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Interviewee/s: ACP1

Interview Date: 27.02.2023

Interviewer: Q

Q: Okay, so that's recording now. So just to start off the interview, would you mind just introducing yourself, saying a little bit about what your profession is and what area of [place] you work in?

ACP1: Yeah, so, like I say, I'm currently sort of working in an advanced clinical pharmacist role, probably very similar to advanced nurse practitioner, an ANP role. In [GP surgery name], which is in an area of [place], seeing patients sort of on a day-to-day basis, diagnosing, prescribing for patients, yeah.

Q: Yeah, great, thank you. So as a researcher who does not work in primary care, I'm not familiar with what happens in practice. It would help my understanding, if this is relevant to your role, if you could give me an example of when you've had a woman in this age group of thirty to thirty-nine years present with a concern about their breast cancer risk or about breast health, or any interactions around breast health, if that's relevant.

ACP1: Yeah, I don't see sort of patients with breast lumps and things like that myself, I have shadowed the GPs though when they've done breast examinations. But yeah, it wouldn’t be something that I would do day-to-day but, like I say, I have sort of been there when the GPs have done it, you know, sort of gone through questions, like I say, breast exam and that kind of thing.

Q: Would you have any experience of prescribing anything that might influence, like, breast cancer risk or would you have any conversations with anyone about that kind of side of it or …

ACP1: Um, I'm trying to think, I mean, maybe when we do get – so I would probably deal with patients, say, with mastitis.

Q: Oh, okay, yeah.

ACP1: So I have dealt with women sort of in that respect. The other thing would be sort of skin changes as well, obviously I need to know sort of all the red flags for cancer to make sure that we are just sort of treating a skin condition on the breast as opposed to it being anything sort of more sinister.

Q: Okay, yeah. And how do you feel about having those interactions, in terms of how confident do you feel?

ACP1: Pretty confident, to be honest, obviously we've got all our guidance and guidelines. My – I do have sort of family history of breast cancer, my mum had breast cancer as well so I am aware of what to look out for. And to be honest, sort of having those conversations, yeah, I think – well, I do sort of feel fairly comfortable, you know, when talking to patients sort of around breast cancer and – yeah and their risk.

Q: Okay, yeah, great, thank you. 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. Before the age of fifty years, at least 65% of women who develop breast cancer do not have a family history and this means that they're 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. Women 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 if you could tell me a little bit about what your immediate thoughts and reactions are to offering women the opportunity to find out their breast cancer risk estimate from the age of thirty years.

ACP1: Yeah, I think it's a really good idea. I mean, we have it – you've mentioned it in the sort of pre-read, the QRISK and things like that, we're very much, sort of in primary care, talking to patients about their heart risk, you know, and their diabetes risk. So for women, yeah, I think it's a – you know, a really good thing and sort of a very – along the similar sort of lines as that.

Q: Could you tell me about why you would think it would be good, what would the benefits be?

ACP1: Benefits, I suppose, you know, well, catching anything earlier for anybody, you know, obviously massive benefits there. Um, yeah, like I say, sort of having those discussions and patients knowing the risks of things, you know and if there is anything that they can modify or change as well to help with that risk, is always a good thing.

Q: Are there any concerns that you would have or anything that springs to mind that you think could be a potential problem with offering this opportunity to women?

ACP1: I mean, you do always come across, you know, the patients who don't want to know, I suppose there is always that sort of section of people. I suppose maybe time might be a consideration, everybody's sort of time in clinic although, again, from the sort of things that you put on the pre-reading as to what might go into that calculation of risk, a lot of that information is there anyway. So yeah, I don't think there would be sort of that much time going into it unless, obviously, you're then having, you know, the discussions then afterwards with women about what it means and things like that, um, yeah.

Q: Yeah, great. So what are your immediate thoughts and reactions to primary care identifying and inviting women to a breast cancer risk assessment?

