**Title: FG1\_06.07.2022**

**Interviewee/s: GP 1, GPR 1**

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

Q: Okay, so that’s recording now. So, if we just start off, just to help the person who’s going to be doing the transcription, if you could each introduce yourself, and if you feel comfortable sharing what your profession is. So, if I could just ask GP 1 to go first.

GP1: Hi, my name’s GP 1. I’ve just finished my GP training [timeframe since finishing]. I’ve been working in a very deprived area of [place] for the last couple of years, and then I’m due to start my salaried GP job next week in [place]. Yeah, that’s me.

Q: Okay, thank you. GPR 1?

GPR1: So, I’m a GP ST2, just finishing, coming towards the end of it, and I work in [place].

Q: Okay, great, thank you. Okay, so breast cancer becomes more common in women in their thirties and is the most common cause of death in women aged thirty-five to fifty. Before the age of fifty years, at least sixty-five percent of women who develop breast cancer do not have a family history, and that means they’re not currently identified as being at increased risk. So, currently, there is no defined systematic mechanism to identify this group of women, so 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 that means women who are identified at increased risk could be offered earlier breast screening, as well as methods to reduce breast cancer risk, such as medication. So, one potential approach is for breast cancer risk assessment and some aspects of risk management to be conducted in primary care. So, I was just wondering, to start off then, 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?

GPR1: So, is this mainly aimed at people who don’t have a family history essentially?

Q: Yes, yeah, yeah.

GPR1: Yeah, I think that age group is – I didn’t know that the percentage was so high that they go on to develop breast cancer without a family history, but you tend to find that it’s that age group of women who tend to ask for GP appointments and come in, and then repeatedly come in because they’re so worried about it. So, I guess if there was a systematic way of defining risk in a way and getting them earlier in, it would be beneficial in terms of putting their minds at ease, and also for us to have something tangible to hold onto. Because essentially, you know, if it doesn’t meet quite the two week wait criteria and they’ve got vague symptoms, it’s very difficult to say, “Well actually, you’re low risk,” or high risk, and most of the time, they say, you know, if in doubt, just refer, which doesn’t really feel like, you know, we’re doing them a good service. Whereas if we had like a risk or something to go by, I guess it would be easier to know who to refer, who not to refer, or if they’re high risk, they have assessment early.

Q: Okay, yeah.

GP1: Yeah, so my immediate thoughts were, yeah, fantastic, you know, it’s going to help women identify if they’re higher risk, pick up breast cancers earlier, save lives. But the flipside of that is, you know, a risk score – that people need to be counselled before obviously having the risk score. I have a lot of patients with health anxiety, so is knowing that risk going to increase that anxiety, and what’s the implication going to have on things like health insurance. So, are they going to have to declare that when trying to get health insurance, that they’re at high risk of breast cancer. So, those were like the caveats to something that sounds really good. Yeah, that was my initial thoughts.

Q: Okay, great, yeah. GPR 1, do you think there’s any caveats, so like how GP 1 mentioned?

GPR1: Yeah, I guess I’ve not been working as long in GP to know, you know, the other side of things, but definitely, yeah, I can imagine people who are more health anxious, they might still go with the – and it’s also like – even with QRISK – like we might say, you know, it’s thirty percent or fifty percent, but then what happens so if they have their assessment done and it’s ruled out, you know. Are we going to be repeating that over the years if they’ve already been assessed? So, I’m not sure how it would work afterwards.

Q: Okay, thank you. What are your immediate thoughts and reactions to primary care identifying and inviting women to a breast cancer risk assessment?

GP1: So, my thoughts – yeah, so primary care’s a bit like in the heart of like the community. We do a lot of primary prevention anyway. And looking at the score, it had a lot about weight and alcohol, so things that we deal with on a daily basis. And again, the flipside is that we’ve just got so much work on at the minute that adding any other things in is difficult in reality. But if time wasn’t an issue and the lack of GPs, then I think GPs are probably quite well placed, because a lot of the disease modifying things are things that we do on a daily basis anyway.

Q: So, you mentioned there about time. Is there any way that you think it could be integrated into anything else that you currently do?

GP1: Hmm, there’s these primary care networks now that are bringing in like allied health professionals. So, there’s one where I’m going to be working that does cancer, or like tries to pick up early cancer detection. And I know it’s not picking up – it’s pre that, it’s not picking up cancer, but whether there could be – whether, you know, it’s these allied health professionals that work under these primary care networks that would do this more in-depth training about the counselling of it and giving the scores out, and discussing with women, rather than like a GP itself.

Q: Okay, yeah.

GPR1: We’re just looking at asymptomatic patients, aren’t we, and just the risk of –

Q: Yeah, so it’s to do with, yeah, basically their risk of developing it in the future, so that hopefully – yeah, so we can offer the women that are at increased risk – we can offer them strategies to manage that risk, yeah.

GPR1: Yeah, so I guess like you don’t necessarily need a GP to calculate the risk if the patient can provide all the information that’s on the assessment score. And like GP 1 said, if somebody else in the MDT could then have that conversation with them without necessarily needing a GP – but I guess if it’s built into the practice, and if I guess over time it’s proven to be something that’s useful and all that, I can definitely see it, you know, five, ten years down the line, becoming normal practice for even GPs to use on a day to day practice basis.

