**Title: FG5\_14.09.2022**

**Interviewee/s: GP 4, GPR 10**

##### Interview Date: 14.09.2022

**Interviewer: Main interviewer (Q), Co-facilitator (V)**

[PART ONE]

Q1: Just make a note of the time, okay, so first of all to help the transcriber distinguish between voices, which is probably going to be quite obvious [laughs]. So just can you each just introduce yourself and if you feel comfortable sharing what your profession is and what part of [place] you currently work in. And GP4 go first.

GP4: All right, hi, GP4, I’m a GP, I work in [place], I also work in the private sector as well, so [name of private hospital facility].

Q1: Thank you, and GPR10.

GPR10: GPR10, GP trainee in my third year of training, and I work in [place].

Q1: Thank you. Okay, so as a researcher who does not work in primary care I am not familiar with what happens in practice. And so just to start off with it would help my understanding if you could give me an example of when you’ve had a woman in this age group present with a concern about their breast cancer risk, or about breast health and talk through what happened and what you did, if you’ve got any examples.

GP4: Yes, yes, there was somebody who that I probably had contact with in the last couple of months, maybe she was in her twenties, she’d presented because of some other I think gut symptoms, and as we were talking she mentioned that she’d had a family history of breast cancer, I can’t recollect what the family history was. She was unclear about a lot of the details, and kind of gave me what she thought to be the family history, and I said, “Look why don’t you go and find out from your parents, you know, what your grandparents, aunts and uncles, etc, had, and the ages that they were diagnosed approximately and then come back and get in touch with me and ‘cos you might need referral to the breast clinic.” And then she got in touch with a colleague, gave a history, got in touch for a third time with an amended history, and I think she’s been referred to the geneticist.

Q1: Okay, so how did you feel about that interaction?

GP4: I mean I think it’s useful, definitely, you know, I see young women who get diagnosed with breast cancer, definitely in primary care, I think knowledge of family history I think people have quite a lot of uncertainty, you know, and it’s quite vague. And I think if you think about how many interactions with a doctor she had, you know, first interaction was about an unrelated cause, and this is kind of incidental. Then she’s had a second interaction to update family history, and then she’s had a third interaction to update family history. So you do kind of think it’s quite a lot – and we still don’t know [all laugh], you know, how much of it is accurate, yeah. So yeah, so I do think it is important, but I don’t think everybody has knowledge of their family history for all sorts of various reasons.

Q1: So how did you feel discussing that family history with her, did you feel comfortable?

GP4: I felt fine, yeah, NICE guidance has got really good clear guidance, you know, that you can pull up, so you know, somebody mentions, ‘cos often you know, what they’re really confident about is their maternal family, family history, you know, that’s often what kind of initiates the conversation. I can’t recollect with this lady, you know, so they tend to be quite clear, my mum she was diagnosed at roughly this age, the rest of it is often quite vague.

Q1: Okay, yeah, okay, thank you, thanks for sharing that, how about you GPR10, any experiences?

GPR10: Yeah, well I’m a trainee so I’ve not got – had loads and loads of experience.

Q1: No, okay.

GPR10: In practice, but yeah there was one when I was – this is when I was a foundation doctor, someone came she’d had I think – I think she previously had ovarian cancer, or I can’t remember why she knew but basically she already knew that she had a BRCA2 mutation. And she was attending because she wanted a referral to the breast surgeons for – well just for an appointment really, maybe whether it’s ongoing screening or whether it was like a prophylactic mastectomy. But she just wanted a referral, but I mean ‘cos I was a trainee I suppose I was, I think that was probably the first time I was really brought in a clinical way confronted the idea of how important BRCA mutations are, she kind of gave me some teaching. But yeah, that was one of my experiences of a lady with coming for counselling about concerns about breast cancer.

Q1: Hmm-hmm.

GPR10: Yeah, she knew that she already had BRCA and she wanted a referral to breast surgeons which I did.

Q1: Okay, yeah, and did you feel like – again just like did you feel comfortable doing that, speaking about that with her?

GPR10: Yeah, yeah, yeah, I mean to be fair – I probably didn’t take that much of a family history, it was quite a long time ago that this happened so I can’t remember it too vividly.

Q1: Oh yeah, no, of course.

GPR10: But yeah I don’t think I did that much of a history, I just kind of just – it was fairly simple consultation really in the end.

Q1: Okay.

GPR10: I suppose one of the other examples, I’ve – one of my experiences of this whole thing is when I was in my second year foundation and I worked in oncology at [place], and I did an audit on BRCA, but this is for patients that have already had breast cancer. And the guidelines had changed, I think in like 2018 in the [place] area, and my audit was around seeing if there’s any women that should have been offered a BRCA, or genetic counselling, and that hadn’t, but according to the guidelines. But yeah, essentially it was even with the breast clinic which are quite good at going through the family history it was quite difficult to figure out the family history for those guys. And it’s not just the breast cancer family history as well, like the history of cancer as well which was all quite mingled and all over the place, and trying to audit as well was a nightmare because it was like it was trying to figure out what is relevant, what’s not relevant, but yeah that’s just another experience that I’ve had.

Q1: Okay, thank you.

GPR10: For –

Q1: Yeah, yeah, thank you, thank you for sharing that, it sounds like you’ve got some great experiences to draw on for the rest of the focus group so thank you for that. Okay, so breast cancer becomes more common in women in their thirties and it’s the most common cause of death in women aged thirty-five to fifty, so before the age of fifty years at least 65% of women who develop breast cancer do not have a family history and are not currently identified as being at increased risk. Currently there is no defined systematic mechanism to identify this group of women. The introduction of breast cancer risk assessment for women aged thirty to thirty-nine years would allow women to find out their risk of developing breast cancer in the future. And this would have the benefit of women who are identified as being at increased risk could then be offered earlier breast screening as well as methods to reduce their breast cancer risk. So I was wondering what are your immediate thoughts and reactions to offering women the opportunity to find out their breast cancer risk estimate from the age of thirty years.

