

General questions

1. What is the FFT?

The friends and family test is an easy-to-understand, comparable question that will be asked of patients about the care and treatment they received in acute inpatient wards or A&E departments.

2. Why are we doing this?

We want NHS organisations to obtain regular and timely feedback from patients about the care provided in the NHS, take ownership of the results and act on the feedback.

The Friends and Family test is unique because it will mean that patients across the country are given the chance to provide feedback on the care they receive via a standard approach, in near real time. Using a simple question makes the process, quick, easy and relevant to specific parts of the NHS.

The answers will be published so patients can see how other services compare. It will also provide a large amount of information that NHS organisations can use, with other sources of intelligence, to identify both successes and problems. This information can be used to improve quality.

3. What will be done with the results?

The results at ward level will be used locally by Trusts to help improve services. CCGs will also want to use the results to help inform their commissioning decisions for their local population. They will also be published so patients and the public can check how their local services perform.

NHS Midlands & East alongside other SHAs will work with organisations in coming months to ensure that the local results are presented in a clear, easily understandable format. In addition, analysis tools for use by trusts and healthcare professionals will be developed.

4. How will national results be published? What are the timescales?

This will be covered in separate technical reporting requirement guidance to be issued later in the year. It is expected that data from the previous month will be published in the following month.

5. How will data be collected and analysed?

Trusts can use a variety of methods of collecting the FFT data – this is covered in the NHS Friends and Family Test Implementation Guidance. Providers will be asked to report results of the FFT locally down to ward level. National reporting of data collected will be covered in separate technical reporting requirement guidance to be published later in the year.

NHS Midlands & East alongside other SHAs will work with organisations in coming months to ensure that the local results are presented in a clear, easily understandable format. In addition, analysis tools for use by trusts and healthcare professionals will be developed. Further guidance on national reporting will be made available later in the year.

6. How much will the Friends and Family Test cost to implement?

Developing real-time systems has been an expectation in the NHS Operating Framework since 2008, and is included in existing funding given to the NHS. Many Trusts already have excellent systems in place to capture feedback from patients.

The overall costs will depend on the methods adopted locally – one of the reasons we have deliberately not specified a particular methodology is to minimise the financial burden and give Trusts some flexibility in how they adapt their existing systems. Wherever possible NHS

organisations will want to build on mechanisms already implemented eg existing real time feedback systems.

In addition improved patient experience can:

- Improve patient satisfaction with services and patient well-being
- Enable better communication between clinicians and patients, potentially improving clinical outcomes
- Boost the reputation of providers of NHS services.

7. When might a further roll out to other services take place?

Discussions are underway about potential roll-out of FFT to other health services. The Department will be working closely with SHAs and provider organisations during the period up to April 2013 so that any roll-out is informed by learning from the current implementation.

8. Why has maternity been left out?

We recognise that feedback on these services are useful for women in making their choices and we will be engaging with stakeholders on how best to achieve roll out of FFT.

On the detail of the question and methodology used

9. Can you explain the decision to go ahead with using the word “recommend” even though previous research identified that this could be problematic?

Research from Picker tested whether it was appropriate to use a recommend question in the context of a national survey, i.e. within other general patient experience questions, not as a specific, standalone recommend question to be asked in near real time. The findings of this initial research raised issues about how patients feel about being asked to recommend services and that they might misunderstand what they were being asked to recommend.

We therefore commissioned further independent research to look specifically at how to ask a standalone recommend question in real time, that is understood by patients, and provides reliable and comparable information.

The question wording in the guidance was recommended by this independent research. The researchers drew on existing work from the UK and abroad, from within health and other sectors, to come up with question wording – including the use of the word ‘recommend’ - and ‘framing text’ that was clear and would make sense to patients. The ‘framing text’ is placed advance of the question where it is used alone, to provide further clarity for patients The researchers also agreed that asking a suitable follow up question is essential to give patients an opportunity to explain their score, and provide insight for staff as to what is working well or less well.

Additional if necessary

The authors of the independent research have confirmed that the word “recommend” is safe to use in NHS settings:

- firstly because it has been deployed successfully in health settings including some NHS services; and
- secondly because our approach to implementation of FFT is using large sample sizes, meaning that, in their view, if small numbers of patients do not respond because they object to the question this would be unlikely to have statistical impact on overall scores.

10. Do patients understand the concept of recommending healthcare?

The research work commissioned concluded that initial problems with the word ‘recommend’ i.e. that patients might be considered to be recommending being ill, could be resolved by adding the phrase ‘if they needed similar care or treatment’. We have also suggested adding some framing text to help clarify the question when it is used on its own. Questions

containing the word 'recommend' have been used successfully in both the GP Patient Survey and by a number of NHS organisations.

11. Why are you using a 6 point response scale?

If trusts are going to be held to account for improvements in patient experience scores, any scoring/answer options must be sensitive enough to differentiate between good and less-good providers, and to reflect changes. This response format has been shown to be easy to understand and use by patients. The format is similar to that used in the GP patient survey, the NHS Staff survey, and in parts of NHS Midlands and East to score their feedback questions which are similar to FFT.

