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How to Measure Client Satisfaction With Stop Smoking Services: A Pilot Project in the UK National Health Service

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This pilot study aimed to develop a tool and methodology for measuring client satisfaction in UK National Health (NHS) Stop Smoking Services (SSS). A brief postcard questionnaire (measuring overall satisfaction with the service, willingness to recommend the service to others and smoking status) and a complete questionnaire (with 20 additional items measuring satisfaction with specific elements of the service) were developed. An NHS SSS mailed the postcard to 298 clients who had set a quit date in the previous quarter, they mailed the complete questionnaire to a subsample of 99 clients. Overall 34% (100/298) of those surveyed responded: 30% (90/298) for the card and 25% (25/99) for the questionnaire (15 people responded to both). Intraclass correlation coefficients (ICC) were found to be acceptable for both the overall service satisfaction item (ICC value = .43, $p = .05$) and the item regarding recommending the service to others (ICC-value = .83, $p < .001$). Hence the tool had reliability and at least face validity and the survey methodology proved practicable. The small modifications made to service delivery and the need for future research are discussed.

Keywords: stop smoking service, client satisfaction, pilot survey

When NHS Stop Smoking Services (SSS) were originally established, guidance from central government indicated that clients' views should be sought regarding the quality of the service they had received (Department of Health, 2000). However, this initial guidance was not reinforced by any subsequent information (or support) about how SSS should conduct this form of assessment. This led to some SSS not measuring client's views at all; while among those services that did, the types and quality of tools used differed greatly. In a survey of English SSS ($n = 172$) in 2007 prior to the ban on smoking in public places it was reported that 72% ($n = 85$) of stop smoking services sought clients' views about their service in a 'systematic' way (L. Hackshaw, personal communication, November 9, 2007). Methods of collecting this data included 52-week questionnaires, end-of-treatment questionnaires, drop-out questionnaires, various client satisfaction questionnaires, telephone calls, web site feedback forms, quarterly staff meetings, focus groups, patient and public involvement groups, follow-up letters and evaluation forms. There is no evidence of how, or indeed if, this client satisfaction data is analysed and interpreted in order to make changes to service provision.

One important component of client's views about a service is how *satisfied* they feel. There is some evidence that surveys that seek to measure overall satisfaction should focus on two dimensions in particular: satisfaction with the service received and satisfaction with the service setting and organisation (Gilbert et al., 1997). Perceptions of the care the organisation takes of its

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'customers' and feelings of trust towards the organisation should also be collected (Gustafsson et al., 2005).

A review of the literature on client satisfaction with health care in general, and smoking cessation interventions in particular, suggests that assessing service user satisfaction can be clinically useful as an outcome measure, a means for improving service delivery, and as a contribution to shifting the balance of power from providers to users (Ferguson & Bauld, 2002). This pilot study aimed to develop a tool and methodology for the measurement of client satisfaction with NHS SSS.

Methods

The first phase of this research project created a NHS Stop Smoking Service (SSS) client satisfaction survey tool. The survey tool was designed for all clients setting a quit date, including clients who set a quit date but who drop out during treatment, and clients who successfully complete the treatment course. The survey tool was designed after consideration of the literature (Ferguson & Bauld, 2002), consultation with expert opinion and piloting with several stop smoking service users.

Client satisfaction surveys of this type require high response rates to be valid. With this in mind a concise (postcard) questionnaire was designed with only three key items to measure overall satisfaction with NHS SSS. They were: 'Overall how satisfied were you with the support you received to stop smoking'; response options were on a Likert scale: 1 (*very satisfied*), 2 (*satisfied*), 3 (*unsure*), 4 (*unsatisfied*) and 5 (*very unsatisfied*). 'Would you recommend this service to other smokers who wanted to stop smoking': 0 (*no*), 1 (*unsure*) and 2 (*yes*) and 'Have you smoked since your last appointment with the service?': 1 (*No, not a single puff*), 2 (*Yes, just a few puffs*), 3 (*Yes, 1–5 cigarettes*) and 4 (*More than 5 cigarettes*). The reverse side of the postcard had a space for free text and asked: 'If there are any changes that you would like to see to the Stop Smoking Service, or if there was anything they did particularly well, then please write them here'.

