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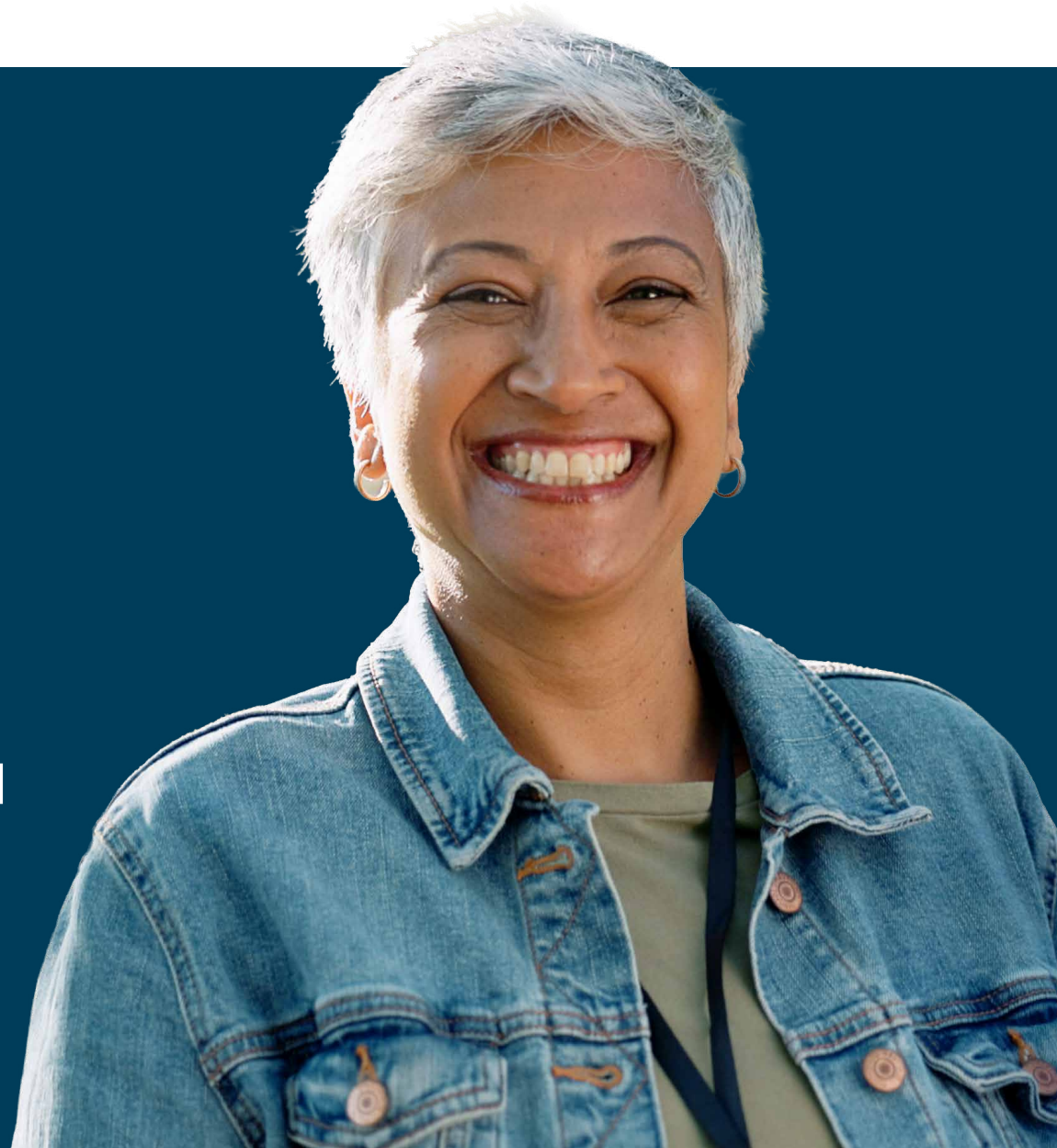
South East London
Integrated Care System

Prevention Toolkit

A practical guide designed to support commissioning, delivery, and improvement teams in implementing prevention interventions



Contents

This toolkit supports commissioning, delivery and improvement of prevention interventions, helping teams make informed decisions about what to prioritise, how to deliver, and how to measure impact in line with the SEL Prevention Framework.

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A toolkit for prevention

Although there are positive examples of local initiatives within the South East London (SEL) Integrated Care System (ICS) including the commissioning and delivery of many evidence-based interventions, current efforts are still not doing enough to benefit those most at risk of health inequity. As a result, they are falling short of delivering population-level health improvements or supporting long-term system sustainability.

In developing our SEL Prevention Framework, stakeholders from across the ICS identified a range of opportunities to strengthen how we commission, deliver, and improve high-value preventative services and support for our residents. These opportunities draw on evidence-based and local good practice, as well as shared challenges and identified gaps. **This toolkit is designed to serve as a practical resource for staff across the ICS involved in commissioning, service delivery, or quality improvement, helping to improve decision-making, service design, and the effectiveness of interventions/care models.**

Our SEL ICS Prevention Framework outlines a collaborative, targeted, and outcomes-focused approach, emphasising the shared responsibility for prevention across NHS and local authority partners.

Developed using insights from system stakeholders on how prevention interventions are designed and delivered, the toolkit provides actionable guidance and links to relevant supporting resources. It covers key areas such as understanding local needs, planning interventions, evaluation, and access to further learning materials to support effective and impactful implementation.

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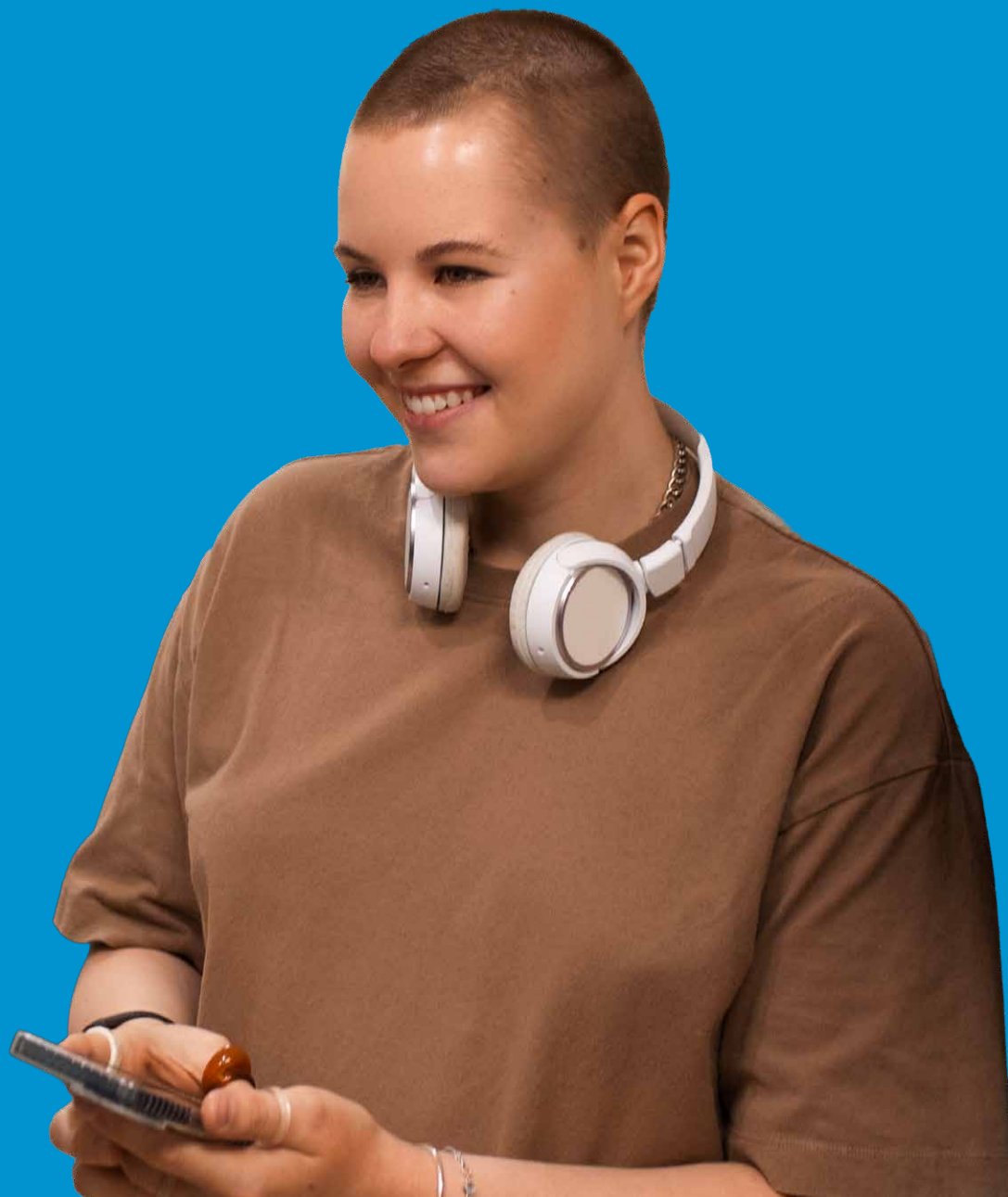
Our prevention offer



Prevention across the life course represents a systematic approach focusing on social determinants, risk reduction, early disease detection, and reducing complications and overtreatment.

The SEL ICS prevention offer will support residents in the healthy, at-risk and rising-risk groups, helping to prevent escalation into more complex needs. Integrated Neighbourhood Teams (INTs) will continue to focus on people at high-risk, as well as some rising-risk residents, to prevent further deterioration and reduce avoidable complexity.

