Cragg Ross Dawson

SHINGLES VACCINE

Qualitative research to inform the introduction of the Herpes Zoster vaccine and communications to encourage its take-up

Report

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Research Unit
COI
Hercules Road
London SE1 7DU

And:

Department of Health

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Contact at
Cragg Ross Dawson: Ben Toombs

Cragg Ross Dawson
Qualitative Research
18 Carlisle Street
London W1D 3BX
Tel +44 (0)20 7437 8945
Fax +44 (0)20 7437 0059
research@crd.co.uk
www.craggrossdawson.co.uk

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A. INTRODUCTION

1. Background and objectives

The Department of Health (DH) is considering a live attenuated vaccine called Herpes Zoster, a single injection of which would give long-term protection against shingles. This vaccine is licensed for those aged 60 and above, and may be given at the same time as the autumn flu jab.

Initial exploratory research was required to inform the introduction of the vaccine and communications designed to encourage take-up, by exploring…

- public understanding and views of shingles
- reactions to the idea of a vaccine
- how people relate it to the flu jab and other injections
- the barriers to take-up
- the benefits and motivations
- the views of nurses

2. Method and sample

Fieldwork was conducted in two phases. The first was designed to reflect the 'audiences' for the vaccine (public and health professionals) and the dynamic in which decisions about vaccination are taken; it comprised the following…

- 15 paired interviews with couples (60 minutes):
  - 5 aged 60-64; 5 aged 65-69; 5 aged 70-85
  - 7 BC1; 8 C2DE
  - 2 with BME respondents
  - 5 respondents had a long-term condition
  - 2 respondents had had shingles

- 8 interviews with single respondents (60 minutes):
  - 2 aged 60-64; 2 aged 65-69; 2 aged 70-79; 2 aged 80+
  - 4 BC1; 4 C2DE
  - 1 with a BME respondent
  - 2 living in residential care; 6 living independently
  - 2 respondents had a long-term condition
  - no respondents had had shingles themselves
- 8 paired interviews with nurses:
  - 3 with district nurses
  - 5 with practice nurses

The second phase was an opportunity to explore further some of the issues arising from the first phase, and in particular to explore the views of people who did not know someone who had had shingles. It comprised the following…

- 2 groups with general public respondents (8 respondents in each; 90 minutes):
  - G1: mixed sex; all knew someone who had had shingles; 4 aged 60-64, 4 aged 65-70; 4 BC1, 4 C2DE
  - G2: mixed sex; none knew someone who had had shingles; 4 aged 60-64, 4 aged 65-70; 4 BC1, 4 C2DE
  - no respondents had had shingles themselves

The groups and interviews took place in London, Hertfordshire, Birmingham and Newcastle; they were conducted between 20 January and 11 February 2009.

B. SUMMARY AND CONCLUSIONS

Attitudes to shingles and a vaccine

1. Shingles is rarely top of mind as a condition that people face in older age, but most respondents knew someone who had had it. These respondents knew that shingles can be nasty and were very sure that they did not want to develop it themselves. They also knew that shingles is more of a risk to older people than younger. Respondents who did not know someone who had had shingles were aware that it is an unpleasant condition and did not want to get it, but the symptoms were much less real for them, and their aversion to developing it was noticeably lower.

2. Despite this widespread aversion to developing shingles, most respondents did not feel especially at risk themselves because their experience suggested it is not very common, and they thought it is contagious, and therefore avoidable. On this basis, many thought a vaccine would be worth having to avoid shingles, but not especially urgent or necessary.

3. Nurses tended to echo this state of knowledge and these views; if anything, they were less convinced by the need for a shingles vaccine than the public respondents, although they would offer it if instructed to do so.

Motivating factors

4. For respondents who knew someone who had had shingles, the fact that it develops 'from within', and is more common than they had thought, was very motivating and unsettling – it suggested that they were more at risk than they had assumed, and that they had little control over whether or not they got shingles. Other information had less impact – either they knew it already or it did not seem especially pertinent.

5. Nurses were less influenced by information about the development and prevalence of shingles – although this was often news to them, they placed less faith in it and/or found it had less personal impact.

6. Public respondents who did not know anyone who had had shingles were much less concerned about it – they had heard of it, but did not really know what it is like. They were interested in information about development and prevalence, but it seemed harder to make this real for them than for those who had experienced shingles in others. They were also more affected by information about symptoms and 'extreme cases' (hospitalisation, complications etc) as they could relate to this, whereas shingles itself was still something of a mystery to them.

Messages to communicate

7. A combination of three factors provides a strong motivation for people to want the shingles vaccine: awareness of what shingles is like; understanding of how it develops; and appreciation of how common it is. If one of these factors is missing, the 'case' for the vaccine is less urgent and less convincing. Motivating communications will therefore need to make shingles 'real' for those who have not experienced it, either personally or in their social circle, as well as providing information about development and prevalence.

8. Views on the most appropriate channels for such communications varied, but many public respondents and nurses felt that information in a letter to patients and in GP surgeries would work well.

Delivering the vaccine

9. On this evidence, trust in nurses and health professionals in general would persuade most people to have the vaccine in whatever way the nurse recommended. There was little to suggest that offering it alongside the flu jab would result in large numbers of refusals, and many could see advantages to this arrangement, although practical issues would need to be borne in mind.

10. Having three vaccines at once would also be acceptable and even desirable for many, in terms of convenience, although some concerns about overloading the system and identifying the cause of any reactions were raised. There would be a need for some flexibility in the system to accommodate different preferences and levels of confidence. Offering all three as a package of vaccines that one needs at 65 would work well for some, perhaps mainly those predisposed to having

them together, because it suggested that they were designed to go together and reduced the complexity of decisions about all three. But it would not be particularly reassuring for others, or welcomed by those who wanted to separate the vaccines out.

Additional information needs

11. This research suggests that many patients, especially those in their 70s and above, would want to know very little about the shingles vaccine. Reassurance from nurses that it is safe and effective enough to be worth having would be sufficient in most cases; indeed, this would often be implied by the fact that the nurse is offering the vaccine in the first place. However, some (especially younger and BC1 patients) would want to see some printed information about its safety (concerns surrounded its newness, rather than the fact that it is a live vaccine) and effectiveness from a reputable source such as the NHS in addition to whatever the nurse could tell them, and almost all would want to hear about the vaccine before being offered it.

10. Nurses would want sufficient evidence to convince them that the vaccine is safe for older people (because it is live) as well as clear guidelines as to who can and cannot have the vaccine. Some background information about shingles would also be useful as understanding was often hazy. This information would be for their own use, to enable them to recommend the vaccine with a 'clear conscience', rather than to pass on to patients.

