

# Implementation and use of the Friends and Family Test as a tool for local service improvement in NHS general practice in England

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## Summary

### Background

Since its announcement in 2012, the Friends and Family Test (FFT) has been rolled out across the English NHS, starting with inpatient, A&E and maternity settings in 2013. In July 2014, a review by NHS England (NHSE) on how the FFT was working noted that the value of the FFT as a tool for quality improvement outstrips its utility for performance management or for informing patient choice. These findings, along with pilot testing, informed the guidance set out for implementing the FFT in general practices (December 2014), mental health and community health services (January 2015), and dental practices, outpatient services and ambulance trusts (April 2015).

The FFT in general practice consists of a single question: “We would like you to think about your recent experiences of our service. How likely are you to recommend our GP practice to friends and family if they needed similar care or treatment?” Answers are recorded on a 5-point scale from “extremely likely” to “extremely unlikely”. This is followed by an open-ended follow-up question asking why the patient gave the particular response.

The Department of Health commissioned PIRU to investigate whether and how the FFT contributes to the improvement of services in general practice. The two principal aims were to examine: how the collection of the FFT is arranged within general practice; and how the FFT quantitative and qualitative data are used by local staff for quality improvement, particularly within the wider context of other approaches to improvement that have been promoted within general practice within the past few years.

### Methods

The project involved semi-structured qualitative interviews with staff from a purposive sample of 42 general practices distributed throughout the four NHSE regions. In addition, interviews were conducted with staff in four NHSE regional teams, two innovative practice organisations and the Royal College of General Practitioners. Within each practice, the target was to complete three interviews: one with a clinician, one with the practice manager or another administrator and one with a representative of the practice’s Patient Participation Group (PPG). One hundred and thirty-four individuals were interviewed in the study.

### Results

Practice staff found the FFT to be easy to implement and to require few additional resources. Nonetheless, practices were not very engaged with the FFT and rarely did more than the minimum required contractually. The purposes of collecting the FFT were often unclear to staff, with many believing that the FFT was intended for performance management, leading to a general lack of local “ownership” of data collection. The FFT was perceived by the majority of staff as a process carried out locally on behalf of DH/NHSE.

FFT quantitative data were considered to lack accuracy as the patients who responded were few in number and generally self-selected, thus producing a biased sample. Moreover, the reference to a “recommendation” in the FFT question was deemed by most interviewees to be inappropriate for general practice because the relationship between practice staff and patients is personal and complex. The free text comments were considered by staff to lack sufficient detail to identify quality of care issues in a way that would enable them to be addressed.



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Positive effects of the FFT on staff morale were reported but several interviewees were frustrated that they could not act on the negative feedback that patients sometimes provided since it was generally anonymous. Overall the impact of the FFT on quality improvement was negligible and other tools (such as practice surveys and patient participation groups) were said to provide better patient feedback and be more helpful for quality improvement.

### **Conclusions**

If a single item instrument, such as the FFT, is to be used to stimulate quality improvement in general practice, then its impact could be improved in four ways by: enhancing the general capacity for managing quality in practices; changing the content of the FFT; improving practice staff understanding the of purpose of FFT; and altering the national reporting requirements.





## 1. Introduction

Obtaining feedback from patients on their experience of using health services is an important indicator of quality of care and an important source of information for improving the care provided. Patient experience of care is included as one of five domains in the NHS Outcomes Framework, and has been measured by national patient experience surveys in England since the late 1990s. More recently, in May 2012, the Prime Minister announced the use of the Friends and Family Test (FFT) in NHS acute hospitals, and since then it has been rolled out to other types of providers. It provides a mechanism for capturing patient feedback in “real time” and is intended to complement patient experience surveys. The current Government mandate to the NHS refers to ensuring that the FFT is used effectively, alongside other sources of feedback, to improve services (Department of Health December 2015).

The FFT is based on a measure developed in the US for the private sector, which asked customers whether they would recommend a product or service to their friends and family (Reichheld 2003). The FFT used by the NHS consists of a single quantitative question:

- “How likely are you to recommend our <ward/A&E department/practice/etc.> to friends and family if they needed similar care or treatment?”

Answers are recorded on a 5-point scale from “extremely likely” to “extremely unlikely”. This is followed by an open-ended question asking why the patient gave a particular response. While providers are free to set a follow-up question of their choice, the initial implementation guidance included several suggestions such as:

- “Please can you tell us the main reason for the score you have given?”;
- “Please can you tell us why you would/would not recommend us to your Friends and Family?”;
- “What was good about your visit?”;
- “What would have made your visit better?”;
- “Can you tell us why you gave that response?”.

NHS England (NHSE) committed to reviewing how the FFT was working six months after it had been implemented in inpatient, A&E and maternity settings. That review (NHS England July 2014) highlighted a number of strengths and limitations, based on the findings of quantitative analysis of FFT data and qualitative research on the implementation, reception and use of the FFT in clinical settings. In particular, the review noted that the value of the FFT as a tool for local quality improvement outstrips its utility for performance management or for informing patient choice. Moreover, it raised the question as to whether the FFT is capable of meeting all the objectives it was originally set and noted that different tools are likely to be needed to meet different requirements.

The review’s recommendations aimed to establish the value of the FFT as a tool for quality improvement (i.e. for formative rather than summative purposes). Several of the recommendations were incorporated in guidance published in July 2014, which outlined the next steps for implementation of the FFT. In particular, the finding that the free-text feedback is essential for local improvement informed the requirements set out for rolling-out the FFT to additional types of provider, so that the collection of the free-text follow-up question is now mandatory.



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Since the review, the FFT has been introduced in general practice (December 2014), mental health and community health services (January 2015), dental practices, outpatient services and ambulance trusts (April 2015). In these settings, NHS providers have been given the flexibility to implement the FFT in a way that best suits their organisations. It is hoped this will lead to local “ownership” of the FFT and greater engagement with the feedback. The way patients engage with services outside hospitals means the way FFT is implemented needs to be different. The Department of Health (DH) and NHSE, therefore, were keen to investigate how the FFT was working in these new settings with a view to potentially making changes and issuing new guidance in the course of 2016.

The DH commissioned PIRU to investigate whether and how the FFT contributes to quality improvement within general practice. NHSE and DH were interested in understanding: how the FFT was implemented within general practice and why particular approaches were adopted; whether particular approaches work better in different settings or for particular patients and whether particular approaches make it more or less easy for general practice staff to engage with the FFT.

The two principal foci of the PIRU project were:

- to examine how the collection of the FFT, and in particular the qualitative comments, was arranged by providers; and
- how the FFT quantitative and qualitative data were used by general practice staff for quality improvement, particularly within the wider context of other approaches to quality assessment that have been promoted within general practice, including the adoption of a local patient experience survey and the setting up of a patient participation group (PPG) in each practice.



## 2. Methods

This was a qualitative study based on interviews with staff from a purposive sample of general practices and the four NHSE regional teams. Alongside staff views, we also sought to obtain the views of patient representatives, particularly those involved in PPGs. In addition, to assist our understanding of context, the views of two representatives of the Royal College of General Practitioners (RCGP) and staff from two general practices that were part of larger and more complex organisations were sought.

### Sample frame of general practices

A purposive sampling frame of general practices was compiled by the research team by matching two lists: the list on the NHSE website showing FFT monthly returns for each practice; the list on the Care Quality Commission (CQC) website showing CQC ratings based on current inspection methods (begun in late 2014). While the first list includes nearly all practices in the country ( $n=7,924$ )\*, at the time of recruiting in October 2015, only a small proportion of those practices had their inspection reports publicly available on the CQC website ( $n=862$  practices); so it was only these latter 862 practices that were included in our sampling frame.

The target was for interviews to be carried out in 40 general practices, 10 in each of the four NHS regions: North, Midlands and East, London, South (excluding London). Further quotas were set within each region as follows:

- At least 1 practice within each quartile of list size ( $Q_1$  = up to 4461 patients;  $Q_2$  = 4462 to 7246 patients;  $Q_3$  = 7247 to 10477 patients;  $Q_4$  = over 10477 patients).
- At least 1 practice within each of the 4 CQC ratings (Outstanding = 30; Good = 712; Requires improvement = 87; Inadequate = 33).
- At least 1 practice located in an urban area and 1 in a rural area (aside from the London region), according to the RUC2011 classification provided by ONS (ONS 2011).
- At least 2 practices collecting the FFT using paper questionnaires, 2 using a tablet/kiosk method of collection, and 2 using SMS/text message for collection.
- At least 1 practice in the top quartile (i.e. 162 responses or more) and at least 1 in the bottom quartile (i.e. under 28 responses) for number of aggregated responses in the five months of January through May 2015.

Furthermore, at a national level, the quotas were to include:

- At least 4 practices who did not submit any data in at least 1 of the 5 months (January through May 2015).
- At least 1 practice collecting their FFT through telephone calls.
- At least 1 practice collecting their FFT through a smartphone app or online.

*Within each practice*, the target was to complete 3 semi-structured qualitative interviews: 1 with a clinician (GP or nurse); 1 with the practice manager (or another administrator who is aware of how the FFT is implemented by the practice); and 1 with a representative of the practice's Patient Participation Group (PPG) (or someone from the local Healthwatch if a PPG interview was not possible).

\*This list included all practices in the General Practice FFT dataset published by NHS England covering the period January to May 2015.



**Table 2.1 Number of participating practices per quota control by NHS region**

<i>Base:</i> <i>General Practices</i>	North	Midlands and East	London	South	Total
<b>Practice List Size</b>					
Quartile 1	6	4	2	2	<b>14</b>
Quartile 2	0	1	2	2	<b>5</b>
Quartile 3	2	5	4	2	<b>13</b>
Quartile 4	2	1	3	4	<b>10</b>
<b>CQC rating</b>					
Outstanding	1	2	1	1	<b>5</b>
Good	7	7	8	6	<b>28</b>
Requires improvement	2	1	2	2	<b>7</b>
Inadequate	0	1	0	1	<b>2</b>
<b>Urban/rural</b>					
Urban	9	5	11	4	<b>29</b>
Rural	1	6	n.a.	6	<b>13</b>
<b>Collection method*</b>					
Handwritten	10	11	10	9	<b>40</b>
Tablet/kiosk	1	1	2	2	<b>6</b>
Sms/text	1	2	4	2	<b>9</b>
Telephone	1	0	1	0	<b>2</b>
App or online	4	4	3	5	<b>16</b>
<b>FFT responses</b>					
Quartile 1	1	2	3	1	<b>7</b>
Quartile 4	2	3	7	5	<b>18</b>
No submission**	7	8	5	6	<b>26</b>
<b>Total</b>	<b>10</b>	<b>11</b>	<b>11</b>	<b>10</b>	<b>42</b>

\* Practices could use more than one method of data collection.

\*\* No FFT data submitted in at least 1 month between January 2015 and May 2015.

Interviews were to be carried out individually and face-to-face, although interviewing the clinician and practice manager together was permitted if the practice requested this, as were telephone interviews if circumstances required (e.g. due to short notice).

Ipsos MORI was contracted to carry out the recruitment and fieldwork for the 40 general practices. Recruitment began on 7 September 2015 and interviewing was carried out between 5 October and 13 November 2015. In all but 2 of the 42 participating general practices, at least 2 interviews were carried out. The profile of these 42 practices is shown in Table 2.1.



