4th December 2025

Making the NHS Friends and Family Test ‘fit for the future’

Authors: Olli Potter, Jenny King, & Chris Graham

publicaffairs@pickereurope.ac.uk | www.picker.org

Picker

Picker is a leading international health and social care charity. We carry out research to understand individuals' needs and their experiences of care. We are here to:

- Influence policy and practice so that health and social care systems are always centred around people's needs and preferences.
- Inspire the delivery of the highest quality care, developing tools and services which enable all experiences to be better understood.
- Empower those working in health and social care to improve experiences by effectively measuring, and acting upon, people's feedback.

Published by and available from:

Picker Institute Europe
Suite 6, Fountain House,
1200 Parkway Court,
John Smith Drive,
Oxford OX4 2JY
Tel: 01865 208100
Email: Info@PickerEurope.ac.uk
Website: picker.org

Registered Charity in England and Wales: 1081688

Registered Charity in Scotland: SC045048

Company Limited by Registered Guarantee No 3908160

Acknowledgements

We would like to thank everyone who, in addition to their time, shared their expertise, insights and experience as part of this project. Our engagement with stakeholders has informed our work and this final report: however, all views, conclusions and recommendations are Picker's own.

A special thanks to the roundtable attendees from the following organisations who helped shape our thinking:

- Barts Health NHS Trust
- Department of Health and Social Care
- Healthwatch England
- Lancashire and South Cumbria NHS Foundation Trust
- NHS Dorset
- NHS England
- Royal College of General Practitioners
- The Health Foundation
- The Institute for Public Policy Research (IPPR)
- The King's Fund
- The Newcastle Upon Tyne Hospitals NHS Foundation Trust
- The Patients Association
- University College London Hospital NHS Foundation Trust

Competing interests

Picker is a charity, and our goal is to improve the quality of person centred care experienced by our ultimate beneficiaries – patients and the public. In support of this goal, we work with policy makers, providers, and professionals to help them understand, measure and improve people's experiences.

Our work includes designing programmes and gathering feedback from patients and the public, both in the NHS and elsewhere. This includes supporting providers with the NHS Friends and Family Test as well as other measurement programmes.

Our track record in measuring people's experiences affords us useful knowledge and insight, which we have drawn on in this review. The analysis and recommendations we present in this report are based on evidence, best practice, and the goal of improving experiences of care – not commercial interests.

A note on language

Throughout this report we use the term ‘patient(s)’ as a broad term to refer to users of all health and social care services – including people who would not ordinarily be referred to as a ‘patient’. This usage is intended to aid readability only and does not imply any prioritisation of physical health compared to other care and support settings.

Contents

Foreword 6

Executive summary 8

- Key findings 8
- Summary of recommendations 8
- Conclusions 10

Introduction 11

Background and context 13

- A short history of the NHS Friends and Family Test (FFT) 13
- How the FFT has developed 13
- Current mandated structure 14

The case for change 16

- Estimated cost to providers 17
- Grounding in the present 18

Strengths and weaknesses of the current approach 20

- Strengths 20
- Weaknesses 21

Opportunities and solutions to make the FFT ‘fit for the future’ 23

Conclusions 25

Recommendations 26

- National 26
- Local 28

Foreword

We all want the highest possible quality of care for ourselves and our loved ones when we interact with the NHS – but those standards are not always met. There are numerous reasons for this, not least that quality measurement and improvement in healthcare is a relatively new phenomenon: it was only five to ten years after I left medical school in 1983 that we began to pay serious attention to healthcare quality in this country.

A key component of quality is patient experience. Not only is it a core aspect of quality in its own right, but insights from patients can help drive improvements in other constituents of quality such as safety and effectiveness. Given this pivotal importance, the Department of Health and Social Care (DHSC) commissioned Picker to collect patient experience data via national surveys, starting with inpatient care, in 2002. The Commission for Healthcare Improvement, which later became the Care Quality Commission (CQC), had recently been established and it used the survey data as part of its inspection processes. Since then, further mechanisms to measure, improve, assess and assure patient experience have been put in place in this country and their impact has been variable. Agreement on reliable, effective mechanisms to assess and improve patient experience at both a local and national level remains relatively elusive.

One key measure is the NHS Friends and Family Test (FFT) which was introduced nationally in 2013 as a single item patient reported measure of their experience of healthcare quality. Mandated in the NHS standard contracts, the FFT is widely used and collects enormous volumes of feedback every month – but questions remain about its value.

Given the importance afforded to patient experience in the recent Ten Year Plan for Health and the Dash review of the patient safety landscape, the time is right for us to re-assess the FFT and to ask whether it is fit for purpose, if it needs to evolve, or if it should be abolished.

Picker is a centre of thought leadership in patient experience and has pioneered the use of experience surveys in this country since 2002. It is ideally placed to work with others to critically assess the utility and impact of the FFT and to make recommendations for its future. This report is an output from a comprehensive literature review and from two roundtables comprising acknowledged experts in patient experience. It makes a number of recommendations about how to evolve the FFT in the current healthcare landscape.

Time and again over several decades, national inquiries have clearly told us that we do not do enough to listen to and act upon the voices of patients. At a time when health services are under such immense pressure, it is more important than ever that we systematically seek the views of patients and use their unique perspectives to help us to continually improve the quality of the services we offer.

For too long, there has been a widely held perception that patient experience is the poor relation of other aspects of healthcare quality, such as safety – as acknowledged by Dr Penny Dash in her recent review of the patient safety landscape. Now is the time to change that perception. The recommendations in this report can help improve all aspects of quality through the systematic collection of insights from those who have the most to gain from improvements in healthcare quality - patients.