GPR10: I thought it was great, I think it’s really great, like especially when you like do the analogy to like someone’s cardiovascular risk, the way we calculate that with such precision, and act on it and do things about it. Yeah, it was – I feel like, you know, I’m a trainee so it’s not that I don’t have load of experiences but we’re obviously quite well set up and we understand how to – how we do these sort of risk calculations and I think we’re quite well versed in understanding them and relaying that information to patients as well. And also with the systems that we have with EMIS and things, I think we’ve got – we’re probably quite well placed to gather all that information, audit it, and you know, and create a number. So it makes sense, so I mean whether it actually is you know, going to reduce morbidity, mortality things like that, I’ve got no idea, whether it’s going to be a worthwhile thing to do I don’t know, but like if it is I can see it working, I think it sounds really good.

Q1: Hmm-hmm.

GP4: Yeah, I mean I think it depends on again how motivated people are to use the information because you know, yes I mean absolutely I think it’s a great thing to have information but some people it might make them quite fearful, particularly if they’re not prepared to make changes. And so I suppose one of the knock on effects is if you’re somebody that’s at moderate risk, I’ve got no idea what the outcomes of the risk assessment would be, but you know, possibly and lifestyle advice is the treatment. And somebody doesn’t have – follow lifestyle advice [laughs] is there this fear that they are this kind of, you know, this timebomb within themselves and that they constantly want reassurance and to be checked, I don’t know.

[00:10:24]

GPR10: Yeah, that’s a really good point actually, I didn’t think of it like that, I suppose part of it is just because it’s cancer isn’t it, it’s not like cardiovascular death, in elderly patients – people really that’s who it is who the – that usually applies to. People aren’t as afraid of it as they are kind of cancer, or getting cancer, even though the risk of death might be quite similar, or the risk of, you know, but it’s just ‘cos it’s the C word, just strikes fear into the heart of people doesn’t it? And yeah like that could cause – I could imagine that causing a lot of anxiety in some people.

GP4: Yes, I think even without screening I think you know, the five year survival rate for breast cancer is very, very, very high isn’t it?

Q1: Hmm-hmm, yeah. Oh I think you’ve muted yourself by accident [all laugh].

GP4: Sorry [all laugh]. Just people who are symptomatic, so I think then if you’re picking up the bigger cohort of people who are just at risk you know, I don’t know what impact that would have on mortality and morbidity.

GPR10: Do you think it –

GP4: And –

GPR10: Sorry.

GP4: No, no, go on I was finished.

GPR10: I was going to say do you think it would encourage people to modify lifestyle factors and things, do you think – do you feel like people would act on it?

GP4: I think some people would, you know, that they would use that information to make changes, but if you think about how many people smoke, how many people who are overweight, how many QRisks you’ve done in your career [laughs], you know, and you turn around and say, “Yes you probably need to lose some weight, and modify your diet, and maybe stop smoking, exercise a little bit more.” And who absolutely don’t [laughs], and you know, make no changes and go on a statin, I think yeah, I think you – like with all things you will get some people who will make changes, some people who won’t, some people will be fearful, some people won’t.

Q1: Yeah, yeah, okay, thank you. So one potential approach is for breast cancer risk assessment and some aspects of risk management to be conducted in primary care, so what are your immediate thoughts and reactions to primary care identifying and inviting women to a breast cancer risk assessment?

GP4: I suppose how long does it take, how frequently does it need to be done, can it be done at another appointment, you know, ‘cos already we have – we are under-doctored, you know, under-appointments, and then to create another thing that needs people being invited in, nurse time, I you know, I think that’s going to be difficult. What do you think?

GPR10: Does it need to be a clinician that does that? Does it – you know, need –

GP4: Yeah, I don’t know, I don’t know what information needs to be collected, but I suppose even if it is – I don’t know, would it – I don’t know, I mean our nurse I know doesn’t have capacity, spare capacity to be doing extra things, so I don’t know who would collect this information and process it. And share it with the patient, and when they come back and they need to make amendments to reassess them.

Q1: So you mentioned there about could it be put together within an existing appointment, or dealt with in another appointment, is there any that you can think of that would be appropriate?

GP4: Well cervical screening, because I mean that’s where you get women of that cohort who come in three yearly, you know, for physical assessment at the moment, so you could incorporate, I don’t know how frequently it would need to be done, but if you could incorporate it at that appointment, possibly could be done in primary care.

Q1: Hmm-hmm.

GP4: That’s probably I suppose you could do ad-hoc at birth control checks but a lot of women might not be on birth control.

Q1: Yeah, yeah.

GP4: Something where they regularly get an invite is cervical screening.

Q1: [Inaudible 00:14:56], oh go on sorry.

GP4: No, no, sorry just thinking out loud [all laugh].

Q1: Do you think it should be primary care’s responsibility to identify and invite women or would it work better if it was structured in terms of being like a separate centrally organised service, the way that breast screening is performed?

GPR10: It depends on the information I think that is needed, I mean if it is just information that you would have already on file, on EMIS, like and it could just calculate quite easily then that could be quite a – it could be a good way for it to be done, but if it is – it depends if it’s just information that the patient would just quite easily have to hand to know themselves. I mean I don’t see why it couldn’t just be an – like a calculator online even, if – and then if it’s positive they can come in and speak to the GP, rather than the GP inviting them in to do it all and go through the rigmarole.

GP4: Yeah, and I suppose the other question is as part of the assessment, a mammogram, because if all people are being invited in for a baseline screening mammogram, they’re physically interested enough to attend. And I suppose their risk could be calculated then and there, you know, if it’s family history, height, weight, smoking, alcohol, you know, why can’t that – information possibly could be shared at that mammography appointment and then the risk is calculated based on that information at that time, those mammogram readings, and then shared and that way it’s not extra sort of work for the GP practice to do.

Q1: Hmm-hmm. Okay, so if we think about the actual breast cancer risk assessment itself, rather than identifying and inviting women, what are your immediate thoughts and reactions to primary care being involved in the actual assessment process, and management?

GP4: Sorry do you mind just repeating that [laughs].

Q1: Yeah, no, of course, yeah, yeah [all laugh]. So I was just wondering what your thoughts and reactions are to primary care actually being involved in the risk assessment so in terms of them calculating the risk, and then being involved in aspects of management of that risk. So maybe seeing a woman and providing lifestyle advice for example, in the context of breast cancer risk reduction.

GP4: I mean I’ll be completely frank we can’t even do that for lipids and cardiovascular risk score, you know, the answer at least in our practice is come in and let’s talk about a statin, or you’re not eligible for a statin, go read this information, you know, I mean we can’t even bring people in for those appointments. So I would put – I would – I think we might struggle to bring young women in to do health and lifestyle assessment appointments, in an ideal world we would, you know, but practically it’s never going to happen.