12. Research also cast doubt over using the FFT as a single indicator of patient experience. How has the methodology been made more robust to take this into account?

FFT is not intended to be the only measure of patient experience. It shines a spotlight on areas where action may need to be taken to improve quality of care. Providers of NHS care are expected to follow up where results show there may be problems.

Impact Assessment

13. Why are you not publishing the impact assessment at the same time as the guidance? Isn't this standard practice?

A full impact assessment on the friends and family test will be published soon. It will look at the long-term costs and benefits of friends and family test - for example extending it in to other settings, rather than just in initial implementation in acute inpatient wards and A&E departments.

NHS Trusts have asked for the guidance on implementation in acute inpatients and A&E to be published as soon as possible to give maximum time to prepare for implementation.

14. When will the IA be published?

The impact assessment will be published later, when decisions on any wider roll-out have been made.

Contracts

15. Will there be a requirement in NHS Contracts to carry out the FFT?

From April 2013, it will be a contractual requirement on all providers of NHS funded acute inpatient services and A&E departments to deliver this work.

Mandate

16. Will there be a requirement to carry out the Friends and Family Test in the Mandate?

Achieving good patient experience was included as a requirement in the draft mandate, including an element around FFT.

NHS Outcomes Framework

17. Does the NHS Outcomes Framework mention the Friends and Family Test?

Requirements to improve patient experience outcomes are included in Domain 4 of the NHS outcomes Framework. FFT will form a key indicator, with the objective subject to baselines and data collected once full roll out has taken place next April.

18. Are we requiring ‘NHS providers’ or ‘providers of NHS funded services’ to carry out the friends and family test?

The requirement is for providers of NHS funded services. This will include independent and private sector providers who provide NHS services to patients.

19. Are the following included in FFT:

- **Maternity patients?**
- **Independent providers?**

Please refer back to the guidance on ‘exclusions’. For this initial phase, the FFT is intended to cover all adult inpatients with an overnight stay, and all A&E attenders who are not admitted, but some groups are excluded to ensure that results are comparable. Children are excluded, and Maternity patients are not included in this work but are being looked at as a part of the wider roll out of the programme.

As above, the Friends and Family Test programme applies to NHS funded care so would apply to independent providers of acute services. The DH and NHS M&E teams will engage with Independent Sector providers on the work.

20. Why is the programme just for acute wards and A&E? Why not day patients or maternity?

While the programme initially covers acute and A&E, we envisage a future roll out to other departments and providers of NHS services. We would encourage providers to adopt and use the Friends and Family methodology as widely as possible; however for the purposes of this programme, only responses from acute and A&E patients should be included in returns.

21. Will FFT be included in CQUINs for 2013/14? If so will focus be on data collection for the first year, then on improving results (as per Safety Thermometer)?

We are currently considering whether there should be a link between FFT and a national CQUIN.

22. Will this work replace an existing CQUIN or form a new CQUIN?

We are currently considering whether there should be a link between FFT and a national CQUIN. However, there is potential for local CQUIN schemes to incentivise score improvements after the implementation of the programme in April 2013. CQUIN Incentives already operate in Midlands and East.

23. When will reporting guidance be available?

The national guidance is currently in development. This reporting guidance is subject to a number of considerations including the Mandate, NHSCBA requirements, and local reporting requirements linked to NHS Choices. Therefore the earliest this will be available is December, subject to the other considerations.

24. When will national reporting begin?

The first month’s data collection will take place in April 2013 and reporting will begin in May 2013. More details will be given in the national reporting guidance.

25. What do you mean by local reporting as opposed to national reporting?

Local reporting covers both public facing results as well as any further requirements that have been agreed with CCGs. National reporting requirements will be covered in separate technical reporting guidance (see Q.24).

26. Why have you not standardised the follow up question as well as the main question to ensure comparison between wards and organisations?

We have allowed flexibility and local determination for the follow up questions so that trusts can include those questions that they believe will be most helpful and relevant to them. In addition, flexibility is needed to ensure that the follow up questions selected are compatible with the data collection routes. Responses to the follow up questions will not be compared between organisations; these are for internal use to direct improvements.

27. Patients who return for multiple episodes of care or who may be included in other sets of surveys may need special consideration as there is a risk of ‘survey overload’.

We believe that it is important that patients should have the opportunity to feedback on every episode of care as each visit will be different and patients may wish to provide feedback on different areas. However, while we would encourage organisations to ensure that 100% of patients are given the opportunity to feedback, no patient should be required to feedback if they do not wish to respond.

28. Real-time patient feedback is in place in many Trusts, relating to wards or departments and working well – it would be most effective to add FFT to these systems.

We would strongly encourage trusts to use existing systems to collect the Friends and Family Test, provided that they meet the requirements of the Implementation Guidance.

29. Why the 48hrs time limit? If the data is in-month could this be acceptable?

The requirement is that patients are asked the questions at or within 48 hours of discharge. This is to ensure that they are asked while their experiences are still front of mind. However, should responses be received after the 48 hour window (for instance on the postal or weblink methodology options), these responses may still be included in the overall score for the trust. Please note that the data collection and reporting methodologies will be confirmed and further outlined in the Reporting Requirements Guidance to be issued later in December 2012.

