NHS
Cheshire and Merseyside

# Clinical Commissioning Policy

## CMICB_Clin091
## Plantar fasciitis- surgical treatment

**Category 2 Intervention - Only routinely commissioned when specific criteria are met**

Contents



**Last Reviewed:** May 2025

*This policy statement will be reviewed 5 years from the date of the last review unless new evidence or technology is available sooner.*

# 1. Policy statement

1.1 Referral for surgical management will not be routinely commissioned unless the following conditions have all been satisfied:
- current BMI is <30 kg/m² **AND**
- patient is experiencing significant pain which is having a profound effect on their quality-of-life **AND**
- conservative treatments (see below in 1.3) have been tried for at least 6 months

1.2 Plantar fasciitis is normally a self-limiting condition and will respond to a variety of simple, conservative measures.

1.3 Initial conservative treatments include advice on weight loss, footwear modification (e.g. insoles/heel pad inserts), simple analgesics and self-administration of stretching exercises. Referral to a physiotherapist and/or a podiatrist is also an option if the initial measures are ineffective.

# 2. Exclusions

2.1 None

# 3. Core Eligibility Criteria

3.1 There are several circumstances where a patient may meet a 'core eligibility criterion' which means they are eligible to be referred for this procedure or treatment, regardless of whether they meet the policy statement criteria, or the procedure or treatment is not routinely commissioned.

3.2 These core clinical eligibility criteria are as follows:
- Any patient who needs 'urgent' treatment will always be treated.
- All NICE Technology Appraisals Guidance (TAG), for patients that meet all the eligible criteria listed in a NICE TAG will receive treatment.
- In cancer care (including but not limited to skin, head and neck, breast and sarcoma) any lesion that has features suspicious of malignancy, must be referred to an appropriate specialist for urgent assessment under the 2-week rule.
  NOTE: Funding for all solid and haematological cancers are now the responsibility of NHS England.
- Reconstructive surgery post cancer or trauma including burns.
- Congenital deformities: Operations on congenital anomalies of the face and skull are usually routinely commissioned by the NHS. Some conditions are considered highly specialised and are commissioned in the UK through the National Specialised Commissioning Advisory Group (NSCAG). As the incidence of some cranio-facial congenital anomalies is small and the treatment complex, specialised teams, working in designated centres and subject to national audit, should carry out such procedures.
- Tissue degenerative conditions requiring reconstruction and/or restoring function e.g. leg ulcers, dehisced surgical wounds, necrotising fasciitis.
- For patients expressing gender incongruence, further information can be also be found in the current ICB gender incongruence policy and within the NHS England gender services programme - https://www.england.nhs.uk/commissioning/spec-services/npc-crg/gender-dysphoria-clinical-programme/

# 4. Rationale behind the policy statement

4.1 Plantar fasciitis is an extremely common, self-limiting condition which will normally respond to a wide variety of conservative measures. Best practice guidelines produced jointly in the UK/Australia suggest that adoption of these measures should be in a stepwise approach.

4.2 Surgery is reserved for those people, in whom, the above measures have proven unsuccessful.

4.3 The American College of Foot and Ankle Surgeons' clinical consensus (2018) statement recommends that surgery should be reserved for chronic, refractory cases which have failed conservative treatment for at least 6 months.

# 5. Summary of evidence review and references

5.1 Plantar fasciitis or heel pain is one of the most common foot conditions treated by healthcare providers.[1] It is characterised by a painful "inflammatory" process involving the plantar fascia (the tight band of connective tissue which supports the arch of the foot)[2] which results in pain on the underside of the heel. It is may be caused by overuse, injury or by mechanical abnormalities and may be associated with micro-tears or fibrosis.[3] It is more noticeable after the "first step" and during weight-bearing tasks particularly after periods of rest.[4] Affected patients may have impaired health-related quality-of-life which could include social isolation, poor perception of health status and reduced functional capabilities. The pain is stabbing in nature and, as stated above, may occur during the very first steps in the morning. However, once the foot is on the go and walking, the pain usually subsides although it is likely to return after long periods of standing or getting up from a seated position.[5]

5.2 Pathologically, the condition isn't the result of excessive inflammation and the changes are more degenerative in nature (although partially reversible) presumably due to repetitive micro trauma.[2] Strictly speaking, the term "fasciitis" refers to inflammation whereas "fasciosis" describes noninflammatory degradation or degeneration. Thus, plantar fasciitis is perhaps a misnomer although this is the term which is generally used in the literature.[6] Usually, the condition is self limiting.[3]

