



Stoke on Trent

Social Marketing Pilot Project

Smoking in Pregnancy and Early Years



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Forward

Late in 2006, Professor Jeff French from the National Social Marketing Centre (NSMC) visited Stoke on Trent PCT. His mission was to encourage those of us involved in health improvement to think about using social marketing in our work. We were inspired by what we heard and in February 2007 we embarked on our first social marketing pilot project. Our mission was to understand more fully the needs of pregnant smokers and design effective interventions that would remove the barriers that prevented them accessing our services. Guided by the key principles and concepts of social marketing, our pilot project has delivered promising initial results. We were thrilled when it was voted “Best Social Marketing Project” in the 2008 HSJ Awards and we truly believe that we can build on the experience we have gained from the pilot project to develop an even better service.

We would like to share with you our journey so far. We hope that you will be inspired to embed social marketing in your own work and that it will help you, as it is helping us, achieve improved results by offering services that are motivating and meaningful to those we are trying to reach.

Good Luck!

Deborah Richardson

1. Introduction and Background

Addressing a very complex issue

It is widely acknowledged that smoking during pregnancy is both a cause and effect of health inequalities and significantly contributes to worsening health outcomes of both mothers and children. Smoking during pregnancy increases the risk of serious complications for both mothers and babies and has been associated with low birth weight and increased risk of sudden infant death syndrome. The impact of passive smoking on infants and children has been associated with an increased risk of chest infections and asthma.

We understood from the outset that we were dealing with a very complex issue to which there are no simple solutions.

The Stoke on Trent picture

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 that this has on the health status of the local population.

Over the past five years, infant mortality rates in Stoke on Trent have remained steady, at around 30 deaths per year. In comparison, national rates and rates in other similar PCT areas have seen a steady decline. It is acknowledged that this unacceptable high infant mortality rate in Stoke on Trent is a reflection of long-standing deprivation. It is also widely recognised that no single agency can achieve improvements in health and that what is required is a radical change in culture within and across organisations, and between organisations and their customers.

A key target of Stoke on Trent's Infant Mortality Strategy is to reduce the number of women who smoke during pregnancy. The percentage of women smoking during pregnancy in Stoke on Trent was approximately 22% in 2006/07 compared with the national figure of 17% and a regional figure of 18%. However we knew from local data that there were significant variations in smoking in pregnancy rates between different areas of the city and this was taken into account when we chose the area to pilot our project.

Building on our existing service

Our challenge was to increase the number of women accessing the existing “Quit for a New Life” Service in the city and for them to ultimately stop smoking. ‘Quit for a New Life’ which has been running since 1999, receives excellent feedback from women who use the service but we knew that we needed to build on this to encourage more women to participate.

The Quit for a New Life Service in Stoke on Trent

Historically the service has offered a structured behavioural support programme and Nicotine Replacement Therapy (NRT) where appropriate, to pregnant women and their families. A Specialist Smoking Cessation Midwife, based at University Hospital of North Staffordshire, provided cessation support to pregnant women and their partners/family. The Specialist Midwife worked with clients on a one-to-one basis, during pregnancy, in the client's home. Face-to-face support continued on a weekly basis for 4-6 weeks supplemented with phone calls. Every pregnant woman is routinely asked about smoking at the booking appointment of her pregnancy. Community midwives almost exclusively initiate the question and make the referrals to the service. All women who express an interest to stop smoking are referred.

A review of the service in 2006 told us we had to consider the following:

- there was a need to develop a better understanding of the needs and wants of pregnant smokers;
- we needed to develop a longer-term strategy to support women to stop smoking before they become pregnant and support women postnatal;
- the capacity for training of midwifery colleagues and other key healthcare professionals was limited;
- there were currently no formal links with other services such as family planning, teenage pregnancy services, children and family services; and
- existing resources need to be used more effectively to meet current demand and have an impact on smoking in pregnancy rates.

We had to address these issues and develop a more robust, long-term strategy that focused on supporting women to stop smoking during pregnancy but also looked at helping them stop before they became pregnant and supporting them postnatal.

2. Setting Up and Scoping our Project

What did we want to achieve?

Our overall behavioural goal was to reduce the number of women who smoked during pregnancy in Stoke on Trent. We decided that our first step towards this goal would be to try to improve the quality and quantity of the referrals to the service by offering a “proposition” or “product” that would be right for the women we were trying to reach.

