

LONDON
SCHOOL of
HYGIENE
& TROPICAL
MEDICINE



LSHTM Research Online

Manacorda, T.; Erens, B.; Black, N.; Mays, N.; (2017) [Accepted Manuscript] The Friends and Family Test in general practice in England: a qualitative study of the views of staff and patients. The British journal of general practice. ISSN 0960-1643 DOI: <https://doi.org/10.3399/bjgp17X690617>

Downloaded from: <http://researchonline.lshtm.ac.uk/3962327/>

DOI: <https://doi.org/10.3399/bjgp17X690617>

Usage Guidelines:

Please refer to usage guidelines at <https://researchonline.lshtm.ac.uk/policies.html> or alternatively contact researchonline@lshtm.ac.uk.

Available under license: <http://creativecommons.org/licenses/by-nc-nd/2.5/>

<https://researchonline.lshtm.ac.uk>

1

2

3 **The Friends and Family Test in general practice in England:**

4 **views of staff and patients**

5

6

7 **Tommaso Manacorda.** Research Fellow, Policy Innovation Research Unit,
8 Department of Health Services Research and Policy, London School of Hygiene
9 & Tropical Medicine, London

10 **Bob Erens.** Associate Professor, Policy Innovation Research Unit, Department
11 of Health Services Research and Policy, London School of Hygiene & Tropical
12 Medicine, London

13 **Nick Black.** Professor of Health Services Research, Policy Innovation Research
14 Unit, Department of Health Services Research and Policy, London School of
15 Hygiene & Tropical Medicine, London

16 **Nicholas Mays.** Professor of Health Policy, Policy Innovation Research Unit,
17 Department of Health Services Research and Policy, London School of Hygiene
18 & Tropical Medicine, London

19

20

21 **Abstract**

22 **Background:** The Friends & Family Test (FFT) was introduced into general
23 practices in England in 2015 to provide staff with information on patients' views of
24 their experience of care.

25 **Aim:** To examine the views of practice staff and patients of the FFT, how the results
26 were used and to recommend improvements.

27 **Design and Setting:** Qualitative study of national representative sample of 42
28 general practices.

29 **Method:** Semi-structured interviews with 43 clinicians, 48 practice managers and 27
30 patient representatives. Interviews audiotaped, transcribed and analysed
31 thematically.

32 **Results:** Although the FFT imposed little extra work on practices, it was judged to
33 provide little additional insight over existing methods and to have had minimal impact
34 on improving quality. Staff lacked confidence in the accuracy of the results given the
35 lack of a representative sample and risk of bias.

36 The FFT question was judged to be inappropriate as in many areas there was no
37 alternative practice for patients to choose, patients' individual needs would not be the
38 same as those of their friends and relatives, and an overall assessment failed to
39 identify any specific aspects of good or poor quality care.

40 Despite being intended to support local quality improvement, there was widespread
41 unease about the FFT, with many respondents perceiving it as a tool for national
42 bodies to monitor general practices.

43 **Conclusion:** If the use of a single item questionnaire is to continue, changes should
44 be made to the wording. It should be focused on stimulating local quality
45 improvement, and practice staff should be supported to use the results effectively.

46 **KEYWORDS:**

47 patient experience; Friends & Family Test; general practice

48

49 **HOW THIS FITS IN**

50 Patient feedback is collected throughout the NHS using a variety of tools, but its
51 contribution to improving quality of NHS services remains unclear^{1,2}. The Friends &
52 Family Test (FFT) was initially implemented in hospitals with the expectation that it
53 would enable patients to choose the best performing providers, but early review
54 showed it was not effective for comparing results across hospitals. Since the FFT
55 showed potential for promoting quality improvement in the acute setting, our study
56 set out to assess whether similar potential exists for the FFT in general practice.
57 While the FFT is shown to be responsive and easy to use, these advantages are
58 outweighed by the inappropriate wording of the FFT question for general practice,
59 the vagueness of its results and the widespread misunderstanding among practice
60 staff about its ownership and purpose.

61 **Introduction**

62 The views of patients on their experience of using health services provides
63 information for quality improvement¹⁻⁴. In England, patients' experience has been
64 measured regularly by national surveys since the late 1990s and the findings form
65 one of five domains of quality in the NHS Outcomes Framework⁵. In primary care,
66 the main national source of data is the annual General Practice Patient Survey⁶.

