

Quality Improvement Tool – Tobacco Dependency

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Part 1 – Introduction

1.1 Background

The British Thoracic Society (BTS) has run a programme of National Respiratory Audits since 2009 with the aim of driving improvements in the quality of care and services provided for patients with respiratory conditions across the UK¹. The programme encompasses a range of adult and paediatric audits, including an audit of smoking cessation services – the “BTS National Audit of the Management of Tobacco Dependency in Acute Care Trusts”².

The role of audit is to drive up quality of care by reviewing everyday practice against national standards and making interventions in pathways where required. This process has become embedded in health care practise as exemplified by the National Institute for Health and Care Excellence (NICE) audit tool programme³.

Improving quality is about making healthcare safe, effective, patient-centred, timely, efficient and equitable. Quality improvement represents a systematic approach that uses specific techniques to improve quality.

Clinical Audit is a Quality Improvement (QI) process. Over recent years, QI methodology has been applied to improve specific pathways and interventions with aim to bring about measurable improvement. The BTS 2021 National Audit of the Management of Tobacco Dependency in Acute Care Trusts identified the NHS was still some way off fulfilling its commitment to help all hospitalised patients that smoke to quit by 2023/4². BTS has used the results of this Audit to set a number of national improvement objectives to improve the medical management of tobacco dependent smokers and fulfil the NHS England Long Term Plan ambitions⁴.

There are many comprehensive sources of information on QI^{5,6,7,8,9} – it is recommended that these resources are reviewed together with local expertise before embarking on QI activity.

This document has been produced under the auspices of the BTS Quality Improvement Committee, to bring together traditional audit results with an overview of QI methodologies, to help healthcare staff design and implement changes to drive up the quality of care in their own institutions, using the 2021 BTS National Audit of the Management of Tobacco Dependency in Acute Care Trusts². This document is best used in conjunction with BTS QI methodology resources⁷.

1.2 Acknowledgements

The British Thoracic Society would like to thank Dr Robyn Fletcher and Professor Sanjay Agrawal for their work on this document, which is an update to the 2016 Quality Improvement Tool on Smoking Cessation.

The British Thoracic Society would like to thank Professor Sanjay Agrawal (Leicester), Dr Alexander Hicks (Southampton), Dr Zaheer Mangera (London) and members of the BTS Tobacco Specialist Advisory Group and BTS Quality Improvement Committee for their work in developing the original 2016 Smoking Cessation Toolkit. The Society is grateful to the following organisations for providing materials for inclusion in the original document: Whittington Health NHS Trust; the CURE Project (Manchester); University Hospitals of Leicester NHS Trust; South London & Maudsley NHS Foundation Trust; and George Eliot Hospital NHS Trust.

Part 2 – BTS National Smoking Cessation/Tobacco Dependency Audit

The 2021 BTS National Audit of the Management of Tobacco Dependency in Acute Care Trusts (previously known as the 2021 National Smoking Cessation Audit) is the third comprehensive Audit of the management of tobacco dependency in NHS acute hospitals, using standards drawn from a range of evidence-based publications.

The aim of the Audit was to examine whether a properly led and staffed hospital tobacco dependency service was present and whether access to the most evidence-based and effective interventions for tobacco dependency was being provided. It also examined the provision of adequate training for staff; that smoking status was being recorded for all patients; current smokers were provided very brief advice; referral for specialised tobacco dependency treatment was made; ongoing support after discharge offered and accessed, licensed pharmacotherapy prescribed and continued upon discharge and that smoke-free hospital grounds were enforced.

The scope of the Audit was hospital-wide, across all specialties (excluding maternity and mental health) and included elective and emergency admissions. The 2021 Audit aimed to provide additional granularity to previous audits and align with the 2021 NICE guidelines and NHS Long Term Plan. 120 institutions participated with 14579 patient records submitted from across the UK.

When compared to the 2019 Audit, and indeed across the six-year period since the first Audit, little progress has been made and the opportunity has been missed to improve the health of sick smokers admitted to hospital, prevent premature mortality and realise healthcare resource savings.

This Audit demonstrates unequivocally that major improvement is required in the provision of evidence-based interventions for people with tobacco dependence. BTS recognises the commitment made to improve tobacco dependency treatment in the NHS Long Term Plan for England and in the plans across all the home nations. BTS supports all NHS organisations across the United Kingdom in striving to improve the delivery of tobacco dependency services in secondary care.

