Title: I6\_01.03.2023

Interviewee/s: GP8

Interview Date: 01.03.2023

Interviewer: Q

Q: Okay, so that's recording now. So first of all, would you mind just briefly introducing yourself and saying a little bit about what your profession is and what area of [place] you currently work in.

GP8: Yeah, so I’m a newly qualified GP and I’ve moved from working in [place] and [place], to working in [place] near [place] six months ago, when I qualified, so [place] is quite a relatively affluent area.

Q: Okay, great, thank you. Okay, so as a researcher who does not work in primary care I am not familiar with what happens in practice. It would help my understanding 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, and talk through what happened and what you did, if you have had that experience.

GP8: Yeah, so I see quite a lot of women with – that can feel a lump, so currently that's quite a common presentation and that would include this age range. So we'd normally take a history, and sometimes it'll be an urgent appointment if they have a high level of concern. And then I would examine them and, depending on the examination, maybe refer them to the breast – so it would be a two week wait referral. I do have people asking about genetics as well and I would sometimes see letters through from the genetics team about these patients.

Q: And how do you feel about having those interactions, if you think specifically about this age group?

GP8: Yeah, I think, um... it's quite common that we see women of all different ages, and younger than this age group as well. And in terms of people asking specifically about their risk, I think that would be more likely if they've recently had a family member diagnosed or kind of, you know, a significant event within their family.

Q: And how confident do you feel talking to women about these types of concerns?

GP8: Yeah, I think in terms of risk we can talk about kind of basic lifestyle things. I don't think it's an area that we're perhaps taught very well, especially through medical school, and I think I probably talk about breast cancer risk a bit more at the moment with HRT, because we're getting a lot of HRT requests, but I appreciate that's in an older age group.

Q: Okay, hmm, mmm. Yeah, so I'm just trying to get a feel for like how confident you feel with dealing with those types of queries, like how – yeah.

GP8: So, if someone came to me and they were worried about their risk, I would look at the NICE guidelines, so the NICE CKS, the clinical knowledge summaries, and then if they met that criteria, then I would refer them on to genetics. But in terms of giving my own opinion as to their risk, yeah, I wouldn't be very confident, I don't think.

Q: Okay, hmm, mmm. And what makes you say that?

GP8: There's just so many factors at play and I guess family history is definitely one of them, but there's so many other things as well. I think there's also like a really high, understandably, a high level of anxiety in these patients, so you kind of – you obviously want to be helpful, but you don't want to be overly either scaring them or being overly reassuring.

Q: Okay, so breast cancer becomes more common in women in their thirties and it's currently 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 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. This would have the benefit of being able to offer women identified as being at increased risk earlier breast screening as well as other methods to reduce breast cancer risk, which we'll come on to talk about more later on. But initially, I was just wondering if you could tell me 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.

GP8: Yeah, I think it's a really interesting idea and to that, to me, sounds quite young. I don't know whether that's because I'm thirty-one, but, you know, certainly with your statistics it's very relevant. I think I would perhaps – if something was rolled out like this in the future, I could see that there’s a bit of a window where somebody's forty, or between forty and fifty, where they're not yet invited for their screening, that they perhaps haven't had the opportunity to do this kind of assessment. So I wonder if there’s a bit of a gap in that age group, but I don't know if, obviously, this would be brought in and whether there'd be a catch up or – I don't know.

Q: Okay, yeah, yeah. Could you expand a little bit on why you initially said that you thought it was interesting, the idea of it?

GP8: Yeah, I guess – in your information you mentioned about being a bit similar to QRISK, so QRISK is something that we do all the time and everybody's really familiar with it, everybody knows what it means, I'm quite happy explaining that to patients. So I was trying to think about – this sounds quite different, it sounds – you know, it's unfamiliar. So I was trying to think whether over time and with information this would become more routine and whether it would feel more kind of, again, like you're following the guidance and it's – you know, that kind of calculation-type risk assessment. And, yeah, I guess if it did make a difference to outcomes for women, especially when they're diagnosed at such a young age, I think that would be really, really interesting and, you know, make a big difference, if it worked.