Q1: And is that to do with resources, or –

GP4: It is to do with resources, yeah, it’s just time, I mean you know, you’ve – we basically give out written information unless there’s something specific I can do, if somebody comes in and books an appointment to specifically talk to me, then of course you know, I’ll have that conversation with them. But you know, just looking at QRisk alone, you know, generally it is lifestyle advice, go on a low fat diet, try and lose some weight, reduce your alcohol. If you need help you can book an appointment in to see the practice nurse or we’ve got clinical pharmacists who might be able to help you. But that you really need to figure it out for yourself really.

Q1: Okay, yeah, yeah.

GPR10: Yeah, I suppose it’s a bit like asking GPs to do a whole screening service on top of what they already do, I suppose it’s quite – it is quite a lot to ask them to do that.

Q1: So you mentioned earlier when you talked about your own experiences in terms of collecting like family history information. So if you think about that, like that’s part of what a risk assessment would be, so it’s just thinking about whether that is something that you’d be comfortable with having more of a role in, or is it – if resources weren’t an issue.

GP4: Hmm.

Q1: Or is there anything else that you think stops primary care from being involved in the actual assessment of risk?

[00:20:05]

GPR10: It sounds like, you know, I would enjoy that, I mean personally ‘cos I’ve got like some interest in oncology as well and seeing where that would go with my personal career, so I would personally be interested in doing that. And also I suppose we are well situated for it ‘cos we’re in the community, we’re near people’s homes, we’re, you know, generally trusted by patients. And hopefully in some ways listened to as well in terms of what we’ve got to say. So you know, we are well situated to do that. So I would be happy to do it, but I suppose – but it depends on all of the finances I suppose and all of the resources about whether the practice is paid to do it, or whether they’ve even got time to do it. So I personally would be happy to do it, but it just depends on the resources, I think actually it is just a key problem.

GP4: Yeah, yeah, and I also think people sometimes don’t necessarily want things on their health records for all sorts of reasons, you know, some people get critical life insurance, you know, and I’m thinking about me personally, you know, my family history, none, nil, nothing. You know, because it affects my – the costs of insurance, you know, and so and health insurance and so people don’t necessarily want to disclose that they smoke or how much they drink and that goes on their medical health records forever [laugh] which might – they then might need to use for other reasons. So I think, I suppose one of the benefits of having it separate would be maybe people would be more honest, you know, at that point in time, yeah, that they’re actually – what they’re actually doing and not the perfect answer that they think we want to hear.

Q1: Yeah, yeah.

GP4: That’s on their notes maybe [all laugh].

Q1: Yeah, thanks. Okay, so risk of developing breast cancer is best calculated with a combination of three measures, so we’re just basically – we’re going to talk about all of them and primary care’s potential role. So yeah, so just going to share a diagram that was in the pre-reading material so that you can see that as I read along. So the first component of risk assessment is a self-reported questionnaire and this would be collecting data about risk factors that we know are associated with breast cancer, that would include height and weight, family history of breast and ovarian cancer. And this would involve asking how many first degree relatives have been affected and what their age of onset was of their diagnosis. Age at first period, age of first pregnancy, oral contraception history, and alcohol consumption. The second component would be a mammogram to assess something called breast density which is the measure of the amount of non-fatty tissue compared to fatty tissue in the breast, with women with a higher proportion of non-fatty tissue being at an increased risk, and then the final component would be a saliva sample in order to analyse DNA. So this would look for something called a polygenic risk score which is a combination of multiple common genetic changes into a single score whilst also looking for the mutations in high risk genes that you’ve mentioned, so like BRCA1 and BRCA2. So as I’ve mentioned there from the first pillar that information would need to be collected, so just wanted to know what you thought about primary care collecting that information on that list there?

GP4: So I mean how often would you be doing this, I mean people’s weight fluctuates and you know, one of the things I’ve kind of noticed during Covid we’re maybe doing less face to face, I’ll ask somebody, “How much do you weigh?” and they don’t have a clue [laughs]. Couldn’t tell you, give you a vague number, don’t have scales, don’t have access to scales, so I think yeah, you know, yes of course we can weigh people but I suppose if people aren’t coming in why would you be weighing them, you know. Maybe at their new patient check which might have been years and years and years ago and they come in for their cervical screening they’re definitely not getting weighed, you know, and having their height checked, you know, they’re having the cervical screening done. So I suppose it’s possible to do these things and if resources were unlimited, you know, you could pop in and do them.

Q1: Hmm-hmm.

GP4: For age of first period I would hope most – I can’t help with that as a GP, I do know [laughs] – they’d have to think about that one, contraceptive history that is something people might not recollect, you know, I suppose it depends on how detailed it is, you know, if it’s have you ever used or if it’s when did you use, you know, they might need to sort of to go through their notes. Alcohol, again you know, that’s self-reported, so hmm. I suppose what might be interesting is as we move to patient held records, you know, at the moment I don’t think that they can write on their records, but they can definitely share information with us, you know. So if it might be of – you know, I’m just thinking like let’s say you did want to harvest that from a set of GP notes, you know, you could have – I’m just trying to think, you know, creating – not creating more work [laughs]. But you know, if you could send out message – you know, a text message because you can share that information, that can be coded in your notes, you know, can you weigh yourself, there are practice scales, you know, in reception that you don’t need to book to use, or in your local pharmacy you can get yourself weighed. And then send us the information back and that can be coded in your notes, so I suppose there are ways, the contraceptive history, you know, if people are downloading their personal GP records they hopefully will have access to all the medications they’ve taken in the past.

Q1: So do you think then it’d be appropriate to ask women to enter their own data for this, for these items?

GP4: I do, ‘cos all of it is just what they’re reporting to us, I mean except for height and weight, you know, but their family history, their age of menstruation, pregnancy, yeah, alcohol, that’s all their information that they’re telling us that we’re then documenting on their behalf, you know, they can do that themselves.

GPR10: Yeah, I agree, I don’t think being in front of a GP would change what they say, particularly. If they want to – if they are going to be inaccurate with it then being in front of a GP won’t change that. I don’t think.

Q1: So do you think women entering the data is preferable to having someone like a dedicated person at the practice that would ask for this information?

