COPD in Doncaster

A social marketing strategy

April 2008

DRAFT REPORT

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COPD in Doncaster

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A Summary

1. Background and Objectives

- Doncaster PCT commissioned Dr Foster Intelligence (DFI) to gain insights into six public health issues and to recommend social marketing strategies aimed at developing long term solutions.
- This report focuses on the issue of reducing hospital admissions for COPD.

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 at most risk of developing COPD. Data sets included health needs mapping, lifestyle data from Mosaic™ and Hospital Episode Statistics.
- Qualitative research with smokers from the key target populations identified by analytics. Participants took part in focus groups and one in-depth telephone interview.

2.2. Sample

- Participants were all smokers aged 45 and over living within the areas identified as having the highest admission rates for COPD. All participants were from the four Mosaic™ lifestyle types identified as being at most risk of admission to hospital for COPD.

3. Key findings

3.1. Analytics

- COPD is one of the largest causes of premature death in Doncaster, accounting for 9% of deaths per year[1]. Prevalence is estimated at 2.3%, although the actual figure is likely to be higher as many cases are undiagnosed[2].
- Analysis of national data sets and Mosaic™ data identified four lifestyle types that account for at least 10% of the population of Doncaster and who have a greater likelihood of hospital admission from COPD than the national average:

  G42: Families with school age children, living in very large social housing estates on the outskirts of provincial cities

  G43: Older people, many in poor health from work in heavy industry, in low rise social housing

  H44: Manual workers, many close to retirement, in low rise houses in ex-manufacturing towns

[1] Public Health Profile 2007, Doncaster PCT
[2] Local Enhanced Service for COPD, Doncaster PCT

H45: Older couples, mostly in small towns, who now own houses once rented from the council

3.2 Qualitative research

- Awareness of COPD was low and more likely to be associated with asthma than smoking. However, respondents were aware of bronchitis and emphysema.
- There was very low awareness of the information available about COPD.
- Smokers are often very reluctant to visit their GP, even when ill, and so messages should empower them to get treatment when they need it.
- Respondents would welcome an invitation from their GP to attend a health check which should include a test for COPD.
- Posters placed in health and non-health settings are the best way of getting the attention of the target audience.
- Using frightening or negative images in marketing materials is likely to make people look away. Images that show how it feels to have COPD are easier to relate to.

4. Recommendations

4.1 Target groups

- The target audience should be smokers aged over 35, in particular those from Mosaic™ lifestyle groups G42, G43, H44 and H45.

4.2 Strategy

- The strategy should combine service development and improvement with marketing and communications activity.

4.2.1 Service development and improvement

- GPs in areas with high COPD admissions/smoking prevalence that are not already participating in the Local Enhanced Service should be targeted to join.
- Training in the diagnosis and management of COPD should be widely available for appropriate health professionals across the PCT.
- The policies and practices of those GPs that have been identified as having higher numbers of COPD admissions than expected should be reviewed.
- Smokers should be invited to have a health MOT, to include tests for COPD, either at their GP practice, workplace or at an appropriate location via a mobile unit.

4.2.2 Marketing and communications

Aims.

- To increase the awareness of the symptoms of COPD amongst smokers and to encourage early diagnosis of the condition.

- To help educate patients to manage the condition themselves with the support of the community based service.

Messages

- A general stop smoking message with information about local stop smoking services.
- Information about the symptoms of COPD, the links to smoking and advice on seeking medical help.
- Information on self-management for those with a diagnosis.

Methods of communication

- Posters in health and non-health settings
- A smoking cessation leaflet with a focus on COPD, developed in conjunction with the stop smoking service
- Telemarketing
- PR activity in the local press

B. Background and Objectives

1. Background

Doncaster PCT commissioned DFI to gain insights into six public health issues and to develop social marketing strategies aimed at achieving long term solutions. The six public health issues are:

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

This report focuses on the issue of reducing hospital admissions for COPD.

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.

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

2. Objectives

2.1. Analytics

The objective of the quantitative analysis was to identify and profile key target audiences in Doncaster who are most risk of COPD.

2.2 Qualitative research

The objectives of the qualitative research were to:

- Better understand (amongst those who are most at risk of developing COPD) attitudes towards health, early diagnosis of COPD and barriers to quit smoking
- Understand smokers' awareness and attitudes towards COPD and barriers to seeking medical help
- Explore people's awareness and knowledge of information and education about COPD and the perceived gaps in this information
- Pre-test material for a social marketing campaign to raise awareness of COPD

C. Method and Sample

1. Analytics

DFI carried out analysis of several national data sets in order to identify key target populations in Doncaster who are at most risk of developing COPD. The national data sets used were:

- Health needs mapping, which matches Mosaic™ lifestyle types with socio-demographic and consumer lifestyle database linked with health data at postcode level
- Hospital Episode Statistics
- Mosaic™ lifestyle data
- Target Group Index data

An explanation of these datasets is contained in Appendix 2.

2. Qualitative Research

Two focus groups were held with smokers aged 45 and over who live in the areas with the highest admission rates for COPD. All participants were from the four Mosaic™ lifestyle types identified as being at most risk of admission to hospital for COPD:

- One group (3 participants) of male smokers aged 45 – 70 from socio-economic groups D or E
- One group (8 participants) of female smokers aged 45 – 70 from socio-economic groups D or E

In addition, a telephone interview with a person diagnosed with COPD and recruited from the Breathe Easy support group was held.