The SEL ICS prevention approach focuses on the 'Vital 5 Plus', building on evidence-based work across the system and aligning with the ambitions of the NHS 10 Year Health Plan for England. This model adopts a life-course perspective, using adult prevention as a lever to improve outcomes for maternal health, children, and young people, ensuring a comprehensive and sustainable approach to wellbeing. This approach aligns to SEL ICS's start well, live well and age well considerations set out for strategic commissioning.

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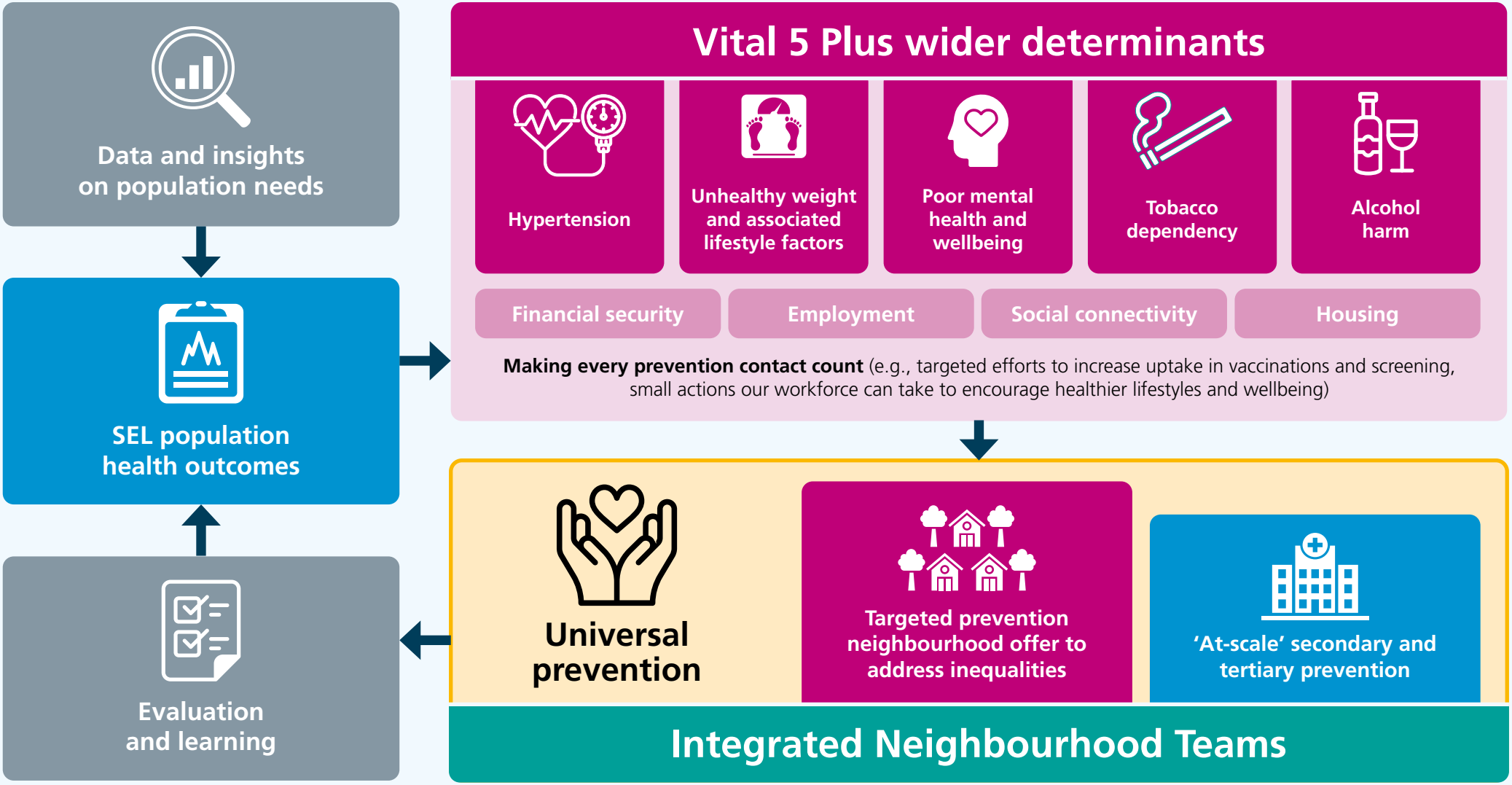
The SEL prevention offer



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The SEL prevention offer

The SEL prevention offer includes three inter-connected tiers:

Universal prevention

For all eligible residents, regardless of 'risk status' or post-code, which seeks to promote overall health and wellbeing, reduce lifestyle risks and prevent infectious disease.

This is through broad population-level access to lifestyle advice, preventative interventions and support - to improve the conditions in which we work, live and grow.

This includes, for example, school and community-based education programmes, oral health, screening and vaccination programmes, smoking bans, and alcohol licensing.

Targeted prevention neighbourhood offer

Designed to enable early detection and intervention for Vital 5 Plus risk factors through a proactive and tailored 'whole-families approach'. This will be targeted specifically at neighbourhoods at rising risk of poorer health outcomes who are more likely to experience health inequalities.

Neighbourhood models enable local variation while maintaining a consistent prevention foundation across the system, allowing for shared learning and comparable outcomes.

'At-scale' secondary and tertiary prevention

Secondary and tertiary preventative interventions delivered across neighbourhoods or pan-borough due to economies of scale with links back into community-based services. For example: women's and girls' health hubs, smoking cessation services across settings, alcohol care teams in hospitals, reablement services, and community valve clinics.

Integrated Neighbourhood Teams

The SEL prevention offer will complement INT models of care. INTs provide a structure for multi-disciplinary collaboration and integrated services across health, care, public services and VCSE. They will deliver holistic, prevention-focused care initially for complex high-risk residents and some at rising-risk of complexity. INTs are part of the wider development of neighbourhood health and care, which seeks to deliver care and support closer to home and enable healthier places.

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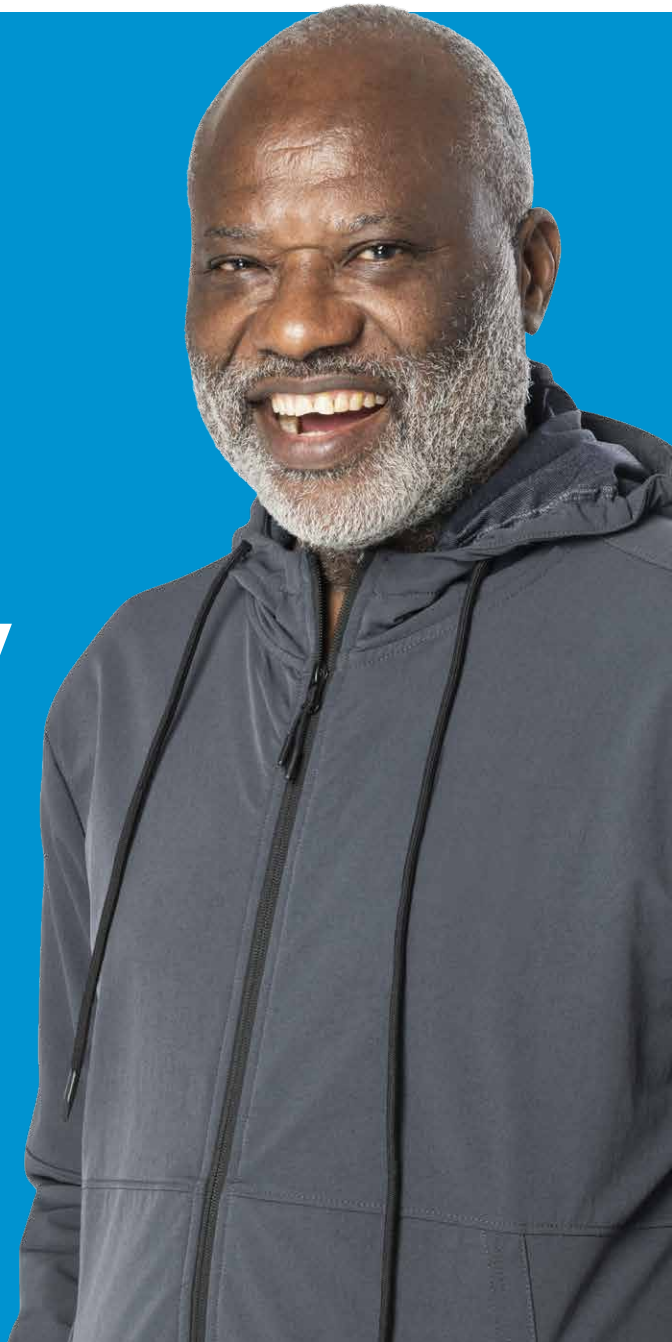
A methodology for high impact prevention



Drawing on insights from SEL's Prevention Framework workshops and good practice literature [1,2], we have developed a methodology to deliver high-impact prevention across commissioning, delivery, and improvement cycles. This approach aligns with the national shift towards **proactive, value and evidence-based strategic commissioning**.

The methodology

- Equips local decision-makers with a structured way by ensuring prevention strategies and interventions are population-driven, evidence-based, and designed with communities.
- Aims to enable delivery of the most strategic gains in population health; shifting prevention further upstream and offsetting future demand and system pressures – particularly as SEL ICS faces rising complexity and the challenges of an ageing population.
- Supports teams to deliver measurable outcomes and financial and social return on investment (ROI), fosters cross-sector collaboration, and embeds continuous learning and evaluation to enable improvement and sustainability.