Interviews with individuals representing all three roles were achieved in 25 practices, while in 15 practices individuals covering 2 roles were interviewed, and in 2 practices it was only possible to interview administrative staff. Overall, 118 individuals were interviewed in the 42 practices. The details are shown in Table 2.2 by region.

**Table 2.2 Number and types of individuals interviewed per practice by NHS region**

**Base: General Practices**

	North	Midlands and East	London	South	Total Practices (Individuals*)
Clinical and administrative staff, and patient representative	8	5	5	7	<b>25 (82)</b>
Clinical and administrative staff only	2	5	5	3	<b>15 (31)</b>
Administrative staff only	0	1	1	0	<b>2 (5)</b>
<b>Total</b>	<b>10</b>	<b>11</b>	<b>11</b>	<b>10</b>	<b>42 (118)</b>

\* In some practices, several individuals covering the same role were interviewed, e.g. both practice manager and deputy practice manager.

As is apparent from Table 2.2, it was most difficult to arrange interviews with patient representatives. This was achieved in 25 practices; in 21 it was the PPG representative who was interviewed, while in the other 4 the interview was with a member of the local Healthwatch.

### Additional interviews

Interviews were also carried out by the PIRU research team to obtain the views of NHSE commissioners, the national professional organisation (RCGP) and those involved in some innovative primary care organisations.

NHSE Regional Teams have a role in commissioning general practices, and are responsible for supporting the implementation of the FFT across all NHS services/providers. Eleven staff members from the Regional Teams were interviewed, distributed as follows: NHSE North (4), NHSE Midlands and East (3), NHSE London (2) and NHSE South (2).

Two representatives from the RCGP were identified through relevant publications and interviewed.

The views and experiences of innovative primary care organisations (such as networks or federations) were also sought, since they may have higher level and/or more structured approaches for obtaining patient feedback and for quality improvement. They may also be in the forefront of digital data management. Three representatives from two innovative practices were interviewed: a practice manager and IT managers from a Multispecialty Community Provider, and a GP from a multi-practice organisation.

### Interviews with practice staff

The topic guide was developed by the PIRU research team in consultation with the researchers at Ipsos MORI and the policy team at DH and NHSE. Although there was considerable overlap between them, there were separate topic guides for: clinical staff; practice managers/administrators; and PPG representatives. The three topic guides are included in the Appendix.



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The topic guides were piloted by members of the PIRU and Ipsos MORI research teams at three general practices in October 2015. Following the pilot, a number of changes were made to the topic guides to include questions on additional issues that emerged.

Interviews were designed to take about 30 minutes per person. In practice, interviews with practice managers/administrative staff often lasted longer, while those with clinical staff were generally somewhat shorter.

The original preference was to separately interview individuals within each practice to encourage a diversity of views, and this was possible in 11 practices. In 20 practices, all individuals were interviewed together for practical reasons, and in the remaining 11 practices, there were both paired and separate interviews (typically the clinical and administrative staff were interviewed together, with the PPG representative interviewed separately).

### **Data analysis**

All interviews carried out by Ipsos MORI were audio recorded and transcribed, except in 4 cases where interviewees refused to be recorded and 1 case where the recorder failed. Interviewers from Ipsos MORI also prepared summary notes based on the interviews in each practice, highlighting the key points to emerge. The interviews carried out by PIRU were not audio recorded, but detailed notes were taken.

All transcripts and interviewer notes were imported into NVIVO and recurrent themes were identified by the lead PIRU researcher to help develop a coding frame. This process highlighted a number of key topics, which were then discussed and summarised in a concise topic list by the full research team. This concise topic list provided the framework used to code the full interview transcripts; it has also been used to structure the findings of this report.

FFT data at general practice level, available on the NHSE website (NHS England 2015), were analysed (using MS Excel) to provide a picture of the number of FFT returns and how this varied by method of data collection.

Practices were grouped into quartiles according to the total number of FFT returns submitted between January and May 2015, and the mean number of returns was calculated.

### **Ethical approval**

Ethical approval to undertake the study was granted by the Research Ethics Committee of the London School of Hygiene & Tropical Medicine (REC reference 10283).

As the study was eligible for Cohort 1 of the stepped implementation of Health Research Authority Approval process, permission for all NHS sites involved in the study was granted through a single application. The application was made through the IRAS online form (IRAS Project ID: 186617) and approved by HRA on 26th August 2015.



### 3. Results

#### Routine response data from NHSE

It must be kept in mind that the FFT does not aim for a representative response from patients, so obtaining high response rates is not essential for it to achieve its purpose. It is rather seeking to identify particular problems or concerns rather than provide an accurate estimate of their frequency. The number of responses provides an indication of how actively the FFT is promoted by particular practices and thus of the level of engagement of practice staff in assessing patients' experiences.

Data published by NHSE about returns for the FFT in general practice suggest that the level of engagement was generally very low.

The mean number of FFT responses that general practices returned monthly to NHSE in the period January to May 2015 was 27.1. The lowest quartile reported 3.0 per month while the best performing quartile reported 71.0.

**Table 3.1 Overall and monthly mean number of FFT responses reported to NHSE\* by all general practices and by the study sample practices between January and May 2015, by total response quartile**

*Base: FFT Responses*

Total Response Quartile:	Sample Practices		All Practices	
	Mean total responses (Jan-May 2015)	Mean monthly responses	Mean total responses (Jan-May 2015)	Mean monthly responses
1st Quartile	17.4	3.5	14.9	3.0
2nd Quartile	56.4	11.3	53.2	10.6
3rd Quartile	124.4	24.9	115.8	23.2
4th Quartile	384.6	76.9	354.9	71.0
<b>All</b>	<b>198.0</b>	<b>39.6</b>	<b>135.3</b>	<b>27.1</b>

Source: NHS England

Table 3.1 shows that practices' willingness to participate in our study was associated with the number of responses they had collected at the time of recruitment. Those getting a higher number of FFT responses were more likely to participate. It is likely, therefore that the views expressed by the staff in the study sample are more positive about FFT than the average.

The NHSE data in Table 3.2 show that the preferred collection method for FFT was a paper questionnaire (handwritten), used by the majority of practices either alone (3262 practices out of 7924; 41.2%) or in combination with a smartphone app or other online tool (1550 practices; 19.6%).

\*Several interviewees, including those from NHSE Regions, explained that technical difficulties using the Calculating Quality Reporting Service (CQRS) for submitting FFT data prevented some practices from returning their results.



**Table 3.2** Number of FFT collection methods used within GP practices by type of collection method. January to May 2015

<i>Base: GP Practices</i>	Handwritten	Smartphone app/online	Tablet/kiosk	Sms/text message	Other	Telephone call	Total
One method	3262	40	88	55	16	2	3463
Two methods	2612	1606	353	368	268	159	2683
Three methods	832	690	253	263	353	123	838
Four methods or more	168	148	95	94	130	78	171
No method specified	–	–	–	–	–	–	769
<b>Total</b>	<b>6874</b>	<b>2484</b>	<b>789</b>	<b>780</b>	<b>767</b>	<b>362</b>	<b>7924</b>

Source: NHS England

As Table 3.3 shows, SMS/text message methods generated the largest number of responses on average.

**Table 3.3** Total and monthly average number of FFT responses reported to NHSE by type of FFT collection method. January to May 2015

<i>Base: FFT Responses</i>	Total responses	Average monthly responses
Sms/text	138,338	35.5
Handwritten	555,895	16.2
Tablet/kiosk	48,909	12.4
Telephone call	9,490	5.2
App/online	40,350	3.2
Other	13040	3.4
Unspecified*	265,911	11.2
<b>Total</b>	<b>1,071,933</b>	<b>27.1</b>

Source: NHS England

\* Includes all responses from the 769 GP practices for which no collection method is known, and responses whose collection method was not specified in other practices.





## Implementing the FFT

### Ease of use

Many staff, including some who were quite critical, acknowledged that the FFT was easy to administer and were appreciative of the short time required for patients to complete it.

*I think it's well put together, I think the cards are nice and simple, they're easy to understand, it's very quick to fill out for those that do fill it out. So in that respect it is very straightforward, it's not something they have to take away and bring back, they can sit and do it in 30 seconds in the waiting room. [Practice Manager]*

*Q: Is there anything you particularly like about the Friends and Family Test at all?*

*A: No.*

*Q: No?*

*A: I think it's quite simple, isn't it, you know [Practice Manager]*

### Collection methods

Consistent with the national results described above, 38 of the 42 sample practices used handwritten FFT collection methods, 17 as a single method. The dominance of handwritten collection methods is not surprising, given that NHSE made available to all practices an FFT “starter kit”, which included sample FFT cards and a collection box.

Typically, the FFT box provided by NHSE was located in the waiting room, often close to the reception desk, with a number of forms beside it. The FFT box and cards would often share the space with other leaflets and papers offered to patients, which sometimes reduced their visibility.



Several managers explained that the handwritten method was chosen as the easiest and cheapest to implement. They often mentioned the materials provided by NHSE as being helpful, and sometimes mentioned that, without any additional payment attached to FFT collection, they did not have the resources necessary for more sophisticated collection methods.

*A: We just thought it was the easiest thing to do.*

*Q: And is that in terms of the patients' completing it or in terms of being able to hand it out?*

*A: In terms of being able to hand it out. [Practice Manager]*

*We decided we would just stick with the cards and the paper. I don't know whether, if I was able to put it on my clinical system on my touch screen, patients might use it, but I wasn't going to go to the expense of an iPad to do it. [...] if there'd been great benefit to the practice I would have invested, but to me there wasn't great, to go out and buy an iPad, there wasn't great, there was no benefit. I was going to get nothing back for that. So we decided that we'll put some posters on the wall, we've got a lights channel, we put it on the lights channel. It's on the GX board, and for the first, probably the first two months, every patient that came in was asked. But that's waned quite a bit since then. [Practice Manager]*



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While it was recognised that handwritten FFT was an easy and cheap collection method, these advantages could be outweighed if a large number of FFT responses were provided. There were concerns over managing the returns and data analysis within existing administrative capacity if a large number of patients responded.

*A: It's absolutely fine, frankly we only get about ten a month.*

*Q: Would you find it more difficult if you had a higher response?*

*A: I suppose if we had hundreds we couldn't cope with it. [...] Because we're a GP practice with a limited amount of resources. We don't have an admin department, we have one part-time administrator, that's all. [Practice Manager]*

Using the practice website or other online apps to collect FFT was included among the possible options in NHSE guidance, although their limitations were made clear (due to relatively low access to the internet among some groups including older patients). The main reason for adopting these methods was to comply with the requirement to collect FFT while minimising the resources used for doing so.

*They did release some documents that you read through and they suggested sort of using the internet, well your websites, because ... [It's] very easy to input on to your own website. And there was guidance, yeah. [Practice Manager]*

*There was a website that emailed me and said: "Is that something that we can help you with?" They were doing a free trial, so we used their link that they sent us to our practice website to collect the feedback. [Practice Manager]*

External providers were sometimes involved when online methods were used, but none of the practices using these methods reported them to be particularly effective, which is consistent with the data shown in Table 3.3.

