NORTH EAST QUALITY OBSERVATORY SERVICE (NATIONAL COLLABORATING CENTRE FOR INDICATOR DEVELOPMENT)

FOR

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

INDICATOR DEVELOPMENT PROGRAMME

Feedback report on piloted indicators

Topic areas: Smoking and Severe Mental Illness (SMI)

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Output: Findings from qualitative pilot to contribute towards recommendations for NICE indicator menu

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1. Summary of pilot findings

Smoking: cessation success in people with bipolar disorder, schizophrenia and other psychoses

The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses recorded as current smokers in the previous 1 to 3 years, who were recorded as ex-smokers in the preceding 12 months.

The indicator has been classified as a network or system level indicator because of concerns about the attribution of responsibility.

Acceptability assessment

Despite overall support for this topic in principle from the interviewees, just over one quarter of survey respondents (28.1%, 18/64) thought that the indicator was important to patients, families and carers. Only one quarter of survey respondents (26.6%, 17/64) felt that this indicator would improve the quality of care for patients with a further 62.5% (40/64) suggesting that it would have no impact.

There were mixed views on whether the indicator was suitable for financial incentivisation (at any level) with only one third of respondents in support of this (32.8%, 21/64). In the interviews most practices did not think that this indicator was acceptable and suggested that their focus should be on the management of the patient’s mental health condition. Those practices in support highlighted that this work was already ongoing, and that this indicator would not add anything.

A mixed response was obtained from the survey and interviews regarding whether the indicator should be network or system level, with under half of survey respondents suggesting primary care network level (43.1%, 22/51) and a further fifth proposing system level. The remaining respondents were unsure.

A few practices thought that the indicator should focus on the process (of offering support and treatment to patients who smoke) rather than on the outcome. This would require amendment of the indicator definition.

Implementation assessment

This outcome-based indicator measures the degree of smoking cessation success in patients with severe mental illness (SMI) who were smokers and it has been classified as a network or system level indicator.

The pilot feedback illustrated the complexities of system or network level outcomes indicators, for which there may be numerous contributing factors. For this indicator, practices identified the following key considerations:

Patient factors: including access and engagement, disease severity, social exclusion, competing lifestyle choices and the affordability of nicotine replacement therapy were all identified as contributing to smoking behaviour and the ability of primary care to deliver change.

Practice factors: there were concerns from some practices about both clinical and administrative workload that this indicator could generate.

System factors: the capacity and effectiveness of smoking cessation services and the role of secondary care in promoting healthy lifestyle behaviours.

Measurement issues: including information flows between secondary and primary care, and definitions relating to 'vaping' versus smoking.

Policy issues concerning QOF payments and other financial incentives in the context of network or system level indicators.

The indicator has been classified as a network or system level indicator because of concerns about the attribution of responsibility, and these concerns were emphasised in the pilot responses in addition to consideration of the feasibility and acceptability of using practice IT systems as a data source. There was a common view that this source could support the indicator as all patients with SMI were identified by the Mental Health QOF register, and that smoking status and smoking cessation were reliably recorded in the clinical system. It was acknowledged that further work was required to reconcile concerns regarding the relevance of the use of e-cigarettes (vaping) to smoking status.

Most pilot responses focused on the limitations of this indicator as a measure of primary care processes rather than recognising the role of system and network level

indicators and the opportunities such indicators can have to improve multi-agency working to deliver better health outcomes. There are some potential concerns about the validity of some of the responses from practices as a result of their focus.

The pilot results have clearly illustrated the complex nature of promoting healthy lifestyles especially for people with SMI. The results emphasise the importance of secondary care and community services, which may help determine whether the indicator would be most useful at system or network level, although the practices had mixed views on this.

These concerns are summarised in the table below, with mitigations suggested for consideration where possible.