GPR10: I mean it sounds more efficient for time, and energy. And yeah, it could be quite easily be done, like on a calculator, and like you say and texted over or we have some online systems where people would pop in all of their blood pressures and it would go straight onto the EMIS through that, so people already do input a lot of their health data into EMIS. So it’s – it wouldn’t be much different I don’t think.

Q1: Do you agree with that GP4?

GP4: I do, yeah, I absolutely do, I think all of this could be you know, calculated and if they don’t know their height and weight, well if they know that they need that information in advance and they have access to their height and weight, or wherever they go for their mammogram they can have their height and weight done. That’s really the only information and the contraceptive history, you know, potentially that might need access to their notes, depending on how detailed it is.

Q1: Yeah, yeah, okay, thank you. So are there any key issues or barriers that you could foresee to like collecting this information from women?

GPR10: I think you mentioned some, about getting an accurate height and weight can be difficult for a lot of people, and like you say that people’s recollection or understanding of their own contraception history, they won’t necessarily know what specific hormones they’ve had, oestrogen based and things. Or and what else, yeah, I mean even if the other problem I suppose, even if it was done by us reading the notes, I don’t know what GP4 thinks about this, but you know, they might have moved around a lot. They might be – had it at uni or something like that and the notes haven’t quite come across, so you still might not be able to fully know, just from that reading the GP notes about their contraception history. In fact a lot of like the sexual health clinics will just give, will do all of the contraception, and you know, I remember it was actually quite difficult to get that information sometimes in my placement in my first year, so that was in [place] and [place] did a lot of the contraception and you wouldn’t get any notification of it. So that that you know, even with a GP that could be a barrier, the contraceptive history.

[00:30:54]

Q1: Okay.

GP4: Yeah, I think not everybody knows their family history either, you know, many people seem to be estranged from the you know, side of the family so couldn’t tell you anything about their dad, and yeah I think the family history bit is going to be possibly difficult, people don’t know. Also people’s understanding of what is primary and secondary is, you know, so that they know that somebody died of lung cancer but was it the primary or the secondary, they may not sort of understand the difference which may make, you know, have an impact on their risk as well. I think people’s knowledge of kind of gynaecological organs, you know, sort of cervix, the ovary, the womb, you know, people get that all muddled, you know, they know that it’s a gynaecological history and I suppose some gynae histories will be relevant, and some gynae histories won’t be. So yeah, so I think people maybe not you know, understanding, having knowledge of there is family history, their own bodies, you know, being quite certain what things mean. And I think, you know, most of us would rather [laughs] have more tests so if it’s a case of god well I don’t know if it was ovarian or cervical, I’ll just say it was ovarian because I’d rather err on the side of caution and give too much information that perhaps isn’t accurate, that might mean I need further tests, that might pick up, put me in a higher risk group which is only going to be beneficial. So you might find you get that, yeah.

Q1: Hmm-hmm.

GP4: Many of our patients, I think the average age of literacy is like nine or eleven, you know, so this might be information that they might struggle to even comprehend what it means.

Q1: Okay, thanks, you can stop sharing that now [name of co-facilitator], thank you. Okay, so one model of how breast cancer risk assessment could work in primary care is the development of a risk assessment tool similar to QRisk, for example scores for mammographic density and genetic risk could be fed into the tool and a risk score generated, once someone in primary care has entered family history, hormonal and lifestyle factors. Primary care could then be responsible for communicating the risk score and making a management plan. What do you think about primary care coordinating the process of breast cancer risk in this way?

GP4: I mean I think there’s got to be like dedicated time to do this, it involves chasing people up, you know, if you think about how an appointment is made, you know, you have to contact the person, invite them in, organise a date that’s suitable. What do you do for those who don’t attend, what do you do for those who turn up but don’t have the information to hand so you’re not able to do the risk. Do you then invite them in on another occasion, you know, I mean I think it just seems like –

GPR10: I mean it’s probably the reason why a lot of the cancer screening isn’t done through the GP anyway, you know, breast – it’s not done through GPs, breast screening I don't think, and that’s for good reason because it just adds more layers of complexity, so for the patients, and for the whole system as well. There are some screening programmes that are done through the GP aren’t there, is bowel – no bowel screening isn’t done through the GP either, is there any?

GP4: No, I mean it’s all centralised and that they just go through our computers to figure out who’s eligible and then they’ll send out the invitations and then we may as a practice chase people up to encourage them to attend, but if they don’t attend then I can’t – they’ll all be different, but they’ll be invited a second time and then they’ll be reinvited centrally when it’s their chance to have it again. So –

Q1: Do you think that model would be more appropriate, that –

GP4: I do, you know, I – you know, in my mind what I think would be brilliant, you go, you have your mammogram, you’re given like a unique code, you put that unique code into the computer, you put all the information in that’s required, and then you’re generated, you know, your low, moderate, high risk. If you’re you know, at a risk that needs any sort of intervention that is then fed back to your practice, this person’s high risk, you know, the advice is blah, blah, blah, blah, whatever it is, or if they’re high risk those people are directly invited in to have whatever it is that you do for high risk people. You know, that’s how I think it should be done, cut out the GP completely [laughs].

GPR10: But you’re saying if they were like a moderate risk they would see the GP, or it would go on the GP system?

GP4: No, I think whatever their risk is it goes on the GP system but if it’s something that needs specific – ‘cos I suppose they’re either going to be low risk, high risk – they get siphoned up to the hospital, or moderate risk and it’s going to be lifestyle advice. And whatever that lifestyle advice is feed it back to us, you know, so we know what they’ve been told, and then if they want to engage you know, if somebody’s overweight and they want to come in and talk to me about weight management I’ll have a talk to them. If they want to talk to me about smoking cessation I’ll have a talk to them, or whoever is the most appropriate clinician. But that they take the initiatives that they want to make change, they contact us, to see how we can help them, other than we chase them down to say you’re high risk, you need to stop smoking, yeah. [Pause] But that would work for me [laughs], I don’t know if you’re not very computer literate how that would work [all laugh].

GPR10: I suppose why don’t we do that with QRisk, with you know, with like other things then, with like fracture risk and for cardiovascular risk as well, I suppose that’s what these guys are trying to say, is that it should be analogous to like the way we handle cardiovascular risk.