ACP1: I think it's a good thing. Like I say, sort of along the same lines of things that are going on anyway, you know, a lot of the same questions being asked, obviously it's just then sort of an add-on for the female patients.

Q: Do you think it fits within the remit of primary care like in terms of thinking about what responsibilities they currently have; how do you think it would fit?

ACP1: Yeah, I mean, I think, obviously maybe there would need to be some training provided for the sort of after discussions, like I say, a lot of the sort of data gathering would be there anyway. But yeah, obviously it's just probably that follow-up part that would be sort of the sticking point, sort of who would have those conversations with the women if they were at increased risk or having to go for earlier breast screening and things like that, sort of explaining it to them. Um, but, no, I just think it's a good idea.

Q: Okay, great. Yeah, we'll come on to talk a little bit – we're kind of going to go through it as a pathway so we will come on to talk about what you think about the after bit so the bit about risk feedback. So if we think specifically about primary care being involved, how acceptable do you think it would be for primary care to be involved more than they currently are in breast cancer risk assessment and management?

ACP1: Yeah, I think it would be acceptable, obviously I think, in terms of how it may work, I think obviously the HCAs are ideally placed to ask questions that may go into the risk assessment and, like I say, they're sort of doing those kinds of things, anyway, for – you know, as part of the health checks and things.

Q: Okay.

ACP1: Yeah, and then, like I say, maybe sort of nurses or myself, sort of that kind of role then, you know, feeding back what the risk has come out as and sort of what that then means for the patient.

Q: Hmm-hmm, okay. What do you think acceptability would depend on, is there any conditions or like anything that you'd expect to be – would have to be in place for it to be acceptable to primary care?

ACP1: Like I say, probably just that training for the clinicians involved and then obviously having then some form of relationship with secondary care. Obviously the women that are at increased risk will then – like you say, sort of the breast screening and things like that, I assume would then still stay with sort of secondary care and they’d be passed over. So yeah, I suppose just consideration then needs to be, well how would that look – you know, what would that look like, how would that be done? You know, and sort of liaising between – because that's a bit of a stumbling block with anything, is the liaising between primary and secondary care.

Q: Oh, okay.

ACP1: It's not that good in any area, really so I think, yeah, just getting processes in place to ensure that that's like a smooth – you know, sort of smooth steps for the patient.

Q: So how do you think that could be improved, then, based on your current experience, if you've said that it's often not very good?

ACP1: Probably just – I suppose regular contact with where you would then be sending that patient.

Q: Okay, yeah.

ACP1: [Overtalking 0:09:57], um…, yeah, sort of that's always good to know and always good for the patients, you know, where will it be, where will I be going for my screening. And, you know, sort of us being able to liaise with them as well and to give any extra information and things like that regarding different patients.

[0:10:18]

Q: Okay, thank you. Okay, so I'm just going to share the diagram that was in the pre-reading, just so it's a bit easier for you to see, if I can find it. Yeah, I do have it open. One second. Okay, can you see that?

ACP1: Yeah.

Q: Yeah, great, so I'm just going to talk through what the breast cancer risk assessment would look like. So currently, evidence suggests that the risk of developing breast cancer is best calculated with a combination of three different measures. So the first would involve the woman completing a self-reported questionnaire and this would be asking them questions about factors that we know affect breast cancer risk. So that would be things like height and weight, family history of breast and ovarian cancer. But as I said earlier, we expect that – this service is aimed at women who don't have a strong family history but obviously we kind of would collect that information to almost filter out the women. So if they did have too strong, we would then refer them to a family history clinic. So that's the reason why we'd collect that. Age at first period, age of first pregnancy, oral contraceptive history and alcohol consumption. And then the second component would entail a woman needing to attend a mammogram and this would be for the purpose of measuring breast density rather than for the purpose of cancer detection. And this is to assess the amount of non-fatty tissue compared to fatty tissue in the breast because we know that women with a higher proportion of non-fatty tissue are at a greater risk of developing breast cancer. The final component would be a woman providing a saliva sample and this is so that we could perform a DNA analysis which would look at something called a polygenic risk score, which is a combination of multiple common genetic changes, which on their own may not convey an increased risk but once they're put together, like cumulatively, they can increase risk. And it would also look for mutations in high risk genes such as BRCA1 and BRCA2 but, like I say, that would be very unlikely in this group of women because they wouldn't have strong family history. So with all that in mind, then, I just wanted to ask whether – like what do you think about primary care collecting information from women about this list of factors in the first column?