The short (postcard) survey tool was complemented by a fuller (complete) questionnaire completed by a sample of clients. The complete questionnaire included the three items detailed above from the postcard tool assessing overall client satisfaction with the local NHS SSS and smoking status. The 23-item questionnaire also asked whether clients would return to the service if they ever needed to stop smoking again and what welcome they thought they would receive. Respondents were asked how easy it was to contact the service, whether they were given an appointment (and if they were given a choice between individual and group treatment) at this initial contact and how long they had to wait to commence treatment. The questionnaire also enquired whether there was any subsequent contact from the service, how convenient the appointment was in terms of time and venue and whether they were offered support with childcare costs. Clients were asked how supportive service staff were, how helpful was the information they provided, and whether they found group treatment and carbon monoxide (CO) monitoring helpful. The questionnaire asked about clients' choice of medication to aid their quit attempt and how easy it was to access this; finally, as with the postcard questionnaire, there was space for free text comments. Copies of the tools are freely available at http://www.scsrn.org.

This pilot project was conducted with one NHS SSS that was also a Smoking Cessation Service Research Network (SCSRN) member. Bath & North East Somerset Stop Smoking Service (BANES) provides a comprehensive smoking cessation service for the population of Bath and North East Somerset Primary Care Trust (PCT; population approximately 186,000). In 2006/7 nearly 1,500 smokers set a quit date with BANES Stop Smoking Service; 79.5% of self-reported quitters were CO validated and a 52% CO-validated 4-week abstinence rate is reported for this period.

The survey was carried out between November 5 and December 5 2007. The BANES service, which uses a client database with good record linkage, identified 308 clients who had set a quit date with the service in the previous quarter (July 1 to September 30, 2007). Only clients who had consented to further contact from the stop smoking service (97%, $n = 298$) were included in the survey. The service provided the research centre at University College London (UCL) with an Excel® database containing a unique identifier (BANES id) plus data on age, gender and ethnicity of these clients. The database also contained information on whether clients were eligible for free prescriptions, and a deprivation score based upon their postcode. Data on type of advisor seen, quit date, medication choice and CO validation of abstinence at end of treatment were also collected. Any data collected by the service that could identify individual clients was removed from the database prior to it being sent to the research centre.

The unique client identification number was added by hand to the postcards and these were included in an envelope (blank except for the unique client identification number) along with an accompanying introductory letter and a pre-paid reply envelope. The blank envelopes containing the postcards were returned to the service where the corresponding name and address were added and posted to clients. In order to test strategies for increasing response rates, and to investigate the importance of increasing salience by communicating urgency (West, 2006), two different deadlines for responses were given to clients. The service database was converted into an SPSS® research database and two groups randomly generated. Fifty-two per cent of the postcards and covering letters ($n = 156$) requested that clients complete and return the postcard questionnaire within 2 days; the

other group (48%, n = 142) urged completion and return within 2 weeks of receipt.

The SPSS® database was also used to randomly generate a sample of 99 clients (33% of the total sample who had received the postcard survey). This subsample were also sent the *complete* questionnaire. As with the postcard survey, the unique client identification number was added by hand to the questionnaires and these were included in an envelope (blank except for the unique client identification number) along with an accompanying introductory letter and a pre-paid reply envelope. The covering letter and the questionnaire urged completion and return of the questionnaire within 2 days. The blank envelopes containing the complete questionnaires were returned to the service where the corresponding name and address were added and posted to clients 2 days after the postcards were mailed.

Completed postcard surveys and the completed questionnaires were mailed, using the pre-paid reply envelopes, to the research team at UCL.

Analysis

Responses from the postcard survey were analysed to provide an overall level of satisfaction and to report on whether respondents would recommend the service to other smokers wanting to quit. Seven respondents to the postcard survey reported being 'very unsatisfied' with the support that they received and yet they said they would recommend the service to other smokers; this and their responses to other items led us to conclude this was a problem with the item and their responses were recoded to 'very satisfied'. One returned complete questionnaire was discounted because of a peculiar response pattern. Intra-class correlation coefficients (ICC) were obtained to assess agreement between responses on the postcard and the complete questionnaire for the two main items: 'Overall, how satisfied were you with the support you received to stop smoking?' and 'Would you recommend this service to other smokers who want to stop smoking?' Differences in overall satisfaction responses according to client, treatment and abstinence characteristics were analysed using chi-squared tests and t tests respectively. Data from the complete questionnaire were analysed to determine satisfaction with particular elements of the service provided by the SCSRN Member Service. Due to the sample size the data were insufficient to provide anything other than descriptive statistics, a flavour of which is given below. Analysis was conducted using SPSS® (version 13.0; SPSS, 2004).