Q: Okay, so you mentioned like an MDT there. So, who do you think would be an appropriate like person to inform –

GPR1: Yeah, so I guess like with the – so, in our practice, we have a cervical screening champion, essentially, who looks at everybody on the list, invites them in, you know, answers any questions about it, who knows way more about the screening itself than I do. I usually ask her, “What do I do if this patient has missed so many? What do we do next?” sort of thing. So, you know, like if we’ve got somebody who can take on that extra responsibility as part of their, you know, QOF targets or whatever in the practice, to do the risk assessments for that age group, or the nurses, some of the nurses – I know some practices have PAs as well. We don’t have any in our current practice. It’s a fairly small practice. But some of the bigger practices have physician associates, you know, and it could just be – you know, you could send the information out to patients in that age group and then invite them to have a discussion, you know, like on an invite only basis, send them out a letter, for example. Then, if they want to talk about it, book in in one of these dedicated clinics to speak to a person in the MDT who’s taking that on in the practice. And then, you know, if it’s a QOF target, the practice will be more willing to achieve it, and therefore try and reach everybody they can.

GP1: I think, like you mentioned the physician associates, that would be a really good one, because a lot of PAs are really, really valuable, but a lot can’t prescribe independently. But with something like this, you’re not prescribing. You’re giving really good, you know, lifestyle advice and counselling. So yeah, I think they’d be in a good position, yeah, to do that.

Q: Okay, yeah. So, when you think about the actual practicalities of inviting women, how do you think that this could be organised? So, I’m kind of thinking about whether you think it could be part of the remit of the breast screening programme, or if it’s like a centrally organised thing, or do you think like individual primary care practices could take it on, the actual invitation part of it?

GPR1: I guess if you want a more consistent approach and you want everybody to be invited in that borough, for example, if you were specifically targeting an area, and if it came from centrally – and usually – I mean, I don’t know how it would plug into it, but, you know, most of the time, you get people coming in when they’ve seen a screening advert somewhere. You know, prostate cancer’s in the news, so lots of people come in asking about it. So, I guess it’s like multipronged, isn’t it, so as sort of like a public health campaign, and getting people on board. And then maybe – I guess, for example, the primary care academy in that area could do letters directed at that age group, and then they contact their GP, if it’s the GP who’s organising, or if it’s like a PA hired by the local area then maybe them. But yeah, it just depends on what funding’s available and who’s doing what, doesn’t it, and where we are in terms of services by then.

[0:10:52]

Q: Yeah, yeah.

GP1: I think if it was just individual practices then – like breast cancer’s, well, unfortunately so common and topical that people would feel like an injustice if I couldn’t have that – you know, the test done, the saliva test and the mammogram and everything, whereas whoever down the road could get that done at their practice. It’s quite easy in primary care to invite people now, ‘cos we use a lot of texts on the accuRx system, so you can send – you know, pick your demographic and then send a blanket text out, and you can also do links on the text. So, if there was information about it and like a little bit of counselling about it then you can send that out. So, it’s not like we have to send letters and paper out anymore.

Q: Okay, yeah. Do you think then that a text message is a better idea, based on your experience of engaging with people through that medium?

GP1: I think it needs a disclaimer that you can – it needs the information on the text to give you information, and it also needs the option to speak to someone in more detail before you have it done if need be. Where I work, texts are quite well received. It’s just like the older people that we struggle with with texts. But I imagine – this is obviously – is it just for thirties to –

Q: Yeah.

GP1: So, you know, most of those have a mobile phone that doesn’t have network issues [laughs], that’s working. So yeah, I can’t see that being an issue.

Q: Yeah, okay. So, what would you say your immediate thoughts and reactions were to the idea of primary care being involved in breast cancer risk assessment and management?

GPR1: I guess it seems natural because, well, we do a lot of screening in other types of cancers anyway, don’t we? But then recently, there’s a pilot in [place] for lung cancer screening, and they’re doing everybody I think who are smokers of a certain age, and they’re getting CT scans, or something along those lines. That’s more centrally organised. I remember getting a call from a patient saying, “I want to be on that.” And I said, “Well, you can’t be, ‘cos we don’t live in the right area.” But yeah, definitely – ‘cos usually it’s more the counselling side of things, and like GP 1 mentioned, it’s all the things that, you know, health promotion wise, we would be targeting anyway, like alcohol consumption, smoking history, etc, etc. We’re more likely to know like if there’s family history as well, everybody in the practice, and have those links. But also either way, you know, breast screening is also organised via GP, isn’t it, although it’s centrally organised. The patients are invited via the GP, but they go elsewhere, isn’t it? So, I guess either way could work, but see, you know, in terms of what’s commissioned, etc. It just depends on that.

GP1: Also, when I read the leaflet, it said about the mammogram, the saliva test and the risk score, that was a bit like the QRISK, so that would be really easy to do in primary care. But it’s where – are the saliva kits coming to the house, like the stool ones do for the stool screening, and then straight off to the lab, or are they being processed by the practice. And the mammogram, I guess obviously that’s not coming from the GP practice. I kind of think it’s easier to not organise it by primary care, ‘cos you can’t do the mammogram in primary care anyway. But then – yeah, I don’t know. It’s a tricky one, ‘cos there’s three components, isn’t there?

Q: Yeah, so we’ll come onto talk about the individual components, and then I’ve kind of proposed some sort of model, so it’s just to get your thoughts on – ‘cos you’ve obviously identified that logistically – we’ve kind of tried to present it as being that you could maybe take the lead in one aspect of it and then you might get the results from the other two, and then like how you feel about coordinating it in that way. But yeah, you’ve already come up with things that I was going to ask [laughs]. So, if you think about your interactions with your primary care colleagues, like how acceptable do you think it would be to ask people to be involved in breast cancer risk assessment, in comparison to what you currently do?

