Reducing smoking prevalence in Doncaster

A social marketing strategy

April 2008

DRAFT REPORT

This report was prepared for our client, Doncaster Primary Care Trust, in accordance with the contract entered into between Dr Foster Intelligence and the client and for the purposes agreed with them. We have relied upon the accuracy of the data and information supplied to us by the client and by other companies and organisations as referenced in the text. If the report is made available by the client to any other recipient, then Dr Foster Intelligence accepts no responsibility for any uses made of it by others.

Private and confidential
Clare Fuller
Client Services Manager

12 Smithfield Street
London
EC1A 9LA

T +44 (0)20 7332 8800
F +44 (0)20 7332 8888
www.drfoster.co.uk

A partnership between
The Information Centre for health and social care and Dr Foster Holdings LLP

Registered Company Number. 3812015

dr foster® intelligence

Smoking in Doncaster

Contents

dr foster® intelligence

A Summary

1 Background and Objectives

- Doncaster PCT commissioned Dr Foster Intelligence (DFI) to gain insights into six public health issues and to develop social marketing strategies aimed at achieving long term solutions.
- This report focuses on the issue of reducing smoking prevalence.

2 Method and Sample

2.1. Method

- Analysis of several national data sets to identify and profile the key target audiences in Doncaster who are most likely to smoke and who are most likely to want to quit smoking. Data sets included health needs mapping, lifestyle data from Mosaic™, Commissioning Dataset and data from Doncaster Stop Smoking service.
- Qualitative research with smokers from the key target populations identified by analytics. Participants took part in a "mystery shopping" exercise by trying to quit smoking using services provided by Doncaster PCT Stop Smoking service and reported on their experiences

2.2. Sample

- 11 (out of 14 recruited) participants took part in the pre "mystery shopping" focus groups. 8 returned to the post "mystery shopping" focus groups.
- Participants were screened to ensure a representative mix of age, gender and cultural/ethnic background. All participants were from socio-economic groups D&E.

3 Key findings

3.1. Analytics

- In 2006, smoking prevalence in the Yorkshire & Humber region was 24%; 1% above the national average. Amongst routine and manual groups this increased to 32%; 2% above the national average. Smoking prevalence in Doncaster is estimated to be above the regional figures.[1]
- Data from Doncaster PCT Stop Smoking Service shows that nearly two-thirds of current service users are female; the age-groups 21-40 and 41-60 are the largest groups and have very similar numbers of clients; Doncaster PCT Stop Smoking service clients come from across the PCT area.

3.2. "Mystery Shopping"

- The majority of participants were not aware of the range of services offered by Doncaster Stop Smoking service and had limited experience of using the service.
- Participants had broadly negative expectations of the service. However, participants' actual experience of the face-to-face Stop Smoking services

[1] General Household Survey/Yorkshire and Humber SHA

confounded their expectations. Experiences were broadly positive and they felt supported and motivated by their encounters. There were exceptions to this, in particular for participants who visited community pharmacists.

- Participants were less positive about their experiences of the telephone helpline and the website. Participants experienced difficulties in accessing the helpline and, when they did get through, they did not receive the help they expected. The website was unfavourably compared with other non NHS websites which were more interactive and inspirational.

4 Recommendations

4.1 Target groups

- C2DE, routine and manual workers should be the primary audience. Men and those aged between 25 and 45 should be prioritised.
- Smokers over 35 should be targeted with messages and information about COPD.
- The audience should be segmented by age and life-stage as motivations to quit change over time.

4.2 Strategy

- The strategy should combine service development and improvement with marketing and communication activity and wider tobacco control activities.

4.2.1 Service development and improvement

- Develop with providers a 'gold standard' service, in terms of delivery and customer care, to ensure consistency in the service offered and in relation to NRT.
- Ensure great customer service is delivered every time through effective performance management.
- Remove any hurdles and simplify the pathway wherever possible.
- Look at following-up smokers for longer if requested, ideally up to 12 weeks.
- Reach out to smokers by taking services to them, eg in workplaces or via a mobile unit.
- Follow-up unsuccessful quitters.
- Consider ways of making the service flexible to the needs of service users.

Telephone helpline

- Man the helpline during office hours and answer messages promptly.
- Minimise the amount of personal details requested during the first call.

4.2.2 Marketing and communications

Aims

- To raise the profile of the stop smoking service
- To build the reputation of the stop smoking service
- To improve access to the stop smoking service

Messages to promote

- A general stop smoking message, alongside information about how the stop smoking service can help.
- The health effects of smoking.
- The financial benefits of using the service, eg that NRT is available on prescription.
- Using the stop smoking service significantly increases the chances of quitting successfully.

Brand identity/logo

- Develop a strong identity or logo to increase smokers' awareness of the service and make it easier for them to find locally.

Brand proposition

- Clarify the brand proposition so that smokers are aware of the range of information, advice and support available.

Website

- Review the purpose of the website and invest in it accordingly.

4.3 Evaluation

- Evaluate the performance of the service via a range of measures which include accessibility, customer experience, and outcomes.
- Evaluate the performance of communications and marketing activities.

B Background and Objectives

1 Background

Doncaster PCT commissioned DFI to provide insights into six public health issues and to develop social marketing strategies aimed at developing long term solutions to these issues. The six public health issues were:

- Reducing the prevalence of smoking
- Increasing the rates of breastfeeding
- Reducing the number of falls in the elderly
- Reducing hospital admissions for COPD
- Increasing physical exercise
- Reducing childhood obesity

This report focuses on the issue of reducing smoking prevalence.

This report contains the initial recommendations for a social marketing strategy. This strategy will be further developed with PCT staff at a workshop on 13 May, 2008 and finalised thereafter.

2 Objectives

2.1. Analytics

The objective of the quantitative analysis was to identify and profile key target audiences in Doncaster who are most likely to smoke and who are most likely to want to quit smoking.

