

<b>Title:</b> Friends and Family Test IA No: 5169  <b>Lead department or agency:</b> Department of Health <b>Other departments or agencies:</b> NA.	<b>Impact Assessment (IA)</b>		
	Date: 01/01/2011		
	Stage: Final		
	Source of intervention: Domestic		
Type of measure: Other			

**Summary: Intervention and Options** **RPC Opinion: RPC Opinion Status**

Cost of Preferred (or more likely) Option			
Total Net Present Value	Business Net Present Value	Net cost to business per year (EANCB on 2009 prices)	In scope of One-In, Measure qualifies as One-Out?
£m	£m	£m	Yes/No   In/Out/zero net cost

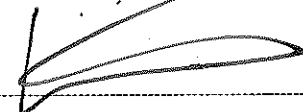
**What is the problem under consideration? Why is government intervention necessary?**  
 Although current patient feedback data provide powerful levers to drive service improvement, they are not as powerful as they could be. National survey data are collected once a year and current real time data is not consistently defined across the NHS. No single source is continuously collected at ward level representatively across all patient groups and specified and used consistently across the NHS over time in a way readily understood by patients and the public. Government intervention is needed to collect data with all these attributes.

**What are the policy objectives and the intended effects?**  
 That the Friends and Family Test will be used to strengthen service improvement in the following ways:  
 - providing frequent feedback at ward level to act as a source of intelligence to indicate quality  
 - comparable and used consistently across the NHS over time to monitor performance,  
 - published in a way that patients and the public can readily understand to help inform choice.  
 - holding to account CCG commissioners,  
 by holding the National Commissioning Board to account through the Outcomes Framework

**What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)**  
 Option 0: Do nothing  
 Option 1: Introduce the Friends and Family Test for adults for A&E and Overnight Inpatient Services  
 Option 2: As for option 1, but during 2013 extend the Friends and Family Test to Maternity episodes.  
 Option 3: As for Option 2, but during 2013 also extend Friends and Family test to outpatients, day cases, children in inpatient care, GP services and Community health services.  
  
 Option 2 is the preferred option

<b>Will the policy be reviewed? It will be reviewed. If applicable, set review date: 03/2017</b>						
Does implementation go beyond minimum EU requirements?				Yes / No / N/A		
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.		Micro No	< 20 No	Small No	Medium No	Large No
What is the CO <sub>2</sub> equivalent change in greenhouse gas emissions? (Million tonnes CO <sub>2</sub> equivalent)				Traded: NIL	Non-traded: NIL	

*I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.*

Signed by the responsible SELECT SIGNATORY:  Date: 15/11/2012

# Summary: Analysis & Evidence

# Policy Option 1

Description: Introduce FFT for Adult Inpatients and A&E only

## FULL ECONOMIC ASSESSMENT

Price Base Year 2012	PV Base Year 2013	Time Period Years 5	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	High: Optional	Best Estimate: 28.4

COSTS (£m)	Total Transition (Constant Price) Years		Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional		Optional	Optional
High	Optional		Optional	Optional
Best Estimate	nil		5.0m	25.0m

### Description and scale of key monetised costs by 'main affected groups'

Costs will arise in collecting Friends and Family Test data, as well as analysing the data. Resource for this is covered within hospital settings in allocations from the previous spending review. Scenario 1 (see Annex 1) assumes all patients use post cards. For scenario 2 (see Annex 2) the mix of data collection methods has been informed by a survey of the NHS. Figures used are taken from Scenario 2

### Other key non-monetised costs by 'main affected groups'

It is unclear to what extent organisations will be able to make use of already existing methods of collecting data. Any technology purchased is likely to be over several years and used for other purposes as well as for the Friends and Family Test. These costs have not been estimated in this impact assessment.

BENEFITS (£m)	Total Transition (Constant Price) Years		Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional		Optional	Optional
High	Optional		Optional	Optional
Best Estimate	nil		10.7m	53.4m

### Description and scale of key monetised benefits by 'main affected groups'

The key benefit is improvement in well-being for those patients who experience good service rather than poor service, where that change is driven by the incentives derived from FFT. We assume 4% see an improvement from poor service to good, each gaining 2% on a quality of life measure for a number of days after the episode of care.

### Other key non-monetised benefits by 'main affected groups'

Improvements not monetised but which may result in further financial benefits are: strengthened patient choice, supporting service improvement; more joined up (ward to board) improvement for provider organisations; strengthened mechanisms to hold commissioners to account; ease of use/simple headline metric that is more easily understood by patients

These benefits would apply for A&E attendances and inpatient admissions

### Key assumptions/sensitivities/risks

Discount rate (%) 3.5

Effective strategies for service improvement need to make use of the full range of patient experience data. The Friends and Family Test will be comprehensively collected for a simple headline question easily understood by patients and the public.

## BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			In scope of OIOO?	Measure qualifies as
Costs: nil	Benefits: nil	Net: nil	No	NA

# Summary: Analysis & Evidence

# Policy Option 2

**Description:** As for option 1, but also roll out FFT for Maternity from October 2013

## FULL ECONOMIC ASSESSMENT

Price Base Year 2012	PV Base Year 2013	Time Period Years 5	<b>Net Benefit (Present Value (PV)) (£m)</b>		
			Low: Optional	High: Optional	Best Estimate: 29.6m

<b>COSTS (£m)</b>	<b>Total Transition</b> (Constant Price) Years		<b>Average Annual</b> (excl. Transition) (Constant Price)	<b>Total Cost</b> (Present Value)
Low	Optional		Optional	<b>Optional</b>
High	Optional		Optional	<b>Optional</b>
<b>Best Estimate</b>	nil		5.1m	<b>25.7m</b>

### Description and scale of key monetised costs by 'main affected groups'

Costs will arise in collecting Friends and Family Test data, as well as analysing the data. Resource for this is covered within hospital settings in allocations from the previous spending review. Scenario 1 (see Annex 1) assumes all patients use post cards. For scenario 2 (see Annex 2) the mix of data collection methods has been informed by a survey of the NHS. Figures used are taken from Scenario 2

### Other key non-monetised costs by 'main affected groups'

It is unclear to what extent organisations will be able to make use of already existing methods of collecting data. Any technology purchased is likely to be over several years and used for other purposes as well as for the Friends and Family Test. These costs have not been estimated in this impact assessment.

<b>BENEFITS (£m)</b>	<b>Total Transition</b> (Constant Price) Years		<b>Average Annual</b> (excl. Transition) (Constant Price)	<b>Total Benefit</b> (Present Value)
Low	Optional		Optional	<b>Optional</b>
High	Optional		Optional	<b>Optional</b>
<b>Best Estimate</b>	nil		11.1m	<b>55.3m</b>

### Description and scale of key monetised benefits by 'main affected groups'

The key benefit is improvement in well-being for those patients who experience good service rather than poor service, where that change is driven by the incentives derived from FFT. We assume 4% see an improvement from poor service to good, each gaining 2% on a quality of life measure for a number of days after the episode of care.

### Other key non-monetised benefits by 'main affected groups'

Improvements not monetised, but which may result in further financial benefits are: strengthened patient choice, supporting service improvement; more joined up (ward to board) improvement for provider organisations; strengthened mechanisms to hold commissioners to account; ease of use/simple headline metric that is more easily understood by patients  
These benefits would apply for A&E attendances, inpatients and maternity.

### Key assumptions/sensitivities/risks

Discount rate (%) 3.5

Effective strategies for service improvement need to make use of the full range of patient experience data. The Friends and Family Test will be comprehensively collected for a simple headline question easily understood by patients and the public.

## BUSINESS ASSESSMENT (Option 2)

<b>Direct impact on business (Equivalent Annual) £m:</b>			<b>In scope of OIOO?</b>	<b>Measure qualifies as</b>
Costs: nil	Benefits: nil	Net: nil	No	NA

# Summary: Analysis & Evidence

# Policy Option 3

**Description:** Roll out FFT for a much wider range of services during 2013

## FULL ECONOMIC ASSESSMENT

Price Base Year 2012	PV Base Year 2013	Time Period Years	Net Benefit (Present Value (PV)) (£m)		
			Low: -170.1m	High: Optional	Best Estimate: 126.1m

COSTS (£m)	Total Transition (Constant Price) Years		Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional		Optional	Optional
High	Optional		Optional	Optional
Best Estimate	nil		79.9m	399.4m

### Description and scale of key monetised costs by 'main affected groups'

Costs will arise in collecting Friends and Family Test data, as well as analysing the data. Resource for this is covered within hospital settings in allocations from the previous spending review. Scenario 1 (see Annex 1) assumes all patients use post cards. For scenario 2 (see Annex 2) the mix of data collection methods has been informed by a survey of the NHS. Figures used are taken from Scenario 2.

### Other key non-monetised costs by 'main affected groups'

It is unclear to what extent organisations will be able to make use of already existing methods of collecting data. Any technology purchased is likely to be over several years and used for other purposes as well as for the Friends and Family Test. These costs are not included.

BENEFITS (£m)	Total Transition (Constant Price) Years		Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional		45.8m	229.2m
High	Optional		Optional	Optional
Best Estimate	nil		105.1m	525.5m

### Description and scale of key monetised benefits by 'main affected groups'

The key benefit is improvement in well-being for those patients who experience good service rather than poor service, where that change is driven by the incentives derived from FFT. We assume 4% see an improvement from poor service to good, each gaining 2% on a quality of life measure for a number of days after the episode of care.

### Other key non-monetised benefits by 'main affected groups'

Improvements not monetised, but which may result in further financial benefits are: strengthened patient choice, supporting service improvement; more joined up (ward to board) improvement for provider organisations; strengthened mechanisms to hold commissioners to account; ease of use/simple headline metric that is more easily understood by patients. These benefits would apply for all surveyed groups.

### Key assumptions/sensitivities/risks

Discount rate (%) 3.5

In addition to risks for earlier options: Given high levels of satisfaction with GP services in the GP Patient Survey, if the Friends and Family Test were extended to GP services there is a risk that gains in patient well being will not be realised to the extent suggested above. It will be expensive because of the high number of GP consultations, so this risks making NPV negative for GP services. This is reflected by the 'low' benefit assumption above.