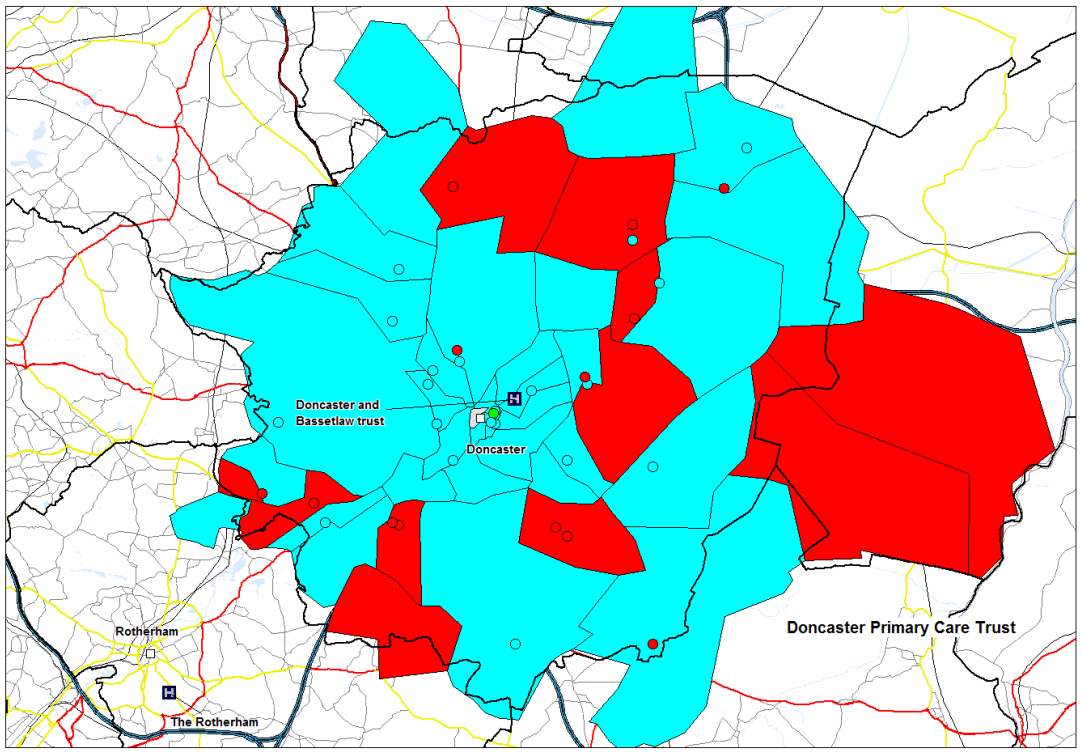
D. Analytics

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 at risk of COPD. This section sets out the main findings from this analysis.

1. Hospital admissions for COPD

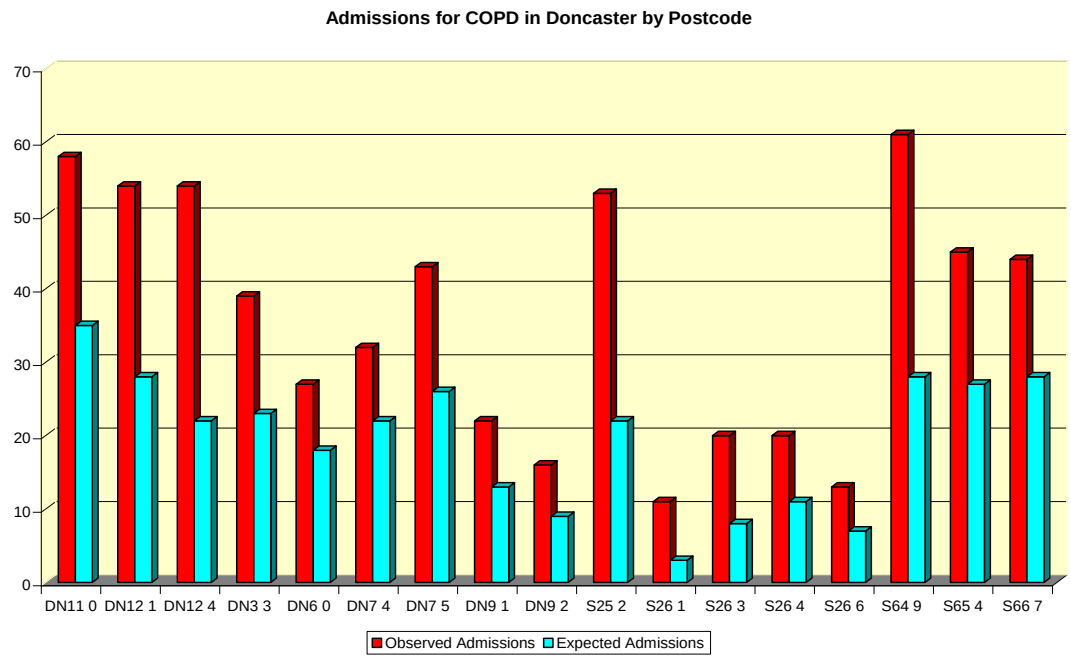
Figure 1.1 shows the standardised admission ratios (SARs) for coronary obstructive pulmonary disease (COPD). Each shaded section represents a postcode sector (some postcode sectors overlap the PCT boundary, the black line in the centre of the map). Areas shaded in red indicate where the standardised admission ratio was significantly higher than average. Areas with the most admissions for COPD were to the north east and southeast of Doncaster, and to the south west.

Figure 1.1 Standardised admission ratios (SARs) for COPD



Graph 1.2 shows by postcode sector where the SAR is statistically significantly high for COPD admissions.

Graph 1.2 Actual versus expected standardised admission ratios (SARs) for COPD by postcode sector



See Appendix 1.1 for SARs by GP practice where the SAR is statistically significantly high for COPD. Appendix 1.2 shows the raw prevalence by GP practice for COPD (Source: QOF). Prevalence varies from 0.18%, a practice with just two people on the register, to 4.35% for a practice with 85 people on the register.

2. Mosaic™ lifestyle groups

The top four Mosaic™ lifestyle groups based on absolute numbers of admissions for COPD in 2006/07 are:

- G42: Families with school age children, living in very large social housing estates on the outskirts of provincial cities (105 admissions)
- G43: Older people, many in poor health from work in heavy industry, in low rise social housing (99 admissions)
- H44: Manual workers, many close to retirement, in low rise houses in ex-manufacturing towns (126 admissions)
- H45: Older couples, mostly in small towns, who now own houses once rented from the council (75 admissions)

NB Criteria for inclusion is a population of more than 10,000 in PCT area.

The risk indices show:

- For COPD, the likelihood of admission to hospital compared with the national average. An index of 100 shows an average level of risk; an index of 200 shows twice the national average level of risk; an index of 300 shows three times the risk; and so on.
- For smoking and quitting, the likelihood that there is an above or below average number of smokers/quitters in each lifestyle type, compared with the national average. An index of 100 shows an average level of likelihood; an index of 200 shows twice the national average level of likelihood; and so on.

Table.3 Risk of COPD by lifestyle type

Lifestyle Type	Population in Doncaster	Index of risk of COPD	Index of likelihood of being a heavy smoker	Index of likelihood of quitting smoking
G42	21256	208	211	164
G43	13148	293	137	188
H44	32491	162	154	170
H45	12467	205	129	118

Source: Experian

E. Qualitative Research

Using qualitative research DFI has been able to explore people's awareness of and attitudes towards COPD and their responses to creative materials. The findings from the qualitative study are detailed below under the following headings:

- Attitudes towards health and healthy living
- Attitudes towards smoking and awareness of COPD
- Smokers' cough
- Awareness of COPD
- Barriers to seeking medical diagnosis
- Views on health information and education
- Views on the creative material

1. Attitudes towards health and healthy living

Key health concerns

The two focus groups raised different health concerns. The key health concerns of women are around controlling their weight as they get older, becoming out of breath when walking and keeping mobile.

