Title: I2\_22.02.2023

Interviewee/s: ANP1

Interview Date: 22.02.2023

Interviewer: Q

Q: Zoom, and I have pressed it on the audio recorder as well. Okay, we're good to go. Okay, so just for the purposes of the introduction of the interview, would you mind just introducing yourself, saying a little bit about your profession and what area of [place] you work in?

ANP1: Yeah, my name is [name] and I work as an advanced nurse practitioner in a rural practice in [place]. We've got five sites at the moment that we work from and see sort of a wide variety of people, from, you know, babies to elderly care, and everything and anything in between. We – we have sort of a higher population of elderly, you know, patients in our demographic.

Q: Okay, great, thank you for that. So as a researcher who does not work in primary care I am not familiar with what happens in practice.

ANP1: Yeah.

Q: I'm not sure if this is something that you would deal with in your role but wanted to check, would you ever deal with a lady that – in the age group of thirty to thirty-nine years that presents with a concern about breast health?

ANP1: Yeah, yeah, quite often, because I see most of the first presentation. So that would be anybody that's – from anything that's just worried about some breast pain, right up to lumps, to suspected cancers, and we can refer on the – we have a two week wait referral system. We have the non-urgent referral system for the younger category when we're not suspecting – you know, when we've not found the two week wait issue but there's still a concern. And then, yeah, we have a fantastic service in [place], that's pretty much a one-stop shop to – you know, they go in and everything's done in one day and they come out either knowing that there's a problem or there's not a problem. So, yeah, we've got a really good service in this area for that.

Q: Okay. So how do you feel during those interactions with women in this age group if they come in with a concern?

ANP1: Quite confident, and I think understanding of why they might be worried, and I think that's something we always try and find out is what is it you're worried about? Because some people have a family member that might have breast cancer or have had a scare, so it might be that they've come in more because they're concerned because of the bigger picture. You know, some people come in with specific things, you know, and I'm quite happy to deal with anything and just, as I say, trying to get the woman's opinion and what their worries are is sort of always the first job, really.

Q: Hmm, mmm, yeah. So you said there that you feel quite confident in those interactions.

ANP1: Yeah.

Q: Could you tell me more about why you feel confident?

ANP1: I think because we've got such a good referral system, that all I have to do is ident – I have to obviously talk to the woman, which I'm always confident talking to patients because you're just finding out the history, you're just finding out the details, what their – as I say, what their worries are, what their concerns are. Finding out the facts that are relevant to what's going on; is there any reason why it could be that this is the problem, you know, you’re sort of finding things out, so, for example, about contraception and medical history and things like that, medications. So I'm quite confident doing all that side of things. And then, as I say, because I know we've got a good referral system, I know that if they're not a two week wait referral, I know I have a sort of an asymptomatic referral pathway, that they'll be seen usually just a little bit slower but will be seen within two weeks that's referred. So, you know, I think they sort of still have quite a high-level sort of of reaction time. So, yeah, I'm quite happy, because I think I know we've got the services there to back us up. So I just see myself really as a – almost like steering, you know, committee, of just getting them to the right place, so that we know they're being seen.

Q: Okay, great, yeah, thank you so much, that just helps my understanding with that so thank you.

ANP1: Yeah.

Q: So, if we move on to talk about the topic of today's interview, 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.

ANP1: Wow.

Q: But 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.

ANP1: Right.

Q: So, currently we don't have a defined systematic mechanism to identify this group of women.

ANP1: Sure.

Q: 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.

ANP1: Yeah.

Q: Women identified as being at increased risk could then be offered earlier breast screening as well as methods to reduce their breast cancer risk.

ANP1: Hmm-hmm..

Q: So I was just wondering if you could tell me first of all, what are your immediate thoughts and reactions to offering women the opportunity to find out their breast cancer risk estimate from the age of thirty years?

ANP1: Sure, yeah, I mean, I think it's a good thing, on the whole. I mean, you'll always get a few – sort of a certain cohort of patients that will get worried by any pre-assessment risk assessment, you know, that we then have to manage that, sort of almost that anxiety or, you know, that risk. But I think, in general, I think anything that puts the person at sort of the – you know, almost in charge of their health risks, I think it's a good thing, because I think if forewarned is forearmed. If you know there's a risk you can – you know, you can sort of take steps to lessen that risk. So, I think, yeah, it's a good – all for any screening that's done, done properly, on a national system, whereby, you know, like the bowel screening and the – you know, the sort of different things, or the breast screening that's there at the moment, anything that's done sort of with the evidence behind it.

