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AGILE & CUSTOMER CENTRIC BRAND PLAN QUALITY CHECKLIST

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With this document, designed by Prof. Edouard Demeire, brand teams can critically assess the quality of their brand marketing plans.

The structure of this document is based on the 4 major building blocks of a good brand plan:

I. **What is the market situation today?**
II. **Where do we want to go?**
III. **How will we get there - How will we know whether we are on track?**
IV. **What does the financial case look like?**

There are **13 quality check points**. The quality of a brand plan depends on the quality of each part, and not on the sum of all parts. Like a chain, its strength is determined by the weakest link.

I. What is the market situation today?

Epidemiological patient potential and **patient flows** should be designed and quantified in order to reflect the business potential of each pool of patients.

☞ Check Point 1:	Ensure your patient data are fact-based, and help to identify key leverage points.

For each of the important stakeholders, a **customer experience journey** needs to be defined. For patients, the journey may evolve from being undiagnosed to compliance to a chosen therapeutic option.

For HCPs, the journey may evolve from a status quo situation, unaware of a new treatment option to the full adoption and advocacy of a therapy.

For certain categories of payers, the journey may start from being unaware of the burden of a disease, over the positive recommendation, to ensuring availability of resources.

☞ Check Point 2:	The customer experience journey should be visually clear, balancing completeness with simplicity. At each stage of the journey, it should be clear what the stakeholder is doing and how they feel about that particular stage – is it a pain point, or on the contrary are they fully satisfied with the experience the pharma company is delivering.

The most important **stakeholders and their essential needs and beliefs along their journey** should be identified. To identify "*essential needs*", think beyond basic assumptions about "*efficacy, side-effects …*"

For instance, patients do not ask doctors to cure their depression; instead they complain they can not sleep well. Once identified, the stakeholders/customers need to be quantified (example for anti-TNFs: 100 Hospital Rheumatologists who treat 10.000 patients, 150 private practice-based Rheumatologists who treat 8.000 patients).

Ultimately, the stakeholder's current beliefs and behaviours will need to be addressed by tactical plans. So, while the stakeholder journeys may sometimes be a little complex, a small number of important insights need to be developed for those steps where pain points can be transformed into positive experiences.

☞ Check Point 3:	Have the stakeholders been quantified? Are their key behaviours, beliefs, essential needs, feelings,… defined for each of the critical steps in their customer experience journey?

The **Competition** needs to be identified, not only as products that have the same mode of action, but also when relevant, indirect competitors or substitute treatment technologies such as surgery, watchful waiting, oral vs. infusion vs. radiation, personalised health care solutions,…

Timelines of approvals for competitors, their label and the share of voice (reps, medical…) should also be identified. Beyond classic competitive intelligence, has an understanding been gained of the situation, objectives… of the competing brand's corporation, leading to competitive foresight?

Rather than gathering megabytes of CI (some of which are stored in databases which is not validated, not updated and little used), has a demand driven CI approach been defined, yielding answers to key questions relevant for the brand's key decisions?

☞ Check Point 4:	Have CI requirements been defined around key decisions to be made for the brand? Does the competitor analysis include foresights both at competing product and competing company level for all major relevant treatment alternatives?

II. Where do we want to go?

The summary of findings from the above situational analysis needs to be presented in a **SWOT** analysis, which covers both internal and external issues. This should fit on one page, with internal issues in *Strengths & Weaknesses* and external issues in *Opportunities & Threats*.

As it will be important to focus resources, best is to use an *Impact & Probability Analysis* at this stage to be able to determine the most important issues in the SWOT (and thus avoiding very lengthy SWOTs).

☞ Check Point 5:	The SWOT analysis should be complete, short and clear, so that it generates truly insightful critical success factors.

During the subsequent **Segmentation** process, market segments need to be defined as homogeneous groups of customers, not as product-based segments (product-based such as the chemo vs. the biologics segment). Customer criteria used to cluster customers should include some of the following:

1. The potential of the segment, as identified in the patient flows for patient sub-populations or in the analysis of patient potential per HCP for doctors or accounts.

2. The level of adoption of customers in different stages of their adoption journey (non-users, loyals, switchers…) and the respective needs and beliefs that drive their behaviour.

3. Groups of customers which have different preferences regarding interaction channels (personae).

The segmentation should be sequential, which means that an adoption-based segmentation should not be attempted unless a potential-based segmentation is already in place and is being monitored. A segmentation based on preferences in terms of interaction channels should only be developed once segments have been prioritised.

☞ Check Point 6:	The segmentation criteria used should be clearly defined, differentiating in terms of patient, adoption and possibly of interaction preference.

Following the segmentation process, a selection needs to be made, stating which segments will be pursued, and in which sequence. Also, a clear statement needs to be made as to which segments will not be pursued.
Then, for the selected segments, a clear prioritisation over time is required. A useful presentation format for this is a *Segment Attractiveness / Competitive Advantage Matrix* of the segments.

☞ Check Point 7:	The determination of priority segments should be fact-based, i.e. based on clearly defined and quantified criteria.

Targeting is then the process of identifying the customers according to the chosen segmentation criteria and then applying the specifically designed action plan to this target list. Although part of the execution of this is performed in collaboration with medical, sales, and any interacting channel, the tactical part of the marketing plan should address the implementation of the targeting with the CRM or account planning system.

The next step is the **Positioning Statement**, which is required for each indication the brand is currently marketed for. A positioning statement must include:

- The target market of customers;
- The comparator (the main competing therapy);
- The discriminator (both functionally and emotionally);
- The reason to believe (data, customer experience...).

