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Welcome to the 2024 Conference News

Delivering the membership benefits to you

Ensuring you know what's on offer

Welcome to the EPHMRA 2024 Conference News

Contents

Member News

Agency Members can include one piece of News for free: 50 words max plus photo/logo.

Member Articles

In addition we encourage companies to submit articles for publication – these can be on any topic you think the EPHMRA audience would find interesting. There is no charge for these articles but it's an offer only available to Agency Members of EPHMRA.

Each article can be one A4 page long (full page) and supplied ready formatted as follows:

No bleed	297mm x 210mm
With bleed	307mm x 220mm
Type Area	277mm x 190mm

Resolution/Artwork - If using photoshop or software dependent on resolution please ensure that it is set at the correct size and that the resolution is set to no less than 300dpi. Finished artwork needs to be supplied in CMYK with embedded fonts, or text should be converted to outlines/paths and supplied as an EPS. Print quality PDF files are also acceptable. PLEASE NOTE: We cannot be held responsible for any misprint, if fonts are not embedded/ converted and the file is not in CMYK.

System - Apple Mac

Programmes - Quark Xpress, Adobe Illustrator, Freehand, Adobe Photoshop

File formats - Graphics should be supplied (CMYK) in the following formats EPS, TIF, JPEGS and Print Quality PDF files.

Copy Deadline

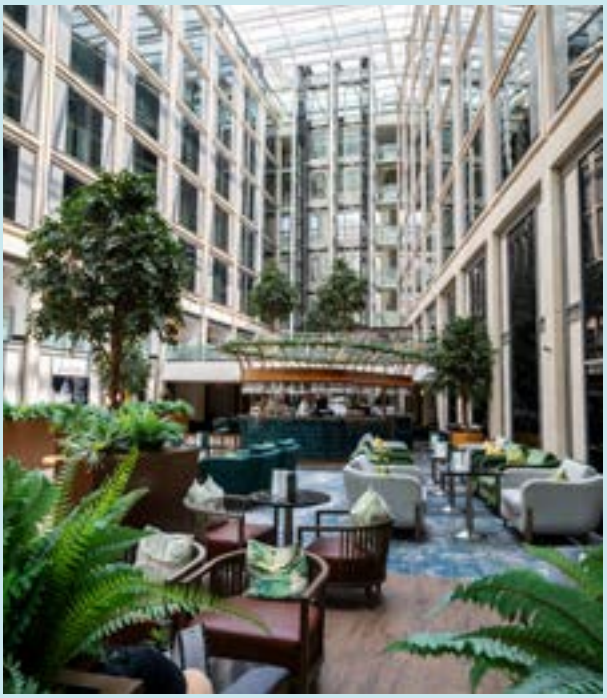
For the March 2025 News - Copy deadline is 15 January 2025
Send to generalmanager@ephmra.org
www.ephmra.org

Get in touch

If you have any enquiries, suggestions or feedback just email us: Bernadette Rogers, General Manager Email: generalmanager@ephmra.org

2024 Conference News

Round up from the London Conference



Over 220 delegates gathered for the 2024 EPHMRA London conference.

The Conference kicked off on Monday 24 June with two workshops:

- AI Workshop with speaker: Dr Andrée Bates
- Forecasting for Non-Forecasters – Challenge & Defend your Forecast, Create Value

On Tuesday (25 June) the Committees were collaborating in their meeting rooms with the AGM taking place at 13.50hrs.

Then the Conference kicked off at 15.30 with the opening address from the President.

2024 Conference Steering Committee

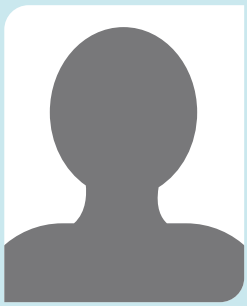
Our Steering Committee comprises of the following people from Agencies and Industry side and EphMRA wishes to thank all of them for all their hard work in advance and during the conference.

AMR KHALIL
Managing Director
Ripple International

ERIK HOLZINGER
Founder & Director
groupH

GEORGINA COOPER
Managing Partner
Basis Health

ROY ROGERS
Director
Research Partnership



LETIZIA LEPRINI
Global Competitive
Strategy Lead, Roche

SARAH PHILLIPS
Vice President
IQVIA

TRACY MACHADO
Senior Director
Elma Research

STEPHEN POTTS
Director
Purdie Pascoe

XIERONG LIU
Senior Director
Ipsos

KRISTINA DIPIETRANTONIO
Executive Vice President
The Planning Shop

Tuesday 25 June

Conference Opening:

Karsten Trautmann, EPHMRA President

Karsten welcomed everyone to the 2024 Conference, and commented on the lively and positive mood of the audience.

Karsten Trautmann

He outlined the inspiring papers and challenging discussions that would be available over the following 48 hours, as well as the opportunities to network with peers and colleagues across the industry.

He reflected on last year's conference, where AI was a hot topic creating some anxiety about what it might mean for our industry as a whole, and our individual jobs, and was pleased to note that we have moved forward in understanding how AI can help us perform better in our jobs, and also our understanding of how to navigate the dangers and pitfalls of this new technology.

This year, he noted, we are facing other emerging trends such as a more restricted payer and policy landscape, aging portfolios and a trend towards niche and rare diseases, all of which will require a different approach and understanding.

Embracing and adapting to change requires understanding, and as insights professionals, we can discuss these changes and see how we can contribute to improved decision-making for our industry in this changing world.

He invited us, through the conference, to learn about new treatment journeys and patient ecosystems; the evolution and role of digital influencers and social media analytics; where (and where not) to apply AI; new forecasting concepts; and how to use insights to deliver better product launches, despite the emerging challenges in our industry.

Karsten highlighted the opportunities for self-development as well, including honing our storytelling skills to increase our value to management, and ultimately to improve patient outcomes via the insights we are generating, to expedite access to medicines and overcome health inequality.

He encouraged us to recognise the value that we as individuals and as a profession can bring to the success of our industry, and therefore the lives of patients.

Karsten highlighted our opportunity to learn from, and network with, over 215 delegates from 92 different companies, including 62 industry delegates, all eager to fulfil the values of the EPHMRA organisation: building community and relationships, learning and discussing, and sharing peer-to-peer.

He reminded us of the variety and reach of the EPHMRA committees working on behalf of members, including specialists in fieldwork, forecasting, classification, devices & diagnostics, data & systems, as well as guiding us on Ethics, Learning & Development, and encouraging young professionals in our industry. He thanked the Programme Committee for all their work to bring together the experts involved in the conference, and the Executive Board for their leadership in securing the future of the organisation.

Karsten's welcome concluded by reiterating the conference objectives to energise and inspire us, helping us to connect or re-connect with colleagues, share new thoughts and ideas, and to bring these inspiring new ideas back to our work-settings to improve our future success.

Panel Discussion: The Future of Healthcare MR

Panellists: Diane Chayer, Leo Pharma; Sarah Phillips, IQVIA; Geoff Birkett, Ensysce Biosciences

Convenor: Amr Khalil, Ripple International

Diane Chayer

Geoff Birkett

Sarah Phillips

Our opening panel discussion went right to the heart of the future of our industry, asking us to think about what the future will bring, the changes we will see, and the issues, challenges and opportunities they may present. The session brought together thought-provoking ideas and observations from an expert panel and challenging questions from an insightful audience, inspiring us to think not only about what the future may hold, but also how we as individuals and organisations can help to shape future success.

Diane got things started with an acknowledgement of the challenges for a new agency in opening and building a relationship with a new client. Procurement, she observed, is often seen as a barrier by both small and larger agencies, where small agencies report that Procurement prefers to concentrate the spending within a few large,

broad-capability, agencies, yet large agencies say that Procurement likes the variety of working with a range of diverse agencies. There is, she noted, an onboarding hurdle to overcome with the admin required to add a new agency to the process system, and also highlighted the perceived risk of letting go of a good agency to try someone new. She did also note that sometimes, the influence of Procurement can be used as an excuse, and that research executives can usually find a way to work with the agency that they want. However, she warned us of the dangers of a long and close client-agency relationship leading to convergence in thoughts and ideas, and a corresponding reduction in the level of challenge and innovation from a long-term agency partner.

She confirmed the preference of pharma researchers to have "partners" rather than "vendors", and the benefits of working with someone who understands your strategy and needs. Diane's tip for opening doors was to start a meaningful interaction, such as sending a webinar invitation for an interesting topic, which will make that agency top of mind for the next project. She also highlighted the two-way nature of long-term partnerships, where an agency may step in to provide additional support in an emergency, and the pharma researcher will avoid negotiating on price as they are aware of the overall service and support that has been provided beyond the parameters of a single research project.

The discussion returned to the theme of partnerships later in the session. An audience member worked across industries, and noted that in other industries there is talk of "technology partners" with peer-to-peer discussion around how business challenges are solved. He noted that in the life sciences industry, there is often still a master-servant relationship, and invited the panel's views on how to progress past this. Geoff agreed that the partnership was the optimal model, and suggested that if an agency is already delivering value and impact, delivering insight in a clear and focused way to be the best people to guide a client to the answer to their business question, they should automatically be treated as partners. Pharma companies, he reasoned, rely on external experts

to bring their familiarity and expertise to a brand team who may be facing a particular challenge for the first time. He suggested that if a master-servant relationship was being imposed, the issue may lie with the client!

Geoff turned our attention to the future impact of technology on our industry, with a prediction that the next 5 years will bring a seismic change in how technology is used. He gave examples of this technology shift already in place today, from Eli Lilly's robotic discovery lab to Glaxo's augmented reality training programmes. Despite the often-mentioned fears that technology such as AI may make many market research jobs redundant, Geoff focused instead on the opportunities that new technology brings, and predicts that the successful companies in the future will be those who figure out what the "next big thing" might be, and how to leverage it for their advantage. He gave an example from the time when the internet was taking off as a new force, where a team member decided to become the company's internet expert and led them through the process, simply because he was a couple of pages ahead of everyone else in the playbook. Geoff advocates making time to scan the horizon and work out how the "next big thing" might affect us all.

A follow-up question from the audience asked the panel how to foster a culture of encouraging employees to explore specialist areas of interest, whilst balancing this against the need to deliver benefit to the business in the longer term. Geoff aligned this with strong leadership and investment in people. A good leader, he said, should establish that an employee is meeting the core requirements of their current job role, and then help them to explore what other avenues or areas might leverage their interest and talent, bringing personal fulfilment whilst providing additional benefit to the team. Diane agreed, highlighting the benefit of graduate programmes where new employees with limited experience but an abundance of new ideas and energy could contribute to the overall benefit of the company. Amr observed that as a society we have become very reactive and focused on short-term immediacy, rather than allowing thinking time to explore interests that might lead to longer term benefits. Sarah noted that the challenge for leaders is in ensuring that new graduates learn the same set of essential basics required as the building blocks of the job, but can then pursue their individual interests and develop into high-performing teams made up of individuals who are passionate about different things, that might benefit the business in the longer term.

Sarah picked up the theme of future changes in the nature of client requests and business needs, and observed that client needs themselves have not changed – they still want faster, agile research, conducted more cheaply, with more actionable outputs. However, she believes that the way in which those questions are answered have changed, and will change further in the future. She reminded us of the times when successive changes and innovations were expected to have a detrimental impact on our industry, from the internet making qualitative research redundant, adverse event reporting making market research untenable, and the advent of AI putting us all out of work. The panel agreed that a data dump of information, whether from new technologies or new research methods, was no substitute for Human Intelligence to identify the insights behind the data, and that, in fact, the healthcare market research and insights industry should be one of the last places to be "damaged" by new technology. Sarah promised us that our insights industry would still be here in 5 years' time, but that we were going to have to adapt and embrace the new technologies and changes. Geoff agreed that our industry objectives of helping patients would remain the same, but the way we achieve this may be radically different in the future.

Sarah identified a new theme emerging: the desire to consider diversity and inclusion when talking to patients. Just as clinical trials are increasingly focused on including a diverse and representative patient population, we need to ensure that our understanding of patients is based on a diverse and representative patient population.

This objective is sometimes given token acknowledgement by including a split for ethnicity or socioeconomic groups in our market research screeners, but Sarah believes that the challenge is greater than this, and requires a different way of working. She gave the example of a study which asked for video-streamed interviews with lower socioeconomic class women in southern USA, and the panel noted the potential barriers to success of a project like this, and other projects with diverse, hard to reach or under-researched respondent populations, not only in terms of recruitment success but also the impact on the amount and nature of information gathered if using traditional research methods with respondents who are not accustomed to taking part in research in this way.

A question from the audience took this discussion a stage further, noting the need to interview respondents from diverse backgrounds in their own environment, and the implications for our industry of a return to face-to-face interviewing. The panel agreed that the industry has changed since COVID, with remote web interviews having become the norm, with the benefit of convenience of respondents, moderators and observers, and with the associated time and cost-efficiencies of remote interviews. Diane highlighted the quality and value of F2F interviews compared with web interviews, but acknowledged the challenges for recruitment, particularly when Fair Market Value principles tended to lead to respondents being offered the same remuneration based on interview duration, whether they were interviewed from home or had to drive for 30 minutes to a viewing facility.

Sarah concluded that the incremental value of F2F interviews over web interviews would need to be clearly demonstrated to justify the cost difference, but that for certain projects, including diverse respondents in the sample would enable us to hear a truly representative patient voice, rather than only the voice of the patient who is willing to speak to us online.

Geoff emphasised the opportunity for technology to help us to access those hard-to-reach respondents, noting that AI may take the strain on some aspects of research, with Human Intelligence then able to focus on reaching patients and uncovering the insights that we will never get from technology. He predicts that those agencies who return to F2F interviewing the soonest will likely reap the rewards of the value that they add. An audience question highlighted that technology can actually amplify social inequality and bias, emphasising the need to meet respondents on their own ground, and invited views on how to achieve this in a consistent, rather than ad hoc, manner. Geoff commented that it was a laudable aim, but that there may be barriers to achieve this in real life. Instead, he encouraged the sharpest minds in our audience to create new offerings which will uncover patient needs, whether via technology or new forms of in-person research. Sarah highlighted the opportunity to reveal insights via means other than interviews, such as via wearable technology or data capture that doesn't involve speaking to the patient. Amr observed that currently we conduct research to suit ourselves, but that we will need to think about how to develop research approaches that will meet the situation and preferences of our diverse respondents.

A question from the audience followed up on the theme of adapting to the future environment, asking what we should do more, what we should do less, and what we should stop doing altogether.

Sarah's response was to encourage us to talk less about new technologies and methodologies until we can demonstrate the real impact of these approaches in driving action and making a difference. Geoff agreed that we need to spend more time working out how to use the tools available to uncover unusual answers, and the need to shift from thinking about the process to spending more time thinking about what we need to know and how to find answers using the tools available.

Sarah also emphasised the need to apply a more holistic view when analysing our research findings. Rather than viewing a primary market research

project in isolation, we should set the findings into context based on a broader understanding from secondary data, social media and other sources. Diane agreed, pointing out that triangulation across insight and competitor intelligence is key when your client does not have market research questions, but broader business questions.

The panel were united in the view that our agencies' proposals and findings need to be distilled into a concise and targeted answer to the clients' needs, making them digestible, simple, clear and compelling to demonstrate how the offering will make life easier for a stressed, time-poor Brand Director or Research Director. Diane shared an example of a talented agency which had delivered an excellent project with an innovative methodology, but in the final presentation had lost the audience's attention by focusing on the clever methodology rather than the answer to the business question. Our panellists expected the trend to shorter results presentations to continue, having evolved from the old days of a full written report to a format of 20 PowerPoint slides, then 12 slides, then 3 slides or a 1-pager for senior management, to three bullet points of actionable insight to help the business.

Our job as insights professionals is to provide answers by distilling information down to key insights that will benefit the (internal or external) client and deliver the solution to their business challenges. The themes discussed in this session, of the need for partnerships between agency and pharma, the benefit of including diverse respondent types in our research, and leveraging technology alongside new methods of traditional research, will help to ensure that our industry can adapt and thrive in tomorrow's world.

Patient social media influencers: The future of healthcare. Why the industry needs influencer engagement strategies

Speaker: Paul Reed, Research Partnership

Convenor: Xierong Liu, Ipsos

Paul Reed

The impact of patient social media influencers on the healthcare industry was the focus of the paper presented by Paul Reed at this year's conference, with contributions from Trishna Bharadia, the UK's leading MS patient advocate and a lecturer at King's College London on patient engagement.

What do we mean by a patient influencer?

Paul began by stating that the online advertising guide defines a lifestyle influencer as being a person with enough celebrity, credibility or authority to change behaviour. A patient social media influencer has a similar kind of definition, but the key difference is that they are authentic, relatable and trusted enough to change patient behaviour in the real world. A patient with a diagnosis goes on social media, looks for other patients, connects with them and listens to the influencer because they are trusted and they like them. As a result of listening, they will act on that behaviour and this can have both a positive and a negative impact on healthcare outcomes.

Paul urged that even though the insights community has for some time been carrying out social media listening to understand the emotional experience of the patient and build the patient journey, we need to go much further and directly engage with patient influencers. They are experts in healthcare with views that are just as valid as a KOL or a doctor. While a

patient influencer can open the door to the lived experience of the patient, they can often be experts in the science of drug discovery and be effective scientific communicators. They can also be great media spokespeople and powerful lobbyists and campaigners.

Why patient influencers are important

There are thousands of patient influencers online who in turn have millions of patient followers. In the UK, 6m people follow patients on social media and in the US, 18% of the population use healthcare information provided by social media influencers. Patient social media influencers are important because:

- Trust in traditional institutions such as the business and media is in decline and patient influencers fill this void.
- We live in the hyper social age. Any patient can connect with other patients for information. However, healthcare misinformation is a huge problem and we need to empower responsible patient influencers to help combat this.
- Patients are empowered and expect to have all their healthcare information available to them. The influencer is the gatekeeper of the healthcare information.

Shifting trust

Paul explained that we are seeing trust shifting from institutions to influencers.

- 60% of individuals at high risk of CV disease do not trust pharmaceutical manufacturers and information produced by them.
- Trust in doctors is still high but is in decline. 87% of doctors say that patients trust them less than they did a decade ago. This is more pronounced in the younger generation.
- 44% of Gen Z trust healthcare systems 'some' or 'a lot' compared to 74% of Baby Boomers. Healthcare influencers have arisen in this gap.
- Whilst 14% of consumers mostly or completely trust a lifestyle influencer, 51% completely or mostly trust a patient influencer. 85% said they would be very or somewhat receptive to a pharma brand if advocated by a patient influencer.

Hyper social age

There are 5 billion social media users around the world i.e. 62% of the population. 70,000 Google health searches take place per minute although in many respects, this is old media. The younger generations (Y and Z) go on Instagram and TikTok to look for healthcare information from influencers because they see them as authentic, relatable and trusted.

However, there is the significant issue of misinformation. In a recent study, 500 mental health videos were taken from TikTok and analysed. 84% of them were seen as misleading but were viewed 24m times and 14% of the videos were "potentially damaging" to the viewer's health. In this environment, responsible influencers can be our allies in combating misinformation.

Patient centricity

We are moving away from a top-down physician-led model to a more collaborative approach between the doctor and the patient and in this environment, the patient needs healthcare information. As doctors don't have time to provide it, patients go online and crowdsource healthcare questions. They are very dependent on influencers as their gatekeeper for all their healthcare information.

Identifying patient influencers

While no two patients are the same and all patient journeys are different, no two patient influencers are the same. It is about identifying the right influencer for the right project.

- The first step in identifying a patient influencer is to use social media analytics to identify the patients that have a significant follower base.
- It is then about profiling i.e. understanding the influencer as a human and understanding their values and objectives.

- Thirdly, it is about engaging i.e. how can we build a long-term relationship.

Both macro and nano influencers can be important. Macro and micro influencers tend to be lifestyle influencers. A celebrity influencer is typically defined as having a million followers, while nano influencers are more niche with around 1000 followers. However, the more followers an influencer has, the less engaged the followers are. Celebrity influencers on TikTok have an engagement rate of 5% of people who like or follow their video content. With nano influencers, the engagement rate is almost 18%.

If this is applied to patient influencers, nano influencers are those in the rare disease setting. They may only be followed by 100 patients, but these patients will be highly engaged and the influencer will be a community leader. They will be a critical stakeholder to build a relationship with if you want to understand the rare disease.

Well-known examples of patient influencers include Michael J. Fox on Parkinson's Disease with 1.5m followers on X, while Dame Deborah James on bowel cancer had 1m followers on Instagram. However, there are many rare disease influencers and on TikTok, #raredisease has 2.5m views. Even though they have small follower bases, these influencers are often celebrities within their communities. Stephanie Ernst, who had twins born with a shared placenta, needed to connect with other parents who had also experienced this. She set up a community on Facebook and while it only has 300+ followers, it is very powerful, with academics and medical researchers joining this community to listen and learn from the parents.

How do we as an industry begin to work with influencers

Paul emphasised that it is important for us to find shared objectives to work with influencers on that will benefit the patient.

- We could engage with the patient influencer as a principal investigator for published research. This has traditionally been done by a KOL but using an expert patient would have multiple benefits. The patient influencer can bring their depth of knowledge on their lived experience and they can also act as a bridge between patients and the medical community. They add credibility based on their experience as a patient and ensure that patient outcomes remain the focus.
- We could collaborate with the patient influencer as a market research project consultant. At kick-off, they could make sure that the questions we are asking are the right ones. They could make sure that the discussion guide and the questionnaire are patient-friendly, that the interpretation is meaningful and that the recommendations will benefit patients.

Trishna reiterated that it is crucial to be authentic and to be able to build trust with the influencer and the wider patient community. This means that:

- Patient influencers cannot be seen to be a mouthpiece for pharma. They need to be seen by the patient community as partnering with organisations that they genuinely respect and believe in. This is linked to the trust that the followers have in the influencer.
- Co-creation is key and it should be a collaboration. It is important to have the right influencer for the right project. Influencers can be drawn from patients with experience, expert patients and patient leaders or consultants. The influencer who is featured in a campaign may not be the same one that is consulted on the development of the project.
- Any material needs to be relevant and targeted.
- Transparency is critical because it leads to effective and trusting partnerships. Be clear about what you are expecting from the influencer and keep them informed and updated throughout the project, including after it has finished. The influencer needs to know what is expected of them and what they can expect from the organisation they are working with. There also needs to be transparency about the parameters you are able to work within, especially

around compensation and what you can and can't ask influencers to do.

Paul concluded by emphasising that patient influencers are professionals. It is therefore essential to have clear contracts in place and payment terms, also to carry out due diligence to make sure that their historic social media posts fit into the values of the companies, agencies and patients involved.

Key takeaways

- Patient influencers are the future of the patient information system. All the information that a patient will get could come from an influencer. As an industry, we need to partner with responsible influencers to help combat misinformation.
- We need to think of patient influencers as being healthcare experts. They can open a door to lived experience and can be excellent scientific communicators as well as powerful campaigners and lobbyists. They are as important as payers and KOLs.
- We need to engage with patient influencers but this will take time. We need to find correct projects and mutual benefits so that we can collaborate successfully.
- Engaging with influencers can create meaningful and impactful change in the lives of patients.

The role of Digital Opinion Leaders within Omnichannel

Speakers: Daniel Ghinn, CREATION.co and Dr Kevin Fernando

Convenor: Xierong Liu, Ipsos

Daniel Ghinn

Kevin Fernando

Using metrics around how and why a Digital Opinion Leader (DOL) is impactful in Type 2 Diabetes (T2D), Daniel Ghinn interviewed Dr Kevin Fernando, one of the top HCPs in this area according to annual analysis by CREATION.co.

Why do you use social media?

Kevin began by explaining that although he had always been an advocate of social media, it came to the forefront of his life during the pandemic as a means of staying in touch with his colleagues. As it emerged that people living with T2D were much more likely to suffer complications - and death - as a result of Covid, social media became an important method of communicating information quickly. With guidelines constantly changing, Kevin did a regular podcast and then had a role with the GP Notebook to keep his colleagues up to date. Social media also provided important camaraderie at a time when many HCPs were working in very isolated circumstances and were no longer able to meet face-to-face.

Post-pandemic, Kevin has continued to disseminate information via social media both to HCPs and to patients. He has also rebranded himself as not only being interested in diabetes but also with an interest in CV renal metabolic. Although he cannot attend all of the conferences in these areas, social media enables him to keep up-to-date with the latest developments.

Analysis in the year to spring 2024:

The CREATION.co analysis found that Kevin's key topics in T2D in the year to spring 2024 were:

- Treatment
- Research & data
- Guidelines
- Cost & access
- Lifestyle choices
- Risk & prevalence
- Awareness and education
- Diagnosis

Other significant metrics include:

- Kevin shared 243 posts on T2D, making him a content amplifier.
- His content has been referenced by 263 others.
- Of the accounts referenced in his T2D conversations, the most referenced were the Primary Care Diabetes Society (24 posts) and two HCPs: Dr Patrick Holmes (28 posts) and Jane Diggle (25 posts).

The top HCPs who referenced Kevin were:

- Robin Conibere (Pharmacist) 12 mentions.
- Bethany Kelly (Nurse) 11 mentions.
- Dr Patrick Holmes (GP) 8 mentions.

Kevin ranked 19th among the top 50 DOLs in T2D conversations globally, with specific rankings including:

- Peer trust 14th
- Treatment interest 28th
- Social activity 35th
- T2D activity 24th

Being a content amplifier

In 2024, Kevin has started to do more directed CPD including tutorials using twitter threads, as it is an easy way for his colleagues to access CPD from trusted sources that encompass a wide number of areas. He also has his own YouTube and TikTok channels with patient-facing content which launched in 2023 and have been very popular, with many of his colleagues in the UK and abroad sending links to their patients to add value and support.

One of Kevin's motivations in producing patient-facing content is to battle misinformation. He can also save time by signposting patients to these videos to help them engage and take their medication regularly.

Kevin reiterated that medicine continues to evolve at an astonishing rate. In the 1950s, the estimated time of the doubling of all medical knowledge was about 50 years. In the 1980s, it was about 7.5 years and in 2010, it was 3 years. In the 2020s, it is now 73 days. What a patient is presenting with may have changed completely in the last three months and this is why Kevin tweets and posts on LinkedIn about treatment and guideline updates to keep other HCPs up to speed.

A large part of Kevin's role is distilling take-home messages into clinical aide memoirs. With colleagues, he puts together one-sheeters with the most recent being on identification, management and interventions for CKD. His mantra is to make life easier for his colleagues and ultimately help improve the lives of patients and within hours of posting, there are tens of thousands of impressions.

Kevin emphasised that as a content amplifier, he creates content but also shares it. If it is a trusted source, he will disseminate it.

How do you decide who to trust and share/ disseminate information from?