2.2. "Mystery shopping" research

The research objectives for the focus groups held before the "mystery shopping" were to:

- Explore the current lifestyle and behaviour of participants
- Explore experiences of previous quit attempts and expectations for their quit attempt as a "Mystery shopper"
- Explore their awareness and experience of NHS stop smoking products and services with a focus on services provided by Doncaster PCT
- Explore perceptions of and attitudes towards NHS stop smoking products and services

The research objectives for the focus groups held after the "mystery shopping" were to:

- Explore experiences of quitting using the Doncaster Stop Smoking Service
- Explore participants' experiences of information pathways into the Stop Smoking Service
- Explore pathways through services – including decisions made and what influenced them
- Explore perceived strengths and weaknesses of the current service
- Explore the ideal stop smoking service

C Method and Sample

1 Analytics

DFI carried out analysis of several national data sets to identify key target populations in Doncaster who are most likely to smoke and who are most likely to want to quit smoking. The national data sets used were:

- Health needs mapping, which matches Mosaic™ lifestyle types with socio-demographic and consumer lifestyle databases linked with health data at postcode level
- Commissioning Data Set (CDS)
- Mosaic™ lifestyle data
- Target Group Index data
- Data from Doncaster Stop Smoking Service

See Appendix for an explanation of these data sets.

2 "Mystery shopping" Research

2.1. "Mystery shopping" process

A "mystery shopping" approach was used in order to gain an inside, first-hand perspective on current services provided by Doncaster PCT Stop Smoking Service.

Participants in the "mystery shopping" exercise were asked to:

- Try to quit smoking using services provided by Doncaster PCT Stop Smoking Service
- Keep a diary of their experiences and fill in a structured workbook during the quit attempt
- Participate in a focus group before the quit attempt to talk about their perceptions of NHS Stop Smoking Services and their expectations for the quit attempt
- Participate in a focus group after the quit attempt to report back about their experiences and give their views on what a "gold standard" stop smoking service would look like

2.2. Advantages of "Mystery Shopping" research

Using the "mystery shopping" technique allowed us to:

- Capture participants' views before, during and after their quit attempt and to chart changes in their views over the process
- Ensure coverage of products and services provided by Doncaster PCT Stop Smoking Service by asking different participants to use a range of services

Qualitative research methods enabled in-depth and flexible exploration of participants' views, feelings, perceptions and experiences.

2.3 Sample

We recruited 14 current smokers from Doncaster. This number allowed for expected drop-outs during the "mystery shopping" process. In the end, 11 smokers took part in the focus groups held before the "mystery shopping". 3 smokers dropped out during the process and 8 returned to the focus groups held after the "mystery shopping.

Participants were screened to ensure a representative mix of age, gender and cultural/ethnic background. All participants were from D and E socio-economic groups, since these were the main target populations identified by analytics as being most likely to smoke.

Participants were split into two groups according to age because previous smoking behaviour and attitudes towards quitting differ according to age. Separate focus groups were held with younger and older smokers:

- Group 1 contained smokers aged between 25 and 40 years old
- Group 2 contained smokers aged between 41 and 55 years old

D Analytics

To support the development of a social marketing strategy, DFI analysed several national data sets to identify and map the target audience and to profile the lifestyle of those most likely to smoke. This section sets out the main findings from the quantitative analysis.

1 Smoking population in Doncaster and Yorkshire & the Humber

In 2006 the General Household Survey estimated that the prevalence of cigarette smoking in the Yorkshire and Humber region was 24%; 1% above the national average. Amongst routine and manual groups this increased to 32%; 2% above the national average. Smoking prevalence in Doncaster is estimated to be above the regional figures[2].

Yorkshire and Humber Public Health Observatory estimated that for 2004/5, Doncaster PCT was amongst the worst PCTs for smoking during pregnancy, with a smoking prevalence of 29% amongst pregnant women. The rate for England as a whole was 18%.

2 Profile of smokers in Doncaster

Analysis of national data sets shows that prevalence of cigarette smoking is associated with the following:

- Not being married
- Manual socio-economic groups
- Being economically inactive (for people between the ages of 16 and 59)

There is a higher level of smoking prevalence amongst smokers who are from socio-economic groups D and E.

Whilst analysis of Mosaic lifestyle data was undertaken, the findings were not felt to be useful as too many groups were identified with smoking.

On the basis of analytics, participants for the “mystery shopping” research were recruited from socio-economic groups D and E. We recruited smokers between the ages of 25 and 55, since there was no evidence to suggest that we should target a particular age-range of smokers. We recruited an equal mix of male and female participants. Although two-thirds of Doncaster Stop Smoking Service’s clients are female, this on its own does not demonstrate that the PCT should target males in order to increase the number of smokers quitting through the service.

3 Profile of current service users

Data from Doncaster PCT Stop Smoking Service shows that:

- Nearly two-thirds of current service users are female
- The age-groups 21-40 and 41-60 have very similar numbers of clients
- Doncaster PCT Stop Smoking Service clients come from across the PCT area

[2] Yorkshire and Humber SHA

3.1. Gender profile of service users

	Total	Percentage
Female	6818	62%
Male	4262	38%

3.2. Age profile of service users

Age Group	Number	Percentage
13-20	381	3%
21-40	4128	38%
41-60	4247	39%
61-80	2166	20%
80+	64	1%
Error (inc <10)	95	1%
Total	10,986	100%

E Qualitative Research

This part of the report is divided into three sections:

1 Findings of the pre-mystery shopping focus groups

2 Findings of the post-mystery shopping focus group

3 Strengths and weaknesses of the service

1 Pre-Mystery Shopping Focus Groups

1.1 Current lifestyle and smoking behaviour

1.1.1 Starting to smoke

The majority of participants started smoking during their teens because their peers were doing it and it was with being cool.

Two participants started before the age of 10. One was introduced to cigarettes by their father, the other by their babysitter.

Two participants started smoking in their twenties, one on millennium eve and the other after a bad relationship. Another participant started smoking when he was in the armed forces.

> *"I started smoking when I was about 12, I wanted to be with the cool kids"*
> **Focus Group Participant, Socio-Economic Group D/E, Age 25-40**

1.1.2 How smoking fits into daily life

The majority of participants smoked between 10 and 20 cigarettes a day. One person smoked 40 roll ups a day, another binge smoked, having days when they did not smoke at all.

One person who smoked around 6 cigarettes a day regarded themselves as being on the margins of being a smoker and a non smoker.

Common smoking behaviours reported were:

- Participants smoked more with other smokers
- Participants reported that they did not smoke in the same room as their children
- Participants reported smoking in their cars/vans as a habit and also because it was a place where they could smoke

Two participants reported that they hid their smoking from others. One participant reported that his wife did not know that he had started smoking again after previously quitting. The other participant reported that she was a secret smoker; her parents did not know she smoked.