SMS text message collection methods were mostly adopted by practices which already had a contract in place with an external provider to manage automatic communications with their patients. These external providers often applied only a marginal additional charge to collect the FFT, allowing practices to comply with minimal effort.

*There were several companies plying their trade and we used [Software name] anyway for all the text messaging and things. And they're reliable and they can help. They send a text when we're doing smoking invitations, so we said we would do that [for FFT], and there's a network, I think we've got a little bit less of a charge because there's five practices [who] work together, so we've got a bit of a reduced payment. [Practice Manager]*

Although SMS/text messages obtained the highest number of responses on average, among the nine sample practices using this method, eight said they chose it to remove the burden of inputting data, and only one said they chose it in order to achieve a higher response.

Although a few practices bought and set up their own tablets / kiosks, they were mostly found in practices where they had been introduced by another organisation, such as the CCG or a network the practice was part of.



Tablets were deemed to be more attractive for patients and capable of generating a higher number of responses. They were also appreciated for collecting the data directly in an electronic format, making it easier to input data to the CQRS. But some practices using this method had not been trained to do so and reported difficulties in extracting the data, which prevented or delayed their submission to CQRS. This may explain why practice managers' perception of this as an effective collection method does not match with the data reported in Table 3.3.

Some mentioned the risk of tablets being stolen and thus the need to place them in sight of the receptionists, which suggests that patients may not have had privacy when responding or may have had worries that their response would not be anonymous. It was also mentioned that children would sometimes play with the tablets, inputting irrelevant data or causing them to freeze or crash.

*I don't know how other more affluent areas do it, maybe they all do it with an iPad. There is actually an iPad floating around that was given to one of the doctors and never saw the light of day again... You could leave that at reception, but quite a lot of stealing goes on here so that clearly wouldn't work. [Practice Manager]*

#### **Burden and workload of FFT**

Interviewees did not describe the FFT as time consuming or a distraction, largely because of the low priority given to it. The FFT did not interfere with the receptionists' normal activities, as receptionists did not hand it out when they were busy. Few clinical staff actively encouraged completion of the FFT. In several cases, it was reported that FFT cards were eventually removed from the GPs' offices, as they did not have the time to promote the FFT, or did not feel comfortable asking for feedback.

*When you start with bits of paper like questionnaires in consultations, by the time you've explained what is the purpose of it, and where it's come from, and the patient struggles... "Well, have you got a pen? And let me get my glasses out of my bag?" You've probably used six to seven minutes of the consultation time filling in a questionnaire and you haven't actually had the opportunity to do the job in hand. [General Practitioner]*



Given the relatively few FFT responses received per month, it is not surprising that staff reported that data returns to NHSE did not take very long, typically estimated to be about an hour or so per month of a Practice Manager's time. In a few cases, the manual inputting of handwritten FFT data into the CQRS was said to be time consuming. It was felt to be quicker to make returns for those using SMS text or tablet/kiosk collection methods, unless there were technical difficulties. Nonetheless, several interviewees felt frustrated by having to complete CQRS returns.

Although problems for those inputting FFT data were resolved by November 2015 (when the majority of interviews took place), the inability of some practices to easily input their data before then is likely to have affected the volume of returns.

The number of free text comments received by practices is not reported to NHS England. As a result, staff were often only able to estimate the number or proportion of FFT responses that included a free text comment. Estimates ranged from 30% to 80%. However, it appears that practices with a larger number of FFT responses were also more likely to get free text comments; practices which were apparently achieving more free text comments, though, did not necessarily say they were valuable or helpful.

Interviews with staff from the two "innovative" practices did not suggest they were any different from the other sample practices in terms of FFT implementation or in their level of engagement. They did not report any corporate level initiatives in relation to the FFT as practices had chosen and implemented their own data collection method, regardless of the network or federation.

## Attitude to, and understanding of, the FFT

### Perception of its purpose and value

Practices generally implemented the FFT in compliance with NHSE requirements and guidance. It was clear though that, for the majority of staff, their only reason for implementing the FFT was to comply with contractual requirements. Many also remarked that the FFT was a low priority within their practice, and this affected how enthusiastically it was administered to patients.

*We do it because we have to. [Practice Manager]*

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

*I don't know, I think it's just been left a little bit [aside] to be honest, it's just, I think there's always 99 other things more [important], so maybe it's not promoted as much as it could be. [Healthcare Assistant]*

Several interviewees also remarked that the absence of targets and financial incentives attached to the FFT made it a pointless exercise.

*It doesn't take a lot of time, but it feels totally pointless because if I put four cards down it's exactly the same as if I put four hundred cards down. There's not a minimum, there's nothing for us to achieve and ...there's no feedback on it. [Practice Manager]*



The majority of staff were unclear about the reasons for collecting the FFT. Many assumed that it was collected by central governing bodies (NHSE and/or DH) in order to monitor the quality of care provided in general practices, and possibly take action where results were poor. This widespread belief was associated with a substantial lack of “ownership” of the FFT on the part of general practice, as staff generally perceived it as something they were required to do on behalf of government.

The mandatory requirement to provide monthly data returns to NHSE was often perceived as evidence of the central purpose of the activity.

*Q: Yeah, so if it's not completely useful for you, why do you think that you have to do it?*

*A: Because it's mandatory. [...] Because we've been told it's contractual, and it has to be reported through 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 ... but they do the central patient surveys anyway, so I don't know what additional benefit the Friends and Family Test is. It's just another task for us to have to carry out. And the patients. [Practice Manager]*

This was possibly reinforced by having the FFT monthly returns made through the same system, CQRS, that is used for the Quality and Outcomes Framework (QOF), under which general practices are assessed on whether they meet national targets. Some practices set their own targets for the number of FFT responses. One member of staff appeared to believe that meeting FFT targets would lead to additional payments.

*I like to get 25 in each month, and we thought 25 was going to be easy to get, but actually it's not, 25 responses is really difficult to get. But I like that I can monitor the amount that are going in the box, and if it's getting to the end of the month and I haven't got my 25, I can stick a member of staff in reception and we can push it. I've asked GPs if they will say to patients on their way out the door, if you want to you can, to get them to try to get patients to fill out a form, you know, if you'd like to, you can fill out a form. But GPs just don't do that. [Practice Manager]*

*I think the targets are fairly high to achieve any payment for it. I don't think we have yet. [General Practitioner]*

It is also possible that the support provided by NHSE Regional Teams reinforced this view, since their involvement was sometimes seen as a reprimand rather than purely supportive by those practices which were struggling to submit data. This could be worrying from a practice's point of view, since Regional Teams have a formal commissioning role and in theory may contractually enforce the implementation of FFT (although in practice none of the interviewees from these organisations said this had ever happened). All this attention from the Regional Teams is likely to have reinforced the idea that FFT data in themselves have value for the centre, beyond just proving that the FFT has been implemented.

*They sent us emails, a few emails, and said yeah, we're going to be doing this, and you've got to be doing that, and we're going to send you all the bits and bobs you need and just do it, get on with it and do it. [Practice Manager]*

*Presumably if I didn't submit it, somebody would rap my knuckles. [Practice Manager]*





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Similarly, the provision of an FFT collection box and sample answer cards, all branded with the NHS logo, may have contributed to the perception that the FFT was being implemented for some central agency, and for an unclear purpose. In a few extreme cases, GPs thought that they were not supposed to read the feedback since it was going to NHSE. It was only during our interviews that they realised this was not the case.

*Q: Do you get to hear much about what people are writing and the scores that are given?*

*A: I don't obviously, they're put in the box so I don't think we can see that can we? Isn't it meant to be confidential? I mean, I don't know, how does it work, do you just put it in the box, and send the box away, or as a practice are we supposed to have a look at it? [General Practitioner]*

*Oh, you have to open the box? [General Practitioner]*

However, most staff were aware that they should regularly examine the feedback provided by patients in order to determine if issues were raised that required action which might lead to improvements. But this was generally perceived as a by-product of the real purpose of the FFT, which was to provide data for central monitoring. The data were not generally considered to be helpful for improving services.

One final short-coming perceived by some practice managers was the anonymity of responders. That meant it was impossible for staff to relate a specific comment to a particular event in a way that would enable the practice to review the care provided, and make any changes necessary.

*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]*

### **Worries about being monitored through an inaccurate tool**

This perception of the FFT being intended for performance management generated some unease, given doubts about its accuracy.

There was consensus that the low number of responses at practice level could not provide results representative of their patients and reliable indications about the quality of services. Staff and patients were also aware that the patients who completed the FFT would be either self-selected, or chosen by the staff administering the test (where card and paper was used). Interviewees felt that the patients most likely to complete FFT would be those who were either very happy or very unhappy, and that this would also affect the representativeness of data. Some interviewees were concerned that a few negative comments from particularly difficult patients might provide a distorted picture. In contrast, others pointed out that positive feedback might well have been influenced by the asymmetry of information or power imbalance between the practice and patients, exacerbated by staff selecting patients to complete the FFT who they thought would portray the practice in a good light.

*I'm afraid I'm quite cynical. I think it's a bit of a waste of time. It's a self-selecting survey, so first we have cards out there, we, the doctors and the clinical staff, can choose to a certain extent who they would like to give the cards to. [Practice Manager]*



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*For us, as long as NHSE look at the data within the context of what else we do in terms of patient involvement, that the FFT data is read in a holistic way, then that is OK. It's a narrow test otherwise. [Practice Manager]*

*[In theory] I can fill [it] every day for me: best GP, best GP.. [General Practitioner]*

Because of this common misunderstanding about its purpose, the FFT was perceived by practice staff and presented to patients as a “survey”, albeit a quite poorly designed one. Many staff explained that having to deal with findings that are very similar month after month, made the FFT a repetitive exercise. In many practices, it was noted that a significant population of heavy service users exists, and that these patients are likely to have been asked to complete the FFT several times already.

*Initially the information is interesting, isn't it? Because it gives an overview of what people think and whether they would recommend the practice to family or whether family are involved or whatever. But then when it's continuous, month after month after month after month, and it's exactly the same sheets and very often very similar patients, I'm not sure that they know what the purpose of it is at all. [Practice Manager]*

*Our patients are really, really, really, really fed up of questionnaires. You're embarrassed asking because you think, oh God, I gave Mr Jones such a questionnaire the other month and I gave him the [practice] questionnaire the month before. [Practice Manager]*

*I think what I'm trying to say is: “Is that ... one person at one point in time, or is it a hundred people feeling that way?” I don't know, so it doesn't really answer that kind of problem, it doesn't give me any sort of guidance as to whether that's a consistent problem. [Practice Manager]*

In one practice the FFT was implemented as a survey. Once a month, staff sent an SMS text message to every patient, regardless of whether they had any recent contact with the practice. Interviewees in this case seemed keen to rule out the experience element and attempted to obtain what they felt would be a more credible overall opinion of the practice.

*PM: One of the biggest things also is that practices that are only getting a few patients a month could be going to their regular patients who are very happy with the practice, so it could skew the view. [...] So we're doing it indiscriminately, as it should be done, whereas I think a lot of practices are probably not doing it indiscriminately. And I think the rules around how it's done, so for instance, is it the GP after the consultation giving the person a Friends and Family [questionnaire] saying: “Oh would you like to fill this out for me?” And that, in a way, is a bit of coercion. [...]*

*PPG: Yeah, it will depend on their one experience, doesn't it?*

In some practices, language barriers were mentioned as hindering access to all patients; this referred not just to the need to translate the FFT question into several languages but also to translating the free text comments into English, which many practices did not have the capacity to do.

