Changing Behaviour, Improving Outcomes

*A New Soci...
for Public H...*

Note:

This document is intended for social marketing and communications professionals working within the Department of Health and Public Health England, the NHS, local authorities, the COI and appointed agencies as well as policy colleagues across government, public health professionals and other interested parties.

We have tried to avoid the use of marketing terminology but this has not always been possible.

A glossary of common marketing terms is included in the appendices.

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Foreword

When asked what is important to us, most of us put our health either at the top or very close to the top of our list[1]. Good health ranks alongside friendships and family, as something that we feel we *need* to function fully and get the most we can from life.

When asked whose responsibility it is to take care of our health, we answer overwhelmingly that it is *entirely our own responsibility*[2].

Yet every day, most of us do at least one thing that we know will put our health at risk[3]: too many of us still smoke, drink more alcohol than we know is good for us, don't take as much exercise as we should, and eat too much of the "wrong" and too little of the "right" food.

Why is this? We tend to blame our lack of willpower and, certainly, this plays a role. We want to live well, but our good intentions can all too easily be overridden. But it isn't just about willpower. Overcoming ingrained habits and maintaining a healthy lifestyle is challenging, usually requiring not only personal motivation but support from those around us.

Poor health benefits no one: it reduces our life expectancy and hurts our families, it harms businesses through days lost to sickness, it costs the taxpayer through escalating healthcare costs and it places a burden on families, carers, charities and community groups. If we are to have the health outcomes we want as a society, we need everyone, be they individuals, families, communities, schools, businesses, civic institutions or voluntary organisations, to help us make this happen. In this sense, health is everyone's business.

Government cannot force people to adopt healthier lifestyles. However, it can help. It can give people information to help them make the right choices. It can help them engage with networks of other people with similar issues, and use digital channels to share information, seek advice and compare their behaviour and symptoms. It can bring together trusted partners, who can reach people in ways that Government can't, and who can themselves provide support and incentives, financial or otherwise, to make change easier and more affordable. Government can work with employers and schools to make healthier lifestyles more achievable and it can provide services and improve access to them. Finally, through insight and creativity, it can inspire us to change.

Today we are publishing the first over-arching social marketing strategy for Public Health England. This strategy outlines a radically new approach for how we propose to use social marketing through people's lives as part of a broader suite of measures to improve those behaviours that affect health outcomes.

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[1] For example, 80% of UK adults agree that "looking after my health is important in my personal life today". *Global MONITOR 2010*, The Futures Company.
[2] 84% of those surveyed agreed that "looking after my health is entirely my responsibility". Ibid.
[3] *Healthy Foundations*, 2007.

This strategy draws on the evidence of what has worked in the past, to focus resources in those areas where Government can do most to help people finally achieve the health that they value so highly.
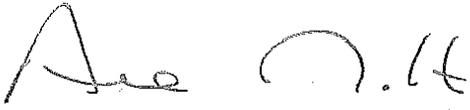
Anne Milton, MP

Parliamentary Under Secretary of State for Public Health

1. Executive summary

1.1   Despite people placing a high value on health and wanting to live healthy lifestyles, the majority of the adult population has at least one of the major lifestyle risks (such as smoking, regularly drinking more than the recommended limits, not being physically active and/or being overweight or obese) that can lead to poor health, increased cost to society and lives cut short[4].

1.2   Changing these behaviours is extremely challenging, often requiring not just individual motivation but sustained support from friends, family and society.

1.3   The Department of Health and the local NHS have pioneered the use of social marketing to change health behaviours, with some considerable success, particularly in areas such as smoking (Smokefree), stroke (FAST) and obesity (Change4Life).

1.4   Social marketing borrows concepts and techniques from commercial sector marketing, such as insight generation and customer segmentation, and applies them to the problems facing our society.

1.5   Without social marketing, there is a risk that people will not attempt the substantial efforts required to improve their behaviours or that attempts to change will fail in the face of ingrained habits and negative market forces.

1.6   However, changing times challenge us to be more creative, more efficient and more innovative in the way we use public resources. This is a time of great change in the way ordinary people access information. New technologies are enabling people to build new networks, create content and share ideas as never before. Public health campaigns can become part of the social currency, so that our target audiences do not just receive our messages, but identify themselves with them, so that they wish to share them with their network.

1.7   This is also a time of great learning and experimentation for the entire marketing industry, as insights from behavioural sciences, popularised by books like *Nudge*, are applied to behavioural issues.

1.8   This strategy responds to the changing political and economic climate to propose a new approach to how marketing will be used to influence health-related behaviour. It also draws on the evidence of what has worked to date, as well as setting up a programme of pilots to establish an evidence base for newer ideas, many of them emerging from behavioural sciences, to change behaviours.

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[4] 71% of adults in England report at least one of the following: being overweight or obese, smoking, regularly drinking above limits, drug abuse or unsafe sex. Source: *Healthy Foundations* dataset, 2007.

1.9   This new approach will be different in that:

- It recommends far fewer social marketing programmes, prioritising those where there is evidence of efficacy.

- With the exception of the smoking (and, when appropriate, health protection campaigns, such as a flu pandemic), we propose to end central single-issue campaigns, instead taking a life course approach through which a trusted brand will deliver support on all topics that are relevant to a person at that stage.

- More will be done at a local level; the centre will do only those things which it alone is best placed to do .

- Emerging insights from the behavioural sciences will be explored to enhance existing programmes and design radically different marketing initiatives.

- Partners, community, charity, civic and commercial, will be encouraged to do more.

- While some advertising, such as the FAST stroke campaign and cancer signs and symptoms, is already resuming, we recommend a shift away from traditional mass media channels, towards those channels government already owns, such as government websites and poster sites in government buildings.

- There will also be a radical step-change in the way we use new technologies, including social media.

- Where our campaigns enter into frequent and regular communications with people, we will test ways of migrating these into digital channels.

- We will work with the Cabinet Office to pilot a payment by results approach in appropriate areas.

1.10   Social marketing will support the approach to improving public health set out in *Healthy Lives, Healthy People* and the draft indicators published for consultation in the Public Health Outcomes Framework

1.11   In order to best support these indicators, the strategy recommends that the centre fund no more than four programmes, the four being (in order of size):

- The Smokefree programme.

- Change4Life (and its sister brand, Start4Life) which will tackle all issues relating to families and middle-aged adults.

- One integrated campaign, which will take a more holistic approach to well being in later life. This activity will seek to empower older people (and, where appropriate their carers) to

seek prompt diagnosis and medical attention (for example through the cancer signs and symptoms campaign), and will challenge the expectation that loneliness, economic and physical inactivity, mental and physical deterioration and reduced quality of life are an inevitable part of the ageing process.

- A new programme, targeting young people, which will seek to influence behaviours, such as smoking, binge drinking, experimenting with drugs and risky sexual behaviours, which form part of a pattern of risk-taking in the transition from the child to adult self.

1.12   These four have been prioritised because they address those segments of the population who are greatest users of health services, because there is prior evidence that marketing can have an impact in these areas and/or because a strong case can be made that people's lifestyles are amenable to change.

1.13   Beyond this life course approach, Government retains an additional responsibility to provide authoritative national information on some topics, such as the health impacts of using illicit drugs or the harms caused by regularly drinking above the recommended guidelines, and will continue to do so.

1.14   Some of these topics, particularly NHS health protection messages including vaccination, do not fit naturally into the life course approach. Messages on these topics will be branded as NHS and will be communicated to all individuals and groups to whom they have relevance, regardless of the stage in the life course they may have reached.

1.15   Much of this information will be provided via help lines and websites, particularly NHS Choices. While we will continue to provide information, we will review what needs to be provided, consider what can best be done through other sources (such as charities) and look at ways to do this more efficiently.

1.16   As local areas take on responsibility for managing demand for local services, they will be encouraged to join up their activity with the four centrally-funded programmes, through the use of toolkits and free access to creative assets.

1.17   We will commit public money only where there is evidence that social marketing can change those behaviours that lead to improved health outcomes. In consequence, this strategy will be delivered with substantially less than the spend committed in previous years.

1.18   This strategy will have implications for how the marketing function is organised within the Department of Health, and for how this interacts with partner agencies and with the proposed Government Communication Centre (GCC), recommended in the Cabinet Office's Review of Government Direct Communication and the Role of the COI.

2. Introduction:
What is social marketing?

2.1   Health-related social marketing is the systematic application of commercial marketing concepts and techniques to achieve specific behavioural goals relevant to improving health and reducing health inequalities[5].

2.2   Social marketing borrows tools and techniques, such as insight generation and customer segmentation, from commercial sector marketing and applies them to problems facing our society. Within health, it is most often used to help citizens change their lifestyles (for example by making improvements to the diets, starting a programme of physical activity, giving up smoking or reducing alcohol consumption), although it can also be used in other ways, such as changing the way citizens engage with services.

2.3   Social marketing is only one tool that Government (and others, working in partnership with Government) can deploy, and indeed it has often been used in conjunction with other policy levers, such as legislation (as in the marketing campaign that accompanied the introduction of Smokefree England).

2.4   Government funded social marketing seeks to ensure that citizens:

- are engaged with their own health and wellbeing,

- understand how their lifestyle choices impact on their current and future health outcomes (and, in the case of parents, their children's health outcomes),

- can obtain sound advice about what constitutes a healthy lifestyle, and

- have access to appropriate services, products and tools to help them change their behaviour.

2.5   The rich body of research and insight developed through the social marketing process helps to ensure that people are at the heart of policy, communications and delivery.

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[5] French, Blair-Stevens, McVey and Merritt , *Social Marketing and Public Health*, 2010

An activity is classed as social marketing when it:

- Is based on real understanding of the target audience: who they are, what they think and believe and what they need.

- Uses insight to develop propositions that offer a real benefit for the audience, not just for the Government.

- Aims to achieve changes to resistant or persistent behaviours, not just to provide information.

- Applies vertically through the process: from understanding the problem and designing the solutions, to delivering and communicating products and concepts.

- Applies horizontally across types of intervention, and is not limited to narrow definitions of communications or marketing.

- Is embraced by all functions, roles and departments, focused on the behavioural goals of the target audience, not the internal structure or divisions of the providers.

Source: DH/NHS Social Marketing Review (*Oxford Strategic Marketing*, 2010)

3. Why there is a need for social marketing?

3.1   Public Health England's mission is to protect people from serious health threats, improving the health of the poorest, fastest.

3.2   The nature of public health has changed dramatically. In the mid 19th century, four out over every five deaths occurred before the age of 65. Today, more than four in five deaths are after 65.

3.3   The nature of health threats has also changed: infectious disease now accounts for only 2% of deaths. Most people now die in old age of non-communicable diseases such as circulatory (accounting for 34% of deaths), cancers (27%), and respiratory diseases (14%). Lifestyle changes, particularly reducing smoking rates and improving diets and physical activity levels, could prevent a substantial proportion of these diseases[6].

3.4   In consequence, the objectives for those engaged in public health have expanded: public health's origins were in ensuring clean water and fresh air in our towns and cities; its role is now expanding to include influencing the everyday habits of millions of people.

3.5   The indicators published for consultation in the Public Health Outcomes Framework (see appendix 2) demonstrate how the remit of public health is expanding further into areas such as social connectedness, health-related quality of life and self-reported wellbeing.

3.6   People value their health and most want to lead healthy lives. For example, 96% of mothers with children aged 2-11 agree that "eating healthily is important to my family"[7] and 63% of smokers say that they want to give up smoking[8].

3.7   Yet the majority (71%) of people have at least one of the main lifestyle risk factors (such as smoking, regularly drinking more than the recommended limits and/or being overweight or obese) that can lead to poor health outcomes[9].

[6] *Our Health and Well-being Today*, HM Government, 2010
[7] Change4Life tracking study, base line report, BMRB, February 2009
[8] *General Lifestyle Survey* (GLF), ONS 2009
[9] Analysis of the Healthy Foundations dataset

Prevalence of five key negative health behaviours (smoking, drinking alcohol above recommended limits, high BMI, drug abuse and unsafe sex).

	% of adult population
Report no negative health behaviours	29
Report at least one	71
Report at least two	28
Report at least three	6
Report at least four	1
Report all five	*

Source: Healthy Foundations, 2007

3.8   Looking more closely at the data:

- 21% of the adult population smokes and, while this had reduced by seven percentage points since 1998, the decline has been greater among high income groups, resulting in a widening of health inequalities;

- 61% of adults and 28% children are overweight or obese[10];

- 82% of men and 65% of women consume more than the recommended 6g of salt per day;

- fewer than 40% of adults do the recommended amount of physical activity;

- 23% of adults regularly drink more than the Chief Medical Officer's recommended guidelines;

- around 3.8% of girls under 18 become pregnant each year (the lowest levels for 30 years)[11];

- the prevalence of sexually transmitted infections continues to increase. Young people under 25 are the most at-risk, with the peak age for women being between 19 and 20 years and for men between 20 and 23 years. Of all the 15-24s diagnosed with an STI, around one in ten currently become re-infected within a year;

- the uptake rate for pre-school immunisations are slowly improving, although there is still considerable regional variation; uptake of the MMR vaccination still lags behind other childhood vaccinations at 82.9% (in 2010);

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[10] *Health Survey of England*, 2009 data
[11] ONS 2009 data.

- each year, around 70-75% of over 65s take up their flu vaccination, but only around half of clinically at-risk people under 65 do so[12] ;

- it is estimated that 5,000 lives could be saved each year if England met the European average on cancer survival rates. One requisite for achieving this would be people going to see their doctor sooner with common signs and symptoms of cancer[13];

- about a third of the population admit to taking illicit drugs at some point in their lives[14].

3.9   Some poor lifestyle behaviours are found together, for example, people who drink more than the recommended guidelines are also more likely than the general population (33.0% vs. 21.5%) to smoke[15].

3.10   These multiple risk factors are likely to extend beyond the arena of health. Many people who drink more than the recommended guidelines, eat a poor diet and smoke may also experience worklessness, financial problems, crime, housing difficulties and other problems. While this highlights the magnitude of the challenge, it also provides opportunities for Government departments to work together to deliver benefits that are felt across society.

3.11   Some of the behaviours we seek to change, such as getting a flu jab or a Chlamydia test, while they require a degree of effort, are relatively easy (and infrequent).

