Introduction

Lung cancer is the UK’s biggest cancer killer in both men and women, and the second most common cancer after breast cancer. Every day in the UK more than 100 people are diagnosed with lung cancer. However, UK lung cancer 5-year survival rates (7%) are lower than those in Europe (16%). Early diagnosis is crucial to improving these disappointing figures.

The Cancer Reform Strategy and the National Awareness and Early Diagnosis Initiative (NAEDI) have focused attention on these aspects of cancer care.

This ‘How To’ guide’ describes one local response to the NAEDI initiative. The Early Lung Cancer Intervention in Doncaster (ELCID) aims to increase the numbers of people diagnosed with lung cancer at an early enough stage to offer them curative surgery to improve survival.

ELCID, also known as ‘3 week cough’ or ‘Cough cough’, has been highlighted as good practice by the Health Inequalities National Support Team and was highly commended in the 2009 HSJ Awards social marketing category.

This ‘How To’ guide should be read in conjunction with the Health Inequalities National Support Team guides [http://www.dh.gov.uk/en/Publichealth/Healthimprovement/NationalSupportTeams/HealthInequalities/index.htm](http://www.dh.gov.uk/en/Publichealth/Healthimprovement/NationalSupportTeams/HealthInequalities/index.htm) and the National Social Marketing Centre toolbox [http://www.socialmarketing-toolbox.com](http://www.socialmarketing-toolbox.com). This guide uses the following 6-step model.
Step 1. Define (building the business case)

This initial step builds the case for an early intervention/early diagnosis project. It requires the problem to be defined and potential solutions to be outlined. It also ensures an assessment of the ability to deliver a solution and the conduct of a preliminary stakeholder analysis.

1.1 Is there a problem locally?

What is the incidence, mortality, 1- and 5-year survival rates from lung cancer in your locality? How does this compare to other areas? How does this compare to international best practice?

Are there any bottlenecks in the pathway such as 2 week wait, cancer waiting times, diagnostics, PET CT, surgical intervention rates?

What evidence is there that cancers are being detected late?


1.2 Is there a solution?

Is there evidence that anything could be done to improve survival? Depending on the nature of the problem the solution may lie in commissioning decisions (such as ensuring rigorous evaluation of physiological reserve with exercise testing, adequate PET CT), service improvement methodology (long cancer waiting times) or interventions targeted at earlier diagnosis.

Good sources of information are the British Journal of Cancer supplement (Vol 101 (S2), 3 Dec 2009), social marketing approaches (including this one) and the Healthy Communities Collaborative.

1.3 Is the solution deliverable?

Are the right people engaged with the project? Has an initial stakeholder analysis been conducted? Has a steering group been established?

Are there any obvious consequences of the proposed solution on the rest of the pathway, such as increased demand for chest X-rays, out-patients, or other diagnostics?
How will the impact of the proposal be measured?

A steering group is essential and the initial membership requires relevant clinician(s) from primary care and secondary care, public health and local cancer commissioner representatives. Skills required include project management and social marketing if available.

1.4 Write an outline project brief and sign off

Can the project aims and objectives be defined as tightly as possible? Are the key stakeholders listed? Can the impact of the proposal be quantified? Is there an agreed project budget? Are there any gaps in knowledge that need to be clarified in step 2?

This is best captured in a project brief, which should be approved by the key stakeholders and have appropriate organisational sign off. The impact of the proposal may be described in terms of contribution to local outcome targets (commissioner or provider led) or may use proxy measures including process measures such as stage of diagnosis or number of chest X-ray referrals.

Reducing cancer mortality is a local priority in Doncaster and is a target for both the PCT and the local authority. Lung cancer contributes more than 10% of the gap in life expectancy between Doncaster and the national average.

In Doncaster a steering group including a GP, a lung cancer physician, a public health specialist and a qualitative researcher reviewed Doncaster’s high incidence, mortality and poor survival from lung cancer. The pathway from primary care through secondary care to treatment was discussed by the steering group and we concluded that the key contributor to our poor survival was late presentation.

The key aim of the project was to increase early diagnosis (measured by stage of diagnosis at presentation). A small non-recurrent budget was identified to allow us to proceed to step 2 and this was agreed at the Doncaster Cancer Partnership Board.
Step 2. Scope (making the case)

This stage is the most crucial. It takes the project brief for early intervention/early diagnosis and defines further the project aims, objectives and barriers. It requires an expanded steering group to ensure a thorough understanding of the clinical and consumer perspectives, and to enable local agreement of the key project insight(s). This step ends with the agreement of the key insight(s) and the sign off of a Project Initiation Document.