*We didn't translate, we don't want to spend money. As it is, we do the other survey [local practice survey], we had to pay £300 or £400 to [have it] translated into Tamil.*



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*But every time when somebody wants something, we can't be translating and spending money like that. Not only Tamil, there are so many other languages. Like a lot of Eastern Europeans, Chinese and all those.... [Practice Manager]*

The ability of the FFT to capture patients' perceptions of quality was also questioned. The FFT question was seen as convoluted and unclear by several interviewees. The wording implies an element of choice, i.e. that friends and family would be in a position to choose their general practice. This was often seen as potentially misleading, especially in rural areas where there may in fact be no choice or in situations where mentioning friends and family would be out of place and possibly confuse patients (e.g. immigrants, students, homeless, etc.).

*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. [PPG Representative]*

*I can understand if you are in a city, and you've got choices, and if people don't get along with one surgery and you haven't had a very good experience, you can recommend: "Oh, well, why don't you go to that surgery then, because you will get good care there". But if you are in a village or in a very rural area it's a completely pointless exercise. [PPG Representative]*

### **Tension between FFT and adherence to clinical guidelines**

The FFT resonates with national policy that encourages practices to pay attention to patients' views. General practices are requested to act as patients' agents in a quasi-customer/retailer relationship. This situation may appear contradictory to the practice's gatekeeping role, such as where patients ask for a prescription or a referral that they do not need. Situations such as this were often cited as being likely to generate negative feedback in the FFT.

*But it's a little bit ironic I suppose. It is a measurement of client, patient happiness as to [whether] the consultation's gone the way that they wish it to. So, you've heard this all before, we've got the government and everyone pushing us for being responsible for antibiotic prescribing and such like, and someone comes for their antibiotic because they want their antibiotic and they don't get their antibiotic because they don't need an antibiotic. [...] So if I could get someone to give me a two from refusing an inappropriate antibiotic rather than a one, well, that's clever of me. But, yeah, it's not a measure of the efficiency of service. [General Practitioner]*

Several staff reported that some patients are increasingly assertive. So rather than a tool for quality improvement, the FFT was perceived by some as providing a means for "difficult" patients who did not get what they want to "punish" practices by giving them a low FFT score.

This view was often accompanied by expressions of mistrust towards central policy-makers and the feeling that the government was not tackling the important issues in primary care.

*The health service is very often, in my experience anyway, seen as being their right [of the patients] and it is only when that right fails that people are prepared to feedback, or feed into the system. [Practice Manager]*





*PM: They're trying to show the public that the government is going to beat primary care with a big stick. I know it applies with dentistry and hospitals as well, doesn't it?*

*GP: It does, yeah. Doctors are greedy.*

*PM: Wield a big stick and so the patients will have a say...*

### **FFT in the context of other sources of patient feedback**

Many interviewees felt the FFT did not add anything to other sources of feedback. A large number mentioned their practice's own survey, often designed in consultation with the PPG and usually carried out once or twice a year. These surveys were reported to provide more helpful insight into patient experience and satisfaction.

*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]*

*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 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]*

We asked about the role of PPGs in practices, specifically in relation to the FFT. Although not fully operational yet in some practices, in the majority of practices PPGs were up and running, and their role was generally acknowledged to be important by clinical and non-clinical staff. The PPGs often provided feedback, and the information they provided was usually deemed more helpful than that generated by the FFT.

*I collect information from our users, service users, and bring that and inform the surgery and Practice Manager and doctors about things that we feel need to be addressed or need to improve, and the actions are taken. So I'm really not sure whether it is the Friends and Family Test that is having that impact or whether it is because we have got our PPG members who are very good at articulating their needs. [PPG Representative]*

Personal relationships between patients and staff were often mentioned as a distinctive trait of general practice. The informal feedback generated by simply talking and listening to patients was also reported to be a valuable source of information about quality.

*So, they are my same patients, they are writing on a different piece of paper, whether they'd let me know directly or they write it for Mr Hunt the Health Minister. [General Practitioner]*

Many participants also mentioned that formal complaint procedures were probably more detailed than the FFT and, in general, more capable of generating information that could be used to improve quality as they would identify a specific episode that the patient was not satisfied about.

Given the number of other mechanisms already being used to collect patients' views, interviewees generally felt that the FFT had little to add, especially given the concerns expressed over its validity (as described in the previous section).



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*So we get the comments' forms that patients do themselves, we get our patients group's anecdotal evidence, we always monitor our complaints and do those in a formal process, and we have, on our website, people can email us comments as well and those come directly into the practice, so we can answer people's comments and questions through that mechanism as well. [Practice Manager]*

Interviewees from the “innovative” practices made similar points about the FFT providing very little additional information to what was already being collected. One such interviewee pointed out that their practice already had a very high level of patient involvement in place, so the FFT could not be expected to add much.

## **Impact of the FFT**

### **Impact on staff morale**

One of the expected benefits of the FFT is to boost staff morale and enhance their motivation as a result of reading the positive feedback provided by patients.

This positive influence on staff was mentioned by many interviewees, although several reported the effect on staff morale to be mixed. As explained above, short and anonymised negative feedback limits opportunities to inform change, and this can be frustrating for staff who feel there is little they can do to put right the issues reported based on such information.

*I think it's just a positive gesture, it just reminds the practice of the positive things that it's doing. [...] Yeah I think we would like to keep it as a positive, a way for recording positive feedback, because actually apart from voluntary feedback from patients there's no actual way of recording these things. [General Practitioner]*

*My heart sinks when I open the box, [...] I think it reduces morale when you read them because there's not always a lot we can do about the complaints; we're really trying to get more appointments and things like that. But they complain, they don't comment about the good things. So you read them and, yeah, I find them really depressing. [Practice Nurse]*

*One month you can be the best thing since sliced bread, and then the next month you're in a hell on earth [...]. And you often have no idea as to why you've gone from excellent to bad, or equally why you've gone from bad to excellent. [Practice Manager]*

### **Impact on quality improvement**

There was wide variation across practices in terms of how FFT data were processed and used at the local level to improve their services. In some practices, there was little awareness that staff were expected to analyse and act on FFT data locally. In others, however, staff tried to make sense of the data and to maximise its value, for example by discussing comments during practice meetings or discussing them with the PPG. There were some practices in which staff even put extra effort and enthusiasm into implementing and examining FFT data, especially in the first few months, by adopting more formal reporting processes and publishing FFT results in the practice.

*They're shared with everybody here, all the partners and all the staff, and we advertise, we put the posters up downstairs, and upstairs there should be a poster somewhere, with this month's response, and we put that on our website as well. [Practice Manager]*



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*And we do try to do a bit of 'you said, we did', on the practice website as much as possible. But, because it is every month, it's really onerous to do it every month. So we tend mainly to just bring the comments to the Patient Participation Group, minute it, and if there's any themes then take the themes. [Practice Manager]*

Regardless of the level of engagement, there were few examples where the FFT was reported to have stimulated quality improvement. In the majority of cases, issues that emerged from the FFT were said to be already known to the practice and, where action was taken to address them, the FFT did not play a decisive role, if any.

*We did some analysis and discovered we have too many telephone slots, so some of those telephone slots will be turned into face to face appointments, because a lot of telephone slots are wasted. It's different avenues of people expressing dissatisfaction; partly Friends and Family, partly coming from patient complaints, partly coming from discussions that we've had with the patient group, and partly from our own observations. [...] As I said at the outset, it's not telling us anything we're not already aware of from the existing forums of asking patients for their feedback. [Practice Manager]*

It must be noted, however, that interviewees in a few practices reported different experiences. In one case, the FFT was enthusiastically cited as being critical for tackling a specific issue to do with wheelchair access. In another, the FFT was reported to have contributed (along with other feedback procedures) to the decision to provide receptionists with additional training.

*Well you're obliged to do it, but it does allow you to make interventions from comments. There was one comment we had about somebody with difficulty getting out of the, 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]*



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## 4. Discussion

### Appropriateness of FFT in general practice

The FFT question is often used by commercial companies, usually made available anonymously to the customer after every contact and phrased in a similar way to the question asked in acute hospitals. Such widespread use suggests that it can be applied in diverse settings. However, most interviewees felt that the phrasing of the question and the way in which the FFT is administered made it inappropriate for use in general practice. Five factors contributed to this view.

#### Lack of choice of general practice

In some rural areas there may be only one practice, so there would be little point for a patient to recommend it to friends and family given that they would have no real choice.

#### Care varies between patients

A customer satisfied with a product can expect that friends and family would receive the same product if they used the same retailer. A patient satisfied with their treatment, however, would be aware that their friends and family would not necessarily receive the same care even if “they needed similar care or treatment” because care depends on individual factors including age, sex, existing health conditions and symptoms.

#### Personal nature of care

The relationship between practice staff and patients is more personal and complex than the one between a customer and a sales assistant. So, it is less likely that a patient who has a good relationship with their practice would assume that it would also be so for their friends and family. The relationship between a patient and their practice implies a different type of bonding from that of a customer with a store. Patients do not “shop around” but tend to stick with the same practice.

#### Lack of practical value for improving quality

The complexity of general practice, in terms of “personalisation” of the services provided and of the importance of the personal relationship between patients and professionals, helps explain why the anonymity and lack of detail of the FFT were criticised and seen as the main obstacles to its use for quality improvement. To some extent, such a limitation is common to many patient experience surveys which, unlike the FFT, provide better representation. But often these surveys present a picture of overall patient experience and lack the detail that is needed to identify specific quality issues, especially in a setting such as general practice.

#### Lack of accuracy

The FFT is not administered as a representative survey. There is no sample and it is simply available after every contact (or in some cases to every patient who happens to look at the practice website). This may facilitate its use for quality improvement, as all patients who feel they have something to say can use it and their feedback is specifically related to their “recent experience of our service”. The problem is that practices may well have no idea which service was recently used by the patient and the patient comments often do not provide the necessary clarification.



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## Perception of FFT as a tool for performance management

The review published in 2014 (NHS England July 2014) explained that quantitative FFT results had little external validity and were therefore not suitable for the purpose of comparing quality of care across providers. This reasoning was fully incorporated in the guidance issued soon after (NHS England March 2015 and NHS Employers, BMA, NHS England July 2014) in order to support FFT implementation in other NHS settings, including in general practices. Despite this, many interviewees believed that FFT results were going to be used to assess and compare quality across general practices. This appears to have resulted from perceptions formed when it was launched in 2012 when its stated role was to enable patients to identify the best performing provider (Prime Minister's Office 2012). This aspect has stuck in the minds of people, including general practice staff.

Also, the requirement for returns of FFT results (not just the number of responses), reinforces the view that NHSE is interested in how individual practices are performing, and may have suggested that the FFT had a rationale similar to the QOF.

Although there is no financial incentive attached to the FFT results, some staff were puzzled that FFT did not include a target. Despite this, some acted as if there were targets.

## Lack of skills in using patient feedback to improve quality

The picture that emerges from accounts of how practices used FFT data and other forms of patient feedback is one of local variation: free text comments read only by Practice Managers and not always relayed to relevant staff; FFT returns left to the PPG to discuss; and, in a few practices, patient views ignored since there was no contractual requirement to do anything with them (at least until our interview took place, when someone may have decided to look at them).

