

Learning together

Evaluation and outcomes

Social marketing learning demonstration sites



About The NSMC

We are The NSMC, the international centre of behaviour change expertise.

We're dedicated to making change happen that improves people's lives.

We do this by supporting organisations to design cost-effective programmes that help people adopt and sustain positive behaviours – those that improve their lives. Eating healthily, being more active and saving energy are just some of the positive changes we have helped our clients achieve.

As well as programme support and strategic advice, we also provide professionals with the skills and resources to design and deliver their own cost-effective behaviour change programmes.

Originally set up by the UK Government, we now have a global reach, applying social marketing skills, knowledge and experience from around the world to solve behavioural challenges.

Contents

4	Foreword
5	Introduction
8	Evaluation and key tips
10	North Tyneside PCT
12	NHS Dudley
14	NHS Kirklees and Kirklees Council
18	NHS Stockport
20	NHS Tameside and Glossop and Tameside Metropolitan Borough Council
22	NHS Brighton and Hove
24	NHS Lewisham
26	NHS Norfolk and NHS Great Yarmouth and Waveney
28	Gateshead, Sunderland and South Tyneside Council
30	NHS Stoke-on-Trent

Foreword



In 2007 the National Social Marketing Centre (The NSMC) set up the Learning Demonstration Sites scheme with funding from the Department of Health. At that time social marketing was relatively undeveloped in England. Three years on the profile of social marketing has increased dramatically, with many government and public sector organisations adopting its principles to ensure that the consumer is at the heart of policy-making and service delivery. This change has been driven largely by local champions such as those involved in The NSMC's learning demonstration sites.

The scheme concluded in March 2010. However, I am extremely pleased that the project teams have continued to use the skills and experience they gained to inform current and future work. Building local capacity and sharing knowledge were key principles of the scheme. We hoped to leave a legacy of learning and expertise that would enhance customer-focused behavioural interventions.

This report presents the journey of each of the projects, including final outcomes and lessons learned from across the sites. For those involved in the scheme, it is a record of your achievements and a gesture of our appreciation for your hard work.

Social marketing continues to be a practical and valuable approach to delivering behaviour change. Its focus on empowering individuals as well as influencing and measuring behaviours is in line with the Government's people-centric, evidence-based approach to public health.

I would like to thank those of you involved in the scheme for your efforts and for the courage and determination you showed in pioneering a new way of thinking and working. I hope you and others will use the experiences and lessons learned from this scheme to continue promoting a people-centred approach to social change.

John Bromley,
Director,
The NSMC

Special thank you note

A big thank you to local project leads and Associates for all your hard work and tenacity on the Learning Demonstration Sites scheme. It has been a great privilege working with you to integrate social marketing into your health improvement programmes.

We are very pleased that all ten sites that started the scheme back in 2007 remained with us throughout our three-year journey. All the projects followed the social marketing process but each one was unique in its task and situation.

Each team faced various challenges and obstacles. Some of these were overcome, some were not – this is the reality of putting theory into practice. However, your stories and experiences provide invaluable learning that can be shared to enhance future work.

The scheme would not have been a success without your involvement, so congratulations and thank you.



Rowena Merritt
Research Manager,
The NSMC



Denise Ong
Senior Researcher,
The NSMC

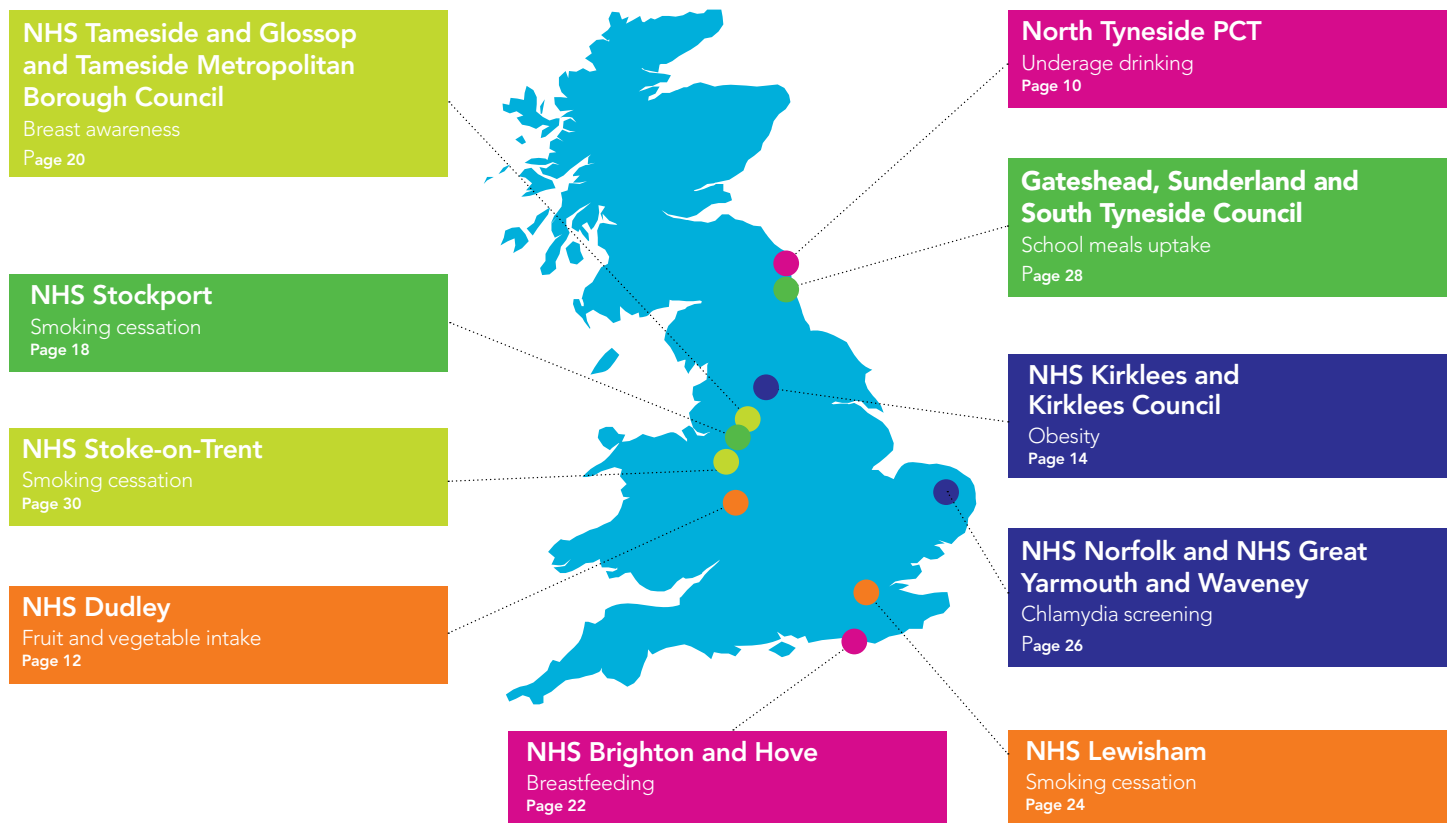
Introduction

The National Social Marketing Centre (The NSMC) is delighted to present this third and final report on the three-year Learning Demonstration Sites scheme, following its successful completion in March 2010.

The NSMC was established in December 2006 as a strategic partnership between the Department of Health (DH) England and Consumer Focus. We work with organisations across government and sectors to enhance behavioural interventions for a social good.

Use of social marketing continues to grow in England. In 2007, ten learning demonstration sites were set up with funding from DH. The aim was to help local areas apply and integrate social marketing into their programmes and strategies, while helping to develop a robust evidence base for social marketing. The learning demonstration sites are also a key component of DH's 'Ambitions for Health' strategic framework to build capacity and skills in applying social marketing principles to health interventions.

The learning demonstration sites were based in Primary Care Trusts (PCTs) and local authorities across the country and addressed a range of health issues.



"It's been a real eye-opener and it's made me change the way I work and I think."

Aims of the Learning Demonstration Sites scheme

The aims of the scheme were to:

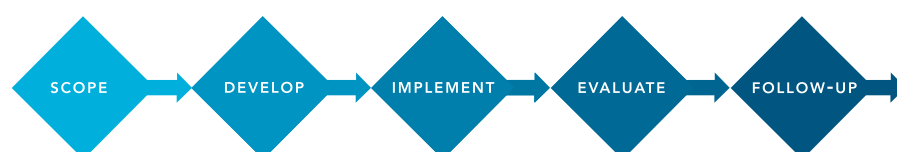
- Stimulate the use and integration of social marketing into local strategic and operational planning
- Build on and develop existing skills in using and applying social marketing concepts and approaches
- Capture learning and promote effective social marketing practice
- Inform and contribute to the development and testing of a growing range of The NSMC's practical resources and tools
- Support further development of the evidence base for effective customer-focused behavioural interventions and social marketing related work

Operating principles

Each of the learning demonstration sites considered all eight of The NSMC's social marketing benchmark criteria when developing their project:

1. **Customer orientation**
2. **Behaviour**
3. **Theory**
4. **Insight**
5. **Exchange**
6. **Competition**
7. **Segmentation**
8. **Methods mix**

Each site also followed The NSMC's planning process.



Further details of the benchmark criteria and an online planning guide can be found on The NSMC's website at www.thensmc.com.

"I would say, without a doubt, the best piece of work I've ever been involved in. I can't imagine not thinking about the process of social marketing when I'm planning, or even commissioning health improvement work in the future."

"It's felt like it's been an upward hill climb and sometimes quite a rugged hill ... they've given us lots of useful tips and I look forward to the evaluation."

"This was a pure project and we went in with a blank canvas ... We basically looked at all the past health promotion material, screwed it up in a ball and chucked it in the bin and said we're starting again, we don't know anything, we don't know what people's lives are like."

"The benefit of this work is that it has been going out to meet people, talk to them, to find out what ticks their boxes ... they actually seem to value that you are asking, that they are being asked about what is going on. But the important thing is that we deliver and it isn't just sort of providing us with information."

"We're just starting with social marketing in our PCT and it's a gift that keeps giving."

Local ownership and resources

Each project used existing local resources and was self-managed, with all key decisions made by the local partners.

The role of The NSMC was to support the local teams in understanding and applying social marketing principles. This approach fostered a collaborative relationship between the local areas and The NSMC.

It also reinforced local leadership and built on existing expertise and skills. In this way, each initiative aimed to leave a 'learning footprint'.

Support from The NSMC

The NSMC provided support for the learning demonstration sites in a range of ways, including:

- Free consultancy days from a dedicated NSMC Associate
- Ready access to The NSMC team for additional support and advice as required
- Web access to NSMC resources and other project documents
- Training events on scoping, development and evaluation for local project leads
- Events for local project teams to discuss their work, share learning and network with other sites and key stakeholders
- Coordination and linking of work across the sites and with national policies, key stakeholders and sources of funding
- Independent evaluation advice and support



Evaluation

Two independent organisations were commissioned by The NSMC to conduct process and outcome evaluations for the scheme.

Process evaluation

In order to capture the projects' experiences and learning in effective implementation of social marketing, the Public Health Action and Support Team (PHAST) were commissioned to undertake an independent process evaluation.