ACP1: Yeah, I think that would be sort of absolutely fine to do in primary care, like I say, sort of – we have similar things, anyway, obviously the oral contraceptive history, alcohol consumption, height and weight and things like that, generally we like to record for, you know, sort of most patients that are attending the surgery for anything else, really. Sort of self-reported questionnaires, we often do them by text and things like that so it's easily done. I would think sort of that part of it easily done in primary care.

Q: Are there any barriers or difficulties that you think there would be to collecting this information from women?

ACP1: Um, not – I personally don't think so, like I say, we use text and things like that like a lot now. So it would just be sort of another sort of round robin of text kind of things that we send for other things as well. So like I say, you always get, you know, some patients who don't respond or what have you but I think the majority – yeah, I think sort of that bit of it would be absolutely fine to, you know, to gather in primary care.

Q: So do you think, then, that text would be the best way to collect this information, rather than have like an appointment with a primary care person or – I'm just wondering what – how you think it should – how you think it would be best collected, basically.

ACP1: Yeah, I would say so because I'd say we do so much by text similar to that, yeah, that would be sort of first point of call, maybe. I mean, with other things, we usually send texts out and then the patients that don't respond, then maybe, you know, get a phone call. But I think the majority of the information, yeah, I can’t see any reason why there'd be any barrier to it being sent sort of via text or email, that kind of thing.

Q: Okay, cool. Is there anything that you think would be needed to perform this task successfully, like anything currently that might improve the collection of this information?

ACP1: I think sort of if this was being implemented in primary care, just sending that information first, you know, this is a new sort of, not service exactly but now we're going to be calculating, you know, women's risk and – yeah so maybe just that, just a bit of information about sort of why it's being done.

Q: And why do you think that, why would that be important?

ACP1: Just to keep the patients informed, I suppose. They do complain sometimes that we do do things and they – you know, they don't know why.

Q: Okay, yeah, yeah.

ACP1: So yeah, just like – just a bit of information, yeah, about sort of why we’re doing it, you know, yeah.

Q: Okay, cool, 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. So, 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 like family history, hormonal and lifestyle factors from the first column. What do you think about primary care coordinating the process of breast cancer risk assessment in this way?

ACP1: Yeah, I think it would be fine. Obviously we'd need the staff [laughs] which is I think and sort of with regards to doing the mammogram for breast density and things like that, maybe sort of in my mind having, you know, sort of a local team or something like that as opposed to individual surgeries sort of doing the mammograms. Yeah, maybe having sort of a specialist team that goes round to them, sort of do that bit of it, I suppose the saliva sample can be done at the same time as the mammogram. But yeah, I think having the tool to then feed it all back into, yeah, is a good idea, yeah.

Q: Why do you think a local team or a specialist team would be beneficial?

ACP1: Just because otherwise you're going to have to train sort of a lot of staff to perform mammograms, assume all the equipment and everything like that will be expensive, cost – the cost and time. Yeah, probably help with that, if it's just a smaller team, like I say, with, you know, a machine. Obviously have these things in car parks, anyway, don't they in trucks and things in car parks so sort of maybe a similar thing in the area, you know, and your patients are invited to go down on a certain day or whatever.

Q: Okay, yeah, yeah that makes sense thank you. So how would you feel about actually communicating the risk result and making a management plan with a patient?