2.1 Review the steering group membership

The steering group needs to have sufficient capacity and capability to analyse quantitative and qualitative data, to understand segmentation methodologies, to discover (or generate) insights and be able to develop and deliver these insights in a social marketing intervention. The group also needs to be able to engage with all stakeholders including public and patients, primary care and secondary care. Communication resources and project management expertise are essential. Experience of community development and health economics may be useful.

Many of these skills will be found ‘in-house’, but external social marketing expertise may be required. The National Social Marketing Centre is a good first point of contact if you want to recruit a social marketing expert to your steering group.

2.2 Review the clinical context

Background information on lung cancer, signs and symptoms and referral guidance is available including Clinical Guidelines on the Referral for Suspected Cancer (NICE CG 27) and the National Collaborating Centre for Acute Care report ‘The Diagnosis and Treatment of Lung Cancer’ (NICE CG 24, 2005).

In addition to mortality and survival data consider:

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<tr>
<th>Stage data</th>
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<td>Surgical intervention rates</td>
<td>From secondary care clinician and cancer registry (LUCADA, clinical audit or local collections)</td>
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<td>Chest x ray use</td>
<td>Assessing the use of chest X-rays using primary and secondary care data.</td>
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<tr>
<td>Return on investment</td>
<td>Is there an assessment of the return on investment e.g. Black (2006) Wisnivesky (2003)?</td>
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2.3 Understand the potential target audiences

Is there an understanding of both primary and secondary audiences, who they are, where they live, their beliefs, attitudes and behaviours and how to influence them?

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<tr>
<th>Data about 'at risk' individuals</th>
<th>As a minimum age, gender, deprivation, geography from public health departments, public health observatories. Have you mapped mortality and admissions from lung cancer? How does this relate to GP practices?</th>
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<tr>
<td>Review evidence on attitudes, awareness and beliefs</td>
<td>National and/or local Cancer Awareness Measure including L-CAM data Published research including Corner (2005 &amp; 2006), Hamilton (2010), Tod (2008), Tod &amp; Rose (2010) Psycho-graphic/Geo-demographic segmentation (ACORN, Health ACORN, PersonicxGeo, P2, OAC etc) available locally, from public health observatories or commercially available</td>
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<tr>
<td>What are the key barriers?</td>
<td>Public – local insights e.g. poor awareness of symptoms, thinking nothing can be done, stigma of smoking, limited empowerment with professionals, feeling the message is not relevant to non and ex-smokers (Tod 2008) Primary care – local insights e.g. worries that they may become overloaded with referrals, risks of x-rays, confusion regarding when to re-refer if x-ray is normal but symptoms persist Secondary care – local insights e.g. capacity in radiology and along the lung cancer pathway</td>
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<td>Local validation</td>
<td>Do you need to validate the above insights with local Patient and Public Involvement including interviews with survivors? Do you need to commission local research?</td>
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One way to organise community engagement thinking is through the use of the Strategic Framework for Community Engagement: 5 elements model, as described by the National Support Team for Health inequalities.
2.4 Develop, agree and sign off key project insight(s).

Set aside time for the steering group to consider all the above information to distil the key insight(s) for the project.

Arriving at the key insight(s) is best done through a facilitated extended steering group meeting. The insights and any other outputs should be documented in a Project Initiation Document (PID).

In Doncaster the project steering group reviewed the staging data and resection rates from LUCADA and also the hospital consultants’ own database. This reinforced the initial assessment that early diagnosis was important. We reviewed our use of chest X-rays in two ways. First the consultant reviewed (from his own data) those patients whom he had seen with lung cancer and whether or not they had a chest X-ray in the time leading up to diagnosis. This demonstrated that as many as 65% of people diagnosed with lung cancer had not had a chest X-ray in the 5 years prior to diagnosis, and many of those individuals had had symptoms warranting investigation. Secondly, our GP reviewed all primary care consultations in their practice (10,000 population) for 1 week and concluded that another 20 chest X-rays a week could have been requested with strict implementation of the NICE guidelines. We concluded from a quick Return on Investment (ROI) calculation that shifting the stage of diagnosis from 10% stage I & II disease to 20% stage I & II could release in the order of £100,000.