Key strategic and operational stakeholders¹ involved in the design and implementation of the projects were interviewed at two points during the scheme: at the scoping stage (October to November 2008) and at the development/implementation stages (June to August 2009). The interviews focused on identifying factors that help and hinder local social marketing projects.

Findings from the process evaluation suggested the following key tips for enhancing success:

1. Securing dedicated local project management and senior support

Top Tip: Appoint a project manager with proven experience of delivering projects to time and budget who will dedicate sufficient time to the project. However, the success of a project should not rest on the shoulders of one individual. Staff changes and absences can cause the project to lose momentum, leading to huge delays.

2. Conducting a focused and rigorous scoping exercise

Top Tip: To increase efficiency during the scoping phase, first clarify with your 'sponsors', commissioners and key project staff what the priorities, timescales and resources are. This will help you concentrate your efforts on what is important and achievable. Make use of existing data where possible and check if these findings can be similarly applied to your area. In some cases, the reasons why people in one region think or behave a certain way are relatively similar to those found in another region.

3. Planning evaluation from the outset and drawing on external expertise

Top Tip: Partnering with an academic institute can be a cost-effective way of acquiring external research and evaluation expertise and capacity. They can help you design an evaluation strategy and draw on post-graduate students to collect and analyse data. Make sure you start planning your evaluation at the start of your project. This will help you define meaningful objectives and outcome measures and ensure that data collection methods are in place before you begin implementation.

4. Involving the local community and target audience

Top Tip: Tap into existing community networks of colleagues within your organisation or partner organisations, such as Community Development Teams. Try to avoid commissioning out the community engagement work so that local relationships can be developed with your organisation (rather than with a third party supplier). These relationships can then be leveraged for future initiatives.

5. Accessing expertise in social marketing

Top Tip: Be clear about where you need extra support and expertise. Marketing is a diverse discipline that requires a broad range of skills. Many professional marketers specialise in one particular area within marketing and it is unrealistic to expect to employ a 'marketer' who has expertise in all areas of marketing. As your project develops, seek the specialist skills as and when you require them. For example, market research and insight generation during the scoping stage, or creative development and media planning if you identify the need for a communications campaign.

6. Engaging key stakeholders and partners and developing an effective communications strategy

Top Tip: Be creative and think laterally about whom to include – consider the third sector, arts and recreation, media and other partners who have a stake in the issue. Don't forget your internal stakeholders. Make sure your sales force – who are the front-line staff who will promote your interventions – are engaged from the start. This ensures that you do not encounter resistance or delays when you reach the implementation stage.

7. Setting clear and achievable behavioural goals

Top Tip: Try to be as specific as you can in defining exactly who you want to adopt what behaviour and by when. Set short, medium and long-term objectives. Be realistic about what you can expect to achieve with limited budget and time – it is not feasible to change a social norm with £20,000 and six months!

These tips were also published in an article (entitled 'Sell your ideas in a buyers' market') in the July 2010 issue of the Health Service Journal, which is available online and in print.



¹ Key strategic stakeholders were DH and NSMC commissioners.

Key operational stakeholders included local project leads and NSMC Associates.

Outcome evaluation

The London School of Hygiene and Tropical Medicine (LSHTM) were commissioned to provide outcome evaluation support to the sites.

Since evaluation expertise within local project teams tends to be fairly limited, each site was offered up to five consultancy days from the LSHTM to help improve the quality of outcome evaluation and build evaluation skills. Three of the sites (Lewisham, North Tyneside and Tameside and Glossop) were offered more comprehensive support to complete full evaluations of their projects. Two sites (Stockport and Kirklees) were allocated funding from The NSMC to subsidise their own evaluation budget and commission local research companies to carry out the evaluation work.

Evaluation methods and outcomes for each site are detailed on the following pages.



DEDICATED LOCAL PROJECT MANAGEMENT AND SENIOR SUPPORT:

"You've got to put someone in charge of this who's done it before"

FOCUSED AND RIGOROUS SCOPING

EXERCISE: *"Don't take anything for granted, don't assume, ask the questions and find out and keep using your insight. And keep going back and going back. And I think really there's a lot of self reflection goes on."*

PLANNING EVALUATION FROM THE OUTSET AND DRAWING ON EXTERNAL EXPERTISE:

"She's very experienced at evaluation, both qualitative and quantitative, she knows exactly what we ought to be looking at... She knows what tools to use and what's feasible and what's not feasible and what you should be comparing. So, yeah, I think she's going to be great."

INVOLVING THE LOCAL COMMUNITY

AND TARGET AUDIENCE: *"The public sector has a short attention span and with community engagement you have to be in it for the long haul."*

ACCESSING EXPERTISE IN SOCIAL

MARKETING: *"I think our project is showing that actually we wouldn't have benefitted nearly so much if we had just brought in an external agency to do this, because we wouldn't have built the same dialogue with the community at all."*

SETTING CLEAR AND ACHIEVABLE

BEHAVIOURAL GOALS: *"They didn't have an action plan that was written down with clear actions and timescales. I'd turn up at the next meeting and we would be going over the same ground. Often no one has taken forward the agreed action points so nothing was done in between meetings. It was frustrating."*

North Tyneside PCT

Jan Thompson and Louise Pinkney

This project aimed to reduce underage kerbside drinking among 13 to 17 year olds in North Tyneside. The areas of Wallsend, Battlehill and Howdon were selected as the pilot sites due to the high prevalence of anti-social behaviour and alcohol-related incidents.



Heavy and harmful drinking patterns have increased among young people in the UK. In North Tyneside, two-thirds of young people drink alcohol and more than half drink at least once a week. Surprisingly, among ten to 17 year olds, girls regularly drink more alcohol than boys (73.3 per cent and 54.4 per cent respectively), a finding that contrasts with the rest of the UK. Consequently, North Tyneside has some of the highest rates of hospital admissions for under-18s due to alcohol-related causes and the teenage pregnancy rate is significantly higher than the national average. Alcohol-related crime and disorder, as well as residents' fear of crime and anxieties about young people drinking on the streets, is also on the rise.

In early 2007, North Tyneside's Alcohol Harm Reduction Strategy Group approached The NSMC to collaborate on a social marketing project to tackle underage kerbside drinking. An initial budget of £64,000 was allocated to the project by North Tyneside PCT.

Scoping

During 2007 and 2008 The NSMC carried out extensive scoping, starting with desk-based secondary research to identify existing information and knowledge about young people and street drinking. Primary research was then undertaken to explore the recreational patterns of young people in North Tyneside, the motivational drivers behind street drinking and the activities and services that could be offered in exchange. Research included interviews with youths picked up by the police for drinking on the streets, their parents, local shopkeepers, trading standards and residents, as well as an audit of out-of-hours youth provision in the local area. Comparative reviews were also conducted to identify good practice elsewhere, drawing on the experience and expertise of those working on similar projects.

The research revealed three main drivers for underage street drinking: lack of attractive and affordable alternative activities; cheap and easy supply of alcohol; and drinking as

a social norm. It also found retailers wanted to reduce proxy sales and intimidation by groups of young people outside their shops in order to attract more business. However, they struggled to identify when an apparently legal sale might be a proxy purchase and perceived a lack of commitment and support from the local authority. It was clear that a two-pronged approach was needed: an exciting alternative to street drinking where young people could meet and spend time with friends; and support for retailers in tackling illegal and proxy sales.

The behavioural goals of the project were to reduce the number of young people drinking alcohol on the streets; the amount they were drinking; and the number of attempts to purchase alcohol illegally. The project also aimed to encourage local retailers to implement a ban on alcohol sales to under-21s during peak times.





“The local police now have a tool to use with alcohol retailers, so they can address the problems raised.”

Development

The comparative reviews showed that successful youth activities had a developmental element to them and involved young people in the selection and design of activities. Through a series of workshops and focus groups, students from a local college helped to identify and design a rolling programme of free, accessible out-of-hours activities that would appeal enough to compete with street drinking.

Further desk-based research and interviews with local retailers, police, licensing and trading standards explored the feasibility of introducing a scheme to tackle illegal and proxy sales. Although retailers supported introducing a ban to under-21s, they wanted more supportive (rather than punitive or antagonistic) measures from police and trading standards. A scheme was therefore developed to encourage retailers to implement a voluntary ban on alcohol sales to under 21 year olds at peak times, with active support from the police, trading standards and licensing.

The entire programme was branded *Sub21*. This communicated the under-21 focus of the proxy sales scheme, while young people associated the brand with substituting street drinking for fun, structured activities.

Implementation

A ten-week rolling programme of out-of-hours activities was piloted in summer 2009 at local venues on Thursday, Friday and Saturday nights. As the main delivery partners, Wallsend Boys Club and Positive Futures offered a variety of activities to appeal to different segments of the target audience, such as nail art, cookery and street dance for girls, and graffiti, bike and ramp building and computer gaming for boys. A Programme Coordinator was hired to manage and promote the activities through schools, community venues, SMS and online.

For local retailers (generally small, independent, family-run businesses), a package of support measures was offered by Northumbria Police and North Tyneside Council to help them tackle illegal and proxy alcohol sales. This included a dedicated 24-hour Crime Line, training sessions on conflict management, resolution and authenticating ID cards and at least two police visits per week. In return, retailers were asked to implement certain measures, including no alcohol sales to anyone 21 years or under between 5pm and closing time on Thursday, Friday, Saturday and bank holidays and reporting any illegal and proxy sale purchase attempts immediately to the 24-hour Crime Line.

Evaluation

To evaluate the effectiveness of the intervention, the LSHTM conducted a survey among young people aged 13 to 17 years attending two schools in North Tyneside. Surveys were undertaken before and after the intervention. The surveys (conducted in April and October 2009) measured self-reported behaviour with regard to drinking and purchasing alcohol (including street drinking and proxy purchases) and the prevalence of negative consequences associated with alcohol consumption. Among the findings were that the proportion of female respondents who reported drinking on the street after the intervention was half that reported before the intervention. There was also a reduction in the most harmful types of drinking among females, including binge drinking and drinking to the point of being sick. However, female respondents were significantly more likely to report drinking at home post-intervention, although encouragingly there was a reduction in the proportion of female respondents reporting buying alcohol in off-licences.

Among male respondents, there does not seem to have been much change in self-

reported drinking behaviour, but the findings suggest they are experiencing greater difficulty in accessing alcohol in the area.

Post-intervention, respondents were significantly more likely not to have asked anyone to buy alcohol for them. Of those who did, both male and female respondents most commonly reported asking a friend.

Efforts to raise awareness of and engage young people with Sub21 were very effective – most young people surveyed had heard of Sub21 and a third reported attending Sub21 activities.

Follow up

Sub21 is now hosted within Extended Schools in North Tyneside Council. The Director of Extended Schools, together with the Sub21 coordinator, is looking to secure future funding for Sub21 to continue. Funding bids are with Drinkaware and the Big Lottery Fund, though the programme currently has funding to run until March 2011. The programme of activities has been developed to include those that are most popular and offer best value for money. Key to this intervention was partnership with Wallsend Boys Club, which had the premises and energy to make the brand work. The Extended Schools Director championed this initiative in the local authority and the local police Chief Inspector supported the programme, both of which were pivotal to the initiative's success. Sustainability is always a challenge with new projects, but the evaluation has shown the success that can be built on.

Safe Durham Partnership has decided to roll out the Sub21 model in county Durham and discussions are underway to do the same in North Shields. Northumberland County Council has also expressed an interest in Sub21.

