Review of Social Marketing within Public Health Regional Settings

Snapshot: November 2008 to January 2009

Department of Health
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Executive Summary

1.1 Background and context

In 2006, the National Consumer Council published 'It's Our Health!', which highlighted the links between social marketing and positive behavioural change, and called for the establishment of a National Social Marketing Centre (NSMC) to help build capacity and skills in social marketing in England. In its response, 'Ambitions for Health', the Department of Health (DH) focused on four key areas:

- increasing knowledge and skills among health professionals
- understanding what motivates people to change their behaviour
- finding innovative ways to improve people's health
- encouraging and supporting partnership working at local and regional level

The NSMC was established in 2006, with a remit that spans all four of these areas. By January 2009, the NSMC had appointed ten Social Marketing Regional Development and Support Managers (RDSMs) — one for each Strategic Health Authority (SHA). The RDSMs' role is to provide guidance and support for social marketing projects and initiatives, tailored to the specific needs of each region.

Their initial task was to undertake a comprehensive social marketing review of their own region, gathering evidence about existing social marketing activity and identifying gaps in knowledge and skills.

1.2 About this report

This report provides a summary of findings from the RDSMs' social marketing review across the ten SHAs. In the two regions which had not yet appointed a Regional Support and Development Manager, two interim freelance consultants were commissioned to carry out the reviews. It aims to give policy-makers, commissioners and health professionals a clear picture of levels of knowledge, understanding and practice in social marketing within the Primary Care Trusts (PCTs), as at early 2009.

It is aimed at policy-makers, commissioners and health professionals, to give an insight into how social marketing is understood, championed and delivered within the local settings.

> This report provides a snapshot in time of how social marketing was being used within PCTs and in some cases with strategic partners.

This report provides a snapshot in time (between November 2008 and January 2009) of how social marketing was being used within PCTs and in some cases with strategic partners. The content is based on in-depth interviews with staff working in a range of different roles in the ten SHAs regions. Findings are grouped under the following headings:

- defining and understanding social marketing
- current social marketing activity
- support for social marketing
- resources
- barriers to social marketing

The report then provides a short summary of conclusions and recommendations – based on the insight gained during the reviews – on how barriers to the adoption of social marketing might be overcome, alongside a compilation of training and development needs across the regions.

1.3 Key findings

Defining and understanding social marketing

Across all regions, awareness of the term 'social marketing' is high, but levels of understanding vary. Some respondents confused social marketing with advertising and/or current health promotion work. Staff in public health and communications had a better level of understanding than those in commissioning.

Most respondents saw social marketing as a valuable way of gaining meaningful insights into customer needs, developing tightly targeted communications and bringing about lasting behaviour change (see Appendix 8). However, there were also negative perceptions, with people describing social marketing as too academic or 'difficult', or pointing out the difficulty of achieving measurable results. Others dismissed it as simply the latest 'buzz word'.

Awareness of the NSMC was very high. Most respondents had made use of the Centre's resources and taken part in NSMC developed training courses (see Appendix 6).

Current social marketing activity

Involvement in social marketing activities varied significantly from region to region. Even in those areas with the highest levels of activity, almost all projects were still in their infancy, contributing to the lack of case studies and evidence cited by many respondents. Projects focused on a range of Public Service Agreement (PSA) targets (see Appendix 7). Overall, the commonest target was smoking cessation, but significant numbers of projects also focused on alcohol consumption, reducing mortality, maintaining a healthy weight, sexual health and MMR uptake.

Projects were assessed against the benchmark criteria developed by the NSMC (see Appendix 2) to measure how far they met a formal definition of social marketing. Projects were most likely to satisfy the criteria for behaviour, customer orientation and segmentation, and least likely to satisfy the criteria for competition, theory and exchange. Some regions were also making extensive use of the NSMC's 'Total Process Planning' Model (see Appendix 3), while others had adopted it for a small minority of projects only.

Support for social marketing

Commitment to social marketing was high. In most PCTs, social marketing was championed at a very senior level, typically by Directors of Public Health or Communication, and many either had already appointed or were planning to appoint people to dedicated social marketing posts. Several regions were in the process of setting up frameworks, steering groups or units to manage social marketing projects. Social marketing was most likely to 'sit' within public health or communication directorates.

Most PCTs had some staff who had taken part in introductory social marketing workshops run by the NSMC. Respondents also talked about topic-based training run by independent providers. National training was funded by the NSMC. Regional or PCT-specific training was funded by the SHA, regional government office or the PCT itself. For most participants, training helped raise awareness. There was strong demand for more practical training.

All regions had received visits from the DH's National Support Teams (NSTs). Some regions with Spearhead areas obviously received more visits and, therefore, were more aware of the feedback advice and guidance on social marketing. As a result of NST visits in some regions, PCTs had been prompted to start looking at how social marketing could help them meet their goals, and to source appropriate social marketing training and support.

In all regions, PCTs had worked with external agencies for all or part of their social marketing activity. There was some concern that this could act as a barrier to the

> Involvement in social marketing activities varied significantly from region to region

development of skills in-house. One PCT was addressing this by running a project in-house but using an external agency as mentor. Contact with agencies seemed to highlight a need for training in procurement and commissioning.

Most, if not all projects involved partnership working, most commonly with the local authority. Other partners included community groups, youth groups, GPs, health workers, Connexions, local schools, acute care providers, football clubs and private sector employers. Regions also cited a range of existing networks, which generally represented either a sector (communications, public health) or a topic (tobacco control, sexual health, obesity). The consensus was that these should expand their remit to include social marketing.

> Most, if not all projects involved partnership working, most commonly with the local authority

Resources

Social marketing was being led — and championed — by PCT staff working in a range of areas and at different levels of seniority. All regions had either already appointed, or were planning to appoint, dedicated social marketers.

In the 2008/09 financial year, the vast majority of PCTs had used money from non-dedicated budgets, typically public health or communications, to pay for social marketing activities. For the 2009/10 financial year, a significant number, though not a convincing majority, were planning to either set up a dedicated social marketing budget or to allocate specific funds to social marketing projects, although this varied considerably from region to region. Amounts allocated also varied considerably, making it difficult to develop a clear, consistent picture of PCT-allocated funding for social marketing.

Barriers to social marketing

The following list provides a summary of the key barriers to developing and implementing social marketing, as cited by all or a significant proportion of the regions (see Appendix 4):

- lack of resources
- lack of capacity
- lack of awareness and understanding
- yearly targets
- lack of robust evidence and case studies
- organisational structure problems
- lack of support
- cultural and ethical issues
- external constraints

1.4 Recommendations for developing social marketing at Primary Care Trust level

Respondents made the following recommendations for overcoming barriers to working with and developing social marketing within the PCT settings (see Appendix 5):

Embedding social marketing within PCTs

- embed social marketing at a strategic level
- increase capacity
- increase budgets for social marketing
- allocate more time for social marketing

Provision of training and support material

- raise awareness and understanding of social marketing

- provide tailored training for staff at different levels and in different roles

- develop practical tools and resources

- make evaluation a priority and develop a robust evidence base

Networks and events to support social marketing

- establish a network for sharing knowledge and resources

- set up social marketing steering groups/regional hubs

- organise events and conferences – regional and national

Background and context

2.1 'It's Our Health!'

In 2006, the National Consumer Council (NCC) launched 'It's Our Health!', the first ever national review of health-related campaigns and social marketing in England. The review highlighted the need for a social marketing approach to encouraging positive behavioural change. Commissioned by the Department of Health (DH) as part of its 'Choosing Health' White Paper commitments, the report set out findings, along with strategic and operational recommendations, on how social marketing could be applied to improve the impact and effectiveness of health promotion at national and local levels.

One of the recommendations was the establishment of a National Social Marketing Centre (the NSMC) to support the DH's National Health Improvement Social Marketing strategy, and deliver a work programme focused on building capacity and skills in social marketing. The NSMC was set up in 2006 as a strategic partnership between the DH and Consumer Focus (formally the NCC).

> One of the recommendations was the establishment of a National Social Marketing Centre

The review also confirmed the growing evidence that social marketing could help more people to live healthier lives. It highlighted gaps in capacity and skills in social marketing, and provided a range of practical recommendations for ways in which the government could build capacity and integrate social marketing into policy and practice. The review also showed where good practice could be built into future learning.

2.2 'Ambitions for Health'

In July 2008, the DH published its formal response to 'It's Our Health!', entitled 'Ambitions for Health: a strategic framework for maximising the potential of social marketing and health-related behaviour'. 'Ambitions for Health' sets out how the DH planned to:

- embed a social marketing approach to improve people's health and change behaviour

- work in partnership across government, and with industry and the voluntary sector, to support the changes people need to make to enjoy the best possible health

- take action on the key learnings from the Health Challenge England road shows and maintain the momentum by ensuring that social marketing is further embedded into public health systems

The new framework for social marketing is based on four key areas:

- **Health capacity:** increasing the skills and knowledge of public health professionals through a series of conferences, seminars and research materials

- **Health insight:** what motivates people to change their behaviour? A new 'Healthy Foundations Lifestage Segmentation Model', due to go live by winter 2009, will provide a 360-degree picture of the population and individual behaviour across issues including obesity, drug and alcohol misuse and smoking. A new 'one stop research shop' will also bring together a vast array of useful data in one place

- **Health innovations:** putting social marketing into action locally, regionally and nationally. Learning from the successes of programmes such as Health Trainers and Life Checks will inform future innovative ways to improve people's health

- **Health partnerships:** establishing a £1 million per annum capacity building fund to provide local and regional support for building partnerships

> Social marketing has been moving steadily up the political agenda

Social marketing has been moving steadily up the political agenda. It is seen by both the Cabinet Office and the Prime Minister's Strategy Unit as an essential tool in the delivery of national strategy at a local level.

2.3 The National Social Marketing Centre

In 2006, the National Social Marketing Centre (NSMC) was established to support the DH's National Health Improvement Social Marketing strategy, and to deliver a work programme focused on building capacity and skills in social marketing and public health. It does this by working with others to increase understanding and practical use of strategic and operational social marketing at national and local levels.

The DH National Support Teams (NSTs) identified the growing demand for professional social marketing support to enable Primary Care Trusts (PCTs) to commission social marketing projects. With the NST input, the Health Improvement Directorate subsequently funded the NSMC to recruit, co-ordinate and professionally develop ten Social Marketing Regional Development and Support Managers (RDSMs), to provide local planning and project management support for the growing interest in social marketing initiatives and programmes at local level within each Strategic Health Authority (SHA) region.

2.4 The Role of the Social Marketing Regional Development and Support Managers

By January 2009, the NSMC had appointed ten RDSMs - one for each SHA. Their role is to provide guidance and support for social marketing projects and initiatives, tailored to the specific needs of each region.