Issues to be considered prior to implementation:

Issue	**Level**	**Detail**	**Mitigating activity / considerations**
Engagement challenges	Patient	It can be challenging to engage patients to attend the practice and value the importance of smoking cessation	Wider initiative for making every contact count (MECC)
Disease severity	Patient	Various examples of condition severity were suggested for exclusion from this indicator	Amendment of indicator definition or guidance
Cost for nicotine replacement therapy	Patient	Some patients may not be able to afford the prescription or to purchase nicotine replacement therapy	Create a funding scheme for patients on low income to reduce health inequalities
Admin workload	Practice	Workload involved in booking patient appointments and recall processes, particularly due to poor engagement by patient cohort	Consider alternative appointment times (when practice is quiet) Offer home visits by social prescribers or other primary care staff
Clinical workload	Practice	Longer appointments and more appointments required as patient cohort is complex	Resources to increase numbers of other clinical staff including pharmacists and nurses Consider MECC

Issue	**Level**	**Detail**	**Mitigating activity / considerations**
			Consider expanding the role of community mental health nurses to address the physical needs of people with SMI
Capacity of smoking cessation services	System	Cessation services may not exist or have capacity to provide the necessary support	Set up in-house cessation services or have a system level approach to ensure adequate services are commissioned and provided
Role of secondary care	System	Supporting smoking cessation	Ensure that promoting physical health and monitoring smoking status is integral to secondary care through MECC and service specifications, and supported by information systems and flows
Data flows from community services	Measurement	Issues with information (smoking status) from services being shared with primary care for the patient record	Consider integration of templates/clinical systems between services or introduce data flow proposals Include community services as a wider initiative for MECC
E-cigarette use	Measurement	Clarification is required regarding users of e-cigarettes with regard to their smoking history	Consider recording 'smoking' in more detail, to differentiate cigarette smoker from those who use nicotine vape or non-nicotine vape Guidance to promote awareness of smoking status classifications outlined in QOF guidance
National policy level	Relationship of the indicator to existing QOF indicators	Two smoking-related indicators are income protected in QOF 24/25 - mixed messages re national priorities?	

2. Background

As part of the NICE indicator development process, all clinical and health improvement indicators proposed for inclusion in the NICE Indicator Menu are piloted, using an agreed methodology, in a representative sample of GP practices across England.

The aim of piloting is to test whether indicators work in practice, have any unintended consequences, and are fit for purpose.

The full background to the inclusion of this topic in the pilot, including a list of piloted indicators, is presented in Appendix A along with a description of the method and approach to piloting.

3. Practice recruitment

A summary of the general practice recruitment methodology is shown in Appendix B.

Number of practices recruited, ready to commence pilot (January 2024)	**30**
Final number of practices in the pilot	**22**
Number of practices participating in feedback	**22**

Feedback was obtained via interviews and an online survey, and it was possible for individuals to participate in both the survey and the interviews. At least one survey was completed (or partially completed) by each of the 22 participating practices. The quantitative responses to the online survey are shown in Appendix E. The table below indicates the practice participation in the pilot specifically for the smoking topic.

Feedback participation for smoking topic by role and method

Staff role	**Interviews - number of participants**	**Survey - number of respondents**
GP	9	35
Pharmacist	2	1
Nurse	2	5
Practice manager	4	14
Other senior management	1	3
Other clinical staff	0	2
Practice administrative staff	1	4
Number of participants	**19**	**64**
Number of practices	**11**	**22**

As described in Appendix A, not all interviews covered all topics and 19 participants from 11 of the 22 practices were asked questions about the smoking topic in their interviews.

Not all 64 survey respondents completed all of the smoking-related indicator survey questions (see Appendix A) and therefore the denominator for each question is included throughout this report.

4. Assessment of clarity, feasibility, reliability and acceptability

4.1. Clarity

There were no specific problems with ambiguity for this smoking cessation indicator, although amendments to the wording were suggested by practices in both the interviews and survey in terms of the indicator type and focus, and smoking status and e-cigarette use (see report section 5 for detail).

4.2. Feasibility and reliability

There was a common view that it would be easy to identify this cohort, as it related to all patients with severe mental illness (SMI) who were on the mental health QOF register, and that the recording of smoking status and smoking cessation in the clinical system was straightforward and not complex. Two practices noted that this information was captured already as part of the physical health check for people with SMI.

The ability to accurately capture information or notifications in a timely manner (or at all) from community smoking cessation services was raised as an issue by some practices (see section 4.3 for detail).

4.3. Acceptability

This section summarises practice views from the interviews and the survey on the acceptability of the topic; and the potential impact of the indicator on quality of care; the importance of the issue for patients and their families; the role of financial incentivisation; and any specific acceptability issues identified. To note that (as described in section 1 of this report) the feedback obtained focused on the role of primary care in delivering smoking cessation or contributing to a larger primary care network rather than being one component of a wider public health system.

Topic feedback

There was overall support in principle for this topic, with practices recognising the benefits of smoking cessation on the quality of care for patients. Three GPs and one practice manager from the interviews suggested that their focus should be on the

specific management of the patient's mental health condition rather than their smoking status.

