**Title: FG3\_02Aug2022**

**Interviewee/s: GPR 7, PA 1, TNA 1, HCA 1, TNA 2**

##### Interview Date: 02.08.2022

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

Q: Okay, so that’s recording now. So, just to help the transcriber distinguish between the different voices, please can I ask each of you to introduce yourself, and if you feel comfortable sharing what your profession is and what part of [place] you work in. And I’m just going to start with the first person that I can, see which is GPR7.

GPR7: Hello, I’m GPR7. I’m an ST3 trainee in [place].

Q: Thank you. PA1?

PA1: Hi, I’m PA1, I’m a physician associate working in [place].

Q: Thank you. TNA1?

TNA1: I’m TNA1. I’m a healthcare assistant/trainee associate from [place].

Q: Thank you. HCA1?

HCA1: Hi, I’m HCA1, I’m a healthcare assistant, and I work for a GP surgery in [place].

Q: Thank you. And finally, TNA2?

TNA2: Hi, I’m TNA2, I’m a trainee nursing associate, and I work in [place].

Q: Brilliant, thank you so much. Okay, so, breast cancer becomes more common in women in their thirties, and is the most common cause of death in women aged thirty-five to fifty. Before the age of fifty years, at least sixty-five percent of women who develop breast cancer do not have a family history and this means they’re not currently identified as being at increased risk. Currently, there is no defined systematic mechanism to identify this group of women. The introduction of breast cancer assessment for women aged thirty to thirty-nine years would allow women to find out their risk of developing breast cancer in the future. Women identified as being at increased risk could then be offered earlier breast screening, as well as methods to reduce their breast cancer risk. So, my initial question then is, 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?

PA1: I think it can only be a positive thing obviously to highlight where that risk is, so that we can address it sooner rather than later. Obviously, you won’t necessarily be able to catch all of the cases, but even highlighting some – but then I guess, on the flipside, you may have women who come out with a low risk score and then they think, “Oh, it’s nothing to worry about,” when actually there may well be something to worry about. But I guess, the more cases you pick up, that can only be a positive thing.

TNA2: Yeah, I agree. I think, you know, the more we can highlight people’s risk and screen them earlier, the better, yep.

TNA1: Yeah, I’m in agreement with it as well. I think it’s a really good idea.

HCA1: I think it’s a really good idea as well, as I didn’t even realise that it affected people with the most common death between thirty-five and fifty. It’s probably shocked me a bit.

PA1: It’s not also just the risk. It’s also raising awareness that those statistics are out there, and that it can affect people young. So, the earlier we have conversations about it, the earlier people will do, you know, regular breast checks and everything as well.

GPR7: I think from the point of view of seeing people in GP surgeries, particularly when you’ve got ladies who are concerned about having breast cancer, it will be really helpful to have a tool like this. So, like the QRisk that you use is so helpful, so helpful, but it needs to be like – people need to be sure that it’s within well defined parameters as well. And I think the other thing where it’s going to be quite helpful is for those patients who unfortunately get recurrence, so they get breast cancer quite early on. So, that cohort can be identified earlier in their disease journey.

Q: Thank you. Can anyone think of any potential downsides of offering this service to women?

TNA2: The only one that I could think of is if perhaps life insurance companies started to use this information against people, if you like, who are trying obviously to secure policies. I suppose that would make the women less inclined to take up on the offer of the risk assessment.

PA1: The other thing is that people may have a bit of a blasé attitude towards it if their risk factor is quite low. They may stop doing regular breast checks and everything else that we obviously recommend, and, you know, the risk factors and things just go out the window. And then obviously that isn’t necessarily just because your risk score is low. It’s not always going to be 100 percent.

Q: Thank you.

TNA1: I think with some people as well, I think if you get told that you are high risk, it might play with their mental health a lot more, ‘cos they feel like they’ve got that overhanging them, over their head, sort of thing.

Q: Yeah, yeah. Okay, thank you. So, one potential approach is for breast cancer risk assessment and some aspects of risk management to be conducted in primary care. What are your immediate thoughts and reactions to primary care involvement in breast cancer risk assessment and management?

HCA1: I think it’s a really good way of catching people, ‘cos obviously they’re in for other reasons, and a lot of the stuff you take from them anyway, like the height and the weight and their alcohol consumption, and it’s quite easy while they’re in opportunistically to ask the other questions as well.

GPR7: I think it’s a good idea, in that you see people quite early on in their disease process, but it just worries me a little bit because you’re asking for something that’s quite specialist to be done in a generalist environment, and I’m not sure that you can risk stratify that. Because with the QRisk – and I love the idea about it being like a QRisk score, ‘cos that’s nice and easy, bam, bam, bam. You’ve got ten questions or whatever, you answer all of those. But a lot of these are like self-reported ones. And then also this breast density – they still need to go through the mammogram system, and then that’s got its own limitations as well. Particularly with younger women, there’s massive limitations there. And then this DNA analysis, I suppose that’s the one that’s the most robust like numbers wise, isn’t it? So, I’m just wondering whether – it’s a cracking idea, but I’m just wondering whether there’s enough robust numbers to make it stronger, if that makes sense.