30. Why are under 16s not included? Can we ask this patient group the Friends and Family question?

Under 16s are not included in this methodology in order to ensure that the results are standardised and comparable. Trusts are encouraged to ask the question of all patient groups however, for the purposes of this programme and the national data returns, responses from under 16s should not be included.

31. You say if a patient is unable to answer the question, their carer or guardian may assist them in answering or answer on their behalf. Should responses completed on behalf of the patient be counted separately?

You may want to include a tick box or some other indicator that a carer or guardian can use to indicate that they are filling in the FFT on the patient’s behalf.

32. How will this work in emergency departments where emotions run high?

We acknowledge the specific challenges in surveying patients in situations where emotions run high. We would encourage trusts to consider this when developing their methodologies and for instance, for emergency departments, providing cards which can be taken away and posted back or web links which are sent after patients are discharged home.

33. How should trusts manage duplication of responses?

Trusts are encouraged to ensure that responses are not duplicated; the method for doing this will depend on the chosen data collection methodology. For instance, if using a card based collection route, only one card should be issued to each patient or if an online collection route is used an identifier should be included to prevent repeat submission of response.

34. How do we demonstrate that the test has been offered to 100% of patients?

We will not be collecting evidence that the test is offered to 100% of patients; however this may be subject to checks/validation. We would expect that trusts publicise the collection of the question and evidence that cards/weblinks/SMS etc are provided to all patients within the mandated groups.

35. Will alternative areas (CDU) be included, such as people treated via A&E on Ambulatory Care Pathway?

CDUs are not included, only type 1 and 2 A&E services. All patients treated in type 1 and 2 A&E departments are included, provided they meet the requirements outlined in the guidance.

36. Will Foundation Trusts be required to participate in this programme? Will Integrated Trusts also be required to participate?

The programme applies to all providers of NHS funded acute and A&E care and will be mandated through standard contracts. Foundation Trusts and Integrated Trusts will be expected to participate for those wards and patients outlined in the implementation guidance.

37. Why is there not one consistent methodology for all?

We acknowledge the benefits of a consistent data collection methodology for all trusts; this would provide a much greater level of standardisation. However, we are keen that trusts are able to use their existing and established data collection routes – providing they comply with the implementation guidance - and the potential costs for trusts in mandating one methodology would be likely to prove prohibitive for the programme.

38. How will this work link with the CQC Inpatient Survey?

The CQC Inpatient Survey is undertaken once per year and with a time lag between treatment and response. While this survey provides robust and helpful information for trusts, the aim of the Friends and Family programme is to provide regular feedback, as close to 'real time' as possible so that trusts can quickly and effectively mitigate any issues and focus on improvements and patients are able to see the recent views of others.

39. Are trusts able to exclude inappropriate patients such as those at the end of life?

Although all the patient groups outlined in the implementation guidance are included, it will be up to trusts to decide if there are specific instances where surveying the patient would not be appropriate and we would encourage a degree of pragmatism. We would not recommend excluding any patient group as a whole but rather taking a case by case view. Carers will be able to complete the FFT on behalf of the patient where they are unable to do this themselves. Where appropriate, ensuring that feedback from end of life patients is listened to is important but the guidance is clear that only patients who are discharged home are included.

40. Reliance on technology-based feedback mechanisms will pose challenges for elderly/frail patients; increasing the number of different feedback mechanisms to deal with 'hard-to-reach' will require extra effort/cost.

We agree that certain data collection routes will provide challenges for certain patient groups – we would encourage organisations to adopt a number of approaches and to regularly review the effectiveness of the different data collection routes.

41. Where can we find examples of 'best practice' in using the Friends and Family Test?

We have adopted a collaborative approach across the country and while NHS Midlands and East initiated the test in April 2012, a number of organisations are developing programmes for real-time patient insight. Further information can be found [here](#).

42. How will the scoring methodology work? Will the scores be made up to give a national patient survey type of league table of red amber and green rated responses? Will there be further information given in the reporting guidance due in November?

These questions will be clarified in the reporting guidance, to be published later in the year.
FAQ posted 15 October 2012

43. When will an easy-read version of the question be available? Some have suggested that the extremely likely to extremely unlikely range will be a challenge to portray.

An easy-read version is being piloted and tested in the Midlands and East which will be shared with other SHAs as soon as the testing phase is complete.
FAQ posted 15 October 2012

44. Are we going to get the final version of the question translated into the most popular languages centrally, to reduce the costs of everyone needing to do so?

We would ask SHAs to collate requests for translated versions of the question so we can ensure that translated versions are circulated for the most requested languages.
FAQ posted 15 October 2012

45. The previous draft contained a section which stated that for ward patients we could collect on a snapshot basis to begin with until our systems are set up, as long as it covered a minimum of 7 consecutive days per area. I assume due to its omission from the final version that this is now not the case and we are expected to survey ALL of the specified inpatients and A&E patients from April?