## BUSINESS ASSESSMENT (Option 3)

Direct impact on business (Equivalent Annual) £m:			In scope of OIOO?	Measure qualifies as
Costs: nil	Benefits: nil	Net: nil	No	NA

# Evidence Base (for summary sheets)

## Problem under consideration

### *Introduction and background*

1. Improving patient experience is a key priority for the Government. This was set out in the White Paper “Equity and Excellence – Liberating the NHS”. The 2012/13 Operating Framework also made clear the priority for the NHS to put the patient centre-stage and to have a focus on improving patient experience:

“NHS organisations must actively seek out, respond positively and improve services in line with patient feedback. This includes acting on complaints, patient comments, local and national surveys and results from “real time” data techniques.

The national patient experience surveys should continue to be monitored and acted upon. In addition, as part of the National Standard Contract we shall expect each local organisation to carry out more frequent local patient surveys, including using “real time” data techniques, to publish the results – including data on complaints – and to respond appropriately where improvements need to be made.”

2. This priority is emphasised further in the NHS Outcomes Framework, where Domain 4 emphasises a focus on ‘ensuring that people have a positive experience of care’.
3. Within this policy context, there will be a clear focus within the emerging NHS structures and organisations on prioritising patient experience when commissioning care. There will be an expectation that Clinical Commissioning Groups will commission care from organisations that improve the quality of patient experience through better insight provided by individual patient feedback. Organisations providing NHS care will be expected to demonstrate that they are collecting, publishing and quickly responding to patient feedback.
4. In recent years there has been an increase in the number of tools and techniques aimed at capturing patient experience. National and local surveys capture wide-ranging data about patients, their views and their experiences. While this provides comparative, robust data for a variety of regulatory, accountability and performance purposes, surveys tend to be infrequent, and so feedback cannot be actioned in real time. (Research carried out by Dr Foster, for example, highlights that although many hospital boards discuss the results of patient surveys, they often fail to act on them).
5. The King’s Fund and the Picker Institute have undertaken research into patient experience measures which have been widely discussed (***What Matters to Patients?, Kings Fund, Sept 2011 and Overarching Questions for Patient Surveys: Development Report for the Care Quality Commission, National Patient Survey Co-ordination Centre, Picker Institute Europe, June 2012***)
6. Reports from CQC and the Francis Report on Mid-Staffordshire NHS Foundation Trust have highlighted the importance of timely, effective mechanisms to highlight where hospitals are failing to provide adequate levels of care and the need to ensure that these failures are made clear to all levels of the organisation, from ward to board. In addition, it is important that feedback is gathered from a full range of patients, with those who may not normally give feedback encouraged and enabled to do so. Publication of the second report from Robert Francis QC is likely to put renewed emphasis on the importance of patient experience as a key driver.

## The proposal – a Friends and Family Test

7. The proposed Friends and Family test is a simple, comparable test that is intended to highlight whether organisations need to improve. The results of the test, when coupled with other sources of data and intelligence, can help identify where they are failing and where they might also identify evidence of success. Versions of the Friends and Family question have been asked in the NHS in a number of formats in recent years, including in national staff surveys and in local surveys. For the first time in 2012/13, the Friends and Family Test was introduced in a standardised format in the Midlands and East region in all acute trusts. Organisations in this region are using the test to help move towards important cultural change, celebrate success, focus improvements and tackle poor quality care.
8. While the initial focus on the “Friends and Family Test” in the NHS will be to drive cultural change, the underlying methodology has a significant provenance in improving financial performance. In other industries this has been inevitably via customer retention and attraction, however the principles of simply identifying the strengths and weaknesses of the service proposition and accurately deploying resources accordingly, are just as relevant to the NHS particularly in the face of current economic challenge. Equally, the use of the methodology and by association the creation of a common language that is accessible to levels of an organisation has proved a powerful tool in optimising employee engagement, focus and thus productivity.
9. On the 25th May 2012, the Prime Minister announced the introduction of the Friends and Family Test to improve patient care and identify the best performing hospitals in England. The introduction of the test was based on recommendations from the Nursing and Care Quality Forum who also made a number of other proposals after consulting frontline nurses, care staff and patients.
  - a. The Prime Minister said:  
***“To really make sure that patients get the right care, we’re moving ahead quickly on one of their [the Nursing and Care Quality Forum] main recommendations: the friends and family test. In every hospital, patients are going to be able to answer a simple question: whether they’d want a friend or relative to be treated there in their hour of need. By making those answers public we’re going to give everyone a clear idea of where to get the best care – and drive other hospitals to raise their game.”***

## Symptoms and diagnosis of the problem

10. There is a variety of existing methods for collecting patient feedback data:
  - National surveys including the National Patient Survey Programme, co-ordinated by the Care Quality Commission, and the GP patient survey
  - 'Real-Time' data collected by local NHS organisations in line with requirements in the Operating Framework
  - A wide variety of locally administered surveys
  - Other methods of gathering feedback locally (including complaints)
11. National surveys typically ask a range of questions. They are conducted on a rolling programme, and results are published, although frequency is annual at best (with the exception of the GP survey). These surveys do provide consistent and comparable data across the NHS, but the infrequent results reduce the effectiveness of the surveys in

driving change. In addition, the results are typically published at NHS Trust level only. This makes it difficult for patients (and clinicians) to relate results to specific, actionable aspects of care.