ACP1: I think after training so we know what all the risks mean, you know, how likely – so just you – like the clinician sort of talking to the patient and does have some sort of expertise in the area after some training. But I mean, we have difficult conversations sort of every day with patients so yeah, I can't see that being an issue. Again, just sort of time, an extra thing to be done by clinicians in the surgery but I think the actual conversation itself would be okay.

Q: Okay. So who do you envisage would be capable of taking on that role at your practice, of the more communicating the risk result and talking about management?

ACP1: Um, like I say, sort of practice nurse would, um – I’d say sort of practice nurse up so then they sort of, you know, advanced practitioners and GPs. I mean, I think practice nurses would be sort of baseline level to have that discussion, probably not for the HCAs to – obviously they could help with the data gathering. But I think, yeah, sort of having – because, you know, some of them could be difficult discussions. Yeah, that's where I'd sort of – I think it would probably be best pitched, sort of the practice level – practice nurse or, yeah, sort of upwards from there.

[0:20:00]

Q: Okay. Are there particular aspects of the process, if you think about it as a whole so obviously I've discussed there about the risk assessment part of it and then management, are there particular aspects of that that you'd feel more or less comfortable with being involved in?

ACP1: Like I say, I mean, sort of actually performing the mammograms themselves, if it was to be practice staff or you know, say myself doing that, obviously we'd need to have training in that be able to do them, you know, do quality sort of examinations and things. So yeah, I think that would be – like I say, sort of training that many staff to do the mammograms is a bit of a stumbling block, you know, for services.

Q: Yeah, okay. And how do you think this process would compare to – if we thought about other screening programmes that primary care are involved in, sort of like cervical screening and bowel screening to a certain extent, I'm just wondering if you compared it to that, kind of the organisation of this, like would you think it would be similar or different and why?

ACP1: Maybe slightly different just because of that mammogram aspect which has always been a secondary care part of the process. Sort of if you were bringing that into primary care, like I say, it's just that training of staff and things, or if it was to stay in secondary care, I think then the issue would be what are you – are all the results being fed back into sort of – you know, are we all using the same computer system or, you know, how is, then, the risk calculated? Obviously, because the self-reports, obviously, like I say, it's very much primary care, we have a lot of that sort of information, anyway. So working collaboratively would probably be the best way because then you're not having to train a load of staff to do mammograms. However, yeah, it's then how is it all brought together to get that risk, you know, calculated in the first place, I suppose.

Q: What – I'm trying to think of my question – with that in mind, then, are there any design considerations for like the risk assessment tool, that you think would need to be considered?

ACP1: Yeah, definitely. I mean, we don't currently have access to like secondary care systems. So it's a massive issue, I think it's a massive issue, anyway, in the NHS, that primary care computer systems and secondary care computer systems don't speak to each other.

Q: Oh, right.

ACP1: So we don't have any sort of interconnecting system so it's then – would one then need to be made or, like I say, maybe then you bring the mammogram into primary care, sort of get around that but then, yeah, you'd – that's why I say maybe like a central team that goes and does it sort of in primary care would be a bit better. Because otherwise, yeah, you're going to have to come up with some way of how it's all then going to be communicated for the risk to be calculated in the first place.

Q: Okay, yeah, yeah, that makes sense, thank you. Okay, what do you – is there anything that you think would be required to be able to communicate the risk score and make a management plan?

ACP1: I think sort of having templates first of all and management plans, you know, the risk is between this percent and this percent so this means this – sort of – yeah, just having that follow-up from when the risk is calculated. And then – yeah, like I say then having, obviously then criteria as to what you are then referring in to secondary care, the risk has to be over this or – then that's, you know, referral in.

Q: Are there any key issues or barriers that you would foresee with taking on that role of communicating the risk result and making a management plan?