Q: Okay. Could you tell me about any benefits that you could see with introducing this for this age group?

GP8: Yeah, so I think if – well, yeah, if it was found to be effective and, say, treatment was – some preventative treatment was initiated for kind of – people were able to take proactive steps, I think that would be a really positive thing, especially if we saw either earlier diagnosis or, you know, a reduction in risk. I think, in some ways, even if everybody is deemed as low risk, if they're having a risk assessment, there's also opportunities to discuss self-examination and just general awareness. And, I guess, a bit like your smear test, kind of – although uptake for that isn't amazing, everybody knows what it is and, you know, kind of it's out there. So yeah, if it could encourage people to self-examine on a regular basis as well, I think that would be good.

Q: Hmm, mmm.

GP8: And then if somebody is deemed to be higher risk, that could increase their motivation for lifestyle changes, so the weight loss or smoking, alcohol. Not that I want to scare people, but if they're more informed, then they might be more motivated in a way.

Q: Yeah, thank you. So on the flipside then, can you think of any concerns that you would have about introducing this?

GP8: Yeah, so I think worry and anxiety for patients is a big one because a lot of the women that I see are already quite worried. Um, I think for some people like attending is difficult, so coming in for extra appointments or tests and perhaps some groups are less likely to – a bit like any screening or assessment, they're less likely to come in than others, so there could kind of again widen inequality in a way if people aren't accessing the things that they're invited to.

Q: Hmm, mmm, yeah. What do you think could be done to facilitate access for women in this age group?

GP8: Um, I think kind of that trying to be flexible. So, you know, people in this age group might have young families or be working full-time, so having later appointments or weekend. And I guess the way – like we’ve not quite got that far, but in terms of how the saliva is collected or, you know, how the mammogram is done and kind of having that accessible and just with anything new, trying to get it out in the community, in different community groups as well.

[10:06]

Q: Hmm, mmm, yeah, okay, thank you. So what are your immediate thoughts and reactions to primary care identifying and inviting women to a breast cancer risk assessment?

GP8: Yeah, I'm going to use the word interesting again, I do think it's an interesting idea. I think what I was a bit unclear about is how much responsibility lay within primary care because, if I think about – and I know this isn't directly a screening tool, it's a risk assessment, but if I think about screening, quite a lot of that is run by the screening service so we don't really get that involved. So the faecal occult blood, the stool sample, the patient is invited – if it's that – if it comes back high then it's all – it's dealt with by the screening, we don't really see it apart from we get copied into the letters. So, you know, primary care, if you've got a good relationship with a patient that can be really helpful, to have these discussions, but at the same time we are quite short of appointments, especially for our – well, for everyone really, but my practice in particular for the nurse, a nursing team. So I think it would be a challenge to fit that in, really.

Q: Hmm, mmm, yeah, okay. Yeah, we'll come on to talk about – more about what you think primary care's responsibility would be when we kind of look at it as a whole, because, yeah, that's basically what I want to try and understand from you guys, is how this would be best organised. And, you know, it's completely fine if you think it shouldn't be ran by primary care. You know, it's just understanding what model you think would be best. So what would you say your immediate thoughts and reactions were to primary care having a greater involvement in breast cancer risk assessment and management than they currently do?

GP8: Um, in terms of risk assessment, I wouldn't – it's difficult because, you know, we do have general approaches for, again, like lifestyle factors, healthy living. I wouldn't say we have a direct approach for breast cancer risk unless somebody came in specifically asking about that, and that is normally based on family history, and, you know, what you're saying is that a lot of these don't have a family history. So I think this is targeting an area that we haven't really got much for at the moment.

Q: Okay, hmm, mmm, yeah. How acceptable do you think it would be, if you thought about yourself and your colleagues, to be more involved in risk assessment and kind of what would acceptability depend upon?