Their initial task was to undertake a comprehensive social marketing review of their own region, gathering evidence about existing social marketing activity and identifying gaps in knowledge and skills. This report provides a summary of findings from those reviews and aims to give policy-makers, commissioners and health professionals a clear picture of levels of knowledge, understanding and practice in social marketing as at early 2009. It will provide a baseline for the RDSMs in building knowledge, skills and capability in social marketing within the regional settings.

Their second objective is to identify a potential or existing NHS social marketing project that has at least three partners and would benefit from strategic social marketing suppport. These projects will be given 'Beacon Partnership' status and specific support and funding from the regional budgets.

Their third and ongoing objective is to ensure that all PCT directors and commissioners of social marketing projects understand what social marketing is and are in a position to commission effective social marketing projects. Working from the evidence gathered

during the review, the RDSMs will identify local training and development needs, and then build regional capacity development plans, to be agreed with the Regional Directors of Public Health and linked to NSMC/DH national strategy for putting social marketing into action nationally, regionally and locally.

2.5 Linking national, regional and local policy

To ensure that the RDSMs are 'on message' and that DH policy and communications are consistent at regional and local levels, each RDSM has responsibility for a health-related topic, such as obesity or tobacco control. They work with the DH policy, communications, campaigns and NST leads responsible for the topics.

Purpose of this report

3.1 Aims

The aim of this report is to provide a snapshot in time (between November 2008 and January 2009) of how social marketing was being used within Primary Care Trusts (PCTs) in England.

It is intended to inform policy-makers, commissioners and health professionals about current levels of understanding, knowledge and practice of social marketing at different levels within PCTs and, in some cases, among their local strategic partners.

It also identifies current and future opportunities for Strategic Health Authorities (SHAs), the Regional Government Offices (RGOs) and the NSMC to support and develop knowledge, skills and capacity in social marketing and support programmes aimed at improving the delivery of services within public health.

3.2 Objectives

The report summarises findings under the following headings.

Defining and understanding social marketing

- How NHS professionals define social marketing
- How these definitions match the NSMC's benchmark criteria for social marketing

Current social marketing activity

- How, and to what extent, PCTs are using social marketing
- The extent to which these social marketing interventions reflect the NSMC benchmark criteria

Support for social marketing

- General levels of interest in and commitment to social marketing
- Whether and, if so, where social marketing is championed within PCTs
- Where responsibility for social marketing sits within PCTs
- Who has had social marketing training, and what impact this has had
- Priority future training needs

Resources

- Levels of human and financial resources available to support the development of social marketing

Barriers to social marketing

- Potential barriers to the development and implementation of effective social marketing interventions

It then provides a short summary of conclusions, before going on to consider how these barriers might be overcome and to set out some suggested next steps.

3.3 Methodology and approach

The content of this report has been informed by in-depth interviews with a range of staff in the ten Strategic Health Authority regions. Some interviews were carried out face-to-face, while others were conducted by telephone. Interviews were semi-structured and lasted between 35 minutes and an hour. Most interviews were conducted individually. The interviews were carried out between November 2008 and January 2009. A standard questionnaire was used throughout, but interviews were not limited solely to the set questions. Wider issues arising were discussed and captured during the meetings. Interviewees included:

> The content of this report has been informed by in-depth interviews with a range of staff in the ten Strategic Health Authority regions

- Directors of Public Health or their deputies
- Public Health professionals (often with lead responsibility for PSA target areas)
- Health Promotion specialists
- Directors of Communication or equivalent
- Communication Managers
- Commissioning Managers

See Appendix 1 for a copy of the full questionnaire.

Key findings

4.1 Defining and understanding social marketing

How healthcare professionals define social marketing

In all the regions, awareness of the term 'social marketing' was high. Levels of understanding, though, varied significantly. Some respondents gave detailed, accurate definitions.

"It's a well-defined process which is about engaging with communities and individuals and understanding better how we can help them change whatever we want to work on."

"Applying the commercial marketing practices including planning and evaluating programmes which are about looking at the way people behave, focusing on target groups so we can improve the outcomes [health outcomes] for individuals and for everyone around them."

In one region, responses were measured against a widely-used academic definition of the term, 'the systematic application of marketing alongside other concepts and techniques to achieve specific behavioural goals for a social good' (French and Blair-Stevens, 2006). Just over half the respondents gave a description of social marketing that at least part-matched this definition.

Across the regions, a significant minority of people confused social marketing with conventional marketing and advertising activities.

"It's sophisticated advertising."

"Advertising for the good of the nation; using advertising to bang home health messages."

In one region, researchers found evidence of confusion between social marketing and health promotion. In some areas, the health promotion workforce saw social marketing as a threat to their traditional way of working, fearing that it could shift the emphasis onto communication and marketing, at the expense of client engagement and redefining services to meet client needs. In others, though, health promotion colleagues welcomed social marketing as a more systematic way of achieving goals they felt they had been working towards for some time.

Understanding varied according to level of seniority and job role. In the case of seniority, there was no consistent correlation: in some regions, leaders were more knowledgeable about social marketing; in others, operational staff and middle managers were better informed. However, in the case of job role, the findings highlighted a very distinct trend, with staff in communications and public health tending to have a better understanding of social marketing than those working in commissioning directorates.

Attitudes to social marketing

A very significant majority of respondents in all regions felt enthusiastic and positive about the potential of social marketing to help them achieve their goals. In one region, 99 per cent of interviewees said they felt there was a clear need for social marketing within their organisation as a whole and/or in their specific work area. Another region had a negative experience of running a high profile social marketing initiative, but their willingness to be open about the experience and learn from it had kept levels of enthusiasm high, and minimised disenchantment about social marketing.

Respondents identified the ability of social marketing to provide meaningful insights into the needs of the target audience, as its key strength.

> Across the regions, a significant minority of people confused social marketing with conventional marketing and advertising activities.

"…It's more than just knowing how old they [target groups] are and where they live – it is about finding out how they tick."

Many also cited the potential advantages which social marketing offered for segmented, tailored communications that meet the needs of tightly defined groups.

"[It] puts us in touch with client groups we most need to work with. We can design services that most fit their needs. [It's] not just one message fits all."

Social marketing was also seen as a way of bringing about lasting changes to people's behaviour.

"It forces us to…change our work rather than [just] giving people a leaflet. It helps [us] understand the difference between raising awareness and changing behaviour."

See Appendix 8 for more quotes highlighting attitudes to social marketing.

Sensitivities

The most common negative perception of social marketing was that it was somehow 'difficult' — a complex academic concept rather than a practical tool. Respondents cited a need for practical toolkits to support the application of social marketing principles and for evidence-based case studies showing how principles have been put into practice. In at least one region, respondents expressed concern that social marketing could be seen as failing to deliver measurable results.

There was also a sense that, while social marketing was good at providing insights, it was less good at translating those insights into action.

> Respondents cited a need for practical toolkits to support the application of social marketing principles

"Social marketing is strong on analysis and weak on providing tools for delivery that we haven't already got."

There was also some scepticism. Some viewed social marketing as just another buzz word. Even among those who were generally enthusiastic about the concept, there was a feeling that social marketing was something health organisations had been doing for years.

"It's just a new language for things we're already doing. It's the Emperor's New Clothes."

See Appendix 8 for more quotes highlighting attitudes to social marketing.

Awareness of the National Social Marketing Centre

Awareness of the National Social Marketing Centre (NSMC) was very high, ranging from around 75 per cent all the way up to 100 per cent in some regions. Most respondents who were aware of the NSMC had also made use of its resources, most commonly the website. See Appendix 6 for a summary of findings.

Significant numbers had also taken part in NSMC training courses and asked NSMC staff for information and advice. While feedback about the Centre was generally very positive, some respondents felt that its resources tended to be academic rather than practical. In one region, awareness was noticeably lower among commissioners than among those working in communications and public health.

4.2 Current social marketing activity

How Primary Care Trusts are using social marketing

The extent and nature of social marketing activity varied significantly across the regions. In one region, which describes itself as an 'early adopter', all PCTs were running social marketing projects and had allocated dedicated social marketing budgets for the financial

year 2009/10 (see page 15 for more on financial resources). In most cases, these projects involved PCTs working with a range of partners including local authorities, community groups and, in some cases, private sector organisations (see page 15 for more detail).

Even in the 'early adopter' region, only two projects out of a total of over 50 had reached the evaluation stage. Most social marketing initiatives were either still being scoped or were in the early stages of implementation. One region described some of its PCTs as 'just beginning to look at how social marketing can help in service redesign and tackling public health issues'. This could explain the apparent shortage of case studies and evidence reported by many respondents.

Projects aimed to tackle a range of individual Public Service Agreement (PSA) targets; none were trying to address more than one target at the same time. Across the regions, the highest priority target appeared to be smoking cessation. Significant numbers of projects also focused on alcohol consumption, reducing mortality across areas including heart disease and cancer, maintaining a healthy weight, sexual health and increasing MMR immunisation uptake. In one region, several projects cited the promotion of emotional and mental wellbeing as a key goal. In those regions with spearhead areas — where health inequalities are a particular challenge — there was evidence of social marketing being used to target tightly defined communities. See Appendix 7 for further details of PSA targets.

Social marketing projects and the NSMC benchmark criteria

The NSMC has developed a set of benchmark criteria, (French and Blair-Stevens (2006), adapted from original benchmark criteria developed by Andreasen (2002)), designed to help identify whether a project or initiative can accurately be defined as 'social marketing'. The criteria were developed following a comprehensive independent review of social marketing methods and approaches. They aim to provide a robust framework to help those planning and developing interventions to ensure they are consistent with the best evidence-based principle and practice in social marketing. The criteria define social marketing interventions as having the following characteristics:

1. CUSTOMER ORIENTATION: Develops a robust understanding of the audience, based on good market and consumer research, combining data from different sources

2. BEHAVIOUR: Has a clear focus on behaviour, based on a strong behavioural analysis, with specific behavioural goals

3. THEORY: Is behavioural theory-based and informed. Drawing from an integrated theory framework

4. INSIGHT: Based on developing a deeper 'insight' approach – focusing on what 'moves and motivates'

5. EXCHANGE: Incorporates an 'exchange' analysis. Understands what the person has to give up to get the benefits proposed

6. COMPETITION: Incorporates a 'competition' analysis to understand what competes for the time and attention of the audience

7. SEGMENTATION: Uses a developed segmentation approach (not just targeting). Avoids blanket approaches

8. METHODS MIX: Identifies an appropriate 'mix of methods'

Appendix 2 sets out the benchmark criteria in full, including guidance on how to identify whether they are being met.

