



The Chartered  
Institute of Marketing

# Measure for measure: metrics and marketers in the NHS

Spring 2009

# Foreword



Marketers in the NHS are increasingly accountable for the resources allocated to them.

I firmly believe marketers have a key role to play in improving patient care, with significant implications for the trusts and bodies that they work for. Metrics and measurement will be at the very heart of this. Measurement and return on investment are needed to ensure that marketing activities are properly monitored, progress accurately assessed, and resources focused on the key areas that matter to patients.

In this our second White Paper on marketing in the NHS, we explore how marketers can ensure they are delivering value for money and making the most of the precious resources they have.

The Chartered Institute of Marketing has worked with marketers from across the NHS to produce this Paper, looking at the importance of measurement in the context of the NHS, how marketers can measure and monitor their activities, and what tools they can use to help them do so.

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“There is a need for strategic marketing to ensure that patients and income are attracted.”

## Executive summary

Whilst many parts of the NHS already collect statistical data for performance measurement, strategic marketing is a relatively new concept to the NHS. It can most accurately be described as ‘service delivery’; something the NHS has always done. However, with the introduction of competition through ‘patient choice’,

especially between secondary and tertiary care trusts, there is a need for strategic marketing to ensure that patients and income are attracted.

In primary care the marketing focus lies primarily on ‘social marketing’ – encouraging us all to lead more healthy lives, thus saving the NHS

money. However, with the planned introduction of more competition in this market, strategic marketing is required here too.

As a result, there have been calls for useful metrics to measure marketing effectiveness in the NHS.

The NHS already has strict accounting practices where metrics are used and some of these can be used for marketing. The availability of detailed patient referral data from Dr Foster, a healthcare information company, allows a number of useful metrics on market share to be calculated and used relatively easily. However, where marketing is measured, it is not always consistent; there is no clear view on exactly what needs to be measured; what metrics should be used, and the risks, assumptions and incorrect conclusions that can emerge from the well-meant application of metrics.

In response, particular metrics need to be chosen for their relevance. These metrics then need to be communicated internally, and the data and information that is gained needs to be fed back into future

strategy. The risks of metrics also need to be considered – there is a danger of measuring too much, and not being able to draw insights due to an abundance of data.

As previously discussed in our first paper on marketing in the NHS<sup>1</sup>, marketing continues to be somewhat misunderstood and underestimated in the NHS, with misconceptions ranging from the belief that it is purely a promotional, tactical part of business, to the view that ‘every pound spent on marketing is a pound not spent on patients’. However, this situation is rapidly changing and there is clear growth in the role of marketing; from its basic ‘drive to a service’ role, through to the complex (and near-real time) feedback of diagnostic data evaluation; both in planned and unplanned settings. By the end of 2009 it is expected that every hospital in England will have at least trialled a patient experience collection and response system.

With more rigorous use of measurement, the value of marketing to the NHS can be proved as an income earner, cost-saver and value-creator – not a cost to the system.



By understanding and investing time in measurement tools, individual trusts and service providers will be able to ensure that they thrive.

# Introduction

It is a business cliché to say that what gets measured gets done. When it comes to marketing, the commercial sector routinely uses a number of metrics, ranging from hard metrics such as revenue and

profit, soft metrics such as loyalty and satisfaction, and perception metrics such as brand awareness, to evaluate the success or otherwise of the company’s marketing and influence future campaigns.

The NHS uses large numbers of metrics already, and the Department of Health, Healthcare Commission, and Monitor indicate how the data is recorded and measured. There is much published on statistical collection, statements of compliance and performance indicators, but little by way of hands-on tools for NHS managers to use to draw strategic conclusions that will benefit the future direction of the organisation, or pointers on how this could be communicated more effectively in future, both internally and externally. Some NHS managers would argue that marketing metrics are applied consistently, whilst others would strongly disagree – so there seems room for outlining a best-practice approach to marketing metrics and offering further suggestions from the commercial sector that could be adapted or considered in future.

Not all marketing metrics from the commercial sector are applicable or directly relevant to the NHS, but

many metrics which on first sight seem irrelevant are in fact of value. With the rise of patient choice, and Payment by Results (PbR), a particular trust or service offering will need to consider metrics like market share and patient satisfaction, because customers and patients will choose to go elsewhere if they do not receive the service they want. By understanding and investing time in these measurement tools, individual trusts and service providers will be able to ensure that they thrive, instead of failing because of the other choices on offer from ‘competitor’ trusts.

Metrics are also useful for influencing strategy because they can identify where budgets should be increased or decreased, and enable managers to spot trends and see where there are gaps that need to be filled. They can also show which procedures run at a surplus and can be expanded and promoted, and which make a loss and need to be reviewed.



## Drivers for metrics

There are three separate drivers for the use of metrics in the health services (NHS and Department of Health):

- Traditional value for money (VFM)
- Improving the service (and responsiveness of the service)
- Driving attitudinal and behavioural change

### **Value for money**

In many counties in the UK, the NHS and the DoH can be the largest buyers of above-the-line advertising. To give one example, NHS Yorkshire and the Humber will spend over £26m on campaigns in 2009, all of which can be accounted for.

### **An improving and responsive service**

Competition in the provider market and pressure from the systems management route is also driving change. As this paper was being written, major moves forward have been made in many parts of the NHS (particularly larger trusts) in moving

from an understanding that patient satisfaction is important, towards the need to reward based on improving delight and advocacy of services.