It must be such that representatives of major departments (sales, medical, regulatory…) all agree that it is optimal, in the sense that:

- The discriminator satisfies an important need for targeted clients;
- Your brand is perceived to be really different;
- And this difference can be justified (a strong reason to believe such as clinically sustainable data, an approved label, a recommendation,…).

☞ Check Point 8:	The positioning statement should be clearly defined, agreed upon and impactful.

At HQ-level, in addition to positioning statements for current indications, a "longer term" brand ambition needs to be defined which accommodates the future positioning statements based on the target product profile in all indications for which data are not available yet.

It is very important that messages are derived from the positioning statement in an appropriate way. Therefore, staff in touch with targeted customers should report back to brand teams whether or not messages genuinely attract interest of the customers in tests.

Do the targeted customers immediately see the difference with the competition and how they will benefit from using your brand? Hence, do the key messages link directly to the most important customer benefits? Finally, are these key messages "ownable", i.e. could competitors make similar key claims? Are trial data available that endorse these claims?

Branding then relates to the consistent implementation of the visuals, messages… in line with the target segment, functional and emotional benefits described in the positioning statement in such a way as to achieve brand recognition, awareness, associations and loyalty.

☞ Check Point 9: The positioning should be impactful & differentiating. Key messages should then implement the brand's positioning in a sustainable way.

III. How will we get there? How will we know whether we are on track?

A limited number of **Critical Success Factors** (CSFs) need to be identified. These CSFs reflect positively phrased "beliefs & behaviours / stages of decision making" that customers have to go through in order to generate sales.
CSFs should not reflect actions, such as "*we lobby the payers*", but rather beliefs and behaviours: "*acceptance by the payers of the products cost/benefit*" or "*physicians accept the need to treat a type of patient*". They should not reflect the current state, but rather the desired state. In other words, the beliefs and behaviours should not be defined as "*currently unwilling to fund*", but "*to be willing to fund*".

The defined CSFs link back to:

1. Segments which have been identified as a priority in the strategy;
2. Pain points identified in the customer experience journey;
3. Key items derived in the SWOT (about competition, customer…).

Plans tend to be much easier to read when issues which were first identified in the customer experience journey, for a segment and in a SWOT, then re-appear phrased in the same way as a CSF with actions. Plans which have CSFs that cannot be found in earlier parts of the plans should be rejected as this would either imply either the situation analysis or the chosen CSFs are wrong.

☞ Check Point 10: The CSFs should be very clearly defined and to the point.

In order to be able to act upon the CSFs, the relevant stakeholders who can influence the issue have to be identified and prioritised.

For example, if obtaining "willingness to fund" is a CSF, would it be either working with a patient organization or gaining positive recommendation of a leading health economist which would be most impactful to "unlock" the CSF.

Other example: for hospital sales, are key opinion leaders who sit on advisory committees relevant stakeholders, or does the hospital pharmacist have the final say? This obviously varies from disease to disease and from country to country.

The **Action Plan** should then be designed in such a way that all of the important actions are targeted towards getting the stakeholders to a particular behavioural objective - so that they resolve the critical success factor.

For instance, the objective of funding a clinical trial could be (1) to get KOLs to endorse local evidence, or (2) to prove our differentiator, or (3) to obtain smooth market access, or (4) all of these.

All members of the cross-functional teams should align as some critical success factors may be achieved through a combination of commercial, access and medical (CAM) tactics. Regardless of who is responsible for their execution, it is preferred and fully compliant to co-create the tactical plans. Obviously, compliant execution requires medical to be responsible for the execution of medical tactics.

☞ Check Point 11: The actions should address the stakeholders beliefs & behaviours, which in turn access the CSFs.

The measurement of "leading" indicators, or **Metrics**, needs to be planned allowing management to track performance before it translates into sales.

Market Share and/or Patient Penetration are not appropriate because they are lagging indicators. The measurement methodology of these "leading" indicators should be part of the plan. Leading indicators can including activity tacking (number of meetings, number of visits, dossier filed by date X,…) which is easy to measure and tracks implementation performance. However, to understand where the team is at addressing stakeholders beliefs & behaviours, KPIs such as awareness, intent to prescribe, belief in trial data,… are better predictors of final outcomes.

☞ Check Point 12: The measurement of performance should be based on leading indicators of belief & behavioural change of the critical stakeholders, addressing key CSFs.

IV. What does the financial case look like?

A number of scenarios of **budget expenditure and sales** need to be defined by the product teams in such a way that senior management understands the short- and long-term resource trade-offs (strategic attractiveness of the product vs. short term sales responsiveness).

These scenarios should not simply be little noise, more noise or a lot of promotion - they should be based on successive sets of segments of customers.

Example: second line metastatic, second line plus first line or second, first line metastatic and adjuvant; or: insufficiently reduced LDL patients, first line patients, undiagnosed patients. For each of the segments selected in one scenario, total epidemiology should be multiplied times treatment rate, market share, dosing, duration and pricing to obtain the sales estimate of that scenario. These inputs are required for the cross-product optimisation processes.

Budget Scenarios generate a clear understanding of up & downside of products in the Franchise in a particular country. This is based on the in-depth analysis of sales potential of each of the segments and actions required per segment.

Historically, companies have defined budgets in Q3 for the whole of the following year. This is clearly not sufficiently agile in a world which is moving faster. Companies should be reallocating resources across their portfolio in an agile way, whenever an event occurs which imposes a re-allocation. An event may be internal, e.g. better or worse clinical trial data or external, e.g. a generic or biosimilar competitor launching earlier or later.

☞ Check Point 13: The Upside/Downside agile budgeting should be based on strategic options and a fact based analysis of required investment and potential sales of the various strategic options.

Thank you

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Or contact Inge Cornelis, Director Client & Product Projects at CELforPharma