1.1.3 Effect of 1 July legislation

Some participants reported that the ban had reduced their smoking, although one participant reported that he was smoking more.

A number of participants reported that it was no longer possible to smoke at work although some workplaces had created designated external smoking areas.

Some participants reported that they smoked less at work as a result of the ban. Many participants reported feeling that the ban had exacerbated the sense of smokers as social outcasts, in particular because they had to smoke outside. Some participants reported that they did not go to the pub as often because they were no longer able to smoke inside.

"Standing outside in a huddle – it looks desperate."
Focus Group Participant, Socio-Economic Group D/E, Age 25-40

"If you're occupied at work, you can get on with it [i.e. not smoke] – you can't have one anyway"
Focus Group Participant, Socio-Economic Group D/E, Age 25-40

1.2 Experiences and expectations of quitting

1.2.1 Past quit attempts

All of the participants had attempted to quit. The majority of participants had attempted to quit more than once. Some were serial quitters: one participant reported that she attempted to quit every New Year; another participant, that he had tried quitting 5 to 6 times; one participant reported that she had tried quitting 3 times in the last 3 months.

The length of time that participants managed to stop smoking varied. More than half of participants had quit for 6 months or more, of these, they had quit for 11, 18 and 24 months.

Motivations for past quit attempts

All the participants acknowledged the negative effects of smoking. For all of them, this had prompted their quit attempts.

Other factors also had an impact on quitting. The following were reported:

- Pregnancy
    - Some participants reported that they stopped smoking when they were pregnant
    - One participant reported that she had tried to cut down during her pregnancy
- Feeling healthier
- Attitudes of close relatives - some participants reported that their children did not like their smoking. This contributed to their motivation to quit.

"[It] Made me physically sick. I started smoking again when the baby was seven months old."
Focus Group Participant, Socio-Economic Group D/E, Age 25-40

"Didn't stop with any [previous] pregnancies, this time I'm cutting down."
Focus Group Participant, Socio Economic Group D/E, Age 25-40

"I've got mild asthma. I could run a few years ago. When I stopped I felt healthier."
Focus Group Participant, Socio-Economic Group D/E, Age 25-40

Reasons for failure of past quit attempts

The reasons that participants cited for returning to smoking included:

- Weight gain – a number of participants expressed concern about putting on weight when they quit
- Stress – Some participants reported that when they stopped smoking, they became stressed and this prompted them to start smoking again
- Boredom
- Social situations where other people were smoking
- End of pregnancy – Two participants reported re-commencing smoking when their babies were born

"I'm putting on stones here. That drives me back to it [smoking]."
Focus Group Participant, Socio-Economic Group D/E, Age 25-40

"Something minor happened. It builds up you get fed up. The first thing I reached for is my mate's fag."
Focus Group Participant, Socio-Economic Group D/E, Age 25-40

1.2.2 Past experiences of using NHS Stop Smoking Services

A minority of participants had previously used the NHS to quit smoking. Two participants reported barriers to accessing the service. These were:

- Too many steps and lacking immediacy - One participant reported that accessing the service was too complicated. She was given a form about quitting. She took it away and rang the number on the form. She was told that she would be contacted when a course became available. However, she wanted to get help immediately.

- No out of hours service - One participant went to see his GP. He was told to attend a clinic and would have to take time off work to do this. He chose to buy patches and quit that way instead.

One participant reported using the stop smoking service on two quit attempts. The first time was a positive experience. The first adviser appeared to have adopted the right tone and monitored the progress of the participant.

"Brilliant the first time. I stopped for a year and a half… First one [the adviser] didn't talk you like a kid. They were good, they rang to find out why I hadn't been in. They followed up."
Focus Group Participant, Socio-Economic Group D/E, Age 41-55

1.2.3 Past experience of using products

Some participants had previously used products to help them quit. They reported the following experiences.

Patches
Patches were the most commonly used products among the participants. Some participants reported that patches had helped them quit, although they reported inconsistent use of patches.

Some participants appeared to have used patches inappropriately.

"I had three patches on at the same time. My temper were sky high."
Focus Group Participant, Socio-Economic Group D/E, Age 25-40

Gum
Two participants had used gum and found that it tasted horrible. This was a disincentive to using it. Another participant reported that it had worked up to a point but he regarded gum as a stop-gap.

Nasal spray
Two participants had used a nasal spray and found it an unpleasant experience. One commented that it was worse than smoking a cigarette.

Inhaler
One participant had used an inhaler and found it helped with quitting by giving him something to do with his hands in the absence of a cigarette.

Zyban
One participant had used Zyban and reported that she may have taken it inappropriately.

Participants did not appear to regard NRT products as a form of medication. This may account for the inappropriate and inconsistent way in which they were used.

Some participants commented that the cost of buying products, in particular patches, was a financial disincentive. It was cheaper to carry on smoking.

1.2.4 Expectations for this quit attempt

Participants thought this quit attempt would differ from previous attempts because they felt more motivated to quit.

The reasons specific reasons cited were:

- Health concerns.
- Guilt and lack of pleasure from smoking.

- Impact of family and awareness of mortality

"This [smoking] becomes larger and larger –Russian roulette….
I don't want to get heart attacks."
Focus Group Participant, Socio-Economic Group D/E, Age 41-55

"Getting to a level of guilt. Every cigarette, I feel guilty about it,
there's no pleasure."
Focus Group Participant, Socio-Economic Group D/E, Age 41-55

"I want to see my kids grow old."
Focus Group Participant, Socio-Economic Group D/E, Age 25-40

1.3 Awareness of stop smoking products and services

1.3.1 Ways in which participants learnt about Stop Smoking services

Participants reported that they learnt about Stop Smoking services through the following channels:

- TV adverts
- Posters at GP surgery
- Stop smoking number on cigarette packets
- Cards with the number on the desk at the GP surgery
- Leaflets at the GP surgery
- Letter in the post
- Adverts on buses
- Word of mouth

Whilst many participants had heard about some Stop Smoking services, they did not generally associate them with Doncaster PCT Stop Smoking Service.