5.3 Plantar fasciitis is said to affect between 4% – 7% of the community [4] and is more likely to occur in middle-aged or older people and in women slightly more than men.[2] The lifetime prevalence is up to 10% of the population.[1] Other common risk factors include a restricted ankle dorsiflexion range of motion, the majority of the work day spent on the feet and a BMI greater than 30 kg/m².[7]

5.4 In most cases, the condition will resolve with minimally invasive management.[2] There are many such options available and these include:

- *Orthoses*: There is moderate quality evidence that foot orthoses are more effective than sham foot orthoses in reducing pain in the medium term.[8] However, it is unclear whether custom-made devices are more effective.[9]
- *Dry needling:* This is a procedure where a fine needle or acupuncture needle is inserted into the skin and muscle. It is aimed at myofascial trigger points which are hyper-irritable spots in skeletal muscle which are associated with a hypersensitive palpable nodule in a taut band. There is low quality evidence that pain intensity is reduced in the short term and moderate quality evidence of improvement in the long-term.[10]
- *Corticosteroid injections:* A Cochrane review found low quality evidence that local steroid injections (compared with placebo or no treatment) may slightly reduce pain for up to one month but not subsequently.[11,12] There is also low quality evidence that injections are more effective than physical therapy but only in the short term.[13] This advantage should be weighed against the risk of fat pad atrophy and plantar fascia rupture.[14]
- *Stretching:* There is low quality evidence that combined calf and plantar stretching is less effective in the short term but moderate evidence that plantar specific stretching has a larger effect in terms of pain score reduction.[15]

- *Autologous blood injection*: This is claimed to promote healing through the action of growth factors present in platelet rich plasma. Despite recommendation in a NICE Interventional Procedures Guidance (IPG 437) published in 2013, patients should be warned of the uncertainty regarding efficacy of this product.[3] This intervention may be more effective in relieving pain and improving function at mid-term follow-up in comparison to steroid injections.[16]
- *Laser treatment:* Although pain scores were significantly reduced for up to 3 months, there was no change in function.[17]
- *Extracorporeal shockwave therapy:* This is a non-invasive treatment in which a device is used to pass acoustic shock waves through the skin to the affected area. The mechanism of action is unknown. In 2009, NICE's IPG 311 recommended that the evidence on efficacy at that time was inconsistent.[18] However, a subsequent meta-analysis concluded that patients on shockwave therapy had better pain control and fewer complications than patients on other methods.[19] In addition, a separate meta-analysis found a significant difference in favour of shock therapy compared to ultrasound for pain control (but not function).[20]
- *Botulinum toxin:* Pain relief was found to be significantly improved at 12 months but functional improvement was apparent for up to 6 months.[21]

### 5.5 National guidelines

Guidelines from the American Physical Therapy Association were published in 2008.[1] These outlined a number of options based on a varying quality of evidence and included dexamethasone iontophoresis (short-term pain relief), manual (physiotherapy) therapy (short-term relief), calf muscle and/or plantar fascia specific stretching (short-term pain relief), calcaneal taping (short-term pain relief) and foot orthoses (short-term relief). Night splint wearing for up to 3 months is recommended for patients with long-term symptoms (>6 months).

5.6 Four years later (2012), a clinical review in the BMJ suggested there was no one particular (preferred) treatment with the highest level of evidence, but several with moderate levels of evidence such as stretching, orthotics, shockwave therapy and injections.[2] Surgery, however, is an option for long-standing cases but this underpinning evidence is based on case series only. In addition, the American College of Foot and Ankle Surgeons' clinical consensus statement (2018) recommended that surgery should be reserved for chronic, refractory cases which have failed conservative treatment for at least 6 months.[6] The College describes 2 surgical procedures comprising plantar fasciotomy (cutting a portion of the plantar fascia) to directly decrease the tension on the fascial band and gastrocnemius (calf muscle) release which decreases the tension indirectly.

5.7 Elsewhere, other reviews have consistently concluded that the current evidence doesn't suggest that any of the commonly used treatments for conservative management are better than another.[22-24]

5.8 Perhaps the best (and most recent) guidance is the review based on a mixed methods design comprising a systematic review, expert interviews and patient surveys from academics in the UK, Denmark and Australia.[4] The formulated consensus view recommended a step care approach and initial treatment should include taping, stretching and individualised education followed by shockwave therapy and then custom orthoses in non-responders. Surgery wasn't considered as an option (presumably owing to lack of RCTs). Interestingly, neither were steroid and platelet rich plasma injections recommended owing to lack of properly (placebo) controlled trials.