NHS and local authority commissioners, providers, and delivery partners can use this methodology to review plans, identify opportunities for improvement, and build a stronger case for investment. It is designed to be flexible, supporting the development of new interventions, the review of existing services, or the consideration of strategic changes.

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Considerations for high impact prevention

1 Local needs, priorities and fit

What does the local population need (data, insight)?

Who is the target population and what outcomes are you trying to achieve?

What health need, inequality or prevention opportunity is being addressed?

What is going on locally and what evidence already exists? How does this fit with current initiatives, is it strategically aligned, will it reduce or conflate fragmentation?

Will it deliver improvements in health equity (e.g. test through equalities impact assessment)?

2 Intervention planning

What is the nature of your intervention(s) - what type of prevention is it, does it meet a gap in existing provision/need?

How could it be delivered in a way that addresses inequalities, makes every family contact count or delivers parity of esteem?

What evidence shows that this intervention is likely to benefit the population of interest? Review evidence of what's cost-effective and effective.

3 Co-design and engagement

How will you undertake engagement / co-design with people and communities to develop proposals and interventions that might be best delivered for your target population, community or geography – and at the right scale?

Who is best placed to deliver it, how and where – and what assets exist in the community that may support the intervention?

4 Intended impact and ROI

What benefits are expected and in what time frame?

What is the financial, and where relevant social, ROI versus cost of delivery?

How does this compare to the relative costs of existing or comparable services or what the evidence base tells you?

What is the total proposed mobilisation and recurrent spend? What is the cost for each person targeted or each outcome delivered?

5 Implementation and delivery

How does the intervention fit with or improve current local service delivery?

What partners need to be involved in delivery?

How will you enable delivery through relevant partners (e.g. strategic commissioning, contracting or funding levers/incentives)?

Can the prevention intervention be delivered through existing workforce or is new capacity or capability required?

What leadership and governance are required to support stakeholder buy-in?

What major strategic and operational risks exist, and how will you manage or reduce them?

6 Evaluating impact

How will you know what success looks like - what will you measure, by when and how?

Are mechanisms to collect and feed back data and learning in place?

How will learnings, data and insights be shared?

7 Review impact

Based on data, insights and learning to date - do you stop or evolve/improve?

If stop, ensure an appropriate exit strategy and translation of learning

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Hints and tips

Grounded in evidence, these hints and tips are designed to support commissioning, delivery and improvement teams in implementing and delivering prevention activities, interventions and programmes.

Understand local need

Use population health management (PHM) to identify priority cohorts, underserved groups, and geographies of high unmet need.

Focus on populations at risk/rising risk and drivers of inequality.

Commission for prevention impact

Commission for outcomes, not activity—prevent deterioration, escalation, and future demand.

Use contractual incentives and aligned commissioning (incl. with local authorities) to drive collaborative prevention across providers and VCSE partners.

Make prevention core business across INTs.

Apply a life-course approach

Prioritise early intervention from pre-conception to older age.

Recognise the influence of life-stage inequalities on long-term health.

Put communities at the centre

Co-design with residents, carers, and VCSE organisations from the outset.

Ensure approaches are inclusive, culturally relevant, and rooted in lived experience.

Deliver through trusted neighbourhood settings and community leaders.

Create flexible, accessible prevention models

Use outreach, non-clinical settings, and blended digital/face-to-face models.

Embed prevention into screening, diagnostic pathways, and everyday interactions.

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Embed prevention into everyday practice

Normalise opportunistic brief advice and motivational conversations.

Integrate prevention into all routine contacts across health, care, and community services.

Offer choice and support control

Provide options that support personalisation and autonomy.

Encourage incremental changes that build confidence and self-management.

Take a holistic approach

Integrate physical and mental health prevention.

Address wider determinants wherever possible (e.g., financial, housing, social support).

Equip and support staff and volunteers

Provide training in brief interventions, motivational techniques, and self-management resources.

Embed prevention in workforce and carer wellbeing strategies.

Use evidence, learning, and value to guide decisions

Prioritise evidence-based interventions and use ROI/ SROI to inform investment.

Develop logic models / theories of change and embed iterative, insight-driven improvement.

Track reach, engagement, equity, and impact, especially for priority groups.

Use feedback from residents and frontline teams to refine delivery.

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Case study 1

Lifestyle Medicine in North Lewisham

Lifestyle medicine looks to deal with the root cause of illness to prevent, treat and reverse chronic disease. A Lifestyle Medicine service in North Lewisham is coming into its fourth year of service, with clear benefits for the community it serves.

North Lewisham is a highly diverse and complex population, with 67% of residents falling within the Core20PLUS cohort. Approximately half of all residents do not speak English as their first language.

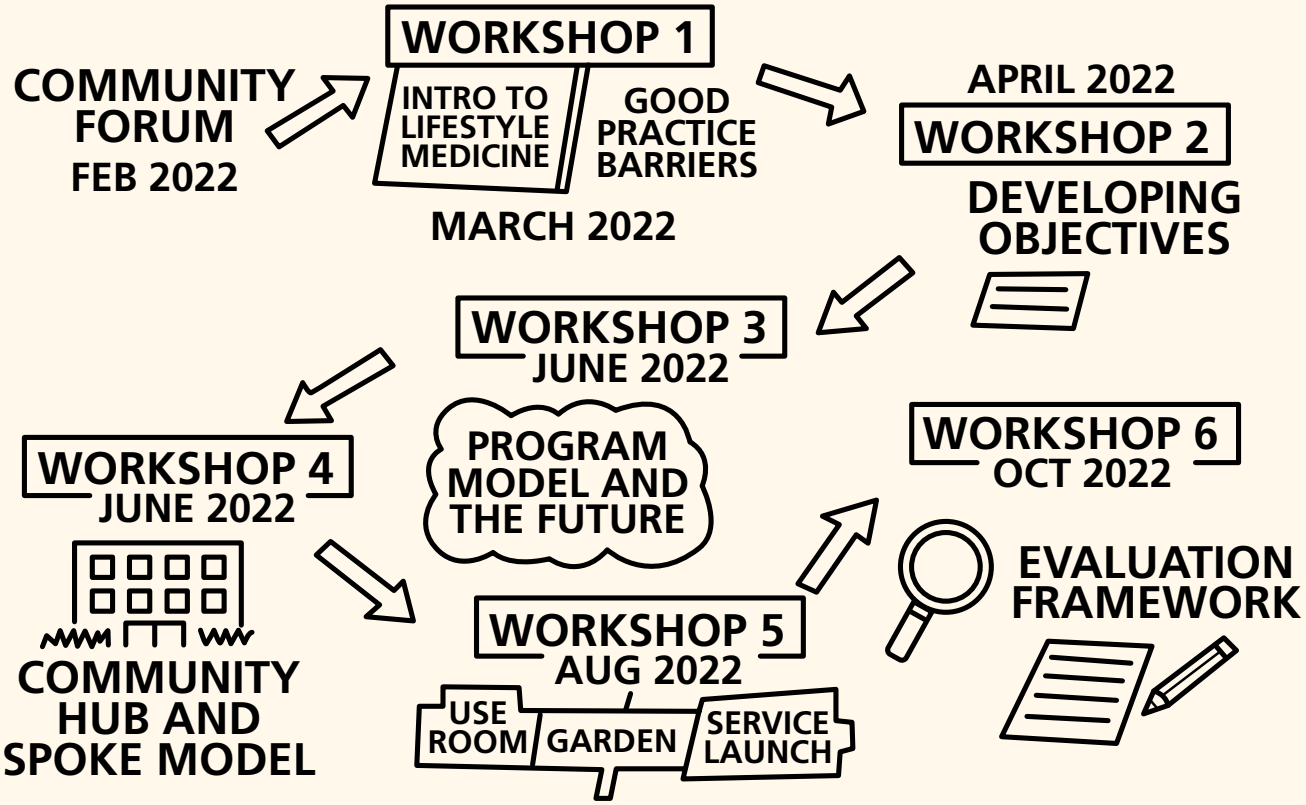
The Primary Care Network (PCN) within North Lewisham serves a population of around 90,000 patients. Many of these individuals experience low trust in services, and barriers to accessing care.

Reducing Cardiovascular Disease (CVD) presented a key opportunity to address local health inequalities, and there is strong evidence supporting the effectiveness of Lifestyle Medicine in achieving this.

In early 2022, the concept of a Lifestyle Medicine service was presented to the PCN Community Forum, which brings together local residents, VCSE organisations, and health stakeholders. The proposal was positively received, leading to the establishment of a co-design group. This group met six times over a seven-month period and collaboratively designed the service from inception to delivery. Discussions focused on key areas including barriers to access and engagement, target populations, approaches to outreach and evaluation, service delivery models, and workforce considerations.

Core principles to emerge from the co-design process

- The service should be delivered by non-clinical facilitators to avoid medicalisation, and minimal use of technical or clinical jargon.
- It should be universally accessible to all individuals within the PCN, without eligibility determined by diagnoses, labels, or numerical thresholds.
- A blended model of group-based sessions and one-to-one support was preferred, recognising the value of peer learning and community support.
- All information and engagement approaches should be culturally appropriate and tailored to effectively reach underserved communities.



How did the co-design workshops influence the service implementation?

Together with the community co-design working group, the team designed the North Lewisham Lifestyle Medicine Service.