Kevin said that:

- Trust is bi-directional. With the CKD information, he tagged in a major global kidney organisation and Kidney Research UK who both re-tweeted the information. He looks for reach but also robustness.
- Different HCPs reference you. Diabetes management today is a multidisciplinary approach driven by doctors but also practice and diabetes nurses as well as pharmacists and dieticians. In other words, information is shared by all disciplines, not just doctors.
- He likes to think that peers trust his content because he is consistent and references everything. He is quite clear if something is his own opinion and this adds trust and value. Endorsements also build trust.

Key takeaways

- Leveraging social media to reach HCPs with clinical messages will be increasingly important.
- Social media is already playing a huge role in distributing patient-facing information, including debunking myths and reinforcing the management of long-term conditions.
- Congresses are relying more and more on social media to disseminate research.

Panel Discussion: Organising the Forecasting Process in Large Organisations

Panellists: Nich Guthrie, Boehringer Ingelheim; Vijay Pillai, Bayer; Arijit Mukhopadhyay, Merck Healthcare

Contributors: Richard Murgatroyd, Roche; Simon Wright, BMS; Daniel Perret GSK; Greg Fazzaro, AstraZeneca

Convenor: Erik Holzinger, groupH

Nich Guthrie | Vijay Pillai | Arijit Mukhopadhyay

Erik opened the session by thanking all the experienced forecasters who have contributed to the discussion, both in preparation for the session and being present on the panel today.

Erik summarised the role of forecasters as having to translate assumptions and data into commercially-meaningful information on which to base business decisions. In large organisations, he noted, this commonly involves co-ordinating multiple different departments, and often uses complex tools. Erik recalled the evolution of forecasting tools from the Excel spreadsheet to proprietary forecasting packages which aim to align and organise the forecasting process, and which require cloud-storage due to the size of the models being created and shared. He noted that some forecasting tools now include AI or Machine Learning add-on functionality, already used for demand planning, but will potentially use across long-term forecasting as well.

A key topic for many large organisations, he explained, is how to organise the forecasting process. Is there a standard approach, or do we see more nuanced solutions specific to every company?

Erik outlined the range of organisational models for forecasting, first showing a standard linear forecasting process starting with data stewards and functions such as finance, marketing and supply chain, all feeding into the brand forecaster and global forecaster, involving analytics, and finally arriving at senior leadership. He also showed a model of integrated collaborative forecasting, where the same stakeholders work in a more collaborative way on a shared platform that everyone can access and monitor progress. He noted that there is also variation in the structure of the forecasting function itself, with some organisations having a centralised forecasting department, whereas others combine forecasting and insight roles within the brand team or therapy area business unit.

Opening the discussion to the panel, Erik asked what would trigger the need to think beyond the confines of a specific forecast model, to encompass organisational aspects of the business?

Nich started from first principles, reminding us that forecasts are only these to make business decisions. Forecasters are trying to represent, as accurately as possible, what is likely to happen in the future. However, the situation will only happen as a result of our actions, so the forecast is there to help us decide what action to take. He noted that the move from simple forecasts to more complex models happens because we want to look at different scenarios and explore how things might be different if our company does X, Y or Z, or if our competitor does A, B or C. We might also want to go back over a forecast and understand what has changed. Nich commented that it is notoriously difficult to ensure that teams document their assumptions clearly, and so a model may help to track these changes.

The challenge, Nich observed, if that for this to work well, we need to build in relationships between

different elements of the model, and that this proves surprisingly difficult to do, both for the forecaster (who has to work out what the appropriate relationships are) and for the brand team (who already have in mind what they would like to do and would like the forecast to confirm it!).

Vijay observed that long-term forecasts are often found to be skewed, due to the volatility of the healthcare environment. Senior managers would like to see a 90-95% accurate forecast, but that is almost impossible, and the forecaster needs to be transparent and manage expectations.

Arijit agreed that there is much more to forecasting than just the model, and that the discussions and story of the outputs are key – but very complex. He observed that many people try to reverse fit the model to the story or trajectory that they want, and the hidden complexity for the forecaster is the potential for disconnect between the assumptions and the story.

Erik summarised that there is therefore a need for documentation, so that the assumptions don't just disappear. Collaboration is important, both in terms of inviting inputs from others, and also sharing the resulting forecast.

Erik asked the panel what would trigger the need to consider a new tool or changing the current forecasting process.

Nich noted that it often seems a continuous process, having never found the right tool at the right time. He described the process of starting with the intention of keeping things simple, with a tool that everyone can use and understand. But then, he explained, there are requests for additional functionality or add-ins, which result in a very complex tool which limits use and understanding, and again triggers the desire to start again with a simple tool – and the cycle repeats. Where the tools are overly complex, he observed, stakeholders may use their own personal tools for their forecast, and use the official tool to report back to the central team (often by reverse-engineering the process to match what they have produced offline). He estimates that teams often use less than 5% of the functionality of the beautiful tools produced by external vendors, because of the onboarding barriers of time and understanding.

Vijay agreed that the design of most models begins with the desire for a simple approach, but that over time it becomes too complex. He also noted that we have to consider people's past experience when selecting forecast models, as their familiarity with a different method may restrict their willingness or ability to adopt a new method or tool, or at least limit the functionality that is used due to the time and effort required to learn how to use it.

Another challenge, Nich noted, was the desire for consistent and integrated forecasts across the different timeframes being forecast, from a monthly demand planning / supply chair forecast, to a 5 year plan for the brand teams, which might be extended to 15 years for strategic planning and senior management. Although the session is focused on the long-term forecasts rather than demand planning, there are situations where the two are difficult to separate, such as when planning scale-up facilities for biologics which take many years to build and therefore might require commercial capacity forecasts as early as the phase 1 development point.

Arijit highlighted a potential problem with integrated strategic forecasting and demand forecasting, as they are managed by different teams. With a real-time tool, every time one team changes one of the assumptions, the whole model changes. There are no backups or version control as you have with an Excel model, so all of the previous assumptions are immediately lost.

Vijay explained the setup at Bayer, where the global team is responsible for delivering long-term forecasts, working closely with the therapy area or brand teams, and that the countries and regions are responsible for the short-term forecasts as part of their performance targets. However, they are currently examining the forecasting processes across all function to see if a more holistic, integrated approach would bring efficiencies over the current set-up of different teams looking at early stage, in-market and late stage products, as products transition through the stages.

Arijit does not currently use a common forecasting tool, and is comfortable with an Excel spreadsheet on his laptop. He commented that it may not have the functionality of a state-of-the-art online solution, but that the purpose of tools should be as enablers, to save time, rather than hinder what you are trying to do, and that the additional functionality may not be helpful. He agreed with Vijay's point that onboarding a new tool often required people to un-learn a lot of familiar processes in order to embrace the new ones.

Erik asked what were the key attributes or needs from a new tool.

Vijay highlighted flexibility, explaining that each function has specific needs. Governance was also key, to aid standardisation and consistency. He explained that when multiple different functions are looking at different types of project, governance is essential to the process, starting with basic things such as source datasets, right through to interpretation and communication within the organisation. He emphasised the importance of documenting assumptions to ensure a shared understanding.

Nich agreed that governance is important, but noted that stakeholders also need ownership, which is enabled when they are able to change or disagree

with assumptions, and give their reasons for doing so. His current model is flexible, allowing changes to be made so that he can see and understand what has been changed. He noted that the value comes from the combination of the global team (who know the product better than anyone) and the local team (who understand their local market better than anyone). It is difficult, he noted, to find a proprietary tool that can capture these nuances and collaborations.

The panel noted the potential for conflict between different stakeholder groups, particularly when a global team has a vested interest in keeping the forecast high, but the local team may want to agree a more conservative target. The challenges of keeping the forecast balanced shouldn't be underestimated.

Vijay's overall priorities when considering a new tool are adding value and improving speed.

Erik then moved the discussion on to the question of whether to make the tool in-house (either completely independently or with external support), or buy-in from a specialist provider (with or without customisation).

Nich's current tool is self-developed with the help of an external consultant. He explained that the key barrier to purchasing an external tool was in convincing senior management to spend potentially £1/2 million on license fees every year without being able to specify what they will get every year for that money. He is very interested in some of the purchased options, which include support with governance and tracking changes, but that a clear choice was not currently apparent.

Arijit is in favour of in-house solutions, where you have more control over the final tool and can dictate the level of simplicity/complexity. His view is that one-size-fits-all doesn't work in forecasting, and that a purchased option would still need to be customised.

Vijay has experience of both systems, and reminded us to consider the in-house capabilities available, not only to create the initial tool, but in the long term to keep abreast of new developments such as AI and ML, when this is not your core competency (unlike an external specialist where it is an area of focus).

Erik opened the discussion to questions from the audience, starting with views on whether cloud-based solutions to connect data from demand planning directly to forecasting. The panel noted that cloud-based applications to share information and models are already common, particularly for reporting, but that the complexities of connecting demand planning data meant it was still a work in progress.

The panel's experience with AI and ML were explored, along with their hopes and concerns. The panel agreed that this was a very hot topic at present, and that development had been progressing at pace with AI and Large Language Models (LLMs) in particular. Vijay's view was that there is great promise for improving efficiency, particularly in the collection, cleansing and integration of data for forecasts but that AI and ML would not necessarily directly improve accuracy. He hypothesised instead that the efficiencies from AI would free up human intelligence to focus on topics that will create more value.

The panel's insight was sought on how best to approach early asset forecasting, where uncertainty is even greater. Vijay observed that the industry has shifted focus from small molecules, through biologics, and now to cell and gene therapy. He noted that this brings new challenges due to the lack of analogues and other data sources which make it difficult to size the patient population. He also noted that the market access / payer impact was likely to be crucial with these types of assets and would need to be explored carefully.

The final audience question explored the panel's views on the value of different input data, and specifically queried the benefits of demand studies, which may show different outcomes from successive iterations. Arijit commented that no data will give you an exact number in your forecast, or won't translate into a specific assumption in the model, but that all datasets will give a direction and a range, which can help to validate whether or not you are on the right path with your forecast.

Erik closed the meeting with the acknowledgement that we could run another forum to cover this topic!

Wednesday 26 June

High-power Patient Involvement: Using Choice Modelling to Inform Early Stage Decision-making, Forecasting and Uptake

Speaker: Ludwig von Butler, SurveyEngine

Convenor: Simon Fitall, Tudor Health

Ludwig von Butler

Ludwig's paper demonstrated how early adoption of Patient Preference Information (PPI) can help to optimise product development, and reduce the probability of product failure, with a consequent increase in Net Present Value.

Ludwig opened by explaining that PPI and choice modelling can bridge a gap between patient needs and the drug development cycle. He has worked with PPI across a number of different industry sectors (including forecasting for transport economics and also environmental economics and policy), and has observed that the use of PPI in healthcare has gained momentum in recent years. Although data on real-world behaviours and choices, he believes, result in the greatest accuracy of future predictions, there is great value in using quantitative patient insights exploring the needs, preferences and mindsets of patients to inform drug development decisions, as this approach allows us to explore trade-offs of hypothetical information about a future product.

Regulators, he explained, have embraced the value of PPI. The FDA, he noted, defines PPI as "the assessment of the relative desirability or acceptability of specified alternatives or choices among outcomes or other attributes that differ among alternative health interventions". He shared the FDA guidelines for including PPI in submissions, representing some of the work that has arisen from the 21st Century Cures Act in the USA, and also shared an extract from a large-scale European project, run over 5 years, which led to the EMA formally stating that they include PPI in their decision-making. Ludwig concluded that it has become very important to regulators that they have accepted the importance of PPI survey results, and perhaps even replace an expert opinion of the assessors with quantified PPI data, and allowing patients views as evidence alongside trial results when evaluating regulatory submissions.

Ludwig highlighted a range of places in a submission where PPI can be used, but explained that he would be focusing on the later stages of development, and in regulatory approval in particular, where he felt PPI is currently leaving a very important mark.

In late stage development, when regulatory and marketing authorisation decisions are being made, PPI studies are used to underline the choice of endpoints, compare key effects and define uncertainties that should be considered in risk-benefit assessments. Ludwig summarised that appropriate PPI could be used to accompany the clinical data, adding the patient preference perspective to decision-making. He highlighted that the decision on whether to conduct a new patient preference study is often prompted by evidence from existing data, indicating the importance of patient choice on relevant endpoints. However, he also pointed out that PPI can potentially offer more benefit in situations where treatment options and the risk:benefit trade-off is less clear. Here, PPI evidence might guide the regulatory bodies in their decisions.

Seeing the impact of PPI on the late stage and regulatory side, Ludwig then considered where else PPI might be a powerful source of insight. He highlighted that at the early stages of product development, PPI can be used internally within the company to change decisions early on, which might enhance drug development efficiency and relevance. Incorporating PPI early on helps to drive innovation and embeds patient-centricity from the very start. He noted that patient unmet need analysis can also help to guide allocation of investment resources within a company portfolio, and, crucially, can help to define the optimal clinical trial endpoints that would be used in decisions to shape development, not only in early trials but also later stage studies. (Examples of this would be using patient preference to guide selection of drug delivery methods and, more broadly, defining key attributes of the TPP).

In short, early PPI focuses on broader insights for strategic direction, and can pivot development strategies accordingly, whereas using PPI in later stages is focused on regulatory approval and ensuring that clinical trial parameters will be accepted by the regulators. At this stage, the clinical trial metrics are fixed, but PPI can aid fine-tuning of regulatory and reimbursement strategy and subsequently, guide messaging strategies.

How is PPI information collected? Ludwig explained that, typically, stated preference surveys are conducted online, selecting from an array of well-known methods to capture patient and HCP insights, depending upon budget or sample size available, such as discrete choice experiments (DCE), best-worst scaling, and thresholding.

The stated preference data is then quantitatively analysed, to derive insights such as the relative importance of different attributes, which can be compared via discrete choice conjoint analysis, with preference shares developed to inform forecast scenarios which can model different potential clinical trial outcomes. The risk-benefit trade-offs can be used to define the maximum acceptable risk and minimum acceptable benefit, to help to shape the TPP, and in turn to inform forecasts and scenario modelling.

Ludwig then shared a hypothetical example of what early PPI input might look like in practice. He showed a schematic of drug development from phase 2 through to regulatory approval, highlighting the different probabilities of success at each stage, and how these culminate in an overall probability of drug development success. He then highlighted the relationship between probability of success at each stage and disproportional impact on NPV due to the acceleration in cumulative cost of development in later stages of development.

He reminded us that incorporation of PPI data has limited impact on the probability of technical success or failure, but could have much greater influence on NPV at the regulatory decision stage, through early guidance on design and subsequent refinement of the TPP to reduce the probability of failure.

Mitigating those low probabilities of success in the early stages, he explained, can be achieved by defining the strategic requirements for success, via the Target Product Profile (TPP), right from the beginning, but specifying the minimum requirements for efficacy, safety, tolerability, formulation, dosing and other properties. The TPP parameter thresholds can be developed based on PPI information, by looking at the risk:benefit trade-offs that patients would find acceptable.

He used the example of a study in Alzheimer's disease where participants were asked to consider the value of delaying onset of symptoms against an increased risk of experiencing a disabling stroke. The example showed that participants were prepared to accept a 5% chance of stroke in exchange for a one year delay in onset of symptoms, which rose to accepting an 11% chance of stroke for a 2 year delay in onset and a 17% chance of stroke for a 3 year delay in symptom onset.

Mapping out all the equally acceptable profiles from these risk:benefit trade-offs gives us a mathematical frontier of acceptable trade-offs, against which we can position possible product profiles. This approach also allows us to develop and analyse a "family" of equally acceptable TPPs, allowing flexibility when faced with the reality of clinical trial results. Ludwig explained how the different TPPs can be plotted on a curve of potential acceptability to regulatory authorities, considering efficacy vs harms. This, he explained, gives greater flexibility than using a single one-off TPP, allowing us to finesse the final TPP selection.

Returning to the drug development schematic, Ludwig showed how, by implementing this approach, a reduction in the risk of regulatory failure by even a modest 5% at Phase 3 (by selecting the best TPP) can lead to a significant uplift in NPV.

Ludwig emphasised the transformative impact of this approach in four key areas:

- Incorporating PPI data helps to streamline the development process by focusing on patient needs and preferences from the very beginning

- Optimising TPP attributes based on PPI data reduces the time and resources spent on less relevant clinical trials (or unnecessary clinical trial endpoints)
- Leveraging PPI from an early stage helps to increase the probability of market success and ultimate patient adoption, which increases the accuracy and reliability of forecasts as more information is added, thereby reducing "unknowns" in the forecast
- This increases the value of our asset by increasing the probability of market success and patient adoption

In the face of this compelling evidence in favour of the implementation of PPI, Ludwig questioned why there was not more widespread adoption of this approach. He highlighted a number of key challenges:

- Internal decision making is sometimes restricted by silos, with limited ability to leverage internal and existing information where the knowledge of these methods may be sitting in different places within the organisation, with different teams working within their own parameters may not necessarily be able to recognise the full value of these studies in adding value through early product design decisions
- The perceived cost of these studies can be high, particularly ones at the later stages or around regulatory approval which, similar to clinical studies, may require a full protocol and compliance / ethics approvals, as well as qualitative stages and pilots. He noted that the valuable insights generated can also be used to guide trial design and elements of the value story, which may help to unlocks the budgets required to fund the studies
- Identifying and engaging a representative patient population can represent an implementation challenge. Sampling an appropriate patient population, rather than proxies such as HCPs or the general population, can impact on budget. He noted that it is often a challenge to balance the desired scientific rigor with the speed and agility needed at early stages of development

Ludwig summarised the key strategies for driving an effective "lightweight" study such as the one he described, making it most cost-effective and less burdensome:

- Leverage existing technology: he advocates reducing the cost of conducting PPI studies by following established standards, rather than "reinventing the wheel" or creating "black boxes", noting that, although the study results are not intended for publication, the other stakeholders involved in internal decision-making will still want to scrutinise the raw data and understand its provenance
- Resourcing expertise: choice modelling and other sophisticated statistical analysis require expertise, and he notes that resourcing the project by using external experts for execution would avoid tying up internal resource, particularly where inhouse market research experts are rare
- Remove "load": Ludwig explained that some items needed in a late-stage clinical study aren't needed for an early-stage study. Making sure that the study keeps within the definition of a market research survey, rather than a clinical study, means that Internal Review Board approval or full clinical trial protocols are not required. Market research surveys can define their own patient populations, and so can sample from the full breadth of the patient population rather than a specific clinical trial population, meaning that a market research study can be conducted within a few weeks, rather than the 12 months required for a clinical study, and at a fraction of the cost
- Work across silos: Ludwig emphasised the benefit of working across teams to centralise some of the dispersed information at an early stage and bring expertise together to influence the decision-making process

Ludwig reiterated the key takeaways that patient preference studies are becoming a part of the patient experience data package, with an increased role and acceptance amongst regulators, and likely to grow more important in the future.

Ludwig concluded with a call to action, highlighting our opportunity to shape the future by increasing the role and acceptance of PPI across the whole product lifecycle, and using the drive from regulators and using PPI at earlier stages to redefine patient engagement internally. He emphasised the role of pharma market researchers as facilitators and custodians of the knowledge, bringing together the right experts, methods and tools, and facilitating the flow of knowledge between silos.

Adding PPI studies to our patient insights toolbox, and implementing PPI input at an early stage, will help us to guide and prepare colleagues who will need that information later in the regulatory phase by hinting at potential outcomes for later studies. Ludwig called on us all to help our clients, internal and external, to understand the power of these methods, and to encourage them to adopt these established methods that are already available to use.

Questions from the audience asked Ludwig where in the product lifecycle this approach might add the greatest value. Ludwig believes the value is greatest where there is the most uncertainty, where the clinical data is not available and you need to transform opinions into acceptable evidence to inform decision-making. He highlighted situations where expert opinion may differ from patient preferences, and the PPI evidence can provide invaluable insight.

A delegate asked if we anticipate an increase in market research being published as part of regulatory submissions. Ludwig expects to see just that, as we talk more about how we obtain the patients' perspective, and its influence increases. He noted that this type of data might have uses outside the academic publication, such as in lay summaries or for use by patient advocacy groups.

"Nice … but just do not mess with my patients!" Lessons from an HCP survey about AI in Latin America and Spain

Speaker: Diego Casaravilla, Fine Research

Convenor: Tracy Machado, Elma Research

In his paper at the EPHMRA conference, Diego Casaravilla presented key results of a recently conducted survey in Spain and Latin America on the attitudes of 1353 doctors to AI and how they feel it may transform the medical profession in the future.

Diego Casaravilla

Oncologists and Chat GPT

Diego explained that prior to the survey, 20 oncologists were asked which future developments they thought would be the most interesting in their specialty over the next ten years and the same question was also asked to Chat GPT.

The respondents were then shown five answers, four of which were from oncologists and one of which was from Chat GPT. They were asked which option they thought was generated by Chat GPT.

The correct answer was option D: immunotherapy, targeted therapy, gene therapy and cell therapy, CAR-T.

Most of the oncologists correctly identified the Chat GPT answer and did so because they found it to be the most complete answer, possibly because they have some familiarity with Chat GPT and understand that it provides good answers.

Doctors and AI

Diego moved on to explain that the same exercise was carried out with the 1353 doctors in Spain and Latin America, but they failed to identify the Chat GPT

answer. Those who got the correct answer were then asked how they did this and the response given was that it was the most complete answer. The doctors who did not spot it believed that the answer seemed to be well elaborated i.e. it was too good to be true. In other words, AI was perceived to be even better than a human being.

Before they were asked which answer came from Chat GPT, the doctors were asked which of the five answers was the best. Interestingly, an answer that was provided by an oncologist was thought to be the best, but a close second was the answer provided by Chat GPT.

Looking at AI more generally, 389 doctors who are already using it were asked how they are using it in their practices, with the main use by far being Chatbots and virtual assistants.

The 1353 doctors were then asked how relevant AI will be in their own practice in a decade's time. The results were extremely consistent across both Latin America and Spain and found that:

- 80% believe that AI will completely or partially transform their own practice.
- 40% think this will be positive but 50% think that the impact will be both positive and negative.

The results confirm the view that doctors are ambiguous about AI i.e. they are not completely for or against it. They are relatively divided on what it will mean for them in their own profession, but they are willing to use AI for assistance in the diagnosis of pathologies, in treatment choices and for using their patients' device data in their treatment decisions.

When asked if they are willing to use it in their own practice for diagnosis or treatment, almost 70% of them are willing to use it to diagnose pathologies or for assistance in treatment choices. 60% (Latin America) and 63% (Spain) are willing to use their patients' device data in their treatment decisions.

Strengths and weaknesses of AI

The survey identified AI's main strength as its capacity to analyse large quantities of medical data, including patterns and anomalies. However:

- The doctors are not happy about AI giving better support and improving the quality of life of dependent and elderly people or enabling better control of chronic patients and their follow-up.
- They would not be happy for AI to deal directly with their patients through Chatbots and virtual assistants providing information and guidance on treatment.

80% of the doctors surveyed think they will need a lot of training to use AI, but there is average interest in having the pharma industry promoting AI training.

Using AI in the pharma industry

The doctors surveyed believe that AI's main roles in pharma will be in the discovery of new medications and in clinical trials.

Turning to sales reps' visits, doctors are looking for a big transformation and most of them think that AI will change reps' visits significantly or somewhat. Only 4% think it will not change reps' visits. They are most interested in AI being used to personalise a visit in terms of understanding their prescription history. However, there are doubts regarding privacy and the protection of patient data. Some doctors feel that AI might not be able to understand the context of their own practice.

Concerns about AI

The survey highlighted some significant concerns about AI and its future role and influence in medicine. These include:

- Errors in the diagnosis or treatment of patients.
- Patients' self-diagnosis.
- The loss of human interaction in the patient-physician relationship.

What should be the medical industry's stance?

Half of the doctors in the survey were supportive of AI but half are waiting to find out more information about it. Spanish doctors were more in favour of AI (63%) than those from Latin America (50%) and specialists from oncology (63%) and rheumatology (61%) were more supportive of it than those in General Practice (49%).

While doctors in the future might be in favour of AI if it makes them 'superhuman', they will be less supportive if AI starts to be in the middle of the patient-doctor relationship and they do not want to be replaced by AI.

Key questions to consider

- Is AI going to completely change our profession or is it just hype?
- Can we distinguish the responses from avatars and humans?
- How will AI transform the relationship with our customers?
- What stance should the healthcare market research community take on AI?

DLBCL and me: a market researcher's personal ethnographic journey

Speaker: Anthony Rowbottom, Boxee Group

Convenor: Tracy Machado, Elma Research

In a highly personal presentation, Anthony Rowbottom gave his experience of Diffuse Large B-Cell Lymphoma (DLBCL) from diagnosis to treatment, including his interaction with patient support and his thoughts on how pharma should deliver this better to meet the true needs of patients.

Anthony Rowbottom

Anthony's personal journey

Anthony began by explaining that in December 2022, he started noticing back pain and mild kidney pain on his right-hand side. The pain increased but scans showed that it wasn't a kidney stone. Anthony was admitted to hospital and contracted sepsis but after interventions and strong antibiotics and surgery, he was discharged just before Christmas.

In January 2023, scans showed that something was pressing onto Anthony's ureter which had caused the sepsis. At that point, the urology team wanted to remove a kidney, while the oncology team wanted to remove a testicle because they thought Anthony had testicular cancer i.e. the specialists were unable to give a categorical answer.

An orchiectomy (removal of right testicle) was performed in February 2023 and a biopsy led to the diagnosis of Stage 2 DLBCL. The tumours had started in Anthony's lymph nodes and two of them were in his pelvis, one of which was pressing against his ureter, while one had travelled down to his right testicle.

Anthony's treatment began in March 2023 as his haematologist wanted him to start chemotherapy as soon as possible. As he also has cardiomyopathy, a number of therapies were involved and a different chemotherapy

regimen was used for the first cycle before he was moved onto R-CHOP which is the standard treatment. Anthony fully admitted that as an engaged patient, you can do a lot of background reading but nothing really prepares you for the physical effects of chemotherapy which in his case included losing part of his tongue, hair loss, having mouth ulcers and having fluid on the lungs. The anticipated effect of sickness fortunately did not occur.

In April 2023, Anthony explained that he had intrathecal chemotherapy delivered directly into the spine to prevent any lymphomas spreading to sanctuary sites, such as the spinal cord or brain. Spinal fluid was taken out and Methotrexate was delivered straight into the spine, with the result that he was not able to walk for two weeks after each of the sessions.

From the results of a PET scan in May 2023, Anthony was considered to be tumour-free but treatment needed to be continued from June until October involving four more rounds of R-CHOP and three more PET scans. During this time, Anthony had two hospital stays because of high dose chemotherapy, two weeks of radiotherapy and a further round of Methotrexate.