C. PUBLIC FINDINGS

1. Segmentation

The sample of public respondents was segmented according to a number of variables that might have had an impact on people's awareness and understanding of shingles, and their attitudes to a vaccine. In fact, respondents' positions on these questions were remarkably consistent – there was little difference between what men and women or people in their 80s and people in their 60s (for example), knew and thought about shingles and vaccination. Where specific differences did occur, they are picked out in the notes below; otherwise, little segmentation of these findings is necessary.

2. Current state of health and concerns for the future

Most respondents in this sample were basically healthy. A number maintained active lifestyles to try to ensure they remained healthy; many of those in their 60s felt as healthy and active as they ever had, and did not feel especially 'old'; and those in their 70s and 80s often felt no less healthy, although they were more prone to temporary 'aches and pains'. Some respondents had long term conditions – diabetes, asthma, arthritis, heart problems etc – but they generally seemed to take these in their stride.

> *"As far as I can make out, it's basically progressive: as you get older, things wear out."*
> Paired depth 4, 60-64, Radlett

Concerns about health in the future were generally vague among those without long-term conditions. Cancer, dementia, 'aches and pains' and others came up across the sample as conditions that respondents assumed they might face, especially if relatives or friends had suffered. But few of these respondents had any specific fears, and many (especially younger) seemed to have given serious health risks in later life little thought. Those with long-term conditions were sometimes most concerned by the fear that these would get worse in the future – although they seemed to be under control at the moment.

On a more day-to-day level, flu was often mentioned as a health issue that people face in later life, although this seemed to be prompted as much by the prominence of the flu jab as by experience of the illness

(see Section 3). No respondent spontaneously mentioned that they might be at risk of developing shingles – it was not top of mind for anyone, although most knew at least one person who had had it (see Section 5).

3. Keeping healthy; the flu jab

Apart from some of those with long-term conditions, few respondents seemed to be on medication for anything. Keeping healthy day to day was a preoccupation for many; the most common methods were taking regular exercise (mostly among those in their 60s), eating well and having the flu jab.

Most seemed to take it for granted that they should have the flu jab, and had it most years. Many had it every year, without question; some missed occasional years, generally because they felt for some reason that they did not need it; but few rejected it entirely. Among those who had the flu jab, confidence in its ability to prevent flu varied. Some believed it did stop them getting flu – sometimes because of general confidence in vaccines, but more often because they had not caught flu in years when they had had the jab.

> *"I know the flu jab so far has been effective… We've both been fortunate. If it stops you getting the flu, it works."*
> Paired depth 6, 70-85, Radlett

Others felt it was worth having but not foolproof – either they had caught flu in a year when they had had the jab, or they knew that there are many strains of flu and the jab only protects against one.

> *"I know the flu one doesn't always work."*
> Paired depth 9, 65-69, Newcastle

Still others felt that it might not prevent flu, but it would reduce the symptoms.

> *"It [the flu jab] doesn't cure it but it gives you a better backing on it."*
> Paired depth 11, 70-85, Newcastle

A large proportion of the sample thought that the flu jab might give them flu, or at least flu-like symptoms. They thought this had happened to them or others they knew, or they had bought into a 'myth' suggesting that this happens. But most respondents seemed to see

this as a 'risk worth taking' – certainly, this belief did not seem to have prevented many from having the jab.

This general feeling that the flu jab is, at the least, 'worth having', seemed to stem from widespread trust in doctors, nurses and health professionals more generally. A nurse's recommendation or endorsement of the jab was enough to persuade most respondents that they should have it; and nurses' reassurance and the ubiquity and established nature of the jab meant there were no concerns about the safety of the vaccine or any significant side effects.

> *"I think if you're going along for a flu jab and your doctor says it's fine, you're going to have it."*
> Paired depth 8, 60-64, Newcastle

The few who did not regularly have the jab cited one of two reasons. Some believed strongly that it would give them flu, often in the face of reassurance from nurses that it would not (perversely, one or two said they had developed flu when they had not taken the jab, but still refused to have it).

> *"I would not have the flu jab purely because my brother, he was ill after."*
> Paired depth 5, 65-69, Radlett

Others believed that they did not need the jab, as they were healthy people who 'did not get ill'. Fear or concern about vaccines or injections in general was never a major issue.

Many respondents had also had the pneumoccocal vaccine (although a number could not remember, and were sometimes reminded by their partners). This had usually been given at the same time as the flu jab; again, it had been recommended by the nurse, and very few had refused it.

4. Attitudes to vaccination in general

Most respondents were very relaxed about vaccines, and had few concerns about them. They were used to having them (especially men who had done national service, and those who had travelled to exotic locations), and they trusted the health professionals on this as with most other health issues.

> *"We don't need that kind of reassurance with our doctors. We have faith in them."*
> Paired depth 7, 60-64, Radlett

Few had stopped to consider how vaccines work or how effective they are – although if pushed many assumed that all vaccines are 'live', and the concept of a 'dead' vaccine was often difficult for them to grasp. 'Side effects' was often mentioned as a potential concern, largely it seemed because of the underlying assumption that vaccines are live and involve putting something 'active' (however vague their understanding of this might be) into the body, but also because some knew that some travel vaccines (yellow fever, for example) do cause side effects.

> *"I would want to know a little bit more about it [a new vaccine]. I'd want to know a little bit about the side effects, if any."*
> Paired depth 1, 70-85, Birmingham

However, these concerns could be alleviated in almost all cases by reassurance from the nurse and the knowledge that the vaccine has been well tested and in use for some time. (On this point, younger and BC1 respondents seemed to want information as reassurance, whereas older and C2D respondents were more likely to accept a nurse's 'endorsement' without so much information to back this up.)

As a consequence, while some expressed concerns or doubts in principle about having two or more vaccines at the same time (usually along the lines of 'overloading the system'), most had accepted this without question if their nurse recommended it. This is exemplified by the fact that most of those who had had the pneumococcal vaccine had had it at the same time as the flu jab on their nurse's recommendation, and had not worried about this, whereas some who had not had the pneumococcal vaccine, and had not therefore been reassured by a nurse that there would be no problems, thought they would rather not have it at the same time as the flu jab.

5. Awareness of shingles

As noted, shingles was never top of mind when respondents talked about the illnesses and conditions they might face (it was never mentioned spontaneously by nurses, either). This was despite the fact that almost all respondents (except those recruited specifically for one

group discussion) knew at least one person who had had shingles, and two respondents had had shingles themselves.

As might be expected, familiarity with the symptoms varied, but most who knew someone who had had shingles seemed fairly well informed. Most commonly, they knew it involves a nasty rash around the midriff (a number noted the myth that the rash joining at the front is linked to fatality – although none really seemed to believe this) and/or on the face. Pain (often severe) in the affected area was mentioned a little less frequently; and pain which continues after the rash subsides was mentioned less frequently again (the term 'post-herpetic neuralgia' was never known).