67 In May 2012, the government in England decided to introduce a Friends and Family
68 Test (FFT) in the National Health Service (NHS) to help patients identify the best
69 performing providers⁷. The FFT was developed in the UK and is based on the net
70 promoter score which was developed in the US for use in commercial settings⁸. It
71 asks customers whether they would recommend a product or service to their friends
72 and family. Answers are recorded on a 5-point scale from "extremely likely" to
73 "extremely unlikely" and this may be followed by an open-ended question asking the
74 reasons for that response.

75 In 2013, the FFT was introduced in NHS acute and maternity hospitals. In July 2014,
76 an NHS England (NHSE) review concluded that while the FFT had only limited value
77 as a metric for performance management, it had potential to promote quality
78 improvement⁹. The open-ended question was seen to be of considerable value and
79 its inclusion became mandatory¹⁰. Throughout 2014 and 2015, use of the FFT was
80 expanded to the rest of health care including general practice. The question to be

81 asked was, “We would like you to think about your recent experience of service. How
82 likely are you to recommend our GP practice to friends and family if they needed
83 similar care or treatment?”

84 The FFT was introduced alongside other existing methods of assessing quality,
85 including significant event analysis, patient experience surveys, complaints and
86 patient participation groups (PPGs) ^{11, 12}.

87 Given that there had been no rigorous published studies of the use of FFT in primary
88 care, our aims were to examine the views of practice staff and patient
89 representatives of the FFT, how the results were used and to recommend
90 improvements.

91 **Methods**

92 *Sampling of general practices*

93 Forty general practices were selected from the 862 practices for which, in October
94 2015, reports from Care Quality Commission (CQC) inspections based on a newly
95 introduced quality rating system for general practice were publically available¹³. Ten
96 practices were elected from each of the four NHS regions. To maximise variation
97 and coverage, practices were selected on size (in quartiles), CQC ratings, location
98 (urban, rural), FFT collection method and FFT response rate. For logistical reasons,
99 42 general practices were eventually recruited (Table 1).

100 *Interviews in general practices*

101 Within each practice, semi-structured interviews were attempted with a clinician (GP
102 or nurse), practice manager (or alternate) and a patient representative from the
103 practice’s Patient Participation Group (or local Healthwatch). In 17 practices, it was
104 not possible to obtain an interview with a patient representative (Table 2).

105 We interviewed 43 clinicians, 48 practice managers and 27 patient representatives
106 (Table 3). The intention was to interview individuals separately to encourage a
107 diversity of views but this was achieved in only 13 practices. In 19 practices, all
108 individuals were interviewed together and in 10 practices there were both paired and
109 separate interviews (typically the clinician and manager were interviewed together,
110 with the patient representative interviewed separately).

111 Practices were approached by letter followed by a phone call, in which the aims of
112 the study were explained. Informed consent was sought from the participants before
113 the interviews took place. Three interview schedules, one for each of the three roles
114 targeted, were developed by the research team and shared with the DH and NHSE.
115 Overall, 84 participants were interviewed face-to-face and 34 by phone. Interviews
116 were undertaken by experienced Ipsos MORI and LSHTM researchers between 5
117 October and 13 November 2015.

118 *Analysis*

119 All interviews were audio recorded and transcribed, except for four interviewees who
120 refused to be recorded and one interview where the recorder failed. Interviewers
121 prepared summary notes based on the interviews in each practice, highlighting the
122 key points to emerge.

123 All transcripts and interviewers' notes were imported into NVivo. A systematic
124 approach to the analysis was employed. This involved the identification of recurrent
125 themes by the lead researcher, which were discussed with the interviewers and
126 research team in order to provide a coding framework for the full interview
127 transcripts. Interpretation of the findings were discussed by the full team to ensure
128 consistency and identify relationships¹⁴. Given the qualitative nature and the sample
129 size of the study, it was not appropriate to explore differences between sub-groups
130 of respondents such as comparing the views of clinicians and patient
131 representatives.

