**Title: FG4\_03.08.2022**

**Interviewee/s: GPR 8, GPR 9, GP 2, GP 3**

##### Interview Date: 03.08.2022

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

Q: Okay, so, in order to help the transcriber distinguish between voices, please can you each introduce yourself, and if you feel comfortable sharing what your profession is and whereabouts in [place] you currently work. I’m just going to start with the person at the top of my screen, so that’s GPR8, if that’s okay.

GPR8: My name’s GPR8, I’m a GP ST3 working in [place].

Q: Thank you. GPR9?

GPR9: Hi, I’m GPR9, I’m a GP ST3 working in [place].

Q: Thank you. And GP3?

GP3: I’m GP3, I’m a GP partner. I work in [place], which is quite close to –

[Screen freezes]

Q: We’ll just move onto you for now, GP2, if that’s okay.

GP2: I’m GP2, I’m a GP. I work in [place], at a practice there.

Q: Are you back, GP3?

GP3: Yeah, sorry, I think my internet is a bit unstable here. I’ll try to change rooms. Can you hear me?

Q: Yeah.

GP3: Did you get what I said before or shall I do it again?

Q: If you wouldn’t mind just doing it again, yeah thank you.

GP3: Yeah, yeah, I’m GP3, I’m a GP partner. I work in [place].

Q: Okay, brilliant, thank you so much everyone. So, breast cancer becomes more common in women in their thirties, and it’s the most common cause of death in women aged thirty-five to fifty. So, before the age of fifty years, at least sixty-five percent of women who develop breast cancer do not have a family history and 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. Women identified as being at increased risk could then be offered earlier breast screening, as well as methods to reduce breast cancer risk. So, just to start off with then, I was wondering 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.

GP3: I mean, when I first read about it, my feeling is quite split, because in a way, is it a screening test? Are you offering a screening test? But then breast cancer, when we talk about screening tests, you know, is there any cure? Would it give people unneeded, unnecessary anxiety? Because are you offering them a double mastectomy if they have a high risk? I’m a bit – because you can’t really modify the breast cancer risk, you know, in a lot of ways. I mean, things like obesity, alcohol, yes, but usually, from my understanding, you know, quite commonly, young women are genetic, so you can’t really alter that. So yeah, my feeling is a bit…

Q: Yeah, so we’ll come on to talk about – there are a couple of things, like preventative measures that could be taken. We’ll come onto it later, but women can take a medication to reduce their risk, so that could be a potential outcome of this, if we were to introduce it.

GPR9: I agree, I also felt a bit split. I think my initial reaction was, great, I’m sure women would love to sort of know their risk and things, but then, like GP3 was saying, I feel like there’d probably be a lot of unnecessary anxiety around it. And I hadn’t thought about double mastectomies and things like that, whether anxiety and things around it would be a little bit concerning, but then I don’t know how many people would necessarily want to know compared to those that would be over-anxious.

GPR8: I’m kind of on the other end, just to be a bit controversial, just in terms of, you know, like the QRisk score, for example, if you actually put a risk into something understandable – I think if somebody does have those increased lifestyle factors, like alcohol use, smoking, those kind of things, hormonal contraception usage, then those are modifiable risk factors. So, if someone said to me, you know, “You’ve got a higher risk of developing breast cancer than the next person,” it would really make me reconsider that extra glass of wine I had at the weekend. But I completely understand from the anxiety side of things. It’s quite difficult if you have no modifiable risk factors. But then equally, maybe it would make you a bit more prone to - motivating people to turn up for appointments and self-check, do breast checks, so yeah.

GP2: Yeah, I guess I would – I don’t necessarily have a problem with the idea of it or onward referral, and like GPR8 is saying, there are things that are modifiable. And as you have mentioned, obviously, there’s chemo preventative measures that can be undertaken. I guess for me, really it’s in terms of how that risk assessment would take place, in what forms so who would be responsible for it. Obviously, you talked about things like SNPs in the pre-reading, but they’re quite specialised blood tests, so who does those, and how it would organise itself in primary care would be my main concern with it.

Q: Okay, yeah, we’ll come on to discuss that in more detail, about, yeah, how it’s organised. So, one potential approach is for breast cancer risk assessment and some aspects of risk management to be conducted in primary care, so what are your immediate thoughts and reactions to primary care involvement in breast cancer risk assessment and management?

GPR9: I think it depends how much extra work that would be in the day to day, because – again, take an example of QRisk, it’s fairly easy to just sort of quickly do a QRisk in terms of whacking it all into EMIS and it comes out with a score. It’s a fairly easy consultation to have. If there was a similar system for breast cancer risk, that’s easy enough to do the score, but actually that consultation is very different to saying to someone, “Oh, you’ve got an increased risk of developing cancer,” than it is to say, “We probably need to put you on a statin.”

Q: Could you explain a little bit more about what you mean when you say it’s different?

GPR9: I think that there’s probably more fear from patients, and it’s a more difficult conversation to have, to sort of put that into context for that specific patient, especially if you’ve got a patient population with maybe a low educational background that might not understand risks and percentages and things, that can be a longer, more time consuming consultation to have.