Based on our review of the current service, we took time to agree our main objectives which were to:

- explore what it is like to be a pregnant smoker in Stoke on Trent;
 - identify the factors that influence the behaviour of pregnant smokers in Stoke on Trent;
 - develop a better understanding of the barriers to accessing existing services;
 - improve our communications with key stakeholders who could influence women who were smoking in pregnancy; and
 - to review and redesign the “Quit for a New Life” Stop Smoking Service based on customer insight and develop an intervention that meets the needs of the client group.

Setting up the project

To guide and monitor our progress we formed a small action focused steering group. The group comprised:

Deborah Richardson, Stoke on Trent Primary Care Trust Principal Health Improvement Specialist and Project Lead

Wendy Dudley, Specialist Smoking Cessation Midwife

Ruth Smith and Joanna Prince, Smoking Cessation Support Workers

Keith Swift, Stoke on Trent Primary Care Trust Design Team Leader

Vivienne Caisey, Social Marketing Consultant, Brilliant Futures

Lisa Cohen, Social Marketing Consultant, XL Communications

Dr Ray Lowry, University of Newcastle upon Tyne, acted as an advisor to the group

Together we formulated a clear project plan, with clear task responsibilities and timelines. We identified areas where we would need to bring in external expertise and spent time understanding how best to commission and use this expertise. At the planning stage we decided we would need to use an external agency to conduct focus groups with the women we were trying to reach. Our consultants coached and guided us through the social

marketing process but it is important to highlight here that the project was controlled and implemented by the Project Lead and the specialist smoking in pregnancy team.

We decided to meet approximately every two months during the course of the project and to communicate through e-mail and phone between meetings. The Project Lead chaired all meetings and we agreed to produce status reports with clear action points on a regular basis.

We organised a project planning day where our steering group identified the Strengths, Weaknesses, Opportunities and Threats (SWOT) of the existing services available to our target audience. We brainstormed on what we hoped to achieve and how we might get there. We discussed openly the obstacles which might get in our way and looked carefully at our resource base.

Defining our target audience

Our core audience for the 'Quit for a New Life' service had always been women who were smoking in pregnancy but we also wanted to explore ways of reaching women who smoked and were planning to become pregnant and women who have had a baby and had stopped smoking, but were tempted or likely to resume.

We segmented our audience geographically by areas covered by the reach of the Children's Centre's in the city. We decided that our pilot intervention would take place in two areas of Stoke on Trent where local data told us that smoking in pregnancy rates were high, namely Meir and Bentilee.

| Children Centre | 2006/07 % |
|-----------------------|-------------|
| Blurton | 22.0 |
| Crescent (Meir) | 32.8 |
| Hope | 14.1 |
| Kingsland | 30.3 |
| S-o-T North | 23.4 |
| Thomas Boughey | 14.0 |
| Treehouse (Bentilee) | 31.4 |
| Westfield | 15.5 |
| Average | 21.7 |

Table 1: Percentage of women who smoked during pregnancy in Stoke on Trent by Children Centre areas

We further segmented by the women's motivation to stop smoking and concentrated on the women who, after talking to a professional, said that they were willing to engage with our service. We knew that we needed to gain a greater understanding of what was needed to get them to this point and make quitting a reality. In social marketing terms we needed to

gain insight into the everyday lives of the women in Stoke on Trent to better understand their personal reasons for smoking and what was preventing them from accessing our service.

Getting key stakeholders on board

Communicating with professional stakeholders was fundamental to the overall success of this project. The 'who, what, why, when and how' of communication was critical to ensure that all were informed about our plans, and had the opportunity to feedback and influence the direction the project took.

Equally important, our communication with professionals played an important part in building confidence in and preserving the reputation of the 'Quit for a New Life' Service.

We wanted to be inclusive in our approach and communicated with a wide range of internal and external stakeholders. We used a variety of methods to communicate with them ranging from email, letter, newsletter, face-to-face meetings, presentations, training events, but of all these methods the most valuable were the numerous personal face-to-face encounters with key stakeholders. The infectious enthusiasm and motivation to make this project succeed was driven by the team themselves and this in turn was embraced by the majority of stakeholders. We produced a '10 Frequently Asked Questions' sheet that outlined the project and explained why we were taking a social marketing approach. We summarised our project plan and invited stakeholders to contribute where appropriate.