> *"…mobility, respiration, which has to do with the smoking, which makes me think that at some time I ought to consider stopping, but I enjoy smoking too much to stop, although it does affect my health. So it's something I know I should think about, and do something about* " **Female Focus Group**

> *"I'm not overweight, but you do get out of breath, especially when it's windy. It knocks it out of you"* **Female Focus Group**

> *"I think it's* [key health concern] *either to lose weight, and if you stop smoking, you put weight on. That's why I won't stop smoking"* **Female Focus Group**

The women also link smoking with premature ageing of their skin and all are in agreement that they have developed a cough as a result of their smoking habit.

> *"When you wake up in the morning, and you're coughing like a woman of 90, aren't you? Sometimes, when you get up, and you get that chest…"* **Female Focus Group**

By comparison, the three men focus on high cholesterol as their main health concern along with a general decline in their fitness and eyesight as they age. General "aches and pains" as well as hardening of the arteries are also associated with ageing.

> *"…getting older, what they say about your arteries hardening"* **Male Focus Group**

> *"Your eyesight's going and you've got these aches and pains. You know that's all just a thing of getting older"* **Male Focus Group**

All the men claim to have changed their diets, cutting down on fats, dairy produce and salt, to address their health problems. They also claim to have reduced the number of cigarettes they smoke. However, this has been the result of factors such as changes in social activities and the introduction of the smoking ban in public places.

With the exception of two women, who claim to have a cough brought on by smoking, coughs are generally linked to allergies or colds.

2. Attitudes towards smoking and awareness of COPD

Attitudes towards smoking

Smoking is enjoyed by all the participants and is associated with situations such as:

- relieving stress
- when you are not active
- socialising with friends.

> *"I walk a lot. I do a lot of walking. And when I'm walking, I don't want a fag, because I enjoy my walking. I walk with a friend. She doesn't smoke. But we can walk for four, five, six miles, and while I'm out walking, I'm not interested. I smoke now, if I've had a bad day, or if I'm stressed. That's when I want a fag*" **Female Focus Group**

> *"I think you smoke more in the winter, when you're shut in, because I don't smoke as much during the summer, when I can keep busy in the garden*" **Female Focus Group**

> *"….you're having a cuppa. And you seem to smoke a fag after. You can do 20 fags in half an hour, because you're sat talking*" **Female Focus Group**

All the men have tried to give up smoking and all have failed. However, they all report that they have cut down on the numbers of cigarettes smoked.

> *"But I do like a cigar, especially when you I go visit a friend, we'll have a drink and we'll both enjoy a cigar together."* **Male Focus Group**

One person had completed a smoking cessation course but has returned to smoking as he missed the enjoyment of it:

> *"I completed the* [smoking cessation] *course they put me on but I enjoy a cigarette and before they brought in the ban at the pub, I found that when I was having a pint of beer I enjoyed having a cigarette at the same time."*
> **Male Focus Group**

Attitudes of other people towards smokers

Participants are made to feel dirty or like a "second class citizen" because they smoke.

> *"I've got two girls at home, and if they bring their friends* [to their home]*, it's come* [fed] *back to me that sometimes the friend's parent has said, oh, you stink of smoke. …You're not dirty, because you smoke, you're not scruffy, but they're* [friends] *offended that, oh, I had to wash everything, all the clothes, they stank, and it was in their hair*" **Female Focus Group**

> *"It's like when you go out somewhere totally different and you sit with people that you don't know that don't smoke, and they look at you, and think, 'oh, you're having a fag!"* **Female Focus Group**

"Well, I go and work in men's clubs and up to the smoking ban it was accepted but now people do look down on you. A lot of them do look down on you" **Male Focus Group**

3. Smokers' Cough

None of the participants associates a smokers' cough with COPD and only one refers to their cough as being a "smokers' cough".

"I know I've got a smokers cough. I wheeze every day now. I've got a constant wheeze. My cough is always chesty. When I get particularly bad, such as I've got an infection coming on and it makes that cough worse, I still smoke, and there's some brilliant black Hall's mentholyptus, because I have to have a cigarette, so I buy a packet of them, and I have one of them so I can have a cigarette. How silly is that?" **Female Focus Group**

Others associate their coughs (of which all but two women claim to have) with colds or the result of childhood illnesses.

"I think you do get more colds when you smoke. I believe that. You pick things up easier. I do believe that. And if I get a cold, then I do get a bad cough. But I have a very severe allergy, so I can cough any time" **Female Focus Group**

"I've developed a cough from that [injury in the back of the throat when he was a child]. *A lot of people have said to me it's because you're smoking*." **Male Focus Group**

The person from the Breathe Easy group had initially been diagnosed with and treated for asthma for 6 years before being diagnosed with COPD.

4. Awareness of COPD

Three women are aware of COPD as a result of a friend or close family member dying of the disease. However, COPD is associated more with asthma than as a direct consequence of smoking.

"Well, we [family] *always put it down to with her being a smoker. And as I say, she did pack in* [smoking 8 years before she died]. *She'd always suffered with asthma, from being a kid, and then when I went with her to the hospital, and they told her it was COPD, and there wasn't much they could do with it*" **Female Focus Group**

Only one male participant had a friend who had died of COPD:

"he was asthmatic and he had suffered with asthma for a lot of years." **Male Focus Group**

None of the other participants has heard of 'COPD' or has heard of the disease by its full medical name of Chronic Obstructive Pulmonary Disease.

The person who has COPD did not know or understand what the disease was until he was referred to a specialist. They were aware of emphysema and pneumonia but not COPD. From his experience he believes that the level of awareness of COPD is generally low amongst the public in Doncaster. Prior to his diagnosis his main concern was that he may have lung cancer. Once diagnosed, his main worries were financial.

However, the hospital consultant was able to provide proof of his disability in order for him to seek social security and to apply for an insurance payment.

> *"*[On being told of the diagnosis] *I was shattered, all I could think was how am I going to cope? What am I going to do?"*
>
> *"I was worried sick about finances / losing my house / feeding the kids* – [the consultant] *gave me the letter to help sort out that stuff* [financial issues]"

5. Barriers to Seeking Medical Diagnosis

Contacting their GP surgery

The GP is, for all but one participant, the first person they go to for medical advice, particularly if they have a persistent cough and phlegm. However, several complain that their main barrier to seeking medical help is their difficulty in getting an appointment. A few say that they do not want to waste their GP's time as their reason for not making an appointment.

Most participants believed that their GP would immediately label them as a 'smoker' and be thinking that they should stop smoking.