The quality improvement process requires understanding the core problem before exploring further solutions. The 2021 BTS National Audit of the Management of Tobacco Dependency in Acute Care Trusts illustrates, through the use of audit data, some of the problems found in Tobacco Dependency within the UK. BTS allows audit sites to review their submitted data against the national dataset via benchmark reports, and has published the national report for public view. Sites are encouraged to review their audit data, or utilise the local version of the audit tool, as part of their quality improvement process.

2.1 BTS Smoking Cessation/Tobacco Dependency Audit 2021 Results

The 2021 Audit identified that 21% of patients admitted to hospital were current smokers, this has reduced from 24% in 2019 and 25% in 2016². This is higher than the 14.1 % prevalence of smoking in the general population¹⁰. The highest prevalence was for those aged 26-35 years (35.8%), patients admitted to respiratory medicine (23%) and amongst patients admitted as emergencies (22.2%) in line with 2019 and 2016 findings¹.

The 2021 Audit was the first to ask specifically about vaping (the inhalation of nicotine in a vapour (rather than smoke) using an e-cigarette or other device designed for this purpose). Vaping status was documented in only 6% of medical records and 16% of patients reporting current use of a vape device.

Key Findings From The Audit

1. Recording of smoking status in hospitalised patients remains inadequate. Between 1 in 4 and 1 in 5 patients were not asked about their smoking status, similar to the 2019 and 2016 Audits
2. Less than half (45%) of current smokers were provided very brief advice
3. 1 in 7 current smokers were referred to a hospital or community-based tobacco dependency treatment service, a modest improvement from 1 in 8 in 2019 and 1 in 12 in 2016
4. Only 9% of current smokers completed a consultation with a specialist tobacco dependency practitioner during their inpatient stay
5. 1 in 3 smokers were offered licensed pharmacotherapy for tobacco dependency but only 5% were actually prescribed NICE recommended most effective treatments
6. Only 6% of patients that vaped prior to hospital admission were allowed to use the existing vape kit during their admission
7. 10% of current smokers were discharged on licensed pharmacotherapy for tobacco dependency and only 3% attended a follow-up service after discharge
8. An assessment of abstinence at 4 weeks was available for 9% of patients. 10% were abstinent at 4 weeks which represents <1% of all smokers admitted to hospital during the audit period
9. Only 1 in 13 hospitals completely enforced smoke-free grounds compared to 1 in 5 in 2019.
10. More hospitals report having hospital-based smoking cessation services on their premises (41% versus 38% in 2019) but access remains poor with only 1 in 2 hospitals having a referral pathway accessible to all healthcare professionals.
11. In 47% of hospitals senior leadership of a smoking cessation service was evident compared to 35% in 2019. However, only 1 in 3 had a dedicated hospital funded tobacco dependency practitioner to support this work.
12. More institutions reported a dedicated space to document a patient's smoking status within an acute admission proforma compared to the 2019 Audit.
13. Provision of licensed pharmacotherapy for tobacco addiction remains variable and only 72% of hospitals report having a guideline to support prescribers.
14. Only 50% of trusts are offering frontline healthcare staff regular smoking cessation training, similar to previous audits

The National Improvement Objectives from the 2021 BTS Audit:

1. All hospitals should identify a healthcare professional(s) to lead on the delivery of a tobacco dependency treatment service and appoint an executive level board member to support the service (**immediate**)

2. All hospitals should introduce a system of regular local data collection of adult inpatient tobacco-dependency pharmacotherapy prescribing *to drive on-going improvement and further encourage delivery of NICE recommended interventions* **(3-6 months)**
3. Ensure all adult patients admitted to hospital have their smoking status recorded **(3-6 months)**
4. Introduce a training package available to all front-line staff to ensure a minimal level of competence in supporting and treating tobacco dependency (e.g. Very Brief Advice) and implement a system of monitoring uptake **(6 months)**
5. At least 90% of tobacco dependent adult inpatients to receive Very Brief Advice during the course of their inpatient stay **(before next national audit)**
6. Offer all hospitalised tobacco dependent patients a referral to a specialist on-site tobacco dependency treatment service **(before next national audit)**
7. Establish a system to monitor the number of patients provided with Very Brief Advice and referred to (and engaging with) a specialist tobacco dependency treatment services **(next 12 months)**

The 2021 BTS Management of Tobacco Dependency across Acute Care Trusts Audit highlights inadequacies in the treatment of tobacco dependence amongst patients admitted to hospital and demonstrates little if no improvement from the 2019 and 2016 Audits. This report has again set ambitious national improvement objectives which are entirely aligned with NHS England's Long Term Plan commitments on tobacco dependence treatment and represent a real opportunity to finally tackle the largest cause of premature death and disability in the UK.

