August 2025

The power of being a clinical lead for tobacco dependence

Overview

1. This briefing sets out the case for NHS organisations implementing Tobacco Dependency Treatment Services (TDTS) to appoint a clinical lead for tobacco dependence.
2. **The NHS has a responsibility to treat tobacco dependency which is pivotal to reducing financial and physical strain on the healthcare system by addressing preventable diseases and deaths caused by smoking.** This is reflected in the NHS commitment to systematically identify and offer treatment to all hospital patients who smoke, along with a contractual requirement to report TDTS data.
3. Having a clinical lead for tobacco dependency within NHS organisations is vital for ensuring tobacco dependency is treated as a clinical priority and facilitating the implementation of TDTS.

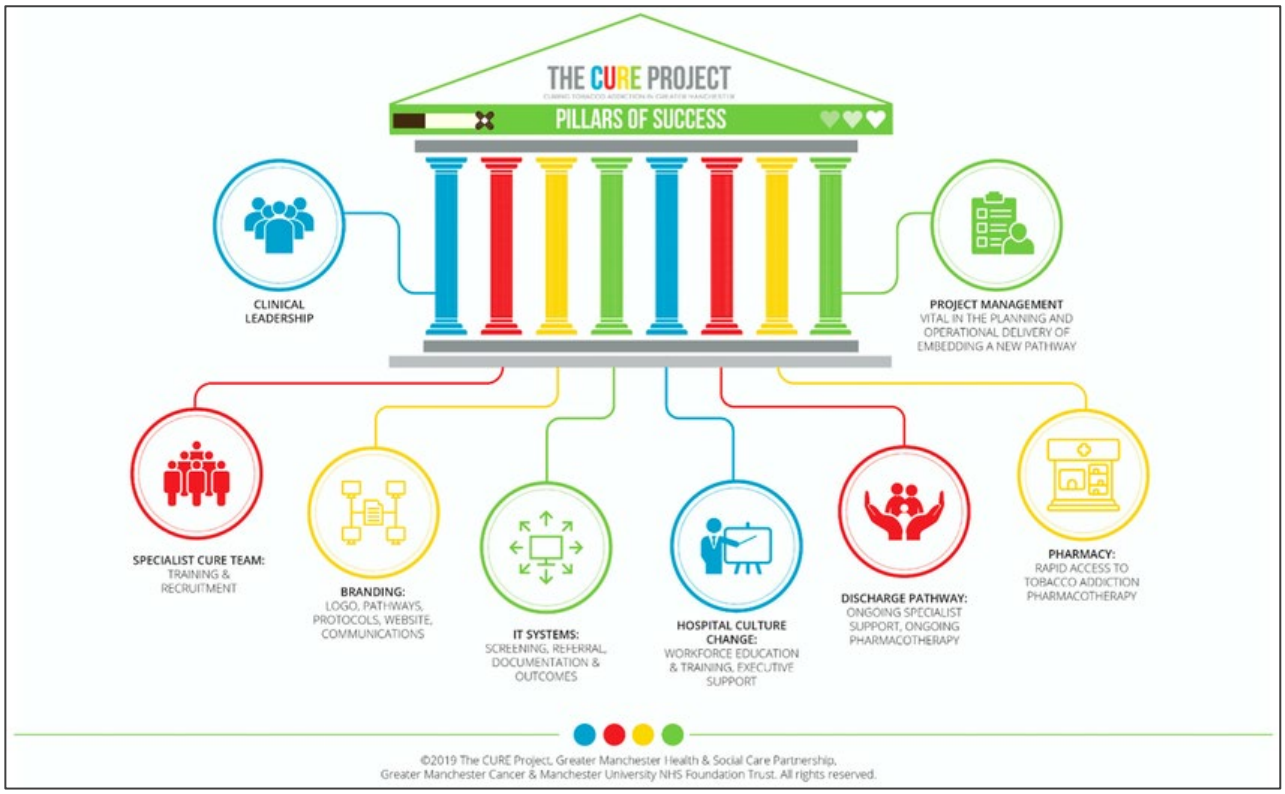
Key Recommendations

4. **For all Acute care (including maternity) and Mental Health NHS Hospital Trusts:**
   - To identify a clinical lead for tobacco dependency to drive implementation and support delivery of Tobacco Dependency Treatment Services within the Trust
   - Clinical leads to work with Tobacco Dependency Treatment Services to integrate and embed continuous quality improvement
5. **For Integrated Care Boards (ICBs):**
   - To invest in a dedicated tobacco dependence lead as part of a systemwide programme to treat tobacco dependency, reduce smoking prevalence and the associated health inequalities. This lead should work with stakeholders across the system, advocating for tobacco dependency treatment to be embedded in all appropriate clinical pathways.
6. **Other actions for your Trust and system**
   - Join the Smokefree NHS Network and get regular updates from ASH about addressing smoking in the NHS.
   - Sign the NHS Smokefree Pledge to demonstrate your organisation's commitment to treating smoking.

Why is clinical leadership necessary?