1.3.2 Awareness/experience of individual smoking cessation services and products

There was very limited awareness and understanding of the different stop smoking products and services offered by Doncaster Stop Smoking Service.

Participants offered the following responses to services and products:

One-to-one sessions with specialist stop smoking advisers
Only one of the participants was aware that this service was available. Half of the participants reported that they would use the service. Those participants who reported that they were unlikely to use the service said it was because they felt that they would feel pressured by the adviser.

Telephone support
A small number of participants were aware that this service was available. Some participants thought the service could be useful, others that the service was unlikely to be helpful. The majority (including those who thought it would be useful) stated that they were unlikely to use it. The reason given by those who thought the service could be useful was a lack of knowledge about how the service would work.

Group sessions
Almost all the participants were aware of group sessions. The majority of participants reported that they would use this service. They stated that the group setting would provide competition to quit, which would motivate them. They also commented that the group would provide the support they felt they needed to cope with family members and friends who smoked.

Community pharmacists
A minority of participants were aware of this service. The majority of participants reported that they were unlikely to use it. The reasons cited for this were: a perception that staff working in pharmacists were unlikely to have the appropriate expertise and no knowledge of the person's medical history.

"I see them as shop assistants"
Focus Group Participant, Socio-Economic Group D/E, Age 41-55

Drop-in
None of the participants were aware of this service. They reported that they were unlikely to use it because they were apprehensive about being with people that they did not know. They regarded the clientele at a drop-in to be changeable.

Nicotine replacement therapy (NRT)
All participants were aware of NRT. However, not all participants were aware that NRT is available on prescription.

Zyban and Champix
A small number of participants were aware of these products.

1.4 Perceptions of NHS Stop Smoking products and services

1.4.1 Perceptions of the NHS

The images and perceptions that participants had of the NHS were mainly negative. Only one participant associated the NHS with a good experience.

Participants associated the NHS with:

- Generally being second rate
- Hospitals being second rate
- Waiting lists
- Disease
- A lack of dentists
- MRSA and germs
- Expensive prescriptions
- Difficulties in accessing their GP

1.4.2 Attitudes towards using and perceptions of NHS Stop Smoking services

Participants responded more positively to Stop Smoking services. They thought of NHS Stop Smoking services as being "good" and "well meaning". They saw Stop Smoking services as somewhere that they could get advice and support.

However, some had concerns about stop smoking advisers being "do-gooders" or expected the stop smoking advisers to think that they would fail in their quit attempt. Some were worried about "feeling stupid" when they accessed the service.

Many participants associated stop smoking services with group sessions. They thought that the service would be predominantly delivered through groups and that these groups would be like Weightwatchers.

Some participants expected Stop Smoking services to be delivered by GPs. Others thought that they would be delivered by nurses. Many either wanted or expected Stop Smoking services to be delivered by people who had successfully quit smoking themselves.

1.4.3 Positives of quitting using the NHS Stop Smoking services

Participants reported that the positive aspects of quitting using the NHS Stop Smoking services were:

- Financial – they cited the provision of cheaper or free products. This is exemplified by a comment from one participant:

  "Not costing if you fail – quite an expensive thing if you fail"
  Focus Group Participant, Socio-Economic Group D/E, Age 41-55

- Expertise – this was summed up by a participant:

  "[They're] Dedicated to doing this not anything else"
  Focus Group Participant, Socio-Economic Group D/E, Age 41-55

- Knowledge of the patient – this was the case where participants regarded their GP as the provider of the Stop Smoking service.

- Diagnosis of other illnesses – participants suggested that the service would be able to identify other illnesses as part of the process of providing help with quitting.

- Tailored individual assistance

- Making it easier to quit

1.4.4 Feelings about using NHS Stop Smoking services

To explore participants' feelings about using Stop Smoking services and their perceptions of the attitudes of service staff, they were asked to provide the text for bubble diagrams.

Feelings about specialist Stop Smoking advisers

In relation to using specialist Stop Smoking advisers, participants expressed the following concerns:

- Being able to quit with the help of the advisers
- Being able to access the required level of support and expertise from the advisers
- That the adviser might know the participant
- Apprehension about what will happen at the first meeting with the adviser
- The ability of the adviser to do something different and/or tell the participant something they did not already know
- Apprehension at "sounding like a loser"

Participants perceived that the advisers would:

- Be judgemental
- Doubt the commitment of the smoker to quitting
- Regard the smoker as a "weak person"

The following quotes are from participants saying what they think Stop Smoking advisers would think of them:

"Phew he stinks of fags"
Focus Group Participant, Socio-Economic Group D/E, Age 25-40

"Does this person really want to stop, or is she wasting my time?"
Focus Group Participant, Socio-Economic Group D/E, Age 41-55

"My god all it is, is will power"
Focus Group Participant, Socio-Economic Group D/E, Age 41-55

Feelings about GPs

In relation to using GPs, participants expressed similar concerns. In addition they had the following additional issues:

- Not being understood, in particular by someone who had never smoked
- Smoking being recorded on their case file
- Concern that the GP would feel that the participant would be wasting their time
- That the GP would regard the participant as being stupid
- That the GP would not be interested in the participant

The following quotes are from participants saying what they think GPs would think of them if they asked for advice on quitting smoking:

"How can someone be so stupid to smoke?"
Focus Group Participant, Socio-Economic Group D/E, Age 25-40

"What time is it, nearly home time?"
Focus Group Participant, Socio-Economic Group D/E, Age 41-55

Feelings about community pharmacists

In relation to using community pharmacists, participants felt that pharmacists were:

- Least able to assist them with quitting
- Likely to regard the participant as just another customer - not as a patient
- Likely to exploit the participant

The following quote is from a participant saying what they thought community pharmacists would think if they asked them for advice on stopping smoking:

"I'm going to sell them the most expensive thing."
Focus Group Participant, Socio-Economic Group D/E, Age 41-55

2 Post-Mystery Shopping Focus Groups

2.1 Success of quit attempts

2.1.1 Changes in smoking behaviour

Participants were asked how successful their quit attempt was. All reported changing their smoking behaviour to some extent during the four week quit attempt.

Half of the participants who attended the post mystery shopping focus groups had stopped smoking. The other half had cut down the amount that they smoked or had stopped for a short period during the four weeks.

The majority were positive that they were going to continue with their quit attempt. The participants who had cut down, regarded this as part of their quit attempt.