ACP1: Barriers, I suppose, are would this sort of create more patients, then, that are referred into secondary care. Obviously everywhere is sort of struggling, anyway, with waiting times and that kind of thing so then would there be sort of a whole, then, extra section of women who are having to then be referred to secondary care and then how would they be able to cope with that? Um…, yeah, I think that would be sort of one of the main ones.

Q: Yeah.

ACP1: I think sort of calculating the risk and having the discussion of the risk might put pressure on, obviously, some places in primary care. Our surgery would probably, sort of thinking about things and who might do things, would probably be able to cope with that, I would think. But others might not if they're absolutely stretched to the limit already, it's an extra thing to be doing.

Q: Okay, okay. So are you saying that you think like staffing and resource is going to be really important for this?

ACP1: Yeah, yeah. And initially sort of getting the training and everything like that because obviously that does take time and, again, money but everything comes down to money, doesn't it, it’s like [laughs], you know, if you don't have the money to have enough staff to be able to do things. So yeah, I think that would be a bit of an obstacle.

Q: Okay, so if we thought a little bit more about what staffing or what professional groups would be involved in this, do you think that there would be any benefit to having someone that was more like trained up maybe to be more of like a risk assessment kind of specialist? Or if you thought about the model of how it would work with the – because obviously mentioned there about different professional groups maybe being able to communicate the risk score, how do you think it would better work in terms of – could there be like one champion for it or, you know, that kind of thing, if you think about what goes on with other risk assessment activities?

ACP1: Yeah, I mean, yeah, you could definitely have, you know, a champion in the surgery, sort of and I think practice nurse would be sort of well-placed for that, because they'd be sort of –from looking at how it might work, like I say, sort of HCA could help with the sort of self-reported questionnaire, although I’d say maybe not because we could get quite a bit of that from the patient, like I say, via text or what have you. Um, I think, obviously, saliva sample isn't too bad because that could be done sort of at the surgery, the patient could just come in and provide the saliva sample, again sort of without – you know, with minimal sort of clinician involvement as well, they could just come to the front desk and pick up, you know, and just drop back in, whatever's needed for that. The mammogram section, I think, is where there's going to be the majority of the issues because, yeah, who's going to – I don't know, I suppose if you had, like I say, sort of a team of nurses going round doing the mammograms – with regards to breast density, because I'm not sure, with a mammogram, is that available sort of there and then? Like as, the mammogram's done, is the result available then? So –

Q: Okay, yeah.

ACP1: Um…, yeah, that might be a bit of a stumbling block if you're then having to wait for the breast density measurement, how that is then communicated back in, like I say, either to the surgery or whoever is calculating the risk.

Q: Okay.

ACP1: But yeah, I'd say – I think a rolling team of nurses would be best though for that regardless of how then the information is then being fed back so that risk can then be calculated with the results of the saliva sample and the results of the questionnaire.

Q: Could you say a little bit more about why you think nurses would be best placed for that.

ACP1: Well, I think – I mean, obviously you may have to have an overseeing consultant but mammograms and things like that, I think are done by sort of a nurse team in secondary care, anyway and obviously then the results are just sort of, you know, fed back to the consultant and sort of gone from there. So that's why I'd say nurses.

Q: Yeah, great, thank you. Okay, so if we go, move on to talk a little bit about what the recommendations for management would be so currently it is imagined that there would be like an output of this tool and it would include what the recommendations would be for management based on the risk result that the woman's received. So it's imagined that women identified as being at increased risk would be able to access earlier breast screening from the age of forty, whereas currently the screening programme doesn't begin till fifty and forty-seven in some areas. In addition to this, 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 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?