Ultimately, we succeeded in creating a meaningful, consistent, dialogue between the project team and the internal and external stakeholders across the locality. Knowing that the image and foundation of the 'Quit for a New Life' service was sound meant that influential stakeholders supported and endorsed the development of the intervention for the women we were trying to reach.

Best practice: The social marketing work of Dr Ray Lowry, University of Newcastle upon Tyne

One of our starting points was the pioneering social marketing work of Dr Ray Lowry and his project that successfully reduced the number of women who smoked whilst pregnant in Sunderland. Dr Lowry shared his experiences with us. His valuable expert advice helped us understand what we could potentially replicate, but more importantly helped formulate our primary research to be sure we obtained a clear picture of what would motivate the women of Stoke on Trent to access our service. We were fully aware that we simply could not copy Dr Lowry's interventions without testing them in Stoke on Trent but the results of his work underpinned the way we approached our project.

A key finding from Dr Lowry's research was that health professionals were unintentionally creating barriers that were stopping pregnant women accessing stop smoking services through a lack of understanding and empathy of women's perspective and circumstance. The women in the Sunderland project felt that they were not being treated as a person and the concern shown by professionals focused almost entirely on the unborn baby. Together with his colleagues, Dr Lowry pioneered the use of role play in training sessions for health

professionals that incorporated a scenario (using verbatim quotes) which brought to life the thoughts, beliefs and concerns of pregnant women smokers. Professionals were encouraged to become 'the sales force' for referrals to a specialist stop smoking service which proved to be highly successful in increasing the quality and quantity of women engaging with the service and ultimately increased substantially the number of quitters. Dr Lowry's work informed our own intervention with professionals as detailed in section 4 of this report.

Finding out what women in Stoke on Trent wanted from the 'Quit for a New Life' service.

We knew that to deliver a service that would be meaningful and motivating to the women, our intervention needed to be based on robust customer insight. We needed to develop an in-depth understanding of what was happening in the worlds of the women we were trying to reach. To achieve this, two focus groups were conducted by a specialist company who had experience in health related qualitative research. This company worked with us to formulate a topic guide for the focus groups, recruited the women, conducted the groups and produced a report.

We were very clear about what we wanted to achieve from the focus groups:

- to reveal women's current smoking habits and any changes they had made during pregnancy;
- to understand participants' experiences, attitudes and emotions to smoking during pregnancy;
- to identify reasons for stopping smoking and the key barriers to stopping smoking whilst pregnant;
- to find out awareness of local support services and participants' attitudes to them; and
- to use the insight from the women to design an ideal local support service in Stoke on Trent.

All participants in the focus groups were mothers of children aged 1-4 years old and all had smoked during their pregnancy.

Developing our understanding – what we learnt

• Current smoking habits and any changes during pregnancy

For most women, there were no great differences between smoking habits before and during pregnancy, however it was perceived that stress levels and emotional intolerance rise during pregnancy, causing the desire to smoke to alleviate these conditions. Only a small number of participants had managed to stop smoking early in the pregnancy or reduced the amount of smoking. It was often the case that once the baby is born, the participant returned to smoking.

In contradiction of their smoking habit during pregnancy, once the baby is born, their smoking habits changed in that they smoked outside of their home, or in the kitchen away from the children. They strived to protect their children from the harmful effects of smoking and fumes. However, they lacked the drive and support needed to stop smoking before the child was born.

• Reasons for Smoking

There was a high awareness of the side effects of smoking during pregnancy and most women knew that it could affect the weight and development of the baby. Some revealed that they felt guilty when smoking during pregnancy and some said that they felt under stress due to knowing or not knowing how it could harm their unborn child.

However it was also quite common that within their acquaintance, family and friends had given birth to healthy big babies and smoked throughout their pregnancy. This gave them reassurance that their behaviour was nothing out of ordinary and lessened any feelings of guilt.

Many women smoked during pregnancy because they maintained it was an enjoyable habit that alleviated stress. Aside from its addictiveness, the main need fulfilled by smoking was for "a personal treat". Smoking was linked with 'me time', i.e. time when they could take a break from the needs of their children and partners. Thus they enjoyed smoking, it provided them with a private relaxing uninterrupted moment. They often had a lifestyle which left them feeling very emotional, stressed or depressed which manifested even greater during pregnancy thus many regarded having a cigarette as their means of escape.