There has also been a move toward understanding 'touchpoints' and building complex diagnostic tools in the core services of maternity, A&E and General Practice.

### **Behavioural change**

The drive for attitudinal and behavioural change, a move from secondary to primary care, and the need to prevent rather than cure (especially in obesity, smoking and excessive drinking), has led to a fast increase in social marketing and related disciplines. The main commissioners of this work are spread across the NHS Communications, Performance and Public Health arenas, and there is now an understanding of the need for metrics at every stage and post-evaluation. An example of this can be found in Diagram 2.

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## What are we measuring?

Before we know what metrics to use, we need to define what we are trying to measure in the NHS. Traditionally, marketers in the NHS work either in communications, public health or commissioning, and most roles can be classed as social marketing. However, strategic marketing is now needed for service delivery to succeed in a competitive marketplace where the patient has choice and GP commissioning means more competition.

There is much more that a marketing approach can do for the NHS. From our research into the marketing metrics available in the commercial sector, the following areas emerge as appropriate for the NHS to draw upon, and are the areas that are likely to generate the most benefit for the organisation, in terms of identifying areas where greater value could be extracted from existing budgets, in saving the organisation

money, and in providing data to improve campaigns in the future. Unlike the medical private sector, or indeed in the commercial sector as a whole, NHS marketers and senior managers also have access to detailed performance data on their competitors and vice versa.

Managers need to be aware of the value of measuring areas of marketing that do not seem as important a priority (for example patient satisfaction) because in fact, it's often these seemingly less important areas that can create the greatest benefits for the organisation. Many patients feel they cannot judge the clinical input and thus 'hotel service' and waiting times become leading issues for choice. A trust that a patient continues to go to because they like the way the staff spoke to them, or like the food, seems like a trivial issue – but it can actually be the differentiator between take-up of services, and thus PbR income, or potential failure or merger of a trust.<sup>ii</sup>

Marketers in the NHS recognise this instinctively and may also show surprise that measuring something like 'lives saved' is not a metric that emerges from the masses of statistical data and performance indicators that the NHS does publish.

This is a situation that looks likely to change with the introduction of PROMs (Patient Reported Outcome Measures) – which are likely to generate further public interest and scrutiny of hospital performance.

The following metrics divide into:

- Financial metrics – revenue and surplus
- Qualitative metrics – loyalty, satisfaction
- Value metrics – perception, comparative measurement

These can be further sub-divided as follows:

- Revenue and surplus
- Segmentation
- Pricing
- Awareness, attitudes and usage
- Market share
- Loyalty
- Satisfaction
- Communications

### Revenue and surplus

It is entirely within the NHS's remit to focus on increasing revenue, because as public funding becomes ever more tightly stretched, more efficiencies need to be found from within the service. Considering commercial sector techniques to increase the numbers of patients

treated and profitability per procedure are possible ways to do this, and are explored later. Without trying to increase income/revenue (the surpluses which are then ploughed back into the service, rather than going to shareholders, as may be the case in the private sector) the NHS's status as free at the point of delivery is unlikely to be sustainable in the long run.

An NHS example of a revenue metric is:

$$I = Pt \times T$$

Income = number of Patients treated (FCEs – Finished Consultant Episodes) x NHS Tariff for each procedure

This information is routinely collected and readily available and is useful to analyse the differential income from each procedure and speciality. NHS billing is now on 'spells'; i.e. one charge covering the patient's stay in hospital from admission to discharge.

### Profitability of Procedures and Finished Consultant Episodes (FCEs)

It is important to analyse which procedures and FCEs make a positive financial contribution (are

profitable) to the trust and which are not. There are two measurements used routinely for this:

**Gross Profit** – considering the contribution made to overall surplus made per procedure without overheads

**Net Profit** – where the overhead apportionment is added

The NHS now uses profitability at EBITDA level (where EBITDA = Earnings Before Interest, Tax, Depreciation and Amortisation).

### Gross Profit or Contribution per procedure/FCE

This is important since a trust cannot continue to offer procedures which make a loss (unless this is a deliberate strategy to attract more patients to complementary treatments). However, those which make a positive contribution to overheads could be promoted to increase income and surplus. Some procedures are 'loss' making but must be offered by trusts; in this instance the idea is to minimise the loss.

Gross profit looks at the surplus made by a procedure/treatment/FCE without the trust overhead. This is useful as the 'tariff' is now 'unbundled'.

$$GP = T - Ac$$

Gross Profit = official 'Tariff' of procedure – Actual cost of providing the service without overhead

### Net Surplus

Measuring the effects of how marketing impacts on the organisation, and isolating marketing's contribution to the NHS, is complex. A general metric that isolates net surplus from a particular marketing campaign or action is therefore a useful starting point for identifying how marketing adds value.

$$NS = (V \times M) - (Em + Eo)$$

Net Surplus = (number of patients treated e.g. hip replacements x tariff) – (procedural costs + overheads)

**NS** is net surplus

**V** is number of patients treated

**M** is margin per patient for the procedure

**Em** is marketing expenses

**Eo** is overheads

Adapted from *Measuring Marketing*, Wiley 2007

If there is an additional promotional cost for a particular procedure or a price discount below the official tariff, this would need to be included in the cost. It isn't possible to offer NHS services to the NHS below the officially published tariff, which covers the bulk of the acute service – however there are exclusions which can be priced locally.