Q: Okay, yeah, so could you explain a little bit about what you meant when you said about it being done properly?

ANP1: Mainly because there seems to have been an upsurge recently of private companies offering these sort of assessments, risk assessments, that aren't necessarily done with the evidence behind it.

Q: Oh, okay.

ANP1: And are done almost as sort of like a – I don't know, because I suppose any assessment is always going to be like a blanket, sort of, but I've seen it whereby they're sort of – it's not targeted at everybody, it's just targeted at people that can afford to pay for the assessment and that to me, then, is worrying. If it's done so it's for everybody in that age group, regardless, then I'm all for it, you know, because that to me then is done properly, rather than cherry picking out these private companies that sort of say, if you can afford the £100 to go and have a blood test, that your doctor would have given you anyway, that's when I get a little bit sort of not so keen. But, if it's a national scheme that's done for the good of the whole population of that age group, then, yeah, great, brilliant.

Q: Okay, thank you. So you mentioned there about potentially for some women this might cause anxiety, I was wondering if you could tell me about any other concerns that you could think of with introducing this.

ANP1: Yeah, not really, because I think, you know, sort of any pre-assessment – sort of any screening like that is going to bring sort of decisions for people to make, which can always be a – you know, sometimes can be a big thing to act on. Whether you – you know, whether you'd choose to act on the information you're given or not. So it could bring about some really difficult, you know, information. And I think – but I think as long as people are counselled beforehand as to, you know, what the test – how – what it's going to show and what sort of level of reassurance they can almost garner from that, because what you don't want is people thinking, right, that's fine, that's told me I've got no risk at all, and then sort of almost not reporting any symptoms that they might have, you know, so I think that's the – because, you know, assessment like – sort of the proposal, it can sort of highlight who's at more risk. But what it – I suppose it's not going to necessarily highlight is people that have got no connective risk. So, you know, if you were just the first person in your family to have breast cancer, there probably – there might not be a precursor for – you know, there might not be sort of anyone in the family. So, you know, I suppose if – just to make sure it's done in such a way that the patients realise it's not a categorical, what you find, you’re not going to get it or your risk is this. So that the patients don't then, as I say, just take it on – because they don't always listen to what's being told to them, or don't take it in, should I say, probably, that's being a bit harsh, don't take it in. So they – you know, I would imagine initially there'd be a lot of assumption that, well, that's all fine and – you know, so that would be the slight sort of concern.

[10:16]

Q: Hmm, mmm, yeah. And can you think of any other benefits? So I know you mentioned about having – being able to manage risk moving forward.

ANP1: Yes, yeah, I think that sort of – I think managing risk is the crucial – and sort of by doing it I'm assuming that they'll be the ones – it's going to sort of highlight – you know, like with the cervical screening, you're going to catch these people that are very much at the sort of forefront of – you know, that might have some of the symptoms now but haven't actually come in or – I think anything that gets people talking about it a bit more, it makes us all a little bit more open and – because I think, as healthcare professionals we're all very open, we talk about anything, we're not that bothered, but it surprises me how many people are still quite reluctant to talk, not even about sort of intimate problems like sort of breast areas, you know, sort of – I've had people come in with sort of awful lesions on their legs, that have turned out to be cancerous, because they've just – they were too embarrassed to talk to anybody about it. And, you know, there are still people out there like that, so, you know, I think anything that can sort of just make people a bit more aware is going to be good.

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

ANP1: Yeah, I mean, it's like anything, all of the NHS is under huge strain at the moment. I mean, if it was funded appropriately, given the right time so that it can be done properly, you know, then fantastic. I don't see it needs to be a secondary care issue. I think we're sort of well placed to do it, we do an awful lot of sort of work in response – you know, like from sort of babies, from child imms to – you know, we do a lot of sort of programmes. I'm trying to think of the things now we do in the school. We do like the HPV and we do the screen – the cervical screening when they, you know, get to twenty-five. So I think the systems could easily be put into place, I don't see that, with appropriate funding, there's an issue at all. And I think sometimes, you know, if we've got to see them to then refer them or something like that, then you're just making two people busy, whereas if it can be done safely in one person, you know – or not person, but one sort of way, then, yeah, in a way sometimes the less people involved the better, you know, as long as the systems would be in place to take on the information that's gained from it. So, you know, if they were screened to find a problem, that then there's sort of a robust pathway, then fantastic, yeah.

Q: Hmm, mmm. So how do you –

ANP1: But obviously I don't pay the wages [laughs], so it's easy for me to say this.