GP3: I mean, for me, if I got my, you know, PCN director hat on, I’d be really – I think, you know, from a day to day – you say, you know, what you need for the risk score, we can easily do it in primary care, because it will be part of our NHS healthcare check anyway. However, it’s the results, you know, like GPR9 was saying. If we can have like some help with the results, like, you know, with the cervical screening, you know, any abnormal results go directly, straight to colposcopy. I mean, if there is support that, you know, any abnormal result will go straight to a central system and they can counsel the woman, I think that would be easier for us. But otherwise, you know, we’re so stretched already.

GPR8: Yeah, I’m kind of – immediately, I thought what the others have said, you know, we’re kind of already doing the risk – you know, when you look at the list of the things that you sent over, the weight and smoking status and all those kind of things, we already do that and we ask about that automatically anyway, so we probably have a lot of that data already within EMIS. But then it is – you know, the blood test side of things, and having the time to discuss that risk, would I feel – I mean, if it was me getting an Accurx through saying, “Your results show that you’re at a slightly increased risk of breast cancer, here’s lots and lots of information about it,” I probably wouldn’t worry that much, because I know that I should probably not drink and do some more exercise. But then, you know, if you don’t have that education and medical background, you’d freak out [laughs]. And I think, yes, if we could have an extra system or, you know, just like a specialist nurse, somewhere where you could refer these patients to – but then how do you decide what’s a high risk, how do you decide what’s a low risk. You know, with QRisk, we’ve got a ten percent cut-off, but why is that deemed high risk versus something else. And I feel like, if I had any kind of increased risk, that to me would be a high risk anyway. So, I think it’s really difficult. I think, on the surface, it’s a really, really great thing, and I’m so passionate about improving access to healthcare for women. I think it’s really sad that it’s all women on this call and there’s no men, but I think that’s a symptom unfortunately of the society that we live in at the minute. But I guess it’s how do we make it work in practice so that we don’t just create a really anxious generation of women, with no adequate support. And I think we just need to make sure that we’re adding in that support later on, after we’ve got the [inaudible 0:10:41].

[0:10:43]

GP2: I think it’d be interesting to know like what rough percentage would be expected to come back as a high risk for onward referral, because – you know, I know we keep mentioning QRisk, but I guess that’s one of the only other kind of risk statuses that we do. Obviously, it’s not uncommon at all, you know, for people to come back high risk on that, so, you know, that does take a lot of time really in terms of educating and counselling patients for that. So, if you were talking like only one percent would come back needing onward referral, you’re probably talking about the very occasional patient, whereas if you’re looking at more like ten percent, I think then that would be looking at a bigger burden really on primary care. So, you know, it would be interesting to know a bit more information about things like that, what kind of – you know, what workload would you foresee it being, you know, how big a workload would it be really, before I think we could truly say whether we’d be happy to take it on or not.

Q: So, you’ve mentioned there about, for instance, like impacts on workload. Is there anything else that you would think that would affect the acceptability of primary care being involved?

GP2: I think probably like education and knowledge, because I don’t think your average primary care doctor would understand some of the genetic alterations and SNPs and stuff. So, I think, you know, if we were conducting those tests in primary care and also breast density, I don’t think that’s extremely well known about. So, I think those factors would probably require training and lots of education for primary care. And it’s a difficult one because I can see in some practices, they may start to be comfortable with nurses leading on stuff like this, in terms of risk assessments and education, whereas at some practices it will become quite heavily doctor led, I think, if it’s quite specialised. So, you’re talking in terms of access to appointments for patients, that probably would be another issue as well. Depending on where you work, access to GP appointments can be very difficult at the moment.

GPR9: That’s a really good point actually, ‘cos imagine getting, you know, like you were saying, an Accurx through saying, “Oh, please contact your GP about your cancer risk results. Oh, we’ve not got an appointment for four weeks, sorry,” it’s not going to make anyone feel great.

GPR8: And also I guess it’s that inverse care law, isn’t it, because women who are in lower socioeconomic groups generally tend to smoke more, drink more, so then the risks are higher. The difficulty in accessing appointments is already higher because it’s difficult. So, then I guess, in those areas, additional help or somewhere outside of the GP practice would be really helpful to send patients to, or even just like a phone appointment with a specialist nurse, but then is that really necessary if they’ve just got modifiable lifestyle factors.

GP2: And I don’t know if you know about things like QOF?

Q: Yeah, yeah.

GP2: You know about that. So, the reason that things like QRisk – well, cervical screening’s national, but, you know, the reason why QRisk, for instance, it is part of QOF and chronic disease reviews. So, unfortunately, if things aren’t necessarily within QOF, they don’t always get done to the same level. I’m not saying that’s right, but that’s the truth of it, if I’m quite honest.

GPR9: Yeah, if I had a little pop-up alert saying, “Encourage this patient to get her screening,” then it would remind me, whereas if I just see a patient that’s thirty to thirty-nine about whatever problem they come in with, I wouldn’t even think to suggest it to them.