To use this metric, you need to be able to calculate customer volume, and margin per customer. The NHS knows customer volume and reports on it, so this information is already available.

*Margin* is a simple metric to calculate:

$$Mc = Rc - Cv$$

Margin = Income per patient (eg tariff) – variable costs per patient (eg direct costs of procedure excluding overheads)

**Mc** is margin per patient

**Rc** is income per patient

**Cv** is variable cost per customer

## Segmentation

The value of measuring the effects of your segmentation is that you can prove, internally and externally, that marketing techniques are creating value for the NHS, rather than being a cost. This is particularly useful for public health social marketing campaigns where health messages need to be aimed at carefully defined segments: anti-smoking campaigns, MMR vaccination etc.

Companies such as Experian and Dr Foster can provide demographic and /or patient data which can be overlaid with local public health data to define segments with precision.

A specific campaign can be designed with ages, cultural needs, religious beliefs and diseases taken together. Uptake can then be closely monitored. This is also useful for hospitals trying to attract patients on the edge of their catchment area from other hospitals.

**Net income contribution** calculates the financial contribution of a particular segment, as a percentage of all segments. It can help with calculating the success or otherwise of a particular campaign and show where budgets should be allocated next time.

$$Sns = \frac{Ss}{\sum St}$$

**Sns** is net income/uptake/ contribution for specific segment or procedure

**Ss** is income from that segment

**∑St** is total income for all segments

An NHS example would be:

$$\frac{\text{income for hip replacements}}{\text{total hospital income}}$$

The Lambeth anti-smoking campaign is a good example of a highly successful use of segmentation to create value (see Case Study 2 on page 28). Take-up was high, results from minimal investment were high, ongoing success rate was good, and it achieved the purpose of getting people to buy-in to the desired goal (pull), rather than a scattergun approach (push).

## Pricing

Pricing is not a concept that is often used in the NHS, because tariffs are fixed. For a service that is ‘free at the point of contact’, the idea of pricing products or services differently is not really possible under the current tariff and Payment by Results (PbR).

Although 70% of services are covered by tariffs, there are areas where the NHS could look at pricing. Price as a concept does not have to be a financial ‘price’ – it can be applied to time or availability. For example, by altering your price – say offering an incentive for a patient willing to receive a process that requires a bed at an unsociable time – you can stimulate demand at times when demand is low. Similarly, in a social marketing campaign, you might offer an unbeatable price to encourage take-up, in the knowledge that the eventual value will be higher than the loss you make on the low price.

For the right reasons, the NHS does not operate a proper market. However, arguably there could be much more flexibility in pricing and trusts could be enabled to set their own prices, depending on their perceived value and quality to patients.

Holiday companies and airlines will change pricing depending on how far in advance you book holidays or airline seats and reduce costs if they have excess capacity that they want to sell. There is no reason why the NHS should not do the same.

Pricing is also a comparative concept, so pricing compared with competitors’ pricing is important. The NHS is in a unique position in that it has published competitor intelligence at its disposal. Pricing can also be looked at more in areas like mental health where tariffs do not always exist.

A basic metric for pricing strategy that will show the value of the strategy you are introducing is as follows:

$$P = PI - D - A - T$$

**P** is the final price realised

**PI** is your ‘list price’ or what you advertise the price as

**D** is discounts; your reduction from the list price, to stimulate demand

**A** is allowances such as co-operative marketing activities

**T** is taxes (if applicable)



## Awareness, attitudes and usage (AAU)

Tracking data using AAU can help the NHS identify:

- What patients and the public think of the service
- Whether they would recommend it to friends and relatives
- ‘Likeability’ factors
- Willingness to search – are they willing to travel for a particular treatment, or would they prefer it to be available nearby

**Awareness** can be evaluated by asking in surveys whether a patient or member of the public knows of a particular treatment/service being offered, and whether that particular treatment/service is the one that customers think of when they are looking for a GP or hospital to meet a particular medical need. This is important to monitor after a particular promotional campaign – for example, if Communications has worked with a local newspaper and patients to publicise a new or innovative treatment being offered or pioneered, or there is an advertisement for patients to take part in a research project.

**Attitudes** can be evaluated by asking what patients think of the service: would they reuse it, if

not why not, and what are their recommendations for improvement – i.e. patient satisfaction rather than merely ‘experience’. You can track this over time to see improvement by asking patients to ‘rate’ a particular service, say quality of food, from 1-5 or 7.

**Usage** can be evaluated by asking a patient how frequently they have used the service and match this to actual usage.

### Caveat – measuring ‘what patients want’

The issue of service and clinical excellence versus ease of location is a challenge. Research has shown that most patients take clinical competence for granted and want to be treated locally. However, exceptions to this are concerns over MRSA and infection rates. Some better-educated patients will research outcomes and will be willing to travel to be treated by the ‘best’ clinician. It is a challenge for marketers and senior managers to differentiate the services and treatments being provided, so patients will become more discerning purchasers and be more willing to consider options outside their local area.

The Royal Colleges have strict criteria to maintain good quality of care by ensuring there are sufficient patient numbers for clinicians to be competent to offer a particular treatment. As with all areas of the NHS, a best-compromise solution has to be found that balances budgets available, likely number of patients and conflicting stakeholder needs. A marketing approach can help by communicating the reasons for the choices made, in ways that help patients and stakeholders understand why the choices have been taken.