Context is king

Anthony revealed that apart from the Methotrexate, it wasn't the treatments themselves that had the biggest impact on his life. It was the "stuff around life" that became harder, possibly as a consequence of him being weaker. This included:

- Both of his parents passing away during 2023.
- Becoming radioactive for 24 hours at a time as a consequence of having PET scans. As this can affect the growth of children and as he has a young family, he therefore had to stay away from home overnight in a hotel.
- Becoming sterile as a result of the chemotherapy and radiotherapy.

The impact of patient support

As a patient and a market research professional, Anthony had unique insight into the materials that were available to him during his treatment.

While there were many catch-all pamphlets issued by charities, very few came from pharma. There was a considerable amount of generic patient information which was repetitious and available online. Most materials were not pharma-sponsored and Anthony noted only two pharma supported leaflets - "My Cancer Treatment Diary" by MSD and a pamphlet from Merck that was specific to a particular treatment. He was given print-outs from the internet and leaflets from Cancer Research, none of which was pharma-created, despite the fact that pharma-created content exists. None of it was tailored to his needs and the information was useful in the early stages but not beyond that.

Anthony's observations included:

- Much of the support that is available is based on stereotypes that are probably decades old. Very little of it impacted the way his family thought and felt about him and his relationships with them. Nothing was talked about or offered via clinicians or patient forums.
- Almost all patient support around hair loss is directed towards women, although he was particularly impacted by this. The only people who were offered cold caps were women and the assumption is that men just get on with it and look

after themselves. There is a possible feeling that women are treated slightly differently.

- The nurse is the focal point. We should rethink what we are doing with nurses and understand them better. The nurse has a huge influence on how likely somebody is to be adherent and how likely they are to stay on treatment despite side-effects. Nurses make the day-to-day decisions and influence the mental health of patients, including how the patient experiences their interaction with the healthcare system.

From his experience, Anthony feels that most patient support misses the mark because it is trying to communicate with the average person. DLBCL in the UK is diagnosed in people who are on average 65 years old and he was the youngest person in the infusion room by about 30+ years. He only interacted with one other patient in their 40s throughout his whole journey and he felt like the odd one out as most patient support is geared towards people of a certain age and life stage. This is particularly significant as while cancer rates have been decreasing in people over the age of 60 because of better diagnostics and public health, they have been increasing in recent years in people aged under 50.

Key takeaways

Anthony concluded with the following thoughts on what he learned from his own experience and how patient support could be improved:

- It is not necessarily about the treatment but the context the patient is in and how they are coping with life. We need to help patients know who to ask about their healthcare.
- We need to think about the person who has the cancer and how can we help them beyond providing generic information that already exists online. This includes thinking about outliers and how we can support them.
- There is no child-appropriate content available to involve children in the process.
- We need to think about the channels that best serve patients and how material will get to them. It is about taking a step back and asking ourselves what problems we can solve for these individuals.

Story Telling

Speakers: Chris Heaney & Beth Hayward, Connecting Truths

Convenor: Amr Khalil, Ripple International

Chris Heaney

Beth Hayward

Chris and Beth entertained us with the story of storytelling, explaining the neuroscience behind a gripping tale and how storytelling structure can be used to create compelling presentations, adapted to our professional audience.

Beth opened the paper with an invitation for us to imagine...

Taking the example of learning to ride a bicycle, Beth noted that we can watch a video to understand what is involved and how it's done, but can we be confident that we can actually get on our bicycle and start pedalling? Chris translated this analogy across to the art of storytelling in business, highlighting that,

or someone who wants to try storytelling for themselves, it is important to see and feel the effect that ideas and words have on a listener – we need to get on the bike and start pedalling. In their paper, they presented a number of different examples of storytelling, each underpinned by a common structure, to give us all the confidence to start telling stories ourselves – just like using stabilisers and a helmet when learning to ride a bike.

Chris noted that humans have told stories for thousands of years. What, he wondered, do stories do, that facts and spreadsheets don't?

Beth introduced us to the neuroscience behind storytelling, by telling us the story of Paul Zac, a professor of Economic Sciences, Psychology and Management at Claremont Graduate University. He had degrees in Maths & Economics, and also studied neurology, which helped him to explore the reason why some people make a decision to be kind, and others to be unkind. As an economist, it would be useful to know why, and as a neurologist, fascinating to know how. He was trying to identify the "golden key" that made people receptive to collaboration with those around them.

Beth described how he had identified that the neurochemical oxytocin, is produced when we feel trusted or are shown kindness, and enhances our sense of empathy. Empathising with others allows us to understand and predict how others might react, and predictability creates a safe environment in which to collaborate.

Beth described how Paul now had part of the "key", but how did that help? He couldn't turn the key to make people release oxytocin and collaborate. Could he? He had noticed that when people were told stories, particularly involving challenging times, it tended to increase the release of oxytocin. He also discovered that in order for people to want to help others, a story must grab our attention – it must be exciting. Tension, Beth explained, releases the stress hormone cortisol, which heightens our attention and engagement, resulting in those stories being remembered weeks later. (A result that many of us would wish for, when we deliver PowerPoint presentations!). Paul noticed that after hearing a relevant, exciting, human story, people were more likely to be collaborative. Humans tell stories to motivate, educate and persuade – and to make a connection. Beth summarised that a good story enters the heart, but the gateway to the heart is unlocked by a "golden key" in the brain.

Chris acknowledged that, in our work situation, there is a potential barrier to storytelling: we may not have the opportunity or platform to tell a detailed and emotionally-charged story. He also noted that our target audiences may not be receptive to our story, due their context (role, workload, priorities, motivation, personality or worldview).

He focused on the different personas of our potential audience, using three examples of an open, warm and chatty individual, contrasted with someone more reserved and unsure, and finally someone far more short-tempered or uncommunicative, which Beth brought to life with a role-play.

Chris explained that, to tell our story, we need to build rapport with our audience by being curious and showing interest in them. He reminded us to do this by using the linchpin of qualitative research, the open question, and demonstrated some example questions in a role-play with Beth. Just as in qualitative interviews, they noted that the "who", "what", "when", "where" and "how" questions are likely to elicit greatest information and show human interest, whereas "why" questions need to be handled carefully to avoid our audience feeling challenged and becoming defensive.

Understanding our audience is one part of storytelling, but Chris and Beth also highlight that in order to tell dramatic and engaging stories about scientific information, we have to think about the structure of our stories.

They introduced us to the story arc consisting of building blocks of "here", "but", "so" and "there", in order to tell a compelling story.

- "here" describes the current state in any story. This might be an introduction to the characters and the condition that they face, including what life is like today or how someone is currently treated
- "but" describes the factors that cause tension. This might be obstacles, threats or challenges such as side effects, the frustration of regular monitoring, or the inability to lead the life our patients want. Beth notes that these are the things that cause the tension and release of cortisol that Paul Zac noticed in his research
- "so" describes the consequence of the change in status quo, or the resolution. How do our characters respond to the obstacles, not just in terms of what they do, but how they feel. When our audience recognises the emotions, oxytocin is released and empathy is engaged. Chris explains that this is the point at which we can best place our market research insight into context, generating excitement about the scientific discovery and its potential
- "there" describes the future state. This might involve helping the audience to visualise what a change in clinical practice might look like, and the part they could play in making it a reality.

Chris and Beth explain that there can be a number of "but" and "so" pairings in a story, to cover all the challenges and solutions that we'd like to present to our audience, but that the same pattern of tension and resolution is used.

Chris shared a pharmaceutical example to demonstrate how to apply this storytelling structure to a scenario we might experience in our work. He used an issue that our industry has grappled with for more than 40 years, without a satisfactory solution: the impact on asthma and COPD patients of poor inhaler technique.

Chris first walked us through the dry facts:

- Poor inhaler technique impacts symptom control
- Age, education level, sex and inhaler type impact correct use
- 60-80% of inhaler users are non-concordant
- This cost €750million to the healthcare economy in in Spain, Sweden and the UK in 2015
- There is a need to develop better devices and support patient concordance to deliver better patient outcomes

Then Beth applied the story arc of "here-but-so-there" to those dry facts, and instead told us a detailed and emotionally-charged story about pharmacist Karim, and his customer, Helen. Over the next 6-7 minutes, Beth brought the story to life, describing the conversation at a fictional dinner party, which revealed that Helen had passed away due to not using her inhalers as intended, and Karim's emotional and then practical response to what had happened, why and what could have gone differently.

When Beth had finished, Chris observed that this was a gripping story, but a long one. In practical terms, a story such as this might be suitable for some personas open and receptive to engaging with the duration and level of detail of the story, but not suitable for others who are less engaged or more time-poor.

For these personas, Beth provided a "one minute version" of the story. This shortened version still contained the characters and emotions, and following the story arc, but in abbreviated form focused on the key complications and resolutions.

Chris again commented that this version may still be too long for some busy listeners, like the gruff persona shared earlier, and introduced a "30 second version" of the story, which was even punchier and more focused.

Chris highlighted that each version follows the same structure, and advised that we need to evaluate the benefits and losses of shortening the story, balancing the need to communicate the details of the data against the needs and preferences of our audiences.

He emphasised that data alone is not enough to communicate our message effectively. We need to be led by the data, but for the message to have impact, we need to appeal to the emotional brain as well as the rational, using a story.Beth highlighted the effectiveness of pairing empathy with data, to challenge our personal stereotypes, biases and assumptions, and to inspire us to take action.

Chris summed up by emphasising that storytelling can be applied to our professional roles, if we consider our audience and reframe our message in a way that invites others to engage. If we tell stories, rather than present facts, Chris believes that we will move a step closer to cementing the role of insights in sparking lasting, positive, change.

Beth left us with the thought that "stories are data with soul".

An audience question noted that scientific publications and presentations avoid anything that resembles storytelling at all, and asked for advice on how to translate storytelling into that setting. Chris agreed that it can be a challenge, but that starting with the context of the clinical study gives the "here", and the reason for conducting the study addresses the "but" – something has changed or an issue has been identified. He notes that we can leverage the insight work which provides a deeper understanding of the patient experience and physician motivations. Chris advocates leaving the "so" until the end, to avoid giving away the "punchline of the joke". He explained that data visualisation, which wasn't covered today, also plays a key role in helping people to understand what lies behind the data, to see the future and wonder what part they can play to be part of the change. Beth added that in the scientific world, people want their work to be taken seriously, and feel that they need to present in a particular way, but that this has the potential to exclude potential audience types. She advocates thinking about the balance of being taken seriously and getting our message across.

A follow-up question explored how "true" our stories need to be, and also noted that our pharmaceutical clients often want us to get to the "so" as quickly as possible, and asked how to allocate appropriate time to the "but". Chris acknowledged the challenge of being asked to communicate often very large datasets in the space of a few minutes. He reiterated that we must be led by the data, but help the audience to tap into the insight by making it more concise, initially by creating a storyboard, but also including references to signpost them to more detailed information. Beth confirmed that the data behind the stories must essentially be true, but when telling the story, the human element is important to get the message across.

An audience question asked about the role of AI, such as language models, for creating stories. Beth questioned the quality and accuracy of AI outputs for this type of work. Chris noted that there is a place for AI, such as translating content into 25 different languages, or selecting from an extensive image library, to free up budget to focus on the story content itself and making it more "human".

An audience member who works for a specialist paediatric pharma company shared the experience of a launch meeting with consultants and KOLs which included an artist at the back of the room creating the story, which the audience reported had been particularly impactful and memorable.

A final question from the audience asked about the speakers' experience in other industry sectors, acknowledging that in healthcare we often focus on rational drivers of behaviour and engage with doctors with facts and figures. Is the healthcare industry as receptive to storytelling as other industries? Beth reminded us that people in the healthcare industry are just as human as anyone else, and will have the same range of personality types and cognitive preferences as humans in other industry sectors. Chris noted that triggering change is always more difficult than maintaining the status quo, and gave the example of a smoking-cessation conference focused on behaviour change, where delegates were invited to role-play the new information as if in a clinical setting, with impactful and memorable results.

Closing the gap between segmentation and real life: how AI can help to identify levers for and develop more targeting approaches

Speakers: Masha Eletskaya and Damian Eade, Lumanity

Convenor: Roy Rogers, Research Partnership

Masha Eletskaya

Damian Eade

Masha and Damian's engaging paper shared with us a Proof-of-Concept pilot study which examined how an AI-generated synthetic stimulus could be used to deepen the insight gained from segmentation studies.

Masha opened by reviewing the common challenges we encounter with segmentation studies. She noted that segmentation is the cornerstone of most product launches; however they can be time-consuming and expensive, and are often difficult to implement. Making the leap from a collection of patient characteristics to a relevant, recognisable and actionable patient segment, remains a challenge. How can we close the gap between segmentation and real life?

Our presenters shared three tools that can be used in sequence to help us develop holistic and valid patient segments – two that use traditional research approaches, and a third that uses an innovative AI approach.

1) Multi-stakeholder perspective – interviewing both physicians and patients

Masha noted that in order to create a relevant, accurate and commercially meaningful patient segmentation, we need to reflect the real patient experience in a way that is recognisable to healthcare professionals (HCPs). To do this, we can bring together the perspectives of both patients and HCPs, exploring attitudes, emotions, perceptions and behaviours, through a combination of interviews and collecting patient record forms (PRFs) from HCPs. Using similar questions for both patients and physicians helps to provide anchors for the analysis, using cluster analysis to identify the segments, before describing and profiling the segments based on demographics, clinical history, treatment history and other relevant characteristics.

This approach, Masha observed, delivers a more holistic and accurate picture than basing the segmentation on only one of the respondent types (such as being able to identify disconnects such as "silent sufferers" who may not present to their physician). The multi-stakeholder perspective confers broad usability on the outputs, such as use in physician interactions and also for direct patient communication or education.

However, compared with a single respondent type perspective, the approach requires greater investment in direct costs, analysis time, and sample construction (to ensure the PFS and real patient samples are comparable).

2) Behavioural science

Once the segments have been created, we can apply behavioural science principles to understand the impact of motivations, drivers and barriers on the potential for behaviour change, and understand how biases, emotions, habits and social factors combine with clinical factors to impact behaviour. This enables us to understand how a pharma company could intervene to impact this behaviour change and ultimately improve patient outcomes.

To uncover the levers for behaviour activation, Masha observed, we want to look at closely at the point of interaction between HCPs and patients. But how can we observe what is happening during the consultation itself?

Damien noted that using the two tools Masha described, we could start to bridge the gap between segmentation and real life, but that we are still not able to observe how these segments present in real life due to privacy and compliance protections.

Previous methods might have employed actors to simulate the conversation, but the difficulties in scripting out what an actor needs to say to reflect segment behaviour would limit the authenticity of the experience.

This led the team to ask themselves whether generative AI could provide a new way to "join the dots" to create a more authentic and holistic representation of the patient segments. The team could programme the segment characteristics and behaviours, and predetermine the degree of characteristics that were expressed, as well as precisely defining the scenario they wanted it to play out, interacting with physicians in real time to generate a more life-like consultation experience and reveal deeper insight.

3) AI-enabled innovative tools

Damien explained that as the team explored this idea, they were working on a patient segmentation study in Haemophilia A with Roche, who agreed to take part in a Proof-of-Concept study to put this theory into practice.

A small-scale pilot study was designed, taking an existing qualitative segmentation study which had revealed four very rich patient segments which had been developed into patient profiles or personas, which went some way towards making them feel more human, but which were not interactive. Could AI take the profiles and create a bot that could "be" the segment, interacting with doctors to help us understand the "real" consultation experience?

Before taking things any further, the team identified two hypotheses which, if confirmed, would deliver value from the exercise. The first, was the value in being able to analyse the consultation

dialogue, including the physician behaviour, interactions and language, to understand what would go on in a real-life consultation. Damien noted that for this study, their focus was on the doctor and their reactions, but not on the virtual bot (which was fundamentally the voice-piece of ChatGPT). The second value hypothesis was the ability to further unpack the decision-making process via subsequent interviews with the doctors, asking them to explain the reasons behind their actions and what the next step would be. Basing the interview on the simulated consultation would provide a more authentic basis for discussion than asking them to think back to their last patient or asking what they "typically" do.

Now it was time to create the bot. Damien reiterated the simple approach – this was minimal viable product (MVP) design, to explore proof of concept, based only on careful construction of the prompt. He admitted that the challenge of developing the prompt was greater than anticipated, with 5 pages of prompt script covering context, "humanness" and the segment characteristics. He described the iterative "trial and error" process needed until the bot produced something sufficiently believable as an actual patient, with the greatest challenge being programming "humanness".

Damien then shared what the consultation interaction looked like: a text exchange between the physician respondent and the bot, where the virtual patient described clinical changes such as additional bruising, which the physician explored and established was likely due to an increase in physical activity (specifically hiking). In an eye-opening moment for the product team, the doctor responded by suggesting a reduction in exercise (a shorter hike) rather than a change in medication.

Damien noted that it was unlikely that a physician would report this consultation outcome in a traditional market research interview, where the behavioural science biases including recall bias, desirability bias and post-rationalisation mean the respondent would be more likely to give a "textbook" answer. The AI tool was helping to uncover real insight into real world behaviours.

Damien reviewed some of the observations from the process of building a generative AI synthetic patient application, summarising the benefits and challenges.

Benefits:

- From a behavioural science perspective, the AI approach produced a conversation that was much more rooted in reality than a traditional market research interview, which encouraged respondents to give honest and grounded responses
- Participants found the experience highly engaging and very interesting
- The AI approach enabled quick and easy changes to be made throughout the interview period, with refinements to the prompts being implemented in a matter of minutes between interviews, compared with the time that would be required to make changes to an actor's script
- There were obvious compliance benefits in using a synthetic patient

Challenges:

- The hurdle of ensuring the virtual patients were sufficiently "human" and faithful to the segment characteristics was extremely challenging, requiring considerable time investment, although Damien hinted that the team had eventually uncovered some shortcut secrets which helped the process
- Setting the context is key. Damien emphasised the importance of preparing the interviewee for the experience, reporting that respondents can feel that the interaction is "creepy"
- Pragmatism is required when dealing with imperfections. Damien noted that considerable time and energy could be spent trying to perfect the synthetic patient, but reminded us that human patients aren't always rational and perfect, and so the bot's imperfections could be accepted as making them more human

Despite the very small-scale of the pilot, the team had learned a great deal, which Masha summarised for us:

- The patient segments were highly recognisable, validating the original segmentation process
- Respondents were given basic demographic and clinical parameters for the patients, as would be available in clinical practice, and were able to understand the segments and identify patients like this from their own practice
- Different segments evoked distinct reactions and different recommendations from the HCPs, and alongside the subsequent qualitative interviews, the team could understand their thought-processes during the consultation, providing far greater detail than might be possible from interviews only based on recall
- Observing the physician-patient interaction revealed opportunities for dialogue optimisation, highlighting the need for education and identifying areas that physicians need to explore directly or employ active listening, as the patient is unlikely to raise the topic naturally
- Some responses were deemed "shockingly brutal", highlighting that the approach helps to overcome behavioural biases such as social desirability

Masha commented that both the clients and the respondents had reacted very positively to the exercise. Respondents were very willing to participate, and found it highly engaging. The client valued the level of insight generated, which far exceeded that from typical qualitative interviews.

Damien then reflected on how to take the pilot to the next level. He shared a videoclip of a demonstration for the recently released ChatGPT-4o version, and highlighted the ability to recognise emotion from your face, and also the "humanness" of the bot, including recognising flattery. The voice interaction, he noted, would take the interaction from a telehealth-style appointment via text to a more realistic voice interaction. The multi-modal input and emotion injection, along with near real-life latency and interruptability all lift the experience closer to a true human interaction.

Damien also noted that the new version of the bot can be trained on your own data, opening further possibilities for application using proprietary information.

Summarising the key takeaways from the pilot, Damien noted that:

- Harnessing a more integrated approach to segmentation, involving more stakeholders, allows us to create a more accurate, holistic and rich picture of patient segments
- AI-driven synthetic stimulus brings segments to life, putting respondents "in the moment" and allowing us to step closer to genuine real-world responses and behaviours
- The simulated consultation gives us a better understanding off the complex dynamics between physicians and patients, driving actionability through identification of drivers and barriers for behaviour change for each segment

He concluded that the AI synthetic stimulus moves us closer, although not all the way, to closing the gap between the conceptual and real life.

A question from the audience asked if the bot could be trained based on the responses emerging. Damien confirmed that the team had built an app to create a secure space, using a priming prompt in the back end, and were able to refine the prompt based on the responses.

The audience was interested in the "humanness" of the bot and how to train-in "humanness". Damien agreed that this was the biggest challenge, but by interpolating between some the details the bot was given, and being asked to create content within limits, along with being able to adjust the balance between being probabilistic and deterministic helped to achieve greater "humanness".

Another audience question asked about the process of validation for the synthetic stimulus. Damien outlined the extensive and iterative validation process, which started with internal validation amongst the team, then a wider group within the business, asking them to validate based on their experience working in haemophilia, and finally validation in the field, through asking physician respondents directly whether the bot was believable, and asking them to describe the segment characteristics, which were then mapped against the predefined segments. Damien noted that for the proof-of-concept study, this process was sufficient, but noted that in future they would conduct further validation via a secure training model.

Improving Messaging Resonance with AI Emotion Recognition

Speaker: Sidi Lemine, Jade Kite

Convenor: Georgina Cooper, Basis Health

Sidi's paper described how emotion analysis can help to select and refine communication messages to enhance impact and confidence, using case studies to show how this approach can be used in the pharmaceutical industry.

Sidi Lemine

Sidi told us a little about his background as a "third culture kid", and how that might explain his fascination with what goes on in other people's minds – a trait that he observes is shared amongst market researchers with their curiosity about how other people think. His first interest was in Artificial Intelligence, driven by the idea of creating models of people's minds, but he found that studying AI at university in the early 2000s was "very boring". Moving to qualitative market research enabled him to continue his passion for understanding the human mind, and his current role brings both disciplines together, carefully integrating AI into traditional research methods.

He recapped the characteristics of AI, describing it as a broad field of science that aims to replicate human thinking with computers. It finds patterns and correlations between data points, and helps us to interpret them, but Sidi is quick to point out that it is not "magic", and is not very intelligent. He emphasises that AI is a tool, and that interpretation is the most important step – AI is not a replacement, but an accelerator, of human thinking.

Focusing on a specific sub-tool of AI, emotion recognition, he explains that this application of AI measures the intensity of emotion from speech. He noted that in the pharma industry with its focus on facts and evidence, we may think that emotion is irrelevant; however, he points out that, according to the Harvard Business Review in 2019, emotionally-connected brands are 50% more likely to be chosen, across all categories, and are 135% more resilient in downturns (and he notes that we are experiencing a downturn which is likely to continue for the foreseeable future). The challenge for our industry is in talking to both sides of the brain, to connect emotionally whist retaining the rational impact of our message and our product.

Just as AI moves from a data signal through analysis of patterns to interpretation, voice emotion analysis uses the same overall process, he explains. Starting with the data (speech or a voice recording), the software recognises the pitch, tone and cadence, from which it extracts the dominant emotions to identify not what is being said, but how it is being said, and identifies the subconscious, "in the moment" (System 1) emotions, rather than conscious emotions being projected. The analysis algorithm then applies some numbers to the measurements to allow us to see, in percentage terms, the strength of the emotion.

It has been used for many years in many ways, from emergency response, mental health and customer service through to our world of market research – anything that requires very quick and very certain

identification of how the participants are feeling. Sidi reassures us that, as AI voice emotion recognition has been around for a while now, it has been trained on very large open-source datasets which confers stability across demographics, language and other variables, and peer reviewed studies assess it to be 90% accurate.

Case Study 1: message optimisation

In his first case study, Sidi shared an example of AI voice recognition being used to help a client build a messaging strategy. The client had a good drug that had experienced a sudden decline in sales due to a change in the market. The client needed to review their communication messages across seven counties and create a new campaign very swiftly, to counter the market change.

To do this, Sidi used online interviews with HCPs and patients to test the messages, and then used emotion recognition to identify the most impactful of the messages.

The first round of interviews explored the different types of messages that the client might use, with different possible avenues of focus explored as "territories". During the interviews, participants talked about what those messages meant to them, and the AI voice emotion analysis looked for differentiation and impact at an emotional (System 1) level. At the same time, the traditional market research approach explored the more rational credibility and objections based on stated responses (using System 2).

This enabled the team to identify the optimal "territory", raising little or no objection but with high emotional impact, and to create messages within the territory.

The second round of interviews was then employed to select the winning messages. This was achieved very quickly by asking respondents simply to read and then re-phrase the message (to check understanding), and quickly note any immediate objections, while the AI analysed the emotional response. This stage didn't explore the traditional areas of meaning and stated reactions, as this had been captured in the qualitative interviews in round 1. This meant that the second-round interviews were of very short duration, and fieldwork time could be reduced to a minimum, with AI analysis taking a fraction of the time of traditional contextual analysis.

Both rounds of fieldwork in 7 countries were completed within 6 weeks, including the creation of the messages. As well as fast fieldwork and fast analysis, Sidi noted the benefit of being able to go to senior management with mathematically-derived support for the research recommendations, in addition to qualitative research insights. He explained that this combination of traditional and AI approaches also delivered alignment across the global and local teams, as every market was run in the same way and evaluated across consistent data points, and also conferred high confidence in the findings. Where reactions did differ between countries, the team was aware of the differences and could action them accordingly.

Case Study 2: TPP optimisation

In his second case study, focused on Target Product Profile (TPP) testing, Sidi described a late entrant (6th to market) in an oncology therapy area, where the product had similar clinical trial data to its competitors, with no obvious differentiation in classic primary endpoints. The study used emotion recognition to look for secondary endpoints with higher emotional impact for oncologists.

Sidi noted that, when reviewing a TPP, oncologists typically skim the key datapoints of Overall Survival and Progression-Free Survival, and perhaps response rate, using their rational brain, but may pay less attention to secondary datapoints further down the page.

In this case study, respondents were asked to skim over the top datapoints (where there was low differentiation) and to focus on the secondary endpoints further down the TPP. They were asked to read them aloud and to provide a "stream of consciousness" response (using System 1) to what they read, highlighting what was interesting and

not interesting. This approach was faster than a full qualitative exploration of each datapoint.

Analysis using emotional recognition looked for the emotional intensity that accompanied each of the secondary datapoints, highlighting any endpoints that elicited higher levels of emotion. The analysis revealed a disconnect between the stated importance (where oncologists claimed that as OS was the same, nothing else mattered) and the emotional response (where some datapoints were associated with high emotional intensity), within a specific subgroup of respondents.

But why? To understand this disconnect, a second round of interviews, conducted with a relevant, small, subgroup of respondents, focused on the high-emotion datapoints to understand the reasons behind the "spikes" of emotion. These were short interviews, focusing on the key question: "we know that this is important to some people, can you explain why?".