GP8: So I think it would be good to have a clear framework of what this risk assessment involves and what we're trying to achieve, whether that's just having patients better informed about their risk or whether we are aiming for treatments or for like prophylaxis and – oh, yeah, is it more about awareness or is it about trying to reduce the rates of breast cancer? And then, you know, as I've mentioned, we are pretty busy, so it would be kind of the time involvement. And I don't understand everything about GP contracts but I know that funding can sometimes make practices a bit more proactive about certain things if there's funding behind it. So I think – yeah, I think time would be a bit of – would be a main concern. But also having that kind of for a new thing to have clear guidance, that not just the GPs would follow, but the nurses and the HCAs.

Q: Hmm, okay, thank you. Okay, so I'm just going to share the diagram that was in the pre-reading material just so that it's on the screen whilst we discuss it. Can you see that okay?

GP8: Yeah.

Q: Okay, great. Okay, so as you will have seen, we're proposing kind of like a three component risk assessment for breast cancer, and this is based on the current evidence base. So we would ask a woman first of all to complete a self-reported questionnaire and this would be asking them about those factors that we know are associated with breast cancer risk. So this would include height and weight to calculate BMI, it would include family history of breast and ovarian cancer, but this is essentially more so that we can direct those who do have a strong family history to a family history clinic. So we assume – we're assuming that a lot of these women wouldn't fulfil that criteria, but we ask it for that reason, so that we're not missing anyone. Age at first period, age of first pregnancy, oral contraceptive history and alcohol consumption. And then the second component would involve the woman needing to undergo a mammogram, and this wouldn't be for the purpose of cancer detection, it would be for the purpose of assessing breast density, which is a measure of the amount of non-fatty tissue compared to fatty tissue in the breast. And we know that women with a high proportion of non-fatty tissue are at an increased risk of developing breast cancer, so that's why we would measure that. And then the final component would involve a woman needing to provide a saliva sample and this is so that we could do a DNA analysis. So that analysis, it would look for mutations in high-risk genes such as BRCA1 and BRCA2, but this is very unlikely given that these women won't have a family history, but we would look at it just to be on the safe side. And then the – we'd also look at – we'd also have an output called a polygenic risk score, which is essentially we've identified like hundreds of common genetic changes which on their own wouldn't cause an increase in breast cancer risk, but once they're cumulatively put together they can increase risk. So that's the reason why we'd include that. So, bearing in mind, then, that overview of the process, I just wanted to ask you first about the first component, so the self-reported questionnaire, what do you think about primary care collecting information from women about this list of breast cancer risk factors?

GP8: Yeah, I think that's fine. We hopefully would have a fairly up to date height and weight already. We might have – we'd have information about pregnancies, we'd obviously have information about the contraception. Alcohol, we do try and ask and we have our own targets for asking about that, anyway. So really we'd be asking about their first period and their family history. I think, you know, on our computer systems we have a lot of templates, so this could be like a template that we could ask and even we could send it out on a text message. So kind of like a batch send, where we just send it out to everyone who's due their self – their assessment and then they can – you know, there isn’t even blood pressure on there, is there, so they would be able to tell us everything, yeah, remotely if needed, actually. So it could be a telephone call or a response to a text message, as long as they had some scales.

Q: Hmm, mmm. So how do you think – bearing in mind those different options that you've just mentioned, how do you think the information would be best collected?

GP8: Um, the reason I mentioned text messages is that I've been looking at text messages recently and there’s a lot – I was quite surprised about how much there is that we can do and Accurx, which are the company that run our text message service, they've got some really good questionnaires. So this could be put into a questionnaire quite easily, I think, in a way that – you know, that can be explained to patients and give them different options. So that's a bit – you know, that could work quite well in itself or it could be an appointment with perhaps one of the HCAs.

Q: What do you think would be best from those two?

GP8: I think probably a text message but if somebody had like learning difficulties or if they didn't have a phone or the internet, then we could bring them in.

Q: Okay, yeah, okay. Are there any difficulties or barriers that you could foresee with trying to collect this information from women?