### Market share

Measuring market share may not be so relevant in primary care as PCTs have relatively few competitors, but with secondary and tertiary care there are competitors that need to be considered.

Market share is an important metric when trying to encourage patients to choose your trust, or to prevent patients from making their choices elsewhere. Having a relevant metric can help with budgets, forecasts and in promoting the popularity of the trust or service.

Once you use the metric over a sustained period, you can identify trends such as whether the service is

growing in strength or declining; and this can help you modify strategies for the future.

Market share is the percentage of a market you hold (either in terms of units or revenue compared with competitors).

$$Pms = \frac{N}{TND}$$

Procedural market share (%) =  

$$\frac{\text{Number of procedures (N)}}{\text{Total number of procedures in defined catchment area (N)}}$$

$$Ims = \frac{I}{TIA}$$

Income market share (%) =  

$$\frac{\text{Income from a procedure (£)}}{\text{Total income for that procedure in defined catchment area (£)}}$$

Adapted from Farris, Bendle, Pfeifer, Reibstein, *Key Marketing Metrics*, Wharton 2009

Data from Dr Foster’s Hospital Marketing Manager (HMM) tool can be invaluable when calculating market share and acute trusts are able to buy this analysis from them.

To calculate market share, firstly the 'market size' must be established. This would be defined as the total number of patients within a defined catchment area. In primary care this would be the area served by the GP practice. In secondary care it would be a geographical area where patients could reasonably be expected to travel to be treated. This area may be much larger for a specialist procedure, and for tertiary referral hospitals it could be as large as the whole of the country ('country' defined as England, Scotland, Wales or Northern Ireland).

In the private sector, market share is often seen as the most important marketing metric of all. With 'patient choice', the value of market share is arguably not considered as highly as it should be, and so looking further at this may be worthwhile.

It's important to recognise the difference between competition for a market, and competition within a market. Most of the competition within the NHS falls into the former category. Defined broadly, competition for a market is where different providers offer the same kind of product, and the competition is in the organisation trying to get the customer to choose you, instead of

another provider. Competition within a market is where an organisation is competing for spend: i.e. persuading people to choose their type of product, instead of a different product.

### Caveats

Addressing market share in the NHS is complex because crucially, in some markets, collaboration can be the best policy (such as stroke care). Best outcomes – such as life expectancy – can often only be achieved if market principles are ignored. For example, ambulance services are an area of natural monopoly that would not be improved by increasing competition within the market.

You can boost market share by offering incentives – a less invasive treatment, better hotel services and customer care, shorter waiting times, and other extras that competitors might not offer. However, this can damage surplus – which is still needed within the NHS as addressed above.

Avoiding bias in questionnaire responses can be achieved by ensuring 'why' and 'what for' are measured; something that is sometimes missed out in NHS patient experience surveys.

For an example of this in practice, see Case Study 1 on page 28.

*Marketers also need to consider:*

- Market demand and market growth – where is demand increasing in the NHS (e.g. more call for responsible drinking programmes) and where is the market growing (e.g. population densities growing in a particular area). Local epidemiology and demographic data is already used in public health and could be better used to forecast changes in service in the future. The NHS already collects much data on these areas and uses it to influence future strategies.
- Penetration is unlikely to be a metric that will significantly change the NHS due to its dominance of the marketplace, but can be used to amend and tailor existing offerings. A good example of penetration is the percentage of potential diabetics that have been identified, diagnosed and treated in a defined geographical area. Penetration is particularly useful in public health campaigns using social marketing techniques. Uptake of vaccinations is another example.

### Loyalty

Loyalty is not a metric in itself, but it is important for the NHS to consider. As with market share, loyalty can be a valuable metric because in the era of patient choice, those services that thrive will be the ones recommended by patients, and to whom patients return for future needs.

It's widely accepted in the private sector that it is more economical to retain existing customers, rather than find new ones. Adapting this idea to save money for the NHS, particularly in social marketing campaigns, loyalty is an especially valuable concept because customers who are loyal count as 'existing customers' who will look for information from you; rather than being 'new customers' who have to be reached – which can incur acquisition costs in terms of communicating your services to them.

Dr Foster (or equivalent) data can show GP referrals for a particular disease/diagnosis and treatment/procedure to different hospitals over time, so changes in trends responding to a change in service delivery or specific promotional campaign can be observed.

Marketers should also consider:

**Cost Per Lead.** In the Lambeth example in Case Study 2, customers were attracted by a relatively low-cost solution. Attracting customers in this way creates awareness and can generate loyalty in the future. Cost per lead can be used to calculate the cost of a marketing campaign with the following formula:

$$\text{CPL} = \frac{\text{TAC}}{\text{TLG}}$$

**CPL** is cost per lead

**TAC** is total advertisement costs

**TLG** is total leads generated

For the NHS this would be an increase in patients treated:

For hospital trusts:

$$\text{CPL} = \frac{\text{Total promotional campaign cost}}{\text{Change in referrals / patient numbers}}$$

For PCTs or public health campaigns:

$$\text{CPL} = \frac{\text{Total promotional campaign cost}}{\text{Change in life style or behaviour i.e. numbers stopping smoking or drinking}}$$