5.9 In summary, plantar fasciitis is a very common heel pain involving the tight band of connective tissues in the arch of the foot (fascia) which may be caused by overuse or injury. The lifetime prevalence is up to 10% in the general population. The pain is stabbing in nature and may subside once walking has commenced. However, it will return after long periods of standing or getting up from a seated position. Usually self-limiting, health-related quality-of-life can be seriously impaired in a small number of people.

5.10 Various treatments are available which include orthoses, dry needling, corticosteroid injections, stretching, platelet rich plasma injections, laser treatment, extracorporeal shockwave therapy and botulinum toxin. However, the limited evidence base suggests that there isn't one particular treatment which is superior to the others. It is generally accepted that surgery is appropriate for long-standing cases in whom the more conservative measures described above have been tried unsuccessfully for at least 3 – 6 months duration.

5.11 Neighbouring CCGs generally do not routinely commission this intervention. The current Cheshire CCG policy is the same as Mersey's.

**REFERENCES**


**1**. McPoil TG, Martin RL, Cornwall MW, et al. Heel Pain—Plantar Fasciitis. *Journal of Orthopaedic & Sports Physical Therapy* 2008;**38**(4):A1-A18. doi: 10.2519/jospt.2008.0302

**2**. Orchard J. Plantar fasciitis. *BMJ : British Medical Journal* 2012;**345**:e6603. doi: 10.1136/bmj.e6603

**3**. Autologous blood injection for plantar fasciitis. Interventional procedures guidance. London: National Institute for health and care excellence, 2013:IPG 437.

**4**. Morrissey D, Cotchett M, Said J'Bari A, et al. Management of plantar heel pain: a best practice guide informed by a systematic review, expert clinical reasoning and patient values. *British journal of sports medicine* 2021;**55**(19):1106-18. doi: 10.1136/bjsports-2019-101970

**5**. Assad S, Ahmad A, Kiani I, et al. Novel and Conservative Approaches Towards Effective Management of Plantar Fasciitis. *Cureus* 2016;**8**(12):e913. doi: 10.7759/cureus.913

**6**. Schneider HP, Baca JM, Carpenter BB, et al. American College of Foot and Ankle Surgeons Clinical Consensus Statement: Diagnosis and Treatment of Adult Acquired Infracalcaneal Heel Pain. *J Foot Ankle Surg* 2018;**57**(2):370-81. doi: 10.1053/j.jfas.2017.10.018 [published Online First: 20171225]

**7**. Hamstra-Wright KL, Huxel Bliven KC, Bay RC, et al. Risk Factors for Plantar Fasciitis in Physically Active Individuals: A Systematic Review and Meta-analysis. *Sports health* 2021;**13**(3):296-303. doi: 10.1177/1941738120970976

**8**. Whittaker GA, Munteanu SE, Menz HB, et al. Foot orthoses for plantar heel pain: a systematic review and meta-analysis. *British journal of sports medicine* 2018;**52**(5):322-28. doi: 10.1136/bjsports-2016-097355

**9**. Hawke F, Burns J, Radford JA, et al. Custom-made foot orthoses for the treatment of foot pain. *Cochrane Database of Systematic Reviews* 2008(3) doi: 10.1002/14651858.CD006801.pub2

**10**. Llurda-Almuzara L, Labata-Lezaun N, Meca-Rivera T, et al. Is Dry Needling Effective for the Management of Plantar Heel Pain or Plantar Fasciitis? An Updated Systematic Review and Meta-Analysis. *Pain medicine (Malden, Mass)* 2021;**22**(7):1630-41. doi: 10.1093/pm/pnab114

**11**. David JA, Sankarapandian V, Christopher PRH, et al. Injected corticosteroids for treating plantar heel pain in adults. *Cochrane Database of Systematic Reviews* 2017(6) doi: 10.1002/14651858.CD009348.pub2

**12**. Arnold MJ, Gruber J. Injected Corticosteroids for Plantar Heel Pain. *American family physician* 2018;**97**(3):169-70.