3.12   Others, however, involve physical and/or psychological addiction. Changing these behaviours is extremely challenging, requiring considerable personal motivation as well as sustained support. Smokers, for example, often make many quit attempts before succeeding in giving up smoking for good. If we want smokers to overcome repeated failures, we need to continue to reinforce the health benefits of quitting (and direct them towards more successful methods of quitting).

3.13   Even where no physical or psychological addiction is involved, changing an ingrained or established habit can still be hard. Many people go on diets or make resolutions to improve their eating or physical activity levels in January, only to slide back into previous bad habits, sometimes before the month is out[16]. Existing incentive structures can work against people's desire to live healthier lives. For example, many ongoing changes in the way we live our lives (such as the decrease in manual and increase in sedentary occupations, or price promotions for energy-dense food) tend to perpetuate poor lifestyles[17]. To ensure sustained change, people need motivation, ongoing support, immediate feedback and frequent reminders[18].

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[12] www.winterwatch.dh.gov.uk
[13] Richards, M.A. (2009) *The size of the prize for earlier diagnosis of cancer in England*. British Journal of Cancer; 101(suppl. 2): S125–9.
[14] Unless otherwise indicated, all data in this section are from *Our Health and Wellbeing Today*, HM Government, 2010.
[15] *Health Survey of England*, 2008.
[16] See the work of Professor Richard Wiseman, especially *Think A Little, Change A Lot*, 2010.
[17] *Foresight: tackling obesities, future choices.* Government Office for Science, 2007.
[18] See evidence reviews by the Cochrane Collaboration and the National Institute for Health and Clinical Excellence.

3.14   Government cannot force people to adopt healthier lifestyles. However, it can help. It can do this by providing people with products and tools to help them change their behaviours, by bringing together partners who can support them and provide incentives, financial or otherwise, to make change easier and more affordable.

3.15   It can also help people connect to networks of others who share similar problems and are trying to change (as in the Smokefree United virtual quitters club) and it can empower and support those public-spirited individuals (such as the 47,000 Change4Life local supporters) who are working, professionally or as volunteers, within their communities to help others.

3.16   The social marketing approach helps uncover insights into why people behave as they currently do and understand barriers, whether perceived or actual, to change.

3.17   Without motivation, there is a risk that people will not make the substantial efforts required to improve these behaviours or that attempts to change will fail in the face of ingrained habits and negative market forces.

3.18   Beyond the force of habit, marketing and communication is required for other reasons, including:

- Addressing low levels of understanding about what constitutes a healthy lifestyle (such as how to shop for, prepare and provide a healthy diet).

- Improving understanding of the impact of everyday behaviours have on future health outcomes (such as the lack of understanding that regularly drinking more than the recommended guidelines can cause cancer or that being sedentary is not just a risk factor for obesity but for many other conditions such as cancer and diabetes).

- Overcoming taboos and cultural reticence about discussing some behaviours (such as sex) and health issues (such as signs and symptoms of bowel cancer) and stigma involved in others (such as dementia).

- Building resilience and negotiation skills (particularly among young people, who may be pressured by their peer group to experiment with risky behaviours) and (among parents) skills for initiating conversations with their children about these behaviours.

- Providing trusted sources of sound advice.

- Buzz monitoring, seeding ideas and influencing social networks.

- Providing tools (such as quit kits, snack swappers and units calculators) to help people change their behaviours.

- Improving understanding of the signs and symptoms of common conditions, particularly cancer and stroke.

- Supplying communications products for local authorities, NHS and other service providers to communicate with the public.

- Creating branded programmes with which industry can join up, facilitating increased private sector funding of Government behaviour change programmes.

3.19   There is also some basic information that Government has a responsibility or duty of care to provide (such as effects of illicit drug use on health).

4. The evidence that social marketing works

4.1.   The Department of Health has a long tradition of using marketing and communications to influence behaviours. Its campaigns are among the most responsive in Government (as monitored by COI's Artemis[19] tool) and as a result, the department has built up substantial databases of citizens who have chosen to make positive changes to their behaviours. The two largest databases, tobacco and Change4Life, contain over 860,000 and over 525,000 citizens respectively.

4.2.   The people on these databases continue to interact with the campaign brands for substantial periods of time. For example, a mailing to a cell of the Change4Life database that had completed the initial profiling questionnaire (*How Are The Kids?*) with a follow-up questionnaire one year later, achieved a 28% response rate – the highest ever recorded in Government.

4.3.   Health related issues can inspire people to get involved, not only to improve their own lives, but to improve the lives of others in their communities. For example, over 47,000 public-spirited individuals have already registered to support the Change4Life social movement by helping others in their community. These people tell us that they spend an average of 19 hours per week on Change4Life related activity, which includes having conversations with people about diet, activity or weight, putting up posters, giving out leaflets or organising events in their local communities. This network includes childminders, teachers, healthcare professionals and volunteers, who are a valuable resource for encouraging social change.

4.4.   However, to have value, social marketing needs to do more than generate response; it needs to change behaviours and to do so in a way that is cost effective, relative to other ways of changing behaviour.

4.5.   There is evidence that social marketing changes behaviours.

4.6.   The Change4Life evaluation indicates that 30% of mothers with children aged 2-11 claim to have changed at least one thing in their children's diets and activity levels as a direct result of Change4Life. If the survey results are true nationally, this equates to over a million families. Basket analysis, carried out by dunnhumby, demonstrated that a sample of 10,000 families who had engaged with Change4Life did indeed make healthier purchase decisions (across a basket of 20 representative food groups), relative to a demographically comparable control sample[20].

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[19] COI's Artemis tool holds data for over 50 Government campaigns and enables Government departments to assess to cost effectiveness of their activities.
[20] *Change4Life: One Year On*, HM Government 2010.

4.7.   There are encouraging signs that social marketing campaigns deliver monetised benefits. In the case of the FAST campaign for stroke, an investment of £8 million delivered healthcare savings of £25million[21].

4.8.   In the case of smoking cessation, the Smokefree campaign generated 200,000 extra quitters, delivering a value of £1.5 billion, against a cost of £20million[22].

4.9.   While it would be wrong to extrapolate from these campaigns to all social marketing, there is enough evidence that well thought-out interventions can deliver good value for money.

4.10.   More detail is included in the Impact Assessment, published with this document.

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[21] Source FUEL.
[22] For more detail on these campaigns, see the Impact Assessment published with this document.

5. Target audiences

5.1.   The majority of health problems fall disproportionately on individuals, families and communities that have lower incomes and lower education levels; some (such as low levels of physical activity) also disproportionately affect particular ethnic groups.

5.2.   Wealthier, educated people with managerial jobs are more likely to have access to health information (for example via the newspapers they read or via employee wellness programmes), to seek out additional information (for example via websites) and to feel confidence in their own ability to use and act upon that information.

5.3.   While access to new technologies has been growing rapidly, there are still nine million people in the UK who have never accessed the internet. These people are more likely to be older, to have fewer qualifications and lower incomes than those who do use the internet[23]. In addition, there are 4.8 million people living in Great Britain who report that they never read or even glance through a newspaper. Moreover, 4.4 million report that they never watch any television news or current affairs programming. 785,000 people could be termed "information poor" in that they fall into both groups[24].

5.4.   In 2007, the Department of Health conducted a major piece of quantitative research and analysis, called the Healthy Foundations segmentation. This explored the relationship between health outcomes, environment and personal motivation[25]. The exercise generated five distinct cluster groups.

Healthy Foundations Cluster Map

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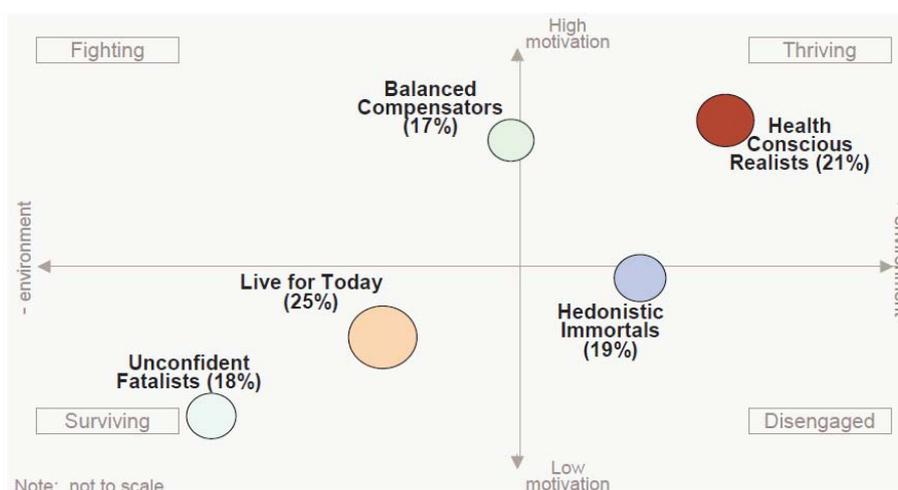
[23] 45% of people with no formal qualifications have used the internet vs. 97% of people with degrees. Source: National Statistics August 2010.
[24] GB TGI, 2009-10.
[25] For more detail, see *Ambitions for health: a strategic framework for maximising the potential of social marketing and health-related behaviour*, HM Government, 2008

5.5.   Two of these groups, "Unconfident Fatalists" and "Live For Todays" report both low personal motivation and an environment that is unsupportive of healthy lifestyles.

5.6.   The most challenged group, Unconfident Fatalists, tend to live in the most deprived areas and are the least likely to be in paid employment. They have higher than average smoking prevalence, higher incidence of obesity and overweight, are the least likely to take exercise, less likely to eat five portions of fruit and vegetables and most likely to have a high GHQ score (i.e. to report poor mental health)[26]. These are the people who would most benefit from lifestyle change. However change will almost certainly require more help and support than information alone can provide.

5.7.   For all people, different lifestyle issues (or combinations of lifestyle issues) occur through the life course, resulting in different needs:

Pre-natal and Pre-school: support relating to the early years, including immunisation, maternal health in pregnancy, smoking in pregnancy, smokefree environments, alcohol and drug use in pregnancy, education in PHSE, breastfeeding, weaning and active play.

School years: parents need support on family diet and physical activity, mental wellbeing (tips for raising a happy child), education in PHSE, smokefree environments, strategies for parents to help their children delay initiation into risky behaviours (smoking, sex, alcohol etc.).

Young people: a trusted source of information on subjects like drugs as well as support and resources to help young people negotiate the transition from their child to their adult selves, including resilience and negotiation skills around smoking, alcohol, drugs and sex.

Mid life: smoking cessation, responsible drinking, weight loss, diet, physical activity, tackling any poor sexual health issues, health and wellbeing at work, at-risk immunisation, planning for future needs.

Retirement: falls prevention, winter preparedness, increasing vigilance for the signs and symptoms of conditions like cancer and dementia, advice for living with conditions (including the impact of alcohol consumption upon those conditions), smokefree homes (for at-risk patients), smoking cessation, maintaining mental wellbeing, making best use of service, planning for future needs, such as end of life care.

5.8.   Beyond individuals and families, social marketing also works to change the behaviours of other audiences, such as opinion leaders, the media and front line staff.

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[26] For more detail, see *Ambitions for health: a strategic framework for maximising the potential of social marketing and health-related behaviour*, HM Government, 2008

6. What are the big insights we have into our target audiences?

6.1.   Changing health-related lifestyle behaviours is seldom easy. In 2010, Oxford Strategic Marketing identified ten universal insights, which can be leveraged to increase success levels[27]. These were:

Insight	Potential Leverage
People can feel powerless to change. However, if people can succeed in one area, they gain a sense of empowerment that can be used to inspire further changes.	Merge databases and pursue cross-selling strategy (e.g. contact successful quitters with offers about other lifestyle changes)
There is a universal belief that "it will never happen to me", especially among younger people.	Consider use of role models as credible witnesses
People live for today, preferring immediate benefits and discounting future negative health consequences.	Develop immediate and tangible rewards and incentives
There are a small number of teachable moments, when major lifestyle events (such as the birth of a first child; or diagnosis of a long-term condition) when people are more open to change and actively seek new information.	Use the communications channels of partners and intermediaries to reach people during these moments
People seek to conform to perceived social norms and will adjust their behaviour to fit in with what they believe other people are doing.	Trial communications solutions that challenge incorrect assumptions about social norms (for example that most people regularly drink more than the recommended guidelines)
People are more likely to start to modify a behaviour if they can make a series of small changes, rather than change completely.	Find ways to break behaviour changes into manageable "chunks" with mechanisms for transitioning people
People are prepared to make changes for others that they would not make for their own health.	Use the power of children as a motivator (and as change-agents within families)
In general, people respond to more positive, optimistic messages.	Place people at the centre of their own change, rather than lecturing; continue more positive tone established by Change4Life
People will not act if they are unsure of the outcome, or if they believe the treatment is worse than the condition.	Use partners, particularly the charities, to spread good news messages (such as improved cancer survival rates) so that people can see a benefit to them in taking the first step towards action
People delay seeking help, even when they notice change, whether because they do not recognise common symptoms of illness or do not feel entitled to access services.	Challenge the assumption that physical and mental deterioration is a natural part of the aging process, or should be accepted as the cost of previous poor behaviours

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[27] For more detail see *Health Improvement Social Marketing Strategy 2010-13*, Oxford Strategic Marketing, 2010.

7. Why there is a need for a new strategy?

7.1.   In its review of social marketing in the Department of Health and the NHS, Oxford Strategic Marketing identified seven flaws in the way marketing resources were being deployed across the system. These were:

- Over-prioritisation of primary prevention (smoking, drinking at harmful levels etc.) to the near exclusion of secondary prevention (such as early detection).

- Very long timescales for payback (whereas secondary prevention might pay back sooner).

- Duplication of resource, for example via the reinvention of insights, duplication of creative assets.

- Too much top down direction and too little local creation, resulting in a lack of local knowledge and local marketers either "cherry-picking" from national initiatives or generating their own ides.

- With the exception of Change4Life, a focus on single-issue campaigns, missing the opportunity to "ladder" people up from successfully tackling one behaviour, to changing others.

- A lack of coordination across Government.

- Failure to employ all marketing levers, particularly intermediary marketing.

This strategy responds to each of these seven points.