There was a range of reasons why participants had not quit. They cited:

- Access to services - Some reported that they had tried to access a service and had difficulties, in some cases they had not tried again
- Being unable to speak directly with a person
- Lack of access to the product that they had requested
- Conditions attached to prescribing NRT
- Too busy with other commitments to quit

"There were nobody there and they only do three days. Why isn't there somebody there all the time when the chemist is open?"
Focus Group Participant, Socio-Economic Group D/E, Age 41-55

"I got the answering machine. I don't like leaving messages on machines"
Focus Group Participant, Socio-Economic Group D/E, Age 41-55

2.2 Experiences of information pathways

2.2.1 Telephone helpline

Participants reported negative experiences of the helpline. These follow:

Difficulties in speaking to an adviser

Participants who tried the telephone helpline reported difficulties in speaking to an adviser. They called the helpline at least three times and on all these occasions the line was either engaged or rang out. Participants reported that they tried telephoning at different times of the day with the same negative result.

One participant called the helpline and received an answering machine message. She commented that she did not like answering machines and declined to leave a message. She was put off from calling the helpline and did not try it again.

Other participants were also put off from making further calls to the helpline after they had failed to speak to an adviser.

"I just got an engaged tone and then I just kept putting it down and re-trying. I rang it about 20 times."
Focus Group Participant, Socio-Economic Group D/E, Age 25-40

Poor response from the adviser

When participants did get through to speak to an adviser they reported disappointing experiences. They expected to receive advice on how they could quit but felt that they were just being asked for information about themselves.

"Well I felt as though she [the helpline adviser] must have just walked into the office straight away, now I've got to go and she couldn't be bothered to talk to me or to explain to me, she was like rushing me. And then she started babbling on about other things…I felt she was all for passing the buck, as if to say, well, don't bother me again if you don't want to make an appointment…. I didn't get what I wanted and I felt worse phoning it [the helpline], I felt daft and silly"
Focus Group Participant, Socio-Economic Group D/E, Age 25-40

Poor follow up

Two participants reported that they were asked for their contact details and were told that an adviser would call them back. Neither participant received a call.

"I expected somebody to call back that day. You know I thought she was going to pass the information to somebody else and they were going to call me straight back. And after the first couple of days I was,

like, well, are they going to ring me back, or they going to ring me back ? And then after that I sacked it off, I just thought, well, obviously they're not bothered."
Focus Group Participant, Socio-Economic Group D/E, Age 25-40

Improvements to the helpline

Participants reported that they had psyched themselves up to telephone the helpline. They expressed disappointment that their resolve to quit had not been capitalised upon and/or responded to.

"When you're smoking, you look for any excuse not to do something [to quit]"
Focus Group Participant, Socio-Economic Group D/E, Age 41-55

Participants suggested that the helpline could be improved in the following ways:

- More staff to answer the phone
- Arrange to call back the caller
- Offer an appointment up front, ie before asking for the smoker's details
- Offer a choice of support (up front) on the phone or face-to-face
- Use ex-smokers to staff the line – there was a presumption by participants that someone who had been through the same situation would exhibit a of greater empathy and understanding
- Provide information that smokers can act on – "If you phoned a helpline and they could access the facilities in your area, make an appointment for you, or tell you where to go."
- Switch the emphasis away from just providing information about the effects of smoking

"You don't need to be told about the dangers."
Focus Group Participant, Socio-Economic Group D/E, Age 25-40

2.2.2 Website

Only a few participants were familiar with or felt comfortable using information technology. Therefore a smaller number of participants tried the website compared to those who tried the telephone helpline.

The experiences of those who tried the website were mixed.

Site layout
Two participants commented that the website had a clean look and was well laid out. One of these participants described the site as "non serious, inviting and friendly".

Site content
The two participants who were positive about the site layout were disappointed by the content. They commented that the site felt underdeveloped. They made comparisons with other websites they had tried such as sites run by ASH and QUIT. They regarded the following features attractive:

- The sites were more interactive

- The sites promoted positive, inspiring messages about quitting – one site featured testimonies for ex-smokers who had quit
- The sites were more involving and provided users with things they could actively do to help themselves quit

Participants reported that the Doncaster Stop Smoking site had none of these features and the content focussed on explaining the Stop Smoking service. Participants regarded this information as being unimportant to them.

They expected to find information about how they could quit smoking rather than information about the service.

One participant, reflecting the views of some others, commented that there was too much text on the site. This was off-putting.

"…absolutely irrelevant information to us. We know why the Doncaster Stop Smoking service is there, its not there to help you paint radiators, is it?"
Focus Group Participant, Socio-Economic Group D/E, Age 25-40

"If you're not clever with computers or you're not clever with reading, which I'm not, all that to me is just too much to sit and read through it."
Focus Group Participant, Socio-Economic Group D/E, Age 25-40

"There wasn't anything there that dragged you into it and you need inspiration, whatever you can get when you try to stop smoking."
Focus Group Participant, Socio-Economic Group D/E, Age 41-55

Language

One participant suggested that the language used on the site did not motivate or encourage smokers to quit.

"Also the language, as a clinical form it works. It's like a form that, it looks like thing that you get from the hospital in a sense, which sort of makes sense in a way, but there's no thrust about positive and having a bit of willpower and stuff like that."
Focus Group Participant, Socio-Economic Group D/E, Age 41-55

Accessibility

One participant found the Stop Smoking Service page on the PCT website but was unable to proceed to other sections of the site. She clicked on a link and was informed that this part of the site was under reconstruction. The participant did not try the site again.

Improvements to the website

Participants suggested that the website could be improved by the following:

- Less text

- Instant access (ie when the page is reached) to advice on quitting
- A step-by-step guide to using/accessing the services

2.3 Pathways through the service

The majority of participants had tried more than one of the following services:

- One-to-one sessions with the specialist stop smoking adviser
- GP
- Practice nurse
- Stop smoking nurse based at the GP surgery
- Community pharmacist
- Telephone helpline
- Website

The majority of participants had positive face-to-face experiences of the Stop Smoking service. Their experience was generally more positive than they expected before the "mystery shopping" process.

Participants reported that staff were non-judgemental, helpful, understanding, welcoming and supportive. The staff were described as "brilliant" and "good" and made participants feel proud and confident about themselves, and reassured that quitting was the right decision.