## Satisfaction

In the era of patient choice, satisfaction becomes a metric that assumes higher importance; patients will ‘vote with their feet’ if it is not considered. Surprisingly, the NHS is only just beginning to measure health outcomes and Patient Reported Outcome Measures (PROMs). Patients will evaluate their experiences based on what tangible evidence for their treatment they can find. Thus, friendliness of staff, quality of food, waiting times, etc. can become almost as important in the patient’s mind as the treatment received and its outcome. The importance of achieving satisfaction needs to be recognised, because it is a relatively low-cost, high-impact metric to consider. Whilst internally doctors and managers are correct in their assumption that satisfaction is of less importance to a customer’s experience of the NHS, it’s important to recognise that due to patient choice, customers will increasingly go elsewhere if this relatively simple metric is not achieved. Satisfaction can therefore make the difference between a thriving trust (which can then concentrate on the other things that matter) and a declining one.

Currently available to all PCTs as a minimum are:

- MORI trackers (quarterly), giving regional trends
- SHA annual WCC polling surveys giving a satisfaction score by PCT and accurate to within +/- 7%
- Many off-the-shelf systems for near real-time feedback. It is expected that every hospital in England will shortly have one of these. Commissioners could ask for this data.

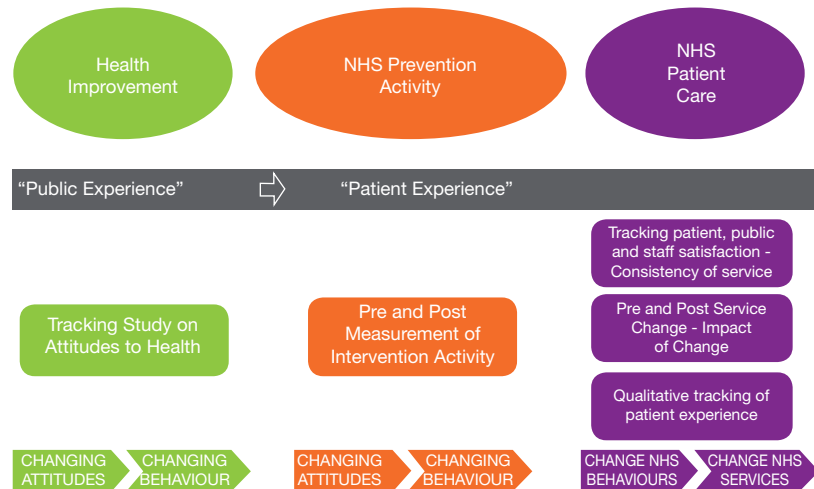
However, satisfaction is not regularly measured in all parts of the NHS. The annual patient surveys measure experience, which is not the same. There is little room for feedback on how quality can be improved. It should be anonymous and patients

should complete it at home, not whilst NHS staff are present. Additionally, it is not transparent, as the survey is carried out on a fixed day per year, so it is possible to alter the treatment of patients to gain a better score.

Furthermore, satisfaction is a crude measure of patient experience and should not be the only metric used. Diagram 1 (overleaf) is an example from NHS Yorkshire & Humber Trust, measuring the patient experience journey. It charts the three areas of NHS intervention: Health Improvement (stop smoking), Prevention Interventions (offer tobacco patch, offer anti-smoking session) and Patient Care (how was your experience of lung cancer).



**Diagram 1: Patient Experience Measurement**



Source: NHS Yorkshire & Humber Trust

Trusts will measure differently depending on which data the individual trusts want to capture, but three broad areas for measurement are outlined in Diagram 2.

**Diagram 2: Areas of Measurement**



Source: NHS Yorkshire & Humber Trust

For NHS Yorkshire & Humber Trust, it's important to draw a distinction between satisfaction trackers and PREMS (Patient Reported Experience Measures).

**Caveat**

There can be bias in satisfaction surveys because some respondents will say what they think the researchers want to hear, but if

numbers are high and surveys carried out regularly this bias can be significantly reduced.

**Communications**

A marketing campaign is often seen as a cost – not a driver of value. To counter this, metrics can be used to show the benefits marketing brings by subtracting the cost of the campaign from the results generated.

A **Programme/Non-Programme Ratio** is a highly useful metric that can do this.

$$\text{PNPR} = \frac{\text{St}}{\text{TSt}}$$

**St** is £ spent on marketing in time t

**TSt** is £ spent on overheads and administration costs

Higher ratios indicate a more efficient operation.

### Communications effectiveness

As we have seen, there is a difference between metrics that measure **value** and value **perception** (e.g. quality of service, impressions of the NHS). There is now a nationally agreed press analysis system for this, an example of which can be seen in Case Study 3 on page 29.

### Direct marketing costs / return on investment (ROI)

If the benefits of direct marketing are being questioned, then ROI metrics that clearly demonstrate the value being created can prove invaluable. These metrics can also be applied to areas such as click-through rates on internet campaigns; cost per click; and advertising.

### Promotion to income increase ratio

This metric can help to prove the value of advertising campaigns.

Total promotional campaign expenditure, divided by total increase in income or uptake or change in behaviour during a fixed time.

$$\text{PIR} = \frac{\text{Pt}}{\text{It}}$$

**PIR** is the ratio of promotion to income increase

**Pt** is total promotional campaign expenditure

**It** is total increase in income or uptake or change in behaviour during time t

The formula describes the effect of your promotional campaigns on total income, which in the NHS's case might be take-up of a campaign. This is used, for example, in the orange section in Diagram 2 on the previous page.

