



Correspondence and Communications

# Reconstruction following breast cancer: The postcode lottery continues - A cross-sectional analysis of English Integrated Care Boards



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**Summary** *Introduction:* For certain patients, breast reconstruction is an integral part of cancer recovery. The Association of Breast Surgery (ABS) and British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS) published guidance which advocates for unrestricted access to these procedures in 2018. Despite this, in 2022, the charity Breast Cancer Now, published a report demonstrating widespread inequalities in the provision of breast reconstruction with many CCGs restricting access to reconstructive procedures. The 2022 transition from Clinical Commissioning Groups (CCGs) to Integrated Care Boards (ICBs) aimed to reduce regional variation. This study evaluates whether ICB policies have improved compliance with national ABS/BAPRAS guidance.

*Methods:* A cross-sectional policy review of all 42 English ICBs was conducted between July and December 2025. Data was obtained via a Freedom of Information (FOI) request to all 42 ICBs alongside a review of any publicly available commissioning policies for breast reconstruction.

*Results:* Responses were received from 100% (42/42) of ICBs. While 71% (30/42) demonstrated alignment with national guidance, 29% (12/42) retained restrictions on access to breast

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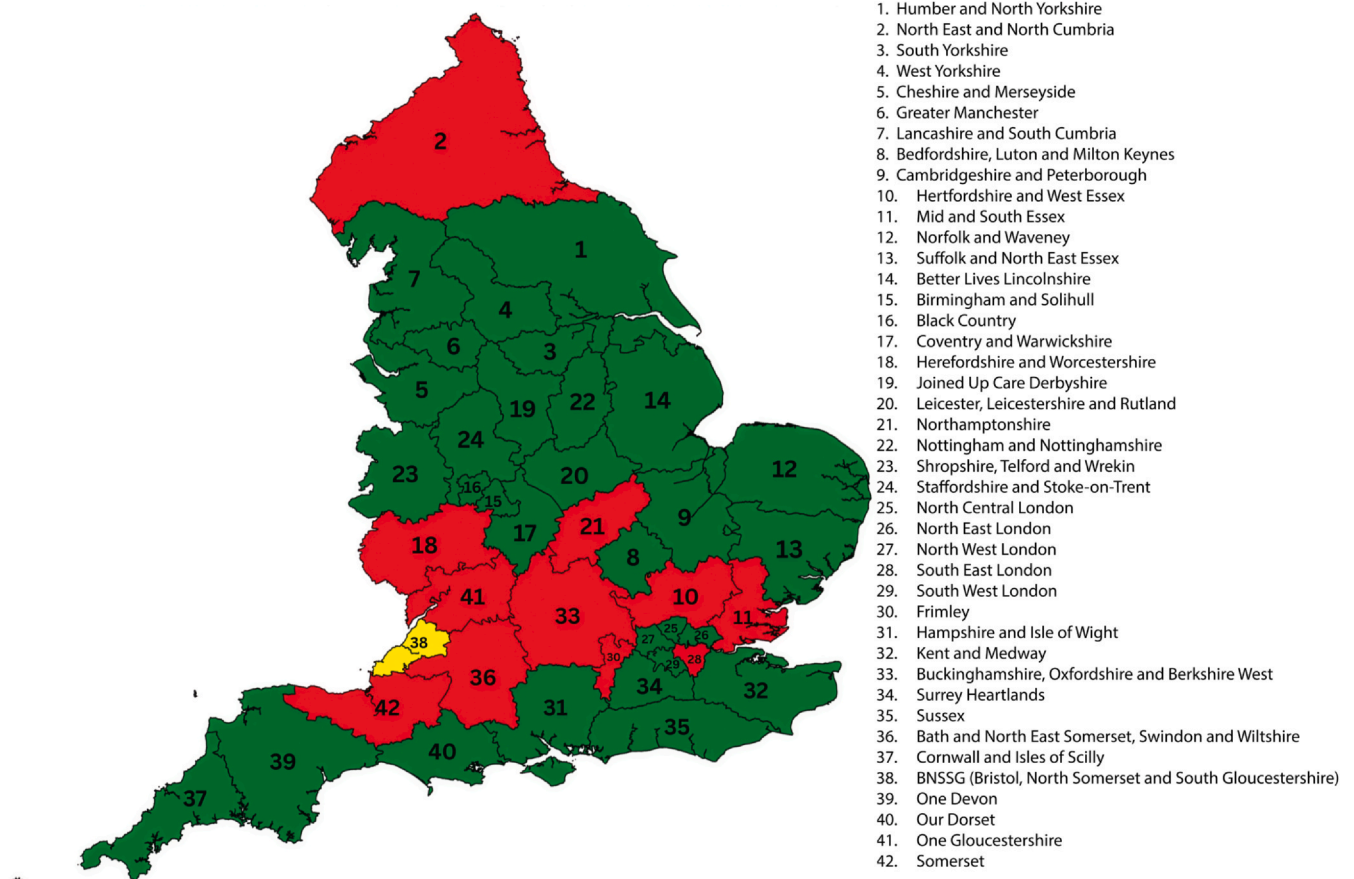
reconstruction. These included caps on procedure counts (ranging from one to four surgeries) and rigid timelines for completion (2-5 years). Restrictive policies directly contradict commissioning guidance that permits multiple procedures to achieve satisfactory reconstructive outcomes.