> *"As soon as you mention smoking, that's it. They* [GPs] *jump on that and say, well, stop smoking*" **Female Focus Group**

Only one person first seeks the advice of a herbalist in Doncaster before considering medical help.

> *"Well, the first thing I always do is I go to herbalists. I always go to a herbalist first and see if they've got anything*" **Male Focus Group**

Nurses are considered, especially by the men, as someone who distributes treatment regimes, such as issuing nicotine patches, and provides general advice.

> *"If you're just going in for your blood pressure or anything simple like that, you see her [nurse] instead of taking the doctor's time up and nine out of ten times she can answer your questions."* **Male Focus Group**

Trustworthy medical sources

Information supplied by the 'NHS' is considered as 'trustworthy', whereas pharmacists are considered to provide advice (which may or may not have been clinically tested) in order to achieve sales.

> *"I trust my GP when I go down there but I'm only dealing on issues that concern me*" **Male Focus Group**
>
> *"as a general rule, any medication or prescription that you get from your GP is more powerful, shall we say, for want of a better word?..... Whatever medication you get on prescription…. most of the time, is more effective than something you can buy over a counter. And also, what you are buying has been tried and tested, hopefully, through the medical council or whatever"* **Female Focus Group**

Women say that they would like to have regular health checks at their doctors' surgery. These health checks should be organised through their GP surgery (rather than letter sent directly by the PCT) and should be in the form of a personal invitation to attend.

> *"I've got breathing problems, and everything, and there may be other things wrong, and you do start, when you get to 45, 50 maybe, you know there are certain things* [medical matters]*, but I don't want to waste doctors' time. I don't want to feel a whinge, and make an appointment. But if I were invited to an overhaul, then I would go.*" **Female Focus Group**

6. Views on health information and education

Sources of health information

Women, in particular, refer to TV documentaries as a source of trusted health information. Only one man mentions a morning TV programme as a source of health information.

> [TV documentaries] *"They're telling you, well, I think so, they're telling you the truth. I don't think they'd be allowed to be on television if they lied*"
> **Female Focus Group**

> *"I watched one of these morning programmes on TV and it had these charts and they were showing you the cholesterol and the doctor there was talking and saying how he tells about cholesterol is the white around your eye. So, afterward I went and looked and I thought I've got one of these bands completely all around my eye. So, I booked into that Wellman clinic*"
> **Male Focus Group**

All the participants consider leaflets in newspapers and 'mail drops' to be the least likely method of receiving health information and only a few women refer to newspapers or magazines as a source of information. Posters, especially in health centres and hospital waiting rooms are, however, considered to be helpful as they are read whilst waiting for an appointment.

Current information leaflets on COPD, keeping warm and Doncaster newspaper article

Several sources of information about COPD currently available in Doncaster were shown to participants. None of the attendees has seen the newspaper article in 'Doncaster Health News', referring to it as a 'Sheffield' paper.

Only one man has seen the leaflets in health centres called 'COPD: Changes to diagnosis and treatment' and 'COPD: living with chronic obstructive pulmonary disease' (both British Lung Foundation leaflets) and one woman recognises the 'Pack It In' leaflet. None of the leaflets has been taken or read by these people.

When the person who has COPD was diagnosed 10 years ago they were not given leaflets. Instead the pulmonary nurse visited his home and provided support and advice.

7. Views on the creative material

Five posters and one leaflet that aimed to raise awareness of COPD were shown to participants to explore their responses. Copies of the visual material have been attached for reference (Appendix 4). Responses to each item are summarised below.

Posters

Poster A: 'Please read aloud'

Five of the eight women think that the poster is "frightening" and would avoid reading such a poster. Three feel that they would not want to think about the disease.

Responses from female focus group:

> *"I wouldn't want to know if I've got that* [COPD] *in case it's not treatable"*
>
> *"I think it's* [Poster A] *more or less telling you, if you're getting this way, from the start, breathless, wheezy, you are going to think, there must be something wrong"*
>
> *"Well, that* [Poster A] *just brought my sister back to me* [who has died of COPD]. *Because that is exactly what happens*"

By comparison, the men did not believe this poster would have an impact on them and would not read past the first line of the quotation. From reading the poster they are unable to know what COPD meant.

Responses from male focus group:

> *"As a poster I'd see that, can you read this out loud, and as soon as I got past chronic obstructive pulmonary disease I think I would probably stop reading"*
>
> *"When I was 20, I don't think I would have read that* [Poster A] *out loud without stopping anyway"*
>
> *"I'd be thinking I don't know what it* [COPD] *is. What are they on about? Why would I want to read* [Poster A] *any further, other than for some reason? Like you say, you're sat in a waiting room and that's up there and you've got nothing to do but wait, all right, I would read it to the end but if it was a poster outside and I'm walking..."*

Poster B: Person drowning in tar

This poster has the biggest impact on all the participants as the message is direct. Several can relate to the picture and the feelings being described in the heading. This poster would make them consider going to the doctors because the tag line refers to medical treatment being available.

Responses from female focus group:

> *"When it* [Poster B] *says 'your airways slowly close up, making it impossible to breathe' that is exactly what it is. And compared to the first one* [Poster A], *it's just short, not sweet, obviously, for what it's saying, but it is to the point, and factual"*
>
> [Poster B] *"shows the guy, or whoever, about to drown, and that must be how it feels. And then, but it is telling you at the bottom, if you suffer from breathlessness or have smoker's cough, you may have COPD. And it just it makes you…I'm going to my doctor's after this, I'm telling you. Seriously, I'm not joking, either. Because it does say you can get treatment that can help. And, no, it won't cure it, but it can ease the symptoms, which is important. If you leave it, you can see yourself being that person who is about to drown*"

"If you see a picture, you'd look at it better than you would just writing…. "

Responses from male focus group:

[Poster B is aimed at] *"Someone who is struggling but won't admit it, that won't take the action necessary that would help him"*

"It might make me want to find out what is COPD. Yes, the actual poster does... It catches your eye straightaway"

"There's an impact [in Poster B]. *What's he doing? You'd read that, not that I... I don't think I suffer from breathlessness but if I did, I think I'd* [visit the doctor]

Poster C: Covered body in a morgue

None of the participants like this poster as it sends a negative message, making them think that a cough or smoking can kill you. Women especially would avoid this poster as the image "plays on their mind". The men do not relate to the image and do not see a connection between COPD and smoking.

Responses from female focus group:

"I don't like that one" [Poster C].