They were also acutely aware of the social stigma in connection with smoking in pregnancy, the "dirty looks" they got from strangers, and comments from medical professionals or their non-smoking friends and family.

• Giving Up

Most of the women in the focus groups had tried to stop smoking at different stages of pregnancy; only a few had succeeded.

All agreed that it had to be their own decision to stop smoking and they could not be forced into it if they are not willing to do it. "Nagging" can have a counterproductive response resulting in defiance, and a stubborn refusal to change attitudes or behaviour. They blamed a lack of willpower or a fear of depression and emotional unrest for their continuance to smoke whilst pregnant.

Those who had tried to stop revealed the importance of the support and encouragement of significant others, particularly their partners who often stopped smoking with them. They appreciated support from midwives who were perceived to be looking after them and caring about them (not only about their unborn child).

• **What kind of service did the women want?**

The women who took part in the focus groups told us that awareness of existing service was low. Women had very clear views about the type of service that would be attractive to them or others who want to stop smoking. Their key message was that they would only use a stop smoking service if they wanted to, thus the tone of the intervention had to be one of invitation and helpful, friendly encouragement.

They told us about what they thought would comprise a support service they might engage with. Ideally it should:

- be very locally based;
- be in an informal, supportive and non-judgmental environment;
- **invite** them to participate in the service – not force or push them into going, avoiding words like ‘refer’;
- run through the day and/or early evenings to enable them to attend outside of the times when their children need them most (i.e. school drop-off/pick-up and bedtime);
- promote **‘me time’** which would be crucial in terms of how the service was ‘sold’;
- offer group sessions which were relaxed, informal and based on ‘slimming world’ or ‘weight watchers’ concept, with ‘role model’ clients who would share experiences and who had been in similar situations;
- be flexible in response to their individual needs and provide a choice of groups, one-to-one contact – or combination of methods.

3. Developing the Project

Looking again at our target audience

Previously, the smoking in pregnancy service focused only on women who were currently pregnant. Research had confirmed that pregnancy is one of the most difficult times for a woman to stop even though there are obvious benefits for the health of the mother and the baby. Although women often attempted to stop during pregnancy, those who succeeded often started smoking again once the baby was born. This confirmed our feedback from professionals that we needed to expand the reach of the ‘Quit for a New Life’ service. We needed to open up numerous opportunities to build relationships and trust with women who could potentially come into contact with the service before, during and after pregnancy. Our goal was to ‘keep the door open’ for these women even if they were not ready to stop or relapsed on a particular attempt.

As a result we decided to redefine our target audience as follows:

- pregnant women;
- women who were thinking about starting a family;
- women who were between pregnancies; and
- women who had children under the age of five.

Understanding the exchange process

We then took time to define the essential benefits our intervention needed to offer to make it attractive to the women whilst at the same time taking into account the barriers the women would need to overcome in order to stop. Below is a summary:

| Perceived benefits | Effort or cost |
|---|---|
| <ul style="list-style-type: none"> • Self esteem – taking control of their lives • Stress management which would include building in ‘me time’ to their lives • Feeling good, looking good • Saving money | <ul style="list-style-type: none"> • Time involved in attempting to stop • Effort involved in stopping • Peer pressure from family and friends who smoke • Influence of other women who continued to smoke during pregnancy and gave birth to healthy babies • Enjoyment of smoking – ‘me time’ – perceived as one of the few things they can do for themselves which helps alleviate stress |

Agreeing core values for the 'Quit for a New Life' service

Having understood the 'exchange' process we had a much better idea of the problems faced by the women wishing to stop and the benefits our service would need to offer them. We spent time interpreting this information and agreed a set of core values for the service we wanted to provide.

This gave us the foundation for the 'Quit for a New Life' brand and underpinned the way we communicated with women who would potentially use the services and how we would promote the service with women, health professionals and other organisations.

We agreed that our core values would be:

- We are women centered providing friendly, non-judgmental support on a flexible and individual basis
- We value the woman not just her pregnancy
- We aim to make support as holistic and accessible as possible
- We aim to share and promote good practice
- We believe in choice and respect
- We deliver on our commitments
- We will be caring, supportive, reliable, accessible and flexible

These values were agreed with professional colleagues and the 'Quit for a New Life' message was tested with women in our target groups. They were highly positive and told us:

- the message sent by the term 'Quit for a New Life' was very attractive;
- the message that the service is 'for you' was clearly understood and was highly inspirational due to their need for personal attention;
- the non-judgmental and non-patronising tone was greatly welcomed especially as it was at odds with their perception of current experiences (e.g. with GPs); and
- the word 'support' had negative links for the women to being a 'victim'. The women were keen to substitute 'support' with the more inspirational word 'encourage'.

