
Lancashire and South Cumbria - Achilles Tendinopathy, Refractory Tennis Elbow and Plantar Fasciitis: treatment with extracorporeal shockwave therapy, autologous blood or platelet rich plasma injections

Listening to communities report

September 2026



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Acknowledgements

Thanks to the people of Lancashire and South Cumbria who gave up the time to share their insight to help Lancashire and South Cumbria ICB improve services.

Introduction

Extracorporeal shockwave therapy (ESWT) is currently commissioned in Lancashire and South Cumbria for a limited range of indications, including chronic calcific tendonitis of the shoulder and tendonitis and other soft tissue disorders of the knee that are refractory to conservative management.

The revised policy proposes that these interventions would not be routinely commissioned for Achilles tendinopathy, refractory tennis elbow and plantar fasciitis, reflecting the current evidence base and prioritising NHS resources for treatments with clearer demonstrated clinical benefit. Changes to the policy would not affect access to standard conservative treatments such as physiotherapy, exercise programmes or other routinely available Musculoskeletal services. It is anticipated that any policy changes would affect a small number of people.

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, social media channels and sharing with partner organisations.

Executive summary

The main findings can be summarised as:

- Review the policy based on robust clinical evidence
- Consider what treatment might be offered to those who have previously benefited from ESWT/ PRP/ autologous blood injections
- Clearly communicate what is available to patients who have chronic, intractable conditions
- Make sure any policy changes do not make health inequalities worse

NHS Lancashire and South Cumbria Integrated Care Board (ICB) serves a population of around 1.8 million people. The ICB regularly reviews its clinical policies to ensure they reflect the latest evidence-based guidance and best practice. As part of this ongoing process, a clinical policy that determines whether a person can have extracorporeal shockwave therapy, platelet-rich plasma therapy or autologous blood injection therapy treatment for certain conditions was up for review and the ICB gathered public feedback on the changes. All clinical policies are backed by national guidance and scientific evidence.

The proposed policy change would formalise the commissioning position for ESWT, PRP and autologous blood injections for Achilles tendinopathy, refractory tennis elbow and plantar fasciitis following review of the latest evidence.

During July and August 2026, 142 people living and working in Lancashire and South Cumbria shared their thoughts on the proposed change in policy.

Just over half of all respondents (58.5%) agreed with the policy changes. Concerns were raised about what treatment would be offered to those who are benefiting from ESWT/ PRP/ autologous blood injections, and what alternatives might be offered to those who had exhausted all other treatments. It was clear that respondents were conscious of the need for

the NHS to save money, and there were concerns that cutting services would exacerbate health inequalities.

What have we been talking to people about and why?

NHS Lancashire and South Cumbria Integrated Care Board (ICB) regularly reviews clinical evidence of effectiveness for various treatments. As part of the evidence review for extracorporeal shockwave therapy (ESWT), platelet-rich plasma (PRP) and autologous blood injections as treatment for Achilles tendinopathy, refractory elbow tendinopathy (tennis elbow) and plantar fasciitis, we wanted to gather a range of opinions.

Extracorporeal shockwave therapy (ESWT)

ESWT is a procedure where shockwaves are passed through the skin to the injured part of the body using a special device. The shockwaves are audible, low energy sound waves, which increase blood flow to the injured area.

Multiple evaluations and reviews of the effectiveness of ESWT for tennis elbow, plantar fasciitis, and Achilles tendinopathy have found little or inconclusive evidence of effectiveness.

Platelet-rich plasma (PRP) and autologous blood injections

PRP is created by taking the patient's blood and spinning it in a centrifuge, separating blood platelets which produce growth factors. PRP is re-injected into the affected tendon. Growth factors may start the healing process and reduce pain and swelling.

In autologous blood injection, whole blood is taken from the patient and re-injected around the affected tendon. Growth factors may start the healing process and reduce pain and swelling.

Reviews of PRP and autologous blood injection as treatment for musculoskeletal soft tissue injuries such as tennis elbow, Achilles tendinopathy and plantar fasciitis found insufficient compelling evidence to support it.

Summary of proposed policy changes:

Evidence reviews identified inconsistent data which does not support ESWT, PRP or autologous blood injections as effective treatments for Achilles tendinopathy, plantar fasciitis, and tennis elbow. The proposed policy recommends that none of these interventions are routinely commissioned for these conditions.

The proposed policy reflects the latest review of the clinical evidence and is consistent with the commissioning approaches adopted by a number of neighbouring NHS organisations. Aligning with neighbouring ICBs gives a consistent, evidence-based approach across the North West region, and reduces the 'postcode lottery' effect where the care someone receives depends on where they live.

Who have we heard from and how?

Deciding who to talk to

We wanted to hear from people likely to experience Achilles tendinopathy, tennis elbow, or plantar fasciitis. We thought that people involved in physical activities like sports may experience these issues, as well as older adults and people with existing physical disabilities or musculoskeletal (MSK) problems.

We also wanted to hear from anyone else with an interest or concern around tendinopathy treatments, regardless of whether or not they were current MSK service users.

How did we speak to people?

We shared an online questionnaire inviting insight and feedback.

We invited multiple organisations to share the questionnaire with their services users and staff. These included nine NHS services focusing on musculoskeletal concerns, pain management, and orthopaedics; 32 sports clubs; and 26 voluntary, community, faith and social enterprise (VCFSE) sector organisations. The invitation was also shared through Place networks across Lancashire and South Cumbria.

Questionnaire

The questionnaire consisted of the following questions:

1. Do you think the reasons for the policy change are reasonable? (Yes/ No/ unsure)
    a. Please explain why or why not
2. Do you think the criteria for access are clear and understandable? (Yes/ No)
    a. If you answer no please explain
3. Do you think the policy disadvantages any individuals or groups? Please explain.
4. Does the policy provide enough information to allow a clinician to discuss a patient's eligibility for treatment? (Yes/ No / not sure) – if you answer no or not sure please explain
5. Do you agree or disagree with the policy change? (Agree/ Disagree)
6. Is there anything else you would like us to consider when implementing the policy?

How many people got involved?

In total, **142** people across Lancashire and South Cumbria completed the survey, with a further 76 surveys started but not completed.

Respondents were able to choose to leave a comment as well as selecting from pre-defined tick boxes. They were able to decline answering demographic questions, although the majority (123) answered at least one question.

Geographical area

We heard from people in all parts of Lancashire and South Cumbria: FY postcodes covering Blackpool, Fylde and Wyre; PR postcodes covering Preston, Chorley, South Ribble and surrounding areas; BB postcodes covering Blackburn, Burnley, Pendle, Rossendale and surrounding areas; LA postcodes covering Lancaster, Morecambe Bay, South Lakeland and Furness; and other postcode areas including West Lancashire, along with borderline areas such as Bacup, Edenfield, and Cumbria which may sit between localities. There was one response which may have been a possible mis-spelling of a Preston area postcode.

Postcode	Number
BB	24
FY	24
LA	34
PR	30
WN	2
Other (BL, CA, OL, Incomplete/unclear)	5

Total	119

Age

Of 123 respondents who answered this question, the majority were over 70 years old (39.8% - 49 individuals). There were no responses from people between 18 – 29 years old.

Age	Number of responses	Percentage of responses
18 – 29 years	0	0
30 - 39 years	3	2.4
40 - 49 years	12	9.8
50 - 59 years	17	13.8
60 - 69 years	42	34.1
70 years and above	49	39.8
Total	123	100

Gender

Of 119 respondents who answered this question, 26.9% identified as male (32 individuals), 70.6% as female (84 individuals), and 3 as non-binary or other gender identity (2.5%).

Ethnicity

Of 122 respondents who answered this question, the majority were white British (113 individuals, 92.6%).

Ethnicity	Number of responses	Percentage of responses
White British	113	92.6
White Irish	2	1.6
Indian	1	0.8
Pakistani	1	0.8
Bangladeshi	1	0.8
Other Asian background	1	0.8
Mixed – white and Black African	1	0.8
Any other ethnic group	1	0.8
Don’t wish to answer	1	0.8
Total	122	100

From the demographics, it is clear that there are significant gaps in representation across Lancashire and South Cumbria. For future engagement it will be important to make sure to hear from younger people, especially adults aged 18- 25; to hear from people from ethnic minority backgrounds; and to hear from men of all ages.

What did we hear?

The strongest themes overall were concerns about cost-cutting, the impact on quality of life, and the loss of treatment options for people with chronic or treatment-resistant pain conditions. Respondents were emphatic that if routine commissioning of ESWT, PRP and autologous blood injections is removed, there should still be clear alternative pathways, clinician discretion, and exceptions for patients who may benefit or who have exhausted other options.