"I won't look at it [Poster C]…. *Because she's covered over"*

"I'd be thinking, oh, that could be me. Have I got that? I'd be thinking about it all the time. It plays on my mind"

[Poster C message is] *"That you're dead. But how? What's the effect?"*

[Poster C message is] *"saying here, it starts with a smoker's cough and then it, untreated, ends up like that."*

Responses from male focus group:

[Poster C message means] *"Nothing. If I saw that up, I'd look, what's that? It wouldn't really do anything to me. I know it says here it kills over 30,000 Britons. It would do nothing for me. It's just somebody on a trolley"*

[Poster C] *"It doesn't do anything compared to this* [Poster B] *one".*

[Poster C is not effective because] *"Purely and simply because my friend who died with COPD didn't smoke"*

Poster D: Candle

All the participants are unclear of the purpose of the image and did not link a snuffed out candle with the phrase 'COPD snuffs out lives'. They are generally unsure of its target audience.

Responses from female focus group:

"*I don't think I'd give that one* [Poster D] *a second glance"*

"If I just saw that [Poster D] *I don't think I'd look at it. I don't think I'd know…what it was trying to tell me, because I've not heard of COPD, so I wouldn't read on any further"*

"What has a candle got to do with…? I don't know"

[Poster D means] "y*ou've snuffed it. It's* [candle] *just snuffed out".*

Responses from male focus group:

"It's [Poster D] *just a candle. It doesn't mean anything. It's a poster you'd just walk past in the street.*

"The actual photo [in Poster D] *doesn't say a great deal to me. I think it's better than the sheet one* [Poster C]*, although this... Where it does say 'if you notice yourself getting breathless doing everyday things', which I suppose I do, but I'd just put that down more to the fact that I'm not as fit as I used to be and I'm just getting older. But then you add on the,' or you have a persistent cough', which I don't. So, it doesn't say a great deal at all"*

"this [Poster D] *does project COPD can snuff out lives and you should get yourself checked out if you're suffering in this way, with breathlessness and coughing, but it doesn't relate, which I'm glad it doesn't, to saying that smoking is* [linked to COPD]"

Poster E: Scar

Overall, participants are unclear of the message and are confused as to why the poster shows flesh instead of a lung. Only one woman considers this poster to be "scary". Compared with the men, several women make the connection between the strap line 'Scars inside your lungs don't heal' as flesh healing but that lungs do not. The women also relate smoking to COPD (as detailed in the strap line). The men dispute the strap line fact that 'if you smoke you're 90% more likely to get COPD'.

Responses from female focus group:

"Well, it's [Poster E] *saying that's how your lungs scar, through smoking"*

" I think it's [Poster E] *trying to tell you that you can get something that will heal, but that won't"*

"I wouldn't stop and look at it [Poster E]. *The only reason I've gone to reading the smaller print at the bottom is because I know that's the point of us being here, and the only useful thing on it, I know it says that scars inside your lungs don't heal, but the most useful is, if you smoke, you're 90% more likely to get COPD."*

"I'd think someone had been stabbed, so I would look at It" [Poster E].

Responses from male focus group:

"This [Poster E] *is like somebody who's just had an accident. I know it's saying... I know the reason what they're saying but what it looks like is, well, it's just somebody who's had an accident*"

"I take it they've just come up with these figures by people who have suffered with it and then saying do you smoke but the people who've smoked, has that smoking been a contributing factor or is it just the fact, yes, we do smoke and it's nothing to do with this COPD anyway"

"A scarred lung would be better than that because that could be a side of pork"

Leaflet

None of the participants consider the leaflet with a balloon inside the cover to be effective and would, like other junk mail, throw it away and not reading it. Several comment how they are unable to blow up a balloon and do not understand the connection with COPD. Only one person would try to blow the balloon up. Others consider balloon blowing a 'technique' and a 'waste of time'.

Responses of female focus group:

"If it [Leaflet] *came on its own, you'd probably pick it up and have a glance at it, rather than if it was in a paper, like say you get two or three* [direct mail], *and you just chuck them straight in the bin."*

"Well, I would try the balloon [issued in the leaflet], *and if I couldn't blow it up, I'd worry"*

"I think balloon blowing's more of a technique as well"

Responses from male focus group:

"What's on that leaflet that makes me want to open it? Nothing".

"If you sent me that leaflet there, I would have just opened it, what's that, and throw it in the bin, probably without looking at it"

Location of posters

Most people suggest that the posters should be positioned in health centres and hospitals and some suggest that such posters should be placed in shop windows (where they sell cigarettes) or pharmacists, displayed on billboards, at bus stops and at train stations.

Media preferences

Poster B is considered to be the most effective as it describes the symptoms of COPD and informs people that the disease can be treated if they visit their doctor. This poster also shocks people but does not frighten them or make them feel negative towards it.

Leaflets are considered to be ineffective as few pick them up and read them.

F. Conclusions

- Secondary analysis of hospital admissions for COPD suggest that there are particular areas within Doncaster PCT and four Mosaic™ lifestyle types that can be targeted with social marketing activity.
- Findings from two focus groups and a member of the support group 'Breathe Easy' highlight the limited awareness of COPD amongst those who are most vulnerable to it. None link the disease with "smokers' cough" and men especially fail to make the link between COPD and smoking.
- Posters are regarded as the best method of raising awareness of the disease and advising people on how they can seek help. Leaflets are often unread and thrown away (regarded as junk mail) and none are automatically picked up and read by participants.
- Of the creative materials shown to participants, Poster B is considered to be the most effective 'message' and image. The poster describes the symptoms of COPD and informs people that medical help can be sought to alleviate the condition.

G. Recommendations

The strong link between COPD and smoking means that a joined-up approach is required if the two issues are to be tackled effectively. This report focuses on our initial recommendations for a social marketing strategy for COPD but it does overlap with our recommended strategy for Doncaster's smoking work. These recommendations will be further developed with PCT staff at the workshop on 13 May and finalised thereafter.

We recommend the PCT should adopt the following approach:

1. Target groups

G42: Families with school age children, living in very large social housing estates on the outskirts of provincial cities

G43: Older people, many in poor health from work in heavy industry, in low rise social housing

H44: Manual workers, many close to retirement, in low rise houses in ex-manufacturing towns

H45: Older couples, mostly in small towns, who now own houses once rented from the council

2. Strategy

Your strategy should combine service development and improvement with marketing and communications activity.

2.1 Service development and improvement

- GPs in areas of high COPD admissions/smoking prevalence that are not already in the Local Enhanced Service should be targeted to participate.
- Training in the diagnosis and management of COPD should be widely available for appropriate health professionals across the PCT. Ensure that health professionals can respond to the increase in demand for diagnosis or information generated by a public education campaign.
- Review the actions and policies of those GP practices that have been identified as having higher numbers of COPD admissions than expected.
- Smokers should be invited to have a health MOT, to include tests for COPD, either at their GP practice, workplace or at an appropriate location via a mobile unit. Invitations should be sent by GPs and not the PCT.