The service is run entirely by Health and Wellbeing coaches, some of which are trained as nutritionists. Patients have six one-to-one sessions working on personalised goals, and five group sessions which cover the six pillars of Lifestyle Medicine. The service remains open to all, but individuals were explicitly invited and targeted from underserved communities, who were at risk of health inequalities.

The service is coming into its fourth year of running. 75% of patients fall within the Core20PLUS5 and 79% are of non-white ethnicity.

Insights

The outcomes demonstrated in the Lifestyle Medicine service show the significance of careful planning, and effective co-design when implementing local services.

The service has demonstrated statistically significant improvements in sleep, social connection, mental health, autonomy to control health, physical activity levels, fruit and vegetable consumption, and control in day-to-day life.

Specifically for diabetic patients, there has been an average reduction in HbA1c of 22mmol/mol at three months and 35mmol/mol at six months. 32% of patients were no longer living with diabetes.

For pre-diabetic patients, an average reduction in HbA1c of 4mmol/mol at 3 and 6 months was seen, with 62% of patients no longer pre-diabetic after receiving the Lifestyle Medicine offer.

Patient satisfaction is very high, with 91% of patients feeling that they got what they expected from the service and the remaining 9% feeling that this was somewhat achieved.

Importantly, this model has demonstrated strong scalability and cost-effectiveness. Through the Lifestyle Medicine Accelerator, it has been successfully spread across multiple NHS settings, including individual GP practices, six additional Primary Care Networks, and a community and leisure provider. Delivery costs have remained low, at approximately £2–£10 per patient, further strengthening the return on investment case.

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Local needs, priorities and fit

Knowing your population and managing data is a key step in designing and delivering prevention interventions.

Population Health Management (PHM) involves using **data** we hold about our patients and communities and their health requirements to plan how we deliver the best, tailored care for our local population. As an approach, it uses data to design new ways of proactively offering patients care before they need to go to the NHS with a problem – and helping them to improve their health and wellbeing. PHM is a way of working that enables us to understand health and care needs in a population. The approach requires:

- quantitative insight about a population acquired from various sources of linked data, and
- qualitative intelligence gathered from care professionals and local communities.

These insights help us identify opportunities to improve or transform the way care and services are delivered to our population to achieve better and more equitable outcomes.

Public Health teams are critical partners in effective planning. They bring expertise and local intelligence that can significantly strengthen your approach — from understanding population health needs to identifying gaps and opportunities in existing prevention services. Their insight can help you align your work with local priorities, avoid duplication, and ensure your plans deliver meaningful impact.

Each local authority publishes a **Joint Strategic Needs Assessment (JSNA)**, which provides a detailed picture of the health and wellbeing needs of the community. Reviewing the JSNA early in your planning process is essential. It will highlight key issues, priority groups, and trends that should shape your objectives and guide your engagement with local stakeholders.

Case Study 1 demonstrates how the Lifestyle Medicine Service in North Lewisham was shaped through effective planning and meaningful co-design, ensuring the service is rooted in a deep understanding of local needs.

Case Study 2 explores how two SEL Women and Girls Health Hubs moved from concept to reality, using insights to inform local planning, implementation, with signs of early impact already emerging for women and girls.

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Supporting resources

More information on population health management as a tool to improve the lives of our residents is available on the SEL ICB **website** and from **NHS England**.

The AI Centre for Value Based Healthcare provides information on its **work** on behalf of London. We work closely with the AI Centre, which is hosted here in SEL.

The Lewisham and Greenwich **PHM team** are delivering a range of projects in their local area, with real-world results.

Various training opportunities are available to those interested in PHM, including through the **NHS Learning Hub** and the NHS England **PHM Academy**. NHS England also hosts an **Applied Population Health Programme**.

The SEL Health Index produced by Ethica Health Partners is a synthesised system-wide report of all SEL JSNAs and is available on our **Futures Website**. Click below for JSNA information for specific SEL boroughs

- Bromley
- Bexley
- Greenwich
- Lambeth
- Lewisham
- Southwark

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Intervention planning

Logic models

Logic models are a practical tool to help teams identify required resources, design targeted activities, track delivery, and measure meaningful outcomes that support people to stay healthier for longer and reduce health inequalities. They also enable ongoing monitoring, supporting timely adjustments and evidence-based decision-making. A logic model can be used to inform the development of a **prevention intervention/programme**, with metrics regularly reviewed to enable decision makers to know whether the initiative is likely to deliver intended benefits/ financial and social ROI.

Case Study 4 – Tobacco Control in SEL – provides a practical demonstration of a logic model, as well as evidence of smoking-related outcomes, economic benefits, and the initiative's wider system-level impact.

Identify inputs

the resources and capabilities needed to support early intervention and proactive care.

Define activities

for example, interventions designed to identify, reduce and manage risk factors and prevent inequalities in access / health outcomes.

Track outputs

including participation, reach, engagement, and delivery metrics.

Measure outcomes

Short- and longer-term changes (e.g., in behaviour, knowledge, and awareness that help people remain healthy and contribute to reducing inequalities in healthy life expectancy).

Monitor progress

using available data and insights to support timely course correction and evidence-informed decision-making.

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Supporting resources

Midlands and Lancashire Commissioning Support Unit (MLCSU) – Logic Model Guide
For commissioners, and evaluation and delivery teams: guidance on developing and using logic models to clearly articulate the link between inputs, activities, outputs, outcomes, and impact.

Marmot Review – Fair Society, Healthy Lives
For evaluation teams and commissioners: evidence on social determinants of health and reducing inequalities; supports outcome-focused prevention planning.

WHO – Health Promotion and Disease Prevention Frameworks
For commissioners and delivery teams: international guidance on upstream prevention and population health strategies.

Process evaluation of complex interventions, Medical Research Council guidance (BMJ)
For commissioners, and evaluation and delivery teams: guidance for conducting process evaluations in complex public health interventions, linking implementation, mechanisms, and context to outcomes.

W.K. Kellogg Foundation. Logic Model Development Guide
For commissioners, and evaluation and delivery teams: practical guide for developing and using logic models to plan, implement, and evaluate programmes.

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Case study 2

SEL Women and girls' health hubs

SEL ICS launched two women's and girls' health hubs in 2025 to make it easier for residents to access the care they need in one convenient place, reducing waiting times for appointments and easing pressure on secondary care services.

The hubs bring together multidisciplinary teams including GPs with a special interest in women's health; consultants in sexual and reproductive health; obstetrics and gynaecology; and nurses and other allied health professionals to provide a one-stop service for:

- heavy menstrual bleeding and associated conditions (e.g. polycystic ovary syndrome, endometriosis)
- menopause assessment and treatment
- pre-conception health
- contraception, including long-acting reversible contraception (LARC)

The hubs are open to all women and girls aged 13 and above in Bexley, Greenwich and Lambeth. All three boroughs are supported by outreach in partnership with local voluntary and community sector organisations, with a focus on women and girls who don't routinely engage in health and care services and those with poorer health outcomes, such as the Core20 population.

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Local needs and planning

- A SEL-wide needs assessment identified four priority areas
- Model was aligned to National Women's Health Strategy priorities and the SEL ICS Joint Forward Plan focussed on intermediate care, minimising duplication with acute services and general practice.

Co-design

- Insights from 1,400+ residents at community events & two cross-sector design workshops.
- Stakeholder interviews, mapping of existing provision incl. focus groups and digital pathway testing
- A community of practice was established to support design and mobilisation.

Community Engagement & Outreach

- VCSE partners delivered targeted outreach to groups less likely to engage with health services.
- Microgrants in Bexley and Lambeth enabled community-led engagement.
- Volunteer Centre Greenwich piloted an approach using digital exclusion heatmaps and personas to identify at-risk cohorts with embedded continuous improvement cycles.

Implementation

- Hubs are delivered as proof-of-concepts via lead provider trusts with PCNs and partners.
- Mobilisation planning covered workforce, estates, IT, and communications.
- A SEL ICS self-management toolkit signposts residents to trusted resources; materials are being translated into 10+ languages.
- An education and training programme provides webinars and masterclasses for clinical and non-clinical staff.

Early Impact & Evaluation

- First year evaluation undertaken indicating lower cost per patient: £121 (Lambeth) and £145 (Greenwich & Bexley) per patient triaged/seen (Compared with £190 acute outpatient tariff – excluding diagnostics/procedures).
- Reduced acute demand through MDT triage and advice-and-guidance.
- Findings to inform year 2 commissioning and delivery

Insights

Integrated models reduce fragmentation
Bringing specialist skills into community settings provides earlier intervention, improves patient journeys, and reduces unnecessary escalation to acute services.

Data-driven design improves targeting
Needs assessments and digital exclusion mapping ensured hubs addressed the most pressing local priorities and inequalities.

Community partnerships enhance reach
Working with VCSE organisations enabled engagement with underserved groups and improved cultural competence.

Co-design strengthens uptake and trust
Resident involvement shaped pathways, communications, and digital tools, ensuring the model is accessible and user-friendly.

Cost-effective prevention
Early evidence shows lower unit costs and reduced acute demand, demonstrating the economic value of preventative community-based care.

Continuous learning improves sustainability
Embedded evaluation, feedback loops, and cross-system collaboration support iterative improvements and long-term impact.

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Co-design and engagement

Effective prevention is rooted in partnership with communities. Designing and delivering prevention activity with people and the VCSE sector is essential to improving population health, reducing inequalities and achieving sustainable system impact. VCSE organisations bring trusted relationships, lived experience and detailed understanding of local needs, cultures and assets

When this insight informs commissioning and service design from the outset, prevention interventions are more accessible, relevant and effective – particularly for underserved communities.