"Just from personal experience, this is a group of patients who really do smoke quite heavily so I think this is a very worthwhile indicator to include so I would endorse it." [GP, interview]

"I think we're always welcoming more smoking cessation so I think as many patients as we can get to stop smoking, we're happy to have them." [GP, interview]

"I think that if their mental illness is severely uncontrolled, I think this is not going to be your focus, you need to get their mental illness to a level where they're able to engage." [GP, interview]

"I think probably this is a cohort of patients that are far more in need of support for their mental health rather than being interrogated about their smoking habits." [GP, interview]

A further three practices noted that work was already being undertaken relating to the offer of smoking cessation advice and recording when patients had quit, suggesting that a separate indicator would not add anything. One practice mentioned that at present there was no focus on smoking cessation as there were no payments associated with it.

One GP suggested that as patients were also managed and supported by secondary care and community mental health teams, these services could also be involved with smoking cessation in future, adding:

"I am not sure I have ever read a psychiatric clinic letter that discusses any form of smoking cessation intervention, but they do frequently note a smoking history." [GP, interview]

This view was also supported by two practices who provided comments in their survey responses.

"Secondary care services would need to encourage and support patients with SMI to stop smoking." [GP, survey]

One practice noted that their mental health specialist team would currently write to the GP to inform them if one of their patients no longer smoked.

Some practices in both the interviews and survey remained of the view that the indicator should be a process rather than an outcome indicator (see section 5 for detail) and their feedback was focused on the issues and factors that may affect the implementation of the offer support and treatment to those who smoke as the intervention, rather than the results of the intervention, namely the number of smokers who had stopped smoking.

While there was support in theory for the rationale of the indicator, nine of the eleven practices interviewed on this topic raised concerns about achievement due to issues with the implementation of the indicator in practice, mainly relating to patient access and engagement. The other practices had more positive views about indicator achievement.

"It's a struggle enough to get this cohort of patients in for their mental health reviews, never mind then passing them over to a different service for the smoking cessation. It's blanketly offered, it's advised, should I say, to patients who smoke, to give up. If that was the case, then yes, we do advise cessation for all of our smokers if and when we see them. But to actually succeed in it, it's literally no." [Practice senior management, interview].

"As a performance measure, I think it's awful [...] This cohort will not come in. We've had to cajole and encourage and basically exception code an awful lot." [Practice manager, interview]

"There is absolutely no way that we will achieve anything in this regardless of how low the bar is." [Practice manager, interview]

"Yes. I think it's a fairly straight forward and easy one to get […] while they're having their care plan assessment done at the time, then it's just a simple question to ask anyway and obviously it benefits for us to try and give them that cessation advice if they do say they are smoking and are smoking heavily. So yes, I do think it's a good one." [Practice senior management, interview]

Similar concerns about access and engagement of the patient cohort and the subsequent impact on achievement of this indicator were also raised by six survey respondents (9.4%). These issues are explored in more detail in section 4.3.5 of this report.

"This is a difficult group to engage and whilst encouraging smoking cessation would

be a helpful indicator, achieving smoking cessation in a defined number would be difficult to achieve." [GP, survey]

Indicator-level feedback

4.3.1. Quality of care

Most respondents to the survey thought that the smoking cessation indicator would have no impact on the quality of care for patients (62.5%, 40/64) and only just over one quarter (17/64) of respondents felt the indicator would improve quality of care (Table 1). The view of seven respondents (10.9%) was that the indicator would 'worsen' the quality of care for patients.

Table 1: Views on the impact of quality of care of the smoking cessation indicator (survey)

What impact do you think the following indicator could have on the quality of care for patients?

	Improve	No change	Worsen	Total
Indicator 1: Smoking: cessation success in people with bipolar, schizophrenia and other psychoses	17 (26.6%)	40 (62.5%)	7 (10.9%)	64

4.3.2. Value to patients

There were mixed views on whether the indicator represented an issue that was important for patients, families and carers (Table 2). Over one quarter of respondents (28.1%, 18/64) thought that the indicator was important to patients, but just under half the respondents (48.4%, 31/64) reported that they did not think this was the case, and a further 15 respondents (23.4%) were unsure.

Table 2: Views on the importance of the smoking cessation indicator to patients, families, and carers (survey)

Do you think the following indicator represents an issue that is important for patients, families, and carers?