The BTS National Tobacco Audit identified key problems and recommended the above areas as a focus for improvement. Quality improvement methodology can be used to help achieve these aims prior to the next round of National Audit. The BTS Quality Improvement Methodology Overview Document can be found on the BTS website here (<https://www.brit-thoracic.org.uk/quality-improvement/>). In the interim, the BTS on-line Tobacco Audit tool is available to support data collection and allows users to measure changes in practice over time. In addition a QI programme will be running in 2023 to teach QI theory and skills and encourage its use locally. The materials from this programme will be available on the BTS website⁷. This programme and its materials will be equally applicable for use across all home nations.

Part 3 – NHS England Long Term Plan

In 2019 NHS England's Long Term Plan⁴ was published which sets out the key ambitions for the service over the next 10 years. In particular the plan sets out new actions to be taken by the NHS to strengthen its contribution to prevention.

Demand for NHS services continues to grow for a number of reasons. The Long Term Plan considers improving upstream prevention of avoidable illness and its exacerbations e.g. smoking cessation as a way to potentially modify the drivers of demand.

A renewed NHS prevention programme will focus on maximising the role of the NHS in behaviour change guided by the top 5 risk factors (smoking, poor diet, high blood pressure, obesity, alcohol and drug use) identified in the Global burden of disease study¹¹.

The plan sets out a significant new contribution by the NHS towards making England a smoke-free society, by supporting people in contact with NHS services to quit based on a successful model implemented in Canada and Manchester¹².

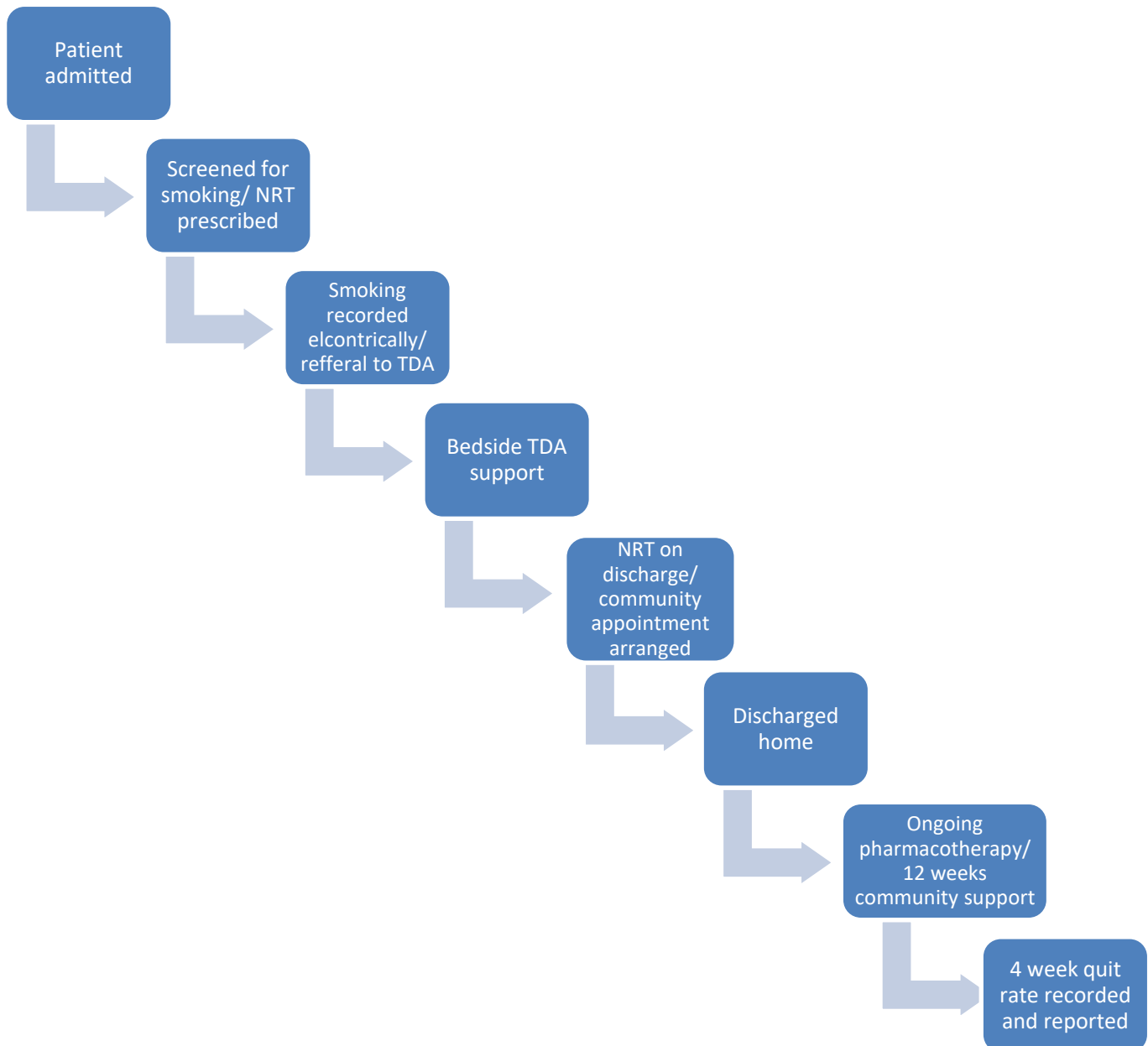
A specific commitment set out in the Long Term Plan is that by 2023/24, all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services. With plans for this model to also be adapted in a new smoke-free pregnancy pathway and a new universal smoking cessation offer in specialist mental health services.