Q: So how do you think this would be best organised then, because I know you've been – like you've mentioned there about like cervical screening and bowl screening?

ANP1: Yeah, I mean, I don't quite know, I mean, whether – it's a difficult one, because I don't know whether what you're – in a way, what you're proposing, would it involve any sort of physical examination or any blood tests or any – you know, I don't know what the sort of proposal would be for how to assess. If it's a questionnaire, if it's a series of questions, but that could be done – as I say, we have quite a lot of contact with this age group with contraceptive issues, so it could be done in sort of a – we have a lot of sort of templates and questionnaires that we could send out to the people. We do it for asthma reviews, diabetic reviews, so in a way it's not dissimilar to just another form, it's just what physical things would need to go with it. But, I mean, health checks are done by our HCAs, so it might be that it’s a series of questioning that they could do. I suppose the difficulty is, again, the age group, is actually them wanting to access it, fitting in with the general practice nine to five sort of style at the moment, and how willing they are, because not always – they’re sometimes quite difficult to get in for things to be done. So smears are often an issue because of them accessing the services. So it might need to be like a primary care service that's not necessarily in a GP surgery, but, you know, some sort of way of having sort of an easy access to it for them.

Q: Okay, yeah, yeah, that makes sense. Okay, yeah, so we'll come on to discuss what the actual risk assessment would look like, and that might change your mind, but –

ANP1: Yeah [laughs].

Q: It's good to get your initial thoughts of it. So I suppose, yeah, my last kind of introductory question then, is what are your immediate thoughts and reactions to primary care involvement in breast cancer risk assessment and management, in terms of how acceptable do you think it would be?

ANP1: Yeah, I don't see that – I think we're sort of well set up for it, because I think we've got, as I say, a whole different range of skill mix of people. We've got from like the HCAs, to the nurses, to us, to doctors, so I think there's a whole tier of people that could easily deliver it, as I say, depending on what your proposals are, really. But, yeah, I don't see it being a major issue if it's funded properly. As I say, that's the issue, I just know how busy services are, so, you know, that's the only concern.

Q: Okay, yeah, great, thank you. Okay, I'm just going to try and share a diagram with you, just because it's a bit easier to – let me know if you can see it or not.

ANP1: Yeah.

Q: Yeah, can you see that? Great, perfect.

ANP1: Yeah, I can.

Q: Yeah, so this is essentially just what – an overview of what the risk assessment would entail for a woman. So we know that risk of developing breast cancer is best calculated with a combination of three different measures, which are represented here in the diagram. So the first part of the risk assessment would involve a woman completing a self-reported questionnaire, and this would be asking questions about known breast cancer risk factors. So that will be things like height and weight to work out BMI, family history of breast and ovarian cancer, age at first period, age of first pregnancy, oral contraceptive history and alcohol consumption. A second component of the risk assessment would involve a woman attending for a mammogram, and this wouldn't be to – wouldn't be used to detect cancer, it would be used to assess what we call breast density, which is a measure of the amount of non-fatty tissue compared to fatty tissue. And the reason that we’d do this is that women with a higher proportion of non-fatty tissue are at an increased risk of developing breast cancer.

ANP1: Hmm right, okay.

Q: Yeah, and then the final component would involve a woman providing a saliva sample so that we could do a DNA analysis. So this would look for multiple common genetic changes which are associated with breast cancer, and these are combined and it forms something called a polygenic risk score, whilst also looking for those mutations in high risk genes, that you might have heard of, like BRCA1 and BRCA2. But because this population we're looking at don't have a family history, it's unlikely that they'll have those high risk genes, but they could still be at increased risk because of these smaller common genetic changes with the polygenic risk. So essentially, that's an overview then, of kind of what the woman would have to undertake for the risk assessment. So the first question is around – so if you take the first aspect, which is the self-reported questionnaire, what do you think about primary care collecting information from women about this list of breast cancer risk factors?

ANP1: Yeah, I don't see it as a great issue depending, really, a lot on where the next stage is done.

Q: Okay.

ANP1: Because it might be that if our only part in it is doing that questionnaire, it might be that that could be sent to the patient with their sort of appointment to go and have this mammogram and sort of, in a way, duplicating workloads. So it's poss – you know, yes, it could be done that's quite sort of straightforward, it's just that you don't want to dilute the amount of times that they're seen and it's sort of – you know, really, I think wants to be just a catch-all. Whereas like the smear, we sort of – we see them, we ask the questions to look for risk. In a very similar way, we do that, then we do our smear sample and the risk sort of factor for – then comes back for what like their risks are, as well as whether there's any problem at the moment. So, yeah, I think I'd – the only thing I'd be worried about is would we be diluting it or making it less attractive for the patients to come in if they've then got to go two places.