Q: Yeah, yeah.

GPR7: Sorry [laughs], I hope that’s alright.

Q: No, no. So, you’re saying there that the evidence base is a consideration.

GPR7: Yeah, because you don’t want to – a lot of these are fairly soft, aren’t they, the self-reporting, fairly soft. And even when it says family history, should it be identified that it’s first degree relatives, second degree relatives, males. I mean, that kind of thing should go in as well, ‘cos that’s quite important, isn’t it, male breast cancer. Yeah.

Q: Thank you.

GPR7: Oh, and one more thing, there’s no smoking in there. Is smoking a risk factor for breast cancer?

PA1: Yeah, it is.

GPR7: But then – yeah, I suppose it’s like, how have these criteria been chosen?

Q: They’re part of a validated algorithm for breast cancer risk, yeah.

GPR7: Okay.

TNA2: The only other thing that I would add is from a sort of workload perspective. I suppose there is a slight overlap in NHS health check candidates, but because it starts at a younger age, at thirty, obviously, that might be considered a drawback in terms of adding pressure, increasing, you know, the services that we’re offering in primary care. It might not, you know, be received too well [laughs] by all. But I think it’s worthwhile doing, definitely, but, you know, that does need considering as well, doesn’t it?

Q: Yeah, so you mentioned there about NHS health checks. Is there anything else that you’re currently involved in that you think maybe could be adapted to include like looking at breast cancer risk? Anything else that it could be integrated with?

[0:10:10]

TNA2: Cytology, yeah.

Q: Sorry, what was that? I didn’t hear.

HCA1: Integrating into the smears.

TNA2: Yeah, that’s what I was just going to say, smears. Baby ims maybe. Postnatal checks.

PA1: Even contraception counselling appointments.

GPR7: I would wonder about these – with this tool, if it’s not robust enough then it’s not going to give you a yes answer and it’s not going to give you a no answer. And then if it gives you that middle grey area, is that a good thing? That’s what would concern me. The main thing that concerns me about this is the breast density side of things.

Q: Okay, could you tell me a little bit more about why?

GPR7: Because breast density, measuring that on a mammogram is just – it’s not very accurate at all. There’s a wide range between women. There’s a wide range between women with different breast sizes, at different parts of their cycle. There’s no real standardising of how the mammogram’s taken itself as well. Breast density, it’s relatively well known that that’s not a very good measure in younger breasts. So, that would worry me, that if they do the breast density then that would – you know, send patients down to getting breast MRI scans, ‘cos that’s the gold standard. If you’ve got a query on the breast density, on the mammogram, then that’s going to be like – I don’t know, it’s going to be directing resources away from being able to answer a question, if that makes sense.

Q: Yeah, yeah, no, thanks for explaining.

GPR7: I just want to say, it’s a cracking idea. I don’t want to be like criticising you at all or anything.

Q: Oh no, no, honestly [laughs], no.

GPR7: It’s like, no, it’s lovely, but –

Q: No, no. Just to reiterate that this is something that doesn’t currently exist, so the reason we’re speaking to people like you is to understand, is this even like a feasible thing to do, and it’s completely okay if people are like, “No, I don’t think it is a good idea.” So no, please don’t feel like you have to respond in a certain way.

GPR7: For sure, the breast density thing, you’d struggle with it.

Q: Okay, yeah, thank you. So, you’ve all kind of spoken about different potential things that might affect how acceptable it would be, like for instance workload. Is there anything else that you immediately think of in response to primary care being involved in this, in terms of how acceptable that would be and what would acceptability depend upon?

GPR7: I suppose I’ll just say again ‘cos no one else – but please somebody do interrupt me. I don’t mind at all. I suppose the acceptability side of it is how easy it is. Like if it’s easy, click, click, click, click, really happy to do that. That makes me really excited. The DNA analysis thing, you do, it’s just – ‘cos that’s all it is, isn’t it? You’re risk stratifying everybody. Everybody’s getting risk stratified, are you going to get cancer? I don’t know, yes or no. And then it’s how reliable are your yes’s and how reliable the no is. But it’s the I don’t knows in the middle. And those are the things in primary care where – that’s our bread and butter really, isn’t it, ‘cos that’s where it develops and changes over time. But it’s very acceptable. I love the idea of it, but it scares me [laughs].

Q: So, just to clarify then, does it scare you because of the breast density?