Many of the general practices we investigated did not have a formal strategy for improving quality from patient feedback. The FFT data were processed and acted on variably across practices. Some lacked the skills and know-how to use patient feedback, including that provided by the FFT, who to share it with, how to act on the free text comments, and how to assess any impact of change on service quality.

*Well, every two to three months I send all the comments round to the clinicians so they can check through their own comments and see if there's any common thread, what they're doing well, what they're doing badly. [Practice Manager]*

*Q: And what about to the PPG? Do you share ...*

*A: I will then share these results with the PPG at every meeting we go to as I do our complaints.*

*Q: And are the comments included in those?*

*A: No. There's simply not time. There's an element of confidentiality in there as well. [Practice Manager]*

*Yeah, they are similar. You can't, I don't know, they are similar, they are similar. They're things like, oh I, doctor didn't spend a lot of time, oh doctor marvellous, nurse really good, receptionist rude, lovely doctors, lovely receptionists, not very nice doctor, you know. It is all the same thing. [Practice Manager]*



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Having a local patient survey was a well-established tool in many practices and was frequently reported as the main source of patient feedback. But such surveys vary in sample size and questionnaire design so the quality of data they generate will inevitably vary.

The contribution of PPGs to quality improvement was apparent in those practices which have them. But in other practices, PPGs were not fully operational and, even where they were, their role was not necessarily consistent with their original purpose.

*Patient participation meeting once a year, they don't want to come, they say: "Don't want to come, we don't have the time for it". But we force them to come now, at least once a year, they are supposed to, every three or four times, at least three times, they say "No, we are not coming, we have got other things to do". But then we ask them and they come to the meeting, would you like to have a meeting? They said "No, this is more than enough, we're happy with ... if there is anything we'll let you know", that's it, end of story. [Practice Manager]*

This patchiness in the ability to assess and improve quality is likely to be due to several factors. Resource constraints and workload were mentioned by almost all practices. In some practices, quality improvement was rather superficial (e.g. PPG meetings held very rarely, no involvement of the PPG in the FFT, no local survey). In several practices, staff felt frustrated that they had limited (or no) options for making changes that would lead to improvements, however slight.

*Q: And do you actually use the data for anything at all?*

*A: Depends what's on there. I can't, if it's negative what can you do with it really? [Practice Manager]*

Others went further and felt that formal tools and processes of patient feedback were unnecessary, as dealing with patients on a daily basis provided more than enough insight into what patients really need. This attitude was more often found in smaller practices, where a more traditional doctor-patient relationship was still in place.

*The doctors have been here 30 years, more. You know how much they [patients] appreciate the staff because they will bring in Christmas cards, gifts, they will bring in, literally, Easter eggs and that, just thank you, box of chocolates, so you know, you can't make people do that. They will bring in gifts for the doctors, even their kids, because her, his son is the lead GP now, so they've seen him grow up... and you know they're appreciated because nobody would bring in thank you gifts or so on, if they weren't. [Practice Manager]*

These attitudes might reflect resistance to changes and innovations that challenge the traditional power balance in the patient-doctor relationship. This would hinder the adoption of patient experience feedback and implementation of quality improvement.



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## Positive views on the FFT

In contrast to concerns and criticisms, interviewees in four of the 42 practices held positive views of the FFT. One practice perceived the usefulness of the FFT data for quality assessment. Staff were pleased both with the large number of responses they received (using SMS text data collection) and with the high percentage of positive results, which they felt made their practice look good. However, their enthusiasm did not extend to using the FFT data for quality improvement.

*Q: And what else do you do with those comments? How do you analyse those, do you try and use the comments?*

*A: No but what we may do this year, because of our PPG report for NHS England, we'll probably include those. We do, we did have a little part of it last year, but now that we're on a roll with it and we're doing really well, we will put it into our report.*

*Q: So you're not currently using the comments for anything?*

*A: No. Just for our own surgery really, if there's any trends of things that patients aren't happy with, then we try to put them right. [...] Yes, we can share them at practice meetings, we can discuss them along with other monthly reviews .... [Practice Manager]*

In two other practices in which staff expressed positive views, we believe that they had assumed they were selected for this study as part of NHSE monitoring (despite making clear that this was an independent evaluation carried out by LSHTM and Ipsos MORI), and that our purpose was to check whether they were correctly following FFT guidance. Thus the positive attitudes expressed by these interviewees may simply have been an attempt to convince us they were implementing the FFT as intended by NHSE.

Only one practice referred to a specific change that had been made in response to an FFT comment. As this practice did not use a local survey and their PPG was at an early stage of being set up, it seems likely that the FFT did contribute to the change.





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## 5. Implications and conclusions

Many of the concerns and views about the FFT expressed by staff and patients in general practice are consistent with those previously observed in acute hospitals (Sizmur et al. 2014, Membership Engagement Services 2015). Whilst this qualitative study was not designed to determine the frequency with which particular views were held, the large diverse sample of practices that participated provides evidence of the types of concerns about and attitudes to FFT held by primary care staff. A large survey would be required to estimate the prevalence of such views. However, where we found recurrent and consistent views, it seems likely that they will be widely held.

Before considering the implications, three limitations of this study need to be recognised. First, as the practices that participated appeared to be more engaged with FFT than those that did not, it is likely that the views we collected tended to be slightly more positive than might be found throughout primary care. Given the generally negative tone detected, this bias would suggest that practice staff in general are even more unenthusiastic than these data portray. Second, although patient representatives were interviewed in 25 of the 42 practices, their views were those of people who were closely involved in the running of a practice and the PPG in particular. As a result, we cannot and have not tried to provide much insight into the views of ordinary patients of FFT. This would require a separate study. And third, we sought and report the perceptions of staff rather than what takes place in general practice. Staff might perceive they are either achieving a lot or very little in improving quality whereas the reality might be quite different.

Overall, the response to the implementation of FFT in general practice might be characterised as disappointing from the perspective of attending to the experiences of patients. This has been for several reasons, outlined in the Results section above. In investigating this, it has also been apparent that there is considerable interest in patients' views in practices, but that other approaches are valued and considered to be of more practical use in improving quality than the FFT.

The principal policy challenge to address is whether to persist with the FFT (or a similar single item questionnaire) or not. If such an approach is favoured, we can offer four suggestions as to how its value might be enhanced:

### 1. Enhance the capacity for managing quality in practices

FFT has been introduced to practices alongside several other pre-existing means of assessing aspects of the quality of care: the Quality & Outcomes Framework, significant event analysis, patient experience surveys, complaints and patient groups. While most of these are mandatory, it was apparent from the interviews that there is significant variability in the extent to which general practices are committed to using quality assessments for quality improvement. A few practices were well advanced in this respect, having set up effective PPGs and appeared to make good use of local surveys. Several practices, however, seemed to struggle in this respect, making poor use of PPGs and local surveys which reflected both some resistance to change and limited resources and knowledge as how to respond to assessments showing less than optimal quality.

Variation in whether and how practices are engaged with quality improvement and patient involvement suggest that there is a need for a strategy to promote these activities. Practice surveys were often mentioned as helpful, so their use and implementation might be further encouraged, possibly promoting sharing and learning from the most successful examples. Support and guidance on how to set up PPGs and how to maximise their contribution to quality improvement initiatives should also be part of any strategy.





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Suggestions about how to improve quality were included in the FFT implementation guidance for NHS funded services (NHS England March 2015 and NHS Employers, BMA, NHS England July 2014), but not in that provided for general practice, which may benefit from specifically designed guidance. A body of literature exists on effective methods and techniques that can be used in general practice to improve quality (Royal College of General Practitioners 2015) and more could be generated from further research.

## **2. Change the content of the FFT**

A simpler and more straightforward question that does not include a reference to “recommendation to friends and family” would probably provide a better measure of patients’ experiences.

In addition, the data generated could be of greater use for quality improvement if practices would be encouraged to collect patients’ views on aspects of the clinical services they provide, and/or on their access arrangements (e.g. opening times, telephone consultations, home visits, etc.). Obtaining feedback on topics of concern for a practice could work as a quick diagnostic tool to make staff aware that a problem exists when negative and consistent feedback was received, and would provide more detailed and timely information on existing quality issues, possibly filling the gaps that may be left uncovered by other approaches.

## **3. Improve practice staff understanding of the purpose of the FFT**

The mechanism of monthly data returns seems to be one of the main factors leading to the confusion about the purpose of the FFT. This has also hindered the perception of the FFT as a tool that belongs to general practices and that can help them improve their services.

In order to encourage local ownership and use of the FFT, the DH and NHSE may need to reduce the monthly reporting demands it makes of general practices, since this often leads to the impression that the rationale for the FFT is for central monitoring purposes rather than a tool to be used by practices for quality improvement. The more demands are made by the centre, the less the feelings of local “ownership”.

Such a strategy may also provide general reassurance about the Government’s agenda being aligned with theirs in prioritising the provision of good quality care. It would dispel the idea that the FFT was meant to be used by “difficult” patients against practices, which was disheartening for many, and would avoid any contradiction between their gatekeeping role and the desire to have satisfied patients.

## **4. Alter the national reporting requirements**

Given the limited usefulness of the quantitative data provided by the FFT, the DH and NHSE should consider asking instead for reports on the quality improvement activities carried out by general practices. In order to avoid the impression of central monitoring, such reporting could be less frequent (e.g. once a year) and qualitative rather than quantitative in form. Such an approach could provide the centre with more detailed and useful information about what general practices are doing to improve quality without giving the impression that they are simply collecting such information in order to monitor the performance of all general practices.