	Yes	No	Unsure	Total
Indicator 1: Smoking: cessation success in people with bipolar, schizophrenia and other psychoses	18 (28.1%)	31 (48.4%)	15 (23.4%)	64

Please note where percentages do not total 100%, this is as a result of rounding.

Some practice GPs highlighted at interview that there could be difficulties in engaging patients to stop smoking as this patient group has a higher smoking prevalence and may be less focused on healthy lifestyle interventions. It was suggested that this cohort are more resistant to give up smoking as they may use this to manage stress and anxiety.

"...and some of them don't want to (stop smoking), whereas often for a lot of these patients, as they all say, their sole pleasure in life and some of them are on medication where they know they can't have alcohol with it or they've had past instances of drug misuse, so they are very limited in their medication and so on. That's very closely monitored, so smoking is the one freedom they have." [GP, interview]

"...obviously this is a cohort that are incredibly difficult to influence, particularly to achieve sensible lifestyle habits." [GP, interview]

"Getting those patients to engage, they've got to want to stop, and I just don't think they do." [GP, interview]

One respondent from a different practice also corroborated this view in the survey:

"These patients are complex and often very fixed in their decision to smoke. This is always something that should be discussed but an unlikely outcome I can see to have genuine improvement." [GP, survey]

Another survey respondent (GP) mentioned that patients with severe mental illness tend to start and then stop smoking on a repeated basis over time which could make this indicator 'meaningless' in their view.

4.3.3. Financial incentivisation

There were mixed views on whether the indicator should be financially incentivised (Table 3) with just under one third of respondents (32.8%, 21/64) agreeing to financial incentivisation and under half of respondents (48.4%, 31/64) not in support of this. A further 12 respondents (18.8%) were unsure. It is possible that some respondents focused on this from a primary care perspective rather than in the context of a network or system level indicator.

Table 3: Views on financial incentivisation of the smoking cessation indicator (survey)

Do you think the following indicator should be financially incentivised?

	Yes	No	Unsure	Total
Indicator 1: Smoking: cessation success in people with bipolar, schizophrenia and other psychoses	21 (32.8%)	31 (48.4%)	12 (18.8%)	64

4.3.4. Quality improvement

Over half of the respondents to the survey thought that the smoking cessation indicator was not suitable as an aid for quality improvement without financial incentive, with 56.3% (36/64) not in support of the indicator (Table 4). Only fourteen respondents (21.9%) felt that the indicator was suitable for quality improvement with the remaining respondents being unsure.

Table 4: Views on suitability of the smoking cessation indicator for quality improvement (survey)

Do you think the following indicator could be suitable for quality improvement, without financial incentive?

	Yes	No	Unsure	Total
Indicator 1: Smoking: cessation success in people with bipolar, schizophrenia and other psychoses	14 (21.9%)	36 (56.3%)	14 (21.9%)	64

Please note where percentages do not total 100%, this is as a result of rounding.

4.3.5. Specific issues identified in interviews and survey

Difficulty engaging patients

As noted in an earlier section of this report, nine practices interviewed on this topic highlighted that it was generally already very difficult to get this patient cohort to attend the practice for their annual physical healthcheck appointments, and concerns were raised that smoking cessation appointments would be ‘one more thing’.

“This cohort of patients can be difficult to manage - just getting them to be concordant with medication and mental health appointments can be a struggle, let alone agreeing to, and complying with, smoking cessation appointments.” [GP, interview]

One GP specifically stated at interview that: *"…you've got patients who maybe aren't as engaged with society as most of us and they feel comfortable only going to one to two places."*

One survey respondent described how they already had to tolerate excessive verbal abuse from this patient group whilst trying to undertake a physical healthcheck.

Conversely, one practice stated in the interview that patient access to their practice was not an issue, and that the smoking cessation requirements of this indicator could be incorporated into their existing appointment system.

"We have a good system for getting patients with SMI into surgery. That's fairly robust. I don't think the smoking cessation is going to be an issue. I think it will just be a bolt on service to what they already receive which I think is pretty good […] I don't think access would be an issue for us." [GP, interview]

One interviewee and four survey respondents felt it was unfair for practices to be responsible for encouraging SMI patients to stop smoking due to the lack of influence they had in terms of the patient accessing the smoking cessation service and the quality of that service (if not offered in-house).