NHS Dudley

Trish Bussell, Stacey Jones and Alex Christopoulos

This project aimed to improve fruit and vegetable consumption in Hawbush, a deprived neighbourhood in Dudley.



Hawbush was selected for a range of reasons but most notably because it has the highest proportion of overweight and obese year six pupils; the highest proportion of year five and year six pupils who do not eat the recommended portions of fruit and vegetables a day; and the highest proportion of year five and year six pupils who only eat one portion (or less) a day. The primary target audience were parents of young children aged four to eleven years, chosen due to the integral role parents play in healthy eating. School staff, parents and the wider community on the estate were chosen as secondary audiences.

In the most deprived areas of Dudley, only 18.4 per cent of residents reported eating at least five portions of fruit and vegetables a day. Eating this amount of fruit and vegetables reduces the risks of cancer, coronary heart disease and many other chronic diseases, yet national and local research showed that some people have poor access to fruit and vegetables simply because shops did not stock them. This was because they have a shorter shelf life, yield lower profit, require special storage and are often perceived to be in low demand. In June 2007, the Food and Nutrition team at NHS Dudley successfully bid to the Big Lottery Fund for a healthy retail project receiving £59,750 and in autumn 2007 became one of The NSMC's learning demonstration sites.

Scoping

From September 2007, initial research and mapping exercises using a variety of software tools identified three areas which were likely to experience food access problems and the type of people that lived in these areas. To better understand these populations and provide information for segmentation, The NSMC carried out six focus groups in December 2007 and February 2008 with around 60 residents in Fatherless Barn, Gad's Green and Hawbush to explore the residents' daily routines, what influences meal times, food purchasing culture, perceptions of and barriers to eating fruit and vegetables and ways of increasing consumption. In addition, Food for Health Advisors interviewed various stakeholders including a headteacher, school health advisors, parent governors, local retailers, supermarkets and local primary care staff, exploring the views of professionals who worked in the areas and gathering ideas on increasing fruit and

vegetable consumption among local residents. Various surveys were also used, including the Dudley Health and Lifestyle Survey which provided further information on the motivations behind fruit and vegetable consumption.

One key insight from the focus groups was the impact of parenting on fruit and vegetable intake. Factors such as 'pester power' tactics, quarrels at meal times and the parents' desire for their children to eat something meant that children exerted a high level of influence over what they ate. Parents were also concerned about the cost of fruit and vegetables and the potential amount of wastage produced. Therefore any interventions needed to help parents provide a desirable offer to children and stimulate demand from children for fruit and vegetables.

Other barriers which needed to be addressed were: poor local access to a variety of fruit and





"We are hoping that the Healthy Retail Project will provide our community with easier access to fresh fruit and vegetables. Above all, we aim to make fresh food an enjoyable, affordable and accessible realistic first choice for everyone."

vegetables of good quality; the price of fruit and vegetables; preparation time and food skills for cooking fruit and vegetables; ingrained habits of eating less healthy foods; and some uncertainty over the health benefits of fruit and vegetables.

The behavioural goals were to encourage parents of young children to consume more fruit and vegetables; consume a wider variety of fruit and vegetables; try different kinds of fruit and vegetables more frequently; purchase more fruit and vegetables; and reduce reported levels of wastage.

Development

The scoping research underlined the importance of a two-pronged approach to fruit and vegetable consumption: focusing on making it easier to buy fruit and vegetables (through availability, price and preparation) and increasing demand for them (increasing skills and confidence, using children's 'pester power' and reducing waste). Based on the research, the project team developed a number of different intervention models and tested them with members of the target audience.

Supply was addressed by setting up a fruit and vegetable stall at a local school to improve the availability of fruit and vegetables. The produce would be offered at competitive pricing compared with the favoured supermarkets and include chopped vegetables and single portion vegetable packs. Recipe packs were designed to be handed out and taster sessions were organised to provide opportunities for people to try new foods without worrying about waste or family members' preferences. To increase demand, educational sessions to raise awareness of healthy eating and the health benefits of fruit and vegetables were developed. They also sought to improve skills in preparing and cooking seasonal fruit and vegetables and provide suggestions on avoiding waste.

Implementation

A dedicated brand, *Bostin Value*, was created to promote the school fruit and vegetable stall run by a local greengrocer at the Hawbush Primary School. It was used on promotional

material including vouchers, price lists and a leaflet sent to parents. The fruit and vegetable stall operated in the school playground on Tuesdays and Thursdays around school finishing time to capture the 'pick-up' market. A trial run of the fruit and vegetable stall took place in the week commencing 23 March 2009 and the stall began regularly operating in late April 2009 (after the Easter break) to continue until November 2010. To increase demand, a Food for Health Advisor was also employed from April 2009 to plan and deliver various skills seminars and awareness raising activities. These included educational sessions for pupils and practical sessions for parents and the wider community, focusing on preparing and cooking cheap meals using seasonal fruit and vegetables and leftovers, tasting new foods and budgeting for food shopping. Family cooking sessions also ran in December 2009, with parents and children cooking together after school.

Evaluation

The LSHTM evaluated the project using a variety of methods. These included a pre- and post-intervention survey of parents, carers and children to assess progress made, using a food recognition quiz, food and vegetables tried questionnaire and food diaries to assess the children's knowledge and current dietary intake. The pre-intervention survey took place in April 2009, the post survey in December 2009 and July 2010. A control school (no intervention) was identified and baseline data was collected in December 2009 to January 2010. This was repeated six months later with the Hawbush evaluation to assess whether changes were brought about by the project interventions. A regular termly audit of the fruit and vegetable stall was conducted to assess volume and type of sales and to profile buyers. The skills sessions were evaluated by the Food for Health Advisor to explore the extent to which they were seen as appropriate and useful by participants. Finally, in-depth interviews with key stakeholders (parents, staff and project workers) were carried out to explore the acceptability of the intervention and examine factors that may have helped or hindered it.

Encouragingly, 25 per cent of parents surveyed post-intervention say they have eaten more fruit and vegetables since the scheme began and 44 per cent say their children now enjoy a wider variety of fruit and vegetables. Pupils surveyed post-intervention have increased the variety of fruit and vegetables they have tried, although the ability to recognise a range of fruit and vegetables has not changed significantly. The audit indicated that purchases at the stall tend to be fruit (rather than vegetables), for snacks (rather than meals) and for the whole family (rather than just for children).

Results from the children's food diaries and stakeholder interviews are pending, but feedback from the skills sessions was promising. Seven out of eight parents reported they had increased confidence in their cooking ability and that their children are eating more fruit and vegetables. All reported that they now cook more, or intend to cook more, at home. Other feedback included the need for a crèche, fewer children to adults at the sessions and fewer recipes to cook, thus aiming for quality rather than quantity. These will be included in the second phase of the cooking course.

Follow up

The importance of having a brand and a logo to give the project an identity should not be underestimated. It gave instant recognition, promoted the project and increased 'hype', which in turn created 'pester power' from the children who encouraged parents to purchase fruit and vegetables from the stall.

July 2010 marks the beginning of the school summer holidays. For sustainability, phase two of the intervention will be implemented with supply further strengthened by supporting the five local convenience stores to sell fruit and vegetables to the local community, thus meeting the increased demand generated by the project. The greengrocer from the Bostin Value stall will deliver fruit and vegetables to the local convenience shops to sell throughout the school summer holidays. Sales at these shops will be monitored and compared to baseline sales prior to these deliveries.

NHS Kirklees and Kirklees Council

Lynne Cliffe, Phil Longworth and Spencer Robinson

This project aimed to halt the year-on-year rise in overweight and obese students aged 16 to 24 in Kirklees in further education (FE) and higher education (HE).



Obesity is an increasing problem across the country. Early adulthood is a key stage at which many people gain significant amounts of weight. According to 2007 data, 33 per cent of 18 to 24 year olds in Kirklees are overweight or obese, with males aged 18 to 24 having the highest rates of overweight and obesity in the country.

While work focusing on childhood obesity was underway, there was a lack of focus on the 16 to 24 year old age group. There was also untapped potential to address the challenge of obesity in collaborating with FE and HE organisations. Kirklees Council and NHS Kirklees invested £100,000 of Communities for Health funding and were supported by The NSMC to initiate a social marketing intervention to tackle obesity in FE and HE students in Kirklees.

Scoping

Desk research to scope national and local activities and understand student's lifestyles, attitudes and behaviours around nutrition and physical activity revealed that there was little existing insight on student obesity. To fill in the knowledge gaps focus groups were carried out and segmented geo-demographically as males aged 16 to 18 in FE; females aged 16 to 18 in FE; males aged 18 to 24 in HE; and females aged 18 to 24 in HE. All participants had a BMI of 25 or above and were attending the University or colleges within Kirklees. A number of workshops and interviews were held with stakeholders to gather insight and develop a wider understanding of the target audience.

The new insights revealed that although students did see the benefits of a healthy lifestyle and appreciated that their current lifestyles needed to change, they lacked the motivation to do so. Several factors competed for their time, attention and inclination to change: hectic study and social calendars; a strong takeaway and drinking culture; and hours spent with the television or on the internet. A lack of cooking skills, tight budgets

and the perception that healthy food and gym memberships are too expensive also deterred students from eating healthily and exercising more.

As heavy consumption of alcohol was seen as a 'rite of passage' attempts to influence this would be poorly received and a waste of resources. The behavioural goals for the project therefore avoided alcohol consumption and focused on encouraging students to increase their physical activity; develop cooking skills; increase their knowledge of healthier lifestyles; and create an awareness of the calorific content of alcoholic drinks and takeaways. The project emphasised that this could be done while having fun, socialising and meeting new people, thereby appealing to the target audience.

Development

Key stakeholders helped develop and refine project ideas, a number of which were pre-tested with members of the target audience. Working with an external marketing agency, a 'stealth not health' approach was adopted and the *Up For It* brand identity was developed.





“Having consumer insight has opened up a whole new set of channels of communication that we wouldn’t have considered using 12 months ago.”

This promoted exercise and healthy eating in a fun and sociable way, fitting with students’ lifestyles without ‘preaching’ about exercise and good nutrition.

Insight suggested that the best time to establish healthy behaviours in students was at the beginning of their studies, as older students would have already established some unhealthy lifestyle behaviours. Starter packs containing basic condiments, cooking ingredients, utensils and recipe cards were offered during Freshers’ Week to encourage first year HE students to make their own meals. Fun activities designed to increase fitness levels and cooking skills were offered to encourage and support students to move more and cook quick and easy meals.

Implementation

The interventions were launched in September 2008, with 2,000 healthy eating starter packs distributed at the University Freshers’ Fairs. Throughout the 2009 spring term, fun, engaging activities were offered on FE and HE campuses, beginning with a ‘Dance your Ass Off’ event at a local nightclub for HE students. This showcased the dance classes on offer in the club and introduced the Up For It brand. ‘Come Dine with Me’ and ‘Take on the Takeaway’ cooking events were held in May 2009 for FE and HE students on the University campus. Students were given packs to enter the ‘Come Dine with Me’ competition as a way of encouraging students to cook their own meals and socialise with friends. A ‘Did You Know?’ leaflet was given to students at the event which showed the calorific value of alcohol in relation to fast food. A dodgeball tournament was held in June 2009 for FE and HE students, to demonstrate that you don’t have to be fit to enjoy physical activity and encourage the formation of dodgeball societies as an alternative to traditional sports. A viral video competition was offered to FE and HE students, encouraging them to make a fun video about healthy eating or exercise and post it on YouTube.