GP1: So, like GPR 1 mentioned, we do prostate, so that’s obviously the blood test, and we always recommend the examination, so that’s at least one appointment and one blood test appointment. So, we do that. We do the cervical screening. That’s more simple, I suppose. That’s just one appointment. So yeah, but then other screening is more central, isn’t it? I think it’s just the time and how practices are going to be funded for that work. But I think you could definitely use some of the associate healthcare and the MDT, yeah, through the primary care networks that have been set up.

GPR1: I think a difficulty is – like, for example, with cervical screening – like we’re just doing the smear, or somebody’s doing the smear, and then it goes off, and then the result – although, you know, it comes to us as a notification, whatever is going to happen with the results is organised centrally. So, you know, if they need a repeat in twelve months, that’s all we’re told. Or if it’s abnormal, we’re told, you know, something will be done about it. We’re not actually picking that up and taking action on it. Because if an allied health professional did the initial risk assessment, and say the risk was above a certain number, therefore they need a mammogram and a saliva test – and it’s fine for them to have that, but, you know, like you were saying, GP 1, if it comes back to us, I don’t know how to interpret that and what to do with the results, or really what to make of it. So, if like with the cervical screening or the faecal occult blood screening, you know, where people can get the test from us but the results of that need to be sorted by somebody who’s got expertise in it to know what to do – so maybe like a two stage approach, that we’re involved with the initial risk assessment, and although we’re notified of the results, we’re not the ones processing the results.

Q: Thank you. Okay, so we’ll go on to talking about the three different measures. So, the risk of developing breast cancer is best calculated with a combination of three measures. So, this is the diagram that was in the pre-reading material, so I don’t know whether – would you find it beneficial if we shared a screen to see the diagram whilst I talk through it, rather than just listening to me list it [laughs]?

GP1: Yeah, if that’s okay. If not, I’ve got it here somewhere.

[Sharing screen]

Q: So, basically then, yeah, like I mentioned, we’ve got the three different measures. So, the first one is like a self-reported questionnaire. So, we’d ask for height and weight, family history of breast and ovarian cancer, and this would involve asking how many affected first or second degree relatives does the person have, and any age of onset, if there is a history of breast and ovarian cancer, age at first period, age of first pregnancy, oral contraceptive history, and alcohol consumption. So, that’s like the first element. And then the second element is breast density, which is a measure of the amount of non-fatty tissue compared to fatty tissue in the breast, and this would be assessed using a mammogram. And then finally, it would be obtaining a saliva sample to look at DNA. So, this will be to assess a polygenic risk score, which is a combination of multiple common genetic changes into a single score, and then also by looking at the mutations in high risk genes, for example BRCA 1 and 2. So, if we talk about the first component first. So, “The following information known to impact breast cancer risks would need to be collected,” which I’ve gone through there, that list. So, it’s asking you, what do you think about primary care collecting information from women about that list of breast cancer risk factors?

[0:20:08]

GP1: Yeah, so most of that information would already be on our GP notes. So, you know, most patients have got a height and weight. You wouldn’t necessarily have first period, but maybe if they’ve come in about their periods – we’ll have alcohol though, we’ll have alcohol, and we’ll have if they’re on contraception. And we’ll have when they were pregnant as well. Family history, we might have if we’ve consulted about that. But most of that we’d already have. That’s fairly easy. The other thing that we can do to get that information is send questionnaires out using the text service, accuRx, which is I think used at most practices. But you can set up questionnaires and put in a few questions, and then it collates – then they fill it out and then send it back, and it’s embedded in our – we use EMIS Web GP system. So, that bit would be fairly easy, I think.

GPR1: Yeah, I agree, and it’s all I guess the relevant history, isn’t it, in terms of oestrogen exposure and the medications we would have access to as well. So, it’s just the family bits, and you want to get as much information as you can about the different ages, what sort of cancers, what else.

Q: So, you mentioned there about potentially sending them texts out to get the women to complete it. Do you think it’s appropriate to ask women to enter their own data, rather than someone coming in and consulting with someone?

GP1: Yeah, well, we do that. We do that, well, for most things now. So, we do that for like asthma reviews. They enter their own data for asthma. We do that for HRT. So, sometimes they’ll fill that out before they come and see us. They usually then see us, if it’s like HRT, to then discuss. But yeah, yeah, we’ve not had any issues with people filling out things.

GPR1: Yeah, I agree. I guess it’s just like – you know, obviously, we’re not going to give them the result of the assessment. They’re just giving us the information, so I don’t think there’s any harm in them just sending us their information. Of course, you know, at the end of it, they’ll want to know what happens with it, so we’d have to work out a way of, you know, discussing – and I guess that could be in the information you send out, that, you know, if your risk is high or x number then we’d contact you to let you know what’s going to happen next. But otherwise they’re just filling it out. They’re not getting the results, so we don’t necessarily need to consult with them.

Q: Okay. Is there any issues or difficulties that you can envisage to like performing this task? So, it’s fine if women would be entering their own data, but it’s just whether you can think of any potential pitfalls of trying to collect this information.