The social marketing projects identified in the course of the review varied considerably in the extent to which they met these criteria. Overall, projects were most likely to satisfy the criteria for behaviour, customer orientation and segmentation, although research in at least one region suggested that there was some scope for a more sophisticated approach to both customer orientation and segmentation. There was significant variation in the areas of *methods mix* and *insight*, with some regions very strong and others very weak.

> Most social marketing initiatives were either still being scoped or were in the early stages of implementation

Projects were least likely to satisfy the criteria for *competition*, *theory* (although in one region 'most projects framed their work with academic theory') and *exchange*. In another region, levels of knowledge and awareness of the criteria as a whole was low, and there was little understanding of social marketing as a systematic process.

The NSMC has also developed a practical tool, the 'Total Process Planning Framework', designed to guide health professionals through the five stages of creating effective social marketing interventions:

1. Scope
2. Develop
3. Implement
4. Evaluate
5. Follow-up

In some regions, the model was being 'widely used'; in others, it had been adopted by a small minority of projects. See Appendix 3 for further details of the Total Process Planning Framework.

> The NSMC has also developed a practical tool, the 'Total Process Planning Framework'

4.3 Support for social marketing

Support for social marketing within Primary Care Trusts

General commitment
Generally, researchers found a high level of commitment to social marketing, although one region pointed to a mismatch between levels of commitment and levels of capacity and funding. Commitment to social marketing is reflected in the fact that, in the majority of PCTs, social marketing was championed at either senior management or board level or both, and that a growing number of PCTs had already appointed or were planning to appoint people to dedicated social marketing posts. In one region, six social marketers were already in post, with plans in place to recruit a further six.

Several regions were taking a collaborative approach to social marketing, setting up frameworks, steering groups or units to review projects, ensuring consistency and reducing duplication. Findings from the review suggest that, in future, more and more regions will be putting frameworks in place and developing strategic plans with the aim of embedding social marketing within their work in a consistent and systematic way.

Champions
The vast majority of respondents in all ten regions agreed that social marketing was being championed at a senior level — often board level — within their organisations and levels of awareness were high. Often, those acting as champions were Directors of Public Health and Directors of Communication, but interviewees also cited the following roles:

- Directors of Engagement
- Senior managers working in public health or communications
- Individuals working in commissioning and patient and public involvement

Where social marketing was championed by more junior staff, they often found it very difficult to exert sufficient influence to push social marketing up the agenda. In some cases, their lack of seniority was compounded by a lack of knowledge and experience.

Sometimes, social marketing budgets and projects were led by someone other than the social marketing champion. Respondents in one region suggested that this could contribute to a situation where the champion was committed to the idea of social marketing, but lacked knowledge and understanding of how to use it effectively. In another, respondents expressed concern that, although they had a champion, social

marketing had yet to be 'institutionalised' into their organisation, and suggested that champions might be supporting public engagement, rather than social marketing.

Where social marketing sat in Primary Care Trusts
Social marketing sat in a number of different places. Most commonly, it was handled by either public health or communications directorates or, in a significant number of PCTs, by both. In one region, it sat within the patient and public involvement directorate. Several regions talked about social marketing being a shared responsibility; in one case, between the public health, communications, commissioning, engagement and strategy teams. While this could create useful opportunities to share expertise, respondents talked about the risk that, without an accepted home within the organisation, social marketing could end up being 'nobody's child'. One region pointed to a 'consensus' among interviewees that social marketing should sit within the commissioning team.

Training

The current picture
Most of the training provided to date had been delivered by the NSMC. This introductory training, consisting of two workshops, aimed to provide an overview of the general principles of social marketing. Most participants came from specific delivery teams, notably Stop Smoking Services, with the remainder mainly drawn from health improvement and communications teams. The programme was developed in the light of feedback from the National Support Teams (NSTs), who had identified a clear need for social marketing training based on PSA topics.

> Across the regions, there was significant variation in levels of both awareness of and participation in social marketing

Across the regions, there was significant variation in levels of both awareness of and participation in social marketing. In one, all public health and communications staff had attended the NSMC workshops. In another, training was described as 'ad hoc' and respondents claimed that only a 'handful' of staff had been given introductory training. In another, staff had not had access to the NSMC workshops and their only development opportunities had been occasional sessions at events and conferences attended by small numbers of people.

Respondents provided some examples of training run by independent providers, including 'masterclasses' and optional sessions focusing on specific topics or audiences. Three regions had run introductory sessions tailored to meet the needs of staff working on smoking cessation, perhaps reflecting the fact that this was the PSA target most commonly addressed by social marketing interventions. One PCT had commissioned a provider to deliver an advanced session on scoping. Some had run their own informal training in-house. Respondents cited a range of providers including government offices of the regions, SHAs and public health networks.

National training was funded by the NSMC. Regional or PCT-specific training was funded by the SHA, regional government office or the PCT itself.

The impact of training
Attendees agreed that the main benefit of training was heightened awareness of social marketing. In one region, 52 per cent cited greater awareness and 40 per cent said they had been able to apply their learning to a social marketing project. This was unusual, though. Generally, respondents were much more likely to say that they had not been able to put their knowledge and skills into practice. Only a small minority had applied their training to developing a social marketing strategy or commissioning social marketing services. One PCT observed that training had helped to build relationships between their communications and public health departments; an unexpected but welcome side-effect.

...some respondents expressed a need for further training in all aspects of social marketing...

Future training needs

Demand for further training is very high. The highest priority appeared to be practical training: guidance on how to apply the principles of social marketing to specific topics and issues. Linked to this was demand for training that incorporated case studies demonstrating the impact of social marketing initiatives. Despite the reasonably high uptake of general introductory training, some respondents expressed a need for further training in all aspects of social marketing, from scoping and development to implementation, evaluation and follow-up.

Other specific training needs included:

- understanding social marketing in the context of world class commissioning
- using social marketing to address health inequalities
- commissioning social marketing
- project management
- confidence-building
- influencing people

National Support Teams

All regions had had visits from the DH National Support Teams (NSTs). Typically, visits covered the following topics:

- tobacco control
- childhood obesity
- teenage pregnancy
- infant mortality
- sexual health
- health inequalities

Following NST visits, some PCTs had been prompted to start looking at how social marketing could help them meet their goals and to source appropriate training.

Working with outside agencies

In all regions, PCTs had involved external agencies in their social marketing activities. Often, this was for one part of the process only — usually scoping or generating customer insights — typically through focus groups. In at least two regions, though, there was evidence of agencies being commissioned to handle entire projects. It was felt that this might be acting as a barrier to the development of skills in-house. By contrast, one region cited a project which was being managed in-house by the PCT, with an external agency acting as mentor.

Several regions also stated that working with outside agencies had served to highlight the urgent need for training in procurement and commissioning. Staff were confused as to what agencies offered, lacked experience in managing external suppliers and felt uncomfortable about spending money on social marketing with 'no guarantee that it would work'. These staff wanted practical support, for example to draft briefs and assess tender responses, as well as access to a list of approved suppliers.

One region reported that agencies were targeting staff with 'products and services incorrectly branded as social marketing', pointing out that this could both threaten the development of a good understanding of social marketing, and lead to opportunistic rather than planned commissioning and procurement. Training would help equip staff to respond appropriately to these unsolicited approaches.

Local networks and partnerships

In almost all cases, social marketing activities involved some form of partnership working. Most commonly, this was with the local authority, but PCTs were also working with a wide range of public, private and voluntary sector organisations including: football clubs, community groups, youth groups, GPs, health workers, Connexions, local schools, acute care providers and private sector employers. Levels of formality varied. In one region, around half of all projects were headed by a multi-agency steering group; in most, such arrangements were in a distinct minority and partnership working took place on a more informal basis.

Most regions also cited a range of existing networks, which generally represented either a sector (communications, public health) or a topic (tobacco control, sexual health, obesity). There was little evidence of these networks engaging in social marketing, although one region stated that its public health network had provided some introductory-level training. The consensus was that there was an urgent need for social marketing networks at regional and local level, and that this would be best met by existing networks expanding their remit to include social marketing.

4.4 Resources

Human resources

As already described, findings showed that social marketing was being led – and championed – by PCT staff working in a range of areas and at different levels of seniority. All regions had either already appointed, or were planning to appoint, dedicated social marketers.

Financial resources

In 2008/09, the vast majority of PCTs had used money from other budgets — typically public health or communications — to pay for social marketing activities. For 2009/10, a significant number, though not a convincing majority, were planning to either set up a dedicated social marketing budget or to allocate specific funds to social marketing projects. This varied considerably from region to region: in one, all PCTs had identified money for social marketing projects for 2009/10 and in three-quarters of cases, this was specifically labelled as a dedicated social marketing budget; in another, just one out of eight PCTs had allocated dedicated funds, despite high levels of awareness and support for social marketing. Others intended to carry on using under spend or 'borrowing' funds from public health or communication budgets.

Actual levels of funding for social marketing varied widely. In one region, four clusters were planning to spend around £250,000 each on social marketing projects. One cluster had put in a bid for twice this amount. In another region, a PCT was planning to spend £1.4 million on social marketing. In another, 19 PCTs were expected to spend £30 million on social marketing between them over the next three years. The remaining four PCTs in the same region did not have specific budgets for social marketing.

In general, it was difficult to develop a clear, consistent picture of overall funding for social marketing. A significant number of respondents were unsure about arrangements in their own organisation. There are a number of possible explanations for this: that funding was coming from a variety of different sources; that the person commissioning social marketing was not necessarily the budget-holder; discrepancies in methods of calculation and what was included in costs; and responsibility for expenditure being split across a number of directorates.

> In general, it was difficult to develop a clear, consistent picture of overall funding for social marketing

4.5 Barriers to social marketing

Potential barriers

The following list provides a summary of the key barriers to developing and implementing social marketing, as cited by all or a significant proportion of the regions:

- **Lack of resources:** respondents were clear that effective social marketing required both time and money. Some public health staff described their frustration at not having discrete social marketing budgets and having other planned budgets diverted to pay for ad hoc social marketing projects. This ad hoc approach was also seen as increasing the likelihood of social marketing projects not being fully developed, implemented, completed and evaluated.

- **Lack of capacity:** at an individual level, respondents cited cases of social marketing being added to the workload of staff who were already at full capacity.

- **Lack of skills:** there was a clear unmet demand for further training. Even where staff had already received training, this was too often theoretical rather than practical, leaving them unsure as to how to apply their skills to real-world situations.

- **Lack of awareness and understanding:** misconceptions about social marketing remained. Respondents talked about the difficulty of working with colleagues who mistakenly believed that they were already 'doing social marketing'. One highlighted a possible correlation between lack of understanding and a lack of management engagement and support.