[20:16]

Q: Okay, yeah, that's makes sense. What do you think, then, about the saliva sample, then, as well?

ANP1: Yeah, that could – I mean, that's something that could be done. That's not a – if we were to do those two parts of it, then, you know, that's not an issue. And I suppose it depends on how the mammogram – is it sort of a – is it a full mammogram or is it something – is it a different piece of kit that might be developed that could be rolled out to sort of primary care units, whereby, you know, other people could be trained to use it? You know, again, like with cervical smears it's – oh, sorry, that's just the delivery guys, I won't be two seconds, if that's okay.

Q: It's okay, no problem.

ANP1: [Pause whilst answering door] Right, I'm back.

Q: Okay, no worries. So, yeah, we were just talking about the saliva sample.

ANP1: Yeah, that could be something that could be easily done, but, as I say, with a pre-questionnaire, I don't see that's an issue, because I'm assuming that would – a bit like the Covid test, would give you an instant answer, that could be just added to the – you know, the questionnaire part.

Q: Okay, yeah, hmm, mmm. So are there any key difficulties or barriers that you think there would be for primary care involvement in each of these three things?

ANP1: Sure. My only thing is their age group and their access to coming into the surgery, they're a difficult group to get in, that would be my only thing. I don't see an issue from primary care outwards, but I would say the issue would be more from getting the people to come in. But having said that, if it's looking at something like this and the risks of developing it, then you're going to have a certain cohort that are really going to be keen to find out that risk. And then you're going to have this sort of – again, this cohort that thinks they're invincible and thinks, oh, no, it's fine, I don't need to worry, I'll be okay. So, you know, I think you've got that – so I think that would be the challenge, more at getting the people to come in rather than the actual what's needed to be done.

Q: Okay. And so what do you think could be done to facilitate access for women?

ANP1: I think – hmm, that's a difficult one. Um, I think it's just got to be sort of something that's, in a way, sold that it's something that's going to be useful for them. Inasmuch as the screening that we've got at the moment is done here for the same reasons, and you're always going to get your people that will come and you're always going to get your people that just don't want to know. So I think there'd need to be sort of – you know, I think TV, I think anything that sort of gets people aware of what's out there, because, you know, then they can understand what's being looked for and – so I think anything like that, that's sort of – and I suppose using a lot of social media to access these people. Because they're in a group, they're not coming from university age, they're – you know, they're an older group, so slightly – we don't have as much contact with that age group apart from like contraception, you know, but there are out sort of – outside sort of contraception clinics that are run in sort of separate units sort of for people that can't access. So it might be that’s something that's – it’s still primary care, but not actually in a GP surgery. So there might be other ways that they could access this that's not just in the nine to five, Monday to Friday category. So there might be sort of other ways that would make it easier for them to access. But that, I think, is the main concern – main issue, I would say.

Q: Yeah, thank you. So, as you were mentioning about like the questionnaire element of it, like collecting that information, how would you envisage that being collected in terms of would that be with a person at a practice or – how do you think would be best?

ANP1: I think it would probably – if we would be doing the saliva samples, it's something that could be sent out to them as a – so that they had it before they booked it – you know, when the appointment was booked, so it could be ready. Or it could be done when they're in there because it's only like sort of an addition to the identifiers that we currently use for various things, you know, name and address and – you know, you've just got a few extra things, like the weight and the – you know, so it could just be added on to the console. I wouldn't imagine it would be – make a huge addition, really, you've just got to weigh somebody and, you know, a few other things to add on there that – you know, as I say, it could either be done that the questions were already sent out so they have an idea and it's going to be poised, or just doing it when they're in there for the saliva sample.

Q: So what professional group do you think would be able to do that?

ANP1: Um, I mean, I don't see why the HCAs couldn't do it, I really don't. I don’t think it needs to be – I think anybody that could have some training, you know, they do diabetic reviews, they do – and they do that with training of knowing what's expected and what they're doing it for and why and – so I think with anything like this, I think possibly that, but I definitely think practice nurse level. I don't think you need to be any higher, necessarily, than that. But, yeah, I would think that, probably, HCAs would be quite, you know, sort of prepared to do it. And I think it would be quite within their sort of skillset to be able to, really, yeah.