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## Appendix Topic guide for interviews with clinical staff

	Notes	Time
<b>Introduction</b>		
<p>Introduce self and project: Qualitative review of the Friends and Family Test (FFT) being undertaken by the Department of Health and NHS England to get structured feedback on how the implementation and use of FFT is working in GP practices.</p> <p>Explain Ipsos MORI role in relation to LSHTM – independent research company – we are impartial: we are neither in favour nor against the FFT, we are just here to hear your views.</p> <p>Explain the interview should last around 30 min depending on how much they have to say.</p> <p>Explain anonymity: names of individual participants or of the practice they work in will not be used when reporting the findings and we will not tell anyone at DH/NHSE who said what. DH/NHSE will not know which practices will have participated in the study. To emphasise, we are not inspecting your practice, we just want to hear your views on the FFT.</p> <p>Ipsos MORI works in accordance with MRS guidelines and the Data Protection Act.</p> <p>Obtain permission to record discussion (we will be using the transcripts in our analysis). BEGIN RECORDING</p> <p>Get signed consent form if interview is face-to-face.</p> <p>Read form and audio record participant’s consent if over telephone.</p>		
<b>Warm up question</b>		
<b>Please briefly tell me about your role in this practice and your involvement with FFT...</b>		1min



	Notes	Time
<b>Initial thoughts on FFT</b>		
<p><b>I'd like to start by getting your initial thoughts on FFT.</b></p> <p><b>What three words would you use to describe the FFT?</b> <i>PROBE:</i></p> <ul style="list-style-type: none"> <li>• What makes you say that?</li> </ul> <p><b>How do you think it is perceived within you practice by...?</b> <i>PROBE:</i></p> <ul style="list-style-type: none"> <li>• Other clinicians</li> <li>• Other staff</li> <li>• Patients</li> </ul> <p><b>Is there anything that you particularly like about FFT?</b> <i>PROBE:</i></p> <ul style="list-style-type: none"> <li>• Use of single question and open text questions</li> <li>• Choice of who can respond and the volume of responses you can collect</li> <li>• Freedom in choice of collection method</li> </ul> <p><b>Is there anything that you particularly dislike about FFT?</b> <i>PROBE AS ABOVE</i></p> <p><b>What do you see as the main purpose of having the FFT in GP practices?</b></p>	<p>If participant starts talking about sampling and response rates, please follow up on this.</p>	2 mins
<b>Data collection of FFT</b>		
<p><b>Please talk me through how FFT data is collected in your practice</b> <i>PROBE:</i></p> <ul style="list-style-type: none"> <li>• How is the FFT data collected? According to NHSE data you have/don't have a combination of methods. Can you confirm this?</li> <li>• Were any arrangements made with external providers for data collection? Can you describe their role?</li> <li>• Are you involved in the administration of FFT?</li> <li>• Does the collection of FFT to any extent affect your work?</li> <li>• When do patients complete the FFT? <i>PROBE:</i> Before or after their appointment</li> <li>• Approximately how many patients are asked?</li> <li>• Who, if anyone, asks patients to complete the FFT (i.e. does a receptionist or clinician directly ask them to complete it? Is the collection made available somewhere in the practice to be filled in by a process of self-selection)?</li> <li>• IF SELF-SELECTION: <ul style="list-style-type: none"> <li>– What do you think of how the FFT materials are displayed?</li> <li>– How clear is this for patients?</li> </ul> </li> <li>• IF THEY ARE PRO-ACTIVELY ASKED TO FILL IT IN: <ul style="list-style-type: none"> <li>– How are patients selected and how often are they asked to complete (e.g. after every appointment)?</li> <li>– Does the practice have an exclusion criterion?</li> </ul> </li> </ul>	<p>The aim here is to understand how the practice implements FFT – <b>if possible try and collect hard copy examples of FFT. Do also note observations and if possible ask to take photos of collection methods if conducting interview in the practice.</b></p> <p>You will need to use the data we have already on the collection method here.</p>	5 mins



	Notes	Time
<b>Data collection of FFT continued</b>		
<p><i>IF CLINICAL STAFF ASK PATIENTS TO RESPOND:</i>  <b>How do you feel about clinical staff directly asking patients the FFT?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>Any positives</li> <li>Any negatives</li> <li>Impact on patient-clinician relationship</li> </ul> <p><i>IF CLINICAL STAFF DOES NOT ASK PATIENTS TO RESPOND:</i>  <b>How would you feel about clinical staff directly asking patients the FFT? PROBE AS ABOVE</b></p> <p><b>What do you think about the way FFT data is currently collected?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>Ability to capture feedback that is helpful for providing better care.</li> <li>Do you have any examples of best practice?</li> <li>Is there anything that could work better?</li> </ul>	<p>Please try and gauge the emotional response to this. If the clinician currently asks proactively, explore how they find this and any issues they experience. If they do not proactively ask the FFT questions, find out why this is and if they would be open to doing this.</p>	
<b>Data analysis</b>		
<p><b>I would like to move on to talk about the data from FFT.</b></p> <p><b>Please describe what happens to the quantitative data (tick-box FFT question) once it is collected</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>Who prepares the data for submission to NHSE?</li> <li>Do you use any tools to prepare/analyse them (e.g. digital/automated tools to process FFT responses)?</li> </ul> <p><b>Are you happy with the current arrangements to submit data to NHSE?</b></p> <p><b>Please describe what happens to the free text comments once they are collected</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>How is it analysed and by whom? Are you or other members of clinical staff involved in it?</li> <li>Have you been using any tools to do this analysis (e.g. digital/ automated tools to process FFT responses)?</li> </ul> <p><b>What, if anything, would help you with the analysis of FFT data?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>Additional support needed?</li> <li>Training or guidance on best practice/what other practices do with their FFT data?</li> </ul> <p><i>IF NO CLINICIANS ARE INVOLVED:</i>  <b>Is there a particular reason for this?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>Time</li> <li>Complexity</li> <li>Resource issues</li> </ul> <p><i>IF NO ANALYSIS TAKES PLACE:</i>  <b>Is there a particular reason for this? PROBE AS ABOVE</b></p>	<p>Here we are trying to understand what approach practices are taking to gather useful data – as with the next section we are looking to get good practice examples from this discussion.</p>	<p>5 mins</p>



	Notes	Time
<p><b>Use of data</b></p> <p><b>What are the main ways you get patient feedback?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Informal, GPPS, CQC rating, FFT</li> <li>• Which have you found the most useful?</li> </ul> <p><b>Have any led to improvements in service? PROBE FOR EXAMPLES</b></p> <p><b>I'd now like to talk about the outputs from the FFT...</b></p> <p><b>How many quantitative responses does your practice get?</b></p> <p><b>Did you notice any specific trend in volume of responses obtained?</b>  <i>[Read and compare with NHSE data obtained from the practice together with interviewee. Ask about gaps in data submission, large drops or rises in responses that are reported]</i></p> <p><b>Approximately how many free-text comments does your practice obtain? Do you know approximately how many were received each month? [Record the monthly data in case they are available]</b></p> <p><b>Are you happy with the current volume of responses obtained?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Quantitative</li> <li>• Qualitative</li> <li>• Any plans to get a more satisfying volume of responses?</li> </ul> <p><b>Aside from NHSE, does your practice share the FFT outputs with anyone else?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Your clinical commissioning group?</li> <li>• Your NHSE local area team?</li> <li>• With staff?</li> <li>• With patients?</li> </ul> <p><b>How are the outputs presented?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• How often are results presented?</li> <li>• Where are they presented?</li> <li>• Use of score, rankings/comparisons, time series, free text comments, coded/synthesised presentation of text (e.g. word clouds)</li> <li>• Would you be able to provide any examples?</li> </ul> <p><b>And what do you think about the way the data is published in the practice?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Is there anything you would like to change about this?</li> </ul> <p><b>IF NOT COVERED:</b></p> <p><b>Do you use the answers for the follow up questions for anything? E.g., local service improvement?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• What are the most typical answers/themes gained from FFT?</li> <li>• What are they most useful for, what are they least useful for?</li> </ul>	<p>We are interested in knowing here how the practice is sharing and using the results. Ideally we want some good case study examples of practices which have used the results to make practical changes to improve patient experience.</p> <p>We are particularly interested in the use of the free text questions. Previous research on FFT in trusts suggests that this information tends to be seen as the most useful output from FFT.</p>	<p>5 mins</p>



	Notes	Time
<b>Use of data continued</b>		
<p><b>How useful are the outputs for the practice?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Have you changed any services or anything else in the surgery as a result of the feedback from the FFT? Any examples?</li> <li>• Were patients involved in these changes? In what way?</li> <li>• Is there anything that would help you to get better use out of the outputs from the FFT?</li> <li>• What support would you need e.g. further guidance?</li> <li>• What impact, if any, has the presentation of the results had on patient-clinician relationships in your practice?</li> </ul> <p><b>Is FFT data used for purposes other than quality improvement?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Staff motivation and/or personal development?</li> <li>• Performance management?</li> </ul> <p><b>IF THEY DON'T USE THE FFT RESULTS:</b>  <b>What would make the FFT results useful for your practice?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• More resource time/money/guidance?</li> </ul> <p><b>Does your practice carry out any of the activities related with the FFT in a coordinated way with other practices?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• IF YES, which ones and with which practices? (E.g. with practices included in the same network/federation? With other practices sharing the same external provider?)</li> <li>• Any significant advantages coming from this collaboration? Any difficulties?</li> </ul>		
<b>Impact of FFT</b>		
<p><b>Now I'd like you to consider the effect the FFT has had on your practice...</b></p> <p><b>What has changed for you as a result of FFT?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Positive examples/Success stories – FFT playing a role in local improvement</li> <li>• Negative examples</li> <li>• What benefits have you experienced from FFT which may not have come out of other existing patient feedback tools?</li> <li>• Positive or negative effects on the way in which the clinical work is carried out</li> </ul> <p><b>What impact do you think FFT has had on staff?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Impact of publication on staff</li> <li>• Any impact of FFT scores and of text feedback</li> </ul> <p><b>Could you tell me about the amount of time that staff spend on managing FFT. Do you feel it is too much/too little?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• To what extent do you feel that administering the FFT is a good use of staff time?</li> </ul>	<p>This section wants to better understand what impact FFT has had both in terms of changes to the practice and attitudes of the staff. You may find that some of what is discussed here has already been covered. Please use your discretion on whether to probe further.</p> <p>Please probe on impact on relationships as we are particularly interested in whether FFT is seen to have a positive or negative impact on relationships.</p>	5 mins



	Notes	Time
<b>Impact of FFT <i>continued</i></b>		
<p><b>And what impact has the FFT had on how you think about patient experience in this practice?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Impact on patient and practitioner relationships</li> <li>• Impact on patient and practice relationship</li> </ul> <p><b>IF NOT ALREADY COVERED?</b>  <b>Finally, can you also tell me about the direct costs associated with FFT?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Administration costs</li> <li>• Data analysis costs</li> <li>• Local publication costs</li> </ul>		
<b>Implementation of the FFT</b>		
<p><b>Going back, can you talk me through how your practice went about setting up the FFT? Were you directly involved in it?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Decisions about questions used and involvement of external providers</li> <li>• Choice of method(s)</li> <li>• Training and engaging staff</li> <li>• Setting up systems to ensure the practice complies with monthly data return requirements</li> <li>• Information used to aid implementation</li> <li>• Usefulness of the information</li> </ul> <p><b>Were there any aspects of setting up the FFT that your practice found particularly challenging? What made that challenging?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Decisions about questions and involvement of external providers</li> <li>• Choice of method(s), training</li> <li>• Engaging staff</li> <li>• Setting up systems to ensure the practice complies with monthly data return requirements</li> <li>• Information used to aid implementation</li> <li>• Usefulness of the information</li> </ul> <p><b>How did you find the information and guidance provided by NHSE about implementation of FFT?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Are there any areas in which it was particularly helpful?</li> <li>• Or areas where more guidance would be helpful?</li> </ul> <p><b>How do you think the set-up of the FFT in your practice could have been better?</b></p> <p><b>What changes, if any, were made to the way the FFT is implemented in you practice since it was first set up in December 2014?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Modes of collections?</li> <li>• More proactive collection?</li> <li>• Sampling approach?</li> <li>• Better staff engagement?</li> <li>• Why were the changes made?</li> </ul>	<p>This section aims to understand how the practice found introducing the FFT and if there was anything they found particularly challenging. Whilst covering some of the issues around negative feelings towards FFT do try to focus conversations on practical difficulties.</p>	5 mins