GPR8: I guess maybe it would be helpful in terms of prescribing. So, if you were prescribing any kind of hormonal medication that may have a slightly increased risk of breast cancer, if you had the screen result within EMIS, and then you had a trigger within EMIS that said, “Consider alternative medication, consider alternative contraception, because this patient is a smoker, a drinker, a young woman, therefore has a slightly higher risk of developing breast cancer, a family history of breast cancer,” I guess like those kind of things could be quite helpful to modify the risk, from a clinician point of view.

GPR9: But then equally, I feel like I get so many pop-ups about [inaudible 0:15:39].

GPR8: Yeah, I know, I know, pop-up fatigue [laughter].

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

GPR8: I think it would be really, really easy, ‘cos you can just batch message people. Whether or not they respond is another matter.

GP3: But it’s the aftermath though, after you invite them, do you have the workforce to do the height, the weight and everything. I mean, it’s all down to funding, isn’t it? If we get funding to do it then, yes.

GP2: Yeah. So, I think my summary of it would be, we’re very well placed to do it, obviously we’re probably the only people that – well, unless you did it as a national programme and it was taken out of GPs, it makes sense just to do it in terms of, we have access to patients, we have a lot of the information already regarding patients. However, as GP3 said, if the funding’s not there and the capacity to do it isn’t there, it’s difficult.

Q: So, you mentioned there about it being like a national programme. Do you think identifying and inviting women to this type of risk assessment – should that be primary care’s responsibility, or do you think it would work better as a national programme like cervical screening?

GPR9: I think it depends what sort of absolute numbers you’re dealing with. If you’re dealing with high numbers of young women developing breast cancer then, yes, it probably should be more of a national thing. Whereas if it’s lower numbers then, okay, maybe primary care’s better – primary care’s definitely better placed, like you were saying, with sort of sending things out. We’ve got the information. But if it’s high numbers then we’ve not got the workforce to do it.

GP2: I think what’s interesting about this is how multi-factorial it is. So, I think the difficulty we’d have with not doing it in primary care is, even if we didn’t deal with the women who were high risk of breast cancer, obviously, the measurements that you’re taking can flag up a number of other issues. So, for instance, if they came back with a low risk of breast cancer but they had a really high cholesterol, or they turned out to be diabetic, then that will inevitably get bounced back to us anyway. So, it depends really I think what you’re measuring, whereas with screening programmes, it’s usually one test. So, you know, if you’re looking at cervical screening, you’ve got one test for that, your mammograms for breast screening or your aneurysm screening, you know, and it rarely flags up anything else. So, that’s what I would – that would be the difficulty of taking it out of primary care, that we may then end up with lots and lots of correspondence about other things that aren’t breast cancer related actually, that are more – and obviously we should know about those things, but that again is another stream of workflow.

GPR8: Yeah, and that’s the really frustrating thing, isn’t it, because arguably that would be an amazing thing, because then it would improve the holistic care of so many women nationwide, but the reality is we just don’t have the resources to do it and that’s the problem. I’ll stop, otherwise I’ll go off on one, but, you know, ultimately, we need more GPs, more nurses, more money, better government [laughter]. I’ll stop. I just feel like we’re not providing the best care that we could be in primary care purely because of resources, and that’s really disappointing.

Q: Is there any way – obviously, you mentioned like resources. Is there any way that this could be integrated into something else that you currently do, do you think? Or is it something that you see as being very separate?

GPR9: Annual checks and things, so for patients who have chronic diseases already, just incorporated into that wouldn’t be much extra work. If they’re going to be having bloods anyway then we could do that all at the same time.

GP2: But your age group’s probably a bit younger than that, isn’t it, for most of them?

[0:20:14]

GPR9: Obviously, if it’s going to be more your sort of Crohn’s and autoimmune things rather than a bigger number of people.

GPR8: What age do we start doing the chronic disease monitoring from?

GP2: Chronic disease monitoring is done for anyone who has a diagnosis of chronic diseases, so hypertension, heart failure, etc, so obviously they tend to be in older patients. And then your well woman and well man check, I’m not even sure what that is, but it’s forty-five plus, isn’t it, usually.

GPR9: Yeah, and it depends on ethnicity too –

GP3: Forty, not forty-five.

GP2: Oh, forty, yeah.

GPR9: You can have it younger for different ethnicities. I think Asian, it’s either thirty-five or thirty. I mean, then that could all be sort of incorporated into the NHS health check. But obviously then you’re limiting which ethnicities you’re checking in terms of breast screening.

GPR8: And I wonder almost if it could be something – if you could put a bit more responsibility on the woman and whether the pharmacy might be able to help, obviously not with the blood side of things, but whether they could do blood pressure checks and weight. But then it’s what you do with that information, isn’t it? Like if you come up with a score, where do you go with that information?

GPR9: New patient checks, you could incorporate it into.

GPR8: Yeah, that’s a good idea.

GPR9: But then obviously it depends how many new patients you get and what your patient turnover is.

GPR8: Or, universities, I wonder, but then again that’s only a particular demographic, isn’t it?

GPR9: It’s actually a bit of an awkward demographic, isn’t it, because they’re too young for all of the chronic disease stuff, but they’re too old for things like university checks.