> *"It is bloody painful when you get it."*
> Paired depth 7, 60-64, Radlett

Reports on the severity of the cases encountered also varied, but many knew someone who had had what they believed to be a 'nasty case'. These had involved a prolonged rash, sometimes lasting significantly more than two weeks, and quite often on the face so that it affected vision; severe, often lasting pain; and/or general effects being felt for many months. Most also believed that there is little that can be done to treat shingles once it has developed, apart from applying cream to the rash (one or two did mention a course of pills that can stop shingles from developing further if it is taken early enough).

> *"I think all I remember about it is trying to put calamine lotion on to stop the itching, but I don't know how you would get rid of it."*
> Paired depth 10, 70-85, Newcastle

In general, therefore, all respondents who knew someone who had had shingles were very sure that they did not want to get shingles themselves. This included those who had had it – they did not want to get shingles again.

Respondents who were unfamiliar with shingles had heard of it, but were much less concerned about it. Many were aware of the symptoms described above, and (unsurprisingly) on questioning said that they did not want to get shingles. But their initial aversion to getting shingles seemed much less extreme than that of those who had had personal experience of it – they were aware of the symptoms 'on paper', but not what it is really like to have shingles.

There was a general feeling that older people are probably more prone to developing shingles than younger people, although this was due more to an assumption that older people are more at risk from most things than any specific knowledge about how shingles works, and many knew of younger people (often in their 40s and below) who had had shingles.

> *"The older people are more at risk."*
> Paired depth 7, 60-64, Radlett

But although they did not want to get shingles and felt sympathy for those who had it, few respondents felt particularly at risk from it themselves, for reasons discussed below.

6. Understanding of shingles

If awareness of shingles was high, albeit rarely top of mind, accurate understanding of how it develops and how prevalent it is was extremely low across the sample.

Most knew that it is somehow related to or associated with chickenpox – it was sometimes referred to as 'the adult version of chickenpox' – and many knew that it is connected to a suppressed immune system, or at least stress, tiredness or old age.

> *"It's like chickenpox but more painful, irritating – a rash all over you."*
> Paired depth 6, 70-85, Radlett

Less accurately, almost all believed that shingles is contagious, and that someone with a low immune system can catch it from a child with chickenpox and/or an adult with shingles. This belief seemed to result partly from the association with chickenpox (which all knew is highly contagious) and partly from a lack of any other explanation for its spread.

> *"A person with shingles can spread the virus"*
> Single depth 3, 65-69, Radlett

In addition, most believed that shingles is a relatively rare condition (compared with flu or heart disease, for example). Although most knew of at least one person who had had shingles, few knew many people (only one or two, from their entire circle of acquaintance, was common), and those who did not know anyone who had had shingles

had heard very little about it in the media, from friends or from health sources.

The combination of these two beliefs meant that few respondents were worried about getting shingles themselves: if it is contagious, they felt they would not get it if they did not come into contact with anyone who had shingles or chickenpox; and since they did not know many people who had had shingles, and did not tend to come into contact with chickenpox, it seemed unlikely that they would get it.

> *"Before you mentioned it I hadn't even thought about [being at risk]."*
> Paired depth 10, 70-85, Newcastle

The effect of challenging and correcting these beliefs on respondents' views of shingles and the need for a vaccine was often dramatic.

7. Views on the need for a vaccine

7.1 Based on respondents' prior knowledge

Since most respondents did not want to get shingles, they thought they would probably take a vaccine if it were offered and recommended by a nurse. However, many were not convinced by the *need* for a vaccine, given their beliefs about the likelihood of their developing shingles, and the predominant view was more *'I may as well have it if it is free and safe'* than *'I really ought to have it'*. This view was echoed by some nurses, who believed that shingles is less prevalent than it actually is, and/or that it is contagious. In light of these beliefs, a few respondents (especially those who did *not* know someone who had had shingles) wondered whether a shingles vaccine would be a good use of public money and nurses' time.

7.2 Based on a proper understanding of shingles

Two pieces of new information had a significant impact on most respondents' views of shingles and attitudes to a vaccine: how it is contracted; and how prevalent it is. The idea that shingles is contracted 'internally', from the dormant chickenpox virus already in the body, rather than 'externally' from someone else, was new and extremely unsettling for many respondents. This information had two important implications. First, respondents no longer felt able to

'control' whether or not they contracted shingles: if it cannot be avoided by staying away from other people, there is little you can do to protect yourself against it.

> *"It's beyond my control whether it happens or not. I can eat as healthy as I want, I can run 20 miles a day; the virus is there."*
> Paired depth 4, 60-64, Radlett

The second implication was that everyone is at risk: if almost everyone has had chickenpox, almost everyone has the potential to develop shingles. Less rational, but also significant on an emotional level, was the insidious notion that shingles is already inside you – this idea was new and made many feel uncomfortable.

> *"You develop it from it being in yourself… that is why I would have [the vaccine]."*
> Paired depth 5, 65-69, Radlett

The prevalence of shingles was also surprising to most. The fact that 20 or 30% of people develop shingles at some point was unexpected, but even more pertinent and shocking for this audience was the fact that half of shingles cases occur in the over 60s, and half of 85-year-olds would have had shingles at some point.

> *"If they … enlightened me as to the percentages [of people who get shingles], I would have it done."*
> Paired depth 5, 65-69, Radlett

As a result of these two pieces of information, most respondents were considerably more concerned about the risk of shingles than they were to begin with, which made the offer of a vaccine against shingles seem all the more attractive. None doubted the truth of any of these facts: despite the difference between them and their own experience, they accepted them as accurate information from the Department of Health.

> *"Bring it on is all I can say now, having read that."*
> Paired depth 8, 60-64, Newcastle

For some, the idea that they could give one of their grandchildren (or another child) chickenpox if they had shingles was also disturbing, and a further reason for wanting the vaccine.

Respondents who knew someone who had had shingles were less affected by other types of information, for example details of the symptoms, 'extreme cases', and the risk of hospitalisation. The symptoms (rash and pain) were familiar to most, even if they did not know some of the detail about neuralgia. The 'extreme cases' leading to complications and even death seemed remote, and the risk of hospitalisation seemed small at 3%.

> *"Actually that does not sound very high, 3% of the population."*
> Paired depth 5, 65-69, Radlett

These reactions confirmed an impression that most respondents saw shingles as a 'standalone' condition, which develops without any external influence and which, when it has run its course, disappears again, although this might take several months. This did not make them any less eager to avoid shingles if at all possible, however: the basic illness alone was considered nasty enough, and as noted most thought that there was little that could be done if they did get it.

> *"It would have to be something very frightening to put me off having the shingles vaccine."*
> Paired depth 4, 60-64, Radlett

Those who did not know someone who had had shingles were less aware of the symptoms, and in particular the severity and lasting nature of the pain. They found it motivating to be told about this, but they were also influenced by the 'extreme' facts and risk of hospitalisation. Although rare, these were problems they could relate to, whereas shingles itself was still a little mysterious to them.