Our hospital consultant reviewed the literature on early presentation of lung cancer and noted that presentation with a cough was a good prognostic indicator (Buccheri 2004 and Imperatori 2006).
The process for defining the target audience(s) was overseen by the steering group. The potential target audiences included primary care staff as well as possible patients, their families and the public. The primary target audience was defined as men aged over 50 living in areas of deprivation. The PersonicxGeo segmentation tool suggested the largest single grouping was GR5 (retired-low income). This allowed linking to ‘customer’ insight through TGI Choices software. This segmentation was provided for us by Yorkshire and Humber Public Health Observatory.

The steering group were unaware of any published studies of the key barriers so we commissioned qualitative research from Sheffield Hallam University (Tod 2008) to explore delays in diagnosis. To understand barriers in primary care and secondary care, the GP and consultant members of the steering group consulted their colleagues and brought that information back.

The two key insights were the general lack of awareness around the symptoms of lung cancer and, secondly, a lack of understanding about the benefits of getting an early diagnosis and how this improves the prognosis.

This was summarised as ‘If you have a cough for 3 weeks go to your doctor and ask for a chest X-ray’.

The following figure describes how the 5 elements model was reflected in the work in Doncaster.
Step 3. Develop (planning for delivery)

This step takes the insight(s) agreed at step 2 and transforms them into an intervention that is fully costed and has a timed delivery plan.

3.1 Define the specific target audience(s)

Have the primary and secondary audiences been defined in as much detail as possible? What size population is this? Are both public and professional audiences defined?

3.2 Develop a list of tactical interventions

Review the evidence base for information on effective strategies. Combine the evidence with the local insight to define the most appropriate strategies to deliver required objectives and develop a range of tactical initiatives to deliver the strategies.

One approach to early diagnosis is to use both ‘push’ and ‘pull’ approaches: ‘pushing’ people towards services and then working with services to ‘pull’ them through as quickly as possible.

Push strategies include:

- Creative-led communication campaigns
  - Outdoor advertising (48 and 6 sheets), buses (inside, outside and bus stops), A4, A3 advertising, pharmacy bags in target communities
  - Door drops (leaflets) in target communities
  - Media advertising including print, radio and television
  - PR in print, radio and television alerting people to the campaign and focusing on stories about people who had lung cancer and survived, to counter the prevalent belief that lung cancer is always incurable

- Face-to-face events and conversations
  - Brief intervention training of ‘health’ workers such as health trainers, community pharmacist staff, community development workers and cancer information workers and ‘tasking’ them to have conversations about a 3 week cough with targeted groups and in targeted localities such as men aged 50-65 in communities with high rates of lung cancer
  - Brief intervention training of community ‘influencers’ such as community leaders, and community ‘champions’ or volunteers so that they can have an informed conversation with people about the dangers of a 3 week cough and advise people on how to act. These ‘influencers’ will either already been known to local community workers or can be identified through stakeholder analysis
Co-creation/co-production initiatives

- Facilitating a project where community organisations or volunteers can develop their own approaches to producing materials and spreading the message.

Face to face events, conversations and co-production initiatives can use materials such as posters, leaflets, DVDs, website, beer mats, and badges developed as part of the creative-led campaign (see appendix for examples).

Review existing materials. Do they reflect the insight or do you need to commission new ones?

Pull strategies include:

- Tiered approach to primary care
  - Written reminders about NICE guidance
  - Practice visits to introduce the initiative
  - Practice training including
    - Raising awareness of lung cancer and symptoms
    - Reminding about the benefits of early diagnosis
    - Reminding about the NICE guidance
    - Delivering Continuing Medical Education (CME) by the secondary care lung cancer team to General Practitioners to highlight the need to review or change practice in light of the NICE referral criteria
  - Brief intervention training for frontline health and social care professionals including GPs, nurses, pharmacists, social care and reception staff so each can respond appropriately if someone comes in with a cough (for materials see the appendix)

- Secondary care
  - Ensure sufficient X-ray capacity
  - Ensure sufficient capacity in the care pathway
  - Review and streamline suspected lung cancer care pathways including systems for rapid review of abnormal chest X-rays by consultants/MDTs as opposed to sending abnormal chest X-ray results back to GPs and asking them to refer under the 2 week wait procedure

3.3 Prioritise strategies according to social marketing principles, project budget, scale of change and timing

Are all strategies costed as well as costing the intended impact (extra chest X-rays, hospital activity etc)? (see Appendix)
It is unlikely that all strategies can be deployed either due to cost, capacity or other issues. For instance, local availability will impact on the placement of outdoor advertising. Engagement with primary care is crucial and clinical leadership is important to deploy both ‘push’ and ‘pull’ strategies.