Professor Alf Collins
Freelance health consultant, former NHS England clinical director for personalised care, and Picker trustee

Executive summary

The NHS Friends and Family Test (FFT), introduced nationally in 2013, was designed to provide a simple mechanism for gathering patient feedback across health services in near real-time. Its form and role have evolved over time: whilst originally it was intended to offer a 'single quality measure', there are now acknowledged limitations in its ability to provide comparable measurement data and to capture the full breadth of patient experience. Today its use is mandated across the NHS, and provider organisations are encouraged to focus on the unstructured comments that it gathers from patients.

This report, developed in collaboration with stakeholders, explores the historical context of the FFT, its current structure, strengths, and weaknesses, and sets out a case for reform. It draws on stakeholder engagement, a published literature review, and wider analysis to assess the FFT's effectiveness and future potential against the wider current political and economic context.

Key findings

- **Strengths:** The FFT has raised the profile of patient experience and provides valuable qualitative insights. It can empower staff when used effectively, and patient comments can highlight areas for improvement.
- **Weaknesses:** The FFT shows limited variation in results, lacks comparability due to inconsistent methodologies, and is only moderately associated with other quality measures. It is vulnerable to misuse and does not always provide actionable insights.
- **Costs:** Collection of the FFT involves considerable expense. For the 205 trusts in England, estimated combined provider costs range from £10-16 million annually. These figures exclude staff time and broader system costs.
- **Wider context:** Recent government publications, including the Ten Year Plan for Health and the Dash Review of the patient safety landscape, emphasise the importance of patient voice and feedback, but highlight shortcomings in current approaches.

Summary of recommendations

Picker recommends reforming the FFT to improve its impact and value for money. Nationally, the Department of Health and Social Care (DHSC) and NHS England (NHSE) (the centre) should:

1. **Maintain the FFT mandate while improving flexibility and comparability through a programme of reform.** This programme of reform should be supported by a diverse advisory group of patients and stakeholders and should deliver national guidance for providers, drawing on examples of local best practice. This guidance should also clarify the purpose of the reformed FFT, rebrand and rename it, and commit to trialling the collection of demographic data to support wider objectives to tackle health inequalities. It should also consider offering a national solution for FFT administration and data capture, such as by providing a facility for patients to be sent and complete FFT surveys through the NHS App.
2. **Continue to mandate the collection of both qualitative and quantitative data, with Artificial Intelligence (AI)-supported analysis explored for qualitative feedback**. Rollout of an AI tool should be coordinated at a national level and appropriate training should be provided to relevant staff.
3. **Continue to ensure public availability of national and local FFT data**, supporting the transparency agenda.
4. **Clarify the role of 'patient experience champions'** outlined in 'Reforming Elective Care for Patients', including how they should support the local use of the FFT.

Locally, providers should:

5. **Continue to submit mandated quantitative data for national benchmarking.**
6. **Support a trial of demographic data collection to identify feedback gaps and variation in patient experience.** Best practice should be shared to inform next steps for adoption after reflection on this initial pilot.
7. **Share best practice examples with national bodies to support wider sector improvement** – providers should report not only what patients told them of their experience, but what they did with this information too.
8. Organisations that are leaders in patient experience measurement should **share best practice examples that showcase approaches that go beyond baseline FFT requirements**.
9. **Report to their board how the FFT is used locally to drive improvement.**
10. **Clearly identify board-level 'patient experience champions' on their existing 'Our Board' webpage, outlining the remit of the role.** The champion's contact

details should not be shared on this page to avoid confusing an already complex complaints landscape.

Full details of our recommendations are **on pages 26-29**.

Conclusions

The FFT has raised the profile of patient experience across the NHS and has given many more people an opportunity to share their feedback. When it is used well, it can offer effective insight for change and can help to maintain staff morale. But there is considerable variation in practice: some organisations are not able to make effective use of the FFT as a tool to aid service improvement, whilst others find its limitations and mandated status restrict their ability to innovate for better patient experiences of care.

Reforming the FFT offers an opportunity to align it with national ambitions for a more person centred NHS while improving its value for money and enhancing the utility of patient feedback in service transformation and design. While reform of the FFT would involve upfront costs, the long-term benefits for patients, staff, and the system justify the initial investment and would be expected to yield a positive return on investment.

Introduction

The NHS Friends and Family Test (FFT) was introduced in 2013 as a simple, near real-time feedback mechanism to capture patients' experiences across health and care services in England. Initially inspired by the 'Net Promoter Score' used in the private sector, the FFT was designed to provide a consistent and accessible way for patients to share their views, supporting the identification of areas of good practice and opportunities for improvement. As a mandated element of the NHS Standard Contract, the FFT has been embedded across a wide range of services.

More than a decade since its national rollout, the FFT remains a widely used tool for capturing patient experience insight. However, its effectiveness and value have come under scrutiny across its lifespan. While the FFT consistently reports high levels of positive feedback – often exceeding 90% across most services – these results contrast sharply with other measures of public satisfaction, such as the British Social Attitudes survey, which has shown declining confidence in NHS services. This discrepancy raises important questions about the FFT's ability to reflect the true breadth and depth of patient experience.