- **Yearly targets:** the need to meet yearly targets was seen as inconsistent with the generally longer timeframes needed to bring about lasting behaviour change. Respondents felt that the funding cycle made it difficult to plan long term and to take a strategic approach to social marketing.

- **Lack of robust evidence and case studies:** there was a strong call for evidence to show that social marketing could deliver results. Respondents also spoke about the difficulties in generating 'hard' evidence.

- **Structural problems:** respondents felt that structural issues, combined with the lack of a natural 'home' for social marketing, led to confusion and lack of ownership and created barriers to effective partnership working and sharing expertise and lessons learned.

- **Lack of support:** respondents wanted more support from senior managers and/or board members, and a proactive social marketing champion.

- **Cultural and ethical issues:** some respondents saw a conflict between the NHS' 'traditional top down approach' and social marketing, where the emphasis was very strongly on consumers. Some identified a mismatch between those commissioning services and their target audiences. Others were concerned that social marketing was 'too directional'.

- **External constraints:** these included an antipathy towards using agencies, and the difficulty of dealing with multiple stakeholders.

Other potential barriers cited by fewer respondents included:

- The cost of commissioning social marketing

- The tendency of local PCTs to see their own circumstances as unique and, therefore, not to share customer insights

- Relying too heavily on one or two 'enthusiasts' and outsourcing social marketing work to commercial agencies, so that skills are not being embedded within the organisation itself

See Appendix 4 for further details.

Conclusions

- Broadly, the findings from the reviews suggest that around a sixth of PCTs were fairly well advanced with social marketing activities and faced few barriers to its further development. Of the remainder, roughly equal numbers either had very low levels of experience and skills, or had some experience and skills but needed significant levels of targeted guidance and support if they were to derive maximum benefit from their social marketing initiatives.

- Across all regions, there was an encouraging level of enthusiasm and demand for social marketing. This was demonstrated in a number of ways:
  - through respondents' attitudes to social marketing
  - by the number of social marketing projects that were already under way
  - by the level at which social marketing was being championed within organisations
  - by the extent to which people were beginning to develop social marketing skills both through formal training and also from informal learning gleaned by working with colleagues, partner organisations and commercial agencies

- Commitment to social marketing was also underlined by the high number of PCTs that had already established — or were planning to establish — dedicated social marketing posts. It was further reinforced by the growing number that were allocating dedicated social marketing budgets for 2009/10.

- The reviews also showed that work was needed to embed social marketing more deeply within PCTs, in particular in directorates outside communications and public health.

- There was a need for better communication about, and a greater understanding of, social marketing. In particular, evidence of its impact and effectiveness.

- There was a need for senior board level commitment and proactive champions who could provide leadership and vision on social marketing.

- Among those responsible for planning, developing and implementing social marketing projects, there was a clear demand for practical support in the form of tools, resources and training.

Increasingly, PCTs were looking for guidance and support in all the above areas. The ten RDSMs will have a vitally important role to play over the next year in working with national, regional and local colleagues to build capacity, encourage best practice and help PCTs to ensure that their social marketing activities are as effective as possible.

> There was a need for better communication about, and a greater understanding of, social marketing

Recommendations

6.1 Overcoming barriers to social marketing

Each region had its own ideas about how best to overcome the barriers listed on pages 20 and 21 but, as with the barriers themselves, there was a high level of consensus.

The following provides a summary of the recommendations put forward by all or a significant number of respondents:

Embedding social marketing within PCTs

- Embed social marketing in strategy and in local, regional and national activities

- Increase capacity, for example by creating a roster of preferred suppliers, promoting the NSMC Associates Scheme, providing project management support, and building social marketing into job descriptions and core competencies

- Increase budgets for social marketing within PCTs

- Allocate more time for social marketing to be undertaken at local level

Provision of training and support material

- Raise awareness and encourage better understanding by using effective internal communications to 'market social marketing'

- Provide tailored training for staff at different levels and in different roles. There was significant demand for practical, topic-based training and training in procurement and commissioning (integrating the principles of World Class Commissioning). Coaching and mentoring to support training was seen as vital to ensure training is put into practice and was sustainable at working level

- Develop practical tools and resources to help health professionals develop and manage social marketing projects

- Make evaluation a priority and develop a robust evidence base. There is a clear need for case studies and other evidence to show that social marketing works

Networks and events to support social marketing

- Establish a social marketing network (possibly a virtual network) where health professionals and social marketers can share knowledge and experiences and access resources

- Set up social marketing steering groups/regional hubs with champions from each PCT

- Organise events and conferences for communications, public health and commissioning staff on the relevance and effectiveness of social marketing to their roles and working together to ensure best practice at all working levels

See Appendix 5 and Appendix 9 for further details.

Engagement considerations

7.1 Looking ahead

Following the regional review, each RDSM has developed a plan for embedding social marketing at regional and local level. These plans have been discussed with Regional Directors of Public Health, Communication leads, relevant colleagues and steering groups or forums before being compiled into this report. Whilst each region's plan and timetable is different, reflecting its own individual circumstances, there is once again broad consensus as to the priority areas for development.

> The first step will be to analyse training needs before developing a comprehensive training plan

Training and embedding skills on all aspects of social marketing is clearly the top priority across the regions. The first step will be to analyse training needs before developing a comprehensive training plan (to include coaching and mentoring as well as formal learning) and providing access to practical tools and resources (see Appendix 9).

Regions are keen to start increasing capacity for social marketing, for example by identifying and recruiting champions from within PCTs (where these are not already in place), and to establish agreed routes for sharing information and good practice.

Social Marketing Regional Development and Support Managers

The regional reviews which form the basis of this report will also provide a baseline for the work of the NSMC's ten Social Marketing Regional Development and Support Managers during 2009/10. The RDSMs' overall remit is to increase capacity for social marketing in their region by providing wide-ranging support tailored to local needs and priorities. That support is likely to include advice on training, identifying opportunities for joint working, providing practical help with commissioning and promoting good communication. The RDSMs will be responsible for reporting on progress to DH against these original plans in March 2010.

Appendix 1: Standard questionnaire

Below is the template questionnaire which was used with respondents for the Review of Social Marketing in Regional Public Health settings.

A. Interview information	
1. Region	
2. Regional Lead	
3. Interview undertaken by	
4. Date of interview	
5. Interview with (name)	
5.1 Job title	
5.2 Department	
5.3 Organisation	

5.4 Organisation type

☐ Primary Care Trusts	☐ SHA	☐ Government Office
☐ Local Authority	☐ 3rd Sector	☐ Private Sector
☐ Secondary Care Trusts	☐ Other Public Sector	

5.5 Main area of work

☐ Commissioning	☐ Public Health
☐ Communications	☐ Topic Lead
☐ Health Promotion	☐ Other

Notes if applicable

B. Social marketing – Knowledge and application

6. What do you understand by the term "social marketing"?
If they don't understand the term or have never heard of it, write down their response then give them a definition.

7. Do you feel there are barriers within your organisation to applying social marketing?

☐ External constraints

☐ Lack of a champion

☐ Lack of awareness / education / training

☐ Lack of capacity

☐ Lack of internal support / commitment from the Board or management

☐ Lack of resources

☐ Lack of skills

☐ Project timeframe vs. yearly targets

☐ Structural problems within PCT

☐ Other (please specify below)

7.1 What could be done to overcome these barriers?

☐ Clear objectives that relate to targets   ☐ Dedicated time

☐ Help to manage projects   ☐ Management buy in

☐ Money   ☐ Support within organisation

☐ Mechanisms to share & learn from best practice   ☐ Training

☐ Other (please specify below)

8. In your opinion, what are the strengths and weaknesses of social marketing?
If they haven't heard of it or have not grasped the common sense definition you gave them earlier, then skip this question.

C. Social marketing support and training	
9. At what levels do you feel social marketing is championed within your PCT?	☐ Board ☐ Senior management/director ☐ Operational management/ topic lead ☐ None
10. Prior to this interview / meeting, were you aware of the National Social Marketing Centre?	☐ Yes (Q11) ☐ No (Q12)

11. How have you made use of any NSMC products or services?

☐ Visited website   ☐ Attended training

☐ Downloaded resources   ☐ Used an associate

☐ Called for advice   ☐ Not at all

                                           ☐ Wasn't aware of any

12. Who in your team has had training on social marketing? *Roles, department (if nobody go to Q13)*

12.1 What was the title of the training and / or what was it about? *Notes if applicable*

12.2 Who funded it?	12.2.1 Who funded it?
12.3 Who delivered it? ☐ NST ☐ Brilliant Futures ☐ Dr Forster ☐ Healthy Weight Loss ☐ Barkers ☐ Demo site ☐ Don't know	12.3.1 Who delivered it? ☐ NST ☐ Brilliant Futures ☐ Dr Forster ☐ Healthy Weight Loss ☐ Barkers ☐ Demo site ☐ Don't know
12.4 When did it take place? ☐ Last 6 months ☐ Within the last year ☐ 2 or more years ago	12.4.1 When did it take place? ☐ Last 6 months ☐ Within the last year ☐ 2 or more years ago
How long was it? ☐ ½ day ☐ One day ☐ 3 days ☐ 5 days ☐ > 5 days	How long was it? ☐ ½ day ☐ One day ☐ 3 days ☐ 5 days ☐ > 5 days

12.6 Did the training make a difference?	12.6.1 Did the training make a difference?
☐ Yes ☐ No	☐ Yes ☐ No
12.7 If yes, how? ☐ Increased awareness and understanding ☐ Applied to project ☐ Included in strategy and commissioning ☐ Other (please specify)	12.7.1 If yes, how? ☐ Increased awareness and understanding ☐ Applied to project ☐ Included in strategy and commissioning ☐ Other (please specify)
12.8. If no, why not? ☐ Not relevant to my work ☐ Poor training ☐ Couldn't see how to apply it ☐ Didn't understand it ☐ Other (please specify)	12.9. If no, why not? ☐ Not relevant to my work ☐ Poor training ☐ Couldn't see how to apply it ☐ Didn't understand it ☐ Other (please specify)

13. Do you think there is a need for social marketing training in your team or organisation?

☐ Yes   ☐ No

13.1 If yes, what training do you think is required?

☐ Introductory level   ☐ Using / applying in particular areas
☐ Research/Insight/Scoping   ☐ Commissioning social marketing
☐ Linking to PSA targets   ☐ Other (please specify)
☐ Redesigning existing services using   ☐ Evaluating campaigns and interventions
☐ Social marketing techniques

Notes if applicable

14. How would you like to share and learn from best practice?

☐ Online   ☐ Dedicated events
☐ Forum   ☐ Network
☐ Publications   ☐ Masterclass
☐ Other (please specify)   ☐ Not a priority for me

Notes if applicable

Have you had a visit from the DH National Support Team?