Whilst smoking rates have significantly decreased in the UK, smoking is still seen to account for more years of life lost than any other modifiable risk factor. Individuals who smoke are known to see their GP over a third more often than non-smokers and smoking is linked to nearly half a million hospital admissions per year.

The Long Term Plans sets out the ambitions for England and BTS recognises the commitment to improve tobacco dependency treatment across all the home nations in their respective services and plans.

Part 4 – Tobacco Dependency Pathway

Quality improvement involves understanding the processes and systems within an organisation. Process mapping is commonly used to map pathways and can be a useful tool to increase staff understanding of how different steps fit together. Each step in the pathway may be associated with problems and therefore has potential for improvement. Therefore each step in the pathway could form the basis of a QI project. An example of a tobacco dependency pathway for hospital inpatients is outlined below.



*TDA = Tobacco Dependency Advisor

Part 5 – Applying QI techniques

The 2021 BTS National Tobacco Audit identified that there is considerable opportunity in clinical practice in acute hospitals across the United Kingdom to treat tobacco dependence. Improving the treatment of patients who are tobacco dependant will reduce short and long term mortality, reduce hospital emergency admissions and readmissions whilst also being highly cost-effective¹³.

A number of areas identified from the National Tobacco Audit could be used for quality improvement. Areas that could have a significant impact include:

- Recording of smoking status and referral of smokers to stop smoking support
- Prescription of nicotine replacement therapy to reduce nicotine withdrawal symptoms
- Training of frontline staff

A more detailed consideration of how to approach each of these topics is set out below. With each of these areas it is important to consider the underlying principles in Quality Improvement, namely: understanding the problem, the processes, the elements of demand, capacity and flow, choosing the tools to bring about change and evaluating and measuring the impact of change.

5.1 Referral Of Smokers To Stop Smoking Services

Problem

Data from the BTS National Tobacco Audit shows that only 1 in 7 smokers in hospital are referred to stop smoking services. Other data sources may include the National COPD Audit although this will apply only to COPD patients.

People who may be able to help identify useful sources of data on referrals locally include:

- Stop smoking services
- IT departments
- Business analysts
- Audit, governance, clinical effectiveness and or quality improvement departments.

Process

Process mapping should identify:

- How and where patients are admitted to the hospital?
- How smoking status is ascertained?
- By whom and where it is recorded?
- Is the recording done electronically and can it be collated into a daily hospital wide report to aid stop smoking specialists locate current smokers on in-patients wards?
- Who refers patients to the in-house or community stop smoking service (i.e. medics, nurses, AHP's, default electronic referral) and is there an electronic method of referral?
- Is there a specified hospital referral and treatment pathway that is regularly promoted that staff know and understand?
- How is referral recorded in notes and discharge summaries or as part of care bundles for specified disease?
- Can referral be automated in some way, to reduce reliance on individual action
- Is there a feedback mechanism so that specific individuals, wards, or departments know how many referrals are being made by them as individuals or in their area?