GP8: Um... not really, but I guess we don't tend to ask people very often about when they started their periods. I guess if somebody had like a very difficult loss of a baby or had a termination or something, they might not be as forthcoming about the age of their first pregnancy, but I don't see a problem with any of the other things on there.

Q: Okay, thank you. And is there anything that you think would be required to perform this task successfully, like anything that you'd need or would the, like, Accurx like questionnaire, is that like good to go kind of thing? Is there anything that you think would be needed to use it successfully?

[20:07]

GP8: Um, as in – well, you'd need like your scales or your height measurement, I can't remember what it's called, if they haven’t got those at home. And, yeah, the questionnaire we'd have to make, but they could do that quite easily.

Q: Okay, cool, thank you. Okay, so if we think about it as a whole approach then. So one model of how breast cancer risk assessment could work in primary care is the development of a risk assessment tool similar to QRISK, for example, scores for mammographic density and genetic risk could be fed into the tool and a risk score generated once someone in primary care has entered family history, hormonal and lifestyle factors, so the risk factors that we've just been talking about. What do you think about primary care coordinating the process of breast cancer risk assessment in this way?

GP8: I can see it working in primary care, um, and we do similar things, say, with – well, I know you've mentioned QRISK, but also with bone density. So like osteoporosis, there's a risk score and you put in the information from the DEXA scan. I guess that's kind of similar to your mammogram there. I think, yeah, if we did it in primary care it would be set up on a template so that you just put the numbers straight in, I guess. In some ways I guess the alternative is that it's done in a – like a one-stop – well, it wouldn't be one, you'd have to wait for your saliva result, wouldn't you – but like in an external clinic where somebody goes, has all the risk questions asked and has their mammogram. Yeah, so I guess it could be done externally as well. Yeah, there's nothing that we definitely can't do in primary care, but, again, it's about having somebody that knows what they're doing and also has the time to do it, yeah.

Q: Yeah, hmm, mmm. So how do you think it would be best organised then, if you were to decide – weighing up, like you said about it may be something external, like if we were, for instance, going to introduce this next week, how would you feel it would work best?

GP8: Um, yeah, I think if there was no – like if money was no obstacle I would have like a separate kind of screening clinic, so a bit like the mammogram when they come round in the lorry.

Q: Oh, yeah, yeah.

GP8: So trying to get it all done in one visit, where the person first sees somebody that could check the height and weight, go through all the risk factors, then they have the mammogram, they do the saliva before they go and they're informed before they leave what will happen. So whether they'll get a letter or they'll get a text message or whatever. So I think if it could all be done in one appointment, that would make it easier for the patient and would minimise kind of people dealing with maybe the mammogram, but not the saliva or kind of not completing the whole thing.

Q: Hmm, mmm. So, if it was to work like that, would you foresee any need for primary care involvement at any point?

GP8: I guess, yeah, that would be more separate and, yeah, in an ideal world, if they were high risk, then they could send them straight on to where they needed to go, but I guess we could always get the results of everything, you know, once it's been collected, externally. If that were another option it would save us doing all the data collection.

Q: Okay, yeah. So how would you feel, then, about communicating the risk score and making a management plan if you were sent the results?

GP8: Yeah, I think, again, I'd want to know a bit more about what was deemed low, middle, high risk and what that meant for the patient because, again, like anxiety, I think would be quite high. I think we can discuss lifestyle factors and that can be done by different members of our team. I wouldn't really know anything about starting Tamoxifen, like prophylactically and – so yeah, there'd need to be some really clear guidance about what we're doing. And again some of our medications we don't prescribe directly from GP, it has to be kind of under specialist guidance. So, if – we can communicate the outcome of the results, as long as we have some guidance about how to interpret them, but then we would need further guidance about, okay, well, where do we go from here and what does that mean?

Q: But do you think that should be primary care's responsibility to do that part of it?

GP8: [Pause] I think it's so difficult, because there's so many things and I think you could look at loads of different things and say that, oh, actually, they could be done in GP, but it's – I guess when – trying to prioritise what we actually do. As to where it should be done, I think if we can normalise it and make it a part of routine care then we can do it if we've got the time and the resources. But, if we don't then I think it would be managed elsewhere, a bit like a screening process.