Smoking cessation services

Eight of the eleven practices interviewed on this topic mentioned that they had access to a smoking cessation service to refer patients into. Four of these practices had an in-house service and the other four had a community service. A further two practices said they had no smoking cessation service or 'virtually no service' and no information was stated from the remaining practice on availability of services. Issues relating to the availability of smoking cessation services is explored in more detail in the 'Barriers to implementation' section of this report.

A few practices raised concerns both in the interviews and the survey about their ability to accurately obtain information relating to the latest smoking status of their patients either from community smoking cessation services or directly from patients, to add this information into the patient record in their clinical system.

“So even though they could have done it (stopped smoking), then how are we then going to know and code it? We’re then relying on a lot of things that are very unlikely to happen as well.” [Practice senior management, interview]

“A GP practice may not be able to affect the achievement as we have no control over how far a patient has to travel to get to the (smoking cessation) service and we have no control over the quality of the service when they get there and we do not know their current success rate of quitting smoking.” [GP, survey]

5. Suggested amendments to indicator definitions and/or wording

This smoking cessation indicator has a focus on outcomes, reporting the proportion of patients with SMI who were recorded as current smokers in the previous 1-3 years who have been recorded as ex-smokers in the preceding 12 months.

Some issues with the definition and wording of the indicator were highlighted by practices in both the survey and interviews. Most survey respondents (65.4%, 34/52) did not think the wording needed to be changed for this indicator, with a further 9 respondents (17.3%) being ‘unsure’. Of the 9 respondents (17.3%) who thought the wording should be changed, only one respondent proposed changes in their free text comments, suggesting that the focus of the indicator should relate to the offer of smoking cessation support rather than success.

“Should be offer of smoking cessation rather than success. Need to implement nationwide smoking cessation services if looking at success in smoking cessation.” [GP, survey]

Two of the interviewed practices made similar suggestions relating to changing the focus of the indicator.

“However, I don’t feel the end result should be as the indicator currently suggests, that it should be ex-smoker. I think it should, if it were to be introduced, be some sort of […] appreciation of the effort that has gone into trying to get them to stop smoking even if the end result might not be them being an ex-smoker.” [Pharmacist, interview]

A GP from one practice raised concerns about achievement thresholds or targets that could be associated with this indicator, stating that high thresholds would be unachievable and, in addition to a practice manager from another practice, requested the ability to exception report patients (using personalised care adjustments) where the practice had ‘fulfilled their duty’ and that their ‘efforts were recognised’ in terms of communication and multiple attempts to engage with the patient.

Supporting guidance

This indicator has an emphasis on promoting continuity of care for people with severe mental illness as it is applicable for up to three years following the original recording of smoking status. This time period is in accordance with the Quality and Outcomes Framework (QOF) guidance for 2023/24 which highlights the potential for ex-smokers to resume smoking within three years of cessation and suggests that practices may choose to record ex-smoking status on an annual basis for three consecutive financial years.

The majority of survey respondents (67.3%, 35/52) did not think any improvements needed to be made to the supporting guidance provided in the pilot handbook, with a further 14 respondents (26.9%) being unsure. Three respondents (5.8%) thought the guidance needed to be improved but none of the respondents provided any further comments or details.

There were no comments or concerns raised by practices in the survey or interviews in relation to the three-year time frame for the denominator of this proposed indicator.

Indicator type

The indicator has been proposed for use at primary care network or system level (rather than at GP practice level) due to concerns about the attribution of responsibility, however it is proposed that the indicator would use general practice IT

systems as a data source. Practices were asked their views on whether this indicator should be based at network or system level within the survey and in the interviews.

There was a mixed response with 22 survey respondents (43.1%) suggesting that network level was most appropriate although in the free text comments two of these practices also proposed that they would prefer practice level. A further 10 respondents (19.6%) stating that their preference was system level, and 19 respondents (37.3%) were unsure.

One survey respondent whose preference was network level provided additional comments for additional context:

“Those (indicators) at PCN level still work similar to QOF - the individual surgeries do their best to hit their individual targets, money then clearly comes back into the PCN to be used as deemed appropriate across our surgeries. If an indicator ran at ICB level, I’m not sure what incentive the GP surgeries would have to work toward those targets as it is unlikely any individual surgery would see any direct benefit if they did a lot of work toward this, compared to a surgery who decided not to focus on ICB level targets?” [GP, survey]

A similar mixed response was also obtained from the interviews. It was acknowledged by practices that the data source would be the clinical system and therefore the indicator could in principle be used at this level. Practices were reminded about the issue of attribution of responsibility regarding smoking cessation services.