There were, however, mixed responses to services provided by community pharmacists. Reasons for this are given below.

The majority of participants found it fairly easy to access face-to-face services.

2.4 Highs and lows during the 4 weeks

Participants were asked to identify high points and low points during the 4 weeks between the pre and post "Mystery Shopper" focus groups.

High points were associated with:

- Making face-to-face contact with a GP, stop smoking adviser or stop smoking nurse
- Overcoming relapses (having a cigarette after quitting)
- Managing to cut down the number of cigarettes smoked
- Use of non-NHS smoking cessation websites

Low points were associated with:

- Participants trying to quit without help from the service and/or without the use of products

- Poor service responses principally from using the helpline and the Doncaster PCT website
- Relapsing

There was no overall pattern to the timing of the highs and lows experienced by participants. The majority of participants experienced highs and lows during the four weeks. However, positive contact with Doncaster PCT Stop Smoking service (through a GP, nurse or specialist adviser) was a key factor in engendering and maintaining a positive feeling about quitting

2.5 Use of a range of services

Participants were asked try a number of services as part of their "Mystery Shopper" experience. This may have accounted for the range of services that participants used.

It is unclear if participants would have continued to try other services (under normal, non-directive circumstances) if they had had a poor, first time experience of one part of the Stop Smoking service.

There was no single common pattern to the pathway followed by participants in their use of the Stop Smoking service. However, two quit approaches appear to emerge from the data:

- Graduated approach to using the service – this is characterised by attempting to quit without any support; followed by attempted and/or use of the helpline or website; followed by face-to-face contact with a GP, stop smoking nurse or stop smoking adviser; use of prescribed NRT
- Adaptive approach to using the service – this is characterised by face-to-face contact generally with a known medical professional eg GP or nurse at the GP practice; followed by further face-to-face booster support from the medical professional and/or support from the helpline or websites (NHS and non-NHS sites).

2.6 Experiences of face-to-face services

The experiences of the different face-to-face services used by participants are detailed below.

GP

Participants who used their GPs were generally positive about the service they received. Participants opted to approach their GPs for face-to-face assistance because they were familiar with them and this was less stressful.

One participant visited their GP every week over the 4 week period. This person had received a prescription for gum that was intended to last for 2 weeks. He used up the gum within one week and had to buy additional gum. He found his GP supportive and understanding.

One participant approached his GP with a request for Champix. His GP informed him that he would need to obtain clarification if this was available to prescribe to the participant.

Another participant was informed by her GP that they would not prescribe any NRT for her unless she agreed to undertake a stop smoking course. She did not want to undertake a course and therefore received no NRT. This approach contrasted with the approach reported by other participants. Their GPs had not stipulated that participants had to undertake the course as a condition for prescribing products.

"You've got all this stopping smoking and particularly if you're a bit shy or whatever, then you've got to go through that whole process which is another stretch, of going to a group thing or people you don't know and that's quite stressful, isn't it."
Focus Group Participant, Socio-Economic Group D/E, Age 41-55

"Champix at the moment in Doncaster isn't here….He's [GP] looking into it.!
Focus Group Participant, Socio-Economic Group D/E, Age 41-55

"I got an appointment the day after with my GP but they wouldn't give me anything on prescription unless I agreed to go on the course, its this group thing and I didn't go."
Focus Group Participant, Socio-Economic Group D/E, Age 41-55

Nurse at GP practice

Participants reported positive experiences of their face-to-face encounters with nurses at their GP practices.

Participants particularly valued the immediacy of the one-stop approach to accessing a prescription for NRT, support and help. There was an expectation that it would take several steps before they could receive a prescription.

One participant valued the additional help that the nurse provided. He was weighed and undertook a carbon monoxide breath test and was told that this would be monitored over the coming weeks.

"I were quite amazed that I got my things there and then, the first week."
Focus Group Participant, Socio-Economic Group D/E, Age 25-40

Specialist stop smoking adviser

Only one participant had experience of using a specialist stop smoking adviser. She was positive about her one-to-one experience with the adviser. This participant had recently given birth and was visited at home by the adviser. The participant was surprised at the amount of time that the adviser spent with her; around an hour. The participant felt encouraged and was given a letter by the adviser to pass on to her GP to obtain a prescription for NRT.

While the experience with the adviser was positive, the participant reported that accessing the service from the adviser took a number of steps which was less positive. These were:

- Step 1 – Participant spoke to an adviser at the GP surgery about quitting while pregnant and was told to wait until the baby was born.
- Step 2 – Participant spoke to the same adviser at the GP surgery after the participant's baby was born. The participant was given leaflets (which the participant did not read) and was told that it might be quicker for the participant to access the Stop Smoking service through the health visitor.
- Step 3 – The health visitor visited the participant and was aware that the participant wanted to quit smoking. The health visitor advised the participant that she would make a referral to a specialist stop smoking adviser.
- Step 4 – A specialist adviser called and arranged a home visit.

"The lady that came out to see me the other day, though, she never mentioned anything to do with the side effects from smoking. I mean she was there for about an hour. I was only expecting her to come out to, you know like you have your meeting at the doctors? I actually expected it to be something like that but it wasn't, she was really, really good and she gave me a letter to take to the doctor for a prescription at the end. So she was really good."
Focus Group Participant, Socio-Economic Group D/E, Age 41-55

Community pharmacist

Four participants used the community pharmacist. Two reported positive experiences, two reported negative experiences.

The participants who had positive experiences reported that the pharmacists were supportive, they provided NRT in one case and advice on the use of gum and managing blood pressure in the other case.

The participants who had negative experiences were disappointed at the lack of service continuity. They reported that they had summoned up the resolve to approach the pharmacist for advice and support to learn that the member of staff who had been trained to provide stop smoking advice was on holiday or was not working on that day. One of the pharmacies approached was part of a national chain of chemists. The participant who used this branch expected a national chain to have more than one trained person available in store to provide the service.