12. In addition, Real time data are collected continuously, and use of 'Real time' mechanisms including hand-held devices and 'voting kiosks' has been promoted across the NHS in recent years. This was re-enforced in the 2012-13 Operating Framework, which said:

***“NHS organisations must actively seek out, respond positively and improve services in line with patient feedback. This includes acting on complaints, patient comments, local and national surveys and results from “real time” data techniques.***

***The national patient experience surveys should continue to be monitored and acted upon. In addition, as part of the National Standard Contract we shall expect each local organisation to carry out more frequent local patient surveys, including using “real time” data techniques, to publish the results – including data on complaints – and to respond appropriately where improvements need to be made.”***

13. Real Time data produces local, relevant, actionable data, but design is inherently local. It is not possible to benchmark results against feedback within other organisations. Overall, therefore, current patient feedback data provide levers to drive service improvement, but they are not as powerful as they could be, because there is no single source that is continuously collected and that:

- Provides feedback at ward level and on a frequent basis
- Specified and used *consistently* across the NHS, permitting benchmarking
- Used consistently over time,
- Published in a way that patients and the public can readily understand.

### **The need for Government intervention**

14. There are two existing market mechanisms for generating new survey data collections. Nationally, CQC co-ordinates national surveys that provide high level results relevant to current requirements of performance management, regulation or accountability. These surveys provide data that are comparable between organisations, but the results may not be immediately meaningful to patients or at a sufficiently granular level to drive change through the mechanism of choice or to enable service improvement at ward level.
15. Local surveys are focussed on local needs, and will tend to be more relevant to individual patients, but they lack the consistency of approach that would enable effective benchmarking. Such data collections will not address the need for data continuously collected at ward level, representatively across all patient groups, specified and used consistently across the NHS over time, in a way readily understood by patients and the public.
16. Government intervention is therefore needed to put in place a national data collection with the characteristics described above. The collection needs to:
- Be continuously collected at ward level to enable service improvement at a granular level;
  - Include all patient groups;
  - Be specified and used consistently across the NHS over time;
  - Be defined in a way readily understood by patients and the public;

- Requires Review of Central Returns (ROCR) approval (to ensure the form filling burden on the NHS is proportionate and justified).

## **Key related government policies**

17. There are existing surveys that gather views from patients, the variety and scope of which have increased in recent years. These include long running national series such as the National Patient Survey Programme, co-ordinated by the Care Quality Commission, and the GP patient survey. In addition, local NHS organisations have begun to make use of 'Real-Time' data collection methods (in line with requirements in the Operating Framework) and a wide variety of locally administered surveys and other methods of gathering feedback.

## **The policy objectives and the intended effects**

18. The proposal is to introduce a 'friends and family test', drawing on the experience of other sectors in asking service users whether they would wish members of their friends and family to have the care or treatment they have just had.

19. The intention is for the data to be collected at a greatly increased frequency, and at a level of aggregation that is much more relevant to patients, so aiming at monthly ward level. Data should be representative across all patient groups, and be used consistently across the NHS over time in a way readily understandable to patients and the public.

20. The proposal is to achieve this via a 'sentinel' question allowing patients and public to interpret quickly the quality of service in a way that is easily understood, and which might influence an individual's perception of the quality of service.

21. The objectives of this approach are to strengthen service improvement:

- through patient choice
- through service improvement from ward to board level within provider organisations;
- by holding to account CCG commissioners,
- by holding the National Commissioning Board to account through the Outcomes Framework

22. The Friends and Family Test (FFT) and how it will impact upon the health service are described below

- a. Characteristics of the Friends and Family Test (FFT)
  - Headline metric more easily understood by patients and the public to be used alongside other patient feedback data
  - Collected continuously
  - Organisation level results published nationally
  - Granular level results (e.g. for hospitals and at a ward level) published locally to drive cultural change within the NHS
- b. Patients and the public will use FFT
  - To provide feedback of their experience with service providers
  - to support choice of provider
- c. Providers will use FFT
  - to support improvement through monitoring FFT scores over time, (detailed time series)



- to pinpoint wards with poor performance, flagging specific issues through follow-up questions
  - to drive improvement through friendly competition between wards through comparative FFT scores
  - to enable development of more personalised services
  - to drive change by enabling action across levels (from board to ward) within organisations
  - To encourage a cultural shift towards a more patient-centred NHS
- d. CCGs will use FFT
- to benchmark for deciding which service provider to use
  - as a possible mechanism through which to reward improvement over time
  - to pinpoint wards where there may be specific issues
- e. The Department of Health and Commissioning Board will use FFT
- As a measure for the Outcomes Framework on which the Board will be held to account by the Department of Health for delivery on its mandate
  - Through inclusion of the FFT in the Commissioning Outcomes Framework to hold CCGs to account.
- f. Organisations with an accountability role such as Health Watch and Health and Wellbeing Boards, will use FFT.
- to benchmark trusts through CCGs and get an overview of performance on patient experience
  - through local, ward level data to pinpoint issues to formulate work programmes, prioritise
  - through scores over time to monitor the improvement of providers
- g. The Care Quality Commission and Monitor (the economic regulator) could make use of FFT to look at scores over time to monitor improvement

### **Framing the options**

23. The broad proposal, then, is to ask specified groups of patients a simple question. The precise wording of the question may vary slightly from setting to setting, but the intention is to assess whether the patient would wish their friends and family to have the care or treatment they have just had. Results will be published, and those results will be used to drive improvement through accountability to the public and to commissioning bodies and as an additional source of information to aid patient choice.