We were satisfied that the tone of the message was such that it promoted a service that was actively engaging with the community and the values communicated that the women are being respected.

Developing ideas and concepts – a two-pronged approach to our intervention strategy

Armed with a clear idea of the values on which to base our service we set about working out plans to redesign how it would be delivered.

Operationally we decided to work on two detailed implementation plans. A professional intervention – looking at what was needed to develop the 'sales force' for our new service and a separate plan for the public intervention – that is, the service we were going to offer our target audience. First we looked at the development of our professional intervention.

Development of the professional intervention

Our professional intervention aimed to:

- raise awareness of the Quit for a New life Service;
- promote the referral pathway into the service;
- promote and deliver brief intervention training; and
- build positive relationships with professionals.

We wanted to ensure that professionals understood the range of services that were on offer through 'Quit for a New Life', and when they had contact with women in our target group felt confident in initiating a discussion about women's smoking behaviour and patterns and were able to facilitate access to the service in a timely and effective manner.

An informed, confident and skilled 'sales force' comprising professionals who would refer women to the service would be pivotal to the success of the public intervention so we have developed a brief intervention training package using scenarios and role play actors to demonstrate an effective five minute intervention. This is where we were able to use the experience of Dr Lowry's work in Sunderland and he worked closely with us to develop the training package. The training was designed to ensure that the women felt that they were important and encouraged the professionals to show empathy in a positive way. The training was designed to be delivered by the smoking cessation midwife to groups of professionals. We also explored the possibility of making a DVD training package which was developed at a later date.

A new referral pack which includes a description of the service, contact details, a clear referral pathway and information for clients was tested with professionals. The style and tone of the materials mirrored those used for the public intervention and aimed to make a visual impact which promoted a positive, clear and motivational message, giving professionals confidence in the service.

Development of the public face of the 'Quit for a New Life' service

Having tested our values and listened very carefully to what women wanted from our service we set about working out plans to redesign how we delivered the service. This involved developing an intervention which effectively **communicated** our agreed values in the way that would be easily understood by the women and would encourage them to use the service. It would mean having the **right 'product' or 'proposition' in the right 'place' and time, 'promoted' appropriately at the right 'price'**, which meant far more than financial costs for the women. It was about us offering them something that was more valuable and attractive to them than their current lifestyle choice of smoking such as 'me time', saving money, better health, and feeling good about themselves.

We considered what women had said about the type of service they wanted. Flexibility and a range of options were important for the majority of women. Now we had to think about what activities we could offer women within the constraints of our resources, time and budgets. We needed to develop an intervention that had the right proposition delivered in an appropriate way. All our ideas were then pre-tested at two further focus groups.

This is what was proposed as a viable range of services which retained many of the features of our existing service but had the significant extra feature of a peer support group:

- one-to-one support (at home or agreed venue);
- peer support group in a community setting – based on a motivational club – e.g. Slimming World;
- mixture of group work and one-to-one support; and
- telephone support.

Developing the peer support group

The women wanted group support as one of the services on offer - the challenge was how to make this element of the service attractive to them and meet some of their key needs. We needed to ensure that the groups were set up in a format that encouraged women to stop smoking but also provided the valuable 'me time' which they told us was so important. The groups aimed to offer a friendly and relaxed environment for women to meet and share their ideas and experiences.

We drew up a model based loosely on weight management programmes, with the first part of the session involving a discussion around how the previous week had gone, highs and lows, tips from fellow quitters, how to tackle the challenges they faced in becoming a non-smoker. The second part of the session was designed to focus on 'me time'.

This included relaxation and pamper sessions which would include aromatherapy, neck/back/head/hand massage, reflexology and more. We worked in partnership with Worker's Education Authority (WEA) to design and deliver these sessions.

A free crèche facility was to be offered to make it easier for women to attend.

Pre testing showed that women liked the range of services that were on offer but were keen to ensure that communications made it clear that there were options of individual and group sessions so that they knew from the outset that they had a choice.