GP2: So, it would probably have to be a completely separate thing, I think.

GPR8: Yeah. It is the cervical smear age group really, isn’t it?

GPR9: If you did it all at the same time, but it’s an already long appointment for a smear, to then do blood pressure, weight, bloods, that makes it a long appointment for nurses.

GPR8: That might be the opportunity to give some information about it. So, if you wanted to give patient information leaflets or something for women to attend their cervical smear appointments, you could give them a patient information leaflet and say, “We know that particular women are at an increased risk of breast cancer. If you want to know more, visit this website.” And they could do some of the preliminary measurements themselves. But then again, I’m kind of thinking about those women who don’t turn up for smear tests.

GPR9: Then those ones that do turn up for smear tests are going to be the ones that probably turn up for the breast cancer stuff anyway, so you’ve got a sort of good background there, haven’t you?

GPR8: This is a really interesting research project [laughter].

Q: I don’t expect to have any answers after this, but – you know [laughter]. So no, it’s just because obviously this is something that doesn’t exist, so the reason we’re doing these focus groups is just to understand like, if it was going to happen, like how would it, how could it actually work in practice, or if it can’t then that’s completely fine. Like don’t feel like you have to be positive about it, by the way [laughter]. Okay, so, that’s just more of the general opening questions, just around like the general idea. So, if we just talk a little bit more in depth about the actual – how the risk is actually calculated. So, the risk of developing breast cancer is best calculated with a combination of three different measures, and [name of co-facilitator]’s just going to share the diagram so that you’ll be able to look at it whilst I read through it. So, as you’ve spoken about, the first would be a self-reported questionnaire, in which women would be asked about their height and weight, family history of breast and ovarian cancer. So, this would include how many affected first or second degree relatives and their age of onset at diagnosis. The woman’s age at first period, age of first pregnancy, oral contraceptive history and alcohol consumption. Then the second component is breast density, which is a measure of the amount of non-fatty tissue compared to fatty tissue in the breast. So, we know that women with a higher proportion of non-fatty tissue compared to fatty tissue are at an increased risk of developing breast cancer. And then finally, as you’ve spoken about, there would be a saliva sample to assess DNA, and this would look at something called a polygenic risk score, which is a combination of multiple common genetic changes into a single score, as well as looking at mutations in high risk genes, such as BRCA 1 and BRCA 2. So, I just wanted to ask a question about the first pillar there, so the self-reported questionnaire items. What do you think about primary care collecting information from women about that list?

GPR9: It’d probably be useful to have anyway, and we should have most of that information. I guess specifics, like age of first period, we probably wouldn’t, but we’re in a good position to get it and a good position to have that information for all the rest of their healthcare.

GPR8: Yeah, I agree.

GP2: That would be easy to collect.

Q: Do you think it would be appropriate to ask women to enter their own data? So, I’m just thinking about if you were to think of physically collecting this information, how would you go about it?

GP2: We are doing that more and more now, so things like – people have annual asthma reviews, for instance. They used to always come and see a nurse, and we’d collect data by asking them questions, whereas now we often send out pre-review questionnaires to patients. We do that with a lot of things. So, you know, I don’t think that would be difficult at all to do.

Q: Based on your experiences, do you think women in this age group would be happy to provide that information that way?

GPR9: I think so.

Q: Are there any issues or barriers that you could foresee with trying to collect this information?

GPR8: I guess access to a smart phone, but the majority of women in this age group tend to have access to a smart phone.

GP2: Some of it’s a bit sensitive, isn’t it? Like pregnancy could be sensitive for various reasons. So, you know, the accuracy of that – if you’re asking people to do it themselves, you would hope, if they’re doing it privately, it wouldn’t be a problem, but, you know, that’s always – but, you know, we ask them about things like this all the time.

GP3: I mean, there will be a proportion of patients who say as well, “I don’t want to know. I just don’t want to know,” so…

GPR9: Also sort of following that – ‘cos I can imagine sending them the questionnaire on Accurx, then reading it, saying, “Oh, I’ll get to that later,” then how many times do you chase them up, and who in the admin team does that. And if things get missed, how much does that matter.

GP3: Yeah, it’s a thing of – you know, if you try it and then they just don’t reply to you, then a few years later they develop breast cancer and they will say, “Well, you didn’t try hard enough, you know. If I knew…” blah, blah, blah. So, would it be opening up cans of worms [laughter].

GP2: And I know we keep saying this, but because of limited resources, this is where you do sometimes require incentivisation to do these things, you know, unfortunately.

GPR9: Also, when would you send it? ‘Cos I mean, if you look at things like oral contraception history and alcohol consumption, that could easily change between the age of thirty and thirty-nine. Like a woman could have a baby at aged thirty, then go on the pill later on. So, if you’ve done that too early, you kind of miss the risk window, unless you’re doing it really regularly, which is then a lot of extra work if you’re doing it annually, even every few years.

GPR8: I guess that’s a good question, isn’t it, how often would you have to be checking this risk. But I’m guessing that some of those risk factors would be weighted differently. So, if you’ve got a family history then perhaps that would be weighted more than two glasses of wine a week, and how you’d weight them.