> *"You see they say hospitalised every year, so it's dangerous."*
> Single depth 3, 65-69, Radlett

The two respondents who had had shingles already were just as keen to have the vaccine as the others, despite learning about the low risk of recurrence.

8. Vaccine information needs

Few respondents wanted to know much about the shingles vaccine, at least initially. Almost all had a high degree of faith in vaccination generally, and did not immediately see why a shingles vaccine should be any less effective than what they assumed for other vaccines. They also trusted their nurse and GP, and assumed the vaccine would be safe and without significant side effects if a health professional were to offer it to them.

> *"All I can say is that I have great faith in the medical profession."*
> Paired depth 8, 60-64, Newcastle

> *"I just think they [medical professionals) know what they're talking about."*
> Single depth 3, 65-69, Radlett

Respondents assumed (although often without saying so at first) that the vaccine would involve a one-off injection. They were not particularly interested in how it works – as noted, many assumed all vaccines are live anyway.

> *"Frankly if someone is going to stab me with a needle to stop me from catching shingles, I don't give a monkeys about whether it is live, not live or whatever."*
> Paired depth 8, 60-64, Newcastle

> *"To me if it's going to help you, I wouldn't care [what form it took]."*
> Paired depth 2, 65-69, Birmingham

However, on further consideration a few concerns did arise. Some respondents questioned the safety of a vaccine which did not yet have a track record of public use. Despite their faith in health professionals, they were a little wary of being the first to have a new vaccine; clinical trials involving limited numbers of people were not reassuring in this respect.

Some also questioned the vaccine's effectiveness on the grounds that shingles is different from contagious illnesses. It was harder for them to see how a vaccine which supposedly stimulates the immune system would combat a virus that is already inside the body rather than one which is attacking from outside. Overall, it was noticeable that those who did not know someone who had had shingles had more questions

and were more wary – the benefits of vaccination were less immediate and overriding for them.

Most of the information that respondents were shown was not especially reassuring on these two questions. Attempts to allay concerns about live vaccines by describing what 'attenuated' means or citing other established examples (BCG, MMR etc) missed the point somewhat: it was not live vaccines per se they were concerned about, but the idea that the shingles vaccine is unproven. The figures regarding effectiveness (51% reduction in cases among the over 60s) were not thought particularly impressive – although many acknowledged that they did not know how effective other vaccines are, and many thought it would be worth having the vaccine even if it only reduced the risk by half.

> *"I do want a vaccination but I wouldn't want a vaccination if I was so old and you only got 65%. I want 100% if possible."*
> Paired depth 11, 70-85, Newcastle

As noted, the most effective reassurance on the first point was expected to be endorsement of the vaccine by a health professional. For many, especially older respondents, the simple fact that the vaccine is offered by a nurse would be enough to persuade them of its safety. For most others, minimal printed information from a reputable source such as the NHS, and verbal reassurance from the nurse, would alleviate concerns.

That said, the fact that the shingles vaccine is being used in the US was also reassuring for many. They assumed US safety measures are effective, in part because of the litigiousness of that society, but also because the size of the US population would mean that any problems with the vaccine would come to light quickly. The fact that the shingles vaccine is a higher dosage of the chickenpox vaccine, which is also used in the US, was often an effective 'second best' reassurance, although highlighting the existence of a chickenpox vaccine did prompt many to ask why it is not available in this country as well.

> *"I would be impressed if it was in general use in America because I know that their standards are very high."*
> Paired depth 4, 60-64, Radlett

There were some, however, who were less reassured by US testing and use, as they believed that any problems in the US would not be reported in the UK.

With regard to effectiveness, few thought that the 51% figure should be made widely known. However well or poorly this compares with the effectiveness of other vaccines, it seemed low in itself.

> *"Although 50%, I think a lot of people would say … I have still got a 50% chance of getting it."*
> Paired depth 5, 65-69, Radlett

However, having seen the figure, a number thought people should be told that the vaccine is not foolproof, as otherwise there might be problems in the future when some of those who had been vaccinated did get shingles. As with concerns about safety, the fact that the vaccine is recommended by the nurse would be enough to persuade most that it is effective.

9. Deciding to have the shingles vaccine

Decisions about whether or not to have the flu jab seemed largely to be personal: respondents in couples often did not talk with each other about the flu jab before having it; and in some cases, one partner had the flu jab regularly while the other had it more sporadically or not at all, and the former usually seemed unable to influence the latter. There had been more discussion between partners about the pneumoccocal vaccine: this seemed more significant, due in part to its one-off nature which made it seem less 'routine' than the flu jab. However, there were still some who went ahead and had it without consulting their partner.

> *"Well the way our relationship is we probably we would not discuss it."*
> Paired depth 5, 65-69, Radlett

Feelings about the shingles vaccine generally seemed to mirror those for the pneumoccocal vaccine. Many would want at least to mention to their partner that they wanted to have it, and to talk about it a little, because it is new and unfamiliar, and a one-off and not routine. But some would decide for themselves, and would not consult their partner.

> *"We would talk about it and make a decision"*
> Paired depth 10, 70-85, Newcastle

These points have implications for communications campaigns, as discussed below.

10. Delivering the vaccine

Having seen the information about the relative prevalence of shingles among older people, most felt that the vaccine should be targeted at those in their 60s and above. The roll-out strategy of vaccination at 65, with a catch-up programme for older age groups, seemed sensible to most, although a few in their late 60s were a little put out by the idea that they would not get the vaccine for a few years (a number seemed to want the vaccine as soon as possible, although this is likely to have been overstated in the research as they were fired up about the thought of getting shingles).

> *"My doctor runs a Well Man clinic which starts when you are 60, so that would be a good time to get [the vaccine]."*
> Paired depth 9, 65-69, Newcastle

However, a number of others were wary about being the first to receive the vaccine, and would have preferred to wait for a few years to ensure that no immediate problems were reported. Although they wanted to avoid shingles, the risk of getting it in the next few years seemed less acute than, for example, the risk of getting flu, so they were prepared to wait and see.

> *"I would not like to be number one in the queue."*
> Paired depth 5, 65-69, Radlett

There was little consistency within sample sectors as to when respondents wanted to receive the vaccine. Among those who were living independently, some said they would go to their GP specially, while others would expect to get it when at the GP for another reason. Many spontaneously said it would make most sense to have it at the same time as the flu jab, and others thought this a good idea when it was put to them.

> *"[They should give it at] the same time as the flu jab."*
> Paired depth 9, 65-69, Newcastle

The few who lived in care homes thought they would take it at the care home, whenever it was offered to them.

The benefits of having the shingles vaccine at the flu jab appointment were mostly thought to be practical. Healthy people do not go to the GP very often, and the flu jab might be the only reason for going in a year. They knew that the flu jab does not take long, so it made sense to have another injection at the same time. Some remembered having the pneumoccocal vaccine at the same time as the flu jab, and thought this had worked well.