In order to be attractive we knew we had to be welcoming and friendly to all participants, make special considerations for women who were not accustomed to attending groups and ensure that the staff running the groups were professional whilst remaining approachable.

We placed great importance on the 'branding' of the new club and a variety of names were considered for the group – Star Quitters, NuU, Me² – and a range of logos designed by the in-house design team at Stock on Trent PCT.



When we tested these names with the women they liked the Me² concept best because it represented togetherness, inclusion and friendliness.

In terms of the brand and logo they made very positive observations;

- Me is in big letters and ² is the baby
- ² could be your friend or your baby
- 'Me²' means you're not on your own
- It's inviting me to join the club and be part of the group
- It's for me, myself ... it's personal

The term 'club' had strong associations with forming new relationships, whilst the term 'me' placed the focus on themselves. In addition it promoted a serious service that was about achieving the end goal of stopping smoking.



We pre-tested our ideas with the women who told us

All were highly attracted to the service as it was more in keeping with an exciting new healthy lifestyle club that has stopping smoking as its key focus rather than a medical initiative to encourage them to stop smoking.

- They were excited by the prospect of positive encouragement to live a healthier lifestyle and by new experiences, e.g. relaxation techniques, which were at odds with their current daily experiences where everyday luxuries such as having a bath in peace were out of their reach.
- They sought to make a bridge between their experiences at the club and their home life and suggested a goodie bag scheme where they could take away a treat related to that day's experience.
- They liked the fact that it was clearly focused on the mother, not the baby and was about meeting new people and making new friends – they embraced the fact that they could drop-in and use the free crèche.
- It promoted a well-being experience that treated them with respect and equality and this was a far more persuasive “pampering” experience than traditional methods that they regarded as “preaching”.

How did we promote our new proposition? - Our campaign to raise the profile of the service

Our research also told us we needed to raise the profile of, and re-brand the 'Quit for a New Life' service. A variety of visuals for the 'Quit for a New Life' brand were tested with women as shown below:



This was the most appealing option. It sent a highly positive message linked to making a healthier lifestyle choice.



A variety of resources and methods of communication were considered relevant to the women in the target audience. A series of posters, leaflets, promotional materials and portable stands were developed for use in a variety of community settings. In addition it was agreed that media activity would be used when appropriate.

The publicity materials we needed to promote the me² club were pre-tested and were bright, bold, eye catching and fun. Women loved the overall look but had a few concerns in terms of what language was used and how it could be interpreted. These had to be addressed as this attention to detail could make or break whether they would ultimately engage with the service or be turned off by what was on offer.

Delivery of the 'Quit For A New Life' service

We had to deliver our services in **places** that were convenient to women and easily accessible. Based on our insight we knew that we needed to offer our service in a variety of ways:

- **In the women's homes** – women may feel comfortable for someone from 'Quit for a New Life' to visit them at home. This helps the women feel in control and also saves them time.
- **Children's Centre's** – many of the women we want to build relationships with spend time at children's centres where there are crèche facilities and an opportunity to socialise with other mums. Testing showed that this would be the ideal place for the Me² Clubs to be piloted.
- **Community venues** – options for community venues could range from the local community centre to community cafes – the Quit for a New Life team is flexible and happy to consider any appropriate venue where women feel comfortable and happy to attend.
- **By phone** – supplementary support can be offered to women by phone or texting. Often they just need a little reassurance that they are doing well or encouragement if they are having a 'bad day'. Reminders about appointments or group sessions can also be sent by text.

Pre-testing of our materials told us:

- The term 'attained smoke free status' was perceived as very lofty and not in keeping with their everyday language. It was recommended that this was replaced by 'achieved a smoke free month'.
- It was important for women that the word 'support' was omitted from all communication as it had negative links to being a 'victim'. Women preferred the more inspirational word 'encourage'.
- The line 'A Stop Smoking Service for Women' helped understanding on an immediate level.
- Showing a range of pictures was appealing as it immediately conveyed a range of fun activities that could lead to a lifestyle change.
- The photo we had used and the term 'me time' were inspirational.

4. Piloting our project

Implementing the professional intervention

A planned programme of training for frontline staff was implemented and we felt confident that the techniques used by Dr Ray Lowry would work well in Stoke on Trent. The training continues to run concurrently with the development of the project. Dr Lowry helped us train actors for role play and the training for the brief intervention was well received. By tapping into planned training days we are also able to keep frontline staff up to date with our project's progress and obtain feedback on both the referral process and new materials.