132 **Results**

133 *The FFT question*

134 Most participants thought the FFT question was inappropriate for use in general
135 practice for three reasons. First, there was concern about its phrasing given there is
136 only one general practice accessible in some parts of the country, so there is no
137 choice. Asking a patient to recommend a particular practice appears out of place and
138 is potentially confusing. Moreover, given that patients may have no experience of
139 other practices, it may be difficult for them to make a comparative judgment about
140 their own practice.

141 Second, given the personal nature of health care needs, it is unlikely that friends or
142 family members will have the same needs. Also, the relationship between a patient
143 and practice staff usually plays a role in determining levels of satisfaction, but a
144 patient cannot assume that friends and family will experience a similar relationship.

145 Third, there was concern about the lack of detail in the answers. A practice performs
146 a wide range of activities to respond to the specific needs of each patient, so the
147 anonymised and generic feedback provided by FFT is of limited value in identifying
148 what activity the patient may have found unsatisfactory.

149 *I can understand if you are in a city, and you've got choices [...] But if you are in a village or in a very rural area it's a completely pointless exercise. [Patient representative]*

150 *Well I'm not sure recommending the practice is the most important issue to patients, is it, whether they'll recommend it to someone else? The most important issue to them is whether or not they've got a good GP and they feel like they're going to be looked after properly. [Patient representative]*

151 *Unless they come and tell you their name, I can't follow it up. I can't make it better because it's not specific enough for me to be able to think, right, OK, on that day this is what happened. [Practice Manager]*

152 *Understanding the aim of the FFT*

153 Staff were often unclear about the reasons for implementing the FFT. Many
154 assumed that it was collected by national bodies (e.g. NHSE, DH), to monitor the
155 quality of care provided and possibly to take action where results were poor. The
156 mandatory requirement to provide monthly returns was perceived as evidence of
157 this. Even the FFT forms and collection box could be perceived as “belonging” to the
158 government, being placed in the practice by NHSE to pursue its own ends.

159 This widespread belief was associated with staff generally perceiving the FFT as
160 something they were required to do on behalf of government rather than in the
161 interests of the practice. In fact, the only reason for implementing the FFT for many
162 practices was to comply with contractual requirements.

Because it's mandatory. [...] Because we've been told its contractual, and it has to be reported though CQRS every month. [...] We're given the dates on which the data has to be in. Why do they want the data? Well I guess it's a measurement of how good, bad or indifferent the practice is from the central point of view [Practice Manager]

163

164 This perception generated unease, given staff's doubts about the validity of the data
165 collected. There was a consensus that the low number of responses at practice level
166 meant that FFT results were unlikely to be representative of practice patients or to
167 provide reliable indicators of service quality. There was awareness that the patients
168 who completed the FFT were self-selected or, maybe, chosen by staff (where paper
169 forms were used). There was concern that a few critical comments might provide a
170 distorted picture, while others pointed out that positive feedback could be influenced
171 by the asymmetry of information or the power imbalance between the practice and
172 its patients.

173 *FFT and the gatekeeping role*

174 The perception of the FFT as a centralised monitoring tool, combined with the very
175 low response rate casting doubt on the generalisability of the results, contributed to
176 the view that its use was susceptible to patients who wished to "punish" practices by
177 giving a low FFT rating if they did not get what they felt they needed or wanted. This
178 perception highlights a potential conflict with the practice's gatekeeping role and
179 perhaps resonates with a wider range of policies in which practices are increasingly
180 requested to act as patients' agents in a quasi-customer/retailer relationship.

It is a measurement of client, patient happiness as to [whether] the consultation's gone the way that they wish it to [...] So if I could get someone to give me a two from refusing an inappropriate antibiotic, well, that's clever of me. But, yeah, it's not a measure of the efficiency of service. [General Practitioner]

181

182 Some even felt that the implementation of the FFT responded to a political decision
183 to punish GPs.

They're trying to show the public that the Government is going to beat primary care with a big stick. [Practice Manager]

184

185 *The FFT and other feedback collection tools*

186 Many interviewees felt the FFT provided little information of value, especially for
187 practices which had other ways of collecting patient feedback. A large number
188 mentioned their practice's own patient survey as being more effective in identifying
189 shortcomings in quality. Other types of feedback included formal complaints and the
190 quality of their personal relationships with patients.

191 Moreover, the open-ended comments were reported to be quite generic and lacking
192 detail, which reduced their value in identifying and addressing quality issues.