The FFT has a number of strengths: it has helped raise the profile of patient experience, ensured a baseline level of feedback is collected regularly across all providers, and has provided a platform for qualitative insights through free-text responses. It can play a role in empowering and educating the workforce and helps with communication of patient experience to senior leaders. However, the FFT also has notable limitations. It was not designed to allow comparisons across providers, and its methodology lacks consistency, making benchmarking challenging. It is also vulnerable to misuse due to its anonymous nature, which potentially allows individuals to submit an essentially unlimited number of responses. Furthermore, while qualitative data is rich and valuable, many providers lack the capacity to analyse it effectively, limiting its impact on service improvement.

In addition to these practical concerns, the wider health policy landscape is evolving. The government's Ten Year Plan for Health, published in July 2025, emphasises the importance of patient voice and feedback, committing to greater use of digital tools and AI to support engagement. The Dash review of the patient safety landscape, published shortly after, highlights the need to rebalance the focus on safety with a renewed emphasis on experience and effectiveness as equal parts in the definition of high quality care. NHS England (NHSE) has also signalled its intention to explore new models of patient feedback through its proposed 'Future of Patient Feedback' programme, while the Ten Year Plan for Health commits to the creation of a directorate of patient experience within the Department of Health and Social Care (DHSC).

Against this backdrop, we have undertaken a comprehensive review of the FFT, drawing on stakeholder engagement, a literature analysis, our expertise in measuring and understanding patient experience, and the wider policy context. This report sets out the case for reforming the FFT to ensure it remains relevant, effective, and aligned with the ambitions of a modern, person centred NHS that is 'fit for the future'. It considers the costs associated with current FFT delivery, the risks and opportunities of different approaches to the future of the FFT, and the views of stakeholders from across the healthcare system.

Our conclusion is that the FFT should not be abolished, nor retained in its current form. Instead, it should be reformed to improve its functionality, comparability, and impact. Reforming the FFT offers an opportunity to enhance its value for patients, staff, and providers, while ensuring that feedback is not only collected, but used meaningfully to drive improvement. This report outlines recommendations for national bodies and local organisations, including changes to the FFT's structure, branding, data collection and analysis, and its governance.

Ultimately, the FFT must evolve to meet the needs of a changing health system. Reforming it now is essential to realising the aims outlined in the Ten Year Plan for Health and the Dash review of the patient safety landscape – patient voice must be amplified if power is to shift from institutions to their patients. Providers and the NHS as a whole owe it to the public to use their feedback to drive improvement and demonstrate person centred change.

Background and context

A short history of the NHS Friends and Family Test (FFT)

The Nursing Quality Care Forum (NQCF), launched in January 2012, recommended the introduction of the FFT in an open letter to the then Prime Minister, David Cameron. The Prime Minister announced the FFT on 25th May 2012 as a way to "improve patient care and identify the best performing hospitals in England", with a commitment to launch the measure in April 2013.

The NQCF's open letter noted the existing use of an FFT in parts of the NHS at a local level but called for a national rollout of a "simple and regular" feedback process, "which organisations can use to gain feedback in real time, at every meaningful level… [to be] used alongside other measures in order to give a total view of the quality of care". It argued that results should be available publicly to allow for quality of care to be compared.

The FFT was rolled out nationally between April 2013 and April 2015, initially in inpatient and accident and emergency services, before expanding to all services from April 2015. It is mandated as part of the NHS Standard Contract[1].

How the FFT has developed

The original design for the FFT was based on the 'Net Promoter Score' (NPS) often used in the private sector and asked patients if they would 'recommend' the service they had used to friends and family members if they needed similar care or treatment. From its launch in April 2013 to April 2014, the FFT reported a 'net score' calculated by subtracting the proportion of 'detractors' from the proportion of 'promoters'[2]. Reporting was changed in May 2014 to present 'percentage recommended' (the proportion of people who said they were 'likely' or 'extremely likely' to recommend the service).

In 2018/19, a review of the FFT was conducted (the FFT Development Project) reflecting on its initial rollout and exploring future changes. The project led to the introduction of a series of changes to the FFT, as well as publication of new guidance. The guidance outlined a set of "fundamental principles" (p4) underpinning the FFT, including:

---

[1] Including for general and acute trusts, community trusts, mental health trusts, GPs and dental practices, independent sector providers with NHS standard contract and ambulance trusts who provide patient transport services.

[2] Note that published data for March 2014 includes 'percentage recommended' rather than 'net score'.

FFT principles

- "All patients and people who use services have the right to provide anonymous feedback quickly and easily, when they want to.
- The FFT is a continuous feedback stream, it is not a one-off feedback opportunity or a traditional survey…
- The feedback should be used to celebrate and build on what is working well, as well as to identify areas where improvements could be made.
- Results and information on changes resulting from the FFT should be made readily available to the public and patients so that they can see that feedback is being listened to and acted on where possible."

Current mandated structure

The changes agreed as part of the FFT Development Project were implemented from April 2020. They included:

- A change to the question presented to patients from the previous 'recommendation' question to a new one that asks about people's overall experiences of services.
- For general/acute inpatients and accident and emergency services, the requirement to collect feedback at discharge or within 48 hours of discharge was removed. In maternity care, the requirements for collecting feedback at specific times were also removed.
- Response rates are no longer reported due to there being no limit on the number of times someone can respond[3].
- Ambulance services can use FFT to assess 'see and treat' or commit to delivery of an annual co-produced patient experience project.

---

[3] However, numbers of responses collected, and the number of eligible patients are still reported.

- Providers can include additional questions as well as the core questions and have a choice about how and to what extent they promote the FFT to their local population.

NHSE's latest FFT guidance for providers outlines the mandated elements of the FFT, including:

Standard question

Thinking about [details of service]… Overall, how was your experience of our service?