Q: Okay, yeah. Okay, so if you think about it again as a whole, so one model of how breast cancer assessment could work in primary care is the development of a risk assessment tool similar to QRISK, which is used for cardiovascular risk. For example, scores for mammographic density and genetic risk could be fed into the tool and a risk score generated once someone in primary care has entered like the family history, hormonal and lifestyle factors, so the things from that questionnaire.

ANP1: Yeah.

Q: What do you think about primary care coordinating the process of breast cancer risk assessment and management in this way?

ANP1: What, so us sort of almost being in charge of the whole part of it, do you mean?

Q: Yeah.

ANP1: I suppose, in a way it's like cervical screening in primary care, I suppose in a way what I'm thinking is that, well, I work in general practice and thinking, well, I don't know how we'd do all that. But I suppose it's not that, is it, it's primary care, so they could be like the screening teams that are primary care-based. So there would just be another screening team set up for this type of thing, so I don't see why it wouldn't work really well. Because I think if you've got specialist – a specialist sort of group doing that for this sort of – you know, for the – that cohort of patients, then everything's just sort of dealt with and – as I say, same as the cervical screening and all of the other screening programmes. I'm just – yeah, I'm just getting a bit confused between primary care and just us, I'm thinking I don't know how we'd do that [laughs], but, yeah, I think it would work quite well in primary care, and, in fact, I think it's something that secondary care needn’t see anything of unless there were, you know, things that triggered – you know, because I'm assuming there'll be certain things that would say, right, well, this triggers a, either that there is a problem or that there's a high risk of a problem, so what do we do next? So that, to me, is when secondary care need to swing into action.

Q: Okay, then, so you said there about like the difference between kind of primary care, as in at the actual GP surgery and like the screening team, could you just tell me a little bit more about – because I'm not – I don't know a lot about how that kind of screening is set up.

[30:08]

ANP1: So we have – in [place] we have – again, I'm not too familiar because I don't do the smears now, so, but there is an [place] sort of organisation that takes responsibility for all of the screening for the smears. So people are sent the invitations externally from them to book an appointment with your local practice to have your smear done. That's all done by the sort of almost like – I say central arm, but central to your area. And then they are responsible for getting everybody trained, they sort of are responsible for keeping the registers of people, so that everyone's trained to do what they should be doing. They're responsible for making sure that all the results are in and, you know, saved correctly and that anybody that's needing any onward treatment is – you know, so, really, they have the responsibility for everything.

Q: Okay.

ANP1: Yeah, and it goes from what's sort of – sort of what sounds like a fairly simple, oh, let's just do a swab, and off we go, there's a lot to get that in – you know, in place, if you like. So I think giving it sort of a separate hub, if you like, just means they would get to do everything properly. And, as I say, whether they then farmed that out, and said, right, I want you to do all the questionnaires, you to do all the, you know, the saliva samples, you know, then that’s sort of to me how it would work. And whether they would then in a primary care capacity organise the equipment like with the sort of – because there are breast screening vans, which I do believe is primary care-run, I'm not 100% sure, but I'm fairly certain the breast screening is primary care, in which case this would sort of, in a way, fit quite nicely in with work that's already being done, so yeah.

Q: Yeah, okay. So, if we move on to talk a little bit about the actual management of risk, how would you feel about communicating the risk score and making a management plan?

ANP1: Again, I think there would be fairly defined sort of information with it as to, right, this is your risk, and a bit like the BMI charts, I imagine it would be on sort of almost like a colour coded almost graph, that was fairly visible so you could see where you were in it and in the risk factors as to – and how far and what things could make the risk less, you know, what's going to make things worse. So I think – yeah, I don't think – I think we're quite well placed to sort of delivering that information, really. And, as I say, it's going to be done – we'd have the training of knowing what to do and at what point, so yeah, I don't see that being an issue.

Q: Do you think it should be primary care actually communicating the risk score?

ANP1: Yeah, I don't see why not, really. I think there's no different in – as I say, to the cervical screening. Yeah, I think they're quite sort of mirrored, really, in a way, so yeah, I don't see that as an issue.

Q: Hmm, mmm, okay. So are there particular aspects of the process that you'd feel more or less comfortable with if we were thinking about involvement in the assessment side versus communicating risk versus management?

ANP1: Yeah, no, I don't think so, because I think, as I say, we see it as a tool. So, if we'd got information that we could tell people is going to help, then, yeah, I'm sort of confident enough to crack on with it. I think that is where, I think, if the patients come back, I think that's where that needs to be delivered by the other end of the practice team, the ANPs, the GPs probably more than the nurses and the healthcare assistants. Because obviously that's quite a difficult conversation, you know, maybe to have with some people, depending on what the results are going to tell them and, you know, because obviously we don't know at the moment what the proposal would be. You know, sort of if you told them the risk, at the minute we don't know what that means in the context of that person. Does that mean we're looking at surgery, does it mean we're just looking at it – mammograms, does it – you know, what does it mean? So I think at the moment, not knowing, it's just a little bit unclear as to, you know, what that sort of would involve us doing.