GPR7: Yeah, it does, because – so, the DNA analysis, that’s fairly black and white, isn’t it? I used to do radiology, so I changed from radiology into GP. So, the DNA analysis, that makes a lot of sense. That’s going to be nice and straightforward to do, ‘cos it’s a saliva sample, not a lot of people can get it wrong. The self-reporting, even within that, you’ve got lots and lots of data. I think if I was reading it in a paper, if I was reading it like in the BMJ, or somebody said, “Oh, this is good,” or GP Online, I’d look at the third breast density bit and I’d be like, “Uh-uh, I’m not using that,” because ultimately – like all joking aside, ultimately, what you’re trying to do is find the people who are going to get cancer when they’re thirty-one. That’s it, isn’t it? That’s the long and short of it. And then if I did use this tool, and if I still had a concern in the back of my head, I probably would still refer them to the breast screening clinic, and then that would negate the purpose of this tool here. So, I’m just wondering if it’s going to bypass, do you know what I mean?

Q: Yeah, okay. So, what do you think about primary care being involved in identifying and inviting women to a breast cancer risk assessment?

PA1: I think if it’s something that’s, you know, got all the clinical evidence and the hard facts behind it, and – okay, we’re saying that summat’s really robust now and we know that it’s accurate, then absolutely, primary care can be involved in that, because that’s where most people are going to go to. That’s where you’re going to get most attendances. You can pick them up here and there as well. So, absolutely, so long as obviously all that evidence is actually behind it and it’s robust.

TNA2: Yeah, I think providing the patients with the information beforehand, advertisement – I think recalling the patient is what we do well in primary care, so from that point of view, I think that it’s something that would probably have a good uptake, yeah.

Q: So, if we think more specifically about how it could potentially be organised in terms of inviting women – so, obviously, you’ve got your breast screening programme, which is like a centrally organised programme whereby like the letters are sent out as if – well, they’re from your GP, but the GPs don’t actually physically send them out. How do you think this would be best organised? In a similar way to the breast screening programme or in a different way?

TNA1: Would you not do it like what we do with the smears, where we just remind them when it’s due, and then we’ll send out a second reminder if they’ve not come, and then they can obviously sign a declaration to say that they don’t want it if – that’s something like we do with the smear test now.

TNA2: Yeah, I would say the same as TNA1, just, you know, each GP practice or PCN is responsible for their cohort of patients, and they’ll be sort of marked accordingly on their uptake, as we do with everything else that’s, you know, related to QOF and things like that. You just push it within your own practice.

PA1: It’s just running those searches within your own practice. It doesn’t take that long to do them. And then obviously, inviting them in, whether that’s via letter – most people have mobile phones and it’s text messages these days. Just whatever’s the easiest way. You don’t even have to do it one way. You could send a text. If you don’t get an answer from that then obviously follow it up with letters if needed.

HCA1: Really, you could have it popping up in your boxes as well, like, you know, in your QOF boxes, that they’re eligible for the breast screening, like QRisk sort of thing. So, obviously, if you’re just doing something in clinic, you could just get them to come back, and give them another appointment to come back, you know, while you’ve already got them in there. You have reminders coming up on the box obviously for everything else, so…

Q: Okay, yeah. And do you think it should be primary care’s responsibility to invite these women? If a breast cancer risk assessment service was going to be set up, do you think it should be primary care that do that?

[0:20:16]

HCA1: Because people are more likely to go to their own GP surgery, I think, to do something like that.

GPR7: I’m not sure if screening should be the responsibility of a GP surgery per se. I think having a central organising agency, like, you know, for cervical screening or for breast screening, just helps to automate it. And it’s the same with the covid vaccinations, isn’t it? That’s how they managed to get it so quickly and so effectively is that they used, you know, the GP practices to give them out, but they just used – it was external, wasn’t it, the arrangement and organisation of it. And that would probably be better done centrally because, as somebody said about QOFs and things, like things go in and out of fashion when it comes to the QOFs and all the things that you get the money for.

Q: Okay, great. So, we’re going to go on now to talk a little bit more about the three different measures of risk. So, we know that the risk of developing breast cancer is best calculated with a combination of three different measures. So, I’m just going to share the diagram that was in the pre-reading material, just so that you can have a look at this whilst I’m talking. So, the first element would be a self-reported questionnaire, which would include height and weight, family history of breast and ovarian cancer, which would include how many affected first or second degree relatives and age of onset at diagnosis, age at first period, age of first pregnancy, oral contraceptive history, and alcohol consumption. The second component would be an assessment of breast density through a mammogram, and this is looking at the amount of non-fatty tissue compared to fatty tissue, because women with a higher proportion of non-fatty tissue are at a greater risk of developing breast cancer. And finally, a DNA analysis, which 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, for example BRCA 1 and BRCA 2. Yeah, so that would be assessed through a saliva sample. So, if we could just talk about the information that I discussed in the first pillar there, from the self-reported questionnaire, what do you think about primary care collecting information from women about that list of items on the left?

