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At risk? Tobacco dependence treatment in the NHS

Findings from a survey of Integrated Care Boards in England

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Foreword

This year's survey of Integrated Care Boards (ICBs) highlights how precarious prevention services in the NHS can be. Despite robust commitments to providing tobacco dependence treatment services – from Labour's manifesto pledge to embed 'opt-out' support for all hospitalised smokers, to the government's 10-Year Plan for Health and a broader 'shift to prevention' – the system is seeing worrying signs of retreat.

This report provides a vital snapshot of progress – and peril. Most NHS trusts have implemented tobacco treatment services, and many ICBs are going beyond the NHS Long Term Plan by reaching into A&E, outpatient clinics, and even paediatrics. The results speak for themselves: services for pregnant women were the first to embed and have near universal coverage, and smoking in pregnancy has fallen by a third in the last two years from 9% to 6%. These are not just statistics – they are healthier babies, safer births, and stronger starts to life.

But against this success, a shadow looms. Over four fifths of ICBs (83%) report funding insecurity as a barrier to sustaining these services. Some have already started decommissioning. Despite tobacco dependence treatment services being proven and essential, they risk losing priority in ICBs due to the abolition of NHS England, the decline in central direction, and the pressure on ICB budgets. Without clear protection, the progress we have made could be reversed.

Even at the top of the system, concern has been voiced. Speaking at a recent webinar held by ASH, Sir Jim Mackey, NHS England Chief Executive, acknowledged the risks and made a powerful call for continuity:

"These things are important to stay focused on… we need to make sure that we don't have any damage done, in this churn we retain the focus, we make sure things move from being maybe not quite commissioned or vaguely commissioned into something that's a bit more structured."

He continued, "We absolutely will hold ICBs to account for how they're spending their money… and as we build that commissioning capacity and capability, this has to be centre stage."

The question now is: how will these commitments be honoured? What is NHSE and the new government doing today to ensure that the critical infrastructure for tobacco treatment is not quietly eroded under the weight of financial turbulence and structural reform?

This is not a plea for special treatment. It is a call for strategic sanity. Treating tobacco dependence is one of the most evidence-based, cost-effective interventions in healthcare. It saves lives, reduces health inequalities, and cuts costs. If this is not centre stage, then what is?

Hazel Cheeseman
Chief Executive
Action on Smoking and Health

Key findings

Commitment to tobacco dependence treatment in the NHS has diverged among ICBs. In many areas, services have expanded beyond the core requirements of the NHS Long Term Plan. Elsewhere, ICBs have started decommissioning.

- Tobacco control, including the implementation of tobacco dependence treatment services, was a high priority in 31% of ICBs and an above average priority in 28% of ICBs
- Most NHS trusts had fully implemented tobacco dependence treatment services:
  - 80% of services were fully implemented in secondary care
  - 71% of services were fully implemented in mental health
  - 91% of services were fully implemented in maternity care
- Across 3 ICBs (9%), tobacco dependence treatment services had been decommissioned in 6 acute trusts and 2 mental health trusts.
- In 50% of ICBs, tobacco dependence treatment services had expanded beyond the core services specified by the NHS Long Term Plan into Accident & Emergency, outpatients, pre-op, and paediatric wards.
- In 21% of ICBs, tobacco dependence treatment services were provided to patients in the community, primarily by mental health trusts.
- Financial insecurity and other problems with funding were obstacles to sustaining tobacco dependence treatment services in 83% of ICBs.
- Most ICBs were working with strategic partners at system-level to sustain tobacco dependence treatment services and promote wider tobacco control.

Recommendations

1. Protect funding for Tobacco Dependence Treatment Services

- Reinstate dedicated, ring-fenced funding to prevent diversion of resources amid wider NHS financial pressures. If this cannot be done then KPIs should urgently be set.
- Provide ICBs with multi-year financial commitments to enable stable service planning, recruitment, and delivery.

2. Hold ICBs to account for implementation and maintenance

- Require ICBs to report on the status and outcomes of tobacco dependence treatment services annually and to hit KPIs.
- Integrate tobacco treatment metrics into ICB performance frameworks, including treatment in acute, mental health, and maternity settings.

3. Support expansion beyond core services

- Building on best practice examples across ICBs, provide dedicated investment to support the scaling of services into A&E, outpatient departments, pre-op care, and paediatrics.

4. Build local commissioning capacity on prevention

- Develop a programme to equip ICBs to commission prevention services using tobacco treatment services as the case study.
- Support ICBs to embed tobacco treatment within their broader prevention, health inequality, and clinical strategies.