**Conclusion:** Structural reorganisation into ICBs has not eliminated the postcode lottery. Compared to prior audits, the proportion of restricted health systems has increased, suggesting regression rather than progress. Almost a third of health systems continue to enforce restrictions on procedure numbers and timelines, directly contravening ABS/BAPRAS guidance.

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For women requiring mastectomy, breast reconstruction is a critical component of holistic recovery, serving to restore physical integrity and psychological wellbeing.<sup>1</sup> Despite this, in 2018, the charity “Breast Cancer Now” highlighted regional disparities in the funding of breast reconstruction with a “postcode lottery” of care across England. Clinical Commissioning Groups (CCGs) enforced restrictive policies on the funding of reconstructive procedures limiting the types of procedures, number of procedures and timeframe in which they must occur.<sup>2</sup>

Reconstruction is rarely a single event. Aside from complication associated revisions, breast implants are frequently not lifetime devices and symmetrisation of the contralateral breast, and nipple-areola reconstruction, are important components of the reconstructive pathway.<sup>3</sup> Whilst efforts are increasingly being made to ‘Get It Right First Time’, with synchronous symmetrizing surgery now performed routinely in some centres, it is not always practical to do so. Logistically, adjuvant radiotherapy may subsequently impact the reconstructed breast and lead to



**Figure 1** Geographic distribution of breast reconstruction commissioning policies across English Integrated Care Boards (ICBs). ICBs are classified using a traffic-light system based on the level of restriction: **Green (Unrestricted)**, **Yellow (Restricted)**: Restrictions apply (e.g., time limits, procedure caps) but can be bypassed in full by a Multidisciplinary Team (MDT) decision. **Red (Restricted and requires funding)**: Restrictions apply which would require a funding request to override.

**Table 1** Classification of specific restrictions identified among the 12 restricted Integrated Care Boards (ICBs).

Nature of restriction	Specific restriction	ICBs utilising the restriction
<b>Procedure numbers</b>	Specifically: Single course of nipple tattooing	- <u>North East and North Cumbria</u>
	Specifically: Maximum 2 cycles of lipofilling	- <u>Bath, Swindon &amp; Wiltshire</u>
	Maximum 2 Procedures	- <u>Mid &amp; South Essex</u>
	Maximum 3 Procedures	- <u>Bristol, North Somerset &amp; South Gloucestershire</u> - <u>South East London</u> (A further allowed for nipple reconstruction under local anaesthetic only) - <u>Somerset</u> - <u>Herefordshire &amp; West Essex</u> (One further procedure if delayed immediate)
<b>Time period to complete reconstructive procedures within</b>	Maximum 4 Procedures	- <u>Gloucestershire</u> - <u>Herefordshire &amp; Worcestershire</u>
	Maximum 1 procedure on the contralateral Breast	- <u>Northamptonshire</u> - <u>Bath, Swindon &amp; Wiltshire</u>
	2 year limit	- <u>Somerset</u>
	3 year limit	- <u>Herefordshire &amp; West Essex</u>
	5 year limit	- <u>Buckinghamshire, Oxfordshire &amp; Berkshire West</u> - <u>Bath, Swindon &amp; Wiltshire</u> - <u>Frimley</u>
	Ambiguous	- <u>Herefordshire &amp; Worcestershire</u> - could be considered cosmetic if presenting 'a number of years' after completing treatment pathway