**13**. Whittaker GA, Munteanu SE, Menz HB, et al. Corticosteroid injection for plantar heel pain: a systematic review and meta-analysis. *BMC musculoskeletal disorders* 2019;**20**(1):378. doi: 10.1186/s12891-019-2749-z

**14**. Lim AT, How CH, Tan B. Management of plantar fasciitis in the outpatient setting. *Singapore medical journal* 2016;**57**(4):168. doi: 10.11622/smedj.2016069

**15**. Siriphorn A, Eksakulkla S. Calf stretching and plantar fascia-specific stretching for plantar fasciitis: A systematic review and meta-analysis. *Journal of bodywork and movement therapies* 2020;**24**(4):222-32. doi: 10.1016/j.jbmt.2020.06.013

**16**. Fei X, Lang L, Lingjiao H, et al. Platelet-rich plasma has better mid-term clinical results than traditional steroid injection for plantar fasciitis: A systematic review and meta-analysis. *Orthopaedics & traumatology, surgery & research : OTSR* 2021;**107**(6):103007. doi: 10.1016/j.otsr.2021.103007

**17**. Wang W, Jiang W, Tang C, et al. Clinical efficacy of low-level laser therapy in plantar fasciitis: A systematic review and meta-analysis. *Medicine* 2019;**98**(3):e14088. doi: 10.1097/MD.0000000000014088
**18**. Extracorporeal shockwave therapy for refractory plantar fasciitis. Interventional procedures guidance. London: National Institute for health and care excellence, 2009:IPG 311.
**19**. Sun K, Zhou H, Jiang W. Extracorporeal shock wave therapy versus other therapeutic methods for chronic plantar fasciitis. *Foot and ankle surgery : official journal of the European Society of Foot and Ankle Surgeons* 2020;**26**(1):33-38. doi: 10.1016/j.fas.2018.11.002
**20**. Li H, Xiong Y, Zhou W, et al. Shock-wave therapy improved outcome with plantar fasciitis: a meta-analysis of randomized controlled trials. *Archives of orthopaedic and trauma surgery* 2019;**139**(12):1763-70. doi: 10.1007/s00402-019-03262-z
**21**. Acosta-Olivo C, Simental-Mendía LE, Vilchez-Cavazos F, et al. Clinical efficacy of botulinum toxin in the treatment of plantar fasciitis: a systematic review and meta-analysis of randomized controlled trials. *Archives of physical medicine and rehabilitation* 2021 doi: 10.1016/j.apmr.2021.10.003
**22**. Babatunde OO, Legha A, Littlewood C, et al. Comparative effectiveness of treatment options for plantar heel pain: a systematic review with network meta-analysis. *British journal of sports medicine* 2019;**53**(3):182-94. doi: 10.1136/bjsports-2017-098998
**23**. Al-Boloushi Z, López-Royo MP, Arian M, et al. Minimally invasive non-surgical management of plantar fasciitis: A systematic review. *Journal of bodywork and movement therapies* 2019;**23**(1):122-37. doi: 10.1016/j.jbmt.2018.05.002
**24**. Salvioli S, Guidi M, Marcotulli G. The effectiveness of conservative, non-pharmacological treatment, of plantar heel pain: A systematic review with meta-analysis. *Foot (Edinburgh, Scotland)* 2017;**33**:57-67. doi: 10.1016/j.foot.2017.05.004

# 6. Advice and Guidance

## 6.1 Aim and Objectives

6.1.1 This policy aims to ensure a common set of criteria for treatments and procedures across the region. This is intended to reduce variation of access to NHS services in different areas and allow fair and equitable treatment for all patients.

6.1.2 This policy relates to the commissioning of interventions which optimise clinical effectiveness and represent value for money.

6.1.3 This document is part of a suite of policies which the Integrated Care Board (ICB) uses to drive its commissioning of healthcare. Each policy is a separate public document in its own right but should be considered alongside all the other policies in the suite as well as the core principles outlined.

6.1.4 At the time of publication, the evidence presented per procedure/treatment was the most current available.

6.1.5 The main objective for having healthcare commissioning policies is to ensure that:
- Patients receive appropriate health treatments
- Treatments with no or a very limited evidence base are not used; and
- Treatments with minimal health gain are restricted.

6.1.6 Owing to the nature of clinical commissioning policies, it is necessary to refer to the biological sex of patients on occasion. When the terms ‘men’ and ‘women’ are used in this document (unless otherwise specified), this refers to biological sex. It is acknowledged that this may not necessarily be the gender to which individual patients identify.