All comments can be found in full in Appendix 1. Personal or sensitive information has been redacted to preserve anonymity.

Question 1. Do you think the reasons for the policy change are reasonable? Please explain why or why not in the box below.

Answer Choices			Response Percent	Response Total
1	Yes		50.70%	72
2	Not sure		21.83%	31
3	No		27.46%	39
			answered	142
			skipped	0

Responses fell into seven categories: those who saw the policy change as being based on finances and were opposed; those who saw it as based on finances and were in favour; concerns about privatisation of the NHS; queries about alternative provision for those who have found this treatment effective; evidence-based treatment; broad agreement; broad disagreement; and uncertain or narrative responses.

Financial – opposed

Comments included “I imagine that finances are the main driver”, “Stop chipping away at the NHS…” and “Is it perhaps a cost cutting exercise?”

Respondents also expressed concern that Lancashire and South Cumbria is following the lead of other ICBs rather than tailoring services to local need, and that anyone who had found conservative management ineffective would need to pay privately for ESWT/ PRP/ autologous blood injections.

There was a sense that the NHS no longer offers the degree of care that people actually need: “The NHS is supposed to be a national organisation to care for all residents cradle to grave paid for by the workers of our country. Now we have to pay [privately] for teeth, eyes and feet care”.

Financial – for

Comments included “Effective use of limited resources. Proven treatments are still available for conditions” and “On a cost benefit analysis - not worth it”.

There was strong feeling that firm evidence is needed to continue paying for services which may benefit small numbers of people. It was also suggested that people who still want ESWT/ PRP/ autologous blood injections can pay for it privately.

Privatisation of the NHS

Comments included “This is just a cost cutting exercise and creeping privatisation” and “Termination of this… treatment… is a further move towards privatising some elements/treatments of the NHS”.

Respondents were suspicious of the reasons for restricting treatment, and concerns about the role of government in funding adequate services.

Alternative provision for people who find treatment effective

Respondents commented “Disregards the minority for whom standard treatment is inappropriate” and queried what would be available for people who had found ESWT/ PRP/ autologous blood injections effective in the past or had not responded to conservative management of their condition – “…to no longer provide these procedures feels like we are neglecting those in need of medical treatment. I always trusted that we are patient led and treat according to need - changing the policy to no longer routinely offer these procedures… is unacceptable…”

Concerns were raised that those who suffer from less well understood conditions like Ehlers Danlos Syndrome will lose access to care, and that patients with long-term chronic pain conditions may be left without treatment options – “The more you stop providing care and treatment for specific aliments/issues, the more you marginalise people who likely don't have the means - financial or otherwise - to get treatment.”.

Evidence-based treatment

Some respondents thought that the policy change was in line with evidence-based practice, and in the absence of robust evidence it makes sense to withdraw ESWT/ PRP/ autologous blood injections as routinely commissioned treatment.

However, there were several comments suggesting that the evidence gap offered Lancashire and South Cumbria an opportunity to research and evidence ESWT/ PRP/ autologous blood injections: “…is the lack of evidence because you have not been looking for it?...” One respondent cited several studies advocating for ESWT/ PRP/ autologous blood injections as a second-line adjunct treatment and encouraged policy makers to consider them(see appendix 1 for further information).

Broad agreement

Comments included “Sounds right and better for all”, “Using evidence-based decisions is acceptable” and “The policy appears to be in line with NICE.”

Broad disagreement

Comments included “Another cop out”, “If they are working on patients you should carry on” and “These conditions… cause long periods of pain, immobility and unemployment. It is counterproductive to not treat people, especially of working age for these conditions.”

Uncertain/ narrative responses

These responses captured a broad range of opinion, especially where people wanted to share their personal experiences of tendinopathy or ESWT/ PRP/ autologous blood injections. One respondent queried whether the policy differentiated between insertional and non-insertional Achilles tendinopathy. Respondents also raised concerns about the meaning

of not routinely commissioning ESWT/ PRP/ autologous blood injections, and whether this allowed for some to receive treatment if all else had failed.

“It appears that the… treatments were thought to be appropriate for those conditions in the past. I wonder if because their success is inconclusive rather than obviously successful then the decision is to err in favour of discontinuing for all… Is there any room for those patients suffering severely from those conditions to try alternatives..? I note… that the phrase “routinely commissioned “might allow for exceptions.”

Question 2. Do you think the criteria for access are clear and understandable? If you answer no, please tell us why in the box below.

Answer Choices			Response Percent	Response Total
1	Yes		68.31%	97
2	No		31.69%	45
			answered	142
			skipped	0

Responses fell into three categories: yes, no, and a narrative response.

Yes
Some respondents found the criteria clear and understandable. Comments included: “I think the reasons are clear but the wording deliberately vague…” and “I have ADHD/ autism and can clearly understand”.

No
Some respondents felt that the criteria were unclear, vague, or confusing: “Patients/service users are not aware of their treatment options, they rely on… their GP/healthcare provider advising them… not enough options are relayed…” and “my understanding is there is no access… How can we have a clear strategy to 'access' when you’re saying no to everyone? that sounds contradictory. So no that is unlikely to be clear to patients.”

Some respondents also highlighted that they have been given conflicting information about ESWT/ PRP/ autologous blood injections: “This statement makes it sound like some clients may be offered it, but have been informed in my practice that PRP was took off license quite a while ago now and not accessible on NHS at all??”

Narrative response
Some respondents shared personal experiences of treatment, and concerns that lack of treatment might cause subsequent health problems: “These… painful conditions… impact on people’s lives [and] restrict mobility… many who currently enjoy an active lifestyle… cease to take part. This will lead to other health issues downstream. Supporting active living is a key feature of the NHS”

Question 3. Do you think the policy disadvantages any individuals or groups? Please explain in the box below.

Answer Choices			Response Percent	Response Total
1	Yes		40.85%	58
2	Not sure		30.99%	44
3	No		28.17%	40
			answered	142
			skipped	0

Responses fell into four categories: yes, the policy disadvantages individuals or groups; no, the policy does not disadvantage individuals or groups; not sure if the policy disadvantages individuals or groups; and narrative responses adding personal experiences.

Yes
The majority of respondents who felt that the policy change will disadvantage individuals or groups were concerned about those suffering from chronic conditions which haven't responded to traditional treatments: "Chronic suffers need to have access to all available treatments. Restricting them is denying health care." They were also concerned about the impact on people suffering from intractable MSK conditions who have either had successful treatment with ESWT/ PRP/ autologous blood injections, or may benefit from them in future: "If other treatments do not work, this may be a last chance for some", "Will disadvantage those who do receive benefits from these treatments" and "Yes… the policy could disadvantage people… who have already tried physiotherapy, exercise programmes and other standard treatments without success."

Concerns were also raised about the potential impact on menopausal women, older adults who may be more likely to experience MSK issues, and people living in poverty who can't afford private health care – "…people… in jobs that can cause such conditions rely on the healthcare they contribute towards…" and "Any low-income users… if they cannot access these without paying privately."

No
Those who responded 'no' felt that the policy was fair and affected everyone equally; they thought that the numbers of people impacted would be low.

Not sure
Respondents who weren't sure if individuals or groups would be disadvantaged mostly felt they didn't have enough information, either about the policy change, possible alternative treatment, or the kinds of people who may suffer from tendinopathy: "I would need much more information in order to answer this question intelligently" and "It's hard to say because it doesn't spell out what alternative treatments are to be offered."

Narrative responses

Respondents shared their personal experiences, support for access to treatments based on clinical need, and concerns about bias: “Treatment should be based on clinical need, not on quotas.”; “Access is always key to any treatments”; and “A policy bias is driven by clinicians… rather than policy. Training and clinical bias should be kept in check”.

Question 4. Does the policy provide enough information to allow a clinician to discuss a patient’s eligibility for treatment? If you answer not sure or no, please tell us why in the box below.

Answer Choices			Response Percent	Response Total
1	Yes		50.00%	71
2	Not sure		25.35%	36
3	No		24.65%	35
			answered	142
			skipped	0

Responses fell into four categories: yes, the policy provides enough information for clinicians to discuss patient eligibility; no, the policy does not provide enough information; not sure if the policy provides enough information; and narrative responses adding personal experiences.

Yes
A single respondent felt that the policy was clear that ESWT/ PRP/ autologous blood injections were simply not available to any patient.

No
Respondents who felt that the policy didn’t give clinicians enough information to discuss patient options raised concerns about lack of information, or that the information was ambiguous.