24. Options for the FFT centre around careful consideration of which aspects of NHS care it should apply to. There are several aspects to be considered:

- i) Value for money: This is what this document attempts to summarise. Are the benefits of introducing FFT greater than the costs?
- ii) Affordability: This is not usually considered directly in impact assessment, but it is an important consideration. Are the (gross) costs of the proposal affordable within available resources?
- iii) Practicality: The requirements of FFT are very specific and have some direct implications on survey methodology. Some of these methodologies may not work in particular settings.
- iv) Sensitivity or risk in assumptions: This is part of any rounded impact assessment. Where the conclusion is contingent on particular

assumptions for which there is a degree of uncertainty, we need to make a balanced assessment of risk.

25. Issues of practicality are important for these proposals. The timescales for introducing the FFT are very short, and it is important that the solution delivers comparable data across the NHS. This means that there is a need for a degree of standardisation. Advice from professional statisticians within the Department of Health is that very subtle differences in methodology could mean that results cannot be compared directly. This might mean, for example:

- Results collected for slightly different target groups
- Results collected with slightly different equipment (eg hand held devices vs card based systems)
- Participants chosen in a way that is not scientifically valid (eg systematically excluding patients who complained).
- Volume of responses large enough to allow valid reporting of results, but not imposing unnecessary costs by being too large.
- Question should be asked in a way that respondents can understand and relate to. This is particularly difficult when asking children for their views, although it does not preclude including this group.

26. These considerations lead to 4 broad options:

- a) Option 0: Do nothing: By default, impact assessments must include a do nothing option. This describes what would be done if the FFT policy is not implemented. By definition the costs and benefits of this option are zero, and other options are judged relative to it.
- b) Option 1: Implement FFT for those groups where issues of practicality are less challenging. It would be easiest to implement FFT for adult inpatients and those who attend A&E. These areas of care are, by their nature, episodic, with an easily identified target audience, a clear end-point, and an established setting within which to ask the FFT question (at point of discharge).
- c) Option 2: As for option 1, but during 2013-14 extend the FFT to cover Maternity services. The practical issues for maternity are more challenging: we would need to consider, for example, whether the survey should come into effect at a post-partum stage, and how it should gather feedback on ante-natal and post-natal care. This is an area of care where 'customer service' aspects are particularly important. The benefits of improved care are therefore likely to be more substantial and there is merit in considering early roll out for this group.
- d) Option 3: As for option 2, but also extend to a wider range of services during 2013, including outpatients, day cases, Mental Health patients, Children, GP services and community services delivered in the community.

### **Framing the benefits**

27. The advantages of a nationally co-ordinated survey like the FFT are that it can help provide insight into service issues that may otherwise be unmonitored. The test allows results to be benchmarked in a consistent way across the country and allows patients to use the results to help inform choice and increase control. These mechanisms enable clinicians and managers to understand the experience of their patients and, when combined with other sources of data and intelligence, to gain insight into what improvement in delivery or services may be required. This will enable organisations to focus current efforts and current resources in a way that delivers improved experience for patients.

28. The benefits arising from improved patient experience fall into two distinct categories. Firstly, and most importantly for the majority of patients, it is expected to improve services in a way that makes patients more content, or more satisfied with the service they receive. This is a direct benefit, represented by improved well-being for the patient.
29. Second, there will be instances where a more patient focussed approach enables a patient to explain a symptom or problem to a clinician in a way that enables a severe illness or risk to be addressed. We would expect such cases to be extremely rare; in virtually all cases we would expect that this process happens already. It is possible that the introduction of FFT could lead to large benefits for a very small number of patients. Whilst those benefits may be substantial in economic terms we do not seek to place a monetary value on them in this assessment.
30. The Centre for Health Economics estimates that patients who are anxious or moderately depressed have a lower quality of life than those that are not. It is estimated that during such a time, a patient's quality of life can be improved by 5% by alleviating the anxiety or depression. In effect, it says that the typical patient places equal value on one full year of healthy life or 20 years of alleviated depression or anxiety. We know from evidence elsewhere, that the estimated social value of one 'Quality Added Life Year' is around £60,000. Using these figures as a guide allows us to attach a monetary value on any improvement in mental well-being, for illustration purposes.

#### Monetising improvements in FFT scores

31. We can equate improved experience, with a marginal improvement in well being for the patient, and this gives us an outline method for valuing the resulting benefit. These are assumptions, based on judgement, and are therefore subject to a degree of uncertainty or margin of sensitivity:
- a. We note that a more contented patient will have a marginally better measure of 'well-being'. This is unlikely to be as large as the improvement arising from alleviating symptoms of depression or anxiety. In this assessment, we assume a quality of life gain of 2%, which seems reasonable relative to the 5% figure quoted above.
  - b. The target audience for improvement is not just those returning the survey, but all patients in the relevant service area.
  - c. Not all patients would see a gain. Typically, we expect that some patients who would have had a poor experience may instead have a good experience.
  - d. This improvement might not last very long – perhaps a few days. The effect would be longer in cases when the patient has been treated for a more severe illness or condition.
32. This gives us an outline methodology for calculating the value of this benefit