Co-design supports earlier intervention, improves uptake and outcomes, and strengthens value for money by targeting resources where they have greatest impact. For Integrated Care Systems, co-design is a core enabler of place-based working and neighbourhood health. It supports statutory duties on involvement and engagement, aligns prevention activity with local priorities, and builds system resilience.

Case Study 3 – Trust and Health Creation Partnership in SEL – offers valuable insights into the early impact of a new partnership designed to rebuild trust in local health services, grounded in co-design and community-led approaches.

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Supporting resources

South East London ICS. What we've heard from local people and communities captures insights from community engagement activities across SEL to inform prevention planning.

South East London VCSE Alliance & King's Health Partners. (n.d.). Trust and Health Creation Partnership outlines collaborative VCSE and academic partnership to support health creation and community-led prevention in SEL.

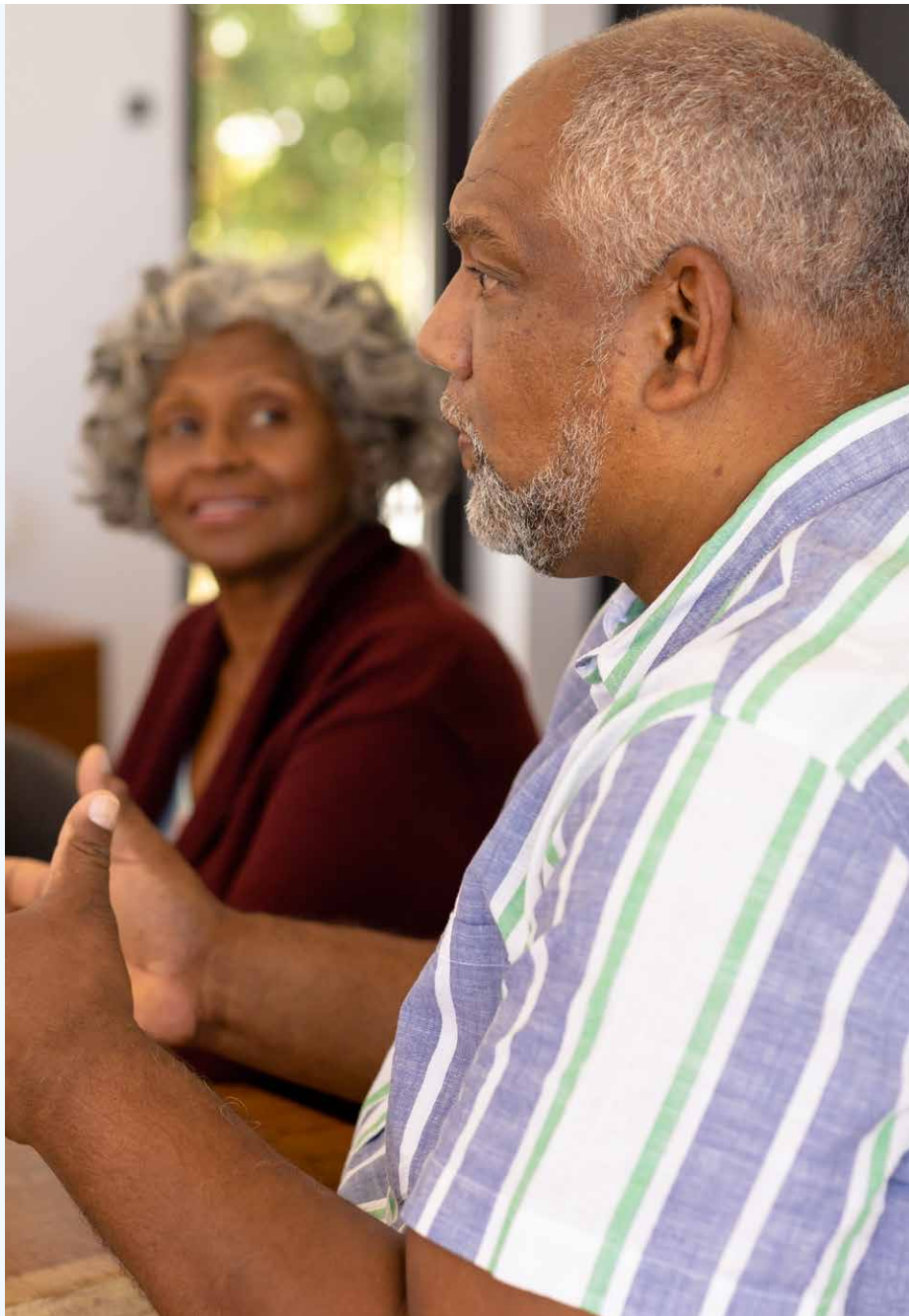
South East London ICS Equality Impact Assessment Toolkit provides support to conduct effective Equality Impact Assessments, providing the necessary guidance and resources to assess and address the impact of work on all individuals, particularly those with protected characteristics.

South East London ICS Engagement toolkit provides practical resources for co-design and community engagement in SEL neighbourhoods.

Care Quality Commission New self-assessment and improvement framework for integrated care systems to address health inequalities through engagement with people and communities provides a framework to address health inequalities through engagement with people and communities.

The **Lifestyle Medicine Accelerator** is a programme that equips NHS teams with evidence-based training, tools and co-designed resources to embed accessible, effective lifestyle medicine into everyday patient care, improving health and wellbeing across local communities.

National Institute for Health and Care Excellence. (2019). Community engagement: Improving health and wellbeing and reducing health inequalities provides guidance on effective community engagement to improve health, reduce inequalities and co-produce interventions.



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Case study 3

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Trust and Health Creation Partnership in SEL

Five community organisations have joined a new partnership focused on rebuilding trust in local health services and supporting residents to live well for longer. This collaboration centres on co-design and community-led approaches and the principle that health is shaped by people and place, not only by clinical care.

Community-led

The partnership is based on the principle that health is created when communities have the power and resources to shape their own outcomes. It works with local 'By and For' VCSE organisations to co-design preventative approaches rooted in lived experience and community strengths.

Building trust

The project aims to rebuild trust between health services and communities facing the greatest health inequalities. It focuses on creating more inclusive, accessible and culturally competent pathways that better reflect people's needs and expectations.

Delivering systemic change through collaboration

By bringing together grassroots organisations, NHS partners and system leaders, the partnership seeks to develop frameworks that challenge existing approaches and embed long-term, structural change in preventative health across SEL.

Insights

This partnership has shown that trust is not something you build first and then move on from – it is created through the same everyday actions that support people's health and wellbeing.

Across our VCSE partners, trust and health are built at the same time, through practical, respectful and reliable work with communities. Through meaningful engagement, community organisations are already doing this every day: meeting people where they are, responding quickly to real needs, creating safe and accessible spaces, and staying alongside people over time.

This collaboration has not introduced health creation to communities; it has helped to recognise and learn from what is already happening. The Partnership aims to gather insights, evidence and metrics to help system partners to build and maintain trust with communities with the aim of improving access to prevention services.

Mama2Mama is one of the five VCSE partners selected as part of the Trust and Health Creation Partnership. Mama2Mama supports families through a dignity-first approach, aiming to provide mothers and babies the best start in life by offering essentials (baby items, emergency formula, hygiene products and equipment) to those most in need.

Hypothesis: Where trust is built intentionally, we see a corresponding increase in uptake of preventative services

Referral growth and system visibility

Before joining the partnership, Mama2Mama averaged around 100 referrals per month. They were well established in Greenwich but had limited visibility across the wider SEL system.

Since joining the partnership, strengthened relationships with VCSE partners have driven a sustained 20% rise in referrals, bringing monthly volumes to 120–150 families.

Equity of access

Beyond volume, the most meaningful change has been in who is accessing the service.

Partnership working has enabled them to reach families they previously struggled to engage — particularly marginalised communities and LGBTQ+ parents — through trusted referral routes.

Collaboration and learning

Regular face-to-face engagement through the T&HC Collaborative has strengthened shared understanding across partners, reduced duplication, and improved clarity around who does what best.

This has resulted in more coherent pathways for families and more effective use of VCSE capacity across SEL.

Impact of funding

The investment has been 'transformational' for a small, grassroots charity.

It enabled Mama2Mama to respond flexibly to need and fund essential items that are typically difficult to resource, including nappies, wipes, toiletries, and the introduction of bedtime packs (pyjamas, a soft toy, and a book).

Looking ahead

This partnership shows early signs of what effective, trust-based collaboration between the NHS, public sector, and VCSE can achieve.

Collaborative models like this could be expanded and funded on a longer-term basis to protect preventative impact and avoid system fragmentation.

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Intended impact and return on investment

Prevention currently represents only 5–6% of NHS spending [3], yet evidence demonstrates that early intervention can dramatically reduce ill health and deliver significant socio-economic benefits.

Investing in preventative healthcare is not just clinically sound - it offers value for money, with initiatives shown to generate substantial returns and strengthen the case for sustained, long-term investment.

Return on Investment (ROI) measures the value generated by prevention activities relative to their costs. By demonstrating financial savings, improved health outcomes, and reductions in health inequalities, ROI provides decision-makers with a powerful tool to prioritise high-impact interventions. It underpins evidence-based planning, promotes efficient resource allocation, and strengthens the case for investing in initiatives that deliver lasting benefits for both communities and the health system [4].

Measuring ROI can be challenging. Prevention benefits often take years to materialise and may result from multiple contributing factors, making attribution difficult. Some outcomes, like improved wellbeing or reduced inequalities, are harder to quantify but remain essential. Accurate ROI assessments require robust data, careful assumptions, and thoughtful interpretation.