☐ Yes (Q15.1)   ☐ No (Q16)

Were you offered advice or training about social marketing by the National Support Team?

☐ Yes   ☐ No

D. Current social marketing approaches and activity

16. Has your PCT had any social marketing programmes or projects running since June 2006?
Expect 3-4 examples, note a maximum of 5.

☐ Yes (Q16.1) ☐ No

16.1 How many?

16.2 Project name and main aims *List all the projects they can remember*	16.3 What was the name (and organisation) of the project lead? *Ask if they know phone no or email.*
SM Project 1	
SM Project 2	
SM Project 3	
SM Project 4	
SM Project 5	

17. What other marketing or communications projects have you run since June 2006? Please include public education campaigns, mass media campaigns, health promotion campaigns and other marketing or education initiatives.
Expect 3-4 examples, note a maximum of 5.

17.1 Project name and main aims *List all the projects they can remember*	17.2 What was the name (and organisation) of the project lead? *Ask if they know phone no or email.*
Non SM Project 1	
Non SM Project 2	
Non SM Project 3	
Non SM Project 4	
Non SM Project 5	

18. What is your PCT's budgeted expenditure on social marketing projects next year?
Note. Financial year runs Apr-Apr

☐ Less than £15 000 ☐ £15 000 - £50 000

☐ £50 000 – £100 000 ☐ £100 000 - £150 000

☐ £150 000 - £200 000 ☐ > £200 000

☐ Don't know ☐ Not willing to disclose

19. Do you have any other comments you would like to make?

Appendix 2: National Social Marketing Centre benchmark criteria

[French, Blair-Stevens (2006) adapted from original benchmark criteria developed by Andreasen (2002)]

1. CUSTOMER ORIENTATION

'Customer in the round'

Develops a robust understanding of the audience, based on good market and consumer research, combining data from different sources.

- A broad and robust understanding of the customer is developed, which focuses on understanding their lives in the round, avoiding the potential to only focus on a single aspect or features

- Formative consumer / market research is used to identify audience characteristics and needs, incorporating key stakeholder understanding

- Range of different research analysis, combining data (using synthesis and fusion approaches) and, where possible, drawing from public and commercial sector sources, to inform understanding of people's everyday lives

2. BEHAVIOUR

Has a clear focus on behaviour, based on a strong behavioural analysis, with specific behaviour goals.

- A broad and robust behavioural analysis undertaken to gather a rounded picture of current behavioural patterns and trends, including for both:
  - the 'problem' behaviour
  - the 'desired' behaviour

- Intervention clearly focused on specific behaviours, i.e. not just focused on information, knowledge, attitudes and beliefs

- Specific actionable and measurable behavioural goals and key indicators have been established in relation to a specific 'social good'

- Intervention seeks to consider and address four key behavioural domains:
  - 1: formation and establishment of behaviour
  - 2: maintenance and reinforcement of behaviour
  - 3: behaviour change
  - 4: behavioural controls (based on ethical principles)

3. THEORY

Is behavioural theory-based and informed, drawing from an integrated theory framework.

- Theory is used transparently to inform and guide development, and theoretical assumptions are tested as part of the process

- An open integrated theory framework is used that avoids the tendency to simply apply the same preferred theory to every given situation

- Takes into account behavioural theory across four primary domains:

  1: bio-physical   *2: psychological*

  3: social   *4: environmental / ecological*

4. INSIGHT

Based on developing a deeper 'insight' approach – focusing on what 'moves and motivates'.

- Focus is clearly on gaining a deep understanding and insight into what moves and motivates the customer

- Drills down from a wider understanding of the customer to focus on identifying key factors and issues relevant to positively influencing particular behaviour

- Approach based on identifying and developing 'actionable insights' using considered judgement, rather than just generating data and intelligence

5. EXCHANGE

Incorporates an 'exchange' analysis, understanding what the person has to give in order to get the benefits proposed.

- Clear analysis of the full cost to the consumer in achieving the proposed benefit (financial, physical, social, time spent, etc.)

- Analysis of the perceived / actual costs versus the perceived / actual benefits

- Incentives, recognition, reward and disincentives are considered and tailored according to specific audiences, based on what those audiences value

6. COMPETITION

Incorporates a 'competition' analysis to understand what competes for the time and attention of the audience.

- Both internal & external competition considered and addressed:

  – *Internal* - e.g. psychological factors, pleasure, desire, risk taking, addiction etc

  – *External* - e.g. wider influences / influencers competing for audiences' attention and time, promoting or reinforcing alternative or counter behaviours

- Strategies aim to minimise potential impact of competition by considering positive and problematic external influences & influencers

- Factors competing for the time and attention of a given audience considered

7. SEGMENTATION

Uses a developed segmentation approach (not just targeting), avoiding blanket approaches.

- Traditional demographic or epidemiological targeting used, but not relied on exclusively
- Deeper segmented approaches that focus on what 'moves and motivates' the relevant audience, drawing on greater use of psycho-graphic data
- Interventions directly tailored to specific audience segments rather than reliance on 'blanket' approaches
- Future lifestyle trends considered and addressed

8. METHODS MIX

Identifies an appropriate 'mix of methods'

'Intervention mix' = strategic social marketing

'Marketing mix' = operational social marketing

- Range of methods used to establish an appropriate mix of methods
- Avoids reliance on single methods or approaches used in isolation
- Methods and approaches developed, taking full account of any other interventions in order to achieve synergy and enhance the overall impact
- Four primary intervention domains considered:

  1: informing / encouraging　　　　　*2: servicing / supporting*

  3: designing / adjusting environment　　　　　*4: controlling / regulating*

Appendix 3: NSMC Total Planning Process Framework

A five stage process developed by the National Social Marketing Centre.

© copyright NSMC
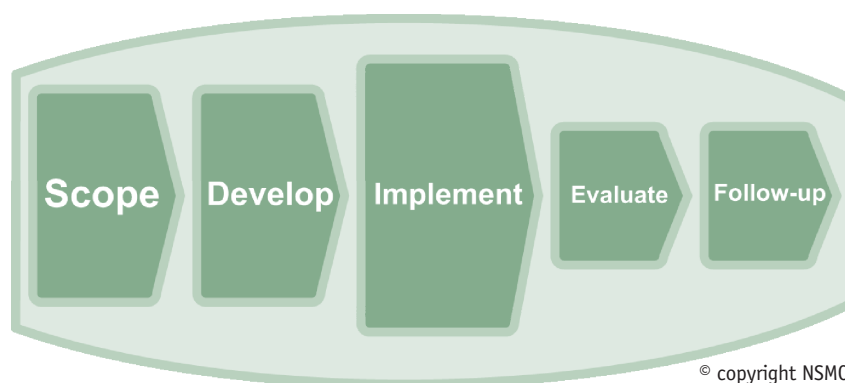
Activities within each stage are rarely sequential and usually involve a much more organic and fluid process.

Scoping

Undertaking effective scoping is a critical success factor. Key aspects include:

- Examining and defining the presenting issue(s) with key stakeholders/partners involved
- Reviewing and assessing potential 'customer' or 'audience' focus and rationale
- Focusing attention on specific behaviours (and groups of behaviours) – establishing initial behavioural goals
- Developing a proposition (ideas and options) for how to move from current behaviours to the desired or target behaviours

Activities are likely to include:

- Engaging stakeholders and partners
- Reviewing relevant evidence and practice
- Clarifying aims and intentions
- Developing customer insights
- Resources review
- Relationship to other interventions
- Intervention mix
- Considering ethical issues
- Audience segmentation and focus
- Potential behavioural focus
- Influences/influencers
- Developing behavioural goals
- Developing an initial 'proposition' to take into next Development Stage

Development

Testing out the proposition and developing a specific social marketing intervention – key aspects include:

- Examining a range of social marketing activity and deciding what 'social marketing mix' to use

- Undertaking primary development work and ensuring that secondary development 'pre-tests' and refines work

- Determining appropriate indicators and how best to verify

- Effective stakeholder involvement and 'priming' are critical success factors to any subsequent implementation

Activities are likely to include:

Primary: Testing out 'the proposition'

- Social marketing options and mix

- Potential incentives and barriers

- Segmentation and targeting

- Further refining aims and objectives

- Indicators of success and verification (short, medium and long term)

- Evaluation research design

- Creative development and design

- Message(s) where relevant to approach

Secondary: Pre-testing/refining/adjusting

- Testing concepts, approaches, and related messages with relevant audience(s)

- Scheduling and phasing action

- Stakeholder supports

Implementation

The most immediately visible stage of social marketing – key aspects include:

- Handling a 'live' and dynamic process that needs to be actively managed to ensure both:
  - Potential new opportunities arising from the intervention are identified and rapidly capitalised on
  - Potential issues and problems anticipated, or rapidly identified and addressed

- Maintaining effective stakeholder engagement is critical – ensuring that "the potential sales-force" are fully informed and are able to actively input to developments as they occur

Activities are likely to include:

- Commence interventions/campaign

- Active live monitoring

- Spotting other potential opportunities

- Tackling possible issues or problems

- Live adjustment and refinement

- Maintaining stakeholder engagement

Complete current stage
- Recording and capturing
- Feeding back, acknowledging and thanking!
- Inputting into developing evidence base

Evaluation

Dedicated to examining and reviewing the intervention – key aspects include:

- Evaluating impact, outcome, process and cost-effectiveness
- Determining the actual impact on specific behavioural goals
- Ensuring relevant stakeholders and partner input – utilising effective participatory evaluation

Activities are likely to include:

Impact
- Assessing achievement of aims and objectives using short, medium and long term indicators
- Audience(s) knowledge, attitudes and particularly behavioural goals
- Opinions of others - parents, opinion leaders, stakeholders
- Wider societal reactions e.g.: media coverage
- Identifying any unintended impact - positive or negative

Process
- Learning from how the work was undertaken - efficiency, effectiveness, equity, quality, engagement, management process, etc

Cost assessment
- Potential cost-effectiveness/cost-benefit

Follow-up

It is important to recognise this as a dedicated stage.