One practice maintained that the uptake of smoking cessation would be improved if this was practice level due to the surgery ‘brand’ and patient perception, with a second practice highlighting that practice level would be feasible for them due to their large practice size. Another practice preferred network level as mental health practitioners already work at this level and potentially could take on this role. A further two practices proposed that system level would be best as it was thought that they could encourage secondary care and specialist services to take a role in this. The remaining practices were unsure.

Indicator exclusions

Practices were asked to consider whether there were any patient groups that should be excluded from this indicator. The majority of interviewees did not think there

should be any exclusions, but the remaining practices suggested those in crisis, the terminally ill or those at a stage where smoking cessation is no longer relevant, and those patients who have already had multiple failed attempts at smoking cessation could be excluded, most likely via exception reporting. Conversely, one interviewed practice thought that it was important to provide smoking cessation advice to the entire cohort even if the patient had lung cancer or was receiving palliative care.

Electronic cigarettes and smoking status

There was some confusion in the interviews and survey in terms of whether the use of electronic cigarettes (or vaping) by a patient defined them as a smoker or an ex-smoker. To note that the Quality and Outcomes Framework (QOF) guidance for 2023/24 states that for the purposes of QOF, users of electronic cigarettes who have never smoked or given up smoking should be classified as non-smokers or ex-smokers respectively.

Four practices in interviews and one survey respondent raised concerns that that more clarity was required regarding the definition of smoking status when the patient was using electronic cigarettes or vapes. One practice added that this was further complicated depending on if the 'vape' contained nicotine, and another pointed out that although there was a code to record the use of electronic cigarettes in the clinical record, it was not possible to indicate the frequency of their use. The general view of one GP regarding the use of vapes to stop smoking (not specifically relating to the SMI cohort) were that:

"We have a lot of patients that have moved to vaping independently without the use of our stop smoke service at all. It has been a very good way, I think, for some patients to come away from cigarettes, but it's just the fact they then seem to not wean down. Whereas other forms of stop smoke service, the idea is to get them off everything, so there's no nicotine going into the system within the three months." [GP, interview].

Two further survey respondents included free text comments relating to this issue, with one respondent stating that 'vapes' were not the solution to smoking cessation but were being used in their local area to 'entice patients to engage', and a second raised concerns that there was pressure on patients to 'vape' instead, in the absence of smoking cessation services.

6. Practices' views on implementation issues and impact

This section covers practice views on: training requirements; workload, resource utilisation (including which healthcare professionals would be involved) and costs (including impact on appointment times); any changes required to practice organisation (e.g. setting up and use of clinical system protocols, recall systems, and templates); any barriers to implementation; assessment of overlap with and/or impact on existing QOF indicators or local schemes; assessment of the impact on health inequalities; and any other overall views on implementation of the indicators (including unintended consequences).

6.1. Training requirements

Practices were asked in the survey whether staff would need any additional training to implement the indicator. Just under half of the survey respondents (47.1%, 24/51) thought that administrative staff would need additional training if this indicator was introduced. A lower proportion (35.3%, 18/51) reported that clinical staff would need additional training. As stated earlier, it is possible that some participants responded to this from a primary care perspective rather than in the context of a network or system level indicator.

6.2. Workload, resource utilisation and costs

6.2.1. Workload

Most survey respondents (67.3%, 35/52) thought the requirements relating to the smoking cessation indicator would generate additional clinical workload, either 'definitely' or 'to some extent' (Table 5).

The survey showed varying views as to which staff groups would be most affected by the clinical requirements of the smoking cessation indicator (Table 6). Around half of respondents reported that 'GPs' (50.0%, 26/52) and 'Nursing' (46.2%, 24/52) would be most affected, and over a quarter of respondents (26.9%, 14/52) thought that pharmacists would also be affected.

One survey respondent suggested that smoking cessation appointments would involve the clinical pharmacist as well as the GP.

As with clinical workload, most survey respondents (78.8%, 41/52) thought that the indicator would ‘definitely’ or ‘to some extent’ generate additional administrative workload (Table 7).

Table 5: Views on additional clinical workload generated by the smoking cessation indicator (survey)

Will the requirements relating to the indicator generate additional CLINICAL workload?