Evaluation

The interventions were evaluated using a mix of qualitative and quantitative methods. Focus groups and interviews with students who attended events and activities provided in-depth understanding of the target audience’s motivations and behaviour in terms of lifestyle and weight management. A street survey of 372 students on FE and HE campuses provided overall healthy eating and exercise data and questionnaires collected after events and activities provided an indication of who attended and their thoughts.

Results suggested that the free starter packs were a success, with the majority of students saying they had used the recipe cards or devised their own meals with the ingredients. The ‘Take on the Takeaway’ competition also received positive feedback with respondents rating it highest for ‘encouraging me to try cooking new dishes’. Female respondents in particular were enthusiastic about the starter packs and cooking events, reporting that the initiatives had given them the confidence and skills to cook more of their own food.

In terms of increasing the amount of healthier foods in students’ diets, particularly fruit and vegetables, 96 per cent of the respondents to the street survey indicated that they ate at least one portion of fruit or vegetables in a typical day. However, only 18 per cent claimed to eat the recommended five plus portions a day, indicating there was still work to be done to improve students’ diets. Encouragingly, 23 per cent of respondents reported that they ate more portions of fruit and vegetables a day than they did six months previously, but 67 per cent reported no change in the amount they ate.

The project also helped to improve take-up of physical activity. According to the street survey, 21 per cent of respondents said they did more exercise than they did six months previously, while 61 per cent said they did about the same amount. The ‘Dance Your Ass Off’ and ‘Take on the Takeaway’ competitions were most favourably received by the female respondents. Having seen the film ‘Dodgeball’,

male respondents were particularly enthusiastic about the dodgeball tournament.

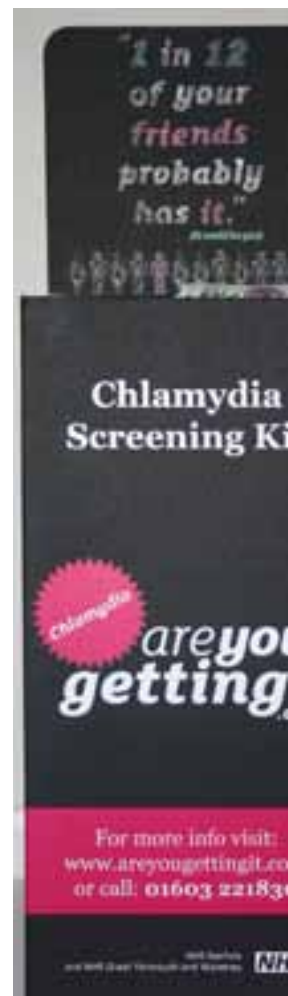
The project was innovative in its use of social media and text messaging as a way of engaging and communicating with the target audience. Between September 2008 and June 2009, the website received approximately 9,500 hits and 123 members joined the Up For It Facebook group.

Follow up

Targeting students for behaviour change can be complex as there is intense competition for their attention. It is crucial not to underestimate the strength of competition and social norms, as many students adopt unhealthy behaviours that they believe are part of a stereotypical student lifestyle. It is therefore advisable to focus resources on target group members who are already contemplating change, being realistic about what can be achieved with the resources available. Also, social media plays a big part in students’ lives and should be used to its full potential.

Building on social marketing skills, knowledge gained and evaluation findings from the initial phase of Up for It, improvements have been made to the project in an ongoing second phase outside of The NSMC’s scheme. This phase is intended to develop sustainable, evidence-based interventions that become embedded in FE and HE settings and explores the use of a business model to demonstrate that successful social marketing initiatives do not require an overspend in order to produce outputs. Initiatives have been developed to be self-funding for enhanced sustainability.

The insights will inform development of future services and robust commissioning specifications for consumer-led services, which should be embedded across all obesity activity. NHS Kirklees have redesigned their weight management provision and are implementing a primary care weight management service. Providers are now delivering a service that is consumer driven and meets the needs of the target group.





NHS Stockport

Sarah Clarke and Fiona Spotswood

This project aimed to increase local people's access to smoking cessation services in Brinnington, an estate in the north of Stockport with a particularly high smoking prevalence.



At local level, increasing the number of successful smoking cessation quit attempts among the 20 per cent most disadvantaged communities has been a joint PCT and local council Public Service Agreement target since 2006, directly leading to the development of the Brinnington initiative. Brinnington is among the top three per cent most deprived areas in England and Wales. 53 per cent of adults in Brinnington estate smoke, which is significantly higher than the Stockport average of 18 per cent and the national average of 24 per cent. In 2006 to 2007, only 203 people accessed the local stop smoking services.

Scoping

After the desk research phase, the team held a series of mixed gender focus groups in spring/summer 2007 with the local community. The groups included: hardened smokers with no intention of quitting; smokers who had tried but failed to quit; smokers who were contemplating quitting; successful quitters; and those currently in the process of quitting. The objectives were to explore: attitudes to services; experiences of successful quitters and those who have dropped out; and why current cessation services had achieved limited success. A series of interviews were also held with key health professionals in Brinnington to explore possible improvements to smoking cessation services to make them more consumer-centric. They found that the existing drop-in group for 'Quit for Life' appealed primarily to older women and so identified men and women with pre-school children as the target segments. In light of this, further focus groups were conducted with representatives of these segments, in order to gain additional insight into their lifestyles and what moves and motivates them.

After the focus groups and interviews were completed, two phases of consultation in March and May 2008 were held with key members of Brinnington's community, including health service providers and managers, ex-smokers, current smoking cessation service

users, community group leaders and organisers and smoking cessation service providers. These workshops focused on developing creative communications concepts and involved brainstorming ideas on the creative proposition, branding and media. The sessions informed the creative brief which was sent to various design agencies.

Insights were gathered from each stage of the primary research and applied to the development of the interventions. It was clear that smoking is very much a part of Brinnington life and is at the heart of much social interaction involving families, neighbours and friends, for example while socialising at the school gate, drinking in the pub or waiting in queues for local services. Therefore to quit smoking would be to go against the social norm and to risk social ostracism. Brinnington smokers were tired of being 'nagged' into quitting and were unlikely to succeed or make an attempt because their support networks consisted of smokers. Furthermore, life on the Brinnington estate tends to be stressful. People often have to cope with financial strain, social unrest from noisy neighbours, unruly family members or caring for several children without the support of a partner. With little money, time or 'personal space', smoking becomes an emotional crutch on which people rely for stress management and a form of escapism.





"The initiative ensures that the desires and needs of local people to get rid of cigarettes from their lives are central to our smoking cessation offer. We look forward to seeing real benefits for people in Brinnington who will be much better supported to make this important behaviour change."

Despite this, there was a real drive to quit, primarily because of financial worry but also because of the fear of ill-health and desire to be a positive role model for children. For women particularly, family is the most important part of their lives and protecting and encouraging them is paramount. Low confidence was a considerable barrier to community participation so services in trusted, safe and familiar environments with familiar faces were crucial. Men were more likely to work, often in shift patterns, so out-of-hours access to support is essential. However, there was a huge stigma for men to admit they needed help and support and most men refused to do so.

The project's behavioural goals were to double the number of smokers accessing local smoking cessation services in Brinnington, increase the number of successful quits and decrease the number of smokers on the estate.

Development

Five creative themes were produced from the design agencies and all were tested with the community in a series of single-gender focus groups in August 2008. Each of the themes was discussed and tested with various stakeholders, and the *Lose the Fags* concept was agreed. However concerns were raised as to whether parents would find the strapline 'give smoking the two fingers' offensive. The photographs were therefore taken in a way that clearly portrays the 'two fingers' pose but gestured to an absent cigarette between two fingers plus added smoke.

The project focused on providing new services which best fit the needs of the two target segments. Men required an after-hours drop-in facility that would relieve them of the stigma of seeking cessation 'advice', while still providing the support they need for a successful quit attempt. Women needed an easily accessible and supportive service run by people they recognised, in a familiar setting which they could attend regularly without the problem of finding childcare. Stress management was

also to be provided as an exchange via the two interventions.

For men, the service was implemented at the Lapwing Centre, the community gym, which enabled them to counter the ill-effects of giving up smoking by using exercise to manage their anger and stress. The Lapwing workers were conscious that anger management is a critical issue for men in Brinnington and so made efforts to introduce new members to methods for coping with stress and anger during their induction process. They also provided regular support in the guise of friendly 'banter' during work outs and in the reception area.

For the women, the intervention was held at the Children's Centre, the largest community nursery and part of Westmoreland School in the centre of the estate. They aimed to counter women's need for cigarettes as stress relief by providing support from a smoking cessation advisor in a warm and friendly environment with refreshments and a crèche where they could take a break away from their children. Attendees of the smoking cessation clinic were actively encouraged to participate in the Children's Centre's other groups, including a Confidence Club, massage, 'stay and play' and a 'women's group' aimed at building skills and confidence.

Implementation

As the intervention involved setting up new smoking cessation services in existing client-facing services in Brinnington at the Lapwing and Children's Centre, additional training was provided. Fitness instructors and Children's Centre staff were trained as smoking cessation advisors and some could deliver appropriate vouchers for nicotine replacement therapy (NRT) which could be exchanged at the local pharmacy. Fitness instructors offered advice on an ad hoc basis and when they were approached by customers as a result of seeing promotional material. They also offered advice at gym induction, where signposting and probing questions have been incorporated into the standard induction questionnaire. The

Children's Centre offered a stop smoking clinic for drop-in/one-to-one appointments, as well as a free crèche for mothers with pre-school age children. A communications strategy was developed to underpin the promotion of new and existing services, using photographs of local residents taken in the area.

Evaluation

The project's primary aim was to double the number of smokers accessing local smoking cessation services in Brinnington. This was measured through returned data from each of the services that smokers from Brinnington could access. In the pre-intervention year (2008/09), 145 quit attempts were made. Figures for 2009/10 showed the decline reversing with 162 quit attempts supported in that year and a further rise is anticipated in 2010/11. Qualitative and quantitative evaluation will take place in September 2010 which is 12 months after all the elements of the intervention went live.

Follow up

The intervention in Brinnington has been a triumph of community partnership, with numerous community organisations having a genuine stake in the intervention. This approach also brought challenges, in that when management changed at the Children's Centre, the new *Lose the Fags* intervention was changed, causing problems with delivery. The *Lose the Fags* team reacted by having more team meetings and increasing communication between partners. It was also difficult for the fitness instructors and Children's Centre staff to adopt smoking cessation into their existing roles and considerable support was required to provide them with the skills and confidence to deliver the *Lose the Fags* intervention on the ground. However, the project is sustainable because existing, established community organisations have adopted smoking cessation as part of their core offering and the *Lose the Fags* project has provided a strong brand to support their efforts. Gradually, quitting smoking is becoming a social norm in Brinnington.

NHS Tameside and Glossop and Tameside Metropolitan Borough Council

Gideon Smith, Debbie Bishop and Denise Ong

This project aimed to increase early cancer diagnosis and reduce late presentation with symptoms and death rates of breast cancer by encouraging more women aged 35 to 50 to be breast aware.