We also commissioned an outside consultancy to produce a DVD of the training which has significantly increased the number of professionals we are able to reach, including those working in Children's Centre's.

All key frontline staff and managers had the opportunity to attend an introduction to social marketing course which has helped staff understand the approach we have taken to this project.

Implementing the public intervention

The Me² Stop Smoking Clubs were launched in February 2008 at the Treehouse Children Centre in Bentilee and the Crescent Children Centre in Meir.



Promoting the Me² Club

Staff at the Children's Centres worked with the 'Quit for a New Life' team to encourage women to attend.

To attract women to the club the team also attended community events and provided taster sessions in the run up to the launch. The clubs were promoted by midwives and leaflets and posters promoting the club were displayed and distributed by local retailers.

The clubs were launched as a six week rolling programme and were refined to suit participant's needs. Each session was structured around:

- meet and greet;
- tips and techniques to help quit smoking;
- help with managing the stressful times;
- building self esteem; and
- an opportunity to relax, try some pamper treats and enjoy some "me" time.

No appointments were needed and each session ran for around 90 minutes. Free crèche places were welcomed by the women.



The Me² Stop Smoking Club

5. Our Progress So Far

The feedback from the women who engaged with the 'Quit for a New Life' service has convinced us that we are now delivering a service that better meets the needs of the women we are trying to reach.

The table below shows the activity data for the 'Quit for a New Life' service for the last three years. The figures show that in 2007/08 when we implemented the new service model there was a marked increase in the number of women who engaged with the service and the number of four week quitters went up from 38 in 2006/07 to 121 in 2007/08

| Year | Number of quit dates set | Number successfully quit at 4 weeks | Quit rate |
|---------|--------------------------|-------------------------------------|-----------|
| 2005/06 | 114 | 70 | 61% |
| 2006/07 | 75 | 38 | 51% |
| 2007/08 | 216 | 121 | 56% |

The Me² Club in Bentilee was very well received and delivered a 60% quit rate with an additional bonus of all women who attended reporting increased self esteem and well being.

The club in Meir was not so successful we believe that this was because of a number of factors including the day of the week it was held. Women who attended the focus groups told us that they would prefer a Friday meeting but this did not prove to be the case and we have worked with staff at the Centre to assess the most appropriate way forward.

The activities offered by the club are now being further developed and rolled out to other Children's Centre's in Stoke on Trent.

We were delighted when our project won the Health Service Journal's Best Social Marketing Project Award and we have now shared our experience with many other organisations who would like to test our findings in their local areas. Many asked us what we considered are our key learning was from our first social marketing project and these are highlighted in the next section.

6. Our Key Learnings and Recommendations for a Successful Social Marketing Project

- Social marketing is not a quick fix – it needs time to fully engage with the process.
- Have a small (we had six people) action focused steering group and agree a clear project plan which sets out timelines and responsibilities at the beginning of the project. Review and revise this as the project progresses.
- Arrange training to be sure that key staff are familiar with the tools and techniques of social marketing.
- Be clear on your objectives and clearly define behavioural goals.
- Ensure key stakeholders are involved from the outset and report back to them during the project. Let them know exactly what is happening, why and when.
- Have a clear internal and external communications plan.
- Commission experts where necessary. We used Social Marketing Consultants and a market research company with experience in health related work to recruit and conduct our focus groups.
- Take advantage of best practice. We were able to learn from Dr Ray Lowry's social marketing work.
- Don't be afraid to think outside of the box – be prepared to look again at your segmentation. Your target audience may not be who you first thought.
- Pre-testing of intervention ideas was critical to the success of the project.
- Be prepared to be challenged. Remember it is what resonates with your target audience that is important (not necessary what resonates with the professionals).
- Understanding that this project was not about creating new leaflets and posters but creating a service that was motivating and meaningful to the women of Stoke on Trent.

7. Further information

Further information on the progress of the project can be obtained from

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Appendix 1

Did Our Project Meet the NSMC National Benchmark Criteria for Social Marketing?