193 *It's not telling us anything we don't already know. If the practice can't make use of it, I don't see the point in collecting it. Because we do surveys twice a year, a more detailed survey where you're asking specific questions. [Practice Manager]*

194 *I think the other surveys we do are probably a little bit more detailed so you get down to more specific information if there is a problem. [...] The [FFT] comments are quite generic, so there's no real... you don't get the detail of information that probably would influence you to make changes, as of yet. [Practice Manager]*

195 *Impact of the FFT*

196 In only four of the 42 practices were positive views about the FFT expressed and in
197 only one was an example of how the results had led to improved quality mentioned.

198 *There's nothing wrong with that little questionnaire other than it's useless [General Practitioner]*

199 *There was one comment we had about somebody with difficulty getting a wheelchair from the car park, so we used that to ensure the landlord changed the way the ramp is in the car park, so it gave us a bit of ammunition and it worked as a leverage to allow change for the better. [Practice Manager]*

200 *Quality improvement in General Practice*

201 On a more general note, we observed significant variability in the extent to which
202 general practices are committed to using quality assessments for quality
203 improvement. A few practices were well advanced having set up effective PPGs and
204 appeared to make good use of local surveys. Other practices, however, seemed to
205 struggle in this respect, partly reflecting resistance to change, and limited resources
206 and knowledge as how to respond to assessments showing less than optimal quality.

207 **Discussion**

208 *Summary*

209 Although the FFT imposed little extra work on practices, it was judged to provide little
210 additional useful insight over existing methods and to have had little or no impact on
211 helping to improve the quality of services. Staff lacked confidence in the accuracy of
212 the results given the low response rate and unrepresentative nature of respondents.

213 The question used in the FFT was judged to be inappropriate as in many areas there
214 was no alternative practice for patients to choose, patient's individual health care
215 needs would not be the same as those of their friends and relatives, and asking for
216 an overall assessment failed to identify any specific aspects of good or poor quality
217 care.

218 Despite being intended to support local quality improvement, there was widespread
219 unease about the FFT with many respondents perceiving it as a tool for national
220 bodies to monitor (and criticise) general practices.

221 *Limitations*

222 There were four limitations. First, the participating practices collected on average a
223 larger number of FFT responses than all practices in England, suggesting that they
224 were more engaged with FFT than those that did not participate. So it is possible that
225 respondents were more positive than might be found throughout primary care. Given
226 the generally negative tone detected, our results might overestimate the support for
227 FFT. Second, patient representatives' views were those of people who were involved
228 to some degree in the running of a practice. Their views may not, therefore, be
229 typical. Our failure to interview a patient representative in some practices may reflect
230 staff achieving less patient engagement. Such practices might be less concerned
231 about the views of their patients which might mean the views we did obtain over-
232 estimate support for FFT. Third, we sought and report the perceptions of staff rather
233 than observing what takes place, which might be different. Fourth, the fact that
234 interviews in practices included both clinical and non-clinical staff, and occasionally
235 patient representatives as well, may explain why we did not find significant
236 differences in views between different types of interviewees.

237 *Comparison with existing literature*

238 Despite the significant differences in implementation, namely the absence of targets
239 and financial incentives associated with achieving higher response rates, many of
240 the concerns and views about the FFT expressed by staff and patients in general
241 practice are consistent with those previously observed in acute hospitals. Past
242 hospital research showed that the FFT is vulnerable to selection bias, making the
243 quantitative data unfit for comparisons across providers^{9, 15}. It was also found that
244 managers from acute and community trusts believed that excessive emphasis was
245 put on the central assurance process rather than on enabling local analysis of
246 qualitative data and quality improvement¹⁶.

247 *Implications for policy and practice*

248 We believe that the principal policy challenge to address is whether to persist with
249 the FFT (or a similar single item questionnaire) or not. If such an approach is
250 favoured, this study suggests there are four ways to enhance its value.

251 First, the content of the FFT could be changed. A simpler and more straightforward
252 question that does not include a reference to “recommendation to friends and family”
253 would probably provide a better measure of patients’ experiences. In addition, the
254 data generated could be of greater use for quality improvement if practices would be
255 encouraged to collect patients’ views on specific aspects of services. Obtaining
256 feedback on topics of concern for a practice could work as a quick diagnostic tool to
257 make staff aware that a problem exists when negative and consistent feedback is
258 received, and would provide more detailed and timely information on existing quality
259 issues, possibly filling the gaps that may be left uncovered by other approaches.