"I went to the chemist and the lady that did this now was on holiday, so why don't they have somebody to cover…I was disappointed, because I psyched myself off and I thought I was going to whooshed away and it just didn't materialise." **Focus Group Participant, Socio-Economic Group D/E, Age 41-55**

"They [pharmacist] were very helpful and I don't smoke may anyway, but it was helpful"
Focus Group Participant, Socio-Economic Group D/E, Age 41-55

3 Strengths and weaknesses of the service

3.1 Strengths

Participants were generally positive about the attitude and expertise of the service staff they encountered in a one-to-one, face-to-face situation.

The staff provided tangible help and support which helped participants to feel motivated and supported in their quit attempt.

Participants were positive about the flexibility of the one-to-one services and felt able to return to use these services at any time.

In addition participants valued any monitoring and feedback on progress that was offered. However, this did not appear to have been offered consistently by all staff.

3.2 Weaknesses

Participants identified the following weaknesses in the current service:

- Inconsistent provision – there were variations in the conditions attached to the prescription of NRT; levels of service, in particular monitoring change/progress through the provision of carbon monoxide testing and measuring weight gain; and the advice given on managing weight gain
- Continuity of provision – specifically in relation to stop smoking advice provided by community pharmacists
- Lack of out of office hours provision to enable people who worked to access services
- Lack of positive, inspirational messages within the literature and promotional information about quitting
- Prescriptions are limited to 12 weeks only

3.3 Ways to improve the service

Participants suggested the following service improvements:

- Consistent provision of services
- Ensure continuity of provision in community pharmacists
- An out of office hours drop-in located in the centre of Doncaster – this could be used as a place to visit when quitters need face-to-face encouragement and/or a pep talk to help with their craving and motivation
- Developing a positive and easily identifiable brand identity for the Doncaster Stop Smoking service. The Smoke Free Doncaster brand was regarded by participants as misleading, as it had associations with smokeless fuel. In addition, although the website carried the Smoke Free Doncaster logo, this was not the name used for the telephone helpline.

- Adopt a more pro-active and inspirational tone to the promotional information to motivate smokers to quit

- Extend the period for providing prescriptions for NRT

"The whole thing is key to this but something like a brand identity, where everything is pulled together like the helpline etc, they're all coming from something that's a life care programme, so its got a name, the Doncaster PCT, its got a logo, it's more a brand type thing, where it's Quit Smoking Doncaster or whatever, so everything is pulled into one place and you can keep seeing the same thing in doctors surgeries."

Focus Group Participant, Socio-Economic Group D/E, Age 41-55

F. Conclusions

- The 2006 General Household Survey estimated that the prevalence of cigarette smoking in the Yorkshire and Humber region was 24%; 1% above the national average. Amongst routine and manual groups this increased to 32%; 2% above the national average.
- Data from Doncaster PCT Stop Smoking service shows that nearly two-thirds of current service users are female; the age-groups 21-40 and 41-60 are the largest groups and have very similar numbers of clients; Doncaster PCT Stop Smoking Service clients come from across the PCT area.
- The majority of participants in the focus groups were not aware of the range of services offered through the Doncaster Stop Smoking service and had limited experience of using the service.
- Participants had broadly negative expectations of the service. Their perception was that the service would be judgemental; staff would lack empathy and understanding; staff would not be able to help them; and that staff would lack the relevant expertise.
- Participants' actual experience of the face-to-face Stop Smoking services confounded their expectations. Their experiences were broadly positive and they felt supported and motivated by their encounters with the face-to-face services.
- Participants were less positive about their experiences of the telephone helpline and the website.
- Participants experienced difficulties in accessing the helpline service. When they did access the service, they did not receive the help they expected.
- The Doncaster Stop Smoking service website was unfavourably compared with other non NHS websites which were more interactive and more inspirational.

G. Recommendations

Our initial recommendations for your smoking strategy are outlined below, however, these will be further developed with PCT staff at the workshop on 13 May and finalised thereafter.

Our recommendations are based on the findings of our research in Doncaster and also on the knowledge gained in recent years from smoking projects in Greater Manchester, Oldham and London.

1 Target groups

- C2DE, routine and manual workers should be the primary audience. Men, who have a higher smoking prevalence and are less likely to use the smoking service, and those aged between 25 and 45 should be prioritised.

- The audience should be segmented by age/life stage as motivations to quit change over time, eg becoming a parent.

- Our work on COPD has identified that smokers over 35 should be targeted with messages and information about the condition.

- The PCT may want to target very low income groups as they are most likely to die prematurely from smoking related disease. However, as these groups are less likely to quit and also less likely to use stop smoking services the cost of reaching them is much greater. Other minority groups such as those from Asian, Eastern European and travelling communities are also meaningful targets but require a separate strategy to that recommended here. With all these groups, the PCT must decide on the appropriate balance between effectiveness and equity when developing its strategy.

2 Strategy

Your strategy should combine service development and improvement with marketing and communications and wider tobacco control activities.

2.1 Service development and improvement

- Develop with providers a 'gold standard' service, in terms of delivery and customer care, to ensure consistency in the service offered and in relation to NRT. Ensure that CO monitoring is an integral part of the service as many smokers say it helps keep them motivated. Weight monitoring should also be offered as fear of gaining weight is one of the biggest disincentives to quitting amongst women. Provide standardised information about NRT to ensure correct usage.

- Promote a service culture that ensures that every encounter the quitter has with the service advances their attempt to quit smoking permanently.

- Improve access to the service provided by pharmacists via the use of appointment times, but continue to offer open access as well.

- Ensure great customer service is delivered every time through effective performance management. Personal recommendation is the best way to build demand for any product and a stop smoking service is no different.

- Remove any hurdles and simplify the pathway wherever possible. Make sure that access is easy for those who self-refer or who are referred by others. If a provider is unable to see a smoker at a time that is convenient for them, they should refer on to someone who can (and, if necessary be paid accordingly).

- Look at following-up smokers for longer if requested, ideally up to 12 weeks. Many smokers say that restricting contact to four weeks is not long enough.

- Reach out to smokers by taking services to them, eg in workplaces or via a mobile unit.

- Following-up unsuccessful quitters is also valuable, they are very likely to return if they feel they will be welcomed back and their feedback is valuable.

- Consider ways of making the service flexible to the needs of service users. For example, a drop-in service in a central location that people can use as and when they want/need it or providing more services outside normal working hours, to enable people to use services without taking time off work (and potentially losing money).