3.4 Reflect the key insight in the communications brief (creative, media planning, PR) and select communication, creative and media planning partners (if needed)

Turning the insight into creative outputs can be done in-house but may need to be commissioned from an external partner. Media buying may also require specialist support.

In addition to creative, media buying and PR support, an overarching communication strategy is required.

External expertise should be commissioned according to local Standing Financial Instructions (SFIs). Using the Central Office of Information (COI) in-house team has the advantage that Intellectual Property remains with the NHS so royalties would not be charged if you or another authority wanted to use the materials for another campaign. (Examples of briefs are in the appendix.)

3.5 Develop the evaluation and monitoring framework

How will the impact be measured? Are there some key pre- and post-measures that can be used as proxies for reduced mortality and improved survival, such as attitudes, knowledge, behavior of the target audience(s), chest X-ray referral rates, numbers of 2 week referrals, numbers of consultant upgrades, number of cancers detected and stage at diagnosis? Is a control group needed?

3.6 Review the plan, sign off and communicate

Have you thought of unintended consequences of your approach? How might you react to outbreaks of 'flu, are you aware of other competing campaigns or campaigns that may increase your effectiveness?

In Doncaster a combined ‘push’ and ‘pull’ approach was developed and the primary target audience was men aged over 50 living in the most deprived areas. We used a combined ‘push’ approach (based around creative led communication campaign and face-to-face events) with the ‘pull’ strategy. Creative, PR and media planning agencies were commissioned to support our limited internal resources.
In 2007 the steering group worked with DIVA creative limited. In 2008 the project became part of a Yorkshire and the Humber SHA social marketing collaborative and were supported by Journey with whom the PCT jointly commissioned a creative agency Sixteenhands. In 2009 the project continued to work with Sixteenhands. These creative agencies were important in both this step and step 4. Concept testing occurred within the pilot community in 2007 through a local GP practice and their patient panel.

The steering group worked with Sheffield Hallam University to develop brief intervention training materials for GPs and frontline health and social care staff. The PCT also used this material to train our community champions.

Three key areas for evaluation were agreed: change in attitudes and/or behaviours of the public; change in chest X-ray referral rates; and change in stage of lung cancer diagnosis.

**Step 4. Implement (execution)**

This step begins with taking initial outcome measures and then focuses on the execution of the tactical interventions.

**4.1 Take baseline evaluation measures**

Chest X-ray referral rates, data on lung cancer diagnoses and staging data were available from our acute trust. We commissioned the Buzzz to conduct interviews with people living in both target communities and control communities to assess their attitudes and stated behaviours before the campaign started. The Cancer Awareness Measure (CAM) or the lung cancer version may be a useful tool.

**4.2 Execute the range of tactical interventions according to timing plan.**

There should be well defined ‘push’ and ‘pull’ strategies and both strategies will need lead-in time.

‘Pull’ strategies need to be implemented before ‘push’ begins so that staff in both primary and secondary care are prepared to respond to people motivated to attend as a result of the campaign. ‘Pull’ strategies, especially work in primary care, need careful planning to engage, meet and deliver any training required.

In 2008 it took the team (PCT public health, GP and/or hospital consultant, creative team) 3 months to ensure all targeted practices were visited and trained.
For ‘push’ strategies, 2-3 months is a minimum time period to develop and plan creative-led communication campaigns and to ensure materials are signed off, ordered, delivered and distributed appropriately.

4.3 Monitor any implementation issues and address

Ensure there is an agreed way of working between all parties. Agree who will take day to day decisions and set up weekly reports from agencies and/or weekly meetings. Ensure there is sufficient capacity to respond to ad hoc requests from media or to take opportunities for ‘good news’ stories.

In Doncaster there have been interventions in 2007, 2008 and 2009. In 2007 the ‘push’ strategy was delivered by DIVA creative. In 2008 and 2009 the creative-led communications campaign was led by Sixteenhands with support from the PCT communications team. The PCT (with support) commissioned media planning from Principles Media in 2008 and Alchemy Media in 2009. In 2008 and 2009 the PCT commissioned Finn to deliver face-to-face and co-production elements. In all three years the ‘pull’ campaign was led by the PCT with support from primary and secondary care leads. In 2007 the evaluation was conducted together with Sheffield Hallam University. In 2008 and 2009 the evaluation of the change in attitudes and behaviours was commissioned by the PCT public health team from the Buzzz. Chest X-ray data and stage data were obtained from the local provider trust.