Specific details of each restriction for each ICB are summarised in [Supplementary Table 1](#).

an alteration of balance, the reconstructed breast will take at least 6 months to settle, and relative symmetry of volume and shape should ideally be achieved prior to performing nipple reconstruction. In addition, synchronous symmetrizing surgery is often not accounted for in clinical coding, so there are also financial considerations. Patients also make decisions about reconstructive and symmetrising surgery in differing time frames.

Joint ABS/BAPRAS Commissioning Guidance explicitly states that breast reconstruction, including symmetrisation, is a core part of cancer treatment and must not be classified as "cosmetic" or "elective".<sup>4</sup> This guidance establishes that reconstruction cannot be time-limited, may require repeat procedures and should include the full range of symmetry/adjustment procedures (nipple reconstruction, surgery on the contralateral breast, lipomodelling etc).

In July 2022, the NHS reorganised into 42 Integrated Care Boards (ICBs) to reduce commissioning variation. This study audits ICB policies to determine whether non-evidence-based restrictions persist under the new structures.

## Methods

A cross-sectional policy review was conducted between July and December 2025 across all 42 English ICBs. Data was obtained via Freedom of Information (FOI) requests and a review of publicly accessible policy documents. ICBs were asked specifically about time or procedure limits for reconstructive procedures, including revisions and contralateral symmetrisation.

## Results

Commissioning policies were successfully retrieved for 42/42 ICBs. While 71% (30/42) of ICBs aligned with national guidance, 29% (12/42) retained specific restrictions ([Table S1](#)). Geographical distribution of restrictive policies is visualised in [Figure 1](#).

Among the 12 restricted ICBs, ten restricted the number of operations a patient could undergo, ranging from a single procedure to a maximum of four procedures. Six ICBs list timing-based restrictions, typically requiring reconstruction to be completed within 2-5 years ([Table 1](#)). The most common restriction type was a procedural cap of three, which was seen in 4 ICBs. Three ICBs ambiguously provide time-based limitations on further surgery that may be considered cosmetic ([Table S1](#)).

## Discussion

This study reveals that 29% of ICBs continue to impose restrictions, contradicting ABS/BAPRAS guidance.<sup>4</sup> Compared to the 2018 enquiry<sup>2</sup> which identified restrictions in just over 20% of CCGs, our finding of 29% represents a concerning regression.

The persistence of procedural caps appears misaligned with the clinical reality of breast reconstruction. Implant based reconstructions involve high revision rates, within just 3 months of immediate reconstruction; 18% of patients require reoperation, and 9% experience implant loss. In an 8

year follow-up period, 9% undergo 3 or more revision procedures.<sup>5</sup> By capping procedures at 2-4 operations, commissioners effectively penalise patients who suffer complications or require standard adjustments, forcing them to accept asymmetrical or incomplete results.

Rigid time limits (2-5 years) are similarly inappropriate, particularly given the COVID-19 pandemic, which caused a 34% reduction in reconstructive activity.<sup>6</sup> Enforcing pre-pandemic deadlines on women facing system-wide delays penalises patients for factors beyond their control. Additionally, ambiguous policy wording places an interpretive burden on frontline clinicians and patients, perpetuating the postcode lottery.

## Conclusion

Structural reorganisation has been insufficient to eliminate inequitable access. Almost a third of health systems maintain restrictions that ignore clinical guidelines. To ensure parity of care, NHS England must mandate the removal of arbitrary caps and reconstruction must be recognised as a standard component of cancer treatment, not a discretionary adjunct.

## Ethical approval

Not required.

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## Declaration of Competing Interest

None declared.

## Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at [doi:10.1016/j.bjps.2026.02.053](https://doi.org/10.1016/j.bjps.2026.02.053).

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