2.2 Marketing and communications

Aims

Marketing and communication activity should aim:

- To encourage smokers to quit
- To increase the awareness of the symptoms of COPD amongst smokers and to encourage early diagnosis of the condition
- To educate patients to manage the condition themselves with the support of the community based service

NB These aims should be quantified and measurable.

Messages

- Communicating a general stop smoking message and including details of local stop smoking services is vital and is recommended as part of the social marketing strategy for smoking.
- The symptoms of COPD and the link with smoking should be made clear. Advice on seeking medical help to relieve the symptoms should also be included as 'a call to action' and to provide reassurance.
- Include descriptions of how it feels to have COPD that are easy for those with the condition to relate to.
- Whilst many people are unaware of COPD, there is awareness of bronchitis and emphysema. Communication should always use language that is meaningful and easily understood by the target audience.
- Smokers are often very reluctant to visit their GP and so messages should empower them to get treatment when they need it.
- Once diagnosed, patients should receive clear information about the actions they can take to self-manage the condition. This should be via face-to-face consultation supported by written materials to take home.

Communication routes

- Posters are an effective means of raising awareness and can be sited in the locations where the target audience live, work and visit. The budget for a poster campaign must be sufficient to allow for good coverage over a period of time.
- Putting information in non-health settings is vital if the target audience, in particular men, are to be reached. Workplaces, shopping buses and pubs, eg via the use of beer mats or posters in toilets, are all effective communication routes.
- Developing, in conjunction with the smoking service, a cessation leaflet with a focus on COPD will ensure consistency of messages.
- Telemarketing can be an effective way of raising awareness of COPD amongst older smokers. Incorporating the messages into a wider campaign, such as 'keep well in the winter', provides an opportunity to address a range of issues.

- PR activity in the local press is an effective way of reaching this audience.

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

Appendix 1

Explanation of datasets

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™.

Mosaic™

Geodemographic neighbourhood-level analysis techniques (Mosaic™ UK – see Appendix 1) 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.

It 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.

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 geodemographic (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.

Hospital Episode Statistics (HES)

Hospital Episode Statistics (HES) is a data warehouse containing details of all admissions to NHS hospitals in England. It includes private patients treated in NHS hospitals, patients who were resident outside of England and care delivered by treatment centres (including those in the independent sector) funded by the NHS. HES also contains details of all NHS outpatient appointments in England.

HES information is stored as a large collection of separate records - one for each period of care - in a secure data warehouse. Each HES record contains a wide range of information about an individual patient admitted to an NHS hospital. For example:

- Clinical information about diagnoses and operations
- Information about the patient, such as age group, gender and ethnic category
- Administrative information, such as time waited and date of admission
- Geographical information on where the patient was treated and the area in which they lived.

Diagnoses are currently coded according to the International Classification of Diseases, 10th Revision (ICD-10) and procedures and interventions according to the Office of Population, Censuses and Surveys: Classification of interventions and procedures, 4th Revision (OPCS-4).

For further information, see HESonline (www.hesonline.nhs.uk).

The Quality and Outcomes Framework (QOF)

The Quality and Outcomes Framework (QOF) is a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results. It is not about performance management but resourcing and then rewarding good practice.

The QOF contains five main components, known as domains. Each domain consists of a set of measures of achievement, known as indicators, against which practices score points according to their level of achievement.

- Clinical: this domain consists of 80 indicators across 19 clinical areas (e.g. coronary heart disease, heart failure, hypertension).
- Patient experience: this domain consists of four indicators that relate to length of consultations and to patient surveys.
- Additional services: this domain consists of eight indicators across four service areas which include cervical screening, child health surveillance, maternity services and contraceptive services.
- Holistic care: this domain is a measure of the breadth of care across the clinical domain.
- Organisational: this domain consists of 43 indicators across five organisational areas – records and information; information for patients; education and training; practice management and medicines management.

For further information, see the online results database (www.qof.ic.nhs.uk/).

Appendix 2

Data by GP practice

Table 1.1 shows SARs by GP practice where the SAR is statistically significantly high for COPD. For the listed surgeries, there were more admissions for COPD than would be expected given the population.

Table 1.1 Standardised admission ratios (SARs) for COPD by GP practice

GP practice code	GP practice name	Observed admissions	Expected admissions	SAR	Lower confidence interval	Upper confidence interval
C86002	THE RANSOME PRACTICE	27	17	159	105	231
C86005	DR DL AGRAWAL'S PRACTICE	36	20	183	128	253
C86009	THE MAYFLOWER MEDICAL CENTRE	26	15	173	113	253
C86015	THE ROSSINGTON PRACTICE	45	23	198	144	264
C86024	CONISBROUGH GROUP PRACTICE	32	19	165	113	232
C86026	EDLINGTON HEALTH CENTRE PRACTICE	31	16	197	134	280
C86033	DR RK NAYAR'S PRACTICE	26	8	316	206	463
C86034	THE NEW SURGERY	29	14	204	137	293
C86037	FIELD ROAD SURGERY	41	26	160	115	217
C86039	THE VILLAGE PRACTICE	32	11	295	202	416
C86604	DR RA GONI'S PRACTICE	15	6	257	143	423
C86605	ASKERN MEDICAL PRACTICE	45	23	198	145	266
C86611	DUNSVILLE MEDICAL CENTRE	12	5	226	117	395
C86614	CHESTNUT HOUSE SURGERY	9	4	241	110	457
C86616	CHURCH VIEW SURGERY	32	11	291	199	411
C86621	WEST END CLINIC	18	7	257	152	407
C86623	DR ME SHEIKH'S PRACTICE	10	5	219	105	403

Table 1.2 shows the raw prevalence by GP practice for COPD (Source: QOF). Prevalence is calculated as the number of people on the practice disease register for COPD divided by the number of people on the practice list. Prevalence varies from 0.18% for the Dove Primary Care Centre with just two people on the register to 4.35% at Dr Sheikh's Practice with 85 people on the register.