The National Social Marketing Centre recommends that eight key benchmarks should be met to determine whether a project is consistent with social marketing. The benchmarks were developed to help strengthen the use of effective social marketing approaches. A full explanation of the benchmark criteria can be found at www.nsmcentre.org

Below we have mapped our project to these benchmarks.

| Benchmark | Evidence |
|---|--|
| <p>Customer Orientation</p> <p>“Customer in the Round”</p> <p><i>Develops a robust understanding of the audience, based on good market and consumer research combining data from different sources.</i></p> | <p>We spent a year researching and understanding the behaviour of our target audience. We developed a clear understanding of what our audience wanted by using focus groups and customer feedback to develop our proposition, tested this with our audience and delivered an intervention that met the needs of the women we were trying to reach and the professionals who delivered the services.</p> <p>We recognised from the outset that consultation with our ‘sales force’ and other stakeholders was critical to the success of this project. Ensuring that they had appropriate training and resources to deliver our services was critical.</p> <p>We were fortunate to be able to learn from the research and work of Dr Ray Lowry who had used social marketing to deliver a successful intervention for pregnant smokers in Sunderland.</p> |
| <p>Behaviour</p> <p><i>Has a strong focus on behaviour, based on strong behavioural analysis with specific behavioural goals.</i></p> | <p>Our research and the subsequent insight ensured we had a clear understanding of why the women in our target audience in Stoke on Trent continued to smoke during pregnancy and what type of services we could offer which would encourage them to change their behaviour. We were clear that our overall goal was to reduce the number of women who smoked during pregnancy and our specific behavioural goal was to improve the quantity and quality of referrals to the specialist smoking cessation in pregnancy team, thereby increasing the number of women who fully engaged with the service.</p> |

| Benchmark | Evidence |
|---|--|
| <p>Theory</p> <p><i>Is behavioural theory based and informed – draws on an integrated theory frame work.</i></p> | <p>Stages of Change Theory, Social Cognitive Theory and Exchange Theory were used to inform our work.</p> |
| <p>Insight</p> <p><i>Based on developing a deeper “insight” approach – focusing on what moves and motivates.</i></p> | <p>By listening to what the women told us they wanted we had a much better idea of what would “move and motivate” them to engage with the ‘Quit for a New Life’ service. We were able to clearly identify the values we wanted to be associated with the service and develop our proposition in a way that was meaningful for our audience. We ran focus groups to gather information that would give us insight into what inventions would resonate with the women and further focus groups to pre-test and develop our intervention.</p> |
| <p>Exchange</p> <p><i>Incorporates an exchange analysis. Understanding what the person has to give to get the benefits proposed.</i></p> | <p>We developed a clear understanding of the benefits we needed to offer and the barriers we needed to overcome that would encourage women to engage with our service.</p> |
| <p>Competition</p> <p><i>Incorporates an analysis to understand what competes for the time and attention of the audience.</i></p> | <p>The women clearly identified what THEY saw as the “competition” to stop smoking. We were able to learn from this and develop an intervention that addressed their main concerns.</p> |

| Benchmark | Evidence |
|---|--|
| <p>Segmentation</p> <p><i>Uses a developed segmentation approach (not just targeting)</i></p> <p><i>– avoids blanket approaches.</i></p> <p>Insight</p> <p><i>Based on developing a deeper “insight” approach – focusing on what moves and motivates.</i></p> | <p>We had robust data and could identify areas in Stoke on Trent where smoking prevalence in pregnancy was high.</p> <p>Our research enabled us to understand why the women found it difficult to stop smoking. Our research also showed that we were more likely to be successful if we redefined our target audience to include smokers who were:</p> <ul style="list-style-type: none"> • Pregnant women • Women who were thinking about starting a family • Women who were between pregnancies • Women who had children under the age of five <p>An opened minded approach and the opportunity to re-examine our target audience based on our insight was crucial to the success of the project.</p> |
| <p>Methods Mix</p> <p><i>Identifies an appropriate mix of methods.</i></p> | <p>We devised a two-pronged intervention approach:</p> <ul style="list-style-type: none"> • an intervention mix for our target audience; • an intervention mix for professionals and stakeholders involved in delivering the service. <p>We used the insight we gained to enhance and refocus the ‘Quit for a New Life’ service. A new support group “Me² club” was piloted, we re-branded the ‘Quit for a New Life’ service with a new logo. We used the intervention to increase the reach of ‘Quit for a New Life’ with an ‘open door’ policy to include women who were not already pregnant.</p> <p>Referral pathways were re-examined and professional given access to new training.</p> |

Appendix 2

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