Q: Is there anything you can think of that would help you to collect that information? So, I know you mentioned about Accurx, like using that. Is there anything that you’d need to be able to do this task, basically?

[0:30:10]

GPR9: An admin person sort of dedicated to it, I guess. Yeah, so they could sort of send it, then review it, whether they’ve had responses, and then send again or chase.

GPR8: You can set that up automatically. So, if someone hasn’t responded to it then the Accurx bot can send out a, “You have not responded, I am going to resend a link,” and then it will resend it. It’s terrifying how much it can do. But yeah, as you say, like how often do you keep doing it before someone then just blocks the number and it becomes a hassle.

Q: Okay, yeah. If no one else has got anything to say about that part of it, we’ll move on to just talking about more the process as a whole. So, one model of how breast cancer risk assessment could work in primary care is the development of a risk assessment tool, similar to QRisk. For example, scores for mammographic density and genetic risk could be fed into the tool, and a risk score generated once someone in primary care has entered family history, hormonal and lifestyle factors. Primary care would then be responsible for communicating the risk score and making a management plan. What do you think about primary care coordinating the process of breast cancer risk assessment in this way?

GPR8: We don’t have the resources right now, that’s the thing.

GPR9: Similar to sort of what we were saying earlier, I guess, isn’t it? It sounds great, but I don’t know practically how to do it.

GPR8: And it would need to be by someone who’s fairly experienced, I was just thinking [inaudible 0:32:13] could do it because one of the placements, but it does need to be by someone fairly experienced because it is really sensitive. Like it’s not just something you can call up and say, “Hey, you’ve got an increased risk of breast cancer. Let’s do this.” It needs proper counselling and proper time with the counselling. So, it’s just that lack of resource. I think it would need to be managed by a community hub, really, a dedicated community hub. Kind of like the breast clinic, the triple assessment, you have an extension of that and then you have breast risk, counselling, you know, where you can send them to.

Q: So, can you think of another model that would work better in terms of – I’m just trying to understand what you think the – desire isn’t quite the right word, but what would you think is the appropriate level of involvement in primary care, if you think about it as a whole process so you’ve got the actual collecting the information for the risk assessment. You’ve got the actual feeding back the risk, and then you’ve got maybe an extra bit about counselling or like referring onwards. So, just trying to understand where you think – and it’s completely fine if you don’t think primary care should be involved in any of it.

GPR8: I think it would be easy to collect the data. That’s not a problem. Whether we then fed all that data to the – so, let’s say you had like a community hub setup. So, we collected all the data, we have the patient databases. We get all that data through, let’s say, Accurx, through a questionnaire, and then all of those with a specific score get referred on automatically to a community hub. So, they get a reply saying, “Your score is xyz. We have referred you on to the community hub for further advice.” Or if your score is low, “Congratulations, your score is very low, there’s nothing you need to do at this point. We’ll reassess your score next year.” I guess the issue is going to be as well though, if you have a fairly high score, if that waiting list is a year long, you’re then sat there knowing you’re at a higher risk of breast cancer and actually you’re not going to be seen for the next year. I think I would be really, really worried if it was me, just knowing that I’m at a high risk and no one’s doing anything about it. But in terms of getting the data, I think that would be super easy to do, and then referring automatically to a community hub.

GP3: I just think that, you know, for us to really roll it out in primary care, involving all of us, in a service that’s already quite stretched, we need to know how sensitive are these tests. With this high risk, you know, what can you actually offer to the patient? Because just like, you know, the covid vaccines, it was a national crisis, we all muscled in and it was just done perfectly and beautifully. But, you know, if you’re telling us that this is a test and we gather all the data, but then we’re just sitting on the results, like GPR8 was saying, you know, nothing much we can do. You’ve got to wait until they’re a certain age or breast cancer comes. Then, you know, what is the point of wasting our time really to collect all this data, all these things, and how many lives are we going to save. I think that’s what we need to know, how many people are we going to identify, doing all this.

GPR9: If there was something like a specialist nurse or something like that that was able to take on the role of discussing this, doing the counselling and things – but then equally, if there was some sort of automatic way of saying, “Okay, well, your risk is increased because of your weight, so here is an automatic referral to Be Well to manage your weight and lifestyle.” Whereas if it’s more sort of starting things like Tamoxifen then that does need someone more specialist then with more time and more knowledge than an everyday GP’s going to have necessarily. So, from that side of things, perhaps they’re more appropriate to be started by things like breast specialist nurses attached to a breast unit, perhaps. But things like the, you know, weight and alcohol, we can sort, but maybe just having the sort of logistics of saying, “Okay, this is the reason why you’re at risk, this can be sorted” – but obviously it’s more difficult when you think of things like family history and things, because we can’t do anything about that in primary care.

GP2: So, sorry for asking a question, but am I right in thinking what you would say is – say we would collect all this information on basically lifestyle and family history factors, and then if they came up as higher risk, would that then entitle them to be having mammograms, in terms of to assess the breast density, or is it a combination of all three factors?