### 6.2 Core Principles

6.2.1 Commissioning decisions by ICB Commissioners are made in accordance with the commissioning principles set out as follows:

- Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment.
- Commissioners require clear evidence of cost effectiveness before NHS resources are invested in the treatment.
- Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment.
- Commissioners will balance the needs of an individual patient against the benefit which could be gained by alternative investment possibilities to meet the needs of the community.
- Commissioners will consider all relevant national standards and consider all proper and authoritative guidance.
- Where a treatment is approved Commissioners will respect patient choice as to where a treatment is delivered, in accordance with the 'NHS Choice' framework.
- Commissioning decisions will give 'due regard' to promote equality and uphold human rights. Decision making will follow robust procedures to ensure that decisions are fair and are made within legislative frameworks.

### 6.3 Individual Funding Requests (Clinical Exceptionality Funding)

6.3.1 If any patients are excluded from this policy, for whatever reason, the clinician has the option to make an application for clinical exceptionality. However, the clinician must make a robust case to the Panel to confirm their patient is distinct from all the other patients who might be excluded from the designated policy.

6.3.2 The ICB will consider clinical exceptions to this policy in accordance with the Individual Funding Request (IFR) Governance Framework consisting of: IFR Decision Making Policy; and IFR Management Policy available on the C&M ICB website: https://www.cheshireandmerseyside.nhs.uk/your-health/individual-funding-requests-ifr/

### 6.4 Cosmetic Surgery

6.4.1 Cosmetic surgery is often carried out to change a person's appearance to achieve what a person perceives to be a more desirable look.

6.4.2 Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore not routinely commissioned by the ICB Commissioner.

6.4.3 A summary of Cosmetic Surgery is provided by NHS Choices. Weblink: Cosmetic procedures - NHS

### 6.5 Diagnostic Procedures

6.5.1 Diagnostic procedures to be performed with the sole purpose of determining whether or not a restricted procedure is feasible should not be carried out unless the eligibility criteria are met, or approval has been given by the ICB or GP (as set out in the approval process of the patients responsible ICB) or as agreed by the IFR Panel as a clinically exceptional case.

6.5.2 Where a General Practitioner/Optometrist/Dentist requests only an opinion the patient should not be placed on a waiting list or treated, but the opinion given and the patient returned to the care of the General Practitioner/Optometrist/Dentist, in order for them to make a decision on future treatment.

### 6.6 Clinical Trials

6.6.1 The ICB will not fund continuation of treatment commenced as part of a clinical trial. This is in line with the Medicines for Human Use (Clinical Trials) Regulations 2004 and the Declaration of Helsinki which stipulates that the responsibility for ensuring a clear exit strategy from a trial, and that those benefiting from treatment will have ongoing access to it, lies with those conducting the trial. This responsibility lies with the trial initiators indefinitely.

# 7. Monitoring and Review

7.1 This policy remains in force until it is superseded by a revised policy or by mandatory NICE guidance or other national directive relating to this intervention, or to alternative treatments for the same condition.

7.2 This policy can only be considered valid when viewed via the ICB website or ICB staff intranet. If this document is printed into hard copy or saved to another location, you must check that the version number on your copy matches that of the one published.

7.3 This policy may be subject to continued monitoring using a mix of the following approaches:
- Prior approval process
- Post activity monitoring through routine data
- Post activity monitoring through case note audits

7.4 This policy will be kept under regular review, to ensure that it reflects developments in the evidence base regarding effectiveness and value.

# 8. Quality and Equality Analysis

8.1 Quality and Equality Impact Analyses have been undertaken for this policy at the time of its review.

# 9. Clinical Coding

### 9.1 Office of Population Censuses and Surveys (OPCS)

Any in primary position
T54.2 Division of plantar fascia NEC
T54.4 Needle fasciotomy of plantar fascia
T52.3 Plantar fasciectomy

### 9.2 International classification of diseases (ICD-10)

With or without
M72.2 Plantar fascial fibromatosis

# Document Control

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| **Ref:** | CMICB_Clin091 Plantar fasciitis- surgical treatment |
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| **Version History** |
|---|
| Version 0.2 – February 2022 – Strengthens the recommendation on weight loss and recommends 6 months as opposed to 3 months conservative treatment. |
| Version 0.3 – May 2025 – This policy was part of a public engagement exercise, there was no feedback received. |