This approach revealed interesting stories around the data that might not have emerged from considering the total patient population, and highlighted a unique problem that oncologists were experiencing that was not spontaneously mentioned as they didn't think it could be solved or were focused on the traditional importance of OS and PFS.

Identifying a specific problem that was solved by the client's drug created an opportunity to initiate a conversation with HCPs and showcase the unique benefit in an underserved patient population. Announcing this "new news" created differentiation from the competitors. This resulted in launch sales 23% above forecast, attributed in part to the field strategy which generated more access to oncologists.

So, how do we make the most of emotion recognition?

Sidi concluded that being able to measure emotion with a degree of objective certainty, rather than basing it on moderator empathy or analyst intuition, enables strong decisions to be made.

However, Sidi cautions against using AI voice emotion recognition as a panacea: he highlighted where this approach works well, and where it works less well.

AI emotion recognition works well for:

- Comparing opportunities
- Selecting the strongest options from a range of possibilities, where it can identify the optimal emotional profile
- High impact but less top-of-mind opportunities, where it identifies subconscious insights and gives confidence by putting numbers alongside the emotion
- Highly structured qualitative methodologies
- Situations where you want deeper insight but lack time or budget
- To align teams and build more confidence in emotional impact

He noted that it works less well for:

- Early stage exploratory research, where it is too early for meaningful comparisons and choices are not yet clear
- Highly formal or "dry" topics where emotion may play a lesser role (such as pricing or payer strategy)
- Some countries where cultural or legal characteristics mean that this approach is not appropriate (such as in Germany, where it is difficult to measure emotion in the speech of a German speaker, and where the AI privacy laws are extremely tight)

Sidi reminded us of the ethical considerations applicable to using this approach, which, although less problematic than for generative AI (such as ChatGPT), should still be considered. He advocates the need for transparency with all stakeholders. Respondents need to be told that their voice (personal data) is going to be analysed with a machine learning system). He also advocates full transparency with clients, regarding accuracy, explaining that no AI

model is 100% accurate, with most models reaching 88-90% accuracy on average, but noting that this margin of error is perhaps lower than that for a human.

He emphasises that proprietary research data belongs to the client and cannot be used for training of AI models. As with any AI, there are privacy and confidentiality concerns around this, but he reassures us that most of the models used for emotion recognition are now stable and "closed". This point should be clarified with your AI provider to confirm whether the model is still being trained and what will happen to the data introduced as part of your project.

Sidi concluded with a quick glimpse of the future possibilities for emotion recognition, where other forms of AI might amplify the power of emotion recognition, such as conversational surveys that analyse voice-activated open-ended surveys to elicit very rich responses very quickly, as a mid-point between qualitative and quantitative research, or generative AI which can enable deep probing in key areas, and then ability of AI to deliver fast and accurate analysis to dramatically reduce timeframes whilst retaining nuanced analysis.

A question from the audience sought clarification on the 90% accuracy of the models, and whether that was for English language models or across all 7 countries included in the cast study, and how that compares with human accuracy. Sidi confirmed that the accuracy figures were global, peer-reviewed, figures in a range of languages and locations across southeast Asia, Africa, Latin America, but that he suspected in some less-researched languages there may be a drop. Regarding human accuracy, estimates from large, stable, models developed in the late 70s and early 80s by behavioural psychologists, indicated accuracy of 75% in humans correctly identifying emotions.

A follow-up question asked how we should interpret the difference in accuracy between humans and AI models, when the complexity of emotion makes it difficult to quantify anyway? Sidi agreed that defining how people feel is an enduring challenge, embraced by qualitative research, but that AI provides an additional datapoint to help us with this challenge in a more structured and objective way.

Another question clarified the issue of transparency, asking if respondents know their voices are being analysed. Sidi confirmed that it is very important to be transparent from the start. He reported that some respondents do decline to take part once they hear that their emotions will be analysed, but interestingly there are fewer rejections from AI analysis than from trying to schedule in-person interviews.

A final question explored how to identify whether the emotion is connected with the thought process around response or the content itself, and asked for any hints or tips. Sidi considered that when using voice emotion analysis we are usually looking for the subconscious System 1 response, rather than a considered System 2 response; therefore the emotion measured will be connected to the instinctive, gut feeling about the content, rather than the thought process of responding.

Segmentation in the time of omnichannel

Speakers: Peter Elston, Roche; and Helen O'Hanlon, IQVIA

Convenor: Sarah Phillips, IQVIA

Peter Elston

Helen O'Hanlon

Peter and Helen shared a segmentation case study which described how Roche developed a personalised Healthcare Professional (HCP) omnichannel communication strategy by linking attitude-based segmentation personas to the company's Customer Relationship Management (CRM) system.

Peter began by setting the context for the project, describing the business issue Roche had faced, and the challenges it presented. He noted that we all share the same broad challenges in the implementation of segmentation, due to the complexity and the number of stakeholders involved, but that the specific challenge for Roche centred on how to use a new global CRM to help them to deliver tailored messages to HCPs.

The new global CRM had replaced a country-specific system, and the company wanted to leverage all the insights that the new system could offer to accelerate the deployment of their omnichannel strategy.

The team needed a physician segmentation to support a new product launch in a competitive market which was new to the company. Focusing on an attitudinal segmentation, Peter explained, would help them to fully understand why HCPs were making their prescribing decisions, and to facilitate behaviour change in adopting the new product. Reflecting the reach of the new global CRM, they wanted to apply the segmentation across the universe of HCPs. Peter acknowledged that traditional, rep-administered, typing tools can be difficult to deploy at a global scale, and tend to focus on the physicians who have meaningful interactions with the face-to-face (F2F) teams, rather than facilitating the full range of omnichannel interactions to reach a broader audience.

Roche's objectives were to have a scalable approach which would automatically link seamlessly with their data systems, which was simple and easy to understand (rather than a "black box" solution). They wanted a personalised approach that would enable tailored omnichannel communications, leveraging the new CRM, that was also easily implemented by the local affiliates with local buy-in, including a feedback loop to measure impact against ATU KPIs, as well as encouraging local teams to share comments on how the messages were landing in their F2F interactions.

Helen explained that HCP segmentation allows us to explore individual attitudes, drivers, emotions, perceptions, information needs and communication preferences, all of which are needed to help personalise content and to deliver it via the individual HCP's preferred communication channel. She noted that, in the post-COVID era, omnichannel is now an essential tool if we want to reach all of our target doctors, rather than only those who interact F2F with our organisations.

She outlined how this was achieved, starting with hypotheses, identifying data-driven segments, then converting them to personas to bring them to life, before integrating them into the CRM for implementation.

Starting with hypothesis-building, the team used existing information from previous market research and inhouse expertise within both Roche and IQVIA, and held a workshop to create a long "shortlist" of hypotheses, as well as identifying evidence gaps.

Market research, she explained, was used to understand and segment the HCPs by attitudes and preferences. Primary market research (PMR) was conducted across 5 markets – a mix of expected markets and some more unusual choices.

Initial qualitative research provided an understanding of HCP involvement in disease management and treatment, including treatment goals, strategy, preferences and frustrations with current treatments. They captured not only the role of efficacy and safety in driving decision-making, but also HCPs' hopes and expectations now and in the future, to understand both the current decision-making landscape but also what would need to happen in the future in order to change that behaviour, effectively future-proofing the work. The PMR focused on the key knowledge gaps identified at the hypotheses stage, and ensured that the outputs were defined by HCP insight rather than assumptions.

The outputs were used to create preliminary archetypes, which were then tested in a quantitative phase. The quantitative segmentation employed a traditional approach, using quantitative primary market research, analysed using factor analysis to identify key variables, and then cluster analysis to define optimal distributions of HPCs across segments.

Integrating the personas into the CRM was facilitated by Artificial Intelligence (AL) and Machine Learning (ML), with ML supplying the "heavy lifting" to extrapolate the PMR in core markets to the universe level. Helen explained that 75% of the PMR data was

used to train the model and test how well it was predicting segments. Then the remaining 25% of the PMR data was used to validate the accuracy of the model. When the team was satisfied that the model was giving the most accurate answers possible, they launched an additional typing tool via the fieldforce which provided the answers to additional critical questions, which were fed back into the model to further boost the accuracy.

Once the team was satisfied with the model, it was extrapolated to the total HCP universe of the 5 PMR markets, and then to the non-PMR markets to cover Roche's global universe.

Based on the segments, the team then took the group of data dimensions and created "personas" to bring those physician segments to life, understanding what information they like and how they like to receive it. Personas, Helen explained, took the process beyond segmentation and make it implementable. They needed to be easy to understand, but would also inspire onward activities within the omnichannel setting.

Peter described how collaborative cross-functional workshops were used to create the personas from the data elements. This approach, Peter explained, fulfilled a second objective of engaging stakeholders and creating ownership and buy-in, involving affiliates, colleagues from CRM and Marketing. Key to success, Peter advised, was focusing on the objectives of the exercise, and trying to communicate to the people who will ultimately read and use these personas to create differentiated communication approaches, and keeping in mind the behaviour change you are trying to engender.

For this project, Peter explained, they were fortunate that three clear segments emerged, one of which was a small "follow-up" segment, allowing them to focus on the 2 main segments. (He noted that too many different segments presented a real challenge for affiliate marketing teams to implement.) The later stage of measuring messaging impact highlighted very clear differences in how the messages resonated with the different segments, and that the messages were moving HCPs along the adoption ladder, reassuring the team that these were real and effective segments.

Reflecting on the project as a whole, Helen reminded us of the key characteristics of the project: it was a global project, but run on a sample, therefore a model was needed to scale-up the sample and ensure it was suitable for global rollout. It was not a stand-alone segmentation, but linked to the CRM data.

Peter summarised the key success factors that drove the success of the project.

Peter emphasised that scalability was key. He noted the benefit of lifting the implementation burden from affiliates by automatically identifying physicians in each segment from the global CRM system, without having to involve rep teams to implement a typing tool in the field. However, there was room for flexibility, with affiliates being able to adjust the segment allocated to a particular physician, if required.

To support the local affiliates with implementation, the Marketing team had done a great job of embedding the personas into their core visual aids, with different narratives for the two different physician types. All the materials were available to the affiliates, to ensure they had the tools to create tailored communication.

As the personas were being developed, the team created a differential between Roche and the competitors, helping to focus on key points that were relevant to each persona.

In terms of ultimate impact, Peter reported that, as an organisation, Roche had embedded the personas as the foundational language integral to the brand strategy and implementation.

Helen summarised the key takeaways from a methodological perspective, highlighting that segments must be robust, clear and understandable, using a data-driven approach with attitudinal data as a foundation. The approach needs to be scalable. Using AI/ML to deliver an automated segment allocation for all the HPCs in your CRM helps to demonstrate value and justify the investment cost.

Peter highlighted the importance of global implementation, embedding the segmentations within the CRM to allow effective deployment of personalised, tailored, messages to individual HCPs. He was grateful that the segmentation had fallen easily into two clear personas, and that the internal teams were very engaged with the process and ready to implement the outputs, and that Roche as an organisation had the ambition to embrace the approach. He reflected that, having been involved with a number of segmentations over the years, this project had more impact than any other, and had delivered more value for the organisation and the brand.

A question from the audience asked how the team engaged with affiliates beyond the core PMR markets. Peter explained that an "old school" process of a traditional launch meeting provided an opportunity for them to ask all their questions, before specialist function meetings were held to aid implementation. He emphasised the need for strong communication.

Peter was asked if the team had experience of using the same approach in another therapy area. He explained that this project was specifically for an initial product launch in a new therapy area, but that there were other products following within the franchise. In anticipation of this, the sample was structured accordingly. He noted that the personas were tailored to the particular launch product, and therefore would need to be adjusted in the future, but would retain the same essence.

An audience question asked how important it is to include channel mix preferences as well as capturing attitudes towards the therapy area and product, in today's world of omnichannel. Peter noted that Roche uses CRM as the conduit for omnichannel, and that communication preferences were part of the segment profiling, to ensure a holistic picture of the physicians and how the team would need to approach the channel mix for particular segments in particular countries.

A final question asked how the personas had been embedded as part of the foundational language of the organisation. Peter acknowledged that the team had been fortunate that the transformation had been facilitated by organisational readiness to embrace the approach, but also emphasised the importance of simplicity and ease, addressing barriers to implementation for affiliates and encouraging stakeholder engagement, ultimately ensuring value for the organisation.

Using AI to reframe the menopause narrative

Speakers: Georgina Cooper and An-hwa Lee, Basis Health

Convenor: Seb Newton, Purdie Pascoe

Georgina Cooper

An-hwa Lee

Georgina and An-hwa shared a case study of the use of generative AI in practice.

Setting the context, Georgina noted that Artificial Intelligence (AI) is an umbrella term that has been around for a long time, encompassing a wide range of different technologies and use cases in our daily lives, such as helping to drive our cars, direct our Google searches and correcting our spelling – even if we don't notice it. Use of AI in our industry has also become more sophisticated, with applications such as emotional recognition, online survey building, transcription and translation, with benefits such as speed, and perhaps cost, but also with cautions such as data quality and data privacy.

This case study, she explained, focused on the newer area of generative AI, where AI technology and

models use existing information and data, learn from it, and then generate something completely new and different. For generative AI, she suggests, we are still in the "in-between times", as we work out how to incorporate it into our work. Basis Health wanted to work on a generative AI case study to understand more about it, and its value and pitfalls, and to put it into action to explore what it may mean for our industry in the future.

An-hwa explained that the topic of menopause had been selected due to its importance and impact on women's lives, to explore their experience and unmet needs, and to identify opportunities for pharma companies to support women and improve the menopause journey in an area where more awareness and education is needed.

On a practical level, for this case study, the team wanted a consumer healthcare topic where they could be confident that there would be plenty of online conversation to analyse. They also noted that, within their mostly female team, this would be a topic where they could contribute their own knowledge, hypotheses and interest!

An-hwa outlined the integrated multi-phase methodology, starting with an initial generative AI phase, which was then validated with a traditional qualitative research phase before repeating the AI phase to see how the findings had evolved. An-hwa highlighted that, at each stage, the human is the driver of the process, with the generative AI as the "copilot".

The initial generative AI phase used publicly-available online data in the US and UK from the previous 2 years as the basis of the data lake. The process, she explained, begins with a query build, where terminology and key terms are selected. Terms such as "menopausal", "menopause symptoms", "hot flushes" etc are used by the AI as it trawls through the data sources to identify conversation themes and clusters from social media (such as facebook, X, TikTok and Reddit), google searches, forums and blogs. The human does some spot checks to

make sure everything is working correctly, and then the AI codifies and quantifies the data, which the model turns into summaries and insights through continuous learning. Again An-hwa highlighted the role of human intelligence in interrogating and querying the AI, asking follow-up questions to better understanding the insights that have been distilled.

In this case study, the AI distilled 10 menopause "territories", in which AI summarised the content of the conversations , the underlying sentiment, and a measure of "maturity". An-hwa explained that "mature territories" where those which are well understood, based on lots of conversations both current and historic. A "growing territory" was one with good awareness, but where something in the environment background has triggered heightened conversations at the present time. "Emerging territories" are those experiencing accelerated growth in conversations.

Human intelligence started to reflect on the AI insight summaries, looking for any interesting trends from emerging and growing territories that might provide an opportunity for the pharma industry to offer support. The human evaluation noted that, contrary to expectations, there weren't any conversations around Hormone Replacement Therapy (HRT) featuring prominently in the territories.

A traditional qualitative phase was then used to see if the generative AI insights could be validated. The team spoke to four women in the UK and 4 in Germany. All were aged 48-56, and all were menopausal. Half of the sample were taking HRT.

The qualitative research identified interesting nuances, and also additional insights. The respondents reviewed the "emerging" trends from the generative AI stage, and concluded that these were interesting topics but not yet relevant for them. The team noted that the sample didn't include influencers or thought leaders, so emerging trends may not yet have been recognised by the respondents. In reaction to the "growing" trends, the respondents again weren't actively engaging with these topics on

social media, but interestingly thought that a younger generation of women would be the target for these trends.

As expected, HRT was a very important discussion topic for the women in the qualitative phase. The team decided to repeat the AI phase to understand the disconnect between the AI phase and the qualitative interviews.

Additional data was provided to the AI model, including the transcripts from the qualitative phase, and then the AI analysis was re-run, revealing several key learnings for the team. The same top territories emerged again, validating the original findings. The process provided a longitudinal perspective on the trends, allowing the team to see, for example, that the emerging trends were growing faster than the mature trends. Examining the HRT topic in particular, the team was able to confirm that the HRT conversations were of course already happening in the first AI phase, but that the generative AI had incorporated them into a topic focused on "health coverage" (ie the insurance and cost of HRT), and so the team hadn't recognised the topic as HRT. Through training the model on the additional data sources, the HRT topics were revealed and the insights could be refined.

The team reflected on whether generative AI had changed the menopause narrative. There were emerging trends identified that could be taken by the pharma industry to develop patient-oriented solutions that are innovative and differentiating, such as support services. Similarly, there were some growing trends that might represent "easy wins", as these topics are already being discussed on social media. These insights would provide great leverage points for companies wanting to be part of the space.

In addition to the outputs from the case study, Georgina reflected more broadly on the process and what the team had learned about using generative AI as an insights solution.

She noted that some of the key insights from generative AI were mirrored in the traditional qualitative research, which conferred confidence in the robustness of the findings and the applicability of generative AI in this use case.

In addition, the generative AI process also identified some different territories and insights that were emerging, which might become areas of differentiation for companies or help them to maintain their competitive edge. These insights may not have emerged from the qualitative research alone.

Repeated iterations of the AI analysis can deliver a longitudinal view, to see how a market landscape is evolving and which trends are shifting or accelerating. For a company actively introducing strategies or tactics in this market, AI could be used to monitor and track the impact of the interventions.

The AI data lake gave access to a breadth of customer types beyond the typical menopausal qualitative sample, including from companies, celebrities, partners, friends and loved ones, which provide a more holistic view of the context, with relative speed and ease.

Georgina noted the importance of the human intelligence in the mix, reiterating that the humans remained in the driving seat, challenging, correcting and interpreting the insights.

She also highlighted the importance of data quality as the basis for the generative AI models to learn and train, and reminded us of the option of a secure datalake including private, proprietary, information as well as public information.

Looking to the future, the team can see generative AI becoming a mainstay tool used to complement or supplement the research process. Georgina noted that this was already happening in the consumer world to generate customer segmentation, customer personas, positioning, or new creative concepts, before being refined further by traditional research approaches.

To leverage these opportunities in healthcare, Georgina noted, our insights professionals will need to develop new capabilities and evolve our skills, as well as identifying new use case studies, to help us evaluate how, when and why we should include

generative AI solutions as part of a research process. One clear learning from Basis's experience was the consistent need for partnership between humans and machines, and Georgina concluded that humans are going to remain in the driving seat from an insights perspective, but that generative AI could be a copilot sharing our journey.

An audience question asked how clients had reacted to this approach. Georgina observed that amongst pharmaceutical clients the reaction had been very varied, with some companies already having advanced internal AI innovation hubs, and others exploring the area with external partners, but consistent between them all was an interest in AI and the expectation that it will change the future for everyone.

A practical question asked how to recognise whether you have built the optimal query to optimise the outputs of the AI model, before moving to the qual phase. An-hwa noted that it is a continuous iterative process, but thankfully a quick and easy one to repeat, so it is easy to repeat the process if you feel the outputs are not quite hitting the mark. Georgina added that there comes a point when, without adding new data, the model is no longer showing you any new outputs.

Another question sought clarification on the HRT topic and the disconnect between the AI outputs and the qualitative discussions. Georgina confirmed that the data had been there from the first stage, but that the generative AI had created a narrative that didn't quite capture the nub of the insight, and had focused on the insurance issue rather than the controversy around HRT. When the qualitative transcripts were used to give the model more data, angles and reflections, the topic was reframed. An-hwa emphasised that this example demonstrated the importance of human analysts playing a huge part in challenging and interpreting the AI insights.

A final audience question asked if the team had experimented with different foundational AI models such as GPT or Claude. Georgina explained that they have an internal AI team which built a bespoke model for the project.

Applying a 'human' approach to strategy development - co-creating a road map for customer engagement

Speakers: Hannah Potter, STRAT7 Incite and Lucy Mitchell, Jazz Pharma

Convenor: Geoff Birkett, Ensysce Biosciences

Lucy Mitchell

Hannah Potter

In their paper, Hannah Potter and Lucy Mitchell presented an overview of the three key ingredients that drive a human approach to strategy development. These are:

- A trusted partnership, in this case between STRAT7 Incite, STRAT7 Advisory and Jazz.
- A thoughtful internal engagement process.
- Engaging with customers as part of the process.

A trusted partnership

Hannah began by describing how the partnership between the two teams at STRAT7 and Jazz was delivered, what it meant for those involved and what it looked like.

Each person within the team brought their own ideas, expertise and experience and everybody was on an equal footing and could step in and out of the process, bringing their own perspectives and points of view. The partnership also:

- Set clear ground rules for the collaboration at the beginning. This included thinking about how everybody could make a success of the collaboration, what this could look like and how team members were going to communicate and meet with one another to ensure smooth working.
- Met in-person as it was important to have an opportunity to get heads together in a room. This helped to make connections, build relationships and support collaboration.
- Ensured regular collaboration with an iterative approach. At the end of each step, the team thought about how they could amend and correct implications for what they did next. There were several occasions where the team deviated from the original plan e.g. adding in a workshop to make sure they were meeting the needs of the project.

All of this created a cohesive approach, with team members stretching and challenging each other in different ways. This helped to build a strong partnership, enabling everybody involved to deliver the best work they could.

A thoughtful internal engagement process

Lucy continued by saying that the internal project team at Jazz was formed to get a wide range of diverse viewpoints so that a vision could be developed that would land well within the business. Individuals were nominated and represented all the roles that had a part to play when engaging with customers. They also had a dual responsibility to represent their markets' views as it was important not to develop work that was relevant for just one market. Some people took on a more advisory role and there was clarity from the start about individual roles and responsibilities so that everybody knew what to expect.

Lucy emphasised the importance of meeting face-to-face for the kick-off project. This provided a good opportunity to get to know each other and build the right environment from the start, ensuring that everybody had a platform to voice their opinions. Before long, the group were having rich and valuable conversations, debating the rights and wrongs of each other's viewpoints. In particular:

- Finding simple ways to make people feel comfortable quickly was a huge step forward in the human approach to developing the strategy.
- It was important to be sensitive and responsive to the needs of internal customers, often adapting the approach to address their concerns.

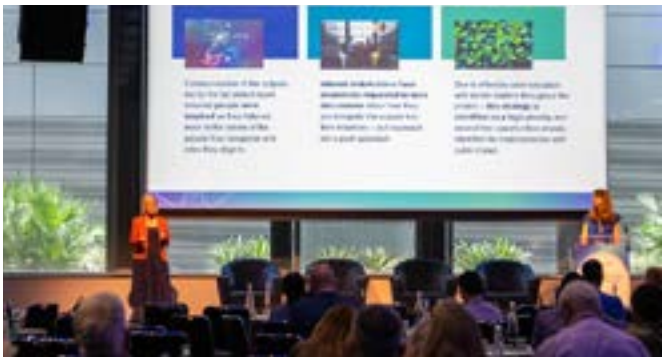
- Communications were tailored and the approach was peppered with a human touch, such as sending the core team a postcard after the summer break to welcome them back. Podcasts and short videos were used alongside more traditional updates to senior leaders, ensuring that everybody had a way that suited them to keep in touch with the project.
- Connections were also made with other parallel projects to find synergies and alignment with the wider Jazz approach to achieve consistent and broader buy-in.

All of these tactics added up to achieving a well-received and inspiring vision that set the team up for effective implementation by creating advocacy and motivation.

Engaging with customers as part of the process

Hannah outlined that this stage was about bringing customers into the process at two key moments.

Early within the strategy development programme, exploratory work was conducted with customers to understand who they were as people i.e. taking away the HCP labels. This involved thinking about what motivated them as individuals and what kind of examples of excellent customer engagement they could think of outside pharma i.e. companies that have offered truly exceptional customer service. The aim was to get inspiration from other parts of the doctors' lives so that foundational principles could be identified that applied across the board in terms of customer engagement.



Turning to pharma, the customers thought about what pharma companies can be doing more specifically i.e. which are doing a good job, what are the archetypes and how they themselves respond to the different typologies of companies. The customers were also asked how Jazz was currently perceived and the features of other pharma companies that Jazz could aspire to.

This first part of customer engagement was critical to help the team build a strategy with customers at its

heart before thinking about building out the vision and the core principles that would sit underneath the vision, as well as key strategic areas of focus.

The next stage involved exploring some of these ideas with prescribers in a second round of engagement with customers. A workshop with customers was held to understand how they responded to some of the elements of the strategy. This was a hugely beneficial exercise because it helped to sell in what had been produced as part of the strategy to the rest of the organisation.

The outcomes

Lucy concluded by highlighting the key outcomes, including:

- By enlisting the help of the core team to share the vision across the business and asking them to give their personal viewpoints on the vision and the impact it will have on their specific roles, it helped to make the results more applicable to their peers and strengthen buy-in.
- Change champions are being recruited i.e. the go-to people in their markets or functions to help drive the change needed in order to successfully deliver the vision.
- The team has been invited to partner on key opportunities such as the launch of a new asset and the expansion into a new market to help integrate the principles of the vision into these initiatives.
- Having inspired senior leaders through the project using insights from actual customers and peers, customer engagement was a key topic at Jazz's mid-year leaders' forum, where the team was asked to present a poster to encourage discussion on transformational big ideas to help accelerate ambition.

Patient Engagement. From Insights to Action. A Paradigm Shift - from the delivery of insights to activation and support

Speakers: Rieke Burfeind, Point Blank Research and Julia Peschny, GSK

Convenor: Kristina DiPiertrantonio, The Planning Shop

Julia Peschny

Rieke Burfeind

The role of market research to enable patient activation in rare disease was the focus of the presentation from Rieke Burfeind and Julia Peschny, who illustrated this with a case study from GSK.

Market research and a patient-centric approach

Rieke began by outlining that the role of patients is changing through them taking more responsibility for themselves and having an increasingly powerful voice. The need for this to happen is particularly acute in rare diseases, where doctors often diagnose too late and it can be hard for patients to obtain information.

While patient empowerment is important to HCP marketing, new stakeholders within pharma companies are becoming more relevant e.g. those responsible for patient partnerships and patient relations. This opens up new opportunities for us as market researchers. Through in-depth analysis, market research can provide comprehensive patient journeys with relevant touch points. In other words, instead of just providing insights, we can be actively involved in solution design based on a truly patient-centric approach.