The ‘pull’ elements were the most time consuming. The PCT public health team wrote to target GP practices and visited all practices in 2007 and 2008. We used existing practice training events, practice meetings or held separate meetings, depending on existing practice arrangements. The practice events ran for a minimum of 30 minutes to cover awareness raising and NICE guidance. Brief intervention training to GPs and practice staff was delivered at the same session or was offered at a different time depending on availability of practice staff. Brief intervention training to GPs was delivered separately from practice staff. Community pharmacists were invited to this training. In addition the secondary care lung cancer team have delivered Doncaster wide training to primary care through our TARGET (protected learning) events.

A range of ‘ways of working’ agreements were used to enable day to day and week to week monitoring between all partners.
Step 5. Evaluate (review)

This step ensures that the delivery of the intervention is reviewed and any impact on the key process or outcome measures is captured. The aim is to arrive at an agreed final project report.

5.1 Review the delivery of the tactical interventions

This is an opportunity to review whether the intervention you planned was actually delivered e.g. did the posters go up? In the right place and for how long? This information should be available from any agency you commission. How much press coverage did you get? What use was there of the website? Did you need to reprint anything? Was the intervention delivered within budget?

5.2 Take post-intervention evaluation measures

Take the post-intervention measures to give pre- and post-measures.

5.3 Commission or conduct additional research if necessary

This could include interviews with key stakeholders, evaluation of the training elements, interviews with patients.

5.4 Debrief

Debrief on all elements of the intervention with the project steering group. Agree conclusions and learning, draft project report and agree dissemination methods including stakeholder feedback.

5.5 Sign off final project report and conclusions

In Doncaster the steering group evaluated all three interventions. In 2007 a feasibility evaluation assessed the ability to deliver a combined ‘push’ and ‘pull’ approach and to address any barriers to delivery.

In 2008 there was a change in the stated attitudes and behaviours in targeted communities: before the intervention 64% of people interviewed said they would go to their doctor and ask for a chest X-ray if they had a cough lasting for more than 3 weeks; after the intervention this increased to 76%. Targeted practices increased their chest X-ray referral rates by 80%, 3 times more than control practices, and the percentage of lung cancers diagnosed early (stage I & II) increased from 11% pre-intervention to 19% post-intervention.

In 2009 there was also a change in stated attitudes and behaviours in targeted communities: before the intervention 54% of people interviewed said they would go to their doctor and ask for a chest X-ray if they had a cough lasting for more than 3 weeks; after the intervention this increased to 67%.
Targeted practices increased their chest X-ray referral rates by 22%. The percentage of lung cancers diagnosed early (stage I & II) increased from 21% pre-intervention to 23% post-intervention.

**Step 6. Follow-up (reflection)**

This stage prompts the steering group to disseminate the work and receive feedback from stakeholders. It then directs the steering group to reflect on the project and assess what the next steps should be.

**6.1 Dissemination and feedback**

Have the conclusions been disseminated to the public, and to all stakeholders? What feedback is there? Has the work been disseminated wider, to commissioners, professional groups, cancer networks, submitted for peer review publication etc?

All those involved in this work have supported other areas interested in applying and/or refining this approach.

**6.2 Refine strategy based on evaluation and learning**

Was there an impact on the original problem? Has the problem been solved fully or partially? Which elements worked well? Which worked not so well? What are the next steps? This could include a change in scale, a change in focus, more or less ‘push’ or ‘pull’.

What is the impact on commissioners? Were there increases in 2 week wait referrals, diagnostics and treatments?

How is this approach sustainable?

In Doncaster the work has been disseminated widely through both professional and key stakeholder groups. The work was shortlisted for a regional Health and Social Care Award in 2009 and was highly commended in the HSJ awards in 2009, both in social marketing.

The initiative has now been run in 2007, 2008 and 2009. Plans for 2010 include widening the approach to include bowel and breast cancers but complementing the ‘pull’ approaches with face-to-face and co-production ‘push’ approaches, rather than creative-led media campaigns.

Both ‘push’ and ‘pull’ approaches can be embedded into normal ways of working. Face-to-face events, conversations and co-production approaches are likely to be more sustainable than creative –led ‘push’ approaches.
References


National Collaborating Centre for Acute Care, February 2005. Diagnosis and treatment of lung cancer. National Collaborating Centre for Acute Care,


Rogers TK. Lung cancer diagnosis. Lung Cancer in Practice 2006;3(1), 8-9


## Acknowledgements

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## Appendix

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