Q: Hmm, mmm. And so how do you think it could be normalised, then?

GP8: Um, so I guess the way that mammograms are and smears, although they're not as great, kind of advertisements, public health campaigns, you know, kind of social media adverts, just getting it out that there's a new risk assessment and that you're entitled to it. Obviously we can send letters and all they can be sent a letter through the post. Again, that's kind of what the screening service would do about the other things. So yeah, just getting the word out there. And we can also encourage people to come in, we can invite people in.

Q: Yeah. Okay, so having – like we've discussed all the – like the risk assessment process and also then about maybe communicating the risk and making a management plan, I was just wondering whether there's particular aspects of that process that you would feel more or less comfortable with being involved in?

GP8: Like the whole thing?

Q: Yeah, yeah.

GP8: I guess one thing that, when I read the three stages, was the kind of genetic testing side of it. So, if we were to send somebody to clinic they would have quite in-depth counselling about genetic testing and what that means and what that could mean for their family. So, if somebody came – I don't know how detailed these results would be, but if somebody was told that they were positive for BRCA or, you know, whatever, we wouldn't normally communicate those sorts of results. So that would be a bit different. And again I think it's just, if you are explaining something like this, you just need to be well informed yourself. And then, you know, it can cause complications for families if some family members don't want to know, some do, and then if they've not been properly counselled, then that can cause some problems, I think, so the genetics, yeah.

Q: Okay. What professional group do you think would be appropriate to communicate a risk score and support someone to make a management plan, within – like what group within primary care, sorry?

GP8: Yeah, so I think we are moving kind of away from doctors doing some things and we've got – I think it really depends on the practice and the experience and confidence of your nurses and HCAs. I think as long as – again, as long as there was good training, I think a nurse would be able to discuss these things. And our HCAs would, you know, often discuss like lifestyle changes, alcohol. I don't know whether they'd be as confident at kind of the more detail or perhaps the extra questions that patients might have, but I think either the clinical team – and I guess that would include your physicians associates and our nursing team, I think that would be fine.

Q: Okay, thank you. Okay, so if we were to develop a tool that was similar to QRISK, are there any – is there any design considerations or anything that you would expect to see in that risk assessment tool that would help?

[30:09]

GP8: Um, as in how – what do you mean, sorry, in terms of like the information that you have to input or how it's displayed?

Q: Yeah, no, just more for you. Like so what requirements would you have from that risk assessment tool if you were going to be using it? Is there anything that you think, oh, that would have to be included in it, from your perspective, if you were going to be the ones using it, how would you – like, I don't know, for instance, in terms of if QRISK displays any charts of anything or that kind of thing.

GP8: Yeah, so it's really helpful for us if these risk scores can be embedded within our computer system. So we use EMIS, so say if we coded somebody’s height and weight, and then you open up the template and it's already got the height and weight there, so that means that we're not having to like duplicate everything by adding it in twice. And I guess, again, if we got the result of the mammogram and there was a code or a score, again that could kind of be pulled in instead of us having to manually enter everything. And then, yeah, so sometimes, going back to the osteoporosis and the fracture so that brings up a graph, which is quite good, and it has like treatment thresholds and like a traffic light colour system. So that's all just quite helpful, especially if you're not doing it really frequently, to see where your patient is sitting, and also, you can use it to show the patient where they are, yeah.

Q: Okay, yeah, thank you. Okay, I think – is there anything more that you wanted to say on any barriers or difficulties to taking on the role of communicating a risk score and/or making a management plan?

GP8: Let me see, I did jot a few things down.

Q: Yeah, of course, no worries.

GP8: Oh, one thing I wondered about was like false reassurance. So, if somebody is deemed low risk, I wouldn't want that to like put them off kind of coming to us if they did feel a lump or if – or then like not checking themselves regularly. So I think I would communicate that, you know, it's only a risk score, it doesn't mean for definite what's going to happen, but, yeah, we'd definitely need to be careful with that.