Estimated benefits	=	Number of patients	x	Percentage of patients affected	x	Average percentage gain (2%)	x	Duration of 'well being effect'	x	Value of a QALY
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33. We do not have baseline data for FFT, or any direct estimate of the degree of improvement that may be possible. However, by examining data from existing national surveys, we are able to frame the following numerical assumptions:
- i) Number of patients affected: All patients in the 'target group' for the survey.
  - ii) Percentage of patients seeing a difference: For working purposes, we assume 4% see an improvement from poor service to good. This is based on results from the national inpatient survey which shows that 8% of patients report their care as less than 'good'. We assume that half of this group may see the benefits arising from FFT.
  - iii) The gain per person is 2% of a QALY, as detailed above.
  - iv) The duration of this 'well-being' gain depends on clinical severity. We make illustrative assumption, or judgements, that the effect may last 5 days for ordinary admissions and maternity, 2 days for GP services and 3 days for other services.
34. As we will see below, this assumption about the duration of any 'gain' for the patient is critical. It is worthwhile reflecting on this judgement. This assumption refers to a small sub-group of patients who have a good experience of care, as a result of improvements driven by FFT. If FFT had not existed, those patients would otherwise have had a poor experience of care. This change is assumed to lead to a moderate improvement in the patient's sense of well-being, for a short period of time after their episode of care. It is important to draw a distinction between gains arising from the transactional and relationship based aspects of care that are most likely to be improved by FFT, and gains arising from improved clinical care. Our model does not assume any gain in clinical outcomes.
35. In this context, it is reasonable to assume that the benefits of a positive experience will be greater in circumstances where patients have undergone a more clinically severe or intense period of care. By simple judgement, we expect that a patient who experiences poor care for a routine inpatient procedure might experience a degree of disquiet for 5 days or so. The duration of this effect for less critical aspects of care would be less.

### **Costs and benefits for each option**

#### Option 0: Do nothing

36. Patient feedback through national surveys and real time data would continue (see key related policies section), but there would be no single source continuously collected at ward level representatively across all patient groups and specified and used consistently across the NHS over time in a way readily understood by patients and the public.
37. In particular no single global 'sentinel' question that allows patients and public to interpret quickly the quality of service in a way that is easily understood, and which might influence an individual's perception of the quality of service. For patients and public to use data in this way, there is a need to recognise that a proliferation of different sources, questions and methodologies can be difficult for members of the public to engage with. Moreover, if the public do not engage, the data cannot influence their views, opinions or actions.
38. The costs and benefits of 'do nothing' are, by definition, zero.

#### Option 1: Introduce the FFT for adults in A&E and overnight inpatient services.

39. The resources required for this option include the means to allow patients to give feedback in a consistent and comparable way.

40. It is envisaged that services will use a range of data collection methods according to local circumstances, as set out in the “*The Friends and Family Implementation Guidance*” (see below)

- On-line rating: patients are given information including a web link which they can use to log on, enter a reference number and provide their feedback
- SMS/Text message: patients are given the question at point of discharge, and are able to text their response (providing an opportunity to send follow up questions to responders)
- Smart phone apps: patients are given details of the app, including a unique reference number, at point of discharge
- “Voting booth” kiosks or hand held devices: positioned in the location from which the patient is discharged, with “voting” controlled to allow each patient to vote once
- Telephone survey – patient is given a free phone number and a unique respondent ID to respond within 48 hours
- Postcard solutions: patients are given a postcard at discharge with an option to complete and return on site or to complete at home and freepost back

41. It is assumed that capital requirements to support this infrastructure have already been put in place as a result of the last spending review. For the majority of trusts, we anticipate that the implementation of this work will therefore require an amendment to current systems..

42. There will be a degree of flexibility locally in the exact technological approach used. We therefore model two separate costing scenarios. Scenario 1 assumes a card-based reporting system whilst scenario 2 assumes that a broader range of (cheaper) options are employed. Scenario 2 is the most likely outcome, and is used in the summary sheets, but scenario 1 is included here as a reference point.

43. The costs are as follows:

Scenario 1: (card based)

**Option 1: Cost for A&E Attendances (type 1 & 2) and Hospital Ordinary Admissions (acute, excluding maternity)**

Cost per annum:	9.4m
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Costs £ million	2013-14	2014-15	2015-16	2016-17	2017-18
Cost over 5 years i	9	9	9	9	9
Discounted costs (:	9	9.1	8.8	8.5	8.2
Net Present Value	44				

Scenario 2: (using other data collection methods)

**Option 1: Cost for A&E Attendances (type 1 & 2) and Hospital Ordinary Admissions (acute, excluding maternity)**

Cost Per Annum (£	5.37
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Costs £ million	2013-14	2014-15	2015-16	2016-17	2017-18
Cost over 5 years i	5.4	5.4	5.4	5.4	5.4
Discounted costs (:	5.4	5.2	5.0	4.8	4.7
Net Present Value	25.0				

44. Costs in the scenarios above represent the costs of carrying out the Friends and Family Test and analysing responses using available existing (capital) equipment. Going forward some organisations may choose to invest in additional technology or equipment for collecting these data, in order to reduce ongoing revenue costs. It is unclear to what extent organisations will wish to make such a move. Any technology purchased is likely to be used over several years and used for other purposes as well as for the Friends and Family Test. These costs have not been modelled in this impact assessment.