> *"Just one visit instead of two. You don't have to go back."*
> Paired depth 9, 65-69, Newcastle

Older respondents in particular who thought they might develop a slight fever in reaction to the vaccine also preferred the idea of having it when the weather was not too warm, as they thought this would make the symptoms easier to bear – autumn seemed appropriate.

In general, the only reasons for objecting to this arrangement were also practical. Some respondents who had had the flu jab when they had gone in for some other reason felt that having the shingles vaccine in addition to both the original reason for the visit and the flu jab would be too much, especially if they were not prepared for it in advance. Few had any real concerns in principle about having the two vaccines together, however, and none said they would refuse if a nurse were to offer them like this.

The idea of having three vaccines at once (flu, shingles and pneumoccocal) was also acceptable to most, provided that the nurse assured them this was safe. But a few (of all ages) were worried about 'overloading the system', and would have preferred not to have all three together (the fact of having three injections did not, in itself, seem to bother them).

> *"I would definitely have it but it would concern me to have all three at once."*
> Single depth 3, 65-69, Radlett

These respondents did not see why they should need to have all three together, and would have been happy to come back specially to have one separately. A few refused point blank to consider having all three together, and would even have refused to have the flu jab, which they were taking already, if they had to have the other two as well. It seemed that no amount of reassurance from nurses would persuade

them otherwise, and the fact that the three vaccines are different (live vs dead; one-offs vs annual) did little to reduce their resistance. As noted, most were not particularly interested in how vaccines work, so being told why the three would not 'interact' or produce conflicting side effects had little effect on their gut feeling that having three together is a bad idea.

There was no suggestion that offering all three vaccines together would make the shingles vaccine seem any less effective than if it were offered on its own. On the contrary, if they are to be offered together, it may be beneficial to present them as a 'package' that is given at 65, rather than as three separate vaccines. Many who were happy to have all three together thought this would be a good idea: it suggested to them that the vaccines are intended to go together, which was reassuring, and it reduced the need to consider each vaccine individually; equally, the clear association of the shingles vaccine with the other two, which are known to be worthwhile and established, reassured some about its necessity and safety.

> *"It suggests it is safe if they are offering it with the other [vaccines]."*
> Paired depth 9, 65-69, Newcastle

That said, many of those who were less happy to have all three vaccines together did not like this idea because it suggested that there is no more flexible option, which they would want to take.

More research would be needed to inform a serious decision on this, but there does seem to be some mileage in the idea of presenting the vaccines as a package, provided that the option to split this package up is retained.

11. Communications needs

Although respondents did not seem to want to know much about the vaccine before having it, most did want some prior warning that they would be having it. Many had been given the flu jab 'on spec', when they had gone for an appointment at the GP for another reason. In these cases, the flu jab had been offered by the nurse, and they had accepted because they knew that flu is common and worth avoiding. They were also familiar with the flu jab and comfortable with it already,

and, as noted, the nurse was reassuring. Some had been offered the pneumoccocal vaccine in this way, and had accepted because they knew about the dangers of pneumonia; others had preferred to go away and think about it, and to come back later.

A shingles vaccine seemed to differ from both these precedents, however. Shingles is not a salient condition, so a vaccine for it would not be expected; the vaccine itself is not familiar and established; and without the information discussed above, the vaccine often does not seem especially urgent or necessary. Many respondents thought that, because it is new and unexpected, they would want to think about the vaccine, or discuss it briefly with their partners, beforehand.

> *"I think a lot of people would have gone away and thought about the shingles vaccine, if they hadn't been given advance notice."*
> Paired depth 4, 60-64, Radlett

The information needs of those who knew and did not know someone who had had shingles differed. Among those who knew someone, some thought that the nurse would be able to provide reassurance about its safety, and information regarding its urgency and necessity, and would be happy to have it 'on spec'. But, as noted, many wanted some reassurance and information in advance, so they could come to the appointment feeling comfortable about it, eager to have it, and having discussed it with their partners beforehand.

The same was true to an extent among those who did not know someone who had had shingles. In these cases too, the nurse could be reassuring and provide information. However, they had an additional need: to make shingles seem like something that *needs* a vaccine. They would be surprised and confused if offered it 'on spec' because they rarely thought about it, and would be likely to assume some change had come about to make a vaccine beneficial *now*. Questions such as 'Am I suddenly at severe risk?' or 'Is there an epidemic or an outbreak?' might well be raised. Without experience of the symptoms, the benefits of the vaccine per se seemed less urgent to these respondents.

Thoughts on the most effective way to tell people about the shingles vaccine before it is offered were fairly vague. Predictably, a number called for large-scale, mass media advertising. Others thought that something along the lines of the annual flu jab campaigns on buses would be appropriate, but many thought that even this would be unnecessary, and that a letter from the GP or information in the surgery would be enough.

> *"The government should be sending round, to maybe everybody who is of pension age or everybody over 55, a leaflet."*
> Paired depth 8, 60-64, Newcastle

Indeed, many said that they had had such letters inviting them to come for a flu jab, and thought that information about the shingles vaccine could be included in this. PR activity to raise awareness of shingles and the vaccine was also suggested by some, for example discussion on GMTV or inclusion in the plot of *Eastenders*.

As discussed above, any such communication would do well to inform people about what shingles is, what it feels like, and what it can (rarely) lead to, although this task is largely fulfilled already for those who know someone who has had shingles.

> *"It would save them a lot of stress and pain if they did take it."*
> Paired depth 9, 65-69, Newcastle

As well as this 'background information', communications should cover the way in which shingles develops and its prevalence. The safety and effectiveness of the vaccine, and what has changed to encourage the government to offer it now, are also salient issues.

D. NURSES FINDINGS

1. Overview

One or two nurses had heard about the possibility of a shingles vaccine, and most knew that a chickenpox vaccine exists. Nurses' comments on shingles, the vaccine and their role in delivering it tended to fall into four categories: first, the extent to which the vaccine is necessary and value for money; second, the information they would need for themselves and to 'sell' the vaccine to their patients; third, the practicalities of delivering the vaccine to patients; and fourth, the content and format of communications for the public.

2. Is the vaccine necessary?

Nurses' understanding of shingles varied. All were aware of it and had come across cases, and all knew that shingles is not pleasant and worth avoiding if possible. But a number shared the misconceptions of many public respondents about how it develops and its prevalence.

A number felt that since shingles is not usually life threatening and (they believed, since none had come across many cases) relatively rare, a vaccine might not provide good 'value for money'. Some drew comparisons with the flu, pneumoccocal and TB vaccines, which they did believe had the potential to save lives and reduce widespread illness.