Introduction

This short report presents the findings from the third annual survey of Integrated Care Boards (ICBs) conducted by Action on Smoking and Health and Cancer Research UK. The primary focus of the survey was the implementation of the tobacco dependence treatment services specified in the NHS Long Term Plan.

The survey was in the field in April and May 2025. One month earlier, in March, the government announced that NHS England would be abolished and that ICBs would have to reduce their running costs. Most of the survey respondents did not know what impact these announcements would have on tobacco dependence treatment services and any other tobacco control work that ICBs are engaged in. Yet this new uncertainty adds to the financial uncertainty that has been a consistent problem for the development of tobacco dependence treatment in the NHS.[1,2]

The findings in this report present a snapshot of ICB commitment to tobacco control at a vulnerable moment. While most ICBs want to sustain this work, others have already started decommissioning.

Methods

The survey was conducted using Survey Monkey and was available online in April and May 2025. Tobacco control leads in ICBs were emailed and asked to complete the survey. Non-respondents were contacted by telephone. Complete responses were received for 32 of 42 the ICBs in England, a 76% response rate.

Most of the data reported here are at ICB level. However, respondents to the survey provided trust-level data on the implementation of tobacco dependence treatment services.

The priority of tobacco control

Respondents to the survey were asked how they perceived the priority given to tobacco control by the ICB. Nearly three fifths (59%) said that tobacco control was either a high priority (31%) or an above average priority (28%). Only one respondent said that tobacco control was a low priority.

Table 1 compares the findings for 2025 with the last two years. Fewer respondents identified tobacco control as a high priority than in 2024, returning to the level recorded in 2023.

[1] ASH & CRUK. Integrated Care Systems and tobacco control: improving outcomes in population health and healthcare. June 2023.
[2] ASH & CRUK. Integrated Care Boards and tobacco control: making good progress. August 2024.

Table 1. Priority of tobacco control in ICBs in England 2023-2025

	2025 (n=32)	2024 (n=26)	2023 (n=28)
High priority	10 (31%)	50%	29%
Above average priority	9 (28%)	23%	21%
Average priority	11 (34%)	15%	43%
Below average priority	1 (3%)	8%	0
Low priority	1 (3%)	4%	2%

Governance and workstreams

All surveyed ICBs had governance in place for tobacco control. Twenty ICBs (62%) had a tobacco dependence treatment steering group and 6 had a tobacco control board (19%). Most surveyed ICBs (27, 84%) had a board which oversaw health inequalities, population health and/or prevention. This was the only form of governance for 8 ICBs (25%). Respondents also identified system-wide alliances such as a Joint Smokefree Generation Strategic Group.

Respondents were asked to identify in their own words the ICB workstreams that contributed to the goals of tobacco control. In addition to specific workstreams on tobacco dependence treatment services, respondents identified workstreams on prevention, population health and inequalities; CVD, respiratory disease, cancer, mental health and maternity services (CORE20+5); long-term conditions; and children and young people.

The following two examples illustrate the range of respondents' experience in integrating tobacco control in wider ICB work:

> *The ICB jointly funds Fresh, the North East regional tobacco programme, as part of its recognition of wider tobacco control. In addition to TDTS services across all 10 Trusts (18 clinical pathways covering inpatient and maternity), there are also links through the LMNS programme; the Lung Cancer Strategy workstream; Long Term Conditions; CVD; Child Asthma workstream; Peadatrics; Mental Health parity of esteem workstream; and respiratory workstreams. We also have some emerging links to develop more joined up work with Learning Disabilities, Waiting Well workstreams and are starting to work more closely with the Alcohol workstream.*

> *Really only the Tobacco Dependence Treatment steering group - despite best efforts on my part to try and get tobacco control integrated into all ICB workstreams this doesn't seem to be on the priority list of the ICB. There is a wider system 'Smoke free Derby and Derbyshire' initiative lead by the Director of Public Health. The ICB comes to those meetings but doesn't play as big a role as I feel they should and don't put any additional funding above what is specified in the TDT budget (which has remained flat for last 3 years).*

Implementation, decommissioning and expansion of tobacco dependence treatment services

Across the surveyed ICBs, most trusts had fully implemented tobacco dependence treatment services (Table 2):

- 80% of services were fully implemented in secondary care
- 71% of services were fully implemented in mental health
- 91% of services were fully implemented in maternity care

However, in some trusts services had not yet been implemented and services had been decommissioned in 6 acute trusts and 2 mental health trusts.