Q: Okay, yeah, yeah.

ANP1: But some of us would be able to do it, in one way or another.

Q: Can you think of any difficulties or barriers to communicating that risk score and helping a patient develop a management plan?

ANP1: Um, no, not really, no. I think only, you know, that if the patients don't want to know the information, but you would assume that if they've come in for the test, that they want to know. So I just see that – no, I don't see that there are any particular barriers for that at all.

Q: Okay. Is there anything that you think would be required to take on that role successfully?

ANP1: Um, I think probably that side of the thing, rather than the actual just taking of the test, the delivering the risk, I think, yes, that will need specific sort of training and knowledge, so that you are well versed with what it all means, what the – you know, and sort of, for example, if you told someone – I mean, I don't know how it would be delivered – but say there was a category from one to ten, and one being okay, ten being not, I'm assuming that each sort of sector, almost, would come with a, well, this is what the risk means. This is what we're looking out for. This is the red flags for – and these are ways that we could probably reduce that risk. So I suppose each sections going to have a – almost like a for and against plan, if you like, of what sort of – what that means. So I think if you've got that, then, yeah, I think that's what we'd need, just good training, really.

Q: Okay, yeah. Yeah, thank you. Okay, so if we move on to talk a little bit more about management, so the output of a risk assessment tool would also include recommendations for management of increased risk. So 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.

ANP1: Yeah.

Q: In addition to this, two strategies that have proven benefit in reducing breast cancer risk are maintaining a healthy weight through diet and exercise and limiting alcohol intake and taking risk reducing medications such as Tamoxifen. These risk management options would need to be discussed and offered to women identified at increased risk. What do you think about primary care providing lifestyle advice about reducing breast cancer risk?

ANP1: Again, I think it's something that we could do, with appropriate time to be able to do it, so we're able to do it properly, and training, so what people are telling the population is the right information. Because I think it's too easy to think, yeah, we can do that, we can add that in, but then not given the proper training to do it. And I think that's where it would become a problem, because you need to know that we're all working in the same way, which is where this sort of separate – almost separate unit works quite well, of sort of one group of people doing the whole thing, in a way lessens those issues. But, yeah, I think we're certainly placed to do it if we've got the proper training and, you know, time.

Q: Hmm, mmm, okay. So do you think there's anything different about providing lifestyle advice with respect to breast cancer risk in comparison with other diseases?

ANP1: Not really. I mean, I'm not necessarily saying the patients are going to take it on board, because I think lifestyle advice is one of those things that, if they want to hear it, they'll hear it, but on the whole people filter out of a conversation the bits they want to do or they think they can do, and ignore the rest. So, if we're seeing someone with a chest infection and we're saying, look, I really think you would be better sort of stopping smoking and doing this and doing that. And, you know, it might be that for the first sort of few weeks you perhaps try and cut down with a vape or something, a lot of people would take that out as, yeah, the doctor says I've got to really stop smoking, but a vape'll be alright and I can just switch off. You know, so they'll miss out key factors, so I think that's sort of the issue, really.

Q: Okay, yeah. So who would you envisage providing this lifestyle advice, if we think, again, about what professional group would be appropriate to do that?

ANP1: Yeah, I would probably say nurses and advanced nurse practitioners because I think they're better at taking on board, you know, what is sort of, you know, like that. If you're giving that sort of information, I think that would be, yeah, better delivered by them, because they're very good at that in their diabetic reviews and, you know, what they're already doing. So I think they'd be well placed to – you know, I think the training wouldn't need to be – doctors shouldn't need training in that sort of thing, but I just think it comes better, perhaps, from a nurse, I would say.

[40:20]

Q: And what are your reasons for feeling that way?

ANP1: Pardon?

Q: What are your reasons for feeling that way?

ANP1: Mainly because, I think, as I say, there's a lot of sort of health promotion almost like a fatigue. People, I think, on the whole, know what they should and shouldn't do and my worry would be that the doctor would just – they'd almost switch off because they're almost expecting the doctor to say you shouldn't do this, you shouldn't do that, you must do this. And so I wonder whether a nurse would be able to deliver it in a slightly more – I don't know, it might be doing a big disservice to doctors, because I'm sure there's a lot of doctors out there that would be doing it very good, but I just think nurses might have that little bit more time and a little bit more sort of personnel skills, that might get that message over there a little better, yeah.