TNA2: It should be quite easy to collate the information. We could even send out – like somebody else mentioned earlier, just send out a text link for an online questionnaire to collect that information, yeah.

TNA1: I think a lot of this stuff as well, we probably already have in a GP surgery. A thirty year old – you know, we would have covered a lot of that already.

PA1: The only thing is that obviously – I mean, age of first period, age of first pregnancy, people might be honest about that, and family history – again, it might need narrowing down about what family history we’re talking about, males, females and ages, and what have you, what degree relative. But then things like alcohol consumption, and height and weight, we all know people aren’t honest with us about those things, and obviously we’re not going to get an accurate reading if they’re not telling the truth there. So, that might – but then you can’t force people to tell the truth equally, so…

Q: So, I know there you mentioned that you could potentially send it out as a text link. Do you think there’s any merit in it being – if it was an in person appointment or over the phone, about like who would be best placed in the practice to collect that information?

TNA2: Anyone who’s seeing the patient really, if the doctor’s got time, if the phlebotomist has got time. If it’s just a case of marking that down and not actually giving counselling then, you know, it could really be anybody collecting the information, yeah.

Q: So, apart from the potential for people not being honest in their responses, are there any other issues or barriers that you could foresee with trying to collect this information?

HCA1: People might not quite remember when their first period was or going back as far as that it might not be accurate, what they say. They might not remember like their oral contraceptive history. Like if you try and think back to when you were seventeen, but what you took, you can’t really remember.

GPR7: There’s no questions for how many children you have.

Q: Yeah, so there’s the, yeah, age of first pregnancy.

GPR7: Age of first pregnancy. ‘Cos multi parities are – it decreases your risk, doesn’t it?

Q: Yeah, yeah.

HCA1: Does breastfeeding decrease your risk as well or…?

Q: Yes, it does, yeah, yeah. That’s a protective factor, yeah, but we wouldn’t be collecting this ‘cos it’s a risk factor, but yeah, you are right.

GPR7: So, are these the questions that you’d ask then?

Q: So, these are the questions that are in the validated tool that I mentioned, yeah.

GPR7: What’s the validated tool called, sorry?

Q: It’s the Tyrer-Cuzick.

GPR7: How do I spell that, sorry?

Q: I can write it in the chat if it’s easier.

GPR7: Oh, here we are.

Q: Yeah. Is there anything in particular that you think would be needed in order to perform this task successfully in terms of getting this information, or do you think it’s quite – you know, based on your own experiences, would it be quite easy to collect this data?

TNA1: I mean, you could use like what we have for like our diabetic patients. We have like a structure – I can’t think what the word is. But you go in, you’ll click on it and it’ll come up with a list of questions that we have to answer.

TNA2: A template.

TNA1: Template, yeah. Something like that would be useful, ‘cos then you’re not missing anything out and you’re covering everything that you need. A bit like what we do with most things in surgery now.

Q: Thank you.

TNA2: What would happen if a patient, say, for instance, was adopted, or their parents had passed away at a young age, and then obviously you haven’t got any family history?

Q: Yeah, that’s a really good question. Yeah, so there are things built into the tool for if people don’t know or are unable to get that – you know, the tool’s able to adapt to that, so it’s more likely to – it’ll always be conservative in terms of, yeah, giving you your risk. It’ll always err on the side of caution.

TNA2: Okay, good.

Q: But yeah, that’s completely valid. There will be people in that position, that obviously don’t know the answers. Okay, so, if we talk about the process as a whole. So, bearing in mind those three different things then, so, one model of how breast cancer risk assessment could work in primary care is the development of a risk assessment tool similar to QRisk. For example, scores for mammographic density and genetic risk could be fed into the tool and a risk score generated once someone in primary care has entered family history, hormonal and lifestyle factors, which are those list of factors that we’ve just discussed. 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?

GPR7: I don’t think it’s a good idea.

TNA2: It sounds too in-depth. It’s too specialist, counselling, yeah. I don’t think we’d be equipped to deal with that.

Q: [GPR7], could you talk a little bit more about why you said you don’t think it’s a good idea?

GPR7: I think it’s from the logistics side of things, ‘cos the successful screening programmes are the ones that seem to be centrally organised and arranged. It’s efficiency really, isn’t it? So, efficiency is when you’re just churning through things as opposed to – so, for example, one of the things that you have, the internal programmes that you use within the GP surgery, that updates every so often, and as that updates every – you know, after however many iterations, certain things get dropped from the templates, so there’s no like safety netting for things like that to get dropped. When it comes to doing some kind of – you know, doing a cancer tool or a cancer validation, I mean, it would just be a poor show if somebody did have a cancer and then they weren’t followed up or something because of an IT issue. So, I’m not saying it’s a rubbish – it’s a bad system, but just - I think with the screening programmes, they have their own quality assurance as well, don’t they? So, the quality assurance is going to be appropriately strong enough, because you’re talking about cancers, where young people and young women are going to die – well, hopefully not but, you know, that’s the reality of it, isn’t it? [Pause] Sorry, did I answer the question?