There were concerns about alternative treatment options: “The policy explains which treatments would not be routinely commissioned, but it does not make it entirely clear how clinicians should deal with patients who have tried all the usual treatments without success… are [there] any exceptional circumstances or alternative treatment pathways available for these patients” and “There is no definition of what constitutes "refractory to conservative management", including the duration of symptoms, types of treatments that should have been attempted, or objective measures of treatment failure”.

Not sure
Around a quarter of respondents felt that as they were not themselves clinicians they couldn’t agree or disagree: “Not qualified to comment on what a clinician may need” and “Not being a qualified health practitioner I wouldn’t know”. Most felt that they would need more information themselves, and that clinicians should use their clinical judgement based on patient eligibility.

Narrative responses

Respondents shared their personal experiences of MSK referral and treatment, with some expressing that they were not aware of ESWT/ PRP/ autologous blood injections. Many commented that the policy change impacts patient choice and may have cost implications: “The policy should outline that shock wave therapy to be exhausted before the need of an operation” and “All ailments deserve to be treated to alleviate pain and suffering, should not be down to cost- any proven remedy should be made available”.

Question 5. Do you agree or disagree with the policy change?

Answer Choices			Response Percent	Response Total
1	Agree		58.45%	83
2	Disagree		41.55%	59
			answered	142
			skipped	0

Just over half of all respondents agreed with the changes to the ESWT/ PRP/ autologous blood injections policy.

Question 6. Is there anything else you would like us to consider when implementing the policy? (comment below)

This question had a high number of responses, with half of all survey respondents (76 respondents out of 142) sharing their views. Comments fell broadly into five categories: concerns about alternative provision and exceptions to the policy; how the wider political landscape impacts on the NHS; that the impact on patients may require reconsideration of the policy; communicating with patients and clinicians around evidence-based practice; and narrative responses.

Alternative provision/ exceptions to policy

There was a clear sense that if the policy change removes access to ESWT/ PRP/ autologous blood injection treatment, especially for those it has been effective for, there needs to be something else instead: “It is not unreasonable to make these treatments [not] routinely available but there needs to be some consideration given to those with intractable conditions” and “Allow for clinically supported exceptions”.

Some suggested alternatives to current commissioning arrangements, such as offering ESWT/ PRP/ autologous blood injections when other treatments have failed, monitoring the treatments for effectiveness over a certain period, and including signposting in the policy so patients are not left with a “dead end”.

Political landscape

There was clear scepticism and suspicion of the policy change, which was viewed as a ‘cost-cutting exercise’ rather than improving patient care or supporting choice – “This is really just about cost isn't it. Nothing wrong with that, but don't beat about the bush.” Some questioned the validity of public engagement: “I suspect these matters have already been decided on and these surveys are just a paper exercise…”

There was frustration with government health funding policy, lack of trust in NHS staff, and concern about longer-term implications of the policy change: "…stop cutting costs. They only lead to further costs to the NHS on down the line. You are destroying people's health with these cuts".

Impact on patients/ reconsider changing policy
Although respondents seemed to accept the reasons for the policy change, many urged reconsideration. They felt that people should have access to all forms of care, especially for those who have previously found it effective or those who have exhausted all other treatments: "…in my book it is important that (the very small number of) patients who have the most severe refractive conditions are given options which may make a massive difference to them, especially relatively inexpensive treatments."

Some felt that the policy change underestimated the impact of chronic pain on people's quality of life: "People first! Pain first quality of life first" and "Please reconsider this change in the policy - I feel it's unethical and we should not be looking at saving costs in this way". It was suggested that patients already receiving ESWT/ PRP/ autologous blood injections should be allowed to continue, and that clinician expertise and discretion should be permitted: "I believe clinicians should have the flexibility to refer carefully selected patients for these treatments where they feel there is a reasonable chance of benefit, rather than applying a blanket policy".

Communicating with clinicians and the public/ research into treatment
Respondents were keen for there to be more and clearer messaging about ESWT/ PRP/ autologous blood injection treatment and research; a number of respondents shared that they had been told ESWT/ PRP/ autologous blood injection treatment has been discontinued even before the proposed policy change. They encouraged listening to frontline clinicians, as well as making sure any changes are clearly communicated.

Narrative responses
Respondents shared their personal experiences and opinions. Some felt that local Lancashire and South Cumbria policy focuses on saving money over patient care, and that restricting access to care would have greater impact down the line for both patients and services: "What has happened to treatment and care in Lancashire it seems more about patients suffering and saving money rather than treating people".

Some queried how older adults had been considered in the process, and that the most effective treatments should be prioritised. One respondent warned that MSK issues can affect anyone – "wait until you get any of the said problems!". More than anything, respondents asked that the process should be evidence-based and fair.

What we have learned

What our patients have told us

- Consider possible alternatives to ESWT/ PRP/ autologous blood injections for patients who have previously found them effective
- Consider permitting ESWT/ PRP/ autologous blood injections in very specific circumstances
- Clarity on terms such as ‘not routinely commissioned’ would help the public understand what is within scope of the policy change
- Make sure those who may be disadvantaged by removal of access to ESWT/ PRP/ autologous blood injections know which treatments are available to them
- Improve communication of policy updates and changes to frontline staff so they have up-to-date information to share with patients
- Policy change process must be evidence-based and fair

Conclusion and recommendations

Although 58.5% of respondents agreed with the policy change, it was clear from the text responses that even those who agreed had some reservations.

Concerns mainly focused on making sure that anyone who had previously found ESWT/ PRP/ autologous blood injections effective should have some way to continue their treatment. Some respondents urged Lancashire and South Cumbria ICB to reconsider the policy change, or to allow for a small number of patients to access ESWT/ PRP/ autologous blood injections under very specific circumstances.

A number of responses suggested there may be an opportunity to better communicate the current or future commissioning position – multiple respondents stated they were unclear or uncertain. Under the current Lancashire and South Cumbria ICB policy, ESWT is already restricted to a limited number of specific shoulder and knee indications and is not routinely commissioned for Achilles tendinopathy, plantar fasciitis or tennis elbow.

It was also mentioned multiple times that patients have already been told these therapies are no longer available on the NHS. A significant number of respondents were concerned that this would have a financial impact on those least able to afford private healthcare. It may be worth considering how to address these concerns in patient-facing communications.

Many respondents agreed that NHS policy should follow national guidance and be based on robust evidence. Some queried whether Lancashire and South Cumbria may be able to undertake research into the effectiveness of ESWT/ PRP/ autologous blood injections as a way to continue allowing this treatment for those likely to benefit.

Frustration with, and suspicion of, any perceived cut to healthcare funding was expressed throughout the responses. This suggests an opportunity for much clearer communication of policy decisions and how those decisions are made.

Recommendations.

- Clear and easily accessible information on current policies – consider adding a plain English version where possible.
- Communicate any changes to policy to frontline clinical staff consistently and in a timely manner.
- Plain English definitions of policy terms such as ‘not routinely commissioned’ in all public-facing materials.
- Have clear alternative treatment pathways for patients who have previously benefited from ESWT/ PRP/ autologous blood injections.
- Make sure the policy is applied consistently, transparently and sensitively in a way that does not increase health inequalities.

Closing the feedback loop.

Policy development colleagues appreciated the insight gathered and offered further information which may be useful for any patients or members of the public who are interested in ESWT/ PRP/ autologous blood injections.

- ‘Not routinely commissioned’ means these treatments would not normally be funded by the NHS for these conditions. Standard musculoskeletal care, including physiotherapy and other routinely commissioned services, would remain available. The detailed clinical policy sets out the commissioning position and any applicable exceptions.
- Feedback highlighted some people’s experiences of benefiting from ESWT/ PRP/ autologous blood injections; however, the evidence review found inconsistent, inconclusive or not enough evidence to support routine commissioning of these treatments for Achilles tendinopathy, plantar fasciitis and refractory tennis elbow.
- Although engagement feedback did not identify any new evidence that would alter the proposed policy position, it highlighted areas where additional communication and delivery support may be needed such as clearer information about alternative treatment options, how patients currently receiving treatment would be supported, and the meaning of certain specific terms.
- If the policy is adopted, these themes will be reflected in delivery planning, patient communication and clinical guidance to make sure it is applied consistently, transparently and sensitively.

Appendix 1 – responses to questionnaire, grouped by theme

Q1. Do you think the reasons for the policy change are reasonable? Please explain why or why not in the box below.