Results

Overall 34% (100/298) of those surveyed responded: 30% (90/298) of the clients who were sent the postcard questionnaire and 25% (25/99) for the complete questionnaire. Fifteen (5%) clients completed both the postcard and the complete questionnaire.

There was no difference in response rates between clients whose letters and postcards urged return within 2 days (54/156; 35% response rate) and for those where 2 weeks was indicated (46/142; 32% response rate), $\chi^2(1) = 0.164$; $p = .7$. The mean response time for postcards was 7.7 days (SD = 3.8, range 3–21); for the complete questionnaire it was 11.1 days (SD = 6.0, range 7–31).

End of treatment data from the SSS showed that most clients (72%, 213/298) were treated in general practice, 11% (33/298) by a specialist advisor, 6% (19/298) in community pharmacies and a small number by a midwife (6%, 17/298), at a drop-in clinic (4%, 12/298), in a youth service (1%, 3/298) and via occupational health (0.3%, 1/298). The survey responses were fairly representative in this regard with 70% (70/100) of those who responded treated in a GP surgery, 10% (10/100) in specialist service, 7% (7/100) through a pharmacy and 13% (13/100) for the rest. Table 1 shows client demographic, medication choice and end of treatment outcome data supplied by BANES Stop Smoking Service for the entire sample, and via survey responses for the postcard and complete questionnaire.

Table 1 shows that at the end of treatment, 4 weeks after the quit date, 71% (211/298) of clients were CO-validated or self-reported abstinent. By the time of the survey 57% (51/90) of postcard respondents reported not smoking at all ('not a single puff'). Six per cent (5/90) reported 'just a few puffs' and 7% (6/90) 'one to five cigarettes'; nearly one-third (31%, 28/90) reported that they had returned to regular smoking. Sixty per cent (15/25) of complete questionnaire respondents reported not smoking at all (not a single puff'), 8% (2/25) reported 'just a few puffs' and one-third (32%, 8/25) reported that they had returned to regular smoking.

Older respondents were overrepresented in both surveys, $\chi^2(4) = 17.68$; $p = .001$ for postcard and $\chi^2(4) = 19.1$; $p = .001$ for questionnaire. People who had been CO-validated abstinent were overrepresented in the postcard survey, $\chi^2(1) = 14.47$, Fisher's exact = .0001, with 39% (67/172) of those abstinent at the end of treatment responding compared to 18% (23/125) of those who were still smoking.

The details of clients' responses to the individual items included in the complete survey are contained in a pilot project report available on the SCSRN website (McEwan, Arnoldi, Bauld, May, Ferguson et al., 2008); a few key results are reported here. Responses to the two main satisfaction items (how satisfied they were with the service and whether they would recommend the service to another smoker) repeated on the postcard and the complete survey are reported here so that correspondences between the two survey formats can be examined.

Overall Client Satisfaction

Respondents to the postcard survey were overwhelmingly satisfied with the support that they received from the