[0:31:34]

Q: Yes, yeah, yeah. Does anyone else have any other thoughts on how they’d feel about taking on this role, so being involved in it to a similar extent – well, a tool that’d be similar to QRisk but being more involved in breast cancer risk assessment in the way that I described?

PA1: I’d just ultimately – I think I echo what other people have said, that it’s a big risk to hold within primary care, where there’s specialist services available. Specialists are available in secondary care, and it’s probably best suited there rather than primary care where, yeah, it’s taking – obviously, we take risks every single day, but it’s a massive one, yeah.

Q: So, can you think of another model that would work better, or is it a case of – a few of you have mentioned there about it being like a specialist area, or is it just something that you think, that is out of the realm of primary care and none of it should be done here?

TNA1: I think maybe the initial taking that information’s a good idea, but then maybe you could say at the end of it, “Right, we’re going to send this off now, and if you’re a certain high risk, they’ll get in touch with you further.” Then you’ve got that specialist service on hand if they need it. I mean, I think the initial taking the information’s okay. I just think it’s after that, it gets a bit complex. You’ve kind of got your hands tied in primary care with things like that. So, I think it’d be a good idea to then say, “Right, if you’re over a certain risk, we’ll send you to – it’ll go off somewhere and then someone will get in touch with you and explain everything,” and then someone else can take over that care from there.

Q: Could you say a little bit more about what you mean about your hands being tied in primary care?

TNA1: Well, I just feel like, if we’ve got that QRisk and – well, the risk thing that we’re saying, and then you say to – when someone’s at high risk at the end of it, and then you’re going – we only have so many minutes for an appointment, and then you’re going, “Right, you’re high risk.” And then what are you going to say to your patient, you’ve got a queue of people outside, “Oh well, you’ll have to now wait for someone else to call you back.” You know, you haven’t got that time to then explain to people what it all is and things.

Q: Yeah, yeah, that makes sense, thank you.

TNA2: Yeah, I agree with what TNA1 said, yeah. You’re a bit stuck.

HCA1: Yeah, ‘cos I don’t think the patient would be happy to just walk out of your surgery when you’ve just said, “Oh, you’re at high risk of breast cancer.” I think they might maybe want a bit more information and maybe a bit more counselling which we probably wouldn’t be qualified to do.

Q: Is there anything you think that could be provided that would help you feel more comfortable with being involved in this? So, I’m thinking there about – ‘cos you’ve just mentioned there about not feeling qualified, HCA1. Yeah, I’m just thinking in terms of – like is it something that, with training, you’d be more open to?

HCA1: You’ve got the information you know, you’ve got all the tools to talk about it all. It’s just like ending the consultation with somebody just saying, “Oh, you’ve come out as being a high risk of maybe developing breast cancer,” and then the patient would be like probably asking you a million questions and you wouldn’t know the answers to anything.

Q: Yeah, okay, yeah.

GPR7: I think it would be a good idea for us to signpost people to it and for there to be information like in waiting rooms for younger people, for younger ladies. But the actual doing it itself I think would be a bit – you know like sometimes we can give FIT tests out. So, if you’re wondering if somebody’s got, you know, like a bowel cancer or something, we can give those out and we can say, “Oh, it might be a good idea to do that.” I think that would be helpful, rather than the actual questionnaires and the data being gathered within a GP surgery.

Q: So, if a tool was going to be developed that was similar to QRisk, are there any particular design considerations for that that you would expect there to be? So, is there any aspects of QRisk that you currently like that you think, “Oh, that would be good to include,” if we were to create a breast cancer risk assessment tool?

GPR7: As easy as possible [laughter], literally just tick boxes, I bloody love it, it’s amazing [laughter]. You can just hammer through which patients you need to kind of spend a bit more time with, which ones you can say, “You’re alright,” and give a leaflet to, you know. It’s very, very useful.

PA1: Yeah, and the more easy it is to use, like tick boxes, the more likely people are to use it as well. If it’s clunky and massive then, with all the good will in the world, people don’t have time to do that, so they just won’t bother.

Q: Okay. So, if this tool obviously would have some outputs in terms of recommendations 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 taking a risk reducing medication, such as Tamoxifen. So, these risk management options would need to be discussed and offered to women identified at increased risk. What do you think about primary care providing lifestyle advice about reducing breast cancer risk?

GPR7: Lifestyle advice is great, ‘cos we do that anyway. So, I expect that this would probably – so, in my mind, this kind of tool I’m thinking would probably – we would signpost it. It would go somewhere central, probably like in a breast clinic where it starts off, and for us to – and for them to discharge the patient to us, to say, you know, “Maintain a healthy weight.” There’s so many things out there – well, allegedly, you know, if they’ve got funding and things. But the advice and the lifestyle risks, and dropping those, GPs are really good. For number one, the GP is a very good place to do that. Number two, taking risk reducing medication such as Tamoxifen, that would have to be under the guidance of a specialist. Like I wouldn’t prescribe that off my own back off a tool. I’d need guidance from the breast team.