Response options: 'Very good', 'good', 'neither good nor poor', 'poor', 'very poor', 'don't know'

At least ONE free text question

Suggested wording: 'Please can you tell us why you gave your answer?' OR 'Please tell us about anything that we could have done better'

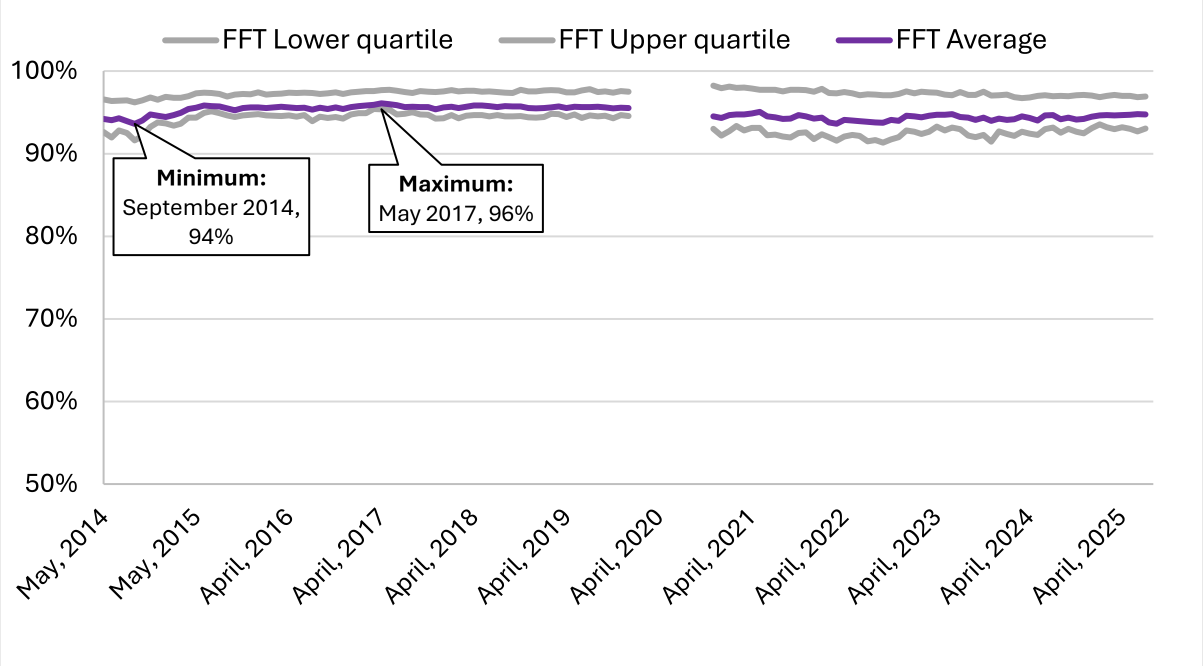
The guidance also states that:

- The FFT must be available to all patients and people who use services, meeting duties under the Equality Act 2010.
- Providers can choose the collection method(s) they use to gather FFT data.
- Data must be submitted monthly for national publication.
- Local results must also be published.
- Providers have a choice regarding how they promote the FFT to their local population, but there is a central set of marketing and branding assets.

The case for change

FFT data is regularly published by NHSE and the most recent infographic (September 2025) shows that the majority of services have average scores of 90% or more for respondents reporting a positive experience. Only three services – urgent and emergency care centres, ambulance services, and mental health services – have national average results below 90%.

Figure 1: Average of trust-level positive response percentages per month, inpatient FFT 2014-2025[4]



This pattern of results has generally been stable throughout the time that FFT data has been collected and reported. For inpatients, for example, the percentage of patients offering a positive response has been reported since 2014[5]: in over a decade, the monthly average score across all NHS trusts has remained continuously within ±1.4% points of an average of 95.4%. Figure 1, above, shows the average percentage of positive responses per trust per month, as well as the upper and lower quartiles from the

---

[4] Note this data is based on the average of results for each NHS trust, excluding independent sector providers, rather than the sum of all responses nationally. Differences are typically small.

[5] From May 2014 to January 2020, this was based on the percentage 'likely' or 'extremely likely' to recommend the service; from the resumption of data collection post-Covid, in December 2020, this is based on the percentage who described their overall experience as 'good' or 'very good'.

distribution of trusts' results: this shows strikingly little variation over time, despite a change in question wording following the pandemic.

The consistently high level of positive response seen in the FFT is at odds with some other measures of patient and public experiences and satisfaction. For example, data from the 2024 British Social Attitudes (BSA) survey shows that public satisfaction with the NHS, and primary care in particular, has plummeted in recent years. Despite this, FFT data from September 2025 shows that 93% of respondents report a positive experience in primary care – which represents a 2% point improvement compared to the 91% reported in September 2022.

On the one hand, this could be attributed to the FFT asking *patients* to rate their experience of care, while the BSA asks the *wider public* for their opinion on services. On the other hand, it may be that the FFT is unintentionally masking patient concerns, either as a result of its methodology, the collection timing, or the narrowness of the standard question. Greater nuance is available via free text responses, but these are not collated or reported nationally: furthermore, the analysis of these data is more burdensome and does not lend itself to comparability.

Estimated cost to providers

Costs associated with collection and use of the FFT are not collected nationally. However, research reported central costs of £12m over 2014-2018, reducing to £1.5m in 2016/17[i]. This excludes costs borne by providers, which are likely to be the majority of FFT expenditure: Robert et al[ii] estimated these at £6m annually for the acute hospitals sector alone. This excludes other sectors using the FFT in the NHS as well as staff costs.