Q: Yeah, thanks for explaining. So, aside from the patient themselves perhaps not listening or taking on board the advice, are there any other issues or difficulties that you think nurses or ANPs would have having this discussion with a patient?

ANP1: No, not really. No, because you could document what you've discussed, so that – you know, it's like anything, there's the risk that people are going to come back and say, well, they didn't tell me that, you know, so I think that needs to be sort of – that would need to be part of almost like a template that could be used, to say that each bit's been discussed. And maybe some sort of take-away sort of assessment result, if you like, of the information and basic health promotion advice could be given, just to sort of reinforce what's being said, I would say that would work quite well.

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

ANP1: Yeah, it's sort of things like cholesterol medication, blood pressure medications. In some groups there's this – you know, some sort of talk of sort of diabetic preventative meds, although that's a bit of a grey area. I'm trying to think of other things. I mean, there's sort of clots you know, things that you would take for prophylaxis and – I'm trying to think what else there might be for – I'm sure there's thousands, but I'm just not thinking of them off the top of my head.

Q: No, it's fine.

ANP1: But I would say, yeah, cholesterol, lifestyle-wise cholesterol is one of the biggies of blood pressure, some of the big ones. But there's an awful lot of sort of preventative stuff given, that when we know that someone's at risk, you look to try and reduce that risk. So this is, you know, potentially could be another tool. So, again, if they hit that risk factor, then I see no reason why we shouldn't sort of, you know, give that medication to – you know, because it would be – again, it would be in a fairly easy to identify cohort, it's not going to be, ooh, shall I give it to this woman because her hair's blonde or – it's going to be on set information, isn't it, and if they don't hit that point, that they're not going to get it, so yeah.

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

ANP1: Yeah, again, I have no problem with it, really, because I think it's just a different way of addressing some of the risk factors that are out there, it's just we don't do it at the moment. So anything would seem a bit strange if you first started doing it, but if it's – if the evidence says that this is going to actually help, then fantastic, you know, because it's a cruel disease and if it can stop, especially, the younger people, you know, having this sort of – you know, the early breast cancers, if we can stop any of those, we're going to have huge – you know, it's going to have a huge impact on, you know, the patients and, you know – well, the impact to the NHS, you know, the costs of treating these cancers. So, you know, I think it could be fantastic to sort of get on board doing it. But I think, like anything, it's just a new thing and it would be a – you know, a lot to take on and you've just got to get your – you know, your sort of – get the processes in place so everyone's doing it properly.

Q: So who do you think is best placed in the practice to have that discussion and be able to prescribe?

ANP1: About the medications?

Q: Yeah.

ANP1: I think that would need to be doctors, and I think ANPs could easily do it, because, again, it wouldn't come with – you know, it wouldn't come with the information on the back of a fag packet, it would come with proper training and protocols and – you know, so, again, it's no different to me prescribing someone that's got high blood pressure or a high cholesterol, looking at the charts and saying, oh, right, well, your risk factors are this. We do risk factors for cardiovascular disease, so this is just a similar thing in a different field. So, you know, your – the scores and the numbers and the risk would almost lead you to what you need to do. They either do need the medication or they don't need the medication and, you know, that's sort of going to stay there until sort of they're reassessed. So I don't see why that's a problem, again, for that to be done in sort of primary care at all.

Q: Hmm, mmm. And why do you think that that would be more appropriate for doctors to do?

ANP1: Because, again, I think it's – not necessarily doctors on their own, but doctors and nurse practitioners, mainly because they've got to be a prescriber to be able to issue it. So, you know, I just think, rather than them seeing a nurse and them being able to counsel them on what they should do, and they're still going to then need that prescription.

Q: Yeah, of course.

ANP1: So that would be the main thing. But, again, we work some of these things out, like sort of pill reviews and things and then they sort of do all the risk stuff and sometimes then they just come to us, and say, right, this person wants this. They're a risk factor so and so for the pill or for this, or whatever, and then we say, right, well, shall we give this one – you know, they'll say that the patient would prefer to have this or this or this. And then, you know, we'll work out what script to do and then we'll do the script for them, and then they make sure it gets to them and – so it could work, but I kind of think we're duplicating again, you know, so I think in some ways, one conversation, with one prescription, job done, really, just to save the duplication of workloads, really.