7. The new 10 Year Health Plan for England places clinical and operational leadership at the core of NHS transformation. This is further emphasised in the Model Integrated Care Board (ICB) Blueprint v1.0, which lays out a framework for the evolving role of ICBs, and places effective clinical leadership as a key enabler to delivering core ICB functions and activities. Research from the CURE evaluation of TDTS highlighted clinical leadership as the first key pillar of success for driving through change and implementing services within acute inpatient settings, noting it as critical to success and sustainability. Learning from early implementer sites highlights the importance of having a clinical lead with dedicated time, knowledge, and influence on workforce practice. NHSE recognises clinical leadership as an essential measure for success through:

- Demonstrating a visible/vocal commitment to tobacco dependency treatment
- Supporting the culture shift to medicalise the treatment of tobacco dependence
- Embedding services into the wider smokefree hospital strategy and systemwide approach to reduce smoking prevalence, the harm from smoking and associated health inequalities.



Source: [Successes and Challenges of implementing Tobacco Dependency Treatment in Health Care Institutions in England, 2022]

8. Clinical leaders in early implementer sites were found to be effective in facilitating innovation and change due to their frontline experience, credibility amongst peers and strategic influence over senior leaders. Clinical leads are uniquely positioned to drive learning and standardisation of pathways/processes among clinical teams and departments, while engaging the wider workforce to take ownership and develop TDTS champion roles.

What does effective clinical leadership in acute trusts look like?

9. Clinical leadership involves health professionals in formal or informal leadership roles. Clinical leads for tobacco dependency can be doctors, senior nurses, pharmacists, public health consultants or other senior members of the multi-disciplinary team working within the hospital. Ideally, they should be involved in delivering clinical care.
10. Clinical leads have a unique mix of experience of healthcare settings and specialities, ability to influence by virtue of their professional knowledge and position in the hospital hierarchy – all of which is necessary to support the embedding of tobacco dependency treatment. This includes:
    - facilitating transformation and actively contributing to change processes that lead to improving healthcare.
    - encouraging improvement and innovation, through creating environment of continuous service improvement.
    - applying knowledge and evidence to produce evidence-based challenge to systems and processes, to critically evaluate and identify opportunities for service improvements.

11. Clinical Leads for Tobacco Dependency within hospital Trusts utilise these leadership skills in their role to deliver against the following 5 key areas of responsibility:

Governance Structure

- Secure Executive sponsorship and SRO for the programme
- Establish & chair/co-chair Multidisciplinary Trust-wide Treating Tobacco Dependency & Smokefree Steering group
- Ensure that this is a Trust-wide programme of work
- Ensure an updated evidenced based smokefree policy is in place

Service Implementation

- To plan & support appropriate infrastructure including Project manager in post
- To provide clinical support to Project Manager & Tobacco Dependency Treatment team
- To liaise with stakeholders internally to ensure pathways are in place for systematic identification of smokers on admission and provision of pharmacotherapy

Training & Engagement

- To raise the profile & importance of treatment of tobacco dependency with peers
- Provide mentorship & ongoing professional develop opportunities to the TDTS
- To undertake teaching within Trust to help role out programme
- Ensure Tobacco dependency treatment is incorporated into annual teaching for doctors in training
- To introduce national training resources for the wider MDT

Data & Quality Improvement

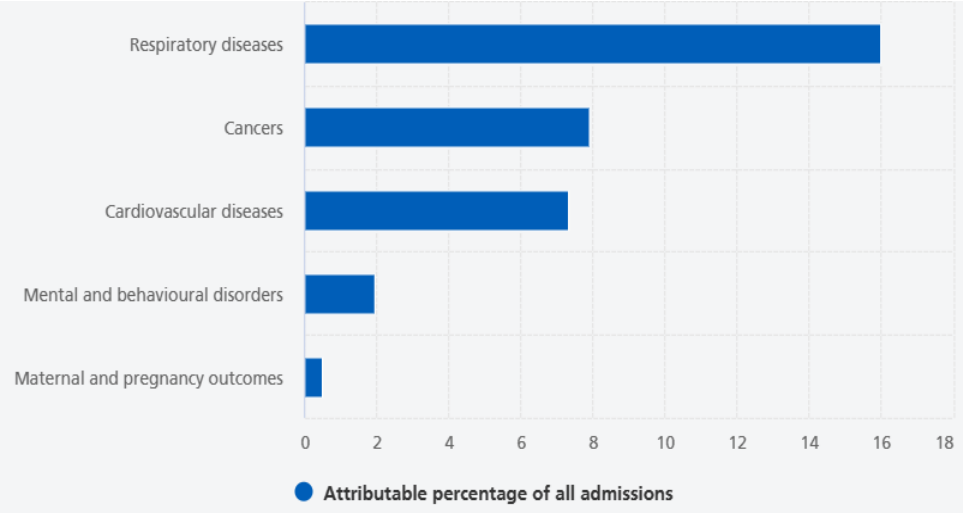
- Ensure accurate data is available for reporting to NHSE as per requirements
- Ensure monitoring / reviewing data & KPIs is embedded into Trust Steering group
- Integrate Quality Improvement (QI) into the service, including teaching and empowering the Tobacco Dependency team in QI & working with the Trust QI team