7.2.   In addition, the role of the centre is changing. By 2013, responsibility for public health (and with it public health social marketing) will be transferred into local authorities. The centre will not mandate how local authorities set about improving health outcomes and so it will be for local areas to decide whether they prioritise resources for social marketing campaigns in future. While we anticipate that local areas will eventually take a leadership role in the development, implementation and funding of social marketing, it is likely that local spending on social marketing will dip during the transition period. It will be crucial to work with local areas, whether NHS or local authorities, to enable them to join up what activity they can fund with national programmes in the least resource-intensive ways possible.

7.3.   Finally, the Department of Health supported over twenty social marketing campaigns in 2009. Some of these were below a threshold of spend at which they could reasonably be expected to have any significant impact on behaviours. Going forwards, we will focus on fewer

programmes, particularly those that have the scale to capture the public's imagination, are attractive to partners and can fund thorough evaluation.

Focus on Single Issue Campaigns
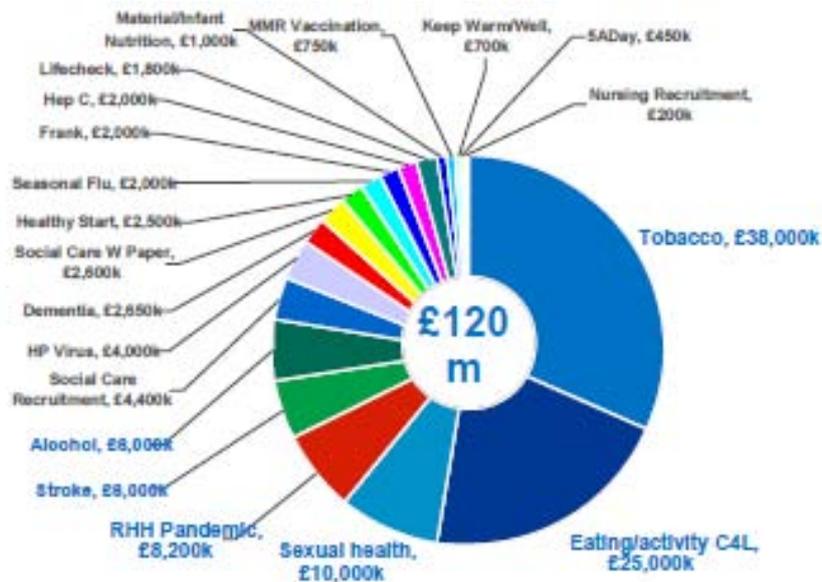
7.4. The example below illustrates the many different identities currently in use for the NHS Health Trainers programme.

Proliferation of brands at a local level: NHS Health Trainers

7.5.   While allowing each local area to each develop its own identity for Health Trainers was intended to reflect the "homegrown" nature of the programme and avoid a "one-size-fits-all" solution, in practice the locally-generated treatments are remarkably similar. On reflection, it would have been more time and cost-effective either for the centre to have produced an identity or for one local area to have developed an identity which was then available to others.

7.6.   This strategy sets some parameters for what should be done centrally, and what is best done locally, to avoid future duplication and waste of resources (see section 8).

7.7.   The Coalition Government has a clear intent to have fewer, more effective communications and a greater devolution of responsibility to partners, both civic and commercial, and is seeking to put more responsibility into the hands of local people. Good social marketing has always been centred on the needs of the target audience, but there is now an opportunity to involve local people and local areas more in the creation and implementation of social marketing programmes, for example via the establishment of local community "bid funds".

7.8.   There have been interesting new developments in the behavioural sciences, which are having a profound impact in the wider marketing community. Popularised by books such as *Nudge*, these ideas challenge us to think differently about how we influence behaviours. In the past, we have generally tried to change attitudes as a precursor or accompaniment to changing behaviours. While this feels intuitively right, it is troubling that, in health, people's behaviours so often conflict with their stated attitudes. By changing the choice architecture, for example by changing default options or changing perceptions of social norms, it may be possible to change what people do without necessarily changing their attitudes.

7.9.   Finally, the Cabinet Office has recently conducted a review of Government marketing and the role of the COI. The implications of this review for the way in which the Department of Health commissions marketing campaigns are covered in section 13.

8. Key principles for the new strategy

8.1. This strategy will result in substantial changes to social marketing, not only to the activity the public may see in future, but also to the way in which we organise ourselves, make decisions, obtain funding and assign budgets.

Summary of how this strategy will be different

There will be far fewer social marketing programmes, prioritising those that are proven to work.

With the exception of smoking, there will be no central single-issue campaigns. Instead social marketing will take a life course approach, through which a trusted brand will deliver support on all topics that are relevant to a person at that stage.

More will be done at a local level; the centre will do only those things which it alone is best placed to do.

Emerging insights from the behavioural sciences will be deployed to enhance existing programmes and design radically different marketing initiatives.

Partners, including commercial sector partners, will be asked to do more.

While some advertising is resuming, we will continue the shift away from traditional mass media channels, towards lower-cost channels and those (such as Government web sites or posters in hospitals and General Practice) that we own.

We will increase our use of social media, to enable people to build and join networks of others who face similar problems and to access, create and share information and ideas through those networks.

Where our campaigns enter into frequent and regular conversations with people, we will test ways of migrating these communications into lower-cost digital channels.

We will work with the Cabinet Office to pilot a payment by results approach in appropriate areas.

8.2   What Government will fund

8.2.1   Our approach to marketing is changing. In the past, we started with the question "how can the Government achieve this?"; in future we will recognise that others, often working in partnership with us, may be better placed to achieve our aims. The Department of Health, working with other government departments, will concentrate on those things which it is best placed to do, such as: the management of the national media owners; brokering relationships with national partners; developing common evaluation frameworks; managing campaigns that cross borders, (such as emerging and social media) and those where economies of scale or the use of common methodologies benefits all, such as negotiating contracts with call centres or the development and stewardship of a small number of brands which can then be used for free by local authorities and GP consortia.

Best done nationally, once	Best done locally and tailored to local needs
Strategic planning and insight generation	
Kick-starting an issue	Local needs assessment
Engaging national high impact media and partners	Driving individuals to local services, managing supply and demand
Buzz monitoring and social media	Identifying local key audiences and "hot spots"
Driving economies of scale	Engaging local community leaders
Acting as a planning and best practice hub	Engaging local healthcare professionals
Maintaining and strengthening core branded programmes	Collecting local data and sharing results

8.2.2   The centre will also take responsibility for ensuring that new developments in the public health evidence base and the implications of these, (for example changes to the Chief Medical Officer's guidance), are fed through to healthcare professionals, partners and local areas.

8.2.3   Communications and marketing will not be an assumed element of all policy initiatives. We will commit public money only where there is a measurable benefit to public health, with an emphasis on those programmes that have been professionally evaluated. Those programmes that are below a threshold where they can gain any serious momentum will be culled. In consequence, the central budget required for marketing activity will be approximately 40% of that spent in previous years.

8.2.4   Even allowing for efficiency savings, the reduced budget has necessitated prioritisation. We cannot afford to maintain all of the activity that we had in the past. We have focused our resources on campaigns that:

- Address the draft indicators outlined in the Public Health Outcomes Framework.

- Speak to people at those time in the life course (such as the formation of families) when they are the highest users of health services.

- Talk to people during key "teachable moments", such as starting a family or entering retirement, identified as most likely to lead to change.

- Tackle issues that are priorities across society, rather than for the health system alone.

- Where there is a duty of care or moral responsibility to provide information.

- Where the public expects and relies upon government information (as in the case of the recent pandemic flu outbreak).

8.2.5   We will move from predominantly single-issue campaigns, to an enhanced version of the model pioneered by Change4Life, whereby a single trusted brand delivers marketing and communications on multiple topics. This will deliver cost efficiencies, for example through shared agency fees, websites and call centres. However, the primary reason is audience-focused. Too often in the past we have held separate conversations with the same people, one day talking to them about their diet, the next about their alcohol consumption, without recognising that poor diet and drinking at higher risk levels are linked behaviours in an unhealthy lifestyle, reflecting deeper and shared problems. As announced in *Healthy Lives, Healthy People*, we will sequence our social marketing programmes through the life course, so that at every stage in an individual's life, there is a trusted source or brand, providing all the information, support and resources, he or she might need.

8.2.6   We will work with the proposed new Government Communications Centre (GCC) and with the proposed Government Communication Oversight Panel to ensure that health communications are included within the new themes for government communications, and aligned with Government strategy and priorities).

8.2.7   The exception to this life course approach will be tobacco. Smoking remains by far the single greatest cause of early death and preventable illness in England, by itself accounting for half of the difference in healthy life expectancy between the richest and the poorest people in society. Given the strong track record of the current approach, we will continue to support people's attempts to give up smoking through the Smokefree programme.

8.2.8   The implications of this approach is that there are some programmes and campaigns that DH will no longer fund centrally, for example:

- Communications to support the Healthy Start Programme.

- Separate communications for the 5 A Day programme.

- A HPV vaccination campaign.

- A Hepatitis C campaign.

- Communications to drive traffic to NHS LifeCheck tools.

8.3   Changes to how funds are deployed

8.3.1   During 2009, 55% of central marketing funds were spent on paid-for forms of publicity, such as advertising and sponsorship, much of this television advertising.

Use of marketing resources, 2009
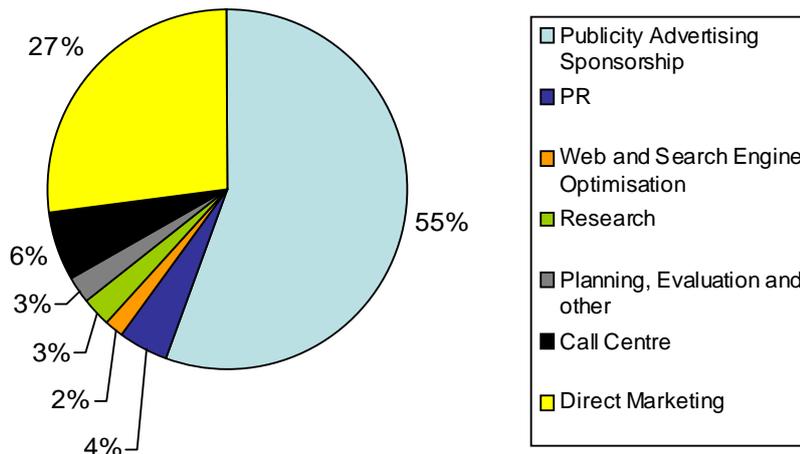
8.3.2   Following the coalition government's freeze on non-essential marketing expenditure, all social marketing programmes were reduced and expenditure on advertising all but ceased.

8.3.3   We have now had the opportunity to learn from the freeze and to assess where the loss of mass communications had a negative impact. For example:

- the number of people joining Change4Life fell by 80%. Calls to the Change4Life information line fell by 90% and web visits by two thirds;

- calls to the FRANK help line fell by 22% and web visits by 17%;

- visits to the Smokefree website fell by 50% The volume of people making a quit attempts also fell, in line with the reduction in purchased media spend.

8.3.4   Evidence submitted to the All Party Parliamentary Group on Smoking and Health concluded that the cessation of marketing activity has resulted in declining quit attempts and subsequent loss of life from smoking-related illness.

"There is good reason to believe that smokers still require information on the urgency of stopping and best ways of achieving this and it is clear that awareness-raising remains an important way of influencing behaviour. Evidence shows that in recent years total spending on government mass media campaigns in a given quarter is associated with smoking cessation activity in that quarter. If, as seems likely, this association is causal, the recent suspension of mass media campaigns will lead to significant loss of life and with every month that passes without further activity the death toll will grow."

(Professor Robert West, 2010)

8.3.5   We now recommend that some advertising, and other forms of mass communication such as sponsorship, paid media partnerships and PR, be resumed. However, this will be at lower levels and as part of a broader marketing mix.

8.3.6   Government is changing its relationship with the agencies, media owners and brands. As part of this, we are redefining our relationship with media owners from a model where we purchase their space or air time, to one where there is greater reciprocity. In the new model, government-generated content should have real value to the media owner. A pioneering example of this would be the Change4Life "Great Swapathon", which leveraged value from News of the World, Asda and major manufacturers. This model embraces a mixed economy approach where we can reciprocally share customer information with media partners to common better effect.

8.3.7   In addition, the recent Cabinet Office Review of Government Direct Communications and the COI announced that Government will invite agencies, media owners, and voluntary and community organisations to join with it in forming a Common Good Communication Council (CGCC), which will invite bids from providers to work for free or near free on campaigns for the common good. We will watch the development of the CGCC with interest and will explore the potential for some of our messaging to be developed and carried through this scheme.

8.3.8   Many of the behaviours we seek to change require continued support and reinforcement. In the past, much of this reinforcement was provided through information and other resources, mailed frequently to the target audience. Many of our most successful case studies involve this form of engagement. However, it is expensive and it is often (although not always) uni-directional, with limited opportunities for people to enter into a dialogue, either with us or with other people who are also trying to change.

8.3.9   In recent years, penetration and use of mobile phones, digital media and social networking sites has increased rapidly among our core target audiences. The Race Online 2012 initiative aims to accelerate this trend and further reduce digital inequality.

8.3.10 New technologies enable us to reach our target audiences in new ways, to amplify our current messages and to target small and discrete groups of people

8.3.11 Unlike traditional media, digital is not a monologue: it enables instant and ongoing dialogues. This enables the user to engage in communications on three distinct levels of dialogue, each of which is relevant for Public Health England:

- Private: securely encrypted communications are passed between parties, allowing transmission of information that is sensitive.

- Personal: customised communications are sent to individuals.

- Public (social media): communications are shared in an unrestricted manner, with the express intention that others may read and share the content.

8.3.12 Social media channels also enable us to rapidly disseminate messages to our networks of supporters (for example via our Twitter feeds).

Adults using the internet every day (Source ONS)
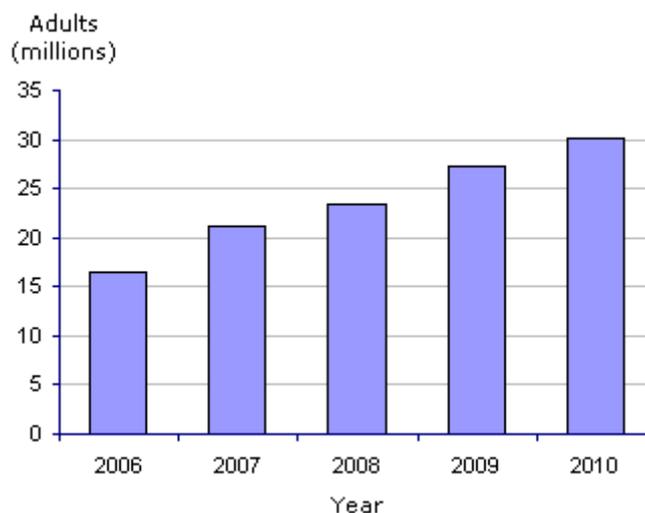
8.3.13 At its best, technology can empower citizens to make better decisions about their wellbeing for themselves (and their dependents), based on their own individual circumstances.