	Yes, definitely	Yes, to some extent	No	Unsure	Total
Indicator 1: Smoking: cessation success in people with bipolar, schizophrenia and other psychoses	15 (28.8%)	20 (38.5%)	13 (25.0%)	4 (7.7%)	52

Table 6: Views on staff groups affected by the clinical requirements (survey)

Which staff group(s) would be most affected by the clinical requirements of the indicator? *Respondents selecting ‘Yes’*

	GP	Nursing	Pharmacist	Other Clinical	Unsure	Total Respondents* (n)
Indicator 1: Smoking: cessation success in people with bipolar, schizophrenia and other psychoses	26 (50.0%)	24 (46.2%)	14 (26.9%)	17 (32.7%)	6 (11.5%)	52

* This is a multiple response question, so the number of responses totals more than 52, as respondents could select more than one response

Table 7: Views on additional administrative workload generated by the smoking cessation indicator (survey)

Will the requirements relating to the indicator generate additional ADMINISTRATIVE workload?

	Yes, definitely	Yes, to some extent	No	Unsure	Total
Indicator 1: Smoking: cessation success in people with bipolar, schizophrenia and other psychoses	22 (42.3%)	19 (36.5%)	7 (13.5%)	4 (7.7%)	52

6.2.2. Time pressure, appointment capacity and appointment type/length

Half of the survey respondents (50.0%, 26/52) thought there would be time pressure issues relating to this indicator (Table 8) and two respondents added free text comments to highlight that the complex nature of the patient's mental health condition could result in a change in the direction of the consultation discussion, which would take additional time to explore.

Just under 30% (15/52) of respondents thought that this indicator could be associated with appointment capacity issues, and most respondents did not think this was an issue (Table 9).

Table 8: Views on time pressure issues in the practice relating to the indicator (survey)

Can you foresee any other time pressure issues in the practice relating to the indicator

	Yes	No	Unsure	Total
Indicator 1: Smoking: cessation success in people with bipolar, schizophrenia and other psychoses	26 (50.0%)	20 (38.5%)	6 (11.5%)	52

Table 9: Views on potential capacity issues in the practice relating to the indicator (survey)

Can you foresee any appointment capacity issues in the practice relating to the indicator?

	Yes	No	Unsure	Total
Indicator 1: Smoking: cessation success in people with bipolar, schizophrenia and other psychoses	15 (28.8%)	29 (55.8%)	8 (15.4%)	52

Practices were asked in the survey and interviews about changes to appointment type and length that may be required to implement this indicator.

Most respondents to the survey did not think that any changes would be required to the appointment type if the indicator was introduced (Table 10a) and one GP interviewee described how they accommodate this patient cohort with appointments at quieter times of the day, acknowledging that some patients may be accompanied by a community nurse or key worker. The practice manager (from the same practice)

added that some patients in this cohort are housebound or don't like leaving the house, suggesting that a home service for smoking cessation could be necessary.

One survey respondent proposed that 'Making every contact count' needed to be built into the indicators, where services in the whole system 'work smarter not harder' to capture different types of information during a single patient appointment (such as smoking status or cessation), which was a view also proposed by a GP interviewee.

There was a split view regarding to changes that would be needed to appointment length (Table 10b), with three survey respondents stating in free text comments that they already varied their appointment length to accommodate different patient needs.

There was general agreement from both the interviews and the survey that this group of patients was difficult to engage, and practices emphasised the importance of longer appointments, potentially over a longer period, for smoking cessation to be a success.

"I think you would want to be allowing a longer smoking cessation period, and I think those offering a service would need to think actually, this patient's going to take a bit longer, my normal twelve-week course that I'm going to give might need to be extended, and to have that flexibility." [GP, interview]

Table 10a: Views on any changes needed to appointment type relating to the indicator (survey)

Do you think there would need to be any changes to appointment TYPE for the following indicator?

	Yes	No	Unsure	Total
Indicator 1: Smoking: cessation success in people with bipolar, schizophrenia and other psychoses	10 (19.2%)	33 (63.5%)	9 (17.3%)	52

Table 10b: Views on any changes needed to appointment length relating to the indicator (survey)

Do you think there would need to be any changes to appointment LENGTH for the indicator?

	Standard appointment	Extended appointment	Total
Indicator 1: Smoking: cessation success in people with bipolar, schizophrenia and other psychoses)	26 (50.0%)	26 (50.0%)	52

6.3. Barriers to implementation

This report has previously highlighted potential practice level barriers to implementation of the indicator, such as patient access and engagement, and workload and time pressures. This section outlines two potential barriers to implementation that may need to be addressed at system or national level.