[0:30:53]

ACP1: Yeah, I think that would be absolutely fine and sort of, I think, primary care would be best placed to do that because we provide that, like I say, for a lot of other risk factors. And to be honest, lifestyle advice is pretty much all the same for – you know, across the board, reduce your alcohol intake, reduce your weight, if you are overweight, or maintain a healthy weight. So yeah, it's just a very small sort of add-on to what we discuss a lot, anyway. I suppose with this it's just that you – maybe your patient cohort are a bit younger. So yeah, maybe it would just be sort of a bit more work because you would have more patients. Obviously these discussions are often older patients, I would say, sort of, when you’re discussing sort of risk, like I say, heart risk factors and, you know, diabetes risk factors, that kind of thing. Maybe your patients are – yeah, sort of more fifty plus. But yeah, I think primary care would be able to – lifestyle advice, absolutely fine. And again, I think all clinicians in primary care are used to giving lifestyle advice as well so, you know, it wouldn't have to be sort of a GP doing that again, it could be – I mean, it could even be healthcare assistant, you know, just to give lifestyle advice.

Q: Okay. So you mentioned there about that perhaps you might have more experience of doing this in a – with an older age group, do you think there's anything different about providing lifestyle advice for a younger group in comparison?

ACP1: Um…, I don't know, really. I suppose your advice is the same, isn't it but yeah, maybe giving them, you know, more sort of different ideas, I don't know. Obviously, with an older age group you don't really go and tell them to exercise vigorously or anything like that, you know, gentle walks and things. But maybe that might be slightly different, very similar, though, very similar conversation I’d say.

Q: Okay, cool. Do you think there's anything different about providing lifestyle advice with respect to breast cancer risk in comparison with other diseases?

ACP1: Um…, I don't know, really. I would say not. From my point of view, I don't really mind having those kinds of discussions with a patient, although I don't know if other clinicians would feel the same, I'm not sure, to be honest. But no, like I say, sort of risks, we discuss risks and how to reduce risks very regularly so it's a very normal conversation that we would have, day-to-day, with patients. So just the fact that it's sort of breast cancer as opposed to, you know, heart or whatever, I can't see that would make much difference.

Q: And why would you say that you feel like confident having those conversations?

ACP1: Like I say, it's done sort of routinely, day-to-day, for other things. Well, I mean, pretty much everything, you know, it's like – yeah, sort of patients are really used to us collecting now sort of alcohol data, smoking data. We do obviously BMIs when we can, when the patients are in and – or we get any chance to collect that data. And such as alcohol and smoking data, is collected anyway for QOF. I don't know if you – so how the surgeries get paid, we have to collect those in other cohorts of patients anyway, so I suppose it would just be like an add-on for this cohort of patients. But yeah, it's just really routine now so yeah, I'd say that's why it's probably not much of an issue, yeah.

Q: Okay. Are there any difficulties that you could foresee with providing that lifestyle advice for reducing breast cancer risk?

ACP1: Like I say, I just suppose it's the time that it might take to add on that section of patients. Um, like I say, you do get some sort of nervous patients as well, you know, bringing in new things such as this and sort of discussing breast cancer risk that could sort of, I don't know how to word it, sort of spook some patients. And then they're very – you know, they're wanting sort of a lot of our information, what does this mean for me? And again, it's just the time it takes then to sort of deal with those patients.

Q: Okay, thank you. Okay, so if we move on to talk about the other management strategy, which would be risk reducing medication, can you tell me a little bit about risk reducing medications that you might prescribe currently within primary care?

ACP1: Well, I mean, statins are the big one, statins, also anti-platelets obviously for certain conditions. Um, yeah, that's – they're the main ones that I prescribe at the minute.

Q: And how do you feel prescribing those?

ACP1: Absolutely fine. Again, it's really routine. You know, you do get your patients who decline and obviously they have – if they've got capacity and they're, you know, more than sort of – they're able to do that, that's their sort of prerogative to, you know, be able to make that decision themselves. But yeah, again, that just – again, it's really routine, you know, high QRISKs and having that discussion then with the patient, that going onto a statin would be sort of beneficial for reducing risk and – so, yeah.

Q: So is that – so just out of interest in kind of what your role is then so would you have those conversations with people then, after they've found out they might benefit from –

ACP1: Yeah.

Q: Okay.