45. It is envisaged that funding for carrying out the Friends and Family Test, analysing results and purchasing technology to collect the data have already been covered by allocations from the last spending review, so issues of affordability do not arise for this option.

### Benefits

46. The benefits of option 1 are calculated with reference to the material above. The benefits are identified as an increase in 'well-being' for some patients, as a result of improved service in affected health service sectors. The calculated benefits for option 1 are as follows:

#### **Option 1: A&E Attendances (type 1 & 2) and Hospital Ordinary Admissions (acute, excluding maternity)**

Benefit £ millions	2013-14	2014-15	2015-16	2016-17	2017-18
Cost over 5 years in today's money	11	11	11	11	11
Discounted (1.5% discount rate)	11	10.8	10.7	10.5	10.4
Net Present Value in 2013-14	53				

47. There is thus a net benefit of £28.4m (Net present value, or NPV) over 5 years.

#### Option 2: As per option 1, but extend to cover maternity from October 2013 (which is the earliest practical date)

48. Costs of this option are calculated in the same way, again with two separate scenarios. We assume that the costs of the extended system impact for half of 2013-14, and then in full from April 2014.

#### Scenario 1 (card based)

##### **Option 2: as per option 1, but extend Maternity by October 2014**

Costs £ million	2013-14	2014-15	2015-16	2016-17	2017-18
Cost over 5 years i	10	10	10	10	10
Discounted costs (:	10	9.4	9.1	8.7	8.4
Net Present Value	45				

#### Scenario 2 (broader methods)

##### **Option 2: as per option 1, but extend to Maternity, by October 2013**

Costs £ million	2013-14	2014-15	2015-16	2016-17	2017-18
Cost over 5 years i	5.5	5.5	5.5	5.5	5.5
Discounted costs (:	5.5	5.3	5.2	5.0	4.8
Net Present Value	26				

49. We note immediately that the costs are off the same order of magnitude as those for option 1. This is because the volumes (number) of patients affected is much smaller for maternity services than it is for inpatients or A&E.

### Benefits

**Option 2: as per option 1, but extend to Maternity October 2013**

Benefit £ millions	2013-14	2014-15	2015-16	2016-17	2017-18
Cost over 5 years in today's money	11	11	11	11	11
Discounted (1.5% discount rate)	11	11.3	11.1	10.9	10.8
Net Present Value in 2013-14	55				

50. This option delivers net benefits of £29.6m NPV over 5 years. This option therefore delivers a marginally better NPV compared to option 1. There is a degree of uncertainty about this conclusion, given the practicality issues in conducting a survey for maternity and the uncertainties about the assumed duration of any benefits. However, it is clear that modelling costs and benefits for maternity services alone yields a positive NPV.

**Option 3: As for option 2 but extend to a much wider range of services by April 2014.**

51. Costs and benefits as follows:

Scenario 1: (card based)

**Option 3 : As per option 2, but also add in a wide range of other services by April 2014.**

Costs £ million	2013-14	2014-15	2015-16	2016-17	2017-18
Cost over 5 years i	10	150	150	150	150
Discounted costs (:	10	144.9	139.9	135.0	130.3
Net Present Value	560				

Scenario 2: (broader methods)

**Option 3 : As per option 2, but extend to a wider range of services by April 2014**

Costs £ million	2013-14	2014-15	2015-16	2016-17	2017-18
Cost over 5 years i	5.5	107.6	107.6	107.6	107.6
Discounted costs (:	5.5	103.8	100.2	96.7	93.3
Net Present Value	399				

52. The costs here are much higher than for other options. This is primarily because costs include coverage of GP consultations. The number of GP consultations in one year is of the order of a quarter of a billion. Volumes are therefore very high, and the cost of administering a survey of this type is also high.

**Benefits**

53. The benefits of this option are as follows:

**Option 3 : As per option 2, but extend to a broader range of services by April 2014.**

Benefit £ millions	2013-14	2014-15	2015-16	2016-17	2017-18
Cost over 5 years in today's money	11	133	133	133	133
Discounted (1.5% discount rate)	11	131.5	129.5	127.6	125.7
Net Present Value in 2013-14	525				

54. Superficially, this option presents the highest level of net benefits: £126.1m NPV over 5 years. However, there are substantial risks in going ahead with this option. This is discussed in more detail below.

**Discussion on costs and benefits**

55. Superficially, it appears that benefits of the FFT outweigh the costs in all sectors, provided it is delivered using 'scenario 2' approaches – making best use of existing technology and kit. If NHS Organisations rely on card-based approaches, the costs outweigh the benefits for areas like General Practice. This finding rests on two factors:
- The cost of administering the survey, which is directly related to the volumes, or number, of patients surveyed.
  - The assumptions about the duration of any 'well-being' gain for the patient.