> *"How effective would it be… to vaccinate everybody, the cost of vaccinating them?"*
> Practice nurse, Birmingham

> *"In 10 years' of experience I have had only one person with shingles, only one."*
> Practice nurse, London

> *"Everyone knows pneumonia, that if they get bad flu that's what they might end up with or what they might die of, but you don't hear of people dying of shingles."*
> Practice nurse, Birmingham

Being told how it develops and how common it is did not make much difference to this view (in contrast to the effect on public respondents). This information was not personally shocking and unsettling in the way that it was for public respondents, and, based on their limited contact with shingles, nurses were noticeably less likely to accept these facts

unquestioningly than the public respondents were. One or two also commented that delivering the vaccine would entail extra work for themselves, while the financial benefits would be restricted to GPs who met targets.

This is not to say that nurses would not deliver the vaccine if the Department of Health decided to make it available, however. All said that they would do so on the grounds that it would help to prevent people from developing a nasty condition, and a few, especially district and community nurses who saw patients at home, felt that it could reduce the amount of time they spent seeing patients for shingles symptoms.

> *"You're spending money in putting in personal care and paying for the medication … once they have got shingles."*
> District nurse, London

In addition, a number said that they would do whatever their GPs or seniors asked them to do, and would endorse this wholeheartedly to patients whether they agreed with it or not. However, none considered it a vital addition to the interventions available for older people.

3. The information needed

All nurses confirmed the trust that public respondents said they had in health professionals, and most thought it likely that their endorsement of the shingles vaccine would be enough to persuade most older people to have it. Indeed, community and district nurses said that many of their house-bound patients were not capable of discussing issues like this, and that consent for the vaccine would be implied by a lack of objection.

Most assumed that, if it were made available, the vaccine would be safe for older people and reasonably effective – in this sense, their trust relationship with the Department of Health was similar to patients' trust in them. However, since the vaccine is live, most would still like to see some hard evidence telling them that it is safe for older people, and information on who can and cannot have it. In addition, they would appreciate information on what any possible reactions to the vaccine might be and how effective it is.

"I would want to know what the side effects are and what to look out for, and what to be telling our patients."
District nurse, London

"I think if we had the information and we knew what we were selling and the advantages and disadvantages, benefits and statistics and that, yes, we would be able to offer it."
District nurse, London

Few expected to pass all this information on to patients, although they would if they were asked. Rather, it was mostly for their own interest and to allow them to recommend the vaccine with a 'clear conscience'.

"I personally wouldn't give something unless I had been reassured."
District nurse, London

4. The practicalities of delivery

As with the public respondents, most nurses felt that the flu jab appointment would be a good opportunity to give the shingles vaccine as well.

"In terms of nursing time it makes sense to do it at the same time."
Community nurse, Birmingham

"If they could combine it with the flu vaccine, that would be ideal."
Practice nurse, London

This was partly for convenience and efficiency from their point of view, but also because the flu jab appointment is often the only time that they see people.

"Trying to get someone in at another time will increase the cost."
District nurse, London

They had few concerns about giving both injections at once, provided they were happy that the shingles vaccine is safe in itself, but a number of practical issues arose. First, the flu jab comes in a pre-loaded syringe and is quick to use; if they had to load the shingles vaccine themselves, or dissolve the vaccine from a powder, this would slow the process down considerably and make it harder to deliver both at the same time.

> *"If we had to draw up another one I would say that would be severely a waste of time."*
> Practice nurse, Birmingham

Following on from this, many people have the flu jab at clinics, where there is only time for the one pre-loaded injection; it might be difficult to fit the shingles vaccine in as well.

Third, if nurses wanted to catch people when they came in for the flu jab, or for any other reason, they would need to keep stocks of the vaccine ready for immediate use. This would require more fridge space, and perhaps more fridges (and thus more floor space). Finally, one or two thought it could take quite a long time for older patients to bare both arms, even if the injections themselves were very quick.

> *"They have to take one, two, three, four layers off, so sometimes the flu jab does take a long time because … they are quite slow."*
> Practice nurse, London.

With these thoughts in mind, a few nurses wondered whether it might be better not to offer the shingles vaccine in the autumn and winter as a matter of course, but, where possible, to give it to people in the summer when they were less busy.

Nurses' views on giving three vaccines at the same time often mirrored those of the public. Most were happy to do so in principle, and pointed to combinations of travel vaccines which are often given to older people. They wanted assurance that doing so would be safe, although they assumed that it would be if this is what the Department of Health advises. They thought that most older people would agree to having all three together if they recommended it, but as noted they questioned the practicalities of offering this.

> *"[I] don't have a problem as long as it's considered safe giving three vaccinations."*
> Practice nurse, Birmingham

> *"If you're talking about having to give three vaccinations in a busy flu clinic, and we're having to draw up a pneumonia and a shingles vaccine as well as the flu, it would probably double our time. We may not push the one that will be the hardest work."*
> Practice nurse, Birmingham

Most did not see why all three *need* to be given together, however, and predicted that some people would refuse to have them like this. In addition, one or two felt that if the patient were to react after having the three vaccines at the same time, it would be hard to tell which one had caused the reaction and to explain this to the patient. They worried that this might make it difficult to persuade the patient to have the flu jab (even on its own) in the future.

> *"And if they have three together and they are unwell, was it the shingles one or was it the flu? Might that put them off coming next year for their flu?"*
> Practice nurse, Birmingham

5. Communications

A number of nurses felt that, until the shingles vaccine becomes established and familiar, patients should find out about it before they are offered it. They would be happy to tell patients about it and to reassure them, but they thought that patients would be more likely to accept it there and then if it were not a total surprise to them. They also thought that the 'weight' of official NHS or Department of Health endorsement would help to reassure those who were less comfortable for some reason. As with the public respondents, a number thought the letter which invites people to have the flu jab would be an appropriate channel for this.

Appendix

Shingles – the symptoms

- Shingles (or Herpes zoster) is a painful skin rash caused by the same virus (varicella zoster virus) that causes chickenpox.

- Anyone who has had chickenpox can develop shingles, as the virus remains in the nerve cells of the body after the chickenpox has disappeared. Usually the virus does not cause any problems but in some people the virus reappears years later, causing shingles.

- Over 99% of the population aged 40 years or more has previously been infected with the virus that causes chickenpox. Some people will have had very mild symptoms or no symptoms at all so won't recall having had chickenpox. This means that all older adults are at risk of developing shingles.

- Shingles usually starts as a rash on one side of the face or body. The rash starts as painful blisters which scab over after 3 to 5 days and usually lasts 7-10 days although complete healing can take up to 4 weeks.

- Before the rash develops, there is often pain, itching, or tingling in the area where the rash will develop. Other symptoms of shingles can include fever, headache, chills, and upset stomach.

- The pain prior to the development of the rash may be described as aching, burning, stabbing or 'shock-like'.

- For about 1 person in 5, severe pain can continue even after the rash clears up and can last for weeks or months and occasionally persists for many years. This pain is called post-herpetic neuralgia. As people get older, they are more likely to develop post-herpetic neuralgia, and it is more likely to be severe.