Yes, you are now required to survey ALL eligible patients (the option from an earlier draft to survey wards on a rolling basis has been removed).
FAQ posted 15 October 2012

46. The FAQs clearly state that we can't change the wording of the question, which I accept. However, we are looking at setting up an automated phone line to take responses. Having two separate questions (for A&E and wards) would require us to set up two numbers. However if we asked a question along the lines of 'Where are you basing your experience on?' we could determine where they were treated (i.e. a ward or A&E). We would then potentially term the FFT question 'How likely are you to recommend our ward or A&E department to friends and family if they needed similar care or treatment?' Would that be acceptable?

As outlined in the FAQs, it is not acceptable to change the wording of the question. The 'ward' and 'A&E' versions should be asked separately so as not to cause confusion as patients may have been treated both in A&E and in a ward. In addition, responses must be clearly attributable, in order to facilitate reporting at ward level.
FAQ posted 15 October 2012

47. Are community hospitals or Intermediate Care Units included?

No, only providers of NHS funded care covering acute adult inpatient and A&E services are included at this stage. However, the methodology is applicable and can be used in a range of care environments and we would encourage this.
FAQ posted 15 October 2012

48. The guidance states that the question should not be administered face to face. It was queried if this also applied to volunteers or just clinical staff?

The question should not be asked face to face by anyone, this includes volunteers. However, it is acceptable for volunteers to assist patients in completing their questionnaires.
FAQ posted 23 October 2012

49. Will there be guidance on how to include people who have learning disability or English as a 2nd language?

An easy read version is being piloted and tested in the Midlands and East; this will be shared with other SHAs as soon as the testing phase is complete. In addition, the DH and M&E teams will develop translated versions of the question for the most commonly requested languages; please send requests through to msc.nationalfriendsandfamilytest@nhs.net
FAQ posted 23 October 2012

50. The group asked if DH would be producing publicity and slides that commissioners and providers could use – have we any more news?

The DH and M&E are developing leaflet and poster artwork that may be used by commissioners and providers to publicise the FFT; these will be circulated in October/November.
FAQ posted 23 October 2012

51. Will there be further guidance on how qualitative data could be analysed and captured?

We will not be publishing guidance on how the qualitative data should be analysed and captured as we have allowed trusts to define the question and methodology on this themselves. However, we will be sharing case studies and learnings via the project web pages at http://www.strategicprojectseo.co.uk/dh_ff_t.php?id_sec=258
FAQ posted 23 October 2012

52. Whilst I understand that the wording of the question is nationally determined the reference to ‘ward’ is not appropriate for our survey / patients. This is because most of our patients stay in a private room as opposed to a ward. Therefore we would like to suggest / request that wording for our survey should be very slightly changed to: “How likely are you to recommend our service to friends and family if they needed similar care or treatment?”. We think this would be more appropriate.

The word 'service' implies the whole journey/wider care whereas 'ward' is more about location. In this instance, the word 'unit' should be used as this is more comparable.
FAQ posted 23 October 2012

53. Some of our Trusts propose using bedside terminals to gather FFT info. Patients would be asked to respond only if it was their day of discharge. On the face of it, this meets the Guidance (p16, Section 3.8) ‘patients should be surveyed on the day of discharge or within 48 hours of discharge’ but I can see a number of issues with this:

- It seems too close to the care environment – the patient may even still be in bed!
- Any assistance would have to be provided by clinical staff
- If discharge happens suddenly, patient may not get opportunity to respond
- There is a danger that patients will respond re the ward they are in, rather than that in which they spent most of their time

Is this an allowed methodology? And if so, what conditions need to be met?

The use of terminals is within the allowed methodology, provided that the survey is undertaken on the day of or within 48 hours of discharge. Trusts and any providers of services to collect the FFT need to ensure that all of the requirements of the implementation guidance are met and that concerns, such as those raised above are addressed (either through amends to a particular data collection route or the availability of alternative data collection routes), in particular that the patient should be surveyed away from the care environment, therefore not while they are in their bed.

FAQ posted 25 October 2012 and revised on 22 November 2012

54. The Guidance (p18) suggests that it may be inappropriate to survey some patients receiving palliative care. Our Steering Group feel that this should be tighter definition – that patients on the EOL pathway at point of discharge should NOT be surveyed.

There is however a danger that such patients (and/or their families/carers) may feel disenfranchised, so Trusts should be encouraged to get feedback from them, albeit perhaps later than ‘at or within 48 hours of discharge’ and more sensitively than via a comment card. The same applies to the families/carers of those patients who die in hospital.

As outlined in the guidance, trusts and staff may feel that it is inappropriate to survey some patients receiving palliative care but this will be left to local judgement. As mentioned in the question, it is important that this group of patients and their families/carers do not feel disenfranchised and are given the opportunity to give feedback, should they wish to.

FAQ posted 25 October 2012

55. Can you please confirm that the current wave does NOT apply to Mental Health acute services/patients?

Initial implementation of the work (from 1st April 2013) applies to providers of NHS funded acute inpatient and A&E services only. In future, the work may be extended to providers of mental health and community services (as well as additional wards and patient groups) but it is not mandatory for these organisations at this time. However, we would encourage organisations who wish to adopt and develop the Friends and Family Test for different wards and patient groups.