Table 3 presents the same data by ICB. Three ICBs had started decommissioning tobacco dependence treatment services, two of which had decommissioned services in mental health trusts as well as acute trusts.

Table 2. Progress in implementing tobacco dependence treatments services (TDTS) by trust

	Acute	Mental health	Maternity
Number of trusts providing this service	113	45	103
Trusts that have fully implemented TDTS	90 (80%)	32 (71%)	94 (91%)
Trusts that have partially implemented TDTS	13 (12%)	10 (22%)	7 (7%)
Trusts that have not implemented TDTS	*4 (4%)*	1 (2%)	2 (2%)
Trusts that have decommissioned TDTS	6 (5%)	2 (4%)	0

Table 3. Progress in implementing tobacco dependence treatments services (TDTS) by ICBs

	Acute	Mental health	Maternity
Number of trusts per ICB providing TDTS (range)	1-11	1-3	1-8
ICBs where all trusts have fully implemented TDTS	20 (62%)	22 (69%)	28 (88%)
ICBs where some trusts have fully implemented TDTS	6 (19%)	0	3 (9%)
ICBs where no trusts have fully implemented TDTS	3 (9%)	8 (25%)	1 (3%)
ICBs that have started decommissioning TDTS	3 (9%)	2 (6%)	0

In half of the surveyed ICBs (16, 50%), tobacco dependence treatment services had expanded beyond the core services specified by the NHS Long Term Plan. Survey respondents described services for people attending Accident & Emergency, outpatients, pre-op, and paediatric wards. Staff were also offered a service.

> *One acute trust is implementing a similar intervention as COSTED in its Emergency Department. Funding is a restriction for others to implement or expand beyond in-patients, however some trusts are working closely with the local authority stop smoking service to explore possibilities in outpatients. There are also some pilots emerging within paediatrics for parents/carers who smoke.*

Two trusts are providing limited support to outpatient departments, with some coverage of pre-operative care and respiratory outpatients. All trusts with maternity services also provide support to partners of pregnant women.

All of our trusts offer tobacco dependence to staff and increasingly we are seeing expansion into outpatient services. Our acute trusts have also established services in paediatric wards.

Tobacco dependence treatment services were provided to patients in the community by trusts in 7 of the surveyed ICBs (21%), primarily by mental health trusts.

Sustaining tobacco dependence treatment services

Survey respondents described in their own words the factors that were sustaining and impeding the delivery of tobacco dependence treatment services.

Although funding was identified by some respondents as an enabler (for without it tobacco dependence treatment services would not exist), more than four fifths of respondents (83%) described problems with funding as an obstacle to sustaining these services. The principal problem cited was the insecurity of funding, a problem which has become more pronounced since the announcement this year of further cuts to ICB budgets. The potential loss of the ring-fence around the funding for tobacco dependence treatment services adds to this uncertainty.

Central non-commitment to funding is always problematic. Trusts are working on a year-to-year basis and can't rely on the following year's funding. This becomes a much larger problem if enough ICBs/Trusts disinvest in services then the funding may be pulled nationally. Data is still not reliable at a national level and this weakens the ability to provide assurances about programme reach and outcomes.

There is a massive squeeze on NHS funding as a whole. It makes the situation within ICBs and trusts very difficult. Even if an ICB provides funding to the trusts, the trusts then need to get internal business cases approved so the funding can be used on tobacco dependence treatment.

The funding moving from a ring-fenced source to baseline and the money being allowed to support deficit means ICBs can choose to reduce spend/commissioning of TTD services.

Three respondents identified a commitment to recurrent funding, despite national uncertainty, as a key factor sustaining the service:

As an ICB and as a wider partner of the Integrated Care Partnership we have outlined a bold ambition within our strategy to reduce smoking prevalence to 5% by 2030. This strategic aim and public commitment was critical in securing agreement for recurrent funding.

Senior leadership support; recurrent funding in place for Treating Tobacco Dependency services; strong, collaborative relationships locally.

ICB commitment to recurrent service funds. Support of local authorities with provision after discharge including NRT and with partner support for maternity. Swap to Stop scheme. National Incentive Scheme. Joint Forward plan priority objective linked to Smoking in Pregnancy.

In contrast, in the three ICBs where decommissioning had begun, respondents identified national uncertainty, the loss of the ring-fence and lack of leadership as obstacles:

Trust Clinical leadership buy in. Funds not ring-fenced and inadequate to scale across multiple specialties. Trusts Clinical & Senior Leadership buy in.