- Evaluation is often seen as the end stage of interventions. However, having a clear and dedicated follow-up stage is critical to ensuring short-term impact are built into on-going medium and longer term work
- The central purpose of this stage is to:
  - Actively consider the outcome from the evaluation stage (avoiding potential for findings to be left on the shelf)
  - To decide how best to capitalise on what has been achieved
  - To be clear about what remains to be achieved
  - To capture and record follow-on decisions to inform further scoping work for any follow-on activities
  - To directly inform further resource decisions for on-going work

Key activities are likely to include:
- Considering with stakeholders implications arising from evaluation
- Following up with relevant decision-makers and commissioners as relevant
- Capitalising on what achieved
- Following-up for medium and long term
- Reviewing in relation to other interventions (non-social marketing) outcomes
- Recording and capturing to inform any future scoping of work

# Appendix 4: Barriers to adopting social marketing
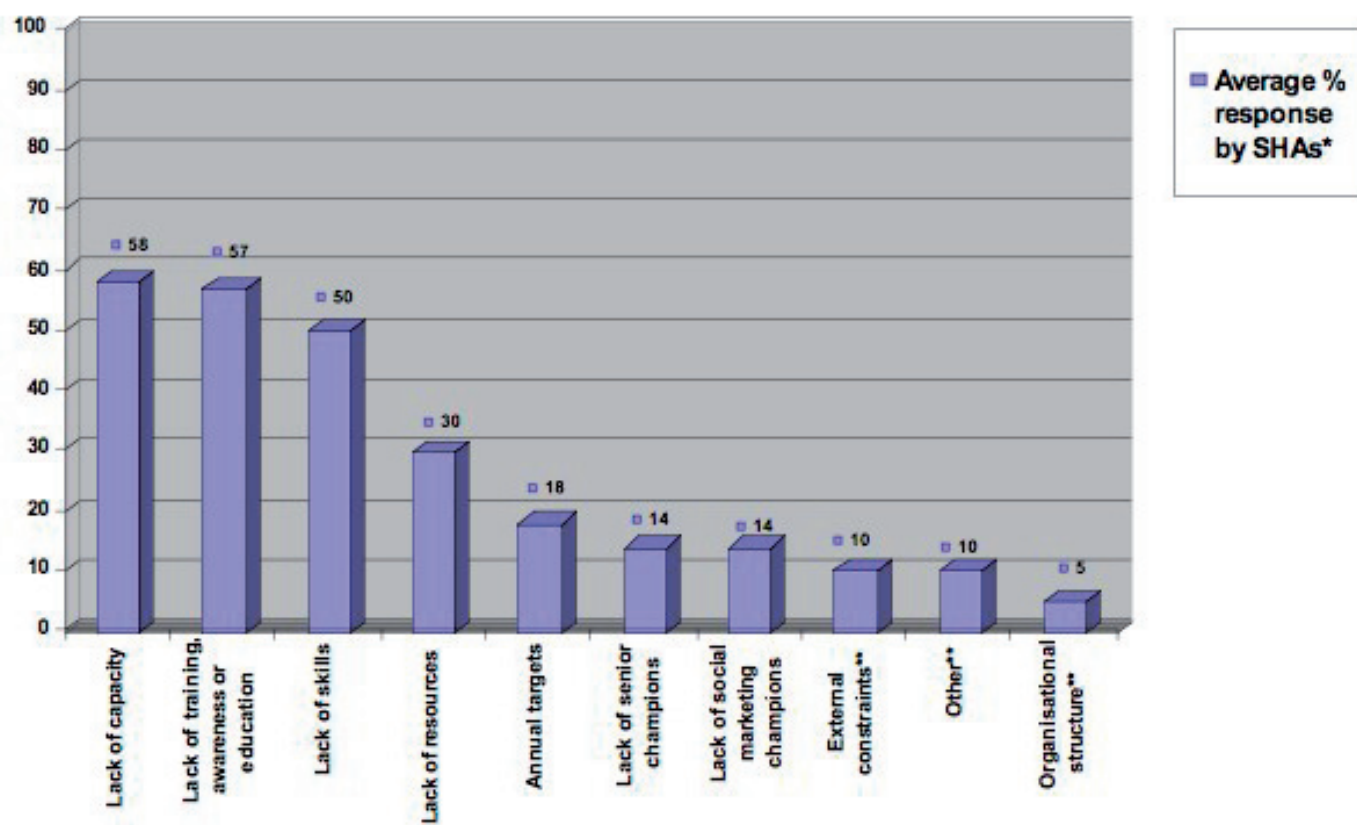
*All % based on average of responses of six SHAs (with exception of ** based on average of responses of five SHAs)*

# Appendix 5: Overcoming barriers to adopting social marketing
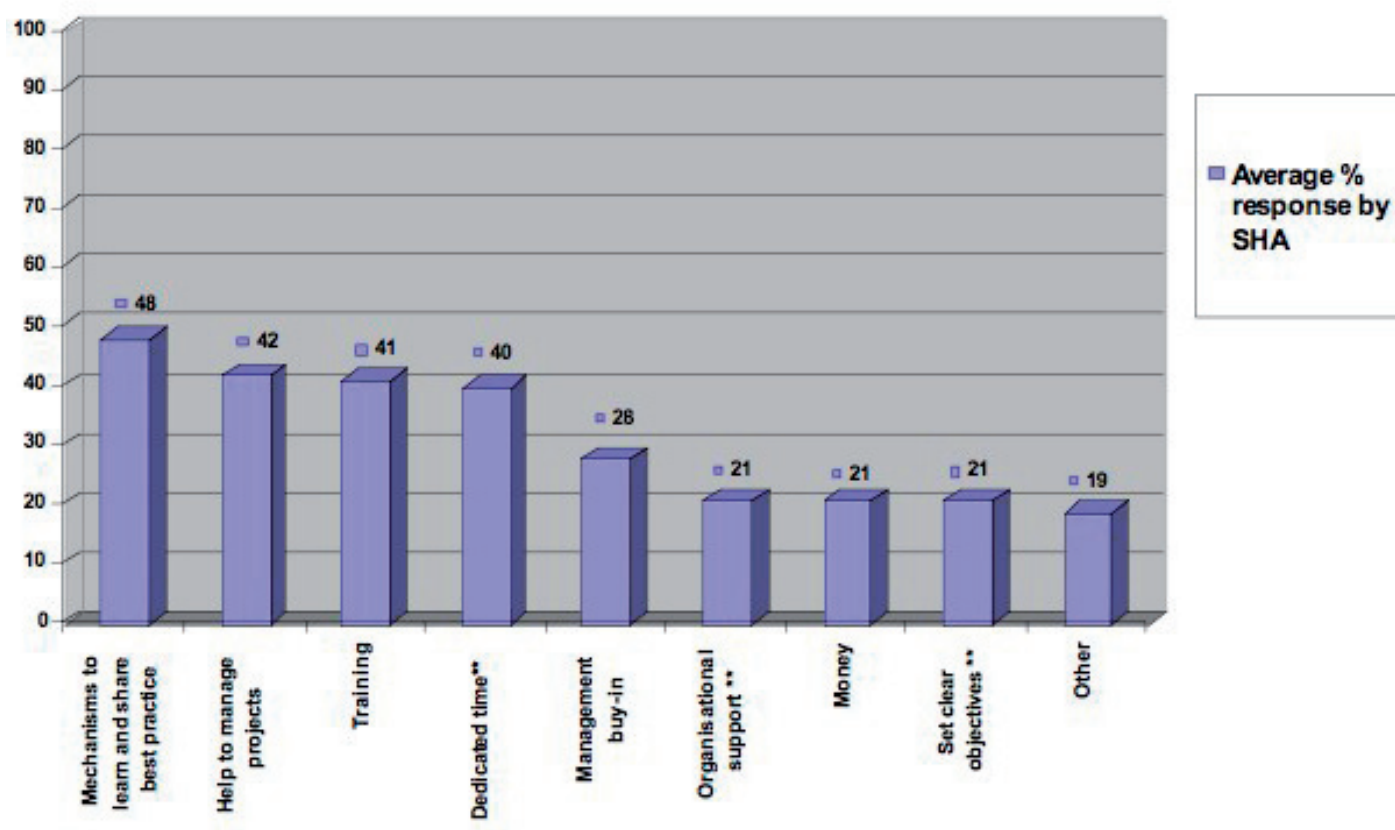
*All % based on average of responses of six SHAs (with exception of ** based on average of responses of five SHAs)*

Appendix 6: Levels of awareness of NSMC and use of NSMC resources
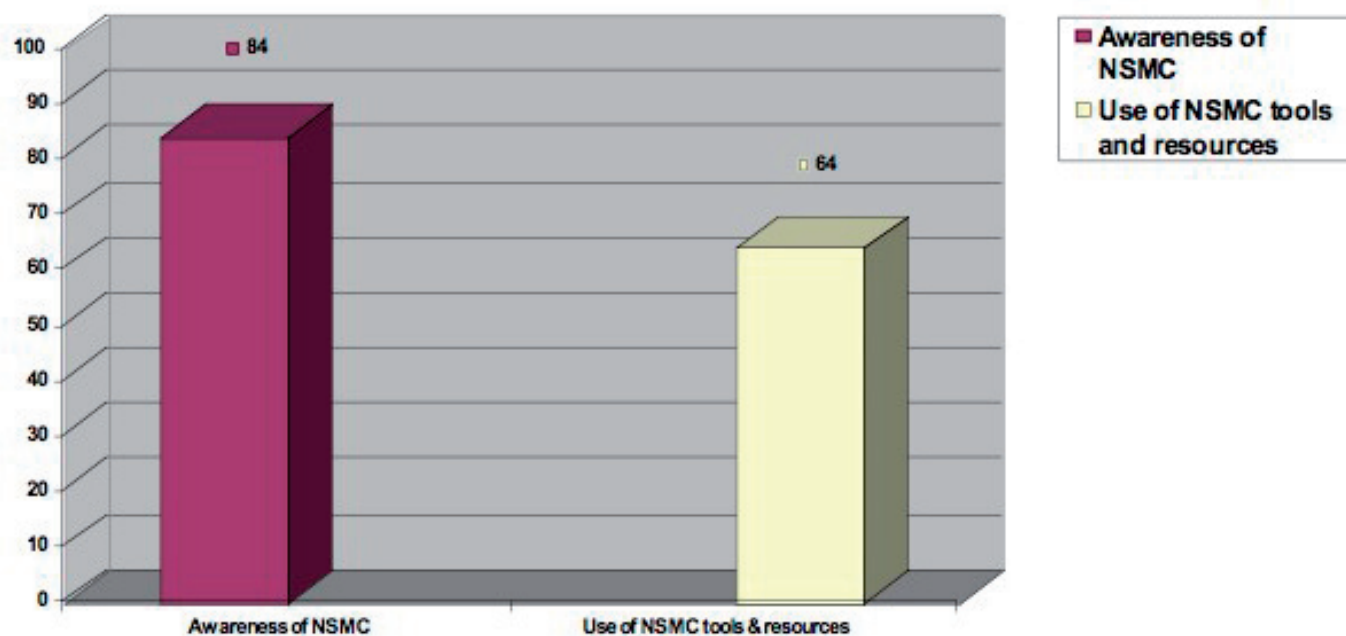
All % based on average of responses of seven SHAs