### Risks and assumptions

56. For Option 3, our conclusion of cost-effectiveness depends on key assumptions about degree of improvement for patients, and that organisations find cost-effective ways to administer the survey. Whilst these assumptions are reasonable sound for other sectors, they are a weaker for GP services for two reasons. Firstly, evidence from the existing GP Patient Survey suggests that satisfaction with GP services is already high. It is possible, therefore, that there is less scope for improvement. It may not be possible to deliver this scale of improvement for 4% of patients.
57. Second, the VFM argument is more marginal for GP services because patients who experience a positive outcome are not likely to feel the effect for as long – our assumption is 2 days. This assumption is critical: if the effect lasts only one day, then costs outweigh benefits. There is uncertainty about the assumptions, so our degree of confidence in this finding is slightly weaker.
58. It would be possible to address this uncertainty, and to strengthen the arguments for extension to GP services, once FFT is in operation in other sectors. A sensible position, therefore, is to recognise the positive NPV for GP services as an option, but not to recommend immediate implementation. Implementation should follow as soon as possible, provided the assumptions above are supported by data from other sectors.
59. To an extent, this conclusion arises because of the way options have been constructed in this assessment. Option 3 includes GP services, but it also includes a range of other services that have not been picked up in other options.
60. For these, similar arguments apply. We have assumed that for those patients affected by change arising from FFT, the gain is a touch lower than it would be for inpatient or maternity care. Whilst the VFM conclusion is less marginal, and benefits do appear to clearly outweigh costs, there is a degree of uncertainty about the conclusion. A minor variation in assumptions would make benefits smaller than costs.
61. In addition, there are simple issues of practicality in delivering surveys on this scale. Whilst FFT is configured to be a simple survey, centred around a single question and the most efficient means of data collection appropriate to each setting, it is still the case that data volumes are large and implementation will take time.
62. *Option 2 presents a good compromise: committing to an option that delivers a high degree of net benefit, with a high degree of confidence. As evidence emerges from early roll-out of this option, it will be possible to strengthen arguments in support of broader roll out as represented by option 3. It is therefore a reasonable policy position to implement option 2, but to require that FFT is implemented more widely subject to practicality.*

### **Unintended impacts**



63. Effective strategies for service improvement need to make use of the full range of patient experience data. The Friends and Family Test will be comprehensively collected for a simple headline question easily understood by patients and the public. There is a risk that an unintended impact of introducing the test may be that it leads to insufficient use of other sources of patient feedback data. These data cover a much broader range of important questions.
64. This risk is mitigated directly by the way the Friends and Family Test is defined. It is a single headline question, designed to highlight areas of concern. It is inevitable, and a vital part of the design of FFT, that it is followed either literally or figuratively by the question 'why'. There will be an expectation that organisations will want to understand the reason behind their FFT data, and existing data sources will provide a rich data source to drive that work. FFT should encourage more incisive and effective use of existing data, rather than undermining its purpose or existence.

### **Expected impact upon equality promotion and inequality mitigation**

65. The Friends and Family Implementation Guidance describes how the Friends and Family Test is intended to address patient experience feedback inequalities (see excerpt below).

*... it is important that adjustments are built in to the system to allow and encourage responses from groups that might otherwise not take part. For patients whose first language is not English, options to answer in their own language should be made available.*

*It may be necessary to offer more than one technological solution to avoid under-representation of certain groups (for example, relying on text messages may lead to under-representation from older patients).*

*All Trusts should be mindful of their responsibilities under the Public Sector Equality Duty in the Equalities Act 2010. There are also obligations under the NHS Constitution to ensure that the approaches chosen meet the duty to promote equality through the services it provides, and to have due regard to the need to eliminate discrimination, advance equality of opportunity, and foster good relations between different people when carrying out their activities.*

*If a patient is unable to answer the question, their carer or guardian may answer on their behalf.*

### **Disproportionate impacts upon rural communities**

66. The Friends and Family Test is about changing the way in which data is collected across the health system. There is no reason to believe this will have any disproportionate impact on rural communities.

### **Direct costs and benefits to business (OIOO)**

67. It is not envisaged the Friends and Family Test will directly impact upon the business community.

### **Rationale and evidence that justify the level of analysis used in the IA (proportionality approach)**

68. Depending on the extent of roll out and data collection methods used, scenarios modelled suggest a net present value cost over 5 years of between £25m and £399m. The Friends and Family Test has been announced by the Prime Minister.
69. Given the scale of costs and the high profile nature of the policy area analysis in this impact assessment is proportionate.

## **Conclusions**

### **Options that are QIPP compliant (i.e. without compromising quality they yield net cash savings by 2014-15)**

70. Analysis in this impact assessment suggest the Friends and Family Test may not be QIPP compliant, since although the policy will support service improvement it is unlikely to yield net cash savings.
71. All things considered, the preferred option is option 2. This is the preferred option because it delivers a high level of net benefit (even using a card based reporting system), at relatively low cost (relative to option 3) and without any of the downside risks of option 3. By extending to maternity patients, it allows patients from an important group to be covered by Friends and Family test at an early stage of implementation.

## **Tracking Progress**

72. Progress from the Friends and Family Test could be tracked in the following ways
- Improvements in data quality during 2013.
  - Improvements in Friends and Family local and national scores, and indications that this is (in part) driven by the existence of FFT itself.
  - A summative evaluation in 5 years, gathering views of stakeholders including commissioners on the impact and usefulness of the Friends and Family Test

## **Description of implementation plan**

73. Arrangements for implanting the Friends and Family test are set out in ***The National Health Service Friends And Family Test Implementation Guidance.***