Implementing risk estimation and risk stratified screening into the NHSBSP

Views of healthcare professionals on feasibility

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PROCAS2

- Feasibility of automated risk estimation as routine part of NHS Breast Screening Programme
- Developing care pathways and refining risk materials
- Automating risk estimation (online)
- Establish major benefits and harms
- Cost effectiveness
- Implementation meetings
BC-Predict (PROCAS2)

- Self-reported information – Tyrer-Cuzick
- Breast density – Volpara
- Genetic factors

Breast screening invite (standard practice) → BC-Predict invite
approx. 2 days after screening invite → Participate in BC-Predict online – Tyrer-Cuzick questionnaire completion → Attend screening mammogram – breast density recorded → Screening results → BC-Predict results to woman and copy to GP
approx. 6 weeks after mammogram result* (but not before receipt of mammogram result)
Methods

Multiprofessional focus groups

<table>
<thead>
<tr>
<th>Service A</th>
<th>Service B</th>
<th>Service C</th>
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<tbody>
<tr>
<td>4 Radiographers</td>
<td>3 Radiographers</td>
<td>2 Radiographers</td>
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<tr>
<td>2 Radiologists</td>
<td>2 Radiologists</td>
<td>1 Radiologist</td>
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<tr>
<td>2 Clinical Fellows (radiology)</td>
<td>3 Clinical Nurse Specialists (breast)</td>
<td>3 Clinical Nurse Specialists (breast)</td>
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<tr>
<td>1 Breast Screening Office Manager</td>
<td>1 Nurse Clinician (primary care)</td>
<td>1 Breast Screening Office Manager</td>
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<tr>
<td>1 GP</td>
<td>1 GP</td>
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<td>2 FHC nurse specialists</td>
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N= 29 healthcare professionals across three breast screening services in England. Screening services were selected for diversity of screening population.
Methods

- Aims of BC-Predict/PROCAS2
- Prototype of how services could run
- How do we modify existing services to allow risk stratified screening?
- Inductive manifest level thematic analysis
Theme 1: System constraints

- Workload & workforce capacity limitations
  
  it's the time that we're expect to give on top of supporting oncology surgeons, not to mention the phones
  And it's not just the time in the clinic either, it's the time, patients will ring (CNS4 – site C)

  how is [Health Secretary] gonna get the money together, then, to fund all this?
  There's so many things at the minute: there's a difficulty recruiting the clinical team, that's the radiologist, the doctors, the radiographers, all that, very, very difficult (R5 – site B)

- Impact of capacity limitations on patient care
  
  the last thing you want then is to identify a woman, and you're struggling with the resources for the next step and then the woman's having to wait, and that will increase her anxiety (R5 – site B)
Theme 2: Risk communication impact

- Risk needs to be communicated to patients in a moral way - balancing resource constraints with risk impact.

  - it does sound quite **scary** being told that your breast cancer risk is whatever. **But we do that a lot for heart disease**, and I think patients are used to it now (GP2 – site B)

  - If you just put **high risk** they’ll be thinking they’re going to get it **tomorrow**, but if you word it more around what the **general population risk is and what their risk is to them** (BCN2 – site B)

  - A very well worded letter that was in layman’s terms, that was **giving a risk equivalent to other things**... Where they could understand by reading it what the **implications** potentially would be (CR5 – site C)
# Theme 3: Accentuating inequity

<table>
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<tr>
<th>Barriers to screening and risk reduction strategies</th>
<th>Additional steps decrease accessibility</th>
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<td>I genuinely think it’s a <strong>self-protective mechanism</strong> for some people, it’s easier to just, no, <strong>I don’t recognise that as a current stress</strong>, so I’m going to <strong>choose not to create that stress</strong> for me...as opposed to I need to establish what my risk is (CR1 – site A)</td>
<td>I think people that weren’t going to come already have <strong>preconceived ideas</strong> and already have their <strong>excuses</strong>...and they will just use this [BC-Predict] for <strong>reinforcement</strong> if they wanted (BSOM2 – site C)</td>
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Conclusions

- Positive attitudes to prevention and risk stratification
- Data focused on concerns about workload & workforce
- Key drivers of risk impact and service implementation
  - Skilled communication of risks and service developments to diverse lay audiences
  - Stratified screening - implemented in financially and time constrained settings without impacting negatively on the recipients.
- Long-term care pathway crucial to success
Future directions

- BC-Predict
- Focus groups & interviews – acceptability
- Questionnaire – Psychological and Health Economic impact
- French – Low risk study (BCN)
Funding & contact information

- NIHR Programme Grant (RP-PG-1214-20016)
- Prevent Breast Cancer Ltd
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