PA1: Yeah, I echo that, that obviously – lifestyle advice, 100 percent, we do it every day anyway. It may just prompt us to do it a little bit more so and to tailor it a bit more. But yeah, the medication, that would be something that you’d want to be getting it from the specialists that are recommending that to be done, and actually be there in writing that this is what they wish to initiate.

[0:40:05]

Q: So, you mentioned there about potentially like signposting to services, for example like weight management. Do you feel that that would be appropriate in the context of breast cancer risk?

GPR7: Sorry, do you mean is that a question that’s appropriate to ask?

Q: Yeah, so I’m just thinking about in the current services that you have that you would refer people to through lifestyle advice.

GPR7: Yeah, yeah, there’s so much out there. There’s a lot out there, and it’s not connected up, which is the – therein lies the problem with the system. But yeah, there are a hell of a lot of services. There are a hell of a lot of people out there who help with the lifestyle. There’s a lot of funding that’s going from councils and from the NHS. So, I don’t think the breast screening or, you know, the tool would have to worry about that side of things, if that makes sense.

Q: Okay, yeah.

GPR7: There’s enough of an infrastructure there to be able to signpost people back to the GP, back to lifestyle.

Q: So, who would you envisage providing lifestyle advice at your practice?

TNA1: Generally, us, the healthcare assistants and nurses that do it in our surgery. GPs may mention it if obviously they’re doing a consult, but it’s mainly down to us, when we’ve got them in for the hypertension and stuff like that. So, it is mainly down to us that deal with that.

HCA1: The health improvement practitioners can obviously do the lifestyle advice as well. They could give extra advice obviously about the alcohol and diet, and stuff to do with breast cancer as long as they had the training for it.

TNA2: Yeah, we have care coordinators, I’m not sure if anyone else has them in their PCN. So, we have like a learning disability, a cancer care coordinator, something that they could perhaps pick up on as well.

TNA1: I think we have a pharmacist as well that’s great at giving that advice. When she’s ringing round, doing medication checks and stuff, she’s great at it. She’ll ask all the questions as well when she’s doing that, and refer if needed.

Q: Are there any potential issues or barriers that you can foresee – well, I know you’ve already said that you provide a lot of lifestyle advice anyway, but is there anything in particular in relation to – if you were talking about it in the context of reducing breast cancer risk, is there any issues or barriers you’d have with having that discussion?

TNA2: No, I wouldn’t have said that there was any barriers that I could foresee.

TNA1: Yeah, I’m the same. I couldn’t see any barriers.

PA1: Yeah, echo that. I think we do it all day every day anyway.

Q: Okay, thank you. So, I’m just going to stop this recording and start a new one.

[End of FG3\_02Aug2022\_part 1]

[Start of FG3\_02Aug2022\_part 2]

Q: Okay, it’s recording again now. So, a couple of you have already mentioned about Tamoxifen, but just to have a bit more of an in-depth conversation about it. What do you think about primary care discussing and prescribing risk reducing medications such as Tamoxifen?

GPR7: Completely impractical. If there’s guidance – if somebody is being seen by a specialist and there is clear guidance where you know that you’re not going to cause somebody danger – ‘cos Tamoxifen in itself has got side effects, so you don’t want to be – you don’t want to be causing harm really, do you?

PA1: No, I think, yeah, exactly that, and if you have it in written communication from the specialist then they should have had that counselling conversation with the patient as well, then fair enough. But you’re not going to go off your own back and do it, and start all that counselling. That needs to come from the specialists themselves.

TNA2: I don’t think, in my role, it’s a place for me to say, really, ‘cos it’s not anything that we would get involved in, prescribing, so…

TNA1: Me too [laughter].

Q: Is risk reducing medication just something that you think is just not appropriate for primary care to be discussing at all?

GPR7: I think with the counselling side of things, that first conversation shouldn’t be with us, not the first meaty one. Like perhaps you can say, “Oh, this has come up, you’re going to be seen by a specialist. They’re going to discuss it with you.” Because the other thing is that you’re consenting people – you need patient’s consent that they’re going to take this drug as well, don’t you? It’s not just prescribing. It’s the fact that the patient wants to take it. Now, you assume that they probably will do, because if they’re in this age group and, you know, they’re more keen about their health, etc, they’re a bit more proactive, but… Yeah, I don’t think that a long term conversation about Tamoxifen from a GP is appropriate.

Q: What would you think about primary care being involved after a specialist had initiated a prescription of it?