- Very rarely, shingles can lead to pneumonia, hearing problems, blindness, brain inflammation (encephalitis) or death.

- Shingles cannot be passed from person to person. A person becomes infected with the virus when they develop chickenpox and the virus is then reactivated years later causing shingles.

- However a person with shingles can spread the virus to a person who has never had chickenpox. The person exposed develops chickenpox. The virus is not spread through coughing or sneezing but by contact with the person's rash while it is in blister-phase and before it crusts over.

Shingles – the figures

- 2 or 3 out of every 10 people will develop shingles in their lifetime.
- The risk of developing shingles increases considerably with age.
- More than half of all cases of shingles occur in people aged over 60.
- Around half of all people reaching 85 years of age will have developed shingles at some point in their life.
- Shingles can recur but the risk is low (Less than 5 in every 100 people who have had shingles will have another attack).
- Around 89,000 people aged over 60 years develop shingles each year in England and Wales.
- Approximately 3 in every 100 people with shingles are hospitalised each year. This risk of becoming hospitalised as a result of shingles increases with age.

Shingles – the vaccine (1)

- Shingles vaccine is a live attenuated vaccine. It is made from a weakened (attenuated) form of the virus that causes chickenpox and shingles.
- It is administered as a single injection in the upper arm.
- A booster dose is not required.
- Patients do not need to be asked about their history of chickenpox or shingles before receiving the vaccine.
- A clinical trial showed that the vaccine reduced the risk of developing shingles by 51% in people aged over 60 years and reduced the incidence of post-herpetic neuralgia by 66.5%.

Shingles – the vaccine (2)

- Live attentuated vaccines are vaccines that are made from the live virus or bacteria, but weakened so they can no longer cause the disease itself.
- Both MMR and BCG are live vaccines which are used in the childhood immunisation programme. The oral polio vaccine which used to be given as part of the childhood immunisation programme is also a live vaccine.
- There are other types of vaccines which are inactivated which means that the vaccine is made from viruses that have been killed. An example of an inactivated vaccine is the flu vaccine.
- In general, people who are 'immunosuppressed' (i.e. they have a weakened immune system either by disease or treatment) should not receive live vaccines. This includes people whose immune system is supressed because they are undergoing treatment for a serious condition such as a organ transplant or cancer, or have a condition which affects the immune system.
- The shingles vaccine is a higher dosage of the vaccine used to prevent chickenpox.

Shingles – delivering the vaccine (1)

- One option for delivering the shingles vaccine is to offer it at the same time as the flu jab that is made available every autumn.
- The flu jab is available free to everyone over the age of 65 and those most at risk from flu, and at a cost to other people who decide to have it.
- Another vaccine is already offered alongside the flu jab: the pneumoccocal vaccine which protects against meningitis, pneumonia and other conditions.
- Both the pneumoccocal vaccine and the shingles vaccine require only one dose, whereas the flu jab needs to be given afresh every year.

Shingles – delivering the vaccine (2)

- Unlike the shingles vaccine, the flu jab is inactivated (dead) and needs to be given every year because the flu strains it protects against vary.
- The pneumoccocal vaccine is also inactivated, but it only needs to be given once.
- Because they are inactivated, neither the flu nor the pneumoccocal vaccine carries the risk of side effects.
- The pneumococcal vaccine is offered to those aged 65 and over – it can be given with the flu jab on the same visit.
- The two vaccines have been offered at the same time for 5 years.

Shingles – possible age strategy

- One option for introducing the shingles vaccine would be to offer it routinely to everyone as they reach 65 years of age. In addition, there may be a catch-up campaign over three years for older groups.

044 Topic guide - groups

1. **Introduction and warm-up**

    - name; ages; (previous) occupations; family details; current interests and activities etc

2. **Current state of health**

    - how would they describe their current state of health; if they are affected by conditions, lifestyle issues etc, how recent are these
    - what do they expect to happen to their health over the next few years; why do they think this
    - which illnesses and conditions do they think might affect them over the next few years
    - what do they know about these illnesses – the symptoms, the risks, the changes of their developing them; which seem most significant from their point of view; which are they most concerned about
    - have they done anything to prevent these illnesses developing; is there anything they can do; where have they found out about this

3. **Recent jabs**

    - did they have a flu jab last autumn; if so, what happened – how were they told about it, where did they receive it etc; if not, why not
    - did they have a pneumococcal jab, perhaps at the same time as the flu jab (show information about this if necessary)
    - have they had any other vaccinations recently – if so, why
    - what is their view of these vaccinations (listen, then prompt) – are they worthwhile, or are they more trouble than they are worth

4. **Awareness and knowledge of shingles**

FROM HERE UNTIL THE MAPPING EXERCISE IN SECTION 8, NOTE SIGNIFICANT CONCERNS ABOUT SHINGLES AND THE VACCINE, AND SIGNIFICANT BENEFITS OF THE VACCINE AND ITS DELIVERY ALONGSIDE THE FLU JAB, ON INDIVIDUAL POST-ITS

- have they or close family/friend ever had shingles – if so, what was it like
- what do they know about shingles; specifically (do not prompt with information)…
  - its symptoms
  - its causes and the way in which it develops
  - its relationship with chicken pox – ie someone with shingles can give someone chicken pox
  - how serious and long-lasting it is
  - who is most at risk, and why
  - how widespread it is
  - its effect on your life – is it debilitating, or just annoying
  - treatment and prevention – what can be done
- how likely do they think they are to contract it; do they think they fall within an at-risk group; what factors increase and decrease the risk of contracting it
- have they ever thought about shingles; if so, what prompted this, what did they think about, and where did they go for information

5. **The need for a vaccine**

- do they think there ought to be a vaccine for shingles; would they take it up if it were offered for free – why
- how effective do they think a vaccine would be, based on what they know about shingles

- would they have any concerns about it; what would they need to know about it before taking it
- do they think a vaccine should be available to everyone, or just certain groups – if so, which groups and why

6. **More informed views**

SHOW SHINGLES CONDITION AND FIGURES INFORMATION CARDS

- which pieces of information did they not know about; how does finding this out affect their views on shingles
- how does this information affect their views on the need for and appeal of a vaccine
- what questions remain about shingles and the vaccine

SHOW SHINGLES VACCINE (1) INFORMATION CARD

- which of these facts seem more significant; what effect on their attitudes to a shingles vaccine do they have
- which facts are self-explanatory, and which need further explanation
- in particular, how clear are 'live vaccine' and the fact that only one dose is needed – what do these mean to them, and what else do they need to know
- what else do they need to know about the vaccine in order to come to a view on it

SHOW SINGLES VACCINE (2) INFORMATION CARD

- what effect on their views does this information have; specifically…
    - the idea of a live vaccine
    - a one-off injection, with no booster
    - the shingles vaccine is in use in the US