8.3.14 Technology also facilitates individual tailoring of information and presentation of choice based on personal circumstances.

8.3.15 Access to new technologies has grown so fast (as has the functionality provided by those technologies) that it is impossible to predict how people will be using them through the life of this strategy. However, at minimum, we would expect to see:

- increased use of social networking sites to connect with others, converse and share information (for example, in only a few months, the Change4Life Facebook page has grown to over 45,000 "fans", who, with minimal interference or moderation from the centre, discuss and swap ideas for healthier lifestyles);

- people expecting to be able to find information and tools where they choose to be, rather than at the brand owner's site (which will require us to create "white-labelled" tools that can be carried on or linked to from partner websites (as we began to do with the Change4Life Great Swapathon on line tool);

- greater use of on line and other technology platforms to access services (in only two years we have seen the proportion of people ordering a smoking cessation Quit Kit "flip" from primarily telephone ordering to primarily online ordering);

- the delivery of products and services through new technologies (a recent example of this is the Drinks App available on NHS Choices. Since its launch in December 2010, 197,000 people have downloaded the drinks tracker app to their iPhones[28]. This is impressive since, in the burgeoning market, only a small percentage of apps become popular. As we go forwards, we will use end-users in the design of our apps (user-centred design) and will build "social functionality" (such as the ability for users to rate and review our apps), since the best rated apps generally become the most popular;

- people joining together to use their power to access discounts (for example via Groupon), which will have implications for how we deliver partner-funded offers (it was a failing of the recent Change4Life Great Swapathon that people were not able to access partner offers online).

8.3.16 Developing our use of social media will be especially important for the youth programme and for families (recent ethnographic research[29] with low income families found that children were significant drivers of new technology within households and researchers witnessed children as young as three using their own laptop computers).

8.3.17 We should remember, however, that this increase has been driven not by websites offering information, but by those offering music, video, shopping, gaming, gambling and gossip, all of which offer a more interesting and stimulating user experience than most current Government campaigns.

Top 10 Wesbites Accessed by Lower Income Families, 2011[30]

1. Microsoft
2. BCentral
3. Google
4. Yahoo
5. Facebook
6. eBay
7. GlamMedia
8. Vevo
9. BBC
10. Viacom

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[28] Source :iTunes App Store.
[29] 2CV 2010.
[30] Source: COI. Definition of low income: adults under 44, with children in home and household income less than £24,999, socio-economic groups C2DE.

8.3.18 People can interact with us, access our services, share our messaging and our products throughout their networks, but the choice of whether to do so is theirs. If we want them to interact with us, we need to provide content that is rewarding and has value in their eyes. A good example of this was Change4Life's Let's Dance activity, which asked families to upload video of their children dancing with the prize of chance to train with Diversity. This attracted over 150,000 YouTube channel views and over 468,000 uploads viewed.

8.3.19 Many in our target audiences are kinaesthetic learners, that is they prefer to learn by doing, rather than by reading or listening. The interactivity that digital platforms afford provides opportunities to use digital platforms to influence behaviours, provided we make those platforms "sticky" enough.

8.3.20 Going forwards, we propose that Government form a network of talented designers, content creators and app developers to work with our target audiences to co-develop new tools based on the needs of the user.

8.3.21 These could include:

- Individual tools (to support individual responsibility), for example health checkers and monitors and data visualisation tools. For example, Change4Life's Walkometer app (used over 10,000 times) allowed users to input their daily exercise and see their output over time in terms of calories burned, steps taken or a distance walked. These tools can quantify change and reward people for that change.

- Group tools (recognising people's need for support) , enabling people to benchmark themselves against others, set goals and make performance against those goals visible to others.

- Aggregating tools, which sort through data to enable people to, for example, find their local park.

- Tools which provide access to expertise or appointment reminders.

- Games, which build health content into gameplay.

8.3.22 We should also explore the huge potential of social media as a mechanism for listening (for example via buzz monitoring) rather than for sending messages out to our audiences. Our Facebook pages are already providing a mechanism for garnering instant feedback on our brands and our activities.

8.3.23 Digital media have a propensity to propel issues into the mainstream that exceed their first-hand reach (as when the mainstream news picks up stories based on what high-profile individuals have tweeted.).

8.3.24 However, not all our audiences are yet using new technologies in this way. For other audiences, we will need to maintain more traditional channels for the time being. We will

therefore test and evaluate a strategy of migration, gradually reducing paper-based materials, sent via the mail, with digital fulfilment.

8.3.25 Using digital technologies will also enable us to create more and better tools that provide opportunities for interaction, co-creation, sharing within a social network and can provide rapid feedback on people's progress. These include apps to allow people to track their alcohol units or calorie expenditure, to calculate how much money they have saved since they quit smoking and share their experiences of quitting with their friends via Facebook.

8.4   Role of civic partners

8.4.1   From April 2013, responsibility for public health marketing will move to local authorities, as they take on overall responsibility for public health. While the centre cannot mandate that local areas prioritise funds for social marketing, our ambition will be that most activity will eventually be developed and implemented at a local level.

8.4.2   Within their new remit, local authorities and GP consortia will take responsibility for managing demand for local services, such as Chlamydia screening or local stop smoking services. While the centre will no longer be running this activity, we will give free access to proven national creative assets (such as Sex: Worth Talking About and FRANK) and will provide toolkits to allow local areas and consortia to adapt these materials as their needs change.

8.5   Role of commercial partners and NGOs

8.5.1   The success of this strategy will depend not only on how efficiently we deploy public funds, but also on how successful we are at attracting others, including the voluntary sector and industry, to support our programmes.

8.5.2   In the past, our approach was "How can Government achieve this?" In future, we will start from a presumption that others may be better placed to achieve our goals, often working in partnership with us.

8.5.3   Industry in particular has far greater marketing resources than the public sector. In 2009, our highest spending year for marketing and communication, only 7% of the marketing and communication on health topics was public sector funded; the commercial sector accounted for 90% and the charities 3%.

Total Media Spend on Health Topics, England 2009 (£m, % share)

Pie chart data:
- Public Promoters: 61, 7%
- 3rd Sector Promoters: 26, 3%
- Commercial Promoters: 255, 31%
- Commercial Competition: 473, 59%
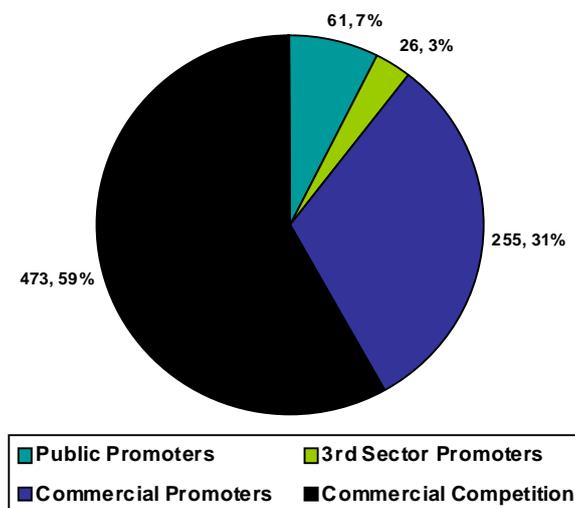
8.5.4 Historically, commercial sector resources were often used to promote behaviours (such as the consumption of foods high in fat, sugar and salt) that lead to poor health outcomes.

8.5.5 However, some sectors, such as the fitness industry, providers of weight loss services or manufacturers of nicotine replacement therapy, have commercial interests that naturally promote healthy behaviours.

8.5.6 Within the food and alcohol industries, some companies, recognising that their customers look to them for help in maintaining healthier lifestyles, have already begun to promote healthier alternatives and responsible consumption.

8.5.7 In response, government has started to work more closely with these companies, aligning their activity with publicly-funded campaigns through co-branded partnership marketing opportunities.

8.5.8 The contribution of partners to government marketing programmes has grown considerably. On Change4Life alone, commercial sector contributions grew from £9 million in 2009/10 to £12 million in 2010/11[31].

8.5.9 While it has been most conspicuous under Change4Life, partner support has also been evident in areas such as tobacco control, where the pharmaceutical industry, both manufacturers and retail, have recently become involved in the Quit Kit.

8.5.10 Partnership marketing is valuable not only for its financial contribution. Commercial brands often have trusting relationships with our key target audiences and can reach them in ways that we cannot, and that are closer to the behaviours we want to influence, for example via targeted offers as part of their loyalty programmes, through in-store signage or by putting nutritional information on restaurant menus. As part of the Public Health Responsibility Deal,

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[31] Source: COI.

commercial companies have recently made individual pledges, for example: to roll out Change4Life branding into 1,000 stores (the Association of Convenience Stores), to provide an additional £1 million to tackle alcohol misuse by young people (Asda), and to aim to remove 100 million units of alcohol from the UK market each year through lowering the strength of a major brand by 2013 (Heineken).

8.5.11 The majority of partner marketing takes the form of in kind contributions, for example:

- PepsiCo's advertising campaign in support of Play4Life

- Nintendo Wii Fit's co-branded activity in support of Change4Life

- In store price promotions from Tesco, offering money off fruit and vegetables

- ITV's support for Walk4Life, working with Walk England, British Heart Foundation and the Ramblers

- The Great Swapathon, a collaboration between Asda, News of the World and seventeen other manufacturers and physical activity providers

Partners also provide access to their customer insight, including access to market intelligence (such as sales data) for the purposes of evaluation.

8.5.12 However, we now need a step change in both the quantity and the nature of partnership marketing. We are beginning to explore other ways for partners to contribute to our programmes, for example via sponsorship of elements of key programmes, such as specific pieces of sub-branded activity within Change4Life.

8.6   Pioneering a different approach

8.6.1   In recent years, the fields of social psychology and behavioural economics have produced rich insights into why we behave as we do. These insights challenge us to think differently about how we engage with people in seeking to change their behaviours. In the past, we have most often attempted to change attitudes as a precursor (or sometimes as a companion) to changing behaviours. There are a number of examples where such techniques have been cost-effective and have built self-efficacy (for example, in the self-management of long-term conditions[32]). Yet we recognise that, in many cases, actual health-related behaviours do not align with stated attitudes or intentions. There is a growing body of evidence to suggest that it is possible to change behaviour by changing the context or environment within which we make decisions and respond to cues, helping people make better choices for themselves.

8.6.2   In 2010, the Institute for Government and the Cabinet Office produced their MINDSPACE report, which provided a toolkit for using behavioural insights in policy.

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[32] See www.expertpatients.co.uk.

8.6.3   This document identified nine key influences on behaviour, captured as the mnemonic "MINDSPACE". This can be used as a simple checklist for policy development:

Messenger	We are heavily influenced by who communicates information
Incentives	Our responses to incentives are shaped by predictable mental shortcuts such as strongly avoiding losses
Norms	We are strongly influenced by what others do
Defaults	We 'go with the flow' of pre-set options
Salience	Our attention is drawn to what is novel and seems relevant to us
Priming	Our acts are often influenced by sub-conscious cues
Affect	Our emotional associations can powerfully shape our actions
Commitment	We seek to be consistent with our public promises, and reciprocate acts
Ego	We act in ways that make us feel better about ourselves

8.6.4   A number of these insights have already been leveraged through Department of Health programmes, for example:

- **Defaults**: introduction of the national bowel cancer screening programme, such that people have to opt out of the test. This has increased the number of tumours being detected by 12%.

- **Salience**: providing relevant information at a key life stage, for example targeted smoking messages during pregnancy, and

- **Commitments**: the use of quit dates to form a public promise to give up smoking.

8.6.5   Others are currently being piloted, for example Change4Life social norming pilot, which seeks to establish whether messaging that references social norms (e.g. "Six out of ten people in Wigan eat their five a day") is more effective in changing people's behaviours than more traditional messages.

8.6.6   While we do not believe that any one of these insights is a "magic bullet", this strategy will make far greater use of the tools and techniques in MINDSPACE, for example by:

- introducing "energy contracts" as part of the Change4Life collaboration with Lazytown (using Commitment);

- assessing the effect of 'prompted choice' on organ donation registration, in partnership with the DVLA. Evidence suggests that this could significantly increase the number of life-saving donors on the register.

9. Meeting our corporate objectives

9.1.   All our social marketing programmes exist to deliver against the wider objectives of the Department of Health and Public Health England

9.2.   The Public Health Outcomes Framework set out over sixty draft indicators supporting the Government's vision for public health, and the domains of: health protection and resilience; tackling the wider determinants of health; health improvement; prevention of ill health and healthy life expectancy; and preventable mortality.

9.3.   There are many, often clinically-driven, indicators, such as emergency readmission rates to hospital or treatment completion rates for TB, over which social marketing will have no influence.

9.4.   For others, such acute admissions as a result of falls, social marketing can have a role to play but only as a small part of a broader policy

9.5.   There are a relatively small number, where we believe social marketing can have a strong influence on the indicator, either in tandem with other policy initiatives, or in isolation.

9.6.   These indicators are set out in the table overleaf

9.7.   In order to make best use of our resources in support of these indicators, we recommend four programmes:

- The Smokefree programme.

- Change4Life (and its sister brand, Start4Life) which will tackle all issues relating to families and middle-aged adults.

- One integrated campaign, which will take a more holistic approach to well being in later life. This activity will seek to empower older people (and, where appropriate their carers) to seek prompt diagnosis and medical attention (for example, if they experience the signs and symptoms of cancer), and will challenge the expectation that loneliness, economic and physical inactivity, mental and physical deterioration and reduced quality of life are an inevitable part of the ageing process.

- A new programme, targeting young people, which will seek to influence behaviours, such as smoking, binge drinking, experimenting with drugs and risky sexual behaviours, which form part of a pattern of risk-taking in the transition from the child to adult self.