People who may be able to help with process mapping include:

- Patients
- Ward nurses
- Pharmacists
- Stop smoking specialists
- Clinical leads
- The Quality Improvement/Audit Team
- Business analysts and general managers.
- Clinical coders
- Business analysts
- Electronic patients record or 'Patient administration system' IT specialists

Demand, flow and capacity

Demand and flow of admission and in-patient areas should be relatively easy to assess. The capacity to treat and refer patients who are tobacco dependant will depend on the systems being in place to identify smokers, whether an electronic report can be created and the personnel identified to offer referral and treatment.

If the treatment and referral is deemed to be the responsibility of clinical staff, sufficient training of these staff will also need to be part of the consideration.

Other factors to consider when designing referral pathways to internal or external stop smoking practitioners include:

- Whether paper or electronic forms will be used?
- Is there sufficient access to forms or computers?
- Are the forms and IT systems updated regularly to reflect changes?
- Are there clear receiving centres for the referrals where referrals can be handled promptly?
- Suitable signposting to flag how referrals can be made with periodic reminders as new staff join.
- The process by which referrals can either be made or stored during nights and weekends.

Choosing the tools to bring about change

Many of the elements for this will be considered in the above sections. Specific areas to consider include:

- Identifying key individuals for leadership roles. These individuals will need to have sufficient time and support to fulfil this role
- Providing sufficient and robust QI training.
- Ensuring staff and patient involvement.
- Recognising the right people to involve in delivery of the task.

Evaluating the impact and measurement of change

Identifying what will constitute success will be important to define at the outset, but may change as 'plan-do-study-act' cycles proceed and hypotheses are amended or different elements of a process are changed.

For example initially it may be that ‘how will we know a change is an improvement’ may refer to recording of smoking status electronically and producing a daily report. Subsequently it may refer to patients being asked if they would like help to quit or measurement of exhaled carbon monoxide routinely or referral for treatment. Other measures may be referrals received by the stop smoking service or numbers of people identified as having quit smoking at 4 weeks. Measuring a sustained change using SPC charts will be important.

Examples and resources:

- Example patient record used to record and treat tobacco dependence (see Appendix 1).
- Best practice case study: targeted intervention using electronic recording of smoking status (see Appendix 2).
- Example stickers for patient notes to act as a prompt to ‘Ask, Advise, Refer’ (see Appendix 3).
- Example referral questions for an electronic patient record and referral system (see Appendix 4).

5.2 Prescription Of Nicotine Replacement Therapy To Reduce Withdrawal Symptoms

Problem

Data from the BTS National Tobacco Audit shows that whilst 1 in 3 smokers were offered licensed pharmacotherapy for tobacco dependency, only 5% were actually prescribed NICE recommended most effective treatments. Other sources of data may include hospital electronic prescribing systems or hospital pharmacy data.

People who may be able to identify sources of data on prescribing of NRT include:

- Pharmacy.
- IT teams where electronic prescribing is present.
- Finance department.

Process

Process mapping could identify opportunities and barriers for prescribing pharmacotherapy:

- Where are the patients admitted as inpatients?
- How are they identified and recorded as smokers?
- Who is asking the patients about prescribing pharmacotherapy to prevent nicotine withdrawal and to promote a quit attempt?
- Who prescribes the treatments? (i.e. medics, nurses, physician assistants, pharmacists)
- Are there ‘patient group directives’ to support non-medical prescribing and administration?
- How quickly do patients receive prescribed cessation medications?
- Are smoking cessation pharmacotherapies available on all wards?
- Is there a comprehensive range on formulary?
- Is electronic prescribing used and what smoking cessation pharmacotherapies are prescribed on discharge?
- How are medicines continued and re-prescribed after discharge before the patient sees the smoking cessation specialist?
- Who teaches patients to use certain medications e.g. nicotine inhalator or buccal patch?
- What regular training is there for staff on smoking cessation pharmacotherapy?

For this issue people who may be able to help with process mapping include:

- Patients.
- Ward nurses.
- Health care assistants.
- Ward clerks.
- Pharmacists.
- Stop smoking specialists.
- Clinical leads.
- The Quality Improvement/Audit Team.
- Business analysts and general managers.