Financial - against

- Just because Cheshire Merseyside and Manchester don't do these, it's not compelling enough to follow suit. this sound more like financial saving and where it has worked in other area you simply ignoring the science
- Money money money .
- I believe It shows that this current government have not fully funded the NHS due to failure with the uk economy and public services are paying the cost of a failed government. [REDACTED]
- I imagine that finances are the main driver
- I had to pay for shock wave therapy for chronic tennis elbow. I had it on both elbows and despite it only worked on one , I had to have an operation on the other . So despite the 50 % efficacy it would still be cheaper than an operation
- Is it being a reduced service as a cost cutting process
- Shockwave treatment was the only thing that worked for my plantar fasciitis. Exercises did nothing. It should be retained for those for whom it does work. I now have a recurrence and will be outraged if I need to pay privately for this treatment to stop me completely disabled and unable to walk
- Stop chipping away at the NHS,
  I dont need these treatments
  But maybe I might on the future.
  I currently have to pay far to much for my dental care
  Not through choice,
  Dental care has been chipped at for years
- Surely each case needs to be treated individually.
- I have Achilles tendinopathy and have received physio but it has not worked so am now having to seek private treatment for shockwave therapy at my own expense. I was informed by my physio at [REDACTED] that this was not available on the NHS but it looks like I was misinformed as this consultation appears to show it is available but you are trying to remove it. Is the real truth that you have implemented this policy before any consultation and you are now seeking to justify your withdrawal.
- Is it perhaps a cost cutting exercise?
- The NHS is suposed to be a national organisation to care for all residents cradle to grave paid for by the workers of our country.
  now we have to pay private for teeth,eyes and feet care

Financial – for

- Effective use of limited resources.
  Proven treatments are still available for conditions.

- As there is no firm evidence for these treatments improving patient outcomes, I would prefer the money being spent in areas that are proven to provide to relief.
- If the evidence is not there for efficacy then it isn't value for money.I ,myself suffered from plantar fasciitis a few years ago and did resort to a little shock wave machine eventually which did help but maybe it would have got better anyway
- If only a very low number of people receive any improvement when there are other forms of treatment available why continue?
- I think different treatments work on different people so offering it for everyone could be costly
- On a cost benefit analysis - not worth it
- according to the data provided, the treatment is not effective and the issue is with cost and time and offering other effective measures
- Whilst this is a recurring and uncomfortable condition this surely can be privately paid for by people either this condition- I have had this condition several times and have bought items to stretch out the bottom of the foot - the NHS can’t fund everything

Privatisation

- This is just a cost cutting exercise and creeping privatisation. My husband is currently having to pay for shockwave therapy as the dry needling and physio didn't work. 1. It should be free to him considering the other procedures didn't work 2. If he had had this in the first place he wouldn't now be limping and need physio and treatment for other secondary issues. In the long run, despite us paying for the shockwaves treatment ourselves it has cost the NHS more as it has caused him more health issues.
- The termination of this kind of treatment is purely cost/budget based. This is a further move towards privatising some elements/treatments of the NHS.

Provision for people who find this effective

- Disregards the minority for whom standard treatment is inappropriate.
  No acknowledgement of cost implications
- Where else will people go for this treatment?
- I know two people that struggle with the conditions listed - to no longer provider these proceedures feels like we are neglecting those in need of medical treatment. I always trusted that we are patient led and treat according to need - changing the policy to no longer routinely offer these procedures I feel is unacceptable and not in line with the patients best interests. We should not be cutting costs in this way, I feel it is against the whole nature of the NHS and what the public deserve and pay contributions towards - ensuring their health care provides the support/proceedures they need in order to live a healthy life without struggling with dibilitating symptoms
- No other effective treatments when conservative measures fail. Some evidence shockwave works
- Any cuts to any service has a detrimental effect on any patient needing that particular service and their overall daily health and wellbeing will be severely impacted.
- Shockwave therapy has been shown to reduce healing time and potential longer term issues for patients who repeatedly suffer tendinopathies such as those with Ehlers Danlos Syndrome. This is particularly important as there is currently no pathway of care for such patients thus they are at significant clinical risk that removal of such treatments will further degrade their MSK health

- Always concerned that those excluded from these treatments, if the treatments are still working for them, can afford to pay if have to go private.
- I don’t feel qualified to judge the medical evidence, but I would like the NHS to ensure that patients with long-term painful conditions are not left without treatment options if standard care has failed. Any decisions should allow doctors to refer suitable patients for these treatments where they are likely to help.
- The more you stop providing care and treatment for specific aliments/issues, the more you marginalise people who likely don't have the means - financial or otherwise - to get treatment. This naturally has a domino effect and also leaves people without treatment. Who takes care of sick people when the people who are supposed to do it decide they don't want to? Why are we stopping care and treatment on the NHS to people in all categories? Money before health is immoral. So you save a bit of money - at the same time you leave people untreated and in pain. You give people no option but to seek private health care. When did that ever work as an affordable option for the working class, disabled, pensioners, and the millions of people who are poor and underserved already? I think this continues the death of the NHS and increases the death of people who simply can't manage.
- I feel that if all other measures have failed, and clients remain constantly in alot of pain over a stated prolonged period of time, PRP injections should be offered to try as an alternative as this is the treatment that i have heard from various outlets and networking that has worked the best for clients
- I believe that allowing the patient to have access to all treatments available can strongly enhance their recovery from the condition from which they are suffering. Compelling evidence does not always mean that the treatment will not work for some. Having suffered from excruciating joint and tendon pain I have been grateful to have been offered various treatment to aim to improve my quality of life even if it has been experimental.Taking away the opportunity for some to be able to access the treatment is likely to have a negative impact on their physical and mental health which then impacts their overall ability to function. If only offered under strict control of a consultant when other conservative treatment has failed this could improve their ability to improve.

Evidence-based treatment

- I have no problem with the review of evidence however the approach is not holistic. You are looking at things in isolation whereas all three can be indicative of enthesitis. Have you mentioned review of diagnosis particularly consideration of link with Psoriatic arthropathy. I note that you have a strategy for biologics versus immune modulators but no ICB or [Trust] strategy covering the primary care secondary care interface.
- It appears the research does not support routine administration of these therapies. It should still be possible if a clinician makes a clinical case as to how this would help individuals on a case by case basis
- In line with evidence based practice.
- There does not appear to be any evidence that the treatment is effective.
- Two of the treatments do not have enough evidence yet to know if they work or not. If people don’t have these treatments the body of evidence for or against will not exist.

Why not keep a pilot study or research study open whilst limiting access only to the study.

- You clearly state there is no sufficient evidence the treatments work
- As an ex GP, I know how important it is that treatment is evidence based.
- If there little evidence to support it's effectiveness
- If the treatment is only marginally effective it should be replaced with something that works better.
- Does not appear to be very effective
- The NHS should only fund treatments with a sound clinical evidence base
- The best treatment should be available to everyone wherever they are in the country
- Just be cause its not yet evidenced doesnt mean it cant be. This needs a review of percentage of patients that actually benefit crom the 3. If its a decent % then keep it. Otherwise we would get rid of loads of potentially bensficial treatments. Patient benefit lver papers and budget lines.
- No real clear evidence base.
- Inconclusive evidence of benefit
- There seems to be little evidence of the true effectiveness of these treatments.
- There appears to be insufficient evidence to demonstrate that these treatments are effective.
- The change in policy is clearly a demonstrated and proven one in other organisations. The data must be sufficent enough to justify these changes.
- if there is no evidence that this treatment works then I can understand why this would no longer be prescribed - BUT is the lack of evidence because you have not been looking for it? or it there evidence that the treatment does little or no good? these are wildly different things
- If there is any evidence to support these claims then I think it would be useful to complete further clinical trials I have plantar fascia it is very debilitating physiotherapy services are not great.
  If these treatments can support pain management I think it is worthwhile rather than simply stopping access to these services
- Evidence based information should be relied on
- These conditions seriously affext quality if life. All treatments under review are Increasingly supported by research
- Does not appear to be good evidence for their efficacy, and other treatments will still be available.
- Regarding ESWT - when used in isolation results and outcomes are limited. But if ESWT is used in conjunction with gastrosoleus stretching, Plantar fascia taping or orthoses - results tend to show superiority. It appears valid for ESWT to be considered an adjunct within a prescribed treatment .This view would keep in line with the Heel pain clinical practice guidelines published by Koc et al. (2023) ESWT is also recommended an a second line adjunct for patients not responding to first line conservative measures as per Morrisey et al., (2021). This was further supported by Cotchett and Morrisey (2026).
  The suggestion that ESWT be decomissioned, particularly for a condition such as PHP, where as a second line treatment it has a role before invasive interventions such as Corticosteroid injection or surgical considerations appears short sighted.