Availability of smoking cessation services

Section 4.3.5 of this report highlighted feedback from the interviews regarding some issues with access to smoking cessation services. Two practices with community-based smoking cessation services thought that it was easier to refer patients when the services were in-house and one of these practices added that there was now a lack of resource relating to smoking cessation in primary care.

"When we did do it (smoking cessation) in-house it was much easier to do". [GP, interview]

"Again, 15 years ago we had someone in the practice that we could refer them to. It felt like it was a really positive thing to do. Whereas now it's these sort of generic NHS stop smoking types of services. So, particularly for this group, where we really want to address it, there's a lack of resource there for us to pipe them into." [GP, interview]

To note that the two practices who had an overall positive view of this indicator in the interviews had in-house smoking cessation services in place.

Feedback from the survey comments supported the interview findings, with some respondents describing that services were only available outside of primary care and commissioned via local authority teams, with one respondent stating there was no local service and no facility to prescribe smoking cessation drugs or aids. Survey respondents highlighted that a local community smoking cessation service was needed, with one specifically proposing that a centralised specialised service was required to have impact on this issue.

“Meaningful stop smoking services - this is a public health domain not a health one currently even though smoking cessation is one of the most useful health interventions it has been removed from health as a service so no point in measuring us on it unless the funding is returned from councils.” [GP, survey]

“In [area] we’ve got virtually nothing in the smoking cessation services. We’ve got no one really to refer to. We obviously, as GP practices, don’t focus on it so much. We don’t get payments anymore. We were told to go to the chemist. The chemist don’t do the services.” [Nurse, interview]

Existing QOF indicators

One practice questioned the rationale for developing this outcomes based network indicator relating to smoking cessation when two related indicators in the 2024/25 QOF contract are (in their view) being ‘stood down’ and proposed that this could raise concerns about mixed messages. To note these are SMOK005: patients with a record of a chronic disease who smoke, who have a record of an offer of support and treatment, and MH021: patients with SMI who received all six elements of the physical health check for people with SMI, which will be income protected in the current financial year (and selected as they have been assessed as carrying a lower risk of deteriorating patient outcomes from income protection).

6.4. Impact on health inequalities

Practices were asked in the interviews and in the survey to consider whether this indicator would have any impact on health inequalities. There were no strong views received from the interviews, and mixed views from the survey (Table 11) with 45.1% (23/51) of respondents suggesting that there would be a positive impact, and slightly more (28/51) being either unsure or proposing a mixed impact.

Table 11: Views on the indicator’s impact on health inequalities (survey)

What do you consider the impact will be on health inequalities for the indicator?

	Positive impact	Negative impact	Unsure or mixed impact	Total
Indicator 1: Smoking: cessation success in people with bipolar, schizophrenia and other psychoses	23 (45.1%)	3 (5.9%)	25 (49.0%)	51

One survey respondent (GP) raised concerns about the cost of nicotine replacement therapy for their patients and the impact on health inequalities:

"If I ask the patient about smoking in the mental health review and they want to stop 90% of my cohort of patients do not have the means to afford the nicotine gums or patches etc...[…] the pharmacies offer this advice already so why not make the most of that and like for HRT create a prepaid card for them to get the smoking cessation meds they need via that. [GP, survey]

6.5. Other overall views on implementation of the indicators (including unintended consequences)

One third of survey respondents did not think there would be any unintended (positive or negative) consequences if the indicator were introduced (33.3%, 17/51) and the same proportion again was unsure (33.3%, 17/51) (Table 12). Only five respondents thought any unintended consequences would be positive (9.8%, 5/51), and the remaining twelve respondents anticipated negative unintended consequences. (Table 12).

Table 12: Views on potential unintended consequences relating to the indicator (survey)

Are there any unintended positive or negative consequences that you can think of that could be experienced locally if these indicators were introduced nationally?

	Yes, positive	Yes, negative	No	Unsure	Total
Indicator 1: Smoking: cessation success in people with bipolar, schizophrenia and other psychoses	5 (9.8%)	12 (23.5%)	17 (33.3%)	17 (33.3%)	51

Please note where percentages do not total 100%, this is as a result of rounding.

Via free text comments, respondents who predicted negative unintended consequences noted issues relating to practice resources, access to smoking cessation services, the ability of the practice to have an impact on smoking cessation rates and increased demand for services. One respondent suggested that although the evidence was strong for the indicator, the achievement rate would be poor. No positive unintended consequences were suggested by respondents.