Tools for ROI

Logic models for ROI

Logic models can be a practical tool for calculating Return on Investment (ROI) by clarifying inputs, activities, outputs, and outcomes (short, medium, long-term), which allows you to identify measurable benefits and costs to demonstrate financial value, prove effectiveness, and justify investments [5].

Inputs → **Activities** → **Outputs** → **Outcomes**

STAR – Socio-Technical Allocation of Resources

STAR is a tool that enables decision-makers to evaluate how resources can generate greater value without increasing expenditure. It supports commissioners in identifying high-impact prevention priorities and making structured, evidence-informed decisions.

STAR
- a tool for commissioners, Health Foundation

Supporting resources for ROI

Paving a new pathway to prevention: Leveraging increased returns on our collective investment. NHS Confederation (2024) This report sets out a practical case for shifting health and care systems toward prevention-first investment, showing how targeted, evidence-led prevention can deliver stronger health outcomes and better value for money.

Return on investment: A guide for NHS finance teams. Healthcare Financial Management Association. (2025). This guide provides practical, finance-focused advice on calculating and interpreting ROI for decisions within NHS organisations. While ROI in the private sector often focuses on pure financial returns, this guidance emphasises how to assess both financial and wider social value to help finance teams support better investment decisions in a prevention context.

Impactability report. Building on expert knowledge: Research and next steps on impactability in health and care. Health Economics Unit (2022) Impactability could offer an important opportunity for health system managers to achieve the triple aims of improving the individual experience of care, improving the health of populations, and reducing the per capita costs of care. This report explains the theory of impactability and its potential value and applications within healthcare. It also provides a definition of impactability for the NHS, allowing better dissemination of information and further use.

Size of the Prize for high blood pressure and Cholesterol. UCLPartners' Size of the Prize resource gives insight into cost savings (at ICB level) of optimising the treatment of blood pressure and cholesterol.

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Case study 4

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Tobacco control in SEL

Cardiovascular disease (CVD) remains a leading cause of premature mortality in England. Smoking is a well-established, modifiable risk factor that significantly increases the risk of coronary heart disease, stroke, and other cardiovascular conditions. The financial toll is also striking – smoking costs SEL ICB an estimated £50.6 million every year in healthcare expenditure alone. In SEL, smoking rates have fallen significantly – from 19.6% in 2011 to 11.2% in 2023 – but the story is far from over.

Stark inequalities persist; prevalence remains highest among people in deprived neighbourhoods and among men compared to women, reflecting broader patterns of health inequity and CVD risk. These disparities demand urgent, targeted action.

In SEL, we've built a coordinated and consistent, system-wide approach to tobacco control that supports population-level risk reduction, enables early intervention through integrated care pathways, and delivers personalised prevention powered by data and digital tools. Every initiative is grounded in evidence and informed by data and real insights from our residents, ensuring solutions that are both effective and community-driven.

The SEL Tobacco Programme is supported by a collective investment of over £5.5M from local authorities and SEL ICB and contributes to the following services/interventions.

- Local Stop Smoking Services (LSSS) commissioned by local authorities
- SEL Hospital Tobacco Dependence Treatment Services across acute, mental health and maternity services
- SEL-wide collaborative initiatives: COSTED (Cessation of Smoking Trial in the Emergency Department), Lung Cancer Screening Programme onsite smoking cessation, Stop B4 Op, SEL Swap to Stop scheme, as well as SmokeFree app

Insights

Impact data shows a 29.7% increase in successful quits compared to 2023/24, with strong gains among disadvantaged groups.

Hospital-based Ottawa Model data showed that:

- 79% of 2,067 inpatients accepted treatment; and
- 35% smoke free at 6 months

Economic benefits:

- Readmissions cut from 11.1% → 5.2%
- 414 bed days saved
- £492k savings
- Cost per quit: £1,713; ICER: £3,325 per life-year gained

System-wide improvements:

- Stop smoking support available in every borough
- Ottawa Model rolled out across all NHS Trusts
- Stronger cross-system partnerships and an active Community of Practice

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Logic model for tobacco control in SEL

Inputs	Activities	Outputs	Outcomes	Impact
Strategic leadership and cross sector partnerships	Mapping for SEL LSSS and planning for enhanced provision	Increased access to consistent, equitable stop smoking support	Higher quit rates across SEL	Reduced premature mortality from CVD
Local Stop Smoking services (LSSS) and Long-Term Plan (LTP) tobacco dependence treatment	Development of SEL data packs for service improvement	Improved co-ordination between LSSS and LTP services	Reduced smoking prevalence especially in Core20PLUS5 populations	Lower NHS demand and healthcare costs
Community engagement and mobilisation resources	Promotion of the Smokefree app and LSSS sign-ups	Increased public awareness and quit campaigns	Reduced CVD-related hospital admissions	Progress toward a smokefree generation in SEL
Data and digital tools for targeted approaches	Implementation of COSTED trials in EDs	Enhanced data recording and service delivery	Improved health and wellbeing	
Funding for service expansion and system-wide initiatives	Lung Cancer screening programme onsite smoking cessation support	Established community of practice to share evidence, best practices, and resources	Reduced smoking related health inequalities	
	Stop B4 Op and 'waiting well'' peri-operative pathways			
	Primary care and pharmacy engagement			
	Rollout of Swap to Stop imitative			
	Ottawa model fully implemented across acute mental health, and maternity services			

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Evaluating impact

Effective prevention requires focusing on whether interventions genuinely reduce deterioration, escalation, and complexity, particularly for populations at risk/ rising-risk of poorer health outcomes. Rather than measuring activity alone, systems should look for early indicators of impact, such as improved engagement, better self-management, and positive shifts in risk-factor trends. These short-term signals help demonstrate progress long before long-term health outcomes appear.

Evaluation needs to be embedded from the start, using a theory of change or logic model to guide what is monitored and why. Data collection should be integrated into existing workflows from the outset to minimise additional burden. Mixed-methods evaluation, combining quantitative data with insights from residents and community partners, ensures understanding of what works, for whom, and in which contexts. Economic tools such as financial ROI help guide investment towards interventions that deliver the greatest value.

To understand variation, prevention activity should be assessed by risk group, life-course stage, and neighbourhood, rather than relying on system-wide averages. Evaluating contribution – not attribution – is critical in complex systems: the aim is to understand how interventions plausibly influence outcomes, not to isolate them from wider system activity. Findings should be presented in simple, actionable formats (e.g., visuals, "continue / adapt / stop" recommendations) so frontline teams can quickly use them to improve practice.

Theories of change (ToC) explore how and why a programme/service achieves its intended outcomes and impacts. It answers questions like:

Which group(s) are you aiming to bring about change for and why?

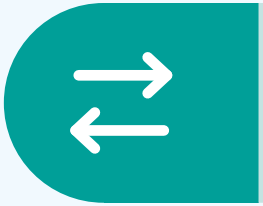
Which outcomes are intended to be achieved, for which groups, and in which timeframes?

Which activities are delivered, and how and why are they expected to bring about change?

Why are theories of change important?

Ensuring a ToC is evidence-based is the first step towards robust impact evaluation.

Helps measure whether services are being delivered with fidelity (as intended) and to understand the resources and activities required if scaled up or replicated



We need to understand what's going in to evaluate what's coming out of the programme/service to understand its impact

Click here to access real-life examples of theories of change used in delivering prevention initiatives.

Case Study 5 – Integrating Mental Health into Pulmonary Rehabilitation – includes a practical theory of change that clearly links activities to meaningful short- and long-term outcomes.

Evaluation Frameworks are structured tools which detail how ToC outcomes will be measured. It is essentially the measurement translation of the ToC. They do this by mapping ToC outcomes against:

- Evaluation or research questions.
- Indicators - observable signs of change (e.g., no. patients signposted to a service).
- Data collection methods (e.g., surveys).
- Data collection timescales.

Why are evaluation frameworks important?

Demonstrate how the ToC will be tested in practice.	Focus evaluations and research on what you really want to measure or understand.	Stay on the same page with other partners/ organisations, as they can act as a joint action plan.

Building local evaluation capability is essential so staff can collect, interpret, and act on data as part of everyday work, not just for reporting purposes.

Prevention efforts must also address health inequalities explicitly, checking who is benefiting and who is being left behind using detailed data and feedback from communities.

Finally, systems should track population-level signals over time, including demand, complexity, and service-mix trends, to understand the broader impact of prevention on the health and care system.

Supporting resources

Goodman, R. M. (1998). Principles and tools for evaluating community-based prevention and health promotion programs. Journal of Public Health Management and Practice, 4(2), 37–47 provides practical principles and tools for evaluating community-based prevention and health promotion programmes.

Click here to access our NHS Futures site for training materials on theories of change and evaluation frameworks and how to apply them to prevention programmes.