260 Second, there is a need to improve practice staff understanding of the purpose of the
261 FFT. The mechanism of monthly data returns seems to be one of the main factors
262 leading to the confusion about the purpose of the FFT. This has also hindered the
263 perception of the FFT as a tool that belongs to the general practices and that can
264 help them improve their services. Considering the limited usefulness of the
265 quantitative data provided by the FFT, the DH and NHSE may reduce or eliminate
266 monthly reporting in order to encourage local ‘ownership’ and use of the FFT. The
267 more demands are made by the centre, the less the feelings of local ‘ownership’.
268 Removing mandatory monthly reporting would dispel the idea that the FFT was
269 meant to be used by “difficult” patients against practices, which was disheartening for

270 many, and would avoid any contradiction between practices' gatekeeping role and
271 their desire to satisfy their patients. Asking for reports on the quality improvement
272 activities carried out by general practices might be a suitable alternative.

273 Finally, there is a need to increase the capacity of general practices to manage
274 quality, that goes beyond the use of FFT. Support and guidance on how to set up
275 local surveys and PPGs, and how to maximise their contribution to quality
276 improvement initiatives should be part of any strategy. Suggestions about how to
277 improve quality were included in the FFT implementation guidance for NHS funded
278 services, but not in that provided for general practices, which may benefit from
279 specific guidance on this aspect ^{10, 17}. A body of literature exists on effective methods
280 and techniques that can be used in general practices to improve quality ¹⁸, and more
281 could be generated from further research.

282

283

284

285

286

287

288

289

290

291 Funding: This study is part of the programme of the Policy Innovation Research Unit
292 (<http://www.piru.ac.uk/>). This is an independent research unit based at the London
293 School of Hygiene and Tropical Medicine, funded by the Department of Health Policy
294 Research Programme (contract 102/1001). Sole responsibility for this research lies
295 with the authors and the views expressed are not necessarily those of the
296 Department of Health. The Department of Health played no role in the design of the
297 study, the interpretation of the findings, the writing of the paper, or the decision to
298 submit.

299

300 Ethical approval: Granted by the Research Ethics Committee of the London School
301 of Hygiene & Tropical Medicine (REC reference 10283). As the study was eligible for
302 Cohort 1 of the stepped implementation of Health Research Authority Approval
303 process, permission for all NHS sites involved in the study was granted through a
304 single application. The application was made through the IRAS online form (IRAS
305 Project ID: 186617) and approved by HRA on 26th August 2015.

306 Competing interests: None

307 Acknowledgements: The authors would like to thank the members of staff and
308 patient group representatives in all the general practices who kindly agreed to give
309 up their time to be interviewed for this project. We would also like to thank the
310 research team at Ipsos MORI – Debbie Lee Chan, Rory Donaldson, Harriet Fowler,
311 Josie Lloyd and Ewa Ochmann – for their significant contribution to developing and
312 testing the interview topic guides, carrying out the fieldwork with general practices,
313 preparing summaries of the interviews and for their observations and discussion of
314 the emerging findings.