GPR7: ‘Cos we get that quite often, like with, for example – what’s the last one that we’ve done – for example, if somebody has been seen in cardiology and they’re on like three different blood pressure tablets, and then frequently these are more complex patients, and they give us very clear parameters and they say, “If x then y, and then y and then z.” And then if you do that then, you know, you just follow that, because that’s what the – you know, that’s from the specialists. That’s what the research has shown. And then it’s all down to safety as well, isn’t it? It’s all down to safety. And Tamoxifen is more of a specialist medication, and you need to – oh, what’s it called? My brain’s gone – you need to monitor the side effects as well, don’t you?

Q: Yeah.

GPR7: So then that would be the other thing then, who’s going to fight over doing that or not doing it [laughter].

Q: Is there anything else anybody wants to add on the topic of risk reducing medication? [Pause] No? Okay. So, overall then, do you think setting up a pathway for breast cancer risk assessment and management activities in primary care is a worthwhile idea?

GPR7: Very much so, very much so, but it just needs slight tweaks to make sure that the – the secret to success is just efficiency, isn’t it, when it’s screening and it’s lots and lots of numbers. You want something really simple, really straightforward. And if we can signpost or even if we can tell people about it then that’s a really good thing as well. You know, like somebody mentioned about mentioning it to ladies in this postnatal check, that’s a great idea. Smears as well, though I’m not really sure how much people take in at smears, ‘cos they’re so worried about getting their smears done as well, ‘cos you don’t want to overload people either. It’s a balance. It’s a balance where people have got to be keen and do it themselves. ‘Cos you don’t want to be too paternalistic either and say, “I think you’ve got a twenty-five percent chance of getting breast cancer in 3.5 years’ time, therefore you’ve got to have this drug that’s going to make you ill,” do you know what I mean? At the end of the day, it’s up to patients as well. We’re assuming they’re going to listen to us [laughter].

TNA2: I think it’s a good thing. I think it’s definitely worth considering, yeah. It can only be offered to people. I’d be a bit – I don’t know. I’d be a bit sceptical though about uptake in the younger people. I think they might be a bit dismissive.

Q: What makes you say that?

TNA2: I just think that – I think when you’re talking about thirty to thirty-five year olds, they probably don’t consider themselves higher risk, yeah, and they probably try to avoid their GP surgery as much as possible [laughter].

GPR7: I wonder if, on the flipside of that though, like if you’ve got the thirty to thirty-five year olds who are high risk, whose aunt has recently passed because she’s got a BRCA 1 gene, I think that you might get quite a good uptake in those, if it’s sufficiently sold to the correct people, if that makes sense. You know, you do frequently get ladies who – I mean, to us it sounds like they’re just getting obsessed about something that’s not going to happen, whereas if you have those ladies where they’ve just had a recent – somebody’s just recently died, an aunt has recently – they’ve been to their funeral – and I’ve had this quite a few times, and they want to get checked out for breast cancer themselves, and they want something that’s quite clear. And that’s where having a QRisk score style thing, where you’ve got x percent of developing this over the next period of time, is more useful than sending them – and more efficient probably and more cost effective than sending them for genetic screening and all that kind of thing.

TNA1: I think it’s fab. Just going off what that lady just said then, I think you get some young ladies and gentlemen that come in and they’ll say something’s happened, someone close to them’s died, and it plays on their mind constantly then. Every time they think something’s wrong with them, they come in and they’re – “Oh, I think I’ve got this ‘cos my dad died of it,” or, “My mum died of it,” or, “My grandma did, and it runs in the family.” I think this is really good to give them a heads up of what – if they are high risk or not, just to kind of calm them down a little bit as well sometimes.

GPR7: The other thing that worries me about the Tamoxifen is the side effects that it has in itself. So, those are like the clots, the thromboembolism and also the endometrial changes as well. Those are both fairly significant. But then I suppose, when you’re going to be consenting people, they’re going to weigh up the risk/benefits themselves as well, aren’t they?

Q: Yeah, yeah.

GPR7: And then the other thing as well is about the… ‘Cos it affects fertility, and then is somebody going to take Tamoxifen to stop themselves from possibly getting a breast cancer, but definitely stops them from having kids. Bloody hell, that’s a long consultation there [laughter]. I’m getting a headache now thinking about it [laughter]. I shouldn’t be dismissive, but you’ve got to – it’s multifaceted, isn’t it? It’s multifaceted. It’s like you can ask a question, but do we want to know the answer. That’s it, isn’t it? And then what we’re going to do with the answer. Pass it on to somebody else [laughter]. Yeah, sorry, I’m getting tired now.

[0:10:25]

Q: That’s alright. PA1 and HCA1, do you have any thoughts on how worthwhile it would be to have primary care involvement in breast cancer risk assessment and management?

HCA1: I think we can definitely get involved, and I think it would be good input for us to be involved. Obviously, we do see a hell of a lot of people week in, week out. Whether we could do the full screening, I’m not sure, but we could definitely signpost, like we signpost people to get the bowel cancer screening done and stuff like that, so definitely an option to have some sort of input into it.