FAQ posted 25 October 2012

56. What does ‘Face to Face’ include and exclude? e.g assistance to complete electronic surveys, reading questions etc.

‘Face to face’ refers to the question being asked by either a staff member or volunteer of a patient, in person which is not allowed within the methodology. However, it is acceptable for volunteers to assist patients in completing their questionnaires, ensuring that the answers given are the patient’s own.

FAQ posted 25 October 2012

57. Why are we moving from manual to electronic collection of data?

The National Friends and Family Test methodology includes both manual and electronic data collection (the ‘manual’ options include postcards and telephone surveys). Whilst electronic means of data collection provides much faster feedback, trusts should implement the Test in a way which meets their duties under the Equalities Act 2010, to assure themselves, their commissioners and others that the chosen methodology is not disproportionately affecting return rates for particular groups

FAQ posted 25 October 2012

58. Is it OK to ask the question in maternity and Children’s Services?

We would encourage provider trusts to use the methodology as widely as possible. However, for the purposes of the national data returns, maternity and children’s services should not be included at this stage.

FAQ posted 25 October 2012

59. Will the 15% be a guideline or a target?

The 15% response rate is an expectation, this is not currently mandated but all trusts are encouraged to seek to achieve at least this level of response.

FAQ posted 25 October 2012

60. Current recommended methodologies to collect the response could be deemed to discriminate against those who are cognitively challenged – not all have a carer or a guardian. How can we make sure we help them to tell us what they think?

For those patients with cognitive impairments and who do not have a carer or guardian to help them, volunteers or advocates may assist patients to complete the questionnaire. In addition, NHS Midlands and East are trialling an easy read version of the question, the

results of this trial will be shared with all.
FAQ posted 25 October 2012

61. Asking Friends and Family test away from care environment – please clarify?

It is important to ensure that responses are not influenced through the patient being surveyed within the care environment. Therefore the question should be asked away from where the patient is cared for, i.e. the patient must not be in their bed and must be away from the staff who have cared for the patient.

FAQ posted 25 October 2012; Updated 16 January 2013

62. P17 National Guidance para 3.9 final point “Volunteers should not view the survey response” How practical is this for acute trusts where patients require help to give their responses?

In particular, if patients do not have a carer/relative and can't use volunteer to view results, who helps this patient to do this? This is applicable for patients who cannot use hands etc.

Ideally patients should be given the opportunity to respond without their responses being viewed by staff members or volunteers. However, pragmatism is encouraged, and where patients need assistance from volunteers in providing their responses then we would encourage trusts to provide this assistance.

FAQ posted 25 October 2012

63. The Guidance specifies a response scale (section 2.1, p11) with numbers 1 to 6 associated with the responses ‘extremely likely’ to ‘don’t know’.

- **Does the number have to be used in a questionnaire?**
- **If the options are presented horizontally (rather than vertically, as in the Guidance) can you please confirm that they should start with ‘extremely likely’ on the left-hand side, and end with ‘don’t know’ on the right-hand side, with the numbers above the boxes and the text below?**

The numbers 1-6 do not have to be used with the associated responses but can be if helpful. If the answers are laid out horizontally they may run from left to right or right to left, this is up to individual trusts.

FAQ posted 19 November 2012

UNIFY2 Data Reporting Guidance

64. What happens if the late returns and the responses from the current month exceed the number of discharges?

We expect late returns to be the exception rather than the rule. Where late returns account for >10% of the monthly return, authorisation will need to be agreed with DH in advance of the submission being made. However, as there is no direct correlation between the total number of potential responses and the number of actual responses, if the total number of responses exceeded total number of potential responses, this would be acceptable.

FAQ posted 17 January 2013

65 Do you mean “day of discharge” or “point of discharge”?

As outlined in the Implementation Guidance of 4th October, the Friends and Family Test should survey patients after they have experienced an episode of care. The Guidance also makes clear that the patients' response needs to be anonymous and not influenced by the method of administration. Therefore, patients should be surveyed away from their care environment at the point of discharge.

FAQ posted 17 January 2013

66. What happens if we decide to post surveys to patients and they do not receive them within 48 hours?

All eligible patients should be surveyed on the day of discharge or within 48 hours of discharge. If postal surveys are used, it is the Trusts responsibility to ensure these timescales are adhered to.

FAQ posted 17 January 2013

67. If we choose to use telephone surveys, how do we decide who is selected?

Where telephone survey methodology is used for a group of patients (this could be by Ward/Department) 100% of all eligible patients should be surveyed on the day of discharge or within 48 hours of discharge. It is the Trusts responsibility to ensure that all eligible patients are surveyed.

FAQ posted 17 January 2013

68. What do you mean by “eligible”?

A5. Eligible patients are in-patients that have been discharged and A&E attendees who left without being admitted, excluding the two major exceptions of patients under 16 and women using maternity services. We have not provided detailed guidance in relation to eligibility because interpretation of the definition is guided by a simple principle of inclusiveness – therefore if in doubt, patients should be included.

FAQs posted 26 November 2012

IMPLEMENTATION

69. Does the FFT response scale need to run from ‘extremely likely’ to ‘don’t know’ or can it be reversed?

The response scale should run exactly as outlined in the implementation guidance; from ‘extremely likely’ to ‘don’t know’.