GSK case study

Julia introduced the GSK case study which aimed to empower and activate patients in the area of eosinophilic diseases in Germany. To achieve this, GSK partnered with a number of agencies as well as patients, PAGs, HCPs and internal cross-functional teams to develop a blueprint from understanding unmet needs through to implementing solutions and measuring the impact.

To understand patients' unmet needs, Point Blank conducted deep-dive interviews and also looked at quant data. At the same time, HCPs were interviewed to understand their perspective and the challenges they face in the German healthcare system.

Before beginning the solution design, a landscape analysis was conducted to understand the market and avoid any duplication. Co-creation workshops were also held with patients to discuss and brainstorm ideas to make sure that all the solutions would be relevant and accepted. These ideas were discussed with HCPs and many were challenged by them. This was critical because buy-in was important from HCPs as well as patients.

After this stage, the internal team prioritised the solutions, aligning the patient unmet needs and the medical unmet needs which were found to be quite similar. All the stakeholders shared the same goals:

- Faster diagnosis.
- Shared decision-making. Patients want to be active and take control of their health.
- Oral corticosteroid reduction because of the side-effects.
- Access for patients to guideline-based therapy.

Solutions

These have included:

- A digital patient hub for eosinophilic diseases that has been co-created with patients and HCPs. The key topics are disease awareness, diagnosis, treatment and advice for patients to get active. The feedback has been very positive, as there is a gap in the provision of patient-accessible and patient-friendly information in German. The hub also includes an HCP finder as the deep-dive interviews indicated that it is a big challenge for patients to find an expert.
- Collaborations with PAGs driven by common goals. GSK sponsors events and has non-monetary collaborations to exchange ideas and insights.
- Patient materials that have been co-created with patients. The materials include information on social services and diagnostic symptoms so that patients can have more informed conversations with HCPs.

Key takeaways

- With the increasing importance of patient relations, new internal stakeholders and customer groups are emerging for market research activities.
- We need to focus on the design of relevant, accessible and high-impact solutions, not just on finding insights.
- Co-creation workshops are more important than classic in-depth exploration.
- Pharma, patients and agencies need to work together to facilitate collaboration.
- The voice of patients must be included, shared and taken seriously.

Optimising Omnichannel Customer Engagement with AI-powered Analytics, Data Integration and LEGO

Speaker: Xierong Liu, Ipsos

Convenor: Roy Rogers, Research Partnership

Xierong Liu

In this paper, Xierong took us on a learning journey from understanding the basics of omnichannel vs multichannel customer engagement, through the ways in which insight teams have an opportunity to play a pivotal role in integrating multiple data sources to deliver actionable insights for the design and evaluation of omnichannel strategies, and finishing with inspiration from LEGO workshops to help cross-functional teams to work together to understand and embed those insights to enhance the benefit to both company and customers.

Xierong opened with a review of multichannel vs omnichannel engagement. Noting that multichannel, as the name suggests, described leveraging multiple channels (not just the sales rep) to reach customers, she explained how a multichannel approach can have great value in delivering a single company- or brand-centric tactical message to all customers, via consistent communication across all channels and touchpoints. However, she noted that this "push" relationship is based on the messaging that the company or brand wishes to communicate, and not tailored to the needs and questions of individual customers (or groups of customers). She noted that this "one size fits all" approach can lead to unwelcome

scenarios such as basic product information (for example, on disease awareness or mechanism of action) being communicated to Key Opinion Leaders or long-standing product champions, which could damage the customer experience and therefore brand engagement.

By contrast, omnichannel engagement takes a customer-centric approach, focusing on specific customer needs in a "pull" relationship to deliver key information appropriate to the needs and wants of the individual customer or group of customers, via the customer's preferred communication channels. This makes things more interesting, she explains, both for them and for us. She noted that omnichannel approaches are far more complex than multichannel, due to the need for multiple campaigns based on the different requirements for each customer (or group of customers). Added to this, the ideal omnichannel approach involves an interconnected network of channels, each acknowledging the information that the customer has received via another channel. For example, three touchpoints of webinar attendance, webinar evaluation and follow-up emails could be integrated, so that different email content would be delivered to attendees of a webinar vs non-attendees, and, if possible, further personalisation could be delivered by tailoring the messaging according to the doctor's reaction to the webinar content.

Xierong reflected that such idealised omnichannel approaches have the potential to deliver the "grand and beautiful shared vision" from our industry, namely, to deliver a meaningful, impactful and personalised experience that is 100% customer-centric.

However, she suggests that many organisations today may struggle to execute the idealised omnichannel experience, and in some cases, may struggle to execute multichannel successfully, for a number of reasons:

1) Because it is complex: the interconnected, personalised communication is highly complex, with multiple campaigns required, delivering different tailored content according to individual customer wants and needs. Tracking the context and customer reactions to the content adds further complexity. Content production and orchestration is highly complex, and requires your cross-functional team to start thinking very differently, and then start doing things very differently

2) Because of the focus on "channels": Xierong suggests that the name "omnichannel" is potentially misleading, as the channels themselves are actually less critical than the personalisation of the message (including content, language used, cadence and even reactions to previous messaging), but that our industry tends to focus on the channels

3) Because it's not "black and white": Xierong notes that both multichannel and omnichannel approaches have their place, and that even within omnichannel the optimal approach may differ not only by brand objectives and market model but also by company stage and maturity with regard to omnichannel capability – there is no "one size fits all" solution

4) Because it requires complex cross-functional collaboration: although our industry is familiar with Marketing, Medical and Regulatory/Access functions working together as a cross-functional team, Xierong points out that an omnichannel cross-functional team is even more diverse, including digital marketing, content creation and analytics, adding to the complexity and the need to find a common understanding and language.

Despite these challenges, Xierong sees a clear opportunity for us as Insight specialists. She notes that omnichannel has its foundation in customer-centricity, and reminds us of the shared industry vision to deliver a meaningful, impactful and personalised experience that is 100% customer-centric. All of the keywords in this vision point to the skills and expertise of the Insights function in delivering good customer understanding:

- Meaningful: we cannot deliver meaningful content unless we understand our customers' needs
- Impactful: we need a framework of KPIs to measure and understand the effectiveness of our campaigns
- Personalised: we cannot personalise unless we understand how Customer A differs from Customer B
- Customer-centric: to deliver true customer-centricity, we need to understand our customers before, during and after our omnichannel execution

Despite the clear indication for the important role of Insights in the design, execution and evaluation of omnichannel approaches, Xierong observes that the Insight function does not always have a seat at the table. She hypothesises that this may be due to a lack of understanding about the role, capability and potential value that Insights can add, and issues a call to action for Insight specialists to engage, educate and influence the omnichannel stakeholders, elevating the role of insight in omnichannel. But how can Insight specialists open the conversation?

Xierong puts forward three questions to ask ourselves and our omnichannel colleagues in order to start that conversation and ensure that Insight becomes an integral part of the omnichannel team:

1) Do we truly understand the customer?

   Xierong hears brand teams claim that they already know all there is to know about their customers, but observes that this may not be the case. She gave an example of a direct quote from an experienced oncologist engaged with the industry, who asked why pharma companies can't work together to send a summary email with all the latest breast cancer news. The quote, she concluded, indicated that the doctor did not fully understand the regulatory, medical and legal restrictions that the industry operates within, which would mean that by the time the newsletter had been agreed and signed off, it would no longer be "news". In another example, a customer expressed discomfort with being described as an "expert" when they felt the area was completely new to them. The customer wondered if the flattering language was being used for the rep's advantage. Here, the seemingly respectful language was having a negative effect. Xierong noted that, in a face-to-face interaction, the rep might be able to observe the doctor's reactions and mitigate, but that this would not be possible via another channel such as email. These examples illustrate a potential for disconnect between customer expectations and company reality, and highlights nuances such as language and understanding that need to be considered for effective omnichannel execution, to avoid disappointing the customer. As Insights specialists, understanding the customer is our everyday job, and we can add value to the omnichannel discussion

2) Do we capture true omnichannel?

   Xierong notes that one challenge levelled at our industry is that we capture perception (or perception based on recall) rather than real experiences. The argument is that perception has the potential to be biased, or to be based on a generalised perception rather than a specific interaction within omnichannel. However, Xierong explains that accumulated experience shapes and forms perceptions, and the perceptions then impact behaviour intentions and ultimate behaviour. She concludes that both experience and perception are important in evaluating our omnichannel activities.

   Our omnichannel colleagues focus on tactical and CRM data which report "real" data (such as how many emails are sent and opened, how many webinars are attended etc), but the "real" data describe behaviour, but not impact. For example, we may know that a doctor has opened an email, but we don't know if the content has had a positive impact on changing their behaviour. Xierong also points out that these "real" data only

provide part of the picture, as they are limited to your own company activity but do not set your omnichannel activity within the competitive landscape. Additionally, the data metrics are focused on a single channel in isolation, rather than considering the interconnected channels as a whole.

But how can we capture integrated experience and perceptions to deliver meaningful omnichannel insights? Xierong suggests that there are many suitable approaches, giving the example of an integration of tactical/CRM data with passive tracking and an omnichannel diary. Passive tracking (eg via an app downloaded to a smartphone, tablet or laptop) allows us to follow customer's digital footsteps, tracking them as they visit and interact with websites, capturing, for example, time of day or activity duration, to help us understand the sequence of activities that doctors interact with in the digital world, whether for our own company or our competitor's digital assets. This approach has been transformed by the use of AI to manage the unwieldy volumes of data generated, allowing us to capture real customer experience and sequences as they navigate the digital platforms and resources available to them. Overlaying the "real" experiences with an omnichannel diary enables us to capture perceptions of each interaction, helping us to understand the reasons behind behaviours, via user-friendly methods such as voice notes. This approach enables us to capture very specific feedback to generate concrete actions points on what should be done differently. It allows us to compare the customer's experience with our own company and the competitors, and we can look at an individual customer or customer groups. Again, AI can be used to process the unstructured responses from the diary across multiple data points.

3) Do we take the insights far enough?

Xierong acknowledges that this is a perpetual question, and is a particular challenge with complex and diverse cross-functional teams involved in omnichannel, but she believes that as an insight function, we are uniquely positioned to use insight as a tool to help connect the cross-functional team, and bring people together to understand each other and work more effectively as a team. Using creative facilitation techniques can help to engage with all stakeholders and bring together their different viewpoints and voices. She uses the example of a LEGO Serious Play workshop where each stakeholder has the opportunity to build their own personal LEGO model to describe what they do in their function, and to tell the story about how they would like to activate customer insight. They then have the opportunity to make changes to the model based on what they have learned about other functions at the workshop. Then all of the functions can work together, using their understanding and recognition of each viewpoint, to build a shared model integrating the different perspectives into a shared vision.

Xierong encouraged us to initiate our next omnichannel conversation, and to prepare by giving some thought to three key issues:

- Company omnichannel adoption: consider where the company sits in terms of their omnichannel transformation journey (eg maturity and structure/capability), and therefore what might be effective and appropriate to address the company's needs and objectives
- Providing concrete guidance on incremental changes: many companies have a grand vision and invest millions, but fail to generate the desired impact. Rather than over-complicating an already complex picture, Xierong advises us to start small, focus on the quick wins, giving concrete evidence to demonstrate the success, impact and value of customer insight to open the door for incremental change within the organisation
- Identifying stakeholders: ensure we identify all the stakeholders that are important for omnichannel

success, and have a plan to bring them on board very early in the process, as well as giving thought to how Insight can help them and bring them together.

A question from the audience asked how we can reconcile the definition of omnichannel as HCP-centric and therefore individualised, vs insight which aggregates key themes at a high level. Xierong acknowledged that this is a philosophical question in terms of how we sometimes consider personalisation at the individual level, but other times we consider personalisation at the group level. She noted that segmentation has a part to play here, whereby moving from a one-size-fits-all multi-channel approach to an omnichannel approach that is tailored to the segment is already a big improvement in our industry. Although segmentation is not a necessity for good omnichannel delivery, Xierong says, it provides a good starting point to help identify key differentiators within the customer group, particularly in Europe where there are some limitations in terms of what is possible, compared with some other markets.

A practical question from the audience asked whether there were any issues with respondents' willingness to install the passive tracking app on their devices, or with ensuring the omnichannel diary is completed fully and accurately. Xierong explained that, since the COVID pandemic, respondent attitudes have changed, and they are more willing to accept the passive tracker and fieldwork partners are now more willing to try to recruit for this type of methodology. She noted that transparency and consent are essential for success, with a customised information pack to explain the methodology and compliance with regulations. She noted that videos have been created to help explain the methodology and reassure respondents. Regarding the omnichannel diary completion, Xierong is sanguine and realistic about the ability to control human behaviour, but that giving specific instructions and reminders were helpful, as well as making the diary task as easy and accessible as possible.

How Agencies and Pharma clients can collaborate to make sure that research and insight is seen as an investment, rather than a cost

Speakers: Paul Griffiths, Client Advocates and Paul Warner, CSL Vifor

Convenor: Stephen Potts, Purdie Pascoe

Paul Griffiths

Paul Warner

In a discussion convened by Stephen Potts, Paul Griffiths (PG) and Paul Warner (PW) offered practical advice on changing the language and agenda around how market research is perceived and the value that it adds to businesses.

Collaboration

Paul G began by emphasising that it is not about an adversarial relationship between the agency and the end client but is about collaboration. It is about how agencies and clients can work together to start to change the dialogue and the terminology around the idea of research as an investment. If you are a client, it requires transparency, trust and vulnerability to be able to say to an agency: "I need you to help me win over stakeholders to make sure that I don't get my budgets cut." Equally, it takes vulnerability from an agency to say: "you need to tell us more about your stakeholders and what you need to do so that we can help you." There doesn't have to be a disconnect between the agency and the client.

Barriers

Paul G continued by saying that there is an issue around risk and perceptions of cost-savings being less

risky than investment. However, without risk, there is no reward. We need to understand the upside risk associated with investing and start talking about it more. The upside risk is that you will sell more or get more value from what you do.

Paul W felt that the conversation needs to be about the value you deliver to the business and how this impacts the decisions that are ultimately made on the commercial side. This is a challenge for a lot of research agencies because you don't even see how your insights are pulled through. Client-side, we need to elevate our role as we are not connected to the end decisions that are made and just become a conduit for the insights. It is impossible to put a dollar value on the ROI of market research as you need to understand how this is pulled through to the commercial decisions that are made.

Market research can be a threat to marketers. The trick is how you partner with them to be able to challenge what they are doing in a productive way.

Paul G discussed issues around procurement and the fact that it can be difficult if the person who is responsible for it has no responsibility for the output and the quality of what is being created. They are incentivised by driving the cost down and they have no accountability for how good the market research will be and how much impact it will have.

Paul G moved on to talk about the trade-off between quality, speed and price. We need to educate our stakeholders that if you reduce budget and you take value out of the research and insight spend, you will compromise on quality or speed.

Stephen added that he has heard anecdotally that procurement teams expect research to be done more cheaply through using AI tools. On the agency side, you may have been challenged by your clients to do this. If AI can maintain quality, carry out research faster and cut costs, it should free up researcher time to do the pull-through i.e. making sure that research results are properly understood and acted upon and that broader teams are fully engaged in the research findings. AI should give humans the time to do things that are really important, rather than just being a means to cut costs.

The value and impact of research

The money that is spent on research in most companies is minimal compared to sales figures. However, all of the decisions that lead to the drug being successfully launched and marketed are derived from research. Whenever there is any pressure on budgets, we need to be more robust.

Paul G reiterated that every time we talk about research as a cost and don't think about it or communicate it as an investment, we are undermining our own validity, our own sense of value as an industry and how we can make an impact for clients.

What can client insight teams and agencies do to help the conversation?

Paul G highlighted three ways in which we can help the conversation around the value that an insight function can generate:

- We need to reframe internal conversations e.g. "you need to invest in research to make a confident and commercial decision."
- Find out the commercial issues in which research can potentially help with decision-making.
- Communicate that research can provide the right solution at the right price at the right quality at the right speed.

Paul W added that we can help companies look around corners at the decisions they are going to have to make in the future. This can be a very effective way to sell insights work internally. Stephen supported this by saying that you need to work with the client to look at the decisions they will be making as a result of the research, including the impact of getting the decisions right or wrong. Paul G described this as a co-creation process in which you are working as a consultant i.e. "what is your issue and how best can we fix it." Although this requires an investment of time on behalf of both the agency and the client, it can be recouped through improving the depth of the relationship and the ability to deliver value that makes sure the relationship is delivering ROI.

Solutions

Creating and executing a successful insight strategy involves being able to say that you have:

- Gone out to your internal stakeholders.
- Found out what their commercial objectives are.
- Created a plan that says: "this is what we are going to do from an insight perspective." This should be captured in a document that can be communicated to stakeholders.

These steps will make the insight team be seen as proactive and commercial. It also means you can defend the investment implications. Having a plan will give the insight team confidence and an ability to manage their stakeholders as well as challenge them.

Manage and promote to your stakeholders

Paul G emphasised that you need to be more promotional about the value you generate as an insight function. You need to be mapping your stakeholders and keeping a log of the value you generate. Make sure you have a record of some of the things you have done and the achievements you have made against an insight strategy so you can go to your stakeholders and demonstrate the value of your team.

Paul W highlighted that it is critical to factor in the role of the creative agency. The closer you can get the insights to the people who are developing the creative or designing the tactic, the more impactful they will be.

In drawing the discussion to a close, Paul G said that while most of what had been mentioned will be happening naturally during the course of your work, it is about being conscious about it.

Key takeaways

- Position research expenditure differently. We need to stop talking about research costs and research budgets and instead talk about research investment.
- Build a relationship with your procurement team. Have a conversation with them about understanding the implications of quality. They might not be familiar with research and insight as a purchase. Educate them so that they understand the implications.
- Be clear that you are relating the decisions that are happening in an organisation back to the research and the investment that has been made. It is in the interest of insight functions to have this conversation and change the narrative. Engage with suppliers and stakeholders to help you do this.

Breaking down barriers: how market research can help to address disparities in HIV prevention

Speakers: Tom Winter, Research Partnership and Bismay Mishra, Gilead Sciences

Convenor: Xierong Liu, Ipsos

Tom Winter

Bismay Mishra

Bismay and Tom shared a case study focused on health equity, which required a different way of thinking, both to uncover relevant insights and to implement them at a global and local level.

Bismay set the context by clarifying the definitions of equality and equity, explaining the difference between "equality", where everyone receives the same, whether it is needed or appropriate for them, and "equity" where everyone receives what they need.

"Health equity", he explained, involves removing the barriers to connecting with the healthcare system, whether accessing doctors and obtaining medications, or staying on the medication they need. These barriers may be due to disparities that arise as a result of circumstances and conditions such as socioeconomic status, age, race and ethnicity, geography, sexual orientation, gender identity and ability. He used the example of a pedestrian crossing at traffic lights: everyone is allowed access to the crossing, but we may have different barriers in how we can access the crossing (eg due to hearing, visual or physical impairment). He noted that healthcare inequity affects certain populations much more than others, and to address it, we need to identify and understand both the populations affected and the barriers they experience.

"Health equity", he explained, emerges at different levels, starting from systemic causes of the social inequities that lead to poor health, through the community level which affects people's ability to be healthy, through to the individual level, where non-medical, social or economic circumstances may hinder their ability to stay healthy and/or recover from illness. Bismay explained that Gilead has focused on the individual and social/community factors, noting that it is more difficult for a company to influence the systemic level (cultural, country, national, or global factors).

Gilead is a key player in the prevention and management of HIV. Bismay observed that, unlike 20 years ago, we now have effective treatment options that mean someone with HIV can lead as long and healthy a life as someone without HIV. However, Bismay highlighted the goal of large global organisations (such as UNAIDS, NIAID, the NHS and CDC) to eradicate HIV by 2030, and noted that, to do that, we need to identify which groups are most affected by HIV, understand their drivers and barriers when seeking prevention or treatment, and address them so that we can develop strategies to remove health inequity.

To highlight the importance of identifying relevant populations, and the dangers of unconfirmed hypotheses or assumptions, he conducted a quick audience poll, asking which ethnic groups have the highest incidence of HIV today. The audience correctly surmised that it would be the Black / African American population. Bismay noted that Sub-Saharan Africa is home to 2/3 of all people living with HIV globally. Bismay then asked which social groups had the highest incidence rates of HIV today. The most common audience answer was men who have sex with men, but Bismay revealed that in the UK it is actually cisgender heterosexual women who have the highest incidence rates of HIV.

He shared further statistics on incidence across the world, suggesting that the way we have previously viewed the relevant populations, collected data and informed strategy, may now be skewed. Defining the research questions that this understanding raises, Bismay emphasised the need to look beyond clinical unmet needs, to understand which communities are in most need, identify their non-clinical barriers, and distil which needs are common and which are unique to specific communities.

Tom then addressed how we can generate the insights needed to drive this strategy for change, sharing a case study involving two project to explore the need for, and access to, Pre-Exposure Prophylaxis (PrEP) for HIV.

He noted that secondary data is the first port of call, but that this may only tell part of the story, as it focuses on observational data rather than the "why" and "how". Primary market research is required to understand these underserved communities.

The first project, he explained, cast the net wide to understand the non-clinical needs of people who would benefit from PrEP (PWBP), including current users, lapsed users, and those naïve to PrEP, from a mix of demographics across the USA, Europe, Canada, Japan and China. The project identified their needs, but also provided anecdotal evidence of underserved communities where HIV infection rates are disproportionately high, but where they are not accessing PrEP as they should be.

The second project involved a deep dive into those underserved communities. The team wanted to know exactly who these communities were, and what their needs and barriers were. Tom identified 3 challenges that the team had needed to overcome, and shared their thinking and approach to solutions.

Challenge 1: recruitment

The first was a recruitment challenge: how to identify the right respondents, when they didn't yet know which communities were underserved; and then how to recruit the right respondents, when they

would be unlikely to agree to take part in market research about barriers to accessing PrEP when their knowledge and experience with PrEP was, by definition, very low.

The team needed to think creatively. Instead of speaking directly to these underserved communities, they spoke to a range of stakeholders who work closely with those communities. This included allied healthcare professionals such as social workers, workers in sexual health clinics and community workers. PrEP prescribers were included, but Tom noted the need to seek out those who were aware of groups other than the "typical" white, men-seeking-men (MSM) who would present at their practice. Similarly nuanced was the selection of advocacy groups, as Tom explained that some patient advocacy groups are focused on treatment rather than PrEP, so they included broader groups such as those advocating for black African communities, vulnerable women or the transgender community. Public Health officials were also included to provide a broader view of the communities and how they could be supported.

Even when this comprehensive target respondent list had been identified, Tom noted the challenges in persuading them to take part, and shared some of the ways in which the team overcame the recruitment challenge. He shared the importance of providing an understanding of the objectives from the start (going beyond the high-level sentence we usually include in

screeners for HCPs familiar with market research), so that the respondents knew exactly what was going to be discussed and could confirm that they felt sufficiently knowledgeable and confident to be able to take part in the discussion.

Tom emphasised the need for flexibility in terms of job title: their title of prescriber, nurse or case worker was less important than their day-to-day involvement in outreach programmes to try to bring people underserved by PrEP into care. Bismay emphasised the partnership between Tom's team and the Gilead team, helping Gilead leaders understand that this was a new and different approach rather than traditional market research.

Tom explained how the team had involved consumer recruiters and patient recruiters, who might already have connections with some of the advocacy groups and respondent types they were looking for, and the importance of asking for referrals to identify other suitable respondents.

Challenge 2: analysis granularity

Tom acknowledged the business need to distil and consolidate findings across the different communities into an output to inform global strategy. However, each community had unique needs. Tom noted that in health equity studies in particular, the reasons that underserved populations exist is because the current "one size fits all" approach does not fit them, and their unique needs and nuances preclude a "one size fits all" recommendation.

The team addressed this challenge with an iterative workshop approach. Bismay observed that the usual project readout, email summary or dashboard would not work for this project, as the insights for one community may be more relevant for some functions than others (eg commercial function vs public policy). The workshop was required to immerse stakeholders in the details and help to translate those insights into something actionable.

Tom described how the insights were anchored to a framework that the team was familiar with – the PrEP care continuum – which helped them to set the detailed insights into context. Bismay explained that different functions work at different stages of the PrEP care continuum, so anchoring the needs or solutions to different parts of the continuum helped to make it relatable for them.

A balance between granularity and global strategy was struck by grouping similar solutions or interventions globally so that it worked at a strategic level, while retaining the details and nuances by community and country for tactical implementation. It was also important to identify remaining knowledge gaps for future research.

Challenge 3: optimising impact based on segmentation of needs

Tom explained that they aimed to speak to respondents who interacted with a number of different communities, so that they could understand which communities have the most need and which groups would most benefit from interventions at different points. In reality, this was ambitious, as for example many advocacy groups focused on one particular population, so the team had the challenge of putting together the big picture from the component pieces of the jigsaw, to give direction on which groups would benefit most from interventions for greatest impact.

Tom noted that there was no perfect way to build an accurate picture, and that triangulation was required based on different sources. Feedback from respondents who worked with different groups was used to understand how they perceived the need relative to the other groups and how they would prioritise initiatives for one group vs another. Secondary data was used to try to size the populations, but the data were patchy by group and by country. (Bismay added that this challenge led to a partnership between Gilead, healthcare providers and public health officials to develop a protocol to accurately quantify these populations, benefitting all parties). The team also looked at needs across the care continuum, looking at communities with the highest number of needs overlaid with the size of those needs.

Bismay summarised the impact of the research on shaping strategy at Gilead.

1) Challenging internal hypotheses:

Bismay noted that HIV has been evolving, and that focusing on Gilead's long-standing connections with existing communities can make it easy to miss how things are changing. The research challenged the preconceived notions within Gilead, and the team was able to take a fresh look to ensure different populations were being prioritised appropriately

2) Level-setting the context for each community:

The research helped Gilead identify where the barriers were (at the systemic, community or individual level) and whether the challenges were Gilead's to solve. For example, the barriers around indigenous Canadian and African-American communities connecting with healthcare focused on mistrust of the healthcare system itself, and so couldn't be solved by Gilead alone

3) Distinguishing between global strategy actions and local tactics

The workshops were used to highlight which areas would be implemented via global strategy, and which insights would be used by local teams to develop their own local strategy and tactics

Tom summarised the key learnings from the experience:

1) Think differently: he highlighted that this was not a typical market research project, and that although it was useful to have hypotheses, it was important to keep an open mind and leave biases and preconceptions at the door. A different approach to sampling and recruitment was required, with maximum flexibility throughout to ensure the right people were identified and included

2) Think both global and local: it was important to find ways to balance the need for global strategy without over-summarising and diluting the needs of each community

3) Invest time in socialising the findings: Tom observed that we sometimes have to take the team on a journey of understanding, to set the context for the emerging insights. Solutions may not be immediately obvious, but workshops with cross-functional teams to debate and discuss helps to extract the greatest value from the research. Bismay added that, 12-18 months later, he is still presenting the insights to various functions in Gilead today, and noted the importance of continuing to socialise the insights as teams and team members change

The first question from the audience asked if external advisors were used to help the team think outside the box. Tom highlighted the use of different recruitment routes such as advocacy groups to go beyond typical pharma recruitment and identify the appropriate respondents. Bismay highlighted the impact of involving external stakeholders such as public health officials to help quantify the populations.