Recent data from Freedom of Information Act (FOIA) requests suggest that the £6m annual cost to providers is likely on the low side. In a review of 39 third party FOIA requests published in 2024[6], we found that the median annual cost of FFT data collection contracts to secondary care providers (including community and mental health as well as acute trusts) was £49,000. However, a minority of providers reported costs in excess of £100,000 – in one case as high as £420,000 – making the mean cost £78,000 per annum. If replicated across these sectors, estimated provider direct costs would be between £10-16m per annum[7]. There are two important limitations to this analysis, however:

---

[6] Unpublished review using data from WhatDoTheyKnow.
[7] Based on 205 NHS trusts and foundation trusts in England as of September 2025.

- It excludes the staff costs associated with management and reporting of the FFT, as well as the costs of data collection in primary care, dentistry, and ambulance services.
- Some providers commission FFT data collection as part of larger contracts that include other services, such as SMS communication to patients. In such cases, the actual cost of the FFT collection would be a proportion of the total only.

FFT data is also collected in general practice and NHS dental settings. These include a far larger number of much smaller providers, so it is unlikely that the costs seen in secondary care providers can be directly translated to these settings. Although general practices collect data in far larger volumes than secondary care providers, more than 80% of GP FFT data is collected via text messages and/or online: as this is often integrated into practice websites or patient communication systems, full disaggregation of costs is likely difficult or impossible.

Grounding in the present

On 3rd July 2025, the government published its Ten Year Plan for Health. The plan commits to embracing engagement with patients and notes its core purpose is “to put power in patients’ hands” (p.22).

While the plan does not contain any specific commitments regarding the FFT that would limit the exploration of future options, it does note that “the NHS does not take patient feedback seriously enough” (p.51) and outlines plans to allow patients to share feedback via the NHS App, supported by AI analysis to drive improvement work. It also calls for the expanded use of Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs), prioritised in maternity care, and to be universally used - with publicly available data - by 2029.

On 7th July 2025, the Dash review of the patient safety landscape was published, providing further detail on announcements included in the Ten Year Plan for Health, including the decision to close local Healthwatch branches, plans to establish a director of patient experience role with the Department of Health and Social Care (DHSC), and the decision to revamp the National Quality Board (NQB) to deliver a “comprehensive strategy to improve quality of care” (p.13). The review concluded that “the focus on safety has been at the expense of other aspects of quality of care” (p.7), namely patient experience and effectiveness of care.

On 30th July 2025, NHSE published a preliminary market engagement notice entitled ‘Future of Patient Feedback: A Roadmap for Measurement, Insight and Improvement’. This programme would “design a future feedback model that is accessible, inclusive, and reflective of the full diversity of patient health journeys” while aligning with products like the NHS App and the Federated Data Platform (FDP), as well as the ambitions outlined in the Ten Year Plan for Health.

On 24th October 2025, NHSE published the Medium Term Planning Framework (MTPF) for 2026/27 to 2028/29. The section on ‘understanding and improving the patient experience’ outlines how providers should “complete at least one full survey cycle to capture the experience of people waiting for care” and “capture near real time experiences with a renewed focus on ensuring effective discharge processes”. The framework outlines that these data should be ‘triangulated’ with other sources, including the FFT, Patient Advice and Liaison Services (PALS) complaints and the results from the Adult Inpatient Survey.

Strengths and weaknesses of the current approach

To identify strengths and weaknesses of the current FFT approach, Picker conducted a literature review looking at the evidence on its validity, reliability and utility. This was published on 12th November 2025 in the Patient Experience Journal (PXJ).

In August 2025, we hosted a stakeholder roundtable to gain further insight on the uses, limitations and opportunities for change related to the FFT. This roundtable was attended by stakeholders from national organisations, think tanks, membership bodies, and providers at both trust and ICB level (see 'Acknowledgements' for more details). We held a follow up meeting in September 2025. Participants shared diverse views on the FFT during the roundtable discussion and follow up meeting, with divergence among participants often correlated to their role within the wider healthcare system and their proximity to FFT collection, analysis and reporting.

Summarised below are the findings from our literature review and our engagement with stakeholders, grouped by identified strengths and weaknesses.

Strengths

Our literature review and conversations with stakeholders identified the following:

- The FFT has raised the profile of patient experience since its inception. It serves to ensure that all NHS providers have at least a basic level of regular patient feedback, including access to both quantitative and qualitative data.
    - One roundtable attendee described the FFT as a 'smoke detector'; a simple tool that might help signal problems, without necessarily being sophisticated enough to identify causes or prescribe solutions. To raise alarms in a timely and appropriate fashion, however, FFT data needs to be regularly reviewed: this can be challenging due to reduced organisational capacity and limited ability to routinely and accurately analyse the rich qualitative data collected from patients, their families, and carers.
- The FFT is helpful alongside other measures like PROMs[iii],[iv]. This is noted in the current NHSE guidance (p.9) which lists eight additional insight sources, including complaints, PALS and national survey programmes.
- Mandating the FFT nationally has 'raised the floor' but has also 'lowered the ceiling' for providers who were already outperforming their peers on local patient

experience and feedback measurement and using the data to drive improvement.

- The FFT might be a "more discerning metric"[v] when assessing care quality compared to questions on satisfaction.