Table 1

Client Demographic, Treatment and Outcome Data

	Total (n = 298) % (n) / mean (sd)	Postcard (n = 90) % (n) / mean (sd)	Complete (n = 25) % (n) / mean (sd)
Gender (female)	60% (179)	62% (56)	64% (16)
Age (mean)	44 (14.8)	44 (14.7)	46 (13.9)
< 18	2% (7)	2% (2)	—
18–34	29% (87)	27% (24)	20% (5)
35–44	25% (73)	11% (10)	—
45–59	27% (81)	37% (33)	60% (15)
60+	17% (50)	23% (21)	20% (5)
Ethnicity			
British	97% (290)	100% (90)	100% (26)
Any other white	0.3% (1)	—	—
White/black Caribbean	1% (3)	—	—
Any other Asian	0.3% (1)	—	—
Caribbean	0.3% (1)	—	—
Chinese	0.3% (1)	—	—
Any other ethnic group	0.3% (1)	—	—
Eligible for free prescriptions	45% (133)	46% (40)	46% (11)
Deprivation (mean)	2.63 (1.42)	2.62 (1.38)	2.60 (1.41)
Most deprived	30% (83)	28% (23)	13% (3)
2nd most deprived	21% (58)	23% (19)	30% (7)
3rd most deprived	18% (48)	20% (16)	30% (7)
2nd least deprived	17% (46)	17% (14)	13% (3)
Least deprived	14% (38)	12% (10)	13% (3)
Pregnant	6% (19)	4% (4)	8% (2)
Medication			
NRT	71% (212)	70% (63)	88% (22)
Bupropion	6% (19)	4% (4)	4% (1)
Varenicline	11% (32)	11% (10)	—
None	12% (35)	14% (13)	8% (2)
Treatment outcome			
Quit (CO-validated)	58% (173)	74% (67)	68% (17)
Self-report quit	13% (38)	12% (11)	16% (4)
Not quit	21% (61)	10% (9)	16% (4)
Lost to follow-up	9% (26)	3% (3)	—
Time since end of treatment (weeks, mean)	25 (3.8)	25 (3.8)	26 (2.9)

stop smoking service (see Figure 1). Virtually all (93%, 84/90) would recommend the service to other smokers who want to stop smoking; 6% (5/90) were unsure and only 1% (1/90) would not make such a recommendation.

Overall satisfaction with the support received from the SSS did not differ according to demographic or treatment variables, nor to smoking status as reported in this survey, nor according to smoking status recorded by the service at the end of treatment. Willingness to recommend the service to others wanting to stop was also unaffected by demographic or treatment variables, or smoking status as reported in this survey. However, 99% (66/67) of those abstinent at the end of treatment would recommend the service to other smokers wanting to stop compared with 78% (18/23) of those who were not confirmed as abstinent ($\chi^2 = 11.46$, $p = .003$).

As with the postcard survey, the vast majority of complete survey respondents were satisfied with the support that they received from the stop smoking service (see Figure 2). A very large majority (80%, 20/25) would recommend the service to other smokers who want to stop smoking and 20% (5/25) were unsure.

The satisfaction item ('Overall, how satisfied were you with the support you received to stop smoking?'), completed by 15 clients in the postcard and the complete questionnaire, was found to have moderate agreement (ICC value = .43, $p = .05$). The recommendation item ('Would you recommend this service to other smokers who want to stop smoking?'), completed by the same respondents, showed greater agreement (ICC-value = .83, $p < .001$).

The complete survey allowed for more in-depth questioning about clients' experience of the service. Again responses were overwhelmingly positive; for example virtually all (96%, 24/25) respondents said that it was easy to contact the service when they had decided

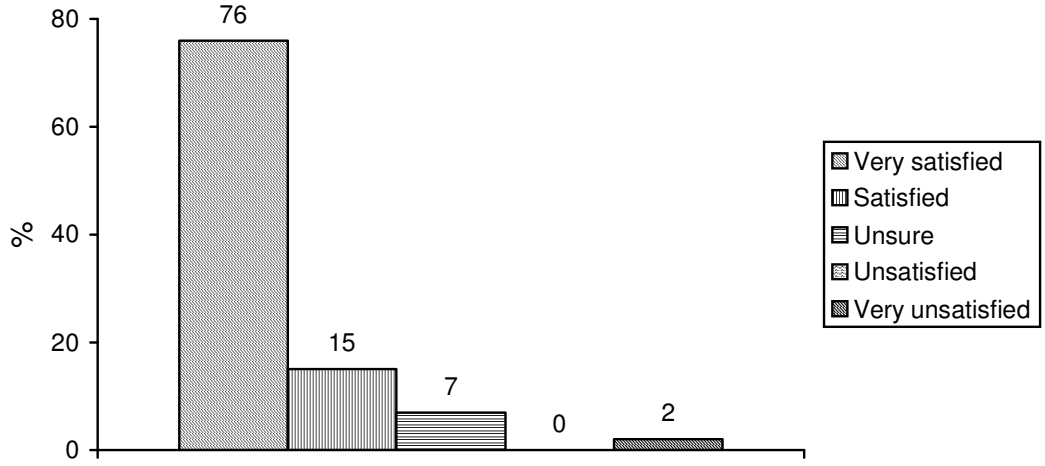

Figure 1
Overall satisfaction, post card survey.