Another question asked for tips on how to make the case for research like this for a product in early launch phase. Bismay explained that this project had the luxury of time, being conducted 3-4 years before launch, but that partnering with other functions beyond marketing to include medical government affairs and public affairs enable a cross-function forum approach which supported the business case.

A further question asked how to reconcile the needs-based segments generated for this project with the generalised patient segments. Bismay explained that the cross-functional teams were open to the insights identifying needs for different populations. Tom noted that traditional segmentation focused on which communities have most need or less need, but that all of these communities would fit into the "most need" category, so a sub-segmentation was needed to look at their unique needs separately.

A final question asked how the team built the whole picture from the many different pieces, and how they resolved any contradictions. Tom confirmed that this was a challenge, as each respondent defined their own communities, and that there were intersections and overlaps which had to be pieced together based on needs. Bismay added that on a more tactical level, the problems and barriers concentrate over certain pieces of the continuum of care, and so the team could focus on the problems rather than the communities, as the problems capture the needs of the community.

Shining A Light on the Inequality of Cancer Outcomes

Speakers: John Grime, Prescient Healthcare Group and Lara Lucchese, BMS

Convenor: Tracy Machado, Elma Research

John Grime

Lara Lucchese

John and Lara's paper shared a study which explored inequalities in the speed of diagnosis, and therefore patient outcomes, for patients from lower socio-economic groups.

Lara opened by sharing some shocking statistics: in the UK, more that 2 million years of life and lost to cancer each year. 30% of cancer cases (80 cases per day) are attributed to socioeconomic deprivation, with those living in more deprived areas in England being 20% more likely to receive a late diagnosis of cancer. BAME populations were over-represented in these disadvantaged groups. Lara described how BMS and the UK charity, Shine Cancer Support, wanted to find a solution to this issue. A market research study was commissioned to explore these issues, and to feed the insights into a nationwide campaign seeking to address cancer care inequalities.

John outlined the market research objective, which was to gather insight from under-represented, hard-to-reach groups, to explore and understand the lived experiences and stories of patients.

He described the 4-step process used to amplify the patient voice and align on campaign direction.

Step 1 - inequalities factbook: the team undertook desk research of BMS's existing insights and publicly-available documents on the topic of disparities in cancer across the UK

Sept 2 – qualitative research: thirty patients took part in 60-minutes interviews to gather rich patient insights, and bring data and statistics to life with unique lived experience. Respondents were from deprived communities or regions of the UK, with a mix of tumour types, ages, genders and ethnicities. John highlighted two recruitment challenges: how to identify the right people, and how to ensure the right environment to enable them to share their experiences. To address these challenges, the team worked with a number of recruitment partners, including a specialist ethnic minorities recruiter, and patient associations. A pre-homework task was provided, with a range of tasks to capture the patient's story in their own words, and in their own time and space, which then formed the basis of the interview discussion. The interviews themselves were offered in a flexible range of formats, including anonymous telephone interviews, videocall or face-to-face in a public setting or the patient's home. Crucially, the moderator was aligned as closely as possible with the patients in age and cultural background, and across several different languages

Step 3 – quantitative research: over 1,000 people, who had been diagnosed with cancer within the last 8 years, took part in a 15-minute online survey, to validate the qualitative phase. A broad and representative range of respondents were recruited via the YouGov, with no specified regions, incomes, ethnicities or ages, to enable analysis to identify patterns in the data between different groups and locations

Step 4 – campaign strategy: insights from the reports and surveys were brought into a multi-stakeholder workshop to generate and inspire potential solutions for the campaign

John shared three key findings that emerged from the research:

1) lack of awareness of symptoms drives late presentation
2) lack of self-advocacy drives delayed diagnosis
3) BAME patients wait longer between first symptoms and diagnosis compared with the broader population

Lara explained that people within

the lower socioeconomic groups were more likely to have less knowledge about cancer. This lack of health literacy had wide-reaching implications, including a reluctance to go to the GP, and an underestimation of how serious the symptoms might be. The research showed that people with a lower disease understanding are more likely to require 2-3 appointments before a specialist referral, compared with those with a stronger cancer understanding.

John explained that a lack of self-advocacy drives diagnostic delay for a number of reasons, including cultural values of stoicism, and the reluctance to take up the doctor's time or "make a fuss", and lack of ability to navigate the gatekeeping systems around appointments and referrals. For some patients, there was a feeling of embarrassment or shame associated with symptoms, rooted in a fear that their behaviour was in some way responsible for the cancer, which led to a delay in sharing symptoms, and a reluctance to shall the full picture of the nature or duration of symptoms.

Within the patient population, John reported that patients from BAME communities were more likely to worry that they are wasting NHS time and resources, with lower socioeconomic groups more likely to want to address and resolve health issues on their own. Additional factors also played a part in diagnostic delay, including attributing the symptoms to other factors and therefore underestimating their significance, and also practical issues such as immigration status limiting access to a doctor, or being unable to take time off work to go to appointments.

The quantitative research confirmed the qualitative findings, and John shared the shocking finding that the BAME population may wait an additional 7 months from symptoms to diagnosis, compared with the while population, with clear implications for prognosis.

Lara and John then shared compelling video testimonials from three different patients:

Precious was diagnosed with Chronic Myeloid Leukaemia at age 33. She explained that she had experienced symptoms but didn't know what they were. She had been to her GP several times, but was told she was tired or stressed. She felt unable to vocalise where to go for help, or what to ask for. She had had symptoms for 6 months before finally being diagnosed after passing out on an underground train. She explained that her community avoids talking about cancer as it is seen as a curse that happens to bad people, and is therefore surrounded by shame.

Belinda was diagnosed with stomach cancer at age 66. She hadn't heard of stomach cancer until that diagnosis. She explained that she had gone to her GP with symptoms 6-7 months prior to diagnosis, and had been offered an endoscopy, but had refused it. Belinda feels that if the doctor had mentioned "cancer", she would have accepted the endoscopy.

Simeon was diagnosed with prostate cancer aged 49. He was waking 2-3 times each night to go to the toilet before his partner persuaded him to go to the doctor. He was diagnosed 6 weeks later. He experienced severe financial difficulty due to his inability to work, with no support due to his immigration status, and had resorted to selling his possessions to pay his rent. He explained that, since his diagnosis, he was now aware or the higher risks of prostate cancer amongst black men. He had also now had discussions with his family, and discovered that there were three generations of men in his family who had experienced prostate cancer, including his three brothers, but that it had never been discussed within the family.

Lara acknowledged the emotional testimonies that they had shared.

She explained that, thanks to the very impactful research, it had highlighted the areas where action was needed and noted the importance not only of raising awareness of this issue but of working on solutions to help improve cancer diagnosis and treatment in the UK.

BMS was aware that they couldn't provide a solution on their own, and so launched the "Cancer Equals"

campaign to engage different stakeholders to co-create the solution with them, including patient advocacy groups, policymakers, the National Health Service and other experts.

The first phase of the campaign raised awareness, with a digital website designed to provide information to support health literacy, and which also included the patient testimonials. The second phase, Lara explained, will be to build the Cancer Equals Coalition of different stakeholders (patient advocates, experts and policymakers) to co-create an effective solution in the real world.

John summarised the three key takeaways from the market research, each with a different implication which had guided the campaign:

1) low awareness: drives late presentation
2) lack of self-advocacy: drives delayed diagnosis
3) BAME patients wait longer: delay between first symptom and diagnosis

Lara explained how the results of the research had impacted how she fulfils her day-to-day market research role, with a greater focus on including patients from different socioeconomic groups and different ethnicities in patient research, to ensure that the voice of these patients is included in their strategy. As an organisation, she highlighted that BMS invests in creating effective cancer treatments, and wants to ensure that all patients have the opportunity to access the best treatments, irrespective of socioeconomic group or ethnicity.

Questions from the audience asked how the Cancer Equals campaign differed from NHS initiatives. Lara emphasised the need to work alongside the NHS initiatives to make sure there is no duplication, but to enrich and support the NHS initiatives with other types of solutions.

Another question asked whether any differences were found between how different populations were treated within the healthcare system and how that impacted outcomes. John reported no noticeable significant differences between individual populations, but noted that the study focus was on the patient experience and how they presented, so it would be difficult to draw conclusions on this point. Lara added that there was definitely some evidence that in the most deprived areas they were sub-optimally served in terms of access to the GP and also delays in referral from the GP to the specialist.

A final question asked if the research had indicated any differences by gender in length of time to diagnosis. John confirmed that there was more shame and embarrassment with female cancers, but that it was a general trend and not limited to female cancers or to female patients.

Thursday 27 June

From Noise to Nuggets: Leveraging Social Media for deeper insights

Speakers: Esme Barrow-Williams and Millie Morgan, HRW

Convenor: Amr Khalil, Ripple International

Esme Barrow-Williams

Millie Morgan

In their paper, Esme Barrow-Willams and Millie Morgan introduced a self-funded study from HRW that explored how insights from social media can be taken further to complement primary market research interviews and provide actionable recommendations.

Background

Esme began by outlining that 6 billion people worldwide are expected to be using social media by 2027 and this growth is being seen across different generations. In the UK, the over 70s are the most online adults after twentysomethings. Social media is becoming such a huge part of our lives that trends can reflect and impact real-life consumer behaviour and attitudes, often spearheaded by influencers. There is an influencer for every domain in life and they have gained so much traction in recent years that more and more are breaking into mainstream media and becoming part of our social and celebrity world. They can gain large followings and facilitate discussions on a wide variety of topics.

In healthcare, social media creates huge amounts of readily available information on the patient and HCP perspectives of various disease experiences. While this can be a critical part of our understanding of these cohorts, HRW decided to explore how insights from social media could be taken one step further to add richness and 'understand the people behind the posts', focusing on cancer patient and care giver experiences. The research was designed to understand why people are posting, with the aim of hearing the patient voice and following the narrative from person to social media post. The study had three phases:

- An interview with a patient influencer and cancer survivor.
- Social media listening on cancer patients and care givers' experiences.
- Linguistic and behavioural science analysis of social media posts to see how many additional insights could be unlocked and translated into actionable recommendations.

The aim was to see how social media adds value in helping us to assess the reality of the patient and care giver experience.

Interview with patient influencer

Esme explained that Warrior Megsie was interviewed for the study. She is an impact influencer and is a survivor of Invasive Globular Carcinoma. She started writing a blog 'Life on the Cancer Train' to help others in the recovery process by reflecting on her own experiences.

Patients have different motivations to share their experiences via social media. Warrior Megsie was motivated to share her experiences because she felt there was such a lack of raw, unfiltered expression in the mainstream media and that there was not enough about the impact on the true recovery experience.

Social media opens the door to topics that patients are spontaneously discussing and that we may never have considered factoring in. In this case, Warrior Megsie talked about the overlap of race and cancer which is rarely considered in pharma market research. This is an example of the sheer breadth of insights that can be captured on social media, allowing us to learn about experiences on a much larger scale than just primary market research alone.

Social media listening and linguistic and behavioural science analysis

Millie described how 17,000 posts pertaining to the experiences of cancer were collected from X (Twitter) and Instagram in the UK and US. The software categorised the posts into different topics to eliminate those that were 'noise' and not relevant.

Experts in linguistic and behavioural science analysis then scrutinised the topics to see what patients and care givers were talking about, with three themes emerging.

Emotional impact is a key theme that is shared on social media and the linguistic analysis found different ways in which this was being articulated.

- Cancer patients often use short and fragmented statements. This conveys a disjointed sense of emotional distress e.g. "I wanted to scream. And cry. And run".
- There was also a repetitive use of modal verbs e.g. 'can't'. Repeating this lack of ability conditions the patient to feeling that they have no control over their circumstances. This is a phenomenon called learned helplessness.
- There is a use of metaphors e.g. "emotional rollercoaster" when patients are discussing their experiences. This indicates the emotional exhaustion which patients and care givers experience over time.

From these findings:

Patient support programmes need to be accessible at different levels of emotional bandwidth.

They need to be accessible when patients are at the bottom of their emotional rollercoaster or experiencing learned helplessness. Language should be used that coaxes patients into accessing support.

The linguistic analysis helped to highlight emotional themes to enable the development of optimal patient support.

Millie explained how the second theme uncovered by the analysis was a surprise. The overall tone of posts on cancer experiences is positive and optimistic, with many linguistic features supporting this finding. These included:

The use of contrastive conjunction. This is when the words 'but' or 'however' are used to join two contrasting statements together e.g. a negative and a positive. The order of the statements can tell us how the patient feels about the content of what they are talking about. If they end on a negative statement, they are quite pessimistic. Ending on a positive statement indicates a more optimistic tone.

Personal anecdotes are often used to express gratitude for the little things that these patients are able to do.

The use of innuendos to diminish cancer and treatment to help regain a sense of power.

The linguistic analysis provided insight into the type of positive framing that might resonate well in communications with patients. It could be utilised to reflect the positive language that patients are using and help them to fortify their resilience. This is something that might not have been identified through in-depth interviews alone, where we tend to focus on the challenges being faced and unmet needs which almost sets the tone to being more negative.

The third theme uncovered by the linguistic analysis was a willingness to support each other as part of a community. Millie explained that this was borne out by Warrior Megsie, who was keen to share her own experiences connecting with others in the community. In particular:

- Patients and care givers often use first person plural pronouns such as we, us and our. This creates a sense of unity, even though there is only one person involved in the post.
- Imperative sentences and direct addresses are also often used to advise others in their community to, for example, "enjoy life and remember that the little things are the big things".

Social support and validation in the form of shared experiences can greatly affect patients' ability to tackle adversity. A problem shared on social media is a problem halved 1000 times. For patients who lack social support, these findings highlight the importance of signposting them towards communities like those found on social media and making communal support accessible to patients regardless of their digital capabilities.

Key takeaways

Social media listening is a valuable data source. It provides an additional angle that is complementary to insights from primary market research interviews. It can bring together many different patient voices and amplify them, as well as provide a means for patients to open up.

Using social media listening as an initial exploratory phase and including relevant influencers can sharpen our understanding and shape our thinking. Influencers can be valuable in terms of recruitment for primary market research as they sit at the core of vast online patient communities.

They can speak to the attitudes and experiences of a range of people affected by a condition and vouch for their needs. This can create a breadth of understanding before deep diving into further research.

Linguistic and behavioural science analysis can help us take insights from social media one step further, providing a complement or even adding to what we already know from primary market research. It can help us to access the true reality of the patient experience and their support needs. Overlaying linguistic analysis and behavioural science can maximise the translation of findings into actionable recommendations.

Utilising in the moment Clickscape data for symptom tracking: a Fibromyalgia patient case study OR Deploying Wearable Symptom Tracking to Better Understand Patient Journeys: Sharing learnings from a Fibromyalgia patient pilot

Speaker: Richard Heath, Blue Yonder Research

Convenor: Letizia Leprini, Roche

Richard Heath's paper shared a case study which gave us a fascinating preview of a new wearable technology that may have wide-reaching applications across healthcare. A system designed for fmcg R&D research, Richard has piloted the Clickscape wearable technology to understand symptoms

Richard Heath

experienced by a particular patient, Molly, who is living with fibromyalgia, with very interesting results.

Richard opened by outlining the challenge that we face as market researchers trying to understand the lived customer (or patient) experience: we want to get as close to the "truth" as we can, but many of the tools available to measure or capture the authentic patient "in the moment" experience actually disrupt the natural flow of the very experience that we are trying to capture. He gave us examples, placing existing tools on a cross-plot of passive vs active tools against real world vs interrupted capture points.

For example, lab testing to explore product flavour preferences works well in the lab, but doesn't tell us how the product might perform in the real world. Diary capture has improved immeasurably with the advent of phone apps rather than the old pen and paper diaries, but even phone apps are still disruptive – Richard points out that our respondents still need to get their phones out and input the required information, often at a difficult or uncomfortable timepoint. Biometrics, he noted, are passive, so don't disrupt daily life or normal behaviours, but are limited to specific metrics such as heartbeat or sweat, which then need to be interpreted. The recall survey, upon which so many market research studies depend, is limited by the accuracy and detail of respondent recall, and can't capture in-the-moment experiences. He illustrated this by asking us all to recall our last visit to a healthcare professional: which diagnostic questions were we asked, and how confident were we that we could give accurate answers based on memory of symptoms or events that may have occurred some time prior to the consultation?

His graph highlighted the "gap" for a tool that could accurately and effectively capture rich, in-the-moment data with minimal disruption to the natural events or behaviours that we are trying to explore – the "active-real world" quadrant. Richard noted that this quadrant was probably empty due to business economics – solutions in this quadrant tended to be expensive when compared with the cost-effective digital world!

Richard then introduced us to a potential tool which might capture the real-world experience with minimal disruption to the respondent. In the healthcare field, this might be accurately measuring symptoms to understand what patients experience and when.

He described the small, wearable, button, connected to a smartphone, in turn connected via Bluetooth to data in the cloud, and explained that the wearer has to click the button either once or twice – a simple action for the respondent, with instantaneous data capture for the researcher. Originally developed to measure fragrances in the consumer world, Richard explained that it could be used to capture any A-B test. In an early pilot, the button technology was trialled head-to-head against a traditional diary app to capture exposure to a specific brand, with respondents asked to record every time they saw the brand, clicking once if it was a positive interaction and twice if it was a negative interaction. The pilot showed that the button technology delivered 15 times more datapoints than the diary app, and that the datapoints were spread throughout the test period, rather than being clustered around the times of the app reminding the respondent to record. Richard's conclusion was that the ease of clicking the wearable button made data capture easier for the respondent than getting their phone out and completing the diary app. Additionally, Richard reported that respondent engagement seemed high, with pilot respondents reporting that they enjoyed the experience, and were happy to continue to generate click data for a two-week period.

Richard introduced us to Molly – a 22-year-old student with fibromyalgia, who was in constant pain from this debilitating condition. Molly is an active student, who commutes to college by car, plays sports, sits in lectures, and leads a busy life which might make it difficult to accurately capture real-time data via a phone app.

In the pilot, Molly used the button to capture when she experienced pain, clicking once if the pain was manageable, and twice if the pain was not

manageable. The test duration was one week, with self-reporting from Molly at the end of the week via video diary. Richard showed a video clip of Molly saying that the week had been fine, with no recall of any flare-ups but just her "regular" pain. However, when Richard shared the click data, it revealed 77 symptom "moments" – an average of 10 per day – of which 52% were unmanageable. The click data showed not only the frequency of symptoms, but also the distribution and pattern across a typical day.

Richard emphasised that the click data itself was a starting point, but that the insight is revealed when other information is added to build a picture around it. The click data was shared with Molly as interview stimulus, and the interviewer carefully explored the context around the findings, to understand what she was doing at each point and how it might impact her symptoms. Richard described the impact that seeing the data had had on Molly herself, reflecting that it was an emotional experience for her, but also empowering as for the first time she could see the impact that fibromyalgia was having on her life, and she felt understood.

A question from the audience highlighted the need to consider respondent wellbeing, particularly when the data may trigger an emotional response, and that interviewer skills, in particular empathy, should be prioritised at all times.

Richard described how, on a practical level, the data helped Molly to understand how her activities impacted her symptoms. For example, the prolonged, intense, activity of clearing out her wardrobe had triggered higher pain levels. Molly commented that "physios and other people tell me to take breaks, and sometimes I forget to listen to it, so having this visualisation really helped me". Richard reported that Molly had requested access to the app on a permanent basis, to help her monitor her condition and self-regulate her activities to minimise future pain flare-ups, and monitor the effectiveness of different treatment approaches, but also because of the increased confidence and independence that it brought her.

Richard concluded by inviting the audience to reflect on whether this approach would add value in healthcare research, beyond that of traditional research methods, and how it might be received by different stakeholders. He summarised his own thoughts on where the approach might provide benefit:

Based on the pilot case study, he summarised that the first benefit was to the patient themselves: Molly had felt empowered to manage her condition more effectively by implementing behaviour change based on an understanding of the evidence of the click data, and felt more confident in her subsequent interactions with her healthcare professionals.

For researchers trying to understand the patient experience, Richard proposed that the benefits were in the ability to accurately measure the frequency and intensity of "moments" (such as the experience of pain), without relying on imperfect patient recall or effortful research tasks.

He also postulated potential benefits to healthcare professionals, but noted that the application would need to be kept very quick and simple to adopt, to avoid overloading already-busy professionals.

The approach could help to build client-side stakeholder engagement, through accurate measurement of treatment impact, but also baseline insights to inform new product development pipelines, communications and positioning, as well as clinical trial design.

Optimising Launch Readiness by Embedding the COM-B Behavioural Science Framework: from theory to practice

Speakers: Weike Xia, SKIM, and Nassima Trad, BMS

Convenor: Sarah Phillips, IQVIA

Weike Xia

Nassima Trad

Weika and Nassima's paper took us beyond the theory behind the COM-B model of behaviour change to a practical example of using COM-B in real life, and the impact that it had on business decisions.

To set the context for the paper, Nassima and Weike took us back in time to a conversation they had one year ago, when Nassima had come to Weike with a business challenge. Nassima had a new product about to be launched: a first-in-class treatment with a new mode of action. It was indicated for a rare cardiovascular disease with high unmet medical need and no real therapeutic options available. The project team was aware of their short window of opportunity before a fast-follower competitor was due to enter the market.

Nassima emphasised the importance of launch readiness to maximise uptake and success, through preparing the market, finding the appropriate patients and engaging the internal teams. Nassima wanted to work with the brand team to reach launch excellence. She wanted a novel approach that would deliver metrics that go beyond the obvious to embrace holistic insight. She wanted to engage the team to develop a full understanding of the triggers within the prelaunch and launch activities that would move customers along the adoption ladder.

Nassima explained that her colleagues in the immunology team had the same challenge, but in a different market situation – they had a great product that they were launching into a more crowded immunology market, but also needed a successful product launch.

Weike summarised that it seemed Nassima was looking for an approach that focused on behaviour, getting to the roots of what would drive HCP behaviour in each situation. Weike thought that Nassima needed flexibility to adapt to different markets, but still provide a holistic framework, and recommended the COM-B framework as a solution to the challenge.

Weike explained that the COM-B framework was holistic and scientifically rigorous, and focused on what drives behaviour change. In order from behaviour change to occur, there must be sufficient drive in at least one of three key factors: capability, opportunity and motivation, and Weike provided an overview:

C = **capability**: for change to occur, there must be **physical** and **psychological** ability to perform the new behaviour. This, she explained, would include knowledge, skills and awareness of the issues at stake

O = **opportunity**: this factor describes the environment within which the behaviour takes place, whether physically (eg the hospital system, or reimbursement guidelines) or **socially** (eg KOLs, peers, patients, expectations and typical behaviours)

M = **motivation**: there must be a motivation for behaviour change to occur, whether that is instinctive emotional or habitual responses (**automatic**) or the **reflective**, conscious, analytical reasoning that is particularly important for HCP decision-making

Weike described how these three factors come together to enable us to consider product launch in

a very holistic way. She explained that this framework can also be integrated into the entire research process, before, during and after the research, from design through to recommendations for next steps. Nassima had agreed that this sounded exactly what she needed.

Now, one and half years later, Nassima and Weike shared with us the BMS product journey, and how the COM-B framework was used before, during and after the research.

Before:

The initial stage, Weike explained, focused on going beyond the obvious KPIs to understand where the focus should be for launch excellence for each product. Starting with existing knowledge about the therapy area and indications (including market landscaping research as well as secondary data and publications about treatment), the team synthesised existing insight into the COM-B framework, identifying what was known about potential hurdles and required behaviour changes for a physician to move from not using the product, to using the product.

This pre-analysis highlighted interesting differences between the two products. For example, for Product X (in the rare CV disease), it was likely that physicians would experience key barriers within "Capability", as they had limited knowledge of what the therapy was and how it would work, which would be a big barrier to uptake. By contrast, for Product Y (in the crowded immunology market), the pre-analysis highlighted potential barriers in "Motivation", where physicians would need to learn about a new treatment which might be perceived as offering little value over existing treatments. Mapping the existing knowledge to the COM-B framework helped to highlight where the greatest pre-launch efforts would be required.

Nassima described how the workshop involved a cross-functional team made up of local brand and sales teams, commercial, medical and insights teams, and also the creative marketing agency. The team reviewed the populated COM-B framework, trying to validate the insights that had already been included to identify the drivers and barriers behind behaviour change, and identifying the knowledge gaps still to be filled. The team then brainstormed the KPIs that would address the barriers to product uptake. Using the COM-B framework united the team members, and generated some additional metrics which were very different from standard launch KPIs. For example, for Product X, they found that it was particularly important to focus on disease awareness and diagnosis, and so these topics were integrated into KPIs.

Weike summarised that, prior to the research, the COM-B approach not only helped to synthesise the existing information into a single framework to aid identification of knowledge gaps, but provided a structure for brainstorming hypotheses within the three different factors. Additionally, the process provided the team with easy-to-grasp terminology to enable all stakeholders to speak the same language, and focused everyone on the common goal.

During:

The next stage involved the transition from metrics to meaning, ensuring that the key questions were included in the subsequent market research. The team was keen to avoid "reinventing the wheel", so they started with a global ATU tracker questionnaire, but then systematically tracked which questions would provide insight for each factor within the COM-B framework. Plotting the questions onto a grid helped to identify that all questions and hypotheses were included, with corresponding questions to provide the answers. (White spaces indicated that insight would be missing, prompting the addition of new questions to ensure all questions were covered).

Examples of new questions were shared, such as a question designed to explore "Capability" and whether physicians would be able to recognise the condition. Presenting respondents with a list of symptoms and asking which CV conditions they would suspect, based on the symptoms, and exploring the tests that would be ordered to confirm diagnosis, would then be analysed to identify knowledge gaps.

A question to address "Opportunity" explored the potential barriers to diagnosis by asking which of a list of factors might delay diagnosis (such as lack of infrastructure to perform diagnostic tests).

A question to address "Motivation" explored the extent to which the diagnostic rate was considered to be a problem, by capturing agreement/disagreement with statement such as "I believe this condition needs more rapid diagnosis", or "I feel I could use some refresher in identifying the symptoms".

The key learning for the team were that that COM-B framework provided a valuable check of whether all the important metrics had been included, using clear, unambiguous language, as well as identifying some redundant questions which did not deliver value. The approach also provided clarity on how the analysis would be structured, which could be easily explained to all stakeholders.