ACP1: Yes, yeah. Every day, pretty much [laughs], a lot, yeah, a lot.

Q: No, I'm just interested in what – yeah, because, like I say, I'm not familiar with all the different roles in primary care and what they do so I'm just interested to understand what – how your role could fit in with this, yeah.

ACP1: Yeah. So I say – so, for example, with statins say yeah, if we get a patient where it's come back high cholesterol, we'll QRISK them and then from that – that's no longer sort of the GP's job to speak to those patients, it's like ours or a prescribing nurse or – so I speak to them and try to, you know, just say – offer them statins, basically.

Q: Okay, yeah. So what do you think about primary care discussing and prescribing breast cancer risk reducing medication, then, such as Tamoxifen?

ACP1: Um, yeah, I mean, again, I think it would be an issue – well, not an issue but training would be needed. Obviously, you know, how is it reducing your risk, all that – you know, so just so that we'd be able to – we're then an expert in it and be able to answer sort of any questions or queries that the patients would then have. But I think once clinicians are trained, then, yeah, I think it would be fine.

Q: Okay. Do you think prescribing risk reducing medication for breast cancer risk is any different from prescribing statins for cardiovascular risk?

ACP1: Yes, I would say so, from a pharmacist's point of view, sort of, with regards to the medication itself. Um…, I think obviously introducing anything new as well, patients are very suspicious too, you know, with anything new. So yeah, just – obviously we'd need sort of the tools and things like that to be able to give the patient, you know, leaflets and all sorts of things that they ask for.

Q: Is there anything else that would make it different aside from it being a new thing?

ACP1: Um.

[0:40:00]

Q: Well, if you think about it as well from the – from your guys' perspective, like the staff perspective.

ACP1: [Pause] It does feel different, I think it would feel different but I don't know why but, yeah, it sort of feels like it was sort of more serious or that if – I don't – yeah, it's difficult to explain but yeah, it does feel different than just giving a statin, I would think. And I think sort of patients would feel that as well if you're offering a woman Tamoxifen to reduce risk of breast cancer, it feels a bit more sort of serious in a way. I know that’s maybe not the right word to use, I don't know but yeah, it does feel different though, yeah but like it might just be because it's new. I don't know but yeah, there's something that makes it sort of more serious and more – yeah.

Q: What do you mean by serious?

ACP1: Um…, I don't know, I mean, I suppose talking about cancer, it's always serious discussions and things like that, although sort of comparing it to statins, you know, when you're talking about sort of heart attacks and things which really along the same lines. Yeah, I don't know, it – yeah, I don't know, it just feels different. I don't know, I can’t explain how or why yeah.

Q: No, that's fine, no, I'm just finding it interesting because you obviously have a – it sounds like you have a different like emotional reaction to –

ACP1: Yeah.

Q: And it's just, yeah, trying to unpick like why that might be but you've kind of said that maybe it’s because it's to do with cancer, maybe.

ACP1: Yeah, maybe, yeah. But like I say, statins and things like that, heart attack and stroke which will kill you too so it's – but, like I say, actually issuing statins and – I think, as well I really don't know, it just – yeah, maybe because it is new. Media and things like that, obviously there's a lot – you know, so much in the media, Aspirin and statins and things so your patient population are very aware of them anyway, whereas issuing Tamoxifen, you know, I think you'd be sort of fully an expert there. I think the patient would have a lot less information just from, you know – from, yeah, the media and other forms of sort of advice and information.

Q: Okay. So aside from training, then, is there anything else that you think clinicians would need to take on this role of discussing and prescribing Tamoxifen?

ACP1: Um…, like I say, time, I think is going to be a bit of an issue, like I say, quite a bit of it can be, you know, added on to other things and wouldn't take much time. But then, yeah, the patients are at high risk and obviously would then, you know, out the other side. So yeah, just clinician time would be sort of another factor. Um…, yeah, I can't think of anything else, though, really.