Table 1.2 Percentage of patients with COPD on practice register

Practice code	Practice name	Practice List Size	Disease Register COPD	Prevalence COPD
C86623	DR ME SHEIKH'S PRACTICE	1,952	85	4.35%
C86603	LYNDHURST	2,062	79	3.83%
C86005	DR DL AGRAWAL'S PRACTICE	6,791	257	3.78%
C86001	CARCROFT DOCTORS GROUP	10,922	401	3.67%
C86033	DR RK NAYAR'S PRACTICE	4,092	148	3.62%
C86604	DR RA GONI'S PRACTICE			3.59%

Practice code	Practice name	Practice List Size	Disease Register COPD	Prevalence COPD
		2,423	87	
C86613	DR JP NELSON'S PRACTICE	3,419	116	3.39%
C86003	HATFIELD HEALTH CENTRE	9,988	337	3.37%
C86034	THE NEW SURGERY	6,714	220	3.28%
C86616	CHURCH VIEW SURGERY	4,061	125	3.08%
C86016	THE LAKESIDE PRACTICE	7,202	217	3.01%
C86037	FIELD ROAD SURGERY	9,363	277	2.96%
C86014	PRINCESS MEDICAL CENTRE	6,602	192	2.91%
C86002	THE RANSOME PRACTICE	6,784	197	2.90%
C86605	ASKERN MEDICAL PRACTICE	9,336	269	2.88%
C86023	BENTLEY SURGERY	6,492	187	2.88%
C86025	FRANCES STREET MEDICAL CENTRE	8,450	241	2.85%
C86018	THORNE HEALTH CENTRE	12,090	335	2.77%
C86614	CHESTNUT HOUSE SURGERY	2,725	73	2.68%
C86606	BARNBURGH SURGERY	1,849	48	2.60%
C86024	CONISBROUGH GROUP PRACTICE	7,715	196	2.54%
C86038	PETERSGATE MEDICAL CENTRE	8,667	212	2.45%
C86039	THE VILLAGE PRACTICE	6,069	147	2.42%
C86625	CONISBROUGH MEDICAL PRACTICE	1,818	44	2.42%
C86026	EDLINGTON HEALTH CENTRE PRACTICE	5,425	131	2.41%
C86021	WHITEHOUSE FARM MEDICAL CENTRE	6,428	147	2.29%
C86621	WEST END CLINIC	3,639	80	2.20%
C86015	THE ROSSINGTON PRACTICE	10,177	218	2.14%
C86022	SANDRINGHAM ROAD HEALTH CENTRE	8,423	180	2.14%
C86013	THE TICKHILL & COLLIERY MEDICAL PRACTICE	9,451	201	2.13%
C86020	ST.JOHNS GROUP PRACTICE	9,731	192	1.97%
C86030	THE PHOENIX MEDICAL PRACT	2,031	40	1.97%
C86017	KINGTHORNE GROUP PRACTICE	8,855	173	1.95%
C86019	THE SCOTT PRACTICE	13,077	240	1.84%
C86612	MOORENDS SURGERY	3,687	66	1.79%
C86006	REGENT SQUARE GROUP PRACTICE	10,384	184	1.77%
C86009	THE MAYFLOWER MEDICAL CENTRE	7,935	129	1.63%
C86012	THE OAKWOOD SURGERY	5,821	93	1.60%
C86007	THE BURNS PRACTICE	9,782	154	1.57%

Practice code	Practice name	Practice List Size	Disease Register COPD	Prevalence COPD
C86011	MOUNT GROUP PRACTICE	12,247	189	1.54%
C86626	PARK VIEW SURGERY	2,549	36	1.41%
C86611	DUNSVILLE MEDICAL CENTRE	3,798	52	1.37%
C86029	ST VINCENT MEDICAL CENTRE	15,840	211	1.33%
C86032	SCAWSBY HEALTH CENTRE PRACTICE	6,077	79	1.30%
C86609	AUCKLEY SURGERY	2,430	30	1.23%
C86629	THE DOVE PRIMARY CARE CTR	1,124	2	0.18%

Appendix 3

Mosaic™ Lifestyle Groups

G42 Families with school age children, living in very large social housing estates on the outskirts of provincial cities

Key Features

- Families
- School age children
- Income Support
- Financial worries
- Council housing
- Public transport
- Poor diet and health
- Free school meals
- Money off coupons

Type G42 contains large numbers of people in large provincial cities, who are on low incomes and are particularly dependent on city councils for housing and for transport.

A poor diet, and heavy smoking and drinking are major contributors to the general poor health of the people in *Type G42*. This is compounded by an inactive lifestyle, with the betting shop and the bingo hall being the places where leisure time is most likely to be spent. Despite many of this population being relatively young, hospital admissions are well above the national average, and alcohol and drug abuse are serious concerns. Teenage pregnancy is also an issue in these areas.

Life is lived solely in the present, and the idea of working towards a better future rarely occurs. Generally, these people are resigned to their destiny, which is one of survival and self-indulgent pleasures, which provide only fleeting satisfaction. They rely on instinct, knowing what they like and liking what they know. There may be small pockets where economic and social conditions are more conducive to optimism and to change, but the critical mass of these areas will tend to create a marked pessimism about life and future prospects.

These people are the old proletariat who have struggled, and who continue to struggle in coming to terms with the new economic order. They are not as impoverished as some, but their lives are beset with financial and personal worries.

Favourite cigarette brands are:

- Lambert & Butler
- Richmond

The most popular places to buy cigarettes are:

- Supermarkets
- Local grocers/convenience stores

The most popular methods of quitting are:

- Nicotine patches
- Nicotine gum

G43 Older people, many in poor health from work in heavy industry, in low rise social housing

Key Features

- Poor older people
- Some retired
- Pension Credit
- Grown up children
- Traditional gender roles
- Poor health
- Working class values
- Football matches
- Heavy viewers of TV

Type G43 is found in parts of declining industrial areas, where a poor but relatively stable, elderly population lives in low rise council owned properties typically forty or more years old.

Financial constraints and circumstances conspire such that these people rarely buy the foods that constitute a good diet, and usually end up with cheap alternatives with little nutritional worth. Many will smoke. Alcohol plays an important part in their lives. Leisure activities are generally passive. With these people being the oldest in this Group this unhealthy lifestyle is coming home to roost, with relatively high rates of hospital admissions for a wide range of serious conditions.

These people are also remnants of the old proletariat, or 'blue-collar' workers who have been left struggling in the new economy. Existence may be humdrum but they are either resigned to it, or they like it that way. A siege mentality may characterise the mindset of some.

Favourite cigarette brands are:

- Lambert & Butler

The most popular places to buy cigarettes are:

- Local grocers/convenience stores
- Supermarkets

The most popular methods of quitting are:

- Nicotine patches

H44 Manual workers, many close to retirement, in low rise houses in ex-manufacturing towns

Key Features

- Families with children
- Traditional working class
- Poorly educated
- Basic occupations
- Traditional gender roles
- Income Support
- Heavy TV viewing
- Heavy smokers
- DIY popular

These are mostly very poor communities, intensely dependent on manufacturing industry.