Appendix 7: Public Service Agreements (PSAs) covered by current social marketing activity
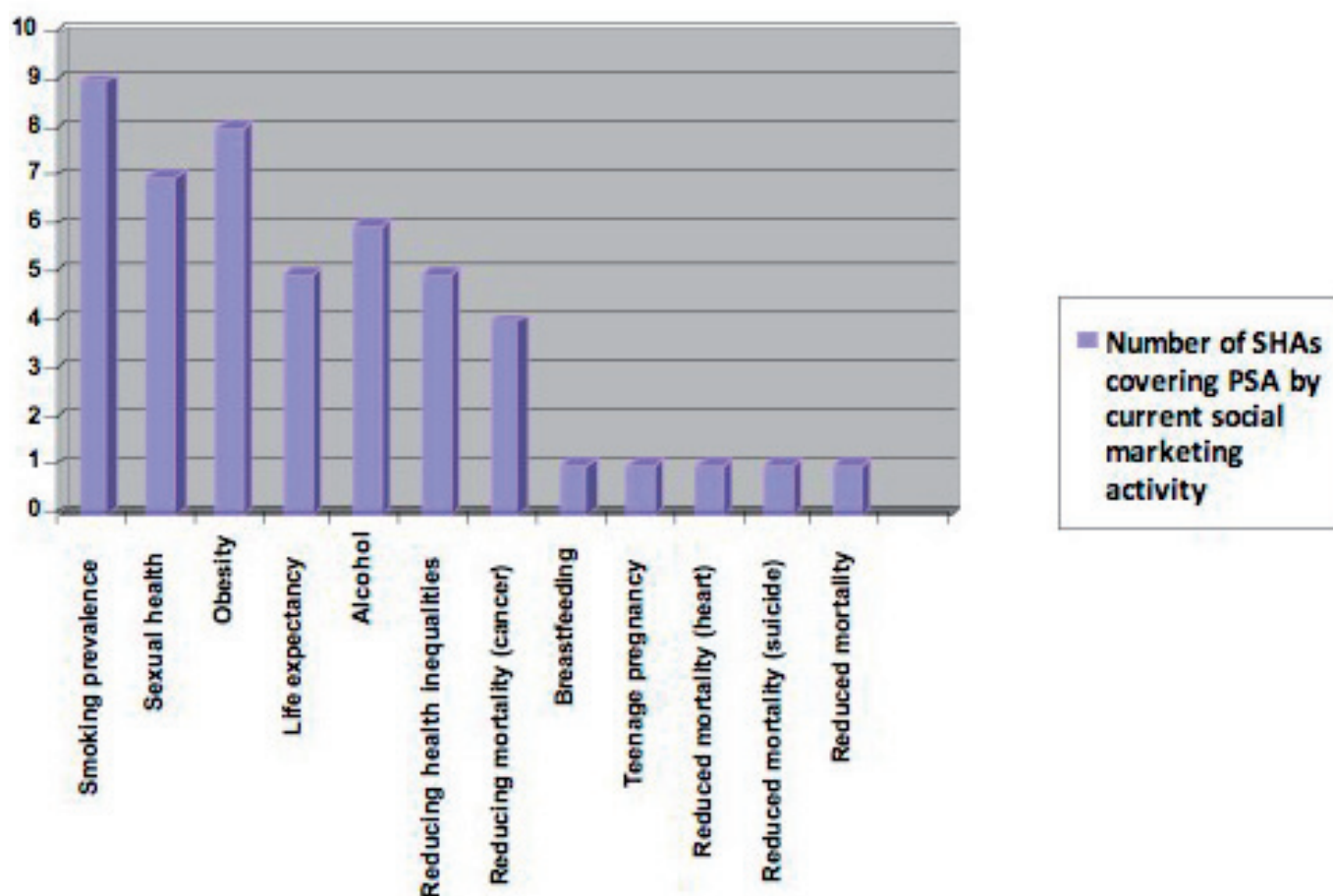
Based on data provided by the Central Office of Information in a review of ten SHAs in England

Appendix 8: Attitudes to social marketing

This appendix provides a range of responses (which have been anonymised) to the following question in the standard questionnaire (Appendix 1):

Question 8: In your opinion, what are the strengths and weaknesses of social marketing?

The responses have been divided into two main sections: Strengths and Sensitivities. Each section has then been divided into groups with common themes.

Strengths of social marketing

Support for social marketing

"Social marketing has to be one of our key responses to the challenges of Wanless."

"There are no barriers. We have committed within the PCT and the council to using social marketing as a major part of our strategies. There is a high level of support and some good programmes running already."

"The national strategy legitimises and recognises work that people have already been doing."

"It's using traditional marketing techniques but for social good... in a sense, marketing better health."

Social marketing as a planned process

"Social marketing stops us from grabbing at a solution too early on the process: this is when we get it wrong, because we haven't had the time to fully explore the issue and frame the problem. When we have used social marketing in the past, often the behavioural goal is not what we thought it was, or that we have never really understood enough about competition and exchange."

"A key strength of social marketing is that it can be embedded into the business plan"

Using social marketing for insight, understanding and segmentation of target groups

"We can reach and engage with people in a way that is attractive to them – often the hardest to reach groups."

"It forces us to recognise our audiences, focus our work, change our work rather than giving people a leaflet. It helps understand the difference between raising awareness and changing behaviour."

"[Social marketing] Puts us in touch with client groups we most need to work with. We can design services that most fit their needs. Not just one message fits all."

"[Social marketing provides a] Better understanding of our local population. It's more than just knowing how old they are and where they live – it is about finding out how they tick."

"It helps us reach people we wouldn't normally reach and focuses on services, not just promotion."

"Insight and exchange are new concepts to us, and are very useful."

Producing targeted, customer-focused campaigns

"It [social marketing] gives our customers a voice."

"We can stop doing SOS communications (send out stuff)."

"[Social marketing provides an] Opportunity to develop customer-centric services."

"It's about putting the customer at the heart of everything, using insight to deliver behavioural change."

"[Social marketing means we can] ... start with the customer and work backwards."

Social marketing to reduce waste and drive efficiencies

"[Social marketing helps with] Really targeting the right people, getting good value for money...not wasting resources."

"[Social marketing] Encourages a joined up approach between departments in the NHS – an elimination of silo working and more matrix management."

"[Social marketing] Concentrates resources rather than using a scattergun approach, therefore using fewer resources and wasting less."

Social marketing to help address health inequalities

"Using the intelligence we have to greater effect [through social marketing]. Really targeting health improvement services. Looking at what people do and how they live their lives and how best to reach them - especially those we don't reach."

"Social marketing is a good tool for ensuring we are reaching our hardest to reach communities and tackling health inequalities. It means we smarten up our approach, set really clear behavioural goals and we use more effective means to touch people. It means we also look at wider community approaches and influences, such as policy and organisational change."

"Targeted interventions that will tackle high areas of deprivation."

"Social marketing helps address health inequalities and those 'hard-to-reach' areas that we traditionally have problems with."

World class commissioning

"The strengths of social marketing are its fit with World Class Commissioning and its positioning alongside partnership working activities, like producing the Joint Strategic Needs Assessment. Social marketing means we can begin to use all the intelligence we have more effectively, to target more effectively."

"It [social marketing] can contribute to strategic objectives around world class commissioning."

Service redesign

"Using social marketing has made us realise we need to redesign our services."

Sensitivities around social marketing

Confusion about/ resistance to the term, 'social marketing'

"'Marketing social marketing' within the PCT is a priority. We need to make sure frontline staff understand what it means. The term 'social marketing' itself is a negative. Health workers have very negative connotations with marketing. We need to present it very carefully."

"It's just a new language for things we're already doing. It's the Emperor's New Clothes."

"Social marketing is really public engagement. We have been doing this for a long time. Social marketing is not really new."

"Not sure it's different from research....we've been doing it for years – it's called public health!"

"We've always done social marketing – it's just now trendy – it's about needs assessment and identifying gaps."

"'Some people mistakenly belief it's a magic bullet."

"'It's still confused with social advertising."

"Social marketing has some negative connotations within public sector staff who perceive it as commercial marketing and sales. Patients could also perceive social marketing as 'marketing', therefore expensive, commercial and not necessary."

Stronger evidence base for success of social marketing

"Needs to be a strong evidence base that those [social marketing] tools are making a difference."

"There is a lack of robust case studies, evaluation and proof that it works."

"Lots of people in the NHS don't believe in health prevention messages. People need to see evidence that social marketing works."

Too academic

"Social marketing is perceived as academic and complicated."

"[Social marketing is] Seen as an entity in itself rather than integral approach."

"The language [used about social marketing] is off-putting and too academic"

Too focused on research/scoping and not on interventions/delivery

"Social marketing is strong on analysis and weak on providing tools for delivery that we haven't already got."

"The challenge for social marketing is moving from research stage into action. There is too much navel -gazing done already and yet more research could lead to inertia."

Pressure on resources

"Labour intensive to do social marketing."

"The costs of commissioning social marketing. Can we afford it?"

"Not always possible to deliver customer needs [through social marketing] in a limited resource environment."

"A weakness is that it's expensive and takes up lots of time."

Need for specialist training

"Not enough expertise to do social marketing. Lack of expert knowledge."

"People are frightened of it – they think it needs 'experts' to do it for them."

Long timescales to deliver/funding cycles

"If you do it properly, you don't get instant results."

"The [annual] funding cycle makes long-term planning difficult."

Ethics

"Do we end up selling things to people that they don't want to buy?"

Need for better commissioning of social marketing

"Things are getting better, but to be honest, when we started using social marketing we didn't really know what we were doing. And the agency we engaged to help us to do it didn't know what they were doing either."

### Need to embed more widely within organisations

"Relationships between communications and public health not always well established – public health think it [social marketing] belongs to them."