Particularly given the associated adverse affects and costs associated with invasive interventions that would require onward referral to secondary or tertiary care.
- If there is definately no evidence this treatment works then it is not unreasonable however these conditions can be very difficult to treat so this treatment should be considered if everything else has failed

Broad agreement
- I am assuming these treatments can still be obtained privately if wanted.
- Service from local physio outposts at [REDACTED] not had good feedback so Gps stopped referrala
- Sounds right and better for all
- I was a student sports therapist in the past and we used E-stim using gel for Achilles tendinitis
- The policy appears to be in line with NICE.
- If there is not enough evidence of the treatment being effective it is fair to change the policy.
- Using evidence based decisions is acceptable
- I think aligning with other providers is important

Broad disagreement
- Another cop out
- Rather than change and not provide to come in line with others , we should be leading the way and others come in line with us
- These are painful conditions that impact on people's lives. They restrict mobility. As a result many who currently enjoy an active lifestyle that contributes to their overall cardiovascular and physical health cease to take part. This will lead to other health issues downstream. Supporting active living is a key feature of the NHS
- The shockwave therapy worked very well for me despite an 8 hour round trip by public transport to get it.
- If they are working on patients you should carry on.
- I think if someone is suffering then treatment should be provided
- These conditions are long suffering and cause long periods of pain, immobility and unemployment. It is counter productive to not treat people, especially of working age for these conditions. In fact they should concentrate on speeding up the diagnosis and treatment rather than delaying and procrastination.
- I thankfully have never needed this treatment but the support in the Furness area is poor as it is. To take more away is shocking and unfair for people in the area to travel to inner cities.
- How can you say the results are inconclusive. I've had some of this treatment, it worked for me.
- Would prefer comparison with nationwide practice rather than one local ICB

Uncertain/ narrative response
- I’m not really sure The data says it’s basically ineffective but for some people it may produce a placebo effect and make them feel as though they’re improving
- Insufficient concrete data given
- I don’t understand how many people have been helped by treatments. Are they being stopped as ineffective or just to save money?

- The “current” policy on the website already restricts access to those with shoulder or knee conditions. Therefore I’m unsure what change is needed, unless policy change has already taken place.
- Can't access so called existing provision via GP
- I have had planter fasciitis and tennis elbow, was not offered any of the treatment mentioned. It was treated with Podiatry for foot problem, and physio for tennis elbow.
- Having had tennis elbow any treatment would of been gratefully received as it was so painful and debilitating
- Possibly, depending on the exact meaning of “not routinely offered” when and how would they be offered?
- It appears that the aforementioned treatments were thought to be appropriate for those conditions in the past. I wonder if because their success is inconclusive rather than obviously successful then the decision is to err in favour of discontinuing for all. I can well understand that there is a need to save money wherever possible. Is there any room for those patients suffering severely from those conditions to try alternatives to physio especially those for whom their work is affected? I note on looking back that the phrase “routinely commissioned “ might allow for exceptions.
- If they not available in other areas close by could you charge them to send their patients to you for treatment
- Taking therapies away from our hospital is a bad idea. We would have to travel out of the area and would inconvenience a lot of people, especially if they don’t have a car! Public transport is difficult in rural areas. As it is, there is not a public bus in my village and it is 2 miles one way to a train station nd 3 miles in the other direction, which would mean a taxi ride to get there
- I put not sure down primarily because I fully respect the need for clear evidence based research to justify treatment for safety and costs but your not offering alternatives that are clear and effective to help prevent, improve or manage. So if current treatment plans are not working then its natural for people to desperately want to try something new. You only find new treatments if you try it, is the mentality. (Putting aside the cost to benefit ratio aside for the moment). Questions to ask our self 1. at what point are pepole coming to you in pain with this issue? at the very beginning, mid or late stage? At what point do these conditions become harder to manage? What other underlying conditions are preventing successful treatment or management? I have been told that had the A and E dr taken me seriously and treated my condition then through physio...I would not be in chronic pain. This is from a Physio and several Dr's. So because no one believed me that I had [REDACTED]. Its not frustrating, its life limiting and demeaning as if I am not believed. What we dont' want is other's to feel this way because your saying no to these treatments. At what point and how can we as patients help you collect the evidence needed to see if these conditions work ? At what point will, if applicable, preventataive measures be put in more quickly and/or underlining conditions be recognised as possibly stalling/hampering progress? With that in mind I hope that the mind set will help you evaluate the responses from those who are suffering from these conditions. [REDACTED]. But because no one in NHS t h inks I am suffering enough because I just get on with it... i do not expect help and by the sounds of it I am already doing what is recommended so its frustrating to then get to the point where I can't move my arm or hands and be told well its chronic now... or do these exercises that I've

already done for years. So that frustrating will feed into your completely rational response to wanting to avoid these other treatments.

- It is reasonable for the ICB to review commissioning policies and ensure that treatments funded by the NHS are supported by evidence of clinical effectiveness, appropriateness and cost-effectiveness. However, the rationale for excluding ESWT for conditions such as plantar fasciitis and Achilles tendinopathy is not entirely clear.
- Given time all of these complaints tend to settle.
- If you are sure it has no benefit why have you kept doing it
- I have no experience of any of these treatments so feel there will be some people for whom they do work
- I have had the shockwave therapy and feel it wasn't harmful but in conjuction with other measures (physio exercises and stretches and custom orthotics) may have helped an overall improvement
- , treatment of any illness, needs looking at,to stop the pain and suffering,, whilst spending thousands on tattoo removal,money spent on treating children, with gender problems, drink and drugs, which are brought on by the people them selves, planter fassciitis is a very painful, foot problem, and since you control the key to the pain facilities,people will suffer, perhaps stopping helping people, who have motorbikes, big expense to the nhs,
- There is dispute over the effectiveness of these therapies. I have Achilles Tendonitis and my Consultant would like to be able to offer shock therapy on the NHS.
- You need to differentiate between insertional and non-insertional Achilles tendinopathy. ESWT is effective for insertional Achilles tendinopathy.
  ESWT is effective for plantar fasciitis.
- In terms of the use of ESWT I am somewhat confused. Whilst I saw nothing to suggest in NICE guidance that it was recommended for use with patients with refractory tennis elbow or Achilles tendinopathy, NICE highlights its potentially valuable use with (what already seems to be a very small number of)patients with chronic & highly impactful plantar fasciitis. Similarly under NICE's management of Achilles tendinopathy (last revised October 2025), it mentions ESWT as a possible specialist management option, noting that it may stimulate the tissue healing response and provide an analgesic effect (with refs). Unless NICE have got it wrong then the decision to deny all patients (and relevant clinicians) with the opportunity for use (and prescription) of this procedure in some circumstances does not seem to reflect the current evidence base. Perhaps however, there have been some large RCT's since the NICE publication showing zero effectiveness. Hence im not sure.

  Also I am confused as to why the current trust policy presented a clear argument for these procedures signed off in 2022, citing good randomised controlled trials showing effectiveness have now been ignored. Again (as for previous comment) it is hard to make a judgement on the basis of inadequate / vague information, as it may be the case that there has been a recent raft of RCT's looking at these procedures for these areas. If that were the case and the results showed no indication that the very small minority of people with these conditions who are very disabled by the pain may gain some benefit from the procedure, then the policy change / the ceasing of these options would be entirely appropriate.

Im not sure why alignment with mersey side and Cheshire is particularly important. Maybe it feels more comfortable making the same clinical policy decisions as our neighbours, but only if the evidence base for these decisions is very solid.

I could find no info from NICE on the use of the other treatments. Nor could I find your previous policy on it, so I have nothing to go on as I have for ESWT. Again I have read the information you give to understand the proposed change but I don't feel I have enough info to agree or disagree as to rationale for the decision you have made to stop their use. All I would say is that If good quality research clearly showed no indication of any potential benefit to selected people with intractable tissue problems (with chronic pain .. and therefore probably both lifestyle and physical & mental health issues), then obviously stopping this option would be the right decision.

Q2. Do you think the criteria for access are clear and understandable? If you answer no, please tell us why in the box below.

Yes

- i have ADHD/ AU AND CAN CLEARLY UNDERSTAND
- I understand
- They are understandable to clinicians like myself.Patients could be provided with links to peer-reviewed papers, but I doubt that anyone would request them.
- The policy is generally understandable, but it could explain more clearly what treatment options will be available for patients whose symptoms do not improve with physiotherapy and other conservative treatments. It would also be helpful to explain whether there are any exceptional circumstances in which these treatments could still be offered.
- I think the reasons are clear but the wording deliberatly vague - it sais there is no evidence that it works in most cases however it does not say wether there is also no evidence it doesn't work - has this evidence even been asked for?