This group was targeted to increase the possibility of early detection in women not yet eligible for free breast screening and to increase uptake of screening once they reach 50. The Ashton Hurst ward was selected as the pilot area since it is one of the most deprived communities in Tameside and both breast screening uptake and breast cancer survival rates are particularly low.

Breast cancer is the most common cause of death from cancer among women in Tameside and Glossop. Although the incidence is no higher than the national average, survival rates are lower, in part due to late presentation. In late 2007, NHS Tameside and Glossop and Tameside Metropolitan Borough Council (MBC) partnered with The NSMC on a £55,000 joint-funded project to increase breast awareness in women.

Scoping

First, desk-based research was carried out which found that the evidence around breast awareness, particularly among women aged under 50, was scant and no baseline existed (locally or nationally) around breast awareness. A street survey was therefore carried out by the LSHTM in Ashton Hurst (intervention area) and South Denton (comparison area), which was matched for age structure, deprivation and rural/urban mix. To further explore women's barriers and motivators for being breast aware, focus groups and interviews were carried out with women in both wards.

The findings from the street survey and qualitative research were largely consistent: women were aware of the dangers of breast cancer but few regularly examined their breasts or felt confident they were doing it correctly and knew what changes to look for, other than lumps. Barriers to breast awareness included a fear of finding breast cancer and a fatalistic view that early detection would not make much of a difference to the outcome. Most women had not been offered advice on breast awareness by their GP or nurse. While many women considered the nurse the most appropriate person to give breast awareness

advice, they were also amenable to receiving health messages in the community from non-health professionals. Stakeholder interviews revealed that while GPs and nurses understood what it means to be breast aware, they were not spontaneously aware of the NHS's breast awareness five-point code: know what feels normal for you; look and feel; know what changes to look for; report any changes without delay; and attend full breast screening if aged 50 or over.

Given limited timescales for implementation, the behavioural goal of the project was to increase the number of women who are aware of their breasts and who examine them regularly. There was a clear need to promote the breast awareness five-point code consistently to the target audience and service providers to give women a full understanding of how to check, what to look for and why to act fast. The team therefore developed an approach that mixed communication, community-based and service-led initiatives.

Development

The creation of the communications campaign was to provide women with a compelling case for regularly checking their breasts





"We're expecting to create a simple effective approach that takes root and lasts."

and the information they needed to identify changes. Four creative concepts and ideas for community-based initiatives were tested using focus groups with target women. The creative concept that clearly struck a chord with the audience was 'Breast Expert'. Using images of strong, confident women, the campaign emphasised the flexibility and ease of becoming breast aware, which gives a sense of empowerment and control.

To support the campaign, the Health Improvement Team organised a 'well woman' event, where breast awareness and other health and wellbeing advice was offered, along with free gifts and fun activities. Efforts were also made to identify and recruit breast aware 'community champions' from the local population, who could help spread the message through peer networks.

Implementation

The three-month pilot campaign was launched in Ashton Hurst on 1 February 2010 with poster advertising at bus stops and on telephone kiosks. The posters encouraged women to visit www.breastaware.net for more details on why and how to be breast aware. An information leaflet was distributed in health and community settings (such as GP surgeries, shops and fast-food outlets) and mailed with an accompanying letter from the PCT to all women in the target group informing them about the campaign and local events. On 18 March 2010, the free 'well woman' event was co-delivered with other health and community stakeholders at Hurst Community Centre. Feature articles were placed in the local media to build awareness of the campaign throughout the area. GPs and practice nurses were briefed about the campaign and nurses were given information about breast awareness. Community workers also received face-to-face training from a Macmillan breast cancer nurse. Due to scheduling conflicts, training for practice nurses was postponed to autumn 2010.

Evaluation

Independent evaluation was conducted by the LSHTM and consisted of three components. To assess any changes in knowledge and behaviour, a case-control study comprising

of face-to-face street surveys was conducted with women aged 35 to 50 in Ashton Hurst and South Denton. Around 100 women were surveyed in both wards before (April to June 2009) and after (June to July 2010) the campaign. Following the campaign, eight face-to-face interviews were conducted with stakeholders who were involved in the scoping, development and implementation of the campaign. Eleven telephone interviews were conducted with women who attended the community event in Ashton Hurst to gather qualitative feedback on the interventions.

When asked what the term 'breast aware' meant to them, the majority of post survey respondents had some knowledge and understanding of it. 42.5 per cent of respondents said it was about checking or regularly checking your breasts for changes and around 15 per cent acknowledged it was about being aware of your breasts more generally (rather than looking specifically for symptoms). However, no respondents referred to the other behaviours in the five-point code (namely seeking medical advice or attending for breast screening). This highlights the need for further work to promote all elements of the five-point code.

Disappointingly, following the campaign the proportion of respondents who reported examining their breasts at least once a month (as recommended by the NHS) fell in the intervention area. However, most of the women interviewed (9 out of the 11) said they checked their breasts at least once a month. Most women who reported checking their breasts are looking for lumps when they examine and are not so vigilant about other symptoms, like changes in breast appearance or feeling. However, compared to pre survey results, a greater proportion of respondents to the post survey mentioned looking for 'lumps and other abnormalities', rather than looking for just lumps.

A key objective of the campaign was to boost women's confidence in their ability to self-examine and to emphasise that there is no one right way to check. Compared to responses gathered before the campaign, the intervention area saw a drop in the proportion of women

who were 'not at all confident' of noticing a change and compared to the comparison area, a greater proportion of respondents reported being 'very confident' of noticing a change.

According to the post survey, 40 per cent of respondents in Ashton Hurst had seen, heard or received something about breast awareness during the campaign period. Of these, 25 per cent said the information prompted them to examine their breasts more regularly and 41.7 per cent said the information made them clearer about what is normal for them and what changes to look for. As an added benefit, feedback from the community development team indicated that the campaign had prompted other positive health behaviours. For example, uptake of exercise activities, like health walks and keep fit classes, picked up in the weeks following the campaign and community event.

Follow up

Some of the interventions are still ongoing with the longer-term aim of building breast awareness into service delivery to ensure its systematic inclusion in all relevant primary care appointments. One prospective option is inclusion in GP contracts to ensure that breast awareness is routinely raised and discussed during cervical screening and family planning appointments. Despite efforts to engage GPs and nurses in the campaign, clinician involvement during the project was disappointing due to various reasons. Sufficient lead-in time needs to be built in and senior level buy-in secured from the start to gain active involvement from GP staff.

Feedback from stakeholders and target women highlighted the importance of family and social networks as key avenues for encouraging women to become breast aware. In addition to print and online media, providing information and the option to discuss any issues or concerns in person would greatly increase women's confidence to self-examine and spot any changes. Greater use of word-of-mouth and face-to-face communication would help to motivate and support women to become breast aware, without requiring the expenditure of paid-for advertising.

NHS Brighton and Hove

Martina Pickin and Catherine Perry-Williams

This project aimed to increase exclusive breastfeeding at six to eight weeks among women who initiate breastfeeding and to increase the length of time that mothers breastfeed (exclusively and partially) to six months plus.



Breastfeeding contributes to the health of both mothers and babies and the Department of Health (DH) recommends that babies should be breastfed exclusively for their first six months. While rates of breastfeeding initiation and continuation six weeks after birth in Brighton and Hove are higher than the national average, the proportion of babies who are entirely formula-fed is much higher in the Neighbourhood Renewal Areas (NRAs) than in non-NRAs. However, local data also showed that women from NRAs who initiated breastfeeding were no more likely to give up breastfeeding in the first six weeks than women from non-NRAs, suggesting that breastfeeding duration rates in the more deprived areas could be improved, thereby reducing health inequalities. The 2005 national infant feeding survey found that 90 per cent of mothers who stopped breastfeeding before six weeks would have liked to breastfeed for longer. Sustaining breastfeeding therefore aligns with health policy as well as the wishes of mothers.

In early 2007, NHS Brighton and Hove partnered with The NSMC on a pilot project to improve breastfeeding duration rates.

Scoping

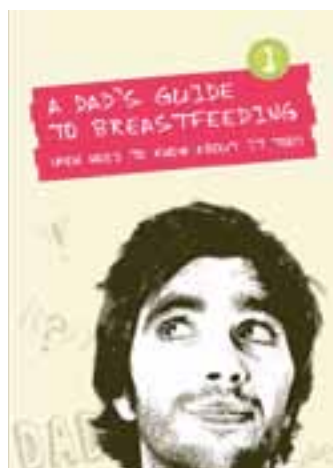
The project team began by reviewing information and evidence from local, regional and national sources. Since breastfeeding initiation rates are relatively high in Brighton and Hove but start to decline around six weeks, the team decided to focus on maintaining exclusive breastfeeding at six to eight weeks among women who start to breastfeed.

As little qualitative research existed on sustaining breastfeeding, individual interviews were conducted with mothers in west Brighton (where there are pockets of deprivation) who were still breastfeeding at six weeks. A key insight was that they were unprepared for the realities of breastfeeding and wanted continuity of support and consistent guidance from health professionals. Indeed, focus groups and interviews conducted with health professionals revealed frequent staff shortages and

fragmented services which prevented health visitors from spending much time with mothers and resulted in women receiving inconsistent advice from different providers.

The research also revealed that women perceived breastfeeding to be painful, tiring, demanding and a responsibility that could not really be shared. Mothers who had lots of support from their partners, family or friends were much more likely to continue breastfeeding. Individual interviews were therefore conducted with eight fathers to explore their knowledge and experiences of breastfeeding and what role they played in feeding. Fathers revealed that they felt largely sidelined in much other written information and in antenatal sessions run by professionals. They wanted specific literature about the practical issues and possible difficulties of breastfeeding and how they could help overcome them.





“We have all learnt a lot from working together and now have a better idea of how we would approach social marketing work in the future.”

To meet the project's goal a range of tactics that addressed various barriers and target audiences was needed. With extensive input from key stakeholders, the project team developed the first PCT-wide strategy for breastfeeding which focused on redesigning the current service and retraining key health professionals to support women to breastfeed.

Development

From the scoping research instead of smaller interventions being developed a strategic approach was taken and the research was used to inform the development of a PCT-wide breastfeeding strategy which will be monitored by the recently established Brighton and Hove Child Health Strategy group. The team faced difficulties in securing additional funding so were not able to action all recommendations in the strategy before the end of the Learning Demonstration Sites scheme, but were able to deliver an information pack for fathers.

Based on the important role of partners in supporting women to breastfeed and the lack of targeted information on breastfeeding for fathers, the team developed an information pack designed specifically for this group. Comprising of ten brightly-coloured information cards and four coasters contained in an A5 cardboard box, the pack outlined the benefits of breastfeeding for both mother and baby, the importance of the father's role in supporting their partner to breastfeed and useful tips and FAQs to help make breastfeeding easier. To guide the content, tone and design of the pack, two further focus groups were conducted with fathers in Brighton and Hove. Views were also sought from individual fathers on three different design options before finalising the design of the packs.