Q: Yeah, no, so it’s a combination of all three. So yeah, that comes onto a question that I had about – so, obviously, we’ve spoken about the first bit quite a lot in terms of the actual lifestyle factors and the family history. Then there’s also – there would need to be a saliva sample collected, and then they’d need to go for a mammogram as well. So, the idea is that - obviously, we know that you don’t perform mammograms in primary care, but it’s just if there was a tool that already – you know, this is in an ideal world – already had the information from those two parts, and then you were putting in like the final piece with the lifestyle and then you’d get a risk. Then it’s to ask you as well, do you think it would be appropriate or make sense for primary care to be involved in the saliva sample collection too? If you think about it as a complete process, like how would you envisage it working?

GPR9: They could just come and collect it. They wouldn’t need appointments. They could just come and collect, self-swab, a bit like with the FIT tests and things. We’d barely need to get involved with that. It would just be interpreting the results like alongside the family history and the self-assessment questionnaire.

Q: What type of tests did you say then, GPR9, sorry?

GPR9: The FIT tests for bowel cancer screening and stuff.

GPR8: I guess you’d need to be very careful that they wouldn’t get missed though. ‘Cos with the FIT tests, like specific people are called for the FIT tests, aren’t they, and someone goes through all of the results, do they, or not [laughter].

GP2: It’s a screening, isn’t it? So, in terms of FIT tests, it’s like centralised screening, basically. So, we get feedback on who hasn’t responded, and then there’s again standards for us to meet in terms of chasing those patients, but in terms of the results and things, they are all dealt with centrally.

GPR8: Okay, so it would need to be a similar system.

GP2: But this isn’t screening, is it? This is risk identification, so it’s different.

[0:40:05]

GPR8: So, then somebody would need to be going through all of the saliva samples.

GP2: Not necessarily, but in terms of – it wouldn’t be a national screening programme, would it? It’s a national risk identification programme.

GPR9: I guess those patients would be volunteering anyway, so then the onus would be on them to come and collect their saliva sample kit. And I guess in theory they –

GP2: Or similar to the FIT, could it not be sent directly to them from somewhere central?

Q: So, aside from resources and like capacity issues, are there any other types of barrier to being involved in the process more than just being involved in the data collection for the lifestyle factors?

GP2: From the GP side, [name of main interviewer], or from patient side, do you mean?

Q: No, from primary care’s perspective.

GPR8: Do you mean in terms of accessing hard to reach patients or just resource wise?

Q: Yeah, just if there’s anything else beyond like that you don’t have the resource to do it. Is there anything else about the topic or about something that you’d think, “Oh, primary care professionals wouldn’t engage with that?”

GP2: I think knowledge really, if I’m honest with you. Like I think, you know, the limit really of our involvement in breast cancer risk is referring to family clinics, basically, for instance, to the genetics clinic. So, you know, we do not spend lots of time doing genetic counselling, you know. We’re not experienced in that, if I’m honest. We’re not experienced in relaying results of BRCA genes and high risk genetic mutations to patients. So, you know, we don’t have the expertise in that. I’m not saying that couldn’t be learnt, but you tend to be more willing to do things that you’re familiar with and that you feel comfortable with, and I think a lot of GPs wouldn’t feel very comfortable in discussing genetic risk to patients.

Q: Is there anything you can think of that could be provided to help primary care have more of a role? I know there you’ve obviously mentioned maybe some sort of training or education for the knowledge aspect.

GPR8: Money, time and more GPs, controversial. I mean, ultimately that’s what it comes down to. I mean, I probably don’t have a huge… I get twenty minute appointments, so, for me, yeah, sure, I’d be happy to do it, but, you know, the salaried doctors and the partners have ten minutes, and I honestly don’t know how they get through their day. So, then asking them to do extra counselling on top of that, I just don’t think it’s possible.

GP2: Yeah, I mean, at the minute, you’ve got basically, you know, really high demand for appointments for other acute medical complaints, so I think it’s – in terms of rollout of something like this, it really – I think you’re talking time, education, training, and you’re probably looking at – well, I would say, specialist type clinics that would be more – within the community, that’s fine, but would probably be better placed at getting numbers through.

GPR8: Although I guess at our practice, we, well, used to have a diabetic nurse who came every week, and we’ve got a mental health nurse who comes every other week. We’ve got a dietician who comes every week or every other week. So, then I guess you could have something like that, like a specialist nurse who comes once a week, talks about all of the risk.

GPR9: Sort of shared between the PCN or something.

GP2: Yeah, but this is where I think information on the – what I was saying before about what percentage you’re looking at, because really, you could do self-reported questionnaire, which just requires someone manning an Accurx, basically, or some sort of system like that. And then you could have swabs sent directly to them, so you don’t have to really get involved in that. And if our only role then was looking at things like onward referral, you know, if that is one patient a month, that’s not a massive workload really, do you know what I mean? If you’re thinking that’s going to be twenty to twenty-five patients a month for a practice, that’s a whole clinic, do you know what I mean, or more than a whole clinic. But, you know, that’s where I think you need an estimate of, you know, what you’re looking at in terms of numbers, really.