- The FFT can play a role in empowering and educating the workforce and helps with communication of patient experience to senior leaders, particularly as it is 'overwhelmingly positive'[vi]. Staff find the FFT's free-text responses more meaningful than the overall scores, but there is limited capacity to process qualitative responses systematically[vii].

- There is a "statistically significant moderate correlation" with GP practices that had a larger proportion of positive online public ratings having higher FFT scores[viii]. This offers some evidence of 'concurrent validity' (that is, that the FFT produce similar findings to another data source seeking to measure something very similar).

- Enabling patients to provide feedback on their care is a longstanding commitment of UK health policy, and has been further emphasised in recent publications like the Ten Year Health Plan and the Dash Review of the patient safety landscape. As such, there is an acknowledgement of the political value of the FFT due to its role in amplifying patient voice.

Weaknesses

Our literature review and conversations with stakeholders identified the following:

- Stakeholders raised concerns as to whether the FFT offers value for money, given the limitations of the numeric data collected and reported nationally, which is not sufficiently comparable to enable benchmarking or to drive improvement.

- There are different goals for collecting FFT data locally and nationally and a challenge in balancing these. Part of this is related to the potential for conflict between the 'patient choice' and 'experience' agendas, with the risk that 'patient choice' is prioritised as a success metric, despite it only being a component of patient experience and person centred care more broadly. At a local level there is a perception that the goal of FFT collection is to improve services and demonstrate community engagement, while at a national level, there is a perceived desire for comparable data to identify outliers and poor performance.

- Stakeholders were also concerned that provider boards do not have protected time and roles to understand and act on patient experience feedback. They noted that this is variable at present and can often be dependent on individual board member interest and/or expertise. The government's 'Reforming Elective Care for Patients' calls for 'patient experience champions' to be identified on each provider board, but the remit and requirements for this role are unclear.

- The FFT is "only moderately associated with conventional measures of hospital quality" and that "caution is needed when using them as a comparative measure of hospital performance."[ix]
- Measures such as the FFT "provide information that is of little value to healthcare providers in delivering improvements"[x] and that the test "may not be a particularly suitable feedback tool for identifying providers potentially in need of improvement"[xi]. Feedback shared as a "measure of overall satisfaction is too general", which makes it difficult to drive specific improvement[xii].
- Participants in one study included in the literature review felt that the pre-2020 wording of FFT was inappropriate in primary care settings due to lack of realistic patient choice, particularly as family and friends are unlikely to have similar conditions or needs, and because the response options lack specificity. This research also noted concerns about the reliability of the results due to low response rates at practice level, which could result in a non-representative sample.[xiii]
- Older patients and men are more likely to give positive response to the FFT and there are sizable differences in responses depending on collection method. For example, online responses are typically less favourable than those completed on a postcard during the care episode, which raises concerns about the potential for bias in comparisons[xiv].
- Roundtable attendees also noted the risk of the FFT being used inappropriately, as well as its vulnerability to abuse and gaming, as it is anonymous and not limited to one response per person per interaction. For example, there were reports of FFT being used vexatiously by dissatisfied complainants.

Opportunities and solutions to make the FFT 'fit for the future'

There are a number of ways in which the national approach to collecting and using information on people's experiences could develop. Broadly, however, the future of the FFT (or indeed of any mandated national collection) could be framed within three core options – **retain** the FFT in its current form, **reform** the FFT, or **abolish** the measure. Each presents potential risks and opportunities for patients, for NHS organisations, and for national bodies. The table below summarises these:

Option	Potential risks	Potential opportunities
Retain (in current form)	Maintenance of status quo.	Familiar well-established approach, providing clarity for providers. Opportunity to advocate for greater use/understanding of the data (staff training etc.).
Reform (which could include a range of options including review, removal of mandate, or major reforms)	Lack of appetite for change within system. Negative impact on staff morale where existing FFT is used for recognition. Disruption and uncertainty during transition and against backdrop of wider system change. Initial costs of implementing changes in the short term.	Greater value for money (after initial cost of reform). Greater insight that can better inform care improvement. Improved patient and staff experience through more meaningful feedback mechanisms.
Abolish (two options – to replace after abolition, or to abolish without replacement)	Abolition may not lead to replacement in context of constrained finances. Loss of patient insight, particularly qualitative	Financial savings if abolished without replacement. Reduced data collection burden for providers, freeing up resources (assuming

Option	Potential risks	Potential opportunities
	responses (if abolition without replacement). Negative public and media perception with abolition seen as removal of vital tool for patient voice and accountability (if abolition without replacement). Negative impact on staff morale (if abolition without replacement). Disruption and uncertainty during transition and against backdrop of wider system change.	abolition without replacement). Opportunity to develop alternative, potentially more effective feedback mechanisms (assuming abolition with replacement).

Ultimately decisions about the future of the FFT will involve a weighing up of benefits and costs. As discussed in the previous section, there are strengths and weaknesses to the current approach – but the table above demonstrates how changes to it or its discontinuation create their own risks and opportunities. The challenge is to find the approach that offers the optimal balance between value and impact whilst managing risks and drawbacks.

Conclusions

Given the evidence from the literature review, stakeholder feedback, and our own analysis, it is Picker's view that the FFT should be reformed to improve its value and impact.

Politically, this aligns with government's ambition for 'change' and its commitment to building an NHS 'fit for the future.' It also aligns with the government's comments regarding amplifying the patient voice, as outlined in the recently published Ten Year Plan for Health, and simplifying the landscape, as per the recommendations outlined in the Dash review of patient safety.