Q: Okay, yeah, that’s an extra consideration, okay, thank you. Okay, so if we move on to talk more about the management aspect of it, so the output of this tool would also include recommendations for management of increased risk, and currently it's imagined that women identified as being at increased risk would be able to access earlier breast screening from the age of forty. 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 also taking risk reducing medication such as Tamoxifen. These risk management options would need to be discussed and offered to women identified at increased risk. So I know you touched on it briefly, but if you could tell me about what you think about primary care providing lifestyle advice about reducing breast cancer risk.

GP8: Yeah, I think the lifestyle advice would be fine as we do that quite a lot, you know, obviously, we probably should do it more than we do, but certainly for diabetes, cardiovascular risk, QRISK, you know, we're used to accessing weight management services, asking about alcohol and smoking. So I think it would be very transferable to apply that to this situation.

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

GP8: Um... not really, not in the way that we would communicate it, I don't think. Um... people are motivated in different ways, so sometimes we can kind of catch them at a point when they're really motivated and, yeah, we have got access to onward referrals, so I wouldn't really see it being that different, no.

Q: Okay, yeah. And who would you envisage being able to provide that lifestyle advice from your practice? I think you mentioned before that you thought that multiple professions could – I’m just wondering what you thought, yeah.

GP8: So, yeah, I think predominantly our nursing team or the HCAs but, you know, we could talk about it as well.

Q: Hmm, mmm. And why, what makes you say that?

GP8: Just because they're really good at it and sometimes they have slightly longer appointments than us as well. So, if I wanted to refer somebody for weight management, so that could be – I'm not sure of all the ins and outs, but that could be kind of reduced-price Slimming World or medication or even like surgery for weight loss. One of our HCAs would see them first and they would take all the bloods that are needed and they'd also explain what's going to happen. So they can kind of do it together if it's – because quite often they do need blood tests before they can go onto those further support.

Q: Okay, thank you. Are there any difficulties or barriers that you could foresee with primary care taking on that role of providing lifestyle advice?

GP8: Um... I guess a lot of people think that they can't get in to see us, that they – you know, they find it hard to get an appointment, so if they got a letter saying that your risk score is moderate or high, you know, you need to come in to see the nurse, and then we say it's going to be six weeks or they ring up and they can't get through, you know, that's not great, is it? Because then that person is kind of sat there not really sure what's going on. And, again, that would be quite worrying, I think, for them.

Q: Okay, yeah, hmm, mmm. What do you think, if anything, would be required to take on this role successfully? So are there any training needs or anything that you think would be helpful to introduce to help people have these discussions?

GP8: Yeah, I think I would be interested if there is specific advice around breast cancer risk and lifestyle, as opposed to our general advice.

Q: Oh, yeah, yeah.

GP8: Because then we could perhaps target that a bit more to the person in front of us, as opposed to just giving kind of general how to be healthy advice.

Q: Hmm, mmm, okay, yeah. Why do you think that would be important?

GP8: I think the person would be more motivated. So, when I talk about HRT, for example, women worry about their breast cancer risk, but there's a bit of a lack of awareness about alcohol and breast cancer, or being overweight increasing your risk. So, actually, if I say that those things increase your risk more than the HRT, then people are a bit more motivated to kind of make those changes.

Q: Okay, yeah, yeah.

GP8: So, if we could say we know that the top two things that you could do are this, then it would be a bit more specific.

Q: Okay, yeah, yeah, thanks for explaining. Okay, so then the other risk management option would be to take risk reducing medication such as Tamoxifen. I was wondering if you could tell me a little bit about risk reducing medications that you might prescribe within primary care currently.

GP8: For breast cancer or just generally?

Q: Yeah, just in general, yeah.

GP8: Yeah, so we do, yeah, a lot of kind of chronic disease management, so, when you're talking about QRISK things like statins.

Q: Oh yeah.