### Response rate

This metric shows how many people respond to an offer – whether that is a campaign, an advert, click-through

rates on the internet, etc. This data can then be used to assess the value of a campaign and decide if it is worth committing more or less budget to it next time.

Response rate is the number of people who responded, divided by the estimated number of viewers.

$$\text{R} = \frac{\text{Pr}}{\text{Pe}}$$

**R** is the response rate

**Pr** is the number of people who responded

**Pe** is the estimated number of people who were exposed to the campaign/ad/received the email or message

This is particularly useful in public health social marketing campaigns, but can also be used when promoting specific services or procedures to particular catchment areas.



Marketing measurement can sometimes be skewed towards the elements that are measurable, rather than what needs to be measured.



## Balancing metrics

Whilst more widespread use of metrics across the board is to be welcomed, metrics usage brings its own issues and these need to be considered. Firstly, there are certain elements that are easier to measure (such as awareness), but which are of less importance when measuring the effects of marketing. Equally, there are some areas that are harder to measure, but more valuable in assessing marketing's value. As a result, marketing measurement can sometimes be skewed towards the elements that are measurable, rather than what needs to be measured. The focus on measuring the effects of communications campaigns is a result of this problem – it's an area that can be measured relatively easily, so there is more evidence of it being measured.

To resolve this issue, a 'balanced scorecard' approach to metrics should be taken. The metrics should meet standard business criteria of being reliable, valid, responsive, clear and relevant. Secondly, whilst

financial payback is important, financial metrics are not the only yardstick marketers should measure their business by. The metrics used should not be overly analytical; financial metrics are useful, but obsessive analysis is not. Again, a balanced approach helps prevent such distraction occurring.

Thirdly, as the use of metrics is complex, there needs to be an emphasis on choosing and communicating a limited number of relevant metrics, rather than trying to do anything and everything. Finally, if it is suspected that the number and variety of metrics is stalling the process, create and implement a 'metric of metrics' – the balanced scorecard approach developed by Kaplan and Norton indicates how to achieve this.<sup>iii</sup> Provided the metric of metrics balances the individual measures, according to their observed contribution to effectiveness, it is unnecessary to worry unduly about the individual factors that constitute the score.

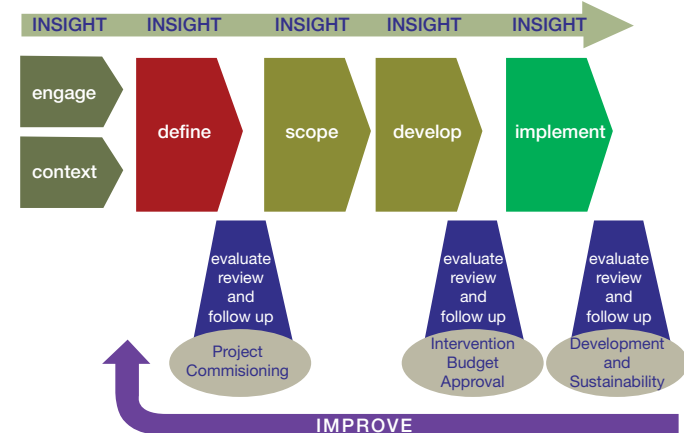


# Internal and external communication of metrics

To demonstrate the effectiveness of marketing to the rest of the organisation, results should be communicated transparently. Platforms for this are straightforward – more usage of internal magazines to publish the impact of marketing campaigns, marketing-related initiatives and social marketing examples and results. Trusts, and

other parts of the NHS, should publish the results of their marketing measurement externally as well, to show how marketing saves the NHS money and extracts more value from existing budgets. More transparent publication would also have the benefit of reducing negative media coverage of marketing in the NHS.

**Diagram 3: Measurement as part of a Marketing Plan – Social Marketing**



Source: NHS Yorkshire & Humber Trust

## Feeding into future strategy

The results of the data collected can be used to influence future marketing strategies. The relative success or otherwise of a campaign is information that can be used to tweak repeated campaigns or social marketing projects.

### Case Study 1: Hospitals

It's important to develop and manage brand reputation and evaluate the effectiveness of marketing in hospitals. Several companies such as Experian and Dr Foster supply these tools. An example that can be used across hospitals (albeit in England only at present) is Dr Foster's Hospital Marketing Manager (HMM). HMM could be used more rigidly across the NHS, to ensure hospitals understand their market, referrals and admission patterns and what impact their marketing is having.<sup>iv</sup>

### Case Study 2: Lambeth Smoking Cessation

In Lambeth, the PCT was concerned that residents were not taking full advantage of smoking cessation services, and wanted to know how to target more people to use the service. Dr Foster introduced Health Needs Mapping (a technique that combines hospital admissions data with socio-demographic data), to find out which smokers were most likely to respond to anti-smoking messages and segment them carefully as described above.

Health Needs Mapping has two uses – it prevents a wasteful scattergun technique and thus saves the organisation money; and it targets those who are most likely to benefit from the initiative, and therefore reaches those that a scattergun technique may miss altogether. Two groups in Lambeth were identified and targeted. In practice, one of the methods used was to put promotional sleeves offering free use of Lambeth's Stop Smoking Service, over cigarette packets on display in local newsagents.