Similarly, NHSE has signalled intent to explore the 'future of patient experience' to assess how patient experience mechanisms can be future proofed. A reformed FFT should play an important role in any revised vision for the future of patient experience, whether this is part of NHSE's project or in the new directorate for patient experience within DHSC.

In proposing reform of the FFT, we recognise the strengths of the current approach – which has undoubtedly raised the profile of patient experience and provides a continuous flow of feedback – whilst also acknowledging its scope for improvement. The evidence suggests that the FFT as it stands has limited comparability and that the quantitative feedback it gathers is uniformly positive – doing little to support national evaluation or to create a case for change. Whilst the qualitative data it gathers is a rich and potentially powerful resource, there is too little capacity for its use locally. AI solutions may reduce the analytic burden of converting data to insight, but they carry their own risks too – and they will not automatically provide capacity for action. These factors, and the level of costs and duplication of effort involved in collecting the FFT data, mean that it cannot, in its current form, be considered to be optimising value for money or patient benefit.

Changes to the FFT should address these limitations. Revisions to the methodology have the potential to upgrade the FFT to offer more comparable, more discerning, and more interrogable insight. These changes need not be costly, particularly if the NHS can take advantage of its existing infrastructure to offer in-house solutions (for example, through the NHS App) or use system-level purchasing power to access economies of scale. Whilst one downside to reform of the FFT is the initial cost of any changes, there is a case to be made for FFT reform offering greater value for money in the long term – both by potentially reducing unit costs of measurement and by increasing its potential for impact. The cost of inaction is, arguably, a greater concern than the cost of change.

Recommendations

These recommendations have been developed with an awareness of current economic pressures across the healthcare sector and the wider economy, alongside the scale of ongoing national reforms and the framework outlined in the recently published Ten Year Plan for Health.

National

These recommendations should be considered for implementation by DHSC and NHSE (the centre), working in collaboration with stakeholders including patients and the public, particularly as the new directorate for patient experience is designed and established as part of the Ten Year Plan for Health.

1. The FFT should be subject to **a programme of reform** but should continue to be nationally **mandated,** where required as per guidance, as part of the NHS Standard Contract[8]. The reformed FFT should provide a minimum standard in near real-time patient feedback, with providers encouraged to share and learn from best practice to build on this baseline locally. The fundamental principles of the FFT, outlined by NHSE in 2019, should remain but be refreshed. Changes to the FFT should improve its functionality whilst maintaining flexibility. To facilitate this, the centre should:
    1.1. **Assemble an advisory group** comprised of stakeholders and patients to co-produce reform of the FFT. This should be part of a wider linkage of 'experience' with 'co-production' and 'engagement' initiatives that are conducted with people and communities to inform service transformation, co-produce services, and understand culture, behaviour, needs, and aspirations.

    1.2. **Provide national guidance on the reformed FFT's mandated structure**, including updated guidance on collection methodologies and timing, in the interest of enabling greater benchmarking and comparability of quantitative results. Reforming to provide a base level of comparability will require limitations to be clearly articulated and managed. Because these reforms will require providers to make changes to commissioned data collection services, they should be introduced over a suitable timeframe that allows providers to

---

[8] Including for general and acute trusts, community trusts, mental health trusts, GPs and dental practices, independent sector providers with NHS standard contract and ambulance trusts who provide patient transport services.

procure and adopt – or simply develop – solutions that meet the new requirements.

1.3. **Consider offering a national solution for FFT administration and data capture,** such as by providing a facility for patients to be sent and complete FFT surveys through the NHS App. This would align to wider policy aims around encouraging digital communication in the NHS and has the potential to significantly reduce the costs of FFT data collection. However, such a change also risks widening inequalities and restricting opportunities to hear feedback from people who are unable or unwilling to interact with digital technologies: to tackle this, alternative approaches should remain available and the FFT should be considered as part of an overall approach to feedback that actively seeks to hear from patients of all backgrounds.

1.4. **Consider publishing a central, optional question bank of additional questions**. This would aid national comparability, while ensuring provider autonomy, a priority in the Ten Year Plan for Health, is built in.

1.5. **Publish guidance based on best practice to support providers to use the reformed FFT with their service users**, allowing for comparison by peer group, for example across mental health services.

1.6. **Trial the collection of demographic data (including postcode)** to allow for a greater understanding of who is responding and any variation in patient experience. Most importantly, this will allow for providers to understand who they are not currently receiving feedback from, which should also be compared with other available data sources such as PALS complaints. The trial should be time-limited, designed to explore how best to implement this change without making the FFT overly burdensome for patients, and its outcomes should be evaluated in collaboration with patients and stakeholders to inform next steps.

1.7. **Clarify the purpose of the reformed FFT** – specifically, ‘to drive improvement based on patient experience data’.

1.8. **Rebrand and rename the reformed FFT** and clearly communicate this change to patients, the public and staff, both via digital and non-digital routes. These changes to the name and branding should signal a clear step change in how the FFT has operated and will encourage those with established negative views of the FFT to judge the updated collection on its own merits.