Implementation

Fathers involved in the focus groups mentioned that they would like to receive the breastfeeding information packs directly from a health professional at the 20-week ultrasound scan or immediately after the baby's birth. This would be accompanied by a short discussion with the couple about breastfeeding facts and tips. However, given that the PCT

had insufficient time to engage local health professionals about distributing the packs, this intervention was implemented by the LSHTM. In March 2010, an LSHTM researcher distributed the packs to 35 parents-to-be or new parents (fathers and mothers) as they attended a 20-week scan in the ultrasound department, or after delivery in the postnatal ward of the Royal Sussex County Hospital in Brighton. These individuals also agreed to be interviewed about their thoughts on the pack.

Evaluation

Given the small-scale and short-term evaluation of the father's pack, it was not feasible to measure the impact of this intervention on duration of breastfeeding. The evaluation, carried out in spring 2010, therefore aimed to assess the knowledge and confidence of fathers involved; describe parents' views on the pack; and gather their perceptions of its impact on breastfeeding. Of the 35 men and women who received the pack and initially agreed to take part in the evaluation study, 18 participated in a 20 to 40 minute follow-up telephone interview.

The guide was welcomed by participants, as most existing information and advice focused primarily on the pregnancy and birthing process, not what happens afterwards. Moreover, all participants thought it was very worthwhile to have information specifically for men. The pack was seen as being more successful in encouraging initiation of breastfeeding than in extending the length of time mothers breastfeed. It was also seen to be most useful for first time fathers and if provided early in the pregnancy. Even participants who had already researched and received advice about breastfeeding were reassured by the pack's contents. The most notable gains for men were ideas on how they could support and provide practical help to their breastfeeding partners and many liked the concept that feeding the mother was in turn feeding their baby. It also helped raise awareness of the importance of the father's role.

The design of the pack attracted the greatest controversy. While some liked it, others very firmly did not. For example, some of the

participants liked the box and particularly appreciated that it was both 'different' and eye-catching, while others criticised what they saw as wasteful and excessive packaging. Opinion was also deeply divided about the pictures used. Several respondents welcomed illustrations of young, trendy looking men and appreciated a divergence from what was described as the normal 'mumsy' images used in pregnancy and baby guides. Others criticised the images for being too 'laddish' and 'blokey'.

There was a common feeling that the pack should clearly list the pros and cons of both bottle and breastfeeding. Other suggestions for improvement included: providing illustrations of men from different ethnic groups and ages pictured with their partners and babies in a caring role; more 'facts' and 'real life' case stories of how to address common problems; greater emphasis on the emotional and psychological needs of the breastfeeding mother; and a list of places where mothers could breastfeed comfortably outside the home.

Follow up

The project is ideally placed to build on the feedback from fathers. The additional information requested for the pack was developed during the course of the project and could be made available. Other feedback, about the pack's design and illustrations, could be used to inform further segmentation of fathers and guide the development of future interventions.

Overall, the project has produced a strong framework to build on. Compelling evidence and insights uncovered during the course of this project will be used to inform the development of future interventions that increase the prevalence of breastfeeding. In retrospect, the pace and delivery of the project would have been helped by a dedicated project manager, earlier engagement of stakeholders and partners and, crucially, robust budget planning and allocation. However, the project has made a significant contribution to breastfeeding strategy and interventions in the future.

NHS Lewisham

Lyn Burton and Gayle Wallace

This project aimed to increase the number of routine and manual smokers accessing and quitting with NHS Stop Smoking Services (SSS) in Evelyn ward, chosen for its high deprivation levels and smoking rates (42 per cent).



Smoking is the leading cause of preventable death and health inequalities. Public Service Agreements (PSAs) since 2004 have set targets to increase and support stop smoking attempts among all adults, particularly in routine and manual groups, with a reduction from 32 per cent to 26 per cent or less among this group in England by 2010. Smoking and its associated health problems is a particularly challenging issue in the ethnically-diverse borough of Lewisham. Lewisham's estimated prevalence of 26.8 per cent is higher than the national and London average and there is widespread deprivation. In 2006, 166 Evelyn residents used a stop smoking service to try and quit and 75 (45 per cent) of them succeeded.

Scoping

The behavioural goals of the project were for twice as many Evelyn residents to use SSS to successfully quit smoking. To explore why people in Evelyn smoke and the barriers and motivators to quitting or using SSS, focus groups with 32 smokers and interviews with six stop smoking service providers in the area were held between December 2007 and June 2009. A solutions group was formed with stakeholders such as Pepys Community Forum, Lewisham Refugee Network, Sure Start, health improvement team and a marketing agency working with Millwall Football Club.

Key insights into why this target audience smokes are that smoking is a core part of social interactions, a form of stress relief and a source of refuge. Giving up smoking may have an isolating impact on relationships and increase perceived levels of stress and anxiety in a deprived ward like Evelyn, where issues of debt, housing and money management contribute towards high stress levels. The intervention needed to focus on how to tackle these issues. Some smokers resented being 'lectured' all the time, expecting health professionals to be disapproving non-smokers who didn't understand how hard it is to stop. Those who had used a service mentioned the wait for a first appointment and sessions being

too short, with no support 'to fall back on' in the longer term. An ideal service would be like a supermarket: open all day, every day. There was no perception of the current service as a unified whole with different options from which to choose, either by potential customers or advisors. People wanted a choice of intensity, model and location.

Mapping the ward's existing provision showed obvious gaps. There were two GP practices in the ward: one did not offer an advisory service and one had limited nursing time for this. Of the three pharmacies, one had no advisor in the shop on Wednesday (market day) and two did not open on Saturdays.

Development

Smokers' reference groups were held at a primary school and a local pub between September 2008 and June 2009 to test ideas and pre-test publicity materials.

People in routine and manual jobs, such as catering, often work long hours and have trouble accessing the SSS. This was particularly relevant on isolated housing estates where facilities and transport links are limited. Two recruitment and outreach workers visited local businesses and provided stop smoking sessions in the workplace. Stress was cited as one of the





"Someone from the focus group suggested, "You could have support set up in a supermarket, 365 days a year, so that when you're ready to quit and want help, there's someone to go to". Our challenge is to turn this idea into an initiative that is feasible for us."

main reasons why people smoke, are reluctant to give up and take up smoking again after quitting. The community advisors running the drop in and weekly clinics in GP practices advised people about using local welfare rights, social housing and voluntary sector organisations to alleviate some of the problems causing them stress. Two stress management workshops were offered to people attempting to stop smoking.

Research shows that another reason people (particularly females) continue to smoke is to control their weight. Outreach advisors encouraged everyone to take up some physical activity to help with stress management and weight management. The local GP exercise referral scheme changed its criteria to include people trying to stop smoking and GPs were happy to support referrals initiated by advisors.

Implementation

A number of interventions were made to respond to the research findings. To fill service gaps, weekly sessions were offered in both GP practices. One pharmacy increased its pharmacist advisor time. Another started to provide Champix stop smoking medication from February 2010. An evening session was tried in the Leisure Centre, but did not attract enough people to continue. The drop-in moved to the Waldron health centre and proved so popular that it extended its hours. A new pharmacy service opened in the same health centre, providing Champix from February 2010.

From April, outreach workers started a programme of visits to organisations, workplaces and key community staff in the ward. In May, they went to local schools to talk to parents at coffee mornings, school fairs and parents' evenings. In December 2009, outreach advisors visited the East London line workforce with a pharmacist who provided NRT directly to those setting a quit date. Millwall and Lewisham's service were featured in a national

campaign and a second smokefree match in February 2010 raised the profile of the service and its link to healthy heart checks. A new Lewisham Stop Smoking website launched in January 2010 advertised Evelyn's services. In March 2010, two stress management workshops were run at the Waldron Health Centre in New Cross but were poorly attended. The plan is now to integrate this into the stop smoking programme, rather than offering a separate session.

Evaluation

The LSHTM evaluated the intervention using three methods. The first was a cross-sectional street survey with a pre- and post-intervention sample of people living and working in the Evelyn ward area. The second was an analysis of routinely-collected service data from Evelyn and New Cross wards for the periods January to December 2008 and January to December 2009. Finally, eight qualitative in-depth interviews with key stakeholders were carried out.

In the pre- and post- street survey, more 'pre' respondents had seen information about stop smoking services and were aware of help available. Most respondents in both groups said they received no help to quit. However, far more in the 'post' group said they had received help in the area where they lived, medicine from a GP or chemist or help from a stop smoking advisor, GP or chemist.

The service data indicated a notable increase (21.3 per cent) in the number of Evelyn residents using a service from 2008 to 2009. This was greater than the 12 per cent increase across Lewisham as a whole, suggestive of the project's impact. The proportion using pharmacy services and sessions run by the outreach advisors increased between 2008 and 2009, while the proportion using a GP-based service decreased. These services doubled the number of people quitting during this period.

Those interviewed considered that some of the lasting benefits of the project were improved knowledge of the target group and improved service provision. Most felt the principle of exchange was not adequately addressed. Extended services did not address barriers to behaviour change (for example, stress and weight management) and a system of incentives was not developed. Some stakeholders thought that the factors that kept the target group smoking (such as their socio-economic situation, social values and cultural norms) were too entrenched and beyond the project's scope.

Follow up

The initial scoping report was too wide – far-ranging, detailed and without a summary. Long delays at the start of the project lost both momentum and potential members of the solutions group. The baseline research was undertaken after activity in the ward had already begun, which skewed the findings of awareness about the service pre- and post-intervention.

Despite these challenges, the application of learning from the demonstration site to other areas is encouraging. Recent data shows that there are more smoking quits in the most deprived areas in Lewisham and that this trend has doubled in 2009 to 2010. Advisors in Bellingham in 2009, another deprived ward with high smoking prevalence, took advice from the project manager for Evelyn on who to consult and how to develop their work in Bellingham. They canvassed local people's views, met with community leaders and visited workplaces, organisations, businesses and shops in the area, before setting up an evening stop smoking drop-in at the leisure centre. This is promoted through their ongoing work in the ward and word-of-mouth from satisfied customers. Advisors have been invited into a bus garage, school and youth project, which increases interest and take-up in the area.

NHS Norfolk and NHS Great Yarmouth and Waveney

Suki Dell and Denise Ong

This project was initiated with the aim of increasing screening activity at screening sites that are part of the Norfolk and Waveney Chlamydia Screening Programme (NWCSP).



The NWCSP is delivered through over 200 sites which include health, education, voluntary and community settings. However many of them return few or no screens at all each year. Therefore, the project targeted existing screening sites, particularly GP staff, to maximise opportunistic screening and support them to deliver increasing and sustainable volumes of chlamydia screening in the longer term.

In 2007 to 2008, just 3.8 per cent of young people were screened for chlamydia in Norfolk and Waveney, far below that year's target of 15 per cent. With targets rising to 17 per cent (2008 to 2009) and 25 per cent (2009 to 2010), NHS Norfolk and NHS Great Yarmouth and Waveney, who jointly fund the NWCSP, partnered with The NSMC on a pilot project to help increase the uptake of chlamydia screening among 15 to 24 year olds with a budget of £60,000.

Scoping

The team began by reviewing existing data and literature and carrying out informal stakeholder consultations with the Department of Health (DH), NWCSP members, other Chlamydia Screening Office (CSO) leads and screening providers in Norfolk and Waveney. Analysis of NWCSP resources and screening figures revealed that while over 200 venues across Norfolk and Waveney had signed up to offer free chlamydia screening to young people on behalf of the NWCSP, most of these sites were returning few or no screens. Given limited resources, the team decided to focus on one target audience. Although this was initially anticipated to be young people, the news that DH was planning a national advertising campaign promoting chlamydia screening to young people prompted the team to focus their local resources on screening providers to avoid duplication.