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Case study 5

Integrating Mental Health into Pulmonary Rehabilitation

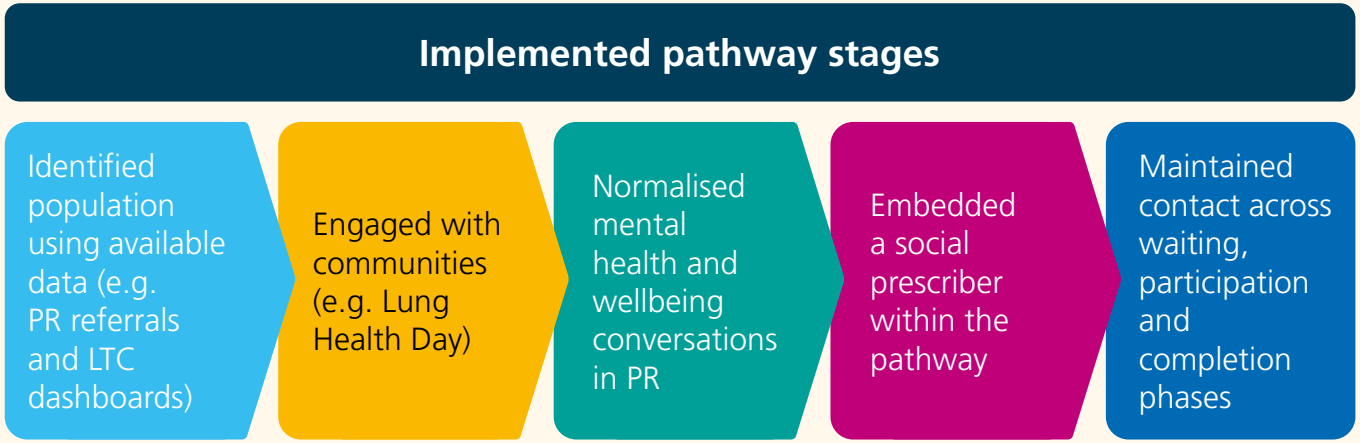
To tackle the challenges patients face beyond their physical health, a core Vital 5 project brought mental health and social prescribing into the heart of the Pulmonary Rehabilitation (PR) care pathway, helping more people start, stay engaged with, and successfully complete PR in SEL.

People living in deprived areas face a much higher risk of developing lung disease and are up to seven times more likely to die from it. Significant social factors such as poor housing, financial strain, smoking, worsening mental health, and limited support drive symptoms, admissions, and mortality.

Findings reported in 2024 showed around 1 in 5 respiratory patients in SEL had clinically significant anxiety and/or depression, contributing to low uptake and non-completion of Pulmonary Rehabilitation (PR).

PR is an evidence-based intervention that improves physical symptoms and mental health outcomes, but its benefits rely on patients being able to access and stay engaged.

We worked with members of the GSTT Integrated Respiratory Team and the Social Prescribing team at Improving Health Limited (a GP federation in Southwark) to address these barriers and reduce inequities by integrating social prescribing into the PR pathway – offering personalised, non-medical support designed to help people manage the social and psychological factors that influence their health and wellbeing.



This project is part of the **King's Health Partners Mind and Body Programme**, which focuses on the **integration of mental and physical healthcare** through evidencing and evaluating initiatives and implementing and scaling successful pilots, including the **IMPARTS** and **PEACS** projects and is informed by the Mind and Body Prevention Guide - *Evidence and guidance for earlier, more connected support*.

Integrating Mental Health into Pulmonary Rehabilitation Theory of Change

Population focus

Inclusion criteria

Residents with respiratory conditions who are eligible for and have been referred for PR and:

1. Would benefit from PR but have declined; or
2. are waiting for PR; or
3. are undergoing PR, including residents who have recently disengaged from their PR course; or
4. Have recently completed PR.

Exclusion criteria

Residents experiencing uncontrolled mental health issues or addictions are not eligible for SP support and should be signposted elsewhere

Inputs

Funding

Vital 5 Health Inequalities funding of £50k, initially for a year.

Staff and providers

A Social Prescribing Link Worker is embedded in the PR team and supported by a Social Prescribing Link Lead.

Space and facilities

Consultation rooms in PR clinic. Home and community SP visits.

Activities

Promotion activities

Resident awareness raised through

1. Referrers and PR staff
2. Media (e.g. newsletters, posters, videos), and
3. Leaflets distributed at completion of PR

Engaging residents

Referrers promote support from the SP as a motivator for PR. For residents who refuse PR, referrers explore reasons and consider referral to the SP. For disengaged residents, SP proactively follows up.

Social Prescriber support

- The SP may use eligible residents' PHQ9 and GAD7 scores for prioritisation. SP will ask residents to complete ONS4.
- Group education sessions on mental health and wellbeing, social prescribing and local VCSE services.1:1 support for residents facing social or mental health barriers to PR – support includes exploring barriers, signposting, accompanying appointments and advocating for residents (e.g. housing, welfare, arts, wellbeing, food banks, physical movement)Dependent on capacity and demand, additional initiatives may be offered, e.g. monthly peer support club with SEL Active (gentle exercise and socialising)

Partnership working

SP collaborates with VCSE partners (e.g. Everyone Health, Everyone Active) to connect residents with local opportunities and expand tailored activities (e.g. walking groups) for those completing or post PR

Discharge

Residents remain on SP caseload until safe discharge. End of engagement: ONS4, PHQ9 and GAD7 completed. Residents informed SP support is still available post-PR.SP provides follow-up check-in call.

Mechanisms of change

These mechanisms sit on top of the existing PR programme being delivered, whereby the SP's role is likely to enhance existing programme benefits through improved engagement

- Proactive, tailored support from SP addresses residents' concerns and reduces barriers to accessing PR. This results in residents accessing PR and associated programme benefits
- SP builds and shares knowledge of local opportunities for physical, social and mental wellbeing activities. Reinforcing PR benefits.
- SP and SP Link Lead build relationships with PR, VCSE, wider SP networks and longer-term partnerships with delivery organisations and VCSE.
- PR staff teaching increases awareness of SP role.

Outputs

- Number of residents contacts by SP
- Number of residents who engage with SP (number and type of appointments, stratified by declining PR, waiting, enrolled, completed)
- Number of group education sessions delivered
- Number of PR decliners who go on to have a referral to, enrol in or complete PR
- Number of pre- and post-questionnaires collected
- Baseline and changes experienced in PR metrics (chronic respiratory disease questionnaire, incremental shuttle walk test, PHQ9 and GAD7

Shorter-term outcomes

Resident level outcomes

- Residents access support for social and wellbeing concerns (e.g. housing, legal welfare, benefits, mental health), enabling them to engage in PR. More residents therefore benefit from core PR outcomes:
  - Increased lung function, muscular endurance and cardiovascular health leading to reduced breathlessness during daily activities and ability to walk further.
  - Gaining confidence and ability to be more active and exercise safely.
  - Gaining knowledge and ability to manage their lung condition
- Residents engage in more movement and physical activity
- Residents engage in more social activities
- Sense of community and belonging
- Improved MH scores
- Reduction in anxiety or depression in residents

Service-level outcomes

- Increased awareness of PR among Primary Care, VCSE and SP networks
- Increased awareness of SP, services and opportunities among PR team.

Longer-term outcomes

Resident level outcomes

- Sustained improvement in physical activity
- Reduced loneliness
- Enhanced mental and physical health outcomes through improved self-management and access to appropriate support.

Service-level outcomes

- Improved uptake and retention for PR
- PR staff have stronger knowledge of and relationships with SP team, freeing up PR staff time from exploring social barriers to engagement
- PR staff have improved understanding of the needs of the target group and suitability of local support offer
- Reduction in residents attending GP for non-medical issues
- Residents managing conditions better after PR leads to fewer repeat enrolments in PR

PR = Pulmonary Rehabilitation SP = Social Prescriber

Key learnings

- Practical support (housing, benefits, navigation) help to reduce overwhelm.
- Emotional reassurance and continuity supported re-engagement.
- PR staff time was freed up, as social prescribers took on non-clinical problem-solving that had previously fallen to clinicians.
- Enhancing understanding and confidence of staff in mental health and wellbeing was a key enabler of this work.

Early evidence of impact

- Improved engagement with PR was observed for some residents who would otherwise have dropped out.
- There were clear qualitative improvements in stress levels, confidence, and emotional stability, as reported through resident feedback and practitioner observations.
- At least 32 residents who had previously declined interventions accepted re-referral to PR specifically because of the support provided through social prescribing demonstrating its role in overcoming barriers that traditional pathways could not address.

Next steps

- More data are needed to understand whether improved engagement translates into consistently higher completion across the pathway.
- Current insights are positive but largely qualitative; longitudinal follow-up is needed to assess sustained benefit.
- Further evaluation is required to understand whether the model delivers value for money when expanded across the system.
- The Social Prescribing Link Worker role has been extended for a further 12 months to allow deeper embedding of the service and provide more time for robust data collection.
- To build a fuller, more equitable picture of impact, we plan to undertake an equality impact analysis in summer 2026 to understand who has benefited and where gaps remain.