Q: So, based on the work that’s been done with risk stratifying the breast screening programme, when they kind of extrapolate it to this age group, they kind of are predicting that twenty percent of women would be picked up as sufficient risk to be offered either the screening or the medication.

GPR9: They’re quite significant numbers actually, aren’t they?

GP2: But then probably more reason for us to have some sort of risk stratify – if it is twenty percent of women who at the minute wouldn’t be getting anything, who could potentially benefit from preventative measures, that’s probably more of an incentive for us to do something.

Q: So yeah, we’ve talked about it more as a process, so if we speak more specifically about the recommendations that there would be for management of increased risk. So, two strategies that have proven benefit in reducing breast cancer risk are maintaining a healthy weight through diet and exercise, and limiting alcohol intake. And the other strategy is taking risk reducing medication, such as Tamoxifen. These risk management options would need to be discussed and offered to women who would be identified as increased risk. I think we’ve touched on this briefly, but what do you think about primary care providing lifestyle advice about reducing breast cancer risk?

GPR8: I mean, I feel like we kind of give the lifestyle advice anyway, you know. There’s like a national push for weight reduction programmes now. Smoking cessation is already within our targets. But then how are we picking those patients up, because if it’s just an overweight woman who’s smoking, who’s not coming to the doctors, then we wouldn’t know about them. So, if they were approached nationally in a specific age group then you probably would be picking up more women with modifiable risk factors, who you wouldn’t ordinarily pick up. Hmm… I can’t remember what the question is [laughter].

Q: It’s just basically, do you think it’s your responsibility to be involved in that part of the process, in terms of giving lifestyle advice?

GPR9: Yeah, I think so. I think that that’s sort of what we’re doing regularly.

GP3: Yeah, we do that anyway, yeah.

GPR8: I do think there’s more of a public health element here as well though, because obesity is definitely, you know, a – would you class obesity as a medical problem, I guess, or a community, population health problem. And if those people aren’t consulting as patients with the doctor then there is more of a higher level need, a population health, public health level need to promote weight reduction strategies. How do we do that in a safe way? Do you do targeted advertising? You know, it comes back to the sugar tax, all those kind of things, and education in schools. It’s part of a much wider problem, and I don’t know what the answer is for that. Because you would have to pick up - those people who were overweight may not realise they’re overweight until we highlight it to them. So, if you’re missing those people because they’re not consulting with you, you’ve lost that opportunity to talk about their modifiable risk factors. I don’t know if I’m making sense.

GPR9: And I guess, if we’re sending sort of an automatic questionnaire to those patients anyway, then we’ve got the opportunity to pick them up for all the other sort of health benefits that go alongside it, even if they’re not engaging with the practice at the moment.

[0:50:36]

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

GP2: I don’t think there is. I don’t think we’re as used to doing it for cancer risk. So, I have started to do that more now because I do a lot of HRT prescribing. So, a lot of the time, I will now talk about weight for breast cancer risk, because obviously adding in HRT, in some people and in some forms, does increase risk of breast cancer slightly. So, I have started to do that a bit more, but I don’t think we’re very used to doing it for cancer risk, apart from smoking and lung cancer, so we do that a lot. I don’t think we’re very used to doing weight in terms of – that might just be me, but I don’t think we are as used to talking about weight for cancer. I think we do it much more for cardiovascular health.

GPR9: Yeah, I agree. I wouldn’t think about referring to weight management for cancer risk, but then I don’t think that it would be any different to what I would do anyway.

Q: Are there any other issues or barriers to primary care providing lifestyle advice?

GPR9: Waiting lists, they’re sometimes a bit of an issue. Different areas have better facilities for weight management.

Q: Do you think there’d need to be anything in place – GP2, you just mentioned there that you might not be used to having these kind of conversations. Do you think there’s anything that could be provided to help with that, or do you think it’s just not necessary, that you can just talk about it?

GP2: Maybe bits of training and updates and, you know, things like that are helpful. Visual tools are really helpful for – or I find them really helpful to have discussions about risk with patients. Risk is quite a complex concept to understand actually for some patients, so simplifying it, you know, in terms of out of ten or out of a hundred, you know, that kind of visual tools and that are quite useful, I think.

GPR9: Like on EMIS, you can sort of get the diagram up for the QRisk side of things, and actually that’s really helpful. I use it less now that we’re doing a lot of telephone consultations, but actually when we were doing face to face more, that was really easy, to say like, “Okay, well, you could be of these ten people, but like a statin will drop it down to this many, but I just don’t know which one you’ll be in.” That made it a lot easier to visualise for me and for patients.

Q: Okay, I’m just going to stop this recording.

[End of FG4\_03.08.2022\_part 1]

[Start of FG4\_03.08.2022\_part 2]

Q: Okay, so the other strategy that I mentioned was risk reducing medication. So, what do you think about primary care discussing and prescribing risk reducing medication, such as Tamoxifen?

GPR9: My initial instinct was no. Like it sort of scared me a bit. I’ve never started prescribing Tamoxifen, and I think that I’d be a lot more comfortable continuing it after it had been initiated by someone in secondary care.

