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EDITORIALS

Friends and family test should no longer be mandatory

Valued by policy makers but generates little insight for practitioners

Glenn Robert *professor of healthcare quality and innovation*¹, Jocelyn Cornwell *chief executive*², Nick Black *professor of health services research*³

¹Florence Nightingale Faculty of Nursing, Midwifery and Palliative Care, King's College London, London, UK; ²Point of Care Foundation, London, UK; ³London School of Hygiene and Tropical Medicine, London, UK

Don Berwick, an international leader in the safety and quality of healthcare, has called for “a significant reduction in the volume and total cost of measurements currently being used and enforced in health care.”¹ He is not alone in arguing that a belief in accountability and market theory “has brought with it excessive measurement, much of which is useless but nonetheless mandated.”²

The inpatient “friends and family test” was introduced in all English acute hospitals in April 2013. The aim was to provide a simple metric that, when combined with follow-up questions, could be used to drive cultural change and improve the quality of care.³ The main question is “How likely are you to recommend our service to friends and family if they needed similar care or treatment?” and respondents can rank their answer from “extremely likely” to “extremely unlikely.” The test was formally reviewed after the first six months of data collection and subsequently extended to maternity, outpatient, ambulance, mental health, community, primary care, and dental services.⁴

Well over 30 million pieces of feedback have now been collected—and the total rises by over a million a month, which NHS England says makes it the “biggest source of patient opinion in the world.”⁵ Collecting and managing such large amounts of data is complex, requiring substantial investments of time and other limited resources.⁶ Over the past four years about £12m (€14m; \$17m) has been allocated centrally to support the test across England, and although expenditure is decreasing, it was still around £1.5m in 2016–17. However, this does not include costs for local implementation, which are borne by providers.⁷ Across the NHS in England these can be considerable. Contracts of £40 000 with external suppliers to manage feedback from the test in each acute provider would amount to around £6m annually in England⁸; this figure excludes other sectors as well as NHS staff costs in gathering and collating the data.

Several years after its introduction, the case for a compulsory friends and family test lacks a strong rationale and scientific evidence. In acute hospitals, teams responsible for improving

patient experience speak of devoting much of their time to collecting, collating, and reporting the data. Often local ambition is restricted to simply attaining adequate response rates, which then tend to be the sole focus of attention for trust boards and local commissioners. This leads to organisations using the data only to judge themselves on response rates and the proportion of respondents who “would/would not recommend” their services. However, invitation and response biases mean results cannot be used as a comparative measure of performance, as NHS England has clearly stated and others continue to highlight.⁹

Beyond the headlines

Although some front line teams are perhaps seeing feedback from their patients for the first time, and some ward managers find the quantitative data helpful, it is the qualitative data gleaned from the open comments section that is more highly valued as it can provide actionable feedback. For many staff, the headline metric lacks credibility and is pushed to the margins of organisations—at best tolerated, often ignored, and sometimes ridiculed. In primary care, a recent evaluation found “widespread unease about the friends and family test,” with many staff perceiving it to be purely a tool for national bodies to monitor them.¹⁰

Recently, NHS England has shifted its interest in the test away from individual providers to assessing patients’ experiences of systems such as emerging accountable care systems. It has also launched a consultation on the design of the test but has made clear that stopping central data collection is not an option.¹¹ The fear seems to be that NHS organisations might stop collecting feedback from patients altogether. But continuing with a compulsory friends and family test risks displacing more fruitful approaches to patient feedback that are more likely to engage clinicians.¹²

Recognising this, the 2013 Keogh report argued that real time patient feedback and comment must “reach well beyond the friends and family test.”¹³ Work in the US is exploring the role of patient narratives in improving the quality of healthcare and

how they might be elicited and reported with the same scientific rigour as well designed surveys that are used extensively for both public reporting and value based payment programmes.¹⁴

The friends and family test may be the biggest source of patient opinion in the world, but rather than a local enabler of quality improvement, it remains a questionable measure of performance. By making it non-mandatory, NHS England could free up the time and resources that providers currently spend on metrics that have little value for practitioners. It is time to stop compelling all NHS organisations to collect large amounts of data of unknown representativeness with poor response rates that give little insight and to heed Berwick's plea: "to measure only what matters, and mainly for learning."¹

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