2. **Both qualitative and quantitative data should continue to be collected** via the reformed FFT. **Analysis of qualitative data should be supported by an AI tool** to ensure data can be better used for improvement at scale. The centre should:
    - 2.1. **Endorse and provide access to an AI tool** for providers to use for analysis of their qualitative data, avoiding duplication of effort and cost across the system.
    - 2.2. **Provide training to staff to ensure they have the skills to interpret the data locally and drive improvement, including the utilisation of an AI tool**. This should start with initial training for the most relevant staff, followed by continuous training as required, and be expanded to others to support broader understanding of patient experience and improvement over time.
3. **National and local data must be made publicly available**, as part of the NHS's commitments to transparency, patient voice, and choice. At a minimum, this should utilise quantitative data collected via the reformed and renamed FFT – but consideration should also be given to the feasibility of using AI technologies to create a regular summary of qualitative themes.
4. **Publish guidance on the role and remit of the 'patient experience champions' featured in 'Reforming Elective Care for Patients'**, ensuring organisational boards have a senior sponsor responsible and accountable for patient experience as a central pillar of care quality.
    - 4.1. The role and effectiveness of 'patient experience champions' should be reviewed after three years, with a vision to introducing, and mandating, dedicated board-level 'Director of Experience' roles in all NHS provider organisations in the future. This should be coordinated in conjunction with the proposed directorate of patient experience within DHSC. Whilst the scope of these roles should extend beyond the implementation and use of the FFT, one of their immediate benefits would be to provide direction and leadership around this programme. National organisations should champion these positions as an important investment to help realise the ambition of creating more person centred health services.

Local

NHS organisations required to deliver the FFT as part of the NHS Standard Contract should:

5. **Continue to submit data from the mandated quantitative elements** to the centre for national benchmarking.

6. **Provide feedback on a trial of demographic data collection as part of the reformed FFT,** highlighting examples of best practice, and demonstrating how data has been utilised to drive change. They should ensure that feedback is received from a cohort that reflects the communities it serves and set out a clear action plan for attaining this goal, if required.
7. **Share best practice examples** with the centre to support the implementation of Recommendation 1.5 and **showcase examples** of where changes have been made to demonstrate to patients and local communities that their feedback is actively used to drive improvements in services.
8. Organisations that are leaders in patient experience measurement, and that demonstrate best practice in the FFT with regard to methodology and analysis, **should share best practice examples with the centre**, showcasing approaches that go beyond baseline FFT requirements and to support peer learning to improve practice across NHS trusts nationally.
9. All organisations **should report to their board on how the FFT is used locally to drive improvement**, using a similar model to complaints reporting.
10. **Identify to the Centre which board member is the ‘patient experience champion’** and list them as such on the organisation’s existing ‘Our Board’ webpage, in support of Recommendation 4. This should clearly outline the remit of the role while ensuring contact details are not shared publicly to avoid confusing the already complex complaints landscape.

References

[i] Robert G, Cornwell J, Black N. Friends and family test should no longer be mandatory. BMJ. 2018;360:k367. doi:10.1136/bmj.k367

[ii] Ibid.

[iii] Stirling P, Jenkins PJ, Clement ND, Duckworth AD, McEachan JE. The Net Promoter Scores with Friends and Family Test after four hand surgery procedures. J Hand Surg Eur Vol. 2019;44(3):290-295. doi:10.1177/1753193418819686

[iv] Monu J, Sunil S. The Net Promoter Score with Friends and Family Test applied to arthroscopic shoulder surgery. Clinics in shoulder and elbow. 2023;26(1):20-24. doi:10.5397/cise.2022.01116

[v] Hamilton DF, Lane JV, Gaston P, et al. Assessing treatment outcomes using a single question: the Net Promoter Score. The Bone & Joint Journal. 2014;96-B(5):622-628. doi:10.1302/0301-620X.96B5.32434

[vi] Carpenter B, Srinivas J. More than a Gold Star: FFT feedback in paediatrics. Archives of Disease in Childhood. 2024;109(Suppl 1):A298-A299. doi:10.1136/archdischild-2024-rcpch.469

[vii] Khanbhai M, Flott K, Manton D, et al. Identifying factors that promote and limit the effective use of real-time patient experience feedback: a mixed-methods study in secondary care. BMJ Open. 2021;11(12):e047239. doi:10.1136/bmjopen-2020-047239

[viii] Boylan AM, Turk A, Velthoven MH van, Powell J. Online patient feedback as a measure of quality in primary care: a multimethod study using correlation and qualitative analysis. BMJ Open. 2020;10(2):e031820. doi:10.1136/bmjopen-2019-031820

[ix] Greaves F, Laverty AA, Millett C. "Friends and family test results only moderately associated with conventional measures of hospital quality." BMJ. 2013

[x] Lawton R, O'Hara JK, Sheard L, et al. Can staff and patient perspectives on hospital safety predict harm-free care? An analysis of staff and patient survey data and routinely collected outcomes. BMJ Quality & Safety. 2015;24(6):369. doi:10.1136/bmjqs-2014-00369

[xi] Borrelli AM, Birch RJ, Spencer K. How does staff and patient feedback on hospital quality relate to mortality outcomes? A provider-level national study. Health Services Management Research. 2023;37(2):115. doi:10.1177/09514848231179182

[xii] Ibid.

[xiii] Manacorda T, Erens B, Black N, Mays N. The Friends and Family Test in general practice in England: a qualitative study of the views of staff and patients. The British Journal of General Practice. 2017;67(658):e370. doi:10.3399/bjgp17X690617

[xiv] Sizmur S, Graham C, Walsh J. Influence of patients' age and sex and the mode of administration on results from the NHS Friends and Family

Picker Institute Europe
Suite 6, Fountain House,
1200 Parkway Court,
John Smith Drive,
Oxford OX4 2JY
Tel: 01865 208100
Email: Info@PickerEurope.ac.uk
Website: picker.org

Registered Charity in England and Wales: 1081688

Registered Charity in Scotland: SC045048

Company Limited by Registered Guarantee No 3908160