GP3: I mean, is there any monitoring that needs to be done as well with Tamoxifen, like osteoporosis risk and all that? So, that will add a lot to our workload and also our budget. And there’ll be people who aren’t suitable, then what do we do?

Q: Would you mind talking a little bit more about why you’d use the word – like you feel uncomfortable, GPR9?

GPR9: I think because it’s not something I’m used to prescribing at all, so I’m not familiar with things like side effects, monitoring, like GP3 was saying. How do I know when to stop it, like which of the patients in the high risk group would just be the lifestyle modification, which ones would be for Tamoxifen, those sorts of things like I don’t know about. So, how can I prescribe safely if I don’t know about it?

Q: Does anyone else have any other thoughts on their confidence –

GP2: I might not necessarily be confident prescribing it, but I think the flipside to that is I guess there are things that maybe ten, fifteen years ago that we would never have foreseen – that we wouldn’t have felt comfortable doing in primary care, that we now do. So, you know, things do change, and a lot of sometimes our beliefs are held because of what we’re traditionally used to doing. So, I think, you know, again, it’s all to do with training, education, how common things become, you know. If you look at the management of diabetes, you know, that’s transformed in the last ten years and we’ve got used to doing it. So, it can be done, but it’s more about again having the knowledge, and also how common it would be. Like I say, with diabetes, it’s really common we see patients with diabetes, so we get used to doing things ‘cos we’re doing it all the time. If we’re doing one per three months Tamoxifen prescribing, we’re not going to – you know, you don’t get that confidence up with it. And then I guess the other issue with this is that you’re talking about a group of women who are potentially wanting to become pregnant and fertile, so, you know, you still – obviously, the average age of having a baby is going up and up, so, you know, you’d be looking at risks of that in women, and risks of endometrial cancer. So, I think there’s some medical reasons and also kind of personal, professional confidence reasons why we would probably struggle with it, but not to say they couldn’t be overcome.

Q: Is there anything that you think could be provided beyond like training or education, to feel more confident in discussing and prescribing risk reducing medication?

GP2: Maybe if you had a contact like at the breast clinic, some people you could easily ask for advice. Or, you know, if there was like a hub or, you know, a team that could facilitate it, that might be helpful.

Q: How about anything to do with like adaptations to infrastructure or guidelines, or that kind of thing?

GPR8: If we had some clear guidelines, that would be amazing, but I feel like, the more we talk about it, the more I’m becoming a bit less optimistic about this [laughter] being led by primary care, and like the better it would be to be in a specialist clinic. I hadn’t even considered the pregnancy element of it.

Q: Okay. So, it’s taking everything into consideration. It’s really good that you said that, GPR8, because I’ve noticed that in other focus groups, that people change their minds through the discussion. So, it’s just more to like finish on kind of – so, the question is, do you think setting up a pathway for breast cancer risk assessment and management activities in primary care is a worthwhile idea?

GPR9: I think it’s a good idea. I don’t know whether it could be fully done in primary care. I think that primary care can really, really contribute to it, because we’ve got so much of the information, particularly in terms of the like self-assessments and things like that. I think that the next stage is the bit that’s more difficult in primary care. So, I don’t think it could be fully left with primary care, but I think it could be sort of a shared care.

GP2: Yeah, I would agree with that. I think we can facilitate it, but I’m not sure we could run the whole thing.

GPR8: Yeah, I agree.

Q: What do you think about that, GP3?

GP3: Same, I think we can definitely help, but we can’t run the show.

Q: Are there any other issues that you think it’s important to consider if we were going to attempt to set up a pathway, or if there was just going to be some primary care involvement in it, is there any other issues beyond what you’ve already discussed that kind of jump out, like, “Well, that would have to be considered?”

GP3: I think you would have to have an opt-in and opt-out option.

GP2: Yeah, and I think you’d have to have, like I said before, really clear guidance or a clear pathway, on women who are identified with high risk of other things, how that gets fed back to – you know, if it was, say, taken away from us and they did a self-reported questionnaire that went somewhere else, how is that information – who’s responsible for feeding it back, how does it come back to primary care. You know, there has to be really clear lines of accountability within the pathway, I think.

GPR9: Also, for those patients who know that they’ve got a strong family history, whether or not this could be used for them. So, for example, in younger women, more in their twenties, who have a strong family history, how could it be used for them as well.

Q: Yeah, so it’s currently envisaged that the first stage of it is currently like an online questionnaire, but if women indicate on that that they’ve got like a strong family history then they’d almost be referred out of the risk assessment part and they’d be referred to their GP to get a referral to a family history clinic. So, that’s currently the idea. So, yeah, like later this year, we will be doing a trial of breast cancer risk assessment in women in this group, just to assess the kind of feasibility and acceptability of it. But we’ve chosen a particular delivery model, but the point of me doing this study is to understand like how it could look potentially in the future, if we show it does decrease mortality and has the evidence base behind it. Yeah, that’s kind of like the next steps with it. Does anybody have anything else to say before I stop the recording?

GP2: No, I don’t think so.

Q: Okay, cool.

[End of recording]