GPR1: I guess just technical difficulties, for example, you know, if the page has timed out, the whole information isn’t complete, and somebody else has to pick it up and complete the rest of it. But most of the time, the main issue isn’t actually the thing itself. It’s getting people to do it, and whether or not they want to do it. Sometimes it’s easier to send them a text and then follow it up with a phone call, answer any relevant questions, and then if they’re not able to do it themselves, to do it with them online. So, I guess that’s one of the main things that usually happens in general practice, getting people to agree to do it, why we think it’s important, and it may not be important to them.

Q: Yeah, yeah. Okay, great. So, as – I don’t think we need the diagram anymore, [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, which I know you’ve already mentioned. So, for example, scores for mammographic density and genetic risk could be fed into a tool, and a risk score generated once someone in primary care has entered the family history, hormonal and lifestyle factors, which we’ve just discussed, the ones in the list. So, this is a potential model, by the way. It’s not definitely going to happen. Primary care would then be responsible for communicating the risk score and making a management plan. So, what do you think about primary care coordinating the process of breast cancer risk assessment in this way?

GP1: We need training [laughs]. I think it’s like how many women are going to be – like what’s going to be identified? Is it going to be like high and low, or high, medium and low, or just like a percentage figure, and what kind of numbers we’re talking about. I think – like when you think about it, we do – like osteoporosis, we get a T score or we get a score, and then we have to deal with that and, you know, give the right medication, depending on that score. So, we deal with results of tests that we don’t necessarily do. But I suppose everyone’s stuck in their ways, so if it’s something that people aren’t used to then, yeah, there definitely needs to be good and clear pathways of what we need to do before it would ever go live.

GPR1: Yeah, definitely. Like even, you know, with the DEXA, although we don’t necessarily understand much of it or do it ourselves, there’s clear guidance about, you know, “If the number is this, do this or give this.” And similarly with QRISK as well, although – you know, it used to be just used for cholesterol management, “If it’s above this number then offer a statin,” but now it’s used in diabetes management as well. And like you know what to do based on all the studies that have happened, looking at the risk score and looking at the reliability of it, and the NICE guidance that’s come out of it, so we know what to do with it. So, I guess, if it was similar to that years down the line and proven to be a reliable method of checking risk, and we knew that, you know, in this many studies – and then it’s easy to explain to patients, isn’t it, when they ask, “Well, what does high risk mean?” And I could say, “Well, you know, one in this many patients would go on to have breast cancer.” But you need robust data behind that. I think if it was at that point and all of that figured out then possibly, although it’s an additional thing to do. It would become the norm if it is something that’s useful - because like secondary care breast cancer services are so inundated with more acute specialist stuff, which is their responsibility, which we can’t do, so if this is something that we can be trained to do, and there’s data and guidelines behind it, then why not. It will, you know, years down the line become the norm for primary care physicians to be doing it.

GP1: I think like the information to give to like GPs is how many lives are you saving by doing this, and what – you know, are you picking up breast cancer earlier because you’re doing extra screening for those that are high risk, but what does that actually equate to in saving women’s lives or improving quality of life. That would be interesting to know. ‘Cos I suppose if you can say, “Oh, doing this is going to save this many lives a year,” then I think people would be like, “Okay, this is going to make a big difference,” yeah.

Q: Do you think – so, if you envisage like the different practice staff in your practice, who would you envisage taking on this role with communicating a risk score and making a management plan?

GPR1: I think if you’re doing the management plan and the risk score, it would have to be a doctor, wouldn’t it? I mean, you could get somebody to gather the initial information, but when you get all the results back, it would have to be a responsible clinician who makes that decision.

GP1: I think it could be like an advanced nurse practitioner or a physician associate that’s had – you know, that’s had like in depth training in that, yeah.

Q: So, if you consider this model that I’ve presented, do you think there would be any benefit in having someone that’s almost like a risk prediction specialist, or like someone that’s dedicated – ‘cos I know you mentioned there about like cervical screening champion type thing –

GP1: I think it would be interesting to know how many numbers it’s going to bring up. So, is it going to identify kind of one woman a month or fifty or a hundred women? Like with a practice of 10,000, I don’t know how many – without knowing the figures, how many, yeah, people it would flag up. ‘Cos if it’s just like – if it’s not that many then I think to leave it to a GP. But I think if it is quite a high number then to have like a champion would be beneficial.

[0:30:28]

Q: So, you’ve mentioned there about obviously maybe needing training. Is there any other difficulties or barriers that you can immediately think of from proposing that primary care was involved in that way?

GPR1: I think if we’re just starting out and, like GP 1 said, there’s loads of numbers, there’s loads of interest, it’s just going to be a sudden – everyone’s inundated with this, isn’t it? So, I guess how you do it in a stepwise way, depending on the number of patients you have and how much capacity you have. Like if a GP is doing it then, you know, you might need somebody who’s done the training to have a dedicated session just doing these, depending on the numbers. Or if, you know, somebody else is doing it, they’ve got additional time to be able to do that. But, you know, again, like a non-medic can only do it if they’ve got very, very specific guidelines to follow, which are very black and white of, “If it’s above fifty, do this. If it’s below fifty, do this.” So, it could be done. It just depends on numbers and how quickly it happens. ‘Cos with a lot of these things, people would be interested - as soon as you send the texts out and everybody wants to go on it then you might struggle, and how you manage it I guess over time as well.

Q: So, you mentioned there that the first part of the risk assessment, so the questionnaire is more kind of in line with what you do anyway in terms of prevention. So, what do you think about – well, would it make sense to be involved in the saliva sample collection part of it as well? Just wondering what your thoughts are about that.