No

- Not clear who gatekeeps access or what descion making pstgway they will use
- Not sure the policy mentions access, just not providing this treatment as not very effective.
- Not sure if some patients would actually be allowed to have these treatments
- I don't know enough about the long term effects
- Not sure. I had ultrasound for a big lump on my ankle which worked really well. Nit sure if this is same treatment
- Not everyone can access online information so it therefore will impact on the knowledge and understanding of what help is available for their condition. Advice guidance and support in person via their GP is vital
- Patients/service users are not aware of their treatment options, they rely to much in their GP/healthcare provider advising them and not enough options are relayed in that advice (ie right to choose etc)
- There don’t appear to be any criteria as the existing treatments are not going to be offered.
- my understanding is there is no access. Now i need to re read....So your asking is the criteria for access clear? How can we have a clear stragety to 'access' when your saying no to everyone? that sounds contradictory. So no that is unlikely to be clear to

patients. You need to reframe it. Do you understand why removing these treatment options are occuring or to some such effect.

- Criteria for access are too narrow and are not written with patients' wishes paramount'
- After reading your introduction I can not remember what the criteria are.
- I was informed it was not available so where is your criteria for access? I cannot see where this is stated
- In that you state it will not be routinely available. Does that mean it could be in some circumstances, or will it not be available ever. I feel this point could be more clearly stated.
- What do you mean by access in this case?
- is there an absolute ban on shockwave therapy or can it be tried if other options fail?
- This statement makes it sound like some clients may be offered it, but have been informed in my practice that PRP was took off license quite a while ago now and not accessible on NHS at all??
- They don't indicate clearly why you are even considering this.
- You need to differentiate between insertional and non-insertional achilles tendonopathy. ESWT is effective for insertional achilles tendonopathy.
  ESWT is effective for plantar fasciitis.
- I say no but Im not sure what this means im sorry. Criteria for access? You are proposing no access to 3 clinical groups for 3 clinical treatments
- The policy clearly identifies the conditions for which ESWT will be routinely commissioned and those for which it will not. However, the access criteria lacks sufficient detail to support consistent clinical decision-making and aid in patient discussions. Providing greater detail on the evidence appraisal process would improve transparency and understanding.

Narrative

- As aforementioned
- GP is a blocker
- I didn't even know this was an option until my sister needed shockwave therapy for plantar 23asciitis – when all other treatments failed to help her
- These are painful conditions that impact on people's lives. They restrict mobility. As a result many who currently enjoy an active lifestyle that contributes to their overall cardiovascular and physical health cease to take part. This will lead to other health issues downstream. Supporting active living is a key feature of the NHS
- We have an excellent cortisone delivery at [REDACTED] and have new qualified Gps to administer
- If this treatment involves MSK or pain Management this is a pretty futile survey anyway considering patients are now waiting 18 months to 2 years for treatment by which time many of those on the waiting lists will have passed away.
- Most people will give up reading before the enff
- What is autologous, what does this mean
- Again the service is already poor in Cumbria. The service in the Dr clinics has been greatly reduced where we had clinics in the surgeries. I see this as an extra cuts on a poor service in a depleting service already.

- Access would be difficult for non drivers to go further than Furness General, perhaps one nd a half hours to two hours away!
- What happens to patients currently receiving these treatments?
- See my previous comments.
- Maybe just another excuse to cut services
- as above

Q3. Do you think the policy disadvantages any individuals or groups? Please explain in the box below.

Yes

- possibly people who have previously found it effective
- If you dont approach the issue that these conditions are manifestations of psoriatic arthropathy
- Bound to disadvantage the suffers.
- Obviously it could disadvantage people who cannot afford to pay for extra private treatment. I understand the NHS doesn't have a bottomless purse and treatments need to be certain of a cure before they are funded.
- Working class people that are employed in jobs that can cause such conditions rely on the healthcare they contribute towards, to then be able to access the FULL range of support via the NHS - they have performed much needed roles and in the process gained these conditions - societies ways of 'taxing' employees should then rectify these conditions via the healthcare system they have been financially contributing towards
- These are painful conditions that impact on people's lives. They restrict mobility. As a result many who currently enjoy an active lifestyle that contributes to their overall cardiovascular and physical health cease to take part. This will lead to other health issues downstream. Supporting active living is a key feature of the NHS
- Will disadvantage those for whom it works , they will have to pay for treatment if they can afford it
- It may do if there are long waiting times for say physio and people are unable to work
- People for whom conservative measures have failed
- If other treatments do not work, this may be a last chance for some.
- Older people, those from other countries whose first language is not English. Those with disabilities and their carers.
- People who can’t afford to go private although the NHS Chartered Physiotherapists and Orthopaedic surgeons should be the experts in this field as long as there is capacity and the waiting lists are not too long?
- Those with chronic MSK conditions such as Ehlers Danlos Syndromes, especially as there being limited other treatments, and no dedicated care pathway, available to them. Thus this change of policy would discriminate against them
- People who are suffering badly and can’t afford to pay privately.
- Individuals who suffer from these conditions. Any condition that involves the feet is particularly tricky as it can affect mobility and being able to get around. There is a paper by vm wright that suggests plantar fasciitis is one of the conditions that affects women post menopause.
- Again if this affects someone’s daily life treatment should be provided

- If the policy is ‘set in stone’ and evidence later shows substantial benefit this would need to be addressed. I am concerned that there may not be the flexibility to address needs.
- Some people have auto immune problems so could be problematic
- The policy is negative towards those who have gone through physio , steroid injections and still suffering and need an alternative before an operation
- Those who can't or struggle to pay. I.e. most of us. Those with other health issues, or older
- I think that some patients will feel aggrieved by the decision, when their condition is not responding to standard treatment. However, that does not justify commissioning treatment which is not supported by clear evidence.
- Females post menopausal, hyper mobile EDS patients
- Chronic suffers need to have access to all available treatments. Restricting them is denying health care.
- What about pensioners, are they supposed to put up with pain. What do you do if physio doesn't work.
- I feel this is a disadvantage to people that work in the country to travel extra long distances for a service that should be available, we’re are not close to a 15 min town/city.
- People who need these treatments
  Will now have no choice to to pay privately for treatments
  That they were brought up being told.
  Work and pay your taxes
- As above. Individuals need individual treatment/diagnosis
- Yes. I think the policy could disadvantage people with long-term painful conditions who have already tried physiotherapy, exercise programmes and other standard treatments without success. If these treatments are no longer routinely available, some patients may be left living with ongoing pain and reduced mobility, which can affect their independence, ability to work, mental wellbeing and quality of life. I believe there should be flexibility for clinicians to consider these treatments on an individual basis where they are likely to benefit the patient.
- I think it possibly does, more clarity on all qualifying sub groups is needed, with accountability to ethnic diversity to also be factored.
- I think it disadvantages those for whom the treatment may be working but the NHS has decided to pull funding from - there will be many individualks for who this is the last ditch attemp to be out of pain
- Pensioners with no car and younger people for the same reason
- Any low income users now and in the future, if they cannot access these without paying privately. If the lack of evidence of success in using these treatments is not there, then that is acceptable. If a money-cutting exercise, then low income users must be considered.
- People who are researching their condition will not understand the removal of such treatments if they are seeing /reading/hearing that they are in use in other countries and actually reading the research. They will want to know why more reserach isn't done. they will likely be wililng to help volunteer and find ways to help you to prove that they either do or do not work. Science cuts both ways. Just because thee is not

enough reserach does not mean it isn't helpful, it just means not enough reserach has been done. That and too often nhs ignores acedotal evidence from patients when it goes beyond saturation point. At what point does the NHS begin to listen and believe patients and the growing research results of other experts outside the NHS? i think the bigger issue is there is not a response to help redirect those suffering from those conditions to a care plan or options that will feel supportive for them.