	Early Years	Family	Young People	Mid life	Older People	Other discrete audiences	Total population
Moderate-high potential for marketing to influence	Breastfeeding initiation and continuation rates	Prevalence of healthy weight in 4-5 and 10-11 year olds	Under 18 conception rate	Prevalence of healthy weight in adults			Population vaccination coverage
	Maternal smoking prevalence	Smoking prevalence over age 18					Access and utilisation of green space
	Rate of dental caries in children aged 5		Chlamydia diagnosis rates	Rate of hospital admission for alcohol related harm	Patients with cancer diagnosed at stages 1 or 2 as a proportion of all cancers		Cycling participation
		Percentage of adults meeting the recommended guidelines on physical activity		Percentage of adults meeting the recommended guidelines on physical activity	Percentage of adults meeting the recommended guidelines on physical activity		
Marketing has marginal influence, as part of a broader policy				Prevalence of recorded diabetes	Fuel poverty	Proportion of people presenting with HIV at a later stage of infection	Screening uptake
					Older people's perception of community safety		Differences in life expectancy between communities
					Health related quality of life for older people		Casualties on England's roads
					Acute admission as a result of falls in older people		Self-reported wellbeing
				Take up of NHS Health Check programme	Take up of NHS Health Check programme		Social connectedness
				Mortality rate for all CVD (including stroke) in persons aged under 75			
				Mortality rate for all liver disease in persons aged under 75			
				Mortality rate from cancers in all persons under 75			
				Mortality rate for COPD in all persons under 75			
					Excess seasonal mortality		Excess seasonal mortality

9.8.   The next sections of this document set out how those four programmes will develop in line with this strategy.

9.9.   Separate documents, giving more detail on each programme, will be published in due course.

10. Applying the strategy: Tobacco control

Summary

Smoking is still the number one cause of premature death and preventable disease in England.

There is a strong international evidence base for the impact of marketing on reducing smoking prevalence.

However, recent evidence suggests that motivation to quit and quit attempts are both in decline. We believe this is at least partly due to the stress and uncertainty created by the current economic climate (which causes people to rely more on everyday "props" and to put off making any significant commitment to change – such as a quit attempt – until a time of greater stability).

The role of the centrally-funded national marketing campaign will therefore be to remind smokers why they need and want to quit, triggering quit attempts at a population level and signposting people to information to help them make more effective quit attempts.

We will also work with a range of national and local partners and with health professionals to ensure they are aware of the important role they can play in prompting quit attempts.

The central programme will expand to include new themes of secondhand smoke and reducing uptake of smoking in young people. We will continue work to address smoking in pregnancy.

Local areas will increasingly take responsibility for driving traffic to services as well as marketing to specific local audiences (e.g. ethnic minority groups), and for issues that or of particular local concern, (such as illicit tobacco).

Background

10.1.   Smoking is still the number one cause of premature death and preventable disease in England. Around half of all regular smokers are eventually killed by a smoking-related illness.

10.2.   While smoking rates have declined over past decades, 21% of adults still smoke. Smoking remains a major factor in health inequalities, accounting for approximately half of the difference in life expectancy between the lowest and highest income groups.

10.3.   Stopping smoking helps prevent smoking-related illnesses and helps people live longer, whatever their age when they quit. However, tobacco is highly addictive and for many people, quitting successfully is extremely difficult.

10.4.   There is a strong international evidence base for the impact of marketing on reducing smoking prevalence. Marketing activity over the last few years has centred on three key objectives: reinforcing smokers' motivation to quit, triggering action and making quitting more successful by signposting people to the support available. We have focused our activities on smokers who work in routine and manual jobs, because of the high prevalence of smoking in these groups (28%) double that of professional and managerial groups.

10.5.   Insight research with routine and manual smokers identified that family and community are very important to them, so motivation campaigns focused on stopping smoking for the sake of family and loved ones – positioning smoking as 'the enemy of the family'. This approach aimed to counter the tendency to discount future benefits associated with traditional health harm messaging (or hyperbolic discounting), by focusing on an inarguable here-and-now motivation rather than a theoretical, future threat to health. Tracking research shows marketing activity persuaded significant numbers of smokers that they should give up smoking now, with a high of 54% smokers agreeing this, following hard-hitting activity in Autumn 2009[33].

10.6.   Smokers are up to four times more likely to be successful if they quit with local Stop Smoking Services. Marketing activity provided over 250,000 referrals[34] to local services in 2009/10, approximately a third of total service throughput[35]. For those people who were unwilling or unable to access a service, we provided information and remote support, for example through the Smokefree Customer Relationship Management (CRM) programme, which increased quitting success rates among participants by 57%[36].

10.7.   However, as the majority of smokers attempt to quit without support, we launched the new 'Quit Kit' product in January 2010, which offered 'a quit attempt in a box'. The Quit Kit incorporated insights from research and behavioural economics to prompt quit attempts and introduce the idea of using NHS support. Nearly 500,000 orders were placed for the Quit Kit in January to March 2010, (boosting orders for support materials by 500% versus the offer of a DVD previous year). 95% of orders were from people who had not previously responded to national marketing. Follow up research demonstrated that the Quit Kit had a strong impact on those who ordered it, with over 80% of people taking some action towards quitting as a result and nearly 60% making a quit attempt (29% reported that they visited a doctor about giving up smoking, 17%that the spoke to a pharmacist and 11% that they visited a local stop smoking service).

10.8.   Econometric modelling has demonstrated a clear relationship between tobacco control marketing activity and people quitting smoking. In 2008 and 2009, tobacco control marketing activity directly stimulated over 1.5 million quit attempts (around a third of the total annual quit

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[33] BMRB Tracking research, Autumn 2009, Smokefree Generation campaign.
[34] This includes contact details of 90,000 individuals which have been passed to the services as a result of marketing activity and 160,000 people who have requested and been given details of their local service. Based on actual figures and estimate to end March 2010.
[35] Approx. 750,000 people set a quit date in 2009/10 with the NHS services (based on actuals in Qs 1 to 3 and an estimate for Q4 as figures not yet available.
[36] COI/Artemis analysis. CRM response. The self-reported quit rate was 52% for CRM and 33% for Control, an increase of 57%.

attempts) and over 100,000 successful quits[37] in each year. The gross one year payback of the campaign in 2009 was £43m[38], in terms of savings to the NHS. After subtracting the costs of campaign spend and providing the stop smoking services to those who used them as a result of marketing activity, this results in a one-year return on marketing investment (ROMI) of £2.07 for every pound of public money spent, and a three-year return of £4.58 for every pound spent.

How the strategy will change

10.9.   However, there is more to be done. The environment is becoming more challenging, in part due to the stress and uncertainty created by the current economic climate (which causes people to rely more on everyday "props" and to put off making any significant commitment to change until a time of greater stability).

10.10. The national ambition, set out in the recently published Tobacco Action Plan is reduce smoking prevalence from its current level of 21% to 18.5% or less by the end of 2015, equating to around 210,000 fewer smokers a year.

10.11. 63% of smokers[39] say they want to quit (down from 72% in 2000), however fewer than four-in-ten (36%) go on to make a quit attempt in any given year[40].

10.12. Recent figures from tracking research suggest that motivation to quit is in decline, with the number of people saying they do not want to quit at all at 30%[41], its highest level since tracking began in 2007. Over recent years there has also been a year on year decline in people making quit attempts, from 43.5% people making a quit attempt in 2007 to 35.8% in 2010[42].

10.13. A key focus for national marketing activity therefore will be to maintain the importance of quitting at the forefront of people's minds, reminding people of their reasons for wanting to quit and seeking opportunities to increase the number of quit attempts among all smokers.

10.14. As part of this, we will work with healthcare professionals to ensure they have access to the latest evidence on the harms of smoking, the effectiveness of the various routes to quit and that they are aware of the important role they can play in prompting quit attempts. This will support system changes, which aim to make referrals of all smokers to support services routine.

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[37] All adult figures, based on direct response to marketing activity and estimated quit rates. Routine and Manual smokers comprise approximately 52% of all adults.
[38] Based on all adults, assuming a cost to the NHS of treating smoking related diseases of £2.7bn in 2005/06.
[39] General Lifestyle Survey, ONS.
[40] Key findings from the Smoking Toolkit Study, Prof Robert West and Dr Jenny Fidler, University College London, Feb 2011.
[41] TNS-BRMB Tobacco tracking data, All Smokers, Oct 2010.
[42] Key findings from the Smoking Toolkit Study, Prof Robert West & Dr Jenny Fidler, University College London, Feb 2011.

10.15. Nationally, we will continue to assist smokers to quit through providing information, products and services, for example, helplines, the Smokefree website and Facebook site and products like the Quit Kit. These will signpost people to the most effective forms of quitting (in particular the stop smoking services), while respecting their individual preferences.

10.16. We know that the majority of people attempt to quit without support. We therefore need to focus on these 'cold turkey' quitters and develop communications and products to reach them and encourage them to make effective quit attempts. The Quit Kit was a good example of this approach – targeting and supporting cold turkey quitters, while making sure people were aware of the additional support available to help them quit successfully. In follow up research, many people reported that they went on to take up this support.

10.17. For smokers who are not yet ready to quit, we will explore ways in which we can help them to take steps towards quitting, for example through encouraging people to make their homes and cars smokefree, and signposting them to new service options which allow them to quit more gradually.

10.18. Given the new ambition to reduce rates of smoking throughout pregnancy to 11% of less by the end of 2015, we will continue to support pregnant smokers, as smoking during pregnancy can cause serious health problems for both mother and child.

A partnership approach

10.19. The evidence suggests that many voices repeating the same messages in the same way, but adapted to the needs of specific target audiences will have the greatest effect. In addition to work with healthcare professionals, we will aim to work with a wide range of partners across the public, private and third sectors to achieve common goals. This could include other government departments, businesses, charities and NGOs and employers

10.20. We will also build on work to galvanise local social marketing efforts and ensure that national and local initiatives work together to achieve maximum impact. At a local level, the role for marketing will increasingly be to focus on specific local communities where prevalence is higher (e.g. ethnic minority groups), as well as tackling any specific local issues such as illicit tobacco. There will also be a greater local role in driving awareness and throughput to the services that can help people quit. Key partners will include for example, local authorities, local Stop Smoking Services, schools, workplaces and local businesses. We will minimise duplication and make the best use of resources by sharing messaging, research learnings, evaluation, best practice guidance and other materials, such as templates, via the available channels, to ensure that partners have access to relevant information and resources.

10.21. We will also explore new themes, for example reducing the exposure to secondhand smoke and reducing the uptake of smoking in young people.

10.22. Smoking in indoor public places and workplaces is now a thing of the past, however exposure to secondhand smoke at home and in private cars remains a significant cause of

death and disease. We will use insight to developing impactful messaging around the harms of secondhand smoke. We will also explore ways of helping people protect their families and communities from the harms of secondhand smoke. This is particularly important for children, who are especially vulnerable to the health harms from secondhand smoke. This could involve community led social norming initiatives and/or providing information and practical tools to help people make their homes and cars smokefree.

10.23. The highest rates of smoking are among young people. Around 28% of people aged 16-24 smoked in 2008. While smoking rates have reduced considerably in recent years, this continues to be a serious problem. An estimated 320,000 young people under the age of 16 try smoking each year in England, and around 6% of pupils aged 11-15 were regular smokers in 2009 (defined as one cigarette a week)[43]. Almost 2/3 current and ex-smokers say they started smoking regularly before they were 18 (39% before age 16)[44].

10.24. While many young people try smoking, only a minority of those smoking go on to become regular smokers. Given the new ambition to reduce rates of regular smoking among 15 year olds to 13% or less by the end of 2015, we will explore ways to support young people in making informed choices and supporting them to act on these by building their resistance skills as part of a cross public health approach to young people. This is likely to involve digital media because of its reach and popularity with the target audience. We will also explore the role of image and influencers on take up of smoking (including parents) and norming approaches that reduce the visibility of smoking and position it as a minority behaviour.

10.25. We will continue to take an insight driven and evidence based approach to developing social marketing initiatives, while also learning from emerging thinking, for example behavioural economics, to develop innovative approaches to influencing behaviour. Where the evidence base is still developing, we will take a test, learn, refine approach to trial ideas to understand their effectiveness. The emphasis will be on efficiency and effectiveness and working within available resources to achieve the greatest impact and value for money. We will publish a new three year marketing strategy for tobacco control in the Spring 2011.

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[43] NHS Information Centre (2010). Statistics on Smoking: England, 2010. NHS Information Centre, Leeds.
[44] Smoking and drinking among adults: A report on the 2009 General Lifestyle Survey, Simon Robinson and Helen Harris, Office for National Statistics, Crown copyright 2011.

11. Applying the strategy: How Change4Life will evolve

Summary

Change4Life (and its sister brand, Start4Life) will become the sole branded programme for all healthy lifestyle information, products and tools for families and for adults in mid-life.

It will support people in making those small, sustainable yet significant lifestyle changes that lead to improved health outcomes.

Its scope will expand to include all advice related to diet and physical activity as well as much of the communication and marketing around drinking above the recommended guidelines.

Should there be future requirements for marketing to these age groups on topics that are currently out of scope (such as tooth decay), Change4Life will be the recommended brand for these topics

History

11.1.   The Change4Life social marketing programme launched in England in January 2009. Originally developed as part of the childhood obesity prevention strategy, it targeted parents of children aged between five and eleven, particularly those from segments of the population where parental attitudes, beliefs and behaviours indicated that their children were most likely to gain excess weight.

11.2.   Whilst Change4Life is government-instigated, it sought to inspire a broader societal movement, through which everyone who has an interest in combating obesity could work together under a common banner. Partners, whether commercial sector, NGO or from within local communities, were encouraged to support Change4Life, create their own initiatives and join these up with the national brand. The brand identity and creative assets were designed to be "open source", i.e. others could use and build upon them.

11.3.   The first year of Change4Life was extremely successful. Awareness of the brand built rapidly and attitudes towards it were (and remain) very positive.

Perception of Change4Life brand

— Mothers of 0-11s (403)

Voice
- supportive vs. judgemental
- treats like adult vs. patronising
- fun vs. boring

Content
- trust vs. don't trust
- clear vs. confusing
- covers everything vs. does not
- relevant vs. not relevant

Involvement
- inspires vs. puts off
- would like to know more vs. would not
- would like to be involved vs. would not

Personalisation
- can be adapted to lifestyle vs. can not
- understand people like me vs. does not

Base: Know something about C4L (Aug-Sep)

bmrb

Change4Life Q3 2009

11.4. Over 400,000 families joined Change4Life in its first year and over a million mothers claimed to have made changes to their children's behaviours as a direct result of the programme[45].