Demand, flow and capacity

Demand and flow of admission and in-patient areas through to discharge should be part of an acute hospitals routine data collection and therefore obtainable as part of a quality improvement process.

The capacity to treat with pharmacotherapy will depend on a variety of factors individual to each trust. Factors to consider in this process include:

- How patients are identified and located.
- Who is discussing options with patients?
- Available medications on formulary.
- Access to appropriate medications on the wards including nights and weekends.
- The number of prescribers with the various associated work patterns.
- Training for prescribers
- The availability of patient group directives
- The ability to prescribe smoking cessation pharmacotherapy at discharge.
- The agreement of funding for prescribing pharmacotherapy.

Choosing the tools to bring about change

As with the previous section, many of the elements for this will be considered in the above sections. Specific areas to consider include:

- Identifying key individuals for leadership roles. These individuals will need to have sufficient time and support to fulfil this role
- Providing sufficient and robust QI training.
- Ensuring staff and patient involvement.
- Recognising the right people to have involved in delivery of the task.

Evaluating the impact and measurement of change

Again, as with the previous section, identifying what will constitute success will be important to define at the outset, but may change as 'plan-do-study-act' cycles proceed and hypotheses are amended or different elements of a process are changed.

For example initially it may be that 'how will we know a change is an improvement' may refer to identifying and recording in-patients who smoke or that have been asked about smoking cessation treatment and pharmacotherapy. Subsequently measuring prescriptions or time to pharmacotherapy could be measured as well as pharmacotherapy on discharge. Measuring a sustained change (after the initial project completion) using SPC charts will be important.

Example and resources:

- Example Patient Group Directive for prescribing NRT by non-medical prescribers (see Appendix 5)
- Free on-line training for healthcare professionals on smoking cessation medications from the National Centre for Smoking Cessation Training (NCSCT)¹⁴
- Free downloadable resources on medications from NCSCT¹⁵

5.3 Training Of Frontline Staff

Problem

Data from the BTS National Tobacco Audit shows that only 50% of frontline staff receive regular training in smoking cessation. Other sources of data may include hospital mandatory training databases or stop smoking service training data.

People who may be able to help identify training include:

- The mandatory training team.
- Clinical education departments.
- The stop smoking service.

Process

Areas that will need to be considered for this issue include:

- How do frontline staff receive training on smoking cessation?
- Is it part of other mandatory training, or is it part of regular departmental postgraduate education that is ad-hoc?
- What training do different staff groups get?
- What is the quality of the training, who delivers it and how engaging or effective is it?
- Are 'link nurses' delivering training?
- How is training publicised and recorded?

People who may be able to help with process mapping include:

- Ward nurses.
- Health care assistants.
- Pharmacists.
- Stop smoking specialists.
- Clinical leads.
- The Quality Improvement/Audit Team.
- The organisational development/human resource department.
- General managers.
- Hospital wide e-learning training department personnel

Demand, flow and capacity

Demand and flow of staff should be predictable based on number of staff, professional background (i.e. nurses, doctors, allied health professionals etc.), and how they normally receive training.

The capacity to train will depend on the resources and skills available to individual trusts. Factors to consider include:

- The type of training delivered (i.e. on-line, face to face, ward based, departmental meetings)
- Number of trainers.
- Ability to cascade training into different clinical areas.
- Training resources.
- Time allocation for staff to receive training.
- Cost.

Choosing the tools to bring about change

The tools described in the previous sections will once again apply but the choice will depend on individual trusts own specific strengths and needs.

Evaluating the impact and measurement of change

Identifying what will constitute success will be important to define at the outset, but may change as 'plan-do-study-act' cycles proceed and hypotheses are amended or different elements of a process are changed.

For example, initially it may be that 'how will we know a change is an improvement' may refer to measuring teaching numbers such as:

- Teaching sessions
- Teaching hours
- Number of staff groups/departments reached.

Subsequently measurement can expand to cover more refined teaching criteria including for example:

- Quality of teaching materials.
- Numbers of trainers
- Numbers of referrals from wards where staff have received training.
- Impact on smoking cessation rates.

Measuring a sustained change using SPC charts will be important.

Resources and examples:

- NSCST free online training module: Very Brief Advice¹⁶
- BTS QI resources⁷

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