Telephone helpline

- As one of the main routes into the service, the telephone helpline must be efficiently run at all times.
- It should be manned, for a minimum, during office hours and messages answered promptly.
- The amount of personal details requested should be kept to a minimum and, wherever possible, calls should always forward the person's quit attempt.

2.2 Marketing and communications

Aims

The aims of your marketing and communications activity should be:

1. To raise the profile of the stop smoking service
2. To build the reputation of the stop smoking service
3. To improve access to the stop smoking service

NB These aims should be quantified and measurable.

Messages

- As more smokers quit without the help of NHS stop smoking services, communication should be a combination of general stop smoking messages alongside information about the service.

- For most people the effects of smoking on their health are the main reasons for quitting.

- Linking health with the cost of tobacco or the effects on children can increase the emotional impact of the message.

- Promote the financial benefits of using the service - specifically that NRT is available on prescription

- Promote the message that using stop smoking services significantly increases the chances of quitting successfully.

Brand identity/logo

- Raising the profile of the service and developing a strong identity or logo will increase smokers awareness and make it easier for them to find the service locally. The current smoke-free logo can be misleading and is associated with smokeless fuel rather than stop smoking services. In addition, the NHS has both positive and negative connotations so it may be advisable to position the service at arm's length from the NHS.

- We would like to explore the issue of branding further in the light of the other research we are currently conducting and during the workshop with staff in May.

Brand proposition

- Clarifying the brand proposition so that smokers are aware of the range of information, advice and support available is vital, as is raising smokers expectations of the service

- Ensuring that smokers are aware that the service is provided by advisors and pharmacists, as well as GPs, is also important as many people are reluctant to visit their GP about stopping smoking.

- Clarifying why smokers should use the service rather than an alternative, such as quitting alone or buying NRT over the counter, is important.

- Men often feel that using a 'support' service is a sign of weakness and so positioning the service as 'providing the tools to help quit' is a more attractive offering for them.

Website

- Review the purpose of your website and invest in it accordingly. Provide information about quitting, as well as the service, and links to other related sites.

.

3 Evaluation

- It is recommended that the PCT evaluate the performance of the service via a range of measures which include accessibility, customer experience and outcomes (still not smoking after four weeks, three months or one year).

- The performance of communications and marketing activities should be measured against their original objectives in terms of awareness, uptake and impact.

4 Wider tobacco control issues

We have not looked in detail at wider tobacco control issues in Doncaster but recommend that they should include:

- Work with schools and other children's services across sectors to ensure everything possible is done to persuade children and young people not to smoke and to make it as difficult as possible for them to smoke.

- The vigorous enforcement of smoke-free legislation, in particular in venues frequented by people from routine and manual groups such as pubs, clubs and bingo halls.

- Work with the police, customs and excise and Doncaster Metropolitan Council to reduce access to contraband tobacco products as it is very likely that most low-income smokers are not paying the full price for their cigarettes.

Appendix

Explanation of datasets

1 Health Needs Mapping

By matching data on Mosaic™ lifestyle types (see below) with several socio-demographic and consumer lifestyle databases, linked with health data at postcode level, Dr Foster Intelligence is able to map the health needs of residents.

Risk levels of admission to hospital have been calculated by correlating Hospital Episode Statistics (HES – see below) with the Mosaic™ database. The process is as follows:

- HES records the postcode of each patient admitted to hospital.
- Using these postcodes, Dr Foster Intelligence has identified the Mosaic™ lifestyle type of every patient admitted to hospital for a number of conditions.
- The proportion of each lifestyle type that was admitted for each of these conditions was then compared with the proportion of all adults admitted. This enabled us to calculate whether, at a national level, members of each lifestyle type were more or less likely than average to be admitted to hospital for each condition.
- Because this gives a level of risk to each lifestyle type for each condition, and because each postcode is assigned to a particular lifestyle type, it is possible to show these levels of risk at a postcode level.

Risk levels for smoking and drinking at a postcode level were calculated by Experian as part of the research process for Mosaic™.

2 Mosaic™

Mosaic™ geo-demographic neighbourhood level analysis techniques applied widely in the private sector are used in this report to:

- Classify people into 11 clearly defined socio-economic groups, and then into 61 sub-groups. These groups are defined at a national level, but can be applied to all UK localised areas.
- Locate these groups geographically, by postcode.

Mosaic™ breaks the UK population into 61 types based on more than 400 data variables. Key within these are the 2001 census, ONS local area statistics, the electoral roll, Experian Lifestyle Survey information, consumer credit activity, Shareholders Register, house price and council tax information. Other data resources incorporated in the analysis include education and crime databases.

The advantage of using Mosaic™ is that it enables a closer understanding of the target audience for any social marketing campaign, as well as an insight into the communications methods to which they will be most receptive.

3 Target Group Index

Target Group Index (TGI, part of the BMRB Group), the largest ongoing research tracking study in Europe, is an established and highly respected survey that was created in 1969 and has since been replicated throughout the world, from North America to Germany and Scandinavia to Israel.

The survey, of 25,000 UK adults (aged 15 and above), is constructed with a 20-minute face-to-face questionnaire, followed by the placement of a wide-ranging, self-completion questionnaire. Responses are then weighted to accurately reflect the UK population and the National Readership Survey. Data is collected continuously and is released in four rolling 12-month periods.

Extensive demographic and geo-demographic (postcode) data is incorporated, together with purchase and usage data on over 4,000 brands in more than 500 product fields. Media exposure and usage, from magazines and newspapers to TV, radio, posters and cinema is measured. In addition, behavioural characteristics such as smoking (as well as giving up), alcohol consumption, diet, minor ailments, propensity to consult a doctor or visit a pharmacist, and so on, are measured.

Attitudinal data, which uses answers to 267 lifestyle statements (with five agreement levels), is taken across a wide variety of categories including media, society, self perception, motivation, interests, finance, food, the environment, diet, health, etc. A further 124 lifestyle questions (agree/disagree) are incorporated.

TGI is used by Dr Foster Intelligence as a means of understanding target groups in terms of communication needs and preferences. Importantly, it also allows the identification of potential strategies for communicating health messages to these audiences.

Results should be treated with some caution, however, as samples for individual lifestyle types are relatively small.

4 Data from Doncaster Smoking Cessation Service

11,081 anonymised client records were provided by Doncaster Smoking Cessation Service for analysis in this report.