GPR1: I don’t know how that would work in terms of – like what do we do in terms of where do we store it, where does it go, which lab does it go to, you know, depending on where you are. And if this is like a [place] thing, it just creates a lot of workload. Whereas with things like FOB – everything else, like there’s dedicated ways of – if it goes postal it goes postal, with the cervical, and as well there’s local labs they may go to. So, you know, if there’s an easy way of getting them – but I would think it would be easier to – if it can be sent to the patient directly, for it to be sent back to you guys, rather than – well, the person organising it rather than via a GP, ‘cos it creates lots of additional workload, doesn’t it, otherwise.

Q: Yeah, yeah.

GP1: I could kind of see a scenario where you could go to an appointment with a HCA and have those questions done, and do the saliva sample there and then send that off, in like a ten or fifteen minute – well, like a ten minute appointment. I’m just thinking like PSA, so that’s for men and that’s a blood test that we send off. So, to like equalise things [laughs], like if you was able to send – yeah, to send off a saliva – yeah, I think it’s doable. I think what I’m envisioning at the minute is it’s three separate bits and all the results need to collate. And then often in primary care, things go missing, and you might have like two of the results back and you might not have the mammogram result. Yeah, so it’s just – it needs to be like streamlined, so that things don’t go missing.

Q: Yeah, that’s really valuable, because I was going to ask, can you think of another model that would work better. So, I suppose you just explained like a potential way it could be done, involving like a HCA. So, that’s kind of what we’re trying to understand, like how do you think it would work, ‘cos we don’t necessarily – like the model I presented isn’t the right one. It’s just an idea, if there was another way.

GPR1: And like are we – we’re not sending anybody who’s in their thirties for a mammogram, are we, so are we doing like the self-reporting, then a risk score from that, and then they go for the other two? Or are we sending everybody between thirty to thirty-nine for all three? [Inaudible 0:34:56] work that out.

Q: Okay, yeah. So, I think at present it would be sending everyone for every part of it.

GPR1: And then the combined risk score, like you said, isn’t it?

Q: Yes, yeah, yeah.

GPR1: So, I guess we could use a template on EMIS, which is used in most of the [place] area. Other areas use different GP systems. But a HCA could just fill out the template, which is premade, populated with this stuff, if they’ve already given us the information before it gets pulled in, or if you need to add anything new, you add that in. And then you tick for and send off the referral for the mammogram at the same time, and print out the label for the saliva sample at the same time, and do it all in one go.

Q: Okay, so you’ve mentioned about training, so I’m just wondering, is there anything else that you would require to take on the role successfully? So, for example, are there any particular design considerations for a risk assessment tool, if we were going to create something like similar to QRISK?

GP1: So, QRISK comes up on our GP programme, EMIS, but the other big GP programme is SystmOne. So, we just click a button and then click – it draws all the information, and then we click calculate and then it just works it out, so it literally takes like five seconds.

Q: Okay, wow.

GP1: To have that embedded into the GP systems would be useful. Likewise, when you – I suppose if we get that mammogram score, or I don’t know how it’s going to work, like the score, and then the saliva score – yeah, so if that information could just be put into the calculator that’s embedded onto the GP system, so then it just comes up with that score.

GPR1: And then with the score, you could just have the information within the template as well, or the link for – to say, you know, “The risk is coming up as medium. This is what you do next,” as a reminder on top of the training.

Q: Yeah. So, is that what currently happens with QRISK?

GPR1: QRISK just gives us the risk score. It doesn’t necessarily tell you, you know, what to do. But I guess it depends on your practice, but it might have a link to read more about this or what to do with it, essentially. Before, when I wasn’t working in GP, we used to use QRISK on a website. So, you manually enter the information in and then it gives you the results, and it has links to other information about things. Similarly, there’s other like factor risk scores and things that are also online, not necessarily embedded into EMIS, where you would have to put in the details of the scans, etc, to get the results. So yeah, definitely the EMIS one works better and way quicker.

Q: Okay, thank you. So, if we think about like the output of this tool, which would also include recommendations for management, which you’ve just kind of mentioned – so, management for 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 secondly, taking risk reducing medication, such as Tamoxifen. So, 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?

GP1: Yeah, I think that’s like our bread and butter. It often goes hand in hand with like other conditions, like fatty liver and pre-diabetes, so I think that’d be fine for us to do. Yeah, I think general practice is best suited for that.

GPR1: Yeah, and it can be done by different healthcare professionals, including nurses as well as doctors.

Q: What are your thoughts on whether there should be a specific service for – if it was lifestyle interventions for breast cancer risk, versus like generic services? Like do you feel currently that you have services to refer people to for weight management?

GP1: We have two. We have weight management – I think it’s called [name of weight management programme] in [place], that I refer a lot of patients to. And when you refer, you can click what conditions they have, so their BMI, and if they have like fatty liver or diabetes. So, you know, there could be an extra box on there that says, “High breast cancer risk.”

[0:40:17]

Q: Oh okay, yeah, yeah.

GP1: And that covers [place].

GPR1: Yeah, so like the tiered services. So, if they just – depending on the BMI and their comorbidities, etc, you refer them to tier two essentially, like similar to Weight Watchers, that sort of thing, or whatever is commissioned in your area. Then if people struggle to lose weight on that then they get referred to tier three if they meet certain criteria. So, I guess it depends on what we think in terms of a patient’s BMI and their relative risk of breast cancer, in terms of how aggressively you’d want to go in managing that. You know, ‘cos it helps otherwise anyway with lots of – preventing other medical problems. I think it just goes hand in hand. It’s part and parcel of treating the person rather than the condition or the risk.