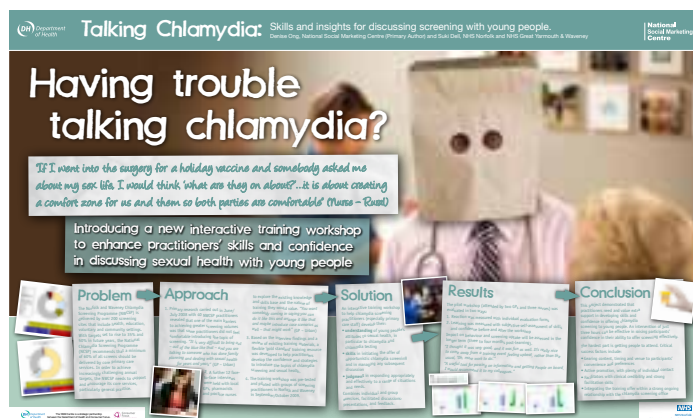
To better understand this target audience, in-depth interviews were held with 40 NWCSP screening providers. Key insights were: a low awareness of annual targets and NWCSP performance leading to low prioritisation and lack of urgency to offer chlamydia screening; a perceived lack of interest and support from the

CSO; and a perceived lack of opportunity, skills or confidence to offer chlamydia screening to young people, particularly where the provider's main service was not sexual health. They also revealed anxieties about raising the issue of screening in unrelated situations and limited understanding of the NWCSP, as well as barriers such as competing priorities, limited time and lack of staff.

To help providers overcome these barriers, the intervention needed to be easy, not too time consuming and improve skills and confidence around screening. In exchange, the intervention offered free screening kits and other collateral; involvement in an important national initiative; and professional development and networking opportunities.

Following the research, the target audience was further segmented into four groups: 'engaged and motivated'; 'interested but restricted'; 'low interest'; and 'low priority'. The interventions were to be targeted at the 'interested but restricted' or 'low interest' groups, as with the right encouragement and support they had the greatest potential to increase screening. They were also segmented according to provider type and the team chose to target core providers (namely GPs and pharmacies). This





“Applying social marketing methodology has required self-discipline that will positively influence how we approach our work in the future. We have gained much from this experience.”

was because they offered the most screening opportunities and there was a national drive to improve health services. Therefore, the behavioural goal of this project was for existing screening providers (particularly in core services) to actively offer chlamydia screening to 15 to 24 year olds.

Development

A stakeholder event was held in November 2008 to engage PCT stakeholders and screening providers and to test and brainstorm intervention ideas. Following the event, five screening providers volunteered to form a solutions group to help develop, pre-test and promote the interventions.

A number of interventions were developed based on insight. First, improved, standardised induction sessions for new sites were introduced, so that they all received at least the minimum information required to successfully carry out screening, ensuring quality control and consistent messaging. Second, bespoke training to build providers' confidence and skills in introducing screening to young people was developed. This was because one of the main barriers identified was that some providers, particularly those whose main remit was not sexual health, were apprehensive about raising the issue of chlamydia screening. Low awareness of annual targets and NWCSF performance to date meant that providers neither felt urgency to offer screening nor that they were part of a larger initiative. Quarterly newsletters and ongoing, systematic contact from the CSO were therefore planned. They aimed to keep the profile of the NWCSF high and motivate sites to screen more proactively by providing ongoing updates on screening levels.

Some providers perceived a lack of interest and support from the CSO once they signed up to the programme, which sometimes led to cynicism and the assumption that there was no real need for screening. Offering sites ongoing proactive support from the CSO would help maintain initial enthusiasm for the programme and the sense that screening is an ongoing priority. For providers whose main remit was not sexual health, chlamydia screening often fell to the back of their minds. Screening was

also often only offered when a young person presented for a sexual health related reason. By designing and piloting pop-up reminders, offering fresh promotional materials and with the enhanced 'Talking Chlamydia' training, the interventions aimed to keep chlamydia screening fresh in the minds of the providers and help them develop the confidence and strategies to introduce screening in unrelated situations. All the interventions, aside from the training, were developed by internal PCT staff. The training workshop was developed by the Central Office of Information (COI).

Implementation

The interventions were launched at slightly different times depending on how quick and easy they were to develop and implement. In June 2009, all new screening sites began receiving the improved induction session from CSO staff. Pop-up reminders were also piloted in three GP clinics between June and August 2009. In July 2009, the first newsletter was distributed to all screening sites and then at quarterly intervals. The Talking Chlamydia workshop was piloted by COI in October 2009 with six GPs and nurses. Based on positive feedback from the pilot, the CSO has continued to offer this workshop locally to providers interested in, or who may benefit most from, this additional training. A range of locally branded materials, including posters, flyers, shelf wobblers and dump bins, were produced and offered to all screening sites, but particularly to pharmacies, from December 2009. Although the CSO produced a new contact plan and enhanced their database with prompts to remind staff to contact each site personally at set intervals, the team has postponed carrying out systematic, targeted follow-ups with all sites until 2010 to 2011 due to staff shortages.

Evaluation

With support from the LSHTM, a three-part evaluation plan was designed. First, annotated time-series data was looked at which used routinely collected screening data to assess progress made by the interventions in increasing the volume of chlamydia screens. The findings were very promising. The improved induction training for new sites

coincided with a threefold increase in chlamydia screening volumes. The dissemination of promotional materials to pharmacies from December 2009 was followed by a 300 per cent increase in chlamydia screens taking place in pharmacies during the period autumn 2009 to February 2010. The data also indicated that general practices (the main provider type targeted) achieved the biggest increase in the number of completed chlamydia screens between April 2009 and March 2010.

Second, post-intervention surveys were taken to explore the extent to which the improved induction sessions and Talking Chlamydia workshops were seen as appropriate and useful by attendees. Again, there were very positive findings: the sessions and workshops were rated very highly by participants for their relevance, delivery and for meeting their objectives. Furthermore, according to a self-assessment of understanding, skills and ability by participants before and after the Talking Chlamydia pilot workshop, all respondents reported improvements on all three measures. Finally, retrospective in-depth interviews were conducted by telephone with screening providers to examine their experiences and views of the interventions.

Follow up

The evaluation data is still being processed by the LSHTM, but there is optimism that the interventions around improving communication to screening sites are valued by providers and effective in prompting them to screen. Findings from the in-depth interviews with providers are pending, together with an assessment of all the long-term benefits of the individual and combined interventions and learning from implementing a social marketing approach. It is hoped that the most effective components can be usefully integrated into the whole NWCSF and provide a resource for other screening programmes elsewhere in the country. For example, the Talking Chlamydia training is currently downloadable from the National Chlamydia Screening Programme website for providers to access free of charge. The quarterly newsletter to all screening sites is currently on its fourth issue and all promotional materials are ordered by providers in all settings on a regular basis.

Gateshead, Sunderland and South Tyneside Council

Bill Kirkup and Emma Heesom

This project aimed to halt the decline in uptake of healthy school meals and to increase their uptake at Key Stage 2 (aged seven to eleven).



The key target audience was initially primary school children but following research and segmentation, headteachers were identified as the primary target audience, with children and parents as the secondary audience.

Following rapid and widespread changes to school meals across England, driven by Jamie Oliver's television campaign, uptake significantly declined. More and more students now opt for packed lunches, but there is a growing concern about their very varied, often low nutritional quality in comparison to school meals. School meals in primary schools make a vital contribution to the dietary intake of school children. The decline in uptake also undermines the financial viability of the school meals service, thereby threatening its ability to continue offering healthy options. In 2007, a collaborative of caterers from the North East, together with Healthy Schools and the local government office, approached The NSMC for guidance in adopting an innovative approach to this issue and were allocated £50,000.

Scoping

The behavioural goal was to increase the number of children in Key Stage 2 eating school meals one to three days a week. The team began in early 2007 by reviewing secondary data, including government policies and previous studies on school meals and healthy eating among children, as well as local, national and international interventions. Semi-structured interviews were held with professionals involved in promoting school meal uptake and healthy eating across schools in the North East, aiming to identify the main factors affecting uptake. A follow-up phase of interviews was carried out in January 2008 with headteachers to understand their attitudes and perceptions of school meals. Primary research was also carried out in spring 2008 with parents and children from the schools in the area. It aimed to investigate how parents and children perceived school meals, reasons for preferring packed lunches or disliking school meals and children's power in the decision-making process.

Key insights from the headteachers indicated there was communication clutter and

confusion around school meals. They had been bombarded with information, legislation and advice since it became a government priority, yet there was confusion around who manages the catering services (headteachers or the local education authority) and what could or could not be included in the meals. They also cited a lack of dining hall management; little understanding of nutritional standards; poor customer service skills; poor quality and presentation of food; and a lack of cooking skills and knowledge of different foods on the part of the parents and children as key barriers. For parents, barriers included a loss of control over being able to provide something they knew their child would like and eat plus financial costs of school meals (particularly for families with more than one child). For children, barriers were that popular but unhealthy options (such as chicken nuggets and chips) were no longer offered at school and they were often confronted with food that was unfamiliar, unpopular and different from what they ate at home.





"The North East is passionate about the wellbeing of our young people and we are always willing to try new things. The social marketing pilot has helped us to come up with some excellent interventions and I am looking forward to seeing them in place."

Evidence showed that if a headteacher is engaged in the school meal agenda, uptake improves, so headteachers were chosen as the primary audience. Through the qualitative research, headteachers were segmented into four groups: 'too busy', 'disengaged and confused', 'trying within their field' and 'passionate and active'. The intervention was targeted at the second and third segments, as it was believed they would be both responsive to and would benefit most from the intervention. The main competition was a lack of time and competing priorities. Therefore, the intervention needed to offer an attractive exchange in terms of improving student behaviour and decreasing time required for disciplining; increasing concentration and academic performance; and contributing to better qualified and more satisfied staff by designing a more pleasant dining environment.

Development

After scoping, a solutions group was set up to help develop the interventions. It was comprised of catering managers, school cooks and dining room attendees, headteachers and health promotion specialists from the local health authority, as well as school clerks and dinner nannies (lunchtime supervisors). Findings from the secondary and primary research were presented to the group, who then helped develop a multi-pronged strategy that focused on engaging headteachers, encouraging children to eat school meals and training dinner nannies to provide a more supportive and pleasant dining experience.

The intervention needed to appeal to both the headteachers (so that they would implement it in their schools) and the children (in order to improve uptake of school meals). For headteachers, the product was improved student behaviour and organisation in the dining hall and the associated long-term health benefits of eating at least one nutritious meal a day; as well as improved communication with caterers and a lower kitchen staff turnover. A myth-busting card and case study compendium, which highlighted

local successful initiatives and overcame misconceptions about the new school meal standards, was also designed. For the children a more relaxed, less crowded and noisy dining room experience was created, using queue management, lunchtime rotation and improved one-to-one management by dinner nannies. Children were considered customers, rather than passive recipients of a service, who made choices based on their own experiences and judgment. The team developed new menus to suit individual school meal tastes; used china plates and bowls as the plastic 'airline' trays were very unpopular; and introduced lunch break changes to ensure each class group is served first at least once a week. Kitchen and dining staff were essential in delivering the new dining room experience, so training in customer service skills, presentation of food, first aid, nutrition standards and positive behavioural management and motivational techniques were part of the mix.