- It disadvantages those who cannot afford the treatment privately as it has shown good results in some patients and indeed I had it [REDACTED] and it was successful for me.
- If you require a treatment and it cannot be provided by the NHS this will affect people across the spectrum of age etc.
- Those who cannot afford private medicine
- those who have tried literally everything and remain in pain years down the line should be offered prp injections. it would counter act the amount of money that is still spent on these clients from GP services, to ongoing physio, time off work sick, continual allied health input etc
- As I said in #1 - people who are poor, marginalised, and otherwise disadvantaged don't get to seek care from private practice because they don't have the money and the vast majority wouldn't even know how to access alternative care if it isn't provided by the NHS.
- People with money can pay private so people who can’t afford it are just being left don’t seem fair
- patients with other conditions not mentioned
- Will disadvantage those who do receive benefits from these treatments
- I think that taking away the opportunity to try all treatments available on the NHS, under a strict treatment plan from a consultant, is depriving the patient from something that could potentially improve their condition and consequently their quality of life. Those who are financially able can seek private health treatment however those who are not are then being denied access.
- people who are in pain, the old and infirm
- People who cannot afford private treatment.
- Groups that have these conditions
- poor people can not afford private care
- I say yes, but please see my comments at the start of this. I am confused as to why your policy would not be in line with current NICE guidance for the use of ESWT for two of the tissue conditions . You will disadvantage a very small number of people who have the most intractable problems and probably extreme / chromic pain from possible access to a (maybe fairly simple?) treatment which may give them improved healing and relief.
  You refer to the policy change being in line with national guidance ... but what guidance is that? A genuine question is - is NICE guidance not used anymore?
- The policy may potentially disadvantage patients with chronic plantar fasciitis and Achilles tendinopathy, which are common conditions associated with significant pain, reduced mobility, loss of function, and impact on employment and quality of life. Whilst the policy acknowledges these impacts, it excludes routine access to ESWT despite NICE Interventional Procedure Guidance supporting its use under appropriate governance arrangements.

The policy appears to rely heavily on the absence of evidence demonstrating superiority over alternative treatments rather than considering ESWT as a treatment option within a wider pathway for patients who have failed conservative management. This may result in inequity, where patients with refractory shoulder and knee conditions can access treatment, but those with similarly persistent and debilitating foot and ankle conditions cannot.
There may also be an impact on working-age adults, people in physically demanding occupations, and individuals unable to access privately funded ESWT services, potentially increasing health inequalities

No

- The policy appears to be fair and will affect everyone equally
- I am surprised that these treatments are available and suspect most people are not aware of their availability so it will disadvantage a very small number of people

Not sure/ maybe

- No detail provide on who has benefited from these treatments
- I would need much more information in order to answer this question intelligently
- It's hard to say because it doesn't spell out what alternative treatments are to be offered.
- i am unsure as do not know if any groups are at a specific disadvantage
- Depends if it works where other treatments fail
- I can't tell which individuals or groups might be disadvantaged. It doesn't say.If the treatments are not proven to be necessarily beneficial is anyone disadvantaged?
- The NHS should have self funded procedures it can't treat the whole world and all people on benefits which is just not fair to people barely earning more than people on benefits

Narrative

- Not offered anyway for some conditions so why are you even bothering doing a supposed consultation
- These treatments will be available privately, no doubt. There will be some people who cannot afford these personal preferences.
- What a ridiculous question! Treatment should be based on clinical need, not on quotas.
- As I mentioned previously……..s placebo effect could have positive or outcome people even if the treatment is clinically ineffective
- It's unclear where "routinely" ends and never begins.
- Access is always key to any teatments
- Futile as the ICB's are amateurish inefficient outfits anyway.
- I believe again feel it is a political failure of the current Government in funding public services.
- Would be good to give the alternative treatment paths for these condition and if in certain circumstances these could be used.
- No comment
- Some people have knowledge of these treatments seemingly working for family members or other people.
- Unless treatment available that works

- There are always exceptions that could be negotiated with GPs & specialists in specific cases
- Pressure on patients to carry on regardless. Older patients are subtly encouraged to perservere and not cost the NHS
- I hear that it's not a proven treatment, nationally.
- The recommended alternatives may not be available in some areas
- These condition do not always respond to the usual treatments and can be very debilitating so other options need to be available
- You need to differentiate between insertional and non-insertional achilles tendonopathy. ESWT is effective for insertional achilles tendonopathy.
  ESWT is effective for plantar fasciitis.
- A policy bias is driven by clinicians [REDACTED] rather than policy. Training and clinical bias should be kept in check

Q4. Does the policy provide enough information to allow a clinician to discuss a patient's eligibility for treatment? If you answer not sure or no, please tell us why in the box below.

Yes

- Yes as I take it from the policy these treatments are simply not offered

No

- Does it give the majority of patients the confidence to discuss their eligibility, probably not
- There is not enough information available.
- The policy details things that do not make a patient an exception, but do not give any indication of what might be considered.
- With reference to my previous comments does it mean that the treatments might be tried on some patients- as a last resort or because they are not satisfied with the other route of physio etc?
- No I believe there is not enough information as to support the local communities in the Furness area, how far and to what cost is this to transport or the patient and thier healing and well-being.
- The information is ambiguous
- The policy explains which treatments would not be routinely commissioned, but it does not make it entirely clear how clinicians should deal with patients who have tried all the usual treatments without success. It would be helpful to include more information about whether there are any exceptional circumstances or alternative treatment pathways available for these patients.
- No.. I can not see where a suitable level of consultation to discuss both cultural, faith based views are noted... If this can be expanded on..or indeed looking at neurodiverse, carers etc to be involved.
- I feel like maybe I read the wrong thing. I did read it quickly but understood no one was accessing? I have read it.. so again my answer remains no given the question. It does not discuss a patients eligibility. You can't be eligible for something that your not providing. This is the type of logic that upsets people irregardless of the reason but more so for people who are impacted by this.

- can only find policy for shockwave, link hasnt been provided for the other 2 options and unable to find it.
  have catagorically been a fast NO if ever asked if a client can have PRP as off license by MHRA and only available privately now
- Does not mention intractable conditions
- There is no option for use of 3 treatments clinicians can currently decide upon using for patients as far as i can understand ... unless I have totally misunderstood the new policy.
- The policy clearly states which conditions are routinely commissioned and which are not; however, it provides limited detail regarding the specific eligibility criteria for treatment. There is no definition of what constitutes "refractory to conservative management", including the duration of symptoms, types of treatments that should have been attempted, or objective measures of treatment failure.
- Additional clarity around clinical thresholds, referral criteria, and the rationale for excluding specific tendinopathies such as plantar fasciitis and Achilles tendinopathy would support more informed discussions with patients and improve consistency in clinical decision-making.
- A criteria used to determine treatment failure is required as without this it then creates uncertainty for both clinicians and patients.

Not sure

- I am not aware of the clincian's background, training and information received. Again I cannot answer this question intelligently.
- I think the policy infers that the treatment will not be given at all not that there is an eligibility criteria. It infers that if you live in a certain postcode that you are not eligible.
- Donot really know enough about this.
- I am not qualified to answer this question
- Not being a qualified health practitioner I wouldnt know, but from a lay-person perspective I believe it is
- Not able to read the appropriate criteria
- No information at all, each case is different. Clinical judgment should be used otherwise you may as well just issue exercise sheets without any consultation with a physio ss they have appeared to have stopped any physical hands in treatment for any condition
- If it the treatments are being withdrawn why is there a need for the clinician to discuss the issue. The question does not really make sense!
- In what circumstances could it be used, if any?
- I do not have the knowledge to assess this.
- Not qualified to comment on what a clinician may need
- Don’t feel I know enough about these treatments
- Would have to understand if I needed treatment
- it does not really explain what a patients eligability might be it just sais it is low referal - are the results of those refered being monitored?

Narrative

- Usual saving money exercise

- You need to explain this in 'words of one syllable' so everyone can understand. NHS is very good at using words normal people don't understand.
- It sounds like all shockwave therapies will be stopped,
- Sadly, from personal experience and that of many others, I am aware that clinicians often don't discuss their eligibility for various treatment options. This needs to be addressed despite whatever the financial costs may be
- The right treatment for the right patient at the right time is critical. Rationing healthcare prevents that
- Allpolicies must be very clear
- Same
- It may do for those with a real understanding of the condition and it's treatment but if you're disabled or unable to relate that to you personally, it will severely impact on your daily life and support you may need
- Alternative treatments will be offered.
- No idea if they are effective
- If it were me, I'd want more info on effective alternatives (in addition to physio)
- As the first answer. More should be done at speed, not less
- The policy should outline that shock wave therapy to be exhausted before the need of an operation
- All ailments deserve to be treated to alleviate pain and suffering should not be down to cost- any proven remedy should be made available
- It provides information that says these treatments aren't going to be available without setting out alternatives.
- Doctors will just say no outright, as they have in my husband's case
- It reads like a blanket decision for all.
- If you are no longer offering these treatments to current users, what do they do, if they are getting relief from the treatments. Again, are other treatments as effective.
- Patient choice not supported
- timeframe not mentioned
- I would like to know more about the potential pain management benefits and how they can support healing quicker reducing recovery time
- Your clinicians do not offer it now in any event as they say it is unavailable
- As long as it's done fairly and those who need it still get it
- Are you kidding me? Since when does a GP discuss anything of substance with a patient. They say they will refer you, but leave the discussion about actual treatment to a specialist that one waits over a year to see. In the meantime one is in pain/having difficulties/lack of care for an ailment that needs treating and they don't have a clue why the GP can't help, nor why they have to wait so long.
- I have had very painful tennis elbow and have never been offered this - in fact with my arthritic knee I was told it would not be effective
- You need to differentiate between insertional and non-insertional achilles tendonopathy. ESWT is effective for insertional achilles tendonopathy.
  ESWT is effective for plantar fasciitis.