Q: So, who would you envisage taking on that role at your practice, so someone to provide lifestyle advice? I think you mentioned there, GPR 1, other staff could do that. I’m just wondering who you think that that would be a role for.

GPR1: So, I think everybody that we mentioned earlier. A lot of the times, you know, when we get high cholesterol results, for example, you know, we don’t necessarily ring the patients unless they need something prescribing. I usually task the administrator to – you know, if they’ve got high lipids – advice, sort of thing, and they would usually ring or send a leaflet, or talk more about that. So, I think in most practices, there are lots of other I guess different people who are able to do that other than even just the clinical ones. The administrators are also trained to be able to do that. And if it’s a case of just sending out the initial information, and if they want to talk about it – like you could send, for example, an accuRx text with advice from the NHS website about, “This is what you might consider.” Or, “If you think that you need extra help, give us a ring. Book in with a nurse, HCA or physician associate to talk more about what can be done.” And then if they need referrals because they’ve tried everything else then that can be escalated to somebody else in the team.

Q: Okay, yeah, yeah. Do you agree with that, GP 1?

GP1: Yeah, yeah. I think like sometimes we have lifestyle appointments with HCAs, and then sometimes it’s mentioned in GP appointments. The nurses often give lifestyle advice, because in our practice they do a lot of the chronic disease, so they’re doing that anyway. Probably less so for the age group that we’re talking about, because they’re unlikely to have the other chronic disease… But I think, yeah, HCA, advanced nurse, physician associate or GP would be fine, yeah.

Q: Okay. Again, are there any issues or barriers to that, to providing lifestyle advice that you can think of?

GPR1: It doesn’t need any sort of additional training, does it, because we’re already doing it, so I can understand why primary care would be involved in that. Because if we were collecting the information about it then it’s one of the things that we know is going to help anyway, so we may as well, you know, deal with it rather than a completely new service who doesn’t have access to all the referrals and the community services that are available. So, we’re best placed to do it really.

Q: Okay.

GP1: Yeah, I think we need to do that anyway to prevent other things, so it’s not really additional work because it’s kind of primary prevention of lots of different things, which would hopefully prevent them from getting anything else as well.

Q: [name of co-facilitator], can I just check how long we’ve been recording for.

V: Forty-four minutes.

Q: Okay, great, yeah. I’m going to stop this one. We’ve nearly finished anyway, but I’ll…

[End of FG1\_06.07.2022\_part 1]

[Start of FG1\_06.07.2022\_part 2]

Q: Okay, so that’s recording again now. Okay, so if we move onto the other management strategy, so what do you think about primary care discussing and prescribing risk reducing medication, such as Tamoxifen?

GP1: That scares me [laughs] a little bit if I’m honest.

Q: Could you explain why [laughs]?

GP1: I just don’t – I would need to look into it. I’d need some really clear-cut guidelines of who would be contraindicated, what the side effects would be. Yeah, I’d just need some guidance and definitely some training on that, I feel.

GPR1: Yeah, definitely, same here. Obviously, you know, we don’t prescribe it. It comes from secondary care. And usually, the things that are started by secondary care, if we’re asked to monitor it, there’s always very clear-cut like shared care protocols, like, “If the patient gets this, do this. If you need to monitor, do this,” sort of thing. So, I was just looking in the BNF about Tamoxifen, and there’s actually a section that’s called Patient Decision Aids by NICE, basically, talking about how you take it for reducing the chance of developing breast cancer. I’d never heard of that before. And, you know, there’s all sorts of risks associated, and you’d need to be really careful about it. And of course you’d need to be a prescriber, to be trained on, be aware of, look up the contraindications. And also it’s not just, you know, “Take this and go off.” Like we have to – they’re in their thirties. We’ll be monitoring it for however long they’re having it for. And we’d need to know how long to have it for, like when does the risk outweigh the benefits of the side effects and the potential complications. So, I think this would probably be the hardest thing to do in the whole process, really.

Q: Okay, yeah, yeah.

GP1: Yeah, I agree with that.

Q: So, what do you think could be provided to help you to take on that role? Would it mainly be training?

GP1: I don’t know if maybe the high risk women would actually then go to the breast clinic. Likewise, the women that we identify who could be tested for the BRCA gene, we would – depending on their family history, we would refer to breast clinic, and they’d do that. And then if they have it, they put them on the right screening pathway for that. So again, I think if they’re at that point where they’d benefit from Tamoxifen, I think maybe they should be under the breast clinic rather than solely GPs.

GPR1: And usually it’s the – so, for our areas, the [name of Medicines Management Group], they give us advice about all of these what we call amber or red drugs that aren’t very simple to prescribe and you need specific SOPs about it. And usually they would say, you know, like who to get advice from in that appropriate specialty. So, maybe if it’s like initiated in secondary care and then there’s clear guidance about how long for and what doses, and that sort of thing, then if we’re just carrying it on and we’re just providing the prescription, it’s not really a problem. But it’s just the knowing and being trained on what to look out for, and when to consider stopping it. And I think we sort of need that as a whole region really rather than just individual clinicians. Because, you know, it’s very easy to read the BNF, isn’t it, but it’s knowing the different percentages of the risk and the benefit.