GP4: Hmm-hmm, but I suppose those are tests that are done in primary care, so you know, the QRisk is a blood test that we do, and that we interpret the result, where their risk is based on mammogram screening, which we don’t do, we don’t know how to interpret, we don’t know what it means.

GPR10: We do the DEXA though don’t we, for osteo – well we don’t do the DEXA sorry but we interpret, or is like osteoporosis risk interpreted in GP, it would be yeah, and we would –

GP4: It’s very ad-hoc, if you look up who – when did you last do a FRAX score on somebody?

GPR10: It’s just in my exams, it’s just in all the exams, yeah.

GP4: It’s not something that we do regularly [all laugh], yeah, it’s that ad-hoc patient who comes in who might say, “Oh yeah my mum had osteoporosis, I’m curious about my risk,” or yeah, “Oh yeah, you know, I’m forty and I’ve gone through the menopause,” and you think, oh yeah we should probably do a DEXA scan. We’re not proactively looking for these people, at least not in my practice.

GPR10: Like we are breast cancer, like we would be doing with breast cancer.

GP4: Well I think if you left it to GPs it might be a bit [laughs] like with breast cancer, you know, if you’re coming in to speak to us then we’ll calculate it for you, if you don’t then we possibly might not have enough time to do it.

GPR10: That’s, I suppose that’s one of the risks isn’t it, if you do leave it to GPs that have got a million other things, other priorities, will it become like, you know, a kind of as ad-hoc as osteoporosis screening is? Yeah.

GP4: Hmm.

GPR10: Rather than having a specialised unit kind of away from the GPs where it’s much more a tight ship for that one condition.

GP4: Yeah. Or you have you know, like the four day NHS cancer screening, you know, there is an appointment that you get specifically to come in, and you’re prepared in advance, and you know, there is dedicated time to go through this with you and pass on your risk, you know, but again I think it’s got to be funded, yeah. And you have to find the time, and if you think about how many vacancies there are in the health service, I don’t even know, even if it was funded, you’ve – if you – if it would be possible to do it, unless you’re not a clinician doing it.

GPR10: I think like you were saying as well with some of the possible negative effects of the screening with anxiety and with just having a different sort of risk category for insurance. I think all these things for you and your family, you know, I think if generally if you are going to do that I think you should do that with full sound knowledge that that’s exactly what you’re going to do, it’s exactly what you want to do and you go into a specialised place to do it. And I suppose it’s just about a little bit about the ethics of screening, and whether going – your GP getting involved in all of that, like oh if it’s like a QOF indicator even, if you’re getting paid to do it, it kind of messes a little bit with the ethics of screening. ‘Cos I might be getting paid to go through all this with you so may as well do it anyway or, you know, sending out how is the letter going to be worded and, you know, how are we going to get these people in. It’s kind of depending on what finances are as well, just I don’t know, it kind of muddies the water a little bit with the ethics, doing it in GP.

[00:41:04]

GP4: That is a really good point, I haven’t thought about that, with yeah, with screening, you know, and are you consenting to all three parts, ‘cos you might go off to a mammogram and not really understand and think oh they’re just testing for breast cancer. And actually unless you specifically consent to the other part which is we’re going to use your family history and all of this other information that we may or may not have in your notes to calculate a risk score that’s going to be there in your notes, and you know, as I said it might affect insurance, it might affect all sorts of things. Yeah, it just might have an impact and have you truly consented to that?

Q1: Hmm-hmm.

GPR10: One of the things as well is I think that a lot of it relies on is how effective the whole thing is, so if you told me this will save of a population of women in my practice, this will save this many lives or you know, you know, you could convince me to get a lot more involved in it. So I do think a lot of like how I feel about it is, particularly being a GP, does depend on how like effective it is. ‘Cos like with prostate cancer that’s the – we keep on – everyone says that that’s, you know, not really effective so there’s no national screening thing, and you don’t, no one sends out letters and things like, you don’t really bother with it, like going out seeking patients proactively. But if that was really effective obviously you would – and there was no national screening thing to do it you would get more involved with it, so I think that that plays into it as well a bit, in my head.

Q1: Hmm-hmm.

GP4: Yeah, yeah.

Q1: So you mentioned earlier GP4 about like how the different components like the testing is, like it’s done outside of primary care, just wondering what your thoughts were on whether it’d be appropriate or it’d make sense to be involved in the saliva sample collection part. So just trying to think about what you really think primary care’s role is in all of this, if there is any role for it at all, or whether you feel like this should all be done in a separate like service?

GP4: I mean I think it should be done [laughs], I think it’s probably quite clear isn’t it, you know, we shouldn’t have anything to do with it. No, I think you know, maybe similar to you know, sort of central screening, we hold a database of who’s eligible, their addresses, and if you struggle to get in touch with them we might be able to help, you know, for cervical screening.

Q1: So you muted again [laughs], oh you’re muted GP4 [all laugh].

GP4: This is a very sensitive computer [all laugh].

Q1: You were saying that you have the database with people’s addresses and that’s where it cut off.

GP4: Yeah, you know, I’d see that, as you know, we’re kind of the information data holder, that I think if you want it done regularly I don’t want to say ‘properly’ you know, but regularly communicated to people, action taken, you know, you probably want something that’s outside of GP.

Q1: Hmm-hmm.

GP4: Realistically, hmm-hmm.

GPR10: Yeah, I think I agree there, if you want it to be like systematic and well organised GP probably isn’t the best place to do, ‘cos there’s just so many different factors in a GP practice, and things that they’re worried about and trying to do that it’s one of hundreds of different priorities for them. Whereas if it’s a set up screening programme that’s their only priority, that’s their only focus, and yeah it – of course it’s going to be better, because they’re just focused on it, so it’d probably be more cost efficient as well really to have it centralised.

Q1: And so if were to imagine like – I know you both kind of said it should be outside of primary care, but if we were to design some sort of risk assessment tool, is there anything that could be done with that tool that would make you more inclined to be involved in risk assessment? Or is there anything about QRisk that you think is particularly good that could be not necessarily you doing the risk assessment, but that could be applied to a tool if we were going to develop it as like a calculator?