There was a 500% increase in the volume of calls to the smoking cessation helpline. The campaign was extended once the successful volume of calls had been monitored, and contributed to a 75% increase in people setting a date to quit smoking. There was also a 110% increase in the number of people who had managed not to re-start after four weeks.<sup>v</sup>

Without measuring the level of calls enquiring about the service, the project may not have been extended to reach its full potential. By measuring specific breakdown results such as setting a date to quit, and follow-up monitoring of how many people had successfully stayed off cigarettes for four weeks, more detailed information about behavioural habits can be built into future campaigns.

### Case Study 3: Measuring Communications

NHS North West carefully tabulates the results of its media coverage, including responses from patients, and publishes it in association with Millward Brown. The measurement system uses a composite impact measure, described as a 'Media Influence Index'. This takes into account elements such as circulation of each publication (as an article in a high-circulation title will have more impact than a smaller one), percentage of the page occupied by the article, columnar spread (as an article with a large headline will have a higher impact than a smaller one) and the location on the page. Each cutting is attributed a value on these parameters, creating a composite measure of impact. Weekly comparisons then allow trends to be created on how much 'noise' is created by a certain issue, product or company.

The measurements are then used to influence future strategy (for example, the story of the 'awful treatment' of a grandmother at Pendle Community Hospital was eventually influential in replacing the entire management team at the rehabilitation unit<sup>vi</sup>). This technique can be used to evaluate the impact of coverage of selected material on any given target audience.

There are some risks associated with this kind of procedure. Firstly, the kind of 'noise' that is generated is not necessarily a measure of the importance of the topic under consideration. For instance, it does not correlate that negative press attention is an indicator of a trust failing in its duties. There are also cases where a decision has been made for public health reasons, but which appear to the media as something to disagree with.

Secondly, it can lead to skewed results when measures are made in a comparative context. The 'favourable' report that Cumbria 'spends more per head on prescription cancer drugs than other parts of the country' for instance, fails to consider the variables that might make this the case. Perhaps there is a higher incidence of cancers in Cumbria, due to demographics – for example older people going there to retire, that makes the higher spend logical. There are many such factors that could be at the root of this positive story, which the metric cannot take into account.



This leads us to a hard to resolve dilemma with metrics. Firstly, accurate metrics are very difficult to introduce satisfactorily, and depend on a balance of issues; and secondly, one of the problems in NHS delivery is one of perception – often, the true result is hidden behind a number of complicated factors.

However, the Millward Brown Précis approach adopted by NHS NorthWest is a starting point to measure the effects of communications and start to establish causal links between marketing and benefits for the organisation and for patients. It can be a useful indicator of what patients need and want, which can then influence future strategy. It can also help push urgent clinical issues into the public arena and help speed their resolution. NHS Cumbria, for example, plans to deliver more services closer to patients, opening two new centres; a response to tabulated patient surveys, and an indicator of how metrics can be used to assess and introduce what patients want and need, in the right place, at the right time.



Metrics can be used to assess and introduce what patients want and need, in the right place, at the right time.



## Conclusions and suggestions for the future

It's difficult to measure marketing in the NHS for a variety of reasons. There are some metrics that will remain unsuitable for use in the NHS, charity or public sectors – return on equity and share of voice for instance are areas that are valuable in the private sector but not appropriate for an organisation that is not supposed to encourage the creation of 'winners' and 'losers'.

However, the introduction of patient choice and an NHS marketplace makes looking at areas such as

measuring churn important (to find out how many patients are being lost to competitor trusts). If customers choose to avoid a trust, the trust will be in a vulnerable position and it needs to find out why patients do not want to go there. Metrics are one way to identify a need, work out how much it will cost to fulfil that need, and provide information for future strategies. The examples outlined in this paper are therefore intended to be a starting point for how a greater use of metrics could prove the value of marketing to the NHS.

There is a danger in the NHS of measuring too much, and being able to draw too little insight as a result. This is because delivery is driven not only by the 'customer' (be that patient, GP or PCT) but also by political and policy decisions. Therefore, measurements in the NHS tend to be a method of checking progress to a target, rather than a diagnostic tool to understand customer behaviours and modify the offer accordingly.<sup>vii</sup>

Similarly, the NHS is not a clear marketplace for a number of reasons, and all metrics have to be considered in the light of this. The recently published Pharmacy White Paper for example encourages pharmacists to take on some screening currently done by GPs, to free up services further down the line. This distorts pricing policy, but can be used to provide better overall value for the NHS, if conducted in the right way.

However, much is being done to address these scenarios at present and some of the best practice examples in this paper are designed to improve the situation where the NHS has huge quantities of data at its disposal, but has been less able in the past to turn that data into insight that can be used for strategic decision making.

As a result, understanding 'touchstones' will be increasingly relevant in the future, to avoid the problem of too much data and too little understanding. Diagram 1 for example shows how patient experience is one of the three legs of the quality agenda, along with clinical outcomes and performance issues.

For the future, it's important that chief executives take the lead in recognising how private sector metrics can help the NHS and identify how the attitudinal metrics (e.g. satisfaction) can create much more value than seems apparent, or even relevant, at first glance.