Implementation

During the 2009 autumn term, three schools piloted the dinner nanny training scheme. Implementation was staggered in order to meet the needs of the pilot schools. Training for dinner nannies was completed weekly and took half a term in each school. The printed communication tools were piloted in another school during the 2009 spring term, although all schools across the boroughs could access the online communication tools. A networking and learning event was held at the start of the implementation phase. Finally, dining room changes were made. China plates and bowls were piloted in one school and changes to the lunchtime rota and menus were implemented in the three schools which received the dinner nanny training. Unfortunately, much of the original planned intervention needed to be scaled back due to funding.

Evaluation

The project was evaluated using various methods. First, by telephone interviews pre- and post-intervention with headteachers in the intervention schools and control schools.

They were contacted in autumn 2009 and were followed up in February 2010 to complete a questionnaire on the school meals agenda. Second, the team looked at school meal uptake data in the pilot schools, collected from the local authority caterers in January 2009 and again after the intervention in January 2010. These were compared against control data, which is the average school meal uptake figure for the local authority. Finally, interviews and qualitative research was carried out with the dinner nannies who received the extra training.

Key findings were that headteachers reported better relationships with catering managers and the majority reported they now felt able to make changes to their menus. Most notably, school meal uptake in the three pilot schools rose by between 3.5 per cent and nine per cent, depending on which intervention mix the schools received. The dinner nanny training intervention has been accredited locally and used as evidence for a national training programme for lunchtime supervisors. As a direct result of the training, one pilot school has made changes to the dining room experience and another has introduced plates and bowls to replace the 'airline' trays.

Follow up

The interventions occurred during the hype around school meals and the national 2010 school meal figures show an increase, but not as high as some of the pilot schools. Several of the caterers have gone on to identify funds for schools to change their dining space, as has the national organisation, the School Food Trust. This pilot underlined the importance of a positive, customer-orientated dining experience – even at a relatively young age, children require a pleasant experience. The lessons could be transferred to many school-based behaviour change interventions. For example, selecting the right target audience (in this case headteachers rather than children) and further segmenting by attitudes and behaviour allowed the team to focus their efforts on those who are most likely to change and make an impact on the desired outcomes.

NHS Stoke-on-Trent

Deborah Richardson and Viv Caisey

NHS Stoke-on-Trent set out to reduce smoking in pregnancy rates in two high-prevalence neighbourhoods, Meir and Bentilee. The target audience was not just pregnant women but also women who were thinking about starting a family, women who were between pregnancies and women who had children under the age of five.

me²

Stop Smoking Club



Smoking in pregnancy is both a cause and effect of health inequalities and significantly contributes to worsening health outcomes of both mothers and children. Stoke-on-Trent is a designated 'Spearhead' area. This status recognises the extent of existing deprivation in the city, the entrenched nature of health inequalities and the impact this has on the health status of the local population. Smoking during pregnancy rates in Stoke-on-Trent are higher than the national average. While the existing smoking in pregnancy service, 'Quit for a New Life', was making good progress, work done on the Infant Mortality Floor Target Action Plan identified that it was not achieving the results needed to make a significant impact. It became clear that a better understanding of why women were not engaging with the existing service was needed.

In early 2007, The NSMC partnered with NHS Stoke-on-Trent to embark on a £30,000 pilot social marketing project to tackle smoking in pregnancy.

Scoping

The behavioural goal was to increase the number of successful quit attempts among pregnant smokers. To achieve this, the project aimed to encourage more women to engage with smoking cessation services (group or one-to-one) by providing a service women wanted to attend.

Two focus groups with target women were conducted in July 2007, one in Meir and one in Bentilee. The groups identified key barriers for giving up smoking while pregnant; explored women's experiences, attitudes and emotions to smoking during pregnancy; and gave an idea of their ideal local support service. Professional staff and other key partners were interviewed for their views on current interventions and services. Desk research was also conducted to identify local, national and regional campaigns that addressed smoking in pregnancy, which provided useful learning around what had and had not proved successful in the past.

Overwhelmingly, the key insight from the focus groups was that women chose to smoke for some 'me time' as it provided them with a chance to unwind and relax. Women stated that they didn't want to be 'nagged' into quitting smoking and they wanted health professionals to stop focusing on the negatives of smoking which they already knew and did little to motivate them to quit.

Other barriers to quitting smoking included the perceived time and effort involved, peer pressure from family and friends to smoke and the pleasure and enjoyment of smoking. To overcome these barriers, the intervention needed to provide compelling and appealing benefits. Importantly, these benefits should not focus on the health of the mothers' babies, but rather on her own personal sense of wellbeing, such as increased self-esteem, alternative 'me time', feeling and looking good and saving money.





"The experience of using a social marketing approach to a sensitive and important area of work has been enlightening and empowering. The project hasn't just been about a campaign and some leaflets, it has provided us with a product that is attractive and relevant to the client group. It has provided a robust way to engage partners and the end user – and we are starting to see the benefits."

Development

Based on these insights, the project team designed a new concept in stop smoking group sessions, which complemented the existing one-to-one visits and telephone support. The target audience's demand for an attractive service was one that was welcoming and encouraging, where they could relax and meet other women who had quit smoking successfully and those who were trying to quit. The new service therefore had to be inviting and non-judgmental and appeal to them as women, not as mothers or pregnant women.

Two further focus groups were held with target women in November 2007 to pre-test the proposed intervention and its brand identity and values. Following this, the Quit for a New Life service was re-branded and re-positioned to include a Me2 Stop Smoking Club, which comprised free group sessions focusing on the positive elements of quitting and new ways of creating 'me time'.

Implementation

The Me2 Clubs were launched in summer 2008 as a six-week rolling programme and were refined to suit participant's needs. Sessions included a meet and greet, tips and techniques to help quit smoking, advice on managing stress, exercises to build self-esteem and, crucially, opportunities to relax, and enjoy some 'me' time. No appointments were needed and each session ran for around 90 minutes, with free crèche places provided and all sessions held locally at the Children's Centres. Small incentives, including Me2 branded products, were provided to members when they joined

and when they reached their individual goals. The club had an open-door policy and women were free to return if they failed to quit at the first attempt, contributing to an environment where women were free from being 'nagged' and judged.

To attract women to the club, the team attended community events and provided taster sessions in the run up to launch. The clubs were promoted by word-of-mouth from midwives, as well as leaflets and posters that were displayed and distributed by local retailers.

The project also addressed the needs of the professionals who would be critical to service delivery. In-depth specialist training was provided for the 'sales force' of the service, including a new brief intervention training package and DVD using 'role play actors' to demonstrate an effective five minute brief intervention. To increase the capacity of the service, two new support workers were recruited.

Evaluation

Data on the percentage of women who smoke during pregnancy city-wide is disappointing. However, the data relating to Children's Centre areas is encouraging. The percentage of women reported as smoking during pregnancy in the Treehouse Children Centre area in Bentilee (where the pilot intervention took place) declined from 31.9 per cent in 2006 to 2007 to 29.2 per cent in 2007 to 2008.

Feedback from the pilot group sessions was very positive. The Me2 Club in Bentilee was

especially well received, delivering an average conversion rate from quit date set to four-week quitter of 60 per cent. Group members also reported increased levels of self-esteem and wellbeing. At the end of 2007 to 2008 the service had delivered 121 four-week quitters compared with 38 in 2006 to 2007.

The club in Meir was not so successful due to a number of factors, including the day of the week it was held. Women who attended the focus groups during the scoping phase said they would prefer a Friday meeting but this did not appear to be the case.

Follow up

The Me2 Club in Meir is being re-evaluated in order to meet women's needs and the team are working with Children's Centre staff to assess the most appropriate way forward. Also, the activities offered by the club are now being further developed and rolled out to other Children's Centres in Stoke-on-Trent.

The team were delighted to win the Health Service Journal's Best Social Marketing Project Award and have shared their experiences with many organisations who wanted to test these findings in their own local areas. Key lessons include: be clear on the project's objectives and clearly define behavioural goals, but be flexible and ready to be challenged – the target audience may not be who you first think they are. It is also important to engage stakeholders from the outset and at each stage of the process. Finally, pre-testing intervention ideas is critical to the success of the project.

Further support from The NSMC

Practical advice and support

If you need some fresh thinking to improve your results, we'll carry out an **expert review** of your current approach to behaviour change. Practical recommendations on how to plan, manage, implement and evaluate your projects will ensure you're able to make progress.

Need help taking a behaviour change approach forward? We can develop a **behaviour change strategy** for your organisation – ensuring you're better placed to deliver effective future programmes.

We'll **support you through developing and managing** your project, with **mentoring** offered as and when you need it. Using our 'learning by doing' approach, we bring our tried and tested behaviour change planning process to your behavioural challenge.

To help make your project happen, we can also **bring your stakeholders together** and secure their involvement in achieving your objectives.

Our **tailored, interactive workshops**, delivered by The NSMC's expert behaviour change professionals, will explore how to take an audience-led approach to your challenge – using the latest thinking in behaviour change from your sector.

Implementing an effective behaviour change project

Whatever your behavioural challenge, our experts' unrivalled experience in **delivering**

behaviour change programmes will ensure it is addressed cost-effectively. Our network of consultants and suppliers means the **best specialists** will take your project forward.

Training and resources

To give you and your team the skills you need to run your own behaviour change projects, we provide both **classroom and e-learning training courses**. Devised and delivered by expert professionals, they draw on real experience of what works.

To help ensure your staff have the right tools and support when they need them, our **online planning guide and toolbox** provides everything they need to plan and implement a behaviour change programme. Tried and tested by a range of professionals and organisations, we can develop specialised versions, tailored to meet your organisational needs.

Supporting your organisation to keep your audiences at the heart of everything you do

We'll help you **develop and conduct research** that will give you a firm foundation for a behaviour change intervention. Our experts will help ensure you get the most from your research budget.

Our **One Stop Shop** database of unpublished market research gives you the means to quickly get to grips with your audience and behavioural challenge. It will enable you to focus your research

and make the best use of your resources.

If you're pushed for time, our **data synthesis** service will package up the most relevant research into your challenge held on the One Stop Shop for you.

Providing best practice in behaviour change

ShowCase is our **online case study database** of behaviour change initiatives. From smoking to active travel, young people to health professionals, it highlights honest learning and success from the real world on a wide range of issues and audiences.

You can follow the journey project teams took and find detailed information on the 'how' of delivering a behaviour change intervention. Capitalise on others' achievements and learn from their mistakes and barriers, without having to commission expensive research.

Independent evaluation

We have specialist experience of **evaluating behaviour change programmes** of all kinds. We'll help you demonstrate the impact of your projects to your stakeholders and capture lessons to improve future work

We'll also help you put together an **evaluation plan** that will ensure you collect the right information to effectively measure success and avoid knowledge gaps from the outset

This report was compiled and
edited by Clare Pickett
and Denise Ong,
The NSMC
in August 2010.

Contact

The NSMC
c/o Consumer Focus
4th Floor, Artillery House
Artillery Row
London SW1P 1RT

020 7799 7900
www.thensmc.com
info@nsmcentre.org.uk

© The NSMC is a strategic partnership
between the Department of Health and
Consumer Focus.