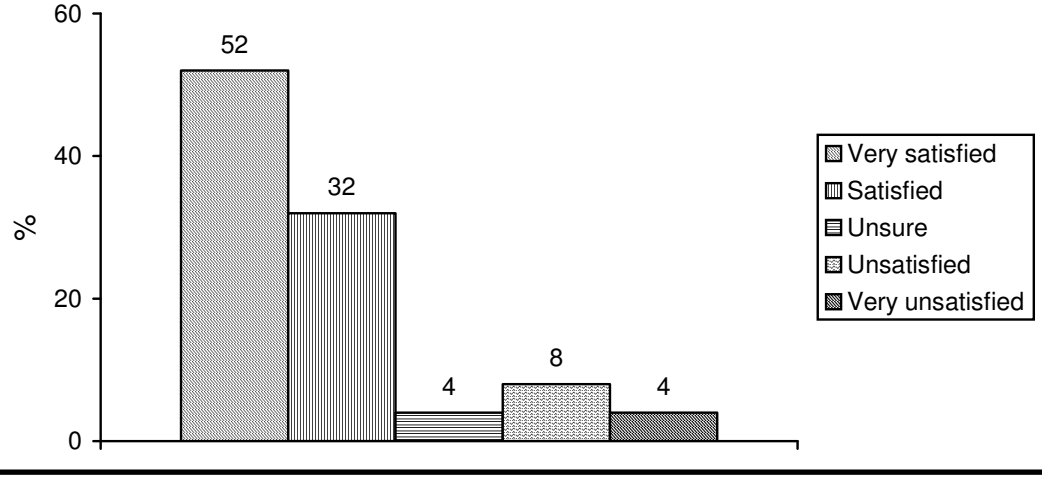

Figure 2
Overall satisfaction, complete survey.

that they wanted to stop smoking. The average length of time clients reported having to wait for their first appointment/group was 8.8 days (*SD* = 8.1, range 1–30) and for 92% (23/25) this wait was acceptable. Eighty-eight per cent of clients reported being 'very satisfied' or 'satisfied' with how supportive staff where and most found both verbal and written information 'helpful' or 'very helpful' (88% (22/25) for verbal and 76% (19/25) for written). Eighty per cent (20/25) reported using NRT to aid their quit attempt, 12% (3/25) varenicline, 4% (1/25) bupropion and 4% (1/25) said they used no medication and virtually all (88%, 22/25) respondents thought that it was easy to get hold of their medication. A small proportion (20%, 5/25) reported that they did not have their CO reading taken every visit. Eighty-four per cent (21/25) of respondents said that in the event that they started smoking again they would go back to the service for help with stopping smoking.

Comments Section

In total 39 respondents made comments; 31% (28/90) of postcards and 48% (12/25) of questionnaires contained comments (one respondent commented on both). Two comments were ambiguous but some respondents made multiple comments, so in total 47 comments were made. Of these 47% (22/47) were positive, for example, 'The support I received was excellent' (ID 9692); 25% (12/47) were autobiographical in nature, such as, 'I let myself down but I am still trying' (ID 9714) and 28% (13/47) were suggestions for improvement. These suggestions were varied in nature: three were to do with increasing the length of contact, two were to increase public awareness through advertising, and the rest were concerning resources; for example, the need for more nurses, improved access to medication. Only two comments were to do with the content of the intervention, one asking for more information/help with withdrawal and one asking for more motivational interventions, such as

videos. No qualitative analyses were conducted on these comments, but they were used by service staff to reflect upon treatment delivery.

Discussion

This study piloted a tool and methodology for routinely measuring client satisfaction with NHS Stop Smoking Services. The items measuring overall satisfaction with the service and whether clients would recommend the service to other smokers wanting to quit proved to be reliable and to have face validity. The response rates for the postcard survey and the complete questionnaire survey were both acceptable. Although urging clients to return the postcard questionnaire within 2 days decreased the mean response time compared with those who were given 2 weeks to respond to the survey, it did not have an impact on the response rate.

Overall, respondents to the surveys closely matched the total sample in terms of gender, ethnicity, eligibility for free prescriptions, deprivation index score and medication choice, also type of treatment received. There was, however, an overrepresentation of clients aged 45 and over in both samples and an overrepresentation of clients CO-validated as abstinent at the end of treatment in the postcard group. Respondents to the complete survey were clearly not representative of the sample as a whole; however, the complete questionnaire did capture client satisfaction data of a more detailed nature about the service.

