Resource impact summary report

Resource impact
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This NICE guideline covers diagnosing and managing early and locally advanced breast cancer. It aims to help healthcare professionals offer the right treatments to people, taking into account the person's individual preferences.

The guideline has been through a series of updates which have added new recommendations on reducing arm and shoulder mobility problems following breast cancer surgery, the use of external beam radiotherapy after breast conserving surgery or mastectomy, further surgery after breast-conserving surgery, prevention and management of lymphoedema, and neoadjuvant chemotherapy and ovarian function suppression (OFS) and testicular function suppression (TFS).

The number of breast cancer cases per year is 89 per 100,000 in England. Lymphoedema affects around 1 in 5 people within 1 year of treatment for breast cancer, so the incidence is around 18 per 100,000 people in England.

The eligible population for OFS is around 6,400 people per year, based on the assumption that all people with female reproductive organs will have been through menopause by age 50. The eligible population for TFS is around 340 people per year.

Neoadjuvant chemotherapy and ovarian/testicular function suppression

The cost of implementing the recommendations for neoadjuvant chemotherapy and OFS/TFS is expected to be low as the recommendations are in line with existing practice.

Previous updates

The cost of implementing the recommendations around lymphoedema prevention and management is expected to be low because compression garments are relatively inexpensive and already widely used and kinesiology tape is recommended only when compression garments are unsuitable.

Depending on current local practice, recommendations which may require additional resources and result in additional costs include:

- Supervised support for functional exercise **(recommendations 1.14.16 to 1.14.19)**. These recommendations may lead to an increase in supervised exercise for people who have had breast surgery. In most areas people are given information about functional exercises to reduce arm and shoulder mobility problems after breast surgery, but the recommendations now say that supervised support should be offered to those at high risk.

Potentially 41% of people who have surgery for breast cancer will be eligible for supervised support and depending on how this is delivered and who delivers it, this could have a significant impact on capacity and costs locally.

Depending on current local practice, recommendations which may release resources and reduce costs include:

- Offer 26 Gy in 5 fractions over 1 week for people with invasive breast cancer having partial-breast, whole-breast or chest-wall radiotherapy, without regional lymph node irradiation, after breast-conserving surgery or mastectomy. **(recommendation 1.13.13)**
- Consider further surgery (re-excision or mastectomy, as appropriate) after breast-conserving surgery for invasive cancer with or without ductal carcinoma in situ (DCIS) if tumour cells are present within 1 mm, but not at, the radial margins (greater than 0 mm and less than 1 mm). **(recommendation 1.4.5)**

The committee was keen that the recommendations allow flexibility in how supported exercise interventions are delivered and so a local template has been produced to support services in modelling their local configuration.

Implementing the guideline may:

- Lead to a reduction in arm and shoulder mobility problems after breast surgery.
- Lead to a reduction in prescribing pain medication in people who have had breast surgery.
- Lead to better health outcomes and care experience.
- Reduce the number of treatment sessions that people who have external beam radiotherapy after breast-conserving surgery or mastectomy receive.
- Improve the patient experience of care for people who have external beam radiotherapy after breast-conserving surgery or mastectomy by reducing the amount of times they need to attend the hospital for treatment.
- For every 100 people who have 5 fractions over 1 week instead of 15 over 3 weeks, we estimate that 1,000 appointments, equivalent to around 125 clinical sessions, will be freed up.
- Reduce the number of people having further surgery after breast-conserving surgery for invasive cancer with or without DCIS.
- Lead to people with lymphoedema having interventions that are more comfortable and convenient which may improve adherence.

The local template allows users to indicate what proportion of people they expect to have individual, group, face to face and virtual supervised support and what agenda for change band the staff would be who they expect to deliver each type of intervention. The number and length of sessions can also be set as well as the amount of non-contact time they expect physiotherapy trained staff to need for each session and the number of participants per session for groups. This enables users to assess what staffing resource will be required to implement the guidance locally. Local one-off costs to provide services (such as IT costs for setting up virtual services or exercise equipment costs) and savings (such as reduced prescribing of pain medication) can be included in the template.

The section of the local template on radiotherapy assumes that currently 10% of people have 15 fractions over 3 weeks with 90% having 5 fractions over 1 week. The template also assumes a radiotherapy fraction to take 30 minutes to deliver. These assumptions can be amended to reflect local practice.

Breast cancer services are commissioned by integrated care boards and NHS England. Providers are NHS hospital trusts and community providers.