GP8: So we prescribe a lot of statins. Other kind of cardiovascular – well, also, you know, even your blood thinners, so your anticoagulants, they're preventative for stroke and things, with people that are known to have an irregular heartbeat. And again that's based on a risk score as well. So, yeah, it's definitely common, but it's just things that we're really familiar with and that have been around for a long time. And we know about the monitoring that's required and quite happy with the kind of patient counselling side of things, yeah.

Q: Hmm, mmm. Okay, then, so what do you think about primary care discussing and prescribing breast cancer risk reducing medication?

GP8: Yeah, I think to me that is quite unfamiliar, but that's my – I guess other people might be more confident with those medications. So we have a formulary of things that we can and can't prescribe and, as I mentioned, I think Tamoxifen is under specialist supervision only. So I guess that would need to change if we were going to prescribe it directly, or it could be amended to that, you know, under certain circumstances we could.

[40:19]

Q: Hmm, mmm. So is there any different – anything different then if you consider – like you said, that you prescribe statins for cardiovascular risk, is your opinion any different, like to think of taking a medication for breast cancer risk?

GP8: Yeah. When you put it like that, why should it be any different? I think, because in my mind those medications are for treatment, and they’re started in the hospital, it’s not something that we would start, but that feels quite different. But if we had the appropriate information and – yeah, I'm not sure about any monitoring requirements either. I don't think there would be any specific ones, but, yeah, I guess it's all about learning about it and having – gaining experience of using it.

Q: Hmm, mmm, yeah, yeah. How acceptable do you think it would be to yourself and like your colleagues to take on that role of having more discussions about breast cancer risk reducing medication and what else would be needed to help you take on that role? So I know that you've mentioned a couple of things.

GP8: It definitely feels less comfortable than the lifestyle advice because that's what we're used to. So I think I would probably prefer breast team or somebody to start that medication and then we could – if somebody was fine on it and they haven't had any issues, we could continue it, which is I guess what we'd normally do with the treatment side of it. But, yeah, I don't think it's a particularly dangerous medication, it's just something that we don't do at the moment.

Q: Okay, yeah. So why would you feel more comfortable, then, if it was – if a breast team started it? Or how could we make you more comfortable with initiating it, aside from, like you said, that maybe guidelines would need to change?

GP8: Yeah, like everything, I guess having some training or some education around it, um, having the confidence that it's a safe thing to do in GP because it’s not what we’ve done before, so why is it different now? And, yeah, like anything, I guess being aware of the side-effects and things that we should be telling people about as well. But, again, some of my kind of more experienced colleagues might feel quite comfortable with that, I'm not sure.

Q: Hmm, mmm, yeah, no, that's fine. So what professional group would be in a position to have those discussions and prescribe it?

GP8: Yeah, so the GPs with the guidelines, yeah, and then potentially some of our pharmacy team as well, especially if it's on a framework. So they can definitely counsel around medication use and then some of them might be able to prescribe but they could even counsel and then send us the prescription if everything is being met.

Q: Okay, yeah, thank you. Okay, a bit of a different question this time, but can you tell me about the impact Covid-19 has had on your practice in general?

GP8: Yeah, so I guess I joined my practice kind of on the way out of Covid. I think we have quite an older population, so we're doing a lot of face-to-face now whereas I think a lot of practices are still doing a lot of telephone.

Q: Okay, yeah.

GP8: From where I worked previously, I think, you know, we definitely saw women face-to-face if they had concerns about a breast lump and I guess some people might not have come in about those kind of genetic concerns or risk factors if they thought that we were too busy. But in general, I would say that we're kind of more – a lot more normal than we were a year or eighteen months ago.

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

GP8: Yeah, I think it's probably been a negative one in that we've been prioritising other things, and patients as well. I think uptake of screening in general was lower during the pandemic, people not wanting to come into the practice or thinking that the appointments weren't there. So, yeah, I think it probably is a negative impact that the pandemic has had.

Q: Hmm, mmm, yeah. Do you see that impact potentially being long-lasting in terms of your responsibilities for like – in prevention?