Q: Thank you. So, is there anything else that you want to say in relation to that part, about the risk reducing medication? So, the questions here are kind of like who would you envisage taking on this role, but I get the impression that it would have to be a GP, would it, because it’s prescribing.

GP1: Yeah, and I think if it was initiated in secondary care by a breast specialist and then we can carry on that prescribing afterwards on like a shared care protocol. So, they’ve had like the counselling by the specialist and then we would continue that. I’d feel more happy with that.

Q: And is that because of perceived like lack of knowledge? I’m just trying to understand like why.

GP1: Yeah, it’s not something that I’d ever prescribed. I don’t know if the like older GPs prescribe it more with – like instead of HRT and things, but yeah, it’s not something that I’ve ever prescribed. And I don’t think I’ve actually ever – I’ve not seen any women on it for years either.

GPR1: Yeah, definitely. Because it’s something that’s prescribed in secondary care and it’s got associated risks of endometrial cancer, DVT and things like that – I guess maybe, you know, if years down the line it became as common as, you know, like women having HRT or whatever else then it might be something that becomes more in trend, I guess. But yeah, I definitely wouldn’t see a GP prescribing it off their own back, not knowing anything about it, and it not being like a thing from the GMMG to say that, you know, “Do this for everybody, and this is what you look out for,” sort of thing.

Q: From the who did you say then?

GPR1: Sorry, the [name of Medicines Management Group]. So, this only applies to our area, I guess. But usually, if you work in primary care, there’s a specialist like medicines group that tells you which drugs are safe to prescribe by a GP and what can come from secondary care, and what sort of things to monitor.

GP1: You also have like RAG lists, so red, amber, green. So green, we prescribe. Amber, we might prescribe, and red, like we don’t initiate. So, I’m just wondering what list that is on at the minute in [place]. I might be able to find out.

Q: I think I have heard of that before, yeah, thank you. Okay, so overall then, do you think setting up a pathway for breast cancer risk assessment and management activities in primary care is a worthwhile idea?

GP1: So, I think it’s definitely worthwhile. I mean, obviously, you’ve not told us like figures and numbers of things, but I imagine hopefully that it is saving lives and it’s something that is increasing. And there are certain things that you’ve mentioned that can decrease the risk. Yeah, so it’s definitely worthwhile.

GPR1: Yeah, I definitely agree with that, you know. It’s very tangible I guess as well. Like it’s very specific about the information that you’ve gathered and what increases the risk, and it’s done in a systematic way where you’ve captured all this really important information about everybody. But then it’s also coupled with some kind of screening test of the saliva, but very objective mammogram testing as well, which normally, you know, you wouldn’t have access to as an asymptomatic woman who’s very anxious or worried about breast cancer, ‘cos you do get those a lot. But if we have said, you know, “We’ve identified you as low risk, therefore we don’t need to go down this route unless you develop symptoms,” you know, it’s very easy to handle patients that way, and objectively for us as well to say, “Actually, we don’t need to do anything about this,” or, “We can leave this alone.” Whereas if you’re high risk then they will be screened, and then if there’s already things that we’re putting in place in terms of preventing then hopefully we can get that number down from sixty-five percent.

GP1: I’ve just checked the Tamoxifen in the RAG list and actually it’s green [laughs].

GPR1: Is it? Interesting.

GP1: But it does say specialist advice in brackets.

Q: Oh okay, okay. That’s interesting background knowledge for me, thanks [laughs].

GPR1: That’s going to be price as well though, isn’t it? Like I don’t know how much it costs, but imagine if loads of people are getting prescribed Tamoxifen, suddenly in primary care somebody will have something to say about it [laughs].

GP1: I suppose it depends on what numbers come out at high risk as well. Like, you know, it’s not a massive workload if you only have a few patients that are high risk, but I don’t know if it’s a few or if it’s hundreds. That information would be really useful as well, ‘cos that would change how you feel really about it.

Q: Yes, that sounds like a really important consideration for you then, the numbers.

GP1: Yeah.

Q: Okay, yeah, that’s fine. And then, GPR 1, I think you mentioned it towards the start, I think you mentioned about QOF points. So, I’m just wondering what your thoughts are on – like would incentives like that kind of help with these – you know, like would that encourage primary care to take on this role?

GPR1: Yeah, so I guess – I mean, I don’t know what’s happening with CCGs now, but normally CCGs would, you know, incentivise GP practices. But it’s for the benefit of the patients, isn’t it, at the end of the day, based on research to say, “This is why we’re doing it.” And I think a lot of the time, when you’re in as a trainee or as a medical student, you know, you get plugged into a GP practice, and they’re more incentivised to do something about it if it’s a QOF target because it helps them, and I guess in a way it’s something objective and achievable in a timeframe, isn’t it? And then you’ve got somebody taking care of it. And if it’s incentivised and money’s paid towards it, the practice are definitely more likely to do more for it, depending on I guess if we’re doing it all or if it’s being done half and half, whichever way. But either way, if there’s QOF points associated with it then the practice will do something about it [laughs].

[0:10:56]

Q: And do you think it could be or it should be integrated into any other existing health checks? So, I know you’ve mentioned like cervical screening and that kind of thing. So, it’s whether you see it as a separate process in its own right, that like that’s breast cancer risk assessment, or whether – is there any potential for it to be integrated into anything else?

GPR1: I think with that age group, isn’t it, it will be difficult to integrate, because although cervical screening starts in the twenties – and the timing wouldn’t be exactly the same. And if we’re just doing it as a one-off then it’d have to be a separate thing.