GP4: Just trying to think of like who gets QRisk assessed, so you know, in my mind it’s people who are mainly coming in for other reasons, you know, so it’s part of their other health assessment. Yes there are a few primary care you know, primary – you know, primary health conditions so like the forty wellness check. But even then, you know, it’s quite variable about who gets invited in, variable how people process the results. I’m just thinking about from our own practice, I mean we actually discussed this at our last practice meeting, some people are, you know, not doing the QRisk and inviting everybody in who’s got an abnormal cholesterol, some people are sending out letters. You know, it’s just there’s no consistency across the board, except for diabetics [laughs] because I don’t know if it's part of QOF and for those who come in for their hypertension reviews, I suspect probably because it’s part of QOF, and you know, then people are forced to do it. So if you make it part of QOF, you know, you probably will get more of a response, consistently.

GPR10: Is QRisk not part of QOF anymore, was it ever, I don’t even know.

GP4: I don’t think for primary prevention, I think if it’s part of the diabetes QOF components I think, QRisk is part of it, and hypertension is part of it, but yeah not sort of – not how many of your patients have –

GPR10: Not just for general people, yeah, yeah. [Pause] It would be strange, like someone would come in for like a throat infection, like a thirty-five year old and then you can’t just like crack onto their family history of cancer in that appointment, that’s just – it’d be strange. It’s that – it is different, and it’s that it is partly with the ethics of screening, and like putting all of this information out there in their record, but also just it doesn’t quite flow really, you know, with the consultation. It just – it wouldn’t be a very nice thing for the patient doctor relationship either, to just if you’re just going to tag it in with other things, that aren’t really relevant to breast cancer at all. Like kind of like you’d do, oh we’re encouraged to do with QRisk and for some reason it works with QRisk in some ways but I’d – I just feel like I don’t think it would work the same with a breast cancer risk calculator. It would just be quite scary for the patient, and wouldn’t feel relevant, and yeah, it might be quite an interruption to the patient doctor relationship as well. If you did it in that way, just like ad-hoc, when you see a patient.

GP4: Yeah. And also I suppose what happens if they kind of get it wrong and then they reconsider, oh God I’m not drinking sixteen units, I’m drinking fifty units, you know, does that involve coming back in, recalculating their score? Or, oh God remember my grandmother, you know, she had breast cancer, it wasn’t brain cancer and I could – it might be something that’s more in the patient’s control [laughs]. Sorry I’ve got a little dog here who’s just trying to say hello [all laugh]. And so you know, maybe you know, if there was some sort of like central portal that they could play around, you know, okay right, okay I was a bit mistaken and I need to change this, does this recalculate my score, you know, that sort of thing, yeah, I don’t know.

Q1: Hmm-hmm, okay, I’m just going to stop this recording.

[END OF RECORDING – 00:50:24]

[PART TWO]

Q1: Okay, cool, that’s recording. So the output of any risk assessment tool would also include recommendations for management of increased risk. So two strategies that have proven benefit in reducing breast cancer risk are maintaining a healthy weight through diet and exercise and limiting alcohol intake, and also taking risk reducing medication such as Tamoxifen. These risk management options would need to be discussed and offered to women identified at increased risk. What do you think about primary care providing lifestyle advice about reducing breast cancer risk?

GP4: I mean I think we’re not very good at it personally, you know, and you can see that through the diabetes interventions, you know, we don’t even offer diabetes lifestyle advice for prediabetics, they all get shunted onto some national – not national, but you know, there’s a local programme that if they’re interested in attending they can attend. You know, because it is complex, you can’t just give a one off intervention to somebody and expect them to change so, you know, I would have thought that you probably need community services for those who are interested in changing to help coach them through it. Because everybody knows be slim, don’t drink, don’t smoke, you know, but that’s not – people aren’t unfamiliar with that message, but how to change, you know? That’s a difficulty, hmm-hmm.

GPR10: Yeah, in a ten minute appointment with the GP you’re probably not going to get the – it’s not the intervention you need really, or that’s going to work like you say, it’s just not long enough, not in depth enough, for it to have any effect. And I don’t know what the evidence is on the effectiveness of GPs just telling people to lose weight, stop smoking, things like that, I presume that it’s quite ineffective, like you’re saying, at actually getting people to change their habits. So if it is really ineffective in a lot of other contexts I don’t see why it would be so much more effective in this context, maybe if cancer you know, people are a bit more afraid of cancer, maybe that would make it more effective, but I doubt it, yeah. But I’d be happy to do it, sorry.

GP4: Yeah, yeah, no, no, and I agree with you, and there might be these kind of community interventions ‘cos, you know, we have like social prescribers and they have access – we have access to things like the gym, you know, there’s the community alcohol team, there are community dieticians. And, you know, they do these sort of large groups of – I don’t quite know what it’s like but, you know, interventions for people’s – about diet for those who are like prediabetic. So I suppose you could utilise some of those services that already exist, you know, in the community if you need to reduce your alcohol, you’re aware of that, if you’re interested this is a group that might be able to help you, or these are the details of your local service, or these are some online links. You know, or we’re running once a month some sort of programme for people to – who are interested in trying to lose weight, you know, how to lose it and keep it off, stay motivated and all that sort of stuff.

GPR10: Yeah, if someone came to me asking for like lifestyle modification advice I would you know, I’d do my best to sort of explore some of their issues, and try to give some advice but I think the best thing I could do is refer them to our social prescriber. Who knows a lot of the services in the area, that they could get access to. So that’s what actually I would do, yeah.

Q1: Hmm-hmm. So am I right in thinking then that you both kind of see it more as primary care’s role would be to like signpost to other services, like services that were available in the community to help with lifestyle?

GP4: I think so, ‘cos it’s not about a single one off intervention, you know, people need sort of ongoing coaching, and we just you know, we’re not so set up to do that. I mean except for smoking cessation, you know, which I would say that the nurses are pretty good at doing, you know, alcohol management, weight management, it wouldn’t be something that we would be very good at managing besides identifying those people who want to change, like you say signposting them, hmm.

Q1: Cool, thank you, okay. So the other risk management option that I discussed was risk reducing medication. What do you think about primary care discussing and prescribing risk reducing medications such as Tamoxifen?

GPR10: I like the idea with you know, the right training and insurance, you know, I see personally just GPs becoming a bit more of – a lot more involved in oncology and a lot more involved in things like chemotherapy and immunotherapies. But you know, I suppose it’s kind of where I want to see my career going towards, to have a bit of a special interest in oncology, and you know, I think you’d probably need to have a GP with a special interest to start prescribing things like Tamoxifen. But yeah personally I would love to do that, that’s a role I would relish, along with other things related to cancer care, so yeah.