Q: Yeah, of course, thank you. Okay, so a little bit of a different question this time. Can you tell me about the impact Covid-19 has had on your practice in general?

ANP1: It's made it extremely busier.

Q: I bet.

ANP1: Apart from the sort of initial sort of months when it first came in and we all started regrouping and working out how to redo things. I think it's had quite an impact on some of the nursing side of things with the screening because, as I say, a lot of that was put on hold initially. And I think, in a way, what it's done is, it's built up a level of distrust from the patients because of the media opinion that GPs are doing nothing and that practices are closed and that we're not actually doing anything, and I think, in reality, we're doing far, far, far more now than we ever have done. So I think it's – in a way I think what Covid has done is sort of just broken down this sort of barrier – this sort of – I wouldn't say – I don't know how I'd describe it, but the opinion of, you know, the relationship between the patients and us, really. I think there's a lot of negative connotations now, brought about by the media. So, yeah, I don't think it's helped.

Q: Hmm, mmm. So what impact, if any, do you think Covid-19 has had on risk assessment and prevention in particular?

ANP1: I mean, I think it took a while – as I say, I think at the beginning it took a little while just to work out how – what we were going to do. Because we were okay, we could adapt to learning how to consult by phone and video, but a lot of this stuff, they can't – the HCAs and the nurses couldn't do by video. Our demographic of patients didn't suit video, our location didn't suit it because often the Wi-Fi was rubbish.

[50:00]

Q: No, yeah.

ANP1: You know, so there were limitations in that respect. But it didn't take us long to get back into it and, you know, we just had to sort of put a limit on some of the specific tests that were aerosol generating. So sort of things like spirometry, things like that couldn't be done, but the actual screening, then we soon realised that if we didn't keep going we were going to get so far behind with the smears and the coils and, you know, the diabetic reviews. And so, as I say, initially it had quite an impact, but then it soon started to get back to some sort of normality, albeit slightly longer appointments to make sure that everybody could do things properly. So yeah.

Q: Yeah, so how do you see breast cancer risk assessment and management fitting in with your practice currently?

ANP1: Yeah, I mean, I think, as I say, I think it depends on what sort of – what process it would be done by, whether it would be a separate agency doing it in the form of like the cervical screening. But I don't see why it would have a huge impact, really, on – you know, because, as I say, with anything, you expect, if there was a service being put in we would be paid for what we do, which then means you'd probably have another member of staff if it was thought it needed it. You know, whatever, I think there'd be, hopefully, as I say, some funding that came with doing it to allow it to happen.

Q: Hmm, mmm. So what do you think, then, is the best way of organising it, if you were to decide?

ANP1: Yeah. If I was to do it, I would set up like a separate agency, like the smear group people, so that you've got somebody in charge of the actual logistics and getting the equipment to the right places, getting the appointments to the right places, the follow-ups, the DNAs, so someone in charge of it. I'd want sort of general practice to have access to all the training so that we knew exactly what we were doing, what information we were delivering, you know, robust programmes so that we could calculate things – you know, not we calculate it, but programmes that work this risk factor out for us. And materials that we could then use to sort of give to the patients. So that's what I'd want, yeah.

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

ANP1: Yeah, I do, yeah, I really do, because I think it's a population that probably too many people are – you know, are dying and, if we could do anything to reduce that – you know, we're losing people in the prime of their lives and leaving young families without mums. And so I think anything that can reduce that risk – obviously it's not practical if you're only looking at saving one life. It is for that person whose life, you know, could be saved, but, you know, I'm assuming that this is being thought of because there is a real likelihood of benefit to the population. So I think anything is good, yeah, if it's done properly.

Q: Thank you. And are there any other issues beyond what you've already brought up, that you think would be important to consider when setting up this pathway?

ANP1: No, I don't think so, no. I think I've sort of said all the things that would worry me.

Q: Okay, yeah. Thank you. So, yeah, that's it, then. So thank you for your time today.

ANP1: Thank you.

Q: 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?

ANP1: No, no, because I didn't sort of have any sort of pre-set thoughts, so no, I'm quite happy with what we've done.

Q: Okay, and what was the most important thing you've told me today?

ANP1: Um, probably just – I mean, as I say, just hopefully helping – if it helps to sort of work out the best way to deliver it, so that it's sort of a workable service. So hopefully my sort of insight from general practice, hopefully that's sort of given a bit of info on how it is from, you know, that you may not have that side of the story, as to how to bring it in.

Q: Yes, definitely.

ANP1: So, yeah, I think that's probably our input.

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

ANP1: Okay.

[END OF RECORDING – 00:55:01]