	Notes	Time
<b>The future of FFT and wrap up</b>		
<p><b>What is the most important message that we should take back to the Department of Health about the FFT in GP practices?</b></p> <p><b>Do you think that any changes should be made to the FFT?</b></p> <p><i>PROBE:</i></p> <ul style="list-style-type: none"> <li>• Which would you say are the most important</li> <li>• Why do you say that?</li> </ul> <p><b>What else would you like to add about the impact of FFT that we have not already discussed?</b></p> <p>THANK AND CLOSE</p> <p>ASK TO SEE COLLECTION MATERIALS/POINTS IF HAVE NOT ALREADY</p> <p>&lt;IF ASKED&gt;</p> <p>LSHTM will be submitting their report to DH at the end of the year. This report will also be made available on their website early next year.</p>		2 mins



## Topic guide for interviews with non-clinical staff

	Notes	Time
<b>Introduction</b>		
<p>Introduce self and project: Qualitative review of the Friends and Family Test (FFT) being undertaken by the Department of Health and NHS England to get structured feedback on how the implementation and use of FFT is working in GP practices.</p> <p>Explain Ipsos MORI role in relation to LSHTM – independent research company – we are impartial: we are neither in favour nor against the FFT, we are just here to hear your views.</p> <p>Explain the interview should last around 30 min depending on how much they have to say.</p> <p>Explain anonymity: names of individual participants or of the practice they work in will not be used when reporting the findings and we will not tell anyone at DH/NHSE who said what. DH/NHSE will not know which practices will have participated in the study. To emphasise, we are not inspecting your practice, we just want to hear your views on the FFT.</p> <p>Ipsos MORI works in accordance with MRS guidelines and the Data Protection Act.</p> <p>Obtain permission to record discussion (we will be using the transcripts in our analysis). BEGIN RECORDING</p> <p>Get signed consent form if interview is face-to-face.</p> <p>Read form and audio record participant’s consent if over telephone.</p>		
<b>Warm up question</b>		
<b>Please briefly tell me about your role in this practice and your involvement with FFT...</b>		1min



	Notes	Time
<b>Initial thoughts on FFT</b>		
<p><b>I'd like to start by getting your initial thoughts on FFT.</b></p> <p><b>What three words would you use to describe the FFT?</b> <i>PROBE:</i></p> <ul style="list-style-type: none"> <li>• What makes you say that?</li> </ul> <p><b>How do you think it is perceived within your practice by...?</b> <i>PROBE:</i></p> <ul style="list-style-type: none"> <li>• Clinicians</li> <li>• Other staff</li> <li>• Patients</li> </ul> <p><b>Is there anything that you particularly like about FFT?</b> <i>PROBE:</i></p> <ul style="list-style-type: none"> <li>• Use of single question and open text questions</li> <li>• Choice of who can respond and the volume of responses you can collect</li> <li>• Freedom in choice of collection method</li> </ul> <p><b>Is there anything that you particularly dislike about FFT?</b> <i>PROBE AS ABOVE</i></p> <p><b>What do you see as the main purpose of having the FFT in GP practices?</b></p>	<p>If participant starts talking about sampling and response rates, please follow up on this.</p>	5 mins
<b>Data collection of FFT</b>		
<p><b>Please talk me through how FFT data is collected in your practice</b> <i>PROBE:</i></p> <ul style="list-style-type: none"> <li>• How is the FFT data collected? According to NHSE data you have/don't have a combination of methods. Can you confirm this?</li> <li>• Were any arrangements made with external providers for data collection? Can you describe their role?</li> <li>• What impact does collecting the data for FFT have on your work/ your workload?</li> <li>• When do patients complete the FFT? <i>PROBE:</i> Before or after their appointment</li> <li>• Approximately how many patients are asked?</li> <li>• Do you calculate a response rate? What is it? Are you happy with the way you do this?</li> <li>• Who, if anyone, asks patients to complete the FFT (i.e. does a receptionist or clinician directly ask them to respond? Is the collection made available somewhere in the practice to be filled in by a process of self-selection)?</li> <li>• IF SELF-SELECTION: <ul style="list-style-type: none"> <li>– What do you think of how the FFT materials are displayed?</li> <li>– How clear is this for patients?</li> </ul> </li> <li>• IF THEY ARE PRO-ACTIVELY ASKED TO FILL IT IN: <ul style="list-style-type: none"> <li>– How are patients selected and how often are they asked to complete (e.g. after every appointment)?</li> <li>– Does the practice have an exclusion criterion?</li> </ul> </li> </ul>	<p>The aim here is to understand how the practice implements FFT – <b>if possible try and collect hard copy examples of FFT. Do also note observations and if possible ask to take photos of collection methods if conducting interview in the practice.</b></p> <p>You will need to use the data we have already on the collection method here.</p>	5 mins



	Notes	Time
<b>Data collection of FFT <i>continued</i></b>		
<p><b>What additional data, if any, do you collect alongside the FFT? For example, demographic data?</b></p> <p><b>What do you think about the way FFT data is currently collected?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Ability to capture feedback that is helpful for providing better care.</li> <li>• Do you have any good practice examples?</li> <li>• Is there anything that could work better?</li> </ul> <p><b>And, how do you think patients find completing the FFT?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• What reactions do you get when you invite people to complete the FFT?</li> <li>• Who is most likely to take part?</li> <li>• Who refuses?</li> <li>• What questions do patients ask about it?</li> </ul>		
<b>Data analysis</b>		
<p><b>I would like to move on to talk about the data from FFT.</b></p> <p><b>Please describe what happens to the quantitative data (tick-box FFT question) once it is collected</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Who prepares the data for submission to NHSE?</li> <li>• Do you use any tools to prepare/analyse them (e.g. digital/automated tools to process FFT responses)?</li> </ul> <p><b>Are you happy with the current arrangements to submit data to NHSE?</b></p> <p><b>Please describe what happens to the free text comments once they are collected</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• How is it analysed and by whom?</li> <li>• Have you been using any tools to do this analysis (e.g. digital/ automated tools to process FFT responses)?</li> </ul> <p><b>What, if anything, would help you with the analysis of FFT data?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Additional support needed?</li> <li>• Training or guidance on best practice/what other practices do with their FFT data?</li> </ul> <p><b>IF NO ANALYSIS TAKES PLACE:</b>  <b>Is there a particular reason for this?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Time</li> <li>• Complexity</li> <li>• Resource issues</li> </ul>	<p>Here we are trying to understand what approach practices are taking to gather useful data – as with the next section, we are looking to get good practice examples from this discussion.</p>	5 mins



	Notes	Time
<p><b>Use of data</b></p> <p><b>What are the main ways you get patient feedback?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Informal, GPPS, CQC rating, FFT</li> <li>• Which have you found the most useful?</li> </ul> <p><b>Have any led to improvements in service? PROBE FOR EXAMPLES</b></p> <p><b>I'd now like to talk about the outputs from the FFT...</b></p> <p><b>How many quantitative responses does your practice get?</b></p> <p><b>Did you notice any specific trend in volume of responses obtained?</b>  <i>[Read and compare with NHSE data obtained from the practice together with interviewee. Ask about gaps in data submission, large drops or rises in responses that are reported]</i></p> <p><b>Approximately how many free-text comments does your practice obtain? Do you know approximately how many were received each month? [Record the monthly data in case they are available]</b></p> <p><b>Are you happy with the current volume of responses obtained?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Quantitative</li> <li>• Qualitative</li> <li>• Any plans to get a more satisfying volume of responses?</li> </ul> <p><b>Aside NHSE, does your practice share the FFT outputs with anyone else?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Your clinical commissioning group?</li> <li>• Your NHSE local area team?</li> <li>• With staff?</li> <li>• With patients?</li> </ul> <p><b>How are the outputs presented?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• How often are results presented?</li> <li>• Where are they presented?</li> <li>• Use of score, rankings/comparisons, time series, free text comments, coded/synthesised presentation of text (e.g. word clouds)</li> <li>• Would you be able to provide any examples?</li> </ul> <p><b>And what do you think about the way the data is published in the practice?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Is there anything you would like to change about this?</li> </ul> <p><b>IF NOT COVERED:</b></p> <p><b>Do you use the answers for the follow up questions for anything? E.g., local service improvement?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• What are the most typical answers/themes gained from FFT?</li> <li>• What are they most useful for, what are they least useful for?</li> </ul>	<p>We are interested in knowing here how the practice is sharing and using the results. Ideally we want some good case study examples of practices which have used the results to make practical changes to improve patient experience.</p> <p>We are particularly interested in the use of the free text questions. Previous research on FFT in trusts suggests that this information tends to be seen as the most useful outputs from FFT.</p>	<p>5 mins</p>



	Notes	Time
<b>Use of data continued</b>		
<p><b>How useful are the outputs for the practice?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Have you changed any services or anything else in the surgery as a result of the feedback from the FFT? Any examples?</li> <li>• Were patients involved in these changes? In what way?</li> <li>• Is there anything that would help you to get better use out of the outputs from the FFT?</li> <li>• What support would you need e.g. further guidance?</li> </ul> <p><b>Is FFT data used for purposes other than quality improvement?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Staff motivation and/or personal development?</li> <li>• Performance management?</li> </ul> <p><b>IF THEY DON'T USE THE FFT DATA:</b>  <b>What would make the FFT results useful for your practice?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• More resource time/money/guidance?</li> </ul> <p><b>Does your practice carry out any of the activities related with the FFT in a coordinated way with other practices?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• IF YES, which ones and with which practices? (E.g. with practices included in the same network/federation? With other practices sharing the same external provider?)</li> <li>• Any significant advantages coming from this collaboration? Any difficulties?</li> </ul>		
<b>Impact of FFT</b>		
<p><b>Now I'd like you to consider the effect the FFT has had on your practice...</b></p> <p><b>What has changed for you as a result of FFT?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Positive examples/Success stories – FFT playing a role in local improvement</li> <li>• Negative examples</li> <li>• What benefits have you experienced from FFT which may not have come out of other existing patient feedback tools?</li> </ul> <p><b>What impact do you think FFT has had on staff?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Impact of publication on staff</li> <li>• Any impact of FFT scores and of text feedback</li> </ul> <p><b>Could you tell me about the amount of time that staff spend on managing FFT. Do you feel it is too much/too little?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• To what extent do you feel that administering the FFT is a good use of staff time?</li> </ul> <p><b>And what impact has the FFT had on how you think about patient experience in this practice?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Impact on patient and practitioner relationships</li> <li>• Impact on patient and practice relationship</li> </ul>	<p>This section wants to better understand what impact FFT has had both in terms of physical changes to the practice and attitudes of the staff.</p> <p>You may find that some of what is discussed here has already been covered. Please use your discretion on whether to probe further.</p> <p>Please probe on impact on relationships as we are particularly interested in whether FFT is seen to have a positive or negative impact on relationships.</p>	5 mins