FAQ posted 16 January 2013

70. Does the response scale need to include the numbers from the implementation guidance?

No, only the text is mandatory.

FAQ posted 16 January 2013

71. If a patient from A&E is dealt with in an MAU (which might involve an overnight stay if they arrive in at A&E in the evening) then should they be classified as an A&E patient or an Inpatient in terms of which FFT question they are asked?

If a patient from A&E is treated in a MAU then they should be classified as an A&E patient; therefore they should be asked the A&E question and logged as an A&E respondent.

FAQ posted 16 January 2013

72. According to the Implementation Guidance, responses must be attributed to the ward where the patient spent the most time. If we are pre-printing/coding this information that means that each ward will need to have cards relating to each of the other wards in the hospital – are you able to clarify expectations?

The Implementation Guidance is clear that it must be possible to assign responses to the relevant ward, where a patient spent the majority of their time. We would encourage organisations to approach this as pragmatically as possible, either through the use of drop down menus, check boxes or a free text option to list the ward.

FAQ posted 16 January 2013

73. If a patient (who is on our trust PAS system) is transferred to an independent provider for treatment (because our trust can’t provide the care), who should ask the patient to complete FFT?

This situation would depend on the type of care provided, rather than the provider. If a patient is transferred from one acute trust to another acute inpatient ward where the service

is provided by a different trust, then the patient should only be surveyed when discharged home from that trust. However, if the patient is discharged from the first provider to their home but is referred for another form of care (ie not acute inpatient care), then they should be surveyed at discharge.

FAQ posted 16 January 2013

74. Are "ward attenders" included in the scope of FFT? i.e those that come to a ward to be treated by a nurse but who are not admitted and have not been to A&E.

No, 'ward attenders' are not included in the scope of FFT; only patients who are admitted as acute inpatients or who have attended A&E.

FAQ posted 16 January 2013

UNIFY REPORTING

75. In reference to the master spreadsheet for uploading to Unify, this will list all wards in a trust. Some months there may be no eligible FFT patients treated in a given ward. Do they have to remove the ward from the return or can they provide a nil return?

If no eligible patients are treated in a given ward for a given month then a nil return is acceptable.

FAQ posted 16 January 2013

76. With regards to A&E we have patients that leave the Trust before treatment, and have refused treatment, are these to be included in the discharge totals?

No, only patients who receive treatment should be included in the totals.

FAQ posted 16 January 2013

77. The structure of the return is built around the concept of a ward with a couple of main specialties. Our sites are not constructed in this way as patients have individual rooms and any could accommodate any patients of a varied case mix and specialties. It seems wrong to pigeon hole our units with one return row against our two most frequent specialties but I am not sure how else to meet this requirement. We can't be the only organisation in this position, what do you suggest we do?

In the instance where sites are arranged in individual rooms rather than wards, we suggest that returns are completed by specialties, with a reporting line for each. NB the FFT question itself should not ask patients to recommend a particular specialty, we suggest using the word "unit" or "hospital" (depending on the number of NHS patients)

FAQ posted 16 January 2013

Procurement of Services by Trusts

78. If trusts are procuring new services how will they do this? And how will suppliers know which trusts will procure and which will not?

Trusts will procure any new services according to their local procurement frameworks. Information on how and whether trusts are procuring new services will not be collected centrally; instead the role of the DH is to support trusts and suppliers where we are able to.

FAQ post 17 January 2013

79. How does the NHS anticipate appointing potential likely research consultants?

The procurement of any support in implementing the FFT will be up to the individual trusts, any consultation services would fall under this category.

FAQ posted 17 January 2013

80. What is the proposed process and timetable for appointment – bearing in mind the process has to be set up for the April 2013?

As above, any appointment of suppliers will be up to individual trusts, this will include the timelines.

FAQ posted 17 January 2013

81. How will individual trusts select which provider to appoint?

Should Trusts decide to procure services, they will use their own procurement processes to manage this and select the provider. Trusts may also wish to refer to the NHS Survey Procurement framework.

FAQ posted 17 January 2013

Unify/Central Reporting

For further information on Unify Reporting please refer to the published Unify Guidance at <http://transparency.dh.gov.uk/2012/11/28/nhs-friends-and-family-test-information/>.

82. Why are there options for listing two specialties? If there is a dominant specialty can only one be reported?

After consultation with trusts it was decided that there should be an option to state up to two specialties, as this allows trusts to reflect the mix of patients on their wards without overcomplicating the reporting process. If more than 80% of patients in a ward are from one specialty then only that specialty should be reported for that ward.

Independent Sector providers of services may have sites which have rooms rather than wards; in this instance a submission for each specialty would be acceptable

FAQ posted 17 January 2013.

83. Trusts may know the specialty of individual patients; will there be an opportunity to report this via Unify?

No, at this stage it will not be possible to report individual responses as we are keen to keep the reporting process as simple as possible. Clearly these responses may be attributed to the relevant specialty within the trust.

FAQ posted 17 January 2013

84. Can you provide further details about the UNIFY reporting system and in what format the data would have to be provided for uploading?