Partnership & Innovation

- To liaise external stakeholders to ensure pathways in place for seamless transfer of care post discharge
- Develop strong working relationships and links to all Trusts across the ICB to ensure coherent strategy and share learning
- Advocate for future service development within Trust to reach more patients who smoke (e.g. A&E, Outpatients, Staff)

Why smoking and why now

12. Smoking is a chronic relapsing long-term condition which places a major burden on the day-to-day business of the NHS, impairs population health outcomes and exacerbates inequalities. Smoking remains the leading cause of preventable illness and death, ranked as the top modifiable risk factor driving death and disability in England, attributable to 15% of all deaths (74,800 deaths) in England in 2020.
13. The cost of treating smoking related illnesses to the NHS is estimated at £1.8 billion per year in England. People who smoke are 36% more likely than non-smokers to be hospitalised and twice as likely to be re-admitted within 30 days. Statistics from NHS England show that in 2022/23 there were an estimated 408,700 hospital admissions due to smoking, up 4.8% on 2021/22. The graph below shows the breakdown of hospital admissions attributable to smoking across key conditions, with smoking accounting for one in six of all admissions for respiratory diseases:



Source: NHS Digital Statistics on Public Health, England 2023

14. Smoking tobacco reduces the efficacy of numerous healthcare interventions including reducing effectiveness of medicines, increasing the risk of complications, and greater risk of readmissions. Stopping tobacco dependency not only prevents disease; it is also an effective treatment itself improving cancer treatment responses, surgical recovery, and reducing cardiovascular and respiratory disease exacerbations.
15. The NHS is uniquely positioned to provide support to smokers at key teachable moments, particularly during a hospital admission. National audits persistently show high proportions of admitted patients who smoke (21% in 2021). The integration of tobacco dependency treatment in the NHS has been proven to significantly improve health and reduce service demand. The BTS Clinical Statement: Medical management of patients with tobacco dependency recognises the important role of clinicians and provides a framework to ensure tobacco dependency is viewed as chronic long term relapsing condition, with treatment the responsibility of **all** healthcare professionals.

Delivering on the shift to prevention

16. The government has committed to shift the NHS from treatment to prevention, as recommended in the Darzi review. This is in addition to a manifesto commitment to halve the gap in healthy life expectancy between the richest and poorest regions in England. Supporting more people to quit smoking is central to achieving both of these objectives.
17. The 2019 NHS Long Term Plan included a commitment to offer tobacco dependency interventions (TDTS) to all patients admitted to hospital and pregnant women who smoke. The new 10 Year Health Plan for England clearly reiterates and strengthens this commitment, emphasising the need to embed opt-out smoking cessation interventions across all routine care in hospitals and do more to encourage people to quit smoking before surgery as part of the shift to prevention. These services are designed to complement and enhance existing smoking cessation provision commissioned by local authorities. Funding for TDTS is now part of baseline ICB funding and these services should be embedded in routine care.
18. NHSE has set out the systematic identification of tobacco dependency and treatment in secondary care as one of the high impact interventions for prevention. The 2025/26 priorities and operational planning guidance sets out a national priority to address inequalities and shift towards prevention by reducing inequalities in line with the Core20PLUS5 approach. Treating tobacco dependence positively impacts all 5 key clinical areas in Core20PLUS5.

Tobacco dependency leadership within the ICB

19. Tobacco dependency leadership can alleviate healthcare system challenges and promote positive change, not only within Trusts but also across ICBs.
20. Reducing smoking will help ICBs contribute to the government's health mission, particularly the shift from treatment to prevention. The Model ICB Blueprint sets out that ICBs role in the system is to undertake strategic commissioning around 3 key purposes as set out below.

ICB purpose	**Impact of smoking cessation**
i) Improve population health	Smoking is the leading cause of preventable death and disease. Those who stop smoking avoid illness, with those who quit sooner experiencing the biggest benefits.
ii) Reduce inequalities	Smoking is concentrated in the most deprived areas and contributes half the difference in healthy life expectancy between rich and poor.
iii) Ensure access to consistently high quality and efficient care	Smokers have poorer treatment outcomes across many areas including surgery, cancer and CVD. Ensuring access to TDTS will improve outcomes and efficiency of care.

21. Leadership for Tobacco Dependency within the ICB can include:
    - Strategic involvement in systemwide programmes.
    - Encouraging trusts to adopt a clinical lead for tobacco dependency, and providing support to the clinical leads across the trusts.
    - Building partnerships to further develop services with a focus on health inequalities.
    - Ensure treating tobacco dependency is a golden thread across relevant ICB workstreams such as long-term conditions, mental health, workforce.
    - Ensure treating tobacco dependency is embedded in ICB strategic plans, including winter planning and Joint Forward Plans.
    - Advocating for prioritisation of funding & additional investment to expand provision.