Funding is a major obstacle; the uncertainties and anxieties arising from the current NHS restructuring exercise are both de-stabilising and demotivating for many, making forward planning and robust partnership work very challenging.

Ring fenced funding or explicit requirements by NHSE to continue to commit investment into tobacco dependence treatment services.

Recruitment and retention of staff was a common problem, related to uncertainty over funding and to controls on spending and recruitment within trusts. Where permanent contracts have been offered, this was cited as an enabler of tobacco dependence treatment services, though trust-level obstacles to recruitment may remain.

Non recurrent funding, so job insecurity. Funding not covering NRT or travel costs. Funding not covering pay awards. Capacity stretched and lack of resilience in teams to cover leave.

Trusts have all employed staff on permanent contracts. Trusts are all delivering well and consider programme has value.

Recurring financial commitment has been critical for sustainability, however there are still challenges with trusts being able to advertise for roles and for the offer to be permanent, due to local recruitment freezes within the trusts. The ICB is supporting conversations to enable this to move forward.

Respondents identified a variety of other factors that are helping to sustain tobacco dependence treatment services including system-wide partnerships, oversight and strategy; leadership from senior management and key stakeholders in trusts; and demonstrable outcomes and value. The following accounts demonstrate a high level of strategic commitment to tobacco dependence treatment services:

The commitments made in the Tobacco Strategy agreed a couple of years ago by ICB and four local authorities. Strong Public Health joint working. Strong commitment from key leads in the ICB including Director of Population Health and Medical Director.

Long-standing historical strategic support for our overall Make Smoking History Programme. Vanguard inpatient and maternity pathways. Leading national pregnancy incentive scheme.

High priority area as part of our agenda to improve prevention services and improve health equity across our population.

In time, it may be the impact of these services that secures their long-term future:

> *Our services were fully implemented early and were evaluated, thus providing enough evidence to make a powerful business case. e.g. SATOD has halved in under three years.*
>
> *The savings the services are delivering for the system in length of stay and re-admission rates for inpatient and maternal outcomes for maternity.*

Wider tobacco control work

Twenty-five of the surveyed ICBs (78%) were pursuing some form of wider tobacco control work beyond the delivery of tobacco dependence treatment services. This typically involved alliances with local authorities and engagement in campaigns, promoting smokefree environments, and tackling the illicit trade.

As a contributor to Fresh, North East and North Cumbria ICB could boast involvement in the most established programme of tobacco control:

> *Fresh: jointly funded with the 12 local authorities and ICB follow the 8 key strand approach. These are 1) Support & Partnerships, 2) Advocacy, 3) Reducing second-hand smoke, 4) Media, Comms & Education, 5) Supporting Smokers to Stop. 6) Reducing illicit trade & advocating for raising the price, 7) Work around tobacco & nicotine regulation, 8) Data, research & evaluation.*

As the promoter of a new centre of excellence, Humber and North Yorkshire ICB has the most ambitious new programme of tobacco control work:

> *The ICB has developed and funded a Centre for Excellence in tobacco control, set up alongside a strong focus on inequality. The Centre is formed of a small central team who coordinate activity for the ICB and convene the system at a regional level. The Centre has agreement from the 15 local authorities in Yorkshire and the Humber for a c10% top slice of the grant funding to form a central pot which is being used to fund regional mass-media campaigns supported by social media and co-production with NCSCT of a 5-year programme of training based on the philosophy of world-class workforce, word-class service. The ICB has also funded NEMS to deliver a large survey looking at illicit tobacco and building on the surveys delivered in Yorkshire and in NENC over the past 10 years. Centre for Excellence has commissioned a public opinion survey across Humber and the North Yorkshire to discover peoples' attitude towards tobacco and tobacco control measures, as well as alcohol and unhealthy foods. The ICB is working as part of a wider collaboration with Greater Manchester, ASH, OHA and AHA on developing an ICB model to deliver across the three biggest killers.*

Conclusion

Most of the findings in this report are positive: tobacco dependence treatment services are now established in most NHS trusts, and many ICBs are expanding these services to new clinical areas and working collaboratively to pursue the wider goals of tobacco control. Yet, for the first time, decommissioning of tobacco dependence treatment services was reported in three ICBs and other respondents expressed concern about the future of these services in the current financial climate. We can only hope that this is a bump in the road and not a turning point. After years of development and a determined effort to establish and embed these services in the NHS, a reversal would be a betrayal of the professionals who have led the work and a disaster for the many patients who are already reaping the benefits of tobacco dependence treatment in the NHS.