The Unify Guidance containing this information has now been published and can be found at <http://transparency.dh.gov.uk/2012/11/28/nhs-friends-and-family-test-information/>.

FAQ posted 17 January 2013

85. Does the trust (and therefore the supplier, in their reporting) have to be in a position to demonstrate the number of patients asked and the number who ultimately take part?

Yes, trusts will be required to list the total number of eligible patients, along with the responses to each category (and therefore the total number of responses).

FAQ posted 17 January 2013

86. Will reporting need to take into account the breakdown of patients treated at A&E or MAU?

No, reporting will be for a combined total of patients treated in A&E and MAUs.

FAQ posted 17 January 2013

87. What are the guidelines for how paper /postal responses should be treated? E.g. where a patient responds on paper within 48 hours of being discharged there will be a delay in inputting this information onto a reporting suite. Should the numbers be

included for the month in which the response is received/input OR for the month in which the patient was discharged? Are there any time restrictions?

Full details on dealing with late returns can be found on page 6 of the Unify Guidance.
FAQ posted 17 January 2013

88. Are nationally submitted results to include demographic information and, if so, are there any specific reporting requirements e.g. age bandings?

No, national submissions do not need to include demographic information.
FAQ posted 17 January 2013

89. Is there any requirement to report on whether the question was answered by the patient or by a carer / guardian?

No, this information does not need to be included as a separate line.
FAQ posted 17 January 2013

90. Is it anticipated that reporting will need to be broken into weekly information?

At this stage reporting will be on a monthly basis, for a whole calendar month only.
FAQ posted 17 January 2013

91. Does the trust (and therefore the supplier, in their reporting) have to be in a position to demonstrate the number of patients asked and the number who actually participated, refused to take part or only partially completed their response?

The trust must supply the total number of patients who were eligible to respond and the total numbers who gave each response category.

Implementation Guidance reference - 4.3 Frequency of Reporting

Organisations will be asked to submit data centrally on a monthly basis. It is assumed that to correctly assign responses to a given time period, all responses will be date stamped with the date of discharge.

FAQ posted 17 January 2013

92. Will the solution need to show both the submission date but offer a facility to enter the date if the discharge was not the day that the patient completed the questionnaire, and should there be any validation to prevent submission outside 48 hours?

Patients must be asked the question at discharge or within 48 hours of discharge and responses must be collated by the time of that month's submission, which is the 9th working day of the following month. The date of discharge will need to be collected to ensure that responses are allocated to the correct reporting month.

Implementation Guidance reference - Data reported centrally will run per calendar month and further details on reporting dates will be specified in separate reporting requirements guidance to be published later in the year.

FAQ posted 17 January 2013

93. Is it anticipated that there will be any future need to report results weekly?

Currently, there is not a requirement to report results to Unify weekly. However, we would encourage trusts to review their results at least on a weekly basis so that any issues can be quickly and effectively addressed.

FAQ post 17 January 2013

Publication Guidance and Research Programme

94. How will you balance the national reporting with the different questionnaire types and different patient types?

As outlined in the implementation guidance, it is the responsibility of trusts to ensure that they implement the test in a way which meets their duties under the Equalities Act 2010. Reporting will focus on results from ward level through to organisational level. Trusts are encouraged to ensure that they are using the FFT to focus on a culture shift towards being a customer-centric organisation and to drive individual trust performance.

FAQ posted 17 January 2013

95. Will the research decide which scoring mechanism will be used?

The research programme will provide evidence to inform the decision on which scoring mechanism should be used.

Whilst the previous FFT process ultimately calculated a one figure score there is no reference to a scoring process in the latest guidelines. Please provide guidelines as to the proposed calculation from April 2013.

The calculation methodology will be clarified in Publication Guidance, due for publication in the new year.

FAQ posted 17 January 2013

96. When will the guidance be available for the National /Site / Ward / CCG Level reporting?

Publication guidance is planned to be available in the new year.

FAQ posted 17 January 2013

97. Please clarify whether “site” level reporting refers to various locations within a trust or whether it is one figure for the “trust” regardless of the various locations?

Within the implementation guidance and the Unify guidance, trust level reporting refers to the whole trust, irrespective of the number of sites. Site level reporting refers to the individual site, for example an individual hospital site, which may be one of several, managed by a trust.

Will the calculation be the same as per the current process and if not, what are the scoring guidelines? Understanding the scoring allows us to ensure that the Trust can report Ward level data in recognisable format.

The calculation and presentation of the results will be clarified in the Publication Guidance, due to be published in the new year.

FAQ posted 17 January 2013

Implementation

98. How ready are ward staff to implement the FFT?

This will vary from trust to trust but there is a clear need to ensure that staff are aware of the test and understand the benefits of implementation.

FAQ posted 17 January 2013

99. Will ward staff be able to collect the data or would there be a preference for external staff to survey?

The principle is that staff members should not be collecting data; patients should not be surveyed face to face. Therefore trusts and suppliers should find alternative data collection routes.

FAQ posted 17 January 2013

100. If trusts are choosing to use a ‘DIY’ solution to implementing the FFT, will the DH be clarifying the hidden costs such as staffing time etc?