- the fact that it is based on the chicken pox vaccine which is already in use in the US since 1995 (explore views of the standard of testing in the US and the size of population)

7. **Delivery of the vaccine**

- when and where would it be best to receive the vaccine; what influences this – convenient location, time, person giving it etc
- would they be prepared to travel to get it; would they be more likely to have it if it were available in-home

SHOW VACCINE DELIVERY (1) CARD OUTLINING PLAN TO OFFER IT ALONGSIDE THE FLU AND PNEUMOCOCCAL JABS

- what do they think of this idea, on the face of it; what are the pros and cons
- would they be likely to take the vaccine if offered at this point – why / why not (probe for any concern about 'overloading the system', or two injections/needles on the same day)
- if they want the shingles vaccine separately, would they prefer to have it at another time of year, or simply on another occasion; what are the pros and cons of offering it alongside the flu jab in the autumn
- from what they know about the flu and pneumococcal jabs, how do these differ from the shingles vaccine; how important is this
- what do they need to know about the flu, pneumococcal and shingles vaccines if they are to come to a view on offering them together

SHOW VACCINE DELIVERY (2) CARD WITH FURTHER INFORMATION ABOUT THE FLU AND PNEUMOCOCCAL JABS

- does this answer their questions; what else do they need to know

- what would offering the shingles vaccine alongside the flu and pneumococcal jabs suggest about the shingles vaccine; specifically…
    - how safe is it – alone, and in conjunction with the other jabs
    - how effective is it
    - how necessary is it
    - how ‘special’ is it – an important decision, or just part of a general protection programme for older people
- what would it take to overcome any concerns they may have about receiving 3 vaccinations at once – what would reassure them
- do they think the shingles vaccine should be presented as an option in its own right, or as part of a ‘protection package’ that includes the pneumococcal jab and is offered at 65 – what are the pros and cons of the latter approach

SHOW AGE STRATEGY CARD

- would this approach make sense; strengths and weaknesses
- how would people in ‘the gap’ (ie 66 -79) feel about this

8. **Communications**

- how would they like to be told about the arrangements for the shingles vaccine – letter, advertising, in person by the nurse
- would they want to know about the vaccine before it was offered by the nurse
- if so, how much do they want to know about the vaccine in advance – which facts and how much detail
- what effect would this type of communication have on their likelihood of taking up the vaccine

9. **Mapping exercise**

- if not already covered…
    - what would persuade and motivate them to take the vaccine; what would trigger this
    - what concerns do they have about the vaccine and the idea of taking it alongside the flu jab; how significant are these – would they present barriers to take up

MAPPING EXERCISE – ARRANGE POST-ITS CREATED DURING THE INTERVIEW INTO HIERARCHIES OF POSITIVE AND NEGATIVE FACTORS

- which issues are most motivating; which most successfully counter the negatives
- are there any negatives or barriers that are not addressed by information or countered by motivations
- which aspects of the vaccine should be…
    - promoted most strongly to make it as appealing as possible
    - addressed as clearly and firmly as possible to alleviate concerns

10. **Summing up**

- what do they think about the shingles vaccine; why would they want or not want to take it
- would they take it as described; what would need to change about it for them to want it
- what should communications focus on if they are to motivate take-up of the vaccine

THANK AND CLOSE.

044 Topic guide – nurses

1. **Introduction**

   - name; experience; length of time in current post//job title, previous roles

2. **General views on vaccination**

   - which population groups do they vaccinate most frequently
   - how often do they vaccinate older people; what do they tend to vaccinate against
   - what do they think of the current vaccination programme for older people

3. **Vaccinations for older people**

   - how does vaccinating older people compare with other population groups – what makes it easier and harder
   - what is the procedure, and how does this vary across the population; how well does this work
   - how well informed do older people tend to be – do they know what vaccines there are, what they do, how they are delivered etc; how does this vary by vaccine, by age, by other demographics
   - do older people tend to ask for vaccines, or do health professionals tend to suggest these; where do they think older people get their information about vaccines
   - how do they feel about giving older people the flu jab and the pneumo vaccine at the same time
   - do they feel that the two vaccinations ‘sit together’ – why / why not
   - do they think that it would be better if some/all older people got the vaccines on separate occasions – why / why not
   - how do they think older people feel about receiving both – are they expecting this and how do they react to the idea; how does this vary across the population

4. **Views of the idea of a shingles vaccine**

- are they aware a vaccine against shingles is being considered; if so, where have they heard about this and what do they know
- what do they think of the idea – is shingles something that older people should be vaccinated against
- whom do they think should receive it – initially and once it has become established
- do they think older people will want it
- how might it be introduced – what would make sense to them

EXPLAIN THAT ONE OPTION WOULD BE TO OFFER IT TO ALL 80+S STRAIGHTAWAY, AND TO ROLL IT IN BY OFFERING IT TO 65S ONLY EACH YEAR; THERE MIGHT ALSO BE A CATCH-UP PROGRAMME TO ENSURE THAT THE AGE GROUPS IN BETWEEN DO NOT MISS OUT.

- what do they think of this plan – pros and cons
- are there likely to be any access issues for those over 80 – what would be the best arrangements for this age group

5. **Details of the vaccine**

EXPLAIN THAT THE VACCINE IS A LIVE ATTENUATED VERSION – USE VACCINE INFORMATION CARD (1) IF NECESSARY

- what do they think of giving live vaccines to older people – are there any other such vaccines
- do live vaccines present any risks or barriers which specifically relate to older people; how significant are these next to the benefits of the vaccine
- how do they expect older people to react to the idea of a live vaccine
- what would they tell older people about live vaccines to reassure or motivate them

6. **Delivery of the vaccine**

- when do they think it would be best to give the vaccine – at a separate appointment, in conjunction with something else etc
- what do they think of the idea of giving it at the same time as the flu jab and the pneumo vaccine – 3 at once
- how confident, clinically, would they be about doing this for older people – how might this vary across the population
- what implications does the fact that the shingles vaccine is live have – bear in mind the other two are inactivated
- how do they expect older people to react to the idea of 3 at once
- what would they need to tell older people about receiving multiple vaccines to reassure or motivate them
- what do they expect the 'logistics' of giving 3 vaccines at once to be like – would they be able to do it in a single appointment slot
- overall, how would this plan compare with giving the vaccines on separate occasions

7. **Communications for older people**

- would they want older people to find out about the shingles vaccine and the way in which it is delivered for themselves, or would they prefer to tell them personally – why
- what do they think older people need and would want to know
- what would they be likely to say to older people about the vaccine and its delivery method if asked
- what would they say to older people pro-actively
- what would motivate older people to want the vaccine; what would the main concerns and barriers be

8. **Summing up**

- do they think this vaccine should be introduced; if so, how best
- what should DH's communications to older people about the shingles vaccine focus on
- which aspects need to be promoted, and which create the need for reassurance
- do they have anything to add

THANK AND CLOSE.