GP4: Yeah, I mean I think with adequate training you know, if they are as easy to use as statins, I don’t know, you know, it’s not something I’ve initiated so I don’t know the side-effects, interactions, what sort of screening that they need, you know, if you are high risk is it just Tamoxifen and that’s it, or are you being followed up regularly by breast clinic. But yeah potentially, you know, it is something that we could if those people are identified, initiate. Yeah, initiate, I mean there has to be training ‘cos of course, you know, there’s the people with side effects, who don’t tolerate it, blah blah blah and that’s where it gets a little bit complicated, so I do think you need good secondary care support for this as well.

GPR10: Hmm, it’s quite a significant medication isn’t it, Tamoxifen, like it can – I think it can cause you have to basically an early – like menopausal symptoms even.

Q1: Yeah.

GPR10: So it’s, you know, like now I wouldn’t touch it with a bargepole now, unless it was widespread and – widespread in GP, really common practice, and I had loads of teaching, I wouldn’t touch it with a bargepole. But yeah, so I think in the short term you’d only – if you wanted to put it into GP you’d have to have like specialist GPs that were interested that had really good training on it. And, you know, and that you refer to them, I think you know then in the sort of medium term you’d have like – like you do in a practice, you often have one or two partners that are a bit more interested in contraception say or HRT, and they would generally lead on all things related to HRT. Or if they didn’t actually just see everyone they would be very involved in advising their other colleagues on the prescriptions so I think, you know, in the medium term it would kind of turn into that, where you’d get kind of one GP with a special interest in doing it. Which – sorry.

Q1: No, I was just going to ask more about – so you said you wouldn’t touch it with a bargepole now, is that mainly because of the lack of training that you’ve had about it, or –

GPR10: Lack of –

Q1: What would change your mind about that?

GPR10: Lack of training, I’ve not got any sort of experience of it and also it’s just not done – I don’t think it’s done so it’s about, you know, what is considered a normal practice in GP to do and the whole – the issues with insurance and things like that, I mean it is quite a big deal prescribing it so, you know, unless it was very standard practice I wouldn’t do it. I don’t think any GPs would really, personally unless it was very standardised.

GP4: Yeah, you know, I hadn’t even thought about it because the only people I see with Tamoxifen are those who’ve been commenced in the hospital and we just take over prescribing. But actually if we think about that cohort, thirty to fifty, there are fertility issues, how do you manage their bone density, what happens if they go through premature menopause, I hadn’t even thought of that. And that’s just for women who don’t have cancer, you know, who are at higher risk and the conversations around that. So actually yeah I change my mind [all laugh], it's probably something that should be initiated in secondary care because there are these quite complex issues, you know, around their reproductive health.

[00:10:23]

GPR10: Yeah, I suppose yeah, if you had a GP – what I kind of would like to do but I would be essentially a secondary care, with the secondary care team, so yeah I completely agree. Secondary care is the right place to do it but like I say, you could – I think you could get GPs involved if they’ve – want to have a bit more of a special interest and probably work under the responsibility, under a consultant so, you know, you would never be fully responsible for everything you do.

Q1: So it’d be a bit more of like a shared care remit?

GPR10: Not quite – shared care I think is when like they’ve started the prescription and correct me if I’m wrong, and then you kind of will take on some of the – you’ll then carry on prescribing it and then help with the monitoring of it. So that I mean that yeah that would also be good, I think that’s probably kind of how it is now. But what I kind of meant is you know, like you have GPs with a special interest in dermatology say, or yeah, and you – I think that would be one way of enticing GPs into that area.

Q1: Hmm-hmm. So oh sorry, go on.

GPR10: No, I was going to – no, that’s fine.

Q1: Are you sure [laughs]? So obviously there you both mentioned there like a need for some sort of training or like support from secondary care, is there anything else you can think of that would help you to discuss or and prescribe risk reducing medication? So I’m thinking about things like guidelines or is there anything else, apart from like training?

GPR10: If there was a NICE guidance, like really clear NICE guidance on starting Tamoxifen and monitoring it in primary care, that would go a long way towards, you know, people feeling happy to do it, huge – that’d be huge, ‘cos you know, NICE guidance is like the bible now in primary care – so I mean still there’d be a lot of people would be very worried about it but if there was clear guidance – ‘cos it’s a legal thing as well, it’s like your insurance, if you start doing stuff that isn’t really mandated to GPs, not common practice you know, you could get in a lot of hot water I believe. But if it was in NICE guidance and very clear, then yeah, you would, that would be a big, big change and big reason why GPs would start doing it I imagine.

GP4: And I just wonder if these women being high risk would be under secondary care for regular monitoring anyway, you know, would they be having annual mammograms or MRI scans or some sort of imaging on a regular basis. And then I suppose if why shouldn’t that be part of that assessment, you know, if you’re higher risk and you’re going in engaging with the hospital regularly, but also it’s to discuss risk reducing medication, hmm-hmm.

GPR10: I mean like I say I’m not a GP but I do know, you know, and I read the BMJ and things like that and opinion pieces, and I think one of the things that is quite frustrating as a GP is secondary care putting more and more of their services into primary care. And it’s you know, more and more specialist services and they’re asking more and more of GPs and it’s hard, and it takes a lot of time, and yeah, there’s lots of risks involved, so yeah. I think, you know, a lot of GPs would be quite unhappy if you started trying to put that responsibility onto them.

GP4: And I think you want things as joined up as possible, you know, you have this test here, this person interprets the result, this person makes a decision, this person has a conversation with you. And when it starts looking like a spider’s web, you know, then it’s whose ultimate responsibility is it? And at the centre is the patient, you know, and so I think I would make it as few, you know, the result interpretation is as close to the person whose requested the test.

Q1: Yeah, yeah, yeah, hmm-hmm. What benefit do you think that would have then?

GP4: Well I think then there kind of is – you know, then people are thinking about how can we make this as efficient as possible, whereas if you’ve got lots of different people involved then X is thinking, oh you know, GP A will sort it out, and GP A’s thinking well no this sound like it’s the hospital’s job and then nobody does anything, and then you’ve got somebody in the middle who isn’t getting the care that they need.

Q1: Yeah, yeah, of course, thank you.