Q: Okay, cool. I think we've covered that. Yeah, so I think we did cover it but just to clarify, who would be able to take on that role of having those discussions and prescribing as well?

ACP1: Yeah, I think it would depend on the risk and the management plan for that patient. Like I say, discussing if it was just lifestyle advice I’d say maybe even a HCA could, you know, because they do do that routinely as well. Obviously, if you are then discussing where you're then maybe prescribing, say, Tamoxifen for a patient, um – mind you, like I say, I mean, sort of at my level, advanced practitioner sort of level, I think would be fine, or GP, I would say. But I would say it would depend on the risk, if it's higher, you know, it would then maybe be different clinicians discussing that then with the patient.

Q: Okay, yeah, great, thank you. Okay, so can you tell me about the impact Covid-19 has had on your practice in general?

ACP1: Um, well I mean, massive [laughs]. So we now do a lot more telephone, we are back to face-to-face though either where the clinician thinks it's needed or the patient requests it. So yeah, it's either or really but a lot more telephone. We have had – well, when we first sort of came out of it, just a massive increase in patients trying to access clinician services as well. Um… I'm not sure why that is but they're much – I don't know.

Q: Okay.

ACP1: So yeah, we just seem to be more stretched, somehow.

Q: Okay. What impact, if any, do you think Covid-19 has had on risk assessment and prevention in particular?

ACP1: [Pause] I suppose during Covid-19 we weren't able to do the risk assessments and things like that, however, it is needed for QOF so obviously the surgery does get paid on it so they're always pushing for it. Like I say, texts get sent out regularly to get alcohol, smoking data, BMI data, even if patients have got blood pressure machines at home, we now sort of communicate the results via text. So I don't really – like I say, with QOF and with you having to get that data in order for the surgery to be paid, I would say that's sort of similar to before Covid now. It's back to normal and back to having to get that data for QOF, because during it they sort of suspended some of the indicators so we didn't need to get as much data but we're back to how we were previous now so yeah, similar.

Q: Okay. How do you see breast cancer risk assessment and management fitting in with your practice currently? Do you think that there's a place for it in the future?

ACP1: Yeah, I think so and I think not just for breast cancer, I think they'll probably start doing a lot more sort of across other disease states as well. Obviously, trying to save money at the other end, you know, so you're not – patients aren't sort of end stage and things like that when you catch them. So yeah, I think we're well placed. Obviously the admin teams and reception teams can do quite a bit of the data gathering, like I say, sort of help with collecting the saliva samples and things like that as well so – like I say, I think we’re well placed for it.

Q: So do you think setting up a pathway for breast cancer risk assessment and management activities in primary care for women aged thirty to thirty-nine years is a worthwhile idea?

ACP1: Yes.

Q: Can you tell me a little bit about why you’d say yes?

ACP1: Like I say, just that early – you know, early detection of anything, good for the patient, good for the NHS. Yeah, I'd be pro, yeah, early detection of – yeah, like I say, most disease states, to be honest, yeah.

Q: Okay. And are there any other issues that you think would be important to consider when setting up this pathway, that you've not already mentioned?

ACP1: No, I think I've mentioned most of it. I think it's the mammogram section of it that's sort of the stumbling block and if that was sort of overcome with, you know, process, then I think that would be – yeah, be the main one. And like I say, just that more stress on secondary care if you – you know, depending on how many you are catching to refer in.

Q: Okay, okay. Okay, thank you, thanks for your time today. That's all the questions I had. I just wanted to ask you is there anything you thought you'd talk about today which you haven't had a chance to say and you want to mention?

ACP1: No.

Q: And what was the most important thing you've told me today?

ACP1: Probably that primary care and secondary care don't talk to each other. So who's going to do that mammogram bit and how that would be fed back into the system [inaudible 0:50:02] I'd say.

[0:50:04]

Q: Okay, great, thank you. I'll stop –

[END OF RECORDING – 0:50:07]