11.5. 2010 was a year of consolidation. Support from local and commercial partners grew substantially and the campaign expanded into new channels, for example through social media.

11.6. In January, materials for parents of very young children were launched via a new sister brand (Start4Life) and, in February, a separate programme launched for adults in mid-life. In March, the Welsh Assembly launched the programme.

11.7. To date Change4Life has been able to fund a substantial amount of activity, within a relatively narrow field of operations (principally diet and physical activity for the under elevens, although activity targeting adults in mid-life and parents with children under two did launch immediately prior to the Restricted Period).

11.8. Going forwards, the programme will also need to address adults and the topic areas will expand. It will require a new funding model, involving a step-change in the contributions made by partners.

11.9. The original Change4Life marketing strategy was guided by a substantial programme of research, including ethnographic research (during which social anthropologists lived with target

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[45] *Change4Life: One Year On*, HM Government, 2010.

families, to gain deep insight into their behaviours and the reasons for their behaviours). This research was originally conducted in 2007. At the end of 2010, we reran this project, using the original researchers but with new families from within the target demographic

11.10. The research found considerable change among the family audience, driven in part by programmes such as Change4Life, but also by the broader climate of economic and political change. This strategy responds to the findings of that research, in particular:

- Families appeared to be taking greater personal responsibility and to be pulling together, both in extended families and across communities, in ways that they were not doing in 2007.

- The researchers reported evidence of a societal movement for healthier lifestyles, including substantial change to beliefs about what constitutes good parenting. Change4Life was one instigator of this movement, but not the sole instigator.

- Target parents now aspire to have a healthy as well as a happy child, and the definition of healthy has evolved to include preventative measures such as physical activity.

- Children (and schools) are acknowledged as important change-makers within the family unit, although there was also visible evidence of parents (and grandparents) continuing to model poor behaviours, and underestimating the impact of this upon their children/grandchildren.

- Many parents have tried to implement change, and among some families there is evidence of these changes become normalised (i.e. "it's just what everyone does now").

- However, the research provided a timely reminder that behaviour change is hard. Some parents had tried to implement healthier lifestyles, failed, and then rejected the concept as too difficult. Others in the study struggled to sustain change, particularly in the face of an adverse environment.

- Change4Life has landed very well with parents, and was appreciated as a resource within a wider societal movement. However, there was a perception that Change4Life had "receded" (particularly due to the cessation of television advertising) and parents expressed a real need for new and fresh products and tools to help sustain change. They particularly valued resources that were tactile, interactive and fun to use.

- Finally, target families had embraced new technologies, particularly gaming and social networking.

How Change4Life is changing

11.11. Going forwards, Change4Life will embody a more holistic approach to health, for example by incorporating messaging that has no specific obesity-benefit (such as salt reduction).

11.12. It will broaden out from its focus on children to also include lifestyle advice for adults, particularly in mid life (and therefore at greatest risk of developing long term illness), whether or not they have children.

11.13. Within families, recognising that parental (and grand-parental) modelling of poor behaviours continues to have a negative impact on children, it will take a whole-family approach to change, by, for example, introducing family "Energy Contracts" (an agreement between parents and children to both adopt more positive behaviours) as part of a collaboration with the children's television programme Lazytown.

11.14. We will explore the possibility of using the insight that children aspire to the behaviours they see in their parents to encourage parents to model good behaviours, such as drinking within guidelines and delaying initiating their children into drinking alcohol until at least age fifteen.

11.15. There will be a radical step-change in the proportion of the campaign that is funded by partners. Contributions from the commercial sector are targeted to increase from £9 million in 2009/10 and £12 million in 2010/11, to a target of £15 million in 2011-12. To facilitate this, the Change4Life Retail Guidance has been revised to allow partners to promote a greater number of product categories.

11.16. While in-kind contributions will continue, we also anticipate a revenue from sponsorship sales of £2 million in 2011/12.

11.17. There will be fewer centrally-led initiatives, but those that are centrally-funded will be regularly-occurring calendar events, to provide partners with advance warning so that they can plan their schedules of activity and better join up with the programme. These include the New Year Great Swapathon, Walk4Life and the Summer of Fun.

11.18. In addition to the support Change4Life has received from commercial organisations, there are already over 47,000 "local supporters": public-spirited individuals or professionals who are passionate about creating change within their communities. The new strategy will involve a reversal of the relationship between these people and the central Change4Life team: a shift from them being asked to support Change4Life to Change4Life increasingly asking what it can do to support them. Our research with local supporters indicates that many operate in other lifestyle areas and we should seek to provide them with whatever materials (including alcohol or drugs) they require. This places local people at the centre of a societal movement for better health, in keeping with the spirit of the Big Society.

11.19. There will be more locally-funded initiatives, and, to facilitate this, money from the central funds will be devolved out to local communities to provide seed-funding for new initiatives.

11.20. The Change4Life programme is one of the most responsive campaigns ever monitored by COI Artemis and has generated a citizen database of over 525,000 plus a local supporter

database of 47,000. Ongoing with communication with these people, who have opted in to positive change (and through them, with their social networks) is key to inspiring and maintaining positive change. Previously we ran two, occasionally intersecting, customer relationship management programmes, one on-line and one paper-based. Going forwards, we will create one integrated programme, which uses the strengths of on line (ability to deliver frequent communication to large numbers at low cost, instant feedback and interactivity) with printed materials for crucial stages only (e.g. action plans).

11.21. Social media allows our target audiences to enter easily into relationships with us: a "like" earned on Facebook takes only a single mouse click, but gives us permission to provide content and updates to the individual for as long as the like remains. This is a longer-term proposition to a more traditional response (such as telephoning an information line or ordering a leaflet). Consequently, Change4Life's Facebook presence (which currently has over 47,000 "likes") will expand, to allow for more co-creation, interactivity, sharing and feedback. Partner support will be integrated into the CRM programme (by, for example, allowing on line users to access vouchers for money off healthy products).

11.22. Recognising that many of the Change4Life target audience are kinaesthetic learners (i.e. they prefer to learn by doing, rather than by reading), we will focus more on interactive, practical tools and less on didactic, wordy leaflets. We will also pilot an experiential programme to allow people to try unfamiliar foods and activities.

11.23. The Start4Life sister brand will continue to be promoted and will expand to cover maternal health in pregnancy (and, when feasible, pre-pregnancy), for example alcohol in pregnancy, and all other advice and information relevant to early years (such as immunisation)

11.24. The strand of activity that addresses adults in mid-life will recommence and the alcohol health harms messaging will be brought more fully under the Change4Life umbrella, embracing not only calorific content of alcohol but also the wider health harms of alcohol. As part of this, we will expand our partnership engagement strategy to include the relevant NGOs, Drinkaware and, if they are willing, the alcohol manufacturers and retailers.

11.25. There are messages and materials relating to drinking above guidelines that will need to be provided outside of the Change4Life campaign. As well as working with Drinkaware and others, we will set aside a portion of resources to develop alcohol-specific messaging within the young people's strand and messaging around the impact of drinking above guidelines upon common health conditions, as part of the older people strand.

11.26. Paid-for media, such as television advertising, will recommence, but as a far lower proportion of total spend than in 2009

12. Applying the strategy: A consolidated approach for the over 60s

Summary

There is great potential to improve health outcomes for people aged over 60 through a combination of active ageing and a recognition of the signs and symptoms of common conditions (leading to earlier presentation to the health service).

We will devote a greater proportion of our resource to this age group and will gain synergies and efficiencies through bringing previously separate campaign strands into closer alignment, under the trusted NHS brand.

This activity will challenge the expectation that mental and physical deterioration and reduced quality of life are an inevitable part of the ageing process and seek to empower older people (and, where appropriate their carers) to seek prompt diagnosis and medical attention across a range of conditions.

Note: Throughout this document, we have used the term "older people" to refer to people aged – approximately – over sixty. We recognise, however, that conditions such as cancer or stroke can occur much younger in some individuals and later (if at all) among others. Also that "people aged over sixty" are a large and diverse group and that many people who fall within it would not define themselves as "older" and certainly not as "old".

12.1.   Illnesses that disproportionately affect the over sixties account for a very significant proportion of healthcare and other costs. Dementia alone costs the UK economy £17 billion a year and, in the next 30 years, the number of people with dementia in the UK will double to 1.4 million, with the costs trebling to over £50 billion a year[46].

12.2.   Stroke costs the NHS and the economy about £8 billion a year, including £3 billion in direct care costs[47].

12.3.   Earlier diagnosis and, in the case of stroke, fast access to services, has the potential to improve survival rates, extend the number of years lived in good health and save money for the taxpayer, individuals and society.

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[46] *Living well with dementia: A National Dementia Strategy* February 2009.
[47] NAO report into stroke services, February 2010.

12.4. Helping older people to remain active benefits the whole of society, not just through reduced healthcare costs but through the economic benefits of older people working longer, and through other forms of participation that increase social cohesion, such as volunteering.

12.5. Despite this, marketing and communication on these topics has historically been a relatively low proportion of our overall efforts to help citizens improve their behaviours.

Driving insights for health behaviours in older people

12.6. The following are the driving insights that have informed our approach to older people marketing:

- Many older people see self-reliance as a virtue, with a strong desire and sense of pride to manage on their own and maintain an independent lifestyle[48].

- Fear can play on the minds of older people, including fear regarding their future health, that diagnosis will identify a problem that will inevitably lead to a 'loss' of control over their life (lifestyle & independence) and a fear that each set-back brings you closer to death[49]

- Consequently, avoidance and denial strategies are common, for example:

   o feeling that what you don't know you can't worry about;

   o finding out more will only lead to new worries;

   o preference to stay deliberately ignorant as knowledge might confirm that fears have some basis;

   o avoiding thinking about things in case they tempt fate;

   o downplaying how bad things are and a reluctance to admit to physical impairments[50].

- Additionally, among groups such as the Unconfident Fatalists, there is no positive expectation that seeking support and help will necessarily lead to better outcome. There is often a feeling that it is too late to improve one's health and that getting help will only lead to increasing levels of care and loss of independence – a belief that physical and mental decline is just to be expected as part of the ageing process[51].

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[48] COI Common Good Research "Communicating effectively with people 50-75", Stimulating World, 2006 and COI Common Good Research "Communicating effectively with older people 76+", Forum, 2006.
[49] Ibid.
[50] Ibid plus NHS Health Checks Vascular Risk Assessment Programme Research Report, Commissioning Support for London, 2009 and Qualitative Research Concerning Attitudes to Dementia, Corr Willbourn, 2009.
[51] Ibid.

- The taboo on discussing death and dying means that people do not express their wishes and preferences, so may not get the care they want. Conversely, they may receive interventions they would have refused given the choice.

- There is often a reluctance to make demands on the health system (e.g. 'not bothering the doctor'), because of a desire not to be a burden on resources when there are others more deserving because of greater need. With many men from lower socio-economic groups, it is sense of pride that drives reluctance to use services, especially if symptoms are perceived to be trivial[52].

- Older people can feel guilt at not be able to cope and having to ask for help. This is especially strong amongst informal carers looking after close relative, which can mean help is not sought until a crisis point is reached. Some groups, such as smokers, can feel guilty that their condition is in some way deserved ('of course I have a cough, I've smoked for 40 years') and that they may be blamed by health professionals if they do seek help.

- Despite this, older people often have a strong and trusting GP relationship (28% of over 75s have seen a GP in last 2 weeks[53]). However GPs are often perceived to be too busy and there is often an assumption one should only visit them when seriously ill[54].

- There do appear to be some key motivations that lead older people to engage with their own health and overcome health problems e.g.:

    o that the advice or treatment is perceived to be likely to result in a better outcome, helping them to maintain their lifestyle/independence[55];

    o prior personal contact with the illness of concern[56];

    o perceived seriousness of illness;

    o meaningful relationships and perception of a role/meaning in life[57].

- There are a number of other key influencers on the way many older people engage with their health, particularly local informal social, who become advocates, sharing knowledge and information about help and services. Women are often an important influence on men in terms prompting them to seek advice[58]. Proximity of friends and family is also a key

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[52] Ibid plus Social Care Customer Journey Research, Diagnostics, 2009 and Early Diagnosis of Cancer, Cragg Ross Dawson, October 2010.

[53] Communicating with the over 75s to support the digital switchover targeted help scheme, Darnton A., July 2006.

[54] NHS Health Checks Vascular Risks Assessment Programme Research Report, Commissioning Support for London, 2009.

[55] COI Common Good Research, Communicating with People 50-75, Stimulating World, 2006.

[56] Qualitative Research concerning attitudes to dementia, Corr Willbourn, 2009.

[57] COI Common Good Research, Communicating Effectively with older people 76+, Forum, 2006.

[58] Ibid plus NHS Vascular Risks Assessment Programme Research Report, Commissioning Support for London, 2009.

factor in health engagement and culture and religion are often a strong influence, particularly for ethnic minority groups.

- There are a number of trigger events that can be important in prompting consideration of older people's health, such as reaching milestone ages (such as 60) and the death of a partner or close relative, which can trigger 'giving up to old age'. Retirement is too often viewed with trepidation, sometimes seen positively as a time of new opportunities, but often in a more pessimistic light – an end of socialisation and structured working life[59].

12.7.   These insights hold true across for many over 50s, although there are variations among different sub-groups of the older population. For example, those born before the Second World War are more likely to resist the idea of state assistance compared to the post war generation, who are more likely to assume and assert their rights to state support[60]. It is helpful to view ageing as a dynamic process with people moving between positive and negative mindsets, depending on their state of health which varies through time.

The role for social marketing

12.8.   In two main ways, marketing has significant potential to extend quality and quantity of life (and save healthcare costs) by achieving behaviour change in older people.

12.9.   First, we should use marketing to encourage people in late middle-age (50-60) to adopt healthy preventative behaviours (such as eating healthily and exercising), which this group can assume to have little influence on health outcomes later in life. This will be done within the adult strand of the Change4Life brand.

12.10. Second, health economics suggest that overall healthcare costs can be substantially reduced by encouraging over 60s to present much earlier for diagnosis on a range of conditions[61], which they are often reluctant to do, again because of attitudes relating to the ageing process.