It is up to trusts to fully explore and analyse the implications of any given data collection solution.

FAQ posted 17 January 2013

101. What is meant by ‘48 hours’?

Patients must be surveyed at or within 48 hours of discharge. However, the responses can be received later than 48 hours, at anytime within the given month.

FAQ posted 17 January 2013

102. Why are the follow up questions not standardised or reported on?

While we agree that the follow up questions are extremely important, we have aimed to ensure that trusts are able to select the follow up questions most relevant to them and that fit with their data collection systems.

FAQ posted 17 January 2013

103. How will organisations use the answers to the follow up questions?

Organisations and wards are developing strategies to process and respond to the follow up questions, including linking responses to date and time of day to give greater granularity of information. These strategies are well embedded in the Midlands and East where trusts and staff have processes in place to ensure that the follow up questions are understood and quickly acted upon.

FAQ posted 17 January 2013

104. What survey methodologies did the organisations in Midlands and East use; and which were the most successful at engaging patients?

In the Midlands and East, where all acute trusts have been asking a version of the FFT since April 2012, a variety of data collection methods have been used. These have been variously successful at engaging different groups of patients (for instance paper surveys can be used by all, electronic methods are more popular with younger audiences etc). In general, using a number of data collection routes ensures that the greatest numbers of patients are engaged with and are able to respond.

FAQ posted 17 January 2013

105. What are the likely daily patient numbers for surveying?

Patient numbers for surveying will vary according to the size of the trust. However, the implementation guidance states that 100% of relevant patients must be given the opportunity to respond, with an expected response rate of at least 15%.

FAQ posted 17 January 2013

106. Is there a maximum length to the surveys i.e. although the main question is asked initially what range of survey lengths were used in the pilot?

We have not set a maximum length to surveys, however we would recommend that they are kept as short as possible, with the FFT question at the beginning, so that patients are more likely to respond and to maintain the integrity of the methodology.

FAQ posted 17 January 2013

107. Are there any guidelines on the use of images / easy read / presentation format for “hard to reach” groups both for electronic / paper completions?

An easy-read version is being piloted and tested in the Midlands and East which will be shared as soon as the testing phase is complete.

FAQ posted 17 January 2013

108. Are questionnaires able to be transmitted into foreign languages as necessary?

Yes, the FFT may be translated into other languages; NHS Midlands and East are currently collating suggestions for translations and will shortly be issuing 10-15 translated versions of the question in the most popular languages.

FAQ posted 17 January 2013

109. How can I be sure that patients are not answering the survey more than once?

It is good practice to ensure that answers are not duplicated and to use a unique reference number which ensures that patients can only answer the survey once. This number can be printed on a questionnaire/postcard and used as a voting control when accessing an online survey.

FAQ posted 17 January 2013

Other

110. Has the use of QR codes been considered by trusts?

While the use of QR codes is widespread, we have not heard of instances of these being developed and used for the FFT. We would encourage all to share new developments, such as the use of QR codes, with the team (at msc.nationalfriendsandfamilytest@nhs.net) so that these can be shared more widely.

FAQ posted 17 January 2013

111. Why is the answer scale inverted for the national FFT question? Or are the numbers superfluous?

The focus when outlining the answer scale was to provide clarity and ease of reading for patients and the public. The numbers do not reflect the scoring methodology; this will be defined in the Publication Guidance, due to be published in the new year.

FAQ posted 17 January 2013

112. What links will the DH/NHSCB be making with between the FFT data and other data such as equality data and other inpatient data?

There are potential risks to the viability of the programme if these links are not made. In order to ensure that responses remain anonymous they will not be linked to patient identifiers (and therefore other data sets). This will also ensure that surveys are kept short, which will encourage response rates and that the data sets are practical and can be easily used.

FAQ posted 17 January 2013

113. Within the wording of the question there is a mixture of tenses, are there any plans to change this?

No, the question is well understood by all and there are no plans to change the wording of the question, therefore in preparation for implementation by the 1st April deadline, systems may be put in place that rely on this format of the question.

FAQ posted 17 January 2013

114. Why are staff not involved in this process? They should be engaged with the work.

We agree that the role of staff members is vitally important to the success of the work and local engagement will be a key part of this. However, this needs to be balanced with the need to ensure that responses remain anonymous and that patients feel able to give open and honest feedback, so staff should not ask the question directly of patients.

FAQ posted 17 January 2013

115. Is there a communications strategy? Will this be shared with suppliers?

The DH teams have developed a communications strategy, along with SHAs. This outlines the importance of engagement and the need to ensure that there is buy in at all levels of provider and commissioner organisations.

FAQ posted 17 January 2013

116. Is it possible for Trusts to map existing data to the new scale (if similar)?

Mapping of existing data to the new scale will need to be assessed by trusts as it will depend on the similarity of their existing question and scale to the national question and scale. This mapping will only be relevant for local purposes. It is important for data returned to the centre via the Unify system that this is based on the actual question, wording and response scale specified in the guidance, and that this has been collected in accordance with the guidance.

FAQ posted 17 January 2013