GP1: Yeah, I think it is quite separate as well, ‘cos you’ve got the saliva testing, yeah, mammogram. I think it’d be, yeah, separate.

Q: Okay, cool. So, finally then, are there any other issues that you can think of that would be important to consider when setting up a pathway for breast cancer risk assessment and management activities in primary care?

GPR1: So, we’ve talked about cost and workload, patient uptake. What else? Yeah, I guess it’s where is the saliva sample – like where are they coming from, where are they being processed for sending, and then the cost and the sort of problems associated with that, and where they’re going, how often they’re going, etc. And with the mammogram, it’s the referrals, like how do we – ‘cos we wouldn’t normally refer for mammograms. So, is there like a centralised service where we’re just plugging in the data to say, “All of these patients need a mammogram,” basically. So, it’s working out the logistics of actually doing those things.

Q: Yeah, yeah.

GP1: I think like the counselling is really important. So, you know, if your risk comes back high risk, do you have to declare that when trying to get life insurance? And is your premium going to go up, or are they not going to give you life insurance because of that? Yeah, so I think that’s quite… You know, the last thing you want to do is for someone to have it all done and then they regret knowing that information, so it needs to be clear what the women are having and their understanding of the result.

Q: So, during their management plan then, do you think that primary care could be trained to provide the counselling, or where do you think that would –

GP1: So, I think it’s hard because when they go to have those questions done, they’re going – like we said, maybe a HCA, ‘cos then they can go and have those questions, do the saliva there and then. But they need that information before they get there, so I think there needs to be a leaflet that clearly states, you know, what they’re having done and the implications of knowing that result. And maybe when they go to the HCA to have the information, you know, they tick a box saying I’ve understood the counselling aspects, so we’ve got that on our GP notes as well, yeah. And I guess you probably can’t have a conversation with everybody before they have it, so some written information would be useful, but then they could ring up if they need to discuss it further before undergoing it, I think.

Q: Yeah, yeah. Okay, is there anything else that either of you would like to add?

GPR1: Yeah, not sure about the mammogram referral again and the prescribing of medication, so it’s just those are a little bit, you know, not clear.

Q: Yeah, that’s fine.

GPR1: I think, like GPR 1 said, like rolling it out. So, if it’s from thirty to thirty-nine – I’m sure they’d do this anyway, they would just do like one year at a time. So yeah, so eventually it’ll include everyone, but not doing nine years of people, ‘cos you won’t be able to catch up. Yeah, I guess they do that with everything anyway.

Q: Okay, yeah, yeah. Okay, so I’ll hand over to [name of co-facilitator] now to provide like a brief summary of what we’ve discussed, if that’s alright.

V: Yeah, so mainly you talked about, you know, having the risk calculation would help identify those at high risk, and it would hopefully save more lives. These women tend to come in worried anyway, and it would be good to give them some sort of concrete health advice, and the risk assessment would help with that. The risk score – perhaps it would need some counselling before and after because of health anxieties, implications for insurance for women at high risk. QRISK is often repeated over the years, so not sure how it would work with breast cancer risk calculation, how often that would be repeated, but overall a good idea. Yeah, so, primary care is at the heart of the community. It makes sense for it to be dealt there, but how much you would be able to do – would you be involved in the initial risk assessment? Who’s going to be responsible for the saliva samples? Where’s it going to go? How much is it going to cost? Does it make sense that it not just goes out in the post to the women, like the FIT tests do for bowel cancer? Who should be sort of communicating risk? So, we do have like cervical screening champions. You talked about HCAs and things like that. When you talked about healthcare advice, you said it was like your bread and butter, so it seems like it should be important that it is with the GPs. That makes sense. You also have systems where you have – especially for the risk assessment, you have things like alcohol intake, weight, and perhaps text messages is the best way to get those missing datapoints. So, there wouldn’t really be many issues with the self-report there, but you would require – if you were giving risk feedback, you’d require a lot of training on that, and is it appropriate for the GPs or anyone at the GPs to actually give that risk feedback. Should it be secondary care with a trained healthcare professional? And you’re at the beginning of it, where you might collate the information but not necessarily feed it back, especially if they were high risk. I think the other main issue was Tamoxifen, who prescribes that. It makes sense that it’s secondary care really and perhaps you carry it on, and feeling a little bit iffy doing that, and not knowing enough about Tamoxifen. And you’d want more training if you ever did have to prescribe that. But I think overall, you guys thought it was a good idea. It just needs specific pathways, not only for the women but also for you guys, so everyone feels confident in what they’re doing. Is there anything else you’d want to add? You actually said a lot more than that, but I’d be here – we’d be another hour [laughs], so I’m trying to pick the main issues. Is there anything you wanted to add? No? Does that sound accurate enough? I’ve captured the main essence?

GP1: Yeah, I think knowing the impact of it as well would be really useful for getting people on board.

V: How do you mean by impact, sorry, just to clarify again?

GP1: So, you know, you might say, “If everybody in England has this, we’re going to save…” I don’t even know figures, but, “We’re going to save 500 women’s lives that are under forty with breast cancer, or give them this many extra years with their family.” Because like obviously some screening tests don’t improve survival rates, and I think – is PSA one of them, possibly? So yeah, so it’d just be, yeah, useful to know how much of an impact it’s going to be.

V: Important to communicate the scale of quality of life and lives saved, and things like that.

GP1: Yeah.

V: Great.

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

[End of Transcript]