GP8: I think it depends on patient perceptions of the GP practice. So I think our practice, because you can come in, you can book direct, face-to-face, we don't really have an awful lot of online stuff, whereas some of the practices do. I'd like to think that we'd be catching up with people that have been missed over the last couple of years. So I'd hope that it wouldn't have too many ongoing impacts in terms of prevention.

Q: Okay, cool, thank you. Okay, so how do you see breast cancer risk assessment and management fitting in with your practice currently, like do you think that there's a place for it in the future?

GP8: Yeah, I think there is a potential place and that might mean expanding our team a little or having some extra hours to kind of – to bring that in. I guess I don't – it would vary between practices in terms of how many people we have in an age group that were eligible as well. Some of the practices, this would be much more workload, I guess, than others. Yeah, I think, from what we've talked about, there's nothing that is really difficult or that we couldn't do, it's more about – thinking about logistically how that would work and who would be leading on it in terms of staff.

Q: Hmm, mmm, yeah. Okay, so if you were to think, then, logistically, and answering your own question then that you just said, what – like if we think overall, like what model do you think would work best, because I know we've discussed different things, like in terms of it being externally-led or – yeah, just basically to summarise kind of what you would envisage primary care's involvement being in it?

GP8: Yeah, so like with all kind of risk assessment and screening, we'd definitely be encouraging patients to go if it was offered. I think my probable – at the moment my preference would probably be that it was external and those results either communicated by the external group or potentially with us, as long as we had very clear guidance about what happened and who went where in terms of onward – you know, if we weren't prescribing the medication, then who would they go to and such.

Q: And could you just say a little bit about why you’d prefer an external service?

GP8: Yeah, so I think mainly our workload at the moment and trying to fit that into what is already quite a busy practice. And I guess one thing I haven't mentioned is that, if we did get extra staff, we don't really have enough space for extra staff, so we haven’t got clinical rooms. So I think a combination of trying to fit that in, potentially having to bring the patient back when they could have it all done in one go, would be preferable, to have it done elsewhere. And but I appreciate, you know, that may not be possible and we might take some responsibility for their discussion afterwards which I think would be okay as long as there was really good guidelines and training around that.

Q: Hmm, mmm, yeah, okay, thank you. So do you think setting up a pathway for breast cancer risk assessment and management activities for this age group of thirty to thirty-nine years is a worthwhile idea?

GP8: Yeah, yeah, like I said at the start, I'm not really sure how it would be introduced and whether there'd be a group of people that felt a bit left out in the middle, but I do think it – you know, it is a big issue and increasing awareness and trying to decrease risk would be of benefit, yeah.

[50:01]

Q: And finally, are there any other issues which you think would be important to consider, that you've not mentioned, if we were to set up a pathway for this?

GP8: What was I going to say [pause] I think it – with that kind of thing, if there was like three different chunks to it, um, you know, what happens if they don't bring back the saliva or what happens if they don't come in for their history bit, because then who would do that chasing? Because I guess we can do quite a lot of chasing in GP and it's just really time consuming. So would that responsibility lie with the patient and that it would be their responsibility to bring it back or would the risk assessment service contact them and say, we've not received your saliva, or just how would that work in terms of getting all of it complete together so that you can get a meaningful result.

Q: Okay, yeah, thank you. Okay, so that's all the questions I had. Thank you for your time today, I really appreciate it. Is there anything you thought you would talk about today which you haven't had a chance to say and you want to mention?

GP8: No, I don't think so, um, no.

Q: No, okay. And what was the most important thing that you've told me today, do you think? The take-home message [laughs].

GP8: Um, that's tough because we've talked about a lot.

Q: Yeah, we have [laughs].

GP8: I think, I really like the idea of reducing risk and improving outcomes, but I think the practicalities of it are not easy at the moment in GP.

Q: Hmm, mmm, okay. And why’s that, what practicalities do you mean?

GP8: So just time and staff, yeah.

Q: Okay, cool, thank you. I'll stop the recorders now.

[END OF RECORDING – 00:52:08]