For more information see mental health courses for SEL Health and Social Care Staff **here**

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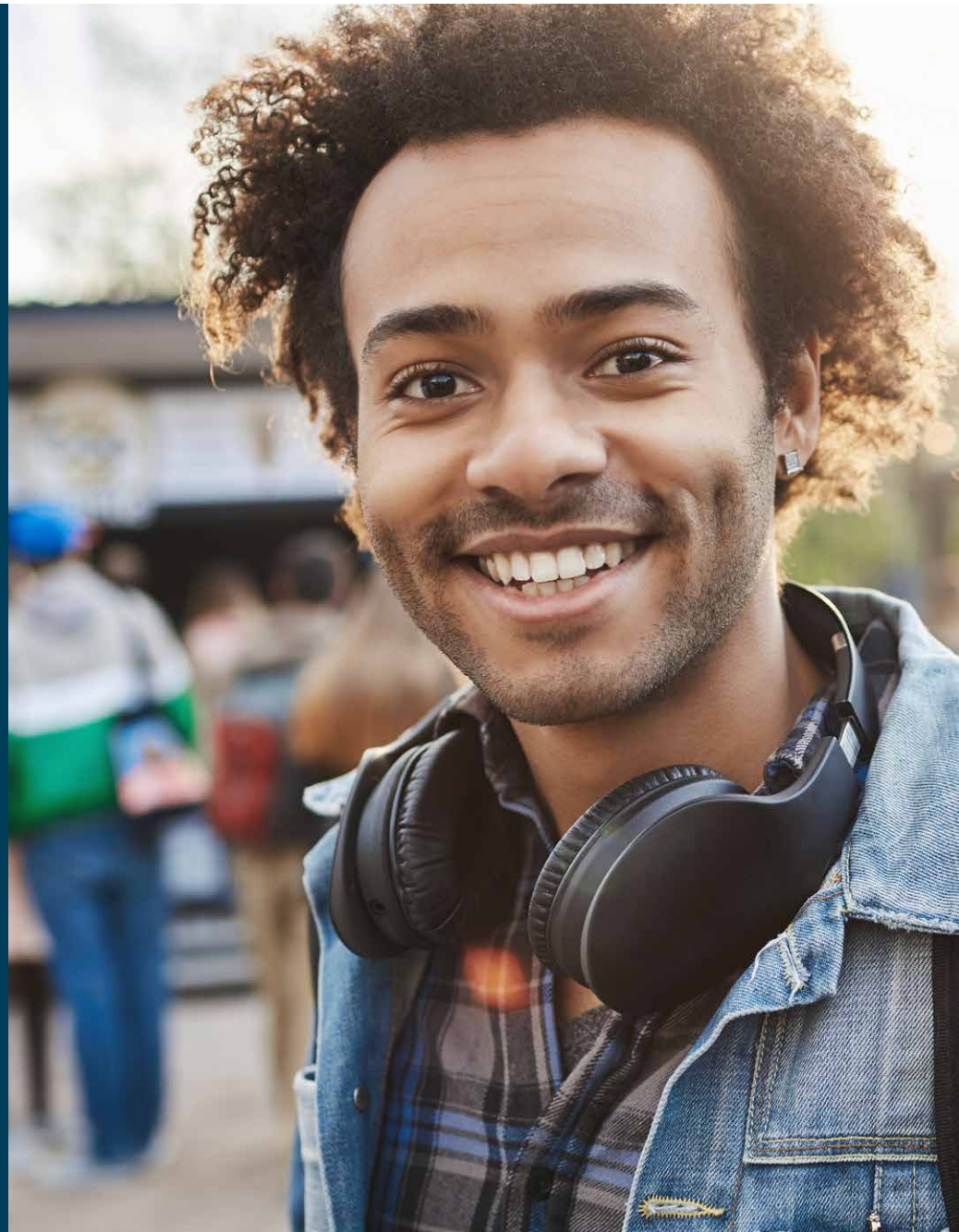
Insights

Do

- Build mental health into existing long-term condition touchpoints
- Invest in roles that address social determinants
- Co-design language, pathways and touchpoints with patients
- Agree evaluation measures from the outset
- Start with lived experience - provide multiple touchpoints so people can express their needs
- Address readiness and patient activation - support people before and around the intervention, not only during the programme itself
- Embed non-clinical support within the clinical pathway - social prescribing must be embedded within PR, not delivered as an external add-on
- Design with equity in mind - Effective prevention models must assume complexity, rather than relying on the idea of 'motivated' patients who can engage without wider support

Don't

- Design standalone mental health pilots disconnected from core pathways.
- Over-rely on referral/signposting alone
- Treat prevention as 'early intervention only'



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Supporting information

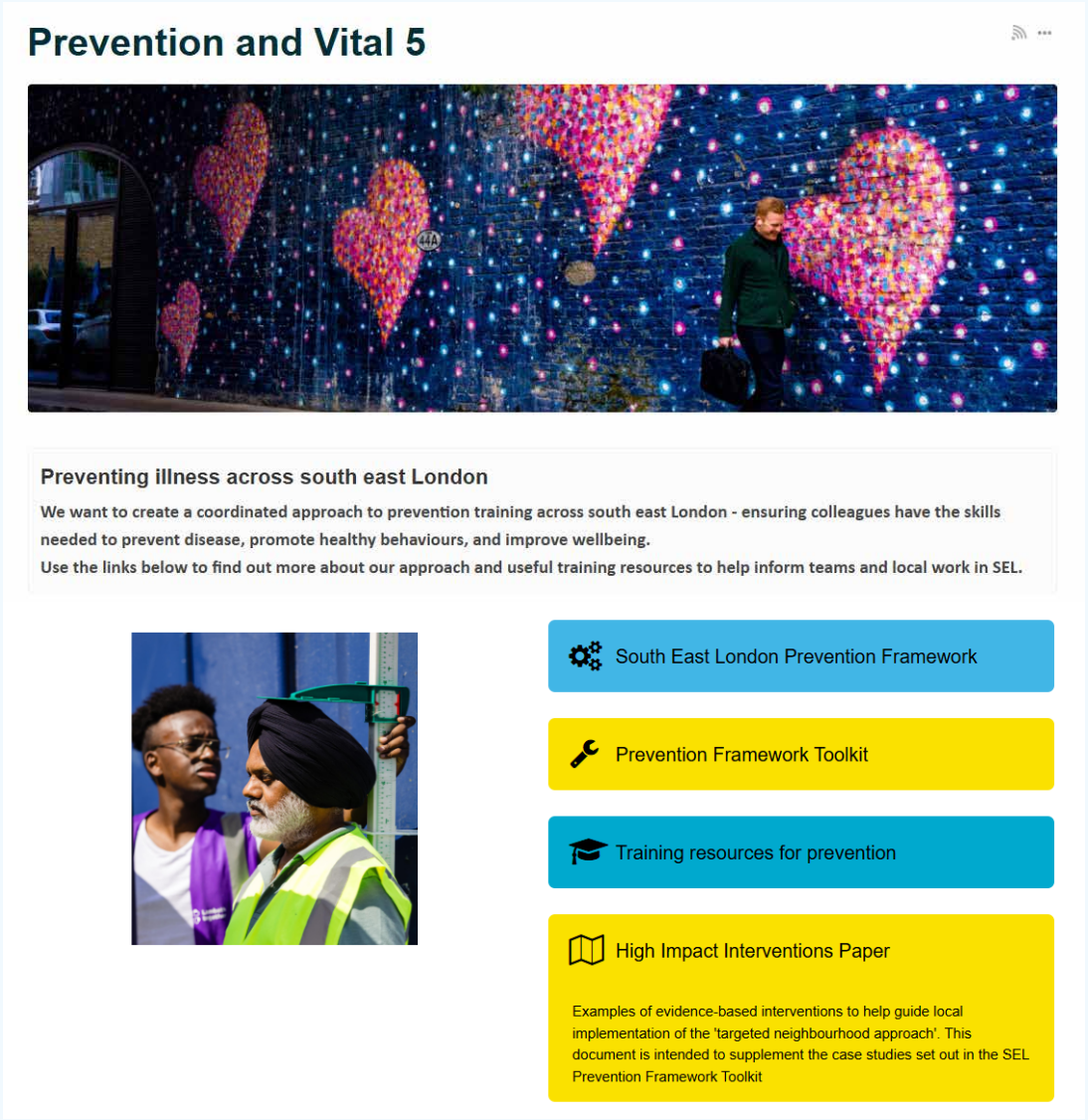
Education and resources

A range of resources and training for ICS staff covering the Vital 5 and prevention is available on our Future NHS workspace.

This includes training for each Vital 5 risk factor area (healthy blood pressure, healthy mind, stop smoking, drinking less, healthy weight), as well as links to prevention and inequalities training and education from across the country.

NHS staff can use the workspace by visiting our homepage and requesting access there. Non-NHS staff will need to send an email request to be granted access. If you have any suggestions or feedback, please contact preventionandequity@kcl.ac.uk

You can find a downloadable copy of this toolkit on our Future NHS Workspace, including up to date and expanded resource links.



Abbreviations

CVD	Cardiovascular disease
CAMHS	Child and Adolescent Mental Health Services
COSTED	Cessation of Smoking Trial in the Emergency Department
CYP	Children and Young People
HCP	Health Care Professional
ICB	Integrated Care Board
ICS	Integrated Care System
INT	Integrated Neighbourhood Team
ICER	Incremental Cost-Effectiveness Ratio
KPI	Key Performance Indicator
LARC	Long-acting reversible contraception
KHP	King's Health Partners
LSSS	Local Stop Smoking Services
LTP	Long Term Plan
ROI	Return on Investment
SROI	Social Return on Investment
SEL	South East London
SMI	Serious Mental Illness
STAR	Socio-Technical Allocation of Resources
VCSE	Voluntary, Community, and Social Enterprise
WHO	World Health Organization

References

(1) Unlocking prevention in integrated care systems NHS Confederation in partnership with Carnall Farrar (2024)

(2) Scotland's Population Health Framework, COSLA and Scottish Government. (2025)

(3) UK health: Focus on prevention can deliver £8 for each £1 invested. Deloitte UK. (2025).

(4) Brousselle, A., Benmarhnia, T., & Benhadj, L. (2016). What are the benefits and risks of using return on investment to defend public health programs? Preventive Medicine Reports, 3, 135–138.

(5) Funnell, S. C., & Rogers, P. J. (2011). Purposeful Program Theory: Effective Use of Theories of Change and Logic Models. San Francisco, CA: Jossey-Bass.