PA1: I agree that we can definitely have some input, but yeah, it’s where those limitations then lie, and where do we draw the line and say this is when we need to signpost onto somebody else. But yeah, 100 percent, I think [GPR7] mentioned it earlier, that we get so many people that come in and they say, “Oh, such and such a body’s had this,” “Such and such a body’s had that. This is why I’m worried about it,” and yes, it would be useful in those situations then. But again then it all comes back to how robust it is and whether you can say with certainty – if that person’s come in very upset that their family has got x, y and z, and then can you say yes or no to them and what have you. But yeah, having that resource to signpost to would definitely be useful.

Q: Great, thank you. So, finally then, are there any other issues that you can think of that would be important to consider if we were to set up a pathway for breast cancer risk assessment and management activities in primary care?

GPR7: I’m being really cynical, but if it can’t be monetised, you’re going to struggle. Sorry.

Q: So, with respect to that, are you meaning about like QOF points, that kind of thing?

GPR7: Yeah, yeah, QOF points and that kind of thing. I think if it’s going to be centralised, like all the other screening programmes, and we signpost, and we also maybe plug in patients, like the ones whose aunt’s died or whatever, that would be a more fruitful use of all the resources.

TNA2: I’d just agree with what [GPR7] said. You’d need to offer incentives, I would have thought, especially when you think about the time it will take from the workforce, like funding extra hours for facilitating it, yeah.

HCA1: Time is definitely an issue, because at the minute – I don’t know about everybody else who works in a GP surgery, we’re not always getting all the time to hit all the other things that we have to do, like the Ageing Well reviews, they just get missed, and all the things like health checks and you’re trying to hit all your QOF stuff as well and then do your BCQ stuff as well. You’re not having time to do all that in the first place, without screening being added on as well. So, it might mean you need the extra bodies to do the work, like you said, and the money coming into that side of it as well.

Q: What’s the BCQ that you just mentioned, HCA1?

HCA1: Well, we do like things – like the NHS health checks have to be hit as well, and like the Ageing Well reviews as well. They’re all separate to like doing the QOF. But there’s that many people that have not had that much stuff done so far, because they’ve not been in for the last two years, trying to catch up at the minute with like loads of stuff. I don’t know if anybody else feels the same way in GP surgery, but it’s just like having another thing that needs doing. I mean, this is obviously going to be a long time down the road, isn’t it, but…

Q: Yeah, yeah.

PA1: I’d just echo all of that. It is all to do with time commitments, and unfortunately a lot of the work comes down to financial incentives within practices. But yeah, equally, if it is outsourced to obviously the central sites and then we just signpost to that then fair enough, that won’t obviously take as much time there.

Q: Okay, thank you. So, that’s all the questions that I had today, so I’m just going to hand over to [name of co-facilitator], who’s just going to provide like a brief summary of what we’ve discussed.

V: So, in general, you think it’s a positive thing, but there are slight concerns that maybe perhaps, if women are at low risk, they could be quite complacent. So, in one way, it could promote breast checks in younger women, but also could work the other way in that women might not check their breasts if they are at lower risk. Something like QRisk would be helpful, but it would have to have well defined parameters. There’s issues with life insurance, in case this sort of information is used again women, and it might not be an incentive for them to come in if that’s an issue. It’s a good way to – so, if you were to collect the information, you’d have a lot of that on file already, so you could collate that information, but then there’s also the idea of maybe you actually just signpost women about this service, so it sits rather with secondary care, ‘cos you feel like it might need a specialist, especially with Tamoxifen, in that you wouldn’t be prescribing that or you wouldn’t feel confident in prescribing that as it’s a specialist medication and all the side effects that could go with that. There’s also the issue about breast density, in that we’re not 100 percent sure the research is there yet and the models are good enough. And also the issue with women who have – whether breast density can be picked up in women at younger ages. You said about the lifestyle advice, that’s almost like primary care’s bread and butter really, so you could be giving that. So, if secondary care, when they’ve seen the specialist, believes that they need some sort of lifestyle advice, they could go back to the GP for that, and you’d be able to signpost women to different services there. Overall, yeah, you think it’s a good idea. You guys think that primary care can be involved to an extent, but how far do you take that. So, where would primary care draw the line with that. And you’d need to know how robust it is, and the figures and research behind that, so that you can give women like some more definite answers if they were coming to you. And also, like you said, unfortunately, a lot of the things in primary care need to be incentivised or monetised for it to be a success, really. You have said a lot more things, but it would take me a lot longer to go through, but that’s the nub of it. Does anyone have anything they’d like to add to that? [Pause] No? Is that a good representation of what you guys thought mainly?

[Participants agree]

Q: Great, thank you guys. So, I’ll stop the recording.

[End of recording 0:18:30]