12.11. Currently, the Department delivers the above two marketing roles via several behaviour change campaigns largely aimed at the same older audience, but across different issues (e.g. cancer early diagnosis, stroke, dementia and Keep Warm, Keep Well). Bringing all these conversations together in a co-ordinated way with a life course approach has significant potential to be both more effective and more efficient.

12.12. In terms of effectiveness, having one consistent conversation with older people around the general issue of taking a positive approach to ageing will probably leverage more behaviour change than a series of fragmented conversations broadly addressing similar health motivations.

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[59] Ibid.
[60] COI Common Good Research, Communicating With Older People, Scoping Study, Wardle McClean, 2005.
[61] See for example Richards, M.A. (2009) *The size of the prize for earlier diagnosis of cancer in England.* British Journal of Cancer; 101(suppl. 2): S125–9.

12.13. For efficiency, bringing a range of issues together via 'one voice' for older people, offers the potential to reduce the fixed costs of running numerous different campaigns.

12.14. The proposed marketing strategy for developing a single health behaviour change conversation is included below.

Strategy

A single health voice for older people

12.15. Over the next three years, we propose to migrate all the separate health marketing campaigns targeted at older people into one integrated campaign under the NHS brand, which will take a more holistic approach to health and wellbeing in later life. This activity will challenge the expectation that mental and physical deterioration and reduced quality of life are an inevitable part of the ageing process and seek to empower older people (and, where appropriate their carers) to seek prompt diagnosis and medical attention across a range of conditions.

A 'kick-start' approach to marketing

12.16. The role for marketing will be to 'kick-start' increased societal awareness of an issue in a positive and motivating way as an essential pre-cursor to subsequent marketing activity, which will be primarily locally driven, such as encouraging the take-up of advice and diagnosis services.

12.17. This means our marketing effort for older people will focus on raising priority issues up the societal agenda (as happened with the FAST campaign on stroke) and then developing creative assets once at the centre, which can be made available to Local Authorities (with the facility for them to be adapted for local use). This approach will avoid wasteful duplication of creative assets in the health system. Additionally, the production of central assets will mean they have critical mass to be pre-tested and evaluated for proof of concept before rolling out, which is not always possible with smaller scale fragmented activities.

12.18. The strategy will also realise the significant opportunity to save marketing money by facilitating better sharing of existing marketing assets in the health system, such as websites and helplines targeting health information and advice at older people.

Working across government

12.19. Given the need for health marketing aimed at older people to set behaviour change in the context of a positive attitude to ageing, there is a need to ensure a joined-up marketing approach with other government departments targeting the same audience. The older people health strategy will engage particularly with DWP, where there is significant potential to realise marketing synergies.

An engagement campaign for general practice

12.20. GPs are a critical intermediary audience for engaging older people, who generally have high levels of contact and trust with their GP across a range of health issues.

12.21. Working in partnership with the Royal College of General Practitioners, Public Health England will develop an engagement plan targeted at older people. This will include providing resources that help to persuade people at the younger end of the age spectrum that it is not too late to engage in preventative behaviours as well as resources to encourage early diagnosis, particularly for over 65s.

12.22. Being diagnosed with a long-term condition, while stressful and upsetting for a patient, is also a key teachable moment, at which the GP has the opportunity to explain how lifestyle changes (such as drinking less alcohol, giving up smoking or being more physically active) can make living with that condition easier. We will ensure that current resources are fit for purpose and where necessary provide new resources for GPs to make these conversations easier (and to ensure that the patient has written materials or access to an on line resource) to refer back to.

Key messaging tasks

12.23. The aim is an integrated campaign, which will take a more holistic approach to well being in later life. Messaging will challenge the expectation that loneliness, physical and economic inactivity, mental and physical deterioration, and reduced quality of life, are an inevitable part of the ageing process. Messaging will also empower older people (and, where appropriate their carers) to seek prompt diagnosis and medical attention. The key elements of behaviour change messaging to support the above will be:

- Re-setting societal expectations about ageing into something positive – challenging attitudes to age and high levels of resignation to low quality of life.

- Encouraging preventative behaviours such as getting older people active.

- Working across government to promote working longer and other forms of social participation, such as volunteering.

- Raising levels of 'symptom literacy', encouraging people to recognise physical and mental changes and acting quicker to realise the benefit of better outcomes.

- Giving people 'permission to ask' for diagnosis and services, empowering them to take responsibility for demanding diagnosis and treatment as a matter of right – diagnosis needs to become a plan of action, not a death knell.

Partnership

12.24. Similar to the requirements for the youth audience above, the older people audience will require a partnership approach to join up the efforts of a very wide range of energetic organisations already seeking to address the health outlook and behaviours of this audience.

12.25. The health partnership for old people will be formed by Public Health England and will co-ordinate a coherent partnership strategy across government, commercial and third sectors to deliver a consistent approach to the messaging tasks summarised above.

13. Applying the strategy: A new approach for young people

Summary

Many people first try behaviours, such as smoking, drinking alcohol, having sex, or taking drugs, between the ages of 10 and 20.

Some of these behaviours bring an immediate risk of poor health outcomes and young people need to be aware of this; others can lead to future illness and premature death if they are maintained over time.

We know that we cannot prevent all risk-taking among young people. However, central government's role will be to create one integrated programme that seeks to build self-esteem, resilience and negotiation skills in young people, so that they are better equipped to manage those risky lifestyle behaviours, and prevent them escalating into lifetime habits.

Evidence from behavioural insights[62] is that this should not be a branded programme. Rather, we propose to work with and through those partners, commercial, charity and civic, who are already trusted by young people.

Local areas will take responsibility for driving traffic to local services. Brands and creative assets from previous campaigns will be made freely available to local areas to facilitate this.

13.1.   People aged between ten and twenty do not themselves place an excessive burden on the health service.

13.2.   However, the transition from childhood to adulthood is the time when many people try behaviours, including smoking, drinking alcohol, having sex or taking drugs, for the first time:

- Every year, approximately 320,000 people under 16 try cigarettes for the first time[63]; two thirds of current and ex smokers report that they started smoking before age 18[64].

- Data from national surveys of drinking behaviour in young people indicate that, by age 15, the vast majority of young people have had their first alcoholic drink[65].

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[62] Cabinet Office (2010) Applying Behavioural Insights to Health: England 2010.
[63] NHS Information Centre (2010). Statistics on Smoking: England, 2010.
[64] 2009 General Lifestyle Survey, Simon Robinson and Helen Harris, Office for National Statistics, Crown copyright 2011.
[65] Guidance on the consumption of alcohol by children and young people, CMO report, 2009.

- The average age at which people first have sexual intercourse is now sixteen and three quarters[66].

- 15% of 11-15 year olds reported taking drugs in the last year[67].

13.3.   For some, this truly is a "trial" – they experiment with risky behaviours, but adopt safer practices as they settle down, get jobs, start relationships and have children.

13.4.   For others, however, what should be a phase, becomes a lifetime habit.

13.5.   It is therefore vital that society equips young people with the skills, knowledge and resilience to navigate their way through this most difficult transition.

13.6.   This is far more than a health issue. Building self-esteem and self-efficacy among young people is an objective for other Government departments, particularly the Department for Education (who have an interest in teenage pregnancy) and the Home Office (who have an interest in civic disorder and crime); its benefits would be felt across the whole of society.

Driving insights for health behaviours in young people

Note: most of the research and insight work commissioned by Government over recent years relating to health and young people has been issue-based (e.g. smoking, alcohol, obesity etc), reflecting the structure of health policy. Relatively little health marketing research and insight has been completed to date relating to young people holistically as a single audience. Developing this evidence-based insight will be a priority within our life course marketing going forward. In the meantime, building particularly on extensive and recent work completed by DCSF on young people's risk taking behaviour in relation to alcohol usage, the following are believed to be the driving insights behind many of the risky health behaviours exercised by young people[68].

13.7.   There is considerable variation in social, biological and environmental influences between people aged 10-20 years old. Nevertheless, there are some general truths that very frequently recur when reviewing insight work that has been conducted recently with young people, for example as part of the development of the *Sex: Worth Talking About* campaign. Those most relevant to the health context are included below.

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[66] National Survey of Sexual Attitudes and Lifestyles, 2000.
[67] Smoking, drinking and drug use among young people in England, 2009, Information Centre for Health and Social Care.
[68] Key sources for this section include: Department for Children Schools and Families (now DfE) Segmentation of children and young people and segmentation of parents and carers, both the Futures Company, 2009; Use of Alcohol among children and young people, Define, April 2008; Young People and Alcohol Customer Insight Desk Research, Edcoms, November 2008; Exploring parent-child alcohol engagement to inform the future alcohol guidance campaign, 2CV; Informing the proposition development of the young people and alcohol campaign, 2CV 2009; Young People and Alcohol Usage and Attitude Study, GfK NOP, 2009 and Young People and Alcohol campaign pitch and creative development research, Define, 2009.

13.8.   For many young people, taking risks is enjoyable, due to the appeal of challenging authority, asserting an adult identity and the thrill of experimenting with new sensations.

13.9.   Perceptions of risk change during adolescence for biological reasons, with the thrill-seeking emotional brain being more dominant in earlier years and the rational adult brain not developing until later.

13.10. Many more vulnerable young people fall into the "Live For Today" Healthy Foundations segment: the long-term seems a life time away (the phenomenon behavioural economists call hyperbolic discounting), so talking about health harms rarely resonates unless they are immediate.

13.11. Social norms are a powerful influence on young people, although overt peer pressure is rarer than their parents perhaps believe.

13.12. Parents, and the examples they set, are usually by far the greatest influence on younger people.

13.13. The parental and family factors that protect young people from risky behaviours include:

- a close family that communicates;

- eating meals together (at least 5 times a week);

- modelling of positive behaviours by parents;

- religious beliefs; and

- things to do/activities after school.

13.14. Yet parents often significantly underestimate their power of influence on the risk taking behaviours of their children, assuming that they are 'not getting through' or being ignored, when in fact this may only appear to be the case.

13.15. Risk taking young people share a number of negative features of their relationship with their parents:

- relationship with their parents is less positive than others – they argue frequently and lack respect;

- they do not speak to their parents about things that matter to them as frequently as other young people; and

- there is low parental involvement in their education.

13.16. Many young people have a driving desire to be seen as adults and the more they are told they are too young, the more they aspire to demonstrating adult behaviour.

13.17. Retaining control is often key for young people, in the sense that they demand autonomy and a say in the way they run their lives. Yet paradoxically, in other respects, they seem happy to lose control (or experiment with loss of control) through risky behaviours (e.g. binge drinking and drugs).

13.18. Attitudes to risk taking are often well on the way to being set as early as eight years old, after which they are hard to influence.

13.19. There are several key events that can trigger changes in young people's outlook on life, particularly the transition between primary and secondary school. Other milestone events include the onset of puberty and leaving full-time education.

13.20. There are also key times of the year when young people seem vulnerable to unhealthy behaviours, notably summer and Christmas holidays, when there is often much less structured activity in place.

13.21. Many risky behaviours among young people derive from a lack of confidence and aspiration (self esteem), which may be symptomatic of other problems and issues in their lives that need addressing in a wider context.

The role for social marketing

13.22. Much of the marketing effort directed at younger people over recent years has aimed to improve health across single issues through separate and parallel campaigns (e.g. campaigns on sexual health, obesity and alcohol consumption), all often competing for attention with the same youth audience. The development of these campaigns has generated a rich body of insight into young people, much of which points to a common set of behavioural influences that are higher level pre-requisites for behaviour change across most risky health behaviours. These higher level needs suggest there are three basic roles for marketing:

- Marketing has a role to play in changing social norms by galvanising a wide variety of partners to promote positive images of health behaviours in society as opposed to negative ones. For example, the recent decline in smoking among children seems partly attributable to the decreasing number of situations in which adults are seen smoking (either in real situations or portrayed in the media).

- Marketing has a role to play in facilitating stronger parental influence on children through better realisation of their role in shaping and avoiding risky behaviour by young people, and also providing strategies and resources for having courageous conversations that might not otherwise take place.

- By promoting activity, marketing can also play a role in facilitating self esteem and reducing the propensity of young people to drift into inactivity, which produces a vacuum in which there may be a desire to experiment with risky behaviours.

13.23. We recommend against traditional marketing campaigns (such as television advertising) for this audience. Instead, a new marketing approach is required for young people, built on partnerships rather than advertising and facilitating effective dialogue in preference to merely imparting information (although the latter is still required at a basic level). The use of social media and other technology-driven channels will be key to engaging with this audience.

Partnership-led marketing strategy

13.24. Many expert organisations are already working to influence health behaviours in young people. Some are already running campaigns on single or multiple issues (such as the "We are the 99%" campaign in London or the "Got Your Back" campaign run by Drinkaware in Newquay). The challenge for partnership marketing is to encourage and retain the energy of these organisations (which often derives from a passionate commitment to a single aspect of youth behaviour), whilst at the same time enabling synergy to be realised from joining up previously fragmented efforts.

13.25. The cornerstone of the young people's marketing strategy will be the formation of a partnership, co-ordinated by Public Health England, which achieves the following:

- Draws together youth public sector and private sector partners from education, health, the police, commercial, local and third sectors into an effective "fighting force" to improve youth lifestyles over the long term.

- Defines and agrees a set of operating principles, so that all partners are supporting the same broad behaviour change priorities and approach.

- Specifically identifies individual organisational objectives into funded account plans.

- Manages each account to ensure delivery of plans and agreed resources.

- Evaluates what works well and less well so that future partnership activities are evidence based.

This partnership will be established throughout 2011 and will begin delivering marketing initiatives at the beginning of 2012.

Branding

13.26. At this stage we do not propose that a consumer brand is established to act as a rallying banner for the youth partnership strategy, since:

- there is a risk that anything perceived to be a big authority-led initiative to change youth behaviours might be cynically received or even ignored;

- many of the sensitive subjects relating to youth health behaviours do not lend themselves to a 'big branded conversation';

- the behaviour change issues to be addressed are all very different and require different tones of conversation, rather than the tone of voice of a single brand. FRANK provides some useful guidance here, where the focused intimacy of the brand derives in large part from it only discussing drugs;

- while the centre will no longer run single issue campaigns in this area, we will make available the brands and creative assets from successful programmes (such as FRANK and Sex: Worth Talking About) for local areas to use and adapt (within sensible guidelines) if they choose.

