NICE Guidance on Family History Screening for Breast Cancer:

Discussion paper for PBC groups

Background

In 2004 NICE published guidance on Breast Screening for women with a family history of Breast Cancer[1] This set out a defined patient pathway with a stepwise progression through primary care (basic family history to identify level of risk), secondary care (detailed risk assessment for women at moderately increased risk +/- regular mammography) and tertiary care (genetic counselling and testing), according to a woman's familial history and risk. Funding to implement this guidance was sought from the previous Hertfordshire PCTs, but they were unable to find the resources to enable implementation.

Many GPs have contacted the new PCTs and the LMC about the difficulties they face in dealing with patients in the absence of any identified service. The introduction of Practice Based Commissioning makes this an appropriate time to revisit discussions about the delivery of a specialist "familial breast cancer" screening service and consider the relative priority this issue should take and how it might be introduced, if so desired.

Family cancer screening is distinct from the National Health Service Breast Screening Programme and there is clear national guidance that routine breast screening should take priority for resources and service delivery. The purpose of this short paper is to ensure PBC groups are informed about the implications of the guidance and the financial consequences were it to be implemented.

Resource implications — PCTs said had no money pressure from LMC & GPs : not much can be offered

Current situation

No secondary care "familial breast cancer assessment" service is currently commissioned. The NICE guidance is explicit that such a service must operate to the same quality standards as those offered in the NHS Breast Screening Programme. The two main reasons for this are that interpretation of pre-menopausal mammographic films is difficult, and that all women should have the same quality of call-recall.

There are existing "Family History Clinics" run at QEII and Hemel hospitals. These were set up before the guidance and do not meet the quality standards of the NICE guidance. A few women with a very strong family history have been funded (through Exceptional Treatment Panel) to be reviewed and monitored in one stop clinics run by routine screening services.

: JTH to take back to PBC groups after speaking to LMC

There is access to genetic testing, but there is no clear pathway that follows the national guidance. This means that some women are referred unnecessarily to genetics centres and also that the recommendations for follow-up made by some centres are inconsistent with the NICE guidance.

If a Family History service is to be developed by local Breast Screening Services it would be preferable to get agreement across groups of PBCs that relate to that service. This would also produce economies of scale, as well as avoiding a situation where access to a service is dependent on post code rather than clinical need.

Met E+N yesterday. Don't have a service really

[1] Familial Breast Cancer – The classification and care of women at risk of familial breast cancer in primary, secondary and tertiary care; Clinical Guideline 14; May 2004

Could have 3° service or implement guidance

Uncomfortable, inequity

genetics bag is H-coordinating existing resource

For discussion / decision

Any secondary care service could only be developed as an "extension" of an NHS breast cancer screening service.

The following options could be considered:

- To continue with the status quo, relying on GPs to as ETP for approval to fund individual women with the strongest family histories, and with a variety of approaches to genetic testing.

- To develop (and possibly need to further fund) a restricted 'Tertiary' care service providing clear genetic counselling and testing pathway. Strict criteria would need to be followed in order to ensure that only women with a "high" risk of a genetic link to breast cancer are referred to this service. Verification of history could prove difficult in the primary care setting. This option would not meet all NICE guidance but could be supported by education events in Primary care.

- To develop and fund linked secondary and tertiary care 'family history' services. It will only be possible for a 'family history' service to be implemented at the Beds and Herts Breast Screening Unit if it is supported by all PCTs. This is because it would be difficult to run a service which could not offer access to all women for whom it is their local screening unit.

~150,000 per year guess

Costs

There are existing genetics SLAs, but further work would have to be done to know whether current activity levels would be sufficient to cover the number of women who might be referred.

To implement a family history clinic at The Beds and Herts Breast screening centre for women in the relevant parts of Hertfordshire would cost in the region of £100,000 per annum, with a further £35,000 needed for a service to Hertsmere and Watford.

Supporting information provides costing of service and numbers of women in each of the previous PCT structure for Beds and Herts who are likely to wish to access the service if delivered by the Beds and Herts Breast Screening Service. The cost is proportionally split between Bedfordshire and Hertfordshire PCTs based on size of population. Watford & Three Rivers and Hertsmere women (19,000 between age 40-49) are not included in the split as their populations are currently screened by the North London Breast Screening Service. Costs are based on figures for start financial year 05/06, so you should assume at least 5% extra to reflect 2.5% annual inflation.

So 30 to Watford / Hertsmere c rest of Herts

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Where implement needs to link in c 2° care services – where falls down is in admin rather than technical
Costs – relatively smaller of genetics
Work done in 2005 – need to at least 2.5% for inflation
Hertsmere x Watford – screening linked to N London ∴ no

CC – ?other parts of country

JH – additional resource for mod/high risk women in service

L&D only case by case

Manchester Nottingham have implemented

11 – E&N want to move ahead
NA this year – resource
priority area for growth next year
business planning this year

MMcG – ?mastectomies if high risk

JH – usually high genetic screening
incident pick up from genetic cascade

11 Speak to Watcom
take it forward
whole of HEAs

will one of a no of priorities

MJ – not do just first come first served

JH some business case work before prioritisation

continue ad-hoc service – Exceptional Rx panel ⟶ known genetic risk

CC – cost?
JH ~£200/women
need training in primary care
11 – rigid protocols