<u>After:</u>

Weike next describe how the COM-B framework, along with standard data analysis, helped to share the approach to creating meaningful insights and recommendations. The key focus was not only on identifying important barriers and drivers of behaviour change, but identifying what matters most in influencing physician behaviour, and therefore where the opportunities lay for BMS to prioritise their activities.

Weike took the three example questions described earlier, and showed how data from the physicians revealed that they were able to recognise the symptoms, but that there are delays in diagnosis due to challenges with diagnostic tests. However, the findings also revealed that less than half of HCPs believed this disorder was underdiagnosed, and therefore did not feel that it was a priority unmet need.

The team was then able to look at the analysis of C, O and M from the framework, and give direction for where BMS could offer support, such as offering additional education or helping to alleviate diagnostic challenges.

As well as looking at each factor in the COM-B framework, Weike described how they also examined how physicians progress through the adoption ladder from awareness, interest, knowledge, attitude and adoption, and identified where the different barriers and opportunities lay along the ladder. For example, she shared that the Capability barrier of lack of awareness would hamper progress from interest to knowledge, and likewise the Motivation barrier between knowledge an attitude, and the Opportunity barrier between attitude and adoption. This additional analysis enabled the BMS team to brainstorm where to prioritise their cross-functional strategy and plan their next actions.

Weike summarised the benefits of the COM-B approach during the analysis stage, highlighting the simple way to transform data into clear barriers and drivers for behaviour change, which then gives guidance on where and how to intervene along the adoption ladder. Weike noted that this is where the COM-B model ends, having provided a compass for next steps. The team then took these findings beyond the COM-B framework and held an activation workshop to brainstorm ideas on how to tackle the current barriers and opportunities for adoption.

Nassima summarised the impact that this method had on the team and on the organisation's approach to launch excellence, highlighting the real impact on organisational readiness with the teams engaged more than 6-9 months before the EU approval. She highlighted the benefit for the market research team, who demonstrated their role as real experts, sharing the structured approach in workshops and brainstorming sessions to create KPIs that went beyond the obvious. Basing all the thinking of behavioural science ensured buy-in from the team.

She also described the impact on market readiness, with a consistent set of KPIs across the region focusing on the leading metrics with greatest impact, such as disease awareness, diagnosis and urgency to treat, to ensure that HCPs would be ready with patients identified by the time the product was launched. BMS was able to proactively implement education events to drive corrective action.

Bringing these elements together, Nassima explained that the combination of organisation readiness and market readiness facilitated a positive launch excellence mindset within the company, enabling brand readiness where stakeholders were able to anticipate and quickly implement concrete actions to drive success. The impact of the market research team was clear, and Nassima shared that the early launch countries are already demonstrating uptake in excess of expectations.

Weike concluded with a summary of how the COM-B framework can help throughout the entire market research process, in very different market situations:

Before: synthesising the findings to identify knowledge gaps and key focus points, inspiring us to go beyond the obvious metrics

During: taking the hypotheses and transforming them into actual questions using a holistic and structured approach

After: framing the insights using the COM-B framework as a compass to action, to identify areas of key drivers and give direction for future action

A question from the audience asked how the team was persuaded to add questions to the questionnaire, when many people are very protective of their standard ATU 45-minute questionnaire with everything in it. Nassima explained that the tracking plan was very robust, and went beyond a standard ATU, and the decision was made to run an additional tracker to monitor disease awareness, which was more agile than the ATU, using an online dashboard for rapid insights and pulse surveys focusing on some very specific questions related to diagnosis, disease awareness and brand awareness.

A comment from the audience complimented the team's approach of presenting HCPs with a list of symptoms rather than asking directly if they were able to diagnose, and asked if there were any other areas where it was important to consider the heuristics and biases that we see in behavioural science which can lead to over-claiming. Weike agreed that, particularly when exploring motivation, we are tempted to ask "are you interested?" and doctors say "oh yes", but then don't prescribe. She explained that they examined behavioural traits not only within the market situation but in general, such as openness to new ideas, to use as an anchor point for likely prescribing. She observed that most physicians see themselves as forward thinking, but actually most of them are in the "wait and see" bucket, so we need different ways to tease out what is actually happening. Nassima added that each element had been assessed using several statements rather than a single one, using pre-defined score expectations, which helped to determine the accurate picture.

Another question asked how they overcame any reluctance from the cross-functional team members in taking part in the brainstorming workshop. Nassima emphasised that they tried to keep it technically simple, without being overly stringent in ensuring that no "opportunity" points strayed into "capability" etc, and instead focused on explaining the overall framework, which helped everyone to understand and to be convinced by the approach. Weike added that the COM-B model itself is quite easy to grasp and seems to make intuitive sense to people, which helps to get stakeholders on board.

An audience member asked how the team managed the global implementation at a regional or country level, without diluting the KPI selection and tracking. Nassima clarified that the team is not a global team but focuses on a cluster or small to mid-sized European markets and the approach had been implemented in eight countries. She explained that they were seen as the stars of the organisation and that their approach had inspired the worldwide team who have deployed a global KPI alignment based on their work, which she recognised as another key success factor for the team.

From stories to solutions: using patient insights to accelerate improvements to the lupus patient pathway

Speakers: Gregg Quy, Elma Research and Mohammed Akrout, Roche

Convenor: Amr Khalil, Ripple International

Gregg Quy

Mohammed Akrout

In their paper, Gregg Quy and Mohammed Akrout described how they used design thinking to articulate patient centricity and implement actions in the context of the lupus patient pathway.

Applying design thinking

Gregg began by outlining the design thinking ethos in which you progress from one module to the next while building and learning from the different insights to arrive at activations and initiatives.

Five different continents were represented, involving 57 patients and 16 HCPs. The study began by using desk research to look at the context the patients are living in. This was followed by internal stakeholder workshops, ethnography and multi-stakeholder workshops to identify what could be done to change these patients' lives.

- Empathy

Empathy is the first part of the design thinking framework. It starts with self-reflection, understanding what we think personally and how this might impact on how we understand patients.

The process began with an online review of conversations and social media listening to look at the context and what patients were saying in terms of themes, topics and unmet needs. This was followed by a comprehensive internal stakeholder workshop to understand the Roche team's knowledge gaps, expertise, hypotheses, biases and what they had previously conducted in terms of project work.

- Define

The second part of the design thinking ethos looks at defining i.e. what are we trying to understand. To achieve this, the team carried out a series of ethnographic immersions through interviewing a series of patients and going into their homes. This immersion enabled an understanding of what was important to patients, their biases, misconceptions, anxieties, frustrations and the moments that matter to them. A variety of stakeholders were involved in terms of the different types of lupus, the time since diagnosis, gender, age and location, so that a broad spectrum of different patients was represented.

- Ideation

The ideation stage was conducted through a series of three multi-stakeholder workshops in the US and Italy, which were both in-person and Latin America which was held virtually. The 3-hour workshops involved a variety of stakeholders including doctors, nephrologists, rheumatologists, patients, patient advocacy group representatives, patient experts and Roche team members. The workshops were designed to solve patient unmet needs and Masters students were also included as non-pharma stakeholders to act as a catalyst for new ideas.

Before the workshops started, a feasibility impact workshop was conducted with Roche to understand the key unmet needs that patients had talked about during the ethnography and look at what Roche could feasibly solve that would have the maximum impact on patients' lives. The team arrived at three basic unmet needs and these were the components that were taken forward to the multi-stakeholder workshops to be solved.

A key part of the process is that everybody operates on an equal footing with an equal voice. It is collaborative and is designed to solve challenges in a co-creative way that everyone feels part of.

- Prototype

Gregg outlined that in this stage, the team looked at the solutions that were developed and stress-tested them in a community validation. New and old patients were invited to take part to review the solutions and what was generated during the design thinking process so that they could validate, optimise or adjust them in ways which were most valuable for their current needs. The aim was to make optimal solutions applicable to as many patients as possible.

The client perspective

Mohammed elaborated on the three key benefits of the study from Roche's perspective which were:

- It added colour and depth to the patient journey.
- It helped to bring real personas to life.
- It created innovative ways to share insights externally and internally through different channels.

The core of the research was the ethnography which created the depth of real-life experience and the emotions and functional journey that the patients go through.

From classifying the patients through their different unmet needs, personas were created according to their ability to cope with lupus, their ability to seek knowledge and their willingness to engage. Four groups emerged that range from overwhelmed and confused (newly diagnosed) to disengaged and mistrustful (second phase) and the patients who co-created much of the material i.e. patient champions.

The Roche team no longer talks about the overwhelmed and confused but 'Sophia', 'Maria' and the other personas who sit in meetings e.g. "this would work well for Sophia". This has been tremendously successful in the conversations the team has had with patient advocacy groups who

have said that for the first time, a pharma company is talking about patients in the way that they see themselves.

For each stage of the patient journey, there is a solution that has been devised through the co-creation carried out by the multi-stakeholders' workshops. The newly-diagnosed patient often has an issue because they get misdiagnosed multiple times which has a negative impact on their wellbeing. In this case, the winning solution in the form of a psychological tool to provide mental health support came from the Latin America workshop.

Other outputs include:

- For internal use, posters were created with quotes and a QR code to the videos of the different personas.
- A magazine has been developed for patients and HCPs to tackle the areas where they have the most problems and provide answers to their questions on a range of topics e.g. fertility, diet.
- A white paper is being published with a patient co-author and a KOL. It will be aimed at KOLs to provide a deeper understanding of lupus patients.
- A graphic novel is being developed to bring to life the different personas. It will also share stories of patients who find their new normal and is inspired by the ethnographic interviews.

Key takeaways

- The study unpacked many different ways to disseminate insights to different audiences.
- It provided an opportunity to build relationships based on mutual understanding both internally and externally.
- Lupus patients are using the insights created as a result of the study.

Are Life Sciences in an AI Echo Chamber?

Speakers: Mark Sales and Raj Modi, Oracle

Convenor: Kristina DiPiertrantonio, The Planning Shop

Mark Sales

Raj Modi

In their paper, Mark Sales and Raj Modi gave an overview of AI from Oracle's perspective, before looking at how generative AI models are being used by organisations to create insights.

Classic AI and Generative AI

Mark began with a brief overview of classic AI, such as NLP, which has been used in research for many years and generative AI, which uses data, information or insights to create something new. Classic AI is going to drive much of what we are going to achieve with generative AI such as GPT.

The best use of AI occurs where you never see it in the workflow. For example:

- 29% of the work that lawyers do today uses it.
- 14% of the work doctors do today uses it.
- 17% of the work that managers do today uses it.

A good example of where it is used but not seen is in human capital management. With an AI-enabled job description, you can type in 'I want a candidate with this experience' and it will write the job advert for you. In other words, it is where we embed it into the way we work that is going to drive the greatest returns for us.

Why is AI hard in healthcare and life sciences?

Mark continued by explaining that AI is problematic in life sciences and healthcare because of the need to deal with data rights and access in multi-stakeholder universes. We are custodians of health data and it is our job to protect it and make sure it doesn't end up being used for the wrong reasons, although as an industry, we have not moved as fast as we should have done to understand what we should and shouldn't do. There is a gap between

domain expertise and life sciences expertise which needs to be closed.

AI should be part of the workflow and not be something we do on the side or separately. Ultimately, only two things matter:

- How accurate the results are. We cannot get things wrong in healthcare and we cannot put something in front of a doctor that is AI-based which could cause harm to a patient.
- Speed, as answers need to happen in real time.

A large amount of real-world data in healthcare is hidden in clinical notes and a challenge for us is how we structure unstructured data. Using AI, the doctor might talk to their phone and the clinical assistant might start to structure the information. This is the first step for us to get better data to tie back to our research.

How do we look at historic data?

With historic data, some of it is structured already but a large amount is unstructured. We can use NLP (classic AI) to go into the datasets and teach an AI model to pull out the right entities. Interacting with the data involves generative AI to create insights. From the real-world dataset, you can start to ask questions about the data by typing natural language queries e.g. how many patients suffer from a certain disease and what were their treatments over the last 12 months.

Applying AI to insights - key takeaways

Raj concluded with an explanation of how generative AI models work and what their capabilities are in terms of insight generation.

A prompt, which is a question or statement, is interpreted by a generative AI model using advanced algorithms. Based on this, a wide range of diverse outputs can be produced, including content creation, blogs, articles etc.

Generative AI can also:

- Create a Q&A chatbot which can be used for conversational simulations.
- Summarise complex text and extrapolate the key points.
- Carry out a semantic search and understand the context around the use of language. AI does not just use words to match to a particular search but can try to understand the context within which these words are used. This can be powerful in being able to understand the underlying sentiment.
- Pull out data and metadata from a range of unstructured data and structure the data. This can be powerful for the downstream use of the data.
- Identify harmful content.
- Be tuned with domain specific information that is relevant to your specific therapeutic area. For example, a generative AI model can be tuned with publications, clinical trial reports or non-traditional data such as social media data or press coverage. It has the ability to integrate all of this data to come up with a holistic perspective. Generative AI is very good at building relationships between diverse datasets and this is a powerful capability which is emerging.
- Provide recommended actions.
- Compare information and insights to previous versions.
- Carry out discrepancy analysis and pull out a historical trend.

Panel Discussion: Analogues in Forecasting: Bread and Butter or Marmite?

Panellists: Manuel Guzman, AplusA; Erik Holzinger, groupH; Arijit Mukhopadhyay, Merck Healthcare

Convenor: Simon Fitall, Tudor Health

Manuel Guzman

Erik Holzinger

Arijit Mukhopadhyay

Simon opened the session by clarifying the title of the panel discussion, explaining that "Marmite" is a very English product which divides opinion – some love it, some hate it! This, he noted, is much like the use of analogues in forecasting, where some forecasters hate them, but to others they are a staple used every day – much like "bread and butter"!

He then outlined three key approaches to forecast inputs, which, in an ideal world, would be triangulated to product a credible forecast:

- mathematical analysis (including order of entry and attribute analysis, particularly valuable for multi-product markets, which can be weighted based on market research and internal assumptions)
- preference share (obtained via Primary Market Research (PMR), and adjusted to improve accuracy)
- analogues (where we don't yet have data from our own product, we can use historical data from a similar product/scenario in order to fill a knowledge gap and produce a forecast in which you can have some confidence)

The challenge for the forecaster, he explained, comes in selecting the most appropriate analogue for each unique situation being forecast. In some cases, selection might be as simple as finding a product similar to your own, such as a product which was also 3rd to market in an established competitive environment, which also demonstrated minor improvements over the existing competition, and was given similar spend levels by the company. We might look at data from this analogue product, such as peak market share, uptake curves, share of patients etc as a proxy for our own product where those data are not yet available.

He noted that different analogues may be better for different circumstances, but that the perfect analogue is hard to find.

Simon opened the discussion to the panel with an invitation to share their experience of how analogues are used in practice.

Manuel outlined his previous role, supporting portfolio management, where it was necessary to triage some of the development opportunities and prioritise them, using a forecast to size the opportunity and unmet need, as well as potential uptake curve, in order to calculate a Net Present Value (NPV) for each opportunity. He explained that the use of analogues varies by market type, giving the example of an established market where the company has its own product, and the forecast may be based on internal sales data and sometime complementary market research. However in a new market, there are no existing data, and analogues can be used as a starting point to build a forecast. This might also be the case for an early stage product where budgets for PMR are limited and there may not be substantial secondary data available to work with.

Arijit had also experienced a similar situation in a previous role, where he focused on a mature portfolio in emerging markets where there were no data. PMR would be a good option here, but due to the time- and cost-investment required, it may not be feasible to conduct comprehensive PMR in all emerging markets. Analogues, he explained, provide a fast and effective

starting point. If PMR data for your own product has been conducted in several major markets (eg USA, 5EU and Japan), an analogue with similar findings could be selected, as it would be reasonable to assume that there would also be some similarity in the emerging markets. He did note that the extent of the "some" might need some consideration, but that this scenario is a common area where analogues are used.

Erik also recounted a wide range of situations where analogues are used, and highlighted a common situation where a company may have a portfolio and a pipeline of products, and wants an idea of uptake curve and erosion curve. He noted that in some markets, where there has been stability, and where the new product is similar to existing products, there might be reason to believe that a new product will follow a similar pattern to what has been seen before. In this scenario, the forecaster might select a basket of analogue products to feed the forecast, and this provides a reasonable justification for the forecast if challenged by senior management.

Simon asked the panel where they saw the use analogues across the product lifecycle.

There was agreement that analogues are used predominantly in the early stages of the product lifecycle, where there is greater uncertainty in the forecast due to less direct experience and lack of data, yet important go/no go decisions still need to be made. Analogues, Manuel explained, help to reduce the uncertainty. Arijit agreed that analogues are commonly used in the early launch stages to predict uptake curves and peak market shares, but are also valuable towards the end of the product lifecycle to forecast erosion after loss of patent exclusivity. The panel agreed that the mid-life stages of the product lifecycle are usually stable, with inhouse data available to refine and check forecasts as required.

Less common scenarios for use of analogues were also highlighted, with Arijit giving the example of price change simulations, where analogues provide insight into what happened in the past when a product

changed price. Erik also highlighted the scenario of a company in an established, busy market who might want to replace their own product. Mathematical models are not designed for these situations, but product analogues from other companies who have done this could provide valuable insight into the likely impact on sales figures but also on the tactics of how they managed the process, which might also be interesting.

The discussion then focused on how analogue data is integrated with data from other sources.

Manuel confirmed that, where available, internal sales data would establish the baseline forecast, but for a strategic opportunity, qualitative and quantitative PMR would be required. He noted that for a potentially disruptive product, it would be important to explore pricing and reimbursement with payers based on a value proposition, covering level and duration of reimbursement to feed into the forecast. Quantitative PMR would be used to explore potential use and uptake. He noted that in some fields such as IV diagnostics, a razor business model may be used where the instrument is placed following a tender process renewed every 3 years, and where the forecast would need to cover replacement rate and adoption over time to create an uptake curve. In diagnostics, the forecast may also be stratified by early vs late adoption, and by laboratory size.

The panel emphasised that as well as data from analogues, it is important to understand drivers and barriers of use, and to integrate that with internal resource commitment. PMR helps to identify the key drivers, and internal discussions may then shape internal resourcing decisions – such as a decision to provide resources to overcoming market access issues to improve the uptake curve.

Arijit agreed that the integration of PMR and analogue data was important to help with forecast credibility – if the analogues and PMR data are saying the same thing, it increases confidence in the forecast. He also noted that analogues can be used prior to the PMR to guide the development of the research tool.

For example, if multiple analogues show consistency in a specific area, that topic may not need to be explored in PMR, which can then focus on the knowledge gaps.

The discussion returned to the challenge of selecting appropriate analogues.

Erik emphasised the importance of stakeholder buy-in at the beginning of the forecasting process, suggesting that the forecaster could propose half a dozen analogues, with advantages and disadvantages of each, and then the stakeholder team would agree which to use. He highlighted that this early-stage consensus helps to build ownership of the final forecast and increases acceptance.

A question from the audience sought the panel's view on how to reassure senior management that the analogues selected were appropriate, including an explanation of which other analogues had been considered and rejected. The panel noted that there are endless descriptors that could be considered when selecting analogues (such as market and product attributes, focusing on specific markets or specialties etc). Erik highlighted the need to look at both market drivers and product drivers, and weight the importance of each according to the specific context. For example, in a stable, generic, mature market, a new product in a new class or with a new mechanism of action would be more likely to disrupt the status quo. However, it would be important to look at both product and market attributes and try to find an analogue that fits both. Arijit agreed that the Target Product Profile (TPP) would provide most of the parameters needed to find an analogue, and then the market parameters can be overlaid to shortlist the analogues with closest fit. He warned against trying to hunt down the "perfect" analogue, noting that if your criteria are too stringent, you may end up with one or no analogues, but trading-off a few variables might allow you to include a larger number of analogue products which are reasonably similar to your profile.

Manuel added that there may be different analogues selected for different scenarios being analysed, for example, using different analogues for the "optimistic" vs "pessimistic" product profiles.

Another audience question asked for advice on how to find analogues for rare diseases.

Here, Erik introduced the potential for AI to help the search. He described his own experience with using Large Language Models (LLMs) to find an answer, and explained that care is needed to use the right prompt in order to elicit a helpful response – but he did note that LLMs are not designed for this purpose, so outputs should be carefully checked. Arijit agreed that AI is likely to be a useful tool in the future, particularly if a specific tool is developed for this purpose.

Arijit noted that it might not be only rare diseases where there was a dearth of analogues, but also for breakthrough therapies in existing indications, such as a new treatment pathway. In these situations, he advocated finding a product that is perhaps 70% close to the TPP, but then adjusting the analogue performance accordingly. He advised considering prioritising the product profile over the market profile in scenarios such as an oral treatment entering an injectable market, where analogues for route of administration may be useful even if they are not in a rare disease.

Manuel highlighted the importance of awareness as a key driver of uptake in rare diseases – to diagnose a rare disease, you need to be able to recognise it. He advocated a bottom-up model approach, complementing analogues with PMR and including the impact of action to raise awareness of the disease.

The impact of the COVID pandemic on the availability and appropriateness of analogues was discussed.

The panel noted that, although usually, analogues from the recent past (eg the preceding 5 years) were seen as the most valuable, in many cases the COVID years would be considered to be outliers. There were variations across product categories noted, with many hospital products crashing during the pandemic period as patients were not coming into the hospital setting, but some diagnostic or respiratory products showing atypically high use. The panel noted that the pandemic years highlighted the resilience of the healthcare industry, with the redistribution of product use within and across indication, and that in the future, the COVID period itself might be considered as an analogue!

Aside from the idiosyncrasies of the 2-3 COVID years, the panel noted that the post-pandemic world had changed in a broader sense, as healthcare systems across the world tried to mitigate the vast costs of the pandemic by increasing reimbursement pressure and the data required to support products.

Involving stakeholders such as medical affairs and real-world evidence teams from early in the forecasting process would help to achieve greater accuracy and credibility.

The Hidden cost of Yes - How and when a well-placed No can be more positive than an automatic Yes

Speaker: James Pickles, Certified Performance Coach

Convenor: Sarah Phillips, IQVIA

How to manage pressure, stress and the feeling of being overwhelmed was the topic of the keynote presentation from James Pickles, who used personal anecdotes to explain the consequences of saying yes and how this can be reassessed using boundaries to enable more positive outcomes.

James Pickles

Being a Yes Person or People-Pleaser

James began by explaining that because there is myriad reinforcement for saying yes and it makes you feel pleased and validated, you say it again. Customer centricity reinforces the idea of saying yes and because it feels virtuous, you carry on.

While there can be many obvious benefits to saying yes, it also comes with an implicit internal pressure to deliver. With every yes, there is a greater expectation and as the pressure rises, the permission to fail goes down, along with the number of times you say no or push back on things.

The unintended cost of yes

James gave a brief overview of the personal consequences he faced as a direct result of saying yes repeatedly over many years in his career both externally and internally. He experienced severe burnout while in public with colleagues and clients, leaving him unable to do any work at all which led to:

- An approximate £90K direct cost to his employer through being off work for 8 months.
- A cost of approximately £1.5m worth of opportunities. All the deals he was working on had to be stopped.
- A bad accident at home which almost led to the loss of a finger.
- An ongoing recovery process five years after the burnout.

Prior to the burnout, James' decision-making was becoming impacted in that he was consistently making less informed and snappier decisions. This continued when he was off work, which resulted in his accident at home.

Identify, set and defend boundaries

James realised that he needed to re-imagine boundaries and understand that they can be healthy and good for us, even though they might once have felt negative and selfish. He also needed to realise that he had spent a lot of time crossing other people's boundaries by mistake.

A healthy boundary is one where you make decisions based on what is best for you and the people around you. In other words, you don't just make them for other people at the cost of you. The sense of autonomy that comes from setting and controlling a boundary gives you control over what you are dealing with. Setting positive and healthy boundaries at work and saying no sometimes will be beneficial for you, your colleagues, your clients and your career. In achieving this, James admitted that he had had to:

- Learn to speak honestly and more openly more often.
- Be clearer on what he needs to perform well and articulate this to other people so that they might understand.

Boundary setting

In order to set successful boundaries, you need to:

- Define i.e. what is the boundary you want to set.
- Communicate i.e. use 'I' not 'you'.
- Use simple and direct language.
- Understand the consequences i.e. the benefits if the boundary is respected and the impact if it isn't.
- Follow through i.e. be clear about what you are going to do if the boundary is overstepped with direct and uninflammatory language.

Boundaries being overstepped

Back-to-back meetings are a typical scenario where boundaries are often overstepped and this can be exacerbated because of diary sharing. James offered some ideas to counteract this, including:

- Avoid back-to-back meetings when possible. Take control of your calendar and put blocks and buffers in. Make it clear you are trying to avoid them.
- Focus on yourself. Everybody works better with breaks between meetings and the quality of work delivered will be better.
- If people realise you are not going to make it to the meeting, construct some language around this e.g. "Because I want to deliver a good job and turn up prepped, focused and ready to execute."
- Structure follow-through e.g. "In five minutes' time I am leaving. If you need anything from me, now is the time. "

Prepare for success

We frequently don't prepare for the meetings we have been invited to and often don't know why we have been invited, what we are going to do in the meeting, whether we need or want to attend and if we can add value. It may also not be necessary to be present for the entire duration of the meeting.

If you have a break between meetings, your brain recalibrates very quickly. It is more restful for your brain to do nothing at all than to do something relaxing. It is also important to ensure that you are hydrated, as 1% dehydration equates to a 12% decrease in productivity.

Boundary breakers

James highlighted that people frequently think it is not a problem to break your concentration and interrupt you. However, we are spreading ourselves too thin to the detriment of what we are involved in. Every yes that somebody gives has a cost to another yes somewhere else. We need to be better at holding the line and giving an informed yes rather than an automatic one.

A fast or a slow No

James concluded by providing some helpful framing for ways in which to 'not say no' but instead say:

- Before I say yes.
- I'm keen to help but help me to understand what I

am saying yes to before I do.

- Can I pause and evaluate.
- Can I make an informed answer and not an automatic one.

This is not easy but is a skill that needs to be learned if we are to deliver the quality of work that we want to. Not everything is urgent and important. We ned to think about what we can reasonably deliver i.e. "If not that, how about this."

Making It Personal: understanding doctors as people to fuel insights-driven omnichannel strategy and personal engagement

Speakers: Elena Brutto and Tasleem Rehmatullah, The Nursery Research and Planning

Convenor: Kristina DiPietrantonio, The Planning Shop

Elena Brutto

Tasleem Rehmatullah

Elena and Tasleem's presentation showed us how a holistic understanding of our customers enables us to move from instructing doctor where to use a product, to developing a personalised, two-way dialogue to engage and motivate them via omnichannel marketing.