However, we will be engaging with stakeholders and potential partners in coming months to mine their experiences and to understand whether a branded entity would have value to them (for example as a sign that they are part of a bigger movement).

13.27. Although the partnership effort and its co-ordinating force is by far the most significant strand of the young people marketing strategy, other secondary strands will be required for the strategy to work as included below.

Information provision

13.28. Beyond marketing, there will still be a need for information provision, as part of our responsibility to young people. This extends to giving advice to the most vulnerable young people, including those in crisis. Where current resources, such as the FRANK help line and website, have established credibility with young people, or with their parents, we will maintain them. However, we will seek to deliver greater efficiencies and cost savings.

13.29. We recognise that Government may not be the most trusted source of information for young people (and for many other vulnerable or at risk groups). We will therefore continue to work through trusted charities and networks, such as Terrence Higgins Trust and the African HIV policy network, to ensure information can be accessed where and in the format people find most useful.

13.30. Much of the health information, advice and guidance provided to young people needs to be woven into an interactive customer relationship management dialogue, which can either be web-based, or telephone. Additionally, the partnership needs to deliver a co-ordinated approach to the way face-to-face conversations take place (e.g. via routes such as The Family Nurse Partnership).

13.31. The job of pointing young people to health services (such as Chlamydia screening and brief interventions designed to reduce alcohol consumption) will increasingly become the responsibility of local authorities and/or GP consortia, although there are undoubted efficiencies to be gained from ensuring collateral for these services are produced once only from the centre with the facility to tailor generic messages according to local requirement.

Behaviour change expertise

13.32. The partnership will need to include a range of youth behaviour change experts, specialising in relevant disciplines such as behavioural economics, neuroscience, risk psychology and studies of genetic predisposition to risk taking. All of these are fast evolving areas of expertise, which need to be joined up into a collective view of what constitutes best practice in influencing health behaviours and youth attitudes to risk taking. One example of a new and emerging approach to behaviour change that might be useful to youth audience is a 'reflexive' approach, where audiences are engaged in reflecting on their own behaviour change journey, the mere process of which has inherently beneficial effects per se[69].

13.33. In addition to academic input, the youth marketing partnership will also capture and share best practice from practitioners working in health behaviour change programmes (such as WeightWatchers, MEND and ASSIST) and will have access to all the knowledge and insight work (and commercial sector data) obtained through the development of past Department of Health campaigns (such as *Sex: Worth Talking About and Talk* to FRANK).

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[69] www.thersa.org/projects/social-brain/reports/changing-the-subject

14. Implications of the four programmes for our brand architecture

14.1.   There will be far fewer nationally supported brands (although local areas may continue to fund single-issue brands, for example to drive traffic to services).

14.2.   Through the life course, an individual's relationship with health sector brands should look like this:

15. Implications for how we work organisationally

15.1.   The Department of Health already recently introduced a thorough and professional process for developing and implementing social marketing programmes (see below) and this process will continue to be used going forwards.

Summary of communications and marketing process: 'COMPASS'

(A) Prioritisation gateway
- ✓ Policy objective
- ✓ Role and contribution for C&M activity
- ✓ Link to dept business objectives
- ✓ Role of DH
- **OUTPUT: agreement/ rejection to proceed**

(B) Project set-up
- ✓ Budget & timescales
- ✓ Governance structure & project team
- ✓ Risks and dependencies
- ✓ Stakeholder support required
- ✓ Need for intermediary marketing plan
- **OUTPUT: business case; PID**

Note: each stage has more detail that underpins it. Challenge will be at design stage to bring this to life whilst keeping the design and language as simple and user friendly as possible

(1) Objectives, measurement & strategic planning
- ✓ SMART objectives
- ✓ Change or impact as a result of activity
- ✓ Projected outcomes; measures for effectiveness and efficiency identified
- ✓ Detail of budget/timescales/resources
- ✓ Dependencies identified
- **OUTPUT: plan v1.0**

(2) Communications planning
Proposition & message
- ✓ Proposition for activity & use of brand
- ✓ Behavioural change journey
- ✓ Development of messages/ creative
- ✓ Other government/ stakeholder/ partnership work

Channels
- ✓ Detailed budget allocation
- ✓ Target audience, segmentation model
- ✓ Media/channel choice
- ✓ Partnership working
- **OUTPUT: plan v2.0**

(3) Implementation
- ✓ Adherence to project milestones
- ✓ Validation of budget allocations
- ✓ Review of risks
- ✓ Governance procedures working
- ✓ Stakeholder engagement
- ✓ Partnership relationships
- **OUTPUT: plan v.3.0**

(4) Evaluation
- ✓ Whether objectives were met
- ✓ Efficiency and effectiveness of activity
- ✓ Review of process and agencies used
- ✓ Sharing the learning more widely
- **OUTPUT: evaluation document**

15.2.   However, the strategy has profound implications for how the marketing function is organised within DH, how it interacts with marketing and communications services across Government, with partners and with agency suppliers.

15.3.   The DH is already engaged in an organisational change process, with the establishment of Public Health England and the NHS Commissioning Board.

15.4.   Historically, there have been marketing personnel based both within DH and, centrally, in the COI. All agency services were procured via the Central Office of Information (COI)'s rosters and contracts were held with the COI, not the DH.

15.5.   Recently, the Cabinet Office published its Review of Government Direct Communications and the Role of the COI. This review recommended:

- The creation of a new Government Communications Centre (GCC), based in Cabinet Office, to develop the Government's communications strategy.

- The brigading of Government Communications into a small number of themes, delivered by dedicated theme teams.

- An invitation to agencies, media owners and voluntary and community organisations to join with Government in forming a Common Good Communication Council, which would invite suppliers to bid for contracts for free or near free.

- The development of a new governance structure to include (subject to approval by the Prime Minister) a Cabinet Sub-committee on Communication and a Government Communication Oversight Panel.

- The retention of a centralised procurement function within the GCC.

15.6.   This review will have profound implications for how we organise our resources and procure suppliers and we will work closely with the Cabinet Office in the implementation of its recommendations.

15.7.   The review makes clear that there will also be fewer people to manage social marketing programmes in future. At the same time, the skill sets required to manage these programmes are changing. In particular, there will be a greater need for:

- business analytical skills;

- client service, sales and negotiation skills (to broker and manage relationships with the commercial sector and other stakeholders);

- consumer understanding and insight mining;

- understanding of behavioural economics and social psychology;

- idea generation/new product development;

- legal support;

- financial support.

Some of these skills are abundant within the civil servant workforce, but others, particularly those involving working with the commercial sector, are less common. This provides opportunities for career development and we will put in place a training and development programme to upskill the workforce for the coming challenges.

15.8.   In addition, we will still need to procure the following from external suppliers.

- Channel planning

- Delivery of creative work

- Research

- External evaluation

15.9.   To date, external agencies have been appointed to work by campaign and by channel, with competitive pitches held for each appointment. This was intended to ensure a fair and transparent process. However, it has resulted in a large number of agencies (there were seven, plus the COI, appointed to Change4Life alone), which in turn results in duplication of cost and fragmentation of knowledge. In future, we will seek to procure fewer agencies, but with deeper relationships, so that synergies can be build and knowledge preserved. The recently announced restructuring of COI's rosters will aid this.

15.10. Moreover, while contracts are held by organisations, it is often highly skilled and visionary individuals who develop our more successful marketing strategies. These individuals can be hampered by the organisational structures in which they work.

15.11. We need to create a procurement mechanism that enables individuals, irrespective of where they are based, to work together in blended teams for the good of the marketing programme in totality.

15.12. We will work with the Cabinet Office to pilot new ways to increase the use of payment by results for our activity. This should be applied in two different ways:

- Ensuring that a proportion of all agencies' fees is dependent upon the delivery of work that meets the client brief and achieves the communications objectives outlined therein. This is standard best practice and should be the norm for all communications activities.

- When feasible, inviting providers to tender for Government communications contracts on the basis that payment will be for the outcomes achieved (for example, inviting providers to deliver a set number of people setting a quit date at an agreed cost per person).

16. Indicative Budgets for 2011/12

16.1.   From April 2011, budgets for marketing and communication will be held centrally within the communications directorate.

16.2.   Changing priorities for spend are reflected in the table below:

	2009-10	20011-12
Smokefree	£38 million	£15 million
Change4Life	£25 million	£14 million
Older People	£14 million	£11 million
Younger People	£16 million	£4 million

17. Evaluating the new strategy

17.1.   In line with DH best practice[70], there will be a stand alone evaluation plan for all four marketing programmes, which will be devised in consultation with internal and external experts and stakeholders.

17.2.   The success of this strategy will ultimately be measured by movements to the indictors contained in the Public Health Outcomes Framework. Since many of these indicators move only slowly and are influenced by many other factors beyond the control of marketing, interim measures will be identified to evaluate the impact of marketing programmes.

17.3.   Each programme's evaluation plan will set out in detail the:

- Evaluation objectives.

- KPIs – devised in relation to the desired behavioural outcomes (and in line with best practice, ie output, outtakes, outcomes and impact).

- Methodology and data sources.

17.4.   We will use a mix of methods, incorporating market research (qualitative and quantitative), commercial sector data (wherever possible, supplied for free as part of our partnership arrangement), online panels, search, buzz monitoring and website analytics as well as other surveys conducted by government departments and agencies, such as Health Survey of England. Our increased use of social media and digital tools will generate vast amounts of behavioural data, which will be used in tracking citizen behaviours.

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[70] See *The DH Marketing Evaluation Handbook*, Feb 2009.

18. Reporting Back

18.1.   It is our intention to maintain the approach outlined in this document for at least the next three years.

18.2.   During this time, we will publish annual updates on how we have spent public money and on what has been achieved as a result.

19. Contacts

19.1.   For more information, contact:

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Appendix 1: Glossary of common marketing terms

Advertising	Communication in any medium (such as television, radio, newspaper or posters), that is funded by the advertiser and where the creative is supplied by the advertiser.
Advertorial	Communication that is funded by the advertiser but appears in the editorial style of the publication (sometimes called "Advertising Features").
Customer Relationship Marketing	The process for continuing dialogue with existing customers, for example to sustain beneficial behaviours, who have usually agreed to continue ("opted in") to such dialogue. Can be paper-based (as when written communications are sent to an existing customer base) or electronic (for example via email).
Digital Engagement	Any contact with the target audience via the internet, including websites, emails and contact on social networking sites.
Direct Marketing	Sending individual communication direct (for example by letter) to a customer.
Media partnerships	Working with a media owner, such as a newspaper or television channel, to develop content. Can be paid for (when the advertiser pays for advertising and receives editorial in addition) or non paid for (when the media owner supports the campaign pro bono).
Partnership marketing	Marketing activity where two or more organisations campaign together to support shared aims. Usually no money changes hands between them.
Response	When a member of the target audience responds to a marketing campaign, for example by going on line to find out more information, calling a help line or using a coupon.
Social Marketing	The systematic application of commercial marketing concepts and techniques to achieve specific behavioural goals relevant to the social good.
Social Media	Media that promote social interaction, using new and accessible technologies (such as social networking sites).
Sponsorship	The use of funds to deliver a product or service (for whose delivery the funding organisation gains credit, as in "The Simpsons, brought to you by Change4Life").

Appendix 2: Proposed Indicators in Public Health Outcomes Framework

Vision: To improve and protect the nation's health and wellbeing and for improving the health of the poorest fastest
Healthy life expectancy
Differences in life expectancy and healthy life expectancy between communities
Domain 1: Health Protection and Resilience
Comprehensive, agreed, interagency plans for responding to public health incidents
Systems in place to ensure effective and adequate surveillance of health protection hazards
Life years lost from air pollution as measured by fine particulate matter
Population vaccination coverage (for each of the national vaccination programmes across the life course)
Treatment completion rates for TB
Public sector organisations with board approved sustainable development management plans
Domain 2: Tackling the Wider Determinants of Health
Children in poverty
School readiness: foundation stage profile attainment for key stage one
Housing overcrowding rates
Rates of adolescents not in education, employment or training at age 16 and 18
Truancy rate
First time entrants to the youth justice system
Proportion of people with mental illness and/or disability in settled accommodation
Proportion of people with mental illness and/or disability in employment
Proportion of people in long-term unemployment
Employment of people with long-term conditions
Incidents of domestic abuse
Statutory homeless households

Fuel poverty
Access and utilisation of green space
Killed and seriously injured casualties on England's roads
The percentage of the population affected by environmental, neighbour and neighbourhood noise
Older people's perception of community safety
Rates of violent crime, including sexual violence
Reduction in proven reoffending
Social connectedness
Cycling participation
Domain 3: Health Improvement
Prevalence of healthy weight in 4-5 and 10-11 year olds
Prevalence of healthy weight in adults
Smoking prevalence in adults (over 18)
Rate of hospital admissions per 100,000 for alcohol related harm
Percentage of adults meeting the recommended guidelines on physical activity
Hospital admissions caused by unintentional and deliberate injuries to 5-18s
Number leaving drug treatment free of drug(s) of dependence
Under 18 conception rate
Rate of dental caries in children aged 5 years
Self-reported wellbeing
Domain 4: Prevention of Ill Health
Hospital admissions caused by unintentional and deliberate injuries (1-5 years)
Rate of hospital admissions as a result of self-harm
Incidence of low birth weight of term babies
Breastfeeding initiation and prevalence at 6-8 weeks after birth
Prevalence of recorded diabetes
Work sickness absence rate
Screening uptake

Chlamydia diagnosis rates per 100,000 young adults aged 15-24
Proportion of persons presenting with HIV at a late stage of infection
Child development at 2-2.5 years
Maternal smoking prevalence
Smoking rate of people with serious mental illness
Emergency readmission rates to hospital within 28 days of discharge
Health-related quality of life for older people
Acute admissions as a result f falls or fall injuries for over 65s
Take up of the NHS Health Check programme by those eligible
Patients with cancer diagnosed at stage 1 and 2 as a proportion of cancer diagnosed
Domain 5: Healthy Life Expectancy and Preventable Mortality
Infant mortality
Suicide rate
Mortality rate for communicable diseases
Mortality rate all cardiovascular disease (including heart disease and stroke) in persons less than 75 years of age
Mortality rate from cancer in persons less than 75 years of age
Mortality rate from chronic liver disease in persons under 75 years of age
Mortality rate from chronic respiratory diseases in persons under 75 years of age
Excess seasonal mortality