Q6. Is there anything else you would like us to consider when implementing the policy?

Alternative provision/ exceptions to policy

- What else you will offer people with tendonopothies instead ?
- Clear access to alternatives that are properly administered and safeguarded as some patients have not had this in the past
- explain further options with patients and choices
- How is easy it to get to see a physio ?
  Develop and ensure that An agreed referral time to first treatment with physio.
- That it is still available where necessary and other treatments have failed
- Perhaps if individuals have already received the treatment and it helped them?
- You should way up the cost of tennis elbow operations before stopping shock wave therapy as it could work and is less expensive for the NHS and less invasive for the patient
- No, but some people will want to try therapies that non-clinical people have suggested that worked for them.
- Alternative relief for patients with long term pain
- Will patients be made aware of other treatments to support their condition
- What other options can be offered where routine treatments such as physio do not work? Include signposting in the policy rather than leaving people with a dead end.
- You need to differentiate between insertional and non-insertional achilles tendonopathy. ESWT is effective for insertional achilles tendonopathy.
  ESWT is effective for plantar fasciitis.
- Consider that by offering these treatments under strict supervision from a consultant when other treatments have failed could result in improved outcomes for the patient. If the patient feels that they are being given the best possible care their level of anxiety will decrease and, as we now understand, the impact of this on the nervous system and in turn the immune system the overall chance of faster recovery is greater.
- It is not unreasonable to make these treatments routinely available but there needs to be some consideration given to those with intractable conditions
- Not just these treatments but so many are on waiting lists for months and months then put on another waiting list before they see a consultant. There must be very experienced practitioners that could intervene that specialize at an early point even if it means home visits. What about home" community care" while waiting and hopefully avoid severe courses of treatment later or operations and blocking beds in hospitals. Proffessional Physiotherapy personnel specialising in each problem could go out to the patient saving hospital time/ spaces/ insurance etc and assess the patient in their home in a relaxed setting.
- Allow for clinically supported exceptions
- Yes …. How to help the people who need this treatment, with no transport from rural areas to avail themselves of further treatment, if it is now going to be one and a half to two hours away by public transport, if there is none! It will discriminate quite a lot of people. It is easier to utilise space in hospitals, but not as convenient for places where transport is hard to come by and we have to rely on others to get us there!
- Do you have alternatives to offer
- Monitoring the treatment for a few weeks?
- To widen research and clinical trials

Political landscape

- I for one as a British born citizen can only hope that a change of Government may presumably improve the public funding in general and the NHS can hopefully receive the government backing and support needed for the future years.
- This is really just about cost isn't it. Nothing wrong with that, but don't beat about the bush.
- I think you should review why your staff do not offer it now if it is still available- it seems to me to be a box ticking exercise to justify a decision that appears to have been made in any event.
- Constant pain is widely underestimated- not self inflicted like being obese or addictions- cost should never be a factor in quality if life- we are not a third world country
- sort your systems out and concentrate on suporting the residents health needs
- I suspect these matters have all ready been decided on and these surveys are just a paper exercise, allowing the people who can afford to pay fir their own private health care
  Can claim they did everything they could .
- Yes, stop cutting costs. They only lead to further costs to the NHS on down the line. You are destroying people's health with this cuts
- Put patients first - salaries are probably more important to some people.

Impact on patients/ reconsider changing policy

- I think it should be re considered
- Don't implement it. Give people the treatment they need when they need it.
- Consider the people (a minority) who will receive no treatment unless they pay for it! Slowly but surely there are elements of NHS privatisation. If it’s purely because of cost, then say so.
- Yes, the quality of life for those who will have to suffer because they can’t afford the treatment.
- Neurodiversity, faith and cultural views on the validity of using this type of injection.
- I think I have said the things I think are important to say, except, in my book it is important that (the very small number of) patients who have the most severe refractive conditions are given options which may make a massive difference to them, especially relatively inexpensive treatments. That said I don't know how much each of these treatments costs.
- I would like you to consider allowing those already recieving the treatment to carry on if they feel that the treatment is working and it is having an effect on thier quality of life
- The long term effect on a clients welfare and lifestyle when in so much pain, after they have followed professional advice and tried everything else on offer and years later remain in pain and life altering for them
- I understand that the NHS has to make difficult decisions about how to use limited resources and that treatments should be supported by good evidence. However, I do not agree that these treatments should be removed as routine options for all patients. Some people with long-term pain may have exhausted all the standard treatments without success. I believe clinicians should have the flexibility to refer carefully

selected patients for these treatments where they feel there is a reasonable chance of benefit, rather than applying a blanket policy.

- Polucy should not be implemented because it severely adversely affects patients' quality of life. These are common conditions affecting many people and are not trivial because they are widespread
- you asked if i disagreed or agreed. but you didn't ask why. that's a huge issue in quantitative research as you have assumed how I would interpret the question and answer choices. I put I disagree with the policy. Not because I disagree with the removal of these things due to lack of evidence. I disagree because its primarily for cost saving without offering a robust alternative or more dilligent way of providing care for these folk, of which I also suffer from but can't bare to go to the GP or anyone anymore because Im just tired of being dismissed. That aside, your taking away hope without offering alternatives and that will upset people no matter how much these treatments lack 'evidence'. What alternative are you offering to help? Even if it is a more heartfelt/bespoke approach that takes a wholistic look at the individual. How can we as patients help your teams collect evidence for things?
- Disagree ONLY if current users getting relief cannot be offered equivalent or better treatment without having to pay.
- Well being mentally and physically for the patients and families multiple people and the poor service already received in the Furness are.
- It is important to clearly explain to patients why they are not able to have a treatment which they may have heard of, and which they have been placing hope in for their condition.
- Consider that others should be offering these treatment not that you should stop, then again it's all about the money and not people's quality of life
- I have suffered with Plantar Fasciitis and it is painful and unpleasant however, there are other treatments for the condition which do give some pain relief.
- People first! Pain first quality of life first
- Please reconsider this change in the policy - I feel it's unethical and we should not be looking at saving costs in this way
- I think that, except in rare circumstances, treatments which are not very effective should no longer be offered via the NHS

Communicating with clinicians and the public/ research into treatment

- obviously a clear message to GP's and other health practitioners of the new policy and its effective implementation date
- Ensuring timely response to any new strong evidence to support treatments for these conditions.
- Listen to the clinicians in your services.
- Clear information about this change and the scientific reasons for it should be made widely available.
- sufficient review of cost effectiveness studies relating to conditions such as PHP and LET. Including a policy that aligns with best practice clinical guidance, reflects adequate QALY findings and the invasiveness of commissioned treatment approaches.
- Doing more thorough research on the efficacy of such treatments

Narrative

- Get rid of the ICB's
- Is it age restricted?
- What has happened to treatment and care in Lancashire it seems more about patients suffering and saving money rather than treating people. GP dont want to refer patient to hospital until it usually to later and then the patient is unable to work , or live a normal life
- wait until you get any of the said problems
- I have written my thoughts BUT my medical knowledge is limited and I am very much in favour of saving money where possible so would trust that any decision for implementing the policy is taken with patients' best interests.
- I think there is a feeling amongst many patients that there is a cure for everything and a quick cure .Clinicians need to be able to help patients manage their expectations
- Patient preference a d unconscious bias of clin staff
- Availability and accessibility of an appropriate AHCP is key to the success of the treatment.
- Take the elderly into consideration, their needs are just as important.
- I think it's important that the most effective treatments are prioritised.
- That reviews at defined intervals take place. Intervals not 10 years !!
  That research is allowed to continue in NHS teaching establishments into the discontinued remedies eg exactly why do they work for some people & not for others.
- Just that it's looked at fairly