	Notes	Time
<b>Impact of FFT continued</b>		
<p><i>IF NOT COVERED:</i>  <b>Finally, can you also tell me about the direct costs associated with FFT?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Administration costs</li> <li>• Data analysis costs</li> <li>• Local publication costs</li> </ul>		
<b>Implementation of the FFT</b>		
<p><b>Going back, can you talk me through how your practice went about setting up the FFT?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Decisions about questions and involvement of external providers</li> <li>• Choice of method(s)</li> <li>• Training and engaging staff</li> <li>• Setting up systems to ensure the practice complies with monthly data return requirements</li> <li>• Information used to aid implementation</li> </ul> <p><b>What aspects of setting up the FFT did your practice find most challenging? What made that challenging?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Decisions about questions and involvement of external providers</li> <li>• Choice of method(s)</li> <li>• Training and engaging staff</li> <li>• Setting up systems to ensure the practice complies with monthly data return requirements</li> </ul> <p><b>How did you find the information and guidance provided by NHSE about implementation of FFT?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Are there any areas in which it was particularly helpful?</li> <li>• Or areas where more guidance would be helpful?</li> </ul> <p><b>How do you think the set-up of the FFT in your practice could have been better?</b></p> <p><b>What changes, if any, have you made to the way the FFT is implemented in you practice since it was first set up in December 2014?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Modes of collections?</li> <li>• More proactive collection?</li> <li>• Sampling approach?</li> <li>• Better staff engagement?</li> <li>• Why were the changes made?</li> </ul>	<p>This section aims to understand how the practice found introducing the FFT and if there was anything they found particularly challenging. Whilst covering some of the issues around negative feelings towards FFT do try to focus conversations on practical difficulties.</p>	5 mins



	Notes	Time
<b>The future of FFT and wrap up</b>		
<p><b>What is the most important message that we should take back to the Department of Health about the FFT in General Practice?</b></p> <p><b>Do you think that any changes should be made to the FFT?</b></p> <p><i>PROBE:</i></p> <ul style="list-style-type: none"> <li>• Which would you say are the most important</li> <li>• Why do you say that?</li> </ul> <p><b>What else would you like to add about the impact of FFT that we have not already discussed?</b></p> <p>THANK AND CLOSE</p> <p>ASK TO SEE COLLECTION MATERIALS/POINTS IF HAVE NOT ALREADY</p> <p>&lt;IF ASKED&gt;</p> <p>LSTHM will be submitting their report to DH at the end of the year. This report will also be made available on their website early next year.</p>		5 mins





## Topic guide for interviews with Patient Participation Group representative

	Notes	Time
<b>Introduction</b>		
<p>Introduce self and project: Qualitative review of the Friends and Family Test (FFT) being undertaken by DH and NHSE to get structured feedback on how the implementation and use of FFT is working in GP practices.</p> <p>Explain Ipsos MORI role in relation to LSTHM – independent research company etc.</p> <p>Explain the interview should last around 30 min depending on how much they have to say.</p> <p>Explain anonymity: names of individual participants or of the practice they work in will not be used when reporting the findings and we will not tell anyone at DH/NHSE who said what. DH/NHSE will not know which practices will have participated in the study. Ipsos MORI works in accordance with MRS guidelines and the Data Protection Act.</p> <p>Obtain permission to record discussion (we will be using the transcripts in our analysis). BEGIN RECORDING</p> <p>Get signed consent form if interview is face-to-face.</p> <p>Read form and audio record participant's consent if over telephone.</p>		
<b>Warm up question</b>		
<b>Please briefly tell me about your role in the Patient Participation Group and your interaction with the practice in relation to FFT...</b>		1min



	Notes	Time
<b>Initial thoughts on FFT</b>		
<p><b>I'd like to start by getting your initial thoughts on FFT.</b></p> <p><b>What three words would you use to describe the FFT?</b> <i>PROBE:</i></p> <ul style="list-style-type: none"> <li>• What makes you say that?</li> </ul> <p><b>How do you think it is perceived within you practice by...?</b> <i>PROBE:</i></p> <ul style="list-style-type: none"> <li>• Patients</li> <li>• Clinicians</li> <li>• Other staff</li> </ul> <p><b>Is there anything that you particularly like about FFT?</b> <i>PROBE:</i></p> <ul style="list-style-type: none"> <li>• Use of single question and open text questions</li> <li>• Choice of who can respond and the volume of responses you can collect</li> <li>• Freedom in choice of collection method</li> </ul> <p><b>Is there anything that you particularly dislike about FFT?</b> <i>PROBE AS ABOVE</i></p> <p><b>What do you see as the main purpose of having the FFT in GP practices?</b></p>	<p>If participant starts talking about sampling and response rates, please follow up on this.</p>	2 mins
<b>Data collection of FFT</b>		
<p><b>Please talk me through how FFT data is collected in your practice</b> <i>PROBE:</i></p> <ul style="list-style-type: none"> <li>• How is the FFT data collected? Is a combination of methods used?</li> <li>• When are patients asked to complete FFT? <i>PROBE:</i> Before or after their appointment</li> <li>• Who, if anyone, asks patients to complete the FFT (i.e. does a receptionist or clinician ask them to fill it in or is the form made available somewhere in the practice to be filled in by a process of self-selection)?</li> <li>• IF SELF-SELECTION: <ul style="list-style-type: none"> <li>– What do you think of how the FFT materials are displayed?</li> <li>– How clear is this for patients?</li> </ul> </li> <li>• IF THEY ARE PRO-ACTIVELY ASKED TO FILL IT IN: <ul style="list-style-type: none"> <li>– How are patients selected and how often are they asked to complete (e.g. after every appointment)?</li> <li>– Does the practice have an exclusion criterion?</li> </ul> </li> </ul> <p><b>How do you think patients find completing the FFT?</b> <i>PROBE:</i></p> <ul style="list-style-type: none"> <li>• Who is most likely to take part?</li> <li>• Who refuses?</li> <li>• What questions do patients ask about it?</li> </ul> <p><b>What sort of opportunity do you think the FFT gives patients to have their voice heard?</b> <i>PROBE:</i></p> <ul style="list-style-type: none"> <li>• To what extent does it capture the kinds of feedback patients want to provide?</li> <li>• How does it compare to other tools/channels available for collecting patients views (e.g. GP Patient Survey, Practice surveys)?</li> </ul>	<p>The aim here is to understand how the practice implements FFT and how the approach is perceived by patients. We are particularly interested in understanding if patients feel the approach the practice has taken allows them to give meaningful feedback.</p>	4 mins



	Notes	Time
<b>Data analysis</b>		
<p><b>I would like to move on to talk about the data from FFT.</b></p> <p><b>Are you aware of any analysis happening on the FFT data in the practice?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Analysis of quantitative data</li> <li>• Analysis of free text comments</li> <li>• How involved has the PPG or the patients been in the analysis of and discussions about the FFT data?</li> </ul> <p><b>How do you feel about the levels of patient involvement in the analysis of the data?</b></p> <p><b>What do you think that the way in which data are currently analysed?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Does it allow for prompt identification of significant issues?</li> <li>• Is there anything that could be done better?</li> </ul> <p><b>IF SUGGESTED THAT NOT AWARE OF ANY ANALYSIS TAKING PLACE:</b>  <b>Is there a particular reason for this?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Time</li> <li>• Complexity</li> <li>• Resource issues</li> </ul>	<p>Again we are trying to understand how involved patients/ the PPG have been in the analysis of the FFT data. We are also looking for good practice examples both in terms of involving patients and using the FFT to improve quality of care.</p>	5 mins
<b>Use of data</b>		
<p><b>What are the main ways patients are able to provide feedback?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Informal, GPPS, CQC rating, FFT</li> <li>• Which have been most useful?</li> </ul> <p><b>Have any led to improvements in service? PROBE FOR EXAMPLES</b></p> <p><b>I'd now like to talk about the outputs from the FFT...</b></p> <p><b>Does the PPG have any involvement in monitoring the number of FFT responses the practice receives each month?</b>  <b>PROBE IF YES:</b></p> <ul style="list-style-type: none"> <li>• Are you involved in any of the issues related to the number of responses? E.g. exploring trends or dips in responses?</li> </ul> <p><b>IF YES TO PREVIOUS QUESTION:</b>  <b>Are you happy with the current volume of responses obtained?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Quantitative</li> <li>• Qualitative</li> <li>• Any plans to get a more satisfying volume of responses?</li> </ul> <p><b>Aside NHSE, does your practice share the FFT outputs with anyone else?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• CCG/NHSE?</li> <li>• With staff?</li> <li>• With patients?</li> </ul>	<p>We are interested in knowing here how the practice is sharing and using the results. Ideally we want examples of practices which have used the results to make practical changes to improve patient experience.</p> <p>We are particularly interested in the use of the free text questions. Previous research Ipsos has conducted on FFT in trusts suggests that this information tends to be seen as the most useful outputs from FFT.</p>	5 mins





	Notes	Time
<b>Impact of FFT</b>		
<p><b>Now I'd like you to consider the effect the FFT has had on your practice...</b></p> <p><b>What has changed as a result of FFT?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Positive examples/Success stories – FFT playing a role in local improvement</li> <li>• Negative examples</li> <li>• What benefits have PPG/the practice experienced from FFT which may not have come out of other existing patient feedback tools?</li> </ul> <p><b>What impact has the FFT had on how the practice thinks about patient experience?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Impact on patient and practitioner relationships</li> <li>• Impact on patient and practice relationship</li> <li>• Any observation of impact of publication and scores on staff</li> </ul>	<p>This section wants to better understand what impact FFT has had both in terms of physical changes to the practice, and attitudes of the staff. You may find that some of what is discussed here has already been covered. Please use your discretion on whether to probe further.</p> <p>Please probe on impact on relationships as we are particularly interested in whether FFT is seen to have a positive or negative impact on relationships.</p>	5 mins
<b>Implementation of the FFT</b>		
<p><b>Thinking back to when FFT was being set up in the practice, what involvement, if any, did the Patient Participant Group have in its implementation?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Decisions about questions and involvement of external providers</li> <li>• Choice of method(s), training</li> <li>• Setting up systems to ensure the practice complies with monthly data return requirements</li> <li>• Information used to aid implementation</li> <li>• Usefulness of the information</li> </ul> <p><b>THOSE WHO WERE INVOLVED:</b>  <b>Are you aware of any difficulties the practice faced in setting up FFT?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• IF YES: Can you tell me a bit more about this?</li> <li>• Decisions about questions and involvement of external providers</li> <li>• Choice of method(s), training</li> <li>• Setting up systems to ensure the practice complies with monthly data return requirements</li> <li>• Information used to aid implementation</li> <li>• Usefulness of the information</li> </ul> <p><b>And how do you feel about the degree of involvement the PPG has had in the implementation of the FFT in the practice?</b></p> <p><b>What, if anything, would you like to have seen done differently?</b></p> <p><b>THOSE WHO WERE NOT INVOLVED:</b>  <b>Why do you think this was?</b>  <b>PROBE:</b></p> <ul style="list-style-type: none"> <li>• Practice's involvement with the PPG</li> <li>• Perceived relevance/ usefulness of FFT</li> <li>• And how do you feel about the degree of involvement the PPG had? Right amount, not enough?</li> </ul>	<p>This section aims to understand how FFT was implemented and what involvement patients/the PPG had in this process.</p>	5 mins



	Notes	Time
<b>The future of FFT and wrap up</b>		
<p><b>What is the most important message that we should take back to the Department of Health about the early implementation of FFT?</b></p> <p><b>And what is the most important thing to change about the FFT now? Why do you say that?</b></p> <p><b>What else would you like to add about the impact of FFT that we have not already discussed?</b></p> <p>THANK AND CLOSE</p> <p>&lt;IF ASKED&gt;</p> <p>LSTHM will be submitting their report to DH at the end of the year. This report will also be made available on their website early next year.</p>		2 mins

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