The overall response rate of 34%, while low in absolute terms, compares with surveys of clients of other stop smoking services (e.g., Kirklees Primary Care Trust, 2007) and favourably with postal surveys of clients of community-based services (e.g., National Treatment Agency for Substance Misuse, 2006). There was little difference in response rates between the postcard and the complete survey (26% and 30% respectively). Two aspects of the design that are likely to be different from the 'real world' may have impacted on response rates; first, the fact the survey was anonymous and conducted by a third party, and second, the fact that the clients receiving the complete questionnaire were a subset of the total sample and so received surveys on two separate occasions. The results suggest the decision to use the postcard or the complete questionnaire could be based on the level of data the service wishes to collect. Clearly the complete questionnaire captured client satisfaction data of a more detailed nature about the service, but it also required more resources to input and analyse that data. The survey process proved manageable, in terms of time and resources, for a stop smoking service with a minimum dataset and good record linkage. It was also practicable for the research centre in terms of data collection.

Surveys of this kind typically result in low response rates. This may be because clients have 'failed' and so don't want to participate, or simply because they no longer consider it relevant, they may also intend to participate, but forget. Whatever the reason, a low response rate is a significant limitation of the study. It may be possible to assess of the impact of the response rate on bias by conducting follow-up waves of surveys to people who did not respond to the first wave. However, methods to improve response rates in future studies should be considered. There are many possibilities, for example, different survey methods, incentives to reply or just emphasising the importance of replies from people in the under-represented groups; in this case that would be clients who are younger, unable to quit or clients who may be less satisfied. Merely urging clients to respond to the survey within different timeframes, 'two days' and 'two weeks', did not have a significant impact upon response rates. One possibility would be to undertake the survey while the client is still in contact with the service. A time point would need to be chosen such that the client has some experience of the service on which to comment, but early enough in their quit attempt that they are still engaged in treatment. This method is being tested in a follow-up study, the protocol of which is available at www.scsrn.org.

Among those who responded the overall level of satisfaction with the support received was very high on both the postcard and complete questionnaire; the reliability of this item was moderately strong. However, it appeared that some respondents (8%) had difficulty interpreting this item and its layout should be given consideration in future research. Similarly, the percentage of respondents willing to recommend the service to other smokers wanting to quit was extremely high; the reliability of this item was strong. Overall satisfaction with the service did not depend on smoking status but willingness to recommend the service to others did, to some degree. However, perhaps surprisingly, even among those who were smoking at the end of treatment, over three-quarters would recommend it to other smokers wanting to stop.

The high level of satisfaction among most respondents, and the willingness to recommend the service to others, suggest that an opportunity exists to utilise these satisfied clients to recruit smokers into treatment. Referral cards aimed at recruiting smokers into treatment with local SSS could possibly be included with client satisfaction surveys. Ongoing contact with ex-clients is also suggested to ensure that the vast majority who reported that they would return to the service in the event that they started smoking again, actually do so. A client satisfaction survey like the one piloted in this study also allows services to monitor abstinence rates post-treatment, for audit purposes and for the purpose of re-engaging relapsed clients.

The free text comments section was well used by respondents. Comments were very positive about the

quality of the support received overall, and about specific components of the service, but clients also used the space to make suggestions for improvements to the service.

Among those who responded the levels of client satisfaction with BANES Stop Smoking Service were high and this, plus individual respondent's comments and data from the complete survey on specific aspects of the service, were discussed with the service manager and an action plan constructed. A copy of the full study report is available on the SCSRN website at: http://www.scsrn.org/scsrn_research.html.

Conclusion

This study piloted a tool and methodology for routinely measuring client satisfaction with NHS Stop Smoking Services. The response rates for the surveys were moderate, but in line with other surveys of this type, with little difference between the postcard and the complete version. The items measuring overall satisfaction with the support received and whether clients would recommend the service to other smokers wanting to quit proved to be reliable. Finally, the methodology was practicable in a service with a minimum dataset and good record linkage. The results of this pilot suggest there may be scope for the future development of a standardised, validated tool for assessing client satisfaction that could be used by all NHS SSS, thus addressing variable practice and providing an opportunity for comparisons between services to be made.

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