Many people living in these areas do not subscribe to a healthy lifestyle. Diet is poor, and many people smoke. Leisure time is more likely to be spent drinking in the working men's clubs that still survive rather than on taking physical exercise. However, unhealthy consumption is perhaps not taken to the extremes that occur in other deprived areas; consequently whilst health is poor there are others who have more serious problems.

These people live unadventurous, working class lives. Local economic and social circumstances are changing and the areas are likely to see some major transformations in the near future.

Favourite cigarette brands are:

- Lambert & Butler
- Mayfair

The most popular places to buy cigarettes are:

- Local grocers/convenience stores
- Supermarkets

The most popular methods of quitting are:

- Nicotine patches
- Nicotine gum

H45 Older couples, mostly in small towns, who now own houses once rented from the council

Key Features

- Older working ages
- Manufacturing jobs
- Low incomes
- Older council housing
- Owner occupied terraces
- Close to countryside
- Few social problems
- Inactive lifestyles
- TV popular

Type H45 contains people of older working age, working in manufacturing industries and living in mixed areas of older council housing and owner occupied terraces.

Whilst these people cannot generally afford particularly healthy foodstuffs, they do tend to limit the really poor foods in their diet. Alcohol and tobacco are features in the lives of many, but these too are more likely to be taken in moderation. As this population is aging it is suffering from health problems; however, when adjusting for age the rate of hospital admissions does not greatly exceed the national average. The sense of order in these communities means that problems such as drug and alcohol abuse and teenage pregnancies are below average.

These people are very insulated from the modern world. Their geographical isolation and the self-contained, self-serving and socially incestuous nature of the communities, results in traditional working class values, preserved largely intact. They are concerned about self-improvement, but only with respect to limited ambitions where acquisitions and a comfortable material existence have a high priority. They have little interest in the wider world, even when it starts nearby. They are reserved and insular, and to some extent protected from the harsh realities faced by others who have a similar heritage. These people are stoical and introverted. They are not adventurous. They prefer the homespun.

Favourite cigarette brands are:

- Lambert & Butler

The most popular places to buy cigarettes are:

- Supermarkets
- Local grocers/convenience stores

The most popular methods of quitting are:

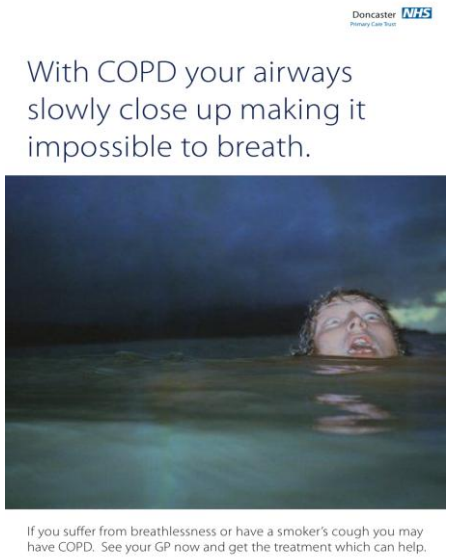
- Nicotine patches

Appendix 4

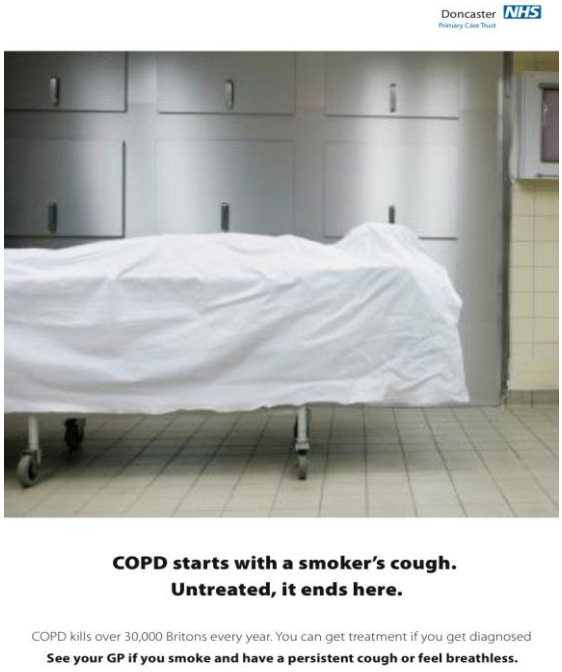
Marketing Material Tested in Groups

Poster A: 'Please read aloud'

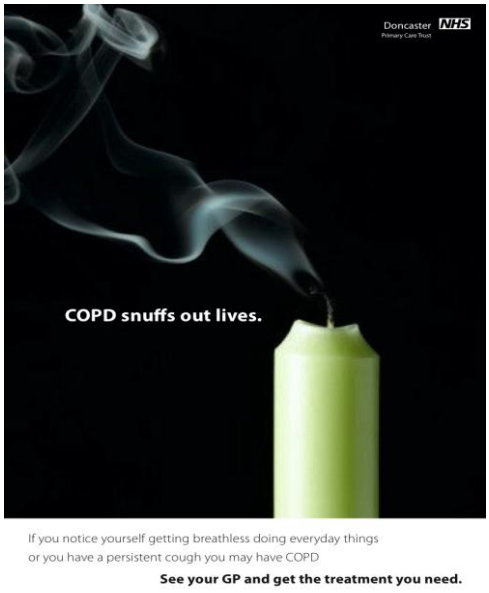
Poster B: Person drowning in tar



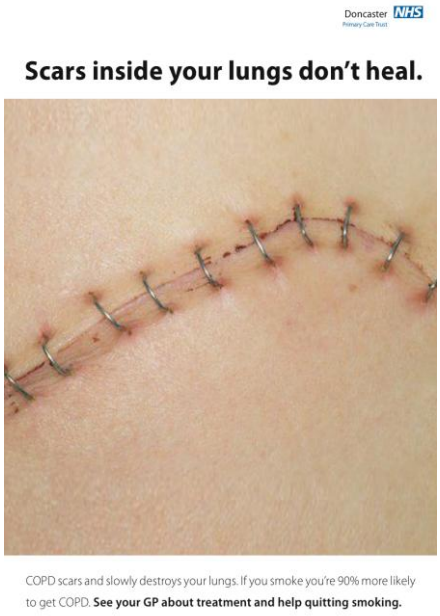
Poster C: Covered body in a morgue



Poster D: Candle



Poster E: Scar



Leaflet

Recognise the symptoms of COPD:

- Breathlessness after going up stairs
- A cough that's lasted a long time
- Coughing up phlegm
- Wheeziness during cold weather

What is COPD?

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Sit amet ornare enim pellentesque nisi erat vitae nulla aenean et lorem semper gravida ipsum.

What can be done to help?

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Sit amet ornare enim pellentesque nisi erat vitae nulla aenean et lorem semper gravida ipsum.