For NHS marketers who would like to increase their knowledge of marketing metrics, The Chartered Institute of Marketing offers several one-day workshops – an Introduction to Marketing Metrics, a Marketing Metrics and the Marketing Mix course, and Digital Metrics and Analytics. The Institute also runs a two-day advanced course, Marketing Metrics – Measuring Marketing Performance. To find out more, visit [www.cim.co.uk/training](http://www.cim.co.uk/training) or call **01628 427200**.

# Notes and sources

- i. The Chartered Institute of Marketing (2008) *The real NHS: the benefits of a marketing approach*. Cookham, The Chartered Institute of Marketing.
- ii. The NHS is not a true market as it is a cash limited service. Politically, it is unlikely that a trust would face closure due to marketplace economics, but the point is still valid.
- iii. Kaplan, Robert S. and Norton, David P. (1996) *Balanced Scorecard: translating strategy into action*. Boston, Harvard Business School Press.
- iv. Correspondence with Research and Information, January 2009.
- v. Dr. Foster Intelligence, Lambeth Primary Care Trust.  
<http://www.drfoosterintelligence.co.uk/successStories/detail.asp?caseID=reachingPeople4> [Accessed on 26 February 2009]
- vi. Millward Brown Précis (2008), NHS North West Media Coverage, November.
- vii. For instance, customer insight informs PCTs that 'ending waiting lists' is no longer as important an issue in the public consciousness as it was a few years ago. It is, however, a central pledge of the Government, and so to prove unnecessary waits have been ended, a trust has to spend significant budget that could be better allocated elsewhere on communicating this fact to an audience who may already know the information. On the other hand, MRSA was not a subject of significant public concern until questions were raised about it in Parliament. Whilst evaluated research to set campaigning objectives and associated measurement systems can be put in place, the NHS has the additional stakeholder of politicians to satisfy as well.

# NHS Advisory Group

Members from across the NHS have worked with The Chartered Institute of Marketing in the development of this Paper. We would like to thank the following for their co-operation and involvement, without whom, this Paper would not have been possible:

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## One day workshop

### Marketing to succeed in a competitive NHS

#### Taking marketing into the NHS – be a winner in a competitive market place

Patient choice, a growing range of service suppliers, and changes to service delivery (closer to home) are resulting in a less stable market place. Marketing provides a culture, tools and a process for identifying and meeting these new challenges pro-actively in pursuit of sustaining profitable patient and income flows.

#### The purpose of this course:

To provide an insight into the application of marketing principles to healthcare service provision within the UK secondary care environment. The workshop will examine how marketing can be used to improve care and the patient experience. It will demonstrate how marketing can influence service development, resource planning and financial performance, in a sector where patient choice prevails.

#### You will learn how to:

- Interact and work more effectively with PCTs and practice-based commissioners to improve clinical and financial performance
- Improve the patient experience by developing new services, modifying care pathways and existing services using 'Patient Choice' and 'Payment by Results' as a stimulus to change
- Apply marketing principles to improve resource planning and financial management
- Develop a marketing plan
- Deliver customer/patient focused services
- Use market research and patient referral information to improve service and planning
- Improve reputation based on favourable patient experience by managing service touch points

#### Who this course is for:

This is an introduction programme for those working in NHS organisations seeking to establish a marketing rather than a service focused organisation. This course is for managers and healthcare professionals involved in the development of marketing plans, implementation and/or development of a 'customer centric' culture in NHS organisations.

#### Course information:

7 CPD hours      Format: One day workshop or in-house team programme  
Level: Foundation      Code: 0878

**To book or for more information contact our experienced training advisors on +44 (0)1628 427200 or email [training@cim.co.uk](mailto:training@cim.co.uk)**

## Two day residential course

### Marketing in the NHS – principles and practice for managers

#### The market in healthcare has arrived – what should we be doing?

With the drive for a more personalised and responsive system, the mismatch between supply and demand, and patients turning into consumers, the NHS is rapidly starting to resemble a market in all but name. The techniques involved in surviving and indeed thriving in market-driven environments are applicable across any organisation - including the NHS.

#### The purpose of this course:

The purpose of this course is to learn the key principles that govern how markets work, to identify how they relate to your organisation, and to apply them to the way that you and your team operate. You will have time to think, to learn and to apply the ideas in a way that will work for you. This training uses some of the key principles of marketing as they relate to the provision of healthcare, and enables managers to apply them to some of the key challenges they face in the NHS.

#### You will learn how to:

- Learn and apply the 7 'golden rules' of marketing in a healthcare context
- Create a marketing plan for your department/team, based on a structured environmental analysis and applying the right capabilities to the right strategy in order to achieve objectives that incorporate the rigours of the market
- Create a communications plan that utilises the concept of a marketing mix, targeted at the right 'market', with appropriate objectives and an understanding of potential barriers to communication
- Identify the critical success factors that are important to your customers
- Create an implementation plan that focuses on the most pressing issues, and identifies the biggest potential risks

#### Who this course is for:

This course is aimed at managers who realise that the NHS is becoming more market-focused, and recognise that they need to learn more about how marketing works, in order to help them survive in a rapidly changing public service.

#### Course information:

14 CPD hours      Format: Two day residential course or in-house team programme  
Level: Advanced      Code: 0090

**To book or for more information contact our experienced training advisors on +44 (0)1628 427200, email [training@cim.co.uk](mailto:training@cim.co.uk) or visit [www.cim.co.uk/0090](http://www.cim.co.uk/0090)**

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