"It has the potential to become 'ghetto-ised' just like communications, whereas everyone needs to be using it or have an understanding of the principles."
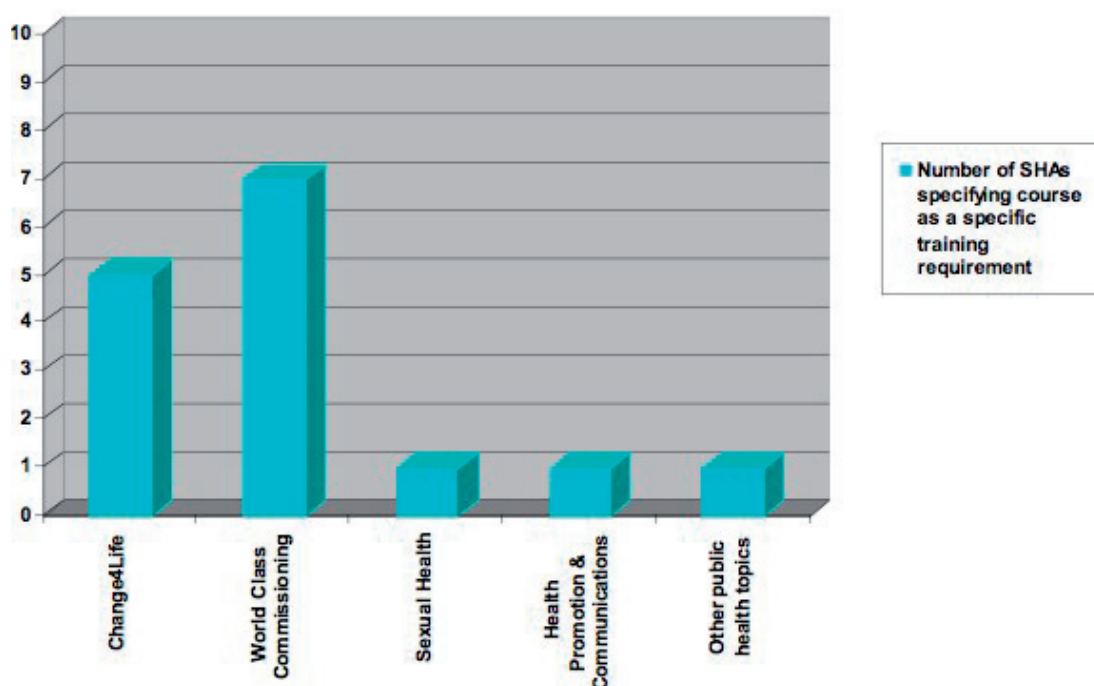
Appendix 9: Regional training and development requirements

These charts summarise specific training course and publication/toolkit requirements identified by respondents to the review.
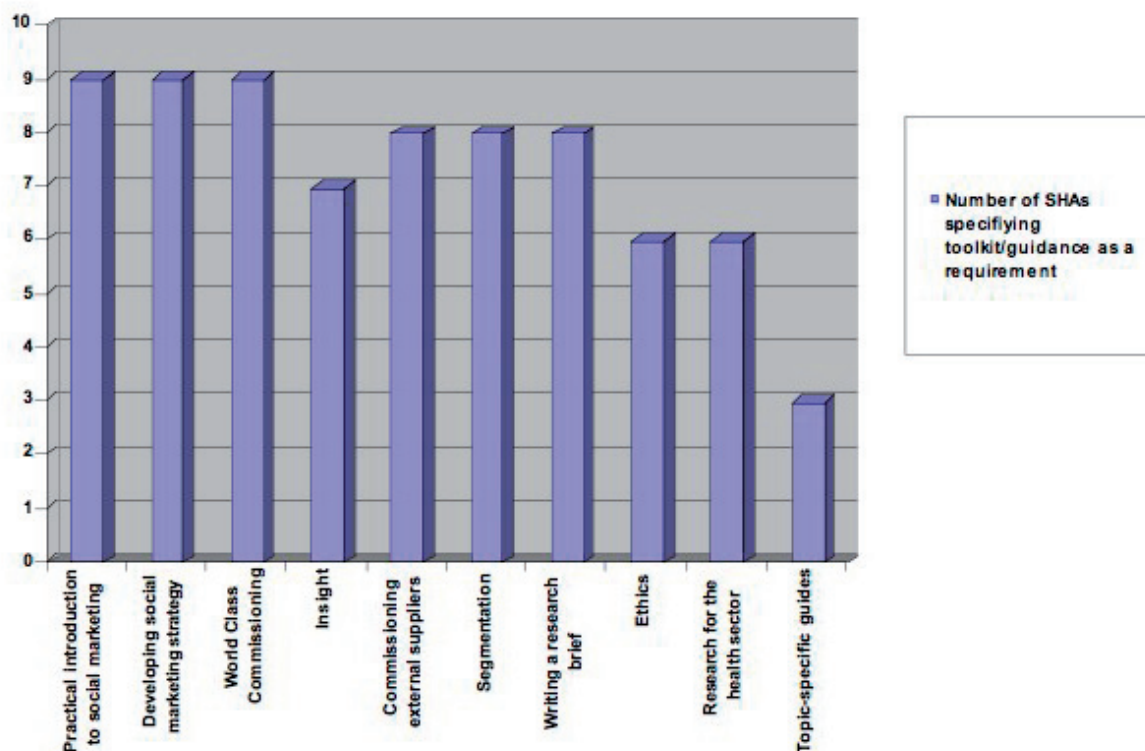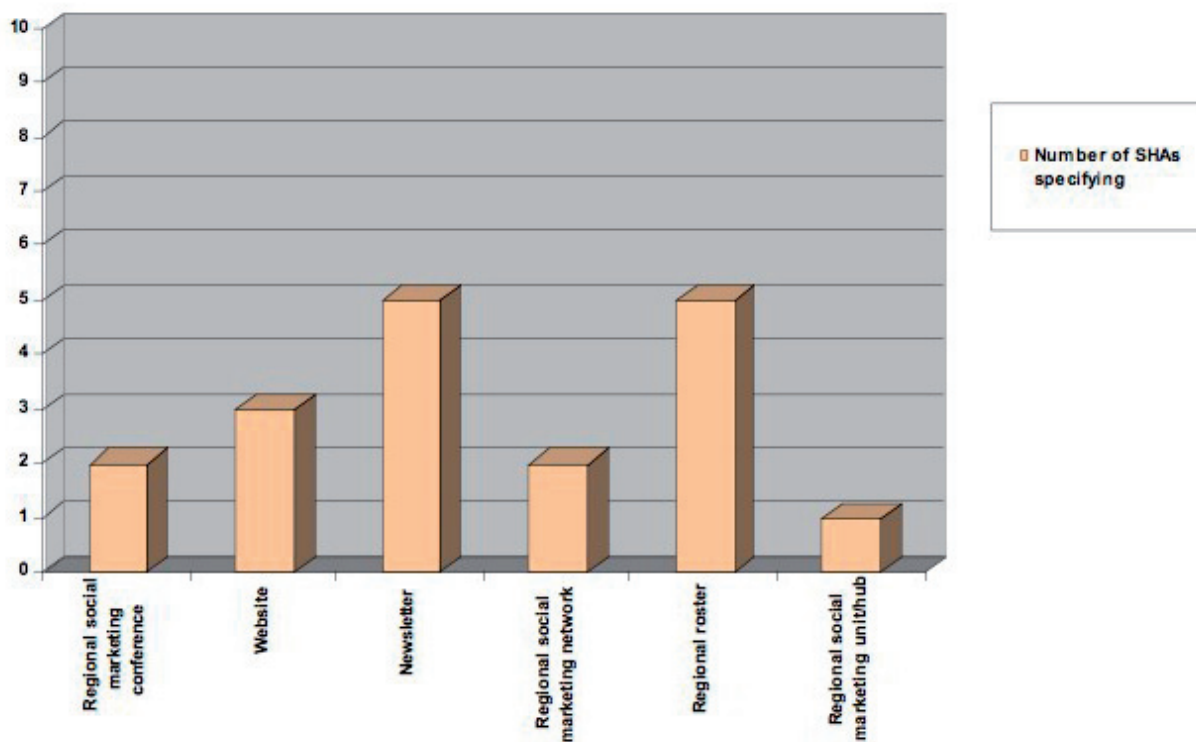
a) Regional training courses
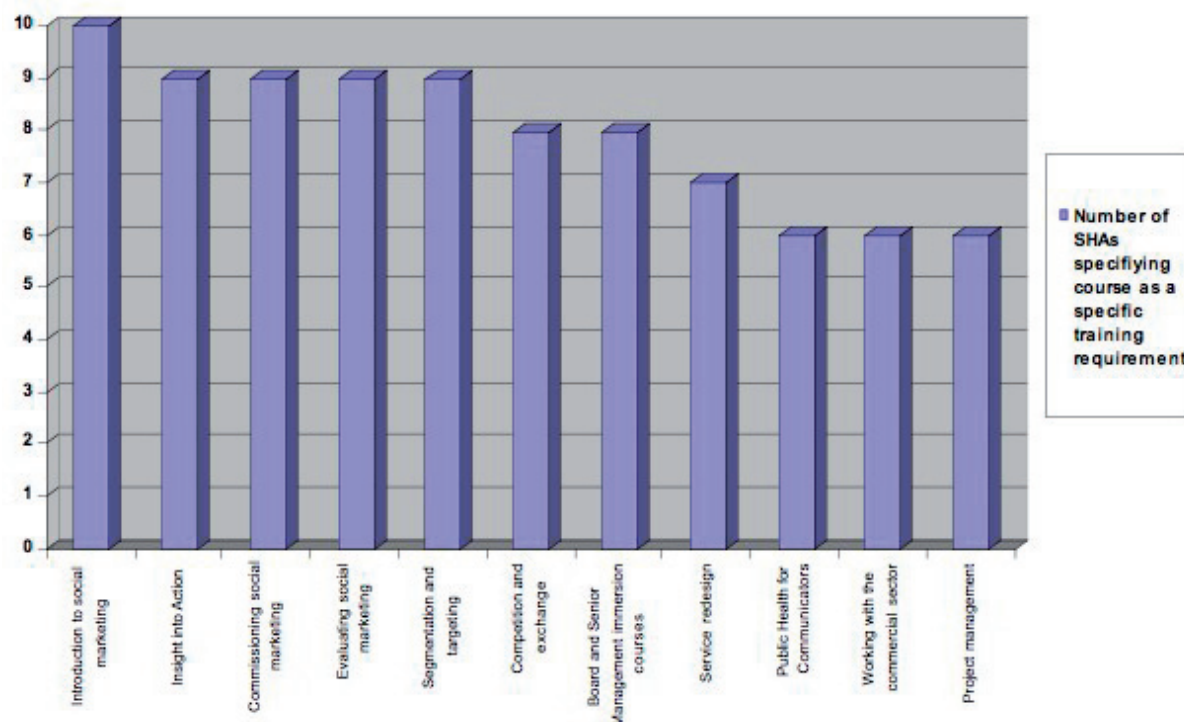
b) Topic-specific regional training courses

c) Toolkits and guides

d) Other resources and support

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