315

316 **References**

- 317 1. Boiko O, Campbell JL, Elmore N, et al., *The role of patient experience surveys in quality*
318 *assurance and improvement: a focus group study in English general practice*. Health Expect,
319 2015. **18**(6): p. 1982-1994.
- 320 2. Asprey A., Campbell JL, Newbould J, et al., *Challenges to the credibility of patient feedback in*
321 *primary healthcare settings: a qualitative study*. Br J Gen Pract, 2013. **63**(608), e200-e208
- 322 3. Carter M, Davey A, Wright C, et al., *Capturing patient experience: a qualitative study of*
323 *implementing real-time feedback in primary care*. Br J Gen Pract, 2016.
- 324 4. Department of Health, *NHS Patient Experience Framework*. 2012, Department of Health:
325 London.
- 326 5. Department of Health, *NHS Outcomes Framework 2016 to 2017 at-a-glance*. 2016,
327 Department of health: London.
- 328 6. Ipsos MORI. *GP Patient Survey*. Available from: gp-patient.co.uk.
- 329 7. Prime Minister's Office, *Hospital "Friends and Family Test" announced*. 2012.
- 330 8. Reichheld FF, *The one number you need to grow*. Harvard business review, 2003. **81**(12): p. 46-
331 55.
- 332 9. NHS England, *Review of the Friends and Family Test*. July 2014.
- 333 10. NHS England, *Friends and Family Test: Guidance*. 2015.
- 334 11. Wright C, Davey A, Elmore N, et al., *Patients' use and views of real-time feedback technology*
335 *in general practice*. Health Expect, 2016.
- 336 12. The Health Foundation, *Measuring patient experience*, in *Evidence scan*. 2013.
- 337 13. Care Quality Commission, *Annual report and accounts 2014/15*. 2015. p. 10.
- 338 14. Pope C, Ziebland S, Mays N, *Analysing qualitative data*. BMJ: British Medical Journal.
339 2000;320(7227):114-116.
- 340 15. Sizmur S, Graham C, and Walsh J, *Influence of patients' age and sex and the mode of*
341 *administration on results from the NHS Friends and Family Test of patient experience*. J Health
342 Serv Res Policy, 2015. **20**(1): p. 5-10.
- 343 16. Membership Engagement Services, *Making sense and making use of patient experience data*.
344 2015.
- 345 17. NHS Employers, B.M.A., NHS England, *Friends and Family Test in General Practice Guidance*.
346 2014.
- 347 18. Royal College of General Practitioners, *Quality improvement for General Practice: A guide for*
348 *GPs and the whole practice team*. 2015

Table 1. Characteristics of general practices selected by region

Characteristic	Value	Regions				
		North	Midlands and East	London	South	Total
Practice list size	<i>Quartile 1 (up to 4454 patients; n=215)</i>	6	4	2	1	13
	<i>Quartile 2 (4455 to 7284 patients; n=216)</i>	0	1	2	2	5
	<i>Quartile 3 (7285 to 10523; n=217)</i>	2	5	4	3	14
	<i>Quartile 4 (over 10524 patients; n=214)</i>	2	1	3	4	10
No. FFT responses	<i>Bottom quartile (over 165 responses; n=217)</i>	1	2	3	1	7
	<i>Top quartile (less than 28 responses; n=214)</i>	2	4	7	5	18
CQC rating	<i>Outstanding (n=30)</i>	1	2	1	1	5
	<i>Good (n=712)</i>	7	7	8	6	28
	<i>Requires improvement (n=87)</i>	2	1	2	2	7
	<i>Inadequate (n=33)</i>	0	1	0	1	2
Location	<i>Rural</i>	1	6	0	6	13
	<i>Urban</i>	9	5	11	4	29
Collection method	<i>Paper (n=752)</i>	10	10	8	10	38
	<i>Tablet/ Kiosk (n=92)</i>	2	3	2	1	8
	<i>SMS/Text Message (n=118)</i>	2	2	4	2	10
	<i>Telephone Call (n=49)</i>	1	0	2	2	5
	<i>Smartphone App/ Online (n=302)</i>	4	2	3	6	15
At least 1 month not submitting (Jan-May 2015) (n=610)		6	7	9	6	28
Total		11	10	11	10	42

Table 2: Number of practices participating by NHS region and by category of interviewee

Interviewees	North	Midlands and East	London	South	Total^a
Clinician, manager and patient	8	6	5	6	25 (82)
Clinician and manager	2	4	5	4	15 (31)
Manager only	0	1	1	0	2 (5)
Total	10	11	11	10	42 (118)

^a *Number of individuals interviewed reported in brackets*

Table 3: Numbers of clinicians, managers and patients interviewed, by NHS Region

	North	Midlands and East	London	South	Total
Clinicians	11	10	12	10	43
GP	4	6	10	7	27
Nurse	7	3	1	3	14
Other clinical staff	0	1	1	0	2
Managers	11	13	13	11	48
Practice manager	10	11	10	9	40
Other administrator	1	2	3	2	8
Patient representative	9	6	5	7	27
PPG rep	7	6	3	6	22
Healthwatch rep	2	-	2	1	5
Total	31	29	30	28	118