GPR10: Quite confusing for the patient as well I imagine, the sort of fractured care, you know, I get my mammogram here but I get my assessment done at GP. I get my annual screening at the hospital but I actually get my Tamoxifen started by the GP, it can be quite confusing for them. But whereas if they think all things breast cancer related are done by one team, or you know, or it’s under one team then it’s a lot more streamlined and less confusing for the patient. And like GP4 was saying, I think, you know, if when you fracture services like that, people don’t have – take as much response – or not responsibility, they don’t know what their responsibilities are, it’s who takes – what’s the word I’m looking for, who takes like … not – well who takes responsibility for it, I’m trying to think of another word for it, but yeah essentially who takes the responsibility for it.

Q1: Hmm-hmm. Okay, so finally then do you think setting up a pathway for breast cancer risk assessment and management activities in primary care is a worthwhile idea?

GP4: No, not really, the truth, I think it’s a worthwhile endeavour, I think it’s important, but I think you want as little GP input as – you want as little GP input in identifying and managing those women, hmm.

Q1: Could you just clarify – oh sorry, could you just clarify again GP4 about like why you think that?

GP4: I think because again, you know, if you want it done systematically.

Q1: Okay, yeah.

GP4: It’s just not going to happen systematically, you know, it could happen systematically absolutely, you know, this could be done in primary care, absolutely. If you had a breast champion who came into the practice, they scoured the notes, they booked appointments, and who’s to say that the hospital doesn’t do that? You know, we’re saying it has to come centrally and it’s all done centrally, why can’t the hospital send out champions and say, you know what we’re going to do a clinic once a week, we just need a room, we’re going to invite your clients in, we’re going to do the risk assessment. We’re going to go through the results with them, we’re going to extract all the information from the computer system and we will discuss medication [laughs] initiating it, carry on prescribing. You know, so it could happen in primary care, I just don’t think the current setup of the primary care team now you’d be able to do that, you’d have to – it’s what are you going to give up, you know, so that you know, that’s the decision. Yeah, of course we can do it, but are we not going to do flu vaccines or childhood immunisations, or cervical screening to make time for this as we can’t do everything.

Q1: Yeah, of course, yeah, no, thank you for that, thanks.

GP4: [Laughs] The dark cloud [all laugh].

Q1: I just don’t want to put words in your mouth so I kind of like –

GP4: Yeah.

Q1: What do you think GPR10?

GPR10: Yeah, yeah, essentially the same, I think often a lot of these things just do come down to resources, and also a GPs like ability to just – to hold all of these many different conditions, and all of these different pathways in their head and do it all to a tee. And that’s the whole reason why we have specialisms. You know, I don’t – it kind of excites me a little bit the idea of having like a bit of a pathway and making – it can even simplify it for a lot of people, when they come in and they go to the GP and they say well what’s – what is my risk of having breast cancer. It could simplify it if part of that is you’ve got a tool, and you’ve got a really good pathway where you can refer them onto the right people, once you’ve gone through that tool with them. So it could be quite helpful for GPs if you know, if people are attending their GP for those questions, and very – that would very rarely happen, like I have never had that person come in and ask me what their breast cancer risk is, but if they did that would be fantastic to have that sort of pathway. And then but then the whole idea of inviting people in to have that conversation is a whole other ballgame, and yeah, that to me sounds more like a proper screening programme which, you know, most cancer screening programmes are best done by a dedicated team. But yeah, that’s yeah.

[00:21:00]

Q1: Hmm-hmm, thank you. Okay, thanks, that’s all the questions that I had today so I’m just going to hand over to [name of co-facilitator] who’s going to provide like a brief summary of what you’ve discussed, you discussed so much that it’s only [laughs] going to be the tip of the iceberg, but just to – so that at the end you can say whether like you agree that that’s representative of the discussion.

GPR10: I’m really sorry, I know that we scheduled for half eight but I’m going to have to go.

Q1: Oh that’s okay, yeah, just to say that I’m going to be emailing you about how to claim the payment, so keep an eye out for that.

GPR10: Oh right, yeah, I didn’t even, there is a payment, great. I had forgot about it.

Q1: Yeah [all laugh], so one more annoying email from me but yeah that’s to make sure you get paid for your time because I really appreciate it.

GPR10: Oh brill, okay thanks, thanks a lot, I forgot about that, sorry I can’t stay till half eight.

Q1: Oh no, no, thank you, thanks.

GPR10: Thanks, nice to meet you all.

Q2: You too [all laugh].

Q1: [Laughs].

Q2: So just for context, I have written 1,500 words on what you have all said [laughs], that only two of you have said.

Q1: Yeah, it was brilliant, really good.

Q2: It was, it was amazing. So let’s think about – so you’ve both had experiences with women talking about breast – potential breast cancer risk, in principle it’s a good idea to be giving women of this age group a risk of developing breast cancer. But how involved primary care are in that is difficult because you have such competing priorities and with all sorts of other things how would that even fit in. And are even primary care the best – is primary care the best place for it, it sounds like it’s more like the NHS breast screening programme in like that it would probably need to be centralised. Also talked about giving lifestyle advice in that you almost struggle to give that at the moment with even diabetes, people with diabetes risk and it’s usually signposts to healthcare – it’s perhaps GPs are just best placed to signpost. Tamoxifen prescription would be contentious, you’d need a lot of training, insurance and reassurance that you were, you know, giving women the right thing and should it actually just be paired with secondary care if they’re having regular screening why wouldn’t they have Tamoxifen as part of that sort of package. [Pause] Getting accurate information from, if you were to get – asking women to, you know, asking women to give you information about their risk, it’s getting accurate information, who takes that – who’s responsible for all of that at primary care, so it’s just again whether actually primary care is well suited to this sort of thing. Also a nice interesting thing about the ethics of actually if primary care are incentivised to do it, is that ethical, you know, being paid to do it, to muddy the waters a bit. And there’s just so much more that you’ve said that I’m just – I think that’s the crux of it, good idea in principle but should primary care be that involved.

GP4: Yeah.

Q2: There you go [laughs].

GP4: I agree with that.

Q1: Is that okay GP4, or is there anything you’d like to add to that?

GP4: No, I think that was the gist of it, I think it’s brilliant, yeah.

Q1: Okay, thank you, I’ll stop the recording.

[END OF RECORDING – 00:24:43]