Elena opened with the sobering statistic that 60% of doctors dismiss online content as "clutter". She believes that our challenge to engage doctors is only going to intensify, as digital marketing gets bigger and broader.

She asked us to consider what we can do to engage doctors more, by personalising our interactions and making them more "human" and less "algorithm", before referencing a case study that addressed this challenge by developing richer, more real personas which illuminated the deeper emotional barriers and motivations to doing something new in a rare oncology indication. She explained that the study outcomes allowed the client to effectively tailor the channel mix and content to generate real engagement at an individual level. The sales reps at the debrief reported that they could immediately identify which persona described their specific customers, as the personas seemed so real.

Tas set the context: she introduced their client, a strategic healthcare consultancy called Possible, who were tasked with building the omnichannel strategy for a biotechnology company as they launch a new asset in rare oncology which would challenge the market dynamics and require HCPs to think about oncology treatment in a different way for this small group of patients with poor prognoses. Possible wanted to develop personas to help them build a compelling omnichannel strategy, and to think about their use of channels and how they were going to approach these customers.

Tas explained that their approach devised a way to build holistic personas that are embedded in doctors emotional and rational behaviours. As humans, she explained, we resist change, so effecting a change in behaviour was going to be difficult. Behavioural science tells us that change requires motivation, the capability to make the change, and also the opportunity to implement that change.

The study would need to go beyond rational metrics, to capture a holistic picture of the oncologist in both their professional and personal lives. Not just their demographics and treatment preferences, but fully exploring their thoughts, beliefs, attitudes, emotions, expectations, mindsets and behaviours, as well as the "why" behind those behaviours.

In this case, research across three European markets showed that the personas developed did hold true across the different cultures and healthcare systems, describing authentic behaviours and the mindsets that drive them.

Elena shared the client's challenge, noting that most products are not miracle cures or even clearly superior in efficacy overall, so how do we encourage doctors to try a new treatment? Product choice is often based on trade-offs, she noted, which have to be communicated to doctors in quite a sophisticated

way, combining evidence and nuance to highlight the positive differences for each customer, and how that trade-off may vary between customer types.

Elena reminded us that, despite their training to exercise critique and be sceptical of the "fuzzy stuff" like marketing, and their pride in being scientific and rational, doctors are people too. Behaviour science tells us that people need both emotional and rational motivators to change the way we think and behave, and Elena notes that doctors are more likely to respond to advertising that has emotional appeal, as well as scientific content.

Tas then outlined the people-first approach, starting with real patient descriptions provided by the doctors via patient record forms, which enabled the discussions of current and future prescribing to be anchored in the reality of patients they could recognise.

In group interviews, a combination of individual and group exercises were important, allowing the team to capture individual responses as well as group dynamic and consensus, replicating the individual thinking and collaboration that takes place in an MDT.

Cognitive interviewing techniques were used, involving asking the doctors to role play as their patients, which revealed nuances that might have been missed using direct questioning, such as patient fears and anxieties.

After the interviews, at the analysis stage, a COM-B framework (exploring capability, opportunity and motivation) was applied, and behaviour change wheel techniques applied to understand how to leverage motivations for each persona in product communications. This stage also provided a shared language for the team, to help them address and overcome the potential barriers identified for each persona.

Elena highlighted the important differential of the people-first mindset embedded by their consumer colleagues. This encompassed a sanity-check of whether the personas developed did actually feel real, and whether the motivations seemed truly human, rather than robotic and mechanical, as well as encouraging them to embrace the "shades of grey" within our typically black and white scientific world. This approach helped the team to understand the consumer within the doctor – or the person inside the white coat.

But what did the personas look like?

The respondent characteristics and insights gleaned from the qualitative research were distilled into four distinct "personas", which were described as fictitious individuals to bring them to life.

Tas described the personas that emerged from the research:

Maverick, Tas explained, was an innovative oncologist, truly inspired by cutting-edge practice, motivated by new and better ways of managing patients, always curious, and obsessed with progress and achievement.

By contrast, Merkel took a more measured and considered approach. She was meticulous, planning every detail of the treatment plan from the very start.

Gallagher was described as impulsive, and wanted to be seen as innovative but is too impatient to be an innovator, quickly moving on to the next drug if they don't see immediate results.

Finally, Hank was characterised as an observer who feared failure and disapproval, resulting in a tendency to hang back and watch other oncologists before making their decision.

Focusing on Maverick and Merkel, Tas revealed that it was the older, more experienced, female doctors, who turned out to be Mavericks – more innovative and more willing to take risks. She noted that the superficial persona descriptors can feel cliched and predictable, and that to truly understand each persona, we need to dig deeper.

Elena then took us deeper into the characteristics and motivations of Maverick, the rule-breaker. Digging deeper through the qualitative interviews

revealed that it was Maverick's position of shared responsibility in the MDT that enabled her to take risks. They discovered that she shies away from in-person consultations, preferring virtual interactions. The analysis identified specific ways to engage with Maverick. For example, she is motivated by reward completion, so will be motivated by treatment success. Introducing a monitoring process might facilitate Maverick and her patient to celebrate when treatment is working, with progress recorded and shared in MDT meetings. Knowing that she wants to be a role model, we can enhance this by showing others that she is at the forefront of medicine, inviting her to lead coaching groups at high profile conferences.

Tas then focused on Merkel, the meticulous doctor, who, whilst keeping in mind patients' sensitivities, balanced those against the rational factors impacting product choice. The analysis showed that Merkel plans the whole treatment journey before prescribing anything, and sticks to the plan quite rigidly. To best engage and motivate Merkel, the client could show data highlighting the impact of NOT using the new drug, playing into her sensitivity to loss-aversion with emotional imagery through digital campaigns. Merkel would also be motivated by the behaviour change technique of vicarious consequences, and could therefore be motivated by other colleagues and KOLs highlighting positive experiences with the drug at webinars or conferences, or via the Mavericks who were sharing their feedback forms in the MDT, therefore motivating two personas at once.

Elena shared video feedback from the client, spotlighting the impact of the study and how the human understanding, not just the numbers, delivers true omnichannel, with behavioural science enabling them to develop a truly actionable strategy with the customer at the centre. This approach enabled the client to take the insight and create a tool that representatives could use in the field to move their customers along the adoption ladder.

Tas highlighted three other business situations where this approach would be valuable:

1. Building out a segmentation: helping your segments to feel more real, and understanding how to motivate them, as well as making them easily identifiable for reps and algorithms
2. In the mix with channel behaviours: understanding what channels, language or content is motivating to your customers in both their personal and professional lives
3. Early campaign development: when thinking about positioning, or choosing which content to leverage, to help understand which customers will be motivated by which channel mix or type of language or content

To truly personalise your omnichannel, you not only need to remember that doctors are people, but have to show it in your marketing.

Elena summarised the impact of powerful personas in understanding the human, not just the numbers, so that personas are identified and used to move customers up the adoption ladder. She concluded that it is the human side of doctors that allows us to turn emotional insight into practical business counsel, and that exploring the human side of doctors allows us to build a more engaging dialogue to encourage them to adopt new behaviours, which in turn may be converted into habits.

If we follow this human approach, Elena believes, we might be able to turn healthcare marketing into the successful consumer marketing that we see around us every day – because doctors are people too.

An audience question asked how the sales force adopted the outputs from the persona research. Elena explained that reps had been involved in the research journey from the beginning, ensuring buy-in, and that an iterative approach to developing the personas had ensured that the final descriptions were recognisable to the reps.

Another question explored the scalability of the approach, bearing in mind the time commitment in involving reps and the rest of the team in the persona development process. On a qualitative level, Elena felt that the distillation of personas might be easier in a larger disease area than within rare oncology, where the larger universe size would allow for quantification.

A delegate noted that, compared with the consumer world, healthcare deals with more homogenous groups of people treating disease, and that the disease remains consistent across countries, but asked if the personas looked different in different markets. Tas explained that they had seen cultural differences and systematic differences, but the personas remained true – albeit in different proportions in different markets. For example, in a smaller market, the size of the MDT was correspondingly smaller, which meant that there were fewer Mavericks appearing due to the difference in setting.

The final question asked what learnings the team would apply to future projects. Elena noted that the iterative process seemed repetitive at times, and that stakeholders would have benefited from a wider timeframe to allow more time for consideration and to allow full exploration of each dimension of the persona.

From X to Z! Exploring differences in attitudes and behaviours between doctors from different generations

Panelists: Dr Monica and Dr Jim

Convenors: Stephen Potts, Purdie Pascoe and YP Convenor Rebecca White, suAzio (2023 Conference Grant Winner)

The attitudes and behaviours among doctors from two different generations was the basis of a panel discussion convened by Stephen Potts and Rebecca White. The discussion involved Dr Monica, a GP who qualified last year and who has been working in the NHS for seven years and Dr Jim, who qualified as a doctor in 1983 and who has worked as a GP since 1986, with the last 32 years spent in the London Borough of Newham.

What motivated you to become a doctor?

Dr Monica: My older sister was diagnosed with Type 1 diabetes at the age of 5 and I saw what a positive impact the NHS had on her life. She is now a doctor and she has always been my role model so I wanted to follow in her footsteps, in spite of her telling me to choose another profession. I did it anyway to hope I could have an impact on somebody else like the healthcare profession had on my sister.

Dr Jim: We had no medicine in the family but I was looking for a steady profession and I thought there is always a need for doctors. It also seemed intellectually stimulating. There are times in medicine when you can think it is a treadmill but I think the trick is to find the puzzles and intellectual conundrums that keep you going.

Has being a doctor lived up to your expectations?

Dr Jim: I didn't realise that I am really interested in people. They are a fascinating puzzle, particularly the way that social and psychological aspects impact the whole family.

Dr Monica: Medicine is not glamourous but I wouldn't change this and I enjoyed my medical school and junior doctor

training. It taught me to mature faster than people not in medicine. I enjoy interacting with people and you learn so much from your patients. You can see a 2-year-old and a 98-year-old in the same day and this is what keeps it fascinating.

Has the doctor-patient relationship changed much since you first started?

Dr Jim: Going back over time, there was more respect in society as a whole. When I trained in a hospital, it was very paternalistic. When there was a problem that the doctors couldn't sort out, there were mutterings that the patient was crazy. I think we have come a long way in our understanding and being at peace with things that we can't work out.

Has the interaction changed with patients?

Dr Jim: I like people to take an interest in their health and it's fine for them to bring stuff to me. My job is to take their problem seriously. If you go into a consultation with that as your goal, you are going to hopefully do all right for your patient.

Did you have expectations for the doctor-patient relationship before you started?

Dr Monica: I didn't have any expectations going in. Training teaches you to be patient-focused and it is important to understand what the patient expects. Having shared decision-making is key and this is what I try and implement.

What has been your most frustrating recent patient?

Dr Jim: This is all about managing somebody's expectations and working in teams. This lady has slight learning difficulties and I have known her for a long time. She has lived alone all her life and is about 55. She had 9 cats and the neighbours complained because it is a council property so the RSPCA took all but one of them away. This started her journey of anxiety. She then became fixated that her bowels did not work. Even though she had tests which were normal, she started going to A&E. We went to Mental Health who said that they would set up a multidisciplinary plan involving all the professionals but saying that her bowels were fine. Over time, this settled down and teamwork was the means to solving this problem although halfway through, I was feeling very stuck.

Have you been at a point with a patient where it is difficult for them to understand where you are coming from?

Dr Monica: There can be a mismatch between your agenda and the patient's agenda. When you feel you are not able to help, it can become quite frustrating. I have a patient who is a young female who has had quite a lot of health problems for her age. She didn't know herself what her concerns were.

What do you think about innovation in your workplace?

Dr Monica: I would like to think I am an early adopter but I am also a creature of habit and routine. I have systems in place that make the 10-minute consultation better. I have a risk strategy in my head - am I safe to send the patient home? When someone comes in and says 'try this', I want to, but then I think that things are already working. There are things that I am trying to implement such as AI but I have tried it a bit and gone back to my old ways. I am forcing myself to do it because overall, I think it may have a really good benefit and save me time. It may also improve the patient experience but I am not there yet. I have tried an AI scribe within my consultations. The patient and I speak and the scribe produces a summary which I read through to see if I am happy with it. It saves time and means that I am looking at the patient rather than typing on the computer.

Dr Jim: I think the new technology is great if it works. When I was younger, I would throw a lot of time at this sort of thing but now life is quite full and I don't have the capacity to test software for people. However, if somebody presents something that really works, I am up for it. Just before Covid, something came along which has completely changed my work and has saved a lot of time. It is called Accurx and it sends a text message which could be an appointment reminder. You can pre-programme it and it then puts the text message in the notes. The downside is that some patients get overloaded with texts. New tech has to work and it has to save time.

You have to think about both the patient and the clinician but if you can get this right, it is a winner. Accurx easily saves me an hour a day and it also improves the consultation. I can send patients an Accurx video to show them, for example, how to use an inhaler and they can watch this again and again on their phone. I think this improves healthcare a lot.

What is your opinion on social media?

Dr Jim: I came off WhatsApp during Covid because you spend your whole life looking at it. I think you have to be a bit careful about social media. I think it can be powerful but you have to be careful about what you consume and I think you have to have parameters on how you use it. Having said that, it is a great way of getting a message out and I think that YouTube is really useful. I used to look at it for tips and tricks when I was teaching medical students because there is some great content on it and it can be good for learning skills.

Dr Monica: At medical school, I relied on YouTube in terms of preparing for OSCEs. I have most recently used it for revising for my GP training exams.

Where do you look for key influences and key opinion?

Dr Monica: There are podcasts that I listen to when I am not as confident in a particular area e.g. nutrition. I am very cautious about the medical advice I consume online because there is not much regulation. It would not be my first port of call to get any advice. I would go to something that is evidence-based or to my senior colleagues.

Dr Jim: NICE Clinical Knowledge Summaries tell you how to treat a range of conditions. The British National Formulary (BNF) is better than it used to be but it doesn't link across drugs. I use Google a lot and look for the NHS leaflets to send to patients. If there is something I don't know about, I go to Google but it has to be used carefully.

How do you think the role of the GP will change in the next 5-10 years?

Dr Monica: I think that AI will have a big influence within primary care. I hope that person-to-person interaction doesn't go as you cannot get this through telemedicine. I hope that in-person examinations stay but I think that in terms of the administrative side, AI might be useful. I think it will be a hybrid.

Dr Jim: I think there is a lot in the relationship that you have with other people which is therapeutic. I think the challenge is how we get value out of AI without throwing away social interaction. I would love to have an AI machine where I can give all my attention to the individual in front of me and the machine pulls out the important bits. We should never lose the patient-doctor interaction.

Picture Perfect Insights: Putting the true value of harnessing AI predictive visual analytics under the microscope

Speakers: Mike Pepp, Beyond Blue Insight and Sukriti Chaudhary, Boehringer Ingelheim

Convenor: Letizia Leprini, Roche

Mike Pepp

Sukriti Chaudhary

In his paper at the EPHMRA conference, Mike Pepp presented two case studies that explored the role of predictive visual analytics (PVA) in improving the process and outcomes of creative content research to create tangible value for clients, creative agencies and researchers. Mike was joined by Sukriti Chaudhary, who gave Boehringer Ingelheim's (BI) perspective on the PVA findings in relation to concepts for a disease state education campaign.

What is PVA?

Mike began by outlining that as PVA predicts what the eye will notice at first glance, it should give us a good insight into the way people look at a piece of visual material by highlighting three key areas:

- The gaze path i.e. what we are going to look at and in which order. This allows us to reduce or eliminate distracting elements that take the eye away from the intended communication.
- The probability of perception i.e. the probability of any key element being seen. This enables us to work with the areas of greater importance.
- The share of attention between elements so that we can make layout improvements to optimise communication.

Applying PVA in two client case studies

In Q4 of 2023, PVA was used to maximise the quality of concepts from BI and Bayer. 3-5 days were built into each project for the visual analytics element and this was done in advance of any field work so that the analysis would not be informed or biased in terms of any respondents or what had been seen in a survey.

Three KPIs across the case studies looked at:

- The impact of PVA on the duration of the project.
- The consistency with alignment with PMR findings.
- The impact on the confidence of decision-making carried out by the client team.
- Three metrics looked at the impact that the tool would have on the concepts themselves in terms of:
- The consistency of interpretation in qual research.
- The ability to convey the creative brief.
- The impact on concept recall.

Case Study 1: Boehringer Ingelheim - Disease state education campaign

Mike introduced the first case study from BI, who had nine creative concepts that they wanted to evaluate for a disease state education campaign. They wanted to use PVA in conjunction with a short preliminary quant survey to identify the five concepts that they should take into qual testing.

- Two concepts were identified using PVA as being likely to perform less well. They were visually complex with a lot of potential for distraction and for people not to get to the overall intended message. There was also poor initial focus on the intended key themes and a high likelihood that all of the intended messages could not be taken in by physicians.
- Five concepts did not have the same weaknesses. They were likely to engage physicians and have some focus on relevant messages, but there were still some key distractions. This meant that for each concept, there was something that was likely to be overlooked. These were concepts that were identified as needing some revision.

- Two concepts stood out using PVA. They had clear gaze paths that were predicted to direct the physicians to the most important concepts in the correct order to shape an appropriate understanding. Both concepts also had a predicted level of challenge or engagement that would be satisfying for the physicians without overburdening them.

The quant survey of 150 physicians showed clear alignment with the PVA. The two concepts that were predicted to underperform did so quite significantly against industry benchmarks and because of an overall lack of cohesiveness.

The two concepts that stood out using PVA also turned out to be the strongest performing concepts identified in the online survey but in addition, one of the concepts in the middle group rose into the top group. This is because it had a very strong and clear visual metaphor that the physicians recognised immediately but the PVA didn't recognise as it is unable to understand content.

Therefore, the PVA predicted two out of the three top performing concepts and also the two weakest concepts. This demonstrates that it has a role to play, although it is not always necessarily able to make the final decisions about concept choice because it doesn't understand some of the finer points in terms of what is going to make a concept perform strongly.

Mike summarised three learnings from using PVA which were very helpful to feed back to the creative team for them to develop the concepts for the next stage of research:

- Reduce the areas of focus.
- Increase 'white space' and do not over-complicate.
- Do not overlay visual elements and a headline. Each element needs its own space and focus so that it can communicate in its own right.

The client perspective

Before looking at the value of PVA, Sukriti emphasised that good concept performance is generally not attributed to layout, but bad layout can be detrimental to concept performance. It is not always clear which layouts are bad. They are dependent on a number of different factors including the audience, the complexity of the information presented and the campaign objectives.

By comparing the results of the PVA, the qual testing and the quant survey, it was possible to:

- Filter out the lowest ranking concepts.
- Obtain early insight into whether internal revisions result in a diluted performance.
- Suggest improvements for optimising performance and making sure that the best concepts are taken forwards. Although the PVA cannot understand visual metaphors, it can tell you which elements of the metaphor are being seen or not.
- Use PVA as a KPI tool for internal alignments as opposed to using the team's intuition and beliefs.
- Provide potential improvements to the qual research i.e. select the findings to improve concepts.

In summarising BI's learnings, Sukriti reiterated that PVA holds the potential to support decisions about creative concepts early on before research budgets are allocated to test sub-optimal concepts.

Case study 2: Bayer - Brand campaign

Mike moved on to present the second case study in which Bayer wanted to maximise their creative options for a brand launch campaign, using PVA in conjunction with iterative rounds of qual testing.

In this case, PVA provided an opportunity to improve and clarify the overall concept meaning by making metaphors clearer. Bayer recognised its value and saw it as being really important in ensuring that there was actionable feedback to direct the simplification and prioritisation of its visual communication.

Key takeaways

- There is a strong case that PVA should be available at an early stage when creative decisions are being made i.e. before field work stimuli are being finalised. This allows it to have an input that will be directly developed in market research.
- PVA should not be owned by the research agency and should be a source of round-table conversation with the creative agency.
- It can provide greater client confidence, with PVA providing feedback to help improve concept layouts. Ideas that have been improved following PVA tend to be less complex and more clearly executed, leading to greater consistency of interpretation.
- From a creative agency's viewpoint, PVA can help to go beyond intuition and anecdotal evidence so that the best concepts can be taken forward.

Patient Engagement in Early Product Development for AML: utilising human-centred design and PAG partnership to bring patients in

Speakers: Ben Walker, Adelphi Research and Alexey Salamakha, Novartis

Convenor: Roy Rogers, Research Partnership

Ben Walker

Alexey Salamakha

In the final presentation at this year's EphMRA Annual Conference, Ben Walker and Alexey Salamakha looked at why patient engagement in early product development is important and presented a case study in which actionable insights were obtained at this stage through close collaboration with a PAG.

The importance of early patient engagement

Alexey began by outlining that today's external environment requires pharma companies to carry out more patient experience data mining and include it in product development. Furthermore, patients want to be at the table when we are talking about product attributes and what is being measured in clinical trials. Pharma is realising that this drives value as bringing patient insights early into product development helps accelerate the clinical trials cycle and avoids costly protocol amendments.

We need to work with patients consistently and systematically at every stage of product development because it has a domino effect. When we start looking at the patient experience in pre-clinical, it impacts

what we do later. We need to engage with patients early because it helps us to:

- Understand what our clinical development strategy should be.
- Design better patient-centric clinical trials through being informed by patient insights.
- Shape the product profile.

All of this improves our ability to bring the right therapy to the right patient population at the right time and stay competitive.

Early-stage involvement and later stage involvement of patients are not separate. They co-exist and the earlier we start, the better we will be prepared for later stage work. All of the work at the early stage lays the ground for:

- Product differentiation.
- Value proposition.
- The messaging platform we develop for patients and HCPs.
- Patient support programmes.

Case study with Novartis

Ben introduced the case study involving Novartis, who approached Adelphi Research in 2023 to look for actionable patient insights to build into their strategic focus for Acute Myeloid Leukaemia (AML). Novartis have two early AML assets in pre-clinical phase 1 with slightly differing populations and indications within the AML space.

The approach taken was a relatively traditional PMR project involving 5 global markets - the US, UK, Germany, China and Japan - with 43 AML patients taking part in 60-minute qual in-depth interviews. Three critical design elements were built into the research:

- Applying a human-centred design thinking framework.
- Partnering with patient organisations and PAGs to get the right understanding of data.
- Going beyond the typical AML patient and working in collaboration to bring the expert view.

The human-centred design thinking framework

Using the design thinking framework, the first two steps involved empathising with the AML patient population and understanding the day-to-day lived experience, as well as defining current problems, unmet needs and challenges. As Novartis works extensively within the oncology space, they had a wealth of previous data and a secondary data review was conducted to start pulling out some of these areas of focus.

This gave a basis for the ideation stage and collaboration with ALAN (Acute Leukaemia Advocates Network). Their aim is to improve patient advocacy and outcomes within the AML community. They also partner with pharma and have extensive networks and relationships. Through Novartis' relationship with ALAN, it was possible to bring global experts on board as consultants.

The stakeholders took part in an ideation workshop, with the first part solidifying the unmet needs that AML patients were experiencing day to day. The participants looked at the phase 1 data and the TPPs that Novartis had for their AML assets to see which areas of the profiles were starting to address some of the unmet needs. This was followed by a discussion to build some hypotheses for the research.

Refining the TPPs and bringing them to life for the patient population continued into the prototype stage, so that the TPPs could be in a physical form that was understandable and relevant to the patients who could then give their actionable insights.

The test phase involved the qual in-depth interviews with patients to test the TPPs and get their feedback.

Ensuring patient understanding of data

Ben explained that the team had two things in mind when they looked at ensuring patients' understanding of the broad clinical assumptions seen in pre-clinical and phase 1.

- It was essential to adopt a sensitive approach as some of the patients were relatively late-stage. Talking about overall survival and progression-free survival are quite clinical and blunt end-points for patients and through the collaborative workshopping, the team looked to break down each of the end points in the profile. Overall survival has a very broad end point and it was therefore important to approach this sensitively i.e. not providing false hope and using 'typically'.
- With neutropenia rates, the end point was broken down into constituent parts to give a really clear explanation to the patients so the data could be fully interpreted in order to get to the actionable insights.

Collaborating with 'expert' patients/advocates

The ALAN advocates and expert patients had a wealth of knowledge which they shared with the team. A couple of super-engaged advocates were appointed to understand and test the methodology, run through the TPPs and provide their thoughts on the profiles to achieve actionable insights.

Ben highlighted that the main challenge presented by the study was the amount of time it took to engage with different stakeholders across various geographies to be available for a workshop. Pharma doesn't always have time at phase 1 and clinical decisions get taken very quickly so ultimately, the insights need to be delivered in a much more agile way to keep pace with the clinical decisions. Other ways to improve similar studies in the future could involve:

- Being more focused with questions during the interviews, particularly on the end points that can change.
- Utilising social media to draw on patient experience and move through the phases more quickly.
- Utilising previous knowledge and literature.

Key takeaways

- With an ever more competitive development space, patient engagement in early- stage product development will become even more critical. We have an opportunity to have the greatest impact when we design the product with the patient.
- Products need to address the critical needs of patients and the only individuals who really know about this are patients.
- Conducting early market research with patients is critical but collecting meaningful insights can be challenging. How we collect and analyse the data becomes critically important.
- Start early, do it consistently and do it in a scientifically robust way to make sure that the needs and the requirements of all the stakeholders are met.

Conference Closing:

Karsten Trautmann, EPHMRA President

Karsten brought the conference to a close, commenting that it had been a great few days, and that he had many people to thank. He thanked the audience and presenters for driving the goals outlined at the beginning of the conference, to inspire and challenge, and leverage the opportunity to discuss, network and reconnect.

In particular, he thanked the Programme Committee for their tremendous work throughout the year, selecting papers, helping presenters with rehearsals to refine their inspirational papers which had, on multiple occasions, inspired Karsten to take the learnings back to his own organisation and see how they might resonate.

He thanked the Committees, working tirelessly in the background as the foundation of the association, supporting us as an industry.

Having already thanked the presenters, he emphasised the inspiration from their papers and the importance of the role of market research and its positive impact on the business.

He thanked his colleagues on the EPHMRA Board, who work together to frame the association and define how we would like to improve and provide more for members.

The conference team were thanked for being on hand to guide everyone around the conference site, and the Audio-Visual team for the smooth running of the technical side of the conference.

Karsten then invited Bernadette to come on stage to commend her for all that she does, both at the conference and throughout the association, noting that everything would only be half as good without her.

He then introduced the 2025 conference, and the opportunity to continue the journey of building our networks, and discussing new and continuing ideas.

He encouraged everyone to respond to the call for papers with ideas to share with the EPHMRA community, to inspire and challenge our colleagues, but also to help us develop as individuals.

Closing the conference, he invited us for a farewell drink in the lobby, before a safe journey home.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